Evaluation of Quality Improvement Program Plan Effectiveness FY2020
Community Mental Health Authority of Clinton, Eaton and Ingham Counties

Table of Contents

Overview

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

Performance Indicators

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

Changes in PI reporting standards were adopted beginning FY 20 Q3, which removed exceptions and exclusions for Indicators 2 and 3, while also eliminating the 95% standard for those indicators.

Indicator #1: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95%
Indicator #2: The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. Standard = 95% for Q1 and Q2, no standard for Q3 or Q4
Indicator #3: Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional. Standard = 95% for Q1 and Q2, no standard for Q3 or Q4
Indicator #4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. Standard = 95%
Indicator #10: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less

FY19 Performance Indicator Results: Medicaid Only

Indicator	Q1	Q2	Q3	Q4	Total
PI 1	97.23%	96.96%	98.29%	97.39%	97.47%
PI 2	96.76%	97.32%	68.70%	68.07%	N/A
PI 3	95.56%	96.44%	64.84%	68.93%	N/A
PI 4	94.62	93.59%	95.63%	100%	95.96
PI 10	9.83%	8.25%	19.05%	15.32%	13.11%

FY19 Performance Indicator Results: Full Population

Indicator	Q1	Q2	Q3	Q4	Total
PI 1	97.86%	97.00%	98.32%	97.46%	97.66%
PI 2	96.42%	97.43%	70.42%	54.65%	N/A
PI 3	96.14%	96.39%	63.73%	68.89%	N/A
PI 4	93.51%	94.94%	93.53%	98.81%	95.20%
PI 10	9.02%	8.12%	18.21%	14.62%	12.49%

Indicators were submitted to MSHN and MDHHS quarterly. Clinical programs have implemented plans of corrections for Indicator 4 and Indicator 10 at various points throughout the year.

Diabetic Monitoring for Individuals with Schizophrenia and Diabetes

Michigan Department of Health and Human Services (MDHHS) requires the Prepaid Inpatient Health Plan (PIHP) to participate in performance improvement projects in accordance with the Balanced Budget Act of 1997 (BBA). The performance improvement project (PIP) should improve the outcomes of the care for the population in which the PIHP serves and be reported and reviewed as part of the CMHSP Quality Assessment and Performance Improvement Program (QAPIP). Health Services Advisory Group (HSAG) serves as the External Quality Review Organization contracted by MDHHS to conduct a validation process for the PIHP annual PIP submission. The validation process will result in a "Met" or "Not Met" Status based on the compliance with 30 defined elements.

Baseline data for the measurement period of January 1, 2018 through December 31, 2018 (CY18) indicated that MSHN had a rate of 33.6 percent (294/874). Figure 1 illustrates the goal of a 7% increase from baseline (33.64%) to be 35.99% for CY19 and CY20. A statistically significant increase is required to demonstrate "real improvement". MSHN demonstrated an improvement, however, did not achieve a statistically significant improvement. Therefore, the standard of "real improvement" was not met. This resulted in a HSAG validation score of "Not Met".

The current measurement period (August 31, 2019 -August 31,2020) demonstrates a decrease in performance. CEI had a baseline of 30.69%, a rate of 26.8% for CY19 with a goal of 35.99%. For CY20 the PIP Goal for CEI is a rate of 36.4%, whereas meeting the Target of 36.8% would show significant increase which is required to demonstrate "real improvement".

Organization	Baseline CY18	PIP Goal CY19	CY19	PIP Goal CY20	Target CY20
MSHN	**33.64%**	**35.99%**	**36.1%**	**36.4%**	38.6%
BABH	32.04%	**35.99%**	34.3%	**36.4%**	38.6%
CEI	30.69%	**35.99%**	26.8%	**36.4%**	38.6%
CMHCM	31.30%	**35.99%**	31.7%	**36.4%**	38.6%
GIHN	40%	**35.99%**	23.5%	**36.4%**	38.6%
HBH	26.67%	**35.99%**	38.5%	**36.4%**	38.6%
The Right Door	33.68%	**35.99%**	37.9%	**36.4%**	38.6%
LifeWays	39.29%	**35.99%**	44.4%	**36.4%**	38.6%
MCN	40%	**35.99%**	33.3%	**36.4%**	38.6%
NCMH	32.52%	**35.99%**	36.8%	**36.4%**	38.6%
Saginaw	52.94%	**35.99%**	40.0%	**36.4%**	38.6%
Shiawassee	41.67%	**35.99%**	22.2%	**36.4%**	38.6%
TBHS	53.33%	**35.99%**	57.7%	**36.4%**	38.6%

Recovery Assessment

Introduction

The following overview of Mid-State Health Network's (MSHN) Recovery Self-Assessment (RSA) 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 Administrator and Provider Assessments. The survey results were aggregated and scored as outlined in the Yale Program for Recovery and Community Health instructions.

Figure 1 MSHN RSA-R Number of Respondents

Program	Administrators		Providers	
	2019	2020	2019	2020
Mid-State Health Network Total	195	124	435	397
Bay-Arenac Behavioral Health Authority	24	11	45	46
Community Mental Health Authority of CEI	4	10	40	50
Community Mental Health for Central Michigan	26	16	41	57
Gratiot Integrated Health Network	6	4	15	27
Huron Behavioral Health	5	4	0	3
LifeWays Community Mental Health	2	5	16	37
Montcalm Care Center	17	5	23	20
Newaygo County Community Mental Health	13	6	24	21
Saginaw County Community Mental Health	20	9	30	26
Shiawassee County Community Mental Health	7	11	0	10
The Right Door for Hope Recovery and Wellness	19	8	28	0
Tuscola Behavioral Health System	2	2	6	13
MSHN SUD Providers	50	35	167	87

The distribution period was June 1, 2020 through June 30, 2020 and this marks the fifth year of implementation for the CMHSP Participants for the RSA-R Administrators Assessment and the second year for the CMHSP Participants and SATP for the RSA-R Provider Assessment. The RSA-R Administrator Assessment is completed by administrators who do not provide direct services to individuals. The RSA-R Provider Assessment is completed by providers who, in

addition to their administrative functions, provide 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 and SAPT 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 may be sent to Sandy Gettel, Quality Manager at sandy.gettel@midstatehealthnetwork.org

MSHN Summary

The responses from the Recovery Self-Assessments were scored as a comprehensive total, separately as six subcategories, and by individual question. The comprehensive score measures how the system is performing, and the subcategories measures the performance of six separate groups of questions. The individual response score for each question in the subcategories is included to assist in determining potential action steps. 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." A mean score of 3.50 or higher indicates agreement with the statements included in the measurement category. 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 and the CMHSP Participants have participated in the RSA-R Administrators Assessment since 2015. MSHN incorporated the Substance Abuse Treatment Providers (SATP) into the RSA-R Administrator Assessment Project and began implementation of the RSA-R Provider Assessment for the CMHSP Participants and the SATP in 2019. The expectation is that MSHN will demonstrate improvement by identifying growth areas from the results, implement action steps, and strengthen the recovery-oriented systems of care provided within the region.

MSHN Comprehensive Summary

MSHN, inclusive of the CMHSP Participants and the SATP, has demonstrated an increase in the comprehensive score for the RSA-R Administrator Assessment since 2015 and the RSA-R Provider Assessment since the addition of the assessment to the project in 2019. Figure 2 demonstrates the progression of the comprehensive score of the Administrator Assessment since 2015. Apart from the Involvement subcategory for 2016 and the Individually Tailored Services subcategory for 2020 , improvement has been demonstrated in each subcategory since 2015. Figure 3 demonstrates the progression of the RSA-R Provider Assessment since its onset in 2019.

Figure 2. MSHN RSA-R Administrator Assessment Comprehensive Score and Subcategory Comprehensive Scores

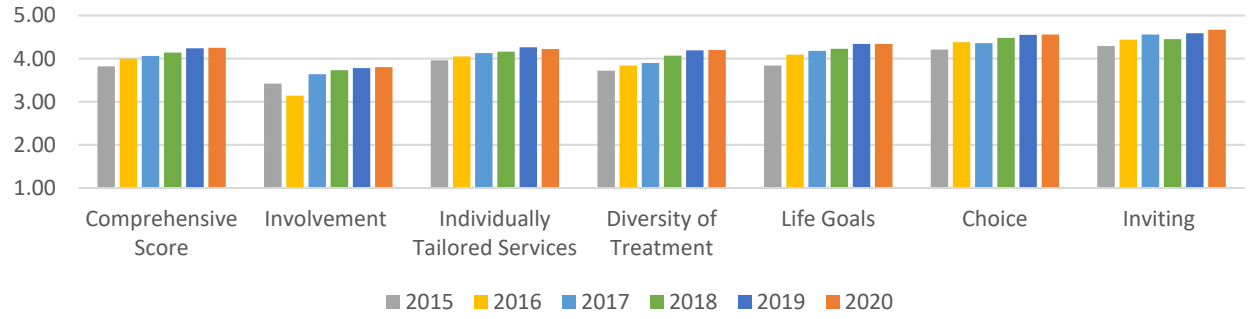


Figure 3. MSHN RSA-R Provider Assessment Comprehensive Score and Subcategory Comprehensive Scores

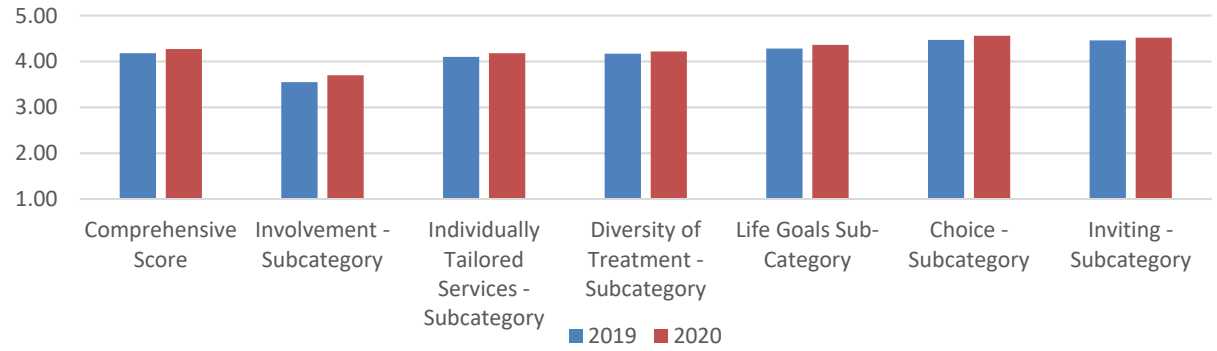


Figure 4. MSHN Comprehensive Score RSA-R Administrator and RSA-R Provider Assessments

	RSA-R Provider Assessment		RSA-R Administrator Assessment	
	2019	**2020**	**2019**	**2020**
Comprehensive Score	4.18	4.27	4.24	4.25
Involvement - Subcategory	3.55	3.70	3.78	3.80
Individually Tailored Services - Subcategory	4.10	4.18	4.26	4.22
Diversity of Treatment - Subcategory	4.17	4.22	4.19	4.20
Life Goals Sub-Category	4.28	4.36	4.34	4.34
Choice - Subcategory	4.47	4.56	4.55	4.56
Inviting - Subcategory	4.46	4.52	4.59	4.67

Figure 4a. MSHN RSA-R Provider and Administrative Assessment Comprehensive Score for Service Program Type

	Provider Assessment					Administrator Assessment			
	2019		2020			2019		2020	
Club House	(n=18)	3.91	(n=20)	4.41		(n=18)	4.16	(n=16)	4.33
Case Management/Supports Coordination	(n=166)	4.19	(n=187)	4.26		(n=85)	4.28	(n=88)	4.25
Intensive Outpatient Therapy	(n=30)	4.28	(n=18)	4.22		(n=27)	4.41	(n=30)	4.43
Outpatient Therapy	(n=215)	4.18	(n=162)	4.21		(n=82)	4.31	(n=78)	4.36
Substance Use Disorder (SUD) Residential	(n=63)	4.13	(n=24)	4.21		(n=27)	4.41	(n=20)	4.57
Assertive Community Treatment (ACT)	(n=23)	4.33	(n=33)	4.24		(n=20)	4.25	(n=21)	4.19
Vocational	(n=25)	4.46	(n=34)	4.48		(n=20)	4.31	(n=14)	4.31
Detox	(n=29)	4.14	(n=9)	4.08		(n=13)	4.29	(n=11)	4.58
Other						(n=27)	4.20		

The comprehensive score for each CMHSP Participant and SATP Administrator Assessment (Figure 5) and the Providers Assessment (Figure 6) illustrate performance above 3.50 indicating general agreement with the statements in the assessment.

Figure 5. CMHSP Participant and SATP RSA-R Administrator Comprehensive Assessment Scores

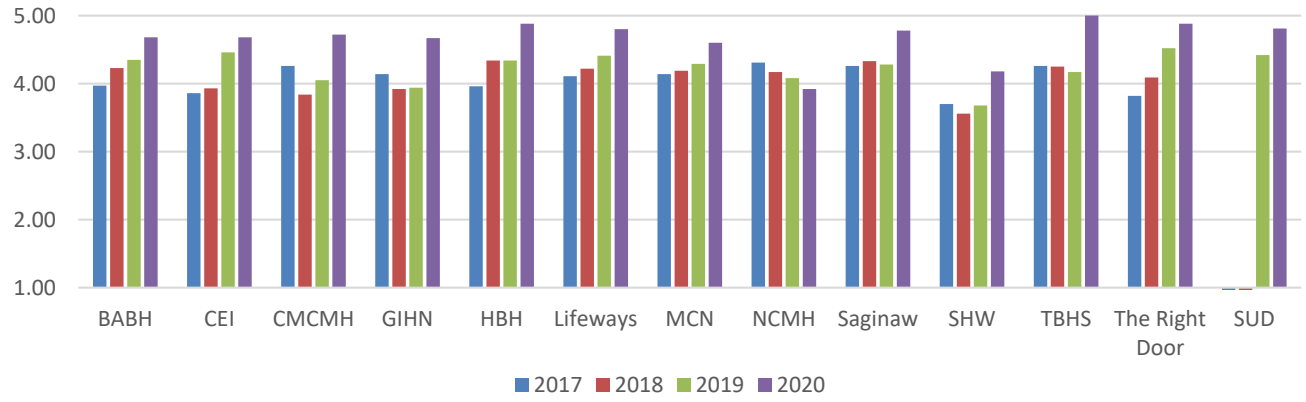
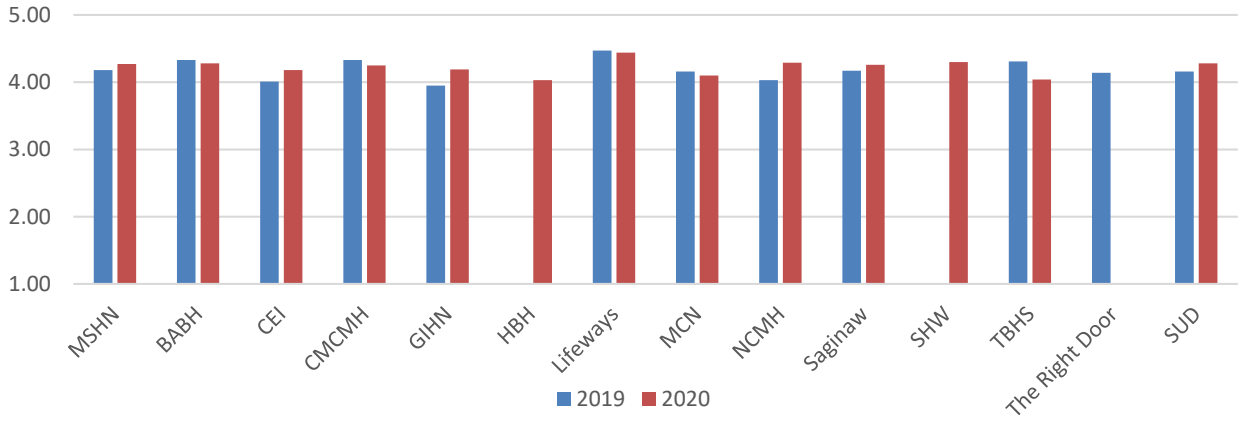


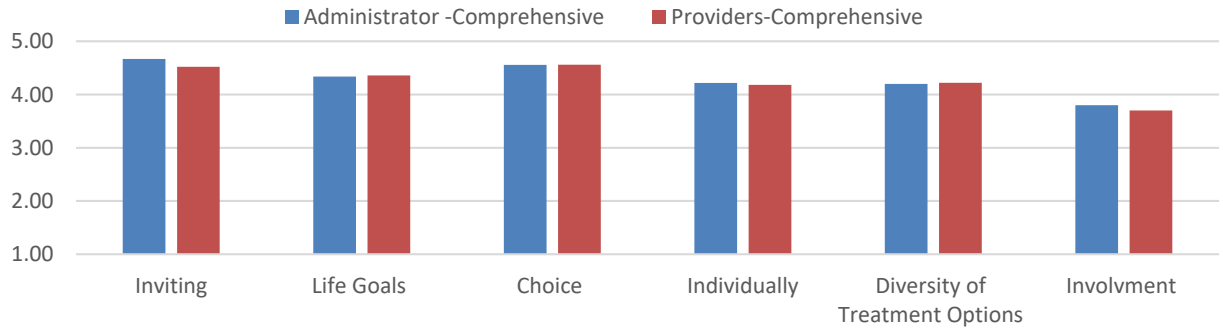
Figure 6. CMHSP Participant and SATP RSA-R Provider Comprehensive Assessment Scores



MSHN Subcategory Summary

The MSHN responses from the RSA-R Administrator Assessment and the RSA-R Provider Assessment were separated by each subcategory. The MSHN CMHSP Participants and SATP RSA-R Administrator Assessment comprehensive score and the RSA-R Provider Assessment comprehensive score for each subcategory as illustrated in Figure 7 demonstrated a score above 3.50, indicating satisfaction or agreement with the statements included in each subcategory.

Figure 7. FY20 RSA-R Administrator and Provider Assessment Comprehensive Subcategory Comparison



Inviting Subcategory

The comprehensive score for both the Administrator and the Provider Assessment was above 3.50 indicating agreement or satisfaction with the statements included in the Invite subcategory. Figure 8 illustrates how MSHN and each CMHSP Participant and SATP responded to the Invite subcategory for FY2020.

Figure 8. CMHSP Participants and SATPs Comparison of FY20 Invite Subcategory Score

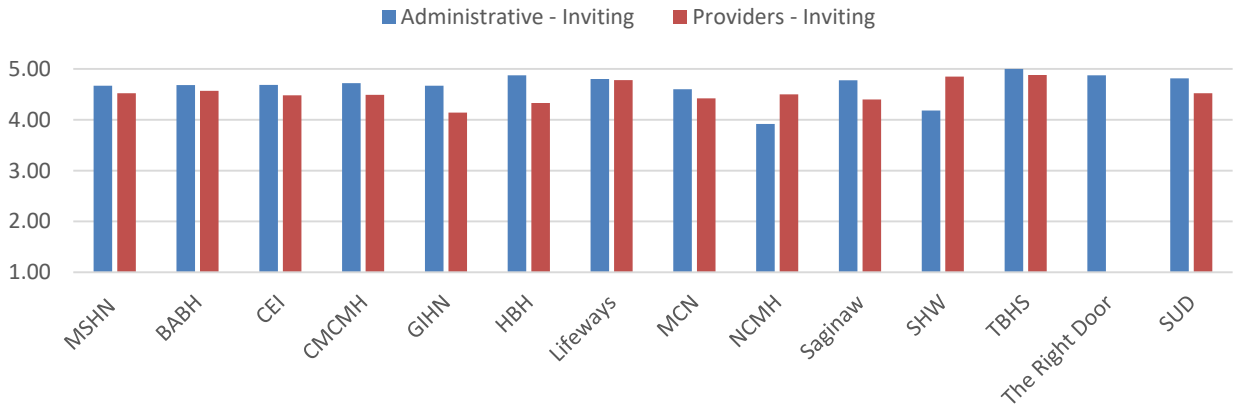


Figure 8a. CMHSP Participants and SATPs comparison of FY20 Invite Subcategory Score with Questions-Administrator Assessment

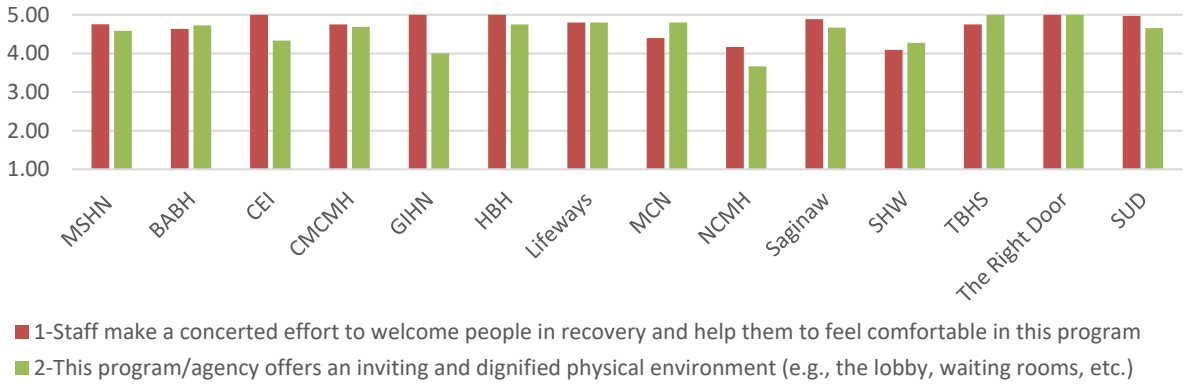


Figure 8b. CMHSP Participants and SATPs comparison of FY20 Invite Subcategory Score with Questions-Provider Assessment

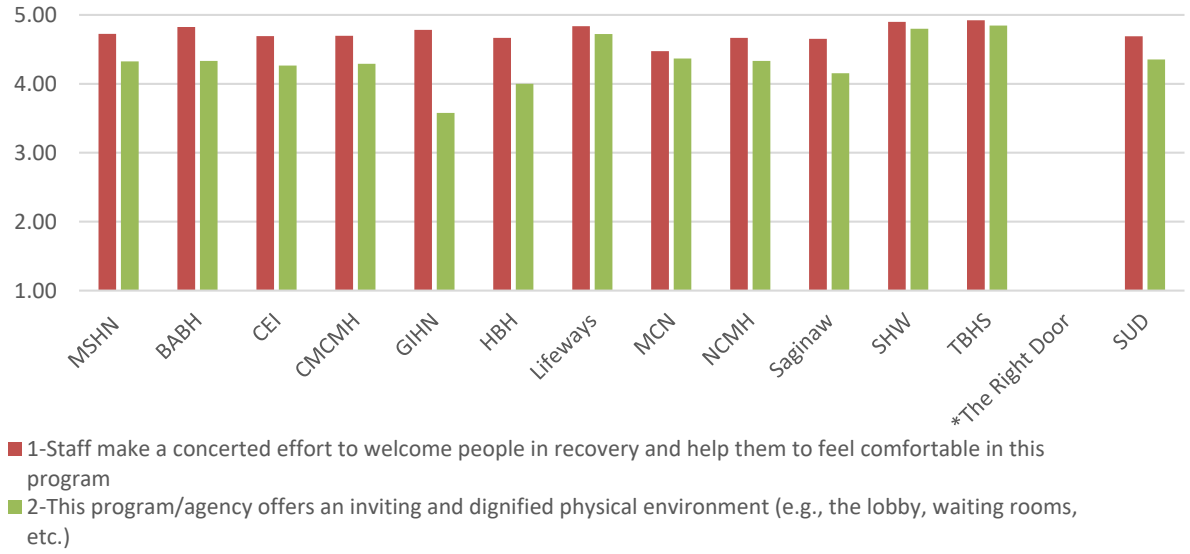
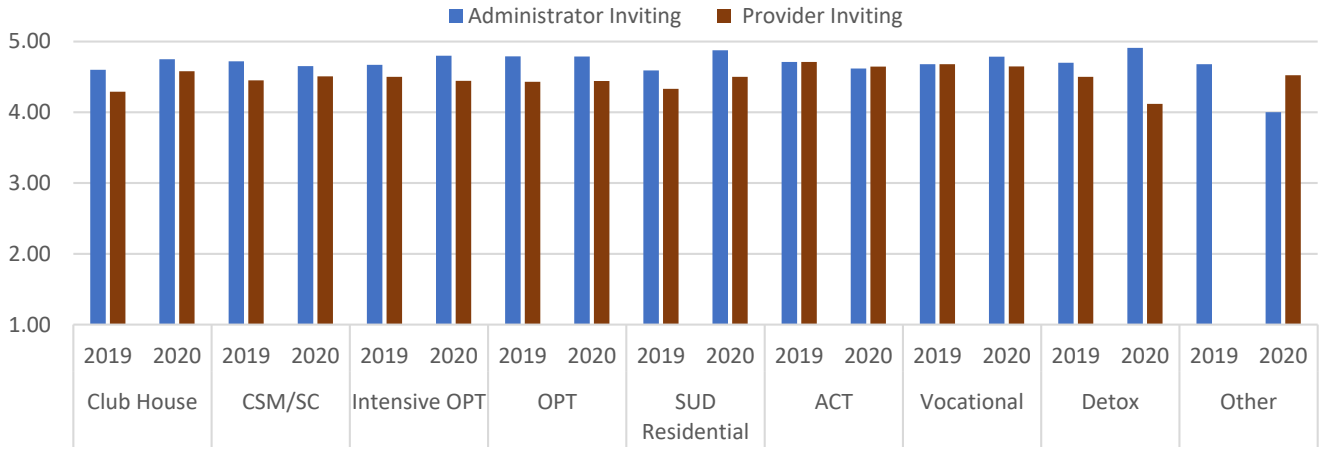


Figure 8c. Service Program Type comparison of the FY20 Inviting Subcategory with the Provider and Administrator Assessments



Choice Subcategory

The comprehensive score for both the Administrator and the Provider Assessment was above 3.50 as illustrated in Figure 9 indicating agreement or satisfaction with the statements included in the Choice subcategory. Figures 9a-9b illustrates how each CMHSP and the SATP scored for each question within the subcategory by RSA-R assessment type. Figure 8c illustrates the comprehensive score of the subcategory by service program type.

Figure 9. CMHSP Participants and SUD Provider Network Comparison of FY20 Choice Subcategory Score

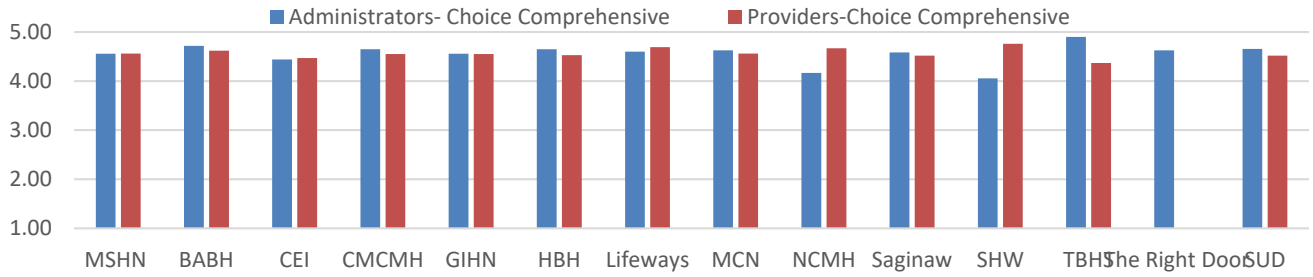


Figure 9a. CMHSP Participants and SATPs comparison of FY20 Choice Subcategory Score with Questions-Administrator Assessment

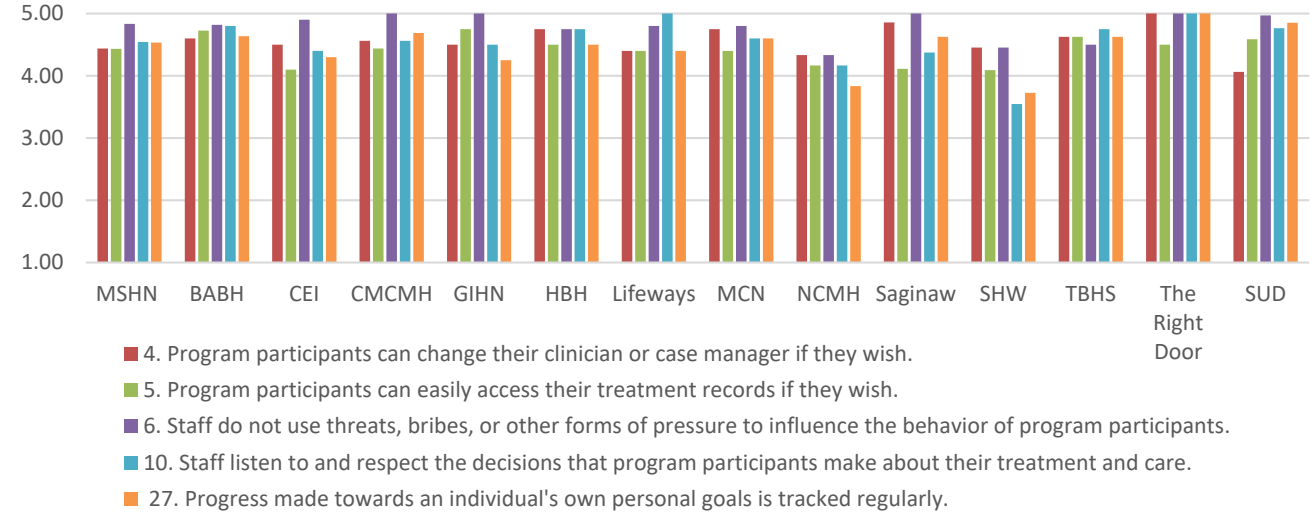


Figure 9b. CMHSP Participants and SATPs comparison of FY20 Choice Subcategory Score with Questions-Provider Assessment (*No Responses from Organization)

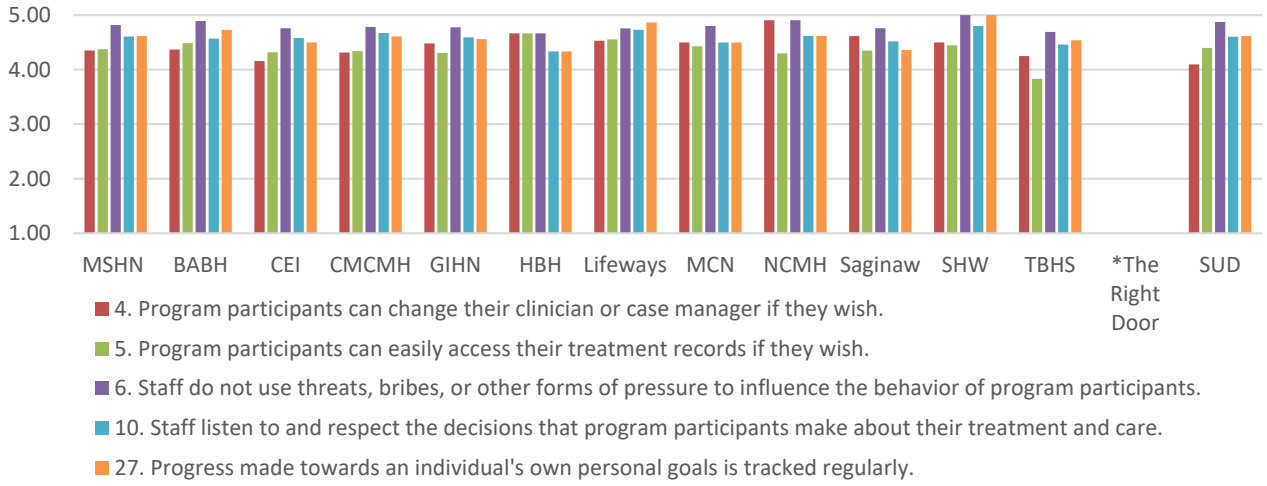
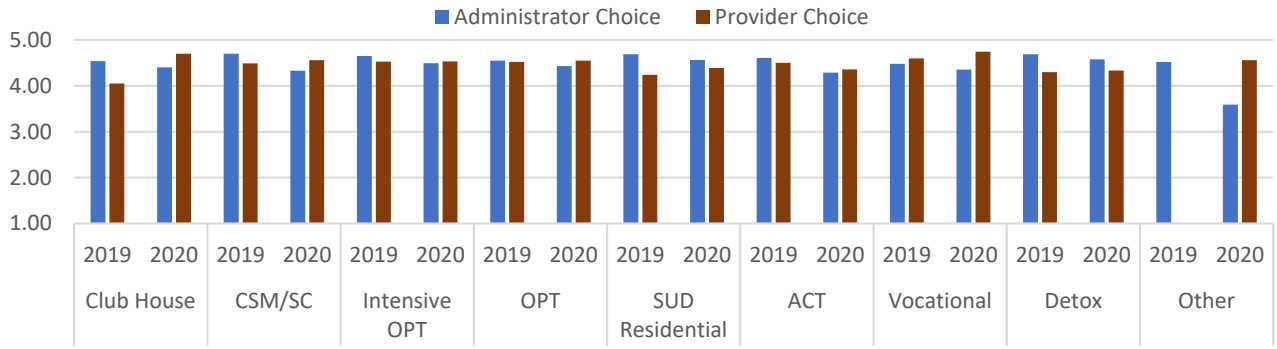


Figure 9c. Service Program Type comparison of the FY20 Choice Subcategory with the Provider and Administrator Assessments



Involvement Subcategory

The comprehensive score for both the Administrator and the Provider assessment for MSHN was above 3.5 as illustrated in Figure 10, indicating agreement or satisfaction with the statements included in the Involvement subcategory. Three CMHSP Participants scored below 3.50 for both the Administrative and the Provider assessment. 10a illustrates how each CMHSP Participant and SATP responded to each question within the Involvement subcategory administrator assessment. Figure 9b illustrates how each CMHSP Participant and the SATP responded to each question within the Involvement subcategory provider assessment. Figure 10c illustrates how each CMHSP Participant and SATP scored by service program type.

Figure 10. CMHSP Participants and SATP comparison of FY20 Involvement Subcategory Score

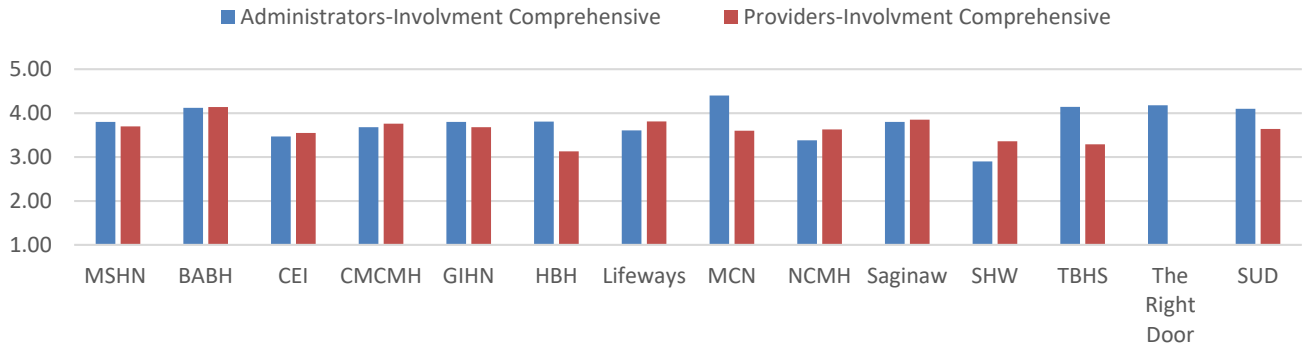


Figure 10a. CMHSP Participants and SUD Provider Network comparison of FY20 Involvement Subcategory Score with Questions-Administrator Assessment

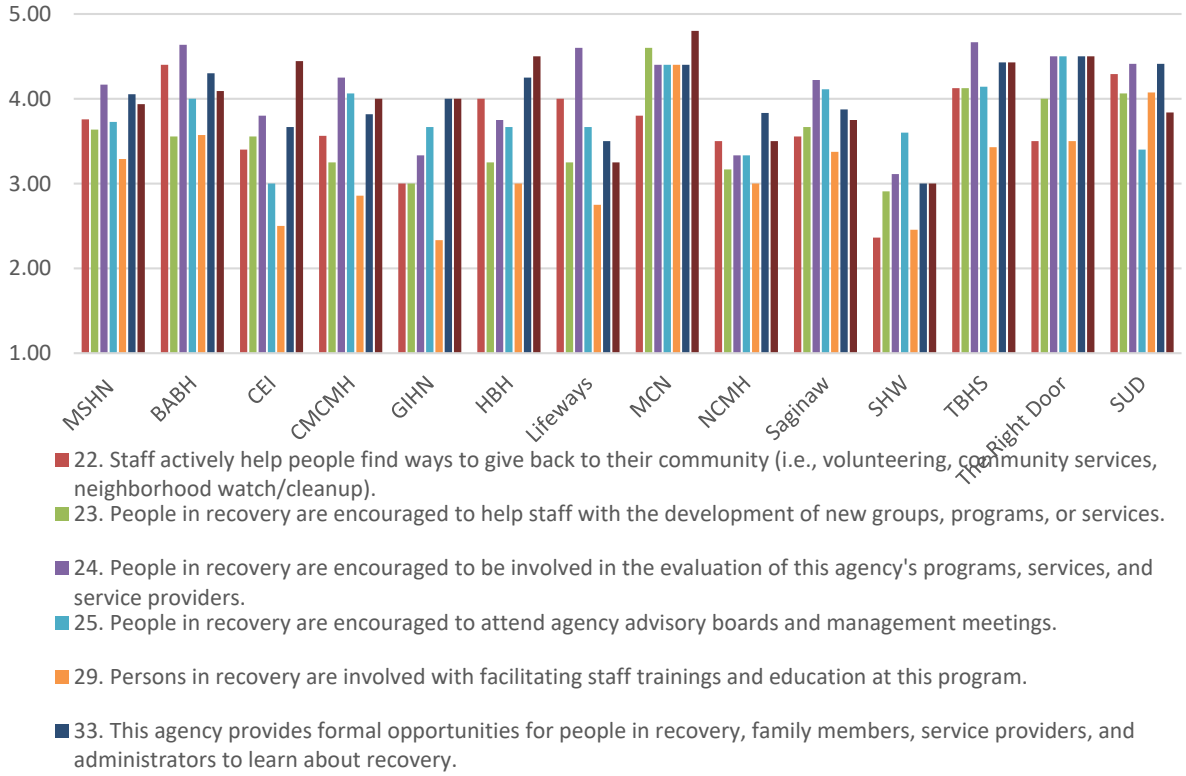
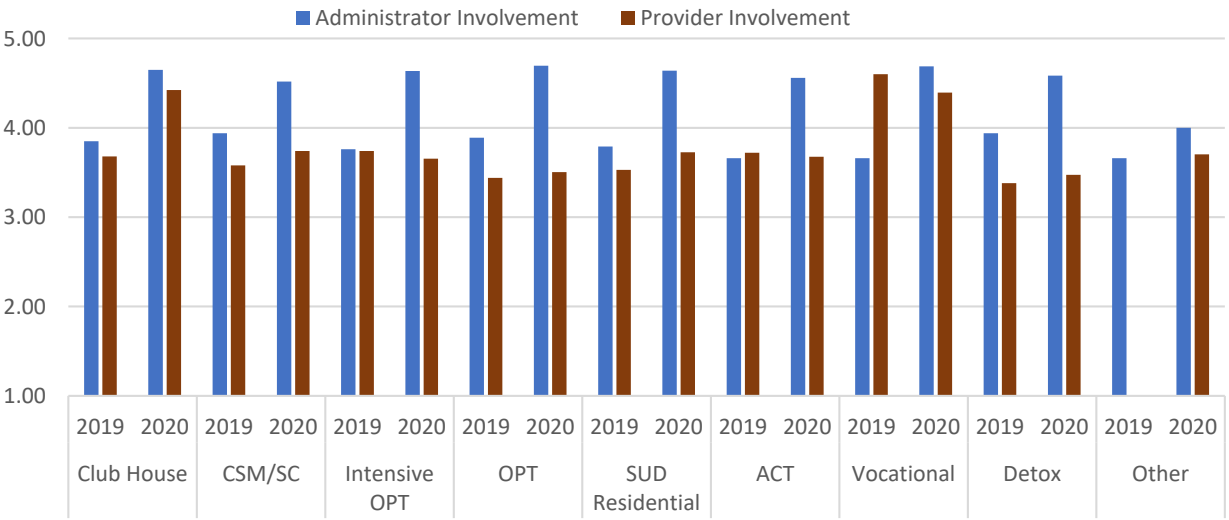


Figure 10b. CMHSP Participants and SUD Provider Network comparison of FY20 Involvement Subcategory Score with Questions-Provider Assessment (*No Responses from Organization)

Figure 10c. Service Program Type comparison of the FY20 Involvement Subcategory



Life Goals Subcategory

The comprehensive score for both the Administrators Assessment and the Provider Assessment was above 3.5 as illustrated in Figure 11, indicating agreement or satisfaction with the statements included in the Life Goals subcategory. Figure 11a-11b illustrates how each CMHSP Participant and SATP responded to the Life Goals subcategory administrator assessment. Figure 11c-11d illustrate how each CMHSP Participant and the SATP responded to the Life Goals provider assessment. Figure 10e demonstrates how each CMHSP Participant and the SATP scored by service program type.

Figure 11. CMHSP Participants and SATP Comparison of FY20 Life Goals Subcategory Score (*No Responses from Organization)

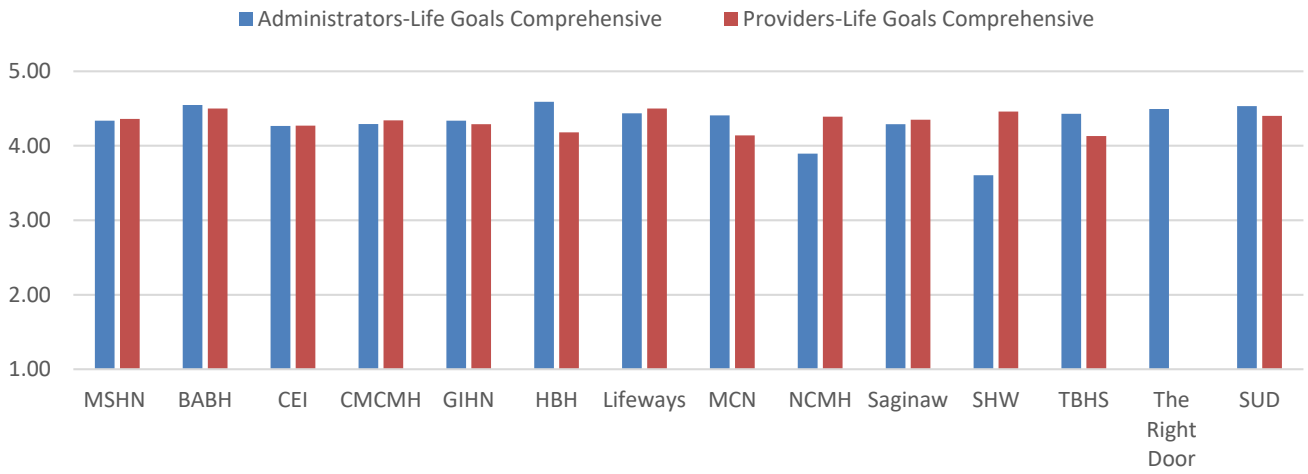


Figure 11a. CMHSP Participants and SATP comparison of FY20 Life Goals Subcategory Score with Questions-Administrator Assessment (Questions 3, 7, 8, 9, 12)

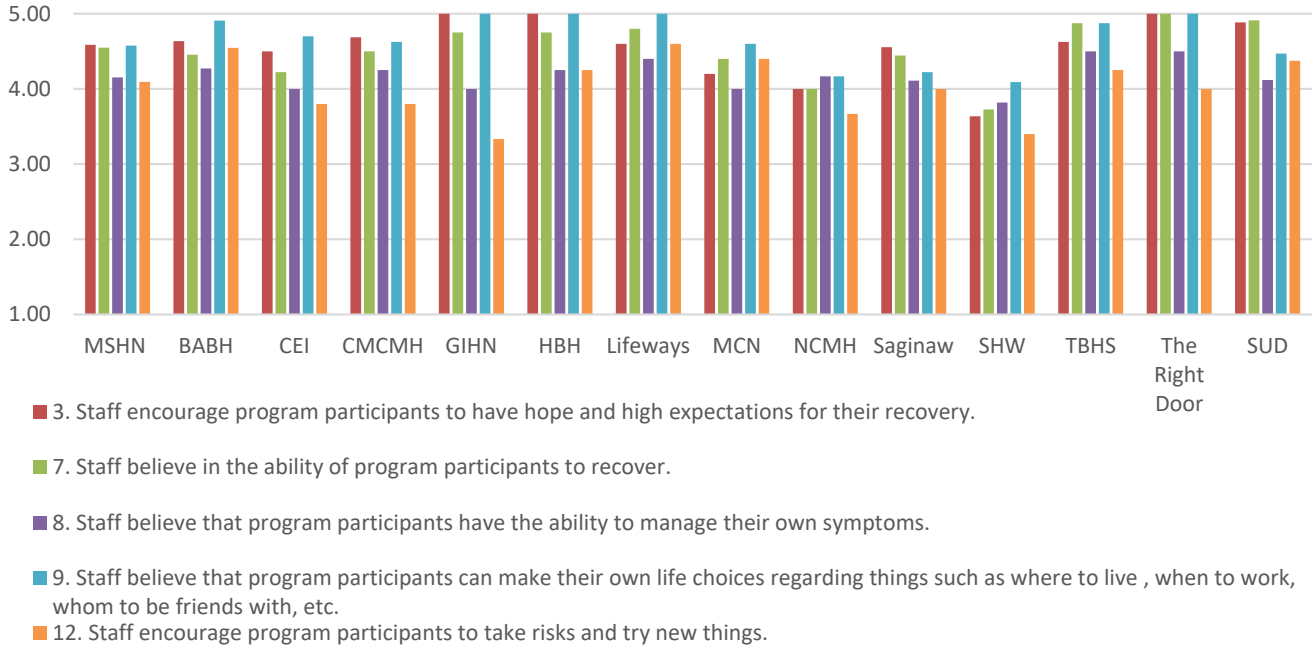


Figure 11b. CMHSP Participant and SATP comparison of FY20 Life Goals Subcategory Score with Questions-Administrator Assessment (Questions 16, 17, 18, 28, 31, 32)

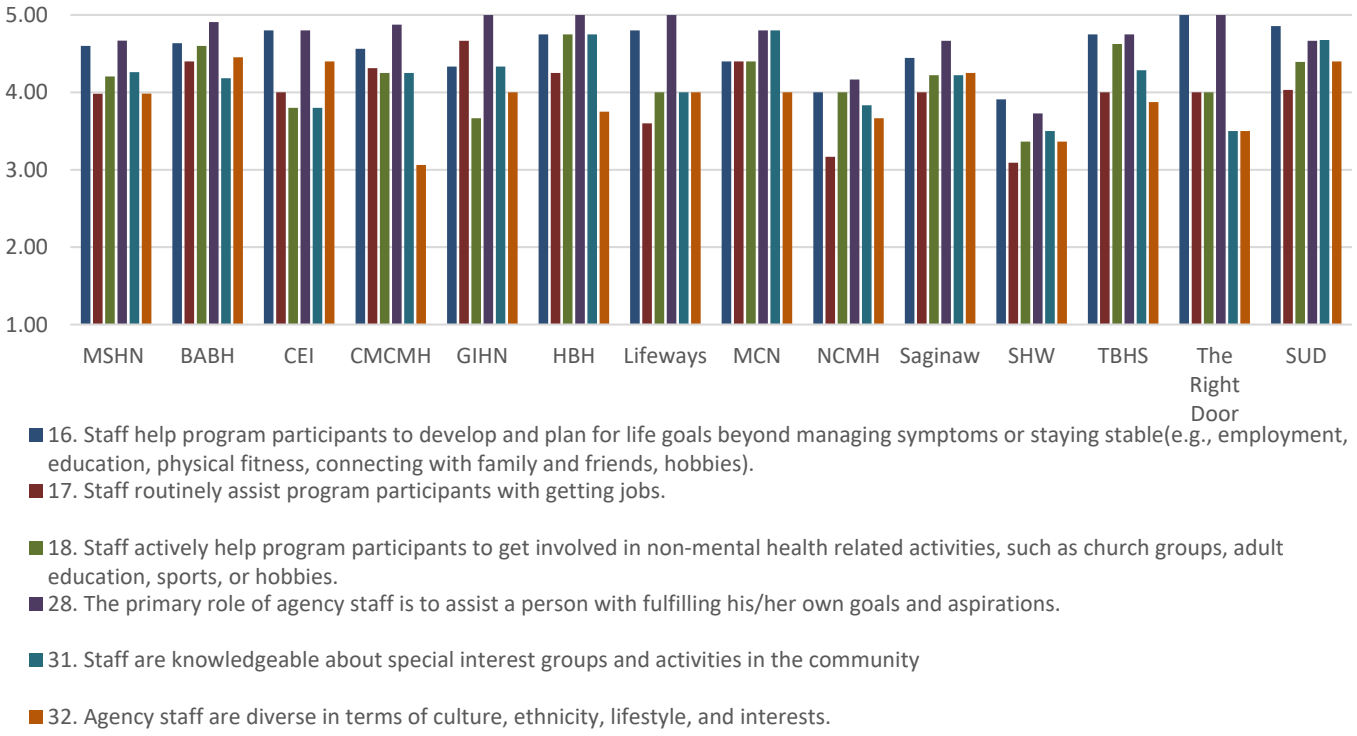


Figure 11c. CMHSP Participants and SATP comparison of FY20 Life Goals Subcategory Score with Questions-Provider Assessment (Questions 3, 7, 8, 9, 12)(*No Responses from Organization)

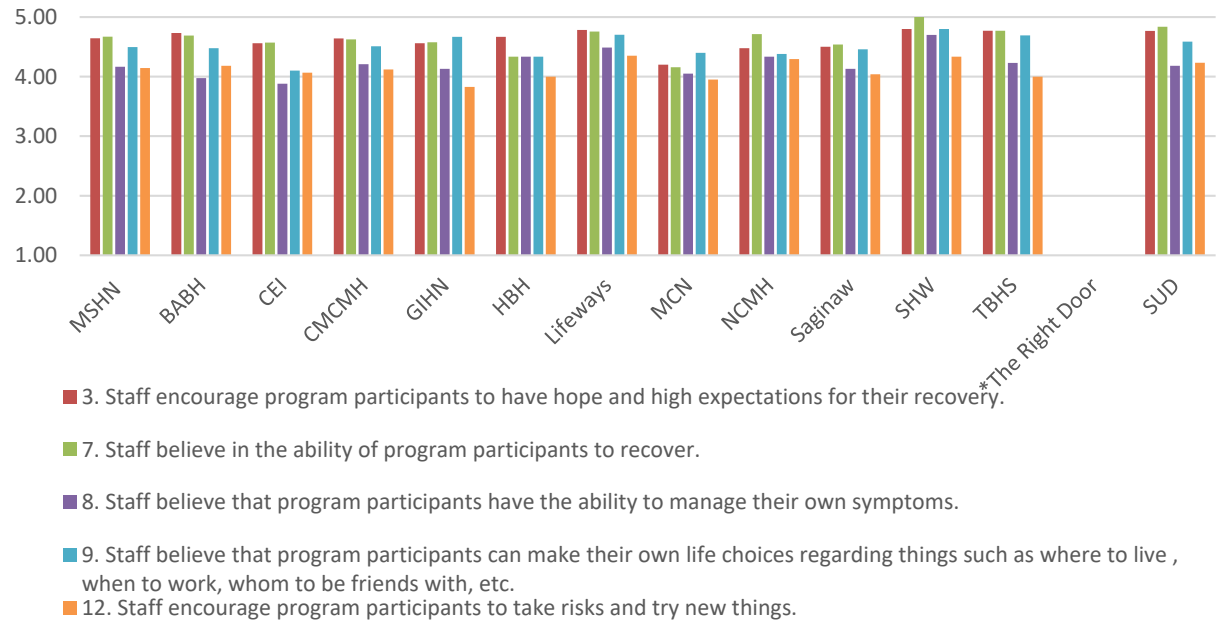


Figure 11d. CMHSP Participants and SATP comparison of FY20 Life Goals Subcategory Score with Questions-Provider Assessment (Questions 16, 17, 18, 28, 31,) (*No Responses from Organization)

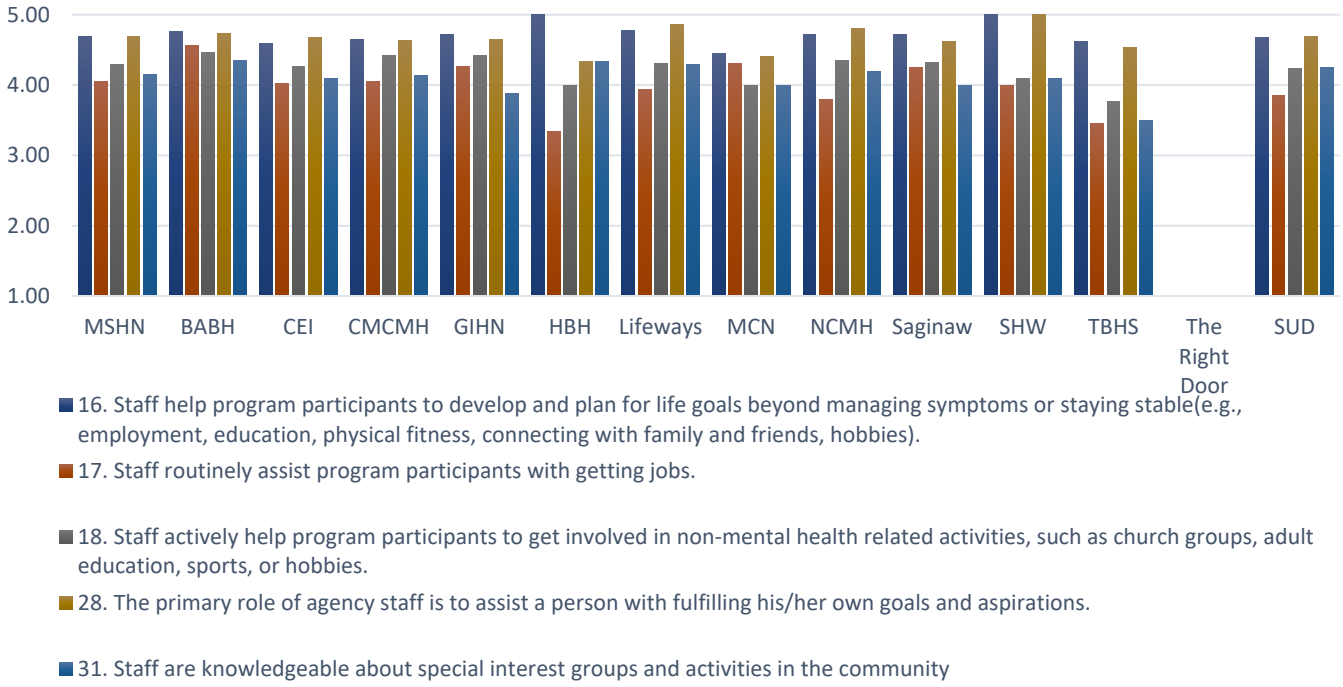
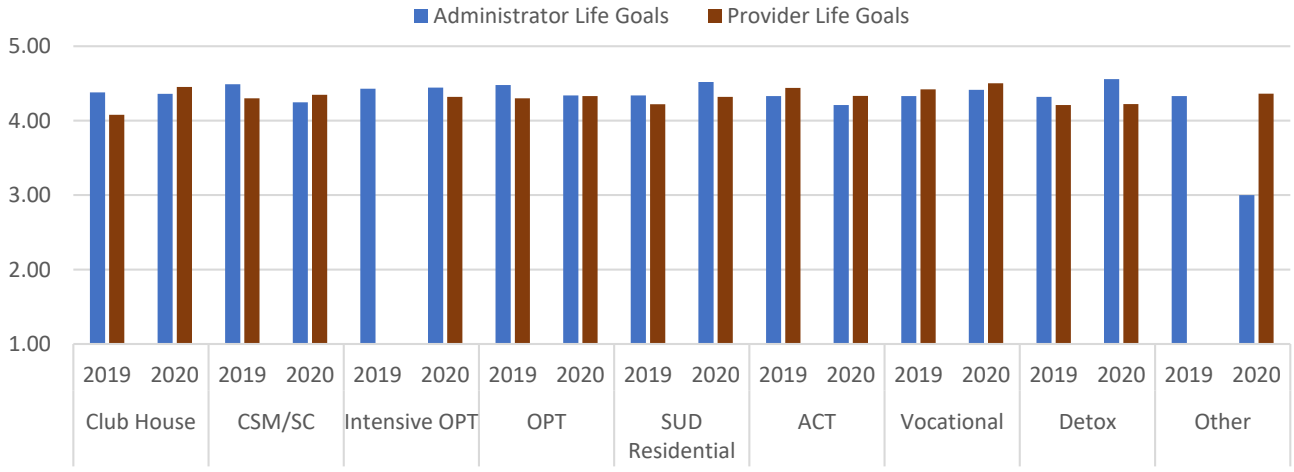


Figure 11e. Service Program Type comparison of FY20 Life Goals Subcategory



Individually Tailored Services Subcategory

The comprehensive score for both the Administrators and the Provider assessment was above 3.5 as illustrated in Figure 12, indicating agreement or satisfaction with the statements included in the Individually Tailored Services subcategory. Figure 12a illustrates how each CMHSP Participant and SATP responded to the Individually Tailored Services subcategory administrator assessment. Figure 12b illustrate how each CMHSP Participant and SATP responded to the Individually Tailored Services subcategory provider assessment. Figure 12c demonstrates how each CMHSP Participant and SATP scored by service program type.

Figure 12. CMHSP Participants and SATP comparison of FY20 Individually Tailored Services Subcategory Score

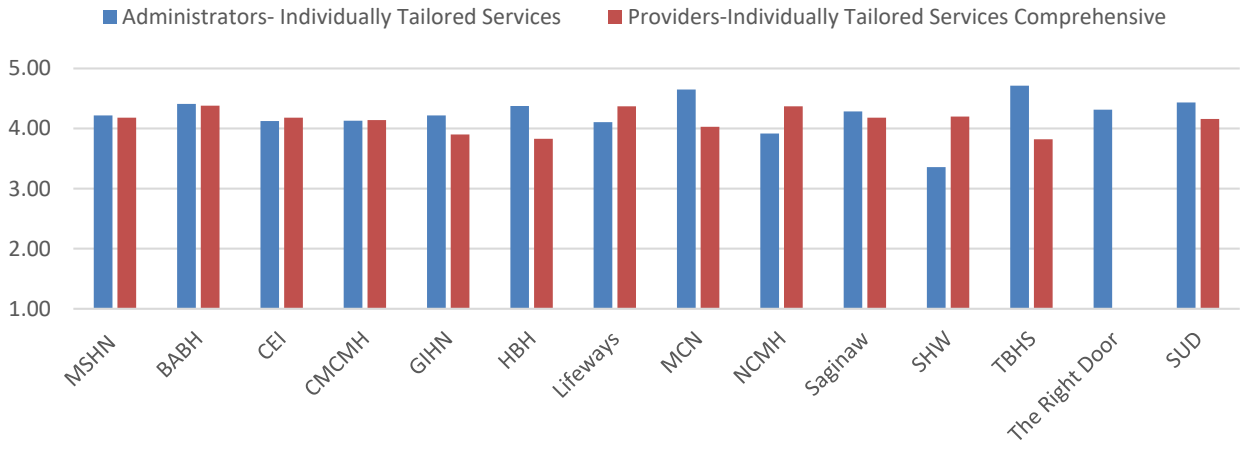


Figure 12a. CMHSP Participants and SATPs comparison of FY20 Individually Tailored Services Subcategory Score with Questions-Administrator Assessment

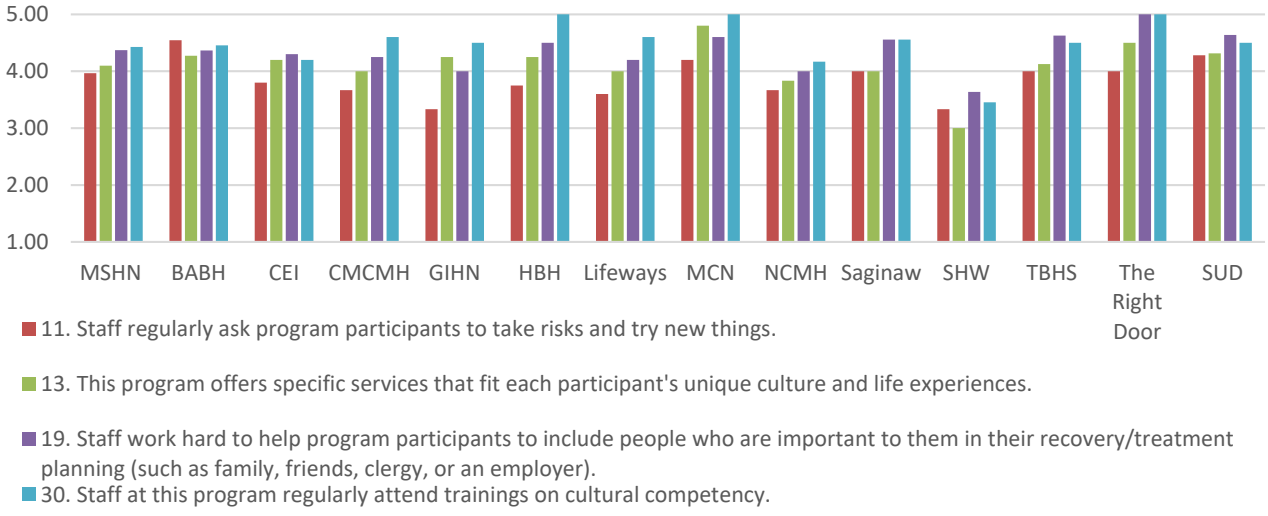


Figure 12b. CMHSP Participants and SATPs comparison of FY20 Individually Tailored Services Subcategory Score with Questions-Provider Assessment (*No Responses from Organization)

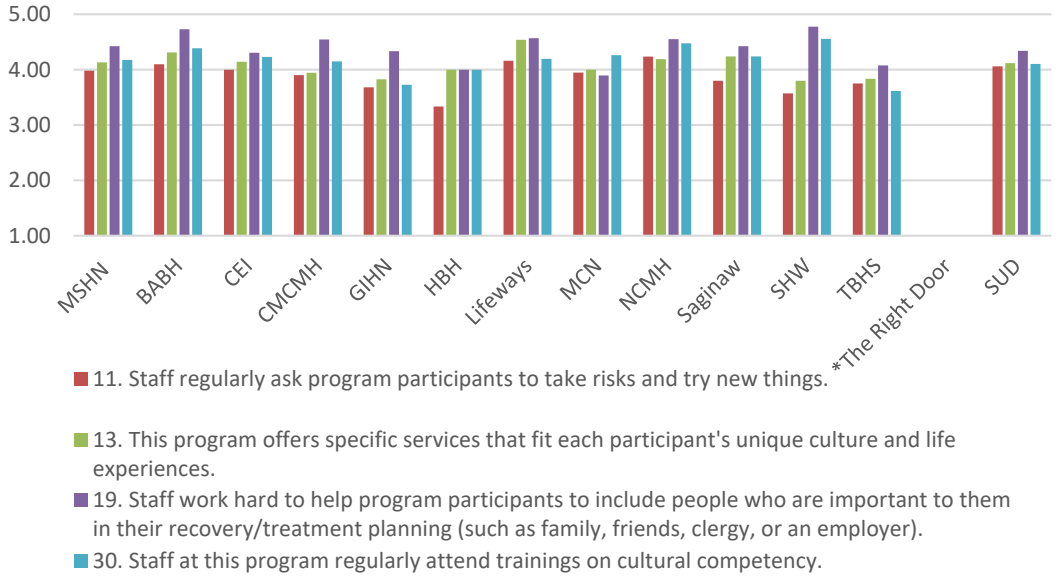
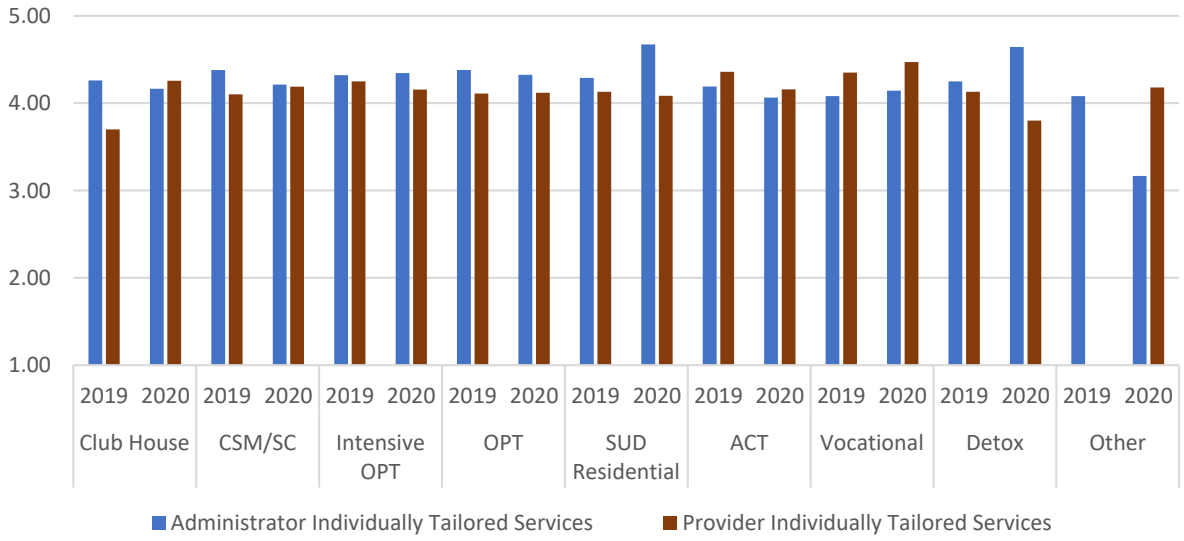


Figure 12c. Service Program Type comparison of FY20 Individually Tailored Services Subcategory



Diversity Subcategory

The comprehensive score for both the Administrator and Provider Assessment was above 3.5 as illustrated in Figure 13, indicating agreement or satisfaction with the statements included in the Diversion subcategory. Figure 13a illustrates how the CMHSP Participants and the SATP responded to the Diversity subcategory administrator assessment. Figure 13b illustrate how each CMHSP Participant and SATP Network responded to the Diversity subcategory provider assessment. Figure 13c demonstrates how each CMHSP Participant and the SATP scored by service program type.

Figure 13. CMHSP Participants and SATPs comparison of FY20 Diversity of Treatment Subcategory Score

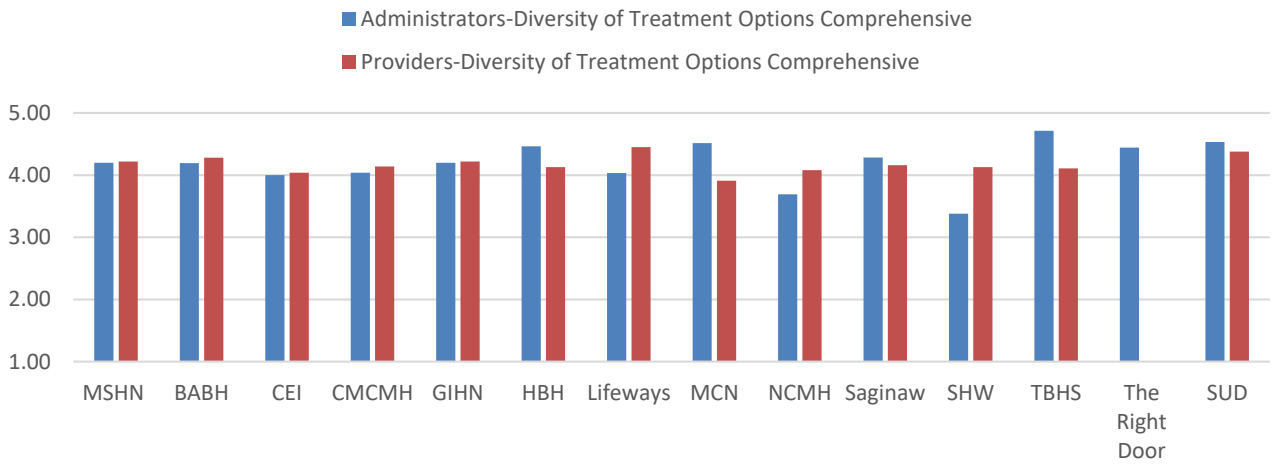


Figure 13a. CMHSP Participants and SATPs comparison of FY20 Diversity of Treatment Subcategory Score with Questions-Administrator Assessment

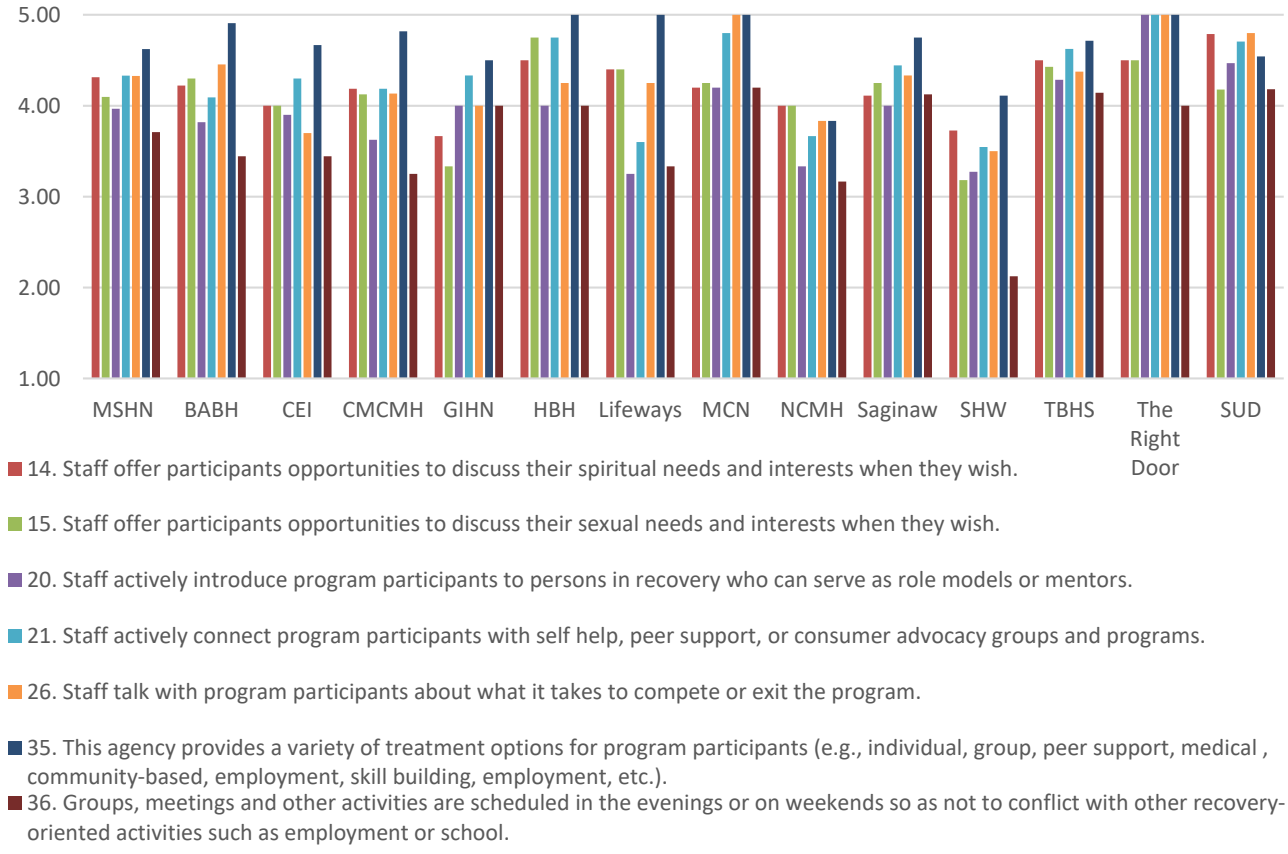


Figure 13b. CMHSP Participants and SATPs comparison of FY20 Diversity of Treatment-Provider Assessment (*No Responses from Organization)

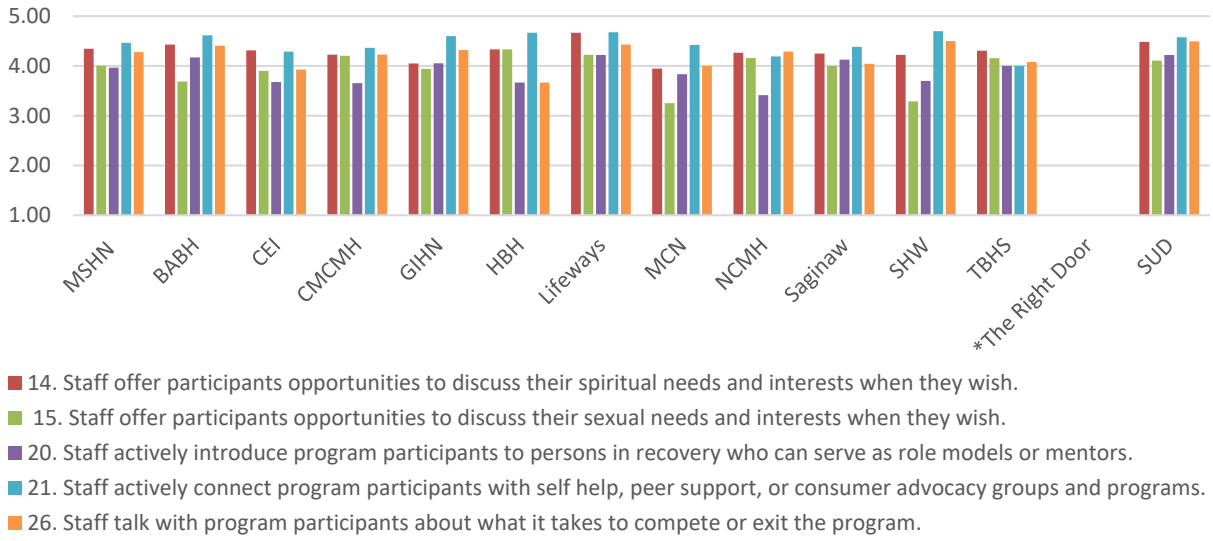
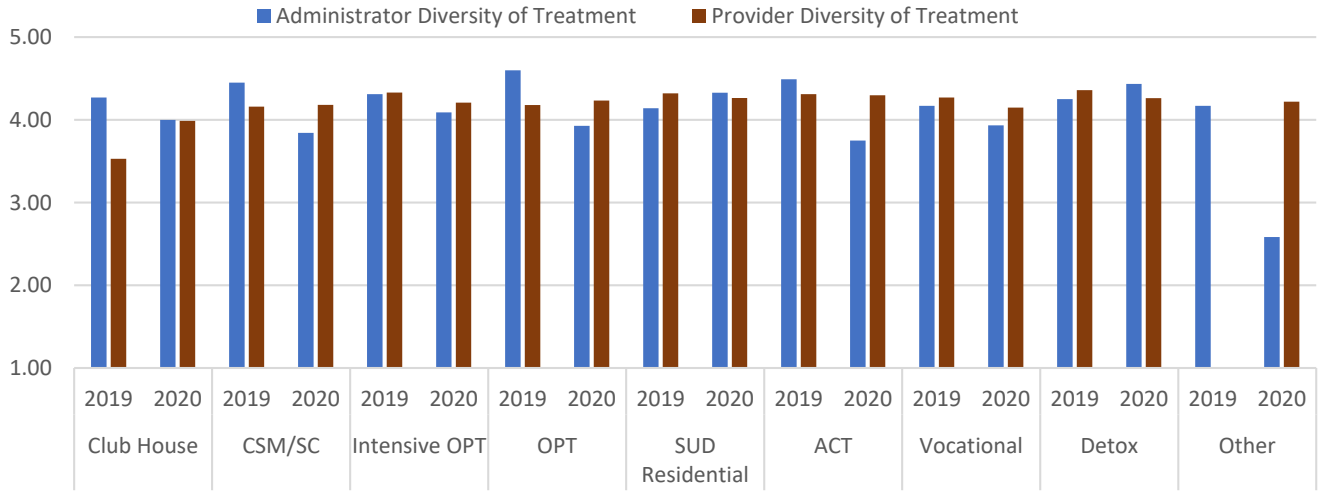


Figure 13c. Service Program Type comparison of FY20 Diversity of Treatment Subcategory



Summary

For FY2020 the RSA-R Administrator Assessment and the RSA-R Provider Assessment was completed by each CMHSP Participant and SATP. Each assessment was scored separately for comparison purposes. The assessments consisted of six (6) separate subcategories that included Inviting, Choice, Involvement, Life Goals, Individually Tailored Services and Diversity of Treatment.

Administrator Assessment

The MSHN RSA-R Administrator Assessment of Recovery demonstrated a comprehensive score of 4.25 in FY20. In 2015 MSHN demonstrated a comprehensive score of 3.82. MSHN has continued to meet the expectation of improvement from the previous year, each subcategory

since 2015 has demonstrated an upward trend. The subcategories in which MSHN has performed well in is the Inviting subcategory (4.67) and the Choice Subcategory (4.56). The Involvement subcategory demonstrated the lowest score since the onset of the project. In 2017 the involvement subcategory did reach 3.64 and has continued to increase each year. Currently all subcategories range from 3.80 to 4.67. Additional analysis was completed using the comprehensive score by provision of clinical services. Eight Service Program Types were utilized. Six of the eight indicated improvement in the recovery environment of the organization exhibiting a range of 4.19-4.58 on a scale from 1-5 with 5 being strongly agree.

Provider Assessment

The MSHN RSA-R Provider Assessment of Recovery met the expectation of improvement each year by demonstrating a comprehensive score of 4.25 in FY20, up from 4.18 in FY19. Each subcategory demonstrated improvement in FY20, ranging from 3.70-4.56. The subcategories performing well included the Choice Subcategory (4.56) and Life Goals Subcategory (4.36). Additional analysis was completed using the comprehensive score by provision of clinical services. Eight Service Program Types were utilized. Five of the eight indicated improvement in the recovery environment of the organization exhibiting a range of 4.08-4.48 on a scale from 1-5 with 5 being strongly agree.

Growth areas to consider include areas that perform below the 3.50 indicating disagreement or room for improvement. In the absence of scores below 3.5, consideration should be given to the questions that offer the most opportunity for improvement or that have demonstrated a decrease since the previous year. The Involvement subcategory demonstrated the largest opportunity for growth. The following questions could benefit from improvement efforts, four of which were identified by both Providers and Administrators and are included in the Involvement Subcategory:

22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup). (Provider-3.97) (Admininstrator-3.76)
20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors. (Provider-3.96)
23. People in recovery are encouraged to help staff with the development of new groups, programs, or services. (Provider-3.61) (Administrator-3.64)
25. People in recovery are encouraged to attend agency advisory boards and management meetings. (Provider-3.47) (Administrator-3.73)
29. Persons in recovery are involved with facilitating staff trainings and education at this program. (Provider-3.14) (Administrator-3.29)
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. (Administrator-3.71)

Evaluation of Effectiveness

The questions that ranked the lowest from FY19 and continue to be the lowest for FY20 are below. The questions demonstrating a score of 3.50 in FY19 required action for improvement.

The expectation is that improvement be demonstrated from previous year. Those that demonstrated an increase are indicated with a "met". Those that did not are indicated with a "not met". Agreement with the statement is defined as a 3.50 score or higher. The red font indicates the scores that were below 3.50.

MSHN		Administrator		Provider	
22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).	2019	3.78		3.80	
	2020	3.76	Not Met	3.97	Met
FY19 Action Required 23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.	2019	3.67		3.23	
	2020	3.64	Not Met	3.47	Met
25. People in recovery are encouraged to attend agency advisory boards and management meetings.	2019	3.73		3.79	
	2020	3.73	Met	3.96	Met
FY19 Action Required 29. Persons in recovery are involved with facilitating staff trainings and education at this program.	2019	3.06		2.92	
	2020	3.29	Met	3.14	Met
FY19 Action Required 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.	2019	3.66		3.49	
	2020	3.71	Met	3.61	Met

The above information indicates that the interventions put in place at each local organization were effective and resulted in an improvement, however continued improvement is required for Question 29.

Next Steps

The results will be reviewed further by the MSHN Quality Improvement Council, the SUD Provider Advisory Committee, and the Regional Consumer Advisory Council considering the growth areas identified above.

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/interventions.

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.

Report Completed by: Sandy Gettel MSHN Quality Manager **Date: 9.3.2020**

MSHN QIC Approved: **Date: 9.24.2020**

Provider Advisory Council Review: **Date: 9.14.2020**

Regional Consumer Advisory Council Review: **Date: 10.9.2020**

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 Administrator Assessment	MSHN	BABH	CEI	CMCMH	GIHN	HBH	Lifeways	MCN	NCMH	SCCMH	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.	*4.83*	*4.82*	*4.90*	*5.00*	*5.00*	4.75	*4.80*	*4.80*	*4.33*	*5.00*	*4.45*	4.50	*5.00*	*4.97*
1-Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program.	*4.75*	4.64	*5.00*	*4.75*	*5.00*	*5.00*	*4.80*	4.40	*4.17*	*4.89*	*4.09*	*4.75*	*5.00*	*4.97*
28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.	*4.67*	*4.91*	*4.80*	*4.88*	*5.00*	*5.00*	*5.00*	*4.80*	*4.17*	*4.67*	3.73	*4.75*	*5.00*	4.67
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.).	*4.62*	*4.91*	4.67	*4.82*	4.50	*5.00*	*5.00*	*5.00*	3.83	*4.75*	*4.11*	4.71	*5.00*	4.54
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).	*4.60*	4.64	*4.80*	4.56	4.33	4.75	*4.80*	4.40	4.00	4.44	3.91	*4.75*	*5.00*	*4.86*
3. Staff encourage program participants to have hope and high expectations for their recovery.	4.59	4.64	4.50	*4.69*	*5.00*	*5.00*	4.60	***4.20***	4.00	4.56	3.64	4.63	*5.00*	*4.89*
2. This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.)	4.58	4.73	4.33	*4.69*	4.00	4.75	*4.80*	*4.80*	3.67	*4.67*	*4.27*	*5.00*	*5.00*	4.66
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.	4.58	*4.91*	*4.70*	4.63	*5.00*	*5.00*	*5.00*	4.60	*4.17*	4.22	*4.09*	*4.88*	*5.00*	4.47
7. Staff believe in the ability of program participants to recover.	4.55	4.45	4.22	4.50	4.75	4.75	*4.80*	4.40	4.00	4.44	3.73	*4.88*	*5.00*	*4.91*

RSA-R Administrator Assessment	MSHN	BABH	CEI	CMCMH	GIHN	HBH	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS	The Right Door	SUD
10. Staff listen to and respect the decisions that program participants make about their treatment and care.	4.54	4.80	4.40	4.56	4.50	4.75	5.00	4.60	4.17	4.38	3.55	4.75	5.00	4.76
27. Progress made towards an individual's own personal goals is tracked regularly.	4.53	4.64	4.30	4.69	4.25	4.50	4.40	4.60	3.83	4.63	3.73	4.63	5.00	4.85
4. Program participants can change their clinician or case manager if they wish.	4.44	4.60	4.50	4.56	4.50	4.75	4.40	4.75	4.33	4.86	4.45	4.63	5.00	4.06
5. Program participants can easily access their treatment records if they wish.	4.43	4.73	4.10	4.44	4.75	4.50	4.40	4.40	4.17	4.11	4.09	4.63	4.50	4.59
30. Staff at this program regularly attend trainings on cultural competency.	4.43	4.45	4.20	4.60	4.50	5.00	4.60	5.00	4.17	4.56	3.45	4.50	5.00	4.50
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).	4.37	4.36	4.30	4.25	4.00	4.50	4.20	4.60	4.00	4.56	3.64	4.63	5.00	4.64
21. Staff actively connect program participants with self help, peer support, or consumer advocacy groups and programs.	4.33	4.09	4.30	4.19	4.33	4.75	3.60	4.80	3.67	4.44	3.55	4.63	5.00	4.71
26. Staff talk with program participants about what it takes to compete or exit the program.	4.33	4.45	3.70	4.13	4.00	4.25	4.25	5.00	3.83	4.33	3.50	4.38	5.00	4.80
14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.	4.31	4.22	4.00	4.19	3.67	4.50	4.40	4.20	4.00	4.11	3.73	4.50	4.50	4.79
31. Staff are knowledgeable about special interest groups and activities in the community.	4.26	4.18	3.80	4.25	4.33	4.75	4.00	4.80	3.83	4.22	3.50	4.29	3.50	4.68
18. Staff actively help program participants to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies.	4.20	4.60	3.80	4.25	3.67	4.75	4.00	4.40	4.00	4.22	3.36	4.63	4.00	4.39
24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.	4.17	4.64	3.80	4.25	3.33	3.75	4.60	4.40	3.33	4.22	3.11	4.67	4.50	4.41
8. Staff believe that program participants have the ability to manage their own symptoms.	4.15	4.27	4.00	4.25	4.00	4.25	4.40	4.00	4.17	4.11	3.82	4.50	4.50	4.12
13. This program offers specific services that fit each participant's unique culture and life experiences.	4.10	4.27	4.20	4.00	4.25	4.25	4.00	4.80	3.83	4.00	3.00	4.13	4.50	4.31
RSA-R Administrator Assessment	MSHN	BABH	CEI	CMCMH	GIHN	HBH	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS	The Right Door	SUD

15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.	4.10	4.30	4.00	4.13	***3.33***	4.75	4.40	4.25	4.00	4.25	3.18	4.43	4.50	4.18
12. Staff encourage program participants to take risks and try new things.	4.09	4.55	3.80	3.80	***3.33***	4.25	4.60	4.40	3.67	4.00	3.40	4.25	***4.00***	4.38
33. This agency provides formal opportunities for people in recovery, family members, service providers, and administrators to learn about recovery.	4.05	4.30	3.67	3.82	4.00	4.25	3.50	4.40	3.83	***3.88***	***3.00***	4.43	4.50	4.41
32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	3.98	4.45	4.40	***3.06***	4.00	***3.75***	4.00	***4.00***	3.67	4.25	3.36	***3.88***	***3.50***	4.40
17. Staff routinely assist program participants with getting jobs.	3.98	4.40	4.00	4.31	4.67	4.25	3.60	4.40	***3.17***	4.00	3.09	***4.00***	***4.00***	***4.03***
20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.	3.97	***3.82***	3.90	3.63	4.00	4.00	***3.25***	***4.20***	***3.33***	4.00	3.27	4.29	***5.00***	4.47
11. Staff regularly ask program participants to take risks and try new things.	3.97	4.55	3.80	3.67	***3.33***	***3.75***	3.60	***4.20***	3.67	4.00	3.33	***4.00***	***4.00***	4.28
34. This agency provides structured educational activities to the community about mental illness and addictions.	3.94	4.09	4.44	4.00	4.00	4.50	***3.25***	***4.80***	3.50	***3.75***	***3.00***	4.43	4.50	***3.84***
22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).	***3.76***	4.40	***3.40***	***3.56***	***3.00***	4.00	4.00	***3.80***	3.50	***3.56***	***2.36***	***4.13***	***3.50***	4.29
25. People in recovery are encouraged to attend agency advisory boards and management meetings.	***3.73***	***4.00***	***3.00***	4.06	3.67	***3.67***	3.67	4.40	***3.33***	4.11	3.60	4.14	4.50	***3.40***
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.	***3.71***	***3.44***	***3.44***	***3.25***	4.00	4.00	***3.33***	***4.20***	***3.17***	4.13	***2.13***	4.14	***4.00***	4.18
23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.	***3.64***	***3.56***	***3.56***	***3.25***	***3.00***	***3.25***	***3.25***	4.60	***3.17***	***3.67***	***2.91***	***4.13***	***4.00***	***4.06***
29. Persons in recovery are involved with facilitating staff trainings and education at this program.	***3.29***	***3.57***	***2.50***	***2.86***	***2.33***	***3.00***	***2.75***	4.40	***3.00***	***3.38***	***2.45***	***3.43***	***3.50***	4.07

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 Providers Assessment	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.	*4.82*	*4.89*	*4.76*	*4.78*	*4.78*	*4.67*	4.76	*4.80*	*4.90*	*4.76*	*5.00*	*4.69*		*4.87*
1. Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program	*4.72*	*4.83*	*4.69*	*4.70*	*4.78*	*4.67*	*4.84*	*4.47*	4.67	*4.65*	4.90	*4.92*		*4.69*
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).	*4.69*	*4.76*	*4.59*	*4.65*	*4.72*	*5.00*	*4.78*	4.45	*4.71*	*4.72*	*5.00*	4.62		4.68
28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.	*4.69*	*4.73*	*4.68*	4.63	*4.65*	4.33	*4.86*	4.40	*4.81*	*4.62*	*5.00*	4.54		*4.69*
7. Staff believe in the ability of program participants to recover.	*4.67*	4.69	4.57	4.63	4.58	4.33	4.76	4.16	*4.71*	4.54	*5.00*	*4.77*		*4.84*
3. Staff encourage program participants to have hope and high expectations for their recovery.	4.64	*4.73*	4.56	*4.64*	4.56	*4.67*	*4.78*	4.20	4.48	4.50	4.80	*4.77*		*4.77*
27. Progress made towards an individual's own personal goals is tracked regularly.	4.62	4.73	4.50	4.61	4.56	4.33	*4.86*	*4.50*	4.62	4.36	*5.00*	4.54		4.62
10. Staff listen to and respect the decisions that program participants make about their treatment and care.	4.61	4.57	*4.58*	*4.67*	4.59	4.33	4.73	*4.50*	4.62	4.52	4.80	4.46		4.60

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.	4.50	4.48	4.10	4.51	***4.67***	4.33	4.70	4.40	4.38	4.46	4.80	***4.69***		4.59
21. Staff actively connect program participants with self help, peer support, or consumer advocacy groups and programs.	4.46	4.62	4.29	4.36	4.60	***4.67***	4.68	4.42	4.19	4.38	4.70	4.00		4.58
RSA-R Provider Assessment	**MSHN**	**BABH**	**CEI**	**CMCMH**	**GIHN**	**HBH**	**Lifeways**	**MCN**	**NCMH**	**SCCMH**	**SHW**	**TBHS**	**The Right Door**	**SUD**
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).	4.42	***4.73***	4.31	4.55	4.33	4.00	4.57	3.89	4.55	4.42	4.78	4.08		4.34
5. Program participants can easily access their treatment records if they wish.	4.38	4.49	4.32	4.34	4.30	***4.67***	4.56	4.43	4.30	4.35	4.44	3.83		4.40
4. Program participants can change their clinician or case manager if they wish.	4.35	4.37	4.16	4.31	4.48	***4.67***	4.53	***4.50***	***4.90***	***4.62***	4.50	4.25		4.10
14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.	4.34	4.43	4.31	4.23	4.05	4.33	4.67	3.95	4.26	4.25	4.22	4.31		4.48
2-This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.)	4.32	4.33	4.27	4.29	***3.58***	4.00	4.72	4.37	4.33	4.15	4.80	***4.85***		4.35
18. Staff actively help program participants to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies.	4.29	4.46	4.27	4.43	4.42	4.00	4.31	4.00	4.35	4.32	4.10	3.77		4.24
26. Staff talk with program participants about what it takes to compete or exit the program.	4.28	4.40	3.93	4.23	4.32	3.67	4.43	4.00	4.29	4.04	4.50	4.08		4.49

24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.	4.18	4.43	3.95	4.17	4.18	***3.33***	4.48	3.94	4.35	4.26	4.33	4.08		4.10
30. Staff at this program regularly attend trainings on cultural competency.	4.18	4.39	4.23	4.15	3.73	4.00	4.19	4.26	4.48	4.24	4.56	3.62		4.10
8. Staff believe that program participants have the ability to manage their own symptoms.	4.16	***3.98***	3.88	4.21	4.13	4.33	4.49	4.05	4.33	4.13	4.70	4.23		4.18
31. Staff are knowledgeable about special interest groups and activities in the community.	4.15	4.35	4.10	4.14	3.88	4.33	4.30	4.00	4.20	4.00	4.10	3.50		4.25
12. Staff encourage program participants to take risks and try new things.	4.14	4.18	4.07	4.12	3.83	4.00	4.35	3.95	4.29	4.04	4.33	4.00		4.23

RSA-R Provider Assessment	**MSHN**	**BABH**	**CEI**	**CMCMH**	**GIHN**	**HBH**	**Lifeways**	**MCN**	**NCMH**	**SCCMH**	**SHW**	**TBHS**	**The Right Door**	**SUD**
13. This program offers specific services that fit each participant's unique culture and life experiences.	4.13	4.31	4.14	3.94	3.83	4.00	4.54	4.00	4.19	4.24	3.80	3.83		4.12
17. Staff routinely assist program participants with getting jobs.	4.05	4.56	4.02	4.06	4.26	***3.33***	***3.94***	4.30	***3.79***	4.25	4.00	***3.46***		***3.85***
15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.	4.00	***3.69***	3.90	4.20	3.94	4.33	4.22	***3.25***	4.16	4.00	***3.29***	4.15		4.11
11. Staff regularly ask program participants to take risks and try new things.	3.98	***4.10***	4.00	***3.90***	***3.68***	***3.33***	4.16	3.95	4.24	***3.80***	***3.57***	3.75		4.06
22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).	***3.97***	4.51	***3.70***	4.13	3.91	4.00	***4.13***	***3.79***	***3.79***	***3.84***	4.00	***3.15***		***3.94***

20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.	***3.96***	4.17	***3.68***	***3.65***	4.05	3.67	4.22	3.83	***3.41***	4.13	3.70	4.00		4.22
23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.	***3.61***	4.11	***3.48***	***3.58***	***3.67***	***3.00***	***3.69***	***3.50***	***3.29***	***3.87***	***2.88***	***3.15***		***3.63***
25. People in recovery are encouraged to attend agency advisory boards and management meetings.	***3.47***	***3.97***	***3.42***	***3.55***	***3.41***	***3.00***	***3.38***	***3.75***	***3.53***	***3.68***	***3.57***	***3.42***		***3.15***
29. Persons in recovery are involved with facilitating staff trainings and education at this program.	***3.14***	***3.48***	***3.11***	***3.18***	***2.93***	***2.33***	***3.04***	***3.00***	***2.85***	***3.47***	***1.75***	***2.67***		***3.31***

Behavior Treatment Plans and Interventions

Introduction

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 Standards for Behavioral Treatment Review attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract.

MSHN monitors that the local CMHSP BTRC follows the requirements outlined within the Standards for Behavior Treatment Review Committees. 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). The following measures are trend data; therefore, no external standard exists. The trend is used to identify any areas requiring further analysis to improve safety of the individuals we serve. This is done by reviewing quarterly data to identify causal factors contributing to an increase rate and an upward trend. The expectation is that each quarter will demonstrate improvement from the previous quarter. CMHSP and/or MSHN will implement interventions to improve safety, thereby changing the direction of the trend.

Data Analysis

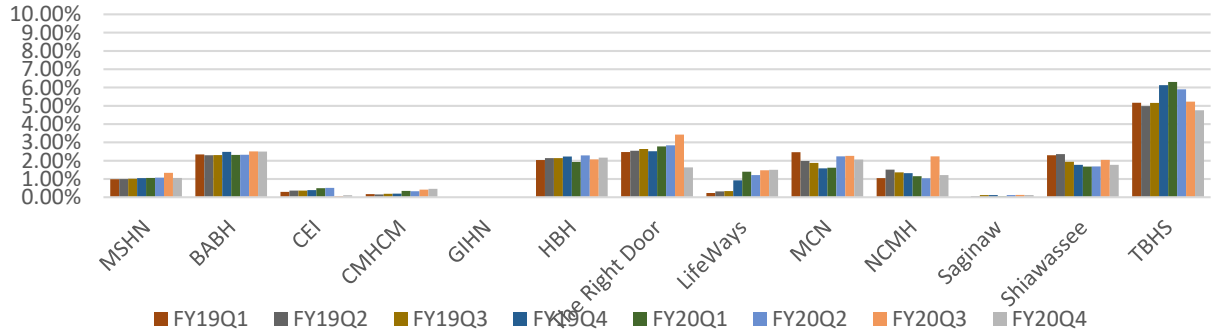
Goal 1: The percent of individuals who have an approved Behavior Treatment Plan, which includes restrictive and/or intrusive techniques, will demonstrate a decrease from previous measurement period.

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 who have an approved behavior treatment plan that include a restrictive and/or intrusive intervention.

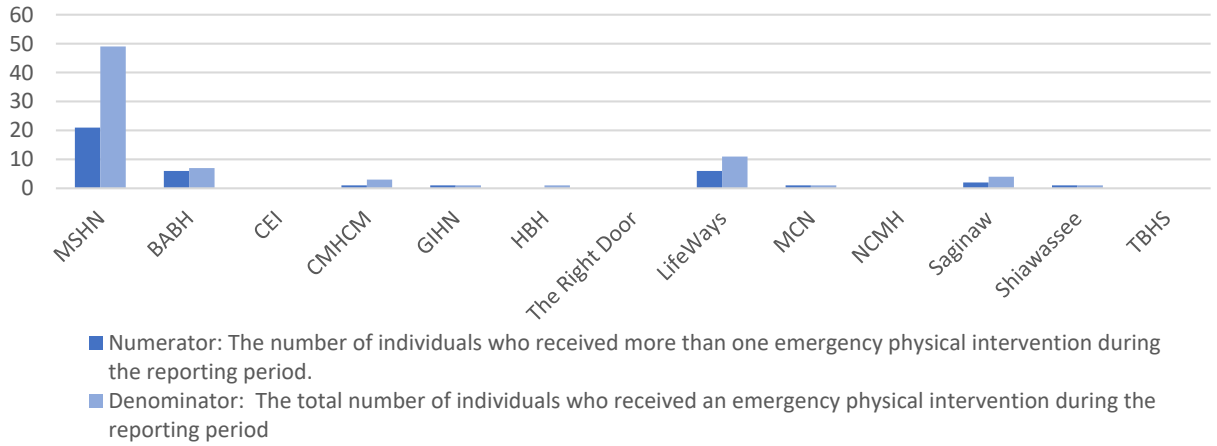
Denominator: The total number of individuals who are actively receiving services during the reporting period.

Figure 1. Percent of Individual served who have a Behavior Treatment Plan with Intrusive/Restrictive Interventions.



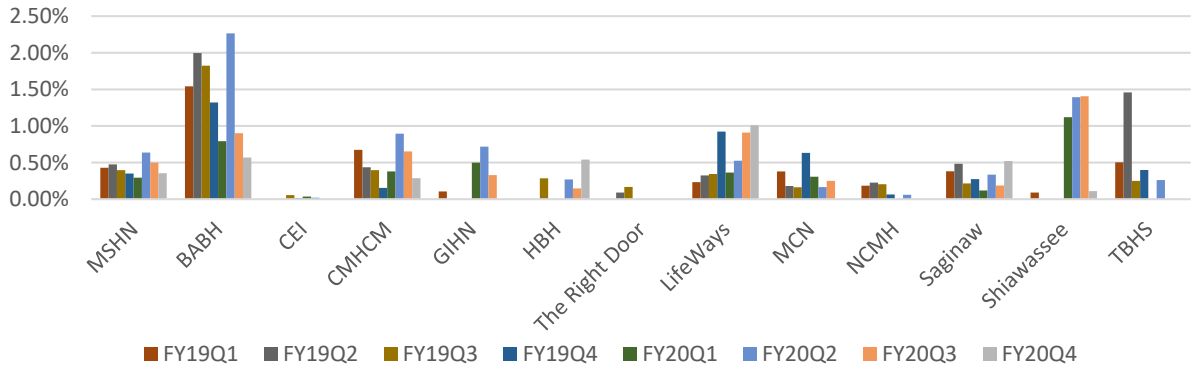
Goal 2: The percent of emergency physical interventions per person served during the reporting period will demonstrate a decrease from previous measurement period.
Study Question 2a**:** Has the proportion of individuals who have received multiple emergency physical interventions decreased over time?
Numerator: The total number of individuals with whom more than one emergency physical intervention was reviewed during the reporting period.
Denominator: The total number of individuals with whom emergency physical interventions were ~~used~~ reviewed during the reporting period.

Figure 2a. The Proportion of Emergency Physical Intervention FY20Q4



Study Question 2b: Has the proportion of physical interventions decreased overtime?
Numerator: The total number of physical interventions reviewed during the reporting period.
Denominator: The total number of individuals who are actively receiving services during the reporting period.

Figure 2b. The percent of emergency physical interventions per person served



Goal 3: The percent of incidents requiring phone calls made by staff to police for behavioral assistance per person served will demonstrate a decrease from previous measurement period.

Study Question 3: Has the proportion of incidents in which police have been called for assistance by staff to manage a behavioral incident decreased?
Numerator: The total number of incidents requiring phone calls made by staff to police for behavioral assistance.
Denominator: The total number of individuals who are actively receiving services during the reporting period.

Figure 3. The percent of incidents per consumer servevd requiring phone calls made by staff to police for behavioral assistance

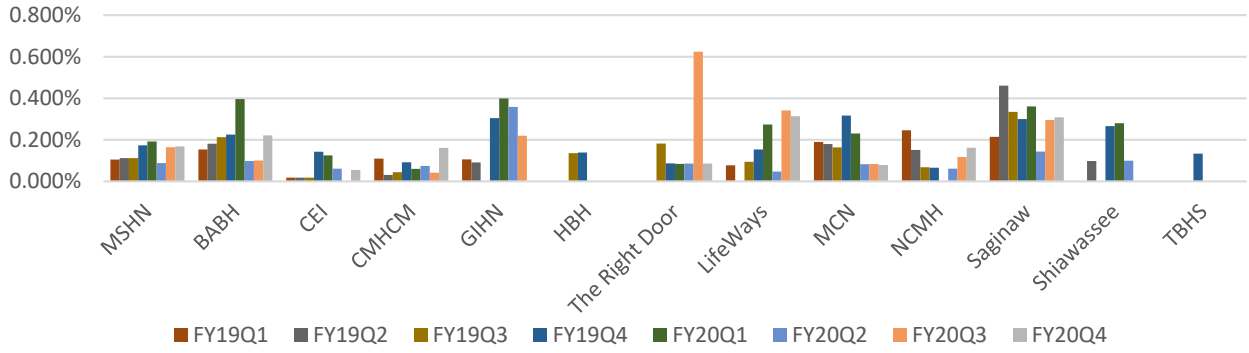
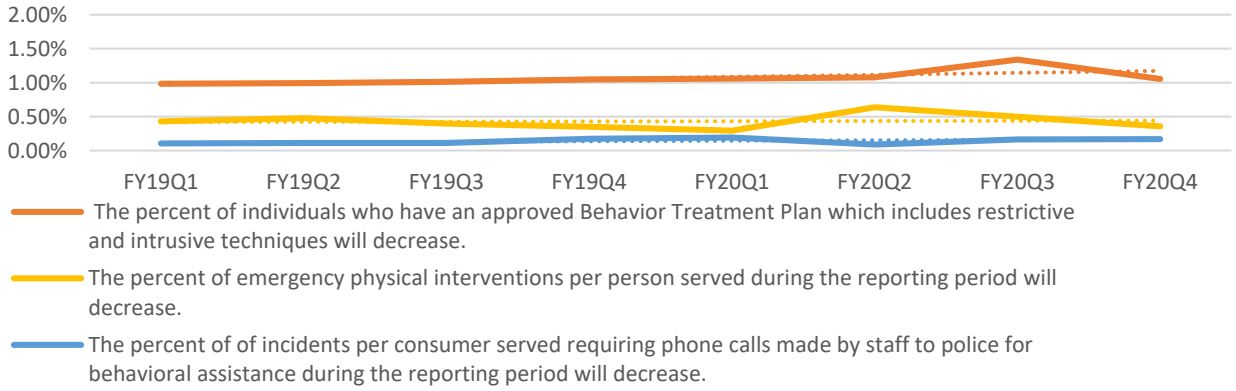


Figure 4. Behavior Treatment Data Trends



Conclusions:
Goal 1: The percent of individuals who have an approved Behavior Treatment Plan, which includes restrictive and/or intrusive techniques, will demonstrate a decrease from previous measurement period.
The standard based on the current goal was met. The number of Behavior Treatment Plans that have been approved for the use of restrictive and intrusive interventions decreased during the past quarter, however, continues to demonstrate an upward trend over the past 4 quarters. Causal factors were identified above. One of the causal factors is related to the awareness and identification of interventions that are restrictive and intrusive in current individual plans of service that should be reviewed and approved by the BTPRC. A recommendation will be made to modify Goal 1 to address the current focus.

Goal 2: The percent of emergency physical interventions per person served during the reporting period will demonstrate a decrease from previous measurement period.
This standard was met. The number of reported emergency physical interventions decreased in FY20Q4, however, continued to demonstrate an upward trend over the previous 4 quarters.
Goal 3: The percent of incidents requiring phone calls made by staff to police for behavioral assistance per person served will demonstrate a decrease from previous measurement period.
This standard was not met. The number of police calls for behavioral assistance have increased during this reporting period, continuing trend slightly upwards based on the previous reporting periods. The trends will continue to be monitored to identify any potential need for action.

Recommendations:

- The regional BTPR workgroup to continue to address the following areas:
    - Discussion related to restrictions, and limitations that require a plan with behavior treatment committee approval. Utilization of the Frequently Asked Questions (FAQ) document to identify and provide guidance for scenarios that may be interpreted differently. *Status: FAQ updated and discussed every other month in coordination with MDHHS Behavior Work Group.*

    - Effective data collection to measure improvements and identify continued areas of risk. *Status: New data collection began April 1st will allow for analysis by program and streamline/combine two data collection processes to increase efficiencies. The first submission was July 31st. A system for aggregating will be developed for output reports was moved to January/February from August/September. Recommendations for modifications have been made to the data collection sheet to further clarify and provide valid information pertaining to number of plans and programs.*
    - Develop minimal competencies based on scope of practice for individuals who write behavior treatment plans. *Status: Not addressed at this time.*
- The BTPRC has requested training to assist in the incorporation of the required elements of the Behavior Treatment Standards. It is recommended that a regional training occur with attendance strongly encouraged by clinical staff and members of each local BTPRC, to ensure all restrictive and intrusive interventions are reviewed, approved and written into a plan as required by MDHHS.
  Status: Training information has been received from MDHHS and the Board Association. Training was discussed at CLC in February. BTPR work group in concert with CLC will develop training for the groups identified above. CMHSPs are submitting current training materials.
- Training on writing Individual Plans of Service to ensure that inclusion of restrictions is identified and referred to BTPRC as needed.
  Status: MSHN is in process of developing a workplan to address IPOS training for the region to support the current strategic initiative on IPOS training, and the MDHHS waiver review corrective action plan.

- The Project Description will be reviewed to update goals for FY21. Recommendations will be approved via consensus through CLC and the BTPR workgroup. QIC will ensure valid data collection is in place to monitor revised goals.

Completed By: Sandy Gettel MSHN Quality Manager **Date: 11/23/2020**

Grievances, Appeals, and Fair Hearings

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

Program	# of Grievances for FY19	FY20
AMHS	4	7
CSDD	7	6
FF	1	1
SAS	1	0
Total	**13**	**14**

Program	# of Appeals for FY19	FY20
AMHS	1	1
CSDD	15	15
FF	4	1
SAS	0	0
Total	**20**	**17**

Program	# of Fair Hearings for FY19	FY20
AMHS	0	0
CSDD	6	4
FF	0	0
SAS	0	0
Total	**6**	**4**

Incident Reporting

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

Category	Incident Reports
Medication	422
Other General Incident	288
Emergency Care	168
Serious Aggressive Event	55
Death	93
Missing Recipient	4
Serious Property Damage	8
Serious Self Injury	4
Exposure to Blood/Bodily Fluids	0
Choking	4
Arrest	6
Uncategorized/complete	145
Incomplete	170
Total	1369

A process error in incident reporting leaving several incidents incomplete or not reviewed. The Medical Director, Quality Improvement Team, and Clinical Programs have begun meeting to create a protocol to avoid these oversights in FY21.

Medication IRs

In FY20, the process error mentioned above led to a large number of medication incident reports that were not reviewed, which led to a staggering drop in numbers compared to the previous year.

Med IR Category	Number of Reports
Missed Med	368
Wrong Dose	27
Wrong Time/Day	13
Staff Signing Error	3
Wrong Person/Med	11
Total	422*

Emergency Care IRs

There were 167 emergency care incidents reviewed in FY20. Of those, 127 were due to illness, and 40 due to injury. 97 resulted in emergency medical treatment and 46 hospitalizations.

Emergency Care	Total	EMT	Hospitalization	No hospital or EMT
Illness	127	72	38	15
Injury	40	25	8	15

Deaths

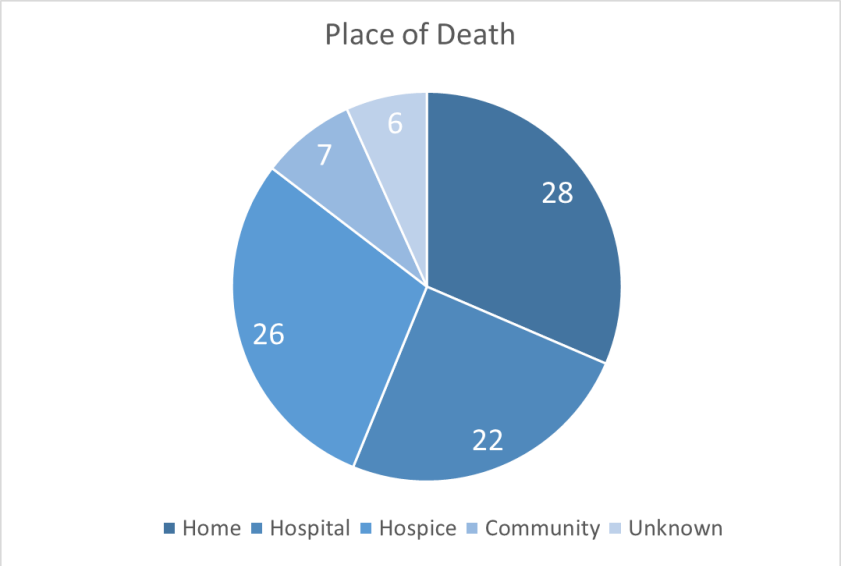
CIRC reviewed 92 deaths in FY20

Cause	# of Incident
Vascular	15
Diabetes*	15
Accidental	14
Suicide	8
Cancer	6
Overdose - Accidental	5
Natural - Unknown	5
Neurological Disorder	4
IR Still In Progress	4
Aspiration	4
Lung Disease	3
Pneumonia	3
Infection	2
Complications of Treatment	2
Liver Disease	1
Total	**92**

***1 COVID-Related death reported as Diabetes due to State regulations**

Age	
Range	**15-90**
Median	**62.5**
Mean	**57**

Program	# of Incidents
AMHS	**68**
CSDD	**17**
ITRS	**6**
FF	**1**



Staff Injuries and Vehicles Accidents

In FY20, there were reported incidents of staff injuries and five vehicle accidents. Reports from Accident Fund on the staff injuries are made available to HR in the spring of 2021. Of the vehicle accidents documented, only one claim was filed. CMHA-CEI paid for repairs on two accidents and one vehicle was totaled.

Sentinel Events

There were no sentinel events reported in FY20.

Medicaid Event Verification Audit

For FY20, there were two Medicaid Event Verification audits held by MSHN. June and December 2020.

Findings from the June 2020 MEV are as follows:

- T1005 was submitted without documentation for the service. Line 627 and 634.
- H2015 was submitted without documentation of the time of the service. Line 635.
- H2015 was submitted without documentation of the service. Lines 667,668,669,675,676,677
- T1005 was submitted without documentation for the service. Lines 627, 634.
- H2015 was submitted without documentation for the service. Lines 667, 668,669,675,676,677.

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

- The provider submitted billing for the wrong day. They have corrected the error.
- The claims will be recouped and provider will receive training by 10/15/2020

Findings from the December 2020 MEV are as follows:

- Line 71, 214, 215, 271, 360, 470, 471, 474, 478: No credentials with clinician's signature
- Line 151: H0039 contacted was dated on 8.28.2020 when actually the date the contact took place was 8.25.2020.

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

- Staff without credentials listed on signature have been confirmed to have proper qualifications and the list of staff was sent to our Reimbursement department to have credentials added to signature in EHR. If any of those staff are not properly credentialed for the service they entered, the service will be voided in the system. Moving forward, QI will bring this issue to our internal Streamline User Group to see if there is a way to add credentialing onto signatures in the system.
- The note for the H0039 service has been amended to show it took place on the correct date.

FY20 Chart Review Results

Chart Review Process

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

Reviews will be completed at least quarterly and will address:

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

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

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

Chart Review Schedule

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

Timeframe	Programs for Chart Review
FY20 1st Quarter	ACT
FY20 2nd Quarter*	Residential (AMHS and CSDD) {HCBS Out of Compliance and HS cases}
FY20 3rd Quarter	Waivers (HSW, CWP)
FY20 4th Quarter	Mobile Crisis Unit (FF)

***FY20 2nd Quarter Chart Reviews were put on hold due to COVID-19 Pandemic, No results for that quarter.**

Chart Review Results

Aggregate Chart Review Standard Ratings	
Completely Met	100% Compliance
Substantially Met	85-99% Compliance
Partially Met	70-84% Compliance
Not Met	69% and Below

FY20 Q1 Chart Review Results

ACT Chart Review FY20 Quarter 1					
Section	**Question**	**Standard**	**# of Charts Reviewed**	**Overall Result FY20 Q1**	***FY18Q4 Results***
Assessment	**Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?**	**1.1**	**68**	**63.97%**	***54.69%***
	Consumer's needs & wants are documented?	**1.2**	**68**	**88.24%**	***100.00%***
	Assessment reflects input and coordination with others involved in treatment?	**1.3**	**65**	**81.54%**	***95.31%***
	Present and history of behavior and/or symptoms are documented and specifies if observed or reported.	**1.4**	**67**	**88.81%**	***95.31%***
	Substance use (current and history) included in assessment?	**1.5**	**57**	**87.72%**	***90.63%***
	Current physical health conditions are identified?	**1.6**	**62**	**93.55%**	***95.31%***
	Current health care providers are identified?	**1.7**	**66**	**93.94%**	***96.88%***
	Previous behavioral health treatment and response to treatment identified?	**1.8**	**67**	**74.63%**	***90.63%***
	History of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) - in the assessment	**1.9**	**61**	**83.61%**	***93.75%***
	Is the population and age specific trauma screening tool completed? - may be separate trauma screening document done during assessment and scanned into EHR		**33**	**6.06%**	
	Safety/risk issues of harm to self or others or by others (e.g. domestic violence) are assessed in all life domains	**1.10**	**67**	**93.28%**	***96.88%***
	If risk of harm to self or others has been identified a crisis plan has been completed (Crisis Plan is Required for home based services)	**1.11**	**45**	**36.67%**	***74.07%***

Preplanning	**Did pre-planning occur prior to the Person Centered Planning meeting or the development of a plan?**	**2.1**	**67**	**72.79%**	***70.31%***
Person Centered Planning / Individual Plan of Service	**Has the LOCUS been completed in the past year?**		**68**	**54.41%**	***78.13%***
	PCP is prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	**3.1**	**68**	**75.00%**	
	PCP includes a description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	**3.2**	**68**	**91.91%**	
	PCP includes the goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured.	**3.3**	**68**	**66.91%**	***95.31%***
	PCP includes the services and supports needed by the person to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs, community resources, and natural supports.	**3.4**	**68**	**89.71%**	
	PCP includes the setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment & work in competitive integrated settings, engage in community life, control person resources, and receive services in the community to the same degree of access as individuals not receiving services and supports from the mental health system.	**3.5**	**0**	**N/A**	
	PCP includes the amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.	**3.6**	**68**	**87.50%**	
	Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports.	**3.7**	**68**	**90.44%**	

	There is documentation of any restriction or modification of additional conditions.	3.8	0	N/A	
	PCP includes the services which the person chooses to obtain through arrangements that support self-determination.	3.9	68	92.65%	
	PCP includes the estimated/prospective cost of services and supports authorized by the CMHSP.	3.10	69	95.65%	
	Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	3.11	68	58.09%	*62.50%*
	The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	3.12	0	N/A	
	A timeline for review.	3.13	67	95.45%	*100.00%*
	Accommodations available for individuals accessing services who experience hearing or vision impairments, including that such disabilities are addressed in clinical assessments and service plans as requested by the person receiving services.	3.14	14	78.57%	
	If applicable, the IPOS addresses health and safety issues.	3.15	52	85.58%	
	If applicable, identified history of trauma is effectively addressed as part of PCP.	3.16	37	50.00%	*96.00%*
	Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	3.2	60	62.50%	*90.63%*
	Consumer has ongoing opportunities to provide feedback on satisfaction with treatment, services, and progress towards valued outcomes?	3.21	68	96.32%	*100.00%*
Service Delivery Consistent with Plan	Are services being delivered consistent with plan in terms of scope, amount, and duration?	6.1	62	62.90%	*60.94%*
	Monitoring and data collection on goals is occurring according to time frames established in plan?	6.2	62	75.81%	*64.06%*

	Are periodic reviews occurring according to time frames established in plan?	**6.3**	**60**	**56.67%**	***57.81%***
	Progress notes document progress towards goals?		**65**	**81.54%**	***95.16%***
	For any services billed at group level--does note show evidence that session was with a group? (TT modifier) - MEV finding		**16**	**93.75%**	***62.50%***
	If there are any peer specialist progress notes, was the service provided by a certified peer specialist? (HE modifier) - MEV finding		**49**	**100.00%**	***50.00%***
Specific Service Requirements	**For ACT services: all members of the team routinely have contact with the individual**	**7.1**	**66**	**84.33%**	***97.58%***
	For ACT service: majority of services occur in consumer home or community	**7.1**	**68**	**89.71%**	***96.77%***
	For medication services, informed consent was obtained for all psychotropic medications?	**7.2**	**68**	**41.18%**	***89.06%***
	Is there evidence of outreach activities following missed appointments?	**7.5**	**37**	**89.19%**	***92.86%***
	Is there evidence of coordination with Primary Care Physician in the record?	**7.6**	**66**	**42.42%**	***62.50%***
	For pre-admission screenings of ACT consumers: if a consumer has a pre-admission screening through crisis services, was this completed by an ACT staff member? (As of 4/1/18)		**12**	**37.50%**	***75.00%***

FY20 Q2 Chart Review Results

HSW Chart Review FY20 Q3		
P. Implementation of Person-Centered Planning	**# of Charts Reviewed**	**Overall**
P.2.1 The individual plan of service adequately identifies the individual's goals and preferences. (HSW PM D-3)	**43**	**98%**
P.2.3. Individuals are provided with ongoing opportunities to provide feedback on how they feel about services, supports and/or treatment they are receiving, and their progress towards attaining valued outcomes.	**44**	**70%**
P.2.4. The individual plan of service is modified in response to changes in the individual's needs. (HSW PM D-6)	**25**	**80%**
P.2.5. The person-centered planning process builds upon the individual's capacity to engage in activities that promote community life. MCL 330.1701(g)	**42**	**88%**
P.2.6. Individual plan of service addressed health and safety, including coordination with primary care providers. (HSW PM D-2.)	**43**	**67%**
P.2.7: The individual plan of service is developed in accordance with policies and procedures established by MDHHS. Evidence: 1. pre-planning meeting, 2. availability of self-determination, and 3. use of PCP process in developing IPOS. (HSW PM D-4)	**41**	**63%**
P.2.8: Services requiring physician signed prescription follow Medicaid Provider Manual requirements. (Evidence: Physician-signed prescriptions for OT, PT, and PDN services are in the file and include a date, diagnosis, specific service or item description, start date and the amount or length of time the service is needed).	**16**	**31%**
P. Plan of Service and Documentation Requirements		
P.5.1. Specific services and supports that align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing are identified in the IPOS. (HSW PM D-1)	**42**	**55%**

P.5.2. Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency and timeframe for implementing. (HSW PM D-7)	**40**	**58%**
P.5.3. The IPOS for individuals enrolled in the HSW is updated within 365 days from their last IPOS. (HSW PM D-5)	**39**	**77%**
G. Waiver Participant Health and Welfare		
G.2 Individual served received health care appraisal. (Date/document confirming_____)	**40**	**15%**

CWP FY20 Q3		
P. Implementation of Person-Centered Planning	**# of Charts Reviewed**	**Overall**
P.1.1: The IPOS is developed through a person-centered process that is consistent with Family-Driven, Youth-Guided Practice and Person Centered Planning Policy Practice Guidelines. (PM-D-3)	**21**	**86%**
P.1.2: The IPOS addresses all service needs reflected in the assessments. (PM-D-1)	**21**	**90%**
P.1.3: The strategies identified in the IPOS are adequate to address assessed health and safety needs, including coordination with primary care providers. (PM-D-2)	**21**	**67%**
P.1.4: The IPOS is developed in accordance with policies and procedures established by MDHHS. Evidence: 1. plan contains measurable goals/objectives and time frames; 2. Category of Care/Intensity of Care determination was completed by staff certified or trained by MDHHS in Category of Care/Intensity of Care determination. (PM D-4)	**21**	**48%**
P. Plan of Service and Documentation Requirements		

P.4.1: A current narrative supports the identified Category of Care/Intensity of Care determination and services are authorized and provided accordingly. (PM-D-4)	**21**	**90%**
P.4.2 Services and supports are provided as specified in the IPOS including type, amount, scope duration and frequency. (PM-D-7)	**21**	**19%**
P.4.4: Physician-signed prescriptions for OT, PT, and PDN services are in the file and include a date, diagnosis, specific service or item description, start date and the amount or length of time the service is needed. (PM-D-4)	**0**	
P.4.5: Physician-signed and dated prescriptions for locally authorized waiver durable medical equipment and supplies are in the file. (PM-D-	**4**	**50%**
P.4.6: The IPOS was updated at least annually	**20**	**95%**
G. Waiver Participant Health and Welfare		
G.2 Individual served received health care appraisal. (Date/document confirming_____)	**21**	**57%**

FY20 Q4 Chart Review Results

Mobile Crisis FY20 Q4		
#	**%**	**Standard**
12.1	**90%**	**These services are for beneficiaries who have been assessed to meet criteria for psychiatric hospital admissions but who, with intense interventions, can be stabilized and served in their usual community environments. These services may also be provided to beneficiaries leaving inpatient psychiatric services if such services will result in a shortened inpatient stay.**
	90%	**Policies include servicing children or youth, ages 0 to 21, with SED and/or I/DD, including autism, or co-occurring SED and SUD**
12.2	**70%**	**Face to face contacts are occurring within one hour or less in urban counties and in two hours in rural counties from the time of the request for ICSS**

12.3	80%	Services include: Assessments (rendered by the treatment team) De-escalation of the crisis Family-driven and youth-guided planning Crisis and safety plan development Intensive individual counseling/psychotherapy Family therapy Skill building Psychoeducation Referrals and connections to additional community resources Collaboration and problem solving with other child- or youth-serving systems, as applicable Psychiatric consult, as needed
	0%	There is evidence of access to an on-call psychiatrist for team members (must be available by telephone at all times).
12.4	90%	For children: ICSS staff consists of at least two who travel to the child or youth in crisis. One team member must be a Master's prepared Child Mental Health Professional (or Master's prepared QIDP, if applicable) and the second team member may be another professional or parapro under appropriate supervision.
	N/A	For adult recipients: An ICSS treatment plan is developed within 48 hours. If the beneficiary receives case management services, the case manager must be involved in the treatment and follow-up services
12.5	40%	For children/youth: If the child or youth is a current recipient of CMHSP services, the existing IPOS and crisis/safety plan must be updated
	60%	For children or youth who are not yet recipients of CMHSP services but are eligible for such services, a family-driven and youth-guided follow-up plan must be developed.
12.6	40%	If the child or youth is a current recipient of CMHSP services, there is evidence of the mobile intensive crisis stabilization team members notifying the primary therapist, case manager, or Wraparound facilitator, as applicable, of the contact with the mobile intensive crisis stabilization team the next business day.
	78%	Evidence that a follow-up contact has been made with the child or youth and parent/caregiver by the primary therapist, case manager, or wraparound facilitator once the primary case holder was informed of the child or youth's contact with the ICSS team.

12.7	**80%**	**If the child or youth is not yet a recipient of CMHSP services but is eligible for such services, the follow-up plan must include:-** **Appropriate referrals to mental health assessment and treatment resources and any other resources the child or youth and parent/caregiver may require**
	50%	**- Next steps for obtaining needed services, timelines for those activities, and identifies the responsible parties.**
	90%	**- The mobile intensive crisis stabilization team members have contacted the parent/caregiver by phone or face-to-face within seven business days to determine the status of the stated goals in the follow-up plan**

Provider Monitoring

Overview

CMHA-CEI has 3 quality advisors who conduct site visits for contract sites for the following contract types:

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

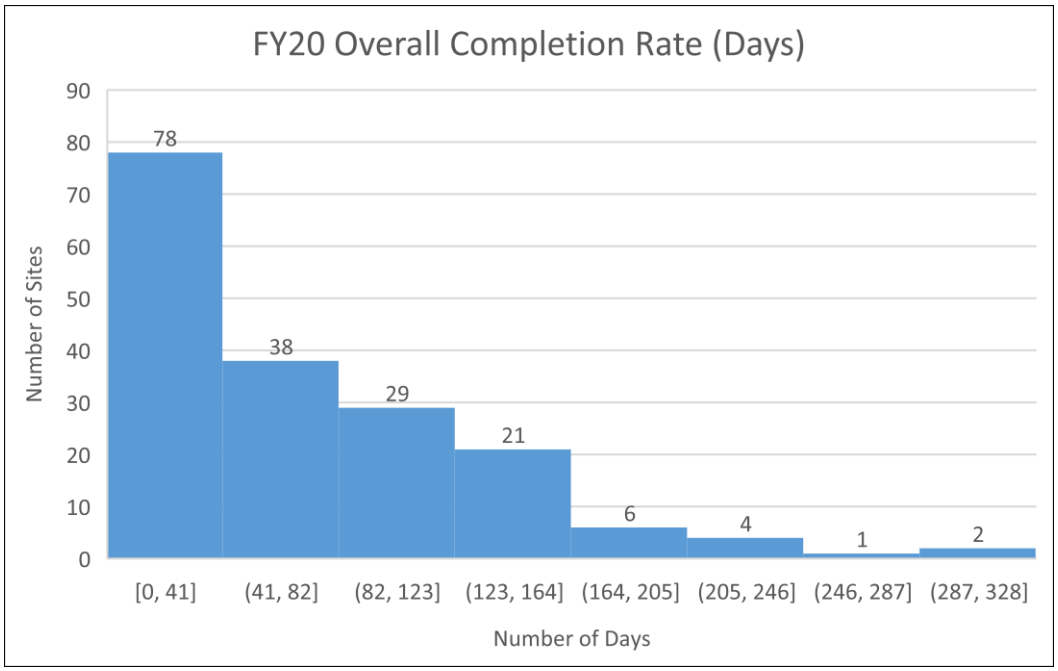
Quality advisors conduct 3 types of site visits annually, a recipient rights review, a quality and compliance review, and a home and community based review, if necessary.

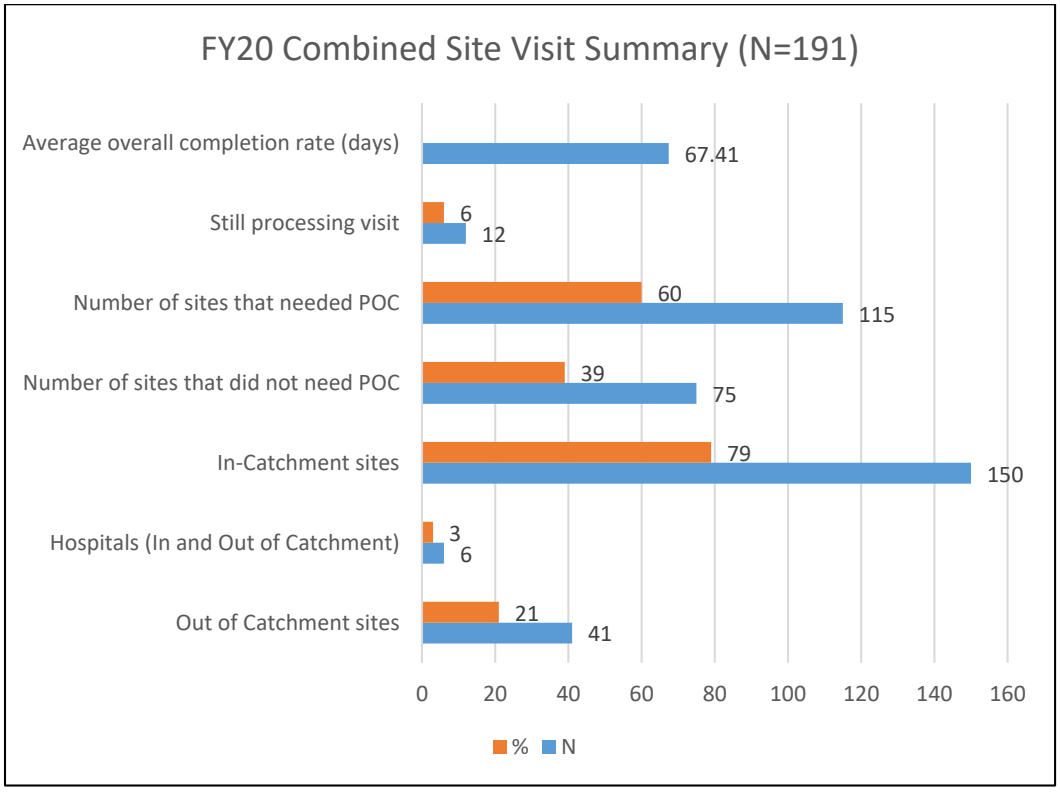
Due to the COVID-19 pandemic, all site reviews beginning in March 2020 were conducted virtually using Zoom video conferencing. In an effort to lessen the burden on residential care providers, site reviews were interim; only required contract components and items present on 2019 Plan of Corrections were assessed.

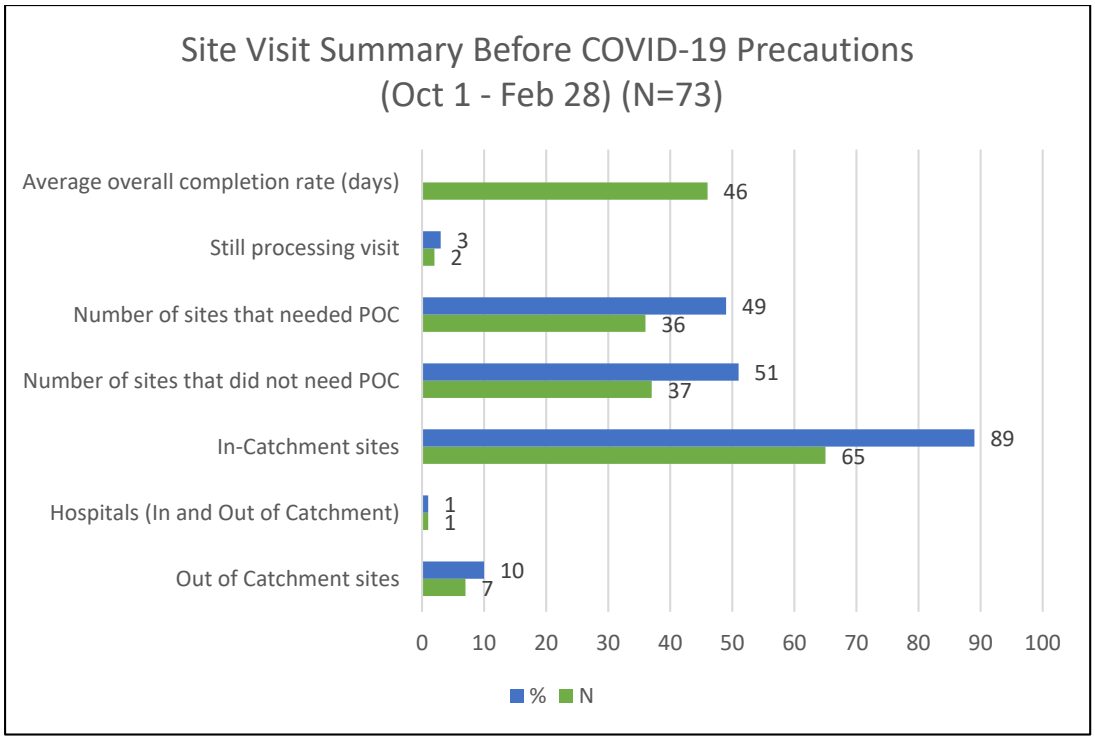
It should be noted that data analysis of site reviews conducted in FY20 may not be reflective of typical site review data, as the situations caused by COVID-19 resulted in an abnormal process.

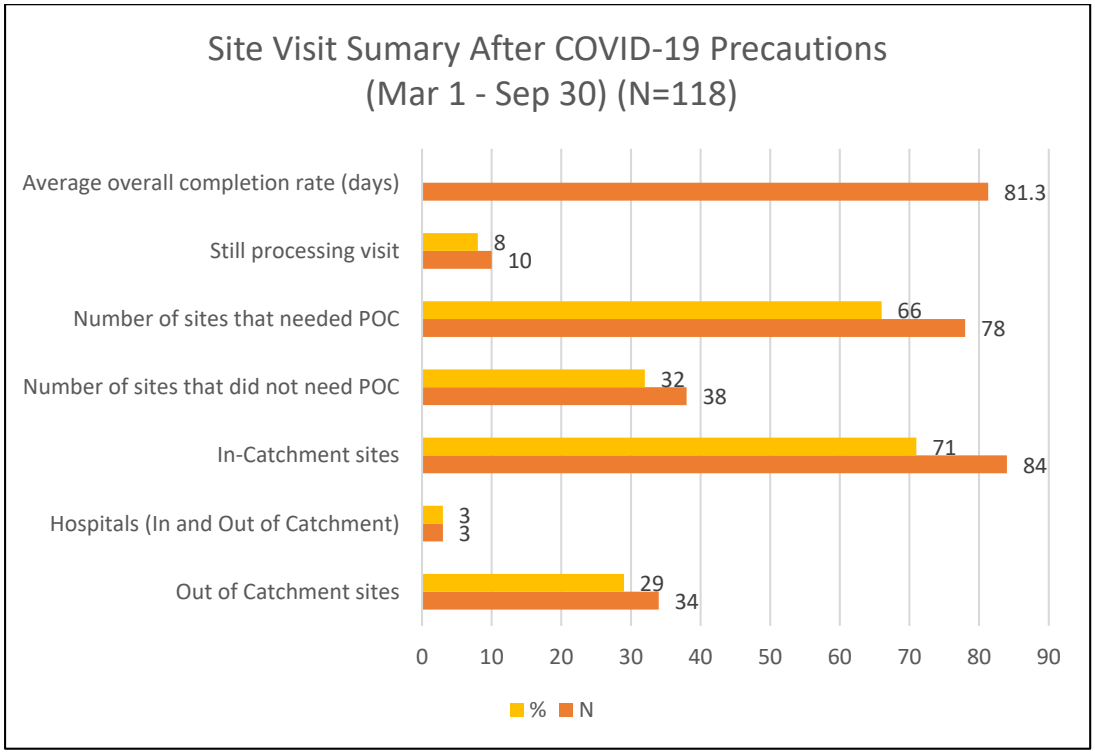
Site Visit Overview

- 191 Site reviews were conducted in FY20
- 18 contracts were terminated and 20 new contracts were established in FY20
- 12 FY20 site reviews are still completing their POC and have not met full compliance.
- Overall completion rate (from initial visit date to full compliance) was an average of 68 days, which was an improvement from 83 days for FY19
    - 60% of sites required a POC, compared to 47% in FY19
    - 40% of sites were found to be in full compliance at the time of review, and did not require a POC, compared to 27% in FY19.


FY20 Overall Completion Rate (Days)
Number of Sites
90
80
70
60
50
40
30
20
10
0
78
38
29
21
6
4
1
2
[0, 41]
(41, 82]
(82, 123]
(123, 164]
(164, 205]
(205, 246]
(246, 287]
(287, 328]
Number of Days


FY20 Combined Site Visit Summary (N=191)
Average overall completion rate (days)
67.41
Still processing visit
6
12
Number of sites that needed POC
60
115
Number of sites that did not need POC
39
75
In-Catchment sites
79
150
Hospitals (In and Out of Catchment)
3
6
Out of Catchment sites
21
41
0
20
40
60
80
100
120
140
160
% N


Site Visit Summary Before COVID-19 Precautions
(Oct 1 - Feb 28) (N=73)
Average overall completion rate (days)
46
Still processing visit
3
2
Number of sites that needed POC
49
36
Number of sites that did not need POC
51
37
In-Catchment sites
89
65
Hospitals (In and Out of Catchment)
1
1
Out of Catchment sites
10
7
0 10 20 30 40 50 60 70 80 90 100
% N


Site Visit Sumary After COVID-19 Precautions
(Mar 1 - Sep 30) (N=118)
Average overall completion rate (days)
81.3
Still processing visit
8
10
Number of sites that needed POC
66
78
Number of sites that did not need POC
32
38
In-Catchment sites
71
84
Hospitals (In and Out of Catchment)
3
3
Out of Catchment sites
29
34
0 10 20 30 40 50 60 70 80 90
% N

Improvement Opportunities

Quality advisors along with Contract & Finance Dept. and Clinical programs will continue to assist providers in the following areas in the coming year:

- Improved online training system (i.e., CMHA-CEI online system, Improving MI Practices system)
- Allocation of more online resource to cut down operating cost (utilize free online services for human resource management i.e., OIG checks, IChat, etc.)
- Collaborate with other CMHs to improve review process for Out of Catchment sites (i.e., Reciprocity process-MCHE web group)
- Enhance the use of CMHA-CEI provider access portal
- Utilize onboarding process to address important topics pertained to compliance (Contract & Finance, and QA's)
- Assisting providers navigate unique challenges caused by COVID-19 pandemic

Policy and Procedure Review

CMHA-CEI Policies and Procedures are to be reviewed annually. In FY19, 93 policies were reviewed out of 127, for a compliance percentage of 73%. 127 procedures were reviewed out of 190, for a compliance percentage of 67%.

In FY20, all Policies and Procedures were reviewed within the one-year timeline, for 100% compliance. Additional formatting updates were made to include specific standards for which a policy or procedure apply. The QI team continues to update Policies and Procedures on a monthly basis with the cooperation of program directors. Future plans for Policy and Procedures are to continue to monitor and update formatting inconsistencies, organize operating guidelines, and implement a Policy and Procedure tracking software.

Health Services Advisory Group (HSAG)

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.

MSHN Audit

MSHN completed its virtual desk audit of CMHA-CEI in June 2020. Findings were as follows:

Program Specific Tool	Finding
HCBS Site Reviews and Follow up	Site Review follow up was not entirely compliant, modifications needed for specific homes.
Jail Diversion and Jail Diversion Screen	Jail Diversion Procedure does not meet compliance and will be addressed at the next QA review
Intensive Crisis Stabilization Services	Policy should include those eligible for services a family-driven and youth-guided follow up plan
SUD Review	House of Commons documentation for weekly treatment schedule and other staff training. Specific treatment plans to follow MSHN requirements/guidelines

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

Finding	Corrective Action
HCBS Site Reviews and Follow up	Photos of repairs and modifications to specific homes provided and accepted.
Jail Diversion and Jail Diversion Screen	Jail Diversion procedure will be reviewed at a later date, per MSHN
Intensive Crisis Stabilization Services	Update CWP Operating Guideline to meet PIHP Compliance
SUD Review	Attached updated scheduling and training checklists, nursing notes and services from selected consumers.

MDHHS Audit

Every two years, MDHHS audits the three waiver programs (SEDW, CWP, and HSW) and the ABA Program. Quality Improvement staff work with the clinical departments to meet the standards MDHHS has set for these programs.

In 2020, CMHA-CEI underwent a full site review by MDHHS for SEDW, CWP, and HSW. The site review was conducted for the full MSHN region and included all 12 CMHSPs in the region. For CMHA-CEI 8 HSW charts, 4 CWP charts, and 7 SEDW charts were reviewed by MDHHS. Areas reviewed were case files, provider qualification, and administrative processes related to health and welfare.

DIMENSIONS/INDICATORS	Yes	No	FINDINGS	REMEDIAL ACTION
A. ADMINISTRATIVE PROCEDURES				
A.1 All				
A.1.1. The PIHP has adopted common policies for use throughout the service area for critical incidents. Medicaid Managed Specialty Supports and Services contract, Section 6.4; AFP Sections 3.8, 4.0 42 CFR 438.214. Waiver Assurance for Participant Safeguards	1	0	See HSW report.	
A.1.2. The PIHP has policy and business procedures to assure regular monitoring and reporting on each network provider for critical incidents. 42 CFR 438.230(b)(4) 42 CFR 438.810 Medicaid Managed Specialty Supports and Services contract, Section 6.4; AFP Sections 2.5, 3.8, 3.1.8 Waiver Assurance for Participant Safeguards	1	0	See HSW report.	
A.1.3 Review and verify that the process	1	0	See HSW report.	

is being implemented according to policy. Waiver Assurance for Participant Safeguards				
A.1.4 PIHP/CMHSP is implementing the Quality Improvement Project as approved by MDHHS.	NA	N A	See HSW report.	
A.1.5 The PIHP/CMHSP has a policy that guides the contracting process with new providers or providers who are expanding their service array. These policies ensure new providers are assessed to ensure they do not require heightened scrutiny based upon isolating of institutional elements. • PIHP/CMHSP provides evidence of the policy • Review of PIHP/CMHSP provisional approval documents	1	0	See HSW Report	
A.2.CWP				
A.2.2. *<u>Claims are coded in accordance with MDHHS policies and procedures (PM I-1)</u> <u>*Correction to embedded language.</u>	13	0		
E. <u>ELIGIBILITY</u> (Medicaid Provider Manual, Menta Health / Substance Abuse)				
E.1. CWP				

E.1.1 Child is developmentally disabled. Evidence: 1. Three or more areas of substantial functional limitations are identified. Within the last 12 months, assessments have been completed and/or supporting documentation obtained that reflect all of the consumer's current functional abilities and any current substantial functional limitations identified in the areas of self-care, understanding and use of language (expressive and receptive), learning (functional academics), mobility, and self-direction. For consumers age 16 and older, functional abilities and any current substantial functional limitations are identified in the areas of capacity for independent living and economic self-sufficiency. Or 2. If the consumer is a minor from birth to age 9, documentation is provided of a related condition and the current rationale to support a high probability of developing a developmental disability. (PM-B-3)	**13**	**0**		

E.1.2 *The child is in need of active treatment. (evidence: Within the last 12 months, assessments have been completed of the need for health and habilitative services designed to assist the consumer in acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings). (PM B-3) Medicaid Provider Manual, Section 15 ***Correction to embedded language.**	13	0		
F. FREEDOM OF CHOICE (Medicaid Provider Manual, Menta Health / Substance Abuse)				
F.1. CWP				
F.1.1 Parent was informed of right to choose among qualified providers. (evidence: Parents signature on the certification form) (PM-D-10)	13	0		
F.1.2 Parent was informed of their right to choose among the various waiver services. Evidence: 1. administrative records policies and procedures, 2. individual records; 3. consumer/Family interviews (PM-D-9)	13	0		
P. IMPLEMENTATION OF PERSON-CENTERED PLANNING				

Medicaid Managed Speciality Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Guideline MCH712 Chapter III, Provider Assurances & Provider Requirements Attach. 4.7.1 Grievances and Appeals Technical Requirement.				
P.1. CWP				
P.1.1: The IPOS is developed through a person-centered process that is consistent with Family-Driven, Youth-Guided Practice and Person Centered Planning Policy Practice Guidelines. (PM-D-3)	12	1	**Newaygo County Mental Health Center** **WSA# 55002** (No vidence of pre-planning).	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS is developed through a person-centered process that is consistent with Family-Driven, Youth-Guided Practice and Person Centered Planning Policy Practice Guidelines. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **NCMH** • By 9/23/2020 WSA # 55002 will be offered Self-Determination / Independent Facilitation with documentation

				in the record by the 90-day f/u site review. • By 9/23/2020 (WSA# 55002) pre-planning will occur to better inform the IPOS process, with evidence in the record by the 90-day f/u site review. Following Audit exit at NCMH, clinician completed the missing pre-plan for 11/7/19. **☒ Systemic Remediation:** **NCMH** • By 10/26/2020 staff training will be provided on the requirement of pre-planning activities that must inform person-centered planning. Director of youth services will train/inform all clinicians at our bi-weekly team meeting of the pre-plan process and the requirement of this document for each client record. Associate Director will provide direct supervision to the assigned clinician of this CWP client around the pre-plan process and will document this in the supervision log at least quarterly. • By 9/1/2020, EMR will be adjusted to include this information as required fields in the pre-planning document. In EMR/PCE the check box allowing for clinicians to do a pre-plan and treatment plan to be completed within the same session date has been removed and this is no longer an option in our system for clients. • Effective 10/23/2020, CM Supervision will monitor a random selection of records quarterly to monitor for this requirement. Associate Director of youth services will provide ongoing supervision to assigned clinician of this CWP case and will review all CWP/SEDW at least quarterly

				to ensure pre-plan document is completed. Random record reviews of all clinician cases will continue to be implemented quarterly to review this requirement as well. **MDHHS Response**: ☒ **Response accepted**
P.1.2. The IPOS addresses all service needs reflected in the assessments. (PM-D-1)	11	2	**Newaygo County Mental Health Center** **WSA# 55002** (Expressed need for generator not resolved within the record.) **Lifeways** **WSA# 20557** (Expressed need for ramp not addressed in the record).	**Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS addresses all service needs reflected in the assessments. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS.** **CMHSP/PHIP Response:** **The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021.** ☒ **Individual Remediation:** **NCMH** • **By 9/23/2020 amendment will be completed to address**

				identified needs in the assessment, not yet resolved in IPOS. Primary clinician updated progress note 12/12/19 to reflect a conversation with parent in regards to the generator. This note reflects that mom changed her mind and no longer wanted to pursue this equipment. **Lifeways** • **LifeWays Note –there was no individual remediation required as updated IPOS on 6/22/20,for the treatment year of 7/26/20 to 7/25/21,addressed ramp.** **☒ Systemic Remediation:** **NCMH** • **By 10/23/2020, staff training will be conducted focusing on the need to resolve all identified needs noted in the assessment, within the IPOS.** **Director of youth services will train/inform all clinicians about the importance of resolving all identified needs that have been addressed within the assessment, IPOS or in individual/family therapy sessions. Training will involve the importance of timely follow through of these requests and documenting thoroughly and new information or changes and how staff will be working to get this need met.** • **Beginning 10/23/2020 on going monitoring by supervisory staff will be done through quarterly clinical chart reviews, for required elements of plans addressing identified needs. Associate Director of youth services will meet in monthly supervison with**

				assigned clinician of CWP case to monitor the case entirely. Supervision logs will reflect on a quarterly basis chart reviews of the CWP case to ensure that any identified needs are being addressed in a timely manner and thorough. **Lifeways** • **By 12/15/20, staff training will be conducted focusing on the need to resolve all identified needs noted in the assessment, within the IPOS.** • **By 12/15/20, monitoring by supervisory staff will be done through quarterly clinical chart reviews, for required elements of plans addressing identified needs.** **MDHHS Response:** ☒ **Response accepted**
P.1.3. The strategies identified in the IPOS are adequate to address assessed health and safety needs, including coordination with primary care providers. (PM-D-2)	10	3	**CMH for Central Michinga** **WSA# 37898**: Could not locate coordination of care with primary care physician. **WSA# 20255**: Could not locate medication consent for psychotropic medications prescribed by CMH, signed by guardian. **Newaygo County Mental Health Center** **WSA# 5500:** Could not locate coordination of care with primary care physician.	**Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the strategies identified in the IPOS are adequate to address assessed health and safety needs, including coordination with primary care physicians.. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS.** **CMHSP/PHIP Response:** **The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at**

				the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. **☒ Individual Remediation:** **CMHCM** • **By 10/15/2020 the following will be completed/reflected in the record for WSA #20255: Medication consent reflecting all meds.** • **By 10/15/2020 the following will be completed/reflected in the record for WSA#37898: A physician collaboration letter will be sent to the primary care physician to demonstrate coordination of care.** **NCMH** • **By 9/23/2020 the following will be completed/reflected in the record. Psychiatric Eval-Coordination of Care-Medication consent reflecting all meds-Resolution of the health and safety matter noted below.-** ○ **Psychiatric Eval** ○ **Coordination of Care** ○ **Medication consent reflecting all meds** ○ **Resolution of the health and safety matter noted below.** **Other- Assigned clinician has completed scanning of all documents in our EMR from Devos, Spectrum Health and Primary Care**

				Physician. Documents were scanned on 6/12/2020.. **☒ Systemic Remediation:** **CMHCM** • **By 10/21/2020 Utilization Manager will complete training at the Super Management team meeting regarding the required elements of addressing health / safety, coordination of care, psychiatric evaluations and medication consents. The expectation is that supervisors will take this discussion back to their clinical teams.** • **Other: CMHCM's current physician collaboration letter is being reviewed to determine if changes are warranted based on the required compliance.** **NCMH** • **By 10/23/2020 additional training will be provided to the staff at large regarding the required elements of addressing health / safety, coordination of care, psychiatric evaluations and medication consents. Director and Associate Director will train/inform all clinicians of the requirement for solid coordination of care in all cases. We will inform them of making sure to address all health and safety needs, any information from outside sources, psychiatric evaluations and medication consents. This training will occur within our team meeting during the month of October. We will also share the quarterly record reviews with each clinician in**

				regards to these areas of the review. **MDHHS Response:** ☒ **Response accepted**
P.1.4. The IPOS is developed in accordance with policies and procedures established by MDHHS. Evidence: 1. plan contains measurable goals/objectives and time frames; 2. Category of Care/Intensity of Care determination was completed by staff certified or trained by MDHHS in Category of Care/Intensity of Care determination. (PM D-4)	11	2	**Lifeways** **WSA# 20557**: Could not find amt scope duration frequency of recommended services, within the plan of service/under treatment goals/recommendations. **Newaygo County Mental Health Center:** **WSA# 55002:** Lack of a habilitative goal (as required within CWP and to support the need for recommended CLS services.)	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS is developed in accordance with policies and procedures established by MDHHS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **Lifeways** • By 12/15/20,the plan will be amended for resolving lack of measurable goals/ objectives/ timeframes. **NCMH** • By 9/23/2020 the plan will be amended for resolving lack of measurable goals/ objectives/

				timeframes. Assigned clinician updated current treatment plan to reflect habilitative goals to support the need for the recommended CLS service. Clinician initiated a meeting with one of our nurses on staff to work on how to write an habilitative goal that would be sufficient and clinically sound. The treatment plan that was updated was for 11/7/19, reflected under the interventions of Goal 1 and 2. ☒ **Systemic Remediation:** **Lifeways** • By 12/15/20, staff training will be conducted on developing measurable goals **NCMH** • By 10/23/2020, staff training will be conducted on developing measurable goals. Clinician initiated a meeting with one of our nurses on staff to work on how to write an habiliative goal that would be sufficient and clinically sound. Directors will plan to talk/train clinicians on how to develop measureable goals that are habilitative to show support for a requested/required service within the plan. Will review examples of measurable goals. This training will occur in a team meeting within the month of October 2020. **MDHHS Response**: ☒ **Response not accepted. –** **X No individual remediation found:** **For Lifeways,** citation was for the lack of reflecting specific amt scope duration of recommended services (rather than lack of measurable goals). Please revise.

				For Newaygo, the citation was for a lack of a habilitative goal (as required by the CWP and for which a waiver service would be required), rather than a lack of developing a measurable goal. Please revise. ☒ No systemic rededication found **For Lifeways**, systemic remediation not related to citation **For Newaygo**, systemic remediation not related to citation ☐ No timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response:** **Newaygo-Individual Remediation** • By 9/23/2020 the plan will be amended for resolving lack of habilitative goals/ objectives/ timeframes. Assigned clinician updated current treatment plan to reflect habilitative goals to support the need for the recommended CLS service. Clinician initiated a meeting with one of our nurses on staff to work on how to write an habilitative goal that would be sufficient and clinically sound. The treatment plan that was updated was for 11/7/19, reflected under the interventions of Goal 1 and 2. **Newaygo-Systematic Remediation** • By 10/23/2020, staff training will be conducted on developing habilitative goals. Clinician initiated a meeting with one of our nurses on staff to work on how to write an habilitative goal that would be sufficient and clinically sound. By 10/31/2020 Directors will plan to talk/train clinicians on how to develop habilitative goals that show support for a

				requested/required service within the plan. Will review examples of habilitative goals. This training will occur in a team meeting within the month of October 2020. **LifeWays-Individual Remediation**: • By 12/15/20, the plan for WSA#20557 will be amended for resolving/addressing service provision, including amount, scope and duration as recommended. **LifeWays-Systemic Remediation** • By 12/15/20, staff training will be conducted, on the need to address/resolve needs identified in the assessments, and amount, scope, duration, within the IPOS; PCP training will be revised to train more in detail addressing/resolving needs identified in the assessments, and amount, scope, duration, within the IPOS. **MDHHS 2nd Response**: ☒ **Response accepted**
P. PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS				
P.4. CWP				
P.4.1: A current narrative supports the identified Category of Care/Intensity of Care determination and services are authorized and provided accordingly. (PM-D-4)	10	3	**CMH of Central Micigan** **WSA# 38468** **Lifeways** **WSA# 20557** **Tuscola Behavioral Health Services** **WSA# 20920**	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that a current narrative supports the identified Category of Care/Intensity of Care determination and services are authorized and provided accordingly. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after

				the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **CMHCM** • By 11/1/2020 for WSA # 38468 the plan will be amended for resolving lack of COC documentation reflected in the record. **Lifeways** • By 12/15/20, Category of Care/ Intensity of Care determination will be completed. • By 12/15/20, CM staff will receive COC training/ certification. **TBHS** • By 10/1/2020, plan will be amended to for resolving lack of COC documentation reflected in the record. • By 10/1/2020, The Clinician will update the current plan of service by way of addendum in order to capture all required items.. ☒ **Systemic Remediation:** **MSHN**

				• By 12/30/20 MSHN will provide regional guidance/training on development of measurable goals/objectives to address the assessed needs including amount scope and duration of services included in the IPOS through the CWP regional work group. • By 1/15/21 MSHN will develop a regional training plan for IPOS development to ensure ongoing training is available for CMHSPs to utilize with in their organization. **CMHCM** • By 10/21/2020 Utilization Manager will complete training at the Super Management team meeting on the requirement of COC / Intensity of Need to be reflected in the plan as driving level of services recommended. The expectation is that the supervisory staff then take this back to their clinical teams**.** **Lifeways** • By 12/15/20, staff training will be conducted on the requirement of COC / Intensity of Need to be reflected in the plan as driving level of services recommended. **TBHS** • By 12/1/2020, The Care Coordination Department will be including specific information within the CWP departmental procedure that includes detailed information for all areas within the category of care to be included in one section within the plan of service. **MDHHS Response**: ☒ **Response accepted**
P.4.2 Services and supports are provided as specified in the	9	4	**CMH of Central Micingan** **WSA# 38468**	Submit a plan that reflects both individual and systemic

IPOS including type, amount, scope duration and frequency. (PM-D-7)			**WSA# 20255** (Amt Scope Duration of recommended services could not be found, and CLS did not occur as recommended). **<u>Newaygo County Mental Health Center</u>** **WSA# 55002** (TCM not occurring as recommended.) **<u>Tuscola Behavioral Health Systems</u>** **WSA# 20920** (OT, CLS, MD services not occurring as recommended.) **<u>NOTATION:</u> Technical Assistance provided around the use of ranges/range language in recommending/authorizing supports and services.** Going forward, MDHHS will expect specific amount/scope/duration/frequency of services to be identified in the IPOS, rather than the use of ranges or "up to" language, to better comply with best practices and to better meet federal and state regulation, as well as contract requirements.	remediation with time frames to ensure that services and supports are provided as specified in the IPOS, including amount, scope, duration and frequency. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **CMHCM** • By 10/15/2020 for WSA# 38468 the plan will be amended for resolving/addressing service provision as recommended. Amount, scope, duration of prior authorized services will be included in the intervention section of the IPOS. • By 10/15/2020 for WSA# 20255 the plan will be amended for resolving/addressing service provision as recommended. Amount, scope, duration of prior authorized services will

				be included in the intervention section of the IPOS. **NCMH** • By 10/23/2020, plan will be amended for resolving/addressing service provision as recommended. Assigned clinician will be scheduling with the family to update current treatment plan to remove targeted case mgt ranges and will input the exact amount of targeted case mgt that will be utilized for this treatment plan as well as the amount, scope and duration under interventions of stated goals within the treatment plan dated 11/7/19. • By 10/23/2020, CM will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity. The current treatment plan reflects using ranges for services based on our EMR and having been informed that we were allowed to do this in our plans. After review with auditors we were informed this is not an option, hence clinician will update this to reflect this change and will put the exact amount of targeted case mgt within the plan. Clinician will also add the amount, scope and duration under the interventions of stated goals in the treatment plan dated for 11/7/19. **TBHS** • By 10/1/2020, plan will be amended for resolving/addressing service provision as recommended. • By 10/1/2020, The clinician will complete an addendum that includes CLS services that are authorized weekly. The addendum will also include additional information related

				to the other medically necessary services recommended based on the category of care to include Respite, CSM, OT services. The family continues to utilize Respite services. During the COVID-19 pandemic, the family reduced some Respite utilization; however, this service has continued to be utilized and billed through Self Determination. • Other: This shall be completed by 11/01/2020. There is evidence within the record to support OT services being billed; however, there has been difficulty obtaining this information from the provider as it is the families' provider of choice through the self-determination process. The Clinician will request this information directly through SD provider, in order to attach it to billings being received and paid through the individual budget as this is a choice voucher case. **☒ Systemic Remediation:** **MSHN** • By 12/30/20 MSHN will provide regional guidance on ensuring services and treatment are provided as specified in the plan including amount scope and duration of services included in the IPOS through the CWP regional work group. • By 1/15/21 MSHN will develop a regional training plan for IPOS development to ensure ongoing training is available for CMHSPs to utilize with in their organization**.** **CMHCM** • By 10/21/2020 Utilization Manager will complete training at the Super Management Team meeting on including amount, scope, duration in the intervention section of the

				IPOS as well as monitoring of service provision to ensure services are being provided as prior authorized. The expectation is that supervisors will then take the training materials/discussion back to their clinical teams. • Other: (See response below) Utilization Review Specialist (URS) will be developing online, recorded training modules to the requirement that services require ongoing monitoring to ensure they are provided as specified in IPOS including the amount, scope, duration and frequency. The modules will also include information on the requirement that the amount, scope, duration of prior authorized services is included in the IPOS. Target date for these trainings to be recorded is 12/31/2020 and they will be available for all staff/supervisors. **NCMH** • By 10/23/2020, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. Staff have been trained in team meeting on the change in documenting authorizations. Informed staff moving forward that they will need to put exact amount of sessions for the services they will be providing. Informed staff that they will also need to reflect the amount, scope and duration under interventions of stated goals in the treatment plan. Meeting minutes reflect this training. **TBHS** • By 12/1/2020, The Care Coordination Department will be including specific information within the CWP

				departmental procedure that includes detailed information for all areas within the category of care to be included in one section within the plan of service. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** **X RE individual remediation recommended:** **For TBHS:** The citation was for not providing services as recommended (per authorizations, defaulted to when recommended amt scope duration could not be found). CLS, under CWP is required to be authorized on a monthly basis (though it can be recommended weekly, flexible monthly). Please revise. The additional information added to the record must include specific amt scope duration of recommended services (beyond listing the authorizations at the end of the plan). ☐ No systemic rededication found ☐ No timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response:** **TBHS Individual Remediation** • By 11/01/2020 for WSA# 20920 the plan will be amended for resolving/addressing service provision as recommended. Amount, scope, duration of prior authorized services will be included in the methodology section of the IPOS for CLS. It will be monitored by the Case Manager monthly to ensure that the medically necessary services are being provided as specified by the plan. • On 10/23/2020 for WSA#20920 the agency has reminded the Fiscal Intermediary of its contractual

				obligation to provide documentation to support the services that were provided for this beneficiary. • By 10/30/2020, the Fiscal Intermediary will provide the supporting documentation. • By 11/01/2020 for WSA# 20920 the plan will be amended for resolving/addressing service provision as recommended. Amount, scope, duration of prior authorized services will be included in the methodology section of the IPOS for MD services. It will be monitored by the Case Manager monthly to ensure that the medically necessary services are being provided as specified by the plan. • A psychiatric evaluation was completed for WSA# 20920 on 6/20/20 and evidence of the services is clearly documented in the EHR. Also, WSA #20920, received psychiatric follow-up on 7/21/20 as clinically indicated in plan. **MDHHS 2nd Response**: ☒ **Response accepted, with evidence of above, expected at the 90 day review.**
P.4.4: Physician-signed prescriptions for OT, PT, and PDN services are in the file and include a date, diagnosis, specific service or item description, start date and the amount or length of time the service is needed. (PM-D-4)	1	0	NA: 12	
P.4.5: Physician-signed and dated prescriptions for locally authorized	NA	NA	NA: 13	

waiver durable medical equipment and supplies are in the file. (PM-D-4)				
P.4.6: The IPOS was updated at least annually. (PM-D-5)	12	0	NA: 1	
P.4.7: The IPOS was reviewed both at intervals specified in the IPOS and when there were changes to the waiver participant's needs (evidence: IPOS is updated if assessments/quarterly reviews/progress notes indicate there are changes in the child's condition). (PM-D-6)	13	0		
B. BEHAVIOR TREATMENT PLANS AND REVIEW COMMITTEES Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1				
B.1.The BTPRC process includes all the following elements as required by the Technical Requirement for Behavior Treatment Plan Review Committees: 1. Documentation that the composition of the Committee and meeting minutes comply with the TR; 2. Evaluation of committees' effectiveness occurs as specified in the TR; 3. Quarterly documentation of tracking and analysis of the use of all physical management techniques and the use of			See HSW Report	

intrusive/restrictive techniques by each individual receiving the intervention; 4. Documentation of the QAPIP's OR QIP's evaluation of the data on the use of intrusive or restrictive techniques; 5. Documentation of the Committees' analysis of the use of physical management and the involvement of law enforcement for emergencies on a quarterly basis; 6. Documentation that behavioral intervention related injuries requiring emergency medical treatment or hospitalization and death are reported to the Department via the event reporting system; 7. Documentation that there is a mechanism for expedited review of proposed behavior treatment plans in emergent situations. Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.				
B.2. Behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees.	NA	NA	NA: 13	

1. Documentation that plans that proposed to use restrictive or intrusive techniques are approved (or disapproved) by the committee 2. Documentation that plans that include restrictive/intrusive interventions include a functional assessment of behavior and evidence that relevant physical, medical and environmental causes of challenging behavior have been ruled out. 3. Are developed using the PCP process and reviewed quarterly 4. Are disapproved if the use of aversive techniques, physical management, or seclusion or restraint where prohibited are a part of the plan 5. Written special consent is obtained before the behavior treatment plan is implemented; positive behavioral supports and interventions have been adequately pursued (i.e. at least 6 months within the past year) 6. The committee reviews the continuing need for any approved procedures involving				

intrusive or restrictive techniques at least quarterly.				
G. **WAIVER PARTICIPANT HEALTH AND WELFARE**				
G.1 Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents. (Date(s) of progress notes, provider notes that reflect this information.).	13	0		
G.2 Individual served received health care appraisal. (Date/document confirming)	13	0		
Q. STAFF QUALIFICATIONS				
Q.1 CWP				
Q.1.1. Clinical service providers and case managers are credentialed by the CMHSP prior to providing services. (Evidence: personnel records and credentialing documents – including licensure and certification and required experience for QIDP). (PM C-1)	18	1	A total of 19 professional staff were reviewed for this performance measure, and Q.1.2. ***Lack of evidence of initial background check, prior to hire.*** **CMH of Central Michigan** **WSA# 20255:** Brianna Cass	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that clinical service providers and case managers are credentialed by the CMHSP prior to providing services.. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action

				will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. **☒ Individual Remediation:** **CMHCM** • The annual criminal background check has been completed for staff cited, and will be provided to MDHHS at 90 day f/u site review • Other: (See response below)The initial background check was not retained in accordance with agency policy. • Other: (See response below) CMHCM has policy and procedures in place to retain initial back ground checks and the most recent annual check there after. This situation can be consistently seen amongst the staff selected for audit who were hired prior to 2017. Once the plan of correction was implemented, agency policy was updated and all initial background checks have been retained. A review of the process will be conducted to ensure it is implemented 100%. **☒ Systemic Remediation:** **CMHCM** • CMHCM has policy and procedures in place to retain initial back ground checks and the most recent annual check there after. This situation can be consistently seen amongst the staff selected for audit who

				were hired prior to 2017. Once the plan of correction was implemented, agency policy was updated and all initial background checks have been retained. A review of the process will be conducted to ensure it is implemented 100% **MDHHS Response**: ☒ **Response accepted, with evidence of review of process expected at the 90 day review.**
Q.1.2. Clinical service providers and case managers are credentialed by the CMHSP ongoing. (evidence: personnel records and credentialing documents-including licensure and certification and required experience for QIDP) (PM C-2)	19	0		
Q.1.3. Non-licensed/non-certified providers meet provider qualifications. Personnel records contain documentation that staff is: 1. At least 18 years of age, 2. In good standing with the law 3. Able to practice prevention techniques to reduce transmission of any communicable diseases. Documentation staff has completed all core training requirements	14	10	**REPEAT CITATION** A total of 24 non-licensed/non-certified staff were reviewed for Q.1.3 and Q.1.4. ***Insufficient Evidence of Emergency Procedure Training***. **Bay-Arenac Behavioral Health** **WSA# 50932:** J. Raddler J.Janowicz L. Janowicz **CMH for Central Michigan:** **WSA# 38468:** Elizabeth Doty Lauren Donkin **WSA# 20255:**	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all non-licensed/non-certified providers meet provider qualifications. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by

– e.g. recipient rights, prevention of transmission of communicable diseases, first aid, CPR, and that staff is employed by or on contract with the CMHSP or hired through Choice Voucher arrangements.) (PM C-3)			Madeline Cooper Marla Hughes Stacy Grimmett ***Insufficient Evidence of Recipient Rights Training*** **CMH for Central Michigan:** **WSA# 20255** Amanda Yonts ***Insufficient Evidence of compleing First Aid Training*** **CMH Authority of Clinton-Eaton-Ingham Counties/CEI:** **WSA# 34468:** Carolyn Green ***Insufficient Evidence of Blood Borne Pathogen Training*** **CMH for Central Michigan:** **WSA# 20255** Amanda Yonts **WSA# 38468:** Elizabeth Doty Lauren Donkin **WSA# 20255:** Madeline Cooper Marla Hughes Stacy Grimmett ***Insufficient Evidence of Initial Background Check Prior to Hire*** **CMH for Central Michigan:** **WSA# 20255** Amanda Yonts	the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **BABH** • By 12/1/20, cited staff for WSA #50932 will have documented evidence that the staff was trained in Emergency Procedures. • Insufficient Evidence of Recipient Rights Training for WSA #50932 staff L. Janowicz did not have a citation listed on the original documentation provided by MDHHS. BABH submitted additional evidence of this training for MDHHS and it was accepted during the desk review. This document was uploaded again in Box (https://app.box.com/file/723110254796 **CMHCM** • By 11/30/20 cited staff for WSA #38468 will provide evidence of Emergency Procedure training. • By 11/30/20 cited staff for WSA #20255 will provide evidence of Emergency Procedure training. • By 11/30/20 cited staff for WSA #20255 will provide evidence of Recipient Rights training. • By 11/30/20 cited staff for WSA #38468 will provide evidence of Blood Borne Pathogen training. • By 11/30/20 cited staff for WSA #20255 will provide evidence of Blood Borne Pathogen training. • For WSA #20255 an initial criminal background check cannot be obtained for

				Amanda Yonts, provider did not retain. A current criminal background check has been obtained dated 4/7/20. **CEI** • By 10/25/220, cited staff for WSA # 34468 will provide evidence of completing first aid training. **☒ Systemic Remediation:** **BABH** • By 12/1/20, BABH will work with Stuart Wilson's office to educate staff on how to properly document Emergency Procedures training with the necessary elements (test signed and dated by staff taking the test, test signed and dated by the office manager (or other office staff), and marked with a 'pass. **CMHCM** • By 10/30/20 CMHSP will communicate with providers to review requirements related to staff credentialing and criminal background checks. • By 12/31/20, the CMHSP will randomly select a staff sample to review required trainings. • Staff credentialing will be reviewed annually as part of the regular Event Verification process. **CEI** • By 12/1/2020, CMHSP will meet with provider to review requirements related to staff credentialing. **MDHHS Response**: **☒ Response accepted (with BABH citation for lack of RR training being removed, for WSA 50932, after confirmation of submission of evidence during Site Review, entered in error, in the SR Report).**
Q.1.4 All CWP providers meet training requirements	13	11	**REPEAT CITATION**	Submit a plan that reflects both individual and systemic

including training of CLS staff on the implementation of the IPOS by the appropriate professional. (Evidence: case file notes identifying the who, what and when of training, personnel files with documentation of training). (PM C-4)			**Bay-Arenac Behavioral Health** **WSA# 50932** J. Raddler J. Janowicz L. Janowicz **CMH for Central Michigan:** **WSA# 20255** Amanda Yonts **WSA# 38468:** Elizabeth Doty Lauren Donkin **Saginaw County CMH Authority** **WSA# 20440:** A. Coenis C. Phibbs K. Andres K. Pendred R. Grassmid	remediation with time frames to ensure that all CSP providers meet training requirements including training of CLS staff on the implementation of the IPOS by the appropriate professional. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **BABH** • By 12/1/20, cited staff will receive required IPOS training specific to the beneficiary they are supporting. **CMHCM** • By 11/30/20 cited staff for WSA #20255 will receive required IPOS training specific to the beneficiary they are supporting. • By 11/30/20 cited staff for WSA #38468 will receive required IPOS training specific to the beneficiary they are supporting.

				SCCMH • By 10/31/2020, cited staff will receive required IPOS training specific to the beneficiary they are supporting. **☒ Systemic Remediation:** **BABH** • By 12/01/20, BABH will work with Stuart Wilson's office to develop a form that would appropriately document that staff have been trained in the IPOS. BABH will educate primary case holders on the process for providing and documenting training of the IPOS to direct care professional staff. **CMHCM** • By 10/30/20 CMHCM will review with CM staff the obligation to provide IPOS training to those providing supports to waiver recipients, in a timely manner (upon update/amending of IPOS). • Effective 11/1/20 Supervisory staff will review quarterly, IPOS trainings provided/documented in the EMR, from a random sample pulled for this purpose. **SCCMH** • By10/31/2020, CMHSP will review with CM staff the obligation to provide IPOS training to those providing supports to waiver recipients in a timely manner (upon update/amending of IPOS) • Effective 1/1/2021,Supervisory staff will review quarterly, IPOS trainings provided/documented in the EMR, from a random sample pulled for this purpose. • Other: The Training Log was revised on 9/9/2020 to capture the requirements to indicate

				that the Case Holder trained the trainer (if not the Case Holder).This is currently in use. **MDHHS Response**: ☒ **Response accepted**
H. HOME VISITS/TRAINING/INTERVIEWS				
H.1. CWP HOME VISIT				
H.1.1 The current IPOS is in the home and the parent /guardian and staff have access to it. (evidence: a copy of the plan is in the home)	NA	NA	No home visits were conducted as a part of this Site Review. **Please see HSW report for outcomes to Person Centered Planning Recipient Interviews, across all three Waivers, conducted as a part of the Full Site Review of MSHN/Region 5**	
H.1.2 The parent is offered a formal opportunity to express his/her level of satisfaction with the CWP. (evidence: as reported to the surveyor by the parent and documented by the surveyor's notes)	NA	NA		
H.1.3 Protocols for managing individual health and safety issues are identified in the IPOS and implemented by staff and parents. Evidence: 1. Crisis and Safety Plans are current, accessible and – per report of the child/youth, parent and	NA	NA		

staff - responsive to need; 2. Staff and parents know what the protocol is, where it is, and how to implement it				

Habilitation Supports Waiver Program

DIMENSIONS/INDICATORS	Yes	No	FINDINGS	REMEDIAL ACTION
C. ADMINISTRATIVE PROCEDURES				
A.1 All				
A.1.1. The PIHP has adopted common policies for use throughout the service area for critical incidents. Medicaid Managed Specialty Supports and Services contract, Section 6.4; AFP Sections 3.8, 4.0 42 CFR 438.214. Waiver Assurance for Participant Safeguards	1	0		
A.1.2. The PIHP has policy and business procedures to assure regular monitoring and reporting on each network provider for critical incidents.	1	0		

42 CFR 438.230(b)(4) 42 CFR 438.810 Medicaid Managed Specialty Supports and Services contract, Section 6.4; AFP Sections 2.5, 3.8, 3.1.8 Waiver Assurance for Participant Safeguards				
A.1.3 Review and verify that the process is being implemented according to policy. Waiver Assurance for Participant Safeguards	1	0		
A.1.4 PIHP/CMHSP is implementing the Quality Improvement Project as approved by MDHHS.	NA	NA	NA: There were no Quality Improvement Projects approved by MDHHS, for this period of review.	
A.1.5 The PIHP/CMHSP has a policy that guides the contracting process with new providers or providers who are expanding their service array. These policies ensure new providers are assessed to ensure they do not require heightened scrutiny based upon isolating of institutional elements. • PIHP/CMHSP	1	0		

provides evidence of the policy • Review of PIHP/CMHSP provisional approval documents				
A.3.HSW				
A.3.1. If a Waiver enrollee receives Environmental Modifications or Equipment, the PIHP has implemented prior authorizations in accordance with their process. (HSW PM A-4)	4	1	**REPEAT CITATION** NA: 38 **CMH Authority of Clinton-Eaton Ingham Counties (CEI)** **WSA# 20128** Could not find evidence of prior authorization process being followed for shower chair or wheel chair reflected as needed in plan	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that, if a Waiver enrollee receives Environmental Modifications or Equipment, the PIHP has implemented prior authorizations in accordance with their processes. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site

				reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **CEI** • By 11/30/2020 the required steps for prior authorizations will be completed by the assigned Occupational Therapist for WSA# 20128 ☒ **Systemic Remediation:** **CEI** • By 11/30/2020, staff updated training will be provided on the prior authorization process required for environmental modifications. **MDHHS Response**: ☒ **Response accepted**
F. FREEDOM OF CHOICE				
F.2. HSW				
F.2.1 Individual had an ability to choose among various waiver services. (HSW PM D-10) Medicaid Provider Manual, Section 15	**42**	**1**	**Shiawassee Health & Wellness** **WSA# 13095**	**CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **SHW** • WSA# 13095 Habilitation Waiver Service Array

				information was provided to the individual, via mail on 6/17/2019,and evidence supporting this has been submitted. **☒ Systemic Remediation:** **SHW** • The current SHW process already requires that individuals are provided with full listing of waiver services options, however it appears the disclosure log in the EMR was not available to the auditor during the review period. The auditor access settings for the EMR have updated to allow access to this area moving forward. Service Array information will continue to be provided to all waiver recipients. **MDHHS Response**: **☒ Response accepted,** **Please produce evidence dated 6/17/19, as well as discolosrue log (update/WSA specific) at the 90 day review. Please note that evidence presented at time of Site Review (if the same), did not meet this standard.**
F.2.2 Individual had an ability to choose their providers. (HSW PM D-11) Medicaid Provider Manual, Section 15	42	1	**Shiawassee Health & Wellness** **WSA# 13095**	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the individual has the ability to choose their providers. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of

				compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **SHW** • Local Provider Choice Listing information was provided to the individual, via mail on 6/17/2019, and evidence supporting this has been submitted. ☒ **Systemic Remediation:** **SHW** • SHW agency process already exists to support individual choice regarding waiver services. This information will continue to be provided to all waiver recipients. Access to the disclosure log in the EMR has been added to auditor permissions moving forward. **MDHHS Response**: ☒ **Response accepted.** **This citation is regarding choice of waiver *providers* (data entry error, above, being assumed for SHW systemic remediation). Please provide above evidence at 90 day review (for both individual and systemic remediation)**
P. IMPLEMENTATION OF PERSON-CENTERED PLANNING				

Medicaid Managed Speciality Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Guideline MCH712 Chapter III, Provider Assurances & Provider Requirements Attach. 4.7.1 Grievances and Appeals Technical Requirement.				
P.2.1 The individual plan of service adequately identifies the individual's goals and preferences. (HSW PM D-3)	42	1	**Saginaw County CMH Authority** **WSA# 17803**	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS adequately identifies the individual's goals and prefernece s. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **SCCMH** • By 10/31/2020 for WSA # 17803, the plan will be amended to reflect his/her goal/preferences. ☒ **Systemic Remediation:** **SCCMH** • By 10/31/2020 staff training will be provided on the need to adequately address the

				preferences and desires of the individual served. • Effective 1/1/2021 quarterly monitoring of a random sample of IPOS plans for HSW will occur by Supervisory staff, so to ensure compliance. **MDHHS Response**: ☒ **Response accepted**
P.2.3. Individuals are provided with ongoing opportunities to provide feedback on how they feel about services, supports and/or treatment they are receiving, and their progress towards attaining valued outcomes.	42	1	**The Right Door** **WSA# 9913**	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring *that individuals are provided with on-going opportunities to provide feedback. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **The Right Door** • By 9/22/2020 for WSA #9913, the record will reflect at least

				quarterly opportunities in which he/she provides feedback on supports/services and progress. • Other: The case manager demonstrated that satisfaction was address of this consumer on 9/22/2020, and will continue to do so at least quarterly. PCP review will take place in March 2021, and the case manager will provide the person served with opportunity at to give more feedback at that time. **☒ Systemic Remediation:** **The Right Door** • By 08/26/2020, 09/17/2020, 09/25/2020, Staff training will be provided on the need to provide ongoing opportunities to provide feedback on supports/services/progress (with documentation in the record of that feedback). Supervisor met with children's case management team on 08/26/2020, and adult case management team on 09/17/2020, and 09/25/2020 to provide training and overview on the need for those served to be given the opportunity to provide feedback on services, supports, and progress. • Effective 11/30/2020, quarterly monitoring of a random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. **MDHHS Response**: **☒ Response accepted** *Correction to embedded language, above.
P.2.4. The individual plan of service is modified in response to changes in the individual's needs. (HSW PM D-6)	39	4	**CMH for Central Michigan** **WSA# 17140:** No review found **CMH Authority of Clinton-Eaton_Ingham Counties/CEI**	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the person-centered planning is *modified in response to changes in the individual's needs. The plan must be submitted within 30 days of receipt of this report and

			WSA# 5170: Goal remained same as prior year **<u>Montcalm Care Network</u>** **12064**: No rationale provided for amended plans/service changes **<u>Saginaw County CMH Authority:</u>** **17803:** Lack of amended plan to reflect change in need for therapy.	the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. **Individual Remediation:** **CMHCM**- • WSA# 17140 This is noted. The current IPOS dated 2/12/2020 contains a review of progress dated 6/18/2020 and progress notes dated 8/21/2020, 7/13/2020, 5/18/2020, 4/6/2020, 3/13/2020 indicate that a discussion on satisfaction and services occurred. The previous IPOS dated 2/6/2019 is unable to be amended/reviewed. **CMH-CEI** • By 11-1-2020 for WSA # 12064, the record will reflect medical necessity for service changes. • By 11/30/2020 for WSA # 74495, the record will reflect at least quarterly opportunities in which he/she provides feedback on supports/services and progress. **MCN**

				• By 11-1-2020 for WSA # 12064, the record will reflect medical necessity for service changes. **SCCMH** • By 10/30/2020 for WSA # 17803, consumers plan will be amended to reflect the disconintuation of therapy. **☒ Systemic Remediation:** **CMHCM** • By 10/21/2020 training will occur at the Super Management Meeting on the need to provide ongoing opportunities to provide feedback on supports/services/progress (with documentation in the record of that feedback). The expectation is that supervisors will then take this training back to their individual teams. • Other: Utilization Review Specialist (URS) will be developing online, recorded training modules to include the need to provide ongoing opportunities to provide feedback on supports/services/progress (with documentation in the record of that feedback). Target date for these trainings to be recorded is 12/31/2020 and they will be available for all staff/supervisors. Additionally, the URS conducting internal record reviews will complete a review of the current record review tool by 11/1/2020 to ensure that this standard is being captured amongst the current internal record reviews being conducted **CMH-CEI-** • By 11/30/2020, staff training will be provided on the need to provide ongoing opportunities to provide feedback on supports/services/progress (with documentation in the record of that feedback). **MCN**

				• By 12-31-2020, all staff are being retrained in PCP processes including providing rationale/medical necessity for changes to the IPOS. • Other: Evidence-PCP training outline, staff training logs **SCCMH** • Other: By 10/31/2020staff training will be provided on the need to amend IPOS when services are changed. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** **For CEI** **X No individual remediation found for CEI. WSA#(s) does not match number cited. Further, they were cited on one record, they responded on two records, neither appearing to be related to original citation. Systemic remediation does not appear to address citations, as well (see below)l.** ☒ **No systemic rededication found, for CEI (for citation noted).** ☐ No timelines indicated ☐ Other: (See response below) *Correction to embedded language, above. **CMHSP/PHIP 2nd Response**: **CEI Individual Remediation** • By 12/01/2020 for WSA #5170,the assigned Supports Coordinator will have completed training on the need to provided opportunities for feedback on supports/services/progress and will implement documentation in the record at least quarterly in which he/she provides feedback on supports/services and progress. After review with the consumer, if needed the plan will be amended to

				incorporate updated goals or objectives by 1/1/2021. **CEI Systemic Remediation**: • By 11/30/2020, staff training will be provided on the need to provide ongoing opportunities to provide feedback on supports/services/progress (with documentation in the record of that feedback). **MDHHS 2nd Response**: ☒ **Response accepted**
P.2.5. The person-centered planning process builds upon the individual's capacity to engage in activities that promote community life. MCL 330.1701(g)	42	1	**CMH Authority of Clinton-Eaton_Ingham Counties /CEI** **WSA# 74495**	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the person-centered planning process builds upon the individual's capacity to engage in activities that promote community life. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021.

				☒ **Individual Remediation:** **CMH-CEI** • By 11/30/2020 for WSA #74495, the plan will be amended to reflect/address his/her community inclusion needs ☒ **Systemic Remediation:** **CMH-CEI** • By 11/30/2020, staff training will be provided on the need to on the HSW requirement to build upon a Waiver recipient's capacity to engage in activities that promote community life **MDHHS Response**: ☒ **Response accepted**
P.2.6. Individual plan of service addressed health and safety, including coordination with primary care providers. (HSW PM D-2.)	33	10	**CMH Authority of Clinton-Eaton_Ingham Counties /CEI** **WSA# 20128** (No coordination of care with primary care physician found). **WSA# 54433** (No medication consent found, reflecting current psychotropic medications). **Lifeways** **WSA# 10930** (No coordination of care found with psychotropic medications. Systemic remediation needed only). **Montcalm Care Network** **WSA#s 7072, 10508, 12064:** (Lack of coordination of care that included psychotropic medication prescribed.) **Shiawassee Health & Wellness** **WSA# 13094** (No coordination of care with primary care physician found.	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the IPOS addresses health and safety, including coordination with primary care providers. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the

			<u>Newaygo County Mental Health Center</u> **WSA#s 64505, 30520** (No coordination of care with primary care physician found.) **<u>Bay-Arenac Behavioral Health</u>** **WSA# 12128** (No coordination of care with primary care physician that included psychotropic medication.)	delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **BABH** • By 12/1/20for WSA # 12128, the following will be completed/reflected in the record:-Coordination of care that contains all psychotropic medications prescribed **CMH-CEI** • By 11/30/2020 the Supports Coordinatorfor WSA #20128 will have the following completed/reflected in the record:-Coordination of Care • By 11/30/2020 the CSDD Medication Clinic for WSA #54433 will have the following completed/reflected in the record: **SHW** • By 11/30/20 for WSA # 13095, the following will be completed/reflected in the record: • Psychiatric Eval • Coordination of Care • Medication consent reflecting all meds • Resolution of the health and safety matter noted below. • Other: This individual was seen for psychiatric services beginning on 4/3/2020 with a psychiatric evaluation. This information, as well as all medication reviews was sent to the primary care physician, as noted in the disclosure log. This information has been submitted as evidence, and is consistent with the SHW process to send care information to the primarcare physician. Auditor access in the EMR has been updated to allow them access to the disclosure log. In addition, training will occur to ensure systemic compliance. **MCN**

				• By 11-1-2020 for WSA # 7072, 10508, 12064, the following will be completed/reflected in the record:-List of psychotropic meds sent to primary care physician **NCMH** • By 12/1/2020 for WSA # 64505, 30520 the following will be completed/reflected in the record:-Psychiatric Eval-Coordination of Care-Medication consent reflecting all meds-Resolution of the health and safety matter noted below.- • Other: CM will arrange for assessment to be sent to primary care physician **☒ Systemic Remediation:** **BABH** • By 10/1/20, additional training will be provided to the staff at Saginaw Psychological Services Inc.(SPSI)regarding the required elements of including psychotropic medications when coordinating care. Emails providing education to SPSI uploaded to Box (https://app.box.com/file/723117270183) and (https://app.box.com/file/723116615882). **Lifeways** • By 12/15/20, additional training will be provided to the staff at large regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations and medication consents **CMH-CEI** • By 11/30/2020, additional training will be provided to the staff at large regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations and medication consents. **SHW** • By 11/1/2020, additional training will be provided to the

				staff at large regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations and medication consents. **MCN** • By 12-31-2020, Electronic Health Record functionality being updated to include psychotropic medication list in the information already being shared as part of care coordination **NCMH** • By 11/1/2020, additional training will be provided to the staff at large regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations and medication consents. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. – No individual remediation found for (CEI) WSA# 54433 (sentence not completed)** ☐ No systemic rededication found. ☐ No timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**: **CEI Individual Remediation** • By 11/30/2020 the Supports Coordinator for WSA #20128 will have Coordination of care completed/reflected in the record. • By 11/30/2020 the CSDD Medication Clinic for WSA #54433 will have Medication consents reflecting all current medications completed/reflected in the record. **MDHHS 2nd Response**:

				☒ **Response accepted**
P.2.7: The individual plan of service is developed in accordance with policies and procedures established by MDHHS. Evidence: 1. pre-planning meeting, 2. availability of self-determination, and 3. use of PCP process in developing IPOS. (HSW PM D-4)	40	3	**Gratiot Integrated Health Network** **WSA# 18001** (lack of attempt to involve guardian in pre-planning activities, for profoundly cognitively impaired individual.) **CMH Authority of Clinton-Eaton_Ingham Counties /CEI** **WSA# 20128** (Lack of review recommended/provided during IPOS year) **WSA# 54433** (No formal review of plan could be found, recommended or provided, as required).	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the IPOS is developed in accordance with the policies and procedures established by MDHHS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **GIHN** • By 9-23-2020 the following will be completed/reflected in the record: for WSA #18001 :- Pre-Planning Meeting-Offer of self-determination-Offer of Independent Facilitation- • Other -Involve guardian in the pre-planning activities as evidenced by the 9-23-20 PCP pre-planning meeting document. **CMH-CEI**

				• By 12/30/2020 the following will be completed/reflected in the record: for WSA # 20128, 54433: • Pre-Planning Meeting • Offer of self-determination • Offer of Independent Facilitation • Other (See below) **☒ Systemic Remediation:** **GIHN** • By 12/31/2020, additional training will be provided to the staff at large regarding the required elements of the person-centered planning process. • Other: By 12-1-2020, GIHN will revise the PCP Pre-Meeting document to include a section to identify individuals who participated in the pre-planning activities. By 12-1-2020, GIHN will also revise the quarterly chart audit tool to include a review measure of guardian involvement in pre-planning activities. • Effective 2/15/2021, quarterly monitoring by Supervisory staff, of a random pull of records, will be conducted for compliance. **CMH-CEI** • By 11/30/2020, additional training will be provided to the staff at large regarding the required elements of the person-centered planning process. **MDHHS Response**: ☒ **Response not accepted. –** **X No individual remediation found** **For CEI: N**o remediation found for citations noted (lack of recommended reviews in the two WSA records noted). Individual remediation recommended does not appear to address this. ☐ No systemic rededication found.

				☐ No timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**: **CEI Individual Remediation** • A treatment plan review will be completed for the following consumers: WSA 20128 & 5433 by 1/1/2020. The treatment plan review will consist of reviewing progress on all goals and address satisfaction with the individual and the guardian. • Other: Case Managers document reviews in progress notes on a monthly basis. A treatment Plan addendum is completed if during the review there are changes needed to services or goals. The Treatment plan language to selecting N/A for periodic review will be updated to clarify actual review process of the program by 1/1/2021. **MDHHS 2nd Response**: For CEI, proposed individual remediation was not initially consistent with requirements as outlined in the Medicaid Provider Manual: "A formal review of the plan with beneficiary and his/her guardian or authorized representative shall occur not less than annually, to review progress towards objectives and to assess beneficiary satisfaction". Michigan Mental Health code also madates that the Plan will note when this review ill occur. This expectation is above and beyond the monthly reviews/monitoring that also occurs by the SC, as well as amendments to the plan of service (that occurs when changes are needed). Additional revisions requested The revised individual remediation from CEI, received 11/13/20, resolves ☒ **Response accepted**

P.2.8: Services requiring physician signed prescription follow Medicaid Provider Manual requirements. (Evidence: Physician-signed prescriptions for OT and PDN services are in the file and include a date, diagnosis, specific service or item description, start date and the amount or length of time the service is needed).	6	3	**REPEAT CITATION** NA: 34 **Lifeways** **WSA# 16934** (OT script) **Shiawassee Health & Wellness** **WSA# 36257** (OT script) **Gratiot Integrated Health Network** **18001** (OT script)	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that services requiring physician signed prescription follow Medicaid Provider Manual requirements. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **GIHN** • Authorization for OT evaluation was entered in error at the time of a provider change (Service had been completed by previous provider). This authorization in question was removed/voided from the consumer record on 9-28-2020. **Lifeways** • LifeWays Note –OT script found out of compliance was from 2019-20 and could not be

				fixed. Current script is in compliance. **SHW** • By 10/1/2020, a physician-signed prescription (with the required elements) will be obtained for OT/PT/PDN support, and reflected in the record. **☒ Systemic Remediation:** **GIHN** • By 12/31/2020, staff training will be conducted, on the need to ensure physician-signed prescriptions for these services, going forward. • Other: By 12-31-2020, UM/QI staff will provide training to supervisors on authorization updates in regard to provider changes. **Lifeways** • CMHSP will develop/provide a guidance tool to provide to primary care physician, to assist in securing the needed elements of the prescription, on 9/18/20. **SHW** • By 10/1/2020, staff training will be conducted, on the need to ensure physician-signed prescriptions for these services, going forward. • Other: The OT forms have been updated and submitted as evidence. **MDHHS Response**: **☒ Response accepted**
P. PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS				
P.5. HSW				
P.5.1. Specific services and supports that align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and	28	15	**REPEAT CITATION** **CMH Authority of Clinton-Eaton Ingham Counties/CEI** **WSA# 20128** (objectives not measurable, and desire/need for SD/Day Programming/CLS needs	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the specific services and supports in the IPOS align with the individual's assessed needs, including measurable goals/objectives,

duration of services, and timeframe for implementing are identified in the IPOS. (HSW PM D-1)			clarification/resolution in the plan). **WSA# 54433** (Objective not measurable, and recommended interventions do not appear to match need, for some goals). **<u>Saginaw County CMH Authority</u>** **WSA# 17803** (Assessed need for Supported Employment/Therapy not addressed in plan) **WSA# 30521 (**Could not find treatment goal for day activity program, assessed as needed. Unable to find recommendation for day programing and therapy services, in specific amt scope duration.) **WSA# 15517** (Goals not measurable) **<u>Bay-Arenac Behavioral Health</u>** **WSA# 5204** (Not all services authorized (are recommended in the Plan, T1999, RD, RN.) **WSA# 12128** (Psychiatric Eval not recommended in plan, yet authorized/provided). **<u>Montcalm Care Network</u>** **WSA#s 7072, 10508, 12064** (Not all objectives are measurable, and plans lack specific recommendations for services in specific amt scope duration.) **<u>Lifeways</u>** **WSA#s 18205, 10930** (Not all needs identified in assessment, addressed in plan. Could not find amt scope duration of recommended services within plan/treatment goals.)	the amount, scope, and duration of services, and timeframe for implementing are identified in the IPOS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **BABH** • By 12/1/20, the plan of service associated with WSA# 5204 will be amended to include all services authorized in the plan. • Other: There is not a way to remediate the individual finding for WSA# 12128. **Lifeways** • By 12/15/20, WSA#'s 18205 and 10930's plan will be amended for resolving/addressing service needs identified in assessments. • By 12/15/20,WSA#'s 71321 and 16934's plan will be amended to include amount scope duration of recommended supports. **CMH-CEI**

			WSA#'s 71321, 16934 (Lack of measurable objectives. Could not find amt scope duration of recommended services within plan/treatment goals) **<u>Gratiot Integrated Health Network</u>** **WSA# 18001** (Could not find recommendations, within the plan, for specific amt scope duration of services to support treatment goals.) **<u>NOTATION:</u> Technical Assistance provided around the use of ranges/range language in recommending/authorizing supports and services.** **Going forward, MDHHS will expect specific amount/scope/duration/frequency of services to be identified in the IPOS, rather than the use of ranges or "up to" language, to better comply with best practices and to better meet federal and state regulation, as well as contract requirements.**	• By 11/30/2020, WSA 20128 plan will be amended for resolving/addressing measurable objectives and including SD/Day programing/CLS needs • By 11/30/2020,WSA #54433 plan will be amended to add in measurable objectives and match need of goal **SCCMH** • By 11/30/2020 plan will be amended for resolving/addressing service needs identified in assessments. • By 11/30/2020 plan will be amended to include amount scope duration of recommended supports. **MCN** • By 11-1-2020, plan will be amended to include amount scope duration of recommended supports. **GIHN** • By 10-30-2020, a new IPOS will be developed for WSA 18001 and will include specific amount, scope and duration of recommended supports. **☒ Systemic Remediation:** **MSHN** • By 12/30/20 MSHN will provide regional guidance/training on development of measurable goals/objectives to address the assessed needs including amount scope and duration of services included in the IPOS through the HSW regional Work Groups. • By 1/15/21 MSHN will develop a regional training plan for IPOS development to ensure ongoing training is available for CMHSPs to utilize within their organization. **BABH** • By 12/1/20, staff will be trained on making sure all services authorized are identified within the IPOS. Staff will also be reminded that a service cannot

				be provided unless it is authorized in the plan. **Lifeways** • By 12/15/20, staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS. • By12/15/20, quarterly monitoring random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. **CMH-CEI** • By 11/30/2020, staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS. **SCCMH** • By 10/31/2020 staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS. • Effective 1/1/2021 quarterly monitoring random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. **MCN** • By 12-31-2020, staff training will be conducted on PCP processes including measurable objectives and amount, scope, duration • Other: Electronic Health Record to be updated to attached amount, scope, duration to specific sections of the plan by 12-31-2020. Evidence-PCP training outline and staff training logs, example PCP when EHR updated. **GIHN** • By 12-1-2020, GIHN will also revise the quarterly chart audit tool to include a review measure of the inclusion of recommendations, within the plan, for specific amount, scope, duration of services to support treatment goals. • By 12-31-2020, staff training will be conducted on inclusion

				of recommendations, within the plan, for specific amount, scope, durationof services to support treatment goals. • Effective 2-15-2021, quarterly monitoring random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** No individual remediation found : **For SCCMH**, no individual remediation found around need for measurable goal/objectives (under WSA# 15517). **For MCN**, no individual remediation found around need for measurable goals/objectives. Please add remediation for this additional finding. ☒ No systemic rededication found: **For CEI**, no systemic remediation found for measurable goals/objectives **For SCCMH**: no systemic remediation found for measurable goals/objectives **For Lifeways**, no systemic remediation found for reflecting recommended amt scope duration of services in the plans. ☐ No timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**: **SCCMH Individual Remediation:** • By 11/30/2020 the IPOS for **WSA# 15517** will be amended to have measurable goals and objectives. **SCCMH Systemic Remediation:** • By 12/31/20 staff training will be conducted, on the need to have measurable goals and objectives for consumers in their IPOS. **MCN Individual Remediation**: • By 11-1-2020, plan will be amended to include amount

				scope duration of recommended supports and objectives revised to be measurable. **LifeWays Systemic Remediation**: • Staff training will be conducted by 12/15/20, on the need to address/resolve needs identified in the assessments, and amount, scope, duration, within the IPOS; PCP training will be revised to train more in detail on addressing/resolving needs identified in the assessments, and amount, scope, duration, within the IPOS **CEI Systemic Remediation:** • By 11/30/2020, staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS and on creating measurable goals/objectives **MDHHS Response**: ☒ **Response accepted**
P.5.2**.** Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency and timeframe for implementing. (HSW PM D-7)	33	10	REPEAT CITATION **Saginaw County CMH Authority** **WSA# 17803** (SC and Therapy services) **WSA# 30521** (MD and Therapy services) **Montcalm Care Network** **WSA# 7072** (SC sevices) **WSA# 12064** (SC and Psychology/BTPRC Services) **Shiawassee Health & Wellness** **WSA# 13095** (Med Reviews and CLS)	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency and timeframe for implementing. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**:

			<u>CMH Authority of Clinton-Eaton_Ingham Counties/CEI</u> **WSA# 20128** (OT services) **WSA# 54433** (Psychiatric, CLS, SC services not occurring as recommended). **<u>Lifeways</u>** **WSA# 10930** (SC and Behavioral Support Services.) **WSA# 16934** (RD, RN OT services) **<u>Gratiot Integrated Health Network</u>** **WSA# 18001** (SC/Periodic Review services)	The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **Lifeways** • By 12/15/20, WSA#'s 10930 and 16934's plan will be amended for resolving/addressing service provision as recommended. **CMH-CEI** • By 11/30/2020 for WSA #20128, the plan will be amended by the Occupational Therapist for resolving/addressing service provision as recommended. • By 11/30/2020 for WSA #54433, Supports Coordinator will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity. **SCCMH** • By 11/31/2020 plan will be amended for resolving/addressing service provision as recommended. • By 11/31/2020 SC will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity. **SHW** • By 10/1/2020, SC will provide rationale in the record for

				disparity between recommended and provided services, and steps to resolve that disparity. • Other: Dustin's PCP was developed by Katryce Brown, Beacon Case Coordinator, identifying that psychiatric services and medication reviews would begin quarterly starting in November of 2019. A psychiatrist with Beacon completed a psychiatric evaluation with Dustin on 3/10/2020. Difficulties arose in providing these services to Dustin as outlined as a result of Dustin having Medicare and Medicaid coverage for these services, however the psychiatrist that provides services to the Beacon home residents is not paneled with Medicare. One psychiatric appointment was provided to Dustin using the Beacon psychiatrist, however this was a general fund expense. SHW promptly took action to arrange alternate psychiatric services for Dustin following this discovery. Appointments were confirmed on 3/30/20 and 4/1/20 date with Dr Saintfort however Dustin declined to participate in this scheduled psychiatric appointments. Since this time Dustin has been working with Dr. Razvan Adam via tele health appointments and services have occurred at the frequency outlined in his IPOS since May of 2020.Support Coordinator will request documentation from Beacon services outlining their actions between November 2019 and March 2020 to ensure psychiatric services were provided to Dustin as outlined in the IPOS. This evidence should include all attempts they made to schedule and provide psychiatric services. **MCN**

				• By 11-1-2020, plan will be amended for resolving/addressing service provision as recommended. **GIHN** • Other: (See response below)On 9-23-2020, the Periodic review was completed with the consumer and her guardian. **☒ Systemic Remediation:** **MSHN** • By 12/30/20 MSHN will provide regional guidance on ensuring services and treatment are provided as specified in the plan including amount scope and duration of services included in the IPOS through the HSW regional Work Group. • By 1/15/21 MSHN will develop a regional training plan for IPOS development to ensure ongoing training is available for CMHSPs to utilize with in their organization. **Lifeways** • By 12/15/20,staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **CMH-CEI** • By 11/30/2020, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted **SCCMH** • By 10/31/2020staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **SHW** • By 11/1/2020, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted.

				• Other: In addition to providing this training, SHW is developing a progress note specific to COFR monitoring to ensure that services are provided as outlined in the IPOS by provider agencies and that provider agencies regularly provide documentation specific to resolving disparities identified **MCN** • By 12-31-2020, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. • Other: Evidence PCP and Periodic Review training and staff training logs **GIHN** • Other: By 12/1/2020, GIHN will revise the Person-Centered Planning Policy to include more specific timeframes in regard to the Period Review. By 12/31/2020, additional training will be provided to the staff at large regarding the required elements of the person-centered planning process. By 12/1/2020, GIHN will revise the quarterly chart audit tool to include a review measure of the periodic review. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** No individual remediation found ☐ No systemic rededication found ☒ No timelines indicated; **For SHW**, no timeline found for development/implementation of COFR progress note to ensure service delivery as outlined. ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**:

				Shiawassee (SHW) Timelines • SHW- A fillable COFR Monitoring form will be created and available on SharePoint for staff use by 11/30/2020. Staff training on the note will also occur by 11/30/2020. A high priority change request (ITR) will be submitted to the EMR vendor (PCE) by 11/30/2020, requesting to add the COFR monitoring note into our EMR as soon as possible. **MDHHS 2nd Response**: ☒ **Response accepted (including revised GIHN systemic remediation)**
P.5.3. The IPOS for individuals enrolled in the HSW is updated within 365 days of their last IPOS. (HSW PM D-5)	40	3	**REPEAT CITATION** **CMH Authority of Clinton-Eaton_Ingham Counties/CEI** **WSA#s 74495, 5170** **Montcalm Care Network** WSA#10508	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the *IPOS for individuals enrlled in the HSW is updated within 365 days of their last IPOS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021.

				☒ **Individual Remediation:** **CMH-CEI** • IPOS for WSA #74495 was completed within 365 days (8/16/2019 and 8/12/2020).- • IPOS for WSA #5170 was completed outside of 365 days (6/14/2019 and 6/19/2020). Staff will complete training identified **below.** **MCN** • By 11-1-2020, the IPOS will be updated. ☒ **Systemic Remediation:** **CMH-CEI** • By 11/30/2020, staff training will be conducted, on the need to ensure tha the IPOS is updated at least annually. **MCN** • By 12-31-2020, staff training will be conducted, on the need to ensure tha the IPOS is updated at least annually. • Effective 11-1-2020, quarterly monitoring of annual updating of the IPOS will occur by SC Supervisory staff. • Other: Evidence PCP training outline and staff training logs **MDHHS Response**: ☒ **Response accepted;** **For CEI, citation was specific to the 2018/2019 IPOS time period, which did exceed 1 year, for WSA 74495. No individual remediation is possible, given the fact that it is in the past, and the matter is being sufficiently addressed with systemic remediation.** *Correction to embedded language, above.
B.1.The BTPRC process includes all the following	1	0		

elements as required by the Technical Requirement for Behavior Treatment Plan Review Committees: 1. Documentation that the composition of the Committee and meeting minutes comply with the TR; 2. Evaluation of committees' effectiveness occurs as specified in the TR; 3. Quarterly documentation of tracking and analysis of the use of all physical management techniques and the use of intrusive/restrictive techniques by each individual receiving the intervention; 4. Documentation of the QAPIP's OR QIP's evaluation of the data on the use of intrusive or restrictive techniques; 5. Documentation of the Committees' analysis of the use of physical management and the involvement of law enforcement for emergencies on a quarterly basis; 6. Documentation that behavioral intervention related injuries requiring emergency medical treatment or				

hospitalization and death are reported to the Department via the event reporting system; 7. Documentation that there is a mechanism for expedited review of proposed behavior treatment plans in emergent situations. Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.				
B.2. Behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. 1. Documentation that plans that proposed to use restrictive or intrusive techniques are approved (or disapproved) by the committee 2. Documentation that plans that include restrictive/intrusive interventions include a functional assessment of behavior and evidence that relevant physical, medical and environmental causes of challenging	3	5	**REPEAT CITATION** NA: 35 **Lifeways** **WSA# 16934** (Bedrails being used, without evidence of BTPRC involvement). **Saginaw County CMH Authority** **WSA# 17803** (PRN medication, atypical for diagnosis of record, being used for behavior control/managementper, with no evidence of BTPRC involvement.) **Shiawassee Health & Wellness** **WSA# 13095** (BTPRC noted, but without evidence of Special Consent nor evidence of quarterly reviews over the last calendar year). **Montcalm Care Network** **WSA# 10508** (Access to food being restricted without involvement of BTPRC) **WSA# 12064** (Line of sight supervision in community,	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site

behavior have been ruled out. 3. Are developed using the PCP process and reviewed quarterly 4. Are disapproved if the use of aversive techniques, physical management, or seclusion or restraint where prohibited are a part of the plan 5. Written special consent is obtained before the behavior treatment plan is implemented; positive behavioral supports and interventions have been adequately pursued (i.e. at least 6 months within the past year) 6. The committee reviews the continuing need for any approved procedures involving intrusive or restrictive techniques at least quarterly.			now discontinued, with no evidence of BTPRC involvement.)	reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **Lifeways** • Other: By 12/15/20, WSA #16934 will be presented to the BTPRC for approval/disapproval of bedrails, with annual follow-up reviews thereafter, for any approved measure. **SHW** • It is the belief of SHW that supporting documentation already existed at the time of the review to meet compliance with this standard. There was a conversion taking place in our EMR and it appears these documents were not yet loaded into the system. The Behavior Specialist was able to pull all information from her records and submit them as evidence. **SCCMH** • By 10/31/2020,WSA #17803 will be presented to the BTRC for approval/disapproval of any restrictive measures recommended, with quarterly follow up reviews thereafter, for any approved measures. **MCN** • Restrictions removed from both plans of services. Therefore, BTPRC involvement not required. ☒ **Systemic Remediation:** **MSHN** • By 12/31/2020, staff training will be conducted, on the required steps for BTRC involvement. o Training has occurred with Lifeways on 6/30/2020, and consultation on 7/29/2020. Training was scheduled with SCCMH for 9/21/2020, however, is in process of being rescheduled and will occur before 12/31/2020.

				○ The CMHSPs will be strongly encouraged to participate in the MDHHS Training tnetavily shclued for 10/16/2020 from 10:00 to 11:30 on the Frequently asked Questions documdantion and guidance provided by MDHHS in collaboration with the MDHHS Behavior Treatment Work Group. **Lifeways** • By 12/15/20,staff training will be conducted, on the required steps for BTRC involvement. **SCCMH** • By 1/1/2021 staff training will be conducted, on the required steps for BTRC involvement. • Effective 1/1/2021 quarterly monitoring of BTRC involved records will occur by SC/Clinical Supervisory staff, for following BTRC technical requirements. • By 11/30/2020 monthly clinical meetings with the Medical Director will be implemented to address clincal issues including those related to Behavior treatment and Medications for behavioral assistance. **MCN** • Completed, staff training will be conducted, on the required steps for BTRC involvement. • Other: Process for referrals to BTPRC has been updated; new Procedure 8123A **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** **X RE individual remediation found** **For Lifeways,** all of the elememts of BTPRC involvement are required, before presentation to the BTPRC. Further, frequency of review by the BTPRC is not the CMHSP decision to make, but rests with the BTPRC, after their review (in

				adherence to the technical requirements). Please revise. **For SHW:** Individual remediation with timelines not clearly noted. Please revise. ☒ Re: systemic rededication found **For MCN:** Timelines not reflected in recommended staff trainings for systemic remediation. If already completed, date in which it was completed needs to be reflected. (Also, though individual remediation has been accepted, evidence of that remediation, i.e. adjustment of plans to address behavioral support needs without restrictive measures, with clinical rationale for recommended changes, will be needed at 90 day review). **For SHW**: Systemic remediation, with timelines, not found. ☐ No timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**: **SHW-Individual Remediation:** • The Special Consent (dated 5/28/2020) and quarterly reviews (1/8/2020, 2/5/2020, 5/5/2020, 8/5/2020)for WSA#13095 are complete and located in the clinical record. • These were submitted at the time of the CAP submission and have been remediated. **SHW-Systemic Remediation** • The root of this issue was not that the Special Consent or quarterly reviews were incomplete, but that they were not housed in the EMR and therefore could not be easily located during the review. • As of 10/1/2020, the EMR (SHIMER) has been updated so all BTPRC documentation is now saved directly in the consumer chart. • SHW will continue to follow BTPRC technical requirements

				and will save supporting documentation in the BTPRC Module in the EMR. **MCN Systematic Remediation** • Staff training completed 6/15/20. Staff training was previously conducted on the required steps for BTRC involvement. • Other: Process for referrals to BTPRC has been updated; see new Procedure 8123A created effective 9/15/20. **LifeWays Individual Remediation** • By 12/15/20, functional behavior assessment will be completed for WSA #16934. • By 12/15/20, special consent will be obtained for WSA #16934. • By 12/15/20, WSA #16934, will be presented to the BTRC for approval/disapproval of any restrictive measures recommended, with quarterly follow up reviews thereafter, for any approved measures. • By 12/15/20, the IPOS will be amended for WSA#16934 to reflect recommendations within the BPT for restrictive measures. **MDHHS 2nd Response**: ☒ **Response accepted, with the expectation (for MCN) that content of BTPRC training conducted on 6/15/20 will be provided at the 90 day review, for confirmation that content addressed areas of citation noted during subsequent MDHHS Site Review.**
G. WAIVER PARTICIPANT HEALTH AND WELFARE Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.				
G.1 Individual provided information/education on how to report abuse/neglect/exploit	41	2	**Shiawassee Health & Welness** **WSA# 13095** (insuffient evidence found in record).	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that the individual is provided information/education

ation and other critical incidents. (Date(s) of progress notes, provider notes that reflect this information.).			**Gratiot Integrated Health Network** **WSA# 18001** (Insufficient evidence found in record.)	on how to report abuse/neglect/exploitation and other critical incidents. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **SHW** • By 10/6/2020, WSA #13095 will be provided information/education on how to report abuse/neglect/exploitation and other critical incidents, as evidenced in the record. • Other: The Resident Handbook Receipt form has been submitted as evidence. This information will be provided to the service recipient and a signature will be obtained by 10/6/2020. **GIHN** • By 9-23-2020, WSA # 18001 will be provided information/education on how to report abuse/neglect/exploitation and other critical incidents, as

				evidenced in the record by PCP Pre-Planning document. **☒ Systemic Remediation:** **SHW** • By 11/30/2020, training will be provided to CM staff regarding this requirement. **GIHN** • By 12/31/2020, training will be provided to CM staff regarding this requirement. • By 12/01/2020, the EMR will be adjusted to include a field that captures this PM in the pre-planning process. • Other: By 12/1/2020, GIHN will revise the quarterly chart audit tool to include a review measure of evidence provided to the individual and guardian, if applicable, on how to report abuse/neglect/exploitation and other critical incident • Effective 02-15-2021 Supervisory staff will monitor this requirement at least quarterly, from a random sample drawn, using a clinical chart review form document available for review within 90 days **MDHHS Response**: ☒ **Response accepted** **Note: Regarding GIHN/WSA# 18001: Citation was due to information being provided only to individual served, and not the guardian, as well. Evidence will be sought, at the 90 day review, that the guardian is also provided with this information (as evidence of sufficiently addressing the citation)** ☐ **Response not accepted. –** No individual remediation found ☐ No systemic rededication found ☐ No timelines indicated ☐ Other: (See response below)

G.2 Individual served received health care appraisal. (Date/document confirming)	43	0		
Q. STAFF QUALIFICATIONS				
Q.2. HSW				
Q.2.1. The PIHP ensures that Waiver service providers meet credentialing standards prior to providing HSW services. (HSW PM C-1) (Evidence: personnel records and credentialing documents – including licensure and certification and required experience for QIDP).	64	3	**REPEAT CITATION** **A total of 67 Professional Staff were reviewed for this waiver.** **CMH for Central Michigan** **WSA# 7329** Kendra Groulx (lack of sufficient evidence of QIDP) **Huron Behavioral Health** **WSA# 17181** **Megan Curtis** (insufficient proof of QIDP) **Shiawassee Health & Wellness** **WSA# 36257** **Suzanne Carter** (insufficient proof of QIDP).	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that Waiver service providers meet credentialing standards, prior to providing HSW services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **CMHCM** • By September 25, 2020, cited staff for WSA # 7329 will provide evidence of being appropriately credentialed. Credentialing was in place however, the staff had a legal

				name change and the correct verification documentation was not located during review time period. Credential documentation for Kendra Groulx uploaded to BOX. **SHW** • By 9/9/2020, evidence of QIDP, or supervision by a QIDP, will be obtained for provision to MDHHS at 90 day f/u site review. **HBH** • By 9/15/2020, evidence of QIDP, or supervision by a QIDP, will be obtained for provision to MDHHS at 90 day f/u site review. • Please Note: Megan Curtis began employment at Huron Behavioral Health on 7/16/2018. Since this time she has been supervised by a credentialed QIDP (i.e., Tracey Dore, MSW, LMSW, QIDP; Jaclyn Callender, MSW, LLMSW, QIDP; & Natalie Nugent, PhD, LP, QIDP). • Furthermore, after completing her first year of employment at HBH, during which time she was supervised by a QIDP, Megan Curtis was eligible for QIDP status, as of 7/16/2019. Her next Credentialing review is scheduled for 1/21/2021 and at this time her QIDP credential will be reviewed and approved by the Credentialing and Privileging Committee at HBH • Evidence to Support Megan Curtis' status as a QIDP is as follows: o Copy of License – Bachelor's Social Worker Limited License (exp. Date 4/30/2021); LARA License Verification Document o CSM/SC Job Description – Documenting that this

				position requires QIDP status or supervision by a QIDPSupervision Logs Signed by Natalie Nugent, PhD, LP ○ Curriculum Vitae for Natalie Nugent, PhD, LP confirming role as BTPRC chair for past 6 years at HBH ○ HBH Credentialing and Privileging Packet for Natalie Nugent - Confirming status as QIDP ○ Supervision Logs Signed by Jaclyn Callender, MSW, LLMSW ○ HBH Credentialing and Privileging Packet for Jaclyn Callender - Confirming status as QIDP ○ Supervision Logs Signed by Tracey Dore, MSW, LMSW, QIDP ○ HBH Credentialing and Privileging Packet for Tracey Dore- Confirming status as QIDP **☒ Systemic Remediation:** **SHW** • Effective 10/1/2020 the CMHSP/HR Dept will retain evidence of QIDP status in personnel records (above/beyond credentialing committee determinations) for proof of staff qualifications **CMHCM** • During this review, it was the understanding of the CMHCM HR department that license verification and indication of the QIDP credential on the worksheet was sufficient. However, it was brought to our attention that copies of the staff's resume and transcripts were required. Going forward, CMHCM HR will ensure all

				required proof of credentials is submitted. **HBH** • Effective October 1, 2020 quarterly monitoring of a random selection of personnel records will be completed quarterly by HR. • Other: HBH has an established Credentialing and Privileging process with monthly meetings scheduled to review applications and provide approval or the need for remediation. All Credentialing and Privileging packets are stored in each employees personnel record and maintained by the HR Director. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** ___ No individual remediation found ☒ No systemic rededication found **For SHW**, how will you give evidence of these remediations, in 90 days. **For CMH for Central MI**: No timeline for systemic remediation (i.e., a specific date for implementation of the expectation to retain back up documentation of credentialing). Further, how will you give evidence of this remediation in 90 days? **For HBH**: what will the quarterly monitoring of HR records be for (not indicated/please specify)? ☐ No timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**: **CMHCM Systematic Remediation** • Effective October 20, 2020 CMHCM HR developed a credentialing submission check list highlighting all

				required documentation (staff resume and transcripts required for QIDP) to be attached to MDHHS credentialing review worksheets to ensure all required proof of credentials is submitted. **HBH Systematic Remediation** • Effective October 1, 2020 quarterly monitoring of a random selection of personnel records will be completed quarterly by HR. Quarterly monitoring will review the newly developed "Qualified Intellectual Disability Professional (QIDP) Designation Qualification Review Form" (Form 90-728) to ensure that QIDP credentialing has been verified. **SHW Systematic Remediation:** • By 12/1/2020, the HR Department will begin complete quarterly reviews of randomly selected personnel files. The MDHHS Professional Staff Credentialing form will be used to review the personnel information for compliance with credentialing requirements. **MDHHS 2nd Response**: ☒ **Response accepted**
Q.2.2. The PIHP ensures that Waiver service providers continue to meet credentialing standards on an ongoing basis. (HSW PM C-2) (Evidence: personnel records and credentialing	62	5	REPEAT CITATION **CMH for Central Michigan** **WSA# 7329** **Kendra Groulx** (lack of sufficient evidence of QIDP) **CMH Authority of Clinton-Eaton Ingham Counties/CEI** **WSA# 20128**	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that Waiver service providers continue to meet credentialing standards on an ongoing basis. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective

documents – including licensure and certification and required experience for QIDP).			**K. Grant** (insufficient proof of QIDP) **<u>Huron Behavioral Health</u>** **WSA# 17181** **Megan Curtis** (insufficient proof of QIDP) **<u>Lifeways</u>** **WSA#s 10718, 16934** **R. Butler** (insufficient evidence of on-going criminal background check.) **<u>Shiawassee Health & Wellness</u>** **WSA# 36257** **Suzanne Carter** (insufficient proof of QIDP	action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **CMHCM** • By September 25, 2020, cited staff for WSA # 7329 will provide evidence of being appropriately credentialed. Credentialing was in place however, staff legal name change created confusion and verificationdocumentation was not located during review time period. Credentinal documentation for Kendra Groulx uploaded to BOX**.** **Lifeways** • LifeWays Note:Updated iChat from 4/22/20 was provided on 9/11/20 to MDHHS and resolved the individual remediation for staff R. Butler. **CMH-CEI** • By 11/30/2020, evidence of QIDP, or supervision by a QIDP, will be obtained for provision to MDHHS at 90 day f/u site review**.** **SHW** • By 9/9/2020, evidence of QIDP, or supervision by a QIDP, will be obtained for provision to

				MDHHS at 90 day f/u site review **HBH** • By 9/15/2020, evidence of QIDP, or supervision by a QIDP, will be obtained for provision to MDHHS at 90 day f/u site review. • Please Note: Megan Curtis began employment at Huron Behavioral Health on 7/16/2018. Since this time she has been supervised by a credentialed QIDP(i.e., Tracey Dore, MSW, LMSW, QIDP; Jaclyn Callender, MSW, LLMSW, QIDP; & Natalie Nugent, PhD, LP, QIDP). • Furthermore, after completing her first year of employment at HBH, during which time she was supervised by a QIDP, Megan Curtis was eligible for QIDP status, as of 7/16/2019.Her next Credentialing review is scheduled for 1/21/2021 and at this time her QIDP credential will be reviewed and approved by the Credentialing and Privileging Committee at HBH • Evidence to Support Megan Curtis' status as a QIDP is as follows: ○ Copy of License – Bachelor's Social Worker Limited License (exp. Date 4/30/2021); LARA License Verification Document ○ CSM/SC Job Description – Documenting that this position requires QIDP status or supervision by a QIDP Supervision Logs Signed by Natalie Nugent, PhD, LPHBH ○ Curriculum Vitae for Natalie Nugent, PhD, LP confirming role as BTPRC chair for past 6 years at HBH

				○ HBH Credentialing and Privileging Packet for Natalie Nugent - Confirming status as QIDP ○ Supervision Logs Signed by Jaclyn Callender, MSW, LLMSW ○ HBH Credentialing and Privileging Packet for Jaclyn Callender - Confirming status as QIDP ○ Supervision Logs Signed by Tracey Dore, MSW, LMSW, QIDP ○ HBH Credentialing and Privileging Packet for Tracey Dore- Confirming status as QIDP **☒ Systemic Remediation:** **CMHCM** • During this review, it was the understanding of the CMHCM HR department that license verification and indication of the QIDP credential on the worksheet was sufficient. However, it was brought to our attention that copies of the staff's resume and transcripts were required. Going forward, CMHCM HR will ensure all required proof of credentials is submitted. **Lifeways** • CMHSP HR Department will develop a tool to assure QIDP credentialing, ongoing, of staff to HSWenrollees by 12/15/20. • Effective12/15/20,the CMHSP/HR Dept will retain evidence of QIDP status in personnel records (above/beyond credentialing committee determinations) for proof of staff qualifications **CMH-CEI** • Effective 11/30/2020 the CMHSP/HR Dept will retain

				evidence of QIDP status in personnel records (above/beyond credentialing committee determinations) for proof of staff qualifications **SHW** • Effective 10/1/2020 the CMHSP/HR Dept will retain evidence of QIDP status in personnel records (above/beyond credentialing committee determinations) for proof of staff qualifications **HBH** • Effective (Date)_October 1, 2020_ quarterly monitoring of a random selection of personnel records will be completed quarterly by HR. • Other: (See response below) HBH has an established Credentialing and Privileging process with monthly meetings scheduled to review applications and provide approval or the need for remediation. All Credentialing and Privileging packets are stored in each employees personnel record and maintained by the HR Director. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** No individual remediation found: ☒ No systemic rededication found **For Lifewys**, systemic remediation does not appear to be related to the citation (not being able to give evidence, at time of Site Review, of on-going criminal background checks). **For CMH for Central MI**: No timeline for systemic remediation (i.e., a specific date for implementation of the expectation to retain back up documentation of credentialing). Further, how will you give evidence of this remediation in 90 days?

				For CEI and SHW, how will you give evidence of these remediations in 90 days? **For HBH**: what will the quarterly monitoring of HR records be for (not indicated/please specify)? ☐ No timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**: **CEI Systemic Remediation:** • Resume will be sent to HR to put in Personnel Folder to show QIDP status. A review of applicable case managers hired within the past year by QI/HR staff will occur by 1/1/2021 to ensure documentation to show QIDP status is in personnel files. **CMHCM Systemic Remediation:** • Effective October 20, 2020 CMHCM HR developed a credentialing submission check list highlighting all required documentation (staff resume and transcripts required for QIDP) to be attached to MDHHS credentialing review worksheets to ensure all required proof of credentials is submitted. **HBH Systemic Remediation:** • Effective October 1, 2020 quarterly monitoring of a random selection of personnel records will be completed by HR. Quarterly monitoring will review the newly developed "Qualified Intellectual Disability Professional (QIDP) Designation Qualification Review Form" (Form 90-728) to ensure that QIDP

				credentialing has been verified. **SHW- Systematic Remediation** • By 12/1/2020, the HR Department will begin complete quarterly reviews of randomly selected personnel files. The MDHHS Professional Staff Credentialing form will be used to review the personnel information for compliance with credentialing requirements. **LifeWays Systematic Remediation** • Effective 11/1/20, quarterly checks of LifeWays QIDP credentialed staff will occur. All of LifeWays' own credentialed staff complete re-credentialing every 24 months, which contains evidence of on-going criminal background check to assure good standing. Evidence of the on-going criminal background check will be maintained by LifeWays Human Resources Department in the staff's personnel file. • By 12/15/20, quarterly monitoring of a random selection of personnel records will be completed quarterly by LifeWays of it's Provider Network's credentialed staff. **MDHHS Response**: ☒ **Response accepted**
Q.2.3. The PIHP ensures that non-licensed Waiver service providers meet the provider qualifications identified in the Medicaid Provider	408	54	**REPEAT CITATION** **A total of 462 non-licensed/non-certified staff were reviewed for this Waiver.** ***Lack of Bloodborne Pathogen***	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all non-licensed/non-certified providers meet provider qualifications. The plan must be submitted within 30 days of receipt of this report and the finding must be

Manual. (HSW PM C-3) Evidence; personnel and training records: 1. At least 18 years of age. 2. Able to prevent transmission of any communicable disease. 3. In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, not an illegal alien). 4. Able to perform basic first aid procedures, as evidenced by completion of a first aid training course, self-test, or other method determined by the PIHP to demonstrate competence in basic first aid procedures.			**CMH Authority of Clinton-Eaton_Ingham Counties/CEI** **WSA# 74638** **Nia Clark** **Zara Afzal** **CMH for Central Michigan** **WSA# 7329:** Candace Wright Nyqula Powell. Philishia Brown Romona Christensen, Tequilla Bovee **WSA# 17140, WSA# 10611:** Crystal Borh Tracy Tessman William Brewer **WSA# 4872:** Debra Roberts **Montcalm Care Network** **WSA# 12064** Wesley Johnson J. Vega K. Raymor **Newaygo County Mental Health Center** **WSA# 30520:** A. Brenner B. Curtis B. Pease J. Curtis J. Hoggins J. Shepherd J. Higgins R. Lemons R. Minaker **WSA# 64505:** B. Shattuck **Shiawassee Health & Wellness** **WSA# 13095:** K. Shavers **The Right Door**	corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **CMHCM** • By 11/30/20, cited staff for WSA #7329 will provide evidence of bloodborne pathogen training. • By 11/30/20. cited staff for WSA #17140 will provide evidence of bloodborne pathogen training. • By 11/30/20. cited staff for WSA #10611 will provide evidence of bloodborne pathogen training. • By 11/30/20. cited staff for WSA #4872 will provide evidence of bloodborne pathogen training. • By 11/30/20. cited staff for WSA #10611 will provide evidence of First Aid training. **CMH-CEI** • By 11/30/2020, cited staff for WSA #74638 will provide evidence of being trained in Bloodborne Pathogens • By 11/30/2020, cited staff for WSA #74638 will provide evidence of first aid training

			WSA# 9913: C. Adams C. Elliott D. Smith D. Ladisky J. Swix L. Hartwick M. Michell P. Fedewa R. Troub **WSA# 12360** April Calahan Jamie Demaray Jennifer Moffit Katelynn Brighton Klista Gillean Shoshannon Johnson Susan rice Tea Valentine **<u>Tuscola Behavioral Health Systerms</u>** **WSA# 12978** Samantha Meffer ***Lack of First Aid Training*** **<u>CMH Authority of Clinton-Eaton_Ingham Counties/CEI</u>** **WSA# 74638:** Sarah Strom **<u>CMH for Central Michigan</u>** **WSA# 10611:** Erin Bennett **<u>Huron Behavioral Health</u>** **WSA# 17181:** Christine Schmitt Debra Reese **<u>Newaygo County Mental Health Center</u>** **WSA# 64505:** B Shattuck D Guiles **<u>Saginaw County CMH Authority</u>**	**SHW** • Other: Individual terminated 6/25/2020 for 13095. • First Aid Training certificate submitted for Catharine Miller and Sherri Baldwin. • CBC checks submitted for Michelle Grazier and Annalia Krish **SCCMH** • By 10/31/20 cited staff for WSA #17803 will secure First Aid Training • By 10/31/20 cited staff for WSA #30521 will secure First Aid Training **The Right Door** • By 9.9.2020, cited staff for WSA #9913 will provide evidence of staff being trained in Blood Borne Pathogens. • By 10.30.2020, cited staff for WSA #9913 will provide evidence of staff being trained in Blood Borne Pathogens. . **MCN** • WSA #12064: Wesley Johnson was terminated within 30 days of hire and did not complete all trainings prior to termination. **NCMH** • By 2/28/21 staff cited for # 64505 will provide evidence of completion of first aid training. **HBH** • Staff Members Debra Reese and Christine Schmitt were cited for not having proof of First Aid Training. • Christine Schmitt completed First Aid Training on 8/17/2020 as part of Huron Behavioral Health's remediation plan. Evidence is Ms. Schmitt's Relias Training Log documenting completion. • Debra Reese completed First Aid Training on 9/15/2020 as part of Huron Behavioral Health's remediation plan. Evidence is Ms. Reese's Relias

			WSA# 17803: K. Matthis **WSA# 30521:** S. Cox **<u>Shiawassee Health & Wellness</u>** **WSA# 13095** Sherri Baldwin C Miller ***Lack of Criminal Background Check*** **<u>Shiawassee Health & Wellness</u>** **WSA# 36257:** Michelle Grazier Annalia Krish	Training Log documenting completion **TBHS** • WSA #12978 By 12/1/2020, Samantha Meffer will complete her bloodborne pathogens training. • WSA #11236 No individual remediation necessary. Background check was completed on 2/17/2016 prior to hire on the same day. She did not start work until background check cleared. **☒ Systemic Remediation:** **CMHCM** • By 10/31/20, CMHSP will notify provider to review requirements related to staff credentialing. • By 12/31/20, the CMHSP will randomly select a staff sample to review required trainings. Staff trainings will be reviewed annually as part of the regular Event Verification process. **CMH-CEI** • By 11/30/2020, CMHSP will meet with provider to review requirements related to staff credentialing. **SHW** • By 9/10/2020, CMHSP will meet with provider to review requirements related to staff credentialing. • Meeting with Beacon held on 9/10/2020 to discuss training requirements. **SCCMH** • By 11/30/2020CMHSP/PIHP will meet with provider to review requirements related to staff credentialing. • Effective 1/1/2021the CMHSP/IDD Director will randomly select a staff sample to review quarterly for required trainings. **MCN** • MCN will be updating its training policy/procedure by 12/1/20 requiring more comprehensive training

				documentation from its providers. **NCMH** • By 11/1/2020, CMHSP/PIHP will meet with provider to review requirements related to staff credentialing regarding proofs for communicable disease training. **HBH** • By October 15, 2020 CMHSP/PIHP will meet with provider to review requirements related to staff credentialing. • Evidence of remediation will include a signed training log outlining the review of provider qualifications and training requirements or HSW cases. **TBHS-Notes** • WSA #12978 Samantha Messer took an unexpected leave of absence prior to and during the MDHHS audit so she did not have an opportunity to complete her bloodborne pathogens training. The group home staff will continue to schedule needed trainings as soon as the TBHS training calendar is received. • WSA #11236 Patricia Vaughn received her criminal background check on the same day she was hired. She did not begin work until her background check cleared. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** **X No individual remediation found** **For The Right Door**, no remediation found for staff associated with WSA# 12360. **For MCN,** no remediation found for staff K Raymor, and J Vega (under WSA# 12064) **For NCMH** , no remediation found for lack of blood borne pathogen training for 9 staff cited. ☒ No systemic rededication found

				For CMCMH, CEI, SHW, NCMH, what evidence will be provided of planned meetings to review credentialing requirements with providers, and what follow up will be provided to ensure that requirements are being met, on-going? **For TBHS**, systemic remediation (for ensuring training completed in a timely manner), above and beyond what is already practiced at your CMH, could not be found. Please provide, with timelines. Note: Patricia Vaughn, under TBHS (WSA 11236) removed as citation after confirmation of CBC prior to hire, with staff compliance totals adjusted accordingly. ☐ No timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**: **The Right Door Individual Remediation** • By 10.30.2020, cited staff for WSA #12360 will provide evidence of staff being trained in Blood Borne Pathogens. **MCN Individual Remediation** • WSA #12064: Wesley Johnson was terminated within 30 days of hire and did not complete all trainings prior to termination. For J. Vega & K. Raymor: The provider agency had been utilizing a practice where the staff read and signed off has having read training materials; they were unable to provide any additional evidence. The Provider reported, in writing, that as of 10/23/20 they have changed their training methods to include a trainer sign off and competency testing. Also, FY21 contract included additional language on requirements for proper training and documentation. As of 9/29/20, staff J. Vega is no longer employed with the

				agency to get any updated training. K. Raymor will be re-trained by 12/31/20. **NCMH Individual Remediation** • By 12/1/2020, cited staff for WSA 30520 will provide acceptable evidence of training in Bloodborne Pathogens if currently employed and working with reviewed individuals. **NCMH System Remediation** • By 11/1/2020, CMHSP/PIHP will meet with provider to review requirements related to staff training and credentialing. • Staff training/credentialing requirements will be reviewed with providers annually as part of the contract review process. • By 2/1/2021, the CMHSP will randomly select a staff sample to review required trainings. Staff trainings will be reviewed annually as part of the contract review process. **SHW System Remediation** • As of June 2019, SHW has been compiling and sending training reports to contracted provider agencies on a monthly basis, demonstrating a proactive approach. The MSHN Training grid requirements (including everything from the Aide Level Credentialing Form) drive the content of the report and outlines what documentation needs to be submitted to SHW. SHW collects and stores primary source evidence of training completion for all internal and external direct care staff. Missing credentialing information is flagged and SHW sends a written request that it be submitted within 14 business days. Training reports are a standing agenda item during the

				monthly Provider Network meeting and open for discussion. Failure to submit the required training/credentialing documentation to SHW within the identified time frame will result in an additional written communication that includes reference to contract compliance and outlines additional sanctions that could be carried out (e.g., claim pullbacks) for using non-qualified staff to provide services. • SHW will continue to refine this process, with full implementation of the process update by 12/31/2020. **TBHS System Remediation** • By November 30, 2020 the Director of Marketing and Training will provide refresher training on how to run Relias training reports to contracted provider network managers. In addition, home managers will be instructed/reminded to run monthly training reports and to review Relias email notifications to ensure staff are current with required trainings. **CMHCM System Remediation** • CMHCM Utilization Manager will meet with all Case Management Supervisors on 10/21/20 to reiterate the Case Manager obligation to provide IPOS training to those providing supports to waiver recipients, in a timely manner (upon update/amending of IPOS). • Effective 11/1/20, Supervisory staff will review quarterly, IPOS trainings provided/documented in the EMR, from a random sample pulled for this purpose. • Effective 11/1/20, all credentialing requirements will

				be reviewed annually with the Medicaid Event Verification process. **CEI System Remediation** • Will show evidence of email to provider sent with reminder of credentialing requirements. Quality Advisor will pull a random sample of staff from provider by 12/31/20 to review required trainings are completed timely and up to date. **MDHHS 2nd Response**: ☒ **Response accepted, with the expectation (for NCMH, under individual remediation) that the cited staff will have the required training if still employed and working with <u>any</u> waiver recipient.**
Q.2.4 All HSW providers meet staff training requirements. (HSW PM C-4) • *Not limited to group home staff. All HSW providers for the samples should meet staff training requirements (includes own home and family home).* evidence: Training records: • *Has received training in the beneficiary's IPOS.*	277	185	**REPEAT CITATION** **<u>Bay-Arenac Behavioral Health</u>** **WSA# 5204**: A.Miller G. Hirsh J. Rogers **<u>CMH Authority of Clinton-Eaton_Ingham Counties/CEI</u>** **WSA# 74638:** Keyonee Kemp Mackenzie Ketchum Lisa Leek Nia Clark Lacey Stringham Maria Trevino **WSA# 7879:** Kevin Johnson **WSA# 54433:** Kobie Houston Tammy Sherman Tyrone Bonds **WSA# 74495:** Lasonya Ware Michele Bishop Natalie Winton-White Lacey Stringham	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all HSW providers meet the staff training requirements specific to beneficiary specific IPOS, prior to providing services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed

			Maria Trevino **WSA# 14938:** Mary Fonchang Otis Ebulela Sarah Stanton **WSA# 54433:** Matthew Tucker **<u>CMH for Central Michigan</u>** **WSA# 4872:** Donald Roberts, Elise Beeckman H Huizinga M. Boxx M. Oles **WSA# 19337:** F. Uzibar H. Hill K. Snear M. Wallace M. Moore **WSA# 17140, WSA# 10611** H Bradley H Henry J. Kipp J. Klopp M. Birdsall M. Vass M. Shafer **WSA# 10611:** L. Lovejoy H Huizinga M. Birdsall **WSA# 17140:** M. Baidoo **WSA# 5450:** H Farless **WSA# 7329:** K. Bannen L. Siegmund L. Kappler M. Aldrich **<u>Gratiot Integrated Health Network</u>** **WSA# 18001:**	care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **BABH** • By 10/31/2020 staff cited for WSA # 5204 will receive required IPOS training specific to the beneficiary they are supporting **CMHCM** • By 11/30/20, cited staff for WSA# 4872 will receive required IPOS training specific to the beneficiary they are supporting • By 11/30/20, cited staff for WSA# 19337 will receive required IPOS training specific to the beneficiary they are supporting • By 11/30/20, cited staff for WSA# 17140 will receive required IPOS training specific to the beneficiary they are supporting • By 11/30/20, cited staff for WSA# 10611 will receive required IPOS training specific to the beneficiary they are supporting • By 11/30/20, cited staff for WSA# 5450 will receive required IPOS training specific to the beneficiary they are supporting. • By 11/30/20, cited staff for WSA# 7329 will receive required IPOS training specific to the beneficiary they are supporting. **CMH-CEI** • By 11/30/2020, cited staff for WSA #74638 will provide evidence of being trained in Bloodborne Pathogens • By 11/30/2020, cited staff for WSA #74638 will provide evidence of first aid training **SHW** • By 11/30/2020, cited staff will receive required IPOS training specific to the beneficiary they are supporting.

			K. Watkins, K. Meyer, K. Smith L. Harris L. Wiles P. Rice R. Elwood, S. Perry S. Chase T. Morrison **<u>Huron Behavioral Health</u>** **WSA# 17181:** Carleen Brieney Ellen Carter **<u>Montcalm Care Network</u>** **WSA# 12064:** Mary Wotring Miranda Irwin Susan Brenner Toni Johnson Wesley Johnson A Cotter A Foster B Biston C Peterson C Brauher J. Vega J. Comfort J. Grassell K. Craigmyle K. Heroy K. Pangborn K. Raymor K. Allbee K. Thrush M. Ebhardt M. Wotring M. Packer M. Irwin S. Brenner T. Johnson W. Johnson **<u>Newaygo County Mental Health Center</u>** **WSA# 30520** A, Brenner B. Curtis B. Pease J. Curtis J. Hoggins J. Shepherd	**SCCMH** • By 12/31/20 or when program re-opens (closed due to COVID-19), cited staff or WSA #30521 will receive required IPOS training specific to the beneficiary they are supporting. • By 10/31/20 cited staff for WSA #15517 will receive required IPOS training specific to the beneficiary they are supporting. By 10/31/20 cited staff for WSA #8298 will receive required IPOS training specific to the beneficiary they are supporting. • By 12/31/20 cited staff for WSA# 8298 will receive required IPOS training specific to the beneficiary they are supporting.will receive IPOS specific tstaff • Other: The following evidence was available during the time of the review. No other action necessary at this time. WSA# 8298: o K.Pearson-– Documentation of both the trainer being trained and the staff being trained was submitted 7/30/20. o Dewitt—Documenation of both the traininer being trained and the staff begin trained was submitted 7/30/20 *The documents provided for K. Pearson and Kaylee Dewitt were sufficient in giving proof of the IPOS training, and so their names will be considered resolved. (MDHHS-CPD)* **MCN** • By 11-1-2020, cited staff will receive required IPOS training specific to the beneficiary they are supporting. **NCMH** • By 12/1/2020, cited staff will receive required IPOS training specific to the beneficiary they are supporting if currently employed and working with reviewed individuals. **HBH**

			J. Higgins R. Lemons R. Minaker **WSA# 15540** A. Vining O. Ogden A. Schultz J. Stulp J. Morgan J. Douglas L. Kotlewski M Rittenhouse S. Pinkston S. Smith Z. Mills **WSA# 64505:** B. Shattuck C. Guiles **<u>Saginaw County CMH Authority</u>** **WSA# 8298:** B. Rainey B. Lehman J. Collver **WSA# 30521:** B. Lehman C. Mora J. Collver K. Pearson K. Dewitt **WSA#5298:** C. Mora **WSA# 15517:** J. Pendred M. Monticelli **<u>Shiawassee Health & Wellness</u>** **WSA# 13095:** Sherri Arrel Sherri Baldwin Alicia Burns Bruno Diene Kellie Fox Amanda Littlejohn B. MacNeal M. Lymon C. Miller M. Ward I. Ramos	• By date indicated below, cited staff will receive required IPOS training specific to the beneficiary they are supporting. • Carleen Brieney completed IPOS training on WSA# 17181 on6/18/2019; Evidence is IPOS-Specific Training and Agreement Form for Personal Care Staff (Signature #4) • Ellen Carter completed IPOS training on WSA# 17181 on 9/9/2020 as part of HBH Remediation; Evidence is IPOS-Specific Training and Agreement Form for Personal Care Staff (Signature #12) **GIHN** • By 11-30-2020 cited staff will receive required IPOS training specific to the beneficiary they are supporting. **TBHS** • By 1/5/2021, cited staff will receive required IPOS training specific to the beneficiary they are supporting. **☒ Systemic Remediation:** **BABH** • By 10/31/2020 CMHSP will review with CM staff the obligation to provide IPOS training to those providing supports to waiver recipients, in a timely manner (upon update/amending of IPOS) **CMCMH** • By 10/30/20 CMHSP will review with CM staff the obligation to provide IPOS training to those providing supports to waiver recipients, in a timely manner (upon update/amending of IPOS) • Effective 11/1/20, Supervisory staff will review quarterly, IPOS trainings provided/documented in the EMR, from a random sample pulled for this purpose. IPOS training records will be reviewed annually with the Event Verification. **CMH-CEI**

			A. Ready S. Williams K. Shavers R. Sheerin S. Jones T. Price J. Terpstra M. Ulrich A. Williams **WSA# 36257:** Heaven Finch Michelle Grazier Annalia Krish **WSA# 21312:** Scott Johnson **<u>The Right Door</u>** **WSA# 9913:** D Ladisky **WSA# 12360:** A. Mukagasana A. Payne C. Perry E. Dilly E. Pelton E. Bouwens G. Nelson J. Dickens J. Vansiclen L.Young M. Vanderkolk M. Taylor P. Warren S. Fudge-Hawkins S. Austin T. McCray **<u>Tuscola Behavioral Health Systems</u>** **WSA# 11236:** Mary Ratza Mary Skinner Cramer Melody Warju Michael Frazee Sarah O'Conner Steven Hill Wendy Ralston Zoe McIntyre C Warmbier J. Ratza **WSA# 12978:** Natasha Bearinger	• By 11/30/2020, CMHSP will meet with provider to review requirements related to staff credentialing. **SHW** • By 11/30/2020, CMHSP will review with CM staff the obligation to provide IPOS training to those providing supports to waiver recipients, in a timely manner (upon update/amending of IPOS). • Other: 13095-Training was completed with CM staff and home mangers regarding the requirements and also how to properly complete the training sheet. Meeting between Beacon and SHW was held on 9/10/2020 to discuss training requirements.36257-The process regarding the IPOS training of Self Determination cases was reviewed and will now be monitored by SD Coordinator. All CM's were trained during team meetings from 9/14-9/22 on the change in process for IPOS trainings for SD service recipients.When the SD Coordinator is notified by Stuart Wilson's office of a new direct care staff, she will send a "to-do" to the case holder informing them of the new staff and the need for IPOS training. This allows for easy tracking in the EMR to ensure the training occurs. **MCN** • By 12-31-2020, CMHSP will review with CM staff the obligation to provide IPOS training to those providing supports to waiver recipients, in a timely manner (upon update/amending of IPOS). • Effective 12-31-2020 Supervisory staff will review quarterly, IPOS trainings provided/documented in the EMR, from a random sample pulled for this purpose. • Other: New PCP training log implemented with all HSW staff by 12-31-2020

			Natasha Wright Nicole Regan Rachel Carlton Roxanne Newmann Samantha Ferguson Samantha Meffer Steven Decker Victor Fox C. Reynero D. Meffer D. Adame D. Bates E. Fulton E. Ward-Swires K. Kammerer J. Dearing J. Schank A. Lynch A. Bristol A. Goniwicka B. Corbin	**NCMH** • By 11/1/2020, CMHSP will review with CM staff the obligation to provide IPOS training to thoseproviding supports to waiver recipients, in a timely manner (upon update/amending of IPOS). • Effective 2/1/2021 Supervisory staff will review quarterly, IPOS trainings provided/documented in the EMR, from a random sample pulled for this purpose **GIHN** • By 12/30/2020 CMHSP will review with CM staff the obligation to provide IPOS training to those providing supports to waiver recipients, in a timely manner (upon update/amending of IPOS). • By 12/30/2020, GIHN will develop a process to ensure HSW providers meet training requirements. • By 2-15-2021 GIHN will review quarterly, all required trainings from a random sample pulled for this purpose. **TBHS** • By 12/5/2020, TBHS will develop a process to ensure that the trainer with appropriate credentials is included on the staff training sheet for HSW consumers **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** **X No individual remediation found** **For CEI**, individual remediation not found for 5 of 6 WSA's listed (and their accompanying staff). **For SCCMH**, under WSA# 8298, there are two different dates by which individual remediation is to occur. Please resolve.For Day programs closed due to COVID, please indicate timeline by which training

				will occur, once open (i.e., within 7 day and before further services are rendered to the WSA by these staff). ☒ RE systemic remediation found **For GIHN**: All systemic remediations need to be enacted within the 90 day perior prior to MDHHS Site Review return visit. Quarterly reviews to occur effective 2/15/21 appear (potentially) to exceed that 90 day period. For TBHS: Systemic remediation needs to include implementation of corrective measures. Though development of process is an important first step, what will be implemented to address? Please revise. Note: Under CMHCM: WSA# 19337, J. Luptowski has been removed as a citation. Under WSA#s 17140 and 10611, M. Boxx has been removed as a citation. Under SCCMHA: WSA# 8298, K Pearson and K. Dewitt have been removed as citations. Staff totals, under Q.2.4 have been adjusted accordingly. ☐ No timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**: **SCCMH Individual Remediation** • Staff at CTS day program will be trained within 7 days of all staff returning to work and before services start for the consumer for WSA#8298 (note: WSA#5298 is actually WSA#8298) and WSA#30521. Anticipated by 12/31/2020 as a return to program date is not determined yet.

				• WSA# 8298- Staff: B Rainey (residential staff) has been trained on the IPOS, please see proof documents in MSHN Box. Staff was trained on 10/29/2019 • WSA#15517- Staff: M. Monticelli (CLS/Respite staff) has been trained on the IPOS, please see proof documents in MSHN box. Staff was trained 9/24/2020 • Note: WSA#15517 – Staff: J Pendred was an error, he actually worked for CWP-WSA#20440 consumer. See MSHN box for those proof documents. Staff trained on 9/17/202. **CEI Individual Remediation:** • By 11/30/20, cited staff for WSA# 74638 will receive required IPOS training specific to the beneficiary they are supporting • By 11/30/20, cited staff for WSA# 7879 will receive required IPOS training specific to the beneficiary they are supporting • By 11/30/20, cited staff for WSA# 54433 will receive required IPOS training specific to the beneficiary they are supporting • By 11/30/20, cited staff for WSA# 74495 will receive required IPOS training specific to the beneficiary they are supporting • By 11/30/20, cited staff for WSA# 14938 will receive required IPOS training specific to the beneficiary they are supporting **TBHS Systematic Remediation** • By 12/5/2020, TBHS will develop a process to ensure that training documentation of the IPOS includes the name of individual(s) trained, content of training, date of training, and trainer information (name, title, and

				credentials) for all HSW consumers • In addition, by 12/30/2020, CMHSP will review with CM staff this process and the obligation to provide IPOS training to those providing supports to waiver recipients, in a timely manner (upon update/amending of IPOS). • Effective 1/30/2021 Quality staff will review quarterly, IPOS trainings provided/documented in the EMR, from a random sample pulled for this purpose. **GIHN System Remediation** • By 1/31/2021, GIHN will review quarterly, all required trainings from a random sample pulled for this purpose. **MDHHS 2nd Response**: ☒ **Response accepted**
H. HOME VISITS/TRAINING/INTERVIEWS				
H.3. HSW HOME VISIT				
Health and safety Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1; 4c CFR 438.208 Administrative rule Section 3(9) of Act 218 P.A. 1979, as amended Administrative Rule R 330.2802 Person-centered Planning Best Practice Guideline	NA	NA	No home visits were conducted as a part of this Site Review. Interviews were conducted across the three waivers, with the following noted Region Wide, for all three Waivers: Strengths: • Basic quality measures were met at 100% (who, what, when, where planning occurs). • Families pleased with delivery of clinical services, and	This information is being provided as technical assistance only (at the present time), to inform practices within your PIHP.

Attachment 3.4.1.1. to the MDHHS Contract AFP Section 2.7 Specialized Residential Settings (Administrative Rule R330.1806) Monitoring medications: R 330.1719 R 330.2813 R 330.7158			responsiveness to their requests. • High level of satisfaction with Wraparound Services through SEDW • Focus on community involvement/inclusion • Families reported overall value in completed IPOS • Knowledge of Independent Facilitation(IF) across all waivers (especially with SEDW) • Some level of budget control noted within Self Determination arrangements. • High level of satisfaction with Telehealth options during COVID (and desire for it to continue). Opportunities for Quality Improvement: • Overall absence was voiced for: – awareness of cost of services – understanding of services available/how to access • Utilization of Independent Facilitation remains low • Difficulties in locating staff to implement plan. • Under Self Directed services, limited or no budget control, or inconsistent	

			implementation of SD arrangements (training requirements, budget approval process, flexibility) • Availability of transition materials/information to assist families in transition from children to adult services • Clarification of how tools and assessments are utilized to determine level of services that are medically necessary.	
<u>Non-Residential Visit</u> (HCBS and Health/Safety) Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1; 4c CFR 438.208 Administrative rule Section 3(9) of Act 218 P.A. 1979, as amended Administrative Rule R 330.2802 Person-centered Planning Best Practice Guideline Attachment 3.4.1.1. to the MDHHS Contract AFP Section 2.7 Specialized Residential Settings (Administrative Rule R330.1806)	NA	NA	No home visits were conducted as part of this Site Review	N/A

DIMENSIONS/INDICATORS	Yes	No	FINDINGS	REMEDIAL ACTION
D. ADMINISTRATIVE PROCEDURES				
A.1 All				
A.1.1. The PIHP has adopted common policies for use throughout the service area for critical incidents. Medicaid Managed Specialty Supports and Services contract, Section 6.4; AFP Sections 3.8, 4.0 42 CFR 438.214. Waiver Assurance for Participant Safeguards	1	0	**See the HSW Report.**	
A.1.2. The PIHP has policy and business procedures to assure regular monitoring and reporting on each network provider for critical incidents. 42 CFR 438.230(b)(4) 42 CFR 438.810 Medicaid Managed Specialty Supports and Services contract, Section 6.4; AFP Sections 2.5, 3.8, 3.1.8	1	0	**See the HSW Report.**	

Waiver Assurance for Participant Safeguards				
A.1.3 Review and verify that the process is being implemented according to policy. Waiver Assurance for Participant Safeguards	1	0	**See HSW Report.**	
A.1.4 PIHP/CMHSP is implementing the Quality Improvement Project as approved by MDHHS. •	NA	NA	**See HSW Report**	
A.1.5 The PIHP/CMHSP has a policy that guides the contracting process with new providers or providers who are expanding their service array. These policies ensure new providers are assessed to ensure they do not require heightened scrutiny based upon isolating of institutional elements. • PIHP/CMHSP provides evidence of the policy • Review of PIHP/CMHSP provisional approval documents	1	0	**See HSW Report**	
A.3.SEDW				
A.3.2 CMHSP has a process to prior authorize all services. (PM A-3)	1	0	**See HSW Report**	

A.3.3 Claims are coded in accordance with MDHHS policies and procedures. (PM I-1)	28	0		
E. ELIGIBILITY (Medicaid Provider Manual, Mental Health/Substance Abuse)				
E.2. SEDW				
E.2.1 Level of Care evaluations are completed accurately. (evidence: sub-scores on CAFAS are consistent with notes and assessments in the record) (PM-B-3)	**28**	**0**		
P. IMPLEMENTATION OF PERSON-CENTERED PLANNING Medicaid Managed Speciality Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Guideline MCH712 Chapter III, Provider Assurances & Provider Requirements Attach. 4.7.1 Grievances and Appeals Technical Requirement.				
P.3 SEDW				
P.3.1 The IPOS is developed through a person-centered process that is consistent with Family-Driven, Youth-Guided Practice and Person Centered Planning Policy Practice Guidelines. (PM-D-3)	**21**	**7**	**REPEAT CITATION** ***Lack of evidence of choice voucher/self-determination arrangements being offered*** **Lifeways** **WSA#s 74418, 67402, 67828, 69144, 69922, 74316** **Saginaw County CMH Authority** **WSA# 69617**	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure that the IPOS is developed through a person-centered process that is consistent with Family-Driven/Youth-Guided Practice and Person-Centered Planning Policy Practice Guidelines. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS.

				CMHSP/PHIP Response: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. **☒ Individual Remediation:** **Lifeways** • By12/15/20, WSA #'s 74418, 67402, 67828, 69144, 69922 and 74316 will offer Self-Determination / Independent Facilitation, with documentation in the record by the 90-day f/u site review. **SCCMH** • WSA 69617 was reviewed. The Choice Voucher and Self-Determination offers are documented on Tab #7 of Pre-plan of Care dated 9/23/2019 This was submitted with the responses to the Comments Sheet on 7/30/2020. A copy of these documents are included in the evidence. **☒ Systemic Remediation:** **Lifeways** • By12/15/20, EMR will be adjusted to include this information as required fields in the pre-planning document.

				• Effective12/15/20,Wraparound Supervision will monitor a random selection of records quarterly to monitor for this requirement. **SCCMH** • By 10/31/2020staff training will be provided on the requirement of pre-planning activities that must inform person-centered planning. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** **X No individual remediation found:** **For SCCMH**: No individual remediation found. The evidence noted in SCCMH response (as presented/highlighted by CMH for P.3.1, to MDHHS on 7/30/20) was "Information about independent was offered – yes. Information abouty factilitation was offered – yes." These statements do not reflect the Choice Voucher/Self Determination being offered/discussed. Please revise. ☐ No systemic remediation found ☐ No timelines indicated ☐ **Other:** **CMHSP/PHIP 2nd Response**: **Saginaw Individual Remediation** • Indication of choice being offered was shown on the Support Plan Meeting Minutes of 9/25/20 for WSA# 69617, please see MSHN box for proof document. Document labeled WSA#69617 P3.1 choice voucher proof **MDHHS 2nd Response**:

				☒ **Response accepted, with the expectation that the above evidence will be newly submitted by SCCMH at the 90 day review (as above noted evidence was not found within the FTP upon review at the time of CAP review).**
P.3.2. The IPOS addresses all service needs reflected in the assessments. (PM-D-1)	**25**	**3**	**CMH Authority of Clinton-Eaton_Ingham Counties/CEI** **WSA# 67048** (Assessment completed after IPOS) **WSA# 69749** (Physical health indicated as need, but not addressed in Plan) **Saginaw County CMH Authority** **WSA# 69617** (Need for respite and psychiatric services not reflected in the Sept '19 Plan.)	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the *IPOS addresses all service needs reflected in the assessments. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **SCCMH** • Amendment will be completed by 10/31/2020to address identified need in assessment, not yet resolved in IPOS. **CMH-CEI**

				• Amendment for WSA # 67049 will be completed by 10/25/2020 to address identified need in assessment, not yet resolved in IPOS. • Amendment for WSA # 67048 will be completed by 10/25/20 to address address all needs identified in the assessment from 4/10/2020. **☒ Systemic Remediation:** **MSHN** • By 12/30/20 MSHN will provide regional guidance/training on development of measurable goals/objectives to address the assessed needs including amount scope and duration of services included in the IPOS through the SEDW regional work group. • By 1/15/21 MSHN will develop a regional training plan for IPOS development to ensure ongoing training is available for CMHSPs to utilize with in their organization. **SCCMH** • By 10/31/2020 staff training will be conducted focusing on the need to resolve all identified needs noted in the assessment, within the IPOS. • Beginning 01/01/2021 monitoring by supervisory staff will be done through quarterly clinical chart reviews for required elements of plans addressing identified needs. **CMH-CEI** • By 12/1/2020, staff training will be conducted focusing on the need to resolve all identified needs noted in the assessment, within the IPOS. • Beginning 12/1/2020, monitoring by supervisory staff will be done through quarterly clinical chart reviews for required elements of plans addressing identified needs. • Other: By 12/1/20, staff training will be conducted focusing on the need to complete

				assessment prior to treatment plan and need to resolve all identified needs noted in the assessment, within the IPOS. • Training for staff during staff meeting on (1) importance of needs pulling over from annual / initial assessment and (2) attaching each need to a goal (3) when to defer. Beginning 12/1/20 monitoring by supervisory staff will be done through quarterly clinical chart reviews for required elements of plans addressing identified needs. • Quarterly reviews (with QI) to ensure (1) needs have pulled over from most recent assessment and (2) are all attached to a goal. • Quarterly individual audits with facilitators (by Wrap Coord/Sup) to review all consumers and ensure needs are listed correctly on treatment plan. Monthly spot reviews (3-4 children from each facilitator) to ensure this is occurring. Monthly reminder in staff meeting. **MDHHS Response**: ☒ **Response accepted, with expectation that quarterly reviews (reflected above, under systemic remediation) will be effective the date of this CAP (10/5/20), with evidence of such reviews available at 90 day review.**
P.3.3 The strategies identified in the IPOS are adequate to address assessed health and safety needs, including coordination with primary care provider. (PM-D-2)	**22**	**6**	**REPEAT CITATION** **CMH Authority of Clinton-Eaton Ingham Counties/CEI** **WSA# 67039** (Lack of sufficient evidence of medication consent) **WSA# 69749** (Physical health indicated as need, but not addressed in Plan) **Lifeways**	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure that the strategies identified in the IPOS are adequate to address assessed health and safety needs, including coordination with primary care provider. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS.

			WSA#s 74418 (lack of med consent for current psychotropic medications prescribed) **WSA# 67828** (lack of med consent for a prescribed psychotropic medication) **WSA# 74316** (lack of med consent for prescribed psychotropic medications) **<u>Newaygo County Mental Health Center</u>** **WSA# 72420** (Lack of coordination of care with primary care physician).	**CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **Lifeways** • By 12/15/20, med consents for current psychotropic medications prescribed will be completed/ reflected in the record for WSA #'s 74418, 67828 and 74316: **CMH-CEI** • By 10/25/20 the following will be completed/ reflected in the record for WSA # 69749-Identified need of physical health will be added to the treatment plan • WSA # 67039 closed in August 2019. **NCMH** • By 10/23/2020 the following will be completed/ reflected in the record:-Psychiatric Eval-Coordination of Care-Medication consent reflecting all meds-Resolution of the health and safety matter noted below. • Other: Assigned clinician will reach out to Primary Care Physician to get all necessary documentation in regards to clients health and safety needs. These will then be scanned into our EMR.

				☒ **Systemic Remediation:** **Lifeways** • By 12/15/20, additional training will be provided to the staff at large regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations and medication consents **CMH-CEI** By 12/1/20 additional training will be provided to the staff at large regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations and medication consents. • Staff will be trained in the health / safety requirement (coordination of care, health care appraisal, psych evals, med consents). A review of the importance and process will occur for all staff. Options for potential goals and/or objectives will be reviewed at that time as well. Strategies will be to involve the Nurse Care Manager, coordinate with the PCP, etc. Consideration will be given to assigning the Nurse Care Manager at the time of intake if health conditions are presented at that time. • When Physical Health is identified on the assessment as a need, a goal / objective will be developed on the treatment plan to address need. The "Physical Health" box next to goal will be checked. • Quarterly reviews (with QI) to ensure this requirement is being met. If this indicator is not met at that time, staff will have 30 days to correct this. • Quarterly individual audits with facilitators (by Wrap Coord/Sup) to review all consumers and ensure needs are listed correctly on treatment plan. • The care pathway for health conditions will be implemented by 1/1/20.

				NCMH • By 10/23/2020, additional training will be provided to the staff at large regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations and medication consents. • Other: Supervisors will train staff in an upcoming team meeting regarding the requirement for coordination of care for each client served. This training will address all documents that could be part of that coordination of care. This will be noted in meeting minutes. Supervisors will also review quarterly record reviews to ensure that this process continues to be implemented and will be reviewed in supervision sessions. **MDHHS Response**: ☒ **Response accepted, with the expectation that quarterly review (referenced above, under systemic remediation, will be effective that date of this CAP (10/5/20) with evidence of such reviews presented at the 90 day review.**
P.3.4 IPOS for enrolled consumers is developed in accordance with policies and procedures established by MDHHS. Evidence: 1. IPOS contains meaningful and measurable goals and objectives. 2. Prior authorization of services corresponds to services identified in the IPOS. (PM-D-4)	**17**	**11**	**REPEAT CITATION** **Bay-Arenac Behavioral Health:** **WSA# 69179** (Objective not measurable) **CMH Authority of Clinton-Eaton Ingham Counties/CEI** **WSA#s 72023, 73414, 74169** (Goals/ojbectives not measurable). **CMH for Central Michingan** **WSA# 63300** (Amt Scope Duration Frequency of recommended services could not be found, for Parent Support Partner and Out Patient Therapy.)	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure that the IPOS for enrolled consumers is developed in accordance with policies and procedures established by MDHHS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be

			<u>Lifeways</u> **WSA#s 74418** (Amt Scope Duration Frequency of recommended services not found for Wrabaround/Psychiatric Services) **WSA# 74316** (Amt Scope Duration Frequency of recommended Wraparound, Home Based and Psychiatric services not found). **<u>Montcalm Care Network</u>** **WSA# 72421: (**Objectives not measurable) **<u>Newaygo County Mental Health Center</u>** **WSA# 72420** (Amt Scope Duration Frequency of recommended services could not be found in Plan) **<u>Saginaw County CMH Authority</u>** **WSA# 69617** (Amt Scope Duration Frequency of recommended Wraparound, Respite and Psychiatric services not found in Plan) **<u>The Right Door</u>** **WSA# 70594** (Objectives not measurable) **<u>NOTATION:</u> Technical Assistance provided around the use of ranges/range language in recommending/authorizing supports and services.** **Going forward, MDHHS will expect specific amount/scope/duration/frequency of services to be identified in the IPOS, rather than the use of ranges or "up to" language, to better comply with**	completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. **☒ Individual Remediation:** **BABH** • Other: WSA# 69179 case is closed so individual remediation cannot occur. **CMHCM** • By10/15/2020 plan will be amended to resolve the need to align recommended services with prior authorization by ensuring the amount, scope, duration of all prior authorized services is includedin the intervention section of the IPOS. **Lifeways** • By 12/15/20, WSA #'s 74418 and 74316's plan will be amended to resolve the need to align recommended services with prior authorizations (in the same amount/ scope/ duration). **SCCMH** • By 10/31/2020 the plan will be amended for resolving lack of measurable goals/ objectives/ timeframes. • By 10/31/2020 plan will be amended to resolve the need to align recommended services with prior authorizations (in the same amount/ scope/ duration) **CMH-CEI** • By 10/25/2020 plan for WSA #s 72023, 73414, 74169 will be amended for resolving lack of measurable goals/ objectives/ timeframes. **NCMH**

			best practices and to better meet federal and state regulation, as well as contract requirements.	• By 10/23/2020 plan will be amended to resolve the need to align recommended services with prior authorizations (in the same amount/ scope/ duration). • Other: Assigned will clinician will work to update the current treatment plan dated for 5/26/2020 to reflect the amount, scope and duration under each goal stated in the treatment plan document **MCN** • By 11-1-2020 plan will be amended for resolving lack of measurable goals/ objectives/ timeframes. **The Right Door** • By 9/4/2020 WSA# 70594 plan will be amended for resolving lack of measurable goals/ objectives/ timeframes. **☒ Systemic Remediation:** **MSHN** • By 12/30/20 MSHN will provide regional guidance/training on development of measurable goals/objectives to address the assessed needs including amount scope and duration of services included in the IPOS through the SEDW regional work group. • By 1/15/21 MSHN will develop a regional training plan for IPOS development to ensure ongoing training is available for CMHSPs to utilize with in their organization. **MCN** • By 12-31-2020, staff training will be conducted on developing measurable goals/ securing prior authorizations. **BABH** • By 12/1/20, the clinical supervisor will ensure staff education is provided during individual supervisions, staff meetings and peer supervisions. Children's supervisor will

				document in the supervision notes the provided education regarding IPOS training on writing measurable objectives. Staff will review IPOS objectives with Team Leader or Supervisor before completion of IPOS is approved. This will be to assure all goals and objectives are stated clearly with specific examples of how to measure level of success and completion of objectives.Education will be provided during the PNOQMC and Leadership Meetings. • Going forward practice/education regarding IPOS goals/objectives will be provided as a standing topic within monthly peer supervisions for the children's team and documented in the Peer Supervision Log. **CMHCM** • By 10/21/2020 Utilization Manager will complete training at the Super Management Team meeting on developing meaningful and measurable goals/ including amount, scope, duration in the interventions of the IPOS and securing prior authorizations. The expectation is that supervisors will then take the training materials/discussion back to their clinical teams. • Other: Utilization Review Specialist (URS) will be developing online, recorded training modules to include the need to provide ongoing opportunities to provide feedback on supports/services/progress (with documentation in the record of that feedback). Target date for these trainings to be recorded is 12/31/2020 and they will be available for all staff/supervisors. Additionally, the URS conducting internal record reviews will complete a review of the current record review tool by 11/01/2020 to ensure that this standard is being captured amongst the current internal record reviews being conducted. **Lifeways**

				• By 12/15/20,staff training will be conducted on developing measurable goals/ securing prior authorizations. **SCCMH** • By 11/31/20, staff training will be conducted on developing measurable goals/ securing prior authorizations. **CMH-CEI** By 12/01/20 staff training will be conducted on developing measurable goals/ securing prior authorizations. • Training for staff during all staff meeting on measurable goals / objectives • Quarterly reviews (with QI) to ensure measurable goals / objectives • Quarterly individual audits with facilitators (by Wrap Coord/Sup) to review measurable goals / objectives • Monthly spot reviews (3-4 children from each facilitator) to ensure measurable goals / objectives. • All supervisors will do monthly reminder in staff meetings **NCMH** • By 10/23/2020, staff training will be conducted on developing measurable goals/ securing prior authorizations. • Other: Supervisors will train and remind staff in a team meeting about adding the amount, scope and duration of authorized services under goals/interventions in all treatment plans. **The Right Door** • By 9/1/2020, staff training will be conducted on developing measurable goals/ securing prior authorizations. **MDHHS Response**:

				☒ **Response not accepted. –** No individual remediation found ☒ No systemic rededication found **For Lifeways**, systemic remediation does not appear to address need for reflecting recommended services within the plan, in specific amt scope duration being recommended. Please revise/include additional information related to this. ☐ No timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**: **LifeWays Systematic Remediation**: • By 12/15/20, staff training will be conducted, on the need to address/resolve needs identified in the assessments, and amount, scope, duration, within the IPOS; PCP training will be revised to train more in detail on addressing/resolving needs identified in the assessments, and amount, scope, duration, within the IPOS. **MDHHS 2nd Response**: ☒ **Response accepted**
P. PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS				
P.6. SEDW				
P.6.1 Services and supports are provided as specified in the IPOS including type, amount, scope duration and frequency. (PM D-7)	**19**	**9**	**REPEAT CITATION** **CMH Authority of Clinton-Eaton_Ingham Counties/CEI** **WSA# 67048** (Wraparound, respite, therapy not occurring as recommended) **WSA# 71378** (CLS services not occurring as recommended, with no	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the IPOS is developed in accordance with the policies and procedures established by MDHHS (*services/supports provided as specified in IPOS, including type,

			rationale in record found, from early Nov '19 to late May'20, re status of those services). **WSA# 74169** (Psychiatric services no occurring as recommended/reflected in the plan). **CMH for Central Michigan** **WSA# 63300 (**Psychiatric, Wraparound or Respite services not occurring as recomeneded). **WSA# 71603**: (Parent Support Partner services not reflected in the plan, only authorized). **Lifeways** **WSA#s 74418** (Lack of Amt Scope Duration of services. Music Therapy and Psychiatric services not occurring as recommended). **WSA# 67828** (Medication reviews not occurring as recommended). **WSA# 69922** (Lack of evidence of medication reviews) **WSA# 74316** (Services not clearly identified in Plan, in amt scope duration, so unable to determine if occurring as recommended, re Wraparound, Home Based, Psyciatric sevices) **The Right Door** **WSA# 70594** (Psychiatric, Nursing and Family Training S5111 not occurring as recommended).	amount, scope duration and frequency). The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. **☒ Individual Remediation:** **Lifeways** • By12/15/20, WSA #'s 74418, 67828, 69922 and 74316's plan will be amended for resolving lack of service provision as recommended. **CMH-CEI** • By 10/25/2020 plan for WSA 67048 will be amended for resolving lack of service provision as recommended. • 71378: Contact note (1/21/20)and Periodic Review document (5/29/20) stated: "The family initially wanted to participate in CLS services and have a FSW assigned to work with P in the community. However, the family changed their mind and the service was not used. This service will be removed from the treatment plan and added at a later time when the family is ready to move forward with an FSW. " Team was in

				ongoing conversations about need and consideration of CLS to fill need. • 74169: 4 reviews provided / scheduled dated 3/2/20, 3/16/20, 3/23/20, 3/26/20, and 5/11/20. **CMHCM** • WSA #63300 –a new IPOS was completed on 8/24/2020 following a transfer between two CMHCM counties. Current CMCHM treatment team will be monitoring to ensure psychiatric, Wraparound, and respite services are provided as prior authorized. • WSA #71603 –PSP services are referenced in the intervention section of the current IPOS; however, by 10/15/2020 the plan will be amended to include the amount, scope, duration of parent support partner services. **The Right Door** • By 9/4/2020 WSA# 70594 plan will be amended for resolving lack of service provision as recommended. **☒ Systemic Remediation:** **MSHN** • By 12/30/20 MSHN will provide regional guidance on ensuring services and treatment are provided as specified in the plan including amount scope and duration of services included in the IPOS through the SEDW regional work group. • By 1/15/21 MSHN will develop a regional training plan for IPOS development to ensure ongoing training is available for CMHSPs to utilize with in their organization. **Lifeways** • By 12/15/20, staff training will be conducted on the need to monitor service utilization and providing documentation specific to resolving disparity noted.

				CMH-CEI
				• By 12/1/20 staff training will be conducted on the need to monitor service utilization and providing documentation specific to resolving disparity noted.
				• (1)Training for staff during staff meeting on scope, duration, frequency and need to reschedule missed/cancelled/no showed appts in same month to meet auth. Document any disparity.
				• (2) Ongoing monitoring
				  ○ Quarterly reviews (with QI) to ensure meeting scope, duration, frequency and proper documentation.
				  ○ Quarterly individual audits with staff (by Coord/Sup) to ensure meeting scope, duration, freq. w/documentation.
				  ○ Monthly self checks with therapists
				  ○ Monthly spot reviews (3-4 children from each staff) to ensure meeting scope, duration, freq. w/ documentation.
				  ○ Monthly reminder / review in staff meeting. Twice monthly review of meeting scope, duration, frequency by supervisors with staff, along with a plan for sustaining or improving.
				• (3) Coverage
				  ○ When arranging vacation coverage, cases must be seen by the covering therapist if the primary therapist is away for 5 or more business days.
				  ○ When there is a cancelation of a session, staff will make every effort to reschedule for as soon as possible, preferably within the same week (1st appts at the beginning of the week are key).
				  ○ If a month has a holiday, training, staff vacation, or any other event(s) that

				decrease the amount of available hours for direct time, staff will plan accordingly in order to ensure scope, duration, and frequency are delivered as stated in the treatment plan. (This may be increasing session time or adding extra sessions during available weeks). **CMHCM** • Other: Utilization Review Specialist (URS) will be developing online, recorded training modules to the requirement that services require ongoing monitoring to ensure they are provided as specified in IPOS including the amount, scope, duration and frequency. The modules will also include information on the requirement that the amount, scope, duration of prior authorized services is included in the IPOS. Target date for these trainings to be recorded is 12/31/2020 and they will be available for all staff/supervisors. • Additionally, the URS conducting internal record reviews will complete a review of the current record review tool by 11/01/2020 to ensure that this standard is being captured amongst the current internal record reviews being conducted. **The Right Door** • By 9/1/2020 WSA# 70594, staff training will be conducted on the need to monitor service utilization and providing documentation specific to resolving disparity noted. **MDHHS Response**: ☒ **Response not accepted. –** **X No individual remediation found** **For CEI**, no individual remediation found for 74169, appearing to dispute citation, perhaps misunderstanding the citation). Per citation/comment sheet, as of 4/6/20, med review authorizations had expired. Though an auth was presented to reflect services were re-authoirzied/extended to 2/29/21, an

				amendment could not be found recommending this extension of authorized psychiatric services. Further, psychiatric eval was provided (3/2/20) without prior recommendation in plan/authorization, per review of record. Please address need for remediation at the individual level. ☐ Re systemic rededication found ☐ No timelines indicated ☐ Other: (See response below) *Correction to embedded language, above. **CMHSP/PHIP 2nd Response**: **CEI Individual Remediation:** • WSA 74169 –By 1/1/2021, wraparound staff will document reasoning in the EHR of why med reviews are continuing to be authorized. In CEI's EHR the authorization of "med review" covers psychiatric evaluation codes. The Treatment Plan will be amended to include Med Review Services by 1/1/2021. **MDHHS 2nd Response**: ☒ **Response accepted with the expectation that CEI will document reasoning for the need for continued med reviews in the Plan of Service/amended plan, to support continued authorizations, and that the plan will reflect the need for both eval and med reviews (as separate, medically necessarly services) regardless of how these authorizations are structured.**
P.6.3 Physician-signed prescriptions for OT, PT, services in the file and include a date, diagnosis, specific service or item description, start date and the amount or length of time the service is needed. (PM D-4)	NA	NA	NA: 27	

P.6.4 The IPOS was updated at least annually	17	0	NA: 11	
P.6.5 The IPOS was reviewed both at intervals specified in the IPOS and when there were changes to the waiver participant's needs (evidence: IPOS is updated if assessments/ quarterly reviews / progress notes indicate there are changes in the condition). (PM D-6)	27	1	**CMH for Central Michingan** **WSA# 63300 (**No evidence of amended plan to address crisis/safety plan, after several contacts by family, between Jan and July of 2020, leading to out of home placement in youth detention).	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that the IPOS is reviewed both at intervals specified in the IPOS and when there were changes to the waiver participant's needs. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **CMHCM** • A transfer between CMHCM counties occurred following the completion of this audit. A new IPOS was completed by the WRAP coordinator on 8/24/2020, and occurred following review of the waiver participant's current needs. ☒ **Systemic Remediation:** **CMHCM**

				• By 10/21/2020 training will occur at the Super Management Meeting on the need to provide ongoing opportunities to provide feedback on supports/services/progress (with documentation in the record of that feedback). Discussion will include the requirement that the IPOS be updated if assessments/quarterly reviews/progress notes indicate there are changes in condition. The expectation is that supervisors will then take this training back to their individual teams. • Other: Utilization Review Specialist (URS) will be developing online, recorded training modules to include the requirement that the IPOS be updated if assessments/quarterly reviews/progress notes indicate there are changes in condition Target date for these trainings to be recorded is 12/31/2020 and they will be available for all staff/supervisors. Additionally, the URS conducting internal record reviews will complete a review of the current record review tool by 11/1/2020 to ensure that this standard is being captured amongst the current internal record reviews being conducted. **MDHHS Response**: ☒ **Response accepted with the expectation that the training on 10/21/20 address specifically the need to address crisis and safety plans, as part of a required review, when child/family are clearly in crisis (as was the case with this individual).**
B. BEHAVIOR TREATMENT PLANS AND REVIEW COMMITTEES Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.				
B.1. The BTPRC process includes all the following elements as required by the	1	0	**See HSW Report**	

Technical Requirement for Behavior Treatment Plan Review Committees: 1. Documentation that the composition of the Committee and meeting minutes comply with the TR; 2. Evaluation of committees' effectiveness occurs as specified in the TR; 3. Quarterly documentation of tracking and analysis of the use of all physical management techniques and the use of intrusive/restrictive techniques by each individual receiving the intervention; 4. Documentation of the QAPIP's OR QIP's evaluation of the data on the use of intrusive or restrictive techniques; 5. Documentation of the Committees' analysis of the use of physical management and the involvement of law enforcement for emergencies on a quarterly basis; 6. Documentation that behavioral intervention related injuries requiring emergency medical treatment or hospitalization and death are reported to the Department via the event reporting system; 7. Documentation that there is a mechanism for expedited review of				

proposed behavior treatment plans in emergent situations. Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.				
B.2. Behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. 1. Documentation that plans that proposed to use restrictive or intrusive techniques are approved (or disapproved) by the committee 2. Documentation that plans that include restrictive/intrusive interventions include a functional assessment of behavior and evidence that relevant physical, medical and environmental causes of challenging behavior have been ruled out. 3. Are developed using the PCP process and reviewed quarterly 4. Are disapproved if the use of aversive techniques, physical management, or seclusion or restraint where prohibited are a part of the plan 5. Written special consent is obtained before the behavior treatment plan is implemented; positive behavioral	2	0	NA: 26	

supports and interventions have been adequately pursued (i.e. at least 6 months within the past year) 6. The committee reviews the continuing need for any approved procedures involving intrusive or restrictive techniques at least quarterly				
G. WAIVER PARTICIPANT HEALTH AND WELFARE				
G.1 Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents. (Date(s) of progress notes, provider notes that reflect this information.).	28	0		
G.2 Individual served received health care appraisal. (Date/document confirming_____)	27	1	**Newaygo County Mental Health Center** **WSA# 72420**	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that the individual served has received a health care appraisal. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area

				during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **NCMH** • By 10/23/2020, WSA # 72420 will receive a health appraisal as evidenced by a completed health appraisal form in the record, signed by the clinician providing the appraisal. • Other: Assigned clinician will request the health appraisal from primary care physician and will scan this in the EHR. ☒ **Systemic Remediation:** **NCMH** • By 10/23/2020, training will be provided to CM staff regarding this requirement. • Clinicians will scan all health appraisals into the EHR. Supervisors will complete quarterly record reviews to ensure this requirement is completed. **MDHHS Response**: ☒ **Response accepted**
Q. STAFF QUALIFICATIONS				
Q.3 SEDW				
Q.3.1 Clinical service providers and Wraparound facilitator are credentialed by the CMHSP prior to providing services. (Evidence: personnel records and credentialing documents – including licensure and certification and required	80	1	A total of 81 licensed/certified staff were reviewed for Q.3.1/Q.3.2 **Lifeways** **WSA# 69922:** K. Gordon (lack of evidence of initial background check prior to hire)	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure that clinical service providers and Wraparound facilitators are credentialed prior to providing services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within

experience for child mental health professionals). (PM C-1)				90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. **☒ Individual Remediation:** **Lifeways** • By 12/15/20, a criminal background check will be completed for staff cited, and provided to MDHHS at 90 day f/u site review **☒ Systemic Remediation:** **Lifeways** • CMHSP HR Department will develop a tool to assure QIDP credentialing, prior to service delivery, of newly hired/assigned staff to SEDW enrollees by12/15/20. • Effective 12/15/20, the CMHSP/HR Dept will retain evidence of QIDP status in personnel records (above/beyond credentialing committee determinations) for proof of staff qualifications. • Effective 12/15/20 quarterly monitoring of a random selection of personnel records will be completed quarterly by HR. **MDHHS Response**: **☒ Response accepted**

Q.3.2 Clinical service providers and Wraparound facilitator are credentialed by the CMHSP ongoing. (Evidence: personnel records and credentialing documents-including licensure and certification and required experience for child mental health professionals). (C-2)	76	5	***Insufficient evidence of 24 hr/yr child specific training*** **<u>Bay-Arenac Behavioral Health</u>** **WSA# 69179:** Amanda Christie Megan VanEver Sharol Dantzer Stephanie Blaylock **<u>Lifeways</u>** **WSA# 69922:** A Gant	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure that clinical service providers and Wraparound facilitators are credentialed on an ongoing basis. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. **☒ Individual Remediation:** **BABH** • Other: BABH created a CEU tracking sheet to identify the trainings that would be considered chidren's specific training for the previous calendar year. The CEU tracking sheet uploaded in Box(https://app.box.com/file/723108662921) contains the tracking sheet for each of the staff attached to WSA# 69179. Additionally, each updated Relias transcript was uploaded into Box

				on 9/24/20 (https://app.box.com/folder/122882772673) with all trainings identified on the CEU tracking sheet. **Lifeways** • By 12/15/20, clarification of staff (A. Gant) cited for lack of training requirement will be provided from Provider for previously attended Autism Training. **☒ Systemic Remediation:** **BABH** • **Other:** Going forward, clinical staff will track all required trainings. Staff may utilize a training tracking form as distributed by the Director of Integrated Care in order to track training. Staff will timely complete the external training form and submit to Staff Development. Trainings will be monitored by the clinical supervisor/manager on a quarterly basis during regularly scheduled clinical supervision to ensure compliance with the standard. • Supervisors will address training needs and completion of required training during the annual performance review and the accompanying Staff Professional Development Plan. Progress with the plan will be monitored on a quarterly basis during regular clinical supervision. • Staff Development has created a new naming convention that will allow easier identification of child related training. **Lifeways** • CMHSP HR Department will develop a tool to assure CMHSP credentialing, prior to service delivery, of newly hired/assigned staff to SEDW enrollees, by 12/15/20.

				• Effective 12/15/20, the CMHSP/HR Dept will retain evidence of CMHSP status in personnel records (above/beyond credentialing committee determinations) for proof of staff qualifications. • Effective 12/15/20 quarterly monitoring of a random selection of personnel records will be completed quarterly by HR. **MDHHS Response**: ☒ **Response not accepted. –** X No individual remediation found **For BABH**: Unclear what the remediation is. (Has the staff cited received the required training, since the close of the review, and it will be presented as evidence in 90 days?) No due date for receiving the required training found. If disputing original citation (i.e., they had the required training at the time of the review, and it was somehow mislabeled), be prepared to provide evidence of course content, in 90 days, to resolve those training. Either way, more information needed ☒ No systemic rededication found **For BABH**: Clear timelines/target dates for recommendations could not be found for systemic remediation. Further, self tracking forms (a version of self-attestation) will be insufficient proof of training, without evidence of backup documentation of receiving the training. Please revise. **For Lifeways**: as evidence of systemic remediation is needed at the 90 day review, the effective date of quarterly monitoring may require an earlier date than 12/15/20 (i.e., effective date 102/20 (date of this CAP) with first quarterly monitoring to occur byt 1/5/21). ☐ No timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**: **BABH Individual Remediation**

				• By 2/1/21 the clinical supervisor will ensure that identified staff for WSA# 69179 who did not meet the 24-hours of children-specific training will receive the additional hours needed. This training will be documented via the BABH external training form if received from an external source and submitted to BABH Staff Development along with a certificate of completion All training will be added to the staff member's training transcript in Relias. Starting no later than 11/1/20 the supervisor(s) will monitor the completion of the outstanding required training on a monthly basis. **BABH Systematic Remediation** • Effective 10/1/2020, a tracking form including the name and date of training, name of trainer, clinical content and certificate of completion provided by the trainer/agency will be completed and reviewed during supervision. Staff may utilize a training tracking form as distributed by the Director of Integrated Care in order to track training. Within 30 days of an external (non-Relias) training, staff will complete the external training form and submit to Staff Development. • Effective 10/1/2020, evidence of trainings will be monitored by the clinical supervisor/manager on a quarterly basis during regularly scheduled clinical supervision to ensure compliance with the standard. • Effective during the annual evaluation process for FY21, supervisors will address training needs and completion of required training during the annual performance review and the accompanying Staff Professional Development Plan. Progress with the plan will be monitored on a quarterly basis during regular clinical supervision.

				• No later than 11/1/20, Staff Development will create a new naming convention that will allow easier identification of child related training. **LifeWays Systematic Remediation**: • By 12/15/20, quarterly monitoring of a random selection of personnel records will be completed quarterly by CMHSP. **MDHHS 2nd Response**: ☒ **Response accepted**
Q.3.3. Non-licensed/non-certified providers meet provider qualifications. Evidence: personnel records contain documentation that staff is: 1. At least 18 years of age, 2. Is in good standing with the law 3. Is free from communicable disease. Documentation staff has completed all core training requirements – e.g. recipient rights, prevention of transmission of communicable diseases, first aid, CPR, and that staff is employed by or on contract with the CMHSP. (PM C-3) 3. In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, not an illegal alien). 4. Able to perform basic first aid procedures, as evidenced by completion of a first aid training course, self-test, or	6	12	A total of 18 non-licensed/non-certified staff were reviewed for Q.3.3/Q.3.4 ***Insufficient Evidence of Emergency Procedures Training.*** **CMH Authority of Clinton-Eaton_Ingham Counties/CEI** **WSA# 72023** Aidn Shank Marissa Clark Paul Brooks **WSA# 74169:** Paul Brooks **WSA# 69749**: Marissa Clark ***Insufficient evidence of Recipient Rights Training*** **CMH for Central MI** **WSA# 63300:** Abigail Steinmeier	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all non-licensed/non-certified providers meet provider qualifications. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. ☒ **Individual Remediation:** **CMH-CEI**

other method determined by the PIHP to demonstrate competence in basic first aid procedures.			Eric Woods Erick Barrows Graham Mcgeehan Isabelle Adsmond **WSA# 71603:** Abigail Steinmeier Erick Barrows Graham Mcgeehan ***Insufficient Evidence of Bloodborne Pathogen Training,*** **CMH for Central MI** **WSA# 63300:** Abigail Steinmeier Errick Barrows Farrah Hollenbeck Graham Mcgeehan Isabelle Adsmond Lori Brown Randy Brown Roy Wilkenson Jr. **WSA# 71603:** Erick Barrows Graham Mcgeehan ***Emergency Procedures Training*** **CMH for Central MI** **WSA# 63300** Abigail Steinmeier Erick Woods Farrah Hollenbeck Lori Brown Randy Brown Roy Wilkenson, Jr.	• Other: By 10/25/20 cited staff (still employed) for WSA72023, 74169, 69749 will complete Emergency Procedures Training **CMHCM** • For WSA #63300 evidence of recipient rights training cannot be obtained for Abigail Steinmeier, Eric Woods, Erick Barrows, Graham Mcgeehan, and Isabelle Adsmond.The staff are no longer work with the consumer or Eagle Village. • For WSA #63300 evidence of blood borne pathogen training cannot be obtained for Abigail Steinmeier, Errick Barrows, Isabelle Adsmond, and Graham Mcgeehan. The staff are no longer work with the consumer or Eagle Village. • For WSA #63300 evidence of emergency procedures training cannot be obtained for Abigail Steinmeier and Erick Woods. The staff are no longer work with the individual or Eagle Village. • For WSA #63300 evidence of First Aid training cannot be obtained for Graham Mcgeehan. The staff are no longer work with the consumer or Eagle Village. • By 11/30/20, for WSA #63300, evidence of blood borne pathogen training will be obtained for Farrah Hollenbeck, Lori Brown, Randy Brown, and Roy Wilkenson Jr. • By 11/30/20, for WSA #63300, evidence of emergency procedures training will be obtained for Farrah Hollenbeck, Lori Brown, Randy Brown, and Roy Wilkenson Jr. • For WSA #71603 evidence of recipient rights training cannot be obtained for Graham Mcgeehan, Abigail Steinmeier, and Erick Barrows. • For WSA #71603 evidence of blood borne pathogen training cannot be obtained for Erick Barrows and Graham Mcgeehan.

			Insufficient Evidence of First Aid Training **CMH for Central MI** **WSA#s 63300, 71603:** Graham Mcgeehan	• For WSA #71603 evidence of First Aid training cannot be obtained for Graham Mcgeehan. **☒ Systemic Remediation:** **CMH-CEI** • By 12/1/2020, CMHSP will meet with provider to review requirements related to staff credentialing. • Effective 12/01/2020 the CMHSP/HR Dept will randomly select a staff sample to review quarterly for required trainings. **CMHCM** • By 10/01/20, CMHSP will meet with respite coordinators to review requirements related to staff credentialing and appropriate authorization of services. • By 11/1/20 CMHCM will contract with all camps providing respite services and credential all staff prior to working with Consumers. • By 12/31/20, the CMHSP will randomly select a staff sample to review required trainings. • Staff credentialing for contracted providers will be reviewed annually as part of the regular Event Verification process. **MDHHS Response**: ☒ **Response not accepted. –** **X** No individual remediation found. **For CMHSM**: As these staff were originally cited as respite providers, and you have since clarified, via email with MDHHS, of these individuals providing therapeutic overnight camp, your planned remediation muct include credentialing for that service, those elements noted in the citation, as well as evidence of the provider being an MDHHS licensed camp with staff trained in working with children with SED. Could not find remediation for giving evidence of cited staff being trained in SED population, nor evidence of camp being licensed by MSDHHS.

				☒ No systemic rededication found **For CMHCM, clarification needed that respite services are not the only applicable service being provided by camps. Therapeutic overnight/day camp services are also being provided, and their services will also need to be a part of contractual arrangements, with staff properly credentialed to provide those services. Please revise.** ☐ No timelines indicated ☐ Other: (See response below) **CMHSP/PHIP 2nd Response**: **CMHCM Individual Remediation** • Effective 11/1/20, each staff providing therapeutic overnight/day camp working with the Consumer identified (WSA# 63300 and 71603) will be credentialled prior to working with him/her. Credentialing will include all MDHHS requirements as well as ensuring the staff providing service are trained in working with children with SED. **CMHCM Systemic remediation** • Effective 11/1/20, prior to Therapeutic overnight/day camp and respite services being authorized, CMHCM will obtain a contract with the camp and ensure there is a license with MDHHS. Contract will include credentialing requirements of all staff providing Respite and Therapeutic overnight camp services. **MDHHS 2nd Response**: ☒ **Response accepted**

Q.3.4 All SEDW providers meet training requirements including training of CLS staff on the implementation of the IPOS by the appropriate professional. (Evidence: case file notes identifying the who, what and when of training, personnel files with documentation of training). (PM C-4)	**9**	**9**	**<u>CMH Authority of Clinton-Eaton Ingham Counties/CEI</u>** **WSA# 72023:** Aidn Shank Marissa Clark **WSA# 73414:** Asad Khan Samantha Bates Sophia Dodge **WSA# 69749:** Marissa Clark **<u>CMH for Central MI</u>** **WSA# 63300** Erick Barrows Randy Brown Roy Wildenson Jr. **<u>Saginaw County CMH Authority</u>** **WSA# 63278** K. Brennenstuhl	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure that all SEDW providers meet training requirements including training of CLS staff on the implementation of the IPOS by the appropriate professional. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. **CMHSP/PHIP Response**: The following plans of correction were submitted by each CMHSP that was found out of compliance with this standard. The identified action will be completed at the CMHSP level and completion of the identified plan will be monitored by MSHN through the submission of evidence by the required due date. Monitoring of the standard and effectiveness of the corrective action will be measured by the performance of the specified area during the delegated managed care site reviews for each CMHSP to occur in 2021. **☒ Individual Remediation:** **CMH-CEI** • By 10/25/20 cited staff for WSA# 72023, 73414, 69749) will receive required IPOS training specific to the beneficiary they are supporting **SCCMH** • By 10/31/2020, cited staff for WSA# 63278 will receive required IPOS training specific to the beneficiary they are supporting. **CMHCM** • For WSA #63300 evidence of IPOS training cannot be obtained for Erick Barrows. The staff

				are no longer work with the consumer or Eagle Village. • For WSA #63300, evidence of IPOS training will be obtained for Randy Brown and Roy Wilkenson Jr. if these staff continue to provide this individual services. This will be done by 11/30/20 if applicable **☒ Systemic Remediation:** **CMH-CEI** • By 12/1/20, CMHSP will review with CM staff the obligation to provide IPOS training to those providing supports to waiver recipients, in a timely manner (upon update/amending of IPOS). o Authorization and goal / objective added to treatment plan and signed by family (approved by supervisor) o Referral form submitted to Respite / CLS Supervisor o Consumer assigned to Family Support (CLS) Worker and (1) referral form reviewed (2) treatment plan goal / objective reviewed with Family Support Worker by Supervisor. o Family Support Worker contacts referring worker (case manager) regarding referral and goal / objective in treatment plan o Referring worker documents that FSW was trained in CLS goals / objectives from treatment plan. • Effective 12/1/20Supervisory staff will review quarterly, IPOS trainings provided/documented in the EMR, from a random sample pulled for this purpose. **SCCMH** • By 10/31/2020 CMHSP will review with CM staff the obligation to provide IPOS training to those providing supports to waiver recipients, in a

				timely manner (upon update/amending of IPOS). • Effective 1/1/2020 Supervisory staff will review quarterly, IPOS trainings provided/documented in the EMR, from a random sample pulled for this purpose. • Other: The Training Log was revised on 9/9/2020 to capture the requirements to indicate that the Case Holder trained the trainer (if not the Case Holder). **CMHCM** • By 10/1/20, CMHSP/PIHP will meet with respite coordinators to review requirements related to staff credentialing and appropriate authorization of services. • By 11/1/20, CMCHM will contract with all camps providing respite services and credential all staff prior to working with Consumers. • By 12/31/20, the CMHSP will randomly select a staff sample to review required trainings. • Staff credentialing will be reviewed annually as part of the regular Event Verification process. **MDHHS Response**: ☐ **Response accepted** ☒ **Response not accepted. –** No individual remediation found ☒ No systemic rededication found **For CMHCM**, systemic remediation appears to be limited to just respite staff. Citation was for therapeutic overnight camp staff., and would need to include such staff, as well. Please revise. ☐ No timelines indicated ☐ Other: (See response below)

				CMHSP/PHIP 2nd Response: **CMHCM Systemic Remediation** • By 11/1/20, CMCHM will contract with providers providing respite or Therapeutic Overnight Respite services and credential all staff prior to working with Consumers. • By 12/31/20, the CMHSP will randomly select a staff sample from respite or Therapeutic Overnight Respite providers to review required trainings completed **MDHHS 2nd Response**: ☒ **Response accepted**
H. HOME VISITS/TRAINING/INTERVIEWS				
H.2. SEDW HOME VISIT				
H.2.1 The current IPOS is in the home and the parent /guardian and staff have access to it. (evidence: a copy of the plan is in the home)	NA	NA	There were no SED-W Home Visits /Interviews regarding performance measures H.2.1 thru H.2.3, as a part of this review. **Please see HSW report for outcomes to Person Centered Planning Recipient Interviews, across all three Waivers, conducted as a part of the Full Site Review of MSHN/Region 5.**	**Please see HSW Report**
H.2.2 The parent is offered a formal opportunity to express his/her level of satisfaction with the SEDW. (evidence: as reported to the surveyor by the parent and documented by the surveyor's notes)	NA	NA	NA	NA

H.2.3 Protocols for managing individual health and safety issues are identified in the IPOS and implemented by staff and parents. Evidence: 1. Crisis and Safety Plans are current, accessible and – per report of the child/youth, parent and staff - responsive to need 2. Staff and parents know what the protocol is, where it is, and how to implement it	NA	NA	NA	NA

Consumer Satisfaction Survey

Summary

In previous years as part of the Community Mental Health Authority of Clinton-Eaton-Ingham's (CMHACEI) quality improvement efforts, a consumer satisfaction survey (11 questions) has been administered to persons who were receiving services and were "open cases" during August of that year.

Due to COVID-19, this year we mailed paper copies of the MSHN Satisfaction Survey's to two sub-groups within the agency. MHSIP (36 question survey) was mailed to our AMHS consumers and YSSF (26 question survey) was mailed to our Family Forward consumers/families in July 2020, with a self-address stamped envelope to return the survey by August 30, 2020. Other surveys were scheduled for SUD and CSDD consumers but ultimately were canceled due to the pandemic. Data results in this report came from self-selected consumers who chose to return questionnaires voluntarily. The respondents to the survey were anonymous.

Respondents for both survey's responded using a 6-point Likert-type scale ("Strongly Disagree," "Disagree," "Undecided," "Agree," "Strongly Agree" and "Not Applicable"). Completed surveys were returned by mail to CMHA-CEI for data entry and analysis.

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

Procedure

The organization compiled a listing of current open cases for both the AMHS and FF programs. Survey forms were then disseminated to consumers open during the survey period.

Findings –

AMHS - Results showed that CEI-CMHA mailed 1998 surveys, of which 261 were returned for a 13.1% completion rate.

FF - Results showed that CEI-CMHA mailed 970 surveys, of which 91 were returned for a 9.4% completion rate.

Survey Response by Program				
	Response by Program			
	Mailed	Returned	% Completed	Not Returned
AMHS	1998	*261*	*13.1%*	*1737*
FF	970	*91*	*9.4%*	*879*
Totals	**2968**	**352**	**11.9%**	**2616**

Analysis of Findings

AMHS - The top three positive responses:

- Staff respected my wishes about who is and who is not to be given information about my treatment services. (4.38)
- I would recommend this agency to a friend or family member. (4.36)
- I like the services that I received. (4.36)

The three lowest responses include:

- My housing situation has improved. (3.94)
- I feel I belong in my community. (3.81)
- I do better in school and/or work. (3.76)

Consumers also had the opportunity to offer their freely to a prompt "Services in the time of COVID". Here are the responses that helped CEI-CMHA improve services:

- I am concerned about having to go back in person to the meetings because I am afraid I might get the corona virus.
- For the last few months I had phone conversation. Everything went well with my case manager and worker.
- Things have been different with the pandemic but all has been managing for the most part!
- The provider has been wonderful through this virus. Not able to see friends.
- Feel disconnected but partly do to COVID-19.
- Extended remote options would benefit in concerns of transportation immobility and time scheduling.

FF – The top positive responses:

- Staff treated me with respect. (4.71)
- Staff were sensitive to my cultural/ethnic background (e.g., race, religion, language) (4.64)
- Staff spoke with me in a way that I understood. (4.63)

The three lowest responses include:

- I am satisfied with our family life right now. (3.45)
- My child is better able to cope when things go wrong. (3.42)
- My child is doing better in school and/or work. (3.28)

Consumers also had the opportunity to offer their freely to a prompt "Services in the time of COVID". Here are the responses that helped CEI-CMHA improve services:

- Video Visits while more "convenient were not as effective for us".
- Our daughter still needs counseling; she does not do well on zoom.
- Due to COVID-19 pandemic services were limited.
- During the 19/20 school year, we had a very hard time getting ahold of our children's therapist. During the pandemic, it's gotten better.

Stakeholder Survey

Annual Submission to MDHHS (Data from FY19, submitted in March 2020)

Requests for Service and Disposition of Requests

	CMHSP Point of Entry-Screening	DD All Ages	Adults with MI	Children with SED	Unknown and All Others	Total
1	Total # of people who telephoned or walked in	346	2494	1484	887	5211
2	Is Info on row 1 an unduplicated count? (yes/no)					
3	# referred out due to non-MH needs (of row 1)	20	114	33	89	256
4	Total # who requested services the CMHSP provides (of row1)	332	2461	1488	819	5100
5	Of the # in Row 4 - How many people did not meet eligibility through phone or other screen	0	109	22	48	179
6	Of the # in Row 4 - How many people were scheduled for assessment	326	2771	1429	750	5276
7	other--referred to SA treatment, referred to Crisis services	0	16	3	118	137
	CMHSP ASSESSMENT	**DD All Ages**				
8	Of the # in Row 6 - How many did not receive eligibility determination (dropped out, no show, etc.)	199	1277	473	7	1956
9	Of the # in Row 6 - how many were not served because they were MA FFS enrolled and referred to other MA FFS providers (not health plan)	0	0	0	0	0
10	Of the # in Row 6 - how many were not served because they were MA HP enrolled and referred out to MA health plan					

11	Of the # in Row 6 - how many otherwise did not meet cmhsp non-entitlement eligibility criteria					
11 a	Of the # in row 11 - How many were referred out to other mental health providers					
11 b	Of the # in row 11 - How many were not referred out to other mental health providers					
12	Of the # in Row 6 - How many people met the cmhsp eligibility criteria				2249	2249
13	Of the # in Row 12 - How many met emergency/urgent conditions criteria					
14	Of the # in Row 12 - How many met immediate admission criteria					
15	Of the # in Row 12 - How many were put on a waiting list	0	0	0	0	0
15 a	Of the # in row 15 - How many received some cmhsp services, but wait listed for other services	0	0	0	0	0
15 b	Of the # in row 15 - How many were wait listed for all cmhsp services	0	0	0	0	0
16	Other - explain	0	0	0	0	0

Wait Lists

Clinic Services	MI Adult	DD	SED	Total
Number on waiting list as of date above		**29**		**29**
Added during the time period covered				**0**
Removed during the time period covered-service provided				**0**
Removed during time period covered - all other reasons				**0**
Number left at the end of the time period covered				**0**

Supports for Residential Living	MI Adult	DD	SED	Total
Number on waiting list as of date above	31		29	60
Added during the time period covered	35			35
Removed during the time period covered-service provided	21			21

Removed during time period covered - all other reasons	11			11
Number left at the end of the time period covered	34			34

Update to Needs Assessment

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

The most recent stakeholder assessment, conducted in 2019 asked the following questions:

1. ***What do you see as being the most significant mental health <u>needs</u> that are not currently being adequately addressed in our community?***
2. ***From your perspective what <u>trends</u> have you identified that CMHA-CEI should be aware of?***
3. ***Based on what you have shared, please identify the top three <u>concerns/priorities</u>.***

For the FY18 Annual Submission, the survey was electronically to 1637 external stakeholders returned 108 responses. The QI Team, Clinical Program Directors, and other CMHA-CEI leaders viewed the responses and created a priority needs list for the following year.

The FY 19 Annual Submission included the following update from the FY18 stakeholder assessment:

Priority Issue	1 Year Update
1. Promote to the public what we do; use data effectively to communicate the vision and benefit of services.	1. Distributed a survey to key leaders/partners in the community to identify the common perceptions/misperceptions of who we are as an agency and what we do. Analysis of results and determination of use of results are pending. An Ad Hoc Committee has become a formal Committee of the Board – titled "Community Access Committee" which has compiled and reviewed results of a community perception survey 2. Update the draft of the agency communication plan to include the development of a tagline that represents our agency and improves our image as well as other updates surrounding brand, image, public perception, and internal and external communication. 3. Aligned targeted CMHA-CEI prevention and outreach events, initiatives, and activities with the updated brand image and tagline. Including, but not limited too new promotional items (clothing, water bottles, etc.), tri-county initiatives, and partnerships connecting with our updated brand image. A new CMHA-CEI style guide was completed in September 2019 along with new tagline "Together We Can". 4. Completed Quality Improvement Plan (QIP) which includes measurement and interventions used throughout the agency to improve clinical and non-clinical services.
Improve on access and	1. We continue to work with community partners by attending weekly and monthly meetings. • Housing Specialist, attends weekly IDDT meetings with community partners

delivery of housing resources to adults with SPMI. (AMHS)	• Brooke Hall, Nova Harahap (HCBS Specialist) and Cindi Borgman (Supervisor) attend monthly Housing CoC meetings. • Cindi Borgman, Supervisor is on the Board of Directors for Housing CoC. • AMHS has Provider Meetings every 2 months • Met with local shelters, met with City of Lansing and now meeting with MSHDA • Staff go to the two largest shelters (Holy Cross and Homeless Angels) as an access representative We continue to work on options for housing within the community • Received Grant to allow us to maintain 4 rooms with Walnut Street Apartment PSH Program • Meet with Management Company (MAG) for improving/developing houses • Joined projects with local property management company for housing efforts (on-going) • Meet with Lansing Housing Coalition (LHC) for improving/developing houses 2. We are currently working on adding the following staff to help with Residential / HCBS needs: • Fully staffed in Residential and have re-stored several FTE positions. • BTP MIFAST is scheduled for January 17, 2020. • Hired Residential Coordinator to help with the large volume of placements and HCBS requirements. In addition, to provide additional support and collaboration with community partners We are also hiring several new Mental Health Therapists within our programs. • Hired FT Bi-Lingual Mental Health Worker to help support our growing bi-lingual cliental. • Hired FT - LGBTQIA MHT to help support our growing cliental.
Improve connection to treatment from crisis services via. emergency room, urgent care, crisis services, mobile crisis services, and shelters. (AMHS)	1. Urgent Care Crisis Services (UCCS) program, stationed in Crisis Services to help assess and connect clients before they leave, specifically if not a current client (in-progress). In addition, we are adding four Mental Health Therapist positions (1 in ART and 1 in Wellness) to assist with the volume of Assessments coming in. 2. Our Mobile Crisis Services is up and running, effective June 5, 2019. This will be an on-going service available to our clients and community to provide support and access within the community. 3. Follow up calls are provided to each client that leaves CS/UCCS 4. UCCS and CRT can provide same-day Assessments to connect clients to services.

Establish additional relationships and collaborations with County ISD's and local School districts around referral practices for mental health services as well as mental health services in schools. (FF)	On the Steering committee for the tri county ISD group to jointly plan for mental health services, staffing and referrals. Developing a position with Clinton ISD where CMHA-CEI staff would provide services in that district. Implementing more school liaison position time within more Ingham county Schools.
Continue to develop Youth Suicide Prevention awareness, planning and collaborations in the tri-county area. (FF)	For the first one, we continue to work closely with both Eaton RESA and Ingham ISD to ensure that constituent districts have access to trainings and resources regarding youth mental health. We are working specifically with Eaton RESA to offer Youth Mental Health First Aid, address RESA programs per request (ex. Stepping Up Together program for pregnant and parenting teens), and participate in multiple county-wide initiatives including Eaton County Handle with Care, Eaton County Substance Awareness Advisory Group, and Suicide Prevention Eaton County. We have presented QPR for Ingham ISD and communicated with constituent districts to address their specific requests including QPR, YMHFA partnerships, and "talks" series of presentations on a variety of youth mental health-related topics. We are also a part of the tri-county Whole Child initiative which is working with the Michigan Department of Education's Michigan Integrated Continuous Improvement Process to address the social-emotional and mental health needs of Michigan students. For the second one, 1. We have provided or partnered to provide 7 Youth Mental Health First Aid trainings between April 2019 and January 2020, with 3 more scheduled to take place by the end of February 2020. 2. We have provided or partnered to provide 11 Question, Persuade, Refer (QPR) suicide prevention trainings with at least 2 more scheduled to take place by the end of February, 2020. These offerings include monthly QPR trainings offered on-site at Families Forward. 3. We continue to distribute Holding On to Life toolkits and other resources at trainings and community events on a regular basis. 5. We have offered or participated in 10 community outreach events between April 2019 and December 2019, including the Families Forward Children's Mental Health Awareness Day fair in August 2019. We anticipate continued participation in these and other community opportunities to provide information on services and connect community partners to needed resources.

Improved and ongoing integration and inclusion in the community (CSDD)	1. CSDD has increased Community Living Support resources to a total of 38 provider groups, with particular focus of expanding our reach into Clinton and Eaton Counties (previously under-represented areas). While this number has improved, continued efforts will be pursued to ensure quality of service provision, and to ensure a sense of sufficient choice among providers across all 3 counties. 2. CSDD has developed two key processes to support true community inclusion and adherence to Medicaid policy. First, this effort led to the development of a Manager level staff position to work directly with providers to train and guide service provision to both HCBS and Medicaid standards and intent. Secondly, CSDD has developed two Community Connector staff positions to assist in monitoring service provision on the ground, and work jointly with case managers to ensure that goals attached to individuals' PCPs can be effectively enacted and supported in the greater community. Beyond staff development efforts, CSDD continues to hold routine provider trainings to both train and guide and refine service provision among our provider groups. These meetings are typically held on a quarterly basis, with additional trainings offered to address emerging needs that either the agency or the providers may be encountering.
Improved access to community based employment. (CSDD)	CSDD has completely revamped its Skill Building program over the past 6 months, working to ensure sound attachment to Medicaid intent and service provision. Additionally, CSDD has developed a Manager level staff position to work directly with employers and contract Supported Employment providers to train and guide service provision to both HCBS and Medicaid standards and intent (specifically mirroring the work established for the oversight of CLS provision). Due to unexpected staff turnover in the Vocational Supports unit, CSDD has not been able to fully implement intended steps to support customized employment designs. Despite this lack of resources, however, the unit is experiencing growth in customized employment efforts through more natural and organic means (often facilitated by case manager, or by extension of our revamped Skill Building services). As such, modest gains are being seen in this area, and these efforts are useful in shaping a model for continued programmatic development ongoing.
Screening, Assessment, Treatment and Coordination of Care for individuals with behavioral health needs who are incarcerated within the three county jails. (SAS)	a. Justice Behavioral health Millage is fully staffed and treating consumers – currently over 100 incarcerated individuals have been enrolled and served. b. The Jail Diversion invitation list has been expanded – the announcement on CEI's social media page is being worked on. c. In progress. New services brochure included information on Jail based services. d. Data is available and graphics are in development e. The program manager of jail services is meeting with each Sheriff's office and key staff. Needs and gaps are being discussed.

Collaborate with tri-county partners to reduce opiate overdose, increase access to treatment and promote recovery within the opioid use disorder population. (SAS)	a. Fund source request is in process, as well as additional funding for 1 FTE Peer Recovery Coach through another grant has also been sent in. b.The Building bridges cohort is still meeting and has been asked to present at the building bridges annual conference in March. MAT will be available to Ingham county inmates by the end of February. c. Access and SAS continue to meet to discuss concerns, needs, strengths. This meeting begin to occur weekly/bi-weekly by March, 2020 d. SBIRT training will occur in 2020 as a part of the CCBHC grant.

Transitions Survey

Satisfaction of Services, Individual Goals, and Overall Life Fulfillment for Individuals Attending a CMHA-CEI Transitions Program, Pre- and Post-Program Closure

In an effort to maintain HCBS compliance, CMHA-CEI's seven Transitions Day Programs were closed in 2019. The Quality Improvement Team conducted part one of a two-part survey with consumers selected at random who attended each Transitions site. The intent of this research is to gather information from consumers who are currently attending the Transitions Programs, related to satisfaction with services and as they relate to their individual goals and overall life fulfillment. Part two of the survey will be administered to the same consumers approximately one year after the closure of each site. The results will be compared and used to monitor and enhance quality of services of individuals with developmental disabilities receiving CMHA-CEI services.

Site	Date of Closure	Number of Participants
Charlotte	January 31, 2019	7
Grand Ledge	February 28, 2019	4
St. Johns	March 31, 2019	8
Mason	April 30, 2019	6
Central	May 31, 2019	16
South	July 31, 2019	20
North	May 1, 2019	56

For part one of the survey, consumers and, when applicable, guardians or other supports met with QI staff at the Transitions site, in their homes, or in the community for a face-to-face interview. The survey consists of 21 questions addressing the consumer's day-to-day life, finances, relationships and goals. Part two of the survey will consist of the same questions and will begin in February 2020. When part two of the survey is complete the QI team will conduct a qualitative analysis to report to the program. Results will also be included in the 2020 Quality Improvement Plan.

CARF

QI staff apply for reaccreditation through CARF every three years. CARF is the accrediting body for all administrative programs at CMHA-CEI and a varying number of clinical programs. The triennial CARF survey determines CMHA-CEI's conformance to all applicable CARF standards on site through the observation of services, interviews with persons served and other stakeholders, and review of documentation.

This Fall, CARF International announced that Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) has been accredited through June 30, 2023. This is the sixth consecutive Three-Year Accreditation that the international accrediting body has given to CMHA-CEI.

The accreditation comes after an exhaustive digitally-enabled survey of the agency was conducted by CARF representatives. It covers all of the agency's administrative units and the following clinical programs:

CARF Accreditation	CMHA-CEI Program(s)
Assertive Community Treatment	Assertive Community Treatment (ACT)
Case Management – Mental Health	Team I Case Management, Team II Case Management, Outreach Case management, Older Adult Services, Eaton County Counseling Center, Clinton County Counseling Center, Mason Rural Outreach Program
Outpatient Treatment – Alcohol and other Drugs – Adults	Clinton County Counseling Center
Outpatient Treatment- Alcohol and other Drugs – Criminal Justice	Correction Assessment and Treatment Services
Residential Treatment – Alcohol and other Drugs – Criminal Justice	House of Commons
Detoxification/Withdrawal Management – Residential – Alcohol and other Drugs – Adults	The Recovery Center
Intensive Family-Based Services – Family Services – Children and Adolescents	Family Guidance Services
Intensive Family-Based Services – Mental Health – Children and Adolescents	Parent-Infant Program, Parent-young Child Program
Case Management/Services Coordination – Psychosocial Rehabilitation – Adults	Life Consultation

Administration and clinical programs at CMHA-CEI will time implementing changes suggested by CARF as well as preparing for the upcoming CARF survey in the spring of 2023. The full list of recommendations from the 2020 Survey was published in a previous Quality Improvement Plan.

Standards for Recommendation	Recommendations
Section 1 – Leadership, Risk Management, Healthy and Safety, Technology, Accessibility, Performance Management	Updates to policies and procedures regarding succession planning, staff workgroups and committees, safety and emergency drills, and accessibility planning
Section 2- Program Service Structure, Screening and Access to Services, Person-Centered Plan, Medication, Records of Persons Served, Transition/Discharge	Work with Clinical Directors to strengthen Clinical Supervision protocol, update Medication Procedure to address the handling of illegal drugs and prescriptions brought in by visitors, and continue to review charts to ensure assessment process includes all needed information for creating a person-centered plan.
Section 3 – Detoxification/Withdrawal Support, Residential Treatment, ACT	Review medical services provided in Detox program and implement changes in staff training, update Corrections Treatment assessment to include risk for recidivism, ensure person-centered planning process includes impact of consumer behavior on applicable victims such as family and loved ones.

ICDP/CC360

To assist CMHA Departments with Performance Improvement – QI has been working to learn ICDP/CC360 Data Systems to pull consumer data. FY21 QI accessed Integrated Care Data Platform (ICDP) to pull Service Utilization for CSDD consumers 18-65 who used services within the past year with Diabetes and Developmental Delays. This data was used to identify the consumer, determine if they had specific billable ICD codes, to meet the goals of the department Diabetic Care Pathway.

Requests for Service and Disposition of Requests

	CMHSP Point of Entry-Screening	DD All Ages	Adults with MI	Children with SED	Unknown and All Others	Total
1	Total # of people who telephoned or walked in	320	2713	1434	887	5354
2	Is Info on row 1 an unduplicated count? (yes/**no**)	No	No	No	No	No
3	# referred out due to non-MH needs (of row 1)	28	98	32	67	225
4	Total # who requested services the CMHSP provides (of row1)	292	2615	1402	820	5129
5	Of the # in Row 4 - How many people did not meet eligibility through phone or other screen	6	179	35	53	273
6	Of the # in Row 4 - How many people were scheduled for assessment	286	2436	1367	767	4856
7	other--referred to SA treatment, referred to Crisis services	0	40	2	234	276
	CMHSP ASSESSMENT	**DD All Ages**	**Adults with MI**	**Children with SED**	**Unknown and All Others**	**Total**
8	Of the # in Row 6 - How many did not receive eligibility determination (dropped out, no show, etc.)	106	757	258	101	1222
9	Of the # in Row 6 - how many were not served because they were MA FFS enrolled and referred to other MA FFS providers (not health plan)	0	0	0	0	0
10	Of the # in Row 6 - how many were not served because they were MA HP enrolled and referred out to MA health plan	unknown	unknown	unknown	unknown	
11	Of the # in Row 6 - how many otherwise did not meet cmhsp non-entitlement eligibility criteria	unknown	unknown	unknown	unknown	
11 a	Of the # in row 11 - How many were referred out to other mental health providers	unknown	unknown	unknown	unknown	
11 b	Of the # in row 11 - How many were not referred out to other mental health providers	unknown	unknown	unknown	unknown	
12	Of the # in Row 6 - How many people met the cmhsp eligibility criteria	180	1639	1107	432	3358

13	Of the # in Row 12 - How many met emergency/urgent conditions criteria	3	571	332	58	964
14	Of the # in Row 12 - How many met immediate admission criteria	unknown	unknown	unknown	unknown	
15	Of the # in Row 12 - How many were put on a waiting list	0	0	0	0	0
15 a	Of the # in row 15 - How many received some cmhsp services, but wait listed for other services	0	0	0	0	0
15 b	Of the # in row 15 - How many were wait listed for all cmhsp services	0	0	0	0	0
16	Other - explain	0	0	0	0	0

Wait Lists

Clinic Services	MI Adult	DD	SED	Total
Number on waiting list as of date above			**48**	**48**
Added during the time period covered				**0**
Removed during the time period covered-service provided				**0**
Removed during time period covered - all other reasons				**0**
Number left at the end of the time period covered				**0**

Supports for Residential Living	MI Adult	DD	SED	Total
Number on waiting list as of date above	19			19
Added during the time period covered	33			33
Removed during the time period covered-service provided	13			13
Removed during time period covered - all other reasons	10			10
Number left at the end of the time period covered	26			26

COVID-19 Priority Needs and Planned Actions

CMHSPs were asked this year to identify Priority Issues related to the impact the COVID-19 pandemic.

Priority Issues Related to COVID-19: a brief explanation of the issue, in order of priority, with 1 being highest.

Impact of COVID-19: Identifies the impact that COVID-19 has had on the CMHSP service region.

CMHSP's Planned Action and Response: brief overview of CMHA-CEI's response and planned action to each priority issue related to COVID-19.

Priority Issue	Reasons For Priority	CMHSP Plan
1. High rate of consumers without access to telehealth	Mandated reduction or suspension of in-person services.	Developed a Phased-In Recovery Plan which corresponds with the MI Stay Safe Plan, providing in-person care to those with urgent need, and expanding in-person services for individuals and families who request it or who have not been able to fully access telehealth services.
2. Transportation of consumers	Safety concerns relating to close contact with consumers, high demand on ambulance transport leading to long waits for hospital transport and decreased availability of public transportation.	• Protocols developed regarding screening, PPE, number and location of individuals in the vehicle, and cleaning. • Filled in gaps created by ambulance transport limitations by boarding consumers within our facilities. • Met with local law enforcement regarding transport of involuntary consumers. • Re-assigned staff to assist in consumer transport needs to support access to treatment, medication, and basic necessities.
3. Access and education on COVID-19 Vaccines	Lack of availability of vaccines and/or training for consumers and staff; lack of access to sign up and access to transportation to vaccination sites. Lack of resources available at appropriate cognitive and educational levels for our population.	• Partner with local health departments and Walgreens (through LTCF partnership) to vaccinate staff and consumers in priority groups. • Anticipate coordination with in-house pharmacy to facilitate additional on-site vaccine clinics. • Include vaccine educational resources and links to community vaccine locations in weekly newsletters to all staff and in bi-weekly newsletters to consumers. • Continue to seek additional resources at appropriate cognitive and educational levels for our population.

4. Spaces for COVID-19 positive consumers – hospitalization or access to secure housing. Regulatory issues impact timeliness of placement.	Rate of consumer infection – especially in licensed AFC and other congregate settings.	• Partnered with Ingham County to house and support COVID-19 positive homeless individuals in hotel. • Regarding congregate settings, Virus Task Force (inclusive of CEO, Medical Director, Chief of Human Resources, Director of Quality, Customer Service and Recipient Rights, Facilities Supervisor, and other support staff) met up to daily to monitor and ensure distribution of resources. Also sent daily email communication of infections of residents or staff in congregate settings to coordinate response. • Clinical programs and Quality Advisors provide regular support and consultation to contracted providers, ensuring appropriate COVID-19 safety plans are in place and to address immediate needs surrounding positive consumers in congregate settings.
5. Staff availability and turnover	COVID-19 shutdowns, remote learning and school closures. Staff providing face to face services during COVID-19 pandemic.	• Temporary Assignments Agreement allowed staff who work in areas where services were stalled by the pandemic to be reassigned to other areas of need. • Temporary Waiver of Accrual Caps allowed staff to go beyond the established cap to accrue time off that they were unable to take off during the pandemic. • Excess Earned Time Banks • Vacation/PTO Buyout Options allowed staff an additional Vacation/PTO buy-down of accrued time in August. • Temporary Enhanced Pay provided enhanced pay during the early months of the pandemic during the Stay at Home Order to all staff working on-site to maintain services to high risk consumers. • Families First Coronavirus Response Act allowed 80 hours of paid time for COVID-19 related quarantine or illness of self or caring for a family member. • Implemented State and Regional DCW premium pay

		• CMHA-CEI Child Care Leave expansion of approved leave time for employees with children ages thirteen and younger or children with disabilities that required care from a parent. • Remote Return to School Options allowed staff with children K-8 or with special needs to work flexible schedules, use PTO, Personal Leave or leave without pay to assist their school age children. • Voluntary Assignments Pay Rates allowed staff to volunteer for additional work in other departments experiencing staff shortages. • Two COVID-19 Payments of $500 to be paid in February and May.
6. Lack of consistency and clarity in state and federal mandates regarding in-person vs. remote work for staff and provision of telehealth vs. in-person services.	State and Federal restrictions on gatherings of people and in-person work environments.	Virus Task Force and COVID Planning workgroup (inclusive of Clinical Directors, CEO, Medical Director, Chief of Human Resources, Director of QCSRR) meet at least weekly to interpret orders and guidance, and review current COVID-19 data and clinical need.

Environmental Modifications

As an agency we processed 1 Environmental Modification request that rolled over from FY19 to FY20. The project was a bathroom remodel, which was re-priced in August 2020 because of building costs increases. The project was approved and started 12/1/2020. FY20 we processed 5 new Environmental Modifications, 3 Bathroom remodels, 1 outdoor wheelchair ramp and 1 Van Conversion. At the end of FY20 none of these Environmental Modifications are under contract. The Van Conversion was abandoned by the family, the cost out of pocket to the family exceeded the cost of purchasing a used van that was already converted.

Healthcare Integration – Care Coordination

Care Coordination Plan

CMHA-CEI is a convener and partner in the implementation of healthcare integration by providing meaningful and manageable approaches in achieving outcomes and improving the overall quality of life for those we serve. Steps taken for CMHA-CEI to meet its vision of healthcare integration are to define staff roles, expand care coordination by building staff knowledge of physical health measures, and build competencies and measure effectiveness.

Healthcare Integration-Pilot Projects in FY21

Program	Focus	Strategies
Families Forward	Asthma/COPD	1. Continue to train staff in Asthma/COPD and behavior aspects of managing 2. Staff will review asthma care plan provided by healthcare staff with parents/guardian 3. Staff will document discussing asthma with identified families 3 times per quarter. 4. Add Nurse Care Manager to advance collaboration.
Adult Mental Health Services	Hypertension	1. Ongoing staff training on HTN-including how to take a blood pressure. 2. Documentation of BP taken on a regular basis. 3. Education and motivational interviewing used with identified consumers and documented in EHR in a consistent and meaningful way. 4. Implementation of a HTN Care Pathway identifying outcome measures of improved Blood Pressure readings.
Integrated Treatment & Recovery Services	Hepatitis C	1. Individuals will be screened by HOC clinical staff to determine IVDU. 2. Individuals who are determined to be IVDU receive a health screen by the HOC nurse to determine Hepatitis screening in the past 12 months. 3. Individuals will be referred for further testing and education as appropriate. 4. If the individual has a PCP, staff will coordinate care. 5. If the individual does not have a PCP, the program will work to assist in establishment of one and then coordinate care.
Community Services for the Developmentally Disabled	Emergency Department Usage	1. The diabetic care pathway team will meet weekly through January 2021 to complete the pathway. 2. Diabetic care pathway team will develop training materials by Marcy 2021. 3. All current CSDD staff will be trained on the care pathway by 6/2021. 4. The care pathway will be implemented by 7/2021. 5. On a quarterly basis reports will be pulled to assess data related diabetic care. Data will be reviewed at monthly manager's meetings. 6. Data will be linked back to the case manager for further review and follow up, as well as for ongoing education on needs of diabetics 7. Case managers will use all data and subsequent meetings with consumers to link to the Person Centered Plan and associated treatment plans per individual need.
Healthcare Integration Programs –	Patients accessing	1. Target providers who historically under-utilize integrated behavioral health staff, and address referral barriers. 2. Highlight success stories of integrated care, and publicize through Sparrow clinic newsletter.

Sparrow/MSU Family Medicine Residency Program	behavioral health services	
Healthcare Integration Programs-Ingham Community Health Centers	Patients accessing behavioral health services	1. Train staff in all clinics on the importance of SBIRT, and provide regular data/feedback on progress. 2. Highlight SBIRT success stories in regularly scheduled clinic-wide staff meetings.

In an effort to promote care coordination at CMHA-CEI, the Culture of Health and Wellness Committee (CHWC) was created to:

- Oversee the implementation of goals and objectives.
- Create an evaluation plan and provide regular progress reports.
- Strengthen the alignment between internal/external workgroups focusing on integrated care.

An online behavioral health screening tool has been added to the agency website. The available screenings are for Depression, Generalized Anxiety Disorder, Adolescent Depression, Bipolar Disorder, Alcohol Use Disorder, Posttraumatic Stress Disorder, Eating Disorders, and Substance Use Disorders.

Updated Goals for FY21

Families Forward:

Goals:

1. Increase use of wellness coaches
2. Provide trainings related to vaping cessation, asthma and other health conditions
3. Implement Asthma Care Pathway
4. Increase PCP linkage and collaboration
5. Increase number of collaborative contacts with PCP's

Outcome Measure:

1. Number of people receiving the treatment
2. Number of people trained
3. Increase numbers of people identified
4. Increase numbers of people with goal in treatment plan
5. Increase number of people with PCP identified

Adult Mental Health Services:

Goals:

1. Increase clinician knowledge base and documentation of physical health indicators (specifically Hypertension).
2. Begin collecting outcome data in OCMS to determine if Blood Pressures have decreased by using the HTN Care Pathway.
3. Expand pilot to one other AMHS Unit.
4. Increase coordination of care between CMHA-CEI and Primary Care Physicians with consistent use of Continuity of Care document.

Identified Population - Dx of Hypertension (HTN) and receiving services through OCMS, ACT, or OAS. Will expand pilot to one other AMHS Unit

Outcomes Measures:

1. 100% of identified clinical staff will be trained in discussing behavioral aspects of HTN with consumers.
2. Increased staff competency in discussing and documenting HTN as part of the clinical record as evidence by EHR reports.
3. 15% of identified consumers in OCMS will show a decrease in Blood Pressure readings by the end of FY 2021.

Community Services for the Developmental Disabled:

Goals:

1. CSDD will complete and Diabetic Care Pathway.
2. CSDD staff will be trained on the diabetic care pathway.
3. CSDD will implement the care pathway.

Identified Population:

Adults (over 18 years of age) served by CSDD who are pre-diabetic or diabetic (Type 1 or 2) except for individuals with gestational diabetes or have been placed on palliative or hospice care.

Outcome Measures:

30% of individuals who are in the diabetic care pathway will reduce their A1C until their numbers are below 5.7% glycohemoglobin.

Integrated Treatment & Recovery Services:

Goal:

1. Increase Hepatitis C Virus (HCV) Screening for consumers at the House of Commons (HOC) Residential Treatment Center who are active IV drug users (IVDU).
2. Assist with care coordination for those identified with HCV through a current Primary Care Physician or becoming connected with a new PCP.

Identified Population: Individuals at HOC who are active IV drug users (IVDU) and residents of Clinton, Eaton, or Ingham Counties.

Outcome Measures:

1. 90% of individuals admitted to HOC who are IVDU will be questioned to determine Hepatitis screening in the past 12 months.
2. 85% of individuals screened will be referred for further testing and education at local HIV/STI prevention programs through local Health Departments.
3. 85% of individuals who have been screened and have stated a diagnosis of Hepatitis C will be assisted with care coordination through a current PCP or a new PCP will be located.

Healthcare Integration Programs- Sparrow/MSU Family Medicine Residency Program:

Goals:

1. Increase number of clinic patients accessing behavioral health services, as a percentage of overall patients served in the clinic.

Identified Population:

All active patients at both Lansing and Mason Sparrow/MSU Family Medicine Residency Clinics.

Outcome Measures:

1. Demonstrated capacity to provide integrated care through reporting total number of patients served, in relation to total number of active clinic patients.

Healthcare Integration Programs - Ingham Community Health Centers

Goals:

1. Increase number of clinic patients completing SBIRT process, as a percentage of patients eligible for the annual screening.

Identified Population: All active patients at Birch, Forest, Women's Health, New Hope and Willow Clinics.

Outcome Measures:

1. At least 50% of those eligible for SBIRT screening will have received it.

Certified Community Behavioral Health Clinic (CCBHC)

Goal:

1. Increase capacity for Mental Health and Substance Use Disorder Services to serve more consumers who have a diagnosis of SMI, SED, and/or SUD to improve consumer access.
2. Increase care coordination of behavioral and physical health needs for consumers who have a diagnosis of SMI, SED, and/or SUD and a co-occurring chronic health condition in order to improve health outcomes.
3. Increase the use of Evidence-Based Practices with consumers who have a diagnosis of SMI, SED, and/or SUD to improve their quality of care.
4. Improve organizational systems and processes to maximize efficiencies in services, professional development, and reimbursements.