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

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Overview

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

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

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

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

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

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

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

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

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

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

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

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

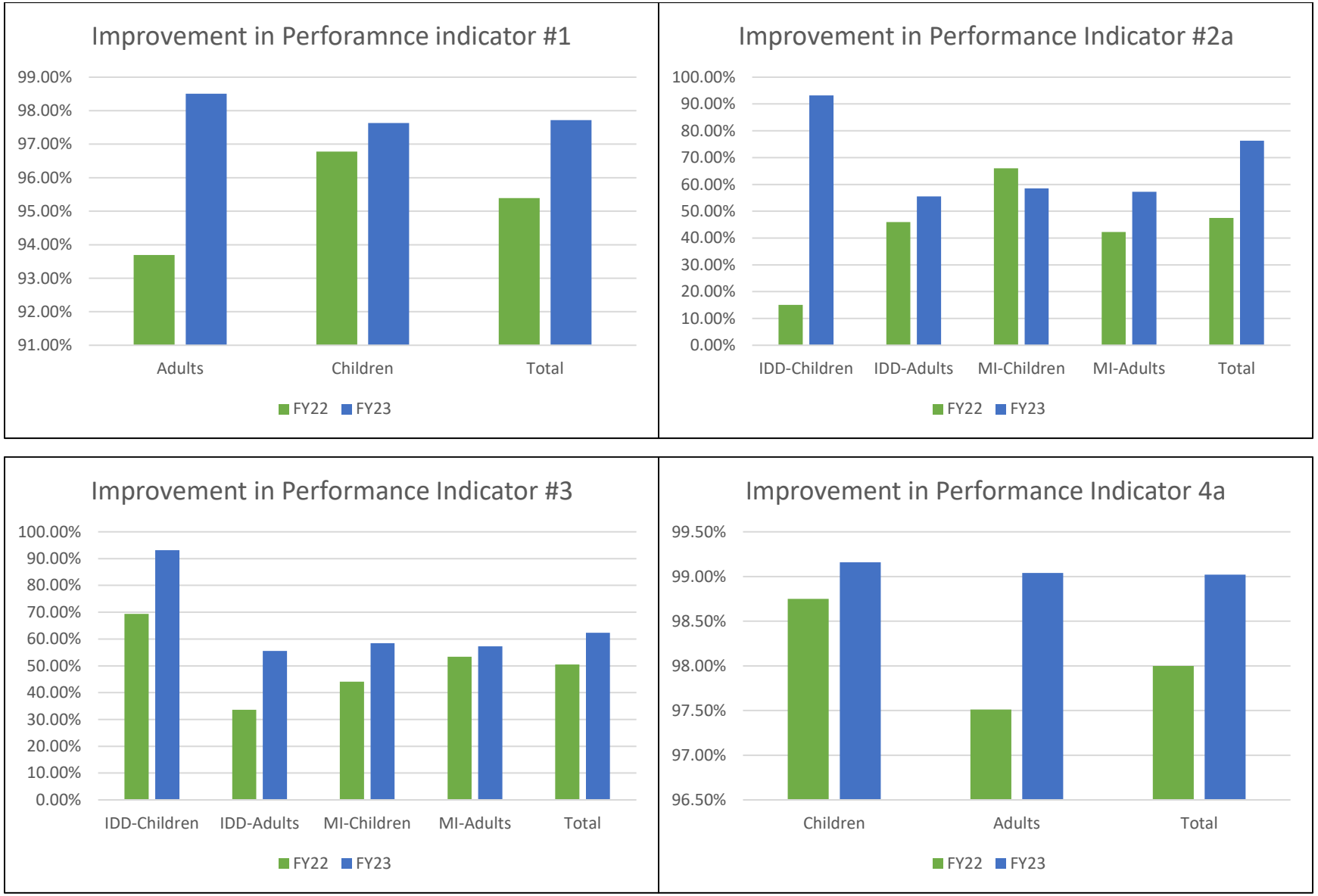


Figure 1. Improved Compliance in Performance Indicators: In data submitted to MDHHS representing the full population of CMHA-CEI consumers, the rates of compliance improved for PIs 1, 2a, 3, and 4a. While there was no significant change in for PI 10 (not pictured), compliance was maintained in FY23.

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

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

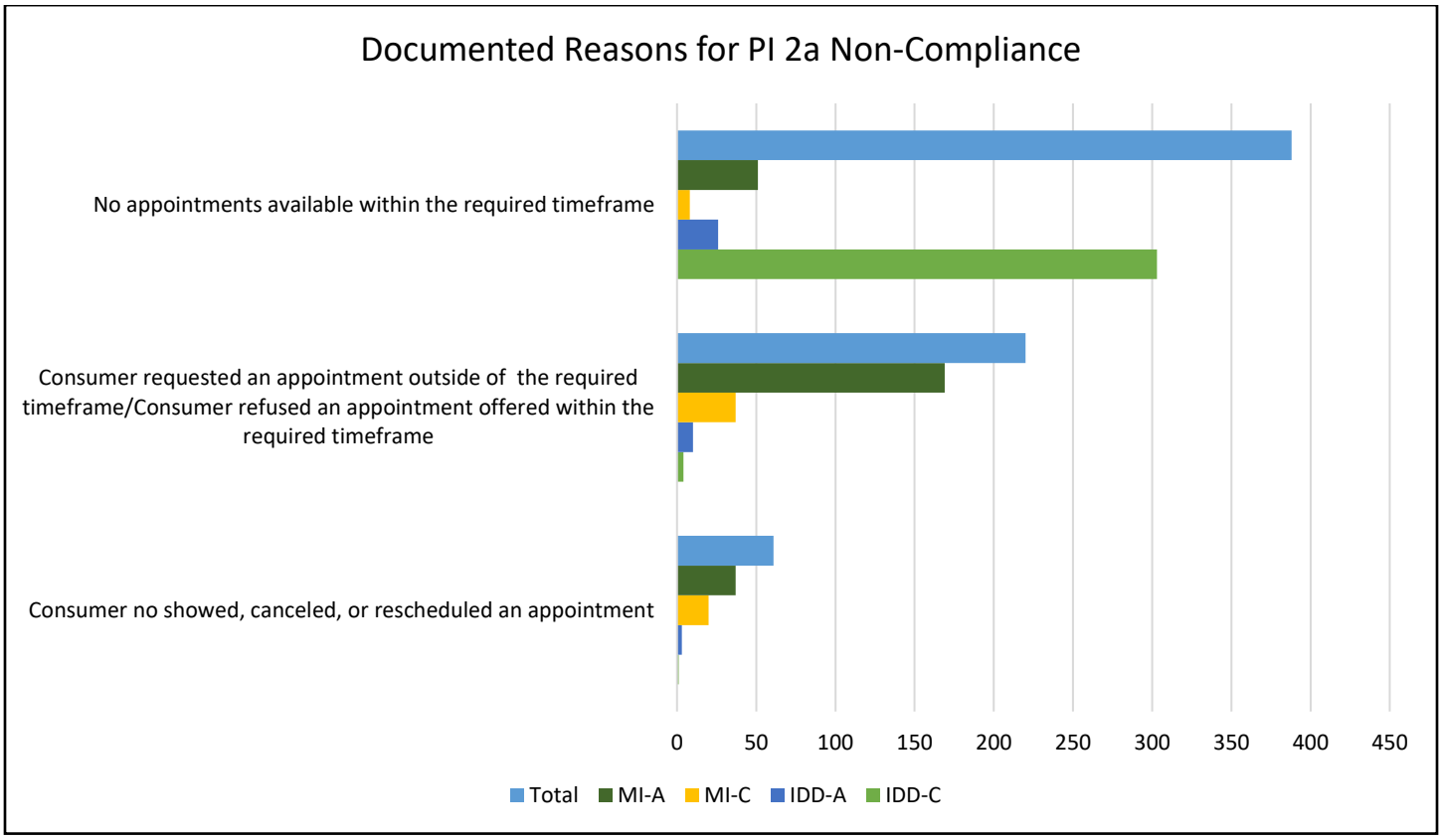


Figure 2. Documentation for timeliness from inquiry to assessment over 14 days: While there are no exceptions for PI 2a, Mid-State Health Network began tracking and navigating the documented reasons for non-compliance. The top documented reasons in FY23 were no appointments available, consumer refusal,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

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

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

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

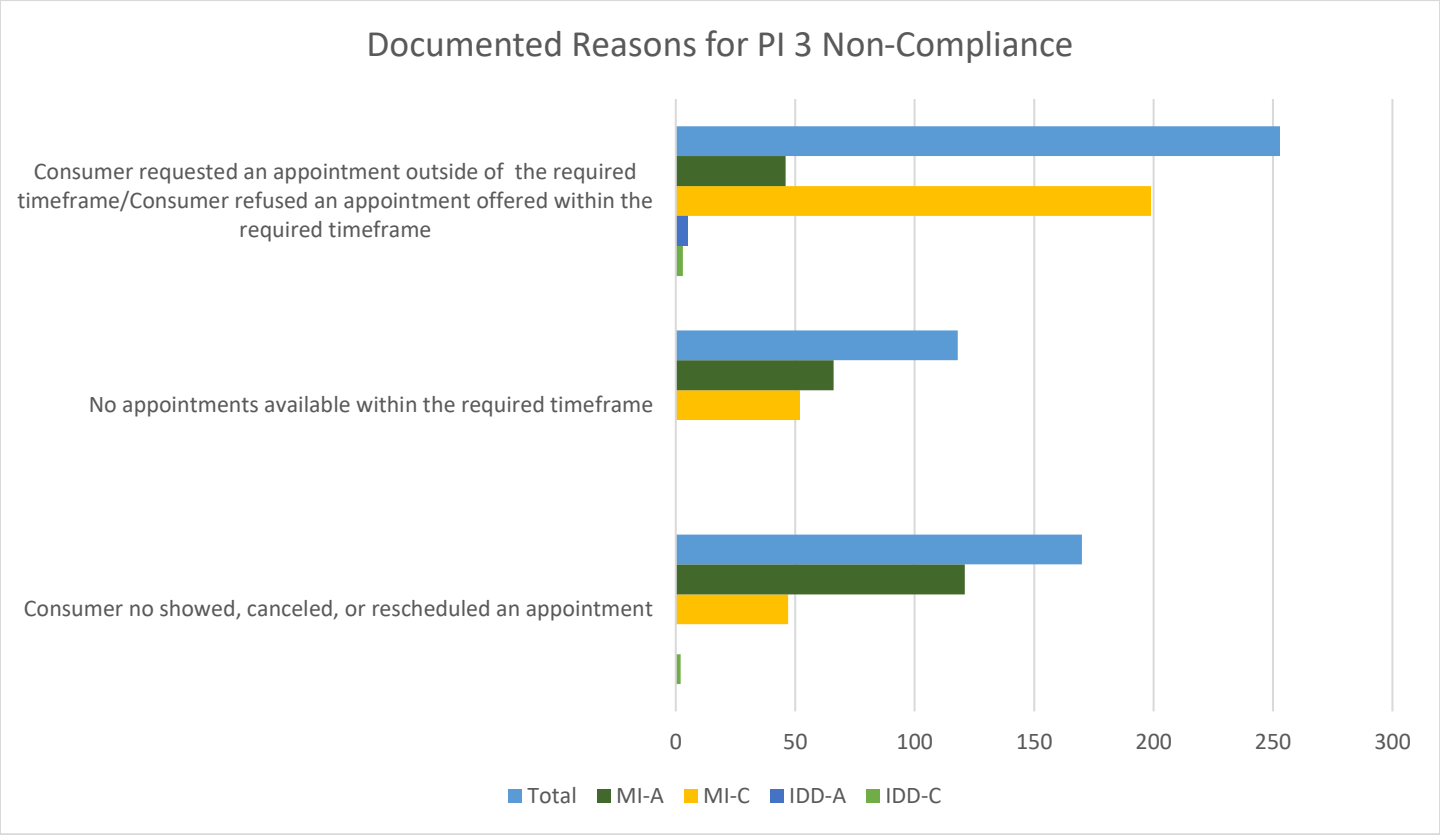


Figure 3. Documentation for timeliness from assessment to start of treatment over 14 days: While there are no exceptions for PI 3, Mid-State Health Network began tracking and navigating the documented reasons for non-compliance. The top documented reasons in FY23 consumer refusal, no appointments available,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

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

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

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

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

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

Performance Improvement Project

Project Description 1- Reduction in Access Disparities

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 6. Timeline for reporting PIP data

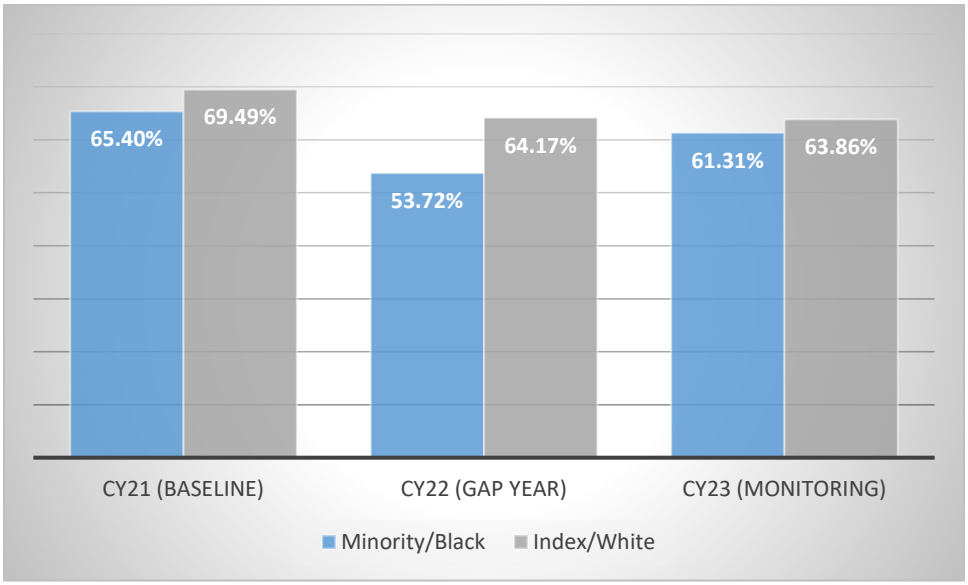


Figure 4. Longitudinal data of those who received a medically necessary service within 14 days of a completed biopsychosocial assessment. The rate of access to services for Index/White population group has demonstrated a downward trend from the baseline year as indicated in the Table 6. The Black/African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

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

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

Project Description 2 – Reduction of Disparities in Penetration Rate:

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

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

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

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

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

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

Table 8. Timeline for reporting PIP data

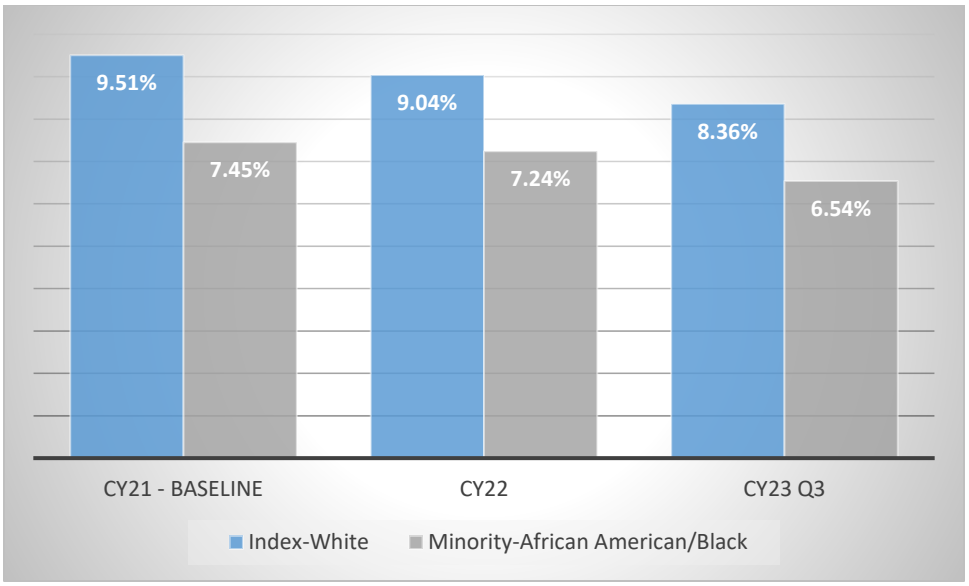


Figure 5. MSHN CMHSP Penetration Rates. Table 10 includes the CMHA-CEI counts and rates of those who qualify for inclusion in this project. A full breakdown of penetration rates across all reported races/ethnicities can be found in the Annual MSHN QAPIP:
https://midstatehealthnetwork.org/download_file/view/7363619c-f6c0-4def-a3c8-bfc04ef75858/193

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

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

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

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

Grievances, Appeals, and Fair Hearings

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

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

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

Incident Reporting

General Incidents

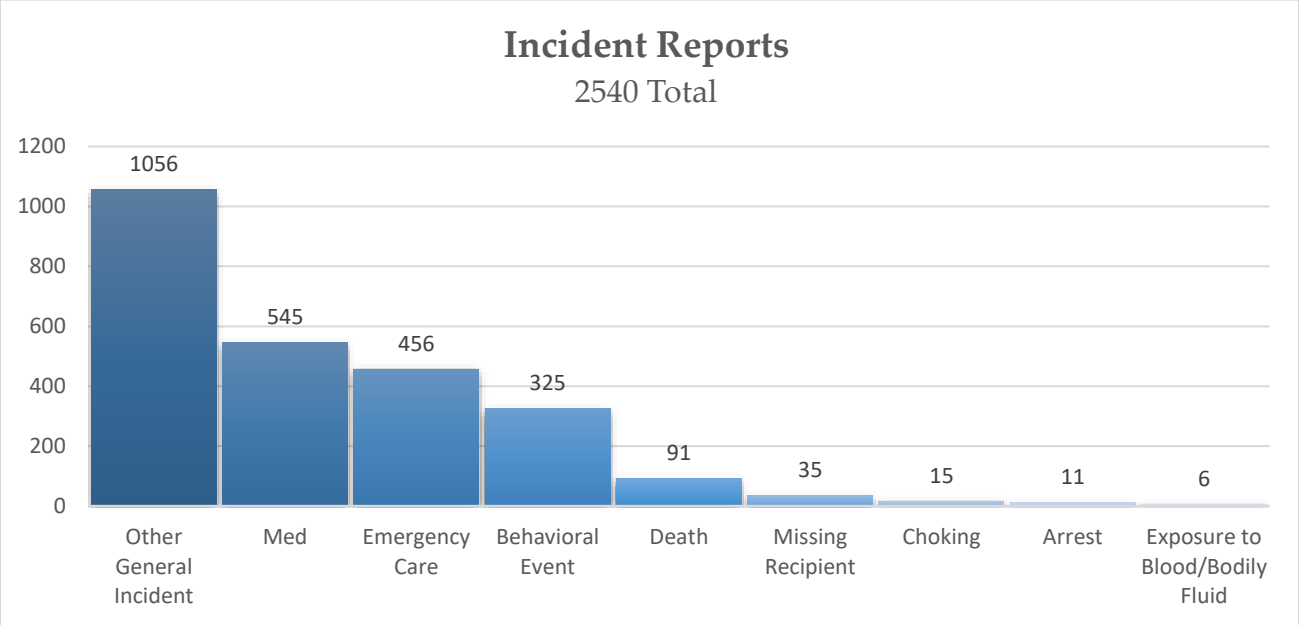


Figure 6. General incident reports by category. Data shows count of IRs completed in FY23

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

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

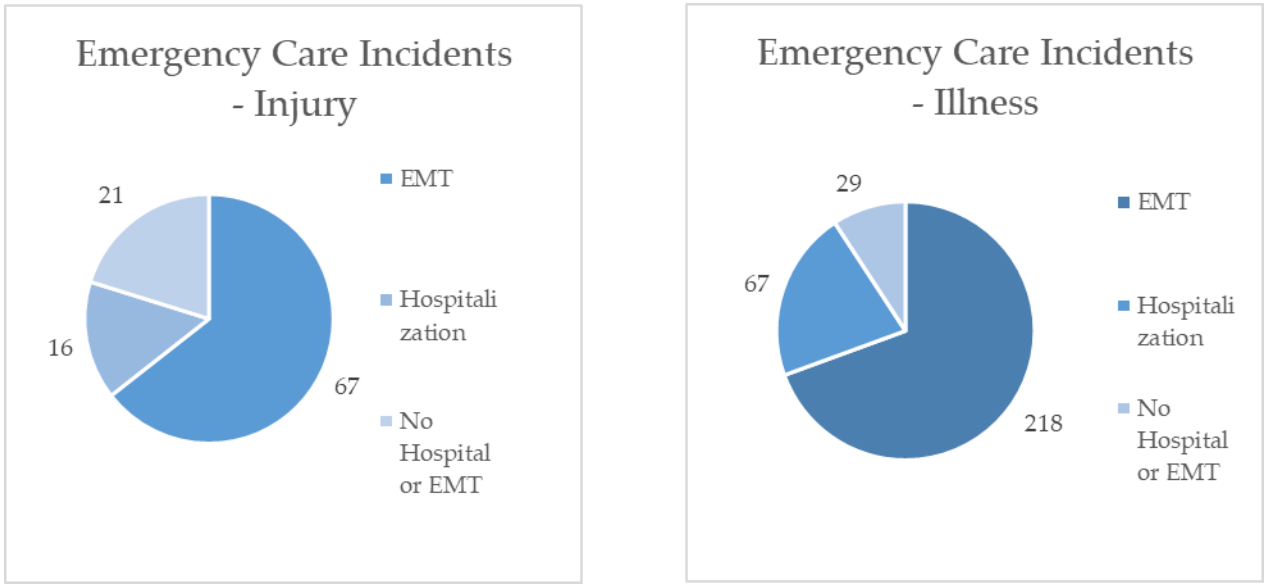


Figure 7. Emergency Care incidents resulting in EMT, Hospitalization, caused by injury or illness

Medication Incidents

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

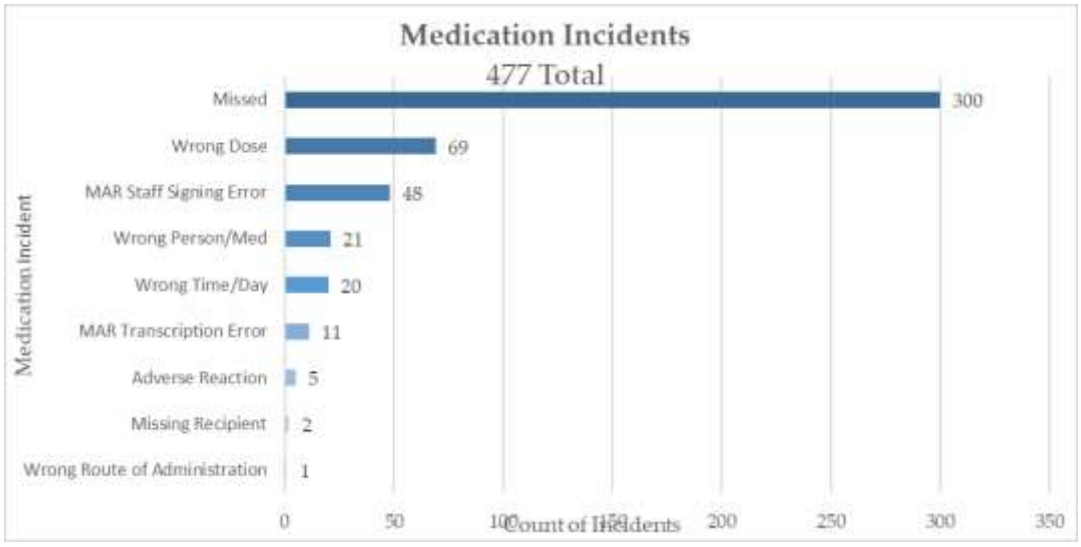


Figure 8. Medication incident reports by category. Data shows count of IRs completed in FY23

Deaths

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

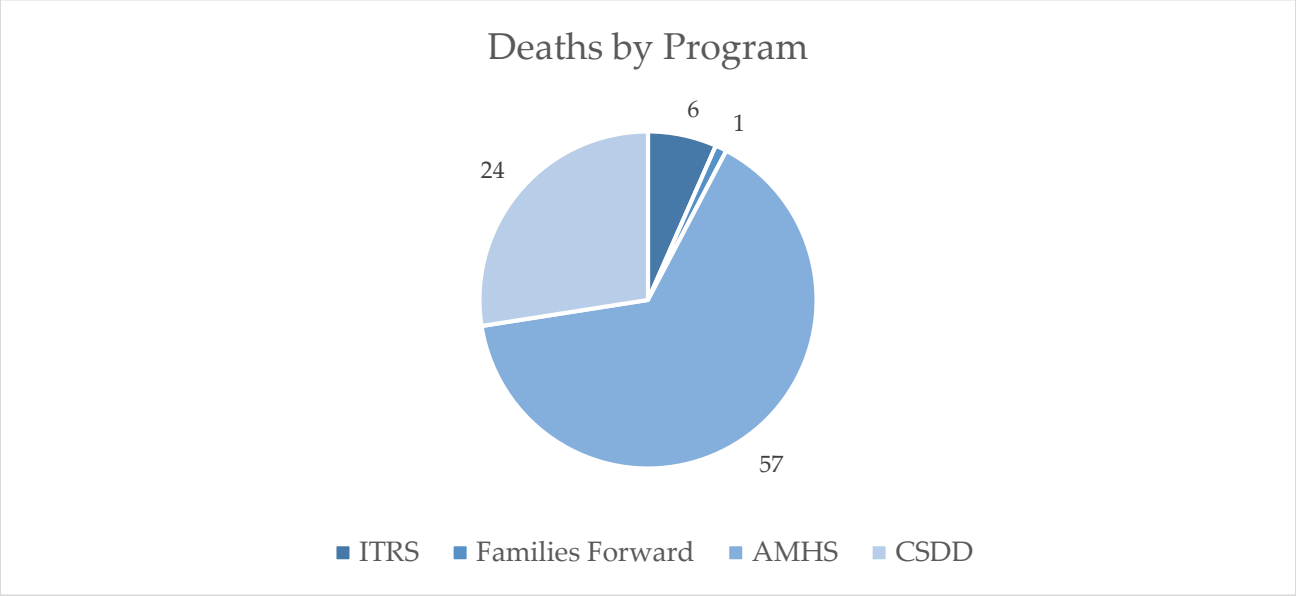


Figure 9. Count of Deaths by age and by CMHA-CEI Program

Sentinel Event Reports

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

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

*one accidental overdose that did not result in death

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

Table 12. Count of Sentinel Events by type and age

Staff Injuries/Vehicle Accidents

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

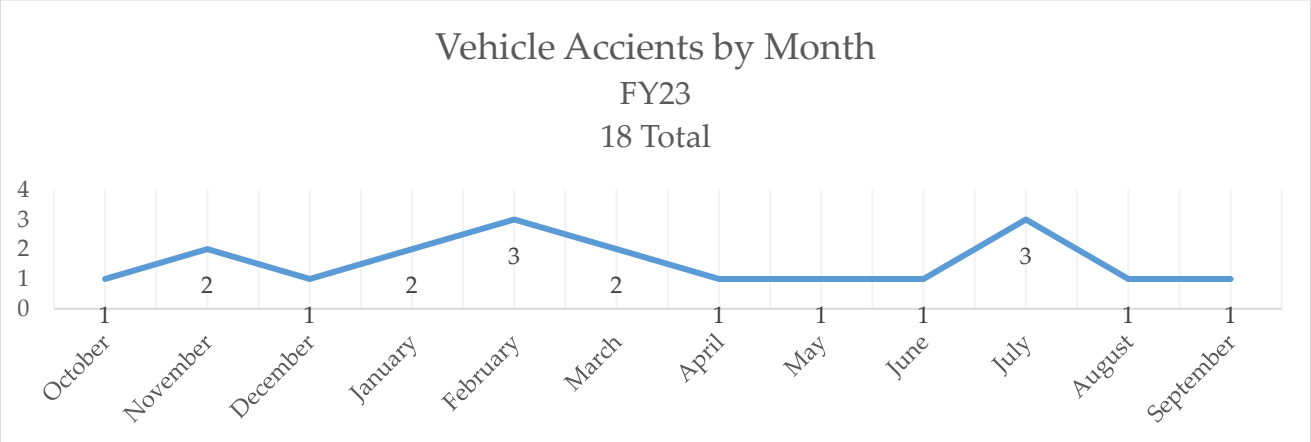
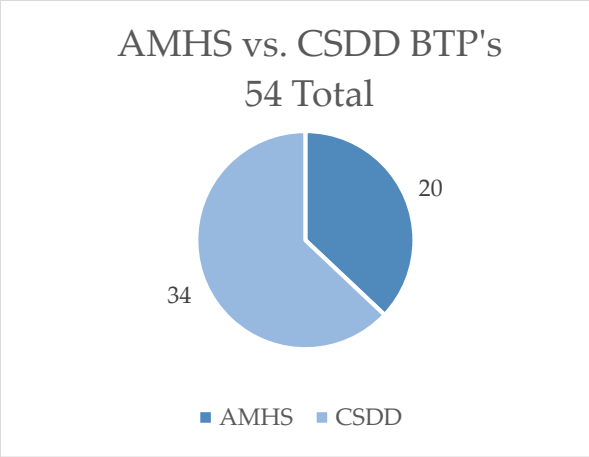


Figure 10. Vehicle Accidents by month in FY23

Behavior Treatment Committee (BTC)

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



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

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

Medicaid Event Verification Audit

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

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

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

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

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

Table 14. FY24 Q1 chart of valid claims percentages

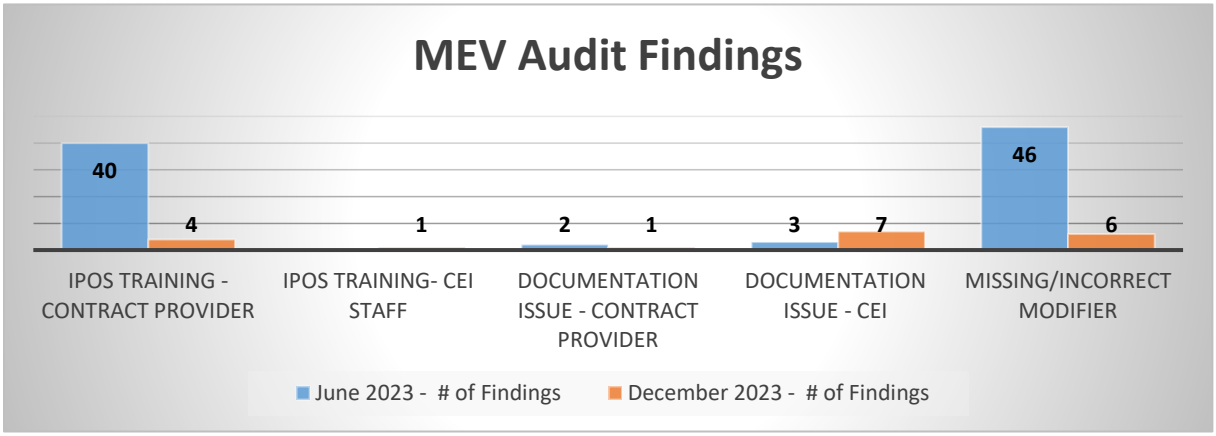


Figure 12. MEV Audit Findings. In FY24, QI began to track findings from MEV audits and their associated categories, in order to identify trends and opportunities for targeted improvements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Findings from the December 2023 MEV are as follows:

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

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

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

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

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

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

FY23 Chart Review Results

Chart Review Process

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

Reviews will be completed at least quarterly and will address:

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

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

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

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

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

Table 15. Chart Review Schedule and Results

FY23 Q1 Chart Review Results - ACT

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

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

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

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

Table 16. Chart Review Results for ACT

FY23 Q2 Chart Review Results – AMHS Case Management

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

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

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

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

Table 17. Chart Review results for AMHS Case Management

FY23 Q3 Chart Review Results - FF

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

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

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

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

Table 18. Chart Review Results for Families Forward

FY23 Q4 Chart Review Results – CSDD

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

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

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

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

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

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

Table 19. Chart Review Results for CSDD

Provider Monitoring

Overview

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

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

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

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

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

Site Visit Overview

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

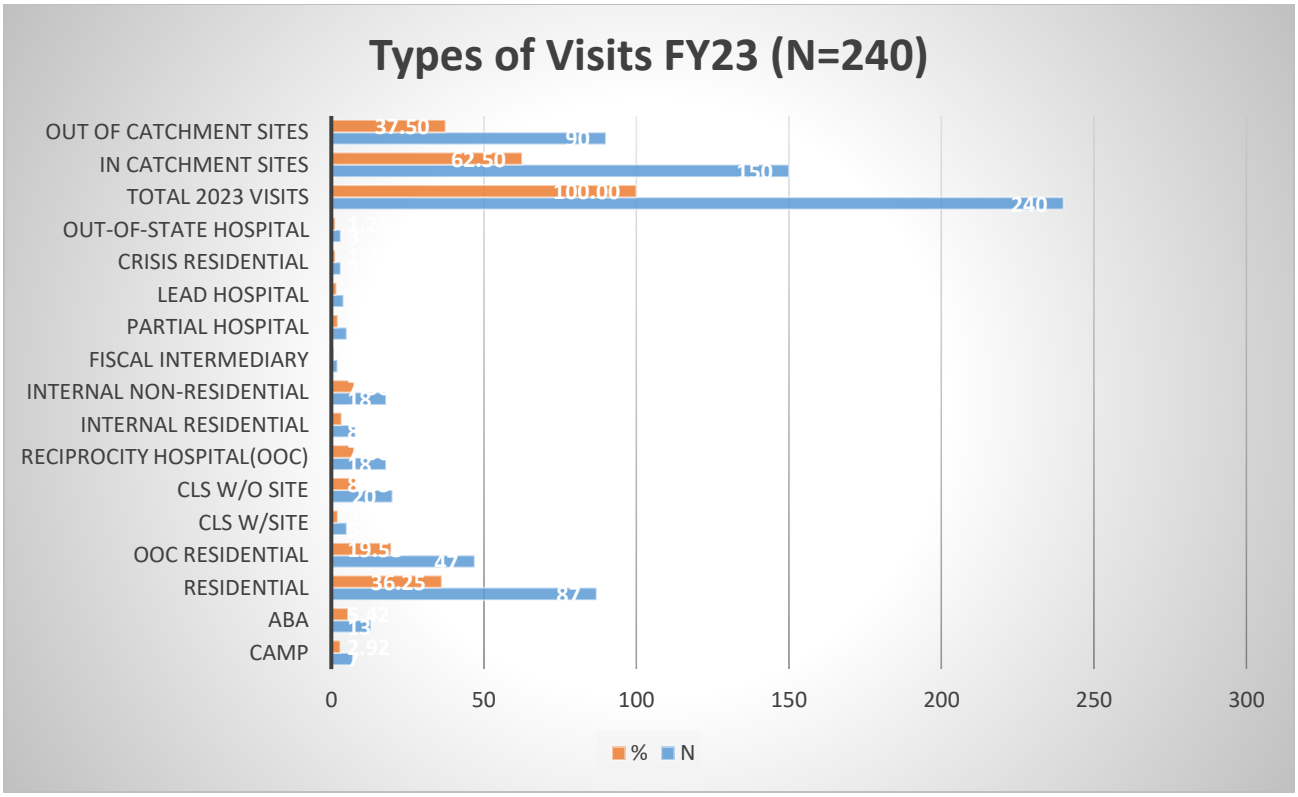


Figure 13. Types of visits completed in FY23.

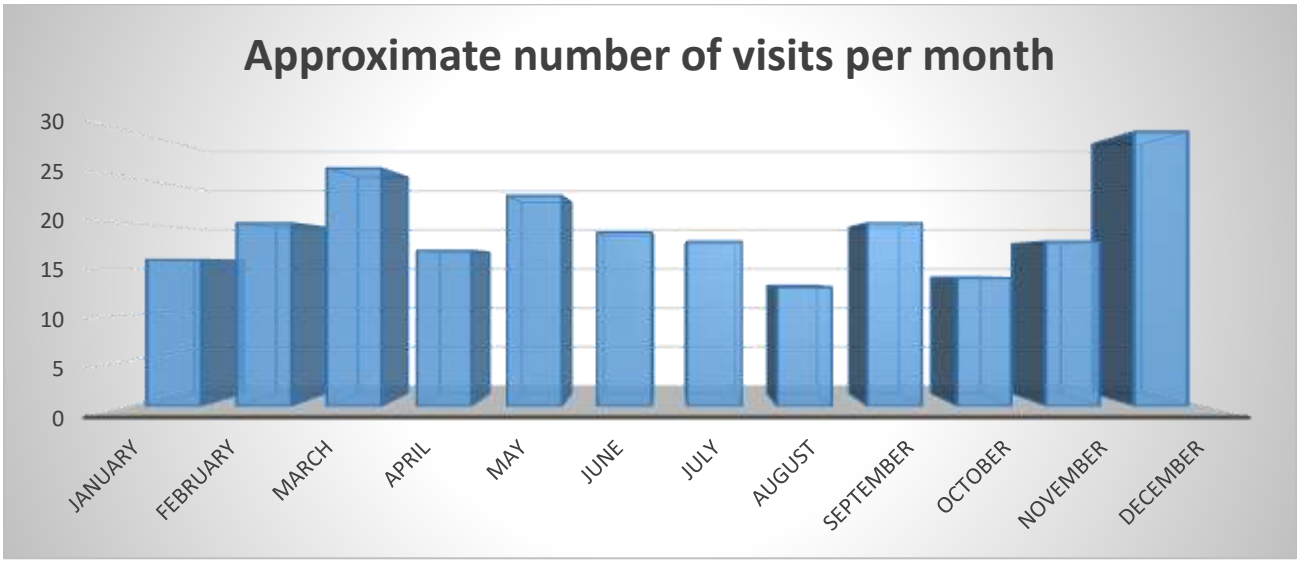


Figure 14. The number of site visited on each month in FY23.

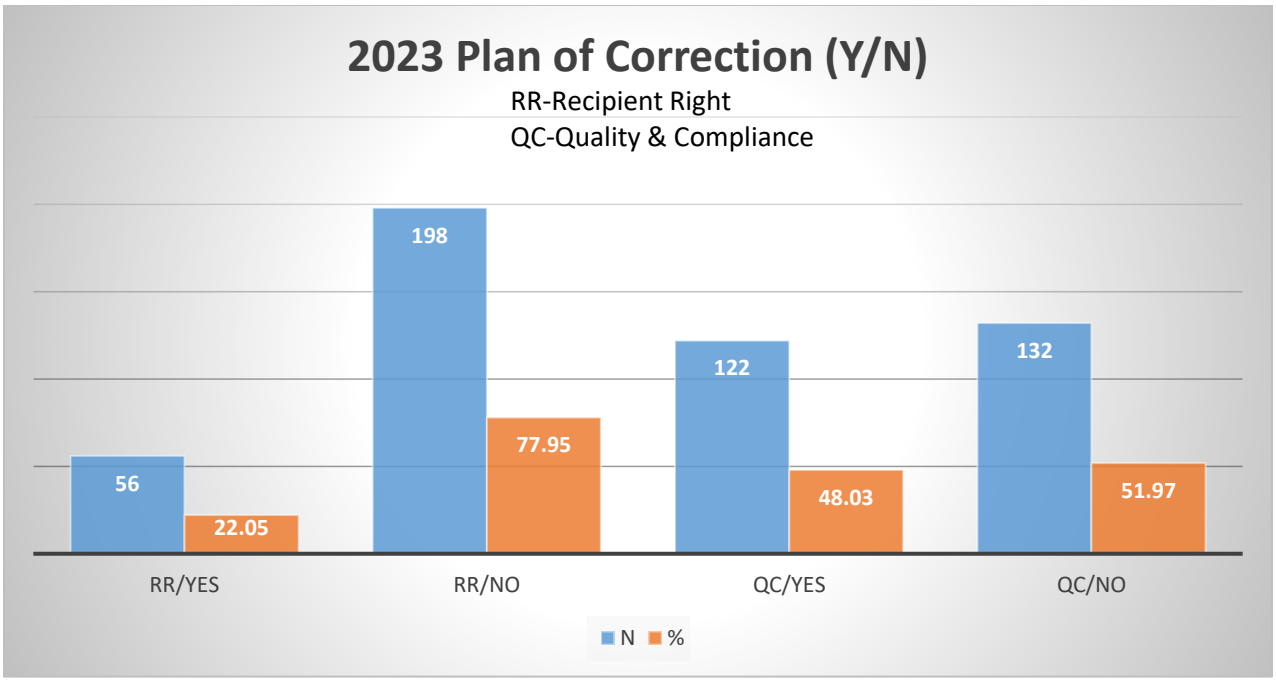


Figure 15. Number of sites requiring Plan of Correction (POC).

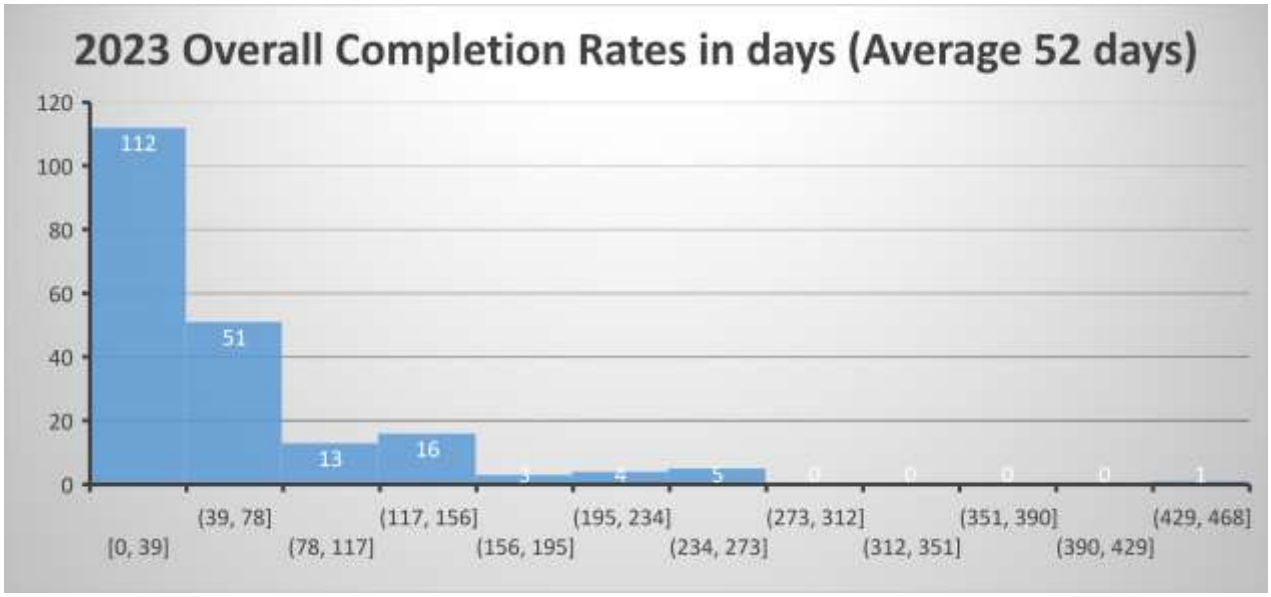


Figure 16. The overall completion rates (days) for FY23.

Improvement Opportunities

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

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

Policy and Procedure Review

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

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

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

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

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

HSAG Report FY23

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

Eligibility and Enrollment Data System:

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

PIHP Actions Related to Previous Recommendations:

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

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

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

Strengths and Opportunities for Improvement:

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

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

Weaknesses:

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

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

MSHN Audit

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

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

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

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

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

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

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

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

Table 21. MSHN Audit Findings

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

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

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

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

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

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

Table 22. MSHN Audit Corrective Action Plan

Consumer Satisfaction Survey

Summary

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

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

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

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

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

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

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

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

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

Procedure

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

Findings

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

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

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

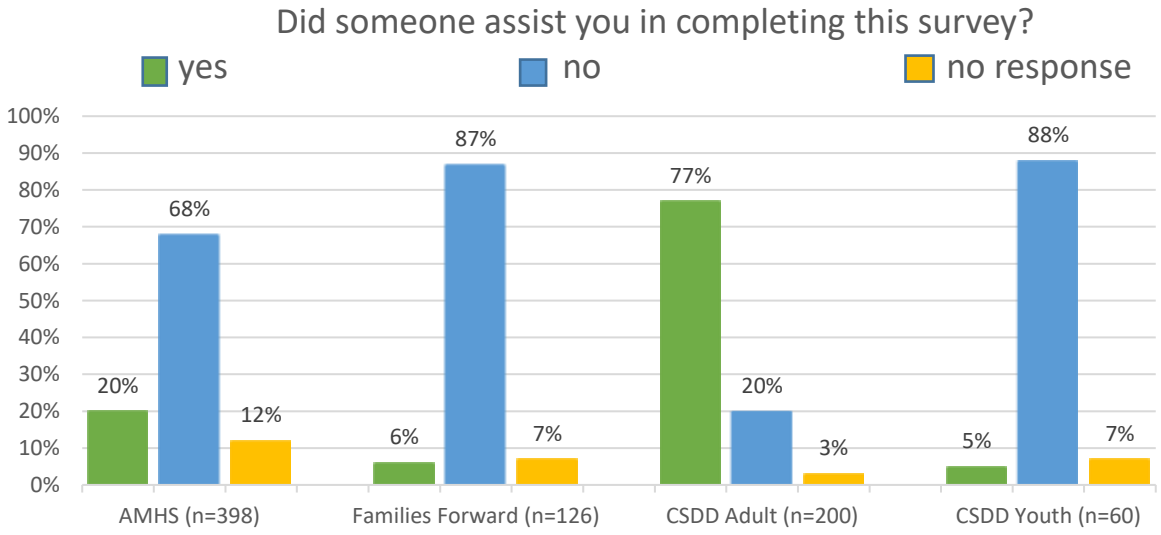


Figure 17. Percentage of respondents with assistance completing satisfaction survey

Analysis of Findings

AMHS – Lower numerical score indicates greater satisfaction.

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

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

Families Forward – Higher numerical score indicates greater satisfaction.

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

CSDD Adult – Lower numerical score indicates greater satisfaction.

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

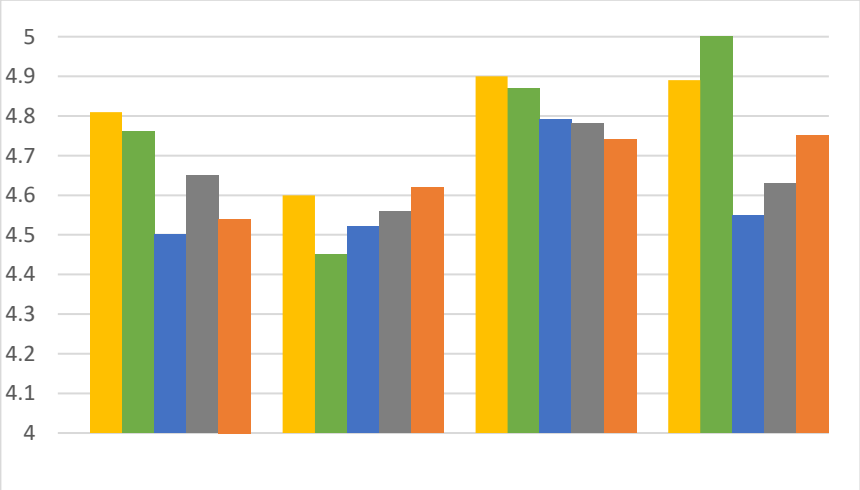
28. My symptoms are not bothering me as much (2.24)

CSDD Youth – Higher numerical score indicates greater satisfaction.

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

ITRS – Higher numerical score indicates greater satisfaction.

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



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

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

National Core Indicators Survey

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

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

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

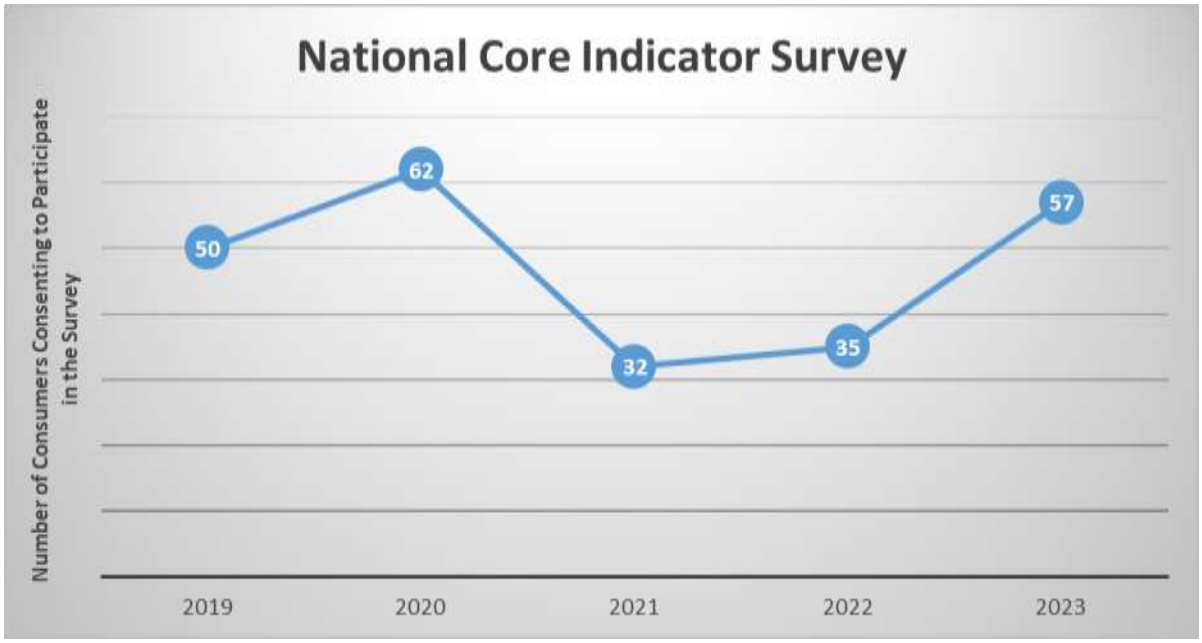


Figure 19. Count of consumers consenting to participate in the NCI Survey by year

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

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

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

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

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

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

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

Table 24. CMHA-CEI CARF Accredited programs

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

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

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

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

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

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

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

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

Outcomes Management: Performance Indicator and Consumer Satisfaction Report

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

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

ICDP and CC360 Data

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

Annual Submission to MDHHS FY23

Requests for Service and Disposition of Requests

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

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

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

Table 26. Annual Report to MDHHS

MSHN FY23 CCBHC Performance Measures

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

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

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

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

Table 27. Quality Bonus Performance Measures

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

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

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

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

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

Table 28. CCBHC State Reported Measures

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

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

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

Table 29. Clinical reported Measures

Next Steps:

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

References

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

CARF International: https://carf.org/

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

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

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

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

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

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

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

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

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

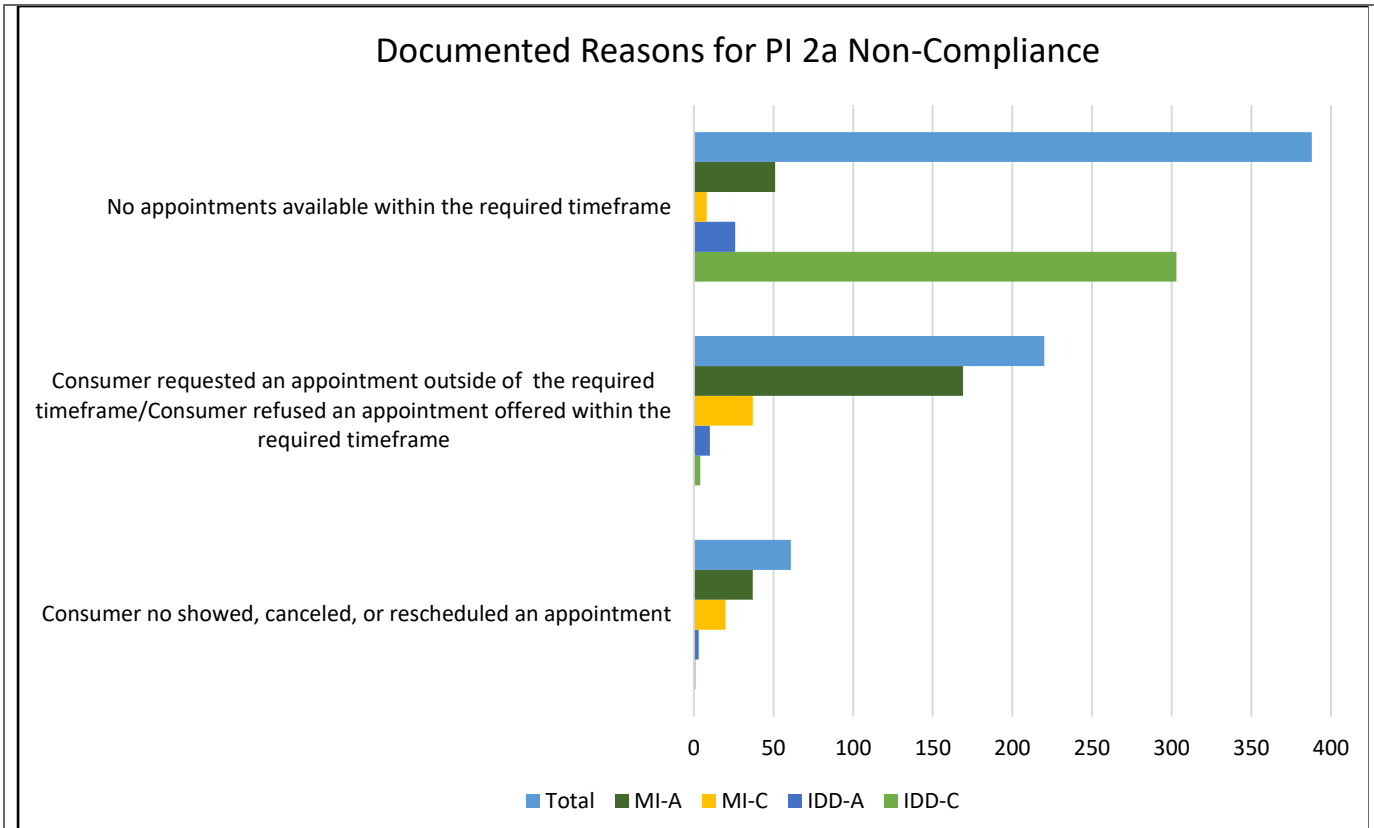

Figure 2. Documentation for timeliness from inquiry to assessment over 14 **days: While there are no exceptions for PI 2a, Mid-State Health Network began tracking and navigating the documented reasons for non-compliance. The top documented reasons in FY23 were no appointments available, consumer refusal,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

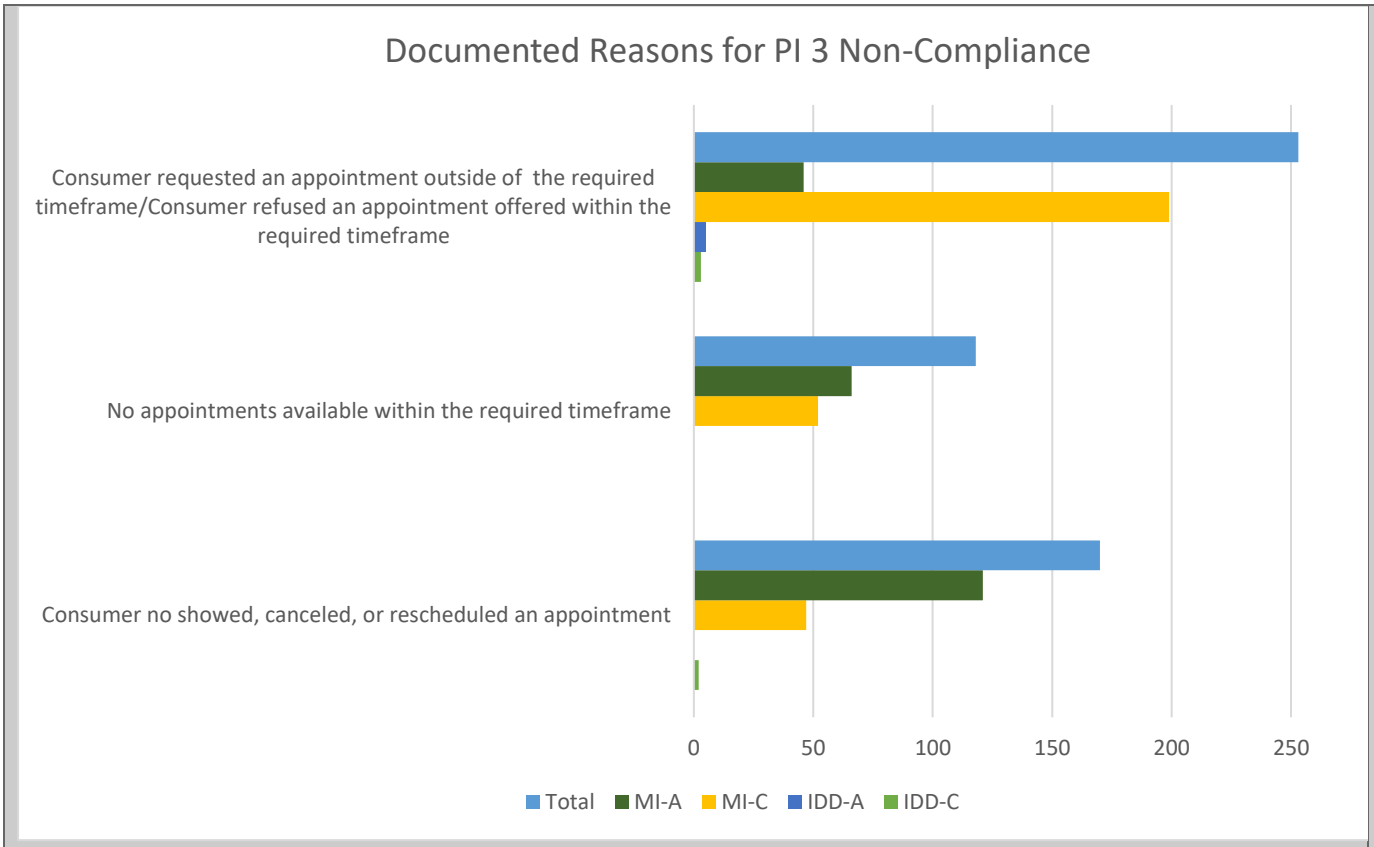

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Figure 3. Documentation for timeliness from assessment to start of treatment over 14 ***days: While there are no exceptions for PI 3, Mid-State Health Network began tracking and navigating the documented reasons for non-compliance. The top documented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

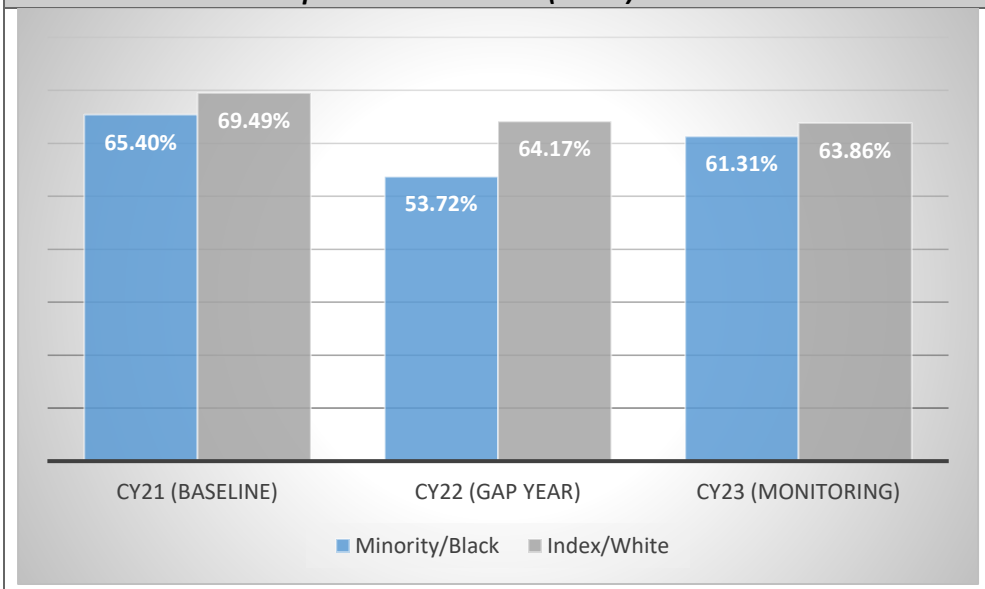

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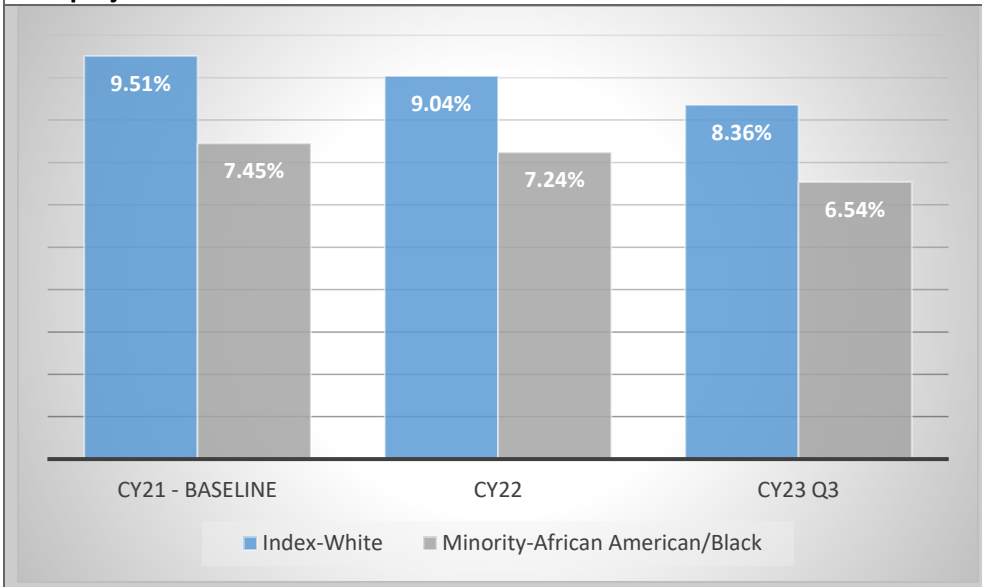
Figure 4. Longitudinal data of those who received a medically necessary service within 14 days of a completed biopsychosocial assessment**. The rate of access to services for Index/White population group has demonstrated a downward trend from the baseline year as indicated in the Table 6. The Black/African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

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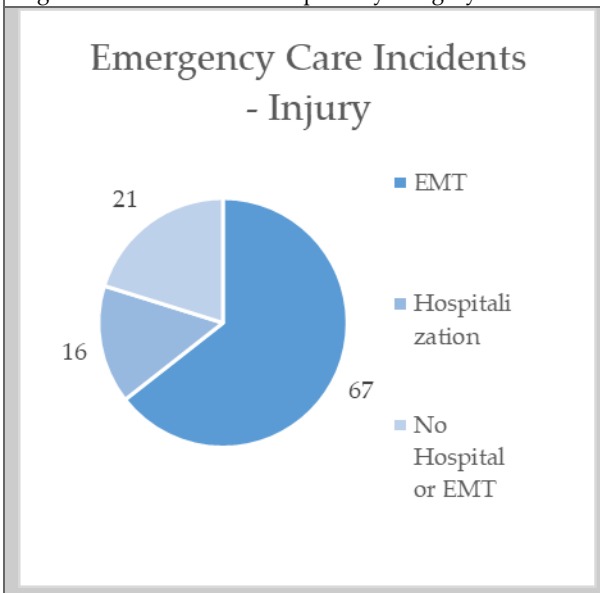 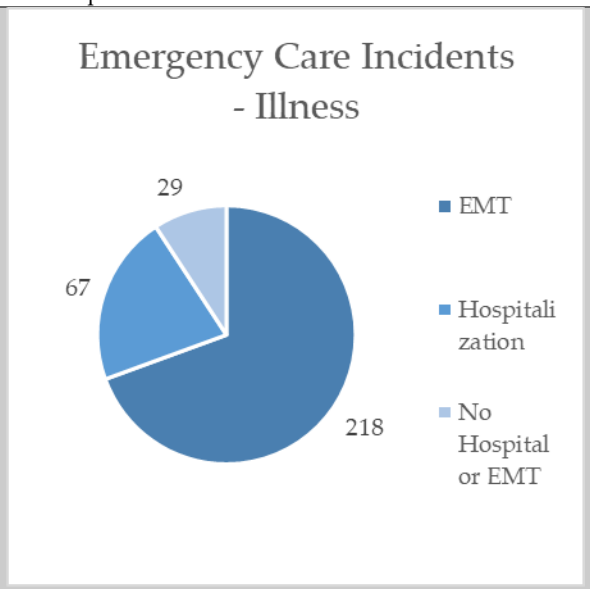 Figure 7. Emergency Care incidents resulting in EMT, Hospitalization, caused by injury or **illness**	19

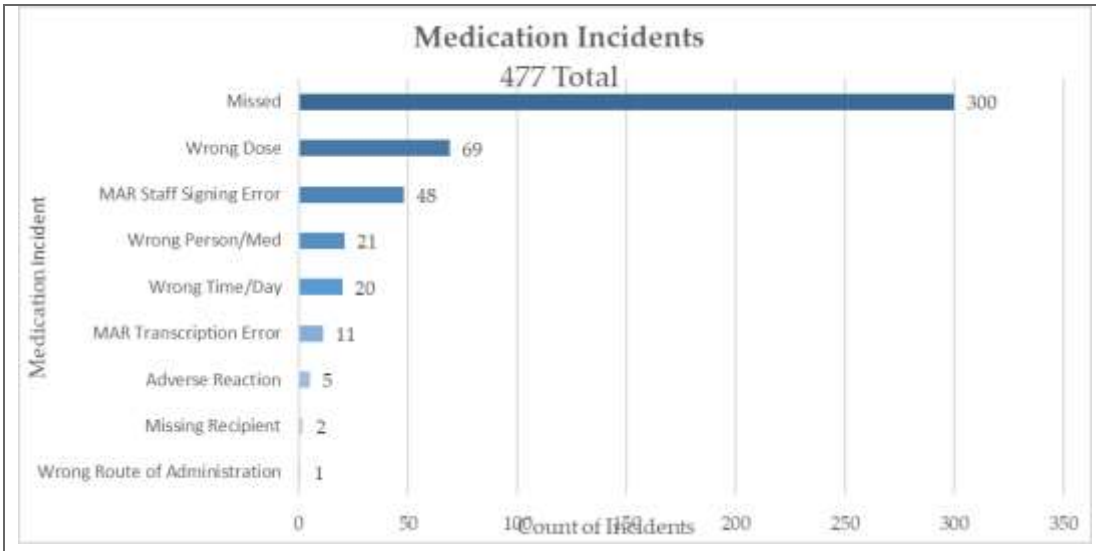

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Figure 8. Medication incident reports by category. Data shows count of IRs completed in **FY23**

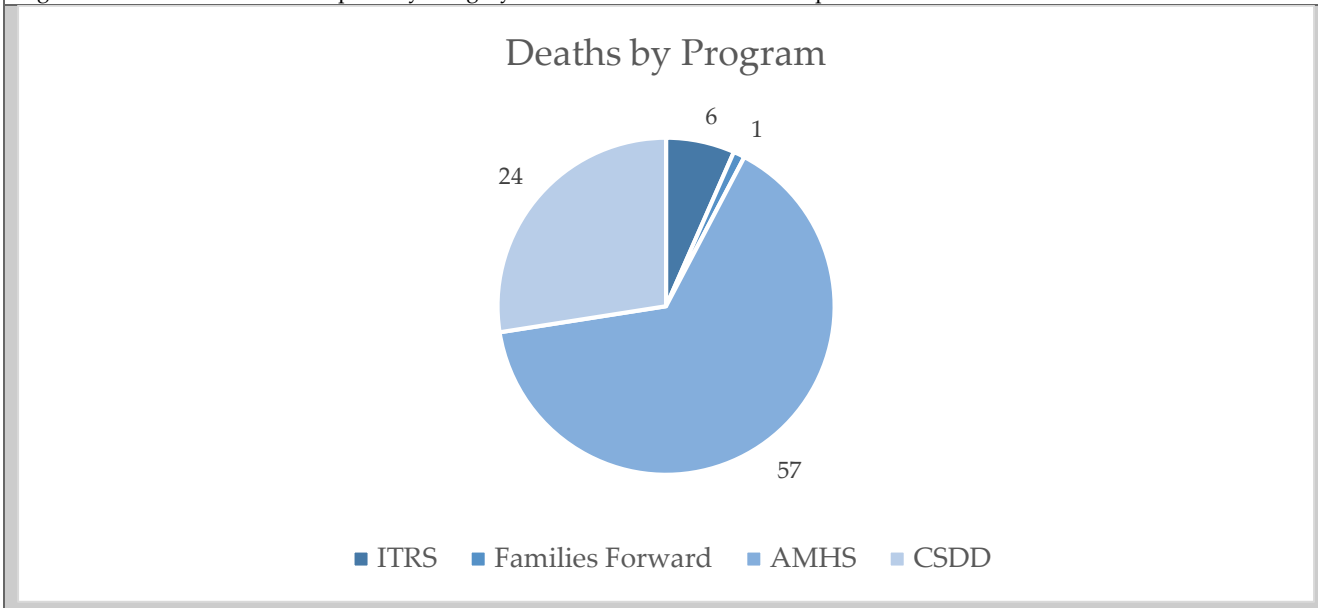

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Figure 9. Count of Deaths by age and by CMHA-CEI **Program**

Figure 10. Vehicle Accidents by month in FY23

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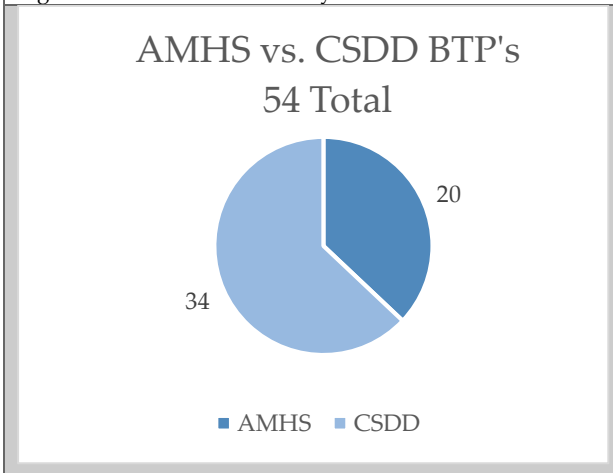

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Figure 11. Count of Behavior Treatment Plans by CMHA-CEI program and Internal vs. Contract **Providers**

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MEV Review Claims Test Percentages by CMHSP, FY24 Q1

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