EVALUATION OF QUALITY IMPROVEMENT PROGRAM PLAN EFFECTIVENESS FY2024

10/1/2023 - 9/30/2024

Community MENTAL HEALTH
CLINTON • EATON • INGHAM
Together we can.

Prepared By:
CMHA-CEI Quality Improvement Team
1/24/2025

Reviewed By:
CMHA-CEI Board Program and Planning Committee
2/10/2025

Approved By:
CMHA-CEI Board of Directors
2/20/2025

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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.

Performance Indicators

Michigan Mission-Based Performance Indicators (MMBPIS)

MDHHS, in compliance with federal mandates, establishes measures in the areas of access, efficiency, and outcomes. Data is abstracted regularly and compiled into quarterly reports that are submitted to MDHHS and MSHN for analysis and regional benchmarking. If 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% or greater.
- Two sub-populations: Children and Adults.

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, higher is better.
- Four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.

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, higher is better.
- Four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.

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% or greater.
- Two sub-populations: Children and Adults.

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.
- Submitted as a count of full population records.

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.
- Two sub-populations: Children and Adults.

Changes in PI reporting standards were adopted beginning FY20 Q3, which eliminated exceptions, exclusions, and the 95% standard for Indicators 2 and 3. Beginning in 2025, new Performance Measures will be implemented through a new Behavioral Health Quality Program through a 3-year rollout. MMBPIS submissions will continue through the end of FY25 and then be replaced by these new Performance Measures. MMBPIS measures may continue to be used internally depending on the timeliness and usability of state-reported new measure data.

New Behavioral Health Quality Program

Beginning in 2025, the Bureau of Specialty Behavioral Health Services in MDHHS will begin using new quality reporting measures with a 3-year rollout. The transformed program will be more comprehensive and better defined, with a more rigorous methodology that aligns with other state and national requirements. Measurement years will switch to calendar years from fiscal years.

The first year will focus on aligning reporting requirements for PIHPs with CMS Core Set Reporting. By the end of the Year 1 measure roll-out, all required CMS Core Set measures will be available by PIHP. The second year will focus on rolling out stratification of measures, along with adding several key measures. The third year will focus on implementing patient experience and Home and Community Based Services (HCBS) measures.

CMHA-CEI and MSHN will be responsible for the ACC Indicator rolling out in Year 2. The ACC will measure Access to Care – appointment within 10 (business) days of request. MDHHS will provide an updated Codebook by June 2025 for measure specification. ACC measurement will be implemented by January 2026 with quarterly data submissions beginning in Summer 2026. MDHHS will be responsible for all 30 other Measures rolling out over the 3 year period, shown below:

Year	Source	Behavioral Health Quality Measure	Program	Domain	Responsibility
Year 1 (2025)	ADD	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	BHCS	MH	MDDHS
	AMM	Antidepressant Medication Management			
	FUH	Follow-up After Hospitalization for Mental Illness*		Access	
	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics		MH	
	APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
	FUA	Follow-up After Emergency Department Visit for Substance Use*		Access	
	FUM	Follow-up After Emergency Department Visit for Mental Illness*			
	IET	Initiation and Engagement into Substance Use Disorder Treatment		SUD	
Year 2 (2026)	SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	BHCS	Comorbid Conditions	MDHHS
	HPCMI	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)			
	OUD	Use of Pharmacotherapy for Opioid Use Disorder		SUD	
	SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia		MH	
	ACC	Access to Care—appointment within 10 days of request	Final Rule	Access	CMHA-CEI
Year 3 (2027)	CAHPS	How people rated their health plan	QRS	Patient Experience	MDHHS
		Getting care quickly			
		Getting needed care			
		How well doctors communicate			
		Health plan customer service			
	HCBS CAHPS	Choosing the Services that Matter to You	HCBS	Patient Experience and Home and Community Based Services	
		Community Inclusion and Empowerment			
		Transportation to Medical Appointments			
		Physical Safety			
		Personal Safety and Respect			
		Staff are Reliable and Helpful			
		Staff Listen and Communicate Well			
		Unmet Needs Composite Measure			
	MLTSS-1	Medicaid Managed Long-Term Services and Supports Comprehensive Assessment and Update	MLTSS		
	MLTSS-2	Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update			
		Social Needs Screening- Tool TBD.	CCBHC	Social Needs	
	MSC	Medical Assistance with Smoking and Tobacco Use Cessation	BHCS	SUD	
	CDF	Screening for Depression and Follow-up Plan*	BHCS	MH	

FY24 MMBPIS Data

Regionally, MSHN demonstrated performance above the State of Michigan average on 12 out of 18 indicators in FY24 Quarter 3. This is a slight decrease from FY24 Quarter 2, where MSHN performed above the State average for 13 of the 18 reported indicators. MSHN performed above the State average for 12 of the 18 indicators in FY24 Quarter 1. This data is sourced from the most recent MMBPIS PIHP Consultative Report FY24 Q3.

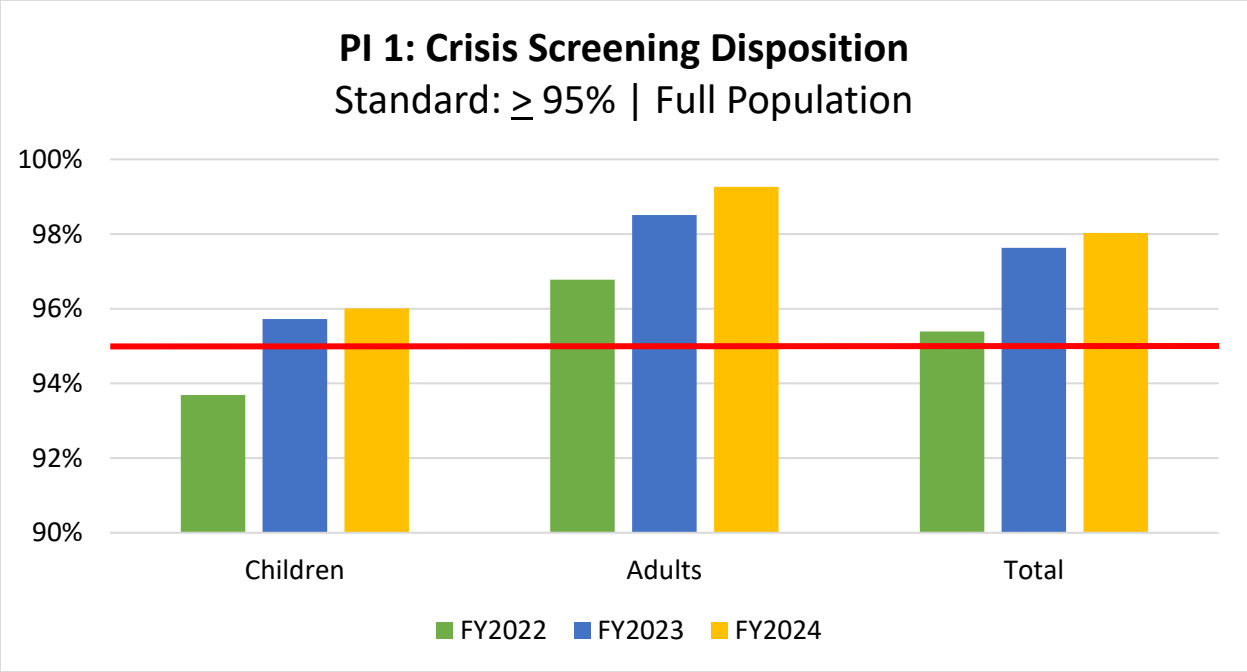
CMHA-CEI saw improvements in Performance Indicators 1, 3, and 10 from FY23 to FY24. There was continued compliance with PI 4a from FY23 to FY24 despite a slight decrease in performance. There was also a slight decrease in PI 2a from FY23 to FY24, but the indicator remains in good standing with improved performance from FY22.

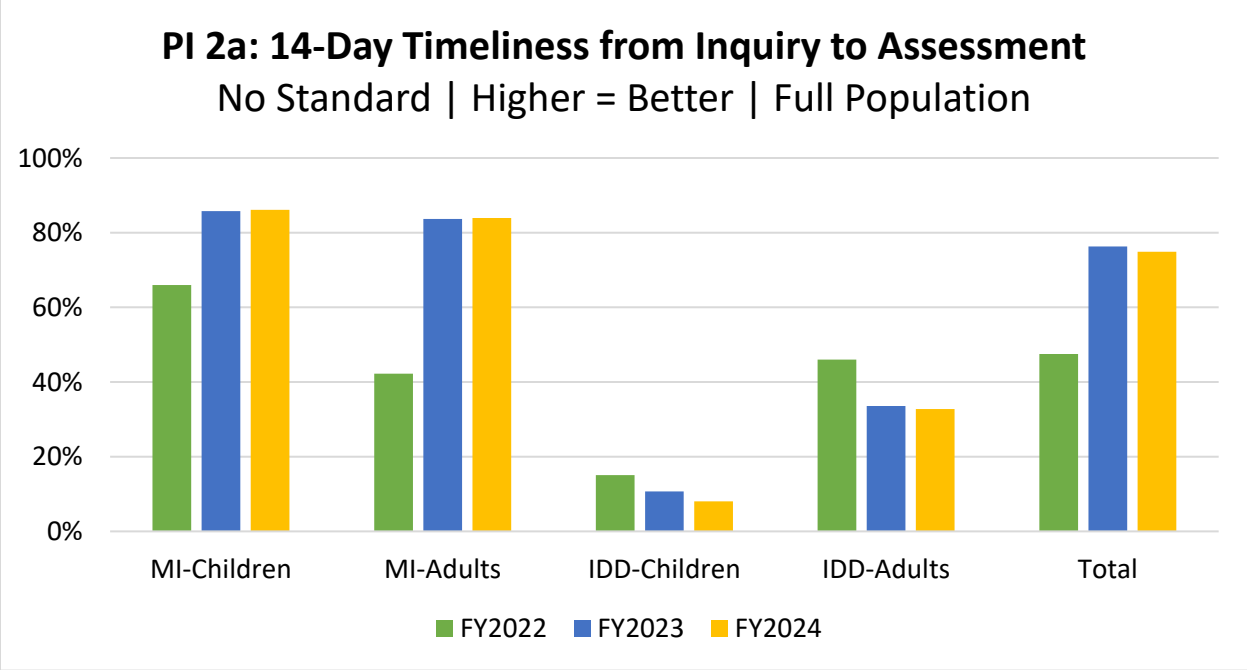
CMHA-CEI Performance Indicator Results (Medicaid Only)

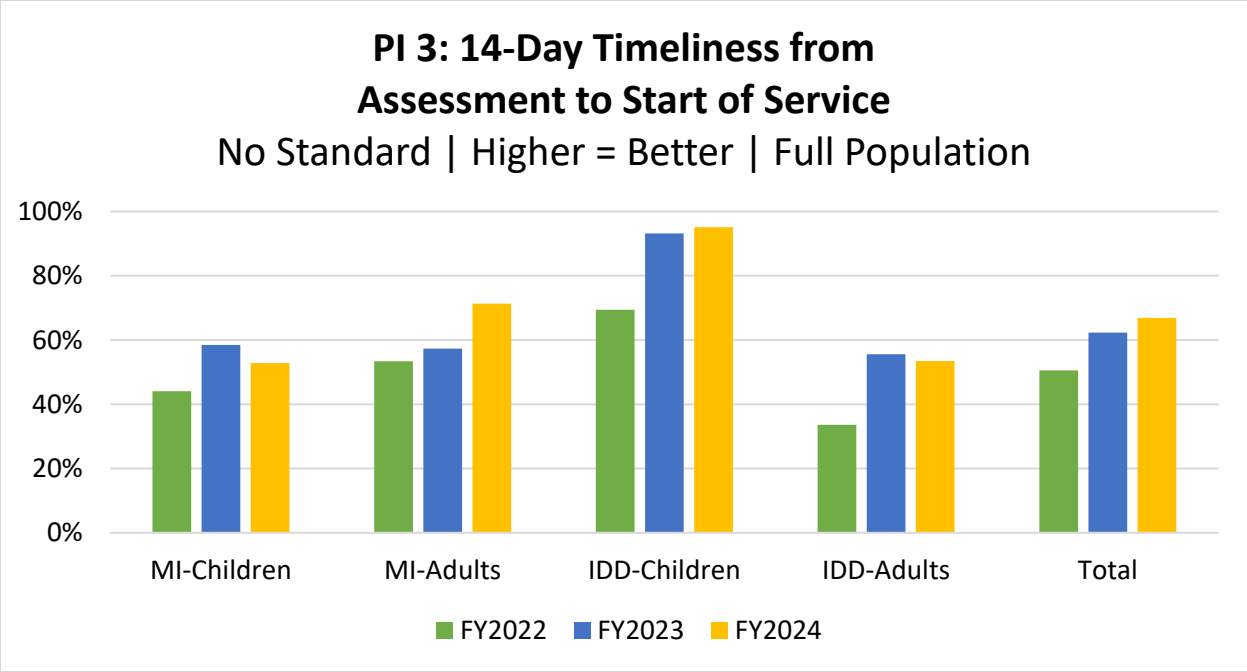
Indicator	Population	FY2022 Total	FY2023 Total	FY2024 Q1	FY2024 Q2	FY2024 Q3	FY2024 Q4	FY2024 Total
PI 1 ≥ 95%	Children	94.44%	95.82%	96.72%	97.04%	95.39%	98.76%	96.88%
	Adults	96.78%	98.53%	99.59%	99.41%	99.24%	99.08%	99.32%
	Total	96.01%	97.69%	98.49%	98.52%	97.83%	98.98%	98.45%
PI 2a	MI-Children	67.23%	84.73%	82.12%	85.71%	84.45%	88.37%	84.92%
	MI-Adults	46.75%	84.31%	82.89%	83.38%	81.77%	84.90%	83.28%
	IDD-Children	19.08%	12.00%	11.54%	10.17%	8.22%	15.38%	11.63%
	IDD-Adults	44.75%	38.50%	37.50%	60.00%	30.00%	20.00%	33.33%
	Total	51.25%	77.28%	74.42%	78.15%	74.83%	75.48%	75.72%
PI 3	MI-Children	42.32%	58.62%	53.09%	55.47%	50.83%	58.64%	52.36%
	MI-Adults	53.64%	57.56%	50.51%	75.62%	79.39%	77.88%	67.76%
	IDD-Children	70.42%	93.04%	96.94%	94.38%	93.68%	94.74%	94.00%
	IDD-Adults	29.61%	54.22%	55.56%	42.86%	63.64%	53.33%	50.00%
	Total	50.29%	62.86%	58.35%	69.37%	70.07%	74.62%	65.54%
PI 4a ≥ 95%	Children	100.00%	98.91%	95.45%	100.00%	100.00%	100.00%	99.03%
	Adults	76.01%	98.42%	99.01%	96.77%	93.60%	96.72%	96.37%
	Total	98.62%	98.57%	98.37%	97.58%	94.67%	97.26%	96.88%
PI 10 ≤ 15%	Children	8.88%	11.30%	11.90%	12.73%	2.08%	8.00%	8.67%
	Adults	10.21%	12.50%	11.93%	9.06%	11.68%	9.22%	10.40%
	Total	9.93%	12.25%	11.93%	9.63%	10.53%	9.07%	10.17%

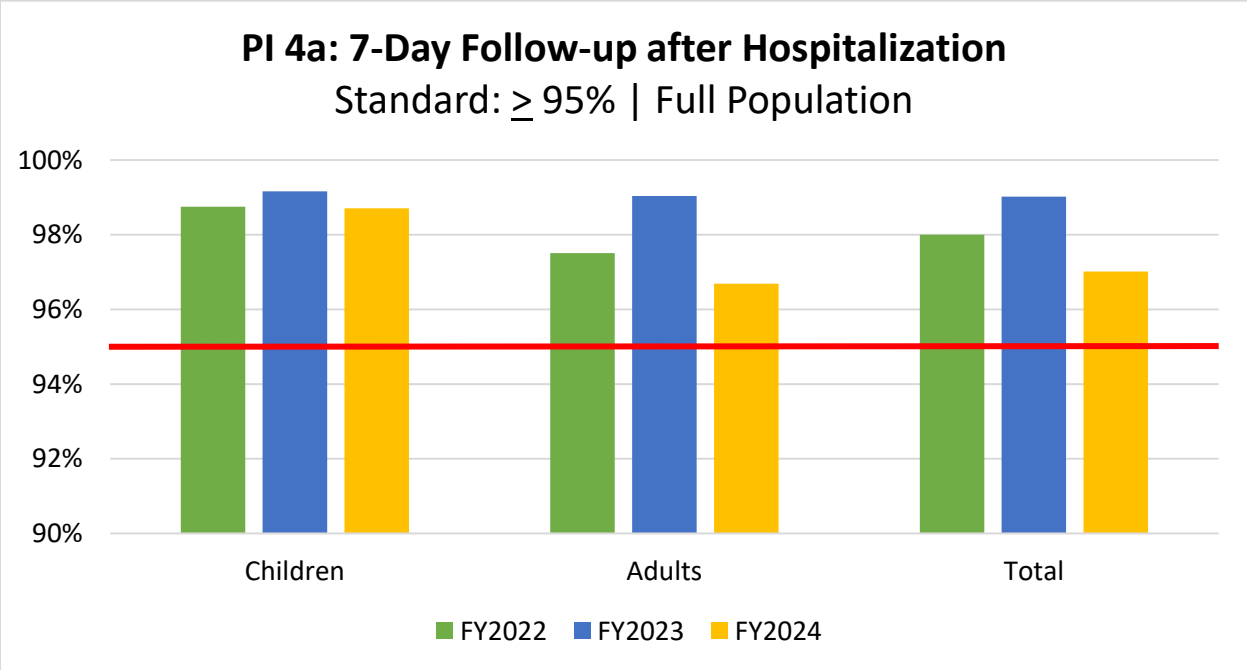
CMHA-CEI Performance Indicator Results (Full Population)

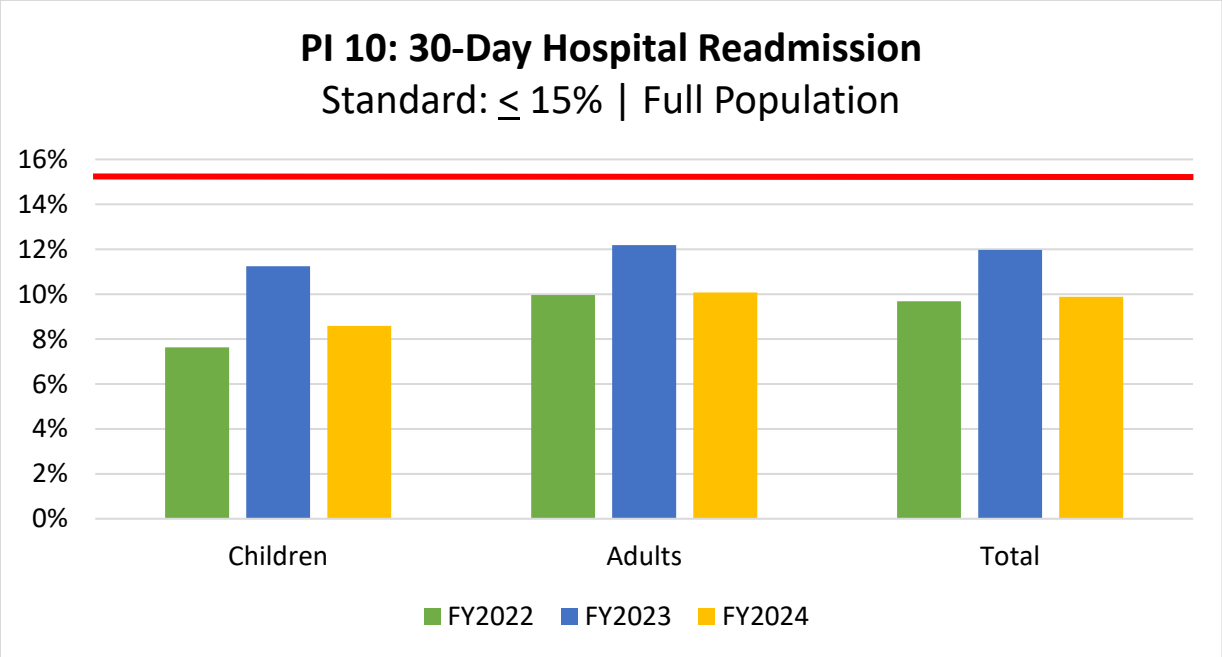
Indicator	Population	FY2022 Total	FY2023 Total	FY2024 Q1	FY2024 Q2	FY2024 Q3	FY2024 Q4	FY2024 Total
PI 1 ≥ 95%	Children	93.69%	95.72%	95.71%	95.60%	94.77%	98.34%	96.01%
	Adults	96.78%	98.51%	99.62%	99.47%	99.16%	98.86%	99.26%
	Total	95.39%	97.63%	98.01%	97.96%	97.49%	98.69%	98.03%
PI 2a	MI-Children	65.98%	85.77%	83.24%	86.93%	85.16%	90.04%	86.10%
	MI-Adults	42.25%	83.68%	83.73%	82.66%	83.20%	85.96%	83.95%
	IDD-Children	15.08%	10.71%	8.47%	7.29%	4.80%	11.48%	8.03%
	IDD-Adults	46.00%	33.58%	44.44%	53.85%	23.08%	21.74%	32.76%
	Total	47.50%	76.29%	73.51%	76.38%	73.52%	76.15%	74.88%
PI 3	MI-Children	44.07%	58.48%	52.07%	56.16%	48.19%	55.56%	52.83%
	MI-Adults	53.39%	57.29%	50.27%	76.18%	81.23%	76.83%	71.29%
	IDD-Children	69.42%	93.18%	97.00%	94.74%	93.88%	94.83%	95.11%
	IDD-Adults	33.61%	55.55%	55.56%	42.86%	63.64%	50.00%	53.49%
	Total	50.54%	62.30%	56.81%	69.72%	68.80%	72.32%	66.89%
PI 4a ≥ 95%	Children	98.75%	99.16%	99.37%	97.67%	100.00%	100.00%	98.71%
	Adults	97.51%	99.04%	99.42%	97.37%	93.53%	97.29%	96.69%
	Total	98.00%	99.02%	99.05%	97.42%	94.53%	97.63%	97.01%
PI 10 ≤ 15%	Children	7.63%	11.24%	11.63%	12.73%	2.00%	8.00%	8.59%
	Adults	9.96%	12.19%	11.69%	9.06%	11.46%	8.51%	10.07%
	Total	9.68%	11.97%	11.68%	9.60%	10.37%	8.45%	9.88%


PI 1: Crisis Screening Disposition
Standard: ≥ 95% | Full Population
100%
98%
96%
94%
92%
90%
Children
Adults
Total
FY2022
FY2023
FY2024


PI 2a: 14-Day Timeliness from Inquiry to Assessment
No Standard | Higher = Better | Full Population
100%
80%
60%
40%
20%
0%
MI-Children
MI-Adults
IDD-Children
IDD-Adults
Total
FY2022
FY2023
FY2024

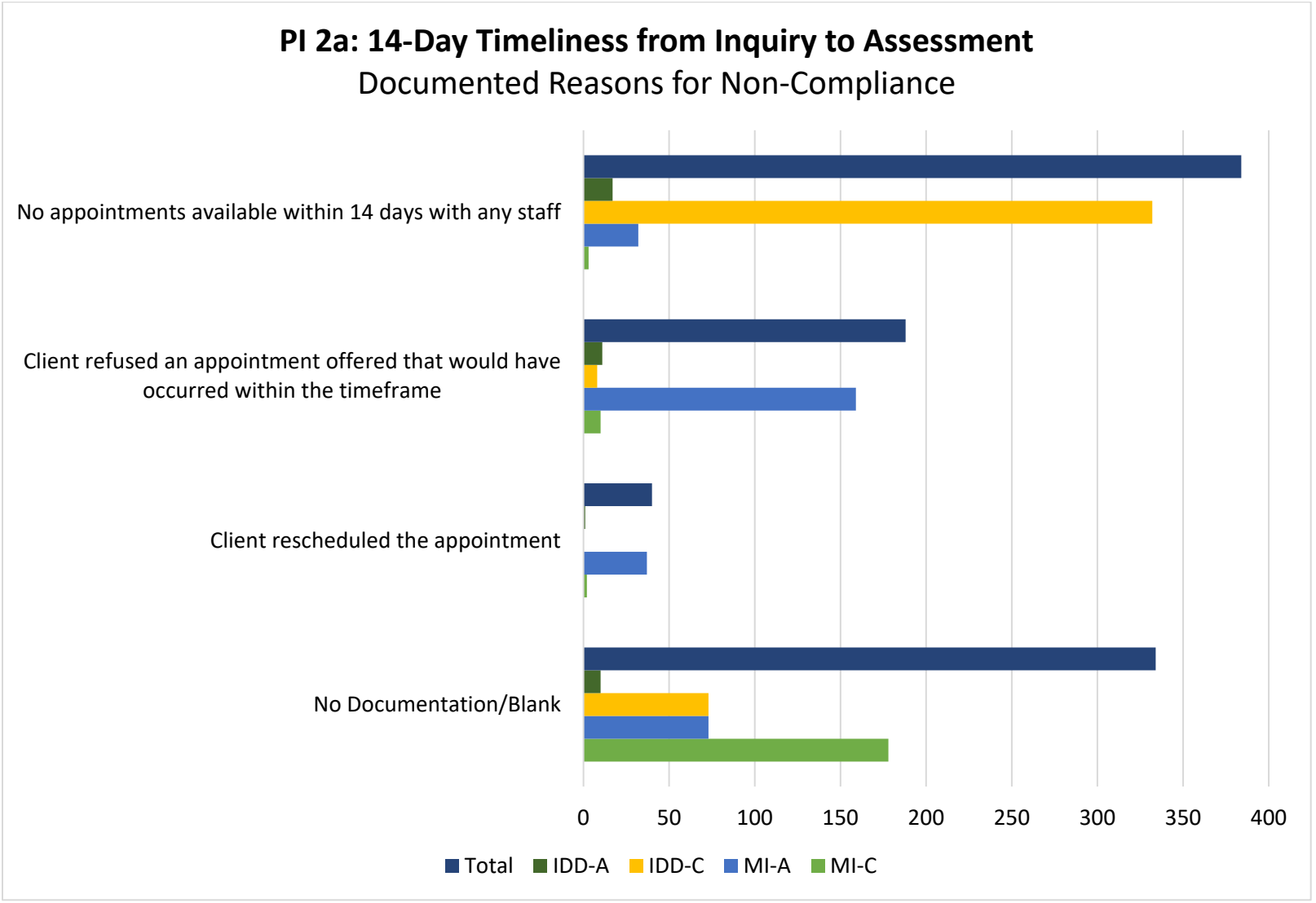

PI 3: 14-Day Timeliness from Assessment to Start of Service
No Standard | Higher = Better | Full Population
100%
80%
60%
40%
20%
0%
MI-Children
MI-Adults
IDD-Children
IDD-Adults
Total
FY2022
FY2023
FY2024


PI 4a: 7-Day Follow-up after Hospitalization
Standard: ≥ 95% | Full Population
100%
98%
96%
94%
92%
90%
Children
Adults
Total
FY2022
FY2023
FY2024



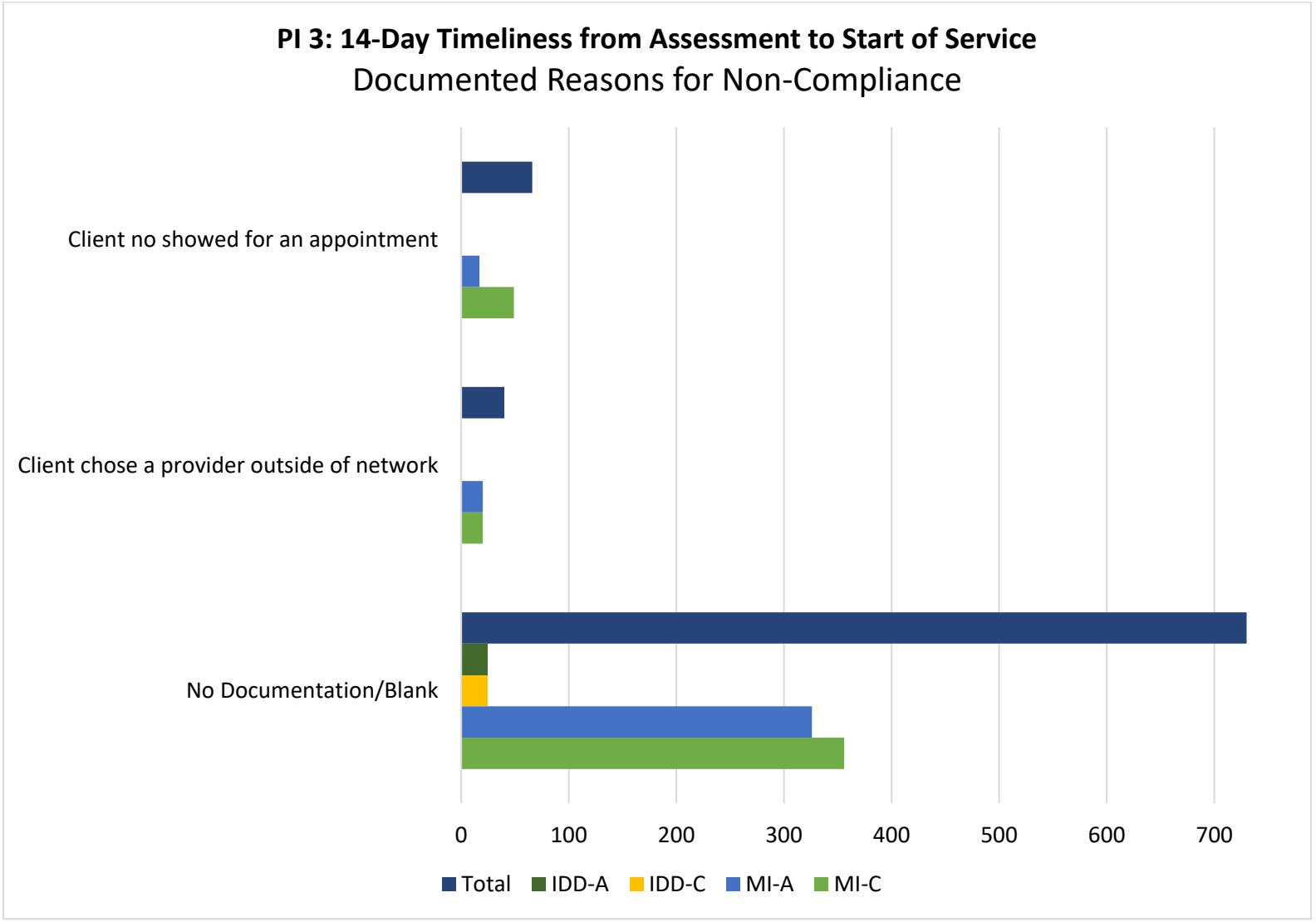
PI 5/6 *Full Population	Total # of New Persons receiving an initial non-emergent face-to-face professional assessment	Total # of Persons assessed but denied services	Total # of Persons requesting a second opinion	Total # of Persons receiving services after a second opinion
FY22 Total	3205	418	22	21
FY23 Total	3855	397	9	7
FY24 Q1	1002	101	0	0
FY24 Q2	1054	100	0	0
FY24 Q3	1085	96	0	0
FY24 Q4	1084	114	3	3
FY24 Total	4225	411	3	3

PI 5/6 *Full Population	% of Persons assessed but denied services	% of Persons requesting a second opinion	% of Persons receiving services after a second opinion
FY22 Total	13%	5%	95%
FY23 Total	10%	2%	78%
FY24 Total	10%	1%	100%


PI 2a: 14-Day Timeliness from Inquiry to Assessment
Documented Reasons for Non-Compliance
No appointments available within 14 days with any staff
Client refused an appointment offered that would have occurred within the timeframe
Client rescheduled the appointment
No Documentation/Blank
0
50
100
150
200
250
300
350
400
Total
IDD-A
IDD-C
MI-A
MI-C

Full Population (Total)	Q1	Q2	Q3	Q4	FY2024
No Documentation/Blank	85	71	95	83	334
Client chose not to pursue services	0	0	1	0	1
Client chose provider outside of network	1	0	0	0	1
Client no showed for an appointment	2	1	2	0	5
Client rescheduled the appointment	9	17	14	0	40
Client refused an appointment offered that would have occurred within the timeframe	45	49	51	43	188
No appointments available within 14 days with any staff	90	86	106	102	384
Staff Cancel/Reschedule	0	1	0	1	2
Other (Unable to complete assessment as a result of an emergent service needed; Closed client comes back within 60 days; Guardianship hearing; OBRA Enrollment; Substance Abuse Enrollment)	0	1	0	0	1
IDD-Adults	Q1	Q2	Q3	Q4	FY2024
No Documentation/Blank	1	1	5	3	10
Client rescheduled the appointment	1	0	0	0	1
Client refused an appointment offered that would have occurred within the timeframe	1	5	1	4	11
No appointments available within 14 days with any staff	2	0	4	11	17
IDD-Children	Q1	Q2	Q3	Q4	FY2024
No Documentation/Blank	16	13	22	22	73
Client refused an appointment offered that would have occurred within the timeframe	0	1	2	5	8
No appointments available within 14 days with any staff	81	75	95	81	332

MI-Adults	Q1	Q2	Q3	Q4	FY2024
No Documentation/Blank	13	12	17	31	73
Client chose not to pursue services	0	0	1	0	1
Client chose provider outside of network	1	0	0	0	1
Client no showed for an appointment	1	1	1	0	3
Client rescheduled the appointment	7	16	14	0	37
Client refused an appointment offered that would have occurred within the timeframe	41	41	44	33	159
No appointments available within 14 days with any staff	6	10	6	10	32
Staff Cancel/Reschedule	0	1	0	1	2
Other (Unable to complete assessment as a result of an emergent service needed; Closed client comes back within 60 days; Guardianship hearing; OBRA Enrollment; Substance Abuse Enrollment)	0	1	0	0	1
MI-Children	Q1	Q2	Q3	Q4	FY2024
No Documentation/Blank	55	45	51	27	178
Client no showed for an appointment	1	0	1	0	2
Client rescheduled the appointment	1	1	0	0	2
Client refused an appointment offered that would have occurred within the timeframe	3	2	4	1	10
No appointments available within 14 days with any staff	1	1	1	0	3


PI 3: 14-Day Timeliness from Assessment to Start of Service
Documented Reasons for Non-Compliance
Client no showed for an appointment
Client chose a provider outside of network
No Documentation/Blank
0
100
200
300
400
500
600
700
Total
IDD-A
IDD-C
MI-A
MI-C

Full Population (Total)	Q1	Q2	Q3	Q4	FY2024
No Documentation/Blank	279	165	145	141	730
Client chose not to pursue services	8	0	0	0	8
Client chose a provider outside of network	3	0	0	0	3
Client no showed for an appointment	11	11	12	6	40
Client rescheduled an appointment	11	16	19	20	66
Client refused an appointment offered within 14 calendar days or requested an appointment outside of 14 calendar days	38	35	58	48	179
No appointment available within 14 days with any staff	7	1	10	5	23
Staff Cancel/Reschedule	2	3	2	5	12
Other (Closed client comes back within 60 days; Client not eligible for ongoing services; Intent of service was medication only or respite only; Substance Abuse Enrollment)	1	0	0	0	1
IDD-Adults	Q1	Q2	Q3	Q4	FY2024
No Documentation/Blank	8	4	4	8	24
IDD-Children	Q1	Q2	Q3	Q4	FY2024
No Documentation/Blank	7	5	6	6	24

MI-Adults	Q1	Q2	Q3	Q4	FY2024
No Documentation/Blank	112	67	57	90	326
Client chose not to pursue services	7	0	0	0	7
Client chose a provider outside of network	2	0	0	0	2
Client no showed for an appointment	11	3	2	4	20
Client rescheduled an appointment	7	4	2	4	17
Staff Cancel/Reschedule	2	2	2	1	7
Other (Closed client comes back within 60 days; Client not eligible for ongoing services; Intent of service was medication only or respite only; Substance Abuse Enrollment)	1	0	0	0	1
MI-Children	Q1	Q2	Q3	Q4	FY2024
No Documentation/Blank	153	89	77	37	356
Client chose not to pursue services	1	0	0	0	1
Client chose a provider outside of network	1	0	0	0	1
Client no showed for an appointment	0	8	10	2	20
Client rescheduled an appointment	4	12	17	16	49
Client refused an appointment offered within 14 calendar days or requested an appointment outside of 14 calendar days	38	35	58	48	179
No appointment available within 14 days with any staff	7	1	10	5	23
Staff Cancel/Reschedule	0	1	0	4	5

Outcomes Management System: Efficiency Objective Data Collection for Integrative Treatment and Recovery Services

Efficiency Objective:	FY 2023-2024											
	Oct-Dec 2023			Jan-Mar 2024			April-June 2024			July-Sept 2024		
	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)							140	39	28%	141	51	36%
2) 95% of clients will have a Primary Care Physician by discharge. (House of Commons)	49	16	33%	57	10	28%	46	7	15%	53	18	33%
3) 90% of clients will have a Primary Care Physician by discharge. (CATS Program)	471	382	81.1%	403	264	65.51%	397	219	55.16%	224	224	100%
4) 80% of clients will successfully discharge. (The Recovery Center)	84	59/52	70%/ 67.49%	90	58/66	64%/ 68.04%	78	42/60	55%/ 63% (-8%)	94	48/48	58%/ 51% (-7%)

*Data is missing from October 2023 to March 2024 for Objective 1 from ITRS Outpatient due to staffing changes throughout that time period

Minimum = 80

Goal = 85

Optimal = 100

Consumer Satisfaction Survey

Summary

As part of CMHA-CEI's quality improvement efforts, satisfaction surveys are administered annually to active consumers. Results are used to gauge the level of satisfaction among consumers, determine ways to improve the quality of practice, and address identified areas of need. The purpose of the survey is to measure the quality of CEI services and summarize the level of satisfaction with the CMH service system.

Adults receiving services from AMHS or CSDD Adult completed the MHSIP adult satisfaction survey. The MSHIP template provided by MSHN utilized a 6 point Likert scale for 36 questions across 7 subscale domains.

MHSIP Likert Scale:
- Strongly Agree (1)
- Agree (2)
- Neutral (3)
- Disagree (4)
- Strongly Disagree (5)
- Not Applicable (9)

MHSIP Domains:
1. General Satisfaction
2. Access
3. Quality and Appropriateness
4. Participation in Treatment Planning
5. Outcome of Services
6. Functioning
7. Social Connectedness

Children, or their families if they were younger than 13, receiving services from Families Forward or CSSD Youth completed the YSSF youth satisfaction survey. The YSSF template provided by MSHN utilized a 5 point Likert scale for 26 questions across 7 subscale domains.

YSSF Likert Scale*:
- Strongly Agree (5)
- Agree (4)
- Neutral (3)
- Disagree (2)
- Strongly Disagree (1)

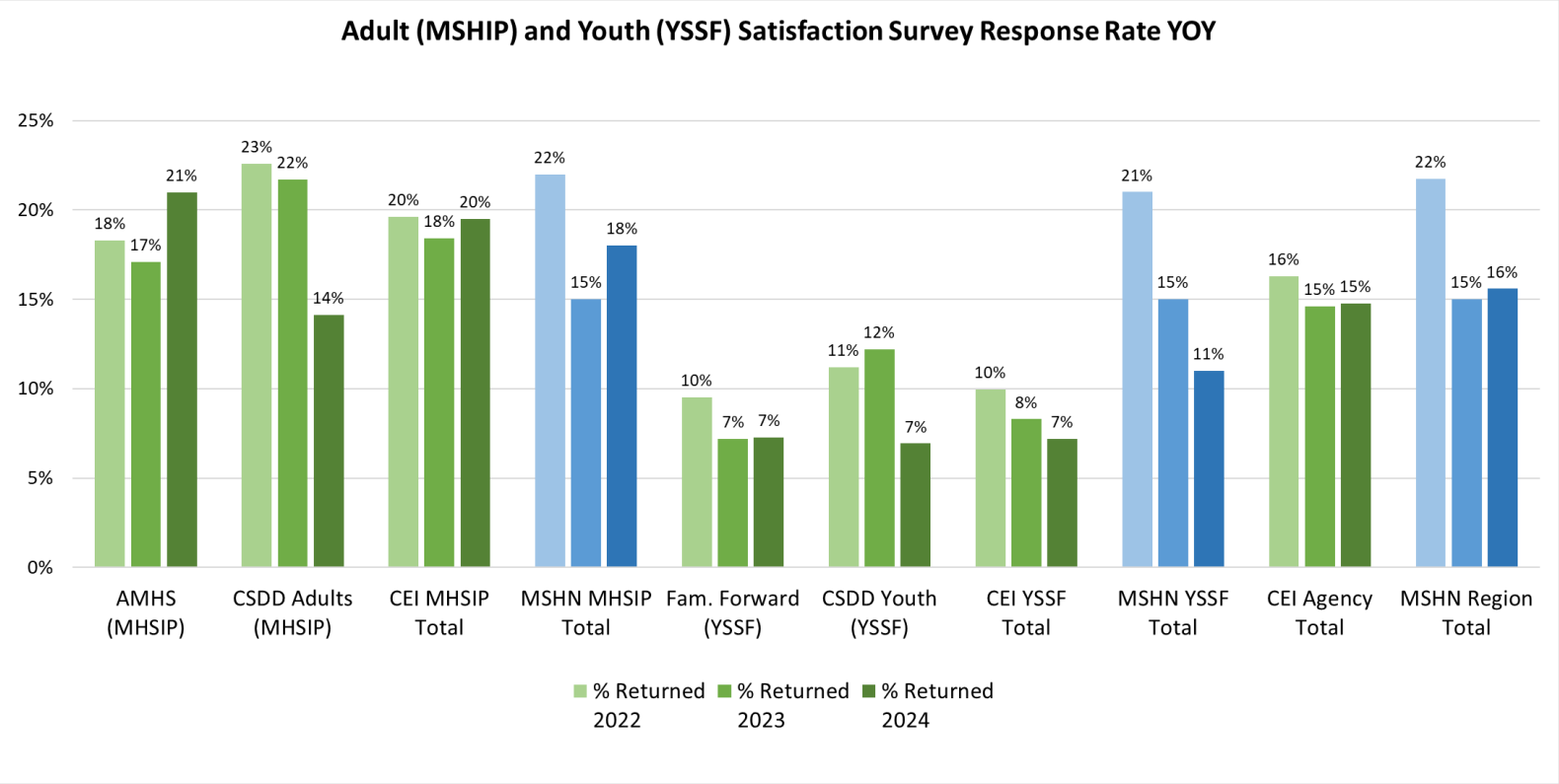
*YSSF numerical order is reversed compared to MSHIP adult survey

YSSF Domains:
1. Cultural Sensitivity
2. Access
3. Appropriateness
4. Participation in Treatment
5. Outcome of Services
6. Social Functioning
7. Social Connectedness

Results from AMHS, Families Forward, and CSDD programs are reported to MSHN annually by the QI Team for analysis. MSHN's report provides CEI with year-over-year regional comparisons and subscale ratings. Further analysis is completed internally to provide a detailed overview of survey performance for each individual CEI program.

In 2024, CMHA-CEI distributed 7,092 total consumer satisfaction surveys to mental health programs. There was an overall rate of return of 14.8%, which represents a slight increase from 2023 to 2024. A year-over-year comparison between individual CEI programs as well as the MSHN region is included on the next page.

Additionally, ITRS distributes satisfaction surveys to their consumers annually. In 2024, the MHSIP adult consumer satisfaction survey was used. 94 total consumers across 5 ITRS programs were surveyed on the quality of the care they received.



Survey Response Rates YOY						
	Distributed 2022	% Returned 2022	Distributed 2023	% Returned 2023	Distributed 2024	% Returned 2024
AMHS (MHSIP)	2,153	18.3%	2,338	17.1%	3,420	21.0%
CSDD Adults (MHSIP)	961	22.6%	926	21.7%	942	14.1%
CEI MHSIP Total	3,114	19.6%	3,264	18.4%	4,362	19.5%
MSHN MHSIP Total	10,600	22.0%	18,793	15.0%	16,567	18.0%
Fam. Forward (YSSF)	1,180	9.5%	1,759	7.2%	2,095	7.3%
CSDD Youth (YSSF)	454	11.2%	491	12.2%	635	6.9%
CEI YSSF Total	1,634	10.0%	2,250	8.3%	2,730	7.2%
MSHN YSSF Total	3,914	21.0%	6,940	15.0%	8,709	11.0%
CEI Agency Total	4,748	16.3%	5,514	14.6%	7,092	14.8%
MSHN Region Total	14,514	21.7%	25,733	15.0%	25,276	15.6%

Procedure – Mental Health Programs

Surveys were mailed out and handed directly to consumers who received services from AMHS, Families Forward, or CSDD programs between 6/3/23 and 7/2/24. 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 at the end of the survey if they wished to be contacted at a later date for follow-up.

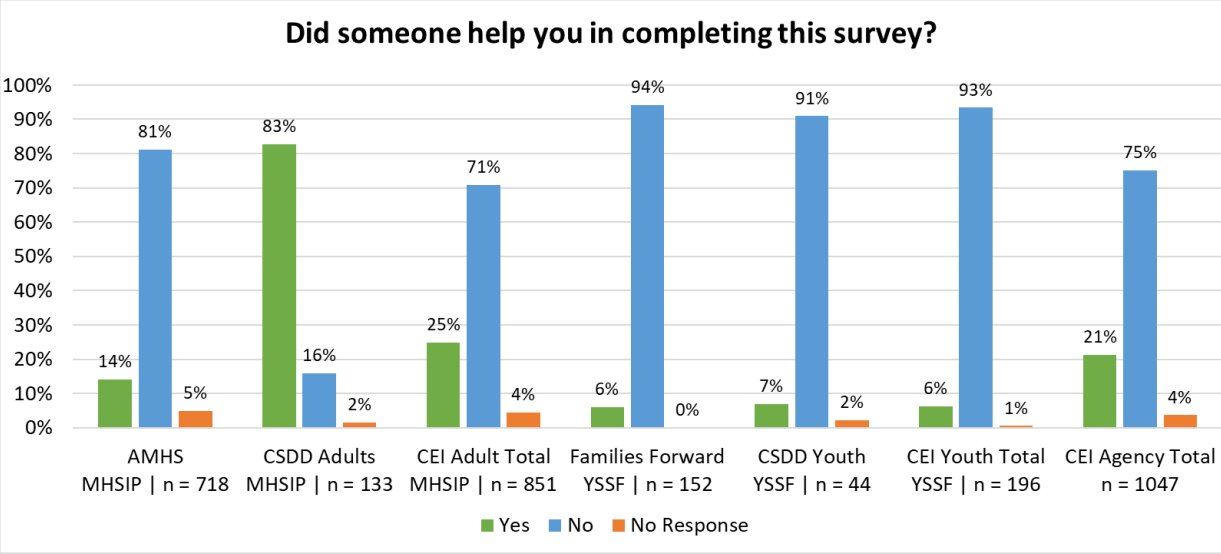
Findings – Mental Health Programs

Across all programs, the difference between the highest and lowest-performing questions remains relatively small. This indicates that consumers continue to be generally satisfied with CEI services. However, year-over-year, questions about the quality of staff and services frequently score above those regarding treatment outcomes.

All AMHS subscale scores and the majority of CSDD Adult subscale scores decreased from 2023 to 2024. However, most subscale scores in both Families Forward and CSDD Youth increased from 2023 to 2024. The MSHN regional average decreased from 2023 to 2024 in every subscale across both of the adult and youth surveys. CEI programs overall outperformed the 2024 MSHN regional average on the majority of subscales in CSDD Adult as well as all subscales in Families Forward and CSDD Youth.

Unfortunately, many consumers did not answer the response method question in 2024. Across all programs, however, the most common survey response method for those who did answer was by mail. The most common method was face-to-face in 2023.

CSDD Adult was the only program surveyed where a majority of consumers received assistance completing the survey. Many AMHS respondents also received assistance.



Analysis of Findings – Mental Health Programs

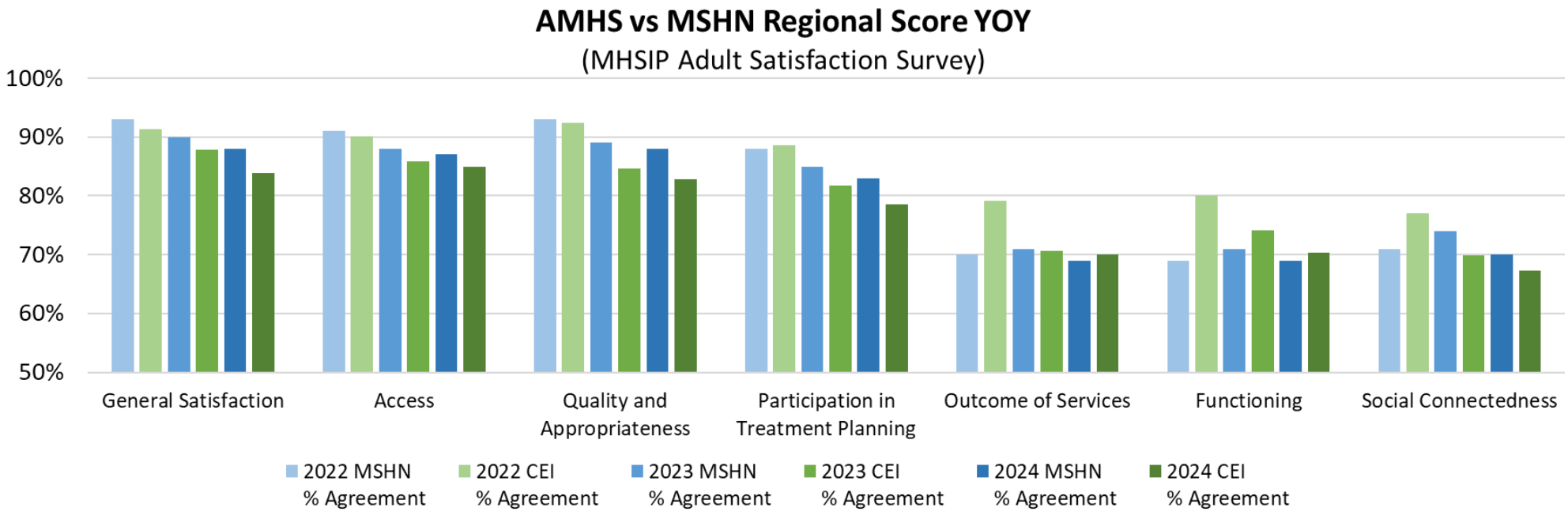
Adult Mental Health Services (AMHS)

Top 3 Questions (average scores)						
	2024 (Score)		**2023 (Score)**		**2022 (Score)**	
AMHS - MHSIP (Lower = Better) 2024: n = 718; Avg Score = 1.87 2023: n = 399; Avg Score = 1.86 2022: n = 394; Avg Score = 1.69	7. Services were available at times that were good for me.	(1.58)	1. I like the services that I received.	(1.58)	1. I like the services that I received.	(1.43)
	1. I like the services that I received.	(1.59)	11. I felt comfortable asking questions about my treatment, services and medication.	(1.61)	7. Services were available at times that were good for me.	(1.47)
	16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	(1.60)	5. Staff were willing to see me as often as I felt it was necessary.	(1.62)	10. Staff believed that I could grow, change and recover.	(1.47)

Bottom 3 Questions (average scores)						
	2024 (Score)		**2023 (Score)**		**2022 (Score)**	
AMHS - MHSIP (Higher = Worse) 2024: n = 718; Avg Score = 1.87 2023: n = 399; Avg Score = 1.86 2022: n = 394; Avg Score = 1.69	28. My symptoms are not bothering me as much.	(2.25)	28. My symptoms are not bothering me as much.	(2.25)	26. I do better in school and/or work.	(1.97)
	31. I am better able to handle things when they go wrong.	(2.17)	27. I am satisfied with my housing situation.	(2.18)	28. My symptoms are not bothering me as much.	(1.96)
	35. I feel I belong in my community.	(2.17)	35. I feel I belong in my community	(2.17)	35. I feel I belong in my community.	(1.96)

AMHS Performance Across the MHSIP Subscales

- Scored Best: Access (85% agreement)
- Scored Worst: Social Connectedness (67% agreement)
- All subscales decreased year-over-year from 2023 to 2024 for both AMHS and the MSHN region.
- Comparing CEI data to MSHN region data for 2024 only:
    - AMHS scored above the regional average on Outcome of Services and Functioning.
    - AMHS scored below the regional average on General Satisfaction, Access, Quality/Appropriateness, Participation in Treatment Planning, and Social Connectedness.



AMHS vs Region (MHSIP) Average Scores: Lower = Better	2022 MSHN % Agreement	2022 CEI vs Region	2022 CEI % Agreement	2022 CEI Avg Score	2023 MSHN % Agreement	2023 CEI vs Region	2023 CEI % Agreement	2023 CEI Avg Score	2024 MSHN % Agreement	2024 CEI vs Region	2024 CEI % Agreement	2024 CEI Avg Score
General Satisfaction	93%	-1.66	91%	1.52	90%	-2.24	88%	1.65	88%	-4.16	84%	1.70
Access	91%	-0.97	90%	1.58	88%	-2.21	86%	1.73	87%	-2.12	85%	1.71
Quality and Appropriateness	93%	-0.55	92%	1.56	89%	-4.40	85%	1.75	88%	-5.24	83%	1.76
Participation in Treatment Planning	88%	+0.59	89%	1.52	85%	-3.32	82%	1.68	83%	-4.41	79%	1.72
Outcome of Services	70%	+9.20	79%	1.82	71%	-0.41	71%	2.06	69%	+1.00	70%	2.07
Functioning	69%	+11.00	80%	1.81	71%	+3.07	74%	1.98	69%	+1.31	70%	2.02
Social Connectedness	71%	+6.03	77%	1.85	74%	-4.13	70%	2.06	70%	-2.67	67%	2.06

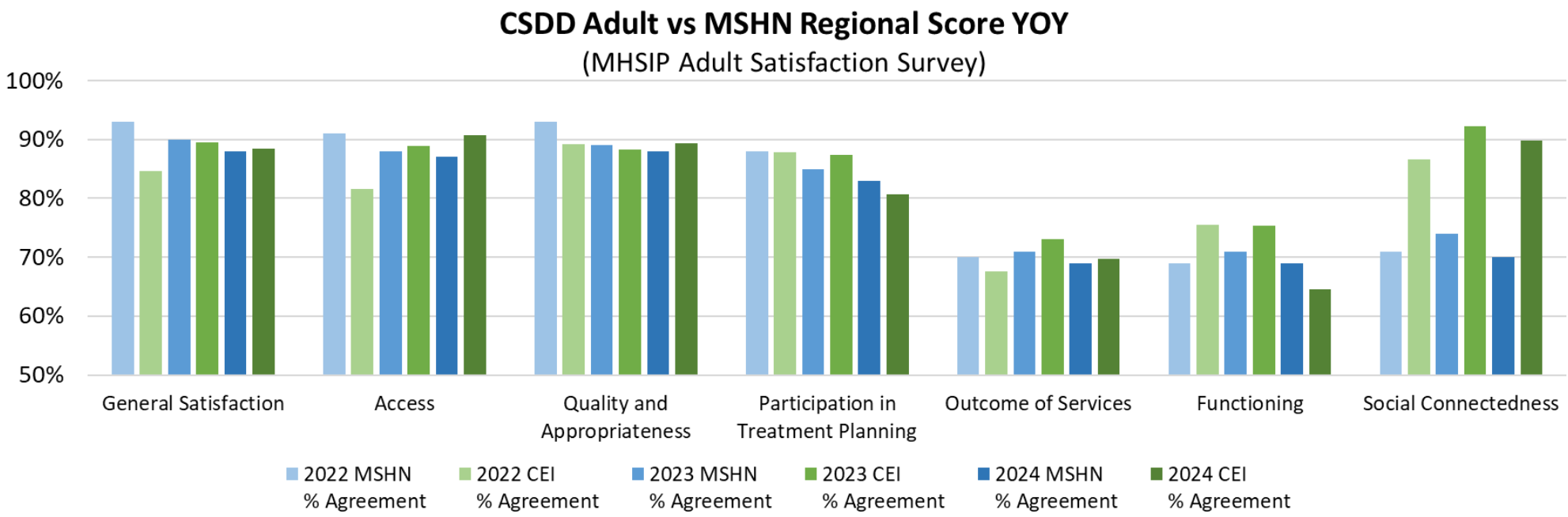
Community Services for the Developmentally Disabled (CSDD) Adult

Top 3 Questions (average scores)			
	2024 (Score)	**2023 (Score)**	**2022 (Score)**
CSDD Adults - MHSIP (Lower = Better) 2024 n = 133; Avg Score = 1.83 2023 n = 201; Avg Score = 1.82 2022 n = 217; Avg Score = 1.88	5. Staff were willing to see me as often as I felt it was necessary. (1.46) 16. Staff respected my wishes about who is and who is not to be given information about my treatment services. (1.46) 4. The location of services was convenient. (1.48)	36. In a crisis, I would have the support I need from family and friends. (1.49) 1. I like the services that I received. (1.58) 34. I have people with whom I can do enjoyable things. (1.58)	11. I felt comfortable asking questions about my treatment, services and medication. (1.60) 5. Staff were willing to see me as often as I felt it was necessary. (1.64) 7. Services were available at times that were good for me. (1.65)

Bottom 3 Questions (average scores)			
	2024 (Score)	**2023 (Score)**	**2022 (Score)**
CSDD Adults - MHSIP (Higher = Worse) 2024 n = 133; Avg Score = 1.83 2023 n = 201; Avg Score = 1.82 2022 n = 217; Avg Score = 1.88	31. I am better able to handle things when they go wrong. (2.75) 23. I am better able to deal with crisis. (2.74) 30. I am better able to take care of my needs. (2.55)	31. I am better able to handle things when they go wrong. (2.25) 23. I am better able to deal with crisis. (2.25) 28. My symptoms are not bothering me as much. (2.25)	26. I do better in school and/or work. (2.29) 23. I am better able to deal with crisis. (2.23) 31. I am better able to handle things when they go wrong. (2.22)

CSDD Adult Performance Across the MHSIP Subscales

- Scored Best: Access (91% agreement)
- Scored Worst: Functioning (64% agreement)
- All subscales decreased year-over-year from 2023 to 2024 for the MSHN region.
- Most subscales decreased year-over-year from 2023 to 2024 for CSDD Adult, except for Access and Quality/Appropriateness which increased from 2023 to 2024.
- Comparing CEI data to MSHN region data for 2024 only:
    - CSDD Adult scored above the regional average on General Satisfaction, Access, Quality/Appropriateness, Outcome of Services, and Social Connectedness.
    - CSDD Adult scored below the regional average on Participation in Treatment Planning and Functioning.



CSDD Adult vs Region (MHSIP) Average Scores: Lower = Better	2022 MSHN % Agreement	2022 CEI vs Region	2022 CEI % Agreement	2022 CEI Avg Score	2023 MSHN % Agreement	2023 CEI vs Region	2023 CEI % Agreement	2023 CEI Avg Score	2024 MSHN % Agreement	2024 CEI vs Region	2024 CEI % Agreement	2024 CEI Avg Score
General Satisfaction	93%	-8.43	85%	1.83	90%	-0.55	89%	1.65	88%	+0.46	88%	1.62
Access	91%	-9.45	82%	1.82	88%	+0.83	89%	1.70	87%	+3.70	91%	1.64
Quality and Appropriateness	93%	-3.84	89%	1.85	89%	-0.70	88%	1.81	88%	+1.38	89%	1.67
Participation in Treatment Planning	88%	-0.20	88%	1.68	85%	+2.28	87%	1.69	83%	-2.27	81%	1.71
Outcome of Services	70%	-2.47	68%	2.13	71%	+2.08	73%	2.03	69%	+0.64	70%	2.17
Functioning	69%	+6.50	75%	2.00	71%	+4.28	75%	1.97	69%	-4.54	64%	2.21
Social Connectedness	71%	+15.62	87%	1.73	74%	+18.27	92%	1.60	70%	+19.84	90%	1.62

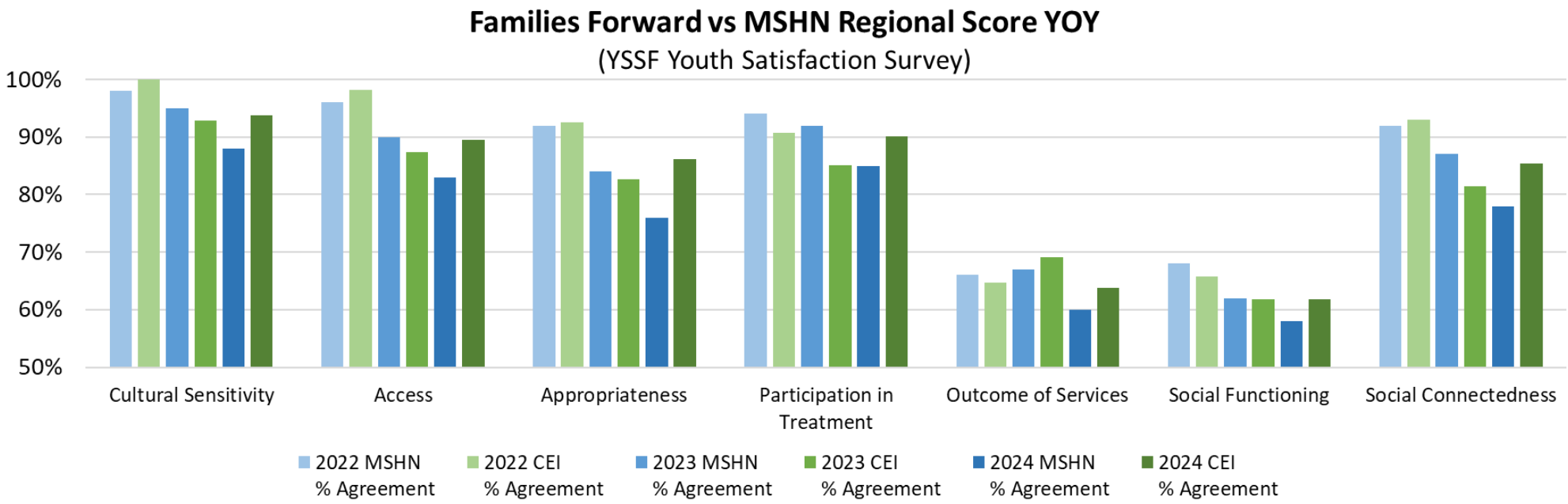
Families Forward

Top 3 Questions (average scores)						
	2024 (Score)		2023 (Score)		2022 (Score)	
Families Forward - YSSF (Higher = Better) 2024 n = 152; Avg Score = 4.22 2023 n = 127; Avg Score = 4.24 2022 n = 112; Avg Score = 4.33	12. Staff treated me with respect.	(4.74)	12. Staff treated me with respect.	(4.67)	12. Staff treated me with respect.	(4.85)
	14. Staff spoke with me in a way that I understood.	(4.72)	14. Staff spoke with me in a way that I understood.	(4.66)	14. Staff spoke with me in a way that I understood.	(4.83)
	13. Staff respected my family's religious/spiritual beliefs.	(4.57)	13. Staff respected my family's religious/spiritual beliefs.	(4.61)	13. Staff respected my family's religious/spiritual beliefs.	(4.73)

Bottom 3 Questions (average scores)						
	2024 (Score)		2023 (Score)		2022 (Score)	
Families Forward - YSSF (Lower = Worse) 2024 n = 152; Avg Score = 4.22 2023 n = 127; Avg Score = 4.24 2022 n = 112; Avg Score = 4.33	20. My child is better able to cope when things go wrong.	(3.41)	19. My child is doing better in school and/or work.	(3.59)	19. My child is doing better in school and/or work.	(3.56)
	21. I am satisfied with our family life right now.	(3.59)	21. I am satisfied with our family life right now.	(3.67)	20. My child is better able to cope when things go wrong.	(3.64)
	19. My child is doing better in school and/or work.	(3.61)	20. My child is better able to cope when things go wrong.	(3.79)	18. My child gets along better with friends and other people.	(3.72)

Families Forward Performance Across the YSSF Subscales

- Scored Best: Cultural Sensitivity (94% agreement)
- Scored Worst: Social Functioning (62% agreement)
- All subscales decreased year-over-year from 2023 to 2024 for the MSHN region.
- Most subscales increased year-over-year from 2023 to 2024 for Families Forward, except for Outcome of Services which decreased from 2023 to 2024.
- Comparing CEI data to MSHN region data for 2024 only:
    - Families Forward scored above the regional average on all subscales including Cultural Sensitivity, Access, Appropriateness, Participation in Treatment, Outcome of Services, Social Functioning, and Social Connectedness.



Families Forward vs Region (YSSF) Average Scores: Higher = Better	2022 MSHN % Agreement	2022 CEI vs Region	2022 CEI % Agreement	2022 CEI Avg Score	2023 MSHN % Agreement	2023 CEI vs Region	2023 CEI % Agreement	2023 CEI Avg Score	2024 MSHN % Agreement	2024 CEI vs Region	2024 CEI % Agreement	2024 CEI Avg Score
Cultural Sensitivity	98%	+2.00	100%	4.76	95%	-2.09	93%	4.63	88%	+5.71	94%	4.65
Access	96%	+2.18	98%	4.69	90%	-2.60	87%	4.51	83%	+6.47	89%	4.48
Appropriateness	92%	+0.59	93%	4.49	84%	-1.32	83%	4.33	76%	+10.09	86%	4.32
Participation in Treatment	94%	-3.35	91%	4.50	92%	-6.96	85%	4.33	85%	+5.13	90%	4.40
Outcome of Services	66%	-1.24	65%	3.75	67%	+2.11	69%	3.80	60%	+3.82	64%	3.73
Social Functioning	68%	-2.29	66%	3.73	62%	-0.21	62%	3.82	58%	+3.84	62%	3.75
Social Connectedness	92%	+0.94	93%	4.35	87%	-5.55	81%	4.26	78%	+7.33	85%	4.25

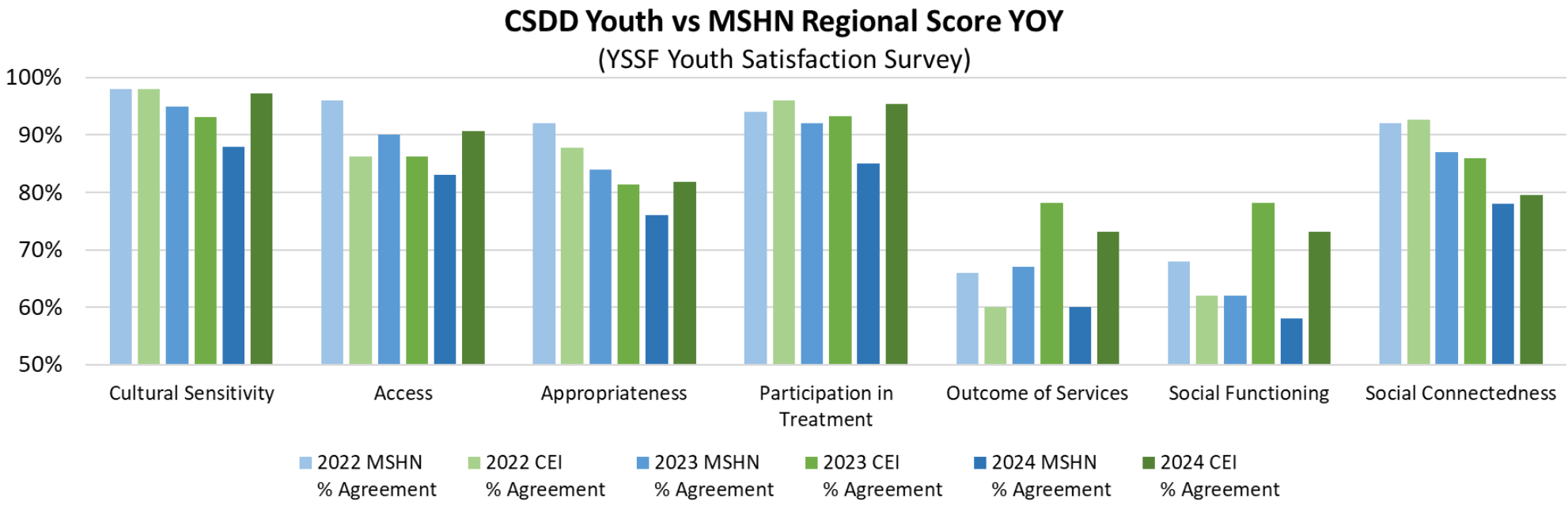
Community Services for the Developmentally Disabled (CSDD) Youth

Top 3 Questions (average scores)						
	2024 (Score)		2023 (Score)		2022 (Score)	
CSDD Youth - YSSF (Higher = Better) 2024 n = 44; Avg Score = 4.24 2023 n = 60; Avg Score = 4.25 2022 n = 51; Avg Score = 4.20	14. Staff spoke with me in a way that I understood.	(4.72)	12. Staff treated me with respect.	(4.57)	14. Staff spoke with me in a way that I understood.	(4.69)
	13. Staff respected my family's religious/spiritual beliefs.	(4.68)	14. Staff spoke with me in a way that I understood.	(4.55)	12. Staff treated me with respect.	(4.65)
	15. Staff were sensitive to my cultural/ethnic background (e.g., race, religion, language).	(4.62)	13. Staff respected my family's religious/spiritual beliefs.	(4.53)	6. I participated in my child's treatment/services.	(4.60)

Bottom 3 Questions (average scores)						
	2024 (Score)		2023 (Score)		2022 (Score)	
CSDD Youth - YSSF (Lower = Worse) 2024 n = 44; Avg Score = 4.24 2023 n = 60; Avg Score = 4.25 2022 n = 51; Avg Score = 4.20	20. My child is better able to cope when things go wrong.	(3.55)	20. My child is better able to cope when things go wrong.	(3.75)	20. My child is better able to cope when things go wrong.	(3.59)
	22. My child is better able to do things he or she wants to do.	(3.63)	22. My child is better able to do things he or she wants to do.	(3.91)	16. My child is better at managing daily life.	(3.72)
	16. My child is better at managing daily life.	(3.85)	21. I am satisfied with our family life right now.	(3.93)	19. My child is doing better in school and/or work.	(3.75)

CSDD Youth Performance Across the YSSF Subscales

- Scored Best: Cultural Sensitivity (97% agreement)
- Scored Worst: Social Functioning and Social Connectedness (73% agreement - tied)
- All subscales decreased year-over-year from 2023 to 2024 for the MSHN region.
- The majority of subscales increased year-over-year from 2023 to 2024 for CSDD Youth, except for Outcome of Services, Social Functioning, and Social Connectedness which decreased from 2023 to 2024.
- Comparing CEI data to MSHN region data for 2024 only:
    - CSDD Youth scored above the regional average on all subscales including Cultural Sensitivity, Access, Appropriateness, Participation in Treatment, Outcome of Services, Social Functioning, and Social Connectedness.



CSDD Youth vs Region (YSSF) Average Scores: Higher = Better	2022 MSHN % Agreement	2022 CEI vs Region	2022 CEI % Agreement	2022 CEI Avg Score	2023 MSHN % Agreement	2023 CEI vs Region	2023 CEI % Agreement	2023 CEI Avg Score	2024 MSHN % Agreement	2024 CEI vs Region	2024 CEI % Agreement	2024 CEI Avg Score
Cultural Sensitivity	98%	0.00	98%	4.62	95%	-1.90	93%	4.52	88%	+9.22	97%	4.66
Access	96%	-9.73	86%	4.39	90%	-3.79	86%	4.36	83%	+7.70	91%	4.55
Appropriateness	92%	-4.24	88%	4.21	84%	-2.64	81%	4.22	76%	+5.82	82%	4.26
Participation in Treatment	94%	+2.00	96%	4.47	92%	+1.22	93%	4.46	85%	+10.45	95%	4.49
Outcome of Services	66%	-6.00	60%	3.76	67%	+11.18	78%	3.96	60%	+13.17	73%	3.85
Social Functioning	68%	-6.00	62%	3.73	62%	+16.18	78%	3.96	58%	+15.17	73%	3.85
Social Connectedness	92%	+0.59	93%	4.14	87%	-1.04	86%	4.30	78%	+1.55	80%	4.19

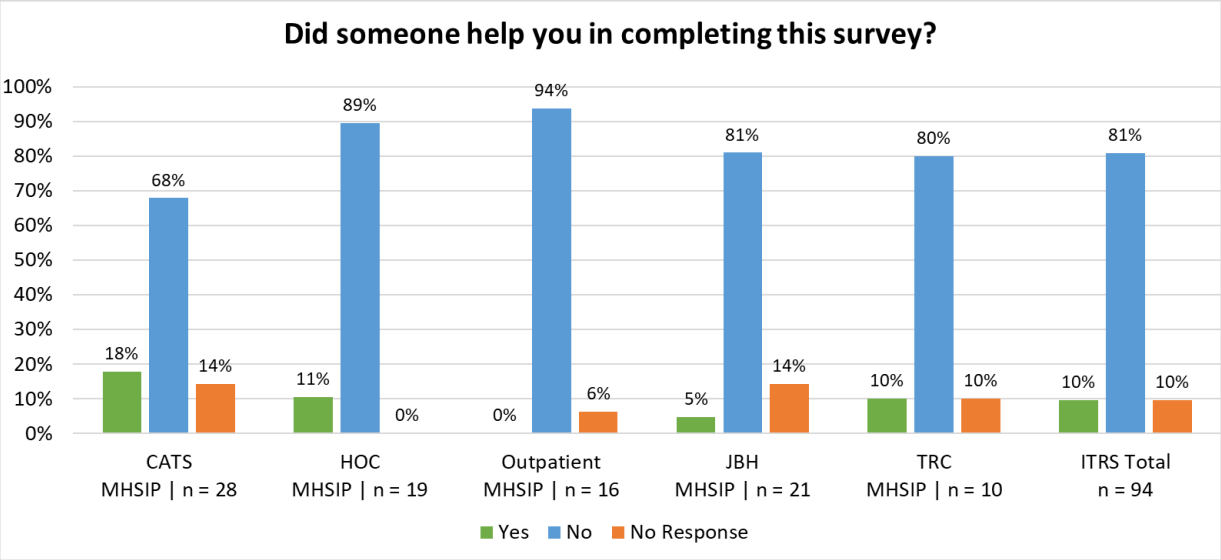
Findings – ITRS Programs

In 2024, the MHSIP adult satisfaction survey described above was distributed by Integrated Treatment & Recovery Services (ITRS) to 94 consumers across 5 programs:

- Correctional Assessment & Treatment Services (CATS) – Ingham County jail
- The House of Commons (HOC) – residential treatment
- ITRS Outpatient (OP) – outpatient treatment
- Justice Behavioral Health (JBH) – mental health
- The Recovery Center (TRC) – detox services

CATS and JBH scored below the MSHN regional average on most subscales while HOC, OP, and TRC outperformed the region on most subscales. The largest discrepancies between the region and ITRS programs occurred in the subscales of Access, Functioning, and Social Connectedness.

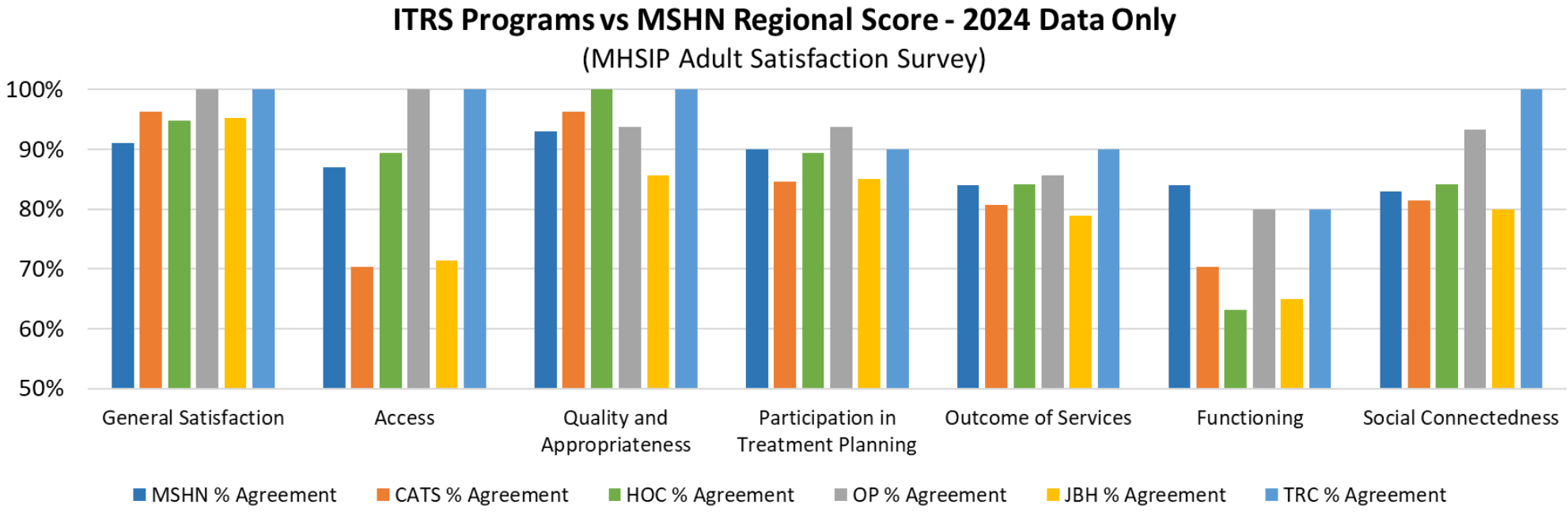
CATS was the ITRS only program surveyed where a significant portion of consumers received assistance completing the survey. Many HOC and TRC respondents also received assistance.



In previous years, a specialized substance use disorder (SUD) satisfaction survey was distributed to treatment programs to assess quality of consumer care. The switch to the general MHSIP adult satisfaction survey occurred region-wide. Year-over-year analysis is not yet possible as a different survey was used in 2023. Data from 2024 will be used as a baseline for comparison in the future.

Analysis of Findings – ITRS Programs

- Questions are scored on a scale of 1 to 5 with lower numerical scores indicating greater performance
- The average satisfaction score across all MHSIP subscales and ITRS programs was 1.72
- Overall, TRC had best average score with 1.40 while CATS had the worst average score with 1.87
- Scored Best (across all programs): General Satisfaction – 97% agreement, average score of 1.42
- Scored Worst (across all programs): Functioning – 70% agreement, average score of 1.93



ITRS Programs vs Region (MHSIP) Average Scores: Lower = Better	MSHN % Agreement	CATS vs Region	CATS % Agreement	CATS Avg Score	HOC vs Region	HOC % Agreement	HOC Avg Score	OP vs Region	OP % Agreement	OP Avg Score	JBH vs Region	JBH % Agreement	JBH Avg Score	TRC vs Region	TRC % Agreement	TRC Avg Score
General Satisfaction	91%	+5.30	96%	1.51	+3.74	95%	1.46	+9.00	100%	1.33	+4.24	95%	1.48	+9.00	100%	1.10
Access	87%	-16.63	70%	2.08	+2.47	89%	1.58	+13.00	100%	1.46	-15.57	71%	1.94	+13.00	100%	1.22
Quality and Appropriateness	93%	+3.30	96%	1.76	+7.00	100%	1.52	+0.75	94%	1.42	-7.29	86%	1.71	+7.00	100%	1.14
Participation in Treatment Planning	90%	-5.38	85%	1.63	-0.53	89%	1.58	+3.75	94%	1.28	-5.00	85%	1.60	0.00	90%	1.20
Outcome of Services	84%	-3.23	81%	1.95	+0.21	84%	1.81	+1.71	86%	1.78	-5.05	79%	2.05	+6.00	90%	1.65
Functioning	84%	-13.63	70%	2.01	-20.84	63%	1.84	-4.00	80%	1.70	-19.00	65%	2.05	-4.00	80%	1.98
Social Connectedness	83%	-1.52	81%	1.90	+1.21	84%	1.72	+10.33	93%	1.67	-3.00	80%	1.84	+17.00	100%	1.47

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 the 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.

In 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 19 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's current CARF Accreditation runs through June 2026. An application for re-accreditation will be completed by December 2025 for a survey in the summer of 2026. Current CARF-accredited CMHA-CEI programs are:

CMHA-CEI Department	CMHA-CEI Program	CARF Core Program
AMHS	ACT - Cedar	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
Families Forward	Parent-Young Child Program	Intensive Family Bases Services – Early Intervention
Families Forward	Parent-Infant Program	Intensive Family Bases Services – Early Intervention
Families Forward	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

The QI Team is 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 data from performance indicators, satisfaction surveys, incident reports, and other internal QI initiatives. Additional information on performance can be found in the annual Quality Improvement Plan (QIP) and QIP Evaluations found online here: http://ceicmh.org/about-us/quality-and-compliance

Findings, Recommendations, and Accreditation Timeline

CARF Survey and Accreditation Timeline		
Date	Action	Comment
June 30, 2023	CMHA-CEI Received full accreditation through 2026 as the result of Virtual Survey	
September 5, 2023	CARF QIP reviewed at Quality Improvement and Compliance Committee	Reviewed recommendations and action items for QIP. Assigned responsibilities to programs and Directors with target deadlines
October 31, 2023	Submitted QIP to CARF	
June 30, 2024	Submit Annual Conformance to Quality Report to CARF	Update on QIP Timeline
January 7, 2025	Review of CARF QIP at QICC Meeting	Review QIP from last CARF survey, look at potential additional programs to be added in 2026.

June 30, 2025	Submit Annual Conformance to Quality Report to CARF	Update on QIP Timeline
December 31, 2025	Application for CARF Reaccreditation	Survey to be scheduled Summer of 2026
June 2026	CARF Survey – On Site	

CARF Findings and Recommendations at a Glance	
Responsible Program	CARF Recommendation
QI/QCSRR	• Assist all programs and administrative units in implementing changes • Chart reviews highlighting specific recommendations
Finance	• Annual Review of Contracts
Human Resources	• Annual Review of Procedures • Workforce and Succession Planning • Code of Ethics (Addressing Peer Support Services and boundaries) • Diversity, Equity, and Inclusion Plan
Information Systems	• Records in EHR be completed and legible – addressing missing information in Assessment and other fields
Properties & Facilities	• Annual review of procedures, tests, drills, and safety inspections
Medical Director	• Updates to Medication Procedures and Physician Peer Review
Clinical Programs	• Uniform use of supervision notes and Suicide Screening • Updates to Guidelines or Program Descriptions to emphasize admission standards and decision making • CATS: Updates to Person Centered Planning that addresses CARF Standards

Policy and Procedure Review

CMHA-CEI hosts 427 active files in PolicyStat, a cloud-based Document Management System. This includes 127 Policies, 238 Procedures, 45 Operating Guidelines, and 17 Forms/User Guides. The system is available for all staff to view and for applicable staff to edit and manage documents. CMHA-CEI has fully transitioned all agency Policies and Procedures into PolicyStat. This transition remains ongoing for program Operating Guidelines and other miscellaneous files such as Forms, User Guides, and Plans.

All agency Policies and Procedures are required to be reviewed at least annually. The review process for Policies and Procedures is built into the PolicyStat system, with specific areas and approval workflows for each document type. The system automatically prompts applicable staff for annual updates and reviews to maintain 100% compliance with CARF and other applicable standards.

The following report from PolicyStat tracks the average lifetime workflow turnaround time for Policies and Procedures since the system went live in FY22:

Policy/Procedure Area	Average Days for Approval	Average # of Review Steps	Average Days Per Step
Administrative Policies	27.3	2.5	11
Administrative Procedures	28.9	2.7	10.8
Clinical Policies	21.8	2.7	8.1
Clinical Procedures	24.8	2.6	9.4
Finance Policies	33.3	2	16.6
Finance Procedures	30.1	2	15
Human Resources Policies	16.7	2	8.3
Human Resources Procedures	5.8	2	2.9

The Quality Improvement Team continues to integrate agency Operating Guidelines into PolicyStat. To date, 45 Operating Guidelines have been converted:

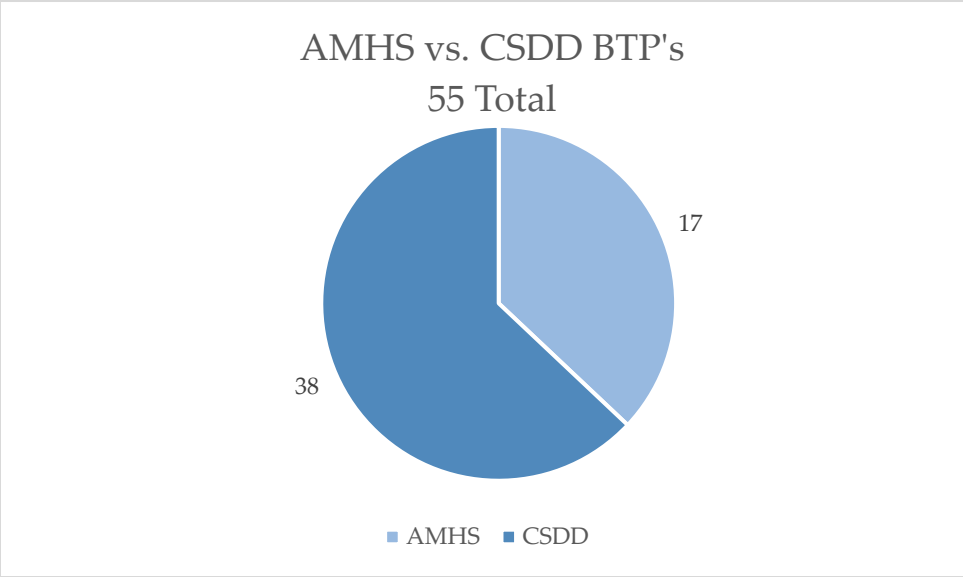
Guideline Area	#	Sub-Areas (if applicable)
Admin Guidelines	31	Access, Admin (General), Corporate Compliance, Customer Service, Property/Facilities, Recipient Rights
Clinical Guidelines	8	N/A – Only Clinical
Finance Guidelines	1	N/A – Only Finance
MI-Adult Guidelines	3	AMHS, Crisis Services
Utilization Management	2	N/A – Only UM

QI has the goal of having all remaining Operating Guidelines converted into PolicyStat and managed by the applicable program in the system by the end of FY25:

Area	Operating Guidelines	Status	Goal
Clinical	8 Files	All Complete Conversion Finalized	Complete
Utilization Management	23 Files	2 Complete 21 Archived Conversion Finalized	Complete
ITRS	118 Files	In Progress All Drafts	Finalize Q1 2025
Admin	42 Files	31 Complete 5 Archived 6 TBD	Q1 2025
Finance	13 Files	1 Complete 12 TBD	Q1 2025
CSDD	~95 Files	All TBD	Q1/Q2 2025
MI-Adult	92 Files	3 Complete 7 Drafts 82 TBD	Q2 2025
MI-Child	72 Files	All TBD	Q3 2025

Behavior Treatment Committee (BTC)

CMHA-CEI's Behavior Treatment Committee conducts expedited, quarterly, annual, and new plan reviews. All Behavior Treatment Plans are monitored through CHMA-CEI's Behavior Treatment Committee which serve several consumers from various agencies throughout the tri-county area. The BTC consists of the Medical Director, AMHS Representatives, CSDD Representatives, Recipient Rights (ex-officio), and QI staff.



Clinician Agency	# of BTPs
CMHA-CEI	34
Gage Consulting	7
ROI	4
Great Lakes Center for Au	4
Flatrock	4
Total Spectrum	1
Centria Healthcare	1

Incident Reporting

Incident categories include consumer deaths, medication errors, emergency care, behavioral episodes, arrests, physical illness, and injuries. Incident report data is reviewed by CIRC for policy review and implementation, patterns, trends, compliance, education and improvement, and presentation to QICC.

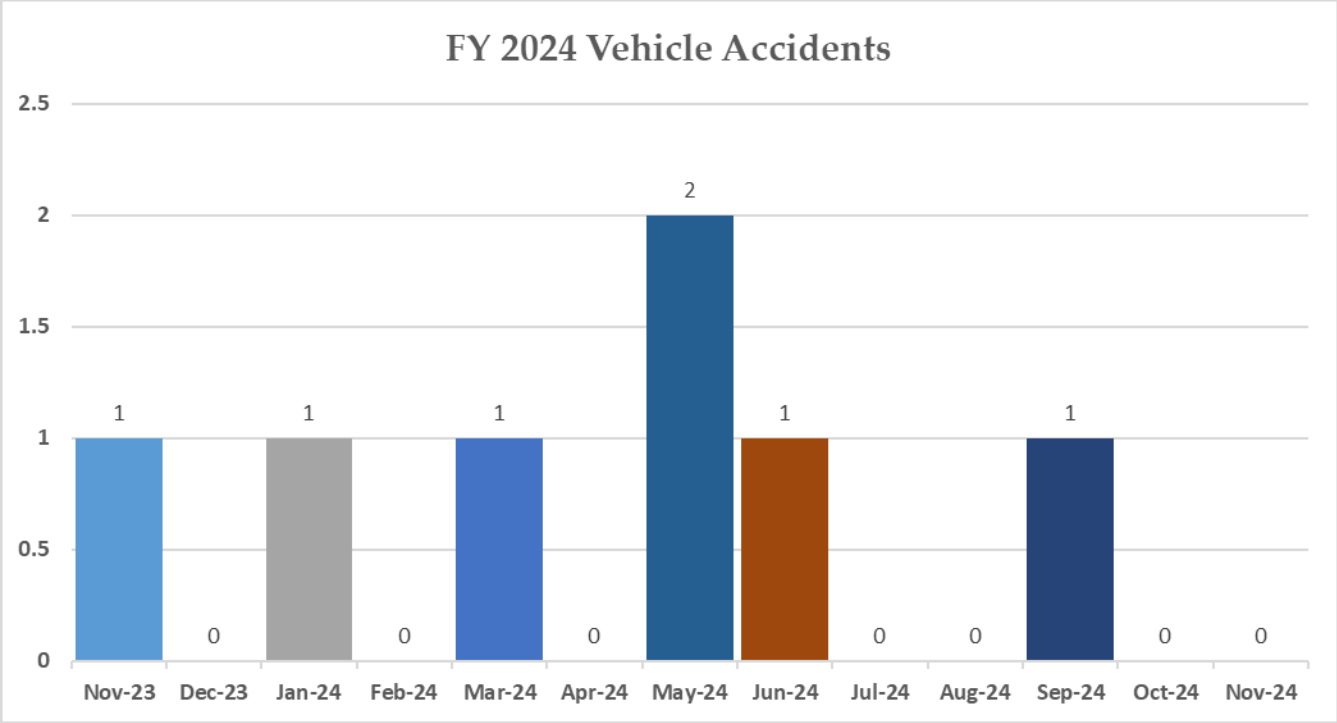
Sentinel Event Reports

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 – FY 2024	Total
Death	16
Suicide	7
Overdose	6
Choking	2
Homicide	1

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.



Grievances, Appeals, and Fair Hearings

When a consumer/guardian has a complaint, 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 three 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.

	FY22	FY23	FY24
# of Grievances	16	13	19
# of Appeals	7	8	12
# of Fair Hearings	0	2	1

Provider Monitoring

Overview

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

- Applied Behavior Analysis/Autism provider
- Hospitals/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 3 types of site visits annually, a Recipient Rights (RR) review, a Quality and Compliance (Q&C) review, and a Home and Community Based Services (HCBS) review, if necessary. Items reviewed during the site visits include:

- Recipient Rights standards and 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 are completed for all in-catchment sites. An option for virtual reviews are available for out-of-catchment sites, and rely on collaboration with other local CMHs to obtain reciprocity review.

2024 Site Visits

- There were 264 contracted providers in 2024. A breakdown of contract type and catchment is shown on figures 1 and 2.
    - 161 (61%) sites are in-catchment and 103 (39%) are out-of-catchment.

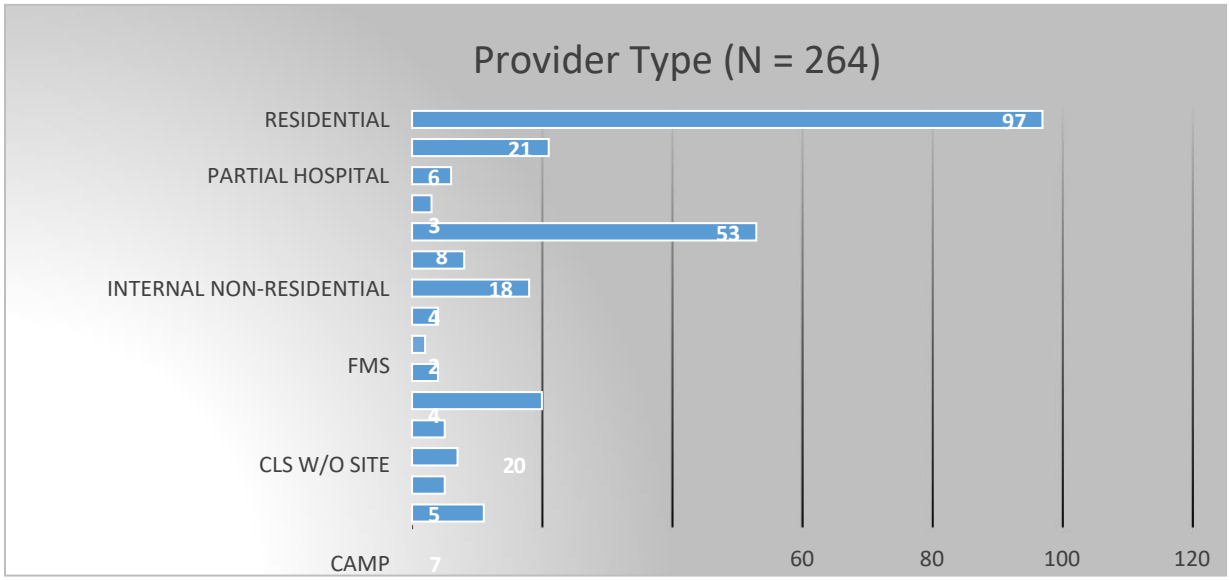


Fig.1. Type of Provider contracted in 2024.

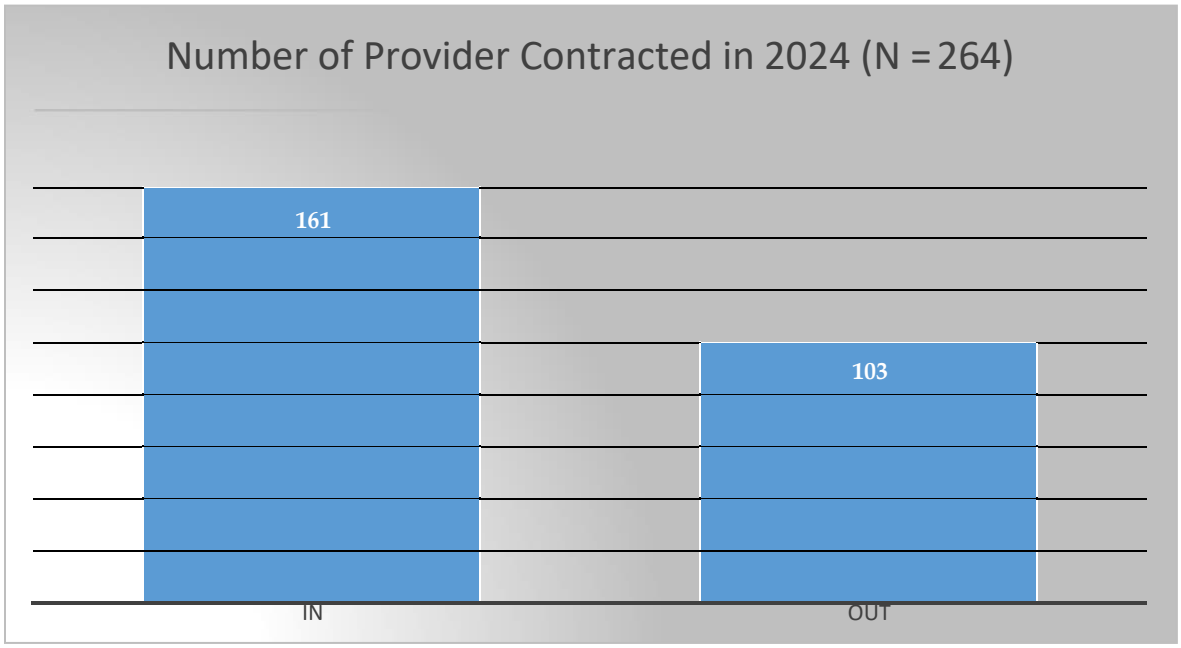


Fig 2. Number of contracted providers according to catchment (In = located within tri-county areas. Out = located outside the tri-county areas).

276 Site reviews were completed in 2024, a 13% increases from 2023 (completed 240 reviews).

- Some sites were visited multiple times due to comply with site visit protocol and in accordance to Recipient Rights standards.
- With the exception of August, there were more than 15 site visits completed for each month (Fig. 3).

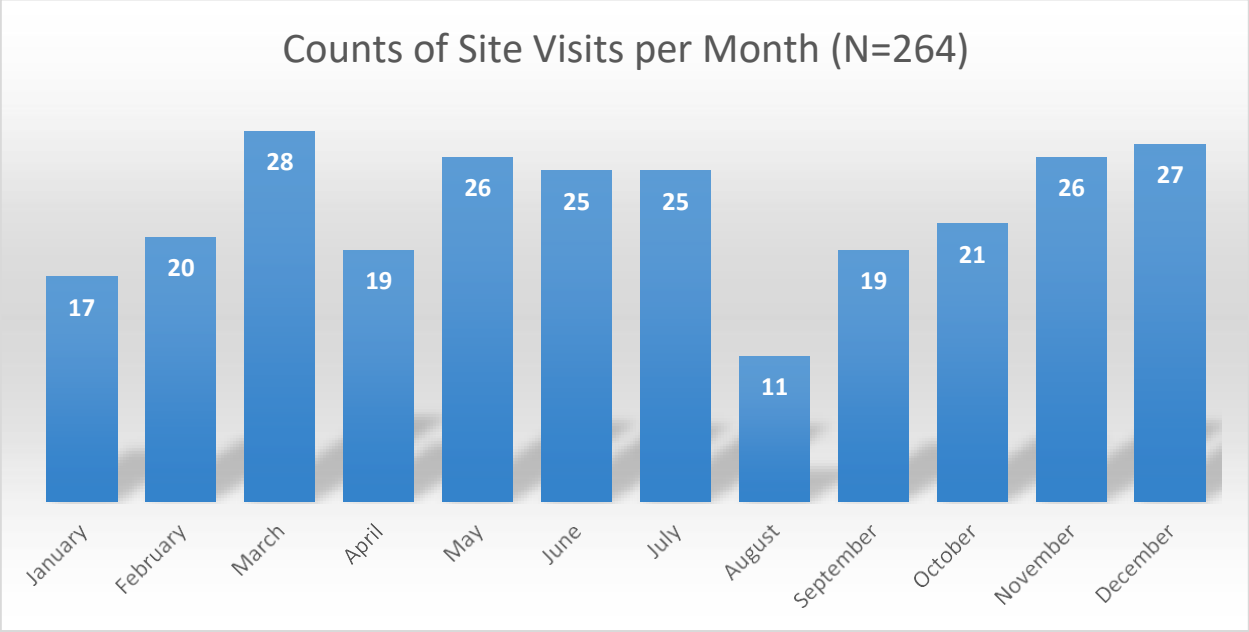


Fig 3. Count of site visits per month in 2024.

As shown on figures 4 and 5, on average, it took provider 50 days to come into compliance (from initial visit date to full compliance), which was slight improvement from 2023 (52 days).

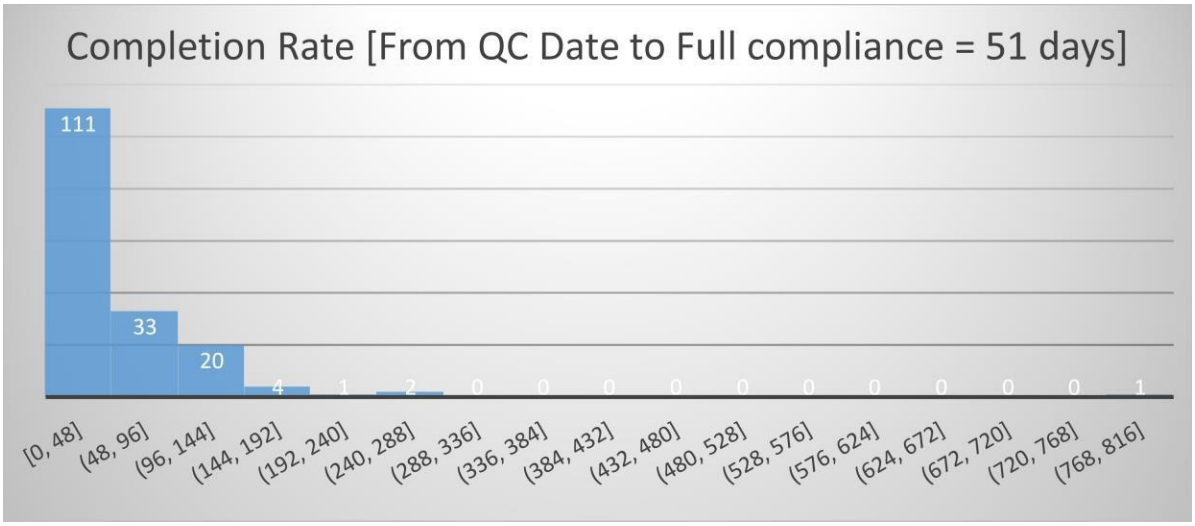


Fig 4. The average completion rate from QC date to full compliance.

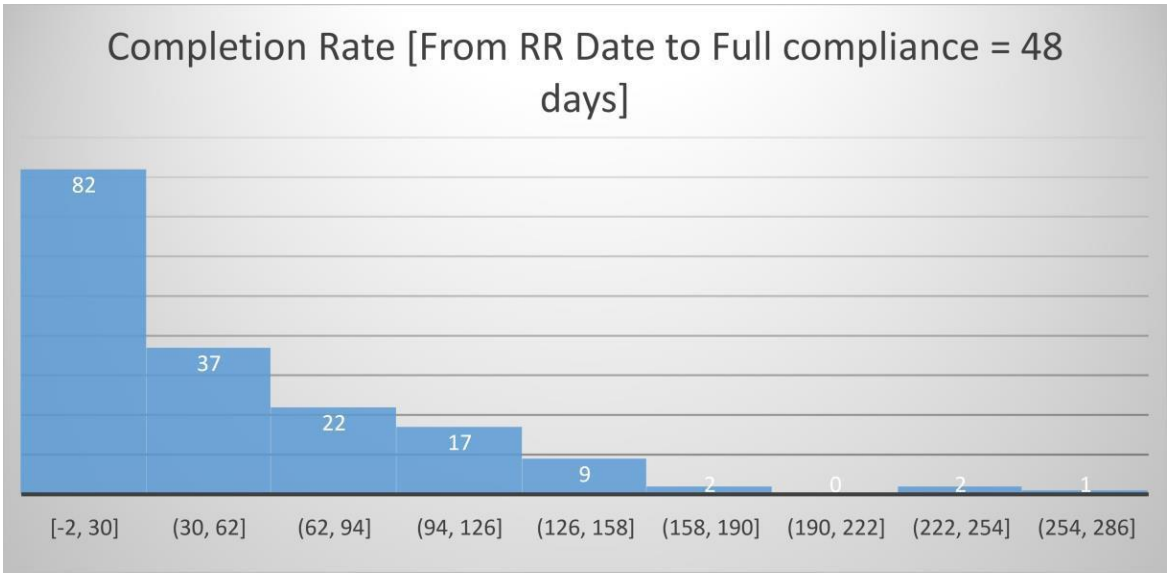


Fig 5. The average completion rate from RR date to full compliance.

2004 POC Data

In 2024, Quality Advisors developed and implement additional process to tract POC data for only selected type of provider. Several standards were selected for this process and it included POC related to medication, IPOS training, IPOS training for other plans, RRO training, incident reporting, and MEV documentation. Additional data tracking included POC that required 90 days monitoring due to RRO, OIG checks, Controlled substances and MEV standards. Below is the breakdown of the type of provider that POC data was collected (N = 170),

- 98 In-Catchment Residential sites
- 45 OOC Residential sites
- 4 CEI internal Residential sites
- 6 CLS with sites and 16 CLS without sites
- 1 Partial Hospital (in-catchment)

Several sites needed 90 days monitoring following the completion of POC,

- One site needed 90 days monitoring due to MEV
- Nine sites needed 90 days monitoring due to OIG checks
- Seven sites needed 90 days monitoring due to Controlled Sub counts
- Nine sites needed 90 days monitoring due to RRO training

The following graphs represents POC data on different standards.

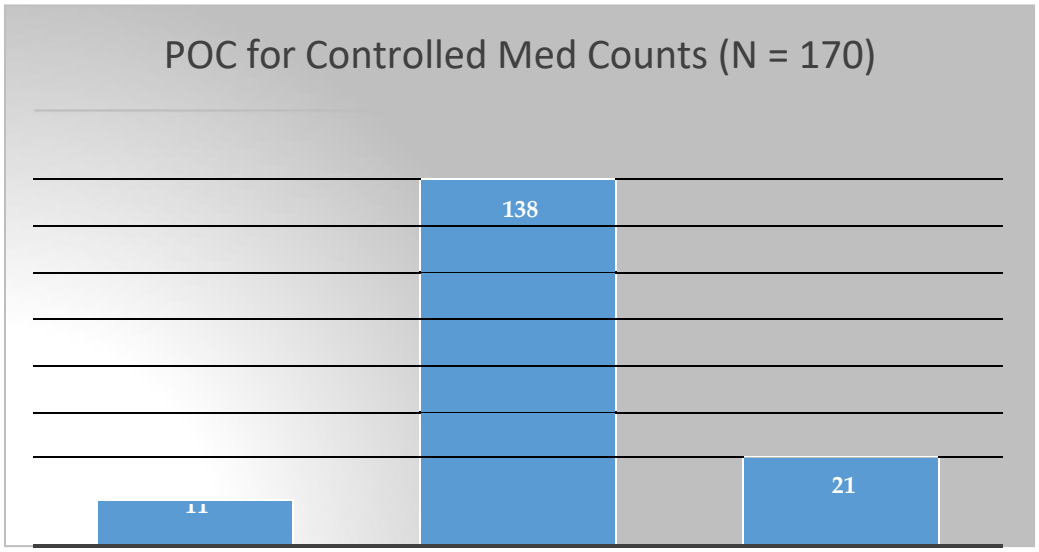


Fig 6. Number of sites that required Plan of Correction (POC) due to Controlled Substance.

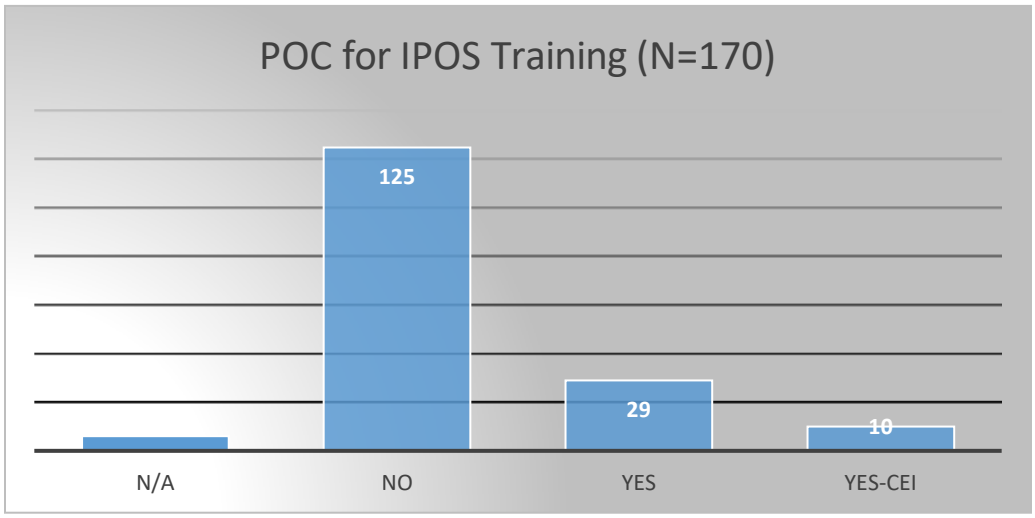


Fig 7. Number of sites that required Plan of Correction (POC) due to IPOS training.

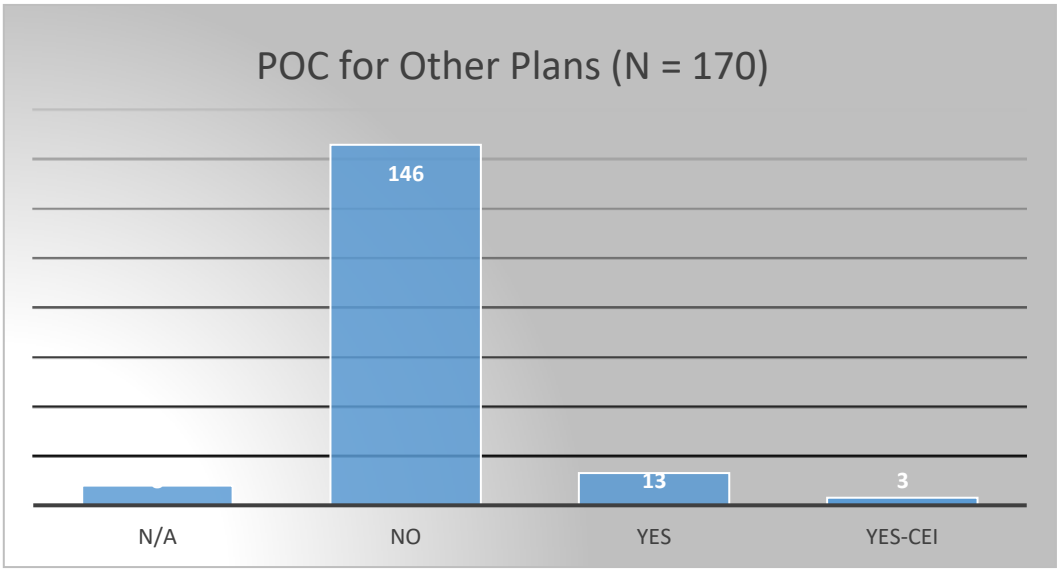


Fig 8. Number of sites that required Plan of Correction (POC) due to Other Plans training (i.e., BTP, Nutrition, and others).

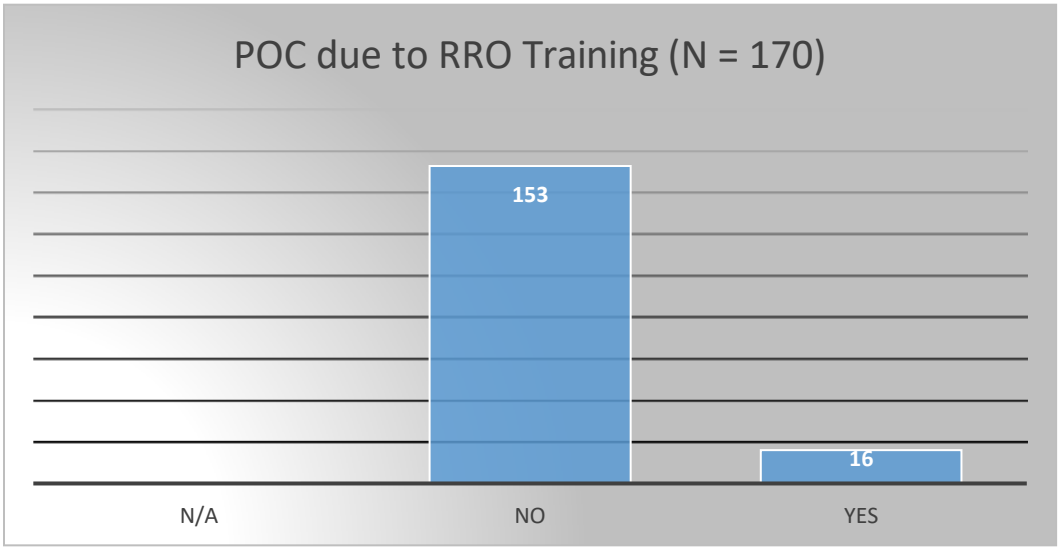


Fig 9. Number of sites that required Plan of Correction (POC) due to RRO training.

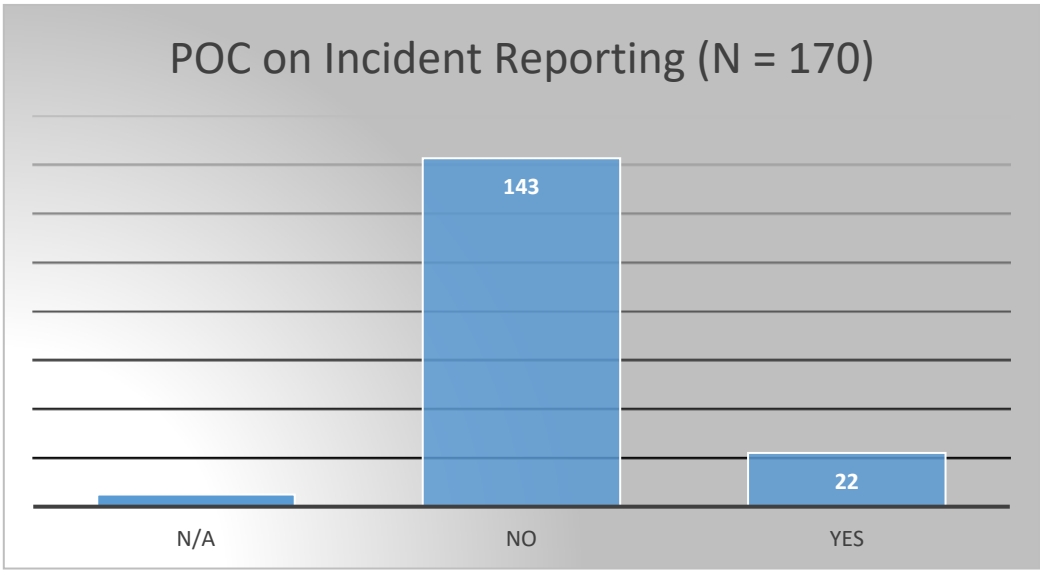


Fig 10. Number of sites that required Plan of Correction (POC) due to Incident Reporting.

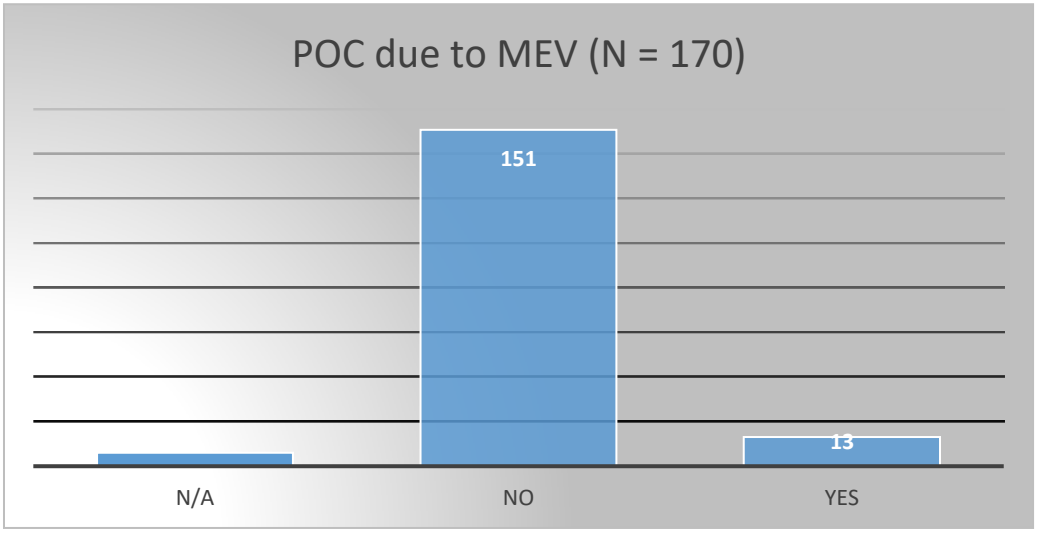


Fig 11. Number of sites that required Plan of Correction (POC) due to MEV.

Improvement Opportunities

Our vision is to facilitate ongoing collaboration by providing support, advocacy and education to contracted service providers. Quality Advisor will be maintaining electronic site visit files, and fidelity reviews of the folders to ensure preparation for upcoming audits (June 2025). Additionally, Quality advisors along with Contract & Finance Dept. and Clinical programs continue to assist providers in the following areas in the coming year:

- Support efforts to move providers to all electronic training
- Allocation of more online resource to cut down operating cost (utilize free online services for human resource management i.e., OIG checks, IChat, etc.)
- Collaborate with other CMHs to improve review process for Out of Catchment sites (i.e., Reciprocity process)
- Enhance the use of CMHA-CEI provider access portal
- Utilize onboarding process to address important topics pertained to compliance (Contract & Finance, and QA's)
- Assisting providers navigate unique challenges caused by the pandemic or any other natural disasters
- Continue to revise site visit process and documentation to improve efficiency
- Collect, review, and assess site visit POC data on a regular basis to make informed choices and target areas for improvement.
- Create site visit specific questions for provider survey.

FY24 Chart Review Results

Chart Review Process

Chart reviews are completed on a quarterly basis by the Quality Improvement and Utilization Management team. Specific programs/units to be chart reviewed are selected through the Quality Improvement and Compliance Committee and by Program request. A random sample of consumer charts are selected for the Clinical Program that is being reviewed, including charts for consumers that have been discharged from services.

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 forwards the results to the Clinical Programs. QI schedules 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 are discussed quarterly at the Quality Improvement and Compliance Committee.

Chart Review Schedule

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

Timeframe	Programs for Chart Review
FY24 1st Quarter	ITRS
FY24 2nd Quarter	AMHS & CSDD - 1915i
FY24 3rd Quarter	FF
FY24 4th Quarter	CSDD

Chart Review Results

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

FY24 Quarter 1 – ITRS

Standard	House of Commons		The Recovery Center		Corrections and Treatment Services		ITRS Outpatient		Total ITRS	
	Total Charts	%	Total Charts	%	Total Charts	%	Total Charts	%	Total Charts	%
Is Client Info (Admin) section on sexual orientation completed? Or is info in another spot?	26	56%	27	37%	25	92%	26	88%	104	68%
Intake/Assessment										
At point of initial contact, provider collected the following: • Date of initial contact, Signature of Staff Person Collecting Information, Follow-up Communication(s) • Presenting Issue • Priority Population Status • Eligibility Determination • ASAM Level of Care Determination	26	96%	27	94%	25	94%	26	96%	104	95%
In addition to required screening information captured in REMI, there is evidence of screening for: • HIV/AIDS, STD/Is, TB, Hepatitis • Trauma	26	73%	27	81%	25	84%	26	88%	104	82%
Evidence consumer has received information regarding: • General nature and objectives of the program • Notice of Privacy • Consent to Treatment • Advanced Directives • Member Handbook • SUD Recipient Rights	26	96%	27	87%	25	96%	26	92%	104	93%
Consumer strengths are documented. Examples of strengths might be a health support network, stable housing, a willingness to participate in counseling, etc.	26	90%	27	89%	25	98%	26	96%	104	93%
FASD - The following circumstances should prompt a clinician to complete a screen to determine if there is a need for a diagnostic	14	100%	15	93%	16	100%	18	94%	63	97%

referral: When prenatal alcohol exposure is known and other FAS characteristics are present, a child should be referred for a full FASD evaluation when substantial prenatal alcohol use by the mother, the client will be referred to the primary care physician for further assessment. When information regarding prenatal exposure is unknown, a child should be referred for a full FASD evaluation.										
Initial assessment and/or timely reassessment contains required elements: • ASAM Level of Care Determination is justified and meets the needs of consumer. • Provisional DSM Diagnosis • Clinical Summary • Recommendations for Care • MDOC referred individuals provided assessment regardless of screening documentation .	26	88%	27	91%	25	94%	26	85%	104	89%
Screening completed for Gambling Disorder in REMI. If screen was positive, the 10-question assessment was completed.	22	14%	19	11%	20	53%	20	93%	81	42%
Individual Treatment/Recovery Planning and Documentation										
Initial treatment plan is developed before consumer is engaged in extensive therapeutic activities: • Outpatient – during/before 3rd session • Residential – within 72-hours of admission • Detoxification – within 72-hours of admission	26	94%	24	75%	25	100%	26	88%	101	90%
Is there evidence of strength-based treatment and recovery planning	26	94%	25	68%	25	96%	24	85%	100	86%
Plan(s) address needs/issues identified in assessment(s) (or clear documentation of why issue is not being addressed) including but not limited to: • Substance Use Disorder(s) • Medical/Physical Wellness • Co-Occurring D/O	26	90%	23	65%	25	92%	24	85%	98	84%

• History/Risk/Present Trauma • Gambling										
Plan includes the following: 1. Matching goals to needs – Needs from the assessment are reflected in the goals on the plan. 2. Goals are in the client's words and are unique to the client – No standard or routine goals that are used by all clients. 3. Measurable objectives – The ability to determine if and when an objective will be completed. 4. Target dates for completion – The dates identified for completion of the goals and objectives are unique to the client and not just routine dates put in for completion of the plan. 5. Intervention strategies – the specific types of strategies that will be used in treatment – group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc. 6. Signatures – client, counselor, and involved individuals, or documentation as to why no signature. 7. Recovery planning activities are taking place during the treatment episode	26	81%	25	52%	25	82%	24	71%	100	72%
Frequency of periodic reviews of the plan are based on the time frame in treatment and any adjustments to the plan. • Outpatient – minimal 90-day • Residential/Withdrawal Management – 7-day	22	59%	14	50%	17	88%	17	82%	70	70%
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	5	70%	8	75%	4	100%	14	93%	31	85%

individuals not receiving services and supports from the mental health system.										
The treatment and recovery plan progress review to check for: 1. Progress note information matching what is in review. 2. Rationale for continuation/discontinuation of goals/objectives. 3. New goals and objectives developed with client input. 4. Client participation/feedback present in the review. 5. Signatures, i.e., client, counselor, and involved individuals, or documentation as to why no signature	25	86%	18	50%	16	91%	16	75%	75	76%
Case management services shall be guided by each client's individualized treatment plan. Treatment plan review(s) will incorporate case management goals and outcomes with targeted completion dates that are consistent with the treatment plan and are reflected and/or modified in treatment plan review(s).	18	89%	13	81%	20	88%	12	88%	63	87%
Record Documentation & Progress Notes										
An evidence-based practice was used and documented in the record for trauma.	25	24%	23	54%	23	100%	25	92%	96	67%
Progress notes reflect information in treatment plan(s): • Identify what goal/objective(s) were addressed during a treatment session • Individual and group sessions that the person participates in must address or be related to the goals and objectives in the plan Document progress/lack of progress toward meeting goals.	26	88%	23	78%	22	91%	17	85%	88	86%
An evidence-based practice was used and documented in the record.	23	48%	23	50%	20	80%	22	86%	88	65%
Services are provided as specified in the plan(s).	26	77%	21	62%	22	80%	19	58%	88	70%
Coordination of Care										
There is evidence of primary care physician coordination of care efforts.	20	80%	24	79%	22	59%	22	52%	88	68%
There is evidence of coordination of care with external entities including, but not limited to, legal system, child welfare system, and behavioral healthcare system.	21	90%	17	85%	17	85%	16	81%	71	86%

• MDOC referred individuals have evidence of at least monthly coordination (sent by the 5th day of the following month) between agency and supervising agent										
There is evidence of effective coordination of care for any consumer currently or previously enrolled with external SUD provider and coordinating care efforts align with best practice guidelines.	16	88%	12	92%	11	91%	15	83%	54	88%
There is evidence that provider makes appropriate referrals and documents follow-up and outcomes, as is applicable to meet the consumer/family needs.	24	85%	24	90%	15	90%	20	75%	83	85%
Discharge/Continuity of Care										
Discharge Summary includes all Continuum of Care Detail(s) including next provider contact information, date/time of intake appointment, relevant information etc.	23	72%	25	66%	15	87%	13	81%	76	74%
MDOC referred individuals have evidence of the following (with appropriate release): • Provider will ensure a recovery plan is completed and sent to the supervising agent within five (5) business days of discharge- plan must include individual's knowledge of plan and any aftercare services • Provider will ensure documentation of informing the client's supervising agent prior to any discharge due to violation of program rules/regulations except in extreme circumstances. Provider will collaborate with the supervising agent for any non-emergency discharge of the referred individual and allow the MDOC time to develop a transportation plan and/or a supervision plan prior to removal.	1	0%	N/A	N/A	2	50%	2	0%	5	20%
Consumer's treatment episode is summarized including: • Status at time of d/c (Status may include prognosis, stage of change, met & unmet needs/goals/objectives, referrals &/or follow-up information) • Summary of received services/ participation • Discharge rationale is clearly & accurately documented	25	86%	26	83%	17	100%	17	79%	85	86%
Residential										

Residential detoxification At the time of admission and prior to any medications being prescribed or services offered, the medical director, a physician, physician's assistant, or advanced practice registered nurse shall complete and document the medical and drug history, as well as a physical examination, of the recipient. Residential The recipient record for residential service categories shall also include medical history and physical examination	8	81%	22	84%	2	0%	3	50%	35	76%
Residential Treatment PROVIDER must assure all consumers entering residential treatment will be tested for TB upon admission and the test result is known within five (5) days of admission	18	100%	19	100%	2	50%	3	17%	42	92%
Chart reflects services provided in accordance with the ASAM LOC Determination. • 3.1 = 5 hours Core Services & 5 hours Life Skills/week • 3.3= 13 hours Core Services & 13 hours Life Skills/week • 3.5 & 3.7 = 20 hours Core Services & 20 hours Life Skills/week	18	92%	16	84%	4	75%	7	86%	45	87%
MDOC Referred Individuals ONLY (with proper release): • Individual referred does not appear or is deemed to not meet residential medical necessity the provider will notify the supervising agent within one (1) business day • Referred individual may not be given unsupervised day passes, furloughs, etc without consultation with the supervising agent. • Leaves for any non-emergent medical procedures should be reviewed/coordinated with the supervising agent • If a MDOC referred individual leaves an off-site supervised therapeutic activity without proper leave to do so, the provider must notify the supervising agent by the day on which the event occurred. • The PIHP/designated provider may require individuals participating in residential treatment to submit to drug	1	100%	N/A	N/A	N/A		N/A	N/A	1	100%

testing when returning from off property activities and any other time there is a suspicion of use. Positive drug test results and drug test refusals must be reported to the Supervising Agent.										
MDOC-Additional reporting notifications for individuals receiving residential care include: • Death of an individual under supervision. • Relocation of an individual's placement for more than 24 hours. • The PIHP/designated provider must immediately and no more than one hour from awareness of the occurrence, notify the MDOC Supervising Agent any serious sentinel event by or upon an individual under MDOC supervision while on the treatment premises or while on authorized leaves. • The PIHP/designated provider must notify the MDOC Supervising Agent of any criminal activity involving an MDOC supervised individual within one hour of learning of the activity.	1	100%	N/A	N/A	N/A		N/A	N/A	1	0%
Medication Assisted Treatment										
Documentation that a medical evaluation, including a medical history and physical examination, has been performed before the patient receives the initial methadone or Suboxone dose. (However, in an emergency situation the initial dose of methadone may be given before the physical examination).	2	50%	1	100%	N/A		N/A	N/A	3	67%
Documented random toxicology testing. SUBOXONE ONLY: toxicology screens must be done at intake and then randomly, at least weekly, until 3 consecutive screens are negative. Methadone ONLY: consumer screened weekly. Monthly only occurs after 6-months of consecutive negative screens. Any positive screen results in new 6-month cycle of weekly screens.	2	50%	2	50%	N/A		N/A	N/A	4	50%

Copies of the prescription label, pharmacy receipt, or pharmacy print out, must be included in the individual's chart or kept in a "prescribed medication log" that must be easily accessible for review.	3	67%	N/A	N/A	N/A		N/A	N/A	3	0%
Documented review of Michigan Automated Prescription System (MAPS) is included in the client file at admission, a prior to any off-site dosing, and prior to any reauthorization requests. Note: Per MDHHS guidance, the MAPS report cannot be placed in the individual's chart. Information can be documented in the chart.	3	0%	N/A	N/A	N/A		N/A	N/A	3	0%
Documentation that there is coordination of care with prescribing physician when there are prescriptions for controlled substances.	2	50%	N/A	N/A	N/A		N/A	N/A	2	0%
All alcohol use and illicit drug use during treatment is addressed in treatment and documented in Progress Notes.	2	50%	N/A	N/A	N/A		1	100%	3	67%
Women's Designated										
There is an assessment of needs completed on consumer & each dependent child.	N/A	N/A	2	0%	N/A		N/A	N/A	2	0%
There is evidence of gender-specific service provision(s): 1. Accessibility 2. Assessment 3. Psychological Development 4. Abuse/Violence/Trauma 5. Family Orientation 6. Mental Health Issues 7. Physical Health Issues 8. Legal Issues 9. Sexuality/Intimacy/Exploitation 10. Survival Skills 11. Continuing Care/Recovery Support	2	100%	6	67%	3	67%	4	100%	15	80%
Recovery Housing										
Resident chart includes the following information: • Standard demographic information	8	100%	13	100%	11	100%	12	100%	44	100%

• Releases of Information (MSHN, Medical, Treatment Provider, Emergency Contact) • Signed Acknowledgement of Rules						

FY24 Quarter 2 – AMHS and CSDD - 1915i

Standard	Total = All		AMHS		CSDD	
	Total Charts	%	Total Charts	%	Total Charts	%
A.5.3 If an enrollee receives Environmental Modifications or Equipment, the PIHP/CMHSP has implemented prior authorizations in accordance with their process.	4	100%	0	N/A	4	100%
E.2.A Evaluations were completed where applicants met the eligibility criteria for 1915(i) State plan HCBS benefit. (SPA 3.1-i.2)	91	87%	51	93%	40	80%
E.2.B The record reviewed reflected evidence that the instruments and tools were appropriately applied to determine eligibility of 1915(i) services	91	90%	51	95%		84%
E.2.C Re-evaluation for eligibility was within 365 days of the last eligibility determination.	90	60%	50	62%	40	65%
P.1.A.1 IPOS had adequate strategies to address their assessed health and safety needs, including coordination with primary care provider. (SPA 3.1-i.2)	91	80%	51	78%	40	81%
P.1.A.2 Individual Plans of Service (IPOS) addresses the assessed needs of a beneficiary.	91	96%	51	97%	40	95%
P.1.A.3 The individual plan of service is developed in accordance with policies and procedures established by MDHHS. Evidence: 1. pre-planning meeting, 2. availability of self-determination, and independent facilitation. 3. use of PCP process in developing IPOS	91	78%	51	72%	40	86%

P.1.B.1 IPOS was updated within 365 days of their last plan of service. (SPA 3.1-i.2)	89	76%	49	72%	40	80%
P.1.B.2 Specific services and supports that align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing are identified in the IPOS.	91	56%	51	52%	40	61%
If physical health is indicated on needs list in assessment and/or if there is a goal related to physical health in the treatment plan, the healthcare integration/physical health goal box is checked	87	58%	48	63%	39	53%
P.1.B.3 Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency and timeframe for implementing	91	57%	51	54%	40	61%
B.1.The BTPRC process includes all the following elements as required by the Technical Requirement for Behavior Treatment Plan Review Committees: 1. Documentation that the composition of the Committee and meeting minutes comply with the TR; 2. Evaluation of committees' effectiveness occurs as specified in the TR; 3. Quarterly documentation of tracking and analysis of the use of all physical management techniques and the use of intrusive/restrictive techniques by each individual receiving the intervention; 4. Documentation of the QAPIP's OR QIP's evaluation of the data on the use of intrusive or restrictive techniques; 5. Documentation of the Committees' analysis of the use of physical management and the involvement of law enforcement for emergencies on a quarterly basis; 6. Documentation that behavioral intervention related injuries requiring emergency medical treatment or hospitalization and death are reported to the Department via the event reporting system; 7. Documentation that there is a mechanism for expedited review of proposed behavior treatment plans in emergent situations. Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.	2	100%	0	N/A	2	100%

B.2. Behavior treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. 1. Documentation that plans that proposed to use restrictive or intrusive techniques are approved (or disapproved) by the committee 2. Documentation that plans which include restrictive/intrusive interventions include a functional behavior assessment and evidence that relevant physical, medical and environmental causes of challenging behavior have been ruled out. 3. Are developed using the PCP process and reviewed quarterly 4. Are disapproved if there is a recommendation for the use of aversive techniques, physical management, or seclusion or restraint in the plan 5. Written special consent is obtained before the behavior treatment plan is implemented; positive behavioral supports and interventions have been adequately pursued (i.e. at least 6 months within the past year) 6. The committee reviews the continuing need for any approved procedures involving intrusive or restrictive techniques at least quarterly.	2	100%	0	N/A	2	100%
G.2 Individual served received health care appraisal. (Date/document confirming_____)	91	73%	51	88%	40	53%

FY24 Quarter 3 – Families Forward

Standard	Families Forward		IOP		Home Based		Urgent Care		Early Intervention	
	Total Charts	%	Total Charts	%	Total Charts	%	Total Charts	%	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?	126	79%	51	62%	67	83%	10	100%	23	80%
Are consumer's needs & wants are documented?	123	91%	51	79%	64	91%	10	100%	23	98%
Present and history of behavior and/or symptoms are documented and specify if observed or reported	124	98%	51	82%	65	100%	10	100%	23	100%
Substance use (current and history) included in assessment?	120	85%	50	76%	62	90%	10	100%	20	85%
Current physical health conditions are identified?	124	95%	51	79%	65	98%	10	100%	23	96%
Current health care providers are identified?	122	82%	50	71%	64	80%	10	85%	23	74%
Previous behavioral health treatment and response to treatment identified?	116	90%	48	69%	60	95%	10	100%	19	92%
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?	123	81%	50	59%	65	85%	10	100%	23	91%
Did crisis screening and other life domain needs screening occur?	123	96%	50	78%	65	98%	10	95%	23	98%
Was consumer offered the opportunity to develop a Crisis Plan?	123	97%	50	81%	65	99%	10	100%	23	100%
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?	123	80%	50	66%	65	89%	10	80%	23	91%

If they are in the SEDW, has the CAFAS/PECFAS been completed quarterly	101	78%	43	29%	51	81%	7	100%	15	73%
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.	122	90%	50	84%	64	92%	10	95%	23	100%
The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	123	91%	50	94%	65	92%	10	100%	23	89%
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)	123	62%	50	69%	65	67%	10	60%	23	72%
The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.	123	92%	50	69%	65	97%	10	85%	23	96%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	123	81%	50	63%	65	85%	10	80%	23	93%
The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	123	76%	50	53%	65	72%	10	100%	23	78%
A timeline for review. (Are reviews occurring at least every 6 months?)	123	50%	50	47%	65	51%	10	30%	23	54%
If applicable, the IPOS addresses health and safety issues.	116	76%	48	88%	60	76%	10	85%	21	74%

If applicable, identified history of trauma is effectively addressed as part of PCP.	116	75%	45	85%	63	68%	10	80%	22	70%
Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	123	57%	50	38%	65	62%	10	80%	23	78%
Are services being delivered consistent with plan in terms of scope, amount and duration? Q3: Review services that occurred during January-March 2024	119	57%	48	38%	64	63%	9	56%	23	65%
Monitoring and data collection on goals is occurring according to time frames established in plan?	119	61%	48	44%	64	63%	9	61%	23	70%
Are periodic reviews occurring according to time frames established in plan?	118	41%	48	22%	64	45%	8	44%	23	46%
NEW: 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?	124	88%	51	71%	65	95%	10	85%	23	96%
For medication services, informed consent was obtained for all psychotropic medications?	49	89%	15	58%	26	96%	8	75%	6	100%
Is there evidence of outreach activities following missed appointments?	105	75%	47	63%	55	83%	5	70%	18	81%
Is there evidence of coordination with Primary Care Physician in the record?	123	73%	50	59%	65	79%	10	100%	23	98%
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.	124	72%	51	71%	65	71%	10	95%	23	76%

FY24 Quarter 4 – CSDD

Standard	Life Consultation		FSP Case Management	
	Total Charts	%	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?	81	78%	49	86%
Are consumer's needs & wants are documented?	82	99%	52	99%
Present and history of behavior and/or symptoms are documented and specify if observed or reported	82	99%	52	98%
Substance use (current and history) included in assessment?	79	97%	39	71%
Current physical health conditions are identified?	81	99%	50	100%
Current health care providers are identified?	82	91%	52	91%
Previous behavioral health treatment and response to treatment identified?	81	96%	46	95%
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?	82	70%	52	86%
Did crisis screening and other life domain needs screening occur?	82	98%	52	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.	80	100%	51	100%

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?	82	89%	52	67%
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.	77	98%	41	80%
The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	82	98%	51	91%
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)	82	31%	51	59%
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)	82	53%	51	79%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	82	90%	51	83%
The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	82	85%	51	82%
A timeline for review. (Are reviews occurring at least every 6 months?)	80	98%	48	96%
If applicable, the IPOS addresses health and safety issues.	77	93%	44	84%
If applicable, identified history of trauma is effectively addressed as part of PCP.	31	48%	30	80%

Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	82	62%	51	63%
Are services being delivered consistent with plan in terms of scope, amount and duration? Q4: Review services that occurred during April - June 2024	82	68%	51	59%
Monitoring and data collection on goals is occurring according to time frames established in plan?	82	77%	50	94%
Are periodic reviews occurring according to time frames established in plan?	75	72%	44	86%
NEW: 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? Ex: If a consumer was authorized to receive Respite services starting February 1st, but no services actually occurred until March 1st, is there an ABDN to explain the delay, or is there a contact note/service note showing that the family chose to delay the start of the service?	73	95%	51	93%
For medication services, informed consent was obtained for all psychotropic medications?	37	54%	12	79%
Is there evidence of outreach activities following missed appointments?	37	81%	25	86%
Is there evidence of coordination with Primary Care Physician in the record?	82	57%	51	73%
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.	82	66%	52	57%

MDHHS Audit

Every two years, MDHHS audits the following waiver programs: SEDW, CWP, HSW, and (i)SPA/1915i. Quality Improvement staff work with the clinical departments to meet the standards MDHHS has set for these programs.

In 2024, CMHA-CEI underwent a full site review by MDHHS for SEDW, CWP, HSW, and iSPA/1915i. The site review was conducted for the full MSHN region and included all 12 CMHSPs in the region. The review was completed virtually. For CMHA-CEI, 8 SEDW, 7 CWP, 9 HSW charts, and 14 (i)SPA/1915i charts were reviewed by MDHHS. Areas reviewed were case files, provider qualifications, and administrative processes related to health and welfare. Below are the findings and remedial action plans accepted by MDHHS.

DIMENSIONS/INDICATORS	Yes	No	FINDINGS	REMEDIAL ACTION
A. ADMINISTRATIVE PROCEDURES				
A.3.3 Claims are coded in accordance with MDHHS policies and procedures. (PM I-1)	22	1	REPEAT CITATION CEI WSA #1890334 – H2021 billed, should be H2022 when SEDW.	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that, claims are coded in accordance with MDHHS policies and procedures. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE: ☒ Individual Remediation: • By 10/31/2024 Claims coded incorrectly for WSA#1890334 will be corrected, and the plan amended, to reflect the correct services that are medically necessary. ☒ Systemic Remediation: • By 10/31/2024 WA staff training will occur around the correct coding of supports/services deemed medically necessary for a recipient. MDHHS Response: ☐ Response accepted ☒ Response not accepted. –

				__No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: For MSHN (<u>for each performance measure cited, throughout this document</u>), please provide additional information on your Delegated Managed Care/DMC Reviews (i.e., frequency these reviews occur, and effective date that these reviews will be enacted, specific to these citations/remediations, and what will occur with the outcomes of these reviews to systemically address these citations, many of them repeat citations). PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective

				action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. MDHHS 2nd Response: Response Accepted
P. IMPLEMENTATION OF PERSON-CENTERED PLANNING Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Guideline MCH712 Chapter III, Provider Assurances & Provider Requirements Attach. 4.7.1 Grievances and Appeals Technical Requirement.				
P.3 SEDW				
P.3.4 IPOS for enrolled consumers is developed in accordance with policies and procedures established by MDHHS. Evidence:	8	15	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure that the IPOS for enrolled consumers is developed in accordance with policies and procedures established by MDHHS. The plan must be submitted

1. IPOS contains meaningful and measurable goals and objectives. 2. Prior authorization of services corresponds to services identified in the IPOS. (PM-D-4)				within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. During the FY2022 full site review, MSHN sent a letter in response to the citation regarding the lack of specific amount, scope and duration (ranges used instead) to Lyndia Deromedi, Manager, Federal Compliance Section of MDHHS on 8/17/2022. The letter titled, Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report proposed the use of reasonable ranges in plans of service, based on medical necessity, and as discussed during the planning meeting and approved by the support team, to allow for the most flexible and efficient approach to providing care to vulnerable individuals in our system. MSHN continues to take the position that the use of ranges is more aligned with the recovery model of care and in alignment with the requirement within the Medicaid Provider Manual. Recovery services are expected to be more dynamic, individualized, flexible, support many pathways, and serve as a partnership/consultative approach that adapts to the needs of the individual. The use of too specific amounts in the PCP appears overly prescriptive and not very compatible with our understanding of recovery as a non-linear process. CEI RESPONSE ☒Individual Remediation: ☐ By (Date) _____ plan will be amended for resolving lack of measurable goals/ objectives/ timeframes. ☐ By (Date) _____ plan will be amended to resolve the need to align recommended services with prior authorizations (in the same amount/ scope/ duration). ☐ Other: (See response below) • WSA #1838025 – Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process,

			<u>CEI</u> WSA #1838025 – No safety/crisis plan developed at initial Wraparound meeting. Mission statement must be decided with Child and Family Team and documented. WSA #1890334 – IPOS goals not measurable (repeat citation); Wraparound plan needs Mission statement that is with Child and Family Team and documented. WSA #1925206 - IPOS goals not measurable (repeat citation). WSA #1938080 – Wrap plan did not include a mission statement decided with family, no outcomes were established in	including the development of a crisis/safety plan during the first meeting and completing the Mission Statement. This team training will be completed by 11/1/24. • WSA #1890334 – CEI Clinical team will review the goals and objectives of the current plan and complete an IPOS addendum by 11/1/2024 to ensure goals/objectives are measurable and the Wraparound plan includes all required components, including the Mission Statement. Supervisors will review treatment plans and review goals/objectives and give immediate feedback to clinicians. Wraparound team will attend a staff training on SEDW fidelity and the required pieces of the wraparound process. This team training will be completed by 11/1/24. • WSA #1925206 –This consumer was discharged from services in February 2024. Staff training regarding components of measurable objectives will occur in unit meetings and at an all-staff meeting; trainings will be completed by 12/1/24 • WSA #1938080: – CEI Clinical team will review the goals and objectives of the current plan and complete an IPOS addendum by 11/1/2024 to ensure goals/objectives are measurable. Supervisors will review treatment plans and review goals/objectives and give immediate feedback to clinicians. Wraparound team will attend a staff training on SEDW fidelity and the required pieces of the wraparound process. This team training will be completed by 11/1/24. • WSA #2160367 – By 11/1/24 an IPOS addendum will be completed to ensure that family strengths are reflected in the IPOS. Supervisors will review treatment plans and review goals/objectives and give immediate feedback to clinicians. ☒ Systemic Remediation: • CEI will review training materials related to person centered planning, components of measurable objectives, and SEDW requirements in unit meetings and an all-staff meeting. These trainings will be completed by December 1, 2024. • Supervisors of ancillary services will review service referrals and if goals/objectives are not measurable, they will give feedback immediately to clinicians. • Quarterly chart reviews will be completed of SEDW records and will include a review of IPOS goals/objectives to ensure they are

			plan, and needs were not addressed with wraparound for youth and family. WSA #2160367 – Strengths and needs of the youth and family were not identified. Mission statement was not decided by family and documented.	measurable, to review enhanced waiver services offered and/or provided to waiver participants, and identify participants are receiving at least one waiver service per month outside of Wraparound. MDHHS Response: ☐ Response accepted ☒ Response not accepted. – __No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) MSHN: Insufficient systemic remediation for the use of ranges (rather than reflecting specific amount/scope/duration/frequency/ASDF of services, as required, within the Plans of Service). MSHN appears to be conveying intent to not remediate those plans that reflect ranges. Please revise, to align with the requirements of MDHHS, so that the CAP can be approved. CEI: WSA #1838025: No individual remediation found (only a remediation that appears systemic). Please add. WSA #1938080 Individual remediation does not match that of the citation. TA: WSA#s 1890334,1938080, 2160367: Individual remediations accepted with expectation of documented involvement of the youth/families in the discussion/amending process.

				PIHP/CMHSP 2nd Response: MSHN MSHN continues to maintain the position that the use of reasonable ranges in the individual plan of service, based on medical necessity and discussed and approved during the planning meeting, is allowable per the definitions provided in the Medicaid Provider Manual, Section 1.7, and the requirements listed in 42 C.F.R. 441.725, MMHC 330.1700-1712, Michigan Administrative Code R. 330.7199, and the federal Balanced Budget Act of 1997, Section 438.10 (f)(6)(v). Therefore, we are not submitting a plan of correction for this finding as we believe we are in compliance with the standard. MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective

				action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI WSA #1838025: This consumer discharged from services in September 2024. No individual remediation is possible. WSA #1938080: This consumer/family withdrew from the SEDW in August 2024 and is no longer enrolled in wraparound services.
P. PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS				

P.6. SEDW				
P.6.1 Services and supports are provided as specified in the IPOS including type, amount, scope duration and frequency. (PM D-7)	4	19	REPEAT CITATION <u>CEI</u> WSA #1627715 – Wraparound not provided per fidelity of the model. Home-Based therapy not provided per IPOS. TA: No second SED Waiver service. WSA #1823599 – Wraparound not provided per fidelity of the model. ~~WSA #1838025~~ – Wraparound not provided per fidelity of the model. Home-Based therapy not	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring services and supports are provided as specified in the IPOS including type, amount, scope, duration, and frequency. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: WSA #1627715 – Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process. This team training will be completed by 11/1/24. Quarterly chart reviews will be completed of SEDW records, including #1627715, and will include a specific review of services delivered as authorized; if there are disparities between recommended services and what is provided, clinical staff will document rationale in the record. WSA #1823599 – Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process. This team training will be completed by 11/1/24. WSA #1838025 - Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process. This team training will be completed by 11/1/24. Clinical team will review the IPOS and if necessary will adjust services authorized with an IPOS addendum and ABDN, completed by 11/1/24. Quarterly chart reviews will be completed of SEDW records, including #1838025, and will include a specific review of services delivered as authorized; if there are disparities between recommended services and what is provided, clinical staff will document rationale in the record. Chart review will also include a review of enhanced waiver services offered/provided, and identify that the consumer is receiving at least one additional wavier service outside of WA.

			provided per IPOS. Adjust IPOS if services are not provided as written (Substance use treatment). WSA #1890334 – Wraparound not provided per fidelity of the model. No second SED Waiver service. Home-Based therapy not provided per IPOS. ~~WSA #1925206~~ - Wraparound not provided per fidelity of the model. CLS, PSP, Psychotherapy, and Home-Based therapy not provided per IPOS. (Closed SEDW) ~~WSA #1938080~~ – Wraparound not provided per fidelity of the model. CLS not provided per IPOS. WSA #2160367 – Wraparound not provided per fidelity of the model. Psychotherapy and respite were not provided per IPOS. No second SEDW service provided.	WSA #1890334 - Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process. This team training will be completed by 11/1/24. Quarterly chart reviews will be completed of SEDW records, including #1890334, and will include a review of enhanced waiver services offered and/or provided, and identify participants are receiving at least one waiver service per month outside of Wraparound. WSA #1925206 - Individual remediation is unable to occur as this consumer was discharged from services in February 2024. Systemic Remediation to address. WSA #1938080 - Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process. This team training will be completed by 11/1/24. Quarterly chart reviews will be completed of SEDW records, including #1938080, and will include a specific review of services delivered as authorized; if there are disparities between recommended services and what is provided, clinical staff will document rationale in the record. WSA #2160367 - Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process. This team training will be completed by 11/1/24. Clinical team will review the IPOS and if necessary will adjust services authorized with an IPOS addendum and ABDN, completed by 11/1/24. Quarterly chart reviews will be completed of SEDW records, including #1838025, and will include a specific review of services delivered as authorized; if there are disparities between recommended services and what is provided, clinical staff will document rationale in the record. Chart review will also include a review of enhanced waiver services offered/provided, and identify that the consumer is receiving at least one additional service outside of Wraparound. WSA #2193441 - Wraparound team will attend a staff training on SEDW fidelity and required pieces of the Wraparound process. This team training will be completed by 11/1/24. Clinical team will review the IPOS and if necessary will adjust services authorized with an IPOS addendum and ABDN, completed by 11/1/24. Quarterly chart reviews will be completed of SEDW records, including #2193441, and will include a specific review of services delivered as authorized; if there are disparities between recommended services and what is provided, clinical staff will document rationale in the record. Chart review will also include a review of enhanced waiver services offered/provided

			WSA #2193441 - Wraparound not provided per fidelity of the model. CLS, therapy, and PSP not provided per IPOS. No second SEDW service provided.	and identify that the consumer is receiving at least one additional service outside Wraparound. ☒ Systemic Remediation: CEI will review training materials related to person centered planning, service delivery, and SEDW requirements in unit meetings and an all-staff meeting. These trainings will be completed by December 1, 2024. Ongoing training and reminders about the importance of delivering services as authorized are provided at program staff meetings and department staff meetings, along with the reminder of documenting when services are not delivered as authorized including treatment plan addendums to change the plan of service as needed. Quarterly chart reviews will be completed of SEDW records and will include a review of services delivered as authorized, enhanced waiver services offered and/or provided to waiver participants, and identify participants are receiving at least one waiver service MDHHS Response: ☐ Response accepted ☒ Response not accepted. – ___No individual remediation found. ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) CEI WSA#s 1627715, 1823599, ~~1838025~~, 1890334, ~~1938080~~, 2160367, 2193441: Remediation is systemic only. Individual remediation lacks documenting for disparity between recommended and provided services, and steps to resolve that disparity. *Also, what will be done regarding the need to provide*

				Wraparound services per fidelity to the model, as well as a second service, for those records cited for lacking this? Will these plans be amended to align Wraparound to the model, or to document if/when the family is declining those levels of recommended supports, as well as the level of supports they are willing to receive? Please revise. ☐ No systemic remediation found ☐ No timelines indicated ☐ Other: (See response below) PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each

				CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI WSA #1838025: This consumer discharged from services in September 2024. No individual remediation is possible. WSA #1938080: This consumer/family withdrew from the SEDW in August 2024 and is no longer enrolled in wraparound services. WSA #1627715:By 12/31/24, the clinical team will review and if necessary, amend the IPOS to align Wraparound to the model and to reflect current home-based needs. The clinical team will ensure

				that services are provided as authorized and documented when scheduled services are cancelled. The clinical team will document the rationale for any reduction in services, steps taken to address barriers, and reflect a discussion about the intensity of services provided through SEDW. If there are disparities between recommended services and what is provided, clinical staff will document services offered, when the family is declining the recommended supports, and the supports they are willing to receive. Quarterly chart reviews of SEDW records will include a review that consumers are receiving a second SED service, and if not, clinical staff will document rationale in the record. WSA #1823599: This consumer/family is no longer enrolled in Wraparound Services and transitioned out in September 2024. WSA #1838025: This consumer discharged from services in September 2024. No individual remediation is possible. WSA #1890334: By 12/31/24, the clinical team will review and if necessary, amend the IPOS to align Wraparound to the model and to reflect current home-based needs. The clinical team will ensure that services are provided as authorized and documented when scheduled services are cancelled. The clinical team will document the rationale for any reduction in services, steps taken to address barriers, and reflect a discussion about the intensity of services provided through SEDW. If there are disparities between recommended services and what is provided, clinical staff will

				document services offered, when the family is declining the recommended supports, and the supports they are willing to receive. Quarterly chart reviews of SEDW records will include a review that consumers are receiving a second SED service, and if not, clinical staff will document rationale in the record. WSA #1938080: This consumer/family withdrew from the SEDW in August 2024. WSA #2160367: By 12/31/24, the clinical team will review and if necessary, amend the IPOS to accurately reflect services. If there are disparities between recommended services and what is provided, clinical staff will document rationale in the record, including when the family is declining the recommended supports and the supports they are willing to receive. Quarterly chart reviews of SEDW records will include a review that consumers are receiving a second SED service, and if not, clinical staff will document rationale in the record. WSA #2193441: This consumer's SEDW is ending October 2024 due to request from the family.
P.6.4 The IPOS was updated at least annually	16	7	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that IPOS is updated at least annually. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews.

			CEI WSA #1627715 – IPOS reviews not completed. WSA #1823599 - IPOS reviews not completed. WSA #1838025 – IPOS reviews not completed. WSA #1890334 – IPOS reviews not completed. WSA #1925206 - IPOS reviews not completed. (Closed SEDW) WSA# 1938080 – IPOS reviews not completed. WSA #2160367 – IPOS reviews not completed.	CEI RESPONSE: ☒ Individual Remediation: ☐ By (Date) _____, for WSA #_____, the required documentation will be entered into the record. ☒ Other: (See response below) WSA #1627715 – By 11/1/24 a review of progress and, if necessary, addendum will be completed to ensure IPOS is up to date. WSA #1823599 - By 11/1/24 a review of progress and, if necessary, addendum will be completed to ensure IPOS is up to date. WSA #1838025 – By 11/1/24 a review of progress and, if necessary, addendum will be completed to ensure IPOS is up to date. WSA #1890334 – By 11/1/24 a review of progress and, if necessary, addendum will be completed to ensure IPOS is up to date. WSA #1925206 -.Consumer has discharged from services, individual remediation unable to occur. WSA# 1938080 – By 11/1/24 a review of progress and, if necessary, addendum will be completed to ensure IPOS is up to date. WSA #2160367 – By 11/1/24 a review of progress and, if necessary, addendum will be completed to ensure IPOS is up to date. ☒ Systemic Remediation: By 10/1/24, the process for completing IPOS reviews will be revised. Effective 10/1/24, IPOS reviews will be completed within the EHR's Treatment Plan Review/Addendum template, which ensures that each goal and objective are appropriately addressed, and satisfaction with supports/services are clearly documented. Training to all staff regarding this process update is ongoing to assist with the transition MDHHS Response: ☒ Response accepted with evidence of the above documentation, as well as on-going training of staff, expected at the 90-day review.

Q. STAFF QUALIFICATIONS				
Q.3 SEDW				
Q.3.1 Clinical service providers and Wraparound facilitator are credentialed by the CMHSP prior to providing services. (Evidence: personnel records and credentialing documents – including licensure and certification and required experience for child mental health professionals). (PM C-1)	65	3	A total of 68 Professional Staff were reviewed under MSHN SEDW REPEAT CITATION CEI *Insufficient evidence of CMHP certification prior to hire, or supervision by a CMHP upon hire, until credentialing requirements met.* WSA# 1838025: Cody Shields WSA# 1938080: Heidi Phillips ~~WSA# 1627715: Rudy Ruffer~~	Submit a plan that reflects both individual and systemic remediation, with time frames to ensure that clinical service providers and Wraparound facilitators are credentialed prior to providing services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE: ☒ Individual Remediation: WSA# 1838025: For cited staff, evidence of CMHP certification prior to hire or supervision by a CMHP will be provided to MDHHS at a 90-day follow-up review. WSA# 1938080 For cited staff, evidence of CMHP certification prior to hire or supervision by a CMHP will provided to MDHHS at a 90-day follow-up review. WSA# 1627715: Per communication 9/5/24, this finding has been withdrawn. Systemic Remediation: CEI's HR department has begun internal meetings to evaluate the QIDP/CMHP credentialing process in order to ensure required credentialing documentation is appropriately maintained. While this internal collaboration will be ongoing, the agency will be implementing necessary steps to track credentialing for new hires

				beginning 12/1/24, and will review current employees at time of re-credentialing MDHHS Response: ☐ Response accepted ☒ Response not accepted. – __No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) CEI: Insufficient systemic remediation. Please provide more specific information about the "necessary steps" planned for implementation a tracking system for new hires, effective 12/1/24 (that evidence of will be provided at the 90-day review). What will be done to capture this information, within the next 90 days, for currently employed staff during their re-credentialing? PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the

				regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action.

				CEI CEI's has begun internal meetings to evaluate the QIDP/CMHP credentialing process in order to ensure required credentialing documentation is appropriately maintained. While this internal collaboration will be ongoing, the agency will be implementing necessary steps to track credentialing for new hires beginning 1/16/25. Tracking will include documenting of verified credentials including CMHP, QIDP, and QMHP status with primary source verification through staff attestation, resume, or transcripts, For currently employed staff CEI will begin documenting verified credentials including CMHP, QIDP, and QMHP status with primary source verification through staff attestation, resume, or transcripts by 1/16/25. MDHHS 2nd Response: Response Accepted with proofs submitted at the 90 Day Follow Up.
Q.3.3. Non-licensed/non-certified providers meet provider qualifications. Evidence: personnel records contain documentation that staff is: 1. At least 18 years of age, 2. Is in good standing with the law 3. Is free from communicable disease.	10	4	A total of 14 Aide Level Staff were review under MSHN SEDW. REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all non-licensed/non-certified providers meet provider qualifications. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS.

Documentation staff has completed all core training requirements – e.g., recipient rights, prevention of transmission of communicable diseases, first aid, CPR, and that staff is employed by or on contract with the CMHSP. (PM C-3) 3. In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, not an illegal alien). 4. Able to perform basic first aid procedures, as evidenced by completion of a first aid training course, self-test, or other method determined by the PIHP to demonstrate competence in basic first aid procedures.			<u>CEI</u> *Lack of evidence of being 18 years or older.* WSA# 1838025: Sophie Phillips	MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: WSA#1838025, evidence of staff being 18 or older has been obtained and will be provided to MDHHS during the 90-day follow-up review. ☒ Systemic Remediation: On 9/6/24, QI staff met with the clinical program and on 9/10/24 QI staff met with the HR department to review requirements related to staff credentialing. MDHHS Response: ☐ Response accepted ☒ <u>Response not accepted</u>. – __No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region

				addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased

				frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action.

Children's Waiver Program (CWP)

DIMENSIONS/INDICATORS	Yes	No	FINDINGS	REMEDIAL ACTION
P. IMPLEMENTATION OF PERSON-CENTERED PLANNING Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Guideline MCH712 Chapter III, Provider Assurances & Provider Requirements Attach. 4.7.1 Grievances and Appeals Technical Requirement.				
P.1. CWP				
P.1.1: The IPOS is developed through a person-centered process that is consistent with Family-Driven, Youth-Guided Practice and Person-Centered Planning Policy Practice Guidelines. (PM-D-3)	10	2	REPEAT CITATION <u>Community Mental Health Authority Clinton-Eaton-Ingham Counties (CEI)</u>:	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS is developed through a person-centered process that is consistent with Family-Driven, Youth-Guided Practice and Person-Centered Planning Policy Practice Guidelines. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____ WSA # _____ will be offered Self-Determination / Independent Facilitation

			WSA 21162 - Pre-plan and IPOS done on the same day with no rationale found.	with documentation in the record by the 90-day f/u site review. ☒ By (Date) 8/29/24 pre-planning will occur to better inform IPOS process, with the PCP meeting to occur by 10.18.24, with evidence in the record by the 90-day f/u site review for WSA #21162 ☐ Other: (See response below) ☒ Systemic Remediation: ☐ By (Date) _____, staff training will be provided on the requirement of pre-planning activities that must inform person-centered planning. ☐ By (Date) _____, EMR will be adjusted to include this information as required fields in the pre-planning document. ☐ Effective (Date) _____, CM Supervision will monitor a random selection of records quarterly to monitor for this requirement. ☒ Other: (See response below) A formal training with case management team will be completed to capture pre-planning process (including purpose, timeline, etc.), with ability to highlight audit findings. Tools will be reviewed, and the importance of documentation will be captured. This will be completed by 10/31/24. Initial review of pre-planning and treatment planning timelines will be included. A follow-up review will occur 3-6 months post-training. MDHHS Response: ☐ Response accepted ☒ Response not accepted. – __ No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated

				☒ Other: (See response below) For MSHN (<u>for each performance measure cited, throughout this document</u>), please provide additional information on your Delegated Managed Care/DMC Reviews (i.e., frequency these reviews occur, and effective date that these reviews will be enacted, specific to these citations/remediations, and what will occur with the outcomes of these reviews to systemically address these citations, many of them repeat citations). PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90

				days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. MDHHS 2nd Response: Response Accepted
P.1.2. The IPOS addresses all service needs reflected in the assessments. (PM-D-1)	6	6	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS addresses all

			CEI: WSA 34468 - Mom indicated several times she wanted his toileting routine to be followed at home, no goals/objectives were found in IPOS in regard to that. WSA 21360 - Lack of sufficient clarity about TCM, and Music Therapy. WSA 21162 - Lack of sufficient clarity about amount scope duration of CLS services being split between two separate providers. WSA 21157 - Lack of sufficient clarity about amount scope duration of TCM.	service needs reflected in the assessments. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☒ By (Date) __10/31/24, amendments will be completed to address identified needs in assessments, not yet resolved in IPOS for WSA #34468, 21360, 21162 and 21157 ☐ Other: (See response below) ☒ Systemic Remediation: ☐ By (Date) _____, staff training will be conducted focusing on the need to resolve all identified needs noted in the assessment, within the IPOS. ☐ Beginning (Date) _____, monitoring by supervisory staff will be done through quarterly clinical chart reviews, for required elements of plans addressing identified needs. ☒ Other: (See response below) A formal training with case management team will be completed which will focus on the golden thread of needs identified in the assessment and the carry-over to the treatment plan. Will review how to defer an identified treatment need, as well as coordinating with community providers to have the identified need met. Training will be completed by 10/31/24 MDHHS Response:

				☐ Response accepted ☒ <u>Response not accepted</u>. – __No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN

				approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. MDHHS 2nd Response: Response Accepted.

P.1.3. The strategies identified in the IPOS are adequate to address assessed health and safety needs, including coordination with primary care providers. (PM-D-2)	10	2	REPEAT CITATION CEI: WSA 21162 - Insufficient evidence of annual health care appraisal. Document found (Questionnaire) lacked signature of author, date or clarity as to the purpose of the form.	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the strategies identified in the IPOS are adequate to address assessed health and safety needs, including coordination with primary care physicians. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☒ By (Date) 10/31/24, an annual health care appraisal will be completed/reflected in the record. Case manager will complete a PCP addendum to reflect identified safety needs. This will be completed by 10/31/24. ☒ Systemic Remediation: ☐ By (Date) _____, additional training will be provided to the staff at large regarding the required elements of addressing health / safety, coordination of care, psychiatric evaluations, and medication consents. ☒ Other: (See response below) A formal training with case management team will be completed to review requirement of adequately addressing assessed health and safety needs within the IPOS as well as ensuring coordination of care with primary physician occurs and is documented in the chart. Training will highlight audit findings and will be completed by 10/31/24. QI will ensure the health and safety needs and

				coordination of care items are reviewed during CEI quarterly chart reviews and will ensure that a review of CWP consumers are completed in the next calendar year MDHHS Response: ☒ Response accepted with documented evidence of the above expected at the 90-day review.
P.1.4. The IPOS is developed in accordance with policies and procedures established by MDHHS. Evidence: 1. plan contains measurable goals/objectives and time frames. 2. Category of Care/Intensity of Care determination was completed by staff certified or trained by MDHHS in Category of Care/Intensity of Care determination. (PM D-4)	4	8	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS is developed in accordance with policies and procedures established by MDHHS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. During the FY2022 full site review, MSHN sent a letter in response to the citation regarding the lack of specific amount, scope and duration (ranges used instead) to Lyndia Deromedi, Manager, Federal Compliance Section of MDHHS on 8/17/2022. The letter titled, Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report proposed the use of reasonable ranges in plans of service, based on medical necessity, and as discussed during the planning meeting and approved by the support team, to allow for the most flexible and efficient approach to providing care to vulnerable individuals in our system.

			CEI: WSA 34468 - Range language used for TCM and Music. Lack of sufficient clarity about TCM. WSA 21162 - Lack of sufficient clarity about TCM and CLS WSA 21157 - Lack of sufficient clarity about TCM is being provided. WSA 20369 - Lack of sufficient clarity about child receiving CWP services in IPOS. WSA 21360 - Lack of sufficient clarity regarding amount and scope of TCM and music therapy.	MSHN continues to take the position that the use of ranges is more aligned with the recovery model of care and in alignment with the requirement within the Medicaid Provider Manual. Recovery services are expected to be more dynamic, individualized, flexible, support many pathways, and serve as a partnership/consultative approach that adapts to the needs of the individual. The use of too specific amounts in the PCP appears overly prescriptive and not very compatible with our understanding of recovery as a non-linear process. CEI Response: ☒ Individual Remediation: ☐ By (Date) _____ the plan will be amended for resolving lack of measurable goals/ objectives/ timeframes. ☐ By (Date) _____ CM staff will receive COC training/ certification. ☒ WSA #34468 plan will be amended, by 10/31/24 to include number TCM and music therapy. WSA #21162 plan will be amended by 10/31/2024 to include number of TCM and CLS. WSA #21157 plan will be amended by 10/31/24 to include number of TCM. WSA #20369 plan will be amended by 10/31/24 to include number of CWP services. WSA #21360 plan will be amended by 10/31/24 to include number of TCM and music therapy. ☐ Other: (See response below) ☒ Systemic Remediation: ☐ By (Date) _____, staff training will be conducted on developing measurable goals ☒ Other: (See response below) Staff will receive training on Goal and Objective writing by 10/31/24. QI staff will ensure goals/objectives are measurable by CEI quarterly chart reviews and will ensure that a review of CWP consumers are completed within the next calendar year. Staff will complete the Category of Care Training prior to assignment of a Children's Waiver

				case. All current staff with CWP cases have completed this training. MDHHS Response: ☐ Response accepted ☒ Response not accepted. – ___No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) MSHN: Insufficient systemic remediation for lack of lack of clarity, within the plans for services being recommended (i.e., for specific amount/scope/duration/frequency/ASDF of services within the Plan). MSHN appears to be conveying intent not remediate those plans that reflect ranges. Please revise, to align with the requirements of MDHHS, so that the CAP can be approved. CEI: For this repeat citation, insufficient individual and systemic remediation. Regarding individual remediation: Only listing amount of services (without also including clarifying scope/frequency/duration) does not sufficiently remediate. Please revise.

				Regarding systemic remediation, the citations (for lack of clarity around services) do not appear to be addressed at all, in planed trainings. Please revise. PIHP/CMHSP 2nd Response: MSHN MSHN continues to maintain the position that the use of reasonable ranges in the individual plan of service, based on medical necessity and discussed and approved during the planning meeting, is allowable per the definitions provided in the Medicaid Provider Manual, Section 1.7, and the requirements listed in 42 C.F.R. 441.725, MMHC 330.1700-1712, Michigan Administrative Code R. 330.7199, and the federal Balanced Budget Act of 1997, Section 438.10 (f)(6)(v). Therefore, we are not submitting a plan of correction for this finding as we believe we are in compliance with the standard. MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary.

				To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been

				addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI Individual Remediation: WSA #34468 plan will be amended, by 12/1/24 to include number TCM and music therapy as well as service scope, frequency, and duration for TCM. WSA #21162 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM and CLS. WSA #21157 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM. WSA #20369 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of CWP services. WSA #21360 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM and music therapy. Systemic Remediation: Staff will receive training on Goal and Objective writing by 12/1/24 that will include guidance on clarifying service amount, scope, frequency, and duration. QI staff will ensure goals/objectives are measurable by conducting CEI quarterly chart reviews that include assessing the clarity of service amount, scope, frequency, and duration within the consumer's IPOS. QI will ensure

				that a review of CWP consumers are completed within the next calendar year. Staff will complete the Category of Care Training prior to assignment of a Children's Waiver case. All current staff with CWP cases have completed this training. MDHHS 2nd Response: Response Not Accepted. MSHN: Insufficient systemic remediation for lack of specific amount /scope /duration / frequency/ASDF of services within the Plan (conveying intent not to remediate those plan that reflect ranges instead). Please revise, to align with the requirements of MDHHS, so that the CAP can be approved. PIHP 3rd Response:
P. PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS				
P.4. CWP				
P.4.2 Services and supports are provided as specified in the IPOS including type, amount, scope duration and frequency. (PM-D-7)	3	9	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that services and supports are provided as specified in the IPOS, including amount, scope, duration, and frequency. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the

			CEI: WSA 34468 - TCM not provided as specified in the IPOS. WSA 21360 – TCM Inconsistent amount, (needs to be clearer in IPOS) WSA 21162 - TCM Inconsistent amount, (needs to be clearer in IPOS) WSA 21157 - TCM Inconsistent amount, (needs to be clearer in IPOS) WSA 20693 TCM not provided as specified in the IPOS. WSA 48404 - TCM not provided as specified in the IPOS.	corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI Response: ☒ Individual Remediation: ☒ By (Date) 10/31/24, WSA #34468, 21360, 21162, 21157, 20693 plan will be amended for resolving/addressing service provision as recommended. Case manager will complete an IPOS addendum to adequately reflect medically necessary services that are being provided while explaining efforts to reduce barriers for ensuring all services are provided within amount, scope, and duration ☐ By (Date) _____, CM will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity. ☐ Other: (See response below) ☒ Systemic Remediation: ☐ By (Date) _____, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. ☒ Other: (See response below) A formal training with case management team will be completed to review and emphasize the importance of ensuring services and supports are provided as specified in IPOS as well as amending the plan if the person's needs change or if the services are not able to be provided. Training will highlight audit findings also and will be completed by October 31, 2024. CEI quarterly chart review will include review of services provided and determination if utilization is within amount, scope and duration and frequency authorized.

				MDHHS Response: ☐ Response accepted ☒ Response not accepted. – __ No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) CEI: No individual remediation found for WSA# 48404. Please provide. PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN

				completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2)

				increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI Individual Remediation: WSA #34468 plan will be amended, by 12/1/24 to include number TCM and music therapy as well as service scope, frequency, and duration for TCM. WSA #21162 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM and CLS. WSA #21157 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM. WSA #20369 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of CWP services. WSA #21360 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM and music therapy. Systemic Remediation: Staff will receive training on Goal and Objective writing by 12/1/24 that will include guidance on clarifying service amount, scope, frequency, and duration. QI staff will ensure goals/objectives are measurable by conducting CEI quarterly chart reviews that include assessing the clarity of service amount, scope, frequency, and duration within the consumer's IPOS. QI will ensure that a review of CWP consumers are completed within the next calendar year. Staff will complete the Category of Care

				Training prior to assignment of a Children's Waiver case. All current staff with CWP cases have completed this training. MDHHS 2nd Response: Response Accepted *TA for CEI WSA# 48404: As this case is now closed, per WSA, no individual remediation is expected.*
G. WAIVER PARTICIPANT HEALTH AND WELFARE				
G.1 Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents. (Date(s) of progress notes, provider notes that reflect this information.).	12	0		
G.2 Individual served received health care appraisal. (Date/document confirming_____)	11	1		Submit a plan that reflects both individual and systemic remediation with time frames to ensure that the individual served has received a health care appraisal. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews.

			CEI: WSA 21162 - Insufficient evidence of annual health care appraisal. Document found (Questionnaire) lacked signature of author, date or clarity as to the purpose of the form.	CEI Response: ☒ Individual Remediation: ☒ By (Date) 10/31/24, WSA # 21162 will receive a health appraisal as evidenced by a completed health appraisal form in the record, signed by the clinician providing the appraisal. ☐ Other: (See response below) ☒ Systemic Remediation: ☐ By (Date) _____, training will be provided to CM staff regarding this requirement. ☐ By (Date) _____, The EMR will be adjusted to include a field that captures this PM in the pre-planning process. ☐ Effective (Date)_____ the EMR will be adjusted to include a field that captures this PM in the pre-planning process. ☐ Effective (Date)_____ Supervisory staff will monitor this requirement at least quarterly, from a random sample drawn, using a clinical chart review form document available for review within 90 days. ☒ Other: (See response below) By 10/31/24, staff training will be provided on the necessity of coordination of care, including the requirement of maintaining a copy of the annual health care appraisal. QI will conduct random audits to ensure compliance with this rule. MDHHS Response: ☒ Response accepted with documented evidence expected at the 90-day review.
Q. STAFF QUALIFICATIONS				

Q.1 CWP				
Q.1.1. Clinical service providers and case managers are credentialed by the CMHSP prior to providing services. (Evidence: personnel records and credentialing documents – including licensure and certification and required experience for QIDP). (PM C-1)	18	7	A total of 25 Professional Staff were review under MSHN CWP. REPEAT CITATION <u>CEI</u> *Insufficient evidence of QIDP prior to hire, or supervision by a QIDP upon hire, until credentialing requirements met.* WSA# 21162, 21157: Alicia Clark WSA# 20693, 48404: Bethany Zimmerman WSA# 21630: Jensen Kurmel *Lack of evidence of initial background check being completed prior to hire.* WSA# 34468: Mary Wilson	MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI Response: ☒ Individual Remediation: ☐ By (Date) _____, evidence of QIDP, or supervision by a QIDP, will be obtained for provision to MDHHS at 90-day f/u site review. ☐ By (Date) _____, a criminal background check will be completed for staff cited, and provided to MDHHS at 90-day f/u site review ☒ Other: (See response below) Evidence of QIDP for WSA #21162, 21157, 20693, 48404, 21630 will be completed by 10/31/24. Evidence of CBC completed prior to hire will be provided at 90-day follow up for WSA #34468. ☒ Systemic Remediation: ☐ CMHSP HR Department will develop a tool to assure QIDP credentialing, prior to service delivery, of newly hired/assigned staff to CWP enrollees, by (Date) _____. ☐ Effective (Date)_____ the CMHSP/HR Dept will retain evidence of QIDP status in personnel records (above/beyond credentialing committee determinations) for proof of staff qualifications ☐ Effective (Date)_____ Supervisory staff will monitor this requirement at least quarterly, from a random sample drawn, using a clinical chart review form document available for review within 90 days. ☐ Effective (Date)_____ quarterly monitoring of a random selection of personnel records will be completed quarterly by HR. ☒ Other: (See response below) CEI's HR department has begun internal meetings to evaluate the QIDP/CMHP credentialing process in order to

				ensure required credentialing documentation is appropriately maintained. While this internal collaboration will be ongoing, the agency will be implementing necessary steps to track credentialing for new hires beginning 12/1/24, and will review current employees at time of re-credentialing MDHHS Response: ☐ Response accepted ☒ Response not accepted. – __No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) CEI: Insufficient systemic remediation. Please provide more specific information about the "necessary steps" planned for implementation a tracking system for new hires, effective 12/1/24 (that evidence of will be provided at the 90-day review). What will be done to capture this information, within the next 90 days, for currently employed staff during their re-credentialing? PIHP/CMHSP 2nd Response: MSHN

				MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as

				outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI Individual Remediation: WSA #34468 plan will be amended, by 12/1/24 to include number TCM and music therapy as well as service scope, frequency, and duration for TCM. WSA #21162 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM and CLS. WSA #21157 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM. WSA #20369 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of CWP services. WSA #21360 plan will be amended by 12/1/24 to include number, scope, frequency, and duration of TCM and music therapy.

				Systemic Remediation: Staff will receive training on Goal and Objective writing by 12/1/24 that will include guidance on clarifying service amount, scope, frequency, and duration. QI staff will ensure goals/objectives are measurable by conducting CEI quarterly chart reviews that include assessing the clarity of service amount, scope, frequency, and duration within the consumer's IPOS. QI will ensure that a review of CWP consumers are completed within the next calendar year. Staff will complete the Category of Care Training prior to assignment of a Children's Waiver case. All current staff with CWP cases have completed this training. MDHHS 2nd Response: Response Accepted
Q.1.3. Non-licensed/non-certified providers meet provider qualifications. Personnel records contain documentation that staff is: 1. At least 18 years of age, 2. In good standing with the law 3. Able to practice prevention techniques to reduce transmission of any communicable diseases.	18	3	A total of 21 Aide Level Staff were reviewed under MSHN CWP REPEAT CITATION <u>CEI</u> *Lack of evidence of Blood Borne Pathogen/BBP training, First Aid Training, and Emergency Procedures training.* WSA# 34468: Kayla Wirtjes	MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI Response: ☒ Individual Remediation: ☐ By (Date) _____, cited staff for WSA #_____ will provide evidence of being 18 or older. ☐ By (Date) _____, cited staff for WSA #_____ will secure a criminal background check ☒ Other: (See response below) Staff identified in the audit are no longer employed and are not available to complete training. ☒ Systemic Remediation:

Documentation staff has completed all core training requirements – e.g., recipient rights, prevention of transmission of communicable diseases, first aid, CPR, and that staff is employed by or on contract with the CMHSP or hired through Choice Voucher arrangements.) (PM C-3)			*Lack of evidence of BBP and Emergency Procedures Training*. WSA# 20369: Thomas Schwander	☐ By (Date) _____, CMHSP/PIHP will meet with provider to review requirements related to staff credentialing. ☐ Effective (Date)_____ the CMHSP/HR Dept will randomly select a staff sample to review quarterly for required trainings. ☒ Other: (See response below) Staff Training on this process will occur by 10/31/24. Staff will receive training on how to the importance of monitoring provider qualification. Staff will also receive a tracking sheet to utilize with families when notified by the Financial Management Service. QI will conduct random CEI audits on a quarterly basis to ensure staff meet provider qualifications. MDHHS Response: ☐ Response accepted ☒ Response not accepted. – ___No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts

				increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual.

				MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. MDHHS 2nd Response: Response Accepted.

Habilitation Support Waiver (HSW)

DIMENSIONS/INDICATORS	Yes	No	FINDINGS	REMEDIAL ACTION
P. IMPLEMENTATION OF PERSON-CENTERED PLANNING Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Guideline MCH712 Chapter III, Provider Assurances & Provider Requirements Attach. 4.7.1 Grievances and Appeals Technical Requirement.				
P.2.1 The individual plan of service adequately identifies the individual's goals and preferences. (HSW PM D-3)	30	8	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS adequately identifies the individual's goals and preferences. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN

			CMH Authority of Clinton-Eaton-Ingham Counties/CEI WSA# 4589: Need for RN services not resolved in the Plan; Perceived need for restrictive gate not resolved in Plan and need for psychiatric services not established in the Plan. WSA# 5430, 4448, 4519: Lack of person-centered goals (service/eligibility goals developed, instead).	MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CMH AUTHORITY OF CLINTON-EATON-INGHAM COUNTIES/CEI RESPONSE ☒ Individual Remediation: ☒ By (Date) 11/1/24 for WSA # 4589, 5430, 4448, the plan will be amended to reflect his/her goal/preferences. ☒ By (Date) 8/29/24 for WSA #4519 annual IPOS will be completed to reflect his/her goal/preferences. ☐ Other: (See response below) ☒ Systemic Remediation: ☒ By (Date) 12/1/24, staff training will be provided on the need to adequately address the preferences and desires of the individual served. ☐ Effective (Date) _____, quarterly monitoring of a random sample of IPOS plans for HSW will occur by Supervisory staff, so ensure compliance. ☐ Other: (See response below) MDHHS Response: ☐ Response accepted ☒ Response not accepted. – ___No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ____ Other

				CEI: Systemic remediation insufficient. Two years ago, the systemic remediation was staff training and quarterly monitoring. 2024 only reflects staff training (not an enhancement of prior systemic remediations, for this repeat citation). Please provide additional information as to how CEI will remediate this matter systemically. For MSHN (for each performance measure cited, throughout this document), please provide additional information on your Delegated Managed Care/DMC Reviews (i.e., frequency these reviews occur, and effective date that these reviews will be enacted, specific to these citations/remediations, and what will occur with the outcomes of these reviews to systemically address these citations, many of them repeat citations). PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct

				the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased

				reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI By 12/1/24, individualized training during supervision will occur on the need to adequately address the preferences and desires of the individuals served. This training will be documented on a staff training log. MDHHS 2nd Response: Response Accepted
P.2.4. The individual plan of service is modified in response to changes in the individual's needs. (HSW PM D-6)	26	3	REPEAT CITATION NA = 9 CEI: WSA# 5170: Plan not amended to add SLP/eating guidelines. WSA# 5091: Plan not amended for inclusion of OT services (evaluation).	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the person-centered plan is modified in response to changes in the individual's needs. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI REPONSE ☒ Individual Remediation: ☒ By (Date) 11/1/24 for WSA # 5170, 5091,

				the record will reflect at least quarterly opportunities in which he/she provides feedback on supports/services and progress. ☒ Other: (See response below) WSA 5170, 5091 IPOS and services will be reviewed by the clinical team and an amendment will be completed if necessary to reflect [OT/SLP] current services and guidelines. completed by 11/31/24" ☒ Systemic Remediation: ☒ By (Date) 12/1/24, staff training will be provided on the need to provide ongoing opportunities to provide feedback on supports/services/progress (with documentation in the record of that feedback). ☐ Effective (Date) _____, quarterly monitoring of a random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. ☒ Other: (See response below) Staff training will be provided on the need to amend treatment plans when individual's needs change. Completed by 11/31/24 MDHHS Response: ☐ Response accepted ☒ Response not accepted. – ____No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) PIHP/CMHSP 2nd Response:

				MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule.

				The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action MDHHS 2nd Response: Response Not Accepted: PIHP/CMHSP 3rd Response:
P.2.5. The person-centered planning process builds upon the individual's capacity to engage in activities that promote community life. MCL 330.1701(g)	35	3	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the person-centered planning process builds upon the individual's capacity to engage in activities that promote

			CEI: WSA# 4589	community life. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☒ By (Date) 11/1/24 for WSA # 4589, the plan will be amended to reflect/address his/her community inclusion needs. ☐ Other: (See response below) ☒ Systemic Remediation: ☒ By (Date) 12/1/24, staff training will be provided on the need of the HSW requirement to build upon a Waiver recipient's capacity to engage in activities that promote community life. ☐ Effective (Date) _____, quarterly monitoring of a random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. ☐ Other: (See response below) MDHHS Response: ☐ Response accepted ☒ Response not accepted. – ____No individual remediation found

				☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) CEI: Systemic remediation insufficient. Two years ago, the systemic remediation was staff training and quarterly monitoring. 2024 only reflects staff training (not an enhancement of prior systemic remediations, for this repeat citation). Please provide additional information as to how CEI will remediate this matter systemically. PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review

				citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action CEI

				By 12/1/24, individualized training during supervision will occur on the need of the HSW requirement to build upon a Waiver recipient's capacity to engage in activities that promote community life. This training will be documented on a staff training log. MDHHS 2nd Response: Response Accepted
P.2.6. Individual plan of service addressed health and safety, including coordination with primary care providers. (HSW PM D-2.)	25	13	REPEAT CITATION <u>CEI</u> WSA# 5274: Lack of medication consents (case now closed). WSA# 5107: Lack of psychiatric evaluation.	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the IPOS addresses health and safety, including coordination with primary care providers. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☒ By (Date) 11/15/24 for WSA # 5274, the annual IPOS will be completed and will include only active services. ☒ By (Date) 11/1/24 for WSA # 5107, the following will be completed/reflected in the record: - Psychiatric Eval

				☒ Systemic Remediation: ☒ By (Date) 12/1/24, additional training will be provided to the staff at large regarding the required elements of addressing health/safety, coordination of care, psychiatric evaluations, and medication consents. ☐ Other: (See response below) MDHHS Response: ☐ Response accepted ☒ Response not accepted. – ___No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary.

				To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance

				and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action MDHHS 2nd Response: Response Accepted
P.2.7: The individual plan of service is developed in accordance with policies and procedures established by MDHHS. Evidence: 1. pre-planning meeting, 2. availability of self-determination, and 3. use of PCP process in developing IPOS. (HSW PM D-4)	25	13	REPEAT CITATION CEI WSA# 5274, 5170, 5107 Periodic Reviews completed without guardian input.	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the IPOS is developed in accordance with the policies and procedures established by MDHHS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☒ By (Date) 11/1/24 the following will be completed/reflected in the record: for WSA # 5170, 5107:

				- Other (See below): Periodic Review will be completed to include guardian input. ☒ By (Date) 11/15/24 the following will be completed/reflected in the record: for WSA #5274: - Other (See below): Guardian will be offered a Periodic Review prior to the 11/15/24 IPOS. If declined, input will be sought and documented within the upcoming IPOS. ☒ Systemic Remediation: ☒ By (Date) 12/1/24, additional training will be provided to the staff at large regarding the required elements of the person-centered planning process. ☐ Effective (Date) _____, quarterly monitoring by Supervisory staff, of a random pull of records, will be conducted for compliance. ☐ Other: (See response below) MDHHS Response: ☐ Response accepted ☒ Response not accepted. – __No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) BABH: WSA# 4171: Insufficient individual remediation. It is within a periodic review (vs a progress note) that input from guardian is needed, as well as a satisfaction check with individual/guardian regarding supports/services. What will BABH do to address this citation? Schedule a Review with the

				individual/guardian, by a specific date, to request/secure the needed involvement? Please revise. CEI: Insufficient systemic remediation. Two years ago, for this repeat citations, CEI had staff training as one of three steps they would take to address systemically. In 2024, only training is recommended to address systemically (not an enhancement of what was recommended in 2022). Please include additional steps that CEI/MSHN will take to address systemically. PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in

				each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action

				CEI By 12/1/24, individualized training during supervision will be provided regarding the required elements of the person-centered planning process occur on . This training will be documented on a staff training log. MDHHS 2nd Response: Not Accepted PIHP/CMHSP 3rd Response:
P.2.8: Services requiring physician signed prescription follow Medicaid Provider Manual requirements. (Evidence: Physician-signed prescriptions for OT and PDN services are in the file and include a date, diagnosis, specific service, or item description, start date and the amount or length of time the service is needed).	5	8	REPEAT CITATION NA= 25 CEI WSA# 5430: OT is indicated in Plan, multiple years, but not prescription(s) found.	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that services requiring physician signed prescription follow Medicaid Provider Manual requirements. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE

				☒ Individual Remediation: ☒ By (Date) 11/1/24 for WSA #5430, a physician-signed prescription (with the required elements) will be obtained for OT/PT/PDN support and reflected in the record. ☐ Other: (See response below) ☒ Systemic Remediation: ☒ By (Date) 12/1/24, staff training will be conducted, on the need to ensure physician-signed prescriptions for these services, going forward. ☐ CMHSP will develop/provide a guidance tool to provide to primary care physician, to assist in securing the needed elements of the prescription, by (Date) _____. ☐ Other: (See response below) MDHHS Response: ☒ Response accepted.
P. PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS				
P.5. HSW				
P.5.1. Specific services and supports that align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing are identified in the IPOS. (HSW PM D-1)	5	33	REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the specific services and supports in the IPOS align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing are identified in the

			CEI WSA#s 5274, 5170, 5107, 5091: Lack of specific ASDF of TCM services (range language used instead). WSA# 4589: Lack of Specific ASDF of services reflected in Plan (ranges used), measurable goal/objectives and prior authorization (within Plan) for psychological services. WSA# 4448, 4519, 5430: Lack of measurable objectives	IPOS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. During the FY2022 full site review, MSHN sent a letter in response to the citation regarding the lack of specific amount, scope and duration (ranges used instead) to Lyndia Deromedi, Manager, Federal Compliance Section of MDHHS on 8/17/2022. The letter titled, Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report proposed the use of reasonable ranges in plans of service, based on medical necessity, and as discussed during the planning meeting and approved by the support team, to allow for the most flexible and efficient approach to providing care to vulnerable individuals in our system. MSHN continues to take the position that the use of ranges is more aligned with the recovery model of care and in alignment with the requirement within the Medicaid Provider Manual. Recovery services are expected to be more dynamic, individualized, flexible, support many pathways, and serve as a partnership/consultative approach that adapts to the needs of the individual. The use of too specific amounts in the PCP appears overly prescriptive and not very compatible with our understanding of recovery as a non-linear process. CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____, plan will be amended for resolving/addressing service needs

				identified in assessments. ☒ By (Date) 11/1/24 for WSA # 5274, 5170, 5107, 5091 plan will be amended to include amount scope duration of recommended TCM services. ☒ By (Date) 8/29/24 for WSA # 4589 annual IPOS will be completed and will include specific amount scope duration of psychological services. ☒ By (Date) 11/15/24 for WSA # 4448, 4519, 5430, annual IPOS will be completed or addendum completed, which will include measurable objectives. ☐ Other: (See response below) ☒ Systemic Remediation: ☒ By (Date) 12/1/24, staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS. ☐ Effective (Date) _____, quarterly monitoring random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. ☒ Other: (See response below) By 12/1/24, staff training will also be conducted on using specific amounts of services rather than ranges and ensuring the IPOS includes measurable objectives. MDHHS Response: ☐ Response accepted ☒ Response not accepted. – ___No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below)

				MSHN: Insufficient systemic remediation for lack of specific amount /scope /duration / frequency/ASDF of services within the Plan (conveying intent not to remediate those plan that reflect ranges instead). Please revise, to align with the requirements of MDHHS, so that the CAP can be approved. CEI: WSA3 4589: Insufficient individual remediation for lack of measurable objectives (not addressed in individual remediation). Insufficient systemic remediation (staff training), for this repeat citation. Staff training was recommended two years ago. What additional steps will CEI take to ensure this citation is not repeated, going forward. PIHP/CMHSP 2nd Response: MSHN MSHN continues to maintain the position that the use of reasonable ranges in the individual plan of service, based on medical necessity and discussed and approved during the planning meeting, is allowable per the definitions provided in the Medicaid Provider Manual, Section 1.7, and the requirements listed in 42 C.F.R. 441.725, MMHC 330.1700-1712,

				Michigan Administrative Code R. 330.7199, and the federal Balanced Budget Act of 1997, Section 438.10 (f)(6)(v). Therefore, we are not submitting a plan of correction for this finding as we believe we are in compliance with the standard. MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each

				CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI WSA #4589 had an addendum completed in August, which includes amount and scope of psychological services.

				Systemic Remediation: By 12/1/24, individualized training during supervision will occur on the need to address/resolve needs identified in the assessments, within the IPOS. This training will be documented on a staff training log. MDHHS 2nd Response: Response Not Accepted <u>MSHN</u>: Insufficient systemic remediation for lack of specific amount /scope /duration / frequency/ASDF of services within the Plan (conveying intent not to remediate those plan that reflect ranges instead). Please revise, to align with the requirements of MDHHS, so that the CAP can be approved. <u>CEI</u> Insufficient individual remediation WSA #4589 Remediation only addressed specific amount, scope, duration and frequency. Remediation needs to also address measurable goals. PIHP/CMHSP 3rd Response: **<u>CEI</u>**

				WSA #4589 will have an addendum completed by 3/4/2025 to ensure goals/objectives are measurable.
P.5.2. Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency, and timeframe for implementing. (HSW PM D-7)	18	20	REPEAT CITATION <u>CEI</u> WSA# 5274: Medication review not provided as specified. WSA# 5170: CLS not provided as specified. WSA# 4589: TCM (including review) and psychiatric services not provided as specified in Plan. WSA# 5091: TCM and CLS services not provided as specified in Plan.	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency, and timeframe for implementing. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____, plan will be amended for resolving/addressing service provision as recommended. ☒ By (Date) 11/1/24 for WSA # 5274, 5170, 4589, 5091, case manager will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity. ☐ Other: (See response below)

				☒ Systemic Remediation: ☒ By (Date) 12/1/24, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. ☐ Other: (See response below) MDHHS Response: ☐ Response accepted ☒ Response not accepted. – ___No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) . CEI: Insufficient systemic remediation. Two years ago, the systemic remediation was staff training (same as above). What additional steps will CEI be taking to address this repeat citation. Please add to/revise. PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of

				delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS

				CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI Systemic Remediation: on 10/17/24 a training was held, and a second staff training will be conducted by 12/1/24, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. Coordinators will follow up on training topics with clinicians during November supervision and document those conversations. MDHHS 2nd Response: Not Accepted CEI: Systemic Remediation lacks ongoing monitoring, such as random quarterly chart reviews.

				PIHP/CMHSP 3rd Response: **CEI:** Systemic Remediation: By 3/4/25, CEI will conduct random quarterly chart reviews on a sample of HSW cases, checking that services and treatment identified in the IPOS are provided as specified in the plan, goals/objectives are measurable and, the type, amount, scope, duration, frequency, and timeframe for implementing for one year are included in the IPOS.
P.5.3. The IPOS for individuals enrolled in the HSW is updated within 365 days of their last IPOS. (HSW PM D-5)	37	1	CEI: WSA# 4589	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the IPOS for individuals enrolled in the HSW is updated within 365 days of their last IPOS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☐ By (Date), the IPOS will be updated.

				☒ Other: (See response below) This consumer's IPOS was reviewed and amended on 8/7/24. The annual IPOS will be completed prior to or on the due date of 2/25/25 ☒ Systemic Remediation: ☒ By (Date) 12/1/24, staff training will be conducted, on the need to ensure that the IPOS is updated at least annually. ☐ Effective (Date) _____, quarterly monitoring of annual updating of the IPOS will occur by SC Supervisory staff. ☐ Other: (See response below) MDHHS Response: ☒ Response accepted
B. BEHAVIOR TREATMENT PLANS AND REVIEW COMMITTEES Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.				
B.2. Behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. 1. Documentation that plans that proposed to use restrictive or intrusive techniques are approved (or disapproved) by the committee 2. Documentation that plans that include restrictive/intrusive interventions include a functional assessment of	5	7	REPEAT CITATION NA = 26	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS.

behavior and evidence that relevant physical, medical, and environmental causes of challenging behavior have been ruled out. 3. Are developed using the PCP process and reviewed quarterly 4. Are disapproved if the use of aversive techniques, physical management, or seclusion or restraint where prohibited are a part of the plan 5. Written special consent is obtained before the behavior treatment plan is implemented; positive behavioral supports and interventions have been adequately pursued (i.e., at least 6 months within the past year) 6. The committee reviews the continuing need for any approved procedures involving intrusive or restrictive techniques at least quarterly.			CEI WSA# 4589: Freedom of movement/FOM limitations within home, without prior approval/oversight of BTPRC. WSA# 5091: FOM limitations (4-sided adult crib) without sufficient justification in the record, or BTPRC oversight/involvement (all elements of).	MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☒ By (Date) 11/1/24 BTP, functional behavior assessment will be completed for WSA # 4589. ☐ By (Date) _____, special consent will be obtained for WSA #_____. ☒ By (Date) 9/9/24, WSA #5091 will be presented to the BTRC for approval/disapproval of any restrictive measures recommended, with quarterly follow up reviews thereafter, for any approved measures. ☐ By (Date) _____, the IPOS will be amended to reflect recommendations within the BPT for restrictive measures. ☐ Other: (See response below) ☒ Systemic Remediation: ☒ By (Date) 11/1/24, staff training will be conducted, on the required steps for BTRC involvement. ☐ Effective (Date) _____, quarterly monitoring of BTRC involved records will occur by SC/Clinical Supervisory staff, for following BTRC technical requirements. ☐ Other: (See response below) MDHHS Response: ☐ Response accepted ☒ Response not accepted. – ____ No individual remediation found

			.	☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) For CEI, for these citations which are considered in need of urgent corrective action, individual remediations are in sufficient. • For WSA# 4589, completing a BTP is only the first step in correcting this matter. Please include the other steps that must also be completed, within the next 90 days, to sufficiently address, with timelines. • For WSA# 5091, please provide information on the required steps that must also be completed, prior to the BTPRC review, with timelines (so that MDHHS is able to confirm corrective action is consistent with the technical requirements).. PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly

				scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual.

				MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI For WSA #4589, the treatment team will determine if there are restrictions in the home and evaluate the need for a BTP. If a BTP is needed, a behavior psychologist will create and implement the plan upon approval by the BTC, by 12/1/2024. For WSA #5091, by 9/9/2024, staff will gather the necessary documents to help inform the BTC if a BTP is warranted. Staff will coordinate with guardian, other supports, primary care physician, and a psychologist to determine if this matter requires BTC oversight or if it is a health and safety concern. The BTC will continue to monitor gathered documentation until this determination is made. By 12/1/2024, staff will update the consumers chart documentation based on the determination. MDHHS 2nd Response: Not accepted

				CEI restrictions are in place at the current time. Rationale not followed from previous response from MDHHS in Blue above. PIHP/CMHSP 3rd Response: **CEI:** For WSA #4589, on 10/23/2024, the consumers IPOS was updated to remove restrictive language. Restrictions are no longer occurring. IPOS was signed on 11/18/2024 by the consumers guardian. For WSA #5091, CMHA-CEI staff obtained a prescription for the adult size crib bed dated 8/21/2024. CEI staff also completed an expedited Behavior Treatment Plan on 12/2/2024. During the expedited BTP period, staff will explore less restrictive measures and develop a full BTP with all requirements of a BTP followed.
Q. STAFF QUALIFICATIONS				
Q.2. HSW				
Q.2.1. The PIHP ensures that Waiver service providers meet credentialing standards prior to providing HSW services. (HSW PM C-1) (Evidence: personnel records and credentialing documents – including licensure and certification and required experience for QIDP).	35	1	A total of 36 Professional Staff were reviewed under MSHN HSW. REPEAT CITATION	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that Waiver service providers meet credentialing standards, prior to providing HSW services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS

			CEI *Insufficient evidence of QIDP prior to hire, or supervision by a QIDP upon hire, until credentialing requirements met.* WSA# 4448: Savannah Scheur	MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE: ☒ Individual Remediation: ☒ By (Date) 10/1/24, evidence of QIDP, or supervision by a QIDP, will be obtained for provision to MDHHS at 90-day f/u site review. ☐ By (Date) _____, a criminal background check will be completed for staff cited, and provided to MDHHS at 90-day f/u site review ☐ Other: (See response below) ☒ Systemic Remediation: ☐ CMHSP HR Department will develop a tool to assure QIDP credentialing, prior to service delivery, of newly hired/assigned staff to HSW enrollees, by (Date) _____. ☐ Effective (Date)_____ the CMHSP/HR Dept will retain evidence of QIDP status in personnel records (above/beyond credentialing committee determinations) for proof of staff qualifications ☐ Effective (Date)_____ Supervisory staff will monitor this requirement at least quarterly, from a random sample drawn, using a clinical chart review form document available for review within 90 days. ☐ Effective (Date)_____ quarterly monitoring of a random selection of personnel records will be completed quarterly by HR. ☒ Other: (See response below) CEI's HR department has begun internal meetings to evaluate the QIDP/CMHP credentialing process in order to ensure required credentialing documentation is appropriately maintained. While this internal collaboration will be ongoing, the agency will be

				implementing necessary steps to track credentialing for new hires beginning 12/1/24, and will review current employees at time of re-credentialing. MDHHS Response: ☐ Response accepted ☒ Response not accepted. – ___No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) CEI: Insufficient systemic remediation. Please provide more specific information about the "necessary steps" planned for implementation a tracking system for new hires, effective 12/1/24 (that evidence of will be provided at the 90-day review). What will be done to capture this information, within the next 90 days, for currently employed staff during their re-credentialing? PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually.

				MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS

				Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI CEI's has begun internal meetings to evaluate the QIDP/CMHP credentialing process in order to ensure required credentialing documentation is appropriately maintained. While this internal collaboration will be ongoing, the agency will be implementing necessary steps to track credentialing for new hires beginning 1/16/25. Tracking will include documenting of verified credentials including CMHP, QIDP, and QMHP status with primary source verification through staff attestation, resume, or transcripts, . For currently employed staff CEI will begin documenting verified credentials including CMHP, QIDP, and QMHP status with primary source verification

				through staff attestation, resume, or transcripts by 1/16/25. MDHHS 2nd Response: Response Accepted
Q.2.2. The PIHP ensures that Waiver service providers continue to meet credentialing standards on an ongoing basis. (HSW PM C-2) (Evidence: personnel records and credentialing documents – including licensure and certification and required experience for QIDP).	35	1	REPEAT CITATION CEI *Insufficient evidence of QIDP, or supervision by a QIDP ongoing.* WSA# 4448: Savannah Scheur	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that Waiver service providers continue to meet credentialing standards on an ongoing basis. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI REPSONSE ☒ Individual Remediation: ☒ By (Date) 10/1/24, evidence of QIDP, or supervision by a QIDP, will be obtained for provision to MDHHS at 90-day f/u site review. ☐ By (Date) _____, a criminal background check will be completed for staff cited, and provided to MDHHS at 90-day f/u site review ☐ Other: (See response below) ☒ Systemic Remediation: ☐ CMHSP HR Department will develop a tool to assure QIDP credentialing, ongoing, of staff to HSW enrollees by (Date) _____.

				☐ Effective (Date)_____ the CMHSP/HR Dept will retain evidence of QIDP status in personnel records (above/beyond credentialing committee determinations) for proof of staff qualifications ☐ Effective (Date)_____ quarterly monitoring of a random selection of personnel records will be completed quarterly by HR. ☒ Other: (See response below) CEI's HR department has begun internal meetings to evaluate the QIDP/CMHP credentialing process in order to ensure required credentialing documentation is appropriately maintained. While this internal collaboration will be ongoing, the agency will be implementing necessary steps to track credentialing for new hires beginning 12/1/24, and will review current employees at time of re-credentialing. MDHHS Response: ☐ Response accepted ☒ Response not accepted. – ___No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) CEI: Insufficient systemic remediation. Please provide more specific information about the "necessary steps" planned for implementation a tracking system for new hires, effective 12/1/24 (that evidence of will be provided at the

				90-day review). What will be done to capture this information, within the next 90 days, for currently employed staff during their re-credentialing? PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each

				CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI CEI's has begun internal meetings to evaluate the QIDP/CMHP credentialing process in order to ensure required credentialing documentation is appropriately maintained. While this

				internal collaboration will be ongoing, the agency will be implementing necessary steps to track credentialing for new hires beginning 1/16/25. Tracking will include documenting of verified credentials including CMHP, QIDP, and QMHP status with primary source verification through staff attestation, resume, or transcripts, . For currently employed staff CEI will begin documenting verified credentials including CMHP, QIDP, and QMHP status with primary source verification through staff attestation, resume, or transcripts by 1/16/25. MDHHS 2nd Response: Response Accepted
Q.2.3. The PIHP ensures that non-licensed Waiver service providers meet the provider qualifications identified in the Medicaid Provider Manual. (HSW PM C-3) Evidence; personnel and training records: 1. At least 18 years of age. 2. Able to prevent transmission of any communicable disease. 3. In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates	258	67	A total of 325 Aide Level Staff were reviewed under MSHN HSW REPEAT CITATION <u>CEI</u> *Insufficient evidence of Emergency Procedures Training*. WSA# 5091: Billie Leonard WSA# 4448: Lori Babcock McKenzie Simmons	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all non-licensed/non-certified providers meet provider qualifications. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation:

to the kind of duty he/she would be performing, not an illegal alien). 4. Able to perform basic first aid procedures, as evidenced by completion of a first aid training course, self-test, or other method determined by the PIHP to demonstrate competence in basic first aid procedures.			WSA# 5170: Michaelle Brown WSA# 5107: Rubonnir Kahumyo, Ron Vaughn *Lack of evidence of Blood Borne Pathogen/BBP training.* WSA# 5170: Erica Kinyan *Lack of date of hire information to determine compliance with initial CBC check.* WSA# 5170: Michaelle Brown *Lack of evidence of completing First Aid training.* WSA# 5170: ~~Sage Royston~~ *Lack of evidence of Recipient Rights/RR Training.* WSA# 5091: Taylor Galloway	☒ On 9/5/24, WSA #5170 (Erica Kinyan) completed emergency procedures. On 9/5/24, WSA #5170 (Michaelle Brown) completed emergency procedures. On 10/30/23, WSA #5091 (Taylor Galloway) completed recipient rights. By 12/1/24, the remaining staff for WSA# 5091: Billie Leonard, WSA# 4448: Lori Babcock and McKenzie Simmons, WSA# 5170: Michaelle Brown, WSA# 5107: Rubonnir Kahumyo, and Ron Vaughn will have proof of completion of emergency training. ☒ By (Date) 10/31/2024 WSA #5170: Michaelle Brown will secure a criminal background check. LARA has issued a letter for her that will automatically notify the provider if anything new shows up. ☐ Other: (See response below) ☒ Systemic Remediation: ☐ By (Date) _____, CMHSP/PIHP will meet with provider to review requirements related to staff credentialing. ☐ Effective (Date)_____ the CMHSP/HR Dept will randomly select a staff sample to review quarterly for required trainings. ☒ Other: (See response below) CEI's Quality Advisors will review requirements related to staff credentialing documents during each provider's annual site visit to ensure compliance standards are being met. Quality Advisors will also stress that for first aid training, the training must specifically state that is first aid training, not just life support. Any non-compliant standards found will result in the provider having to submit a corrective action plan and may also be put on a 90-day monitoring. HR Dept will randomly select a staff sample to review quarterly for required trainings, Effective upon MDHHS approval of the systemic remediation

				MDHHS Response: ☐ Response accepted ☒ Response not accepted. – ___No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) CEI: No individual remediation found for *Lack of evidence of Blood Borne Pathogen/BBP training.* WSA#5170: Erica Kinyan *Lack of evidence of completing First Aid training.* WSA# 5170: Sage Royston *Lack of date of hire information.* WSA# 5170: Michaelle Brown *TA: Regarding CEI systemic remediation, evidence of the first quarterly review (documented outcomes of provider compliance with required trainings) will be required at the 90-day review, to successfully meet the systemic remediation.* PIHP/CMHSP 2nd Response:

				MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule.

				The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI On 9.5.24,WSA #5170 (Erica Kinyan) completed Blood Borne Pathogens. File name: WSA #5170 Environmental Safety and BBP Trainings Erica Kinyan. As of 6.22.24, WSA #5170 (Sage Royston) no longer works for that provider so cannot complete first aid training. By 12.1.24, CEI will obtain date of hire information for WSA #5107 (Michaelle Brown).

				MDHHS 2nd Response: Response Accepted with proof of individual and systemic remediation provided at the 90 day follow up review.
Q.2.4 All HSW providers meet staff training requirements. (HSW PM C-4) • *Not limited to group home staff. All HSW providers for the samples should meet staff training requirements (includes own home and family home).* evidence: Training records: • *Has received training in the beneficiary's IPOS.*	294	31	REPEAT CITATION CEI WSA# 5091: Amy Ramirez, Autumn McGovern, Keri Bennett, Nicole Earhart, Shay Cook, Shelly Melrose, Taylor Galloway, Tosha Parks WSA# 4448: Tammy Sherman	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all HSW providers meet the staff training requirements specific to beneficiary specific IPOS, prior to providing services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☒ By (Date) 12/1/24, cited staff will receive required IPOS training specific to the beneficiary they are supporting. ☐ Other: (See response below) ☒ Systemic Remediation: ☐ By (Date) _____ CMHSP/PIHP will review with CM staff the obligation to provide IPOS training to those providing supports to waiver recipients, in a timely manner (upon update/amending of IPOS).

				☐ Effective (Date)_____ Supervisory staff will review quarterly, IPOS trainings provided/documented in the EMR, from a random sample pulled for this purpose. ☒ Other: (See response below) CEI's Quality Advisors will review requirements related to IPOS documentation during each provider's annual site visit to ensure compliance standards are being met. Any non-compliant standards found will result in the provider having to submit a corrective action plan and may also be put on a 90-day monitoring period. If compliance is not met, it is CEI's process to involve our Contracts Department to initiate possible sanctions ranging from pauses on referrals, payments being withheld, or termination of the contract. If the issue is found to have been caused by an error by CEI's case managers, this will be reported to the case manager and their supervisor for remediation. MDHHS Response: ☐ Response accepted ☒ Response not accepted. – ___No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) CEI:: Insufficient systemic remediation. No timelines/target dates found that fall within a 90 day remediation period. What evidence will be provided of systemic remediation, in 90 days, to

				demonstrate efforts to address this. Please revise. PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in

				alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI Systemic Remediation: CEI's Quality Advisors will review requirements related to IPOS documentation to ensure all staff have been trained on the IPOS as evidenced by signing the IPOS In-Service sheet by 12.1.24 and annually during each provider's annual site visit to ensure compliance standards are being met. Any non-compliant standards found will result in

				the provider having to submit a corrective action plan and may also be put on a 90-day monitoring period. If compliance is not met, it is CEI's process to involve our Contracts Department to initiate possible sanctions ranging from pauses on referrals, payments being withheld, or termination of the contract. If the issue is found to have been caused by an error by CEI's case managers, this will be reported to the case manager and their supervisor for remediation. MDHHS 2nd Response: Response accepted with proof of both individual and systemic remediation provided at the 90 Day Follow Up.

State Plan Amendment / (i)SPA (1915i)

DIMENSIONS/INDICATORS	Yes	No	FINDINGS	REMEDIAL ACTION
F. FREEDOM OF CHOICE				
F.2. iSPA				
F.1. C.1 Individual was informed of their right to choose among PROVIDERS.	65	11		Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the individual has the ability to choose their providers. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected

			<u>CMH Authority of Clinton-Eaton-Ingham Counties/CEI</u> WSA#: 1353439	within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CMH AUTHORITY OF CLINTON-EATON-INGHAM COUNTIES/CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____ WSA # _____will receive information regarding right to choose iSPA providers, with documentation in the record by the 90-day f/u site review. ☒ Other: (See response below) WSA # 1353439 was informed of the right to choose iSPA providers on 7-25-24. ☒ Systemic Remediation: ☐ By (Date) _____, training will be provided on the advising of iSPA recipients of this information, and documentation of the conveyance of this information in the record. ☐ By (Date) _____, EMR will be adjusted to include this information in required fields within the pre-planning document. ☒ Other: (See response below) This individual was receiving Case Management from an out of county provider. On 7/1/24, a CEI Case Manager was assigned to ensure that iSPA recipients are informed of this information and that there is documentation of the conveyance of this information in the record. MDHHS Response: ☐ Response accepted. ☒ <u>Response not accepted</u>. –

				___No individual remediation found. ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: CEI: For systemic remediation, more information is needed. What will the newly assigned CEI case manager specifically do to ensure that iSPA recipients will receive notification of their right to choose among providers of service, and that the conveyance of that information will be sufficiently documented in the record. What will be provided in 90 days to give evidence of this? PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the

				citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI Systemic: This individual was receiving Case Management from an out of county provider. On 7/1/24, a CEI Case Manager was

				assigned to ensure that iSPA recipients are informed of this information and that there is documentation of the conveyance of this information in the record. On 7/25/2024, CEI Case Manager met with individual to complete their annual assessment and IPOS pre-plan, which identifies the individual's ability to choose amongst providers. This documentation can be provided if/when requested.
F.1.C.2: Individual was informed of their right to choose among SERVICES.	49	27		Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the individual has the ability to choose their services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____ WSA # _____will receive information regarding right to choose among iSPA services, with documentation in the record by the 90-day f/u site review. ☒ Other: (See response below) WSA # 1353439 was informed of the right to choose iSPA providers on 7-25-24.

			CEI WSA# 1353439	☒ Systemic Remediation: ☐ By (Date) _____, training will be provided on the advising of waiver recipients of this information, and documentation of the conveyance of this information in the record. ☐ By (Date) _____, EMR will be adjusted to include this information in required fields within the pre-planning document. ☒ Other: (See response below) This individual was receiving Case Management from an out of county provider. On 7/1/24, a CEI Case Manager was assigned to ensure that iSPA recipients are informed of this information and that there is documentation of the conveyance of this information in the record. MDHHS Response: ☐ Response accepted. ☒ Response not accepted. – ___ No individual remediation found. ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: CEI: Insufficient individual remediation. It is choice of services that must be conveyed, not providers as reflected in individual remediation. Please revise. Re Systemic Remediation, more information is needed. What will the newly assigned CEI case manager specifically do to ensure that iSPA recipients will receive notification of their right to choose among services, and that the conveyance of information

				will be sufficiently documented in the record. What will be provided in 90 days to give evidence of this? PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule.

				The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI Individual: WSA#1353439 was informed of the right to choose iSPA providers, choice of services, and was informed about how to request new providers/services on 7/25/2024. Systemic: This individual was receiving Case Management from an out of county provider. On 7/1/24, a CEI Case Manager was assigned to ensure that iSPA recipients are informed of this information and that there is documentation of the conveyance of this information in the record. On 7/25/2024, CEI Case Manager met with individual to complete their annual assessment and IPOS pre-plan, which identifies the individual's ability to choose amongst providers. This documentation can be provided if/when requested.

				MDHHS 2nd Response: Response Accepted. TA: CEI see highlighted response above. Last 2 sentences reverts back to providers not services.
P. IMPLEMENTATION OF PERSON-CENTERED PLANNING Medicaid Managed Specialty Services and Supports Contract, Attachment P 3.4.1.1. Person-Centered Planning Guideline MCH712 Chapter III, Provider Assurances & Provider Requirements Attach. 4.7.1 Grievances and Appeals Technical Requirement.				
P.1.A.1: Individual plan of service addressed health and safety, including coordination with primary care providers.	54	22		Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the IPOS adequately addresses health and safety, including coordination with primary care physicians. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____ for WSA # _____, • Health care coordination with primary care physician will occur, and/or. • A psychiatric evaluation will be obtained, and/or

			CEI WSA# 1353194: Lack of COC with PCP. WSA# 1353192: Lack of COC with PCP and lack of signed medication consents. WSA#s 1353181, 1353439: Lack of COC with PCP, psychiatric eval and med consent signed by guardian.	• A signed medication consent will be obtained, and/or • Other:_____ ☒ Other: (See response below) WSA#1353194 will have in his chart proof of COC with PCP by Nov 30th 2024 and a signed medication consent will be obtained by Nov. 20/24. WSA# 1353192 will have in her chart proof of COC with PCP by Oct. 8th 2024 and a signed medication consent will be obtained by Nov. 20/24. WSA#1353181 and 1353439 will have in their chart proof of COC with PCP by Nov 30th and a signed medication consent by guardian will be obtained by Nov. 5th/24. ☒ Systemic Remediation: ☐ By (Date) _____, staff training will be provided on the need to adequately address the health and safety of the individual served. ☐ Effective (Date) _____, quarterly monitoring of a random sample of IPOS plans for HSW will occur by Supervisory staff, so ensure compliance with this performance measure.. ☒ Other: (See response below) By Dec. 31/24, staff training will be provided on the need to adequately address the health and safety on the individuals served. Effective Oct 1st. 2024, quarterly monitoring of random sample of IPOS plans for HSW will occur by coordinator or supervisor staff, so ensure compliance with this performance measure. MDHHS Response: ☐ Response accepted. ☒ Response not accepted. – ___No individual remediation found.

				☐ No systemic remediation found. ☐ No timelines indicated. _X_ Other: CEI: Lack of individual remediation for WSA#s 1353181, 1353439, specific to their need for psychiatric evaluations. Please revise. fCMHCM: Lack of Individual remediation for WSA# 1353592: "COC found in chart under Record of Disclosure documents dated: 03/10/2023". A documented dated March 2023 is too old to have met the requirement at the time of the annual review or at the 90-day review. Please revise, for this annual requirement. PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the

				citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI Individual: WSA#1353181 and WSA#1353439 will have proof of Coordination of Care with their Primary Care Physician in their chart, and, if needed, a 1)

				psychiatric evaluation and 2) a signed medication consent by 11/30/2024. MDHHS 2nd Response: Response Accepted with proof of Individual and Systemic remediations provided at the 90 Day Follow Up
P.1.A.2. The individual plan of service addresses the assessed needs of a beneficiary.	67	9	<u>CEI</u> WSA# 1353183: Need for job coaching services not addressed the Plan.	Submit a plan that reflects both individual and systemic remediation with time frames for ensuring that the individual plan of service adequately address needs of a beneficiary. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____ for WSA # _____, the plan will be amended to reflect6 the assessed needs of the individual served ☒ Other: (See response below) WSA# 1353183: By 12/1/24, the employment related needs will be reassessed with the individual and the plan will be updated if the needs are still present. ☒ Systemic Remediation: ☐ By (Date) _____, staff training will be provided on the need to adequately address needs

				(identified in assessments or during on-going services), within the plan of service. ☐ Effective (Date) _____, quarterly monitoring of a random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance with the performance measure.. ☒ Other: (See response below) By 11/1/24, staff training will be provided on the need to adequately address needs (identified in assessments or during on-going services), within the plan of service. MDHHS Response: ☐ Response accepted. ☒ Response not accepted. – ___No individual remediation found. ☐ No systemic remediation found. ☐ No timelines indicated. ☒ Other: (See response below) PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN

				completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action.

				MDHHS 2nd Response: Response Accepted
P.1.A.3: The individual plan of service is developed in accordance with policies and procedures established by MDHHS. Evidence: 1. pre-planning meeting, 2. availability of self-determination, and 3. use of PCP process in developing IPOS. (HSW PM D-4)	53	23	<u>CEI</u> WSA# 1353189: Periodic Review completed without Guardian input. WSA#1353169: Lack of adequate due process for removal of respite from Plan of Service. WSA# 1353179: Lack of sufficient evidence of guardian involvement (or attempts to get guardian involvement) in pre-planning process. WSA# 1353183: Lack of adequate due process for removal of psychiatric services, and lack of sufficient transition planning prior to moving	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the IPOS is developed in accordance with the policies and procedures established by MDHHS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____ the following will be completed/reflected in the record: for WSA #_____: - Pre-Planning Meeting - Offer of self-determination - Offer of Independent Facilitation - Other (See below) WSA# 1353189: Guardian input will be sought and documented thoroughly in the pre-planning process by 12/8/24. WSA#1353169: An IPOS addendum was completed on 5/17/24 to authorize Respite. WSA# 1353179: Individual closed to services on 11/16/23.

			recipient from a stable living arrangement, to another setting, without sufficient rationale for the move. WSA# 1353439: Lack of pre-planning, including the offering of Independent Facilitation/IF & Self Directed/SD services. IPOS effective date before IPOS meeting held.	WSA # 1353183: By 12/1/24, the clinical team will review the IPOS and authorized services with the consumer/guardian to ensure services meet the consumers identified need. If necessary, an IPOS addendum will be completed. WSA# 1353439: A pre-planning meeting, to include the offer of Independent Facilitation and Self-Directed Services was completed on 7/25/24. The IPOS was held on 8/9/24 ☒ Systemic Remediation: ☐ By (Date) _____, additional training will be provided to the staff at large regarding the required elements of the person-centered planning process. ☐ Effective (Date) _____, quarterly monitoring by Supervisory staff, of a random pull of records, will be conducted for compliance. ☒ Other: (See response below) By 12/1/24, additional training will be provided to the staff at large regarding the required elements of the person-centered planning process to include due process. MDHHS Response: ☐ Response accepted. ☒ Response not accepted. – __No individual remediation found. ☐ No systemic remediation found. ☐ No timelines indicated. ☒ Other: (See response below) CEI: Insufficient systemic remediation. No mention found in planned training of the need for guardian involvement/attempted

				involvement in planning and plan review activities. Please revise. PIHP/CMHJSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by

				MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI Systemic: By 12/1/2024, additional staff training will be provided to staff at large regarding the required elements of the person-centered planning process, including education regarding involvement/attempts at involvement of the guardian or other supports, the pre-planning process, availability of self -determination, using the PCP to develop the IPOS, etc. PIHP/CMHSP's 3rd Response:
P. PLAN OF SERVICE AND DOCUMENTATION REQUIREMENTS				

P.1.B.1: The IPOS for individuals enrolled in the iSPA is updated within 365 days of their last IPOS.	59	3	NA = 14 CEI WSA# 1353169 WSA#1353439	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the IPOS for individuals enrolled in the iSPA is updated within 365 days of their last IPOS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____, the IPOS will be updated. ☒ Other: (See response below) WSA# 1353169: The annual IPOS will be completed by 9/27/24, which is within 365 days of the previous IPOS. WSA#1353439: The IPOS was updated on 8/9/24. ☒ Systemic Remediation: ☐ By (Date) _____, staff training will be conducted, on the need to ensure that the IPOS is updated at least annually. ☐ Effective (Date) _____, quarterly monitoring of annual updating of the IPOS will occur by SC Supervisory staff. ☒ Other: (See response below) By 12/1/24, staff training will be conducted on the need to ensure that the IPOS is updated at least annually. MDHHS Response: ☒ Response accepted.

P.1.B.2. Specific services and supports that align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing, are identified in the IPOS.	11	65	<u>CEI</u> WSA# 1353071: Lack of specific ASDF of TCM services and measurable goal objectives. WSA# 1353169: Lack of specific ASDF of TCM services within Plan, and lack of recipient based measurable goal objectives. WSA# 1353179: Lack of specific ASDF of services within the Plan. WSA# 1353182: Lack of specific ASDF of TCM services within Plan, and measurable objectives. WSA# 1353183: Lack of specific ASDF of TCM and Psychiatric services (ranges used instead). WSA# 1353439: Lack of specific ASDF of services, and lack of behavioral treatment goal/objective, recommended in Behavior Treatment Plan/BTP. WSA# 1353189: Ranges used for TCM. Not all goal/objectives are measurable. WSA# 1353190: Not all goal/objectives are measurable.	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the specific services and supports in the IPOS align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing are identified in the IPOS. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. During the FY2022 full site review, MSHN sent a letter in response to the citation regarding the lack of specific amount, scope and duration (ranges used instead) to Lyndia Deromedi, Manager, Federal Compliance Section of MDHHS on 8/17/2022. The letter titled, Service Range Response Letter Subject: 2022 1915 c HCBS Waivers Site Review Report proposed the use of reasonable ranges in plans of service, based on medical necessity, and as discussed during the planning meeting and approved by the support team, to allow for the most flexible and efficient approach to providing care to vulnerable individuals in our system. MSHN continues to take the position that the use of ranges is more aligned with the recovery model of care and in alignment with the requirement within the Medicaid Provider Manual. Recovery services are expected to be more dynamic, individualized, flexible, support many pathways,

			WSA# 1353191: TCM and Medication Reviews use range language for services. WSA# 1353194: Lack of specific ASDF for all services. Not all goal/objectives are measurable. WSA# 1353192: Not all goal/objectives are measurable. WSA # 1353195: Not all goal/obj are measurable.	and serve as a partnership/consultative approach that adapts to the needs of the individual. The use of too specific amounts in the PCP appears overly prescriptive and not very compatible with our understanding of recovery as a non-linear process CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____, plan will be amended for resolving/addressing service needs identified in assessments. ☐ By (Date) _____, plan will be amended to include specific amount scope duration frequency of recommended supports, and/or to include measurable goal/objectives ☒ Other: (See response below) WSA# 1353071, WSA# 1353169, WSA# 1353182, WSA# 1353183, WSA# 1353189, WSA# 1353195, and WSA# 1353191: By 12/1/24, plan will be amended to include specific amount scope duration frequency of recommended supports, and to include measurable goal/objectives WSA# 1353179: Individual closed to services on 11/16/23. WSA# 1353439: By 12/1/24, plan will be amended to include goals will be included related to the Behavior Treatment Plan. (1353190) by Sep. 30th annual treatment will be completed with measurable goal objectives. (1353192) by Sep. 30th annual treatment will be completed with measurable goal objectives. (1353194) by Nov. 1st annual treatment will be completed with measurable goal objectives. ☒ Systemic Remediation: ☐ By (Date) _____, staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS, as well as the requirement for specific amount scope duration frequency of recommended services and measurable goal/objectives.

				☐ Effective (Date) _____, quarterly monitoring random sample of IPOS plans for HSW will occur by Supervisory staff, to ensure compliance. ☒ Other: (See response below) By 12/1/24, staff training will be conducted on the need to address/resolve needs identified in the assessments, within the IPOS, as well as the requirement for specific amount scope duration frequency of recommended services and measurable goal/objectives. By Nov. 30th, staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS, as well as the requirement for specific amount scope duration frequency of recommended services and measurable goal/objectives. MDHHS Response: ☐ Response accepted. ☒ Response not accepted. – ___No individual remediation found. ☐ No systemic remediation found. ☐ No timelines indicated. ☒ Other: (See response below) MSHN: Insufficient systemic remediation for lack of specific amount/scope/duration/frequency/ASDF of services within the Plan (conveying intent not to remediate these citations). Please revise, to align with the requirements of MDHHS, so that the CAP can be approved.

				CEI: WSA# 1353439, WSA# 1353194: Insufficient individual remediation. No remediation found for lack of specific ASDF. Please revise. PIHP/CMHSP 2nd Response: MSHN MSHN continues to maintain the position that the use of reasonable ranges in the individual plan of service, based on medical necessity and discussed and approved during the planning meeting, is allowable per the definitions provided in the Medicaid Provider Manual, Section 1.7, and the requirements listed in 42 C.F.R. 441.725, MMHC 330.1700-1712, Michigan Administrative Code R. 330.7199, and the federal Balanced Budget Act of 1997, Section 438.10 (f)(6)(v). Therefore, we are not submitting a plan of correction for this finding as we believe we are in compliance with the standard. MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in

				FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule. The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action.

				CEI Individual: By 12/1/2024, WSA#1353194's IPOS will be amended to include specific amount, scope, duration, and frequency of recommended supports, and include measurable goals and objectives. Individual: By 12/1/2024, WSA#1353439's IPOS will be amended to include specific amount, scope, duration, and frequency of recommended supports. The addendum will include measurable objectives and goals related to the Behavior Treatment Plan.
P.1.B.3: Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency, and timeframe for implementing.	25	51	<u>CEI</u> WSA# 1353190: TCM not provided as specified. WSA# 1353191: Medication Reviews not provided as specified in Plan. WSA# 1353194: Medication Reviews not provided as specified in Plan. WSA# 1353192: TCM, CLS, Therapy not provided as specified. WSA# 1353195: TCM, Medication Reviews, Nutrition services not provided as recommended in Plan. WSA# 1353071: TCM, Support Employment	Submit a plan that reflects both individual and systemic remediation, with time frames for ensuring that the services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency, and timeframe for implementing. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews.

			Services not provided as specified. WSA# 1353169: Lack of recipient/guardian satisfaction check at time of Plan Review, and CLS not provided as specified in Plan. WSA# 1353179: Psychiatric and CLS services (no CLS logs made available) not provided as specified in Plan. Also failure of CEI to maintain sufficient capacity (for level IV residential facility) to allow this individual to reside in a lesser restrictive setting (before individual was moved to a nursing home). WSA# 1353181: TCM, Peer Services, Psychiatric, CLS services not provided as specified. WSA# 1353182: Lack of guardian involvement/attempts to get guardian involvement in Plan Review. WSA# 1353183: TCM (monthly and full Plan Review) not provided as specified/required. WSA# 1353439: TCM, Psychiatric and psychological services not occurring as specified.	CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____, plan will be amended for resolving/addressing service provision as recommended. ☐ By (Date) _____, SC will provide rationale in the record for disparity between recommended and provided services, and steps to resolve that disparity. ☒ Other: (See response below) (WSA#1353190) By Sep. 30th annual treatment plan will be completed resolving the disparity between TCM recommended and provided services. WSA# 1353191: By 12/1/24, plan will be amended for resolving/addressing service needs. (WSA#1353194) By Oct. 30th annual treatment plan will be completed resolving the disparity between Medication Reviewed recommended and provided services. (WSA#1353192) By Sep. 30th annual treatment plan will be completed resolving the disparity between TCM and CLS recommended and provided services. (WSA#1353195) By Nov. 30 annual treatment plan will be completed resolving the disparity between Medication Reviewed and Nutrition recommended and provided services. WSA# 1353071: By 12/1/24, plan will be amended for resolving/addressing service needs, including Supported Employment. WSA #1353169: The IPOS review will be completed by 12/1/24 resolving the disparity between CLS recommended and provided services with guardian satisfaction documented. WSA# 1353179: Individual closed to services on 11/16/23. (WSA#1353181) By Nov. 30 annual treatment plan will be completed resolving the disparity between Medication Reviewed recommended and provided services. WSA# 1353182: The IPOS review will be completed by 12/1/24 with evidence of guardian input. WSA# 1353183: By 12/1/24 annual treatment plan will be reviewed as specified and then monthly as required.

				WSA# 1353439: By 12/1/24, a review of current provider capacity will occur and new referrals made if services cannot be provided to the frequency needed of the person. ☒ Systemic Remediation: ☐ By (Date) _____, staff training will be conducted, on the need to monitor service utilization and providing documentation specific to resolving disparity noted. ☒ Other: (See response below) By 12/1/24, staff training will be conducted on the need to address/resolve needs identified in the assessments, within the IPOS, as well as the requirement for specific amount scope duration frequency of recommended services and measurable goal/objectives. By Nov. 30th, staff training will be conducted, on the need to address/resolve needs identified in the assessments, within the IPOS, as well as the requirement for specific amount scope duration frequency of recommended services and measurable goal/objectives. MDHHS Response: ☐ Response accepted. ☒ Response not accepted. – No individual remediation found. ☐ No systemic remediation found. ☐ No timelines indicated. ☒ Other: (See response below) CEI

				WSA# 1353439 Individual remediation does not resolve the discrepancy of service included in the EMR for this individual. Please revise. PIHP/CMHSP 2nd Response: MSHN MSHN conducts annual Delegated Managed Care (DMC) reviews of the 12 CMHSPs in our region addressing specific programs and areas of delegated managed care annually. MSHN also conducts increased monitoring and follow-up reviews which may take place outside of the regularly scheduled annual monitoring timeframes when necessary. To ensure consistency, MSHN utilizes the same review standards as MDHHS when conducting waiver reviews. MSHN completed a waiver review of all CMHSPs in FY24. MSHN will conduct the follow-up/CAP implementation review in FYQ1 FY25. At which time MSHN will also include the MDHHS citations and remediations outlined in each CMH plan of correction if the citations differ from the MSHN review citations. MSHN will review for full implementation of the MDHHS approved corrective action plan as well as the MSHN approved corrective action plan within 90 days for each CMHSP for every applicable standard. After reviewing for implementation in FY25Q1, MSHN will continue to regularly review waiver programs in alignment with the annual review schedule.

				The reviews will ensure that the plan of correction approved by MDHHS and by MSHN respectively have been implemented by the CMH to ensure compliance with the waiver requirements as outlined in the MDHHS CMS approved waiver plans MDHHS Policies and Procedures, and the MI Medicaid Provider Manual. MSHN will be addressing the specific CMHSP findings through CAP guidance and review of proof of implementation and will act on any citations that have not been addressed. Those actions can/will include one or more of the following: 1) increased frequency of monitoring and oversight, 2) increased reporting, 3) technical assistance, or in some instances, 4) contract non-compliance action. CEI Individual: By 12/1/2024, WSA#1353439's IPOS will be reviewed and amended resolving the disparity between TCM, psychological services, and psychiatric services.
C. BEHAVIOR TREATMENT PLANS AND REVIEW COMMITTEES Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.				
B.2. Behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan Review Committees.	0	6	NA = 70	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that behavioral treatment plans are developed in accordance with the Technical Requirement for Behavior Treatment Plan

1. Documentation that plans that proposed to use restrictive or intrusive techniques are approved (or disapproved) by the committee 2. Documentation that plans that include restrictive/intrusive interventions include a functional assessment of behavior and evidence that relevant physical, medical and environmental causes of challenging behavior have been ruled out. 3. Are developed using the PCP process and reviewed quarterly 4. Are disapproved if the use of aversive techniques, physical management, or seclusion or restraint where prohibited are a part of the plan 5. Written special consent is obtained before the behavior treatment plan is implemented; positive behavioral supports and interventions have been adequately pursued (i.e. at least 6 months within the past year) 6. The committee reviews the continuing need for any approved procedures involving intrusive or restrictive techniques at least quarterly.			CEI: WSA# 1353179: Potentially restrictive equipment (seatbelts on wheelchair for a previously ambulatory individual, following falls, without sufficient documentation in the record to rule out this equipment being used to restrict her ability to ambulate. If to restrict ambulation, no evidence of BRPRC involvement. (Closed iSPA) WSA#1353439: For freedom of movement/FOM limitations, lack of special consent, the less restrictive interventions attempted, and timely BTPRC approval and oversight, as required.	Review Committees. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____, BTP, functional behavior assessment will be completed for WSA #_____. ☐ By (Date) _____, special consent will be obtained for WSA #_____. ☐ By (Date) _____, WSA #_____ will be presented to the BTRC for approval/disapproval of any restrictive measures recommended, with quarterly follow up reviews thereafter, for any approved measures. ☐ By (Date) _____, the IPOS will be amended to reflect recommendations within the BPT for restrictive measures. ☒ Other: (See response below) WSA# 1353179: Individual closed to services on 11/16/23. WSA#1353439: A referral was made to a new behavioralist to review the current needs and supports. By 12/1/24, an updated plan will be presented to the BTRC for approval/disapproval of any restrictive measures recommended. ☒ Systemic Remediation: ☐ By (Date) _____, staff training will be conducted, on the required steps for BTRC involvement. ☐ Effective (Date) _____, quarterly monitoring of BTRC involved records will occur by SC/Clinical Supervisory staff, for following BTRC technical requirements.

				☒ Other: (See response below) By 12/1/24, staff training will be conducted on the required steps for BTRC involvement. MDHHS Response: ☐ Response accepted with proof of Individual and Systemic remediation submitted at the 90 Day follow up review. ☒ Response not accepted. __ No individual remediation found ☐ No systemic remediation found. ☐ No timelines indicated. ☒ Other: (See response below) CEI: For WSA# 4589, completing a BTP is only the first step in correcting this matter. Please include the other steps that must also be completed (including special consent, inclusion into the Plan of Service, etc), within the next 90 days, to sufficiently address, with timelines. PIHP/CMHSP 2nd Response: MSHN CEI *MDHHS indicated the incorrect WSA above (4589). This was confirmed by CPD on 10/25/24.

				Individual: WSA#1353439: By 12/1/2024, a referral to a behavior psychologist will be made to review the current needs and supports. An updated Behavior Treatment Plan will be developed, in accordance with documenting the restrictions/intrusive techniques, an FBA, and special consent. The Behavior Treatment Plan will be included in the individuals IPOS. The Behavior Treatment Plan will be monitored through quarterly reviews by the Behavior Treatment Committee.. MDHHS 2nd Response: Response Not Accepted. CEI: Not only does the BTP need to be developed by the 90 day follow up, but all of the steps required under the BTPRC technical requirements. Please provide dates in which the FBA and special consent will be completed, the IPOS will be amended to include these interventions as well as BTPRC review/approval. PIHP/CMHSP 3rd Response: **CEI:** On 11/25/2024, WSA#1353439 Behavior Treatment Plan was presented to CMHA-CEI Behavior Treatment Committee which included all required elements of the BTPRC Technical Requirements. The FBA and special consent was completed on 11/25/2024, and the IPOS will be

				amended to reflect these interventions by 12/1/2024.
G. WAIVER PARTICIPANT HEALTH AND WELFARE Medicaid Managed Specialty Services and Supports Contract, Attachment P.1.4.1.				
G.1 Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents. (Date(s) of progress notes, provider notes that reflect this information.).	72	5	CEI WSA# 1353439	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that the individual is provided information/education on how to report abuse/neglect/exploitation and other critical incidents. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____, WSA # _____ will be provided information/education on how to report abuse/neglect/exploitation and other critical incidents, as evidenced in the record by _____. ☒ Other: (See response below) WSA#1353439: By 11/1/24, will be provided information and education on how to report abuse/neglect/exploitation and other critical incidents as evidenced in the record through the service note. ☒ Systemic Remediation: ☐ By (Date) _____, training will be provided to CM staff regarding this requirement.

				☐ By (Date) _____, The EMR will be adjusted to include a field that captures this PM in the pre-planning process. ☐ Effective (Date)_____ the EMR will be adjusted to include a field that captures this PM in the pre-planning process. ☐ Effective (Date)_____ Supervisory staff will monitor this requirement at least quarterly, from a random sample drawn, using a clinical chart review form document available for review within 90 days. ☒ Other: (See response below) By 12/1/24, training will be provided to CM staff regarding this requirement.
G.2 Individual served received health care appraisal. (Date/document confirming_____)	71	5	CEI WSA#s 1353190, 1353194, 1353192,	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that the individual served has received a health care appraisal. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the in action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____, WSA # _____ will receive a health appraisal as evidenced by a completed health appraisal form in the record, signed by the clinician providing the appraisal. ☒ Other: (See response below)

				WSA#1353190 will receive a Health Appraisal by Nov. 2024 as evidenced by a completed health appraisal form in the record, signed by the clinician provident the appraisal. (WSA#1353192) will receive a Health Appraisal by Nov. 2024 as evidenced by a completed health appraisal form in the record, signed by the clinician provident the appraisal. (WSA#1353194) will receive a Health Appraisal by Nov. 2024 as evidenced by a completed health appraisal form in the record, signed by the clinician provident the appraisal. ☒ Systemic Remediation: ☐ By (Date) _____, training will be provided to CM staff regarding this requirement. ☐ By (Date) _____, The EMR will be adjusted to include a field that captures this PM in the pre-planning process. ☐ Effective (Date)_____ the EMR will be adjusted to include a field that captures this PM in the pre-planning process. ☐ Effective (Date)_____ Supervisory staff will monitor this requirement at least quarterly, from a random sample drawn, using a clinical chart review form document available for review within 90 days. ☒ Other: (See response below) By Dec. 2024, training will be providing to CM staff regarding this requirement. Effective Dec.2024, the EMR will be adjusted to include a field that captures this PM in the pre-planning process Effective Oct. 2024, Supervisory staff will monitor this requirement at least quarterly, from a random sample drawn, using a clinical chart review form document available for review within 90 days. MDHHS Response: ☒ Response accepted with proof of individual and systemic remediation provided at the 90 Day Review.

Q. STAFF QUALIFICATIONS				
Q.2. iSPA				
Q.4.3. The PIHP ensures that non-licensed iSPA service providers meet the provider qualifications identified in the Medicaid Provider Manual. Evidence; personnel and training records: 1. At least 18 years of age. 2. Able to prevent transmission of any communicable disease. 3. In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, not an illegal alien). 4. Able to perform basic first aid procedures, as evidenced by completion of a first aid training course, self-test, or other method determined by the PIHP to demonstrate competence in basic first aid procedures.	210	62	There was a total of 272 Aide Level Staff reviewed under MSHN iSPA CEI *Lack of evidence of First Aid Training* WSA# 1353194: Amy Smith WSA#s 1353179, 1353197: Carol Fischer WSA# 1353192: Denise Reeves WSA# 1353181: Larry Chillers *Lack of evidence of initial background check being completed prior to hire.* WSA# 1353182: Ashlee Ruthig Myra Ruthig Rodney Baxter WSA# 1353189: Helen Bushrey Lisa Bailey *Lack of Emergency Procedures Training*	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all non-licensed/non-certified providers meet provider qualifications. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____, cited staff for WSA #_____ will provide evidence of being 18 or older. ☐ By (Date) _____, cited staff for WSA #_____ will secure a criminal background check ☒ Other: (See response below) By 11/4/2024, cited staff for WSA #1353194, will provide evidence of First Aid Training. By 11/4/2024, cited staff for WSA #1353179 and 1353197, will provide evidence of First Aid Training. By 11/4/2024, cited staff for WSA #1353192, will provide evidence of First Aid Training. By 11/4/2024, cited staff for WSA #1353181, will provide evidence of First Aid Training. By 11/4/2024 cited staff for WSA #1353182: The non-compliance with requirements was discussed with the new

			WSA# 1353190: Aster Mekonnen Daniel Collar WSA# 1353189: Helen Bushrey* Jennifer Young WSA# 1353182: Myra Ruthig* *Lack of Blood Borne Pathogen/BBP Training* WSA# 1353190: Gloria Doebler WSA# 1353181: James Wilson Larry Chillers,* Tiffany Sims *Lack of evidence of name change to resolve credentialing evidence.* WSA# 1353195: Hope Jenks	owners on 06/06/24 and they are aware of the requirements for any new staff moving forward. By 11/4/2024 cited staff for WSA #1353189 will obtain and submit a criminal background check. By 11/4/2024, cited staff for WSA #1353190, will provide evidence of Emergency Procedures Training. By 11/4/2024, cited staff for WSA #1353189, will provide evidence of Emergency Procedures Training. By 11/4/2024, cited staff for WSA #1353182, will provide evidence of Emergency Procedures Training. By 11/4/2024, cited staff for WSA #1353190, will provide evidence of Blood Borne Pathogen/BBP Training. By 11/4/2024, cited staff for WSA #1353181, will provide evidence of Blood Borne Pathogen/BBP Training. By 11/4/2024, cited staff for WSA #1353195, will provide evidence of legal name change to resolve credentialing evidence. ☒ Systemic Remediation: ☐ By (Date) _____, CMHSP/PIHP will meet with provider to review requirements related to staff credentialing. ☐ Effective (Date)_____ the CMHSP/HR Dept will randomly select a staff sample to review quarterly for required trainings, with fust full review provided to MDHHS at the 90-day review.. ☒ Other: (See response below) Quality Advisors will review requirements related to staff credentialing documents during each provider's annual site visit to ensure compliance standards are being met. Any non-compliant standards found will result in the provider having to submit a corrective action plan and may also be put on a 90-day monitoring period. If compliance is not met, it is CEI's process to involve our Contracts Department to initiate possible sanctions ranging from pauses on referrals, payments being withheld, or termination of the contract Emergency Training completion: This training requirement was not met due to Mid-State Health Network having the incorrect information on their training grid that is provided to every CMHSPs within the region prior to the new fiscal year.

				CEI now knows that the training requirement standard for environmental training is every three years as indicated on the FY25 MSHN training grid. Quality Advisors will review staff trainings at every annual site review and corrective action plans will be requested from the provider if non-compliance is identified. HR Dept will randomly select a staff sample to review quarterly for required trainings, Effective upon MDHHS approval of the systemic remediation MDHHS Response: ☐ Response accepted ☒ Response not accepted. – ___No individual remediation found ☐ No systemic remediation found ☐ No timelines indicated ☒ Other: (See response below) CEI: TA: Systemic remediation accepted with evidence of the first quarterly review, of provider credentialing records, due at the 90-Day review. PIHP/CMHSP 2nd Response:
Q.4.4 All iSPA providers meet staff training requirements. *Not limited to group home staff. All iSPA providers for the samples should meet*	195	77	CEI: WSA# 1353182: Ashlee Ruthig,	Submit a plan that reflects both individual and systemic remediation with time frames to ensure that all iSPA providers meet the staff training requirements specific to beneficiary specific IPOS, prior to providing

staff training requirements (includes own home and family home). evidence: Training records: • *Has received training in the beneficiary's IPOS.*			Kristy Ruthig, Rodney Baxter WSA# 1353195: Asia Walls. Ayana Simmons, Dakotha Drushel, Hope Jenks, India Marizette, Jazzlyn Campbell, Raziya Terry, Teighlor Campbell Kathleen Price WSA#s 1353179, 1353197: Carol Fischer WSA# 1353183: Chris Rhymes, Lola Suttles WSA# 1353191: Danielle Struble, Esperanza Leonard, Isaiah Alston, Jennie Edmond, Matilda Sipeolu, Milagros Martinez Saige Rice, Salome Solo Zano, Steven Parker, WSA# 1353181: Tiffany Sims	services. The plan must be submitted within 30 days of receipt of this report and the finding must be corrected within 90 days after the corrective action plan has been approved by MDHHS. MSHN MSHN will monitor to ensure implementation of plans of correction for findings identified during Delegated Managed Care (DMC) reviews. CEI RESPONSE ☒ Individual Remediation: ☐ By (Date) _____, cited staff will receive required IPOS training specific to the beneficiary they are supporting. ☒ Other: (See response below) By 11/4/2024, cited staff for WSA #1353182 will receive required training in the IPOS for the consumer they are supporting. By 11/4/2024, cited staff for WSA #1353195 will receive required training in the IPOS for the consumer they are supporting. By 11/4/2024, cited staff for WSA #1353179 and #1353197 will receive required training in the IPOS for the consumer they are supporting. By 11/4/2024, cited staff for WSA #1353183 will receive required training in the IPOS for the consumer they are supporting. By 11/4/2024, cited staff for WSA #1353191 will receive required training in the IPOS for the consumer they are supporting. By 11/4/2024, cited staff for WSA #1353181 will receive required training in the IPOS for the consumer they are supporting. ☒ Systemic Remediation: ☐ By (Date) _____, CMHSP/PIHP will review

				with/train CM staff the obligation to provide IPOS training to those providing supports to iSPA recipients, in a timely manner (upon update/amending of IPOS), . as well as the 4 elements required as evidence for training: • Date of Training • Content of Training (including date of IPOS) • Who was trained (legible names) • Who did the training (legible name/title) ☐ Effective (Date)_____ Supervisory staff will review quarterly, IPOS trainings provided/documented in the EMR, from a random sample pulled for this purpose. ☒ Other: (See response below) By 12/30/2024, CEI will review with/train case managers on the obligation to provide IPOS training to staff working with the beneficiary. This training will occur in a timely manner upon creating/amending the IPOS. Training documentation will include the date of training, who was trained, who did the training, and content of the training (IPOS). Quality Advisors will review requirements related to IPOS documentation during each provider's annual site visit to ensure compliance standards are being met. Any non-compliant standards found will result in the provider having to submit a corrective action plan and may also be put on a 90-day monitoring period. If compliance is not met, it is CEI's process to involve our Contracts Department to initiate possible sanctions ranging from pauses on referrals, payments being withheld, or termination of the contract. If the issue is found to have been caused by an error by CEI's case managers, this will be reported to the case manager and their supervisor for remediation

MSHN Audit

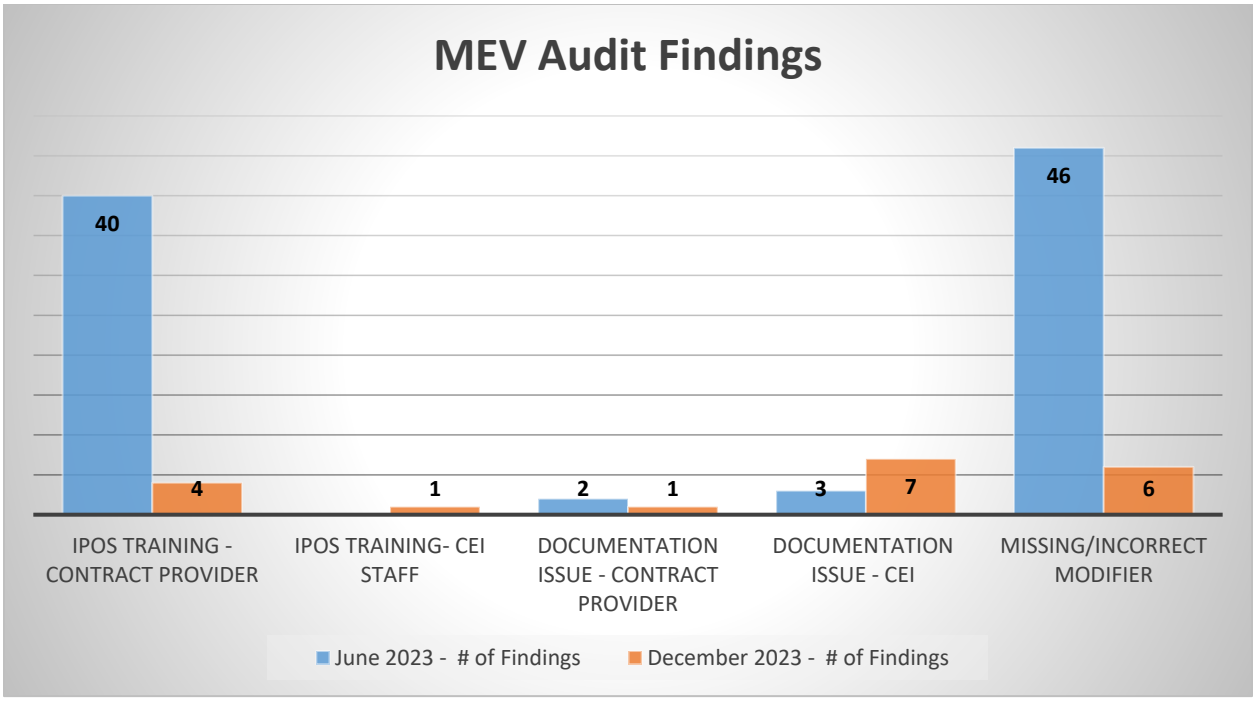
MSHN developed a Delegated Managed Care Review cycle that spans over 3 years and consolidates MSHN reviews with external reviews (when possible). The 3-year review cycle was implemented starting in FY24, and is intended to improve agency monitoring and corrective action implementation.

MSHN conducted a virtual desk audit of CMHA-CEI in June 2024. CMHA-CEI scored 100% in the Administrative Review and did not have any findings.

Medicaid Event Verification Audit

For FY24, there were two Medicaid Event Verification audits held by MSHN during June and December 2024. 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.

In FY24, QI started to track the number of findings from MEV audits and their associated categories in order to identify trends and opportunities for targeted improvements. The summary of findings are identified in a chart below:



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

June 2024 MEV Audit

Findings from the June 2024 CMH MEV audit are as follows:

- Line 223. 9a-1:30p. Units billed (32) to do not agree with documentation (18).
- Lines 12, 17. Unable to verify IPOS training. (Training form says, "Type in "staff name" Please" for the Written Name and there is no staff signature/Signature field is blank.)
- Line 13. Unable to verify RBT training. (RBT training certificate says that staff completed "00 hours of instruction")
- Line 108. Unable to verify staff qualifications for to justify HN modifier as staff only signs with “MHA”.
- Lines 129, 137. Missing staff credential modifier, HO. Provider uploaded evidence of voided/corrected encounter to Box. No further action required.
- Lines 247, 251, 253, 261. Staff signs as an RN, but AG modifier billed. TD modifier should be used for RN. Per CEI, this has been an ongoing issue within the EHR. They are still waiting on an internal correction to the system from the EHR vendor – the system issue has been identified and the vendor is working on the correction. The services have been temporarily voided until the fix is

implemented. Provider uploaded evidence of voided encounter. No further action required.

- Lines 247, 251. Missing HH modifier. Per CEI, this has been an ongoing issue within the EHR. They are still waiting on an internal correction to the system from the EHR vendor – the system issue has been identified and the vendor is working on the correction. The services have been temporarily voided until the fix is implemented. Provider uploaded evidence of voided encounter. No further action required.

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

- Line 223. CMHA-CEI Finance department has completed a recoupment from the Provider for the over-payment. Uploaded the letter informing provider of the recoupment on July 11th. "Line 223_Dawns Early Light-MEV Audit Takeback 07.10.24" to Provider Supporting Documents > MEV in Box
- Lines 12, 17. CMHA-CEI Finance department has completed a recoupment from the Provider for the services associated with the staff that did not have a completed IPOS form. Uploaded to Provider Supporting Documents > MEV in Box the letter informing provider of the recoupment on July 11th. "Line 12_17_Autism Spectrum -MEV Audit Takeback"
- Line 13. Uploaded supporting documentation to Provider Supporting Documents > MEV in Box.
- Line 108. Uploaded supporting documentation to Provider Supporting Documents > MEV in Box.

Findings from the June 2024 SUD MEV audit are as follows:

- Lines 8, 11, 12, 14, 17, 19, 20. Unable to verify Life Skills/Self Care hours for the week of 11/8/2023 - 11/14/2023 as there is no supporting documentation verifying that the required 20 hours were met (besides a consumer-attested log that contains no dates/times - only checkmarks noting the activities).
- Lines 22, 25, 27. Unable to verify Life Skills/Self Care hours for the week of 11/15/2023 - 11/21/2023 as there is no supporting documentation verifying that the required 20 hours were met (besides a consumer-attested log that contains no dates/times - only checkmarks noting the activities).

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

- CMHA-CEI acknowledges these findings and understands that MSHN will complete the voids for the noted services.

December 2024 MEV Audit

Findings from the December 2024 MEV are as follows:

- Lines 2-9, 179-193, 277-284, 286-291, 293. The individual plan of service (IPOS) was not signed by the consumer or parent/guardian.
- Line 132. 6:35a-8:01a. Should be 5 units, not 6. The provider uploaded evidence of voided/corrected encounter and advised that error that led to the issue has been resolved. **No further action required**.
- Line 133. 4p-7:29p. Should be 13 units, not 14. The provider uploaded evidence of voided/corrected encounter and advised that error that led to the issue has been resolved. **No further action required**.
- Line 134. 9a-5:10p. Should be 32 hours, not 33. The provider uploaded evidence of voided/corrected encounter and advised that error that led to the issue has been resolved. **No further action required**.
- Line 140. 4p-7:12p. Should be 12 units, not 13. The provider uploaded evidence of voided/corrected encounter and advised that error that led to the issue has been resolved. **No further action required**.
- Line 146. 4p-8:10p. Should be 16 units, not 17. The provider uploaded evidence of voided/corrected encounter and advised that error that led to the issue has been resolved. **No further action required**.
- Line 274. The provider uploaded documentation that said service took place from 1:30-3 and 3-3:30 (as the initial documentation did not contain a start/stop time). The provider should have billed 1:30-2:30 as 96116 (First 60 Minutes) and 2:30-3:30 as 96121 (Each Additional 60 Minutes).
- Line 121. The 0373T service was billed under Trinity Medler in error. Documentation shows that the service was provided by Noah Mehl and Dennis Covert. Service should be billed under one of those staff.
- Line 196. The progress note is missing a description of what occurred during the service - just says "Respite".
- Lines 257, 267, 270. Unable to locate IPOS training for James Wilson.
- Lines 258, 261, 264-266. Unable to locate IPOS training for Tiffany Sims.

- Lines 282, 283, 286, 287, 289, 290. Unable to locate IPOS training for Linda Taylor.
- Line 255. US modifier is missing in billing as 6 patients were served. Provider uploaded evidence with correction to billing to add the US modifier. **No further action required.**
- Lines 259, 262, 268, 271. Staff is an RN, TD modifier should be billed, not AF. *Services should only be billed under the supervisor when the rendering staff is not fully credentialed/qualified to bill the service. In this case, the RN is capable of providing and billing the 96372 service and the service does not need to be billed under a supervising physician – it should be billed with Teri Rodgers as the rendering provider using the TD modifier, not AF. Incident-to billing rules do not apply to Medicaid. Billing should be in accordance with the Medicaid Provider Manual and MDHHS code chart, not Medicare billing rules.

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

- Lines 2-9, 179-193, 277-284, 286-291, 293: These findings were brought to the CEI Directors group on 1/28/25 for discussion and clinical review of internal processes on obtaining treatment plan signatures. CEI's Content of the Clinical Record Procedure 3.2.10 has been updated on the requirement to obtain signatures on all treatment plan addendums. This has also been added to the agenda for the next meeting of the internal group tasked with updating the EHR scheduled for 3/6/25 to determine what EHR updates can be completed to ensure clinicians have consistent and accurate reminders/prompts to gather all Treatment Plan signatures. QI is reviewing annual staff training instructions regarding treatment plan signatures and documentation requirements and will complete any updates necessary by 3/14/25.
- Line 274. The CEI Finance team has identified this billing issue was due to a billing code set-up error and has added this to the Reimbursement analyst projects with a plan to correct the code setup by 3/21/25.
- Line 121: CEI Finance-Claims has corrected this issue. Service claim is now billed under Noah Mehl as the rendering provider. Documentation of this correction is located in the file Client 8 Line 121 Finding Proof of Correction
- Line 196. Training regarding service documentation requirements and standards will be provided by the clinician to the provider by 3/14/2025. A reference guide will be created for Employer Of Record expectations and responsibilities related to staff training and service documentation by 2/21/25. This guide will be

provided as an additional resource for consumers and families utilizing Self-Determination to ensure required trainings occur and documentation is appropriately maintained.

- Lines 257, 267, 270. The Clinical program has reviewed their process for completing and documenting staff training in the IPOS and in December 2024 implemented a plan to correct this error moving forward for all consumers within the program. In addition, the program Coordinator reviewed the requirements for training in the consumer IPOS with the primary clinician of this consumer.
- Lines 258, 261, 264-266. The Clinical program has reviewed their process for completing and documenting staff training in the IPOS and in December 2024 implemented a plan to correct this error moving forward for all consumers within the program. In addition, the program Coordinator reviewed the requirements for training in the consumer IPOS with the primary clinician of this consumer.
- Lines 282, 283, 286, 287, 289, 290. CEI staff was unable to locate documentation of original IPOS training to Self-Determination service provider, and provider CLN was also unable to locate IPOS training documentation. Training was provided to CEI staff on requirement to maintain documentation of IPOS training and required elements. Training will be provided to the Employer Of Record with reminder that they are required to train staff in the IPOS and maintain documentation by 3/14/25. A reference guide will be created for Employer Of Record expectations and responsibilities related to staff training and service documentation by 2/21/25. This guide will be provided as an additional resource for consumers and families utilizing Self-Determination to ensure required trainings occur and documentation is appropriately maintained.
- Lines 259, 262, 268, 271. These claims have been corrected and documentation has been uploaded to Box as “Lines 259_262_268_271 Corrections”. The CEI Finance department is actively working to address billing set up and prevent future errors.

MDHHS Submission

Request for Services and Disposition of Requests 10.1.23-9.30.24

	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	742	3100	1854	1298	6994
2	Of the # in Row 1 (all people who telephoned or walked in), total # of people referred out due to non-mental health needs	69	133	40	120	362
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	673	2967	1814	1178	6632
4	Of the # in Row 3 (People requested services the CMHSP provides), total # of people who did not meet eligibility through phone or other screening	13	123	21	24	181
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	660	2844	1793	1154	6451
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 intake/biopsychosocial assessment (dropped out, no show, etc.)	Unknown	Unknown	Unknown	Unknown	Unknown
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.	178	801	321	914	2214
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	178	801	321	914	2214
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?	482	2043	1472	240	4237
13	Of the # in Row 12 (Met CMHSP intake criteria) - total # of people	26	594	409	35	1064

	who met emergency/urgent/priority conditions criteria					
14	Of the # in Row 12 (Met CMHSP intake criteria) - total # of people who met regular/routine/usual admission criteria	456	1449	1063	205	3173
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

HSAG Report FY2024

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:

- Of the 12 CMHSPs reviewed, 11 affiliates used EMRs supported by PCE and subsequently received their eligibility extract files directly into their EMR systems; CMHA-CEI received its eligibility data through a secure file transfer protocol (FTP) site or downloaded the data from REMI.
- HSAG found no issues with MSHN's receipt and processing of eligibility data.
- No major changes occurred during the measurement period.
- CMHSPs independently verified enrollment data and payments.
- IT councils, the QIC, and finance departments monitored and resolved reconciliation issues.
- Effective dates, terminations, and historical spans were properly managed.

PIHP Actions Related to Previous Recommendations:

- HSAG found a documentation error in CMHA-CEI's wait time records. MSHN identified seven additional similar cases and implemented corrective actions, including validation checks and staff training.
- MSHN's QI team reviewed all out-of-compliance cases for accuracy before submission, ensuring proper validation of reported data.
- During the SFY 2024 audit, HSAG confirmed that MSHN had completed the recommended corrective actions and integrated the improvements.
- MSHN continued efforts to educate CMHSP staff on accurate documentation to prevent similar errors in the future.

Strengths and Opportunities for Improvement:

Strength #1: MSHN's subcontracted CMHSPs continued to participate in discussion at QIC meetings to assist in identifying causal factors, barriers, and effective interventions. Best practices were also identified and shared with other CMHSPs and PIHPs, including processes, policies and procedures, and protocols used. [Quality, Timeliness, and Access]

Strength #2: MSHN implemented various improvement strategies such as increasing the number of staff members and network providers, incorporating the practice of "teach back" (i.e., having members repeat back what they are being told to confirm understanding) during care coordination and appointment reminders, performing appointment reminder phone calls to discuss any barriers and develop relationships with members, and expanding hours of operation. [Quality, Timeliness, and Access]

Key Weaknesses & Recommendations

- **Incorrect Population Data for CMHA-CEI**: Two cases in indicators #2 and #3 had incorrect population designations due to changes after the initial report was run. Recommendation: MSHN should implement its remediation plan to cross-check reports before submission and add validation checks to improve accuracy.
- **Data Entry & Reporting Errors**: Errors were found in eligibility (Tuscola), compliance classification (Lifeways), and documentation of follow-up appointments (Lifeways). Recommendation: MSHN should enhance validation processes, conduct quarterly spot checks, and provide staff retraining as needed.
- **Low Performance on Key Indicators**: MSHN's rates for indicator #2 (timely biopsychosocial assessments) fell below the 75th percentile, and indicator #3 (ongoing services after assessments) fell below the 50th percentile. Recommendation: MSHN should continue improvement efforts to ensure timely access to assessments and services, which are crucial for consumer engagement.
- **Need for Stronger Data Validation**: Issues arose due to incorrect data classification, missing documentation, and reporting errors. Recommendation: MSHN should strengthen validation processes, enhance cross-checking procedures, and ensure accurate data integration from multiple sources.

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 2024-2025 survey, a total of 44 consumers consented to participate in the survey. This was a 23% decrease compared to the previous survey year.

Agency Staff Trauma Self-Assessment Results

Total Agency Results (FY24 vs FY21)

FY 24 Total Result Summary	FY 21 Total Result Summary	**Survey Score Methodology:** (higher score = more positive) 1 – Strongly Disagree 2 – Disagree 3 – Agree 4 – Strongly Agree **Other Options:** Do Not Know (DNK) Not Applicable to My Role (NA)
217 Total Completed Surveys	254 Total Completed Surveys	
179 responses from Clinical Programs (83%)	188 responses from Clinical Programs (74%)	
153 responses from Clinical Roles (71%)	147 responses from Clinical Roles (58%)	

Program	Completed Surveys FY24	Completed Surveys FY21
AMHS	60	72
CSDD	22	50
FF	39	41
ITRS	58	25
Administrative	38	66

Highest Ranking Questions

FY 24 Question	Average Overall Score	Clinical Program Score	Clinical Role Score	FY 21 Question	Average Overall Score	Clinical Program Score	Clinical Role Score
Staff members have regular team meetings.	3.50	3.51	3.54	There are private, confidential spaces available to conduct intake assessments.	3.42	3.42	3.39
Staff does not discuss the personal issues of one consumer with another consumer.	3.44	3.47	3.49	Staff collaborates with consumers in setting their goals.	3.47	3.49	3.52
Staff collaborates with consumers in setting their goals.	3.37	3.40	3.39	Staff does not discuss personal issues of one consumer with another consumer.	3.51	3.36	3.51
FY 24 Highest Section Average: Assessing and Planning Services - Developing Goals and Plans (3.32)				**FY 21 Highest Section Average:** Conducting Intake Assessments -Intake Assessment Follow-Up: Developing Goals and Plans (3.38)			

Lowest Ranking Questions

FY 24 Question	Average Overall Score	Clinical Program Score	Clinical Role Score	FY 21 Question	Average Overall Score	Clinical Program Score	Clinical Role Score
The organization provides a space for children to play.	2.40	2.42	2.37	The program provides a space for children to play.	2.47	2.45	2.32
Staff members ask consumers for their definitions of physical safety.	2.50	2.51	2.52	Material is posted about traumatic stress (e.g. what it is, how it impacts people, and available trauma-specific resources).	2.52	2.43	2.38
Staff at all levels of the agency receive training and education on: What is asked in the intake assessment.	2.55	2.61	2.65	The program incorporates child-friendly decorations and materials.	2.56	2.5	2.4
FY 24 Lowest Section Average: Training and Education - Staff at all levels of the program receive training and education on the following topics (2.74)				**FY 21 Lowest Section Average:** Reviewing Policies (2.77)			

Most Frequent "Do Not Know," "Not Applicable," or Blank Responses

(least answered questions)

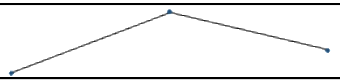
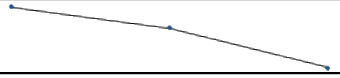
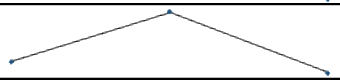
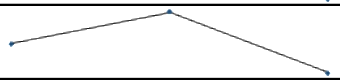
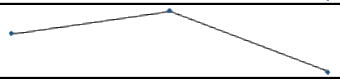
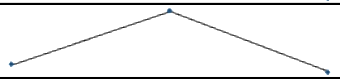
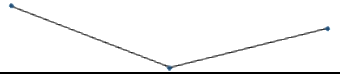
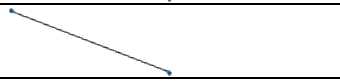
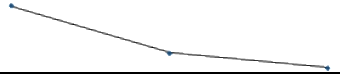
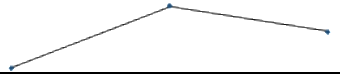
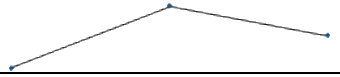
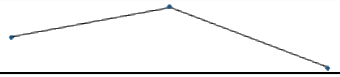
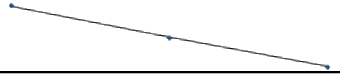
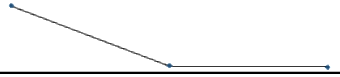
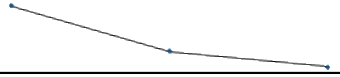
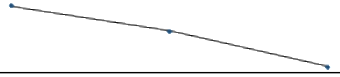
FY 24 Question	Number Not Answered	Percent of Question Responses	FY 21 Question	Number Not Answered	Percent of Question Responses
The agency involves consumers in its review of policies.	125	58%	The intake assessment includes questions about: Children's history of physical health issues.	163	64%
The intake assessment includes questions about children's achievement of developmental tasks.	112	52%	The intake assessment includes questions about: Children's history of mental health issues.	162	64%
The intake assessment includes questions about children's history of physical health issues.	107	49%	The intake assessment includes questions about: Children's achievement of developmental tasks.	153	60%
The intake assessment includes questions about children's history of mental health issues.	106	49%	The intake assessment includes questions about: Children's trauma exposure (e.g. neglect, abuse, exposure to violence).	150	59%
The intake assessment includes questions about children's trauma exposure (e.g. neglect, abuse, exposure to violence).	97	45%	The program involves consumers in its review of policies.	143	56%
The intake assessment includes questions about previous head injury.	97	45%	The intake assessment includes questions about: Quality of relationship with child or children (e.g. caregiver/child attachment).	130	51%

Least Frequent "Do Not Know," "Not Applicable," or Blank Responses

(most answered questions)

FY 24 Question	Number Not Answered	Percent of Question Responses	FY 21 Question	Number Not Answered	Percent of Question Responses
Staff members have regular team meetings.	1	0.5%	Staff members have regular team meetings.	6	2%
Bathrooms are well lit.	4	2%	Staff members have a regularly scheduled time for individual supervision.	12	5%
The common areas within the organization are well lit.	8	4%	Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress-reducing strategies).	16	6%
Staff members have a regularly scheduled time for individual supervision.	9	4%	Staff at all levels of the program receive training and education on the following topics: What traumatic stress is.	20	8%
Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress reducing strategies).	14	7%	Staff at all levels of the program receive training and education on the following topics: The relationship between mental health and trauma.	21	8%
The agency has a formal system for reviewing staff performance.	14	7%	The program has a formal system for reviewing staff performance.	21	8%
			Bathrooms are well lit.	21	8%

Overall Section Average Score YOY

#	Overall - All Programs YOY Staff Trauma Assessment Survey Section (Higher score = Better result | Top 3 = Green | Bottom 3 = Red)	2024 Average Overall Score	2021 Average Overall Score	2017 Average Overall Score	Section YOY Trendline 2024 2021 2017
1	Staff at all levels of the program receive training and education on the following topics:	2.74	2.90	2.80	
2	Staff Supervision, Support and Self-Care	3.00	2.95	2.85	
3	Establishing a Safe Physical Environment	2.85	2.94	2.83	
4	Establishing a Supportive Environment - Information Sharing	2.98	3.04	2.92	
5	Establishing a Supportive Environment - Cultural Competence	3.09	3.14	3.02	
6	Establishing a Supportive Environment - Privacy and Confidentiality	3.25	3.34	3.24	
7	Establishing a Supportive Environment - Safety and Crisis Prevention Planning	2.97	2.84	2.92	
8	Establishing a Supportive Environment - Open and Respectful Communication	3.04	3.04		
9	Establishing a Supportive Environment - Consistency and Predictability	3.03	3.01	3.00	
10	Conducting Intake Assessments - The intake assessment includes questions about:	3.15	3.20	3.18	
11	Conducting Intake Assessments - Intake Assessment Process	3.25	3.35	3.30	
12	Conducting Intake Assessments - Intake Assessment Follow-Up	3.31	3.33	3.29	
13	Developing Goals and Plans	3.32	3.38	3.31	
14	Offering Services and Trauma-Specific Interventions	3.14	3.09	3.04	
15	Involving Current and Former Consumers	3.10	2.88	2.88	
16	Creating Written Policies	3.19	3.07	3.03	
17	Reviewing Policies	2.85	2.77	2.65	

AMHS (FY24 Data Only)

60 Completed Program Surveys	*Child-focused questions removed

Highest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff members have regular team meetings.	3.42	2%
Staff does not discuss the personal issues of one consumer with another consumer.	3.30	12%
The program updates releases and consent forms whenever it is necessary to speak with a new provider.	3.29	20%
Highest Section Average: Assessing and Planning Services - Conducting Intake Assessments: Intake Assessment Follow-Up (3.22)		

Lowest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff at all levels of the agency receive training and education on: What is asked in the intake assessment.	2.02	23%
Staff at all levels of the agency receive training and education on: How working with trauma survivors impacts staff.	2.24	18%
Staff members ask consumers for their definitions of physical safety.	2.24	30%
Lowest Section Average: Training and Education - Staff at all levels of the program receive training and education on the following topics (2.45)		

Most Frequent "Do Not Know," "Not Applicable," or Blank Responses

(least answered questions)

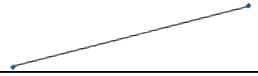
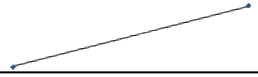
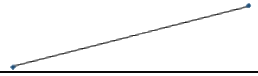
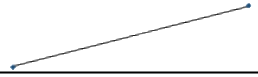
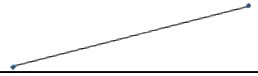
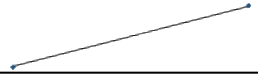
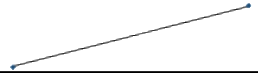
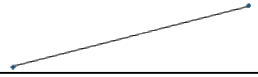
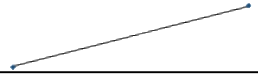
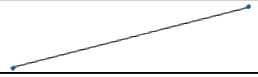
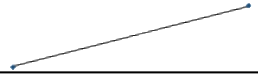
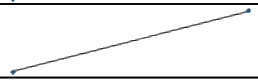
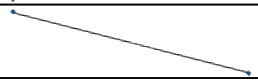
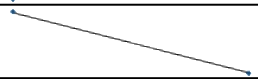
Question	Number Not Answered	Percent of Question Responses
The agency involves consumers in its review of policies.	34	57%
The intake assessment includes questions about previous head injury.	32	53%
The agency reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors.	30	50%
The agency recruits former consumers to serve in an advisory capacity.	26	43%
Former consumers are invited to share their thoughts, ideas and experiences with the agency.	26	43%
The agency has a written statement that includes a commitment to understanding trauma and engaging in trauma-sensitive practices.	26	43%

Least Frequent "Do Not Know," "Not Applicable," or Blank Responses

(most answered questions)

Question	Number Not Answered	Percent of Question Responses
The common areas within the organization are well lit.	0	0%
There are private spaces for staff and consumers to discuss personal issues.	0	0%
Bathrooms are well lit.	0	0%
Staff members have regular team meetings.	1	2%
Staff and other professionals do not talk about consumers in common spaces.	2	3%
Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress reducing strategies).	2	3%
Staff members have a regularly scheduled time for individual supervision.	2	3%
Consumer rights are posted in places that are visible (e.g. room checks, grievance policies, mandatory reporting rules).	2	3%

AMHS Section Average Score YOY

#	AMHS YOY (*excludes child-focused questions) Staff Trauma Assessment Survey Section (Higher score = Better result | Top 3 = Green | Bottom 3 = Red)	2024 Average Overall Score	2021 Average Overall Score	Section YOY Trendline 2024 2021
1	Staff at all levels of the program receive training and education on the following topics:	2.45	2.90	
2	Staff Supervision, Support and Self-Care	2.81	2.86	
3	Establishing a Safe Physical Environment	2.70	2.91	
4	Establishing a Supportive Environment - Information Sharing	2.74	3.01	
5	Establishing a Supportive Environment - Cultural Competence	2.90	3.05	
6	Establishing a Supportive Environment - Privacy and Confidentiality	3.10	3.29	
7	Establishing a Supportive Environment - Safety and Crisis Prevention Planning	2.65	2.71	
8	Establishing a Supportive Environment - Open and Respectful Communication	2.80	2.87	
9	Establishing a Supportive Environment - Consistency and Predictability	2.82	2.91	
10	Conducting Intake Assessments - The intake assessment includes questions about:	2.98	3.07	
11	Conducting Intake Assessments - Intake Assessment Process	3.19	3.31	
12	Conducting Intake Assessments - Intake Assessment Follow-Up	3.22	3.26	
13	Developing Goals and Plans	3.20	3.28	
14	Offering Services and Trauma-Specific Interventions	3.05	3.06	
15	Involving Current and Former Consumers	2.97	2.69	
16	Creating Written Policies	3.08	3.11	
17	Reviewing Policies	2.65	2.56	

CSDD (FY24 Data Only)

22 Completed Program Surveys	*Child-focused questions included

Highest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff members have regular team meetings.	3.45	0%
Staff does not discuss the personal issues of one consumer with another consumer.	3.45	9%
Staff members have a regularly scheduled time for individual supervision.	3.43	5%
Staff and/or consumers are allowed to prepare or have ethnic-specific foods.	3.43	36%
Highest Section Average: Assessing and Planning Services - Conducting Intake Assessments: Intake Assessment Follow-Up (3.30)		

Lowest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
The organization provides a space for children to play.	2.06	27%
Each consumer has a written crisis prevention plan which includes a list of triggers, strategies and responses which are helpful and those that are not helpful and a list of persons the consumer can go to for support.	2.38	27%
The agency involves staff in its review of policies.	2.38	41%
Lowest Section Average: Adapting Policies - Reviewing Policies (2.63)		

Most Frequent "Do Not Know," "Not Applicable," or Blank Responses

(least answered questions)

Question	Number Not Answered	Percent of Question Responses
The agency recruits former consumers to serve in an advisory capacity.	12	55%
The agency involves consumers in its review of policies.	12	55%
The agency reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors.	11	50%
Consumers who have violated rules are approached in private.	10	46%
The intake assessment includes questions about children's trauma exposure (e.g. neglect, abuse, exposure to violence).	10	46%
The intake assessment includes questions about children's achievement of developmental tasks.	10	46%
Former consumers are invited to share their thoughts, ideas and experiences with the agency.	10	46%

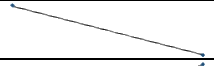
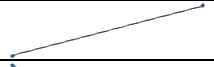
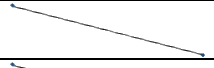
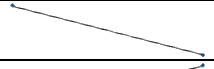
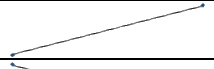
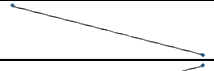
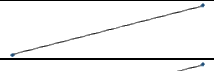
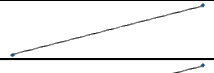
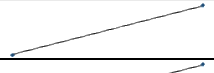
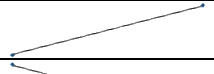
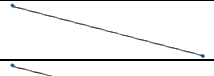
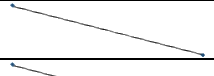
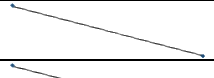
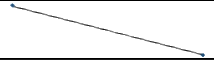
Least Frequent "Do Not Know," "Not Applicable," or Blank Responses

(most answered questions)

Question	Number Not Answered	Percent of Question Responses
Program information is available in different languages.	0	0%
Staff and other professionals do not talk about consumers in common spaces.	0	0%
Bathrooms are well lit.	0	0%
Staff members have regular team meetings.	0	0%
Part of supervision time is used to help staff members understand their own stress reactions.	1	5%
The common areas within the organization are well lit.	1	5%

Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress reducing strategies).	1	5%
Staff members have a regularly scheduled time for individual supervision.	1	5%
Agency staff monitors who is coming in and out of the program/agency.	1	5%

CSDD Section Average Score YOY

#	CSDD YOY Staff Trauma Assessment Survey Section (Higher score = Better result | Top 3 = Green | Bottom 3 = Red)	2024 Average Overall Score	2021 Average Overall Score	Section YOY Trendline 2024 2021
1	Staff at all levels of the program receive training and education on the following topics:	2.64	2.60	
2	Staff Supervision, Support and Self-Care	3.04	2.68	
3	Establishing a Safe Physical Environment	2.81	2.77	
4	Establishing a Supportive Environment - Information Sharing	2.97	2.83	
5	Establishing a Supportive Environment - Cultural Competence	3.03	3.10	
6	Establishing a Supportive Environment - Privacy and Confidentiality	3.28	3.28	
7	Establishing a Supportive Environment - Safety and Crisis Prevention Planning	2.83	2.36	
8	Establishing a Supportive Environment - Open and Respectful Communication	2.89	2.91	
9	Establishing a Supportive Environment - Consistency and Predictability	3.09	2.82	
10	Conducting Intake Assessments - The intake assessment includes questions about:	3.13	3.32	
11	Conducting Intake Assessments - Intake Assessment Process	3.23	3.32	
12	Conducting Intake Assessments - Intake Assessment Follow-Up	3.30	3.35	
13	Developing Goals and Plans	3.23	3.39	
14	Offering Services and Trauma-Specific Interventions	2.83	2.69	
15	Involving Current and Former Consumers	3.17	2.54	
16	Creating Written Policies	3.09	3.04	
17	Reviewing Policies	2.63	2.49	

Families Forward (FY24 Data Only)

39 Completed Program Surveys	*Child-focused questions included

Highest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff does not discuss the personal issues of one consumer with another consumer.	3.62	5%
Staff and/or consumers are allowed to speak their native languages within the agency.	3.58	15%
Staff members have regular team meetings.	3.54	0%
Highest Section Average: Assessing and Planning Services - Developing Goals and Plans (3.46)		

Lowest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff at all levels of the agency receive training and education on: The relationship between homelessness and trauma.	2.31	26%
Staff at all levels of the agency receive training and education on: Cultural differences in how people understand and respond to trauma.	2.34	18%
Staff at all levels of the agency receive training and education on: How working with trauma survivors impacts staff.	2.41	26%
Lowest Section Average: Training and Education - Staff at all levels of the program receive training and education on the following topics (2.66)		

Most Frequent "Do Not Know," "Not Applicable," or Blank Responses

(least answered questions)

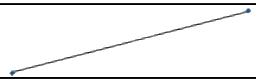
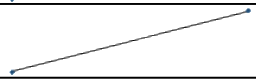
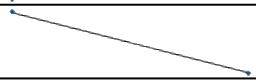
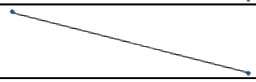
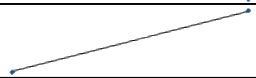
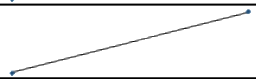
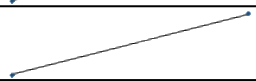
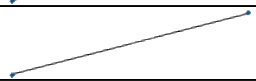
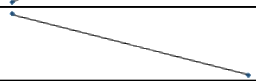
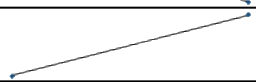
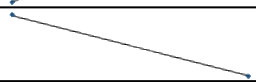
Question	Number Not Answered	Percent of Question Responses
The agency involves consumers in its review of policies.	25	64%
The agency recruits former consumers to serve in an advisory capacity.	19	49%
The organization has regularly scheduled procedures/ opportunities for consumers to provide input.	18	46%
Consumers who have violated rules are approached in private.	17	44%
Former consumers are invited to share their thoughts, ideas and experiences with the agency.	17	44%
Written policies are established based on an understanding of the impact of trauma on consumers and providers.	17	44%
The agency reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors.	17	44%

Least Frequent "Do Not Know," "Not Applicable," or Blank Responses

(most answered questions)

Question	Number Not Answered	Percent of Question Responses
Staff members have a regularly scheduled time for individual supervision.	0	0%
Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress reducing strategies).	0	0%
Staff members have regular team meetings.	0	0%
Bathrooms are well lit.	0	0%
Part of supervision time is used to help staff members understand their own stress reactions.	1	3%
The organization incorporates child-friendly decorations and materials.	1	3%

Families Forward Section Average Score YOY

#	Families Forward YOY Staff Trauma Assessment Survey Section (Higher score = Better result | Top 3 = Green | Bottom 3 = Red)	2024 Average Overall Score	2021 Average Overall Score	Section YOY Trendline 2024 2021
1	Staff at all levels of the program receive training and education on the following topics:	2.66	3.01	
2	Staff Supervision, Support and Self-Care	3.12	3.17	
3	Establishing a Safe Physical Environment	2.92	2.92	
4	Establishing a Supportive Environment - Information Sharing	2.97	2.97	
5	Establishing a Supportive Environment - Cultural Competence	3.28	3.15	
6	Establishing a Supportive Environment - Privacy and Confidentiality	3.35	3.38	
7	Establishing a Supportive Environment - Safety and Crisis Prevention Planning	3.37	3.37	
8	Establishing a Supportive Environment - Open and Respectful Communication	3.19	3.08	
9	Establishing a Supportive Environment - Consistency and Predictability	3.08	3.07	
10	Conducting Intake Assessments - The intake assessment includes questions about:	3.26	3.23	
11	Conducting Intake Assessments - Intake Assessment Process	3.27	3.37	
12	Conducting Intake Assessments - Intake Assessment Follow-Up	3.37	3.44	
13	Developing Goals and Plans	3.46	3.49	
14	Offering Services and Trauma-Specific Interventions	3.24	3.28	
15	Involving Current and Former Consumers	3.16	3.11	
16	Creating Written Policies	3.24	3.25	
17	Reviewing Policies	2.86	2.30	

ITRS (FY24 Data Only)

58 Completed Program Surveys	*Child-focused questions removed

Highest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff members have regular team meetings.	3.60	0%
Staff does not discuss the personal issues of one consumer with another consumer.	3.54	2%
Staff collaborates with consumers in setting their goals.	3.50	3%
Highest Section Average: Assessing and Planning Services - Conducting Intake Assessments: Intake Assessment Follow-Up (3.43)		

Lowest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff members ask consumers for their definitions of physical safety.	2.71	29%
Staff at all levels of the agency receive training and education on: Cultural differences in how people understand and respond to trauma.	2.74	9%
Each consumer has a written crisis prevention plan which includes a list of triggers, strategies and responses which are helpful and those that are not helpful and a list of persons the consumer can go to for support.	2.76	29%
Lowest Section Average: Creating a Safe and Supportive Environment - Establishing a Supportive Environment: Safety and Crisis Prevention Planning (3.01)		

Most Frequent "Do Not Know," "Not Applicable," or Blank Responses

(least answered questions)

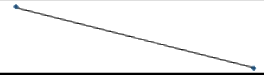
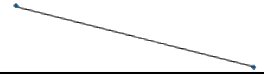
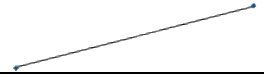
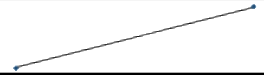
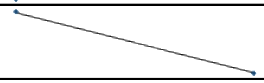
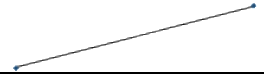
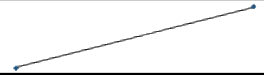
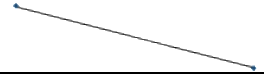
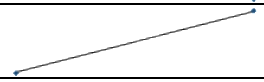
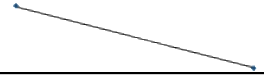
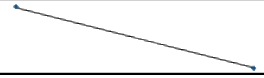
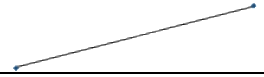
Question	Number Not Answered	Percent of Question Responses
The agency involves consumers in its review of policies.	27	47%
Outside agencies with expertise in cultural competence provide on-going training and consultation.	24	41%
Written safety plans are incorporated into consumers' individual goals and plans.	21	36%
Staff and/or consumers are allowed to prepare or have ethnic-specific foods.	20	35%
The agency recruits former consumers to serve in an advisory capacity.	20	35%

Least Frequent "Do Not Know," "Not Applicable," or Blank Responses

(most answered questions)

Question	Number Not Answered	Percent of Question Responses
Staff at all levels of the agency receive training and education on: How to establish and maintain healthy professional boundaries.	0	0%
Staff members have regular team meetings.	0	0%
There are private spaces for staff and consumers to discuss personal issues.	0	0%
Staff does not discuss the personal issues of one consumer with another consumer.	1	2%

ITRS Section Average Score YOY

#	ITRS YOY (*excludes child-focused questions) Staff Trauma Assessment Survey Section (Higher score = Better result | Top 3 = Green | Bottom 3 = Red)	2024 Average Overall Score	2021 Average Overall Score	Section YOY Trendline 2024 2021
1	Staff at all levels of the program receive training and education on the following topics:	3.09	3.08	
2	Staff Supervision, Support and Self-Care	3.14	3.05	
3	Establishing a Safe Physical Environment	3.11	3.08	
4	Establishing a Supportive Environment - Information Sharing	3.16	3.24	
5	Establishing a Supportive Environment - Cultural Competence	3.25	3.17	
6	Establishing a Supportive Environment - Privacy and Confidentiality	3.40	3.44	
7	Establishing a Supportive Environment - Safety and Crisis Prevention Planning	3.01	2.94	
8	Establishing a Supportive Environment - Open and Respectful Communication	3.25	3.31	
9	Establishing a Supportive Environment - Consistency and Predictability	3.14	3.10	
10	Conducting Intake Assessments - The intake assessment includes questions about:	3.25	3.25	
11	Conducting Intake Assessments - Intake Assessment Process	3.34	3.44	
12	Conducting Intake Assessments - Intake Assessment Follow-Up	3.43	3.31	
13	Developing Goals and Plans	3.43	3.47	
14	Offering Services and Trauma-Specific Interventions	3.28	3.26	
15	Involving Current and Former Consumers	3.12	3.01	
16	Creating Written Policies	3.29	3.35	
17	Reviewing Policies	3.05	2.82	

Administrative (FY24 Data Only)

38 Completed Admin Surveys		*Child-focused questions included
QCSRR Completed 29 Surveys	IS Completed 9 Surveys	No Surveys completed in other Administrative Programs

Highest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff members have regular team meetings.	3.47	0%
Staff members have a regularly scheduled time for individual supervision.	3.38	11%
The intake assessment includes questions about history of trauma (e.g. physical, emotional or sexual abuse, neglect, loss, domestic/community violence, combat, past homelessness).	3.33	53%
Highest Section Average: Adapting Policies - Creating Written Policies (3.20)		

Lowest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff at all levels of the agency receive training and education on: What is asked in the intake assessment.	2.20	34%
The organization provides a space for children to play.	2.27	61%
Staff at all levels of the agency receive training and education on: How to develop safety and crisis prevention plans.	2.28	34%
Lowest Section Average: Training and Education - Staff at all levels of the program receive training and education on the following topics (2.75)		

Most Frequent "Do Not Know," "Not Applicable," or Blank Responses

(least answered questions)

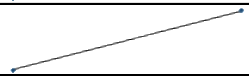
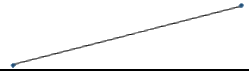
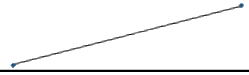
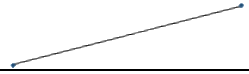
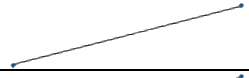
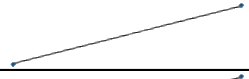
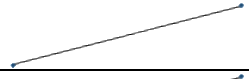
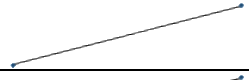
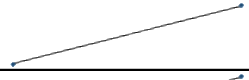
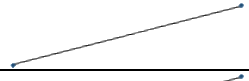
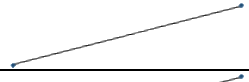
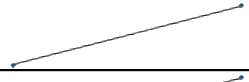
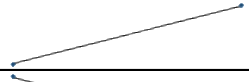
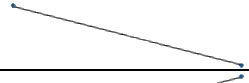
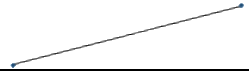
Question	Number Not Answered	Percent of Question Responses
Staff members ask consumers for their definitions of physical safety.	32	84%
The intake assessment includes questions about previous head injury.	30	79%
Staff members ask consumers for their definitions of emotional safety.	29	76%
The agency involves consumers in its review of policies.	27	71%
Before leaving the program, consumers and staff develop a plan to address any future needs.	26	68%
The program informs consumers about why questions are being asked.	25	66%

Least Frequent "Do Not Know," "Not Applicable," or Blank Responses

(most answered questions)

Question	Number Not Answered	Percent of Question Responses
Staff members have regular team meetings.	0	0%
The common areas within the organization are well lit.	1	3%
Bathrooms are well lit.	2	5%
The agency has a formal system for reviewing staff performance.	2	5%
Staff members have a regularly scheduled time for individual supervision.	4	11%
The agency has written policy to address potential threats to consumers and staff from natural or man- made threats (fire, tornado, bomb threat, and hostile intruder).	4	11%

Admin Section Average Score YOY

#	Admin YOY (GA/QCSRR/Finance/HR/IS) Staff Trauma Assessment Survey Section (Higher score = Better result | Top 3 = Green | Bottom 3 = Red)	2024 Average Overall Score	2021 Average Overall Score	Section YOY Trendline 2024 2021
1	Staff at all levels of the program receive training and education on the following topics:	2.75	3.06	
2	Staff Supervision, Support and Self-Care	2.93	3.03	
3	Establishing a Safe Physical Environment	2.90	3.09	
4	Establishing a Supportive Environment - Information Sharing	3.13	3.28	
5	Establishing a Supportive Environment - Cultural Competence	3.01	3.24	
6	Establishing a Supportive Environment - Privacy and Confidentiality	3.09	3.41	
7	Establishing a Supportive Environment - Safety and Crisis Prevention Planning	2.99	3.15	
8	Establishing a Supportive Environment - Open and Respectful Communication	3.07	3.24	
9	Establishing a Supportive Environment - Consistency and Predictability	3.16	3.30	
10	Conducting Intake Assessments - The intake assessment includes questions about:	3.14	3.27	
11	Conducting Intake Assessments - Intake Assessment Process	3.12	3.36	
12	Conducting Intake Assessments - Intake Assessment Follow-Up	3.14	3.40	
13	Developing Goals and Plans	3.12	3.32	
14	Offering Services and Trauma-Specific Interventions	3.07	3.45	
15	Involving Current and Former Consumers	3.18	3.46	
16	Creating Written Policies	3.20	3.17	
17	Reviewing Policies	2.87	3.05	

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 FY24, 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 FY24 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 FY25 QI will continue to monitor CCBHC specific measurements and address priority Care Alerts noted in the program.

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