MSHN

Mid-State Health Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Report FY2021

Prepared By: MSHN Quality Manager -January 2022
Reviewed and Approved By: Quality Improvement Council –January 20, 2022
Reviewed By: MSHN Leadership – February 16, 2022
Reviewed By: MSHN Operations Council – February 28, 2022
Reviewed and Approved By: MSHN Board – March 1, 2022

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I. Introduction

The Mid State Health Network (MSHN) Quality Assessment and Performance Improvement Program (QAPIP) is reviewed annually for effectiveness. The review includes the components of the QAPIP, the performance measures, and improvement initiatives, as required based on the MDHHS PIHP contract and the BBA standards. In addition to ensuring the components continue to meet the requirements, each strategic initiative is reviewed to determine if the expected outcome has been achieved. Following the review of the Annual QAPIP Report, recommendations are made for the Annual QAPIP Plan which includes a description of each activity and a work plan for the upcoming year. The Board of Directors receives the Annual QAPIP Report and approves the Annual QAPIP Plan for following year. The measurement period for this annual QAPIP Report is October 1, 2020, through September 30, 2021. The scope of MSHN's QAPIP is inclusive of all CMHSP Participants, the Substance Use Disorder Providers, and their respective provider networks.

II. Organizational Structure

a) Structure

The structure of the QAPIP allows each contracted behavioral health provider to establish and maintain its own unique arrangement for monitoring, evaluating, and improving quality. The MSHN Quality Improvement Council, under the direction of the Operations Council, is responsible for ensuring the effectiveness of the QAPIP. Process improvements will be assigned under the auspices of MSHN to an active PIHP council, committee, workgroup, or task specific Process Improvement Team.

b) Components

Recipients

MSHN continues the legacy of its founding CMHSP Participants by promoting and encouraging active consumer involvement and participation within the PIHP, the respective CMHSP participants and their local communities. Recipients of services participate in the QAPIP through involvement on workgroups, process improvement teams, advisory boards, and Quality Improvement (QI) Councils at the local and regional level. Recipients provide input into policy and program development, performance indicator monitoring, affiliation activities/direction, self- determination efforts, QI projects, satisfaction findings, consumer advocacy, local access and service delivery, and consumer/family education, etc. In addition to the participation of recipients of services in quality improvement activities, MSHN and the CMHSP Participants/SUD Providers strive to involve other stakeholders including but not limited to providers, family members, community members, and other service agencies whenever possible and appropriate. Opportunities for stakeholder participation include the PIHP governing body membership; Consumer Advisory activities at the local, regional, and state levels; completion of satisfaction surveys; participation on quality improvement work teams or monitoring committees; and focus group participation. Stakeholder input will be utilized in the planning, program development, and evaluation of services, policy development, and improvement in service delivery processes.

MSHN will provide oversight and monitoring of all members of its contracted behavioral health network in compliance with applicable regulatory guidance. For the purposes of the Quality Management functions germane to successful PIHP operations, the following core elements shall be delegated to the Community Mental Health Services Programs and SUD Providers within the region:

- Implementation of Compliance Monitoring activities as outlined in the MSHN Corporate Compliance Plan
- Development and Implementation of Quality Improvement Program in accordance with PIHP Quality Assessment and Performance Improvement Plan
- Staff Oversight and Education
- Conducting Research (if applicable)

MSHN will provide guidance on standards, requirements, and regulations from the MDHHS, the External Quality Review, the Balanced Budget Act, and/or other authority that directly or indirectly affects MSHN PIHP operations. Communication related to standards and requirements will occur through policy and procedure development, constant contact, training, and committees/councils. MSHN will retain responsibility for developing, maintaining, and evaluating an annual QAPIP and report in collaboration with its CMHSP Participants and Substance Use Disorder Providers. MSHN will comply with 42 CFR Program Integrity Requirements, including designating a PIHP Compliance Officer. Assurances for uniformity and reciprocity are as established in MSHN provider network policies and procedures.

Communication of Process and Outcomes

The MSHN Quality Improvement Council (QIC) is responsible for monitoring and reviewing performance measurement activities including identification and monitoring of opportunities for process and outcome improvements in collaboration with other committees and councils, and the CMHSP Participants and SUD Providers. A quality structure should identify clear linkages and reporting structures. Quarterly, members of the committees, councils, and other relevant MSHN staff review the status of the organizational performance measures to identify trends, correlations, and causal factors, establishing a quality improvement plan to address organizational deficiencies.

For any performance measure that falls below regulatory standards and/or established targets, quality improvement plans are required. After QIC meetings, reports are communicated through regular reporting via Councils, Committees, the Board of Directors, and Consumer Advisory Council meetings. Status of key performance indicators, consumer satisfaction survey results, and performance improvement (PI) projects are reported to consumers and stakeholders, as dictated by the data collection cycle. The Board of Directors receives an annual report on the status of organizational performance. Final performance and quality reports are made available to stakeholders and the general public as requested and through routine website updates.

MSHN is responsible for reporting the status of regional PI projects and verification of Medicaid services to MDHHS. These reports summarize regional activities, achievements, and include interventions resulting from data analysis.

The expectation of the use of practice guidelines are included in provider contracts. Practice guidelines are reviewed and updated annually or as needed and are disseminated to appropriate providers through relevant committees/councils/workgroups. All practice guidelines adopted for use are available on the MSHN website.

c) Governance

Board of Directors

The MSHN's Board of Directors employs the Chief Executive Officer (CEO), sets policy related to quality management, and approves the PIHP's QAPIP, including the priorities as identified in this plan. The QAPIP

Plan is evaluated and updated annually, or as needed, by the MSHN Quality Improvement Council.

Through the Operations Council, Substance Use Disorder Oversight Policy Board and MSHN CEO, the MSHN's Board of Directors receives an Annual Quality Assessment and Performance Improvement Report evaluating the effectiveness of the quality management program and recommending priorities for improvement initiatives for the next year. The report describes quality management activities, performance improvement projects, and actions taken to improve performance. After review of the Annual Quality Assessment and Performance Improvement Report through the Board of Directors, the QAPIP Report will include a list of the Board of Directors' and will be submitted to the Michigan Department of Health and Human Services (MDHHS).

Chief Executive Officer

MSHN's CEO is hired/appointed by the PIHP Board and is the designated senior official with responsibility for ensuring implementation of the regional QAPIP. The MSHN CEO has designated the Quality Manager as the chair of the MSHN Quality Improvement Council. In this capacity, the Quality Manager under the direction of the Director of Compliance, Customer Service and Quality, is responsible for the development, review, and evaluation of the Quality Assessment and Performance Improvement Plan and Program in collaboration with the MSHN Quality Improvement Council.

The MSHN CEO allocates adequate resources for the quality management program and is responsible for linking the strategic planning and operational functions of the organization with the quality management functions. The CEO assures coordination occurs among members of the Operations Council to maintain quality and consumer safety. Additionally, the CEO is committed to the goals of the quality improvement plan and to creating an environment that is conducive to the success of quality improvement efforts, ensuring affiliation involvement, removing barriers to positive outcomes, and monitoring results of the quality improvement program across the PIHP. The CEO reports to the PIHP Board of Directors recommending policies and/or procedures for action and approval. The CEO is responsible for managing contractual relationships with the CMHSP Participants and Substance Use Disorder Providers and for issuing formal communications to the CMHSP Participants/SUD Providers regarding performance that does not meet contractual requirements or thresholds. Similarly, the CEO is responsible for assuring ongoing monitoring and compliance with its MDHHS contract including provision of performance improvement plans as required.

Medical Director

The MSHN Medical Director and MSHN Addictions Treatment Medical Director consults with MSHN staff regarding service utilization and eligibility decisions and is available to provide input as required for the regional QAPIP.

The MSHN Medical Director is an ad hoc member of the MSHN Quality Improvement Council and demonstrates an ongoing commitment to quality improvement; participating on committees and work teams as needed, reviewing quality improvement reports, sentinel events, and critical incidents; and assisting in establishing clinical outcomes for the PIHP.

CMHSP Participants/SUD Providers

A quality representative from each CMHSP is appointed by the CMHSP CEO to participate in the MSHN Quality Improvement Council. Substance Use Disorders services are represented on the Council by MSHN SUD Staff. CMHSP Participant/SUD Provider staff have the opportunity to participate in and to support

the QAPIP through organization wide performance improvement initiatives. In general, the CMHSP Participant/SUD Provider staff's role in the PIHP's performance improvement program includes:

- Participating in valid and reliable data collection related to performance measures/indicators at the organizational or provider level.
- Identifying organization-wide opportunities for improvement.
- Having representation on organization-wide standing councils, committees, and work groups.
- Reporting clinical care errors, informing consumers of risks, and making suggestions to improve the safety of consumers.
- Responsible for communication between the PIHP QIC and their local organization.

Councils and Committees

MSHN Councils and Committees are responsible for providing recommendations and reviewing regional policy's regarding related managed care operational decisions. Each council/committee develops and annually reviews and approves a charter that identifies the following: Purpose, Decision Making Context and Scope, Defined Goals, Monitoring, Reporting and Accountability, Membership, Roles and Responsibilities Meeting Frequency, Member Conduct and Rules, and Upcoming Goals supporting the MSHN Strategic Plan. The Operations Council approves all council/committee charters. Each council/committee guides the Operations Council who advises the MSHN CEO. These recommendations are considered by the Operations Council on the basis of obtaining a consensus or simple majority vote of the twelve CMHSP participants. Any issues remaining unresolved after Operations Council consideration will be subject to a vote with the majority position being communicated to the MSHN Board. The MSHN CEO retains authority for final decisions or for recommending action to the MSHN Board.

Among other duties, these councils/committees identify, receive, and respond on a regular basis to opportunities and recommendations for system improvements arising from the MSHN Quality Assessment and Performance Improvement Program and reports annually on the progress of accomplishments and goals.

Regional Medical Directors

The Regional Medical Directors Committee, which includes membership of the MSHN Medical Director and the CMHSP participant Medical Directors, provide leadership related to clinical service quality and service utilization standards and trends.

SUD Oversight Policy Board

Pursuant to section 287 95) of Public Act 500 of 2012, MSHN established a Substance Use Disorder Oversight Policy Board (OPB) through a contractual agreement with and membership appointed by each of the twenty-one counties served. The SUD-OPB is responsible to approve an annual budget inclusive of local funds for treatment and prevention of substance use disorders; and serves to advise the MSHN Board on other areas of SUD strategic priority, local community needs, and performance improvement opportunities.

SUD-Provider Advisory Council (PAC)

The PAC was charged with serving in an advisory capacity to MSHN to represent SUD providers offering input regarding SUD policies, procedures, strategic planning, quality improvement initiatives, monitoring and oversight processes, to support MSHN's focus on evidence-based, best practice service, delivery to persons served, and assist MSHN in establishing and pursuing state and federal legislative, policy and

regulatory goals. The broad-based SUD-PAC included every Level of Care (LOC) and recovery housing. In the four years since the SUD-PAC was established, engagement and membership declined. Due to lack of efficiency, it is recommended that the MSHN SUD provider network utilize workgroups to serve in an advisory capacity to MSHN to represent SUD providers and to offer input regarding SUD policies, procedures, strategic planning, quality improvement initiatives, monitoring and oversight processes, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served. Each SUD provider workgroup is specific to a Level of Care (LOC) or recovery and functional areas including, Women's Specialty Services, Medication Assisted Treatment, Residential, as well as prevention and a broader recovery-oriented workgroup. The MSHN SUD provider workgroups will be used for advisory input around the functions that gave rise to the SUD-PAC's original intent.

Regional Consumer Advisory Council (RCAC)

The RCAC is charged with serving as the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports requirements in the region.

III. Annual Reports

a) MSHN Councils Annual Reports FY21

Team Name: Mid-State Health Network Operations Council

Team Leader: Joseph Sedlock, MSHN Chief Executive Officer

Report Period Covered: 10.1.20-9.30.21

Purpose of the Operations Council:

The MSHN Board has created an OC to advise the Pre-paid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) concerning the operations of the Entity. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the MSHN CEO to bring local perspectives, local needs, and greater vision to the operations of the Entity so that effective and efficient service delivery systems are in place that are accountable to the entity board, funders and the citizens who make our work possible.[1]

Responsibilities and Duties[2]:

The responsibilities and duties of the OC shall include the following:

- Advise the MSHN CEO in the development of the long-term plans of MSHN.
- Advise the MSHN CEO in establishing priorities for the Board's consideration.
- Make recommendations to the MSHN CEO on policy and fiscal matters.
- Review recommendations from Finance, Quality Improvement, and Information Services Councils other Councils/Committees asassigned.
- Assure policies and practices are operational, effective, efficient and in compliance with applicable contracting and regulatory bodies[3];and
- Undertake such other duties as may be delegated by the Entity Board.

[1] Article III, Section 3.2, MSHN/CMHSP Operating Agreement

[2] Ibid., unless otherwise footnoted

[3] Operations Council Charter, February 2014

Defined Goals, Monitoring, Reporting and Accountability[4]

The Operations Council shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Expanded service access (penetration rates),
- Fiscal accountability,
- Compliance, and
- Improved health outcomes/satisfaction.

Additionally, the OC seeks to assess and achieve the following secondary goals:

- Retained function contracts achieved defined results,
- Collaborative relationships are retained (Evaluation of principles and values),
- Board satisfaction with OC advisory role,
- Staff perception and sense of knowing what is going on,
- Efficiencies are realized through standardization and performance improvement, and
- Benefits are realized through our collective strength.

Annual Evaluation Process:

a. Past Year's (FY 21) Accomplishments:

- Strong COVID-19 pandemic response coordination and regional collaboration.
  - Developed regional responses to provider questions and published definitive responses, published and updated pertinent regional pandemic-related guidance documents, published and updated COVID-related operational protocols.
  - Implemented regional direct care worker premium pay initiative with multiple extensions through the year.
  - Implemented regional provider support and stabilization initiatives.
  - Provided financial and in-kind supports to dozens of in-region providers.
  - Considered regional workforce recognition program (was not implemented regionally due to audit finding concerns).
  - Distributed personal protective equipment (PPE) to all regional CMHSPs and dozens of residential and ambulatory care providers, including substance use disorder network.
  - Pursued a formal request with MDHHS for a temporary moratorium on Specialized Residential Site Review activity for Providers struggling with Audits, HCBS oversight, MEV reviews, etc. to not have compliance issues if items are postponed.
  - Committed to MSHN-led, regional approaches to standardize to the extent feasible responses to the COVID-19 pandemic.
    - Met weekly during most of the pandemic response period in this fiscal year to coordinate regional and local pandemic status/response.
    - Facilitated workforce and beneficiary engagement in vaccination activities.
  - Developed regional statement/communication regarding recommendation that all regional meetings be mandated "Video On".
- Monitored regional financial performance, including regional budget amendments for current year budget and provided input on FY 22 budget.
- Supported regional participation in the State's Bed Registry Pilot to collect inpatient denial data.
- Reviewed and approved changes and additions to the current year (FY 21) and next year (FY 22):
  - Delegated Managed Care Review Tools

[4] Ibid.

- MSHN/CMHSP Medicaid Sub-Contracting Agreement
- Regional training grid
- Regional Financial Management Services contract
- Regional Psychiatric Inpatient Hospital contract
- Regional ABA/Autism Services Contract

- Reviewed and approved changes to the:
  - FY21-22 Population Health and Integrated Care Plan
  - FY21 Consumer Handbook
  - FY 21 Regional Network Adequacy Assessment
  - MMBPIS Indicator and Performance Reports, including new indicators and changes to measurement methodology
  - QAPIP FY20 Annual Effectiveness report
  - FY21 QAPIP Plan and Workplan
  - Corporate Compliance Plan
- Approved the proposal to add consumer representation on MSHN councils and committees. Approved the charters for both QIC and Customer Service.
- Supported the Independent Facilitation (IF) regional contracting proposal to secure IF services.
- Discussed and supported current COFR policy.
- MSHN earning and distribution of FY 20 Performance Bonus Incentives.
- Strong engagement, collaboration, and regional commitment to strategic planning through multiple strategic planning meetings.
- Considered and supported a MSHN-held Crisis Residential Contract for the benefit of beneficiaries in the region.
- Presented the FY21 Balanced Scorecard with a new report including the CCBHC metrics in draft form until final CCBHC metrics have been determined along with the role of the PIHP.
- CCBHC – related planning and preparation.
- Approved MSHN to negotiate the RELIAS contract to determine best option for the region.
- Prepared for MiCAL expansion into MSHN region.
- Approved updated charters to Councils, Committees and Workgroups.
- Approved updated Policies and Procedures as presented for review.
- Reviewed multiple regional reports; Satisfaction Surveys, Denials & Grievances, Priority Measures, MMBPIS, Critical Incidents, Penetration Rates, Telehealth Utilization, Behavior Treatment, Acute Care Services.
- Reviewed External Regional Audit Results; HSAG Compliance, Performance Measure Validation, Performance Improvement Plan (PIP).

b. <u>Upcoming Goals for Fiscal Year Ending, September 30, 2022:</u>

- Continue provider support during COVID-19 pandemic response period:
  - Address workforce crisis regionally through continuation of Direct Care Worker Premium Pay initiative.
  - Continue regional provider stabilization initiative.
- Advocate for system reform changes that work for beneficiaries in the region while addressing, responding to, and planning for changes to the public behavioral health system as a result of legislative/other proposals for system redesign.
- Implement applicable portions of the MSHN Strategic Plan for FY 2022-2023.

Team Name: Finance Council
Team Leaders: Leslie Thomas MSHN Chief Financial Officer
Report Period Covered: 10.1.20-9.30.21

Purpose of the Finance Council

The Finance Council shall make recommendations to the Mid-State Health Network (MSHN) Chief Finance Officer (CFO), Chief Executive Officer (CEO) and the Operations Council (OC) to establish all funding formulas not otherwise determined by law, allocation methods, and the Entity's budgets. The Finance Council may advise and make recommendations on contracts for personnel, facility leases, audit services, retained functions, and software. The Finance Council may advise and make recommendations on policy, procedure, and provider network performance. The Council will also regularly study the practices of the Entity to determine economic efficiencies to be considered.

Responsibilities and Duties:

Areas of responsibility:

- Budgeting – general accounting and financial reporting
- Revenue analyses
- Expense monitoring and management - service unit and recipient centered
- Cost analyses and rate-setting
- Risk analyses, risk modeling and underwriting
- Insurance, re-insurance, and management of risk pools
- Supervision of audit and financial consulting relationships
- Claims adjudication and payment; and
- Audits.

Monitoring and reporting of the following delegated financial management functions:

- Tracking of Medicaid expenditures
- Data compilation and cost determination for rate setting
- FSR, EQI or other MDHHS costing initiatives
- Verification of the delivery of Medicaid services; and
- Billing of all third-party payers.

Monitoring and reporting of the following retained financial management functions:

- PIHP capitated funds receipt, dissemination, and reserves
- Region wide cost information for weighted average rates
- MDHHS reporting; and
- Risk management plan

Defined Goals, Monitoring, Reporting and Accountability

- Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2019 and February 2020. The audits will be available to the PIHP once they are reviewed by their respective Board of Directors. The goal is to have all CMHSP reports by April 2020. A favorable fiscal audit will be defined as those issued with an unqualified opinion. A favorable compliance audit will be defined as one that complies in all material aspects with relevant contractual requirements.
- Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2019 Final Reports due to MDHHS February 28, 2020, are received from the CMHSPs to the PIHP. The

goal for FY20 will be to spend at a level to maintain MSHN's anticipated combined reserves to 15% as identified by the board. This goal does not override the need to ensure consumers in the region receive medically necessary care.

- Work toward a uniform costing methodology: The PIHP CFO will participate in a Statewide workgroup initiated by MDHHS and Community Mental Health Administration to establish standard cost allocation methods. The goal is to reduce unit cost variances for each CPT or HCPCS. The Medicaid Uniform Cost Report (MUNC) is due to MDHHS February 28, 2020. MDHHS compiles PIHP reports and send an analysis to the PIHPs in June of 2020. Finance Council will review rates per service and costs per case for service codes identified in the Service Use and Analysis report suite. Finance Council will evaluate if action is needed based on State comparisons.
- Uniform Administrative Costing – MSHN's CFO participates in the PIHP CFO council. The PIHP CFO council developed definitions, grids, and guidelines for uniform administrative costing. Finance Council members agreed to follow the methodology guidance from MSHN. CMHSPs must show evidence of meeting MSHN's guidelines through its Administrative Cost Report (ACR) narrative.
- Monitor the impact on savings and reserves related to addition of Serious Emotional Disturbances (SED) Waiver and Children's Waiver funding now included in the PIHP's capitation. Both programs were previously funded directly to the CMHSPs on a fee- for-service basis.
- Improve accuracy of interim reporting and projections in order to plan forpotential risk related to use of reserve funds.
- Monitor changes related to 1115 waiver and its impact on the region's funding.

Annual Evaluation Process

a. Past Year's Accomplishments
    - FY 2020 fiscal audits were complete and submitted by the PIHP and 12 CMHSPs. The PIHP's and all CMHSP audits rendered an unqualified opinion. Compliance Examinations were finalized for the PIHP and all CMHSPs. The PIHP's Compliance Examination is completed after the CMHSPs to ensure all adjustments to Medicaid and Healthy Michigan Plan are included. The PIHP and its 12 CMHSPs complied in all material aspects with attestation standards set forth by the American Institute of Certified Public Accountants.
    - MSHN achieved a fully funded (7.5%) Internal Service Fund for FY 2020. In addition, the region boasted savings of more than $31.8 M which is approximately 5.2% of revenue for a total risk reserve of 12.7%.
    - MDHHS and Milliman worked through FY 21 to develop a Standard Cost Allocation (SCA) process. Throughout FY 21, Milliman has conducted SCA workgroup meetings and started statewide bi-weekly question and answer sessions. Although the implementation date of SCA is FY 22, only four MSHN's CMHSPs will meet this deadline (The Right Door, Lifeways, Saginaw, and Tuscola). The other eight CMHSPs received approval for an FY 23 implementation.
    - The SED and CW are incorporated into Medicaid funding for MDHHS reporting. MSHN also tracks each revenue source to ensure sufficiency for covering CMHSP expenses. In FY 21 revenues are sufficient to meet service needs.
    - MSHN successfully submitted FY 21 Encounter Quality Initiative (EQI) reports to MDHHS. EQI reporting replaced Utilization Cost Reports submitted in previous fiscal years.

b) In addition to the accomplishments listed above, MSHN's Region successfully implemented strategies to maintain provider fiscal stability during the COVID-19 pandemic. The goal was to ensure providers continued service delivery including implementing many changes such as audio only telehealth expansion and increased in-person safety measures. MSHN expended provider

stability funds with existing FY 21 revenue as MDHHS did not disburse additional funds for this initiative.

c) Further, Direct Care Workers (DCW) were granted a $2 per hour premium pay increase for MDHHS identified services. In March 2021, the rate was increased to $2.25 per hour and all DCW payments include an additional 12% to cover the provider's associated administrative expenses. The State of Michigan's budget included continuation of the DCW premium pay and the effective October 1, 2021, boosted the hourly rate to $2.35.

Upcoming Goals for Fiscal Year Ending September 30, 2022, Goals:

- Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2021 and February 2022. The audits will be available to the PIHP once they are reviewed by their respective Board of Directors. The goal is to have all fiscal CMHSP reports by April 2022 and compliance exams by June 2022. A favorable fiscal audit will be defined as those issued with an unqualified opinion. A favorable compliance audit will be defined as one that complies in all material aspects with relevant contractual requirements.
- Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2021 Final Reports due to MDHHS March 31, 2022, are received from the CMHSPs to the PIHP. The goal for FY21 will be to spend at a level to maintain MSHN's anticipated combined reserves to 15% as identified by the board. This goal does not override the need to ensure consumers in the region receive medically necessary care.
- Work toward a uniform costing methodology: The PIHP CFO will participate in a Statewide workgroup initiated by MDHHS and Milliman to establish standard cost allocation methods. Regionally, Finance Council will review rates per service and costs per case for service codes identified in the Service Use and Analysis report suite. Finance Council will evaluate if action is needed based on State comparisons.
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.
- Monitor changes related to 1115 waiver and its impact on the region's funding.

TEAM NAME: Information Technology Council

TEAM LEADER: Forest Goodrich, MSHN Chief Information Officer

REPORT PERIOD COVERED: 10.1.20-9.30.21

Purpose of the Council or Committee:

The MSHN IT Council (ITC) is established to advise the Operations Council (OC) and the Chief Executive Officer (CEO) and will be comprised of the Chief Information Officer (CIO) and the CMHSP Participants information technology staff appointed by the respective CMHSP CEO/Executive Director. The IT Council will be chaired by the MSHN CIO. All CMHSP Participants will be equally represented.

Responsibilities and Duties:

The responsibilities and duties of the ITC include the following:

- The IT Council will provide information technology leadership by collaborating for the purpose of better understanding MDHHS and other regulatory requirements, sharing knowledge and best practices, working together to resolve operational issues that affect both CMHSPs and MSHN, and achieve practical solutions. The IT Council will assist CMHSP IT staff in keeping up to date on current technology and with MDHHS and MSHN requirements by exchanging knowledge and ideas, and promoting standard technology practices and efficiency throughout the region. The IT Council will advise the MSHN CIO and assist with MSHN IT planning that benefits both MSHN and the individual CMHSP Participants.

Defined Goals, Monitoring, Reporting and Accountability:

The IT Council shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Representation from each CMHSP Participant at all meetings
- Successfully submit MDHHS required data according to MDHHS requirements regarding quality, effectiveness, and timeliness
- Collaborate to develop systems or processes to meet MDHHS requirements (e.g., BH-TEDS reporting, Encounter reporting)
- Accomplish annual goals established by the IT Council and/or OC, such as:
  a. Work on outcome measure data management activities as needed.
  b. Improve balanced scorecard reporting processes to achieve or exceed target amounts.
  c. Transition health information exchange (HIE) processes to managed care information system, when appropriate, to gain efficiencies in data transmissions.
- Meet IT audit requirements (e.g., EQRO).

Annual Evaluation Process:

a. Past Year Accomplishments
   - Representation from each CMHSP Participant at all meetings
     - There was a 99% attendance rate during FY20 ITC meetings. 100% attendance occurred in 10 meetings. Participation remains active as we are a highly collaborative group, sharing expertise and project strategies.
   - Successfully submit MDHHS required data regarding quality, effectiveness, and timeliness
     - We exceeded 95% compliance standard for submitting BH-TEDS with all three transaction types: mental health, substance use, and crisis records. (M, A, Q transactions)
     - MDHHS reported we were measured at 99.1% in encounter reporting timeliness and

volume submissions at quarterly intervals. MSHN reconciled 100% to MDHHS warehouse records at year-end.
    - MSHN met the requirements for MDHHS performance incentives that included evaluating Veterans Navigator quarterly reporting and Veteran's status in BH-TEDS reporting and submitting BH ADT records by two CMHSPs in the region to MiHIN. (CEI and Lifeways)
- Several initiatives that ITC assisted with during this fiscal year are:
    - Continued trending telehealth events during pandemic.
    - Assisted with encounter alignment to meet EQI reporting requirements.
- Facilitate health information exchange processes
    - Changed the active care relationship process (ACRS) to derive from CMHSP systems so that data exchange is timely.
    - Implemented COVID-19 response file exchange.
    - Transitioned LOCUS data exchange to HIE between CMHSP systems and MSHN.
    - Admission, Discharge and Transfer records are received directly into CMHSP EMR.
    - Continued pilot process with MDHHS and MiHIN for Substance Use Disorder eConsent in MI Gateway.
- Goals established by Operations Council
    - Improvements with balanced scorecard reporting.
    - Continue trending COVID-19 and telehealth reports.
    - Manage upgrades to MCG Indicia and guidelines.
- Meet external quality review requirements
    - Health Services Advisory Group conducted a review for MDHHS and evaluated performance measures and information systems capabilities. Both areas were successful and approved.

b. Goals for fiscal year ending September 30, 2022
- Active participation by all CMHSP representatives at each monthly meeting.
- Meet current reporting requirements as defined by MDHHS.
- Improve Employment and Minimum Wage field values in BH-TEDS reporting process.
- Pilot CC360 API integration in EMRs.
- Provide analysis with Medicaid disenrollment impact.
- Work to achieve balanced scorecard target values.
- Continue implementing BH ADT record submission to MiHIN for shared HIE processing.
- Work toward achieving goals established by Operations Council.
- Prepare for and pass audit requirements of the external quality review.

TEAM NAME: Quality Improvement Council
TEAM LEADER: Sandy Gettel, MSHN Quality Manager
REPORT PERIOD COVERED: 10.1.20 – 9.30.21

Purpose of the Council or Committee:

The Quality Improvement Council was established to advise the Operations Council and the Chief Executive Officer concerning quality improvement matters. The Quality Improvement Council is comprised of the MSHN Quality Manager, the CMHSP Participants' Quality Improvement staff appointed by the respective CMHSP Participant Chief Executive Officer/Executive Director and a MSHN SUD staff representing substance use disorder services as needed. The Quality Improvement Council is chaired by the MSHN Quality Manager. All Participants are equally represented on this council.

Responsibilities and Duties:

The responsibilities and duties of the QIC include the following:

- Advise the MSHN Quality Manager and assist with the development, implementation, operation, and distribution of the Quality Assessment and Performance Improvement Plan (QAPIP) and supporting MSHN policies and procedures.
- Recommend and monitor the development of internal systems and controls to carry out the Quality Assessment and Performance Improvement Program and supporting policies as part of daily operations.
- Development of valid and reliable data collection related to performance measures/indicators at the organizational/provider level.
- Identification of organization-wide opportunities for improvement including but not limited to the safety of consumers.
- Evaluating the effectiveness of the QAPIP.
- Determining the appropriate strategy/approach to promote compliance and detect potential violations and areas of risk as well as areas of focus.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.

Defined Goals, Monitoring, Reporting and Accountability

The QIC established metrics and monitoring criteria to evaluate progress on the following primary goals:

- Implementation of the Quality Assessment and Performance Improvement Program (QAPIP) Plan.
- Performance Measures included within the QAPIP as required by MDHHS and identified through Operations Council.
- Improvement efforts as it relates to external reviews including but not limited to the External Quality Reviews and MDHHS reviews.
- Compliance and oversight of the above identified areas.

Additionally, the QIC seeks to assess and achieve the following secondary goals:

- Retained function contracts achieved defined results.
- Collaborative relationships are retained.
- Reporting progress through Operations Council.
- Regional collaboration regarding expectations and outcomes.
- Efficiencies are realized through standardization and performance improvement.
- Improved performance is realized through our collective strength.

Annual Evaluation Process:

a. Past Year's Accomplishments: The QIC had twelve (12) meetings during the reporting period and in that time completed the following tasks:
   - Reviewed and approved the FY20 Quality Assessment and Performance Improvement Report.
   - Reviewed, revised, and approved the FY21 Quality Assessment and Performance Improvement Plan.
   - Reviewed, revised, and developed current regional policies and procedures in areas of Quality Improvement.
   - Reviewed the Annual Medicaid Event Verification Report.
   - Reviewed the Quality Assessment Performance Improvement (QAPI) Report which includes trends, strengths and growth areas from site reviews that occurred within the quarter.
   - Reviewed and approved the FY21 Delegated Managed Care Site Review Tools.
   - Reviewed key performance indicators (Diabetes Screening, Follow Up to Hospitalization, Diabetes Monitoring) quarterly identifying trends and action steps as needed.
   - Reviewed the Recovery Self-Assessment data (Administrator, Provider) identifying trends and growth areas.
   - Evaluated the effectiveness of the interventions and reviewed the data for the performance improvement project "Diabetes Monitoring for Schizophrenia Diagnosis" identifying barriers and interventions.
   - Identified a proposed new PIP topic for CY22
   - Reviewed the Critical Incident Data quarterly, developed a more in-depth analysis for identifying trends and growth areas for development of focused improvement efforts; developed a corrective action plan to address the timeliness of reporting incidents; developed a process to collect supplement data (drug related and COVID as a contributing factor) for death reporting.
   - Reviewed the Michigan Mission Based Performance Indicator System (MMBPIS) data quarterly report identifying trends and actions steps for improvement.
   - Monitored the process for collection and analysis of the new (Indicator 2, Indicator 2e and 2b, and Indicator 3) Michigan Mission Based Performance Indicator System (MMBPIS).
   - Reviewed the Behavior Treatment Review Data quarterly, identifying trends and growth areas
   - Participated in the External Quality Reviews (Performance Improvement Project, Performance Measurement Validation, Compliance Review), completing and implementing required corrective action and recommendations.
   - Completed satisfaction surveys for representative populations, identifying trends and growth areas for development of focused improvement efforts.
   - Completed annual review and update of QIC charter.

b. Goals for Fiscal Year Ending, September 30, 2022
   - Incorporate consumer representatives in QIC Council and meetings.
   - Report and complete a QAPIP report to assess the effectiveness of the QAPIP.
   - Conduct ongoing bi- annual review of required policies, revising as needed to ensure compliance of MDHHS/MSHN requirements and processes.
   - Continue implementation, monitoring and reporting of progress on the two (2) regional Performance Improvement Projects.
   - Continue quarterly monitoring of quality and performance improvement related to the QAPIP, streamlining the reporting and improvement process in coordination with clinical

committees/councils when relevant.
  - Behavior Treatment Review
  - Critical Incidents
  - Performance Improvement (MMBPIS)
  - Consumer Satisfaction
  - Follow Up to Hospitalization (FUH)
- Review available healthcare data for identification of trends and quality improvement opportunities.
- Incorporate Ethnic/Racial disparities into the relevant performance measures including but not limited to the FUH performance measure.
- Continue to measure stakeholder feedback and/satisfaction.
- Continue to develop a process to strengthen and to ensure training for Person-Centered Planning, Independent Facilitation and Self Determination implementation.
- Will perform at or above standard for identified performance measures.
- Monitor progress of and evaluate the effectiveness of site review corrective action plans.

b) MSHN Advisory Councils FY21 Annual Reports

Team Name: Regional Consumer Advisory Council
Team Leader: Gordon Matrau, Chairperson
Report Period Covered: 10.1.20-9.30.21

Purpose of the Consumer Advisory Council:

The Consumer Advisory Council will be the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports and coordinating agency requirements in the region. The Consumer Advisory Council includes representatives from all twelve (12) CMHSP Participants of the region.

Responsibilities and Duties:

Other responsibilities and duties of the CAC shall include the following:

- Provide representation to the MSHN CAC on behalf of the local consumer councils.
- Assist with effective communication between MSHN and the local consumer advisory mechanisms.
- Advise the MSHN Board of Directors relative to strategic planning and system advocacy efforts for public mental health.
- Advise MSHN Board of Directors related to regional initiatives for person-centered planning, self-determination, health care integration, independent facilitation, recovery, eligibility management, network configuration, and other consumer-directed options.
- Provide recommendations related to survey processes, customer satisfaction, consumer involvement opportunities, consumer education opportunities, quality and performance improvement projects and other outcome management activities.
- Focus on region-wide opportunities for stigma reduction related to mental health and substance use disorder issues.

Defined Goals, Monitoring, Reporting and Accountability

- The CAC shall review aggregate reports received from the Quality Assessment and Performance Improvement Program (QAPIP), provide recommendations, and give guidance and suggestions regarding consumer-related managed care processes.
- Provide feedback for regional initiatives designed to encourage person-centered planning, self- determination, independent facilitation, anti-stigma initiatives, community integration, recovery and other consumer-directed goals.
- Share ideas and activities that occur at the local CMHSP level and create an environment that fosters networking, idea sharing, peer support, best practices, and resource sharing.

Annual Evaluation Process:

a. Past Year's Accomplishments: The Consumer Advisory Council had 6 meetings during the reporting period and in that time, they completed the following tasks:
    - Reviewed the Annual Compliance Summary Report
    - Reviewed changes to the FY21 MSHN Consumer Handbook
    - Reviewed Quality Improvement Performance Measure Reports that included Performance Indicators, Behavior Treatment Review and Oversight, Critical Incidents, Grievance and

Appeals, and Medicaid Fair Hearings

- Reviewed and provided feedback on the satisfaction survey results
- Reviewed and provided feedback on the MSHN Compliance Plan
- Reviewed and provided feedback on the MSHN Council/Committee Consumer Representative process
- Reviewed and provided feedback on 2022-2023 MSHN Strategic Plan
- Reviewed and provided feedback on Quality Assessment and Performance Improvement
- Partnered with MSHN to promote the Regional HCBS Final Rule Presentation
- Education on the Veteran Navigator program
- Education on and discussion on Veterans: Homelessness and Mental Health Support
- Reviewed outcomes from Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and Performance Improvement Project (PIP) annual reviews
- Reviewed and revised council charter
- Discussed the Public Behavioral Health System Redesign and explored advocacy opportunities
- Improved practices for ongoing communication between MSHN and local councils
- Ongoing discussion on ways to strengthen Person Centered Planning, Independent Facilitation and Self Determination Implementation
- Reviewed and approved RCAC annual effectiveness report
- Continued online meetings through Zoom in response to the global pandemic

b. Upcoming Goals for Fiscal Year 2022 Ending, September 30, 2022:

- Provide input on regional educational opportunities for stakeholders
- Provide input for ongoing strategies for the assessment of primary/secondary consumer satisfaction
- Review regional survey results including SUD Satisfaction Survey and external quality reviews
- Review annual compliance report
- Annual review and feedback on QAPIP
- Annual review and feedback on Compliance Plan
- Annual review of the MSHN Consumer Handbook
- Review and advise the MSHN Board relative to strategic planning and advocacy efforts
- Provide group advocacy within the region for consumer related issues
- Explore ways to improve Person Centered Planning, Independent Facilitation and Self Determination Implementation
- Improve communication between the Regional Consumer Advisory Council and the local CMHSP consumer advisory groups
- Explore ways to get more consumers involved in the RCAC and local consumer councils
- Public Behavioral Health System Redesign Advocacy

TEAM NAME: Substance Use Disorder Provider Advisory Committee (SUD-PAC)
TEAM LEADERS: Shannon Myers, Treatment Specialist; Jill Worden, Prevention Lead; Melissa Davis, QAPI Manager; Kathrin Flavin, Utilization Management and Dani Meier, Chief Clinical Officer
REPORT PERIOD COVERED: 10.1.2020 – 9.30.2021

Purpose of the Council or Committee:

MSHN Leadership has created a Substance Use Disorder Provider Advisory Committee (SUD-PAC) to serve in an advisory capacity to MSHN regarding SUD policies, procedures, strategic planning, monitoring and oversight processes, to assist MSHN with establishing and pursuing state and federal legislative, policy and regulatory goals, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served.

Responsibilities and Duties:

The responsibilities and duties of the SUD-PAC include the following:

- Serve as liaison between MSHN and SUD provider network
- Evaluate MSHN strategic plan as it relates to the SUD system and provide input into regional implementation of strategic action items.
- Provide input on MSHN's Quality Assurance Reviews (review process, standards, QI enhancement).
- Evaluate annual provider satisfaction survey results and provide input into regional action.
- Support implementation of evidence-based best practice service delivery to persons served.
- Provide input and advocacy on prevention (PX), treatment (TX), and recovery network policies & procedures.
- Support and provide input on MSHN and MDHHS performance improvement initiatives.
- Provide input on MSHN's Prevention, Treatment and Recovery annual plan processes.
- Provide input on regional concerns that impact providers and/or clients (e.g., barriers to access).
- Support fulfilment of state and federal legislative, policy and regulatory goals.

Defined SUD-PAC Goals:

- Enhance communication between MSHN and SUD Provider Network
- Strengthen SUD strategic objectives and implementation
- Assess MSHN's Quality Assurance Reviews for clarification
- Identify methods to encourage feedback to satisfaction surveys process
- Support delivery of evidence-based best practices
- Promote clarification of prevention, treatment, and recovery network policies/procedures
- Uphold MSHN and MDHHS performance improvement initiatives
- Identify methods to improve MSHN's Prevention, Treatment, and Recovery annual plan process
- Ensure regional concerns that impact providers and/or clients are identified
- Promote clarification of state and federal legislative, policy and regulatory goals

Past Accomplishments:

In the past year, the SUD-PAC has done the following:

- Held group discussions on staffing difficulties
- Held group discussions on State System proposed changes
- Held multiple discussions and provided input to MSHN on how pandemic was affecting treatment, prevention and recovery services and possible solutions
- Held group discussions on LGBTQ+ inclusion and ideas to support increased penetration in services
- Held discussions on increasing diversity, equity, and inclusion in the MSHN region
- Continued to review and receive statewide ASAM Continuum assessment updates
- Offered input on SUD provider audit process and tools
- Discussed barriers to SUD PAC efficacy in meeting its defined purpose and role and considered alternatives.

Reviewed the following:

- Offered input on SUD provider audit process and tools
- Required trainings
- Reviewed the annual plan process
- Provider satisfaction survey results
- Provider workforce attraction, retention, and regional issues
- Proposed contract changes
- MMBPIS SUD Summary Report
- MSHN SUD Sentinel Events
- PAC calendar
- SUD Provider Manual
- 2022 QAPI Standards
- Provider Risk Assessment tool
- CAIT license questions and updates
- Reviewed financial changes related to reductions in Block Grant funds, provider stabilization, and COVID relief funds

Future Plans:

A consistent issue throughout the life of the SUD-PAC has been sustained engagement and ways that this has impacted its defining purpose, first and foremost, to provide advisory input on multiple levels of SUD regional issues and operations, and secondarily, to serve as liaison with the broader provider network. As noted above, this was raised and discussed with the group in FY21 and in previous years. Over time, changes were made to attempt greater engagement, for example, handing over meeting facilitation to a provider member of the SUD-PAC as Chair. These and other efforts didn't offer significant improvement even prior to the COVID pandemic and with the pandemic's impact on provider capacity and workforce issues, SUD-PAC engagement continued to decline in 2020 and 2021.

A common theme was that with the diversity in SUD-PAC membership—inclusive of prevention, treatment at every level of care, and recovery providers—there were frequent gaps in what was

relevant or useful as topics or foci of the group. By contrast, MSHN's provider workgroup groups that are more focused around functional areas—Women's Specialty Services (WSS), Medication-Assisted Treatment (MAT), and Recovery providers, for example, have been meeting for years with solid engagement and a high sense of relevance and utility for provider members. A recently developed Residential Treatment workgroup has had similar engagement and appreciation from members for what the group has to offer in terms of targeted and focused problem-solving and information-sharing.

It was determined therefore that in FY22, MSHN would use these more targeted provider groups organized around functional and operational domains as a venue for provider input and engagement with MSHN. While not formally disbanded, the SUD-PAC will suspend its activity in FY22 as MSHN explores the impact of these other provider groups.

MSHN is grateful to those providers whose staff have served on the SUD-PAC and have contributed their time and labor to increasing and improving collaboration and communication between the provider network and MSHN.

c) MSHN Oversight Policy Board FY21 Annual Report

Team Name: Substance Use Disorder Oversight Policy Board
Team Leader: Chairman John Hunter, SUD Board Member
Report Period Covered: 10.1.20-9.30.21

Purpose of the Board: The Mid-State Health Network (MSHN) Substance Use Disorder (SUD) Oversight Policy Board (OPB) was developed in accordance with Public Act 500 of 2012, Section 287 (5). This law obliged MSHN to "establish a substance use disorder oversight policy board through a contractual agreement between [MSHN] and each of the counties served by the community mental health services program." MSHN/s twenty-one (21) counties each have representation on the OPB, with a designee chosen from that county. The primary decision-making role for the OPB is as follows:

- Approval of any portion of MSHN's budget containing local funding for SUD treatment or prevention, i.e. PA2 funds
- Has an advisory role in making recommendations regarding SUD treatment and prevention in their respective counties when funded with non-PA2 dollars.

Annual Evaluation Process:

a. Past Year's Accomplishments:
   - Received updates and presentations on the following:
     - MSHN SUD Strategic Plan
     - MSHN SUD Prevention & Treatment Services
   - Approval of Public Act 2 Funding for FY20 & related contracts
   - Approved use of PA2 funds for prevention and treatment services in each county
   - Received presentation on FY21 Budget Overview
   - Received PA2 Funding reports – receipts & expenditures by County
   - Received Quarterly Reports on Prevention and Treatment Goals and Progress
   - Received Financial Status Reports on all funding sources of SUD Revenue and Expenses
   - Provided advisory input to the MSHN Board of Directors regarding the overall agency strategic plan and SUD budget
   - Executed new three-year SUD Intergovernmental Agreement
   - Received new written updates from Deputy Director including state and federal activities related to SUD
   - Received updates on MDHHS proposed future of Behavioral Health
   - Provided input and received information/updates on Block Grand Reduction Strategies
   - Received updates on MDHHS State Opioid Response Site Visit Results
   - Received information on COVID-19 and Provider Status
   - Shared prevention and treatment strategies within region

b. Upcoming Goals for FY22 ending, September 30, 2022:
   - Approve use of PA2 funds for prevention and treatment services in each county
   - Improve communications with MSHN Leadership, Board Members and local coalitions
   - Orient new SUD OPB members as reappointments occur
   - Receive information and education on opioid settlement and strategies
   - Provide input into COVID related funding specific to Substance Use Disorder Treatment and prevention
   - Monitor SUD spending to ensure it occurs consistent with PA 500

d) MSHN Committee FY21 Annual Reports

Team Name: Clinical Leadership Committee
Team Leader: Todd Lewicki, Chief Behavioral Health Officer
Report Period Reviewed: 10.1.20-9.30.21

Purpose of the Clinical Leadership Committee (CLC):

The MSHN Operations Council (OC) has created a CLC to advise the Prepaid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) and the OC concerning the clinical operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CEO and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Responsibilities and Duties

The responsibilities and duties of the CLC shall include the following:

- Advise the CEO and OC in the development of clinical best practice plans for MSHN (including implementation and evaluation);
- Advise the CEO and OC in areas of public policy priority including high risk, high cost, restrictive interventions, or that are problem prone.
- Provide a system of leadership support, collaborative problem solving and resource sharing for difficult cases.
- Support system-wide sharing though communication and sharing of major initiatives (regional and statewide).
- Assure clinical policies and practices are operational, effective, efficient and in compliance with applicable contracting and regulatory bodies
- Undertake such other duties as delegated by the CEO or OC.

Defined Goals, Monitoring, Reporting and Accountability

The CLC shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Improved health outcomes.
- Increased use of evidenced based practices.
- Improved collaboration of the region's clinical leadership including member satisfaction with the committee process and outcomes.
- Increased use of shared resources and problem solving for difficult cases.

Additionally, the CLC seeks to assess and achieve the following secondary goals:

- CEO and OC satisfaction with CLC advisory role,
- Staff perception and sense of knowing what is going on, and
- Efficiencies are realized through standardization, performance improvement and shared resources.

Annual Evaluation Process

a. Past Year's Accomplishments

The CLC will be involved in monitoring, developing, and recommending improvements to:

- Continue exploring opportunities to maximize partnership role with the Regional Medical Directors
- Focus on 1915i service oversight transition to PIHP for annual eligibility authorizations
- Continued work relating to Parity for all CMHSP services
- Provide support to MCG Parity system
- Discuss, explore, and initiate program opportunities in psychiatric residential treatment facility implementation
- Continue to discuss options for difficult placement situations and create protocol as appropriate
- Continue to assess the impact of the COVID-19 pandemic and opportunities to enhance services for affected individuals related to PTSD, trauma-focused care, etc.
- Explore and recommend opportunities for innovative service models including telehealth and others as allowed by state rule.
- Continue oversight of regional HCBS compliance and related issues
- Complete work on crisis residential unit for adults in MSHN region

b. Upcoming Goals (FY2022) (CF=carry forward from FY2021)

- Carry forward some goals from previous year
- Address workforce shortage
- Address crisis resources uniformly across the region
- Stabilize CLS and residential systems of care, including staffing and provider stability (CLS and spec. res.). Include planning relating to serving persons with behavioral issues.
- Deal with crisis response to meth and substance induced psychosis.
- (CF) Continue exploring opportunities to maximize partnership role with the Regional Medical Directors
- (CF) Focus on 1915i service oversight transition to PIHP for annual eligibility authorizations
- (CF) Address psychiatric residential treatment facility (PRTF) as MDHHS begins implementation.

Team Name: Regional Medical Director's Committee
Team Leaders: Dr. Zakia Alavi
Report Period Covered: 10.1.20-9.30.21

Purpose of the Regional Medical Directors Committee (MDC)

As created by the MSHN Operations Council (OC), the MDC functions to advise the MSHN Chief Medical Officer (CMO), the MSHN Chief Executive Officer (or designee), the MSHN Chief Behavioral Health Officer (CBHO), and the OC concerning the behavioral health operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CMO, CEO (or designee), CBHO, and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Responsibilities and Duties

The responsibilities and duties of the MDC shall include the following:

- Contribute to regional plan development as well as review, advise, and recommend approval of the regional plans as appropriate but specifically the following:
    - Population Health and Integrated Care Plan
    - Utilization Management Plan
    - Quality Assurance and Performance Improvement Plan
- Advise MSHN and the OC in the selection, monitoring and improvement initiatives related to regional performance measures.
- Advise MSHN and OC in the development of clinical best practice guidelines for MSHN (including implementation and evaluation).
- Provide a system of leadership support, collaborative problem solving and efficient resource sharing for high risk cases.
- Support collaboration with Primary Care/Physical Health Plans related to Population Health Activities as well as local community efforts
- Support system-wide sharing though communication and sharing of major initiatives (regional and statewide).
- Assure clinical policies and practices are operational, effective, efficient, and in compliance with applicable contracting and regulatory bodies; and
- Undertake such other duties as may be delegated by the CMO or OC.

Defined Goals, Monitoring, Reporting and Accountability

The MDC shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Improved health outcomes.
- Increased use of clinically targeted evidenced based practices and promising practices.
- Improved collaboration of the region's Regional Medical Directors including member satisfaction with the committee process and outcomes.
- Improved collaboration with primary care physicians and health plans
- Increased use of shared resources and collaborative problem solving for difficult cases.

Additionally, the MDC seeks to assess and achieve the following secondary goals:

- CMO and OC satisfaction with MDC advisory role,
- Staff education, inclusion and information related to regional strategies; and
- Efficiencies realized through standardization, performance improvement and shared resources.

Annual Evaluation Process

a. Past Year's Accomplishments
    - Case consult and documentation process begun.
    - Behavior Treatment Plan Review Committee feedback on medication guidelines.
    - Input into Population health and Integrated Care Plan and Quarterly Reports
    - MCG Indicia clinical support tool
    - Discussion on behavioral health system redesign.
    - Review of outlier analyses and use of CAFAS and LOCUS and related issues.
    - Review and input into data, including MSHN performance improvement projects, health equity analysis.
    - Establishment of bi-weekly RMD COVID calls to trouble shoot and establish protocols for response within the region.
    - Guidance relating to Residential Safety, Agency Reopening, and Mask Wearing Guidance.

b. Upcoming Goals
    - Core service menus for LOCUS and CAFAS
    - Assisted Outpatient Treatment
    - COVID discussion for planning
    - Continued input into behavior treatment processes
    - Ongoing input into population health and integrated care
    - Ongoing input into data-related decisions
    - Maintaining/improving staffing at all levels.
    - Incorporate medical point of view into resource decisions, care decisions, increasing collaborative efforts. (Includes grant opportunities). Provide input into clinical leadership processes, improve linkages with Clinical Leadership Committee. Protect time to ensure that there is medical director input and address with Operations Council.
    - Create a description of the minimum functions/roles expected of a medical director.
    - Improve relationship with MDHHS around processes related to CMH functions (i.e., determination of hospitalization). Address improving collaboration in the authorities that exist in the CMH and MDHHS.
    - Address MI-SMART at a regional level, to also include adequate coverage at the hospital. Include medical issues the individual is experiencing and hospital capability to address.

TEAM NAME: Utilization Management Committee
TEAM LEADER: Skye Pletcher**,** MSHN Director of Utilization and Care Management
REPORT PERIOD: 10.01.2020 – 9.30.2021

Purpose of the Council or Committee: The Utilization Management Committee (UMC) exists to assure effective implementation of the Mid-State Health Network's UM Plan and to support compliance with requirements for MSHN policy, the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract and related Federal & State laws and regulations.

Responsibilities and Duties: The responsibilities and duties of the UMC include the following:

- Develop and monitor a regional utilization management plan.
- Set utilization management priorities based on the MSHN strategic plan and/or contractual/public policy expectations.
- Recommend policy and practices for access, authorization and utilization management standards that are consistent with requirements and represent best practices.
- Participate in the development of access, authorization and utilization management monitoring criteria and tools to assure regional compliance with approved policies and standards.
- Support development of materials and proofs for external quality review activities.
- Establish improvement priorities based on results of external quality review activities.
- Recommend regional medical necessity and level of care criteria.
- Perform utilization management functions sufficient to analyze and make recommendations relating to controlling costs, mitigating risk and assuring quality of care.
- Review and monitor utilization patterns and analysis to detect and recommend remediation of over/under or inappropriate utilization; and
- Recommend improvement strategies where adverse utilization trends are detected.
- Ensure committee coordination and information sharing to address continuity and efficiency of PIHP processes.

Defined Goals, Monitoring, Reporting and Accountability- As defined by the MSHN Utilization Management Plan:

- Define specifics of regional requirements or expectations for CMHSP Participants and SUD Providers relative to prospective service reviews (pre-authorizations), concurrent reviews and retrospective reviews for specific services or types of services, if not already addressed in policy.
- Define any necessary data collection strategies to support the MSHN UM Program, including how the data resulting from the completion of any mandatory standardized level of care, medical necessity or perception of care assessment tools will be used to support compliance with MSHN UM policies.
- Define metrics for population-level monitoring of regional adherence to medical necessity standards, service eligibility criteria and level of care criteria (where applicable).
- Define expected or typical population service utilization patterns and methods of analysis to identify and recommend possible opportunities for remediation of over/under utilization.
- Implement policies and systems to ensure consistency with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
- Set annual utilization management priorities based on the MSHN strategic plan and/or contractual/public policy expectations.
- Recommend improvement strategies where service eligibility criteria may be applied inconsistently

across the region, where there may be gaps in adherence to medical necessity standards and/or adverse utilization trends are detected (i.e., under or over utilization).

- Identify focal areas for MSHN follow-up with individual CMHSP Participants and SUD Providers during their respective on-site monitoring visits.

Annual Evaluation Process:

a. Past Year's Accomplishments: The UMC had eleven meetings during the reporting period. In that time the following tasks were completed:
    - A thorough review of the UMC annual report schedule was conducted in order to evaluate the ongoing relevance and effectiveness of the data being reviewed by the committee. A number of recommendations were made related to eliminating areas of redundancy where similar data is being monitored by more than one regional committee or certain regional processes have become more automated and standardized over time resulting in there no longer being a need for data monitoring by the committee.
    - Ongoing review of data reports related to performance on regional UM and integrated health priority measures with CMH participants reporting on change strategies when performance is outside of established expected thresholds
    - Implemented and refined an exception-based review system of over/under utilization of services according to the common LOCUS benefit grid for adults with serious mental illness and CAFAS benefit grid for children with serious emotional disturbance.
    - Deployed new outlier data reports with TBD Solutions in order to monitor service variance between CMHSP organizations as well as individual consumer outliers, however, there have been challenges with providing CMHSPs access to their own data without exposing underlying data for the region. This will continue to be addressed as a goal in FY22
    - Ongoing cross-functional dialogue with QI Council, Clinical Leadership Committee (CLC), and Provider Network Management.
    - Completed training and deployed the Interrater Reliability training module for MCG Behavioral Health Guidelines
    - Completed quarterly retrospective reviews for acute care services using the MCG Behavioral Health Guidelines and established a regional target of 95% or more correct application of medical necessity criteria. During FY21 the target was achieved for all quarters in which reviews were conducted.
    - Ongoing UMC discussion relative to prospective, concurrent, and retrospective UM processes. UMC members share best practices in order to promote efficiency and consistency throughout region.
    - Reviewed data relative to quarterly Balanced Scorecard
    - Implemented improved tracking capabilities as a region to ensure authorization determinations are made within established timeframes (14 Days for Standard Requests, 72 Hours for Expedited Requests)
    - Began monitoring quarterly ACT utilization data to evaluate if services are being delivered consistent with evidence-based practice guidelines for average hours of service per individual per week
    - Implemented new quarterly MDHHS Service Authorization Denials Report and deployed an automated process for gathering and reporting data to ensure regional consistency
    - Began monitoring quarterly telehealth utilization data and overall impact on service delivery and engagement

b. Upcoming Goals for Fiscal Year Ending, September 30, 2022

- Follow utilization management priorities based on the MSHN strategic plan and/or contractual/public policy expectations.
- Recommend policy and practices for access and authorization standards that are consistent with requirements and represent best practices.
- Evaluate opportunities for improvement in 24/7/365 Access to SUD Services; consider availability of after-hours acute services (withdrawal management, residential)
- Ensure representative SUD presence on UMC
- Implementation of an exception-based review system of over/under utilization of services according to the common SIS benefit grid for individuals with intellectual and/or developmental disabilities.
- Completion of regional standard clinical service protocols and/or practice guidelines project
- Establish performance improvement priorities identified from monitoring of delegated utilization management functions.
- Recommend improvement strategies where adverse utilization trends are detected.
- Recommend opportunities for replication where best practice is identified.
- Continue to focus on population health measures related to care coordination.
- Ongoing integration of substance use disorder (SUD) into utilization management practices.
- Ensure there is synchronized (as able) content matter expert input into processes shared by UM (i.e. QI, Finance, Clinical, etc.).
- Address succession planning for UMC members relative to skill set needed by committee members.
- Input into HCBS data, findings, and system improvements, as appropriate.

TEAM NAME: Regional Compliance Committee

TEAM LEADER: Kim Zimmerman, Chief Compliance and Quality Officer

REPORT PERIOD REVIEWED: 10.1.20-9.30.21

Purpose of the Compliance Committee:

The Compliance Committee will be established to ensure compliance with requirements identified within MSHN policies, procedures and compliance plan; the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract; and all related Federaland State laws and regulations, inclusive of the Office of Inspector General guidelines and the 42 CFR 438.608.

Responsibilities and Duties:

The responsibilities and duties of the Compliance Committeeshall include the following:

- Advising the MSHN Chief Compliance and Quality Officer on matters related to Compliance.
- Assist in the review of, and compliance with, contractual requirements related toprogram integrity and 42 CFR 438.608.
- Assist in developing reporting procedures consistent with federal requirements.
- Assist in developing data reports consistent with contractual requirements.
- Assisting with the review, implementation, operation, and distribution of theMSHN Compliance Plan.
- Reviewing and updating, as necessary, MSHN policies and procedures related to compliance.
- Evaluating the effectiveness of the Compliance Plan.
- Determining the appropriate strategy/approach to promote compliance and detect potential violations and areas of risk as well as areas of focus.
- Recommending and monitoring the development of internal systems and controls to carry out the Compliance Plan and supporting policies as part of daily operations.
- Reviewing compliance related audit results and corrective action plans,making recommendations when appropriate.
- Assisting in development and implementation of compliance related training.

Defined Goals, Monitoring, Reporting and Accountability

The Compliance Committee shall establish metrics and monitoring criteria to evaluate progress:

- As defined in the Compliance Plan

Annual Evaluation Process

a. Past Year's Accomplishments
   - Revised and approved the MSHN Compliance Plan
   - Provided feedback and approval for the Annual Compliance Summary Report
   - Reviewed and updated the Committee Charter
   - Provided feedback on the MSHN FY22-23 Strategic Plan
   - Provided opinion on Preponderance Rule (H2015 Memo)
   - Reviewed FY20-21 Contract Comparison for Compliance and Quality
   - Review of 21st Century Cures Act for compliance with standards
   - Review of new Mediation requirements (House Rule 5043)
   - Reviewed CMH Patient Access Rule and InterOp Station for compliance with standards
   - Reviewed trends in the OIG Quarterly Reports
   - Reviewed Medicaid Policy Bulletins and Medicaid Manual and implementedchanges

regionally and locally as needed

- Reviewed changes/revisions to state and federal policies and regulations, includingbut not limited to:
    - Department of Justice Compliance Program Guidelines
    - COVID-19 requirements and technical guidance
    - Anti-Kickback Law
    - Stark Law
    - Medicaid Final Rule
- Reviewed information provided at the PIHP Compliance Officers meetings
- Reviewed outcomes from external site reviews for necessary changes andcompliance related issues
- Provided consultation on local compliance related matters
- Developed, implemented, reviewed and made necessary corrections for quarterlydata mining activities
    - Death to encounter data report
- Provided feedback on MSHN practices to include but not limited to:
    - Delegated Managed Care Review tools
- Review and revise compliance policies and procedures

b. Upcoming Goals for Fiscal Year Ending, September 30, 2022

- Identify compliance related educational opportunities including those aimed at training compliance officers
- Review data, trends, type/nature of findings for recommended quality improvement
- Strengthen review of Medicaid Policy Bulletins and Contract Revisions to assure compliance with changes and updates
- Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies
- Review requirements of telehealth for compliance and identification risk points

TEAM NAME: Provider Network Management Committee
TEAM LEADER: Kyle Jaskulka, MSHN Contract Manager
REPORT PERIOD REVIEWED: 10.1.20-9.30.21

Purpose of the Provider Network Management Committee: PNMC is established to provide counsel and input to Mid-State Health Network (MSHN) staff and the Operations Council (OC) with respect to regional policy development and strategic direction. Counsel and input will typically include: 1) network development and procurement, 2) provider contract management (including oversight), 3) provider qualifications, credentialing, privileging and primary source verification of professional staff, 4) periodic assessment of network capacity, 5) developing inter- and intra-regional reciprocity systems, and 6) regional minimum training requirements for administrative, direct operated, and contracted provider staff. In fulfilling its charge, the PNMC understands that provider network management is a Prepaid Inpatient Health Plan function delegated to Community Mental Health Service Programs (CMHSP) Participants. Provider network management activities pertain to the CMHSP direct operated and contract functions.

Responsibilities and Duties: The responsibilities and duties of the PNMC include the following:

- Advise MSHN staff in the development of regional policies for Provider Network Management;
- Establish regional priorities for training and establish training reciprocity practices for (CMHSP) Subcontractors;
- Support development of regional PNM monitoring tools to support compliance with rules, laws, and the PIHPs Medicaid contract with MDHHS.
- Provide requested information and support development of periodic Network Adequacy Assessment;
- Monitor results of retained functions contract for Network Adequacy Assessment;
- Support development and implementation of a Regional Strategic Plan as it relates to Provider Network Management functions;
- Establish regionally standardized contract templates and provider performance monitoring in support of reciprocity policy;
- Recommend and deploy strategies to ensure regional compliance with credentialing and recredentialing activities in accordance with MDHHS and MSHN policy; and
- Recommend and deploy strategies to ensure regional compliance with ensuring provider qualifications requirements are verified for all non-licensed independent practitioners.

Defined Goals, Monitoring, Reporting and Accountability: The PNMC shall establish goals consistent with the MSHN Strategic Plan and to support compliance with the MDHHS – PIHP contract including:

- Completion of a Regional Network Adequacy Assessment;
- Development of reciprocity agreements for sub-contract credentialing/re-credentialing, training, performance monitoring, and standardized contract language;
- Maintain a regional training plan in accordance with state requirements as identified in the MDHHS/MSHN Specialty Supports and Services Contract.

Annual Evaluation Process

a. Past Year's Accomplishments (FY21):
    - Addressed findings from HSAG audit, specific to provider credentialing and recredentialing systems; revised policies and procedures

- Continued to refine and support the statewide and intra-regional provider performance monitoring protocols resulting in improved provider performance and administrative efficiencies;
- Established and continued with an intra-regional provider performance monitoring protocol for ABA/Autism provider network; continued regional provider performance monitoring for Fiscal Intermediary and Inpatient Psychiatric Services;
- Establish relevant key performance indicators for the PNMC scorecard;
- Continued to monitor and refine regional provider directory to ensure compliance with managed care rules;
- Reviewed, revised, and issued regional contracts for Autism/ABA, Inpatient Psychiatric, and Fiscal Intermediary Services;
- Improved and continued coordination with regional recipient rights officers to support contract revisions;
- Began implementation of statewide training reciprocity plan within the MSHN region;
- Development and continued support of regional training coordinators workgroup to support implementation;
- Began the development of regional web-based provider application;
- Provided input into PCE Provider Management Module enhancements.

b. Upcoming Goals (FY22):
- Address recommendations from the 2021 assessment of Network Adequacy as it relates to provider network functions; update the Assessment of Network Adequacy to address newly identified needs;
- Develop an action plan to address repeat findings related to provider credentialing and recredentialing process requirements through training/technical assistance and monitoring; monitoring and oversight of CMHSPs demonstrate improvement in credentialing and credentialing systems;
- Establish relevant key performance indicators for the PNMC scorecard;
- Monitor and implement Electronic Visit Verification as required by MDHHS;
- Initiatives to support reciprocity:
    - Contracting:
        - Develop regionally standardized boilerplate and statement of work for: Therapeutic Camps, Community Living Supports, Residential, Vocational; Independent Facilitation
    - Procurement:
        - Fully implement the use of a regional web-based provider application;
        - Publish provider selection processes on MSHN web;
    - Monitoring:
        - Fully implement specialized residential reciprocity provider monitoring plan;
    - Training:
        - All CMHSPs will have 100% of applicable trainings vetted in accordance with the training reciprocity plan;
- Advocate for direct support professionals to support provider retention (e.g. wage increase; recognition)
- Develop and implement regionally approved process for credentialing/re-credentialing reciprocity

TEAM NAME: Customer Service Committee
TEAM LEADER: Dan Dedloff, MSHN Customer Service & Rights Specialist
REPORT PERIOD COVERED: 10.1.20 – 09.30.21

Purpose of the Customer Service Committee: This body was formed to draft the Consumer Handbook and to develop policies related to the handbook, the Regional Consumer Advisory Council (RCAC), and Customer Services (CS). The Customer Services Committee (CSC) will continue as a standing committee to assure the handbook is maintained in a compliant format, and to support development and implementation of monitoring strategies to assure regional compliance with CS standards. This committee will be supported by the Director of Quality, Compliance, and Customer Service and will report through the Quality Improvement Council (QIC).

Responsibilities and Duties: The responsibilities and duties of the CSC will include:

- Advising the MSHN Director of Quality, Compliance, and Customer Service and assisting with the development, implementation and compliance of the Customer Services standards as defined in the Michigan Department of Health and Human Services (MDHHS) contract and 42 CFR including the Balanced Budget Act Requirements
- Reviewing and providing input regarding MSHN Customer Services policies and procedures
- Reviewing, facilitating revisions, publication, and distribution of the Consumer Handbook
- Facilitating the development and distribution of regional Customer Services information materials
- Ensuring local-level adherence with MSHN regional Customer Services policies through implementation of monitoring strategies
- Reviewing semi-annual aggregate denials, grievances, appeals, second opinions, recipient rights and Medicaid Fair Hearings reports
- Reviewing audit results from EQR and MDHHS site reviews and assisting in the development and oversight of corrective action plans regarding Customer Services.
- Assisting in the formation and support of the RCAC, as needed; and
- Individual members serving as ex-officio member to the RCAC.

Defined Goals, Monitoring, Reporting and Accountability

The CSC shall establish metrics and monitoring criteria to evaluate progress on the following primary goals:

- Customer Service Handbook completion, updates and SUD incorporation
- Regional Customer Service policy development
- Tracking and reporting Customer Service information; and
- Compliance with Customer Service Standards and the Grievance and Appeal Technical Requirement, PIHP Grievance System for Medicaid Beneficiaries.

Additionally, the CSC seeks to assess and achieve the following secondary goals:

- Retained function contracts achieved the defined results
- Collaborative relationships are retained
- Reporting progress through Quality Improvement Council
- Regional collaboration regarding customer service expectations and outcomes
- Efficiencies are realized through standardization and performance improvement; and
- Benefits are realized through our collective strength.

Annual Evaluation Process:

a. Past Year's Accomplishments: The CSC had six committee bi-monthly meetings during the reporting period in which they completed the following tasks:
   - Reviewed, revised, facilitated publication of, and completed regional distribution for the MSHN FY21 Consumer Handbook
   - Facilitated publication and electronic regional distribution of the MSHN FY21 Consumer Handbook: Spanish language version for each of the 12 CMHSP and the MSHN SUD Provider Handbook
   - Reviewed, analyzed and reported regional customer service information for:
     - Denials
     - Grievances
     - Appeals
     - Medicaid Fair Hearings
     - Recipient Rights
   - Updated, reviewed, and approved language updates for the MDHHS standardized templates
   - Implemented the MDHHS quarterly Grievance and Appeals data reporting
   - Electronic Health Record process improvements to better capture MDHHS Grievance and Appeals data reporting

b. Upcoming Goals for Fiscal Year 2021 Ending, September 30, 2022
   - Conduct an annual review and revise the MSHN Consumer Handbook to reflect contract updates and regional changes
   - Determine oversight & monitoring of regional Appeals and Grievances using the MDHHS data reporting, in accordance with customer service standards
   - Advocate for improvements to the MDHHS Notices to improve consumer friendly language
   - Develop a standardized training for the Adverse Benefit Determination process
   - Continue reporting and monitoring customer service information
   - Continue to explore regional Customer Service process improvements
   - Continue to develop, where applicable, MSHN standardized regional forms
   - Continue to identify Educational Material/Brochures/Forms for standardization across the region

e) MSHN Workgroups FY21 Annual Reports

Team Name: Autism Benefit Workgroup

Team Leader: Kara Hart

Report Period Reviewed: 10.1.20-9.30.21

Purpose of the Autism Workgroup:

The Autism Benefit Workgroup was established to initiate and oversee coordination of the autism benefit for the region. The Autism Benefit Workgroup is comprised of the Waiver Coordinator and the Community Mental Health Service Provider (CMHSP) autism benefit staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The Autism Benefit Workgroup is chaired by the Waiver Coordinator. All CMHSPs are equally represented on this workgroup.

Responsibilities and Duties:

The responsibilities and duties of the Autism Benefit Workgroup shall include the following:

- Advising the MSHN Waiver Coordinator.
- Assist with the development, implementation, and operation of the autism benefit within the region, and supporting MSHN policies and procedures.
- The workgroup representatives will be responsible for passing along pertinent information to impacted team members at their CMHSP.
- Reviewing and recommending changes and/or revisions to policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the autism benefit program.
- Determining the appropriate strategy or approach to promote compliance and detect potential violations and areas of risk as well as areas of focus, consistent with sound clinical documentation and service billing practices.
- Recommending and monitoring the development of internal systems and controls to carry out the supporting policies as part of daily operations.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.
- Implementing processes that incorporate best practices and encourage continuous quality improvement for autism program operations and service-related outcomes.

Defined Goals, Monitoring, Reporting and Accountability

The established metrics and monitoring criteria originally identified in the replaced 1915(i) State Plan Amendment (iSPA) and as represented in the now-expanded Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit to evaluate progress on the following primary goals:

- Assess eligibility for autism services, including Applied Behavior Analysis (ABA)
- Ensure WSA access and efficiencies
- Carry out administrative tasks for Autism (including WSA)
    - Initial Eligibility, Application, and Service Start,
    - Dis-enrollments
    - Autism transfers (within and outside of MSHN region)
    - Tracking of pending cases (referred and awaiting an evaluation)
- Ensure that services are provided within the amount, scope, and duration as specified in the

Individual Plan of Service (IPOS)
    - Direct ABA
    - Observation and Direction
    - Overdue re-evaluations
    - Overdue Individual Plans of Service (IPOS)
- Ensure each CMHSP has policies and procedures addressing the standards of the autism benefit
- Assist CMHSPs to ensure that rendering providers have appropriate training and credentialing
- Implementation of corrective action to both Mid-State Health Network (MSHN) and Michigan Department of Health and Human Services (MDHHS) Autism site review findings
- Ensure individuals begin services within 90 days of enrollment
- Increase provider network capacity to address continued increase of individuals enrolled to ensure better care, and better service
- Increase frequency of Family Training encounters for those enrolled
- Continuous efforts to support and encourage recruitment, training, and retention of qualified autism staff
- Oversight of implementation of behavior treatment standards for enrolled individuals, if intrusive or restrictive measures are being used and in the IPOS
- Support compliance and oversight of the above identified areas

Annual Evaluation Process

a. Past Year's Accomplishments:
    - Communicated about autism provider workgroup and provider audit process
    - Preparation and implementation of autism policy updates (effective 9.1.2021)
    - Served as a conduit of information from MDHHS which included sharing state plan, appendix K, return to school guidance, billing and code chart updates, telehealth, and any updated COVID-19 pandemic changes
    - Significant enrollment growth in the program (October 2020- 1371 enrolled and July 2021-1639 enrolled. As of July, a 20% increase
    - Shared and discussed Behavior Treatment FAQ
    - Regional response to changes in MDHHS AUT Section leadership and practices
    - Regional participation and leadership around the MSU Family Guidance project, including publications from the project
    - Collaboration with Autism Operations Workgroup on updating of standardized regional contract for autism services as needed
    - Coordination of ABA provider audits and credentialing reciprocity
    - Regional response and coordination of modifications to service delivery during the COVID-19 pandemic

b. Upcoming Goals:
    - Continue to monitor and modify processes related to COVID-19 service delivery
    - Adjust to code changes and new policy language
    - Update policies in contracts based on new benefit language
    - Continue to work to improve quality provider network capacity
    - Continue efforts to ensure individuals are receiving services within 90 days of enrollment.

Team Name: Child Waiver Program (CWP) Workgroup
Tam Leader: Tera Harris
Report Period Reviewed: 10.1.2020-9.30.2021

Purpose of the CWP Workgroup:
The CWP Workgroup was established to initiate and oversee coordination of the CWP for the region. The CWP Workgroup is comprised of the MSHN Waiver Coordinator and the Community Mental Health Service Provider (CMHSP) CWP staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The CWP Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSP participants are equally represented.

Responsibilities and Duties:
The responsibilities and duties of the CWP Workgroup shall include the following:

- Advising the MSHN Waiver Coordinator.
- Assist with the development, implementation, and operation of the CWP within the region, and supporting MSHN policies and procedures.
- The workgroup representatives will be responsible for passing along pertinent information to impacted team members at their CMHSP. Reviewing and recommending changes and/or revisions to policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the CWP program.
- Determining the appropriate strategy or approach to promote compliance and detect potential violations and areas of risk as well as areas of focus, consistent with sound clinical documentation and service billing practices.
- Recommending and monitoring the development of internal systems and controls to carry out the supporting policies as part of daily operations.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.
- Implementing processes that incorporate best practices and encourage continuous quality improvement for CWP program operations and service-related outcomes.

Defined Goals, Monitoring, Reporting and Accountability
The intent of this program is to provide Home and Community Based Waiver Services, as approved by Centers for Medicare and Medicaid Services (CMS) for children with developmental disabilities who meet a certain level of care, along with state plan services in accordance with the Medicaid Provider Manual.

- Assess eligibility for the CWP
- Carry out administrative tasks for CWP
    - Initial Pre-Screen Eligibility, Application, and Service Start,
    - Annual Recertification,
    - Disenrollment's
    - Age-Offs,
    - CWP Slot Transfer (as appropriate), and
    - CWP Financial Monitoring
- Ensure that services are provided within the amount, scope, and duration as specified in the Individual Plan of Service (IPOS)
- Ensure each CMHSP has policies and procedures addressing the standards of the CWP,
- Assist CMHSPs to ensure that rendering providers have appropriate training and credentialing
- Implementation of corrective action to Michigan Department of Health and Human Services

(MDHHS) CWP site review findings
- Support compliance and oversight of the above identified areas

Annual Evaluation Process

a. Past Year's Accomplishments
   - Formal approval of corrective action plan implementation that began in 2020 following MDHHS site review
   - Regional monitoring of CWP standards for each CMHSP
   - Completion of second year of delegated site reviews for CWP program specific standards as well as CWP clinical charts
   - Development and distribution of monthly CWP reports
   - Development and distribution of monthly overdue and coming due CWP certifications
   - Serve as conduit of information from MDHHS- sharing trainings, updated policies, billing and code changes, overnight health and safety, and any updated COVID-19 pandemic changes
   - Created and shared Behavior Treatment FAQ
   - Reviewed and approved draft CWP policies and procedures
   - Adjusted processes related to service delivery due to COVID-19 pandemic
   - Shared MSHN strategic plan
   - Created form for Prior Review and Approval Requests (PRARs)

b. Upcoming Goals
   - Ensure full implementation of corrective action plan related to MDHHS and MSHN CWP findings
   - Continue to work to ensure the entire region is prepared to support individuals needing the supports of the CWP
   - Emphasize the importance of and encourage participation in regional CWP meetings and trainings

Team Name: Home and Community Based Services (HCBS) Workgroup
Team Leader: Katy Hammack
Time Period Reviewed: 10.1.20-9.30.21

Purpose of the HCBS Workgroup:
The HCBS Workgroup was established to initiate and oversee coordination of the HCBS program for the region. The HCBS Workgroup is comprised of the Waiver Manager, Waiver Coordinators, and the Community Mental Health Service Provider (CMHSP) HCBS staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The HCBS Workgroup is chaired by the Waiver Manager. All CMHSPs are equally represented.

Responsibilities and Duties:
The responsibilities and duties of the HCBS Workgroup shall include the following:

- Advising the MSHN Waiver Manager/Coordinators.
- Assist with the development, implementation, and operation of the HCBS program within the region, and supporting MSHN policies and procedures.
- The workgroup representatives will be responsible for passing along pertinent information to impacted team members at their CMHSP.
- Reviewing and recommending changes and/or revisions to policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the HCBS program.
- Determining the appropriate strategy or approach to promote compliance and detect potential violations and areas of risk as well as areas of focus, consistent with sound clinical documentation and service billing practices.
- Recommending and monitoring the development of internal systems and controls to carry out the supporting policies as part of daily operations.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.
- Implementing processes that incorporate best practices and encourage continuous quality improvement for HCBS operations and service-related outcomes.

Defined Goals, Monitoring, Reporting and Accountability

- Monitoring and oversight to ensure compliance with all federally mandated HCBS standards.
- Assessing for policy and procedure development and updates.
- Review of any HCBS data including status related to project completion timelines.
- Review of any new HCBS related MDHHS requirements and updates.
- Review of best practice strategies to address potential barriers to attaining full HCBS resolution.
- Promote discussion of any HCBS related items to assist in promoting regional consistency in interpretation of HCBS standards.
- Review of specific CMHSP/provider HCBS accomplishments and best practices.
- Monitoring and guidance related to Behavior Treatment standards for HCBS individuals with such interventions.
- Bring the region to full HCBS resolution before March 2023
- Updates and discussion in target areas of compliance, such as PCPs and BTPs
- Assess for policy/procedure development
- Coordinate with other PIHP/MDHHS systems as appropriate- HCBS Leads, BTPRC Workgroup, Recipient Rights, etc.
- Disseminate information from MDHHS/BDHHA on HCBS Issues

    - Field questions
    - Gain Workgroup feedback
    - HCBS-pandemic updates
    - HCBS FAQ updates
    - BTPRC FAQ updates
    - WSA/Optum updates
- Monitoring and reporting of current survey projects
    - Trends, themes
    - Documentation issues
    - Progress & Deadlines
- Heightened Scrutiny Updates
- REMI Audit Module Updates and discussion and training (as appropriate)
- Dissemination of conferences and trainings

Annual Evaluation Process

a. Past Year's Accomplishments

- Full Remediation of all original and "exit ramp" C waiver and b3 (1915i-SPA) out of compliance cases
- Full Compliance Validation of all providers with Compliant survey results conflicting with participant survey results
- Establishment of Remi Audit Module and streamlined remediation process including the incorporation of utilizing a virtual review process
- Regional monitoring of HCBS standards through Delegated Managed Care reviews
- Completed Bi-Annual MDHHS and HSAG audits

b. Upcoming Goals

- Complete Heightened Scrutiny-Out of Compliance remediation before July 2022
- Survey, assess, and remediate, if necessary, individuals identified on the non-Responder survey list
- Identification and surveying of providers who have received provisional approval status between June 2020 through October 2021.
- Establish a region-wide transition plan for individuals in lieu of providers unable/willing to come into HCBS Compliance

Team Name: Habilitation Supports Waiver (HSW) Workgroup
Team Leader: Tera Harris
Report Period Reviewed: 10.1.20-9.30.21

Purpose of the HSW Workgroup:

The HSW Workgroup was established to initiate and oversee coordination of the HSW program for the region. The HSW Workgroup is comprised of the Waiver Coordinator and the Community Mental Health Service Provider (CMHSP) HSW staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The HSW Workgroup is chaired by the Waiver Coordinator. All CMHSPs are equally represented.

Responsibilities and Duties:

The responsibilities and duties of the HSW Workgroup shall include the following:

- Advising the MSHN Waiver Coordinator.
- Assist with the development, implementation, and operation of the HSW program within the region, and supporting MSHN policies and procedures.
- The workgroup representatives will be responsible for passing along pertinent information to impacted team members at their CMHSP.
- Reviewing and recommending changes and/or revisions to policies and procedures and developing new policies and procedures as needed.
- Evaluating the effectiveness of the HSW program.
- Determining the appropriate strategy or approach to promote compliance and detect potential violations and areas of risk as well as areas of focus, consistent with sound clinical documentation and service billing practices.
- Recommending and monitoring the development of internal systems and controls to carry out the supporting policies as part of daily operations.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.
- Implementing processes that incorporate best practices and encourage continuous quality improvement for HSW operations and service-related outcomes.

Annual Evaluation Process

a. Past Year's Accomplishments
   - Formal approval of corrective action plan implementation that began in 2020 following MDHHS site review
   - Continued corrective action measures related to underutilization of HSW slot allocation
   - Distribution of monthly HSW reports and monthly overdue/coming due data
   - Regional monitoring of HSW standards for each CMHSP
   - Completion of delegated site reviews for HSW program specific standards and clinical charts
   - Implemented process for reviewing and monitoring initial applications and recertifications for restrictive and intrusive techniques and/or Behavior Treatment Plans
   - Served as conduit of information from MDHHS – sharing trainings, updated policies, billing and code changes, and any updated COVID-19 pandemic changes.
   - Adjusted processes related to service delivery and administrative tasks due to COVID-19 pandemic
   - Shared MSHN strategic plan
b. Upcoming Goals
   - Ensure full implementation of corrective action plan related to MDHHS and MSHN HSW findings

- Continue to ensure 95% slot allocation utilization is maintained
- Continue to identify potential HSW candidates for enrollment
- Emphasize the importance of and encourage participation in regional HSW meetings and trainings

Team Name: Severe Emotional Disturbance (SED) Waiver Workgroup

Team Leader: Kara Hart

Report Period Covered: 10.1.20-9.30.21

Purpose of the SEDW Workgroup:

The SEDW Workgroup was established to initiate and oversee coordination of the SEDW for the region. The SEDW Workgroup is comprised of the MSHN Waiver Coordinator and the Community Mental Health Service Provider (CMHSP) SEDW staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The SEDW Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented.

Responsibilities and Duties:

The responsibilities and duties of the SEDW Workgroup shall include the following:

- Advising the MSHN Waiver Coordinator.
- Assist with the development, implementation, and operation of the SEDW within the region, and supporting MSHN policies and procedures.
- Reviewing and recommending changes and/or revisions to policies and procedures and developing new policies and procedures as needed.
- The workgroup representatives will be responsible for passing along pertinent information to impacted team members at their CMHSP.
- Evaluating the effectiveness of the SEDW program.
- Determining the appropriate strategy or approach to promote compliance and detect potential violations and areas of risk as well as areas of focus, consistent with sound clinical documentation and service billing practices.
- Recommending and monitoring the development of internal systems and controls to carry out the supporting policies as part of daily operations.
- Reviewing audit results and corrective action plans, making recommendations when appropriate.
- Implementing processes that incorporate best practices and encourage continuous quality improvement for SEDW program operations and service-related outcomes.

Defined Goals, Monitoring, Reporting and Accountability

The intent of this program is to provide Home and Community Based Waiver Services, as approved by Centers for Medicare and Medicaid Services (CMS) for children with Serious Emotional Disturbances, along with state plan services in accordance with the Medicaid Provider Manual.

- Assess eligibility for the SEDW
- Ensure WSA access and efficiencies
- Carry out administrative tasks for SEDW (including WSA)
    - Initial Eligibility, Application, and Service Start,
    - Annual Recertification,
    - 3rd year Recertifications (higher scrutiny reviews)
    - Dis-enrollments
    - SEDW transfers, and
    - SEDW Financial Monitoring
- Ensure that services are provided within the amount, scope, and duration as specified in the Individual Plan of Service (IPOS)
- Ensure each CMHSP has policies and procedures addressing the standards of the SEDW
- Assist CMHSPs to ensure that rendering providers have appropriate training and credentialing

- Implementation of corrective action to Michigan Department of Health and Human Services (MDHHS) SEDW site review findings
- Provide support to ensure appropriate payments rendered for SEDW enrollees receiving services
- Support compliance and oversight of the above identified areas

Annual Evaluation Process

a. Past Year's Accomplishments:
   - Formal approval of corrective action plan implementation that began in 2020 following MDHHS site review
   - Increase in overall enrollments of SEDW participants—add percentage
   - Regional monitoring of SEDW standards for each CMHSP
   - Completion of second year of delegated site reviews for SEDW program specific standards as well as SEDW clinical charts
   - Development and distribution of monthly SEDW reports
   - Development and distribution of monthly overdue and coming due SEDW certifications
     - Monthly monitoring includes addition of tracking of 45-day pending information and missing Medicaid ID
   - Serve as conduit of information from MDHHS- sharing trainings, updated policies, billing and code changes, overnight health and safety, foster care county of jurisdiction, and any updated COVID-19 pandemic changes
   - Created and shared Behavior Treatment FAQ
   - Reviewed and approved draft SEDW policies and procedures
   - Adjusted processes related to service delivery due to COVID-19 pandemic
   - Shared MSHN strategic plan
   - Provided clarification about CAFAS and PECFAS scoring requirements and required timeframes
   - Clarified psychiatric level of care
   - Clarified enrollment for a year, encouraging families to stay enrolled for entire year eligible

b. Upcoming Goals:
   - Ensure full implementation of corrective action plan related to MDHHS and MSHN SEDW findings
   - Continue to work to increase overall regional enrollments of SEDW
   - Expand SEDW enrollment and provide support of SEDW enrollment to all CMHSPs in the region
   - Emphasize the importance of and encourage participation in regional SEDW based trainings

IV. Performance Measurement Review and QAPIP Work Plan FY21

Performance measures are monitored on a quarterly or annual basis dependent on the measure. A status of "Met" indicates the desired performance has been achieved for the measurement period. . A status of "Not Met" indicates the desired performance has not been achieved for the measurement period. A status of "Not Met" results in the identification causal factors/barriers interfering with obtaining/sustaining the desired performance. The assigned committee/council in collaboration with other relevant committees/councils develop interventions designed to improve the performance of the measure. Effectiveness of the interventions are monitored through performance measure reporting or other as specified in the improvement plans. Specific information can be found in the performance summaries attached to this report and referenced below for each indicator. **Indicates data that has not been finalized.

a) Performance Indicators

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in access, efficiency, and outcomes. Pursuant to its contract with MDHHS, MSHN is responsible for ensuring that its CMHSP Participants and Substance Use Disorder Providers are measuring performance through The Michigan Mission Based Performance Indicator System in addition to key performance indicators established by MSHN. Performance is monitored quarterly. When minimum performance standards or requirements are not met, CMHSP Participants/SUD Providers will submit a form identifying causal factors, interventions, implementation timelines, and any other actions they will take to correct undesirable variation. Regional trends are identified and discussed at the QIC for regional planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified. A status of "met" indicates MSHN met the standard for FY21. A status of "not met"' indicates the standard was not met.

Goal: MSHN will meet or exceed the Michigan Mission Based Performance Indicator System standards for Indicators 1, 4, 10 as required by MDHHS.

MSHN met the standards as indicated below.

Attachment 2: MSHN MMBPIS Performance Summary FY21Q4

Strategic Priority	Indicator	Committee/ Council Review	FY20	FY21	Status/ Recommendations
	Michigan Mission Based Performance Indicator System (MMBPIS)				
Better Care	MSHN will meet or exceed the standard for indicator 1: Percentage of Children who receive a Prescreen within 3 hours of request (>= 95% or above)	QIC	99.53%	99.58%	Met/Continue
Better Care	MSHN will meet or exceed the standard for indicator 1: Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95% or above)	QIC	99.12%	99.22%	Met/Continue
Better Care	Indicator 2. a. Effective on and after April 16, 2020, the percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children. (No Standard)	QIC	73.61%	67.39%	Continue
Better Care	Indicator 2 b. Effective April 16, 2020, 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 substance use disorders. (No Standard)	QIC/SUD	92.39%	**80.98%	Continue
Better Care	Indicator 3: Effective April 16, 2020, percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). (No Standard)	QIC	75.45%	71.34%	Continue
Better Care	MSHN will meet or exceed the standard for indicator 4a1: Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%)	QIC	98.10%	98.90%	Met/Continue
Better Care	MSHN will meet or exceed the standard for indicator 4a2: Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%)	QIC	96.59%	97.02%	Met/Continue
Better Care	MSHN will meet or exceed the standard for indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%)	QIC/SUD	97.29%	96.68%	Met/Continue
Better Care	MSHN will meet or exceed the standard for indicator 10a: Re-admission to Psychiatric Unit within 30 Days-Children (standard is <=15%)	QIC	8.46%	7.97%	Met/Continue
Better Care	MSHN will meet or exceed the standard for indicator 10b: Re-admission to Psychiatric Unit within 30 Days- Adults (standard is <=15%)	QIC	12.48%	12.62%	Met/Continue

b) Behavioral Health Treatment Episode Data (BH-TEDS)

It is the expectation of the Michigan Department of Health and Human Services (MDHHS) that MSHN will monitor the completion and quality of the Behavioral Health Treatment Episode Data Set (BH-TEDS). The BH-TEDS is used to support the identification of Veterans within our provider network, and to support the MMBPIS. MSHN identified two areas related to the BH-TED to be included in the QAPIP Plan.

MDHHS requires MSHN to identify beneficiaries who may be eligible for services through the Veteran's Administration (VA). This is to be completed through a quarterly submission of the Veteran's Navigator (VN) Data Collection form, improving, and maintaining the data quality of the BH-Teds military and veteran's fields, and monitoring and analyzing the data discrepancies between the VN form and the BH-TEDS. A narrative report is completed on the comparison findings of the veterans reported on the VN form and BH-TEDS, including actions taken to improve the quality of the data submitted to MDHHS annually. MSHN QIC monitors the progress of the actions identified in the narrative.

Health Services Advisory Group, as the external auditor for MDHHS, provided recommendations related to the quality of the BH-TEDS fields specific to the MMBPIS. Recommendations include Mid-State Health Network and the CMHSP participants to 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. MDHHS calculates annual indicators using the BH-TEDS data specific to employment, wages, and living arrangements.

MSHN QIC in coordination ITC have developed steps to monitor and improve the quality of the BH-TEDS submitted during FY22.

- BH-TEDS fields will be monitored during the DMC review.
- A full review of the BH-TEDS is performed to identify any illogical combinations.
- Quality improvement initiatives are completed based on the results of the reviews.

Attachment 3 MSHN Veterans FY21 Q1Q2

	BH-TEDS Data	Committee/ Council	FY20	FY21	Status/ Recommendations
	MSHN will demonstrate an improvement with the quality of data for the BH-TEDS data. (Military fields, living arrangements and employment, LOCUS, Medicaid ID)	QIC	NA	99%	Military Fields- Complete/Continue Living Arrangements and Employment-In Progress/Continue LOCUS-In Progress/Continue

c) Performance Improvement Projects

MDHHS requires the PIHP to complete a minimum of two performance improvement projects per year. One of the two is chosen by the department based on Michigan's Quality Improvement Council recommendations. This project is subject to validation by the external quality review (EQR) organization and requires the use of the EQR's form. The second or additional PI project(s) is chosen by the PIHP based on the needs of the population served, previous measurement and analysis of process, satisfaction, and/or outcome trends that may have an impact on the quality of service provided. The QIC approves the performance improvement projects and presents to relevant committees and councils for collaboration.

Data collected through the performance improvement projects are aggregated, analyzed and reported at the QIC meeting. A project/study description is written and identifies the data collection timeframe, the data collection tool, data source, and whether measure if local or regional. The project/study description incorporates the use of standardized data collection tools and consistent data collection techniques. Each data collection delineates strategies to minimize inter-rater reliability concerns and maximize data validity. Additionally, if sampling is used, sampling method used, the population from which a sample is pulled, and appropriate sampling techniques to achieve a statistically reliable confidence level. The default confidence level for MSHN performance measurement activity is a 95% confidence level with a 5% margin of error.
MSHN participated in two performance improvement projects during FY21. Two new Performance Improvement Projects (PIP) will be implemented during FY22.

Recovery Self- Assessment (PIP)
Goal: To increase the degree to which CMHSP participants and SUD Providers implement recovery-oriented practices.
MSHN met the goal for FY21.

Diabetes Monitoring (PIP-Validated by HSAG)
Goal: The percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year. (Standard is 7% increase from baseline).
MSHN met the goal for CY21.
MSHN meet the goal of achieving a status of "Met" on the External Quality Review Performance Improvement Validation Report.

Attachment 4 MSHN Recovery Self-Assessment Annual Report FY21
Attachment 5 MSHN MI2020-21_PIHP PIP Validation Report

Strategic Priority	Performance Improvement Projects	Committee / Council	CY20	CY21	Status/ Recommendations
Better Care	PIP – The degree to which programs implement recovery-oriented practices will demonstrate a 3.50 or above annually. (>=3.50)	QIC	4.25	4.24	Met-PIP ended. Discontinue
Better Care	PIP - The percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year will demonstrate a statistically significant increase from previous reporting period. (Target- 38.6%)	QIC	39.07%	49.20%	Met-PIP ended. Discontinue
Better Care	MSHN will achieve a status of "Met" on the Performance Improvement Validation Review.	QIC	Not Met	Met	Met/Discontinue

d) Adverse Event Monitoring

Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrants PIHP review. Subsets of the adverse events will qualify as "reportable events" according to the MDHHS Critical Event Reporting System. These include MDHHS defined sentinel events, critical incidents, and risk events. MSHN also ensures that each CMHSP Participant/SUD Provider has a system in place to monitor these events, utilizing staff with appropriate credentials for the scope of care, and within the required timeframes. MSHN submits and/or reports required events to MDHHS including events requiring immediate notification as specified in the MDHHS-PIHP FY22.

MSHN delegates the responsibility of the process for review and follow-up of sentinel events, critical incidents, and other events that put people at risk of harm to its CMHSP Participants and SUD Providers.[5] MSHN will ensure that the CMHSP and SUD Providers have taken appropriate action to ensure that any immediate safety issues have been addressed, including the identification of a sentinel event within three business days in which the critical incident occurred and the commencement of a root cause analysis within two business days of the identification of the sentinel event. Following completion of a root cause analysis, or investigation, the CMHSP will develop and implement either a plan of action or an intervention to prevent further occurrence or recurrence of the adverse event, or documentation of the rationale for not pursuing an intervention. The plan shall address the staff and/or program/committee responsible for implementation and oversight, timelines, and strategies for measuring the effectiveness of the action.

[5] Quality-Sentinel Events Policy

MSHN provides oversight and monitoring of the CMHSP Participant/SUD Provider processes for reporting sentinel events, critical events, and risk events and/or events requiring immediate notification to MDHHS[6],[7]. In addition, MSHN oversees the CMHSP Participant/SUD Provider process for quality improvement efforts including analysis of all events and other risk factors, identified patterns or trends, the completion of identified actions, and recommended prevention strategies for future risk reduction. The goal of reviewing these events is to focus the attention of the CMHSP Participant/SUD Provider on potential underlying causes of events so that changes can be made in systems or processes in order to reduce the probability of such events in the future.

Goal: MSHN will demonstrate a decrease in the rate of critical incidents/sentinel events from previous reporting period.
MSHN met 9 out of 13 areas as indicated below. The following recommendations are being made:
Combine CMHSP participant goals that have been met be into one goal for a higher-level review of critical and sentinel events.
Combine the SUDTP goals into one goal due to the low number of sentinel events.

Attachment 6 MSHN Critical Incident Performance Summary FY21Q4
Attachment 7 MSHN Critical Incident Performance SUDTP Report FY21Q4

Strategic Priority	Event Monitoring and Reporting	Committee / Council	FY20	FY21	Status/ Recommendations
Better Care	*MSHN will demonstrate a 100% completion rate of Critical Incident/Event performance summary (SUDTP) quarterly.	**QIC**	**NA**	**100%**	Met/Discontinue
Better Care	The rate of arrests, per 1000 persons, served will demonstrate a decrease from previous year. (CMHSP)	QIC	0.352	0.147	Met/Combine
Better Care	The rate, per 1000 persons served, of persons who received emergency medical treatment for an injury or medication error will demonstrate a decrease from previous year. (CMHSP)	QIC	3.165	2.813	Met/Combine
Better Care	The rate, per 1000 persons served, of individuals who were Hospitalized for an injury or medication error will demonstrate a decrease from previous year.	QIC	0.266	0.220	Met/Combine
Better Care	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP)	QIC	2.450	2.956	Not Met/ Continue
Better Care	The rate, per 1000 persons served, of Suicide Deaths will demonstrate a decrease from previous year. (CMHSP)	QIC	0.150	0.146	Met/Combine

[6] Quality CMHSP Participant Monitoring & Oversight Procedure
[7] Quality Monitoring & Oversight of SUD Service Providers Procedure

Strategic Priority	Event Monitoring and Reporting	Committee / Council	FY20	FY21	Status/ Recommendations
Better Care	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from previous from previous year. (SUDTP)	SUD TX/UM	0.023	0.014	Met/Continue
Better Care	The rate of deaths per 1000 persons served will demonstrate a decrease from previous reporting period. Sentinel	SUD TX/UM	0.320	0.000	Met/Combine
Better Care	The rate of accidents requiring emergency medical treatment and/or hospitalization per 1000 persons served will demonstrate a decrease from previous reporting period. Sentinel	SUD TX/UM	0.000	0.000	Met/Combine
Better Care	The rate of physical illness requiring admissions to hospitals per 1000 persons served will demonstrate a decrease from previous reporting period. Sentinel	SUD TX/UM	0.320	1.808	Not Met/Combine
Better Care	The rate of arrest or convictions per 1000 persons served will demonstrate a decrease from previous reporting period. Sentinel	SUD TX/UM	0.000	0.000	Met/Combine
Better Care	The rate of serious challenging behaviors per 1000 persons served, will demonstrate a decrease from previous reporting period. Sentinel	SUD TX/UM	0.000	0.226	Not Met/Combine
Better Care	The rate of medication errors, per 1000 persons, served will demonstrate a decrease from previous reporting period. Sentinel	SUD TX/UM	0.000	0.904	Not Met/Combine

e) Behavior Treatment

MDHHS requires data to be collected based on the definitions and requirements that have been set forth within the MDHHS Standards for Behavioral Treatment Review and the MDHHS Quality Assessment and Performance Improvement Program Technical Requirement 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, including the evaluation of the effectiveness of the Behavior Treatment Committee by stakeholders. Data is 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. Only techniques approved by the Standards of Behavior Treatment Plan, agreed to by the individual or his/her guardian during the person-centered planning, and supported by current peer- reviewed psychological and psychiatric literature may be used.

By asking the behavior treatment committees to track these data, it provides important oversight to the protection and safeguard of vulnerable individuals. This data is analyzed on a quarterly basis by MSHN and is available to MDHHS upon request. MSHN analyzes the data on a quarterly

basis to address any trends and/or opportunities for quality improvements. MSHN also uses this data to provide oversight via the annual site review process at each of the CMHSPs. Data shall include numbers of interventions and length of time the interventions were used per person.

Goal: MSHN will collect data as required by MDHHS, analyzing the data quarterly, identifying trends, patterns, strengths, and opportunities for improvement.
MSHN met the goals as indicated below.

Attachment 8 Behavioral Treatment Performance Summary FY21Q4

Strategic Priority	Behavior Treatment	Committee / Council	FY20	FY21	Status/ Recommendations
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (Standard-95%)	UM	NA	61%	Recommended-New for FY22
Better Care	The percent of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques will decrease from previous year.	QIC	1.13%	1.19%	Not Met/Modify to Trend Data
Better Care	The percent of emergency physical interventions per person served during the reporting period will decrease from previous year.	QIC	0.45%	0.44%	Met/Combine physical interventions and 911 calls. See below
Better Care	The percent of 911 calls by staff for behavioral assistance per person served during the reporting period will decrease from previous year.	QIC	0.15%	0.11%	Met/Combine physical interventions and 911 calls. See below
Better Care	The percent of emergency interventions (911 calls, physical management) during the reporting period will decrease from previous year.	QIC	1.49%	0.59%	Met/Continue

f) Stakeholder and Assessment of Member Experiences

The aggregated results of the surveys and/or assessments were collected, analyzed, and reported by MSHN in collaboration with the QI Council, the Clinical Leadership Committee, the Provider Network Management Committee, and Regional Consumer Advisory Council, who identified areas for improvement and recommendations for action as appropriate. Regional benchmarks and/or national benchmarks were used for comparison. The findings were incorporated into program improvement action plans as needed. Actions are taken on survey results of individual cases, as appropriate, to identify and investigate sources of dissatisfaction and determine appropriate follow-up at the CMHSP Participant/SUD Provider level. The reports have been presented to the MSHN governing body, the Operations Council, Regional Consumer Advisory Council,

CMHSP Participants and SUD Providers, and accessible on the MSHN website, Findings are also shared with stakeholders on a local level through such means as advisory councils, staff/provider meetings and printed materials.

Goal: MSHN will provide opportunities for stakeholder/consumer feedback related to member (all populations served) experiences. MSHN will analyze trend patterns, strengths, and opportunities for improvement.
MSHN met the goal based on the comprehensive score of each survey. Performance as it relates to individual subscales can be found in the following attachments:

Attachment 9 MSHN Member Satisfaction Annual Report FY2021
Attachment 10 MSHN FY21 Provider Satisfaction Survey Final no comments
Attachment 3 MSHN The Recovery Self-Assessment Annual Report

Strategic Priority	Stakeholder and Assessment of Member Experiences	Committee / Council	FY20	FY21	Status/ Recommendations
Better Care	*MSHN will demonstrate a 100% completion rate of assessments for each representative population served (SUD, MI/SED, IDD inclusive of LTSS) with development of action plan to address findings annually.	QIC	3	3	Met -Discontinue
Better Care	The rate of satisfaction with SUD services and treatment received will meet or exceed a comprehensive score of 80%.	QIC	4.58	4.61/ 95%	Met-Continue
Better Care	The rate of satisfaction with services and treatment received for a mental health (including LTSS) will meet or exceed a comprehensive score of 80%.	QIC	89%	85%	Met/Continue
Better Care	The rate of satisfaction with services and treatment received for a serious emotional disturbance will meet or exceed a comprehensive score of 80%.	QIC	4.13/ 85%	4.18/ 87%	Met/Continue
Better Provider System	Provider surveys demonstrate satisfaction with REMI enhancements - Provider Portal (SUD Network) (Standard 80%)	PNMC	100%	75%	Not Met/Continue
Better Provider System	SUD providers satisfaction demonstrates 80% or above with the effectiveness and efficiency of MSHN' s processes and communications (SUD Network) (Standard 80%)	PNMC	70%	79%	Not Met/Continue
Better Provider System	Autism/ABA provider network will demonstrate satisfaction with regionally organized performance monitoring procedures (CMHSP Network) (Standard 80%)	PNMC	NA	New 73%	Not Met/Continue

Strategic Priority	Member Appeals and Grievance Performance Summary	Committee / Council	FY20	FY21	Status/ Recommendations
Better Care	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service. (Standard-95%)	CSC	98%	98.27%	Met/Continue
Better Care	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal. (Standard-95%)	CSC	98%	98.82%	Met/Continue
Better Care	The percentage (rate per 100) of Medicaid second opinion requests regarding inpatient psychiatric hospitalization denials which are resolved in compliance with state and federal timeliness standards, including receiving a written provision of disposition (standard-95%)	CSC	100%	D/C	Discontinue
Better Care	The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance (standard-95%)	CSC	100%	98.72%	Met/Continue

g) Clinical Practice Guidelines

MSHN supports and requires the use of nationally accepted and mutually agreed upon clinical practice guidelines including Evidenced Based Practices (EBP) to ensure the use of research -validated methods for the best possible outcomes for service recipients as well as best value in the purchase of services and supports. Practice guidelines include clinical standards, evidenced-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individuals served.

The process for adoption, development, and implementation is based on key concepts of recovery, and resilience, wellness, person centered planning/individual treatment planning and choice, self-determination, and cultural competency. Practices will appropriately match the presenting clinical and/or community needs as well as demographic and diagnostic characteristics of individuals served. Practice guidelines utilized are a locally driven process in collaboration with the MSHN Councils and Committees. Practice guidelines are chosen to meet the needs of persons served in the local community and to ensure that everyone receives the most efficacious services. Clinical programs will ensure the presence of documented practice skills including motivation interviewing, trauma informed care and positive behavioral supports.

Practice guidelines will be monitored and evaluated through data analysis and MSHN's site review process to ensure CMHSP participants and SUDT providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization. Additionally, information regarding

evidenced based practices is reported through the annual assessment of network adequacy. Fidelity reviews shall be conducted and reviewed as part of the local quality improvement program or as required by MDHHS.

The use of practice guidelines and the expectation of use are included in provider contracts. Practice guidelines are reviewed and updated annually or as needed and are disseminated to appropriate providers through relevant committees/councils/workgroups. All practice guidelines adopted for use are available on the MSHN website.

Attachment 8 MSHN Behavioral Treatment Review Data FY21Q4
Attachment 11 ACT Utilization FY21Q4

Strategic Priority	Clinical Practice Guidelines	Committee / Council	FY20	FY21	Status/ Recommendations
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period.	CLC	NA	61% (Q3Q4)	Recommended- New for FY22
Better Care	MSHN's ACT programs will demonstrate an increase in fidelity for average minutes per week per consumer (120 minutes).	UMC	NA	New	Recommended new for FY22

h) Credentialing and Re-credentialing

MSHN has established written policy and procedures[8] in compliance with MDHHS's Credentialing and Re-Credentialing policy for ensuring appropriate credentialing and re-credentialing of the provider network. Whether directly implemented, delegated, or contracted, MSHN shall ensure that credentialing activities occur upon employment/contract initiation, and minimally every two (2) years thereafter. MSHN written policies and procedures[9] also ensure that non-licensed providers of care or support are qualified to perform their jobs, in accordance with the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes chart.

Credentialing, privileging, primary source verification and qualification of staff who are employees of MSHN, or under contract to the PIHP, are the responsibility of MSHN. Credentialing, privileging, primary source verification and qualification of CMHSP Participant/SUD Provider staff and their contractors is delegated to the CMHSP Participants/SUD Providers. MSHN monitors CMHSP Participant and SUD Provider compliance with federal, state, and local regulations and requirements annually through an established process including desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies.

[8] Provider Network Credentialing/Recredentialing Policy and Procedure
[9] Provider Network Non-Licensed Provider Qualifications

In 2019, Human Services Advisory Group (HSAG) conducted an audit of Mid-State Health Network (MSHN) and the MSHN network resulted in findings for both the CMHSP and SUD network specific to Credentialing. As a result, MSHN has determined that increased monitoring must be implemented.

The plan for increased monitoring went into effect January 2021. Increased monitoring includes a quarterly report to be submitted with a file review by those organizations that have a score of 90% or less on the credentialing/recredentialing standards during the delegated site review. The quarterly report includes 1) the status of implementation of their CAP, specific to credentialing and recredentialing, 2) identification of training/technical assistance needs, 3) list of practitioners credentialed during the reporting quarter.

MSHN conducted 9 full reviews for CMHSP participants in FY2021. Of those, 3 of 9 scored under 90% compliance with staff credentialing/re-credentialing file reviews. Any provider scoring under 90% compliance will be subject to additional credentialing reporting/oversight.

MSHN conducted 13 full reviews for SUD providers in FY2021. Of those, 9 of 13 scored under 90% compliance with staff credentialing/re-credentialing file reviews. Any provider scoring under 90% compliance is subject to additional credentialing reporting/oversight.

Attachment 18 MSHN 2-21 Compliance Summary Report

Strategic Priority	Provider Monitoring	Committee / Council	FY20	FY21	Status/ Recommendations
Better Provider	MSHN providers will demonstrate an increase compliance with the MDHHS/MSHN credentialing, recredentialing and non-licensed provider staff qualification requirements. (SUD-Section 8; CMHSP-Section 11)	PNMC	SUDP: 69.12% (FY20) CMHSP: 96.68% (CY19) HSW-76% (MDHHS FY20) CWP-74% (MDHHS FY20) SED-89% (MDHHS FY20)	SUDP 85.88% CMHSP 91.08%	SUDP-Met/Continue CMHSP-Not Met/Continue
Better Provider	All CMHSP participants (12) will have 100% of applicable trainings vetted in accordance with the training reciprocity plan (CMHSP Network)	PNMC	NA	New 8	Continue

i) Verification of Services

MSHN has established a written policy and procedure for conducting site reviews to provide monitoring and oversight of the Medicaid and Healthy Michigan funded claims/encounters submitted within the Provider Network. MSHN verifies the delivery of services billed to Medicaid and Healthy Michigan in accordance with federal regulations and the state technical requirement.

Medicaid Event Verification for Medicaid and Healthy Michigan Plan includes testing of data elements from the individual claims/encounters to ensure the proper code is used for billing; the code is approved under the contract; the eligibility of the beneficiary on the date of service; that the service provided is part of the beneficiaries individualized plan of service (and provided in the authorized amount, scope and duration); the service date and time; services were provided by a qualified individual and falls within the scope of the code billed/paid; the amount billed/paid does not exceed the contract amount; and appropriate modifiers were used following the HCPC guidelines.

Data collected through the Medicaid Event Verification process is aggregated, analyzed, and reported for review at the QI Council and Regional Compliance Committee meetings, and opportunities for improvements at the local or regional level are identified. The findings from this process, and any follow up needed, are reported annually to MDHHS through the Medicaid Event Verification Service Methodology Report.

Goal: MSHN will verify delivery of services through oversight of the claims and encounters submitted to Medicaid. MSHN will identify trends, patterns, strengths, and opportunities for improvement, reporting annually to MDHHS.
MSHN met the goal as indicated below for FY21.

Attachment 12 MSHN FY2021 Medicaid Event Verification Methodology Report

Strategic Priority	Medicaid Event Verification	Committee/ Council	FY20	FY21	Status/ Recommendations
Better Care	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service date and time matching the claim date and time of the service. CMHSP/SUD.	CCC	CMHSP: 99.02% SUD: 94.05%	CMHSP: 99.30% SUD: 99.50%	Met
Better Care	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service provided falls within the scope of the service code billed.	CCC	CMHSP: 98.20% SUD: 95.45%	CMHSP: 98.76% SUD: 99.28%	Met

j) Utilization Management

MSHN ensures access to publicly funded behavioral health services in accordance with the Michigan Department of Health and Human Services contracts and relevant Medicaid Provider Manual and Mental Health Code requirements.

Utilization review functions are delegated to CMHSP Participants in accordance with MSHN policies, protocols, and standards. This includes local-level prospective, concurrent, and retrospective reviews of authorization and utilization decisions and/or activities regarding level of need and level and/or amount of services, consistent with PIHP policy, standards, and protocols.

A Regional Utilization Management Committee comprised of each CMHSP Participant assists in the development of standards and reviews/analyzes region-wide utilization activity and trends. Communication with individuals regarding UM decisions, including adverse benefit determination notice, right to second opinion, and grievance and appeals will be included in this delegated function.

MSHN retains utilization review functions for substance use disorder (SUD) services in accordance with MSHN policies, protocols, and standards. This includes local-level prospective, concurrent, and retrospective reviews of authorization and utilization decisions and/or activities regarding level of need and level and/or amount of services, consistent with PIHP policy, standards, and protocols. Initial service eligibility decisions for SUD services are delegated to SUD providers through the use of screening and assessment tools.

MSHN ensures that screening tools and admission criteria are based on eligibility criteria established in contract and policy and are reliably and uniformly administered. MSHN policies are designed to integrate system review components that include PIHP contract requirements and the CMHSP Participant's/SUD Provider roles and responsibilities concerning utilization management, quality assurance, and improvement issues.

MSHN has established criteria for determining medical necessity, and the information sources and processes that are used to review and approve provision of services. MSHN and its CMHSP Participants/SUD Providers use standardized population-specific assessments or level of care determination tools as required by MDHHS. Assessment and level of care tools guide decision making regarding medical necessity, level of care, and amount, scope, and duration of services. No one assessment shall be used to determine the care an individual receives, rather it is part of a set of assessments, clinical judgment, and individual input that determine level of care relative to the needs of the person served.

MSHN has mechanisms to identify and correct under-and over-utilization of services as well as procedures for conducting prospective, concurrent, and retrospective reviews. MSHN ensures through policy and monitoring of the CMHSP Participants/SUD Providers that qualified health professionals supervise review decisions and any decisions to deny or reduce services are made by health care professionals who have appropriate clinical licensure and expertise in treating the beneficiary's condition. Through policy and monitoring of CMHSP Participants/SUD Providers, MSHN shall ensure that reasons for treatment decisions are clearly documented and available to persons served; information regarding all available appeals processes and assistance through customer services is communicated to the consumer; and notification requirements are adhered to in accordance with the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services.

Attachment 13 MSHN Behavioral Health Quarterly Report
Attachment 14 MSHN UM Plan FY20-21
Attachment 15 MSHN UM Quarterly Report
Attachment 16 MSHN Integrated Population Health Integrated Care Report

k) Long Term Supports and Services for Vulnerable Adults

Strategic Priority	Priority Measures-	Committee/ Council	FY20	FY21	Status/ Recommendations
Better Value	Reduction in number of visits to the emergency room for individuals in care coordination plans between the PIHP and MHP (Target 100%)	UM/ Integrated Care	56%	75%	Not Met/Continue
Better Care	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%)	UM	96.50%	98.5%	Not Met/Continue
Better Care	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan. (Standard 100%)	UM	NA	New 81.5%	Not Met/Continue
Better Care	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth. (Standard 0% decrease over previous fiscal year)	UM	NA	New +6%	Continue
Better Value	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages (Standard <=5%)	UM	NA	New <1%	Continue
Better Care	MSHN will be in full compliance with the Adverse Benefit Determination notice requirements.	CSC		New 95%	Not Met/Continue
Better Care	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization.	CLC	95.60%	94.90%	Not Met/Continue
Better Care	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (Standard 95%)	CLC	92%	89%	Not Met/Continue
Better Care	MSHN's CMHSP partners will report completing at least one community education activity on fetal alcohol spectrum disorder (FASD). (Standard 50%)	CLC	25%	50%	Met/Continue
Better Care	MSHN's provider network will demonstrate 95% compliance with trauma-competent standard in the site review chart tool. (Standard 100%)	CLC	100%	99.07%	Not Met/Continue

l) Key Priority Measures

Goal: MSHN, through the CMHSPs, will demonstrate performance above the required standard for each priority measure to ensure optimal health, safety, and welfare of the individuals served. Identification of trends, patterns, strengths and opportunities for improvement will be completed quarterly.

MSHN met the standard for nine of the eleven measures used to monitor the health, safety and welfare of individuals served as indicated in the table below.

	Priority Measures	Committee/ Council	FY20	FY21	Status/ Recommendations
Better Health	MSHN will demonstrate improvement from previous reporting period (79%) of the percentage of patients 8-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Diabetes Screening Report (Data Source-ICDP) Michigan 2020-84.43%	QIC	74.25%	84.68%	Met/Continue Maintenance
Better Health	MSHN will demonstrate an increase from previous measurement period in the percentage of individuals 25 to 64 years of age with schizophrenia or bipolar who were prescribed any antipsychotic medication and who received cardiovascular health screening during the measurement year. Cardiovascular Screening (Data Source-ICDP) Michigan 2020-73.16%,	CLC	46.09%	54.88%	Not Met/Continue
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. (Data Source-ICDP) Michigan 2020-44.44%	CLC	75.82%	60.52%	Not Met/Continue
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. (Data Source-ICDP) Michigan 2020 54.65%	CLC	98.61%	97.12%	Not Met/Continue
Better Care	Plan All-Cause Readmissions-The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (<=15%) (Data Source-ICDP) Michigan 2020 9.09%	UM	11.23%	11.59%	Met/Continue
Better Care	The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%) (Data Source – ICDP) Michigan 2020 82.49%	UM	89.55%	91.69%	Met/Continue
Better Care	The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%) (Data Source-ICDP) Michigan 2020 89.64%	UM	93.51%	95.68%	Met/Continue

m) Performance Based Incentive Payments

	Joint Metrics	Committee/ Council	FY20	FY21	Status/ Recommendations
Better Care	The percentage of discharges for adults who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. FUH Report, Follow-Up After Hospitalization Mental Illness Adult (standard-58%). Racial/ethnic group disparities will be reduced. (*Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences). (Data Source-ICDP)	QIC	71.32%	75.34%	Met/Continue Update to include disparities (adults and children combined)
Better Care	The percentage of discharges for children who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. Follow-Up After Hospitalization Mental Illness Children (standard-70%). Racial/ethnic group disparities will be reduced. (*Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) (Data Source-ICDP)	QIC	75.71%	89.32%	Met/Continue Update to include disparities (adults and children combined)
Better Health	Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence.	Integrated Care/UMC	27.1% Q3	28%	Met/Continue update to include disparities.
	Performance Based Incentive Payments	**Committee/ Council**	**FY20**	**FY21**	**Status/ Recommendations**
Better Care	Identification of enrollees who may be eligible for services through the Veteran's Administration. (Narrative Report BH-TEDS and Veteran Services Navigator Data)	ITC/QIC	Complete	Complete	Met/Continue
Better Health	Increased data sharing with providers (narrative report)	ITC	Complete	Complete	Met/Continue
Better Care	MSHN will demonstrate an increase over previous reporting period of Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence (2018 level Initiation-36.81%; Engagement 22.30%) (informational only)	SUDT	63.71% 47.61%	57.48% 50.12%	Met/Continue-Modify to include the completion of the Validation.
Better Health	Increased participation in patient centered medical homes (narrative)	UM	Complete	Complete	Met/Continue

n) External Reviews

Based on the results of the external reviews a corrective action plan was developed by MSHN in coordination with the CMHSP participants and SUDTP. The corrective action plan was approved by HSAG for completion during FY20-FY21.
Areas identified and included in the work plan and respective section of the QAPIP Report are listed below.

- Individual Plan of Service (IPOS) development and implementation (includes coordination with ABA providers, amount scope and duration, measurable goals, authorization of services)
- Credentialing and staff qualification requirements (ABA and waiver programs)
- Qualitative and quantitative assessments for each representative population served annually with development of action plan to address findings.
- Adverse Benefit Determinations time frames
- Appeal Resolution Notice content requirements
- PIP-Obtain statistical improvement from previous reporting period.

The following external reviews were completed for FY21:

- HSAG Performance Measure Validation Review-Full Compliance
- HSAG Compliance Review-Partial Compliance
- HSAG Performance Improvement Project-Met

The findings and recommendations will be incorporated into the QAPIP Performance Measures and Work Plan for FY22.

Attachment 17 MSHN External Quality Review Summary 2021

o) Quality Priorities and Work Plan FY21

Organizational Structure and Leadership	Objectives/Activities/Evaluation Method	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN will have an adequate organizational structure with clear administration and evaluation of the QAPIP	To develop in collaboration with the QIC the annual QAPIP evaluation and QAPIP plan. (QAPIP Description, QAPIP Work Plan and Organizational Chart of the QAPIP).	Quality Manager	11.18.2021	Complete/Continue
	Development of a process to monitor the progress of the quality workplan performance measures inclusive of other departments designated responsibilities in the QAPIP (UM, PNM, CC, Clinical-SUD and CMHSP, IT).	Quality Manager	9.30.2021	In Progress/ Continue
Governance	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**Status/ Recommendations**
Board of Directors will approve the QAPIP Plan and Report	To submit the annual QAPIP Plan and Report to the board.	Deputy Director/Director of Compliance, Quality, Customer Services	1.1.2022	Complete/Continue
Board of Directors review QAPIP Progress Reports	To submit QAPIP progress reports to the Board. Attachment Balanced Score Card. Attachment Key Priority Measures, Attachment MSHN Quarterly Compliance, Quality and Customer Services Report	Deputy Director/Director of Compliance, Quality, Customer Services	6.1.2021	Complete/Continue
QAPIP will be submitted to Michigan Department of Health and Human Services	To submit the Board approved QAPIP Report and Plan to MDHHS. (via MDHHS FTP Site) Review reporting timeframes and submission deadline for QAPIP submission to MDHHS with contract negotiating team.	Quality Manager/QIC CEO	~~1.31.2022~~ Revised to 2/28/2022 10.1.2021	Complete/Continue Complete/Discontinue <u>Recommendation</u>: Modify Reporting to address timeliness of submission and Complete Data for Q4
Include the role of recipients of service in the QAPIP	QAPIP Description, and Organizational Chart of the QAPIP.	Quality Manager/QIC	1.31.2022	Complete/Continue

Communication of Process and Outcome Improvements	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
*The QAPIP Plan and Report will be provided annually to network providers and to members upon request.	*To distribute the completed Board approved QAPIP Effectiveness Review (Report) through committee/councils, MSHN Constant Contact, and email. To post to the MSHN Website. To ensure CMHSP contractors receive the QAPIP.	Quality Manager	1.31.2021 Annually	Complete/Continue
*The Practice Guidelines MSHN will communicate practice guidelines to the providers annually.	*To distribute Practice Guidelines through committee/councils, MSHN Constant Contact, and post to MSHN Website.	Chief Behavioral Health Officer; Committee/Council Leads including sponsored workgroups. (OC, UM, CLC, TX. UM Team Meeting)	1.31.2022 Annually	Complete/Continue
Guidance on Standards, Requirements, and Regulations	To complete MSHN Contract Monitoring Plan and Medicaid Work Plan, post updates to MSHN Website, and distribute through committee/councils, MSHN Constant Contact.	Quality Manager- QIC, CLC, UM, CLC, ITC, CSC, SUDP, FC, OC	As needed, minimum annually	In Progress/Continue
Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	To present reports on Consumer Satisfaction Survey Results, Recovery Survey Assessments, Key Priority Measures, MMBPIS, Behavior Treatment Review Data, Event Data, Quality policies/procedures and Customer Service Reports to RCAC and PAC quarterly for feedback.	Customer Services Specialist; Quality Manager; Director of Compliance, Customer Services, Quality, MEV; Director of Utilization and Care Management	December, February, April, June, August, October	RCAC- Complete/Continue <u>Recommendation</u>: PAC-Discontinue Utilize focused Level of Care Groups in FY22
Performance Measurement and Quality reports are made available to stakeholders and general public	To upload to the MSHN website the following documents: QAPIP Plan and Report, Satisfaction Surveys, Performance Measure Reports; MSHN Scorecard, and MSHN Provider Site Review Reports, in addition to communication through committees/councils.	Director of Compliance, Customer Services, Quality, MEV; CC, QIC, UM, CLC, ITC, CSC, SUDP, FC, OC	Quarterly	Complete/Continue

MMBPIS	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
*MSHN will meet or exceed the MMBPIS standards for Indicators 1, 4, 10 as required by MDHHS.	CMHSPs to upload detail data utilizing MSHN template quarterly through REMI.	CMHSP Participants	Q1 3.15.2021 Q2 6.15.2021 Q3 9.15.2021 Q4 12.15.2021	Complete/Continue
	MSHN submit MMBPIS to MDHHS quarterly.	Quality Manager	Q1 3.31.2021 Q2 6.30.2021 Q3 9.30.2021 Q4 12.31.2021	Complete/Continue
	MSHN to complete performance summary, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations), and present/provide to relevant committees/councils and providers quarterly.	Quality Manager QIC, Medical Directors, Tx/UM, PAC, RCAC, SUDP.	Q1 April Q2 July Q3 October Q4 January	CMHSP-Complete/Continue SUD-Complete/Continue <u>Recommendation</u>: NAA Work Plan-Refer Network Adequacy issues to PNMC.
	CMHSPs to develop and submit improvement plans quarterly.	CMHSP Participants	Q1 April; Q2 July; Q3 October; Q4 January	Completed/Continue
	SUD Providers to develop improvements quarterly	SUDPs	FY21 Q3	In Progress/ Continue
	MSHN will develop or have available documentation for education and training of performance indicator requirements.	Quality Manager	Annually through QIC/PAC/SUD Provider Meeting	Complete/Continue
	MSHN to complete primary source verification of submitted records during the DMC review.	QAPI	Biennially with follows ups based on findings	Complete/Continue <u>Recommendation</u>: SUD-Indicator 4b-Verification of accurate data entry in REMI. Additional Medicaid Eligibility. (See HSAG report-New to the PIHP)

BH-TEDS	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN will improve the quality of BH-TEDS data.	MSHN will identify areas of discrepancy for the BH-TEDS data for FY21Q1. Veterans' data (military fields), Employment data-minimum wage, Living arrangements, LOCUS records, Medicaid IDs on update and M records.	CIO-ITC	2.28.21	Veterans - Complete/Continue- Employment-Minimum Wage; Living Arrangements; LOCUS; Medicaid ID- In Progress/Continue- Recommendation: QI efforts for completion through QIC/ITC.
	Causal factors will be determined based on review BH-TEDS data.	Quality Manager- QIC; IT Project Manager- CMHSPs	3.31.21	In Progress/Continue
	Narrative completed comparing BH-TEDS (veteran's military fields) and VN Report for FY21 Q1Q2 data.	CIO, Quality Manager- QIC; IT Project Manager- ITC	6.30.21	Complete/Continue
	Action steps developed to address incomplete data, discrepancies. Veterans' data (military fields), Employment data-minimum wage, Living arrangements.	CIO, Quality Manager- QIC; IT Project Manager- ITC	7.31.21	Veterans Data- Complete/Continue Employment-Minimum Wage; Living Arrangements- In Progress/Continue
	MSHN QIC will monitor progress through quarterly performance reports.	Quality Manager- QIC; IT Project Manager- ITC	Quarterly	Veterans Data- Complete/Continue Employment-Minimum Wage; Living Arrangements- In Progress/Continue

Performance Improvement Projects	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
Will engage in two performance improvement projects during the waiver renewal period.	To complete the Annual Recovery Self-Assessment-Provider/Administrator Report	Quality Manager/QIC/CLC/RCAC	Annually/May	Complete Continue with new PIP
	To complete the Diabetes Monitoring Performance Report quarterly and complete the Annual Submission to HSAG.	Quality Manager/Data Coordinator, QIC, Regional Medical Directors	Quarterly-December, March, June, September	Complete Continue with new PIP
Quantitative and Qualitative Assessment of Member Experiences	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**	**Status/ Recommendations**
*MSHN will demonstrate an 80% or above for assess consumer experience and take specific action as needed, identifying sources of dissatisfaction, outlining systematic action steps, monitoring for effectiveness, communicating results. *Member assessment of experiences will represent all served (including LTSS), and address the issues of the quality, availability, and accessibility of care.	MSHN in collaboration with CMHSPs and SUDPs will identify a qualitative process and distribute surveys and assessments based on the population and services received. (MHSIP/YSS) (SUD Satisfaction)	Quality Manager-QIC/SUDP	March, April	Complete/Continue Recommendation: Explore use of the MHSIP for SUDP. Explore for IDD or use of HCBS ongoing for IDD
	MSHN to complete an Annual Member Experience Report to include trends, causal sources of dissatisfaction, interventions in collaboration with relevant committees/councils.	Quality Manager-QIC/CLC/RCAC/SUDP/PAC	July	Complete/Continue
MSHN will assess the recovery environment	MSHN to complete the Annual RSA Report to include trends, causal factors, interventions in collaboration with relevant committees/councils.	Quality Manager-QIC/CLC/RCAC/SUDP/PAC	July	Discontinue

Event Monitoring and Reporting	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date	Status/ Recommendations
MSHN will ensure Events (Sentinel/Critical/Risk) as specified in the PIHP Contract, are monitored, and submitted to MDHHS.	To submit Critical Events to MSHN monthly. To submit Critical Events to MDHHS monthly	CMHSPs Quality Manager	The 26th of each month. The last day of each month	Complete/Continue Recommendation: Develop Dashboard for tracking and monitoring timeliness. Increase frequency of submission as needed. MSHN will ensure Events (Sentinel/Critical/Risk) as specified in the PIHP Contract, are monitored, and submitted to MDHHS within the required timeframes.
	To submit Critical Events to MSHN Quarterly (Provider Portal development) To submit Sentinel Events to MSHN Quarterly or sooner based on event notification requirements (Provider Portal/Supplement reporting development)	CMHSPs/SUDPs	January 15, April 15, July 15, October 14	Complete/Continue
	To submit Sentinel Events to MDHHS 2x annually	Quality Manager	Q1-Q2 April 30, Q3-Q4 October 30	Complete/Continue
MSHN Will complete oversight through primary source verification of critical incidents and sentinel events; review of the process for follow up of recommendations and consistency with MSHN/MDHHS requirements.	To complete the Delegated Managed Care Report. Critical Incident Reporting System (CIRS) tool.	Quality Manager	Biennially with follows ups annually as needed	CMHSP Complete/Continue SUDP In Progress/Continue Recommendations: Include the oversight of the Risk Event process

Event Monitoring and Reporting	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN will ensure appropriate follow up will occur for all events dependent on the type and severity of the event and may including a root cause analysis, mortality review, immediate notification to MDHHS.	To complete the Delegated Managed Care Report. Critical Incident Reporting System (CIRS) tool.	Quality Manager	Biennially with follows ups annually as needed	CMHSP Complete/Continue SUDP In Progress/Continue
MSHN will ensure Individuals will have the appropriate credentials for review of scope of care.	To complete the Delegated Managed Care Report. Critical Incident Reporting System (CIRS) tool.	Quality Manager	Biennially with follows ups annually as needed	CMHSP Complete/Continue SUDP In Progress/Continue (FY22)
CMHSP Participants and SUD Treatment Providers will achieve established targets as applicable. Trends, patterns, strengths, and opportunities for improvement identified. The PIHP must analyze at least quarterly the critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.	To complete the CIRS Performance Reports (including standards, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence) quarterly. To distribute the Performance Reports to relevant committees/councils/providers for review and follow up.	Quality Manager (QIC relevant committees	Quarterly (Q4 January, Q3 April, Q2 July, Q3 October)	Complete/Continue <u>Recommendations:</u> Add timeliness report/summary to the Quarterly report. Information Technology Request (ITR) for Dashboard Development. Further development of Risk Events
*MSHN will demonstrate a 100% completion rate of the Critical Incident Review System performance reports quarterly.				Complete/Discontinue

Medicaid Event Verification	Objectives/Activities	Assigned Person or Committee/Council	Frequency/Due Date	Status/ Recommendations
Will verify delivery of services billed to Medicaid	To complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.	MEV Auditor	Annual schedule for each provider	Complete/Continue
MSHN will identify trends, patterns, strengths and opportunities for improvement.	To complete The MEV Annual Methodology Report.	Director of Compliance/Quality/ CS, MEV auditor	1.31.2022	Complete/Continue
The MEV Methodology Report will be submitted to MDHHS annually as required.	To submit the Annual MEV Methodology Report to MDHHS.	Director of Compliance/ Quality/CS	12.31.2021	Complete/Continue
Utilization Management Plan	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**	**Status/ Recommendations**
MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements, utilizing uniform screening tools and admission criteria	To complete/review the MSHN Utilization Management Plan annually. To utilize uniform screening tools and admission criteria. LOCUS, CAFAS, MCG, ASAM, SIS, DECA	Director of Utilization and Care Management	12.1.2021 Quarterly/Annually	Complete/Continue Recommendation: Change to every other year to be consistent with the MSHN policy/procedure.
MSHN will identify trends, patterns of under / over utilization, medical necessity criteria, and the process used to review and approve provision of medical services.	MSHN to complete performance summary quarterly reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations).	Director of Utilization and Care Management	Quarterly/annually See UM Reporting Schedule	Complete/Continue
*MSHN will achieve full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements.	Oversight of compliance with policy through primary source verification during Delegated Managed Care Reviews. Development of new timeliness standard to be reviewed quarterly.	Quality Assurance and Performance Improvement (QAPI) Customer Service Specialist	Biennial Full Review with follow up annually as needed. Quarterly	Complete/Continue modify language. Recommendation: Add as a performance measure
*MSHN will achieve full compliance with the appeal resolution notice contact as required by MDHHS.	Refresher training will be conducted Oversight of compliance during Delegated Managed Care Reviews.	Customer Service Specialist QAPI	1.25.2020 Biennial Full Review with follow up annually as needed.	Complete/Continue Recommendation: Add as a performance measure

Practice Guidelines	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN adopts practice guidelines that are nationally, or mutually accepted by MDHHS and MSHN.	The QAPIP Plan and related policies/procedure will include a process for adoption, evaluating and communicating practice guidelines.	CBHO-CLC and Regional Medical Directors	Annually	Complete/Continue
*MSHN will communicate and disseminate practice guidelines to providers and members annually and upon request.	*To distribute Practice Guidelines through committee/councils, MSHN Constant Contact. Upload clinical practice guidelines, including MDHHS specified guidelines to the MSHN website.	CBHO; Committee /Council Leads including sponsored workgroups.	1.31.2022 Annually	Complete/Continue
CMHSPs will adhere to the standards within the accepted practice guidelines.	To provide oversight during DMC Review to ensure providers adhere to practice guidelines as appropriate to the population served. (Identify specific sections)	QAPI	Biennially with follows ups based on findings	Complete/Continue
*MSHN will meet the standards for PCP/IPOS development for those receiving services, specifically the Autism Benefit, SEDW Waiver, CWP Waiver, and HSW	MSHN will complete and implement a regional training plan to address Person Centered Planning and the development of the Individual Plan of Service. The following elements will be incorporated into the planning process and document: • Choice voucher/self-determination arrangements offered • Assessed needs in IPOS • Strategies adequately address health and safety and primary care coordination • Goals are measurable and include amount, scope and duration • Prior authorization of services corresponds to services in IPOS • IPOS is reviewed and updated no less than annually • Include guardian in PCP process • Category/intensity of Care (CWP)	Director of Compliance, Quality and Customer Services; Waiver Manager, Waiver Coordinator	2.17.2021	In Progress/Continue

Oversight of "Vulnerable People"	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
Will evaluate health, safety and welfare of individuals "vulnerable people" served in order to determine opportunities for improving oversight of their care and their outcomes. This includes members with special health care needs, members with long-term services and supports. This will include assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable.	MSHN will analyze performance measures- Behavior Treatment, Integrated Population Health Report, Key Performance Measures, Behavioral Health Report for trends and patterns and develop action for areas of concern.	Director of Utilization Management, Chief Behavioral Health Officer, HCBS Manager, Autism Coordinator	Annually/ Quarterly	Complete/Continue Recommendations: Identify specific measures for analysis of the vulnerable population including LTSS in Description.
	To complete clinical record reviews during the delegated managed care review.	QAPI, Autism Coordinator, HCBS Manager	Biennial Full Review with follow up annually as needed.	Complete/Continue
Behavior Treatment	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/Due Date**	**Status/ Recommendations**
MSHN will ensure behavioral treatment plans are developed in accordance with the Standards for Behavior Treatment Plan Review Committees. Behavior Treatment Data to include intrusive or restrictive techniques, and/or emergency physical intervention and 911 call to law enforcement, will be reviewed quarterly. Oversight will occur during Delegated Managed Care Site Reviews. *MSHN will demonstrate an increase in fidelity to the MDHHS Behavioral Treatment Standards for all IPOSs reviewed during the reporting period.	To develop/update the BTPR regional template, project description, policy and procedure.	BTPR Work Group, QIC, CLC, QM, Autism Coordinator	Annually	Complete/Continue
	To complete Behavior Treatment Performance Reports (including barriers, improvement efforts, recommendations, and status of recommendations) quarterly.	QM/BTPR Work Group/CLC/QIC	Q1-February Q2- May Q3- August Q4-November	Complete/Continue
	CMHSPs to upload BTPR Regional Template for CMHSP data submissions	CMHSP	Q1-1.31.2021 Q2-4.30.2021 Q3-7.31.2021 Q4-10.31.2021	Complete/Continue
	CMHSPs to develop action steps based on performance.	CMHSP Participants	Quarterly	Complete/Continue
	MSHN to develop/provide education and training in coordination with the CMHSP. MSHN to complete primary source verification of reported events during the DMC Review	HCBS Manager, Autism and Waiver Coordinators	Biennial Full Review with annual follow up as needed	Complete/Continue Training will occur as part of CAPs during the DMC process.

Autism Waiver Monitoring	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN will ensure CMHSP participants are in compliance with the Autism Benefit.	To complete performance reports. To identify patterns, trends, and identification of improvement recommendations and actions steps as needed.	Autism Coordinator	Quarterly	Complete/Continue
*MSHN will have oversight of the Autism Benefit program requirements and corrective action related to the MDHHS Site Review.	To complete the DMC Site Review Report, ensuring ABA Treatment plans are developed in coordination with the IPOS goals and best practice standards.	Autism Coordinator	Biennial Full Review with follow up to occur in the off year.	Discontinue MDHHS Autism Reviews have been phased out.

Credentialing, Provider Qualification and Selection	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
*The PIHP shall have written credentialing policies/ procedures for ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform their services. *The PIHP complies (ensures all delegates performing credentialing functions comply) with all initial (including provisional) credentialing requirements according to the Initial Credentialing Audit Tool, re-credentialing, and organizational credentialing tool. *Clinical service providers are credentialed by the CMHSP prior to providing services and ongoing. *All providers (non-licensed and licensed) will demonstrate an increase in compliance with staff qualifications, training, credentialing and recredentialing requirements.	To provide communication, training, and technical assistance on policy and procedures. Resources developed to support compliance with requirements and made available on MSHN website. Revised process to include additional monitoring and reporting based on repeat non-compliance with credentialing and recredentialing requirements. Primary Source Verification and credentialing and recredentialing policy and procedure review will occur during the DMC Review. REMI Provider Portal implemented to assist with document management for SUD Organizational provider qualifications.	QAPI Managers PNMC Contract Specialist Director of Provider Network Autism Coordinator Waiver Manager	Biennial Full Review with follow up to occur in the off year. Regional results reported quarterly via Provider Network Report.	Complete-Continue Complete/Discontinue

Provider Monitoring	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
CMHSP will ensure subcontractors are in compliance with MSHN standards and requirements.	To complete annual Delegated Managed Care (DMC) Site Review Reports and Corrective Action Plans.	CMHSP (as delegate) Contract Specialist QAPI	Biennially. Interim year review includes review of new standards and evaluation of required corrective action implementation.	Complete/Continue
MSHN will ensure the CMHSP participants and SUD providers are in compliance with standards and regulations.	To complete annual DMC Site Review Reports and Corrective Action Plans.	QAPI-Subject Matter Experts		Complete/Continue Recommendations: Add Performance Measure
MSHN will ensure the CMHSP participants and SUD providers are in compliance with standards related to Financial Management regulations.	CMHSP participants are not subject to additional fiscal oversight by MSHN as they are required to obtain a Certified Public Accounting Firm Financial Audit and Compliance Examination. In addition, CMHSPs receiving Federal Funds meeting the 2 Code of Federal Regulations (CFR) 200 threshold must also obtain a Single Audit. MSHN does however review the CMHSP audits to identify adverse opinions. CMHSP Compliance Examination results are included in MSHN's Compliance Examination report. Any findings must be addressed by the PIHP and remedied. SUD Providers are subject to Fiscal Monitoring and Oversight by MSHN Finance Staff to ensure Sub-recipient requirements are met	Financial Specialist		Complete/Continue CY 20 Sub-Recipient Financial Review-

External Reviews	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date	Status/ Recommendations
MSHN will coordinate external site reviews between external body and the provider network. MSHN will receive full compliance on external site reviews.	Completion of the MDHHS Waiver Review Follow Up Completion of Health Services Advisory Group (HSAG) Compliance Review, Performance Measure Validation Review, Performance Improvement Project Validation Review.	Quality Manager-QIC; Directors of Utilization and Care Management UMC, Customer Services-Compliance-Quality CCC, Provider Network PNMC, Customer Services Specialist-CSC; Waiver Manager, Waiver Coordinators; CBHO; CIO	Annually	Complete/Continue
MSHN will coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews.	MDHHS Waiver Review HSAG Compliance Review	Quality Manager-QIC; HCBS Waiver Manager, Waiver Coordinators-Waiver Workgroups; Directors of Provider Network, Utilization and Care Management, Customer Services- Compliance-Quality; CIO	Annually	Complete/Continue <u>Recommendations:</u> Include a smart goal specific to the compliance review and PMV review indicating an increase in the performance as it relates to specific standards/recommendation
MSHN will monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	MDHHS 1915 (c) Waiver Final Report HSAG Compliance Review	Quality Manager-QIC; Waiver Managers, Waiver Coordinators-Waiver Workgroups; Directors of Provider Network, Utilization and Care Management, Customer Services- Compliance-Quality, Customer Services Specialist; CIO	Biennial Full Review with follow up to occur in the off year.	Complete/Continue

V. Definitions/Acronyms

Community Mental Health Services Program (CMHSP): A program operated under Chapter 2 of the Michigan Mental Health Code - Act 258 of 1974 as amended.

CMHSP Participant refers to one of the twelve-member Community Mental Health Services Program (CMHSP) participant in the Mid-State Health Network.

Contractual Provider refers to an individual or organization under contract with the MSHN Pre-Paid Inpatient Health Plan (PIHP) to provide administrative type services including CMHSP participants who hold retained functions contracts.

Critical Incident Reporting System (CIRS): Suicide; Non-suicide death; Arrest of Consumer; Emergency Medical Treatment due to injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of physical management; Hospitalization due to Injury or Medication Error: Hospitalization due to injury related to the use of physical management.

Customer: For MSHN purposes customer includes all Medicaid eligible individuals (or their families) located in the defined service area who are receiving or may potentially receive covered services and supports. The following terms may be used within this definition: clients, recipients, enrollees, beneficiaries, consumers, primary consumer, secondary consumer, individuals, persons served, Medicaid Eligible.

Long Term Services and Supports (LTSS)- Older adults and people with disabilities who need support because of age; physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves, and who receive care in home-community based settings, or facilities such as nursing homes. (42 CFR §438.208(c)(1)(2)) MDHHS CQS – identify the Home and Community Based Services Waiver. MI-Choice to be recipients of LTSS.

Prepaid Inpatient Health Plan (PIHP): In Michigan a PIHP is defined as an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR part 401 et al June 14, 2002, regarding Medicaid managed care. (In Medicaid regulations, Part 438. Prepaid Health Plans (PHPs) that are responsible for inpatient services as part of a benefit package are now referred to as "PIHP" The PIHP also known as a Regional Entity under MHC 330.1204b also manages the Autism ISPA, Healthy Michigan, Substance Abuse Treatment and Prevention Block Grant and PA2. "

Provider Network: Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's subcontractors.

Research: (as defined by 45 CFR, Part 46.102) means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

Root Cause Analysis (RCA): Root Cause Analysis: A root cause analysis (JCAHO) or investigation (per CMS approval and MDHHS contractual requirement) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998)

Sentinel Event (SE): Is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event

Stakeholder: A person, group, or organization that has an interest in an organization, including consumer, family members, guardians, staff, community members, and advocates.
Subcontractors: Refers to an individual or organization that is directly under contract with CMHSP and/or SRE to provide services and/or supports.
SUD Providers: Refers to substance use disorder providers directly contracted with MSHN to provide SUD treatment and prevention services.
Vulnerable Person- An individual with a functional, mental, physical inability to care for themselves.

Acronyms

ABA: Applied Behavioral Analysis
BTPRC: Behavior Treatment Plan Review Committee
CBHO: Chief Behavioral Health Officer
CCC: Corporate Compliance Committee
CLC: Clinical leadership Committee
COFR: County of Financial Responsibility
CSC: Customer Services Committee
CMS: Center for Medicare/Medicaid Services
CQS: Comprehensive Quality Strategy
CWP: Child Waiver Program
EQR: External Quality Review
FC: Finance Committee
HCBS: Home and Community Based Standards
HSAG: Health Services Advisory Group
HSW: Habilitation Supports Waiver
ITC: Information Technology Committee
MEV: Medicaid Event Verification
MHSIP: Mental Health Statistics Improvement Program
MMBPIS: Michigan Mission Based Performance Indicator System
PNMC: Provider Network Management Committee
QIC: Quality Improvement Council
SEDW: Severe Emotional Disturbance Waiver
UMC: Utilization Management Committee
YSS: Youth Satisfaction Survey

VI. Quality Assessment and Performance Improvement (QAPIP) Priorities FY22

QAPIP priorities shall guide quality efforts for FY22. The FY22 QAPIP Priorities (Figure 1) include completion of required elements of the QAPIP, growth areas based on external site reviews, and the evaluation of effectiveness of the FY21 QAPIP Plan.

Figure 1. QAPIP Priorities and Work Plan

Organizational Structure and Leadership	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**
MSHN will have an adequate organizational structure with clear administration and evaluation of the QAPIP	To develop in collaboration with the QIC the annual QAPIP evaluation and QAPIP plan. (QAPIP Description, QAPIP Work Plan and Organizational Chart of the QAPIP).	Quality Manager	11.30.2022
	Development of a process to monitor the progress of the quality workplan performance measures inclusive of other departments designated responsibilities in the QAPIP (UM, PNM, CC, Clinical-SUD, IT).	Quality Manager	9.30.2021
Governance	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**
Board of Directors will approve the QAPIP Plan and Report	To submit the annual QAPIP Plan and Report to the board.	MSHN Deputy Director MSHN-Chief Compliance and Quality Officer (CCQO)	1.1.2022 1.31.2023
Board of Directors review QAPIP Progress Reports	To submit QAPIP progress reports to the Board.	MSHN Deputy Director MSHN CCQO	Quarterly
QAPIP will be submitted to Michigan Department of Health and Human Services	To submit the Board approved QAPIP Report and Plan to MDHHS. (via MDHHS FTP Site)	MSHN Quality Manager QIC	1.31.2022 1.31.2023
	Review reporting timeframes and submission deadline for QAPIP submission to MDHHS with contract negotiating team.	MSHN CEO	10.1.2021
Include the role of recipients of service in the QAPIP	QAPIP Description, and Organizational Chart of the QAPIP.	MSHN Quality Manager	1.31.2022 1.31.2023

Communication of Process and Outcome Improvements	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
The QAPIP Plan and Report will be provided annually to network providers and to members upon request.	To distribute the completed Board approved QAPIP Effectiveness Review (Report) through committee/councils, MSHN Constant Contact, and email. To post to the MSHN Website. To ensure CMHSP contractors receive the QAPIP.	MSHN Quality Manager	3.2.2022 2.28.2023
Guidance on Standards, Requirements, and Regulations	To complete MSHN Contract Monitoring Plan and Medicaid Work Plan, post updates to MSHN Website, and distribute through committee/councils, MSHN Constant Contact.	MSHN CCQO QIC, CLC, UM, ITC, CSC, SUDP, FC, OC	As needed, minimum annually
Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	To present reports on Consumer Satisfaction Survey Results, Key Priority Measures, MMBPIS, Behavior Treatment Review Data, Event Data, Quality policies/procedures and Customer Service Reports to RCAC.	MSHN Customer Services Manager	Quarterly
Performance Measurement and Quality reports are made available to stakeholders and general public	To upload to the MSHN website the following documents: QAPIP Plan and Report, Satisfaction Surveys, Performance Measure Reports; MSHN Scorecard, and MSHN Provider Site Review Reports, in addition to communication through committees/councils.	MSHN CCQO CC, QIC, UM, CLC, ITC, CSC, SUDP, FC, OC	Quarterly
MDHHS Performance Indicators	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**
MSHN will meet or exceed the MMBPIS standards for Indicators 1, 4, 10 as required by MDHHS. (PM)	Complete quality checks on data prior to submission through affiliate uploads in REMI. (Verify Medicaid Eligibility, Data Accuracy)	CMHSP Participants	Q1-3.15.2022 Q2-6.15.2022 Q3-9.15.2022 Q4-12.15.2022
	Submit MMBPIS data as required to MDHHS quarterly.	MSHN-Quality Manager	Q1 3.31.2021 Q2 6.30.2021 Q3 9.30.2021 Q4 12.31.2021
	Complete performance summary, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils.	MSHN-Quality Manager QIC, RMDC, CLC/UM	Q1 April Q2 July Q3 October Q4 January

MDHHS Performance Indicators	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will meet or exceed the MMBPIS standards for Indicators 1, 4, 10 as required by MDHHS. (PM)	Document causal factors and interventions quarterly when performing below the standard.	CMHSP Participants SUD Providers	Q1-3.15.2022 Q2-6.15.2022 Q3-9.15.2022 Q4-12.15.2022
	Complete primary source verification of submitted records during the DMC review.	MSHN-Quality Assurance Performance Improvement (QAPI) Manager	Annually (Interim or Full Review)
MSHN to verify Medicaid eligibility prior to MMBPIS submission to MDHHS (PMV-2021)	Validate logic in REMI for Medicaid Enrollment Dates /Medicaid Eligibility in the PI Output Report.	MSHN-QM MSHN-CIO	3.31.2022
MSHN will demonstrate an increase in compliance with access standards for the priority populations. (in addition to those included in the MMBPIS) (Compliance Review) (PM)	Establish a mechanism to monitor access requirements for priority populations.	MSHN-QM MSHN-UCM Director	4.30.2022
	Establish a mechanism to monitor access requirements for Individuals enrolled in CCBHC.	MSHN-QM MSHN-UCM Director	4.30.2022
BH-TEDS	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**
MSHN will demonstrate an improvement or maintain data quality for the BH-TEDS. (PM)	MSHN will identify areas of discrepancy for the BH-TEDS data for FY22. Veterans' data (military fields), Employment data-minimum wage, Living arrangements, LOCUS records, Medicaid IDs on update and M records.	MSHN-CIO ITC	6.30.2022
	Causal factors with action steps will be determined to address incomplete data and/or illogical combination based on review BH-TEDS data. Veterans' data (military fields), Employment data-minimum wage, Living arrangements.	MSHN-Quality Manager MSHN CIO QIC/ITC	9.30.2022
	Narrative completed comparing BH-TEDS (veteran's military fields) and VN Report for FY21/22 data, including actions steps.	MSHN QM-QIC MSHN CIO MSHN VN	1.31.2022 7.1.2022

Performance Improvement Projects	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
Will engage in two performance improvement projects during the waiver renewal period.PIP 1: The racial or ethnic disparities between the minority penetration rate and the index (white) penetration rate will be reduced or eliminated. (PM)PIP 2: The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergency biopsychosocial assessment will demonstrate an increase. (PM)	Complete the design of the Required PIP addressing disparities-Penetration Rate.Identify baseline data, causal factors, and interventions. Submit to HSAG as required.Complete the design of the Optional PIP MMBPIS Indicator 3. Identify baseline data, causal factors and interventions	MSHN-QM MSHN-UM/Integrated Care Director QIC, UMC/CLC	6.30.2022
	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils. Submit PIP 1 to HSAG as required for validation.	MSHN-QM MSHN-UM/Integrated Care Director QIC, UMC/CLC	12.31.2022 3.31.2023 6.30.2023 9.30.2023
Quantitative and Qualitative Assessment of Member Experiences	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**
MSHN will obtain a qualitative and quantitative assessment of member experiences for all representatives' populations, including members receiving LTSS, and take specific action as needed, identifying sources of dissatisfaction, outlining systematic action steps, monitoring for effectiveness, communicating results. (PM)	Identify a qualitative process and distribute surveys and assessments based on the population and services received. (MHSIP/YSS) (SUD Satisfaction). Complete an annual report to include the trends, causal sources of dissatisfaction, and interventions in collaboration with relevant committees/councils. Develop proposal for the administration of qualitative and quantitative assessment of member experience, and provider satisfaction for the region.	MSHN-Customer Services Manager MSHN-Quality Manager QIC/CSC/SUDP/PNMC/ QMT/RCAC/CLC	9.30.2022
	Utilize the analysis of the National Core Indicator Data, provided by MDHHS, to identify trends and areas for improvement.	MSHN-QM MSHN-CBHO QIC, CLC, Waiver Work Groups	Annual as available
MSHN will demonstrate an increase in applicable providers within the network that are "in compliance" with the HCBS rule. (PM)	Evaluate/remediate compliance with the HCBS Rule for individuals receiving services.Identify causal factors for not meeting the standard and remediate based on the results.	MSHN-Waiver Managers	Quarterly

Quantitative and Qualitative Assessment of Member Experiences	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will demonstrate full compliance with the completion of a SIS assessment in accordance with the MDHHS required guidelines. (1x every three years) (PM)	Review internal report for compliance rate, identify causal factors and interventions for not meeting the standard. (How many have received a SIS within 3 years. How many meet the criteria for the completion of a SIS assessment.) (Power Bi report)	MSHN-CBHO/SIS Assessor CMHSP Participants CLC	Quarterly
MSHN will meet or exceed the standard for Appeals and Grievance resolution in accordance with the MDHHS standards. (PM)	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations).	MSHN-Customer Services Manager CSC	Quarterly
Event Monitoring and Reporting	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**
MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract.	Submit Critical Events monthly.	CMHSP Participants MSHN-QM	Last business day of each month
	Submit Sentinel Events (Provider Portal)	SUDPs (Residential Recovery Housing)	1.15.2022 4.15.2022 7.15.2022 10.15.2022
	Submit Sentinel Events to MDHHS as required. (egrams)	MSHN-QM	4.30.2022 10.30.2022
	Submit Sentinel Events (immediate notification) to MSHN based on notification requirements of the event. (24 hour, 48 hours, 5 days)	CMHSP Participants SUDPs (Residential)	As Needed
	Develop Dashboard for tracking and monitoring timeliness.	MSHN-QM	9.30.2022
	Conduct oversight through the DMC review, ensure appropriate follow up is occurring for all events dependent on the type and severity of the event, including a root cause analysis, mortality review, immediate notification to MDHHS as applicable. Conduct primary source verification of critical incidents and sentinel events.	MSHN-QM MSHN-QAPI	Annually (Interim or Full Review)
CMHSP Participants and SUD Treatment Providers will demonstrate a decrease in the rate of adverse events from previous reporting period. (PM)	Complete the CIRS Performance Reports (including standards, trends, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence) quarterly.	MSHN-QM QIC, CLC/UM, RMDC, RCAC, Focused work groups	1.31.2022 4.30.2022 7.31.2022 10.31.2022

Medicaid Event Verification	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will meet or exceed a 90% rate of compliance of Medicaid delivered services in accordance with MDHHS requirements.	Complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.	MSHN-MEV Auditor	See annual schedule for each provider
	Complete The MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement.	MSHN-CQCO MSHN MEV Auditor CCC, QIC	12.31.2022
	Submit the Annual MEV Methodology Report to MDHHS as required.	MSHN-CQCO	12.31.2022
Utilization Management Plan	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**
MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements	Complete/review the MSHN Utilization Management Plan.	MSHN-UCM Director	Bi-Annually 2023
	MSHN to complete performance summary quarterly reviewing trends, patterns of under / over utilization, medical necessity criteria, and the process used to review and approve provision of medical services. Identify CMHSPs/SUDPs requiring improvement and present/provide to relevant committees/councils.	MSHN-UCM Director	Quarterly/ Annually See UM Reporting Schedule
	Utilize uniform screening tools and admission criteria. LOCUS, CAFAS, MCG, ASAM, SIS, DECA	MSHN-UCM Director	Quarterly/ Annually
MSHN will demonstrate full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements. (PM)	Oversight of compliance with policy through primary source verification during Delegated Managed Care Reviews.	MSHN-UCM Director MSHN-QAPI Managers	Annually (Interim or Full Review)
	Development of REMI process for tracking timeliness of authorization decisions.	MSHN-UCM Director	3.31.2022
MSHN will meet or exceed the standard for compliance with the adverse benefit determination notices completed in accordance with the 42 CFR 438.404.(PM)	Develop ABD training for staff. Staff to complete training.	MSHN-Customer Service Manager CMHSP Participants, CSC	5.31.2022 9.30.2022
	Oversight of compliance during Delegated Managed Care Reviews.	MSHN-Customer Service Manager MSHN-QAPI Managers	Annually (Interim or Full Review)

Practice Guidelines	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will adopt, develop, implement nationally accepted or mutually agreed upon (MSHN/MDHHS) clinical practice guidelines/standards, evidenced based practices, best practice, and promising practices relevant to the individual served.	Identify practice guidelines adopted/required for use in the MSHN region. Review guidelines currently in policy/procedure.	MSHN-CBHO MSHN-UCM Director CLC/UMC, RMDC	6.30.2022
	MSHN will communicate and disseminate the practice guidelines accepted for use on the MSHN website, as requested, and through regional committees/councils.	MSHN-CBHOMSHN-UCM DirectorCLC/UMC, RMDC	1.31.2022 1.31.2023
MSHN will demonstrate full compliance with the MDHHS required practice guidelines. (PM)	Oversight during DMC Review to ensure providers adhere to practice guidelines as required.	MSHN-CBHO MSHN-QAPI MSHN-CCO	Annually (Interim or Full Review)
MSHN will demonstrate an increase for individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan. (PM BSC)	MSHN will complete and implement a regional training plan to address Person Centered Planning and the development of the Individual Plan of Service. The following elements will be incorporated into the planning process and document: · -Choice voucher/self-determination arrangements offered -Assessed needs in IPOS -Strategies adequately address health and safety and primary care coordination -Goals are measurable and include amount, scope and duration -Prior authorization of services corresponds to services in IPOS -IPOS is reviewed and updated no less than annually -Include guardian in PCP process -Category/intensity of Care (CWP)	MSHN-CQCP MSHN-UCM Director	2.17.2021 4.1.2022
MSHN will demonstrate an increase in fidelity to the Evidenced Based Practice-Assertive Community Treatment Michigan Field Guide, for average minutes per week per consumer. (PM)	Complete a quarterly utilization summary of the average minutes per week/per consumer that will include the identification of barriers, interventions, and progress.	MSHN-UCM DirectorUMC	Quarterly

Oversight of "Vulnerable People"/Long Term Supports and Services	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will evaluate health, safety and welfare of individuals "vulnerable people" served in order to determine opportunities for improving oversight of their care and their outcomes.	MSHN will analyze performance measures-Behavior Treatment, Integrated Population Health Report, Key Performance Measures, Behavioral Health Report for trends and patterns and develop action for areas of concern.	MSHN-UCM Director MSHN-CBHO MSHN- Waiver Managers/Coordinators	Annually/ Quarterly
	Complete clinical record reviews during the delegated managed care review.	MSHN-QAPI Manager MSHN-Waiver Managers/ Coordinators	Annually (Interim or Full Review)
MSHN will assess the quality and appropriateness of care furnished to members(vulnerable people) receiving LTSS including an assessment of care between care settings, a comparison of services and supports received with those set forth in the members treatment/service plan. (PM)	Analyze performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) completed for Behavior Treatment, Integrated Population Health Report, Key Performance Measures for efforts to support community integration.	MSHN-UCM Director MSHN-CBHO MSHN- Waiver Managers/Coordinators MSHN-QAPI	Annually/ Quarterly
MSHN will establish conflict of interest standards for assessments and IPOS development.	Establish a board approved regional conflict free policy.	MSHN-UCM Director	5.31.2022
Behavior Treatment	**Objectives/Activities**	**Assigned Person or Committee/Council**	**Frequency/ Due Date**
MSHN will demonstrate an increase in compliance with the MDHHS Behavior Treatment Standards. (PM)	Oversight will occur during Delegated Managed Care Site Reviews. Including primary source verification of reported incidents.	MSHN-Waiver Managers	Annually (Interim or Full Review)
Behavioral treatment plans are developed, approved or disapproved in accordance with the Standards for Behavior Treatment Plan Review Committees.	Submit data on Behavior Treatment Plans where intrusive and or restrictive techniques have been approved by the behavior treatment committee and where emergency interventions have been used (physical management, 911 calls for behavioral assistance).	CMHSP Participants BTPR Work Group	Q1-1.31.2021 Q2-4.30.2021 Q3-7.31.2021 Q4-10.31.2021
	Complete Behavior Treatment Performance Reports that analyze the use of emergency interventions, plans approved with restrictive and/or intrusive interventions, and adherence to the BTPR Standards (including barriers, improvement efforts, recommendations and status of recommendations).	MSHN-QM MSHN-Waiver Manager QIC, CLC/UM	Q1-2.27.2022 Q2- 5.31.2022 Q3- 8.31.2022 Q4-11.30.2022

Provider Monitoring	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will be in compliance with PIHP Contract Requirements.	Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN-QAPI MSHN Content Experts	Annually (Interim or Full Review)
	Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews.	MSHN-QM Relevant committees/councils	9.30.2022 9.30.2023
MSHN will demonstrate an increase in compliance with the External Quality Review (EQR)-Compliance Review. (PM-specific to CAP areas)	Implement corrective action plans for areas that were not in full compliance, and quality improvement plans for recommendations. See CAP for specific action steps. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN-CBHO MSHN-UCM Director MSHN-Customer Services MSHN-QM MSHN-Contract Manager MSHN-Lead QAPI Manager	9.30.2022 9.30.2023
MSHN will demonstrate full compliance with the EQR-Performance Measure Validation Review.	Implement quality improvement plans for recommendations provided by the external quality review team. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN-QM-QIC CMHSP Participants MSHN-CIO-ITC MSHN-IT Manager	9.30.2022 9.30.2023
MSHN will receive a score of "Met" for the EQR-Performance Improvement Project Validation.	No action needed at this time.	MSHN-Quality Manager CMHSP Participants	9.30.2022 9.30.2023
MSHN will demonstrate an increase in compliance with the MDHHS 1915 Review. (SEDW, CWP, HSW, HCBS, Autism)	Monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	MSHN-QM MSHN-Waiver Managers/ Coordinators MSHN- CBHO	9.30.2022 9.30.2023
MSHN will demonstrate full compliance with the MDHHS Substance Use Disorder Protocols.	Provide evidence to support SUD requirements	MSHN-Quality Manager MSHN-CCO; SUD Tx Team	9.30.2022
MSHN will demonstrate full compliance with the Autism Benefit Standards. (PM)	Monitor systematic remediation for effectiveness through DMC reviews and performance monitoring through data.	MSHN-Waiver Manager	9.30.2022
MSHN will demonstrate assurances of adequate capacity and services for the region, in accordance with the MDHHS Network Adequacy standards.	Complete Network Adequacy Assessment including all required elements	MSHN-Contract Manager	9.30.2022

Provider Qualifications	Objectives/Activities	Assigned Person or Committee/Council	Frequency/ Due Date
MSHN will ensure physicians, other healthcare providers, and non-licensed individuals are qualified to perform their jobs. MSHN will have credentialing policies/ procedures, in accordance with MDHHS Credentialing and Re-Credentialing Process, for ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform their services. MSHN ensures all delegates performing credentialing functions comply with all initial (including provisional/temporary) credentialing requirements according to the Initial Credentialing Audit Tool, re-credentialing, and organizational credentialing tool. Clinical service providers are credentialed by the CMHSP prior to providing services and ongoing.	An analysis will be completed to identify trends, and progress of the performance measure, including barriers and interventions.	MSHN-QAPI Lead Manager	Quarterly
	Primary Source Verification and credentialing and recredentialing policy and procedure review will occur during the DMC Review.MSHN will increase monitoring for providers scoring less than 90% on the file review and will be subject to additional review of credentialing and re-credentialing records.	MSHN QAPI Managers	Annually (Interim or Full Review) Report-Quarterly
	Review semi-annual credentialing and re-credentialing report to ensure credentialing within the appropriate timeframes.	MSHN-QAPI Lead Manager	Semi-Annually (include months)
Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. (PM)	Will conduct oversight during the DMC-Program Specific Review	MSHN-Autism Coordinator MSHN-Waiver Manager	Annually (Interim or Full Review)
Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements. (PM)	Will conduct oversight during the DMC-Program Specific Review	MSHN-Autism Coordinator MSHN-Waiver Manager	Annually (Interim or Full Review)

An effective performance measurement system allows an organization to evaluate the safety, accessibility and appropriateness, the quality and effectiveness, outcomes, and an evaluation of satisfaction of the services in which an individual receives. MSHN utilizes a balanced score card/dashboard and performance summaries to monitor organizational performance. Those areas that perform below the standard are included in the annual QAPIP. Figure 2 demonstrates indicators used to monitor the performance of MSHN.

Figure 2. Performance Measures FY22

Strategic Priority	Michigan Mission Based Performance Indicator System	Committee / Council	FY21
Better Care	MSHN will meet or exceed the standard for indicator 1: Percentage of Children who receive a Prescreen within 3 hours of request (Standard is 95% or above)	QIC	99.58%
Better Care	MSHN will meet or exceed the standard for indicator 1: Percentage of Adults who receive a Prescreen within 3 hours of request (Standard is 95% or above)	QIC	99.22%
Better Care	Indicator 2. a. Effective on and after April 16, 2020, the percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children. (No Standard)	QIC	63.69%
Better Care	Indicator 2 b. Effective April 16, 2020, 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 substance use disorders. (No Standard)	QIC/SUD	**80.98%
Better Care	Indicator 3: Effective April 16, 2020, percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). (No Standard)	QIC	71.34%
Better Care	MSHN will meet or exceed the standard for indicator 4a1: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above) (Child)	QIC	98.90%
Better Care	MSHN will meet or exceed the standard for indicator 4a2: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (Standard is 95% or above) (Adult)	QIC	97.02%
Better Care	MSHN will meet or exceed the standard for indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (Standard is 95% or above)	QIC/SUD	96.68%
Better Care	MSHN will meet or exceed the standard for indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Child)	QIC	7.97%
Better Care	MSHN will meet or exceed the standard for indicator 10: Re-admission to Psychiatric Unit within 30 Days (Standard is 15% or less) (Adult)	QIC	12.62%
Better Care	MSHN will demonstrate and increase in compliance with access standards for the priority populations. (Baseline)	UMC	New

	BH-TEDS Data	Committee /Council	FY21
Better Care	MSHN will demonstrate an improvement with the data quality on the BH-TEDS living arrangements fields. (Baseline)	QIC	New
Better Care	MSHN will demonstrate an improvement with the data quality on the BH-TEDS employment fields. 3 categories. (Baseline)	QIC	New
Better Care	MSHN will demonstrate an improvement with the data quality on the BH-TEDS LOCUS fields. (Baseline)	QIC	New
Better Care	MSHN will increase access and service utilization for Veterans and Military members. (Baseline)	QIC	New
	Performance Improvement Projects	**Committee /Council**	**FY21**
Better Care	PIP 1: The racial or ethnic disparities between the minority penetration rate and the index (white) penetration rate will be reduced or eliminated. (Baseline)	QIC	New
Better Care	PIP 2: The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergency biopsychosocial assessment will demonstrate an increase. (Baseline)	QIC	New
	Assessment of Member Experiences	**Committee /Council**	**FY21**
Better Care	Percentage of consumers indicating satisfaction with SUD services. (Standard 80%/3.50)	QIC	95%/4.61
Better Care	Percentage of children and/or families indicating satisfaction with mental health services. (Standard 80%/3.50)	QIC	87%/4.18
Better Care	Percentage of adults indicating satisfaction with mental health services. (Standard 80%/3.50)	QIC	85%
Better Care	Percentage of individuals indicating satisfaction with long term supports and services. (Standard 80%/3.50)	QIC	85%
Better Care	MSHN will demonstrate an increase in applicable providers within the network that are "in compliance" with the HCBS rule. (Baseline)	CLC	New
Better Care	MSHN will demonstrate full compliance with the completion of a SIS assessment in accordance with the MDHHS required guidelines. (1x every three years) (Baseline)	CLC	New

	Member Appeals and Grievance Performance Summary	Committee /Council	FY21
Better Care	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service. (Standard 95%)	CSC	98.27%
Better Care	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal. (Standard 95%)	CSC	98.82%
Better Care	The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance. (Standard 95%)	CSC	98.72%
	Adverse Event Monitoring and Reporting)	**Committee /Council**	**FY21**
Better Care	The rate of critical incidents, per 1000 persons served will demonstrate a decrease from previous year. (CMHSP) (excluding deaths)	QIC	8.343
Better Health	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP)(Natural Cause, Accidental, Homicidal)	QIC	2.96
Better Care	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from previous year. (SUDP)	SUD	0.014
	Joint Metrics	**Committee /Council**	**FY21**
Better Care	Percent of care coordination cases that were closed due to successful coordination (Standard-<= to 50%)	UMC/IC	100%
Better Value	Reduction in number of visits to the emergency room for individual in care coordination. (Standard 100%)	UMC/IC	75%
Better Care	J.1 Implementation of Joint Care Management Processes	UMC	Complete
Better Care	J.2 The percentage of discharges for adults (18 years or older) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. FUH Report, Follow-Up After Hospitalization Mental Illness Adult (Standard-58%)	QIC	75.34%
Better Care	J.2 The percentage of discharges for children (6-17 years) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. Follow-Up After Hospitalization Mental Illness Children (Standard-70%)	QIC	89.32%

	Joint Metrics	FY21	Joint Metrics
Better Care	J.2 Racial/ethnic group disparities will be reduced. (*Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) *Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children)*	QIC	0
Better Care	J.3 Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Standard 27%) based on CY21	UMC/IC	28%
Better Care	J.3 Reduce the disparity BSC Measures for FUA. *Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use.*	UMC	1
	Performance Based Incentive Payments	**Committee /Council**	**FY21**
Better Care	P.1 Identification of beneficiaries who may be eligible for services through the Veterans Administration. a. MSHN will demonstrate an improvement or maintain data quality on the BH-TEDS military and veteran fields. b. Monitor and analyze data discrepancies between VSN and the BH-TEDS data.	ITC/QIC	Complete
Better Health	P.2 Increased data sharing with other providers (narrative report) (include action steps in work plan)	ITC	Complete
Better Care	P.3 The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: -Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis. (Completion of the Validation only)	SUDT	Complete
Better Health	P.4 Increased participation in patient centered medical homes (Narrative)	UMC	Complete

	Priority Measures	Committee /Council	FY21
Better Care	MSHN will demonstrate improvement from previous reporting period (79%) of the percentage of patients 8-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Diabetes Screening Report (Data Source-ICDP) Michigan 2020-84.43%	QIC	84.68%
Better Health	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar who were prescribed any antipsychotic medication and who received cardiovascular health screening during the measurement year. Cardiovascular Screening (Data Source-ICDP) Standard-Incremental progression toward meeting the performance rate of Michigan 2020-73.16%	CLC	54.88%
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. (Data Source-ICDP) Standard- Incremental progression toward meeting the performance rate of Michigan 2020-44.44%	CLC	60.52%
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. (Data Source-ICDP) Standard- 2020 54.65%	CLC	97.12%
Better Care	Plan All-Cause Readmissions-The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (<=15%) (Data Source-ICDP) Standard-Michigan 2020 9.09%	UM	11.59%
Better Care	The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%) (Data Source – ICDP) Standard-Michigan 2020 82.49%	UM	91.69%
Better Care	The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%) (Data Source-ICDP) Standard-Michigan 2020 89.64%	UM	95.68%
Better Care	MSHN will demonstrate an increase over previous reporting period of Initiation in Treatment (IET) of Alcohol and Other Drug Dependence.	SUDT	57.48%
Better Care	MSHN will demonstrate an increase over previous reporting period of Engagement in Treatment (IET) of Alcohol and Other Drug Dependence.	SUDT	50.12%

	Utilization Management/LTSS	Committee /Council	FY21
Better Care	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%)	UM	98.50%
Better Care	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan. (Standard 100%)	UM	81.50%
Better Care	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth. (Standard 0% decrease over previous fiscal year) standard is 1-10% decrease.	UM	6%
Better Value	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages (Standard <=5%)	UM	1%
Better Care	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% or greater HSW slot utilization.	CLC	94.90%
Better Care	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (Standard 95%)	CLC	89%
Better Care	MSHN's provider network will demonstrate 95% compliance with trauma-competent standard in the site review chart tool. (Standard increase over 2016 or 95%?)	CLC	99.07%
Better Care	MSHN will demonstrate full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements. (Baseline)	UMC	New
	Behavior Treatment	**Committee /Council**	**FY21**
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOSs reviewed during the reporting period. (95%)	QIC/CLC	61% (2 quarters)
Better Care	The percent of individuals who have an approved Behavior Treatment Plan which includes restrictive and intrusive techniques. (Track and trend)	QIC	1.16%
Better Care	The percent of emergency interventions (911 calls, physical management) during the reporting period will decrease from previous year.	QIC	0.59%
	Trauma	**Committee /Council**	**FY21**
Better Care	MSHN will demonstrate a 95% rate for the completion of Trauma Organizational Assessments every three years.	CLC	99.07%

	Clinical Practice Guidelines	Committee /Council	FY21
Better Care	MSHN will demonstrate full compliance with the use of MDHHS required practice guideline. (PM) Inclusion, Consumerism, Personal Care in Non-Specialized Residential Settings, Family Driven and Youth Guided, Employment Works Policy and Practice Guidelines. (Baseline Development)	CLC	New
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period.	CLC	61%
Better Care	MSHN's ACT programs will demonstrate an increase in fidelity for average minutes per week per consumer (120 minutes). (Baseline)	UMC	New
	Provider Monitoring	**Committee /Council**	**FY21**
Better Provider System	Provider surveys demonstrate satisfaction with REMI enhancements - Provider Portal (SUD Network) (Standard 80%)	PNMC	73%
Better Provider System	SUD providers satisfaction demonstrates 80% or above with the effectiveness and efficiency of MSHN's processes and communications (SUD Network) (Standard 80%)	PNMC	79%
Better Provider System	Autism/ABA provider network will demonstrate satisfaction with regionally organized performance monitoring procedures (CMHSP Network) (Standard 80%)	PNMC	73%
Better Provider System	MSHN will demonstrate an increase in performance with the External Quality Review-Compliance Review. (PM) Comprehensive Score.	QIC/CLC	85%
Better Provider System	All CMHSP participants (12) will have 100% of applicable trainings vetted in accordance with the training reciprocity plan (CMHSP Network) (Standard 12)	PNMC	8
Better Provider System	MSHN will demonstrate full compliance for the Autism Benefit Standards. (Regional Monitoring) (Program Specific Monitoring). Regional Monitoring DMC Program Specific	CLC	 84.43% 82.72%
Better Provider System	Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. MDHHS Review 95.51%	PNMC	FY20 95.51%
Better Provider System	Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements. MDHHS Review 72.52%	PNMC	FY20 72.52%

	Clinical SUD	Committee /Council	FY21
Better Care	Initiation of AOD Treatment. Percentage who initiated treatment within 14 days of the diagnosis. (Inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, medication treatment). Standard above 2020 Michigan levels I: 40.8%)	SUD Clinical	55.52%
Better Care	Engagement of AOD Treatment-Percentage who initiated treatment and who had 2 or more additional AOD services or medication treatment within 34 days of the initiation visit. (Standard above Michigan 2020 levels. E: 12.5% 2016 needs clarification)	SUD Clinical	38.27%
	Certified Behavioral Health Clinic (CCBHC) Performance Measures	**Committee /Council**	**FY21**
Better Care	Follow-Up After Hospitalization for Mental Illness ages 18+ (adult age groups) (FUH-BH-A) Standard-58%	QI	New
Better Care	Follow-Up After Hospitalization for Mental Illness ages 6-17 (child/adolescents) (FUH-BH-A) Standard- 70%	QI	New
Better Health	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-BH) Standard 58.50%	QI	New
Better Care	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH) Standard I-42.5%; E-18.5%	QI	New
Better Health	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A) Standard 13%	QI	New
Better Health	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C) Standard 23.9%	QI	New
Better Health	Depressions Remission at Twelve Months (DEP-REM-12)	QI	New
Better Care	Preventative Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI_SF)	QI	New
Better Care	Preventative Care and Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	QI	New
Better Care	Preventative Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	QI	New
Better Care	Screening for Depression and Follow-Up Plan. Age 18 and older (CDF-AD)	QI	New
Better Care	Time to initial Evaluation (I-EVAL)	QI	New
Better Care	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-BH)	QI	New
Better Care	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are using Antipsychotic Medications (SSD)	QI	New
Better Care	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	QI	New
Better Care	Follow-Up Care for Children Prescribed ADHD Medication (ADD-BH)	QI	New
Better Health	Housing Status (HOU)	QI	New
Better Care	Patient Experience of Care Survey (PEC)	QI	New
Better Care	Youth/Family Experience of Care Survey (Y/FEC)	QI	New
Better Health	Plan All-Cause Readmission Rate (PCR-AD)	QI	New
Better Care	Antidepressant Medication Management (AMM-AD)	QI	New

Attachments

Attachment 1 MSHN QAPIP Communication

Attachment 2 MSHN MMBPIS Performance Summary FY21Q4v2

Attachment 3 MSHN Veterans Narrative FY21Q1Q2

Attachment 4 MSHN Recovery Self-Assessment Annual Report FY21

Attachment 5 MSHN MI2020-21_PIHP_PIP-Validation_Report F1

Attachment 6 MSHN Critical Incident Performance Report FY21Q4

Attachment 7 MSHN Critical Incident Performance Report SUDTP FY21Q4

Attachment 8 MSHN Behavior Treatment Review Data FY21Q4

Attachment 9 MSHN Member Satisfaction Annual Report FY2021

Attachment 10 MSHN FY21 Provider Satisfaction Survey Final no comments

Attachment 11 ACT Utilization FY21Q4

Attachment 12 MSHN FY2021 MEV Methodology Report

Attachment 13 Behavioral Health Department Quarterly Report FY21Q4

Attachment 14 MSHN UM Plan FY20-21 Approved

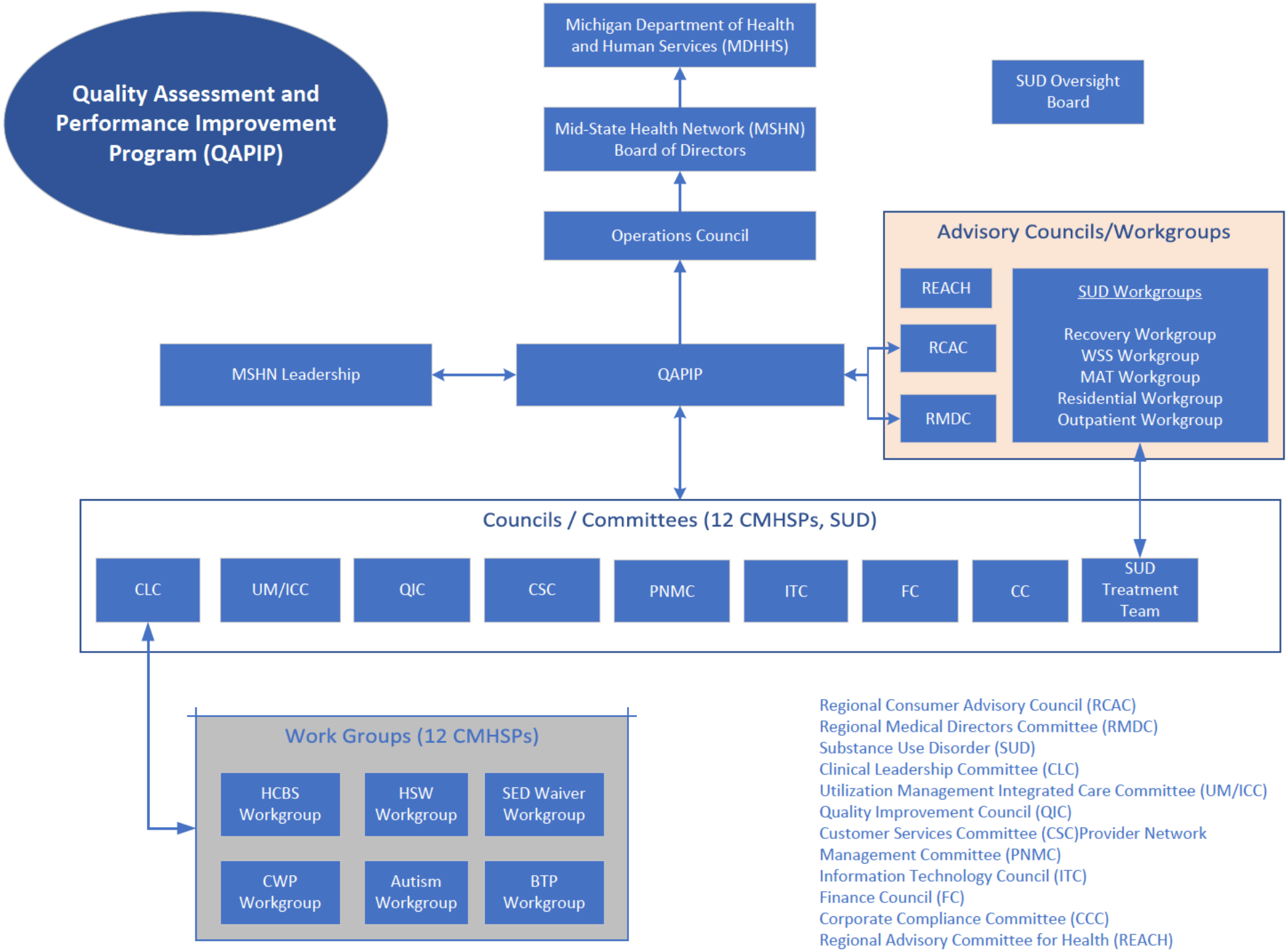
Attachment 15 UM Quarterly Report 2021 Q4 FINAL

Attachment 16 MSHN Pop Health Integrated Care Report FY21Q4 Revised

Attachment 17 MSHN External Quality Review Summary 2021

Attachment 18 MSHN 2021 Compliance Summary Report

Attachment 19 MSHN Governing Body Form 9.2021



Regional Consumer Advisory Council (RCAC)
Regional Medical Directors Committee (RMDC)
Substance Use Disorder (SUD)
Clinical Leadership Committee (CLC)
Utilization Management Integrated Care Committee (UM/ICC)
Quality Improvement Council (QIC)
Customer Services Committee (CSC)Provider Network
Management Committee (PNMC)
Information Technology Council (ITC)
Finance Council (FC)
Corporate Compliance Committee (CCC)
Regional Advisory Committee for Health (REACH)
Women's Specialty Services (WSS)
Medication Assisted Treatment (MAT)

Revised 2.1.2022

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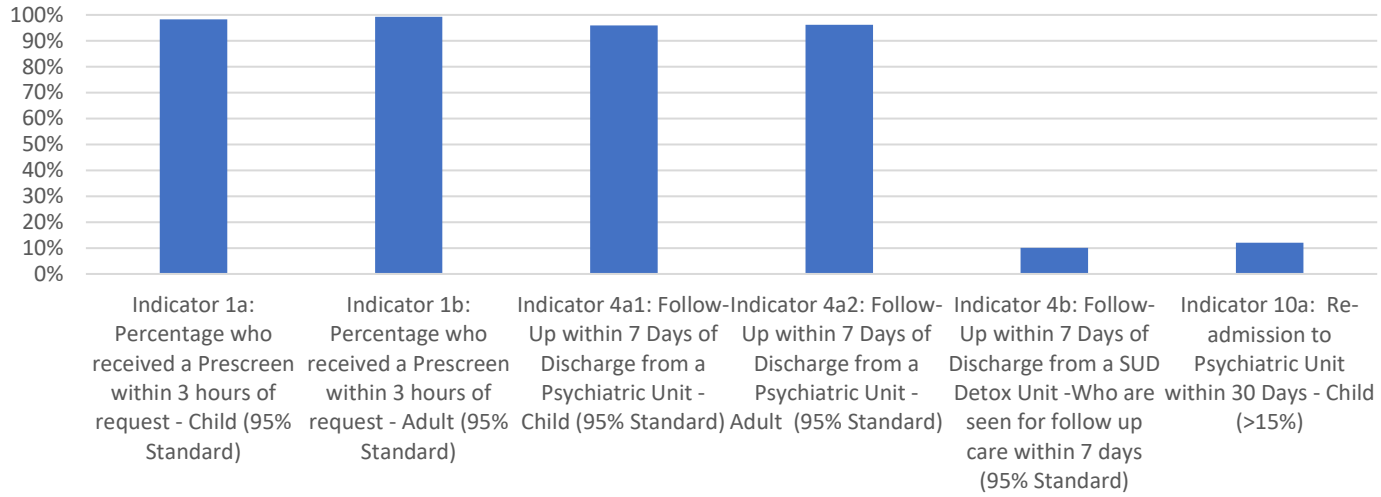
Executive Summary

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in the area of access, efficiency, and outcomes. Pursuant to its contract with MDHHS, MSHN is responsible for ensuring that it's CMHSP Participants and Substance Use Disorder Providers are measuring performance through the Michigan Mission Based Performance Indicator System (MMBPIS) established by MDHHS. This data is to be reported and reviewed as part of the Quality Assessment and Performance Improvement Program (QAPIP). MSHN regional performance is monitored through quarterly performance summaries. Regional trends are identified and discussed at the Quality Improvement Council (QIC) for regional planning efforts and coordination. When minimum performance standards or requirements are not met the CMHSP Participant/SUD Providers identify causal factors, intervention, implementation timeline to correct undesirable variation. Effectiveness of improvement efforts are monitored through quarterly performance data.

Goal: MSHN will meet or exceed the Michigan Mission Based Performance Indicator System standards for Access (Indicators 1 and 4) and Outcomes (Indicator 10). Access Indicators 2 and 3 have no standard for the first year.

MSHN achieved the goal for FY21Q4. MSHN provided access to treatment for 95% or more consumers within 3 hours of a request for a prescreen and within 7 days of a discharge from a psychiatric inpatient hospitalization or a Detox Unit. Eighty-seven percent or more consumers who were discharged from a psychiatric inpatient unit did not require inpatient psychiatric care during the 30 days following their discharge.

Figure 1. MSHN MMBPIS performance rate for Indicators 1, 4, and 10 for FY21Q4



The following CMHSP participants demonstrated performance below the standard for FY21Q4:
Indicator 1: NCMH-Children; TBHS-Children
Indicator 4: BABH-Adults; The Right Door-Adults; Lifeways-Adults; SHW-Adults
Indicator 10: BABH-Adults; CEI-Children; CMHCM-Children; The Right Door-Adults

Data Analysis

The MMBPIS data collected is based on the definition and requirements that have been set forth within the Michigan Mission Based Performance Indicator System (MMBPIS) Code Book FY20, and the Reporting Requirements attached to the PIHP contract. Additional instructions are available in the REMI Help documents; and the MMBPIS Project Description. This measure allows for exclusions and/or exceptions based on each individual indicator.

MDHHS, in coordination with the PIHPs and CMHSP participants, developed and implemented new indicators to be reported for FY20Q3. The new indicators measure the following:

- Effective 4/1/2020. The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. (adults and children with a mental illness and/or developmental disability)
- Effective 4/1/2020. The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. (adults and children with a mental illness and/or developmental disability)
- Effective 4/1/2020. 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 person with SUD.
- Discontinued 3/31/2020. 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. (adult and children with mental Illness and/or a developmental disorder and /or a substance use disorder)
- Discontinued 3/31/2020. The 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. (adult and children with mental Illness and/or a developmental disorder and /or a substance use disorder)

The following changes were made from the previous Indicators.

- No external standard currently is available, collecting baseline for two years
- No exceptions are permitted for indicators 2 and 3
- Those with the Autism Benefit are included
- Count forward from all requests for service
- Count those with a completed bio-psychosocial (full or updated) on the day it was completed
- Count forward from the completed bio-psychosocial (full or updated) to an ongoing covered service.
- Count of those receiving an ongoing covered service (not limited to professional service only)
- SUD indicator uses the BH-TEDS admissions data and aw file of requests from the PIHP for those that never completed an admission.

Access

Indicator 1: Percentage of Children/Adults who received a Prescreen within 3 hours of request (standard is 95% or above)

This indicator defines disposition as the decision made to refer or not to refer for inpatient psychiatric care. The start time is when the consumer is clinically, medically and physically cleared and available to the PIHP or CMHSP. The stop time is defined as the time when the person who has the authority approves or disapproves the hospitalization. For the purposes of this measure, the clock stops, although other activities to complete the admission may still be occurring.

MSHN met the standard for FY21Q4. In Figure 2, MSHN demonstrated a performance rate of 98.32% (704/716) for FY21Q4 of the Children who requested a prescreen received one within three (3) hours. This was a decrease from previous quarter (99.38%). MSHN demonstrated a performance rate of 99.17% (2625/2647) of the Adults who requested a prescreen received one within three (3) hours. There was no change from previous quarter. Ten CMHSP participants performed above the standard of 95% for the Children and twelve of the CMHSP participants performed above the standard for the Adults.

Indicator 2a: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. MI adults, MI children, I/DD adults, I/DD children. (Effective 4/1/2020 No Standard the 1st 2 years)

MSHN demonstrated a 66.31% (2384/3595) performance rate for all population categories for Indicator 2 (Figure 2). Figure 6 provides an overview of reasons for "out of compliance".

Indicator 2b: 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 Substance Use Disorders. (Effective 4/1/2020 No Standard the 1st 2 Years)

Expired Requests: MSHN SUD providers had 341 individuals who requested and were approved for SUD treatment, however never received a service. This information is submitted to MDHHS for inclusion into the calculation of Indicator 2b. According to the preliminary data, available at the at the time of this report, MSHN demonstrated an 87.99% (2338/2657) for those who requested a service and received a treatment or service within 14 days.

Indicator 3: Percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. MI adults, MI children, I/DD adults, and I/DD children (Effective 4/1/2020 No Standard the 1st 2 Years):

MSHN demonstrated a 70.81% (2047/2891) performance rate for all population categories within Indicator 3 (Figure 2). Figure 6 provides an overview of reasons for "out of compliance".

Figure 2. PIHP and CMHSP Indicator 2 and 3 performance rate.

	#2a - 1st Request Timeliness					#3 - 1st Service Timeliness				
Affiliate / CMH	MI / Child	MI / Adult	DD / Child	DD / Adult	Total	MI / Child	MI / Adult	DD / Child	DD / Adult	Total
Bay-Arenac	67.44%	59.91%	22.73%	90.00%	61.08%	69.31%	72.39%	60.00%	87.50%	71.28%
CEI	68.27%	43.94%	37.84%	50.00%	54.46%	53.50%	59.04%	67.19%	22.22%	56.69%
Central MI	64.74%	70.13%	85.71%	93.75%	70.27%	72.13%	73.74%	82.50%	94.12%	74.79%
Gratiot	91.23%	78.85%	*100.00%	**	83.44%	80.36%	67.06%	*50.00%	**	72.03%
Huron	75.00%	77.78%	*100.00%	*0.00%	76.06%	66.67%	65.71%	*50.00%	*0.00%	64.41%
The Right Door	78.13%	82.35%	*75.00%	100.00%	81.46%	73.58%	80.61%	*100.00%	100.00%	79.63%
LifeWays	51.95%	49.15%	53.57%	65.22%	51.00%	53.57%	59.16%	73.91%	55.56%	58.14%
Montcalm	78.69%	82.24%	81.82%	100.00%	81.90%	74.00%	71.77%	100.00%	85.71%	73.94%
Newaygo	50.70%	59.29%	*100.00%	*66.67%	57.34%	75.00%	86.41%	*50.00%	*66.67%	81.82%
Saginaw	79.82%	79.41%	90.63%	77.78%	80.92%	85.53%	77.19%	93.22%	86.36%	81.82%
Shiawassee	70.83%	75.00%	62.50%	*66.67%	72.36%	76.92%	71.15%	85.71%	*50.00%	74.00%
Tuscola	52.94%	47.69%	*100.00%	*0.00%	51.43%	100.00%	94.44%	100.00%	**	97.01%
MSHN SUD										
Total/PIHP:	67.61%	64.81%	68.33%	77.27%	66.31%	68.15%	71.10%	79.39%	70.19%	70.81%

*n=equal to or less than 6 eligible records. **No eligible records for reporting

Indicator 4a: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (standard is 95% or above):

MSHN met the standard for FY21Q4. In Figure 3, MSHN demonstrated a 99.21% (125/126) performance rate for Children. This is an increase from previous reporting period (98.39%). MSHN demonstrated performance of 95.97% (571/595) performance rate for adults. This is a decrease from previous reporting period (96.67%). Twelve CMHSP participants demonstrated performance above the standard for Children and eight CMHSP participants demonstrated performance above for Adults.

Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (standard is 95% or above):

MSHN met the standard for FY21Q4 In Figure 3, MSHN demonstrated a 96.15% (175/182) performance rate for individuals who were seen for follow-up care within 7 days of discharge from a detox unit. This is a decrease from previous reporting period (95.30%). Nine out of eleven SUD providers demonstrated performance above the standard. Additional information related to those identified as "exceptions" is found in Figures 7-10.

The following are exceptions for Indicator 4a and 4b:

- Consumers who request an appointment outside the seven-day period, refuse an appointment offered within the seven-calendar day period, do not show for an appointment or reschedule (The dates of refusal or dates offered must be documented).
- Consumers who choose not to use CMHSP/PIHP services. For the purposes of this indicator, Providers who provide substance abuse services only, are currently not considered to be a CMHSP/PIHP service.

Outcomes

Indicator 10: Re-admission to Psychiatric Unit within 30 Days (standard is 15% or less):

Individuals who chose not to use PIHP services were identified as an "exception" for this measure. MSHN met the standard for FY21Q4 as indicated in Figure 3, MSHN demonstrated a 10.14% (15/148) performance rate for Children who were re-admitted within 30 days of being discharged from a psychiatric hospitalization. MSHN demonstrated a 12.05% (113/938) performance rate for Adults who were readmitted within 30 days of being discharged from a psychiatric hospitalization. This was a decrease in performance for Adults (11.72%) and Children (6.71%) from the previous reporting period. Nine CMHSP participants met the standard for both Children and Adults.

Figure 3. PIHP and CMHSP Indicator 1, 4a, 4b, and 10 performance rate for FY21Q4

	#1 - Pre-Admission screening		#4a - Hospital Discharges F/U		#4b - Detox F/U	#10 - Inpatient Recidivism	
Affiliate / CMH	Child	Adult	Child	Adult	SUD	Child	Adult
Bay-Arenac	100.00%	98.84%	95.45%	93.33%		10.34%	18.95%
CEI	97.33%	97.89%	100.00%	95.73%		20.69%	12.14%
Central MI	100.00%	100.00%	100.00%	100.00%		18.18%	10.26%
Gratiot	95.83%	100.00%	100.00%	100.00%		0.00%	6.67%
Huron	100.00%	98.98%	*100.00%	100.00%		12.50%	8.00%
The Right Door	96.97%	98.73%	*100.00%	93.10%		*0.00%	20.00%
Life Ways	100.00%	100.00%	100.00%	94.85%		0.00%	11.02%
Montcalm	100.00%	97.89%	*100.00%	95.45%		*0.00%	14.58%
Newaygo	90.00%	96.97%	*100.00%	100.00%		*0.00%	13.33%
Saginaw	100.00%	100.00%	*100.00%	98.70%		13.64%	9.45%
Shiawassee	96.55%	99.13%	*100.00%	84.21%		*0.00%	11.11%
Tuscola	86.67%	100.00%	*100.00%	100.00%		*0.00%	4.55%
MSHN SUD					96.15%		
Total/PIHP:	98.32%	99.17%	99.21%	95.97%	96.15%	10.14%	12.05%

(*n=less than or equal to 6; red indicates the standard was not met, green indicators the standard was met)

Figure 4. MSHN longitudinal data Indicators 1, 2, 3 performance rate.

	Population	FY20Q1	FY20Q2	FY20Q3	FY20Q4	FY21Q1	FY21Q2	FY21Q3	FY21Q4
Indicator 1: Percentage who received a Prescreen within 3 hours of request (95% Standard)	Children	98.60%	99.51%	99.19%	98.57%	99.53%	98.19%	99.38%	98.32%
	Adults	99.17%	98.71%	99.44%	99.16%	99.35%	99.00%	99.36%	99.17%
***Indicator 2: Percentage who have had a completed Bio-psychosocial Assessment within 14 Days. (Effective 4.1.2020 No Standard)**	MI Child			79.72%	76.93%	70.56%	71.91%	67.15%	67.61%
	MI Adults			74.15%	69.25%	63.21%	66.00%	60.75%	64.81%
	DD Child			69.05%	68.56%	64.88%	66.20%	61.80%	68.33%
	DD Adult			81.13%	71.69%	70.27%	74.00%	69.41%	77.27%
	Total			75.52%	71.69%	65.69%	68.13%	63.06%	66.31%
Indictor 2b:	MSHN SUD			92.59%	92.18%	86.28%	87.84%	81.29%	**87.99%
Expired Requests	MSHN SUD			52	44	81	42	237	341
***Indicator 3: Percentage of who had a Medically Necessary Service within 14 Days. (Effective 4.1.2020 No Standard)**	MI Child			70.83%	70.83%	68.30%	70.92%	65.80%	68.15%
	MI Adults			77.61%	77.61%	74.52%	73.70%	71.14%	71.10%
	DD Child			71.74%	71.74%	73.94%	79.10%	80.30%	79.39%
	DD Adult			76.74%	76.74%	57.14%	59.55%	68.35%	70.19%
	Total			75.57%	75.57%	72.04%	72.67%	69.83%	70.81%

**MDHHS calculated measure, unconfirmed at date of report. Green represents those that met or exceeded the standard. Red indicates the standard was not met.

Figure 5. MSHN Longitudinal data. Indicators 4 and 10 performance rate.

	Population	FY20Q1	FY20Q2	FY20Q3	FY20Q4	FY21Q1	FY21Q2	FY21Q3	FY21Q4
Indicator 4: Percentage who had a Follow-Up within 7 Days of Discharge from a Psychiatric Unit/SUD Detox Unit (95% Standard)	Children	98.28%	98.64%	98.17%	97.30%	98%	100%	98.39%	99.21%
	Adults	95.14%	95.92%	96.77%	98.51%	97.53%	97.93%	96.67%	95.97%
	MSHN SUD	98.39%	97.83%	97.78%	95.15%	98.31%	96.95%	95.30%	96.15%
Indicator 10a: Percentage who had a Re-admission to Psychiatric Unit within 30 Days (>15% Standard)	Children	4.35%	5.97%	16.06%	7.45%	6.82%	8.22%	6.71%	10.14%
	Adults	11.59%	10.06%	14.30%	13.98%	13.11%	13.62%	11.72%	12.05%

Green represents those that met or exceeded the standard. Red indicates the standard was not met.

Out of Compliance/Exception Data

MSHN completes an analysis of those records that were "out of compliance" and those that were identified as "exceptions. Exceptions are allowed for Indicators 4 and 10. Indicators 2 and 3 do not allow for exceptions. If an individual does not meet the timelines as required the record is considered to be "out of compliance". MSHN provides additional analysis to further determine causal factors

Figure 6. PIHP and CMHSP Indicator 2 and 3 Reasons for "Out of Compliance"

Out of Compliance Categories	#2a 1st Request	#2b SUD Time to Treatment	#3 Rec'd Service	Total
Consumer chose provider outside of network;	5	0	1	6
Consumer refused an appointment offered within the timeframe	107	29	102	238
Consumer rescheduled the appointment	104	10	69	183
(blank)	432	245	286	963
Biopsychosocial not completed	31	0	0	31

Cancelled/No Show by Consumer	442	21	295	758
Consumer chose not to pursue services	41	2	13	56
Consumer not eligible for ongoing services	0	0	12	12
Consumer requested an appointment outside the 14-day requirement	4	0	10	14
Intent of service was medication only or respite only.	0	0	1	1
Medical Transfer	0	0	1	1
No appointment available within 14 days with any staff	23	7	38	68
Staff cancel/reschedule	18	3	13	34
Unable to be reached	0	2	0	2
Unable to complete Biopsychosocial, emergent service needed	4	0	3	7
Grand Total	**1211**	**319**	**844**	**2715**

*Figure 7. Indicator 4a MSHN and the CMHSP participants exception rate. *Pandemic Emergency Orders*

Indicator 4a	FY20Q1	*FY20Q2	*FY20Q3	*FY20Q4	*FY21Q1	*FY21Q2	FY21Q3	FY21Q4
BABH	31.86%	35.92%	32%	32.36%	29.73%	36.19%	36.10%	33.87%
CEI	33.33%	49.51%	28%	27.50%	45.16%	62.96%	34.93%	54.29%
CMHCM	30.28%	25.51%	3%	56.63%	29.89%	27.59%	46.24%	14.12%
GIHN	31.71%	23.91%	14%	21.88%	17.14%	16.67%	12.37%	13.04%
HBH	52.00%	37.50%	36%	21.43%	55.56%	31.25%	12.12%	33.33%
Lifeways	37.40%	40.49%	37%	38.85%	13.04%	44.88%	37.50%	15.00%
MCN	29.79%	20.45%	26%	27.50%	40.83%	26.09%	22.50%	43.46%
Newaygo	9.09%	22.73%	14%	9.09%	17.14%	26.67%	51.84%	7.41%
Saginaw	30.94%	26.83%	24%	20.14%	21.05%	17.92%	19.44%	28.57%
SHW	17.39%	18.52%	35%	20.83%	34.29%	19.23%	27.27%	31.39%
The Right Door	21.43%	10.34%	12%	16.67%	25.64%	25.71%	21.77%	43.59%
TBHS	52.63%	19.35%	19%	33.33%	52.38%	31.82%	31.03%	35.71%
MSHN	**33.17%**	**35.74%**	**26%**	**32.36%**	**35.07%**	**30.83%**	**36.10%**	**37.79%**
Indicator 4b MSHN	**57.82%**	**54.61%**	**51.09%**	**52.19%**	**57.86%**	**57.05%**	**50.66%**	**43.65%**

*Figure 8. Indicator 10-MSHN and the CMHSP Participants exception rate. *Pandemic Emergency Orders*

Indicator 10	FY20Q1	*FY20Q2	*FY20Q3	*FY20Q4	*FY21Q1	*FY21Q2	*FY21Q3	FY21Q4
BABH	0.00%	00.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
CEI	11.28%	2.57%	21.10%	29.34%	29.49%	22.71%	23.15%	27.02%
CMHCM	0.00%	00.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
GIHN	0.00%	00.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
HBH	0.00%	00.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Lifeways	3.54%	4.96%	3.66%	4.62%	3.21%	2.93%	0.00%	0.00%
MCN	0.00%	00.0%	0.00%	0.00%	0.00%	0.00%	3.67%	3.46%
Newaygo	0.00%	00.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Saginaw	0.00%	00.0%	0.00%	1.85%	0.00%	0.00%	0.00%	0.00%
SHW	0.00%	00.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
The Right Door	0.00%	00.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
TBHS	0.00%	00.0%	0.00%	6.67%	0.00%	4.55%	0.00%	0.00%
MSHN	**3.06%**	**1.78%**	**7.63%**	**9.46%**	**5.64%**	**7.16%**	**7.16%**	**8.12%**

Figure 9. Indicator 10, 4 Reasons for "Exception".

Exception Categories	#10 - Inpatient Recidivism	#4a - Hospital Discharges F/U	#4b SUD - Detox Follow-Up	Total
Consumer chose not to pursue services	9	43	69	121
Consumer chose provider outside of network(Consumer chose not to use CMHSP/PIHP services)	87	106	22	215
Consumer rescheduled the appointment	NA	23	2	25

Consumer no showed for an appointment	NA	258	13	271
Consumer refused an appointment within the required timeframe	NA	2	28	30
Required Medical Admission- Transfer Found	NA	1	3	4
Assessment not completed due to an emergent service needed	NA	1	0	1
Custom	NA	1	0	1
Consumer Incarcerated	NA	3	0	3
Requested an appointment outside of the 7 day period	NA	0	4	4
Unable to complete an assessment	NA	0	0	0
Grand Total	**96**	**438**	**141**	**675**

Conclusion

MSHN achieved the goal for FY21Q4. MSHN provided access to treatment for 95% or more consumers within 3 hours of a request for a prescreen and within 7 days of a discharge from a psychiatric inpatient hospitalization or a Detox Unit. Eighty-seven percent or more consumers who were discharged from a psychiatric inpatient unit did not require inpatient psychiatric care during the 30 days following their discharge.

The following CMHSPs demonstrated performance below the standard for the following indicators for FY21Q4 and require a review of a current corrective action plan or development of a plan:
Indicator 1: NCMH-Children; TBHS-Children
Indicator 4: BABH-Adults; The Right Door-Adults; Lifeways-Adults; SHW-Adults
Indicator 10: BABH-Adults; CEI-Children; CMHCM-Children; The Right Door-Adults

Causal Factors/Barriers

- Increased Level of Care needed
- An increase in the severity of mental health issues
- Mental health compounded with substance use issues
- An increase in families not cooperating in follow up treatment for their child or family member
- The limited availability of increased level of care placements resulting in repeated hospitalizations
- Lack of coordination upon discharge with inpatient unit
- Home environment not supportive of recovery
- Medications needing additional adjustment to address behavioral concerns/instability
- Individual not cooperative with prescribed medication regimen upon discharge
- Individuals' medication was not in full effective upon discharged/early discharge
- Hospital discharged against the CMHSP recommendations
- Complicated medical issues affecting mental health
- The cost of the medication/ insurance limitations (Medical Directors Feedback)
- The inpatient unit prescribing Benzos (Medical Directors Feedback)
- The inpatient unit's inability to prescribe an injectable medication (Medical Directors Feedback)

Interventions

- Implementation of psychiatric urgent care to circumvent inpatient admissions and to assist individuals who have been discharged
- Staff including peers to reach out through face-to-face attempts for those who do not follow up after discharge

- Retrospective review occurring on all cases to identify trends to avoid future hospitalizations. Implementation of weekly team meetings to discuss hospital admissions and discharges ensuring coordination occurs
- Increased coordination and linking with provider including the Psychiatrist to ensure medical needs are met
- Increased level of care provided through available alternate resources
- Implementation of a Hospital Utilization Group (HUG).Reviews individual with 2 or more hospitalizations in 6 months and/or level of stay greater than 6 days.
- Utilization of paraprofessionals/Family Support Assistant services
- Ensuring housing and SUD treatment referrals are discussed during the admission process

Recommendations

- All CMHSPs who demonstrate performance below the standard for each population group will determine causal factors and barriers contributing to those that do not meet the required timelines.
- An improvement plan should be developed within 30 days of the submission of the report and include causal factors, barriers, action steps to remediate the deficiency, dates of completion, and process to measure effectiveness.
- Indicators 2 and 3 are currently baseline data collection, therefore, improvements will be focused on ensuring valid, reliable, and actionable data is being collected.
    - Consensus of categories for "out of compliance" reasons to be used for documentation.
- Only allowable exception reasons to be used.
- Development of a powerpoint to be used for the SUD providers and the CMHSP Participants to address the intent and requirements of each performance indicator including the expectation of required documentation. A focus will be any common areas of deficiency that has been demonstrated in the regions during this past year.
- The use of the power point training and/or other documentation for training of new staff as well as annual review for all staff.
- Additional emphasis to develop consistent processes will continue by utilizing the Frequently Asked Questions (FAQ) Document currently available and updated in the REMI Help documents.
- CMHSPs should review data prior to submission to ensure the appropriate data elements are submitted according to the format as indicated in the instructions.
- All CMHSPs should review the records to ensure those submitted are eligible for Medicaid at least one month during the reporting period. MSHN to incorporate steps to verify Medicaid eligibility prior to submission to MDHHS.
- SUD providers should ensure documentation is accurate and completed as required in REMI.
- MSHN will implement a QI process for SUD providers who perform below the standard.

Prepared by: Sandy Gettel, MSHN Quality Manager **Date:** 12/16/2021
Approved by: MSHN QIC **Date:** 12/20/2021

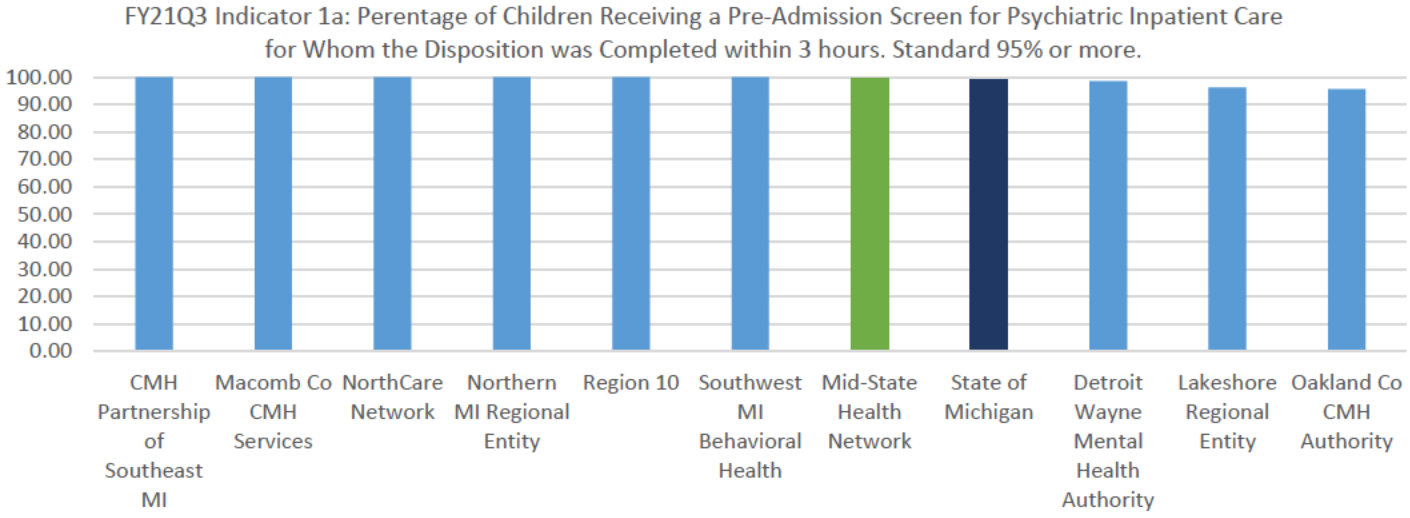
Attachment 1

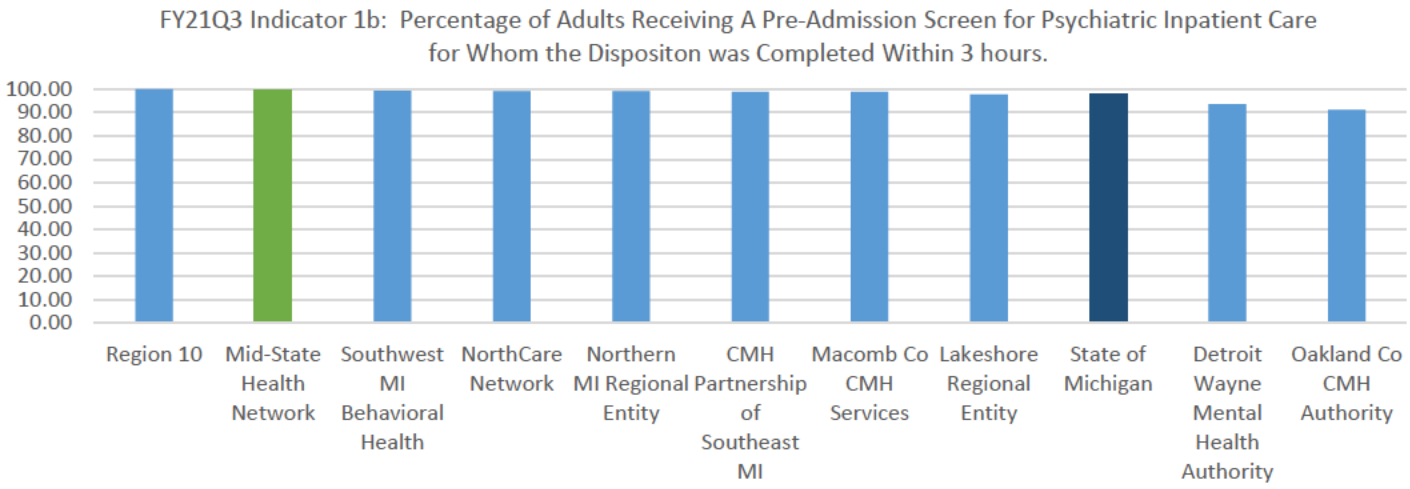
PIHP MMBPIS Comparison Report -FY21Q3 Final State Data

An analysis was completed to identify how MSHN performed compared to other PIHPs and the State of Michigan. In addition to the indicators that are calculated and reviewed quarterly by MSHN, the following indicators calculated by MDHHS were included:

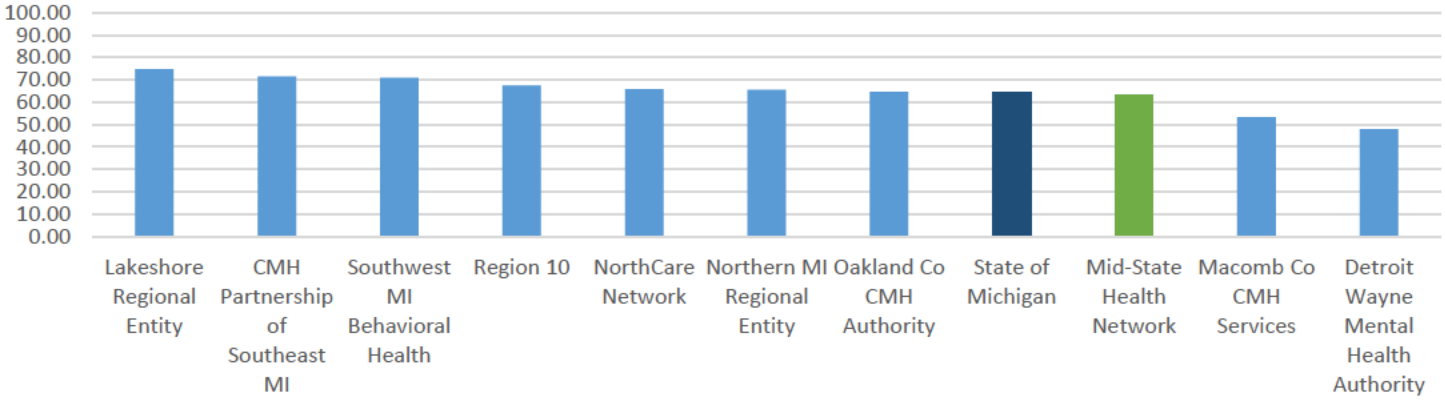
Indicator 5: Percentage of Area Medicaid Recipients Having Received PIHP Managed Services.
Indicator 6: The Percent of Habilitation Supports Waiver (HSW) Enrollees in the Quarter Who Received at Least One HSW Service Each Month Other Than Supports Coordination.

MSHN Performed above the State of Michigan Performance for ten of the twelve indicators, performing in the top five for seven indicators of twelve indicators.

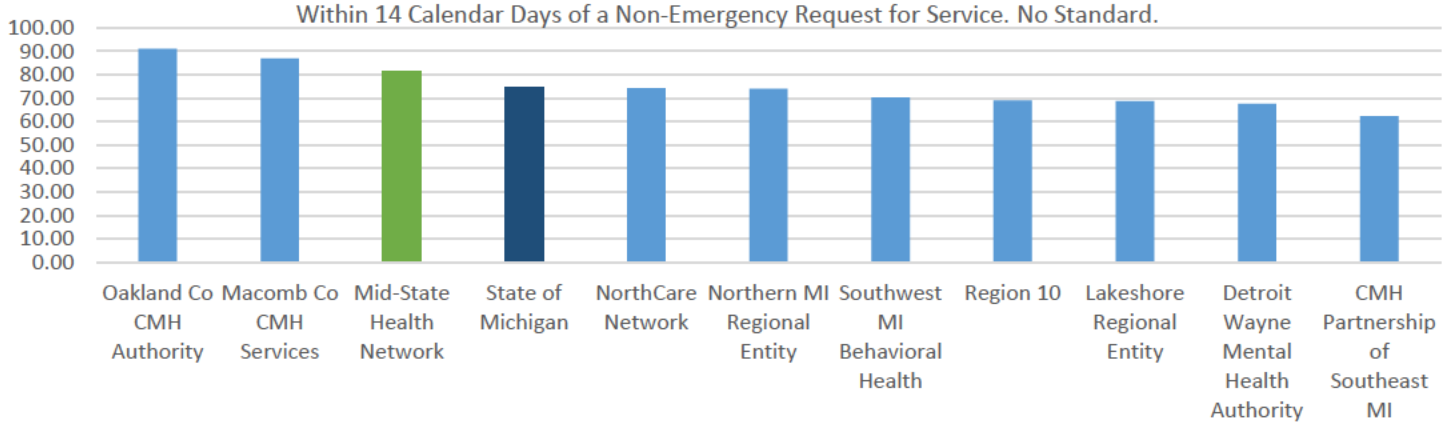




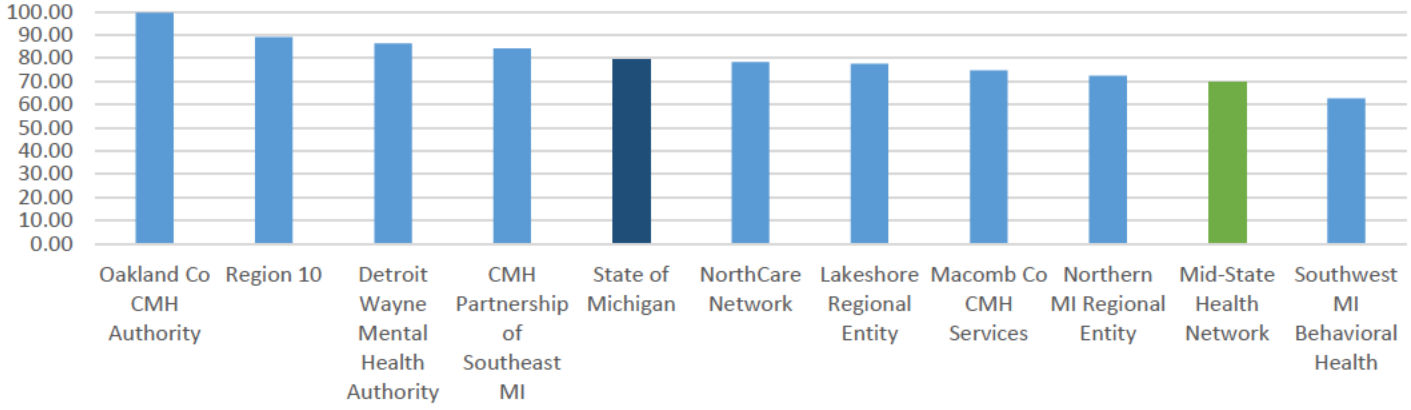
FY21Q3 Indicator 2: Percentage of New Persons Receiving a Completed Biopsychosocial Assessment within 14 Calendar Days of a Non-emergent Request for Service. No Standard.



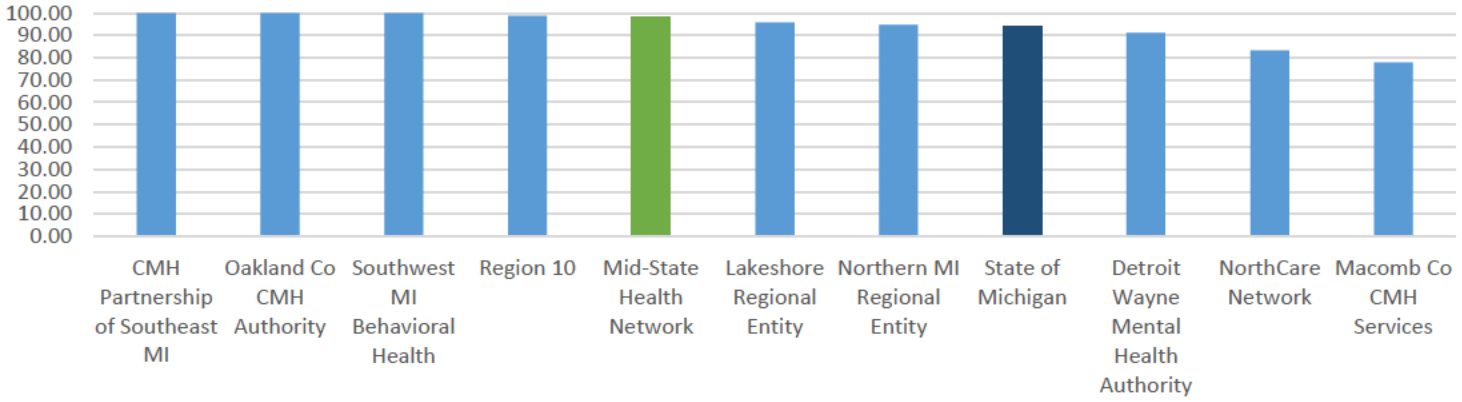
FY21Q3 Indicator 2e: Percentage of New Persons Receiving a Face to Face Service for Treatment or Supports Within 14 Calendar Days of a Non-Emergency Request for Service. No Standard.



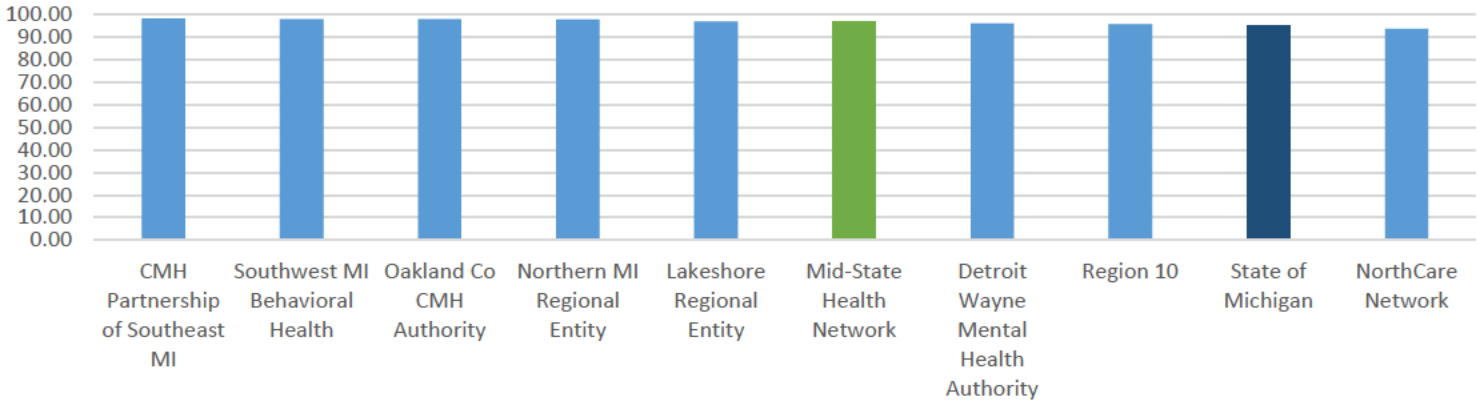
FY21Q3 Indicator 3: Percentage of New Persons Starting any Medically Necessary On-going Covered Service Within 14 Days of Completing a Biopsychosocial Assessment. No Standard.



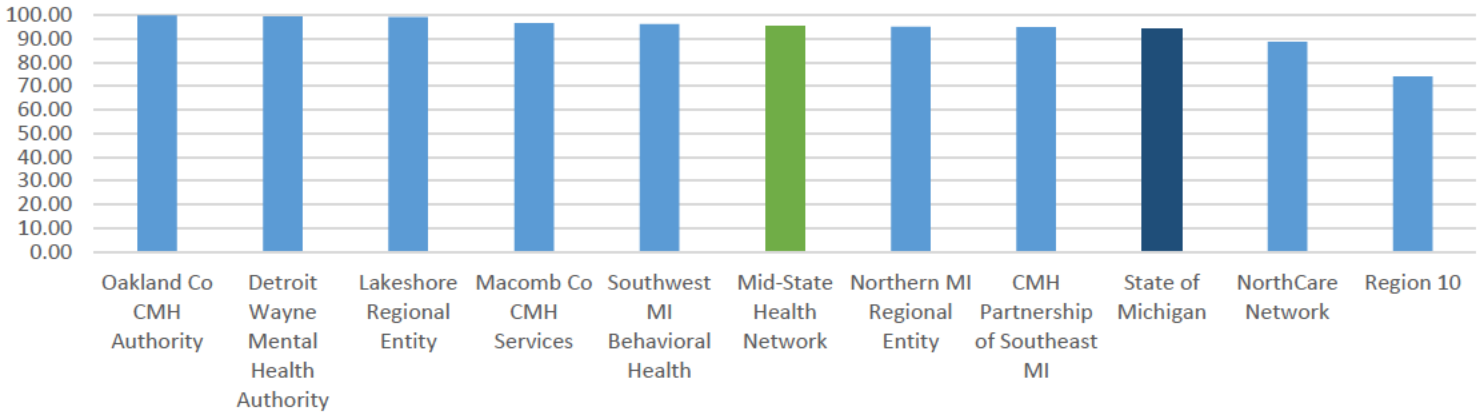
FY21Q3 Indicator 4a(1): Percentage of Children Discharged from a Psychiatric Inpatient Unit Who are Seen for Follow Up Care within 7 Days. Standard 95% or more



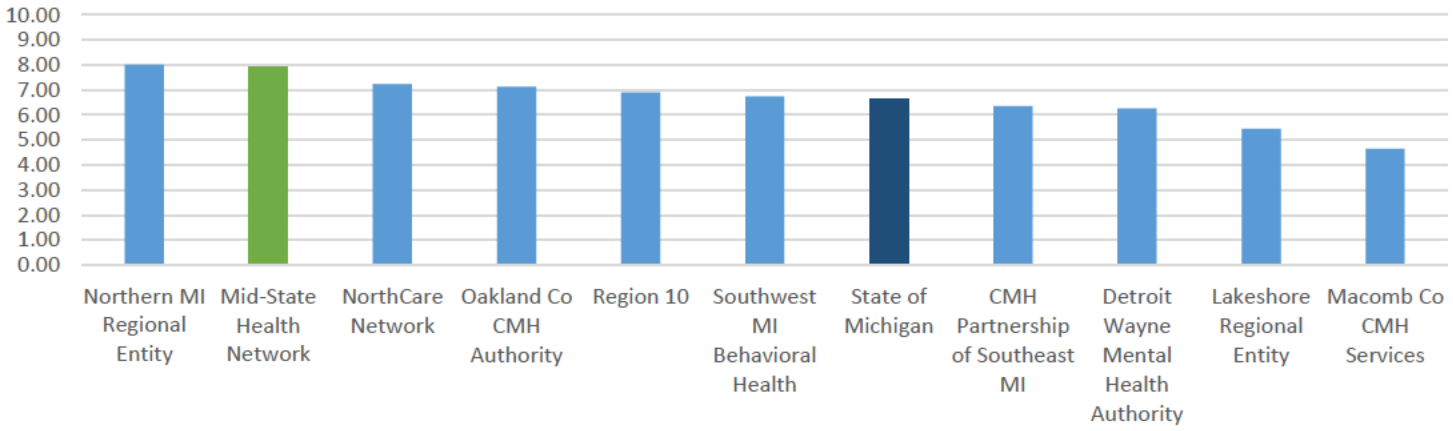
FY21Q3 Indicator 4a(2): Percentage of Adults Discharged from a Psychitric Inpatient Unit Who are Seeen for Follow Up Care Within 7 Days.
Standard 95% or more



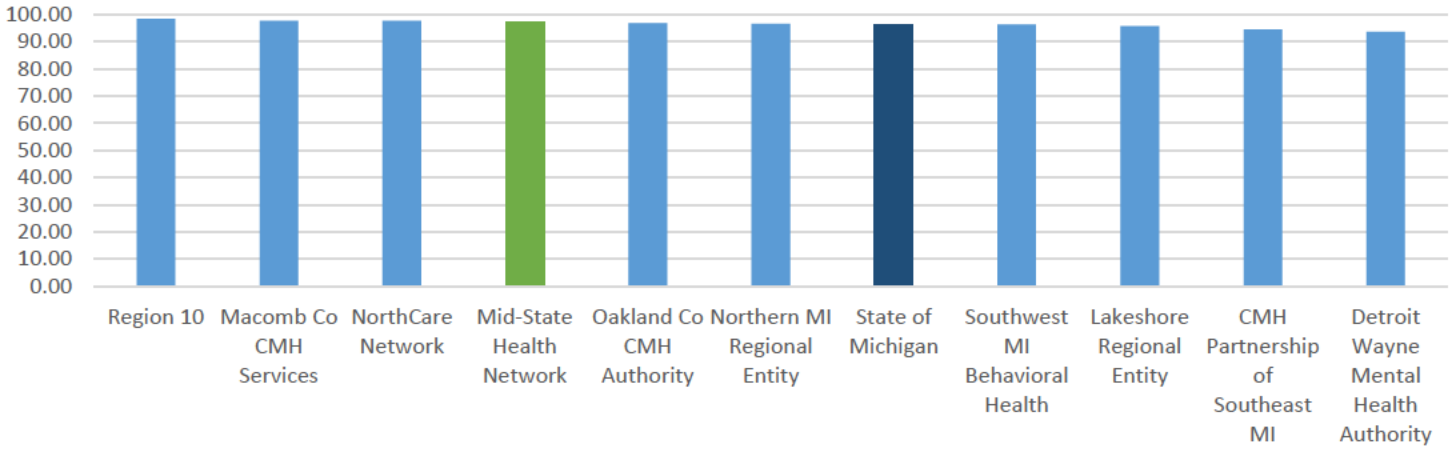
FY21Q3 Indicator 4b: Percentage of Discharges from a Substance Abuse Detox Unit Who are Seen for Follow-Up Care withn 7 Days. Standard 95% or more



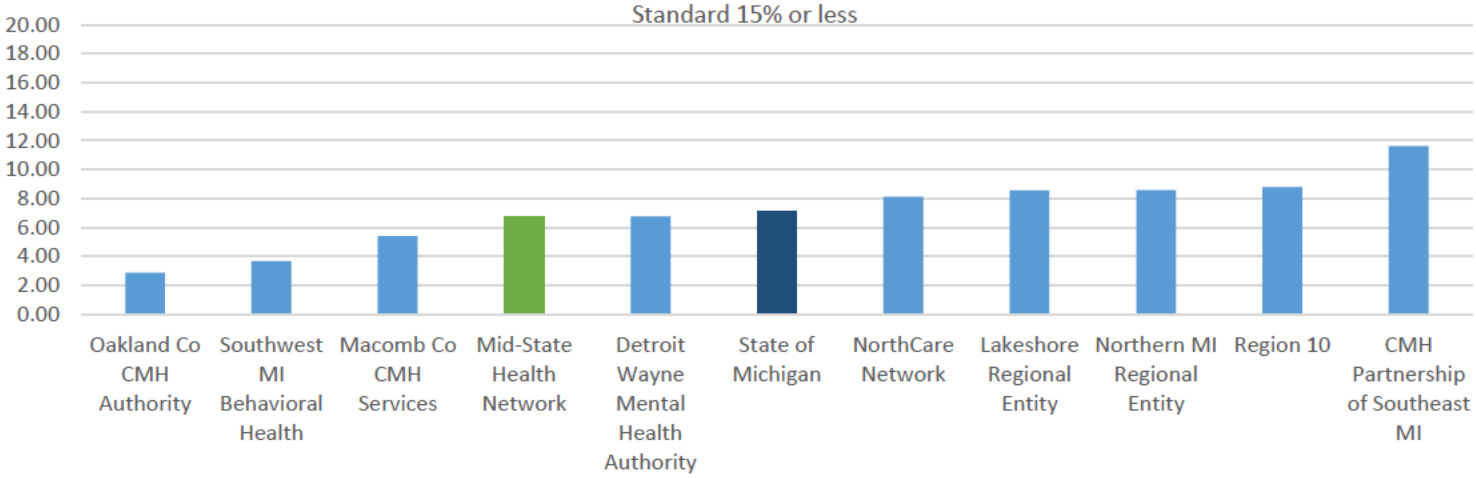
FY21Q3 Indicator 5: Percentage of Area Medicaid Recipients Having Recieved PIHP Managed Services



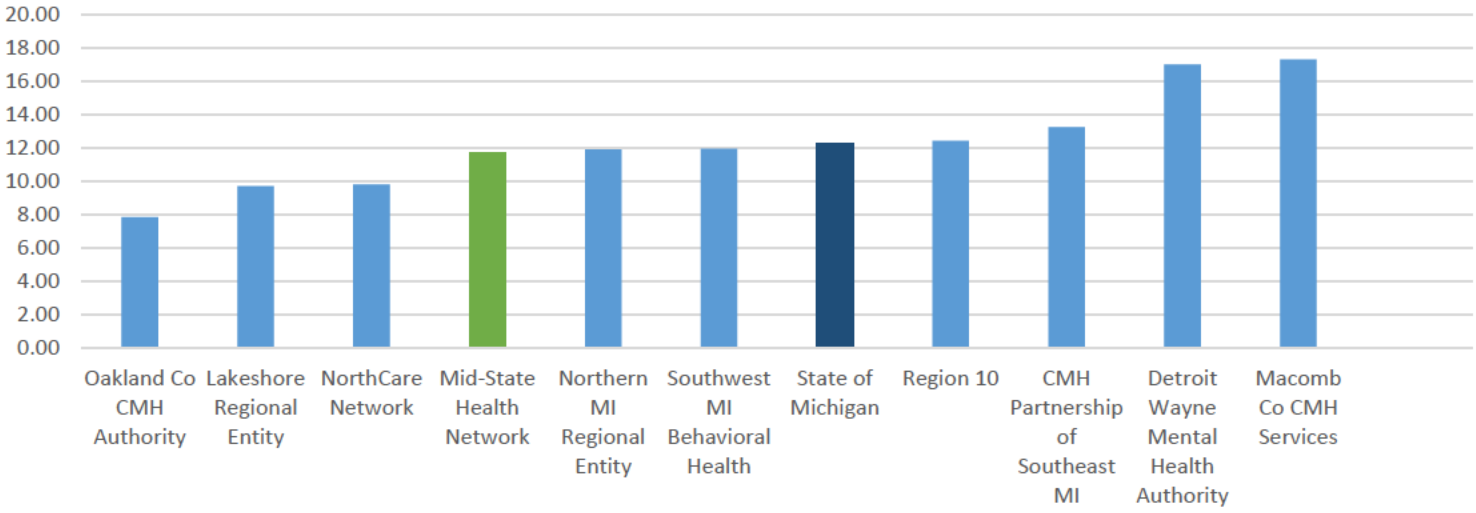
FY21Q3 Indicator 6; The Percent of Habilitativion Supports Waiver (HSW) Enrollees Who Recieved a Least One HSW Service Each Month Other Than Supports Coordination



FY21Q3 Indicator 10a: Percentage of Children Readmitted to Inpatient Psychiatric Units Within 30 Calendar Days-Children.
Standard 15% or less



FY21Q3 Indicator 10b: Percentage of Adults Readmitted to Inpatient Psychiatric Units Within 30 Calendar Days-Adults.
Standard 15% or less



MSHN
Mid-State Health Network

Quality Assessment Performance Improvement Program
BH-TEDS Quality Monitoring- Veterans & Military Fields

Introduction

Mid-State Health Network (MSHN) provides services to approximately 66,543 individuals per year. It is the expectation of the Michigan Department of Health and Human Services (MDHHS) that MSHN will identify beneficiaries who may be eligible for services through the Veteran's Administration (VA). This will be completed through the quarterly submission of the Veteran's Service Navigator (VSN) Data Collection form, improving, and maintaining the data quality of the BH-Teds military and veteran's fields, and monitoring and analyzing the data discrepancies between the VSN and the BH-TEDS data. A narrative report on the comparison findings of the veterans reported on the VSN form and BH-TEDS, including actions taken to improve the quality of the data will be completed and submitted to MDHHS BHDDA by 7/1/2021.

Data Quality/Completeness

The data used for this quality review include the total reported BH-TEDS A and M records for the measurement period of 10/01/20 through 03/31/21. BH-TEDS Q records were not included in the analysis. The following BH-TEDS fields were reviewed for completeness and potential illogical combinations: Veterans Status, Military Service Era, Branch Served, Family Service, and VA Enrollment.

The following recommendations were made, and actions taken to improve data quality and completeness for FY21 based on the analysis of the FY20Q1Q2 data.

- MSHN will work with MDHHS to better define a process to eliminate or accept a BH-TEDs record that is out of range for individuals who have received MAT.

  Status: MSHN staff assisted MDHHS staff to exclude the out of range BH-TEDS records due to MAT individuals. Phil C. agreed after a lengthy discussion that it is more important to maintain those individuals admission records as they remain open for multiple years versus admitting and discharging every year in order to have an in range record. MDHHS is still considering an Update record process for SUD individuals.

- MSHN will work with MDHHS to better define a process or eliminate the submission of records for jail services, OBRA Assessments, nursing home services, those who have a different county of financial responsibility (COFR), or who have been hospitalized either in a State facility or community hospital.

  Status: MSHN staff actively participate on a statewide BH-TEDS workgroup where issues like jail services, OBRA assessments and such are discussed and determined how to handle those as exceptions in reporting. Carol H. is responsible for submitting change recommendations for BH-TEDS record exceptions and did so with several of these events, including most recently to remove transportation only services.

- MSHN will build a report in the managed care information system (REMI) to identify the "Not Collected" records to support improvement efforts.

  Status: MSHN staff developed reports based on its managed care information system dataset to show by CMHSP any records that do not meet the criteria for using "Not Collected" as a value with Veterans and Military fields in BH-TEDS reporting.

  MSHN participated in discussions and improvements with MDHHS to revise CHAMPS edits and validations through DTMB for FY21 that rejects BH-TEDS records if they don't meet the Veterans and Military field validations for "Not Collected." This has significantly improved the required veteran and military status fields for BH-TEDS. Additional updates to the BH-TEDS military fields for FY21 include the following:

- Veteran Status Y/N
- Most Recent Military Era-If Veteran Status="Yes", must be 01, 02, 03, 04, 05, 06.
- Branch Served- If Veteran Status ="Yes", must be 01, 02, 03, 04, 05, 06, 07
- Client/Family Military Service- If Veteran Status = "Yes" Client Family Service must be 01
- VA/Other Support Services-If Veteran Status = "Yes" Individual/Family connected to VA or other supported services must be 01 or 02.

- MSHN Quality Improvement Council (QIC) will work to improve the clinical workflow to identify trigger events in the electronic health record for a BH-TEDs admission, update, and discharge record; the process in which a BH-TEDS record is sent.

  Status: The CMHSP participants have incorporated the BH Teds data elements into the clinical workflow by incorporating the BH-TEDS data elements or a prompt to update/complete the BH-TEDs episode into the clinical documents such as the Assessment, Update Assessment, and the Discharge Summary etc.

Findings

A total of 11301 A and/or M BH-TEDS record were submitted during the measurement period.
Figure 1 demonstrates the percentage of acceptable and unacceptable records submitted. Unacceptable records are defined as records with a response choice of "Not Collected". Records with a Veteran Status of "Yes" demonstrated a 100% acceptance rate. Records with a Veteran Status of "No" demonstrated <1% rate of unacceptance. The data was reviewed for any potential illogical combinations. Illogical combinations are defined as records that may not make logical sense based on a combination of responses. Combinations reviewed included records with a response choice of Veteran Status "No" yet indicated Recent Military Service other than Peace Time Era or Veteran Status of "Yes" however, indicated Recent Military of Peace Time Era. Less than 1% were found to have potential illogical combinations.

Figure 1: Status of Submitted BH-TEDS Records During the Measurement Period-Veteran Fields

	Veteran Status	Most Recent Military Era	Branch Served	Client/Family Military Service	VA/Other Support Services
SUD A Records	**3655**	**3655**	**3655**	**3655**	**3655**
% Acceptable	100%	100%	100%	100%	100%
MH M Records	**7646**	**7646**	**7646**	**7646**	**7646**
% Acceptable	98.93%	99.62%	99.65%	99.66%	99.45%
% Unacceptable	1.07%	0.38%	0.35%	0.34%	0.55%

Veteran Service Navigator and BH-TEDS Report Comparison.

The data used for the Veteran Service Navigator and the BH-TEDS comparison include the BH-TEDS A and M records submitted, and the number of contacts reported on the Veteran Service Navigator Reports (2) during the measurement period. BH-TEDS Q records were excluded from the analysis. The total percentage and number of BH-TEDS records indicating a Veteran Status of "Yes" were compared to the number of individuals reported on the VSN contact data collection form submitted to MDHHS for the same measurement period. All BH-TEDS records indicating Veteran Status of "Yes" that did not have a contact through the VSN were further investigated to determine the cause and identify improvement efforts.

MSHN
Mid-State Health Network

Quality Assessment Performance Improvement Program
BH-TEDS Quality Monitoring- Veterans & Military Fields

Findings

MSHN submitted 11301 BH-TEDS A and M records during the measurement period of 10/1/2020 through 3/31/2021. Of the BH-TEDS records submitted 178 (1.58%) reported a veteran status of "Yes". Of the 178 who identified themselves as veterans 36 (20%) reported being connected to veteran related services.

MSHN's Veteran Service Navigator Data Collection form reported 81 individuals had contact with the Veterans Service Navigator during the measurement period. Three (1.69%) of those individuals had a BH-TEDS record submitted within the same reporting period. Seventy-eight did not have an open BH-TEDS record.

Barriers

- Veterans do not always identify as veterans in the BH-TEDs
- Veterans maybe receiving assistance through alternate resources in the community such as county veteran coordinators.
- Unable to confirm the validity of the responses in the military fields i.e.. those reporting "Enrolled in VA services" are engaged in services, or a Veteran response of "Yes" or "No".
- Unable to match those from the VSN report to BH-TEDS
- No formalized referral process that includes the tracking of those who decline VSN services
- Lack of funding for SUD services for veterans

Summary

MSHN performed at a high-level for the completion and accuracy of the Military Fields in the BH-TEDS data. The performance rate indicates that actions taken to improve the FY20 quality and completeness of the BH-TEDS Military data have been effective.

Veteran Service Navigator services were provided to 1.69% of those who identified themselves as veterans within the BH-TEDS. The majority (98%) of the individuals receiving services from the VSN are currently not enrolled in services through a MSHN provider.

Action Steps

- Build a referral process into the screening and assessment process for the Mental Health and Substance Use providers for notification to the Veteran Services Navigator when a person identifies as a veteran.
- Establish a process for regional collaboration with the submission of the quarterly VSN Report.
- Provide Education to the provider organizations related to VSN services available.
- Collect two identifiers to ensure appropriate verification of records within REMI.
- Advocate for the use of a 1115 waiver process for veterans to access VA services and participate in CMHSP/SUD services within our network.
- Monitor the quality and completion of the veteran and military field values.
- Monitor utilization of services for veterans through performance measure.

RECOVERY SELF-ASSESSMENT
FY21 ANNUAL REPORT

Mid-State Health Network

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Executive Summary

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 strongly agree.

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 over the 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

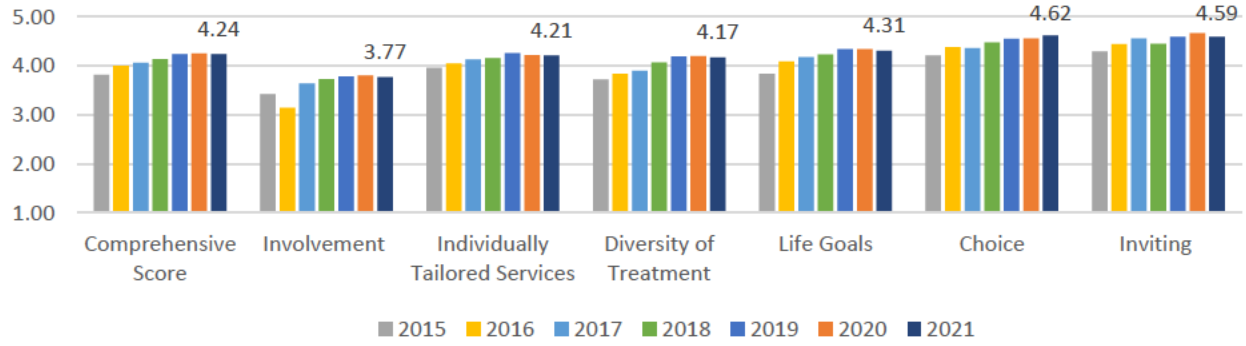


Figure 3. MSHN RSA-R Provider Assessment Comprehensive Score and Subcategory Comprehensive Scores

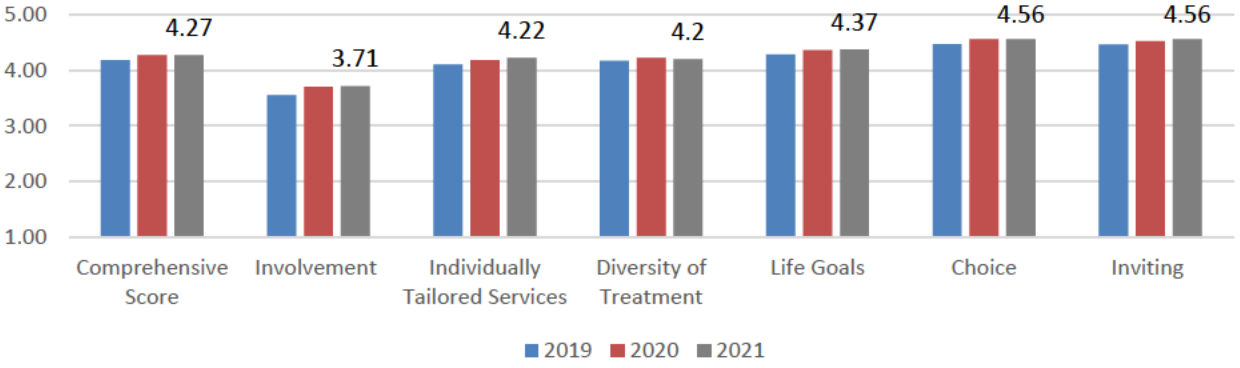


Figure 4a. MSHN RSA-R Provider and Administrative Assessment Comprehensive Score for CMHSP and SATP Service Program Type

	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

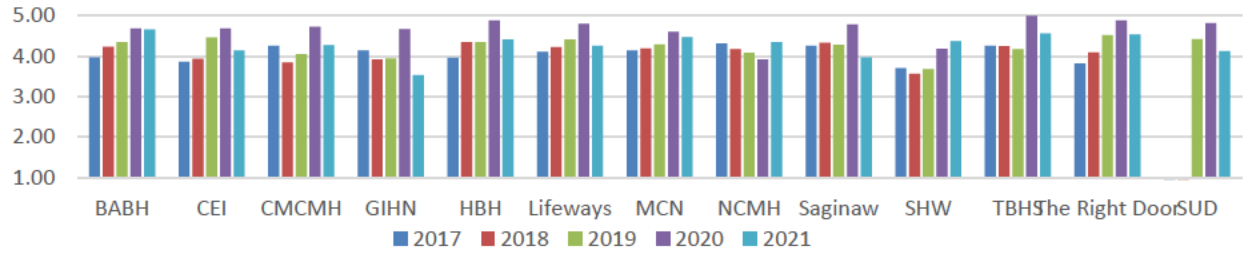
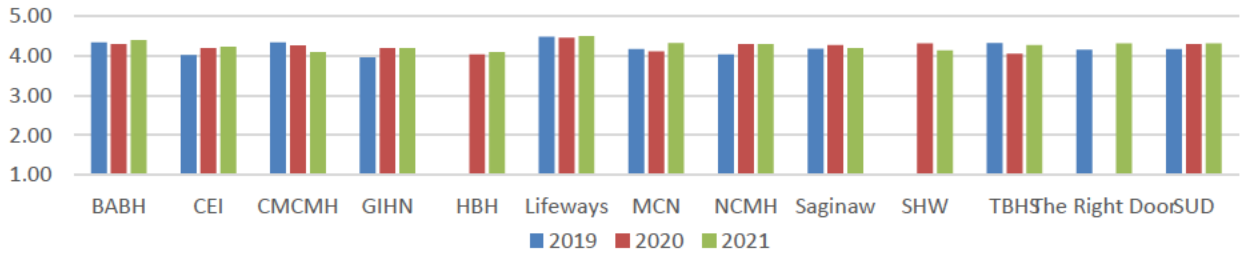


Figure 6. CMHSP Participant and SATP RSA-R Provider Comprehensive Assessment Scores



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

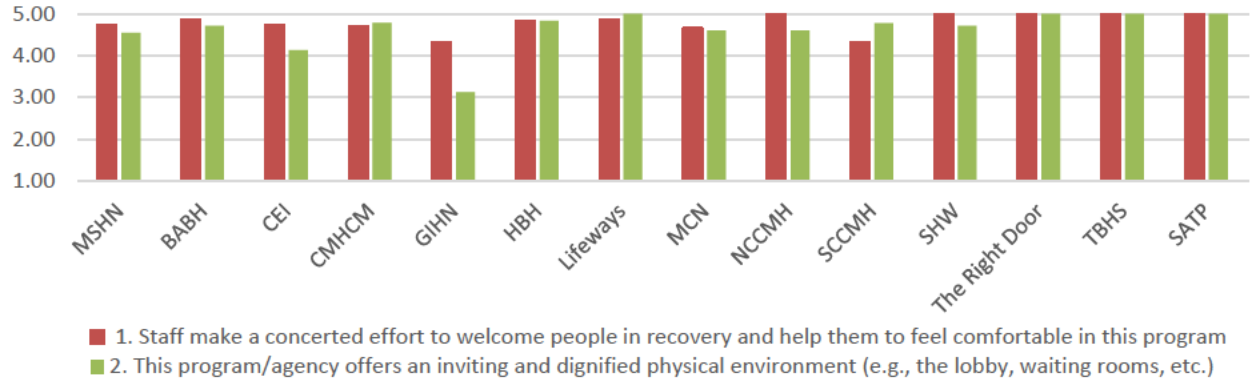


Figure 8b. CMHSP Participants and SATPs comparison of FY21 Inviting Subcategory Score with Questions-Provider Assessment

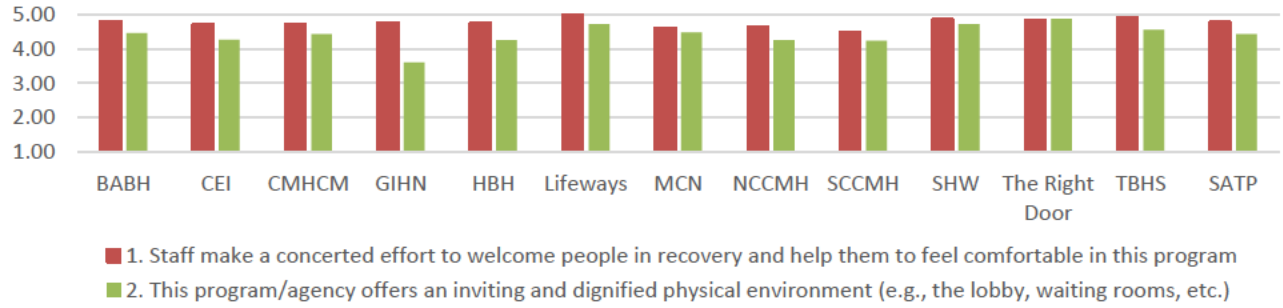
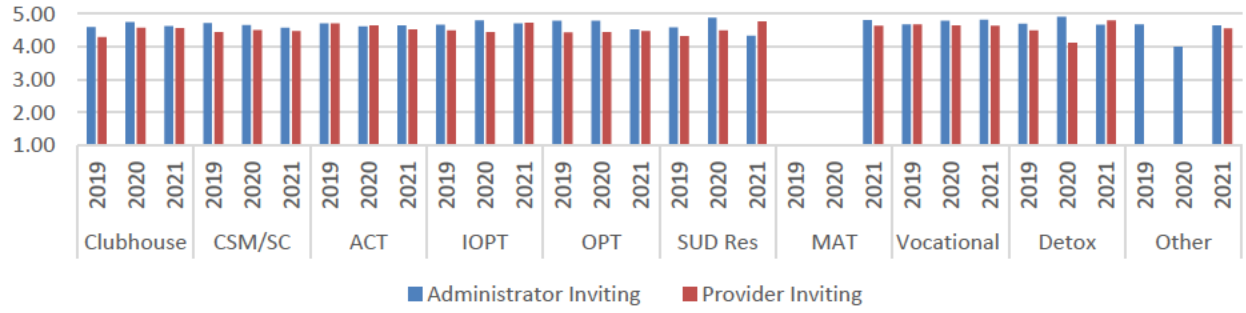


Figure 8c. Service Program Type comparison of the Inviting Subcategory with the Provider and Administrator Assessments



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

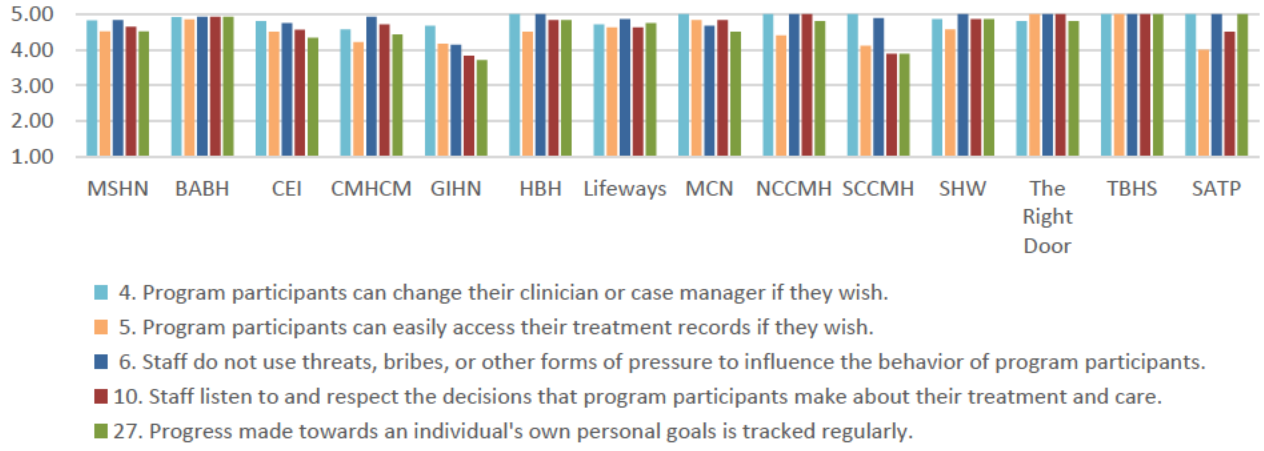


Figure 9b. CMHSP Participants and SATPs comparison of FY21 Choice Subcategory Score with Questions-Provider Assessment

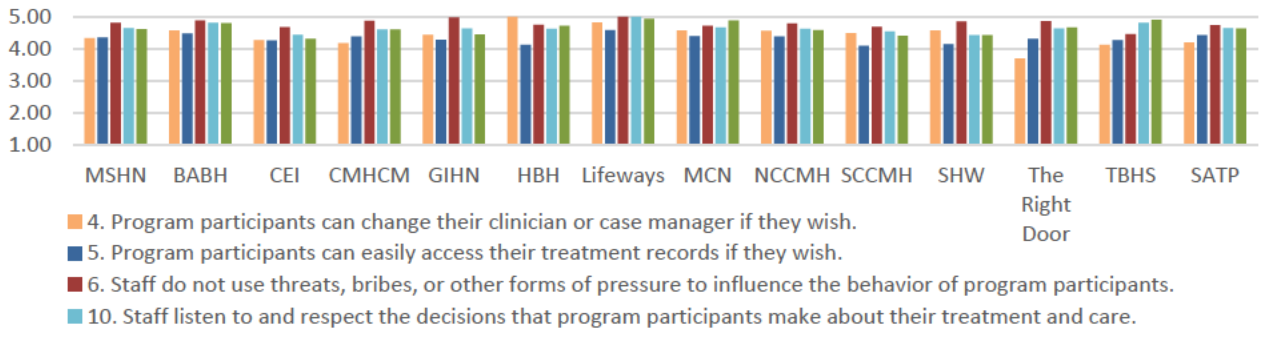
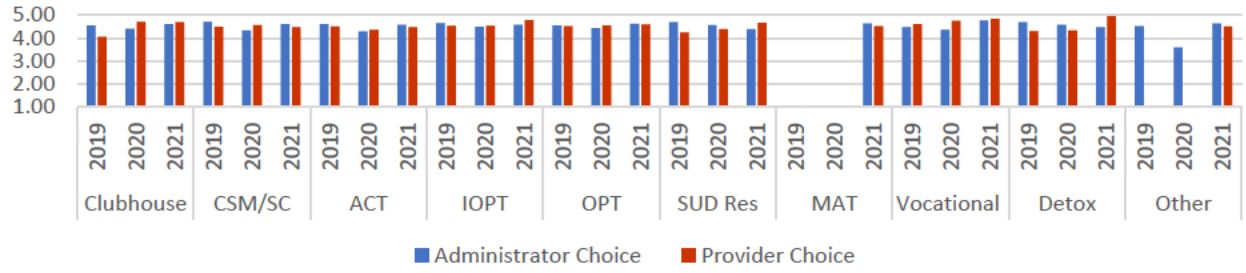


Figure 9c. Service Program Type comparison of the Choice Subcategory with the Provider and Administrator Assessments. No data collected for MAT in 2019 and 2020.



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

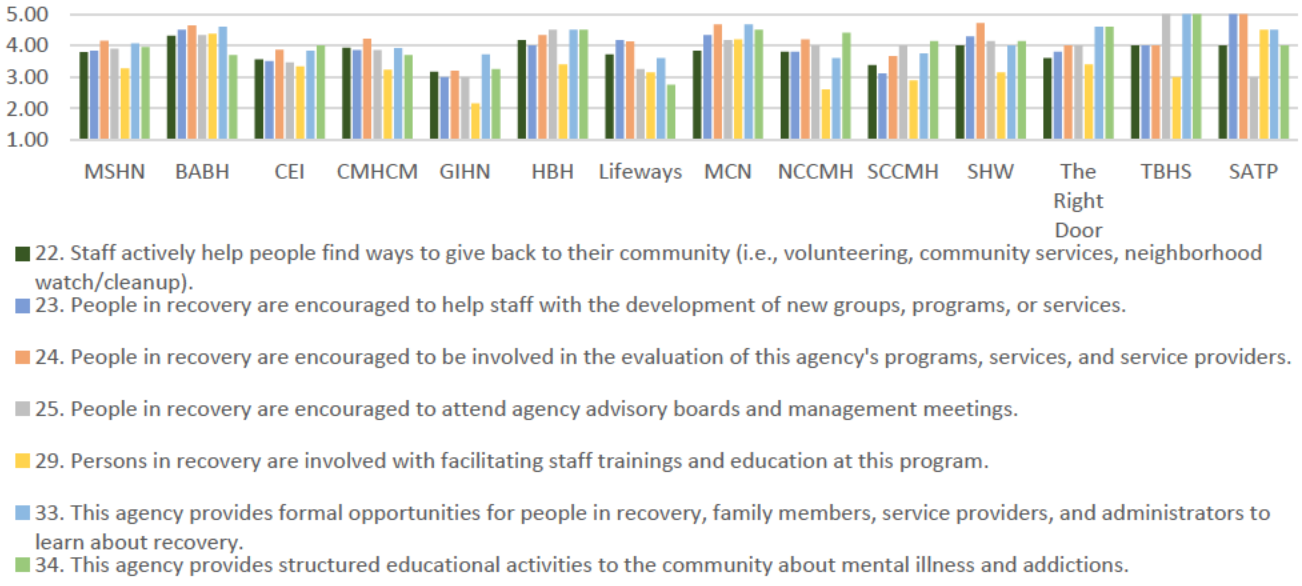


Figure 10b. CMHSP Participants and SUD Provider Network comparison of FY21 Involvement Subcategory Score with Questions-Provider Assessment

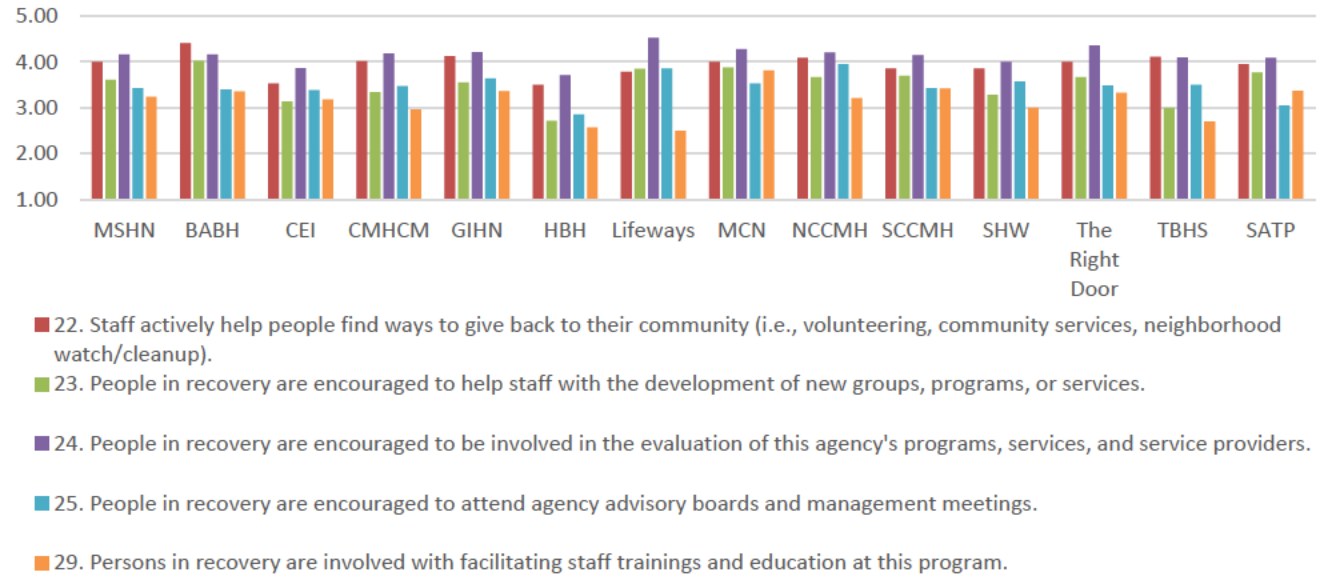
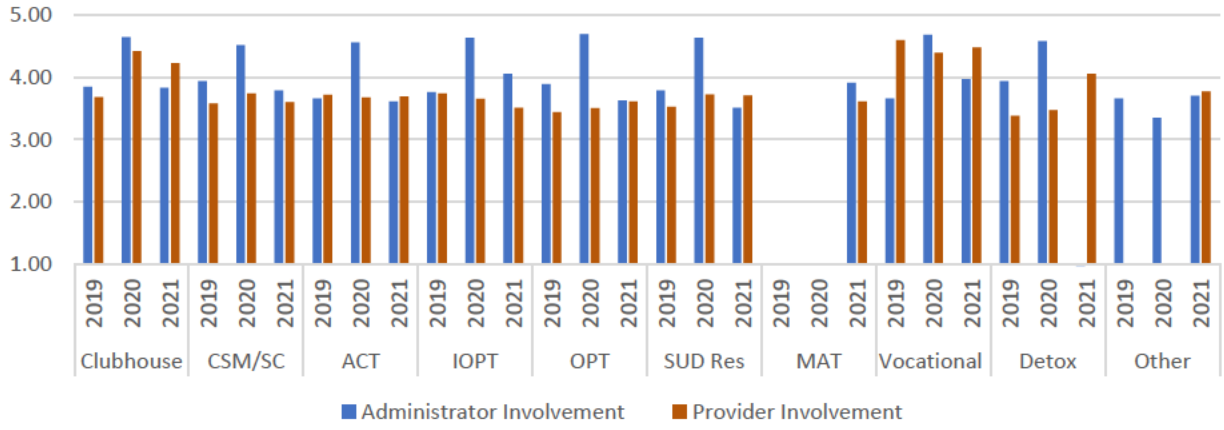


Figure 10c. Service Program Type comparison of the Involvement Subcategory



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)

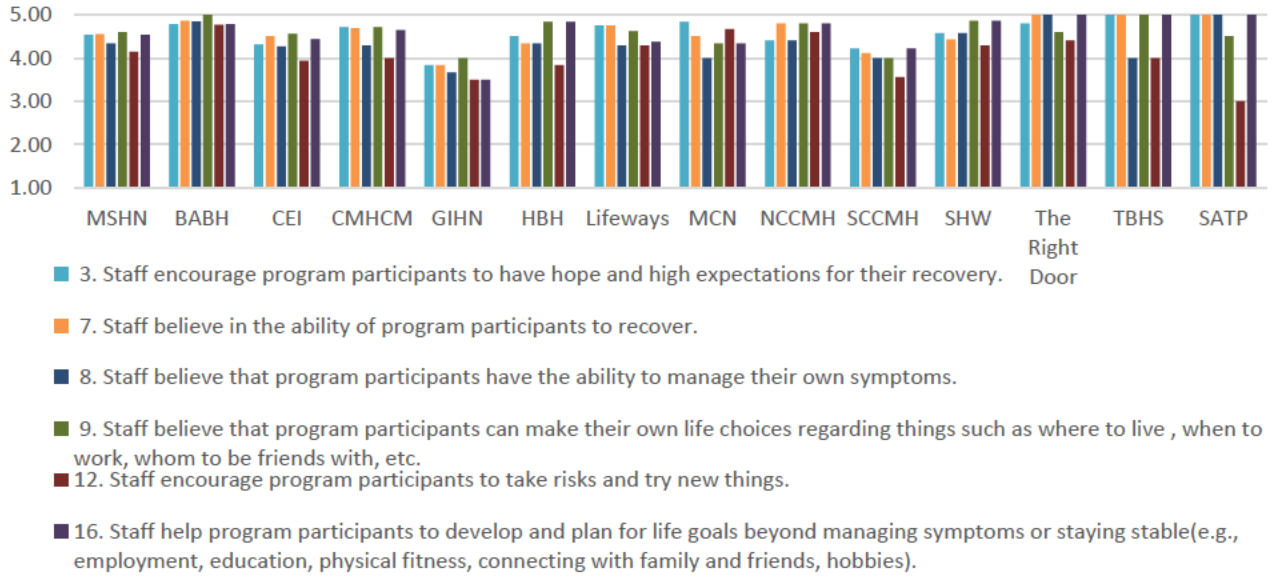


Figure 11b. CMHSP Participant and SATP comparison of FY21 Life Goals Subcategory Score with Questions-Administrator Assessment (Questions 16, 17, 18, 28, 31, 32)

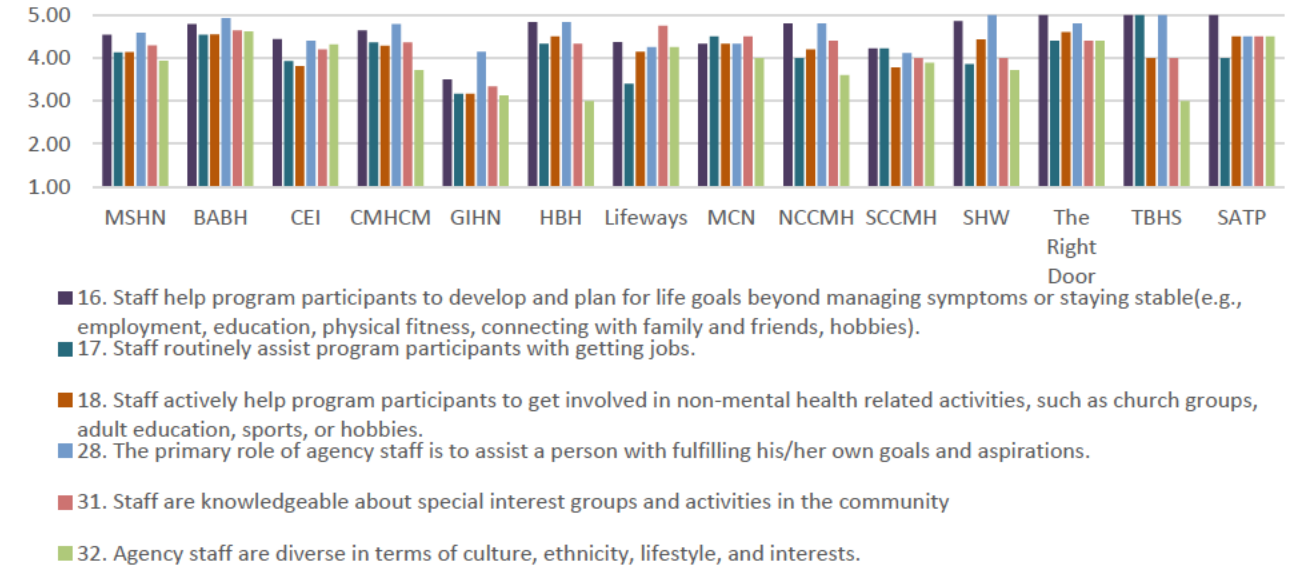


Figure 11c. CMHSP Participants and SATP comparison of FY21 Life Goals Subcategory Score with Questions-Provider Assessment (Questions 3, 7, 8, 9, 12)

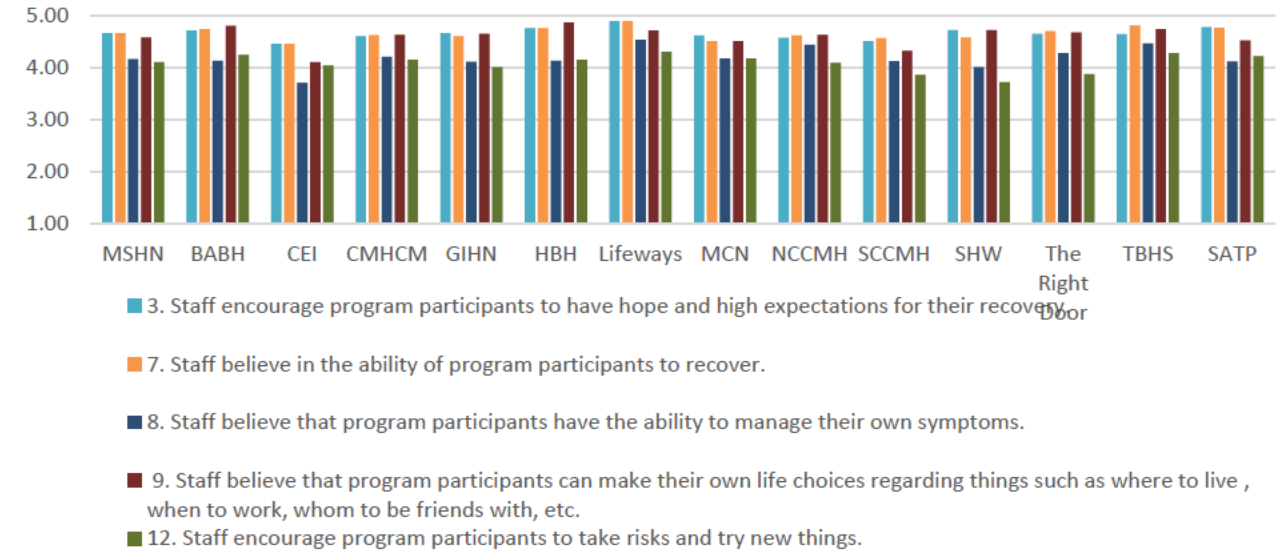


Figure 11d. CMHSP Participants and SATP comparison of FY21 Life Goals Subcategory Score with Questions-Provider Assessment (Questions 16, 17, 18, 28, 31, 32)

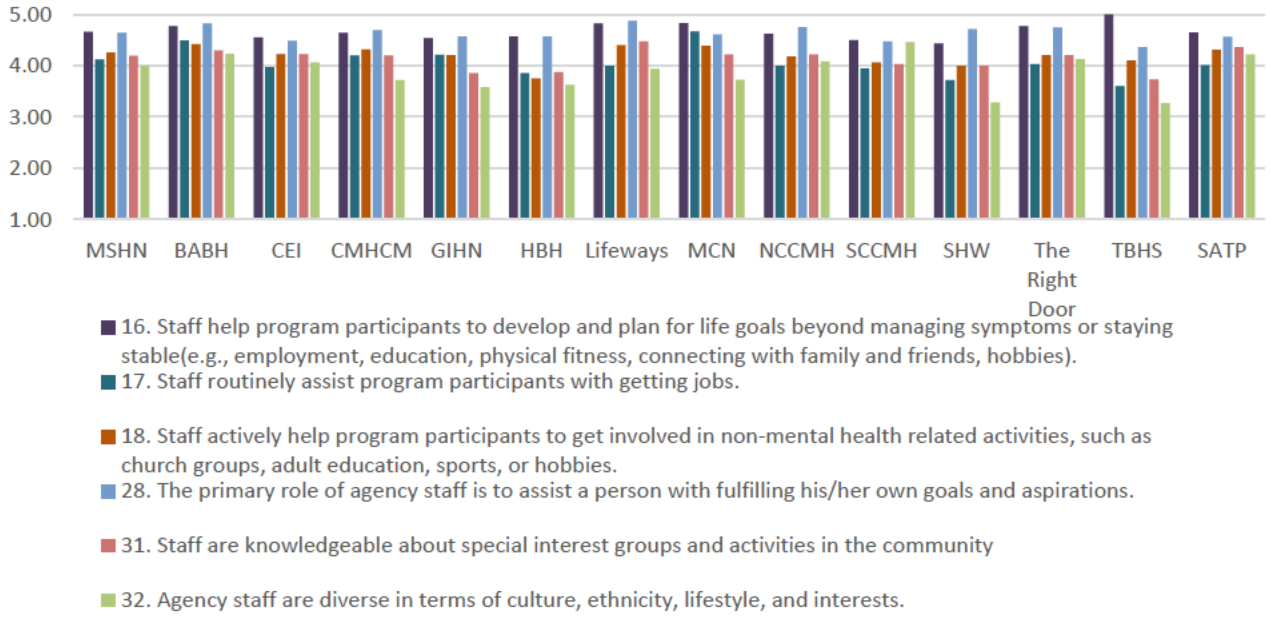
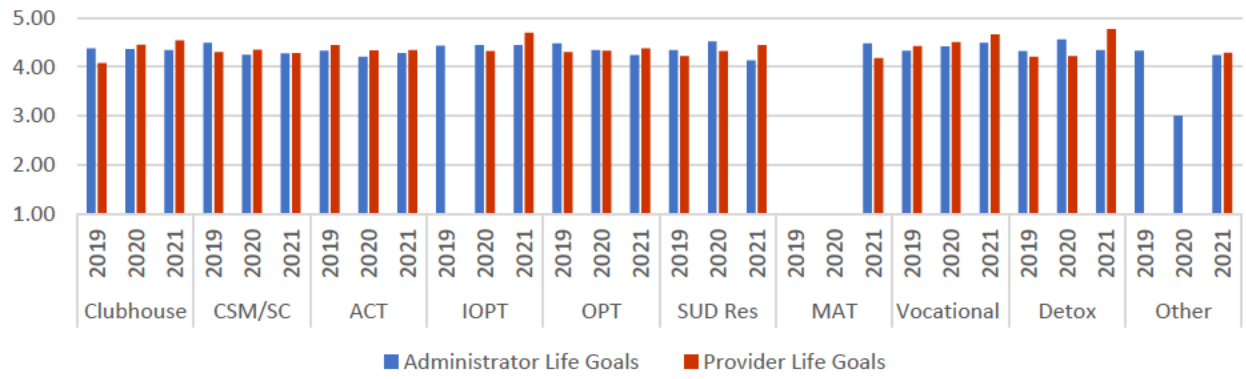


Figure 11e. Service Program Type comparison of Life Goals Subcategory



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

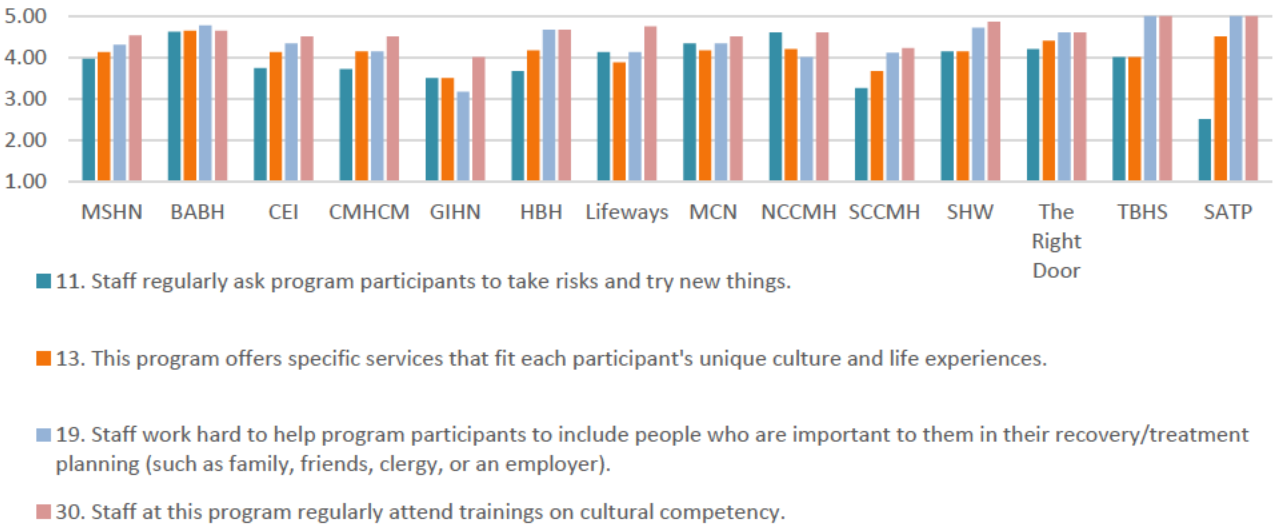


Figure 12b. CMHSP Participants and SATPs comparison of FY21 Individually Tailored Services Subcategory Score with Questions-Provider Assessment

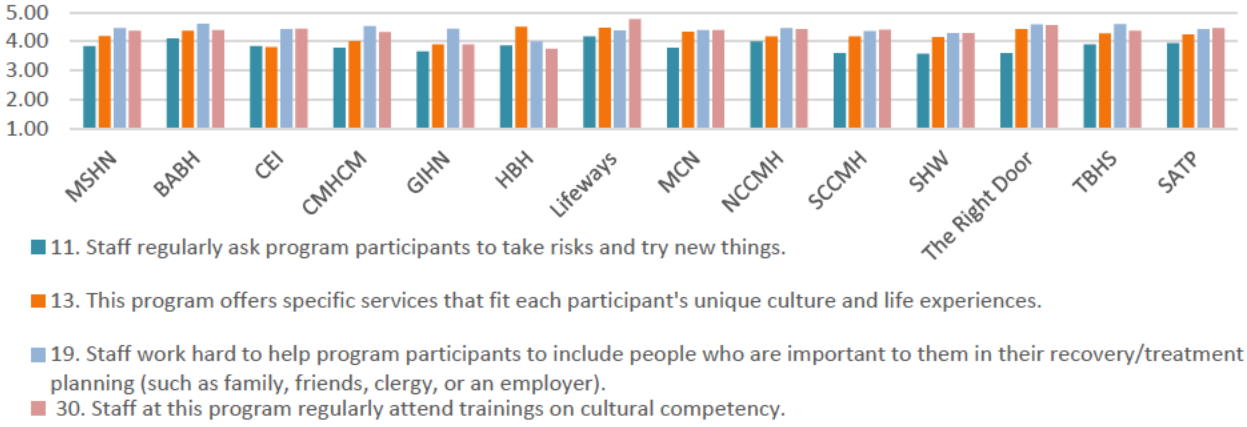
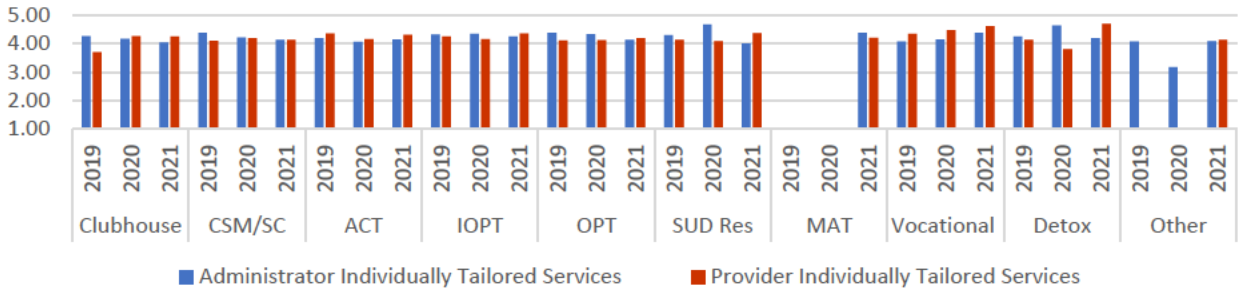


Figure 12c. Service Program Type comparison of Individually Tailored Services Subcategory



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

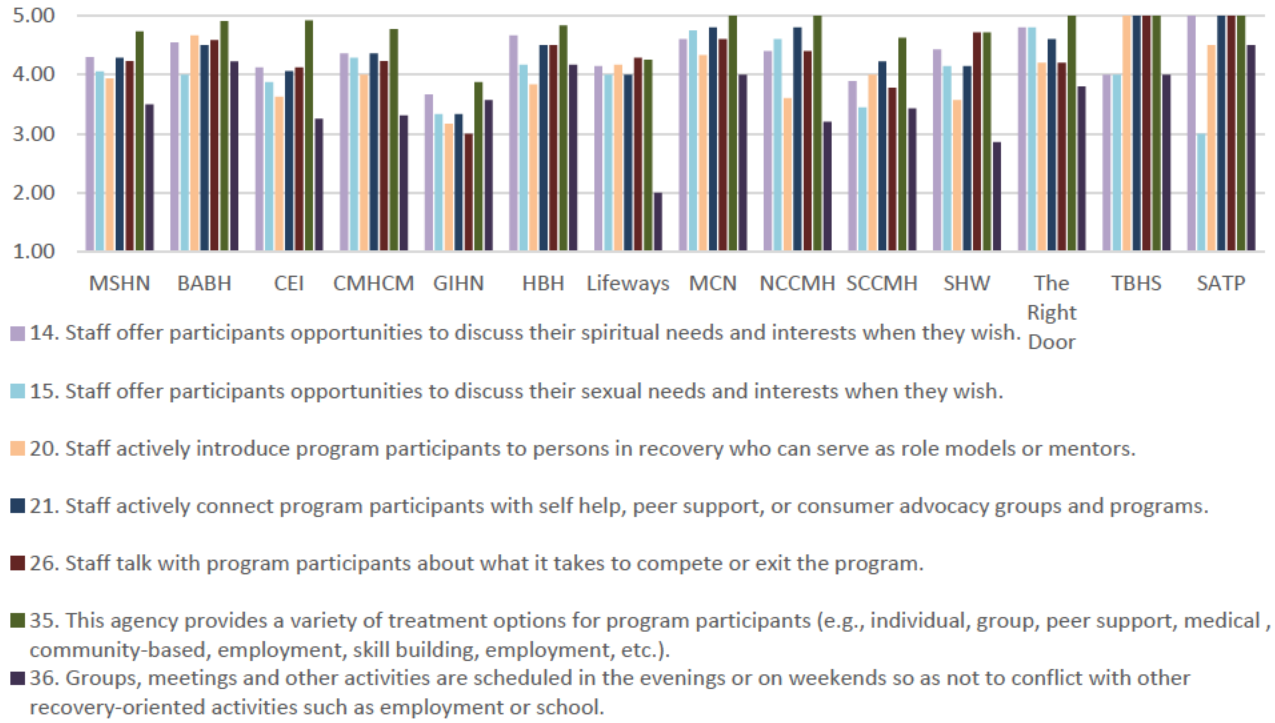


Figure 13b. CMHSP Participants and SATPs comparison of FY21 Diversity of Treatment-Provider Assessment

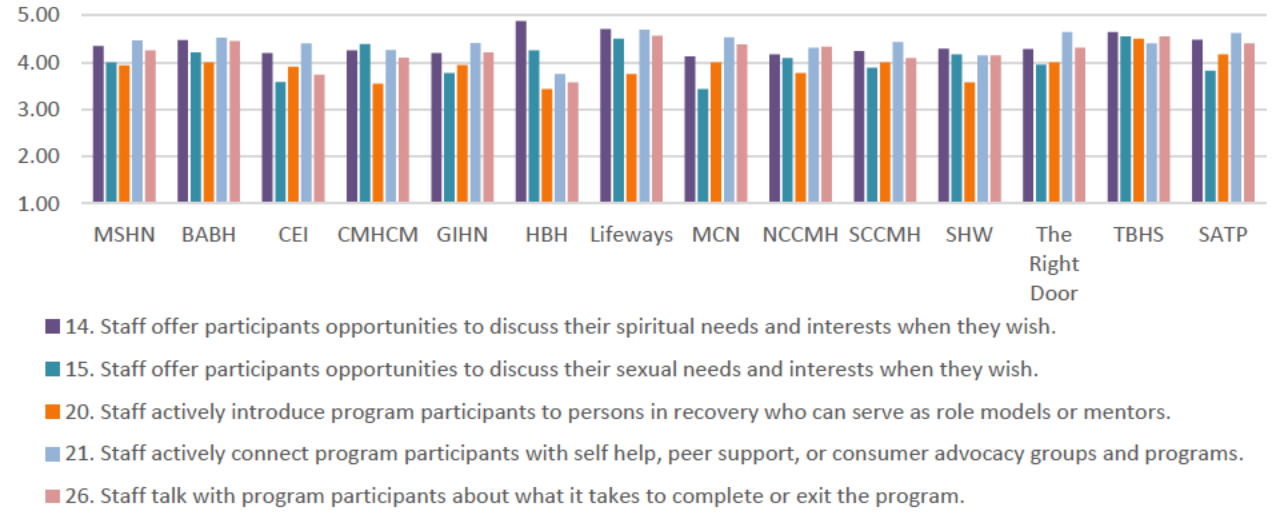
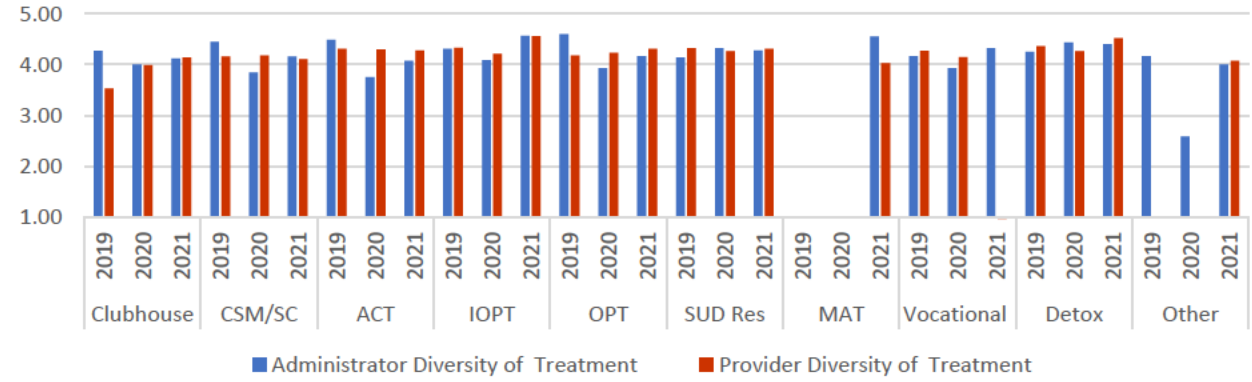


Figure 13c. Service Program Type comparison of Diversity of Treatment Subcategory



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) 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.

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 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 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 strongly agree.

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 over the 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 MSHN Quality 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

Attachment 2

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 to discuss 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

Behavioral Health and Developmental Disabilities Administration
Prepaid Inpatient Health Plans

2020–2021 PIP Validation Report

Patient With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test

for

Region 5—Mid-State Health Network

October 2021

For Validation Year 4

HSAG HEALTH SERVICES ADVISORY GROUP

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Appendix A. PIP Validation Tool A-1

Appendix B. PIP Summary Form B-1

Acknowledgements and Copyrights

1. Background

The Code of Federal Regulations (CFR), specifically 42 CFR §438.350, requires states that contract with managed care organizations (MCOs) to conduct an external quality review (EQR) of each contracting MCO. An EQR includes analysis and evaluation by an external quality review organization (EQRO) of aggregated information on healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG) serves as the EQRO for the State of Michigan, Department of Health and Human Services, (MDHHS)—responsible for the overall administration and monitoring of the Michigan Medicaid managed care program. MDHHS requires that the Prepaid Inpatient Health Plan (PIHP) conduct and submit performance improvement projects (PIPs) annually to meet the requirements of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid members in PIHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves.

For State Fiscal Year (SFY) 2020–2021, MDHHS required PIHPs to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). In accordance with §438.330(d)(2)(i–iv), each PIP must include:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve quality improvement (QI).
- Evaluating effectiveness of the interventions.
- Planning and initiating activities for increasing and sustaining improvement.

As one of the mandatory EQR activities required by 42 CFR §438.358(b)(1)(i), HSAG, as the State's EQRO, validated the PIPs through an independent review process. Since these PIPs were initiated in SFY 2018, in its PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-1] When the PIHPs initiate new PIPs, HSAG will use and follow CMS' publication, *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019.[1-2]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Aug 23, 2021.

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Aug 23, 2021.

1. HSAG evaluates the technical structure of the PIP to ensure that **Mid-State Health Network** designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., study question, population, indicator(s), sampling techniques, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well **Mid-State Health Network** improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that any reported improvement is related to and can be logically linked to the quality improvement strategies and activities conducted by the PIHP during the PIP.

Rationale

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and non-clinical areas.

For this year's 2020–2021 validation, **Mid-State Health Network** continued its state-mandated PIP topic: ***Patient With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test***. The study topic selected by **Mid-State Health Network** addressed CMS' requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

Summary

The goal of this PIP is to increase annual hemoglobin A1c and low-density lipoprotein cholesterol testing among Medicaid members with diabetes and schizophrenia. Monitoring these test results can assist in controlling diabetes; prevent serious health complications such as blindness, kidney disease, and amputations; and lead to improvement in health and functional outcomes of members. This PIP topic represents a key area of focus for improvement by **Mid-State Health Network.**

Table 1-1 outlines the study indicator for the PIP.

Table 1-1—Study Indicator

PIP Topic	Study Indicator
Patient With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test	The percentage of members with schizophrenia and diabetes who had an HbA1c and LDL-C test during the measurement period.

Validation Overview

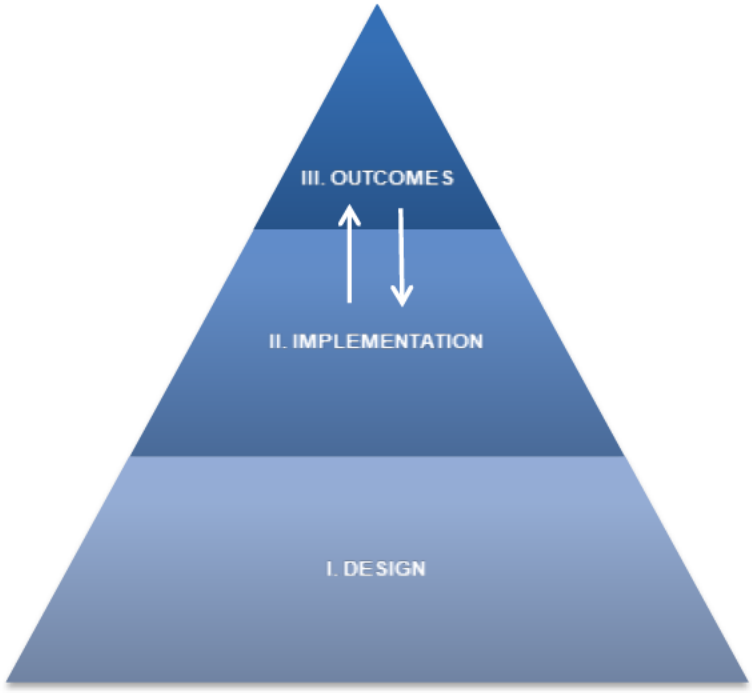
HSAG obtains the information and data needed to conduct the PIP validation from **Mid-State Health Network**'s PIP Summary Form. This form provides detailed information about **Mid-State Health Network**'s PIP related to the steps completed and evaluated by HSAG for the 2020–2021 validation cycle.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*. **Mid-State Health Network** would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provides a General Comment with a *Met* validation score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*) HSAG gives the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

Figure 1-1 illustrates the three stages of the PIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the methodological framework for the PIP. The steps in this section include development of the study topic, question, population, indicators, sampling techniques, and data collection. To implement successful improvement strategies, a methodologically sound study design is necessary.

Figure 1-1—Stages



Once **Mid-State Health Network** establishes its study design, the PIP process progresses into the Implementation stage. This stage includes data analysis and interventions. During this stage, **Mid-State Health Network** evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage is the final stage, which involves the evaluation of real and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistically significant improvement over the baseline and the improvement is sustained with a subsequent measurement period. This stage is the culmination of the previous two stages. If the outcomes do not improve, **Mid-State Health Network** investigates the data collected to ensure that **Mid-State Health Network** has correctly identified the barriers and implemented appropriate and effective interventions. If it has not, **Mid-State Health Network** should revise its interventions and collect additional data to remeasure and evaluate outcomes for improvement. This process becomes cyclical until sustained statistical improvement is achieved.

Validation Findings

HSAG's validation evaluated the technical methods of the PIP (i.e., the study design), the implementation of quality improvement strategies and the PIP outcomes through annual remeasurements. Based on its review, HSAG determined the overall methodological validity of the PIP and assessed for improvement in the study indicator outcomes. Table 2-1 summarizes the PIP validated during the review period with an overall validation status of *Met*, *Partially Met*, or *Not Met*. In addition, Table 2-1 displays the percentage score of evaluation elements that received a *Met* score, as well as the percentage score of critical elements that received a *Met* score. Critical elements are those within the validation tool that HSAG has identified as essential for producing a valid and reliable PIP. All critical elements must receive a *Met* score for a PIP to receive an overall *Met* validation status. A resubmission is a PIHP's updates to the previously submitted PIP with revised/additional documentation.

Table 2-1 illustrates the validation scores for both the initial submission and resubmission.

Table 2-1—2020–2021 PIP Validation Results for Mid-State Health Network

Name of Project	Type of Annual Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Patient With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test	Submission	95%	100%	*Met*
	Resubmission	100%	100%	*Met*

[1] **Type of Review**—Designates the PIP review as an annual submission, or resubmission. A resubmission means the PIHP was required to resubmit the PIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.

Table 2-2 displays the validation results for **Mid-State Health Network**'s PIP evaluated during 2019–2020. This table illustrates the PIHP's overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 2-2 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 2-2—Performance Improvement Project Validation Results for Mid-State Health Network

Stage	Step		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	1.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	2.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	3.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	4.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	5.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	6.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	7.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	8.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	9.	Real Improvement Achieved	100% (3/3)	0% (0/3)	0% (0/3)
	10.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			**100% (3/3)**	**0% (0/3)**	**30% (0/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**100% (20/20)**		
Percentage of Score of Applicable Critical Evaluation Elements *Met*			**100% (10/10)**		
Validation Status			***Met***		

Mid-State Health Network submitted the Design, Implementation, and Outcomes stages of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met*. The following subsections highlight HSAG's findings associated with each validated PIP stage.

Design

Mid-State Health Network designed a scientifically sound project supported by the use of key research principles, meeting 100 percent of the requirements in the Design stage. The technical design of the PIP was sufficient to measure and monitor PIP outcomes.

Implementation

Mid-State Health Network met 100 percent of the requirements for the data analysis and implementation of improvement strategies. The PIHP conducted accurate statistical testing comparing the Remeasurement 1 results to the baseline results and provided a narrative interpretation of that comparison. Appropriate quality improvement tools were utilized to conduct its causal/barrier analysis and to prioritize the identified barriers. Intervention evaluation results were provided for interventions as appropriate.

Outcomes

Mid-State Health Network was assessed for improvement of the study indicator outcomes. Remeasurement 2 achieved the overall goal of statistically significant improvement over the baseline and the plan-selected goal.

Analysis of Results

Table 2-3 displays baseline, Remeasurement 1, and Remeasurement 2 data for **Mid-State Health Network**'s ***Patient With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*** PIP. The goal is to increase annual hemoglobin A1c and low-density lipoprotein cholesterol testing among Medicaid members with diabetes and schizophrenia.

Table 2-3—Performance Improvement Project Outcomes for Mid-State Health Network

Study Indicator Results				
Study Indicator	**Baseline (1/1/2018–12/1/2018)**	**Remeasurement 1 (1/1/2019–12/31/2019)**	**Remeasurement 2 (1/1/2020–12/31/2020)**	**Sustained Improvement**
Patient(s) with Schizophrenia and Diabetes who had an HbA1c and LDL-C test during the report period	33.6%	36.1% ⇔	49.2% ↑*	

⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↑* The remeasurement rate demonstrated statistically significant improvement ($p < 0.05$) over the baseline rate.

For the first measurement period, **Mid-State Health Network** reported that 36.1 percent of patients with schizophrenia and diabetes had an HbA1c and LDC-C test. The Remeasurement 1 plan-selected goal was set at 36 percent. The overall goal of the PIP is to achieve statistically significant improvement over the baseline rate of 33.6 percent. The study indicator achieved the plan-selected goal and, although it did not achieve statistically significant improvement, **Mid-State Health Network** demonstrated an improvement of 2.5 percentage points over the baseline rate for the first remeasurement period.

For the second remeasurement period, **Mid-State Health Network** reported that 49.2 percent of patients with schizophrenia and diabetes had an HbA1c and LDL-C test. The Remeasurement 2 plan-selected goal was set at 38.6 percent. The overall goal of the PIP is to achieve statistically significant improvement over the baseline rate of 33.6 percent. The study indicator achieved both statistically significant improvement and the plan-selected goal.

Mid-State Health Network noted that the coronavirus disease 2019 (COVID-19) pandemic, which occurred during the second remeasurement period, impacted the rate due to stay-at-home orders as well as limited transportation and access to laboratories and physician offices.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. The PIHP's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the PIHP's overall success in achieving the desired outcomes for the PIP.

Mid-State Health Network's causal/barrier analysis involved brainstorming and the completion of the fishbone diagram to identify the barriers by the quality improvement council and regional medical directors' group. Each Community Mental Health Service Program (CMHSP) reviewed its baseline data and provided feedback regarding barriers to the PIHP. The quality improvement council and regional medical directors group prioritized the identified barriers based on the effort of, and relevance to, each CMHSP and potential impact of the outcome.

From these processes, **Mid-State Health Network** determined the following top barriers:

- Lack of coordination and communication occurring between the primary care physicians (PCPs) and the CMHSPs.
- Lack of access to labs.
- Information regarding completed labs is not available.
- Inaccurate and untimely data.

To address these barriers, **Mid-State Health Network** initiated the following interventions:

- The PIHP developed and provided a brief document to the PCPs and CMHSP clinicians that explains when it is appropriate for protected health information (PHI) to be shared for the purposes

of coordination of care, treatment, and payment. The PIHP medical director provided education related to PHI to be shared for the purposes of coordination of care, treatment, and payment to the joint group of medical directors and PCPs.

- The PIHP implemented a process to improve transportation availability. This included the development of an information sheet to provide to members at the time of their appointments with instructions for accessing the transportation available in each CMHSP's geographical location.
- The PIHP implemented a process for lab services to be obtained on-site at each CMHSP location. This included a mobile lab, trained medical staff members, and an on-site lab draw station.
- The CMHSP utilized care alerts to determine who does not have a claim for a completed lab. A record review is completed to identify if a lab was ordered. If the results are in the record and a claim was submitted to Medicare, the CMHSP can enter "addressed" into the Integrated Care Data Platform (ICDP).
- The PIHP developed and implemented a process for quarterly data validation to ensure data received from the Care Connect 360 extract and processed by Zenith Technologies in the ICDP is consistent with the HEDIS specifications and is completed within the expected time frames.

3. Conclusions and Recommendations

Conclusions

The ***Patient With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test*** PIP received a *Met* validation score for 100 percent of critical evaluation elements, 100 percent for the overall evaluation elements across all steps validated, and a *Met* validation status. **Mid-State Health Network** developed a methodologically sound improvement project. The PIHP collected and reported accurate study indicator results using a systematic data collection process and conducted appropriate statistical testing for comparison between measurement periods. The causal/barrier analysis process included the use of appropriate quality improvement tools and a collaboration with the regional medical directors' group in the identification and prioritization of barriers. The PIHP achieved statistically significant improvement over the baseline performance for the study indicator.

Recommendations

As the PIP progresses, HSAG recommends the following:

- **Mid-State Health Network** should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- **Mid-State Health Network** should continue to evaluate the effectiveness of each intervention. Decisions to continue, revise, or discontinue an intervention must be data driven.
- **Mid-State Health Network** should seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.
- **Mid-State Health Network** should reference the PIP Completion Instructions annually to ensure that all requirements for each completed step have been addressed.

Appendix A. PIP Validation Tool

The following contains the final PIP validation tool for **Mid-State Health Network**.

Demographic Information			
Plan Name:	Region 5 - Mid-State Health Network		
Project Leader Name:	Sandy Gettel	Title:	Quality Manager
Telephone Number:	(517) 220-2422	E-mail Address:	sandy.gettel@midstatehealthnetwork.org
Name of Project:	***Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test***		
Submission Date:	8/13/2021		

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
1.	**Select the Study Topic(s): The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of healthcare. The topic may also be specified by the State. The study topic:**		
C*	1. Was selected following collection and analysis of data. N/A is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The study topic was selected following the collection and analysis of the plan-specific data.
	2. Has the potential to affect member health, functional status, or satisfaction. The scoring for this element will be Met or Not Met.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIP has the potential to affect member health, functional status, or satisfaction.

Results for Step 1

Total Evaluation Elements

Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
2	2	0	0	0

Critical Elements

Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements	Scoring	Comments
Performance Improvement Project Validation		
2. **Define the Study Question(s): Stating the study question(s) helps maintain the focus of the QIP and sets the framework for data collection, analysis, and interpretation. The study question:**		
C* 1. Was stated in simple terms and in the recommended X/Y format. N/A is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The study question was stated in simple terms using the recommended X/Y format.

Results for Step 2

Total Evaluation Elements

Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

Critical Elements

Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements	Scoring	Comments
Performance Improvement Project Validation		
3. **Define the Study Population: The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding members with special healthcare needs. The study population:**		
C* 1. Was accurately and completely defined and captured all members to whom the study question(s) applied. N/A is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP accurately and completely defined the study population. **General Comment**: The PIHP should use the most recent version of the HEDIS technical specifications for each remeasurement period. **Re-review August 2021**: The PIHP clarified that the most recent version of the HEDIS technical specifications were used. The general comment has been addressed.

Results for Step 3

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
4.	**Select the Study Indicator(s): A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The study indicator(s):**		
C*	1. Was well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The study indicators were based on HEDIS technical specifications. **General Comment**: The PIHP should use the most recent version of the HEDIS technical specifications for each remeasurement period. **Re-review August 2021**: The PIHP clarified that the most recent version of the HEDIS technical specifications were used. The general comment has been addressed.
	2. Included the basis on which the indicator(s) was developed, if internally developed.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	The study indicator was not internally developed.

Results for Step 4

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
2	1	0	0	1

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
5.	**Use Sound Sampling Techniques: (If sampling is not used, each evaluation element will be scored Not Applicable [NA]). If sampling is used to select members in the population, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling methods:**		
	1. Included the measurement period for the sampling methods used (e.g., baseline, Remeasurement 1).	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	2. Included the title of applicable study indicator(s).	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	3. Included the population size.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
C*	4. Included the sample size.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	5. Included the margin of error and confidence level.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
	6. Described in detail the method used to select the sample.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.
C*	7. Allowed for the generalization of results to the study population.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling will not be used.

Results for Step 5

Total Evaluation Elements

Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
7	0	0	0	7

Critical Elements

Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
2	0	0	0	2

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
6.	**Reliably Collect Data: The data collection process must ensure that the data collected on the study indicator(s) was valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures include:**		
	1. Clearly defined sources of data and data elements collected. N/A is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The documentation included the data sources and data elements for collection.
C*	2. A clearly defined and systematic process for collecting data that included how baseline and remeasurement data were collected. N/A is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP specified a systematic method for collecting baseline and remeasurement data.
C*	3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	The PIHP used administrative data collection only.
	4. The estimated degree of administrative data completeness percentage. Met = 80-100 percent Partially Met = 50-79 percent Not Met = <50 percent or not provided	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The estimated degree of administrative data completeness was between 80 percent and 100 percent, and the PIHP explained how it determined the administrative data completeness.

Results for Step 6

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
4	3	0	0	1

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
2	1	0	0	1

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
7.	**Analyze Data and Interpret Study Results: Clearly present the results for each study indicator(s). Describe the data analysis performed and the results of the statistical analysis, if applicable, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined. The data analysis and interpretation of the study indicator outcomes:**		
C*	1. Included accurate, clear, consistent, and easily understood information in the data table.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP included accurate, clear, consistent, and easily understood information in the data table.
	2. Included a narrative interpretation that addresses all required components of data analysis and statistical testing.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	It appears that the PIHP conducted its statistical testing comparing Remeasurement 2 (R2) to Remeasurement 1 (R1). Each remeasurement period should be compared to the baseline. The PIHP must recalculate the statistical testing and accurately report the outcomes using R2 and the baseline. **Re-review August 2021**: The PIHP conducted statistical testing comparing Remeasurement 2 to the baseline. The validation score for this evaluation element has been changed to *Met*.
	3. Identified factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP identified and discussed factors that threatened the internal or external validity of the findings.

Results for Step 7

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
3	3	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
8.	**Improvement Strategies(interventions for improvement as a result of analysis): Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies are developed from an ongoing quality improvement process that included:**		
C*	1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP documented its causal/barrier analysis process, described its quality improvement (QI) team, processes/steps, and tools used.
	2. Barriers that were identified and prioritized based on results of data analysis and/or other quality improvement processes.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	Identified barriers were prioritized based on data analysis and/or appropriate quality improvement processes.
C*	3. Interventions that were logically linked to identified barriers and will directly impact study indicator outcomes.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The interventions were logically linked to identified barriers and have the potential to impact indicator outcomes.
	4. Interventions that were implemented in a timely manner to allow for impact of study indicator outcomes.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The interventions were implemented in a timely manner to allow for impact of the indicator outcomes.
C*	5. Evaluation of individual interventions for effectiveness.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP described its process for evaluating the effectiveness of each intervention and included the evaluation results.
	6. nterventions that were continued, revised, or discontinued based on evaluation results.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	Interventions were continued, revised, or discontinued based on evaluation for effectiveness of outcomes.

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements	Scoring	Comments
Performance Improvement Project Validation		

Results for Step 8

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
6	6	0	0	0	3	3	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
9.	**Assess for Real Improvement: Real improvement or meaningful change in performance is evaluated based on study indicator(s) results.**		
	1. The remeasurement methodology was the same as the baseline methodology.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	Repeated measurements used the same methodology as was used for the baseline measurement.
	2. The documented improvement meets the State- or plan-specific goal.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The study indicator achieved the plan-specific goal.
C*	3. There was statistically significant improvement over the baseline across all study indicators.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIHP achieved statistically significant improvement over the baseline for the study indicator.

Results for Step 9

Total Evaluation Elements

Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
3	3	0	0	0

Critical Elements

Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
10.	**Assess for Sustained Improvement: Sustained improvement is demonstrated through repeated measurements over comparable time periods.**		
C*	1. Repeated measurements over comparable time periods demonstrated sustained improvement over the baseline.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	Not Assessed. Sustained improvement cannot be assessed until statistically significant improvement over the baseline has been achieved across all study indicators, and a subsequent measurement period has been reported.

Results for Step 10

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*Not Applicable*
1	0	0	0	0

* "C" in this column denotes a critical evaluation element.
** This is the total number of all evaluation elements for this review step.
*** This is the total number of critical evaluation elements for this review step.

Table A-1—2020-2021 PIP Validation Tool Scores: Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test for Region 5 - Mid-State Health Network											
	Review Step	**Total Possible Evaluation Elements (Including Critical Elements)**	**Total Met**	**Total Partially Met**	**Total Not Met**	**Total NA**	**Total Possible Critical Elements**	**Total Critical Elements Met**	**Total Critical Elements Partially Met**	**Total Critical Elements Not Met**	**Total Critical Elements NA**
1.	Select the Study Topic(s)	2	2	0	0	0	1	1	0	0	0
2.	Define the Study Question(s)	1	1	0	0	0	1	1	0	0	0
3.	Define the Study Population	1	1	0	0	0	1	1	0	0	0
4.	Select the Study Indicator(s)	2	1	0	0	1	1	1	0	0	0
5.	Use Sound Sampling Techniques	7	0	0	0	7	2	0	0	0	2
6.	Reliably Collect Data	4	3	0	0	1	2	1	0	0	1
7.	Analyze Data and Interpret Study Results	3	3	0	0	0	1	1	0	0	0
8.	Improvement Strategies(interventions for improvement as a result of analysis)	6	6	0	0	0	3	3	0	0	0
9.	Assess for Real Improvement	3	3	0	0	0	1	1	0	0	0
10.	Assess for Sustained Improvement	1		Not Assessed			1	Not Assessed			
Totals for All Steps		**30**	**20**	**0**	**0**	**9**	**14**	**10**	**0**	**0**	**3**

Table A-2—2020-2021 PIP Validation Tool Overall Score: Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test for Region 5 - Mid-State Health Network	
Percentage Score of Evaluation Elements Met*	**100%**
Percentage Score of Critical Elements Met**	**100%**
Validation Status***	***Met***

* The percentage score for all evaluation elements Met is calculated by dividing the total Met by the sum of all evaluation elements Met, Partially Met, and Not
The Not Assessed and Not Applicable scores have been removed from the scoring calculation

** The percentage score of critical elements Met is calculated by dividing the total critical elements Met by the sum of the critical elements Met, Partially Met, and Not

*** Met equals high confidence/confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not credible.

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS
HSAG assessed the validity and reliability of the results based on CMS validation protocols and determined whether the State and key stakeholders can have confidence in the reported PIP findings. Based on the validation of this PIP, HSAG's assessment determined the following:
Met: **High confidence/confidence in reported PIP results. All critical evaluation elements were Met, and 80 to 100 percent of all evaluation elements were Met across all activities.** ***Partially Met:*** **Low confidence in reported PIP results. All critical evaluation elements were Met, and 60 to 79 percent of all evaluation elements were Met across all activities; or one or more critical evaluation elements were Partially Met.** ***Not Met:*** **All critical evaluation elements were Met, and less than 60 percent of all evaluation elements were Met across all activities; or one or more critical evaluation elements were Not Met.**

Summary of Aggregate Validation Findings

[X]	***Met***	[ ]	***Partially Met***	[ ]	***Not Met***

Appendix B. PIP Summary Form

Appendix B contains the final PIP Summary Form **Mid-State Health Network** submitted to HSAG for validation. HSAG made only minor grammatical corrections to these forms; the content/meaning was not altered. This appendix does not include any attachments provided with the PIP submission.

Appendix B: State of Michigan 2020-21 PIP Summary Form
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test
for Region 5 - Mid-State Health Network

Demographic Information	
Plan Name: **Mid-State Health Network**	Type of Delivery System: Clinical
Project Leader Name: Sandy Gettel	Title: Quality Manager
Telephone Number: 517-220-2422	Email Address: sandy.gettel@midstatehealthnetwork.org
Name of Project: Patient(s) with Schizophrenia and Diabetes who had an HbA1c and LDL-C test during the report period.	
Submission Date: June 28, 2021	
Resubmission Date: August 13, 2021	

Appendix B: State of Michigan 2020-21 PIP Summary Form Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test for Region 5 - Mid-State Health Network

Step 1: Select the Study Topic. The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of healthcare. The topic may also be specified by the State.

Study Topic: The study topic is "Patient(s) with schizophrenia and diabetes who had an HbA1c and LDL-C test during the report period." The study topic aligns with a HEDIS Measure. The study topic was one of the identified topics by the Michigan Department of Health and Human Services Shared Metric Workgroup. This workgroup developed a list of topics, including this one, to have shared monitoring of health plan performance on national measures.

The goal of this PIP is to ensure that adult consumers with schizophrenia and diabetes receive both the HbA1c and LDL-C tests to ensure ongoing monitoring of an existing health condition.

The previous performance improvement project completed by Mid-State Health Network was "Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications." This project demonstrated positive results by meeting the established goals during remeasurement period one and remeasurement period two. The percentage of those who completed the diabetes screenings was 73.7% at baseline and was at 80.4% for remeasurement period two. The interventions applied included utilizing the ICDP database to run care alert reports monthly providing real time data, providing education to beneficiaries during person-centered planning on the importance of ongoing monitoring by a primary care physician and coordinating the completion of the screenings through the CMHSP or through the primary care physician. The results of this project exceeded our established goals. When compared to benchmark rates, MSHN started at 73.7% during baseline as compared to 83.6% for the Medicaid Health Plans and showed a marked improvement by our observed rate being at 80.4% and the Medicaid Health Plans rate being at 82.6% during remeasurement period two.

Based on the success of the interventions being applied, choosing the project "Patient(s) with Schizophrenia and Diabetes who had an HbA1c and LDL-C test during the report period" was a natural next step to continue to utilize the interventions to full capacity and to continue to emphasis coordination of care among beneficiaries.

Provide plan-specific data: This topic was chosen by the PIHP to make sure consumers were receiving certain physical health screenings and tests that might be performed outside of standard age- and sex-specific guidelines. HEDIS definitions were used as these are the gold standard for patient care and by using these guidelines, PIHP findings can be compared to other healthcare organizations (more directly

Step 1: Select the Study Topic. The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of healthcare. The topic may also be specified by the State.

comparable to other PIHPs as socioeconomic factors would be similar). The HbA1c is relevant to test for blood glucose levels over time as it quantifies how well an individual's blood glucose levels are being controlled. The LDL-C is relevant to predict an individual's risk of developing heart disease. Typically, those who have been diagnosed with diabetes have an increased risk for heart disease. Completing both the HbA1c and the LDL-C will test for controlled blood glucose levels and risks for developing heart disease.

Historical Data for the region is not available for MSHN.

Baseline data received during the report period January 1, 2018 through December 31, 2018 for "Patient(s) with Schizophrenia and Diabetes who had an HbA1c and LDL-C test during the report period" indicated that MSHN had a rate of 52.6% (543/1031) for those who received a HbA1c and LDL-C. By comparison, the Michigan Weighted Average (MWA)which consists of the Medicaid Health Plans in Michigan, demonstrated 69.97% for those who received a HbA1c and LDL-C test during the baseline measurement year.

During a validation check it was identified that the diagnosis of Bi-polar and Schizophrenia were both included in the baseline data for the calendar year 2018. The diagnosis of Bipolar should not be included in the specifications for the "Patient(s) with Schizophrenia and Diabetes who had an HbA1c and LDL-C test during the report period" project. This error occurred when the measurement periods were changed from fiscal year to calendar year. The baseline data was then rerun with the correct specifications. The revised baseline data was determined to be 33.6 percent (294/874).

Describe how the study topic has the potential to improve consumer health, functional status, or satisfaction: HEDIS measures are designed to assess the quality of healthcare services received and this topic will help identify whether those receiving specialty behavioral health services for schizophrenia are receiving screenings and tests related to controlling diabetes and assessing risks for heart disease.

Step 2: Define the Study Question(s). Stating the question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The Study Question(s) should:

- Be structured in the recommended X/Y format: "Does doing X result in Y?"
- State the problem in clear and simple terms.
- Be answerable based on the data collection methodology and study indicator(s).

Study Question(s): Do targeted interventions increase the percentage of consumers diagnosed with schizophrenia who have an annual HbA1c and LDL-C test?

Step 3: Define the Study Population. The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding consumers with special healthcare needs.

The study population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include the inclusion, exclusion, and diagnosis criteria.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify consumers, if applicable.
- Capture all consumers to whom the study question(s) applies.
- Include how race and ethnicity will be identified, if applicable.

Study Population: Medicaid enrolled adults with schizophrenia who have been diagnosed with diabetes.

Enrollment requirements (if applicable): Medicaid eligible adults (18-64 years old) receiving services from the PIHP who have at least one PIHP reported encounter to the State's data warehouse. Continuous Medicaid Enrollment applies to the study question. Members with more than one gap in enrollment, or one gap greater than 45 days as determined by the 834 enrollment file will be excluded. Included Medicaid Scope and coverage codes D1, D2, F1, F2, K1, K2, P1, T1, T2.

Consumer age criteria (if applicable): Adults age 18 years to 64 years of age as of the end of the measurement period.

Inclusion, exclusion, and diagnosis criteria:

The potentially eligible members will include those between the ages of 18 and 64, at of the end of the measurement period, who also satisfy the following:

- One, or both, of the following conditions during the measurement year:
  - At least one acute inpatient encounter, with any diagnosis of schizophrenia
  - At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia

Step 3: Define the Study Population. The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding consumers with special healthcare needs.

The study population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include the inclusion, exclusion, and diagnosis criteria.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify consumers, if applicable.
- Capture all consumers to whom the study question(s) applies.
- Include how race and ethnicity will be identified, if applicable.

- Members with diabetes, must be determined by the following (during the measurement year or the year prior to the measurement year)
    - Claim/encounter data:
        - At least two outpatient visits, observation visits, ED visits or nonacute inpatient encounters, on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two encounters
        - At least one acute inpatient encounter with a diagnosis of diabetes
    - Pharmacy data:
        - Members who were dispensed insulin or oral hypoglycemic/anti-hyperglycemic on an ambulatory basis

The eligible population, will be calculated by excluding the potentially eligible members who meet the following conditions:

- Members with no more than one gap in enrollment of up to 45 days during the measurement year as determined by the 834 enrollment file. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled.

Diagnosis/procedure/pharmacy/billing codes (if applicable):

The attached *SMD_Value Sets-2018.xlsx* file of the code sets published in 2018 by the National Quality Forum to be used for the HEDIS measure "Patient(s) with Schizophrenia and Diabetes who had an HbA1c and LDL-C test during the report period" were used.

Step 3: Define the Study Population. The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding consumers with special healthcare needs.

The study population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include the inclusion, exclusion, and diagnosis criteria.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify consumers, if applicable.
- Capture all consumers to whom the study question(s) applies.
- Include how race and ethnicity will be identified, if applicable.

A summary of HEDIS specification changes for 2019. The impact of the changes can be found in Step VII.

- *Clarified that schizoaffective disorder is included in the measure in the description and step 1 of the event/diagnosis.*
- *Incorporated telehealth into the measure specification*
- *Restructured the e codes and value sets for identifying members with schizophrenia (step 1). Refer to the Value Set Directory for adetailed summary of changes.*

The attached SMD Value Set 2019 file code sets published in 2018 by the National Quality Forum to be used for the HEDIS measure "Patients(s) with Schizophrenia and Diabetes who had an HbA1c and LDL-C test during the report period" were used.

A summary of HEDIS specification changes for 2020. The impact of the changes can be found in Step VII.

- *Modified value sets to make them compatible with digital measure formatting.*
- *Removed "with or without a telehealth modifier" language; refer to General Guideline 43.*
- *Clarified the telehealth requirements for identifying the event/diagnosis.*
- *Updated value sets used to identify acute and nonacute inpatient events with a diagnosis of diabetes.*
- *Added the Rules for Allowable Adjustments of HEDIS section.*

The attached SMD Value Set 2020 file code sets published in 2019 by the National Quality Forum to be used for the HEDIS measure "Patients(s) with Schizophrenia and Diabetes who had an HbA1c and LDL-C test during the report period" were used.

Step 4: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound. **The description of the study Indicator(s) should:** • Include the complete title of the study indicator(s). • Include a narrative description of the numerator(s) and denominator(s). • Include the rationale for selecting the study indicator(s). • If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually. • Include complete dates for all measurement periods (with the day, month, and year). • Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound. • Include the State-designated goal, if applicable.	
Study Indicator 1: Patient(s) with Schizophrenia and Diabetes who had an HbA1c and LDL-C test during the report period .	**Provide a narrative description and the rationale for selection of the study indicator. Describe the basis on which the indicator was adopted, if internally developed.** The goal of this PIP is to ensure that adult consumers with schizophrenia and diabetes receive both the HbA1c and LDL-C tests to ensure ongoing monitoring of an existing health condition. The study topic aligns with the HEDIS Measure "Patient(s) with schizophrenia and diabeteswho had an HbA1c and LDL-C test during the report period" as specified in the most recent HEDIS Technical Specifications.

Step 4: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound. **The description of the study Indicator(s) should:** • Include the complete title of the study indicator(s). • Include a narrative description of the numerator(s) and denominator(s). • Include the rationale for selecting the study indicator(s). • If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually. • Include complete dates for all measurement periods (with the day, month, and year). • Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound. • Include the State-designated goal, if applicable.	
	This topic was chosen by the PIHP to make sure consumers were receiving certain physical health screenings and tests that might be performed outside of standard age- and sex-specific guidelines. HEDIS definitions were used as these are the gold standard for patient care and by using these guidelines, PIHP findings can be compared to other healthcare organizations (more directly comparable to other PIHPs as socioeconomic factors would be similar). The HbA1c is relevant to test for blood glucose levels over time as it quantifies how well an individual's blood glucose levels are being controlled. The LDL-C is relevant to predict an individual's risk of developing heart disease. Typically, those who have been diagnosed with diabetes have an increased risk for heart disease. Completing both the HbA1c and the LDL-C will test for controlled blood glucose levels and risks for developing heart disease.
Numerator Description:	Those in the denominator who had the HbA1c and an LDL-C test performed during the measurement year.

Step 4: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include a narrative description of the numerator(s) and denominator(s).
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Denominator Description:	The entire eligible populations for the study indicator based on HEDIS specifications for the SMD measure.
Baseline Measurement Period (include date range) 01/01/2018 – 12/31/2018	01/01/2018 – 12/31/2018
Remeasurement 1 Period (include date range) 01/01/2019 – 12/31/2019	01/01/2019- 12/31/2019
Remeasurement 1 Period Goal	A 7% increase over the baseline rate (not a 7 percentage-point increase Revised: The baseline rate is 33.6%. The remeasurement 1 goal is 36.0%. See step 1 on page 3 for reason of revision.
Remeasurement 2 Period (include date range) 01/01/2020 – 12/31/2020	01/01/2020 -12/31/2020

Step 4: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include a narrative description of the numerator(s) and denominator(s).
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Remeasurement 2 Period Goal	A 7% increase over the remeasurement period 1 rate of 36.1%. The remeasurement period 2 goal is 38.6%.
State-Designated Goal or Benchmark	N/A (However, health plan ranking from MI2020 HEDIS 2020 Results Statewide Aggregate Report indicated the Michigan Weighted Average for those who received a HbA1c and LDL-C test during 2020 measurement year was 68.3%. 68.3% excludes those enrolled in Medicare and Medicaid.
Source of Benchmark	
Study Indicator 2: [Enter title]	**Provide a narrative description and the rationale for selection of the study indicator. Describe the basis on which the indicator was adopted, if internally developed.** *Not Applicable – Only one Study Indicator for this Project*
Numerator Description:	*Not Applicable – Only one Study Indicator for this Project*
Denominator Description:	*Not Applicable – Only one Study Indicator for this Project*

Step 4: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include a narrative description of the numerator(s) and denominator(s).
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Baseline Measurement Period (include date range) MM/DD/YYYY to MM/DD/YYYY	*Not Applicable – Only one Study Indicator for this Project*
Remeasurement 1 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	*Not Applicable – Only one Study Indicator for this Project*
Remeasurement 1 Period Goal	*Not Applicable – Only one Study Indicator for this Project*
Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	*Not Applicable – Only one Study Indicator for this Project*

Step 4: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound. **The description of the study Indicator(s) should:** • Include the complete title of the study indicator(s). • Include a narrative description of the numerator(s) and denominator(s). • Include the rationale for selecting the study indicator(s). • If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually. • Include complete dates for all measurement periods (with the day, month, and year). • Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound. • Include the State-designated goal, if applicable.	
Remeasurement 2 Period Goal	*Not Applicable – Only one Study Indicator for this Project*
State-Designated Goal or Benchmark	*Not Applicable – Only one Study Indicator for this Project*
Source of Benchmark	*Not Applicable – Only one Study Indicator for this Project*
Study Indicator 3: [Enter title]	**Provide a narrative description and the rationale for selection of the study indicator. Describe the basis on which the indicator was adopted, if internally developed.** *Not Applicable – Only one Study Indicator for this Project*
Numerator Description:	*Not Applicable – Only one Study Indicator for this Project*
Denominator Description:	*Not Applicable – Only one Study Indicator for this Project*

Step 4: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include a narrative description of the numerator(s) and denominator(s).
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Baseline Measurement Period (include date range) MM/DD/YYYY to MM/DD/YYYY	*Not Applicable – Only one Study Indicator for this Project*
Remeasurement 1 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	*Not Applicable – Only one Study Indicator for this Project*
Remeasurement 1 Period Goal	*Not Applicable – Only one Study Indicator for this Project*
Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	*Not Applicable – Only one Study Indicator for this Project*

Step 4: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include a narrative description of the numerator(s) and denominator(s).
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Remeasurement 2 Period Goal	*Not Applicable – Only one Study Indicator for this Project*
State-Designated Goal or Benchmark	*Not Applicable – Only one Study Indicator for this Project*
Source of Benchmark	*Not Applicable – Only one Study Indicator for this Project*

Use this area to provide additional information, if necessary.

Step 5: Use Sound Sampling Techniques. If sampling is used to select consumers of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling techniques should be in accordance with generally accepted principles of research design and statistical analysis.

The description of the sampling methods should:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each study indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling techniques support generalizable results.

Measurement Period	Study Indicator	Population Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY–MM/DD/YYYY				

Describe in detail the methods used to select the sample:

N/A, all eligible consumers will be included in the study.

Appendix B: State of Michigan 2020-21 PIP Summary Form
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test
for Region 5 - Mid-State Health Network

Step 6: Reliably Collect Data. The data collection process must ensure that data collected for the study indicators are valid and reliable.

The data collection methodology should include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the study indicators.
- A copy of the manual data collection tool, if applicable.
- An estimate of the administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply)

[ ] Hybrid—Both medical/treatment record review (manual data collection) and administrative data.

[ ] Medical/Treatment Record Abstraction
- Record Type
  - [ ] Outpatient
  - [ ] Inpatient
  - [ ] Other

_____

Other Requirements
- [ ] Data collection tool attached
- [ ] Other data

_____

[X] Administrative Data
- Data Source
  - [X] Programmed pull from claims/encounters
  - [ ] Complaint/appeal
  - [X] Pharmacy data
  - [ ] Telephone service data/call center data
  - [ ] Appointment/access data
  - [ ] Delegated entity/vendor data _____
  - [X] Other _Medicaid Claims Dataset_____

Other Requirements
- [X] Codes used to identify data elements (e.g., ICD-9/ICD-10, CPT codes)___ ICD-9/10, CPT Codes, NDC_____
- [ ] Data completeness assessment attached
- [ ] Coding verification process attached

Estimated percentage of administrative data completeness: _95_ percent.

[ ] Survey Data
- Fielding Method
  - [ ] Personal interview
  - [ ] Mail
  - [ ] Phone with CATI script
  - [ ] Phone with IVR
  - [ ] Internet
  - [ ] Other

_____

Other Requirements
- [ ] Number of waves

_____
- [ ] Response rate _____
- [ ] Incentives used _____

Step 6: Reliably Collect Data. The data collection process must ensure that data collected for the study indicators are valid and reliable. **The data collection methodology should include the following:** • Identification of data elements and data sources. • When and how data are collected. • How data are used to calculate the study indicators. • A copy of the manual data collection tool, if applicable. • An estimate of the administrative data completeness percentage and the process used to determine this percentage.		
	Describe the process used to determine data completeness: Claims and encounters are submitted to MDHHS from all types of providers. MDHHS will not accept claims/encounters into its warehouse without meeting the minimum standards for submission. Providers are required to submit Medicaid encounters to MDHHS within 30 days after the service was provided. Transactions will not be accepted if they do not meet completeness requirements. Typically, over 95% of the transactions are submitted within the 30 days after service date timeframes.	

Step 6: Determine the Data Collection Cycle.	Determine the Data Analysis Cycle.
[ ] Once a year [ ] Twice a year [ ] Once a season [X] Once a quarter [ ] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe):	[X] Once a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe):

Describe the data collection process:

Data analysis plan:

Rates are determined by dividing the number of those in the study population with the physical health service of interest (HbA1c and LDL-C) by all those in the study population. Rates will be compared between measurement periods using 2-proportion tests (95% two-sided confidence interval). Benchmark rates for the same HEDIS measure are available for a single year for Medicaid Health Plans in Michigan and will be used to compare to MSHN rates using 2-proportion tests (95% two-sided confidence interval). The Michigan specifications for the HEDIS measure excludes those with Medicare and Medicaid.

Data collection process:

Data from the Medicaid Claims Dataset are all physical and mental health claims (excluding substance use disorder claims) for CMHSP consumers that were paid by Medicaid. Claims are updated nightly and available for the PIHP to retrieve from MDHHS once per week. Claims can be retrieved less frequently from MDHHS as well. These claims contain information on eligibility criteria (prescription fills) as well as outcomes of interest (PCP visits and HbA1c and LDL-C test). Claims are limited to identifying that a service was provided (with associated ICD-9/10 codes where applicable) but do not report the results from any screenings/tests.

Step 1: The PIHP will use the enrollment file (834) to identify all Medicaid enrollees in the measurement year. A file listing these individuals (5656) is uploaded per MDHHS requirements to DEG mailbox.

Step 2: On the following Monday morning claims files (5657) should be ready for downloading from the DEG mailbox

Step 3: Data is imported and merged with any previous claims data files

Step 4: The potentially eligible members will include those between the ages of 18 and 64, at of the end of the measurement period, who also satisfy the following:

- One, or both, of the following conditions during the measurement year:
  - At least one acute inpatient encounter, with any diagnosis of schizophrenia
  - At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia

Describe the data collection process:

- Members with diabetes, must be determined by the following (during the measurement year or the year prior to the measurement year)
  - Claim/encounter data:
    - At least two outpatient visits, observation visits, ED visits or nonacute inpatient encounters, on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two encounters
    - At least one acute inpatient encounter with a diagnosis of diabetes
  - Pharmacy data:
    - Members who were dispensed insulin or oral hypoglycemic/anti-hyperglycemic on an ambulatory basis

Step 5: The eligible population (denominator), will be calculated by excluding the potential eligible members who meet the following conditions:

- Members with no more than one gap in enrollment of up to 45 days during the measurement year as determined by the 834 enrollment file. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled.

Step 6: The progress of the eligible population (numerator), will be calculated by counting the members who meet the following condition:

- A HbA1c and LDL-C tests performed during the measurement year

Data retrieval and analysis can be done by PIHP-contracted personnel or through a vendor supplied this same Medicaid Claims Data by the PIHP. Either process will follow the same data collection steps and yield the same results.

To ensure the completeness and accuracy of the data in determining the study indicator rate, the PIHP will take into account the time lag allowed for the submission of claims for the CMHSP consumers. The data utilized to determine the study indicator rate will be retrieved for analysis 90 days after the end of the measurement period.

Appendix B: State of Michigan 2020-21 PIP Summary Form
Patients With Schizophrenia and Diabetes Who Had an HbA1c and LDL-C Test
for Region 5 - Mid-State Health Network

Step 7: Study Indicator Results. Enter the results of the study indicator(s) in the table below. For HEDIS-based PIPs, the data reported in the PIP Summary Form should match the validated performance measure rate(s).

Enter results for each study indicator—including the goals, statistical testing with complete *p* values, and the statistical significance—in the table provided.

Study Indicator 1 Title: [Enter title of study indicator]

Time Period Measurement Covers	Indicator Measurement	Numerator	Denominator	Rate or Results	Goal	Statistical Test, Statistical Significance, and *p* Value
01/01/2018–12/31/2018	Baseline	294	874	33.6%	NA	NA
	Remeasurement 1	303	840	36.1%	36.0%	Two sample test of proportions. There is no statistical significance. The p value is .291.
	Remeasurement 2	321	652	49.2%	38.6%	Two sample test of proportions. The difference is statistically significant, with p value <0.0001
	Remeasurement 3					

Study Indicator 2 Title: [Enter title of study indicator]

Time Period Measurement Covers	Indicator Measurement	Numerator	Denominator	Rate or Results	Goal	Statistical Test, Statistical Significance, and *p* Value
MM/DD/YYYY–MM/DD/YYYY	Baseline					
	Remeasurement 1					

Step 7: Study Indicator Results. Enter the results of the study indicator(s) in the table below. For HEDIS-based PIPs, the data reported in the PIP Summary Form should match the validated performance measure rate(s).

Enter results for each study indicator—including the goals, statistical testing with complete *p* values, and the statistical significance—in the table provided.

	Remeasurement 2					
	Remeasurement 3					

Step 7: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

Describe the data analysis process and provide an interpretation of the results for each measurement period.

Baseline Measurement:

For the Baseline Measurement period of 01/01/2018-12/31/2018, the total number of Medicaid Beneficiaries that were eligible to be included in the study were 1032. MSHN had a total of 543 beneficiaries (52.6%), out of the eligible 1032, have had an LDL-C and a HbA1c test performed during the baseline measurement year. MSHN's goal for Baseline to Remeasurement Period one is to increase the results by a 7%, to 56.3%, which is a 3.7% percentage point increase over the baseline rate of 52.6%.

Revised Baseline Measurement:

For the Baseline Measurement period of 01/01/2018-12/31/2018, the total number of Medicaid Beneficiaries that were eligible to be included in the study were 874. MSHN had a total of 294 beneficiaries (33.6%) out of the eligible 874, who had an LDL-C and a HbA1c test performed during the baseline measurement year. MSHN's goal for Baseline to Remeasurement Period one is to increase the results by 7%, to 36.0% which is a 2.40 percentage point increase over the baseline rate of 33.6%

For the Baseline Measurement period, rates were determined by dividing the number of those in the study population with the physical health service of interest (diabetes monitoring) by all those in the study population. Rates will be compared between measurement period using 2-proportion tests (95% two-sided confidence interval). Benchmark rates for the same HEDIS measure are available for a single year for

Step 7: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

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- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

Medicaid Health Plans in Michigan and will be used to compare to MSHN rates using 2-proportion tests (95% two-sided confidence interval).

Benchmark Data Source.

Performance benchmarks were obtained by summarizing performance by health plans across Michigan using the data published on the Michigan Department of Health and Human Services (MDHHS) website for the 2018 HEDIS results, 2019 HEDIS results, and the 2020 HEDIS results. For the measurement periods of 2018, 2019, and 2020 we used figures reported in Figure 8-34 (2018 HEDIS Report), Figure 8-34 (2019 HEDIS Report), and Figure 8-34 (2020 HEDIS Report) respectively. Those figures provide screening rates and population sizes for each Medicaid health plan. For instance, for the UPP plan in 2020, the rate is 81.3% for a
population of 80, which means that (0.8125)(80) = 65 were screened in 2020 in UPP. Similar counts of screened individuals were determined for the other reported groups.

Using the same process, the screened rate among baseline groups from Figure 8-34 of the
2020 HEDIS Report is 1,701 out of 2490 or 0.6831.
2019 HEDIS Report is 1,634 out of 2,316 or 0.7056
2018 HEDIS Report is 1,585 out of 2,265 or 0.6997.

It should be noted that individuals with both Medicaid and Medicare are excluded from theAggregated HEDIS Report.

Factors that may impact the data

It was identified that the incorrect specifications had been applied following a change in the measurement year from fiscal year to calendar

Step 7: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

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- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

year. This resulted in a recalculation of the baseline rate. Prior to this identification, the PIHP had been reaching the goal as specified. Once the issue was identified and the new baseline was rerun, enough time was not allowed for reassessment of and application of additional interventions to impact the final remeasurement data.

The specification for this HEDIS measure was revised for 2019. The baseline year utilized the 2018 HEDIS specifications.

The remeasurement year 1 utilized the 2019 HEDIS specifications.

A summary of changes that may have an impact on the project going forward include the following:

- *Clarified that schizoaffective disorder is included in the measure in the description and step 1 of the event/diagnosis.* The clarification of the inclusion of the schizoaffective disorder will have no impact on MSHN data going forward. This was a clarification and not an addition. The schizoaffective disorder had already been included in the data set for MSHN.
- *Incorporated telehealth into the measure specification.* The telehealth codes added to the value set will increase the denominator in such a way that was not allowed in 2018. The addition of this will negatively impact the rates as it is not possible to obtain the required laboratory tests through a telehealth service included in the 2019 specifications.

Restructured the codes and value sets for identifying members with schizophrenia (step 1). Refer to the Value Set Directory for adetailed summary of changes. As indicated above this change will have no impact since the schizoaffective codes were already included in the MSHN Data.

Step 7: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

Remeasurement year 2 utilized the 2020 HEDIS specifications.

A summary of changes in the 2020 specifications area as follows:

- *Modified value sets to make them compatible with digital measure formatting*. This change has had no impact on the project.
- *Removed "with or without a telehealth modifier" language; refer to General Guideline 43*. This change had no impact on the project.
- *Clarified the telehealth requirements for identifying the event/diagnosis*. This change had no impact on the project.
- *Updated value sets used to identify acute and nonacute inpatient events with a diagnosis of diabetes*. This change had no impact on the project.
- *Added the Rules for Allowable Adjustments of HEDIS section*. This had had no impact on the project.

Attachment 2 SMD Technical Specifications 2019
Attachment 2a SMD Technical Specifications 2020
Attachment 3 M. HEDIS 2019 Volume 2 VSD 11.05.2018
Attachment 3a M. HEDIS 2020 Volume 2 VSD 10.1.2019

Step 7: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

The following is a description of how the calculations for the remeasurement data for this project are determined based on the 2020 HEDIS Specifications:

(The denominator) The potentially eligible members will include those between the ages of 18 and 64, at of the end of the measurement period, who also satisfy the following:

- One, or both, of the following conditions during the measurement year:
  - At least one acute inpatient encounter, with any diagnosis of schizophrenia or schizoaffective disorder.
  - At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, and with any diagnosis of schizophrenia or schizoaffective disorder.
- Members with diabetes, must be determined by the following (during the measurement year or the year prior to the measurement year)
  - Claim/encounter data:
    - At least two outpatient visits, observation visits, telephone visits, online assessments, ED visits or nonacute inpatient encounters, non-acute inpatient discharges on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two encounters
    - At least one acute inpatient encounter without telehealth, and with a diagnosis of diabetes
    - Only one of the two visits may be a telehealth visit, telephone visit, or an online assessment.
    - Only include acute non-inpatient without telehealth.
  - Pharmacy data:

Step 7: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

- Members who were dispensed insulin or oral hypoglycemic/anti-hyperglycemic on an ambulatory basis

The eligible population (denominator), will be calculated by excluding the potential eligible members who meet the following conditions:

- Members with no more than one gap in enrollment of up to 45 days during the measurement year as determined by the 834-enrollment file. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled.

2019 HEDIS specifications include the following: Clarification of the inclusion of Schizoaffective Disorder. The inclusion of the Telehealth Modifier Value Set and the Telehealth POS Value Set.

The progress of the eligible population (numerator), will be calculated by counting the members who meet the following condition:

- A HbA1c and LDL-C tests performed during the measurement year

Baseline data will be compared to remeasurement period one following completion of the first year. Baseline and remeasurement period one data and remeasurement period one goal will then be compared to remeasurement period two after the close of the second year.

Data will be analyzed against the interventions and used to determine the most/least effective strategies. In areas where significant change has occurred, strategies and interventions that led to the increase will be analyzed. These techniques will be considered for implementation across

Step 7: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

the PIHP.

Currently only baseline data is available, therefore, there is no random variations, population changes, sampling errors or statistical significance discussion that can occur. This will be reviewed during the analysis of the remeasurement one period.

Additionally, there are no factors identified that threaten the internal or external validity of the findings. After a casual/barrier analysis is completed and the data is analyzed for remeasurement period 1, factors that threaten validity may be evident and will be assessed at that time. Any issues that cause errors or any statistically significant increases or decreases that may have occurred during the remeasurement process will be reviewed after the completion of remeasurement period one.

Results and Interpretation

Baseline to Remeasurement 1:

Change in PIHP Performance Compared to Baseline.

To compare the screening rates of the PIHP between 2018 and 2019, we conducted a two sample test of proportions. The rate of screening in the PIHP's 2019 sample is higher (36.1%) than the rate in the 2018 sample (33.6%), demonstrating a 2.5 percentage point (or 7.4 percent) improvement from the 2019 sample over the baseline 2018 sample. The difference is not statistically significant, with P-value 0.2906. A 95% confidence interval for the difference in rate ranges from -2.1 to 6.9 percentage points.

Step 7: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

Comparison of PIHP Monitoring Rates with Benchmark Rates. The result of a two-proportion test for 2019 data show that there is a significant difference (P-value of 3.325×10^{-69}) between the screening rate for MSHN PIHP at 36.1% and the statewide health plans HEDIS rate at 70.6%. A 95% confidence interval gives the difference as being in the range of 30.7 and 38.2 percentage points. A similar analysis performed using data from 2018 shows a significant difference (P-value of 1.254×10^{-77}) between the 2018 PIHP screening rate of 33.6% and the 2018 HEDIS rate of 70%. In the case of 2018 data, a 95% confidence interval for the difference in rate ranges from 32.7 to 40.0 percentage points.
Rates for PIHP monitoring are, in both cases, lower than the benchmark rates at a statistically significant level. This may be in part to the impact of the individuals with dual coverage (Medicaid/Medicare). If MSHN were to exclude those with dual coverage the baseline rate for 2018 would be 67.48% compared to the 2018 Michigan HEDIS results of 69.98%. The MSHN 2019 rate excluding those with dual coverage would be 68.77% compared to the 2019 Michigan HEDIS results of 70.33%.

Change in Benchmark Performance Compared to Previous Year. Earlier we noted that PIHP providers made gains in 2019 over the prior year, where 95% confidence estimates ranging from -2.1 to 6.9 percentage points over 2018 performance. If we conduct a two sample proportion test between HEDIS rates from 2018 to 2019, we see the 95% confidence estimate for the change of overall screening rate for provider groups in the HEDIS Aggregate Report ranges from being down 3.2% to being up 2.1% from 2018 to 2019. Demonstrating similar results to the PIHP comparison from 2018 to 2019.

Step 7: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

Impact Analysis Measurement Baseline to Year 1

It was identified that the incorrect specifications had been applied following a change in the measurement year from fiscal year to calendar year. This resulted in a recalculation of the baseline rate. Prior to this identification, the PIHP had been reaching the goal as specified. Oncethe issue was identified and the new baseline was rerun, enough time was not allowed for reassessment of and application of additional interventions to impact the final remeasurement data. The recalculation results demonstrated a decrease in the number eligible for the study population. The impact of this may have been directly related to the removal of individuals with a Bipolar Disorder. During the previous Individuals with a Bipolar Disorder were included in the previous PIP. Processes was implemented and effective in demonstrating an increase in individuals who were screened for diabetes. The positive effects of the previous performance improvement project were carried over to the current project. Once removed the data was impacted negatively.

MSHN is dependent on the data provided by MDHHS through Care Connect 360 and processed by ICDP. The following factors have animpact on the project:

- System errors or issues related to the attribution of a record to a designated CMHSP at the State level may impact the results.
- Claims submitted by the physicians' offices do not include claims submitted to Medicare for the required lab work, or lab work billedunder a code not included within the value set of the HEDIS specifications.

As indicated above individuals that have received lab work that has been billed to Medicare require coordination with the physician's office to ensure the information about the receipt of the lab work is available. Fifty-four percent of the eligible population include individuals with dualcoverage

Step 7: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

(Medicare /Medicaid). 81% (433) of those not screened had dual coverage ((Medicare /Medicaid). The results of the lab work are dependent on the ability to receive the required evidence of the completed lab work from the physician offices, therefore promoting increased coordination among providers. If MSHN were to exclude those with dual coverage the baseline rate for 2018 would be 67.48% compared to the 2018 Michigan HEDIS results of 69.98%. The MSHN 2019 rate excluding those with dual coverage would be 68.77% compared to the 2019 Michigan HEDIS results of 70.33%.

The specification for this HEDIS measure was revised for 2019. The baseline year utilized the 2018 HEDIS specifications. The remeasurement year 1 utilized the 2019 HEDIS specifications. A summary of changes that may have an impact on the project going forward include the following:

- *Clarified that schizoaffective disorder is included in the measure in the description and step 1 of the event/diagnosis.* The clarification of the inclusion of the schizoaffective disorder will have no impact on MSHN data going forward. This was a clarification and not an addition. The schizoaffective disorder had already been included in the data set for MSHN.
- *Incorporated telehealth into the measure specification.* The telehealth codes added to the value set will increase the denominator in such a way that was not allowed in 2018. The addition of this will negatively impact the rates as it is not possible to obtain the required laboratory tests through a telehealth service included in the 2019 specifications.
- *Restructured the codes and value sets for identifying members with schizophrenia (step 1). Refer to the Value Set Directory for adetailed summary of changes.* As indicated above this change will have no impact since the schizoaffective codes were already included in the

Step 7: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

MSHN Data

An additional factor having an impact on the rate includes the effects of COVID 19 and Executive Orders issued by the Governor. March 2020 through June 2020 (at the time of this reporting) was under various levels of stay at home orders interfering with the ability for individuals to receive non-essential life sustaining services. Contributing factors include limited transportation issues, limited access to laboratories, and physician offices. This has affected all individuals in which we serve, with a significant effect on those that are elderly and/or have compromised immune systems. It is unknown at this time the impact this has had and will have going forward on the ability to obtain the required lab work for this measure.

Impact Analysis Baseline to Remeasurement Year 2

MSHN through the Regional Medical Directors and the Quality Improvement Council have identified factors that have affected the results during 1.1.2020-12.31.2020.

- MSHN is dependent on the data provided by MDHHS through Care Connect 360 and processed by ICDP. Any system errors or issues related to the attribution of a record to a designated CMHSP at the State level may impact the results.
- Claims that have not been submitted via Medicaid and lab work completed but not billed separately are not included in the Care Connect 360 data. Medical record review to confirm completion or coordination with the Primary Care Physician is required to

Step 7: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

obtain health information. Attachment 1 demonstrates the percentage of individuals with both Medicaid and Medicare. A comparison will be completed to the Michigan Medicaid data from 2019 and/or 2020 based on the availability of data.

- Effects of COVID 19 and Executive Orders / Epidemic Orders issued by the Governor and/or the Michigan Department of Health and Human Services. Michigan has been under various levels of stay at home orders interfering with the ability for individuals to receive non-essential life sustaining services. (limited transportation, limited access to laboratories and physician offices)
    - 3.24.2020 Executive Order 2020-21-Suspension of all non-essential activities.
    - Actions for Non-Emergency Medical Transportation Provided During Covid 19
    - 10.14.2020 MIOSHA Emergency Rules
    - 4.13.2020- Long Acting Injectables and Antipsychotic Medications
- The number of claims submitted to support this measure have decreased since March 2020 (onset of the Executive Orders – Shelter in Place). The number of telehealth services have increased; however, this has minimum impact on the positive results of this measure. The two areas that have affected the rate of this measures include the closure of laboratories and closure and/or limitations of public transportation.

Attachment 4 MSHN Claims Utilization

Step 7: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

There are no factors identified that threaten the internal or external validity of the findings.

Baseline to Remeasurement 2:

Change in PIHP Performance Compared to Baseline.

To compare the monitoring rates of the PIHP between 2018 and 2020, we conducted a two-sample test of proportions. The rate of monitoring in thePIHP's 2020 sample is higher (49.2%) than the rate in the 2018 sample (33.6%), demonstrating a 15.6 percentage point improvement from the 2020 sample over the Baseline (2018) sample. The difference is statistically significant, with P-value < .0001. A 95% confidence interval for the difference in rate ranges from -20.6 to -10.7 percentage points. (Attachment 7 Final PIP Calculation)

Change in PIHP Performance Compared to Remeasurement 1.
To compare the screening rates of the PIHP between 2019 and 2020, we conducted a two-sample test of proportions. The rate of screening in thePIHP's 2020 sample is higher (49.2%) than the rate in the 2019 sample (36.1%), demonstrating a 13.1 percentage point (or 44.6 percent) improvement from the 2020 sample over the Remeasurement 1 (2019) sample. The difference is statistically significant, with P-value < .0001. A 95% confidence interval for the difference in rate ranges from 8.1 to 18.1 percentage points.

Comparison of PIHP Monitoring Rates with Benchmark Rates. The result of a two-proportion test for 2020 data show that there is a significant

Step 7: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

difference (P-value of 4.44×10^{-16}) between the screening rate for MSHN PIHP at 49.2% and the statewide health plans HEDIS rate at 68.3%. A 95% confidence interval gives the difference as being in the range of 14.9 and 23.4 percentage points.

Rates for PIHP monitoring are lower than the benchmark rates at a statistically significant level. This may be in part to the impact of the individuals with dual coverage (Medicaid/Medicare). If MSHN were to exclude those with dual coverage the baseline rate for 2020 would be 65.1% compared to the 2020 Michigan HEDIS results of 68.3%. There is not a statistically significant difference between the two samples with a P-value 0.2957 and 95% confidence internal ranging from -2.9 to 9.3 percentage points.

Change in Benchmark Performance Compared to Previous Year. Earlier we noted that PIHP providers made gains in 2020 over the prior year, 13.1 percentage points, where 95% confidence estimates ranging from 8.1 to 18.1 percentage points over 2019 performance. If we conduct a two sample proportion test between HEDIS rates from 2019 to 2020, we see a decrease 3.2 percentage points, where the 95% confidence estimate for the change of overall screening rate for provider groups in the HEDIS Aggregate Report ranges from being down 0.4% to being up 4.8% from 2019 to 2020. Demonstrating that the PIHP made improvements while the HEDIS performance decreased.

Attachment 5 MI2020_HEDIS_Aggregate_Report
Attachment 6 MI2019_HEDIS-Aggregate_Report

Step 7: Data Analysis and Interpretation of Study Results. Clearly document the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the results. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the results to the goal and the type of statistical test completed. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII.

Baseline to Remeasurement 3:

Baseline to Final Remeasurement:

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

Please describe the process used to identify barriers and develop corresponding interventions. Include the team/committee/group that conducted the causal/barrier analysis and the QI tools used to identify barriers, such as data mining, key driver diagram, fishbone diagram, process-level data, etc. Describe the process used to prioritize the barriers and designate high-priority barriers. Lastly, describe the process used to evaluate the effectiveness of each intervention. The documentation should be dated to identify when steps in the ongoing quality improvement process were initiated and revisited.

Describe the causal/barrier analysis process, quality improvement team consumers, and quality improvement tools:

The PIHP utilized the regional Quality Improvement Council and the regional Medical Directors group to identify region wide barriers to receiving an LDL-C and an HbA1c test as well as causal factors and interventions to overcome the barriers. The process used for the causal/barrier analysis was brainstorming and the completion of a Fishbone Diagram.

Each CMHSP reviewed their local baseline data and provided feedback regarding barriers to the PIHP using their local quality improvement process. The barriers identified and reviewed using a Fishbone Diagram. Strike through indicates the removal of a barrier. The barriers were re prioritized based on the effectiveness / impact of the intervention on the outcome.

Attachment 1 Mid-State Health Network Fishbone Diagram-Diabetes Monitoring

Describe the processes, tools, and/or data analysis results used to identify and prioritize barriers:

The PIHP utilized the Quality Improvement Council and regional Medical Directors group to identify and review the region wide barriers and causal factors. The barriers were prioritized based on the effort of and relevance to each CMHSP and potential impact on the outcome.

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

Describe the processes and measures used to evaluate the effectiveness of each intervention: The interventions will be evaluated using the following methods:

Intervention 1: Develop and provide a brief explanation document to the Primary Care Physicians and the CMHSP clinicians of when Protected Health Information (PHI) can be shared for the purposes of coordination of care, treatment and payment. Additionally, the MSHN Medical Director will provide education related to when Protected Health Information can be shared for the purposes of coordination of care, treatment and payment to the joint group of Medical Directors and Primary Care Physicians.

Evaluation of Effectiveness: The CMHSPs will track the number of physician offices that have received the brief explanation document ofwhen PHI can be shared for the purposes of coordination of care, treatment and payment, and as a result have begun to share information and/or coordinate care.

Intervention 2: Implement process to improve transportation availability. This will include developing an information sheet to provide consumers at the time of their appointment with instructions for accessing transportation through what is available in each CMHSPs geographical location. This may vary by location but should include any of the following: list of vendors, process for scheduling transportation with the Department of Human Services, provision of bus tokens and/or vouchers, other transportation services based on each specific location.

Evaluation of Effectiveness: The PIHP will track the number of CMHSPs who have provided transportation information to their consumers. MSHN will identify via ICDP who has completed the lab work as ordered. The number of HbA1c and LDL-C claims will increase.

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

Intervention 3: Implement process for labs services to be obtained onsite at the CMHSP location. This may include mobile lab, trained medical staff, on-site lab draw station.

Evaluation of Effectiveness: The CMHSPs will track the number of labs that have been completed utilizing the onsite lab option. The number of HbA1c and LDL-C will increase.

Intervention 4: CMHSP will utilize the care alerts to determine who does not have a claim for a completed lab. A record review is completed to identify if lab was ordered. If ordered is it in the record or can it be obtained. If the results are in the record and a claim was submitted to Medicare the CMHSP can enter "addressed" into ICDP.

Evaluation of Effectiveness: The CMHSPs will complete a record review of the individuals identified with an open care alert, indicating that a claim has not been submitted for a HbA1c and LDL-C. The CMHSP will indicate "addressed" within ICDP, for those individuals that have a lab result for the HbA1c and LDL-C present in the record. ICDP Report will indicate that claims have been "addressed" and primary source verification will occur during the delegated managed care review as needed to verify.

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

(New Effective Measurement Period 2 Intervention 5: Develop and implement a process of data validation quarterly to ensure the data received from the Care Connect360 extract and processed by Zenith Technologies in the Integrated Care Data Platform is consistent with the HEDIS specifications and is completed within the expected timeframes.

Evaluation of Effectiveness: Data Validation will occur four times during the calendar year. The results will conclude the data is valid based on the HEDIS specifications. The data will be available, providing updates 1 time per quarter. Any issues will be logged with a process for improvement identified.

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

Barriers/Interventions Table:

Use the table below to list barriers, corresponding intervention descriptions, intervention type, target population, and implementation date. For each intervention, select if the intervention was (1) new, continued, or revised, and (2) consumer, provider, or system. Update the table as interventions are added, discontinued, or revised.

Date Implemented (MM/YY)	Select if Continued, New, or Revised	Select if Consumer, Provider, or System Intervention	Priority Ranking	Barrier	Intervention That Addresses the Barrier Listed in the Previous Column
1/1/2019	Discontinued	Provider Intervention		Lack of Coordination occurring between the Primary Care Physician and the CMHSP-No process in place to communicate.	1. Develop and provide a brief explanation document to the Primary Care Physicians and the CMHSP clinicians of when Protected Health Information (PHI) can be shared for the purposes of coordination of care, treatment and payment. Additionally, the MSHN Medical

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

					Director will provide education related to when Protected Health Information can be shared for the purposes of coordination of care, treatment and payment to the joint group of Medical Directors and Primary Care Physicians.
1/1/2019	Continue March 2020 Continue with revisions.	System Intervention	3	Access to labs. March of 2020- Epidemic/Emergency orders implemented limiting/discontinuing public transportation, non-essential treatments, contact with individuals outside of your household. (see epidemic/emergency orders. Orders)	2. Implement process to improve transportation availability. This will include developing an information sheet to provide consumers at the time of their appointment with instructions for accessing transportation through what is available in each CMHSPs geographical location. This may vary by location but should include any of the following: list of vendors,

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

					process for scheduling transportation with the Department of Human Services, provision of bus tokens and/or vouchers, other transportation services based on each specific location. Revision-Case by case based on need, until organizations / services open safely, and public transportation is reinstated. open and services
1/1/2019	Continue Discontinue March 2020	System Intervention	4	Access to labs	3. Implement process for labs services to be obtained onsite at the CMHSP location. This may include mobile lab, trained medical staff, on-site lab draw station.

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

1/1/2019	Continue	System Intervention	1	Information of completed labs not available.	4. CMHSP will utilize the care alerts to determine who does not have a claim for a completed lab. A record review is completed to identify if lab was ordered. If ordered is it in the record or can it be obtained. If the results are in the record and a claim was submitted to Medicare the CMHSP can enter "addressed" into ICDP.

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

4/2020	New Continue with revisions	System Intervention	2	Data inaccurate and untimely.	1. Develop and implement a process of data validation quarterly to ensure the data received from the Care Connect 360 extract and processed by Zenith Technologies in the Integrated Care Data Platform is consistent with the HEDIS specifications and is completed within the expected timeframes. Decrease data validations to annual.

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

Report the evaluation results for each intervention and describe the steps taken based on the evaluation results. Was each intervention successful? How were successful interventions continued or implemented on a larger scale? How were less-successful interventions revised or discontinued?

Describe evaluation results for each intervention:

Describe next steps for each intervention based on evaluation results:

Intervention 1: Develop and provide a brief explanation document to the Primary Care Physicians and the CMHSP clinicians of when Protected Health Information (PHI) can be shared for the purposes of coordination of care, treatment and payment. Additionally, the MSHN Medical Director will provide education related to when Protected Health Information can be shared for the purposes of coordination of care, treatment and payment to the joint group of Medical Directors and Primary Care Physicians.

Evaluation of Effectiveness: The CMHSPs will track the number of physician offices that have received the brief explanation document of when PHI can be shared for the purposes of coordination of care, treatment and payment, and as a result have begun to share information and/or coordinate care.

Measurement Period 1

Analysis: Each CMHSP has developed a brief explanation document, continuity of care document, and/or a direct feed into the medical records to be shared for the purposes of coordination of care, treatment, and payment. This has resulted in increased coordination. As a result, all the CMHSPs report that coordination with the Primary Care Physician is no longer a barrier.

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

This intervention will be discontinued.

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

Intervention 2: Implement process to improve transportation availability. This will include developing an information sheet to provide consumers at the time of their appointment with instructions for accessing transportation through what is available in each CMHSPs geographical location. This may vary by location but should include any of the following: list of vendors, process for scheduling transportation with the Department of Human Services, provision of bus tokens and/or vouchers, other transportation services based on each specific location.

Evaluation of Effectiveness: The PIHP will track the number of CMHSPs who have provided transportation information to consumers. MSHN will identify via ICDP who has completed the lab work as ordered. The number of HbA1c and LDL-C claims will increase.

Measurement Period 1

Analysis: Each CMHSP has provided information of options for transportation and education for individuals in their organization. The number of individuals who have had a claim for the HbA1c and the LDL-C has increased for 5 of the 12 CMHSPs. There is evidence of this intervention being effective based on the increase in claims for 42% of the CMHSPs.

This intervention will continue.

Measurement Period 2

Analysis: The public transportation was suspended throughout the region beginning March 2020, continuing operations at varied times throughout the region as a result of the epidemic/emergency orders. See Epidemic, Executive, and Emergency Rules listed above. Transportation information was not provided to consumers when in office services were suspended. The intervention was revised to

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

include assistance with transportation on a case-by-case basis when needed.

This intervention will continue with revisions. Revisions-Case by case based on need, until organizations / services open safely, and public transportation is reinstated. open and services.

Intervention 3: Implement process for lab services to be obtained onsite at the CMHSP location. This may include mobile lab, trained medical staff, on-site lab draw station.
Evaluation of Effectiveness: The CMHSPs will track the number of labs that have been completed utilizing the onsite lab option. The number of HbA1c and LDL-C will increase.

Measurement Period 1
Analysis: Two CMHSPs offer an onsite lab Monday through Friday. Of these both experienced an increase in labs received. Four CMHSPs offer an onsite lab limited days of the week. None of these CMHSPs have currently experienced an increase in completed labs. Six CMHSPs do not currently offer a lab on site as a result of previous low utilization and lab available nearby. Of the six, one CMHSP did demonstrate an increase in the individuals who received a lab.
This intervention will continue.

Measurement Period 2
Analysis: Organizations developed alternative methods of operations to be consistent with the epidemic orders.
The Essential Service only order was issued March 24, 2020 (Executive Order 2020-21). Six organizations provided onsite or mobile laboratories beginning in 2019 through January of 2020. Onsite laboratories, including mobile laboratories, were discontinued in March 2020.

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

Additional barriers identified include, however, not limited to the following: physical illness, quarantined staff and quarantined individuals served. See the Epidemic, Executive, and Emergency Rules listed above.

Intervention 3 was discontinued March 2020 and will be evaluated for reinstatement in FY22 as communities safely open consistent with local health department guidance.

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

Intervention 4: CMHSP will utilize the care alerts to determine who does not have a claim for a completed lab. A record review is completed to identify if lab was ordered. If ordered is it in the record or can it be obtained. If the results are in the record and a claim was submitted to Medicare the CMHSP can enter "addressed" into ICDP.

Evaluation of Effectiveness: The CMHSPs will complete a record review of the individuals identified with an open care alert, indicating that a claim has not been submitted for a HbA1c and LDL-C. The CMHSP will indicate "addressed" within ICDP, for those individuals that have a lab result for the HbA1c and LDL-C present in the record. ICDP Report will indicate that claims have been "addressed" and primary source verification will occur during the delegated managed care review as needed to verify.

Measurement Period 1

Analysis: Eight CMHSPs have a process to review the care alerts from ICDP and follow up to ensure that each individual is marked with an "addressed" as appropriate. Addressed is marked in ICDP when a lab is located in the medical record in absence of a claim. This may occur for those individuals who have a primary insurance in addition to Medicaid, and Medicaid does not pay for the lab work. Four CMHSPs do not have a current process in place to review the ICDP Care Alerts. Each of the four are in progress for developing an effective system.

This intervention will be continued.

Measurement Period 2

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

Analysis: The number of CMHSPs with a process for staff to complete care alerts increased from 8 to 12 during measurement period 2. Care alerts trigger a follow up action to ensure the required labs are ordered and/or a copy is reviewed/obtained for the medical record. Those marked "addressed" are records that indicated the required testing had not been received through submitted claim in ICDP/CC360, however documentation of the required lab results was located in the medical record. The primary reason for this is the service was billed to Medicare for those individuals who have dual coverage of Medicaid/Medicare. Sixty percent of the eligible population include individuals with dual coverage (Medicare /Medicaid). Seventy-three percent (241) of those not screened had dual coverage ((Medicare /Medicaid). The results of the lab work are dependent on the ability to receive the required evidence of the completed lab work from the physician offices, therefore promoting increased coordination among providers. Without a record review 120 individuals would have not been reported as receiving the required tests for inclusion in the numerator.

	"Addressed"	*Required Claims Present*	Total received the required testing	No testing received	Grand Total
Medicare/Medicaid	*117*	*36*	153	241	394
Medicaid Only	*3*	*165*	168	90	258
MSHN	*120*	*201*	321	331	652

Intervention 4 was effective and will continue with no revisions.

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

(New) Intervention 5: Develop and implement a process of data validation quarterly to ensure the data received from the Care Connect 360 extract and processed by Zenith Technologies in the Integrated Care Data Platform is consistent with the HEDIS specifications and is completed within the expected timeframes.

Evaluation of Effectiveness: Data Validation will occur four times during the calendar year. The results will conclude the data is valid based on the HEDIS specifications. The data will be available, providing updates 1 time per quarter. Any issues will be logged with a process for improvement identified.

Measurement Period 2:
Analysis: Data Validation Occurred two times during the measurement period.
The data processed through ICDP was matched against the specifications within the PIP, any mismatches would be investigated to determine the cause. Actions would then be identified to address areas that would potentially threaten the validity of the project.

December 2020 Valid-Consistent with the PIHP/HEDIS specifications
April 2021 Valid-Consistent with the PIP/HEDIS specifications

Step 8: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should include the following:

- Processes used to identify barriers/interventions.
- Processes used to prioritize barriers.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness each intervention and the evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

Validation	Mismatches Identified	Causal Factors	Actions Taken	Did results affect the Validity of the Project
Data through 8/30/2020	25/840 records had mismatched CMHSP attributions. 97% accuracy rate	The attribution file for the CMHSPs is based on the current open record and not the record open at the time of the submitted claim.	Each mismatch is reviewed to determine the actual CMHSP that are responsible for the record. Communication occurs with the CMHSP as needed.	No, does not affect the validity of the project for the Region.
Data through 12/31/2020	12/652 records had mismatched CMHSP attributions. 98% accuracy rate	The attribution file for the CMHSPs is based on the current open record and not the record open at the time of the submitted claim.	Each mismatch is reviewed to determine the actual CMHSP that are responsible for the record. Communication occurs with the CMHSP as needed.	No, does not affect the validity of the project for the Region.

Intervention 5 will continue, with revisions of 1 time annually.

Quality Assessment Performance Improvement Program
Quality Improvement Council – Critical Incidents FY21

Summary of Project

The data collected is based on the requirements that have been set forth within the Critical Incident Reporting System (CIRS) attached to the PIHP contract and available on the MDHHS Website. This data is to be reported and reviewed as part of the CMHSP Quality Assessment and Performance Improvement Program (QAPIP) quarterly to address any trends and/or opportunities for quality improvements.

The following incidents are reported by the CMHSP Participants:

- Deaths-Suicide-Any individual actively receiving services including those who were seen for an emergency service in previous 30 days.
- Non-Suicide-All Waiver Groups or individuals residing in 24 hour specialized residential and/or Child Care Institution or receiving Community Living Supports, Supports Coordination, Targeted Case Management, ACT, Home-Based, and Wraparound. Subsets of deaths include natural cause, accidental, homicidal.
- Emergency Medical Treatment-All Waiver Groups or individuals residing in 24 hour specialized residential and/or Child Care Institution.
- Hospitalization- All Waiver Groups or individuals residing in 24 hour specialized residential and/or Child Care Institution.
- Arrests- All Waiver Groups or individuals residing in 24 hour specialized residential and/or Child Care Institution.

Data Analysis

1. The critical incident reporting system is trend data; therefore, no external 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 contributing to an upward trend. The expectation is that each CMHSP and/or MSHN will implement interventions to improve safety, thereby changing the direction of the trend. At the end of each year a final report is produced which includes a comparison to the previous FY. The final report also updates any numbers of incidents that have been reported throughout the year that may not have been included on the previous quarterly report. Figure 1 provides an annual comparison of events. MSHN met the standard, demonstrating a decrease in rate from FY20 for Arrests, EMT, Hospitalization, and Suicide.

Figure 1: MSHN Critical Events Annual Comparison (Rate per 1000)

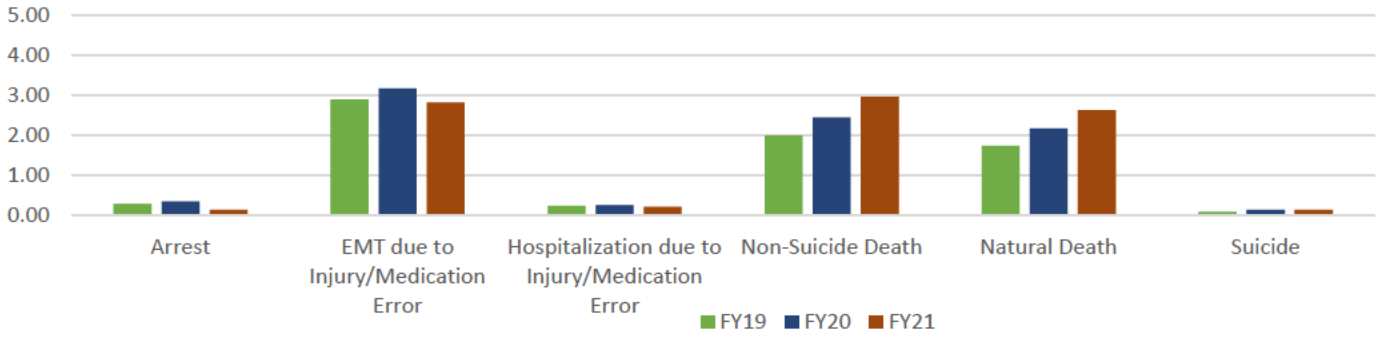
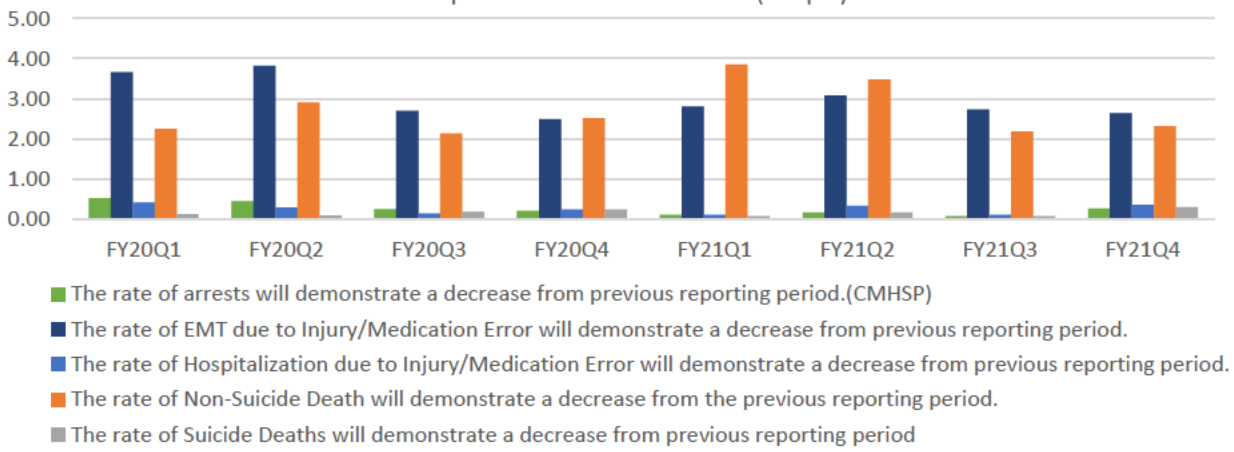


Figure 1a: Critical Incident Reporting System
Rate per 1000 consumers served (unique)



2. **The rate of arrests, per 1000 persons, served will demonstrate a decrease from previous reporting period.**
   MSHN did not meet the standard for FY21Q4.
   MSHN met the standard for FY21 as indicated in Figure 1.

Figure 2. Rate of Arrests per 1000 Served. *Pandemic-Emergency Orders in Place

Organization	FY20Q1	FY20Q2*	FY20Q3*	FY20Q4*	FY21Q1*	FY21Q2*	FY21Q3*	FY21Q4
MSHN	**0.523**	**0.437**	**0.245**	**0.202**	**0.101**	**0.164**	**0.064**	**0.257**
BABH	0.303	0.310	0.000	0.000	0.000	0.000	0.000	0.000
CEI	0.000	0.203	0.000	0.000	0.000	0.000	0.000	0.000
CMHCM	0.739	0.389	0.924	0.359	0.176	0.341	0.000	0.494
GIHN	0.001	0.002	0.001	0.001	0.000	0.000	0.000	0.000
HBH	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
The Right Door	0.000	0.891	0.000	0.000	0.000	0.000	0.000	0.000
LifeWays	0.000	0.000	0.000	0.000	0.462	0.223	0.217	0.427
MCN	0.000	0.763	1.047	0.792	0.000	0.738	0.000	0.000
NCMH	0.935	1.015	0.000	0.812	0.000	0.000	0.000	0.000
Saginaw	0.495	0.252	0.297	0.000	0.000	0.238	0.236	0.698
Shiawassee	5.020	1.112	0.000	1.111	0.000	0.000	0.000	0.000
TBHS	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000

3. The rate, per 1000 persons served, of persons who received emergency medical treatment for an injury or medication error will demonstrate a decrease from previous reporting period.
MSHN met the standard for FY21 as indicated in Figure 1.
MSHN met the standard for FY21Q4 as indicated below.

Figure 3. Rate of Emergency Medical Treatment for an Injury or Medication Error per 1000 served. *Pandemic-Emergency Orders in Place

Organization	FY20Q1	FY20Q2*	FY20Q3*	FY20Q4*	FY21Q1*	FY21Q2*	FY21Q3*	FY21Q4
MSHN	**3.664**	**3.817**	**2.692**	**2.487**	**2.804**	**3.081**	**2.732**	**2.634**
BABH	3.035	1.859	5.553	0.948	1.604	1.237	1.222	1.524
CEI	0.565	0.609	0.723	0.731	2.397	3.421	3.638	2.749
CMHCM	4.248	3.698	3.696	3.591	3.527	3.069	1.992	2.469
GIHN	2.830	11.340	1.410	1.046	6.270	0.000	1.887	5.894
HBH	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
The Right Door	0.814	0.891	1.232	0.000	0.859	0.000	0.000	0.000
LifeWays	3.333	4.422	3.253	2.912	3.002	4.021	3.035	2.349
MCN	2.799	6.107	6.283	0.000	3.063	0.738	2.807	1.404
NCMH	0.000	0.000	0.000	4.870	0.000	0.775	0.808	0.842
Saginaw	6.191	4.542	4.454	4.038	2.167	5.243	3.062	3.958
Shiawassee	8.032	7.786	4.580	3.333	7.384	5.247	7.194	8.018
TBHS	7.284	6.572	8.368	8.537	6.211	7.134	8.333	2.433

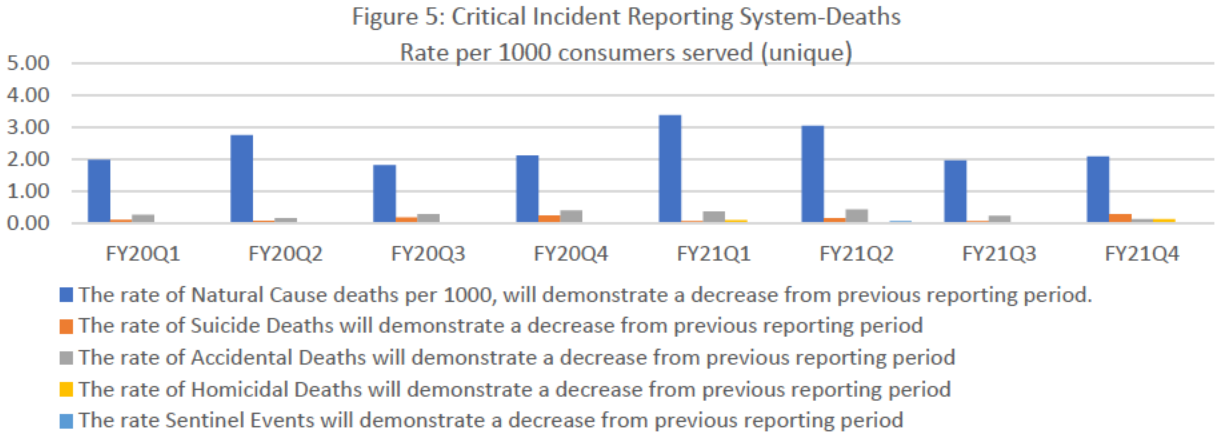
4. The rate, per 1000 persons served, of individuals who were Hospitalized for an Injury or Medication Error will demonstrate a decrease from previous reporting period.
MSHN met the standard for FY21 as indicated in Figure 1.
MSHN did not meet the standard for FY21Q4.

Figure 4. Rate of Hospitalizations for an injury or medication error per 1000 served. *Pandemic-Emergency Orders in Place

Organization	FY20Q1	FY20Q2*	FY20Q3*	FY20Q4*	FY21Q1*	FY21Q2*	FY21Q3*	FY21Q4
MSHN	**0.411**	**0.278**	**0.140**	**0.235**	**0.101**	**0.328**	**0.096**	**0.353**
BABH	0.607	0.000	0.000	0.316	0.000	0.619	0.000	0.000
CEI	0.188	0.000	0.000	0.000	0.000	0.000	0.000	0.000
CMHCM	0.739	0.389	0.000	0.359	0.000	0.170	0.332	0.165
GIHN	0.943	2.062	0.000	0.000	1.045	0.000	0.000	0.982
HBH	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
The Right Door	0.000	0.000	0.000	0.000	0.859	0.000	0.000	0.000
LifeWays	0.238	0.260	0.591	0.448	0.000	0.670	0.000	0.854
MCN	0.000	0.000	0.000	0.000	0.000	1.476	0.000	0.000
NCMH	0.000	1.015	0.000	0.000	0.000	0.000	0.000	1.684
Saginaw	0.248	0.252	0.297	0.475	0.241	0.238	0.236	0.698
Shiawassee	0.000	0.000	1.527	0.000	0.000	1.049	0.000	0.000
TBHS	1.041	0.000	0.000	0.000	0.000	0.000	0.000	0.000

5. The rate, per 1000 persons served, of Deaths will demonstrate a decrease from previous reporting period. MSHN met the standard for three of the four types of deaths monitored.

   MSHN demonstrated an increase in natural cause death, homicidal, and suicide death for FY21Q4. A decrease was exhibited for accidental deaths. Accidental deaths include any unexpected death that is not a result of the natural course of an illness, including an overdose or other unexpected death that may not have been attributed to a suicide or homicide. Accidental deaths require additional information to be reviewed to identify the cause. Deaths from a suicide or homicide are not included in the numbers for accidental deaths below. MSHN did not meet the standard for FY21Q4 or for FY21 compared to FY20 as indicated in Figure 1.



The rate, per 1000 persons served, of Suicide Death will demonstrate a decrease from previous reporting period. MSHN did not meet the standard for FY21Q4. MSHN did not meet the standard for FY21 compared to FY20 as indicated in Figure 1.

Figure 6. Rate of Suicide Deaths per 1000 served

Organization	FY20Q1	FY20Q2*	FY20Q3*	FY20Q4*	FY21Q1*	FY21Q2*	FY21Q3*	FY21Q4
MSHN	**0.112**	**0.080**	**0.175**	**0.235**	**0.068**	**0.164**	**0.064**	**0.289**
BABH	0.000	0.000	0.000	0.316	0.321	0.000	0.000	0.000
CEI	0.376	0.203	0.723	0.366	0.000	0.540	0.173	0.687
CMHCM	0.000	0.000	0.231	0.000	0.000	0.000	0.000	0.329
GIHN	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
HBH	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
The Right Door	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
LifeWays	0.238	0.000	0.296	0.224	0.000	0.000	0.000	0.214
MCN	0.000	0.000	0.000	0.000	0.000	0.738	0.000	0.000
NCMH	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Saginaw	0.000	0.252	0.000	0.475	0.000	0.238	0.000	0.233
Shiawassee	0.000	0.000	0.000	0.000	1.055	0.000	0.000	0.000
TBHS	0.000	0.000	0.000	0.000	0.000	0.000	1.190	1.217

6. The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous reporting period. MSHN did meet the standard for FY21Q4. MSHN did not meet the standard for FY21 compared to FY20 as indicated in Figure 1.

Figure 7. Rate of Non-Suicide Deaths per 1000 served

Organization	FY20Q1	FY20Q2*	FY20Q3*	FY20Q4*	FY21Q1*	FY21Q2*	FY21Q3*	FY21Q4
MSHN	**2.243**	**2.863**	**2.133**	**2.521**	**3.851**	**3.474**	**2.186**	**2.313**
BABH	2.428	1.240	3.702	4.110	4.811	4.949	2.138	2.438
CEI	2.635	2.233	2.892	2.925	5.531	4.321	4.331	3.093
CMHCM	2.032	3.114	1.848	1.616	2.646	3.069	2.158	1.481
GIHN	0.000	3.093	2.821	0.000	1.045	2.833	0.000	1.965
HBH	1.333	1.445	0.000	0.000	9.763	0.000	0.000	0.000
The Right Door	0.000	2.674	1.232	0.861	0.859	1.709	0.873	3.503
LifeWays	1.667	3.122	1.774	2.912	4.849	4.021	1.734	2.135
MCN	2.099	0.000	2.094	1.585	1.531	2.214	0.702	2.807
NCMH	0.000	7.107	1.323	0.000	1.638	0.000	0.000	0.000
Saginaw	3.467	2.523	3.860	3.563	4.093	3.813	2.591	3.260
Shiawassee	0.000	0.000	1.527	0.000	2.110	3.148	0.000	2.291
TBHS	2.081	5.476	6.974	7.317	1.242	3.567	2.381	1.217

Figure 8. Rate of MSHN Natural Cause Death per 1000 served. Red text indicates the leading 5 causes of death.

Rate Per 1000 of Natural Cause	FY20Q1	FY20Q2*	FY20Q3*	FY20Q4*	FY21Q1*	FY21Q2*	FY21Q3*	FY21Q4
Unknown	0.1869	0.2386	0.2447	0.2017	0.4729	0.2294	0.2250	0.5461
Heart Disease	0.2991	0.5964	0.5594	0.4706	0.4391	0.4261	0.3536	0.3212
Cancer	0.2617	0.4771	0.2098	0.2689	0.4053	0.5244	0.1929	0.2249
Neurological Disorders	0.2243	0.1590	0.0699	0.1681	0.3378	0.2950	0.0964	0.0964
Lung Disease	0.0748	0.1988	0.2797	0.1345	0.1689	0.2950	0.0643	0.0964
Infection, including AIDS	0.0748	0.2386	0.0350	0.1008	0.2702	0.2622	0.1929	0.0000
Kidney disease	0.1122	0.0795	0.0699	0.0672	0.1013	0.0656	0.0643	0.1285
Pneumonia/Influenza	0.1869	0.1590	0.0699	0.1008	0.3378	0.2622	0.0964	0.1606
Vascular Disease	0.1869	0.0795	0.0699	0.1681	0.1351	0.1639	0.2571	0.0321
Diabetes Mellitus	0.2243	0.0398	0.0350	0.1008	0.2364	0.2294	0.2250	0.1606
Aspiration or Aspiration Pneumonia	0.0748	0.1988	0.0699	0.0336	0.2364	0.0328	0.0321	0.1927
Acute Bowel Disease	0.0000	0.0795	0.0350	0.0000	0.1013	0.0983	0.0321	0.0000
Complication of Treatment	0.0000	0.0795	0.0000	0.0672	0.0000	0.0328	0.0000	0.0321
Liver Disease/Cirrhosis	0.0374	0.1193	0.0699	0.1681	0.0676	0.0656	0.1286	0.0642
Endocrine Disorders	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
Inanition	0.0374	0.0000	0.0000	0.0672	0.0676	0.0656	0.0000	0.0321

Figure 8a. The rate of change from previous quarter.

Cause of Death	FY20Q1	FY20Q2*	FY20Q3*	FY20Q4*	FY21Q1*	FY21Q2*	FY21Q3*	FY21Q4
Unknown	-0.0137	0.0516	0.0062	-0.0430	0.2712	-0.2435	-0.0044	0.3211
Heart Disease	-0.0019	0.2973	-0.0370	-0.0888	-0.0315	-0.0130	-0.0725	-0.0323
Cancer	-0.0392	0.2154	-0.2674	0.0592	0.1364	0.1191	-0.3316	0.0320
Neurological disorders	0.1909	-0.0653	-0.0891	0.0982	0.1697	-0.0428	-0.1986	-0.0001
Lung Disease	-0.0924	0.1240	0.0809	-0.1452	0.0344	0.1261	-0.2307	0.0321
Infection, including AIDS	0.0079	0.1638	-0.2036	0.0659	0.1694	-0.0080	-0.0694	-0.1929
Kidney disease	0.0787	-0.0326	-0.0096	-0.0027	0.0341	-0.0358	-0.0013	0.0642
Pneumonia/Influenza	0.1200	-0.0279	-0.0891	0.0309	0.2369	-0.0756	-0.1658	0.0642
Vascular Disease	0.1535	-0.1074	-0.0096	0.0982	-0.0330	0.0288	0.0933	-0.2250
Diabetes mellitus	0.1574	-0.1845	-0.0048	0.0659	0.1356	-0.0070	-0.0044	-0.0644
Aspiration or Aspiration pneumonia	0.0079	0.1240	-0.1289	-0.0363	0.2028	-0.2037	-0.0006	0.1606
Acute bowel disease	-0.1337	0.0795	-0.0446	-0.0350	0.1013	-0.0030	-0.0662	-0.0321
Complication of treatment	0.0000	0.0795	-0.0795	0.0672	-0.0672	0.0328	-0.0328	0.0321
Liver disease/cirrhosis	0.0374	0.0819	-0.0494	0.0982	-0.1005	-0.0020	0.0630	-0.0643
Endocrine disorders	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
Inanition	0.0374	-0.0374	0.0000	0.0672	0.0003	-0.0020	-0.0656	0.0321

7. The rate of incidents (excluding deaths) reported outside of 60 days will demonstrate an decrease from previous reporting quarter. MSHN demonstrated a rate of 7.14% in FY21Q4 for incidents reported outside the required time frames for FY21Q4. This was a decrease from 7.79% in FY21Q3.

   Critical incidents are required to be reported within timelines specified by MDHHS. The PIHP monitors the timeliness of the reporting. Arrests, Emergency Medical Treatment and Hospitalization are to be reported within 60 days after the end of the month in which the incident occurred. Suicide deaths are to be reported within 30 days after the end of the month in which the case of death was determined. If 90 days has elapsed without a determination of cause of death, a "best judgement" determination should be used to determine if the death was a suicide. Non-suicide deaths are to be reported within 60 days after the end of the month in which the death occurred, unless reporting is delayed while an attempt is made to determine if the death was a suicide. In which case the death should be reported within 30 days after the end of the month in which it was determined to be a non-suicide death.
   *Deaths that have been reported within 90 days are considered within the required timeframes for this report.

Figure 9. FY21Q4 Timeliness Counts

FY21Q4				
Organization	Total Reported	Total Reported within Required Time Frames	Total Reported Outside of the Required Timelines	Compliance Rate
MSHN	182	169	13	93%
BABH	13	13	0	100%
CEI	38	35	3	92%
CMHCM	30	30	0	100%
GIHN	9	5	4	56%
HBH	0	0	0	NA
The Right Door	4	4	0	100%
LifeWays	28	24	4	86%
MCN	6	6	0	100%
NCMH	3	1	2	34%
SCCMH	38	38	0	100%
SHW	9	9	0	100%
TBHS	4	4	0	100%

Conclusion:

Annual Comparison

MSHN met the standard for Arrests, Emergency Medical Treatment, Hospitalization for Injury or Medication Error, and Suicide Deaths by demonstrating a decrease in the rate per 1000 from the rate for FY20. MSHN did not meet the standard for Non-Suicide Death. Non-Suicide Deaths include accidental, natural cause death, and homicide. Asterisks are used in the tables to assist in identifying the potential impact of the pandemic on the data. Special attention has been given to accurate reporting. An increased emphasis was placed on identifying the cause of death to ensure accurate and effective intervention can be applied. The cause of death where the response was "unknown" increased and is related to the number of indeterminant deaths on the death certificate or cause of death not being received within 3 months. Deaths are reported in CIRS, however where COVID is the cause, or a contributing factor will need to be reported outside of the CIRS. In FY21Q4 the leading cause of death was unknown, heart disease then cancer. MSHN's leading cause of death for FY21 includes heart disease. Attachment 1 provides the numbers of events for comparison of events for each CMHSP participant.

Barriers:

CMHSPs are requesting death certificates to verify the cause of death for accurate reporting and interventions. This has resulted in a delay in reporting, and additional cost. County offices are charging different amounts for the request of a death certificate. CMHSPs are required to make a Best Judgement determination if a cause of death cannot be determined by 90 days after the event. This continues to results in a high number of reported unknowns.

Death Reporting related to COVID is dependent on receipt of the death certificate.

Recommendations:

- CMHSPs should review all critical incidents for causal factors and potential intervention to decrease the reoccurrence.
- CMHSPs should update the death "unknown" field within 60 days but no later than 90 days.
- CMHSPs should work with county offices to develop a feasible and affordable process for obtaining death certificates.
- CMHSPs and SUD Providers should report all sentinel events to MSHN. The use of the notes section in the CIRS will be explored. *Status:* A standard form was developed for reporting.
- MSHN QIC and CMHSPs should review unexpected and accidental deaths to identify specifically the cause of death such as drug related, accidental overdose, or any other cause that may benefit from an intervention. Each unexpected death should result in additional information being obtained, and each sentinel event should result in a root cause analysis with identified action to prevent reoccurrence. There was consensus that based on the definitions in the contract of sentinel events, suicide deaths would be included as a sentinel event. Clinical judgement should be used to determine if unexpected deaths are a sentinel event. *Status:* Development of a standard form for tracking and reporting sentinel events has been completed.

Prepared by: Sandy Gettel, Quality Manager **Date:** 12/7/2021
Approved by: MSHN QIC **Date:** 12/20/2021

Attachment 1

Table 1: Critical Event-Arrests

Organization	FY20Q1	FY20Q2	FY20Q3	FY20Q4	FY20	FY21Q1	FY21Q2	FY21Q3	FY21Q4	FY21
MSHN	14	11	7	6	38	3	5	2	8	18
BABH	1	1	0	0	2	0	0	0	0	0
CEI	0	1	0	0	1	0	0	0	0	0
CMHCM	4	2	4	2	12	1	2	0	3	6
GIHN	1	2	1	1	5	0	0	0	0	0
HBH	0	0	0	0	0	0	0	0	0	0
The Right Door	0	1	0	0	1	0	0	0	0	0
LifeWays	0	0	0	0	0	2	1	1	2	6
MCN	0	1	1	1	3	0	1	0	0	1
NCMH	1	1	0	1	3	0	0	0	0	0
SCCMH	2	1	1	0	4	0	1	1	3	5
SHW	5	1	0	1	7	0	0	0	0	0
TBHS	0	0	0	0	0	0	0	0	0	0

Table 2: Critical Event-Emergency Medical Treatment due to Injury or Medication Error. Highlighted cells indicate an update from previous report.

Organization	FY20Q1	FY20Q2	FY20Q3	FY20Q4	FY20	FY21Q1	FY21Q2	FY21Q3	FY21Q4	FY21
MSHN	98	96	77	74	345	83	94	85	82	344
BABH	10	6	15	3	34	5	4	4	5	18
CEI	3	3	3	4	13	13	19	21	16	69
CMHCM	23	19	16	20	78	20	18	12	15	65
GIHN	3	11	1	1	16	6	0	2	6	14
HBH	0	0	0	0	0	0	0	0	0	0
The Right Door	1	1	1	0	3	1	0	0	0	1
LifeWays	14	17	11	13	55	13	18	14	11	56
MCN	4	8	6	0	18	4	1	4	2	11
NCMH	0	0	0	6	6	0	1	1	1	3
SCCMH	25	18	15	17	75	9	22	13	17	61
SHW	8	7	3	3	21	7	5	7	7	26
TBHS	7	6	6	7	26	5	6	7	2	20

Table 3: Critical Event-Hospitalization due to Injury or Medication Error. Highlighted cells indicate an update from previous report.

Organization	FY20Q1	FY20Q2	FY20Q3	FY20Q4	FY20	FY21Q1	FY21Q2	FY21Q3	FY21Q4	FY21
MSHN	11	7	4	7	29	3	10	3	11	27
BABH	2	0	0	1	3	0	2	0	0	2
CEI	1	0	0	0	1	0	0	0	0	0
CMHCM	4	2	0	2	8	0	1	2	1	4
GIHN	1	2	0	0	3	1	0	0	1	2
HBH	0	0	0	0	0	0	0	0	0	0
The Right Door	0	0	0	0	0	1	0	0	0	1
LifeWays	1	1	2	2	6	0	3	0	4	7
MCN	0	0	0	0	0	0	2	0	0	2
NCMH	0	1	0	0	1	0	0	0	2	2
SCCMH	1	1	1	2	5	1	1	1	3	6
SHW	0	0	1	0	1	0	1	0	0	1
TBHS	1	0	0	0	1	0	0	0	0	0

Table 4: Critical Event-Non-Suicide Death. Highlighted cells indicate an update from previous report.

Organization	FY20Q1	FY20Q2	FY20Q3	FY20Q4	FY20	FY21Q1	FY21Q2	FY21Q3	FY21Q4	FY21
MSHN	60	73	61	75	269	114	106	68	72	360
BABH	8	4	10	13	35	15	16	7	8	46
CEI	14	11	12	16	53	30	24	25	18	97
CMHCM	11	16	8	9	44	15	18	13	9	55
GIHN	0	3	2	0	5	1	3	0	2	6
HBH	1	1	0	0	2	7	0	0	0	7
The Right Door	0	3	1	1	5	1	2	1	4	8
LifeWays	7	12	6	13	38	21	18	8	10	57
MCN	3	0	2	2	7	2	3	1	4	10
NCMH	0	7	1	0	8	2	0	0	0	2
SCCMH	14	10	13	15	52	17	16	11	14	58
SHW	0	0	1	0	1	2	3	0	2	7
TBHS	2	5	5	6	18	1	3	2	1	7

Table 5: Critical Event- Natural Cause Death. Highlighted cells indicate an update from previous report.

Organization	FY20Q1	FY20Q2	FY20Q3	FY20Q4	FY20	FY21Q1	FY21Q2	FY21Q3	FY21Q4	FY21
MSHN	53	69	52	63	237	100	93	61	65	319
BABH	6	4	10	13	33	14	15	7	7	43
CEI	12	9	11	10	42	25	21	23	17	86
CMHCM	8	16	6	8	38	14	16	13	9	52
GIHN	0	2	1	0	3	1	2	0	2	5
HBH	1	1	0	0	2	7	0	0	0	7
The Right Door	0	3	1	1	5	1	1	1	3	6
LifeWays	7	12	4	11	34	19	17	7	10	53
MCN	3	0	2	1	6	2	2	1	4	9
NCMH	0	7	1	0	8	2	0	0	0	2
SCCMH	14	10	11	14	49	12	13	7	11	43
SHW	0		1	0	1	2	3	0	1	6
TBHS	2	5	4	5	16	1	3	2	1	7

Table 6: Critical Event-Accidental Death. Highlighted cells indicate an update from previous report.

Organization	FY20Q1	FY20Q2	FY20Q3	FY20Q4	FY20	FY21Q1	FY21Q2	FY21Q3	FY21Q4	FY21
MSHN	7	4	8	12	31	11	13	7	4	35
BABH	2	0	0	0	2	1	1	0	1	3
CEI	2	2	1	6	11	3	3	2	1	9
CMHCM	3	0	1	1	5	1	2	0	0	3
GIHN	0	1	1	0	2	0	1	0	0	1
HBH	0	0	0	0	0	0	0	0	0	0
The Right Door	0	0	0	0	0	0	1	0	1	2
LifeWays	0	1	2	2	5	1	1	1	0	3
MCN	0	0	0	1	1	0	1	0	0	1
NCMH	0	0	0	0	0	0	0	0	0	0
SCCMH	0	0	2	1	3	5	3	4	1	13
SHW	0	0	0	0	0	0	0	0	0	0
TBHS	0	0	1	1	2	0	0	0	0	0

Table 7: Critical Event-Homicidal Death

Organization	FY20Q1	FY20Q2	FY20Q3	FY20Q4	FY20	FY21Q1	FY21Q2	FY21Q3	FY21Q4	FYY21
MSHN	0	0	1	0	1	3	0	0	4	7
BABH	0	0	0	0	0	0	0	0	0	0
CEI	0	0	0	0	0	2	0	0	0	2
CMHCM	0	0	1	0	1	0	0	0	0	0
GIHN	0	0	0	0	0	0	0	0	0	0
HBH	0	0	0	0	0	0	0	0	0	0
The Right Door	0	0	0	0	0	0	0	0	0	0
LifeWays	0	0	0	0	0	1	0	0	0	1
MCN	0	0	0	0	0	0	0	0	0	0
NCMH	0	0	0	0	0	0	0	0	0	0
SCCMH	0	0	0	0	0	0	0	0	2	2
SHW	0	0	0	0	0	0	0	0	2	2
TBHS	0	0	0	0	0	0	0	0	0	0

Table 8: Critical Event Suicide Death. Highlighted cells indicate an update from previous report.

Organization	FY20Q1	FY20Q2	FY20Q3	FY20Q4	FY20	FY21Q1	FY21Q2	FY21Q3	FY21Q4	FY21
MSHN	3	2	5	7	17	2	5	2	9	18
BABH	0	0	0	1	1	1	0	0	0	1
CEI	2	1	3	2	8	0	3	1	4	8
CMHCM	0	0	1	0	1	0	0	0	2	2
GIHN	0	0	0	0	0	0	0	0	0	0
HBH	0	0	0	0	0	0	0	0	0	0
The Right Door	0	0	0	0	0	0	0	0	0	0
LifeWays	1	0	1	1	3	0	0	0	1	1
MCN	0	0	0	0	0	0	1	0	0	1
NCMH	0	0	0	0	0	0	0	0	0	0
SCCMH	0	1	0	2	3	0	1	0	1	2
SHW	0	0	0	0	0	1	0	0	0	1
TBHS	0	0	0	1	1	0	0	1	1	2

Quality Assessment Performance Improvement Program
Substance Use Disorder Residential Providers
Critical Incidents FY21

Summary of Project

The data collected is based on the definition and requirements that have been set forth within the Sentinel Event/Critical Incident Reporting System (CIRS) attached to the PIHP contract and available on the MDHHS Website.

The following incidents are reviewed by the Substance Use Residential Providers and Recovery Housing providers to determine if the event is sentinel or not sentinel. If sentinel a root cause analysis must be completed and a plan of action developed, or documentation as to why an action plan was not needed. The reported events for the Substance Abuse Residential Providers is reported to MDHHS as required:

- Death: That which is not by natural cause or does **not** occur as a natural outcome to a chronic condition (e.g. terminal illness) or old age.
- Unexpected deaths: Deaths that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.
    - Deaths as a result of staff action or inaction, or subject to a recipient rights investigation, licensing, or police investigation requires additional information to be submitted to the Quality Manager or designee at MSHN within 36 hours of the notification of an investigation for reporting to MDHHS (MSHN must report to MDHHS within 48 hours of the notification of an investigation occurring).
- Injury -Injury by accident resulting in a visit to an emergency room, medi-center and urgent care clinic/center and/or admissions to hospital
- Physical illness resulting in admission to a hospital: Does **not** include planned surgeries, whether inpatient or outpatient. It also does **not** include admissions directly related to the natural course of the person's chronic illness, or underlying condition. For example, hospitalization of an individual who has a known terminal illness in order to treat the conditions associated with the terminal illness is not a sentinel event.
- Serious challenging behaviors: Behaviors not already addressed in a treatment plan and include significant (in excess of $100) property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence that result in death or loss of limb or function to the individual or risk thereof. All unauthorized leaves from residential treatment are not sentinel events in every instance) Serious physical harm is defined by the Administrative Rules for Mental Health (330.7001) as "physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient."
- Medication errors: Mean a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage which resulted in death or loss of limb or function or the risk thereof. It does not include instances in which consumers have refused medication.
- Administration of Narcan: Reported within 48 hours to MSHN
- Sentinel Event: An “unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, ‘or risk thereof’ includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome." (JCAHO, 1998)

Data Analysis

This data is to be reported and reviewed as part of the MSHN Quality Assessment and Performance Improvement Program (QAPIP). MSHN will analyze the data to address any trends and/or opportunities for quality improvements.

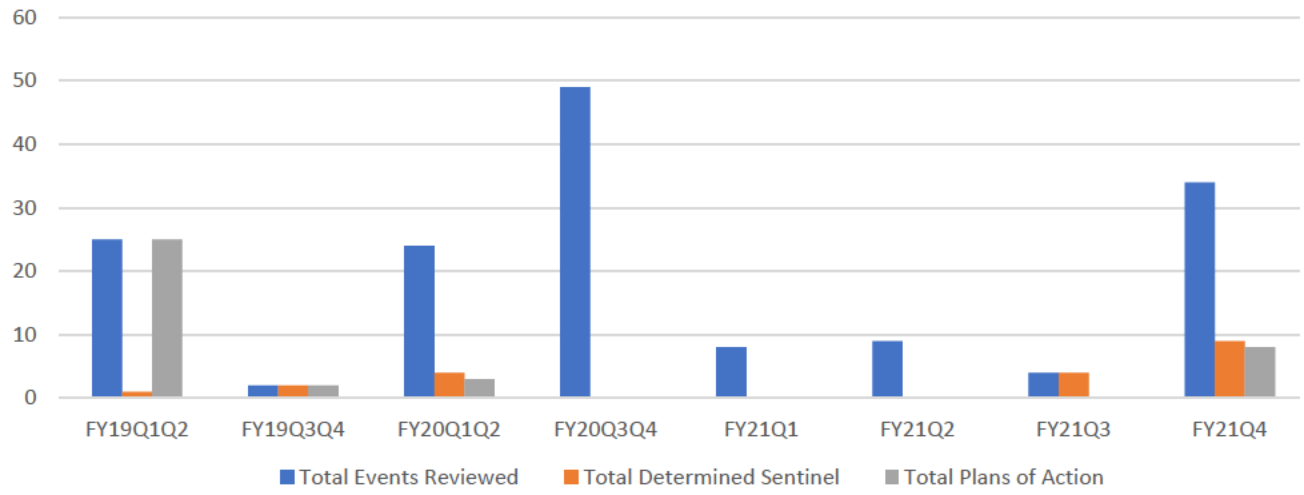
The critical incident reporting system is trend data; therefore, no external exists. MSHN utilizes a linear trend over a minimum of 4 reporting periods. The trend is used to identify any areas requiring further analysis to improve safety of the individuals we serve. This is done by reviewing quarterly data to identify causal factors contributing to an increase rate contributing to an upward trend. The expectation is that each provider and/or MSHN will implement interventions to improve safety, thereby changing the direction of the trend.

Goal: Critical/Sentinel Events will be reported, as required, to MSHN.

Interventions:

- Develop an efficient data collection process. *Status: Sentinel Event Document Submission was built into the Provider Portal. This will continue to be monitored for enhancements, accuracy of data, and additional efficiencies.*
- Provide education and training on event requiring review, determination of sentinel events, completion of root cause analysis. *Status: Training was completed and will be ongoing.*
- Verify events reviewed and reported are consistent with definitions provided by MSHN/MDHHS across the region. *Status: Primary Source Verification will occur in FY22.*
  - The number of events reviewed are accurately reported for each organization providing services to the required populations.
  - The number of events determined to be sentinel are a subset of those events reviewed.
  - The number of plans of action are equal to the number of events determined to be sentinel events or documented as to why no actions were necessary.

Figure 1: The number of reported events



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Substance Use Residential Providers are required to review critical incidents to determine if they are sentinel. If sentinel, a root cause analysis must be completed, with the determination of actions steps to prevent reocurrance. MSHN must analyze the data quarterly for patterns and/or trends. Quality improvement efforts should be implemented for relevant areas. Based on the number of events reported as critical versus sentinel the numbers are beginning to be reported more as expected. Accuracy will be better determined during the DMC, primary source verification.

The number of providers required to report (SUD Admission Report for Reporting Period): 40
The number of providers who submitted report: 27

1. The rate of reported sentinel events per 1000 served will demonstrate a decrease. FY21 demonstrated an increase in the rate of sentinel events since FY19. This could be a result of additional training received related to the reporting.
   Note: Quarterly Analysis began FY21

Figure 2: Rate per 1000 per incident/event type

MSHN Death of Recipient	FY19Q1Q2	FY19Q3Q4	FY20Q1Q2	FY20Q3Q4	FY21Q1	FY21Q2	FY21Q3	FY21Q4
Critical Event Reviewed	0.629	0.495	0.696	0.000	0.000	0.000	0.000	0.000
Sentinel Event	0.629	0.495	0.696	0.000	0.000	0.000	0.000	0.000
Plan of Action	0.629	0.495	0.696	0.000	0.000	0.000	0.000	0.000
MSHN Accidents requiring emergency room visits and/or admissions to hospitals	**FY19Q1Q2**	**FY19Q3Q4**	**FY20Q1Q2**	**FY20Q3Q4**	**FY21Q1**	**FY21Q2**	**FY21Q3**	**FY21Q4**
Critical Event Reviewed	1.257	0.000	2.784	2.959	2.679	2.329	0.000	3.933
Sentinel Event	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Plan of Action	1.257	0.000	0.000	0.000	0.000	0.000	0.000	0.000
MSHN Physical illness requiring admissions to hospitals	**FY19Q1Q2**	**FY19Q3Q4**	**FY20Q1Q2**	**FY20Q3Q4**	**FY21Q1**	**FY21Q2**	**FY21Q3**	**FY21Q4**
Critical Event Reviewed	3.771	0.495	2.784	1.775	2.679	3.106	3.996	8.850
Sentinel Event	0.000	0.495	0.696	0.000	0.000	0.000	3.996	3.933
Plan of Action	3.771	0.495	0.000	0.000	0.000	0.000	0.000	2.950
MSHN Arrest or conviction of recipients	**FY19Q1Q2**	**FY19Q3Q4**	**FY20Q1Q2**	**FY20Q3Q4**	**FY21Q1**	**FY21Q2**	**FY21Q3**	**FY21Q4**
Critical Event Reviewed	4.400	0.000	0.000	1.183	0.000	0.000	0.000	0.000
Sentinel Event	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Plan of Action	4.400	0.000	0.000	0.000	0.000	0.000	0.000	0.000
MSHN Serious challenging behaviors	**FY19Q1Q2**	**FY19Q3Q4**	**FY20Q1Q2**	**FY20Q3Q4**	**FY21Q1**	**FY21Q2**	**FY21Q3**	**FY21Q4**
Critical Event Reviewed	2.514	0.000	10.438	2.367	1.786	1.553	0.000	3.933
Sentinel Event	0.000	0.000	1.392	0.000	0.000	0.000	0.000	0.983
Plan of Action	2.514	0.000	1.392	0.000	0.000	0.000	0.000	0.983
MSHN Medication errors	**FY19Q1Q2**	**FY19Q3Q4**	**FY20Q1Q2**	**FY20Q3Q4**	**FY21Q1**	**FY21Q2**	**FY21Q3**	**FY21Q4**
Critical Event Reviewed	3.143	0.000	0.000	20.710	0.000	0.000	0.000	16.716
Sentinel Event	0.000	0.000	0.000	0.000	0.000	0.000	0.000	3.933
Plan of Action	3.143	0.000	0.000	0.000	0.000	0.000	0.000	3.933

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Summary: MSHN demonstrated an increase in the rate of sentinel events since FY19. The increase for FY21 is attributed to medication errors, however, the rate of medication errors did decrease in FY21 (4.179) compared to FY20 (20.710). The largest increase was in the rate for events reviewed for physical illness requiring admission to hospital by MSHN SUD providers (FY21-4.657 versus FY20-2.279). The provider network did have increased reporting of critical incidents that were reviewed, followed by a subset of those being determined sentinel. A Root Cause Analysis (RCA) was completed for the reported sentinel events and action was implemented based on the outcome of the RCA. Approximately twenty-seven SUD providers submitted the Sentinel Event Report for FY21Q4. Contributing factors may include the following: a new reporting system; the submission of sentinel events into the Provider Portal Document Submission process; trainings provided; the pandemic pf COVID 19. The accuracy of the reporting, consistent with the definition and instructions provided from MDHHS, will be verified with primary source verification occurring during the delegated managed care review.

Recommendations:

- The providers should continue to report events and follow up with system reviews as needed to avoid any recurrence.
- SUD Providers should review and report all critical and sentinel events to MSHN quarterly. MSHN to enforce compliance with the reporting requirements.
  Status: FY21Q4 was received through the portal only. Sentinel Event reporting through the portal includes alerts for unexpected deaths and administration of Narcan. Reports of submissions and events from Provider Portal requires development. Requires ongoing training to ensure reporting is being completed.
- Each sentinel event should result in a root cause analysis with identified action to prevent reoccurrence. *Status: Actions related to these deaths will be included in the primary source verification during the Delegated Managed Care Reviews.*
- MSHN to review a sample of critical incidents during SUD Delegated Managed Care reviews consistent with the SUD Oversight Policy.
- MSHN to continue to work with Providers to validate the data and ensure the correct process is used for reviewing and reporting.

Prepared by: Sandy Gettel, Quality Manager **Date:** 12/8/2021

Reviewed by: SUD Performance Measurement Team **Date:** 12/8/2021

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Attachment 1

MSHN SUD Residential	FY19	Rate	FY20	Rate	FY21	Rate
Total Events Reviewed	27	1.392	73	3.808	60	2.148
Total Determined Sentinel	3	0.135	4	0.232	13	0.535
Total Plans of Action	27	1.392	3	0.174	8	0.328
MSHN Death of Recipient	**FY19**	**Rate**	**FY20**	**Rate**	**FY21**	**Rate**
Critical Event Reviewed	2	0.562	1	0.348	0	0.000
Sentinel Event	2	0.562	1	0.348	0	0.000
Plan of Action	2	0.562	1	0.348	0	0.000
MSHN Accidents requiring emergency room visits and/or admissions to hospitals	**FY19**	**Rate**	**FY20**	**Rate**	**FY21**	**Rate**
Critical Event Reviewed	2	0.629	9	2.871	10	2.235
Sentinel Event	0	0.000	0	0.000	0	0.000
Plan of Action	2	0.629	0	0.000	0	0.000
MSHN Physical illness requiring admissions to hospitals	**FY19**	**Rate**	**FY20**	**Rate**	**FY21**	**Rate**
Critical Event Reviewed	7	2.133	7	2.279	20	4.657
Sentinel Event	1	0.248	1	0.348	8	1.982
Plan of Action	7	2.133	0	0.000	3	0.737
MSHN Arrest or conviction of recipients	**FY19**	**Rate**	**FY20**	**Rate**	**FY21**	**Rate**
Critical Event Reviewed	7	2.200	2	0.592	0	0.000
Sentinel Event	0	0.000	0	0.000	0	0.000
Plan of Action	7	2.200	0	0.000	0	0.000
MSHN Serious challenging behaviors	**FY19**	**Rate**	**FY20**	**Rate**	**FY21**	**Rate**
Critical Event Reviewed	4	1.257	19	6.403	8	1.818
Sentinel Event	0	0.000	2	0.696	1	0.246
Plan of Action	4	1.257	2	0.696	1	0.246
MSHN Medication errors	**FY19**	**Rate**	**FY20**	**Rate**	**FY21**	**Rate**
Critical Event Reviewed	5	1.571	35	10.355	17	4.179
Sentinel Event	0	0.000	0	0.000	4	0.983
Plan of Action	5	1.571	0	0.000	4	0.983
Administration of Narcan*	**FY19**	**Rate**	**FY20**	**Rate**	**FY21**	**Rate**
Critical Event Reviewed	NA	NSA	NA		5	1.130

*New MSHN reportable event for FY21

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.

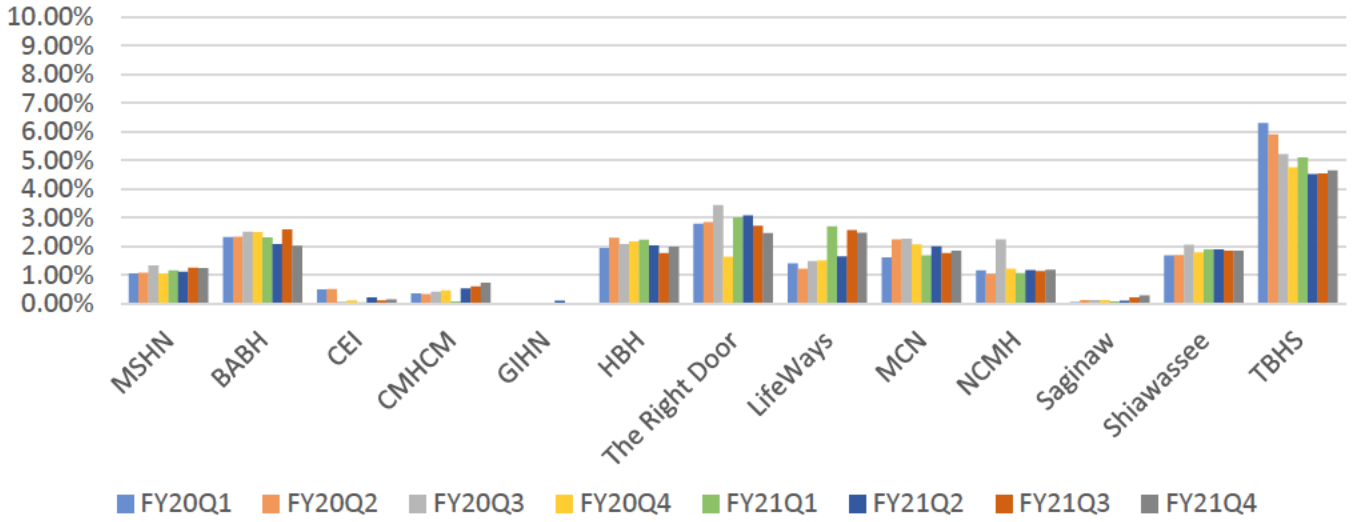
Data Analysis

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.

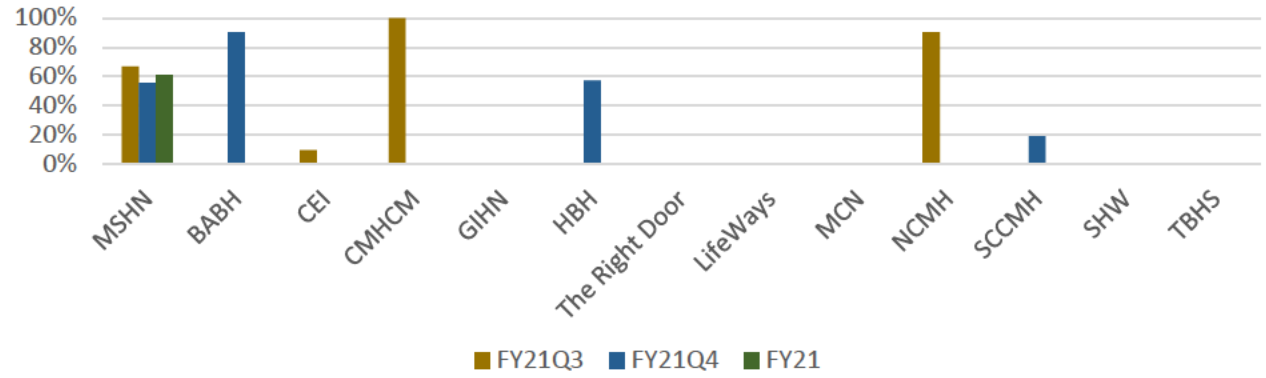
1. The number of plans may be attributed to the increased monitoring and oversight from MDHHS as it relates to the monthly review of HSW re-certification; and increased monitoring of the Individual plans of Service, Behavior Treatment Plans and home visits where unreported restrictions are identified; and more accurate identification and oversight of restrictions.
2. The incorporation of the individuals receiving the autism benefit into the CMHSP BTRC process. Most of the CMHSPs have begun to review plans that have restrictive or physical interventions for individuals receiving Applied Behavioral Analysis (ABA) services.
3. Plans that include Medication for behavioral assistance are being incorporated into the review process. Each CMHSP has a process to begin to look at individuals (children and adults) 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 total number of Behavior Treatment Standards reviewed through the monthly delegated managed care reviews.

Figure 2. Percentage of Behavioral Treatment Plan Standards Met

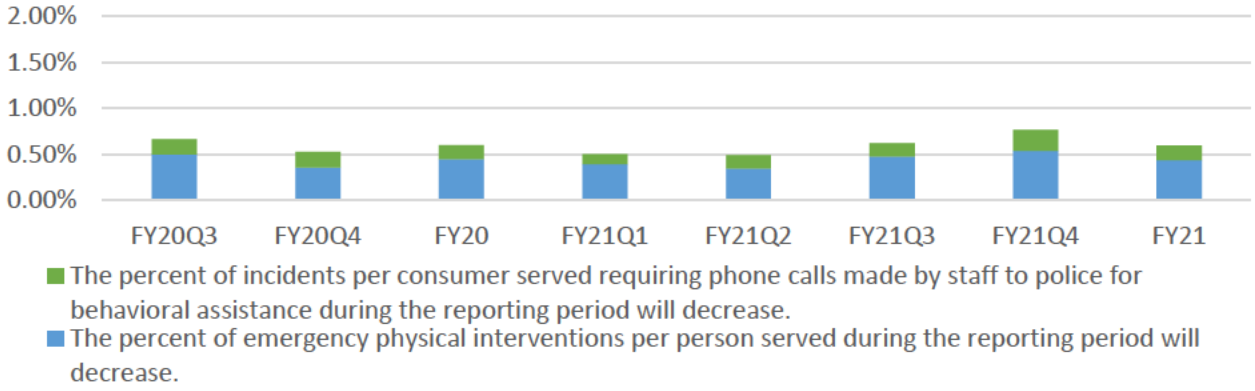


Goal 3: The percent of emergency physical interventions per person served during the reporting period will demonstrate a decrease from previous measurement period.

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

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

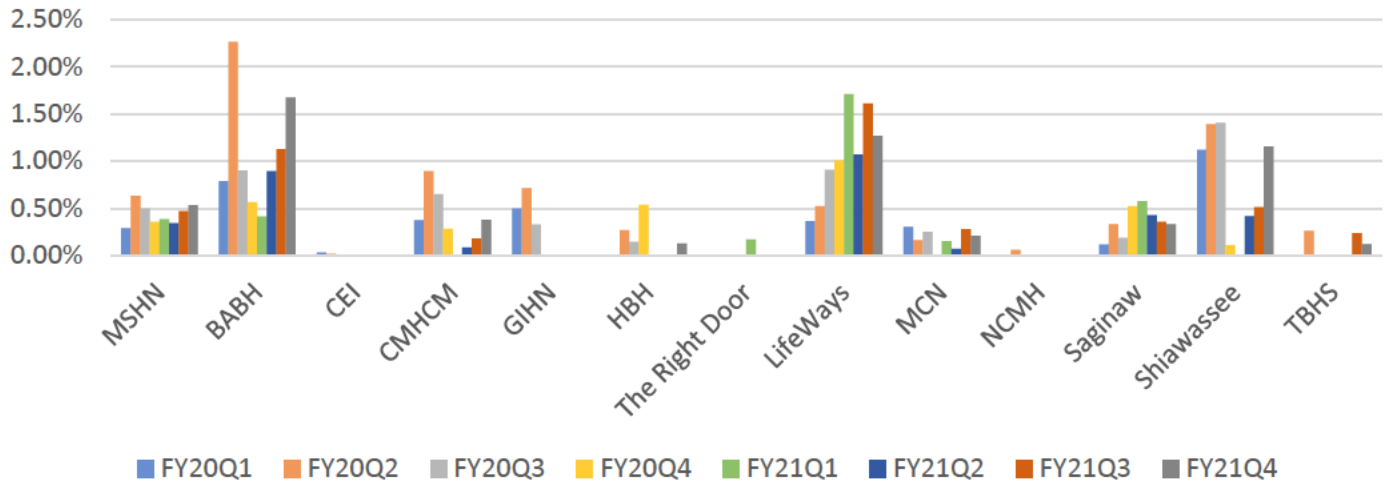
Figure 3. The percentage of emergency interventions used per person served



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

Numerator: The total number of emergency physical interventions (EPI) reviewed during the reporting period. (Total # 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

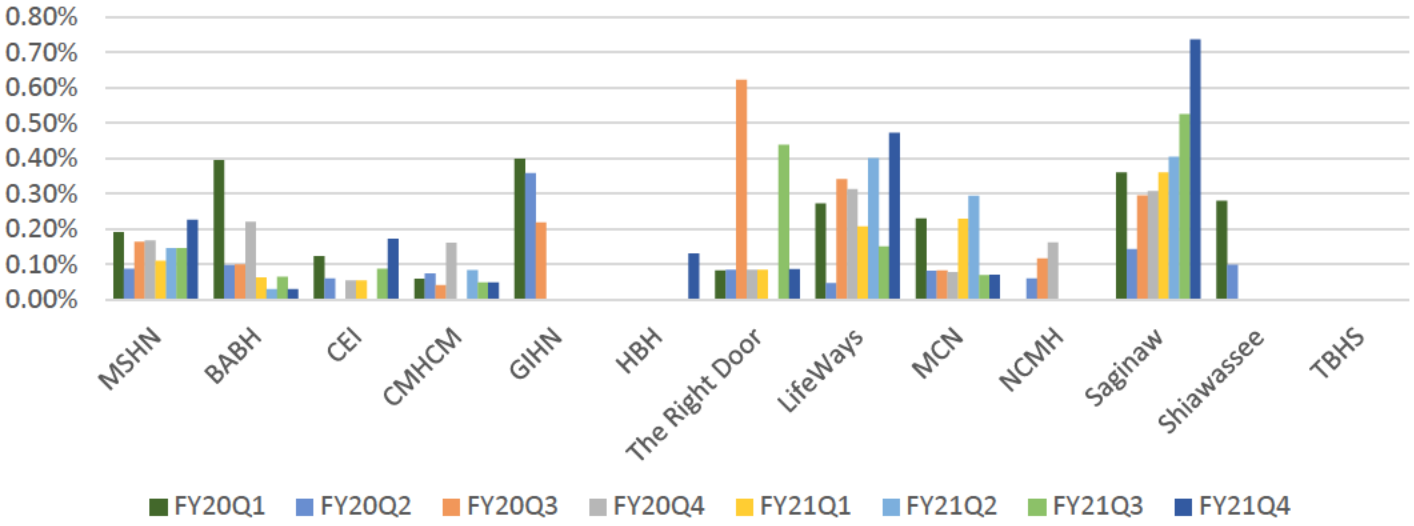


Figure 4a. Behavior Treatment Data Trends

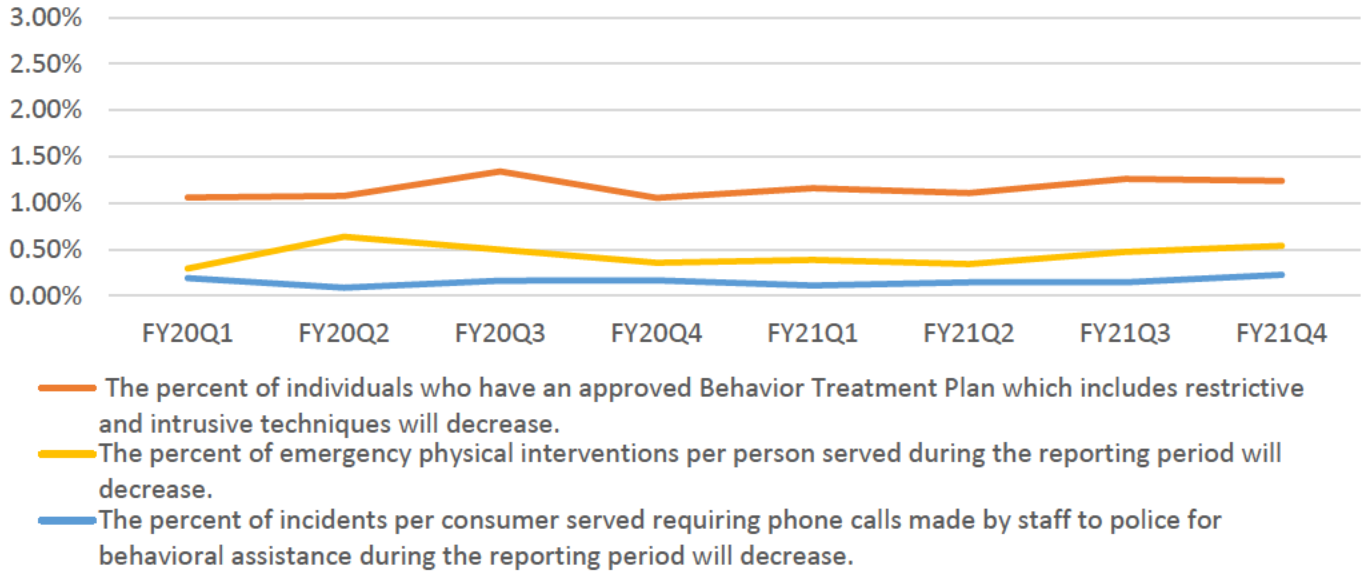


Figure 4b. The percentage of BTP by waiver program with an emergency intervention by benefit program reviewed during the reporting period.

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 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.

The percent of individuals served who have a behavior plan that include intrusive or restrictive interventions has increased during 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 the DMC 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.

<u>Status:</u> 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.
  <u>Status:</u> 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

MEMBER SATISFACTION
FY21 ANNUAL REPORT

Mid-State Health Network

MSHN
Mid-State Health Network

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Executive Summary

The Mid-State Health Network (MSHN) Quality Assessment and Performance Improvement Program, as required by the Michigan Department of Health and Human Services (MDHHS), annually administers a survey to a representative group of individuals served. MSHN, in collaboration with the Community Mental Health Services Program (CMHSP) and their contracted providers, utilized the Mental Health Statistics Improvement Program Survey (MHSIP) for adults; and the Youth Services Survey (YSS) for children and their families. MSHN in collaboration with the Substance Use Disorder Treatment Providers (SUDTP) utilized a MSHN developed satisfaction survey for individuals receiving SUD services. The data obtained by each CMHSP participant and SUDTP was provided to MSHN for regional analysis with the opportunity to identify strengths, growth areas, and implement improvement within the region. The results of the surveys are reported to MSHN's Quality Improvement Council (QIC) and available to stakeholders on the MSHN Website and upon request. The survey data provides a snapshot of how the individuals perceive the care that is received. The findings are utilized to improve the quality, access and effectiveness of care received.

MHSIP was completed by adults, 18 years and older, with a mental illness(n=1444). Seven domains were analyzed for the MHSIP. The three subscales that scored the highest were the Perception of Quality and Appropriateness, Perception of Participation in Treatment, and the Perception of General Satisfaction. The Perception of Social Functioning and the Perception of Outcomes of Services subscales scored the lowest.

The YSS was completed by children and families who experience a severe emotional disorder(n=575). Seven domains were analyzed for the YSS. The two subscales that scored the highest were the Perception of Cultural Sensitivity and Perception of Access. The Perception of Outcomes of Services, and the Perception of Social Functioning subscales scored the lowest.

The SUD Satisfaction Survey was completed by individuals who received a service from a substance use disorder treatment provider(n=2131). Six subscales were analyzed for the SUD Survey. The two subscales that scored the highest were the Perception of Cultural/Ethnic Background, and the Perception of the Welcoming Environment. The Perception of the Appropriateness and Choice with Services, and the Perception of Coordination of Care/Referrals to Other Resources (demonstrated most improvement) subscales scored the lowest.

Methodology

The distribution method for the 2021 Satisfaction Survey included face to face, mailed, electronic, or phone surveys. Each survey included a list of statements that are categorized by subscales. The statement is rated using a Likert scale. Those statements that have a "Blank" or a response of "Not Applicable" were removed from the sample. Individuals who were missing more than 1/3 of total responses (blanks, or invalid response) were removed from the report. If one question was left blank, the responses of the remaining questions for that subscale were excluded from the

calculations of that subscale. The mean of each individual question is calculated. The total number of respondents who were "in agreement" was divided by the total respondents.

Limitations

This report was developed utilizing voluntary self-reflective surveys. The information from this report is intended to support discussions on how the various provider practices may improve treatment offered to individuals. The information from this report should not be used to draw conclusions or make assumptions without further analysis. Accommodations made as a result of the regulatory changes related to the COVID Pandemic include modifications of the distribution method to include face to face, mailed, or phone surveys. Caution should be taken when using this data to make decisions. The results, therefore, are specific to the perception during that time, and when comparing to other measurement periods.

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.

As indicated in Figure 2, the subscales in which MSHN performed above the 80% standard included 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)

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.

Annual Consumer Satisfaction Survey Summary

MSHN analyzed the data from satisfaction surveys representative of Adults and Children who experience a mental illness and individuals served by the SUD Treatment Providers in the MSHN region. MSHN met the desired threshold (80%) for ten (10) of the fourteen (14) subscales within the MHSIP (adults with mental illness) and the YSSF (children with severe emotional disturbance). The two (2) subscales that did not meet the desired threshold for both populations were the following: Perception of Outcomes of Services and Perception of Social Functioning. MSHN did meet the desired threshold (3.5), demonstrating an increase in five (5) of the six (6) subscales for those receiving SUD services.

All population groups indicated they were "treated with respect", "services were available when needed", and they were satisfied with the services received.

The satisfaction surveys were presented to the Quality Improvement Council (QIC), Clinical Leadership Committee (CLC), Regional Consumer Advisory Committee (RCAC) for review and determine recommendations for any improvements.

Recommendations

- Each CMHSP to review internally to establish an action plan identifying growth areas, barriers, interventions, and process to monitor effectiveness of interventions.
- QIC in collaboration with relevant MSHN committees/council will establish a regional quality improvement plan to address the low response rates.
- QIC will identify regional barriers, relevant regional interventions, with measures of effectiveness.
- Distribution methods will be explored to determine the most effective method.
- Surveys will be streamlined to decrease survey fatigue.
- QIC to monitor for effectiveness of regional and local improvement plans.

Attachment 1 MSHN Member Satisfaction Survey Adults with a Mental Illness.

Attachment 2 MSHN Member Satisfaction Survey for Children with a Severe and Emotional Disorder.

Attachment 3 MSHN Member Satisfaction Survey for Individuals Receiving Substance Use Treatment.

Introduction

The Mid-State Health Network (MSHN) Quality Assessment and Performance Improvement Program, as required by the Michigan Department of Health and Human Services (MDHHS), annually administers a survey to a representative group of individuals served. MSHN, in collaboration with the Community Mental Health Services Program (CMHSP) and their contracted providers, utilized the Mental Health Statistics Improvement Program (MHSIP) to conduct a region wide perception of care survey to adults experiencing a mental illness to determine any areas that may be deficient within the region. The data obtained by each CMHSP was provided to MSHN for regional analysis. The survey outcomes were compared to the previous year's Perception of Care Reports and is reported to MSHN's Quality Improvement Council (QIC) and available to stakeholders on the MSHN Website and upon request.

Methodology

The population group included adults with a mental illness, 18 years and older, who received services between June 1, 2021 and July 30, 2021. The raw data was required to be received by MSHN no later than August 8, 2021. MSHN prepared an analysis, which included comparison data of CMHSPs.

Changes made to the methodology include the following:

- FY2019/20 The population group was expanded to include all youth individuals and families served. As a result of the pandemic and emergency orders, accommodations were made in the distribution methods by allowing mailed survey, phone surveys, electronic surveys, and face to face when available.

Seven subscales are included in the survey. Each subscale included multiple questions related to the subscale topic. The subscales are as follows: General Satisfaction, Access to Care, Quality of Care, Participation in Treatment, Outcomes of Care, Functional Status, and Social Connectedness. Questions left "Blank" or a response choice of "Not Applicable" are removed from the sample. To obtain individual subscale scores, each response is assigned the following numerical values:

Strongly Agree=1
Agree=2
Neutral=3
Disagree=4
Strongly Disagree=5
Not Applicable=9

Individuals missing more than 1/3 of total responses (blanks, or invalid response) are excluded from the calculations. Subscale line items that include a blank result in all subscale line items to be excluded from the calculations of that subscale. Note that the number of responses included in the subscale average/mean and subscale percentage of agreement could be less than that of

each individual question as a result of the exclusion of unanswered questions when calculating the subscale.

The mean of each individual subscale line item is calculated. Those less than or equal to 2.5 are considered to be "in agreement". The total number of respondents who are "in agreement" is then divided by the total respondents. The resultant number is then multiplied by 100 to provide a percentage.

The results are analyzed as follows:

PIHP and CMHSP

- By Subscale
- By Subscale Line Item

Survey Response Rates

The response rate was calculated by dividing the number of surveys received by the number distributed. The number of surveys distributed was determined using three different methods; number mailed, the number offered, and the unique number of individuals served during the time period. The process used for distribution may skew the response rates. Figure 1 indicates the return rate for each CMHSP where data was available prior to August 31th, 2021.

Figure 1 MSHN and CMHSP participant response rates

	2013	2014	2015	2016	2019/20**	2020/21**		
MHSIP	Response Rates	Response Rates	Response Rates	Response Rates	Response Rates	Response Rates	Distributed/ Served	Received
MSHN	41%	34%	46%	56%	18%	15%	9323	1444
BABH	41%	64%	59%	29%	19%	17%	1206	205
CEI	44%	13%	46%	47%	13%	3%	919	26
CMHCM	55%	21%	28%	81%	11%	13%	2113	282
GIHN	*	*	*	*	35%	8%	471	39
HBH	18%	23%	58%	41%	5%	7%	220	16
The Right Door	50%	*	*	*	13%	23%	362	83
Lifeways	23%	37%	43%	42%	32%	31%	1398	428
MCN	26%	25%	40%	27%	20%	10%	252	26
NCMH	17%	*	*	*	34%	21%	530	110
Saginaw	85%	78%	88%	60%	14%	10%	1376	141
Shiawassee	45%	38%	45%	93%	20%	12%	234	28
TBHS	87%	50%	52%	100%	25%	25%	242	60

*No data available ** 2019/20 all adult programs (ACT, OPT, CSM) included in the results

Survey Findings

MSHN's percentage of agreement for each subscale for FY21 scored above the desired threshold for four out of seven subscales. Figure 2 demonstrates the percentage of agreement for each subscale. MSHN scored the highest in the "Perception of Quality and Appropriateness" and "Perception of Participation in Treatment Planning" and" General Satisfaction". The subscales that did not score above the desired threshold of 80% include "Perception of Social Connectedness", "Perception of Functioning", and "Perception of Outcome of Services".

Figure 2. MSHN Subscale Ranking Percentage of Agreement

Subscale	2013	2014	2015	2016/17	2019/20	FY20 U.S Rate	2021
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%**

2019/20 forward includes all programs (OPT/CSM/ACT) included in the results.

In addition to the subscale score, a score is calculated to determine agreement with the individual question. This is completed using two methods. The first method calculates the percentage of those who demonstrated a 2.50 or below. The MSHN score of each subscale since 2013 is demonstrated in Figure 3. The CMHSP score of each subscale since 2013 is exhibited in Appendix A.

Figure 3. MSHN MHSIP Longitudinal Data by Subscale and Subscale Line Item
(2013-2017 include ACT only; beginning 2019 includes adults in OPT, CSM, ACT).

Adults	2013	2014	2015	2016/17	2019/20	2020/21
General Satisfaction	86%	90%	84%	83%	92%	**92%**
Q1. I like the services that I received.	88%	92%	89%	86%	92%	**92%**
Q2. If I had other choices, I would still choose to get services from this mental health agency.	83%	84%	83%	81%	89%	**88%**
Q3. I would recommend this agency to a friend or family member.	84%	91%	83%	82%	92%	**91%**
Perception of Access	91%	92%	85%	85%	91%	**92%**
Q4. The location of services was convenient.	83%	87%	85%	82%	89%	**90%**
Q5. Staff were willing to see me as often as I felt it was necessary.	91%	89%	88%	89%	90%	**90%**
Q6. Staff returned my calls within 24 hours.	86%	90%	90%	84%	88%	**87%**
Q7. Services were available at times that were good for me.	88%	91%	87%	88%	92%	**93%**
Q8. I was able to get all the services I thought I needed.	84%	87%	84%	83%	87%	**88%**
Q9. I was able to see a psychiatrist when I wanted to.	80%	83%	80%	79%	81%	**81%**
Perception of Quality and Appropriateness	89%	97%	83%	85%	92%	**92%**
Q10. Staff believed that I could grow, change and recover.	87%	91%	88%	86%	88%	**90%**
Q12. I felt free to complain.	79%	85%	77%	79%	86%	**90%**
Q13. I was given information about my rights.	90%	91%	90%	90%	93%	**92%**
Q14. Staff encouraged me to take responsibility for how I live my life.	88%	92%	88%	86%	91%	**88%**
Q15. Staff told me what side effects to watch for.	78%	84%	79%	75%	82%	**83%**
Q16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	87%	92%	88%	89%	93%	**93%**
Q18. Staff were sensitive to my cultural/ ethnic background.	82%	91%	81%	79%	89%	**87%**
Q19. Staff helped me obtain the information I needed so that I could take charge of managing my illness and disability.	88%	90%	88%	82%	89%	**89%**
Q20. I was encouraged to use consumer-run programs.	84%	93%	84%	80%	85%	**84%**
Perception of Participation in Treatment Planning	86%	94%	88%	84%	92%	**93%**
Q11. I felt comfortable asking questions about my treatment, services, and medication.	86%	93%	89%	88%	90%	**90%**
Q17. I, not staff, decided my treatment goals.	80%	87%	80%	79%	87%	**87%**

Perception of Outcome of Services	73%	84%	56%	70%	75%	**71%**
Q21. I deal more effectively with daily problems.	80%	84%	82%	77%	80%	**79%**
Q22. I am better able to control my life.	81%	82%	79%	78%	78%	**76%**
Q23. I am better able to deal with crisis.	76%	79%	77%	76%	74%	**72%**
Q24. I am getting along better with my family.	78%	74%	76%	69%	73%	**70%**
Q25. I do better in social situations.	68%	70%	78%	63%	65%	**61%**
Q26. I do better in school and/or work.	58%	61%	60%	35%	62%	**63%**
Q27. My housing situation has improved.	69%	76%	73%	64%	69%	**64%**
Q28. My symptoms are not bothering me as much.	71%	66%	72%	66%	60%	**64%**
Perception of Functioning	84%	73%	70%	72%	77%	**76%**
Q29. I do things that are more meaningful to me.	80%	75%	75%	74%	74%	73%
Q30. I am better able to take care of my needs.	82%	79%	81%	75%	78%	75%
Q31. I am better able to handle things when they go wrong.	74%	72%	74%	71%	68%	**68%**
Q32. I am better able to do things that I want to do.	79%	77%	72%	71%	72%	**70%**
Perception of Social Connectedness	84%	82%	78%	70%	81%	**79%**
Q33. I am happy with the friendships I have.	85%	77%	81%	68%	78%	**75%**
Q34. I have people with who I can do enjoyable things.	80%	79%	82%	71%	79%	**79%**
Q35. I feel I belong in my community.	71%	70%	70%	62%	65%	**61%**
Q36. In a crisis, I would have the support I need from family or friends.	81%	79%	74%	73%	81%	**76%**

The second method provides the mean or average of each question. A score of 2.50 or lower indicates agreement with the statement. Figure 4 provides the mean of each subcategory.

Figure 4. MSHN 2020/21 Subscale Ranking Mean <=2.50 indicates agreement

Subscale	FY20	FY21
General Satisfaction	1.56	**1.59**
Perception of Participation in Treatment Planning	1.62	**1.61**
Perception of Quality and Appropriateness	1.63	**1.62**
Perception of Access	1.65	**1.66**
Perception of Social Connectedness	1.97	**2.09**
Perception of Functioning	2.06	**2.13**
Perception of Outcome of Services	2.08	**2.16**

Summary

The satisfaction survey for adults with a mental illness was completed by each CMHSP Participant. Each survey was scored separately for comparison purposes. The survey consisted of the following subscales: general satisfaction, perception of access, perception participation treatment, perception of quality and appropriateness, perception of outcomes of services, perception of social connectedness, perception of social functioning.

The subscales in which MSHN performed 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%)

The 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.

Growth areas to consider include performance below 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 those that ranked the lowest or 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. The following question 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)

Recommendations

- Distribute the 2020/21 Perception of Care Report to the CMHSP participants through the following committee/council review: Quality Improvement Council (QIC), Regional Consumer Advisory Committee (RCAC)
- Each CMHSP to review internally to establish an action plan identifying growth areas, barriers, interventions, and process to monitor effectiveness of interventions.
- QIC in collaboration with relevant MSHN committees/council will establish a regional quality improvement plan, identifying regional barriers, relevant regional interventions, with measures of effectiveness.
- Modify the methodology to include a recommended length of time an individual should be in services prior to taking the survey.

Completed by: Sandy Gettel Quality Manager MSHN **Date**: September 20, 2021
Reviewed by MSHN QIC **Date**: September 23, 2021
Reviewed by Regional Consumer Advisory Council **Date:** October 8, 2021

Appendix A. MHSIP MSHN and CMHSP Longitudinal Data of Percentage of Agreement.

Report not completed in 2018. *No Utilizers of ACT Services **No ACT Program

		MSHN	BABH	CEI	CMHCM	GIHN	HBH	The Right Door	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS
General Satisfaction	2013	**86%**	84%	79%	89%	*	89%	100%	86%	100%	75%	94%	80%	72%
	2014	**90%**	71%	100%	86%	*	100%	*	90%	100%	*	95%	100%	90%
	2015	**85%**	84%	90%	73%	*	91%	**	86%	73%	**	92%	78%	86%
	2016/17	**83%**	91%	83%	79%	*	100%	**	79%	100%	**	80%	93%	92%
	2019/20	**92%**	90%	86%	88%	96%	95%	98%	96%	89%	94%	89%	90%	85%
	2020/21	**92%**	92%	74%	88%	95%	100%	99%	94%	88%	98%	88%	89%	93%
Access	2013	**91%**	92%	83%	98%	*	88%	100%	94%	80%	100%	88%	90%	85%
	2014	**92%**	79%	100%	91%	*	86%	*	97%	100%	*	95%	67%	80%
	2015	**86%**	92%	89%	82%	*	89%	**	83%	69%	**	93%	88%	86%
	2016/17	**86%**	91%	89%	87%	*	86%	**	79%	80%	**	83%	85%	96%
	2019/20	**91%**	90%	86%	86%	97%	89%	94%	95%	83%	94%	89%	90%	89%
	2020/21	**92%**	94%	68%	87%	93%	100%	94%	94%	87%	94%	88%	96%	93%
Quality and Appropriateness	2013	**89%**	91%	82%	86%	*	89%	100%	89%	100%	100%	91%	89%	86%
	2014	**97%**	89%	100%	95%	*	100%	*	98%	100%	*	100%	100%	78%
	2015	**85%**	86%	89%	78%	*	93%	**	84%	76%	**	89%	84%	88%
	2016/17	**91%**	91%	100%	89%	*	100%	**	90%	100%	**	83%	92%	91%
	2019/20	**92%**	90%	86%	88%	96%	89%	98%	98%	89%	98%	88%	83%	91%
	2020/21	**92%**	88%	67%	88%	97%	91%	95%	98%	91%	94%	88%	92%	96%
Participation in Treatment Planning	2013	**86%**	92%	72%	90%	*	88%	100%	82%	100%	100%	85%	80%	81%
	2014	**94%**	90%	100%	90%	*	100%	*	97%	100%	*	95%	88%	80%
	2015	**84%**	87%	90%	83%	*	95%	**	82%	65%	**	85%	83%	88%
	2016/17	**78%**	91%	70%	78%	*	71%	**	77%	67%	**	76%	79%	87%
	2019/20	**92%**	90%	86%	85%	97%	89%	92%	97%	91%	97%	88%	81%	91%
	2020/21	**93%**	91%	67%	85%	97%	93%	98%	97%	92%	98%	90%	96%	95%
Outcome of Services	2013	**73%**	72%	73%	74%	*	83%	100%	82%	50%	67%	80%	86%	44%
	2014	**84%**	50%	100%	92%	*	75%	*	86%	100%	*	92%	67%	57%
	2015	**74%**	76%	86%	66%	*	86%	**	75%	67%	**	77%	70%	66%
	2016/17	**68%**	57%	78%	75%	*	71%	**	50%	50%	**	79%	67%	69%
	2019/20	**75%**	65%	77%	67%	80%	58%	67%	85%	69%	79%	73%	60%	77%
	2020/21	**71%**	62%	50%	65%	72%	77%	71%	92%	72%	79%	73%	59%	71%
Social Functioning	2013	**84%**	96%	79%	83%	*	88%	100%	87%	60%	33%	90%	100%	68%
	2014	**73%**	60%	88%	89%	*	67%	*	71%	80%	*	86%	33%	60%
	2015	**75%**	72%	82%	67%	*	82%	**	75%	68%	**	79%	77%	68%
	2016/17	**69%**	73%	63%	74%	*	71%	**	63%	80%	**	80%	46%	65%
	2019/20	**77%**	71%	78%	65%	82%	68%	65%	87%	73%	87%	73%	71%	68%
	2020/21	**76%**	65%	54%	70%	75%	88%	73%	85%	72%	87%	76%	71%	68%
Social Connectedness	2013	**84%**	92%	94%	84%	*	100%	67%	78%	100%	67%	88%	89%	69%
	2014	**82%**	73%	100%	68%	*	50%	*	86%	80%	*	95%	100%	60%
	2015	**77%**	73%	77%	74%	*	84%	**	75%	65%	**	87%	83%	68%
	2016/17	**66%**	73%	61%	66%	*	71%	**	61%	33%	**	75%	57%	74%
	2019/20	**81%**	76%	83%	70%	85%	68%	75%	89%	70%	91%	80%	69%	71%
	2020/21	**79%**	70%	68%	73%	79%	88%	67%	85%	84%	87%	85%	71%	83%

Appendix B. MHSIP-The mean score for each subscale line item

2021	MSHN	BABH	CEI	CMCMH	GIHN	HBH	The Right Door	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS
General Satisfaction	**1.59**	**1.56**	**2.35**	**1.69**	**1.35**	**1.35**	**1.29**	**1.62**	**1.96**	**1.44**	**1.63**	**1.65**	**1.47**
Q1. I like the services that I received.	1.56	1.52	2.08	1.63	1.33	1.31	1.35	1.60	1.69	1.35	1.61	1.61	1.47
Q2. If I had other choices, I would still choose to get services from this mental health agency.	1.65	1.60	2.61	1.79	1.41	1.31	1.23	1.64	2.31	1.54	1.69	1.64	1.52
Q3. I would recommend this agency to a friend or family member.	1.58	1.56	2.38	1.65	1.31	1.44	1.27	1.61	1.88	1.44	1.58	1.71	1.42
Perception of Access	**1.66**	**1.64**	**2.20**	**1.76**	**1.44**	**1.41**	**1.48**	**1.63**	**1.94**	**1.61**	**1.67**	**1.66**	**1.55**
Q4. The location of services was convenient.	1.57	1.57	2.04	1.59	1.34	1.44	1.39	1.54	1.73	1.71	1.55	1.44	1.60
Q5. Staff were willing to see me as often as I felt it was necessary.	1.62	1.60	2.15	1.73	1.41	1.44	1.46	1.60	1.96	1.46	1.70	1.71	1.42
Q6. Staff returned my calls within 24 hours.	1.70	1.71	2.32	1.83	1.53	1.27	1.41	1.66	2.08	1.63	1.77	1.68	1.53
Q7. Services were available at times that were good for me.	1.56	1.57	1.96	1.62	1.28	1.19	1.27	1.58	1.88	1.52	1.59	1.64	1.47
Q8. I was able to get all the services I thought I needed.	1.67	1.59	2.31	1.81	1.44	1.38	1.59	1.64	1.77	1.67	1.71	1.57	1.57
Q9. I was able to see a psychiatrist when I wanted to.	1.83	1.84	2.45	1.99	1.71	1.79	1.78	1.76	2.25	1.67	1.70	1.92	1.73
Perception of Quality and Appropriateness	**1.62**	**1.69**	**2.21**	**1.69**	**1.39**	**1.50**	**1.48**	**1.51**	**1.85**	**1.64**	**1.72**	**1.71**	**1.56**
Q10. Staff believed that I could grow, change and recover.	1.58	1.65	1.96	1.67	1.21	1.69	1.42	1.51	1.65	1.53	1.74	1.56	1.47
Q12. I felt free to complain.	1.59	1.75	2.28	1.48	1.44	1.69	1.46	1.51	1.88	1.65	1.72	1.79	1.55
Q13. I was given information about my rights.	1.53	1.55	2.08	1.64	1.33	1.50	1.43	1.39	1.96	1.59	1.56	1.57	1.50
Q14. Staff encouraged me to take responsibility for how I live my life.	1.63	1.74	2.04	1.88	1.26	1.38	1.48	1.47	1.72	1.61	1.71	1.52	1.46
Q15. Staff told me what side effects to watch for.	1.74	1.90	2.52	1.52	1.60	1.57	1.68	1.65	2.04	1.83	1.94	2.07	1.84
Q16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	1.49	1.47	2.08	1.68	1.15	1.33	1.28	1.41	1.62	1.46	1.59	1.39	1.43
Q18. Staff were sensitive to my cultural/ ethnic background (e.g., race, religion, language, etc.).	1.64	1.69	2.10	1.91	1.44	1.38	1.47	1.47	1.88	1.65	1.61	1.70	1.55
Q19. Staff helped me obtain the information I needed so that I could take charge of managing my illness and disability.	1.65	1.67	2.38	1.60	1.45	1.47	1.58	1.62	1.81	1.61	1.73	1.78	1.62
Q20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	1.74	1.81	2.45	1.86	1.63	1.47	1.55	1.54	2.12	1.82	1.87	2.00	1.67
Perception of Participation in Treatment Planning	**1.61**	**1.65**	**2.08**	**1.78**	**1.35**	**1.48**	**1.49**	**1.47**	**1.86**	**1.59**	**1.65**	**1.73**	**1.60**
Q11. I felt comfortable asking questions about my treatment, services, and medication.	1.57	1.56	2.04	1.80	1.33	1.33	1.40	1.48	1.85	1.50	1.57	1.61	1.51
Q17. I, not staff, decided my treatment goals.	1.64	1.73	1.96	1.75	1.36	1.63	1.59	1.47	1.88	1.68	1.73	1.85	1.68

Perception of Outcome of Services	**2.16**	**2.30**	**2.82**	**2.26**	**2.05**	**1.78**	**2.22**	**2.04**	**2.19**	**2.03**	**2.05**	**2.40**	**2.18**
Q21. I deal more effectively with daily problems.	1.96	2.14	2.67	1.98	1.74	1.73	1.94	1.89	2.00	1.70	2.04	2.21	1.97
Q22. I am better able to control my life.	2.01	2.16	2.69	2.05	1.90	1.56	1.92	1.95	2.08	1.85	1.99	2.25	2.07
Q23. I am better able to deal with crisis.	2.09	2.24	2.71	2.26	1.85	1.75	2.10	1.96	2.00	1.96	2.01	2.18	2.10
Q24. I am getting along better with my family.	2.15	2.23	2.88	2.28	2.03	1.87	2.01	2.14	2.08	2.00	1.90	2.44	2.12
Q25. I do better in social situations.	2.35	2.45	2.85	2.47	2.26	1.81	2.53	1.95	2.24	2.28	2.17	2.61	2.30
Q26. I do better in school and/or work.	2.28	2.49	3.17	2.43	2.24	1.57	2.44	1.98	2.28	2.12	2.22	2.43	2.36
Q27. My housing situation has improved.	2.23	2.22	2.71	2.23	2.18	2.07	2.33	2.23	2.35	2.25	1.98	2.46	2.25
Q28. My symptoms are not bothering me as much.	2.32	2.53	2.85	2.40	2.30	1.80	2.59	2.16	2.56	2.17	2.15	2.64	2.36
Perception of Functioning	**2.13**	**2.31**	**2.87**	**2.22**	**2.06**	**1.73**	**2.24**	**1.98**	**2.27**	**1.97**	**2.05**	**2.24**	**2.17**
Q29. I do things that are more meaningful to me.	2.09	2.24	2.88	2.18	2.00	1.75	2.16	1.96	2.20	1.94	1.99	2.25	2.20
Q30. I am better able to take care of my needs.	2.04	2.23	2.88	2.12	1.95	1.81	2.11	1.93	2.19	1.79	1.97	2.14	2.08
Q31. I am better able to handle things when they go wrong.	2.21	2.46	2.88	2.31	2.13	1.63	2.32	2.04	2.31	2.05	2.17	2.25	2.20
Q32. I am better able to do things that I want to do.	2.16	2.33	2.81	2.26	2.16	1.75	2.36	1.98	2.38	2.09	2.07	2.32	2.20
Perception of Social Connectedness	**2.09**	**2.13**	**2.49**	**2.18**	**1.96**	**1.94**	**2.32**	**2.08**	**2.14**	**1.90**	**1.90**	**2.16**	**1.98**
Q33. I am happy with the friendships I have.	2.03	2.07	2.42	2.10	1.95	1.75	2.25	2.02	2.16	1.81	1.88	2.07	2.00
Q34. I have people with who I can do enjoyable things.	1.99	2.03	2.42	2.06	1.77	1.94	2.06	1.98	2.12	1.79	1.90	2.25	1.87
Q35. I feel I belong in my community.	2.35	2.40	2.68	2.53	2.44	2.27	2.90	2.23	2.42	2.23	2.08	2.21	2.31
Q36. In a crisis, I would have the support I need from family or friends.	1.98	2.02	2.42	2.03	1.67	1.81	2.10	2.09	1.85	1.75	1.74	2.11	1.75

MSHN
Mid-State Health Network

Appendix C. MHSIP Subscale Line Item Ranked

Questions	MSHN	BABH	CEI	CMCMH	GIHN	HBH	The Right Door	Life-ways	MCN	NCMH	SCCMH	SHW	TBHS
Q16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	1.49	1.47	2.08	1.68	1.15	1.33	1.28	1.41	1.62	1.46	1.59	1.39	1.43
Q13. I was given information about my rights.	1.53	1.55	2.08	1.64	1.33	1.50	1.43	1.39	1.96	1.59	1.56	1.57	1.50
Q1. I like the services that I received.	1.56	1.52	2.08	1.63	1.33	1.31	1.35	1.60	1.69	1.35	1.61	1.61	1.47
Q7. Services were available at times that were good for me.	1.56	1.57	1.96	1.62	1.28	1.19	1.27	1.58	1.88	1.52	1.59	1.64	1.47
Q4. The location of services was convenient.	1.57	1.57	2.04	1.59	1.34	1.44	1.39	1.54	1.73	1.71	1.55	1.44	1.60
Q11. I felt comfortable asking questions about my treatment, services, and medication.	1.57	1.56	2.04	1.80	1.33	1.33	1.40	1.48	1.85	1.50	1.57	1.61	1.51
Q3. I would recommend this agency to a friend or family member.	1.58	1.56	2.38	1.65	1.31	1.44	1.27	1.61	1.88	1.44	1.58	1.71	1.42
Q10. Staff believed that I could grow, change and recover.	1.58	1.65	1.96	1.67	1.21	1.69	1.42	1.51	1.65	1.53	1.74	1.56	1.47
Q12. I felt free to complain.	1.59	1.75	2.28	1.48	1.44	1.69	1.46	1.51	1.88	1.65	1.72	1.79	1.55
Q5. Staff were willing to see me as often as I felt it was necessary.	1.62	1.60	2.15	1.73	1.41	1.44	1.46	1.60	1.96	1.46	1.70	1.71	1.42
Q14. Staff encouraged me to take responsibility for how I live my life.	1.63	1.74	2.04	1.88	1.26	1.38	1.48	1.47	1.72	1.61	1.71	1.52	1.46
Q18. Staff were sensitive to my cultural/ ethnic background (e.g., race, religion, language, etc.).	1.64	1.69	2.10	1.91	1.44	1.38	1.47	1.47	1.88	1.65	1.61	1.70	1.55
Q17. I, not staff, decided my treatment goals.	1.64	1.73	1.96	1.75	1.36	1.63	1.59	1.47	1.88	1.68	1.73	1.85	1.68
Q19. Staff helped me obtain the information I needed so that I could take charge of managing my illness and disability.	1.65	1.67	2.38	1.60	1.45	1.47	1.58	1.62	1.81	1.61	1.73	1.78	1.62
Q2. If I had other choices, I would still choose to get services from this mental health agency.	1.65	1.60	2.61	1.79	1.41	1.31	1.23	1.64	2.31	1.54	1.69	1.64	1.52
Q8. I was able to get all the services I thought I needed.	1.67	1.59	2.31	1.81	1.44	1.38	1.59	1.64	1.77	1.67	1.71	1.57	1.57
Q6. Staff returned my calls within 24 hours.	1.70	1.71	2.32	1.83	1.53	1.27	1.41	1.66	2.08	1.63	1.77	1.68	1.53
Q20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	1.74	1.81	2.45	1.86	1.63	1.47	1.55	1.54	2.12	1.82	1.87	2.00	1.67
Q15. Staff told me what side effects to watch for.	1.74	1.90	2.52	1.52	1.60	1.57	1.68	1.65	2.04	1.83	1.94	2.07	1.84
Q9. I was able to see a psychiatrist when I wanted to.	1.83	1.84	2.45	1.99	1.71	1.79	1.78	1.76	2.25	1.67	1.70	1.92	1.73
Q21. I deal more effectively with daily problems.	1.96	2.14	2.67	1.98	1.74	1.73	1.94	1.89	2.00	1.70	2.04	2.21	1.97
Q36. In a crisis, I would have the support I need from family or friends.	1.98	2.02	2.42	2.03	1.67	1.81	2.10	2.09	1.85	1.75	1.74	2.11	1.75
Q34. I have people with who I can do enjoyable things.	1.99	2.03	2.42	2.06	1.77	1.94	2.06	1.98	2.12	1.79	1.90	2.25	1.87
Q22. I am better able to control my life.	2.01	2.16	2.69	2.05	1.90	1.56	1.92	1.95	2.08	1.85	1.99	2.25	2.07
Q33. I am happy with the friendships I have.	2.03	2.07	2.42	2.10	1.95	1.75	2.25	2.02	2.16	1.81	1.88	2.07	2.00
Q30. I am better able to take care of my needs.	2.04	2.23	2.88	2.12	1.95	1.81	2.11	1.93	2.19	1.79	1.97	2.14	2.08
Q23. I am better able to deal with crisis.	2.09	2.24	2.71	2.26	1.85	1.75	2.10	1.96	2.00	1.96	2.01	2.18	2.10
Q29. I do things that are more meaningful to me.	2.09	2.24	2.88	2.18	2.00	1.75	2.16	1.96	2.20	1.94	1.99	2.25	2.20

Questions	MSHN	BABH	CEI	CMCMH	GIHN	HBH	The Right Door	Life-ways	MCN	NCMH	SCCMH	SHW	TBHS
Q24. I am getting along better with my family.	2.15	2.23	2.88	2.28	2.03	1.87	2.01	2.14	2.08	2.00	1.90	2.44	2.12
Q32. I am better able to do things that I want to do.	2.16	2.33	2.81	2.26	2.16	1.75	2.36	1.98	2.38	2.09	2.07	2.32	2.20
Q31. I am better able to handle things when they go wrong.	2.21	2.46	2.88	2.31	2.13	1.63	2.32	2.04	2.31	2.05	2.17	2.25	2.20
Q27. My housing situation has improved.	2.23	2.22	2.71	2.23	2.18	2.07	2.33	2.23	2.35	2.25	1.98	2.46	2.25
Q26. I do better in school and/or work.	2.28	2.49	3.17	2.43	2.24	1.57	2.44	1.98	2.28	2.12	2.22	2.43	2.36
Q28. My symptoms are not bothering me as much.	2.32	2.53	2.85	2.40	2.30	1.80	2.59	2.16	2.56	2.17	2.15	2.64	2.36
Q25. I do better in social situations.	2.35	2.45	2.85	2.47	2.26	1.81	2.53	1.95	2.24	2.28	2.17	2.61	2.30
Q35. I feel I belong in my community.	2.35	2.40	2.68	2.53	2.44	2.27	2.90	2.23	2.42	2.23	2.08	2.21	2.31

Appendix D. MSHN and CMHSP MHSIP Total Valid Count for Each Question

Questions	MSHN	BABH	CEI	CMCMH	GIHN	HBH	The Right Door	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS
Q1. I like the services that I received.	1437	204	26	281	39	16	83	426	26	108	141	28	59
Q2. If I had other choices, I would still choose to get services from this mental health agency.	1427	204	23	278	39	16	81	426	26	106	140	28	60
Q3. I would recommend this agency to a friend or family member.	1432	203	26	279	39	16	81	426	26	108	140	28	60
Q4. The location of services was convenient.	1414	195	26	270	38	16	82	427	26	109	138	27	60
Q5. Staff were willing to see me as often as I felt it was necessary.	1430	202	26	280	39	16	80	426	26	108	139	28	60
Q6. Staff returned my calls within 24 hours.	1409	192	25	271	38	15	82	426	25	108	140	28	59
Q7. Services were available at times that were good for me.	1435	203	26	280	39	16	81	428	26	108	140	28	60
Q8. I was able to get all the services I thought I needed.	1437	204	26	280	39	16	82	425	26	110	141	28	60
Q9. I was able to see a psychiatrist when I wanted to.	1287	191	22	261	31	14	68	355	24	100	136	26	59
Q10. Staff believed that I could grow, change and recover.	1417	201	25	276	39	16	78	424	26	109	136	27	60
Q11. I felt comfortable asking questions about my treatment, services, and medication.	1426	203	26	276	39	15	81	423	26	109	141	28	59
Q12. I felt free to complain.	1422	204	25	279	39	16	78	423	26	106	138	28	60
Q13. I was given information about my rights.	1432	203	25	277	39	16	82	426	26	110	140	28	60
Q14. Staff encouraged me to take responsibility for how I live my life.	1394	201	25	253	38	16	81	421	25	110	138	27	59
Q15. Staff told me what side effects to watch for.	1332	193	25	273	35	14	76	365	24	103	140	27	57
Q16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	1410	201	25	261	39	15	81	426	26	108	140	28	60
Q17. I, not staff, decided my treatment goals.	1413	203	26	272	39	16	82	427	25	97	139	27	60
Q18. Staff were sensitive to my cultural/ ethnic background (e.g., race, religion, language, etc.).	1351	187	21	270	36	13	77	406	24	101	133	27	56
Q19. Staff helped me obtain the information I needed so that I could take charge of managing my illness and disability.	1419	200	26	273	38	15	78	426	26	109	141	27	60
Q20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	1389	190	22	278	38	15	76	413	26	107	139	27	58
Q21. I deal more effectively with daily problems.	1429	203	24	278	39	15	80	427	26	109	140	28	60
Q22. I am better able to control my life.	1430	204	26	278	39	16	79	427	26	109	138	28	60
Q23. I am better able to deal with crisis.	1425	201	24	279	39	16	77	426	26	109	140	28	60

Questions	MSHN	BABH	CEI	CMCMH	GIHN	HBH	The Right Door	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS
Q24. I am getting along better with my family.	1380	195	24	270	39	15	75	409	25	109	135	27	57
Q25. I do better in social situations.	1095	202	26	280	38	16	78	95	25	110	140	28	57
Q26. I do better in school and/or work.	889	140	18	198	29	7	43	227	18	52	100	21	36
Q27. My housing situation has improved.	1280	180	24	248	33	14	66	385	26	102	127	24	51
Q28. My symptoms are not bothering me as much.	1420	200	26	279	37	15	80	423	25	110	138	28	59
Q29. I do things that are more meaningful to me.	1432	202	26	282	39	16	80	425	25	109	140	28	60
Q30. I am better able to take care of my needs.	1426	202	26	275	39	16	79	427	26	109	139	28	60
Q31. I am better able to handle things when they go wrong.	1433	203	26	280	38	16	82	426	26	109	139	28	60
Q32. I am better able to do things that I want to do.	1436	204	26	280	37	16	81	428	26	110	140	28	60
Q33. I am happy with the friendships I have.	1412	197	26	277	39	16	77	423	25	108	136	28	60
Q34. I have people with who I can do enjoyable things.	1421	202	26	272	39	16	81	426	26	108	137	28	60
Q35. I feel I belong in my community.	1409	201	25	272	39	15	73	425	26	109	137	28	59
Q36. In a crisis, I would have the support I need from family or friends.	1417	200	26	276	39	16	78	426	26	109	133	28	60

Introduction

The Mid-State Health Network (MSHN) Quality Assessment and Performance Improvement Program, as required by the Michigan Department of Health and Human Services (MDHHS), administered an annual survey to a representative group of individuals served. MSHN, in collaboration with the Community Mental Health Services Program (CMHSP) and their contracted providers, utilized the Youth Satisfaction Survey for Families (YSSF) to conduct a region wide perception of care survey for Home Based Services (HBS), Outpatient Therapy (OPT), and Case Management (CSM). The data obtained by each CMHSP was provided to MSHN for regional analysis and was used to determine any areas that may benefit from quality improvement efforts to increase satisfaction and improve services. The survey results were reported to MSHN's Quality Improvement Council (QIC), the Regional Consumer Advisory Council, and is available to stakeholders on the MSHN Website and upon request.

Methodology

The population group included individuals 17 years or younger who received services between June 1, 2021 and July 30, 2021. The raw data was required to be received by MSHN no later than August 31, 2021. MSHN prepared an analysis, which included comparison data between the CMHSP participants.

Changes made to the methodology include the following:

- FY2019/20
    - The population group was expanded to include all youth individuals and families served.
    - As a result of the pandemic and emergency orders, accommodations were made in the distribution methods by allowing mailed survey, phone surveys, electronic surveys, and face to face when available.

Seven subscales were included in the survey. Each subscale included multiple questions related to the subscale topic. The subscales are as follows: Quality and Appropriateness (satisfaction with service), Access to Care, Family Participation in Treatment Planning, Outcomes of Care, Cultural Sensitivity of Staff, Social Connectedness, and Social Functioning. Questions with a response choice of "blank" were removed from the sample. To obtain individual subscale scores, each response is assigned the following numerical values:

Strong Agree = 5
Agree = 4
Neutral = 3
Disagree = 2
Strongly Disagree = 1

Individuals missing more than 1/3 of total responses (blanks, or invalid response) are excluded from the calculations. Subscale line items that include a blank result in all subscale line items to be excluded from the calculations of that subscale. Note that the number of responses included

in the subscale average/mean and subscale percentage of agreement could be less than that of each individual question as a result of the exclusion of unanswered questions when calculating the subscale.

Individual mean scores greater than or equal to 3.50 are classified as being "in agreement." The total number of respondents "in agreement" is then divided by the total number of respondents with the result multiplied by 100.

The results are analyzed as follows:

PIHP and CMHSP

- By Subscale
- By Subscale Line Item

Survey Response Rates

The response rate was calculated by dividing the number of surveys received by the number distributed. The number of surveys distributed was determined using three different methods; number mailed, the number offered, the unique number of individuals served during the time period. The process used for distribution may skew the response rates. Figure 1 indicates the return rate for each CMHSP where data was available prior to August 31, 2021.

Figure 1. MSHN and CMHSP Participants Return Rate

	2013	2014	2015	2016/17	2019/20**	2020/21**		
YSSF	Response Rates	Response Rates	Response Rates	Response Rates	Response Rates	Response Rates	Distributed/ Served	Received
MSHN	32%	22%	40%	33%	17%	15%	3786	575
BABH	15%	28%	15%	30%	13%	14%	390	54
CEI	37%	9%	63%	10%	9%	2%	861	17
CMHCM	24%	31%	41%	39%	5%	9%	565	51
GIHN	95%	42%	31%	70%	23%	10%	224	22
HBH	10%	100%	38%	41%	9%	21%	58	12
The Right Door	*	52%	35%	46%	11%	21%	165	34
Lifeways	15%	34%	33%	36%	59%	42%	389	163
MCN	20%	32%	34%	39%	9%	6%	149	9
NCMH	*	100%	21%	23%	65%	39%	188	74
Saginaw	13%	59%	30%	29%	8%	8%	534	41
Shiawassee	43%	10%	40%	79%	11%	12%	137	16
TBHS	56%	56%	77%	75%	25%	65%	126	82

*No data available **All youth programs (OPT/CSM/HBS) included in the results.

Survey Findings

MSHN's percentage of agreement for each subscale for FY21 scored above the desired threshold for five out of seven subscales. Figure 2 demonstrates the performance of each subscale compared to the previous year. MSHN scored the highest in the "Perception of Cultural Sensitivity", "Perception of Access", and "Perception of Participation in Treatment". Each subscale scored above the desired threshold of 80% except the "Perception of Outcomes of Services" and "Perception of Social Functioning".

Figure 2. MSHN Subscale Ranking Percentage of Agreement

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%

**All programs (OPT/CSM/HBS) included in the results.

In addition to the subscale score, a score is calculated to determine agreement with the individual question. This is completed using two methods. The first method calculates the percentage of those who demonstrated a 3.50 or above (Figure 3 and Appendix A). The second method as demonstrated in Figure 4 provides the mean of each question. A score of 3.50 or higher indicates agreement with the statement.

Figure 3. MSHN YSS Longitudinal Data by Subscale and Subscale Line Item
(2013-2017 includes HBS only; beginning 2019 includes all youth programs OPT, CSM, HBS)
(* Subscale added in 2014, **Distributed and collected during COVID-19)

Youth	2013	2014	2015	2016/17	**2019/20	**2020/21
Perception of Access	90%	92%	90%	90%	95%	**96%**
Q8. The location of services was convenient for us.	96%	98%	97%	97%	94%	**97%**
Q9. Services were available at times that were convenient for us.	96%	95%	95%	96%	92%	**92%**
Perception of Participation in Treatment	95%	95%	96%	95%	94%	**93%**
Q2. I helped to choose my child's services.	91%	90%	92%	90%	92%	**93%**
Q3. I helped to choose my child's treatment goals.	98%	96%	97%	97%	94%	**97%**
Q6. I participated in my child's treatment.	97%	97%	99%	98%	96%	**87%**
Perception of Cultural Sensitivity	98%	99%	97%	98%	98%	**99%**
Q12. Staff treated me with respect.	96%	100%	98%	99%	97%	**97%**
Q13. Staff respected my family's religious/spiritual beliefs.	93%	94%	96%	97%	94%	**96%**
Q14. Staff spoke with me in a way that I understand.	98%	99%	99%	99%	98%	**99%**
Q15. Staff were sensitive to my cultural/ethnic background.	93%	93%	95%	92%	94%	**96%**
Appropriateness	**90%**	**92%**	**90%**	**90%**	**87%**	**89%**
Q1. Overall, I am satisfied with the services my child received.	92%	93%	95%	95%	89%	**90%**
Q4. The people helping my child stuck with us no matter what.	91%	91%	93%	92%	89%	**89%**
Q5. I felt my child had someone to talk to when she/he was troubled.	88%	90%	92%	89%	85%	**81%**
Q7. The services my child and/or family received were right for us.	91%	88%	92%	92%	87%	**82%**
Q10. My family got the help we wanted for my child.	86%	82%	87%	87%	82%	**83%**
Q11. My family got as much help as we needed for my child.	80%	77%	80%	83%	75%	**80%**

Youth	2013	2014	2015	2016/17	**2019/ 20	**2020/21
Perception of Outcome of Services	**63%**	**65%**	**60%**	**65%**	**62%**	**68%**
Q16. My child is better at handling daily life.	65%	69%	64%	68%	64%	**69%**
Q17. My child gets along better with family.	67%	67%	63%	67%	63%	**70%**
Q18. My child gets along better with friends and other people.	65%	63%	61%	62%	64%	**69%**
Q19. My child is doing better in school and/or work.	62%	65%	61%	65%	53%	**62%**
Q20. My child is better able to cope when things go wrong.	58%	59%	56%	58%	56%	**59%**
Q21. I am satisfied with our family life right now.	56%	61%	55%	61%	66%	**70%**
Q22. My child is better able to do things he or she wants to do.	63%	66%	62%	68%	69%	**71%**
Perception of Social Connectedness	92%	92%	84%	88%	92%	**92%**
Q23. I know people who will listen and understand me when I need to talk.	88%	88%	85%	88%	89%	**91%**
Q24. I have people that I am comfortable talking with about my child's problems.	88%	91%	88%	89%	93%	**93%**
Q25. In a crisis, I would have the support I need from family or friends.	76%	80%	81%	82%	88%	**86%**
Q26. I have people with whom I can do enjoyable things.	79%	87%	81%	88%	89%	**89%**
Perception of Social Functioning	*	69%	61%	66%	65%	**71%**
Q16. My child is better at handling daily life.	65%	69%	64%	68%	64%	**69%**
Q17. My child gets along better with family.	67%	67%	63%	67%	63%	**70%**
Q18. My child gets along better with friends and other people.	65%	63%	61%	62%	64%	**69%**
Q19. My child is doing better in school and/or work.	62%	65%	61%	65%	53%	**62%**
Q20. My child is better able to cope when things go wrong.	58%	59%	56%	58%	56%	**59%**
Q22. My child is better able to do things he or she wants to do.	63%	66%	62%	68%	69%	**71%**

Figure 4. The mean score for each subscale on scale from 1-5 with 5 being "Strongly Agree".

Subscale	MSHN 2020	MSHN 2021
Perception of Cultural Sensitivity	4.60	4.66
Perception of Access	4.50	4.56
Perception of Participation in Treatment	4.47	4.43
Perception of Social Connectedness	4.33	4.38
Appropriateness	4.31	4.27
Functioning	3.70	3.80
Outcomes	3.70	3.80

Summary

The Youth Satisfaction Survey for Families was completed by each CMHSP Participant. Each survey was scored separately for comparison purposes. The survey consisted of the following subscales: perception of access, perception participation treatment, perception of cultural sensitivity, appropriateness, perception of outcomes of services, perception of social connectedness, perception of social functioning.

The subscales in which MSHN performed above the 80% standard include the following:

- Perception of Cultural Sensitivity
- Perception of Access
- Participation in Treatment
- Social Connectedness
- Appropriateness

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)

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% or below a score of 3.50 for the subscale line item, consideration should be given to the questions that are ranked the lowest or 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)

Recommendations

- Distribute the 2020/21 Perception of Care Report to the CMHSP participants through the following committee/council review: Quality Improvement Council (QIC), Regional Consumer Advisory Committee (RCAC)
- Each CMHSP to review internally to establish an action plan identifying growth areas, barriers, interventions, and process to monitor effectiveness of interventions.
- Evaluate methodology to incorporate a length of time open to treatment to complete survey.

Completed by: Sandy Gettel Quality Manager MSHN **Date:** September 20, 2021
Reviewed by MSHN Quality Improvement Council **Date:** September 23, 2021
Reviewed by MSHN Regional Advisory Council **Date:** October 8, 2021

Appendix A. MSHN and CMHSP Longitudinal Data of Percentage of Agreement

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

		MSHN	BABH	CEI	CMHCM	GIHN	HBH	The Right Door	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS
Appropriate-ness	2013	90%	64%	86%	91%	97%	100%	93%	90%	91%	100%	100%	100%	91%
	2014	92%	80%	93%	92%	100%	79%	91%	93%	87%	100%	90%	100%	94%
	2015	90%	93%	86%	85%	92%	83%	89%	91%	85%	80%	94%	86%	98%
	2016/17	90%	97%	90%	91%	81%	86%	88%	91%	85%	80%	100%	89%	98%
	**2019/20	87%	79%	80%	79%	87%	86%	88%	94%	88%	95%	85%	77%	100%
	**2020/21	89%	88%	65%	72%	90%	100%	94%	88%	67%	93%	95%	88%	99%
Access	2013	98%	93%	99%	100%	97%	100%	100%	96%	100%	100%	100%	100%	97%
	2014	98%	93%	100%	96%	100%	100%	96%	97%	93%	100%	100%	100%	100%
	2015	96%	100%	94%	97%	96%	90%	100%	96%	95%	100%	83%	93%	97%
	2016/17	97%	98%	97%	95%	95%	93%	98%	97%	90%	100%	100%	98%	100%
	**2019/20	95%	93%	94%	92%	98%	86%	100%	98%	81%	96%	93%	85%	100%
	**2020/21	96%	94%	94%	90%	95%	100%	97%	97%	78%	95%	100%	100%	99%
Outcome of Services	2013	63%	77%	86%	100%	59%	100%	93%	90%	100%	100%	100%	100%	97%
	2014	65%	53%	73%	55%	79%	57%	62%	63%	71%	40%	70%	67%	74%
	2015	60%	67%	71%	49%	59%	51%	56%	56%	61%	66%	62%	67%	64%
	2016/17	65%	71%	73%	65%	49%	45%	45%	66%	59%	63%	86%	55%	80%
	**2019/20	62%	55%	47%	38%	70%	50%	62%	67%	60%	75%	56%	62%	73%
	**2020/21	68%	62%	35%	56%	55%	73%	74%	71%	56%	75%	68%	56%	78%
Cultural Sensitivity	2013	98%	86%	96%	98%	97%	100%	100%	97%	100%	60%	100%	100%	91%
	2014	99%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	97%
	2015	97%	100%	96%	98%	96%	100%	100%	95%	96%	95%	100%	93%	99%
	2016/17	98%	100%	100%	100%	93%	100%	100%	95%	97%	100%	100%	95%	100%
	**2019/20	98%	96%	98%	98%	100%	100%	97%	99%	100%	100%	95%	100%	100%
	**2020/21	99%	98%	100%	94%	95%	100%	100%	100%	100%	99%	98%	94%	100%
Participation in Treatment	2013	95%	46%	55%	59%	81%	0%	64%	57%	64%	100%	100%	60%	75%
	2014	95%	93%	91%	98%	100%	93%	96%	96%	87%	80%	90%	100%	94%
	2015	96%	100%	94%	94%	92%	100%	98%	96%	98%	100%	100%	90%	99%
	2016/17	95%	98%	95%	99%	92%	100%	98%	94%	93%	89%	100%	92%	96%
	**2019/20	94%	93%	94%	96%	91%	71%	97%	97%	94%	96%	95%	77%	100%
	**2020/21	93%	94%	94%	92%	91%	100%	97%	87%	78%	96%	98%	94%	100%
Social Connectedness	2013	92%	77%	86%	100%	94%	100%	93%	90%	100%	100%	100%	100%	97%
	2014	92%	93%	86%	94%	100%	86%	91%	97%	93%	60%	90%	67%	89%
	2015	84%	93%	79%	85%	94%	90%	87%	83%	81%	80%	100%	70%	89%
	2016/17	88%	84%	88%	89%	87%	68%	72%	90%	87%	67%	75%	85%	88%
	**2019/20	92%	91%	86%	83%	95%	100%	90%	97%	94%	97%	91%	92%	100%
	**2020/21	92%	92%	82%	76%	91%	100%	100%	96%	78%	90%	90%	81%	96%
Social Functioning	*2013	*	*	*	*	*	*	*	*	*	*	*	*	*
	2014	69%	60%	73%	60%	82%	50%	71%	66%	79%	40%	90%	67%	76%
	2015	61%	71%	73%	50%	61%	53%	59%	55%	62%	67%	67%	68%	64%
	2016/17	66%	71%	74%	65%	51%	43%	46%	67%	60%	63%	83%	56%	80%
	**2019/20	65%	56%	53%	52%	72%	43%	66%	70%	60%	76%	61%	62%	73%
	**2020/21	71%	62%	59%	65%	55%	73%	76%	73%	56%	74%	72%	69%	83%

(* Subscale not collected in 2013; added in 2014, **Distributed and collected during COVID-19)

Appendix B. The CMHSP YSS mean score for each subscale and subscale line item Scale from 1-5 with 5 being "Strongly Agree".

	MSHN	BABH	CEI	CMHCM	GIHN	HBH	The Right Door	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS
Perception of Access	4.56	4.36	4.47	4.32	4.36	4.71	4.65	4.60	4.00	4.71	4.52	4.31	4.75
Q8. The location of services was convenient for us.	4.61	4.42	4.71	4.41	4.50	4.75	4.71	4.62	4.11	4.77	4.56	4.31	4.78
Q9. Services were available at times that were convenient for us.	4.51	4.30	4.24	4.24	4.23	4.67	4.59	4.58	3.89	4.65	4.49	4.31	4.73
	MSHN	BABH	CEI	CMHCM	GIHN	HBH	The Right Door	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS
Perception of Participation in Treatment	4.43	4.24	4.29	4.31	4.24	4.69	4.69	4.20	4.19	4.68	4.47	4.50	4.79
Q2. I helped to choose my child's services.	4.46	4.13	3.88	4.18	4.27	4.67	4.53	4.57	4.22	4.58	4.29	4.44	4.78
Q3. I helped to choose my child's treatment goals.	4.60	4.22	4.29	4.31	4.36	4.67	4.74	4.69	4.33	4.77	4.59	4.56	4.80
Q6. I participated in my child's treatment.	4.23	4.37	4.71	4.45	4.09	4.75	4.79	3.35	4.00	4.70	4.54	4.50	4.79
	MSHN	BABH	CEI	CMHCM	GIHN	HBH	The Right Door	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS
Perception of Cultural Sensitivity	4.66	4.36	4.73	4.49	4.43	4.79	4.80	4.67	4.31	4.87	4.56	4.47	4.87
Q12. Staff treated me with respect.	4.70	4.48	4.65	4.49	4.50	4.83	4.76	4.74	4.22	4.84	4.59	4.56	4.89
Q13. Staff respected my family's religious/spiritual beliefs.	4.63	4.31	4.75	4.44	4.32	4.75	4.79	4.64	4.33	4.89	4.53	4.31	4.85
Q14. Staff spoke with me in a way that I understand.	4.70	4.43	4.82	4.57	4.45	4.83	4.82	4.71	4.33	4.88	4.66	4.56	4.85
Q15. Staff were sensitive to my cultural/ethnic background.	4.62	4.22	4.71	4.46	4.45	4.75	4.82	4.61	4.33	4.88	4.46	4.44	4.86
	MSHN	BABH	CEI	CMHCM	GIHN	HBH	The Right Door	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS
Appropriateness	4.27	4.15	3.59	3.95	4.17	4.71	4.51	4.10	3.78	4.50	4.34	4.23	4.72
Q1. Overall, I am satisfied with the services my child received.	4.42	4.22	3.47	4.06	4.32	4.58	4.59	4.50	4.11	4.53	4.44	4.25	4.73
Q4. The people helping my child stuck with us no matter what.	4.45	4.19	4.12	4.04	4.24	4.83	4.68	4.46	3.78	4.70	4.37	4.31	4.76
Q5. I felt my child had someone to talk to when she/he was troubled.	4.14	4.15	3.76	4.00	4.33	4.83	4.53	3.56	3.78	4.50	4.32	4.13	4.77
Q7. The services my child and/or family received were right for us.	4.12	4.21	3.71	4.04	4.18	4.75	4.47	3.47	3.78	4.47	4.44	4.44	4.76
Q10. My family got the help we wanted for my child.	4.30	4.07	3.29	3.86	4.09	4.67	4.38	4.38	3.67	4.45	4.32	4.25	4.68
Q11. My family got as much help as we needed for my child.	4.20	4.06	3.18	3.71	3.86	4.58	4.44	4.26	3.56	4.34	4.15	4.00	4.64

(* Subscale not collected in 2013; added in 2014, **Distributed and collected during COVID-19)

	MSHN	BABH	CEI	CMHCM	GIHN	HBH	The Right Door	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS
Perception of Outcome of Services	3.80	3.70	3.34	3.63	3.44	3.88	3.80	3.88	3.21	4.04	3.75	3.58	3.92
Q16. My child is better at handling daily life.	3.84	3.81	3.35	3.78	3.45	4.00	3.94	3.83	3.00	4.14	3.78	3.50	3.95
Q17. My child gets along better with family.	3.83	3.74	3.65	3.60	3.45	3.92	3.88	3.88	3.44	4.04	3.83	3.56	3.94
Q18. My child gets along better with friends and other people.	3.84	3.74	3.53	3.60	3.41	3.92	3.94	3.86	3.11	4.14	3.85	3.63	4.00
Q19. My child is doing better in school and/or work.	3.78	3.45	3.12	3.65	3.23	3.82	3.79	3.99	3.33	3.93	3.70	3.56	3.90
Q20. My child is better able to cope when things go wrong.	3.63	3.57	2.94	3.50	3.41	3.73	3.65	3.64	3.11	3.84	3.63	3.56	3.79
Q21. I am satisfied with our family life right now.	3.82	3.83	3.29	3.55	3.59	3.91	3.71	3.94	3.22	4.12	3.62	3.44	3.89
Q22. My child is better able to do things he or she wants to do.	3.86	3.74	3.53	3.69	3.55	3.82	3.71	3.98	3.22	4.07	3.85	3.81	3.94
	MSHN	BABH	CEI	CMHCM	GIHN	HBH	The Right Door	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS
Perception of Social Connectedness	4.38	4.20	4.07	4.01	4.20	4.67	4.48	4.41	3.64	4.58	4.53	4.14	4.57
Q23. I know people who will listen and understand me when I need to talk.	4.46	4.21	4.29	4.02	4.09	4.67	4.59	4.45	3.44	4.64	5.22	4.06	4.60
Q24. I have people that I am comfortable talking with about my child's problems.	4.46	4.28	4.12	4.04	4.18	4.75	4.68	4.53	3.56	4.70	4.43	4.13	4.66
Q25. In a crisis, I would have the support I need from family or friends.	4.28	4.25	3.76	4.02	4.18	4.58	4.32	4.28	3.78	4.42	4.29	4.19	4.50
Q26. I have people with whom I can do enjoyable things.	4.32	4.06	4.12	3.96	4.36	4.67	4.32	4.36	3.78	4.55	4.20	4.19	4.54
	MSHN	BABH	CEI	CMHCM	GIHN	HBH	The Right Door	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS
Perception of Social Functioning	3.80	3.68	3.35	3.64	3.42	3.87	3.82	3.87	3.20	4.02	3.77	3.60	3.92
Q16. My child is better at handling daily life.	3.84	3.81	3.35	3.78	3.45	4.00	3.94	3.83	3.00	4.14	3.78	3.50	3.95
Q17. My child gets along better with family.	3.83	3.74	3.65	3.60	3.45	3.92	3.88	3.88	3.44	4.04	3.83	3.56	3.94
Q18. My child gets along better with friends and other people.	3.84	3.74	3.53	3.60	3.41	3.92	3.94	3.86	3.11	4.14	3.85	3.63	4.00
Q19. My child is doing better in school and/or work.	3.78	3.45	3.12	3.65	3.23	3.82	3.79	3.99	3.33	3.93	3.70	3.56	3.90
Q20. My child is better able to cope when things go wrong.	3.63	3.57	2.94	3.50	3.41	3.73	3.65	3.64	3.11	3.84	3.63	3.56	3.79
Q22. My child is better able to do things he or she wants to do.	3.86	3.74	3.53	3.69	3.55	3.82	3.71	3.98	3.22	4.07	3.85	3.81	3.94

(* Subscale not collected in 2013; added in 2014, **Distributed and collect during COVID-19)

Appendix C. YSS Questions Ranked

Scale 1-5 with 5 being in agreement. Green indicates most agreement; Red indicates the least agreement.

Questions	MSHN	BABH	CEI	CMHCM	GIHN	HBH	The Right Door	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS
Q14. Staff spoke with me in a way that I understand.	4.70	4.43	4.82	4.57	4.45	4.83	4.82	4.71	4.33	4.88	4.66	4.56	4.85
Q12. Staff treated me with respect.	4.70	4.48	4.65	4.49	4.50	4.83	4.76	4.74	4.22	4.84	4.59	4.56	4.89
Q13. Staff respected my family's religious/spiritual beliefs.	4.63	4.31	4.75	4.44	4.32	4.75	4.79	4.64	4.33	4.89	4.53	4.31	4.85
Q15. Staff were sensitive to my cultural/ethnic background.	4.62	4.22	4.71	4.46	4.45	4.75	4.82	4.61	4.33	4.88	4.46	4.44	4.86
Q8. The location of services was convenient for us.	4.61	4.42	4.71	4.41	4.50	4.75	4.71	4.62	4.11	4.77	4.56	4.31	4.78
Q3. I helped to choose my child's treatment goals.	4.60	4.22	4.29	4.31	4.36	4.67	4.74	4.69	4.33	4.77	4.59	4.56	4.80
Q9. Services were available at times that were convenient for us.	4.51	4.30	4.24	4.24	4.23	4.67	4.59	4.58	3.89	4.65	4.49	4.31	4.73
Q2. I helped to choose my child's services.	4.46	4.13	3.88	4.18	4.27	4.67	4.53	4.57	4.22	4.58	4.29	4.44	4.78
Q23. I know people who will listen and understand me when I need to talk.	4.46	4.21	4.29	4.02	4.09	4.67	4.59	4.45	3.44	4.64	5.22	4.06	4.60
Q24. I have people that I am comfortable talking with about my child's problems.	4.46	4.28	4.12	4.04	4.18	4.75	4.68	4.53	3.56	4.70	4.43	4.13	4.66
Q4. The people helping my child stuck with us no matter what.	4.45	4.19	4.12	4.04	4.24	4.83	4.68	4.46	3.78	4.70	4.37	4.31	4.76
Q1. Overall, I am satisfied with the services my child received.	4.42	4.22	3.47	4.06	4.32	4.58	4.59	4.50	4.11	4.53	4.44	4.25	4.73
Q26. I have people with whom I can do enjoyable things.	4.32	4.06	4.12	3.96	4.36	4.67	4.32	4.36	3.78	4.55	4.20	4.19	4.54
Q10. My family got the help we wanted for my child.	4.30	4.07	3.29	3.86	4.09	4.67	4.38	4.38	3.67	4.45	4.32	4.25	4.68
Q25. In a crisis, I would have the support I need from family or friends.	4.28	4.25	3.76	4.02	4.18	4.58	4.32	4.28	3.78	4.42	4.29	4.19	4.50
Q6. I participated in my child's treatment.	4.23	4.37	4.71	4.45	4.09	4.75	4.79	3.35	4.00	4.70	4.54	4.50	4.79
Q11. My family got as much help as we needed for my child.	4.20	4.06	3.18	3.71	3.86	4.58	4.44	4.26	3.56	4.34	4.15	4.00	4.64
Q5. I felt my child had someone to talk to when she/he was troubled.	4.14	4.15	3.76	4.00	4.33	4.83	4.53	3.56	3.78	4.50	4.32	4.13	4.77
Q7. The services my child and/or family received were right for us.	4.12	4.21	3.71	4.04	4.18	4.75	4.47	3.47	3.78	4.47	4.44	4.44	4.76
Q22. My child is better able to do things he or she wants to do.	3.86	3.74	3.53	3.69	3.55	3.82	3.71	3.98	3.22	4.07	3.85	3.81	3.94
Q18. My child gets along better with friends and other people.	3.84	3.74	3.53	3.60	3.41	3.92	3.94	3.86	3.11	4.14	3.85	3.63	4.00
Q16. My child is better at handling daily life.	3.84	3.81	3.35	3.78	3.45	4.00	3.94	3.83	3.00	4.14	3.78	3.50	3.95
Q17. My child gets along better with family.	3.83	3.74	3.65	3.60	3.45	3.92	3.88	3.88	3.44	4.04	3.83	3.56	3.94
Q21. I am satisfied with our family life right now.	3.82	3.83	3.29	3.55	3.59	3.91	3.71	3.94	3.22	4.12	3.62	3.44	3.89
Q19. My child is doing better in school and/or work.	3.78	3.45	3.12	3.65	3.23	3.82	3.79	3.99	3.33	3.93	3.70	3.56	3.90
Q20. My child is better able to cope when things go wrong.	3.63	3.57	2.94	3.50	3.41	3.73	3.65	3.64	3.11	3.84	3.63	3.56	3.79

Appendix D. MSHN and CMHSP YSS Total Valid Count for Each Question

Questions	MSHN	BABH	CEI	CMHCM	GIHN	HBH	The Right Door	Lifeways	MCN	NCMH	SCCMH	SHW	TBHS
Q1. Overall, I am satisfied with the services my child received.	574	54	17	50	22	12	34	163	9	74	41	16	82
Q2. I helped to choose my child's services.	572	54	17	51	22	12	34	161	9	74	41	16	81
Q3. I helped to choose my child's treatment goals.	574	54	17	51	22	12	34	163	9	74	41	16	81
Q4. The people helping my child stuck with us no matter what.	573	53	17	51	21	12	34	163	9	74	41	16	82
Q5. I felt my child had someone to talk to when she/he was troubled.	571	54	17	51	21	12	34	160	9	74	41	16	82
Q6. I participated in my child's treatment.	573	54	17	49	22	12	34	163	9	74	41	16	82
Q7. The services my child and/or family received were right for us.	574	53	17	51	22	12	34	163	9	74	41	16	82
Q8. The location of services was convenient for us.	573	53	17	51	22	12	34	163	9	74	41	16	81
Q9. Services were available at times that were convenient for us.	574	54	17	51	22	12	34	162	9	74	41	16	82
Q10. My family got the help we wanted for my child.	573	54	17	50	22	12	34	163	9	74	41	16	81
Q11. My family got as much help as we needed for my child.	573	54	17	51	22	12	34	163	9	73	41	16	81
Q12. Staff treated me with respect.	575	54	17	51	22	12	34	163	9	74	41	16	82
Q13. Staff respected my family's religious/spiritual beliefs.	571	54	16	50	22	12	34	163	9	74	40	16	81
Q14. Staff spoke with me in a way that I understand.	575	54	17	51	22	12	34	163	9	74	41	16	82
Q15. Staff were sensitive to my cultural/ethnic background.	572	54	17	50	22	12	34	163	9	73	41	16	81
Q16. My child is better at handling daily life.	573	53	17	50	22	12	34	163	9	74	41	16	82
Q17. My child gets along better with family.	574	54	17	50	22	12	34	163	9	74	41	16	82
Q18. My child gets along better with friends and other people.	574	54	17	50	22	12	34	163	9	74	41	16	82
Q19. My child is doing better in school and/or work.	564	53	17	49	22	11	34	157	9	74	40	16	82
Q20. My child is better able to cope when things go wrong.	571	54	17	50	22	11	34	163	9	74	41	16	80
Q21. I am satisfied with our family life right now.	568	54	17	49	22	11	34	162	9	73	39	16	82
Q22. My child is better able to do things he or she wants to do.	571	54	17	49	22	11	34	163	9	74	40	16	82
Q23. I know people who will listen and understand me when I need to talk.	572	53	17	50	22	12	34	163	9	73	41	16	82
Q24. I have people that I am comfortable talking with about my child's problems.	572	53	17	50	22	12	34	163	9	74	40	16	82
Q25. In a crisis, I would have the support I need from family or friends.	573	53	17	50	22	12	34	163	9	74	41	16	82
Q26. I have people with whom I can do enjoyable things.	573	53	17	50	22	12	34	163	9	74	41	16	82

Mid-State Health Network
Substance Use Treatment Provider
Member Satisfaction Survey FY21

Introduction

The following is a report of the Mid-State Health Network's (MSHN) Substance Use Disorder (SUD) Treatment Providers (SUDTP) Consumer Satisfaction Survey results. The survey was developed to assist MSHN and SUD Providers in developing a better understanding of the strengths and weaknesses in the quality of services provided to the SUD consumer population.

This report was developed utilizing a voluntary self-reflective survey. The information from this report is intended to support discussions on how various SUD Provider practices may improve treatment offered to individuals. The information from this overview should not be used to draw conclusions or make assumptions without further analysis. It should be noted the 2020 survey was distributed during the time period when emergency orders were in place as a result of the pandemic. The results, therefore, are specific to the perception during that time. Caution should be used when comparing 2020 to 2021 and other measurement periods going forward.

Any questions regarding the report should be sent to Sandy Gettel, MSHN Quality Manager, at sandy.gettel@midstatehelathnetwork.org.

Methodology

The survey was distributed to adult and adolescent consumers who received a service from a MSHN SUD Treatment Provider between June 16, 2021 and July 16, 2021 to assess the perceptions of the individual treatment received. The survey was offered in person and by mail.

Five thousand five hundred and seventy-three consumers (5573) received a service during the distribution period resulting in a FY21 response rate of 38.23%, an increase from FY20 (16.46%). Two thousand one hundred and thirty-one (2131) surveys were completed. Thirty-one (31) organizations participated in the consumer satisfaction survey process. Figure 1 identifies the programs represented in the survey report. Consumers were able to report participation in more than one program, therefore the total involved in individual programs is larger than the number of respondents.

Figure 1. The count of consumers represented in survey by program

Program	2020	2021
Case Management (CSM)	18	39
Outpatient (OPT)	520	671
Detox	25	10
Residential Substance Use Disorder (Res. SUD)	179	183
Medication Assisted Treatment (MAT)	80	796
(blank)	287	441

Six subscales are included in the survey. Each subscale has multiple questions related to the subscale topic. The subscales are as follows: welcoming environment, information on recipient rights, cultural/ethnic background, appropriateness and choice with services, treatment planning and progress toward goals, coordination of care/referrals to other resources. All items were rated using a 5-point Likert scale that ranged from 1 = "strongly disagree" to 5 = "strongly agree." The response choices of "Not Applicable" were excluded from the calculations.

For each respondent, the scores for each item in the subscale are summed, then divided by the total number of items in the subscale. The result is a mean score for each individual respondent that may vary between 1 and 5. Individual mean scores greater than or equal to 3.50 are classified as being "in agreement." Those questions that had no response or "blank" were removed from the sample.

The responses from the SUD Consumer Satisfaction surveys were scored as a comprehensive total of all questions, comprehensive total of each subscale, as well as individually for each of the fifteen questions. The comprehensive score measures how the system is performing overall, the comprehensive domain score measures focus areas, and the individual questions measure the performance for the stated question from all survey responses.

Survey Findings

MSHN's overall comprehensive score was 4.61, which indicates an overall agreement with all statements on the survey. The total comprehensive score for the survey demonstrated a continuous increase since 2015. Figure 2 illustrates the scores for each year since 2015. The survey results demonstrate an upward trend since 2015. The satisfaction survey was not completed in 2019. The perception of member experience was received through the administration of the Recovery Self-Assessment for persons served.

Figure 2. MSHN's performance ranked by subscale based on averages

Green cells indicate scores at the top of the range. Red cells indicate scores at the bottom of the range.

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

Figure 3. MSHN survey questions ranked from highest to lowest based on average score.

Each question is color coded based on the subscale color in Figure 2. Green cells indicate scores at the top of the range. Red cells indicate scores at the bottom of the range .

Question	2015	2016	2017	2018	2020	2021
10. I was involved in the development of my treatment plan and goals.	4.38	4.56	4.57	4.56	4.65	4.75
5. I was informed that information about my treatment is only given with my permission.	4.54	4.61	4.63	4.62	4.70	4.70
6. My cultural/ethnic background was respected.	4.5	4.59	4.61	4.60	4.66	4.68
11. My goals were addressed during treatment.	4.37	4.54	4.56	4.54	4.65	4.68
1. Staff was courteous and respectful.	4.55	4.57	4.54	4.56	4.68	4.66
13. I feel that I am better able to control my life as a result of treatment.	4.26	4.49	4.54	4.54	4.64	4.66
2. I would recommend this agency to others.	4.45	4.54	4.53	4.54	4.62	4.63
3. I was informed of my rights.	4.46	4.56	4.52	4.51	4.61	4.63
12. My goals were changed when needed to reflect my needs.	4.17	4.42	4.47	4.47	4.58	4.62
8. I received services that met my needs and addressed my goals.	4.32	4.53	4.54	4.52	4.59	4.60
15. My treatment plan includes skills and community supports to help me continue in my path to recovery and total wellness.	3.59	4.43	4.46	4.42	4.55	4.60
7. I was given information about the different treatment options available that would be appropriate to meet my needs.	4.25	4.41	4.43	4.41	4.50	4.53
14. Staff assisted in connecting me with further services and/or community resources.	3.20	4.37	4.40	4.36	4.48	4.53
9. I was given a choice as to what provider to seek treatment from.	4.01	4.36	4.35	4.29	4.40	4.43
4. I know how to contact my recipient rights advisor.	4.15	4.30	4.33	4.27	4.36	4.39

An illustration of each individual question within a subscale is provided in Figures 4-9. This information is used to compare the responses to questions within the subscale and to determine more specifically what area of focus can benefit from improvement efforts.

Figure 4. MSHN's Cultural and Ethnic Background subscale individual question score

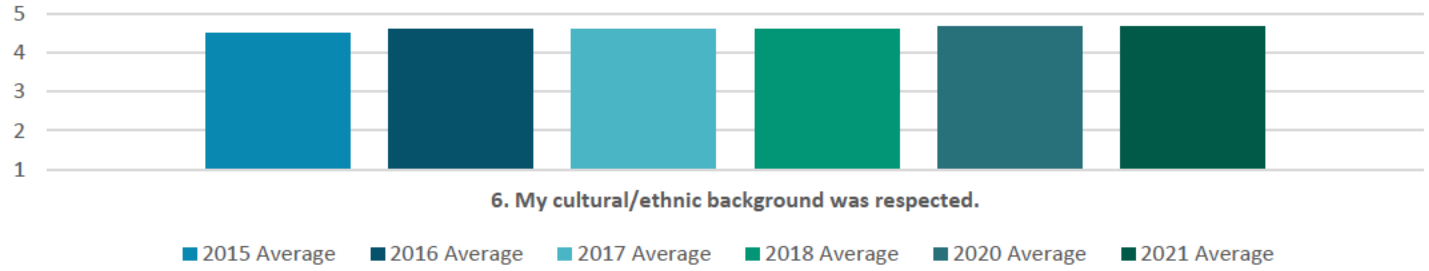


Figure 5. MSHN's Welcoming Environment subscale score individual question score

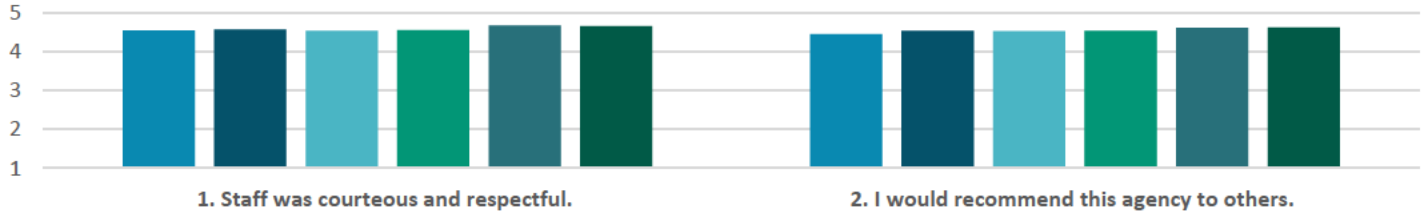


Figure 6. MSHN's Information on Treatment Planning/Progress Towards Goal subscale individual question score

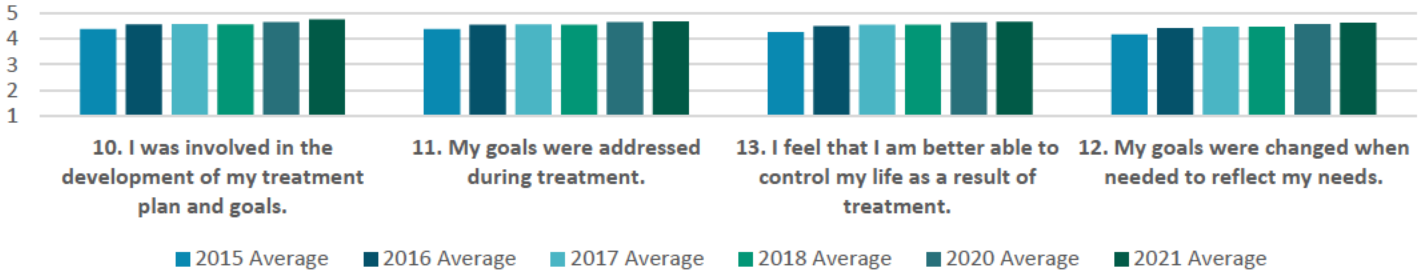


Figure 7. MSHN's Information on Recipient Rights subscale score individual question score

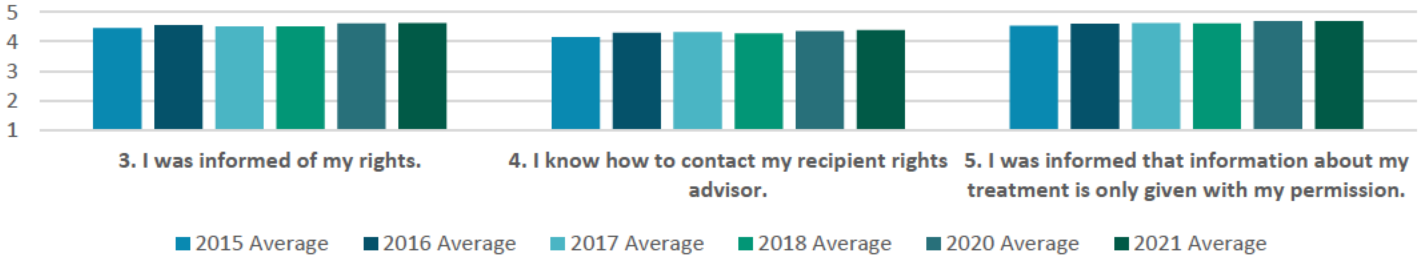


Figure 8. MSHN's Coordination of Care/Referrals to Other Resources subscale individual question score

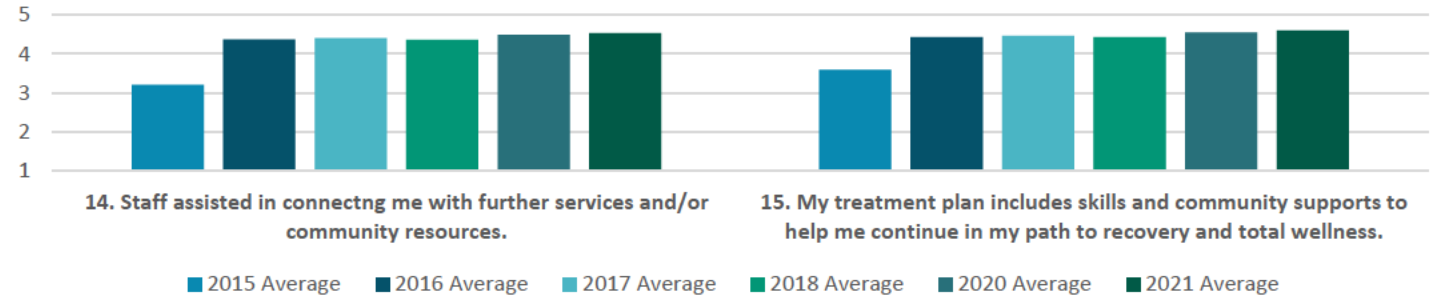
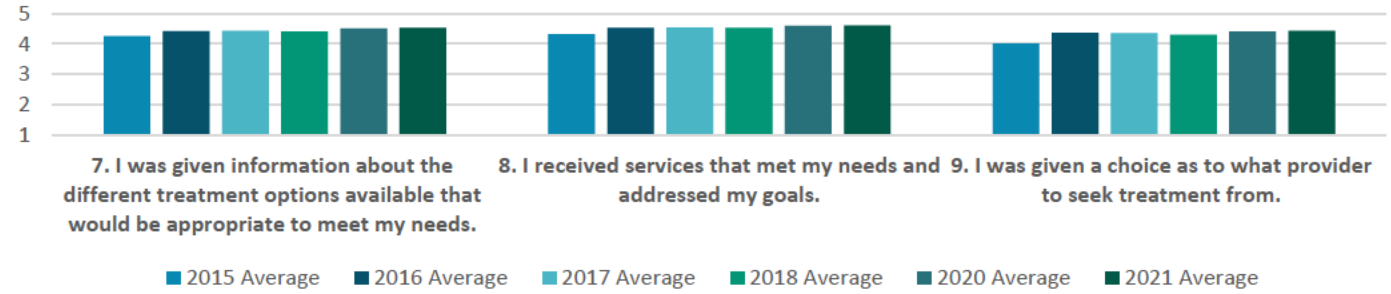


Figure 9. MSHN's Information on Appropriateness and Choice with Services subscale individual question score



Conclusion:

In summary, MSHN demonstrated improvement in the total comprehensive score, the subscale comprehensive score, and each individual question. The subscale that scored the highest was Cultural and Ethnic Background. The subscales that illustrated the most improvement were Coordination of Care/Referrals to Other Resources, and Treatment Planning and Progress Toward Goals.

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.

All scores were above 3.50, indicating agreement.

Recommendations/Next Steps

- The survey will be reviewed with regional committees/councils to identify any additional areas for feedback that should be included in the next survey.
- Each provider should review individual organizational data to determine if any action is needed. Action items should be focused on areas that exhibit a score below 3.50 or have decreased from previous review.
- In the absence of areas not meeting the expectation of agreement (3.50) with the statements, the organization should review the lowest scoring questions for growth opportunities.
- Based on the scores there is no follow up at this time.
- MSHN will explore the use of a validated survey for the SUDTP.

Completed by: Sandy Gettel Quality Manager **Date**: August 31, 2021
Reviewed by: SUD Treatment Team **Date:** October 6, 2021
Reviewed by: Regional Consumer Advisory Council **Date:** October 8, 2021

Appendix A The total count for each response choice

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	Total Questions Not Answered	Total Questions Answered (D)
Welcoming Environment							
Staff was courteous and respectful.	9	19	95	420	1495	93	2038
I would recommend this agency to others.	23	15	107	419	1464	103	2028
Information on Recipient Rights							
I was informed of my rights.	16	17	96	463	1440	99	2032
I know how to contact my recipient rights advisor.	51	82	178	483	1314	23	2108
I was informed that information about my treatment is only given with my permission.	14	11	57	440	1600	9	2122
Cultural /Ethnic Background							
My cultural/ethnic background was respected.	12	10	81	442	1567	19	2112
Appropriateness and Choice with Services							
I was given information about the different treatment options available that would be appropriate to meet my needs.	27	36	147	483	1426	12	2119
I received services that met my needs and addressed my goals.	17	25	119	478	1482	10	2121
I was given a choice as to what provider to seek treatment from.	38	62	197	462	1338	34	2097
Treatment Planning/Progress Towards Goals							
I was involved in the development of my treatment plan and goals.	4	9	56	360	1659	43	2088
My goals were addressed during treatment.	5	20	70	436	1548	52	2079
My goals were changed when needed to reflect my needs.	8	26	117	436	1469	75	2056
I feel that I am better able to control my life as a result of treatment.	11	8	110	418	1523	61	2070
Coordination of Care/Referrals to Other Resources							
Staff assisted in connecting me with further services and/or community resources.	16	42	164	442	1394	73	2058
My treatment plan includes skills and community supports to help me continue in my path to recovery and total wellness.	6	36	123	454	1447	65	2066

MSHN

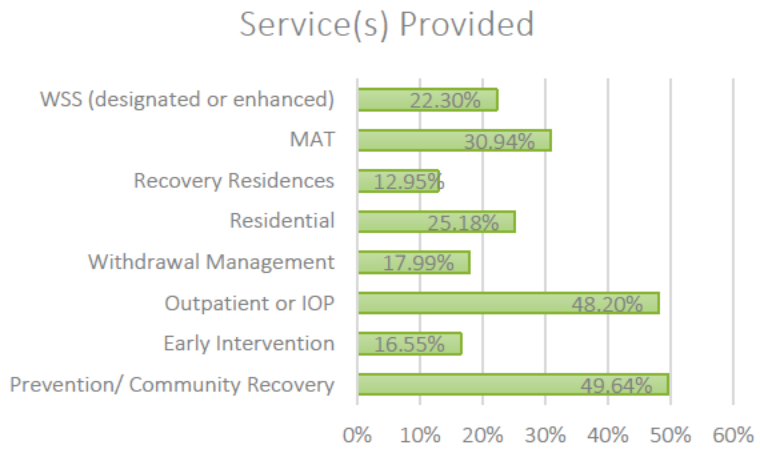
Mid-State Health Network

SUD Provider Satisfaction Survey

9.1.21

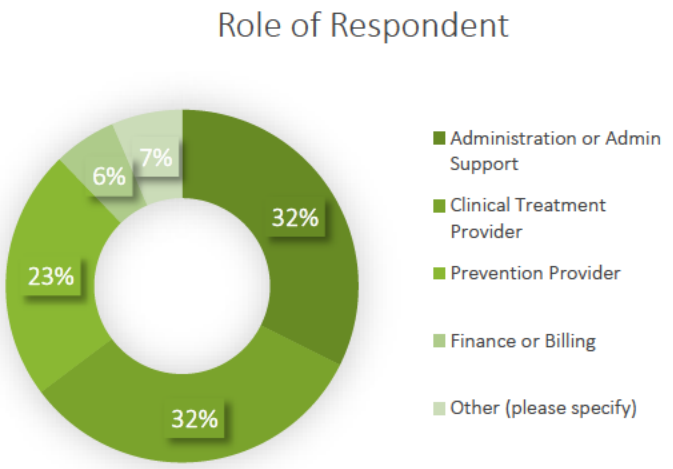
The MSHN Provider Satisfaction Survey was administered to contracted SUD providers during April 2021. The survey was administered via the MSHN Constant Contact, along with direct outreach to program administrators. In addition, MSHN staff who routinely interact with providers included a link in their email signature during the response period. The number of responses increased by 50% from 2018, with 139 responses received.

SUD providers at all levels of the organization were encouraged to respond based on experiences with MSHN during fiscal year 2020 with *very satisfied* considered to mean, 'I would not make major changes to MSHN on the issue' and *very dissatisfied* to mean, 'I have considered ending my contract with MSHN based on the issue.' Respondents who did not have experience with a particular function or process were asked to indicate *no experience*. The charts in this report represent the weighted average for each question with 5 indicating *very satisfied* and 1 indicating *very dissatisfied*. Results are represented in aggregate, with NA values eliminated from the aggregated score. ***MSHN will focus its improvement efforts where aggregate score is less than 3.5.***

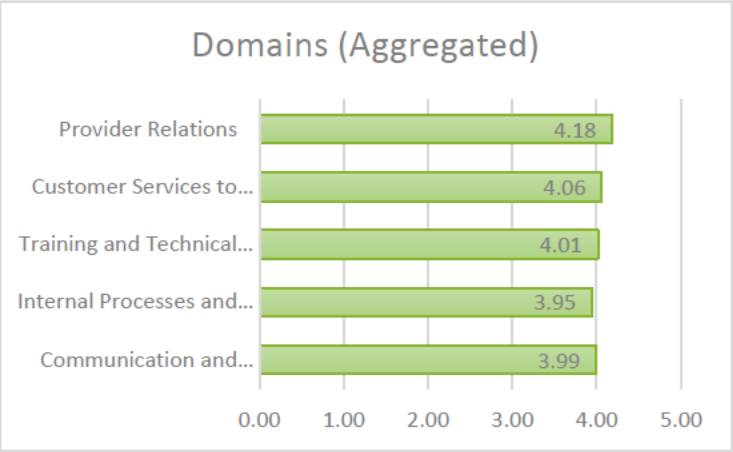


Respondents were asked to report the type of services they provided to MSHN beneficiaries. Providers often provide multiple levels of care, so responses are in duplicate. Feedback was received from providers across the continuum of care.

Role of Respondent: Respondents were asked to identify their primary role within their organization. A majority of responses were received from program administrators or admin support staff, clinical treatment providers, and prevention providers. Responses were also received from billers, case managers, and peer recovery coaches.

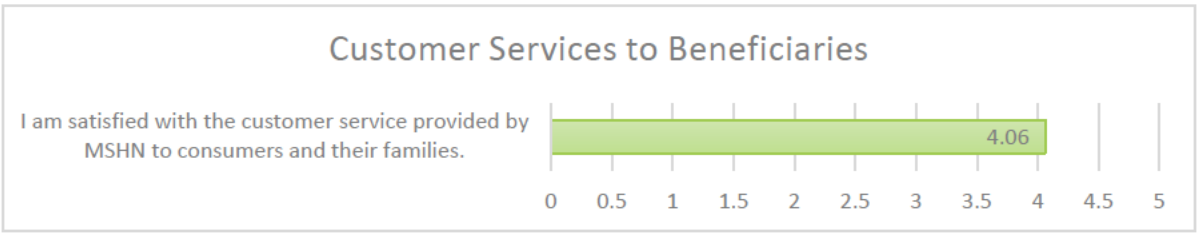


Domains: The survey was organized in a way that respondents were able to identify the key functions they are involved in when conducting business with MSHN. Each MSHN leadership team member will receive provider feedback specific to their department's operations and staff. This report has been organized by key domains: *MSHN processes and operations, customer services to to beneficiaries, provider relations, training/technical assistance, and communications /collaboration*. MSHN will employ a continuous quality improvement model that develops initiatives to improve process/quality (plan), implements initiatives (do), monitors progress frequently (study) and amends as needed (act).



Customer Services to Individuals Receiving Services

Customer Service operates as the front door of MSHN and is available to assist beneficiaries and stakeholders with their questions and concerns. This includes providing information regarding the services and benefits available, how to access services, handling individual complaints and grievances. Respondents were asked to rate their satisfaction with customer services provided by MSHN to individuals served.

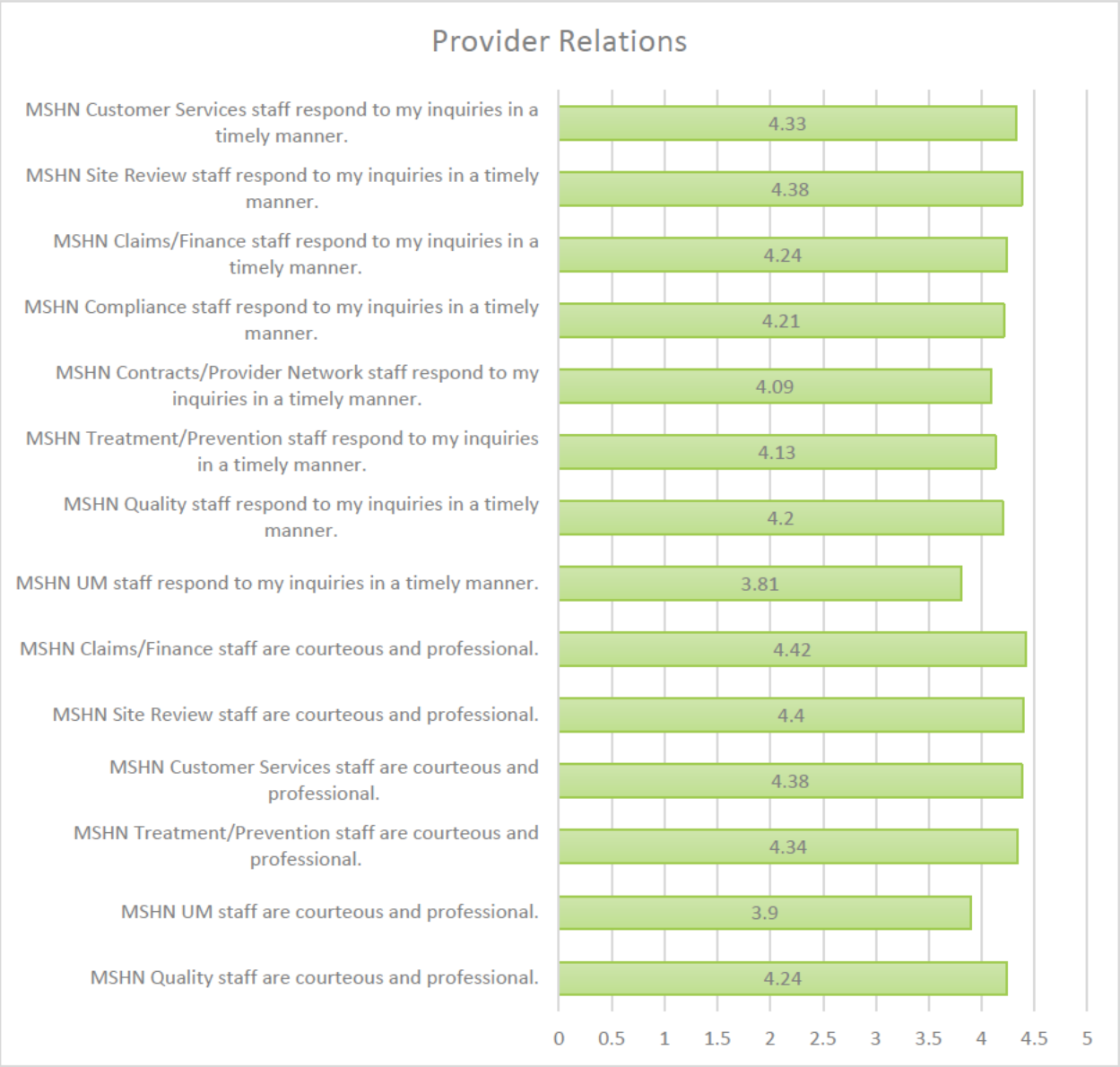


Internal Processes and Operations

MSHN is committed to ensuring its processes are efficient and effective. Respondents were asked to rate its satisfaction of key processes and operations as well as some new processes implemented within the past year.

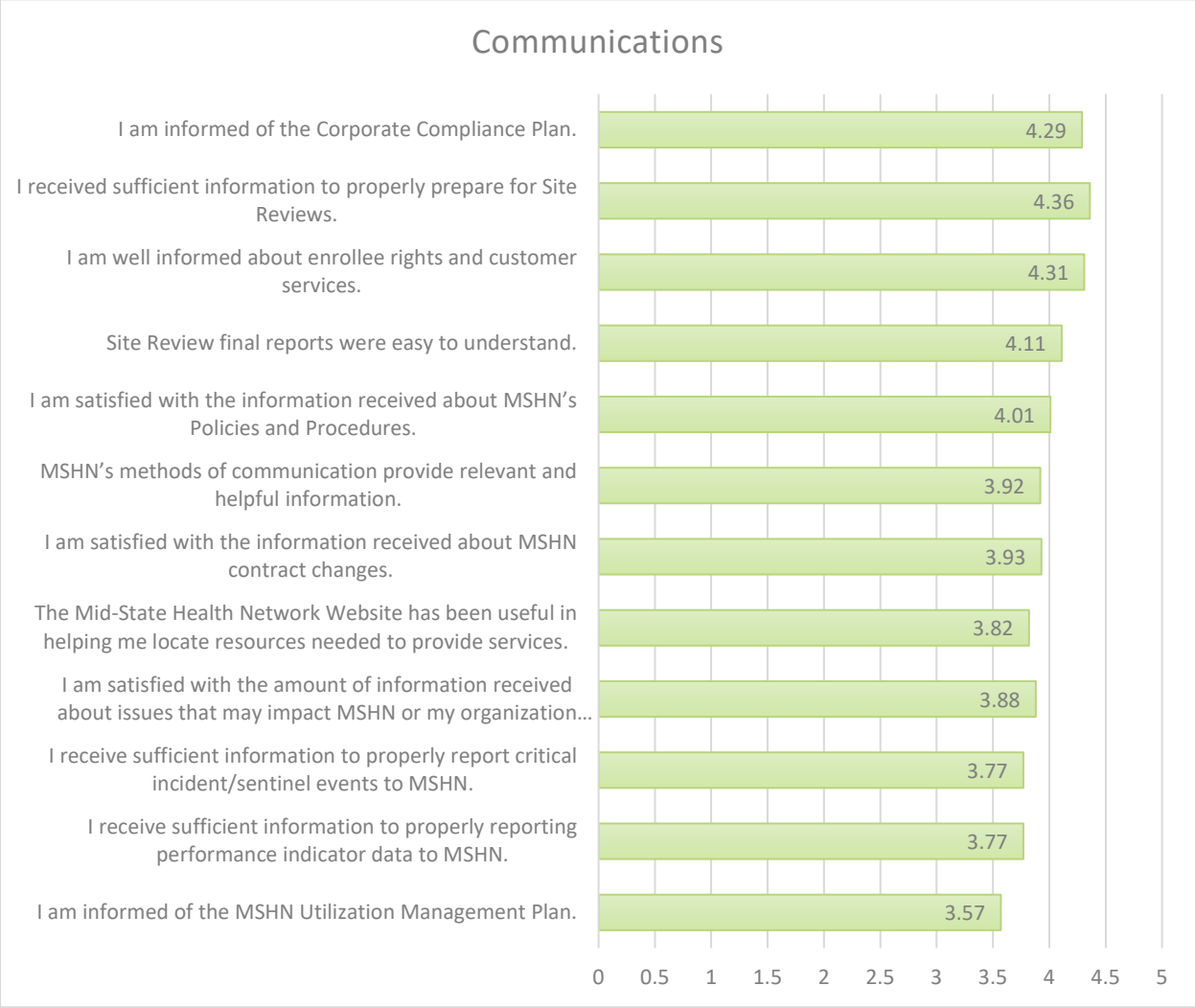
Provider Relations

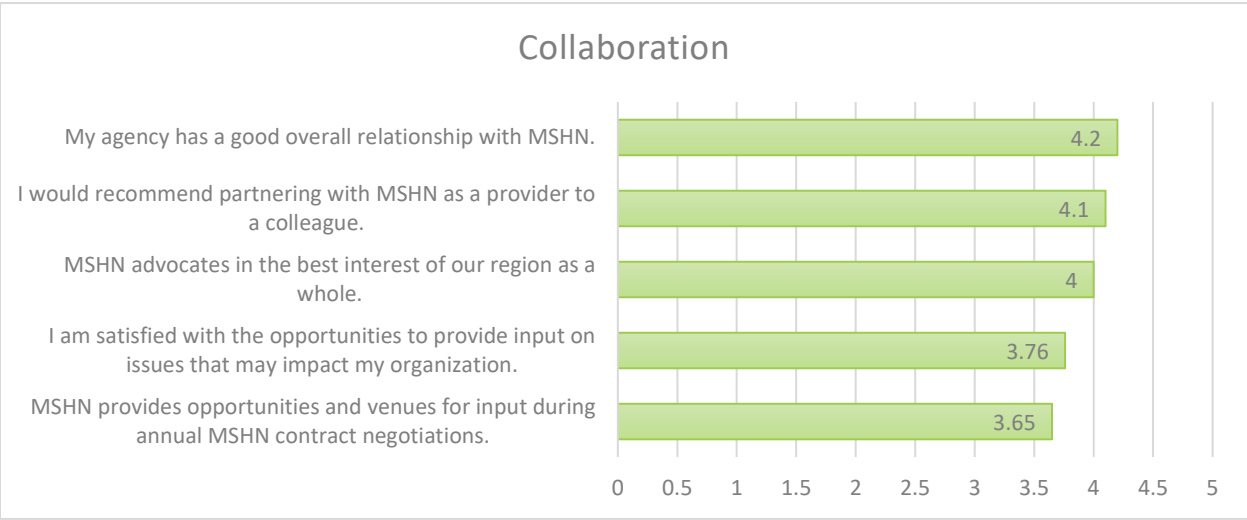
MSHN values its provider partners and is committed to developing strong working relationships with the provider system. Respondents were asked to rate staff courtesy/professionalism and timeliness in responding to inquiries.



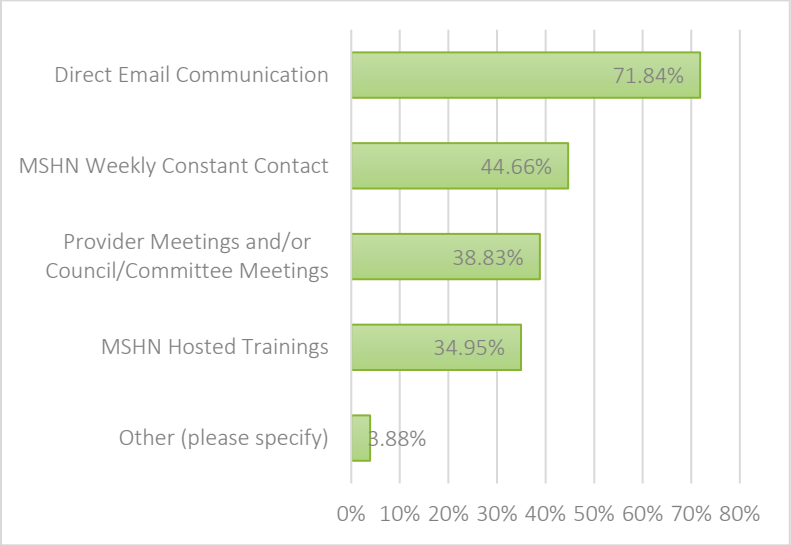
Communications and Collaboration

It is MSHNs goal to develop and maintain collaborative relationships with the provider system, striving to employ effective communication strategies, ensuring the provider system is informed of new requirements, changes to contractual obligations, as well as issues and matters that impact the provider system such as legislative, funding, and state policy matters.


Communications
I am informed of the Corporate Compliance Plan.
4.29
I received sufficient information to properly prepare for Site Reviews.
4.36
I am well informed about enrollee rights and customer services.
4.31
Site Review final reports were easy to understand.
4.11
I am satisfied with the information received about MSHN's Policies and Procedures.
4.01
MSHN's methods of communication provide relevant and helpful information.
3.92
I am satisfied with the information received about MSHN contract changes.
3.93
The Mid-State Health Network Website has been useful in helping me locate resources needed to provide services.
3.82
I am satisfied with the amount of information received about issues that may impact MSHN or my organization...
3.88
I receive sufficient information to properly report critical incident/sentinel events to MSHN.
3.77
I receive sufficient information to properly reporting performance indicator data to MSHN.
3.77
I am informed of the MSHN Utilization Management Plan.
3.57
0
0.5
1
1.5
2
2.5
3
3.5
4
4.5
5


Collaboration
My agency has a good overall relationship with MSHN.
4.2
I would recommend partnering with MSHN as a provider to a colleague.
4.1
MSHN advocates in the best interest of our region as a whole.
4
I am satisfied with the opportunities to provide input on issues that may impact my organization.
3.76
MSHN provides opportunities and venues for input during annual MSHN contract negotiations.
3.65
0
0.5
1
1.5
2
2.5
3
3.5
4
4.5
5

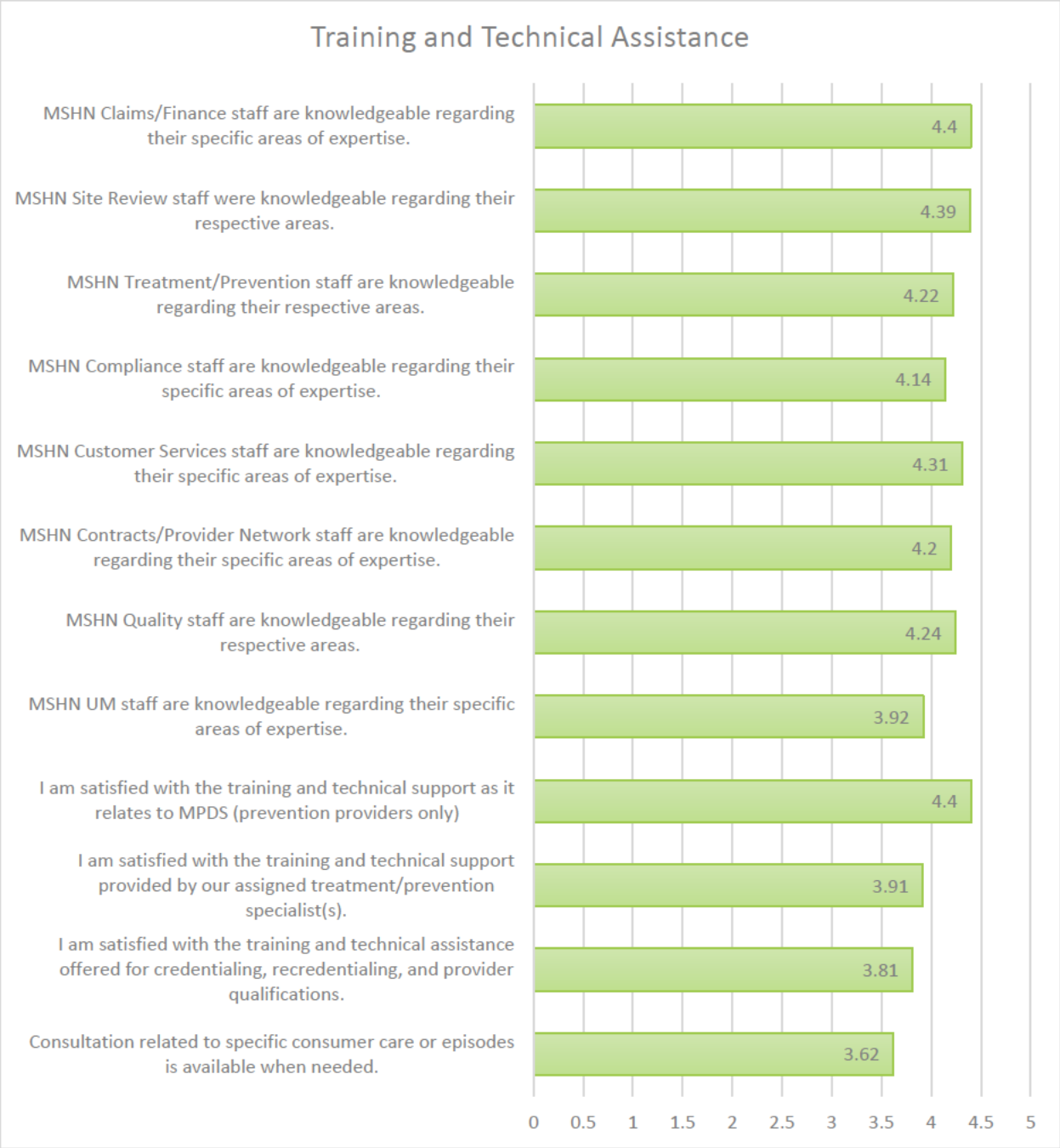
Communication Methods: Respondents were asked to identify their preferred method of communication. While the weekly constant contact is the primary mode of communication to the SUD provider system, feedback from providers identifies direct email as the most preferred method for communication. For the 3.88% (n=4) that responded with 'other', the following responses were provided:



- Maybe instead of a weekly email, a bi-weekly email would be better (1)
- Phone (1)
- Email updates when there are changes i.e., REMI process expected to work isn't working (1)
- When extremely important changes, such as funding or processes, would be better to have follow up from treatment specialist or contract specialist to ensure transition to new way of doing something is smooth. Too often we get the information via constant contact, have a power point training that isn't recorded for future viewing, and then have to try to implement it. Often questions are asked and we are referred back to a PowerPoint that doesn't provide a high level of detail or what seems like a canned response that does not fully answer the questions we had. At times we just need a personal conversation. (1)

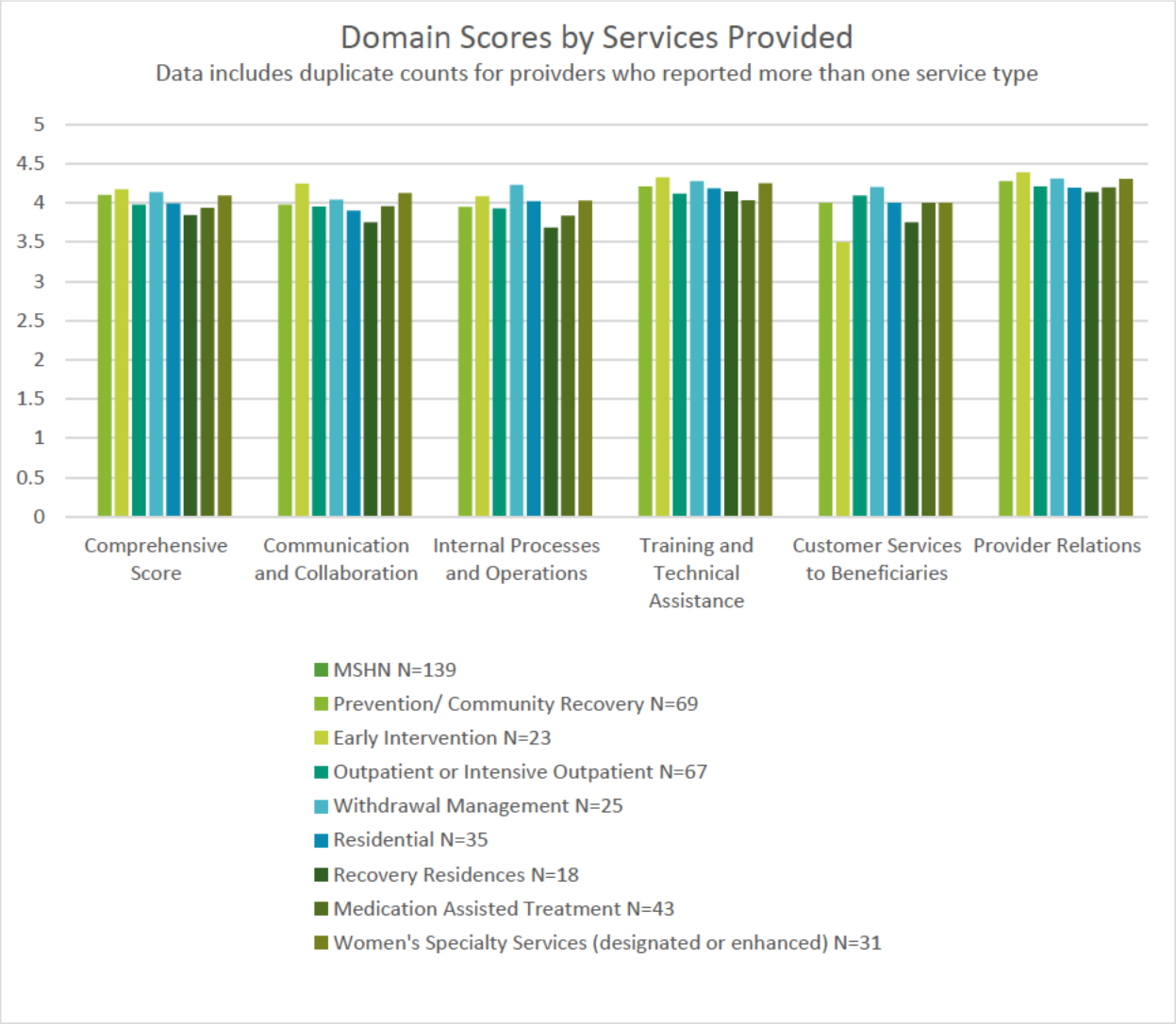
Training and Technical Assistance

MSHN staff offer training and technical assistance to the provider system based on identified regional needs, provider specific needs, and upon request from a provider. It is important that training and technical assistance is valuable to the provider system.



By Service Provider Type

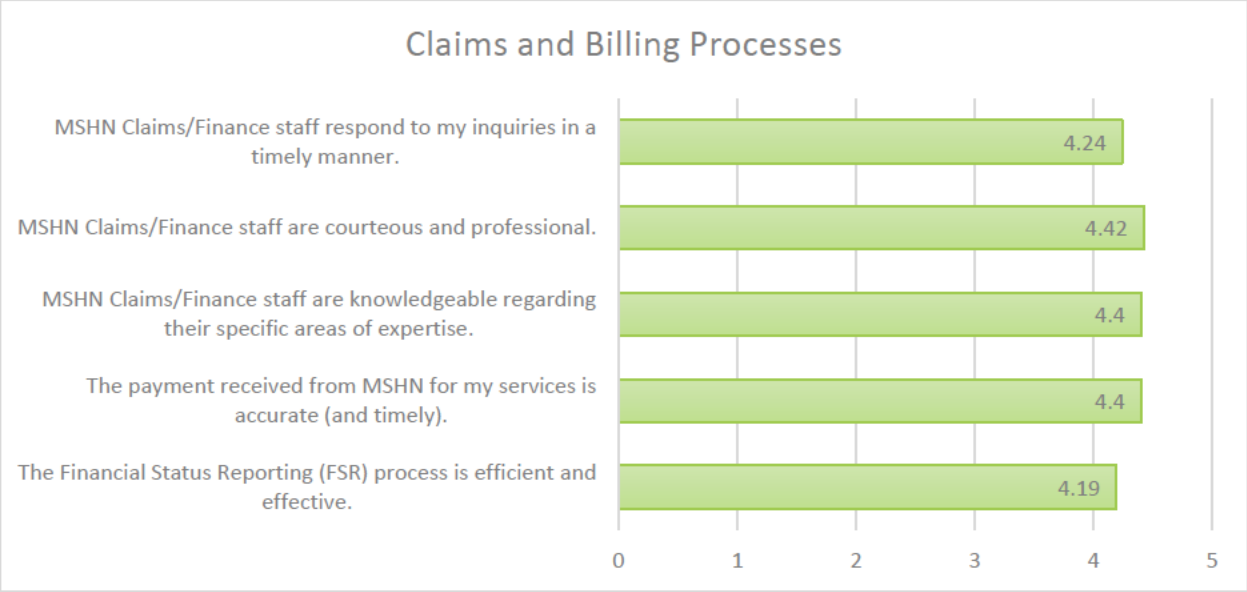
MSHN analyzed the data by provider service type to review each domain area by specific provider category.



Department Specific

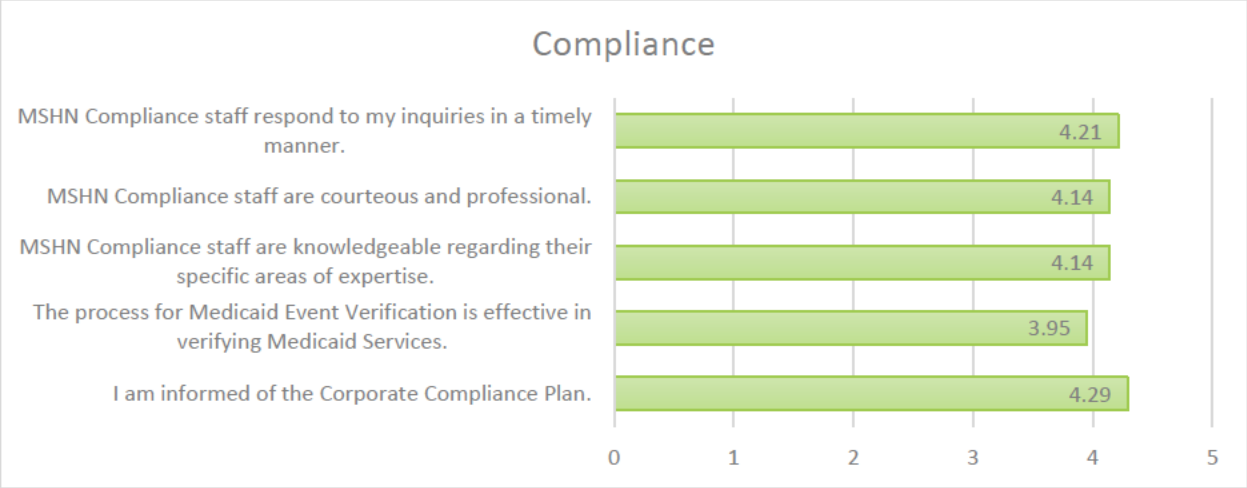
Finance

Total Reponses: 25

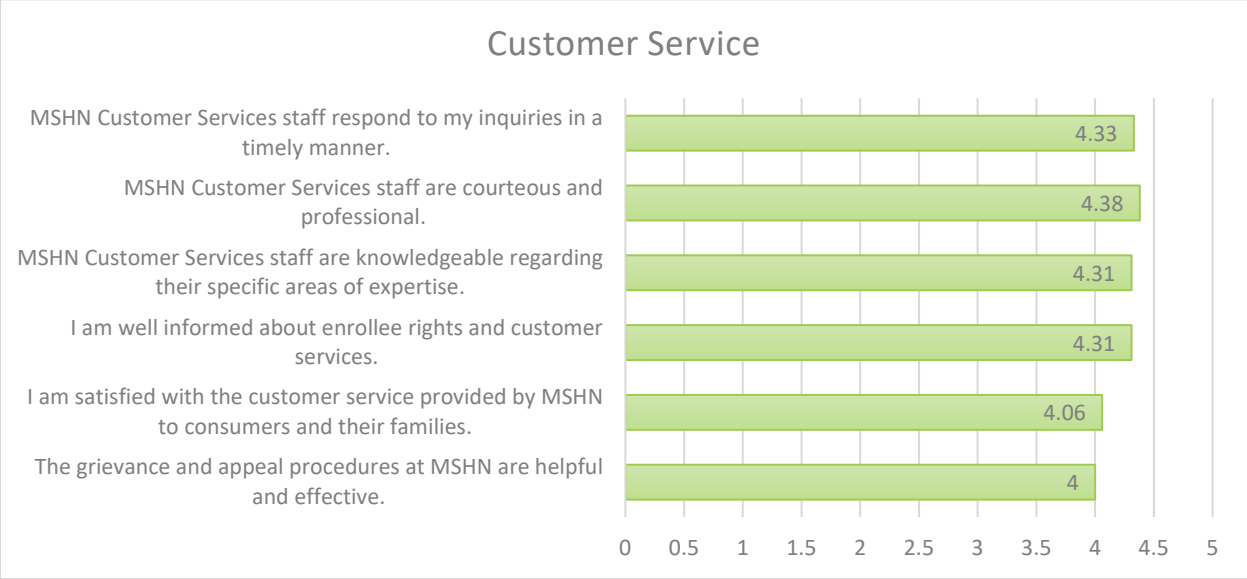


Quality, Compliance, Customer Services

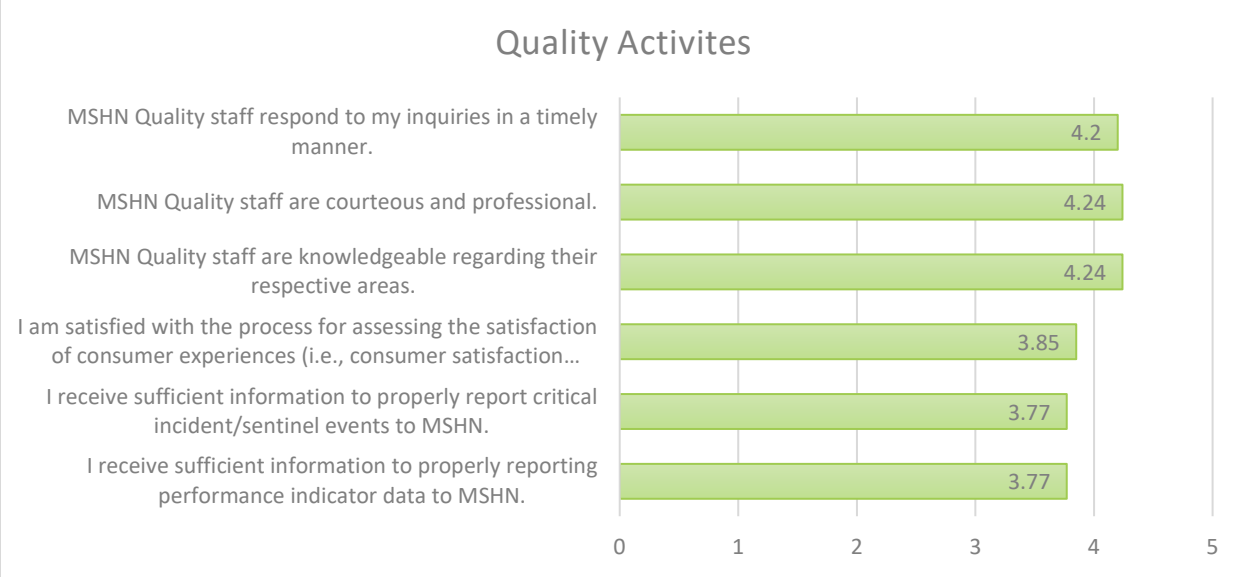
Total Reponses: 21



Total Reponses: 16

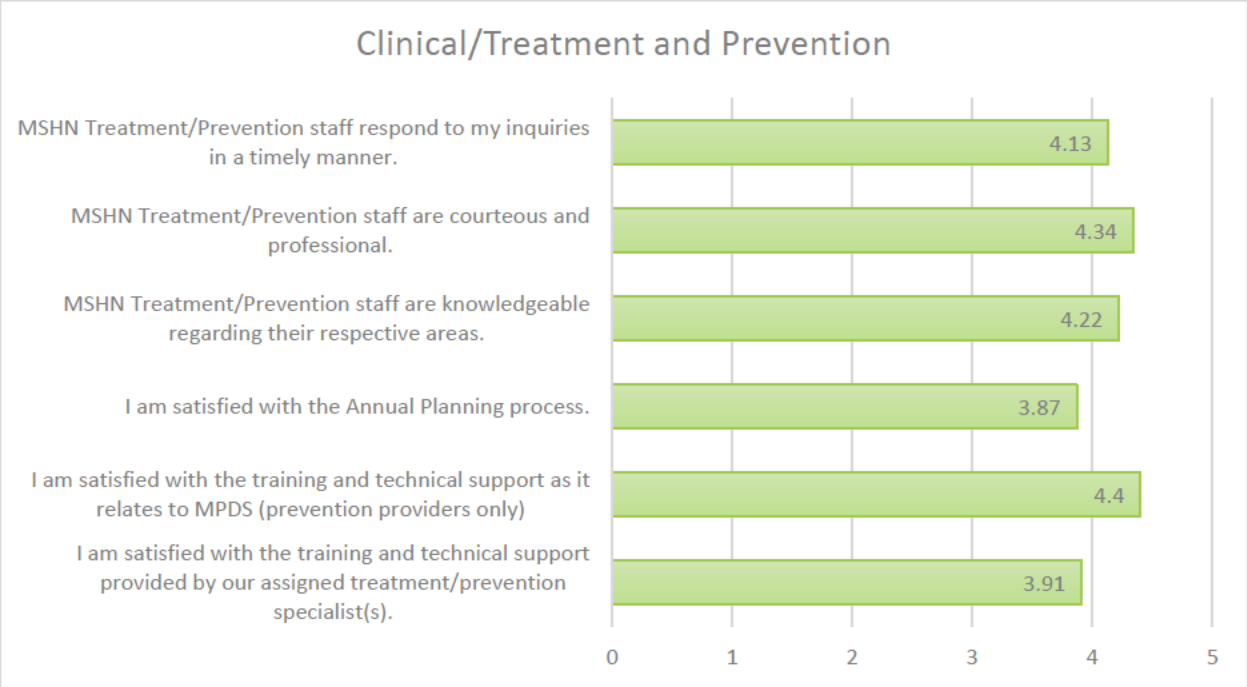


Total Responses: 28



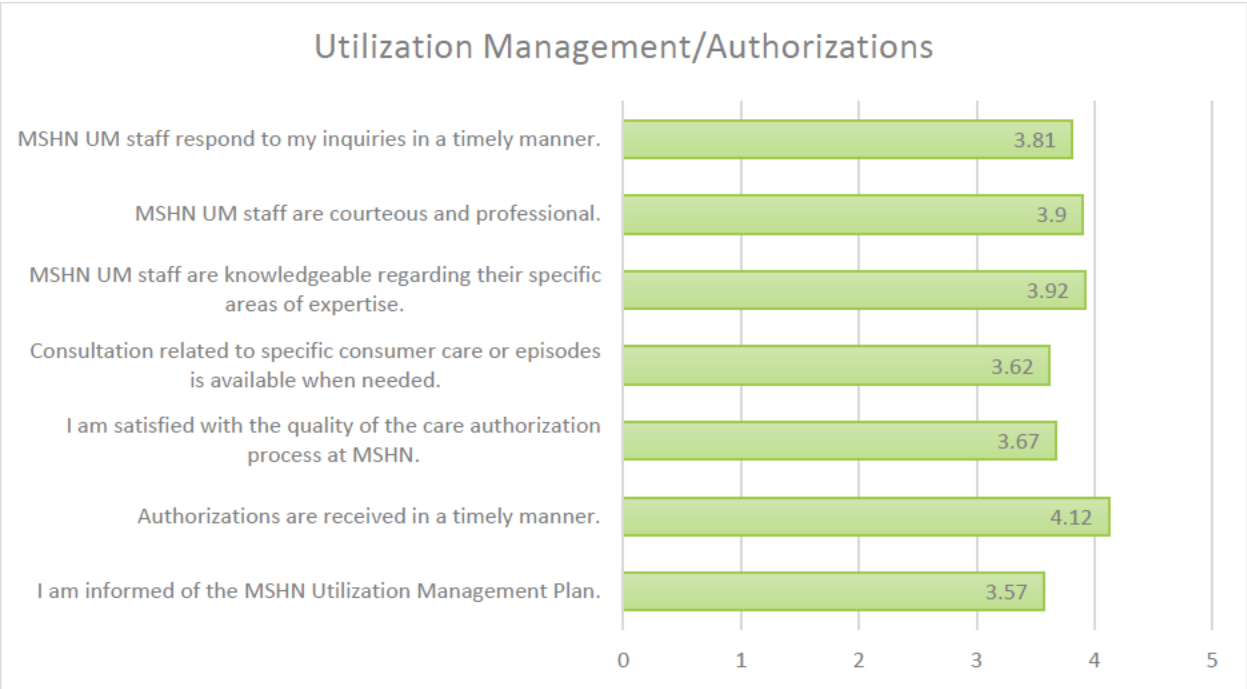
Clinical – Treatment and Prevention

Total Reponses: 71



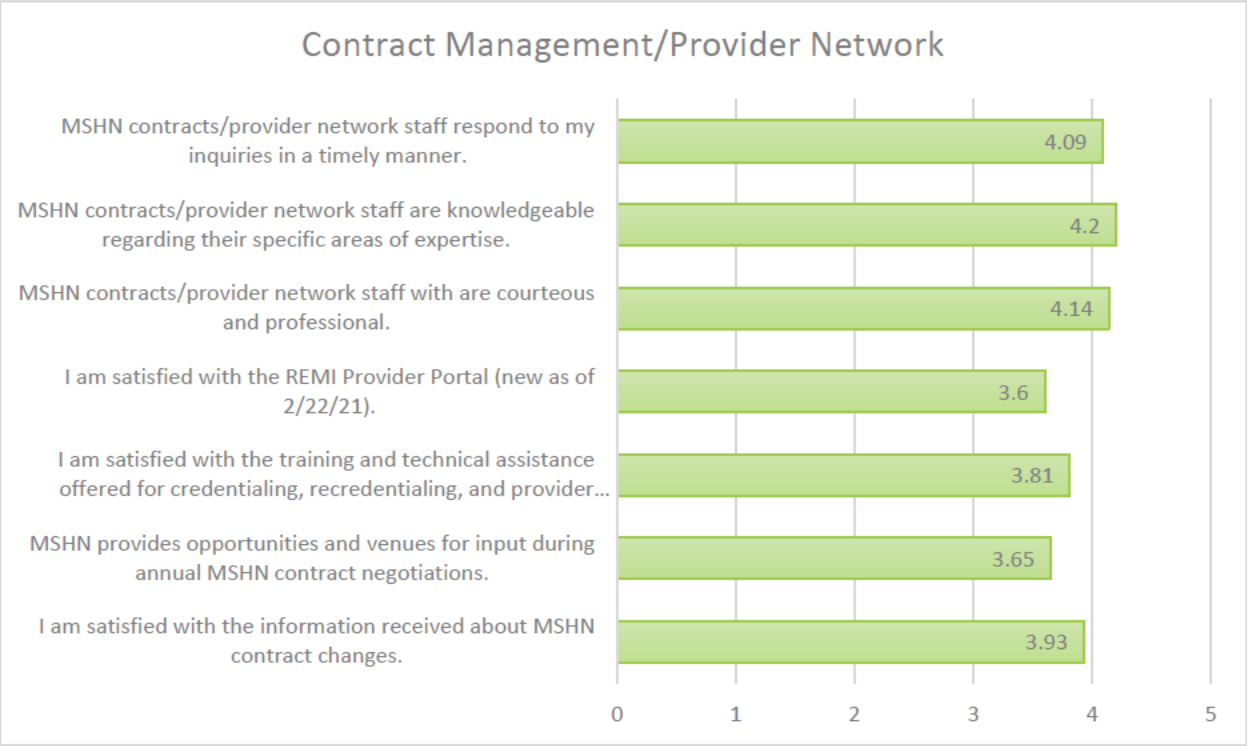
Utilization Management

Total Reponses: 61; however, some may have indicated NA for one or more statement.

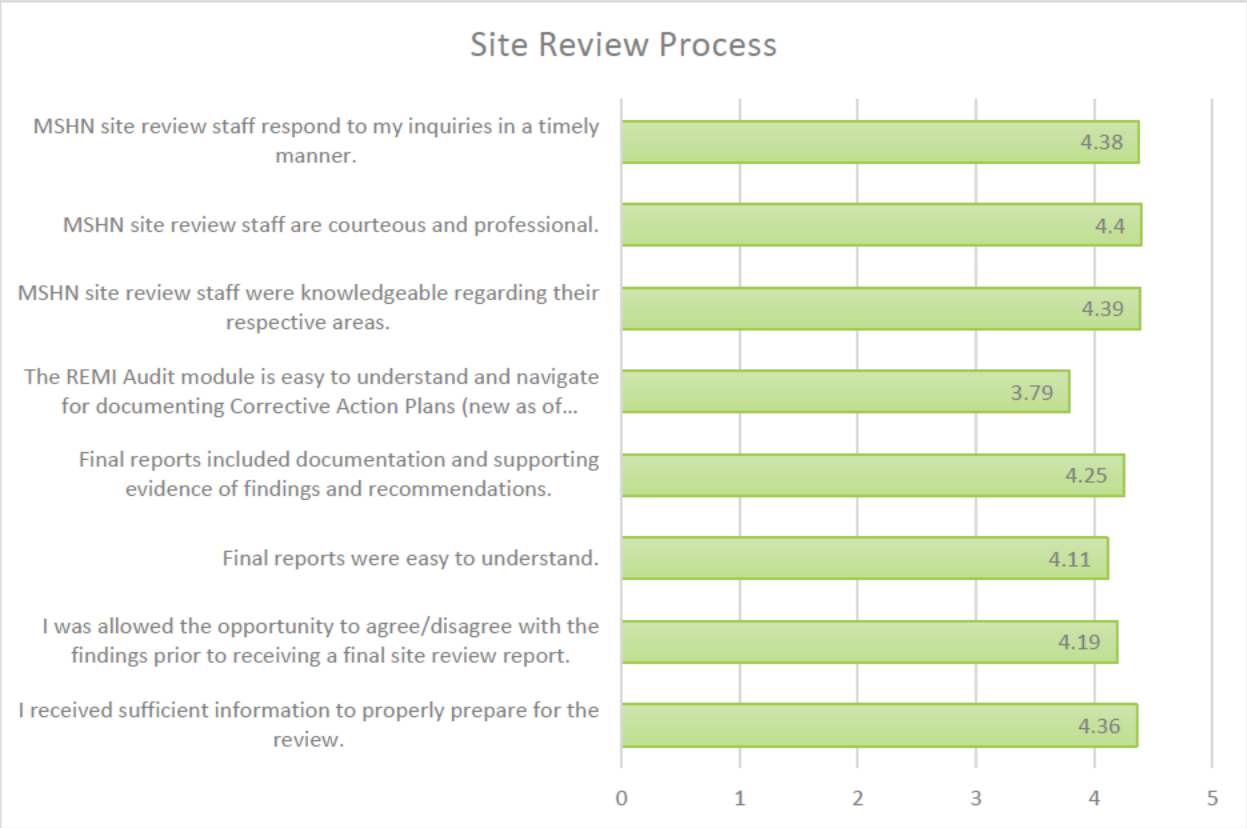


Provider Network Management

Total Reponses: 71



Total Reponses: 57



Follow Up Discussions

Providers were offered the opportunity for MSHN to follow-up for further discussion. Three individuals requested a follow-up call. MSHNs Director of Provider Network conducted follow-up meetings. Discussion/feedback is outlined below.

- MSHN is very supportive, great to work with, assist (TA) with errors in MPDS. The prevention team is amazing. The constant contact is very clear – providers can easily identify relevant information. Weekly is good for consistency and knowing when it is coming - feels proactive. Provider meetings – incumbent upon the person attending to identify relevant information (prevention vs. treatment). F2F vs virtual – respondent is centrally located so travel is not an issue and the social aspect is appreciated when F2F. Zoom has been common for everyone for some time now, so virtual certainly makes sense.

Recommendations

- Establish an agency-wide timeliness standard for responding to provider inquires (e.g., phone calls/emails returned within 1 business day). Consider agency-wide customer service training and/or standards.
- Obtain additional input from SUD PAC on the content appropriate for the MSHN newsletter vs. direct email communication.

Next Steps

- Provider Follow-up: July 2021
- Communication Plan:
    - MSHN Leadership Review: September 1, 2021
        - Provide department specific results and raw data
        - Review and feedback of proposed actions
    - MSHN All Staff Review: September Staff Meeting
        - Review and feedback of proposed actions
    - SUD-PAC Review: September 13, 2021
    - All Network Constant Contact/Website: October 1, 2021
- Finalize workplan to address opportunities for improvement including: October 15, 2021

MSHN
Mid-State Health Network

Assertive Community Treatment (ACT) Utilization FY21 Q4

Background

MDHHS issued the "Requirements for Reporting Assertive Community Treatment" Memo on 11/20/2020 followed by the "Clarification to Requirements for Reporting Assertive Community Treatment" Memo on 11/23/2020. The purpose of the memos was to clarify the minimal expectations for provision of ACT services. One of the identified expectations was an average of 120 minutes of contact per consumer per week. Although this expectation is not currently included in the Michigan Medicaid Provider Manual it is included in the Substance Abuse and Mental Health Services Administration (SAMHSA) *Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Kit,* as well as the *Michigan Field Guide to ACT*. MDHHS indicated that clarifying language will be added to a future revision of the MMPM.

Service Utilization Summary

Regional ACT (H0039) service utilization data is being monitored during FY21 to evaluate if services are currently being delivered to fidelity. Average weekly contact per consumer was calculated using the methodology as described in the *Michigan Field Guide to ACT*.

Average Minutes Per Week/Per Consumer

	FY21 Q2			FY21 Q3			FY21 Q4		
CMHSP	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun	21- Jul	21-Aug	21-Sep
Saginaw	90	97.5	109	131	150	147	176.25	116.25	N/A*
Tuscola	82.5	86.25	90	82.5	80	90	82.5	78.75	N/A*
BABHA	41	45	49	45	30	30	30	30	N/A*
CEI	45	52.5	75	64	52.5	56	67.5	67.5	N/A*
CMHCM	34	34	45	38	34	41	37.5	45	N/A*
Huron	41	37.5	45	41	34	49	56	52.5	N/A*
Lifeways	19	19	22	19	19	19	19	19	N/A*

*Denotes incomplete claims data at this time

Highlighted Field= 85% - 100% fidelity to model (96-120 average minutes per week/per consumer)

While service delivery has been impacted by the COVID-19 pandemic, it should be noted that the pre-pandemic data indicates ACT services were not being provided to fidelity in the MSHN region.

Date of UM Committee Review: 11/18/2021

Committee Discussion & Response to Data:

- Saginaw CMH- Shared best practices. ACT teams have been diligent about frequent contacts throughout pandemic as it is vital to helping persons served maintain stability. PPE is used by teams as well as creative methods of social distancing when meeting in community. Phone contacts also used when face to face contact is not feasible.
- LifeWays- Completed data validation and conducted fidelity reviews with their 3 contracted ACT teams after reviewing the Q3 report and believe there are data discrepancies. Will follow up with Skye to attempt to reconcile differences in data.

Recommendations & Next Steps:

A. Identify Barriers -COVID, possible staffing issues
B. CMHSPs will validate data and notify MSHN if any inconsistencies are found
C. Quarterly data monitoring by UM Committee
D. FY22 Monitoring- Consider addition of new program-specific standard for FY22 DMC review cycle

Next Review: February 2022 UMC Meeting

Pre-Paid Inpatient Health Plan

Medicaid Event Verification Methodology Report

Fiscal Year 2021

(October 1, 2020 – September 30, 2021)

Methodology Report Outline

Introduction & Background

Process Summary/Sampling Methodology

Data Analysis/Summary of Results

1. Summary of Analysis
    a. Study Results
    b. Data Charts

Deficiencies/Corrective Action

A. Fiscal Year 2021 Deficiencies
B. Repeated Deficiencies

Process/Performance Changes and Improvements

Future Outlook

Introduction & Background

In accordance and compliance with the Michigan Department of Health and Human Services (MDHHS) Contract[1], Mid-State Health Network (MSHN) submits the Medicaid Event Methodology Report that summarizes the verification activities across the PIHP region. The region includes 12 Community Mental Health Specialty Program (CMHSP) participants; Bay-Arenac Behavioral Health, Clinton-Eaton-Ingham Community Mental Health Services Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, Huron Behavioral Health, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health, Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness, The Right Door and Tuscola Behavioral Health Systems. Also, within the PIHP region are 51 substance use disorder (SUD) treatment providers that include 106 different treatment service locations, 36 agencies that provide prevention services and 3 SUD recovery only providers.

MSHN conducts oversight of the Medicaid claims/encounters submitted within the region by completing either an onsite review or a desk review of the provider networks policy and procedures and the claims/encounters submitted for services provided for all 12 of the CMHSPs and for all substance use disorder treatment providers who provide services using Medicaid funding. Of the 51 SUD treatment providers, only the providers that were in region providers, that provided Medicaid eligible services and used Medicaid funding were included in the review. SUD disorder treatment providers that were in another PIHP region and had a MEV review completed in that region were not included in the MEV summary as MSHN accepts the reviews of the other PIHPs.

During this review period, changes continued to be implemented to the review process in response to the COVID-19 pandemic. Executive Orders and guidance issued from the Michigan Department of Health and Human Services (MDHHS) changed how services were being delivered for both behavioral health and substance use disorder service providers. Beginning in March 2020, MSHN moved to completing the MEV site reviews exclusively by remote access versus on site reviews and this practice has continued throughout Fiscal Year 2021. This worked well for the CMHSPs who have electronic medical records that can be accessed remotely, however, for many of the SUD Providers this was a difficult change as many do not have electronic medical records. In order to lessen the burden on the SUD providers, MSHN followed the guidance in the MDHHS Medicaid Event Verification Process Guideline (MDHHS/PIHP contract attachment) which states a separate sampling and verification must be performed at each major provider in the PIHP network, as well as a single test encompassing all remaining providers. Major providers include ALL providers paid via a sub-capitation arrangement and any other providers that represent more than 25% of the PIHP claims/encounters in either unit volume or dollar value, whether directly contracted through the PIHP or subcontracted through a CMHSP, Core Provider, or MCPN.

[1] Michigan Department of Health and Human Services, Behavioral Health and Developmental Disabilities Administration, Medicaid Verification Process Guideline

Process Summary/Sampling Methodology

Medicaid claims verifications are conducted for both CMHSPs and for substance use providers, utilizing a random sample.

Sample selection for the CMHSP includes both the direct services provided by the CMHSP and the services provided by the contract providers of the CMHSP. The sample selection for the substance use providers included only direct services provided as the SUD providers do not utilize subcontracts for services.

The random sample is selected using a non-duplicated sample of 5% of beneficiaries served in the previous 2 quarters. The sample selection is set with parameters not to exceed a maximum of 50 and a minimum of 20 beneficiaries. The number of claims/encounters for each beneficiary selected in the sample has a maximum of 50 claims/encounters per beneficiary.

Note: The sample size was reduced to 10 beneficiaries for the SUD providers only during FY21 to ease the administrative burden of transferring required documents to MSHN as most SUD providers do not have an Electronic Management Record.

The sample selection for CMHSPs includes at least one beneficiary from each of the following programs: Assertive Community Treatment (ACT), Autism, Crisis Residential, Home Based Services, Habilitation Supports Waiver (HSW), Self Determination, Targeted Case Management (TCM)/Supports Coordination Services, and Wraparound. Substance Use Provider samples includes at least one beneficiary from each of the following service types as applicable to the provider: Detox, Stabilization, Residential, Out-Patient Services, Peer Services, Medication Assisted Treatment and Recovery Housing.

The samples are pulled using FastLane, which is a product of PEC Technologies. The database pulls all encounters that meet the criteria selected to include procedure codes, modifiers, funding sources, institutions and start and end date filter of encounters. Once the sample is pulled using the selected criteria, the system randomizes the list using a random sorting guide and then pulls out a sample based on the pools and weighs (various procedure codes that are grouped so that certain items are pooled or weighted given those priority in the sample). The configuration has a minimum size, maximum size and percentage of pool sample size. The system checks how many encounters are available and takes that value and multiplies it by the percentage of pool value. If that value is in the minimum-maximum range it uses that value. If it is smaller than the minimum, then the minimum is used. If it is larger than the maximum, then the maximum is used.

Data Analysis/Summary of Results

Summary of Analysis

Records and claims were reviewed over the course of the full fiscal year, October 1, 2020 – September 30, 2021. Data presented in the below chart is relative to the 12 CMHSP's and 37 substance use disorder treatment providers reviewed during this period.

The attributes tested during the Medicaid Event Verification review include: A.) The code is allowable service code under the contract, B.) Beneficiary is eligible on the date of service, C.) Service is included in the beneficiary's individual plan of service, D.) Documentation of the service date and time matches the claim date and time of the service, E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed, F.) Amount billed and paid does not exceed contractually agreed upon amount, and G.) Modifiers are used in accordance with the HCPCS guidelines.

A 90% compliance standard is the expectation per the state technical requirement for Event Verification.

CMHSP

	A	B	C	D	E	F	G
BABHA*	100%	100%	100%	99.74%	100%	100%	100%
CEI	100%	100%	100%	100%	99.00%	100%	100%
CMHCM	100%	100%	98.78%	98.31%	97.68%	98.78%	96.41%
Gratiot*	100%	100%	100%	98.97%	98.15%	100%	99.04%
Huron	100%	100%	99.92%	99.92%	99.01%	99.52%	99.57%
Lifeways*	100%	100%	99.28%	98.79%	99.76%	100%	78.86%
Montcalm	100%	100%	100%	99.63%	99.91%	99.96%	96.67%
Newaygo	97.97%	97.97%	97.96%	97.51%	96.76%	97.96%	73.69%
Saginaw*	100%	100%	100%	99.94%	100%	100%	100%
Shiawassee*	100%	100%	100%	99.76%	100%	100%	100%
The Right Door	100%	100%	100%	99.88%	97.92%	100%	98.72%
Tuscola	100%	100%	100%	99.82%	96.94%	100%	98.71%
MSHN Average	**99.83%**	**99.83%**	**99.63%**	**99.30%**	**98.76%**	**99.69%**	**95.14%**

Note: A) The code is allowable service under the contract, B) Beneficiary is eligible on the date of service, C) Service is included in the persons individualized plan of service, D) Documentation of the service date and time matches the claim date and time of the service, E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed, F.) Amount billed and paid does not exceed contractually agreed upon amount, and G.) Modifiers are used in accordance with the HCPCS guidelines.

**Denotes the CMHSPs that only had one MEV review completed in FY21 due to the need to reschedule because of COVID-19. These CMHSPs will have the second review completed in FY22.*

For the CMHSPs who had two reviews completed during the fiscal year, the percentage is an average of the scores for both reviews.

SUD

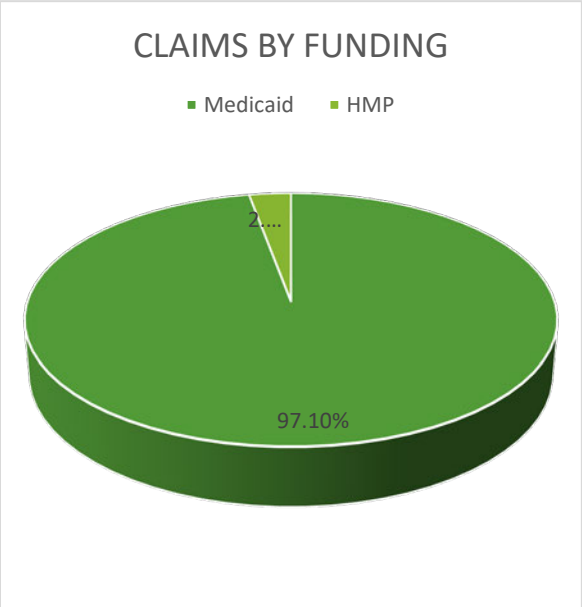
	A	B	C	D	E	F	G
SUD Providers	100%	100%	100%	99.50%	99.28%	100%	99.84%

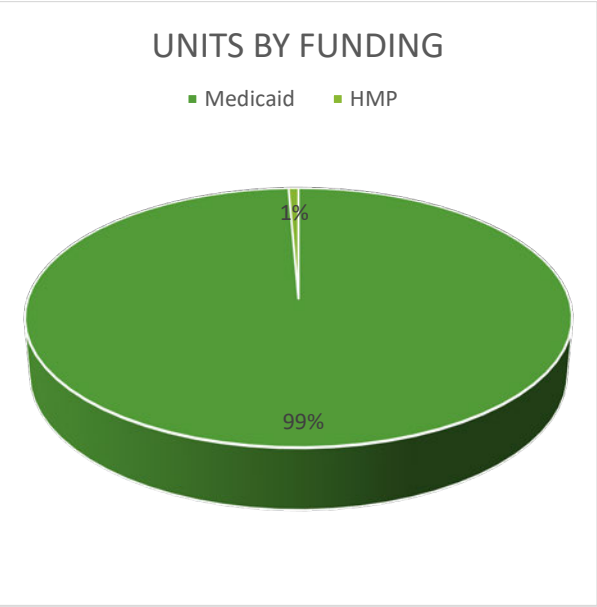
Note: This chart represents an average of the scores for all 37 SUD providers who had an individual site review and those involved in the combined single site review.

Note: A) The code is allowable service under the contract, B) Beneficiary is eligible on the date of service, C) Service is included in the persons individualized plan of service, D) Documentation of the service date and time matches the claim date and time of the service, E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed, F.) Amount billed and paid does not exceed contractually agreed upon amount, and G.) Modifiers are used in accordance with the HCPCS guidelines.

Summary of CMHSP Claims Reviewed by Funding Source:

In total 11,223 claims were reviewed. Of the 11,223 claims reviewed 10,897 of the claims were billed as Medicaid and 326 of the claims were billed using Healthy Michigan Plan Funding. The 11,223 claims included 94,528 units of service. Of the 94,528 units reviewed 93,890 were billed as Medicaid and 638 were billed as Healthy Michigan Plan. The dollar amount of the claims reviewed totaled $3,382,578.68. Of the $3, 382,578.68 reviewed $3,276,249.00 were billed using Medicaid funding and $106,329.68 were billed using Healthy Michigan funding.

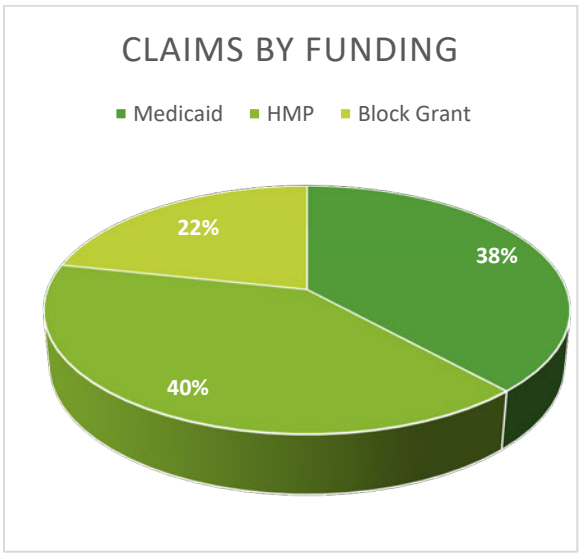


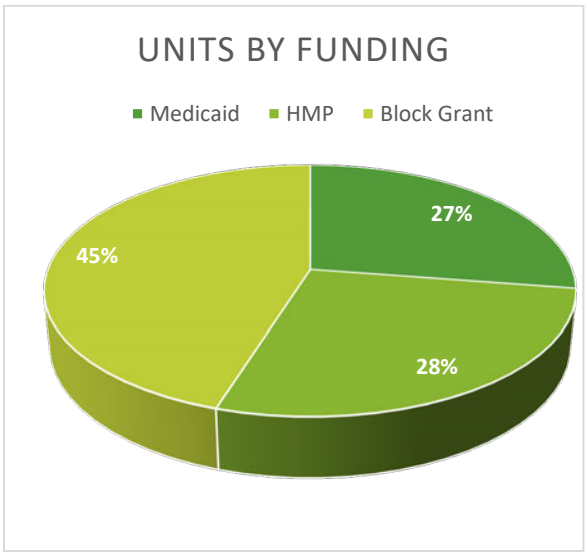


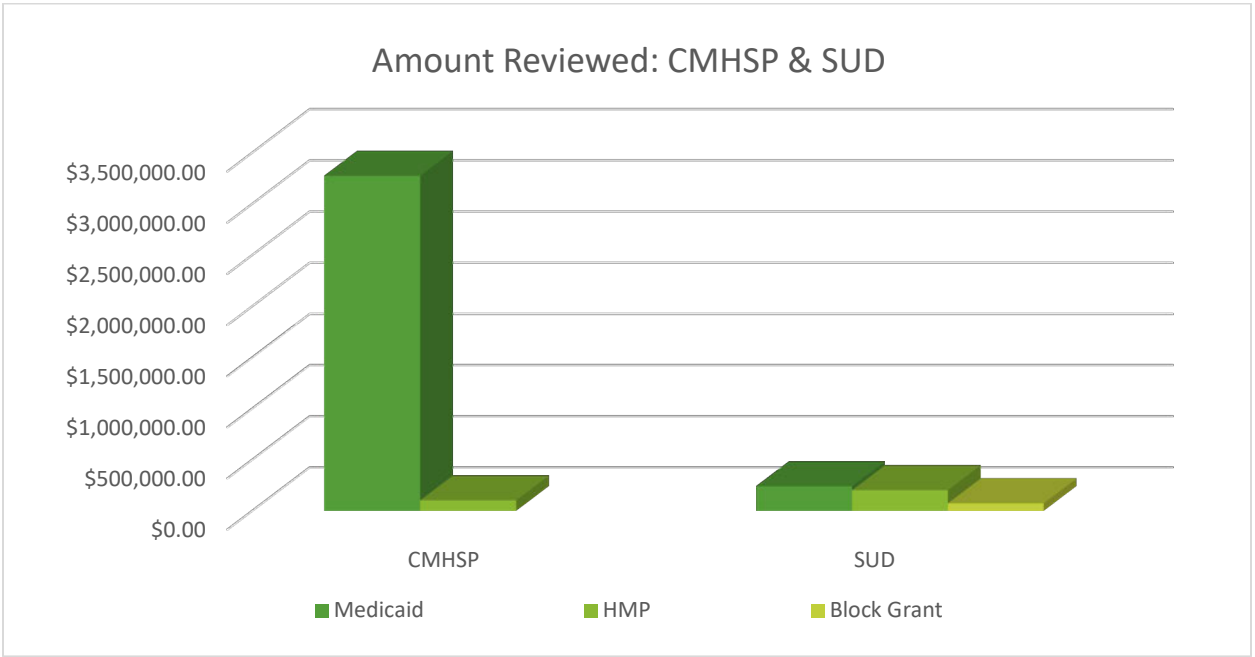
Summary of SUD Claims Reviewed by Funding Source:

In total 5,379 claims were reviewed. Of the 5,379 claims reviewed 2,056 of the claims were billed as Medicaid, 2,159 of the claims were billed using Healthy Michigan and 1,164 of the claims were billed as Block Grant Funding. The 5,379 claims included 11,426 units of service.

Of the 11,426 units reviewed, 3,133 were billed as Medicaid, 3,137 were billed as Healthy Michigan Plan and 5,156 were billed as Block Grant funding. The dollar amount of the claims reviewed totaled $527,020.71. Of the $527,020.71 reviewed $243,607.45 were billed using Medicaid funding, $206,269.50 were billed using Healthy Michigan and $77,142.76 was billed using Block Grant funding.







The services reviewed for the CMHSPs included ACT, autism, crisis residential, homebased, HAB waiver, self-determination, targeted case management and supports coordination, wraparound, behavior treatment plan, children's waiver and SED Waiver. As some people were enrolled in more than one program and services were counted in more than one program, the overall total of claims/encounters do not match the claims/encounters total from the total by

funding source. The program total is based on program enrollment and not by independent service provided such as assessments, outpatient, treatment plan reviews, and medication reviews.

CMHSP Services Reviewed by Program			
Program	**Claims**	**Units**	**Amount**
ACT	379	1,127	$43,702.16
Autism	1,045	10,129	$257,435.41
Crisis Residential	367	1,038	$171,745.72
Habilitation Supports Waiver	1,531	17,1416	$722,715.83
Home Based Services	1,278	6,115	$385,836.15
Self Determination	1,180	15,961	$139,461.09
Targeted Case Management and Supports Coordination	4,547	38,765	$1,268,246.64
Wraparound	543	1,786	$130,793.19
Behavior Treatment Plan	422	3,128	$232,416.45
Children's Waiver	235	4,030	$50,995.56
SED Waiver	100	401	$40,485.08

Note: The services for Behavior Treatment Plan, Children's Waiver and SED Waiver were not tracked prior to FY21 Q2. During FY21 Q2, the MEV forms were updated to an electronic process that included tracking these additional services.

The services reviewed for the SUD providers included detox(residential), stabilization (residential), residential, outpatient, peer delivered services, medication assisted treatment, and recovery housing. As some people were enrolled in more than one program and services were counted in more than one program the overall total of claims/encounters do not match the claims/encounters total from the total by funding source. The program total is based on program enrollment and not by independent service provided such as assessments, psychotherapy, treatment plan reviews, and medication reviews.

SUD Services Reviewed by Program			
Program	**Claims**	**Units**	**Amount**
Detox/Residential	51	115	$37,532.00
Stabilization (Residential)	21	50	$45,764.70
Residential	451	2,143	$146,511.16
Out Patient	2,546	3,411	$213,323.75
Peer Supports	1,164	2,113	$92,734.46
Medication Assisted Treatment	833	854	$8,580.00
Recovery Housing	289	1,238	$22,574.64

Note: The services for stabilization (residential), residential and recovery housing were not tracked prior to FY21 Q2. During FY21 Q2, the MEV forms were updated to an electronic process that included tracking these additional services.

Deficiencies/Corrective Action

Fiscal Year 2021 Deficiencies

MSHN requires deficiencies found during the Medicaid Event Verification process be resolved immediately through one or more of the following methods:

- Billing records re-billed with correct information (e.g. code change, funding source change);
- Billed services in error voided;
- Person centered plans updated with correct authorization; and
- Reduction to future payments on subcontractor claims as necessary

For deficiencies found as a system issue, network providers are required to document a corrective action plan and demonstrate sufficient monitoring and oversight to ensure implementation. Corrective action plans may consist of education and training, data software system changes, and process changes along with related expected timelines for implementation.

MSHN reviews and monitors the corrective action plans during the following review cycle to ensure implementation of the plan indicated. For substance use disorder providers, the claims/encounters are voided immediately by MSHN for any claims/encounters determined to be invalid. The CMHSPs complete their own corrections and voids for claims/encounters found to be invalid and MSHN reviews to ensure this has been completed correctly. If deemed necessary by MSHN, additional follow up and sampling of selected elements is completed to ensure system and process change.

Based on the MEV review for FY2021, 12 CMHSPs were placed on a new plan of correction and of the 37 substance use disorder treatment providers reviewed, 7 were placed on a new plan of correction. In addition, all CMHSPs and substance use disorder treatment providers who were placed on a plan of correction during FY2020, were removed from those plans during FY2021.

The overall findings included a total dollar amount of invalid claims identified for CMHSP's direct and indirect services of $172,561.76 and $39,892.40 for substance use disorder treatment providers. All invalid claims were corrected based on MSHN's established process.

NOTE: Many of the invalid claims were corrected by submitting additional documentation and by resubmitting claims with correct modifiers, dates, times, etc. These claims, units and dollars are included in the summary of disallowed amounts as they were original findings that documentation did not support during the review.

If suspicion of fraud or abuse was present, the CMHSPs and SUD Treatment Providers were required to report to MSHN for further review and follow up. As part of MSHN's ongoing compliance process, MSHN completes an initial investigation to determine if reporting to MDHHS Office of Inspector General (OIG) is required. This process occurs throughout the year as the reports are received. Beginning with the FY2019 review cycle and continuing through FY2021, all MEV reviews were reported quarterly to the Office of Inspector General (OIG).

Repeated Deficiencies

Though the MSHN combined average for CMHSPs and SUD providers did not fall below the departments 90% accuracy rate for any area reviewed, there were providers that had attributes tested that fell below the 90% accuracy standard.

The 90% accuracy standard is defined as the total number of valid claims reviewed for all attributes tested. The formula used to determine the percentage of valid claims is total valid claims reviewed/total claims reviewed = percentage of valid claims. A valid claim is defined as a claim included in the sample that does not have a finding identified. A provider can fall below the 90% accuracy standard for the review without falling below the 90% standard on any individual attribute tested and a provider can fall below the 90% standard for individual attributes without falling below the 90% standard for the entire review.

During FY2021, two (2) CMHSPs and two (2) SUD Providers fell below the 90% accuracy standard when combining all the invalid claims together for all attributes tested. By comparison, during FY2020, there was one (1) CMHSP and four (4) SUD Providers that fell below the 90% accuracy standard.

The attributes that had the most deficiencies identified for both the CMHSPs and the SUD providers included the following:

1. Attribute D: Documentation of the service date and time matches the claim date and time of the service.
2. Attribute E: Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed.

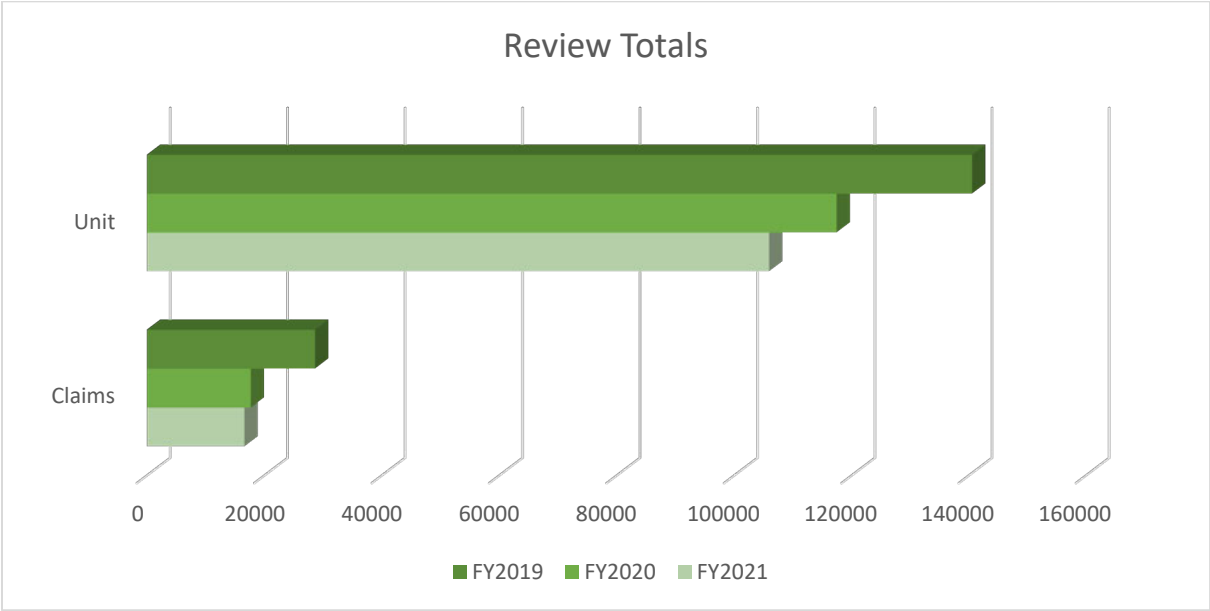
3. Attribute G: Modifiers are used in accordance with the HCPCS guidelines.

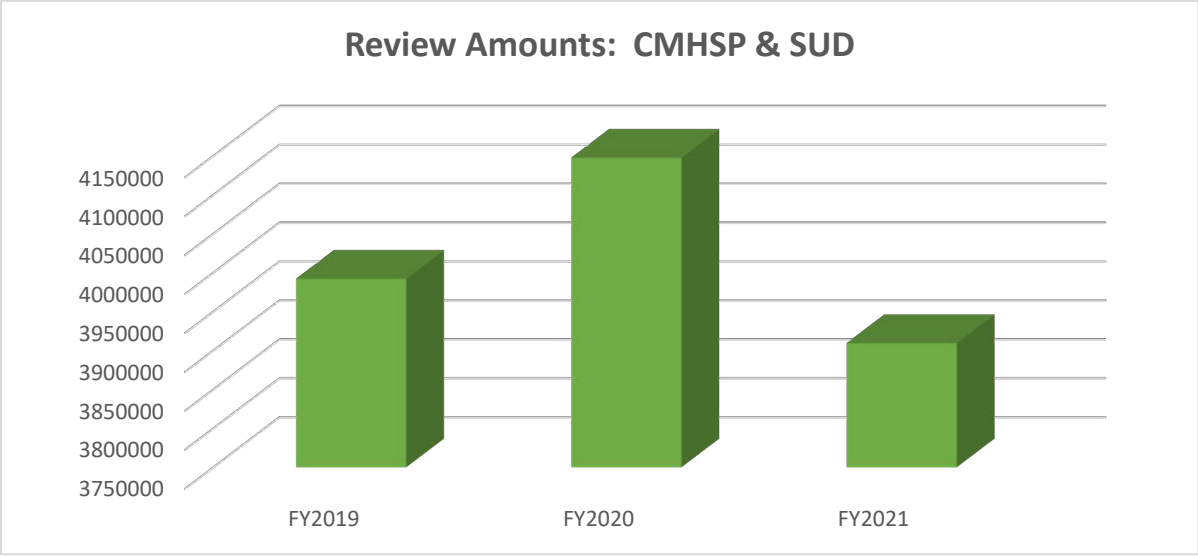
Process/Performance Changes and Improvements

Process Changes:
The claim and units reviewed for both the CMHSPs and SUD providers was less in FY2021 than in FY2020. However, the dollar amount reviewed for FY2021 was higher for both the CMHSPs and SUD providers than in FY2020.

The reduction in claims and units reviewed can be attributed to continued changes implemented in response to COVID -19. The number of beneficiaries included in the reviews was reduced for the SUD providers to lessen the administrative burden due to completing the reviews as desk audits. Most of the SUD providers do not have electronic health records (EHR) so all documents were required to be uploaded to a secure location for review versus being accessed electronically. Many of the SUD providers were also involved in a single site review instead of individual site reviews which decreased the overall number of claims and units included in that review.

The increase in the dollar amount reviewed can continue to be attributed to the inclusion of block grant funding and the increase of peer delivered services within the SUD provider reviews. For the CMHSPs, the increase can be attributed to the random sample pulling more claims in services such as Habilitation Supports Waiver and Wraparound where the costs tend to be more significant.





Process Improvements:

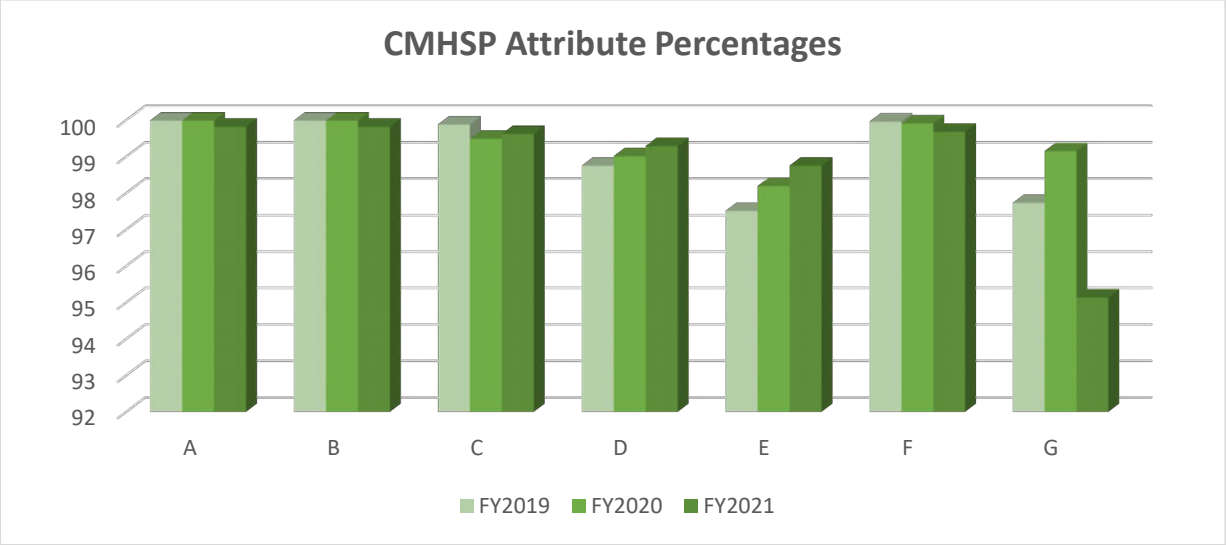
Process improvements implemented from previous MEV reviews included the development of new forms for the claims review, summary report, plan of correction and data tracking. The claims review form moved from a manual calculation process to an automated process for calculating the number of claims, units, dollar amounts, identification of the services being reviewed, among other elements. The summary report has been standardized and the data elements automatically fill from the claims review form removing the potential errors that occur as part of a manual process. The automated process has improved the accuracy, efficiency and reporting timeframes by decreasing the amount of time previously required to complete the reports. In addition, a new tracking form was developed to track required elements for the MEV annual report and OIG quarterly report.

Performance Improvements:

Regionally the CMHSPs have shown slight improvements from FY2020 to FY2021 for the following attributes:

1. C: Service is included in the beneficiary's individual plan of service.
2. D: Documentation of the service date and time matches the claim date and time of the service.
3. E: Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed.

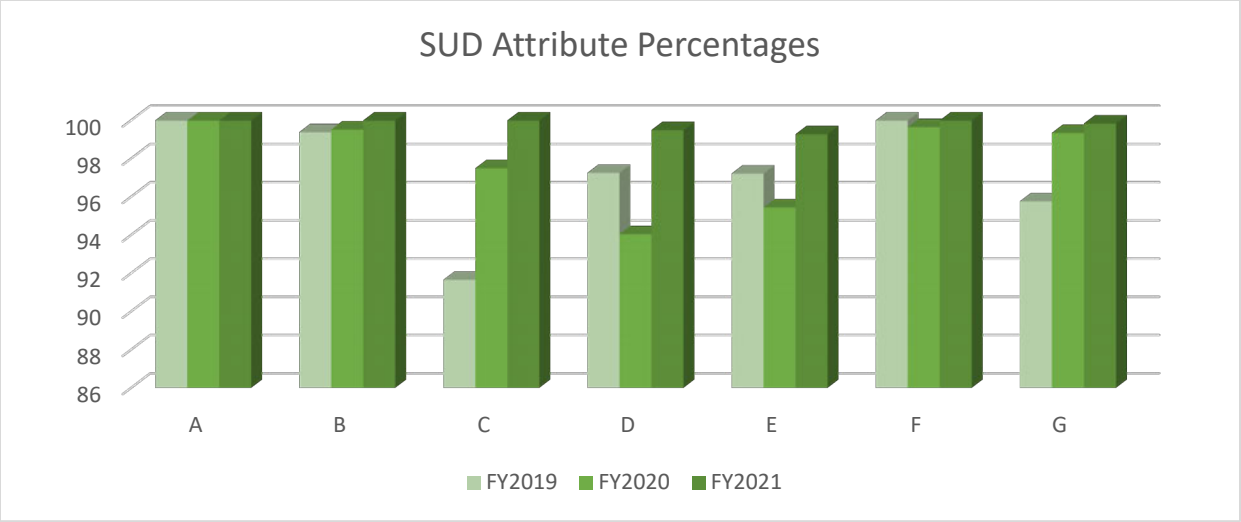
These improvements may be attributed to an increased focus on improving the quality of documentation, improved staff trainings and ongoing monitoring and oversight. In addition, MSHN has safeguards in place to guard against duplicate and incomplete claims being submitted.



Regionally the SUD providers review showed improvements from FY2020 to FY2021 for the following attributes:

1. B: Beneficiary is eligible on the date of service.
2. C: Service is included in the beneficiary's individual plan of service.
3. D: Documentation of the service date and time matches the claim date and time of the service.
4. E: Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed.
5. F: Amount billed and paid does not exceed contractually agreed upon amount.
6. G: Modifiers are used in accordance with the HCPCS guidelines.

These improvements may be attributed to continued training and technical assistance provided by MSHN to the providers as part of the MEV site reviews. The SUD provider network is also doing better with understanding the supporting documentation that is required to show compliance with the attributes.



Note: The above chart does not include the same SUD providers from year to year but is representative of the region.

MSHN will continue to provide ongoing support to our provider network to ensure compliance with the attributes reviewed during the MEV site reviews. This will include training opportunities and identified quality improvements based on data trends.

MSHN also reviews the event verification results with the following council and committees:

- MSHN Compliance Committee (internal committee)
- Regional Compliance Committee (external committee consisting of members of the CMHSPs)
- MSHN Quality Improvement Council (external committee consisting of members of the CMHSPs)

Councils and committees review and provide feedback for region-wide performance improvement opportunities. In addition, discussion and sharing regarding local improvement opportunities provides collaboration efforts to increase compliance.

Future Outlook

MSHN is beginning its seventh year of reviews and will continue to focus on plans of corrections from previous reviews to ensure indicated quality improvements are taking place as well as providing ongoing technical assistance in the areas that demonstrate the lowest percentages. MSHN will work with the CMHSPs and the SUD provider network to collaboratively share information in the areas of best practice documentation and processes that have been identified during reviews. The MEV policy and procedure will be reviewed internally on an ongoing basis to ensure compliance with Federal and State standards and to ensure consistency and best practices are followed. The quarterly reports that were implemented in FY2020 have continued and include the findings, recommendations, plans of correction and quality improvement opportunities based on data trends. MSHN also continues to report all the findings from the MEV reviews on the OIG quarterly reports for feedback and approval.

MSHN
Mid-State Health Network

MSHN Behavioral Health (CMH) Department Quarterly Report

July 2021 – September 2021 (FY21Q4)

Prepared by: MSHN Waiver Assistant and Chief Behavioral Health Officer

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I. Introduction

The Behavioral Health (CMH) Department at Mid-State Health Network consists of several functions that oversee and support contractual obligations with the Michigan Department of Health and Human Services (MDHHS) and Community Mental Health Services Programs (CMHSPs). Pre-Paid Inpatient Health Plans (PIHPs) such as MSHN, have the responsibility to oversee the waiver services for eligible beneficiaries. MSHN is responsible for provision of certain enhanced community support services for those beneficiaries in the service areas who are enrolled in Michigan's 1915(c) Home and Community Based Services Waiver for persons with developmental disabilities. MSHN oversees the following 1915(c) waivers: The Children's Waiver Program (CWP), the Habilitation Supports Waiver (HSW), and the Waiver for Children with Serious Emotional Disturbance (SEDW).

The Autism Benefit is provided under Michigan's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services. MSHN is responsible for the provision of specialty services Medicaid benefits and makes these benefits available to beneficiaries referred by a primary EPSDT screener, to correct or ameliorate a qualifying condition discovered through the screening process. The EPSDT is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The Autism Benefit is for children under 21 years of age and focuses on behavioral health treatment services (BHT) and applied behavioral analysis (ABA) evidence-based practice services.

MSHN Home and Community-Based Services Rule Transition (HCBS) efforts developed because of the following: On January 16, 2014, the Centers for Medicare & Medicaid Services (CMS) released the Home and Community Based Services (HCBS) Final Rule (CMS 2249-F/2296-F). The HCBS Final Rule specifies requirements for programs offering HCBS under the 1915(c), 1915(i), 1915(k), some 1915(b)(3) and 1115 authorities of the Social Security Act. These requirements aim to improve the quality of the lives of individuals, allowing them to live and receive services in the least restrictive setting possible with full integration in the community. MSHN must make sure that its provider network of CMHSPs and their sub-contracted providers are compliant with the HCBS Rule and continue to undertake activities to ensure follow through in this transition.

The Supports Intensity Scale (SIS) is an assessment instrument designed by the American Association on Intellectual and Developmental Disabilities (AAIDD) to identify support needs the beneficiary could benefit from to live life in the community like any other person his or her age. MSHN must ensure that a SIS is given to each Michigan Medicaid-eligible beneficiary, age 16 and older (as of 10/01/2020) with an Intellectual/Developmental Disability (IDD), who are currently receiving case management or supports coordination or respite only services at minimum of once every three years (or more or if the person experiences significant changes in their support needs). The MSHN region has eight SIS assessors assigned to cover CMHSP sections of the region.

The Clinical Leadership Committee (CLC) consists of the clinical leaders of each CMHSP and MSHN. The MSHN Operations Council (OC) has created the CLC to advise the Prepaid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) and the OC concerning the clinical operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, its purpose is to inform, advise, and work with the CEO and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

The Regional Medical Directors Committee (RMDC), as created by the MSHN OC, the RMDC functions to advise the MSHN Chief Medical Officer (CMO), the MSHN Chief Executive Officer (or designee), the MSHN Chief Behavioral Health Officer (CBHO), and the OC concerning the behavioral health operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CMO, CEO (or designee), CBHO, and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

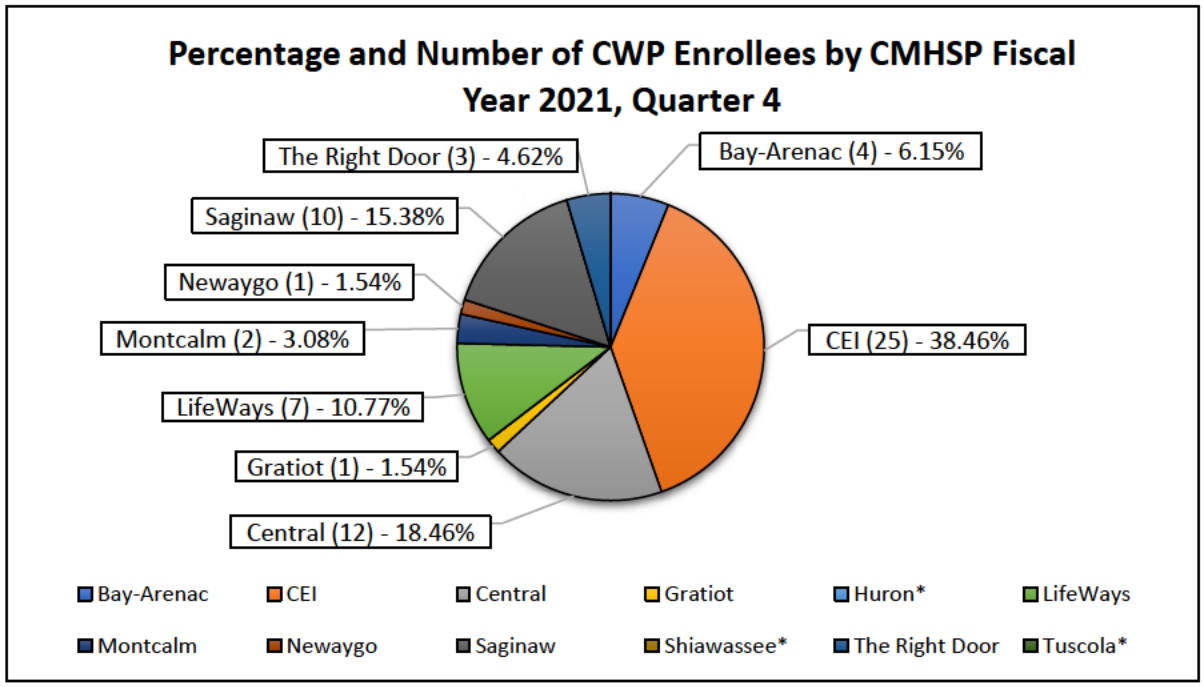
II. Waivers

A. Children's Waiver Program (CWP)

At the end of the fourth quarter (Q4) of Fiscal Year 2021 (FY21), Mid-State Health Network's (MSHN) Children's Waiver Program (CWP) had a total of 65 enrollees, which was a 1.56% increase since the end of the third quarter. Three of the region's CMHSPs did not have any individuals enrolled in the program at that time (Huron, Shiawassee, Tuscola). Of the CMHSPs with enrollees, CEI made up the greatest portion (38.46%).

Fiscal Year 2021, Quarter 4 CWP Enrollment by CMHSP					
CMHSP	**End of Q3**	**Jul 2021**	**Aug 2021**	**Sep 2021**	**% Change from Q3**
Bay-Arenac	4	4	4	4	**0%**
CEI	25	25	25	25	**0%**
Central	12	12	13	12	**0%**
Gratiot	1	1	1	1	**0%**
Huron	0	0	0	0	**N/A**
LifeWays	7	7	7	7	**0%**
Montcalm	0	0	0	2	**N/A**
Newaygo	1	1	1	1	**0%**
Saginaw	11	11	11	10	**-9.09%**
Shiawassee	0	0	0	0	**N/A**
The Right Door	3	3	3	3	**0%**
Tuscola	0	0	0	0	**N/A**
MSHN Total	**64**	**64**	**65**	**65**	**1.56%**

***Note: Any discrepancies from Q3 report or monthly reports can be accounted for by disenrollments or enrollments from prior months submitted/processed late.**



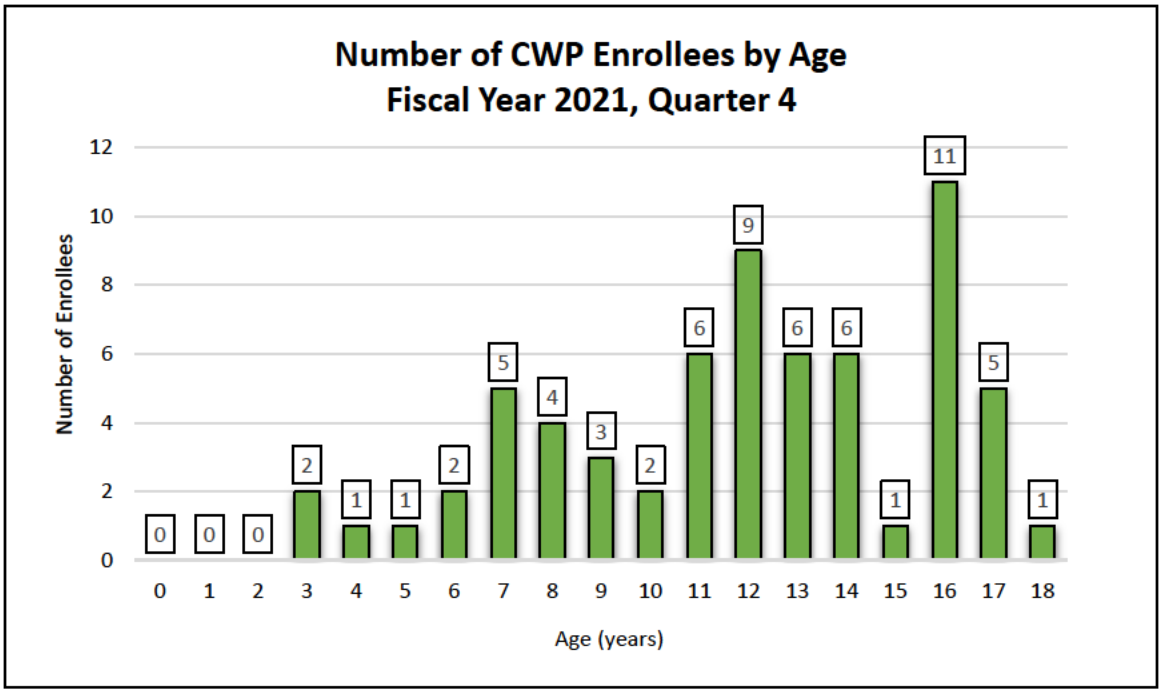
Weighing List (Prescreen) and Invitation Data and Trends

The CWP has a limited number of slots for the entire state of Michigan. Given this, individuals are prescreened to determine eligibility and subsequently placed on the Priority Weighing List to wait for an Invitation to enroll in the program. Based on the most recent Waiver Renewal Application from October 1, 2019, 100 additional slots will be opening over the first three years of the five-year approval. In the second year of the application, beginning October 1, 2020, 50 of the additional 100 slots were opened. MSHN CMHSPs were offered three invitations during the second quarter of Fiscal Year 2021. Currently, MSHN has zero individuals on the Weighing List (meaning they have been prescreened).

Weighing List and Invitation by CMHSP – End of FY21, Quarter 4		
CMHSP	**Weighing List**	**Invitation**
Bay-Arenac	**0**	**0**
CEI	**0**	**0**
Central	**0**	**0**
Gratiot	**0**	**0**
Huron	**0**	**0**
LifeWays	**0**	**0**
Montcalm	**0**	**0**
Newaygo	**0**	**0**
Saginaw	**0**	**0**
Shiawassee	**0**	**0**
The Right Door	**0**	**0**
Tuscola	**0**	**0**
MSHN Total	**0**	**0**

CWP Age-Related Data and Data Trends

At the end of FY21 Q4, the average age of individuals enrolled in the CWP was 11.86 years old, with the youngest enrollee being 3 years old and the oldest enrollee being 18 years old. During Q4, there were 2 age-offs. An individual ages off at the end of the month in which they turn 18; CMHSPs are given a 90-day notice from MSHN when they have someone approaching age-off. An individual that ages off the CWP has the highest priority for enrollment in the Habilitation Supports Waiver (HSW) program.



Summary

MSHN's Children's Waiver Program ended FY21 Q4 with 65 enrollees, which was a 1.56% increase from Q3 of the fiscal year. The region currently has 0 individuals on the Priority Weighing List. The average age of enrollees at the end of Q4 was 11.86 years old. The region experienced 2 age-offs throughout the quarter.

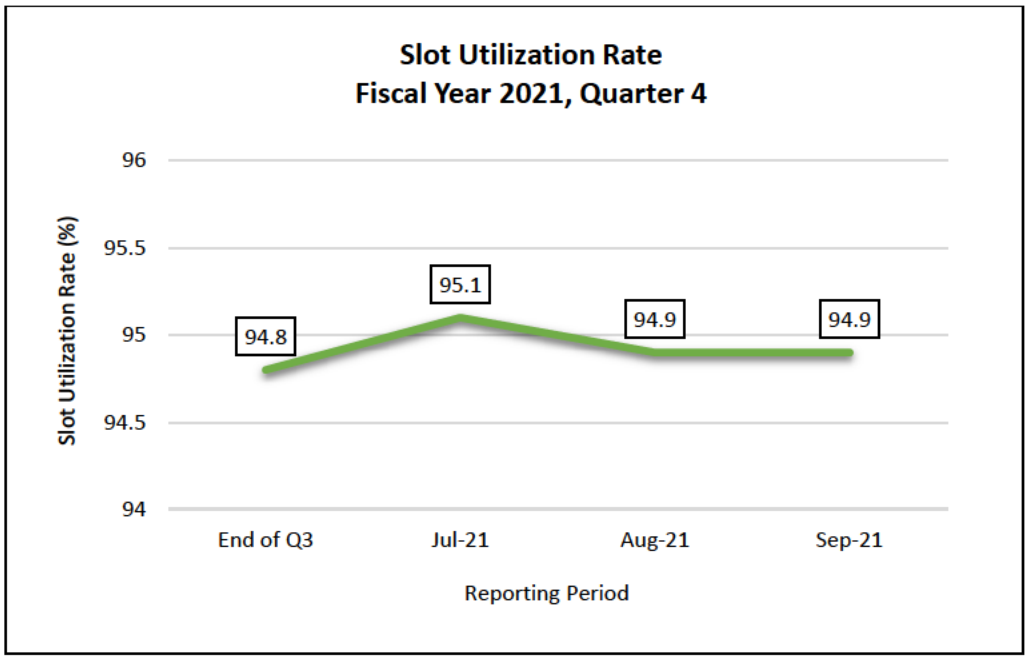
B. Habilitation Supports Waiver (HSW) Program

HSW Slot Utilization and Data Trends

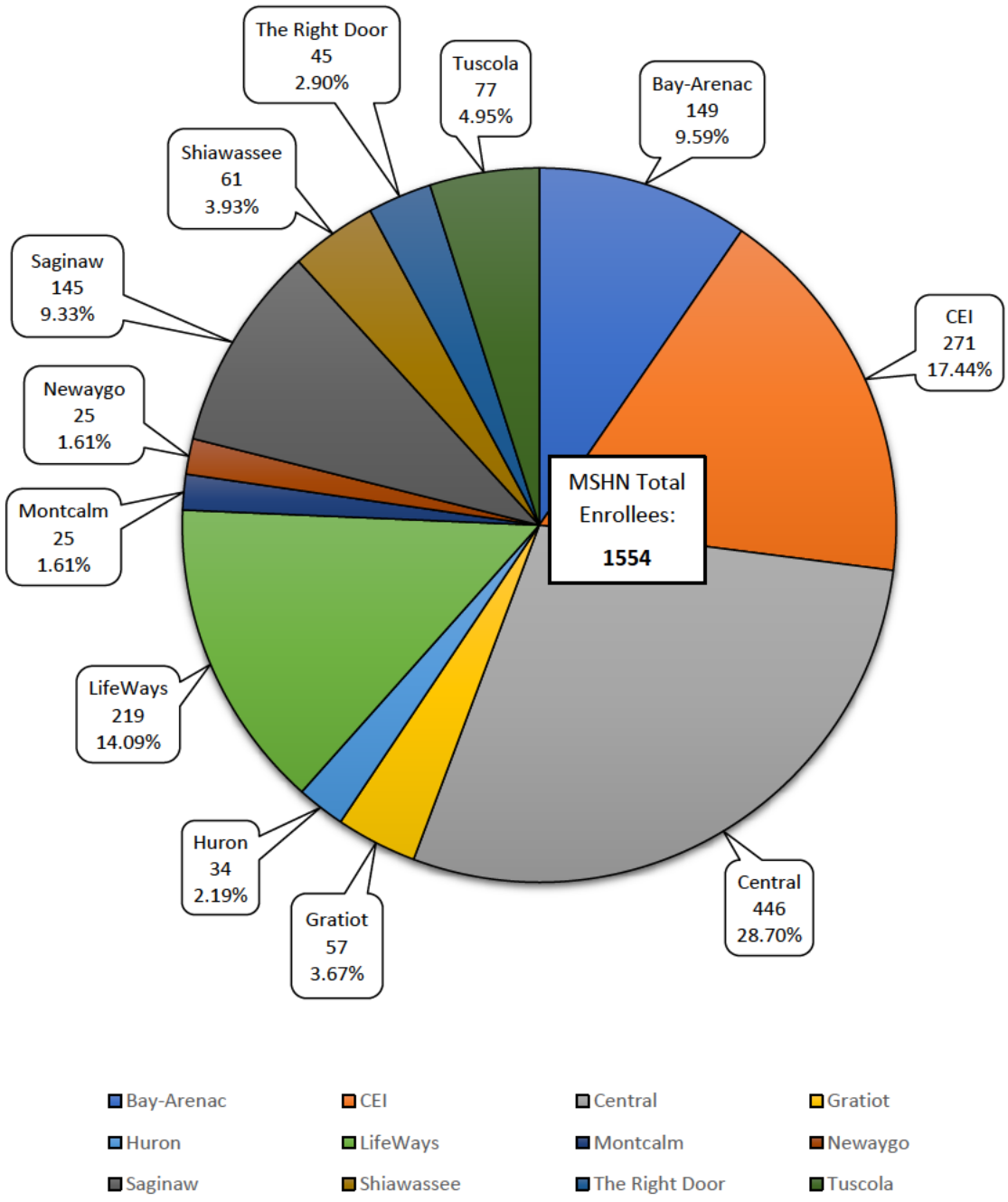
Over FY21 Q4, MSHN dropped below compliance of the 95% slot utilization standard set by Michigan Department of Health and Human Services (MDHHS). MSHN currently has a slot allocation of 1,637 slots. At the end of September, 1,554 slots, or 94.9%, were being utilized. This is a 0.13% increase since the end of Q3. The following charts represent the utilization distributions within the fourth quarter, since the third quarter, and among CMHSPs. While MSHN is no longer under corrective action by MDHHS, MSHN's goal is to attain 100% slot utilization, but at a minimum will continue with corrective efforts until 97% utilization has been achieved.

Slot Utilization by CMHSPs for Fiscal Year 2021, Quarter 4						
CMHSP	End of Q3	Jul 2021	Aug 2021	Sep 2021	% Change within Q4	% Change from Q3
Bay-Arenac	151	150	148	149	-0.67%	-1.32%
CEI	261	270	269	271	0.37%	3.83%
Central	448	446	447	446	0%	-0.45%
Gratiot	58	58	58	57	-1.72%	-1.72%
Huron	36	36	36	34	-5.56%	-5.56%
LifeWays	219	218	216	219	0.46%	0%
Montcalm	25	25	25	25	0%	0%
Newaygo	26	26	26	25	-3.85%	-3.85%
Saginaw	145	145	145	145	0%	0%
Shiawassee	61	61	61	61	0%	0%
The Right Door	46	46	45	45	-2.17%	-2.17%
Tuscola	75	76	76	77	-1.32%	2.67%
MSHN Total	1551	1557	1552	1554	-0.19%	0.19%

***Note: Any discrepancies from Q3 report or monthly reports can be accounted for by disenrollments or enrollments from prior months submitted/processed late.**



Number and Percentage of HSW Enrollees by CMHSP
Fiscal Year 2021, Quarter 4

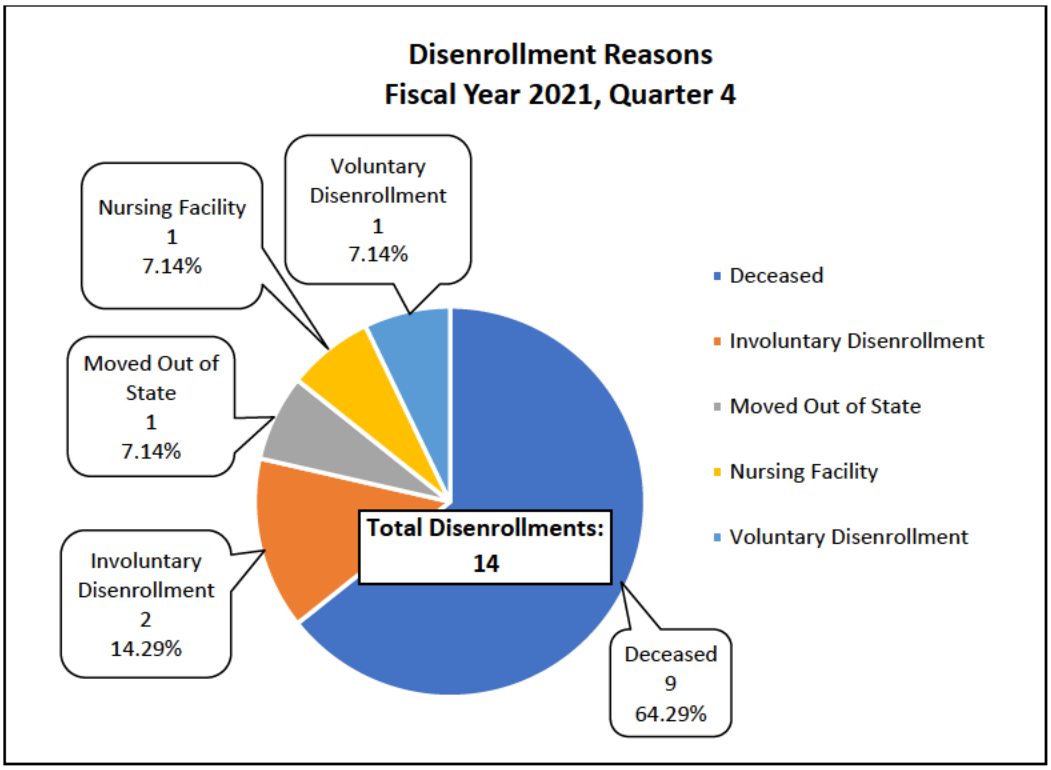


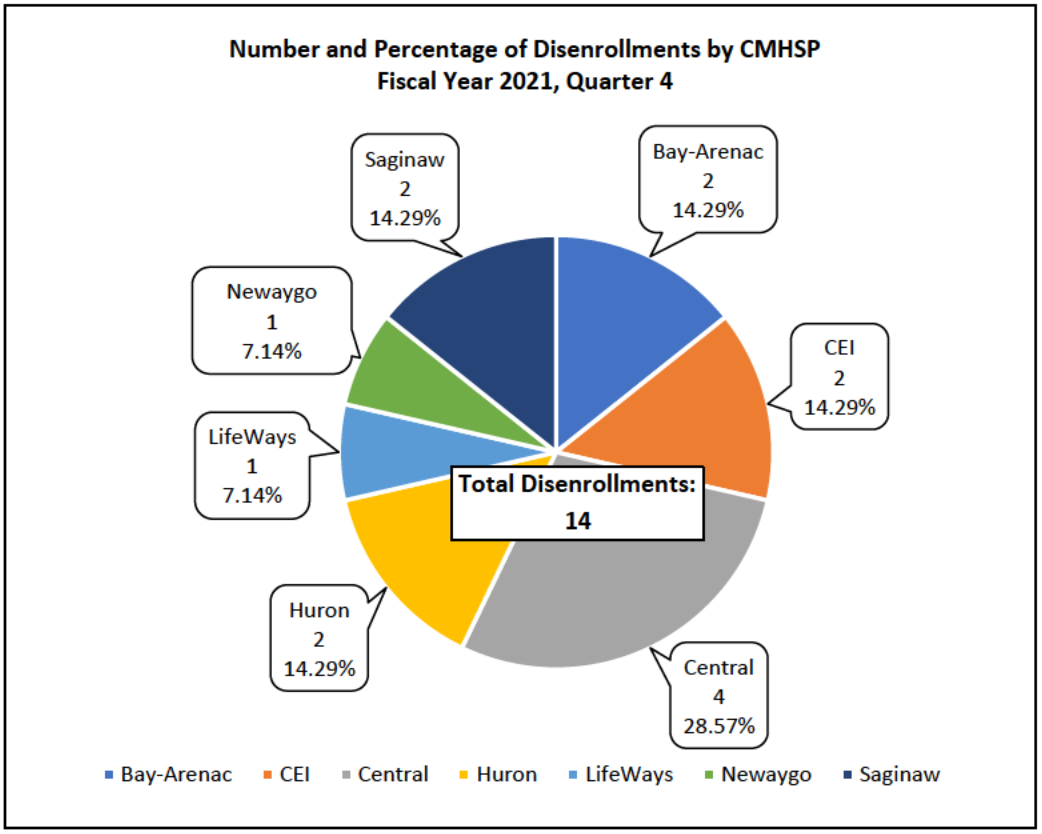
Disenrollments and Data Trends

Throughout Q4, MSHN had a total of 14 disenrollments which were accounted for by five broad categories: Deceased, Involuntary Disenrollment, Moved Out of State, Nursing Facility, and Voluntary Disenrollment. The broad category of Voluntary Disenrollment included 1 reason this quarter and that was because the consumer's family decided to no longer participate in habilitative services. The biggest reason for disenrollment was consumer death, accounting for 64.29% of fourth quarter disenrollments.

Disenrollment Reasons for Fiscal Year 2021, Quarter 4				
	Jul 2021	Aug 2021	Sep 2021	Total
Deceased	5	1	3	**9**
Involuntary Disenrollment	0	2	0	**2**
Moved Out of State	0	1	0	**1**
Nursing Facility	1	0	0	**1**
Voluntary Disenrollment	1	0	0	**1**
Total	**7**	**4**	**3**	**14**

Disenrollment Reasons by CMHSP for Fiscal Year 2021, Quarter 4						
CMHSP	Deceased	Involuntary	Moved Out	Nursing	Voluntary	Total
Bay-Arenac	2	0	0	0	0	**2**
CEI	1	0	0	1	0	**2**
Central	4	0	0	0	0	**4**
Gratiot	0	0	0	0	0	**0**
Huron	0	2	0	0	0	**2**
LifeWays	0	0	0	0	1	**1**
Montcalm	0	0	0	0	0	**0**
Newaygo	0	0	1	0	0	**1**
Saginaw	2	0	0	0	0	**2**
Shiawassee	0	0	0	0	0	**0**
The Right Door	0	0	0	0	0	**0**
Tuscola	0	0	0	0	0	**0**
Total	**9**	**2**	**1**	**1**	**1**	**14**

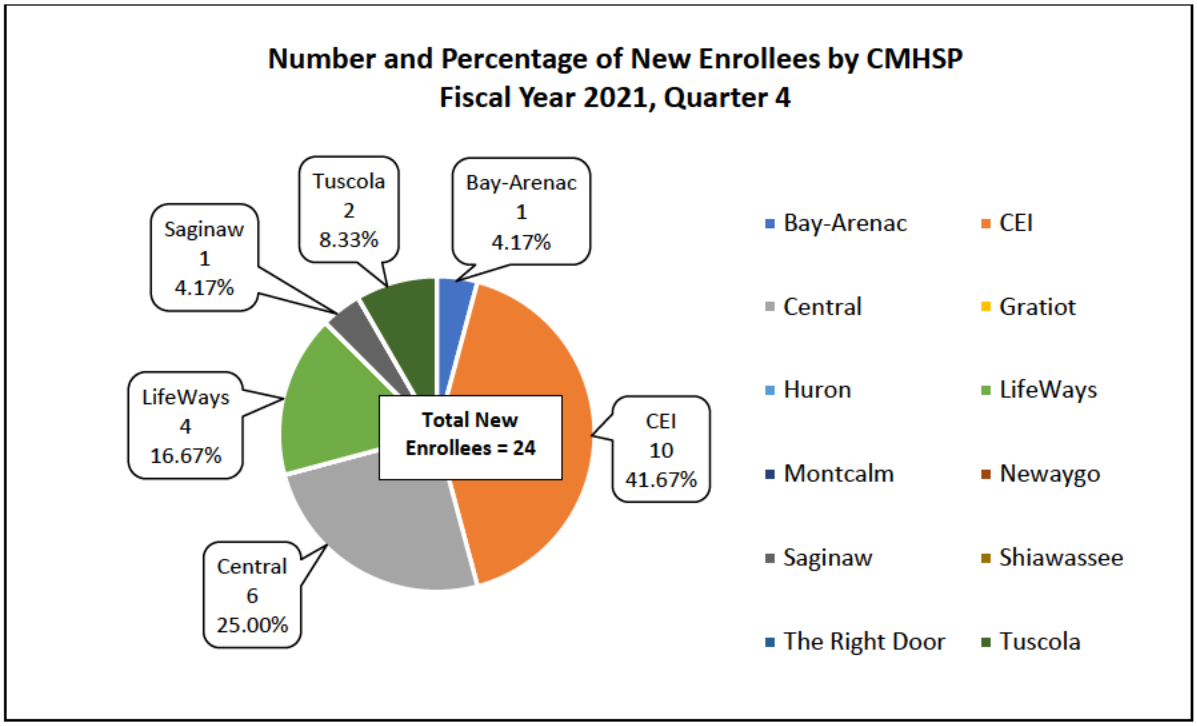

Disenrollment Reasons
Fiscal Year 2021, Quarter 4
Voluntary Disenrollment 1 7.14%
Nursing Facility 1 7.14%
Moved Out of State 1 7.14%
Involuntary Disenrollment 2 14.29%
Total Disenrollments: 14
Deceased 9 64.29%
Deceased
Involuntary Disenrollment
Moved Out of State
Nursing Facility
Voluntary Disenrollment


Number and Percentage of Disenrollments by CMHSP
Fiscal Year 2021, Quarter 4
Saginaw 2 14.29%
Bay-Arenac 2 14.29%
Newaygo 1 7.14%
CEI 2 14.29%
LifeWays 1 7.14%
Total Disenrollments: 14
Huron 2 14.29%
Central 4 28.57%
Bay-Arenac
CEI
Central
Huron
LifeWays
Newaygo
Saginaw

New Enrollments and Data Trends

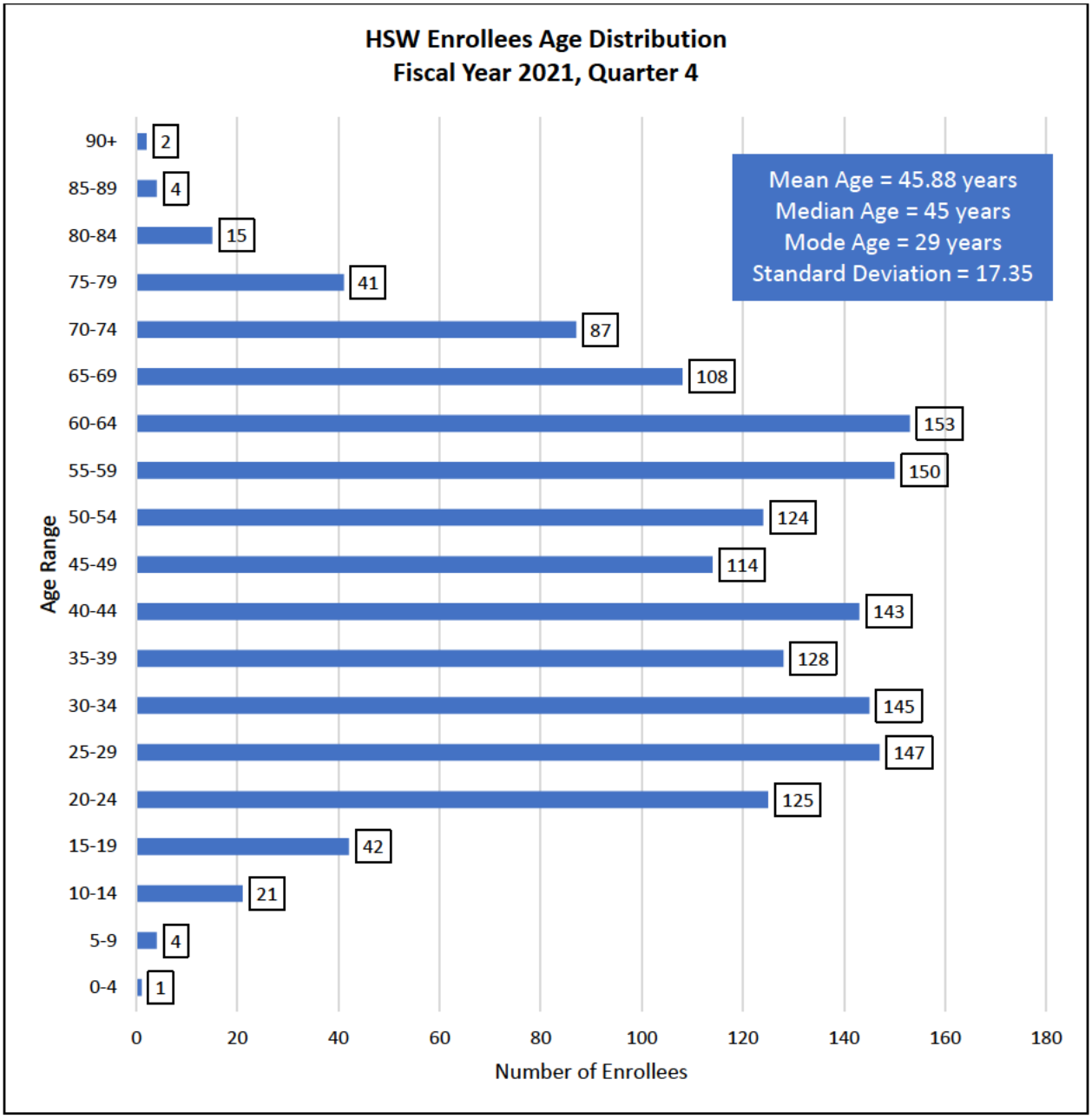
Throughout Q4, MSHN had a total of 24 new enrollments. This was 3 more than the new enrollments for Q3 (21). Six of the region's 12 CMHSPs (Bay-Arenac, CEI, Central, LifeWays, Saginaw, and Tuscola) experienced at least 1 new enrollment during Q4. MSHN also experienced 2 transfers to the region during Q4 (these cases are not represented in the charts below).

New Enrollees by CMHSP for Fiscal Year 2021, Quarter 4				
	Jul 2021	Aug 2021	Sep 2021	Quarter 4 Total
Bay-Arenac	0	0	1	1
CEI	8	0	2	10
Central	1	3	2	6
Gratiot	0	0	0	0
Huron	0	0	0	0
LifeWays	0	1	3	4
Montcalm	0	0	0	0
Newaygo	0	0	0	0
Saginaw	0	1	0	1
Shiawassee	0	0	0	0
The Right Door	0	0	0	0
Tuscola	1	1	0	2
MSHN Total	10	6	8	24



HSW Age Distribution Data

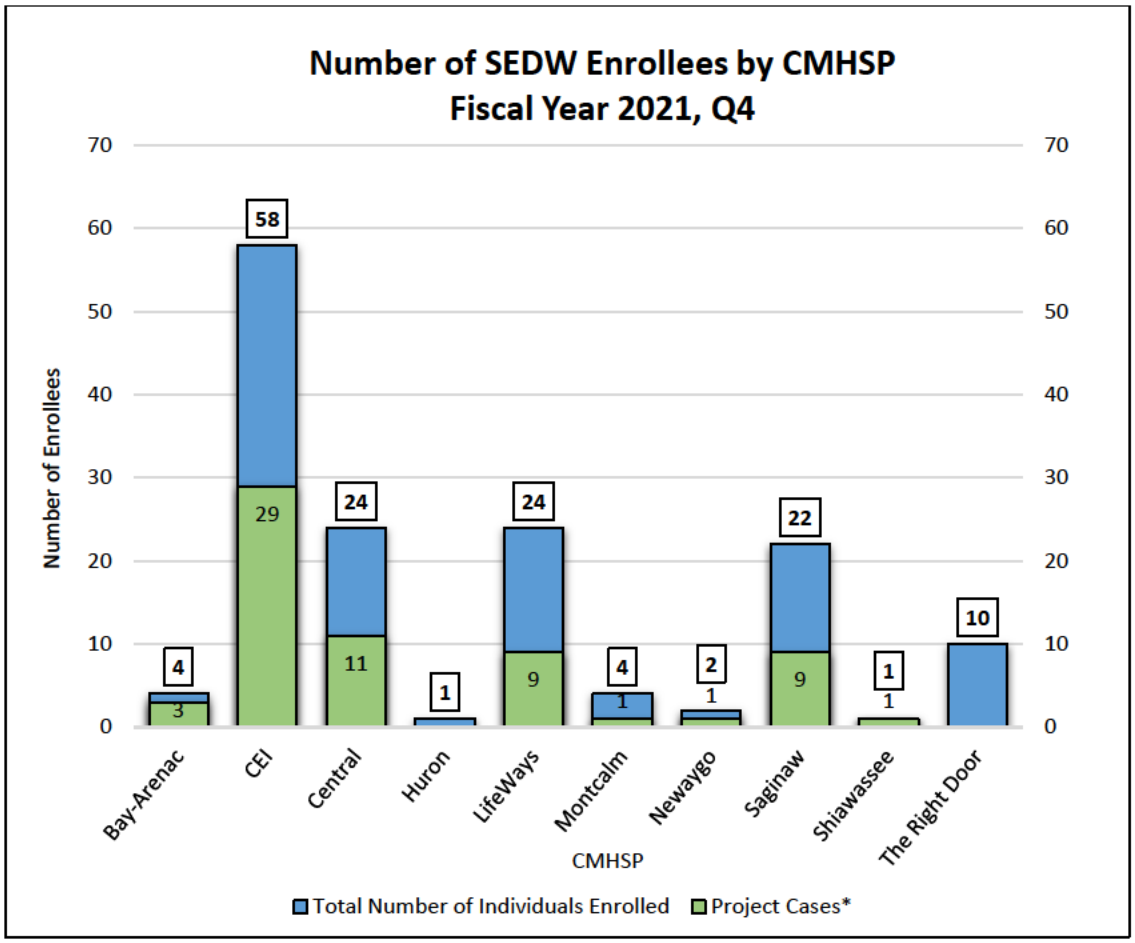
The following histogram presents age distribution data for the Mid-State Health Network (MSHN) region. At the end of Q4, there were 1,554 individuals enrolled in the MSHN HSW program, ranging in age from 4 to 92 years old. The average age of enrollees in the region was 45.88 years old (SD=17.35).



Summary

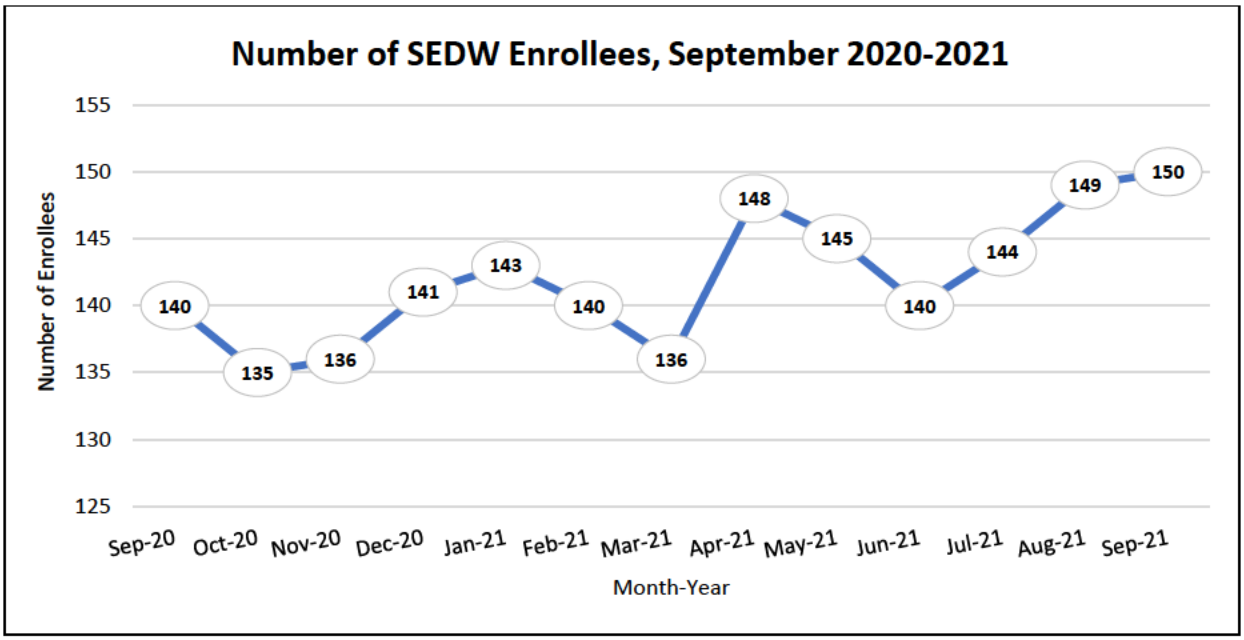
Mid-State Health Network's (MSHN) Habilitation Supports Waiver (HSW) program FY21 Q4 with 1,554 enrollees, which was a 0.13% increase from Q3. The slot utilization rate at the end of Q4 was 94.9% meaning MSHN dropped below compliance with the 95% slot utilization standard set by Michigan Department of Health and Human Services (MDHHS). The region experienced 14 disenrollments and 24 new enrollments throughout Q4. The biggest reason for disenrollment was consumer death (64.29%) throughout the quarter. The average age of enrollees was 45.88 years old and ranged from 4 to 92 years old.

C. Waiver for Children with Serious Emotional Disturbance (SEDW)



* "Project Cases" are children with open foster care cases through Michigan Department of Health and Human Services (MDHHS) and children adopted out of the Michigan Child Welfare System. Project Cases are counted as a part of the total number of enrollees for each Community Mental Health Service Program (CMHSP).

At the end of Q4, Mid-State Health Network's (MSHN) Serious Emotional Disturbance Waiver (SEDW) program had a total of 150 enrollees, of which there were 64 Project Cases.



SEDW participation has increased by over 76% since MSHN assumed responsibility for the program on October 1, 2019. Currently, 10 of the 12 CMHSPs in MSHN's region have at least one child/family on the SEDW.

Table 1:
SEDW Enrollment Numbers by CMHSP, 2021 Ending Q4

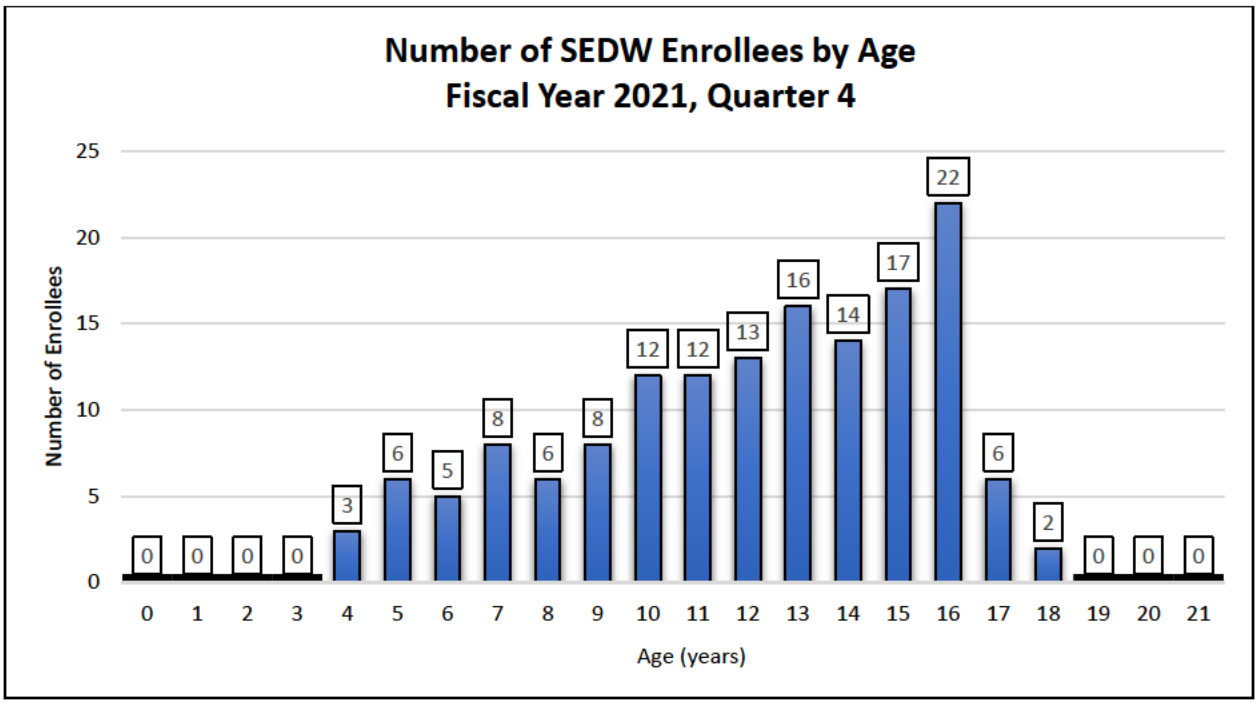
CMHSP	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun	21-Jul	21-Aug	21-Sep
Bay-Arenac	3	4	5	5	4	3	3	4	4
CEI	55	52	52	58	55	57	58	59	58
Central	24	24	27	28	27	23	24	25	24
Huron	0	0	0	0	0	0	0	0	1
LifeWays	22	21	20	23	22	21	22	22	24
Montcalm	4	3	2	3	3	4	4	5	4
Newaygo	3	3	2	2	2	2	2	2	2
Saginaw	26	26	21	22	23	22	23	24	22
Shiawassee	1	1	1	1	1	1	1	1	1
The Right Door	5	6	6	6	8	7	7	7	10
Gratiot	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Tuscola	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Total	**143**	**140**	**136**	**148**	**145**	**140**	**144**	**149**	**150**

Table 2:

Total Number of SEDW Past Due Re-certifications, 2021, Ending Q4

CMHSP	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun	21-Jul	21-Aug	21-Sep
Bay-Arenac	1	1	1	2	2	0	0	1	0
CEI	11	11	11	10	9	10	10	12	7
Central	0	4	3	3	2	0	4	6	4
Huron	0	0	0	0	0	0	0	0	0
LifeWays	3	0	1	2	1	0	1	2	2
Montcalm	1	0	0	0	0	0	0	1	0
Newaygo	2	1	0	0	1	0	0	0	0
Saginaw	1	3	0	0	0	1	0	1	1
Shiawassee	0	0	0	0	0	0	0	0	0
The Right Door	2	1	1	1	1	0	2	2	1
Gratiot	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Tuscola	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Total	**21**	**21**	**17**	**18**	**16**	**11**	**17**	**25**	**15**

MSHN had a total of 15 SEDW past due certifications at the end of Q4. MSHN will continue to send out monthly reminders to CMHSPs to highlight the necessary documents needed to increase compliance with this standard.



At the end of Q4, the average age of individuals enrolled in the SEDW was 12.03 years old.

Table 3:
SEDW Coming Due Re-certifications (within 90 days), 2021, Ending Q4

CMHSP	Re-certifications Coming Due
Bay-Arenac	1
CEI	9
Central	3
Huron	0
LifeWays	3
Montcalm	0
Newaygo	1
Saginaw	6
Shiawassee	1
The Right Door	1
Gratiot	*0*
Tuscola	*0*
Total	25

A detailed list of coming due re-certifications is sent out to each CMHSP SEDW Lead monthly. This is an effort to stay on top of program monitoring and oversight and to maintain compliance with state and federal waiver requirements.

Summary

MSHN's Waiver for Children with Serious Emotional Disturbance (SEDW) ended FY21 Q4 with 150 enrollees, 64 of which were Project Cases. Currently 10 of 12 CMHSPs in the region have at least one child/family enrolled. At the end of Q4, there were 15 past due certifications, 25 coming due re-certifications, and the average age of individuals was 12.03 years old.

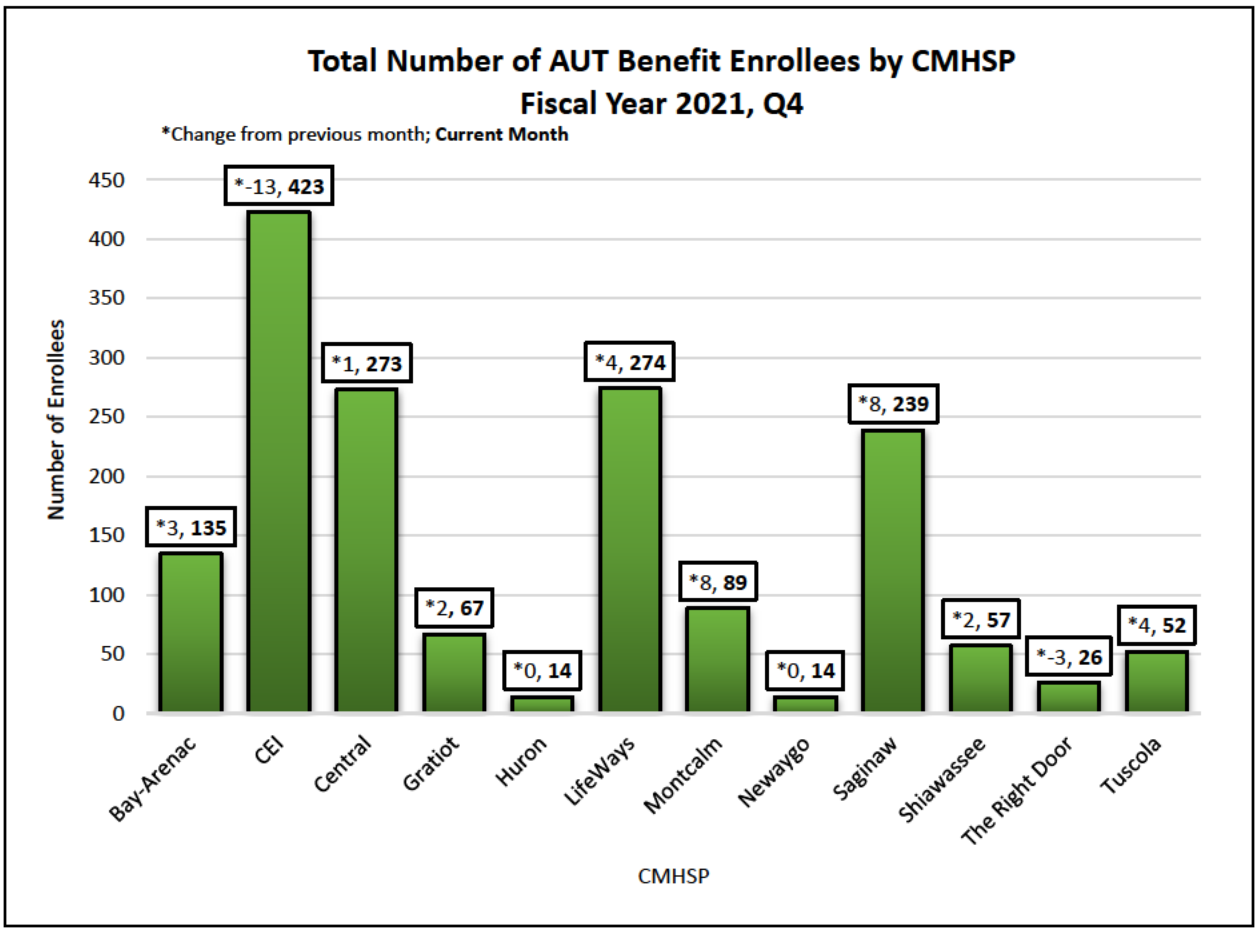
III. Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

A. Autism Benefit

Table 1:
Total Number of AUT Benefit Enrollees by CMHSP, 2021, Ending Q4

CMHSP	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Bay-Arenac	122	122	125	126	127	128	131	132	135
CEI	392	396	398	412	430	431	429	436	423
Central	217	223	227	243	265	267	267	272	273
Gratiot	60	63	65	65	66	69	65	65	67
Huron	9	11	12	12	11	12	13	14	14
LifeWays	251	255	263	270	272	279	279	270	274

CMHSP	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Montcalm	79	85	84	93	77	81	79	81	89
Newaygo	15	15	14	15	17	18	18	14	14
Saginaw	202	194	204	203	213	220	227	231	239
Shiawassee	44	44	53	55	55	58	56	55	57
The Right Door	29	30	30	31	29	29	30	29	26
Tuscola	40	39	38	42	44	46	45	48	52
Total	**1460**	**1477**	**1513**	**1567**	**1606**	**1638**	**1639**	**1647**	**1663**



Mid-State Health Network's (MSHN) Autism Benefit enrollment data for the end of Q4 is shown in *Table 1: Total Number of AUT Benefit Enrollees by CMHSP, 2021, Ending Q4* and subsequent chart. Enrollment numbers have increased by 16 since last month. Eight of MSHN's twelve Community Mental Health Service Programs (CMHSPs) (Bay-Arenac, Central, Gratiot, LifeWays, Montcalm, Saginaw, Shiawassee, and Tuscola) have experienced continued enrollment growth within that period.

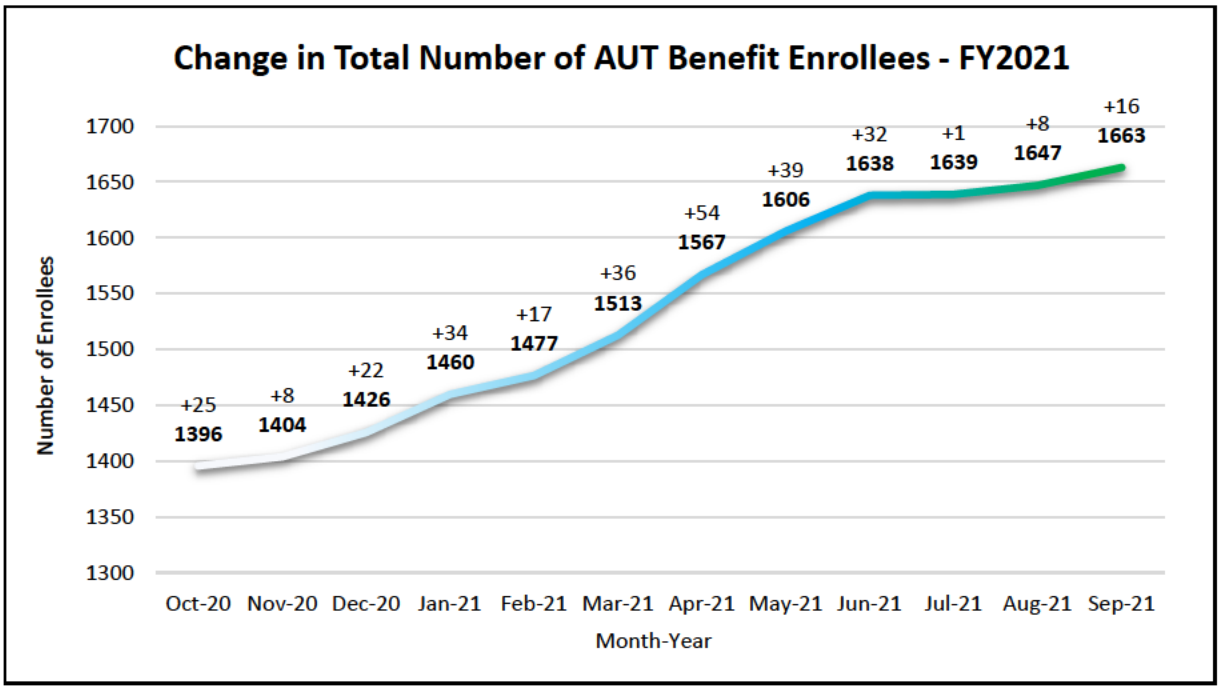


Table 1.1:

Total Pending AUT Benefit Enrollees, 2021, Ending Q4

CMHSP	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Bay-Arenac	9	11	16	8	14	15	13	11	11
CEI	21	24	28	33	28	27	30	25	32
Central	60	67	67	72	55	63	68	69	63
Gratiot	26	23	21	19	20	18	14	14	16
Huron	0	0	0	0	0	0	0	0	0
LifeWays	33	37	36	34	34	37	27	34	26
Montcalm	27	15	18	13	19	18	16	20	7
Newaygo	0	0	0	0	0	0	0	0	0
Saginaw	28	23	24	35	44	38	50	67	70
Shiawassee	12	10	5	3	7	6	7	10	8
The Right Door	5	4	4	4	3	2	3	1	1
Tuscola	0	0	0	0	0	0	0	0	0
Total	**221**	**214**	**219**	**221**	**224**	**224**	**228**	**251**	**234**

Table 1.1: Total Pending AUT Benefit Enrollees, 2021, Ending Q4 depicts the number of individuals who have presented at each CMHSP requesting (but still waiting for) an autism evaluation. Positive changes indicate an increase in referrals and those still waiting for an assessment. Negative changes indicate CMHSP movement – getting testing for individuals and making diagnostic decisions (either qualifying or non-qualifying).

Table 2:

Reason for Disenrollment, 2021, Ending Q4

Reason	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Approved/Declined	0	5	7	1	5	7	5	1	3
Met TX. Goals	5	3	2	2	3	3	5	6	3
Out of State	1	0	0	1	1	3	0	1	0
No Medicaid	0	0	0	0	0	1	0	0	0
Age Off	0	1	1	0	1	1	1	2	0
Voluntary D/E	6	16	9	10	4	12	17	6	15
Other	1	2	4	2	0	1	4	1	3
Total	**13**	**26**	**23**	**16**	**14**	**28**	**32**	**33**	**24**

The top reason for disenrollment at the end of Q4 were Voluntary Disenrollments. Those who voluntarily disenroll from the benefit have received Applied Behavior Analysis (ABA) treatment and have requested to disengage from services. The reasons identified range from the family needing a break from the intensive services, the family believing the services are no longer beneficial, health concerns related to COVID-19, etc.

Table 3:

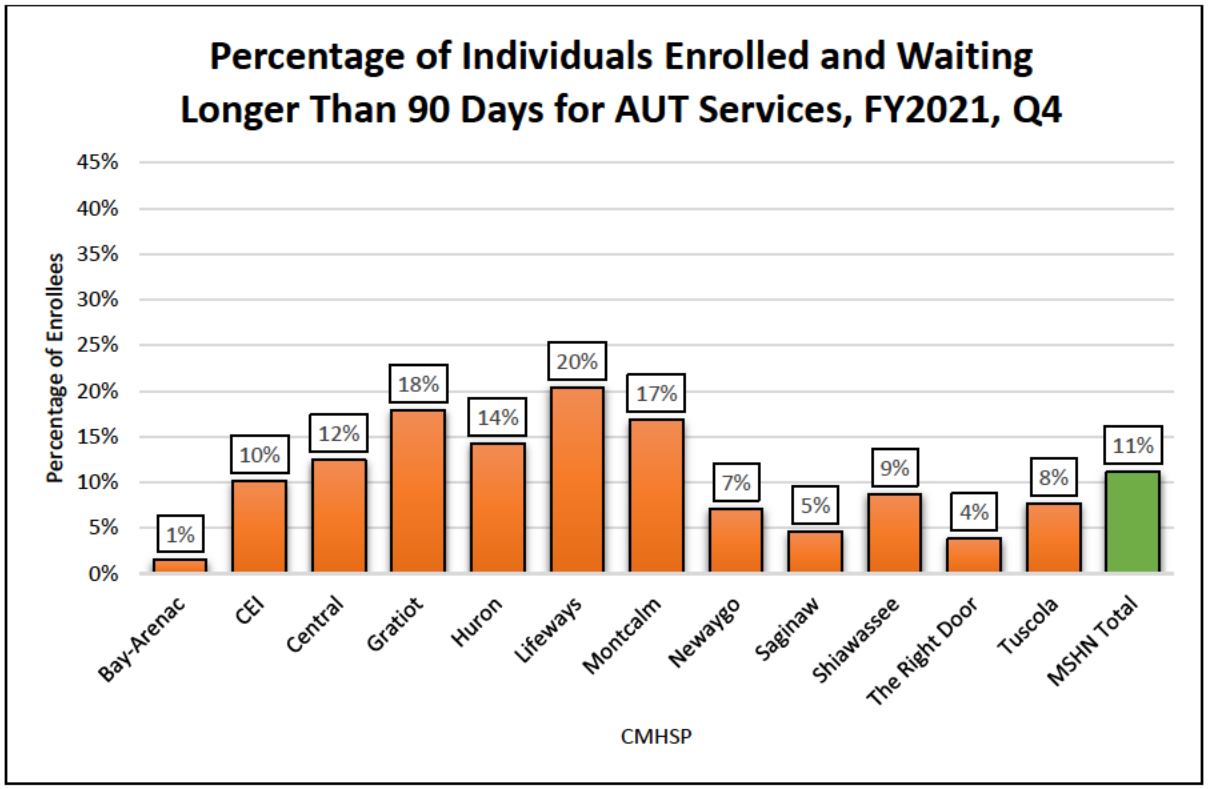
Overdue Re-evaluations Greater Than 30 Days, 2021, Ending Q4

CMHSP	Sep-21
Bay-Arenac	12
CEI	187
Central	91
Gratiot	22
Huron	4
LifeWays	39
Montcalm	44
Newaygo	2
Saginaw	130
Shiawassee	0
The Right Door	2
Tuscola	3
Total	**536**

Currently, due to the pandemic, Michigan Department of Health and Human Services (MDHHS) has suspended the requirement for annual re-evaluations. Also, as of September 1, 2021, re-evaluations will only be required every 3 years. MSHN had temporarily stopped sending overdue re-evaluation notices to CMHSPs while waiting on direction from MDHHS but will continue doing so. (It should be noted that the new 3-year policy does not apply to re-evaluations that were due prior to the September 1st implementation date. Those re-evaluations will still need to be completed.) In addition, MSHN will begin providing notification to CMHSPs of any 3-year re-evaluations coming due within 6 months of being due.

Table 4:
Total Number of Individuals Enrolled Waiting Longer than 90 days for Services, 2021, Ending Q4

CMHSP	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Bay-Arenac	2	7	3	2	3	4	7	7	2
CEI	40	39	31	28	32	28	41	44	43
Central	18	20	14	10	12	10	17	33	34
Gratiot	4	7	4	1	3	8	8	9	12
Huron	1	1	2	2	2	0	0	0	2
LifeWays	41	40	52	47	51	52	56	49	56
Montcalm	36	34	35	37	31	10	19	20	15
Newaygo	0	0	0	0	0	0	1	3	1
Saginaw	4	3	0	8	8	1	5	6	11
Shiawassee	6	5	7	9	4	4	2	2	5
The Right Door	1	1	1	3	3	1	1	2	1
Tuscola	1	2	1	2	0	0	1	2	4
Total	**157**	**159**	**150**	**149**	**149**	**118**	**158**	**177**	**186**



MSHN ended the quarter with an average of 11% of its enrolled population waiting longer than 90 days to start services. Half of the region's twelve CMHSPs have less than 10% of their enrolled population waiting longer than 90 days. MSHN will continue to work with the region to address issues related to

longer wait periods in addition to increasing network capacity to ensure that all individuals receive services within 90 days of program eligibility.

Table 5:

Total Number of Overdue Individual Plans of Service (IPOS), 2021, Ending Q4

CMH	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Bay-Arenac	0	0	0	0	1	0	0	1	6
CEI	28	21	30	16	24	21	26	28	34
Central	2	5	4	2	3	4	7	9	9
Gratiot	2	7	4	4	4	5	6	11	15
Huron	0	0	0	1	0	0	0	0	1
LifeWays	22	7	23	11	20	20	20	24	23
Montcalm	28	31	30	30	26	25	28	31	34
Newaygo	0	0	0	0	0	0	0	2	1
Saginaw	4	2	1	2	7	3	5	9	21
Shiawassee	0	0	0	0	0	0	0	1	2
The Right Door	2	3	3	1	0	1	2	2	0
Tuscola	4	0	1	0	2	1	3	6	3
Total	**92**	**76**	**96**	**67**	**87**	**80**	**97**	**124**	**149**

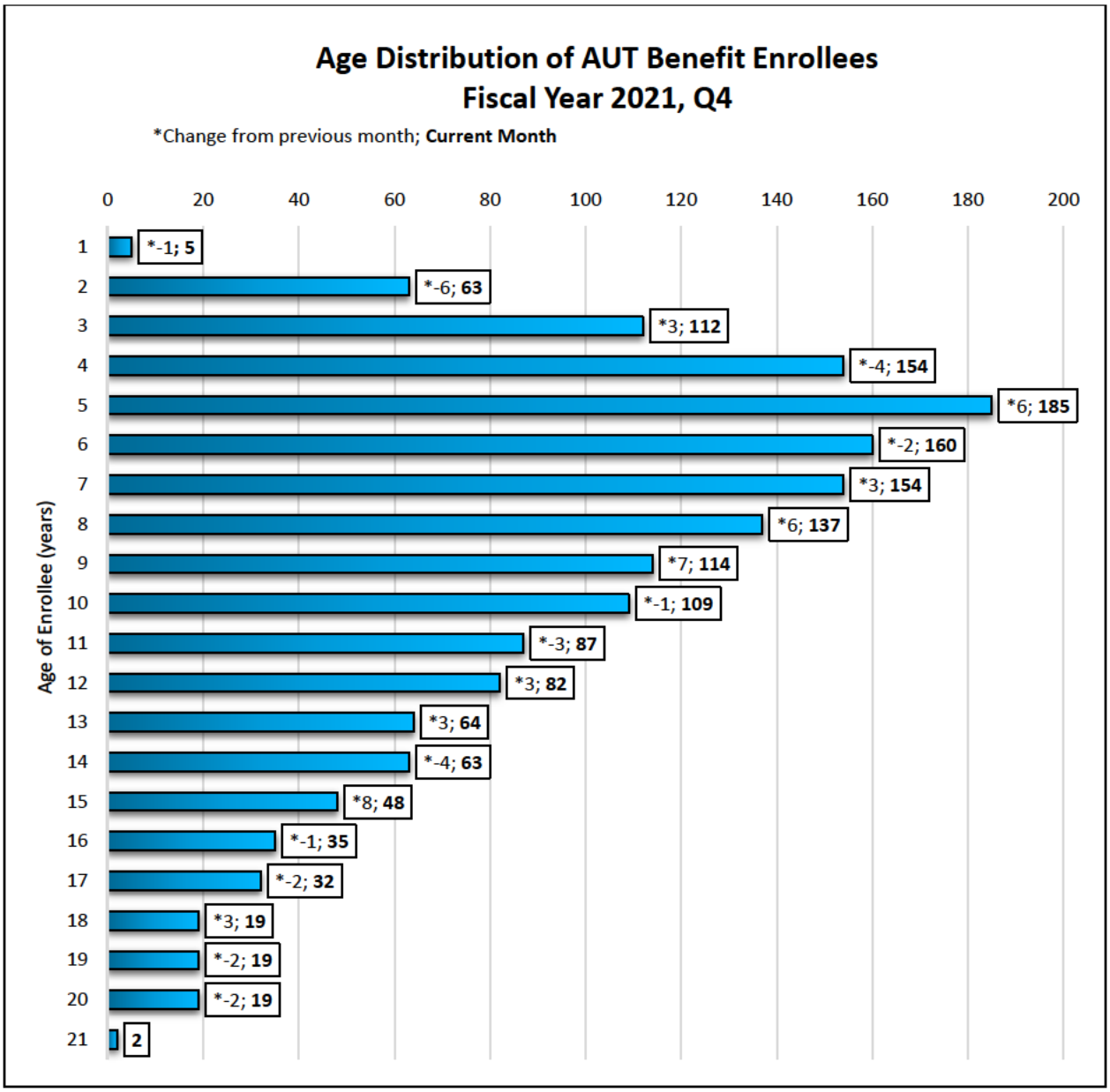
Overdue IPOS increased by 25 over the past month. MSHN continues to track this data and send monthly overdue reports with specific data to the region. The new allowances for increased use of tele-health for services such as person-centered planning meetings should allow for the network to improve compliance with this standard while maintaining appropriate COVID-19 precautions.

Table 6:

New Evaluations by Classification, FY2021, 2021, Ending Q4

Classification	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Autism	41	51	56	51	66	53	23	35	41
ASD	13	4	15	18	7	14	6	4	8
Not Qualified	27	24	23	18	26	28	23	20	30
Total	**81**	**79**	**94**	**87**	**99**	**95**	**52**	**59**	**79**

New evaluations have increased by 20 since last month but have maintained consistent ratios of those qualifying compared to non-qualifying assessments.



The average age of individuals receiving AUT services at the end of Q4 was **8.34 years** old.

Summary

MSHN's Autism Benefit program ended FY21 Q4 with 1,663 individuals enrolled, which was an increase of 25 enrollees since the end of Q3. At the end of Q4, there were 234 pending enrollees, 24 disenrollments and 536 overdue re-evaluations greater than 30 days. The total number of individuals enrolled waiting longer than 90 days for services was 186 (an average of 11% for the region). Additionally, there were 149 overdue Individual Plans of Service (IPOS) and 79 new evaluations. The average age of individuals was 8.34 years old.

IV. Home and Community-Based Services Rule Transition (HCBS)

A. HCBS FY21Q4 Updates:

Provisional Approval Applications and Surveys

As new licensed facilities open and receive licenses and accreditation, MSHN works with CMHSPs to receive provisional approval applications and surveys. This ensures that individuals who are either new waiver recipients or who have moved to a facility licensed after the initial rounds of surveys are still counted and assured freedom from an isolating and/or an institutionalized setting. Under extenuating circumstances, an individualized approval may be granted. MSHN has assumed survey administration from MDHHS and will be disbursing surveys to providers with individuals placed under provisional approval between June 2020 and October 2021 in November.

Compliance Validation

The deadline for completion is July 1, 2022, however all compliance validation casework was completed by HCBS Coordinators on June 17th, 2021

Completed CAP/Remediation confirmation

BHDDA has requested the PIHPs to provide information on out of compliance cases (not heightened scrutiny) that have been remediated. This was requested of MDHHS by the Centers for Medicare and Medicaid Services. Each PIHP was given a document that confirmed the remediations have taken place, when they have taken place, and, in cases where remediation was not necessary, why remediation did not occur. The deadline for completion was July 30th, 2021. MSHN Coordinators completed this on June 25th, 2021.

Heightened Scrutiny – Out of Compliance Remediation

MDHHS has partnered with Michigan State University to analyze all remaining Heightened Scrutiny cases (i.e., the cases which MDHHS was previously unable to de-escalate or “exit ramp” to Out of Compliance), including on-site reviews as deemed necessary.

MSU is working directly with each CMH independently to conduct this analysis. Although MSHN is not directly involved with this stage of the process, the HCBS team is tracking development, offering support, and anticipating its role the next stage, post-analysis.

On June 29th, MDHHS provided MSHN a list of 35 WSA IDs that have been moved from Heightened Scrutiny to Out of Compliance. In September 2021, MDHHS updated this list to include a combination of WSA IDs for individuals receiving services from providers that had been moved from Heightened Scrutiny to Out of Compliance, as well as all cases potentially eligible for de-escalation to Out of Compliance, for a total of **319 unique cases**. Survey questions requiring remediation were also included in this list, of which there were **1,435 in total**. MSHN and the PIHPs have been tasked with remediating the remaining questions before July 1, 2022.

Non-Responder Follow-up Actions

MSHN received a list of 39 individuals that MDHHS has reported as missing a complete survey from their assigned provider. HCBS Coordinators worked with their CMH counterparts to identify 16 individuals on this list that have either changed providers, left services, passed away, or received the survey in error.

Of the remaining 23 (60% of the initial total) of currently open/active WSA ID cases, HCBS Coordinators will be personally administering the surveys to the providers for these individuals. HCBS Coordinators will then submit the surveys for analysis and complete the CAP/Remediation process as necessary. This will be completed before July 2022.

B. Project Summary/Completed Projects

On March 17, 2014, the Centers for Medicare and Medicaid Services (CMS) published a new set of rules for the delivery of Home and Community Based Services through Medicaid waiver programs. Through these rules, the Centers for Medicare and Medicaid Services aim to improve the experience of individuals in these programs by enhancing access to the community, promoting the delivery of services in more integrated settings, and expanding the use of person-centered planning.

In response, the Michigan Department of Health and Human Services is developing a statewide transition plan to bring its waiver programs into compliance with the new regulations while continuing to provide vital services and supports to Michigan citizens. The Department is committed to an inclusive process partnering with people receiving services, their allies, health care providers, and other organizations to create a transition plan that serves the best interests of the people of Michigan while also meeting requirements from the Centers for Medicare and Medicaid Services.

From The State of Michigan Website "Home and Community-Based Services Program Transition"
https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943-334724--,00.html

Following the initiation of the statewide transition plan process, surveys were distributed to or on behalf of every Michigan resident with a qualifying Habilitation Supports Waiver ("C Waiver") to determine their service provider's current level of compliance with the Centers for Medicare and Medicaid Services' new rules.

Based on the individual survey results, a respondent's provider could fall in to one of three categories for each survey: under Heightened Scrutiny, In Compliance, or Out of Compliance.

A survey categorized as under Heightened Scrutiny provided answers that may have implied that the responded is either isolated from their community or receiving services in an institutionalized setting. Survey results with Heightened Scrutiny were submitted to Michigan State University, who contracted with MDHHS, in order assess sites under Heightened Scrutiny in person. Their results were then submitted to an all-volunteer Heightened Scrutiny committee composed of members from all over Michigan, who had the option of de-escalating the Heightened Scrutiny case to Out of Compliance status in a category referred to as an "Exit Ramp," which will be discussed later in this report.

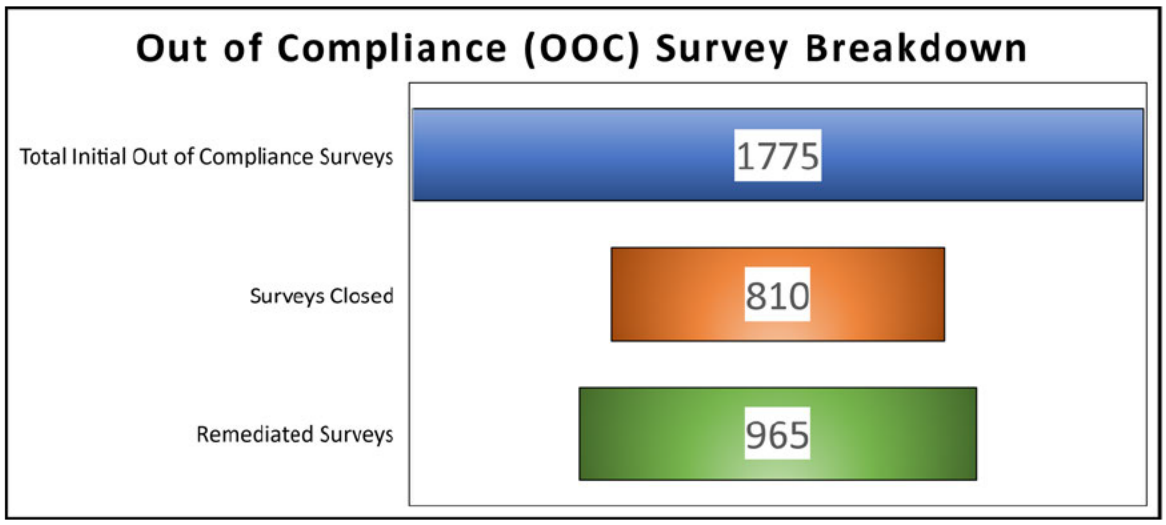
Surveys assessed as In Compliance generated a letter for each survey, which were then sent to the provider by MSHN. Remaining Out of Compliance surveys are assessed by MSHN's HCBS Transition team.

An out of compliance survey is considered "closed" if, during the course of the remediation process, it is discovered that the respondent is either no longer receiving services from their provider, has moved

residences, has passed away, or has mistakenly completed a survey for a service that they are not actually receiving.

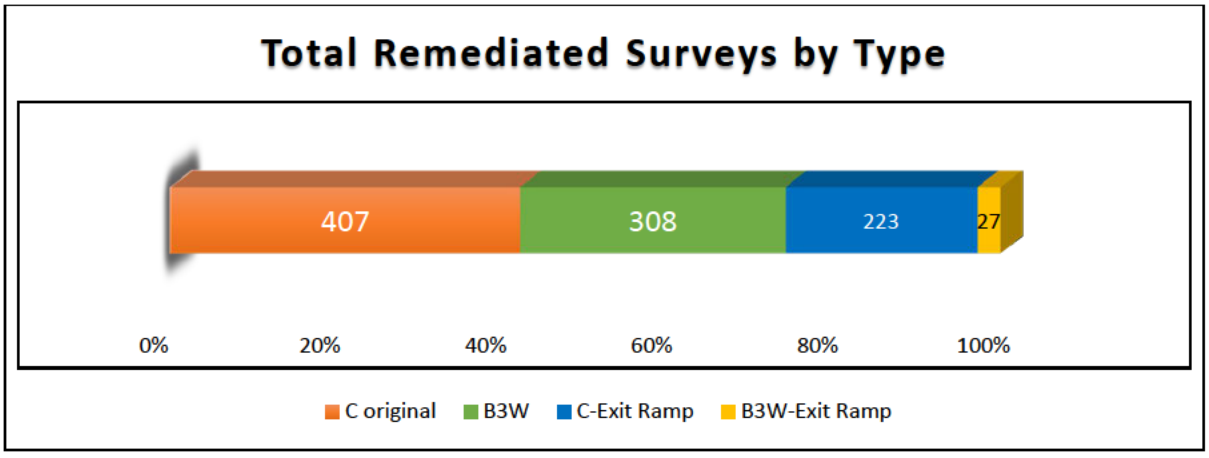
An out of compliance survey that is considered "eligible" requires a service provider or CMHSP to submit a Corrective Action Plan (CAP), review and approval of this CAP by MSHN's HCBS Transition Team, and subsequent review of all requested evidence demonstrating that the CAP has been completed. Following this final step, a survey is considered fully remediated by MSHN and the State of Michigan.

This rule was later expanded to include services provided to individuals enrolled in the Managed Specialty Services and Supports Waiver Program ("B3W Waiver," now officially designated the "1915(i) Waiver"). In July 2017, MSHN distributed approximately 2,700 additional surveys to B3W Waiver enrollees in Region 5.

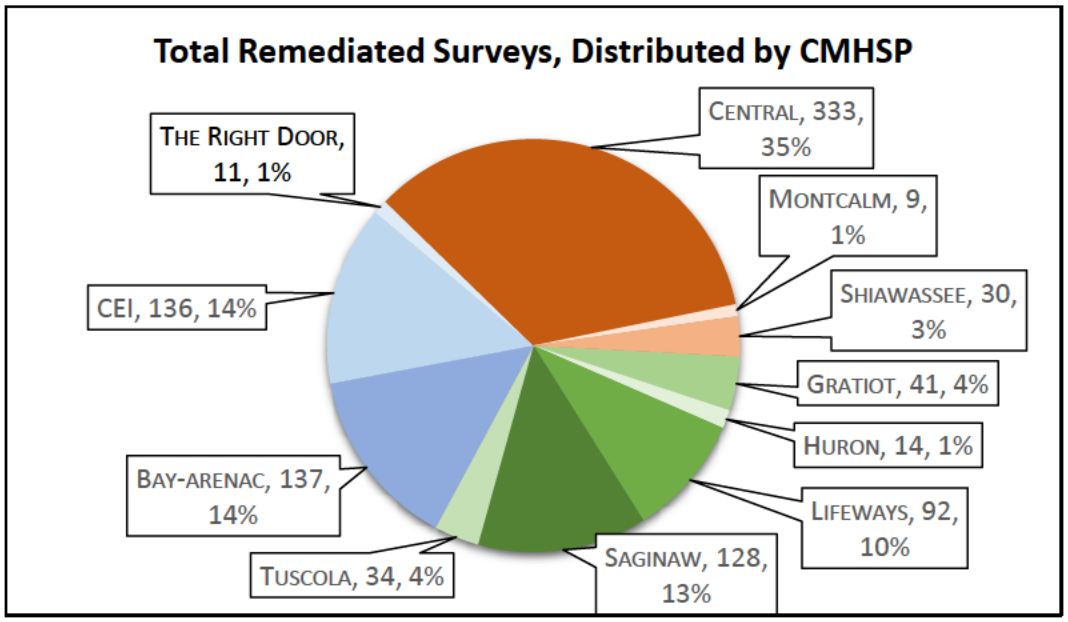


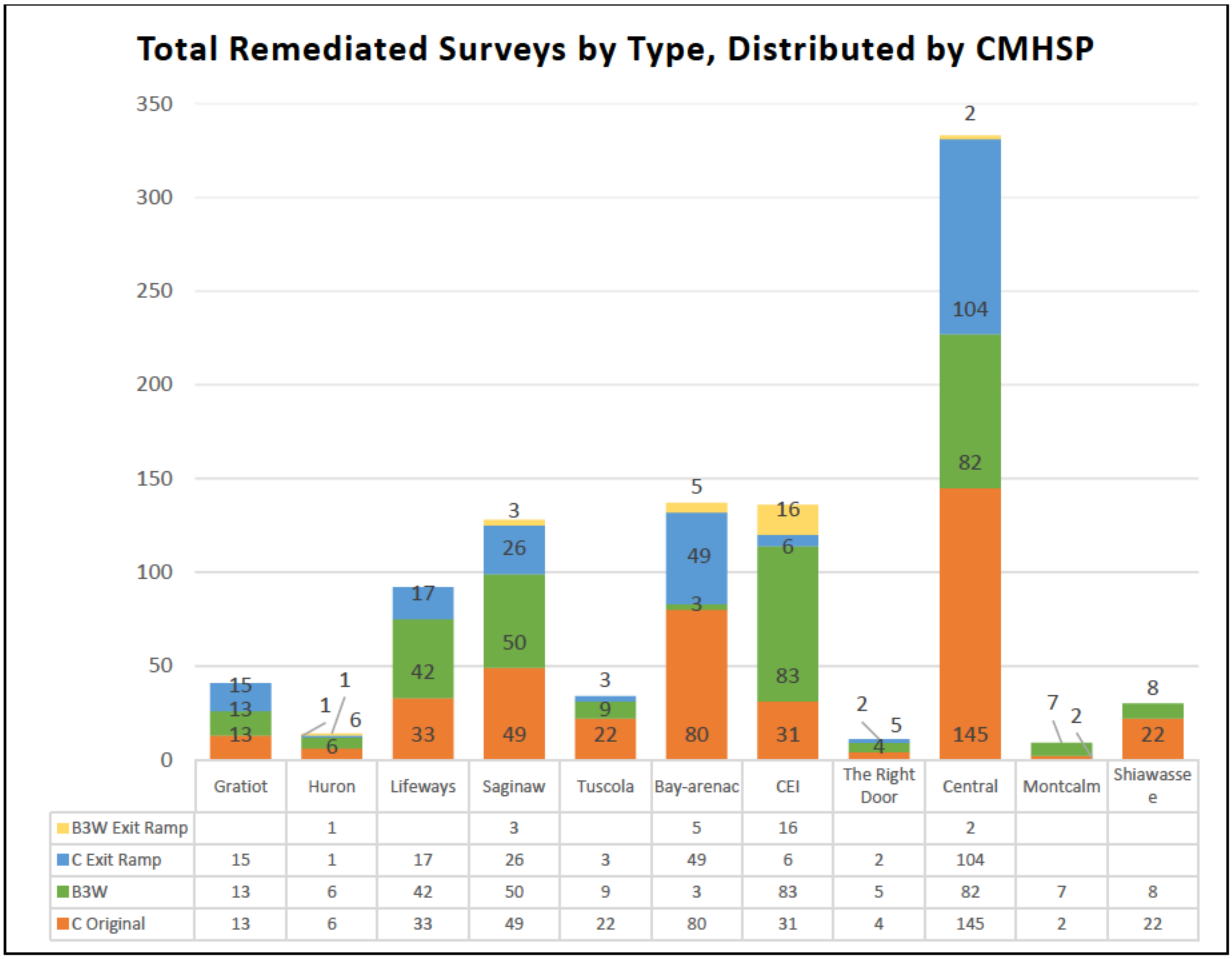
The "Exit Ramp" Process:

Following an analysis of Heightened Security surveys, MDHHS has periodically de-escalated surveys from Heightened Scrutiny to Out of Compliance. Surveys that have undergone this process are given the separate designation of "exit ramp surveys" by MDHHS and by MSHN.



**Please note that all survey respondents from Newaygo CMH were either In Compliance or fell under Heightened Scrutiny.*





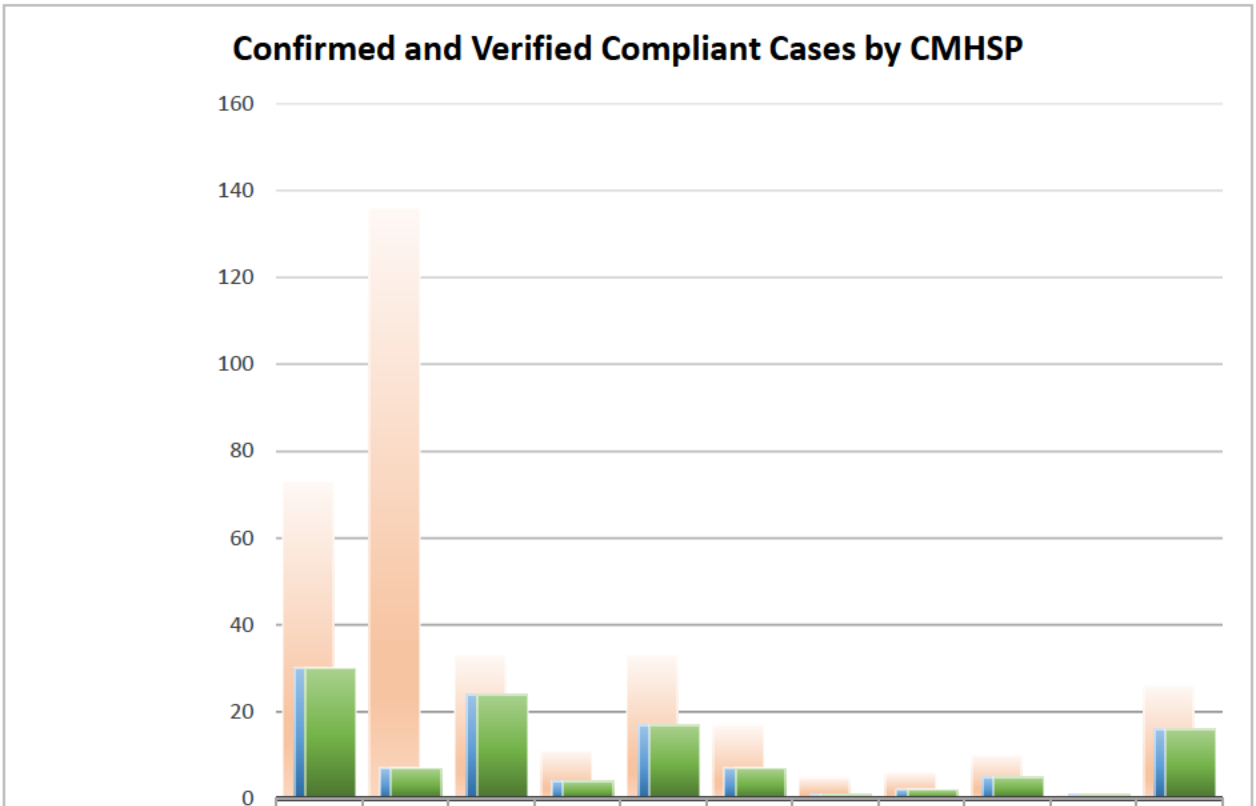
On September 3rd, 2020, Mid-State's HCBS team completed the remediation for the remaining 965 Out of Compliance surveys. On June 3rd, 2021, CMS tasked BHDDA with identifying remediation dates and details for every individual WSA ID involved in the remediation process. The PIHPs have been given until July 31st to complete this task. As of June 30th, Mid-state has completed 1,347 of 1,387, or 97% total.

Compliance Validation

Instrumental to the HCBS New Rule Transition has been the verification surveys resubmitted by providers who returned surveys reviewed initially as "Compliant." This verification ensures the accuracy and the continued compliance of the providers surveyed.

The first step in this validation is the verification of the status of individuals on behalf of whom surveys were conducted. MDDHS provided each of the PIHPs a list of individuals for whom providers returned an "In Compliance" survey on December 18th, 2020. MSHN's HCBS Lead and coordinators are working with regional CMHSPs to verify if the listed individuals continue to receive services from the surveyed sites.

351 surveys marked as In Compliance were sent to MSHN and distributed to each CMHSP for verification that the subject of each survey was still receiving the same HCBS services at the same physical location. 114 were confirmed.



	Bay-Arenac	CEI	Central	Gratiot	Huron	Lifeways	Montcalm	Saginaw	Shiawassee	Right Door	Tuscola
Sent by MDHHS	73	136	33	11	33	17	5	6	10	1	26
Confirmed by CMHSP	30	7	24	4	17	7	1	2	5	1	16
Verified Compliant or closed	30	7	24	4	17	7	1	2	5	1	16

On February 22nd, MDHHS submitted a master list of validation questions to each PIHP. Of the 114 CMH-confirmed surveys, MDHHS tasked MSHN with questions from 100 provider surveys to validate as In Compliance. MDHHS has given the PIHPs an estimated six months to complete this process. Providers with survey questions that cannot be validated In Compliance may be placed on Heightened Scrutiny or Out of Compliance. Mid-State coordinators worked with their CMHSP counterparts and with providers directly to accomplish this task well ahead of schedule. As of June 17th, all Compliant cases had either been verified or confirmed closed.

The disparity between cases identified in the MDHHS WSA database as currently open and active at the same provider location, receiving the same services as they had been at the time they were surveyed, 351, and the actual number, 63, represents an 18% accuracy rate.

Surveys distributed in 2020

MDHHS has partnered with Wayne State University's Developmental Disabilities Institute (DDI) to administer an additional round of the previous survey to providers of HCBS services.

Providers received surveys for individuals that met at least one of the three following conditions:

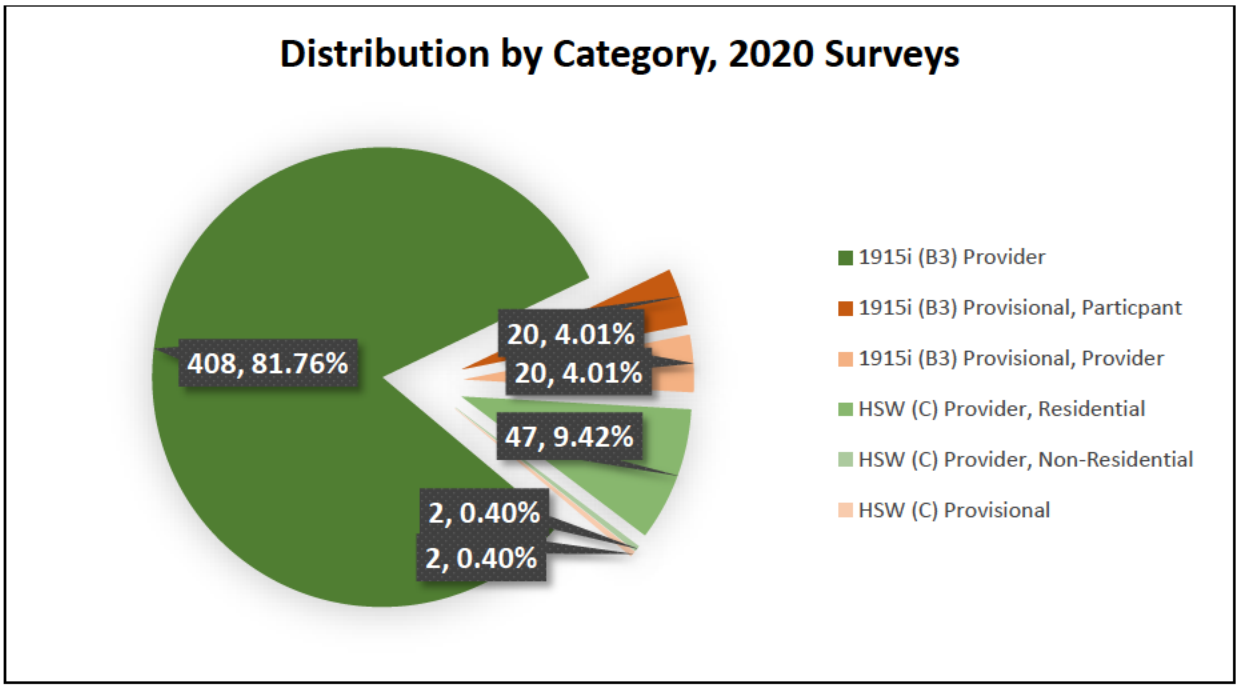
(1) The survey(s) submitted during the last survey process was received with errors

(2) They did not submit a survey during the previous survey process

(3) They completed a provisional survey and need to complete a full survey

557 new surveys were administered digitally to providers for 454 individuals receiving HCBS services. The survey was open for submission between July 6, 2020 and August 14, 2020. During this period, CMHSPs were able to verify the eligibility of the surveys. If an individual had died, no longer received services from the surveyed provider, or if the provider did not meet survey criteria, a survey was excluded. CMHSPs and partnering providers were able to verify 499 of the 557 original expected surveys, for an overall validation rate of 90%.

Surveys submitted after midnight on August 15, 2020, were considered past due and were not accepted. Of the 499 expected surveys, 443 were received by the deadline for an 89% rate of return.



Ongoing Monitoring and Evaluation

Following the completion of the HCBS Rule Transition process, the Centers for Medicare and Medicaid Services (CMS) and MDHHS have tasked the 10 PIHPs with annually monitoring and evaluating providers in their catchment for continued compliance.

V. Supports Intensity Scale (SIS)

A. Summary

General Purpose:

The Supports Intensity Scale (SIS®) is a strengths-based, comprehensive assessment tool that measures an individual's support needs in personal, work-related, and social activities to identify and describe the types and the intensity of the supports an individual requires. The SIS® includes background information on health, medical conditions, activities of daily living and cognitive, social, and emotional skills. The SIS® was designed to be part of person-centered planning processes that help all individuals identify their unique preferences, skills and life goals. The SIS® is a reliable and valid assessment developed and copyrighted by the American Association on Intellectual and Developmental Disabilities (AAIDD).

The SIS Assessment is administered to individuals meeting the following eligibility requirements:

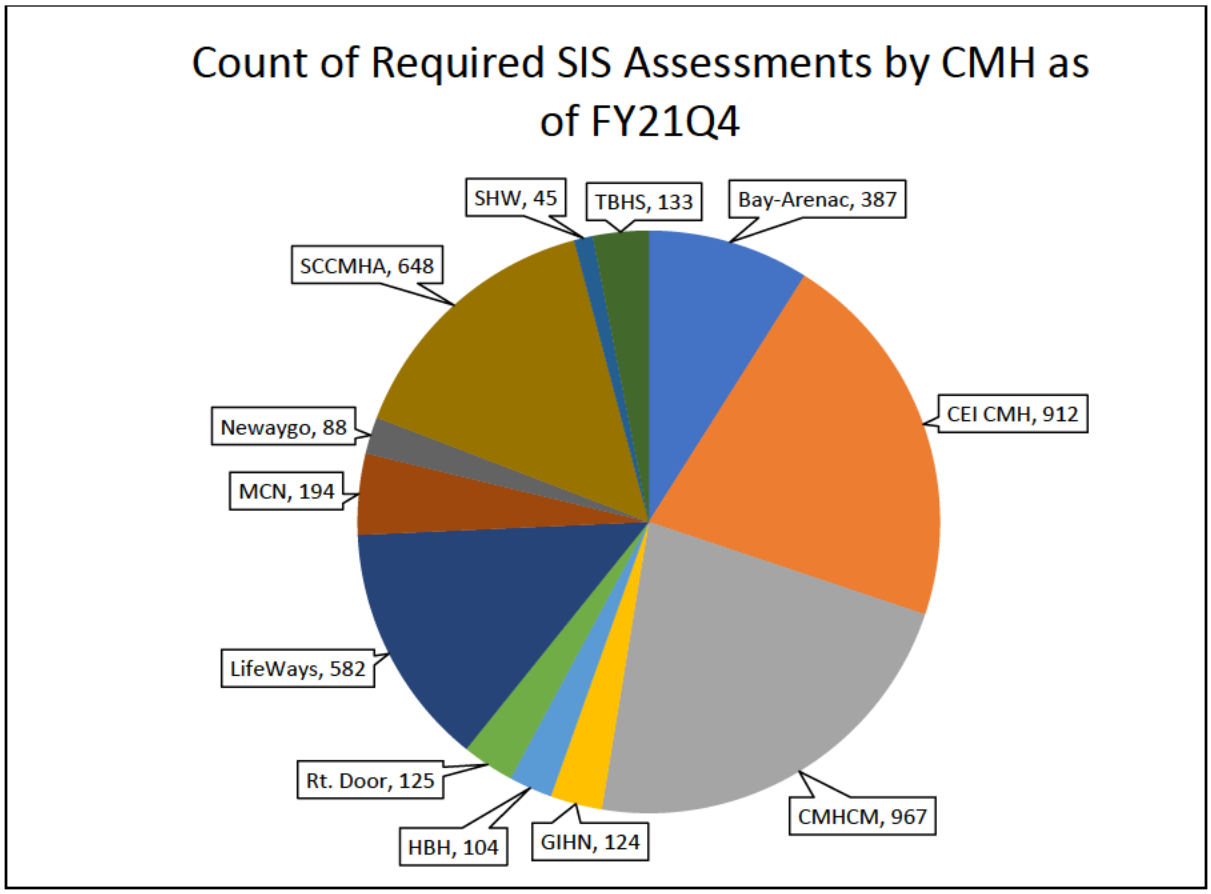
- Is Michigan Medicaid eligible and receiving behavioral health services
- Is 16 years or older (Lowered from 18 on Oct 1, 2020)
- Has a disability designation of intellectual/developmental disability (I/DD)
- Is *currently* receiving case management, supports coordination, or respite only services

MDHHS. (2021 June) Supports Intensity Scale® Implementation Manual

https://www.michigan.gov/documents/mdhhs/MDHHS_SIS_Manual_Version2.2_727728_7.pdf

Table 1:
Count of Required SIS Assessments by CMH for FY21Q4

FY21Q4 Count Required	Total
Bay-Arenac Behavioral Health	387
CEI CMH	912
CMH for Central Michigan	967
Gratiot Integrated Health Network	124
Huron Behavioral Health	104
Ionia - The Right Door	125
LifeWays CMH	582
Montcalm Care Network	194
Newaygo CMH	88
Saginaw County CMHA	648
Shiawassee County CMHA	45
Tuscola Behavioral Health Systems	133
Total	4309

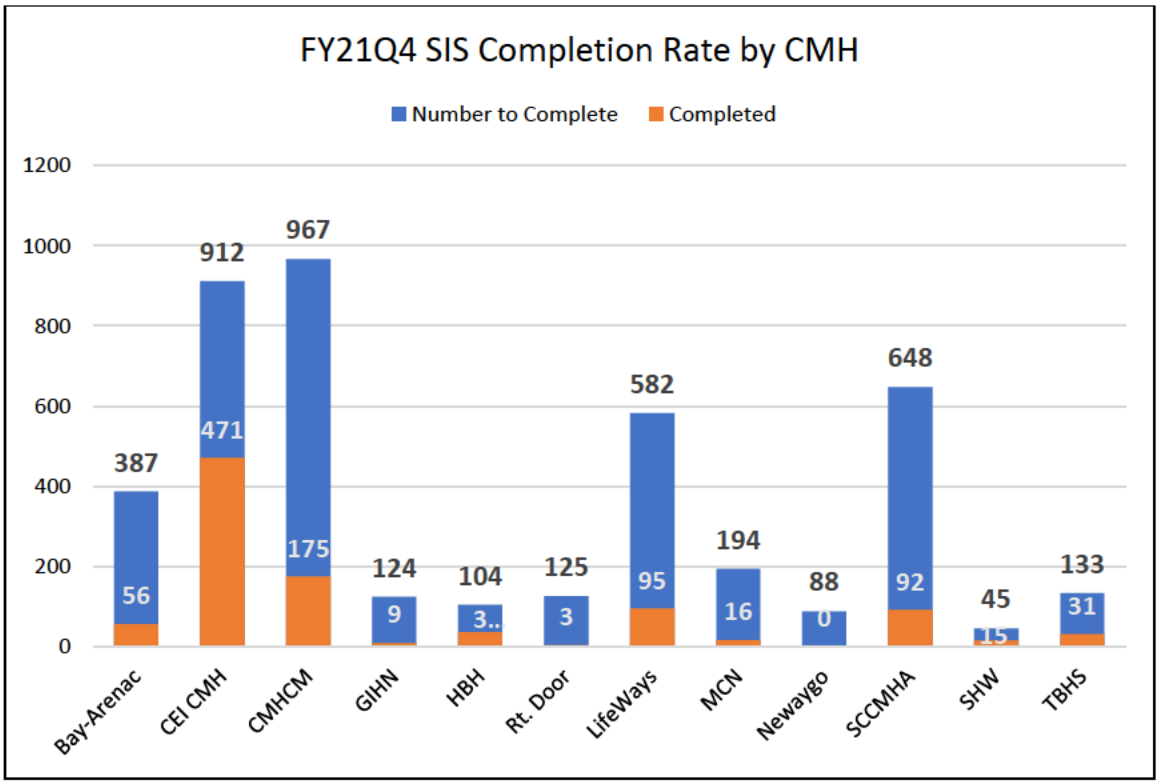


SIS Online data comprises the numerator (*see Table 2; FY21Q4 Completion Rate by CMH*), or those individuals who have received a SIS assessment by a SIS assessor as entered in the required SIS Online system. Please note that the denominator for an individual's SIS eligibility is determined by taking MDHHS BH-TEDS data, Encounter Data (includes Assessment (with HW)) case management, supports coordination, or respite only, and whether one of these qualifying services has been provided and *claimed* within the last 90 days. Given this parameter, the number of required SIS assessments fluctuates between quarters. Additionally, starting October 1, 2021, the SIS billing will include a "WY" instead of HW, and HN for Bachelors level assessor, or HM for less than Bachelors level (four years work experience). MSHN is limited to the data sources in gathering numerator and denominator data, that is, MSHN's partner CMHSPs have the full data set. Further, while the above chart shows the number of required assessments as of FY21Q4, the effect of the COVID-19 pandemic continues to suppress CMHSP denominators due to some individuals requesting services be placed on hold until pandemic conditions improve. Thus, the denominator is expected to rise steadily throughout FY21 and into FY22.

Mid-State Health Network is required to have a 100% SIS completion rate for all eligible individuals within their individual three-year timeframe. The three-year timeframe is relative to the last time *each individual* received a SIS assessment, *or* if the individual declined, being re-invited to receive the SIS within a year. The current "cycle" began on October 1st, 2020, and will conclude on September 30th, 2023.

Table 2:
FY21Q4 SIS Completion Rate by CMH

CMH	Number to complete	Completed	%
Bay-Arenac	387	56	14.47%
CEI	912	471	51.64%
Central	967	175	18.10%
Gratiot	124	9	7.26%
Huron	104	36	34.62%
Ionia – The Right Door	125	3	2.40%
LifeWays	582	95	16.32%
Montcalm	194	16	8.25%
Newaygo	88	0	0.00%
Saginaw	648	92	14.20%
Shiawassee	45	15	33.33%
Tuscola	133	31	23.31%
Total	**4309**	**999**	**23.18%**



A goal of 100% completed SIS assessments for eligible individuals sets a pace of 33.33% per year, or 8.33% per quarter. MSHN's current rate of completion for the fourth quarter is 23.18%. The percent complete for FY21Q3 was 51.16% for a 9-month average of 28%. This remains in line with the required pace. However, the accuracy (including count for numerator and denominator) of the SIS data is specific to each quarter and is affected by different factors, typically related to timing, including:

- Entry of disability designation in BH-TEDS
- Closure (or non-closure when it should have been closed) of a case/case episode
- Date of encounter
- Date of submission of encounter
- New individual to services
- Individual is now deceased
- Whether the individual declined (see next section) a SIS, and the year timeframe still applies

<u>Declined Assessment Process and Rights</u>

Individuals and/or guardians may decline to participate in the SIS® Assessment process. Declining the SIS® Assessment will have no impact on the individual's ability to receive new and/or ongoing services. Individuals and/or guardians may opt out of the SIS® Assessment at any point during the assessment. All declined assessments (including the decline to follow-ups) must be documented by the PIHP specifying the date the assessment was declined in the electronic health record.

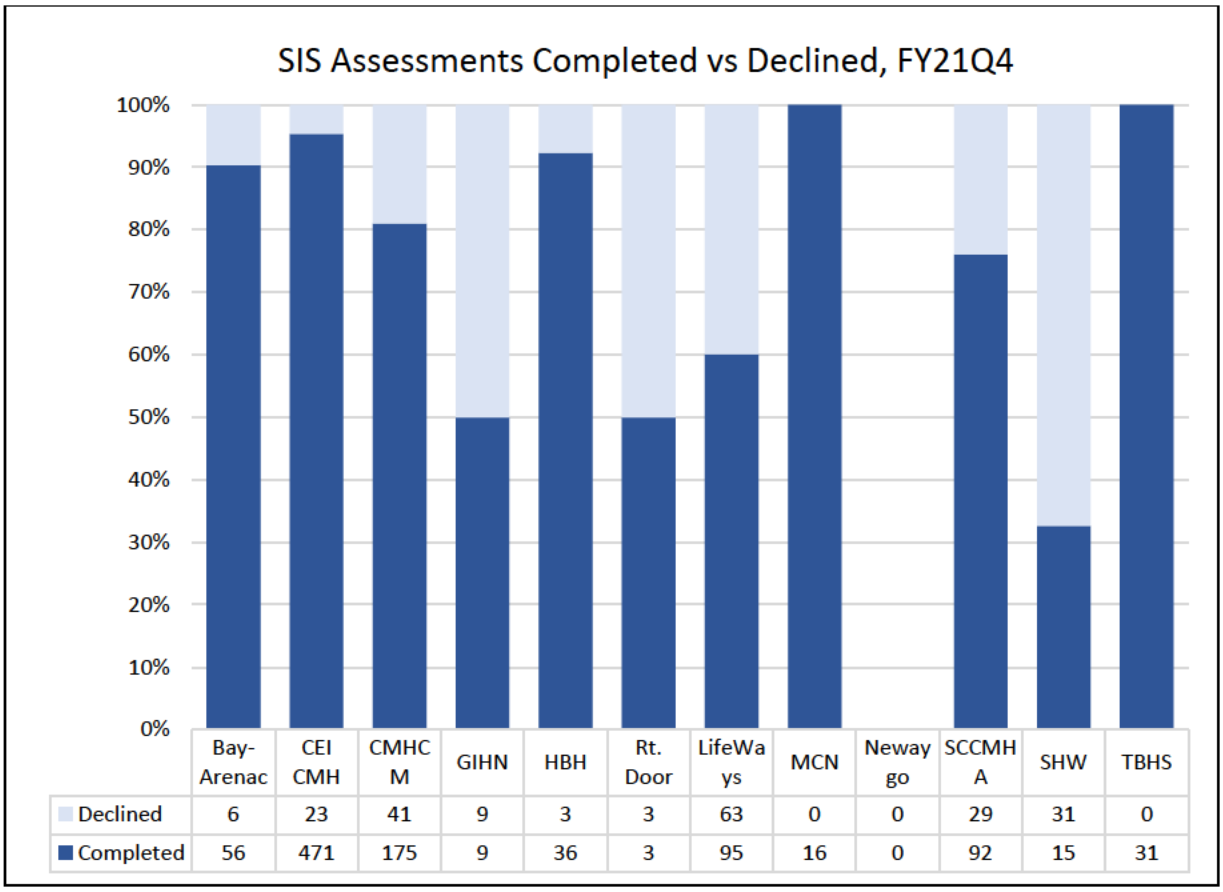
PIHPs or their designee shall continue to engage, at least annually, individuals who did not participate in the SIS® Assessment to increase their understanding of the benefits of this process and how results will be used.

MDHHS. (2021 June) Supports Intensity Scale® Implementation Manual

https://www.michigan.gov/documents/mdhhs/MDHHS_SIS_Manual_Version2.2_727728_7.pdf

Table 3:
SIS Assessments Completed v. Declined FY21Q4

CMH	Number to Complete	Completed	Declined	% Declined
Bay-Arenac Behavioral Health	387	56	6	1.55%
CEI CMH	912	471	23	2.52%
CMH for Central Michigan	967	175	41	4.24%
Gratiot Integrated Health Network	124	9	9	7.26%
Huron Behavioral Health	104	36	3	2.88%
Ionia - The Right Door	125	3	3	2.40%
LifeWays CMH	582	95	63	10.82%
Montcalm Care Network	194	16	0	0.00%
Newaygo CMH	88	0	0	0.00%
Saginaw County CMHA	648	92	29	4.48%
Shiawassee County CMHA	45	15	31	68.89%
Tuscola Behavioral Health Systems	133	31	0	0.00%
Total	**4309**	**999**	**208**	**4.83%**



	Bay-Arenac	CEI CMH	CMHCM	GIHN	HBH	Rt. Door	LifeWays	MCN	Newaygo	SCCMHA	SHW	TBHS
Declined	6	23	41	9	3	3	63	0	0	29	31	0
Completed	56	471	175	9	36	3	95	16	0	92	15	31

Please note that for FY21Q4 and since the beginning of the pandemic in early 2020, SIS Assessments may have declined due to COVID safety measures and use of telehealth services. Additionally, the number of individuals eligible for a SIS assessment also decreased due to individual choice to delay services.

B. Regional Issues

- SIS assessors continued completing assessments via telehealth during FY21Q4 and began to include face to face assessments as requested. Some individuals are awaiting the end of the pandemic to receive a SIS.
- The upload process for data relating to individuals declining to receive a SIS assessment has been completed and implemented. It is being integrated into MSHN PowerBI reporting systems and will be in use FY21Q4.
- The percent of individuals who have had at least one SIS within their individual previous three-year time span is relative to the individual rather than a static three-year cycle.
- Planning for the SIS-Child (SIS-C) Assessment will occur in FY22 with projected implementation in FY23.

Mid-State Health Network Utilization Management Plan

Pre-Paid Inpatient Health Plan

Mid-State Health Network, Utilization Management Committee Approved: 02.2020
Mid-State Health Network Medical Director Approved: 04.2020
Mid-State Health Network, Operations Council Approved: 04.2020

I. Utilization Management Plan Overview

The structure of the Mid-State Health Network (MSHN) Utilization Management Program is described in the MSHN policy and procedure manual. MSHN policies and procedures outline the components of the MSHN UM program, including service access procedures, medical necessity standards, and service eligibility criteria.

See MSHN Policies and Procedures:

- Utilization Management: Utilization Management
- Utilization Management: Access System
- Utilization Management: Retrospective Sample Review-Acute Care Services Policy & Procedure
- Utilization Management: Level of Care System (LOC) for Parity Policy & Procedure

In addition, the following service-related policies address service-specific utilization management requirements where they exist, such as enhanced eligibility criteria and regulated service authorization procedures. Services which have specific UM requirements are typically those which are Medicaid waiver-based or grant funded, and therefore have individual enrollment or highly specialized requirements which must be met.

See MSHN Policies and Procedures:

- Service Delivery System: Habilitation Supports Waiver
- Service Delivery System: Autism Spectrum Disorder Benefit
- Service Delivery System: SUD Services – Women's Specialty Services

The MSHN Utilization Management (UM) Plan is strategic in nature and serves to support compliance with the aforementioned UM and related service policies. It applies to managed specialty supports and services delivered through the 1115 Pathways to Integration Demonstration Waiver, i.e., those for individuals experiencing mental illness, serious emotional disturbance, substance use disorders and intellectual and developmental disabilities. The UM Plan is used by the MSHN Utilization Management Committee to:

- Define specifics of regional requirements or expectations for CMHSP Participants and SUD Providers relative to prospective service reviews (pre-authorizations), concurrent reviews and retrospective reviews for specific services or types of services, if not already addressed in policy;
- Define any necessary data collection strategies to support the MSHN UM Program, including how the data resulting from the completion of any mandatory standardized level of care, medical necessity or perception of care assessment tools will be used to support compliance with MSHN UM policies;
- Define metrics for population-level monitoring of regional adherence to medical necessity standards, service eligibility criteria and level of care criteria (where applicable);
- Define expected or typical population service utilization patterns and methods of analysis to identify and recommend possible opportunities for remediation of over/under utilization;
- Implement policies and systems to ensure consistency with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

- Set annual utilization management priorities based on the MSHN strategic plan and/or contractual/public policy expectations;
- Recommend improvement strategies where service eligibility criteria may be applied inconsistently across the region, where there may be gaps in adherence to medical necessity standards and/or adverse utilization trends are detected (i.e., under or over utilization); and
- Identify focal areas for MSHN follow-up with individual CMHSP Participants and SUD Providers during their respective on-site monitoring visits.

II. Definitions

These terms have the following meaning throughout this Utilization Management Plan.

1. CMHSP Participant: refers to one of the twelve-member Community Mental Health Services Program (CMHSP) participants in MSHN Regional Entity.
2. Concurrent Review: During the course of service delivery (i.e. point of care), ensuring an appropriate combination of services is authorized; concurrent review occurs within the context of philosophical frameworks governing decision making regarding services (e.g., consumer self-determination, person centered planning and trauma informed and recovery oriented care); may include re-measurement(s) of need utilizing standardized assessment tools; for Medicaid enrollees, concurrent UM decision making includes Advance Notice to the consumer.
3. Crisis Residential: Services that are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries (adult or child) experiencing an acute psychiatric crisis when clinically indicated. Services must be provided to beneficiaries in licensed crisis residential foster care or group home settings not exceeding 16 beds in size.
4. Crisis Stabilization: Structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Can be stabilized and served in the consumer's usual community environments.
5. Intellectual/Developmental Disability (I/DD): Developmental disability means If applied to an individual older than 5 years of age, a severe, chronic condition that meets all of the following requirements: Is attributable to a mental or physical impairment or a combination of mental and physical impairments, is manifested before the individual is 22 years old, is likely to continue indefinitely, results in substantial functional limitations in three or more of the following areas of major life activity, self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency; reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated. If applied to a minor from birth to 5 years of age, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability. Intellectual disability means a condition manifesting before the age of 18 years that is characterized by significantly sub average intellectual functioning and related limitations in 2 or more adaptive skills and that is diagnosed based on the following assumptions: valid assessment considers cultural and linguistic diversity, as well as differences in communication and behavioral factors, the existence of limitation in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the individual's particular needs for support, specific adaptive skill limitations often coexist with strengths in other adaptive skills or other personal capabilities, and with appropriate supports over a sustained period, the life functioning of the individual with an

intellectual disability will generally improve.

6. Prospective Review: Determination of the appropriateness of a level of care or service setting before services are initiated; associated with admission to a program, agency or facility and the application of global medical necessity, benefit eligibility or access/admission criteria; may include baseline measurements of need utilizing standardized assessment tools; for Medicaid enrollees, prospective UM decision making includes Adequate Notice to the consumer.
7. Provider Network: refers to MSHN CMHSP Participants and Substance Use Disorder (SUD) Service Providers directly under contract with the MSHN PIHP to provide/arrange for behavioral health services and/or supports. Services and supports may be provided through direct operations or through the subcontract arrangements.
8. Retrospective Review: After service delivery, evaluation of whether the scope, duration and frequency of services received met consumer need; includes determination of whether or not intended outcomes were achieved; may include post-discharge measurement of health outcomes or re-measurement of need utilizing standardized assessment tools; retrospective review may occur specific to a service, program or facility.
9. Serious Emotional Disturbance (SED): As described in Section 330.1100c of the Michigan Mental Health Code, a serious emotional disturbance is a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS, and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities.
10. Serious Mental Illness (SMI): As described in Section 330.1100c of the Michigan Mental Health Code, a serious mental illness is a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbances, but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness.
11. Staff: Refers to an individual directly employed and/or contracted with a CMHSP Participant or SUD Service Provider.
12. Stakeholder: A person, group, or organization that has an interest in an organization, including consumer, family members, guardians, staff, community members, and advocates.
13. Substance Use Disorder (SUD): The taking of alcohol or other drugs as dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

III. Prospective, Concurrent and Retrospective Utilization Management Review

A note about data processes for utilization management data review: utilization management involves the review of data and this review should be preceded by the use of as many different systematic research methods as possible in that these processes are expected to be a study of evidence in order to answer a question that is raised in the data (Vogt, 2007). Methodology matters as does the reliability and validity of data collection/measurement and analysis, and thus, UM processes will employ techniques that are appropriate and consistent with prevailing behavioral science data gathering techniques intended to glean actionable information and insight into the behavioral health and substance use disorder systems of the MSHN region.

A. Prospective Utilization Review

MSHN will have a prospective utilization review process for non-emergent mental health and substance use disorder services, which will include the following components:

1. Service eligibility determination, through an access screening process
2. Verification of medical necessity, through a clinical assessment process (which may occur concurrently or sequentially with the access screening process)
3. Standardized assessments and/or level of care tools for certain clinical populations
4. Specialized testing/evaluations for certain services
5. Certification for certain enrollment-based services
6. Pre-authorization (amount, scope, and duration) for certain services

Service eligibility and medical necessity criteria for each clinical population are outlined in the MSHN Access System policy, including requirements for second opinions and advanced/adequate notice of denials.

1. Eligibility Determinations and Verification of Medical Necessity

Eligibility determinations and verification of medical necessity will be performed by CMHSP Participants for mental health services, and by SUD providers for substance use disorder services. An exception is Autism Spectrum Disorder services, which are may be initiated by through a screening during well-child visits, and has a state-mandated comprehensive evaluation process, as discussed further below.

To ensure adequate integration, MSHN has established a coordinated service access process. CMHSPs and the SUD provider networks in their respective catchment areas will coordinate access processes, ensure there is 'no wrong door' for linking to services, and ensure there is a single point of contact for after-hours service inquiries from Medicaid enrollees and other individuals seeking mental health and SUD services. CMHSP Access Centers may assist with screening individuals seeking SUD services.

Coordination of care will also occur with primary health care providers.

2. Standardized Assessments and/or Level of Care Tools

For certain clinical populations, the Michigan Department of Health and Human Services (MDHHS) requires the use of standardized assessments or level of care determination tools during the initial

assessment phase, minimally to inform, and in some instances, to guide decision making regarding the appropriate level of care. No one assessment shall be used to determine the care an individual receives, rather it is part of a set of assessments, clinical judgment, and individual input that determine level of care. The following assessments/tools will be utilized in the MSHN region:

- Substance Use Disorder services
  - ASAM (American Society of Addiction Medicine) level of care placement criteria
  - GAIN (Global Appraisal of Individual Needs) comprehensive biopsychosocial assessment
- Children and Adolescents with Serious Emotional Disturbance
  - DECA (Devereaux Early Childhood Assessment, for ages birth-47 months)
  - CAFAS (Child and Adolescent Functional Assessment Scale (for ages 5-19)
  - PECFAS (Preschool and Early Childhood Functional Assessment Scale (for ages 3-5, or age 7)
- Adults with Mental Illness
  - LOCUS (Level of Care Utilization System for Psychiatric and Addiction Services)
- Individuals with Intellectual/Developmental Disabilities
  - SIS (Supports Intensity Scale)

3. Specialized Testing/Evaluation and Certification

Certain Medicaid services have additional requirements for service eligibility or medical necessity, including enrollment/certification and/or specialized testing/evaluation, which will be followed by the MSHN region:

- Specialized testing/evaluation required:
  - Autism Spectrum Disorder Benefit
    - Full medical and physical examination, and screening for autism spectrum disorder performed by primary care provider
    - ADOS-2 (Autism Diagnostic Observation Schedule), comprehensive clinical interview and Developmental Disabilities-Children's Global Assessment Scale (DD-CGAS) completed by CMHSP Participant
- Additional documentation of medical necessity by an appropriately licensed/registered health professional:
  - Occupational Therapy (Physician's order is also required)
  - Physical Therapy (Physician's order is also required)
  - Speech, Hearing and Language Therapy
  - Behavior Treatment/Applied Behavioral Analysis (ABA)
  - Health Services
  - Private Duty Nursing (Physician's order is also required)
  - Medication Administration and Medication Review
  - Medication Assisted Treatment (MAT)
- Certification of need required:
  - Habilitation and Support Waiver (for Adults with Intellectual and Developmental Disabilities)
  - Personal Care in Specialized Residential

MDHHS will retain lead responsibility for managing enrollment and eligibility determinations for the Autism Benefit (waiver). Additional requirements are outlined in the MSHN Autism Spectrum Disorder Benefit policy.

MSHN centrally manages the Children's Waiver Program (CWP), Habilitation Supports Waiver (HSW), and Waiver for Children with Severe Emotional disturbance (SEDW) certifications. CMSHP Participants will initially certify and annually recertify those persons enrolled in these waivers. The MDHHS regulates the number of HSW certificates available to the region. Eligibility requirements including outlined in the MSHN CWP, HSW, and SEDW policies.

MSHN also has responsibility to ensure that women who qualify for specialty substance use disorder (SUD) services are provided those services by designated providers and to ensure the provider network conveys an atmosphere that is welcoming, helpful and informative for its clients. See the MSHN Policy *SUD Services-Women's Specialty Services* for more information.

If not otherwise specified here, CMHSP Participants or SUD Providers, where applicable, will assess and document medical necessity by properly qualified professionals in their clinical records, including obtaining any required physician's orders. SUD Providers will use a centralized managed care software system for this purpose, called Regional Electronic Medical Information (REMI).

4. Level of Care Thresholds and Placement Criteria

Mid-State Health Network (MSHN) and its provider network shall ensure that determination decisions are informed by consistent application of medical necessity criteria by implementing regional admission and service guidelines that include service code-level thresholds for individuals via a nationally recognized recommended Level of Care (LOC) instrument(i.e. CAFAS/PECFAS, LOCUS, or SIS), and person-centered planning process. The MSHN Level of Care System (LOC) Policy and Procedure defines the regional expectations for level of care thresholds and placement criteria.

Any MDHHS-specified level of care thresholds and/or placement criteria which must be applied to the results of standardized assessments during the service eligibility determination process are outlined in the MSHN Access System policy. Requirements including a priority rubric for allocation of HSW slots are outlined in the MSHN HSW policy.

If not otherwise specified by MDHHS, once MSHN general service eligibility and medical necessity criteria are met, the level of care and/or placement for services will be based upon assessment of the individual consumer. Person centered planning activities, self-determination principles and individual goals for recovery define how the services are to be provided to address individual consumer goals. See the MSHN Policy *General Management: Person/Family Centered Plan of Service* for more information.

5. Pre-Authorization of Services

Pre-authorization for a defined episode of care will be required for the following services due to the cost and/or intensity of the service to require:

- Inpatient Psychiatric Hospital Admission
- Autism spectrum disorder services
- Crisis Residential Services
- Intensive Crisis Stabilization Services
- Outpatient Partial Hospitalization Services

In addition, the following services may have additional clinical review and/or administrative authorization at the CMHSP Participant or SUD Provider level to ensure required resources are available to support individual plans of service:

- Community Living Supports
- Recovery Housing
- Housing Assistance
- Assistive Technology
- Enhanced Medical Equip & Supplies
- Enhanced Pharmacy
- Environmental Modifications
- Goods & Services
- Personal Emergency Response Systems

For all other MSHN services, pre-authorization for mental health or SUD services will not be necessary. At their discretion, CMHSP participants use authorization of services to help manage provider network capacity and financial resources.

6. Service Denials Resulting from Prospective Utilization Review

CMHSPs and SUD Providers will offer second opinions and provide advanced/adequate notice of denials as outlined in the MSHN Access System policy.

7. Monitoring Access Eligibility and Medical Necessity Determinations

Each CMHSP and SUD Provider will monitor individual service eligibility and medical necessity determinations for consistency with local and regional policy. MSHN will monitor whether the individual eligibility and medical necessity determinations that have been made are consistent with MSHN policies through record reviews during annual on-site visits to CMHSP Participants and SUD Providers. MSHN will also review individual SUD eligibility determinations through its electronic managed care information system.

The MSHN UM Committee in conjunction with MSHN staff will monitor regional compliance with the access eligibility and medical necessity criteria at the population level through the review of metrics.

a) Metrics

The following metric(s) will be used for 2020-2021 for purposes of monitoring medical necessity and service eligibility:

Managed Care Requirement	Type	Indicator and Associated Tools (if any)	Data source	Definition	Threshold/ Benchmark	Frequency
Medical Necessity: 42CFR 438; Medicaid	Medical Necessity and	Service penetration per population	MMBPIS data	Unduplicated consumers served by disability designation - MIA, SED, I/DD, SUD	MMBPIS data state average	Bi-Annually

Managed Care Requirement	Type	Indicator and Associated Tools (if any)	Data source	Definition	Threshold/ Benchmark	Frequency
Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Contract - QAPIP Attachment P7.9.1	Service Eligibility					
		Potential tools for identification of causal factors for desirable/ undesirable variance: - Disposition of Service Requests	Annual Submission			

b) Interventions

If an individual record review during a site review raises questions regarding compliance with MSHN service eligibility and medical necessity criteria, the issue will be addressed with the CMHSP or SUD Provider through the site review process.

The MSHN UM Committee will review access and eligibility reports to identify potentially undesirable variances in access to service at the population level. For purposes of ensuring appropriate access to the Medicaid benefit managed by the region, undesirable variance will be defined as:

- Possible inconsistency with regional service eligibility and/or medical necessity criteria; and/or
- Possible inconsistency with recommended level of care service benefit array
- Possible inconsistency with coordination of benefit requirements as defined by the State Medicaid Agency.

Based upon its findings, the UMC will identify potential interventions for consideration. Interventions will vary, depending upon the nature of the variance and anticipated causal factors, but may include the following interventions, presented in order of intensity, from least to highest:

1. Verify data
2. Request further analysis and verification
3. Request change strategies from stakeholders
4. Provide regional training
5. Modify or clarify regional service eligibility and/or medical necessity criteria through proposed revisions to MSHN policy
6. Re-evaluate required credentials for access/intake staff

All official interventions that a stakeholder, CMHSP, or the UMC takes shall be documented on a "Change Strategy" form to record responses to data analysis that have occurred via the utilization management context (i.e. in UMC or local CMHSP UM processes).

B. Concurrent Utilization Review

Concurrent reviews will be performed by CMHSPs for mental health services and appropriate MSHN UM Specialist staff will perform concurrent SUD UM reviews.

Each individual receiving services will have an individual plan of service which outlines the services to be received, including the amount, scope and duration. The amount, scope and duration of each service, if not subject to the enrollment, authorization or other limitations described earlier in this plan, will be

determined by the person who will be receiving the service and their SUD Provider or CMHSP, through a person centered and recovery oriented planning process.

Utilization decisions will not be made outside of the person-centered planning process unless otherwise required by MDHHS (as described in this UM Plan). The individual plan of service for each person receiving services will specify the frequency of periodic (i.e., concurrent) review as determined in dialogue with the person receiving services. Plans will be reviewed at least annually.

CMHSPs may utilize service authorization protocols at the local level in order to trigger additional review of medical necessity for service requests (generated through the person-centered planning) which reflect potential over or under utilization of services.

The process of periodic and/or annual review of individual plans of service will incorporate documentation or re-assessment of the individual's continued service eligibility and medical necessity for the services being received.

1. Services Requiring Enrollment or Pre-Authorization

Concurrent review for the following services will be required to document continuing medical necessity and adherence to service specific eligibility criteria, if any. The review process may require re-administration of population/service specific assessments, renewal of certification, or re-authorization. Specific need thresholds may be required. These services will not continue unless re-authorization/re-certification takes place or thresholds are still shown to be met.

- Continuing Stay Reviews (i.e., per episode of care):
  - Psychiatric Inpatient Hospitalization
  - Crisis Residential Services
  - Crisis Observation Care
  - Intensive Crisis Stabilization Services
  - Outpatient Partial Hospitalization Services]
  - Medication Assisted Treatment (MAT)
  - Detoxification/Withdrawal Monitoring (Residential Treatment for SUD)
- Semi-Annual Orders:
  - Physician Orders (for exceptions to standard hours for Private Duty Nursing)
- Annual Orders, Authorizations and Certifications:
  - Autism Services Authorization
  - Habilitation and Support Waiver Re-Certification
  - Physician Orders for Occupational Therapy, Physical Therapy and Private Duty Nursing

2. Services Not Requiring Enrollment or Pre-Authorization

For services not requiring enrollment or pre-authorization, the person-centered planning process will determine whether services are to continue. However, the re-administration of standardized tools/assessments will be required for selected populations or services, to inform the person-centered planning process and to support decision making regarding continued eligibility and medical necessity:

- Quarterly:
  - CAFAS or PECFAS (for SED Children)
  - DECA
  - ASAM (or more frequently upon change in clinical status)

- Annually:
  - LOCUS (for MI Adult)
  - ADOS-2 and DD-CGAS (for Autism Services)
  - Assessment of Personal Care Needs (for Specialized Residential)
- Every 3 Years:
  - Supports Intensity Scale (SIS) (for individuals with Intellectual and Developmental Disabilities)

3. Required Related Service Needs

In addition to the above requirements for authorization of services, the following requirements will be met for HSW services, 1915(I)services and private duty nursing, as outlined in the MDHHS Medicaid Manual:

- A HSW beneficiary will receive at least one HSW service per month in order to retain eligibility.
- Individuals receiving Medicaid Waiver 1915(I) funded services will have one or more goals in their individual plan of service that promote community inclusion and participation, independence, and/or productivity.
- Individuals receiving private duty nursing will also receive at least one of the following habilitative services: Community living supports, out-of-home non-vocational habilitation, or prevocational or supported employment.

4. Service Reduction or Loss of Eligibility Resulting from Concurrent Review

CMHSPs and SUD Providers will provide advanced/adequate notice of denials as outlined in the MSHN Access System policy for any service reduction resulting from loss of eligibility or lack of medical necessity. Unless MSHN service eligibility and medical necessity criteria are not being met, all utilization decisions will be made in the context of person centered planning activities.

5. Monitoring Continuing Eligibility and Medical Necessity Determinations

Each CMHSP and SUD Provider will monitor individual continuing stay/eligibility/medical necessity determinations for consistency with local and regional policy. MSHN will monitor whether continuing stay/eligibility/medical necessity determinations that have been made are consistent with MSHN policies through record reviews during annual on-site visits to CMHSP Participants and SUD Providers. MSHN will also review individual SUD determinations through the electronic managed care information system as needed.

The MSHN UM Committee in conjunction with MSHN staff will monitor regional compliance with continuing stay/eligibility/medical necessity criteria at the population level through the review of metrics.

a) Metrics

The following metric(s) will be used for 2020-2021, based upon a regional priority to address in particular crisis response capacity and utilization of detox services:

Managed Care Requirement	Type	Indicator and Associated Tools (if any)	Data source	Definition	Threshold/ Benchmark	Frequency
Over/Under Utilization: 42CFR 438; Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Contract - QAPIP Attachment P7.9.1	Utilization of Acute Level of Care	Inpatient Recidivism	MMBPIS data	Percent of MI and DD children/ adults readmitted to an inpatient psychiatric unit within 30 days of discharge.	15% or less.	Quarterly
		Crisis/Acute Service Utilization (MCG Behavioral Health Criiteria): • Inpatient Psychiatric • Crisis Residential • Crisis Stabilization • Emergency Services	Encounters; use Census Data rather than persons served Retrospective review of MCG Behavioral Health Criteria	Count each of the four services that comprise crisis/acute services to calculate rate by CMH and by region Each CMH will conduct quarterly retrospective reviews of a sample of crisis/acute cases to determine if MCG Behavioral Health Criteria was met for medical necessity for the service	Most common (i.e., mode) clinical profiles per population 95% or more of crisis/acute cases reviewed will meet medical necessity criteria for the service as defined by MCG Behavioral Health Criteria	Quarterly
		SUD: Residential Utilization	REMI claims; use Census Data rather than persons served	Count by four services to calculate rate by CMH and by region	Most common (i.e., mode) clinical profile	Bi-Annually
		Detox Recidivism	REMI data; use Census Data rather than persons served	The percent of adults with SUD readmitted to an detox unit within 30 days of discharge.	15% or less.	Bi-Annually
		Potential tools for identification of causal factors for desirable/ undesirable variance: - Utilization of ACT, HB, emergency services?	Encounters			Bi-Annually

In addition, CMHSPs will monitor to ensure required related services are being utilized, as previously addressed in this plan:

- HSW beneficiaries received at least one HSW service per month.
- Individuals receiving Medicaid Waiver 1915(I) funded services had one or more goals that promote community inclusion and participation, independence, and/or productivity.
- Individuals receiving private duty nursing received at least one of the following habilitative services: Community living supports; out-of-home non-vocational habilitation; or prevocational or supported employment.

b) Interventions

If an individual record review by MSHN during the site review process raises questions regarding compliance with continued service eligibility and medical necessity based on regional criteria, the issue will be addressed with the CMHSP or SUD Provider through the site review process.

The MSHN UM Committee will review access and eligibility reports to identify potentially undesirable variance in service utilization at the population level. For purposes of ensuring utilization of the Medicaid benefit managed by the region, undesirable variance will be defined as:

- Possible lack of continuing service eligibility and medical necessity over the course of an episode of care.
- Possible over and under-utilization of services when compared to the distribution of service encounters, associated measures of central tendency (i.e. mean, median, mode, standard deviation), and consumer clinical profiles (i.e., functional needs) across the region.

Based upon its findings, the UMC will identify potential interventions for consideration. Interventions will vary, depending upon the nature of the variance and anticipated causal factors, but may include the following interventions, presented in order of intensity, from least to highest:

1. Verify data
2. Request further analysis
3. Request change strategies from stakeholders
4. Provide regional training
5. Modify or clarify regional service eligibility and/or medical necessity criteria through proposed revisions to MSHN policy and/or development of clinical service protocols
6. Set utilization thresholds or limits

All official interventions that a stakeholder, CMHSP, or the UMC takes shall be documented on a "Change Strategy" form to record responses to data analysis that have occurred via the utilization management context (i.e. in UMC or local CMHSP UM processes).

C. Retrospective Utilization Review

Retrospective review will be performed by CMHSPs for mental health services. MSHN UM Specialists perform the reviews for SUD services. Consistent with MSHN strategic plan efforts, the MSHN UM Committee, in conjunction with MSHN staff, will perform retrospective utilization review at the population level through the review of metrics.

Retrospective review will focus on the cost of care, service utilization, and clinical profiles. Analysis will consider encounter data in conjunction with level of care tools such as ASAM, LOCUS, SIS, CAFAS/PECFAS, DD Proxy Measures and other clinical need/outcomes data as available. BH-TEDS and Medicaid claims data will be incorporated as warranted.

a) Metrics

The following metric(s) will be used for 2020-2021 for purposes of monitoring utilization retrospectively:

Managed Care Requirement	Type	Indicator and Associated Tools (if any)	Data source	Definition	Threshold/ Benchmark	Frequency
Cost: 42CFR 438; Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program	Service Utilization Data overlaid with Assessed Level of Need Data (ie:	Cost ***Indicators*** by Code ***(i.e., Program Cluster)*** Per Member Per Month: - CLS - Autism	Sub-Element Report (*remember this is a reach back and accounts for all costs*); Compare to current encounter file data	Look at H2015, H2016, H0043 for CLS. Look retroactively for autism from previous benefit to expansion.	Cost for each member ID for CLS and Autism services, per month, in a histogram. Goal is a bell curve or normal distribution.	Fiscal Year

Managed Care Requirement	Type	Indicator and Associated Tools (if any)	Data source	Definition	Threshold/ Benchmark	Frequency
Contract - QAPIP Attachment P7.9.1	LOCUS, CAFAS, SIS)	Tools for identification of causal factors for desirable/ undesirable variance: -Level of Need Assessment Data (i.e. CAFAS, LOCUS, SIS, ASAM) -MSHN Loevel of Care Service Benefit Packages	CAFAS, LOCUS, SIS, ASAM and encounters	Review service grouping outliers and organizational outliers where there is considerable variance in the provision of services relative to the assessed level of need	Normal distribution of service provision relative to assessed level of need	Quarterly

b) Interventions

The MSHN UM Committee will review service utilization reports to identify potentially undesirable variance in service utilization at the population level. For purposes of ensuring effective management of Medicaid resources managed by the region, undesirable variance will be defined as:

- Inconsistency with regional service eligibility and/or medical necessity criteria; and/or
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6. Set utilization thresholds or limits
7. Address service configuration to affect utilization

c) Other Retrospective Review (Health Outcomes)

Identify population health outcomes metrics to be monitored by focusing on persons that have chronic health conditions which are co-morbid with a serious and persistent mental health illness, serious emotional disturbance, co-occurring substance use disorder and/or a developmental disability.

In an effort to ensure collaboration and integration between Medicaid Health Plans (MHPs) and Pre-Paid Inpatient Health Plans (PIHPs), the Michigan Department of Health and Human Services has developed the joint expectations for both entities. The integration of physical and mental health services provided by the MHP and PIHP for shared consumer base plans and clinical pathways which encourage 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. Coordinate the physical health assessment through the consumer's MHP as necessary.

Based on the findings, the UMC will identify improvement opportunities based upon health outcome indicators.

Managed Care Requirement	Type	Indicator and Associated Tools (if any)	Data source	Definition	Threshold/ Benchmark	Frequency
Integration Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program)	Integration with Physical Health	Children and adolescents' access to primary care practitioners (PCP): percentage of members 12 months to 19 years of age who had a visit with a PCP.	ICDP	See link	>=75%, State average for MHP performance, national performance via NCQA	Fiscal Year
		Adults' access to preventive/ambulatory health services: percentage of members 20 years and older who had an ambulatory or preventive care visit.	ICDP	See link	>=75%, State average for MHP performance, national performance via NCQA	Fiscal Year
		Reduction in number of visits to the emergency room.	ICDP and integrated care cohort	The number of individuals who are on track to have less ER visits than they had during the 12 months previous to starting an integrated care plan.	State average for performance as available	Quarterly
		Reduction in admits for psychiatric/physical health reasons.	ICDP and integrated care cohort	The number of individuals who are on track to have less IP visits than they had during the 12 months previous to starting an integrated care plan.	State average for performance as available	Quarterly
		Follow up after Hospitalization for Mental Health (FUH) for Children	ICDP and Care Connect 360		70%	Quarterly
		Follow up after Hospitalization for Mental Health (FUH) for Adults	ICDP and Care Connect 360		58%	Qaurterly

References

MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1115 Pathways to Integration Waiver Demonstration

MDHHS Medicaid Provider Manual, Mental Health/ Substance Abuse chapter

Michigan Mental Health Code, 330.1100a and b

Vogt, W.P. (2007). Quantitative research methods for professionals. Boston, MA: Pearson Education, Inc.

Utilization Management Quarterly Report

July 2021 – September 2021 (FY21 Q4)

Prepared by: MSHN Utilization Management Department

Background & Purpose

The MSHN Utilization Management (UM) department provides oversight of access and referral for substance use disorder (SUD) treatment services and authorization of SUD treatment services. The UM department also provides support and technical assistance to the SUD provider network related to these content areas. The purpose of this report is threefold:

1. **Summarize Quarterly Activity** of MSHN UM Department in the primary areas of utilization review: prospective, concurrent, and retrospective

2. **Conduct Environmental Scan** of external and internal factors which may affect the UM Department's ability to adequately perform responsibilities

3. **Plan for Future Initiatives** during FY22 and beyond

Prospective Utilization Review

The MSHN Utilization Management Plan identifies the following components of prospective utilization review:

1. Service eligibility determination through an access screening process
2. Verification of medical necessity through a clinical assessment process
3. Standardized assessment and/or level of care tools for certain clinical populations
4. Specialized testing/evaluations for certain services
5. Certification for certain enrollment-based services
6. Pre-authorization (amount, scope and duration) for certain services

Service Eligibility & Access Screening Process

MSHN began reimbursing the SUD provider system for performing clinical screenings (called Level of Care Determinations) on 5/1/2021. Some of the anticipated outcomes were:

- Providers are incentivized to perform Level of Care Determinations at the time of the request for service rather than waiting until the individual comes to an initial assessment appointment. In theory, this facilitates more timely access to care by ensuring the person seeking services is connected to the most appropriate level of care to meet their needs immediately rather than waiting up to 14 days until a full assessment is completed.

- Increased data collection with a downstream effect of improved MMBPIS (Michigan's Mission-Based Performance Indicator System) reporting accuracy for SUD Access to Service Indicator #2b.

There were 4,893 Level of Care Determinations completed during FY21 Q1-Q2. By comparison there were 6,840 Level of Care Determinations completed during Q3-Q4, an **increase of 40%** after MSHN

began reimbursing providers for performing Level of Care Determinations. Increased frequency is a step in the right direction however it is equally important to ensure that clinical screenings are completed accurately and result in the most appropriate level of care recommendation for the person seeking services. The following table summarizes the dispositions of Level of Care Determinations performed during Q3-Q4:

Eligible - Referred to another SUD Provider	161
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There were 6,400 Level of Care Determinations completed during Q4 in which the person met eligibility criteria to receive SUD treatment services. Of those, only 161 (less than 3%) were referred to a different SUD provider than the one who performed the screening.

97% of screenings result in SUD providers referring individuals to their own programs, indicating a high likelihood that people are not being offered treatment options that may be better suited to meet their individual needs (i.e., Medication-Assisted Treatment, Women's Specialty Services, Co-Occurring, Intensive Outpatient Programming, etc.)

As reported during Q3, the UM Department conducted an updated Access Analysis to quantify a number of challenges with the current delegated access model including the issues already described here. Additionally, the analysis addressed recent and upcoming initiatives which impact access to SUD services. The analysis resulted in a recommendation to centralize access functions for specific high-cost high-intensity services: withdrawal management, residential treatment, and recovery housing.

Significant system-level changes such as centralized access would be difficult to achieve immediately due to a number of other major initiatives occurring simultaneously in FY22- primarily the statewide implementation of the ASAM Continuum assessment for SUD services and MDHHS Demonstration Project for Certified Community Behavioral Health Centers (CCBHC). It is recommended that MSHN leadership continue to evaluate changes to the current fully delegated access model given the ongoing evidence that SUD Providers are not performing delegated access functions appropriately. Of greatest concern is the likelihood that individuals seeking SUD treatment services are not being offered the most appropriate treatment options to meet their needs or unbiased choice of treatment providers. One option to consider is delegating all SUD access functions to the region's CMHSP participants in order to

remove the inherent conflict of interest that occurs with SUD providers performing access and screening functions.

Access System Interface with MiCAL and MiCARE

MDHHS is currently engaged in a number of statewide initiatives designed to improve access to behavioral health and SUD services and supports. The Michigan Crisis and Access Line (MiCAL) will be a statewide call line to support Michiganders with behavioral health and substance use disorder needs to locate care regardless of severity level or payer type. The MSHN UM department will work collaboratively with MDHHS to develop a plan for implementation of MiCAL in the MSHN region (anticipated during FY22). Implementation planning will also include training for UM department staff on the use of the new MDHHS partner portal which will be used to communicate information about individuals from the MSHN region who contact MiCAL for assistance with accessing services.

The Michigan Care Access Referral Exchange (MiCARE) is a statewide registry of openings in behavioral health and SUD treatment programs designed to facilitate more timely and efficient referrals of individuals in need of services to programs with the capacity to treat them. MiCARE will be implemented in the MSHN region during FY22 Q1 and will include information about community-based psychiatric hospital openings as well as withdrawal management and SUD residential program openings.

Standardized Assessments/Level of Care Tools

Implementation training for the ASAM Continuum assessment (the MDHHS-required standardized assessment for SUD services) occurred in July, August, and September prior to the 10/01/2021 statewide implementation date. PCE Systems completed programming for REMI to enable interface with the online ASAM Continuum database and assessment tool. SUD Providers are able to access the ASAM Continuum assessment through a link in REMI. Once the assessment is complete, relevant clinical information from the Continuum assessment is pulled into the client's chart in REMI. The MSHN UM team reviews information from the ASAM Continuum assessment in order to confirm medical necessity criteria for the services being requested for the individual.

Recommendations & Next Steps

- **Q1 Recommendation:** Work with MSHN Treatment team to evaluate clinical information that is currently gathered in REMI compared to information gathered in ASAM Continuum Assessment. Eliminate redundancies and streamline data entry for provider network wherever possible.
    - **Status:** Complete

- **Q3 Recommendation:** If MSHN decides to centralize SUD Access for specific services, training will be developed for the provider network prior to implementation. Internal UM department procedures and workflow will also be developed
    - **Status:** On hold

- **Q3 Recommendation:** UM Department staff will complete training on the use of the MDHHS partner portal in order to interface with MiCAL when it is implemented in the MSHN region. The

UM Department will develop internal procedures to ensure appropriate follow-up with individuals who contact MiCAL for assistance with access to services.

- **Status:** On hold; Awaiting training and MiCAL rollout in the MSHN region

Concurrent Utilization Review

The MSHN Utilization Management Plan identifies the following components of concurrent utilization review:

1. Each individual receiving services has an individualized plan of service (treatment plan) which outlines the services to be received
2. The amount, scope, and duration of each service will be determined by the person receiving the service and their SUD Provider or CMHSP through a person-centered and recovery-oriented process
3. The individualized plan of service for each person will specify the frequency of review
4. The periodic review of individual plans will incorporate documentation or re-assessment of the individual's continued service eligibility and medical necessity for the services being received
5. The PIHP may utilize service authorization protocols in order to trigger additional review of medical necessity for service requests which reflect potential over or under utilization of services

Concurrent Authorization Reviews: Potential Over-Utilization

A concurrent review is triggered in the REMI system when the amount of services being requested for a specific individual consumer exceeds the typical utilization range for a given service for a given time period. These authorization requests are routed to a queue for UM department review in the REMI system. The table below indicates the total number of authorizations processed in the REMI system each quarter during FY21, including those that were automatically approved and those that required concurrent review.

FY 21	Auto Approved	Concurrent Review	Total	Average Rate of Concurrent Review	Average Number of Concurrent Reviews per Week
Q1	8175	812	9016	9%	68
Q2	7680	1355	8998	15%	113
Q3	7690	1034	8596	12%	86
Q4	7860	1020	8891	11.5%	85

During a concurrent review a MSHN UM specialist verifies that the higher amount of services being requested are medically necessary to meet the needs of the person according to the clinical

documentation submitted with the authorization request. If the documentation is sufficient to support medical necessity the authorization request is approved. If there is not adequate documentation of medical necessity the UM specialist will return the authorization to the requesting provider for more information. The table below indicates the number of authorizations requiring concurrent review each quarter and of those, the amount that had to be returned to the requesting provider:

FY 21	Concurrent Review	Returned to Requestor	Percent Returned to Requestor
Q1	812	247	30.4%
Q2	1355	471	34.8%
Q3	1034	342	33.1%
Q4	1020	357	35.0%

Authorization dashboards are used by the UM department to identify specific provider agencies who require higher rates of concurrent authorization review and/or a high percentage of authorizations returned, potentially indicating the need for additional provider training around individual service planning and documentation of medical necessity criteria. When concerns with a provider agency are identified through high rates of concurrent review and/or a high percentage of returned authorizations the following progressive steps are taken:

1. A MSHN UM specialist reaches out to the agency clinical supervisor to discuss the reasons for the high number of authorizations requiring concurrent review and to provide technical assistance. Technical assistance was provided to the following providers during Q4 related to concurrent authorization review:
    a) [redacted] - Technical assistance (TA) was conducted with the provider on 7/22/2021. A MSHN Treatment Specialist and UM Specialist offered support and education in the areas of clinical service provision, medical necessity criteria (ASAM), individualized treatment planning, and individualized length of stay as opposed to a one-size-fits-all program model (ie: "Our program is 9-12 months and everyone completes 4 levels"). The full TA log can be found here: [redacted]

2. If high levels of concurrent authorizations persist despite UM technical assistance, the UM department will complete a retrospective review of a larger sample of client records from the agency. UM retrospective review findings are provided to the MSHN Tx Team with a referral for additional technical assistance/training in the areas of individualized treatment planning and ASAM criteria for medical necessity. (See Retrospective Utilization Section of this report)

3. Depending on the severity of concerns and lack of improvement despite previous technical assistance, the UM and TX teams will implement a Performance Enhancement Plan (PEP) with the provider. The UM team and TX team conduct periodic PEP progress meetings to provide technical assistance and monitor progress toward the established performance improvement

targets. The MSHN TX team and UM team currently have open PEPs with the following providers:

a) [redacted] – PEP open since April 2020. Members of the TX and UM teams conducted a PEP progress review meeting with the provider on 8/31/2021 which resulted in finding the provider had still not been able to achieve compliance with the performance metrics identified in the PEP. The full PEP and progress review notes can be found here: [redacted]

Recommendations & Next Steps

- **Q1 Recommendation:** Work with MSHN TX team to develop a process for evaluating the efficacy of technical assistance and training
    - **Status:** Complete; MSHN Chief Compliance & Quality Officer revised the Provider Non-Compliance Procedure with input from all departments. The revised procedure includes specific timeline expectations for providers to implement corrective action in response to technical assistance and the progressive steps to be taken if a provider is not able to demonstrate improvements as a result of repeated technical assistance.

- **Q2 Recommendation:** Develop Utilization Management training for the SUD Provider Network to provide more detailed guidance about the type of medical necessity documentation that is needed in authorization requests to address the high percentage of authorizations that are being returned to requestors
    - **Status:** Complete; Live Zoom training dates scheduled for November and recorded training will be available on the MSHN website for providers to access

Retrospective Utilization Review

The MSHN UM Plan identifies the following components of retrospective utilization review:

1. Retrospective review will focus on cost of care, service utilization, and clinical profile
2. Inconsistency with regional service eligibility and/or medical necessity criteria; and/or
3. Possible over and under-utilization of services when compared to the distribution of service encounters, associated measures of central tendency (i.e. mean, median, mode, standard deviation), and consumer clinical profiles (i.e., functional needs) across the region.

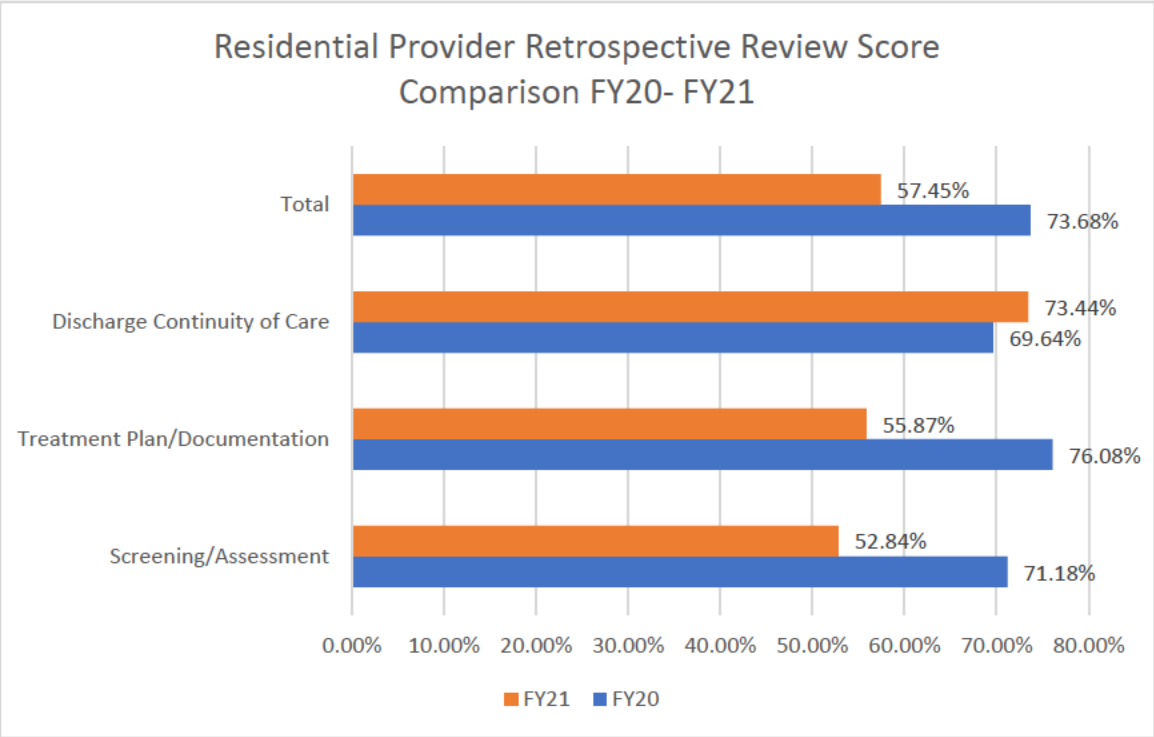
During FY21 Q4 the UM department focused its retrospective review activity on Residential Treatment services. The UM Department identified 8 SUD providers for targeted retrospective review based on outlier criteria, meaning service utilization fell outside of typical use patterns. UM specialists performed a targeted review for each identified provider of a 5% sample of client cases (minimum 2, maximum 8 cases) that received the identified service during the fiscal year. The table below identifies each provider selected for review, the outlier criteria which triggered the review, and the sample size.

Provider	Outlier Criteria	5% Sample Clients Served, (Max 8 Min 2)
	Potential Overutilization- LOS 50% longer than regional average	2
	Potential Underutilization – LOS 40% shorter than regional average	8
	Potential Underutilization – LOS 40% shorter than regional average	3
	Potential Underutilization – LOS 50% shorter than regional average	6
	High rate of authorizations requiring concurrent review (30%)	6
	High rate of authorizations requiring concurrent review (39%)	8
	High rate of authorizations requiring concurrent review (23%)	3
	High rate of authorizations requiring concurrent review (31%)	3

A total of 39 cases were reviewed using the UM Retrospective Audit Tool in REMI. The following table indicates overall performance of the selected providers in each functional review area as well as total score:

Provider	Screening/ Admission/ Assessment	Individual Tx, Recovery Plan & Documentation	Discharge/ Continuity of Care	Total Score for Provider
	63.89%	71.67%	100%	**74.58%**
	33.33%	57.69%	50%	**48.46%**
	56.25%	50%	100%	**61.36%**
	50%	71.05%	100%	**67.65%**
	61.11%	57.14%	0%	**56.45%**
	55.56%	45%	100%	**52.50%**
	44.23%	44.44%	50%	**40.70%**
	58.33%	50%	87.50%	**57.95%**
Average Score (All Providers)	**52.84%**	**55.87%**	**73.44%**	**57.45%**

Average performance dropped considerably between FY20 Q4 and FY21 Q4 retrospective reviews of residential treatment services, most noticeably with regard to the quality of clinical documentation such as screenings, assessments, and treatment plans. One possible causal factor could be provider understaffing and high staff turnover due to the ongoing COVID-19 pandemic.



Typically, such low scores would trigger a referral to the MSHN treatment team for Technical Assistance in the areas where providers performed poorly. All 8 providers that were reviewed during this quarter struggled in the domains of Screening, Admission, Assessment and Individual Treatment, Recovery Planning and Documentation. Rather than perform individual TA with each provider, the UM team will develop a training to address the identified areas of deficiency which will be offered to these providers specifically as well as the full provider network. Additionally, the statewide required implementation of the ASAM Continuum Assessment is expected to correct the identified deficiencies in assessment documentation. TA referrals will be made for 3 of the 8 providers who have previously received technical assistance in these areas (Flint Odyssey House, Saginaw Odyssey House, Sacred Heart). Additional technical assistance will be given and the providers will be monitored for implementation of corrective action.

Recommendations & Next Steps

- **Q4 Recommendation (NEW):** Generate Technical Assistance (TA) referrals to the Treatment team for the following providers as a result of the Q4 retrospective review activity: Flint & Saginaw Odyssey House, Sacred Heart

- **Q4 Recommendation (NEW):** UM team to develop network-wide training on conducting clinical access screenings (Level Of Care Determinations) for CMHSPs and SUDSPs to be offered during FY22 Q1-Q2.

Environmental Scan

Internal: Department Workflow

UM phone call dashboards in Power BI were completed during Q4. The dashboards will be used to track metrics related to incoming calls to the UM Department. The data will be used in several ways:

- Monitor incoming call volume and implications for staff time/availability
- Assess distribution of workload among UM specialists
- Monitor/address productivity as needed
- Ensure that call routing logic is functioning as intended so that calls are answered in a timely manner
- Identify if there are additional staffing needs related to access to services
- Identify any needed areas of improvement to ensure compliance with MDHHS Access Standards

Month	Total Incoming Calls	Average Calls per Week
July	1510	377
August	1066	266
September	Not Available	Not Available

External: MDHHS Service Authorization Denials Quarterly Report

As previously reported, MDHHS implemented a new Service Authorization Denials report during FY21 which requires a quarterly submission from the PIHP containing aggregate data for the region. The report gathers information about adverse benefit determination notices that were issued to consumers as a result of service authorization denials. There were significant challenges with the initial submission for Q1-Q2, primarily because there was not an automated way to easily generate some of the required data points and not all CMHSPs were tracking all data points since there was no prior notification from MDHHS that reporting would be required. This resulted in significant time and effort to manually collect data retrospectively.

Following the submission of the Q1-Q2 report MSHN and the 11 CMHSPs that utilize PCE Systems as their electronic medical record vendor collaborated with PCE to develop an automated report to ensure consistent data collection and standard reporting. The report was not completely finalized and implemented in time for the Q3 report submission so the same challenges and data inconsistencies from the Q1-Q2 submission continued. The FY21 Q4 submission is due to MDHHS on 11/15/2021. The PCE automated report has been successfully implemented and it is expected that most of the data inconsistencies will be resolved.

The MSHN UM Department and MSHN Customer Service will continue to monitor subsequent quarterly reports and address any issues identified by MDHHS through the appropriate regional committee(s) (Utilization Management and/or Customer Service).

Next Quarter Focus

Retrospective Review Process

The MSHN UM department will continue to conduct retrospective reviews on a quarterly basis, focusing on different levels of care or types of service according to the following schedule:

Quarter	Outpatient	Intensive Outpatient/ Medication-Assisted Tx	Withdrawal Management	Residential
1	X			
2		X		
3			X	
4				X

SUD Units/Cost reports will be reviewed each quarter for the scheduled service type and provider agencies who are identified as regional outliers for that service type will be selected for targeted review. Additional targeted retrospective reviews could be triggered outside of the quarterly review schedule in response to potential overspending concerns, detection of significant utilization variance by a particular provider or group of providers, or according to other regional priorities and initiatives.

Utilization Management Quarterly Report

July 2021 – September 2021 (FY21 Q4)

Prepared by: MSHN Utilization Management Department

Background & Purpose

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97% of screenings result in SUD providers referring individuals to their own programs, indicating a high likelihood that people are not being offered treatment options that may be better suited to meet their individual needs (i.e., Medication-Assisted Treatment, Women's Specialty Services, Co-Occurring, Intensive Outpatient Programming, etc.)

As reported during Q3, the UM Department conducted an updated Access Analysis to quantify a number of challenges with the current delegated access model including the issues already described here. Additionally, the analysis addressed recent and upcoming initiatives which impact access to SUD services. The analysis resulted in a recommendation to centralize access functions for specific high-cost high-intensity services: withdrawal management, residential treatment, and recovery housing.

Significant system-level changes such as centralized access would be difficult to achieve immediately due to a number of other major initiatives occurring simultaneously in FY22- primarily the statewide implementation of the ASAM Continuum assessment for SUD services and MDHHS Demonstration Project for Certified Community Behavioral Health Centers (CCBHC). It is recommended that MSHN leadership continue to evaluate changes to the current fully delegated access model given the ongoing evidence that SUD Providers are not performing delegated access functions appropriately. Of greatest concern is the likelihood that individuals seeking SUD treatment services are not being offered the most appropriate treatment options to meet their needs or unbiased choice of treatment providers. One option to consider is delegating all SUD access functions to the region's CMHSP participants in order to

remove the inherent conflict of interest that occurs with SUD providers performing access and screening functions.

Access System Interface with MiCAL and MiCARE

MDHHS is currently engaged in a number of statewide initiatives designed to improve access to behavioral health and SUD services and supports. The Michigan Crisis and Access Line (MiCAL) will be a statewide call line to support Michiganders with behavioral health and substance use disorder needs to locate care regardless of severity level or payer type. The MSHN UM department will work collaboratively with MDHHS to develop a plan for implementation of MiCAL in the MSHN region (anticipated during FY22). Implementation planning will also include training for UM department staff on the use of the new MDHHS partner portal which will be used to communicate information about individuals from the MSHN region who contact MiCAL for assistance with accessing services.

The Michigan Care Access Referral Exchange (MiCARE) is a statewide registry of openings in behavioral health and SUD treatment programs designed to facilitate more timely and efficient referrals of individuals in need of services to programs with the capacity to treat them. MiCARE will be implemented in the MSHN region during FY22 Q1 and will include information about community-based psychiatric hospital openings as well as withdrawal management and SUD residential program openings.

Standardized Assessments/Level of Care Tools

Implementation training for the ASAM Continuum assessment (the MDHHS-required standardized assessment for SUD services) occurred in July, August, and September prior to the 10/01/2021 statewide implementation date. PCE Systems completed programming for REMI to enable interface with the online ASAM Continuum database and assessment tool. SUD Providers are able to access the ASAM Continuum assessment through a link in REMI. Once the assessment is complete, relevant clinical information from the Continuum assessment is pulled into the client's chart in REMI. The MSHN UM team reviews information from the ASAM Continuum assessment in order to confirm medical necessity criteria for the services being requested for the individual.

Recommendations & Next Steps

- **Q1 Recommendation:** Work with MSHN Treatment team to evaluate clinical information that is currently gathered in REMI compared to information gathered in ASAM Continuum Assessment. Eliminate redundancies and streamline data entry for provider network wherever possible.
    - **Status:** Complete

- **Q3 Recommendation:** If MSHN decides to centralize SUD Access for specific services, training will be developed for the provider network prior to implementation. Internal UM department procedures and workflow will also be developed
    - **Status:** On hold

- **Q3 Recommendation:** UM Department staff will complete training on the use of the MDHHS partner portal in order to interface with MiCAL when it is implemented in the MSHN region. The

UM Department will develop internal procedures to ensure appropriate follow-up with individuals who contact MiCAL for assistance with access to services.

- **Status:** On hold; Awaiting training and MiCAL rollout in the MSHN region

Concurrent Utilization Review

The MSHN Utilization Management Plan identifies the following components of concurrent utilization review:

1. Each individual receiving services has an individualized plan of service (treatment plan) which outlines the services to be received
2. The amount, scope, and duration of each service will be determined by the person receiving the service and their SUD Provider or CMHSP through a person-centered and recovery-oriented process
3. The individualized plan of service for each person will specify the frequency of review
4. The periodic review of individual plans will incorporate documentation or re-assessment of the individual's continued service eligibility and medical necessity for the services being received
5. The PIHP may utilize service authorization protocols in order to trigger additional review of medical necessity for service requests which reflect potential over or under utilization of services

Concurrent Authorization Reviews: Potential Over-Utilization

A concurrent review is triggered in the REMI system when the amount of services being requested for a specific individual consumer exceeds the typical utilization range for a given service for a given time period. These authorization requests are routed to a queue for UM department review in the REMI system. The table below indicates the total number of authorizations processed in the REMI system each quarter during FY21, including those that were automatically approved and those that required concurrent review.

FY 21	Auto Approved	Concurrent Review	Total	Average Rate of Concurrent Review	Average Number of Concurrent Reviews per Week
Q1	8175	812	9016	9%	68
Q2	7680	1355	8998	15%	113
Q3	7690	1034	8596	12%	86
Q4	7860	1020	8891	11.5%	85

During a concurrent review a MSHN UM specialist verifies that the higher amount of services being requested are medically necessary to meet the needs of the person according to the clinical

documentation submitted with the authorization request. If the documentation is sufficient to support medical necessity the authorization request is approved. If there is not adequate documentation of medical necessity the UM specialist will return the authorization to the requesting provider for more information. The table below indicates the number of authorizations requiring concurrent review each quarter and of those, the amount that had to be returned to the requesting provider:

FY 21	Concurrent Review	Returned to Requestor	Percent Returned to Requestor
Q1	812	247	30.4%
Q2	1355	471	34.8%
Q3	1034	342	33.1%
Q4	1020	357	35.0%

Authorization dashboards are used by the UM department to identify specific provider agencies who require higher rates of concurrent authorization review and/or a high percentage of authorizations returned, potentially indicating the need for additional provider training around individual service planning and documentation of medical necessity criteria. When concerns with a provider agency are identified through high rates of concurrent review and/or a high percentage of returned authorizations the following progressive steps are taken:

1. A MSHN UM specialist reaches out to the agency clinical supervisor to discuss the reasons for the high number of authorizations requiring concurrent review and to provide technical assistance. Technical assistance was provided to the following providers during Q4 related to concurrent authorization review:
    a) [redacted] - Technical assistance (TA) was conducted with the provider on 7/22/2021. A MSHN Treatment Specialist and UM Specialist offered support and education in the areas of clinical service provision, medical necessity criteria (ASAM), individualized treatment planning, and individualized length of stay as opposed to a one-size-fits-all program model (ie: "Our program is 9-12 months and everyone completes 4 levels"). The full TA log can be found here: [redacted]

2. If high levels of concurrent authorizations persist despite UM technical assistance, the UM department will complete a retrospective review of a larger sample of client records from the agency. UM retrospective review findings are provided to the MSHN Tx Team with a referral for additional technical assistance/training in the areas of individualized treatment planning and ASAM criteria for medical necessity. (See Retrospective Utilization Section of this report)

3. Depending on the severity of concerns and lack of improvement despite previous technical assistance, the UM and TX teams will implement a Performance Enhancement Plan (PEP) with the provider. The UM team and TX team conduct periodic PEP progress meetings to provide technical assistance and monitor progress toward the established performance improvement

targets. The MSHN TX team and UM team currently have open PEPs with the following providers:

a) [redacted] – PEP open since April 2020. Members of the TX and UM teams conducted a PEP progress review meeting with the provider on 8/31/2021 which resulted in finding the provider had still not been able to achieve compliance with the performance metrics identified in the PEP. The full PEP and progress review notes can be found here: [redacted]

Recommendations & Next Steps

- **Q1 Recommendation:** Work with MSHN TX team to develop a process for evaluating the efficacy of technical assistance and training
    - **Status:** Complete; MSHN Chief Compliance & Quality Officer revised the Provider Non-Compliance Procedure with input from all departments. The revised procedure includes specific timeline expectations for providers to implement corrective action in response to technical assistance and the progressive steps to be taken if a provider is not able to demonstrate improvements as a result of repeated technical assistance.

- **Q2 Recommendation:** Develop Utilization Management training for the SUD Provider Network to provide more detailed guidance about the type of medical necessity documentation that is needed in authorization requests to address the high percentage of authorizations that are being returned to requestors
    - **Status:** Complete; Live Zoom training dates scheduled for November and recorded training will be available on the MSHN website for providers to access

Retrospective Utilization Review

The MSHN UM Plan identifies the following components of retrospective utilization review:

1. Retrospective review will focus on cost of care, service utilization, and clinical profile
2. Inconsistency with regional service eligibility and/or medical necessity criteria; and/or
3. Possible over and under-utilization of services when compared to the distribution of service encounters, associated measures of central tendency (i.e. mean, median, mode, standard deviation), and consumer clinical profiles (i.e., functional needs) across the region.

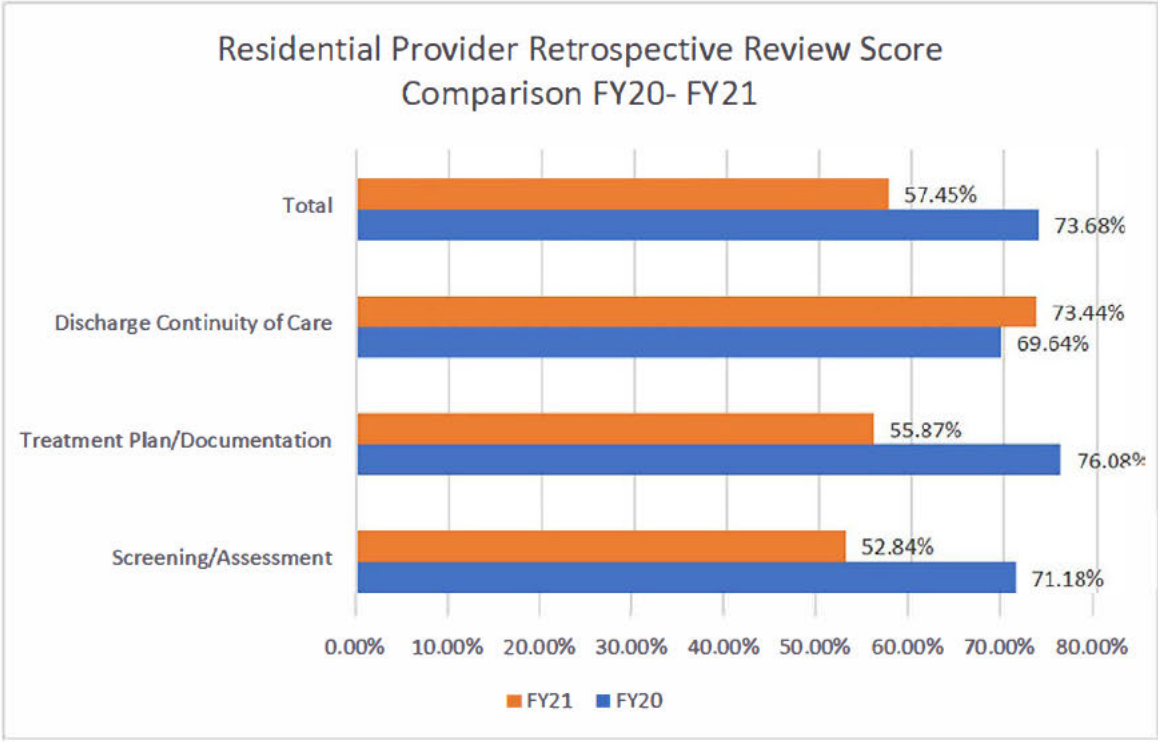
During FY21 Q4 the UM department focused its retrospective review activity on Residential Treatment services. The UM Department identified 8 SUD providers for targeted retrospective review based on outlier criteria, meaning service utilization fell outside of typical use patterns. UM specialists performed a targeted review for each identified provider of a 5% sample of client cases (minimum 2, maximum 8 cases) that received the identified service during the fiscal year. The table below identifies each provider selected for review, the outlier criteria which triggered the review, and the sample size.

Provider	Outlier Criteria	5% Sample Clients Served, (Max 8 Min 2)
[redacted]	Potential Overutilization- LOS 50% longer than regional average	2
[redacted]	Potential Underutilization – LOS 40% shorter than regional average	8
[redacted]	Potential Underutilization – LOS 40% shorter than regional average	3
[redacted]	Potential Underutilization – LOS 50% shorter than regional average	6
[redacted]	High rate of authorizations requiring concurrent review (30%)	6
[redacted]	High rate of authorizations requiring concurrent review (39%)	8
[redacted]	High rate of authorizations requiring concurrent review (23%)	3
[redacted]	High rate of authorizations requiring concurrent review (31%)	3

A total of 39 cases were reviewed using the UM Retrospective Audit Tool in REMI. The following table indicates overall performance of the selected providers in each functional review area as well as total score:

Provider	Screening/ Admission/ Assessment	Individual Tx, Recovery Plan & Documentation	Discharge/ Continuity of Care	Total Score for Provider
[redacted]	63.89%	71.67%	100%	**74.58%**
[redacted]	33.33%	57.69%	50%	**48.46%**
[redacted]	56.25%	50%	100%	**61.36%**
[redacted]	50%	71.05%	100%	**67.65%**
[redacted]	61.11%	57.14%	0%	**56.45%**
[redacted]	55.56%	45%	100%	**52.50%**
[redacted]	44.23%	44.44%	50%	**40.70%**
[redacted]	58.33%	50%	87.50%	**57.95%**
Average Score (All Providers)	**52.84%**	**55.87%**	**73.44%**	**57.45%**

Average performance dropped considerably between FY20 Q4 and FY21 Q4 retrospective reviews of residential treatment services, most noticeably with regard to the quality of clinical documentation such as screenings, assessments, and treatment plans. One possible causal factor could be provider understaffing and high staff turnover due to the ongoing COVID-19 pandemic.



Typically, such low scores would trigger a referral to the MSHN treatment team for Technical Assistance in the areas where providers performed poorly. All 8 providers that were reviewed during this quarter struggled in the domains of Screening, Admission, Assessment and Individual Treatment, Recovery Planning and Documentation. Rather than perform individual TA with each provider, the UM team will develop a training to address the identified areas of deficiency which will be offered to these providers specifically as well as the full provider network. Additionally, the statewide required implementation of the ASAM Continuum Assessment is expected to correct the identified deficiencies in assessment documentation. TA referrals will be made for 3 of the 8 providers who have previously received technical assistance in these areas (Flint Odyssey House, Saginaw Odyssey House, Sacred Heart). Additional technical assistance will be given and the providers will be monitored for implementation of corrective action.

Recommendations & Next Steps

- **Q4 Recommendation (NEW): Generate Technical Assistance (TA) referrals to the Treatment team for the following providers as a result of the Q4 retrospective review activity:**

- **Q4 Recommendation (NEW): UM team to develop network wide training on conducting clinical access screenings (Level Of Care Determinations) for CMHSPs and SUDSPs to be offered during FY22 Q1-Q2.**

Environmental Scan

Internal: Department Workflow

UM phone call dashboards in Power BI were completed during Q4. The dashboards will be used to track metrics related to incoming calls to the UM Department. The data will be used in several ways:

- **Monitor incoming call volume and implications for staff time/availability**
- **Assess distribution of workload among UM specialists**
- **Monitor/address productivity as needed**
- **Ensure that call routing logic is functioning as intended so that calls are answered in a timely manner**
- **Identify if there are additional staffing needs related to access to services**
- **Identify any needed areas of improvement to ensure compliance with MDHHS Access Standards**

Month	Total Incoming Calls	Average Calls per Week
July	1510	377
August	1066	266
September	Not Available	Not Available

External: MDHHS Service Authorization Denials Quarterly Report

As previously reported, MDHHS implemented a new Service Authorization Denials report during FY21 which requires a quarterly submission from the PIHP containing aggregate data for the region. The report gathers information about adverse benefit determination notices that were issued to consumers as a result of service authorization denials. There were significant challenges with the initial submission for Q1 Q2, primarily because there was not an automated way to easily generate some of the required data points and not all CMHSPs were tracking all data points since there was no prior notification from MDHHS that reporting would be required. This resulted in significant time and effort to manually collect data retrospectively.

Following the submission of the Q1-Q2 report MSHN and the 11 CMHSPs that utilize PCE Systems as their electronic medical record vendor collaborated with PCE to develop an automated report to ensure consistent data collection and standard reporting. The report was not completely finalized and implemented in time for the Q3 report submission so the same challenges and data inconsistencies from the Q1-Q2 submission continued. The FY21 Q4 submission is due to MDHHS on 11/15/2021. The PCE automated report has been successfully implemented and it is expected that most of the data inconsistencies will be resolved.

The MSHN UM Department and MSHN Customer Service will continue to monitor subsequent quarterly reports and address any issues identified by MDHHS through the appropriate regional committee(s) (Utilization Management and/or Customer Service).

Next Quarter Focus

Retrospective Review Process

The MSHN UM department will continue to conduct retrospective reviews on a quarterly basis, focusing on different levels of care or types of service according to the following schedule:

Quarter	Outpatient	Intensive Outpatient/ Medication-Assisted Tx	Withdrawal Management	Residential
1	X			
2		X		
3			X	
4				X

SUD Units/Cost reports will be reviewed each quarter for the scheduled service type and provider agencies who are identified as regional outliers for that service type will be selected for targeted review. Additional targeted retrospective reviews could be triggered outside of the quarterly review schedule in response to potential overspending concerns, detection of significant utilization variance by a particular provider or group of providers, or according to other regional priorities and initiatives.

Population Health and Integrated Care Quarterly Report

July 2021 – September 2021 (FY21 Q4)

Prepared by: Director of Utilization & Care Management

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Attachment A: FY21 Performance Based Incentive Pool (PBIP) Contractual Requirements & Deliverables

Attachment B: FY21 Q4 WHAM Performance Metrics Report

Background & Purpose

Mid-State Health Network (MSHN) is committed to increasing its understanding of the health needs of individuals within its 21-county service region and finding innovative ways to achieve the goals of better health, better care, better value, and better provider systems by utilizing informed population health and integrated care strategies. MSHN and its regional partners have a number of specific population health and integrated care initiatives underway during FY21 as detailed in the MSHN 2020-2022 Population Health and Integrated Care Plan (midstatehealthnetwork.org). The primary objectives of this quarterly report are as follows:

1. Monitor adherence to the MSHN Population Health & Integrated Care Plan
2. Report progress toward MDHHS-PIHP contractual integrated health performance requirements
3. Describe other current population health and integrated care initiatives
4. Provide additional recommendations as necessary regarding organizational needs in the areas of population health and integrated care

Michigan Department of Health and Human Services (MDHHS)-Prepaid Inpatient Health Plan (PIHP) Contractual Integrated Health Performance Requirements

FY21 PIHP-Only Pay for Performance Measure(s)

Note: Please refer to Attachment A of this report for a full copy of the FY21 Performance-Based Incentive Pool (PBIP) contract requirements and deliverables

A. Identification of Enrollees who may be eligible for services through the Veteran's Administration

MSHN FY21 Q4 Progress: During Q4 the MSHN Veteran Navigator (VN) participated in 14 meetings with community veterans' coalitions and other stakeholders that serve veterans and their families. Outreach activities by the MSHN VN focus on increasing awareness of the availability of publicly-funded behavioral health and SUD treatment services and effective coordination with the Veteran's Administration.

The MSHN VN position was vacant during the month of September 2021, however has since been filled and the new VN will be onboarded during FY22 Q1.

B. Increased data sharing with other providers (sending ADTs through Health Information Exchange)

MSHN FY21 Q4 Progress: To achieve compliance with this performance metric at least one CMHSP within the PIHP region must submit Admission Discharge and Transfer (ADT) messages to the Michigan Health Information Network (MiHIN) electronic data exchange daily by the end of FY21. CEI CMH and LifeWays CMH became fully operational and began sending ADTs during the month of September, thus achieving full compliance for the region on this metric. Newaygo CMH is currently in the production phase with MiHIN and anticipates being fully operational during FY22 Q1. All other CMHSPs in the region are in various stages of planning and implementation, with full implementation for the region anticipated during FY22.

Additionally, throughout FY21 MSHN has been participating in a pilot project with MDHHS and MiHIN for sending ADT messages related to SUD services. During Q4, MSHN was one of three PIHPs to participate in initial testing. MSHN and the other PIHPs that participated in testing had concerns that the project's electronic consent management process was not fully compliant with 42 CFR Part 2 requirements for the handling of SUD treatment information. MDHHS and MiHIN are working to address the identified concerns prior to moving forward with continued testing. It is expected that testing will continue in FY22 Q1, at which time MSHN will seek a willing SUD provider partner to assist with the next stage of production.

C. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

MSHN FY21 Q4 Progress: This measure is informational-only for FY21 meaning there are no deliverables to submit to MDHHS, however it is expected that PIHPs will be performing data analysis to determine baseline performance and identify possible interventions to improve performance. There are two elements of initiation and engagement which are monitored:

- **IET – 14 Day:** The percent of adolescents and adults with a new diagnosis of alcohol or other drug abuse or dependence who initiate treatment through an inpatient admission, outpatient visit, intensive outpatient or partial hospitalization encounter, telehealth or medication treatment within 14 days of the diagnosis.
- **IET – 34 Day:** The percent of adolescents and adults who initiated treatment and who were engaged in any ongoing alcohol or other drug treatment within 34 days of the initiation visit.

One of the challenges with this performance measure is that MDHHS calculates the PIHP's performance rate using data for all Medicaid beneficiaries in the PIHP region, not just individuals served by a MSHN CMH or SUD provider. The reports MSHN developed to track this measure are limited to only data pertaining to persons served by MSHN CMH and SUD providers. Figures 1 and 2 below represent the differences in the rates of initiation and engagement between all Medicaid beneficiaries living in the PIHP region (MSHN CC360) and Medicaid beneficiaries who received SUD treatment through a MSHN-contracted provider (MSHN Served) in comparison to state and national averages.

Figure 1: IET - 14 Day

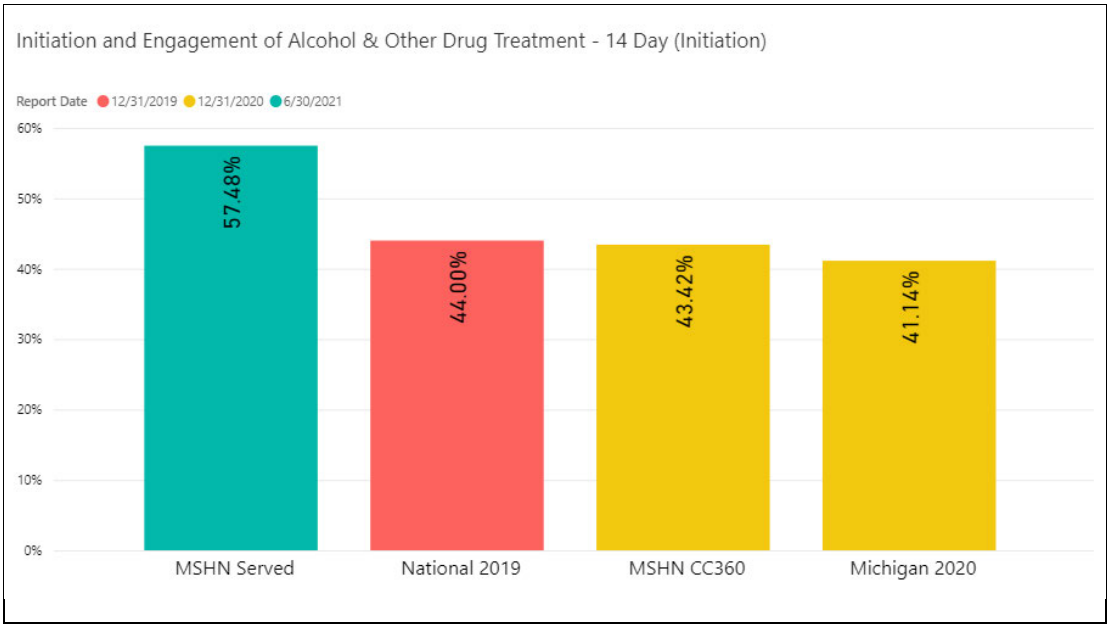
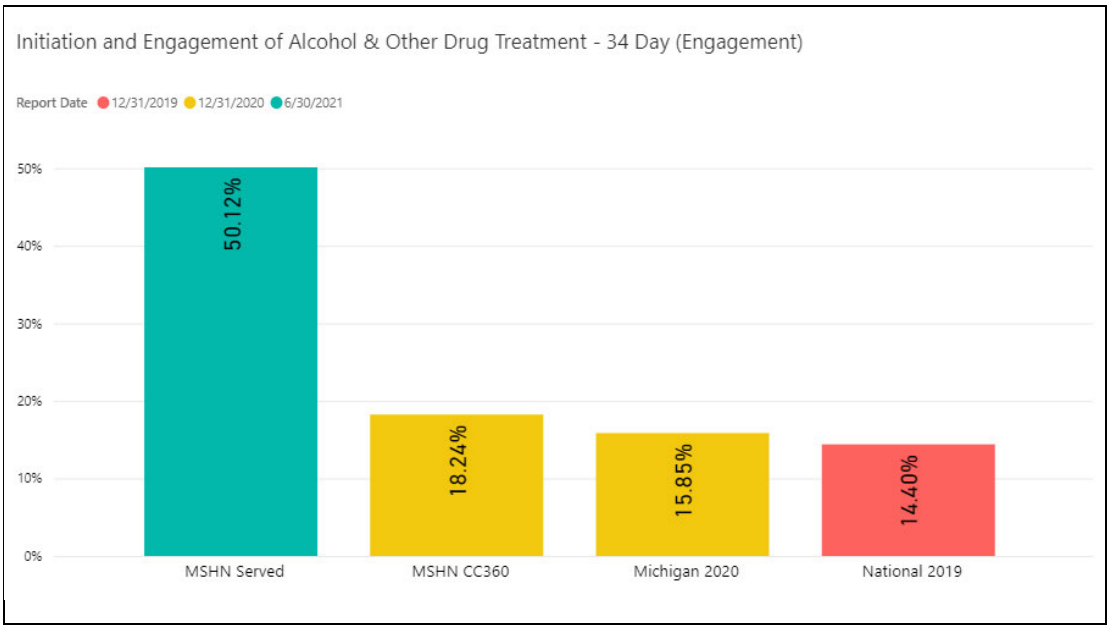


Figure 2: IET - 30 Day



MDHHS acknowledges that PIHPs do not have access to the full data set for this performance measure, which is one of the primary reasons it has remained informational-only rather than having a set performance benchmark. MSHN will share IET performance data with SUD and CMH providers during FY22 to identify where disparities may exist and develop improvement strategies.

D. Increased Participation in Patient-Centered Medical Homes Narrative Report

MSHN FY21 Progress: MSHN Population Health & Integrated Care staff collaborated with the regional Clinical Leadership Committee in FY21 Q4 to gather updates about CMHSP efforts and achievements for inclusion in the FY21 Narrative Report submission. The FY21 narrative report was submitted to MDHSS by the required deadline. A copy of the FY21 Narrative Report can be found on the MSHN website:
Population Health & Integrated Care - Mid-State Health Network (midstatehealthnetwork.org)

FY21 Medicaid Health Plan (MHP)/PIHP Joint Metrics

Note: Please refer to Attachment A of this report for a full copy of the FY21 Performance-Based Incentive Pool (PBIP) contract requirements and deliverables

MSHN integrated health staff participate in the MDHHS MHP-PIHP Joint Metrics Quality Workgroup on a bi-monthly basis. The focus of the workgroup is to review joint metrics data and provide feedback related to setting performance benchmarks for FY22. A workgroup meeting was held on 9/27/2021 during Q4, at which time MDHHS provided an updated scoring methodology that will be used to calculate racial/ethnic health disparities for the FY21 joint performance metrics.

Additionally, MSHN and United Health co-chair a voluntary statewide workgroup of MHP-PIHP representatives. The focus of the voluntary workgroup is a collaborative effort to develop workflows and processes with one another that support and operationalize the integrated health contractual requirements. Workgroup meetings were held on 7/22, 8/26, and 9/23 during Q4. One of the primary accomplishments of the workgroup during FY21 was a revision of the risk criteria which are used to identify individuals for care management between the PIHP and Medicaid Health Plan (Joint Care Management Process described below). The revised risk criteria include additional factors such as homelessness and substance use and offer enhanced ability to identify more individuals who may benefit from care management.

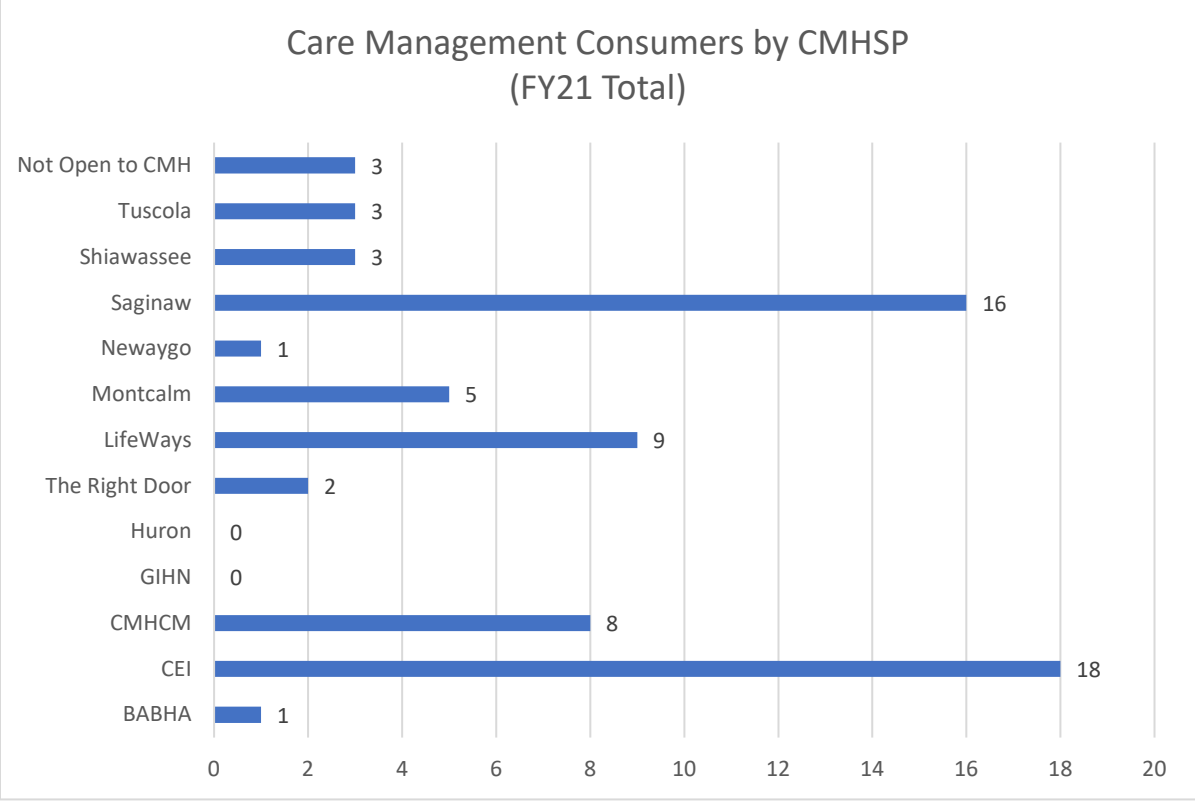
A. Implementation of Joint Care Management Processes

MSHN FY21 Q4 Performance: On a monthly basis MSHN participates in care coordination meetings with each of the 8 Medicaid Health Plans (MHP) that operate within the PIHP's 21-county region. Mutual members are identified using risk-stratification criteria such as multiple chronic physical and behavioral health conditions, high levels of emergency department and

inpatient utilization, and lack of engagement with a primary care provider. Joint care plans are developed to strengthen coordination between payors and providers in order to meet members' complex needs.

MSHN had open care plans for 70 individuals during FY21. All individual care plans are reviewed and discussed with the corresponding Medicaid Health Plans each month during care coordination meetings. Monthly written updates are provided in CC360 for all open care plans. The distribution of individuals with open care plans during FY21 among CMHSPs is represented in Figure 3 below. Of note, there were no individuals identified from Huron Behavioral Health or Gratiot Integrated Health who met the established risk criteria during FY21. As noted above, revised risk criteria will be used during FY22 which will offer an enhanced ability to identify more individuals.

Figure 3: Number of Consumers involved in Joint Care Management Process with Medicaid Health Plans by CMHSP



B. Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days

MSHN FY21 Q4 Performance: The MSHN Quality Improvement Council (QIC) provides a quarterly report on this performance measure and participates in quality improvement activities when adverse trends are identified. In order to meet the new requirement for FY21 to reduce racial disparities for this metric, QIC also conducts a quarterly data analysis to determine if racial/ethnic disparities exist in the region. If racial/ethnic group disparities are identified for the region during a given quarter, MSHN staff will perform additional data analysis at the CMHSP level. Each CMHSP demonstrating a significant racial/ethnic disparity will be required to complete an improvement plan identifying any individual or system issues that may have impacted the performance.

The FUH data analysis for Q4 is not yet finalized by Quality Improvement Council, however during Q3 the total combined performance of all CMHSPs in the MSHN region exceeded the benchmark rates of 70% follow-up for Children and 58% follow-up for Adults. There are no statistically significant racial/ethnic disparities during Q1-Q3 of FY21.

MSHN staff and the regional Quality Improvement Council (QIC) will continue to review the data each quarter to ensure follow up is occurring for all individuals as well as continue to review the minority population disparities. When the MSHN region demonstrates a disparity between the minority rate and the white rate additional analysis will be completed to determine where improvement efforts should be focused. This will include an analysis of both the Medicaid Health Plan and the CMHSP participants' minority population groups and the index (white) groups.

C. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

MSHN FY21 Q4 Performance: MSHN does not currently have access to event level data for hospital emergency department (ED) use when the reason for the visit is related to substance use disorders. Without event level data it is difficult to monitor this metric in "real time" and take immediate action. Data is provided to PIHPs by MDHHS retrospectively, usually 3-6 months after the ED visit occurred. The most recent data provided by MDHHS is for a 12-month period of time from 4/01/2020 – 3/31/2021. The following table represents MSHN regional performance rates compared to statewide total performance rates for all Medicaid beneficiaries.

Race/Ethnicity	MSHN Rate	Statewide Rate
TOTAL POPULATION	28.30%	26.98%
AFRICAN AMERICAN / BLACK	17.66%	14.05%
AMERICAN INDIAN / ALASKA NATIVE	31.51%	34.77%
ASIAN AMERICAN	10.00%*	5.77%*

HISPANIC	22.86%	24.50%
NATIVE HAWAIIAN & OTHER PACIFIC ISLANDER	60%*	36.36%*
WHITE	30.46%	32.76%

**Does not meet minimum population requirements (30 persons) to be included in MDHHS performance calculations*

PIHPs have continued to advocate for improvement efforts around the ability to obtain real time data. During FY21 Q4 MDHHS made modifications in Care Connect 360 so that a report can be generated to identify ADTs for SUD-related ED visits. During FY22 Q1 MSHN will begin monitoring weekly ADT reports to identify more focused strategies for portions of the region where follow-up rates might be lower for specific populations. This data analysis will be shared with CMHSP participants to inform strategies in their local communities.

MSHN and its CMHSP participants and SUD service providers have implemented a number of population level strategies to improve follow up care for individuals after they visit the ED for alcohol or substance-related issues. Population level interventions during FY21 Q4 included:

- Project ASSERT – Project ASSERT is a model of early intervention, screening, and referral to treatment for individuals in hospital and primary care settings. MSHN-funded peer recovery coaches trained in Project ASSERT are currently located in hospital emergency departments in 13 counties in the MSHN region. Individuals who present to the hospital ED with substance-related concerns are offered the opportunity to speak with a Project ASSERT peer recovery coach who offers appropriate referrals and and follow-up support.

***2,147 individuals** received screening and follow-up support from Project ASSERT coaches in response to a substance-related hospital ED visit during FY 2021*

- Jackson County Engagement Center – The Home of New Vision Engagement Center in Jackson County is an innovative program where individuals can stay for 24-48 hours and receive support from SUD counselors and peer recovery coaches who assist them with developing a plan for ongoing treatment services and support. When individuals present to the local hospital ED for issues related to SUD they are offered a referral to the Engagement Center if appropriate. During FY21 Q4 the Engagement Center admitted 107 individuals and provided screening and referral services to 154 individuals.

*During FY21 Q4 the Engagement Center admitted **107 individuals** and provided screening and referral services to **154 individuals***

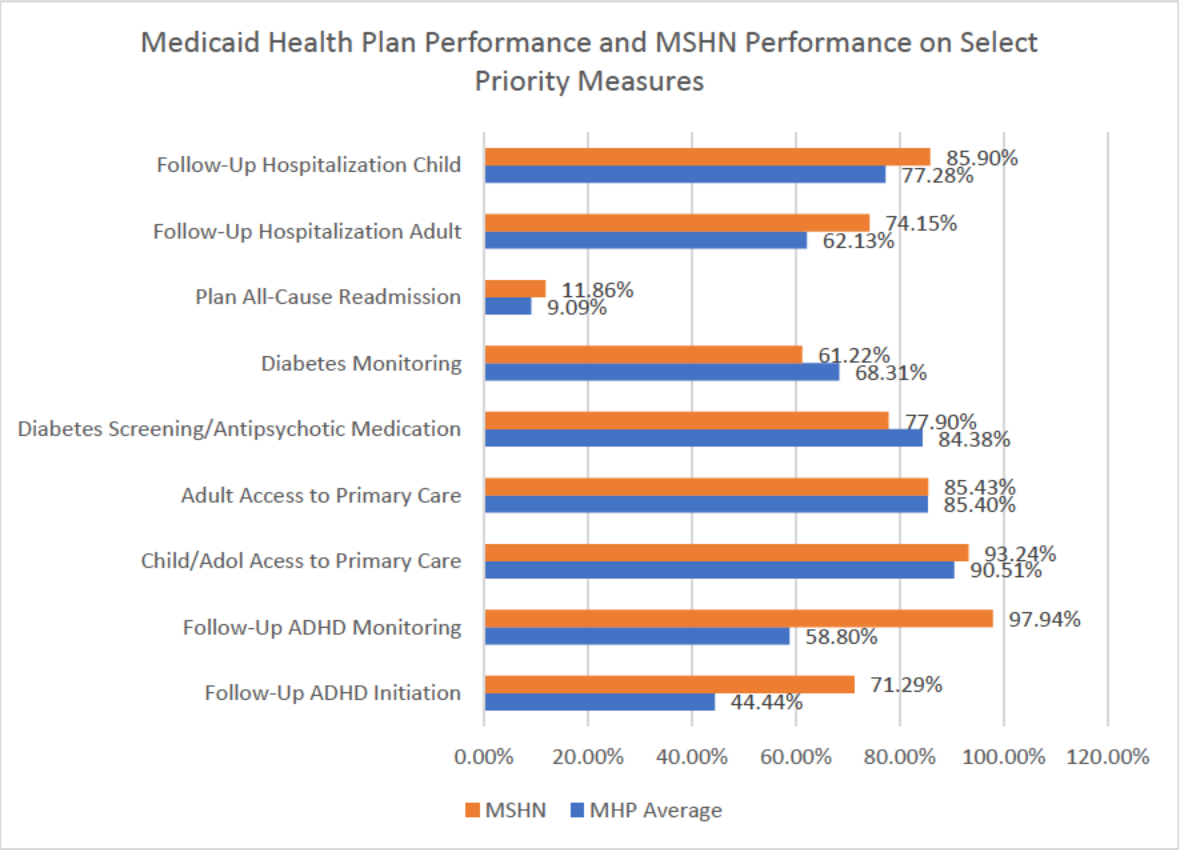
Other Population Health and Integrated Care Initiatives

Population Health and Integrated Care Measurement Portfolio

With input from its regional councils and committees, MSHN developed a performance measure portfolio based on national healthcare industry standards. MSHN utilizes data analytics software to monitor and track these measures regionally as well as by individual performance of each CMHSP. Metrics are reviewed quarterly by regional MSHN councils and committees for ongoing input into performance improvement strategies. Expanded descriptions for each performance measure, rationale for selection, and accompanying clinical protocols are contained in the MSHN 2020-2022 Population health and Integrated Care Plan

During FY 21 Q1-Q3 MSHN as a region continued to perform above Michigan Medicaid Health Plan (MHP) averages on 6 of 10 priority measures. The full 2020 HEDIS Performance Report for Michigan MHPs is available on the MDHHS website. Figure 4 depicts a comparison of Medicaid Health Plan average performance with MSHN regional performance during FY 21 Q1-Q3 on select Priority Measures. Data for FY 21 Q4 is not yet finalized.

Figure 4: Comparison of MSHN performance with Michigan Medicaid Health Plan performance on select priority measures



*(*Note: Although Cardiovascular Screening is included in the MSHN Measurement Portfolio it is not included in the Medicaid Health Plan Performance Report and thus is not depicted in this graph)*

Whole Health Action Management (WHAM)

MSHN was awarded FY21 Mental Health Block Grant (MHBG) funding for the purpose of providing training and professional development to its region-wide peer support specialist workforce as health coaches in order to support integrated behavioral health and physical health services for persons served. WHAM is a peer-support model developed by the National Council's SAMHSA-HRSA Center for Integrated Health Solutions to promote whole health self-management. Current health literature and research consistently identify numerous positive outcomes for individuals who practice chronic disease self-management.

MSHN contracted with the National Council for Behavioral Health to offer 3 train-the-facilitator opportunities in Whole Health Action Management (WHAM) during FY 2021 for peer support specialists working with adults with serious mental illness including those with co-occurring substance use

disorders. Trainings took place in November 2020, April 2021, and August 2021. Please see Attachment C for the Q3 WHAM Performance Metrics Report, which includes information on the number of peers who completed each training.

Health Equity & Social Determinants of Health

As indicated, MDHHS has incentivized PIHPs and MHPs to reduce racial disparities on integrated health performance metrics during FY21 (Follow-Up After Hospitalization for Mental Illness and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence.) Beyond contractual requirements to address racial and ethnic disparities, MSHN is committed to identifying and addressing other health disparities where they exist in the region and ensuring all individuals have the resources and opportunities needed to be healthy, especially if they belong to socially disadvantaged or marginalized groups.

MSHN and its regional councils, committees, and board of directors have been engaged in planning activities for the FY22-FY23 organizational Strategic Plan. MSHN is incorporating the following recommendations with support from its Board of Directors:

- Adoption of Health Equity as a regional strategic priority
- Establishment of a health equity advisory group
- Completion of an organizational diversity, equity, and inclusion (DEI) self-assessment and development of a workplan targeting areas for improvement
- Regional initiatives to address social determinants of health which may impact racial health disparities such as employment, housing, education, food security, transportation, and home broadband internet access.

SUD Value Based Purchasing (VBP)

Currently on hold due to SUD provider staffing shortages and other competing initiatives such as statewide implementation of the ASAM Continuum assessment tool. MSHN will continue internal planning activities during FY22 in order to prepare for future implementation of SUD VBP arrangements when the provider network stabilizes. Planning activities include:

- Review and identify performance metrics for specific types of services and levels of care (Examples: increased employment rate for individuals receiving recovery housing services, decreased re-admission rate to withdrawal management level of care)
- Evaluate alternate payment models (APMs) that incentivize quality outcomes over volume of service
- Continue to develop and enhance data collection and reporting for quality measures

Environmental Scan:

There are a number of initiatives developing simultaneously throughout Michigan with broad goals of improving integrated behavioral health and physical health care experiences and health outcomes for Medicaid/Healthy Michigan Plan beneficiaries. The following table provides a summary of key initiatives (not meant to be an exhaustive list), MSHN level of involvement, and planning considerations.

INITIATIVE	DESCRIPTION	MSHN INVOLVEMENT	PLANNING CONSIDERATIONS
Complex Care Management for Unenrolled	Proposal for PIHPs/CMHSPs to provide complex care management for individuals who are not enrolled in a Medicaid Health Plan	PIHPs submitted proposal to BHDDA in May 2021; currently awaiting response from BHDDA.	If proposal is accepted by BHDDA MSHN will work with applicable regional councils/committees to develop policies, procedures, and processes. Consider data needs for outcome reporting
SAMHSA Certified Community Behavioral Health Clinic (CCBHC) "EXPANSION GRANTS"	Planning grants awarded to CEI CMH, Saginaw CMH, and LifeWays CMH for infrastructure development to meet requirements as a CCBHC	There is no formal PIHP role in Expansion grants, however CCBHC sites must coordinate with PIHPs as the payer for SUD services.	MSHN will provide support as needed/requested by CCBHC sites in the areas of population health and care coordination (especially as it relates to coordination with SUD service providers)
State of Michigan Center for Medicare/Medicaid Services (CMS) CCBHC Demonstration Project	Limited to organizations certified by MDHHS during the 2016 CCBHC planning grant. CCBHC demonstration project sites within MSHN region include CEI CMH, Saginaw CMH, The Right Door	The MDHHS CCBHC handbook identifies responsibilities for PIHP including quality reporting, pass-through payments and reconciliation, beneficiary enrollment in the Waiver Support Application (WSA), and care coordination	10/1/2021 was the "go live" date for the demonstration project. MSHN continues to meet regularly with the 3 CMHSP CCBHC sites to identify and address operational challenges.

Summary & Next Quarter Focus:

MSHN and its CMHSP participants are currently involved in a number of population health and integrated care initiatives including MDHHS contractual requirements, PIHP strategic priorities, and innovative pilot projects. Activities during FY22 will focus on the following:

- Quarterly health equity data analysis for PIHP/MHP joint performance metrics; results of data analysis will be shared with CMHSP participants and MHPs
- Continue internal planning activities for future SUD Value Based Purchasing (VBP) pilot projects
- Continue regular project implementation meetings for CCBHC demonstration project in collaboration with the 3 CMHSP CCBHC site locations, including assessment of MSHN resource and staffing needs to support CCBHC activities

utilized to cover a funding deficit only after that fund sources risk reserve has been fully utilized. The surplus funds must be used before the ISF can be utilized.

b. While there is flexibility in month-to-month expenditures and service utilization related to the different funding sources in MMSSSP, the Contractor must submit encounter data on service utilization - with transaction code modifiers that identify the service for each specific MMSSSP program. The encounter data (including cost information) will serve as the basis for future MMSSSP capitated rate development.

6. Capitated Payments and Other Pooled Funding Arrangements
Medicaid funds may be utilized for the implementation of, or continuing participation in, locally established multi-agency pooled funding arrangements developed to address the needs of beneficiaries served through multiple public systems. Medicaid funds supplied or expensed to such pooled funding arrangements must reflect the expected cost of covered Medicaid services for Medicaid beneficiaries participating in or referred to the multi-agency arrangement or project. Medicaid funds cannot be used to supplant or replace the service or funding obligation of other public programs.
7. OHH Payments
The State will provide a monthly case rate to the Contractor based on the number of OHH beneficiaries with at least one OHH service during a calendar month. The Contractor will reimburse the OHHP for delivering health home services. Depending on the current services provided by the OHHP, the Contractor can negotiate a rate with the OHHP while following the guidelines below, requirements in the approved SPA, Policy 2006-BHDDA, and the OHH Handbook.
8. BHH Payments
The State will provide a monthly case rate to the Contractor based on the number of BHH beneficiaries with at least one BHH service during a calendar month. The Contractor will reimburse the HHP for delivering health home services. Depending on the current services provided by the HHP, the Contractor can negotiate a rate with the HHP for value-based payment (VBP) while following the requirements in the approved SPA, policy, and the BHH Handbook.

C. MIChild
The State will provide the federal and matching share of MIChild funds as a capitated payment based upon actuarially sound Per Enrolled Child Per Month (PECPM) methodology for MIChild-covered mental health services. The MIChild capitation payment will be scheduled and/or adjusted to occur monthly. When applicable, additional payments may be scheduled.

D. Contractor Performance Bonus
Contract withholds and the Performance Bonus Incentive Program have been established to support program initiatives as specified in the MDHHS Medicaid Quality Strategy.

1. Withhold Arrangements
   a. The State will withhold 0.2% of BHMA, BHMA-MHP, BHHMP, and BHHMP-MHP capitation payments to the Contractor. The withheld funds will be issued to the Contractor in the following amounts within 60 days of when the required report is received by the State:
      i. 0.04% for timely submission of the Projection Financial Status Report – Medicaid
      ii. 0.04% for timely submission of the Interim Financial Status Report – Medicaid
      iii. 0.04% for timely submission of the Final Medicaid Contract Reconciliation and Cash Settlement
      iv. 0.04% for timely submission of the Encounter Quality Initiative
      v. 0.04% for timely submission of encounters (defined in Schedule E)
   b. Performance Bonus Incentive Pool (PBIP)
      i. Withhold and Metrics
      The State will withhold 0.75% of BHMA, BHMA-MHP, BHHMP, BHHMP-MHP, HSW-MC, CWP-MC, and SEDW-MC payments for the purpose of establishing a PBIP. Distribution of funds from the PBIP is contingent on the Contractor's results from the joint metrics, the narrative report, and the Contractor-only metrics referenced below.
      ii. Assessment and Distribution
      PBIP funding awarded to the Contractor will be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system. The 0.75% PBIP withhold will be distributed as follows:
         a. Contractor-only Pay for Performance Measure(s): 30%
         b. Contractor Narrative Reports: 40%
         c. MHP/Contractor Joint Metrics: 30%
         d. The State will distribute earned funds by April 30 of each year.
   c. OHH Benefit
   The State will withhold 5% of monthly case rate payments to the Contractor. The State will distribute pay for performance payments to the Contractor within one year of the end of the performance year. The Contractor must distribute pay for performance monies to OHHPs that meet the quality improvement benchmarks in accordance with the timelines and processes which can be found in the OHH Handbook at the following

website: https://www.michigan.gov/documents/mdhhs/OHH_Handbook_V1.3_7-17-2018_630838_7.pdf. The State will only claim federal match once it determines quality improvement benchmarks have been met and providers have been paid. If quality improvement benchmarks are not met by any of the OHHPs within a given performance year, the State share of the withhold will be reserved and reinvested for OHH monthly case rate payments. Subsequent performance years will operate in accordance with this structure.

d. BHH Benefit
The State will withhold 5% of monthly case rate payments to the Contractor. The State will distribute pay for performance payments to the Contractor within one year of the end of the performance year. The Contractor must distribute pay for performance monies to BHHPs that meet the quality improvement benchmarks in accordance with the timelines and processes which can be found in the BHH Handbook at the following website: www.michigan.gov/BHH. The State will only claim federal match once it determines quality improvement benchmarks have been met and providers have been paid. If quality improvement benchmarks are not met by any of the BHHPs within a given performance year, the State share of the withhold will be reserved and reinvested for BHH monthly case rate payments. Subsequent performance years will operate in accordance with this structure.

2. Contractor-only Pay for Performance Measures (P1, P2, (P3 is informational only) = 30% of total withhold, P4 Narrative = 40% of total withhold).

Measure	Description	Deliverables
P.1. PA 107 of 2013 Sec. 105d (18): Identification of beneficiaries who may be eligible for services through the Veteran's Administration (50 points). The State acknowledges that not all Veterans interacted with by the Veteran Navigator and on the VSN will have a CMHSP contact and thus will not have a BH-TEDS file (50 points).	a. Timely submission of the Veteran Services Navigator (VSN) Data Collection form through DCH File transfer. b. Improve and maintain data quality on BH-TEDS military and veteran fields. c. Monitor and analyze data discrepancies between VSN and BH-TEDS data.	a. The measurement period for the VSN Data Collection form will be the current fiscal year. The VSN Data Collection form will be submitted to the State by the last day of the month following the end of each quarter. b. The measurement period for the BH-TEDS data quality monitoring will be October 1 through March 31. c. The Contractor must compare the total number of individual veterans reported on BH-TEDS and the VSN and conduct a comparison. By July 1, the Contractor must submit a 1-2-page narrative report on findings and any actions taken to improve data quality.
P.2. PA 107 of 2013 Sec. 105d (18): Increased data sharing with other providers (50 points)	Send ADT messages for purposes of care coordination through health information exchange.	At least one CMHSP within a Contractor's service area, or the Contractor, will be submitting Admission Discharge and Transfer (ADT) messages to the Michigan Health Information Network (MiHIN) Electronic Data Interchange (EDI) Pipeline daily by the end of FY21. By July 31, the Contractor must submit, to the State, a report no longer than two pages listing CMHSPs sending ADT messages, and barriers for those who are not, along with remediation efforts and plans. In the event that MiHIN cannot accept or process Contractor's ADT submissions this will not constitute failure on Contractor's part.
P.3. Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence No points, informational only	The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: -Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis. -Engagement of AOD Treatment: The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or Medication	This measure will be informational only. Data will be stratified by race/ethnicity and provided to the Contractor by the State. The Contractor is encouraged to track, trend and address statistically significant racial or ethnic groups. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2019 with July 1, 2020-June 30, 2021.

Measure	Description	Deliverables
	Assisted Treatment (MAT) within 34 calendar days of the initiation visit.	Note: The State recognizes the Contractor does not have a full data set for analyses.
P.4. PA 107 of 2013 Sec. 105d (18): Increased participation in patient-centered medical homes (40% of total withhold)	Narrative report summarizing participation in patient-centered medical homes (or characteristics thereof). Points for Narrative Reports will be awarded on a pass/fail basis, with full credit awarded for submitted narrative reports, without regard to the substantive information provided. The State will provide consultation draft review response to the Contractor by January 15th. The Contractor will have until January 31st to reply to the State with information.	The Contractor must submit a narrative report of no more than 10 pages by November 15th summarizing prior FY efforts, activities, and achievements of the Contractor (and component CMHSPs if applicable) to increase participation in patient-centered medical homes. The specific information to be addressed in the narrative is below: 1. Comprehensive Care 2. Patient-Centered 3. Coordinated Care 4. Accessible Services 5. Quality & Safety

3. MHP/Contractor Joint Metrics (30% of total withhold)
   Joint Metrics for the Integration of Behavioral Health and Physical Health Services
   To ensure collaboration and integration between Medicaid Health Plans (MHPs) and the Contractor, the State has developed the following joint expectations for both entities. There are 100 points possible for this initiative. The reporting process for these metrics is identified in the grid below. Care coordination activities are to be conducted in accordance with applicable State and federal privacy rules.

Category	Description	Deliverables
J.1. Implementation of Joint Care Management Processes (35 points)	Collaboration between entities for the ongoing coordination and integration of services.	Each MHP and Contractor will continue to document joint care plans in CC360 for beneficiaries with appropriate severity/risk, who have been identified as receiving services from both entities. Risk stratification criteria is determined in writing by the Contractor-MHP Collaboration Work Group in consultation with the State. Quarterly, the State will select beneficiaries at random and review their care plan in CC360.
J.2 Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days using HEDIS descriptions (40 points)	The percentage of discharges for beneficiaries six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.	1. The Contractor must meet set standards for follow-up within 30 Days for each rate (ages 6-17 and ages 18 and older. The Contractor will be measured against an adult minimum standard of 58% and a child minimum standard of 70%. Measurement period will be July 1, 2020-June 30, 2021. 2. Data will be stratified by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2019 with July 1, 2020-June 30, 2021. The points will be awarded based on MHP/Contractor combination performance measure rates. The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given entity. See MDHHS BHDDA reporting requirement website for measure specifications (query, eligible population, and additional details) and health equity scoring methodology, at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

Category	Description	Deliverables
J3. Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (25 points)	Beneficiaries 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days.	Data will be stratified by the State by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2019 with July 1, 2020-June 30, 2021. The points will be awarded based on MHP/Contractor combination performance measure rates. The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given entity. See MDHHS BHDDA reporting requirement website for measure specifications (query, eligible population, and additional details) and health equity scoring methodology, at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

FISCAL YEAR 2021 WHAM STATEMENT OF WORK & PERFORMANCE METRICS

Objective	Activity	Responsible Staff	Date Range for Activity to be Accomplished	Expected Outcome	Measurement
1. Development of peer specialists as health coaches to support integrated behavioral and physical healthcare for individuals with a serious mental illness including those with co-occurring substance use disorders	Whole Health Action Management Training: In partnership with the National Council for Behavioral Health, MSHN will offer 3 Train-The-Facilitator events during FY21. Each training event will accommodate up to 30 participants	Skye Pletcher, MSHN Director of Utilization & Care Management	All trainings conducted by September 2021. Approximate Dates (pending availability of National Council Staff/Trainers): November 2020 April 2021 August 2021	1. Increase the # of peers certified in WHAM in the MSHN region	70-90 peers will become certified in WHAM during FY21 Each of the 12 CMH organizations in the MSHN region will have 1 or more WHAM certified peers by September 2021 **Q1 Progress: 15 peers became certified in WHAM during Q1. 4 CMH organizations in the MSHN region had peers complete WHAM training during Q1.** **Q2 Progress: No new WHAM trainings held during Q2. There are 2 more trainings scheduled in April 2021 and August 2021** **Q3 Progress: 24 peers became certified in WHAM during Q3. 3 CMHSP organizations and 8 service provider organizations had**

FISCAL YEAR 2021 WHAM STATEMENT OF WORK & PERFORMANCE METRICS

					peers complete training during Q3 **Q4 Progress: 8 peers became certified in WHAM during Q4. 4 CMHSP organizations and 2 service provider organizations had peers complete training during Q4.**
2. Peers who complete training will effectively implement WHAM programming in their organizations	Develop & implement organizational policies/procedures that incorporate the use of WHAM materials, tools, and programming 8-week WHAM peer support group curriculum One-to-one peer support and health coaching	Skye Pletcher, MSHN Director of Utilization & Care Management CMHSP Clinical Service Directors WHAM-certified peer facilitators	Implementation throughout FY21 following completion of trainings; ongoing through FY22 MSHN evaluation and monitoring of implementation efforts during FY22 site review activity	1. Increased inclusion of whole health goals in person-centered planning for individuals with chronic conditions 2. Each of the 12 CMH organizations in the MSHN region will offer opportunities for participation in WHAM to individuals with serious mental illness including those with co-occurring substance use disorders during FY21-FY22	Relevant whole health goal(s) are included in person-centered planning for 90% or more of individuals who participate in WHAM programming, as evidenced by MSHN site review monitoring standards during FY22 Each of the 12 CMH organizations in the MSHN region will offer at least 1 cycle of the 8-week WHAM peer support group during FY21-FY22 **Q1 Progress: Not started this quarter. This objective will be addressed later in the fiscal year as more peers complete training and begin**

					implementation within their organizations **Q2 Progress: Not started this quarter. This objective will be addressed later in the fiscal year as more peers complete training and begin implementation within their organizations** **Q3 Progress: MSHN is developing a survey tool which will be administered during Quarter 4 to peers who became certified in WHAM during FY21. The survey tool will assess the level of implementation of WHAM and identify any barriers to effective implementation.** **Q4 Progress: Each of the 12 CMHSPs in the MSHN region now have peers trained in WHAM and report effective implementation of WHAM with persons served. Additionally, other service provider organizations have**

					implemented WHAM in a variety of settings: Peer recovery drop-in program, re-entry program for adults with mental illness being released from jail, sober transitional living program, and co-located integrated health clinic.

Introduction

Health Services Advisory Group (HSAG) contracts with the Michigan Department of Health and Human Services (MDHHS) to conduct an independent review of quality and outcomes, timeliness, and access to services provided by Mid-State Health Network (MSHN). The three EQR mandatory activities include the following: The Performance Measures Validation, The Compliance Review, and The Performance Improvement Project Validation. A quality improvement plan (QIP) including improvement goals and objectives in response to the external quality review should be incorporated into MSHN's Quality Assessment and Performance Improvement Program.

Validation of Performance Improvement Projects (PIP)

MDHHS requires that the Prepaid Inpatient Health Plan (PIHP) conduct and submit performance improvement projects (PIP) annually to meet the requirements of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid enrollees in PIHPs must be tracked, analyzed, and reported annually. A PIP provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves.

MSHN's Performance Improvement Project for 2018 through 2021 was *The percentage of Patient with Schizophrenia and Diabetes who had an HbA1c and LDL-C test during the measurement period.*

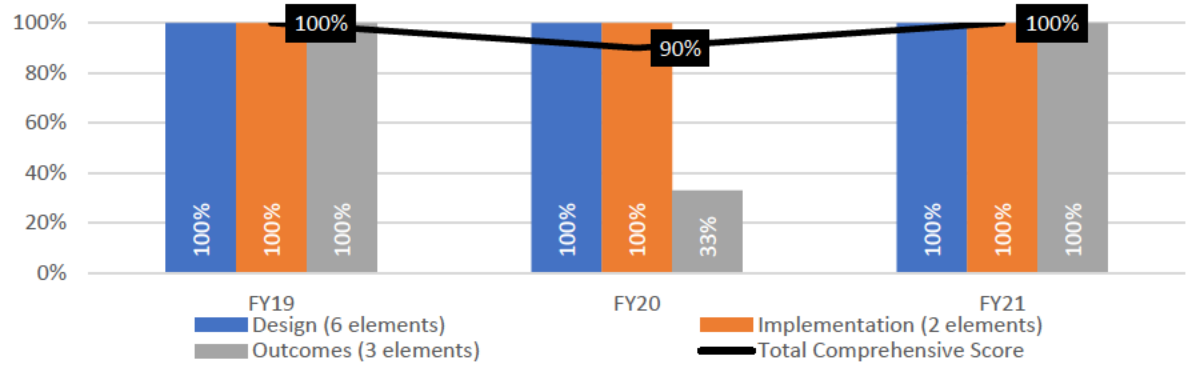
Date Summary Submitted 6.25.2021
Draft Report Received 7.19.2021
Date of Resubmission 8.12.2021
Final Report Received: 10.25.2021

Validation Findings

MSHN received a status of "Met" indicating High confidence in reported PIP results.
HSAG reviewed the PIP for 9 evaluation elements. MSHN received 100% for all elements.

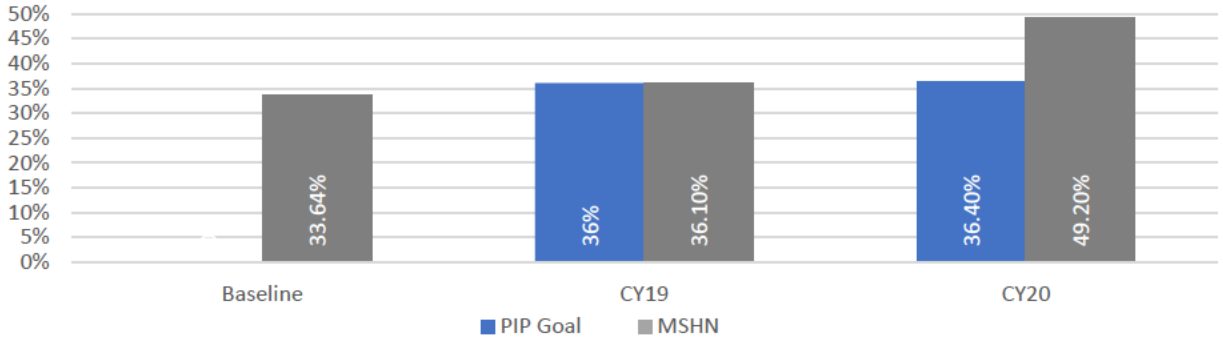
- Percentage Score of Evaluation Elements Met 100%
- Percentage Score of Critical Elements Met 100%

Figure 1. Performance Improvement Project Validation



FY20-Did not achieve statistically significant improvement.

Figure 2. Diabetes Monitoring



Data Analysis

Mid-State Health Network (MSHN) conducted a causal/barrier analysis following the first remeasurement period. It was determined that the service was billed to Medicare for those individuals who have dual coverage of Medicaid/Medicare.

- Sixty percent of the eligible population include individuals with dual coverage (Medicare /Medicaid).
- Seventy-three percent (241) of those not screened had dual coverage ((Medicare /Medicaid).
- The results of the lab work were dependent on the ability to receive the required evidence of the completed lab work from the physician offices, therefore promoting increased coordination among providers.

The Community Mental Health Specialty Program (CMHSP) participants utilized the care alert system in the Integrated Care Data Platform (ICDP) to determine who did not have a claim for a completed lab.

- A record review was completed for those who did not have a submitted claim to identify if a lab was ordered.
- If ordered, was it in the record or could it be obtained?
- If the results were in the record and a claim was submitted to Medicare the CMHSP entered a status of "addressed" into ICDP.
- If the required labs were not ordered the CMHSP would utilize/develop a process for coordination with the provider to obtain an order

The number of CMHSP participants who utilized the ICDP system to "address" labs increased from eight during the first measurement period to all twelve utilizing ICDP to "address" labs during the second measurement period.

Performance Measure Validation

The purpose of performance measure validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state and federal specifications and reporting requirements. According to CMS' *External Quality Review (EQR) Protocols, October 2019*,[1] the mandatory PMV activity may be performed by the state Medicaid agency, an agent that is not a PIHP, or an external quality review organization (EQRO).

The PMV is conducted through an evaluation of system compliance, an overview of data integration and control procedures, and primary source verification. The following activities beginning in March, led up to the final PMV Remote Review on June 22, 2021.

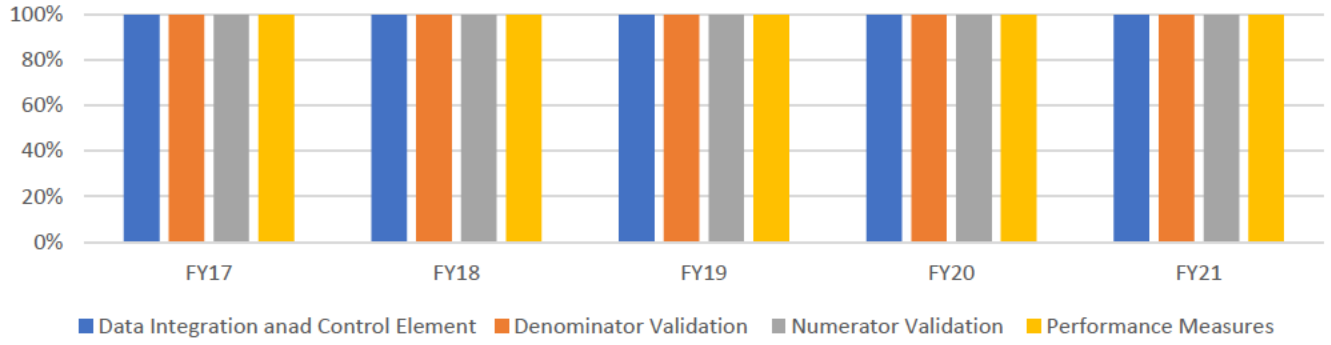
- Statewide PIHP Technical Assistance Webinar
- PIHP completion/submission of the PIHP ISCAT and supporting documentation
- PIHP submission of Member Level Detail File
- Source Code Review
- Primary Source Verification Desk Review

Draft Report Received 9.3.2021
Final Report Received: 9.30.2021

Validation Findings:
MSHN received a status of "Reportable" indicating the performance indicators were compliant with the State's specifications and the rate can be reported.

- The Data Integration and Control- Thirteen Standards 100%
- Denominator Validation -Seven Standards (2 NA) 100%
- Numerator Validation – Five Standards 100%
- Performance Measures-Fourteen Measures Fully Validated 100%

Figure 3. External Quality Review-Performance Measure Validation



Strengths:
MSHN proactively created supplemental materials to support staff interpretation and system configuration of the new MDHHS performance indicators and met with all CMHSPs in its region as a group to walk through the MDHHS

MSHN worked with the CMHSPs and PCE system to continuously evaluate opportunities for front-end data validation edits to reduce the amount of record review and validation needed prior to MDHHS submission. Codebook and supplemental materials prior to system configuration and staff training.

Growth Areas:
During PSV it was determined that one CMHSP (CEI) reported non-compliant cases as compliant for Indicator #3.
During PSV it was determined that one CMHSP (Newaygo) reported two non-Medicaid consumer cases for Indicator #1 and Indicator #3.

Recommendations:

- Mid-State Health Network should consider performing an additional validation of the quarterly submissions against its own encounter data prior to MDHHS submission to ensure that no-show appointments are not being confused for follow-up services.
- Mid-State Health Network should consider performing a final validation step of the quarterly submissions against its own eligibility data to ensure that all non-Medicaid consumers are excluded from the measures.
- 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.
- Mid-State Health Network confirm its reporting logic is accurately capturing new PIHP consumers for Indicators #2 (i.e., #2a–2e) and #3, as defined in the MDHHS Codebook (i.e., never seen by the PIHP for mental health services or for services for intellectual and developmental disabilities, or it has been 90 days or more since the individual has received mental health or I/DD services from the PIHP). This recommendation is not specific to Mid-State Health Network and is a universal recommendation for all PIHPs to ensure ongoing future accuracy of reporting the performance

Compliance Review

According to federal requirements located within Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the state, an agent that is not a Medicaid prepaid inpatient health plan (PIHP), or its external quality review organization (EQRO) must conduct a review within a three-year period to determine a Medicaid PIHP's compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post stabilization services requirements described in §438.114 and the quality assessment and performance improvement requirements described in §438.330.

The Compliance Review is conducted over a period of 3 years. HSAG conducted a review of the first 6 standards for year one(2021). The remaining 7 standards will be reviewed n year 2 (2022). The third-year is used for a focused review on those standards that received a "not met" the previous two years resulting in a corrective action plan. The third year (2023) score is the score of all standards after the CAP has been completed.

The following activities beginning in March led up to the final Compliance Review on July 19, 2021.

- Technical Assistance Webinar
- Submission of universe files for service authorizations
- Submission of case files for service authorization (10)
- Submission of completed compliance review tools
- Submission of checklists
- Submission of Supporting Documentation

Changes in 2021

Health Services Advisory Group modified the tools to align with Federal Managed Care Final Rule.
The compliance review standards in Michigan were reduced from 17 standards to 13 standards.

The standards for Staff Qualifications and Training; and Disclosure of Ownership, Control and Criminal Convictions were removed. Standards related to the validation of the Network Adequacy were included.

Figure 4. Crosswalk of new standards

Previous Standards	New Standards
Standard I—QAPIP Plan and Structure (8)	**Standard XIII**—Quality Assessment and Performance Improvement Program
Standard II—Quality Measurement and Improvement (8)	
Standard III—Practice Guidelines (4)	**Standard XI**—Practice Guidelines
Standard IV—Staff Qualifications and Training (3)	n/a
Standard V—Utilization Management (16)	**Standard VI**—Coverage and Authorization of Services (11)
	Standard II—Emergency and Post stabilization Services (10)
Standard VI—Customer Service (39)	**Standard I**—Member Rights and Member Information
Standard VII—Grievance Process (26)	**Standard IX**—Grievance and Appeal Systems
Standard VIII—Members' Rights and Protections (13)	**Standard I**—Member Rights and Member Information (19)
Standard IX—Subcontracts and Delegation (11)	**Standard X**—Subcontractual Relationships and Delegation
Standard X—Provider Network (12)	**Standard VII**—Provider Selection
Standard XI—Credentialing (9)	
Standard XII—Access and Availability (19)	**Standard III**—Availability of Services (7)
	Standard IV—Assurances of Adequate Capacity and Services (4)
Standard XIII—Coordination of Care (11)	**Standard V**—Coordination and Continuity of Care (14)
Standard XIV—Appeals (54)	**Standard IX**—Grievance and Appeal Systems
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions (14)	n/a
Standard XVI—Confidentiality of Health Information (10)	**Standard VIII**—Confidentiality
Standard XVII—Management Information Systems (14)	**Standard XII**—Health Information Systems

Draft Report Received 9.17.2021
Final Report Received: November 1, 2021
Corrective Action Plan Due: December 1, 2021

Total Comprehensive Score 85%
Standard I-Member Rights and Member Information 19 elements - 84%
Required actions based on findings:

- The PIHP must ensure that written materials that are critical to obtaining services include all the requirements identified in this element.
- The PIHP must make a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen regularly by, the terminated provider. Notice to the member must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.

Recommendations:

- PIHP consider including the evaluation of the CMHSPs' tracking mechanisms for member requests for translation of informational materials, and routine analysis of the linguistic needs of members to the PIHP's Annual Delegated Managed Care monitoring tool.
- According to CMS guidance provided in the 2016 Medicaid Managed Care Rule pertaining to provider directories, CMS proposed that "provider directories be made available on the MCO's, PIHP's, PAHP's, or if applicable, PCCM entity's Web site in a machine readable file and format specified by the Secretary." While not specifically identified in the Medicaid Managed Care Rule, "machine-readable file" is defined by the Hospital Price Transparency Final Rule as: "A digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of machine-readable formats include, but are not limited to, .XML, .JSON and .CSV formats." Although the PIHP received a score of Met for this element, HSAG strongly recommends the PIHP implement a process to routinely evaluate and confirm its provider directory posted to its website is in a machine-readable format. The PIHP's implementation of HSAG's recommendation will be reviewed during future compliance reviews, and the PIHP may receive a score of Not Met if not adequately addressed.

<u>Standard II-Emergency Post stabilization Services 10 elements - 100%</u>

Recommendations: This was a new standard this year. The recommendation applies to all standards.

- PIHP develop a written procedure specific to behavioral health/SUD emergency and post stabilization services. This procedure should consider all federal requirements and how they apply to the scope of services provided by and financial responsibilities of the PIHP. Additionally, the PIHP should consider how these requirements apply to the emergency room and hospital setting versus emergency services obtained through community provider locations

<u>Standard III-Availability of Services 7 elements - 71%</u>

Required action based on findings

- The PIHP must require out-of-network providers to coordinate with the PIHP for payment and ensure the cost to the member is no greater than it would be if the services were furnished within the network, including a prohibition on balance billing in compliance with 42 CFR §438.106, 42 CFR §438.116, and the Medicaid Provider Manual.
- The PIHP must meet and require its network providers to meet MDHHS' standards for timely access to care and services and establish mechanisms to regularly monitor compliance and take corrective action if there is a failure to comply. This should apply to all screening and appointment standards in addition to those reported through MMBPIS.

Recommendations:

- PIHP educate its staff members and update policy, as needed, to ensure a member's right to a second opinion as required under the federal managed care rule is widely understood in addition to a member's right to a second opinion for the denial of eligibility and the denial of inpatient hospitalization required under the Michigan Mental Health Code.

- The PIHP should specifically include in its SCA a prohibition on balance billing. Additionally, while PIHP staff members could speak to sub-elements (a)–(c), HSAG recommends that these requirements are clearly reflected in the PIHP's policies, procedures, oversight and monitoring documentation, or other materials, as applicable.
- PIHP include a provision within its provider contracts prohibiting providers from offering hours of operation that are less than the hours of operation offered to commercial members or not comparable to Medicaid fee-for-service (FFS), if the provider serves only Medicaid members.

Standard IV-Assurances of Adequate Capacity and Services 4 elements - 25%

Required actions based on findings:

- The PIHP must give assurances to MDHHS and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with MDHHS' standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1).
- The PIHP must submit its assurances of adequacy capacity to MDHHS annually and at any time there has been a significant change, including changes in PIHP services, benefits, geographic service area, composition of or payments to its provider network, or for the enrollment of a new population in the PIHP.
- The PIHP must maintain plan on how network adequacy standards will be effectuated in its region. The PIHP's plan must consider at least the following parameters: maximum time and distance; timely appointments; and language, cultural competence, and physical accessibility

Recommendations:

- The PIHP should work with MDHHS to determine when the annual submission of its assessment of adequate capacity, in accordance with MDHHS' defined network adequacy standards, should be submitted.
- HSAG recommends the PIHP has a documented process to ensure that MDHHS is notified within seven days of any changes to the composition of the provider network organizations that negatively affect access to care. HSAG also recommends the PIHP enhance written procedures to address network changes that negatively affect access to care that should consider various action steps such as an assessment of the impact of the change, addressing the health and safety of members, addressing gaps in member access to care, seeking out-of-network providers, recruitment and retention of providers, and identifying roles and responsibilities of various PIHP departments/staff, etc. Additionally, the PIHP's process should consider other changes in the composition of its provider network in addition to provider terminations (e.g., temporary closures, relocation of a provider).

Standard V-Coordination and Continuity of Care 14 elements - 93%

Required action based on findings:

- The PIHP must establish conflict of interest standards for the assessments of functional need and the person-centered service plan development process that apply to all individuals and entities, public or private.

Recommendations:

- PIHP explicitly clarify that a review of signed release of information forms or a statement that the member has refused is included in the PIHP's review as well as the primary care physician's name and address.
- PIHP's policies appropriately reflect the HCBS Final Rule and the requirements should there be a modification to a member's freedom and rights afforded under the HCBS Final Rule and the required documentation that must be included in the service plan. The PIHP's processes should clarify expectations for when a modification is imposed due to a physical need or due to the restrictions of another individual residing in the home.
- PIHP create a written procedure specific to conflict-free case management and the safeguards in place to avoid conflicts of interest (and/or ensure its provider network has the necessary written procedures and safeguards in place). The PIHP should ensure its provider network complies with and understands these provisions. Additionally, the PIHP should ensure that case managers specifically receive training on conflict-free case management.

Standard VII-Coverage and Authorization of Services 11 elements - 91%

Required action based on findings:

- The PIHP's ABD notices must include the content requirements of 42 CFR §438.404.

Recommendations:

- PIHP should consider implementing a standardized interrater reliability process that includes standardized test case scenarios, reviewing the performance of each individual authorization decision-maker and taking corrective action when appropriate, and using the overall interrater reliability results to conduct targeted training and update policies and processes, as necessary, to improve the consistency in authorization decision-making.
- HSAG recommends the PIHP and its CMHSPs develop a mechanism to confirm staff awareness, such as an affirmation or attestation that utilization management staff members making authorization decisions are required to sign upon employment and annually specifying they understand they will not be incentivized for denying, limiting, or discontinuing medically necessary services to any member.

Next Steps

- MSHN will develop a Performance Improvement Project for FY22-FY25 to address Racial Disparities, as required by MDHHS, for validation by HSAG.
- MSHN will develop a corrective action plan based on the Final Compliance Review Report to be submitted by December 1, 2021.
- Goals and objectives to address the External Quality Review findings and relevant recommendations will be added to the QAPIP Work Plan for FY22.

Delegated Managed Care & Program Specific Site Review Summary Report 2021

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CMHSP Delegated Managed Care Review (DMC)

QAPI conducted Delegated Managed Care (DMC) reviews for nine of the twelve (9/12) Community Mental Health (CMH) agencies within the region in FY21. Full reviews include a full programmatic review of policies, procedures, and sample files and charts.

Delegated Managed Care Review Tool

Includes review of 192 standards. The focus of this section is to ensure compliance with requirements. Overall compliance for this timeframe is 95.45%.

Table 1: Delegated Managed Care Tool

DMC Standards	# Of Standards	2021 Results
Information Customer Service	13	99.57%
Enrollee Rights and Protections	9	100%
24/7/365 Access	17	94.81%
Provider Network Sub-Contract Providers	14	100%
Service Authorization and UM	7	96.83%
Grievance and Appeals	20	99.06%
Person Centered Planning	30	99.81%
Coordination of Care/Integration	6	96.30%
Behavior Treatment Plan Review Committee	21	77.51%
Consumer Involvement	3	100%
Provider Staff Credentialing	22	91.08%
Quality and Compliance	7	100%
Ensuring Health and Welfare	8	96.03%
Information Technology	9	100%
Trauma Informed Care	6	99.07%
Overall		**95.45%**

Scores represent Jan 1- Sept 30, 2021, as QAPI transitions reporting to Fiscal Year from Calendar Year.

Program Specific (PS) Non-Waiver Review Tool

Includes review of fifty-eight (58) standards. The focus of this section is to ensure compliance with requirements. Overall compliance for this timeframe is 95.42%.

Table 2: Program Specific Non-Waiver Tool

PS Non-Waiver Standards	# Of Standards	2021 Results
ACT	5	100%
Self-Direction/Self-Determination	8	100%
Peer Delivered and Operated (Drop In)	2	100%

Home-Based Services	6	100%
Clubhouse	7	100%
Crisis Residential	10	100%
Targeted Case Management	4	100%
Autism/ABA	9	82.72%
Children's Intensive Stabilization Services	7	94.44%

Scores represent Jan 1- Sept 30, 2021, as QAPI transitions reporting to Fiscal Year from Calendar Year.

Program Specific (PS) Waiver Review Tool

Includes review of forty-five (45) standards. The focus of this section is to ensure compliance with requirements. Overall compliance for this timeframe is 95.88%.

Table 3: Program Specific Waivers Tool

PS Waiver Standards	# Of Standards	2021 Results
Habilitation Supports Waiver	7	99.12%
Home and Community Based Services	14	96.43%
Children's Waiver Program	12	96.43%
Severe Emotional Disturbances Waiver	12	92.63%

Scores represent Jan 1- Sept 30, 2021, as QAPI transitions reporting to Fiscal Year from Calendar Year.

Clinical Chart Review Tool

Includes review of eighty-five (85) standards. The focus of this section is to ensure compliance with requirements. Overall compliance for this timeframe is 93.11%.

Table 4: Clinical Chart Review Tool

Clinical Chart Standards	# Of Standards	2021 Results
Intake/Assessment	13	96.01%
Pre-Planning	10	87.91%
PCP/IPOS	21	92.37%
Documentation	3	100%
Customer Service	5	95.58%
Delivery and Evaluation	3	89.25%
Service Delivery	23	92.74%
Discharge/Transfers	4	100%
Integrated Physical/Mental Health Care	3	97.66%

Scores represent Jan 1- Sept 30, 2021, as QAPI transitions reporting to Fiscal Year from Calendar Year.

Encounters and BHTEDs Review

Includes a sample review of professional encounters and institutional encounters to ensure compliance in addition to a review of CMHSP business processes related to FY21 CLS changes and LOCUS scores.

Table 5: Encounters and BHTEDs Business Process Review Tools

Encounters and Business Processes	2021 Results
Professional Encounters Review	99.21%
Institutional Encounters Review	100%
Encounters Business Processes- CLS Changes	100%

Scores represent Jan 1- Sept 30, 2021, as QAPI transitions reporting to Fiscal Year from Calendar Year.

Strengths

- In most cases, the HCBS charts the individuals hopes and dreams, wants and needs were addressed and emphasized in the charts reviewed.
- CMHSPs were 100% compliant with FY21 CLS change implementation regarding encounters and business practices.
- CMHSPs have strong consumer involvement in many aspects of day-to-day activities and decisions.

Areas for Improvement

- The region continues to struggle with Behavior Treatment Review Committee compliance. Plans reviewed and approved by the BTPRC do not include all required elements as outlined in the MDHHS Technical Requirements. In some instances, there are plans in place without proper reviews, clinical chart reviews identify restrictions of individuals that do not have a behavior treatment plan in place.
- Credentialing files are often missing the NPDB inquiry or allowable alternative documentation. Additionally, some files were not approved by a credentialing committee or a designated credentialed staff.
- The clinical chart review has found that CMHSPs do not always address the specific Person-Centered Planning (PCP) format or tool chosen by the person to be used for the PCP.
- Clinical chart reviews indicate PCP pre-planning does not always address what accommodations a person may need to meaningfully participate in the meeting (including assistance for those individuals that use behavior as communication).
- Amount, scope, and duration was not met in several charts reviewed.

Regional Monitoring

MSHN and CMHSPs conducted regional monitoring for Autism, Fiscal Management Services, and Licensed Psychiatric Hospitals. The initial reciprocity protocols for these services started in 2018 and supported MSHN's ongoing strategic priority of ensuring effective and efficient provider network management systems.

Autism Regional Monitoring

Of the forty-seven providers under contract with one or more CMHSP in the region, seventeen providers were subject to a regionally organized audit, therefore reducing the number of audits to a single audit inclusive of all provider sites. Auditing teams include representatives from various CMHSPs. The review scores below reflect the first full year of reviews which took place FY21.

Table 6: Autism Regional Monitoring Scores

Autism Providers	2021 Results
ABA Connections	89.93%
ABA Insight	N/A
ABA Pathways	81%
Acorn Health of Michigan	92.70%
Autism Plus	99%
Autism Systems	95.97%
Central Michigan University	73%
Centria	94%
Children's Therapy Center	85%
Game Changer	90%
Gateway	90%
Mercy Plus	82%
Northshore	81%
Positive Behavior Supports	68.50%
Residential Options	92%
TAPS	44.90%
Total Spectrum	92%

N/A- Review to be conducted FY22.

Financial Management Services (FMS)

FMS providers were scheduled for interim reviews in 2021. In October 2020, MDHHS released a revised Self-Direction Implementation Guide. The guidance removed many requirements that FMS providers had previously been responsible for in their scope of work. The findings identified the previous year were no longer applicable. The regional monitoring team sent final reports to FMS providers and included this information. Full reviews will be conducted in FY22.

Licensed Psychiatric Hospital (LPH) Regional Monitoring

QAPI and CMHSPs conducted annual reviews for 8 of the 9 regional licensed psychiatric units (LPH). Full reviews include compliance verification of quality standards, Recipient Rights Annual Standards, Recipient Rights policy standards (if applicable) and Consumer Record Documentation and Service standards.

In 2020, The State Office of Recipient Rights (ORR) determined review results should not include an overall compliance rating due to "limited availability of the assessor to access all necessary information". [Source - 04.20.2020 ORR Email from Andrew Silver.] In accordance with ORR guidelines, 2021 LPH RR

Reviews are noted as being either compliant or non-compliant. In an effort to efficiently demonstrate the overall regional recipient rights compliance outcomes, the below table shows an overall compliance percentage based on 60 (annually reviewed) standards. Each standard is valued at 1 point.

Table 7: LPH 2021 Regional Monitoring Scores

LPH	Consumer Record Outcomes	RR Compliance %	Quality Outcomes	CAP Status
Cedar Creek	92%	98%	100%	Complete
Healthsource	95%	93%	100%	Complete
Henry Ford/Allegiance Health	100%	100%	100%	NA
Hillsdale Hospital	100%	100%	92%	Complete
McLaren Bay Region	NA	NA	NA	NA
Memorial Healthcare	93%	92%	92%	Complete
Mid-MI Med Center Alma	94%	93%	100%	Complete
Mid-MI Med Center Midland	98%	97%	100%	Ongoing (Status update requested)
Sparrow	92%	95%	100%	Ongoing (Status update requested)

Additional LPH/U notes:

- The McLaren Bay Region review will occur on 12.15.21 and results will be added to the following quarterly compliance report.
- CEI added a new LPH/U provider (Brightwell Behavioral Health) which will be included in the 2022 outcomes reports.

Strengths:

- CMHSPs have taken steps to assign LPH Review Leads in an effort to ensure more efficient communications between the LPH/CMHSP/MSHN.
- LPHs score consistently high, over 90%, in each of the areas reviewed.

Opportunities for Improvements:

- CMHSPs should complete the review tools, using all standardized forms, as intended.
- CAP updates should be timelier and provided in a manner that is relevant to any relevant party, e.g., out-of-region CMHSPs.

SUDSP Treatment Provider Delegated Function Reviews

QAPI completed both full and interim reviews during the FY2021 timeframe. Interim reviews include a review of any new standards identified for the year and review to ensure implementation of approved corrective action from the full review the year before. Interim reviews are not scored. Full reviews include consumer chart reviews, validation of process requirements, staff files, policies, and procedures. Reviews by provider are inclusive of all provider sites. For providers that our outside of

the MSHN region, MSHN honors the monitoring and auditing conducted by the PIHP in the region the providers are located.

The QAPI team conducted 15 full reviews and 10 interim reviews throughout January 2021 - September 2021.

Delegated Functions Tool Results

The Delegated Functions Review tool includes a review of 111 standards. Overall compliance during this timeframe for full reviews is 93.58%.

Table 8: SUD Delegated Functions Scores

Delegated Functions Standards	# Of Standards	2021 Results
Access and Eligibility	4	83.93%
Information and Customer Service	17	98.74%
Enrollee Rights and Protections	14	99.73%
Grievance and Appeals	17	93.07%
Quality and Compliance	15	97.54%
Individualized Treatment & Recovery Planning & Documentation	17	92.22%
Coordination of Care	4	88.18%
Provider Staff Credentialing	22	85.88%
IT Compliance/IT Management	1	100%

Scores represent Jan 1- Sept 30, 2021, as QAPI transitions reporting to Fiscal Year from Calendar Year.

Program Specific Results

The Program Specific tool includes a review of twenty-seven (27) standards specific to various treatment program requirements. Overall compliance during this timeframe for full reviews is 90.42%.

Table 9: SUD Program Specific Scores

Program Specific Standards	# Of Standards	2021 Results
ASAM	1	89.29%
Residential	2	75%
Peer Recovery Support Services	1	93.75%
Women's Specialty Services	3	87.50%
Medication Assisted Programs	10	100%
Recovery Residences	10	86.67%

Scores represent Jan 1- Sept 30, 2021, as QAPI transitions reporting to Fiscal Year from Calendar Year.

Consumer Chart Review Results

The SUDSP treatment chart review tool includes a total of fifty-four (54) standards. Overall compliance during this timeframe for full reviews is 76.52%.

Table 10: SUD Program Specific Scores

SUDSP Chart Reviews	# Of Standards	2021 Results
Screening, Admission, Assessment	8	83.62%
Treatment/Recovery Planning	10	76.83%
Progress Notes	2	81.18%
Coordination of Care	4	56.09%
Discharge/Continuity of Care	3	62.50%
Residential	5	70%
Medication Assisted Treatment	15	86%
Women's Designated/Women's Enhanced	1	60.71%
Recovery Housing	6	75%

Scores represent Jan 1- Sept 30, 2021, as QAPI transitions reporting to Fiscal Year from Calendar Year.

Strengths

- Grievance and Appeal reviews included a sample review of Adverse Benefit Determination letters and grievances and appeals as reported. Policies and procedure compliance has improved.
- SUD providers have implemented the SUD Member Handbook which was new for the region in 2021.
- Review of provider Enrollee Rights policies and procedures indicated improvement overall.
- The SUD network adapted to the challenges of COVID-19 by ensuring services were still provided to individuals in our region including implementing telehealth.

Areas for Improvement

- The pre-screen is not always documented or entered into REMI timely as required.
- The network continues to work on improving coordination of care efforts with primary care physicians, other providers, and probation/parole officers.
- Adverse Benefit Determination letters do not always include all elements. However, MSHN has recently implemented use of REMI for these letters which should eliminate further issues.
- Credentialing files do not always include all elements. The most common findings include Credentialing was not approved by a credentialing committee or designated credentialed alternative, NPDB reports were not always present or the allowable three alternative documentation requirements.
- Trauma Informed Care policies throughout the network did not always include all elements as outlined in the MDHHS Trauma Policy.
- Clinical charts reviews show that referrals and follow up were not always completed or documented.

- Clinical charts indicate low compliance when reviewing for effective coordination of care for any consumer currently or previously enrolled with external SUD provider and coordinating care efforts align with best practice guidelines.

Governing Body Form

To be completed by the PIHP and submitted to MDHHS along with its annual QAPIP submission no later than February 28th of each year.

Name of PIHP		
Mid-State Health Network		
List of members of the Governing Body (add additional rows as needed)		
Name	**Credentials**	**Organization** (if applicable)
1. Jim Anderson	2022	Bay Arenac Behavioral Health
2. Brad Bohner	2022	LifeWays CMHA
3. Joe Brehler	2022	CEI CMH
4. Craig Colton	2023	Huron Behavioral Health
5. Bruce Cadwallender	2024	Shiawassee Health & Wellness
6. Michael Ciezniewski	2023	Saginaw County Community Mental Health
7. Ken DeLaat	2023	Newaygo County Mental Health
8. David Griesing	2024 Member at Large	Tuscola Behavioral Health
9. Dan Grimshaw	2023	Tuscola Behavioral Health
10. Tina Hicks	2024	Gratiot Integrated Health
11. Diane Holman	2022	CEI CMH
12. John Johansen	2024	Montcalm Care Network
13. Steve Johnson	2022	Newaygo County Mental Health
14. Jeanne Ladd	2024	Shiawassee Health & Wellness
15. Pat McFarland	2023	Bay Arenac Behavioral Health
16. Rhonda Matelski	2023	Huron Behavioral Health
17. Deb McPeek-McFadden	2024	The Right Door for Hope, Recovery & Wellness
18. Gretchen Nyland	2022	The Right Door for Hope, Recovery & Wellness
19. Irene O'Boyle	2023 Vice Chairperson	Gratiot Integrated Health

20. Kurt Peasley	2024 Vice Chairperson	Montcalm Care Network
21. L. Joseph Phillips	2022	CMH for Central Michigan
22. Tracey Raquepaw	2022	Saginaw County CMHA
23. Kerin Scanlon	2022	CMH for Central Michigan
24. Ed Woods	2024-Chairperson	LlifeWays CMHA

Date the Governing Body approved the annual QAPIP (prior SFY QAPIP evaluation, current SFY QAPIP description, and current SFY QAPIP work plan)*
Date: 3/1/2022
Dates the Governing Body received routine written reports from the QAPIP (during the prior SFY; add additional rows as needed)*
Date: 11/10/2020
Date: 1/12/2021
Date: 3/2/2021
Date: 5/4/2021
Date: 9/14/2021
MDHHS Feedback
Click or tap here to enter text.

*The PIHP should be prepared to submit Governing Body meeting minutes and written reports to MDHHS upon request.