Evaluation of Quality Improvement Program Plan Effectiveness FY2019
Community Mental Health Authority of Clinton, Eaton and Ingham Counties

July 2020

Approved by CMHA-CEI Board of Directors - September 17, 2020

Table of Content

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

Diabetic Monitoring for Individuals with Schizophrenia and Diabetes

This Performance Improvement Project (PIP) was selected by the Prepaid Inpatient Health Plan (PIHP) because it complements the Affordable Care Act's (ACA) related efforts in health integration and mirrors current efforts across the healthcare industry for accreditation standards (Health Plan Employer Data and Information (HEDIS) and National Committee for Quality Assurance (NCQA)). 2019 has been the initial measurement year for this initiative to establish baseline. The measure is used to assess the percentage of members ages 18 to 64 with Schizophrenia and Diabetes who had both a low-density lipoprotein cholesterol (LDL-C) test and a hemoglobin A1c (HbA1c) test during the measurement year. Technical requirements are provided by HEDIS.

The table below shows the number of consumers from each community mental health center dually diagnosed with schizophrenia and diabetes who received both an LDL-C and an HbA1c test compared with those who received only one of the tests or neither of the tests. For instance, Community Mental Health Authority – Clinton, Eaton, Ingham (CMHA-CEI) had a total of 202 consumers with schizophrenia and diabetes. Only 30.69% of them (n=62) received both an LDL-C and HbA1c test, while the remainder (n=140) only received one or neither of the tests. Among all community mental health centers in the list, 33.64% of consumers dually diagnosed with schizophrenia and diabetes received both tests.

FY2019	N	Y	% of Y	Total
Bay-Arenac CMH	70	33	32.04	103
CMHA-CEI	140	62	30.69	202
Central Michigan CMH	90	41	31.30	131
Gratiot Integrated Health Network	12	8	40.00	20
Huron Behavioral Health	11	4	26.67	15
Lifeways CMH	63	32	33.68	95
Montcalm Care Network	17	11	39.29	28
Newaygo County CMH	9	6	40.00	15
Saginaw County CMH	139	67	32.52	206
Shiawassee Health and Wellness	8	9	52.94	17

The Right Door	7	5	41.67	12
Tuscola Behavioral Health Systems	14	16	53.33	30
TOTAL:	**580**	**294**	**33.64**	**874**

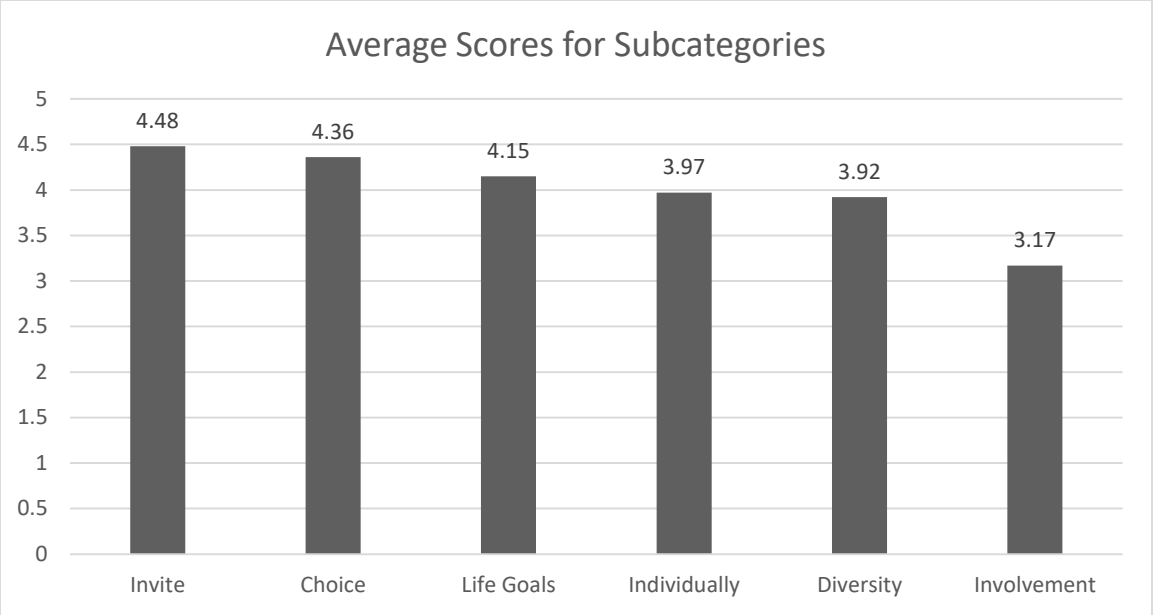
Recovery Assessment

As providers of care for individuals who live with persistent behavioral health challenges, it is important to move toward understanding and implementing systems of care that reinforce and promote the principles of recovery. The recovery assessment PIP is designed to join with the behavioral healthcare sector in this movement and quantify the Community Mental Health Services Programs (CMHSP's), including CMHA-CEI's, capacity to deliver recovery-oriented care to the consumers served. Historically, two instruments have been used: The Recovery Self-Assessment (RSA) and the Recovery Assessment Survey (RAS). Results from the administration guide individual treatment, professional development, and organizational change efforts.

In 2019, only the RSA was utilized by CMHA-CEI. The RSA is a 36-item measure designed to gauge the degree to which programs implement recovery-oriented practices. It is a self-reflective tool and is designed to identify strengths and target areas of improvement as agencies and systems strive to offer recovery-oriented care. Forty staff members from CMHA-CEI participated in the RSA, with the majority of them reporting that they provide case management/supports coordination (n=24) or outpatient therapy (n=17).

	N	%
Case Management/ Supports Coordination	24	60%
Outpatient Therapy	17	42.5%
Club House	6	15%
Substance Use Residential	2	5%
Intensive Outpatient	1	2.5%
Assertive Community Treatment (ACT)	1	2.5%
Vocational	0	--

There were 6 subcategories or domains: invite, choice, involvement, life goals, individually tailored services, and diversity. On average, CMHA-CEI scored highest in the "invite" subcategory and lowest in the "involvement" subcategory.



Categories and Associated Survey Questions	Average Score
Subcategory: Invite	***4.48***
▶ **1: Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in programs.**	*4.58*
▶ **2: This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.).**	*4.38*
Subcategory: Choice	***4.36***
▶ **4: Program participants can change their clinician or case manager if they wish.**	*4.03*
▶ **5: Program participants can easily access their treatment records if they wish.**	*4.11*
▶ **6: Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.**	*4.60*
▶ **10: Staff listen to and respect the decisions that program participants make about their treatment and care.**	*4.45*
▶ **27: Progress made towards an individual's own personal goals is tracked regularly.**	*4.56*
Subcategory: Life Goals	***4.15***

Categories and Associated Survey Questions	Average Score
▶ **3. Staff encourage program participants to have hope and high expectations for their recovery.**	*4.35*
▶ **7. Staff believe in the ability of program participants to recover.**	*4.37*
▶ **8. Staff believe that program participants have the ability to manage their own symptoms.**	*3.74*
▶ **9. Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.**	*4.35*
▶ **12. Staff encourage program participants to take risks and try new things.**	*3.95*
▶ **16. Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies).**	*4.59*
▶ **17. Staff routinely assist program participants with getting jobs.**	*3.92*
▶ **18. Staff actively help program participants to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies.**	*3.95*
▶ **28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.**	*4.53*
▶ **31. Staff are knowledgeable about special interest groups and activities in the community.**	*3.97*
▶ **32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.**	*3.90*
Subcategory: Individually Tailored Services	***3.97***
▶ **11. Staff regularly ask program participants to take risks and try new things.**	*3.84*
▶ **13. This program offers specific services that fit each participant's unique culture and life experiences.**	*3.86*

Categories and Associated Survey Questions	Average Score
▶ **19. Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer).**	*4.11*
▶ **30. Staff at this program regularly attend trainings on cultural competency.**	*4.08*
Subcategory: Diversity	***3.92***
▶ **14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.**	*4.08*
▶ **15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.**	*3.94*
▶ **20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.**	*3.63*
▶ **21. Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.**	*4.00*
▶ **26. Staff talk with program participants about what it takes to complete or exit the program.**	*3.94*
Subcategory: Involvement	***3.17***
▶ **22: Staff actively help people find ways to give back to their community (i.e., volunteering, community services, and neighborhood watch/cleanup).**	*3.42*
▶ **23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.**	*3.19*
▶ **24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.**	*3.75*
▶ **25. People in recovery are encouraged to attend agency advisory boards and management meetings.**	*2.71*
▶ **29. Persons in recovery are involved with facilitating staff trainings and education at this program.**	*2.58*

Behavior Treatment Plan Review Committee

Introduction

It is the expectation of the Michigan Department of Health and Human Services (MDHHS) that all public mental health agencies protect and promote the dignity and respect of all individuals receiving public mental health services. All public mental health agencies shall have policies and procedures for intervening with an individual receiving public mental health services who exhibits seriously aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. These policies and procedures shall include protocols for using the least intrusive and restrictive interventions for unprecedented and unpredicted crisis or emergency occurrences of such behaviors. For all other non-emergent or continuing occurrences of these behaviors, the public mental health service agency will first conduct appropriate assessments and evaluations to rule out physical, medical, and environmental (e.g., trauma, interpersonal relationships) conditions that might be the cause of the behaviors.

If and when interventions are to be used for the purpose of treating, managing, controlling or extinguishing predictable or continuing behaviors that are seriously aggressive, self-injurious, or that place the individual or others at risk of harm, the public mental health agency shall develop an individual behavior treatment plan to ameliorate or eliminate the need for the restrictive or intrusive interventions in the future (R. 330.7199[2]][g]) and that:

- Adheres to any legal psychiatric advance directive that is present for an adult with serious mental illness;
- Employs positive behavior supports and interventions, including specific interventions designed to develop functional abilities in major life activities, as the first and preferred approaches;
- Considers other kinds of behavior treatment or interventions that are supported by peer-reviewed literature or practice guidelines in conjunction with behavior supports and interventions, if positive behavior supports and interventions are documented to be unsuccessful; or
- As a last resort, when there is documentation that neither positive behavior supports nor other kinds of less restrictive interventions were successful,

proposes restrictive or intrusive techniques, described herein, that shall be reviewed and approved by the Behavior Treatment Plan Review Committee.[1]

The MDHHS policy regarding Behavior Treatment Plan Review Committees (BTPRC) is as follows:

"…all publicly-supported mental health agencies shall use a specially-constituted committee, often referred to as a 'behavior treatment plan review committee' called for the purposes of this policy the 'Committee.' The purpose of the Committee is to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions, as defined here in section IV, with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. The Committee shall substantially incorporate the standards herein, including those for its appointment, duties, and functions."[2]

BTPRCs ensure that behavior plans are written within the framework of a culture of gentleness, which includes: provision of a sense of safety; teaching the individual that engagement with others is good; teaching the individual to value others; providing opportunities to establish meaningful relationships; enhancement of the individual's sense of self-value; assurance of consistency through structure; provision of opportunities to express autonomy while receiving supports; optimal learning environment; skills to promote companionship, esteem, problem solving, coping; and community inclusion.

The BTPRC has the following responsibilities, as required by the MDHHS Technical Requirement for BTPRCs:

- Review and approve or disapprove any plans that propose to use restrictive or intrusive interventions

[1] Michigan Department of Health and Human Services (MDHHS) Behavioral Health & Developmental Disabilities Administration: Standards for Behavior Treatment Plan Review Committees, Revision FY17
[2] Michigan Department of Health and Human Services (MDHHS) Behavioral Health & Developmental Disabilities Administration: Standards for Behavior Treatment Plan Review Committees, Revision FY17

- For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. Plans with intrusive or restrictive techniques require minimally a quarterly review.
- Ensure that the composition of the Committee meets the Technical Requirement specifications.
- Document the Committee's activities through meeting minutes that clearly delineate the actions of the Committee.
- Implement a process for evaluation of Committee's effectiveness.
- On a quarterly basis, analyze the use of all physical management and involvement of law enforcement for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention
- Provide a mechanism for expedited review of proposed behavior treatment plans in emergent situations.

The Committee shall be comprised of at least three individuals:

- One board certified behavior analyst or licensed behavior analyst, and/or licensed psychologist with specified training
- One member shall be a licensed physician/psychiatrist
- A representative of the Office of Recipient Rights (non-voting)
- Other non-voting members may be added at the Committee's discretion and with the consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist (PSS)

The Committee shall keep all of its meeting minutes, and clearly delineate the actions of the Committee. All members shall be appointed for a term of not more than two years (members may be reappointed).

Behavior treatment plans are developed in accordance with the Technical Requirement for BTPRCs.

1. Plans that use restrictive or intrusive techniques shall be approved by the committee prior to implementation.
2. A functional assessment of behavior, with evidence that relevant physical, medical and environmental causes of challenging behavior have been ruled out, is documented prior to plan implementation.

3. There is documentation that positive behavioral supports and interventions have been adequately pursued prior to implementation of restrictive or intrusive techniques.
4. Plans are developed through the person-centered planning process.
5. Written special consent must be given by the individual, his/her guardian, or the parent of a minor prior to the implementation of a plan that includes intrusive or restrictive interventions.
6. Plans that propose to use physical management and/or involvement of law enforcement in a non-emergent situation; aversive techniques; or seclusion or restraint in a setting where it is prohibited by law shall be disapproved.
7. There is a plan for monitoring and staff training to assure consistent implementation and documentation of the intervention.
8. The committee reviews the continuing need for any approved procedures involving intrusive or restrictive techniques at least quarterly.

A behavior treatment plan is required to have BTPRC approval when **restrictive** or **intrusive** techniques are used. **Restrictive** techniques are defined as those which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques as limiting or prohibiting communication with others when that communication would be harmful to the individual; prohibiting unlimited access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee. **Intrusive** techniques are defined as those that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage or control an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.

A BTPRC may choose to review other formally developed behavior treatment plans that don't include restrictive or intrusive techniques. Before approving a plan, the Committee must determine that: the plan does not propose to use aversive techniques, physical

management, seclusion or restraint; the plan is supported by current, peer-reviewed literature; a functional behavioral analysis has been performed; positive behavioral supports and interventions have been adequately pursued; dates are set to review the plan at least quarterly; and an inquiry has been made to determine that the restrictive or intrusive techniques do not put the specific individual in harm's way due to medical, psychological or other risk factors.

Furthermore, health and safety issues identified in the assessment must be addressed through the person centered planning process. Those that require modification to the individual's Home and Community Based Services (HCBS) rights will need to go to a BTPRC in the event that the issue is tied to a challenging behavior. However, if it is only a health and safety issue, it can be addressed in the Individual Plan of Service (IPOS). When individuals are exhibiting behavior that put themselves or others at risk, it is the CMH's responsibility to ensure the development and implementation of appropriate plans to ensure customers' health and safety. Repeated use of crisis intervention (e.g., physical management / law enforcement involvement), for example, requires that the CMH initiate a review process to evaluate positive alternatives or the need for a specialized intervention plan. Repeated health and safety-related incident reports (aggression toward others, self-harm, etc.) is another indication that a plan review is needed. The MDHHS Standards for BTPRC "Expedited Review" process is to be used to address situations where there is the potential for health and safety risk, and the current plan is not working. Any staff working with individuals should be promptly trained in any new plan development.

The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's Quality Assessment and Performance Improvement Plan (QAPIP) or the CMHSP's Quality Improvement Program (QIP), and be available for MDHHS review. Physical management and/or involvement of law enforcement, permitted for intervention in emergencies only, are considered critical incidents that must be managed and reported according to the QAPIP standards. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.[3]

[3] Michigan Department of Health and Human Services (MDHHS) Behavioral Health & Developmental Disabilities Administration: Standards for Behavior Treatment Plan Review Committees, Revision FY17

Updates

CMHA-CEI's Adult Mental Health Services (AMHS) department hosted a Michigan Fidelity Assessment Screening Team (MiFAST) review on January 17, 2020 to assist with developing the tools and structure to potentially begin their own BTPRC in the future.

Furthermore, a part of the BTPRC process includes a study required by the Michigan Department of Health and Human Services (MDHHS). The data collected is based on the definition and requirements that have been set forth within the Behavioral Technical Requirements attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract.

Mid-State Health Network (MSHN) delegates the responsibility for the collection and evaluation of data to each local CMHSP BTPRC, including the evaluation of effectiveness of the BTPRC by stakeholders. Data will be collected and reviewed quarterly by the CMHSP where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. This data is to be reviewed as part of the CMHSP QIP and reported to the PIHP Quality Committee (QAPIP). MSHN monitors that the local CMHSP BTPRC follows the requirements outlined within the Standards for Behavior Treatment Review Committees. MSHN will analyze the data on a quarterly basis to address any trends and/or opportunities for quality improvements. Data shall include numbers of interventions and length of time the interventions were used per person.[4]

Study Conclusions

Data was collected and analyzed on the following indicators. Conclusions based on the results are also included.

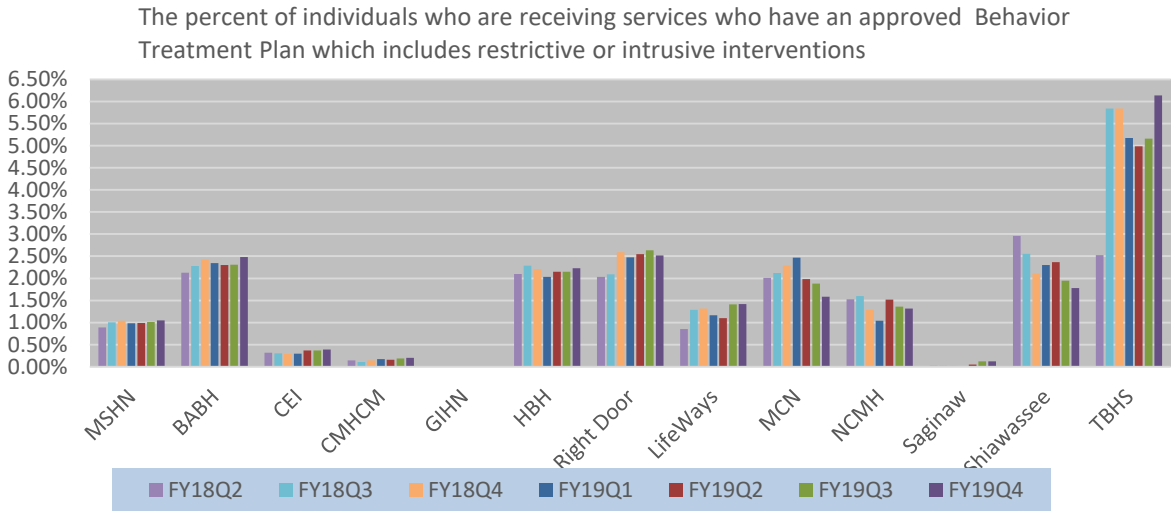
<u>Study Question 1:</u>

Has the proportion of individuals who have a Behavior Treatment Plan with a restrictive/intrusive intervention decreased over time?

1.44% (FY14Q2) compared to 1.05% (FY19Q4) of the individuals served have a Behavior Treatment Plan with Intrusive and/or Restrictive Interventions. This indicates that the

[4] Quality Assessment and Performance Improvement Program: Quality Improvement Council-Behavior Treatment Review Data FY20Q1

proportion is lower than first reported in FY14Q2. FY18Q3 demonstrated a slight upward trend as the organizations are developing additional processes to address the following variables: an increased number of individuals receiving Applied Behavioral Analysis (ABA) services through Autism Clinics, and plans that identify restrictions as a result of the Home and Community Based Standards. There is an increased amount of individuals who have been incorporating the use of medications for behavioral assistance for children which has also resulted as an increase in the number of plans. Since that time, the BTPRCs have been working with the psychologists and the Applied Behavior Analysis clinics in coordinating efforts in educating related to the interventions and identifying alternative methods of intervening.



Study Question 2a:

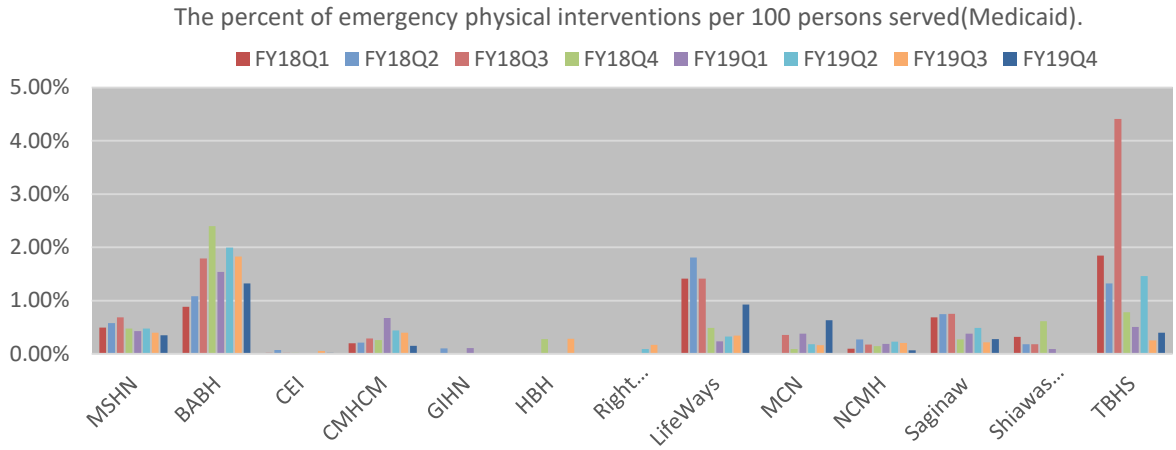
Has the proportion of individuals who have received multiple emergency physical interventions decreased over time?

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

Study Question 2b:

Has the proportion of physical interventions decreased overtime?

0.53% (FY14Q2) compared to 0.35% in FY19Q4 (n=105/29950) have received an emergency physical intervention. This shows a slight decrease over time. This will continue to be monitored as to address any factors that may be causing a variance.



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

HBH	**# of Individuals who had more than 1 EPI**	0	0	0	1	0	0	0	0
	# of individuals who had an EPI	0	0	0	1	0	0	1	0
Right Door	**# of Individuals who had more than 1 EPI**	0	0	0	0	0	0	0	0
	# of individuals who had an EPI	0	0	0	0	0	0	2	0
LifeWays	**# of Individuals who had more than 1 EPI**	6	5	3	0	2	2	2	4
	# of individuals who had an EPI	7	9	9	4	5	5	5	8
MCN	**# of Individuals who had more than 1 EPI**	0	0	1	0	1	1	0	1
	# of individuals who had an EPI	0	0	2	1	3	1	2	2
NCMH	**# of Individuals who had more than 1 EPI**	0	0	0	1	0	0	0	0
	# of individuals who had an EPI	1	3	2	1	2	3	1	1
Saginaw	**# of Individuals who had more than 1 EPI**	8	4	4	2	5	5	1	1
	# of individuals who had an EPI	10	9	8	7	8	8	7	5
Shiawassee	**# of Individuals who had more than 1 EPI**	0	0	0	1	0	0	0	0
	# of individuals who had an EPI	3	2	2	1	1	0	0	0
TBHS	**# of Individuals who had more than 1 EPI**	4	3	4	1	1	3	1	0
	# of individuals who had an EPI	5	4	8	3	3	5	1	3

Physical Intervention	**FY18Q1**	**FY18Q2**	**FY18Q3**	**FY18Q4**	**FY19Q1**	**FY19Q2**	**FY19Q3**	**FY19Q4**
Supine Hold	(8) 5%	(8) 5%	(6) 3%	(8) 6%	(10) 8%	(11) 8%	(11) 9%	(11) 11%
Wraps/Holds	(68) 48%	(86) 50%	(138) 67%	(104) 74%	(105) 80%	(107) 74%	(84) 69%	(73) 72%
Transport/Escort	(24) 17%	(29) 17%	(29) 14%	(12) 9%	(8) 6%	(7) 5%	(16) 13%	(11) 11%

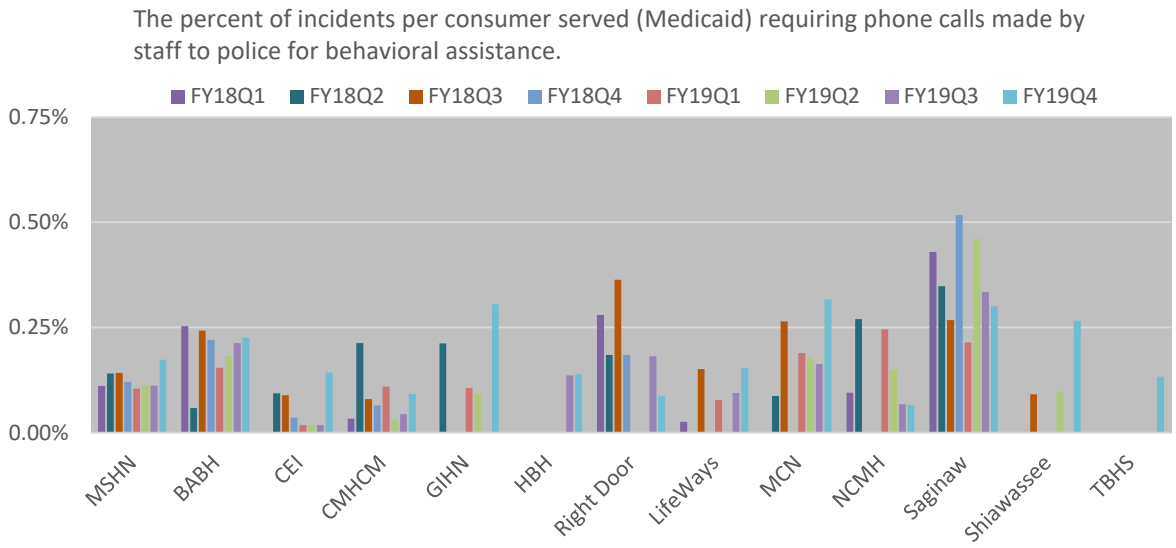
Hands Down with Resistance/ Hand Wrist Grab	(18) 13%	(17) 10%	(26) 13%	(17) 12%	(7) 5%	(17) 12%	(8) 7%	(4) 4%
Other/ Unidentified	(24) 17%	(33) 19%	(8) 4%	(0)	(1)	(3) 2%	(3) 2%	(2) 2%
MSHN Total	(142) 100%	(173) 100%	(207) 100%	(141) 100%	(131) 100%	(145) 100%	(122) 100%	101 (100%)

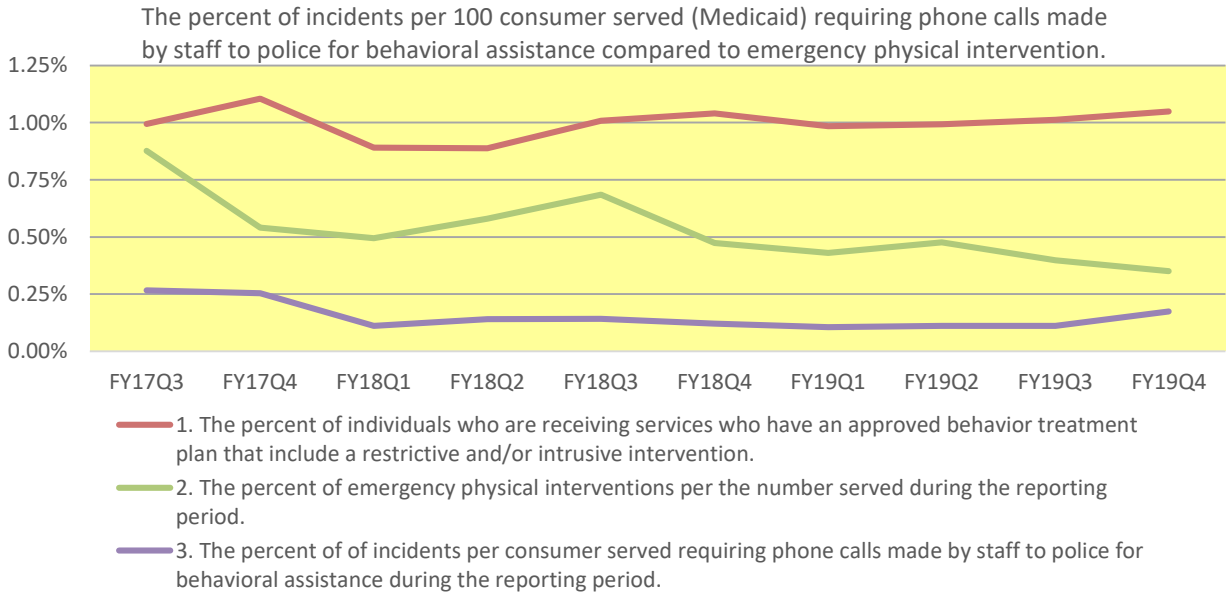
Length of time of intervention	**FY18Q 1**	**FY18Q 2**	**FY18 Q3**	**FY18 Q4**	**FY19Q 1**	**FY19Q 2**	**FY19Q 3**	**FY19Q 4**
The total number of interventions within this time frame ≤ 5 minutes	79	73	101	93	104	105	82	53
The total number of interventions within this time frame 6-10 minutes	20	23	23	16	14	13	17	8
The total number of interventions within this time frame 11-15 minutes	16	19	24	22	8	14	11	20

Study Question 3:

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

0.32% (FY14Q2) compared to 0.17% in FY19Q4 (n=52/29950). During the time this has been monitored, the overall percentage has been trending downward with some quarters fluctuating and showing slight increases. The highest was 0.37% in FY14Q3 and the lowest was 0.11% from FY18Q1 to FY19Q3.





Improvement Strategies

Recommendations as determined by the regional BTPRC include the following:

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

- The BTPRC has requested training to assist in the incorporation of the required elements of the Behavior Treatment Standards. Training information has been received from MDHHS and the Board Association. Further discussion and approval to determine next steps will occur.
- Continue to utilize a Frequently Asked Questions Document to identify scenarios that may be interpreted differently and provide guidance as a result of discussion with the BTPRC.

Care Coordination Plan

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

Healthcare Integration-Pilot Projects in FY19

Program	Focus	Strategies
Families Forward (FF)	Asthma/COPD	1. Continue to train staff in Asthma/COPD and behavior aspects of managing 2. Staff will review asthma care plan provided by healthcare staff with parents/guardian 3. Staff will document discussing asthma with identified families 3 times per quarter. 4. Add Nurse Care Manager to advance collaboration.
Adult Mental Health Services (AMHS)	Hypertension (HTN)	1. Ongoing staff training on HTN-including how to take a blood pressure. 2. Documentation of BP taken on a regular basis. 3. Education and motivational interviewing used with identified consumers and documented in The Electronic Health Record (EHR) in a consistent and meaningful way.
Substance Abuse Services (SAS)	Hepatitis C	1. Individuals will be screened by House of Commons (HOC) clinical staff to determine IVDU. 2. Individuals who are determined to be IVDU receive a health screen by the HOC nurse to determine Hepatitis screening in the past 12 months. 3. Individuals will be referred for further testing and education as appropriate. 4. If the individual has a PCP, staff will coordinate care. 5. If the individual does not have a PCP, the program will work to assist in establishment of one and then coordinate care.
Community Services for the Developmentally Disabled (CSDD)	Emergency Department Usage	1. Using a report developed by the IS department, case managers will verify connection (or lack thereof) to a Primary Care Physician for all individuals supported via Supported Independent Resource Teams (SIRT). 2. Case managers will meet individually with consumers to assess accuracy of report, appropriateness of current physician connection (and/or explore

		potential barriers to connections), and provide education of possible physician options if currently lacking such connection. 3. If connection with a primary care physician is required, Mental Health Workers within the unit will facilitate further linkages. Case managers will update the EHR to reflect accurate status. 4. On a quarterly basis, Life Consultation Admin. staff will pull reports to (1) assess data related to usage of local EDs and (2) determine key issues presenting as in need of care. Data will be linked back to the case manager for further review and follow up, as well as for ongoing education of alternatives involving the primary care physician. 5. Case managers will use all data and subsequent meetings with consumers to link to the Person Centered Plan and associated treatment plans per individual need.
Healthcare Integration Programs	Patients accessing behavioral health services	1. Establish new contract with Sparrow/MSU Family Medicine Residency Program that allows for increased staffing in two clinics. 2. Development of presentation for providers to educate on the Behavioral Health Consultant Model and how it enhances the provider's clinical practice.

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

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

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

Updated Goals for FY20

Families Forward:

- Improve collaboration and communication with primary care physicians about behavioral health goals, diagnoses, and medication management

- Collect Data from referrals and ADT feeds along with other health collection sites, to identify possible family physical health condition education groups. Will provide 3 groups this FY20.
- Provide staff education on physical health concerns through lunch and learns
- Implement Health Care Integration Service with Nurse Care Manager (NCM) into all Families Forward programs

Adult Mental Health Services:

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

Community Services for the Developmental Disabled:

- Decrease usage of local Emergency Departments (ED) for health care related needs, and identify key issues being addressed via ED usage currently
- Increase linkage to Primary Care Physician for more comprehensive and sustainable health care.

Substance Abuse Services:

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

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

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

Grievances, Appeals, and Fair Hearings

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

FY19 Program – Grievances, Appeals and Hearings Data

Program	# of Grievances for FY19	# of Appeals for FY19	# of Fair Hearings for FY19
AMHS	4	1	0
CSDD	7	15	6
FF	1	4	0
SAS	1	0	0
Total	13	20	6

Incident Reporting

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

CIRC Incident Review FY19

Category	Incident Reports
Medication	806
Other General Incident	270
Emergency Care	188
Serious Aggressive Event	94
Death	64
Missing Recipient	16
Serious Property Damage	12
Serious Self Injury	8
Exposure to Blood/Bodily Fluids	7
Choking	6
Arrest	3
Total	**1474**

Medication Incident Reports (IR)

In FY19, the majority of incident reports were medication errors. Of the 806 medication incident reports, 648 were due to missed meds. 55% of missed meds were due to consumer refusal.

Med IR Category	Number of Reports
Missed Med	678
Wrong Dose	55
Wrong Time/Day	43
Staff Signing Error	14
Wrong Person/Med	13
Adverse Reaction	3
Total	**806**

Emergency Care Incident Reports

There were 188 emergency care incidents reviewed in FY19. Of those, 122 were due to illness, and 49 due to injury. 115 resulted in emergency medical treatment and 46 hospitalizations.

Outcome	Illness	Injury	Other	Total
EMT	63	37	8	**115**
Hospitalization	45	7	1	**46**
No Hospital or EMT	14	5	8	**27**
Total	**122**	**49**	**17**	**188**

Consumer Deaths

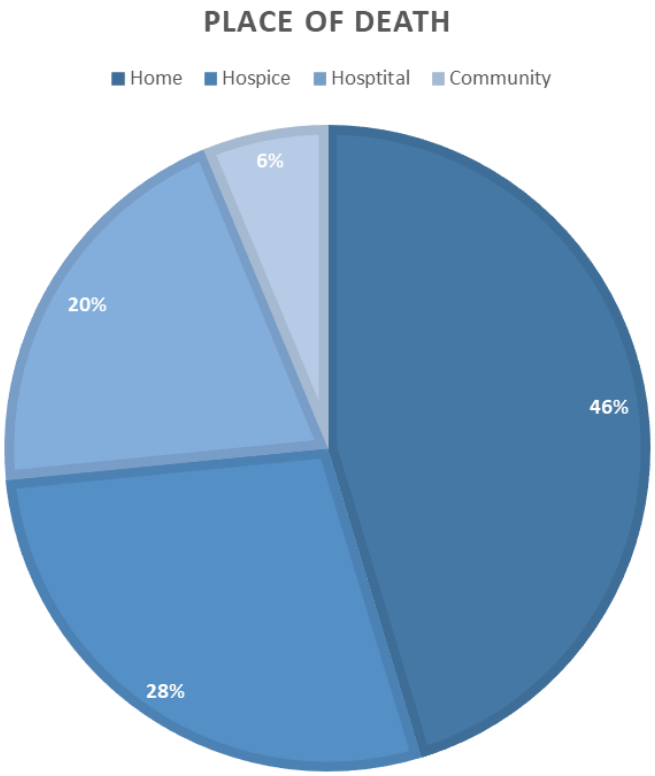
CIRC reviewed 64 consumer deaths in FY19

Cause	# of Incidents
Vascular	**13**
Accidental	**7**
Cancer	**7**
Diabetes	**7**
Suicide	**5**
Infection	**5**
Neurological disorders	**4**
Pneumonia	**4**
Kidney Disease	**3**
Lung Disease	**3**
Natural Unknown	**2**
Respiratory	**1**
Liver Disease	**1**
Aspiration	**1**
Homicide	**1**
Total	**64**

Age	
Range	**17-86**
Median	**59**
Mean	**57**

Program	# of Incidents

AMHS	**41**
CSDD	**19**
SAS	**3**
FF	**1**



Staff Injuries and Vehicles Accidents

In FY19, there were 73 reported incidents of staff injuries and five vehicle accidents. Reports from Accident Fund on the staff injuries are made available to HR in the spring of 2020. Of the vehicle accidents documented, only one claim was filed. CMHA-CEI paid for repairs on two accidents and one vehicle was totaled.

Sentinel Events

There were no sentinel events reported in FY2019.

Medicaid Event Verification

For FY19, there were two Medicaid Event Verification audits held by MSHN. June and December 2019.

Findings from the June 2019 MEV are as follows:

The following CAP was submitted and accepted by MSHN to address the above findings:

Findings from the December 2018 MEV are as follows:

MEDICAID CLAIMS/SERVICES VERIFICATION SELECTION
1. **Obtain claims/encounters from Provider for chart selection. Verify appropriate Medicaid eligibility. Verify service recorded/billed as indicated in chart, for example same date of service, length of time, and correct code.** **Purpose** The purpose of the claims test is to determine that sufficient evidence exists to support the validity of the selected claims. **Method of selection** Sample was determined using the methodology identified in the MSHN MEV Review procedure. The sample size consisted of 35 beneficiaries having either Medicaid or Healthy Michigan Plan coverage. Based on Community Mental Health for Clinton, Eaton, and Ingham Counties total population of people served being 3,992 using Medicaid or Healthy Michigan Plan funding the sample size of 50 beneficiaries was selected. Fifteen (15) beneficiaries were removed from the sample as the minimum sample had been reviewed and the required compliance standard was met. **Attributes Tested** A. Code is an allowable service code under the contract B. Beneficiary is eligible on the date of service

C. Service is included in the beneficiary's individual plan of service
D. Documentation of the service agrees to the claim date and time of service
E. Documentation of the service provided falls within the scope of the service code billed
F. Amount billed does not exceed contractually agreed amount
G. Modifiers are used in accordance with the HCPCS guidelines

Procedures

Documentation was reviewed for all attributes tested. Based on the examination of the documentation each attribute was rated on the review tool within the claims test as present (Y), not present (N), or not applicable (NA).

Claims Test

Attributes tested	Totals
Code is an allowable service code under the contract	100%
Beneficiary is eligible on the date of service	100%
Service is included in the beneficiary's authorization/treatment plan	100%
Documentation of service agrees to the claim date and time of service	96.85%
Documentation of service provided falls within the scope of the service code	94.37%
Amount billed does not exceed contractually agreed upon amount	100%
Modifiers are used in accordance with the HCPCS guidelines	98.56%
Total	**91.55%**

*Please note the total is not an average of the scores but the total valid claims. The formula used to determine the percentage of valid claims is: total valid claims reviewed/total claims reviewed=percentage of valid claim. A valid

claim is defined as a claim included in the sample that does not have a finding identified.

Conclusion

Community Mental Health for Clinton, Eaton, and Ingham Counties had a total of 888 claims/encounters reviewed which included 7,935 units of service. Of the 888 claims/encounters reviewed 870 of them were submitted as Medicaid and 18 of them were submitted as Healthy Michigan Plan (HMP) claims/encounters. The amount of services reviewed totaled $177,686.54. Of the $177,686.54 total claims reviewed, $165,434.98 of the claims/encounters were submitted using Medicaid and $12,251.56 were submitted using Healthy Michigan Plan.

Total by Funding Source			
	Medicaid	HMP	Total
Claims/ Encounters	870	18	888
Units	7,901	34	7,935
Dollar	$165,434.98	$12,251.56	$177,686.54

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

Services Reviewed by Program			
Program	Claims	Units	Amount
ACT	26	37	$6,372.42
Autism	47	883	$13,053.42

Crisis Residential	5	5	$2,147.80
Habilitation Supports Waiver (HSW)	89	2,306	$14,806.58
Home Based Services	36	129	$14,572.92
Self Determination	150	2,751	$13,493.75
Targeted Case Management	599	2,809	$126,283.36
Wraparound	4	18	$4,780.52

2. Internal controls were reviewed to ensure that clean and appropriate claims are submitted for billing. Items reviewed may include Electronic Medical Record (EMR), policy/procedure, or other. The control is supported if there are not invalid claims that the control is in place to prevent.

Purpose

The purpose of this test is to determine that the selected items provide evidence that controls have been properly implemented in accordance with the design and to meet the control objectives as described at the Control Documentation Form

Method

All controls identified by the provider will be tested during the MEV review. The provider will be asked to demonstrate any control that is part of an EMR. Any claim found to be invalid that was not captured by an identified control will results in that control be identified as not present.

Attributes Tested

A. System in place to verify Medicaid/Healthy Michigan Plan eligibility
   -Eligibility verifications are completed on a monthly basis.
B. System in place to ensure there are not duplicate billings for a service
   -Claims cannot be processed for billing within the EMR if there is an overlapping or duplicate billable event for the client or the clinician.

C. System in place to ensure that a person does not have more than 1 claim/encounter billed during the same time period
- Claims cannot be processed for billing within the EMR if there is an overlapping or duplicate billable event for the client or the clinician.

D. System in place to ensure that a claim/encounter being billed is authorized
-Validations set up in the EMR require an authorization for services prior to claim submission

E. - System in place to verify that codes are approved Medicaid/Healthy Michigan Plan Codes
-Codes are set up in the EMR according to Medicaid, Healthy Michigan Plan, and HCPC coding.

F. System in place to ensure that invalid claims/encounters are corrected
-Invalid claims/encounters are flagged within the EMR for follow up.

Conclusion

Comments: Most of the internal controls in place at Community Mental Health for Clinton, Eaton, and Ingham Counties are built into the EMR where billings are processed. Community Mental Health for Clinton, Eaton, and Ingham Counties utilizes Streamline for their EMR.

Comments:

Noted: The MEV review for Community Mental Health for Clinton, Eaton, and Ingham Counties was completed as a desk review December 4, 2019 through December 9, 2019. Documentation for CLS, Personal Care, Respite, and Skill Building are not maintained within the EMR. Hard copy documentation of these services was uploaded to BOX for review. All identified findings were shared with staff prior to the completion of the review for possible follow up.

Summary of Findings and Corrective Action

Strengths:

- Community Mental Health for Clinton, Eaton, and Ingham Counties completes eligibility verifications on a monthly basis
- Community Mental Health for Clinton, Eaton, and Ingham Counties has an EMR in place that has internal validations to identify invalid claims/encounters

Findings: Findings require a remedial action/corrective action plan within 30 days of the review report date for any item that did not meet the compliance standard. A detailed corrective action plan which addresses the steps to be taken to assess and correct claims and encounters that could not be verified and includes measurable criteria in regard to how the objective/outcome will be achieved will need to be submitted to MSHN.

- H2015 was submitted for more units than the documentation supports. Lines 205, 209, 211, 212, 218, 235, 249, 507, 516, 517, 518, 533, 541, 546, 553, 565, 568, 570, 571, 575, and 576 on the review tool.
- H2015 was submitted without supporting documentation for the service. Lines 234, 243, 360, 361, 363, 367, 368, 371, 372, 376, 377, 380, 395, 396, 399, 400, 404, 405, 408, 409, 473-493, and 495 on the review tool.
- H2014 was submitted without supporting documentation for the service. Lines 582, 585, 586, and 589 on the review tool.
- H2014 was submitted for more units than the documentation supports. Line 620 on the review tool.
- H0039 was submitted for a service the documentation states the person did not attend. Line 890 on the review tool.
- HS modifier was not used for a service the beneficiary was not present. Lines 918, 919, and 927 on the review tool.
- 96372 was submitted outside of ACT. Lines 908 and 913 on the review tool.

Recommendations: Recommendations do not require a formal corrective action plan. Recommendations are suggestions for best practice but are not required changes.

- Recommend scanning all documentation into the EMR
- Recommend using a standard naming convention for all documentation scanned into the EMR
- Recommend developing a process to ensure CLS staff are trained in beneficiaries' individual plan of service. Lines 3, 43, and 655 on the review tool.
- Recommend developing a process to make sure behavior technicians are trained in the beneficiary's individual plan of service prior to providing services. Line 58 on the review tool.
- Recommend adding more narrative to CLS notes. Line 270 on the review tool.
- Recommend training CLS provider on documentation standards at this time only timesheets are available and there is not supporting documentation for

the service that occurred. Lines 360, 361, 363, 367, 368, 371, 372, 376, 377, 380, 395, 396, 399, 400, 404, 405, 408, 409, 473-493, and 495 on the review tool.

- Recommend training CLS and Personal Care provider on documentation standards. Lines 410-459 on the review tool.

Corrective Action Plan:

- H2015 claims will be voided and re-entered to match the times on the documentation for lines 205, 209, 211, 212, 218, 235, 249, 533, 541, 546, 553, 565, 568, 570, 571, 575, and 576 on the review tool within 30 days of CAP approval. CMHA-CEI Quality Advisor will follow up with these providers to discuss accurate billing submission.
- H2015 claims will be voided and re-entered to match the times on the documentation for lines 507, 516, 517 and 518 on the review tool within 30 days of CAP approval. CMHA-CEI Quality Improvement team will meet with fiscal intermediary and clinical program to discuss contractual requirements to submit accurate billing.
- H2014 claim will be voided and re-entered to match the time on the documentation for line 620 on the review tool within 30 days of CAP approval. CMHA-CEI Quality Advisor will follow up with this provider to discuss accurate billing submission.
- H0039 claim will be voided for line 890 on the review tool within 30 days of CAP approval. Appropriate staff will receive training on billing for services without the consumer present in team meetings and/or supervision.
- H2015 claims will be voided for lines 234 and 243 on the review tool within 30 days of CAP approval. CMHA-CEI Quality Advisor will follow up with provider to discuss requirement to complete and submit documentation for services provided.
- H2015 claims will be voided for lines 361, 363, 367, 368, 371, 372, 376, 377, 380, 395, 396, 399, 400, 404, 405, 408, 409, 473-493, and 495 on the review tool within 30 days of CAP approval. The clinical program has worked with the fiscal intermediary to include the documentation on the employee's timesheet and this was implemented 10/1/19. This is expected to reduce the number of claims from the fiscal intermediary that do not have supporting documentation. CMHA-CEI Quality Improvement team will meet with fiscal intermediary and clinical program to discuss contractual requirements to submit supporting documentation going forward.
- H2014 claims will be voided for lines 582, 585, 586, and 589 on the review tool within 30 days of CAP approval. These claims were provided by one of CMHA-CEI's Transitions Program sites, which are no longer open.

- 96372 claims will be voided and claims will be re-entered with ACT code for lines 908 and 913 on the review tool within 30 days of CAP approval. Appropriate staff will receive training on using ACT codes in team meetings and/or individual supervision.
- The claims for lines 919 and 927 have been voided and re-entered using the HS modifier. The claim for line 918 on the review tool will be voided and re-entered to include the HS modifier within 30 days of CAP approval. Appropriate staff will be trained on the use of the HS modifier within 30 days of CAP approval in team meetings and/or individual supervision.

FY 2019 Chart Review Results

FY 2019 (October 2018 – September 2019)

Chart Review Process

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

Reviews will be completed at least quarterly and will address:

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

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

The clinical record review results will be discussed quarterly at the QICC.

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
FY19 1st Quarter	Assertive Community Treatment (ACT) and Substance Use Disorders (SUD) (HOC and Clinton County Counseling Center (CCCC)
FY19 2nd Quarter	Waivers (HSW, CWP, SEDW)
FY19 3rd Quarter	Contracted Case Management Services (Beacon, Case Management of Mid-Michigan, County of Financial Responsibility (COFRs))
FY19 4th Quarter	AMHS Wellness Programs

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

FY19 Q1 Results

Assertive Community Treatment (ACT) Chart Review FY19 Quarter 1				
Section	**Question**	**Standard**	**# of Charts Reviewed**	**Overall**
Assessment:	Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	1.1	32	**54.7%**
	Consumer's needs & wants are documented?	1.2	32	**100.0%**
	Assessment reflects input and coordination with others involved in treatment?	1.3	32	**95.3%**
	Present and history of behavior and/or symptoms are documented.	1.4	32	**95.3%**
	Substance use (current and history) included in assessment?	1.5	32	**90.6%**
	Current physical health conditions are identified?	1.6	32	**95.3%**
	Current health care providers are identified?	1.7	32	**96.9%**
	Previous behavioral health treatment and response to treatment identified?	1.8	32	**90.6%**
	History of Trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma)	1.9	32	**93.8%**
	Is the population and age specific trauma screening tool completed?	N/A	N/A	**N/A**
	Safety/risk issues of harm to self or others or by others (e.g. domestic violence) are assessed in all life domains	1.10	32	**96.9%**
Preplanning:	Did pre-planning occur prior to the Person Centered Planning meeting or the development of a plan?	2.1	32	**70.3%**
	If risk of harm to self or others has been identified a crisis plan has been completed (Crisis Plan is Required for home based services)	2.6	27	**74.1%**
Person Centered Planning / Individual	Consumer is actively involved in making informed decisions and meaningful choices regarding services/treatment?	3.2	32	**96.9%**
	Is medical necessity documented for each authorized service identified in the plan?	3.7	32	**100.0%**
	Has the LOCUS been completed in the past year?	N/A	32	**78.1%**

Plan of Service:	Does LOCUS match services authorized?	N/A	32	**56.3%**
	Plan includes meaningful activities, community supports and services that will be provided to encourage consumer inclusion in the community, participation, independence and/or productivity?	3.9	32	**96.9%**
	Is the planned frequency of review of the plan is documented?	3.10	32	**100.0%**
	Are goals, objectives and interventions clear and measurable?	3.11	32	**95.3%**
	Were all required signatures obtained?	3.12	32	**62.5%**
	Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	3.13	32	**90.6%**
	Accommodations available for individuals accessing services who experience hearing or vision impairments, including that such disabilities are addressed in clinical assessments and service plans as requested by the person receiving services	3.14	32	**100.0%**
	If applicable, identified history of trauma is effectively addressed as part of PCP	3.16	25	**96.0%**
Service Delivery Consistent with Plan:	Consumer has ongoing opportunity to provide feedback on satisfaction with treatment and services?	3.3	32	**100.0%**
	Are services being delivered consistent with plan in terms of scope, amount and duration?	6.1	32	**60.9%**
	Monitoring and data collection on goals is occurring according to time frames established in plan?	6.2	32	**64.1%**
	Are periodic reviews occurring according to time frames established in plan?	6.3	32	**57.8%**
	Progress notes document progress towards goals?	N/A	32	**95.2%**
	If any services billed at group level, does note show evidence that session was with a group? (TT modifier) - MEV finding	N/A	4	**62.5%**
	If there are any peer specialist progress notes, was the service provided by a certified peer specialist? (HE modifier) - MEV finding	N/A	21	**50.0%**
Specific Service Requirements:	For ACT services: all members of the team routinely have contract with the individual	7.1	31	**97.6%**
	For ACT service: services are delivered in the community	7.1	31	**96.8%**
	For medication services, informed consent was obtained for all psychotropic medications?	7.2	32	**89.1%**
	Is there evidence of outreach activities following missed appointments?	7.5	28	**92.9%**
	Is there evidence of coordination with Primary Care Physician in the record?	7.6	32	**62.5%**
	For Pre-admission screenings of ACT consumers: if a consumer has a pre-admission screening through crisis services, was this completed by an ACT staff member? (As of 4/1/18)	N/A	6	**75.0%**

SAS Chart Review							
Section	Question	# of HOC Charts Reviewed	HOC %	# of CCCC Charts Reviewed	CCCC %	# of Charts Reviewed Overall	Overall
Assessment:	Is there a copy of the Assessment in the EHR?	31	62.90%	40	100.00%	71	83.80%
	Is the assessment entered/scanned timely?	28	53.57%	39	93.59%	67	76.87%
Person Centered Planning / Individual Plan of Service:	Is there a copy of the treatment plan in the EHR?	33	92.42%	40	100.00%	73	96.58%
	Is the treatment plan entered/scanned in Timely?	33	65.15%	40	63.75%	73	64.38%

FY19 Q2 Results

Habilitation Supports Waiver (HSW) Chart Review				
Section	Question	Standard	# of Charts Reviewed	Overall
Administrative Requirements	If a Waiver enrollee receives Environmental Modifications or Equipment, has the PIHP implemented prior authorizations in accordance with their process?	A.3.1	6	0.00%
Plan of Service / Documentation Requirements	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.	P.5.1	78	53.21%
	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.	P.5.2	78	66.03%
	The IPOS for individuals enrolled in the HSW is updated within 365 days of their last IPOS.	P.5.3	78	78.85%

Children's Waiver Program (CWP)			
Question	Standard	# of Charts Reviewed	Overall
A current narrative supports the identified Category of Care/Intensity of Care determination.	P.4.1a	21	61.90%
Narrative supports the services that are authorized	P.4.1b	21	92.86%

Services and supports are provided as specified in the IPOS including type, amount, scope duration and frequency.	P.4.2	21	90.48%
Billings reflect only those services and frequencies of services that are identified in the IPOS.	P.4.3	21	88.10%
Is the IPOS updated at least annually?	P.4.6	20	100.00%

Serious Emotional Disturbance Waiver (SEDW) Chart Review			
Question	Standard	# of Charts Reviewed	Overall
Level of Care Evaluations are completed accurately.	E.2.1	12	75.00%
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.	P.3.1	40	71.25%
The IPOS addresses all service needs reflected in the assessments.	P.3.2	42	95.24%
The strategies identified in the IPOS are adequate to address assessed health and safety needs, including coordination with primary care provider.	P.3.3	44	59.09%
IPOS for enrolled consumers is developed in accordance with policies and procedures established by MDHHS.	P.3.4	44	85.23%
Services and supports are provided as specified in the IPOS including type, amount, scope duration and frequency.	P.6.1	42	63.10%
Billings reflect only those services and frequencies of services that are identified in the IPOS. (PM I-1)	P.6.2	3	66.00%
The IPOS was updated at least annually.	P.6.4	34	85.29%

FY19 Q3 Results

Contracted Case Management				
Section	Question	Standard	# of Charts Reviewed	Overall
Assessment	Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	1.1	23	93.48%
	Previous behavioral health treatment and response to treatment identified?	1.8	21	64.29%
	History of Trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma)	1.9	23	73.91%
Preplanning	Did pre-planning occur prior to the Person Centered Planning meeting or the development of a plan?	2.1	23	63.04%
	Was consumer offered the opportunity to develop a Crisis Plan?	2.5	20	50.00%

Person Centered Planning / Individual Plan of Service	Consumer is actively involved in making informed decisions and meaningful choices regarding services/treatment?	3.1	23	**80.43%**
	The plan addresses needs/issues identified in assessment (or clear documentation of why issue is not being addressed)	3.4	23	**65.22%**
	Is the amount, scope and duration identified for each authorized service in the PCP?	3.8	23	**76.09%**
	Plan includes meaningful activities, community supports and services that will be provided to encourage consumer inclusion in the community, participation, independence and/or productivity?	3.9	21	**80.43%**
	Is the planned frequency of review of the plan as documented?	3.10	23	**95.65%**
	Are goals, objectives and interventions clear and measurable?	3.11	23	**63.04%**
	Were all required signatures obtained?	3.12	23	**60.87%**
	Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	3.13	20	**37.50%**
	If applicable, identified history of trauma is effectively addressed as part of PCP. (or clear documentation of why trauma is not addressed)?	3.16	18	**30.56%**
Enrollee Rights & Protections	Consumer was provided written information related to Recipient Rights?	4.1	23	**97.83%**
	Consumer was informed of Informal Conflict Resolution?	4.2	23	**97.83%**
	Consumer was given accurate and timely information about the Grievance and Appeal Process?	4.3	23	**93.48%**
Service Delivery Consistent with Plan	Consumer has ongoing opportunities to provide feedback on satisfaction with treatment and services?	6	22	**95.45%**
	Are services being delivered consistent with plan in terms of scope, amount and duration?	6.1	23	**58.70%**
	Are periodic reviews occurring according to time frames established in plan?	6.3	18	**75.00%**
Specific Service Requirements	For medication services, informed consent was obtained: a. for all psychotropic medication b. the right to withdraw consent at any time	7.2	20	**30.00%**
	Is there a physician prescription or referral for each specialized service (PT, OT, Speech therapy, etc)	7.3	2	**100.00%**
	Is there evidence of coordination with Primary Care Physician in the record?	7.6	22	**41.30%**

Discharge / Transfer	For closed/transferred cases, was the discharge summary/transfer completed in a timely manner? (consistent with CMSHP policy of 30 calendar days)	8.1	3	83.33%

FY19 Q4 Results

AMHS Wellness Programs				
Section	**Question**	**Standard**	**# of Charts Reviewed**	**Overall**
Assessment	Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	1.1	3	**100%**
	Consumer's needs & wants are documented?	1.2	3	**83%**
	Substance use (current and history) included in assessment?	1.5	3	**83%**
	Current physical health conditions are identified?	1.6	3	**100%**
	Current health care providers are identified?	1.7	3	**100%**
	Previous behavioral health treatment and response to treatment identified?	1.8	3	**100%**
	History of Trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma)	1.9	3	**83%**
	Safety/risk issues of harm to self or others or by others (e.g. domestic violence) are assessed in all life domains	1.10	3	**100%**
Preplanning	Did pre-planning occur prior to the Person Centered Planning meeting or the development of a plan?	2.1	3	**67%**
Person Centered Planning / Individual Plan of Service	The plan addresses needs/issues identified in assessment (or clear documentation of why issue is not being addressed)	3.4	3	**33%**
	Is the amount, scope and duration identified for each authorized service in the PCP?	3.8	3	**33%**
	Plan includes meaningful activities, community supports and services that will be provided to encourage consumer inclusion in the community, participation, independence and/or productivity?	3.9	3	**33%**
	Are goals, objectives and interventions clear and measurable?	3.11	3	**17%**
	Were all required signatures obtained?	3.12	3	**33%**
	Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	3.13	3	**0%**
Service Delivery Consistent with Plan	Are services being delivered consistent with plan in terms of scope, amount and duration?	6.1	3	**67%**
	Monitoring and data collection on goals is occurring according to time frames established in plan?	6.2	3	**67%**
Discharge / Transfer	For closed cases, was the discharge summary/transfer completed in a timely manner? (consistent with CMSHP policy)	8.1	3	**50%**

	Does the discharge / transfer documentation include: a. Statement of the reason for discharge b. Individual's status / condition at discharge	8.2	2	**100%**
	Was ABDN Sent?	N/A	2	**50%**
Other	Is level of care appropriate for assessed need?	N/A	4	**100%**

Provider Monitoring

Overview

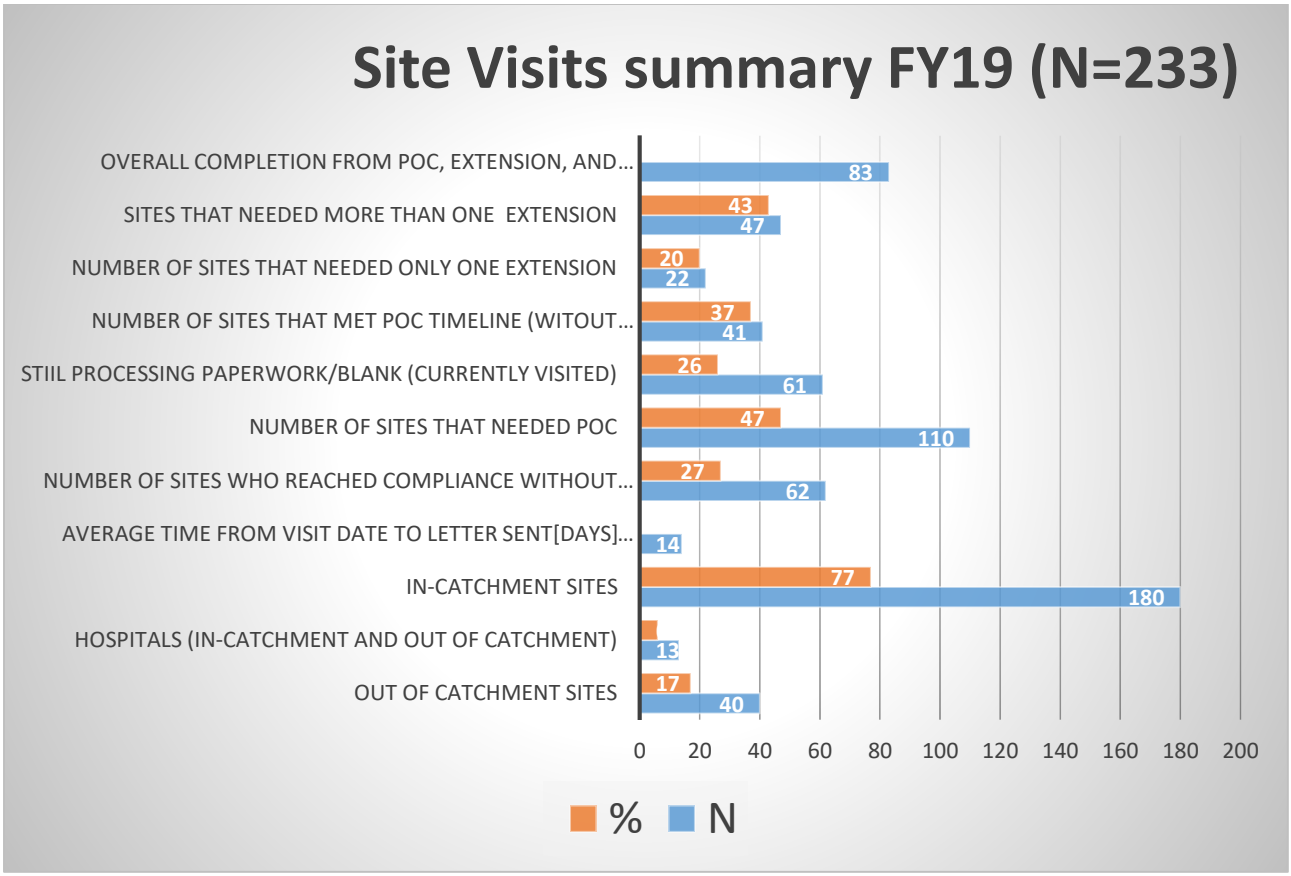
CMHA-CEI has 3 quality advisors who conduct site visits for contract sites for the following contract types:

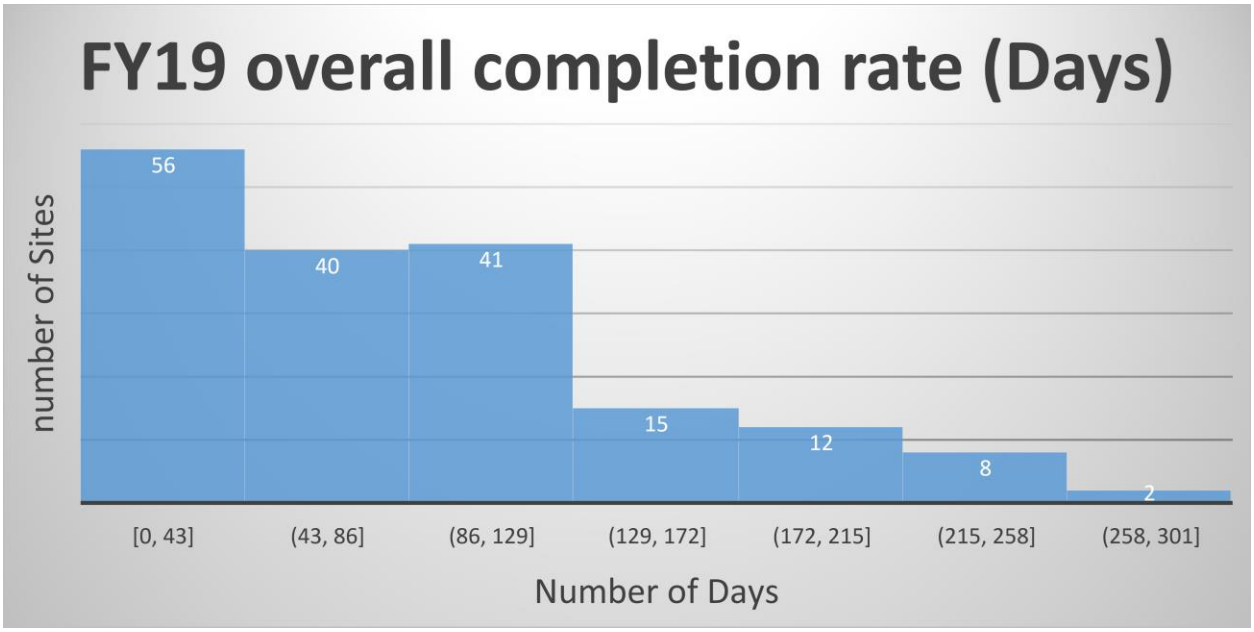
- Applied Behavior Analysis/Autism provider
- Hospitals
- Community Living Support (CLS)/Respite/Nursing
- Residential type A & B
- Pre-Vocational Training/Skill Building
- CMH-CEI-Residential and Non Residential

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

Site Visits Overview

- Overall completion rate (from visit date to full compliance) improve from 140 days (5 months) for FY18 to 83 days (3 months) for FY19
- Only 47% required Plan of Corrections (POC) in 2019 compared to 78% in 2018
- Improvement in compliance rate means,
    - The percentage of sites found to be in full compliance and thus not requiring POC improved from 14% in 2018 to 27% in 2019
    - The number of sites requiring multiple extension for their POC decreased in 2019 (43%) compared to 2018 (59%)
- Noticeable areas of improvements include staff training, human resource managements, PCP training and implementation, and follow up with the QAs
- There are more Out of Catchment (OOC) sites and Hospitals visited in 2019 compared to 2018 (20 OOC and 4 Hospitals in 2018 Vs 40 OOC and 13 Hospitals in 2019)





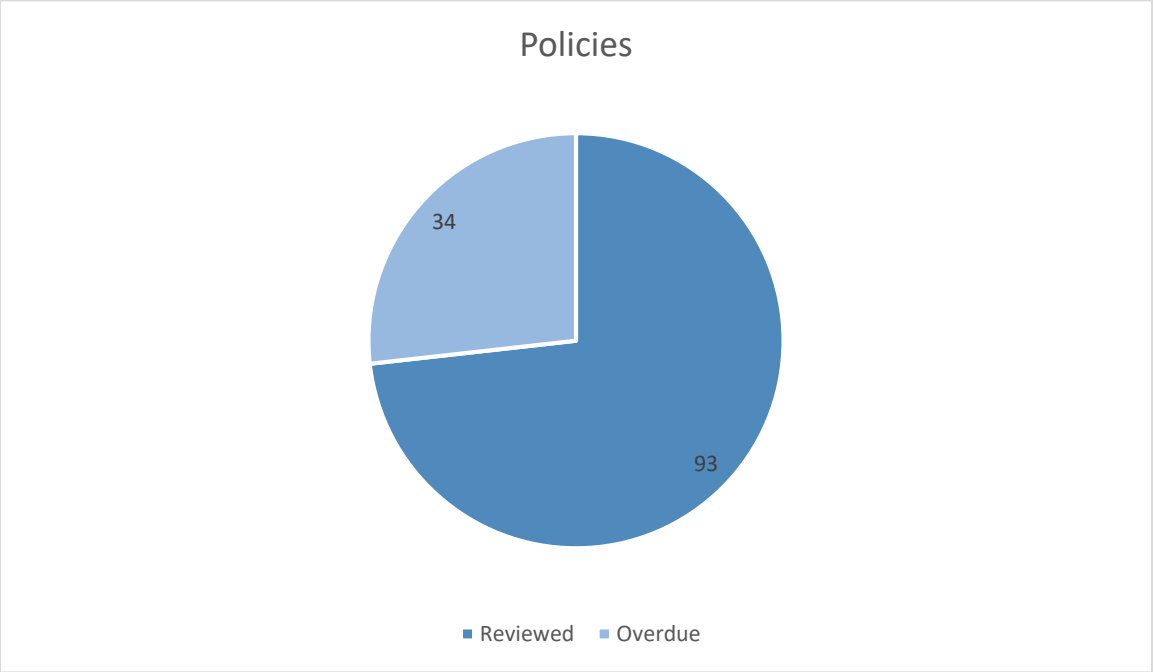
Improvement Opportunities

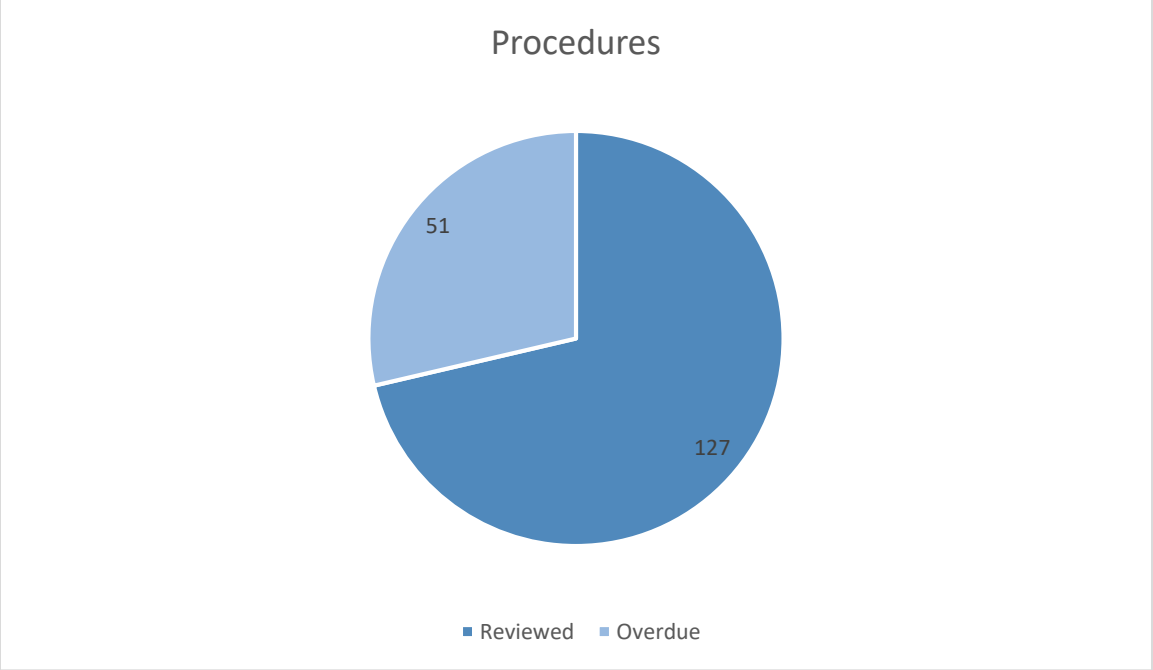
Quality Advisors (QA) along with Contract & Finance Dept. and Clinical Programs will continue to assist providers in the following areas in the coming year:

- Improved online training system (i.e., CMHA-CEI online system, Improving MI Practices system)
- Allocation of more online resource to cut down operating cost (utilize free online services for human resource management i.e., Office of Inspector General (OIG) checks, IChat, etc.)
- Collaborate with other CMHs to improve review process for OOC sites (i.e., Reciprocity process-MCHE web group)
- Implementation of CMHA-CEI provider access portal
- Utilize onboarding process to address important topics pertained to compliance (Contract & Finance, and QA's)

Policy and Procedure Review

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





Introduction

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

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

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

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

Directions for Completion

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

Please contact the following HSAG staff members with any questions:

Lee Ann Dougherty, MHA
LDougherty@hsag.com | 614.477.9735

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

Table 1—Compliance Monitoring—Recommendations and PIHP Response

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

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

Standard VII—Grievance Process

3. STATUS: Completed

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

7. STATUS: Completed

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

- **Standard IX—Subcontracts and Delegation**

5. STATUS: Completed

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

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

- **Standard XII—Access and Availability**

4. STATUS: Completed and Ongoing

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

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

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

FY18Q3 – 0 CMHSPs. MSHN performance was 97.79%.

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

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

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

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

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

- **Standard XIV—Appeals**

3. STATUS: Completed

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

8. STATUS: Completed

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

11. STATUS: Completed

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

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

12. STATUS: Completed

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

Table 2—Performance Measures—Recommendations and PIHP Response

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

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

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

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

PIHP Performance Measures Review Response

STATUS: Complete and Ongoing

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

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

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

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

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

Table 3—PIP—Recommendations and PIHP Response

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

Performance Indicators (PI)

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

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

Indicator #2: The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. Standard = 95%

Indicator #3: Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional. Standard = 95% within 14 days

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

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

FY19 Performance Indicator Results: Medicaid Only

Indicator	Q1	Q2	Q3	Q4	Total
PI 1	96.4%	97.68%	97.05%	96.11%	96.81%
PI 2	97.15%	96.8%	91.1%	97.54%	97.54%
PI 3	93.98%	94.24%	92.89%	94.41%	93.88%
PI 4	95.59%	92.96%	96.15%	95.28%	95.28%
PI 10	7.61%	8.25%	12.44%	8.64%	8.64%

FY19 Performance Indicator Results: Full Population

Indicator	Q1	Q2	Q3	Q4	Total
PI 1	96.6%	95.7%	97.17%	96.27%	96.44%
PI 2	97.28%	96.99%	90.79%%	97.15%	97.14%
PI 3	94.1%	94.61%	91.42%	93.88%	93.50%
PI 4	95.62%	92.52%	92.91%	94.20%	93.81%
PI 10	7.06%	8.61%	8.55%	9.62%	8.46%

Numbers in red are those that fall below the standard

Indicators were submitted to MSHN and MDHHS quarterly. Clinical programs as well as the Access Department have implanted plans of corrections for PI 2, PI 3, and PI 4 at various points throughout the year.

MDHHS has approved changes in PI reporting beginning in Q2 FY2020. These changes will include an elimination of exceptions and certain exclusions. Baseline data will be collected for at least the first year before a new standard is set for each indicator.

MSHN Audit

CMHSP NAME: CMH-CEI	DATE OF SUBMISSION: 8/12/2019
	DATE MSHN RECEIVED: 8/12/2019
	DATE MSHN APPROVED: 10/30/2019

#	STANDARD
1.1	INFORMATION AND CUSTOMER SERVICES (CUSTOMER SERVICE)
Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
2.1	ENROLLEE RIGHTS AND PROTECTIONS (CUSTOMER SERVICE)
Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
3.1	ACCESS & AVAILABILITY (UTILIZATION MANAGEMENT)
Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
4.1	CMHSP PROVIDER NETWORK - Sub-Contract Providers (PROVIDER NETWORK)
Summary of Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
5.1	SERVICE AUTHORIZATION & UTILIZATION MANAGEMENT (UTILIZATION MANAGEMENT)
Summary of Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
6.1	GRIEVANCE & APPEALS (CUSTOMER SERVICE)

#	STANDARD
Summary of Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
7.1	PERSON-CENTERED PLANNING & DOCUMENTATION STANDARDS (UTILIZATION MANAGEMENT
Summary of Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
8.1	COORDINATION OF CARE (QUALITY IMPROVEMENT)
Summary of Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
9.1	BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE (QUALITY IMPROVEMENT)
Summary of Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
10.1	CONSUMER INVOLVEMENT (CUSTOMER SERVICE)
Summary of Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
11.1	PROVIDER/STAFF CREDENTIALING (PROVIDER NETWORK)
Summary of Findings and Corrective Action	
Findings: (Partial) • The CMHSP's policy and procedures for re-credentialing require, at a minimum: • Re-credentialing at least every two years • An update of information obtained during the initial credentialing. • A process for ongoing monitoring, and intervention when appropriate, of provider sanctions, complaints, and quality issues pertaining to the provider, which must include, at a minimum, a review	

#	STANDARD
	of: o Medicare/Medicaid sanctions. o State sanctions or limitations on licensure, registration, or certification. o Beneficiary concerns, which include grievances (complaints) and appeals information. o CMHSP quality issues Reviewer Note: Partial finding. The contracted staff file reviewed did not have evidence of re-credentialing. The provider did complete prior to the completion of the MSHN review. However, the re-credentialing was outside of the 2-year requirement.
Corrective Action Plan: CMHA-CEI's Quality Advisors complete annual Quality and Compliance monitoring of contract providers, which includes a review of credentialing and verification that re-credentialing is completed every two years. This can be seen in Section C of the example of the Quality and Compliance Monitoring Tool for ABA providers, which can be found here. The use of this tool began in April 2019 and will be used ongoing. The Quality Advisors develop a plan of correction related to any out-of-compliance standards and monitor the provider until compliance is achieved. MSHN Approved; 8.15.19; AD. MSHN to review sample contractor monitoring report during interim review in 2020. Recommend adding a credentialing component to all provider monitoring- not just ABA.	
12.1	QUALITY COMPLIANCE (QUALITY IMPROVEMENT)
Summary of Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
13.1	ENSURING HEALTH & WELFARE /OLMSTEAD (QUALITY IMPROVEMENT)
Summary of Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
14.1	INFORMATION TECHNOLOGY (IT) MANAGEMENT
Summary of Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
15.1	TRAUMA INFORMED CARE

#	STANDARD
Summary of Findings and Corrective Action	
Findings: • Collaboration with community organizations to support development of a trauma informed community that promotes behavioral health and reduces likelihood of mental illness and substance use disorders Reviewer Note: Evidence provided does not directly respond to the standard in regard to community collaboration.	
Corrective Action Plan: CMHA-CEI currently collaborates with various community organizations to support development of a trauma informed community that promotes behavioral health and reduces likelihood of mental illness and substance use disorders. Please see proof of the following here: • Participation in Mid-Michigan's Trauma Collaborative Steering Committee • Participation in Mid-Michigan's Trauma Training Committee • Hosting educational events such as the Coordination of Care dinner event, "Building 3-D Resiliency in Children, Families, and the Workforce to Sustain Trauma-Responsive Communities" CMHA-CEI also partners with MDHHS on trauma screening and referrals, with Eaton Regional Education Service Agency on training initiatives (including trauma-focused training), supervises and oversees the statewide Trauma-Focused Cognitive Behavioral Therapy training team, and participates in the "Handle With Care" Michigan Initiative and Clinton County Voices for Health. CMHA-CEI is hosting a Children's Mental Health Awareness Day Fair in August 2019. See flyer here. Further, CMHA-CEI is collaborating with NAMI-Lansing to encourage community attendance at this event and at NAMI-Lansing's Mental Health Awareness event in October 2019, as seen here. Accepted, MD, 08.22.19. Please maintain documented compliance with standard.	

#	STANDARD
1.1	JAIL DIVERSION

Summary of Findings and Corrective Action

Findings:

- The CMHSP has a Jail Diversion data report that includes a unique consumer ID, the date of the diversion, the type of crime, and the diagnosis.
  Reviewer Note: The report provided only identifies 13 individuals in the course of 12 months; MSHN reviewer questions accuracy of report given the size of CMH catchment and involvement with multiple mental health and treatment/recovery courts across 3 counties. Discussed during on-site review with Debra Willard and KC Brown and determined that additional procedural guidance needs to be developed so that different CMH programs have clarity on how/when to gather data accurately for individuals involved in pre-booking diversions as well as post-booking diversions.

Corrective Action Plan:

The Director of Substance Abuse Services & Corrections Mental Health has met with Adult Mental Health Services staff to review the EHR and its ability to count all jail diversion activity. The AMHS staff will be trained on how to utilize this portion of the EHR. The SAS Director will follow up with AMHS and Specialty Court managers before 12/31/19 to ensure that staff are recording jail diversion data and assist in problem solving.

MSHN Approved; 8.23.19; SP. MSHN to review updated jail diversion report during interim review in 2020.

2.1	ASSERTIVE COMMUNITY TREATMENT (ACT)

Summary of Findings and Corrective Action

Findings:

- ~~Majority of ACT services are provided according to the beneficiary's preference and clinical appropriateness in the beneficiary's home or other community locations rather than the team office. Reviewer Note: Evidence should include a method for ensuring the following requirement: The average number of visits per day/week/month/etc. provided by the whole team, not individual ACT team members, to an individual consumer will comprise 80% of home or community contacts.~~Provider demonstrated onsite compliance during review by developing a method for tracking services and demonstrating compliance within record as well as verbal attestation(s) and interview responses. Thank you. Score updated 07.17.19, ACT Outcomes – 100% MD, 07.17.19

Corrective Action Plan: NA

#	STANDARD
3.1	SELF-DETERMINATION
Summary of Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
4.1	PEER DELIVERED AND OPERATED SERVICES (Drop-In) (If applicable)
Summary of Findings and Corrective Action	
Findings: NA	
Corrective Action Plan: NA	
5.1	HOME-BASED SERVICES
Summary of Findings and Corrective Action	
Findings: • ~~(Partial) -The worker-to-family ratio meets the 1:12 requirements established in the Medicaid Provider Manual. For families transitioning out of home-based services, the maximum ratio is 1:15 (12 active, 3 transitioning). Reviewer Note: No indication of consumer status which would indicate transitioning and allow for 15 clients.~~ Per request, provider confirmed consumers transitioning and writer has recommended identifying consumers that are transitioning in order to demonstrate compliance with standard. Score updated 07.17.19, MD	
Corrective Action Plan: NA	
6.1	CLUBHOUSE PSYCHO-SOCIAL REHABILITATION PROGRAM (If applicable)
Summary of Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
7.1	CRISIS RESIDENTIAL SERVICES
Summary of Findings and Corrective Action	
Findings: None.	
Corrective Action Plan: NA	
8.1	TARGETED CASE MANAGEMENT
Summary of Findings and Corrective Action	

#	STANDARD
Findings: None.	
Corrective Action Plan: NA	
9.1	Habilitation Supports Waiver
Summary of Findings and Corrective Action	
Findings: • The individual plan of service is modified in response to changes in the individual's needs. Reviewer Note: Review of PCP outlined goal/objectives around OT services. After further clarification it is noted that this individual has not received OT services since 2017 yet it is still reflected in the PCP. • 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. Reviewer Note: Chart review indicated that the individual did not receive monthly Supports Coordination and required by HSW and indicated in plan.	
Corrective Action Plan: • Supports Coordinator sent ABDN to terminate OT services (6/12/19) with an effective date of two weeks (6/26/19), found here. • Staff will receive training in HSW requirements, including receiving monthly supports coordination, prior to 12/31/19 in staff meetings and/or individual supervision. • Recently, the Life Consultation unit hired an HSW Coordinator who will be reviewing all HSW treatment plans on an annual basis going forward to ensure compliance. MSHN reviewed and approved. KH 8.27.19	
10.1	AUTISM BENEFIT/APPLIED BEHAVIORAL ANALYSIS
Summary of Findings and Corrective Action	
Findings: • Beneficiaries ongoing determination of level of service (every six months) has evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with ABLLS-R or VB-MAPP. Reviewer Note: Evidence in BHT Benefit language of this expectation. However, the six-month assessment for this individual was not conducted within six months.	
Corrective Action Plan: In an effort to stay on track with the 6-month assessment requirement of the BHT benefit, an Excel file with most recent assessment date and due date of next assessment for each individual served was created and provided to each ABA provider agency, uploaded to Box here. Additionally, recent	

#	STANDARD
communication was provided to each ABA provider agency (following the MDHHS site review) that addresses this requirement, uploaded to Box here. MSHN Approved; BG 8.23.19	
11.1	HOME AND COMMUNITY BASED SERVICES
Summary of Findings and Corrective Action	
Findings: • If a restriction for a consumer is medically necessary, due to health and safety, modifications are addressed in the consumer's PCP and all requirements are followed and documented in consumer chart. Reviewer Note: Policies and procedures state any restriction must go through BTPRC. Reviewers noted that one individual at Aurelius Road Home had a completely bare/empty bedroom. There was one vinyl mattress on the floor and no bedding visible. Reviewers noted that two individuals at MLK Road Home had their personal belongings locked up in the laundry room and Home Manager indicated there was no one in the home with a behavior plan in place.	
Corrective Action Plan: • Aurelius Road Home: The individual selected for review has medical necessity for the restrictions addressed in the positive support plan, uploaded here. All modifications have been addressed (in accordance with the positive support plan) or are in the process of being addressed to become compliant with HCBS. The bed for the individual selected has been ordered and will be modified to ensure dignity and cleanliness. CAP not approved as written. CEI to ensure that this individual has access to safe personal property in his living space. Examples include: room personalization such as wall decals, items of interest, sheets/blankets, etc. • MLK Road Home: One consumer that still resides at MLK AFC has a legal guardian. Legal guardian instructed MLK AFC staff to keep consumer's personal belongings in the laundry room where consumer still has access but needs to ask staff. There's no BTP as this is the legal guardian's instructions. The second individual no longer lives in MLK AFC. CAP not approved as written. Any modification or restriction of an individual's rights must be based upon health or safety risks to the individual. Restrictions cannot be placed upon an individual based on the preferences, values or convenience of the guardian or the provider. Any modification to an individual's freedom as outlined by the HCBS Rule must be consistent with the required modification process and be clearly documented in the individual's plan of service and Behavior Treatment Plan.	
CMH-CEI 2nd CAP Response: Aurelius Road Home:	

#	STANDARD

The consumer's approved Positive Support Plan (found here) includes details about health and safety needs that require restrictions related to his extreme PICA behavior on page 7 (Section D). The consumer has a history of ingesting fabric and wall fixtures (such as wall trim and electrical outlets). In an effort to ensure the consumer's safety, and also allow for the personalization of his space, his support team will meet to discuss ideas for how his bedroom can be safely personalized. This team meeting will take place within 30 days of the approved CAP.

CAP not approved as written. If a restriction is medically necessary due to health and safety concerns, this must be addressed in the consumer's PCP and all requirements are followed and documented in consumer chart. It is not clear as to what corrective action is being taken other than the team will meet to discuss ideas. This is not enough to approve as a corrective action plan and should include steps that will be taken. Documentation should address that positive interventions and supports have been used prior to any modifications or additions to the PCP, including less intrusive methods of meeting the needs that have been tried. While this CAP response is specific to the individual's health and safety needs, the home should also include policy and or procedural changes as to how this will occur for any individual requiring health and safety considerations.

MLK Road Home:

AMHS Housing staff will work to educate the guardian about HCBS rules. In this particular case, this consumer throws their clothes away as part of their symptoms of mental illness. Staff will address this issue in the Health and Safety portion of the treatment plan by adding that the client's clothes will kept separate in order to ensure that the clients basic health needs are met (being clothed).

AMHS is working on hiring a behavioral psychologist to write BTP's. This position will be posted by 10/1/19. Once AMHS has a psychologist to write BTP's, this situation will be added to their duties to address.

CAP partially approved as written. Any modification or restriction of an individual's rights must be based upon the assessed health or safety risks that the individual's behavior represents. Restrictions cannot be placed upon an individual based on the preferences, values, or convenience of the guardian or the provider. Any limitation to an individual's freedom as outlined by the HCBS Rule must be consistent with the required documentation process and be clearly noted in the individual's person-centered plan and behavior treatment plan (as appropriate). Supporting documentation such as a functional assessment to determine possible reasons for inappropriate behaviors and/or ability to manage tasks and activities should be present. Processes should be put into place that address these concerns in order to balance health and safety with HCBS Rule freedoms. The CAP should focus on:

- Organizational processes to ensure that changes happen with any individual where there is a concern for health and safety
- All guardians are educated about the Federal HCBS Rule
- Processes involving the transition from the findings in a functional assessment to whether a behavior treatment plan is needed
- Ensure all CAP elements have specific timeframes identified

#	STANDARD

CEI 3rd CAP Response:

Aurelius Road Home:

A Comprehensive Functional Assessment will be completed within 30 days of the approved CAP. This assessment will detail the positive supports that have been utilized to reduce behavior and outline the medical necessity to determine if there is any continued need for restrictive measures. The Positive Support Plan will be updated and approved within 90 days of the completed assessment.

CAP approved as written. Please submit updated assessment and PSP for review when complete. KH/BG 10.4.19

MLK Road Home:

The following actions will be taken for corrective action:

1. CMHA-CEI staff will work to educate guardians about HCBS Federal Rule by 6/30/20.
   CAP not approved as written. CEI is expected to be complete with all CAP and remediation efforts by 4/30/20 per MDHHS guidelines. Minimally, CEI should be able to provide evidence of training of guardians with the first opportunity by 12/31/19 with completion of all guardian education prior to the deadline of 4/30/20.

2. Case Managers will assess and document health and safety needs and assure documentation is noted in the person-centered plan by 12/31/19.
   CAP approved as written. Please submit updated PCP for review when complete.

3. CMHA-CEI will continue efforts to hire and/or contract Behavioral Psychologist to assess and write Positive Support Plans/Behavior Treatment Plans with goal of completing this by 1/30/20.
   CAP approved as written.

4. A process for Behavior Treatment Planning in AMHS (including referral, assessment, plan, committee) will be developed by 3/30/20.
   CAP not approved as written. If CEI plans to develop a Behavior Treatment Planning process within AMHS by 3/30/20, then MSHNs expectation is that CEI will assure that any restrictions are reviewed and identified in the PCP in the interim. Additionally, CEI currently has a Behavior Treatment Planning committee with processes in place. To ensure the committee has a thorough understanding of the unique needs of those served in AMHS, it may be beneficial to add additional AMHS staff to the current committee in place.

5. CMHA-CEI/AMHS staff will continue to dialogue with MSHN HCBS staff (meeting scheduled 10/10/19) to further develop implementation ideas and address areas of Health and Safety that present a challenge.

#	STANDARD

CAP approved as written.

6. CMHA-CEI staff will update program guidelines to reflect HCBS rules by 6/30/20.
   CAP not approved as written. If any CEI guidelines need to be updated to reflect HCBS standards, they must be completed and updated to staff prior to 4/30/19.

CEI 4th Response:

MLK Road Home:

The following actions will be taken for corrective action:

1. CMHA-CEI staff will work to educate guardians about HCBS Federal Rule by 4/30/20.

   CAP approved as written, KH 10/30/19.

2. Case Managers will assess and document health and safety needs and assure documentation is noted in the person-centered plan by 12/31/19. Case Managers will document how individuals have daily choice and input into ADL's (i.e. Clothing, etc.) PCP about specific consumer will be amended by 12/31/19 that includes health/safety/choice/input updates.

   CAP approved as written, KH 10/30/19.

3. CMHA-CEI will continue efforts to hire and/or contract Behavioral Psychologist to assess and write Positive Support Plans/Behavior Treatment Plans with goal of completing this by 1/30/20.

   CAP approved as written, KH 10/30/19.

4. A process for Behavior Treatment Planning in AMHS (including referral, assessment, plan, committee) will be developed by 3/30/20. The interim plan is to develop a way to have discussion and documentation of healthy/safety concerns in the PCP for those individuals living with some form of restriction until CEI hires a BTP specialist to assess for necessity.

   CAP approved as written, KH 10/30/19.

5. CMHA-CEI/AMHS staff will continue to dialogue with MSHN HCBS staff (meeting scheduled 10/10/19) to further develop implementation ideas and address areas of Health and Safety that present a challenge.

   CAP approved as written, KH 10/30/19.

6. CMHA-CEI staff will update program guidelines to reflect HCBS rules by 4/30/20.

   CAP approved as written, KH 10/30/19.

11.2	HOME AND COMMUNITY BASED SERVICES SITE REVIEWS

Summary of Findings and Corrective Action

Findings:

#	STANDARD

CEI Aurelius Home

- Is the home free of fences, gates, locked doors, or other ways to block individuals from entering or exiting certain areas of their home/grounds? If no, how are residents' freedoms preserved with these barriers? Is this addressed in all Positive Support/Behavior Plans?
  Reviewer Note: Multiple locked door areas including: locked personal care closets, locked bathroom downstairs, locked clothing closets, entire kitchen cabinets locked.
- Do all bedrooms have appropriate keyed locks? If no, is this addressed in Positive Support/Behavior Plan?
  Reviewer Note: Bedroom doors had keyed locks; however, one door had a sign that indicated the door could only be locked manually by staff.
- Do all individuals residing in the home have access to an individualized key to their room? If no, is this addressed in Positive Support/Behavior Plan?
  Reviewer Note: No evidence that individuals carry their own keys to their rooms. Home manager indicated that she was not aware of residents carrying their own keys.
- Do all bathrooms have appropriate privacy locks? If no, is this addressed in Positive Support/Behavior Plan?
  Reviewer Note: The bathroom accessible to all residents does not have the ability to lock.
- Do all individuals have full access to the bathroom? If no, is this addressed in Positive Support/Behavior Plan?
  Reviewer Note: Downstairs bathroom is locked at all times; no reason given as to why this bathroom would need to be locked. Staff indicated this is a "staff only" bathroom. Third bathroom within the home, located inside one residents locked bedroom, does not appear to be functioning (no toilet paper, no soap, etc.).
- Can individuals access the bathroom at any time? If no, is this addressed in Positive Support/Behavior Plan?
  Reviewer Note: Downstairs bathroom is locked at all times; no reason given as to why this bathroom would need to be locked. Staff indicated this is a "staff only" bathroom. There is a bathroom in one resident's room; however, it did not appear that it has been used (no soap, toilet paper, etc.). This leaves one accessible bathroom for the 3 residents. Resident selected for review has a habilitative goal to increase Independence with personal care skills. Reviewers observed that all residents personal care items were locked in the bathroom requiring staff assistance to access.
- Is the inside of the residence free from cameras, visual monitors, audio monitors and alarms? If no, how are residents' freedoms preserved with these barriers? Is this addressed in all Positive Support/Behavior Plans?
  Reviewer Note: One monitor (camera/motion sensor) was mounted on the wall in the entry way. Once pointed out, Residential Supervisor removed from the wall and placed it in his vehicle.
- Do individuals have full access to the laundry area without restrictions? If no, is this addressed in Positive Support/Behavior Plan?
  Reviewer Note: Door to the laundry room is locked at all times. In regard to the resident whose plan was reviewed, in his positive support plan he has a goal to assist with laundry.
- All individuals have a signed lease and/or Resident Care Agreement with Summary of Resident Rights?
  Reviewer Note: Lease was submitted; however, lease expired in 2016. MSHN has requested copy of current lease.

CEI MLK Road Home AFC

- Is the home free of fences, gates, locked doors, or other ways to block individuals from entering or exiting certain areas of their home/grounds? If no, how are residents' freedoms preserved with these barriers? Is this addressed in all Positive Support/Behavior Plans?

#	STANDARD
	Reviewer Note: Reviewers found multiple locked gates/areas both outside and inside the home including: front and rear entrances with locked gates, locked exterior doors, front closet, activity room, kitchen, laundry, etc. The Provider indicated that there are no residents currently residing in this home with a Support plan warranting these restrictions. • Do staff ask before entering individuals' bedrooms/bathrooms? Reviewer Note: The home manager reported that she conveys this expectation in her staff training but could not remember if it is in writing. Reviewers observed staff knocking and announcing herself, but also observed staff using door peepholes to see if residents are within. Freedom of privacy is not preserved for residents when staff, other residents, or even visitors can look clearly into their room at any time without residents' permission or awareness. • Is the inside of the residence free from cameras, visual monitors, audio monitors and alarms? If no, how are residents' freedoms preserved with these barriers? Is this addressed in all Positive Support/Behavior Plans? Reviewer Note: Active video cameras are mounted externally at each entrance, and internally within the foyer, great-room, and each bedroom hallway, and other internal locations. Staff stated the cameras are non-recording, but this has not been verified. A monitor with several camera displays is located in the Staff office, and visually observable to people standing in the dining room. As noted previously, exit doors at the end of each bedroom hallway are not locked against egress, but set off a very loud alarm which can only be turned off by staff key. Each bedroom door has an electronic monitor which elicits an audio notification to staff office. • Do individuals have full access to the kitchen without restrictions? If no, is this addressed in Positive Support/Behavior Plan? Reviewer Note: Review team observed that primary door into kitchen is a half-door of which both halves lock. It was made anecdotally clear that residents are discouraged from entering the kitchen when staff are working- And when staff are not present in the kitchen, it is kept locked. The Provider expressed concern and fears of residents being harmed by sharps or hot items, hygiene/sanitation issues, and food budgetary issues if residents were to be granted free access to the kitchen. • Do individuals have access to food at any time? If no, is this addressed in Positive Support/Behavior Plan? Reviewer Note: In the dining area, peanut butter and bread were observed available, and a refrigerator solely for resident's use was also present in the dining room. Access to the home's general food supplies are kept locked in the kitchen and pantry. • Can individuals reach and use the home's appliances as they need? If no, is this addressed in Positive Support/Behavior Plan? Reviewer Note: Both the kitchen, its appliances, and the laundry room with their appliances are kept locked unless staff are available to open and assist. • Do individuals have full access to the laundry area without restrictions? If no, is this addressed in Positive Support/Behavior Plan? Reviewer Note: Both laundry rooms are kept locked and only staff have keys. One laundry room contained twelve cabinets, all of which were locked at time of visit. Staff reported the second laundry room was the same. • Do individuals have a way to communicate with individuals outside of the setting without restrictions? And can it be used in a private place? Reviewer Note: The residence provides one house phone which is not cordless. This phone is located in a corner of the great room and has no privacy. The Home Manager states that the house phone has been destroyed several times in the previous several months. She says the phone in her office could be available for private conversations, but it was pointed out that resident's PHI could be compromised. • Does the residence allow friends and family to visit without rules on hours or times?

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	Reviewer Note: A sheet delineating rules for visiting hours and expected behavior was observed in the residence, and quickly removed by staff. • Does the residence/provider have "House Rules" or something similar? Reviewer Note: Review team observed various sheets of house rules in the home- Visiting Hours rules; Bedroom Cleanliness; Kitchen Rules; Activity Guidelines; and a system of "Levels" for Community Access. CEI QI team reports that they verified the presence of these rules in Feb. '19 and advised the home that any such rules are not allowed by HCBS and should be removed.

Corrective Action Plan:

CEI Aurelius Home:

- In accordance with the individual's positive support plan, the Aurelius home will have all cabinets, fridge, freezer, and closets locked. All door handles not addressed in the positive support plan have been replaced in accordance with HCBS standards. CAP approved as written. Onsite verification to be completed by CEI Quality Advisor to ensure compliance with HCBS standards within given timeframes.
- The door mentioned in bullet point 2 has been replaced to function properly. The sign on the door has been removed. CAP approved as written. Onsite verification to be completed by CEI Quality Advisor to ensure compliance with HCBS standards within given timeframes.
- People residing the home will have keys made for them unless addressed in an individual's positive support plan. CAP approved as written. Onsite verification to be completed by CEI Quality Advisor to ensure compliance with HCBS standards within given timeframes.
- Door handles have been replaced in the bathroom, so they have the ability to be locked. CAP approved as written. Onsite verification to be completed by CEI Quality Advisor to ensure compliance with HCBS standards within given timeframes.
- Downstairs bathroom is and will remain unlocked and able to be used by all individuals residing at Aurelius. The "staff only" sign was removed during the site visit and was discussed in a team meeting. Toiletry items have been put in the 3rd-bedroom bathroom. The individual selected for review does have a restriction addressed in the individual's positive support plan restricting all cleaning supplies and toxic material; thus the need for locking his personal hygiene supplies. CAP approved as written. However, Aurelius Home Manager should ensure that residents understand and are aware that individuals have full access to all bathrooms within the home. Onsite verification to be completed by CEI Quality Advisor to ensure compliance with HCBS standards within given timeframes.
- Baby monitor camera was removed during the site visit and has been disposed of. CAP approved as written. CEICMH to ensure that cameras/monitors are not added to sites without following the modification process.
- A lockable cabinet is in the process of being installed to hold cleaning materials and the laundry room door will be unlocked once that cabinet is installed in order to remain in compliance with the individual's positive support plan. CAP approved as written. Onsite verification to be completed by CEI Quality Advisor to ensure compliance with HCBS standards within given timeframes.
- A new lease has been generated by Michigan Asset Group (management company) effective 8/1/2019. CAP approved as written. Proof of lease to be verified by CEI Quality Advisor to ensure compliance with HCBS standards within given timeframes.

#	STANDARD

CEI MLK Road Home AFC

- As MLK AFC is a Level IV Specialized Residential program, the gates have a delayed egress of 15 seconds to allow staff to attempt to redirect or accompany consumers. This is due to multiple consumers having been hit by cars on the M-99 highway, including one consumer fatality. Consumers have access to exit the home/grounds as they choose. Maintenance staff will change the gate lock to a passcode for entry, where consumers will be given the codes to enter the grounds as they choose. CAP not approved as written. If there are restrictions on entering or exiting certain areas of the home, a modification in the individual's Person-Centered Plan due to health or safety needs is required. The rationale for restrictions should be documented in the PCP and Behavior Plan.
- MLK AFC will unlock front closet and laundry room (there's a work order for maintenance to change the door lock) for open access. MLK has installed a phone jack in the Activity room which has a door for privacy. CAP approved as written. Onsite verification to be completed by CEI Quality Advisor to ensure compliance with HCBS standards within given timeframes.
- A work order has been submitted to maintenance to fill in the peepholes. MLK house manager will develop a guideline and training for house staff to ensure freedom of privacy and document the training/review in the staff meeting notes. CAP approved as written. MLK AFC should ensure that the staff training emphasizes that increased monitoring ("hourly bed checks") must be medically necessary and clearly indicated in an individual's PCP and Behavior Plan if necessary. Onsite verification to be completed by CEI Quality Advisor to ensure compliance with HCBS standards within given timeframes.
- Regarding cameras, visual monitors, audio monitors, and alarms: Given that MLK AFC is a Level IV Specialized Residential program, MLK AFC has these devices to protect consumers due to several incidents that led to the installation of those devices. CMHA-CEI will re-angle the computer monitor in the staff office and install a screen protector so it cannot be visually observed by others. CMHA-CEI will discuss with the fire marshal turning down the alarm volume for the hallway outer doors. CMHA-CEI will also remove electronic monitors on the bedrooms that elicit an audio notification to the staff. CAP not approved as written. If cameras, visual monitors or audio monitors are necessary, a modification in the individual's Person-Centered Plan due to health or safety needs is required. The rationale for restrictions should be documented in the PCP and Behavior Plan.
- The kitchen will be open at all times, except during meal preparation. This is due to MLK AFC Level IV Specialized Residential status and for consumers and staff safety. The half door in the kitchen is being evaluated by maintenance staff for a compliant door handle. CAP not approved as written. Unclear if this CAP indicates that the pantry is also unlocked. If restriction to kitchen/pantry access is necessary, a modification in the individual's Person-Centered Plan due to health or safety needs is required. The rationale for restrictions should be documented in the PCP and Behavior Plan.
- Consumers have full access to food. MLK staff have been stocking more food in the dining room area and fridge. CAP approved as written. CEI Quality Advisor to do a thorough review of this area of the home and ensure that residents have access to a reasonable amount of a variety food provided by the home as well as any snacks or food they purchase themselves within the given timeframes.

#	STANDARD
	• Consumers have full access to home appliances. There is a fridge and microwave available in the dining area for consumer use as well as the appliances in the kitchen. CAP not approved as written. CAP indicates that kitchen appliances are only accessible when staff are not preparing meals. If restriction to kitchen access is necessary, a modification in the individual's Person-Centered Plan due to health or safety needs is required. The rationale for restrictions should be documented in the PCP and Behavior Plan. • Consumers will have full access to the laundry room. The Facilities Manager is working on changing the laundry room door handle to meet compliance. Consumers will be able to do their laundry on their own and/or staff will do it with them. Staff will document it in consumers' log if they require staff assistance to do their laundry. CAP approved as written. CEI Quality Advisor to ensure that not only is the door to the laundry free from locks but also any cupboards/drawers to ensure compliance with HCBS standards within given timeframes. • Consumers have full access to communication devices. If consumers do not have their own cell phone, MLK house has provided a phone in the activity room, where consumers can now talk privately. CAP approved as written. Onsite verification to be completed by CEI Quality Advisor to ensure compliance with HCBS standards within given timeframes. • MLK AFC allows friends and family members to visit without rules or specific visiting hours. Any rules in the house have been removed, and consumers and staff are aware. CAP approved as written. CEI Quality Advisor to review any supporting documentation such as home meeting minutes that indicate consumers and staff have been made aware of their rights to ensure compliance with HCBS standards within given timeframes. • MLK AFC has removed all rules in the home and will review this with residents at house meeting and with staff at staff meetings. CAP approved as written. CEI Quality Advisor to review any supporting documentation such as home meeting minutes that indicate consumers and staff have been made aware of their rights to ensure compliance with HCBS standards within given timeframes.
	CMH-CEI 2nd CAP Response: Staff/Case Managers will address this issues of the gates, kitchen access, kitchen appliances, in the Health and Safety portion of the treatment plan by adding that the clients who are on NGRI status have already agreed to this plan/living arrangement in order to leave the State Hospital. Non NGRI clients will also need to have these restrictions added to their health and safety portions of their treatment plans. These restrictions are in order to ensure that the clients basic health and safety needs are met. AMHS is working on hiring a behavioral psychologist to write BTP's. This position will be posted by 10/1/19. Once AMHS has a psychologist to write BTP's, these situations will be added to their duties to address. CAP not approved as written. Please provide evidence that the provider has documentation to support all health and safety restrictions in the home (gates, cameras, kitchen and kitchen appliances) according to the MDHHS/PIHP Contract (Person-Centered Planning Policy), and the Michigan Medical Provider Manual (HCBS chapter) in order to be considered compliant with the HCBS Final Rule, any limitation to an individual's rights and freedoms must be documented in their Individual Plan of Service (IPOS). The CAP should address processes should be put into place

#	STANDARD

that ameliorate these concerns in order to balance health and safety issues with HCBS Rule freedoms. The CAP should consider:

- Each individual's rights and freedoms,
- Agreement/assent noted in the individual's records where the limitation exists but does not apply to them,
- Inclusive of feedback on page 11,
- Ensure processes are formalized in policy and procedure,
- CAP should include timeframes for completion

CEI 3rd CAP Response:

The following actions will be taken for corrective action:

1. CMHA-CEI staff will update program guidelines to reflect HCBS rules by 6/30/20.
   CAP not approved as written. If any CEI guidelines need to be updated to reflect HCBS standards, they must be completed and updated to staff prior to 4/30/19.

2. Case Managers will assess and document health and safety needs and assure documentation is noted in the person-centered plan, including agreement as noted in the individual's records where the limitation exists but does not apply to them by 12/31/19.
   CAP approved as written. Please submit updated PCP for review when complete.

3. CMHA-CEI will continue efforts to hire and/or contract Behavioral Psychologist to assess and write Positive Support Plans/Behavior Treatment Plans with goal of completing this by 1/30/20.
   CAP approved as written.

4. A process for Behavior Treatment Planning in AMHS (including referral, assessment, plan, committee) will be developed by 3/30/20.
   CAP not approved as written. If CEI plans to develop a Behavior Treatment Planning process within AMHS by 3/30/20, then MSHNs expectation is that CEI will assure that any restrictions are reviewed and identified in the PCP in the interim. Additionally, CEI currently has a Behavior Treatment Planning committee with processes in place. To ensure the committee has a thorough understanding of the unique needs of those served in AMHS, it may be beneficial to add additional AMHS staff to the current committee in place.

5. CMHA-CEI/AMHS staff will continue to dialogue with MSHN HCBS staff (meeting scheduled 10/10/19) to further develop implementation ideas and address areas of Health and Safety that present a challenge.
   CAP not approved as written. If any CEI guidelines need to be updated to reflect HCBS standards, they must be completed and updated to staff prior to 4/30/19.

CEI 4th Response:

See above, CAP approved as written, KH 10/30/19.

CHART SPECIFIC REVIEWS

(NOT INCLUDED ABOVE IN DMC REVIEW)

PERFORMANCE INDICATOR SELECTION

Summary of Findings and Corrective Action

Findings: None.

Corrective Action Plan: NA

CRITICAL INCIDENTS SELECTION

Summary of Findings and Corrective Action

Findings: None.

Corrective Action Plan: NA

STAFF TRAINING RECORDS REVIEW

Summary of Findings and Corrective Action

Findings:

There were a few instances where internal staff had completed training outside of the required timeframes. Additionally, the contracted provider staff file reviewed did not have evidence of all required training in the required timeframes. The issue internally was an issue with the Relias system and was remedied during MSHN review. As corrective action, please identify how CEI will ensure contracted providers are aware of, and are completing, required trainings.

Corrective Action Plan:

To ensure that contracted providers are aware of required trainings, the Performance Indicators and Objectives contract exhibit has been updated to make training requirements clear for contracted providers. An example of the revised contract exhibit can be found here. Providers are also able to reference training requirements on CMHA-CEI's website under Provider Resources and in their copy of CMHA-CEI's Provider Manual. Additionally, CMHA-CEI's Quality Advisors complete annual Quality and Compliance monitoring of contract providers, which includes a review of training requirements. An example of the Quality and Compliance Monitoring Tool can be found here. The Quality Advisors develop a plan of correction related to any out-of-compliance standards and monitor the provider until compliance is achieved.

MSHN Approved; 8.15.19; AD. MSHN to review sample contractor monitoring report/completed tools during interim review in 2020.

MEDICAID CLAIMS/SERVICES VERIFICATION SELECTION

Summary of Findings and Corrective Action

Findings:

- H2015 was submitted without supporting documentation for the service. Lines 247, 277, and 278 on the review tool.
- H2015 was submitted for more units than the documentation supports. Line 250, 252, 254-256, 269, 271, 272, 274, and 275 on the review tool.
- T1017 was submitted without supporting documentation. Lines 373, 374, and 659 on the review tool.
- H0032 was submitted for a service that the note did not reflect it was face to face. Amended documentation was uploaded 6/17/2019 so no further corrective action is required. No further corrective action necessary 6.25.2019
- T1005 was submitting without supporting documentation for the service. Lines 617, 618, 620, 621, 623, and 624 on the review tool.
- H2015 was submitted for more units than the documentation supports. Line 625, 629, 630, 632-634, 636, 637, 639-644, 647, 648, 651, and 652 on the review tool.
- H2015 was submitted without start and stop times for the service. Lines 809, 810, 812-819, 821-847, 849-855, 857, and 858 on the review tool.
- H2014 was submitted without supporting documentation. Lines 917 and 942 on the review tool.
- QJ modifier was not used for a service that was provided to a beneficiary while incarcerated. Line 979 on the review tool.
- 97151 was submitted for more units than were provided face to face. Line 1053 on the review tool.

Corrective Action Plan:

- Claims for lines 247, 277, and 278 on the review tool will be voided by 9/30/19.

MSHN accepted 8.22.2019 SM

- Claims for lines 250, 252, 254-256, 269, 271, 272, 274, and 275 on the review tool will be resubmitted for the correct number of units by 9/30/19.

MSHN accepted 8.22.2019 SM. It is noted this is outside of the 30 days to complete a corrective action.

- For line 659 on the review tool, the case manager updated the T1017 note to include content. Copy of note uploaded to Box here.

MSHN accepted 8.22.2019 SM

- For lines 373 and 374 on the review tool, the clinician will add content to the notes by 9/30/19.

Not accepted. Please provide supporting documentation for the service submitted. 8.22.2019 SM

- Claims for lines 617, 618, 620, 621, 623, and 624 on the review tool will be voided and funds will be recouped from the contract provider. CMHA-CEI's Quality Advisors will discuss appropriate documentation at next site visit.

Not accepted. Please clarify if the corrective action will take place within the 30 days identified in the MEV procedure. 8.22.2019 SM

- Claims for lines 625, 629, 630, 632-634, 636, 637, 639-644, 647, 648, 651, and 652 on the review tool will be resubmitted for the correct number of units. CMHA-CEI's Quality Advisors will discuss appropriate documentation at next site visit.

Not accepted. Please clarify if the corrective action will take place within the 30 days identified in the MEV procedure. 8.22.2019 SM

- Claims for lines 809, 810, 812-819, 821-847, 849-855, 857, and 858 on the review tool will be voided. Documentation processes for H2015 will be reviewed with this program to ensure start/stop times are included on documentation for this service by 12/31/19.

Not accepted the corrective action identified is outside of the 30 days to complete a corrective action in the MEV procedure. Please resubmit with a corrective action within the 30 days or provide information on the circumstances that require an extension. 8.22.2019 SM

- Claims for lines 917 and 942 on the review tool will be voided and funds will be recouped from the contract provider.

Not accepted. Please clarify if the corrective action will take place within the 30 days identified in the MEV procedure. 8.22.2019 SM

- The claim for line 979 on the review tool will be resubmitted to include the QJ modifier.

Not accepted. Please clarify if the corrective action will take place within the 30 days identified in the MEV procedure. 8.22.2019 SM

- The claim for line 1053 on the review tool will be resubmitted for the correct number of units. Senior Autism Psychologist has followed up with the contract providers regarding changes in billing 97151 after 1/1/19. Proof of correspondence uploaded to Box here.

Not accepted. Please clarify if the corrective action will take place within the 30 days identified in the MEV procedure. 8.22.2019 SM

CMH-CEI 2nd CAP Response:

- For lines 373 and 374 on the review tool, the clinician added content to the notes to reflect services provided. Uploaded to Box here and here.
- Claims for lines 617, 618, 620, 621, 623, and 624 on the review tool will be voided and funds will be recouped from the contract provider within 30 days of CAP approval. CMHA-CEI's Quality Advisors will follow up with contract provider to discuss appropriate documentation within 30 days of CAP approval.
- Claims for lines 625, 629, 630, 632-634, 636, 637, 639-644, 647, 648, 651, and 652 on the review tool will be resubmitted for the correct number of units within 30 days of CAP approval. CMHA-CEI's Quality Advisors will follow up with provider to discuss appropriate documentation within 30 days of CAP approval.
- Claims for lines 809, 810, 812-819, 821-847, 849-855, 857, and 858 on the review tool will be voided within 30 days of CAP approval. Documentation processes for H2015 will be reviewed with this program to ensure appropriate documentation of CLS within 30 days of CAP approval.
- Claims for lines 917 and 942 on the review tool will be voided and funds will be recouped from the contract provider within 30 days of CAP approval.

• The claim for line 979 on the review tool will be resubmitted to include the QJ modifier within 30 days of CAP approval. • The claim for line 1053 on the review tool will be resubmitted for the correct number of units within 30 days of CAP approval. This service took place on 1/15/19, and the Senior Autism Psychologist has followed up with the contract providers regarding changes to billing 97151 on 2/4/19 to ensure appropriate billing. Proof of correspondence, with date, uploaded to Box here. MSHN accepted 9.13.2019 SM
PROVIDER NETWORK CONTRACT SELECTION REVIEW
Summary of Findings and Corrective Action
Findings: None.
Corrective Action Plan: NA
PROVIDER MONITORING REVIEWS
Summary of Findings and Corrective Action
Findings: None
Corrective Action Plan: NA
MMBPIS COMPLIANCE REPORT REVIEW
Summary of Findings and Corrective Action
Findings: None.
Corrective Action Plan: NA
ENCOUNTER DATA SYSTEMS AND RECORD VALIDATION
Summary of Findings and Corrective Action
Findings: None.
Corrective Action Plan: NA
QUALITY INDICATOR DATA SYSTEM AND RECORD VALIDATION SELECTION
Summary of Findings and Corrective Action
Findings: None.
Corrective Action Plan: NA
BH TEDS PROCESS/DOCUMENT AND RECORD VALIDATION

Summary of Findings and Corrective Action
Findings: None.
Corrective Action Plan: NA
CLINCIAL CHART DOCUMENT AND RECORD VALIDATION
Summary of Findings and Corrective Action
Findings: Please submit plan for meeting compliance with each bulleted standard identified. • Consumer needs & wants are documented. • History of trauma is screened for and identified. • Pre-planning addressed who will be invited. • Pre-planning identified potential conflicts of interest and/or disagreements that may arise & allowed consumer opportunity to say what she/he did or did not want to discuss. • Pre-planning addressed accommodations that may be needed to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication). • Pre-planning addressed who will take notes at the meeting. • There is evidence that applicable consumers had an ability to choose among various waiver services. • There is evidence that applicable consumers had an ability to choose among various waiver providers. • Goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured. • Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services & supports. • The services which the person chooses to obtain through arrangements that support self-determination. • Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved). • If applicable, IPOS addresses health and safety issues. • If applicable, identified history of trauma is effectively addressed as part of the PCP. • For children's services, IPOS is family-driven & youth guided. • Autism – As part of the IPOS, there is comprehensive individualized ABA behavioral plan of care. IPOS addresses risk factors / plans to minimize, etc. • Plan is given to consumer w/in 15-business days. • Consumer received accurate and timely information about Grievance and Appeal Process. • Medicaid consumers receive written authorization decisions no later than 14 calendar days following receipt of a request for service auth, etc. • Provider is informed verbally or in writing of the action if a service authorization request was denied or services were authorized in an amount, duration or scope that was less than requested. • Services are delivered consistent with plan in terms of scope, amount, and duration. • Medication Services – informed consent is obtained and there is evidence consumer was informed of right to withdraw consent.

- There is a physician prescription or referral for each specialized service.
- There is evidence of PCP Coordination of care and/or a referral to PCP.
- Home Based services include 4-hours of face-to-face services per month.
- There is evidence consumer had assistance selecting, employing, and directing/retaining qualified providers.
- For autism benefit – Beneficiaries ongoing determination of level of service (every six months) has evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with ABLLS-R or VB-MAPP.
- For all applicable services – there is evidence of corrective action implementation.
- CMHSP will ensure a basic health care screening is complete on individuals who have not visited a PCP for more than 12 months. Conditions are brought to attention of individual along with interventions/information.

Corrective Action Plan:

MSHN Response – Accepted and will review implementation in 2020. In addition to accepting plan, please ensure there is some means of action implemented within 30-days upon receipt of this response that ensures communication to service providers, links to resources, and immediate oversite and support from supervisors. MSHN will review for implementation and is offering the following recommendations:

- Send applicable team members the identified compliance issue and corresponding internal policy/procedure with guidance on how to implement via EMR OR Clinical Documentation.
    - Encourage access to supervision.
- Identify online/cost efficient trainings for each content area (Improving Practices, Relias, etc.)
- Share, with relevant team members, the MDHHS Person Centered Planning Policy and ensure this is reviewed and discussed as a QI practice during team meeting
- Implement Internal Reviews [utilize MSHN record review tool] and utilize results to prioritize focus for quality improvement opportunities

See additional feedback below and please reach out with questions/concerns. MD, 08.23.19.

Training for the following findings related to the **assessment** will be provided to appropriate staff in supervision and/or team/staff meetings before 12/31/19:

- Consumer needs & wants are documented.
- History of trauma is screened for and identified.

Accepted, however, time frame for CAP appears excessive. Screening for trauma indicates a 75% compliance with only 33% of the treatment plans showing trauma was effectively addressed. Recommendation – send a link to the CEI procedure & age-appropriate screening tools to each department supervisor and ensure this is discussed during team meetings within 30-days. Encourage guidance and support as CEI always does with team members. Also, please don't hesitate to reach out w/ barriers. Thank you, MD, 08.23.19

Training for the following findings related to **pre-planning** will be provided to appropriate staff in supervision and/or team/staff meetings before 12/31/19:

- Pre-planning addressed who will be invited.
- Pre-planning identified potential conflicts of interest and/or disagreements that may arise & allowed consumer opportunity to say what she/he did or did not want to discuss.
- Pre-planning addressed accommodations that may be needed to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).
- There is evidence that applicable consumers had an ability to choose among various waiver services.
- There is evidence that applicable consumers had an ability to choose among various waiver providers.

Recommendation – share the MDHHS Policy with relevant team members and ask supervisors to review and offer program – specific responses that include understanding that narrative should be used when needed due to EMR limitations. Per norm, offer support and guidance if/when applicable. Thank you, MD, 08.23.19

Training for the following findings related to **treatment planning** will be provided to appropriate staff in supervision and/or team/staff meetings before 12/31/19:

- Goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured.
- Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services & supports.
- The services which the person chooses to obtain through arrangements that support self-determination.
- Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).
- If applicable, IPOS addresses health and safety issues.
- If applicable, identified history of trauma is effectively addressed as part of the PCP.
- For children's services, IPOS is family-driven & youth guided.
- Plan is given to consumer w/in 15-business days.

Recommendation – share the MDHHS Policy with relevant team members and ask supervisors to review and offer program – specific responses that include understanding that narrative should be used when needed due to EMR limitations. Per norm, offer support and guidance if/when applicable. Thank you, MD, 08.23.19

Training for the following findings related to **enrollee rights & protections** will be provided to appropriate staff in supervision and/or team/staff meetings before 12/31/19:

- Consumer received accurate and timely information about Grievance and Appeal Process.

See notes above. Thank you, MD 08.23.19

Training for the following findings related to **service authorization & utilization management** will be provided to appropriate staff in supervision and/or team/staff meetings before 12/31/19:

- Medicaid consumers receive written authorization decisions no later than 14 calendar days following receipt of a request for service auth, etc.

See notes above. Thank you, MD 08.23.19

Training for the following findings related to **specific service requirements** will be provided to appropriate staff in supervision and/or team/staff meetings before 12/31/19:

- Services are delivered consistent with plan in terms of scope, amount, and duration.
- Medication Services – informed consent is obtained and there is evidence consumer was informed of right to withdraw consent.
- There is evidence of PCP Coordination of care and/or a referral to PCP.
- Home Based services include 4-hours of face-to-face services per month.
- There is evidence consumer had assistance selecting, employing, and directing/retaining qualified providers.

See notes above. Thank you, MD 08.23.19

In addition to staff training, CMHA-CEI conducts an internal chart review which includes the findings listed above. Findings from CMHA-CEI's internal chart review are provided to and reviewed with applicable programs to improve compliance. Per 3.2.13C, Clinical Record Reviews Procedure only 1 record may be completed annually and therefore, MSHN recommends programs conduct internal peer reviews, as part of QI process & that this begin immediately. Results should be shared but, as is always experienced by this writer, CEI is encouraged to maintain its supportive/team-focused, strengths-based teaching methods for supporting staff. MD, 08.23.19.

Please find the corrective action steps for the remaining findings below:

Finding: Pre-planning addressed who will take notes at the meeting.

CAP: CMHA-CEI will include a statement in our Person Centered Planning procedure that it is CMHA-CEI's expectation that the facilitator of the PCP meeting will also take notes during the meeting. This change will be made by 10/31/19. MSHN Response: Accepted and recommend proposing this as a question vs. statement in alignment with policy language. 8.23.19, MD

Finding: CMHSP will ensure a basic health care screening is complete on individuals who have not visited a PCP for more than 12 months. Conditions are brought to attention of individual along with interventions/information.

CAP: In an effort to meet this requirement currently, training on coordination of care related to medical follow up will be provided to appropriate staff in supervision and/or team/staff meetings

before 12/31/19. Additionally, CMHA-CEI will bring this requirement to the appropriate agency committee before 12/31/19 for review to develop a process to meet standard.

See notes above. Thank you, MD 08.23.19

Autism Program Specific Findings:

- For autism benefit – Beneficiaries ongoing determination of level of service (every six months) has evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with ABLLS-R or VB-MAPP.
- Autism – As part of the IPOS, there is comprehensive individualized ABA behavioral plan of care. IPOS addresses risk factors / plans to minimize, etc.

CAP: In an effort to stay on track with the 6-month assessment requirement of the BHT benefit, an Excel file with most recent assessment date and due date of next assessment for each individual served was created and provided to each ABA provider agency, uploaded to Box here. Additionally, recent communication was provided to each ABA provider agency (following the MDHHS site review) that addresses this requirement. This letter also includes information about expectations of the individualized ABA behavioral plan of care/IPOS requirements. Copy of letter uploaded to Box here.

Accepted, BG, 08.23.19

The following two findings were removed after correspondence with M. Davis (details in Consumer Record Review Final Report):

- Provider is informed verbally or in writing of the action if a service authorization request was denied or services were authorized in an amount, duration or scope that was less than requested. Confirmed, MD, 08.23.19 – Note, confirmed w/ MSHN reviewer. Thank you for providing evidence CEI & sorry for oversite.
- For all applicable services – there is evidence of corrective action implementation. Confirmed, MD, 08.23.19 – Note, confirmed w/ MSHN reviewer. Thank you for providing evidence CEI & sorry for oversite.
- There is a physician prescription or referral for each specialized service. Confirmed, MD, 08.23.19 – Note, confirmed w/ MSHN reviewer. Thank you for providing evidence CEI & sorry for oversite.

Provider:	CMH-CEI	**Date of MSHN Report Submission:**	7.12.19
SA:	All Location	Date of Provider Submission to MSHN:	8.12.19

Instructions: For each finding, please explain the specific steps for which your agency will take to come into full compliance, including the expected timeframe for implementation/completion. MSHN will request documentation/evidence of CAP implementation upon the next scheduled site review/desk review. Depending on the nature of the finding, MSHN may conduct a focused follow-up site visit. For technical support, please contact your treatment, prevention, and/or utilization management specialist. CAP's must be summited within 30 days of the date you received the site visit report from MSHN.

Delegated Functions Findings and Corrective Action
Access and Eligibility Findings and Corrective Action
Findings: None.
Corrective Action: NA
Customer Service/Recipient Rights Findings and Corrective Action
Findings: None.
Corrective Action: NA
Enrollee Rights Findings and Corrective Action
Findings: None.
Corrective Action: NA
Grievance & Appeals Findings and Corrective Action
Findings: None.
Corrective Action: NA
Quality & Compliance Findings and Corrective Action

Findings: None.

Corrective Action: NA

Individual Treatment & Recovery Planning Findings and Corrective Action

Findings:

- The individualized treatment plan adequately identifies the individual's chosen or preferred outcomes and goals, identified needs, and utilizes consumer's strengths to establish effective methods of pursuing goal(s).
  Reviewer Note: Individual chart reviews indicate this is not consistently happening according to Person Centered Planning Procedure 3.3.25 - strengths are not always identified as part of the treatment planning process or referenced within the person-centered plan.
- Services and supports identified in the individualized treatment plan assist the individual in pursuing outcomes consistent with their preferences and goals.
  Reviewer Note: Individual chart reviews indicate this is not consistently happening according to Person Centered Planning Procedure 3.3.25 - services and supports were not always identified on the treatment plans and how they would be used to assist consumer in achieving desired outcomes.
- Treatment and recovery planning include the individual, counselor, family or other supports as identified by the client.
  Reviewer Note: In individual chart reviews, some consumers were co-occurring and engaged in MH treatment services. It did not appear that the other providers were engaged in person-centered SUD planning or treatment plan reviews with the consumer and SUD service provider. Moving toward a more integrated system of care with co-occurring providers is encouraged.
- The treatment plan adequately addresses needs identified in the biopsychosocial assessment, utilizing client strengths, to achieve desired outcomes.
  Reviewer Note: Individual consumer chart reviews did not indicate this was consistently happening according the Person-Centered Planning Procedure 3.3.25. Client strengths were not consistently integrated into PCP.
- The frequency of plan review for the individual is specified in the plan. Frequency and scope of monitoring of the plan reflects the intensity of the beneficiary's health and welfare is identified in the plan.
  Reviewer Note: This procedure is reflective of CMH treatment plan review process but does not reflect the required frequency of review for SUD service.
- FASD Policy/procedures: • Prevention procedures are complete and implemented into programming. • FASD pre-screen procedures are complete and implemented into programming. Providers should have evidence of risk factors in procedures.
  Reviewer Note: Procedure does not specifically cover FASD pre-screen and its implementation into programming and person-centered treatment plans when appropriate. Individual chart reviews did not demonstrate evidenced of FASD screening and use as part of PCP process

Corrective Action:

CMHA-CEI will develop an Operating Guideline by 10/31/19 that will address:

- The Substance Abuse Services (SAS) programs follow the MDHHS Treatment Policy #6 for treatment planning. CMHA-CEI will establish an Operating Guideline that follows the MDHHS Treatment Policy #6. CMHA-CEI will add a reference to this Operating Guideline in relation to SAS programs and treatment planning processes for these programs in the Person Centered Planning Procedure 3.3.25 by 10/31/19.
- This Operating Guideline will include information about the Strengths, Needs, Abilities, and Preferences (SNAP) approach as well as other requirements including information about supports/services, timelines for treatment planning, treatment plan reviews, FASD, and amount, scope, and duration of services.
- With different levels of care within SAS programs, each program has a different timeline for treatment reviews. In addition to this being addressed in the Operating Guideline, staff will receive training on these levels of care and timelines for treatment plan reviews by 12/31/19.
- FASD directives as outlined in the MDHHS Treatment Policy #11. This policy states:
  "Substance use disorder treatment programs are in a unique position to have an impact on the FASD problem in two ways. First, it is required that these programs include FASD prevention within their treatment regimen for those women that are included in the selective or indicated group based on Institute of Medicine (IOM) prevention categories. Second, for those treatment programs that have contact with the children born to women who have used alcohol it is required that the program screen these children for FASD and, if appropriate, refer for further diagnostics services."
  Currently, there are no SAS programs that have contact with children. SAS programs that treat women will ensure that clinical staff receive training on the FASD directives, which will be included in the Operating Guideline, by 12/31/19. This training will include the need to have informational materials readily available and the need to make appropriate referrals for populations at risk, as will be outlined in the Operating Guideline. Programs that do not treatment women and/or children will also have FASD information available. Further, appropriate SAS programs will include FASD materials with other materials that are given to consumers at intake. The "Intake Acknowledgement Form" will be updated to indicate that FASD materials are received. Appropriate staff will receive training in this process in supervision and/or team/staff meetings by 12/31/19.

SAS programs use the SNAP approach. Training will be provided to appropriate staff in supervision and/or team/staff meetings in order to ensure that SNAP elements are included in the treatment plan by 12/31/19.
MSHN Accepted, SP, 8-23-2019, MSHN to ensure implementation at time of interim review.

Clinical managers will use a checklist to complete reviews of treatment plans that include best practice/desired elements that need to be present prior to signing off on the treatment plan as the clinical supervisor. This checklist will include SNAP, information on supports/services, etc. This will be implemented by 10/31/19.
MSHN Accepted, SP, 8-23-2019, MSHN to ensure implementation at time of interim review.

The interim plan that was used at the time of the chart review in the House of Commons will no longer be utilized. The program will use an initial treatment document that directly corresponds to the master treatment plan. This initial plan will be in place no longer than 72 hours, at which time the assessment and master treatment plan will be in place.
MSHN Accepted, SP, 8-23-2019, MSHN to ensure implementation at time of interim review.

For individuals who are co-occurring, with specific focus on those consumers who are case managed by local CMHSPs or who are involved in Mental Health Court, the primary therapist will correspond and invite other providers to treatment plan reviews. This contact will be documented on a contact note and/or the actual treatment plan review process. Training for this process will be provided to appropriate staff in supervision and/or team/staff meetings by 12/31/19.

MSHN Accepted, SP, 8-23-2019, MSHN to ensure implementation at time of interim review.

Coordination of Care/Quality Improvement Findings and Corrective Action

Findings: None.

Corrective Action: NA

Provider Staff Credentialing Findings and Corrective Action

Findings:

- All staff members have an individualized personnel file which includes, but is not limited to: complete job description which has been signed, documentation of orientation, annual evaluation, training, etc.
  Reviewer Note: Annual evaluations are no always conducted annually or as outlined in CEI policy.
- All individuals performing staff functions must: 1) Be certified appropriate to their job responsibilities under one of the credentialing categories or an approved alternate credential; or 2) Have a registered development plan and be timely in its implementation; or 3) Be functioning under a time-limited plan.
  Reviewer Note: No evidence of verification of Development plans in personnel file (J. Snyder- DP-C, Q. Lerma- DP-S).
- Initial Credentialing at a minimum, policies, and procedures for the initial credentialing of the individual practitioners must require verification from primary sources of: a. Licensure or certification; b. Board Certification, or highest level of credentials attained if applicable, or completion of any required internships/residency programs, or other postgraduate training; c. Documentation of graduation from an accredited school; d. NPDB/HIPDB, in lieu of the NPDB/HIPDB, all of the following: i. Minimum 5-year history of professional liability claims resulting in a judgment or settlement; ii. Disciplinary status with regulatory board or agency; iii. Medicare/Medicaid sanctions. e. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the AMA or AOA may be used to satisfy the PSV of (a), (b), and (c).
  Reviewer Note: CEI does not have MCBAP certification primary source verification in place. IN some instances of personnel file review, there was no evidence of MCBAP certifications in file. MSHN Reviewer verified proper certifications on MCBAP website during review.
- At a minimum, the re-credentialing policies for physicians and other licensed, registered, or certified health care providers must identify procedures that address the re-credentialing process and include requirements for each of the following:
  1. Re-credentialing at least every two years.
  2. An update of information obtained during the initial credentialing.
  3. A process for ongoing monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider, which must include, at a
  minimum, review of:
  a. Medicare/Medicaid sanctions.
  b. State sanctions or limitations on licensure, registration, or certification.

c. Member concerns which include grievances (complaints) and appeals information.
d. Quality issues.
Reviewer Note: CEI does not have MCBAP certification primary source verification in place. In some instances of personnel file review, there was no evidence of MCBAP certifications in file. MSHN Reviewer verified proper certifications on MCBAP website during review.

Corrective Action:

CMHA-CEI will work to develop processes that will keep employees' certifications (MCBAP and development plan) in the personnel file. An initial meeting including relevant departments will occur before 10/31/19 to begin developing these processes with a tentative implementation date of 12/31/19.
MSHN Approved; 8.28.19, AD. In the meantime, please ensure all staff has the correct certifications prior to implementing the process. MSHN to ensure implementation during interim review.

SAS has a log that documents upcoming expiration dates for staffs' certifications. This log will be reviewed in SAS meetings quarterly. SAS managers will follow up with their staff in an effort to ensure re-certifications are completed on time.
MSHN Approved; 8.28.19, AD. MSHN to ensure implementation at time of interim review.

QI will work with SAS to ensure that employee annual evaluations are included on this spreadsheet and also reviewed in quarterly SAS meetings. This follow up action will take place before 10/31/19.
MSHN Approved; 8.28.19, AD. MSHN to ensure implementation at time of interim review.

Provider Staff Training Findings and Corrective Action

Findings:

- Trainings were found to have not always been completed within the required timeframes, however, all trainings are current. As corrective action, please indicate how CEI SUD will ensure that staff completes training as required in the future.

Corrective Action:

Clinical supervisors receive a report from Relias that informs them of trainings that are coming due for their staff. To ensure that staff complete trainings in a timely manner, clinical supervisors will review this list with appropriate staff during supervision.

MSHN Approved; 8.28.19, AD. MSHN to review sample training of staff during interim review to ensure current. Please be sure to review the FY20 contract attachment-Training Grid as changes have been made for FY20.

Program Specific Findings and Corrective Action

ASAM Summary of Findings
Findings: • Service hours are consistent with the requirements indicated by the approved LOC Determination. Reviewer Note: CEI SAS program descriptions including the types of services offered and hours of services offered generally meet the ASAM requirements for the approved program levels of care. Noted exception is House of Commons program which is not currently meeting the ASAM requirements for a Level 3.5 residential program (20 hours core services/20 hours Life Skills and Self-Care weekly). This was discussed on-site with HOC program coordinator Quenton Lerma on 6.6.2019 who identified challenges of insufficient clinical staffing at times to meet core service hour requirements and also no current process for documentation of how life skills/self-care hours are being met.
Corrective Action: The House of Commons has modified group schedules and added four additional groups to the weekly schedule in an effort to allow more options for consumers to meet the 20-hour requirement. This will allow consumers to have a menu of groups to choose from (much like college electives). The House of Commons has revised the weekly schedule sheets, i.e. Weekly Treatment Forms, for the consumers, which includes not only core hours, but life skills. These forms track attendance by group therapists, who are now utilizing individual stamps to denote the consumer was in group. This form also includes individual therapy and any case management activity that occurred during the week. The Weekly Treatment Forms are reviewed by the primary therapists. The forms serve as verification of group attendance and verification of other clinical time spent in place of group and are placed in the clinical chart. MSHN Accepted, SP, 8-23-2019, MSHN to ensure implementation at time of interim review.
Residential Summary of Findings
Findings: • Provider has deleted any program materials that reference short/long-term programming & implemented into practice. Reviewer Note: HOC Resident Handbook Page 17, Program Completion: States that MSHN-funded clients can stay "from 30-90 days. For MSHN-CA clients who require a letter of completion for court purposes you must stay 60 days." This info is not accurate; all length of stay is driven by the individual needs of the client and not pre-determined timeframes. Note: program brochure states that length of stay is variable based on individual need. Recommendation to update resident handbook for consistency • Service hours are consistent with the requirements indicated by the approved LOC Determination. Reviewer Note: When performing on-site program walk-through on 6/6, MSHN staff observed the residential program schedule which was in accordance with ASAM Level 3.5 recommended core service hours. However, HOC currently does not have a method for tracking/documenting individual consumer participation in the necessary hours of Life Skills/Self-Care. MSHN staff offered recommendations and technical assistance to

program coordinator Quenton Lerma. In addition, this standard is being scored "partially met" because the client chart reviewed for this program did not contain documentation of the required number of both core service hours and life skills/self-care for an ASAM 3.5 program

Corrective Action:

The handbook, which will be renamed “Guide to Services,” is being updated to more accurately demonstrate the individualized support that is provided. Contract requirements for timeframes will be removed and information about probation status will be included.
MSHN Accepted, SP, 8-23-2019, MSHN to ensure implementation at time of interim review.

See information about Weekly Treatment Forms as outlined in the previous Corrective Action section. This form will increase accountability and availability for core service hours and life skills/self-care. MSHN Accepted, SP, 8-23-2019, MSHN to ensure implementation at time of interim review.

Case Management Summary of Findings

Findings: None

Corrective Action: NA

Peer Recovery Supports Services Summary of Findings

Findings: None

Corrective Action: NA

Women’s Specialty Services Summary of Findings

Findings: NA

Corrective Action: NA

Medication Assisted Treatment Summary of Findings

Findings: NA

Corrective Action: NA

Recovery Residence Summary of Findings

Findings: NA

Corrective Action: NA

Financial Findings and Corrective Action

Findings:

- VI.2.2 - Provider's Financial data is integrated w/IS to:
  - Reconcile care costs (GL) by units, episode, population, provider and administrative cost distribution (to perform costing/set rates & prepare state reports).
  - Review of monthly FSR submissions
  - Review process of managing services and risk within the funding assumptions.

- VI..2.3 (Partial) - Provider's Financial management reports are available frequently to ensure ID of problem areas & systems in place for appropriate action, including:
  - Monthly financial statements to management and Board
  - Aged accounts receivable
  - Aged accounts payable
  - General Ledger
  - Balance Sheet
  - Income Statement

Corrective Action:

Supporting documentation that addresses these findings can be found here.

8.23.2019 BM - The Finance Council document that was submitted in Box does not meet either of the partially met standards. Please see the additional documents needed below:

VI. 2.2 – The provider submitted supporting documentation to support expenses billed to MSHN. The provider will need to set up a time to discuss the supporting documentation with the Financial Specialist as the expenses billed does not equal the supporting documentation that was submitted.

VI.2.3 – The provider will need to submit the Board Meeting Minutes that correspond with the FY 17 financial statements. The provider could also submit monthly or quarterly financial statements that were approved and reviewed by the Board as well as the Board Meeting Minutes that correspond to those financial statements.

Please contact Financial Specialist, Brandilyn Mason at brandilyn.mason@midstatehealthnetwork.org or (517) 993-5702 for additional clarification of what is required to meet standards.

CMH-CEI 2nd CAP Response:

CMHA-CEI's CFO discussed feedback with MSHN's Financial Specialist. Supporting documentation was uploaded to Box for the following standards:
VI.2.2—found here.
VI.2.3—found here.

09.17.2019 BM – MSHN Approved. After speaking with the CFO and the additional documents that were provided, both standards are sufficiently meet.

Performance Indicator Findings and Corrective Action

Findings: NA. Performance Indicator(s) will be conducted during the interim portion of the 2019/2020 Quality Assurance Review. Thank you, MD, 07.11.2019

Corrective Action: NA

Consumer Chart Review Findings and Corrective Action – Refer to Chart Review Summary

Findings:

Please make a plan of correction to adequately comply with each of the following standards:

- Evidence of screening for communicable diseases in accordance to Sate of MI policy
- FASD – provider implements prevention/education efforts and these are documented in records; FASD prescreen(s) complete when applicable and referrals made when applicable
- Amount/Scope/Duration for all authorized services are on the plan, appropriate for consumer's identified goals/objectives; medically necessary
- Initial tx plan is developed before consumer is engaged in extensive therapeutic activities & follows MSHN requirements/guidelines for SUD levels of care. As discussed during previous onsite review, CEI should discontinue use of interim treatment plans.
- Plans address needs/issues identified in assessment or there is clear indication of why issue not addressed
- Plans written using SMART criteria
- Services/supports/interventions – support individual in pursuing preferred outcomes/goals; provider uses EBPs to fidelity
- Reviews occur as is appropriate – based on plan/time in treatment, etc.
- Evidence of ongoing consumer involvement
- Progress notes reflect info in treatment plans
- Adjustments are made to plans based on consumer's additional/changing needs/goals, etc.

- There is evidence of primary care physician coordination of care efforts
- There is evidence of coordination of care w/ external entities such as legal/child welfare/behavioral healthcare systems
- Provider makes referrals appropriately and documents follow-up/outcomes in consumer record

Corrective Action:

Finding: Evidence of screening for communicable diseases in accordance to Sate of MI policy
CAP: CMHA-CEI has a health screen form that includes screening for communicable diseases. SAS programs will begin to use this form during intake. Appropriate staff will receive training related to this process in supervision and/or team/staff meetings by 12/31/19.
MSHN Accepted, SP, 8-29-2019, MSHN to ensure implementation at time of interim review.

Finding: FASD – provider implements prevention/education efforts, and these are documented in records; FASD prescreen(s) complete when applicable and referrals made when applicable
CAP: See CAP from "Individual Treatment & Recovery Planning" section. SAS programs that treat women will ensure that clinical staff receive training on the FASD directives, which will be included in the Operating Guideline, by 12/31/19. This training will include the need to have informational materials readily available and the need to make appropriate referrals for populations at risk, as will be outlined in the Operating Guideline. Programs that do not treatment women and/or children will also have FASD information available. Further, appropriate SAS programs will include FASD materials with other materials that are given to consumers at intake. The "Intake Acknowledgement Form" will be updated to indicate that FASD materials are received. Appropriate staff will receive training in this process in supervision and/or team/staff meetings by 12/31/19. Not Accepted, the corrective action is 3-months away and action should be completed within 30-days. In addition, there should be prescreening needs embedded into consumer intake/assessment. Please provide plan for this as CEI works with EHR, it is anticipated team members will provide evidence of implemented action conducted via narrative prior to EMR development changes. Thank you, MD, 08.29.19

Finding: Initial TX plan is developed before consumer is engaged in extensive therapeutic activities & follows MSHN requirements/guidelines for SUD levels of care. As discussed during previous onsite review, CEI should discontinue use of interim treatment plans.
CAP: Documentation was reviewed and approved onsite with MSHN reviewer for an "Intake Treatment Plan," which will document the client's goals for first 72 hours while the assessment and treatment plan are completed. MSHN Accepted, SP, 8-29-2019, Please ensure that all Master Treatment Plans are all completed within first 72 hours for detox and residential levels of care.

Findings:
- Amount/Scope/Duration for all authorized services are on the plan, appropriate for consumer's identified goals/objectives; medically necessary
- Plans address needs/issues identified in assessment or there is clear indication of why issue not addressed
- Plans written using SMART criteria
- Services/supports/interventions – support individual in pursuing preferred outcomes/goals; provider uses EBPs to fidelity
- Progress notes reflect info in treatment plans
- Adjustments are made to plans based on consumer's additional/changing needs/goals, etc.
- Provider makes referrals appropriately and documents follow-up/outcomes in consumer record

CAP: Training to address the above standards will be provided to appropriate staff in supervision and/or team/staff meetings by 12/31/19. Not accepted, this would fall beyond a reasonable scope of time to address issues and does not assure ongoing support of team members and ongoing quality improvement oversite as some of these would fall into 'repeat' finding categories. Thank you, MD, 08.29.19

Finding: Reviews occur as is appropriate – based on plan/time in treatment, etc.
CAP: With different levels of care within SAS programs, each program has a different timeline for treatment reviews. In addition to this being addressed in the Operating Guideline referenced in the "Individual Treatment & Recovery Planning" section, staff will receive training on these levels of care and timelines for treatment plan reviews by 12/31/19. Not accepted, this would fall beyond a reasonable scope of time to address issues and does not assure ongoing support of team members and ongoing quality improvement oversite as some of these would fall into 'repeat' finding categories. Thank you, MD, 08.29.19

Finding: Evidence of ongoing consumer involvement
CAP: SAS is implementing a new form for consumer feedback for services in order to demonstrate consumer involvement. This form will be implemented by 10/31/19. Accepted, MD, 08.29.19 MSHN will review for implementation during next QA review. Thank you.

Findings:

- There is evidence of primary care physician coordination of care efforts
- There is evidence of coordination of care w/ external entities such as legal/child welfare/behavioral healthcare systems

CAP: Coordination of care will be another item added to the supervisor checklist that was mentioned in the "Individual Treatment & Recovery Planning" section. Training on coordination of care will be provided to appropriate staff in supervision and/or team/staff meetings before 12/31/19. Not accepted, this would fall beyond a reasonable scope of time to address issues and does not assure ongoing support of team members and ongoing quality improvement oversite as some of these would fall into 'repeat' finding categories. Thank you, MD, 08.29.19

CMH-CEI 2nd CAP Response:

Finding: FASD – provider implements prevention/education efforts, and these are documented in records; FASD prescreen(s) complete when applicable and referrals made when applicable
CAP: See CAP from "Individual Treatment & Recovery Planning" section. SAS programs that treat women will ensure that clinical staff receive training on the FASD directives, which will be included in the Operating Guideline, by 12/31/19. This training will include the need to have informational materials readily available and the need to make appropriate referrals for populations at risk, as will be outlined in the Operating Guideline. Programs that do not treatment women and/or children will also have FASD information available. Further, appropriate SAS programs will include FASD materials with other materials that are given to consumers at intake. The "Intake Acknowledgement Form" will be updated to indicate that FASD materials are received. Appropriate staff will receive training in this process in supervision and/or team/staff meetings by 12/31/19. Not Accepted, the corrective action is 3-months away and action should be completed within 30-days. In addition, there should be prescreening needs embedded into consumer intake/assessment. Please provide plan for this as CEI works with EHR, it is anticipated team members will provide evidence of implemented action conducted via narrative prior to EMR development changes. Thank you, MD, 08.29.19
2nd CAP:

The guideline mentioned in the original CAP response will be developed by 10/31/19. Once developed, appropriate staff will receive training within 30 days. Items to further address this finding include:

1. SAS Administration reviewed each program's intake checklist to ensure FASD was covered in the intake process and materials on FASD were readily available to consumers. This occurred immediately after the site review.
2. All presumptive eligibility/screening documents in SAS programs that treat women will include FASD screening questions. These documents are then scanned into the agency's EHR. Screening forms will be revised by 9/30/19.
3. The Operational Guidelines for the programs that treat women are being revised to include that FASD directives are followed and clinical staff are trained on the processes involved. The revision will be in place by 9/30/19.
4. Each SAS program has a New Employee Checklist, which includes all the necessary job duties/training that need to occur within the first 30 day of employment. Each of those program checklists will be revised to include the FASD process and include that each new employee completes the Fundamentals of Fetal Alcohol Spectrum Disorder on the RELIAS online training site. This revision will be in place by 9/30/19.

MSHN Accepted; 9.17.19, MD.

Findings:

- Amount/Scope/Duration for all authorized services are on the plan, appropriate for consumer's identified goals/objectives; medically necessary
- Plans address needs/issues identified in assessment or there is clear indication of why issue not addressed
- Plans written using SMART criteria
- Services/supports/interventions – support individual in pursuing preferred outcomes/goals; provider uses EBPs to fidelity
- Progress notes reflect info in treatment plans
- Adjustments are made to plans based on consumer's additional/changing needs/goals, etc.
- Provider makes referrals appropriately and documents follow-up/outcomes in consumer record

CAP: Training to address the above standards will be provided to appropriate staff in supervision and/or team/staff meetings by 12/31/19. Not accepted, this would fall beyond a reasonable scope of time to address issues and does not assure ongoing support of team members and ongoing quality improvement oversite as some of these would fall into 'repeat' finding categories. Thank you, MD, 08.29.19

2nd CAP: Training to address the above standards will be provided to appropriate staff in supervision and/or team/staff meetings within 30 days of CAP approval. CMHA-CEI also conducts internal chart reviews, which include the above standards. The SAS programs are a part of this internal chart review process and will receive feedback as chart reviews are completed.

MSHN Accepted; 9.17.19, MD.

Finding: Reviews occur as is appropriate – based on plan/time in treatment, etc.

CAP: With different levels of care within SAS programs, each program has a different timeline for treatment reviews. In addition to this being addressed in the Operating Guideline referenced in the "Individual Treatment & Recovery Planning" section, staff will receive training on these levels of care and timelines for treatment plan reviews by 12/31/19. Not accepted, this would fall beyond a reasonable scope of time to address issues and does not assure ongoing support of team members and ongoing quality improvement oversite as some of these would fall into 'repeat' finding categories. Thank you, MD, 08.29.19

2nd CAP: The guideline that is mentioned for this CAP has been approved to be developed by 10/31/19. Appropriate staff will receive training in supervision and/or team/staff meetings within 30 days of guideline completion. Prior to guideline implementation, appropriate staff will receive training on these levels of care and timelines for treatment plan reviews within 30 days of CAP approval.

MSHN Accepted; 9.17.19, MD.

Findings:

- There is evidence of primary care physician coordination of care efforts
- There is evidence of coordination of care w/ external entities such as legal/child welfare/behavioral healthcare systems

CAP: Coordination of care will be another item added to the supervisor checklist that was mentioned in the "Individual Treatment & Recovery Planning" section. Training on coordination of care will be provided to appropriate staff in supervision and/or team/staff meetings before 12/31/19. Not accepted, this would fall beyond a reasonable scope of time to address issues and does not assure ongoing support of team members and ongoing quality improvement oversite as some of these would fall into 'repeat' finding categories. Thank you, MD, 08.29.19

2nd CAP: The above findings will be addressed during staff meeting(s) within 30 days of CAP approval. Further, the Clinical Supervisor Checklist has been revised to include coordination of care. This document will be used when reviewing charts in supervision with employees going forward. The revised document can be found here. CMHA-CEI also conducts internal chart reviews, which includes verification of coordination of care. The SAS programs are a part of this internal chart review process and will receive feedback as chart reviews are completed.

MSHN Accepted; 9.17.19, MD.

MSHN Medicaid Event Verification Review – Corrective Action Plan

#	STANDARD
1	Code is allowable under the contract
Findings and Corrective Action	
Findings: No findings identified.	
Corrective Action Plan: N/A	
2	Beneficiary is Eligible on the date of service
Findings and Corrective Action	
Findings: No findings identified.	
Corrective Action Plan: N/A	
3	Service is included in the beneficiary's individualized plan of service
Findings and Corrective Action	
Findings: House of Commons • Treatment plans are not completed within the 72-hour timeframe identified in the provider manual for residential providers. An interim plan is being completed at admission and is left ongoing for 14 days, which is out of compliance with the provider manuals guidance to complete treatment plans within 72 hours and BSAAS policy #6 requirement that plans must be completed with the person receiving services. Lines 57, 107, and 134 on the review tool. Please ensure that treatment plans are developed with the person receiving services within the required timeframe.	
Corrective Action Plan: Documentation was reviewed and approved onsite with MSHN reviewer for an "Intake Treatment Plan," which will document the client's goals for first 72 hours while the assessment and treatment plan are completed. Appropriate staff will receive training for this process in supervision and/or team/staff meetings by 12/31/19.	

#	STANDARD

Not accepted. The corrective action timeframe is outside of the 30 days to implement corrective action identified in the MEV procedure. Please resubmit with a corrective action within the required timeframe. 8.22.2019 SM

CMH-CEI 2nd CAP Response:

Documentation was reviewed and approved onsite with MSHN reviewer for an "Intake Treatment Plan," which will document the client's goals for first 72 hours while the assessment and treatment plan are completed. Appropriate staff will receive training for this process in supervision and/or team/staff meetings within 30 days of CAP approval.

MSHN accepted 9.13.2019 SM

4	Documentation of the service agrees to the claim date and time of the service

Summary of Findings and Corrective Action

Findings:

Clinton County Counseling Center

- H0001 was submitted for a service date that the assessment was not completed. Line 8 on the review tool. This service will be voided. Please ensure that encounters are submitted for the date the service is completed.

Corrective Action Plan:

The H0001 encounter and 90837 service will be voided and resubmitted to meet H0001 encounter reporting requirements by 9/30/19. Supervisor will follow up with staff to ensure appropriate use of H0001 and 90837 for future reporting.

MSHN accepted. It is noted that though the date identified to resubmit the claims is outside of the 30 days to implement a corrective action in the MEV procedure it is accepted as the claims will be voided by MSHN claims staff prior to the 30 days. 8.22.2019 SM

5	Documentation of the service provided falls within the scope of the service code billed

Summary of Findings and Corrective Action

Findings:

Clinton County Counseling Center

- 90837 was submitted for a service date that the assessment was finished. Line 9 on the review tool. This service will be voided. Please ensure that psychotherapy codes are not submitted for the extra time it takes to complete an assessment. Per the HCPCS guidelines aa encounter is reported once for the same service even if it spans more than one date.

#	STANDARD

House of Commons

- There was not supporting documentation of 20 hours of core services as required for a 3.5 level of care per BSAAS policy #10. Please ensure that there is documentation of all core services, and the response to them by the client per BSAAS policy #10.

Corrective Action Plan:

CCCC:

The H0001 encounter and 90837 service will be voided and resubmitted to meet H0001 encounter reporting requirements by 9/30/19. Supervisor will follow up with staff to ensure appropriate use of H0001 and 90837 for future reporting.

MSHN accepted. It is noted that though the date identified to resubmit the claims is outside of the 30 days to implement a corrective action in the MEV procedure it is accepted as the claims will be voided by MSHN claims staff prior to the 30 days. 8.22.2019 SM

HOC:

The House of Commons has modified group schedules and added four additional groups to the weekly schedule. This will allow consumers to have a menu of groups to choose from (much like college electives). The House of Commons has revised the weekly schedule sheets, i.e. Weekly Treatment Forms, for the consumers, which includes not only core hours, but life skills. These forms track attendance by group therapists, who are now utilizing individual stamps to denote the consumer was in group. This form also includes individual therapy and any case management activity that occurred during the week. The Weekly Treatment Forms are reviewed by the primary therapists. The forms serve as verification of group attendance and verification of other clinical time spent in place of group and are placed in the clinical chart.
Not accepted. Please identify how it will be ensured that each core service has supporting documentation that not only includes time spent in the service but also the person receiving services response to the service per BSAAS policy #10. 8.22.2019 SM

CMH-CEI 2nd CAP Response:

HOC:

The Weekly Treatment Form mentioned in the first CAP response will ensure that individuals are receiving 20 hours of core services as defined in BSAAS Policy #10. Therapists providing core services will document information about the individual services provided in their progress notes, which will also include the duration of the service, as well as consumer response to the service. Applicable staff will be trained to include this information in their progress notes during team meetings and/or supervision within 30 days of CAP approval.

MSHN accepted 9.13.2019 SM

6	Amount billed does not exceed the contractually agreed upon amount

#	STANDARD
Summary of Findings and Corrective Action	
Findings: No findings identified.	
Corrective Action Plan: N/A	
7	Modifiers are used in accordance with the HCPCS guidelines
Summary of Findings and Corrective Action	
Findings: No findings identified.	
Corrective Action Plan: N/A	

MDHHS Audit

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

In 2019, the QI Team helped facilitate MDHHS's audit of CMHA-CEI's ABA Program. The State selected 21 consumers to be reviewed. The consumers selected nine of CMHA-CEI's contracted ABA providers.

Preparation for the Autism audit included verifying up-to-date credential information of all levels of providers. The ABA Program and QI Team also reviewed providers' training compliance and background checks.

There were findings related to IPOS addressing consumer needs, services being provided as specified in the plan, credentialing standards for QLP, BCBA/BCaBA or QBHP, and BT, and ongoing determination of level of service. In an effort to address these findings, a letter was sent to providers to emphasize requirements and standards. In addition, CMHA-CEI will complete chart reviews of consumers receiving ABA services and a tracking sheet was created to assist CMHA-CEI in keeping providers accountable to standards. A Corrective Action Plan (CAP) was required for each provider found not in compliance.

Performance Measures	Yes	No	Percent Compliant
1. Beneficiaries IPOS addresses the needs. **A.** As part of the IPOS, there is a comprehensive individualized ABA behavioral treatment plan that includes specific targeted behaviors for improvement, along with measurable, achievable, and realistic goals for improvement. The IPOS must address risk factors identified for the child and family, specify how the risk factor may be minimized and describe the backup plan for each identified risk	53	15	78%
2. Beneficiaries ABA services and supports are provided as specified in the IPOS, including:	20	41	33%
A. ABA Adaptive Behavior Treatment (i.e. 97153) administered by behavior technician, face to face, one on one	54	7	89%
B. ABA Clinical Observation and Direction (i.e. 97155) administered by qualified professional (BCBA, BCaBA, QBHP)			

3. Beneficiaries' providers of the ABA services meet credentialing standards. (A) Qualified Licensed Practitioner (QLP) (B) ABA Supervisor (BCBA/BCaBA or QBHP) (C) Behavior Technician (BT)	30	38	44%
4. Beneficiaries' ongoing determination of level of service has evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with ABLLS-R or VB- MAPP or other appropriate documentation of analysis (i.e., graphs, assessment reports, records of service, progress reports, etc.)	49	17	74%

Annual Submission to MDHHS

Requests for Service and Disposition of Requests

	CMHSP Point of Entry-Screening	DD All Ages	Adults with MI	Children with SED	Unknown and All Others	Total
1	**Total # of people who telephoned or walked in**	**365**	**2423**	**1537**	**590**	**4915**
2	**Is Info on row 1 an unduplicated count? (yes/no)**					
3	**# referred out due to non-MH needs (of row 1)**	**20**	**191**	**38**	**59**	**308**
4	**Total # who requested services the CMHSP provides (of row1)**	**345**	**2232**	**1499**	**531**	**4607**
5	**Of the # in Row 4 - How many people did not meet eligibility through phone or other screen**	**3**	**106**	**22**	**21**	**152**
6	**Of the # in Row 4 - How many people were scheduled for assessment**	**342**	**2126**	**1477**	**510**	**4455**
7	**other--referred to SA treatment, referred to Crisis services**	**8**	**466**	**324**	**26**	**824**

	CMHSP ASSESSMENT	**DD All Ages**	**Adults with MI**	**Children with SED**	**Unknown and All Others**	**Total**
8	Of the # in Row 6 - How many did not receive eligibility determination (dropped out, no show, etc.)					2016
9	Of the # in Row 6 - how many were not served because they were MA FFS enrolled and	0	0	0	0	0

	referred to other MA FFS providers (not health plan)					
10	Of the # in Row 6 - how many were not served because they were MA HP enrolled and referred out to MA health plan	unknown	unknown	unknown	unknown	
11	Of the # in Row 6 - how many otherwise did not meet CMHSP non-entitlement eligibility criteria	unknown	unknown	unknown	unknown	
11a	Of the # in row 11 - How many were referred out to other mental health providers	unknown	unknown	unknown	unknown	
11b	Of the # in row 11 - How many were not referred out to other mental health providers	unknown	unknown	unknown	unknown	
12	Of the # in Row 6 - How many people met the CMHSP eligibility criteria	unknown	unknown	unknown	unknown	2383
13	Of the # in Row 12 - How many met emergency/urgent conditions criteria	unknown	unknown	unknown	unknown	
14	Of the # in Row 12 - How many met immediate admission criteria	unknown	unknown	unknown	unknown	
15	Of the # in Row 12 - How many were put on a waiting list	0	0	0	0	0
15a	Of the # in row 15 - How many received some CMHSP services, but wait listed for other services	0		0	0	0
15b	Of the # in row 15 - How many were wait listed for all CMHSP services	0	0	0	0	0
16	Other - explain					0

Wait Lists

Clinic Services	MI Adult	DD	SED	Total
Number on waiting list as of date above		**19**	**18**	**37**
Added during the time period covered				**0**
Removed during the time period covered- service provided				**0**
Removed during time period covered - all other reasons				**0**
Number left at the end of the time period covered			**18**	**18**

Supports for Residential Living	MI Adult	DD	SED	Total
Number on waiting list as of date above	24	2		26
Added during the time period covered	49			49
Removed during the time period covered- service provided	34			34
Removed during time period covered - all other reasons	9			9
Number left at the end of the time period covered	28			28

Needs Assessment

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

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

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

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

Priority Issue	Reasons For Priority	CMHSP Plan
1. Promote to the public what we do; use data effectively to communicate the vision and benefit of services.	Improvement is needed to engage consumers and the public and for CMHA-CEI to be more visible.	1. Identify and assess the audience we need to reach and their current perceptions of the agency by January 2019. 2. Develop a brand image and other identifiers for the agency by April 2019. 3. Adopt and implement an outreach and promotional strategy for the organization by April 2019 4. Design and implement an evaluation strategy to measure change in perception and participation and have report by September 2020. Develop Phase 2 of plan by January 2021.
2. Establish additional relationships and collaborations with County ISD's and local School districts around referral practices for mental health services as well as mental health services in schools. (Families Forward)	There is an increased necessity for mental health services for students. Having mental health services in schools will increase access.	1. Meet with Michigan Department of Education about pilot ideas 2. Meet with local ISD's about funding and frameworks and potential pilots 3. Meet with interested school districts in potential partnerships and pilots.
3. Continue to develop Youth Suicide Prevention awareness, planning and collaborations in the tri-county area. (Families Forward)	High suicide rates	1. Provide a minimum of quarterly MHFA and other EB trainings in community. 2.Get new prevention therapist trained in QPR. 3. Start and offer monthly QPR trainings to families in FF AMD in the community. 4. In conjunction with Lifesavers distribute Life toolkits to community partners to give to families upon psychiatric hospital discharge 5. Participate in quarterly MH navigation efforts in the community to provide

		information on services and connect community partners to needed resources. 6. Host CMHAD event to enroll people for service and promote mental health awareness.
4. Improve on access and delivery of housing resources to adults with SPMI. (AMHS)	Housing continues to be a universal need across the population of those persons with mental illness. CMHA CEI has addressed this need by adding a Housing Specialist and HCBS Specialist. The priority exists to deliver this service to consumers in a way that best meets their needs and the needs of the community.	1.Continue to work with community partners for options for housing for adults with SPMI. 2. Add staff to provide community living services, case management, and provider support.
5. Improve connection to treatment from crisis services via. emergency room, urgent care, crisis services, mobile crisis services, and shelters. (AMHS)	CMHA-CEI provides ongoing therapeutic services to persons with moderate to severe mental health conditions. It is noted across populations that these persons continue to have barriers to entry to mental health services.	1. Provide assessment and referral assessment via. urgent care, movable crisis services, and emergency rooms. 2. Plan and develop mobile crisis services to provide support and access in the community.
6. Screening, Assessment, Treatment and Coordination of Care for individuals with behavioral health needs who are incarcerated within the three county jails. (SAS)	Approximately 2 million people with mental illness are booked into jails each year. Nearly 15% of men and 30% of women booked into jails have a serious mental health condition. Local county jails in Clinton, Eaton and Ingham Counties are experiencing increased levels of individuals arrested and booked who have behavioral health diagnosis, including mental illness, Substance Use Disorders and Cognitive Impairments. The general public, is for the most part, unaware of the services provided by CMHA-CEI within the three county jails and more work needs to be completed to insure the community and community partners of available services.	To increase public awareness of behavioral services in the county jails amongst the general public and community partners, including coordination of care efforts CMHA-CEI will: a. Develop a brochure for behavioral health services offered within the jails. b. Open quarterly jail diversion meetings to more than current stakeholders (possibly community members or consumers of services) c. Insure CMHA-CEI staff are aware of services within the jails. d. Maintain data and outcome measures to be shared with community partners. e. Work with each county Sheriff's office to share services being offered within

		the jails to their stakeholders and community members, via attending meetings, brochures, fact sheets, etc.
7. Collaborate with tri-county partners to reduce opiate overdose, increase access to treatment and promote recovery within the opioid use disorder population. (SAS)	The Ingham County Health Department's Ingham Opioid Abuse Prevention Initiative, of which CMHA-CEI Substance Abuse Services attends reported as of January, 2019; that there were a total of 94 drug related deaths during the past year; 79 of which were opioid related. In that same time period, there were 278 overdose cases responded to by law enforcement within the three county region. Overdose deaths have remained stable over the past two years, but more work is needed to reduce this number. Ingham County is not an anomaly, either. MDHHS reports that there was 17x increase in overdose deaths, from 1999-2016 (99 deaths to 1,699 deaths). In 2017 there were 2,729 deaths from drug overdoses, more than deaths from car crashes.	As a provider of SUD treatment programs, and a member of Ingham County's Opiate overdose task force, CMHA-CEI will strengthen efforts with prevention, treatment advocacy & treatment retention in the Tri-county area. a. Increase Jail Re-entry case management and Peer Recovery Coach programming to reduce the risk of overdose for individuals discharging from incarceration who have been diagnosed as Opioid Use Disorder Severe, or who meet the State's definition of Priority Population. b. Partner with Ingham Health Department's Community Health Clinics to provide Medication Assisted Treatment at Health Clinics in Lansing; and within the Ingham County Jail. c. Increase public knowledge of the SUD Provider Network with the PIHP region by working with CMHA-CEI Central Access, CMHA-CEI Public Communications and collaborating with other stakeholders; such as; Tri-County CIT (Crisis Intervention Training for Law Enforcement); Homeless Resolution Network; Prevention Coalitions; Unite to Fight Addiction-MI; Families Against Narcotics-Okemos/Lansing and Eaton County, etc. d. Work with CMHA-CEI Clinical Programs to implement SBIRT training to key personnel who may be

		screening for other behavioral health issues. 5.
8. Improved and ongoing integration and inclusion in the community (CSDD)	Due to needs arising from HCBS compliance, individuals with intellectual and developmental disabilities are challenged to find new ways to integrate and connect with their communities beyond simply via "I/DD programs and paid staff". This priority exists in commitment to ensuring that individuals make this adjustment in meaningful and life sustaining ways, and are able to retain a fully person centered focus as they shift out of traditional day program supports.	1. Continued expansion of Community Living Support resources across the tri-county area, ensuring appropriate number of providers in all regions served. 2. Expansion of training and support to the provider network to ensure Medicaid based support facilitates true community integration and expansion of participation in ways meaningful to consumers.
9. Improved access to community based employment. (CSDD)	In conjunction to input from a national employment specialist review in 2018, CMHA-CEI was found to be underdeveloped in offering employment opportunities for individuals with Intellectual and Developmental Disabilities, most notably in areas where individuals were afforded opportunities for standard or higher than minimum wage. This pairs with a State wide focus to decrease and/or eliminate sub-minimum wage jobs for this population, and thus demonstrates an overall need to assist individuals with I/DD needs towards improved access and support in finding community integrated forms of employment.	1. Increase number of support staff dedicated to this focus area, and to provide support across all levels of skill building and vocational support needs. 2. Continue development of "customized employment" approach, meeting I/DD employees at current skill levels, and then pairing mindfully with community partners to expand access points towards meaningful employment.

Consumer Satisfaction Survey

Summary

As part of the Community Mental Health Authority of Clinton-Eaton-Ingham's (CMHACEI) quality improvement efforts, a consumer satisfaction survey was administered to persons who were receiving services and were "open cases" during August of 2019. Data results in this report came from self-selected consumers who chose to return questionnaires voluntarily. The respondents to the survey were anonymous.

In August of 2019, case managers were provided a listing of consumers open on their caseload, along with a questionnaire for each consumer to complete. Questionnaires were coded to programs where each consumer was "opened in" for CMH services. Case managers were asked, during their next meeting with the consumer (over a 9-week period), to have the consumer complete a survey and return it to their area designee. All surveys were then forwarded to the CMHA-CEI QCSRR department for coding and data entry.

The survey instrument consisted of eleven items recommended by the Michigan Department of Health and Human Services (MDHHS). Although the same eleven questions were asked of all participants, the response-rating format differed between programs. Respondents in programs for persons with developmental disabilities answered on a 3-point Likert scale: "Yes," "Not Sure," or "No." Respondents at other mental health programs responded using a 5-point Likert-type scale ("Strongly Disagree," "Disagree," "Neither," "Agree," "Strongly Agree"). Also, each survey contained a section to identify each respondent's ethnic background, as well as, who completed or assisted in completing the survey (i.e., self, parent, friend, or staff). If a respondent elected not to respond or could not communicate answers, a section was provided on the survey to record this information.

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

Survey Development

CMHA-CEI developed the Consumer Satisfaction Survey based on a comprehensive literature review and consultation with other mental health agencies (within and outside the state), including recommendations from the Michigan Department of Health and Human Services (MDHHS). The survey was reviewed by CMH consumers, its Advocacy Groups and clinicians to establish face and content validity of the questionnaire.

In January 1996, CMHA-CEI conducted a consumer satisfaction survey of persons who received crisis intervention, inpatient prescreening or partial hospitalization prescreening services from CMH's Emergency Services unit from August through December 1995. CMHA-CEI randomly selected a sample of 200 consumers from a population of more than 900 for the specified period. The survey was conducted for two purposes: 1) to serve as a pilot for use of this instrument with all CMH clients; and 2) to fulfill contractual obligations with the MDHHS relative to client satisfaction measures. The consumer satisfaction survey used in the pilot study represented a combination of a tool of items developed by the Michigan Department of Community and the Client Satisfaction Questionnaire (CSQ-8) developed by Attkisson (1982). The objective was to develop a client-centered questionnaire that evaluated the care experience from the clients' perspective.

The inter-tem correlation matrix was reviewed using exploratory factor analysis (i.e., principal components with communalities followed by Varimax rotation). An oblique multiple groups factor analysis with communalities (i.e., confirmatory factor analysis) was then employed to evaluate the resulting factor structure. The result of this analysis procedure yielded one factor or scale containing nine items. Cronbach's coefficient alpha is a statistical formula which measures the internal consistency of a multi-item survey. A high coefficient alpha (.80 or greater) computed for survey items indicates that the items are highly inter-correlated, and are all measuring the purported survey dimension. Internal consistency was found to be high (.9332) among the pilot group in 1986 and similarly for the respondents during the 2001 administration (.9375)

The final version of the survey (based on the pilot investigation) used by CMHA-CEI consists of nine items. Each item is rated on 5-point Likert-type scales (Strongly Disagree to Strongly Agree) that allow for neutral responses. The instrument also includes a section for the client to record comments.

The survey was revised for the 2002 administration by the addition of two consumer survey questions (i.e., CMH staff follows my person centered plan or family centered plan and CMH helped me identify natural supports) and one demographic question (i.e., ethnic background) at the recommendation of the MDHHS.

The survey was again revised in 2006 administration to reflect current federal racial categories. Question numbers 10 and 11 were modified to include clarifying language for "person centered planning" and "natural supports." In addition, at the end of the survey, space was provided for respondents to self-identify if they wanted to be contacted by the CMH to follow up on their comments.

Procedure

The organization compiled a listing of current open cases. Survey forms were then disseminated to consumers open during the survey period. Completed surveys were returned in-person or by mail to the CMHA-CEI QCSRR department for data entry and analysis.

Findings

Results showed that 2,094 individuals returned a survey. Of those, 1,195 (57%) completed a survey, 325 (15%) chose not to respond and 574 (27%) could not communicate their responses. For the latter figure, most of these persons receiving services were persons with developmental disabilities.

	N	%
Total Surveys Submitted	2,094	--
Completed surveys	1,195	57.1%
Chose not to respond	325	15.5%
Unable to communicate	574	27.4%

The majority of consumers completed most of the surveys on their own (n=736, 61%). However, staff (n=265, 22%), and parents or guardians (n=104, 8%), also assisted consumers in completing surveys.

	N	%
Self	736	61.6%
Parent (or guardian)	104	8.7%
Friend	6	0.5%
Representative/Staff assisted	265	22.2%
Blank/Nonresponse	84	7.0%
Not Applicable *(person chose not to or was unable to complete survey)*	899	--

The survey asked respondents to identify themselves as Hispanic or Latino. Approximately 83% (n=999) stated that they were not Hispanic or Latino.

Overall, many of the respondents were White (n=768, 64%), African American (n=216, 18%), American Indian (n=12, 1%), Asian (n=18, 1.5%) and Other race (n=98, 8%).

Hispanic or Latino	**N**	**%**
Yes	111	9.3%
No	999	83.6%
Blank/Nonresponse	85	7.1%
Not Applicable *(person chose not to or was unable to complete survey)*	899	--
Race	**N**	**%**
African American	216	18.1%
American Indian	12	1%
Native Hawaiian/Pacific Islander	0	0%
White	768	64.3%
Asian	18	1.5%
Other	98	8.2%

Blank/Nonresponse	83	6.9%
Not Applicable *(person chose not to or was unable to complete survey)*	899	--

Analysis of Findings

Satisfaction rates represent the percentage of "Agree" and "Strongly Agree" responses for each question among consumers in Adult Mental Health Services (AMHS), Families Forward (FF), and Substance Abuse Services (SAS), as well as the percentage of "Yes" responses by Community Service for the Developmental Disabled (CSDD) respondents. Overall, consumers who were receiving services from CMHA-CEI were positive with their current services and treatment from their programs and staff. Moreover, their satisfaction rates per question either improved or stayed the same compared with last year—none of the satisfaction rates decreased.

Ninety-six percent of respondents answered "Agree" or "Strongly Agree" to the statement that staff are "courteous and respectful." Ninety-three percent agreed or strongly agreed that "staff have the knowledge and skills to serve me well." Ninety-two percent agreed or strongly agreed that staff "[follow] my person centered plan (PCP) or family centered plan." Ninety-one percent agreed or strongly agreed that CMHA-CEI "responded promptly to my request for services"; that they helped them "to get the right type of services for my problem"; that the services they receive "help me to function better in my life"; and that if they "were to seek help again, [they] would come back to the same program." Moreover, 91% agreed or strongly agreed that they were satisfied with CMHA-CEI services in general. Ninety percent agreed or strongly agreed that CMHA-CEI staff understood their needs and situation. Eighty-nine percent agreed or strongly agreed that "if a friend or family member were in need of similar services, [they] would recommend [their] CMHA-CEI program to him or her." Lastly, eighty-eight percent agreed or strongly agreed that CMHA-CEI helped them find natural supports.

	2012	2013	2014	2015	2016	2017	2018	2019
	%	%	%	%	%	%	%	%
1. CMHA-CEI responded promptly to my request for services.	91	91	91	90	91	87	88	**91**

2. CMHA-CEI staff are courteous and respectful.	96	94	96	95	95	95	94	**96**
3. CMHA-CEI staff helps me to get the right type of services for my problem.	92	91	91	90	91	93	89	**91**
4. In general, I am satisfied with the services provided by CMHA-CEI.	94	93	93	93	92	91	91	**91**
5. CMHA-CEI staff understand my needs and situation.	92	91	92	90	90	90	90	**90**
6. CMHA-CEI staff have the knowledge and skills to serve me well.	93	94	91	92	93	92	92	**93**
7. If a friend or family member were in need of similar services, I would recommend my CMHA-CEI program to him or her.	92	90	89	90	90	88	88	**89**
8. The services I receive help me to function better in my life.	91	91	91	90	90	89	89	**91**
9. If I were to seek help again, I would come back to the same program.	99	89	91	90	89	89	89	**91**
10. CMHA-CEI staff follows my person centered plan (PCP) or family centered plan.	91	91	90	89	89	89	88	**92**
11. CMHA-CEI helped me identify natural supports.	87	87	85	84	87	83	85	**88**

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

In an effort to maintain HCBS compliance, CMHA-CEI's seven Transitions Day Programs were closed in 2019. The QI team conducted part one of a two-part survey with consumers selected at random who attended each Transitions site. The intent of this research is to gather information from consumers who are currently attending the Transitions Programs, related to satisfaction with services and as they relate to their individual goals and overall life fulfillment. Part two of the survey will be administered to the same consumers approximately one year after the closure of each site. The results will be compared and used to monitor and enhance quality of services of individuals with developmental disabilities receiving CMHA-CEI services. Currently due to the COVID-19 Pandemic, Part two of this survey is on hold.

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

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

Commission on Accreditation of Rehabilitation Facilities (CARF)

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

CMHA-CEI has applied for reaccreditation through June 2023. The agency's current accreditation will expire in June 2020.

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

Administration and clinical programs at CMHA-CEI have spent time implementing changes suggested by CARF after the last survey in 2017, as well as preparing for the

upcoming CARF survey in the spring of 2020. The full list of recommendations from the 2017 Survey was published in a previous Quality Improvement Plan.

Standards for Recommendation	Recommendations
Section 1 – Leadership, Risk Management, Healthy and Safety, Technology, Accessibility, Performance Management	Updates to policies and procedures, risk management plan, emergency procedures
Section 2- Program Service Structure, Screening and Access to Services, Person-Centered Plan, Medication, Records of Persons Served, Transition/Discharge	Ensure documents include original or electronic signatures, updates to policies and procedures, education and training on medication administration and storage
Section 3 – Detoxification/Withdrawal Support, Residential Treatment, ACT	Updates to Policies and Procedures, education and training, and staffing

Appendix - Acronym Guide

Assertive Community Treatment (ACT)

Applied Behavior Analysis (ABA)

Adult Mental Health Services (AMHS)

Affordable Care Act's (ACA)

Behavior Treatment Plan Review Committees (BTPRCs)

Commission on Accreditation of Rehabilitation Facilities (CARF)

Children's Waiver Program (CWP)

Clinton County Counseling Center (CCCC)

Community Living Support (CLS)

Community Mental Health Authority – Clinton, Eaton, Ingham (CMHA-CEI)

Community Mental Health Services Program (CMHSP)

Community Services for the Developmentally Disabled (CSDD)

Corrective Action Plan (CAP)

Critical Incident Review Committee (CIRC)

Culture of Health and Wellness Committee (CHWC)

Emergency Departments (ED)

Families Forward (FF)

Habilitation Supports Waiver (HSW)

Health Plan Employer Data and Information (HEDIS)

Hemoglobin A1c (HbA1c)

Hepatitis C Virus (HCV)

Home and Community Based Services (HCBS)

House of Commons (HOC) Residential Treatment Center

Health Services Advisory Group (HSAG)

Hypertension (HTN)

Individual Plan of Service (IPOS)

Incident Reports (IR)

IV drug users (IVDU)

Low-density lipoprotein cholesterol (LDL-C)

Michigan Department of Health and Human Services (MDHHS)

Michigan Fidelity Assessment Screening Team (MiFAST)

Mid-State Health Network (MSHN)

National Committee for Quality Assurance (NCQA)

Peer Support Specialist (PSS)

Performance Indicators (PI)

Prepaid Inpatient Health Plan (PIHP)

Primary Care Physician (PCP)

Out of Catchment (OOC)

Quality Advisors (QA)

Quality Assessment and Performance Improvement Plan (QAPIP)

Quality, Customer Service and Recipient Rights (QCSRR)

Quality Improvement (QI) Staff

Quality Improvement and Compliance Committee (QICC)

Quality Improvement Program (QIP)

Recovery Self-Assessment (RSA)

Recovery Assessment Survey (RAS)

Serious Emotional Disturbance Waiver (SEDW)

Substance Abuse Services (SAS)

Substance Use Disorders (SUD)