MSHN

Mid-State Health Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP) 2019

ANNUAL EFFECTIVENESS AND EVALUATION 2018

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SECTION ONE – ANNUAL PLAN

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM 2018-2019

I. OVERVIEW

Mid-State Health Network (MSHN) is a regional entity, which was formed pursuant to 1974 P.A. 258, as amended, MCL §330.1204b, as a public governmental entity separate from the CMHSP Participants that established it. The CMHSP Participants formed Mid-State Health Network to serve as the prepaid inpatient health plan ("PIHP") for the twenty-one counties designated by the Michigan Department of Health and Human Services as Region 5. The CMHSP Participants include Bay-Arenac Behavioral Health, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network , Huron County Community Mental Health Authority, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness, The Right Door and Tuscola Behavioral Health Systems. In January 2014, MSHN entered into its first contract with the State of Michigan for Medicaid funding, and entered into subcontracts with the CMHSPs in its region for the provision of Mental Health, Substance Use Disorder, and Developmental Disabilities services. The contract was expanded in 2014 to include an expanded Medicaid benefit, the Healthy Michigan Plan. The FY2015 contract expanded to include administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention. For FY2018, MSHN continues to sub-contract with CMHSPs within the region to provide Medicaid funded behavioral health services as well as directly contracting with Substance Use Disorder Providers within the region for the provision of all public funded SUD services.

MSHN monitors the overall quality and improvement of the PIHP. Responsibilities of the Quality Management Program are outlined in the Quality Assessment and Performance Improvement Plan (QAPIP). The scope of MSHN's QAPIP program is inclusive of all CMHSP Participants, the Substance Use Disorder Providers and their respective provider networks. Performance monitoring covers all important organizational functions and aspects of care and service delivery systems. Performance monitoring is accomplished through a combination of well-organized and documented retained, contracted and delegated activities. Where performance monitoring activities are contracted or delegated, MSHN assures monitoring of reliability and compliance.

II. PHILOSOPHICAL FRAMEWORK

The program design is based on the Continuous Quality Improvement (CQI) model of Shewhart, Deming and Juran. The key principles of the CQI model, as recently updated by Richard C.

Hermann ("Developing a Quality Management System for Behavioral Health Care: The Cambridge Health Alliance Experience", November 2002), are:

- Health care is a series of processes in a system leading to outcomes;
- Quality problems can be seen as the result of defects in processes;
- Quality improvement efforts should draw on the knowledge and efforts of individuals involved in these processes, working in teams;
- Quality improvement work is grounded in measurement, statistical analysis and scientific method;
- The focus of improvement efforts should be on the needs of the customer; and
- Improvement should concentrate on the highest priority problems.

Performance improvement is more narrowly defined as, "the continuous study and adaptation of health care organization's functions and processes to increase the probability of achieving desired outcomes, and to better meet the needs of clients and other users of services" (The Joint Commission, 2004-2005). MSHN employs the Plan-Do-Study-Act (PDSA) cycle, attributed to Walter Shewhart and promulgated by Dr. W. Edwards Deming, to guide its performance improvement tasks (Scholtes P. R., 1991).

Performance measurement is a critical component of the PDSA cycle. Measures widely used by MSHN for the ongoing evaluation of processes, and to identify how the region can improve the safety and quality of its operations, are as follows:

- A variety of qualitative and quantitative methods are used to collect data about performance;
- Well-established measures supported by national or statewide databases are used where feasible and appropriate to benchmark desired performance levels; if external data is not available, then local benchmarks are established;
- Statistically reliable and valid sampling, data collection and data analysis principles are followed as much as possible; and
- If the nature of the data being collected for a measure limits the organization's ability to control variability or subjectivity, the conclusions drawn based upon the data are likewise limited.

Data is used for decision making throughout the PIHP and its behavioral health contract providers through monitoring treatment outcomes, ensuring timeliness of processes, optimizing efficiency and maximizing productivity and utilizing key measures to manage risk, ensure safety, and track achievement of organizational strategies. MSHN's overall philosophy governing its local and regional quality management and performance improvement can be summarized as follows:

- Performance improvement is dynamic, system-wide and integrated;
- The input of a wide-range of stakeholders – board members, advisory councils, consumers, providers, employees, community agencies and other external entities, such as the Michigan Department of Health and Human Services, are critical to success;
- An organizational culture that supports reporting errors and system failures, as the means

to improvement, and is important and encouraged;

- Improvements resulting from performance improvement must be communicated throughout the organization and sustained; and
- Leadership must establish priorities, be knowledgeable regarding system risk points, and act based upon sound data.

III. QUALITY AND COMPLIANCE

a) STRUCTURE (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2019) (42 Code of Federal Regulations (CFR) 438.358, 2002)

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 (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2019) (42 Code of Federal Regulations (CFR) 438.358, 2002)

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
- Develop 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.

MSHN will retain responsibility for developing, maintaining, and evaluating an annual QAPIP plan 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 (Region 5 PIHP 2013 Application for Proposal for Specialty Prepaid Inpatient Health Plans, 2013, p. 2.7.3).

c) GOVERNANCE (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2019)

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 quality management 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 and the result of those actions. After review of the Annual Quality Assessment and Performance Improvement Report, through the MSHN CEO the Board of Directors submits the report 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

Through consultative council involvement, the MSHN Medical Director provides leadership related to clinical service quality and service utilization standards and trends. The 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.

The MSHN Medical Director consults with MSHN staff regarding service utilization and eligibility decisions and is available to provide input as required for the regional QAPIP. As necessary, consultation occurs between the MSHN Medical Director and CMHSP Participant and Substance Use Disorder Medical Directors.

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 is 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 the 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, and
- Reporting clinical care errors, informing consumers of risks, and making suggestions to improve the safety of consumers.

Councils and Committees

MSHN has Councils and Committees that 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, Past Year's Accomplishments and Upcoming Goals. 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 CMHSPs. Any issues remaining unresolved after Operations Council consideration will be subject to a vote with the minority 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.

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.

Practitioners- SUD-Provider Advisory Workgroup

PAW is charged with serving in an advisory capacity to MSHN to offer input 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.

Recipients (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program- Attachment P7.9.1, 2019)

MSHN continues the legacy of its founding CMHSP Participants by promoting and encouraging active consumer involvement and participation within the PIHP, the respective CMHSPs and their local communities. MSHN has formed a Regional Consumer Advisory Council that 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 requirements in the region.

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.

d) COMMUNICATION OF PROCESS AND OUTCOMES (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2019)

The Quality Improvement Council (QIC) is responsible for monitoring and reviewing performance measurement activities. MSHN, in addition to the CMHSPs Participants/SUD Providers, identify and monitor opportunities for process and outcome improvements.

For any performance measure that falls below regulatory standards and/or established targets, plans of correction are required. After QIC meetings, reports are communicated through regular reporting via Councils, Committees, and 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 and achievements, and include interventions resulting from data analysis.

e) MEDICAID EVENT VERIFICATION (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2019 and Medicaid Event Verification Technical Requirement-Attachment P.6.4.1)

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 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); services were provided by a qualified individual; the amount billed/paid does not exceed the contract amount; and appropriate modifiers were used following the HCPCS guidelines.

Data collected through the Medicaid Event Verification process is aggregated, analyzed and reported for review at the QI Council 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. All CMHSP Participants/SUD Providers of MSHN have implemented the generation of a summary of Explanations of Benefits in accordance with the MDHHS Specialty Mental Health Services Program contract. This will provide an additional step to ensure that consumers are aware of service activity billed to their insurance.

f) QUANTITATIVE AND QUALITATIVE ASSESSMENT OF MEMBER EXPERIENCES (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2019)

The opinions of consumers, their families and other stakeholders are essential to identify ways to improve processes and outcomes. Surveys and focus groups are an effective means to obtain input on both qualitative and quantitative experiences. Consumers receiving services funded by the PIHP are surveyed by MSHN at least annually using standardized survey tools . The tools vary in accordance with service population needs, and address quality, availability, and accessibility of care. Focus groups are conducted as needed to obtain input on specific issues. Consumers may also be queried by the CMHSP Participants/SUD Providers regarding the degree of satisfaction via periodic reviews of the status of their person-centered plans, as well as during discharge planning for the cessation or transition of services. Other stakeholders provide input through a survey process. Regional benchmarks are used for comparison.

The aggregated results of the surveys are collected, analyzed and reported by MSHN in collaboration with the QI Council and Regional Consumer Advisory Council, who identify strengths, areas for improvement and make recommendations for action and follow up as appropriate. The data is used to identify best practices, demonstrate improvements, or identify problem areas. The QI Council determines appropriate action for improvements, and the resulting findings are incorporated into program improvement action plans. At the CMHSP Participant/SUD Provider level, actions is taken on survey results of individual cases, as appropriate, to identify and investigate sources of dissatisfaction and follow-up.

Survey results are included in the annual PIHP QAPIP Report and presented to the MSHN governing body, accessible on the MSHN website, the Operations Council, Regional Consumer Advisory Council, CMHSP Participants and SUD Providers. Findings are also shared with stakeholders on a local level through such means as advisory councils, staff/provider meetings and printed materials.

IV. PROVIDER NETWORK

a) CREDENTIALING, PROVIDER QUALIFICATION AND SELECTION (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2019)

In compliance with MDHHS's Credentialing and Re-Credentialing Processes (FY19 Attachment P7.1.1,FY19 Attachment PII.B.A), MSHN has established written policy and procedures 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 also ensure that non-licensed providers of care or support are qualified to perform their jobs.

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.

MSHN policies and procedures are established to address the selection, orientation and training of directly employed or contracted staff. PIHP employees receive annual reviews of performance and competency. Individual competency issues are addressed through staff development plans. MSHN is responsible for ensuring that each provider, employed and contracted, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements, including relevant work experience and education, and cultural competence. The CMHSP Participants/SUD Providers are likewise responsible for the selection, orientation, training and evaluation of the performance and competency of their own staff and subcontractors.

b) PROVIDER MONITORING (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2019)

MSHN uses a standard written contract to define its relationship with CMHSP Participants/SUD Providers that stipulated required compliance with all federal and state requirements, including those defined in the Balance Budget Act (BBA), the Medicaid Provider Manual, and the master contract between the PIHP and MDHHS.

Each CMHSP Participant/SUD Provider is contractually required to ensure that all eligible recipients have access to all services required by the master contract between the PIHP and MDHHS, by either direct service provision or the management of a qualified and competent provider panel. Each CMHSP Participant/SUD Provider is also contractually required to maintain written subcontracts with all organizations or practitioners on its provider panel. These

subcontracts shall require compliance with all standards contained in the BBA, the Medicaid Provider Manual, and the Master Contract between the PIHP and the MDHHS.

Each CMHSP Participant/SUD Provider is required to document annual monitoring of each provider subcontractor as required by the BBA and MDHHS. The monitoring structure shall include provisions for requiring corrective action or imposing sanctions, up to and including contract termination if the contractor's performance is inadequate. MSHN continually works to assure that the CMHSP Participants/SUD Provider maintain common policies, review common standards, and evaluate common outcomes. MSHN monitors compliance with federal and state regulations annually through a process that includes any combination of desk review, site review verification activities, and/or other appropriate oversight and compliance enforcement strategies as necessary. MSHN has developed a process for coordinating and/or sharing annual contractor monitoring reviews to avoid duplication of efforts and to reduce the burden on shared contractors. CMHSPs Participants/SUD Providers that are unable to demonstrate acceptable performance are required to provide corrective action, will be subject to additional PIHP oversight and interventions, and may be subject to sanctions imposed by MSHN, up to and including contract termination.

c) EVENT MONITORING AND REPORTING (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2018)

MSHN submits and/or reports required events to MDHHS such as critical incidents (including sentinel events), and events requiring immediate notification as specified in the Medicaid Managed Specialty Supports Services contract within the timelines required by MDHHS.

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. 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 these events, adverse events, will qualify as "reportable events" according to the MDHHS Event Reporting System. These include MDHHS defined critical incidents, risk events, and sentinel 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 will ensure that the CMHSP and SUD Provider have taken appropriate action to ensure that any immediate safety issues have been addressed.

MSHN provides oversight and monitoring of the CMHSP Participant/SUD Provider processes for reporting sentinel events, critical events, and risk events as defined in the Medicaid Managed Specialty Supports and Service Concurrent 1915 (b)/(c) Waiver Program FY19 Attachment P7.9.1 and/or events requiring immediate notification to MDHHS. 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. 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, time lines, and strategies for measuring the effectiveness of the action

V. CLINICAL

a) OVERSIGHT OF "VULNERABLE PEOPLE" (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2019)

MSHN assures the health and welfare of the region's service recipients by establishing standards consistent with MDHHS contract requirements and reporting guidelines for all CMHSPs and subcontracted providers. Each CMHSP Participant/SUD Provider shall have processes for addressing and monitoring the health, safety and welfare of all individuals served.

MSHN ensures that services are consistently provided in a manner that considers the health, safety, and welfare of consumers, family, providers and other stakeholders. When health and safety, and/or welfare concerns are identified, those concerns will be acknowledged, and actions taken as appropriate. MSHN monitors population health through data analytics software to identify adverse utilization patterns and to reduce health disparities.

MSHN monitors compliance with federal and state regulations annually through a process that may include any combination of desk review, site review verification activities and/or other appropriate oversight and compliance enforcement strategies as necessary. CMHSP organizations and SUD Providers that are unable to demonstrate acceptable performance may be subject to additional PIHP oversight and intervention.

b) CULTURAL COMPETENCY

MSHN and its Provider Network shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

Competence includes a general awareness of the cultural diversity of the service area including race, culture, religious beliefs, regional influences in addition to the more typical social factors such as gender, gender identification, sexual orientation, marital status, education, employment and economic factors, etc.

VI. UTILIZATION MANAGEMENT

a) UTILIZATION MANAGEMENT PLAN (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2019)

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.

MSHN directly or through delegation of function to the CMHSP Participants/SUD Providers acting on its behalf, is responsible for the overall network's utilization management (UM) system. Each CMHSP Participant/SUD Provider is accountable for carrying out delegated UM functions and/or activity relative to the people they serve through directly operated or contracted services.

Initial approval or denial of requested services is delegated to CMHSP Participants/SUD Providers, including the initial screening and authorization of psychiatric inpatient services, partial hospitalization, and initial and ongoing authorization of services for individuals receiving community services. All service authorizations are based on medical necessity decisions that establish the appropriate eligibility relative to the identified services to be delivered. 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.

Utilization review functions are delegated to CMHSP Participants/SUD Providers 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.

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 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 decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to provide treatment. 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.

b) AUTISM BENEFIT (Medicaid Managed Specialty Supports and Services Early and Periodic Screening, Diagnosis and treatment (EPSDT) State plan Home and Community-Based Services Administration and Operation)

MSHN oversees provision of the autism benefit within its region. MSHN delegates to the CMHSPs the application of the policies, rules and regulations as established. MSHN assures that it maintains accountability for the performance of the operational, contractual, and local entity efforts in implementation of the autism program. MSHN tracks program compliance through the MSHN quality improvement Strategy and performance measures required by the benefit plan. MSHN collects data on the performance of the autism benefit consistent with the EPSDT state plan and reviews this data monthly to quarterly with the CMHSPs within its region and calls for ongoing system and consumer-level improvements. This data is shared with the MDHHS as required, for reporting individual-level and systemic-level CMHSP quality improvement efforts.

<u>Autism Benefit Review</u>
Re-evaluations shall address the ongoing eligibility of the autism benefit participants and are updated annually. All providers of ABA services shall meet credentialing standards as identified in the EPSDT benefit and Michigan Medicaid Manual to perform their function.

c) BEHAVIOR TREATMENT (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)(c) Waiver Program 2018 Attachment P1.4.1, Standards for Behavior Treatment Plan Review Committees-Revision FY17)

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. MSHN also receives CMHSP behavior treatment data regarding consumers on the habilitation supports waiver. This data has been piloted and tracked in the MSHN region and provides sub-assurances within participant safeguards that require additional oversight & monitoring by the Michigan Department of Health and Human Services (MDHHS) for habilitation supports waiver enrollees around use of intrusive and/or restrictive techniques for behavioral control. 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 MHHS upon request. CMHSP data is reviewed as part of the CMHSP Quality Program and reported to the MSHN QIC at a defined frequency. 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.

d) PRACTICE GUIDELINES (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2019)

MSHN supports CMHSP Participants local implementation of practice guidelines based on the Medicaid Provider Manual, the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program, and Evidence Based Practice models. The process for determining what practice guidelines were utilized is 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. Practice guidelines as stated above are reviewed and updated annually or as needed and are disseminated to appropriate providers.

e) PERFORMANCE MEASUREMENT

General Methods (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2019)

The Quality Assessment and Performance Improvement Program encourages the use of objective and systematic forms of measurement. Each established measure should align with MSHN's goals and priorities and needs to have clear expectations, promote transparency, and be accountable through ongoing monitoring.

Measures can be clinical and non-clinical. Desired performance ranges and/or external benchmarks are included when known. MSHN is responsible for the oversight and monitoring of the performance of the PIHP including data collection, documentation, and data reporting processes to ensure compliance with PIHP contract requirements and State and Federal processes and requirements.

Establishing Performance Measures:

The measures established should reflect the organizational priorities, have a baseline measurement when possible, have an established re-measurement frequency (at least annually) and should be actionable and likely to yield credible and reliable data over time.

Information is the critical product of performance measurement that facilitates clinical decision-making, organizational decision-making (e.g., strategic planning and day-to-day operations),

performance improvement, and priorities for risk reduction. Data must be systematically aggregated and analyzed to become actionable information.

Data Collection and Setting Performance Targets:

Data is aggregated at a frequency appropriate to the process or activity being studied. Statistical testing and analysis is then used as appropriate to analyze and display the aggregated data. PIHP data is analyzed over time to identify patterns and trends, and compared to desired performance levels, including externally derived benchmarks when available.

When a performance measure has an established performance target set through contract requirements, then that target will be utilized to measure performance. If there is no set performance target, baseline data should be considered prior to setting a target. Baseline data is a snapshot of the performance of a process or outcome that is considered normal, average, or typical over a period. The baseline may already be established through historical data or may still need to be collected. If baseline data is not available for an established measure, then the measure should be implemented for a period of time (typically up to one year) prior to establishing performance targets. When collecting baseline data, it is important to establish a well-documented, standardized and accurate method of collecting the data and set ongoing frequencies to review the data (monthly, quarterly, etc.)

Once the baseline has been established for a measure, it can be determined if a performance target should be established or not. If the baseline data is at or above the state and national benchmarks, when available, and deemed within acceptable standards, it is up to the monitoring committee or team to determine if a performance measure should be established or if the measure should just continue to be monitored for variances in the baseline data. If the baseline data is below the state and national benchmarks, when available, then a performance target should be established that is at, or greater than, the state and national average.

When establishing performance targets, the following should be considered (as defined in the Health Resources and Service Administration (HRSA) Quality Tool Kit):

a) *Minimum or Acceptable Level.* Performance standards can be considered "minimum" or "acceptable" levels of success.
b) *Challenge Level*. This level defines a goal toward which efforts are aimed. Performance results below this level are acceptable because the level is a challenge that is not expected to be achieved right away.
c) *Better Than Before.* The performance measurement process is comparative from measurement period to measurement period. Success is defined as performance better than the last period of measurement. This definition comes out of the continuous quality improvement (CQI) perspective.

Targets may be defined in several ways including the following:

a) Defining a set target percentage for achievement – such as 75% will meet the outcome being measured

b) Defining a percentage change for achievement – such as the percentage will increase by 10% over an established length of time

Data Analysis:
The data should be reviewed at the established intervals and analyzed for undesirable patterns, trends, or variations in performance. In some instances, further data collection and analysis may be necessary to isolate the causes of poor performance or excessive variability.

The appropriate council, committee, or workgroup, in collaboration with the QIC, will prepare a written analysis of the data, citing trends and patterns, including recommendations for further investigation, data collection improvements to resolve data validity concerns, and/or system improvements.

Region wide quality improvement efforts will be developed based on the patterns and trends identified and will be reviewed for effectiveness at established intervals within the appropriate MSHN council, committees, workgroups, etc. In some instances, provider level corrective action may be necessary in addition to, or in lieu of, region wide improvement efforts.

Performance Improvement Action Steps:
Process improvements are achieved by taking action based upon data collected and analyzed through performance measurement activities. Actions taken are implemented systematically to insure any improvements achieved are truly associated with the action. Adhering to the following steps promotes process integrity:

- Develop a step by step action plan;
- Limit the number of variables impacted;
- Implement the action plan, preferably on a small or pilot scale initially, and
- Collect data to check for expected results.

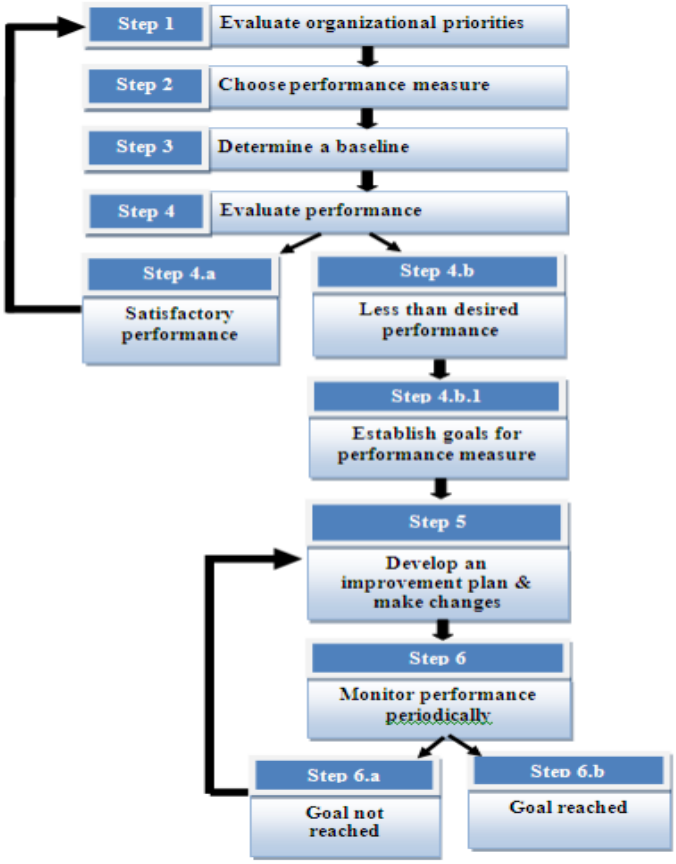
The process of measurement, data collection, data analysis and action planning is repeated until the desired level of performance/improvement is achieved. Sustained improvement is sought for a reasonable period of time (such as one year) before the measure is discontinued. When sustained improvement is achieved, measures move into a maintenance modality, with a periodic reassessment of performance to insure the desired level of quality is being maintained, as appropriate, unless the measure(s) mandated by external entities such as the MDHHS require further measurement and analysis.

When the established minimum performance standards or requirements are not met, CMHSP Participants/SUD Providers will submit a corrective action plan the includes the following:

- Causal factors that caused the variance (directly and/or indirectly)
- Interventions that will be implemented to correct the variance
- Timelines for when the action will be fully implemented
- How the interventions will be monitored
- Any other actions that will be taken to correct undesirable variation

The appropriate MSHN staff, council, committee, workgroup, etc. will monitor the implementation and effectiveness of the plans of correction. The effectiveness of the action plan will be monitored based on the re-measurement period identified.

Process Map of Performance Management Pathway (defined by HRSA)



Performance Indicators

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 use of standardized performance indicators.

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. The form will be reviewed by the MSHN CO and the MSHN contractor to ensure sufficient corrective action planning. Regional trends will be 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.

Performance Improvement Projects

MDHHS requires the PIHP to complete a minimum of two PI 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. The population from which a sample is pulled, the data collection timeframe, the data collection tool, and the data source are defined for each measure, whether local or regional. A description of Project/Study is written for each measure which documents why the project was chosen and identifies the data that was used to determine there was a problem and who is affected by the problem. It incorporates the use of valid standardized data collection tools and consistent data collection techniques. Each data collection description delineates strategies to minimize inter-rater reliability concerns and maximize data validity. Provisions for primary source verification of data and maintenance of documentation are also addressed in the description of the project/study. If sampling is used, appropriate sampling techniques are required 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.

Identification of Quality Concerns and Opportunities for Improvement

Measures are selected consistent with established MSHN QAPIP priorities, as specified in this plan. The PIHP quality management program uses a variety of means to identify system issues and opportunities for improvement.

Prioritizing Measures (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2019)

Measures are chosen based upon selection and prioritization of projects, data collection, and analysis of data, and will be based on the following three factors:

Focus Area: Clinical (prevention or care of acute or chronic conditions; high volume or high risk services; continuity and coordination of care), or Non-Clinical (availability, accessibility, and cultural competency or services; interpersonal aspects of care; appeals, grievances, and other complaints.)

Impact: The effect on a significant portion of consumers served with potentially significant effect on quality of care, services, or satisfaction.

Compliance: Adherence to law, regulatory, or accreditation requirements; relevancy to stakeholders due to the prevalence of a condition, the need for a service,

access to services, complaints, satisfaction, demographics, health risks or the interests of stakeholders as determined through qualitative and quantitative assessment.

VII. Definitions

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.

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.

MMBPIS: Michigan Mission Based Performance Indicator System

MSHN: Mid-State Health Network

MDHHS: Michigan Department of Health and Human Services

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.

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.

(2019). *Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program.*

(2019). *Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1*

(2013). *Region 5 PIHP 2013 Application for Proposal for Specialty Prepaid Inpatient Health Plans.*

(2004-2005). The Joint Commission. *Comprehensive Accreditation Manual for Behavioral Health Care.*

(May 13, 2011). *Michigan Department of Community Health (MDCH)/Prepaid Inpatient Health Plan (PIHP) Event Reporting v1.1, Data Exchange Workgroup-CIO-Forum.*

(2019). *Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)(c) Waiver Program 2019 Attachment P1.4.1, Standards for Behavioral Treatment Plan Review Committees-, Revision FY'17.*

(November 2002). "Developing a Quality Management System for Behavioral Health Care: The Cambridge Health Alliance Experience". *Harvard Review of Psychiatry*.

(1991). Scholtes, P. R. In *The Team Handbook* (pp. 5-31). Madison, WI: Joiner Associates, Inc.

SECTION TWO – ANNUAL REPORTS

I. Council FY18 Accomplishments & FY19 Goals

ANNUAL REPORT

TEAM NAME: Operations Council

TEAM LEADER: Joseph P. Sedlock, MSHN Chief Executive Officer

REPORT PERIOD COVERED: 10.01.2017-09.30.2018

Purpose of the Operations Council**:** The MSHN Board has created the Operations Council (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 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.

Responsibilities and Duties: 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, Information Technology Councils and other Councils/Committees as assigned;
- Assure policies and practices are operational, effective, efficient and in compliance with applicable contracting requirements and regulatory standards; and
- Undertake such other duties as may be delegated by the Entity Board.

Defined Goals, Monitoring, Reporting and Accountability

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

- Expanded local 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 and delegated function contracts achieved defined results, and are carried

out in a manner that achieves consistency, standardization and cost-effectiveness
- 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.

OC Annual Evaluation Process

a. Past Year's Accomplishments: The OC had 13 meetings during FY18. The following accomplishments during FY18 of particular significance are noted:
    - Completed Annual Policy & Procedure Review Processes;
    - Retained commitment to core values and collective focus despite external threats associated with 298;
    - Facilitated MSHN/CMHSP partner dialog on administrative and clinical efficiencies including short- and long-term financial management strategies;
    - Provided input on regional financial operations and results of operations and budgets;
    - Enacted regional psychiatric inpatient standardized contract template and change management processes;
    - Implemented regional psychiatric inpatient provider performance monitoring/review systems;
    - Enacted regional fiscal intermediary standardized contract template and change management processes;
    - Implemented regional fiscal intermediary provider performance monitoring/review systems;
    - Discussed strategies for addressing fall-out related to the operations of another PIHP (LakeShore Regional Entity);
    - Completed annual reviews and revisions of all Council/Committee Charters;
    - Successful advocacy to address financial resource diminishment caused by migration of individuals from the DAB category;
    - Addressed regional distribution of MSHN-earned performance incentives resulting in over $3.2M in local resources being provided to CMHSP participants;
    - Continued implementation of the SIS (Supports Intensity Scale) and LOCUS region-wide;
    - Completed a thorough review and update to the MSHN/CMHSP Operating Agreement (except Article IV, which remains under discussion);
    - Supported regional implementation of statewide training reciprocity agreements;
    - Approval of Utilization Management, Compliance, Quality Assurance and Performance Improvement, Risk Management and Population Health Plans.
    - Regional implementation of Veteran's Navigator (grant funded);
    - Addressed Hepatitis A outbreak and related local responses;
    - Provided input and feedback on the development of the 2018-2020 regional strategic plan;
    - Participated in evaluation of benefits/costs to conclude that MSHN should not seek

NCQA accreditation;

- Provided advice and consultation on compliance with federal parity regulations and purchase of related tools (software) as well as regional implementation;
- Continued advocacy for admission of appropriate individuals to psychiatric inpatient care and expanded crisis intervention services across the region;
- Supported regional response to the request of a CMHSP Participant for a cash advance and related actions to mitigate regional risk;
- Created a Regional Medical Directors Committee for collaboration between the Medical Directors of the MSHN and CMHSPs;
- Created an Autism Standardization Workgroup;
- Created Standard Consent Form Workgroup;
- Created Admissions and Benefit Standardization Workgroup;
- Took initial steps to address emergency services and crisis intervention staff secondary trauma and burnout;
- MSHN Provider Network Adequacy Assessment was approved;
- Regional standardized implementation of the Direct Care Worker Wage increase;
- Cooperated with implementation of the MSHN Managed Care Information System
- Began consideration of a regional contract for Training with Relias;
- Partnered in the development and implementation of a plan for full funding of the regional Internal Service Fund;
- Participated in dialog with MSHN over contracting with the Michigan Department of Corrections for managed care services relating to community-based substance use disorder treatment services for parolees and probationers;
- Continued support for enhanced local access for citizens with substance use concerns through SUD provider network partnerships with CMHSPs on a 24/7/365 basis.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2019

- Assist MSHN with implementation of the 2018-2020 Regional Strategic Plan objectives;
- Partner to address “298” pilot phase and related challenges, including the potential separation of one CMHSP from the MSHN region;
- Improve consistency, standardization and cost-efficiency in retained and delegated managed care activities;
- Establish systems to improve performance in metrics outlined in the MDHHS Performance Incentive Bonus section. E.g. follow-up after hospitalization for mental illnesses between PIHPs and MHPs and within the MSHN region, Follow-up to SUD ER, Plan All Cause Readmission, increase in Patient Centered Medical Homes;
- Home and Community Based Services Waiver Transition implementation;
- 1115 (and associated) Waiver implementation (if approved by CMS);
- Identify and implement improvements in region-wide approaches to inpatient care, from pre-admission screening systems to provider performance monitoring to contracting and all related systems; expand use of telehealth services as

appropriate;

- Full implementation of the parity software solution within the region;
- Increase efficiency through collective provider network management functions;
- Continue advocacy for systemic improvement in access to inpatient care and identify and develop sub-inpatient regional crisis response systems/options; Develop and implement (for possible Statewide use) systems for psychiatric inpatient care bed availability.

ANNUAL REPORT

TEAM NAME: Finance Council

TEAM LEADER: Leslie Thomas, MSHN Chief Financial Officer

REPORT PERIOD COVERED: 10.1.17 - 9.30.18

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:

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

Monitoring and reporting of the following delegated financial management functions:

a. Tracking of Medicaid expenditures;
b. Data compilation and cost determination for rate setting;
c. FSR, Administrative Cost Report, MUNC and Sub-element preparation;
d. Verification of the delivery of Medicaid services; and
e. Billing of all third-party payers.

Monitoring and reporting of the following retained financial management functions:

a. PIHP capitated funds receipt, dissemination, and reserves;

b. Region wide cost information for weighted average rates;
c. MDHHS reporting; and
d. Risk management plan.

Defined Goals, Monitoring, Reporting and Accountability

Goals:

- Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2017 and February 2018. 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 2017. 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 2018 Final Reports due to MDHHS February 28, 2019, are received from the CMHSPs to the PIHP. The goal for FY18 will be to spend at a level to maintain MSHN's anticipated combined reserves to 7.5% 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: MSHN has developed a Service Use Analysis suite of reports as a guideline for this process. The reports have been used to guide service activity data collection to identify significant variances related to service functions. The first phase of the process includes the review of five high volume codes.
- Assure region wide rates are within acceptable deviations from state wide rates: The Medicaid Uniform Cost Report (MUNC) is due to MDHHS February 28, 2018. MDHHS will compile the PIHP reports and send an analysis to the PIHPs in June of 2018. Finance Council will follow the MSHN costing methodology and utilize MUNC to identify rates per service and costs per case exceeding one standard deviation of the state PIHP average. Following the Finance Council costing methodology, an analysis will be performed of outliers and recommendations offered to address service provision or costing for service provision as applicable.
- Completion of Finance Council Dashboard – MSHN staff and Finance Council members completed its work to populate the fiscal year 2017 Dashboard.
- 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 the change in Autism funding.

- Determine how New Managed Care Rules impact our Region and implement changes as necessary.
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.
- Monitor Medicaid expansion for any changes related to the Affordable Care Act and its impact on the region.
- Monitor changes related to 1115 waiver and its impact on the region's funding.

Annual Evaluation Process

Past Year's Accomplishments

- FY 2017 fiscal audits were complete and submitted by the PIHP and 12 CMHSPs. The PIHP's and nine of the CMHSP audits rendered an unqualified opinion. In addition, two CMHSPs received unqualified opinions with findings and one CMHSP's audit resulted in an unqualified opinion with a misstatement. 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 received findings as a result of ones issued to two CMHSPs and for its use of Internal Service Fund dollars provided to Saginaw CMH throughout the fiscal year to mitigate risk associated with cash flow to cover operations. MSHN is appealing this finding with MDHHS and is awaiting a final decision. The other 10 CMHSPs had no findings and complied in all material aspects with attestation standards set forth by the American Institute of Certified Public Accountants. The FY 2017 Finance dashboard is complete. The committee members agreed to leave the same measures in place for FY 2018.
- The CMHSPs agreed in theory to implement the administrative guidelines from the PIHP CFO committee. These guidelines were further enhanced with MHSN clarification and acceptably measures. CMHSPs will demonstrate ongoing compliance through the Administrative Cost Report (ACR) narrative and MSHN monitoring tools.
- The Finance Council developed an alternate disbursement strategy for FY 2018 revenue in order to have the funds align with the number of Autism consumers served. The definition of consumers served is those active in the WSA. Finance Council continues to evaluate alternative Autism funding
- One significant impact of the new Managed Care Rules relates to calculation of the Medical Loss Ratio (MLR) for PIHPs. PIHP CFOs reviewed the rule and defined a consistent calculation methodology. This information has been shared with MDHHS, Operations Council, and Finance Council. The new tool will be used for FY 2018 reporting.

Upcoming Goals for Fiscal Year Ending September 30, 2019

- Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2017 and February 2018. 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 2018. 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 2017 Final Reports due to MDHHS February 28, 2018, are received from the CMHSPs to the PIHP. The goal for FY18 will be to spend at a level to maintain MSHN's anticipated combined reserves to 7.5% 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: MSHN has developed a Service Use Analysis suite of reports as a guideline for this process. The reports have been used to guide service activity collection information to identify significant variances related to service functions. The first phase of the process includes the review of five high volume codes.
- Assure region wide rates are within acceptable deviations from state wide rates: The Medicaid Uniform Cost Report (MUNC) is due to MDHHS February 28, 2018. MDHHS will compile the PIHP reports and send an analysis to the PIHPs in June of 2018. Finance Council will follow our costing procedure and utilize this report to determine rates per service and costs per case for which we are not within one standard deviation of the PIHP averages within the state. Following the Finance Council procedure, an analysis will be performed of outliers and steps will be taken to adjust service provision or costing for service provision for all rates unless it is determined by the CEOs that our variances from the PIHP averages are acceptable.
- Completion of Finance Council Dashboard – MSHN staff and Finance Council members completed its work to populate the fiscal year 2017 Dashboard. Uniform Administrative Costing – MSHN's CFO participates in the PIHP CFO council. A workgroup of this 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 the change in Autism funding.
- Determine how New Managed Care Rules impact our Region and implement changes as necessary.
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.

- Monitor Medicaid expansion for any changes related to the Affordable Care Act and its impact on the region.
- Monitor changes related to 1115 waiver and its impact on the region's funding.

ANNUAL REPORT

TEAM NAME: Information Technology Council

TEAM LEADER: Forest Goodrich, MSHN Chief Information Officer

REPORT PERIOD COVERED: 10.1.17 – 9.30.18

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, SIS encounters, Rendering Provider NPI reporting);
- Accomplish annual goals established by the IT Council and/or OC, such as:
    a. Continue to work on quality and outcome measures as needed for the MSHN region.
    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:

1. Past Year Accomplishments

Representation from each CMHSP Participant at all meetings;

- There was a 93% rate of attendance at FY18 ITC meetings. 100% attendance occurred in 9 meetings.

Successfully submit MDHHS required data regarding quality, effectiveness and timeliness;

- This process includes: encounters, BH-TEDS, QI, PI and CIR. Year-end statistics from MDHHS showed that we were 100% timely with encounter submissions.
- CMHSPs were successful with implementing the FY18 BH TEDS record changes and for submitting all records with this specification. A summary report was submitted that identified areas that were difficult in capturing BH-TEDS information.

Collaborate to develop systems or processes to meet MDHHS requirements;
Several initiatives for collaboration occurred during the year. They were:

- Implement a new managed care information system and work through conversion processes and timing to ensure the least amount of interruption in required reporting.
- Develop report to show BH-TEDS missing/present to Encounters submitted.
- Establish volume and timeliness reports and measures to review quarterly.
- Participate with parity process and software selection.
- Evaluate LARA license number reporting issues and improve data reporting for required encounters.

Facilitate health information exchange processes;

- Worked with MiHIN to improve the ADT transactions received for the region.
- Changed the method to send/receive data with SIS Online tool.
- Converted the Enrollment and Payment file processing into REMI.
- Developed a secure FTP site for exchanging protected health information within the region and CMHSP participants.

Goals established by Operations Council;

- Further developed balanced scorecard reports for IT council review and monitoring.

- Implemented new processing for BH-TEDS and encounter submissions through a managed care information system (REMI).

Meet external quality review requirements;

- Health Services Advisory Group conducts the annual audit for MDHHS and it was successful. The materials that MSHN submitted were reviewed and approved without any findings. CMHSPs participated in the site review process and we continue to receive high marks for a highly functional delegated model and working well together.

2. Goals for fiscal year ending September 30, 2019
   - Active participation by all CMHSP representatives at each monthly meeting.
   - Meet current reporting requirements as defined by MDHHS for submitting information.
   - Continue to work on quality and outcome measures as needed for the MSHN region.
   - Improve balanced scorecard reporting processes to achieve or exceed target amounts.
   - Continue transitioning health information exchange (HIE) processes to managed care information system, when appropriate, to gain efficiencies in data transmissions.
   - Work toward achieving goals established by Operations Council.
   - Prepare for and pass audit requirements of the external quality review.

ANNUAL REPORT

TEAM NAME: Quality Improvement Council

TEAM LEADER: Kim Zimmerman, MSHN Director of Compliance, Quality & Customer Service;
Sandy Gettel, MSHN Quality Manager

REPORT PERIOD COVERED: 10.1.17 – 9.30.18

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 Director of Customer Service, Compliance and Quality Improvement, 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. The Quality Improvement Council is chaired by the Director of Customer Service, Compliance and Quality Improvement. All Participants are equally represented on this council.

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

- Advising the MSHN Director of Customer Service, Compliance and Quality Improvement and assisting with the development, implementation, operation, and distribution of the Compliance Plan, Quality Assessment and Performance Improvement Plan (QAPIP) and supporting MSHN policies and procedures;
- Reviewing and recommending changes/revisions to the Compliance Plan and QAPIP, related policies and procedures and developing new policies and procedures as needed;
- Evaluating the effectiveness of the Compliance Plan and QAPIP;
- 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 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 Plan (QAPIP),
- Implementation of the Compliance Plan;
- Implementation of the action plans related to the Application for Participation (AFP);
- Performance Measures related to Quality Improvement (QI)
- 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; and
- Benefits are realized through our collective strength

Annual Evaluation Process:

a. Past Year's Accomplishments: The QIC had eleven (11) meetings during the reporting period and in that time completed the following tasks:
    - Reviewed and revised the MSHN Corporate Compliance Plan;
    - Reviewed and provided feedback on the FY18 MSHN Compliance Summary report;
    - Reviewed and revised current regional policies and procedures in areas of Quality Improvement and Compliance;
    - Ongoing updates reviewed related to the new Consent to Release Information policy to meet contract compliance;
    - Reviewed MSHN Network Adequacy Assessment 2017;
    - Summary report and annual review of MHSIP and YSS satisfaction surveys;
    - Data collection, summary report and quarterly review of Behavior Treatment Data
    - Data collection, summary report and quarterly review of Performance Indicators (MMBPIS) (including revised process for uploading the file to REMI and revised template) Data collection, summary report and quarterly review of Critical Incidents;
    - Review the Follow-Up after Hospitalization (children and adults) data quarterly;
    - Feedback and participation in the External Quality Reviews (Performance Improvement Project, Performance Measurement Validation, Compliance);
    - Revised, implemented and providing ongoing monitoring for two (2) regional Performance Improvement Projects (PIP) (HEDIS Measure and the Recovery Self-Assessment);
    - Reviewed Medicaid Event Verification process and Annual Methodology Report;
    - Continued coordination of efforts with the MSHN Utilization Management

Committee specific to monitoring outcome measures;
- Provided coordination and monitoring for the MDHHS site review and the required plans of correction;
- Revised quarterly reporting formats for performance measures to focus more on trend analysis, identification of outliers and development of region wide quality improvements;
- Reviewed and revised the MSHN FY17-18 QAPIP;
- Completed the FY17-18 annual QAPIP effectiveness review;
- Reviewed the FY17 and FY18 SUD Satisfaction Survey Summary report;
- Reviewed and approved of revisions to the Annual Delegated Managed Care site review process for FY18;
- Developed QIC balanced scorecard performance report and reviewed quarterly;
- Completed annual review and update of QIC charter;
- Developed project study for review of performance measure "Diabetes Monitoring for Schizophrenia Diagnosis" (inclusive data analysis, protocols, performance standards, plans of correction and quarterly review).

b. Upcoming Goals for Fiscal Year Ending, September 30, 2019
   - Report and complete an assessment of the annual effectiveness of the QAPIP;
   - Conduct ongoing annual review of required policies;
   - Continue implementation, monitoring and reporting of progress on the two (2) regional Performance Improvement Projects;
   - Continue monitoring of quality and performance improvement related the QAPIP
     - Behavior Treatment Review
     - Critical Incidents
     - Performance Improvement (MMBPIS)
     - Consumer Satisfaction
   - Provide Feedback on annual Compliance Summary Report;
   - Review available healthcare data for identification of trends and quality improvement opportunities;
   - Develop a process to measure stakeholder feedback and/satisfaction;
   - 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.

II. Advisory Council FY17 Accomplishments & FY18 Goals

ANNUAL REPORT

TEAM NAME: Regional Consumer Advisory Council

TEAM LEADER: Tina Bertram, Chair Person

REPORT PERIOD COVERED: 10.1.17 – 9.30.18

Purpose of the Consumer Advisory Council: The Consumer Advisory Council (CAC) 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:

- Past Year's Accomplishments: The RCAC had 6 meetings during the reporting period in that time they completed the following tasks:
    - Reviewed the FY17 Annual Compliance Report;
    - Reviewed and provided feedback on the Annual FY17 -18 Compliance Plan;
    - Reviewed changes to the FY18 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 SUD satisfaction survey results;
    - Reviewed and approved RCAC annual effectiveness report;
    - Reviewed and provided feedback on the Quality Assessment and Performance Improvement;
    - Annual review of the MSHN RCAC policy for feedback;
    - Education on MSHN SUD Services and Home and Community-Based Services from MSHN staff;
    - Reviewed outcomes from Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and Performance Improvement Project (PIP) annual reviews;
    - Reviewed and revised council charter;
    - Reviewed and provided feedback regarding MSHN's Strategic Plan;
    - Improved practices for ongoing communication between MSHN and local councils;
    - Provided input on MSHN's QIC-CSC Balanced Scorecard;
    - Provided input on MSHN's updated website and provider directory;
    - Received MSHN Compliance Training;
    - Discussed ways to strengthen Person Centered Planning, Independent Facilitation and Self Determination Implementation;
    - Improved group dynamic and cohesiveness;

- Upcoming Goals for Fiscal Year 2019 Ending, September 30, 2019
    - 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 RCAC policy;
- Annual review of 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;
- Convene special work sessions to develop letters of support/advocacy on regional issues to address time sensitive legislation as a group.

III. Oversight Board FY17 Accomplishments & FY18 Goals

ANNUAL REPORT

TEAM NAME: SUD Oversight Policy Board

TEAM LEADER: Chairman John Hunter, SUD Board Member

REPORT PERIOD COVERED: 10.1.17 – 9.30.18

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 on the following:
     - MSHN Strategic Plan
     - MSHN SUD Prevention & Treatment Services
   - Election of OPB Board Officers;
   - Approval of Public Act 2 Funding for FY18 & related contracts;
   - 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;
   - Received reports on SUD regional site review status;
   - Received Opioid regional and state information & related CDC Guidelines;

- Received information on MDHHS State Targeted Response Grants;
- Received education on Prevention Activities in the region;
- Received information on OROSC Gambling Disorder Prevention Project;
- Received FY17 Compliance Reports & Quarterly FY18 Reports;
- Offered insight on SUD programming, funding and functions;
- Received updates on SUD LARA & Administrative Rules;
- Offered recommendations and insight regarding effective use of collaborative and community efforts;
- Received updates on legislative activities related to SUD funding and section 298;
- Reviewed and updated the SUD Intergovernmental Agreement (expires 12.31.18);
- Reviewed and offered input into the FY19-FY20 MSHN Strategic Plan.

b. Upcoming Goals for FY19 ending, September 30, 2019:
   - Approve use of PA2 funds for prevention and treatment services in each county;
   - Define allocation process of PA2 use by county for prevention and treatment;
   - Improve communications with MSHN Leadership, Board Members and local coalitions;
   - Updated SUD Intergovernmental Agreement signed by all twenty-one counties;
   - Orient new SUD OPB members as reappointments occur;
   - Share prevention and treatment strategies within region;
   - Provide advisory input to the MSHN Board of Directors regarding the overall agency strategic plan and SUD budget; and
   - Monitor SUD spending to assure it occurs consistent with PA 500.

IV. Committee & Workgroup FY17 Accomplishments & FY18 Goals

ANNUAL REPORT

TEAM NAME: Autism Benefit Workgroup

TEAM LEADER: Barb Groom, MSHN Waiver Coordinator
Katy Hammack, MSHN Waiver Coordinator
REPORT PERIOD COVERED: 10.1.17 – 9.30.18

Purpose of the Council or Committee:
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 Mid-State Health Network's (MSHN) Waiver Coordinator and the Community Mental Health Service Prover (CMHSP) autism benefit staff who are appointed by their respective CMHSP Chief Executive Officer/Executive Director. The Autism Benefit Workgroup is chaired by the Waiver Coordinator. All CMHSPs are equally represented on this council.

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

- Advising the MSHN Waiver Coordinator(s).
- Assist with the development, implementation, and operation of the autism benefit 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.
- 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 autism benefit workgroup via the established metrics and monitoring criteria identified in the MSA 15-59 Bulletin to evaluate progress on the following primary goals:

- Reduction and elimination of overdue re-evaluations;
- Reduction and elimination of overdue Individual plan of service (IPOS);
- Hours of Applied Behavior Analysis (ABA) within a quarter must be within the IPOS suggested range for the intensity of service plus or minus a variance of 25%.
- Number of hours of ABA observation during a quarter are equal to or greater than 10% of the total direct ABA service provided.
- Tracking of pending cases (only referred and awaiting an evaluation);
- Implementation of the agreed upon correction actions related to the 2017 Michigan Department of Health and Human Services (MDHHS) Autism Benefit site review findings;
- Compliance and oversight of the above identified areas.

Additionally, the autism benefit workgroup seeks to assess and achieve the following secondary goals:

- Collaborative relationships are retained;
- Continue to increase provider capacity;
- Reporting progress through the MSHN Clinical Leadership Council or MSHN Quality Improvement Council, as identified;
- Regional collaboration regarding expectations and outcomes;
- Efficiencies are realized through standardization and performance improvement; and
- Benefits are realized through our collective strength (knowledge, experience, abilities, and resources).

Annual Evaluation Process:

a. Past Year's Accomplishments
    - The Autism Benefit Workgroup met quarterly and as needed.
    - Continued to provide several training opportunities aimed at increasing capacity and implementation of ABA treatment services; 2-day PEAK, 2-day EFL, QBS Training, Family Guidance Training.
    - Established new email inbox specific to Autism to make process more efficient for submissions of forms.
    - Focused on performance data for the following; overdue re-evaluations, overdue IPOS, suggested range of intensity (direct ABA and observation and direction), overdue service start date and no ABA services (within Department specified timeframe).
    - Maintain a monthly report on the status of the autism benefit.
    - Provided guidance and assistance on expected credentialing practices and oversight.

- Clarified expectations regarding school hours and ABA treatment expectations.
- Developed partnership with Michigan State University for the purpose of increasing quantity and quality of Family Guidance Services for those enrolled in the Autism Benefit.
- Added 15 new contracted ABA Providers to our region.
- Worked with the Department to improve Data Integrity.
- Provided information and support related to Section 959 State Autism Budget.
- Created MSNH AUT Operations Workgroup with the goal to develop a standardized autism provider contract and a regional autism provider performance monitoring process.
- Conducted monthly Delegated Managed Care Review reviews and provided reports of trends.
- Workgroup members presented at various conferences on numerous subject areas related to the Autism Benefit.
- Assisted with obtaining prior authorization for tele-practice use for 142 individuals.
- Provided input to MDHHS for Case Management Trainings.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2019
   - Improve access to quality ABA care to all Medicaid eligible beneficiaries.
   - Prepare for and complete MDHHS Autism Site Visits.
   - Work with system to facilitate the transfer to the new CPT Codes as of January 1, 2019.
   - Increase workforce capacity at all ASD and ABA Provider levels working within the Medicaid program.
   - Evaluate outcomes through assessment data collection and ongoing supervision.
   - Increase collaboration across systems and settings.
   - MSHN will provide regional trainings related to sexuality, diagnostics, challenging behaviors and others as needed.
   - Develop standardized ABA contractual language within our region.

ANNUAL REPORT

TEAM NAME: Clinical Leadership Committee

TEAM LEADER: Linda Schneider, CLC Chair &
Todd Lewicki, MSHN Chief of Behavioral Health Officer

REPORT PERIOD COVERED: 10/1/17 – 9/30/18

Purpose of the Council or Committee:

The MSHN Operations Council (OC) has created a CLC to advise the Pre-Paid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) and the OC concerning the clinical operations of the Entity 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 the Entity 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 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 case discussion ("grand rounds");
- Support system-wide sharing though communication and sharing of major initiative (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 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:

Past Year's Accomplishments:

- Completed the LOCUS workgroup and recommendations with handoff to the Utilization Management Committee for implementation;
- Identified a target for the Cardio Screening for Antipsychotics Measure;
- Addressed and clarified the role of the CMHSP access centers relative to the Michigan State Police Angel Program and how to help persons with SUD access services;
- Reviewed and revised MSHN's Person-Centered Plan policy;
- Implemented a shared CLC and UMC joint meeting format to address topic area overlaps and initiatives;
- Started to address the management of threats to schools and began a School Safety Workgroup to be continued into FY19;
- Began to address the Federal Parity Rule and other federal requirements, including Home and Community-Based Services Rule Transition and the Electronic Visit Verification;
- Addressed policy and procedure input for the Parity Rule and the use of MCG to conduct acute care services reviews retrospectively;
- Ongoing review of MSHN Balanced Score Card with focus on ADHD follow up, collaboration with MDOC, trauma-informed care, and continuity of care;
- Facilitated the biannual renewal of CMHSP Home-Based Services programs;
- Input into the Gambling Disorder regional strategies;
- Ongoing CLC review and discussion of MSHN and MDHHS notices, policies and procedures (e.g. Service Philosophy and Treatment Philosophy, expectation for mobile child crisis services, etc.

- Input into the Mobile Intensive Crisis Stabilization Services for Children;
- Ongoing review of the BHDDA Network Adequacy Standard methodology and results;
- Discussion of Integrated Health Workgroup activities and CMHSP role;
- Addressed Veteran access to services via survey regarding TRICARE and experiences and barriers;
- Addressed the proposal to include authorization data (278 file transaction) for purposes of Parity Rule adherence with the other PIHPs;
- Continued to delineate PCP and address role of independent facilitation, including conflict free perspective;
- Discussion regarding Regional Medical Director Committee role and coordination with the CLC on clinical matters;
- Begun discussions on first episode psychosis and the potential to address this via partnership with Regional Medical Director's Committee;
- Medical clearance following a prescreen was discussed as a starting point to engage the Medical Directors and hospitals to improve processes and outcomes;
- Began the process of addressing staff burnout and turnover;
- Continued to address data via the MSHN Balanced Scorecard;
- Clubhouse spenddown grant system established for participating CMHSPs;
- Consideration of options related to coverage/staffing issues and agency emergency options.

Goals for Fiscal Year 2019; Ending September 30, 2019

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

- Medical Population health outcomes in collaboration with MSHN's ongoing work with the region's Medicaid Health Plans;
- Partner with UMC around the implementation of regional consistency in use of LOCUS, CAFAS/PECFAS, SIS, and training (by MDHHS) in the GAIN;
- Ongoing efforts to strengthen coordination of care between primary and behavioral health care services and seek to expand best practices;
- HCBS Rule implementation; Parity Rule implementation;
- Electronic Visit Verification implementation;
- Continued implementation of competencies in diagnosis and treatment of co-occurring conditions, trauma, gender competence and cultural competence (including military competency training);
- Continuing process improvement service coordination between providers, different levels of care, etc.;
- Continuing partnership opportunities with the Regional Medical Director's Committee;

- Building capacity in psychiatric services, for children and adolescents in particular;
- Regional consistency in access standards and delivery of services;
- Address ongoing initiatives, including School Safety, Integrated Health, Staff Burnout, Telehealth, and other ongoing program requirements.

Role and Perspectives of Medical Directors:

- MSHN Medical Director, Dr. Zakia Alavi, will be a linkage to CLC to address Medical Director perspectives and carry forward CLC content to the Regional Medical Director's Committee.

ANNUAL REPORT

TEAM NAME: Customer Service Committee

TEAM LEADER: Dan Dedloff, MSHN Customer Service & Rights Specialist

REPORT PERIOD COVERED: 10.1.17 – 09.30.18

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:

1. 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;
2. Reviewing and providing input regarding MSHN Customer Services policies and procedures;
3. Reviewing, facilitating revisions, publication, and distribution of the Consumer Handbook;
4. Facilitating the development and distribution of regional Customer Services information materials;
5. Ensuring local-level adherence with MSHN regional Customer Services policies through implementation of monitoring strategies;
6. Reviewing semi-annual aggregate denials, grievances, appeals, second opinions, recipient rights and Medicaid Fair Hearings reports;
7. Reviewing audit results from EQR and MDHHS site reviews and assisting in the development and oversight of corrective action plans regarding Customer Services;
8. Participating in MSHN's Delegated Managed Care Review process;
9. Assisting in the formation and support of the RCAC, as needed; and

10. 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 11 committee meetings during the reporting period in which they completed the following tasks:
   - Reviewed, revised, facilitated publication of, and completed regional distribution for the MSHN FY18 Consumer Handbook;
   - Facilitated publication and electronic regional distribution of the MSHN FY18 Consumer Handbook: Spanish language version;
   - Reviewed and revised regional policies and procedures in areas of Customer Service/Customer Handbook, Customer/Consumer Service Policy, Regional Consumer Advisory Council, Information Accessibility/Limited English Proficiency (LEP), Medicaid Beneficiary Appeals/Grievances, Advance Directives, Customer Service/Confidentiality & Privacy, and Reporting Medicaid Beneficiary Appeals, Grievances, Recipient Rights and Administrative Hearings.
   - Review, analyze and report regional customer service information including:
     - Denials
     - Grievances
     - Appeals
     - Second Opinions
     - Medicaid Fair Hearings
     - Recipient Rights
   - Provided oversite related to Consumer Satisfaction Surveys (FY18 Substance Use

Disorder Consumer Satisfaction);
- Regional standardization of the Notice of Grievance Receipt, Notice of Appeal Receipt, Notice of Appeal Approval, Notice of Appeal Denial, and Notice of Grievance Resolution.

b. Upcoming Goals for Fiscal Year 2019 Ending, September 30, 2019
   - Conduct ongoing annual review of required policies and procedures;
   - Conduct annual review and revisions to the MSHN Consumer Handbook to reflect contract updates and regional changes;
   - Continue to develop, where applicable, MSHN standardized elements of regional forms;
   - Continue reporting and monitoring customer service information;
   - Evaluate oversight & monitoring of regional grievances & appeals, in accordance with customer service standards;
   - Review consumer satisfaction surveys, develop and implement action plans as required per the customer service elements;
   - Increase the percentage met for the MSHN Denial, Appeal, Grievance, and Second Opinion Report;
   - Continue to identify Educational Material/Brochures/Forms for standardization across the region;
   - Explore a standardized regional Customer Satisfaction Survey.

ANNUAL REPORT

TEAM NAME: HSW Workgroup

TEAM LEADER: Katy Hammack, MSHN Waiver Coordinator

REPORT PERIOD COVERED: 10.01.17 – 9.30.18

Purpose of the Council or Committee:

The Habilitation Supports Waiver (HSW) Workgroup was established to initiate and oversee coordination of the HSW benefit for the region. The HSW Workgroup is comprised of the MSHN Waiver Coordinator and the CMHSP HSW Coordinator staff appointed by the respective CMHSP Chief Executive Officer/Executive Director. The HSW Workgroup is chaired by the Waiver Coordinator.

Annual Evaluation Process:

a. Past Year's Accomplishments
   - The HSW Workgroup met quarterly during FY 17.
   - The HSW Workgroup ensured priority management of cases through ranking of Supports Intensity Scale (SIS) ranked standard scores.
   - Reviewed HSW dashboard data and formulate plan for correction-open slots, recoupments, recertification data, overdue IPOS, overdue consents.
   - Prepared for and participated in the 2018 MDHHS site review results.
   - Continued to review and discuss Home and Community Based Services (HCBS) rule changes as they relate to both the C- and B-Waivers.
   - Participated in onsite reviews of Providers in the process of implementing corrective action plans.
   - Reviewed and provided input into the HCBS survey process for C-Waiver and B3 Waiver.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2019
   - Continue to use and institute corrective processes in overseeing HSW performance within the region.

- Continue focus on increasing the number of slots available for consumers within the region.
- Continue to oversee the HCBS rule change as set forth by MDHHS including but not limited to:
  a. Assisting providers in coming into compliance with the HCBS rule.
  b. Participating in onsite reviews of providers in the process of implementing corrective action plans.
  c. Assisting in the transition process for beneficiaries residing in settings that are unable or unwilling to come into compliance.
  d. Continue the ongoing monitoring of providers and CMHSP collaboration with regards to the HCBS rule.
- Ensure proper implementation of new i waiver once approved by the Centers for Medicare and Medicaid (CMS).
- Meet quarterly to address regional needs.

ANNUAL REPORT

TEAM NAME: Provider Network Management Committee

TEAM LEADER: Carolynn Watters, MSHN Director of Provider Network Management Systems

REPORT PERIOD COVERED: 10.1.17 – 9.30.18

Purpose of the Council or Committee: 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) credentialing, privileging and primary source verification of professional staff, and 4) periodic assessment of network capacity. 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 agreements for (CMHSP) Sub-Contractors;
- Support development of regional PNM monitoring tools to support compliance with rules, laws, and the PIHPs Medicaid contract with MDCH.
- Provide requested information and support development of periodic Network Capacity Assessment;
- Monitor results of retained functions contract for Network Capacity Assessment;
- Support development and implementation of a Regional Strategic Plan;
- Look for opportunities and recommend strategies to establish uniformity in contract language and rates, to achieve best value;
- Continue to develop intra-regional reciprocity systems to increase efficiencies;
- Recommend and deploy strategies for sub-contractor credentialing reciprocity agreements.

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:

1. Completion of a Regional Network Capacity Assessment; establish and execute plans to address service gaps;
2. Recommend policy and practices for improved network management compliance and efficiency;
3. Establish performance improvement priorities identified from monitoring of delegated provider network management functions;
4. Increased efficiency through regional contracting when providers are shared;
5. Development of reciprocity agreements for sub-contract credentialing/re-credentialing, training, performance monitoring, and standardized contract language;
6. Implement strategies to establish regional inpatient rate negotiations for best value; and
7. Fully execute regional agreements with Medicaid Health Plans due to rebidding of health plans; strategic relationship to align with additional health plan and PIHP contract requirements.

Annual Evaluation Process:

- Past Year's Accomplishments: The PNMC had ten meetings during the reporting period in that time they completed the following tasks:
- Addressed recommendations from the 2017 assessment of Network Adequacy as it relates to provider network functions, particularly around reciprocity;
- Recommended policy and practices for improved network management compliance and efficiency;
- Executed regionally standardized FI contract;
- Completed annual performance monitoring protocol in accordance with the regional quality monitoring and evaluation policy and procedure, establishing a baseline for performance;
- Developed a regionally standardized inpatient psychiatric contract (in use by 10 of 12 CMHSPs);
- Completed annual performance monitoring protocol in accordance with the regional quality monitoring and evaluation policy and procedure as well as the statewide protocol for inpatient psychiatric services, reducing to a single audit for IPH/Us;
- Developed a regional provider directory in accordance with managed care rules;
- Developed a regional autism operations workgroup to address provider network

issues including contract management, staff qualifications and credentialing, and monitoring

- Upcoming Goals for Fiscal Year Ending, September 30, 2019
- Address recommendations from the 2018 assessment of Network Adequacy as it relates to provider network functions; update the Assessment of Network Adequacy to address newly identified needs;
- Continue to refine and support the statewide and intra-regional inpatient provider performance monitoring protocol resulting in improved provider performance and administrative efficiencies (strategic priority);
- In concert with MSHN, successfully negotiate regional inpatient contracts resulting in improved rates and performance results (strategic priority);
- Continue to refine and support the intra-regional Fiscal Intermediary provider performance monitoring protocol resulting in improved provider performance and administrative efficiencies over baseline year (strategic priority);
- Establish new key performance indicators for the PNMC scorecard;
- Continue to monitor and refine regional provider directory to ensure compliance with managed care rules;
- Fully implement statewide training reciprocity plan within the MSHN region (strategic priority);
- Expand regional autism service capacity to ensure sufficient network capacity to meet consumer demand (strategic priority);
- Evaluate provider capacity for residential, employment and other community living related services at the network level as a result of HCBS rule impact (strategic priority);
- Develop a regional plan for the coordination of focus groups for CMHSP provider network to identify primary workforce concerns and issues (strategic priority).

ANNUAL REPORT

TEAM NAME: SIS Workgroup

TEAM LEADER: Todd Lewicki, MSHN Chief Behavioral Health Officer

REPORT PERIOD COVERED: 10.01.17 – 9.30.18

Purpose of the Council or Committee: The Supports Intensity Scale (SIS) Implementation Workgroup was established to initiate and oversee coordination and implementation of the Supports Intensity Scale assessments for the region. The SIS Implementation Workgroup is comprised of the Waiver Director and the CMHSP SIS assessor staff appointed by the respective CMHSP Chief Executive Officer/Executive Director. The SIS Implementation Workgroup is chaired by the Waiver Director.

Annual Evaluation Process:

a. Past Year's Accomplishments
   - The SIS Workgroup met quarterly during FY18.
   - Added SIS assessors to the region.
   - Assessment completion tracking continues to be a major focus.
   - Began work to use PCE EMRs to prefill data in SIS Venture forms to enhance data reliability and efficiency.
   - SIS assessor analysis for coverage: began next three-year plan for SIS assessment completion.
   - Fully utilized SIS Quality Lead function.
   - Reviewed SIS policies and procedures.
   - Review of SIS white paper.
   - Maintained consistent review of SIS data, including requirement to submit closed or refused cases to MSHN.
   - MSHN hire of direct-supervised SIS assessor.
   - Shift of SIS workgroup responsibilities to the MSHN SIS Assessor.
   - Ongoing data reviews, including completions, domain data, planning related to connection to person centered planning.
b. Upcoming Goals for Fiscal Year Ending, September 30, 2018
   - Utilize appropriate resources to increase SIS assessment completion.
   - Continue to work with CMHSP supports coordinators in use of SIS in person centered planning.

- Use of an AAIDD-approved SIS training for supports coordinators.
- Posting of SIS training in Relias.
- Continue to mature data review and actioning related to addressing needs, significance of support needs, and important to and important for data.
- Obtain further clarification of completion numbers from MDHHS.
- Establish a completed assessment tracking system that uses MDHHS' criteria (includes different elements that appear to alter actual numbers).
- MSHN continued presence at State SIS Steering meetings for information coordination.
- Address MDHHS recommendations relative to SIS expansion: SIS-A for 16 and up, the Annual Review Procedure (ARP), and the SIS-C for ages 5-15.
- Continue to ensure proper tracking and progress toward meeting weekly, monthly, and annual assessment targets.
- Refine quality assurance processes.
- Enhance tracking and completion of assessments.
- Initiate new deployment plan for SIS assessors within the region, possibly including a move to one contract.
- Ensure all first three-year cycle of expected assessments are complete.

ANNUAL REPORT

TEAM NAME: Utilization Management Committee

TEAM LEADER: Skye Pletcher**,** MSHN Director of Utilization and Care Management

REPORT PERIOD COVERED: 10.1.17 – 9.30.18

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 Mental Health 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;
- 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.

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:
    - Reporting and refinement of the Mid-State Supplemental Value dataset
    - Ongoing review of data reports related to performance on UM measures with CMH participants reporting on change strategies of performance feel outside of established expected thresholds
    - Refinement of SIS and CAFAS data systems.
    - Creation of a LOCUS data system and implementation of an exception-based review system of over/under utilization of services according to a common LOCUS benefit grid
    - Ongoing cross-functional dialogue with QI Council, Clinical Leadership, and Provider Network Management.

- Implementation of some joint meeting sessions between UMC and Clinical Leadership Committee (CLC) to maximize efficiency around shared agenda items
- Continued use of Data Lab group to define and refine UM measures.
- Expanded SUD reporting in committee to include monitoring of SUD Residential Utilization and Detox Recidivism
- Review of acute level service data and crisis stabilization service need.
- Decision on data comparisons to review, i.e. per 1,000 population and per 1,000 served.
- UM discussion relative to prospective, concurrent, and retrospective UM processes.
- Implementation of a new project to develop regional standard clinical service protocols
- Implementation of new process for CMHSP

b. Upcoming Goals for Fiscal Year Ending, September 30, 2019
   - 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;
   - Ensure representative SUD presence on UMC;
   - Formalization of CAFAS, SIS, and LOCUS in UM systems;
   - Review and monitor utilization patterns and analysis to detect and recommend remediation of over/under or inappropriate utilization;
   - Completion of regional standard clinical service protocols 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 UM practices;
   - Shift analysis of variance of certain codes to the UM Committee.
   - 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 UM members relative to skill set needed by committee members.
   - Input into HCBS data, findings, and system improvements, as appropriate.

SECTION THREE – EVALUATION AND PRIORITIES

I. 2018 Annual Effectiveness Review of QAPIP Goals and Objectives

2018 QAPIP Annual Effectiveness Review				
Objective	**Evaluation Method**	**Met, Partial, Unmet**	**Strategic Planning Objective**	**Council / Committee**
Components				
Provide Oversight & Monitoring of the Provider Network	Implement Compliance Monitoring activities	Met	Enhance organizational quality & compliance	QIC
	Implement QAPIP	Met		QIC
Guidance on Standards, Requirements & Regulations	Council & Committee review of MDHHS Contract and External Quality Review Requirements	Met		All
Governance				
Board sets policy related to quality management	MSHN Quality Policies	Met	Enhance organizational quality & compliance	Board of Directors
Board annually approves QAPIP & related priorities	Board approval of MSHN QAPIP	Met		Board of Directors
QAPIP updated annually and reviewed by the QIC	Updated QAPIP and QIC approval	Met		QIC
Communication of Process and Outcomes				
QIC monitors performance measurement activity	Performance Measure (PM) Reports	Met	Enhance organizational quality & compliance	All
Identify opportunities for process and outcome improvements	Recommendations included in PM Reports	Met		ALL
Require corrective action plans for measures below regulatory standards and/or targets	Corrective action plan submissions & reviews	Met		QIC
Regular reports to Councils, Committees, Board of Directors and Advisory Councils	Council & Committee Annual Reports	Met		All
Consumers & Stakeholders receive reports on key performance indicators,	Consumer Satisfaction Survey Results: SUD Satisfaction Survey, National Core Indicator (NCI) Survey	Met	Increase the voice of MSHN's	RCAC, QIC

consumer satisfaction survey results and performance improvement projects	Customer Service Reports	Met	customers and key stakeholder	RCAC, CSC
	Behavioral Treatment Review Oversight Report	Met		RCAC, BTPRC
	Performance Improvement Projects: **Recovery Self-Assessment	Met		QIC
	Performance Improvement Projects: Diabetes Monitoring	Met		RCAC, QIC
	Michigan Mission Based Performance Indicator System (MMBPIS)	Met		RCAC, QIC
	HEDIS Measures: FUH-Adult and Child, Diabetes Screening	Met		RCAC, QIC
	MSHN Balanced Score Card	Met		All
Board of Directors receive annual report on status of organizational performance	MSHN Scorecard, Annual QAPIP Effectiveness Review Report	Met	Enhance organizational quality & compliance	MSHN CEO
Performance and Quality reports are made available to stakeholders and general public	MSHN website includes: Quality Assessment Performance Improvement Plan, Compliance Plan, Compliance Reports, MMBPIS Summary, External Site Reviews, Internal Site Reviews, Satisfaction Survey Reports, Recovery Assessment Reports	Met	Increase the voice of MSHN's customers and key stakeholder	All Stakeholders
Medicaid Event Verification Attachment 1				
Verifies delivery of services billed to Medicaid	The completion of the PIHP Medicaid Event Methodology Report	Met	Public resources are used efficiently and effectively	QIC
Results aggregated, analyzed and reported at QIC	FY18 MEV Report completed and reviewed with QIC	Met		QIC
Opportunities identified for improvement	FY18 MEV Report reviewed by; Discussion on improvements to the process and review of trends of non-compliance	Met		QIC
Reported annually to MDHHS	FY18 MEV Report sent to MDHHS	Met		MSHN Deputy Director

Quantitative and Qualitative Assessment of Member Experiences Attachment 2 & 3				
Surveys analyzed*	Substance Use Disorder Report - Satisfaction Survey	Met	Improved behavioral health treatment/service outcomes	QIC, RCAC
	The National Core Indicator (NCI) Survey	Met		QIC, RCAC
Identified strengths and opportunities for improvement	SUD Satisfaction Survey Summary	Met		QIC, RCAC
	The National Core Indicator (NCI) Survey	Partial		QIC, RCAC
Surveys shared with QIC and RCAC	SUD Satisfaction Survey Summary	Met	Increase the voice of MSHN's customers and key stakeholder	QIC, RCAC
	The National Core Indicator Survey	Met		QIC, RCAC
Credentialing, Provider Qualification and Selection				
Ensure CMHSP adherence to MSHN credentialing policy	Credentialing/Re-Credentialing policy has been developed in accordance with MDHHS contract requirements; FY18 on-site review completed	Met	Enhance organizational quality & compliance	PNC
Provider Monitoring Attachment 4 & 5				
CMHSP annual monitoring of provider subcontractors	Annual Delegated Managed Care (DMC) Site Review, MEV reviews, and Financial auditing completed for FY18.	Met	Enhance organizational quality & compliance	QIC, PNC
MSHN monitoring of CMHSPs and SUD Provider Network compliance		Met		QIC, PNC
Event Monitoring and Reporting Attachment 5 & 6				
Critical Incident Reporting to MDHHS	Critical Incident Performance Reports	Met	Assume increased responsibility for healthcare outcomes	QIC
Trends and patterns identified	Critical Incident Reporting occurs on a quarterly basis to QIC; Trends & Patterns are identified and reviewed on a quarterly basis	Met		QIC
Oversight of CMHSP risk analysis and reduction	On-site reviews completed at CMHSP's as part of DMC review in FY18	Met		QIC
Oversight of "Vulnerable People" Attachment 5				
CMHSPs monitor health, safety and welfare of individuals served	Annual DMC site reviews-clinical record reviews	Met	Assume increased responsibility for	QIC

Related concerns are acknowledged, and action taken as appropriate	Annual DCM site reviews- plans of correction	Met	healthcare outcomes	QIC
Utilization Management Plan				
UM Committee develops standards for utilization	Utilization Management Plan and Committee Report	Met	Public resources are used efficiently and effectively	UMC
Utilization activity and trends are reviewed and analyzed	Utilization Management Plan and Committee Report	Met		UMC
Identification of under-and-over utilization	Utilization Management Reports	Met		UMC
Uniform screening tools and admission criteria	Utilization Management Committee – LOCUS has been selected	Met	Improved behavioral health treatment/ service outcomes	UMC
Autism Waiver Monitoring				
Compliance with Autism Benefit program requirements	Quarterly Autism Reports; FY18 on-site CMHSP DMC Program Specific Review	Partial	Improved access to care	Autism Workgroup
Trends and patterns identified	Quarterly Autism Reports	Met		Autism Workgroup
Oversight of CMHSP corrective action related to the MDHHS site review	Ongoing monitoring of corrective action plan responses and implementation outcomes	Met		Autism Workgroup
Behavior Treatment Attachment 8				
Quarterly analysis of adherence to BTR Standards	BTR Performance Reports	Met	Improved behavioral health treatment/service outcomes	QIC, BTPRC
Trends and patterns identified	BTR Performance Reports includes patterns and related improvement recommendations	Met		QIC, BTPRC
Practice Guidelines				
CMHSP implementation of practice guidelines	Utilization Management Plan and Committee Report	Met	Improve access to care	UMC
	MSHN desk review verifications of local implementation; FY18 on-site reviews completed	Met	Improve access to care	UMC
Performance Measurement Attachment 7, 9, 10				

Priority Performance Measures *(Met=Standard exist and has been met or no standard exist, and improvement has been made.* *New=No comparison data yet.)*	FUH Report, Follow-Up After Hospitalization Mental Illness Adult (joint metric)	Met	Assume increased responsibility for healthcare outcomes	QIC
	Follow-Up After Hospitalization Mental Illness Children (joint metric)	Met		QIC
	Diabetes Monitoring Report-Baseline year (PIP)	Met-		QIC
	Diabetes Screening Report (pay for performance measure)	Met		QIC
	*Cardiovascular Screening	Met		CLC
	*FU Children ADHD Med Initiation Phase	Met		CLC
	*FU Children ADHD Med Continuation & Monitoring (C&M) Phase	Met		CLC
	Plan All-Cause Readmissions (joint metric)	Met		UMC
	*Adult Access to Care	Met		UMC
	*Children Access to Care	Met		UMC
	*Initiation of Alcohol and Other Drug (AOD) Treatment	New		CLC
	*Engagement of Alcohol and Other Drug (AOD) Treatment	New		CLC
	Follow Up After Emergency Department Visit for Alcohol and other Drug Dependence (joint metric)	New		
Performance Improvement Projects	PIP - RSA Report	Met		QIC
	PIP - HEDIS Diabetes Monitoring Report	Met		
Performance Indicators	MMBPIS Reports	Partial	Improve Access to Care	QIC

The satisfaction surveys, MSHIP and YSS were not implemented per MDHHS in 2018.
*indicates not required
Attachments can be found in the of FY19 QAPIP FY18 Annual Effectiveness Review

II. MSHN FY18 Strategic Plan Priorities & Objectives

Strategic Objective	Goal/Measurement	Status	Recommendations
Better Health			
MSHN will improve its population and integrated health activities, and will develop a comprehensive integrated care/population health management plan			
MSHN will develop and establish a measurement portfolio to improve use of data in monitoring regional performance metrics and assist with decision making, both internally and at the council, committee and board levels.	1. Continue deployment of the knowledge services improvement strategy to enhance use of data in all decision-making venues, including MSHN councils, committees and workgroups	Complete	Discontinue
Implement standardized assessment tools across the region for all populations served	1. Develop systems to aggregate and report on regional performance in standardized assessments and outcomes reporting	Complete	Continue
Better Care			
Improve Access to Care			
MSHN ensures a consistent service array (benefit) across the region and improves access to specialty behavioral health and substance use disorder services in the region	1. All Medicaid and Healthy Michigan Specialty Behavioral Health Services described in the Medicaid Provider Manual are available through CMHSP direct-operated or contracted providers	Complete	Discontinue
	2. Fully implement the region's access and authorization practice guidelines to achieve a common benefit	In Progress	Continue

	3. Standardize practices for documentation of medical necessity to assure people are receiving an appropriate scope, duration and intensity of care	In Progress	Continue
	4. MSHN will ensure there are uniform access and utilization management criteria in place, and will monitor admissions and denials for conformity with the established criteria	In Progress	Continue
	5. Monitor compliance with Autism Benefit program requirements	In Progress	Continue
Improve the Role of MSHN Customers and Key Stakeholders in MSHN Operations			
Implement regional educational opportunities and input sessions around new initiatives and ongoing operational matters	1. Establish regional opportunities for key stakeholder and provider input and communications	In Progress	Modify/ Continue
Stakeholder feedback demonstrates effective, efficient and collaborative operations	1. Deploy a survey tool to measure participating provider satisfaction and achieve 80% satisfaction with the effectiveness and efficiency of MSHN's processes and communications	Complete	Discontinue
MSHN will improve and integrate stakeholder and consumer input systems	1. Evaluate feasibility of survey consolidation and streamlining	In Progress	Modify/ Continue
Enhance Organizational Quality and Compliance			
MSHN implements its approved Quality Assessment and Performance Improvement Plan (QAPIP), and	1. Quality review tools are developed and implemented across the Substance Abuse	Complete	Discontinue

specific Performance Improvement Plans, to improve quality and care across the region	Prevention and Treatment (SAPT) provider network		
MSHN will provide leadership on improving the consistency and implementation of person-centered planning in the region	1. MSHN will strengthen review of person-centered planning implementation in its provider network oversight activities	In Progress	Continue
Better Value			
Public Resources are Used Efficiently and Effectively			
Implementation of the region's utilization management (UM) plans demonstrate achievement of defined goals	1. MSHN adopts and implements site review protocol for utilization management (UM) reviews that are consistent with the regionally adopted UM plan	Complete	Discontinue
	2. Audited medical records demonstrate evidence of consistently applied medical necessity criteria, consistent with regionally approved criteria and to support scope, duration and intensity of services	Complete	Discontinue
Regional Public Policy Leadership Supports Improved Health Outcomes and System Stability			
MSHN develops and implements plan for PIHP accreditation	1. Implement necessary accreditation-related action plans regionally and within the PIHP	9/30/18	Discontinue
MSHN will ensure consistent, standardized, and cost-effective operations and will position the region for continued success regardless of payer structure	1. MSHN and its CMHSP participants will evaluate centralization of selected contracting functions	Not Started	Continue

	2. MSHN and its CMHSP participants will revisit the delegated managed care functions grid and update, and will consider conducting evaluations of the effectiveness and efficiency of delegating managed care functions	Not Started	Continue
MSHN's Provider Network Management Systems are effective and efficient	1. MSHN publishes provider performance data to consumers and the public	In Progress	Continue

III. QAPIP Priorities for Fiscal Year 2019 (Based on the FY19/FY20 MSHN Strategic Plan Priorities and Objectives)

Strategic Objectives	Goal/Measurement	Assigned Committee/ Council
Better Health		
Improve Population and Integrated Health Activities		
MSHN will expand the use and adoption of the Regional Electronic Medical Information (REMI) System and other applicable software platforms in use across the region to support improved population health outcomes, coordinated and integrated care activities, effectiveness and efficiency.	1. MSHN will improve and standardize processes for exchange of data between MSHN and MHPs; CMHSPs and MSHN. MSHN and SAPT Providers and will facilitate CMHSP-to-CMHSP data exchange in order to reduce duplication when gathering needed information for reporting.	QIC & ITC
Improved Behavioral Health Treatment/ Service Outcomes		
MSHN will work with CMHSPs to MONITOR key indicators, supported by MSHN data analysis tools and analytics, such that these metrics inform both regional and county contractual performance targets, and are value added for decision making at councils, committees and board governance levels at MSHN and at all CMHSPs	1. MSHN will continue to monitor and increase performance related to selected priority measures, key performance indicators and MDHHS's required metrics.	QIC & UMC

Better Care		
Improve Access to Care		
MSHN ensures a consistent service array (benefit) across the region and improves access to specialty behavioral health and substance use disorder services in the region.	1. Fully implement the region's access and authorization practice guidelines to achieve a common benefit.	QIC & UMC
	2. Standardize practices for documentation of medical necessity to assure people are receiving an appropriate scope, duration and intensity of care.	QIC, CLC & UMC
	3. MSHN will ensure there are uniform access and utilization management criteria in place and will monitor admissions and denials for conformity with the established criteria.	QIC
MSHN and participating CMHSPs establish processes to assist individuals served in maintaining eligibility for Medicaid and/or Healthy Michigan Program coverage.	1. MSHN will monitor CMHSP and SAPT provider consumer verification practices through its site review process and Medicaid event verification audit.	QIC
Improve the Role of MSHN Customers and Key Stakeholders		
Stakeholder feedback demonstrates effective, efficient and collaborative operations	1. Deploy a survey tool to measure participating provider satisfaction and achieve 80% satisfaction with the effectiveness and efficiency of MSHN's processes and communications	QIC
MSHN will improve and integrate stakeholder and consumer input and utilize compiled input to improve system performance and provide feedback to stakeholders on systems improvements made.	1. Improve communications linkages between provider input forums, executive leadership and governance	QIC
	2. Evaluate feasibility of survey consolidation and streamlining	QIC

Enhance Organizational Quality and Compliance		
MSHN will provide leadership on improving the consistency and implementation of person-centered planning, self-determination and independent facilitation in the region	1. MSHN will strengthen MSHN QAPI reviews of person-centered planning, independent facilitation and self-determination implementation in its provider network oversight activities	QIC, CCC & CLC
	2. MSHN will use data gathered in its provider network oversight activities to develop specific training and/or learning communities to strengthen person-centered planning, independent facilitation and self-determination implementation	QIC, CCC & CLC
Better Value		
Regional Public Policy Leadership Supports Improved Health Outcomes and System Stability		
MSHN will ensure consistent, standardized, and cost-effective operations and will position the region for continued success regardless of payer structure	1. MSHN ensures full implementation of agreed upon regionally standardized processes at all CMHSPs and the PIHP	QIC, PNC & UMC
	2. MSHN evaluates penetration rate, cost and other metrics and addresses undesirable variation through its councils and committees in order to promote standardized, consistent and cost-effective operations across the region	QIC, ITC, UMC, CLC, FC & PNC
MSHN's Provider Network Management Systems are effective and efficient	1. MSHN publishes provider performance data to consumers and the public	QIC & PNC
	2. Evaluate the effectiveness of regionally organized fiscal intermediary and inpatient provider performance monitoring systems developed in prior years	QIC & PNC

Better Provider System		
MSHN ensures that it engages a provider network with adequate capacity and competency		
MSHN enhances existing quality assessment and performance improvement systems that promote continuous improvement and enhanced accountability for clinical and fiscal performance	1. MSHN will develop and begin reporting on the provider scorecard	QIC & PNC
	2. MSHN will strengthen regional performance improvement systems in the SAPT provider network	QIC
	3. MSHN will provide training and education related to data integrity, reporting standards, use of data in decision making and provider development	QIC, ITC, PNC, CLC, UMC
	4. MSHN will integrate fiscal information and performance results into its quality assessment and performance improvement systems	QIC, FC, PNC
MSHN engages in activities to simplify administrative complexity and enhance provider satisfaction	1. Fully implement the REMI provider network monitoring (audit) module including provider response feature to streamline processes and promote efficiencies (including SUD and CMHSP delegated managed care audits).	QIC, PNC, ITC
	2. MSHN will develop internal functional area annual plans (inclusive of provider responsibilities related to strategic projects/initiatives, and operational requirements such as audits, annual plans, reporting requirements, etc.) To identify overlap/redundancy and opportunities for cross functional collaboration to streamline processes.	QIC, PNC

V. MSHN Balanced Scorecard Report

				Target Ranges		
Key Performance Indicators	**Aligns with**	**Actual Value**	**Target Value**			
Better Health						
Complete SIS Assessments for adult persons with IDD	MSHN Strategic Plan FY17-FY18	62%	100%	>=75%	50%-74%	<50%
Percent of providers who are in compliance with the HCBS Rule.	MSHN Strategic Plan FY17-FY18, MDHHS State Transition Plan	47%	90%	>=76%	26%-75%	<=25%
MSHN will have a complete set of standardized assessment databases developed.	MSHN Strategic Plan FY17-FY18, MDHHS State Transition Plan	100%	100%	100%	66%	33%
Child and adolescent access to primary care.	MSHN Strategic Plan FY17-FY18, MDHHS State Transition Plan; Measurement Portfolio Engaging Primary Care	96%	100%	>=75%	50%-74%	<50%
Adult access to primary care.	MSHN Strategic Plan FY17-FY18, MDHHS State Transition Plan; Measurement Portfolio Engaging Primary Care	95%	100%	>=75%	50%-74%	<50%
Increase use cases with MiHIN	Health Information Exchange	1	2	2	2	1

ADHD medication follow up. This HEDIS measure reports the percentage of children newly prescribed ADHD medication who received at least three follow-up visits.	Aligns with strategic plan goal to establish clear criteria and practices that demonstrate improved primary care coordination and with Performance Measure Portfolio (Monthly)	Initiation: 82.5% ; C & M: 96.9% (September 2017 - August 2018)	Increase over FY 2017 (Initiation 72.86%; C & M 97.25%)	I:74% C&M: 99%	I:70% C&M:95%	I: 65% C&M: 91%
Increased access to Women's Specialty Programs as reflected by increase by county of women receiving WSS compared to previous fiscal year (2016).	Aligns with MSHN SUD strategic plan goals to increase WSS (p.15)	1136 FY18 (Oct-Aug)	5% increase in women receiving WSS (FY17 1216)	Increase by 61+	20-60	<19
Data exchange with MHPs	Health Information Exchange	1	3	3	1	0
Better Care						
Penetration rate by population shall increase 10% annually.	MSHN Strategic Plan FY17-FY18, MSHN UM Plan	7%	Improve over 2017	>= 9.93%	9.92% - 9.04%	< 9.03%
Percent of care coordination cases that were closed due to successful coordination.	MSHN Strategic Plan FY17-FY18, MDHHS State Transition Plan	58%	100%	>=50%	25%-49%	<25%
Standard for Follow-up After Hospitalization for Adults with Mental Illness is met (FUH)	Measurement Portfolio NQF 0576	79%	58%	>=58%	0	<58%

Standard for Follow-up After Hospitalization for Children with Mental Illness is met (FUH)	Measurement Portfolio NQF 0576	84%	70%	>=70%	0	<70%
Address network capacity for detox services and medication assisted treatment, including availability of methadone, vivitrol and suboxone at all MAT locations	MSHN Strategic Plan FY17-18; Network Adequacy Assessment	15	6 over current	>6	4-Mar	<3
Develop improved crisis and inpatient capacity for targeted acute care needs	MSHN Strategic Plan FY17-18; Network Adequacy Assessment	2.76% decrease	decrease 10%	>10%	7-9%	<6%
The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (Plan All Cause Readmissions)	MSHN Strategic Plan FY17-FY18, MSHN UM Plan; Measurement Portfolio NQF 1768	11%	<=15%	<=15%	16-25%	>25%
Define typical population service utilization patterns and methods of analysis to identify and recommend possible opportunities for remediation of over/under utilization.	MSHN Strategic Plan FY17-FY18, MDHHS State Transition Plan	75%	100%	>=75%	50%-74%	<50%

Better Value						
Reduction in number of visits to the emergency room.	MSHN Strategic Plan FY17-FY18, MDHHS State Transition Plan	69%	100%	>=75%	50%-74%	<50%
Reduction in admits for psychiatric/physical health reasons.	MSHN Strategic Plan FY17-FY18, MDHHS State Transition Plan	80%	100%	>=70%	45%-69%	<45%
Develops a regional FI contract resulting in improved rates through standardization	PNMC Annual Action Plan	100%	100%	>99%	83-99%	<82%
MSHN reserves (savings & ISF)	Board of Directors Risk Management Target	8.70%	7.50%	≥ 7% and ≤ 8%	≥ 6.5% and < 7% or >8% and ≤ 8.5%	< 6.5% or > 8.5%
MSHN Administrative Budget Performance actual to budget (%)	MSHN's board approved budget	98%	≥ 90%	≥ 90%	> 85% and < 90%	≤ 85% or >100%
MSHN demonstrates performance within one standard deviation of statewide rates for 10 CPT/HCPCS codes as designated by Finance Council	MDHHS reported values	22%	80%	≥80%	≥ 70% and ≤ 80%	≤60%

SECTION FOUR – PERFORMANCE MEASUREMENT ATTACHMENTS

Attachment 1. FY2018 Medicaid Event Verification Annual Methodology Report
Attachment 2. Consumer Satisfaction Reports –Substance Use Disorder Report FY2018
Attachment 3. Consumer Satisfaction Report-National Core Indicator Report 2011-2017
Attachment 4. Provider Satisfaction Survey
Attachment 5. Internal Monitoring and Auditing Summary
Attachment 6. FY2018 Critical Incident Report
Attachment 7. Priority Measures Report
Attachment 8. FY2018 Behavior Treatment Review Oversight Report
Attachment 9. Michigan Mission Based Performance Indicator System (MMBPIS) FY2018
Attachment 10. Performance Improvement Project – HEDIS Diabetes Monitoring
Attachment 11. Performance Improvement Project – Recovery Self-Assessment 2018

Attachment 1

Pre-Paid Inpatient Health Plan

Medicaid Services Verification Methodology Report

Fiscal Year 2018

(October 1, 2017 – September 30, 2018)

Methodology Report Outline

Introduction & Background

Process/Methodology Summary

Summary of Results

A. Summary of analysis
B. Study Results
C. Data Chart

Deficiencies/Plans of Correction

A. Fiscal Year 2018 Deficiencies
B. Repeated Deficiencies

Process/Performance Improvement

Future Outlook

Introduction & Background

In accordance and compliance with the Medicaid Managed Specialty Supports and Services 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 twelve (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 57 substance use disorder (SUD) treatment providers that include 12 treatment providers that have multiple service locations and 38 agencies that provide prevention services.

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 57 SUD treatment providers, only the 37 providers that were in region providers, that provided Medicaid eligible services and used Medicaid funding were included in the review. The 37 providers included 64 unique service provider locations. 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.

Process Summary/Sampling Methodology

Medicaid claims verifications are conducted bi-annually (twice a year) for CMHSPs and annually (once a year) for substance use providers, utilizing a random sample. One (1) CMHSP review is completed as an onsite review and one (1) CMHSP review is completed as a desk review. Sample selection for the CMHSP includes both the direct services provided by the CMHSP and the services provided at contract providers of the CMHSP. Substance use providers with multiple locations with distinct site licenses had a sample reviewed for each location.

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.

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

[1] Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 18 – Attachment P.6.4.1

includes at least one beneficiary from each of the following service types as applicable to the provider; Detox, Residential, Out-Patient Services, Peer Services, and Medication Assisted Treatment.

MSHN implemented a managed care information system during the second quarter of FY2018. After the implementation of the new system the sampling methodology was changed to allow samples to be pulled more efficiently from one location. The updated process started with the CMHSP data. The next stage in the sampling process will begin to move the SUD samples into the new process.

From October 1, 2017 through March 31, 2018 the sample was pulled using Microsoft Sequel Server and Excel. Microsoft Server Sequel will use program scripts to pull the beneficiaries served during the previous two quarters from the MSHN Data Warehouse. Every beneficiary will then be assigned a random number within Excel. An additional column will then be created within Excel and the formula "=rand()" will then be used to select the random 6% of beneficiaries. Only the top 5 % of beneficiaries will be used to complete the sample for the review if all the required program types are met. If the sample does not include one beneficiary from each required program type the last beneficiary will be removed from the 5% sample and the next beneficiary on the sample list that meets the criteria will be used. If all the program types are not met with the 6% sample pulled, then the process will be run again to select additional beneficiaries. This will be done until all the required program types are selected.

Beginning April 1, 2018, the samples for the CMHSP reviews are managed in Microsoft SQL Server. A record set is extracted using query logic in Microsoft SQL Server. These scripts pull any beneficiary records where those beneficiaries had service encounters at any time during the prior six-month period. This extract is used to randomly generate 5% of the total beneficiaries in the record set. The 5% beneficiaries are determined by using script logic that has an algorithm to make sure the required program types can be met. This algorithm will run through the dataset randomly until a 5% sample is attained. If all the program types cannot be met using this algorithm, then the script runs using records for that program type until all have a selected 5% sample.

The summary incorporates services that are documented in the CMHSP electronic health record and those services not documented in the EHR (paper charts and/or contracted providers).

Data Analysis/Summary of Results

Summary of Analysis

Records and claims were reviewed over the course of the full fiscal year, October 1, 2017 – September 30, 2018. Data presented in the below chart is relative to the 12 CMHSP's and 37 substance use disorder treatment providers which includes 64 service locations 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%	99.78%	99.68%	100%	97.34%
CEI	100%	100%	98.57%	89.97%	93.36%	100%	99.36%
CMHCM	100%	100%	99.72%	94.09%	93.14%	100%	99.31%
Gratiot	100%	100%	100%	99.42%	100%	100%	100%
Huron	100%	100%	100%	99.47%	99.65%	100%	100%
Lifeways	100%	100%	100%	94.15%	97.38%	99.36%	99.89%
Montcalm	100%	100%	99.41%	96.47%	98.24%	100%	100%
Newaygo	100%	100%	100%	89.53%	97.82%	99.51%	97.56%
Saginaw	100%	100%	100%	99.10%	99.41%	100%	99.51%
Shiawassee	100%	100%	99.74%	99.67%	95.21%	100%	98.34%
The Right Door	100%	100%	99.53%	99.29%	99.53%	100%	99.61%
Tuscola	100%	100%	100%	99.23%	99.15%	100%	100%
MSHN Average	**100%**	**100%**	**99.75%**	**96.68%**	**97.71%**	**99.91%**	**99.24%**

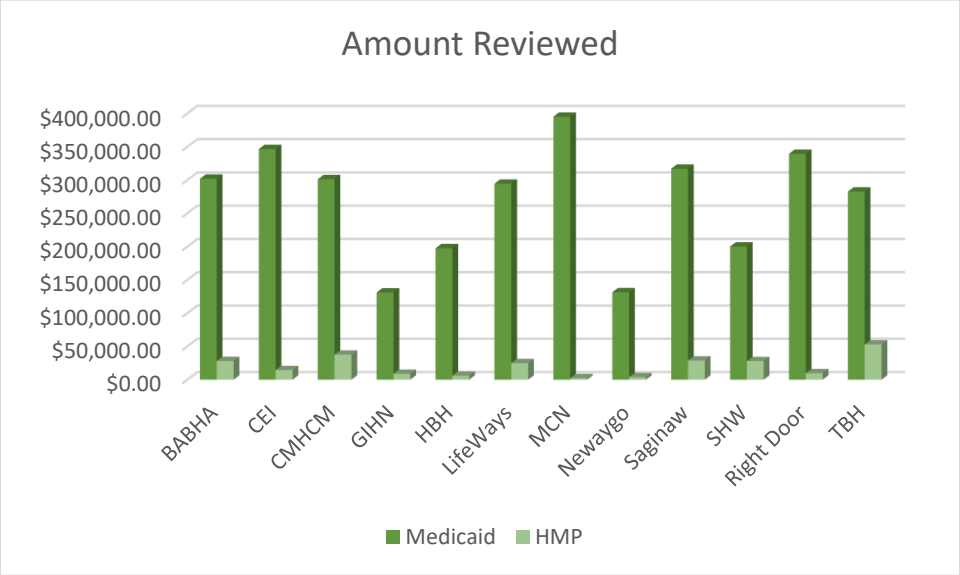
Note: A) The code is allowable service under the contract, B) Beneficiary is eligible on the date of service, C) Service is included in the persons individualized plan of service, D) Documentation of the service date and time matches the claim date and time of the service, E.) Documentation of the service 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.

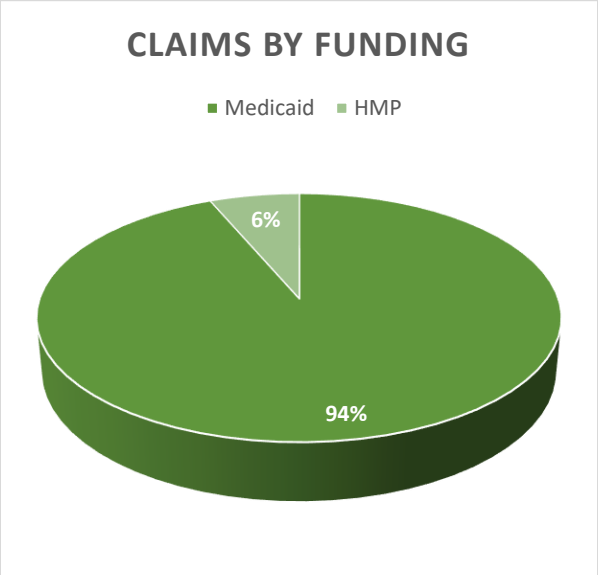
SUD

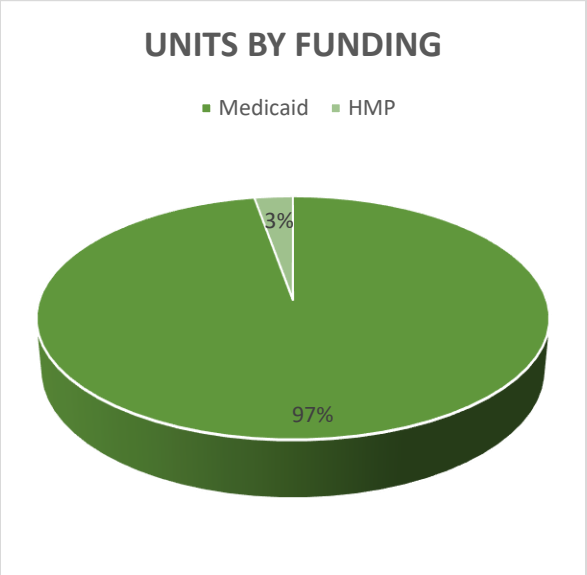
	A	B	C	D	E	F	G
SUD Providers	**100%**	**99.28%**	**88.84%**	**92.37%**	**96.67%**	**99.94%**	**96.90%**

Summary of CMHSP Claims Reviewed by Funding Source:

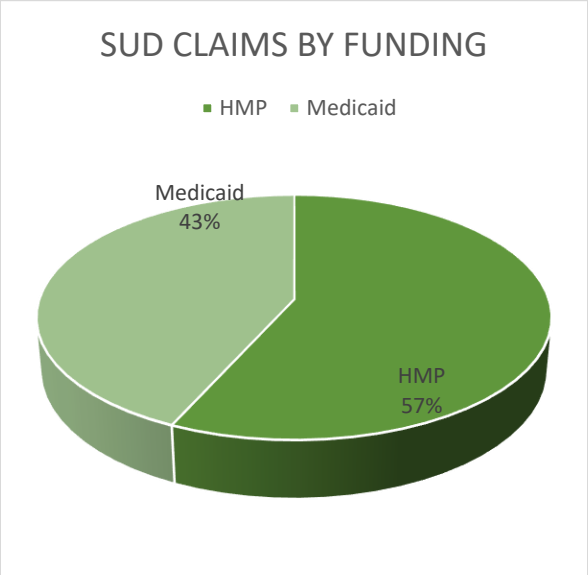
In total 14,564 claims were reviewed. Of the 14,564 claims reviewed 13,632 of the claims were billed as Medicaid and 932 of the claims were billed using Healthy Michigan Plan Funding. The 14,564 claims included 115,238 units of service. Of the 115,238 units reviewed 112,026 were billed as Medicaid and 3,212 were billed as Healthy Michigan Plan. The dollar amount of the claims reviewed totaled $3,483,323.44. Of the $3,483,323.44 reviewed $3,238,230.03 were billed using Medicaid funding and $245,093.41 were billed using Healthy Michigan funding.

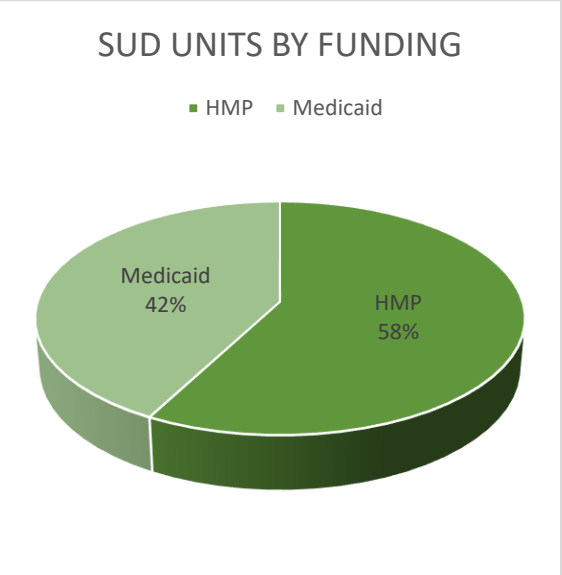






Summary of SUD Claims Reviewed by Funding Source:
In total 19,775 claims were reviewed. Of the 19,775 claims reviewed 8,541 of the claims were billed as Medicaid and 11,234 of the claims were billed using Healthy Michigan Plan Funding. The 19,775 claims included 26,928 units of service. Of the 26,928 units reviewed 11,368 were billed as Medicaid and 15,560 were billed as Healthy Michigan Plan. The dollar amount of the claims reviewed totaled $1,835,809.57. Of the $1,835,809.57 reviewed $765,174.47 were billed using Medicaid funding and $1,070,635.10 were billed using Healthy Michigan funding.





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

CMHSP Services Reviewed by Program

Program	Claims	Units	Amount
ACT	1,357	3,797	$248,060.90
Autism	1,373	5,252	$168,725.38
Crisis Residential	151	181	$80,010.33
Habilitation Supports Waiver	3,535	46,166	$1,097,368.90
Home Based Services	1,778	7,311	$539,382.13
Self Determination	3,118	50,838	$299,619.71
Targeted Case Management and Supports Coordination	4,414	23,997	$1,176,148.27
Wraparound	416	1,354	$173,264.99

The services reviewed for the SUD provider were from detox and residential, outpatient, peer delivered services, and medication assisted treatment. 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	5,263	7,135	$1,161,548.00
Medication Assisted Treatment	7,372	7,777	$140,069.00
Outpatient	7,854	12,730	$586,330.57
Peer Services	1,704	3,724	$50,221.00

Deficiencies/Corrective Action

Fiscal Year 2018 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 FY2018, 12 CMHSPs were placed on a new plan of correction and 60 substance use disorder treatment provider locations were placed on a new plan of correction. 12 CMHSPs were removed from a previous plan of correction and 50 substance use disorder treatment provider locations were removed from a previous plan of correction. There were seven (7) substance use provider locations that had a repeat issue identified in the corrective action plan.

The overall findings included a total dollar amount of invalid claims identified for CMHSP's direct and indirect services of $115,953.91 and $288,050.74 for substance use disorder treatment providers. All invalid claims were corrected based on MSHN's established process.

NOTE: Many of the invalid claims related to documentation was due to a lack of understanding what documentation was needed to support the claims. In these instances, additional documentation was sent with the plan of correction to justify the claims originally found to be invalid. These 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 apparent, the CMHSPs and substance use 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 and/or the Office of Health Service Inspector General is required. This process occurs throughout the year as the reports are received.

Repeated Deficiencies

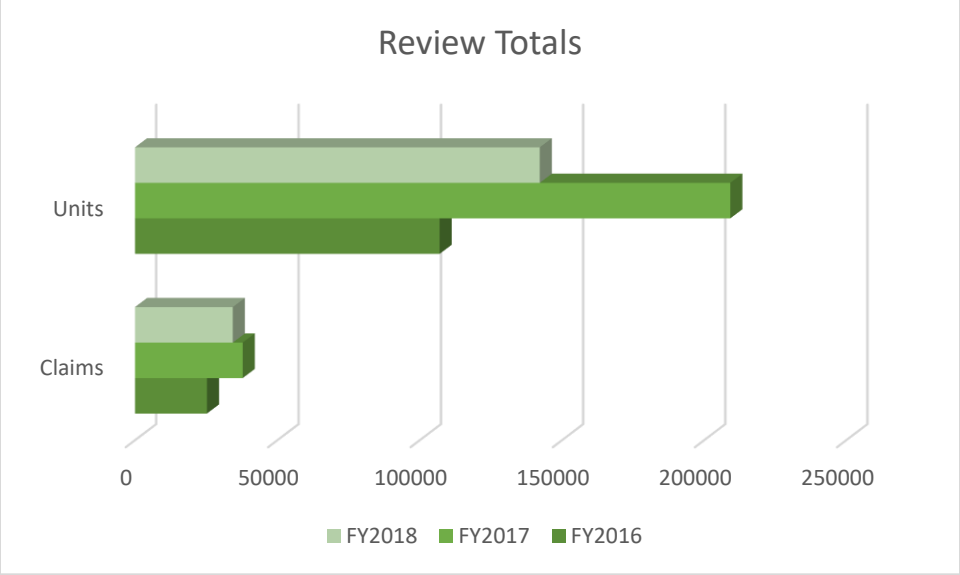
Though the MSHN combined average for CMHSPs and SUD providers did not fall below the departments 90% accuracy rate for any area reviewed, there were providers that had elements tested that fell below the 90% accuracy standard. For those that fell below the 90% standard, a follow up review was completed by MSHN.

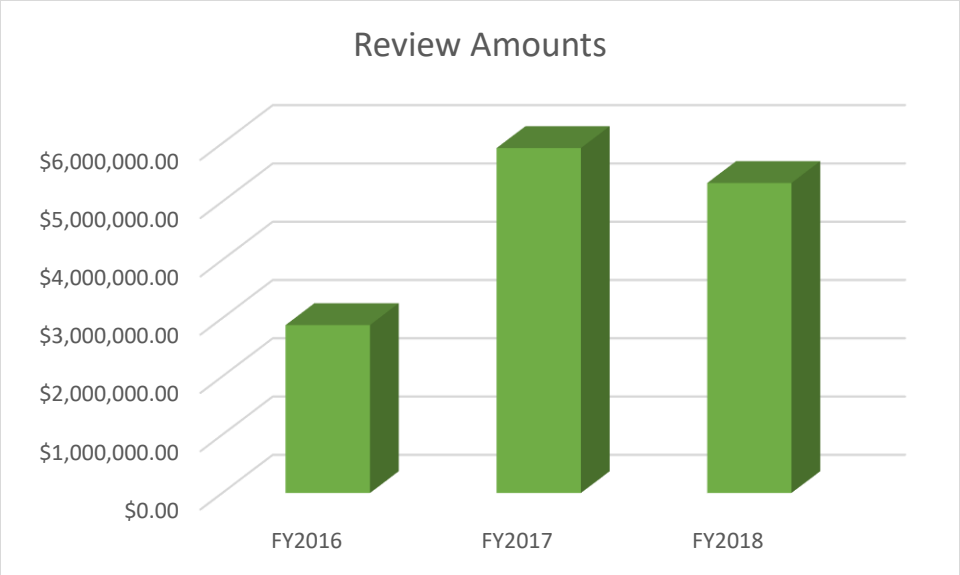
A review of the elements tested from the MEV reviews completed at each CMHSP and SUD provider during FY2017 and FY2018 indicated there were not any repeated deficiencies at the CMHSPs. However, seven (7) SUD providers had repeat deficiencies from FY2017 to FY2018. The deficiencies for the SUD providers included documentation of the service date and time matching the claim date and time of the service and service being included in the beneficiary's individual plan of service.

Process/Performance Improvement

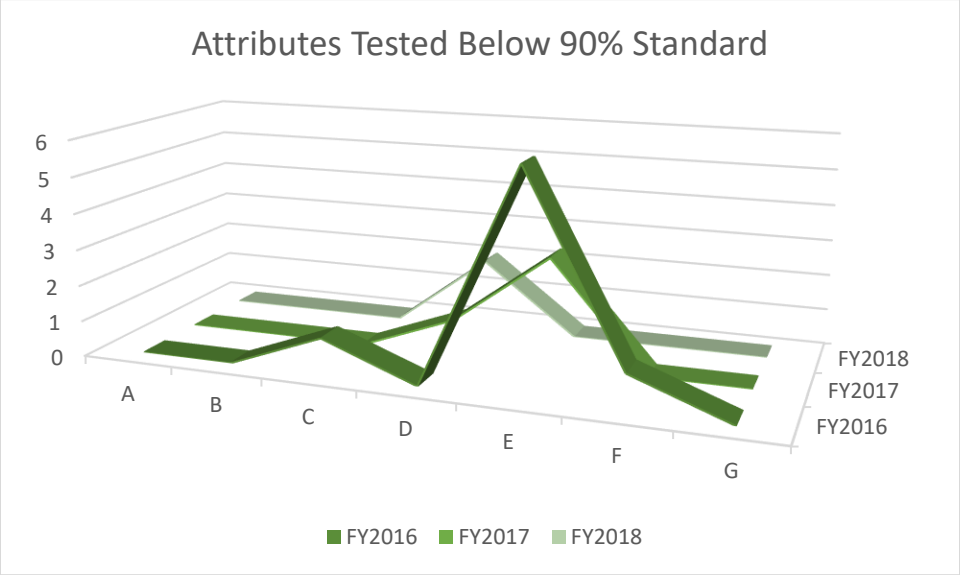
Process Improvements:
Process improvements implemented from previous MEV Reviews include the sampling efficiencies related to the new managed care reporting system. Additionally, the managed care reporting system has internal validations in place to identify overlapping claims, duplicate claims, and claims submitted without an authorization.

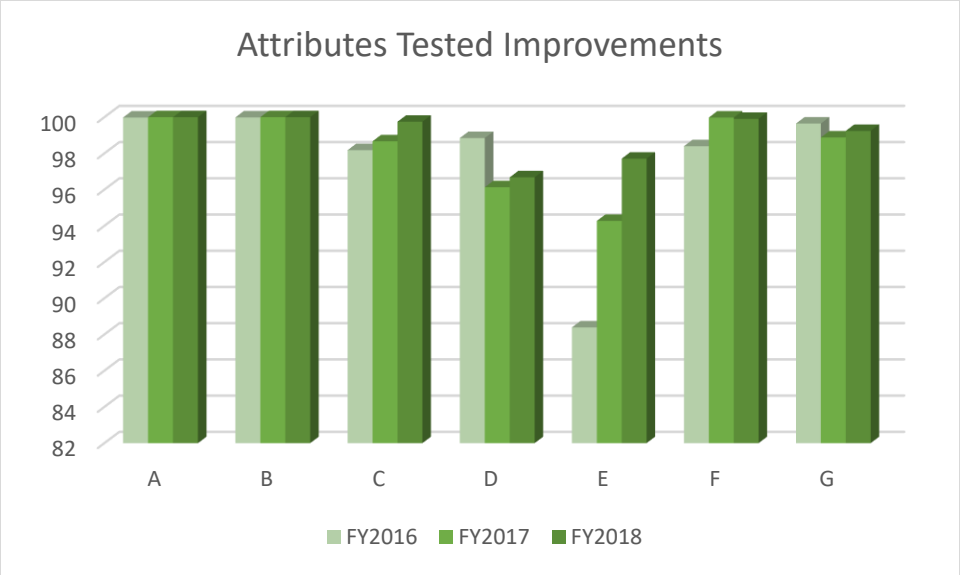
The claims, units, and amount reviewed for FY2018 is less than the claims, units, and amount reviewed for FY2017. The reduction is based on 6 CMHSP's having 3 reviews in FY2017 opposed to the 2 scheduled reviews completed in FY2016 and FY2018. The additional reviews in FY2017 were completed to align the Delegated Managed Care Review and the Medicaid Event Verification reviews and were not based on performance.





Performance Improvements:
During FY2016 there were 7 CMHSP's with at least one element tested that fell beneath the 90% accuracy standard. During FY2017 this was reduced to 4 CMHSPs with at least one element below the 90% accuracy standard. This was further reduced to 2 CMHSP's with at least one element falling below the 90%accuracy standard during FY2018.





While there were some common findings for the CMHSPs that were identified during the MEV reviews that included the lack of documentation for per diem and 15-minute community living supports, personal care, and skill building, there was improvement shown from FY2017 to FY2018 for elements C, D, E, and G. This was a result of improvements put into place by many of the providers, that included the creation of new documentation standards/forms following the FY2016 and FY2017 review process.

There was improvement shown from FY2017 to FY2018 for elements B and E for the SUD providers reviewed. Some SUD providers fell below the 90% accuracy standard for "service is included in the beneficiaries individual plan of service." To assist with this, MSHN offered treatment planning development training during a region wide provider meeting and offered individualized technical assistance regarding treatment planning to providers that fell below the 90% accuracy standard. All providers who fall below the required 90% accuracy standard are required to have a secondary MEV review completed. Additionally, based on the finding of staff providing services who did not possess the appropriate qualifications and/or credentials, MSHN's managed care reporting system is being updated to check for required staff credentials, prior to processing submitted encounters/claims. These process improvements are expected to be reflected during the FY2019 review cycle.

MSHN also reviews the verification results with the following council and committees:

Note: MSHN council and committee membership consists of representatives from each CMHSP.

- MSHN Regional Consumer Advisory Council
- MSHN Quality Improvement Council

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 fourth year of reviews and will focus on plans of corrections from previous reviews to ensure indicated quality improvements are taking place. MSHN will work with the CMHSPs and the SUD provider network to collaboratively develop consistent documentation that adheres to best practice standards across the region. MSHN will evaluate the internal MEV policy and procedure on an ongoing basis to ensure compliance with Federal and State standards as well as to ensure consistency and best practices are followed. MSHN will work with the other PIHP's to standardize the MEV review process. MSHN will complete a quarterly review of outstanding issues related to the MEV review and identify any trends found during the reviews in FY2019.

Attachment 2

MSHN
Mid-State Health Network

Overview of Mid-State Health Network FY2018 SUD Consumer Satisfaction Survey Summary Report

Introduction

The following is a summary of the Mid-State Health Network's (MSHN) SUD Consumer Satisfaction survey. The survey was developed to assist MSHN and the SUD Providers in developing a better understanding of the strengths and weaknesses in the quality of services provided to the SUD population.

The tool was distributed to adult and adolescent consumers who were served by SUD Treatment Providers within the MSHN provider network to assess the perceptions of individual recovery. All items were rated using a 5-point Likert scale that ranged from 1 = "strongly disagree" to 5 = "strongly agree."

The distribution period was June 13, 2018 to July 13, 2018 and this marks the fourth year of implementation. This report was developed utilizing voluntary self-reflective surveys from 3048 consumers representing MSHN's region. There were 3545 surveys distributed by a total of 63 SUD Provider locations with 457 surveys refused.

The information from this report is intended to support discussions on how the various SUD Provider practices may facilitate or impede recovery. The information from this overview should not be used to draw conclusions or make assumptions without further analysis.

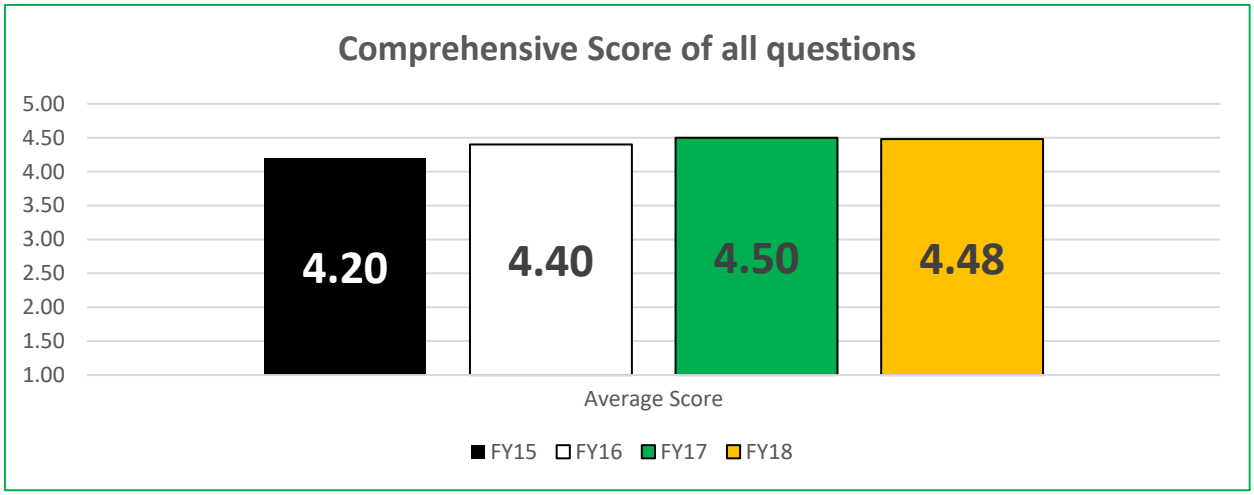
Any questions regarding the report should be sent to Dan Dedloff, MSHN Customer Service and Recipient Rights Specialist, at dan.dedloff@midstatehealthnetwork.org.

MSHN Summary

The responses from the SUD Consumer Satisfaction surveys were scored as a comprehensive total of all questions, as well as individually for each of the fifteen questions. The comprehensive score measures how the system is performing overall, and the individual questions measure the performance for the stated question from all survey responses.

Figure 1 illustrates how MSHN's SUD Providers scored comprehensively for Fiscal Years (FY) 2015 to 2018.

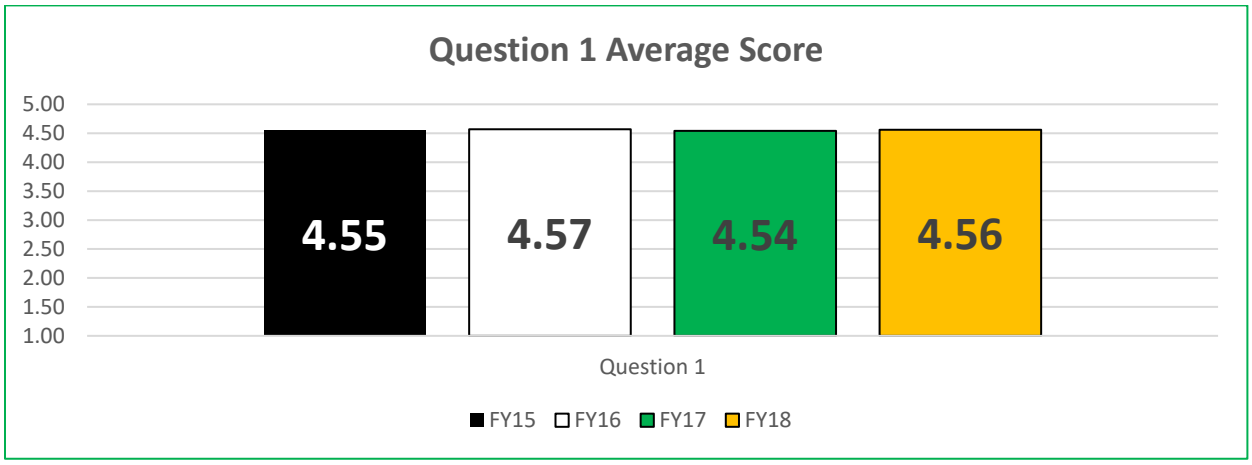
Fig. 1 – MSHN Comprehensive Score



The comprehensive score for FY15 was 4.20, 4.40 for FY16, 4.50 for FY17, and 4.48 for FY18. This demonstrates a 0.02 decrease for FY18 for how the system performs overall.

Figure 2 illustrates how MSHN's SUD Providers scored in response to question 1 of the SUD Satisfaction Survey for FY15, FY16, FY17, and FY18.
Question 1: Staff was courteous and respectful.

Fig. 2 – MSHN question 1 score

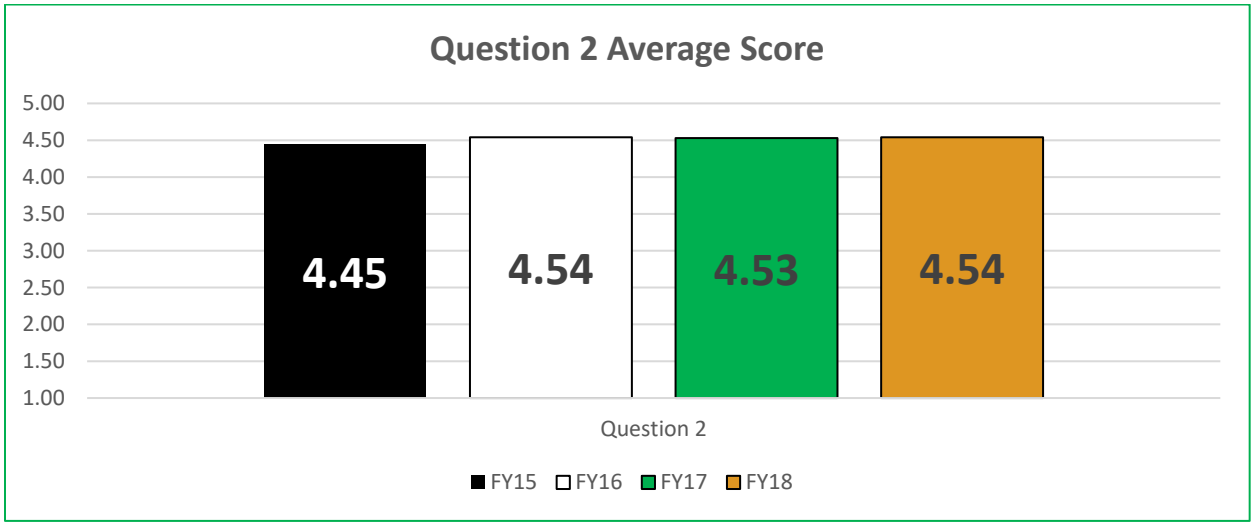


The average score for FY15 was 4.55, 4.57 for FY16, 4.54 for FY17, and 4.56 for FY18. This demonstrates a 0.02 increase from FY17.

Figure 3 illustrates how MSHN's SUD Providers scored in response to question 2 of the SUD Satisfaction Survey for FY15, FY16, FY17, and FY18.

Question 2: I would recommend this agency to others.

Fig. 3 – MSHN question 2 score

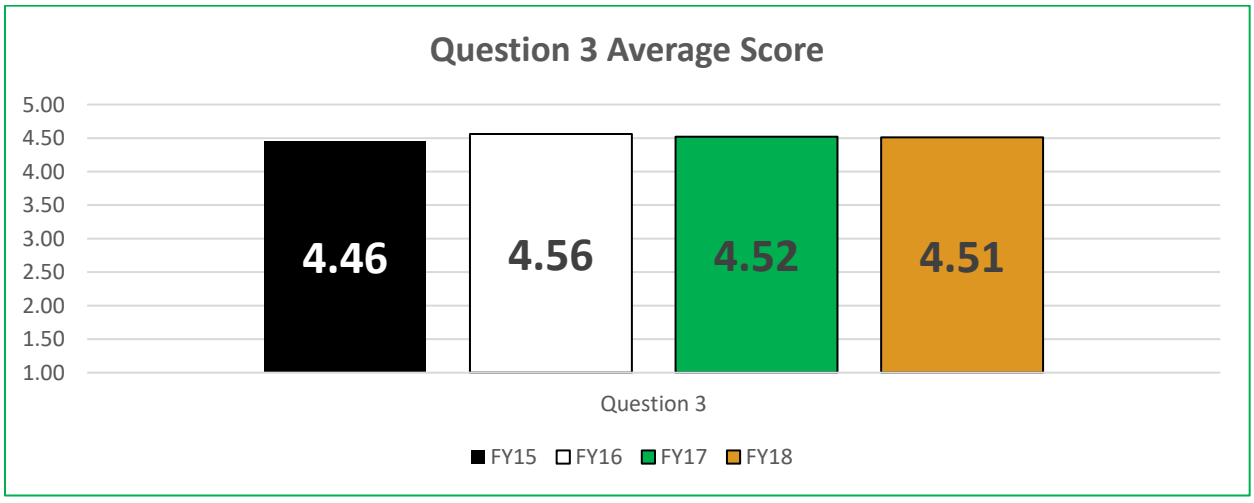


The average score for FY15 was 4.45, 4.54 for FY16, 4.53 for FY17, and 4.54 for FY18. This demonstrates a 0.01 increase from FY17.

Figure 4 illustrates how MSHN's SUD Providers scored in response to question 3 of the SUD Satisfaction Survey for FY15, FY16, FY17, and FY18.

Question 3: I was informed of my rights.

Fig. 4 – MSHN question 3 score

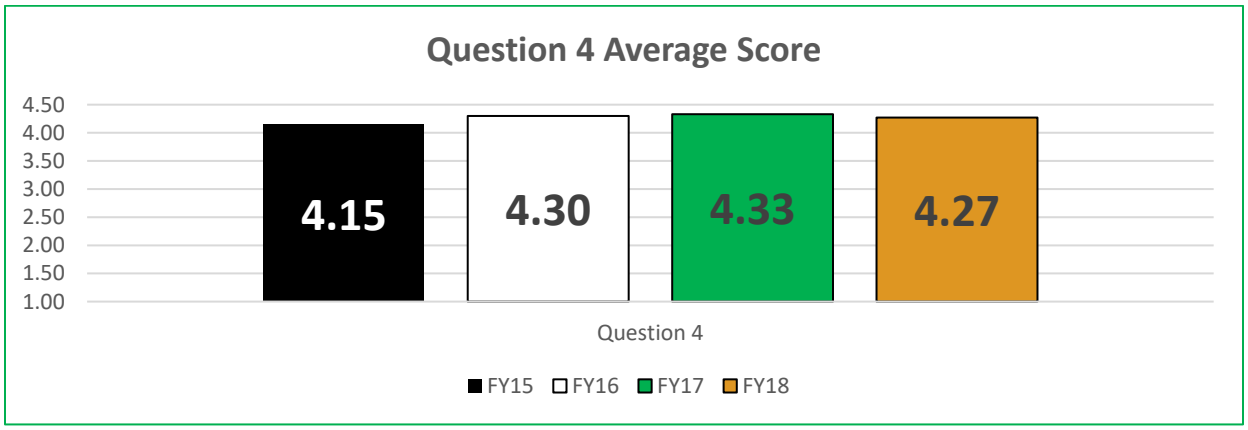


The average score for FY15 was 4.46, 4.56 for FY16, 4.52 for FY17, and 4.51 for FY18. This demonstrates a 0.01 decrease from FY17.

Figure 5 illustrates how MSHN's SUD Providers scored in response to question 4 of the SUD Satisfaction Survey for FY15, FY16, FY17, and FY18.

Question 4: I know how to contact my recipient rights advisor.

Fig. 5 – MSHN question 4 score

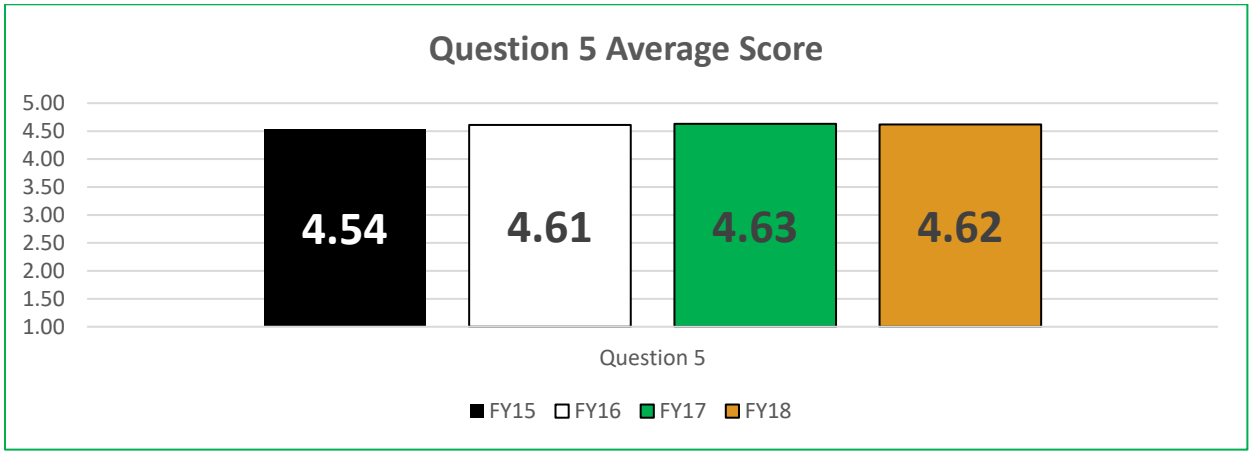


The average score for FY15 was 4.15, 4.30 for FY16, 4.33 for FY17, and 4.27 for FY18. This demonstrates a 0.05 decrease from FY17.

Figure 6 illustrates how MSHN's SUD Providers scored in response to question 5 of the SUD Satisfaction Survey for FY15, FY16, FY17, and FY18.

Question 5: I was informed that information about my treatment is only given with my permission.

Fig. 6 – MSHN question 5 score

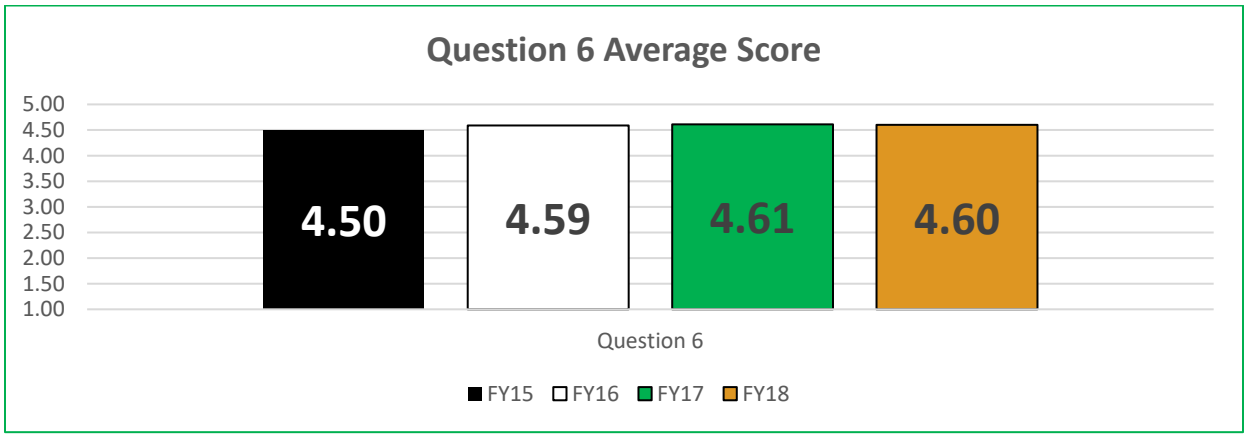


The average score for FY15 was 4.54, was 4.61 for FY16, 4.63 for FY17, and 4.62 for FY18. This demonstrates a 0.01 decrease from FY17.

Figure 7 illustrates how MSHN's SUD Providers scored in response to question 6 of the SUD Satisfaction Survey for FY15, FY16, FY17, and FY18.

Question 6: My cultural/ethnic background was respected.

Fig. 7 – MSHN question 6 score

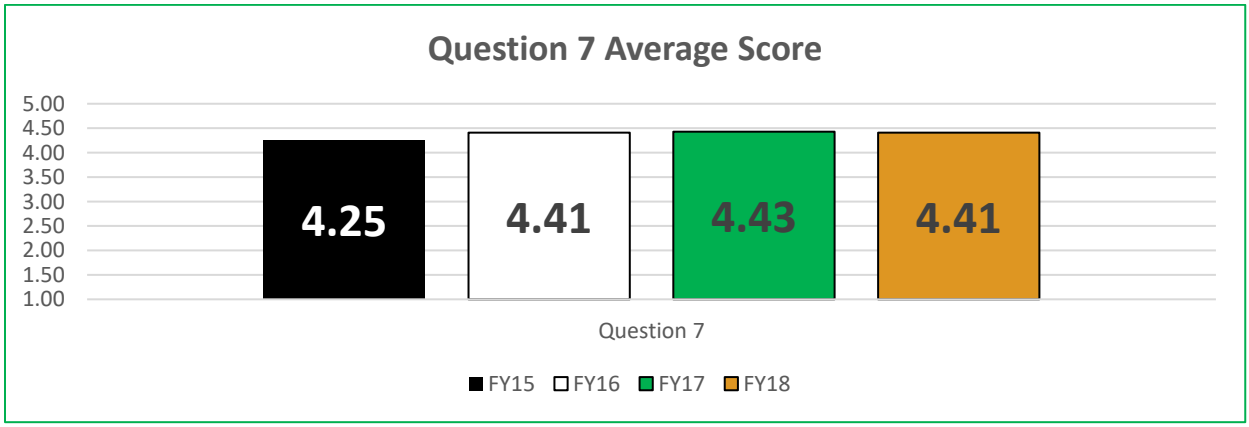


The average score for FY15 was 4.50, 4.59 for FY16, 4.61 for FY17, and 4.60 for FY18. This demonstrates a 0.01 decrease from FY17.

Figure 8 illustrates how MSHN's SUD Providers scored in response to question 7 of the SUD Satisfaction Survey for FY15, FY16, FY17, and FY18.

Question 7: I was given information about the different treatment options available that would be appropriate to meet my needs.

Fig. 8 – MSHN question 7 score

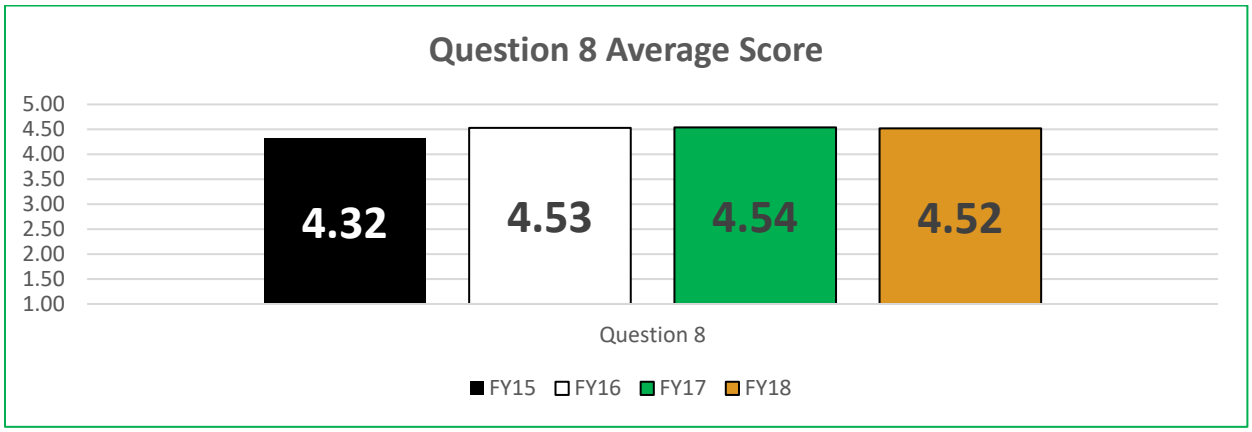


The average score for FY15 was 4.25, 4.41 for FY16, 4.43 for FY17 and 4.41 for FY18. This demonstrates a 0.02 decrease from FY17.

Figure 9 illustrates how MSHN's SUD Providers scored in response to question 8 of the SUD Satisfaction Survey for FY15, FY16, FY17, and FY18.

Question 8: I received services that met my needs and addressed my goals.

Fig. 8 – MSHN question 8 score

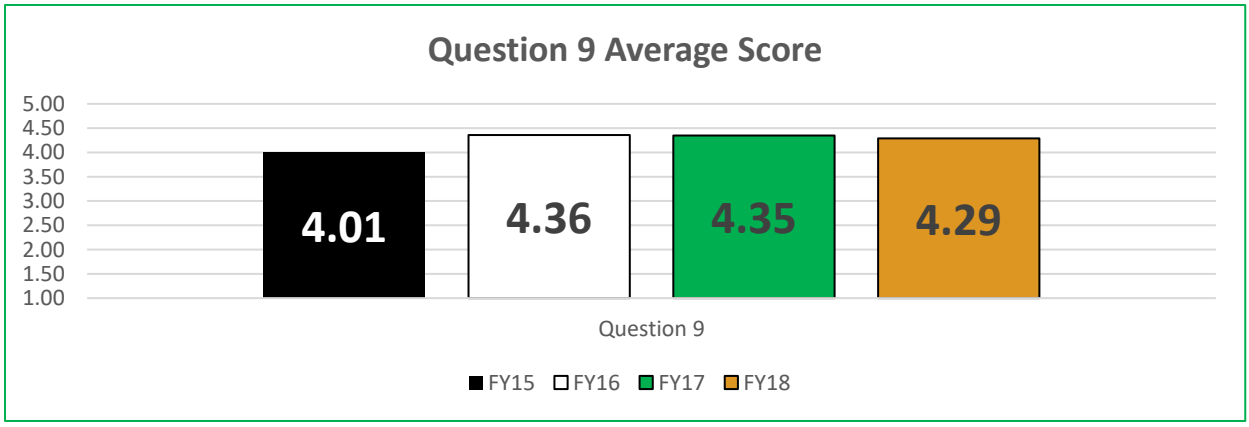


The average score for FY15 was 4.32, 4.53 for FY16, 4.54 for FY17, and 4.52 for FY18. This demonstrates a 0.02 decrease from FY17.

Figure 10 illustrates how MSHN's SUD Providers scored in response to question 9 of the SUD Satisfaction Survey for FY15, FY16, FY17, and FY18.

Question 9: I was given a choice as to what provider to seek treatment from.

Fig. 10 – MSHN question 9 score

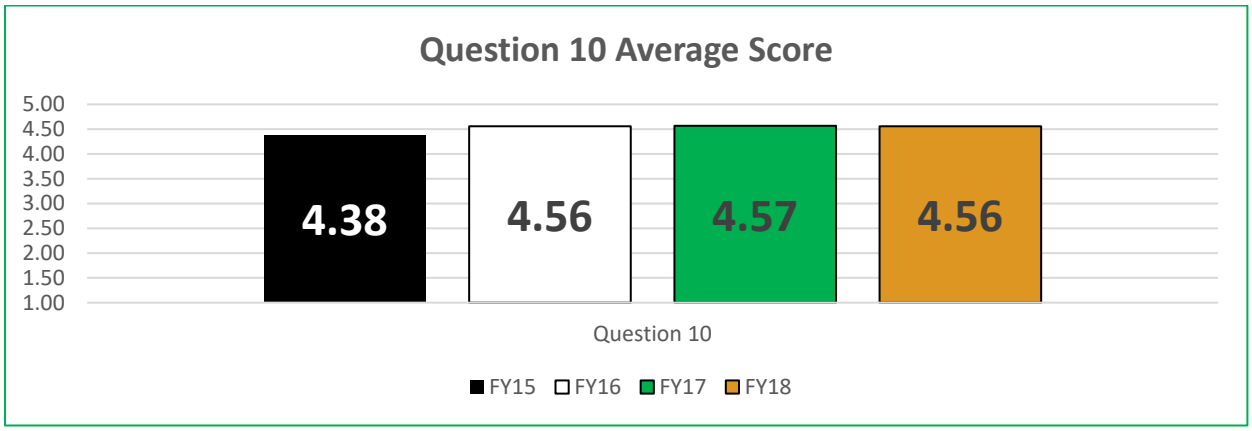


The average score for FY15 was 4.01, was 4.36 for FY16, 4.35 for FY17, and 4.29 for FY18. This demonstrates a 0.06 decrease from FY17.

Figure 11 illustrates how MSHN's SUD Providers scored in response to question 10 of the SUD Satisfaction Survey for FY15, FY16, FY17, and FY18.

Question 10: I was involved in the development of my treatment plan and goals.

Fig. 11 – MSHN question 10 score

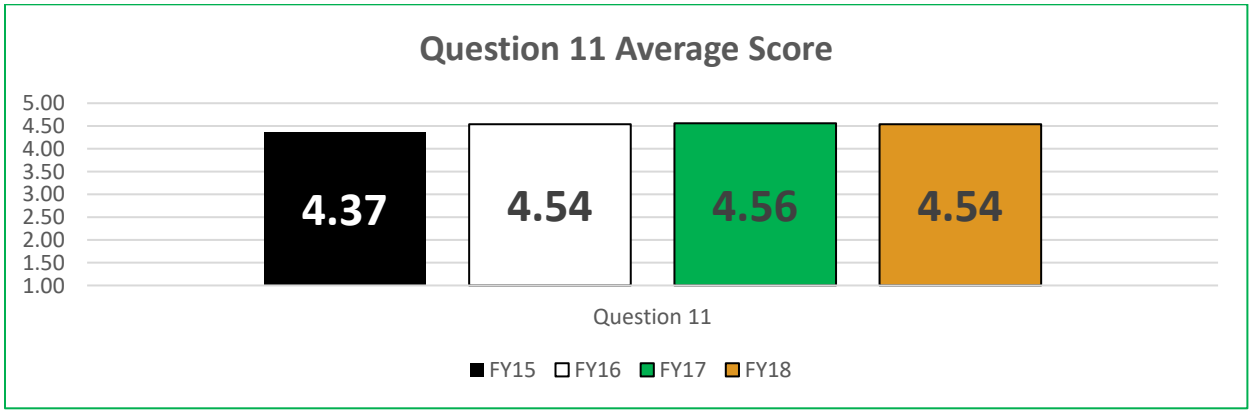


The average score for FY15 was 4.38, 4.56 for FY16, 4.57 for FY17, and 4.56 for FY17. This demonstrates a 0.01 decrease from FY17.

Figure 12 illustrates how MSHN's SUD Providers scored in response to question 11 of the SUD Satisfaction Survey for FY15, FY16, FY17, and FY18.

Question 11: My goals were addressed during treatment.

Fig. 12 – MSHN question 11 score

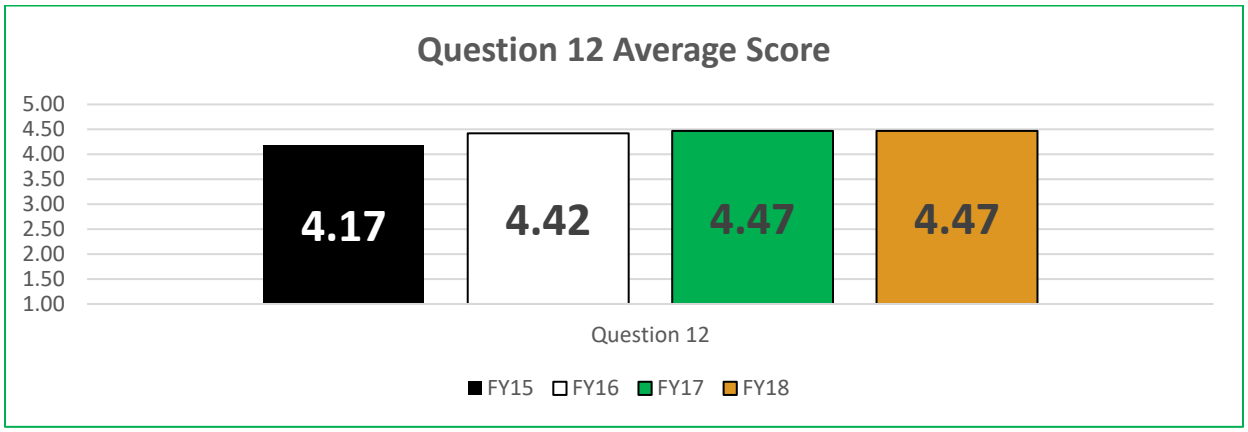


The average score for FY15 was 4.37, 4.54 for FY16, 4.56 for FY17, and 4.54 for FY18. This demonstrates a 0.02 decrease from FY17.

Figure 13 illustrates how MSHN's SUD Providers scored in response to question 12 of the SUD Satisfaction Survey for FY15, FY16, FY17, and FY18.

Question 12: My goals were changed when needed to reflect my needs.

Fig. 13 – MSHN question 12 score

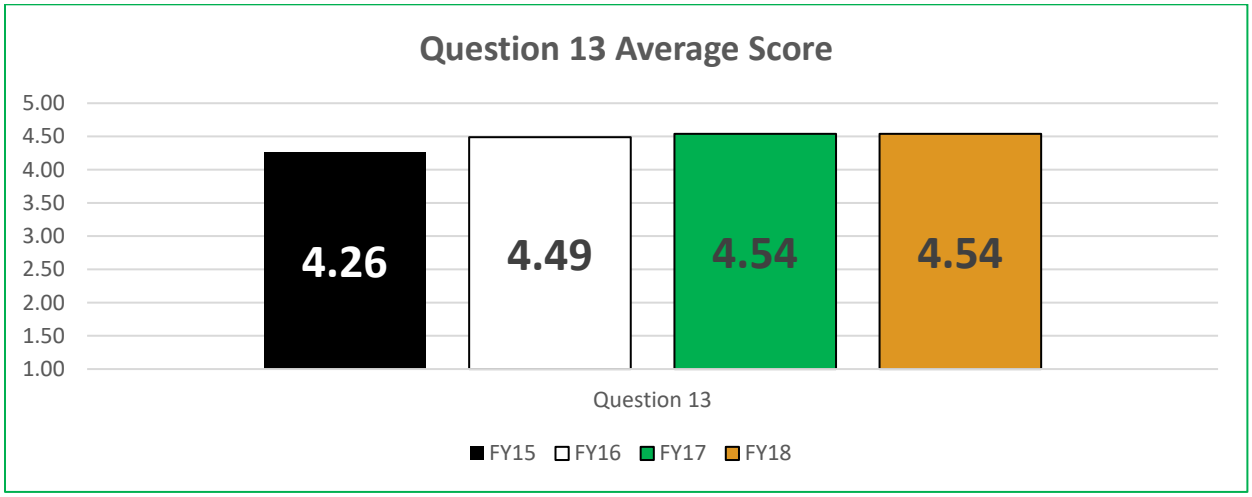


The average score for FY15 was 4.17, 4.42 for FY16, 4.47 for FY17, and 4.47 for FY18. This demonstrates an unchanged score from FY17.

Figure 14 illustrates how MSHN's SUD Providers scored in response to question 13 of the SUD Satisfaction Survey for FY15, FY16, FY17, and FY18.

Question 13: I feel that I am better able to control my life as a result of treatment.

Fig. 14 – MSHN question 13 score

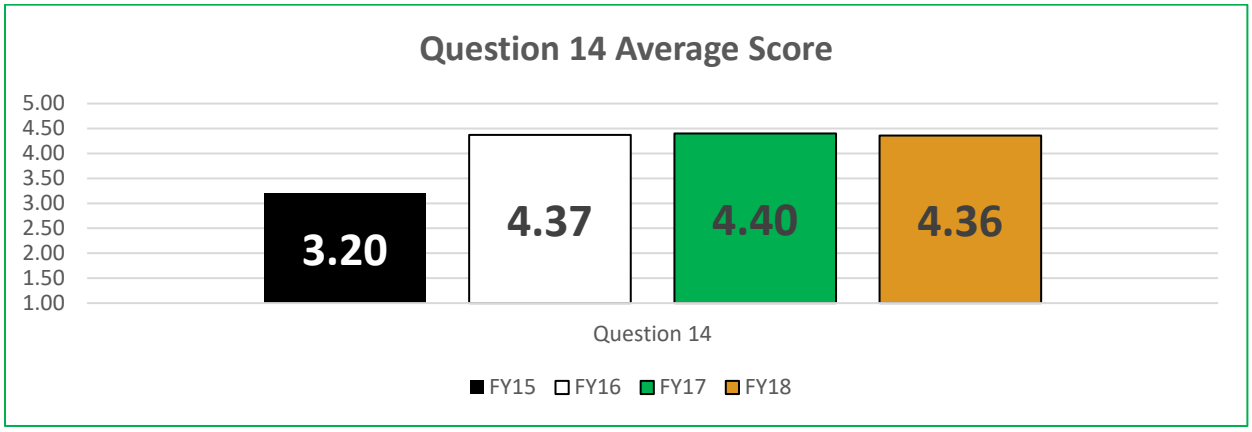


The average score for FY15 was 4.26, 4.49 for FY16, 4.54 for FY17, and 4.54 for FY18. This demonstrates an unchanged score from FY17.

Figure 15 illustrates how MSHN's SUD Providers scored in response to question 14 of the SUD Satisfaction Survey for FY15, FY16, FY17, and FY18.

Question 14: Staff assisted in connecting me with further services and/or community resources.

Fig. 15 – MSHN question 14 score

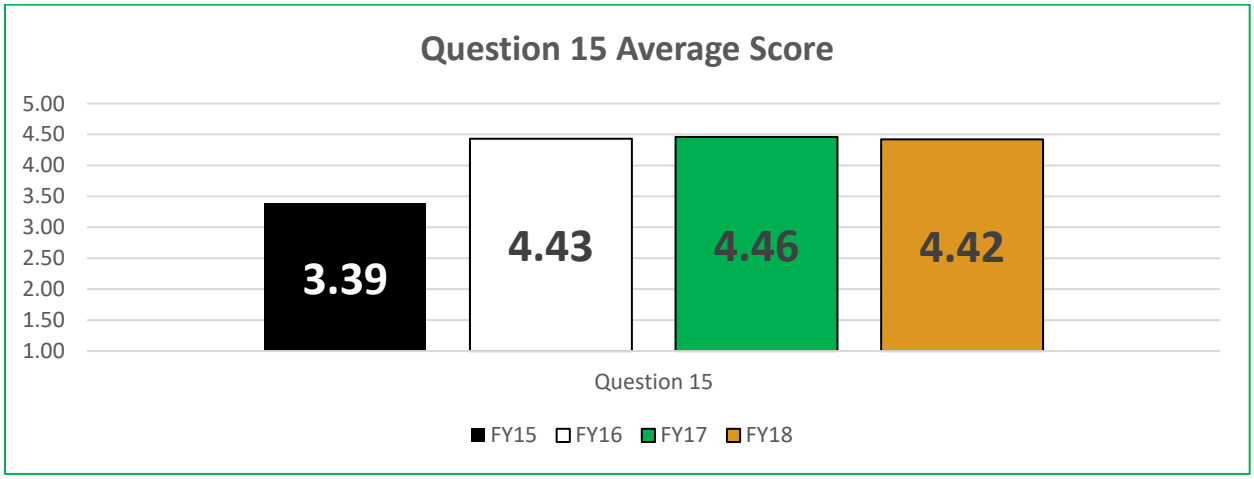


The average for FY15 was 3.20, 4.37 for FY16, 4.40 for FY17, and 4.36 for FY18. This demonstrates a 0.04 decrease from FY17.

Figure 16 illustrates how MSHN's SUD Providers scored in response to question 15 of the SUD Satisfaction Survey for FY15, FY16, FY17, and FY18.

Question 15: My treatment plan includes skills and community supports to help me continue in my path to recovery and total wellness.

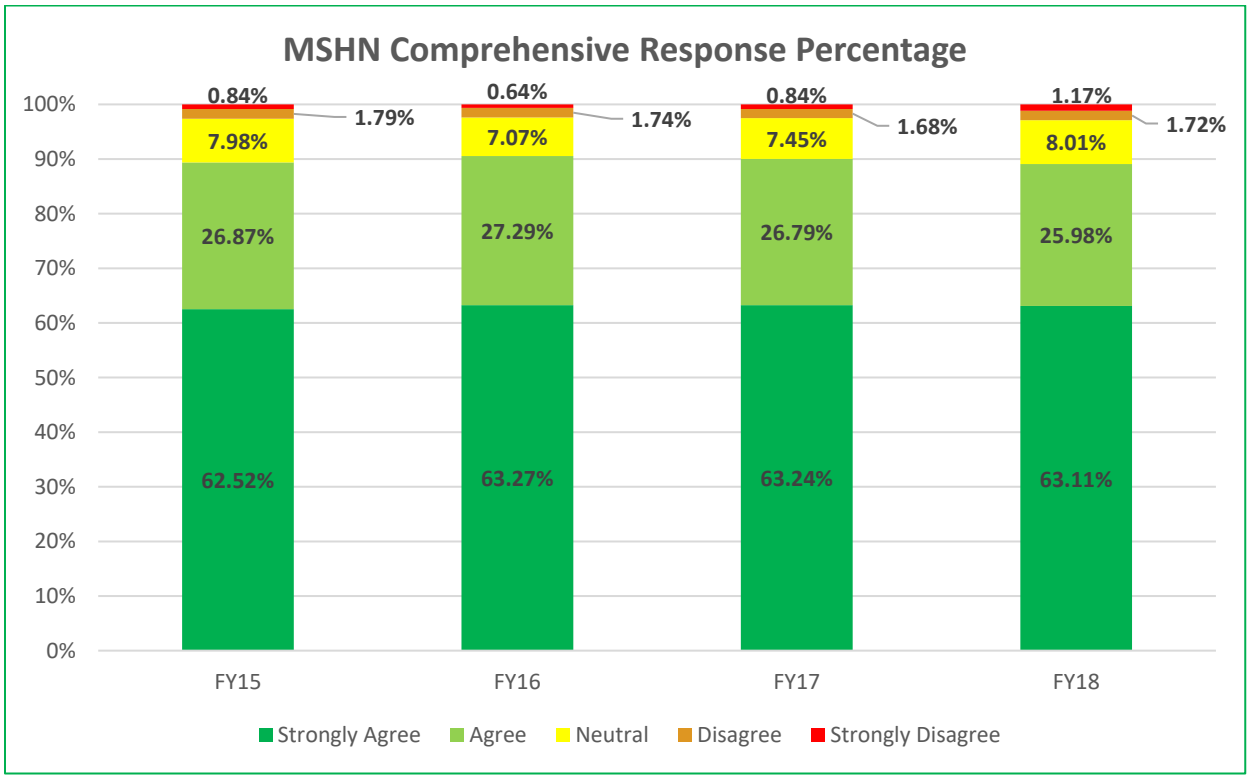
Fig. 16 – MSHN question 15 score



The average score for FY15 was 3.39, 4.43 for FY16, 4.46 for FY17, and 4.42 for FY18. This demonstrates a 0.04 decrease from FY17.

Figure 17 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey comprehensively for FY15, FY16, FY17, and FY18.

Fig. 17 – MSHN Comprehensive Response Percentage



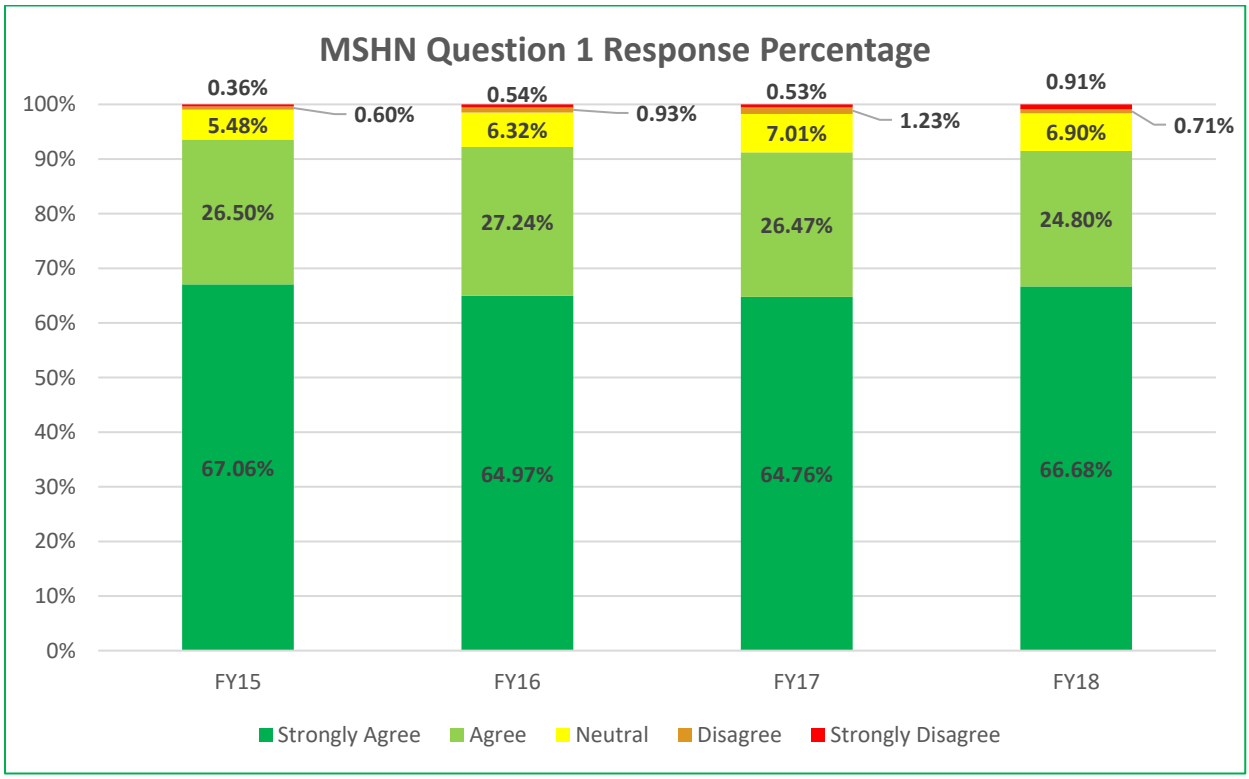
For FY18, 63.11% strongly agreed, 25.98% agreed, 8.01% were neutral, 1.72% disagreed, and 1.17% strongly disagreed. For FY17, 63.24% strongly agreed, 26.79% agreed, 7.45% were neutral, 1.68% disagreed, and 0.44% strongly disagreed. For FY16, 63.27% strongly agreed, 27.29% agreed, 7.07% were neutral, 1.74% disagreed, and 0.64% strongly disagreed. For FY15, 62.52% strongly agreed, 26.87% agreed, 7.98% were neutral, 1.79% disagreed, and 0.84% strongly disagreed.

FY18 had 89.09% that agreed or strongly agreed, FY17 had 90.03% that agreed or strongly agreed, FY16 had 90.56% that agreed or strongly agreed, FY15 had 89.39% that agreed or strongly agreed. This demonstrates a decrease of 0.94% in positive responses from FY17.

Figure 18 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey question 1 in FY15, FY16, FY17, and FY18.

Question 1: Staff was courteous and respectful.

Fig. 18 – MSHN Question 1 Response Percentage



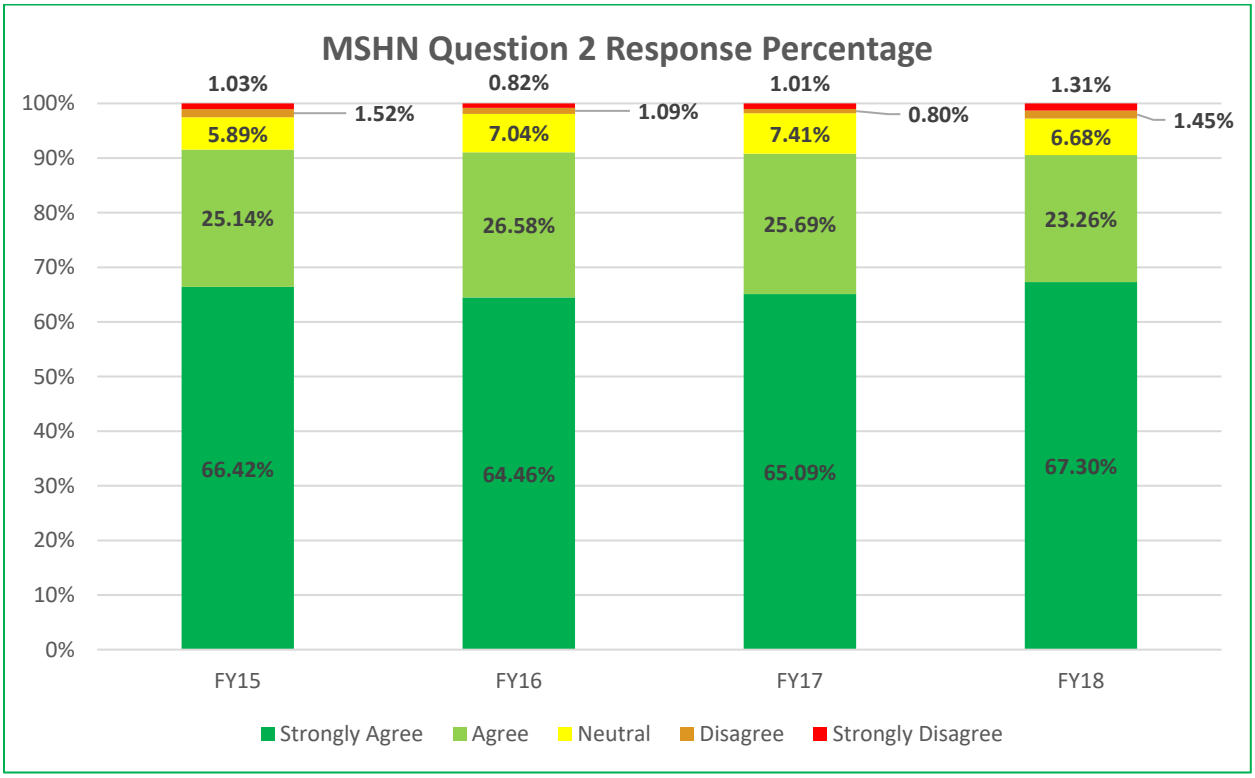
For FY18, 66.68% strongly agreed, 24.80% agreed, 6.90% were neutral, 0.71% disagreed, and 0.91% strongly disagreed. For FY17, 64.76% strongly agreed, 26.47% agreed, 7.01% were neutral, 1.23% disagreed, and 0.53% strongly disagreed. For FY16, 64.97% strongly agreed, 27.24% agreed, 6.32% were neutral, 0.93% disagreed, and 0.54% strongly disagreed. For FY15, 67.06% strongly agreed, 26.50% agreed, 5.48% were neutral, 0.60% disagreed, and 0.36% strongly disagreed.

FY18 had 91.48% that agreed or strongly agreed, FY17 had 91.23% that agreed or strongly agreed, FY16 had 92.21% that agreed or strongly agreed, FY15 had 93.56% that agreed or strongly agreed. This demonstrates an increase of 0.25% in positive responses from FY17.

Figure 19 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey question 2 in FY15, FY16, FY17, and FY18.

Question 2: I would recommend this agency to others.

Fig. 19 – MSHN Question 2 Response Percentage



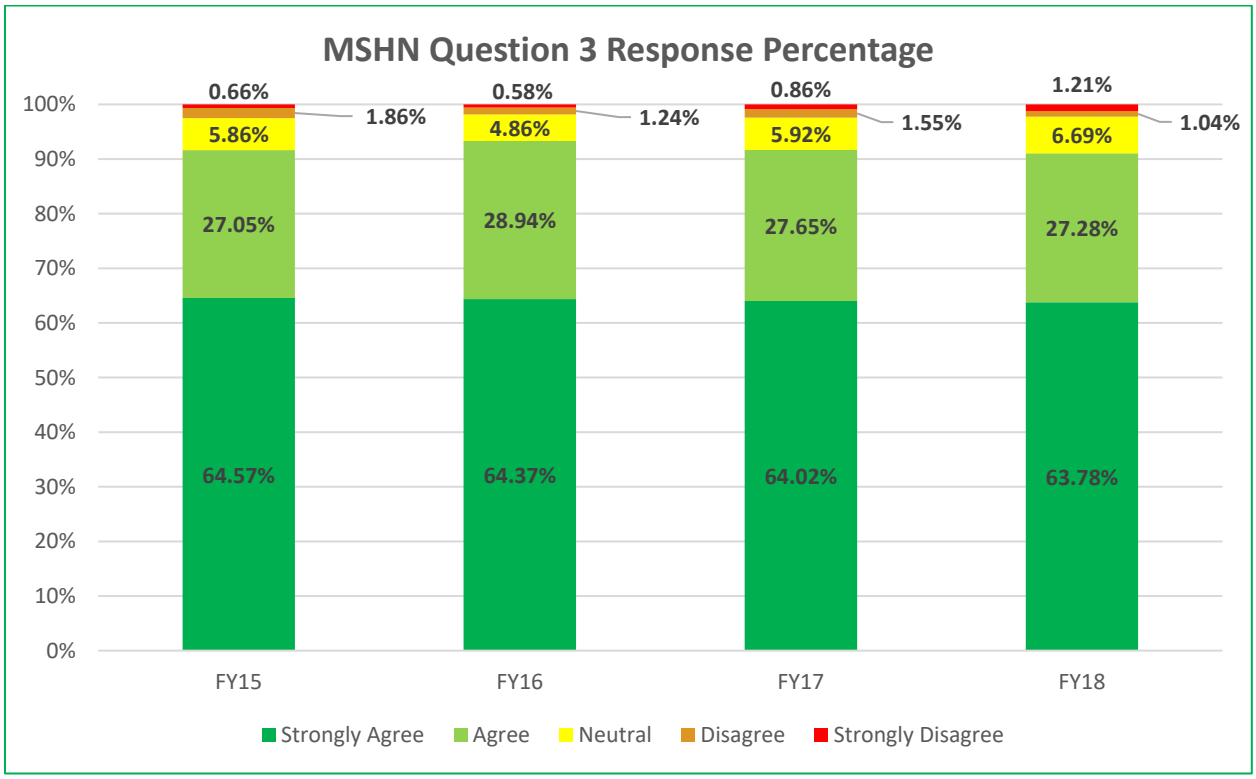
For FY18, 67.30% strongly agreed, 23.26% agreed, 6.68% were neutral, 1.45% disagreed, and 1.31% strongly disagreed. For FY17, 65.09% strongly agreed, 25.69% agreed, 7.41% were neutral, 0.08% disagreed, and 1.01% strongly disagreed. For FY16, 64.46% strongly agreed, 26.58% agreed, 7.04% were neutral, 1.09% disagreed, and 0.82% strongly disagreed. For FY15, 66.42% strongly agreed, 25.14% agreed, 5.89% were neutral, 1.52% disagreed, and 1.03% strongly disagreed.

FY18 had 90.56% that agreed or strongly agreed, FY17 had 90.78% that agreed or strongly agreed, FY16 had 91.04% that agreed or strongly agreed, FY15 had 93.04% that agreed or strongly agreed. This demonstrates a decrease of 0.22% in positive responses from FY17.

Figure 20 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey question 3 in FY15, FY16, FY17, and FY18.

Question 3: I was informed of my rights.

Fig. 20 – MSHN Question 3 Response Percentage



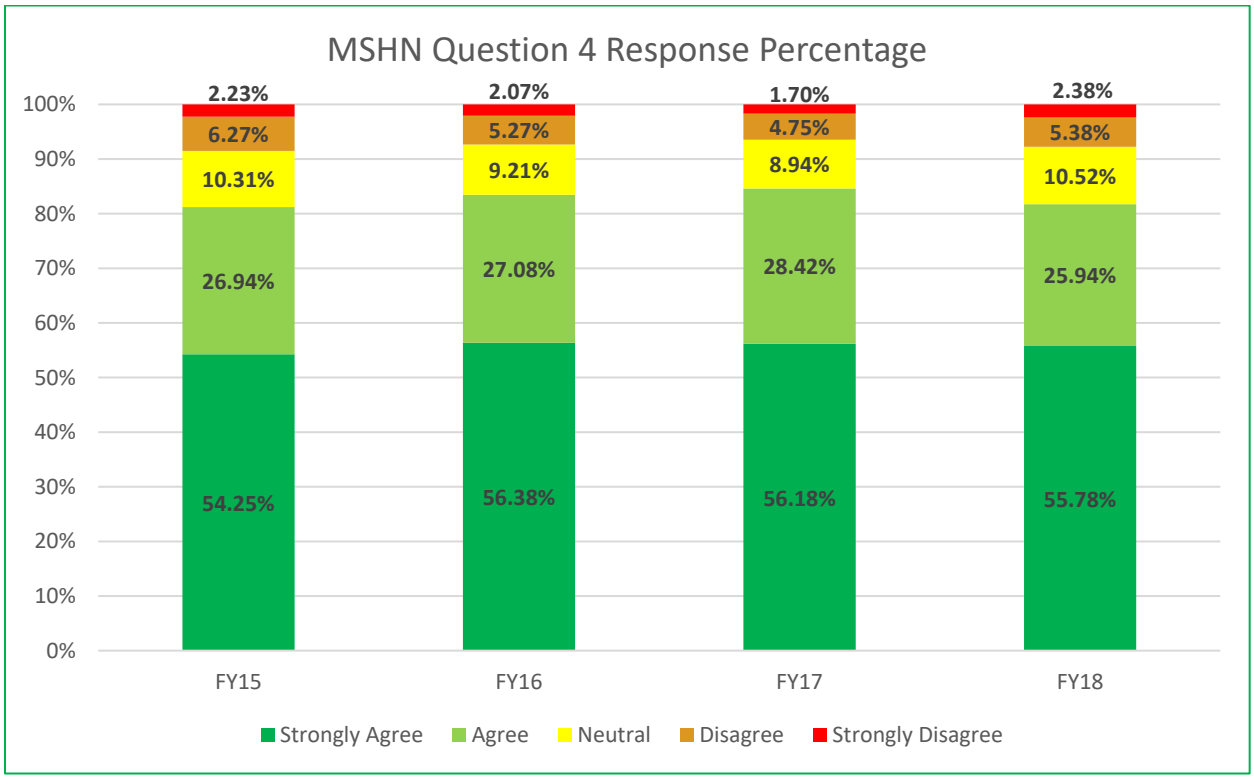
For FY18, 63.78% strongly agreed, 27.28% agreed, 6.69% were neutral, 1.04% disagreed, and 1.21% strongly disagreed. For FY17, 64.02% strongly agreed, 27.65% agreed, 5.92% were neutral, 1.55% disagreed, and 0.86% strongly disagreed. For FY16, 64.37% strongly agreed, 28.94% agreed, 4.86% were neutral, 1.24% disagreed, and 0.58% strongly disagreed. For FY15, 64.57% strongly agreed, 27.05% agreed, 5.86% were neutral, 1.86% disagreed, and 0.66% strongly disagreed.

FY18 had 91.06% that agreed or strongly agreed, FY17 had 91.67% that agreed or strongly agreed, FY16 had 93.31% that agreed or strongly agreed, FY15 had 91.62% that agreed or strongly agreed. This demonstrates a decrease of 0.61% in positive responses from FY17.

Figure 21 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey question 4 in FY15, FY16, FY17, and FY18.

Question 4: I know how to contact my recipient rights advisor.

Fig. 21 – MSHN Question 4 Response Percentage



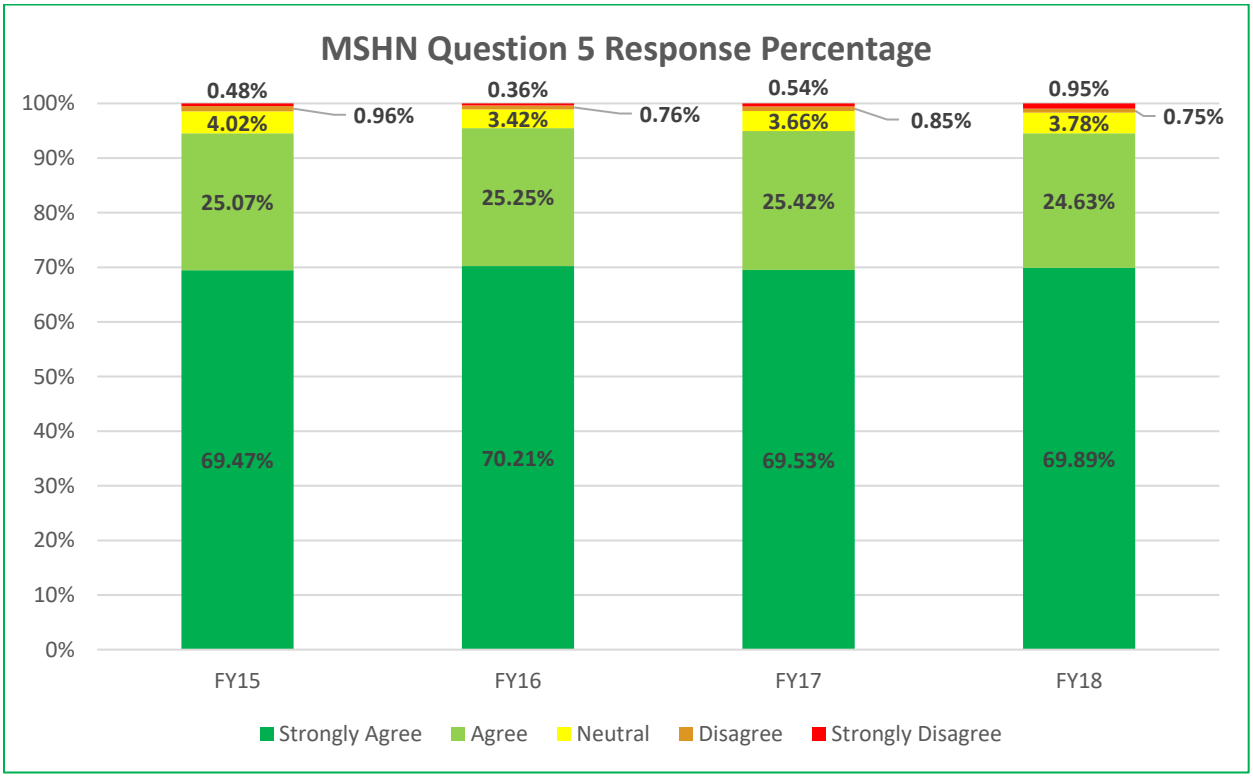
For FY18, 55.78% strongly agreed, 25.94% agreed, 10.52% were neutral, 5.38% disagreed, and 2.38% strongly disagreed. For FY17, 56.18% strongly agreed, 28.42% agreed, 8.94% were neutral, 4.75% disagreed, and 1.70% strongly disagreed. For FY16, 56.38% strongly agreed, 27.08% agreed, 9.21% were neutral, 5.27% disagreed, and 2.07% strongly disagreed. For FY15, 54.25% strongly agreed, 26.94% agreed, 10.31% were neutral, 6.27% disagreed, and 2.23% strongly disagreed.

FY18 had 81.72% that agreed or strongly agreed, FY17 had 84.60% that agreed or strongly agreed, FY16 had 83.46% that agreed or strongly agreed, FY15 had 81.19% that agreed or strongly agreed. This demonstrates a decrease of 2.88% in positive responses from FY17.

Figure 22 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey question 5 in FY15, FY16, FY17, and FY18.

Question 5: I was informed that information about my treatment is only given with my permission.

Fig. 22 – MSHN Question 5 Response Percentage



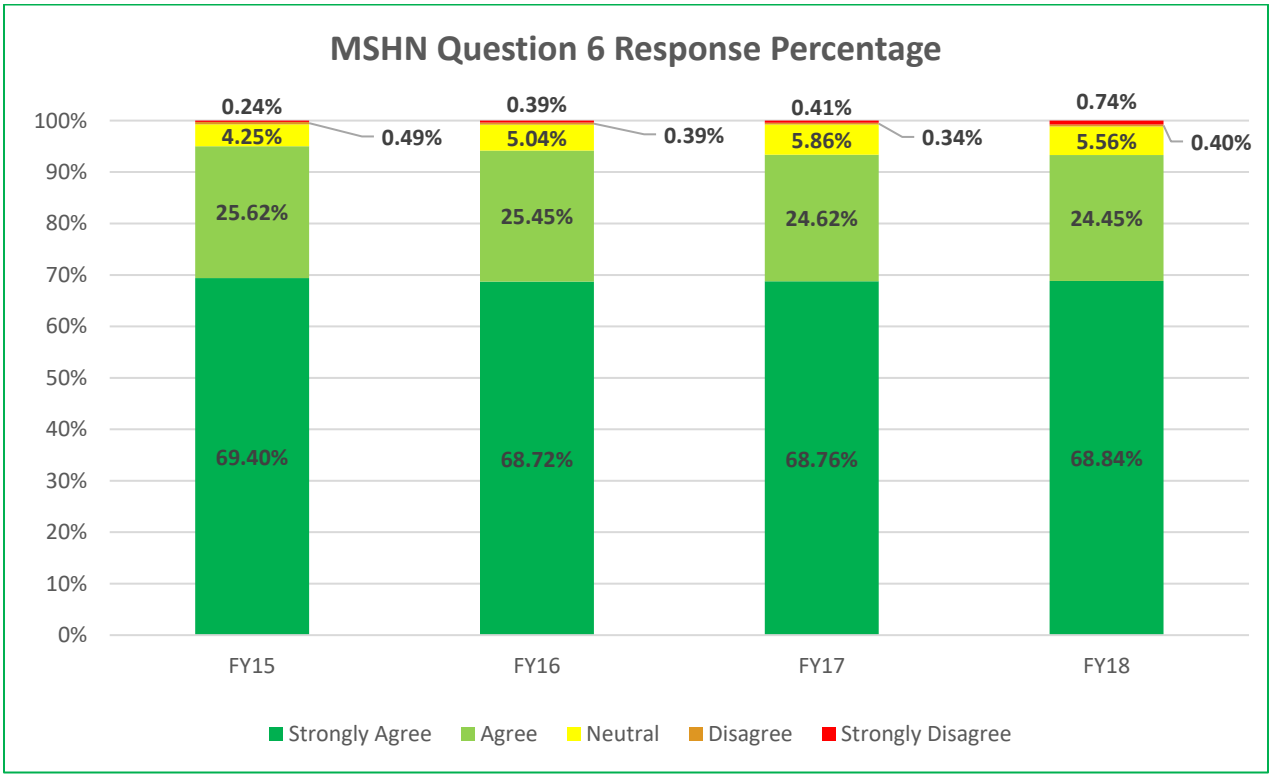
For FY18, 69.89% strongly agreed, 24.63% agreed, 3.78% were neutral, 0.75% disagreed, and 0.95% strongly disagreed. For FY17, 69.53% strongly agreed, 25.42% agreed, 3.66% were neutral, 0.85% disagreed, and 0.54% strongly disagreed. For FY16, 70.21% strongly agreed, 25.25% agreed, 3.42% were neutral, 0.76% disagreed, and 0.36% strongly disagreed. For FY15, 69.47% strongly agreed, 25.07% agreed, 4.02% were neutral, 0.96% disagreed, and 0.48% strongly disagreed.

FY18 had 94.52% that agreed or strongly agreed, FY17 had 94.95% that agreed or strongly agreed, FY16 had 95.46% that agreed or strongly agreed, FY15 had 94.54% that agreed or strongly agreed. This demonstrates a decrease of 0.43% in positive responses from FY17.

Figure 23 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey question 6 in FY15, FY16, FY17, and FY18.

Question 6: My cultural/ethnic background was respected.

Fig. 23 – MSHN Question 6 Response Percentage



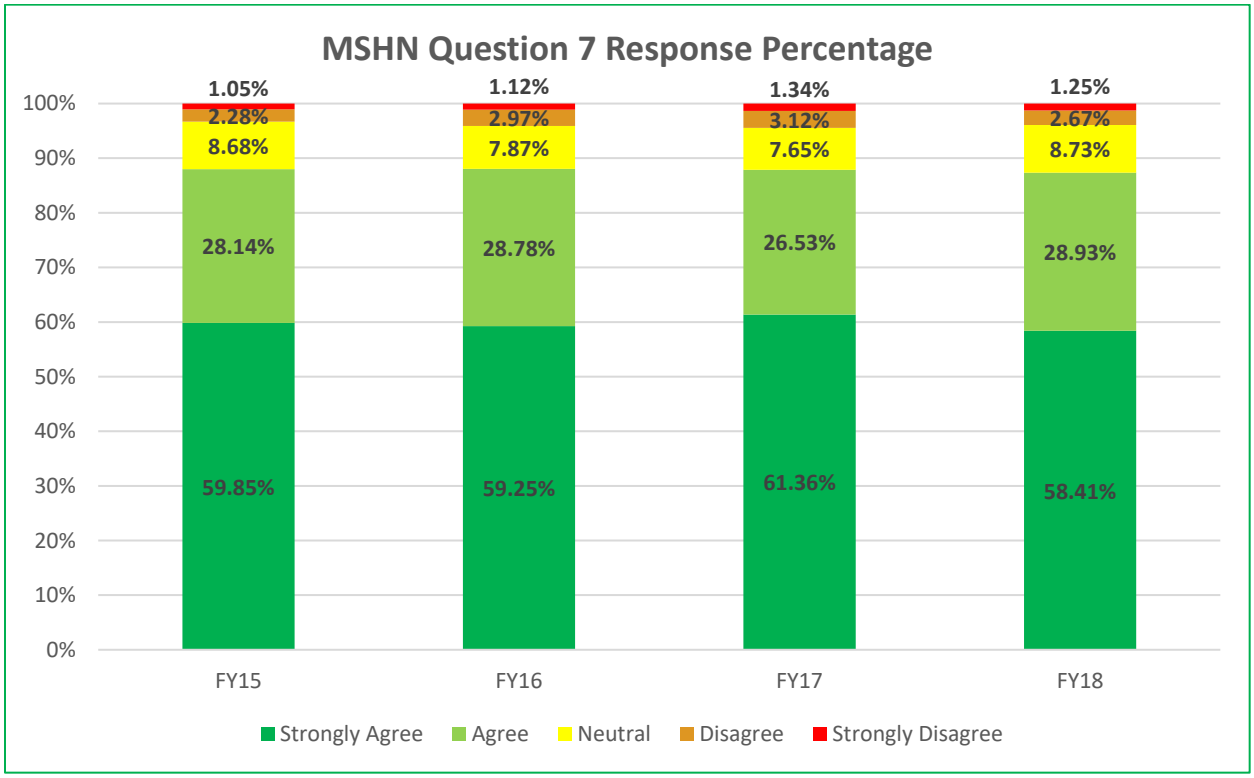
For FY18, 68.84% strongly agreed, 24.45% agreed, 5.56% were neutral, 0.40% disagreed, and 0.74% strongly disagreed. For FY17, 68.76% strongly agreed, 24.62% agreed, 5.86% were neutral, 0.34% disagreed, and 0.41% strongly disagreed. For FY16, 68.72% strongly agreed, 25.45% agreed, 5.04% were neutral, 0.39% disagreed, and 0.39% strongly disagreed. For FY15, 69.4% strongly agreed, 25.62% agreed, 4.25% were neutral, 0.49% disagreed, and 0.24% strongly disagreed.

FY18 had 93.29% that agreed or strongly agreed, FY17 had 93.38% that agreed or strongly agreed, FY16 had 94.17% that agreed or strongly agreed, FY15 had 95.02% that agreed or strongly agreed. This demonstrates a decrease of 0.09% in positive responses from FY17.

Figure 24 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey question 7 in FY15, FY16, FY17, and FY18.

Question 7: I was given information about the different treatment options available that would be appropriate to meet my needs.

Fig. 24 – MSHN Question 7 Response Percentage



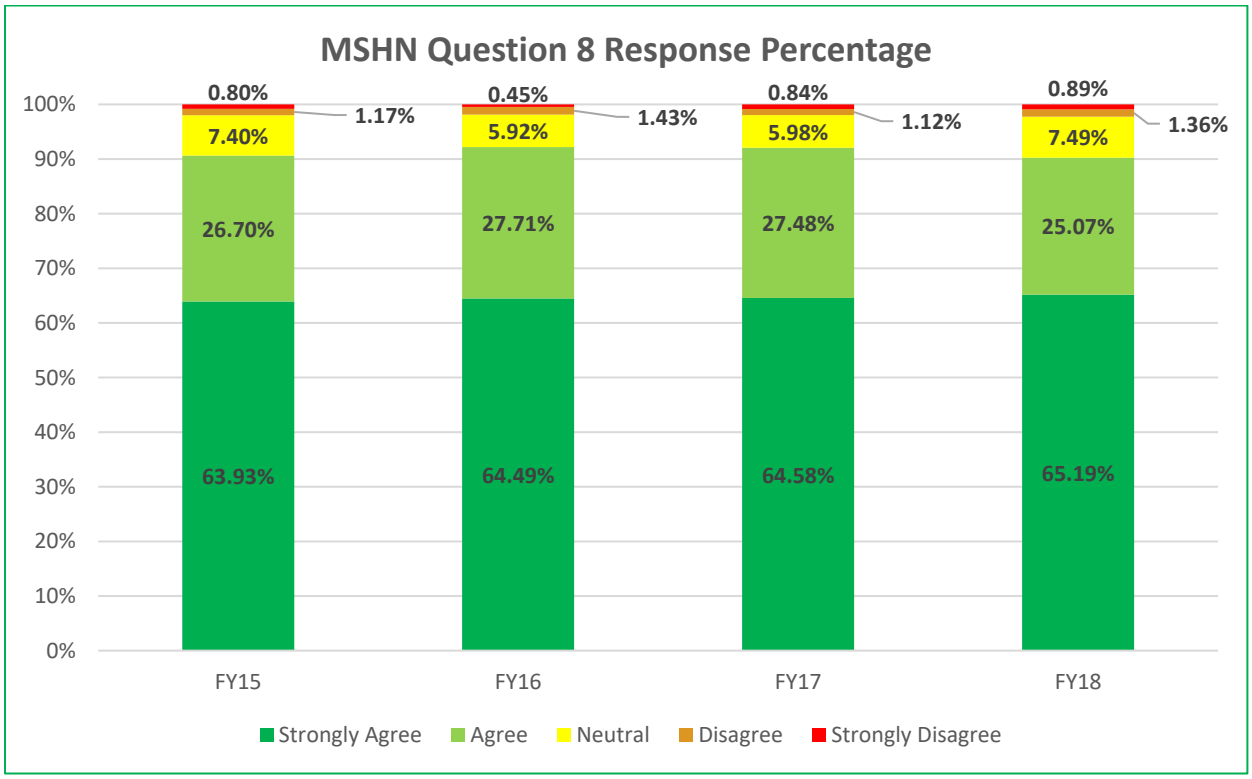
For FY18, 58.41% strongly agreed, 28.93% agreed, 8.73% were neutral, 2.67% disagreed, and 1.25% strongly disagreed. For FY17, 61.36% strongly agreed, 26.53% agreed, 7.65% were neutral, 3.12% disagreed, and 1.34% strongly disagreed. For FY16, 59.25% strongly agreed, 28.78% agreed, 7.87% were neutral, 2.97% disagreed, and 1.12% strongly disagreed. For FY15, 59.85% strongly agreed, 2814% agreed, 8.68% were neutral, 1.05% disagreed, and 1.05% strongly disagreed.

FY18 had 87.34% that agreed or strongly agreed, FY17 had 87.89% that agreed or strongly agreed, FY16 had 88.03% that agreed or strongly agreed, FY15 had 87.99% that agreed or strongly agreed. This demonstrates a decrease of 0.55% in positive responses from FY17.

Figure 25 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey question 8 in FY15, FY16, FY17, and FY18.

Question 8: I received services that met my needs and addressed my goals.

Fig. 25 – MDHN Question 8 Response Percentage



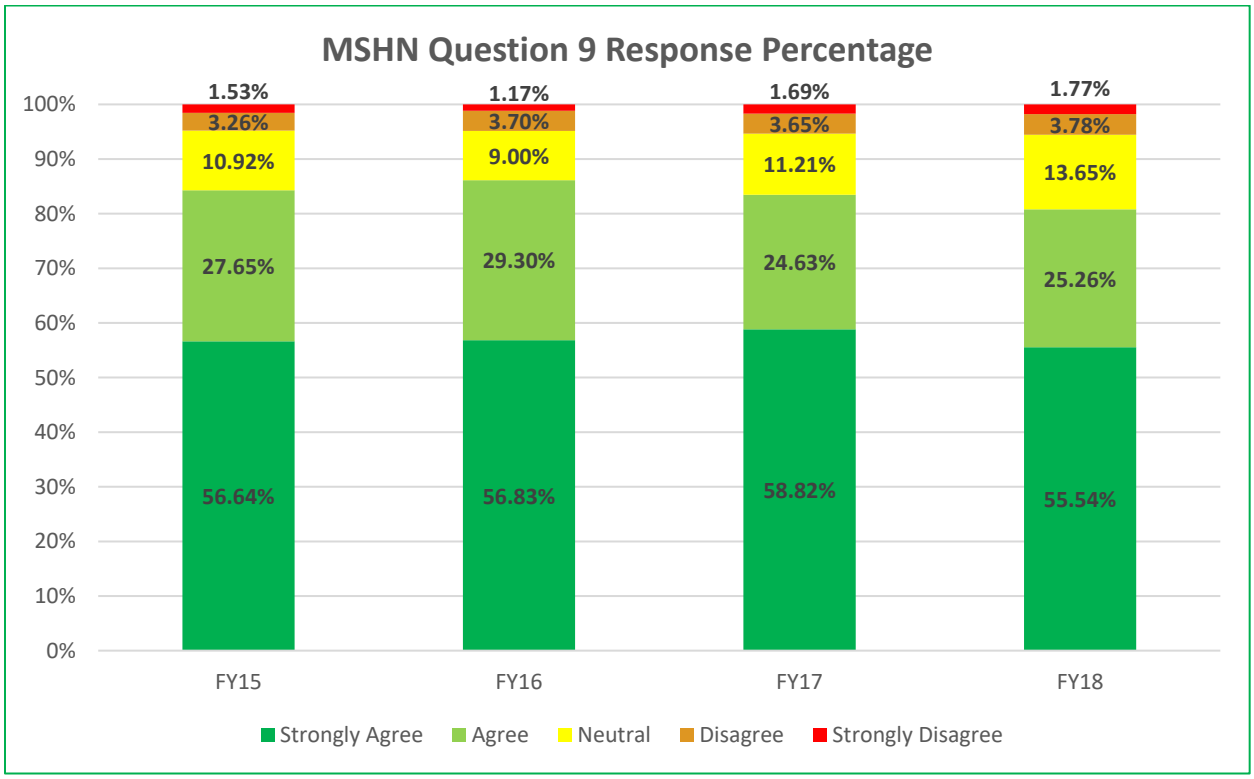
For FY18, 65.19% strongly agreed, 25.07% agreed, 7.49% were neutral, 1.36% disagreed, and 0.89% strongly disagreed. For FY17, 64.58% strongly agreed, 27.48% agreed, 5.98% were neutral, 1.12% disagreed, and 0.84% strongly disagreed. For FY16, 64.49% strongly agreed, 27.71% agreed, 5.92% were neutral, 1.43% disagreed, and 0.45% strongly disagreed. For FY15, 63.93% strongly agreed, 26.70% agreed, 7.40% were neutral, 1.17% disagreed, and 0.80% strongly disagreed.

FY18 had 90.26% that agreed or strongly agreed, FY17 had 92.06% that agreed or strongly agreed, FY16 had 92.20% that agreed or strongly agreed, FY15 had 90.63% that agreed or strongly agreed. This demonstrates a decrease of 1.80% in positive responses from FY17.

Figure 26 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey question 9 in FY15, FY16, FY17, and FY18.

Question 9: I was given a choice as to what provider to seek treatment from.

Fig. 26 – MSHN Question 9 Response Percentage



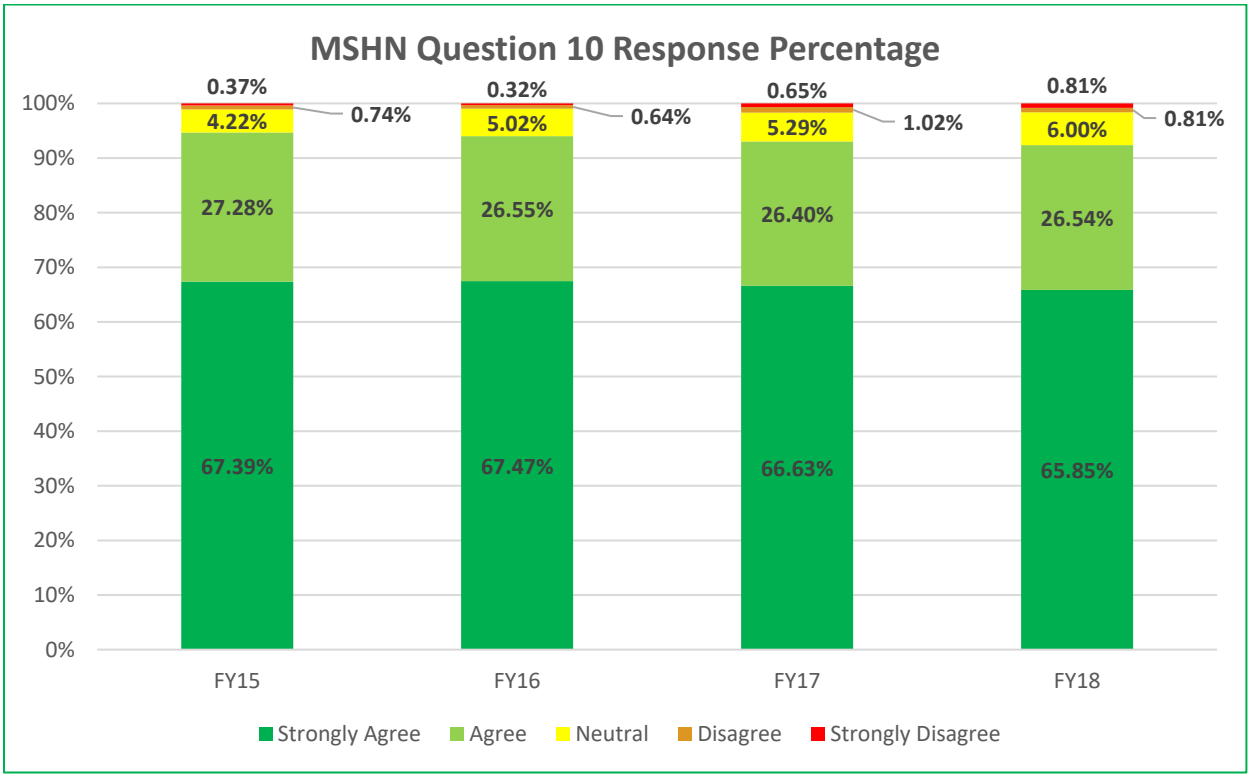
For FY18, 55.54% strongly agreed, 25.26% agreed, 13.65% were neutral, 3.78% disagreed, and 1.77% strongly disagreed. For FY17, 58.82% strongly agreed, 24.63% agreed, 11.21% were neutral, 3.65% disagreed, and 1.69% strongly disagreed. For FY16, 56.83% strongly agreed, 29.3% agreed, 9% were neutral, 3.70% disagreed, and 1.17% strongly disagreed. For FY15, 56.64% strongly agreed, 27.65% agreed, 10.92% were neutral, 3.26% disagreed, and 1.53% strongly disagreed.

FY18 had 80.80% that agreed or strongly agreed, FY17 had 83.45% that agreed or strongly agreed, FY16 had 86.13% that agreed or strongly agreed, FY15 had 84.29% that agreed or strongly agreed. This demonstrates a decrease of 2.65% in positive responses from FY17.

Figure 27 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey question 10 in FY15, FY16, FY17, and FY18.

Question 10: I was involved in the development of my treatment plan and goals.

Fig. 27 – MSHN Question 10 Response Percentage



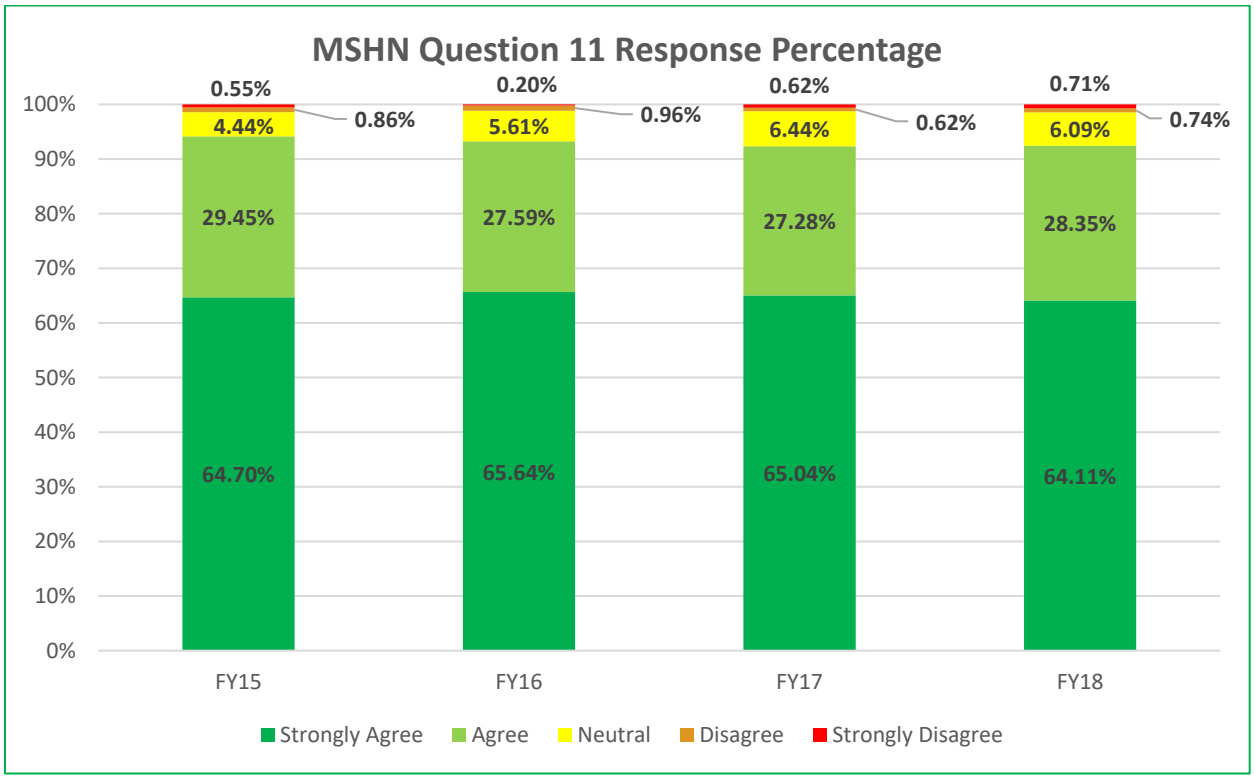
For FY18, 65.85% strongly agreed, 26.54% agreed, 6.00% were neutral, 0.81% disagreed, and 0.81% strongly disagreed. For FY17, 66.63% strongly agreed, 26.40% agreed, 5.29% were neutral, 1.02% disagreed, and 0.65% strongly disagreed. For FY16, 67.47% strongly agreed, 26.55% agreed, 5.02% were neutral, 0.64% disagreed, and 0.32% strongly disagreed. For FY15, 67.39% strongly agreed, 27.28% agreed, 4.22% were neutral, 0.74% disagreed, and 0.37% strongly disagreed.

FY18 had 92.39% that agreed or strongly agreed, FY17 had 93.03% that agreed or strongly agreed, FY16 had 94.02% that agreed or strongly agreed, FY15 had 94.67% that agreed or strongly agreed. This demonstrates a decrease of 0.64% in positive responses from FY16.

Figure 28 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey question 11 in FY15, FY16, FY17, and FY18.

Question 11: My goals were addressed during treatment.

Fig. 28 – MSHN Question 11 Response Percentage



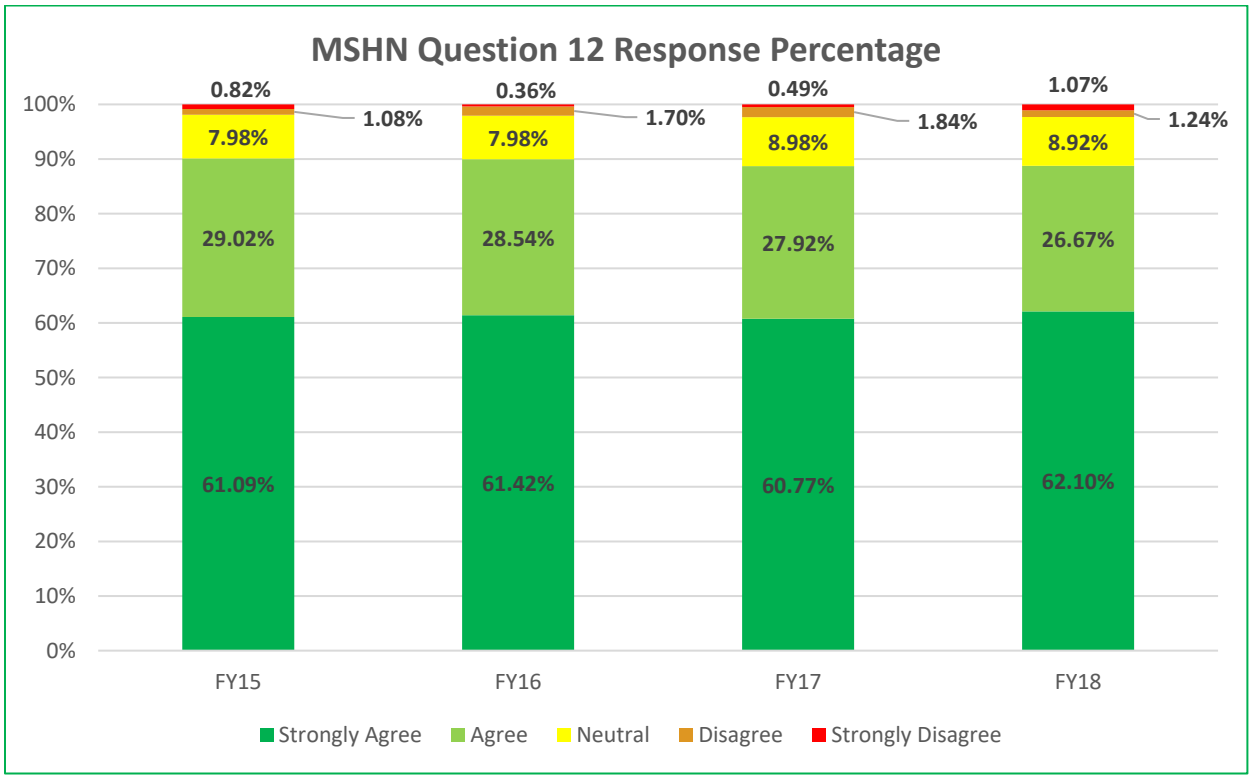
For FY18, 64.11% strongly agreed, 28.35% agreed, 6.09% were neutral, 0.74% disagreed, and 0.71% strongly disagreed. For FY17, 65.04% strongly agreed, 27.28% agreed, 6.44% were neutral, 0.62% disagreed, and 0.62% strongly disagreed. For FY16, 65.64% strongly agreed, 27.59% agreed, 5.61% were neutral, 0.96% disagreed, and 0.20% strongly disagreed. For FY15, 64.7% strongly agreed, 29.45% agreed, 4.44% were neutral, 0.86% disagreed, and 0.55% strongly disagreed.

FY18 had 92.46% that agreed or strongly agreed, FY17 had 92.32% that agreed or strongly agreed, FY16 had 93.23% that agreed or strongly agreed, FY15 had 94.15% that agreed or strongly agreed. This demonstrates an increase of 0.14% in positive responses from FY17.

Figure 29 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey question 12 in FY15, FY16, FY17, and FY18.

Question 12: My goals were changed when needed to reflect my needs.

Fig. 29 – MSHN Question 12 Response Percentage



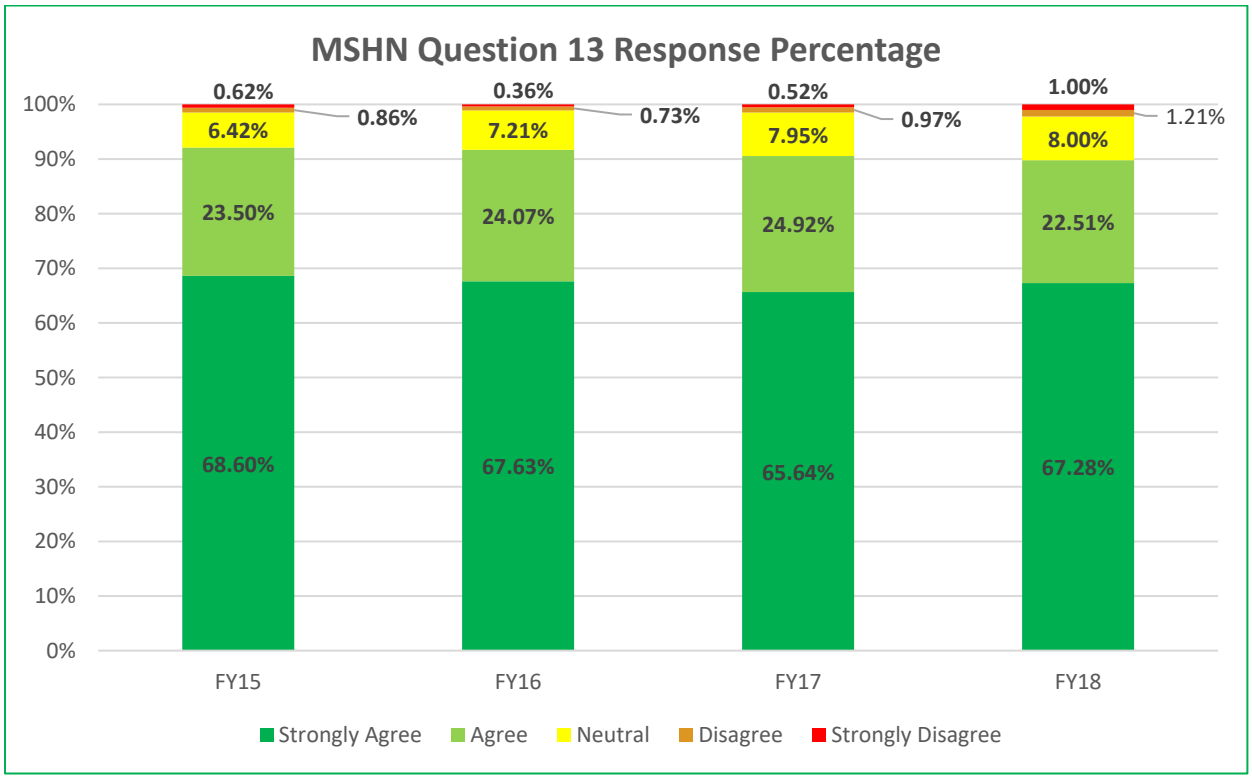
For FY18, 62.10% strongly agreed, 26.67% agreed, 8.92% were neutral, 1.24% disagreed, and 1.07% strongly disagreed. For FY17, 60.77% strongly agreed, 27.92% agreed, 8.98% were neutral, 1.84% disagreed, and 0.49% strongly disagreed. For FY16, 61.42% strongly agreed, 28.54% agreed, 7.98% were neutral, 1.70% disagreed, and 0.36% strongly disagreed. For FY15, 61.09% strongly agreed, 29.02% agreed, 7.98% were neutral, 1.08% disagreed, and 0.82% strongly disagreed.

FY18 had 88.69% that agreed or strongly agreed, FY17 had 88.69% that agreed or strongly agreed, FY16 had 89.96% that agreed or strongly agreed, FY15 had 90.11% that agreed or strongly agreed. This demonstrates an increase of 0.08% in positive responses from FY17.

Figure 30 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey question 13 in FY15, FY16, FY17, and FY18.

Question 13: I feel that I am better able to control my life as a result of treatment.

Fig. 30 – MSHN Question 13 Response Percentage



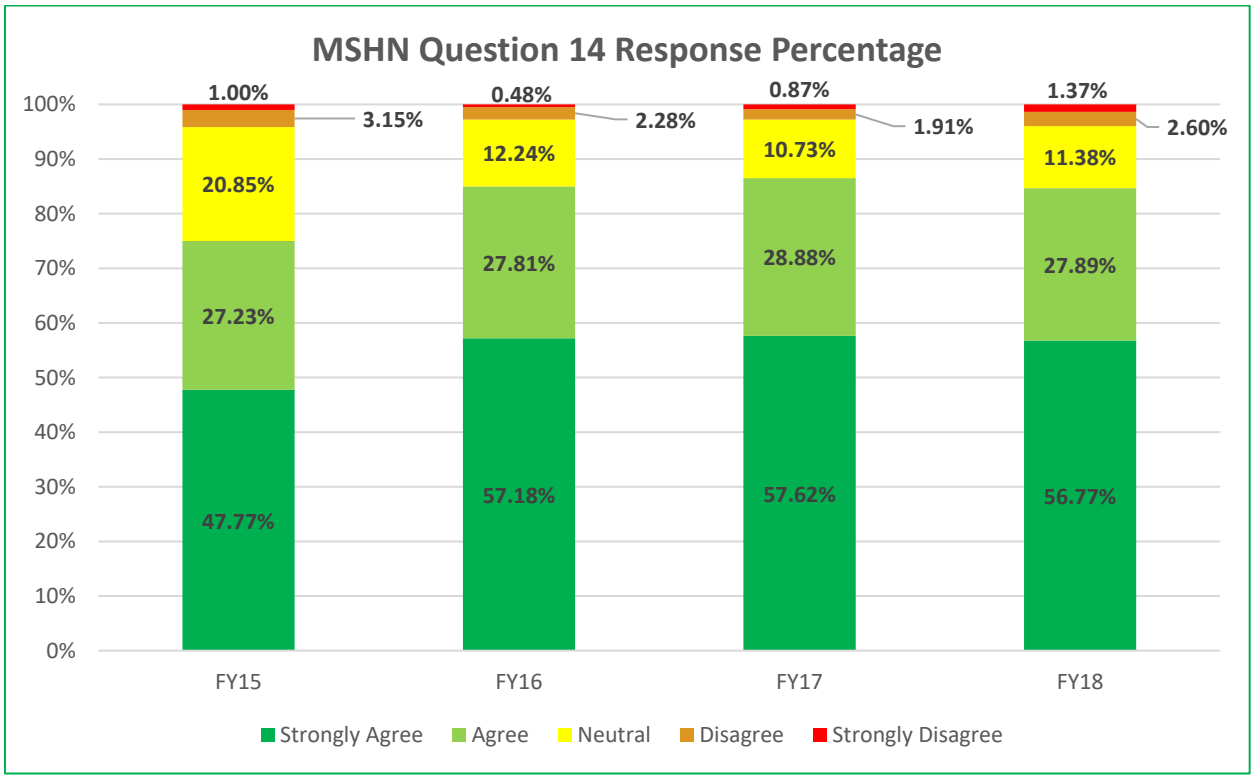
For FY18, 67.28% strongly agreed, 22.51% agreed, 8.00% were neutral, 1.21% disagreed, and 1.00% strongly disagreed. For FY17, 65.64% strongly agreed, 24.92% agreed, 7.95% were neutral, 0.97% disagreed, and 0.52% strongly disagreed. For FY16, 67.63% strongly agreed, 24.07% agreed, 7.21% were neutral, 0.73% disagreed, and 0.36% strongly disagreed. For FY15, 68.60% strongly agreed, 23.5% agreed, 6.42% were neutral, 0.86% disagreed, and 0.62% strongly disagreed.

FY18 had 89.79% that agreed or strongly agreed, FY17 had 90.56% that agreed or strongly agreed, FY16 had 91.70% that agreed or strongly agreed, FY15 had 92.10% that agreed or strongly agreed. This demonstrates a decrease of 0.77% in positive responses from FY17.

Figure 31 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey question 14 in FY15, FY16, FY17, and FY18.

Question 14: Staff assisted in connecting me with further services and/or community resources.

Fig. 31 – MSHN Question 14 Response Percentage



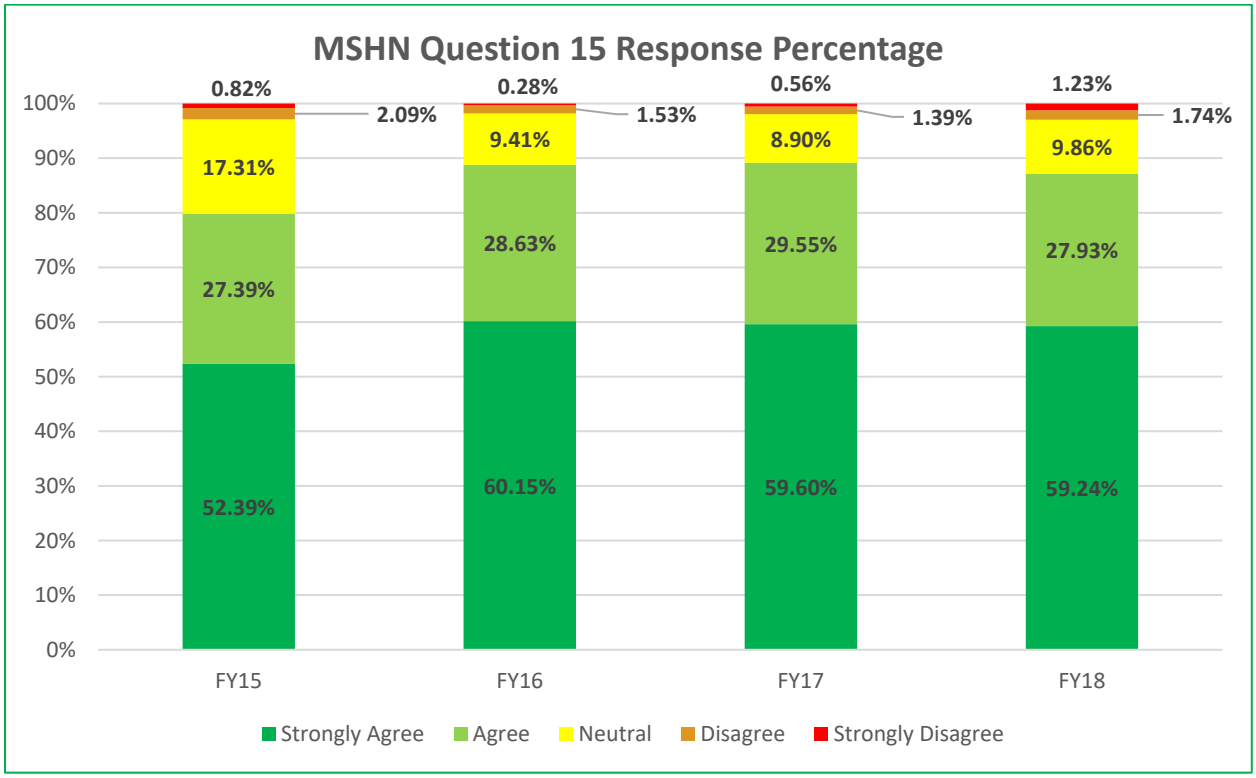
For FY18, 56.77% strongly agreed, 27.89% agreed, 11.38% were neutral, 2.60% disagreed, and 1.37% strongly disagreed. For FY17, 57.62% strongly agreed, 28.88% agreed, 10.73% were neutral, 1.91% disagreed, and 0.87% strongly disagreed. For FY16, 57.18% strongly agreed, 27.81% agreed, 12.24% were neutral, 2.28% disagreed, and 0.48% strongly disagreed. For FY15, 47.77% strongly agreed, 27.23% agreed, 20.85% were neutral, 3.15% disagreed, and 1.00% strongly disagreed.

FY18 had 84.66% that agreed or strongly agreed, FY17 had 86.50% that agreed or strongly agreed, FY16 had 84.99% that agreed or strongly agreed, FY15 had 75.00% that agreed or strongly agreed. This demonstrates a decrease of 1.84% in positive responses from FY17.

Figure 32 illustrates how the SUD consumers responded to the SUD Consumer Satisfaction Survey question in FY15, FY16, FY17, and FY18.

Question 15: My treatment plan includes skills and community supports to help me continue in my path to recovery and total wellness.

Fig. 32 – MSHN Question 15 Response Percentage



For FY18, 59.24% strongly agreed, 27.93% agreed, 9.86% were neutral, 1.74% disagreed, and 1.23% strongly disagreed. For FY17, 59.60% strongly agreed, 29.55% agreed, 8.90% were neutral, 1.39% disagreed, and 0.56% strongly disagreed. For FY16, 60.15% strongly agreed, 28.63% agreed, 9.41% were neutral, 1.53% disagreed, and 0.28% strongly disagreed. For FY15, 52.39% strongly agreed, 27.39% agreed, 17.31% were neutral, 2.09% disagreed, and 0.82% strongly disagreed.

FY18 had 87.17% that agreed or strongly agreed, FY17 had 89.15% that agreed or strongly agreed, FY16 had 88.78% that agreed or strongly agreed, FY15 had 79.78% that agreed or strongly agreed. This demonstrates an increase of 1.98% in positive responses from FY17.

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Conclusion:

In summary, the survey results identified a comprehensive score for all questions combined show a positive satisfaction response of 89.09% for FY18. This demonstrates a 0.94% decrease from the FY17 positive satisfaction response of 90.02%. This slight decrease is contrasted with the significant majority of the responses being positive. The results of the satisfaction surveys highlight that most SUD consumers are satisfied with their SUD treatment provider and the services which they receive.

The results will be reviewed further by the MSHN Quality Improvement Council, the Customer Service Committee, the Regional Consumer Advisory Council and the local SUD Providers to determine possible region wide improvement efforts as well as identification of any trends that have occurred from year to year. Areas of improvement will be targeted toward the scores that showed a decrease from prior years. Each SUD Provider will also be encouraged to review their local results for analysis and identification of local improvement efforts.

Completed by: Mid-State Health Network **Date**: September 19, 2018

MSHN QIC Approved: September 27, 2018

Voices of Adults with I/DD 2015-2016

Ann Carrellas, LMSW, Doctoral Candidate
June Malachowski, LMSW
September 2018

MI DDI
Michigan Developmental Disabilities Institute

Community Service
Education
Research
Dissemination

WAYNE STATE UNIVERSITY

Attachment 3

NCI Overview--National

National program survey involving

- 46 States (including Michigan), the District of Columbia and 22 sub-state entities
- 40,000 respondents yearly

Goal

- to assess family and adult consumer *perceptions* of and *satisfaction* with their community mental health system and services

National Adult Consumer Survey (ACS) totals in 2015-2016

- 45 states including the District of Columbia
- Total number of interviews—17,682

NCI Overview--Michigan

- Michigan has been involved since 2012
- Michigan conducted the Family/Guardian Survey to 2016 and the Adult Consumer Survey (ACS) to present time
- Family/Guardian Survey – 500+ respondents a year by mail until 2016
- Adult Consumer Survey – at least 400 respondents a year by personal interviews required by NCI
  - 2015 410
  - 2016 435
  - 2017 508 (MDHHS requested 500)
  - 2018 660 (MDHHS requested increase for better sample representation)

Parts of the NCI Survey

Pre-survey

Background Information

Section 1—for the individual only

Section 2—individual and with the assistance of a proxy if needed

Michigan Update

- January – May, 2018: In-person interviews are conducted
- January – June 15, 2018: MI-DDI provides ongoing data review and cleaning
- June 15, 2018: Complete data entry of at least 660 survey into ODESA
- June 30, 2018: Deliver Data to NCI/HSRI

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Wayne State University

Outcome Domains

- Choices
- Work
- Access & Community Inclusion
- Relationships
- Satisfaction
- Service Coordination
- Health, Wellness, & Medication
- Respect and Rights
- Safety
- Self-Determination

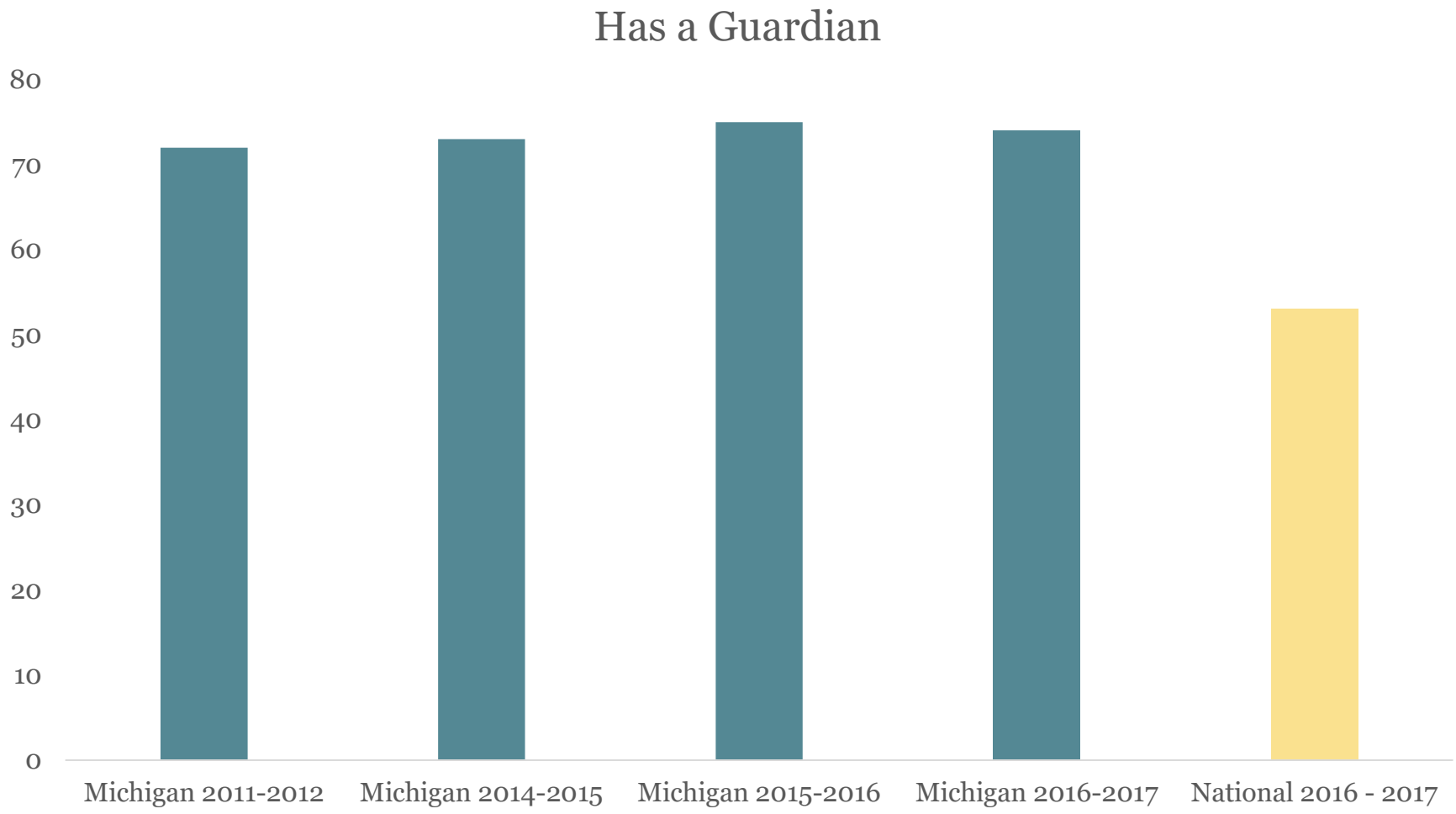
Demographic Characteristics of Adults with I/DD (%)

Variable	Michigan 2011 – 2012 N=407	Michigan 2014 – 2015 N=410	Michigan 2015 – 2016 N=435	Michigan 2016-2017 N=505	National 2016–2017 N=21,382
Age (mean)	44	45	45	44	42
Gender (male)	60	58	55	56	58
Ethnicity					
White	75	79	78	76	72
Black	19	17	18	17	16
Other	5	4	4	5	9
Marital Status (single)	97	NA	97	96	94

Michigan Developmental Disabilities Institute

Wayne State University

Demographic Characteristics of Adults with I/DD (%)



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Demographic Characteristics of Adults with I/DD (%)

Variable	Michigan 2011 – 2012 N=407	Michigan 2014 – 2015 N=410	Michigan 2015 – 2016 N=435	Michigan 2016-2017 N=505	National 2016 – 2017 N=21,382
Severity of Disability					
Mild	40	37	34	35	39
Moderate	22	31	32	30	29
Severe/Profound	32	24	25	28	22
Unspecified	NA	NA	8	7	10

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Demographic Characteristics of Adults with I/DD (%)

Variable	Michigan 2011 – 2012 N=407	Michigan 2014 – 2015 N=410	Michigan 2015 – 2016 N=435	Michigan 2016-2017 N=505	National 2016 – 2017 N=21,382
English Primary Language	99	95	96	97	97
Means of Expression (spoken)	72	76	79	77	78
Mobility					
Independent	71	72	76	71	77
With Assistance	15	17	15	19	15
Non-Ambulatory	13	11	8	10	8

Demographic Characteristics of Adults with I/DD (%)

Variable	Michigan 2011 – 2012 N=407	Michigan 2014 – 2015 N=410	Michigan 2015 – 2016 N=435	Michigan 2016-2017 N=505	National 2016 – 2017 N=21,382
Residence					
Family Home	32	26	34	29	39
Independent	21	25	20	25	39
Group Home (2-15 persons)	32	42	40	41	31
Other (AFC)	14	7	8	3	3
Behavior					
Self-Injurious	26	23	25	22	23
Disruptive	38	41	40	39	34
Destructive	24	27	26	26	25

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Choices (Had choice or input in choosing , % said Yes)

Variable	Michigan 2011 – 2012 N=407	Michigan 2014 – 2015 N=410	Michigan 2015 – 2016 N=435	Michigan 2016-2017 N=505	National 2016 – 2017 N=21,382
Home	50	56	54	46	53
Home Staff	56	49	58	52	64
Roommate	37	33	37	30	41
Job	77	89	84	83	86
Day Activity	61	66	64	62	62
Daily Schedule	76	83	87	83	82
How to Spend Free Time	86	95	94	94	91
How to Spend Money	82	90	87	87	86
Case Coordinator	63	55	74	88	85

Work (%/Yes)

Variable	Michigan 2011 – 2012 N=407	Michigan 2014 – 2015 N=410	Michigan 2015 – 2016 N=435	Michigan 2016-2017 N=505	National 2016 – 2017 N=21,382
Community paid job	17	14	17	14	19
Wages/community job bi-weekly	$160	NA	$139.93	NA	$287.49
Hourly wage/community job	$8.30	NA	$7.60	NA	$9.75
Has community employment goal	15	22	26	24	28
Wants a job in the community	NA	45	42	57	46
Paid benefits (vacation, sick time)	22	16	15	25	27

Work (%/Yes)

Variable	Michigan 2011 – 2012 N=407	Michigan 2014 – 2015 N=410	Michigan 2015 - 2016 N=435	Michigan 2016- 2017 N=505	National 2016 - 2017 N=21,382
Jobs Most Common • Cleaning • Retail • Food Prep • Assembly	 43 7 6 13	 31 20 9 11	 33 10 22 12	 36 13 13 10	 30 16 21 10
Type of job • Competitive • Supported* Individual Group	NA	 26 23 51	 22 35 59	 22 27 57	 36 35 30
Takes classes, training to get a job	NA	NA	31	23	21
Attends a Day Program/ Workshop	59	68	56	51	59
Volunteers	36	36	30	34	34

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**Receives Michigan or other funded supports*

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Access & Community Inclusion (%/Yes)

Variable	Michigan 2011 – 2012 N=407	Michigan 2014 – 2015 N=410	Michigan 2015 – 2016 N=435	Michigan 2016-2017 N=505	National 2016 – 2017 N=21,382
In the past month*:					
Shopping	87	87	91	86	90
Errands	85	90	88	84	88
Entertainment	73	69	77	70	77
Out to Eat	83	85	86	81	81
Religious Serv.	47	42	45	38	45
Vacation in Past Year	42	40	39	38	45
Staff Have Adequate Training	90	88	87	90	89

**Percent of people who did these activities at least once*

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Relationships (%/Yes)

Variable	Michigan 2011 – 2012 N=407	Michigan 2014 – 2015 N=410	Michigan 2015 – 2016 N=435	Michigan 2016-2017 N=505	National 2016 – 2017 N=21,382
Has Friends	68	66	70	71	77
Has a Best Friend	73	75	NA	70	72
Able to See Friends	72	79	78	70	79
Able to See Family	76	78	87	73	80
Feels Lonely	44	42	12	14	11
Can go on a Date	77	86	76	68	73
Gets to Help Others	88	87	NA	NA	NA
Has someone to talk to if afraid	NA	NA	89	94	94

Questions?

- Questions
- Comments
- How would you like to see this information used?

Attachment 4

MSHN

Mid-State Health Network

SUBSTANCE USE DISORDER (SUD) PROVIDER SATISFACTION SURVEY

FY18

The MSHN Provider Satisfaction Survey was administered to contracted SUD providers during December and January of 2018. Three new questions were added to the survey, with several demographic indicators removed to ensure anonymity. The SUD Provider Advisory Committee was offered the opportunity to provide feedback on changes to the survey, including methods to increase the response rate. The survey was administered via the MSHN Constant Contact, along with direct outreach to program administrators. In addition to announcing the release of the survey at an SUD Quarterly Provider meeting, MSHN staff who routinely interact with providers included a link in their email signature during the response period. The number of responses more than doubled over last year, with ninety-two (92) responses received.

Carolyn T. Watters
Director of Provider Network Management Systems

SUD providers at all levels of the organization were encouraged to respond based on experiences with MSHN during fiscal year 2018 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 issue 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'. Each chart also includes the total respondents in parenthesis following the year (e.g. 2018 (92))

Question 1: Respondents were asked to rate satisfaction with MSHN in the areas related to **administration and organization**. The following charts represent matters based on functional area. Some matters cross over functional areas and may be represented on multiple charts.

Chart 1: Provider Network

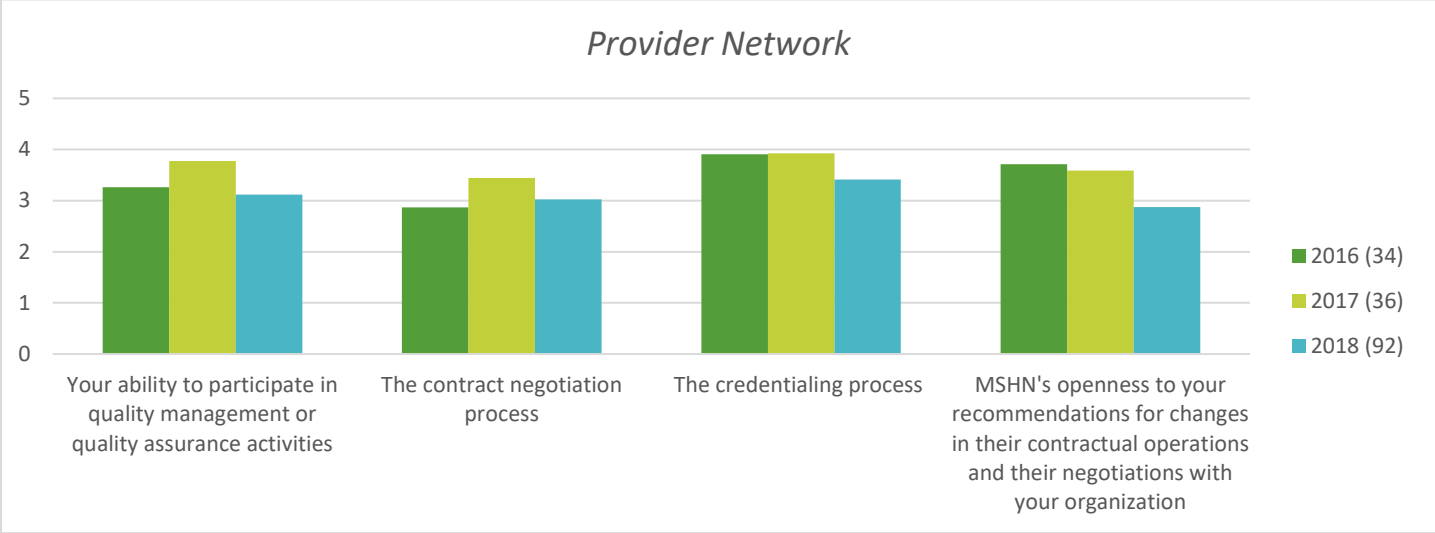


Chart 2: Quality and Compliance

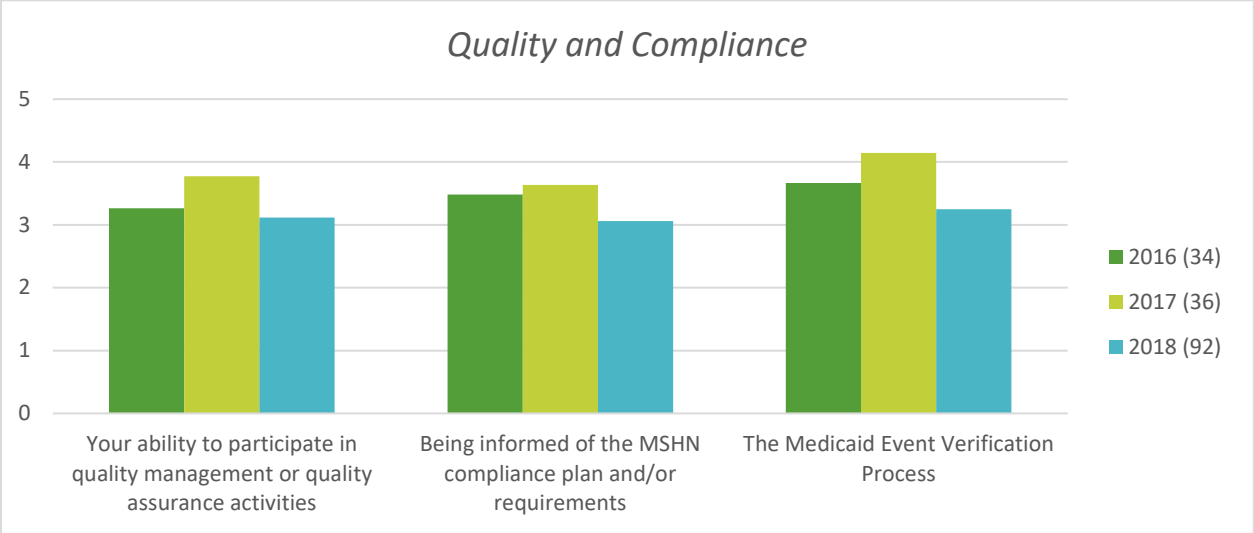


Chart 3: Treatment and Prevention

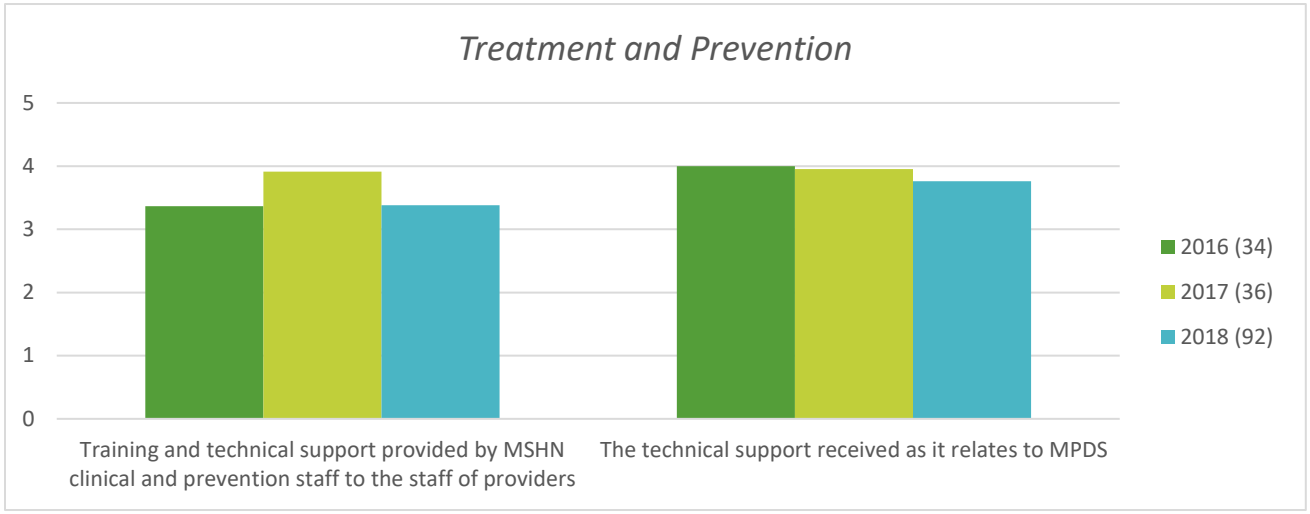


Chart 4: Utilization Management

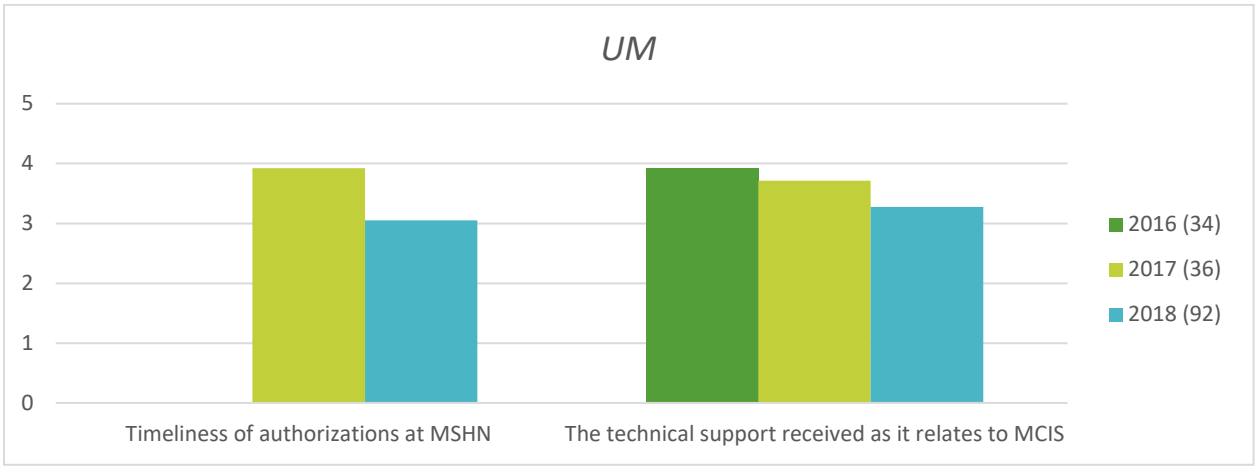


Chart 5: Finance and Claims

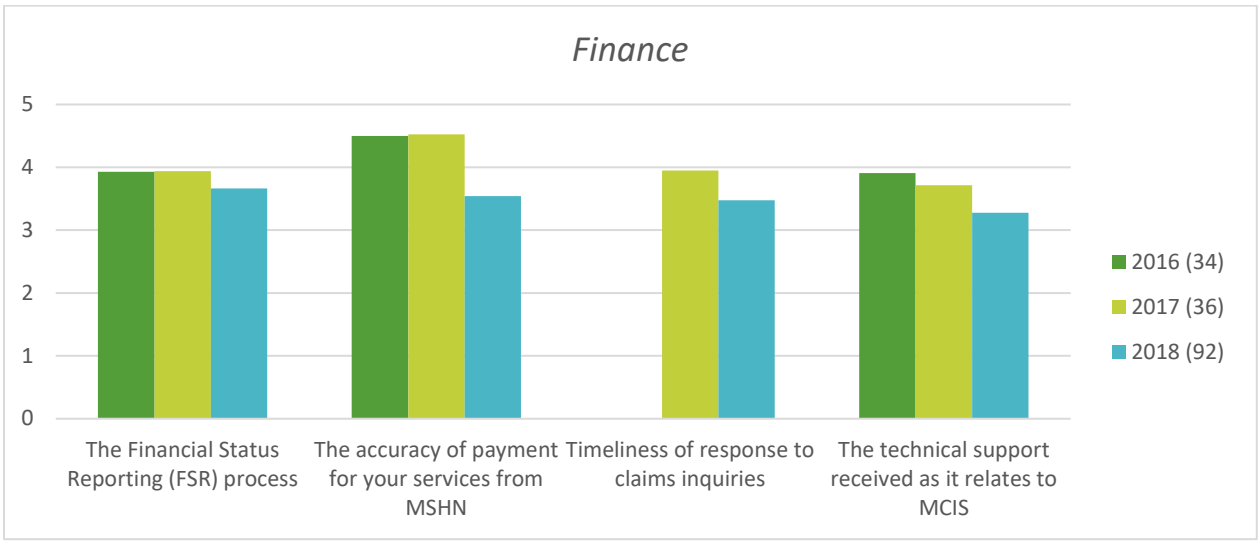


Chart 6: General

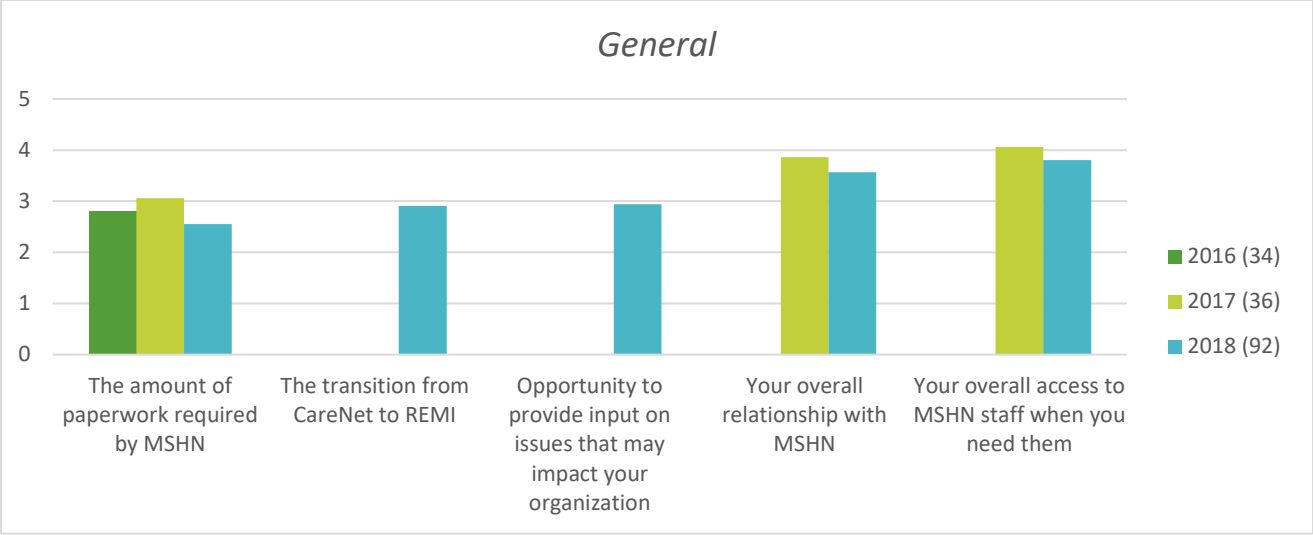


Chart 7: Communications

Question 2: Respondents were asked to rate satisfaction with MSHN in the areas related to **clinical care** (Treatment Providers only). The following charts represent matters based on functional area.

Chart 8: Utilization Management

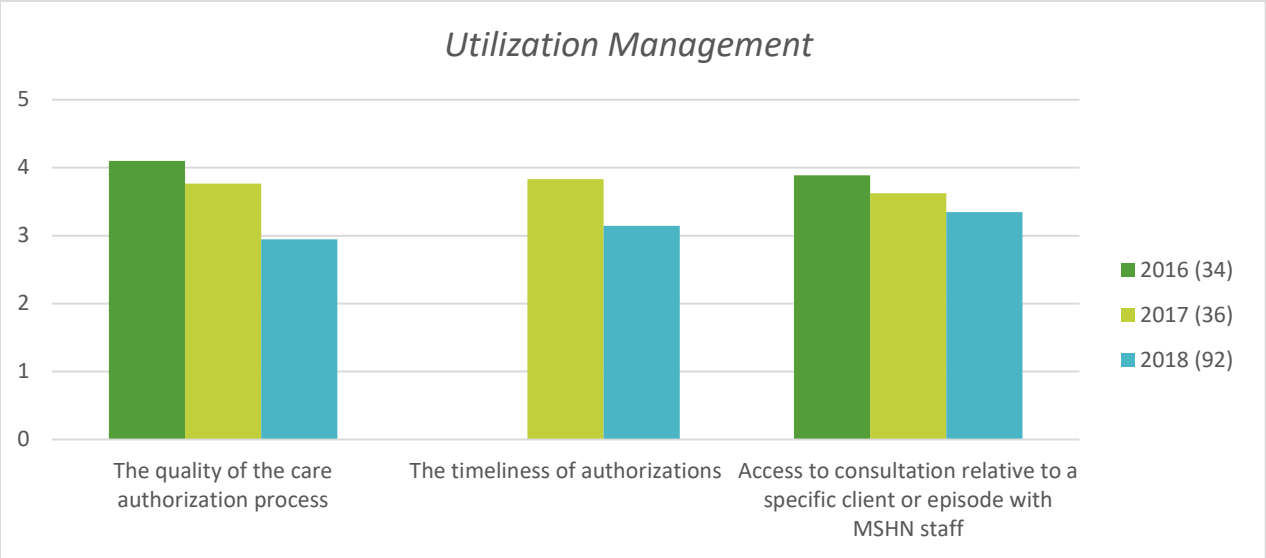
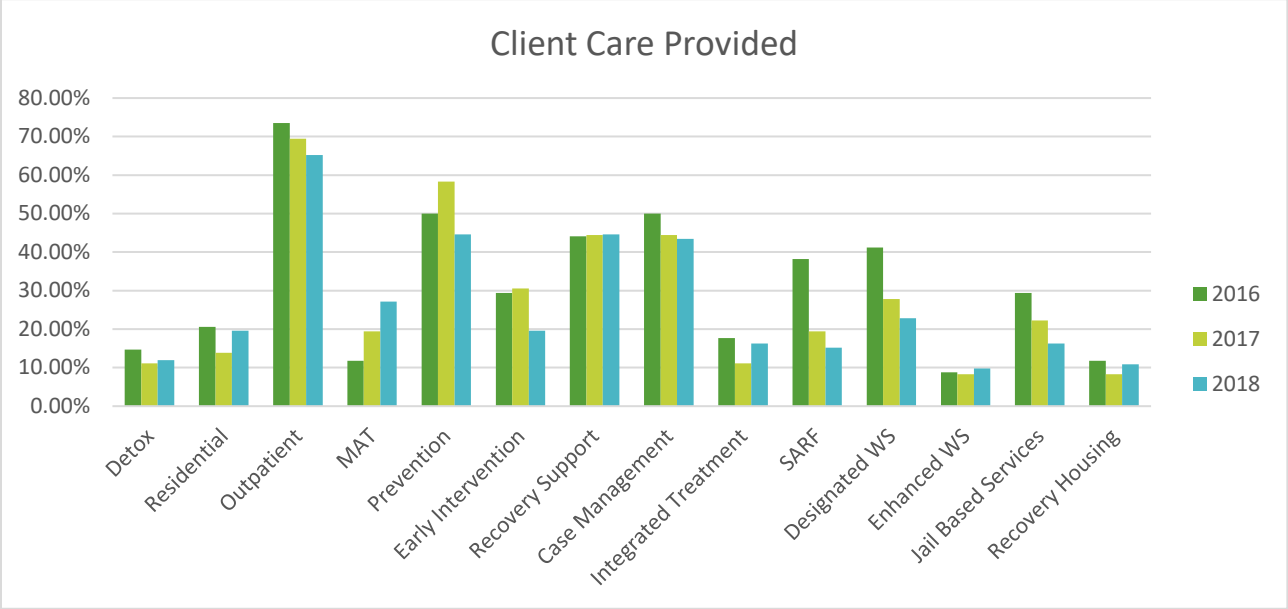


Chart 9: Customer Services

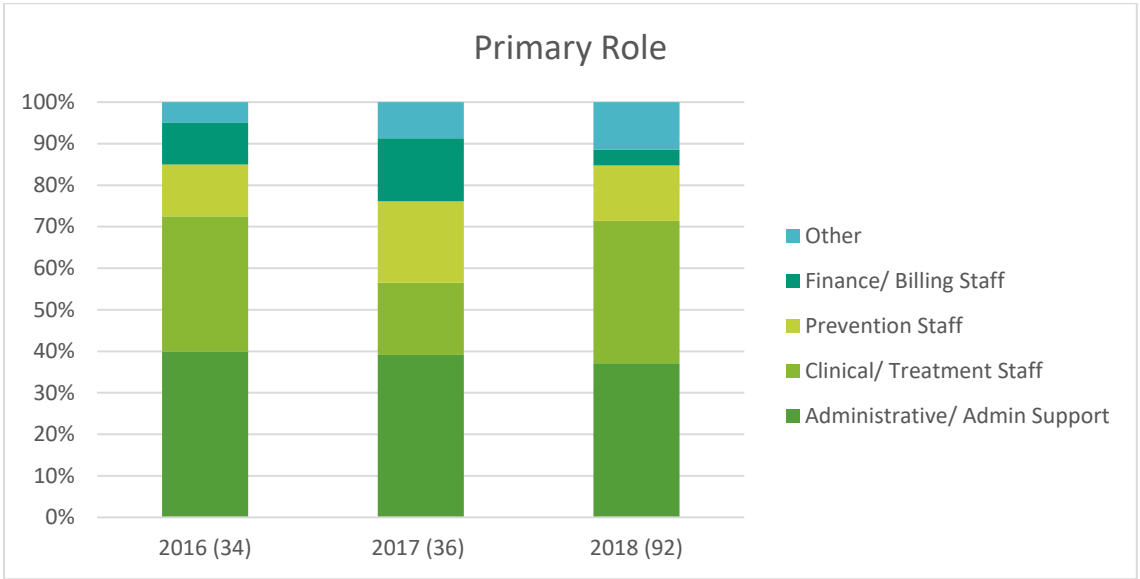
Question 3: Respondents were asked to report the type of care provided. Providers often provide many levels of care, so responses are duplicate.

Chart 10: Client Care Provided



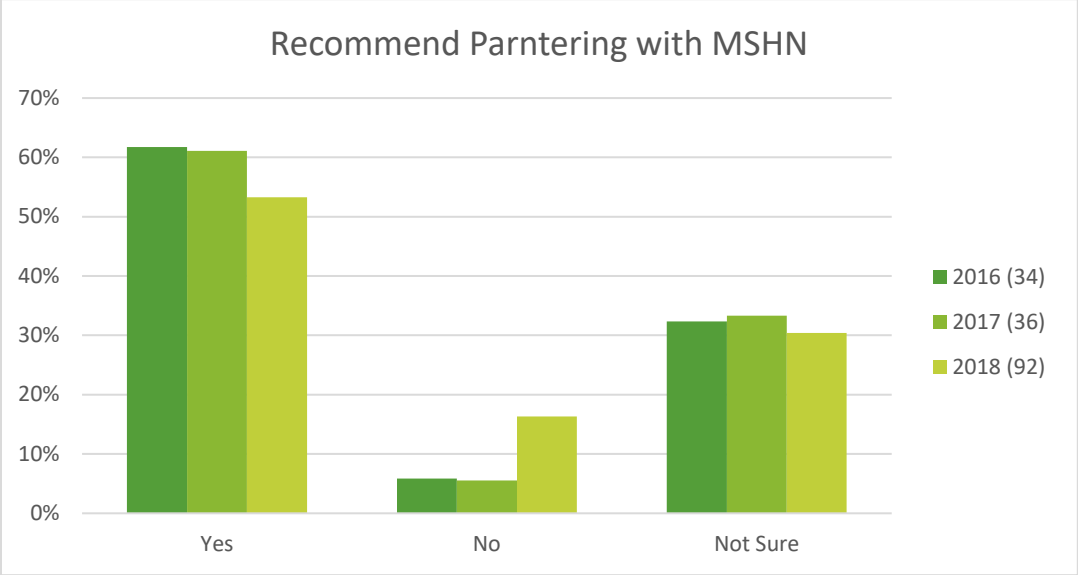
Question 4: Respondents were asked to identify their primary role within their organization. Chart 11 represents the role of the respondent. Administrative/administrative support staff historically represent the greatest number of responses. There was a marked increase in participation and feedback from clinical staff in 2018.

Chart 11: Role of respondent



Question 5: Respondents were asked if they would recommend partnering with MSHN to a provider colleague. The number of those indication yes, fell from 61% in 2017 to 53% in 2018.

Chart 12: Recommend partnering with MSHN



2017 Survey Feedback - Improvement Initiatives

- MSHN website redevelopment with provider and consumer focus; sough input from providers via SUD-PAC Committee and SUD provider meetings.
- Quality Assurance and Performance Improvement (QAPI) staff identify regional performance improvement opportunities based on results of annual audits; recommend regional trainings to appropriate functional areas.
- QAPI staff provide on-site technical assistance during annual audits based on provider needs; communicate individual provider TA needs to treatment specialist for additional support.
- Contract review process included a formal venue for review of contract changes and provider feedback via SUD-PAC Committee.
- Training at SUD provider meeting specific to Grievance and Appeals and Compliance and REMI claims submission and clinical processes.
- Additional staff member (Recovery Specialist) added to Clinical Team to support programs providing Recovery Support Services.

2018 Survey Feedback – Next Steps

- Share results:
    - MSHN Leadership Review: January 23, 2019
    - MSHN All Staff Review: February 14, 2019
    - SUD-PAC Review: March 11, 2019
- Develop workplan to address opportunities for improvement including:
    - Identifying ways to reduce paperwork; eliminate duplication; review documentation requirements for efficiencies.
    - Address cross-functional collaboration to improve communications to providers.
    - Review feedback regarding REMI processes for possible improvement and/or provider education and training.

Attachment 5

Monitoring and Auditing

Mid-State Health Network External Audits

MDHHS Habilitation Supports Waiver Site Visit Report: July 18th – August 27th

The Michigan Department of Health and Human Services (MDHHS) conducted an on-site review for our region from July 18, 2018 through August 27, 2018. The purpose of the review was to provide monitoring on the service delivery requirements of the 1915 (c) waivers that include the Habilitation Supports Waiver (HSW), the Waiver for Children with Serious Emotional Disturbance (SEDW), the Children's Waiver Program (CWP) and the Wraparound Fidelity review.

Note: The SEDW, CWP and Wraparound Fidelity review is the responsibility of the CMHSPs and therefore not included in the MSHN summary report.

The 2018 site review included the review of administrative procedures, beneficiary files, staff records and home visits.

Total Cases Reviewed (76)
Total Licensed Staff Records Reviewed (184)
Total Non-Licensed Staff Records Reviewed (1,124)
Total Home Visits (7)

Summary of the findings:

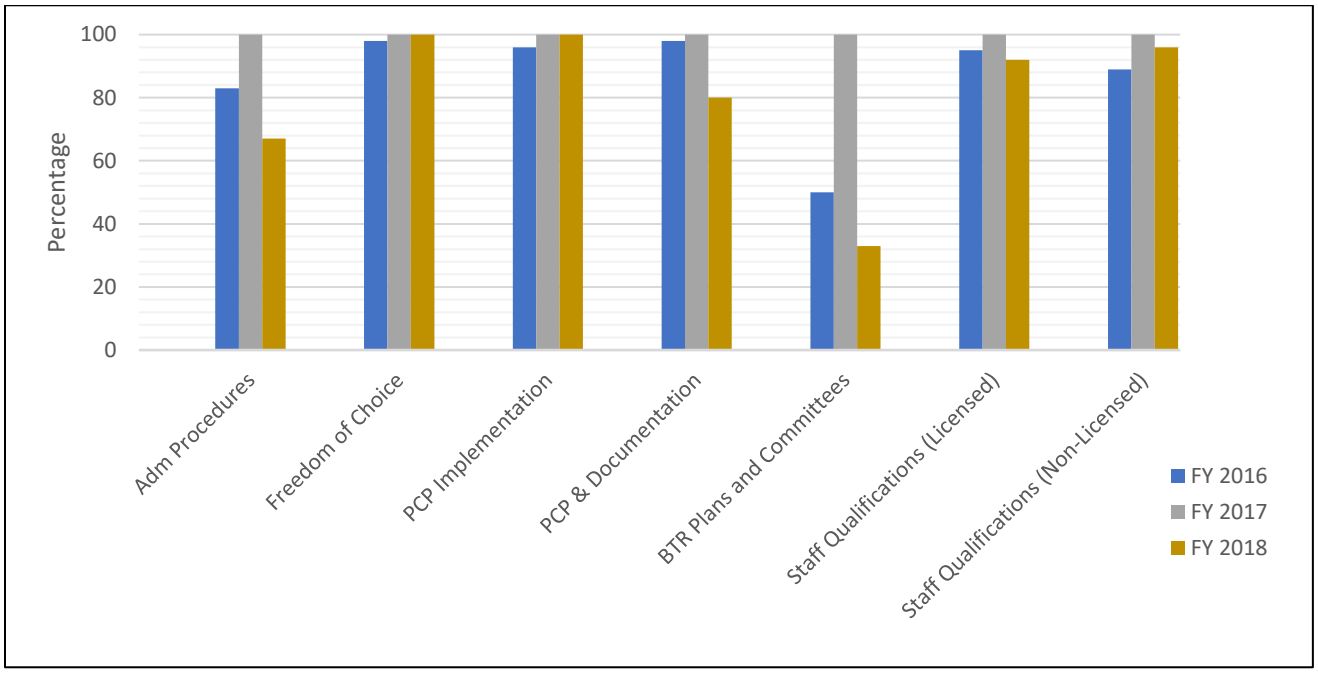
A. Administrative Procedures (5 elements): 67%
B. Freedom of Choice (2 Elements): 100%
C. Implementation of Person Centered Planning (7 Elements): 100%
D. Plan of Service and Documentation Requirements (3 Elements): 80%
E. Behavior Treatment Plans and Review Committees (2 Elements): 33%
F. Staff Qualifications (Licensed) (2 Elements): 92%
F.1. Staff Qualifications (Non-Licensed) (2 Elements): 96%
G. Residential Home Visits/Training/Interviews (7 homes): 29%
H. Non-Residential Home Visit (2): 50%

Note: The percentages were calculated by dividing the total number of charts that received a score of "yes" (full compliance) by the total number of charts reviewed.

Next Steps:

MSHN was required to submit a plan of correction to MDHHS for all elements that received less than "full compliance." During the FY2018 site review, MSHN was found to have repeat citations (from the FY2016 review) for eight standards. MSHN will be monitoring the repeat citations to ensure full compliance during the next review.

Comparison of Results for Full Review (FY2016), Follow Up Review (FY2017) & Full Review (FY2018):



Note: FY2017 was a follow up review only for the plans of correction from the previous year.

MDHHS Substance Use Site Review Report: July 11th & 18th

The Michigan Department of Health and Human Services (MDHHS) completed an on-site review at Mid-State Health Network (MSHN) on July 11th and 18th, 2018. The purpose of the review was to determine compliance with the Substance Use Agreement with the Centers for Medicare and Medicaid services. MHDDS reviewed compliance with established standards as well as provide opportunities for quality improvement. The review was completed as a desk audit, as well as an on-site review. The desk audit consisted of the review of supporting documentation to show compliance with each of the identified standards. The on-site review consisted of follow up on any standards that needed clarification from the desk audit as well as discussion with MSHN staff on our process and procedures for providing oversight and monitoring for the provider network

MSHN was determined to be in full compliance with thirteen out of thirteen standards.

Summary of Findings:

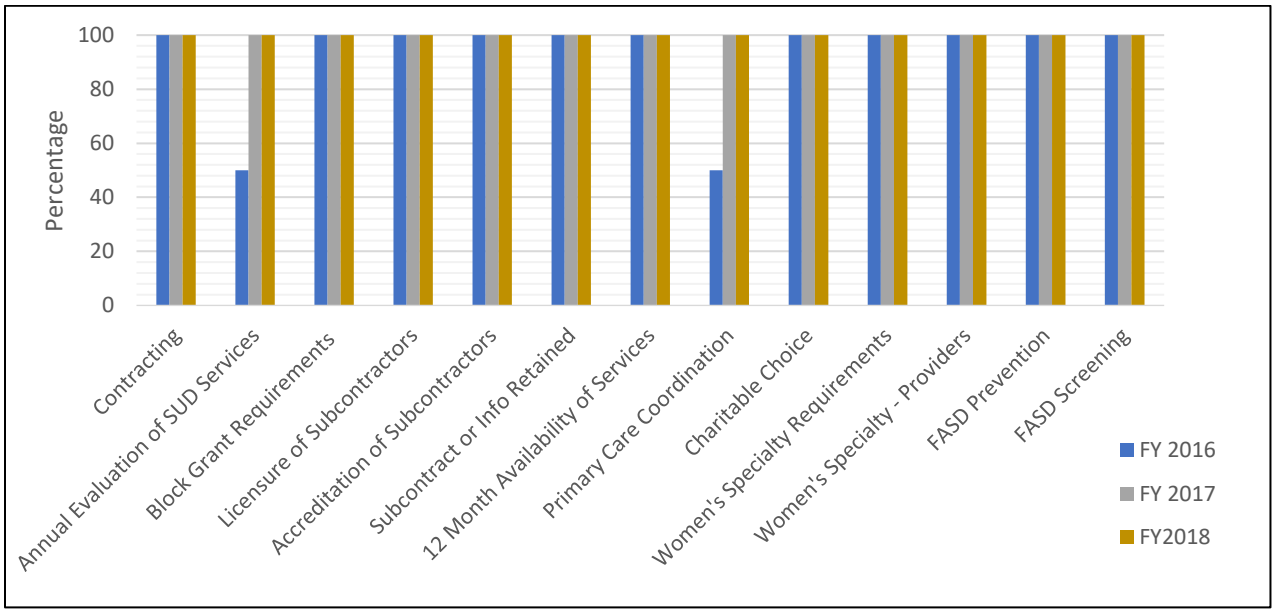
(Scoring: 2 = Full Compliance (100%); 1 = Partial Compliance (50%); 0 = Non-Compliance (0%))

1. Contracting – ***2***
2. Annual Evaluation of SUD Services –***2***
3. Selected Specific Block Grant Requirements Applicable to PIHPs – ***2***
4. Licensure of Subcontractors – **2**
5. Accreditation of Subcontractors -***2***
6. Subcontractor Information to be Retained at the PIHP - ***2***
7. 12- Month Availability of Services – ***2***
8. Primary Care Coordination – ***2***

9. Charitable Choice - ***2***
10. Women's Specialty Services Federal Requirements - ***2***
11. Women's Specialty Services Requirements Regarding Providers - ***2***
12. Fetal Alcohol Spectrum Disorders (FASD) Prevention Activities - ***2***
13. Fetal Alcohol Spectrum Disorders (FASD) Screening - ***2***

Next Steps:
MSHN received a status of full compliance with all required standards. No further action is required.

Comparison of Results for Full Review (FY2016), Follow Up Review (FY2017) & Full Review (FY2018):



MDHHS Autism Site Visit:
The Michigan Department of Health and Human Services did not complete an Autism review during FY2018. A full review will be completed during FY2019.

MDHHS – Health Services Advisory Group (HSAG) – Performance Measurement Validation (PMV) Report: July 17th

Validation of performance measures is one of three mandatory external quality review (EQR) activities required by the Balanced Budget Act of 1997 (BBA). State Medicaid agencies must ensure that performance measures reported by their managed care organizations (MCOs) are validated. Health Services Advisory Group, Inc. (HSAG), the EQRO for the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration, conducted the validation activities for the prepaid inpatient health plans (PIHPs) that provided mental health and substance abuse services to Medicaid-eligible recipients. 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 specifications and reporting requirements.

HSAG completed MSHN's review onsite on July 17, 2018.

Data Collection and Analysis:

For this review, HSAG validated a set of performance indicators that were developed and selected by the Michigan Department of Health and Human Services (MDHHS). This review was completed as a desk audit and an on-site review. To conduct the on-site review, HSAG collected information using several methods including interviews, system demonstrations, review of data output files, primary source verification, observation of data processing and review of data reports.

Summary of Findings:

Performance Indicators (12 Elements): **100%**

Compliance was assessed through a review of the following:

- Information Systems Capabilities Assessment Tool (ISCAT)
- Source Code (programming language) for performance indicators
- Performance Indicator reports
- Supporting documentation
- Evaluation of system compliance

Data Integration, Data Control and Performance Indicator Documentation (13 Elements): **100%**
Denominator Validation Findings (7 Elements): **100%**
Numerator Validation of Findings (5 Elements): **100%**

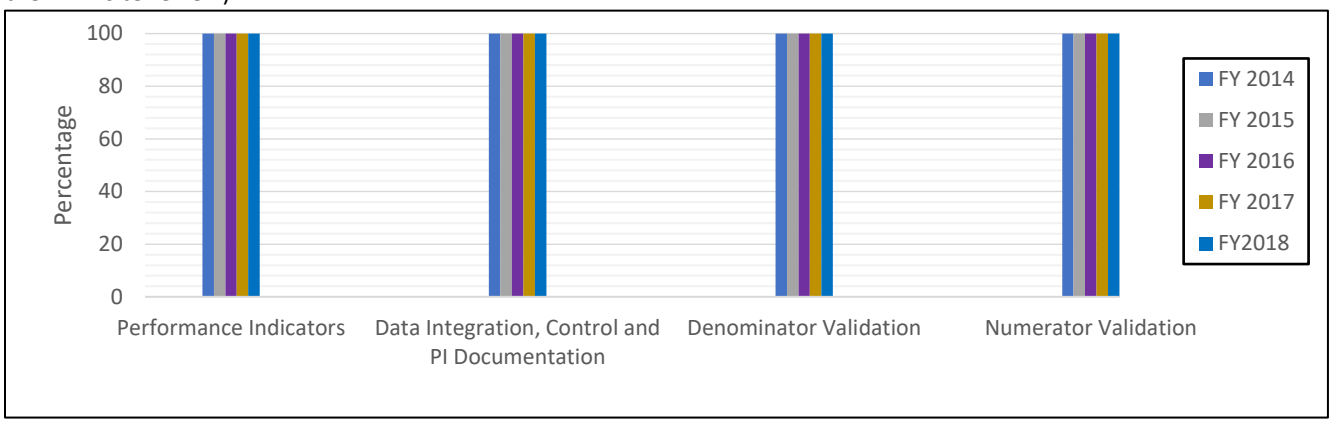
Strengths:

HSAG noted that MSHN was very well prepared for this site review and that MSHN continues to demonstrate appropriate oversight processes for all CMHSPs. MSHN has created a standard template document to ensure that all CMHSPs have the same understanding of how to report performance indicators and lessen the error threshold. MSHN demonstrated that eligibility effective dates, termination dates, historical eligibility spans, and identification of dual (Medicare/Medicaid) members were identified appropriately.

Next Step(s):

MSHN will continue to monitor performance and review areas for improvement. No corrective action is required to be submitted to HSAG for this review and HSAG did not identify any areas of improvement for MSHN.

Comparison of FY2014, FY2015, FY2016, FY2017 and FY2018 Results: (HSAG completes a full review each year for the PMV site review)



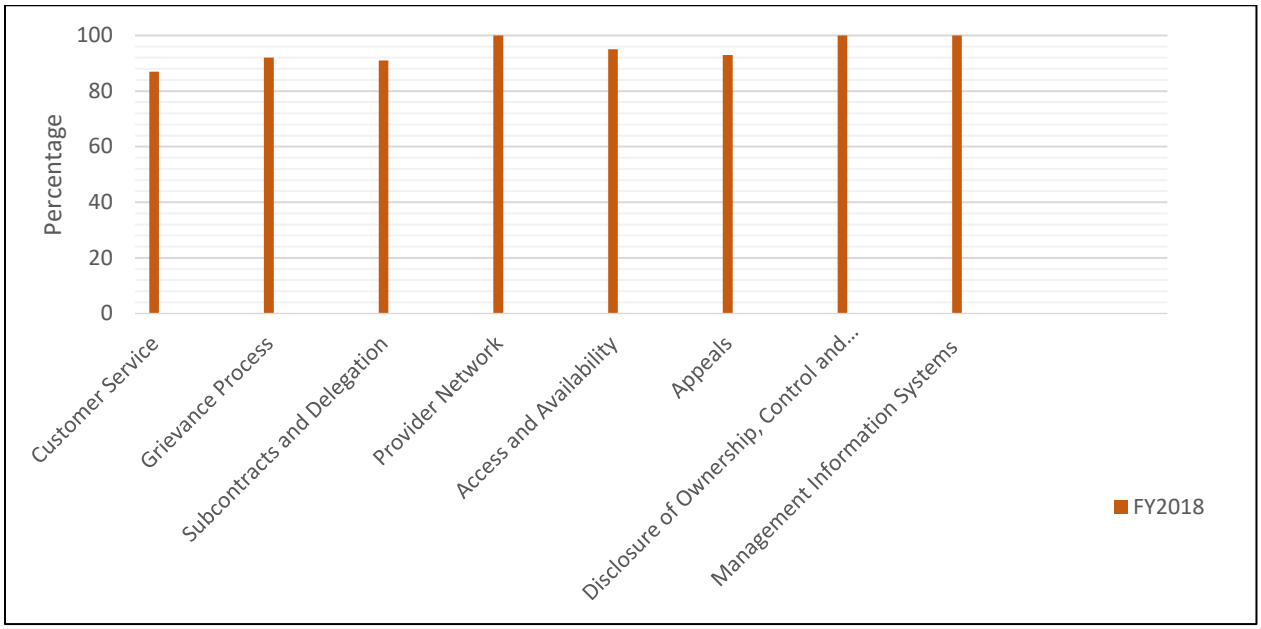
MDHHS– Health Services Advisory Group – Compliance Monitoring Review: June 7th & 8th

According to federal requirements located within the Code of Federal Regulations (CFR), 42 CFR §438.358, the state, its agent that is not a Medicaid prepaid inpatient health plan (PIHP), or an external quality review organization (EQRO) must conduct a review to determine a Medicaid PIHP's compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To comply with the federal requirements, the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration (BHDDA) contracted with Health Services Advisory Group, Inc. (HSAG), as its EQRO to conduct compliance monitoring reviews of the PIHPs.

HSAG performed a desk review of MSHN's documents and completed an on-site review that included reviewing additional documents and case files and conducting interviews with key MSHN staff members. HSAG evaluated the degree to which MSHN complied with federal Medicaid managed care regulations and the associated MDHHS contract requirements in the following 8 of 17 performance categories:

- Standard VI—Customer Service (39 Elements)
- Standard VII—Grievance Process (26 Elements)
- Standard IX—Subcontracts and Delegation (11 Elements)
- Standard X—Provider Network (12 Elements)
- Standard XII—Access and Availability (19 Elements)
- Standard XIV—Appeals (54 Elements)
- Standard XV—Disclosure of Ownership, Control, and Criminal Convictions (14 Elements)
- Standard XVII—Management Information Systems (14 Elements) (New Standard for FY 2018)

Results for FY2018:



The results included the following:

- MSHN achieved full compliance in 3 out of the 8 standards reviewed
- MSHN fully met 176 out of 189 elements reviewed
- The overall compliance score for all standards was 93%

Strengths:

The following were some of the identified strengths.

- Customer Service meeting minutes were thorough and documented collaborative discussions on topics such as educational materials, changes to federal and State requirements, updates to the customer handbook, policy, and reporting requirements.
- MSHN consistently acknowledged and resolved grievances in a timely manner.
- The Notice of Grievance Resolution letters included the appropriate content, including the results of the grievance process and the date the grievance process was concluded.
- Exhibit A of the subcontract between MSHN and CMHSPs clearly outlined managed care functions and whether they were retained by MSHN or delegated to the local CMHSPs.
- MSHN demonstrated strong performance related to access and availability and MSHNs aggregated rates were at or above the contractually required minimum performance standard of 95 percent for 14 of the 15 measures reviewed.
- MSHN demonstrated effective monitoring processes to ensure no staff member or provider was excluded from participating in Medicare, Medicaid, and other federal healthcare programs.
- Robust reports, including detailed utilization data, were being shared with the utilization management and quality improvement teams to assist them in process improvement efforts.

Next Step(s): MSHN is required to submit a plan of correction for the elements not found in full compliance. The plan of correction will be monitored by the appropriate councils, committees and workgroup.

MDHHS – Health Services Advisory Group –Performance Improvement Project (PIP) Report: Validation Year 1: 2017 - 2018

MDHHS requires that the PIHP conduct and submit a Performance Improvement Project (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 consumers 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. By assessing PIPs, HSAG assesses each PIHP's "strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients," according to the Code of Federal Regulations (CFR) at 42 CFR 438.364(a)(2).

For State Fiscal Year (SFY) 2017–2018, MDHHS required PIHPs to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv).

Validation year 1 is the design stage which 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.

Study Indicator:

PIP Topic	Study Indicator
Patients 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.

2017 – 2018 Performance Improvement Project Validation Results for Mid-State Health Network:

Stage	Step		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)

Design	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	VI.	Accurate/Complete Data Collection	100% (2/2)	0% (0/2)	0% (0/2)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Percentage Score of Applicable Evaluation Elements *Met*			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

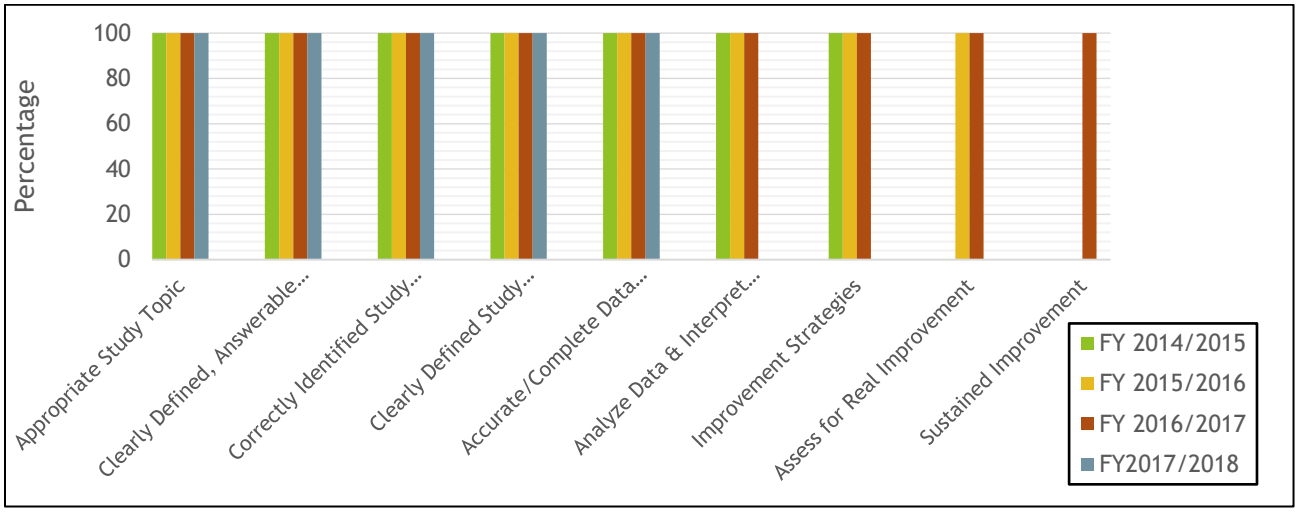
Strengths:

MSHN received an overall "Met" status for all applicable evaluation elements for the first six steps of the PIP process. MSHN designed a scientifically sound project supported by the use of key research principles and the technical design was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process.

Next Steps:

MSHN is not required to submit a plan of correction for the PIP. MHSN will progress to the implementation stage of the PIP for the upcoming year.

Comparison of FY2014/2015, FY2015/2016, FY2016/2017 and 2017/2018 Validation Results:



Note: Assessment for Real Improvement was not measured during FY2014/2015

Note: Sustained Improvement was not measured during FY2014/2015 and FY2015/2016

Note: For 2017/2018, only the first 5 measures were reviewed for year 1

Attachment 6

MSHN Critical Incident Report (FY 2018)

IR End Date: 9-30-18, Data Submission: 10-31-18

Board/Census	Incident Type	Quarter 1 Totals	Quarter 2 Totals	Quarter 3 Totals	Quarter 4 Totals	FY18 Total	FY Incidents Per Persons Served
Bay Arenac Behavioral Health	Suicide	0	0	2	0	2	0.0004
	Non-Suicide Death	10	14	8	3	35	0.0073
	EMT due to Injury/Medication Error	5	11	11	5	32	0.0067
Pers. Served(FY18):	Hospitalization due to Injury/Medication Error	2	0	0	0	2	0.0004
	Arrest	0	0	2	1	3	0.0006
4,809	**Total**	**17**	**25**	**23**	**9**	**74**	**0.0154**
CMH Central Michigan	Suicide	2	0	0	0	2	0.0002
	Non-Suicide Death	6	5	5	9	25	0.0029
	EMT due to Injury/Medication Error	29	32	34	40	135	0.0158
Pers. Served(FY18):	Hospitalization due to Injury/Medication Error	0	0	2	2	4	0.0005
	Arrest	2	4	3	0	9	0.0011
8,539	**Total**	**39**	**41**	**44**	**51**	**175**	**0.0205**
CMHA CEI	Suicide	2	1	1	2	6	0.0006
	Non-Suicide Death	19	18	14	12	63	0.0066
	EMT due to Injury/Medication Error	5	6	7	3	21	0.0022
Pers. Served(FY18):	Hospitalization due to Injury/Medication Error	0	0	0	2	2	0.0002
	Arrest	0	0	0	0	0	0.0000
9,590	**Total**	**26**	**25**	**22**	**19**	**92**	**0.0096**
Gratiot CMH	Suicide	0	0	1	0	1	0.0009
	Non-Suicide Death	0	0	0	1	1	0.0009
	EMT due to Injury/Medication Error	0	1	6	10	17	0.0160
Pers. Served(FY18):	Hospitalization due to Injury/Medication Error	0	0	2	0	2	0.0019
	Arrest	0	1	0	0	1	0.0009
1,063	**Total**	**0**	**2**	**9**	**11**	**22**	**0.0207**

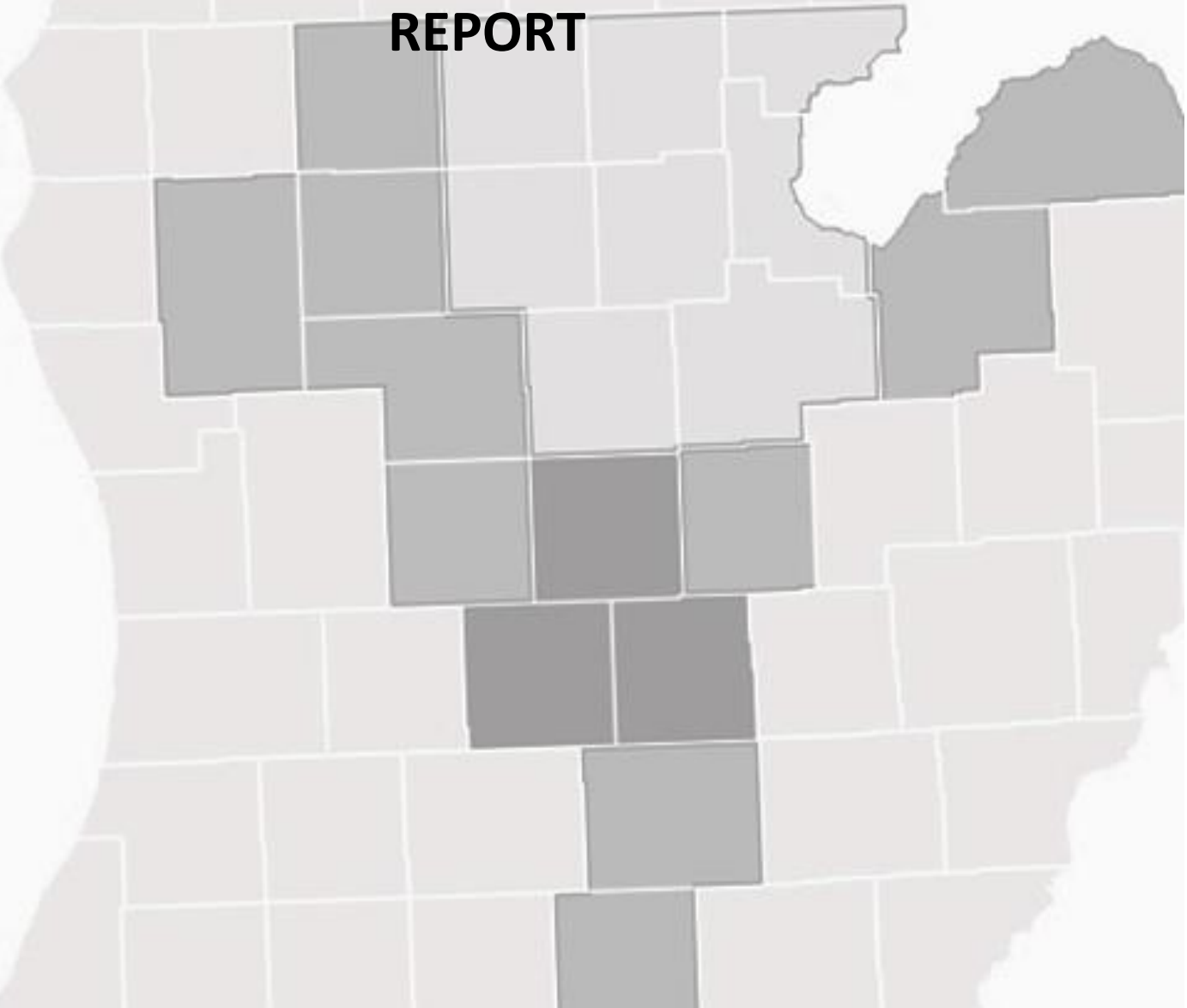
Board/Census	Incident Type	Quarter 1 Totals	Quarter 2 Totals	Quarter 3 Totals	Quarter 4 Totals	FY18 Total	FY Incidents Per Persons Served
Huron Behavioral Health	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	2	2	3	0	7	0.0076
	EMT due to Injury/Medication Error	0	0	0	0	0	0.0000
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
Pers. Served(FY18):	Arrest	0	0	0	0	0	0.0000
918	**Total**	**2**	**2**	**3**	**0**	**7**	**0.0076**
The Right Door for Hope, Recovery and Wellness (Ionia)	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	1	0	4	1	6	0.0041
	EMT due to Injury/Medication Error	0	2	5	3	10	0.0069
	Hospitalization due to Injury/Medication Error	0	0	0	2	2	0.0014
Pers. Served(FY18):	Arrest	1	2	2	1	6	0.0041
1,457	**Total**	**2**	**4**	**11**	**7**	**24**	**0.0165**
Lifeways	Suicide	0	1	0	6	2	0.0004
	Non-Suicide Death	10	22	12	8	50	0.0106
	EMT due to Injury/Medication Error	5	18	14	5	45	0.0096
	Hospitalization due to Injury/Medication Error	1	1	3	1	10	0.0021
Pers. Served(FY18):	Arrest	1	2	1	21	5	0.0011
4,710	**Total**	**17**	**44**	**30**	**27**	**112**	**0.0238**
Montcalm Care Network	Suicide	0	0	0	2	2	0.0011
	Non-Suicide Death	1	1	4	1	7	0.0038
	EMT due to Injury/Medication Error	3	5	0	5	13	0.0071
	Hospitalization due to Injury/Medication Error	0	0	0	1	1	0.0005
Pers. Served(FY18):	Arrest	0	1	1	0	2	0.0011
1,828	**Total**	**4**	**7**	**5**	**9**	**25**	**0.0137**

Board/Census	Incident Type	Quarter 1 Totals	Quarter 2 Totals	Quarter 3 Totals	Quarter 4 Totals	FY18 Total	FY Incidents Per Persons Served
Newaygo CMH	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	2	2	1	0	5	0.0033
	EMT due to Injury/Medication Error	3	3	1	0	7	0.0046
Pers. Served(FY18):	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
	Arrest	0	1	1	0	2	0.0013
1,538	**Total**	**5**	**6**	**3**	**0**	**14**	**0.0091**
Saginaw CMH	Suicide	1	0	0	1	2	0.0003
	Non-Suicide Death	13	14	9	13	49	0.0081
	EMT due to Injury/Medication Error	32	28	29	20	109	0.0179
Pers. Served(FY18):	Hospitalization due to Injury/Medication Error	2	2	1	2	7	0.0012
	Arrest	0	0	3	3	6	0.0010
6,083	**Total**	**48**	**44**	**42**	**39**	**173**	**0.0284**
Shiawasseee CMH	Suicide	1	0	0	0	1	0.0005
	Non-Suicide Death	3	4	2	2	11	0.0053
	EMT due to Injury/Medication Error	1	7	6	3	17	0.0082
Pers. Served(FY18):	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
	Arrest	0	0	1	0	1	0.0005
2,066	**Total**	**5**	**11**	**9**	**5**	**30**	**0.0145**
Tuscola BH Systems	Suicide	0	1	1	1	3	0.0027
	Non-Suicide Death	1	0	1	1	3	0.0027
	EMT due to Injury/Medication Error	5	7	2	4	18	0.0165
Pers. Served(FY18):	Hospitalization due to Injury/Medication Error	1	1	2	0	4	0.0037
	Arrest	0	0	0	0	0	0.0000
1,092	**Total**	**7**	**9**	**6**	**6**	**28**	**0.0256**
MSHN TOTALS	Suicide	6	3	5	7	21	0.0005
	Non-Suicide Death	68	82	63	49	262	0.0060
	EMT due to Injury/Medication Error	88	120	115	101	424	0.0097
Pers. Served(FY18):	Hospitalization due to Injury/Medication Error	6	4	10	14	34	0.0008
	Arrest	4	11	14	6	35	0.0008
43,693	**Total**	**172**	**220**	**207**	**177**	**776**	**0.0178**

Attachment 7

MSHN
Mid-State Health Network

PRIORITY MEASURE PERFORMANCE REPORT



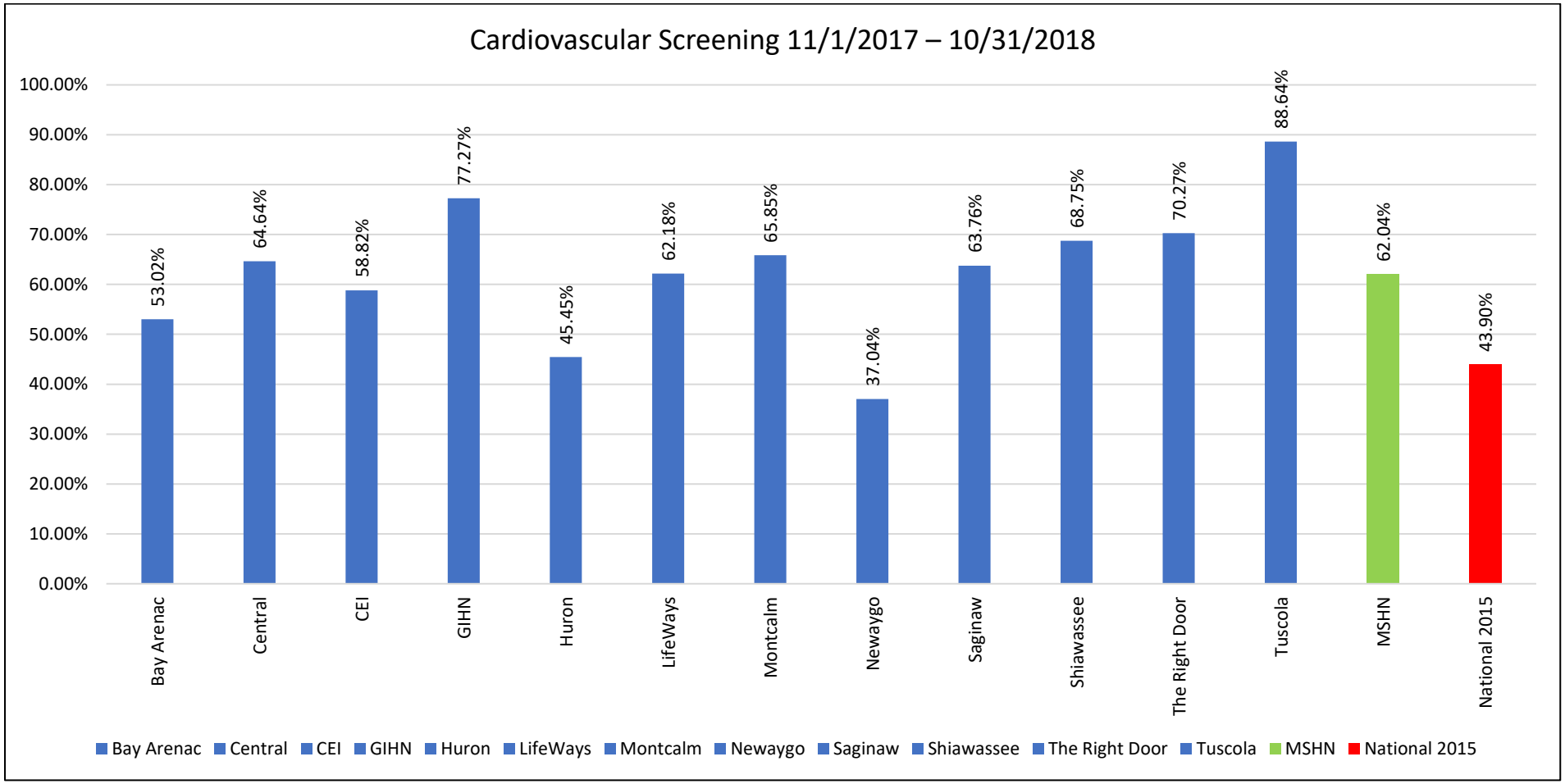
Cardiovascular Screening 11/1/2017 – 10/31/2018

Measure Description:
The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.

Numerator Statement:
Individuals who had one or more LDL-C screenings performed during the measurement year.

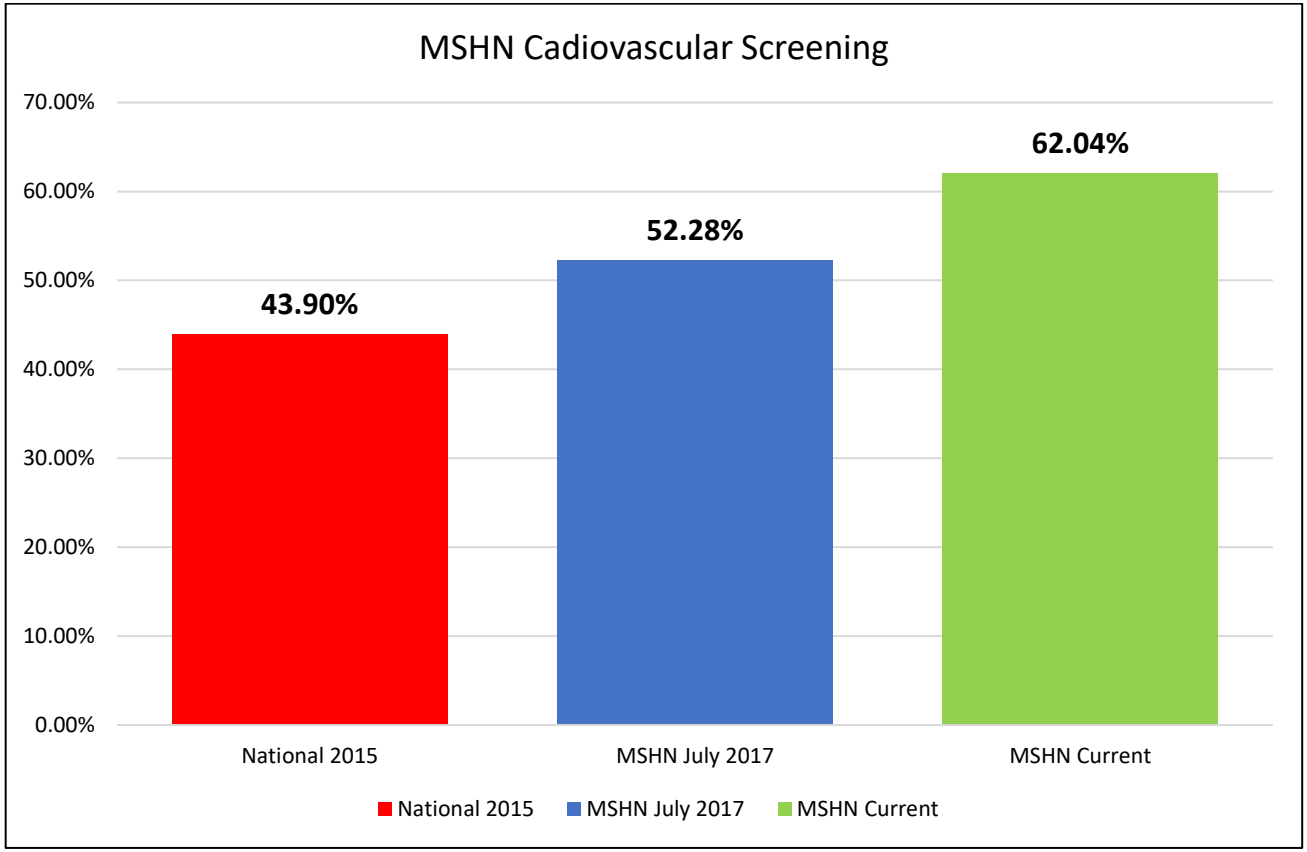
Denominator Statement:
Individuals ages 25 to 64 years of age by the end of the measurement year with a diagnosis of schizophrenia or bipolar disorder who were prescribed any antipsychotic medication during the measurement year.

Exclusions:
Individuals are excluded from the denominator if they were discharged alive for a coronary artery bypass graft (CABG) or percutaneous coronary intervention (PCI) (these events may occur in the measurement year or year prior to the measurement year),nor diagnosed with ischemic vascular disease (IVD)(this diagnosis must appear in both the measurement year and the year prior to the measurement year),chronic heart failure, nor had a prior myocardial infarction (identified in the measurement year nor as far back as possible).



Cardiovascular Screening 11/1/2017 – 10/31/2018

Agency/Health Plan	Performance
Bay Arenac	53.02%
Central	64.64%
CEI	58.82%
GIHN	77.27%
Huron	45.45%
LifeWays	62.18%
Montcalm	65.85%
Newaygo	37.04%
Saginaw	63.76%
Shiawassee	68.75%
The Right Door	70.27%
Tuscola	88.64%
MSHN	62.04%
Michigan 2016	N/A
National 2015	43.90%



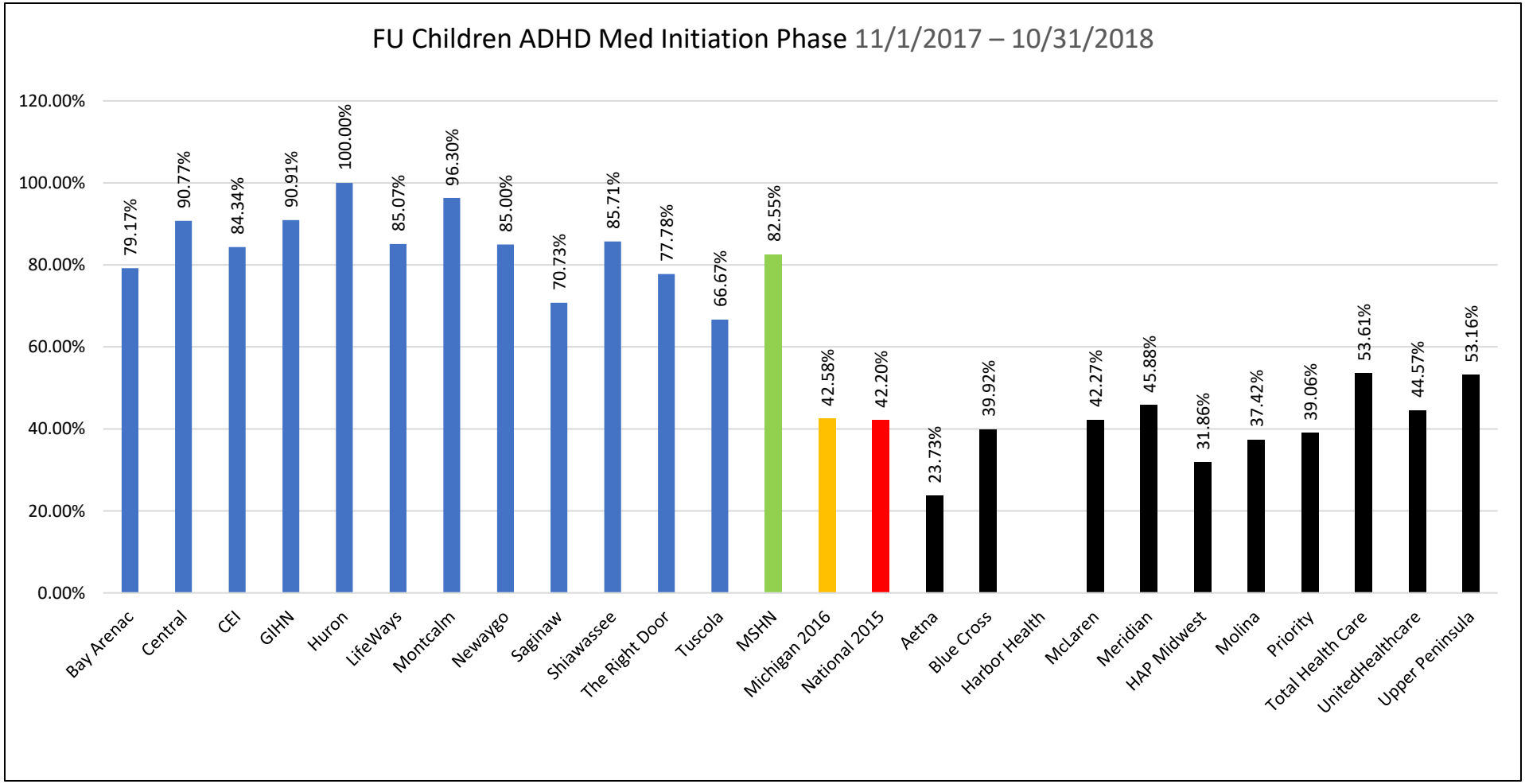
FU Children ADHD Med Initiation Phase **11/1/2017 – 10/31/2018**

Measure Description:
The percentage of children (6-12 years of age) newly prescribed ADHD medication who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

Denominator Statement:
All children in the 6-12 years of age range who were dispensed an ADHD medication during the 12-month Intake Period.
Members must be continuously enrolled for 120 days prior to the earliest prescription dispensing date through 30 days after the earliest prescription dispensing date.

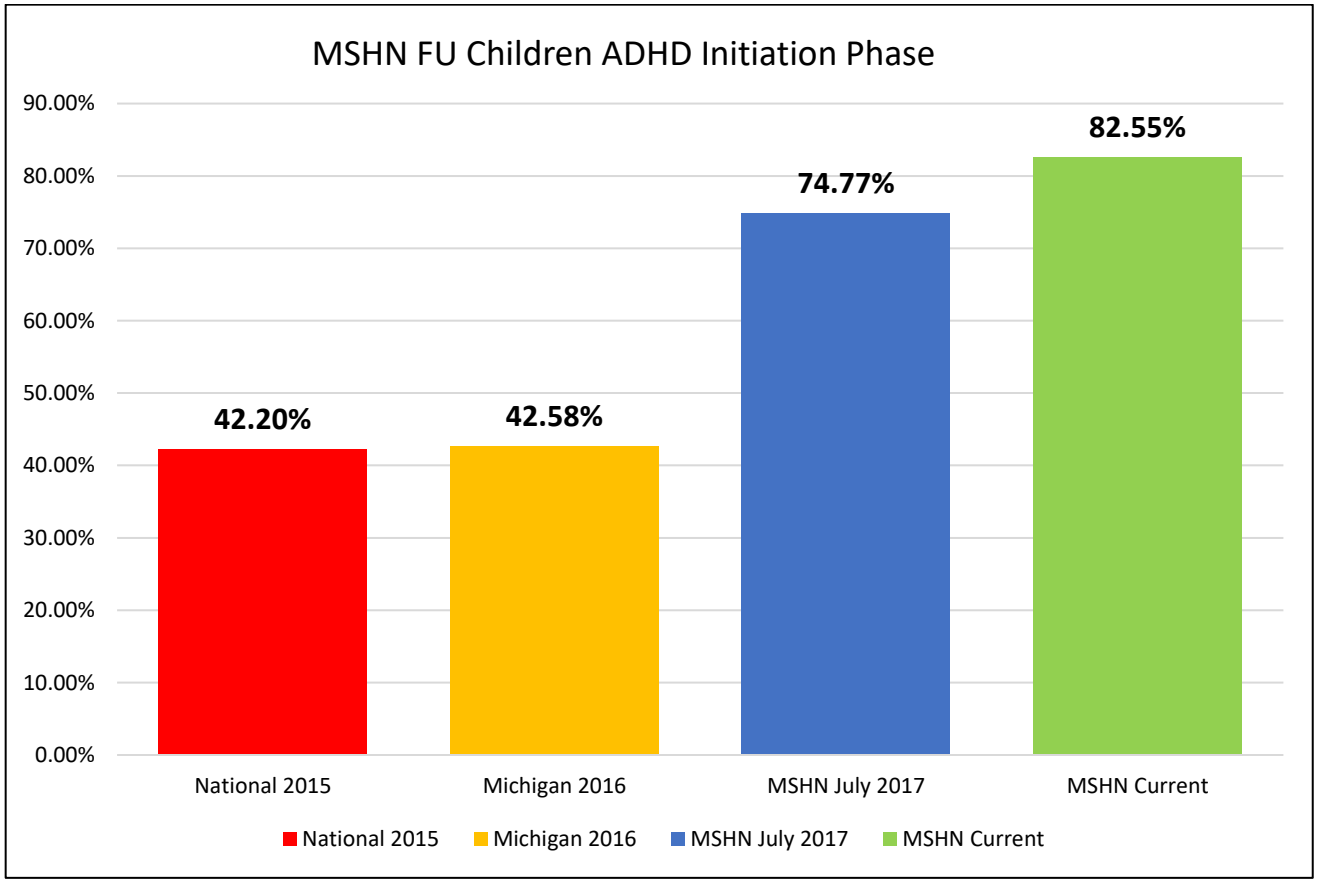
Numerator Statement:
An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the earliest prescription dispensing date.

Exclusions:
Members who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the earliest prescription dispensing date.



FU Children ADHD Med Initiation Phase 11/1/2017 – 10/31/2018

Agency/Health Plan	Performance
Bay Arenac	79.17%
Central	90.77%
CEI	84.34%
GIHN	90.91%
Huron	100.00%
LifeWays	85.07%
Montcalm	96.30%
Newaygo	85.00%
Saginaw	70.73%
Shiawassee	85.71%
The Right Door	77.78%
Tuscola	66.67%
MSHN	82.55%
Michigan 2016	42.58%
National 2015	42.20%
Aetna	23.73%
Blue Cross	39.92%
Harbor Health	N/A
McLaren	42.27%
Meridian	45.88%
HAP Midwest	31.86%
Molina	37.42%
Priority	39.06%
Total Health Care	53.61%
United Healthcare	44.57%
Upper Peninsula	53.16%



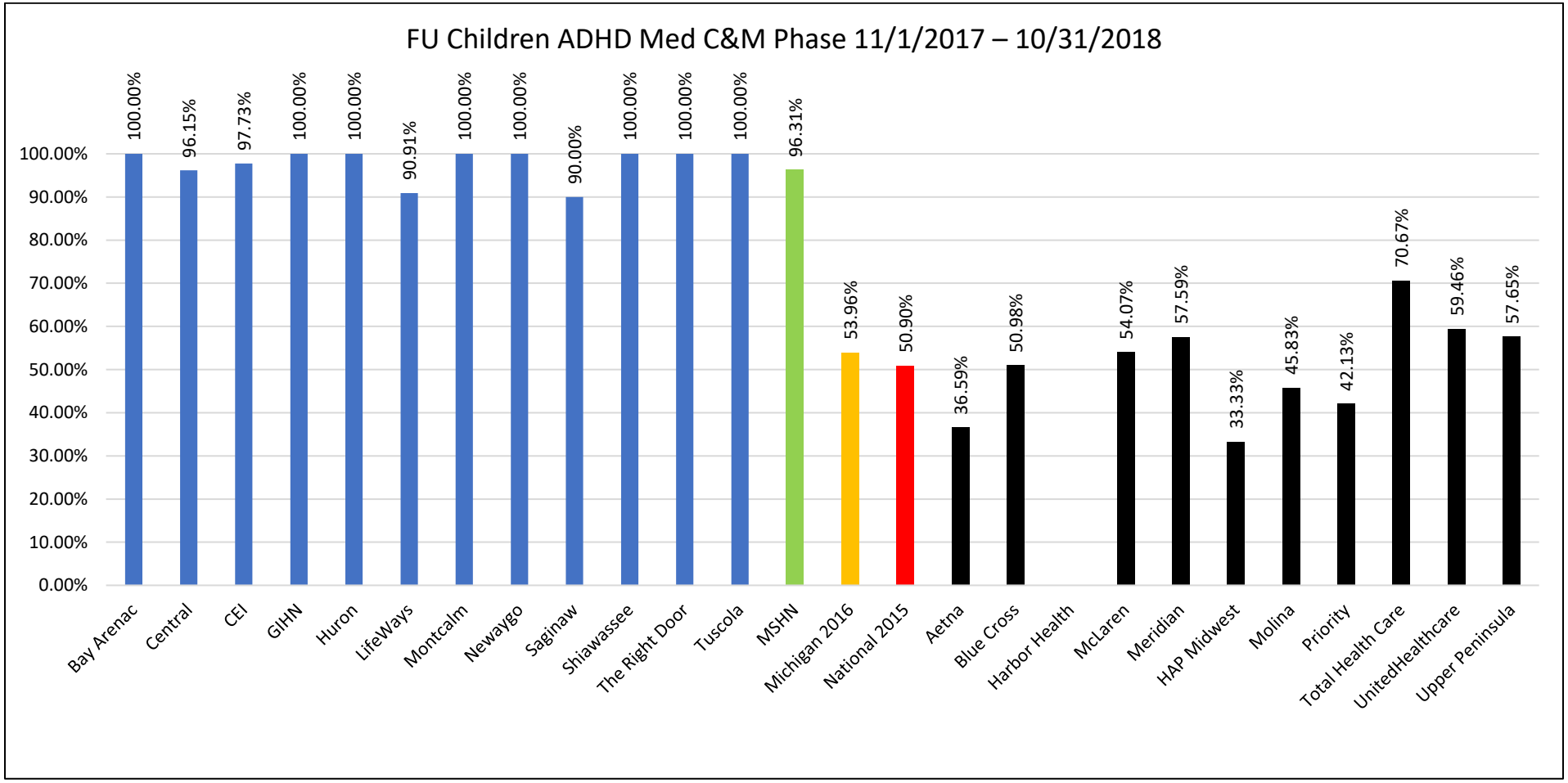
FU Children ADHD Med Continuation & Monitoring (C&M) Phase **11/1/2017 – 10/31/2018**

Measure Description:
The percentage of members 6–12 years of age 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 within 270 days (9 months) after the Initiation Phase ended.

Denominator Statement:
All eligible population of initiation phase.
Members must be continuously enrolled for 120 days prior to the earliest prescription dispensing date and 300 days after the earliest prescription dispensing date.
Member must fill prescriptions to provide continuous treatment for at least 210 days out of the 300-day period.

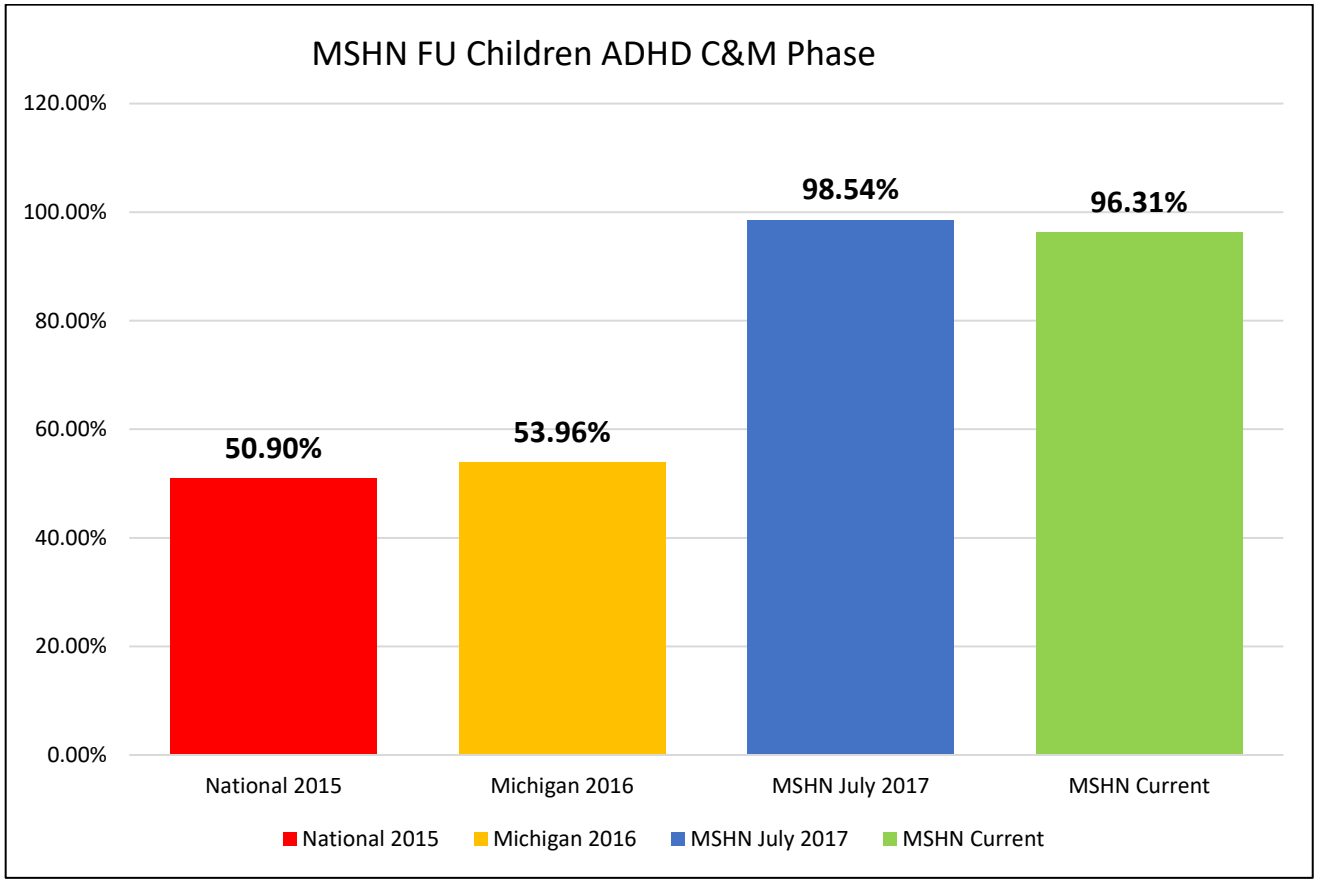
Numerator Statement:
Numerator Statement compliant for Initiation Phase, and at least two follow-up visits from 31–300 days (9 months)

Exclusions:
Members with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through end date of the measurement year.



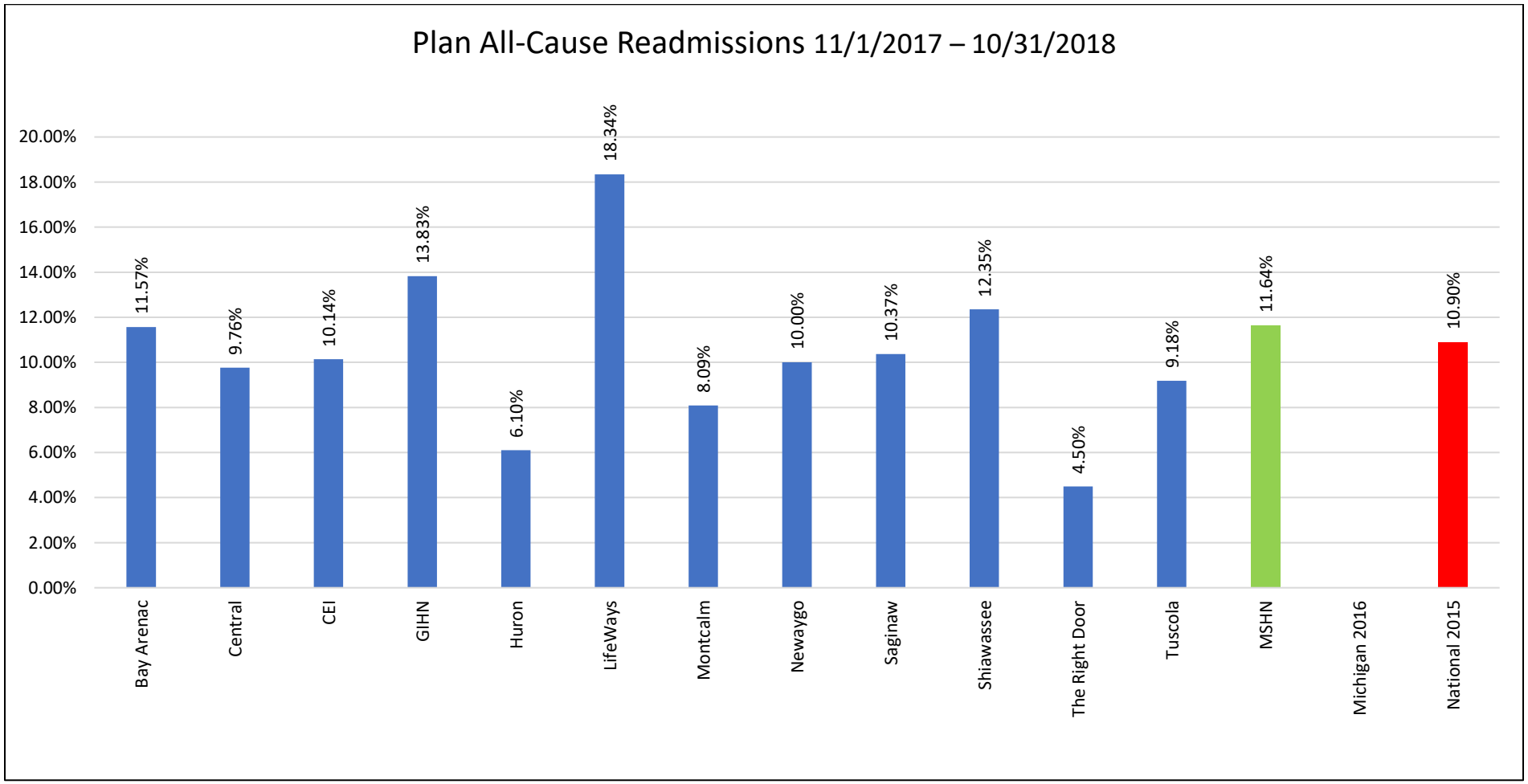
FU Children ADHD Med Continuation & Monitoring (C&M) Phase 11/1/2017 – 10/31/2018

Agency/Health Plan	Performance
Bay Arenac	100.00%
Central	96.15%
CEI	97.73%
GIHN	100.00%
Huron	100.00%
LifeWays	90.91%
Montcalm	100.00%
Newaygo	100.00%
Saginaw	90.00%
Shiawassee	100.00%
The Right Door	100.00%
Tuscola	100.00%
MSHN	96.31%
Michigan 2016	53.96%
National 2015	50.90%
Aetna	36.59%
Blue Cross	50.98%
Harbor Health	N/A
McLaren	54.07%
Meridian	57.59%
HAP Midwest	33.33%
Molina	45.83%
Priority	42.13%
Total Health Care	70.67%
United Healthcare	59.46%
Upper Peninsula	57.65%



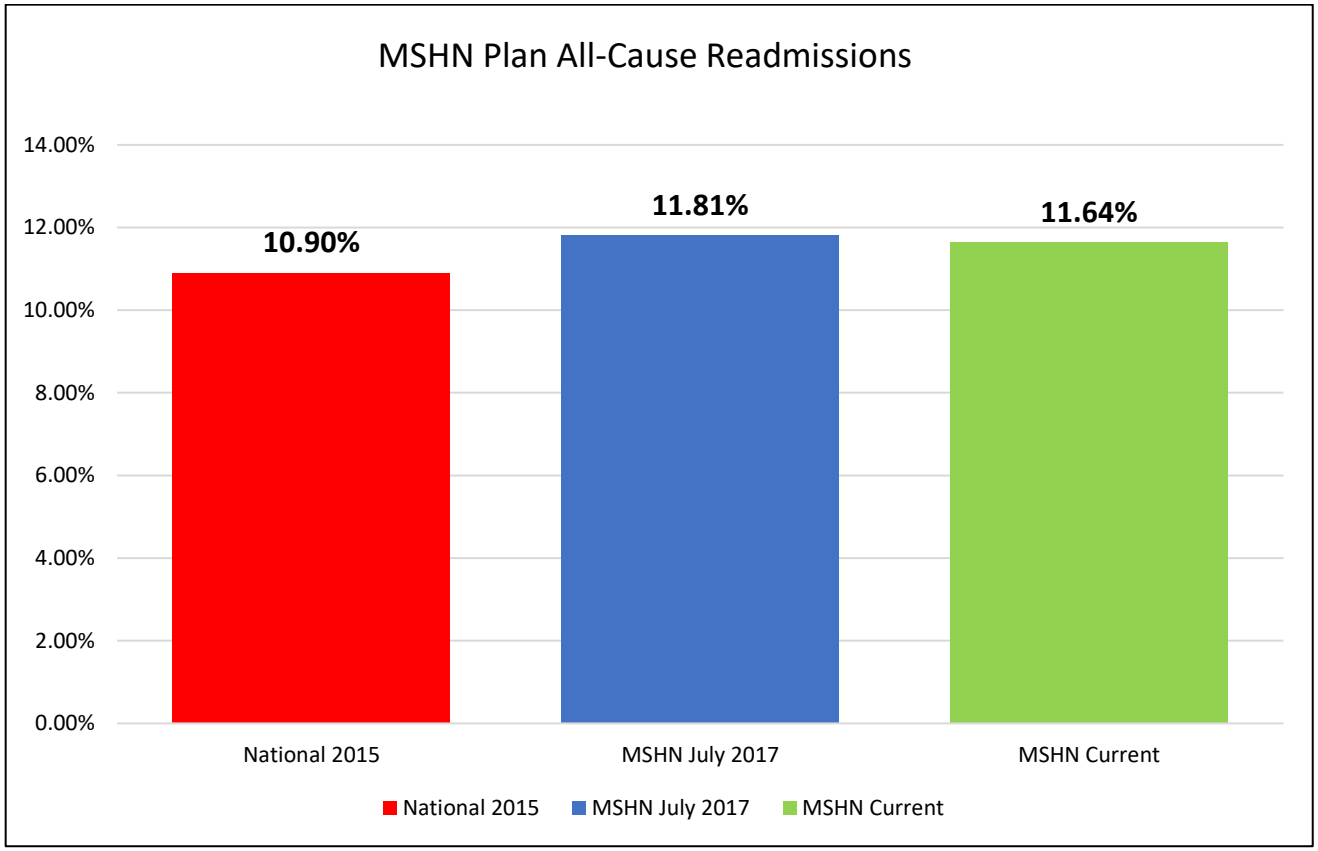
Plan All-Cause Readmissions 11/1/2017 – 10/31/2018

Measure Description:
For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.
Denominator Statement:
An acute inpatient discharge on or between start date and end date of the measurement year.
Member must be continuously enrolled.
Numerator Statement:
At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.
Exclusions:
Any acute inpatient hospital discharges with a principal diagnosis of pregnancy
Inpatient stays with discharges for death.



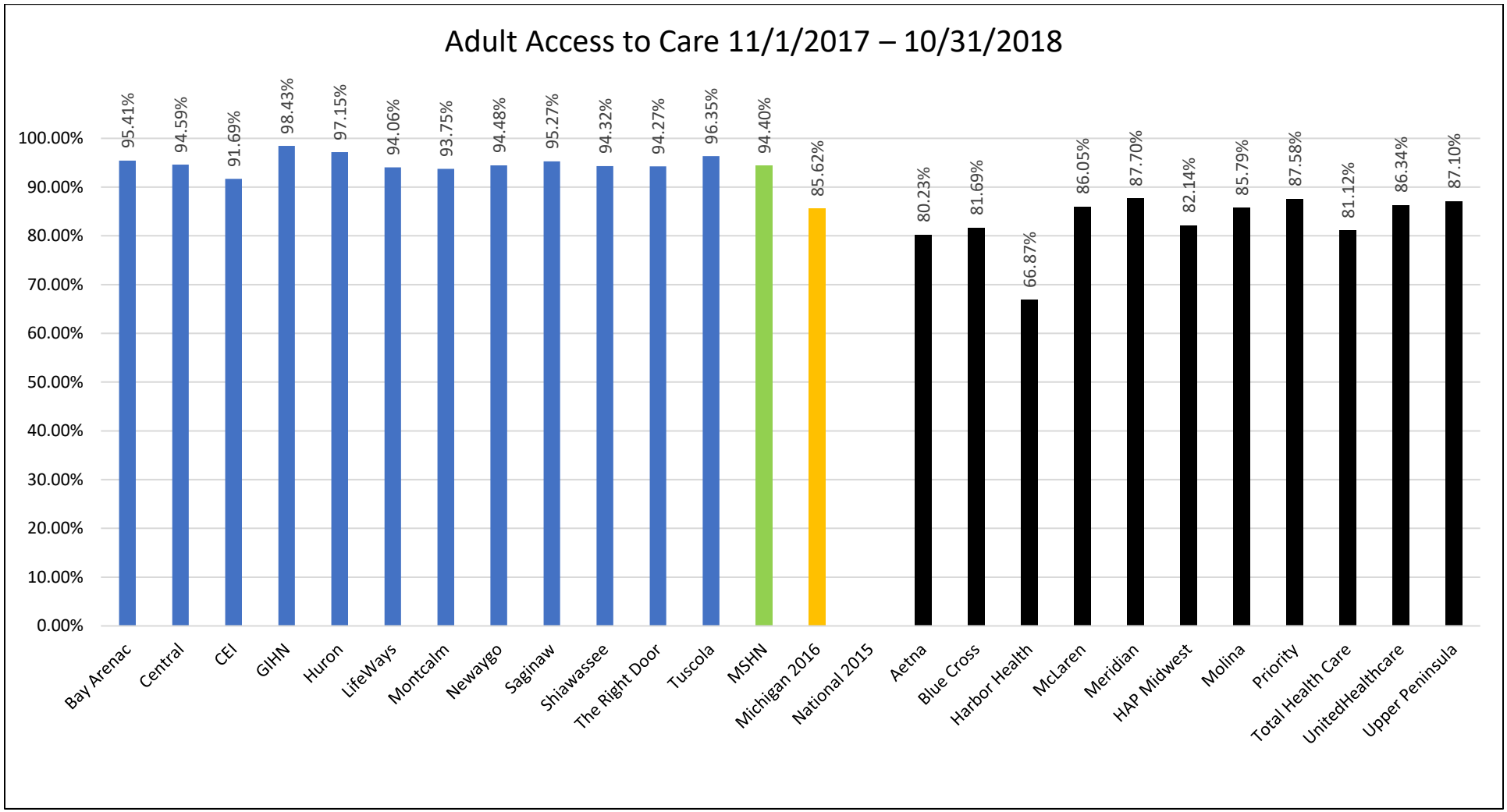
Plan All-Cause Readmissions 11/1/2017 – 10/31/2018

Agency/Health Plan	Performance
Bay Arenac	11.57%
Central	9.76%
CEI	10.14%
GIHN	13.83%
Huron	6.10%
LifeWays	18.34%
Montcalm	8.09%
Newaygo	10.00%
Saginaw	10.37%
Shiawassee	12.35%
The Right Door	4.50%
Tuscola	9.18%
MSHN	11.64%
Michigan 2016	N/A
National 2015	10.90%



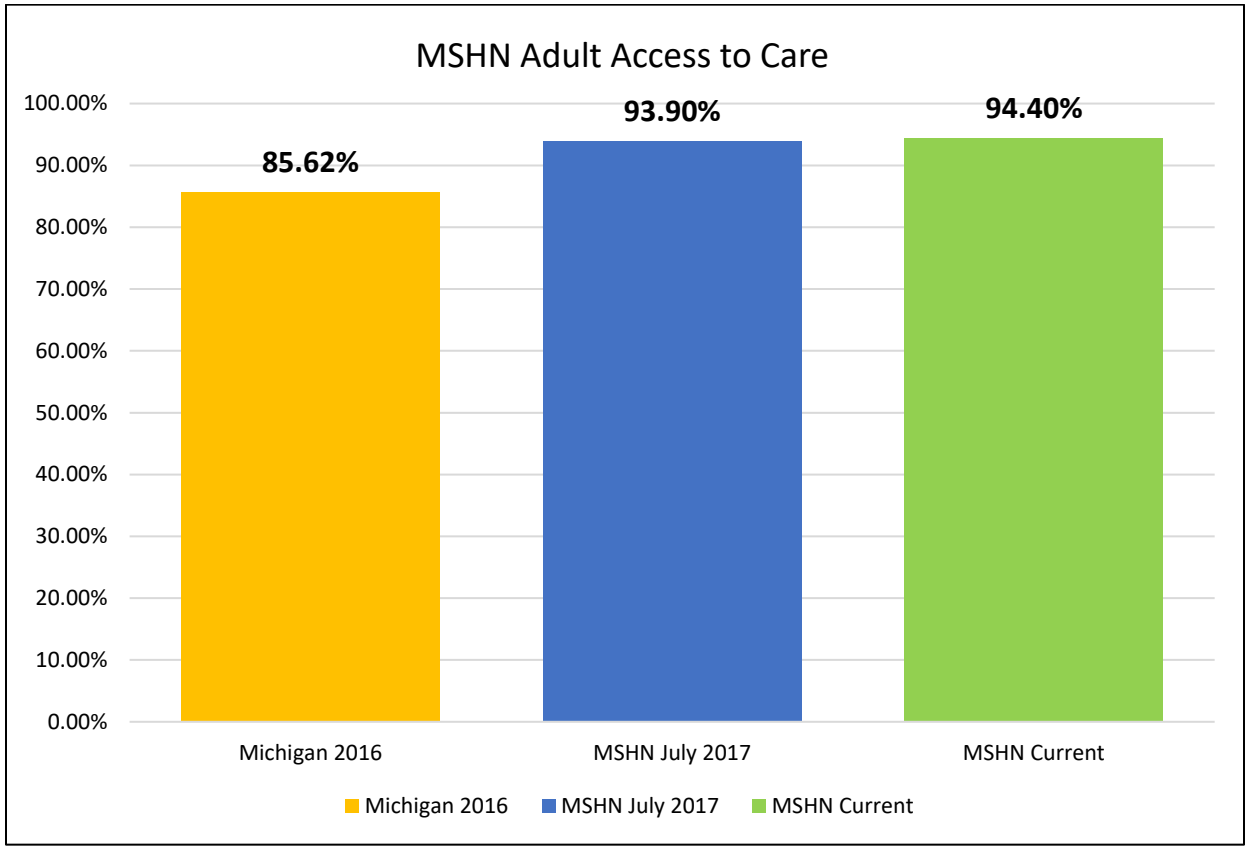
Adult Access to Care 11/1/2017 – 10/31/2018

Measure Description:
The percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.
a) Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year.
b) Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.
Numerator Statement:
One or more ambulatory or preventive care visits during the measurement year or the two years prior to the measurement year.
Denominator Statement:
Any consumer 20 years of age or older as of the end of the measurement year (e.g., December 31) who have at most one month gap in coverage during each year of continuous enrollment.



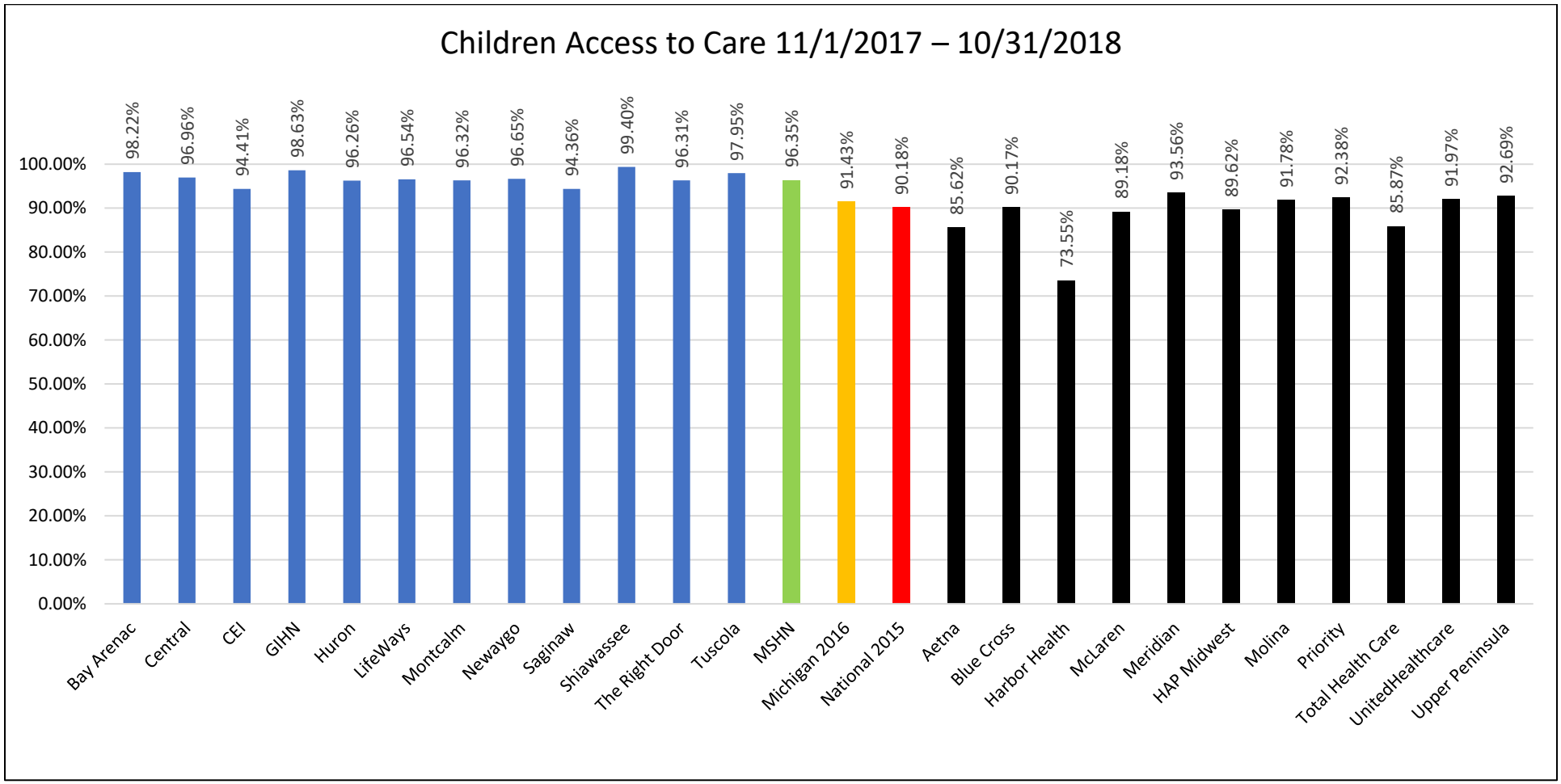
Adult Access to Care 11/1/2017 – 10/31/2018

Agency/Health Plan	Performance
Bay Arenac	95.41%
Central	94.59%
CEI	91.69%
GIHN	98.43%
Huron	97.15%
LifeWays	94.06%
Montcalm	93.75%
Newaygo	94.48%
Saginaw	95.27%
Shiawassee	94.32%
The Right Door	94.27%
Tuscola	96.35%
MSHN	94.40%
Michigan 2016	85.62%
National 2015	N/A
Aetna	80.23%
Blue Cross	81.69%
Harbor Health	66.87%
McLaren	86.05%
Meridian	87.70%
HAP Midwest	82.14%
Molina	85.79%
Priority	87.58%
Total Health Care	81.12%
United Healthcare	86.34%
Upper Peninsula	87.10%



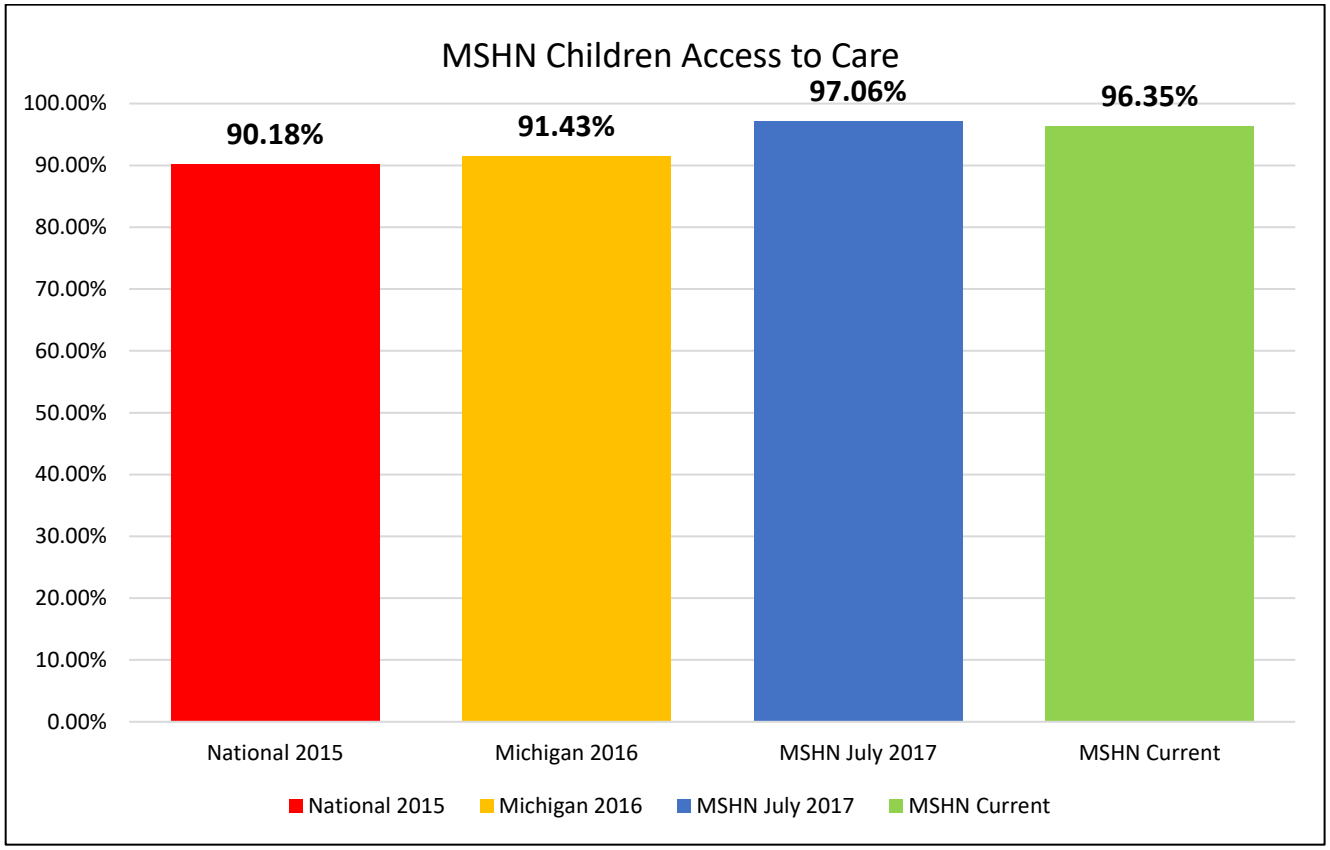
Children Access to Care 11/1/2017 – 10/31/2018

Measure Description:
The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.
a) Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.
b) Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.
Numerator Statement:
For 12–24 months, 25 months–6 years: One or more visits with a PCP during the measurement year.
For 7–11 years, 12–19 years: One or more visits with a PCP during the measurement year or the year prior to the measurement year.
Denominator Statement:
Any consumer 12 months to 19 years of age as of the end of the measurement year (e.g., December 31) who have:
a) At most one month gap in coverage during the measurement year for ages 12 months to 6 years.
b) At most one month gap during the reporting year and the previous year for ages 7 years to 19 years.



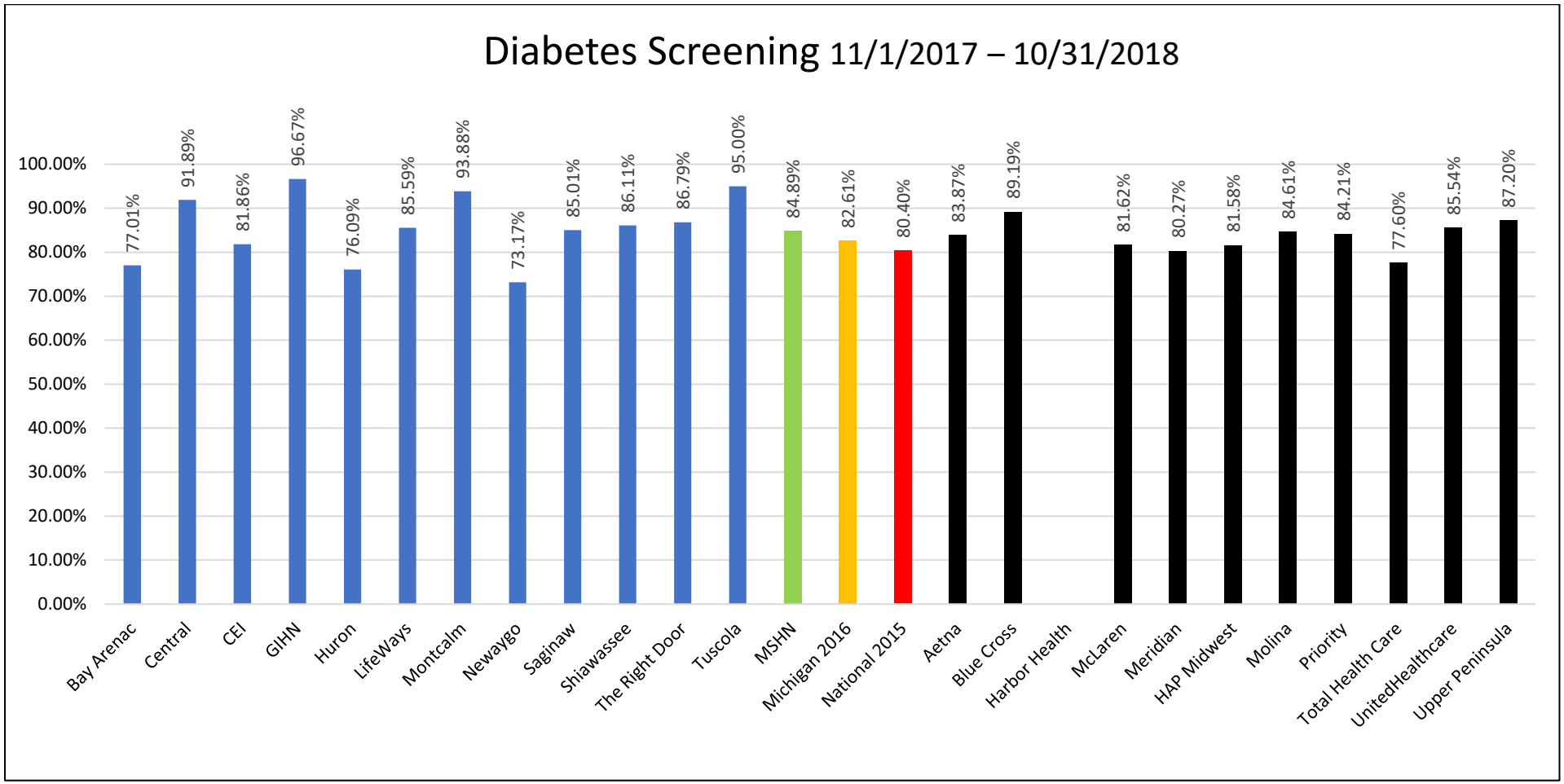
Children Access to Care 11/1/2017 – 10/31/2018

Agency/Health Plan	Performance
Bay Arenac	98.22%
Central	96.96%
CEI	94.41%
GIHN	98.63%
Huron	96.26%
LifeWays	96.54%
Montcalm	96.32%
Newaygo	96.65%
Saginaw	94.36%
Shiawassee	99.40%
The Right Door	96.31%
Tuscola	97.95%
MSHN	96.35%
Michigan 2016	91.43%
National 2015	90.18%
Aetna	85.62%
Blue Cross	90.17%
Harbor Health	73.55%
McLaren	89.18%
Meridian	93.56%
HAP Midwest	89.62%
Molina	91.78%
Priority	92.38%
Total Health Care	85.87%
United Healthcare	91.97%
Upper Peninsula	92.69%



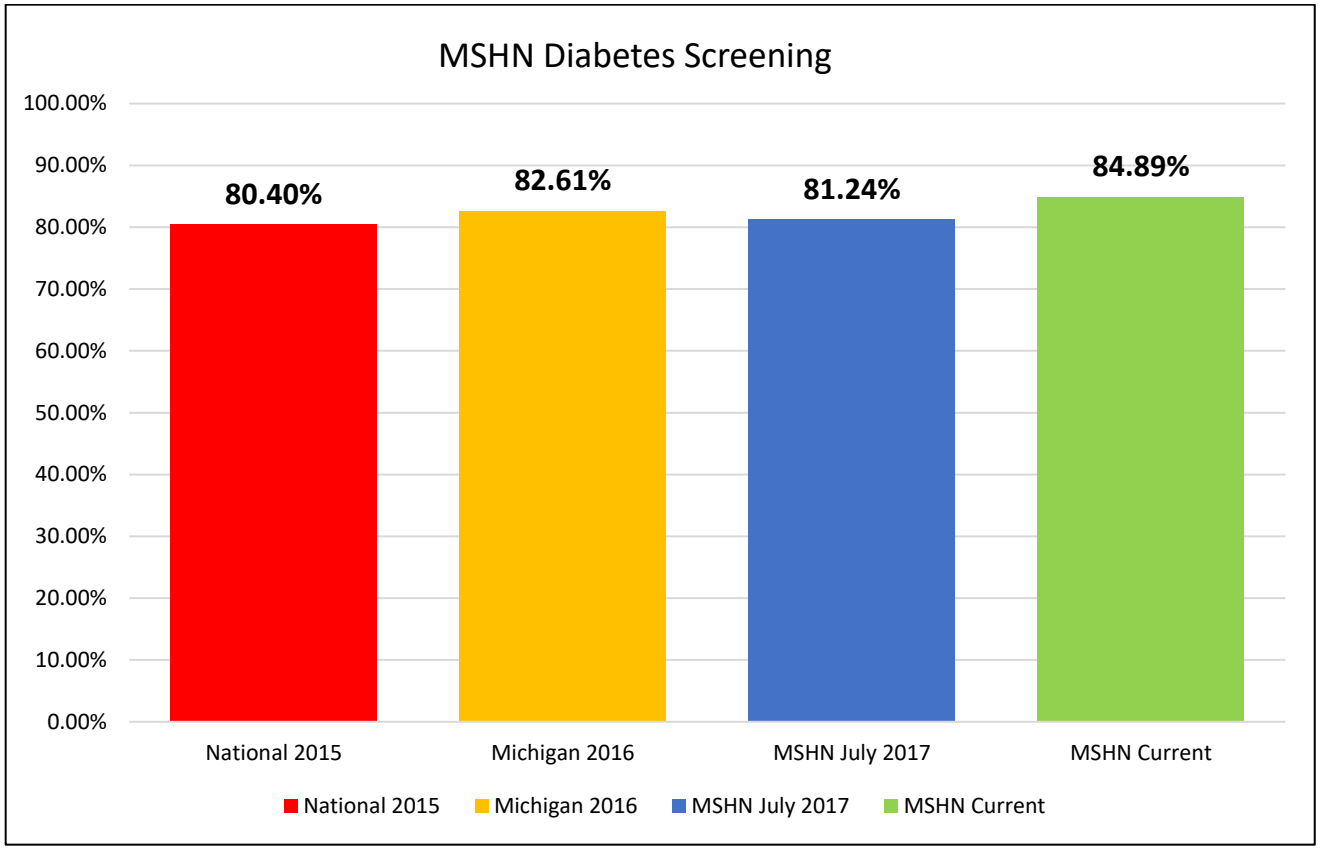
Diabetes Screening 11/1/2017 – 10/31/2018

Measure Description:
The percentage of patients 18 – 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.
Numerator Statement:
One or more glucose or HbA1c tests performed during the measurement year.
Denominator Statement:
Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.
Exclusions:
Exclude patients with diabetes during the measurement year or the year prior to the measurement year.
Exclude patients who had no antipsychotic medications dispensed during the measurement year.



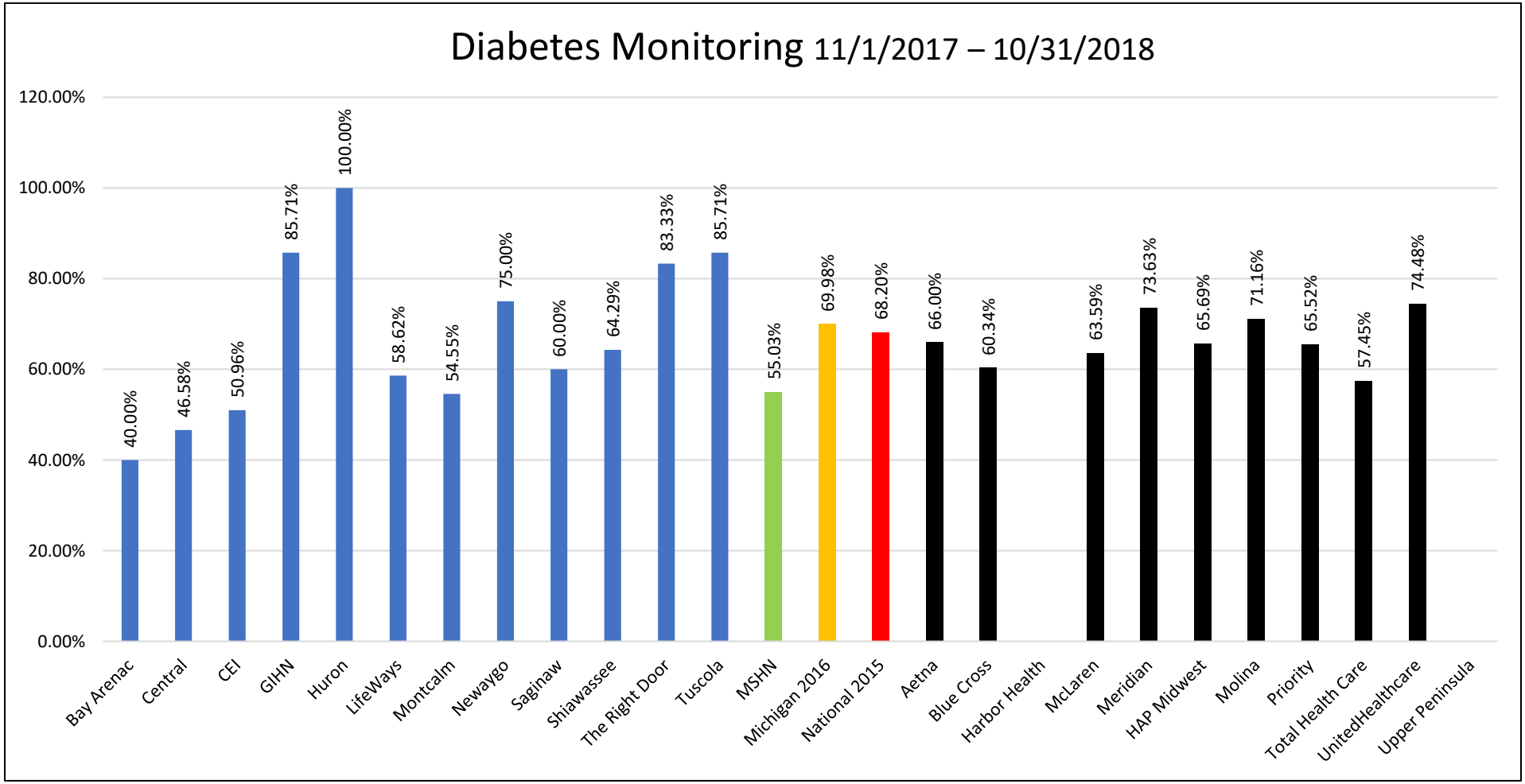
Diabetes Screening 11/1/2017 – 10/31/2018

Agency/Health Plan	Performance
Bay Arenac	77.01%
Central	91.89%
CEI	81.86%
GIHN	96.67%
Huron	76.09%
LifeWays	85.59%
Montcalm	93.88%
Newaygo	73.17%
Saginaw	85.01%
Shiawassee	86.11%
The Right Door	86.79%
Tuscola	95.00%
MSHN	84.89%
Michigan 2016	82.61%
National 2015	80.40%
Aetna	83.87%
Blue Cross	89.19%
Harbor Health	N/A
McLaren	81.62%
Meridian	80.27%
HAP Midwest	81.58%
Molina	84.61%
Priority	84.21%
Total Health Care	77.60%
United Healthcare	85.54%
Upper Peninsula	87.20%



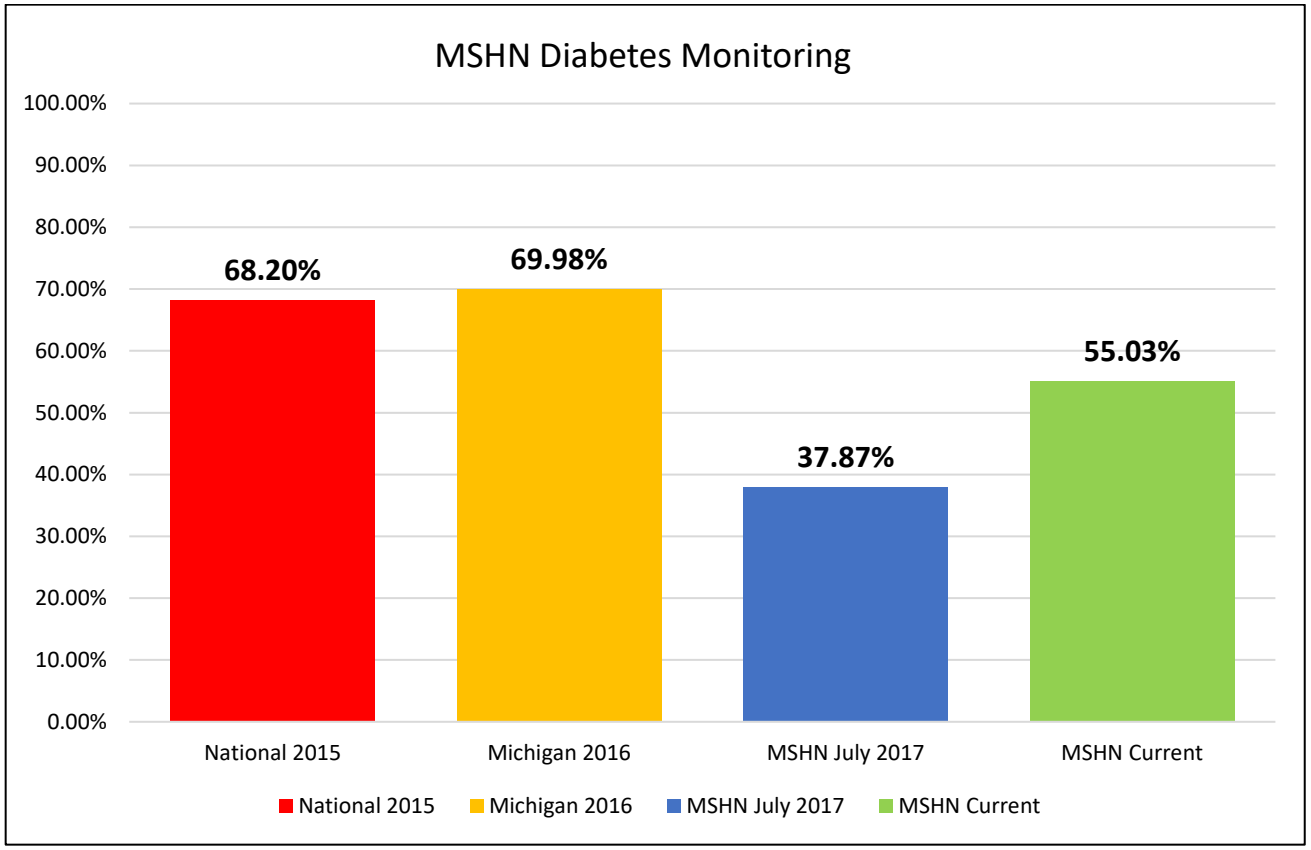
Diabetes Monitoring 11/1/2017 – 10/31/2018

Measure Description:
This measure is used to assess the percentage of members 18 to 64 years of age with schizophrenia and diabetes who had both a low-density lipoprotein cholesterol (LDL-C) test and a hemoglobin A1c (HbA1c) test during the measurement year.
Numerator Statement:
A hemoglobin A1c (HbA1c) test and a low-density lipoprotein cholesterol (LDL-C) test performed during the measurement year.
Denominator Statement:
Medicaid members 18 to 64 years during the measurement year with schizophrenia and diabetes.
Exclusions:
Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.



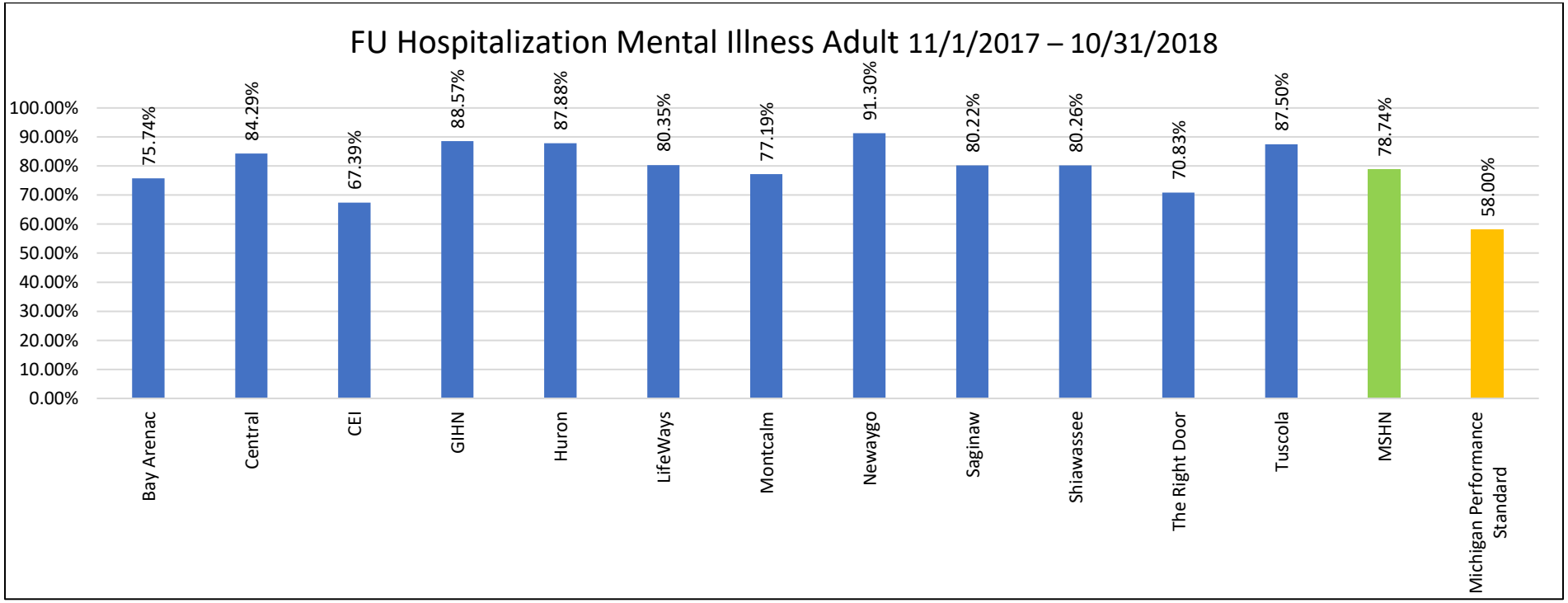
Diabetes Monitoring 11/1/2017 – 10/31/2018

Agency/Health Plan	Performance
Bay Arenac	40.00%
Central	46.58%
CEI	50.96%
GIHN	85.71%
Huron	100.00%
LifeWays	58.62%
Montcalm	54.55%
Newaygo	75.00%
Saginaw	60.00%
Shiawassee	64.29%
The Right Door	83.33%
Tuscola	85.71%
MSHN	55.03%
Michigan 2016	69.98%
National 2015	68.20%
Aetna	66.00%
Blue Cross	60.34%
Harbor Health	N/A
McLaren	63.59%
Meridian	73.63%
HAP Midwest	65.69%
Molina	71.16%
Priority	65.52%
Total Health Care	57.45%
United Healthcare	74.48%
Upper Peninsula	N/A



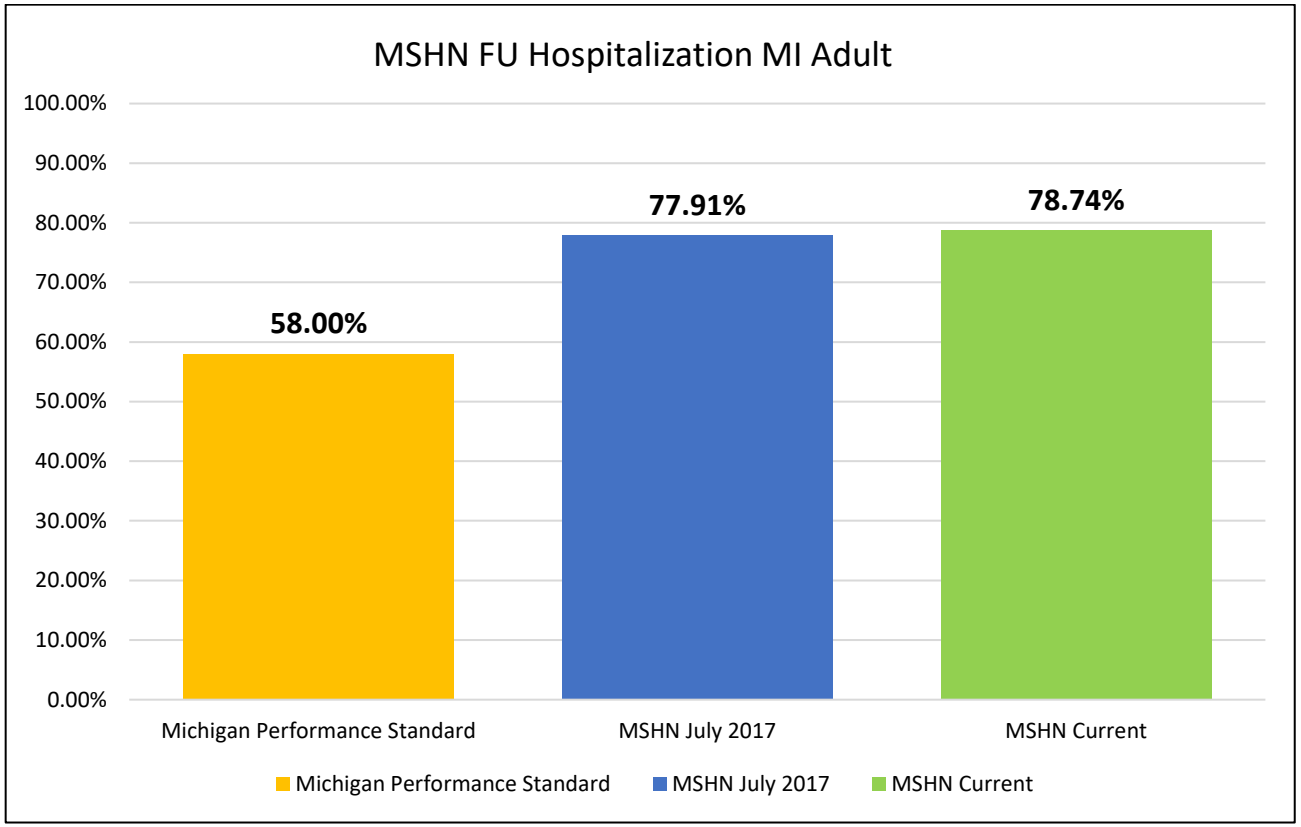
Follow-Up After Hospitalization Mental Illness Adult 11/1/2017 – 10/31/2018

Measure Description:
The percentage of discharges for members with 21 years or 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 a mental health practitioner.
Rates Reported:
The percentage of discharges for which the member received follow-up within 30 days of discharge.
Numerator Statement:
An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.
Denominator Statement:
Members with 21 years or 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 a mental health practitioner.
Exclusions:
Exclusions Exclude discharges followed by readmission or direct transfer to a non-acute facility within the 30-day follow-up period, regardless of principal diagnosis for the readmission. Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set).
These discharges are excluded from the measure because re-hospitalization or transfer may prevent an outpatient follow-up visit from taking place.



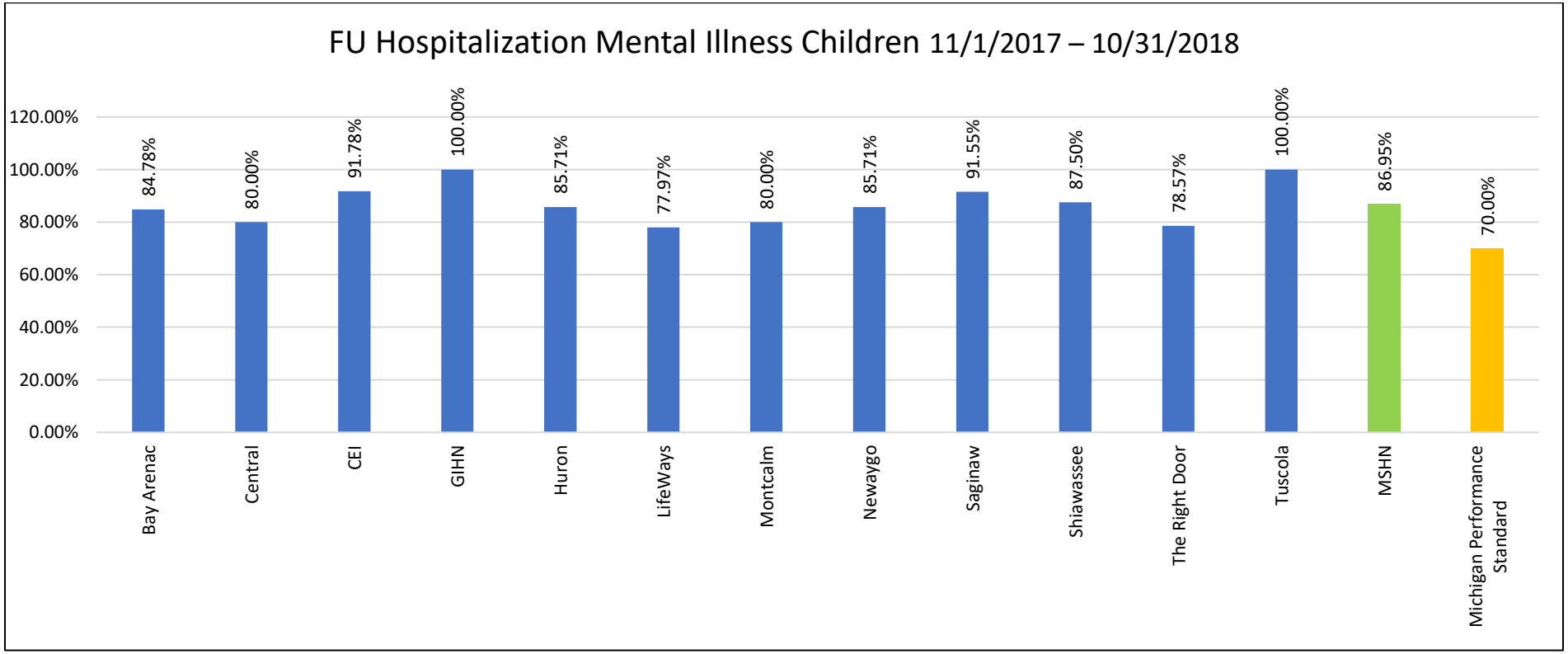
Follow-Up After Hospitalization Mental Illness Adult 11/1/2017 – 10/31/2018

Agency/Health Plan	Performance
Bay Arenac	75.74%
Central	84.29%
CEI	67.39%
GIHN	88.57%
Huron	87.88%
LifeWays	80.35%
Montcalm	77.19%
Newaygo	91.30%
Saginaw	80.22%
Shiawassee	80.26%
The Right Door	70.83%
Tuscola	87.50%
MSHN	78.74%
Michigan Performance Standard	58.00%



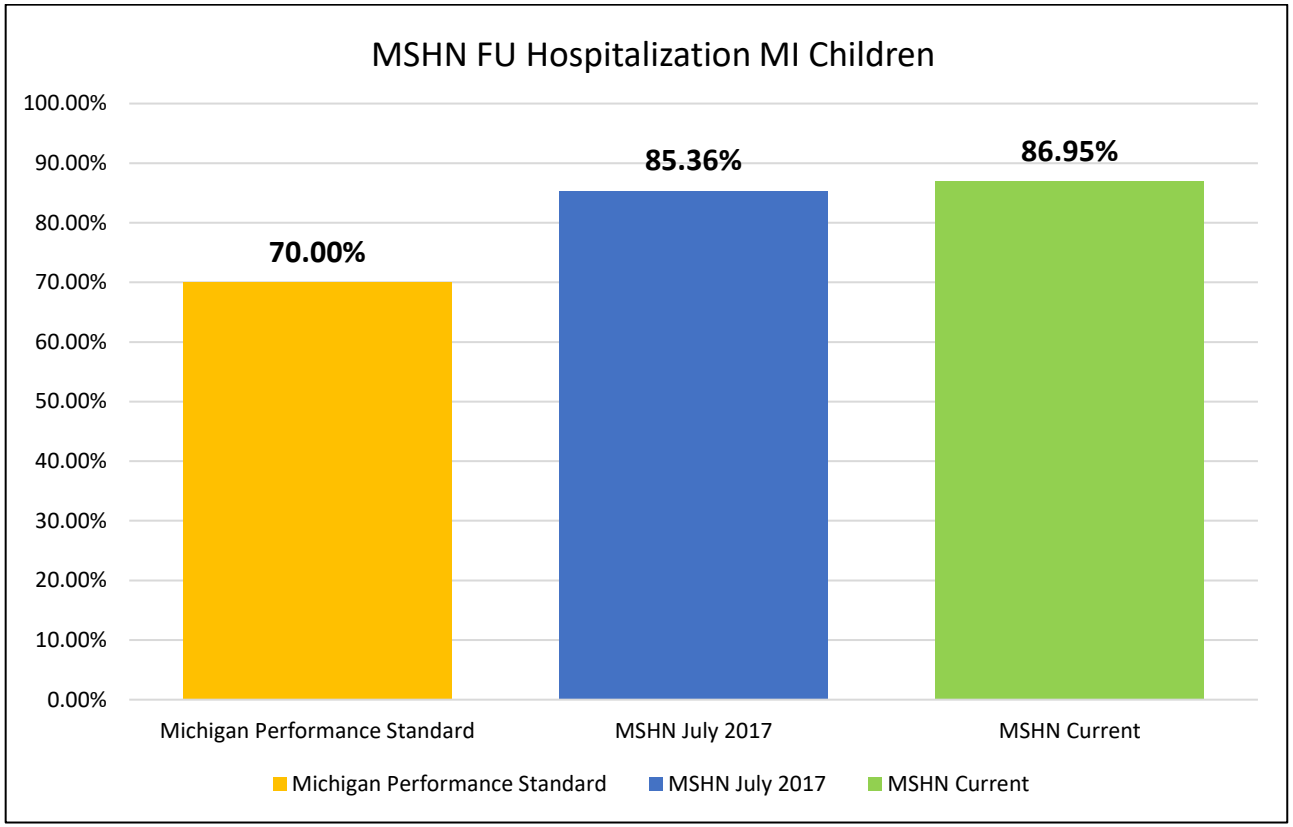
Follow-Up After Hospitalization Mental Illness Children 11/1/2017 – 10/31/2018

Measure Description:
The percentage of discharges for members with 6 years - 20 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 a mental health practitioner.
Rates Reported:
The percentage of discharges for which the member received follow-up within 30 days of discharge.
Numerator Statement:
An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.
Denominator Statement:
Members with 6 years - 20 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 a mental health practitioner.
Exclusions:
Exclusions Exclude discharges followed by readmission or direct transfer to a non-acute facility within the 30-day follow-up period, regardless of principal diagnosis for the readmission. Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set).
These discharges are excluded from the measure because re-hospitalization or transfer may prevent an outpatient follow-up visit from taking place.



Follow-Up After Hospitalization Mental Illness Children 11/1/2017 – 10/31/2018

Agency/Health Plan	Performance
Bay Arenac	84.78%
Central	80.00%
CEI	91.78%
GIHN	100.00%
Huron	85.71%
LifeWays	77.97%
Montcalm	80.00%
Newaygo	85.71%
Saginaw	91.55%
Shiawassee	87.50%
The Right Door	78.57%
Tuscola	100.00%
MSHN	86.95%
Michigan Performance Standard	70.00%



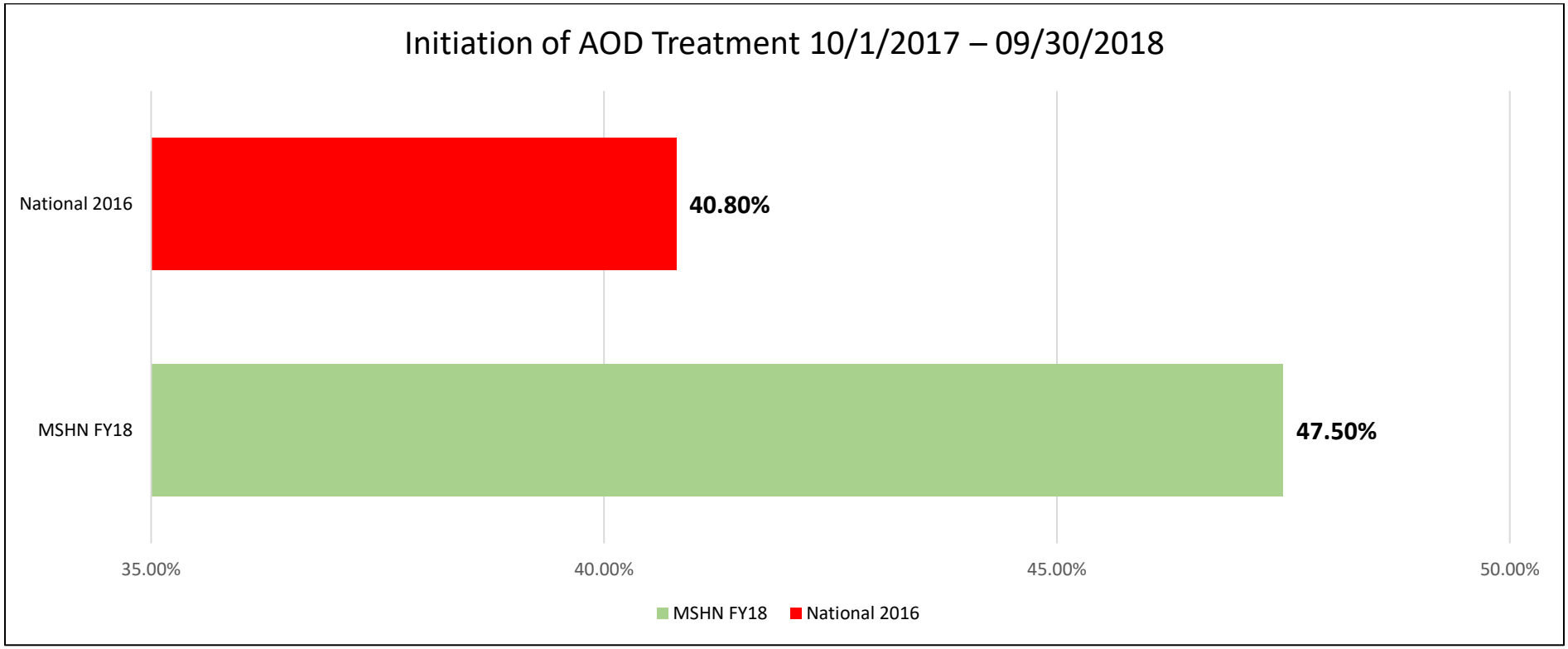
Initiation of Alcohol and Other Drug (AOD) Treatment 10/1/2017 – 09/30/2018

Measure Description:
The percentage of adolescent and adult patients (13+ years of age) with a new episode of alcohol or other drug (AOD) dependence who received the following.
Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Numerator Statement:
Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the index episode start date.

Denominator Statement:
Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement period.

Exclusions:
Exclude patients who had a claim/encounter with a diagnosis of AOD during the 60 days (2 months) before the Index Episode Start Date. Exclude patients whose initiation of treatment event is an inpatient stay with a discharge date after December 1 of the measurement year.



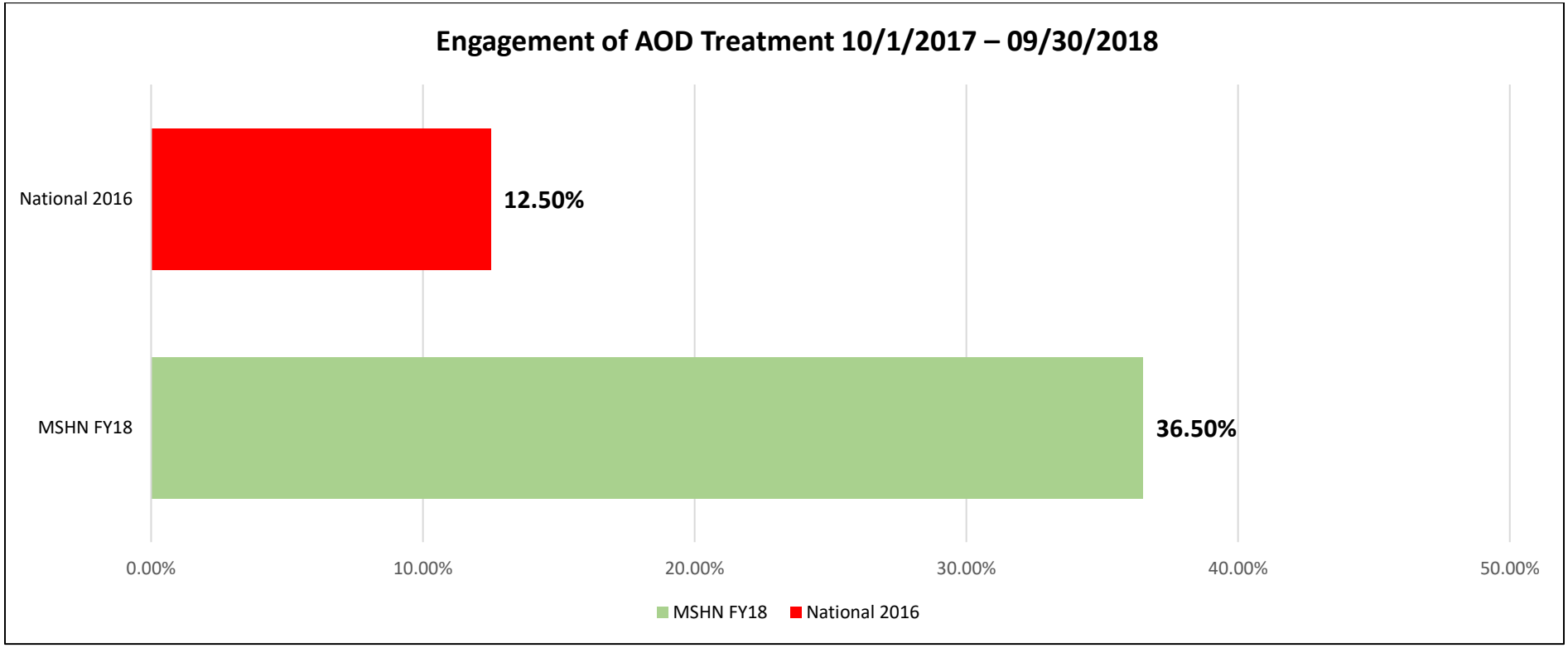
Engagement of Alcohol and Other Drug (AOD) Treatment 10/1/2017 – 09/30/2018

Measure Description:
The percentage of adolescent and adult patients (13+ years of age) with a new episode of alcohol or other drug (AOD) dependence who received the following.
Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Numerator Statement:
Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).

Denominator Statement:
Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement period.

Exclusions:
Exclude patients who had a claim/encounter with a diagnosis of AOD during the 60 days (2 months) before the Index Episode Start Date. Exclude patients whose initiation of treatment event is an inpatient stay with a discharge date after December 1 of the measurement year.



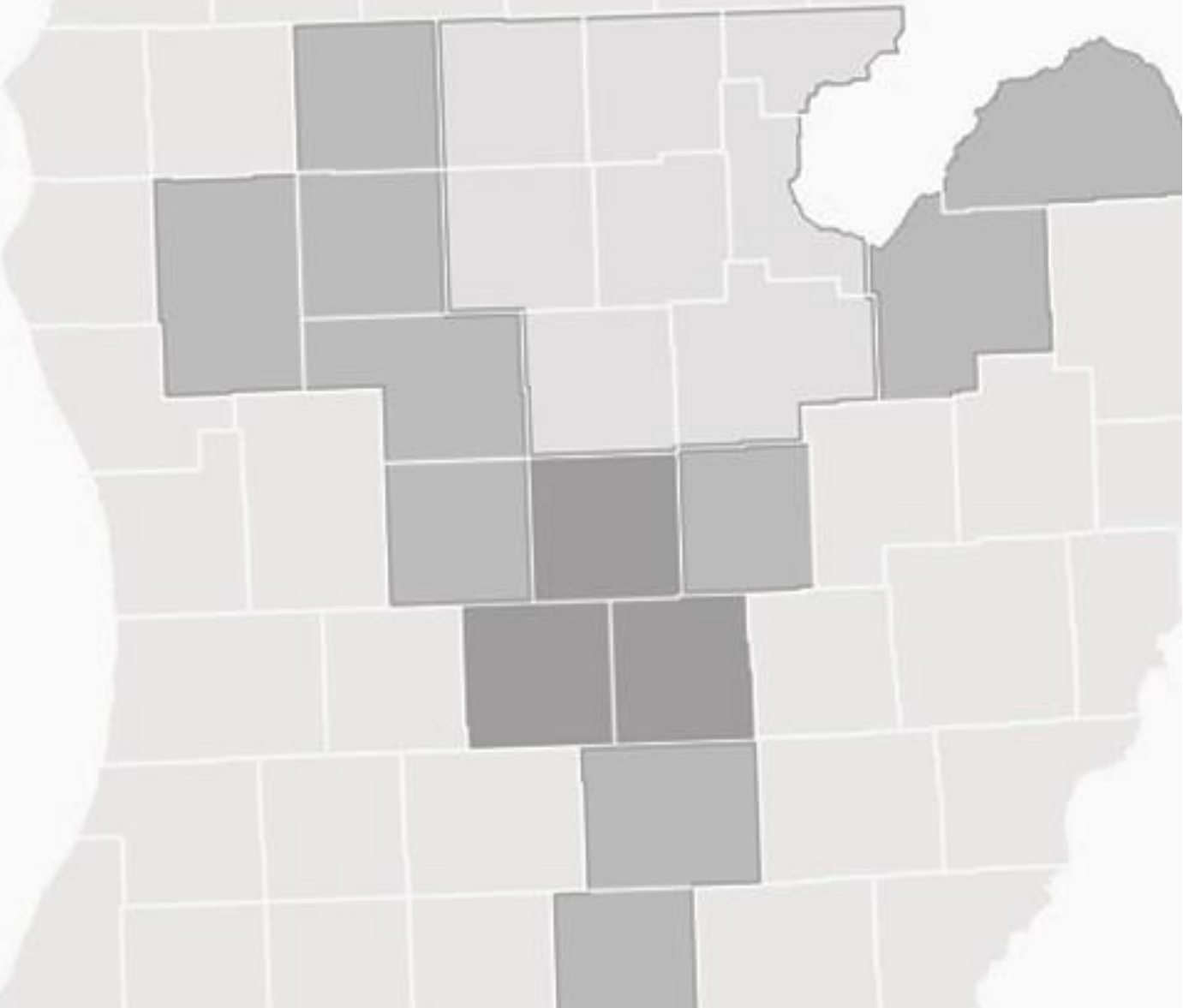
MSHN

Mid-State Health Network

Updated: December 12, 2018

Questions about this report should be sent to:

Joseph.wager@midstatehealthnetwork.org



Attachment 8

Quality Assessment and
Performance Improvement Program

Summary Report

Title of Measure: Behavior Review Data

Committee/Department: Quality Improvement Council

Reporting Period (month/year): FY2018 Q4

Data Analysis: (threats to validity; statistical testing; reliability of results; statistical significance; need for modification of data collection strategies)

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 Behavioral Technical Requirements 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 Quality Committee (Quality Assessment and Improvement Program). MSHN monitors that the local CMHSP BTRC follows the requirements outlined within the Technical Requirement for Behavior Treatment Review Committees. MSHN will analyze the data on a quarterly basis to address any trends and/or opportunities for quality improvements. Data shall include numbers of interventions and length of time the interventions were used per person.

Data Interpretation: (performance against targets and benchmark data)

Study Question 1: Has the proportion of individuals who have a **Behavior Treatment Plan** with ~~received~~ a restrictive/intrusive intervention decreased over time?

Numerator: The total number of individuals that have an approved behavior treatment plan that include a restrictive and/or intrusive intervention.

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

Currently, MSHN is taking steps to standardize this process by:

- Discussing the process at Regional BTRC meetings.
- Identifying and defining standard restrictive and intrusive techniques used consistently throughout MSHN. Most commonly used interventions have been defined for regional use.

FY18Q1
Out of the 12 CMHSP's, 256 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 0.89% (256/28729) consumers served in the region for FY18Q1 as of December 31, 2017 who have an approved plan for behavior treatment with a restrictive or intrusive intervention.

FY18Q2
Out of the 12 CMHSP's, 265 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 0.89% (265/29834) consumers served in the region for FY18Q2 as of March 31, 2018 who have an approved plan for behavior treatment with a restrictive or intrusive intervention.

FY18Q3
Out of the 12 CMHSP's, 305 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 1.01% (305/30234) consumers served in the region for FY18Q3 as of July 30, 2018 who have an approved plan for behavior treatment with a restrictive or intrusive intervention. The variance relates to four main categories which will be addressed in the recommendations.

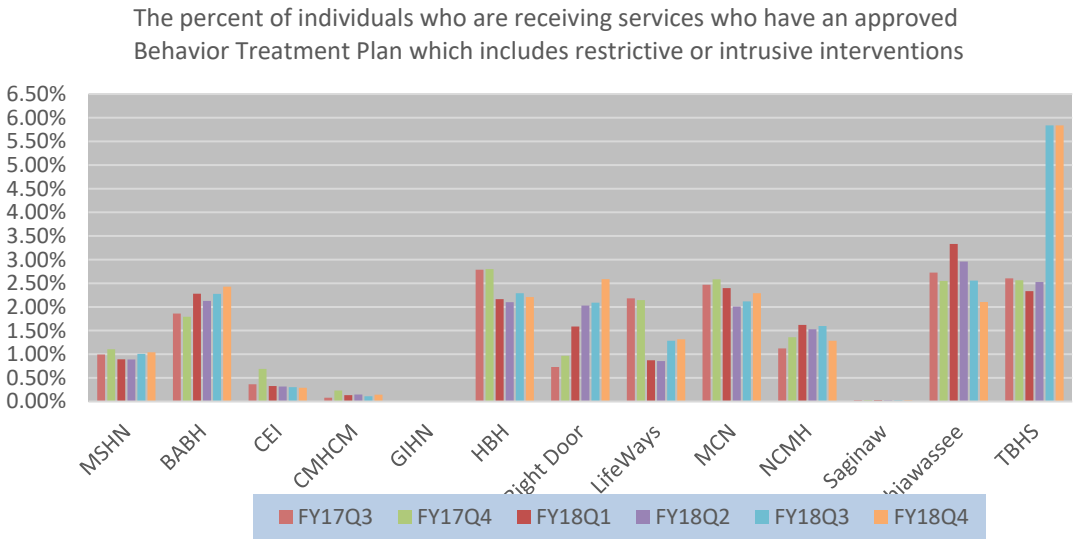
1. The restrictions that are identified through the Home and Community Based Standards. The exact impact is unknown. There is a need to further define what specific restrictions require behavior treatment review and what restrictions can be addressed in the Individual Plan of Service. MDHHS has not provided any specific guidance related to this area.
2. The incorporation of the individuals receivng the autism benefit. Most of the CMHSPs have begun to review plans that have restrictive or physical interventions for individuals receiving Applied Behavioral Analysis (ABA) services. These interventions have not been discussed with the regional BTPC therefore it is likely that consistent definitions are to being used causing the increase in reported interventions.
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. The MDHHS Standards for Behavior Treatment do not address children specifically as it relates to standards of care and indications for the medication.
4. Psychologist available to evaluate and write behavior treatment plans. The revised Behavioral Treatment Standards indicate "the Committee shall be comprised of at least three individuals one of whom shall be a board certified behavior analyst (BCBA) or licensed behavior analyst (LBA) and/or a licensed psychologists defined in the Medicaid Provider Manual. A committee member who has prepared the behavior treatment plan must recuse themselves from the final decision making of the committee. Therefore if an organization has one psychologist they have been unable to develop a plan and approve it. The addition of the BCBA or LBA may provide some additional opportunities.

Each CMHSP is at a different level of implementation with the issues identified above. The sudden increase for TBHS is related to issue number 3 above the rate increase equates to 24 number of individuals.

FY18Q4

Out of the 12 CMHSP's, 310 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 1.04% (310/29785) consumers served in the region for FY18Q4 as of October 31, 2018 who have an approved plan for behavior treatment with a restrictive or intrusive intervention. The variance continues to relate to four main categories as identified during the FY18Q3 analysis.

Figure 1



Study Question 2a: Has the proportion of individuals who have received multiple emergency physical interventions decreased over time?

Numerator: The total number of individuals with whom more than one emergency physical intervention was used during the reporting period.

Denominator: The total number of individuals with whom emergency physical interventions were used during the reporting period.

Study Question 2b: Has the proportion of physical interventions decreased overtime?

Numerator: The total number of physical interventions used during the reporting period.

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

FY18Q1

During this reporting period 37 individuals received an emergency physical intervention. A total of 142 emergency physical interventions were used. Less than 1% (0.13% - 37/28729) of the individuals (Medicaid) served received an emergency physical intervention. This is a slight increase in the rate per 100 consumers served from the previous reporting period. Of the 37 who received an emergency physical intervention, 24 (65%) individuals received more than one physical intervention. Figure 2 identifies the percent of individuals served who received an emergency physical intervention. Figure 3 demonstrates the number of individuals who received an emergency physical intervention and the number of individuals who received more than 1 emergency physical intervention during the reporting period.

FY18Q2

During this reporting period 44 individuals received an emergency physical intervention. A total of 173 emergency physical interventions were used. Less than 1% (0.15% - **44** ~~**52**~~/29834) of the individuals (Medicaid) served received an emergency physical intervention. This is a slight increase in the rate per 100 consumers served from the previous reporting period. Of the 44 who received an emergency physical intervention, 20 (45%) individuals received more than one physical intervention. Figure 2 identifies the percent of individuals served who received an emergency physical intervention. Figure 3 demonstrates the number of individuals who received an emergency physical intervention and the number of individuals who received more than 1 emergency physical intervention during the reporting period. (note correction in strike and bold completed 11/2018)

FY18Q3

During this reporting period 52 individuals received an emergency physical intervention. A total of 207 emergency physical interventions were used. Less than 1% (0.17% - 52/30234) of the individuals (Medicaid) served received an emergency physical intervention. This is a slight increase in the rate per 100 consumers served from the previous reporting period. Of the 52 who received an emergency physical intervention, 24 (46%) individuals received more than one physical intervention. Figure 2 identifies the percent of individuals served who received an emergency physical intervention. Figure 3 demonstrates the number of individuals who received an emergency physical intervention and the number of individuals who received more than 1 emergency physical intervention during the reporting period. The increase in reported physical interventions is suspected to be related to the number of individuals who are receiving ABA services. The autism clinics that are providing services utilize different programs for physical and non physical intervention. The regional Behavioral Treatment Review Committee has reviewed the NAPPI, CPI, and Safety Care programs. These interventions have been classified into categories agreed upon by the committee to assist with data analyses. There is a need to review the current categories and techniques to ensure that the newly incorporated programs used by the Autism Clinics are included. These interventions include safety measures and additional physical interventions. Any techniques that are related to safety measure would be removed and not categorized as physical interventions. These issues are addressed in the recommendations.

FY18Q4

During this reporting period 36 individuals received an emergency physical intervention. A total of 141 emergency physical interventions were used. Less than 1% (0.12% - 36/29785) of the individuals (Medicaid) served received an emergency physical intervention. This is a slight increase in the rate per 100 consumers served from the previous reporting period. Of the 36 who received an emergency physical intervention, 16 (44%) individuals received more than one physical intervention. Figure 2 identifies the percent of emergency physical interventions per 100 served. Figure 3 demonstrates the number of individuals who received an emergency physical intervention and the number of individuals who received more than 1 emergency physical intervention during the reporting period. There is a decrease in the total number of emergency physical interventions and the number of individuals who received an emergency physical intervention. The variance as demonstrated will result in a review of the data to identify why the decrease. Currently the Regional Behavior Treatment Review committee is reviewing the techniques and definitions to ensure consistent application of the terms.

Figure 2

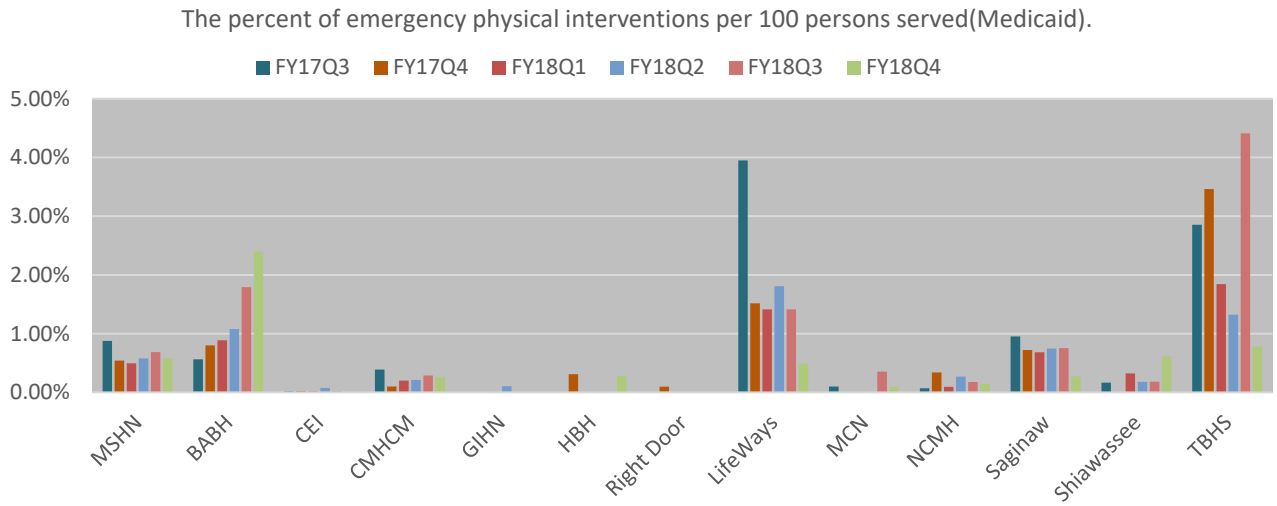


Figure 3

		FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
MSHN	**# of Individuals who had more than 1 EPI**	**22**	**24**	**20**	**24**	**16**
	# of individuals who had an EPI	**60**	**37**	**44**	**52**	**35**
BABH	**# of Individuals who had more than 1 EPI**	4	4	5	8	8
	# of individuals who had an EPI	7	6	7	11	8
CEI	**# of Individuals who had more than 1 EPI**	0	0	0	0	0
	# of individuals who had an EPI	1	1	4	1	1
CMHCM	**# of Individuals who had more than 1 EPI**	0	2	3	4	2
	# of individuals who had an EPI	6	4	5	9	9
GIHN	**# of Individuals who had more than 1 EPI**	0	0	0	0	0
	# of individuals who had an EPI	0	0	1	0	0
HBH	**# of Individuals who had more than 1 EPI**	1	0	0	0	1
	# of individuals who had an EPI	1	0	0	0	1
Right Door	**# of Individuals who had more than 1 EPI**	0	0	0	0	0
	# of individuals who had an EPI	1	0	0	0	0
LifeWays	**# of Individuals who had more than 1 EPI**	5	6	5	3	0
	# of individuals who had an EPI	19	7	9	9	4
MCN	**# of Individuals who had more than 1 EPI**	0	0	0	1	0
	# of individuals who had an EPI	0	0	0	2	1
NCMH	**# of Individuals who had more than 1 EPI**	1	0	0	0	1
	# of individuals who had an EPI	2	1	3	2	1
Saginaw	**# of Individuals who had more than 1 EPI**	8	8	4	4	2
	# of individuals who had an EPI	13	10	9	8	7
Shiawassee	**# of Individuals who had more than 1 EPI**	0	0	0	0	1
	# of individuals who had an EPI	0	3	2	2	1
TBHS	**# of Individuals who had more than 1 EPI**	3	4	3	4	1
	# of individuals who had an EPI	10	5	4	8	3

EPI=Emergency Physical Intervention

FY18Q1

One hundred and fifty-seven (157) emergency physical interventions were used during FY18Q1 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. A slight decrease was noted for the use of the supine hold and wrap hold and a significant decrease was noted for the category of other/unidentified. A slight increase was noted for the use of transport/escort and hands down hold from the previous quarter. According to the distribution of interventions, during this quarter, the wrap hold category had the highest percentage of use.

FY18Q2

One hundred and seventy- three (173) emergency physical interventions were used during FY18Q2 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. According to the distribution of interventions, during this quarter, the wrap hold category had the highest percentage of use. The category of unidentified increased from the previous quarter, but interventions were identified when using this category that included: arm block, use of helmet, and shoulder check.

FY18Q3

Two hundred and seven (207) emergency physical interventions were used during FY18Q3 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. According to the distribution of interventions, during this quarter, the wrap hold category had the highest percentage of use. The number of unidentified were 8 which included a "take down to floor" and "body positioning". As it relates to the incorporation of the Autism Benefit and the HCBS the number of interventions have increased. The Autism Clinics are using a different intervention program which has not been discussed at the regional BTPC. The names of such interventions have not been fully incorporated into the data collection process. Additionally, interventions that may be considered as "Safety Measures" may be counted as physical intervention. These programs and techniques used will be incorporated into the data collection process.

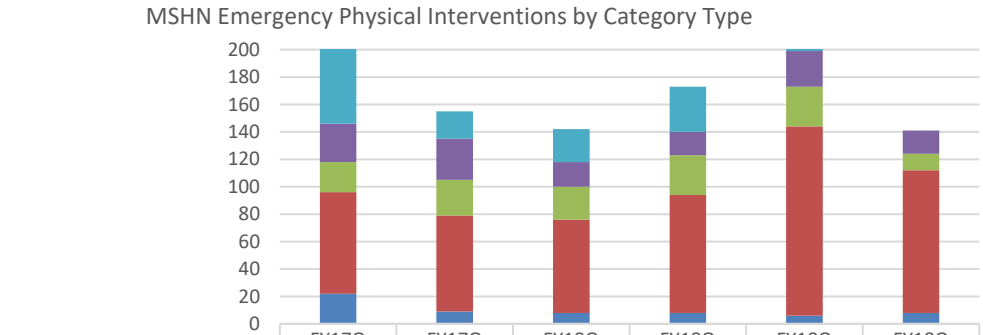
FY18Q4

One hundred and forty-one (141) emergency physical interventions were used during FY18Q4 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. According to the distribution of interventions, during this quarter, the wrap hold category had the highest percentage of use (74%).

Figure 4

Physical Intervention	**FY17Q4**	**FY18Q1**	**FY18Q2**	**FY18Q3**	**FY18Q4**
Supine Hold	(9) 6%	(8) 5%	(8) 5%	(6) 3%	(8) 6%
Wrap Hold (wrap around hold, CPI team hold, NAPPI capture wrap, standing wrap, seated wrap, body hug, basket wrap, 1-2 stability hold, chair stability hold)	(70) 45%	(68) 48%	(86) 50%	(138) 67%	(104) 74%
Transport/Escort (come along, CPI Transport, primary escort, 2 person escort, modified transport)	(26) 17%	(24) 17%	(29) 17%	(29) 14%	(12) 9%
Hands down with resistance	(30) 19%	(18) 13%	(17) 10%	(26) 13%	(17) 12%
Other/Unidentified	(20) 13%	(24) 17%	(33) 19%	(8) 4%	(0)
MSHN Total	(155) 100%	(142) 100%	(173) 100%	(207) 100%	(141) 100%

Figure 4b



	FY17Q3	FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
Other/Unidentified	114	20	24	33	8	0
Hands down with resistance	28	30	18	17	26	17
Transport/Escorts	22	26	24	29	29	12
Wrap Holds	74	70	68	86	138	104
Supine Hold	22	9	8	8	6	8

The length of time for the interventions was based on each individual intervention. It was agreed by the BTRC/QI Council that the length of time will be reported based on time intervals of ≤ 5 minutes, 6-10 minutes, and 11-15 minutes. This process for reporting will become standardized over the next year. Figure 5 identifies the number of interventions and the length of time for each, 1 was reported to be outside of the 15-minute window, and 11 were reported as unknown. The number of those not reporting the length of time for the intervention had been increasing however has decreased for FY18Q4. Follow up regarding the unreported and reported outside of the window was completed at each CMHSP to ensure a process is in place to collect the length of time for each intervention. Interventons appeared to be effective.

Figure 5

Length of time of intervention	**FY17Q4**	**FY18Q1**	**FY18Q2**	**FY18Q3**	**FY18Q4**
The total number of interventions within this time frame ≤ 5 minutes	81	79	73	101	93
The total number of interventions within this time frame 6-10 minutes	30	20	23	23	16
The total number of interventions within this time frame 11-15 minutes	23	16	19	24	22

Study Question 3: 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.

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

FY18Q1

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY18Q1 was .11% (32/28792). The total number of reported incidents requiring phone calls for police

assistance throughout MSHN during FY18Q1 was 54. Six CMHSP Participants utilized police assistance during this reporting period. This was the same number of CMHSP's who utilized the police for behavioral assistance in the previous quarter. It should be noted that police interventions are used primarily for individuals with a mental illness.

FY18Q2

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY18Q2 was .14% (42/29834). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY18Q2 was 52. Eight CMHSP Participants utilized police assistance during this reporting period. This was a decrease in the number of CMHSP's who utilized the police for behavioral assistance in the previous quarter. It should be noted that police interventions are used primarily for individuals with a mental illness.

FY18Q3

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY18Q3 was .14% (43/30234). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY18Q3 was 43. Six CMHSP Participants utilized police assistance during this reporting period. This was a decrease in the number of CMHSP's who utilized the police for behavioral assistance in the previous quarter. This data includes only those that reside in a 24 hour residential. Note the decrease in Saginaw beginning with FY18Q1 was a result of reporting defination s.

FY18Q4

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY18Q4 was .12% (36/29785). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY18Q4 was 36. Five CMHSP Participants utilized police assistance during this reporting period. This was a decrease in the number of CMHSP's who utilized the police for behavioral assistance in the previous quarter. This data includes only those that reside in a 24 hour residential.

Figure 6

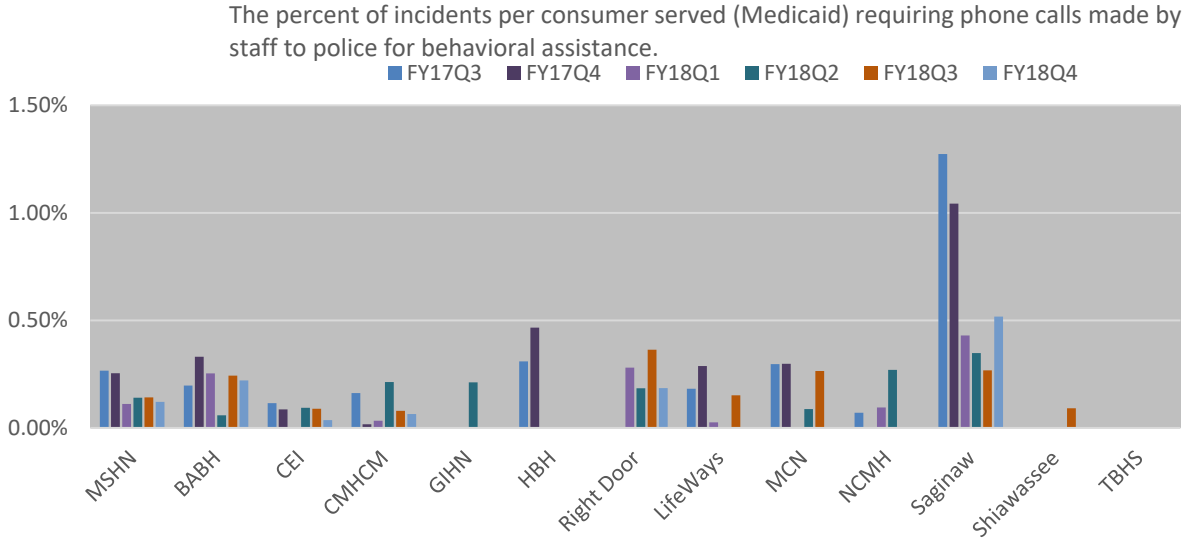
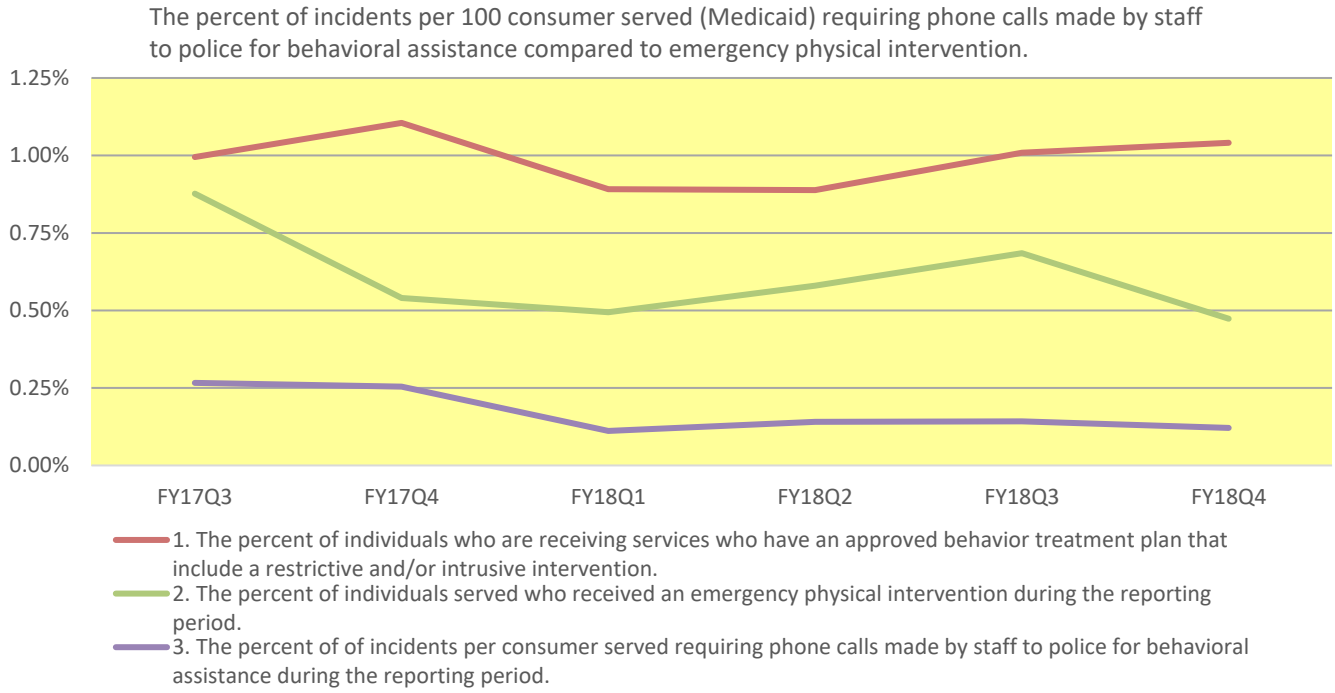


Figure 7



Conclusions:

Study Question 1: Has the proportion of individuals who have a **Behavior Treatment Plan** with ~~received~~ a restrictive/intrusive intervention decreased over time? 1.44% (FY14Q2) compared to 1.04% (FY18Q4) of the individuals served have a Behavior Treatment Plan with Intrusive and/or Restrictive Interventions. This indicates that the proportion is lower than first reported in FY14Q2. For FY14,FY15,FY16 Quarter 2 demonstrated the highest percentage of individuals who have a plan with restrictive and intrusive interventions. Beginning in FY17 no distinct pattern emerged. The number of plans had a downward trend from FY14Q2 through FY16Q1. FY16Q2 exhibited a spike in the number of plan approved, however has overall trended downward since that time. FY18Q3 is beginning to show a slight upward trend as the organizations are developing additional processes to address the following varaiables: an increased number of individuals receiving Applied Behavioral Analysis Services through Autism Clinics, and plans that identify restrictions as a result of the Home and Community Based Standards. There is an increased amount of individuals who have been incorporating the use of medications for behavioral assistance for children which has also resulted as an increase in the number of plans.

Study Question 2a: Has the proportion of individuals who have received multiple emergency physical interventions decreased over time? In FY14Q2 25% (16/65) of the individuals who had received an emergency physical intervention received multiple physical interventions. In FY18Q4 44% (16/36) have received multiple intervenions, however as indicated above the the total number of individuals who have received an intervention has decreased over time.

Study Question 2b: Has the proportion of physical interventions decreased overtime? .53% (FY14Q2) compared to .47% (FY18Q4) have received an emergency physical intervention. This shows a slight decrease over time. This has ranged from highest of 1.11% in

FY15Q2 to the lowest of .41 in FY16Q1. The PIHP has developed consistent definitions and reporting mechanisms that have assisted with the accuracy of the reporting. There were fluctuations with slight increases and slight decreases between FY14Q3 through FY18Q4. Factors have been identified that may be contributing to the increase. These factors include the use of physical management techniques with individuals who are receiving services Applied Behavioral Analysis for autism. This will continue to be monitored as to address any factors that may be causing an increase.

Study Question 3: Has the proportion of incidents in which police have been called for assistance by staff to manage a behavioral incident decreased? .32% (FY14Q2) compared to .12% (FY18Q4) indicates a decrease in the proportion of incident in which the police have been called for police assistance with a behavioral incident over time. During the time this has been monitored, the overall percentage has been trending downward with some quarters fluctuating and showing slight increases. The highest was .37% in FY14Q3 and the lowest was .11% in FY18Q1.

Observation: For FY18Q4, the number of individuals who had an approved behavior treatment plan that included a restrictive and/or intrusive intervention increased from 265 in FY18Q2 to 310 in FY18Q4. However the number of actual emergency physical interventions was the lowest it has been since FY16Q4. The number of restrictive and intrusive plans did increase at a higher rate that the number served. Factors contributing to this could be the increase of the use of ABA services, individuals on restrictions as a result of the Home and community Based Standards, and/or individuals in transition from a more restrictive setting, children who are receiving medications for behavioral assistance being reviewed.

Improvement Strategies:

Recommendations as determined by the regional Behavioral Treatment Committee include the following:

Reinstitute monthly/bi-monthly regional Behavior Treatment Committee meetings initially then switch to quarterly or as needed.

Submit any programs other than the CPI, NAPPI and Safety Care, that are currently being used for physical, non physical intervention techniques by the CMHSPs, and the autism clinics to MSHN Quality Staff. The purpose is to incorporate new techniques into the current definitions document. Specifically identifying safety measures for exclusion puproses formthe data and those interventions that require approval by the local BTPRC. The purpose is to ensure consistent definitions and interpretation of all techniques, and to ensure the reporting process for data analysis includes the appropriate interventions.

MSHN waiver staff will review the HCBS to make recommendations for what restrictions should be incorporated into the Individual Plan of Service and /or approved by the Behavior Treatment Committee. The purpose is to provide consistency across the region utilizing any guidance available from MDHHS.

Review the required qualifications necessary to complete the assessment used to determine the need for a Behavioral Plan and to develop the Behavior Treatment Plan. The purpose is to assist in the development

of a process that will be effective for those CMHSP with capacity issues related to the psychologist and the need for plans for children who are receivng medication for behavioral assistance.

It is recommended that a review of the reported emergency interventions occur to identify the time frames of any unreported time frames of the emergency physical interventions and the factors for the interventions to be longer than 15 minutes.

Analysis By: Sandra Gettel, Quality Manager **Date: November 30, 2018**

MSHN QIC: **Approved: January 24, 2019**

MSHN BTRC: **Reviewed: December 17, 2018**

MSHN
Mid-State Health Network

Quality Assessment and
Performance Improvement Program

Summary Report

Title of Measure: Michigan Mission Based Performance Indicators **MI/DD Adult/Child Data/SUD**

Reporting Period (month/year): FY18Q4

Data Analysis: (threats to validity; statistical testing; reliability of results; statistical significance; need for modification of data collection strategies)

The data is fully valid and reliable. The data is obtained through the state reporting process. This measure allows for exclusions and exceptions. Exceptions are those that chose to have an appointment outside of the 14 days, refuse an appointment that was offered the dates or offered appointments must be documented. Those excluded are those who are dual eligible (i.e. Medicaid/Medicare as indicated in the MDHHS Codebook).

For those CMHSPs who have contracted providers, those numbers are included in the total for that CMHSP. That CMHSP is responsible for insuring that action is taken to improve performance when needed. There may be times when each provider has only one who has not been in compliance, however, when combined, it results in a percentage that is less than the expected threshold. CMHSPs will document action taken to resolve such an issue in the future. When an individual served has received services form both a SUD Provider and a CMHSP, the individual served will be counted in the SUD counts and removed from the CMHSP counts.

Indicator 1 defines disposition as the decision that was 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.

Indicator 2 defines a new person as an individual who has not received services at that CMHSP/PIHP within the previous 90 days. A professional assessment is defined as a face to face assessment with a professional designed to result in a decision to provide ongoing services from a CMHSP. OBRA and Autism consumers are excluded from this count.

Indicator 3 indicates that those consumers who are in respite or medication only services are an exception; other environmental circumstances also apply. See MDCH full instructions for more specific information regarding those situations.

Indicator 4 does not include dual eligible in the count. Consumers who choose to have an appointment outside of the 7-day window or refuse an appointment within the 7-day window, and those who no show and do not reschedule. Consumers who choose to not use CMHSP services may be documented as an exception.

Indicator 10 (old 12) indicates those consumers who choose to not use a CMHSP are documented as an exception, and not included in the count.

The above information was taken from the Performance Indicator Codebook. Please refer to the original document for any additional or more specific instructions.

Figure 1

Affiliate / CMH	#1 - Child	#1 - Adult	#2 - MI / Child	#2 - MI / Adult	#2 - DD / Child	#2 - DD / Adult	#2 - SUD	#2 - Total
Bay-Arenac	100.00%	100.00%	98.72%	96.84%	100.00%	100.00%		97.56%
CEI	99.13%	98.46%	97.71%	97.39%	100.00%	100.00%		97.62%
Central MI	100.00%	100.00%	100.00%	99.69%	100.00%	100.00%		99.80%
GIHN	100.00%	100.00%	100.00%	100.00%		100.00%		100.00%
Huron	100.00%	100.00%	100.00%	100.00%	100.00%			100.00%
The Right Door	100.00%	100.00%	100.00%	96.88%				97.53%
LifeWays	100.00%	99.36%	97.83%	99.34%	92.31%	100.00%		98.52%
Montcalm	100.00%	100.00%	98.21%	100.00%	100.00%	100.00%		99.42%
Newaygo	92.31%	100.00%	100.00%	98.89%	100.00%	100.00%		99.22%
Saginaw	99.17%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%
Shiawassee	100.00%	99.11%	95.00%	96.36%	100.00%	100.00%		96.33%
Tuscola	100.00%	100.00%	96.15%	100.00%	100.00%	100.00%		98.90%
MSHN SUD							99.08%	99.08%
Total/PIHP:	**99.36%**	**99.45%**	**98.59%**	**98.84%**	**99.04%**	**100.00%**	**99.08%**	**98.91%**

Indicator 1: Percentage of Children/Adults who received a Prescreen within 3 hours of request (standard is 95% or above) – In Figure 1, MSHN demonstrated a 99.36% compliance (617/621) of the **Children** who requested a prescreen received one within three (3) hours. Eleven (11) CMHSPs demonstrated performance above the standard for **Children** and one (1) CMHSP demonstrated performance below the standard. MSHN demonstrated a 99.45% compliance (2728/2743) of the **Adults** who requested a prescreen received one within three (3) hours. All twelve (12) CMHSPs demonstrated performance above the standard for **Adults.**

Indicator 2: Initial Assessment within 14 Days - Children/Adults (standard is 95% or above) – In Figure 1, MSHN demonstrated a 98.91% (4170/4216) compliance for **all population categories** within the indicator. Figure 1 exhibits each CMHSP's performance related to the specific population group. All twelve CMHSPs demonstrated performance above the standard for **MI-Children, MI-Adults, and DD-Adults**. Eleven (11) CMHSPs demonstrated performance above the standard for **DD-Children.** SUD providers demonstrated performance above the standard for the **Substance Use Disorder (SUD)** population.

Figure 2

Affiliate / CMH	#3 - MI / Child	#3 - MI / Adult	#3 - DD / Child	#3 - DD / Adult	#3 - SUD	#3 - Total	#4a - Child	#4a - Adult	#4b SUD - SUD	#10 - Child	#10 - Adult
Bay-Arenac	97.26%	96.92%	85.71%	100.0%		96.73%	100.0%	100.0%		16.0%	8.65%
CEI	95.15%	96.58%	100.0%	100.0%		96.07%	100.0%	96.32%		11.63%	8.73%
Central MI	99.15%	98.18%	100.0%	100.0%		98.59%	100.0%	100.0%		12.50%	12.68%
Gratiot	100.00%	100.0%				100.0%	100.0%	100.0%		14.29%	10.34%
Huron	100.00%	100.0%	0.00%			98.04%	100.0%	100.0%		20.00%	0.00%
Ionia	100.00%	100.0%				100.0%	100.0%	95.83%		0.00%	19.35%
LifeWays	95.77%	100.00%	100.0%	100.0%		98.80%	100.0%	91.43%		0.00%	10.99%
Montcalm	95.00%	98.41%	100.0%	100.0%		97.37%	100.0%	100.0%		66.67%	10.71%
Newaygo	95.45%	97.26%		85.71%		96.08%	100.0%	100.0%		0.00%	19.05%
Saginaw	97.44%	100.0%	100.0%	100.0%		99.53%	100.0%	100.0%		6.25%	14.18%
Shiawassee	100.00%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%		50.00%	15.91%
Tuscola	100.00%	98.08%	100.0%	100.0%		98.88%	100.0%	100.0%		0.00%	5.00%
MSHN SUD					98.12%	98.12%			97.52%		
Total/PIHP:	**97.35%**	**98.60%**	**97.56%**	**98.53%**	**98.12%**	**98.15%**	**100.00%**	**97.50%**	**97.52%**	**11.80%**	**11.03%**

Indicator 3: Start of Service within 14 Days (standard is 95% or above) – In Figure 2, MSHN demonstrated a 98.15% (3293/3232) compliance for **all population** categories within the indicator. Figure 2 exhibits each CMHSP's performance related to the specific population group. All CMHSPs demonstrated performance above the standard for **MI-Child and MI-Adult.** Seven (7) CMHSPs demonstrated performance above the standard for **DD-Children** with 3 CMHSPs having no individuals in the eligible population. Eight (8) CMHSPs demonstrated performance above the standard for the **DD Adult** population. Three (3) CMHSPs did not have any in the eligible population group. All applicable SUD providers demonstrated performance above the standard for the **Substance Use Disorder (SUD)** population. Three CMHSPs demonstrated performance below the standard.

Indicator 4a: Follow-Up within 7 Days of Discharge from a Psychiatric Unit (standard is 95% or above) – In Figure 2, MSHN demonstrated a 100% (127) compliance for **Children** with a diagnosis of mental illness. MSHN exhibited a 97.50% (585/600) compliance for **Adults** who have a diagnosis of mental illness. Eleven (11) CMHSPs demonstrated performance above the standard for this population with one (1) CMHSPs performing below standard.

Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (standard is 95% or above) – In Figure 2, MSHN demonstrated a 97.52% (157/161) compliance for individuals who were seen for follow-up care within 7 days of discharge from a detox unit. Performance was above the standard for the **Substance Use Disorder (SUD)** population.

Indicator 10: Re-admission to Psychiatric Unit within 30 Days (standard is 15% or less) – In Figure 2, MSHN demonstrated a 11.80% (19/161) compliance for **Children** who were re-admitted within 30 days of being discharged from a psychiatric hospitalization. Eight (8) CMHSPs demonstrated performance above the standard with three (4) CMHSPs demonstrated performance below the standard. MSHN

demonstrated a 11.03% (105/952) compliance for **Adults** who have a diagnosis of mental illness. Nine (9) CMHSPs demonstrated performance above the standard with three (3) CMHSP demonstrated performance below the standard.

Figure 3 shows a comparison of the performance indicator percentages starting in FY17 Quarter 1 to current. MSHN was within the established standards set by the state for each of the performance indicators during the current reporting period. MSHN will continue to monitor individual CMHSP performance requiring improvement plans as needed to ensure performance remains above the standard across the PIHP, and that interventions are effective in addressing the deficiencies.

Figure 3

MMBPIS		FY17Q1	FY17Q2	FY17Q3	FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
Indicator 1a & 1b: Pre-screen within 3 hours of request	Children	99.10%	99.17%	99.42%	99.59%	99.72%	99.59%	99.02%	99.36%
	Adults	98.72%	98.89%	99.31%	99.47%	99.31%	99.31%	99.48%	99.45%
Indicator 2: % of Persons Receiving an Initial Assessment within 14 calendar days of First Request	MI-Child	98.19%	98.90%	98.51%	98.48%	98.77%	98.34%	98.61%	98.59%
	MI-Adult	98.81%	98.78%	99.26%	99.65%	99.10%	98.55%	99.05%	98.84%
	DD-Child	98.67%	100.00%	97.30%	98.68%	100.00%	98.73%	98.73%	99.04%
	DD-Adult	100.00%	100.00%	100.00%	98.86%	100.00%	98.75%	100.00%	100.00%
	SUD	98.41%	98.47%	98.39%	98.95%	98.65%	99.37%	99.12%	99.08%
	Total	**98.55%**	**98.78%**	**98.82%**	**99.16%**	**98.92%**	**98.79%**	**98.99%**	**98.91%**
Indicator 3: % of Persons Who Started Service within 14 days of Assessment	MI-Child	97.87%	97.23%	96.98%	96.72%	95.55%	96.33%	96.18%	97.35%
	MI-Adult	97.50%	97.31%	98.25%	97.46%	97.90%	98.26%	98.31%	98.60%
	DD-Child	100.00%	96.97%	100.00%	94.74%	83.05%	98.08%	100.00%	97.56%
	DD-Adult	93.94%	97.37%	98.48%	98.55%	100.00%	98.57%	100.00%	98.53%
	SUD	100.00%	100.00%	100.00%	99.91%	99.80%	99.30%	97.19%	98.12%
	Total	**98.46%**	**98.18%**	**98.61%**	**98.16%**	**97.68%**	**98.12%**	**97.48%**	**98.15%**
Indicator 4a, and Indicator 4b: Persons seen within 7 days of Inpatient Discharge and Substance Abuse Detox	Children	98.13%	98.52%	99.22%	100.00%	100.00%	98.40%	96.18%	100.00%
	Adults	97.11%	98.26%	96.97%	96.55%	97.17%	98.12%	97.38%	97.50%
	SUD	100.00%	97.60%	97.51%	98.69%	97.90%	98.80%	98.78%	97.52%
Indicator 10: % of Discharges Readmitted to Inpatient Care within 30 days of Discharge	Children	9.43%	8.11%	8.97%	11.88%	12.20%	10.12%	7.29%	11.80%
	Adults	11.88%	9.85%	7.61%	11.10%	10.34%	9.09%	9.59%	11.03%
	KEY:	**Above Standard**		**Below Standard**					

Figures 4 through 7 exhibit the percentage of exceptions that were reported for the total population. The variance might indicate a difference in practice or definition. Attachment A includes the exceptions for CMHSP and each specific population group.

Figure 4: Indicator 2 - Exception Report

Indicator 2	FY17Q1	FY17Q2	FY17Q3	FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
BABH	13.33%	17.95%	16.26%	13.73%	7.67%	10.88%	14.95%	13.07%
CMHCM	2.79%	3.69%	6.07%	4.11%	3.99%	5.20%	9.55%	8.65%
CEI	7.98%	8.26%	6.90%	10.58%	8.81%	9.39%	11.29%	10.10%
GIHN	1.59%	28.40%	15.50%	6.06%	19.01%	25.58%	7.27%	1.03%
HBH	19.72%	29.17%	18.06%	12.28%	23.16%	12.86%	15.79%	9.09%
Lifeways	12.32%	11.76%	6.44%	6.10%	11.51%	18.73%	13.37%	8.45%
MCN	1.68%	3.47%	0.93%	1.87%	3.38%	1.71%	4.07%	0.58%
Newaygo	2.91%	4.62%	10.31%	3.76%	21.76%	15.76%	21.03%	15.13%
Saginaw	4.53%	1.14%	1.81%	1.10%	0.55%	1.46%	3.87%	3.30%
SHW	3.45%	2.13%	12.96%	4.65%	4.35%	1.71%	1.59%	0.00%
The Right Door/Ionia	23.74%	29.94%	37.68%	25.00%	32.50%	23.14%	12.88%	12.90%
TBHS	22.39%	14.39%	23.21%	23.76%	32.61%	20.20%	37.63%	13.33%
SUD								5.67%
MSHN	**7.33%**	**9.74%**	**9.47%**	**7.76%**	**9.65%**	**9.75%**	**9.07%**	**8.23%**

Figure 4: The following are exceptions for Indicator 2: Consumers who request an appointment outside the 14 calendar day period or refuse an appointment offered that would have occurred within the 14 calendar day period, or do not show for an appointment or reschedule it. Dates offered or refused must be documented.

Figure 5: Indicator 3 - Exception Report

Indicator 3	FY17Q1	FY17Q2	FY17Q3	FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
BABH	16.67%	17.88%	20.28%	27.06%	13.74%	17.82%	23.92%	15.42%
CMHCM	14.18%	21.49%	17.86%	19.65%	14.33%	18.83%	16.45%	21.81%
CEI	27.79%	28.92%	23.65%	22.76%	29.95%	28.31%	37.76%	34.20%
GIHN	9.78%	28.67%	11.76%	10.48%	12.38%	12.40%	13.73%	17.58%
HBH	18.57%	27.14%	23.19%	20.75%	9.59%	25.35%	18.60%	22.73%
Lifeways	14.15%	15.31%	19.34%	23.28%	30.24%	29.88%	24.22%	14.92%
MCN	21.05%	22.27%	17.99%	20.00%	11.86%	25.98%	30.81%	23.49%
Newaygo	17.65%	22.09%	25.32%	18.06%	24.32%	17.31%	27.33%	16.39%
Saginaw	23.55%	27.73%	26.89%	25.61%	29.74%	31.87%	28.80%	35.67%
SHW	16.67%	5.00%	11.86%	7.50%	12.00%	10.28%	14.16%	12.62%
The Right Door/Ionia	23.97%	23.26%	29.85%	14.02%	32.52%	22.52%	16.98%	10.34%
TBHS	3.28%	3.92%	4.30%	1.25%	2.56%	0.00%	7.59%	4.30%
SUD								6.27%
MSHN	**18.21%**	**22.01%**	**20.58%**	**20.53%**	**21.03%**	**22.45%**	**17.97%**	22.19%

Figure 5: The following are exceptions for Indicator 3: Consumers who request an appointment outside the 14 calendar day period or refuse an appointment offered that would have occurred within the 14 calendar day period, or do not show for an appointment or reschedule it. Dates offered or refused must be documented.
OR
Consumers for whom the intent of service was medication only or respite only and the date of service exceeded the 14 calendar days. May also exclude environmental modifications where the completion of a project exceeds 14 calendar days. It is expected, however, that minimally a request for bids/quotes has been issued within 14 calendar days of the assessment. Lastly, exclude instances where consumer is enrolled in school and is unable to take advantage of services for several months.

Figure 6a: Indicator 4a – Exception Report

Indicator 4a	FY17Q1	FY17Q2	FY17Q3	FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
BABH	32.38%	35.83%	28.24%	31.40%	34.35%	31.47%	32.72%	29.69%
CMHCM	10.00%	38.08%	22.22%	17.28%	8.57%	17.78%	8%	29.11%
CEI	44.71%	38.08%	40.78%	52.04%	47.87%	48.39%	41.33%	46.30%
GIHN	57.50%	17.86%	30.00%	26.67%	12.82%	6.25%	13.79%	13.89%
HBH	37.04%	36.36%	54.17%	43.75%	30.77%	25.93%	18.18%	27.78%
Lifeways	24.03%	35.55%	29.70%	41.38%	47.95%	38.36%	38.74%	44.86%
MCN	18.75%	17.78%	12.50%	40.00%	21.95%	36.11%	22.22%	24.24%
Newaygo	27.27%	14.29%	45.45%	23.81%	37.50%	33.33%	28.57%	20.83%
Saginaw	20.51%	26.95%	18.30%	28.46%	25.16%	20.14%	23.42%	22.42%
SHW	30.00%	0.00%	21.74%	15.00%	22.22%	45.65%	27.27%	22.00%
The Right Door/Ionia	10.00%	41.94%	28.57%	7.69%	8.70%	18.18%	14.63%	21.21%
TBHS	51.52%	23.53%	46.15%	40.00%	48.28%	53.57%	37.50%	37.50%
MSHN	**30.64%**	**33.62%**	**29.81%**	**36.41%**	**34.85%**	**34.17%**	**31.33%**	34.80%

Figure 6a: The following are exceptions for Indicator 4a: Consumers who request an appointment outside the seven-day period or refuse an appointment offered that would have occurred within the seven-calendar day period, or do not show for an appointment or reschedule it. Must document dates of refusal or dates offered.
OR
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. Therefore, a 3 would be chosen and they would be considered an exception.

Figure 6b: Indicator 4b - Exception Report

Indicator 4b	FY17Q1	FY17Q2	FY17Q3	FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
MSHN	0.00%	0.00%	1.63%	0.80%	43.06%	50.59%	**50.75%**	53.74%

Figure 6b: The following are exceptions for 4b: Consumers who request an appointment outside the seven-day period or refuse an appointment offered that would have occurred within the seven-calendar day period, or do not show for an appointment or reschedule it. Must document dates of refusal or dates offered.
OR
Consumers who choose not to use CA/CMHSP/PIHP services.

Figure 7: Indicator 10 - Exception Report

Indicator 10	FY17Q1	FY17Q2	FY17Q3	FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
BABH	0.00%	0.00%	0.00%	0.00%	0.00%	0.69%	**0.00%**	**0.00%**
CMHCM	0.00%	0.83%	0.00%	0.00%	0.00%	0.00%	**0.00%**	**0.00%**
CEI	3.53%	0.83%	2.15%	2.94%	2.65%	1.56%	**3.23%**	**2.15%**
GIHN	50.00%	39.29%	17.24%	13.33%	0.00%	0.00%	**0.00%**	**0.00%**
HBH	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**	**0.00%**
Lifeways	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**3.49%**	**5.53%**
MCN	2.94%	2.22%	0.00%	3.23%	2.33%	0.00%	**2.78%**	**6.06%**
Newaygo	0.00%	14.29%	36.36%	14.29%	0.00%	26.67%	**0.00%**	**0.00%**
Saginaw	0.00%	2.13%	0.00%	0.00%	0.00%	0.00%	**0.00%**	**0.00%**
SHW	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**	**0.00%**
The Right Door/Ionia	0.00%	0.00%	0.00%	0.00%	0.00%	2.22%	**0.00%**	**0.00%**
TBHS	0.00%	0.00%	7.89%	4.00%	0.00%	0.00%	**2.86%**	**0.00%**
MSHN	**3.33%**	**1.78%**	**1.68%**	**1.64%**	**0.63%**	**0.92%**	**1.68%**	**1.85%**

Figure 7: The following are exceptions for Indicator 10: Discharges who choose not to use CMHSP/PIHP Services.

The following table identifies the individual CMHSP's that are required to submit a plan of correction for the current quarter, the plans of correction that are in place from the previous 3 quarters and the performance indicators that each CMHSP are identified as having a best practice for achieving the established standard.

	Current Quarter's Performance Below Standard Requiring Action	**Intervention plan in place and being monitored to reach full impact**					**Regional Best Practice** (≥ 3 data points)
		FY18Q3	FY18Q2	FY18 Q1	FY17 Q4	FY17 Q3	
BABH	3c, 10a	4a1, 10b	3a, 10a	N/A	3c, 10a	3a,4a2,	1, 2
CMHCM	NA	NA	N/A	10a	NA	NA	1, 2, 3, 4
CEI	NA	NA	N/A	N/A	2c, 3a, 4a2	2c,3d	1, 10
GIHN	NA	3a, 10a	2a	N/A	10b	10a,10b	1, 4
HBH	3c, 10a	NA	3a, 10a	N/A	10a	10a	1, 2, 4
Lifeways	2c, 4a2,	2c, 3a, 4a1	3d, 10b	N/A	NA	NA	1,
MCN	10a	3a,	2d	N/A	10a	NA	1, 3, 4
Newaygo	1a, 3d, 10b	NA	N/A	N/A	NA	NA	2, 4,
Saginaw	NA	4a1	3a, 3c	3a	3c, 3d	10a	1, 2, 4
SHW	10a, 10b	3a	4a1, 4a2	10a	3a	3a,4a2,10b	1, 2
The Right Door	10b	1a	1a, 2a, 2c, **10a(10b)**	3a	2a, 3b, 10a, 10b	10a	4
TBHS	NA	10b	10b	10b	3a	NA	1, 2, 4

Note: The plans of correction are only in effect for the previous 3 quarters. If an indicator is noted as out of compliance and a plan has been in place for 3 or more quarters, then the CMH is required to submit a new plan of correction. Plans required are highlighted in the current quarter's performance below standard requiring action column.

Improvement Strategies:

Those indicators that are listed under "Best Practice" are those that have met the standard for 95% for all populations for 3 or more quarters. Since corrective action plans often are in place for up to 4 quarters before they reach full impact, it may not be unusual for someone to have a corrective action plan in place and still meet the criteria for "Best Practice". For those who have indicators listed under the "Best Practice" column, it may be useful to share what is being done with others.

All CMHSPs who demonstrate performance below the standard for each population group will submit a corrective action plan to MSHN within 30 days of the presentation of this report to the Quality Improvement Council. The corrective action plan should be completed using the standard template and include a specific date of impact, and clearly identify the indicator in which the action is addressing.

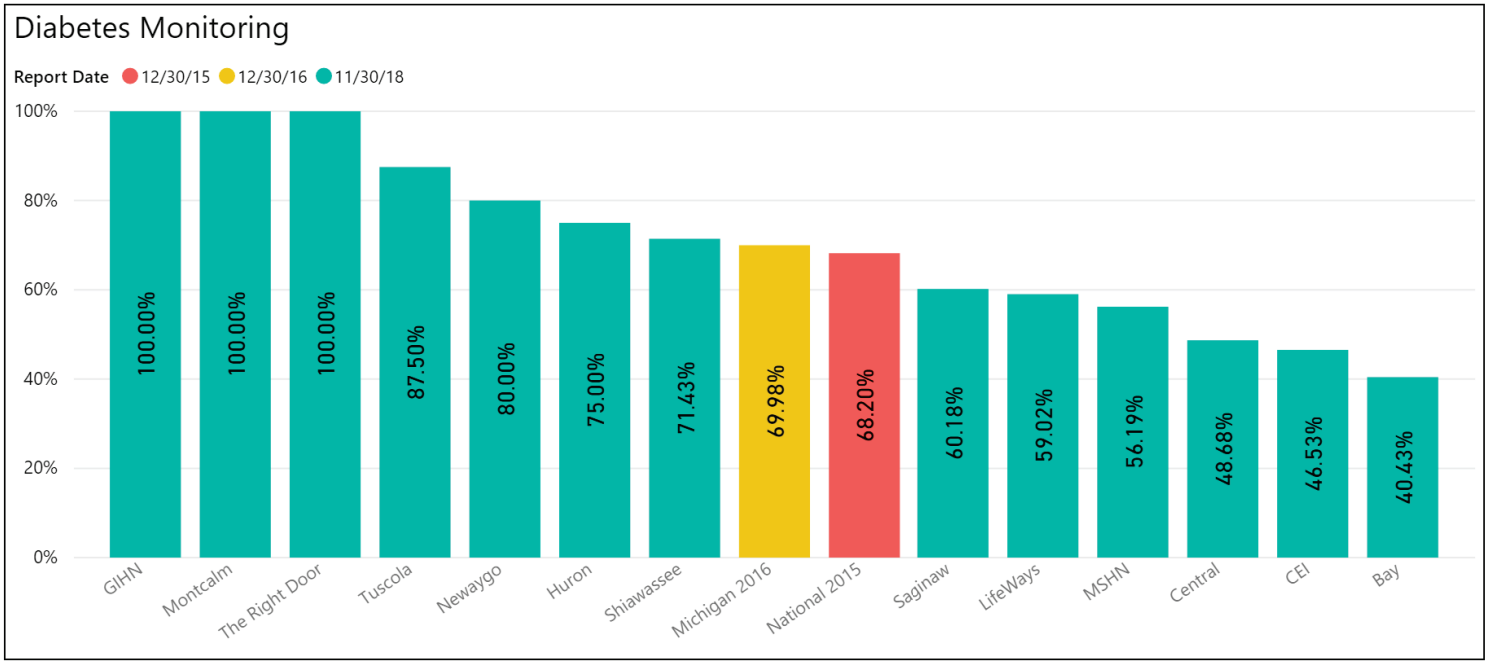
CMHSPs should review data prior to submission to ensure the appropriate data elements are submitted according to the format as indicated in the instructions. The exception data should be identified based on the definitions provided in the instruction document. This information will be

reviewed during the Quality Improvement Council meeting to ensure there is a clear understanding of the expectations.

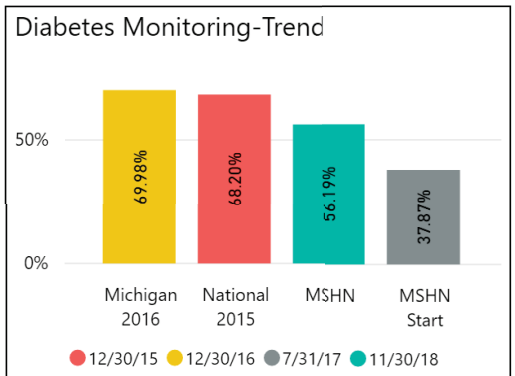
Completed by: MSHN **Date: January 3, 2019**

MSHN QIC Approved: **Date: January 24, 2019**

Attachment 10



Organization	Yes	No	Percentage
Bay	19	28	40.43%
CEI	47	54	46.53%
Central	37	39	48.68%
GIHN	9	0	100.00%
Huron	3	1	75.00%
LifeWays	36	25	59.02%
Michigan 2016			69.98%
Montcalm	10	0	100.00%
MSHN	254	198	56.19%
National 2015			68.20%
Newaygo	4	1	80.00%
Saginaw	68	45	60.18%
Shiawassee	10	4	71.43%
The Right Door	4	0	100.00%
Tuscola	7	1	87.50%



Measure Description: This measure is used to assess the percentage of members 18 to 64 years of age with schizophrenia and diabetes who had both a low-density lipoprotein cholesterol (LDL-C) test and a hemoglobin A1c (HbA1c) test during the measurement year.

Numerator Statement: A hemoglobin A1c (HbA1c) test and a low-density lipoprotein cholesterol (LDL-C) test performed during the measurement year.

Denominator Statement: Medicaid members 18 to 64 years during the measurement year with schizophrenia and diabetes.

Exclusions: Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Last updated: 01/22/2019

Update frequency: monthly extract of data from ICDP.

For consumer level detail, access the Interated Care Delivery System (ICDP) by Zenith Technology Solutions

Overview of Mid-State Health Network Recovery Self-Assessment Survey Summary Report FY 2018

Provider Network Administrator Measure

Introduction

The following overview of Mid-State Health Network's (MSHN) Recovery Self-Assessment (RSA) Survey was developed to assist MSHN Community Mental Health Service Program (CMHSP) Participants and other stakeholders develop a better understanding of the strengths and weaknesses in MSHN's recovery-oriented care. This report was developed utilizing voluntary self-reflective surveys completed by administrators representing all CMHSP programs that provide services to adults with a Mental Illness diagnosis. There was a total of 111 respondents representing all 12 CMHSPs. The survey results were aggregated and scored as outlined in the Yale Program for Recovery and Community Health instructions.

Agency	Respondents
Mid-State Health Network total	111
Bay-Arenac Behavioral Health Authority	9
Community Mental Health Authority of CEI	17
Community Mental Health for Central Michigan	13
Gratiot Integrated Health Network	7
Huron Behavioral Health	5
LifeWays Community Mental Health	10
Montcalm Care Center	11
Newaygo County Community Mental Health	5
Saginaw County Community Mental Health	15
Shiawassee County Community Mental Health	6
The Right Door for Hope Recovery and Wellness	10
Tuscola Behavioral Health System	3

The distribution period was November 15, 2018 through December 14, 2018 and this marks the fourth year of implementation.

The information from this report is intended to support discussions on improving recovery-oriented practices by understanding how the various CMHSP practices may facilitate or impede recovery. The information from this overview should not be used draw conclusions or make assumptions without further analysis.

Any questions regarding the report should be sent to Sandy Gettel, Quality Manager at sandy.gettel@midstatehealthnetwork.org

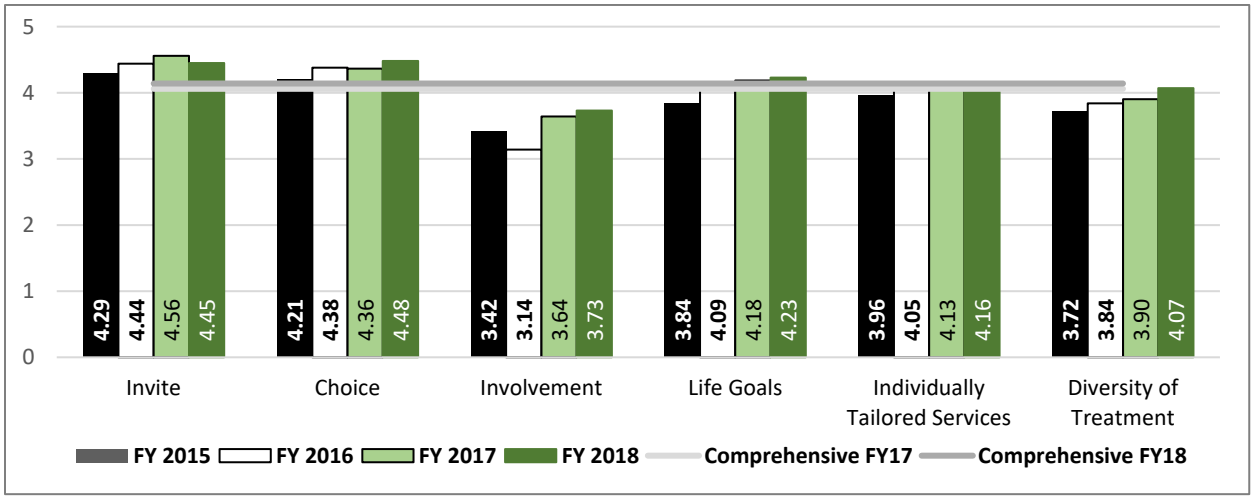
MSHN Summary

The responses from the Recovery Self-Assessment surveys were scored as a comprehensive total and separately as six subcategories. 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." The comprehensive score measures how the system is performing, and the subcategories measures the performance of six separate parts. The individual response score for each question in the subcategories is included to assist in determining potential action steps. In addition to analyzing the mean score for each subcategory an analysis was completed utilizing the percentage of each subcategory for MSHN. The "not applicable" and "do not know" responses were removed from the analysis.

MSHN Comprehensive Summary

MSHN has demonstrated an increase in the comprehensive score since the onset of the project in FY2015. The comprehensive score was 3.82 for FY 2015, 4.00 for FY 2016, 4.06 for FY 2017, and 4.14 for FY 2018. Figure 1 illustrates how MSHN's twelve CMHSPs scored themselves comprehensively and in the six separate subcategories.

Figure 1 – MSHN Score by Subcategory

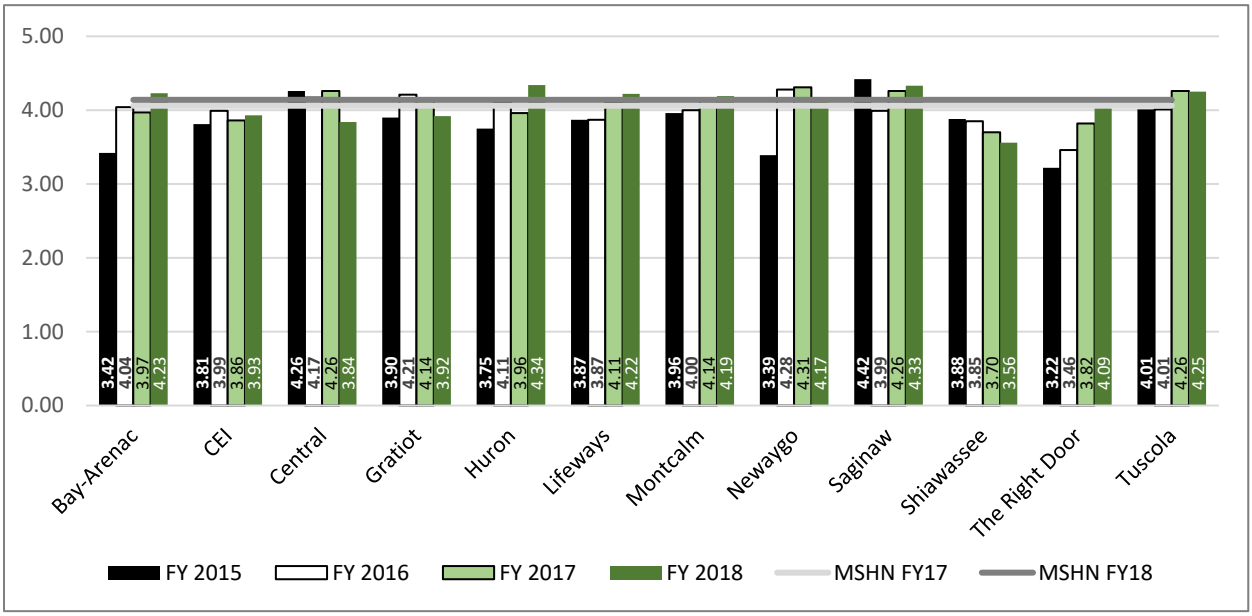


MSHN CMHSP Summary

The responses from the Recovery Self-Assessment scores were separated by each CMHSP comprehensively, and by each of the subcategory scores.

The MSHN average was 3.82 for FY 2015, 4.00 for FY 2016, 4.06 for FY 2017, and 4.14 for FY2018. As indicated in Figure 2 seven (7) CMHSPs demonstrated an increase in the comprehensive score. Each CMHSP scored above 3.5 which would indicate satisfaction.

Figure 2 – Comparison of CMHSP Comprehensive Score



Invite Subcategory

The MSHN average was 4.29 for FY 2015, 4.44 for FY 2016, 4.56 for FY 2017, and 4.45 for FY18. Figure 3 illustrates how all 12 CMHSPs responded to the Invite subcategory for FY 2015, FY 2016, FY 2017, and FY 2018. Figure 4 illustrates how each CMHSP scored by percentage of agreement to each question in the Invite subcategory. The questions included in Invite subcategory are as follows:

1: Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in programs.

2: This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.).

Figure 3 – Comparison of CMHSP Invite Subcategory Score

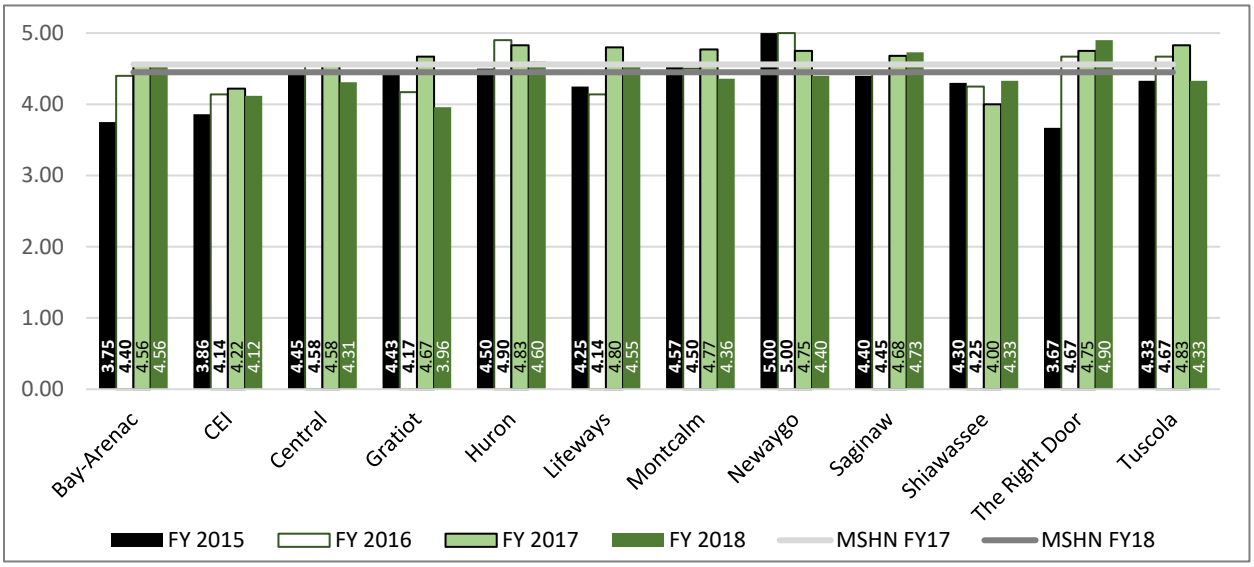
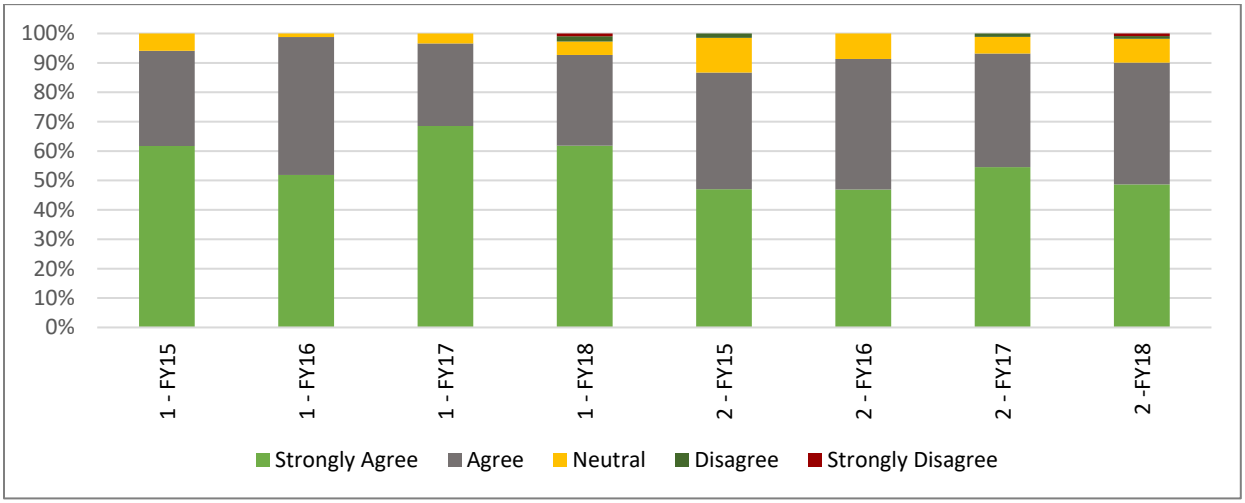


Figure 4 – MSHN – Invite Subcategory Survey Response by Percentage.



Choice Subcategory

The MSHN average was 4.21 for FY 2015, 4.38 for FY 2016, 4.36 for FY 2017, and 4.52 for FY18. Figure 5 illustrates how all 12 CMHSPs responded to the Choice subcategory for FY 2015, FY2016, FY 2017, and FY 2018. Figure 6 illustrates how each CMHSP scored by percentage of agreement to each question in the Invite subcategory. The questions included in the Choice subcategory are as follows:

4: Program participants can change their clinician or case manager if they wish.
5: Program participants can easily access their treatment records if they wish.
6: Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.
10: Staff listen to and respect the decisions that program participants make about their treatment and care.
27: Progress made towards an individual's own personal goals is tracked regularly

Figure 5 – Comparison of CMHSP Choice Subcategory Score

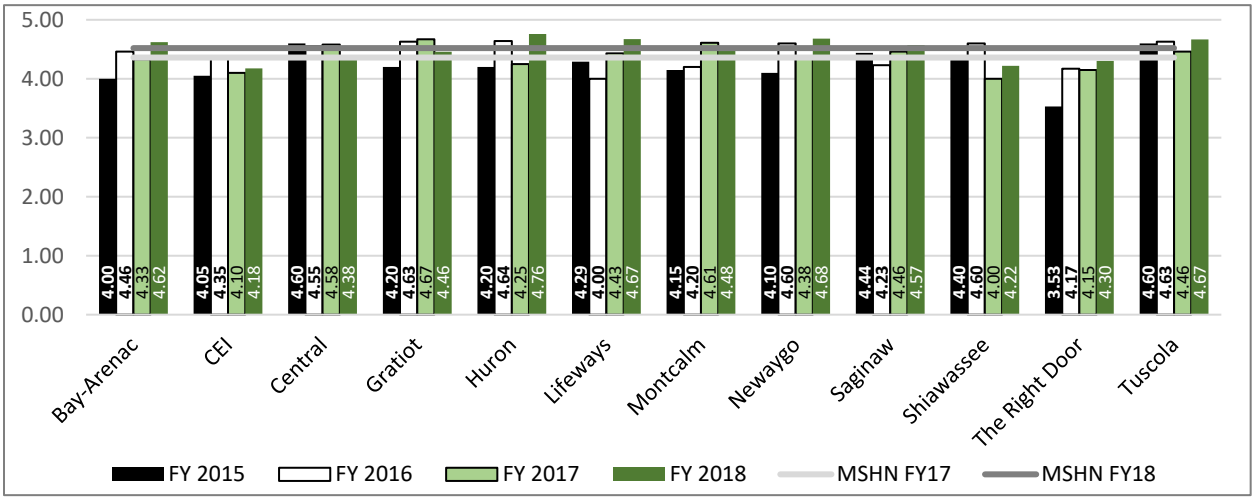
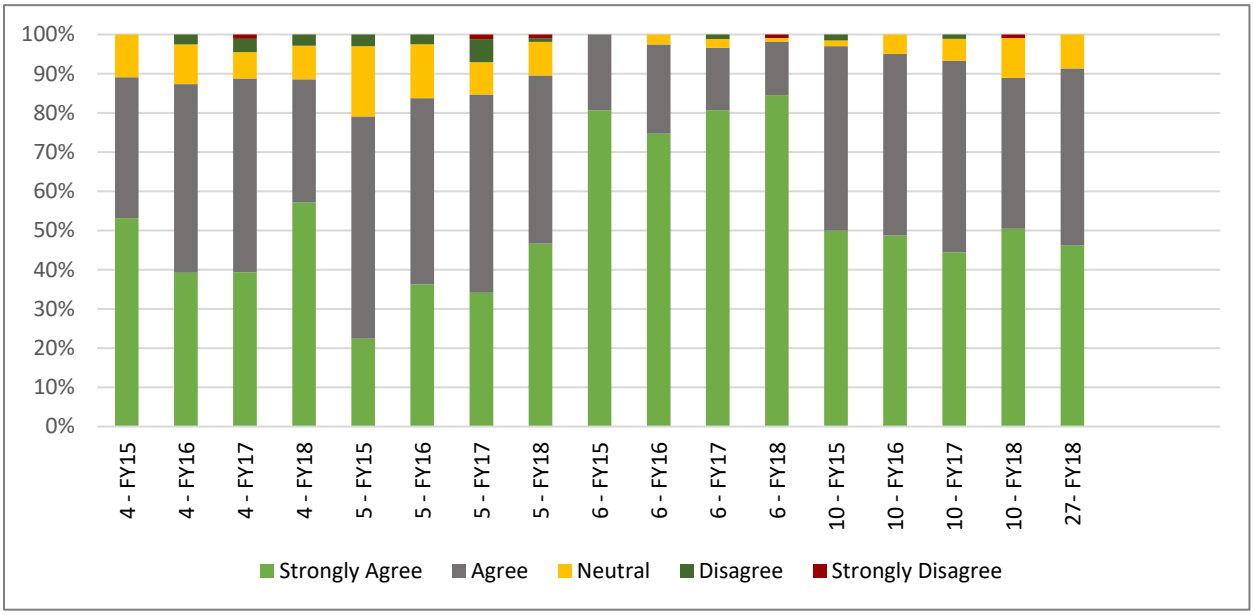


Figure 6 – MSHN Choice Subcategory Survey Response by Percentage



Involvement Subcategory

The MSHN average was 3.42 for FY 2015, 3.14 for FY 2016, 3.64 for FY 2017, and 3.73 for FY18. Figure 7 illustrates how all 12 CMHSPs responded to the Involvement subcategory. Figure 8 illustrates how all 12 CMHSPs scored by percentage of agreement to each question in the Invite subcategory. The questions included in the Involvement subcategory are as follows:

22: Staff actively help people find ways to give back to their community (i.e., volunteering, community services, and neighborhood watch/cleanup).
23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.
24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.
25. People in recovery are encouraged to attend agency advisory boards and management meetings.
29. Persons in recovery are involved with facilitating staff trainings and education at this program.
33. This agency provides formal opportunities for people in recovery, family members, service providers, and administrators to learn about recovery.
34. This agency provides structured educational activities to the community about mental illness and addictions.

Figure 7 – Comparison of CMHSP Involvement Subcategory Score

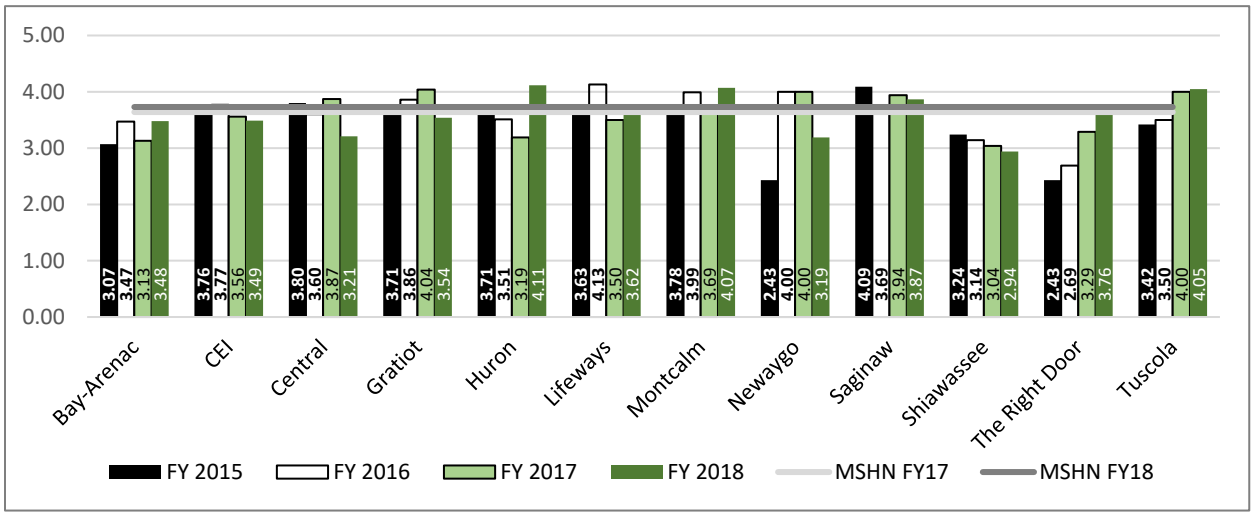
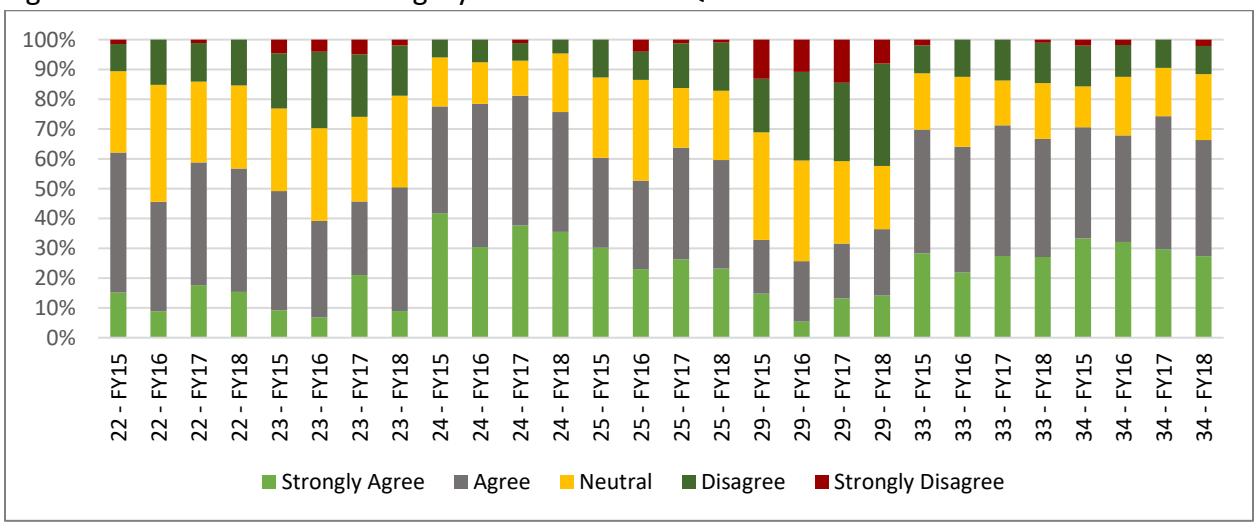


Figure 8 – Involvement Subcategory FY18 Individual Questions



Life Subcategory

The MSHN average was 3.84 for FY 2015, 4.09 for FY 2016, 4.18 for FY 2017, and 4.23 for FY 2018. Figure 9 illustrates how all 12 CMHSPs responded to the Life Goals subcategory. Figure 10 illustrates how each CMHSP scored by percentage of agreement to each question. The questions included in the Life Goals subcategory are as follows:

3. Staff encourage program participants to have hope and high expectations for their recovery.
7. Staff believe in the ability of program participants to recover.
8. Staff believe that program participants have the ability to manage their own symptoms.
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.

12. Staff encourage program participants to take risks and try new things.
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).
17. Staff routinely assist program participants with getting jobs.
18. Staff actively help program participants to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies.
28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.
31. Staff are knowledgeable about special interest groups and activities in the community.
32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.

Figure 9 – Comparison of CMHSP Life Goals Subcategory Score

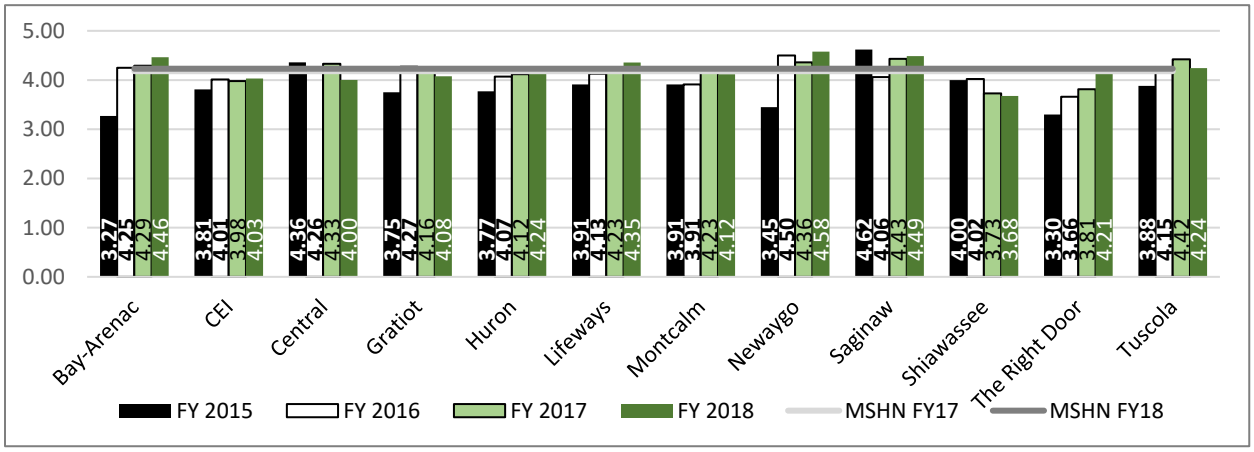
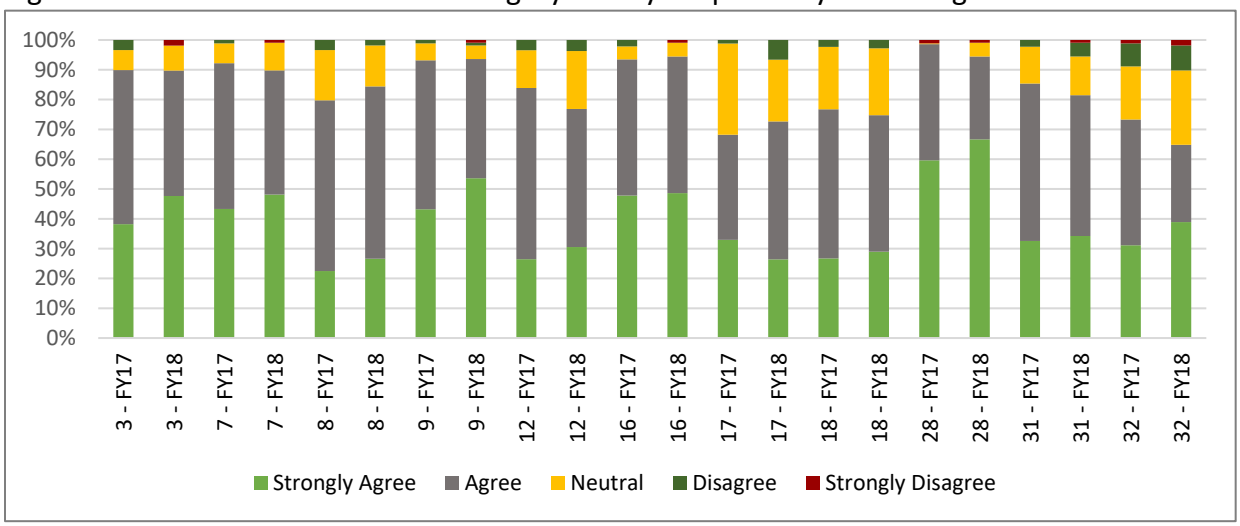


Figure 10 – MSHN – Life Goals Subcategory Survey Response by Percentage



Individually Tailored Services Subcategory

The MSHN average was 3.96 for FY 2015, 4.05 for FY 2016, 4.13 for FY 2017, and 4.16 for FY 2018. Figure 10 illustrates how all 12 CMHSPs responded to the four (4) Individually Tailored Service subcategory questions in comparison to other years. Figure 11 illustrates how each CMHSP scored by percentage of agreement to each question. The questions included in the Individually Tailored Service subcategory are as follows:

11. Staff regularly ask program participants about their interests and the things they would like to do in the community.
13. This program offers specific services that fit each participant's unique culture and life experiences.
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).
30. Staff at this program regularly attend trainings on cultural competency.

Figure 10 – Comparison of CMHSP Individually Tailored Services Subcategory Score

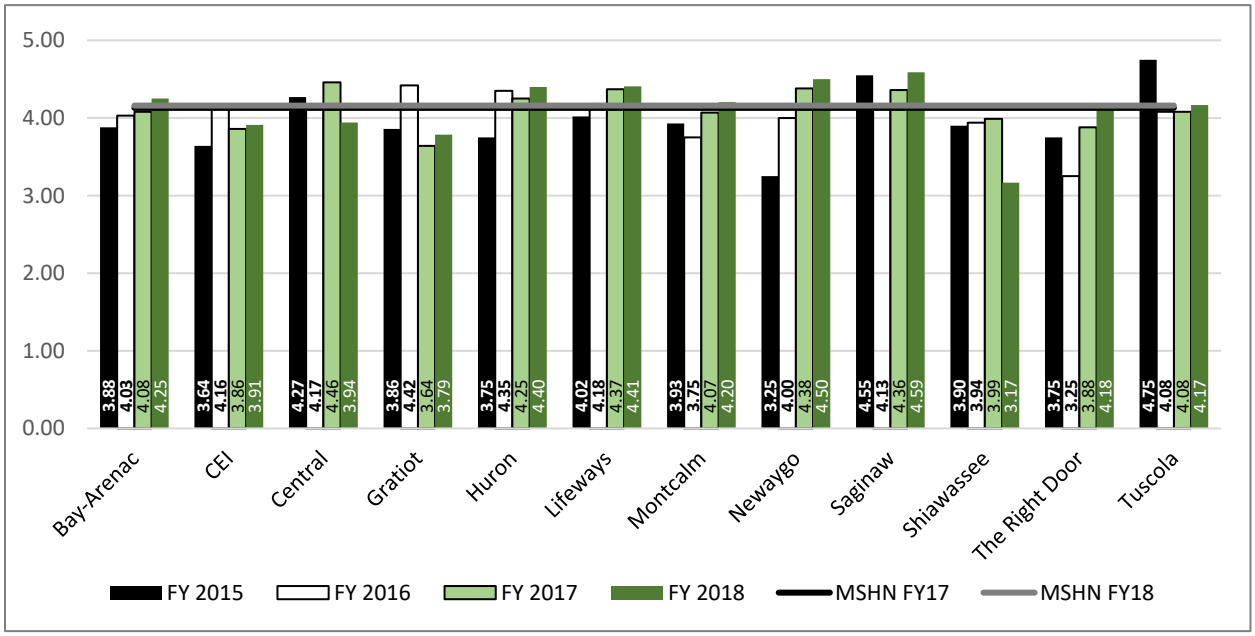
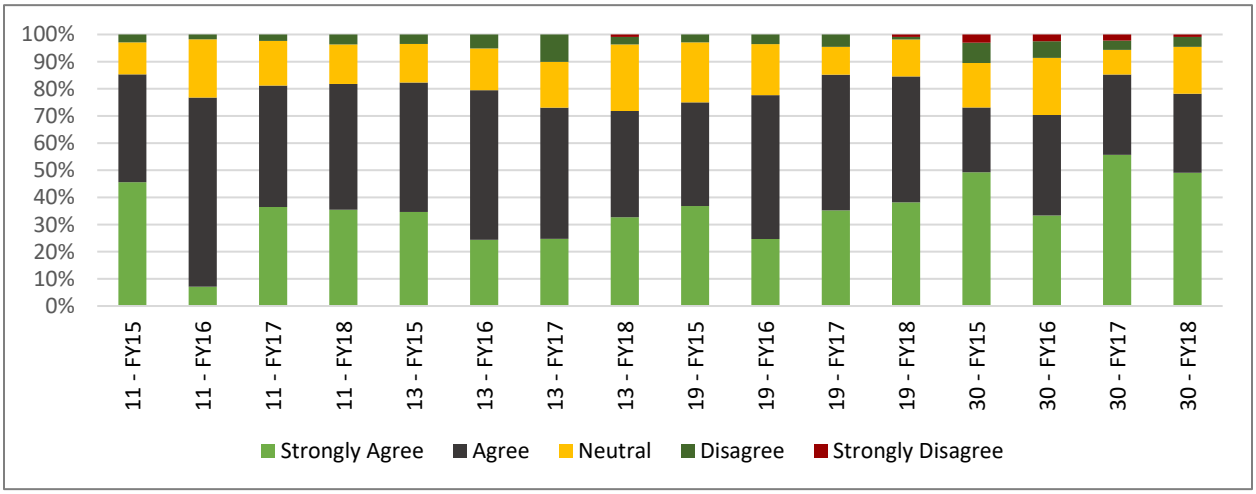


Figure 11 – MSHN – Individually Tailored Service Subcategory Survey Response by Percentage



Diversity Subcategory

The MSHN average was 3.72 for FY 2015, 3.84 for FY 2016, 3.90 for FY 2017, and 4.07 for FY18. Figure 12 illustrates how each CMHSP scored in the Diversity of Treatment subcategory. Figure 13 illustrates how each CMHSP scored by percentage of agreement to each question. The questions included in Diversity of Treatment Option subcategory are as follows:

14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.
15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.
20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.
21. Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.
26. Staff talk with program participants about what it takes to complete or exit the program.
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.).
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.

Figure 12 – Comparison of CMHSP Diversity of Treatment Subcategory Score

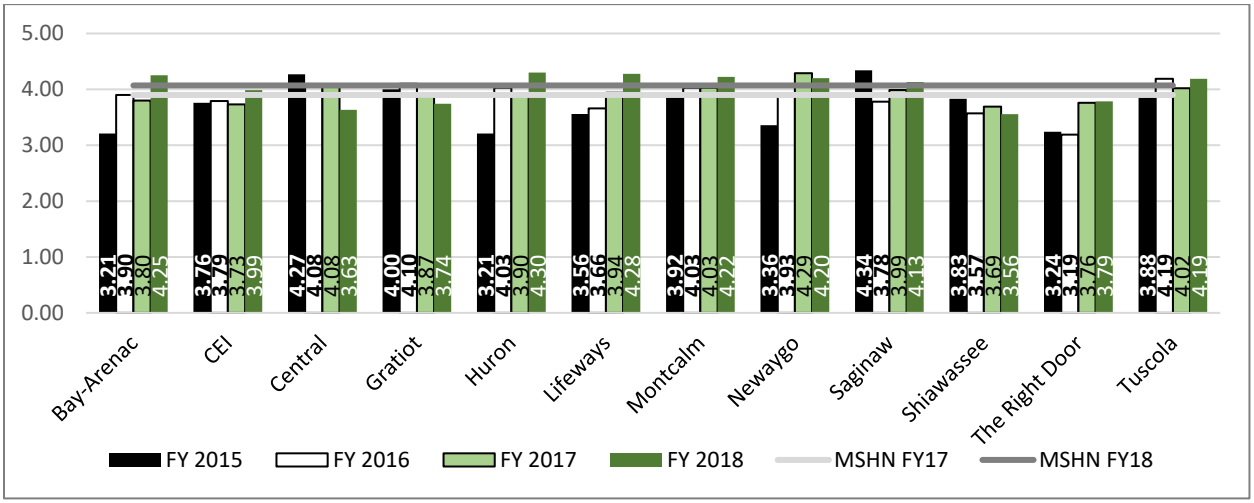
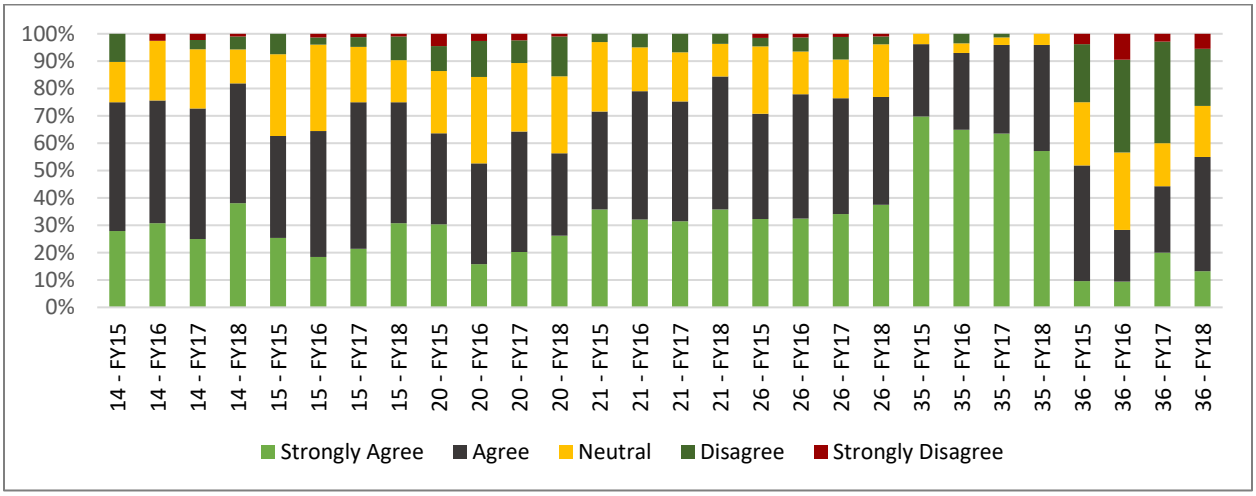


Figure 13 – MSHN - Diversity of Treatment Option Subcategory Survey Response by Percentage



Summary:

For the FY2018 survey period there was an increase of 16 participants overall who completed the assessment. The assessment consisted of six (6) separate subcategories that included Invite, Choice, Involvement, Life Goals, Individually Tailored Services and Diversity of Treatment. Five of the six sub categories demonstrated an increase.

The subcategories showed the following changes in the MSHN average score when compared to FY 2017 to FY 2018:

MSHN overall demonstrated an increase in all subcategory except the Invite subcategory. Invite: A decrease of .11 was exhibited from 2017. Three (3) CMHSP Participants demonstrated an increase in this subcategory. The question that scored the lowest was #2(4.36) - This program/agency offers an inviting and dignified physical environment. Each CMHSP demonstrated an average above 3.5 indicating agreement. Although this subcategory decreased from last year the average ranks 5th highest for all sub categories.

Choice: An increase of 0.12 was exhibited from 2017. Nine (9) of the CMHSP Participants demonstrated an increase. All responses scored above 3.5 indicating agreement with the statement. Questions #10 (4.40)– Staff listen to and respect the decisions that program participants make about their treatment and care and #27 (4.35)– Progress made towards an individual's own personal goal is tracked regularly, were the lowest overall for the region.
Involvement: An increase of 0.09 was demonstrated. Seven (7) CMHSP participants demonstrated an improvement. The questions that ranked the lowest within this sub category are #29 (3.11) Persons in recovery are involved with facilitating staff trainings and education at this program, #23 (3.55) People in recovery are encouraged to help staff with the development of new groups, programs, or services and #22(3.66) Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).
Life Goals: An increase of 0.05 was demonstrated. Seven (7) CMHSP Participants demonstrated an improvement in FY18. All responses scored above 3.5 for MSHN, indicating agreement with the statement. The mean for each question was above 3.50, however those questions that were ranked the lowest were #32 (3.92) Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests, and #17 (3.94) Staff routinely assist program participants with getting jobs.
Individually Tailored Services: An increase of 0.03 was demonstrated. Ten (10) CMHSP Participants demonstrated an increase. The question that ranked the lowest within this sub category was #13 (4.00) This program offers specific services that fit each participant unique culture and life experiences.
Diversity of Treatment: 0.17 increase. Eight (8) CMHSP Participants demonstrated improvement in FY18. The mean of all questions was above 3.5. The question that ranked the lowest within this sub category was #20 (3.72) Staff actively introduce program participants to person in recovery who can serve as role models or mentors.

Attachment 1 demonstrates the responses for each question ranked from the lowest to highest average for MSHN. The results will be reviewed further by the MSHN Quality Improvement Council to determine if there are any trends evident and if any regional improvement efforts would be recommended. Areas of improvement will be targeted toward below average scores (based on the regional average of all scores) and priority areas as identified through review by the Regional Consumer Advisory Council. Each CMHSP will also review their local results in all subcategories and identify any of local improvement recommendations.

Report Completed by: Mid-State Health Network **Date:** February 20,2019

MSHN QIC Approved: Date: February 28, 2019

#		MSHN	BABH	CEI	CMCMH	GIHN	HBH	Lifeways	MCN	NCMH	Saginaw	SHW	TBHS	The Right Door
29	Persons in recovery are involved with facilitating staff trainings and education at this program.	**3.11**	2.33	3.06	2.30	3.17	3.40	3.22	3.86	2.00	3.20	2.67	3.33	3.33
36	Groups, meetings, and other activities are scheduled in the evenings or on weekends so as not to conflict with other	**3.52**	3.71	3.57	3.08	3.86	4.60	3.00	3.89	2.00	2.63	2.00	3.67	3.60
23	People in recovery are encouraged to help staff with the development of new groups, programs, or services.	**3.55**	3.13	3.27	2.92	3.40	4.00	3.33	4.11	3.25	3.60	2.67	3.67	3.50
22	Staff actively help people find ways to give back to their community (i.e., volunteering, community services,	**3.66**	3.75	3.31	3.00	3.67	4.40	3.90	3.56	3.40	3.86	2.83	4.33	3.60
20	Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.	**3.72**	3.57	3.76	2.83	3.60	3.60	3.50	3.67	3.25	4.47	3.50	4.00	3.70
25	People in recovery are encouraged to attend agency advisory boards and management meetings.	**3.81**	3.25	3.50	3.42	3.17	4.40	3.20	4.33	2.67	4.00	3.40	4.33	3.89
33	This agency provides formal opportunities for people in recovery, family members, service providers, and	**3.89**	3.78	3.67	3.31	3.67	4.20	4.00	4.18	3.40	4.00	3.25	4.00	4.00
32	Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	**3.92**	3.67	4.06	3.54	3.86	3.00	4.30	4.00	4.00	4.80	3.00	3.33	3.78
34	This agency provides structured educational activities to the community about mental illness and addictions.	**3.94**	4.00	3.85	3.69	4.00	4.00	3.38	4.09	3.40	4.00	2.75	4.00	3.90
17	Staff routinely assist program participants with getting jobs.	**3.94**	4.25	4.00	3.85	4.14	3.80	3.90	4.11	4.60	4.00	3.33	3.67	3.33
13	This program offers specific services that fit each participant's unique culture and life experiences.	**4.00**	4.22	3.71	3.77	3.71	4.60	4.20	4.18	4.60	4.29	3.00	4.00	4.00
18	Staff actively help program participants to get involved in non-mental health related activities, such as church groups, adult	**4.04**	4.33	3.88	3.58	3.71	4.20	4.30	3.89	4.60	4.33	3.33	4.33	3.90
15	Staff offer participants opportunities to discuss their sexual needs and interests when they wish.	**4.06**	4.44	4.00	3.92	3.40	4.00	4.22	4.10	4.80	3.86	3.33	4.00	3.40

12	Staff encourage program participants to take risks and try new things.	**4.12**	4.11	4.06	3.92	3.83	3.80	4.20	4.18	4.60	3.93	3.50	4.00	4.20
24	People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service	**4.12**	4.11	3.75	3.83	3.71	4.40	4.30	4.36	4.20	4.40	3.00	4.67	4.11
8	Staff believe that program participants have the ability to manage their own symptoms	**4.14**	4.33	3.82	3.85	3.83	4.40	4.20	3.73	4.60	4.21	4.00	4.33	4.50
31	Staff are knowledgeable about special interest groups and activities in the community.	**4.15**	4.67	4.00	3.85	3.57	4.20	4.30	4.09	4.20	4.50	3.40	4.00	3.90
11	Staff regularly ask program participants about their interests and the things they would like to do in the community.	**4.16**	4.00	4.19	3.85	3.71	3.80	4.60	4.09	4.60	4.47	3.33	4.67	4.20
21	Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.	**4.19**	4.33	4.12	3.62	4.17	4.20	4.40	4.50	3.80	4.53	4.17	4.33	3.80
14	Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.	**4.21**	4.50	4.19	3.75	3.50	4.60	4.40	4.18	4.75	4.21	4.00	4.33	3.70
26	Staff talk with program participants about what it takes to complete or exit the program.	**4.22**	4.88	4.13	3.69	3.50	4.40	4.40	4.10	4.00	4.36	3.40	4.00	3.90
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).	**4.23**	4.44	3.81	3.92	3.86	4.40	4.50	4.18	4.40	4.67	3.50	4.33	4.40
30	Staff at this program regularly attend trainings on cultural competency.	**4.24**	4.33	3.94	4.23	3.86	4.80	4.33	4.36	4.40	4.93	2.83	3.67	4.10
27	Progress made towards an individual's own personal goals is tracked regularly	**4.35**	4.89	4.18	4.00	4.00	4.40	4.70	4.56	4.20	4.57	3.60	4.33	4.22
2	This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.).	**4.36**	4.33	4.12	4.46	3.43	4.40	4.50	4.55	4.00	4.60	4.33	4.33	4.80
7	Staff believe in the ability of program participants to recover.	**4.39**	4.56	4.12	4.08	4.43	4.40	4.50	4.18	4.75	4.64	3.83	4.33	4.70
10	Staff listen to and respect the decisions that program participants make about their treatment and care.	**4.40**	4.44	4.12	4.42	4.29	4.60	4.50	4.27	4.80	4.50	3.67	4.67	4.60

3	Staff encourage program participants to have hope and high expectations for their recovery.	**4.41**	4.78	3.88	4.31	4.17	4.80	4.50	4.27	4.20	4.71	3.67	4.33	4.44
16	Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g.,	**4.41**	4.75	4.24	4.08	4.29	4.80	4.60	4.09	4.80	4.79	4.00	4.33	4.50
5	Program participants can easily access their treatment records if they wish.	**4.42**	4.67	4.00	4.38	4.57	4.80	4.56	4.33	4.40	4.00	4.20	4.67	4.30
4	Program participants can change their clinician or case manager they wish.	**4.44**	4.22	3.88	4.42	4.43	5.00	4.70	4.78	5.00	4.93	4.80	4.67	3.50
9	Staff believe that program participants can make their own life choices regarding things such as where to live, when to work,	**4.45**	4.67	4.12	4.38	4.43	4.40	4.40	4.36	5.00	4.64	4.17	5.00	4.50
1	Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program	**4.53**	4.78	4.12	4.15	4.50	4.80	4.60	4.18	4.80	4.87	4.33	4.33	5.00
35	This agency provides a variety of treatment options for program participants (e.g., individual, group, peer support,	**4.56**	4.33	4.13	4.54	4.29	5.00	4.75	4.80	4.60	4.88	4.50	5.00	4.40
28	The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.	**4.61**	5.00	4.18	4.58	4.57	4.80	4.70	4.40	5.00	4.80	4.20	5.00	4.50
6	Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.	**4.81**	4.89	4.71	4.69	5.00	5.00	4.90	4.45	5.00	4.86	4.83	5.00	4.90

Color Key Codes for each Subcategory
Inviting Comprehensive
Choice Comprehensive
Involvement Comprehensive
Life Goals Comprehensive
Individually Tailored Services Comprehensive
Diversity of Treatment Comprehensive