Evaluation of Quality Improvement Program Plan Effectiveness FY2021
Community Mental Health Authority of Clinton, Eaton and Ingham Counties

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Overview

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

Performance Indicators

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

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

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

Indicator #2: The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. Standard = 95% for Q1 and Q2, no standard.

Indicator #3: Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional. Standard = 95% for Q1 and Q2, no standard.

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 5#: The percentage of Face-to Face Assessment with Professionals that result in decisions to deny CMHSP services (only submitted for full population)

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

FY21 Performance Indicator Results: Medicaid Only

Indicator	Q1	Q2	Q3	Q4	Total
1 - Total	**98.49%**	**96.8%**	**98.25%**	**97.74%**	**97.82%**
1 - Children	98.6%	96.21%	98.79%	97.33%	97.73%
1 - Adults	98.44%	97.05%	98.05%	97.89%	97.86%
2a - Total	**51.44%**	**57.37%**	**50%**	**54.46%**	**53.32%**
2a – IDD-C	41.86%	46.81%	44.44%	37.84%	42.74%
2a – IDD-A	41.86%	37.04%	42.1%%	50%	42.97%
2a – MI-C	70.13%	72.01%	64.38%	68.27%	68.70%
2a – MI-A	43.36%	52.04%	44.13%	43.94%	45.87%
3 - Total	**59.9%**	**59.05%**	**56.86%**	**56.58%**	**58.10%**
3 – IDD-C	65.63%	68.09%	72.73%	67.19%	68.41%
3 – IDD-A	13.33%	7.69%	36.84%	22.22%	20.02%
3 – MI-C	45.32%	49.77%	47.03%	53.5%	48.91%
3 – MI-A	73.54%	67.54%	63.06%	58.8%	65.74%
4a - Total	**96.47%**	**81.82%**	**96%**	**96.53%**	**92.71%**
4a - Children	100%	100%	100%	100%	100.00%
4a - Adult	95.65%	80%	95.27%	95.73%	91.66%
10 - Total	**13.64%**	**12.06%**	**7.34%**	**13.19%**	**11.56%**
10 - Children	6.67%	17.24%	0%	20.69%	11.15%
10 - Adults	14.74%	11.4%	7.34%	13.19%	11.67%

FY21 Performance Indicator Results: Full Population

Indicator	Q1	Q2	Q3	Q4	Total
1 - Total	**98%**	**97%**	**98%**	**98%**	**98%**
1 - Children	99%	96%	98%	97%	98%
1 - Adults	99%	97%	98%	98%	98%
2a - Total	**40%**	**48%**	**40%**	**40%**	**42%**
2a – IDD-C	29%	44%	38%	31%	36%
2a – IDD-A	32%	29%	29%	43%	33%
2a – MI-C	67%	69%	61%	65%	66%
2a – MI-A	32%	40%	33%	30%	34%
3 - Total	**63%**	**59%**	**57%**	**57%**	**59%**
3 – IDD-C	48%	67%	73%	66%	64%
3 – IDD-A	78%	11%	33%	25%	37%
3 – MI-C	62%	52%	49%	55%	55%
3 – MI-A	63%	65%	63%	59%	63%
4a - Total	**94%**	**93%**	**95%**	**76%**	**89%**
4a - Children	96%	100%	100%	100%	99%
4a - Adult	93%	92%	95%	97%	94%
5 - Total	**5%**	**5%**	**4%**	**9%**	**6%**
10 - Total	**14%**	**12%**	**7%**	**13%**	**12%**
10 - Children	4%	16%	0%	21%	10%
10 - Adults	16%	11%	8%	12%	12%

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

Diabetic Monitoring for Individuals with Schizophrenia and Diabetes

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

This measure is used to assess the percentage of members ages 18-64 with Schizophrenia and Diabetes who had both a low-density lipoprotein cholesterol (LDL-C) test and a hemoglobin A1c test during the measurement year.

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

The 2020 calendar year measurement period (January 1, 2020 – December 31, 2020) demonstrates a decrease in performance. CEI had a baseline of 30.69% in CY18 and a rate of 26.8% for CY19 with a goal of 35.99%. For CY20, the PIP Goal for CEI was a rate of 36.4% and the actual rate was 24.58%. CEI participated in a corrective action plan to address any individual or systematic issues. After completing a corrective action plan, a final measurement period (July 1, 2020 – June 30, 2021) demonstrated that CEI had a rate of 49.21%, which is a significant increase.

Organization	Baseline CY18	PIP Goal CY19	CY19	PIP Goal CY20	CY20	7/1/20 – 6/31/21
MSHN	**33.64%**	**35.99%**	**36.1%**	**36.4%**	39.65%	44.15%
BABH	32.04%	**35.99%**	34.3%	**36.4%**	44.95%	45.98%
CEI	30.69%	**35.99%**	26.8%	**36.4%**	24.58%	49.21%
CMHCM	31.30%	**35.99%**	31.7%	**36.4%**	39.62%	34.97%
GIHN	40%	**35.99%**	23.5%	**36.4%**	77.35%	60.00%
HBH	26.67%	**35.99%**	38.5%	**36.4%**	30.86%	40.00%
The Right Door	33.68%	**35.99%**	37.9%	**36.4%**	95.83%	62.50%
LifeWays	39.29%	**35.99%**	44.4%	**36.4%**	43.97%	33.33%
MCN	40%	**35.99%**	33.3%	**36.4%**	56.60%	50.00%
NCMH	32.52%	**35.99%**	36.8%	**36.4%**	44.85%	57.89%
Saginaw	52.94%	**35.99%**	40.0%	**36.4%**	37.67%	44.09%
Shiawassee	41.67%	**35.99%**	22.2%	**36.4%**	42.05%	40.00%
TBHS	53.33%	**35.99%**	57.7%	**36.4%**	82.44%	68.18%

Figure 1.

Recovery Self-Assessment

Introduction

The Recovery Self-Assessment was one of two tools required to be completed by Michigan Department of Health and Human Services(MDHHS). Mid-State Health Network (MSHN) chose the Administration of the RSA Administrator and Provider Version as a regional Performance Improvement Project (PIP) from FY15 through FY21. FY21 marked the completion of the PIP, requiring an evaluation to determine if continuation would provide additional benefits.

The following overview of Mid-State Health Network's (MSHN) Recovery Self-Assessment (RSA) was developed to assist MSHN Community Mental Health Service Program (CMHSP) Participants and Substance Abuse Treatment Providers (SATP) develop a better understanding of the strengths and weaknesses in MSHN's recovery-oriented care. The information from this report is intended to support discussions on improving recovery- oriented practices by understanding how the various CMHSP and SAPT practices may facilitate or impede recovery. This report was developed utilizing voluntary self-reflective surveys completed by administrators and providers representing all CMHSP and SATP that provide services to adults with a Mental Illness and or Substance Abuse diagnosis.

Summary

Did the targeted interventions increase the region's recovery environment?
For FY2021 the RSA-R Administrator Assessment and the RSA-R Provider Assessment was completed by each CMHSP Participant and SATP. Each assessment was scored separately for comparison purposes. The assessments consisted of six (6) separate subcategories that included Inviting, Choice, Involvement, Life Goals, Individually Tailored Services and Diversity of Treatment. A score of 3.50 or higher indicates overall satisfaction with the statements in the assessment. MSHN scored a 3.50 or higher on the total comprehensive score, and each subcategory for both the administrator and provider assessment.

Administrator Assessment

An upward trend is exhibited with no significant change since FY15. The subcategories in which MSHN has performed well continues to be the Inviting Subcategory (4.59 a decrease from 4.67) and the Choice Subcategory (4.62 an increase from 4.56). The Involvement Subcategory continues to demonstrate the lowest score since the onset of the project (3.77 an increase from 3.71). In 2017 the Involvement Subcategory did reach 3.64 and has continued to increase each year. Currently all subcategories range from 3.77 to 4.62. Additional analysis was completed using the comprehensive score by provision of clinical services. Nine service program types were utilized. Seven of the eight (one of the nine was new therefore no comparative data exists) decreased. The recovery environment of the organization, based on the assessment of the administrators, exhibited a range of 4.07-4.41 on a scale from 1-5 with 5 being strongly agree.

Provider Assessment

An upward trend is exhibited with no significant change since FY19. MSHN met the expectation of improvement each year by demonstrating a comprehensive score of 4.27 in FY21, up from 4.18 in FY19. Each subcategory stayed the same or demonstrated improvement, in FY21, ranging from 3.71-4.56. The subcategories performing well included the Choice Subcategory (4.56) and Inviting (4.56). Involvement continued to score lowest for the provider assessment. Additional analysis was completed using the comprehensive score by provision of clinical services. Nine service program types were utilized. Seven of the nine (one of the nine was new therefore no comparative data exists) indicated improvement in the recovery environment of the organization exhibiting a range of 4.18-4.80 on a scale from 1-5 with 5 being stronglyagree.

Conclusion

The questions that ranked the lowest in both the RSA-Administrator Assessment and the RSA-Provider Assessment from FY20, continue to be among the lowest for FY21, however improvement was exhibited. Growth areas to consider include the Involvement subcategory, particularly the opportunity to attend agency advisory boards, management meetings; and to facilitate staff trainings and education.

Interventions implemented in FY20 demonstrated effectiveness. MSHN has increased opportunities of consumer involvement through the addition of membership on MSHN regional committees and/or councils. MSHN, beginning in October 2021 will include two primary and/or secondary consumers to the membership of the MSHN Quality Improvement Council and the MSHN Customer Service Committee.

The results were reviewed further by the MSHN Quality Improvement Council, the SUD Provider Network, and the Regional Consumer Advisory Council considering the growth areas identified above. Each CMHSP Participant and SUD Provider reviewed their organization to determine the need for local improvement recommendations/interventions. Based on the additional reviews the following recommendations were made.

- Providers will continue to provide opportunities for consumer involvement in the organization. Communication of opportunities include but is not limited to the following methods: internal/external postings, newsletters, newspapers, assigned worker, and social media.
- Based on the completion of the PIP and improved performance demonstrated overthe past 6 years, QIC has recommended the administration of the RSA-R Provider and Administrator Versions be discontinued effective FY22.

Methodology

The responses from the Recovery Self-Assessments were scored as a comprehensive total, separately as six subcategories, and by individual question. The comprehensive score measures how the system is performing, and the subcategories measures the performance of six separate groups of questions. The individual response score for each question in the subcategories is included to assist in determining potential action steps. The tool is intended to assess the perceptions of individual recovery and all items are rated using the same 5-point Likert scale that ranges from 1 = "strongly disagree" to 5 = "strongly agree." A mean score of 3.50 or higher indicates agreement with the statements included in the measurement category. In addition to analyzing the mean score for each subcategory, an analysis was completed utilizing the mean score separated by program type for each provider. The "not applicable" and "do not know" responses were removed from the analysis. MSHN and the CMHSP Participants have participated in the RSA-R Administrators Assessment since 2015. MSHN incorporated the Substance Abuse Treatment Providers (SATP) into the RSA-R Administrator Assessment Project and began implementation of the RSA-R Provider Assessment for the CMHSP Participants and the SATP in 2019. The expectation is that MSHN will demonstrate improvement by identifying growth areas from the results, implement action steps, and strengthen the recovery-oriented systems of care provided within the region. The number of respondents for each RSA-R Administrator and Provider Assessments are illustrated in Figure 1.

Figure 1 MSHN RSA-R Number of Respondents

Program	Administrators			Providers		
	2019	2020	2021	2019	2020	2021
Mid-State Health Network	195	124	123	435	397	426
Bay-Arenac Behavioral Health Authority	24	11	14	45	46	56
Community Mental Health Authority of CEI	4	10	16	40	50	31
Community Mental Health for Central Michigan	26	16	14	41	57	56
Gratiot Integrated Health Network	6	4	8	15	27	42
Huron Behavioral Health	5	4	6	0	3	8
LifeWays Community Mental Health	2	5	8	16	37	17
Montcalm Care Center	17	5	6	23	20	18
Newaygo County Community Mental Health	13	6	5	24	21	24
Saginaw County Community Mental Health	20	9	5	30	26	35
Shiawassee County Community Mental Health	7	11	7	0	10	7
The Right Door for Hope Recovery and Wellness	19	8	5	28	0	39
Tuscola Behavioral Health System	2	2	1	6	13	11
MSHN SUD Providers	50	35	28	167	87	82

The distribution period was June 1, 2021 through July 31, 2021. This marks the third and final year of performance improvement project. The RSA-R Administrator Assessment is completed by administrators who do not provide direct services to individuals. The RSA-R Provider Assessment is completed by providers who, in addition to their administrative functions, provide direct services to individuals.

MSHN Comprehensive Summary

MSHN, inclusive of the CMHSP Participants and the SATP, has demonstrated a decrease of .01 in the comprehensive score for the RSA-R Administrator Assessment for FY21. MSHN had no change in performance for the RSA-R Provider Assessment for FY21 compared to FY20. Figure 2 demonstrates the progression of the comprehensive score of the Administrator Assessment since 2015. Figure 3 demonstrates the progression of the RSA-R Provider Assessment since its onset in 2019. Figure 4a provides a comprehensive score by Service Type, demonstrating a decrease in 1 out of 8 for the Provider Assessment and a decrease in 7 out of 8 for the Administrator Assessment. These areas will be further explored through the subcategory analysis.

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

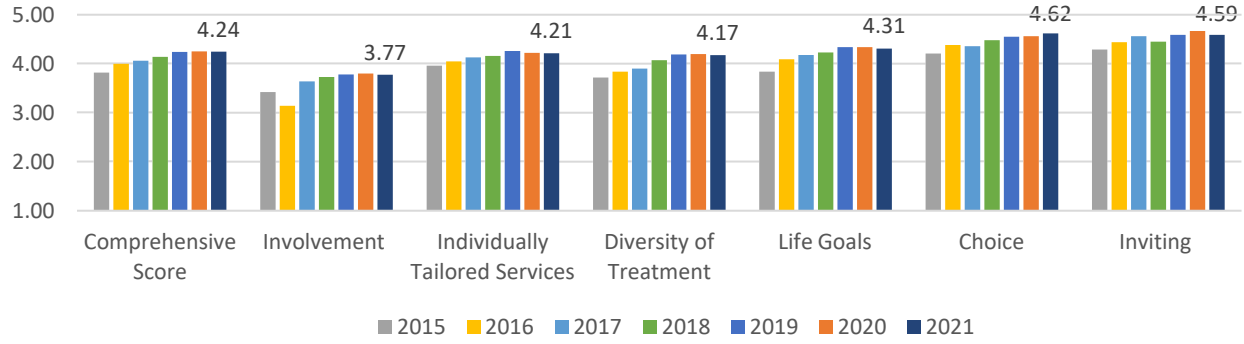


Figure 3. MSHN RSA-R Provider Assessment Comprehensive Score and Subcategory Comprehensive Scores

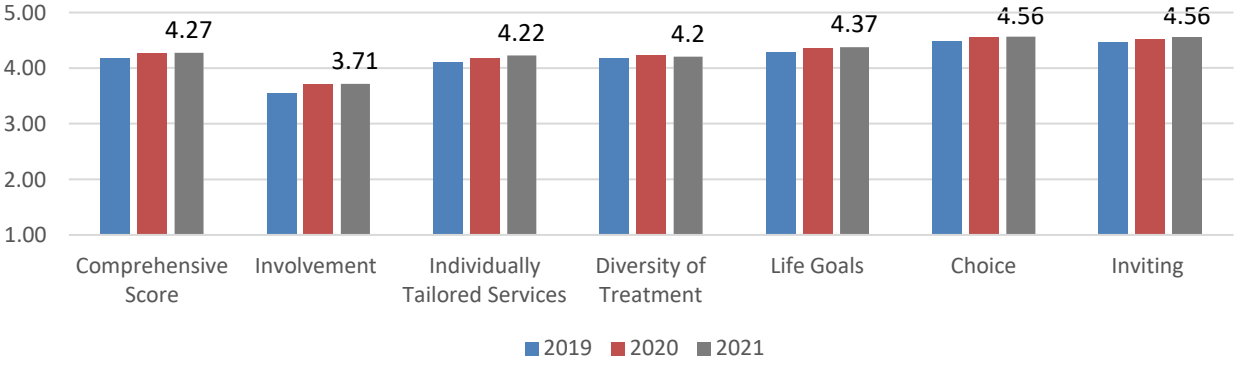


Figure 4a. MSHN RSA-R Provider and Administrative Assessment Comprehensive Score for CMHSP and SATP Service Program Type

	Provider Assessment						Administrator Assessment					
	2019		2020		2021		2019		2020		2021	
	n	score	n	score	n	score	n	score	n	score	n	score
Club House	18	3.91	20	4.41	14	4.42	18	4.16	16	4.33	12	4.22
Case Management/Supports Coordination	166	4.19	187	4.26	150	4.18	85	4.28	88	4.25	73	4.21
Intensive Outpatient Therapy SUDP	30	4.28	18	4.22	11	4.48	27	4.41	30	4.43	7	4.41
Outpatient Therapy	215	4.18	162	4.21	142	4.27	82	4.31	78	4.36	72	4.17
Substance Use Disorder (SUD) Residential	63	4.13	24	4.21	26	4.37	27	4.41	20	4.57	16	4.07
Assertive Community Treatment (ACT) CMHSP	23	4.33	33	4.24	29	4.26	20	4.25	21	4.19	20	4.16
Vocational	25	4.46	34	4.48	22	4.63	20	4.31	14	4.31	22	4.41
Detox	29	4.14	9	4.08	6	4.80	13	4.29	11	4.58	9	4.27
MAT					7	4.44					8	4.41
Other					102	4.21	27	4.20			32	4.15

The comprehensive score for each CMHSP Participant and SATP Administrator Assessment (Figure 5) and the Providers Assessment (Figure 6) illustrate performance above 3.50 indicating general agreement with the statements in the assessment. Two CMHSPs demonstrated an increase in the comprehensive score for FY21 for the Administrators Assessment. Nine CMHSPs and MSHN SATPs demonstrated an increase in the comprehensive score for the Provider Assessment in FY21.

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

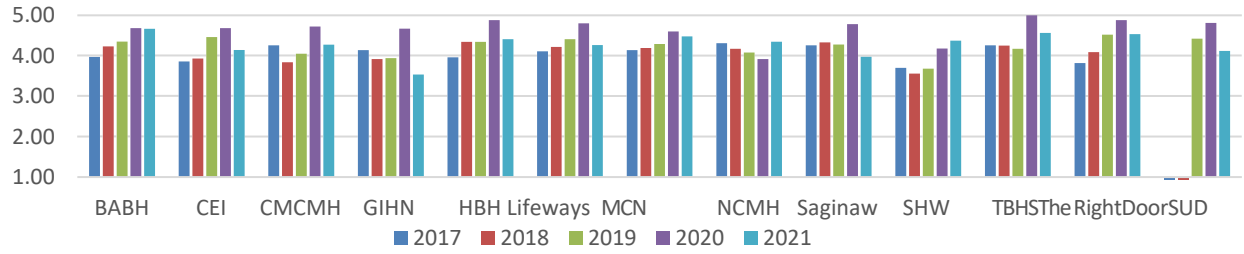
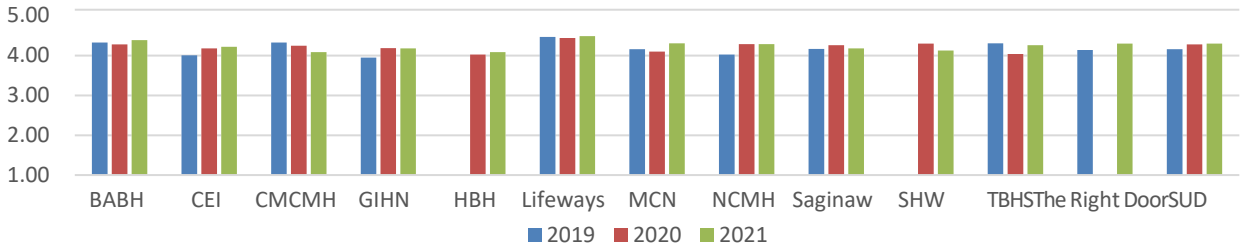


Figure 6. CMHSP Participant and SATP RSA-R Provider Comprehensive Assessment Scores



MSHN Subcategory Summary

The MSHN responses from the RSA-R Administrator Assessment and the RSA-R Provider Assessment were separated by each subcategory.

Inviting Subcategory

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

Figure 8a. CMHSP Participants and SATPs comparison of FY21 Inviting Subcategory Score with Questions-Administrator Assessment

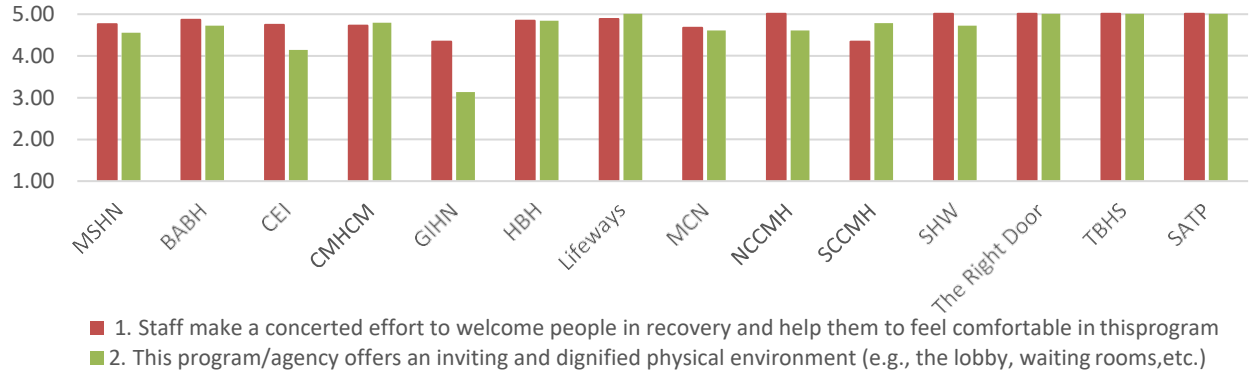


Figure 8b. CMHSP Participants and SATPs comparison of FY21 Inviting Subcategory Score with Questions-Provider Assessment

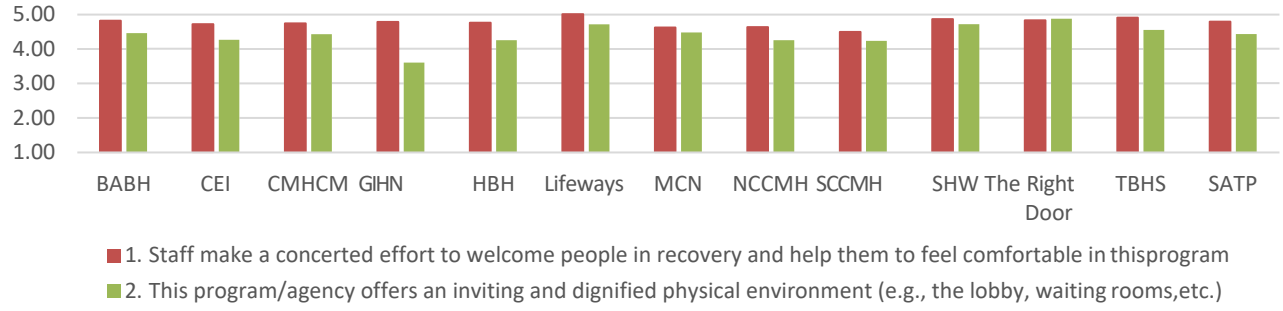
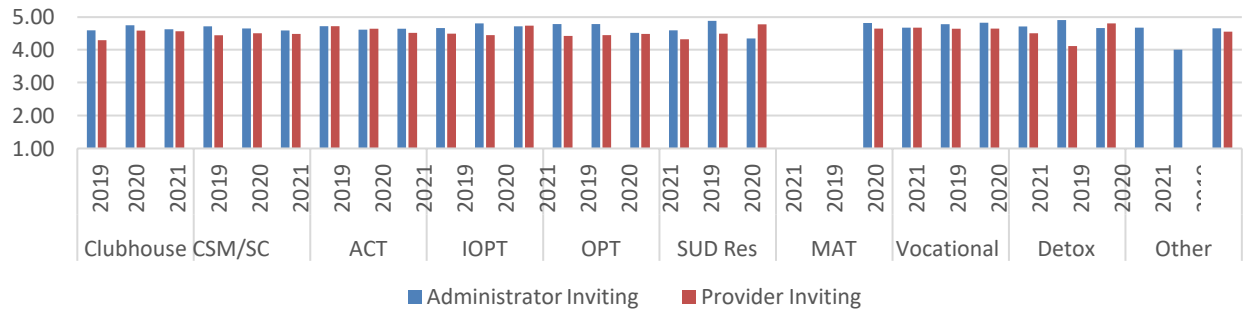


Figure 8c. Service Program Type comparison of the Inviting Subcategory with the Provider and Administrator Assessments



Choice Subcategory

The comprehensive score for both the Administrator and the Provider Assessment was above 3.50. Figures 9a-9b illustrates how each CMHSP and the SATP scored for each question within the subcategory by RSA-R assessment type. Figure 9c illustrates the comprehensive score of the subcategory by service program type.

Figure 9a. CMHSP Participants and SATPs comparison of FY21 Choice Subcategory Score with Questions-Administrator Assessment

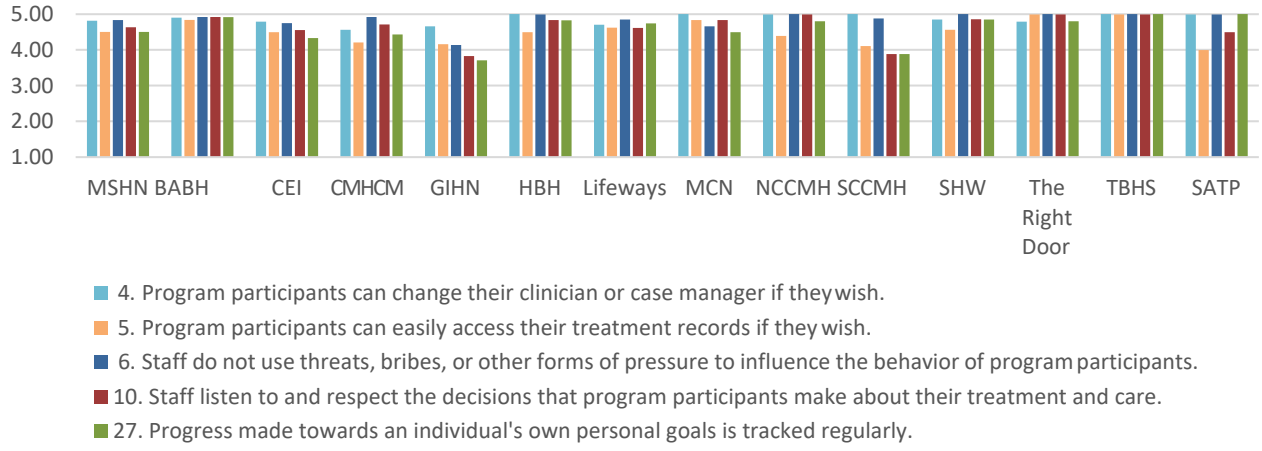


Figure 9b. CMHSP Participants and SATPs comparison of FY21 Choice Subcategory Score with Questions-Provider Assessment

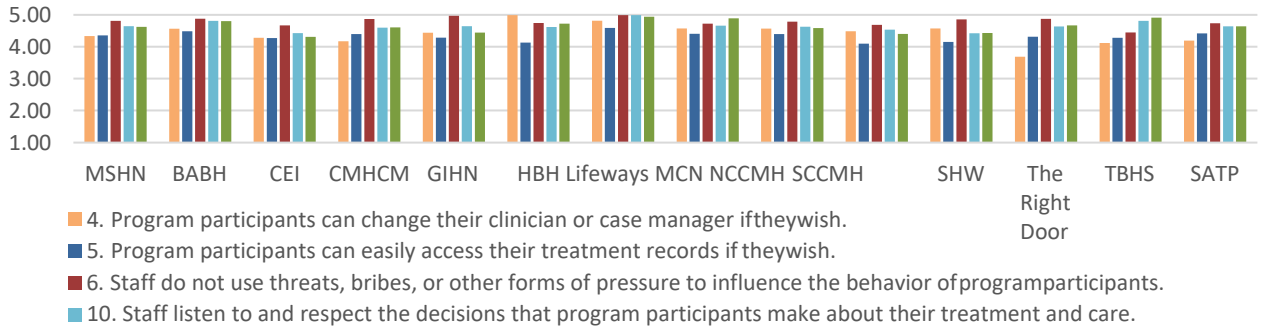
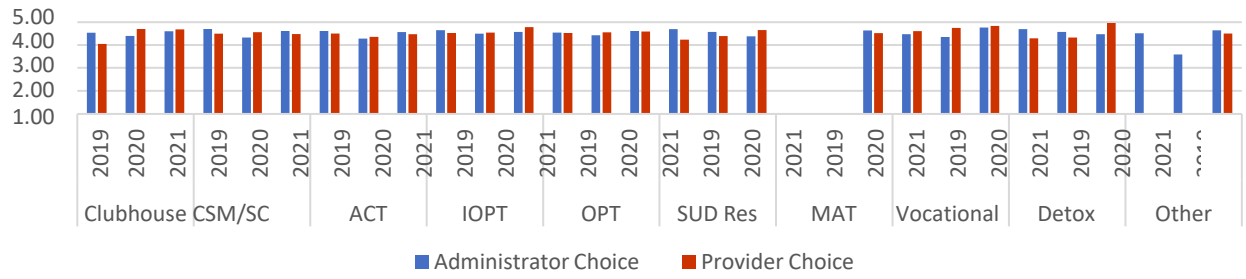


Figure 9c. Service Program Type comparison of the Choice Subcategory with the Provider and Administrator Assessments. No data collected for MAT in 2019 and 2020.



Involvement Subcategory

The comprehensive score for both the Administrator and the Provider assessment for MSHN was above 3.50. 10a illustrates how each CMHSP Participant and SATP responded to each question within the Involvement subcategory administrator assessment. Figure 10b illustrates how each CMHSP Participant and the SATP responded to each question within the Involvement subcategory provider assessment. Figure 10c illustrates how each CMHSP Participant and SATP scored by service program type.

Figure 10a. CMHSP Participants and SUD Provider Network comparison of FY21 Involvement Subcategory Score with Questions-Administrator Assessment

Figure 10b. CMHSP Participants and SUD Provider Network comparison of FY21 Involvement Subcategory Score with Questions-Provider Assessment

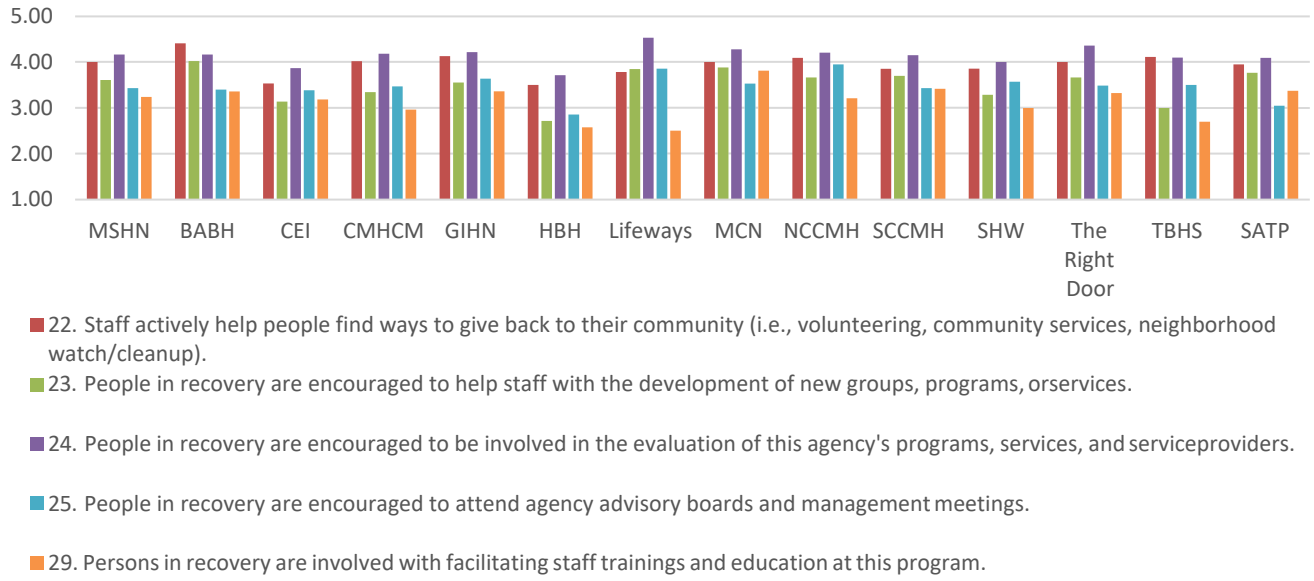
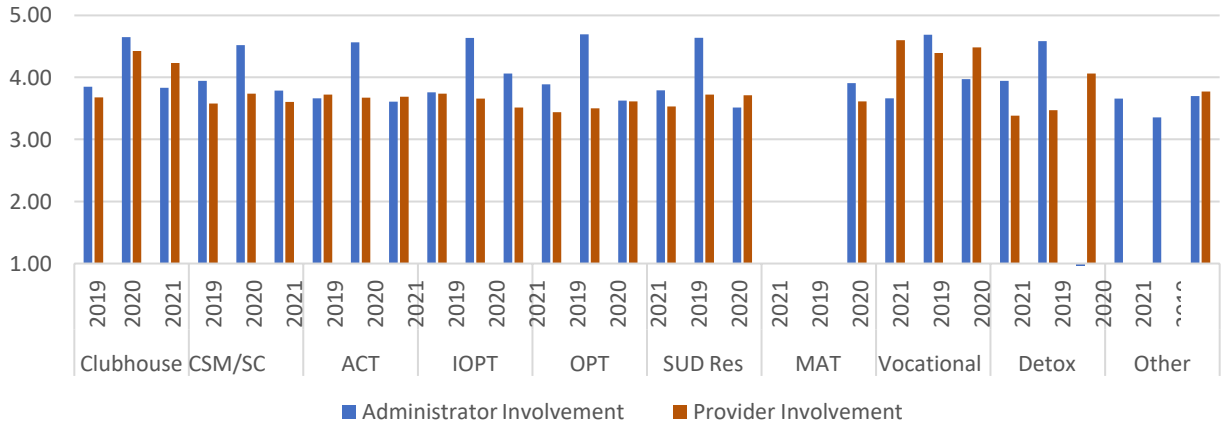


Figure 10c. Service Program Type comparison of the Involvement Subcategory



Life Goals Subcategory

The comprehensive score for both the Administrators Assessment and the Provider Assessment was above 3.50. Figure 11a-11b illustrates how each CMHSP Participant and SATP responded to the Life Goals subcategory administrator assessment. Figure 11c-11d illustrate how each CMHSP Participant and the SATP responded to the Life Goals provider assessment. Figure 11e demonstrates how each CMHSP Participant and the SATP scored by service program type.

Figure 11a. CMHSP Participants and SATP comparison of FY21 Life Goals Subcategory Score with Questions-Administrator Assessment (Questions 3, 7, 8, 9, 12)

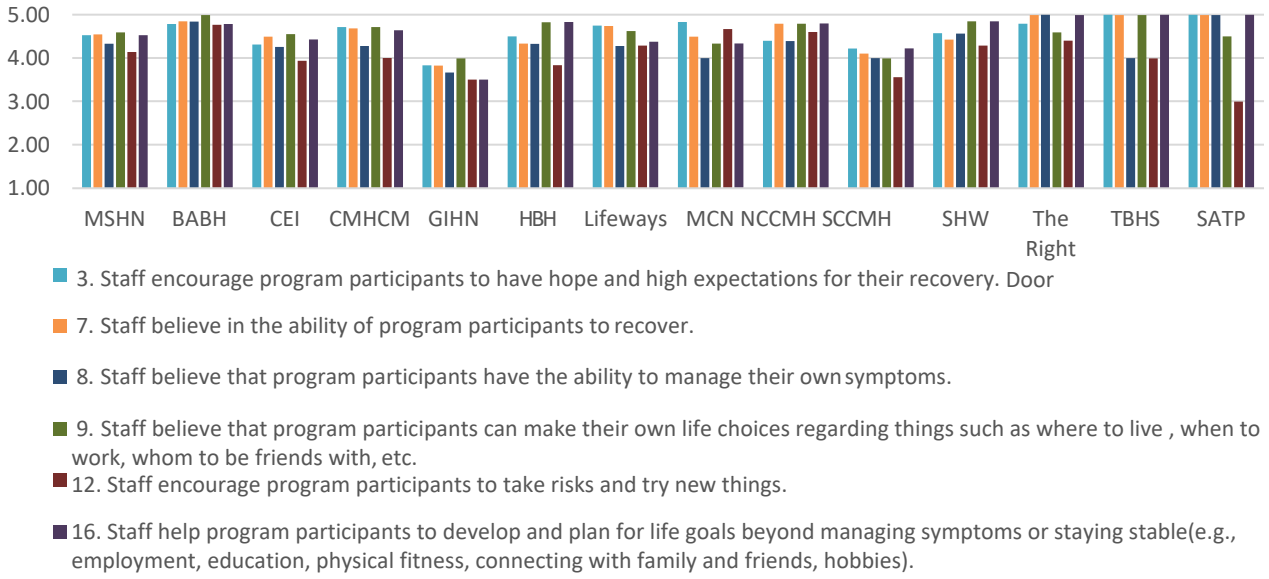


Figure 11b. CMHSP Participant and SATP comparison of FY21 Life Goals Subcategory Score with Questions-Administrator Assessment (Questions 16, 17, 18, 28, 31, 32)

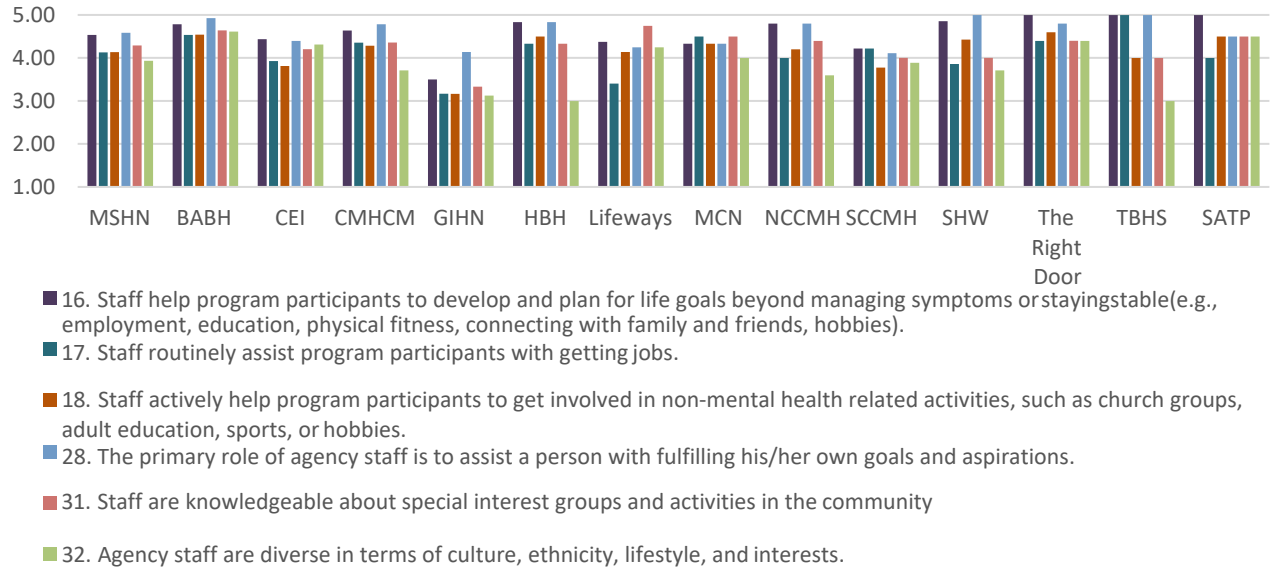


Figure 11c. CMHSP Participants and SATP comparison of FY21 Life Goals Subcategory Score with Questions-Provider Assessment (Questions 3, 7, 8, 9, 12)

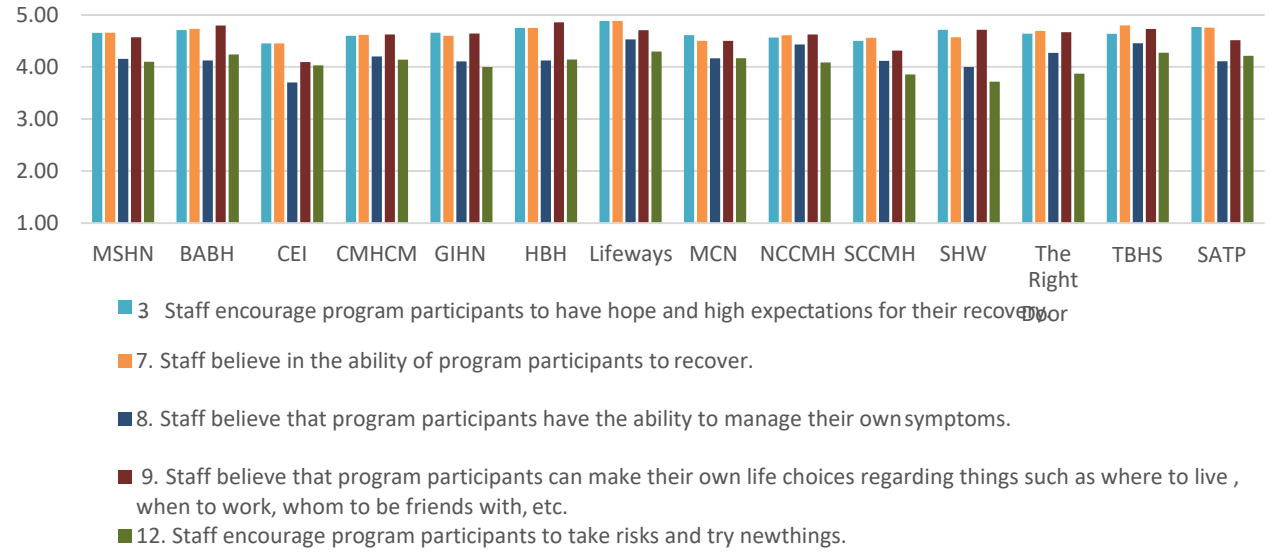


Figure 11d. CMHSP Participants and SATP comparison of FY21 Life Goals Subcategory Score with Questions-Provider Assessment (Questions 16, 17, 18, 28, 31, 32)

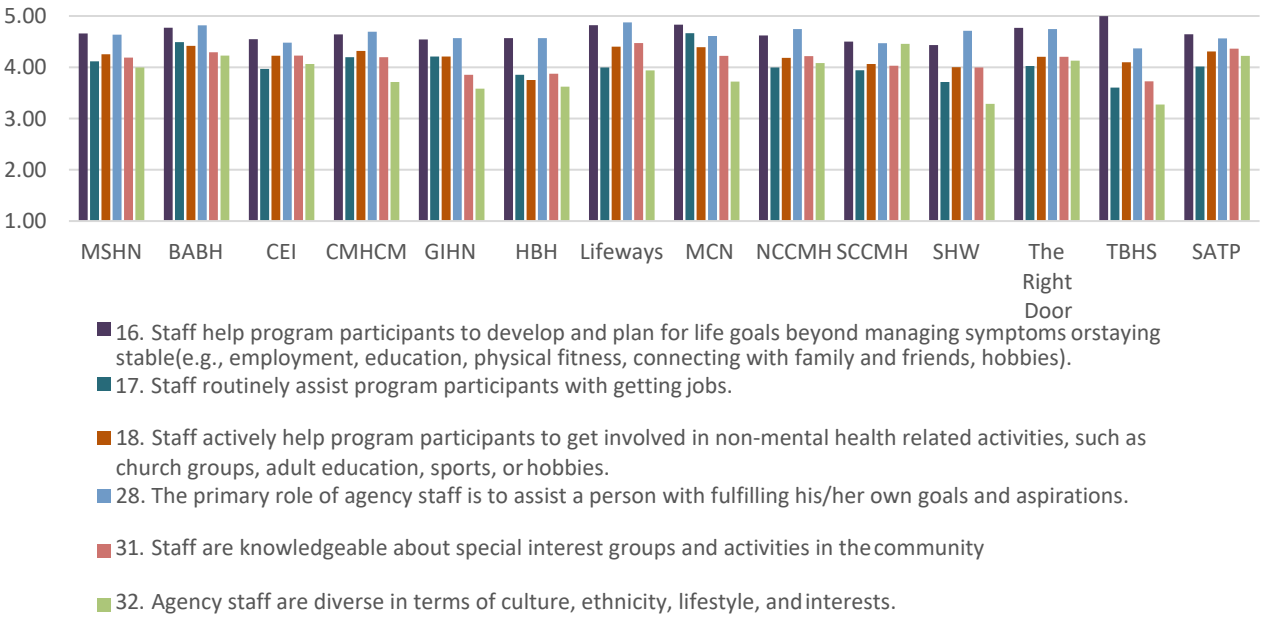
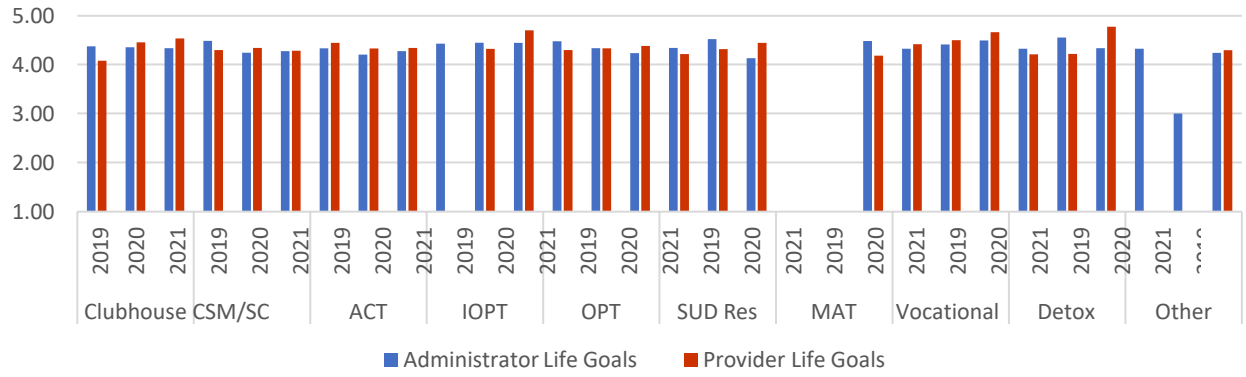


Figure 11e. Service Program Type comparison of Life Goals Subcategory



Individually Tailored Services Subcategory

The comprehensive score for both the Administrators and the Provider assessment was above 3.50. Figure 12a illustrates how each CMHSP Participant and SATP responded to the Individually Tailored Services subcategory administrator assessment. Figure 12b illustrate how each CMHSP Participant and SATP responded to the Individually Tailored Services subcategory provider assessment. Figure 12c demonstrates how each CMHSP Participant and SATP scored by service program type.

Figure 12a. CMHSP Participants and SATPs comparison of FY21 Individually Tailored Services Subcategory Score with Questions-Administrator Assessment

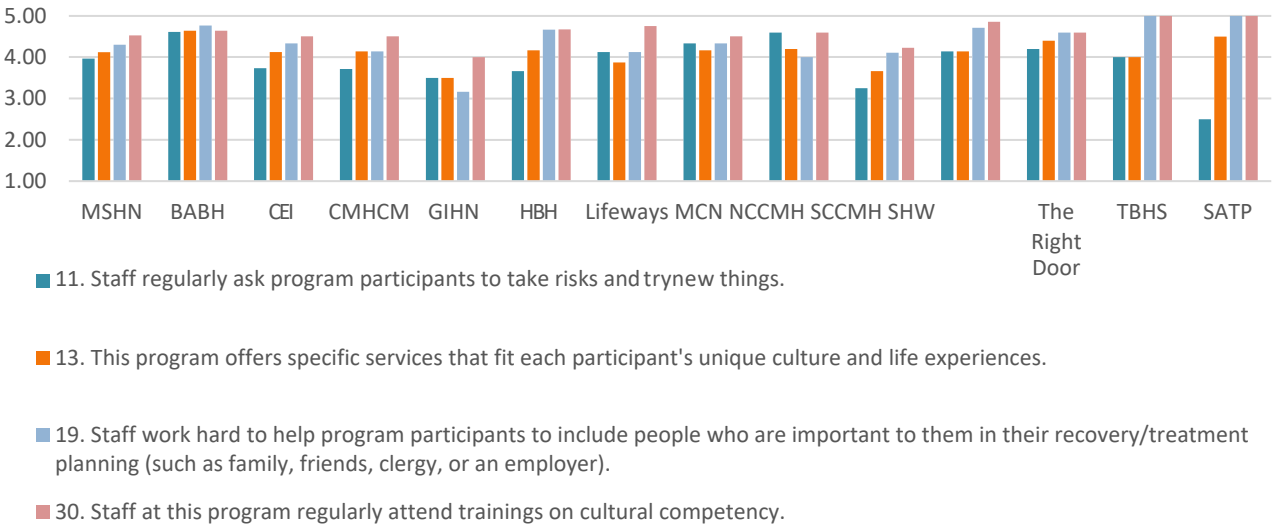


Figure 12b. CMHSP Participants and SATPs comparison of FY21 Individually Tailored Services Subcategory Score with Questions-Provider Assessment

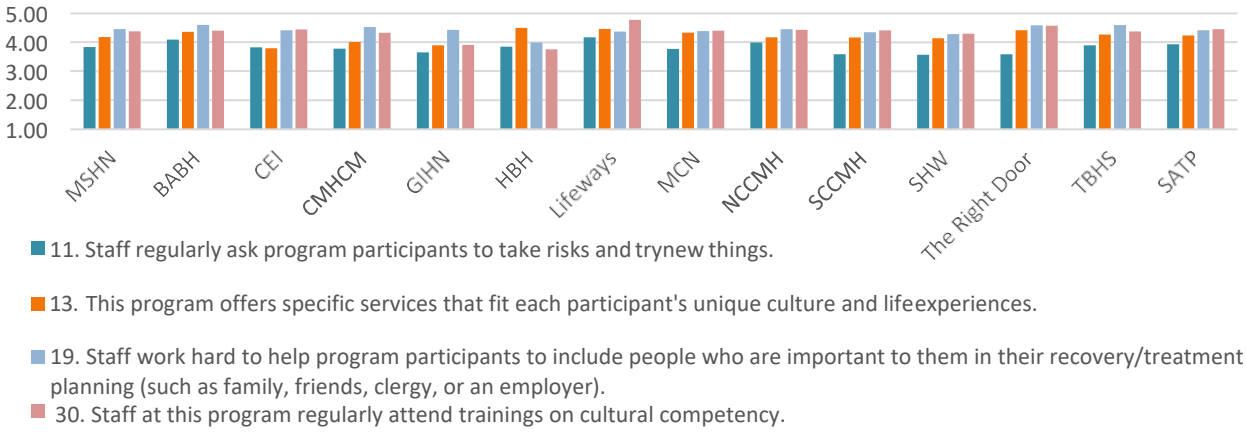
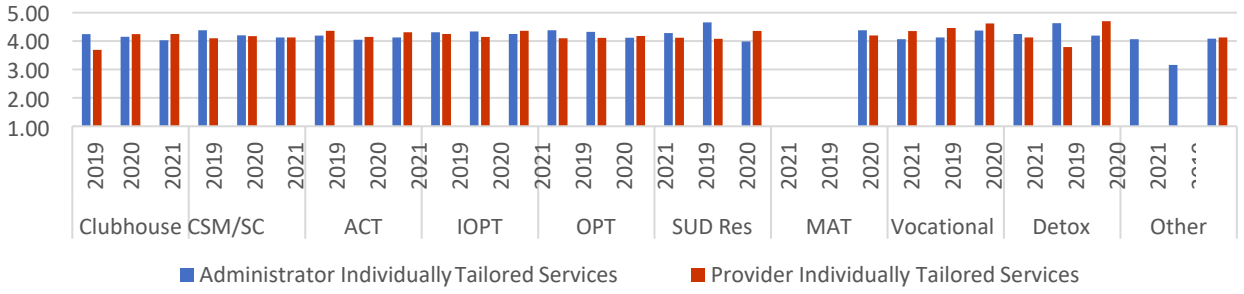


Figure 12c. Service Program Type comparison of Individually Tailored Services Subcategory



Diversity Subcategory

The comprehensive score for both the Administrator and Provider Assessment was above 3.5. Figure 13a illustrates how the CMHSP Participants and the SATP responded to the Diversity subcategory administrator assessment. Figure 13b illustrate how each CMHSP Participant and SATP Network responded to the Diversity subcategory provider assessment. Figure 13c demonstrates how each CMHSP Participant and the SATP scored by service program type.

Figure 13a. CMHSP Participants and SATPs comparison of FY21 Diversity of Treatment Subcategory Score with Questions-Administrator Assessment

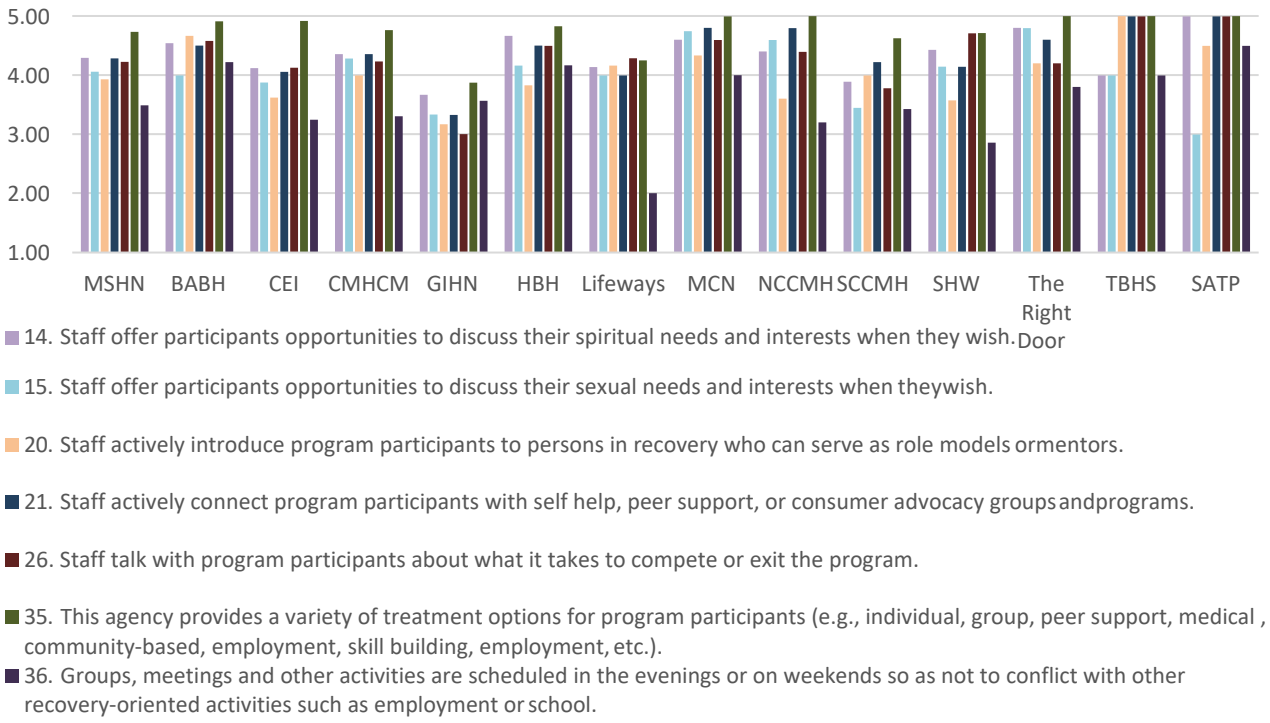


Figure 13b. CMHSP Participants and SATPs comparison of FY21 Diversity of Treatment-Provider Assessment

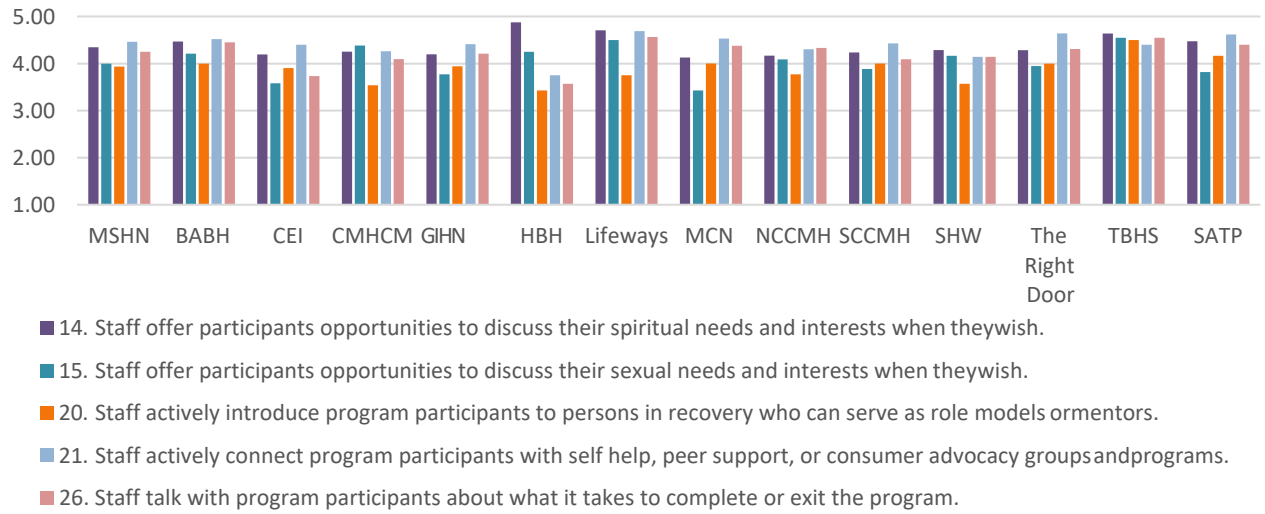
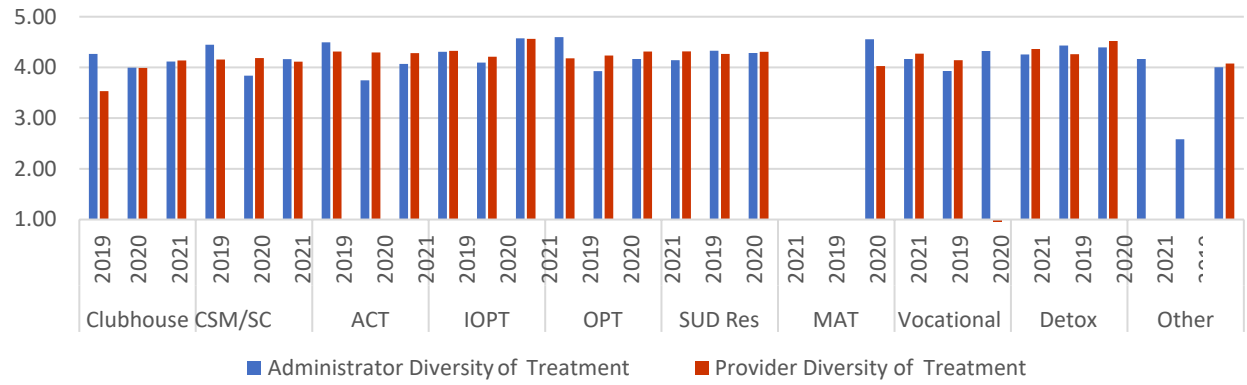


Figure 13c. Service Program Type comparison of Diversity of Treatment Subcategory



Summary

For FY2021 the RSA-R Administrator Assessment and the RSA-R Provider Assessment was completed by each CMHSP Participant and SATP. Each assessment was scored separately for comparison purposes. The assessments consisted of six (6) separate subcategories that included Inviting, Choice, Involvement, Life Goals, Individually Tailored Services and Diversity of Treatment.

Administrator Assessment

Did the targeted interventions increase the region's recovery environment? MSHN met the expectation of a total comprehensive score of 3.50 or higher on the RSA Administrator Assessment, indicating overall satisfaction with the statements in the assessment. Additionally, MSHN demonstrated a score of 3.50 and higher for each subcategory. An upward trend is exhibited with no significant change since FY2020. The subcategories in which MSHN has performed well continues to be the Inviting Subcategory (4.59 a decrease from 4.67) andthe Choice Subcategory (4.62 an increase from 4.56). The Involvement Subcategory continues to demonstrate the lowest score since the onset of the project (3.77 an increase from 3.71). In 2017 the Involvement Subcategory did reach 3.64 and has continued to increase eachyear. Currently all subcategories range from 3.77 to 4.62. Additional analysis was completed using the comprehensive score by provision of clinical services. Nine service program types were utilized. Seven of the eight (one of the nine was new therefore no comparative data exists) decreased. The recovery environment of the organization, based on the assessment of the administrators, exhibited a range of 4.07-4.41 on a scale from 1-5 with 5 being strongly agree.

The 5 questions that scored the highest

Questions	MSHN
6. Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.	4.84
4. Program participants can change their clinician or case manager if they wish.	4.82
1. Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program	4.75
35. This agency provides a variety of treatment options for program participants (e.g., individual, group, peer support, medical, community-based, employment, skill building, employment, etc.).	4.73
10. Staff listen to and respect the decisions that program participants make about their treatment and care.	4.64

The five questions that scored the lowest

Questions	MSHN
25. People in recovery are encouraged to attend agency advisory boards and management meetings.	3.89
23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.	3.83
22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).	3.80
36. Groups, meetings and other activities are scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.	3.49
29. Persons in recovery are involved with facilitating staff trainings and education at this program.	3.27

Provider Assessment

Did the targeted interventions increase the region's recovery environment? The MSHN RSA-R Provider Assessment of Recovery met the expectation of improvement each year by demonstrating a comprehensive score of 4.27 in FY21, up from 4.25 in FY20. Each subcategory stayed the same or demonstrated improvement in FY21, ranging from 3.71-4.56. The subcategories performing well included the Choice Subcategory (4.56) and Inviting (4.56). Involvement continued to score lowest for theprovider assessment. Additional analysis was completed using the comprehensive score by provision of clinical services. Nine service program types were utilized. Seven of the nine indicated improvement in the recovery environment of the organization exhibiting a range of 4.18-4.80 on a scale from 1-5 with 5 being stronglyagree.

The five questions that scored the highest

Provider	MSHN
6. Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.	4.81
1. Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program	4.75
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).	4.66
7. Staff believe in the ability of program participants to recover.	4.66
10. Staff listen to and respect the decisions that program participants make about their treatment and care.	4.65

The five questions that scored the lowest

Provider	MSHN
20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.	3.93
11. Staff regularly ask program participants to take risks and try new things.	3.84
23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.	3.61
25. People in recovery are encouraged to attend agency advisory boards and management meetings.	3.43
29. Persons in recovery are involved with facilitating staff trainings and education at this program.	3.24

Evaluation of Effectiveness

Interventions implemented in FY20 demonstrated effectiveness. MSHN has increased opportunities of consumer involvement. MSHN, beginning in October 2021 will include two primary and/or secondary consumers to the membership of the MSHN Quality Improvement Council and the MSHN Customer Service Committee.
The questions that ranked the lowest in both the RSA-Administrator Assessment and the RSA-Provider Assessment from FY20, continue to be among the lowest for FY21, however improvement was exhibited. Growth areas to consider include subcategories or questions that perform below the 3.50 indicating disagreement or room for improvement. Question 29 continued to receive a score of less than 3.50 for both the administrator and provider assessments. Additionally, consideration should be given to the questions that offer the most opportunity for improvement or that have demonstrated a decrease since the previous year. The Involvement subcategory demonstrated the largest opportunity for growth.

The results were reviewed further by the MSHN Quality Improvement Council, the SUD Provider Network, and the Regional Consumer Advisory Council considering the growth areas identified above. Each CMHSP Participant and SUD Provider reviewed their organization to determine the need for local improvement recommendations/interventions. Based on the additional reviews the following recommendations were made.

Recommendations

- Providers will continue to provide opportunities for consumer involvement in the organization. Communication of opportunities include but is not limited to the following methods: internal/external postings, newsletters, newspapers, assigned worker, and social media.
- Based on the completion of the PIP and improved performance demonstrated overthe past 6 years, QIC has recommended the administration of the RSA-R Provider and Administrator Versions be discontinued effective FY22.

Attachment 1 demonstrates the average response for each question the MSHN Administrators Assessment.
Attachment 2 demonstrates the average response for each question on the MSHN Providers Assessment.

Report Completed by: Sandy Gettel MSHNQuality Manager **Date: 8/31/2021**
MSHN QIC Review: **Date: 9/23/2021**
Provider Network Review: **Date: 9/23/2021**

Attachment 1

Comparison by Organization

Key	*Five Lowest Scores **Five Highest Scores for each organization

Recovery Self-Assessment – Administrator Version

Administrator	MSHN	BABH	CEI	CMHCM	GIHN	HBH	Lifeways	MCN	NCCMH	SCCMH	SHW	The Right Door	TBHS	SATP
Inviting														
1. Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program	**4.75**	4.86	**4.73**	**4.71**	**4.33**	**4.83**	**4.88**	4.67	**5.00**	**4.33**	**5.00**	**5.00**	**5.00**	**5.00**
2. This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.)	4.55	4.71	4.13	**4.79**	3.13	**4.83**	**5.00**	4.60	4.60	**4.78**	4.71	**5.00**	**5.00**	**5.00**
Life Goals														
3. Staff encourage program participants to have hope and high expectations for their recovery.	4.54	4.79	4.31	**4.71**	3.83	4.50	**4.75**	**4.83**	4.40	4.22	4.57	4.80	**5.00**	**5.00**
7. Staff believe in the ability of program participants to recover.	4.55	4.86	4.50	4.69	3.83	4.33	**4.75**	4.50	4.80	4.11	4.43	**5.00**	**5.00**	**5.00**
8. Staff believe that program participants have the ability to manage their own symptoms.	4.34	4.85	4.27	4.29	3.67	4.33	4.29	4.00	4.40	4.00	4.57	**5.00**	4.00	**5.00**
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.	4.60	**5.00**	**4.56**	**4.71**	4.00	**4.83**	4.63	4.33	4.80	4.00	**4.86**	4.60	**5.00**	4.50
12. Staff encourage program participants to take risks and try new things.	4.15	4.77	3.94	4.00	3.50	3.83	4.29	4.67	4.60	3.56	4.29	4.40	4.00	3.00
16. Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable(e.g., employment, education, physical fitness, connecting with family and friends, hobbies).	4.54	4.79	4.44	4.64	3.50	**4.83**	4.38	4.33	4.80	4.22	**4.86**	**5.00**	**5.00**	**5.00**
17. Staff routinely assist program participants with getting jobs.	4.13	4.54	3.93	4.36	3.17	4.33	3.40	4.50	4.00	4.22	3.86	4.40	**5.00**	4.00
18. Staff actively help program participants to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies.	4.14	4.55	3.81	4.29	3.17	4.50	4.14	4.33	4.20	3.78	4.43	4.60	4.00	4.50
28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.	4.59	**4.93**	4.40	**4.79**	**4.14**	**4.83**	4.25	4.33	4.80	4.11	**5.00**	4.80	**5.00**	4.50
31. Staff are knowledgeable about special interest groups and activities in the community	4.29	4.64	4.20	4.36	3.33	4.33	**4.75**	4.50	4.40	4.00	4.00	4.40	4.00	4.50
32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	3.94	4.62	4.31	3.71	3.13	3.00	4.25	4.00	3.60	3.89	3.71	4.40	3.00	4.50

Administrator	MSHN	BABH	CEI	CMHCM	GIHN	HBH	Lifeways	MCN	NCCMH	SCCMH	SHW	The Right Door	TBHS	SATP
Choice														
4. Program participants can change their clinician or case manager if they wish.	4.82	4.91	4.80	4.57	4.67	5.00	4.71	5.00	5.00	5.00	4.86	4.80	5.00	5.00
5. Program participants can easily access their treatment records if they wish.	4.51	4.85	4.50	4.21	4.17	4.50	4.63	4.83	4.40	4.11	4.57	5.00	5.00	4.00
6. Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.	4.84	4.93	4.75	4.93	4.14	5.00	4.86	4.67	5.00	4.89	5.00	5.00	5.00	5.00
10. Staff listen to and respect the decisions that program participants make about their treatment and care.	4.64	4.93	4.56	4.71	3.83	4.83	4.63	4.83	5.00	3.89	4.86	5.00	5.00	4.50
27. Progress made towards an individual's own personal goals is tracked regularly.	4.51	4.92	4.33	4.43	3.71	4.83	4.75	4.50	4.80	3.89	4.86	4.80	5.00	5.00
Individually Tailored Services														
11. Staff regularly ask program participants to take risks and try new things.	3.97	4.62	3.73	3.71	3.50	3.67	4.13	4.33	4.60	3.25	4.14	4.20	4.00	2.50
13. This program offers specific services that fit each participant's unique culture and life experiences.	4.12	4.64	4.13	4.14	3.50	4.17	3.88	4.17	4.20	3.67	4.14	4.40	4.00	4.50
19. Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning	4.31	4.77	4.33	4.14	3.17	4.67	4.13	4.33	4.00	4.11	4.71	4.60	5.00	5.00
30. Staff at this program regularly attend trainings on cultural competency.	4.53	4.64	4.50	4.50	4.00	4.67	4.75	4.50	4.60	4.22	4.86	4.60	5.00	5.00
Diversity of Treatment														
14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.	4.29	4.55	4.13	4.36	3.67	4.67	4.14	4.60	4.40	3.89	4.43	4.80	4.00	5.00
15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.	4.06	4.00	3.88	4.29	3.33	4.17	4.00	4.75	4.60	3.44	4.14	4.80	4.00	3.00
20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.	3.93	4.67	3.63	4.00	3.17	3.83	4.17	4.33	3.60	4.00	3.57	4.20	5.00	4.50
21. Staff actively connect program participants with self help, peer support, or consumer advocacy groups and programs.	4.28	4.50	4.06	4.36	3.33	4.50	4.00	4.80	4.80	4.22	4.14	4.60	5.00	5.00
26. Staff talk with program participants about what it takes to compete or exit the program.	4.23	4.58	4.13	4.23	3.00	4.50	4.29	4.60	4.40	3.78	4.71	4.20	5.00	5.00

35. This agency provides a variety of treatment options for program participants.	**4.73**	4.91	**4.92**	**4.77**	3.88	**4.83**	4.25	**5.00**	**5.00**	**4.63**	4.71	**5.00**	**5.00**	**5.00**
36. Groups, meetings and other activities are scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.	3.49	4.22	3.25	3.31	3.57	4.17	2.00	4.00	3.20	3.43	2.86	3.80	4.00	4.50
Involvement														
22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).	3.80	4.31	3.56	3.93	3.17	4.17	3.71	3.83	3.80	3.38	4.00	3.60	4.00	4.00
23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.	3.83	4.50	3.50	3.86	3.00	4.00	4.17	4.33	3.80	3.11	4.29	3.80	4.00	**5.00**
24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.	4.15	4.64	3.87	4.21	3.20	4.33	4.13	4.67	4.20	3.67	4.71	4.00	4.00	**5.00**
25. People in recovery are encouraged to attend agency advisory boards and management meetings.	3.89	4.33	3.47	3.86	3.00	4.50	3.25	4.17	4.00	4.00	4.14	4.00	**5.00**	3.00
29. Persons in recovery are involved with facilitating staff trainings and education at this program.	3.27	4.38	3.33	3.23	2.17	3.40	3.14	4.20	2.60	2.89	3.14	3.40	3.00	4.50
33. This agency provides formal opportunities for people in recovery, family members, service providers, and administrators to learn about recovery.	4.07	4.60	3.83	3.92	3.71	4.50	3.60	4.67	3.60	3.75	4.00	4.60	**5.00**	4.50
34. This agency provides structured educational activities to the community about mental illness and addictions.	3.95	3.70	4.00	3.69	3.25	4.50	2.75	4.50	4.40	4.14	4.14	4.60	**5.00**	4.00

Key	*Five Lowest Scores **Five Highest Scores for each organization

Recovery Self-Assessment Provider Version

Provider	MSHN	BABH	CEI	CMHCM	GIHN	HBH	Lifeways	MCN	NCCMH	SCCMH	SHW	The Right Door	TBHS	SATP
Inviting														
1. Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program	4.75	4.81	4.71	4.73	4.78	4.75	5.00	4.61	4.63	4.49	4.86	4.82	4.90	4.78
2. This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.)	4.37	4.45	4.26	4.42	3.60	4.25	4.71	4.47	4.25	4.23	4.71	4.87	4.55	4.43
Life Goals														
3. Staff encourage program participants to have hope and high expectations for their recovery.	4.65	4.71	4.45	4.60	4.66	4.75	4.88	4.61	4.57	4.50	4.71	4.64	4.64	4.77
7. Staff believe in the ability of program participants to recover.	4.66	4.73	4.45	4.62	4.60	4.75	4.88	4.50	4.61	4.56	4.57	4.69	4.80	4.76
8. Staff believe that program participants have the ability to manage their own symptoms.	4.15	4.12	3.70	4.20	4.11	4.13	4.53	4.17	4.43	4.12	4.00	4.27	4.45	4.11
9. Staff believe that program participants can make their own life choices regarding things such as where to live , when to work, whom to be friends with, etc.	4.57	4.80	4.10	4.63	4.64	4.86	4.71	4.50	4.63	4.31	4.71	4.67	4.73	4.51
12. Staff encourage program participants to take risks and try new things.	4.10	4.24	4.03	4.14	4.00	4.14	4.29	4.17	4.08	3.85	3.71	3.87	4.27	4.22
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).	4.66	4.77	4.55	4.64	4.54	4.57	4.82	4.83	4.63	4.50	4.43	4.77	5.00	4.65
17. Staff routinely assist program participants with getting jobs.	4.12	4.49	3.97	4.20	4.21	3.86	4.00	4.67	4.00	3.94	3.71	4.03	3.60	4.01
18. Staff actively help program participants to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies.	4.26	4.42	4.23	4.31	4.21	3.75	4.40	4.39	4.18	4.06	4.00	4.21	4.10	4.31
28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.	4.64	4.82	4.48	4.70	4.57	4.57	4.88	4.61	4.75	4.47	4.71	4.74	4.36	4.56
31. Staff are knowledgeable about special interest groups and activities in the community	4.19	4.30	4.23	4.20	3.85	3.88	4.47	4.22	4.22	4.03	4.00	4.21	3.73	4.37
32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	4.00	4.23	4.06	3.71	3.59	3.63	3.94	3.72	4.08	4.46	3.29	4.13	3.27	4.22

Provider	MSHN	BABH	CEI	CMHCM	GIHN	HBH	Lifeways	MCN	NCCMH	SCCMH	SHW	The Right Door	TBHS	SATP
Choice														
4. Program participants can change their clinician or case manager if they wish.	4.33	4.57	4.28	4.18	4.44	5.00	4.82	4.57	4.57	4.49	4.57	3.69	4.13	4.20
5. Program participants can easily access their treatment records if they wish.	4.35	4.48	4.27	4.39	4.28	4.13	4.59	4.40	4.39	4.09	4.14	4.31	4.27	4.42
6. Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.	4.81	4.89	4.68	4.88	4.98	4.75	5.00	4.72	4.79	4.69	4.86	4.87	4.45	4.74
10. Staff listen to and respect the decisions that program participants make about their treatment and care.	4.65	4.82	4.43	4.61	4.64	4.63	5.00	4.67	4.63	4.54	4.43	4.64	4.82	4.65
27. Progress made towards an individual's own personal goals is tracked regularly.	4.62	4.80	4.31	4.61	4.45	4.71	4.94	4.89	4.58	4.41	4.43	4.67	4.91	4.63
Individually Tailored Services														
11. Staff regularly ask program participants to take risks and try new things.	3.84	4.10	3.83	3.79	3.66	3.86	4.18	3.78	4.00	3.59	3.57	3.59	3.90	3.94
13. This program offers specific services that fit each participant's unique culture and life experiences.	4.19	4.36	3.80	4.02	3.90	4.50	4.47	4.33	4.17	4.17	4.14	4.42	4.27	4.24
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).	4.46	4.60	4.42	4.53	4.44	4.00	4.38	4.39	4.46	4.35	4.29	4.59	4.60	4.42
30. Staff at this program regularly attend trainings on cultural competency.	4.37	4.39	4.43	4.32	3.90	3.75	4.76	4.39	4.42	4.40	4.29	4.56	4.36	4.46
Diversity of Treatment														
14. Staff offer participants opportunities todiscuss their spiritual needs and interests when they wish.	4.35	4.47	4.19	4.25	4.20	4.88	4.71	4.13	4.17	4.24	4.29	4.28	4.64	4.48
15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.	4.00	4.21	3.58	4.38	3.77	4.25	4.50	3.43	4.09	3.88	4.17	3.95	4.55	3.82
20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.	3.93	4.00	3.90	3.54	3.94	3.43	3.75	4.00	3.77	4.00	3.57	4.00	4.50	4.16
21. Staff actively connect program participants with self help, peer support, or consumer advocacy groups and programs.	4.46	4.52	4.40	4.26	4.41	3.75	4.69	4.53	4.30	4.43	4.14	4.64	4.40	4.62
26. Staff talk with program participants about what it takes to complete or exit the program.	4.25	4.45	3.73	4.09	4.21	3.57	4.56	4.38	4.33	4.09	4.14	4.31	4.55	4.40

Provider	MSHN	BABH	CEI	CMHCM	GIHN	HBH	Lifeways	MCN	NCCMH	SCCMH	SHW	The Right Door	TBHS	SATP
Involvement														
22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).	4.00	4.41	3.53	4.02	4.13	3.50	3.79	4.00	4.09	3.85	3.86	4.00	4.11	3.95
23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.	3.61	4.02	3.14	3.35	3.56	2.71	3.85	3.88	3.67	3.70	3.29	3.67	3.00	3.77
24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.	4.16	4.17	3.87	4.18	4.22	3.71	4.53	4.28	4.21	4.15	4.00	4.36	4.10	4.09
25. People in recovery are encouraged to attend agency advisory boards and management meetings.	3.43	3.40	3.39	3.47	3.64	2.86	3.86	3.53	3.95	3.43	3.57	3.49	3.50	3.05
29. Persons in recovery are involved with facilitating staff trainings and education at this program.	3.24	3.36	3.19	2.96	3.36	2.57	2.50	3.81	3.21	3.42	3.00	3.32	2.70	3.37

2021 CMHA-CEI Self-Assessment - Trauma Survey Results Analysis by Program

Total Results

- 254 Completed Surveys
- 188 responses from Clinical Programs (74%)
- 147 responses from those in clinical roles (58%)

Program	Completed Survey Number
AMHS	72
CSDD	50
FF	41
SAS	25
GA/QCSRR/Finance/HR/IS	66

Highest Ranking Questions

Question	Average Score Overall	Clinical Program Score	Clinical Role Score
There are private, confidential spaces available to conduct intake assessments	3.42	3.42	3.39
Staff collaborates with consumers in setting their goals	3.47	3.49	3.52

Staff does not discuss personal issues of one consumer with another consumer	3.51	3.36	3.51

Highest Category: Conducting Intake Assessments -Intake Assessment Follow-Up: Developing Goals and Plans (3.38)

Lowest Ranking Questions

Question	Average Score Overall	Clinical Program Score	Clinical Role Score
The program incorporates child-friendly decorations and materials	2.56	2.5	2.4
The program provides a space for children to play	2.47	2.45	2.32
Material is posted about traumatic stress (e.g. what it is, how it impacts people, and available trauma-specific resources)	2.52	2.43	2.38

Lowest Category: Reviewing Policies (2.77)

*Scores ranged from 1-strongly disagree to 4-strongly agree

Questions answered with: "Do Not Know" or "Does Not Apply" Most Often

Question	Number not answered	Percent of total Responses
Conducting Intake Assessments -The intake assessment includes questions about: Children's history of physical health issues	163	64%
Conducting Intake Assessments -The intake assessment includes questions about: Children's history of mental health issues	162	64%
Conducting Intake Assessments -The intake assessment includes questions about: Children's achievement of developmental tasks	153	60%
Conducting Intake Assessments -The intake assessment includes questions about: Children's trauma exposure (e.g. neglect, abuse, exposure to violence)	150	59%

The program involves consumers in its review of policies	143	56%
Conducting Intake Assessments -The intake assessment includes questions about: Quality of relationship with child or children (e.g. caregiver/child attachment)	130	51%
Conducting Intake Assessments -The intake assessment includes questions about: Previous head injury	128	50%
The program recruits former consumers to serve in an advisory capacity	127	50%
Former consumers are invited to share their thoughts, ideas, and experiences with the program	127	50%
The program has access to a clinician with expertise in trauma and trauma-related interventions (on-staff or available for regular consultation)	122	48%

Questions answered with: "Do Not Know" or "Does Not Apply" Least Often

Question	Number not answered	Percent of total Responses
Staff members have regular team meetings	6	2%
Staff members have a regularly scheduled time for individual supervision	12	5%
Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress-reducing strategies)	16	6%
Training and Education Staff - Staff at all levels of the program receive training and education on the following topics: What traumatic stress is	20	8%
Training and Education Staff - Staff at all levels of the program receive training and education on the following topics: The relationship between mental health and trauma	21	8%
The program has a formal system for reviewing staff performance	21	8%
Bathrooms are well lit	21	8%

AMHS

Highest Ranking Questions

Question	Average Score	Percent who answered "DNK" or "DNA"
Staff members have regular team meetings	3.43	4%
Staff does not discuss personal issues of one consumer with another consumer	3.43	6%
There are private, confidential spaces available to conduct intake assessments	3.38	31%

Lowest Ranking Questions*

Question	Average Score	Percent who answered "DNK" or "DNA"
Staff members ask consumers for their definitions of physical safety	2.38	35%
Material is posted about traumatic stress (e.g. what it is, how it impacts people, and available trauma-specific resources)	2.41	29%
Each consumer has a written crisis prevention plan which includes a list of triggers, strategies, and responses which are helpful and those that are not helpful and a list of persons the consumer can go to for support	2.44	40%

*Removing for children specific questions

Questions answered with: "Do Not Know" or "Does Not Apply" Most Often*

Question	Percent of AMHS Responses
Written safety plans are incorporated into consumers' individual goals and plans	44%
The program recruits former consumers to serve in an advisory capacity	47%

Former consumers are invited to share their thoughts, ideas, and experiences with the program	47%
The program reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors	47%
The program involves consumers in its review of policies	54%

*Removing for children specific questions

Questions answered with: "Do Not Know" or "Does Not Apply" Least Often

Question	Percent of total AMHS Responses
The common areas within the program are well lit	3%
Bathrooms are well lit	3%
Staff shows acceptance for personal, religious, or spiritual practices	3%
Staff and other professionals do not talk about consumers in common spaces	3%

CSDD

Highest Ranking Questions

Question	Average Score	Percent who answered "DNK" or "DNA"
Staff does not discuss personal issues of one consumer with another consumer	3.44	4%
Re-assessments are done on an on-going and consistent basis	3.43	30%
Staff collaborates with consumers in setting their goals	3.51	26%

*"DNK" = Do not know, "DNA"= Does not apply

Lowest Ranking Questions*

Question	Average Score	Percent who answered

		"DNK" or "DNA"
Topics related to trauma are addressed in team meetings	2.15	4%
Material is posted about traumatic stress (e.g. what it is, how it impacts people, and available trauma-specific resources)	2.15	20%
Each consumer has a written crisis prevention plan which includes a list of triggers, strategies, and responses which are helpful and those that are not helpful and a list of persons the consumer can go to forsupport	2.05	26%

*Removing for children specific questions

Questions answered with: "Do Not Know" or "Does Not Apply" Most Often*

Question	Percent of CSDD Responses
The program has access to a clinician with expertise in trauma and trauma-related interventions (on-staff or available for regular consultation)	46%
The program has a written statement that includes a commitment to understanding trauma and engaging in trauma-sensitive practices	48%
The program reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors	46%
The program involves consumers in its review of policies	48%

*Removing for children specific questions

Questions answered with: "Do Not Know" or "Does Not Apply" Least Often

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

FF

Highest Ranking Questions

Question	Average Score	Percent who answered "DNK" or "DNA"
Staff members have regular team meetings	3.54	0%
Staff does not discuss personal issues of one consumer with another consumer	3.66	7%
Staff collaborates with consumers in setting their goals	3.68	17%

Lowest Ranking Questions

Question	Average Score	Percent who answered "DNK" or "DNA"
Cultural differences in how people understand and respond to trauma	2.56	5%
The program provides consumers with opportunities to make suggestions about ways to improve/change the physical space	2.50	27%
Material is posted about traumatic stress (e.g. what it is, how it impacts people, and available trauma-specific resources)	2.45	29%

Questions answered with: "Do Not Know" or "Does Not Apply" Most Often

Question	Percent of FF Responses
The program recruits former consumers to serve in an advisory capacity	44%
The program reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors	46%
The program involves consumers in its review of policies	66%

Questions answered with: "Do Not Know" or "Does Not Apply" Least Often

Question	Percent of total Responses
Staff members have regular team meetings	0%
The program helps staff members debrief after a crisis	0%

ITRS

Highest Ranking Questions

Question	Average Score	Percent who answered "DNK" or "DNA"
The program informs consumers about the extent and limits of privacy and confidentiality (e.g. the kinds of records that are kept and where, who has access to this information, and when it is mandatory to report information to child welfare or police)	3.48	0%
Staff does not discuss personal issues of one consumer with another consumer	3.52	0%
Staff collaborates with consumers in setting their goals	3.50	20%

Lowest Ranking Questions

Question	Average Score	Percent who answered "DNK" or "DNA"
Part of supervision time is used to help staff members understand their own stress reactions	2.77	12%

Outside agencies with expertise in cultural competence provide on-going training and consultation	2.71	32%
The program recruits former consumers to serve in an advisory capacity	2.77	48%
The program involves consumers in its review of policies	2.60	40%

*Removing for children Specific Questions **Ranked Most Often for "DNK" or "DNK"

Questions answered with: "Do Not Know" or "Does Not Apply" Most Often

Question	Percent of total Responses
The program provides consumers with opportunities to make suggestions about ways to improve/change the physical space	52%
Staff/consumers are allowed to prepare or have ethnic-specific foods	48%
The program recruits former consumers to serve in an advisory capacity	48%

Questions answered with: "Do Not Know" or "Does Not Apply" Least Often

Question	Percent of total Responses
The relationship between homelessness and trauma	0%
Different cultures (e.g. different cultural practices, beliefs, rituals)	0%
Cultural differences in how people understand and respond to trauma	0%
De-escalation strategies (i.e. ways to help people calm down before reaching the point of crisis)	0%
Staff members have regular team meetings	0%

Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress-reducing strategies)	0%
Staff members have a regularly scheduled time for individual supervision	0%
The program helps staff members debrief after a crisis	0%
The program informs consumers about the extent and limits of privacy and confidentiality (e.g. the kinds of records that are kept and where, who has access to this information, and when it is mandatory to report information to child welfare or police)	0%
Staff and other professionals do not talk about consumers in common spaces	0%
Staff does not discuss personal issues of one consumer with another consumer	0%

QCSRR

Highest Ranking Questions

Question	Average Score	Percent who answered "DNK" or "DNA"
Staff members have a regularly scheduled time for individual supervision	3.55	12%
The environment outside the program is well lit	3.59	32%
The common areas within the program are well lit	3.55	20%
Bathrooms are well lit	3.60	20%

Lowest Ranking Questions

Question	Average Score	Percent who answered "DNK" or "DNA"
What is asked in the intake assessment	2.65	32%
Topics related to trauma are addressed in team meetings	2.53	24%
Part of supervision time is used to help staff members understand their own stress reactions	2.67	16%

Questions answered with: "Do Not Know" or "Does Not Apply" Most Often

Question	Percent of total Responses
Staff members ask consumers for their definitions of physical safety	80%
The program informs consumers about why questions are being asked	88%
The program informs consumers about what will be shared with others and why	80%
Throughout the assessment process, the program staff observes consumers on how they are doing and responds appropriately	84%
The program educates consumers about traumatic stress and triggers	80%

Questions answered with: "Do Not Know" or "Does Not Apply" Least Often

Question	Percent of total Responses
What traumatic stress is	0%
How traumatic stress affects the brain and body	4%
The relationship between mental health and trauma	4%
Different cultures (e.g. different cultural practices, beliefs, rituals)	4%
Cultural differences in how people understand and respond to trauma	4%
De-escalation strategies (i.e. ways to help people calm down before reaching the point of crisis)	4%
How to establish and maintain healthy professional boundaries	4%
Staff members have regular team meetings	4%
Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress-reducing strategies)	4%
The program provides opportunities for on-going staff evaluation of the program/agency	4%

GA/HR/IS/Finance

Highest Ranking Questions

Question	Average Score	Percent who answered

		"DNK" or "DNA"
Staff members have a regularly scheduled time for individual supervision	3.67	49%
The environment outside the program is well lit	3.75	90%
The common areas within the program are well lit	3.63	80%
Bathrooms are well lit	3.67	49%

Lowest Ranking Questions

Question	Average Score	Percent who answered "DNK" or "DNA"
Topics related to trauma are addressed in team meetings	2.72	39%
Part of supervision time is used to help staff members understand how their stress reactions impact their work with consumers	2.65	59%
The program involves consumers in its review of policies	2.75	71%

Questions answered with: "Do Not Know" or "Does Not Apply" Most Often

Question	Percent of total Responses
Each consumer has a written crisis prevention plan which includes a list of triggers, strategies, and responses which are helpful and those that are not helpful and a list of persons the consumer can go to for support	85%
Staff members ask consumers for their definitions of emotional safety	88%
There are private, confidential spaces available to conduct intake assessments	85%
The program informs consumers about why questions are being asked	88%
The program provides an adult translator for the assessment process if needed	85%
Re-assessments are done on an on-going and consistent basis	85%
Staff collaborates with consumers in setting their goals	85%

Before leaving the program, consumers and staff develop a plan to address any future needs	85%
The program provides opportunities for care coordination for services not provided within that organization	88%
The program educates consumers about traumatic stress and triggers	88%
The program has access to a clinician with expertise in trauma and trauma-related interventions (on-staff or available for regular consultation)	90%
Current consumers are given opportunities to evaluate the program and offer their suggestions for improvement in anonymous/confidential ways (e.g. suggestions boxes, regular satisfaction surveys, meetings focused on necessary improvements, etc)	85%

Questions answered with: "Do Not Know" or "Does Not Apply" Least Often

Question	Percent of total Responses
Staff members have regular team meetings	2%
Staff members have a regularly scheduled time for individual supervision	7%
The program has a formal system for reviewing staff performance	12%

Behavior Treatment Plan Review Report

Quality Assessment and Performance Program
Behavior Treatment Data Review FY21Q4

Title of Measure: Behavior Review Data

Summary of Project: The study is required by the Michigan Department of Health

and Human Services (MDHHS). The data collected is based on the definition and requirements that have been set forth within the Standards for Behavioral Treatment Review attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract.

MSHN delegates the responsibility for the collection and evaluation of data to each local CMHSP Behavior Treatment Review Committee (BTRC), including the evaluation of effectiveness of the BTRC by stakeholders. Data will be collected and reviewed quarterly by the CMHSP where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. This data is to be reviewed as part of the CMHSP Quality Improvement Program (QIP) and reported to the PIHP. MSHN monitors that the local CMHSP BTRC follows the requirements outlined within the Standards for Behavior Treatment Review Committees. The following measures are trend data; therefore, no external standard exists.
MSHN utilizes a linear trend over a minimum of 4 reporting periods. The trend is used to identify any areas requiring further analysis to improve safety of the individuals we serve. This is done by reviewing quarterly data to identify causal factors contributing to an increase rate and an upward trend. The expectation is that each quarter will demonstrate improvement from the previous quarter. CMHSP and/or MSHN will implement interventions to improve safety, thereby changing the direction of the trend. FY20Q3 MSHN modified the method for data collection. The data measures the plans that have been reviewed each quarter. The Behavior Treatment Standard requires that at minimum all plans should be reviewed quarterly. Those CMHSPs that have had a significant increase or decrease should note the reason for the difference.

Data Analysis

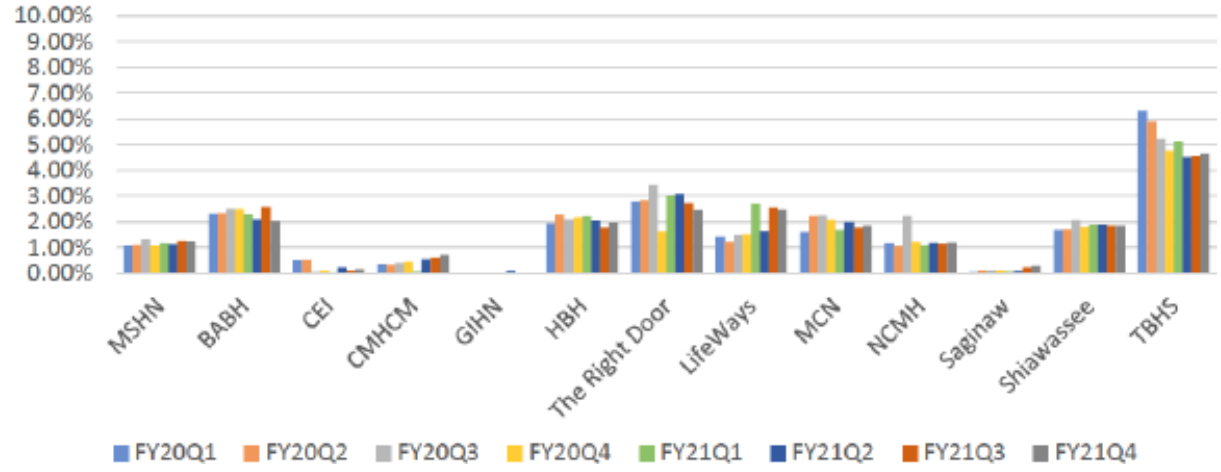
Study Question 1**:** The proportion of individuals with a restrictive and/ or intrusive behavior treatment plan will be monitored quarterly to address causal factors for positive or negative change**.**

Numerator: The total number of plans with restrictive and intrusive interventions reviewed during the reporting period.
Denominator: The total number of individuals who are actively receiving services during the reporting period.

This question reviews the rate per 100 of plans approved with restrictive and

intrusive interventions per the number of individuals who have been served per quarter. Currently each CMHSP has a committee in place to approve or disapprove plans which include restrictive and intrusive interventions as required on a quarterly basis.

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



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

1. The number of plans may be attributed to the increased monitoring and oversight from MDHHS as it relates to the monthly review of HSW re-certification; and increased monitoring of the Individual plans of Service, Behavior Treatment Plans and home visits where unreported restrictions are identified; and more accurateidentification and oversight ofrestrictions.
2. The incorporation of the individuals receiving the autism benefit into theCM HSPBTRC process. Most of the CMHSPs have begun to review plans thathave restrictive or physicalinterventionsforindividualsreceivingApplied Behavioral Analysis(ABA) services.

3. Plans that include Medication for behavioral assistance are being incorporated into the review process. Each CMHSPhas a process to begin to look at individuals (children and adult s) receiving medication for behavioral assistance. However, the capacity to review each child on medication has been identified as a barrier.

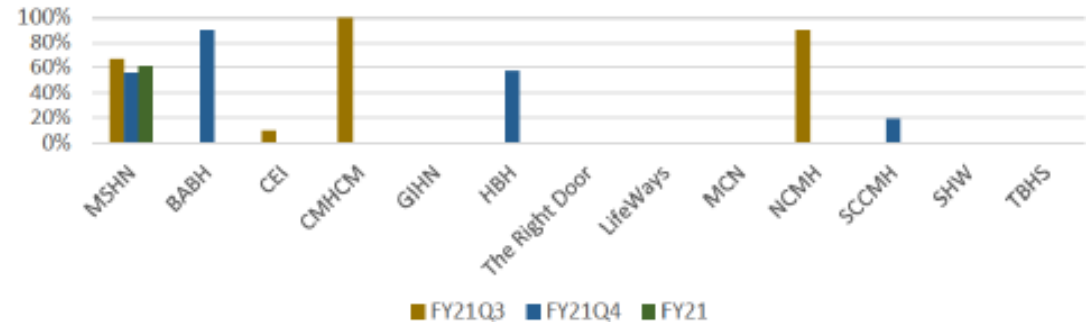
Goal 2: MSHN will ensure behavioral treatment plans are developed in accordance with the Standards for Behavior Treatment Plan Review Committees.

Study Question 2: MSHN will ensure behavioral treatment plans are developed in accordance with the Standards for Behavior Treatment Plan Review Committees.

Numerator: The number of Behavior Treatment standards meeting full compliance through the monthly delegated managed care reviews.

Denominator: The tot al number of Behavior Treatment Standards reviewed through the monthly delegated managed care reviews.

Figure 2. Percentage of Behavioral Treatment Plan Standards Met



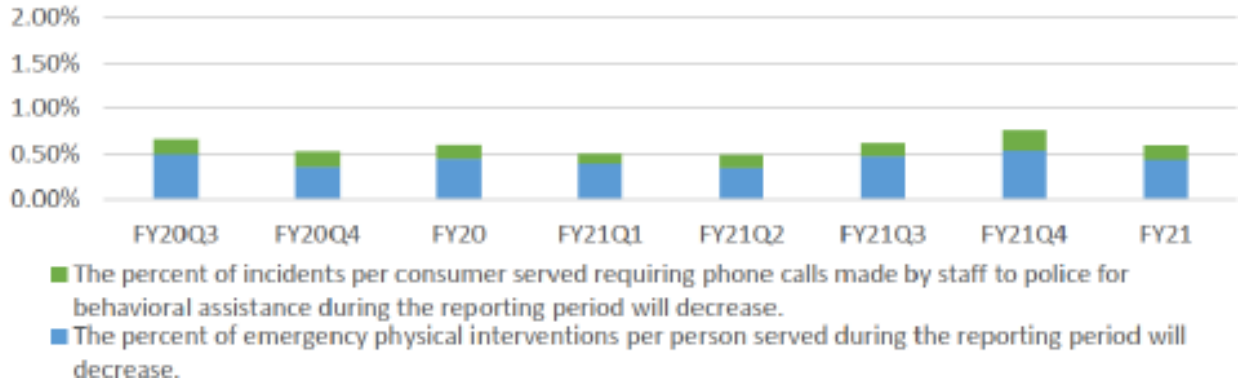
Goal 3: The percent of emergency physical interventions per person served during the reporting period will demonstrate a decrease from previous measurement period.

Study Question 3: Has the proportion of incident s in which the use of emergency intervention decreased over time (Figure 3)?

Numerator: The total numberr of emergency interventions reviewed during the reporting period.

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

Figure 3. The percentage of emergency interventions used per person served

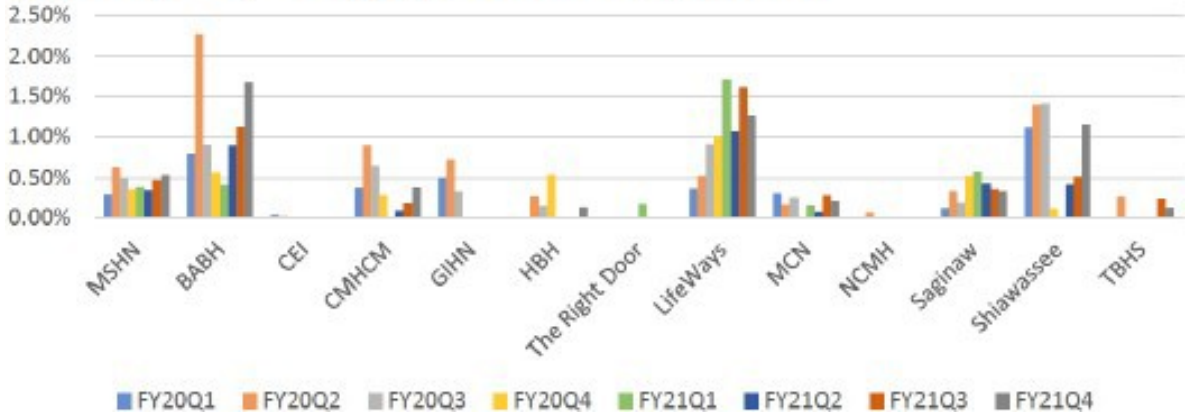


Study Question 3a: Has the proportion of incidents in w hic h the use of emergency physical intervention decreased over time?

Numerator: The total number of emergency physical interventions (EPI) reviewed during the reporting period. (Tot al # of physical management, Column Q)

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

Figure 3a. The percentage of emergency physical intervention per person served



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

Numerator: The total number of incidents requiring phone calls made by staff to police for behavioral assistance reviewed during the reporting period. (Total # of 911 calls, Column R)

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

Figure 3b. The percentage of 911 calls for behavioral assistance per person served

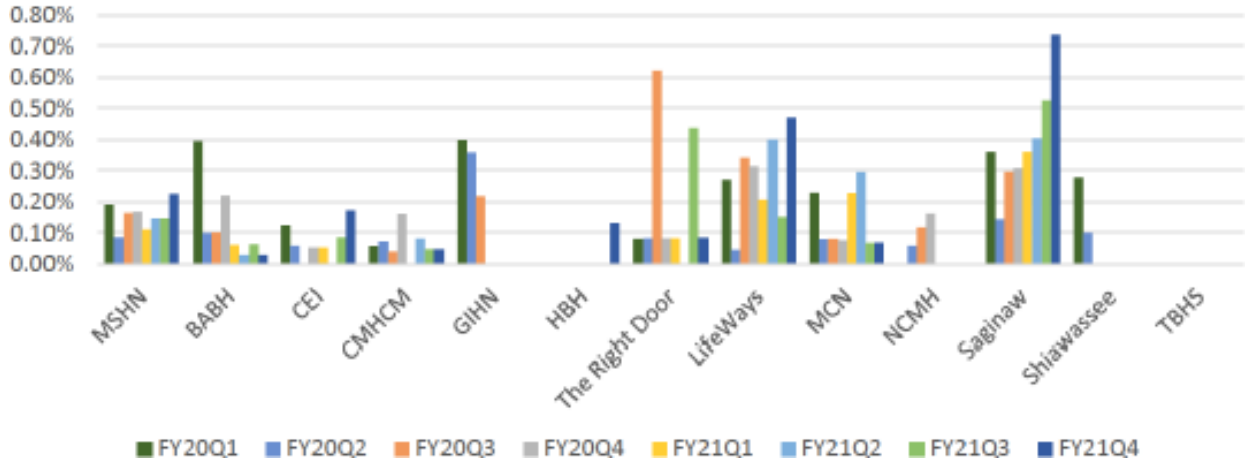


Figure 4a. Behavior Treatment Data Trends

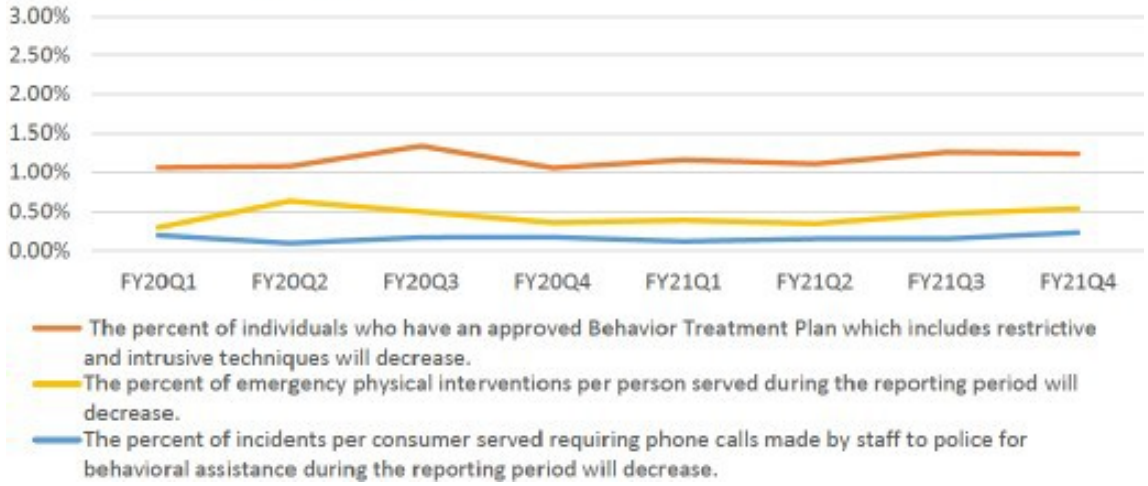


Figure 4b. The percentage of BTP by waiver program with an emergency intervention by benefit program reviewed during the reporting period.

Program	# in Program	% of Total in Program per persons served	# Physical Intervention	% Physical Intervention per benefit program	# 911 Calls	% 911 Calls per benefit program
Autism	23	6.01%	29	12.02%	1	4.35%
CWP	4	1.04%	0	0.00%	0	0.00%
HSW	202	52.74%	97	57.45%	29	14.36%
SEDW	1	0.26%	0	0.72%	1	100.00%
No Waiver	151	39.43%	40	29.81%	39	25.83%
CWP-Autism	1	0.26%	0	0.00%	0	0.00%
SED-Autism	0	0.00%	0	0.00%	0	0.00%
HSW-Autism	1	0.26%	0	0.00%	0	0.00%
Total	383	100%	166	NA	70	NA

Conclusions:

Goal 1: The pro port ion of individuals with a restrictive and/ or intrusive behavior treatment plan will be monitored quarterly to address causal factors for positive or negative change.

The percent of individuals served who have a behavior plan that include intrusive or restrictive interventions has increased du ring this past quarter for MSHN. This could be a result of additional education and oversight to ensure plans that include intrusive and restrictive interventions are monitored in accordance with the

MDHHS Behavioral Treatment Standards. The current rate for the region is 1.24% (383/30873) this is a decrease from FY21Q3 (1.26%-386/30636).

Goal 2: MSHN will ensure behavioral treatment plans are developed in accordance with the Standards for Behavior Treatment Plan Review Committees.
This measure began in FY21Q3. Six CMHSP Participants were reviewed since the onset of the measure. Improvement is expected to be seen at the end of FY22 when each CMHSP has competed the oversight review cycle, and received training based on the initial review. Currently MSHN has a score of 61% (77/126). The standard of 95% was not met.

Goal 3: The percent of emergency interventions per person served during the reporting period will demonstrate a decrease from previous measurement period. The standard was not met. (236/30873)

Goal 3a: The percent of emergency physical interventions per person served during the reporting period will demonstrate a decrease from previous measurement period. MSHN demonstrated an increase in physical interventions in FY21Q4 (.54% - 166/30873) compared to FY21Q3 (.47%). Thirty-five individuals received a physical intervention. Twenty received more than one physical intervention during the reporting period.

Goal 3b: The percent of incidents requiring phone calls made by staff to police for behavioral assistance per person served will demonstrate a decrease from previous measurement period. MSHN demonstrated an increase in 911 calls made by staff for behavioral assistance in FY21Q4 .23% (70/30873) compared to FY21Q3 .15%. This standard was not met.

Recommendations:

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

- Effective data collection to measure improvements and identify continued areas of risk. Status: *New data collection is effective for FY22Q1. This has been modified to include the number of behavior treatment plans with restrictive and intrusive interventions, the number 911 calls, and emergency physical interventions. The compliance with the Behavioral Treatment Standards will be reviewed through theDMC Oversight process.*
- Develop minimal competencies based on scope of practice for individuals who write behavior treatment plans. Status: *Not addressed at this time.*

- The BTPRC has requested training to assist in the incorporation of the required elements of the Behavior Treatment Standards. It is recommended that a regional training occur with attendance strongly encouraged by clinical staff and members of each local BTPRC, to ensure all restrictive and intrusive interventions are reviewed, approved and written into a plan as required by MDHHS.

  Status: *Training information continues to be distributed as provided by MDHHS and the Board Association. BTPR work group in concert with CLC will develop training as needed based on the DMC and external audit results.*

- Training on writing Individual Plans of Service to ensure that inclusion of restrictions is identified and referred to BTPRC as needed.
  Status: *MSHN is in process of developing a workplan to address IPOS training for the region to support the current strategic initiative on IPOS training, and the MDHHS waiver review corrective action plan.*

Completed By: Sandy Gettel MSHN Quality Manager Date: 11/11/2021
Reviewed By: Quality Improvement Council Date: 11/18/2021

Grievances, Appeals, and Fair Hearings

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

	Total in FY 20	Total in FY21
# of Grievances	14	12
# of Appeals	17	5
# of Fair Hearings	4	0

Incident Reporting

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

Category	Incident Reports
Arrest	**1**
Choking	**4**
Exposure to Blood/Bodily Fluids	**6**
Missing Recipient	**10**
Serious Self Injury	**12**
Serious Property Damage	**36**
Death	**145**
Serious Aggressive Event	**245**
Other General Incident	**396**
Emergency Care	**431**
Med	**2046**
Total	**3332**

Medication IRs

In FY21, the process error mentioned above led to a large number of medication incident reports that were not reviewed, which led to a staggering drop in numbers compared to the previous year.

Med IR Category	Number of Reports
Missed Med	1948
Wrong Dose	50
Wrong Time/Day	23
Staff Signing Error	6
Wrong Person/Med	13
Total	**2046**

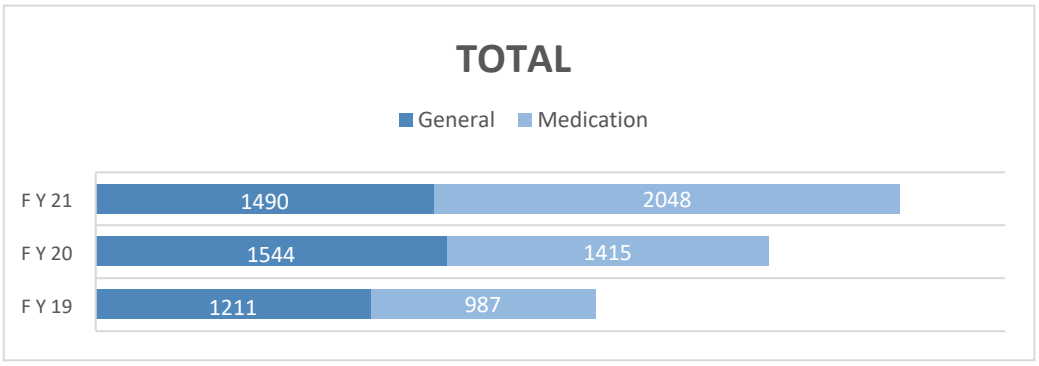
Summary of missed Meds:

Reason	IRs
Refused after prompting	548
No reason provided/Incomplete	1177
Med unavailable (pharmacy)	23
Refused (consumer unavailable)	39
Med unavailable for other reason	75
Refused due to illness	11
Staff Error	77
Total	368

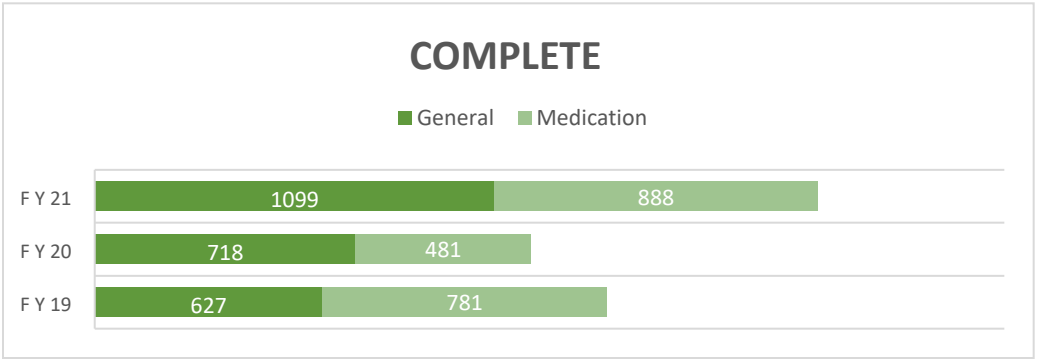
Emergency Care IRs

Emergency Care	# of IRs
Illness	**299**
EMT	170
Hospitalization	107
No hospital or EMT	21
Injury	**99**
EMT	78
Hospitalization	15
No hospital or EMT	6
Not Specified	**33**
EMT	17
Hospitalization	5
No hospital or EMT	11
Grand Total	**431**

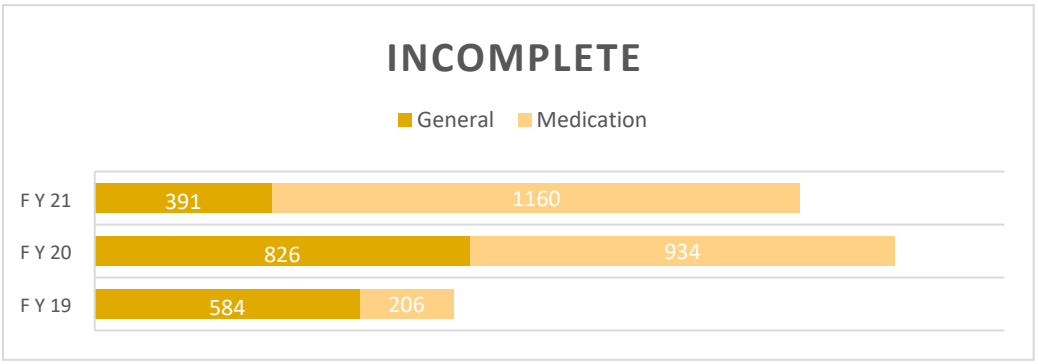
In FY20, a process error in incident reporting leaving incidents incomplete or not reviewed was identified. The Medical Director, Quality Improvement Team, and Clinical Programs have begun meeting to create a protocol to avoid these oversights. In FY21, all incomplete incidents were reviewed by Quality Improvement, but were indicated as incomplete for record keeping purposes. Agency goals for FY22 and beyond are to have fewer incomplete incidents each year until a point is reached where all IRs are reviewed by programs before reaching QI.



A breakdown of incident reports, including complete and incomplete from the past three fiscal years.



A breakdown of completed incident reports from the past three fiscal years.

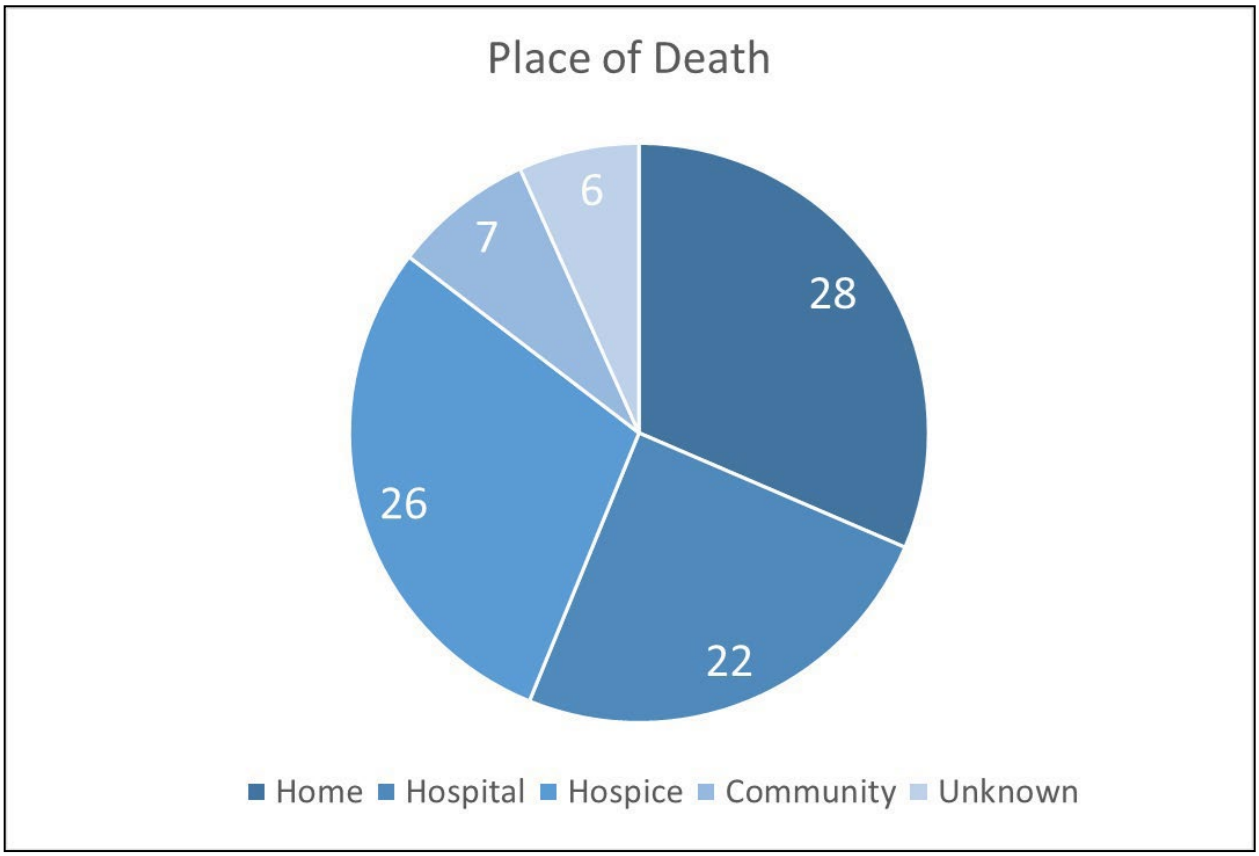


A breakdown of incomplete incident reports from the past three fiscal years.

Deaths

Cause	# of Incident
Vascular	15
Diabetes*	15
Accidental	14
Suicide	8
Cancer	6
Overdose- Accidental	5
Natural- Unknown	9
Neurological Disorder	4
Aspiration	4
Lung Disease	3
Pneumonia	3
Infection	2
Complications of Treatment	2
Liver Disease	1
Total	92

***1 COVID-19 related death reported as diabetes due to State regulations**



Age	
Range	15-90
Median	62.5
Mean	57

Program	# of incidents
AMHS	68
CSDD	17
ITRS	6
FF	1

Total	92

Staff Injuries and Vehicles Accidents

In FY21, there were 27 workplace employee related injuries or illnesses reported to Human Resources which required medical treatment. There were 21 workplace injuries or illnesses reported where no medical treatment was needed.

FY21 also included five vehicle accidents, one of which resulted in an employee injury.

Sentinel Events

CMHA-CEI reported two sentinel events in FY21. An unexpected death at our Assertive Community Treatment (ACT) program on 6/15/2021, and an unexpected death at our Crisis Residential Unit on 8/4/2021. Both of these events were reported to MSHN, the ACT event reported to CARF, and the BCU event to Michigan Department of License and Regulatory Affairs.

Medicaid Event Verification Audit

For FY21, there were two Medicaid Event Verification audits held by MSHN. June and December 2021.

Findings from the June 2021 MEV are as follows:

- H0019 Core services were not attained. Lines 63, 64, 67, 69, 70, 74, 76, 79, 80, 83, 85, 86, 88.

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

- It is noteworthy to acknowledge that during this timeframe there was a COVID-19 outbreak at the House of Commons (HOC) which lead to staff absences. Our action plan moving forward includes documentation of when staff are offsite as well as if there are any disruptions in program coverage. In addition, for the remainder of the fiscal year, ITRS is implementing a program wide volunteer list to assist with program coverage; including in the event of another health/safety emergency staffing need.
- The claims will be voided and recouped.

Findings from the December 2021 MEV are as follows:

- Line 195. Documentation indicates encounter was attendance at a Wraparound meeting. Per encounter reporting rules, when other service providers attend Wraparound meetings, they do not report the activity separately.
- Lines 56, 830, 832, 834. Documentation indicates service was provided strictly for the purpose of providing transportation to the beneficiary. No goals or objectives were addressed to support the provision of community living supports.
- Lines 162, 163, 165, 171, 176. Wraparound services were reported as H2021. Beneficiary was a recipient of the Children with Serious Emotional Disturbances Waiver; therefore, the Wraparound service should be reported as H2022.
- Lines 254, 255, 256, 261, 262, 268, 269, 272, 273, 274, 278, 279, 280, 281, 286, 287, 288, 289, 295, 296, 297, 298. Missing beneficiary specific IPOS training record for Amanda Mealy.

- Lines 405. 406, 407, 410, 411, 412, 415, 416, 417, 418, 423, 427, 428, 429, 431, 432, 433, 434, 436, 437, 438, 441, 444, 446, 448, 450, 452. Missing beneficiary specific IPOS training

record for behavior technicians. CEI CMH has confirmed evidence of training is not available from provider.

- Lines 1 through 10, 12 through 22, 24 through 32, 34 through 51, 73, 74, 77 through 82, 84 through 91, 93 through 100, 102 through 109, 111 through 114, and 116 through 119. Documentation indicates services are provided through a self-determination arrangement yet are missing the U7 modifier.
- Line 23. Missing HK modifier. FI service (T2025) became a HSW reportable service on 10-1-20.
- Lines 160, 161, 172, 174, 177, 189, 201, and 203. Encounters were reported as "family, beneficiary not present" yet body of each progress notes indicates child was present.

- Lines 164, 166, 167, 168, 169, 173, 175, 178, 179, 182, 183, 184, 186, 187, 190, 191, 196, 197, 199, 200. Encounters were provided by a Parent Support Partner but reported without the HM modifier. Encounters were also provided to the family without the beneficiary present but did not include the HS modifier.
- Line 231. Missing HS modifier. Encounter reported as client present. Body of the note indicates, "therapist met with parent, client was not at home for session."

- Lines 265, 302. Missing HS modifier. Documentation does not support presence of beneficiary at the family training session.
- Line 641. Missing GT modifier. Body of progress note indicates "therapist met with client on Zoom due to family request."
- Lines 254, 255, 256, 261, 262, 268, 269, 272, 273, 274, 278, 279, 280, 281, 286, 287, 288, 289, 295, 296, 297, 298. Documentation indicates services are provided through a self-determination arrangement yet are missing the U7 modifier.

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

- Line 195 - CMHA-CEI's Finance Department will work with the clinical program and void the Line 195 claim within 30 days of CAP approval.
- Lines 56, 830, 832, 834 will be placed in error status and be voided by CMHA-CEI's Finance Department.
- Lines 162, 163, 165, 176 will be voided and correctly resubmitted as H2022 by CMHA-CEI's Finance Department and the clinical program.
- Line 171 was found to be originally entered as H2022 so no correction is needed.
- Lines 254, 255, 256, 261, 262, 268, 269, 272, 273, 274, 278, 279, 280, 281, 286, 287, 288, 289, 295, 296, 297, 298, 405. 406, 407, 410, 411, 412, 415, 416, 417, 418, 423, 427, 428, 429, 431, 432, 433, 434, 436, 437, 438, 441, 444, 446, 448, 450, 452 that were missing beneficiary specific IPOS training will be voided and payment for those services will be recouped

from the provider. CMHA-CEI Quality Advisor will follow up with the provider and remind of the IPOS training requirement.

- Line 23 will be voided and re-submitted with HK modifier.
- Lines 160, 161, 172, 174, 177, 189, 201, and 203 will be voided and re-submitted without the HS modifier.
- Lines 164, 166, 167, 168, 169, 173, 175, 178, 179, 182, 183, 184, 186, 187, 190, 191, 196, 197, 199, 200 will be voided and re-submitted with the HM and HS modifiers.
- Line 231 will be voided and re-submitted with the HS modifier.
- Lines 265 and 302 have been updated to include the HS modifier. CMHA-CEI's Finance Department will work with the clinical program for Line 641 to void the claim and correctly re-submit with the missing modifier within 30 days of CAP approval.
- Lines 1 through 10, 12 through 22, 24 through 32, 34 through 51, 73, 74, 77 through 82, 84 through 91, 93 through 100, 102 through 109, 111 through 114, and 116 through 119 and Lines 254, 255, 256, 261, 262, 268, 269, 272, 273, 274, 278, 279, 280, 281, 286, 287, 288, 289, 295, 296, 297, 298 - CMHA-CEI's Finance Department reviewed the internal system and discovered an error that did not allow the U7 modifier to be reported in the encounters. CMHA-CEI's IS team has updated the setting and an encounter run will be completed on 3/15/22 to replace the missing U7 modifiers and re-submit the claims.

FY21 Chart Review Results

Chart Review Process

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

Reviews will be completed at least quarterly and will address:

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

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

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

Chart Review Schedule

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

Timeframe	Programs for Chart Review
FY21 1st Quarter	HCBS
FY21 2nd Quarter	Residential (AMHS and CSDD) {HCBS Out of Compliance and HS cases}
FY21 3rd Quarter	Mobile Crisis
FY21 4th Quarter	Self-Determination

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

FY21 Q1 Chart Review Results

HCBS Chart Review FY21 Quarter 1				
BH Teds	# of Charts Reviewed	Overall %	Cost Center 6000	Cost Center 8000
Is the living arrangement selection correct on the most recent Bh-Teds document?	74	97%	86%	99%
Is the detailed residential care living arrangement selection correct in the most recent Bh-teds document?	74	92%	71%	94%
Pre Planning				
It is documented that information about filing a RR complaint was provided to the consumer in a way they can understand and use.	74	66%	71%	65%
Person Centered Planning / Individual Plan of Service				
Was the Treatment Plan completed Timely? (within 365 days of prior Treatment plan)	74	91%	57%	95%
There are NO resitriction on the individual's ability to choose among services and providers including those in the larger community? (In this context services/provider refers to dentist, PCP, getting haircut, etc.)	74	81%	86%	81%
There are NO restriction on the individual's ability to come and go from the home?	74	64%	HCSB	61%
There are NO restriction on the individual's ability to move inside and outside the home when they want?	74	71%	86%	69%
Clinical Chart				
Is it documented that the individual had choice in picking their direct support workers?	74	58%	29%	61%
Is it documented that individual can change services and supports as they wish?	74	63%	36%	66%

Is there documentation that the person had choice in choosing where to live?	74	67%	79%	66%
Is it documented that individual had choice in choosing their housemates and roommates?	74	45%	29%	46%
Did they choose the agency who provides their residential services and supports?	74	50%	36%	51%
Total Charts		74	7	67

FY21 Q2 Chart Review Results

HSW Chart Review FY21 Q2		
	# of Charts Reviewed	Overall %
Intake/Assessment:		
Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	36	76%
Are consumer's needs & wants are documented?	36	99%
Consumer chart reflects input and coordination with others involved in treatment?	36	99%
Present and history of behavior and/or symptoms are documented and specify if observed or reported	36	94%
Substance use (current and history) included in assessment?	30	98%
Current physical health conditions are identified?	31	100%
Current health care providers are identified?	36	97%
Previous behavioral health treatment and response to treatment identified?	36	99%
Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	34	74%

Did crisis screening and other life domain needs screening occur?	33	100%
Was consumer offered the opportunity to develop a Crisis Plan?	36	97%
CWP Only:Child is developmentally disabled.	2	100%
CWP Only: The child is in need of active treatment	2	100%
Pre-Planning		
Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan?	36	69%
Pre-planning addressed when and where the meeting will be held.	35	97%
Pre-planning addressed who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).	36	92%
Pre-planning identified any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and making a plan for how to deal with them.	35	0%
Pre-planning addressed the specific PCP format or tool chosen by the person to be used for PCP.	36	0%
Pre-planning addressed what accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).	34	96%
Pre-planning addressed who will facilitate the meeting.	36	97%
Pre-planning addressed who will take notes about what is discussed at the meeting.	36	86%
When Applicable (Autism, Self-Determination, Waiver, Home-Based, CWP): Evidence enrollee had an ability to choose among various waiver services.	11	91%
When Applicable (Autism, Self-Determination, Waiver, Home-Based, CWP): Evidence enrollee had an opportunity to choose their providers.	10	95%
Person Centered Planning /Individual Plan of Service		

The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	36	72%
The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	36	92%
The community and outcomes identified by the person and how progress toward achieving those outcomes will be measured.	35	69%
The services and supports needed by the person to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs, community resources, and natural supports.	35	97%
The setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment & work in competitive integrated settings, engage in community life, control person resources, and receive services in the community to the same degree of access as individuals not receiving services and supports from the mental health system.	35	84%
The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.	30	97%
Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports.	36	36%

There is documentation of any restriction or modification of additional conditions & documentation includes: 1. The specific & individualized assessed health or safety need. 2. The positive interventions and supports used prior to any modifications or additions to the PCP regarding health or safety needs. 3. Documentation of less intrusive methods of meeting the needs, that have been tried, but were not successful. 4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need. 5. A regular collection and review of data to measure the ongoing effectiveness of the modification. 6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. 7. Informed consent of the person to the proposed modification. 8. An assurance that the modification itself will not cause harm to the person.	14	93%
The services which the person chooses to obtain through arrangements that support self-determination.	3	67%
The estimated/prospective cost of services and supports authorized by the CMHSP	36	97%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	35	86%
The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	36	6%
A timeline for review.	30	95%
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	4	63%
If applicable, the IPOS addresses health and safety issues.	33	95%
If applicable, identified history of trauma is effectively addressed as part of PCP.	23	70%
For children's services: The plan is family-driven, and youth guided.	13	92%

Autism Only: Beneficiaries IPOS addresses the needs. A. As part of the IPOS, there is a comprehensive individualized ABA behavioral plan of care that includes specific targeted behaviors for improvement, along with measurable, achievable, and realistic goals for improvement. The IPOS must address risk factors identified for the child and family, specify how the risk factor may be minimized and describe the backup plan for each identified risk. For example, a risk factor might be how to ensure consistent staffing in the event a staff did not show up. The backup plan is that the agency has a staff who is already trained in this child's IPOS and that staff person can be sent in the event a staff does not show up to provide a service.	3	50%
For Crisis Residential: • IPOS is developed within 48-hours of admission. • Includes discharge planning information & need for aftercare/follow-up services • Includes case manager • If stay exceeds 14-days, interdisciplinary team develops a subsequent plan based on comprehensive assessments	1	50%
Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	36	38%
Consumer has ongoing opportunities to provide feedback on satisfaction with treatment, services, and progress towards valued outcomes?	35	94%
Documentation		
Consumer was provided written information related to Recipient Rights?	36	85%
Was consumer was informed of Informal Conflict Resolution?	36	79%
Consumer was given accurate and timely information about the Grievance and Appeal Process?	36	93%
Customer Service		
Decisions to deny or authorize service in an amount, duration or scope that is less than requested are made by a health care professional who has the appropriate clinical expertise in treating the consumer's condition or disease?	4	88%

The CMHSP provides Medicaid consumers with written service authorization decisions no later than 14 calendar days following receipt of a request for service authorization, unless the PIHP has authorized an extension; and the CMHSP provides Medicaid consumers with written Service authorization decisions no later than 72 hours following receipt of a request for expedited service authorization, if warranted by the consumer's health or functioning, unless the PIHP has authorized an extension.	7	100%
Reasons for decisions are clearly documented and available to the recipient.	1	100%
Delivery and Evaluation		
Are services being delivered consistent with plan in terms of scope, amount and duration?	36	53%
Monitoring and data collection on goals is occurring according to time frames established in plan?	36	72%
Are periodic reviews occurring according to time frames established in plan?	29	59%
Program Specific Service Delivery		
For ACT services: a. all members of the team routinely have contact with the individual b. right to withdraw consent c. majority of services occur in consumer home or community	4	88%
For medication services: • informed consent was obtained for all psychotropic medication • evidence consumer informed of their right to withdraw consent at any time	23	50%
Is there a physician prescription or referral for each specialized service (Physical Therapy, Occupational Therapy, Speech Therapy, etc.)?	3	67%
Is there direct access to a specialist, as appropriate for the individual's health care condition?	2	100%
Is there evidence of outreach activities following missed appointments?	13	88%
Is there evidence of coordination with Primary Care Physician in the record? If not, is there evidence of referral to a PCP? If client declined referral, is there documentation of client decline?	36	54%
For Home Based Services: Services are provided in the family home or community to an expected/acceptable frequency.	6	100%

For Home Based Services: A minimum of 4-hours of individual and/or family face-to-face home-based services per month are provided by the primary home-based services worker (or, if appropriate, the evidence-based practice therapist).	7	93%
For Self-Determination: There is a copy of the SD Budget	2	0%
There is a copy of the SD Agreement	2	75%
There is evidence that individual has assistance selecting, employing, and directing & retaining qualified providers.	4	75%
For Autism Benefit/Applied Behavioral Analysis: Beneficiaries ongoing determination of level of service (every six months) has evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with ABLLS-R or VB-MAPP.	2	100%
For Autism Benefit/Applied Behavioral Analysis: Observation Ratio: Number of Hours of ABA observation during a quarter are > to 10% of the total service provided.	2	100%
For all applicable Waiver Programs: The IPOS was reviewed both at intervals specified in the IPOS and when there were changes to the waiver participant's needs.	3	83%
For all applicable Waiver Programs: The IPOS is updated at least annually/365 days For 1915(i)- formal review of plan with individual and/or guardian completed.	4	100%
For all Waiver Programs: Individual provided information/education on how to report abuse/neglect/exploitation and other critical incidents.	4	75%
For all Waiver Programs: Individual served received health care appraisal.	4	50%
Discharge / Transfers		
For closed cases, was the discharge summary/transfer completed in a timely manner? (consistent with CMSHP policy)	1	100%
Does the discharge/transfer documentation include: a. Statement of the reason for discharge; and b. Individual's status /condition at discharge	1	100%
Integrated Physical and Mental Health care		

The CMHSP encourages all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services.	36	86%
As authorized by the consumer, the CMHSP includes the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the person-centered plan.	28	36%
The CMHSP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.	33	74%

Mobile Crisis FY21 Q3			
Children's Intensive Crisis Stabilization Services	Standard	# of Charts Reviewed	Overall %
Face to face contacts are occurring within one hour or less in urban counties and in two hours in rural counties from the time of the request for ICSS	12.2	23	69.6%
Services include: Assessment, Intensive individual counseling/psychotherapy, Family therapy, Skill building, Psychodeducation	12.3	23	93.5%
For children: ICSS staff consists of at least two who travel to the child or youth in crisis. One team member must be a Master's prepared Child Mental Health Professional (or Master's prepared QIDP, if applicable) and the second team member may be another professional or parapro under appropriate supervision.	12.4	23	97.8%
For children/youth: If the child or youth is a current recipient of CMHSP services, the existing IPOS and **crisis/safety plan must be updated**		15	63.3%
For children or youth who are not yet recipients of CMHSP services but are eligible for such services, a family-driven and youth-guided follow-up plan must be developed.		6	75.0%

If the child or youth is a current recipient of CMHSP services, there is evidence of the mobile intensive crisis stabilization team members notifying the primary therapist, case manager, or Wraparound facilitator, as applicable, of the contact with the mobile intensive crisis stabilization team the next business day.	12.6	15	73.3%
Evidence that a follow-up contact has been made with the child or youth and parent/caregiver by the primary therapist, case manager, or wraparound facilitator once the primary case holder was informed of the child or youth's contact with the ICSS team.		18	88.9%
If the child or youth is not yet a recipient of CMHSP services but is eligible for such services, the follow-up plan must include:	12.7		
-Appropriate referrals to mental health assessment and treatment resources and any other resources the child or youth and parent/caregiver may require		8	100.0%
- Next steps for obtaining needed services, timelines for those activities, and identifies the responsible parties.		8	93.8%
- The mobile intensive crisis stabilization team members have contacted the parent/caregiver by phone or face-to-face within seven business days to determine the status of the stated goals in the follow-up plan		14	82.1%

FY21 Q4 Chart Review Results

Self-Determination FY21 Q4		
	# of Charts Reviewed	Overall
Intake/Assessment:		
Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	63	74%
Are consumer's needs & wants are documented?	63	94%
Consumer chart reflects input and coordination with others involved in treatment?	63	95%
Present and history of behavior and/or symptoms are documented and specify if observed or reported	63	97%
Substance use (current and history) included in assessment?	62	76%
Current physical health conditions are identified?	63	99%
Current health care providers are identified?	62	98%

Previous behavioral health treatment and response to treatment identified?	63	97%
Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	59	88%
Did crisis screening and other life domain needs screening occur?	62	100%
Was consumer offered the opportunity to develop a Crisis Plan?	63	100%
Pre-Planning		
Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan?	63	85%
Pre-planning addressed when and where the meeting will be held.	63	100%
Pre-planning addressed who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).	63	100%
Pre-planning identified any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and making a plan for how to deal with them.	63	0%
Pre-planning addressed the specific PCP format or tool chosen by the person to be used for PCP.	63	0%
Pre-planning addressed what accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).	63	100%
Pre-planning addressed who will facilitate the meeting.	63	100%
Pre-planning addressed who will take notes about what is discussed at the meeting.	63	99%
When Applicable (Autism, Self-Determination, Waiver, Home-Based, CWP): Evidence enrollee had an ability to choose among various waiver services.	61	79%

When Applicable (Autism, Self-Determination, Waiver, Home-Based, CWP): Evidence enrollee had an opportunity to choose their providers.	61	79%
Person Centered Planning /Individual Plan of Service		
The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	63	71%
The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	63	95%
The community and outcomes identified by the person and how progress toward achieving those outcomes will be measured.	63	75%
The services and supports needed by the person to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs, community resources, and natural supports.	63	100%
The setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment & work in competitive integrated settings, engage in community life, control person resources, and receive services in the community to the same degree of access as individuals not receiving services and supports from the mental health system.	63	94%
The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.	63	94%
Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports.	63	100%

There is documentation of any restriction or modification of additional conditions & documentation includes: 1. The specific & individualized assessed health or safety need. 2. The positive interventions and supports used prior to any modifications or additions to the PCP regarding health or safety needs. 3. Documentation of less intrusive methods of meeting the needs, that have been tried, but were not successful. 4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need. 5. A regular collection and review of data to measure the ongoing effectiveness of the modification. 6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. 7. Informed consent of the person to the proposed modification. 8. An assurance that the modification itself will not cause harm to the person.	10	95%
The services which the person chooses to obtain through arrangements that support self-determination.	62	93%
The estimated/prospective cost of services and supports authorized by the CMHSP	63	100%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	63	87%
A timeline for review.	63	0%
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	63	100%
If applicable, the IPOS addresses health and safety issues.	63	93%
If applicable, identified history of trauma is effectively addressed as part of PCP.	27	54%
Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	63	55%
Consumer has ongoing opportunities to provide feedback on satisfaction with treatment, services, and progress towards valued outcomes?	63	89%

Documentation		
Consumer was provided written information related to Recipient Rights?	63	94%
Was consumer was informed of Informal Conflict Resolution?	63	100%
Consumer was given accurate and timely information about the Grievance and Appeal Process?	63	100%
Delivery and Evaluation		
Are services being delivered consistent with plan in terms of scope, amount and duration?	62	58%
Monitoring and data collection on goals is occurring according to time frames established in plan?	62	85%
Program Specific Service Delivery		
For Self-Determination: There is a copy of the SD Budget	62	2%
There is a copy of the SD Agreement	61	62%
There is evidence that individual has assistance selecting, employing, and directing & retaining qualified providers.	62	92%

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.

The majority of site reviews were conducted virtually in FY21. Some in-person site reviews resumed in August 2021 for follow-up on previous review findings and required corrective action plans.

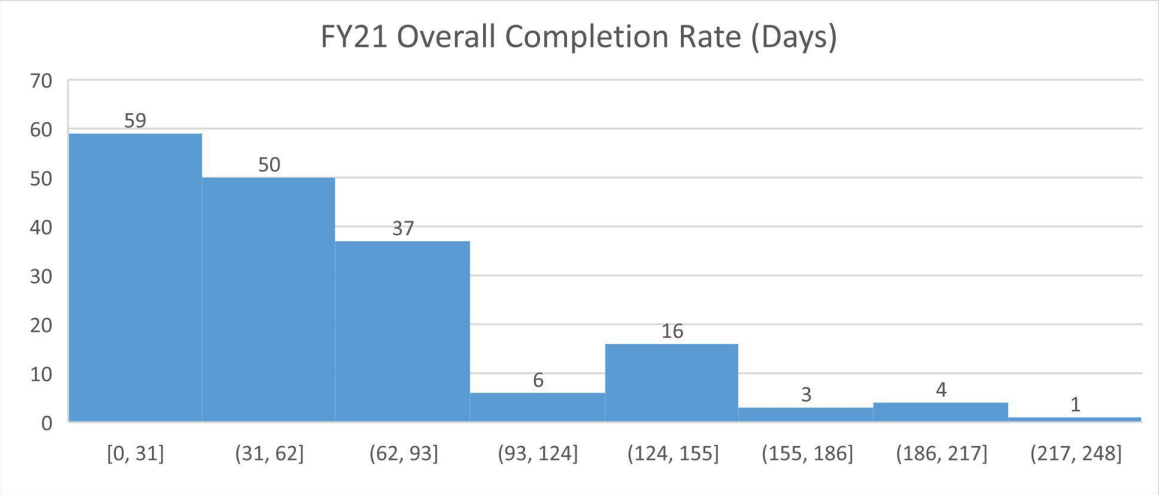
Quality Advisors assisted approximately 15-20% of CMHA-CEI providers in navigating a heightened scrutiny process in FY21. This process was initiated following a MDHHS survey completed during 2014-2016 and involved strict review of provider services and supports. Providers completed a remediation process with MSHN verifying implementation of corrective action plans. The requirements of the heightened scrutiny process may have contributed to delayed completion rates.

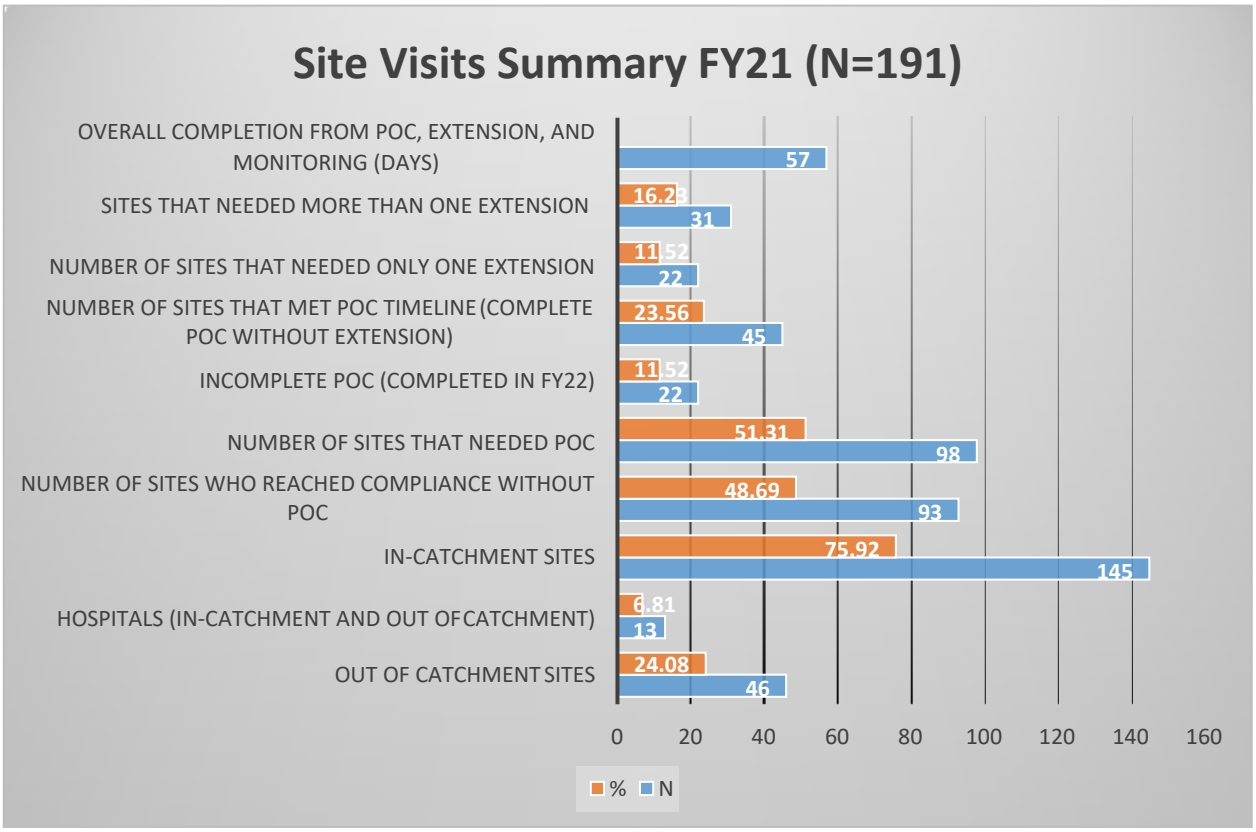
MDHHS waived some provider requirements in FY21 due to ongoing COVID-19 challenges. Quality Advisors focused on assisting providers in navigating COVID-19 protocol, reporting requirements, and other burdens providers experienced.

Site Visit Overview

- 191 Site reviews were conducted in FY21
- 20 contracts were terminated and 29 new contracts were established in FY21
- 22 FY21 site reviews corrective action plans were completed in FY22

- Overall completion rate (from initial visit date to full compliance) was an average of 57 days, which was an improvement from 68 days for FY20
    - 53% of sites required a POC, compared to 60% in FY20
    - 47% of sites were found to be in full compliance at the time of review, and did not require a POC, compared to 40% in FY20.





Improvement Opportunities

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

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

Policy and Procedure Review

In FY21, all Policies and Procedures were reviewed within the one-year timeline, for 100% compliance. Formatting updates were made to have all the Policies and Procedures have the same format. The QI team continues to update Policies and Procedures on a monthly basis with the cooperation of program directors. Future plans for Policy and Procedures are to continue to monitor and update formatting inconsistencies, organize operating guidelines, and implement a Policy and Procedure tracking software

HSAG Report FY21

Validation Results

HSAG evaluated **Mid-State Health Network**'s data systems for the processing of each type of data used for reporting the MDHHS performance indicators. General findings, strengths, and areas for improvement for **Mid-State Health Network** are indicated below.

Eligibility and Enrollment Data System Findings

HSAG had no concerns with how **Mid-State Health Network** received and processed eligibility and enrollment data.

No major eligibility and enrollment system or process changes were noted for the measurement period. **Mid-State Health Network** contracted with PCE for eligibility and encounter data processing within the PIHP's comprehensive electronic medical record (EMR) system, the Regional Electronic Medical Record (REMI). REMI was used for storing and producing the registry, performance indicator data, Behavioral Health Treatment Episode Data Set (BH-TEDS) data, and encounter data files for submission to MDHHS. PCE retrieved the Electronic Data Interchange (EDI) 834 eligibility files from the State daily, uploaded the files to REMI, split the eligibility and enrollment data by county, and distributed the data to the 12 CMHSPs hourly. Of the 12 CMHSPs, 11 organizations used EMRs supported by PCE and subsequently received their eligibility extract files directly into their EMR systems; one CMHSP received its eligibility data through secure file transfer protocol (FTP). **Mid-State Health Network** confirmed that, along with PCE, the PIHP had ongoing discussions with MDHHS to improve the quality and utility of data contained on the EDI 834 file. As a result, **Mid-State Health Network** used information obtained from EDI 270/271 Eligibility and Benefit Inquiry and Response files as its source of truth through an integrated process in REMI.

Mid-State Health Network's eligibility process incorporated standard pre- and post-processing edits to ensure the accuracy and completeness of incoming and outgoing files. Additionally, **Mid-State Health Network** validated the EDI 834 eligibility files against the EDI 820 Payment Order and Remittance Advice files to ensure that each member for whom a payment was received had current, matching eligibility data. To support ongoing validation and verification of eligibility data, REMI included a series of monitoring reports to track eligibility trends. Similarly, each CMHSP used its own validation process as an added quality check, which involved confirming whether a payment was received for a member to verify the accuracy of the enrollment files. Providers, staff members, and PIHP affiliates performed real-time eligibility verification through the State's website, Community Health Automated Medicaid Processing System (CHAMPS). **Mid-State Health Network** also convened an Information Technology Council whose mandate included review and resolution of reconciliation issues.

Adequate reconciliation and validation processes were in place to ensure that only accurate and complete eligibility and enrollment information was housed in the data system and communicated to the CMHSPs. **Mid-State Health Network** demonstrated that eligibility effective dates, termination dates, historical eligibility spans, and dual (Medicare-Medicaid) members were identified appropriately.

Medical Services Data System (Claims and Encounters) Findings

HSAG had no major concerns with how **Mid-State Health Network** received and processed claims and encounter data for performance indicator reporting.

Mid-State Health Network delegated claims processing to its contracted CMHSPs, with the exception of SUD data, which was processed by **Mid-State Health Network** for all CMHSPs. Each CMHSP was responsible for collecting and processing claims and, subsequently, submitting encounter data using **Mid-State Health Network**'s REMI system. The CMHSPs were required to submit EDI 837 professional and institutional encounters to **Mid-State Health Network** each month for review, validation, and processing, along with BH-TEDS data. If errors were detected, each CMHSP had the ability to retrieve its error file for review and correction. Additionally, **Mid-State Health Network** contracted with CEI to conduct an annual site review that included a detailed record review of EMR data in comparison to BH-TEDS data submitted. This oversight included the reconciliation of data between the MDHHS data warehouse and REMI encounter data files.

Data files received from the CMHSPs were loaded into REMI via an automated process. REMI contained validation edits and processes that allowed **Mid-State Health Network**, and its CMHSPs, to assess the accuracy of data at major transmission points—i.e., to **Mid-State Health Network**, to REMI, and to MDHHS. Only after passing key staging validation were data files imported into production systems. The PIHP continued to perform a validation process on each encounter to ensure that all submitted files met the 837 file format requirements. Upon passing all validation processes, the data were submitted to the State. The State generated a 999 response file, confirming receipt of each submission. In addition, one week or more following the PIHP's file submission, the PIHP received a 4950 detailed response file, which included an explanation for each file and record rejection that occurred. Each CMHSP had the capability to download and review its response file from **Mid-State Health Network**'s REMI system.

Performance indicator data were captured and submitted by each CMHSP quarterly. **Mid-State Health Network** and the CMHSPs maintained comprehensive technical specifications that translated MDHHS Codebook requirements into CMHSP-specific system requirements. **Mid-State Health Network** ensured consistency in the application and interpretation of performance indicators across its partners through the Quality Improvement Council (QIC), which met regularly to review reporting requirements; address PIHP/CMHSP performance; and implement corrective actions, where appropriate. Additionally, **Mid-State Health Network** maintained a Frequently Asked Questions (FAQ) document containing all decisions and clarifications discussed by the QIC or received from MDHHS. Prior to submitting performance indicator data to the PIHP, each CMHSP had multiple validation processes in place, which included trending, outliers, and validation of exceptions. Each quarter, detailed information was submitted to **Mid-State Health Network**. All data files were placed into a staging table, where several validations were applied to ensure data completeness and accuracy.

For performance metric production, **Mid-State Health Network** used source code in the PCE system for aggregating the CMHSPs' data. Each CMHSP was responsible for identifying cases for inclusion in each data element (e.g., denominator, numerator, exceptions) based on the measure specifications

provided in the MDHHS Codebook. Member-level detail files, along with summary rate files, were submitted to the PIHP. The files were reviewed by the PIHP, and any notable issues were reviewed with the CMHSPs. Validated data were then placed into a calculation table to finalize the measure rates for reporting. During this process, duplicate records across the CMHSPs were identified and eliminated from the file, with case precedence going to SUD cases. Due to the multiple validations in place at the CMHSP level as well as the PIHP level, and due to the CMHSPs using the same PCE system, therewere rarely issues with the data submitted to the State for reporting. Source code was received, reviewed, and approved by HSAG for the SFY 2020-2021 reporting period.

During PSV of members' records, several cases were identified for follow-up and clarification from some of the CMHSPs reviewed. Nearly all the clarification requested was provided and satisfactorily resolved. However, there were four discrepancies found in the PSV samples that appeared to be related to CEI source code for Indicator #3 including no-show appointments as follow-up service dates and non-Medicaid or ineligible CMHSP consumers in the eligible population for the Indicators #1 and #3. Due to the number of discrepancies in the sample size and the proportion of the CEI records in the numerator for the measure, **Mid-State Health Network** was given an opportunity to do additional validation of the remaining CEI records reported as compliant for Indicator #3. **Mid-State Health Network** reported back that an additional 33 out of 303 CEI records that had been reported as compliant could not be validated, leading to a 1.8 percent rate bias for Performance Indicator #3. **Mid-State Health Network** took immediate corrective action with the CMHSP for the Q3 2021 submission, reporting that they plan to do a full validation of all compliant records prior to submission to ensure that source code was corrected.

HSAG had no significant concerns with how **Mid-State Health Network** received and processed claims and encounters for performance indicator reporting.

Behavioral Health Treatment Episode Data Set (BH-TEDS) Data Production

Mid-State Health Network continued to use REMI to collect, manage, and produce the BH-TEDS data for submission to MDHHS. Built to align with MDHHS specifications, core data validation edits and file requirements were incorporated into the implementation of REMI. The PIHP worked with the CMHSPs to include BH-TEDS reporting into its processes, and to provide validation regarding BH-TEDS completeness and improve the quality of BH-TEDS reporting.

The PIHP's REMI system collected BH-TEDS data through direct data entry and receipt of properly formatted BH-TEDS files submitted by the CMHSPs. Both processes implemented all validations contained in the MDHHS BH-TEDS Coding Manual. All required validations, including data consistency and completeness, were enforced at the point where the data were submitted to the system.

The PIHP submitted validated and clean BH-TEDS files to the State based on the State's requirements. After submission, the PIHP received detailed response files and error reports that included explanations for any file rejections that occurred. These response files were processed and loaded into the PIHP's REMI system. Once loaded, the response files were separated according to CMHSP and distributed to each CMHSP for review and correction. Each CMHSP had the ability to log into REMI and obtain its

corresponding response file. The PIHP and CMHSPs implemented additional data quality and reasonability checks of the BH-TEDS records, beyond the state-specified requirements, before the data were submitted to the State.

Based on demonstrations of **Mid-State Health Network**'s BH-TEDS data entry and submission processes, no significant concerns were identified in the PIHP's adherence to the state-specified submission requirements. However, during HSAG's review of the final BH-TEDS data submitted by MDHHS, HSAG noted one member record with discrepant employment and minimum wage BH-TEDS data from one CMHSP, CEI. During the SFY 2020 audit, HSAG recommended that **Mid-State Health Network** and the CMHSPs employ enhancements to their BH-TEDS validation process to ensure there are no discrepant data entered. This validation process should account for discrepancies in wage and income values. HSAG also recommended that **Mid-State Health Network** and the CMHSPs continue to perform enhanced data quality and completeness checks before the data are submitted to the State. This review should target the data entry protocols and validation edits in place to account for discrepancies in wage and income values. Since there was one discrepant member record noted for CEI, HSAG encourages **Mid-State Health Network** to prioritize HSAG's previous recommendations to ensure accurate BH-TEDS data are submitted to the State.

PIHP Oversight of Affiliate Community Mental Health Centers

HSAG found that **Mid-State Health Network** had sufficient oversight of its 12 affiliated CMHSPs.

Mid-State Health Network continued to demonstrate appropriate oversight processes for all CMHSPs. The PIHP continued to use a standard template document to ensure that the CMHSPs have the same understanding of how to report performance indicators and lessen the error threshold. Consistent communication and monthly QIC committee meetings facilitated the resolution of any issues and provided opportunities to collaborate on solutions. In addition, the PIHP performed a full evaluation for each CMHSP, which included on-site desk audits and chart reviews for compliance with data capture and reporting requirements. A corrective action plan (CAP) was implemented for any CMHSP that did not meet the required standard for a measure.

PIHP Actions Related to Previous Recommendations and Areas of Improvement

Building on previous successful efforts to create supplemental documentation aids for the interpretation of MDHHS Codebook specifications, **Mid-State Health Network** developed instructional documents to assist the CMHSPs with interpretation and configuration of the new indicators and a standardized template for REMI submission to ensure the consistent reporting of performance indicators. Further, **Mid-State Health Network** met with all CMHSPs as a group prior to the start of system configuration for the new indicators to walk through the specifications and instructional documents to ensure alignment on interpretation while also providing ongoing technical assistance and training sessions throughout the year. **Mid-State Health Network** also reported that the CMHSPs worked hard to configure validations at the point of data entry by front-end clinical and clerical staff members wherever

possible, based on previous recommendations intended to reduce the validation and error correction during the quarterly submission process.

Mid-State Health Network also continued several quality improvement initiatives to address challenges and improve indicator rates through its QIC. **Mid-State Health Network**'s QIC reviewed indicator rates at least quarterly and addressed deficiencies while also identifying solutions for improving rates. While the CMHSPs are responsible for developing internal CAPs, the implementation of the CMHSP plans was overseen by the PIHP and QIC. If a region-wide issue was identified, **Mid-State Health Network** implemented system-wide interventions to address performance deficiencies. One CMHSP reported that **Mid-State Health Network** requires subtype categories to be reported to the QIC for non-compliant records to evaluate performance trends, which is not required by MDHHS. It noted that it had learned from the non-compliant subtypes that staffing shortages were found to have an impact on Indicator #2 and Indicator #3, and are planning as a result to implement a same-day access process to streamline intake procedures.

Performance Indicator Specific Findings and Recommendations

Based on all validation activities, HSAG determined results for each performance indicator. The CMS Performance Measure Validation Protocol identifies three possible validation finding designations for performance indicators, which are defined in Table 6. For more detailed information, please see Appendix B.

Table 6—Designation Categories for Performance Indicators

Reportable (R)	Indicator was compliant with the State's specifications and the rate can be reported.
Do Not Report (DNR)	This designation is assigned to indicators for which the PIHP rate was materially biased and should not be reported.
Not Applicable (NA)	The PIHPs were not required to report a rate for this indicator.

According to the protocol, the validation designation for each indicator is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of DNR because the impact of the error biased the reported performance indicator by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the indicator could be given a designation of R. Audit elements and their scoring designations (i.e., *Met*, *Not Met*, and *Not Applicable [NA]*) can be found in Appendix A—Data Integration and Control Findings and Appendix B—Denominator and Numerator Validation Findings. Table 7 displays the indicator-specific review findings and designations for **Mid-State Health Network**.

Table 7—Indicator-Specific Review Findings and Designations for Mid-State Health Network

Performance Indicator		Key Review Findings	Indicator Designation
#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.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R
#2	The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R
#2e	The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with SUDs.	The PIHPs were not required to report a rate for this indicator.	NA
#3	The percentage of new persons during the quarter starting any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R
#4a	The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R
#4b	The percentage of discharges from a substance abuse detox unit during the quarter that were seen for follow-up care within 7 days.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R
#5	The percent of Medicaid recipients having received PIHP managed services.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#6	The percent of HSW enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R

Performance Indicator		Key Review Findings	Indicator Designation
#8	The percent of (a) adults with mental illness, and the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/ intellectual or developmental disability served by the CMHSPs and PIHPs who are employed competitively.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#9	The percent of (a) adults with mental illness, the percent of (b) adults with intellectual or developmental disabilities, and the percent of (c) adults dually diagnosed with mental illness/ intellectual or developmental disability served by the CMHSPs and PIHPs who earned minimum wage or more from any employment activities.	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#10	The percentage of readmissions of MI and I/DD children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge.	The PIHP/CMHSPs calculated this indicator in compliance with MDHHS Codebook specifications.	R
#13	The percent of adults with intellectual or developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R
#14	The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).	MDHHS calculated this indicator in compliance with MDHHS Codebook specifications.	R

MSHN Audit

MSHN conducted a complete virtual desk audit of CMHA-CEI in June 2021. Findings were as follows:

Delegated Managed Care Tool	Finding
INFORMATION (CUSTOMER SERVICES) 1.9	Letters reviewed do not meet standard. The standard requires CEI to give written notice informing consumers upon terminating a provider contract.
ENROLLEE RIGHTS AND PROTECTIONS (CUSTOMER SERVICE) 3.12	found in Access System Procedure 3.1.02C, but there were no call logs uploaded to ensure that this was happening. When this auditor inquired on if examples could be uploaded, the response was, "At this time we are not able to follow up with individuals within 2 days, but we are working on increasing the capacity of our Customer Service team to ensure that moving forward we are able to meet this."
GRIEVANCE & APPEALS (CUSTOMER SERVICE) 6.5	A sample of letters reviewed indicated that there was missing language specifically related to legal reference on the letters used by CEI. See ABD letter review tool (Tab 1): https://mshn.app.box.com/file/751524363934
GRIEVANCE & APPEALS (CUSTOMER SERVICE) 6.13	Policy and procedures indicate that acknowledgement letters are sent. However, a review of sample grievance and appeals found of the 4 files reviewed (2 grievance and 2 appeal) that 2 files did not have acknowledgement letters. See review tool (Tab 2 and Tab 3): https://mshn.app.box.com/file/751524363934
GRIEVANCE & APPEALS (CUSTOMER SERVICE) 6.20.	In the 4 cases reviewed (2 grievances and 2 appeal) 1 disposition letter were outside of the required timeframe. See review tool (Tab 2 and Tab 3): https://mshn.app.box.com/file/751524363934
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.3	Despite policies in place, no evidence of signed special consent for the behavior plan written on 1.12.2021, but not signed by clinician until 4.29.2021. Evidence of Behavior Treatment Committee review and approval on 2.21.21 of unsigned plan with no signed special consents. Signed consent available in record as of 5.3.2021. However plan reviewed, approved, and implemented in February of 2021. For the AUT chart reviewed, there is evidence in the record of a Behavior Intervention Plan (BIP) that contains intrusive/restrictive measures and no evidence that committee has ever reviewed the plan or standards met, including special consent.

BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.4	Despite procedures in place, evidence in chart reviewed that intrusive techniques written into the plan of service (1:1 staffing even in bathroom and video camera in private bedroom) on 1.25.21, but no evidence that expedited review occurred. Furthermore, PCP dated 1.25.21 referenced "will follow plan when written", yet, plan dated 1.12.2021. Additionally, previous PCP written 8.28.20 referenced that the team will "follow plan when written". Assessment dated 12.9.20 references the use of PRN Xanax for "moments of high need" but not addressed in the PCP or the Behavior Treatment Plan. There is no evidence in the AUT chart reviewed that an expedited review occurred for the Behavior Intervention Plan dated 3.26.21 or for the medications that are being prescribed. Reviewed Emergency Behavior Plan Review dated 2.28.2020 (when plan came over from Shiawassee). Emergency meeting indicates that updated FBA will be completed within 30 days 3.28.20) and a new plan within 90 days (5.28.20). However, this did not occur within the specified timeframes in the review notes OR in the Behavior Treatment Standards.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.5	Despite procedure in place, no evidence provided that standard has been met in practice. Response from CEI indicates that evidence of this standard not available. Review of MEV claims does not indicate that behavior treatment review is being billed for individuals going through the committee.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.6	Despite policy and procedures in place, AUT case reviewed referenced physical management in the Behavior Intervention Plan but there is no evidence that this plan has been reviewed or approved by the BTPRC (not listed on CEI provided list for BTPs reviewed), or evidence that plan containing restrictive/intrusive techniques contains all identified standards (medications, QBS for non-compliance, gentle physical guidance, reactive strategies for elopement, etc).
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.7	Despite the policies/procedures in place, the positive support plan reviewed does not contain the results of assessments to rule out physical, medical, and environmental causes of the challenging behaviors. However, Comprehensive Functional Assessment dated 12.2.20 (but not signed by clinical until 4.29.21) referenced environmental causes only.

BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.8	Despite the policies in place, it appears that the functional behavioral assessment reviewed as part of the Positive Support Plan on 2.21.21 was not signed by the psychologist in the EMR until 4.29.21. As such, reviewer unable to find evidence that the plan forwarded to the committee was accompanied by the comprehensive assessment. The AUT chart reviewed was never forwarded to the committee.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.9	Despite procedures in place, reviewer unable to see evidence that this standard addressed in the charts reviewed. For the BTP chart reviewed, the PCP dated 1.25.21 identified the use of a video monitor in use in the individuals bedroom (referenced as due to a seizure). This practice was not included or addressed in the "Positive Support Plan" and there was no evidence that this technique had been considered, reviewed, or approved. The "Positive Support Plan" did, however, reference LOS and arms reach in the community, as well as LOS even in the bathroom. Those two intrusive techniques were identified to be used for problem behaviors primarily. The AUT chart reviewed was never forwarded to the committee.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.10.	Review of Behavior Plan verified the use of the kind of positive supports and interventions used to support this individual. However, review of AUT plan containing behavior interventions was not ever reviewed or approved by the committee.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.11	Despite procedure in place, reviewer unable to find evidence of this standard in the records.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.12	Standard Not addressed in documents reviewed and no evidence of standard in practice of the charts reviewed.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.13	Standard Not addressed in documents reviewed and no evidence of standard in practice of the charts reviewed.
BEHAVIOR TREATMENT PLAN	Standard Not addressed in documents reviewed and no evidence of standard in practice of the charts reviewed.

REVIEW COMMITTEE 9.14	
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.15	Standard Not addressed in documents reviewed and no evidence of standard in practice of the chart reviewed.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.16	Standard Not addressed in documents reviewed and no evidence of standard in practice of the chart reviewed.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.17	Standard Not addressed in documents reviewed and no evidence of standard in practice of the chart reviewed.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.18	Standard Not addressed in documents reviewed and no evidence of standard in practice of the chart reviewed.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.19	Despite procedures in place, Behavior Treatment plan provided (called a Positive Support plan, in error) does not include the frequency of reviewing collected data. Furthermore, there is evidence that the plan was reviewed by the committee on 2.21.21, but not again at the time of this review (no evidence of quarterly BTPRC reviews). In follow up, CEI has indicated they are not doing the required quarterly reviews for the case selected.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.20.	Standard Not addressed in documents reviewed. Evidence in the behavior plan that psychologist will in-service staff on the plan, and a progress note indicates training with home manager of the plan on 5.14.2021. There is no indication of when the plan will be implemented. It is important to note, however, that the timeline for plan writing, signing, approval and implementation is unclear and inconsistent in this chart reviewed.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.21	Standard Not addressed in documents reviewed and no adequate evidence of standard in practice of the chart reviewed.

PROVIDER/STAFF CREDENTIALING (PROVIDER NETWORK) 11.2	A review of 5 staff files indicated that Corporate Compliance and COD training is not always completed with the required timeframes. For corrective action, please indicate how CEI will ensure that Corporate Compliance and COD training is completed timely and provide evidence of completion for COD training for TB and GW
PROVIDER/STAFF CREDENTIALING (PROVIDER NETWORK) 11.7	CEI does not complete NPDB query for staff. In lieu of this query, the following must be verified: i. Minimum 5-year history of professional liability claims resulting in judgement or settlement ii. Disciplinary status with regulatory board or agency; and iii. Medicare/Medicaid Sanctions Licensed provider disciplinary status is part of the LARA verification which was completed. Sanction checks were completed. There was no evidence of verification of 5 year professional liability claims resulting in judgement or settlement. CEI does not currently have a process in place to ensure that a qualified practitioner and/or credentialing committee approves credentialing. They are currently working implementing a procedure. CEI did inquire as to if MSHN could approve the Medical Director. Reviewer recommended considering a committee to approve and offered to follow up with MSHN Leadership if CEI determines they would prefer that option rather than an internal committee. In one file reviewed, there was a gap in work history and there was no evidence of explanation provided.

PROVIDER/STAFF CREDENTIALING (PROVIDER NETWORK) 11.9	Upon review of staff files, the following findings were identified: CEI does not complete NPDB query for staff. In lieu of this query, the following must be verified: i. Minimum 5-year history of professional liability claims resulting in judgement or settlement ii. Disciplinary status with regulatory board or agency; and iii. Medicare/Medicaid Sanctions Licensed provider disciplinary status is part of the LARA verification which was completed. Sanction checks were completed. There was no evidence of verification of 5 year professional liability claims resulting in judgement or settlement. CEI does not currently have a process in place to ensure that a qualified practitioner and/or credentialing committee approves credentialing. They are currently working implementing a procedure. CEI did inquire as to if MSHN could approve the Medical Director. Reviewer recommended considering a committee to approve and offered to follow up with MSHN Leadership if CEI determines they would prefer that option rather than an internal committee. MCBAP Primary source verification does not appear to be part of the credentialing process or verified at time of credentialing/re-credentialing.
PROVIDER/STAFF CREDENTIALING (PROVIDER NETWORK) 11.17	While some timeframes are identified related to when re-credentialing takes place and temporary privileging timeframes, the policies and procedures do not define timeliness of application as it relates to primary source verification and review/decision making process. Reviewer provided link to MSHN policy and procedures for provider to use/include.
PROVIDER/STAFF CREDENTIALING (PROVIDER NETWORK) 11.21	While this is not applicable to the provider at this time, the language should be added to the policy in the even that this occurs.
PROVIDER/STAFF CREDENTIALING (PROVIDER NETWORK) 11.22	No evidence in policy or procedures provided.

ENSURING HEALTH & WELFARE /OLMSTEAD (QUALITY IMPROVEMENT) 13.2	Policies and procedures met the standards. Five records that were submitted to MDHHS via MSHN were reviewed for primary source verification. The partial rating was received as a result of 5 records that were reviewed for primary source verification did not include a fully completed IR. The section missing was actions taken to prevent reoccurrence. It is the expectation that actions be identified when relevant, to remove the risk of injury in the future, not to identify actions taken for treatment of the injury.
TRAUMA INFORMED CARE 15.4	Did not find language embedded in policy. Per review of randomly selected records, this is not occurring as indicated. Procedure should include the specific tool to use for specific population.
Non Waiver	
Autism/ABA 8.1	• Reviewed: -3.3.25 Person Centered Planning, Policy and Procedure (A. Met) -3.3.26A Autism Benefit Protocol Guideline, Draft (B) -C: Reviewed 3.3.26 Autism Spectrum Disorder Benefit Guideline, Draft (C) • Partially met B and C due to Draft status of guideline instead of fully-finalized, approved Policy and Procedure. • *MSHN reviewed documentation submitted on 6.23.2021 with an effective date of 7.1.2021.
Autism/ABA 8.2	Reviewed: 3.3.26 Autism Spectrum Disorder Benefit Guideline, Draft Despite related draft guideline language, the clinical chart review did not demonstrate evidence that this standard is in practice; please see clinical chart review. *MSHN reviewed documentation submitted on 6.23.2021 with an effective date of 7.1.2021.

Autism/ABA 8.3	Reviewed: 3.3.26A Autism Benefit Protocol Guideline, Draft Partially met due to Draft status of guideline instead of fully-finalized, approved Policy and Procedure. However, evidence in practice that standard in place. MSHN reviewed documentation submitted on 6.23.2021 with an effective date of 7.1.2021
Autism/ABA 8.4	Reviewed: 3.3.26: Autism Spectrum Disorder Benefit Guideline, Draft 3.3.26B: Autism Benefit Compliance Monitoring Guideline, Draft Partially met due to Draft status of guidelines instead of fully-finalized, approved Policy and Procedure. MSHN reviewed documentation submitted on 6.23.2021 with an effective date of 7.1.2021.
Autism/ABA 8.5	Reviewed: 3.3.26: Autism Spectrum Disorder Benefit Guideline, Draft 3.3.26B: Autism Benefit Compliance Monitoring Guideline, Draft Partially met due to Draft status of guidelines instead of fully-finalized, approved Policy and Procedure. MSHN reviewed documentation submitted on 6.23.2021 with an effective date of 7.1.2021.

Autism/ABA 8.6	Reviewed 2019 CEI Corrective Action Plan, approved by MDHHS, for Autism Review 3.3.26: Autism Spectrum Disorder Benefit Guideline, Draft 3.3.26B: Autism Benefit Compliance Monitoring Guideline, Draft Audit 07/15/2021 Page 16 of 25 Despite related draft guideline language, the clinical chart review did not demonstrate evidence that this standard is in practice; please see clinical chart review. Additionally, language is missing from Draft Protocol. MSHN reviewed documentation submitted on 6.23.2021 with an effective date of 7.1.2021.
Autism/ABA 8.7	Reviewed: 2019 CEI Corrective Action Plan, approved by MDHHS, for Autism Review 3.3.26: Autism Spectrum Disorder Benefit Guideline, Draft 3.3.26B: Autism Benefit Compliance Monitoring Guideline, Draft In review of credentialing packets in the clinical chart, MSHN found the following staff to be out of compliance: QBHP, M.E. - Overdue background Check (last 4/16/2019). Also, this individual completed her BACB coursework in in August of 2018. As such, she would have only been qualified to perform as a QBHP until August of 2020, but continues to be allowed due to COVID-19 relaxations. BT, D.S.- Evidence of Beneficiary-specific IPOS Training (Signed 12/3/20), but billed for multiple services for this individual prior to the signed date. MSHN reviewed additional documentation submitted on 6.23.2021 as evidence of appropriate credentialing, as requested. As a result, this standard is partially met, as the guidelines submitted are not in effect at the time of this review.

Autism/ABA 8.8	Reviewed: Autism Benefit Tracker (not updated since 2/2020) 2019 CEI Corrective Action Plan, approved by MDHHS, for Autism Review 3.3.26: Autism Spectrum Disorder Benefit Guideline, Draft, 3.3.26A: Autism Benefit Protocol Guideline, Draft 3.3.26B: Autism Benefit Compliance Monitoring Guideline, Draft Evidence in chart of practice. Partially met given due to items stated in draft guidelines, not formal Policies and Procedures. MSHN reviewed documentation submitted on 6.23.2021 with an effective date of 7.1.2021
Autism/ABA 8.9	Reviewed: 2019 PIHP Autism/ABA Site Review Report from MDHHS. CEI's Approved Correction Plan Evidence of implementation of CAP not found.
Wavier Specific	
HSW 1.6	Evidence of corrective action implementation reviewed. Selected consumer chart was compliant with many of the standards that were cited in the most recent MDHHS site review. Amount, scope, duration: this was a citation from the MDHHS site review and the current case review also had findings in this area. Several of the services were provided out of the authorized amount, scope, and duration either under or over utilized (see 6.1 of current chart review). Additionally, several of the interventions used range language which MDHHS has advised against (see 3.6 of current chart review). Per the MDHHS 2020 Review Final CAP: "Technical Assistance provided around the use of ranges/range language in recommending/authorizing supports and services. Going forward, MDHHS will expect specific amount/scope/duration/ frequency of services to be identified in the IPOS, rather than the use of ranges or “up to” language, to better comply with best practices and to better meet federal and state regulation, as well as contract requirements."

SUD Delegated Managed Care Review	
4.5	MSHN requested sample letters of 4 individuals. Discharge summaries were provided however there was no evidence that ABD letters were sent or used. CEI stated that they do not send letters at HOC. TRC and CATS requested letters - ABD letters were not completed.
4.11	Upon review of the templates provided as evidence, it was noted by reviewer that the most current templates are not being utilized. The templates are dated 12-17 however, the most current grievance template is dated 6/19 and the most current appeal template 7/19. Review of grievance file did not include the most current acknowledgement/receipt template and was missing information that should be completed by the provider.
4.12	Disposition letter templates provided are not the current templates in use. Templates provided are from 2017 and the most current templates are 2019. Additionally, upon review of a grievance file, there was not evidence of a disposition letter sent. However, CEI reported that the acknowledgement and disposition letter were sent on the same day.
SUD Program Specific	
1.1	Ensure elements of standard are represented in policy and therefore into practice with services.
2.1	TRC Policy Indicates TB test completed within 24 hours of admission. HOC policy 8.5.9ITRS, HOC Resident Health & Care Coordination indicates TB tests is completed within 7 days of admission. The OROSC/BSAAS policy indicates that the TB is completed at admission. Partially compliant as House of Commons does not complete TB testing at admission.
2.2	Partial Compliance given as the residential detoxification identifies specific staffing to complete the medical history and examination. This policy is incorrect for The Recovery Center. The recovery center indicates a nursing assessment will be completed within 24 hours. However, it does not indicate a medical history and examination as required in the LARA SUD Program
3.1	RECIEPT Admission Intake Procedure meets some of this criteria but not all. Please note that the policies updated have a heavy focus on case management and little on peer recovery. Recommend balancing the content for CM and PRC, with greater information about PRC included.

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

Delegated Managed Care Tool	Corrective Action Plan
INFORMATION (CUSTOMER SERVICES) 1.9	Procedure will be updated by 8/31 to include the language, When they receive notice, Quality Advisors will send reminders to programs to send out a notice to all consumers that the contract is ending.
ENROLLEE RIGHTS AND PROTECTIONS (CUSTOMER SERVICE) 3.12	Starting 8/9/2021 Access Staff will track all request for SUD services, following up with 100% of consumers who made contact (spoke to a live agent or left a voicemail) to ensure that they receive a call within two business days of their initial contact. We will track this in Bluebook – Access Message and Call Back Record.
GRIEVANCE & APPEALS (CUSTOMER SERVICE) 6.5	CEI has implemented the requested language in June 2021. Please see attached revised form that is being utilized in our system. (added attachment titled: Revised ABDN, notes with supporting documentation for DMC standard 6.5
GRIEVANCE & APPEALS (CUSTOMER SERVICE) 6.13	Affective May 1, 2021 a robust tracking system has been implanted including but not limited to an excel spreadsheet and a module in the electronic health record that requires the upload of the acknowledgement and disposition letters. This module assists in tracking the timeframe for each notice sent and assists CEI in accurate assessment of timely notices. This system has been implemented and is currently being utilized by all compliance staff.
GRIEVANCE & APPEALS (CUSTOMER SERVICE) 6.20.	" Affective May 1, 2021 a robust tracking system has been implanted including but not limited to an excel spreadsheet and a module in the electronic health record that requires the upload of the acknowledgement and disposition letters. This module assists in tracking the timeframe for each notice sent and assists CEI in accurate assessment of timely notices.

	This system also allows for reports to be generated which assists the CEI staff in accurately reporting all information to MSHN, which eliminates many human errors that accounted for the inaccuracies. "
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.3	"1. Evidence of signed special consent for the autism chart reviewed – The parent signed the ABA plan on 4/1/21 – This plan will be provided by 9/10/21. 2. The expedited review of the ABA plan was completed on 8/6/21 and was reviewed at the 8/16/21 BTRC. Documents will be provided by 9/10/21. 3. An updated ABA plan will be presented to the BTRC on 10/18/21. MSHN will be provided with the meeting minutes by 10/30/21
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.4	"1. Expedited BTPRC reviews for cases not in compliance were completed on 8/6/21. 2. Behavior Treatment policies and procedures will be updated to incorporate all Behavior Treatment Standards, BTP FAQ clarifications, and strategies and be finalized by 12/1/21. 3. PCP writers and providers will be trained on the need for expedited reviews if there is an emergent need for a restrictive/intrusive technique to ensure these techniques are not implemented without full review and BTPRC approval by 1/1/22. 4. The BTPRC will update their review tool to assure all plans approved contain all Behavior Treatment Standards and begin utilizing the tool effective 12/1/21. 5. CEI will develop an expedited review tool which will ensure all Behavior Treatment Standards are meet before restrictive/intrusive techniques are implemented. Will begin utilizing this tool effective 12/1/21 6. The BTPRC will develop a process to review intrusive techniques (i.e. oral medications) by 12/1/21. 7. CEI Behavior clinicians working in CSDD were trained on this standard on July 30, 2021 "
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.5	"1. CEI will evaluate the committee's effectiveness by sending out surveys by 8/30/21. 2. CEI will begin entering claims for the Behavior Treatment Reviews as a means to increase monitoring, recoup for services rendered, and to be able to pull data associated with those individuals who have plans being reviewed by 12/1/21.

BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.6	"1. The expedited review of the ABA and BTP plans selected was completed on 8/6/21 and was reviewed at the 8/16/21 BTRC. Documents will be provided by 9/10/21. 2. An updated ABA and BTP plan will be presented to the BTRC on 10/18/21. MSHN will be provided with the meeting minutes by 10/30/21 3. The updated plans for the AUT and BTP charts selected will be provided after their review and approval at the BTRC meeting by 10/31/21. 4. Evidence of ABA provider trainings and handout given to ABA providers will be provided by 9/10/21. 5. Evidence of CEI Behavior clinicians training will be provided by 9/10/21 "
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.7	The plans for the BTP and AUT charts selected will be updated to contain results of assessment to rule out physical medical and environment causes of the challenging behavior and then reviewed by the BTRC on 10/18/21. The updated plans and the BTRC review will be provided by 10/30/21.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.8	The behavior plan for the AUT Chart selected will be updated to contain a functional assessment of the behavior and then reviewed by the BTRC on 10/18/21. The updated plans and the BTRC reviews will be provided by 10/30/21.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.9	The plans for the BTP and AUT charts selected will be updated to contain results of inquiries about any medical, psychological or other factor that might put the individual subjected to intrusive or restrictive techniques at high risk of death injury or trauma and then be reviewed by the BTRC on 10/18/21. The updated plans and the BTRC review will be provided by 10/30/21.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.10.	"1. Expedited BTPRC reviews for cases not in compliance were completed on 8/6/21. 2. The BTPRC will update their review tool to assure all plans forwarded to committee contain all standards prior to approval and implementation. and begin utilizing the tool effective 12/1/21.

	3. By 12/1/21 the Behavior Plan template will be updated to include language related to amount, scope and duration of the use of positive supports as part of the rationale for recommendation of more restrictive/intrusive strategies, as well as other BTPRC standards, prior to review, approval, and implementation. 4. CEI Behavior clinicians working in CSDD were trained on this standard on July 30, 2021. 5. ABA providers have all been trained in this standard effective 8/3/21. "
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.11	The plans for the BTP and AUT charts selected will be updated to contain evidence of continued efforts to review less restrictive options to intrusive or restrictive techniques and then be reviewed by the BTRC on 10/18/21. The updated plans will be provided by 10/30/21.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.12	"1. The Policy and procedures for Behavior Management will be updated to include required standards. The updated policies will be finalized by 1/1/22. 2. The BTPRC will update their review tool to assure all plans forwarded to committee contain all standards prior to approval and implementation. and begin utilizing the tool effective 12/1/21. 3. The Behavior Plan template will be updated to include the required standards and will begin utilized by 12/1/21. 4. CEI Behavior clinicians working in CSDD were trained on this standard on July 30, 2021. 5. ABA providers have all been trained in this standard effective 8/3/21. "
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.13	"1. The Policy and procedures for Behavior Management will be updated to include required standards. The updated policies will be finalized by 1/1/22. 2. The BTPRC will update their review tool to assure all plans forwarded to committee contain all standards prior to approval and implementation. and begin utilizing the tool effective 12/1/21. 3. The Behavior Plan template will be updated to include the required standards and will begin utilized by 12/1/21. 4. CEI Behavior clinicians working in CSDD were trained on this standard on July 30, 2021. 5. ABA providers have all been trained in this standard effective 8/3/21. "
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.14	The plans for the BTP and AUT charts selected will be updated to contain the plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s) and then reviewed by the BTRC on 10/18/21. The updated plans will be provided by 10/30/21.

BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.15	The plan for the BTP chart selected will be updated to contain goal-expected outcomes of the Behavior Treatment Plan and then be reviewed by the BTRC on 10/18/21. The updated plan will be provided by 10/30/21.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.16	The plan for the BTP chart selected will be updated to contain objectives with baseline and steps to achieving the behavior goal and then be reviewed by the BTRC on 10/18/21. The updated plan will be provided by 10/30/21.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.17	The plan for the BTP chart selected will be updated to contain Methodology-interventions implemented to decrease target behaviors, a schedule and /or timing and things to be done to increase additional adaptive behaviors and then be reviewed by the BTRC on 10/18/21. The updated plan will be provided by 10/30/21.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.18	The plan for the BTP chart selected will be updated to contain measurement-how the baseline will be established, what is being measured, and assessment of the impact of behavior treatment interventions on the individual and then be reviewed by the BTRC on 10/18/21. The updated plan will be provided by 10/30/21.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.19	The plan for the BTP chart selected will be updated to contain plan Review-frequency of reviewing collected data and then be reviewed by the BTRC on 10/18/21. The updated plan will be provided by 10/30/21.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.20.	"The plan for the BTP chart selected will be updated to contain plan Staff In-Service - who is responsible for training staff and when the plan will be implemented and then be reviewed by the BTRC on 10/18/21. The updated plan will be provided by 10/30/21. Evidence of staff training/in-servicing of plan will be provided by 11/15/21.
BEHAVIOR TREATMENT PLAN REVIEW COMMITTEE 9.21	The plans for the BTP and AUT charts selected will be updated to contain Staff Responsible- the CM who will implement and manage the plan and then be reviewed by the BTRC on 10/18/21. The updated plans will be provided by 10/30/21.

PROVIDER/STAFF CREDENTIALING (PROVIDER NETWORK) 11.2	" TB has been assigned COD training but has failed to complete this on time. Tamara and her supervisor have been made aware (email sent on 7/26/21) that she needs to complete this by 8/6/21. GW completed her COD training on 6/28/21 The Training Unit Coordinator has updated the Training Plan in our Relias Learning system to incorporate the COD required training for all staff that fall under this requirement. Corporate Compliance is required for all staff initially (90 days from hire) and annually. Relias currently sends out reminders to staff and their supervisors of trainings that are due soon, and will continue to send reminders when staff have not completed the training(s) and are overdue. "
PROVIDER/STAFF CREDENTIALING (PROVIDER NETWORK) 11.7	"Case specific remediation: 1. Medication consent for all medication prescribed on 6/11/21. 2. Expedited BTPRC reviews for cases not in compliance were completed on 8/6/21. Systemic remediation: 1. Behavior Treatment policies and procedures will be updated"
PROVIDER/STAFF CREDENTIALING (PROVIDER NETWORK) 11.9	"Human Resources will establish a Credentialing Committee by October 1st. The Credentialing Committee will consist of a minimum of two Human Resource staff members who are trained in credentialing requirements. The CMHA-CEI Credentialing and Re-Credentialing Procedure will be updated to reflect the role of the Credentialing Committee by August 2nd. The Human Resources team will review options regarding the NDPB query vs. alternative options, and will make a decision of which method(s) of verification will be conducted in the Credentialing and Re-Credentialing process. This decision will be made by October 1st, and the Credentialing and Re-Credentialing procedure will be updated to reflect the process. The Credentialing Checklist utilized by Human Resources in the Credentialing and Re-Credentialing process will be updated to include the MCBAP certification for SUD staff members. Quality concerns will be noted on the credentialing checklist. If there are no quality concerns this will be noted as well. Training will be provided to Human Resource staff on updates to the Credentialing and Re-Credentialing process, and changes in the checklist by October 1st. "

PROVIDER/STAFF CREDENTIALING (PROVIDER NETWORK) 11.17	The Credentialing and Re-Credentialing Procedure 2.1.08H has been revised to include the Attachment A timeframes from the MSHN Credentialing and Re-credentialing - Individual Practitioners Procedure and references the attachment under section II.A. 2, "Attachment A identifies the timeframes for completing Primary Source Verification of items within the credentialing packets."
PROVIDER/STAFF CREDENTIALING (PROVIDER NETWORK) 11.21	The CMHA-CEI Credentialing and Re-Credentialing Procedure #2.1.08H Section II.F.3.a. was revised on August 2nd to include the following language: "All licenses, registrations or certifications must be for the state of Michigan. If an employee is licensed in a state other than Michigan that license will not be considered as part of the credentialing process and HR staff will not verify licenses from other states."
PROVIDER/STAFF CREDENTIALING (PROVIDER NETWORK) 11.22	The CMHA-CEI Credentialing and Re-Credentialing Procedure #2.1.08H Section II. D was revised on August 2nd to include the following language: "Credentialing and Re-credentialing processes shall not discriminate against: (a) a health care professional solely on the basis of license, registration, or certification; or (b) a health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment."
ENSURING HEALTH & WELFARE /OLMSTEAD (QUALITY IMPROVEMENT) 13.2	The QI team, which reviews all Incident Reports monthly, will closely review the review section of the IR and for any critical incident that will be submitted to MSHN and MDHHS will make sure there is information in the IR on preventing reoccurrence. If that language is missing, the QI staff will reach out to the reviewer to obtain this information and will note it on the QI review section. Critical Incidents will continue to be reviewed monthly at CIRC and QI will include in their update at CIRC on this CAP. QI has begun this review as of July 9, 2021 and will report at CIRC on this starting August 6, 2021.
TRAUMA INFORMED CARE 15.4	""""The specific trauma screen tools by population will be added to the procedure by 8/31/21. To be added to procedure: FF – CTAC ITRS – ACES AMHS – PCL-C CSDD – CTAC Will be scanned in chart as "trauma screen + date""
Non Waiver	

Autism/ABA 8.1	"1. The following guidelines have been finalized and an were effective 7/1/21. 3.3.26A Autism Benefit Protocol Guideline, 3.3.26 Autism Spectrum Disorder Benefit Guideline 2. Staff and providers will be trained in the Guidelines by 1/1/22 as evidenced by meeting minutes or training records.
Autism/ABA 8.2	1. Finalized guidelines will be provided by 9/10/21 2. The IPOS will be updated to reflect this standard and will be provided by 11/1/21. 3. The ABA plan will be updated to reflect this standard and will be provided by 11/1/21.
Autism/ABA 8.3	"1. The following guidelines have been finalized and were effective 7/1/21. 3.3.26A Autism Benefit Protocol Guideline, 3.3.26 Autism Spectrum Disorder Benefit Guideline 2. Staff and providers will be trained in the Guidelines by 1/1/22 as evidenced by meeting minutes or training records.
Autism/ABA 8.4	"1. The following guidelines have been finalized and were effective 7/1/21. 3.3.26A Autism Benefit Protocol Guideline, 3.3.26 Autism Spectrum Disorder Benefit Guideline 2. Staff and providers will be trained in the Guidelines by 1/1/22 as evidenced by meeting minutes or training records.
Autism/ABA 8.5	"1. The following guidelines have been finalized and were effective 7/1/21. 3.3.26A Autism Benefit Protocol Guideline, 3.3.26 Autism Spectrum Disorder Benefit Guideline 2. Staff and providers will be trained in the Guidelines by 1/1/22 as evidenced by meeting minutes or training records.
Autism/ABA 8.6	1. Finalized guidelines will be provided by 9/10/21 2. Trainings on the guidelines will be provided during September and October and evidence of this trainings will be provided by11/1/21. 3. Evidence of the procedure to utilize the Autism Benefit Tracker will be provided by 10/1/21. 4. The ABA plan will be amended to assure it meets this standard and will be provided by 11/1/21. 5. The WSA will be updated within 7 days of the plan beingamended.

Autism/ABA 8.7	"1. The following guidelines have been finalized and were effective 7/1/21. 3.3.26A Autism Benefit Protocol Guideline, 3.3.26 Autism Spectrum Disorder Benefit Guideline 2. Staff and providers will be trained in the Guidelines by 1/1/22 as evidenced by meeting minutes or training records. 3. CEI will develop a process to ensure that once the COVID emergency is over, that QBHP's who have completed their coursework over two years ago have passed the BCBA exam and are certified through LARA by 10/1/21. 4. CEI will develop a process to ensure the supervising BHT clinician who is providing the service is the one listed in the WSA by 1/1/21. This process will be included in the written guidelines. 5. By 10/1/21 a procedure will be in place to utilize the Autism benefit tracker within the EMR to track, monitor and modify service delivery of ABA services on a consistent basis.
Autism/ABA 8.8	"1. The following guidelines have been finalized and were effective 7/1/21. 3.3.26A Autism Benefit Protocol Guideline, 3.3.26 Autism Spectrum Disorder Benefit Guideline 2. Staff and providers will be trained in the Guidelines by 1/1/22 as evidenced by meeting minutes or training records. 3. By 10/1/21 a procedure will be in place to utilize the Autism benefit tracker within the EMR to track, monitor and modify service delivery of ABA services on a consistent basis.
Autism/ABA 8.9	"1. Providers will be trained in the information contained in the letter sent on 7/2/19 by 1/1/22. 2. A full review of the ABA program will be completed in FY22 Q1. This review will include the following standards in chart reviews: • For Autism Benefit/Applied Behavioral Analysis: Beneficiaries ongoing determination of level of service (every six months) has evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with ABLLS-R or VB-MAPP. • For Autism Benefit/Applied Behavioral Analysis: Beneficiaries IPOS are reviewed at intervals specified in the MSA 15-59 (minimally every three months) and if indicated, adjusting the service level and setting(s) to meet the child's changing needs. • For Autism Benefit/Applied Behavioral Analysis: Beneficiaries whose average hours of ABA services during a quarter were within the suggested range for the intensity of service plus or minus a variance of25%. • For Autism Benefit/Applied Behavioral Analysis: Observation Ratio: Number of Hours of ABA observation during a quarter are > to 10% of the total service provided

	3. By 10/1/21 a procedure will be in place to utilize the Autism benefit tracker within the EMR to track, monitor and modify service delivery of ABA services on a consistent basis.
Wavier Specific	
HSW 1.6	"Training on pre-planning, pre-planning tools, documentation requirements, and Person Centered Planning with the Case Management and Clinical Units to be completed by 11/1/21. This will include the requirement for specific amount/scope/duration/frequency of services to be identified in the IPOS.
SUD Delegated Managed Care Review	
4.5	CMHA-CEI Compliance/Privacy Officer, will train ITRS Leadership on ABD requirements, August 27, 2021. Evidenced by meeting minutes.
4.11	CMHA-CEI Quality Customer Service Recipient Rights office and ITRS Administration met August 2, 2021 to ensure current forms are used and completed correctly. The new Recipient Rights Advisor for ITRS Programs is Jessica Scutt, Compliance Specialist.
4.12	When the program manager met with the consumer in response to their complaint, the consumer verbally informed the manager that they desired to withdraw their complaint. Since no further action was taken, it was not understood that a disposition letter needed to be given to a consumer. CMHA-CEI Quality Customer Service Recipient Rights office and ITRS Administration met August 2, 2021 to ensure forms are used correctly. The new Recipient Rights Advisor for ITRS Programs is Jessica Scutt, Compliance Specialist.
SUD Program Specific	
1.1	KC Brown, ITRS Director, created Operating Guideline 8.1.21 ASAM Criteria Level of Care for ITRS SUD programs to follow, effective 7/20/21.
2.1	KC Brown, ITRS Director, has revised House of Commons Operating Guideline #8.5.9, Resident Health & Care Coordination, to comply with requirements of TB test completion upon admission.

2.2	"KC Brown, ITRS Director, has revised House of Commons Operating Guideline #8.5.9, Resident Health & Care Coordination. KC Brown, ITRS Director, has revised The Recovery Center Operating Guideline #8.8.1, Intake, Admission, Discharge and Follow-Up with correct requirements for medical history, physical examination and medication records.
3.1	KC Brown, ITRS Director, has revised the following Operating Guidelines to include more Peer Recovery Coaching: #8.1.19 ITRS Admin Peer Recovery Coaches, #8.9.1 RECEIPT Admission & Intake Process and #8.9.2 RECEIPT Case management & Peer Recovery Coach Services.

MDHHS Audit

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

In 2020, CMHA-CEI underwent a full site review by MDHHS for SEDW, CWP, and HSW. The site review was conducted for the full MSHN region and included all 12 CMHSPs in the region. For CMHA-CEI 8 HSW charts, 4 CWP charts, and 7 SEDW charts were reviewed by MDHHS. Areas reviewed were case files, provider qualification, and administrative processes related to health and welfare. MDHHS did not complete audits of the waiver programs or the ABA program in 2021, as it was an interim review year. In 2022, MDHHS will complete a full site review for SEDW, CWP, HSW, and the ABA program. The audit will be completed virtually, and will be scheduled between July 2022 – August 2022.

Consumer Satisfaction Survey

Summary

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

Due to COVID-19, this year we mailed paper copies of the MSHN Satisfaction Survey's to two sub-groups within the agency. MHSIP (36 question survey) was mailed to our AMHS consumers and YSSF (26 question survey) was mailed to our Family Forward consumers/families in July 2021, with a self-address stamped envelope to return the survey by August 30, 2021. Other surveys were scheduled for SUD and CSDD consumers but ultimately were canceled due to the pandemic. Data results in this report came from self-selected consumers who chose to return questionnaires voluntarily. The respondents to the survey were anonymous.

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

Survey findings were submitted to MSHN, which completed a final report inclusive of all CMHSPs within the region.

Survey Findings

MSHIP Findings-The satisfaction survey for adults with a mental illness was completed by one- thousand, four hundred and forty-three (1443) individuals in the MSHN region. The survey utilized a 5 point Likert scale with 1 strongly agree and 5 strongly disagree. Anything under 2.50 is considered to be in agreement with the statement. The survey consisted of the following subscales: general satisfaction, perception of access, perception of participation treatment, perception of quality and appropriateness, perception of outcomes of services, perception of social connectedness, perception of social functioning.

The subscales as indicated in Figure 1. that demonstrated performance above the 80% standard included the following:

- Perception of Quality and Appropriateness (92%)
- Perception of Participation in Treatment (93%)
- General Satisfaction (92%)
- Perception of Access (92%)

Attachment 1 indicates the average of subscale line items (questions) that scored the highest include:

- Q16. Staff respected my wishes about who is and who is not to be given information about my treatment services. (1.49)
- Q1. I like the services that I received. (1.56)
- Q13. I was given information about my rights. (1.53)
- Q7. Services were available at times that were good for me. (1.56)
- Q4. The location of services was convenient. (1.57)
- Q11. I felt comfortable asking questions about my treatment, services, and medication. (1.57)

Figure 1. MSHN MHSIP 2020/21 Subscale Ranking (*2013-2017 includes HBS only; beginning 2019 includes all adult programs OPT, CSM, ACT)

Subscales	FY14	FY15	FY16	FY17	FY20	FY20 U.S Rate	FY21
Perception of Quality and Appropriateness	89%	97%	83%	85%	92%	90.8%	**92%**
Perception of Participation in Treatment Planning	86%	94%	88%	84%	92%	86.9%	**93%**
General Satisfaction	86%	90%	84%	83%	92%	90.1%	**92%**
Perception of Access	91%	92%	85%	85%	91%	88.9%	**92%**
Perception of Social Connectedness	84%	82%	78%	70%	81%	79.2%	**79%**
Perception of Functioning	84%	73%	70%	72%	77%	-	**76%**
Perception of Outcome of Services	73%	84%	56%	70%	75%	79.6%	**71%**

Growth areas to consider include areas that performed below the 80% for subscales or above 2.50 in the subscale line items indicating disagreement. In the absence of scores below 80% for the subscale or 2.50 or higher for the subscale line-item consideration should be given to the questions that offer the most opportunity for improvement or that have demonstrated a decrease since the previous year. Subscales where MSHN did not score above the desired performance included the following:

- Perception of Social Functioning (76%)
- Perception of Outcomes of Services(71%)
- Perception of Social Connectedness (79%)

No subscale line items (questions) scored above 2.50 indicating disagreement. The following questions scored the highest indicating room for improvement:

- Q35. I feel I belong in my community. (2.35)
- Q26. I do better in school and/or work. (2.28)
- Q25. I do better in social situations. (2.35)
- Q28. My symptoms are not bothering me as much. (2.32)
- Q27. My housing situation has improved. (2.23)

YSSF Findings-The Youth Satisfaction Survey for Families was completed by five hundred and seventy-five children (575) and/or families in the MSHN region. The survey utilized a 5 point Likert scale with 1 strongly disagree and 5 strongly agree. Anything over 3.50 is considered to be in agreement with the statement. The survey consisted of the following subscales: perception of access, perception of participation treatment, perception of cultural sensitivity, appropriateness, perception of outcomes of services, perception of social connectedness, perception of social functioning.

the following:

- Perception of Cultural Sensitivity (99%)
- Perception of Access (96%)
- Participation in Treatment (93%)
- Social Connectedness (92%)
- Appropriateness (89%)

Attachment 2 indicates the average of the subscale line items (questions) that scored the highest include:

- Q14. Staff spoke with me in a way that I understand (4.70)
- Q12. Staff treated me with respect (4.70)
- Q13. Staff respected my family's religious/spiritual beliefs (4.63)
- Q15. Staff were sensitive to my cultural/ethnic background (4.62)
- Q8. The location of services was convenient for us. (4.61)

Figure 2. MSHN YSSF 2020/19 Subscale Ranking.

(*2013-2017 includes HBS only; beginning 2019 includes all youth programs OPT, CSM, HBS)

Subscale	MSHN *2013	MSHN *2014	MSHN *2015	MSHN *2016/17	MSHN 2019/20	U.S 2020	MSHN 2021
Perception of Cultural Sensitivity	98%	99%	97%	98%	98%	94.6%	99%
Perception of Access	90%	92%	90%	90%	95%	89.2%	96%
Perception of Participation in Treatment	95%	95%	96^	95%	94%	89.4%	93%
Perception of Social Connectedness	92%	92%	84%	88%	92%	88.4%	92%
Appropriateness	90%	92%	90%	90%	87%	89.2%	89%
Functioning	-	69%	61%	66%	65%	-	71%
Outcomes	63%	65%	60%	65%	62%	74.6%	68%

Growth areas to consider include areas that perform below the 80% for subscales or below 3.50 in the subscale line items indicating disagreement. In the absence of scores below 80% for the subscale or 3.50 for the subscale line item, consideration should be given to the questions that offer the most opportunity for improvement or that have demonstrated a decrease since the previous year. Subscales where MSHN did not score above the desired performance included the following:

- Perception of Outcomes of Services (68% an increase from 62%)
- Perception of Social Functioning (71% an increase from 65%)

No subscale line items (questions) scored below a 3.50. the following question scored the lowest indicating room for improvement:

- Q17. My child gets along better with family (3.83 an increase from 3.75)
- Q19. My child is doing better in school and/or work (3.78 an increase from 3.57)
- Q20. My child is better able to cope when things go wrong (3.63 an increase from 3.55)

Quality Assessment and Performance Improvement Program 2020/21 Annual Satisfaction Survey Report

SUDTP Satisfaction Survey Findings-The satisfaction survey for individuals receiving treatment for substance use disorder was completed by two thousand one-hundred and forty (2140) individuals within the MSHN region. The survey utilized a 5 point Likert scale with 1 strongly disagree and 5 strongly agree. Anything over 3.50 is considered to be in agreement with the statement. MSHN demonstrated improvement in the total comprehensive score. The subscale that scored the highest as indicated in Figure 3. was Cultural and Ethnic Background and Treatment Planning/Progress Towards Goal. The subscales that illustrated the most improvement were Coordination of Care/Referrals to Other Resources, Treatment Planning and Progress Toward Goals. All scores were above 3.50 indicating agreement

Figure 3. MSHN's performance ranked by subscale based on averages.

Subscale	2015 Average	2016 Average	2017 Average	2018 Average	2020 Average	2021 Average
Comprehensive Survey Total	4.20	4.40	4.50	4.48	4.58	4.61
Cultural /Ethnic Background	4.50	4.59	4.61	4.60	4.66	4.68
Welcoming Environment	4.50	4.56	4.54	4.55	4.65	4.64
Treatment Planning/Progress Towards Goal	4.30	4.50	4.54	4.53	4.63	4.68
Information on Recipient Rights	4.38	4.49	4.49	4.47	4.56	4.57
Coordination of Care/Referrals to Other Resources	3.40	4.40	4.43	4.39	4.52	4.57
Appropriateness and Choice with Services	4.19	4.43	4.44	4.41	4.50	4.52

The subscale that scored the lowest was Appropriateness and Choice of Service, however, the score was an improvement over FY20.
The lowest scoring questions, as indicated below, ranged from 4.39-4.60 on a scale from 1-5 with 5 being strongly agree.

- 15. My treatment plan includes skills and community supports to help me continue in my path to recovery and total wellness.
- 7. I was given information about the different treatment options available that would be appropriate to meet my needs.

- 14. Staff assisted in connecting me with further services and/or community resources.
- 9. I was given a choice as to what provider to seek treatment from.
- 4. I know how to contact my recipient rights advisor.
- 8. I received services that met my needs and addressed my goals.

Stakeholder Assessment Survey

	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	443	2951	1412	853	5659
2	Is Info on row 1 an unduplicated count? (yes/no)					
3	# referred out due to non-MH needs (of row 1)	16	73	28	61	178
4	Total # who requested services the CMHSP provides (of row1)	427	2878	1384	792	5481
5	Of the # in Row 4 - How many people did not meet eligibility through phone or other screen	13	329	71	34	
6	Of the # in Row 4 - How many people were scheduled for assessment	414	2549	1313	758	
7	other--referred to SA treatment, referred to Crisis services	0	32	3	152	
	CMHSP ASSESSMENT	**DD All Ages**				
8	Of the # in Row 6 - How many did not receive eligibility determination (dropped out, no show, etc.)					
9	Of the # in Row 6 - how many were not served because they were MA FFS enrolled and referred to other MA FFS providers (not health plan)					

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

ICDP/CC360 Data

To assist CMHA Departments with Performance Improvement – QI has been working to learn ICDP/CC360 Data Systems to pull consumer data. FY21 QI accessed Integrated Care Data Platform (ICDP) to pull Service Utilization data for consumers enrolled in CCBHC services. In FY22, QI will increase access to ICDP in order to monitor CCBHC specific measurements and to address Care Alerts noted in the program.

CC360 was primarily accessed in FY21 to monitor COVID-19 vaccination rate information. The information was presented in Virus Task Force meetings, and was used to assist in agency decision making surrounding COVID-19.

Annual Submission to MDHHS FY21

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	443	2951	1412	853	5659
2	Is Info on row 1 an unduplicated count? (yes/**no**)	No	No	No	No	No
3	# referred out due to non-MH needs (of row 1)	16	73	28	61	178
4	Total # who requested services the CMHSP provides (of row1)	427	2878	1384	792	5481
5	Of the # in Row 4 - How many people did not meet eligibility through phone or other screen	13	329	71	34	447
6	Of the # in Row 4 - How many people were scheduled for assessment	414	2549	1313	758	5034
7	other--referred to SA treatment, referred to Crisis services	0	32	3	152	187
	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.)	Unknown	Unknown	Unknown	Unknown	
9	Of the # in Row 6 - how many were not served because they were MA FFS enrolled and referred to other MA FFS providers (not health plan)	Unknown	Unknown	Unknown	Unknown	
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	162	1007	294	158	1621
11 a	Of the # in row 11 - How many were referred out to other mental health providers	unknown	unknown	unknown	unknown	
11 b	Of the # in row 11 - How many were not referred out to other mental health providers	unknown	unknown	unknown	unknown	
12	Of the # in Row 6 - How many people met the cmhsp eligibility criteria	252	1510	1016	448	3226
13	Of the # in Row 12 - How many met emergency/urgent conditions criteria	8	523	303	61	895
14	Of the # in Row 12 - How many met immediate admission criteria	unknown	unknown	unknown	unknown	
15	Of the # in Row 12 - How many were put on a waiting list	0	0	0	0	0
15 a	Of the # in row 15 - How many received some cmhsp services, but wait listed for other services	0	0	0	0	0
15 b	Of the # in row 15 - How many were wait listed for all cmhsp services	0	0	0	0	0
16	Other - explain	0	0	0	0	0

Wait Lists

Clinic Services	MI Adult	DD	SED	Total
Number on waiting list as of date above		87	35	122
Added during the time period covered				0
Removed during the time period covered-service provided				0
Removed during time period covered - all other reasons				0
Number left at the end of the time period covered				0

Supports for Residential Living	MI Adult	DD	SED	Total

Number on waiting list as of date above	24			24
Added during the time period covered	36			36
Removed during the time period covered-service provided	28			28
Removed during time period covered - all other reasons	14			14
Number left at the end of the time period covered	18			18

Priority Needs and Planned Actions

CMHSPs were asked this year to identify Priority Issues.

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

Priority Issue	Reasons For Priority	CMHSP Plan
1. Access to Care	Receiving record numbers or request for services.	CMHA-CEI is continuing to increase access to care through our clinics utilizing the CCBHC model. CMHA-CEI will continue to increase CCBHC services by working with the state on being a demonstration site and to continue to apply for CCBHC Expansion Grant funds.
2. Training of Direct Care Staff	The pandemic put a hold on some in-person trainings like Culture of Gentleness Trainings.	Begin in-person Working with People (Culture of Gentleness) training during FY22 for internal and contracted direct care staff.
3. Recruitment and Retention of Staff	Behavioral health workforce shortage and would like to make CMHA-CEI the behavioral health employer of choice in our catchment area. Will need additional staff to serve a mild-to-moderate population in anticipation of CCBHC.	Current efforts and plans for recruitment and retention are: 1. Wage Increase to all staff 2. Wage Compensation Study on positions a. Phase 1 completed for hardest-to-fill positions – Master's Level Clinical Positions and Nursing. Wage adjustment was done 4/1/22

		b. Phase 2 to study wage and compensation for other positions not recently reviewed. 3. Retention payment implemented in December 2021 4. One-to-One Vacation buyout implemented in December 2021 5. Expanded Student Debt Relief for 2022 6. Planning for a MSU Scholars Cohort to launch in upcoming MSU summer and fall semesters. CEI will sponsor a cohort of nine (9) Bachelor's level clinical staff in obtaining a Master's of Social Work degree. 7. Media Campaign underway that includes commercials, digital ads, and billboards and is titled "Work at CMHA-CEI and make a difference". 8. Resume Manager Adaptive Leadership training and other manager training supports.
4. Strain on Crisis Service Units and Emergency Departments due to lack of local psychiatric beds.	Individuals boarding in crisis services or hospital emergency units while waiting for hospital bed. Need for additional diversion services to prevent boarding	CMHA-CEI has been informed that we will receive funds to start up a local Crisis Stabilization Unit for the Capital Area. A Crisis Stabilization Unit (CSU) is a structured, secure, and multidisciplinary service, functioning within a coordinated continuum of care, and is crucial in filling the gaps in our community in treating persons experiencing an acute episode of mental illness and/or substance use who are a risk to themselves or others. A CSU is a key element in reducing psychiatric hospitalizations, eliminating psychiatric boarding in emergency departments, and

		providing a resource for local law enforcement. CMHA-CEI will be working with local entities to plan for a local CSU.
5. Lack of Housing options - Improve on access and delivery of housing resources to adults with SPMI.	Housing continues to be a universal need across the population of those persons with mental illness. CMHA CEI has addressed this need by adding staff in our AMHS Housing Unit. 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.

Vaccination Rates

Using data available through the MDDHS CareConnect360 program (CC360), Quality Improvement staff were able to monitor the percentage of active CMHA-CEI consumers with a Medicaid coverage plan who received at least one dose of the COVID-19 vaccine. This data provided a visual representation of COVID-19 vaccination status and trends. Parameters to the data available from CC360 are noted below:

- The data includes consumers who had/have an active enrollment during the past year
    - The vaccination data only includes consumers with a Medicaid coverage plan (primary or secondary)
    - Vaccination data is provided from the Michigan Care Improvement Registry (MCIR) and may be delayed in the CC360 program as pharmacies or health departments enter data into the system.

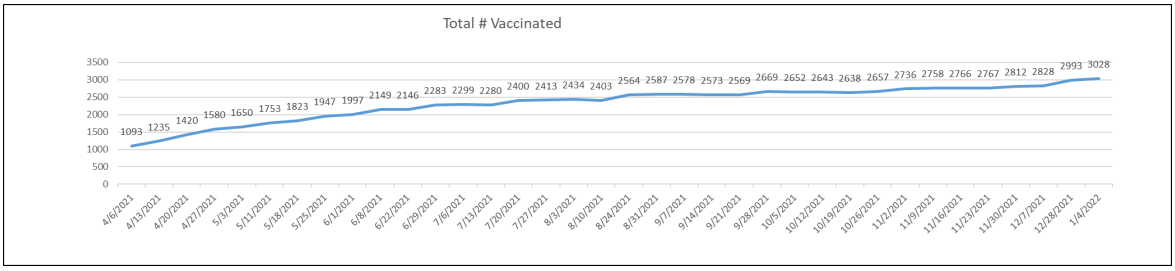


Figure 1: The total number of unique individuals who received at least one dose of the COVID-19 vaccine

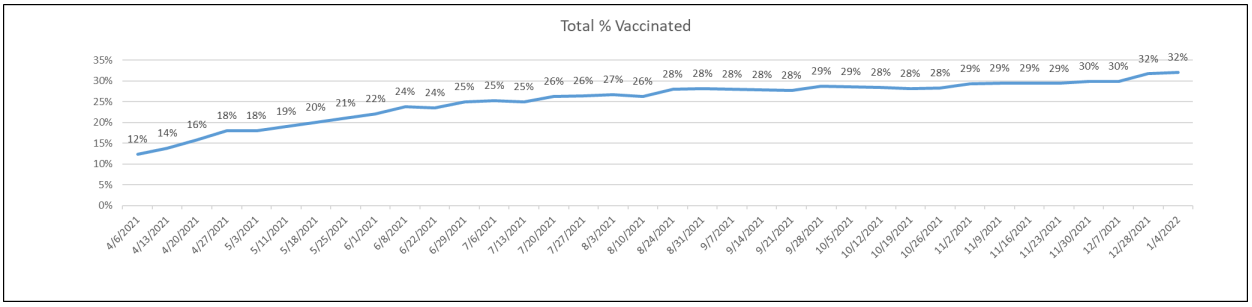


Figure 2: The percentage of total consumers with a Medicaid coverage plan who received at least one dose of the COVID-19 vaccine.