

Quality Improvement (QI) Council Meeting Snapshot

Meeting Date: May 28th, 2026, 9:00am-11am

Attendance:

- | | | | |
|---|---|---|---|
| <input checked="" type="checkbox"/> MSHN – Kara Laferty | <input checked="" type="checkbox"/> Central – Jenelle Lynch | <input checked="" type="checkbox"/> MCN – Sally Culey | <input checked="" type="checkbox"/> SHW – Amy Phillips |
| <input checked="" type="checkbox"/> BABH –Sarah Holsinger | <input checked="" type="checkbox"/> Central – Alysha Fisher | <input checked="" type="checkbox"/> MCN – Melissa MacLaren | <input checked="" type="checkbox"/> SHW – Vicky Hoffman |
| <input checked="" type="checkbox"/> CEI – Elise Magen | <input type="checkbox"/> GIHN – Taylor Hirschman | <input checked="" type="checkbox"/> MCN – Joe Cappon | <input checked="" type="checkbox"/> TBHS – Josie Grannell |
| <input checked="" type="checkbox"/> CEI – Shaina McKinnon | <input checked="" type="checkbox"/> Huron – Levi Zagorski | <input checked="" type="checkbox"/> MCN – Adam Stevens | <input checked="" type="checkbox"/> The Right Door – Susan Richards |
| <input checked="" type="checkbox"/> CEI – Mica Gardyko | <input checked="" type="checkbox"/> Lifeways – Emily Walz | <input checked="" type="checkbox"/> SCCMH – Holli McGeshick | <input checked="" type="checkbox"/> The Right Door – Jill Carter |
| <input checked="" type="checkbox"/> CEI – Bradley Allen | <input checked="" type="checkbox"/> Newaygo – Andrea Fletcher | <input checked="" type="checkbox"/> SCCMH – Jenna Brown | <input checked="" type="checkbox"/> Other: GIHN- Sarah Bowman |
| <input checked="" type="checkbox"/> CEI – Kaylie Feenstra | <input type="checkbox"/> Newaygo – Jill Mckay | | |

AGENDA ITEM TOPIC	KEY DECISIONS/QUESTIONS	ACTION REQUIRED (WHO, WHEN)
Review/Approvals (All)	<p>Announcement: Congratulations Sally C. on her retirement in June! This is her last QIC meeting. Thank you Sally for all of the amazing work you have done in Quality over the years and for your wonderful contributions to QIC and the MSHN region. We wish you the absolute best in retirement!</p> <ul style="list-style-type: none"> • Review/Approve Meeting Minutes from April 23rd, 2026 <ul style="list-style-type: none"> ○ Approved- no questions or concerns • Any changes/additions to this month’s Agenda? <ul style="list-style-type: none"> ○ No changes or additions noted 	
Consent Agenda (All)	<ul style="list-style-type: none"> • No items for consent on this agenda 	
In-Person QIC Meeting	<ul style="list-style-type: none"> • Discussion: After speaking to a few group members, there was potential interest in having an in-person group meeting this summer. Can we please take a poll by raise of hands if people would be interested in holding our June, July, or August meeting in person? If there is interest in this, would anyone be able to host us? <ul style="list-style-type: none"> ○ There was agreement by the QIC that an in-person meeting should occur this summer. After voting, it was decided that a hybrid meeting would be offered for July’s QIC meeting (July 23rd) at Saginaw. • Action Needed: Kara will work with Holli at Saginaw to set-up the room and necessary technology to offer a hybrid meeting for the July QIC meeting. 	

<p>MDHHS Waiver Audit Updates (All)</p>	<ul style="list-style-type: none"> • Discussion: MSHN reviewed 907 staff files and submitted to MDHHS. Additional files were reviewed and determined (by CMHs) to be duplicates or that the staff did not provide a waiver-specific service (those files were subsequently deleted at the direction of the CMH file owner) <ul style="list-style-type: none"> ○ All Admin review documents were submitted as well ○ MDHHS review begins 5/18 and this schedule was sent out • Action Needed: No action needed, informational only at this time. 	
<p>HSAG Audit Timelines PMV 2026 (Kara/All)</p>	<ul style="list-style-type: none"> • Discussion: <ul style="list-style-type: none"> ○ The ISCAT was completed by MSHN and submitted to HSAG which included everyone's source code. ○ Year 1 HEDIS metrics will also be reviewed, but it is unclear what the outcome of that review may be and what questions will be asked of MDHHS. ○ Please note that MSHN was informed that only 5 PSV files will be selected for indicator 2 for the entire MSHN region for this year! We will be required to do our typical Proof-of-Service (POS) document review where you provide all of the proofs for this sampling to ensure our logic for indicator 2 (we should receive the sample by EOB on 6/3 to provide to CMHSPs for completion by EOB 6/5). Official/final due dates will be provided once we receive that sample from HSAG. MSHN will have a virtual review then between 6/15/26-7/31/26, date unknown at this time (but it is tentatively set for the week of July 7th). • Action Needed: No action needed, informational only at this time. Kara will provide sample to the CMHSPs when this is received from HSAG. 	
<p>Final HSAG Performance Improvement Projects (PIPs) Report (Kara)</p>	<ul style="list-style-type: none"> • Document: HSAG PIP Submission 2026 • Discussion: This is informational only, please note that the final HSAG PIP report was submitted to HSAG on May 5th. This final report to HSAG identified that we made statistically significant improvements in eliminating the racial disparity between the index (White) population and the Black/African-American population, however, there remained a statistically significant difference in the reduction in rates of compliance for White individuals between the baseline and CY2025. • Action Needed: No action needed, informational only at this time. 	
<p>Performance Improvement Topic (Kara/All)</p>	<ul style="list-style-type: none"> • Discussion: Kara was informed at the PIHP QI Workgroup meeting that as of 5/12/26, MDHHS informed one of the regions that MDHHS is leaning towards allowing PIHP choice of a Medicaid core measure for a PIP, however, this has not been officially approved by HSAG yet. If this is the case, we'll need to select a HEDIS measure. Other regions are currently waiting on starting PIP discussions until further guidance has been provided by MDHHS. No official timeframes for implementation have been discussed by MDHHS yet. <ul style="list-style-type: none"> ○ Top 3 projects identified through surveying include: <ul style="list-style-type: none"> ▪ Improving rates with Access to Care metric (same logic as indicator 2), 7/12 votes ▪ Focus on increasing compliance for the FUM-30 TOT HEDIS metric, 6/12 votes ▪ Medicaid Redetermination support and continuity of coverage, 4/12 votes • QIC Discussion occurred about the difficulties that increasing compliance for the ACC metric would bring as so much work has already been done with this metric. Without significantly changing the numerator/denominator logic, it's likely that improvement opportunities will be limited with the ACC metric due to improvement efforts that have already taken place. • QIC also discussed the CDF metric- CCBHC's have this already built in their systems for CCBHC clinic measure reporting. The group requested additional information on this HEDIS metric (as this is a year 3 metric for the Behavioral Transformation project with MDHHS that will need to be looked at anyways) to determine how MDHHS is pulling this metric. 	

	<ul style="list-style-type: none"> • Action Needed: Kara to reach out to MDHHS to determine the logic behind the percentage calculation for CDF to garnish additional information to determine if this would be a good project. At this time, further discussion on potential PIP's will be held until additional information is obtained through MDHHS relating to timeframes and allowable PIPs. 	
<p>Satisfaction Surveying- progress and FY26 surveying (Kara/All)</p>	<ul style="list-style-type: none"> • Documents: All FY26 CMHSP Satisfaction survey information and documents • Discussion: Does anyone have any questions relating to the FY26 Satisfaction Survey process or documents that have been provided to begin implementation of this project in June? <ul style="list-style-type: none"> ○ CEI requested confirmation regarding CCBHC individuals; because we are no longer requesting that these individuals have separate program confirmation within reporting to MSHN, it is okay to just submit CCBHC individuals within the overarching survey data that is provided to us. Please note that if specific CCBHC direction has been provided by MDHHS relating to CCBHC only individuals vs. dual served being provided in their data set for surveying that is due, please follow their direction/guidance. • Action Needed: CMHs to begin surveying process in June. 	
<p>Critical Incident Submissions (Kara/All)</p>	<ul style="list-style-type: none"> • Discussion: MSHN received updated MDHHS direction (please see email here) relating to critical incident falls on 5/15/26. Please note that for any falls that are occurring, the notes/additional information section of the incident should be updated to ensure that the narrative carries through to the CRM which indicates what happened that led to the fall. In addition, if asked to complete remediations, you must include details relating to the fall, what interventions were provided, and what actions are being taken to remediate these falls for this individual and/or this provider. Please see below for additional information received from MDHHS: <div data-bbox="527 732 1560 1479" style="border: 1px solid black; padding: 10px;"> <p>Falls:</p> <ul style="list-style-type: none"> • MDHHS will stop requesting remediations for every fall reported effective 5/15/26. • Effective 5/15/26, when MDHHS completes their review of a critical incident reporting a fall we will be pending them back to request more information. In this section, just provide a brief summary of what happened that led to the fall. When reporting falls, please be sure the narrative is completed to provide this information. • The PIHP will still be required to complete current remediations requested in the PIHP queue. In those remediations, please provide the following information: <ul style="list-style-type: none"> ○ Details regarding the fall. ○ What interventions were provided. ○ Language that indicates the PIHP will continue to monitor the number of falls for this individual has and if a pattern is noted, the PIHP will request intervention or corrective action. <p>Emergency Medical Treatment or Hospitalization Due To Injury:</p> <ul style="list-style-type: none"> • Effective July 1, 2026, MDHHS will be requesting that further information be provided related to these critical incidents in the narrative section of the critical incident. Information should include what transpired that led to the emergency medical treatment or hospitalization. • For current incidents under MDDHS review, if we see a pattern, we will request a remediation. In the remediation we need the following information: <ul style="list-style-type: none"> ○ A summary of the PIHP review of the incidents. (What did you find, is there correlation, etc.) ○ What actions or interventions were taken to remediate. (The individual started a new service, medication changes, increase in frequency of services or supervision, modifications.) </div> <p>This is the field within the IR that must be completed to carry forward these notes to the CRM on incidents:</p>	

Reporting Information

This event is reportable:
 Yes No

General Fund ⓘ Third Party Payer/Commercial Insurance ⓘ

Void

Provider Name ⓘ Submitter ID ⓘ Incident ID ⓘ

Notes/Additional Information

- **Additional Critical Incident Reminders:**
 - We are receiving a lot of reminders about being out-of-compliance for death determinations, as a reminder we are able to submit best determination judgments and note that these are only best judgment determinations. These must be submitted within 90 days of the death occurring and we can update the cause of death later once official results (autopsy/death reports) have been obtained.
 - We have a lot of timeliness remediations that have been occurring; this is a reminder that if you are outside of the timelines for reporting incidents, you will be required to complete a remediation form. Remediations must include ways in which you have changed process, trained staff, etc. to prevent these issues from reoccurring. MDHHS is watching for patterns of this and to determine if interventions are working.
 - **Discussion:** CEI asked questions relating to EMT due to injuries and what is currently being reported by their system. It appears not everyone is consistent in the reporting of this category, specifically regarding follow-up with PCPs as well as urgent care facilities. All CMHSPs should review their criteria for reporting of EMR due to injury categories and ensure that systems are accurately reporting these so we have consistency as a region.
- **Action Items:** All CMHSPs to review MSHN policies and procedures relating to critical incident submissions as well as the latest FAQ document which is located here (<https://mshn.app.box.com/file/2250961703013>) along with the manual that is currently in draft form located here: <https://mshn.app.box.com/file/2234491732703> to ensure that CMHSP critical incident reporting is capturing all incidents correctly.

MSHN HEDIS Metrics/Priority Measure Report (Kara/All)

- **Documents:** [MDHHS Final Year One HEDIS Metrics Report](#) , [MSHN HEDIS Year 1 Report](#), [MSHN HEDIS Metrics and Measure Information](#)
- **Discussion:** MSHN was recently provided the Year One final HEDIS metric report from MDHHS. This report was reviewed and condensed to just MSHN Year One performance along with longitudinal data to summarize and pull out metrics to action. As requested by the MSHN QIC group, expectations relating to HEDIS metrics by the CMHSPs was added to the MSHN HEDIS Year 1 Report as well as the MSHN HEDIS Metrics and Measure Information document to ensure CMHSPs are aware of requirements as well as expectations.
- Please note that quarterly detail files for the priority measures will contain a column which indicates whether an individual has touched the CMH system (via encounter data) so that it is easier for CMHs to review truly actionable individuals rather than all Medicaid individuals in your catchment area. This will roll out for CY2025Q4 data (which should be available in June).
- After discussion of these documents, the CCBHCs let the group know that there was discussion relating to new CY26 codes counting into HEDIS metrics; the following information was recently provided by MDHHS relating to FUH, FUM, and FUA measures where case management will now count into the numerator for these measures for the 2026 reporting period:

	<p style="text-align: center;">Matthew Kelley, Data & Evaluation Specialist at kelley122@michigan.gov</p> <ul style="list-style-type: none"> • Notice of Addition of T1017 for FUH, FUM, FUA Measures <ul style="list-style-type: none"> ○ The 2026 CMS Core Set allows for T1017 (targeted case management) to count toward the numerator for the follow-up measures (FUH, FUM, FUA). This change applies to the Calendar Year 2026 reporting period only. ○ Future State-led measure TA will further discuss interpreting the Core Sets to identify the codes applicable to each of the State-led measures. • Action Needed: CMHSPs to review HEDIS metric reports, specifically the obligations of the CMHSPs and follow-up for when CMHSP performance is below benchmarks. 	
<p>Upcoming Reporting Requirements</p>	<ul style="list-style-type: none"> • MDHHS Waiver Audit- 5/18/26-7/31/26- MSHN has developed a process and guidance on documentation submission, timelines, and related matters (Amy D. sending out weekly updates/FAQ's) • MMBPIS FY26Q2 Data- 6/15/2026 deadline (as a reminder, CCBHC only individuals should be removed prior to data submission to MSHN). CCBHC's, if at all possible, please submit your data as soon as possible and we will complete the encounter data validation checks we have been doing since not all of you have a PCE flag in your system to remove individuals. 	
<p>Standing Agenda Item: Committee Updates (Kara/All)</p>	<ul style="list-style-type: none"> • MDHHS QIC Updates: Next meeting is June 3rd, no updates from May • PIHP Quality Workgroup Updates (Kara): The PIHP QI workgroup met on 5/12/26. The focus of this meeting included: <ul style="list-style-type: none"> ○ PIP projects and estimated timelines (as of 5/12/26, most PIHPs have not started discussions on identification of a PIP due to lack of information provided by MDHHS on direction) ○ MMBPIS/Performance Metrics: It was confirmed that most other PIHPs are doing the same double validation checks using encounter data as MSHN is where CCBHC consumers are being removed from reporting. Oakland (they are a CCBHC), have indicated they are excluding anyone that MIGHT have been a CCBHC consumer from their screening request as omissions/exclusions ○ Critical Incidents: Concern across all the PIHPs that there is duplicate reporting potentially occurring as MDHHS is requiring CCBHC individuals be entered into the CRM separately- additional direction and discussion has not occurred with the PIHPs at this time from MDHHS • CIR PIHP Leads Meeting: Review of the Critical Incident Technical handbook that was presented by PIHP workgroup members in March of 2025 to MDHHS was gone through. This conversation will continue in June as not all questions were answered/addressed by MDHHS. • Quality Transformation Workgroup: Cancelled for May, next meeting on 7/22/26 – email from MDHHS stated, “We also have heard the feedback and desire to not expand the scope of topics as the workgroup does not have everyone that may be needed for those discussions. We have decided to change the meeting cadence to meet every other month and will take the broader and other quality-related topics to the QIC meetings. We look forward to meeting with you in July and will plan to discuss the data that becomes available in June, and any questions related to that. If anything comes up between now and then please don't hesitate to reach out.” • BH-TEDs Updates: Holli- MH-CLD Update document for current updates to MH-CLD changes • National Core Indicator Advisory Council: Any updates from any council members? 	

<p>Standing Agenda Item: Open Discussion/Consultation (All)</p>	<ul style="list-style-type: none"> • Move to June meeting as unable to discuss in May due to time: Holli- Saginaw: Staff has brought up frustrations from persons served when they are transferring from other counties to our services because they indicate they are not aware that there will be a lapse in their services, specifically CLS services and that the process essentially starts over with Intake. My question/conversation with the group would be what are their transfer procedures like? Do they speak with the person that is transferring about the lapse in service, is it the responsibility of the incoming CMH, what can we do better to improve this process, etc. 	
<p>Relevant Informational Documents that may be of Interest:</p>	<ul style="list-style-type: none"> • 2025 Accurate Picture Initiative Statewide Satisfaction Survey Report- CMHAM • PBIP FY26 Joint Care Specifications • MDHHS Final Year One HEDIS Metrics Report • HSAG Final Reports and Results for Priority Measure Validation (PMV), Encounter Data Validation (EDV), and Compliance from 2025 	
<p>Previous Action Item Follow-up</p>	<ul style="list-style-type: none"> • Priority Measure Report FY25Q4: Kara to put together an informational document/presentation around expectations and HEDIS measures for the CMHSPs to begin looking at (Completed for May QIC meeting) 	

Summary Action Items from Meeting

<p>CMHSP's</p>	<ul style="list-style-type: none"> • Critical Incident Submissions: All CMHSPs to review MSHN policies and procedures relating to critical incident submissions as well as the latest FAQ document which is located here (https://mshn.app.box.com/file/2250961703013) along with the manual that is currently in draft form located here: https://mshn.app.box.com/file/2234491732703 to ensure that CMHSP critical incident reporting is capturing all incidents correctly. • MSHN HEDIS Metrics/Priority Measure Report: CMHSPs to review HEDIS metric reports, specifically the obligations of the CMHSPs and follow-up for when CMHSP performance is below benchmarks.
<p>MSHN/Kara</p>	<ul style="list-style-type: none"> • In-Person QIC Meeting: Kara will work with Holli at Saginaw to set-up the room and necessary technology to offer a hybrid meeting for the July QIC meeting. • Performance Improvement Project Topics: Kara to reach out to MDHHS to determine the logic behind the percentage calculation for CDF to garnish additional information to determine if this would be a good PIP.