MSHN
Mid-State Health Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP) 2017

ANNUAL EFFECTIVENESS AND EVALUATION 2016

Prepared By: MSHN Compliance Officer & Quality Improvement Council – January 26, 2017
Reviewed By: MSHN Operations Council – February 21, 2017
Approved By: MSHN Board –

TABLE OF CONTENTS

SECTION ONE – ANNUAL PLAN

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM 2016-2017

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 County Community Mental Health Services Authority, , 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 County Community Mental Health Authority, The Right Door (formerly Ionia County Community Mental Health Authority) 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 FY2017, 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. STRUCTURE (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016) (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.

IV. COMPONENTS (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016) (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).

V. GOVERNANCE (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2015)

<u>Board of Directors</u>
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 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 Compliance Officer (CO) as the chair of the MSHN Quality Improvement Council. In this capacity, the CO 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 **(Section Two)**. 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 **(Section Three)**.

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.

Recipients (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

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.

VI. COMMUNICATION OF PROCESS AND OUTCOMES (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

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.

VII. PERFORMANCE MEASUREMENT

General Methods (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

The Quality Assessment and Performance Improvement Program encourages the use of objective and systematic forms of measurement. Each measure must have a baseline measurement when possible, should be re-measured at least annually, and should be actionable and likely to yield credible and reliable data over time. 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.

MSHN implements a Balanced Score Card (**Section Four**) to monitor the effectiveness of the PIHPs strategic priorities and provides dashboards to evaluate performance overtime for all important

organizational functions.

Data Collection and Analysis

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 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.

Undesirable patterns or trends in performance are identified, as well as undesirable variations in performance, and acted on as appropriate. In some instances, further data collection and analysis is necessary to isolate the causes of poor performance or excessive variability.

MSHN staff, in collaboration with the QIC, prepares an analysis of the data, including recommendations for further investigation, data collection improvements to resolve data validity concerns, and/or system improvements.

Taking Action

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.

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, 2016)

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.

VIII. EVENT MONITORING AND REPORTING (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

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 FY16 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

IX. BEHAVIOR TREATMENT (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)(c) Waiver Program 2016 Attachment P1.4.1, Technical Requirement for Behavioral Treatment Plan Review Committees-2012)

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 Technical Requirement for 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 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 shared on a quarterly basis with MDHHS. 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. Data shall include numbers of interventions and length of time the interventions were used per person.

X. 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 through MSHN. 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 on a monthly basis with the CMHSPs within its region and calls for ongoing system and consumer-level improvements.

XI. QUANTITATIVE AND QUALITATIVE ASSESSMENT OF MEMBER EXPERIENCES (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

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.

XII. PRACTICE GUIDELINES (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

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 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 each individual receives the most efficacious services. Practice guidelines as stated above are reviewed and updated annually or as needed, and are disseminated to appropriate providers.

XIII. CREDENTIALING, PROVIDER QUALIFICATION AND SELECTION (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

In compliance with MDHHS's Credentialing and Re-Credentialing Processes (FY16 Attachment P7.1.1,), 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 the 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 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.

XIV. MEDICAID EVENT VERIFICATION (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016 and Medicaid Event Verification Technical Requirement)

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.

XV. UTILIZATION MANAGEMENT PLAN (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

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. Communication with individuals regarding UM decisions, including adequate and advance notice, right to second opinion, and grievance and appeals will be included in this delegated function.

Utilization review functions is 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, and 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.

XVI. PROVIDER MONITORING (Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program - Attachment P7.9.1, 2016)

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.

XVII. OVERSIGHT OF "VULNERABLE PEOPLE"

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.

(2017). *Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program.*

(2017). *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.*

(2017). *Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)(c) Waiver Program 2015 Attachment P1.4.1, Technical Requirement for Behavioral Treatment Plan Review Committees-, Revision FY'12.*

(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.

I. Council FY16 Accomplishments & FY17 Goals

ANNUAL REPORT

TEAM NAME: Operations Council

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

REPORT PERIOD COVERED: 10.1.15 – 9.30.16

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 Services 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 10 meetings during the reporting period. The role of the Operations Council is in part to advise MSHN, oversee operations, and promote effective and efficient operations. The following accomplishments of particular importance are noted:
    - Addressed CMHSP-level cash flow difficulties being experienced at just over half of the region's CMHSPs and partnered to identify and implement resolution strategies
    - Successful External Quality Reviews by the Health Services Advisory Group (HSAG)
    - Successful MDHHS Contract Compliance Review
    - Expanded Autism Spectrum Disorder covered benefits across the region
    - Ensured successful implementation of the Supports Intensity Scale (SIS) system across the region
    - Enhanced Waiver compliance, utilization and quality management systems
    - Completed Operations Council and Board Retreats leading to revised Regional Strategic Plan
    - Confirmed and continued implementation of CMHSP Five Year Funding Smoothing Plan
    - Assisted in the development of funding criteria for PA2 projects
    - Planned for future collaboration, implemented and led collaboration activities between MSHN and Medicaid Health Plans
    - Continued work on Home and Community Based Services Waiver Transition (including consumer/provider survey process)
    - Enhanced local access for citizens with substance use concerns through SUD provider network partnerships with CMHSPs on a 24/7/365 basis
    - Continued metrics development and monitoring (Operations Council Balanced Scorecard)
    - Continued addressing penetration rate improvement strategies
    - Advocacy with Certificate of Need Commission (and other policy makers) to improve access for individuals requiring psychiatric inpatient care, especially those with challenging behaviors, and advocated for expanded inpatient bed availability
    - Completed Annual Policy Review Processes
    - Retained commitment to core values and collective focus despite external threats associated with Governor Snyder's Budget Proposal, in particular sec. 298.
    - Developed regional approach to consumer-initiated care transitions and CMHSP out-of-county placements.
    - Assisted in the development of improved and streamlined admission processes for veterans.
    - Facilitated CMHSP partner dialog on administrative and clinical efficiencies including short- and long-term financial management strategies

b. Upcoming Goals for Fiscal Year Ending, September 30, 2017
    - Improve consistency, standardization and cost-efficiency in retained and delegated managed care activities
    - Establish systems to improve performance in follow-up after hospitalization for mental illnesses between PIHPs and MHPs and within the MSHN region
    - Home and Community Based Services Waiver Transition implementation
    - 1115 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.

- Collaborate and support CCBHC Prospective Payment System funding to MDHHS-designated pilot sites (assuming Federal approval)
- Establish effective regional utilization management systems, including regional eligibility, medical necessity, authorization, utilization review and related protocols and procedures to promote universal and equitable local access to care across the region
- Increase efficiency through collective provider network management functions
- Increase focus on meaningful metrics to measure performance and impacts
- Achieve comprehensive penetration rate improvement strategies
- 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.
- Assist MSHN with implementation of the 2017/2018 Regional Strategic Plan

ANNUAL REPORT

TEAM NAME: Finance Council

TEAM LEADER: Leslie Thomas, MSHN CFO

REPORT PERIOD COVERED: 10.1.15 - 9.30.16

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 2015 and February 2016. 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 2016.
- Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2015 Final Reports due to MDHHS February 28, 2016, are received from the CMHSPs to the PIHP. The goal for FY16 will be to spend at a level to reduce MSHN combined reserves to 7.5% as identified by the board.
- Work toward a uniform costing methodology: Finance Council will begin working on uniform unit costing for services in FY 2016.
- Assure region wide rates are within acceptable deviations from state wide rates: The Medicaid Uniform Cost Report (MUNC) is due to MDHHS February 28, 2016. MDHHS will compile the PIHP reports and send an analysis to the PIHPs in June of 2016. 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 – Finance Council members continue to populate the fiscal year 2014 Dashboard. The goal is to have the dashboard complete by April 2016.
- 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. Due to time constraints MSHN's Finance Council will develop a subset of guidelines for this reporting cycle.
- Monitor the impact on savings and reserves related to the change in Autism funding.

Annual Evaluation Process

a. Past Year's Accomplishments:
    - Finance Council should establish an objective measure for favorable fiscal and compliance audit: The majority of CMHSPs in the region submitted audits to MSHN by the April 2016 guideline.
    - Meet targeted goals for spending and reserve funds: It is anticipated that reserves will decrease when the FY 2016 FSRs are received the by end of February. FY 2015 had a reserve 10.9%. FY 2016 will have an approximate reserve of 6.63%. The reduction is related to a $9.4M abatement of Internal Service Funds (ISF) to assist with FY 2016 CMHSP Autism Cost settlements. MSHN will continue to disburse benefit stabilization funds in fiscal year 2017 to cover anticipated PEPM deficits for some CMHSPs and to also cover 24/7 365 Substance Use Disorder (SUD) Access.
    - The Finance Council's efforts continue related to uniform costing for services. The FY 2015 dashboard has been completed as well as a Medicaid Utilization Net Cost (MUNC) comparison in order to identify significant outliers by Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes.
    - The Finance Council established a workgroup in order to improve reporting consistency related to administrative costs. Although there have been several meetings, the workgroup continues its efforts to establish more consistent reporting in conjunction with the Administrative Cost Tool developed by the PIHP CFOs. The goal is to clearly define FY 2016 reporting changes by mid-December.

- MSHN has gathered Autism expense information from the CMHSPs throughout FY 2016. This information along with data contained within the Projected and Interim FSRs submitted by the CMHSPs has allowed MSHN to clearly identify the amount of Medicaid savings needed to cover cost associated with the fee screen established as of January 1, 2016.

b. Upcoming Goals for Fiscal Year Ending September 30, 2017:
   - Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2016 and February 2017. 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 2016 Final Reports due to MDHHS February 28, 2017, are received from the CMHSPs to the PIHP. The goal for FY17 will be to spend at a level to maintain MSHN's anticipated combined reserves to 7.5% as identified by the board.
   - Work toward a uniform costing methodology: Finance Council will continue working on uniform unit costing for services in FY 2017.
   - Assure region wide rates are within acceptable deviations from state wide rates: The Medicaid Uniform Cost Report (MUNC) is due to MDHHS February 28, 2017. MDHHS will compile the PIHP reports and send an analysis to the PIHPs in June of 2017. 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 2015 Dashboard. The goal is to have the FY 2016 dashboard complete by April 2017.
   - 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. Due to time constraints MSHN's Finance Council will develop a subset of guidelines for this reporting cycle.
   - 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 CIO

REPORT PERIOD COVERED: 10.1.15 – 9.30.16

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; and
- Meet IT audit requirements (e.g., EQRO).

Annual Evaluation Process:

a. Past Year Accomplishments
    - Representation from each CMHSP Participant at all meetings:
        - There was a 95% rate of attendance at FY16 ITC meetings. 100% attendance occurred in 9 meetings.
    - Successfully submit MDHHS required data according to MDHHS requirements regarding quality, effectiveness and timeliness;
        - Successful data submission as we met all requirements for MDHHS.

    - This process includes: encounters, BH-TEDS, QI, PI and CIR. Year-end statistics from MDHHS showed that we were 100% timely with encounter submissions.
- All CMHSPs were successful in changing operations to report BH TEDS records.
- All CMHSPS converted to reporting using ICD-10 codes.
- Dashboard reporting based on MSHN data warehouse was identified as a goal and ITC worked to develop additional reporting needs and to make those reports available and useful. Actual dashboard reporting will continue in FY2017 as a goal.
- Accomplish annual goals established by the IT Council and/or OC:
    - Developed a Health Information Exchange process with MiHIN, MSHN and All CMHSPs to receive Admission/Discharge/Transfer records and to make this information available in CMHSP EMRs for treatment purposes.
    - Continued the development of Utilization Management supplemental data set to be received from CMHSP EMRs into MSHN data warehouse.
    - Developed a process to use the MDHHS 834 enrollment file to identify which Medicaid Health Plan (MHP) a consumer is enrolled.
- Meet IT audit requirements (e.g., EQRO):
    - The HSAG audit was a success as all of the documentation submitted was reviewed and approved. No items needed correction in FY2016. All 12 CMHSPs participated in the site review process and documentation supports findings and recommendations.

b. Upcoming Goals for Fiscal Year Ending September 30, 2017
- Participation by all CMHSPs at each monthly meeting.
- Continue to meet the requirements defined for successfully submitting MDHHS defined reporting.
- Develop necessary alerts and/or lists to support addressing any quality measures and outcomes as defined by MDHHS. (Follow-up after hospitalization)
- Further develop HIE processes so that data can move between CMHSPs and MSHN as appropriate for improving consumer health and protecting privacy.
- Achieve goals established by the IT Council and/or OC; and
- Meet IT audit requirements (e.g., EQRO)

ANNUAL REPORT

TEAM NAME: Quality Improvement Council

TEAM LEADER: Kim Zimmerman, MSHN Director of Compliance, Customer Service and Quality

REPORT PERIOD COVERED: 10.1.15 – 9.30.16

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 Compliance Officer (CO) and the CMHSP Participants' Quality Improvement staff appointed by the respective CMHSP Participant Chief Executive Officer/Executive Director. 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.
- Implementing a Peer Review Process that incorporates best practices related to the QAPIP and Compliance Plan to encourage continuous quality improvement.

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);
- 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 thirteen (10) meetings during the reporting period and in that time completed the following tasks:
    - Reviewed and revised the MSHN Corporate Compliance Plan
    - Annually reviewed and revised (as needed) current regional policies and procedures in areas of Quality Improvement and Compliance
    - Implementation and quarterly reporting/review of regional QAPIP including:
        - Behavior Treatment Review
        - Critical Incidents
        - Performance Improvement (MMBPIS)
        - Consumer Satisfaction (MHSIP and YSS)
    - Feedback and participation in the External Quality Review (Compliance Monitoring Review)
    - Revised, implemented and providing ongoing monitored for two (2) regional Performance Improvement Projects (PIP) (HEDIS Measure and the RSA/RAS)
    - Provided feedback on SUD integration into current policies, procedures and practices (including Compliance Plan and QAPIP)
    - Reviewed and provided feedback on the MSHN Compliance Summary report
    - Assisted in establishing ongoing monitoring for the region wide Medicaid Event Verification process
    - Developed regional standardized Privacy Notice
    - Increased 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 QAPIP
    - Completed the annual QAPIP effectiveness plan

b. Upcoming Goals for Fiscal Year Ending, September 30, 2017
    - 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
    - Complete annual review and revisions of Corporate Compliance Plan
    - Provide Feedback on annual Compliance Summary Report
    - Review available healthcare data for identification of trends and quality improvement opportunities
    - Review Clinical Outcomes Data (Autism, CAFAS, SIS, LOCUS, etc) in coordination with other MSHN committees for effectiveness, comparison and opportunities for quality improvement
    - Explore BH-TEDS data as related to QI efforts

II. Advisory Council FY16 Accomplishments & FY17 Goals

ANNUAL REPORT

TEAM NAME: Regional Consumer Advisory Council

TEAM LEADER: Kim Zimmerman, MSHN Director of Compliance, Customer Service and Quality

REPORT PERIOD COVERED: 10.1.15 – 9.30.16

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

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

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

Defined Goals, Monitoring, Reporting and Accountability

The CAC shall review aggregate reports received from the Quality Assessment and Performance Improvement Program (QAPIP), provide recommendations, and give guidance and suggestions regarding consumer-related managed care processes.

Provide feedback for regional initiatives designed to encourage person-centered planning, self-determination, independent facilitation, anti-stigma initiatives, community integration, recovery and other consumer-directed goals.

Share ideas and activities that occur at the local CMHSP level and create an environment that fosters networking, idea sharing, peer support, best practices, and resource sharing.

Annual Evaluation Process:

a. Past Year's Accomplishments: The RCAC had 6 meetings during the reporting period in that time they completed the following tasks:
   - Reviewed the Annual Compliance Report
   - Reviewed and provided feedback on the Annual Compliance Plan
   - Reviewed the Summary Report related to the FY15 Performance Improvement Projects
   - Reviewed changes to the 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 input on the MHSIP and YSS satisfaction survey results
   - Reviewed and provided feedback on the SUD satisfaction survey results
   - Discussed internal delegated managed care site reviews and outcomes
   - Discussed external quality reviews including MDHHS and HSAG reviews and outcomes
   - Reviewed the MDHHS National Core Indicator (NCI) reports (A Guide to PCP and The Importance of Relationships) and provided feedback on identified barriers
   - Reviewed and approved RCAC annual effectiveness report
   - Reviewed and provided feedback on the Quality Assessment and Performance Improvement Program (QAPIP)
   - Reviewed various MSHN policies and procedures for feedback
   - Received various presentations related to Customer Service and Quality such as MDHHS site review results, Autism and HSW waiver program, Utilization Management, Substance Use Disorder, External Quality Reviews, 298, 42 CFR, Compliance Training, MSHN strategic planning, etc.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2016:
   - 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 MHSIP, YSS, and external quality reviews
   - Review annual compliance report
   - Annual review and feedback on QAPIP
   - Annual Review and Feedback on Compliance Plan
   - Annual review of policies and procedures related to Customer Service
   - Annual review of MSHN Consumer Handbook
   - Review and advise MSHN Board relative to strategic planning and advocacy efforts
   - Provide advocacy for consumer related issues identified as region wide barriers
   - Develop letters of support/advocacy on issues that affect quality of life for those served (for example, the reduction/elimination of spend downs)

III. Oversight Board FY16 Accomplishments & FY17 Goals

ANNUAL REPORT

TEAM NAME: SUD Oversight Policy Board

TEAM LEADER: Carl Rice, PhD. SUD Board Member

REPORT PERIOD COVERED: 10.1.15 – 9.30.16

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 Education on the following:
     - MSHN Strategic Plan
     - SUD Strategic Plan
     - MSHN SUD Prevention Services
   - Election of OPB Board Officers
   - Approval of revisions to ByLaws
   - Approval of Public Act 2 Funding for FY16
   - Received PA2 Funding reports – receipts & expenditures by County
   - Received Quarterly Reports on Prevention and Treatment Goals and Progress
   - Received reports on SUD regional site review status
   - Approved and adopted MSHN Interest Allocation Policy
   - Offered insight on SUD programming, funding and functions
   - Offered recommendations and insight regarding effective use of collaborative and community efforts

b. Upcoming Goals for FY17 ending, September 30, 2017:
   - Approve and monitor use of PA2 funds for prevention and treatment services in each county;
   - Monitor and provide input regarding the implementation of the three-year SUD Strategic Plan;

- Explore strategies for jail diversion including coordination with Department of Corrections;
- Share successful 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 FY16 Accomplishments & FY17 Goals

ANNUAL REPORT

TEAM NAME: Autism Benefit Workgroup

TEAM LEADER: Katy Hammack, MSHN Waiver Coordinator

REPORT PERIOD COVERED: 10.1.15 – 9.30.16

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.
- 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).

<u>Annual Evaluation Process:</u>

a. Past Year's Accomplishments
   - The Autism Benefit Workgroup met quarterly and as needed
   - The Autism Benefit Workgroup responded to the individual elements of results of the MDHHS site review of the CMHSP autism programs and continued to work on related products.
   - Updated autism policy to reflect the new MSA-1559 policy due to expansion
   - Provided several training opportunities aimed at increasing capacity and implementation of ABA treatment services.
   - Provided training to prepare for the implementation of the new ABA CPT Codes.
   - Update forms for Autism Benefit (Referral, Enrollment, Re-evaluation and Disenrollment).
   - Develop reports on the 3 elements (overdue reevaluations, overdue IPOS, service outside the plus/minus 25% identified in the IPOS).
   - Created guide for tracking conditions needed for autism payment.
   - Developed new transfer form when consumer moving out of one CMH to another whether in region or out.
   - Developed standardized pre-authorization form for cases requesting to have ABA during a typical school day.
   - Provided guidance and assistance in implementing the new CPT codes as it related to ABA effective Oct. 1, 2016
   - Provided guidance and assistance on cases requesting to use Telepractice for ABA for the purposes of teaching parents/guardians to provide ABA interventions and for Supervisors of ABA services to provide clinical observation and direction.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2017
   - Continued improvement in autism performance indicators, with application of corrective actions.
   - Continue to address university partnerships, and contractual opportunities with the goal of increasing capacity.
   - Develop standardized ABA contractual language within our region.
   - Develop a procedure related to ABA during typical school hours.
   - Increase understanding and provide guidance on cases that have both Medicaid and private insurance.

ANNUAL REPORT

TEAM NAME: Clinical Leadership Committee

TEAM LEADER: Linda Schneider, CLC Chair & Dani Meier, MSHN CCO

REPORT PERIOD COVERED: 10/1/15 – 9/30/16

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.

Revisions/Updates to CLC Charter:

- Minor edits were made by the CLC to its charter in August and were approved by the Operations Council in September 2016.
- These changes included removal of requirement that the "recorder" be a voting CLC member and removal of "Grand rounds" language from charter.

Annual Evaluation Process:

a. Past Year's Accomplishments:
   - CLC review, input and/or approval of multiple MSHN and MDHHS policies, e.g. Access standards, SED/Eligibility, Trauma policies, TA 11, et al.
   - Continuous review and input re: Network Adequacy Assessment
   - Implementation and oversight of regional 24/7/365 access protocol for SUD consumers
   - Discussion of regional approaches to self-determination, fiscal intermediary and challenges of excessive training expectations
   - Review and discussion of standardization of LOCUS to determine levels of care (establishment of UM-CLC workgroup)
   - Further discussion of regional applications of CAFAS, SIS assessment tools
   - Engagement with Knowledge Services Project through identification of key data elements that can be mined, analyzed and used to inform development of clinical practice, procedure and policies
   - Survey of veteran services across CMHs
   - Review of new" Psychiatric Board Certification Standards – re: peer review
   - Standardization of outcome measures and benchmarks for every clinical service
   - Implementation issues around Evidence Based Practices (EBPs)
   - Supported regional efforts to create CMHSP hubs for distribution of Narcan overdose reversal medication kits
   - Developed plan for CMHSP clinical staff to access SUD Medical Director
   - Worked on practices for coordination of care with PCP

b. Upcoming Goals for Fiscal Year 2016 Ending, September 30, 2017

   The CLC will be involved in monitoring, developing and recommending improvements to:
   - Population health outcomes including emergency department use and access to primary care physicians in collaboration with MSHN's ongoing work with the region's Medicaid Health Plans
   - Developing regional consistency in use of CAFAS, LOCUS, trauma screening and other assessment tools to determine eligibility, level of care, etc.
   - Strengthen coordination of care between primary and behavioral health care services and seek to expand best practices
   - Expansion and implementation of trauma competence, gender competence and cultural competence

- Expansion and development of services to active military and veterans including becoming paneled with Tri-Care
- Implementation of CLS interactive reports to benchmark regional consistency in utilization and/or authorization for services
- Collaboration with diversion initiatives, DOC, law enforcement and the courts
- Improved service coordination between providers, different levels of care, etc.
- Expanded and integrated prevention services
- Building capacity in psychiatric services, for children and adolescents in particular
- Expansion of MAT services and distribution of Naloxone
- Regional consistency in access standards and delivery of services

ANNUAL REPORT

TEAM NAME: Customer Service Committee

TEAM LEADER: Jeanne Diver, MSHN Customer Service and Rights Specialist

REPORT PERIOD COVERED: 10.01.15 – 09.30.16

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. 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 MSHN Compliance Officer (CO) 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 CO 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 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 ten (10) meetings during the reporting period in which they completed the following tasks:
    - Revised MSHN Customer Service Handbook to include changes within the Region and contractual changes
    - Developed and revised regional policies and procedures in areas of Customer Service and Consumer Advisory Council
    - Developed template language for Grievances and Appeal brochure and Advance Directive brochure
    - Review, analyze and report regional customer service information including:
        - Grievances
        - Appeals
        - Second Opinions
        - Medicaid Fair Hearings
        - Recipient Rights
    - Provided feedback and participation in the External Quality Review
    - Integrated Substance Use Disorder (SUD) into current practices, policies/procedures, consumer handbook, etc.
    - Provided input on SUD provider manual
    - Provided input with establishing outcomes related to Consumer Satisfaction Surveys (MHSIP, YSS, and FY2016 Substance Use Disorder Consumer Satisfaction)
    - Although 100% is the goal, maintained 92% and higher for several consecutive quarters of the MSHN Appeals, Grievances, and 2nd Opinion Report
    - Initiated planning for efficiencies related to Limited English Proficiency (LEP)

b. Upcoming Goals for Fiscal Year Ending, September 30, 2017
    - Conduct ongoing annual review of required policies and procedures
    - Conduct annual review and revisions to MSHN Consumer Handbook to reflect regional changes and contract updates
    - Develop, where applicable, MSHN standardized elements for 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 Appeals, Grievances, and 2nd Opinion Report
    - Update the State's Customer Service training power point for regional consistency
    - Develop the Grievance and Appeal training power point template
    - Evaluate other customer service areas for regional efficiencies

ANNUAL REPORT

TEAM NAME: HSW Workgroup

TEAM LEADER: Katy Hammack, MSHN Waiver Coordinator

REPORT PERIOD COVERED: 10.01.15 – 9.30.16

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 16.
   - The HSW Workgroup incorporated changes to MDHHS forms used for HSW eligibility.
   - The HSW Workgroup ensured priority management of cases through child waiver and rubric.
   - Reviewed and discussed upcoming Home and Community Based Services (HCBS) rule changes as they relate to the HSW.
   - Prepared survey process for those selected in the sample phase of the HCBS changes.
   - Reviewed potential recoupments process.
   - Reviewed HSW dashboard data and formulate plan for correction-open slots, recoupments, recertification data, overdue IPOS, overdue consents.
   - Coordinated and prepared for the 2016 MDHHS site review.
   - Coordinated and reviewed HSW Corrective Action Plan (CAP).
   - Developed action plan and follow through on HSW CAP.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2017
   - Continue to use and institute corrective process for report set for overseeing HSW performance within the region.
   - Focus on filling number of slots available for consumers within the region.
   - Oversee the HCBS rule change as set forth by MDHHS including but not limited to:
     a. Ensure beneficiaries and providers complete HCBS survey at 100% completion by Jan. 31, 2017.
     b. Assist providers in coming into compliance with the HCBS rule.
     c. Assist in the transition process for beneficiaries residing in settings that cannot come into compliance.
     d. Continue the ongoing monitoring of providers with regards to the HCBS rule.
   - Ensure proper implementation of new 1115 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: S. Vandermay/P. Bush CMHSP Participants

REPORT PERIOD COVERED: 10.01.15 – 9.30.16

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
- Establish regional contract negotiations reciprocity;
- Recommend and deploy strategies for sub-contractor credentialing reciprocity agreements; and
- Support development of regional agreements with Medicaid Health plan agreements.

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

a. Past Year's Accomplishments: The PNMC had eleven meetings during the reporting period in that time they completed the following tasks:
   - Completed and had approved a regional Assessment of Network Adequacy;
   - Reviewed and updated region-wide training requirements and training objectives (MSHN Training Glossary);
   - Regional advocacy for improved access to psychiatric inpatient facilities;
   - Through the Fiscal Intermediary Workgroup, drafted a standard contract and regional monitoring protocol;
   - Drafted a plan for region-wide inpatient contract negotiations with six (6) priority inpatient hospitals, though deferred; and
   - County of Care Responsibility policy drafted by Operations Council with the intent to eliminate COFR agreements within the region to improve intra-region efficiency.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2017
   - Address recommendations from the 2016 assessment of Network Adequacy as it relates to provider network functions; update the Assessment of Network Adequacy to address newly identified needs;
   - Support the Regional Inpatient Operations Workgroup to implement a single psychiatric inpatient contract template and a single regional psychiatric inpatient provider performance monitoring template; Implement standardized Fiscal Intermediary practices for contract, including regional monitoring;
   - Develop a plan to implement new managed care rules related to provider network functions;
   - Address intra-regional reciprocity between CMHSP participants relative to requirements applied to sub-contracted service providers;
   - Develop PNMC scorecard;
   - Closely monitor and prepare for HCBW changes as it relates to residential monitoring and implications to provider network development.

ANNUAL REPORT

TEAM NAME: SIS Workgroup

TEAM LEADER: Todd Lewicki, MSHN UM and Waiver Director

REPORT PERIOD COVERED: 10.01.15 – 9.30.16

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 FY16.
   - Creation of SIS Assessment database that included aggregate completion data.
   - Assessment completion tracking.
   - Finalized SIS Manual received and utilized.
   - Formalized SIS workgroup with a charter.
   - Formalized SIS Quality Lead function.
   - Discussion of support types in SIS assessment.
   - Tracking of SIS completions and reasons.
   - Reviewed use in planning for support of person centered planning processes.
   - Formalized the SIS Quality Lead Policy.
   - Ongoing data reviews, including completions, domain data, planning related to connection to person centered planning.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2017
   - Utilize appropriate resources to increase SIS assessment completion.
   - Continue to work with CMHSP supports coordinators in use of SIS in person centered planning.
   - Continue to mature data review and actioning related to addressing needs, significance of support needs, and important to and important for data.
   - MSHN continued presence at State SIS meetings for information coordination.
   - Continue to ensure proper tracking and progress toward meeting weekly, monthly, and annual assessment targets.
   - Continue to refine quality assurance processes.
   - Enhance tracking and completion of assessments.

ANNUAL REPORT

TEAM NAME: Utilization Management Committee

TEAM LEADER: Todd Lewicki, MSHN UM and Waiver Director

REPORT PERIOD COVERED: 10.1.15 – 9.30.16

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;
- 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.

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

1. CMHSP participants shall ensure that the access system staff are qualified, credentialed and trained consistent with the Medicaid Provider Manual, the Michigan Mental Health Code and the MDHHS/PIHP contract.
2. CMHSP participants shall ensure that there is no conflict of interest between the coverage determination and the access to, or authorization of, services.
3. CMHSP participants shall monitor provider capacity to accept new individuals, and be aware of any providers not accepting referrals at any point in time.
4. CMHSP participants shall routinely measure telephone answering rates, call abandonment rates and timeliness of appointment and referrals at any point in time. Any performance issues shall be addressed through the PIHP Quality Assurance and Process Improvement Plan.
5. CMHSP participants shall assure that the access system maintains medical records in compliance with state and federal standards.

6. The CMHSP participants shall work with individuals, families, local communities, and others to address barriers to using the access system, including those caused by lack of transportation.

Annual Evaluation Process:

a. Past Year's Accomplishments: The UMC had ten meetings during the reporting period in that time the following tasks were completed:
   - Updated the regional Utilization Management Plan:
     - Levels of utilization review
     - Types of specific utilization management measures
     - Change strategy form
   - Agreement on Mid-State Supplemental Value dataset, including:
     - Finalization and definition of MSSV dataset
     - Partnering with IT to coordinate MSSV deployment
     - MSSV mapping into CMHSP EMR systems
     - EMR vendor collaboration on mapping
     - CMHSP onboarding monitoring
     - CMHSP implementation of MSSV data submission
   - Formalized set of UM measures including:
     - Service penetration per population
     - Consistent application of eligibility criteria (MSSV)
     - Inpatient recidivism
     - Crisis/Acute service utilization
     - Cost indicators by code (CLS, autism)
     - Use of tools to assist in measuring variance (CAFAS, LOCUS, SIS)
     - Access to primary care
   - Policy review using data related to UM.
   - Creation of SIS and CAFAS data systems.
   - Cross-functional dialogue with QI Council, Clinical Leadership, and Provider Network Management.
   - Review traditional managed care flow and prepare for MSHN version.
   - Review of veteran access to care.
   - Use of new decision-agenda.
   - Action list task-tracking.
   - Use of DataLab group to define and refine UM measures.
   - HMP penetration rate tracking. Begin HMP plan to increase penetration.
   - Inclusion of UM SUD staff into UM Committee.
   - Begin planning for expanded SUD staff presence in committee.
   - Inclusion of IT staff as ad hoc into UM processes and supplemental data planning.

b. Upcoming Goals for Fiscal Year Ending, September 30, 2017
   - 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;
   - Finalize and implement second set of UM measures;
   - Complete implementation 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;
   - Establish performance improvement priorities identified from monitoring of delegated utilization management functions;
   - Utilize Change Strategy form in review of UM data variance;
   - Recommend improvement strategies where adverse utilization trends are detected;
   - Recommend improvement strategies where best practice is identified;
   - Fully implement BH-TEDS and MSSV datasets into UM data reporting;
   - Recommend areas of focus for population health measures related to care coordination;
   - Complete plan for increasing HMP penetration;
   - Ongoing integration of substance use disorder (SUD) into UM practices;
   - Use MSHN Sharepoint site to disseminate UMC reports and activities.

SECTION THREE – PERFORMANCE MEASUREMENTS

I. Behavior Treatment Review Reports

Summary Report

Title of Measure: Behavior Review Data

Committee/Department: Quality Improvement Council

Reporting Period (month/year): FY2016-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. (MSHN Final Draft Quality Assessment and Performance Improvement Plan, pg. 8)

Data Interpretation: (performance against targets and benchmark data)

Study Question 1: Has the proportion of individuals who have 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:

- Receiving clarification from MDHHS regarding the actual requirement for the monitoring of the restrictive and intrusive interventions. Clarification has been received, and it was determined that monitoring of restrictive and intrusive interventions should occur at the CMHSP level and not at the PIHP level.
- Participating in the MDHHS Behavioral Treatment Work Group to review the technical requirements attached to the Medicaid Specialty Supports and Services contract.
- 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.

FY15Q4
Out of the 12 CMHSP's, 306 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 1.14% (306/26778) consumers served in the region for FY15Q4 as of October 30, 2015 and have an approved plan for behavior treatment with a restrictive or intrusive intervention.

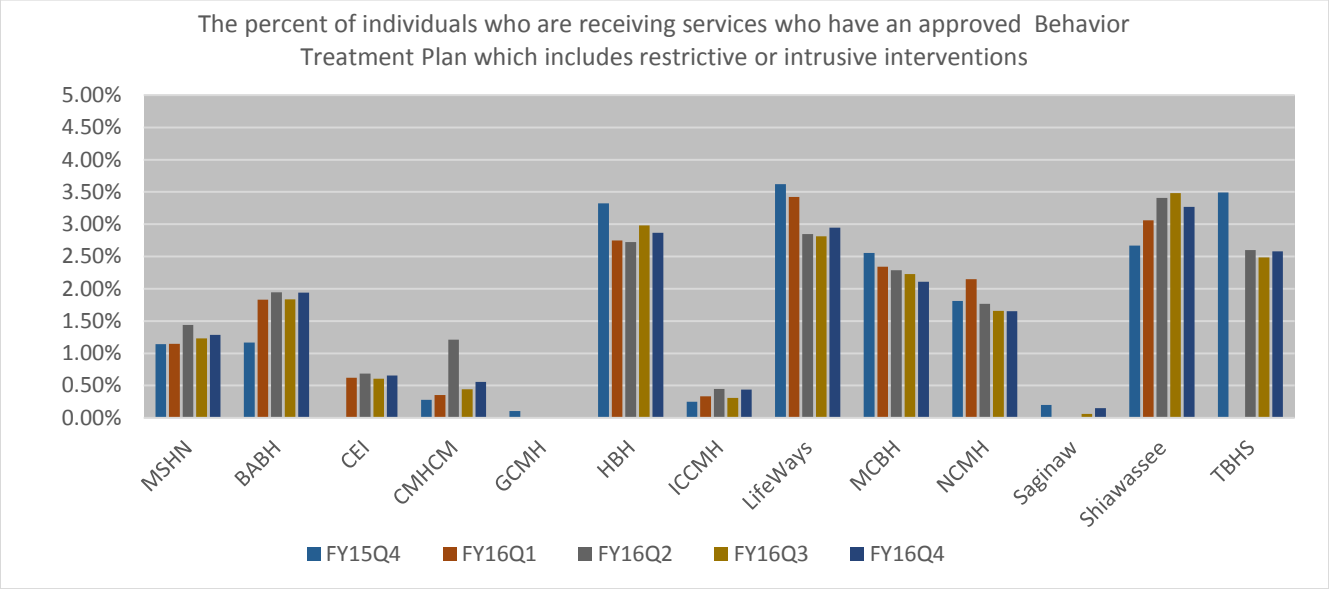
FY16Q1
Out of the 12 CMHSP's, 305 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 1.15% (305/26552) consumers served in the region for FY16Q1 as of December 31, 2015 and have an approved plan for behavior treatment with a restrictive or intrusive intervention.

FY16Q2
Out of the 12 CMHSP's, 384 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 1.44% (384/26684) consumers served in the region for FY16Q2 as of March 31, 2016 and have an approved plan for behavior treatment with a restrictive or intrusive intervention.

FY16Q3
Out of the 12 CMHSP's, 342 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 1.23% (342/27827) consumers served in the region for FY16Q3 as of June 30, 2016 and have an approved plan for behavior treatment with a restrictive or intrusive intervention.

FY16Q4
Out of the 12 CMHSP's, 355 individuals have an approved behavior treatment plan that include a restrictive and/or intrusive intervention. That equates to 1.28% (355/27627) consumers served in the region for FY16Q4 as of September 30, 2016 who have an approved plan for behavior treatment with a restrictive or intrusive intervention.

Figure 1



Study Question 2: Has the proportion of individuals who have received physical intervention decreased overtime?

This will be monitored by looking at the numerators and the denominators below.

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.

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

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

FY15Q4

During this reporting period 65 individuals received an emergency physical intervention. A total of 161 emergency physical interventions were used. Less than 1% (.60% -161/26778) of the individuals (Medicaid) served received an emergency physical intervention. This is a decrease in the rate per 100 consumers served from the previous reporting period. Of the 65 who received an emergency physical intervention, 34 (52%) individuals received more than one 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. Figure 2 identifies the percent of individuals served who received an emergency physical intervention.

FY16Q1

During this reporting period 46 individuals received an emergency physical intervention. A total of 109 emergency physical interventions were used. Less than 1% (.41% -109/26552) of the individuals (Medicaid) served received an emergency physical intervention. This is a decrease in the rate per 100 consumers served from the previous reporting period. Of the 46 who received an emergency physical intervention, 19 (41%) individuals received more than one 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. Figure 2 identifies the percent of individuals served who received an emergency physical intervention.

FY16Q2

During this reporting period 53 individuals received an emergency physical intervention. A total of 125 emergency physical interventions were used. Less than 1% (.47% -125/26684) 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 53 who received an emergency physical intervention, 20 (38%) individuals received more than one 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. Figure 2 identifies the percent of individuals served who received an emergency physical intervention.

FY16Q3

During this reporting period 48 individuals received an emergency physical intervention. A total of 149 emergency physical interventions were used. Less than 1% (.54% -149/27827) 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 48 who received an emergency physical intervention, 24 (50%) 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.

FY16Q4

During this reporting period 60 individuals received an emergency physical intervention. A total of 125 emergency physical interventions were used. Less than 1% (.45% -125/27627) of the individuals (Medicaid) served received an emergency physical intervention. This is a slight decrease in the rate per 100 consumers served from the previous reporting period. Of the 60 who received an emergency physical intervention, 29 (48%) 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.

Figure 2

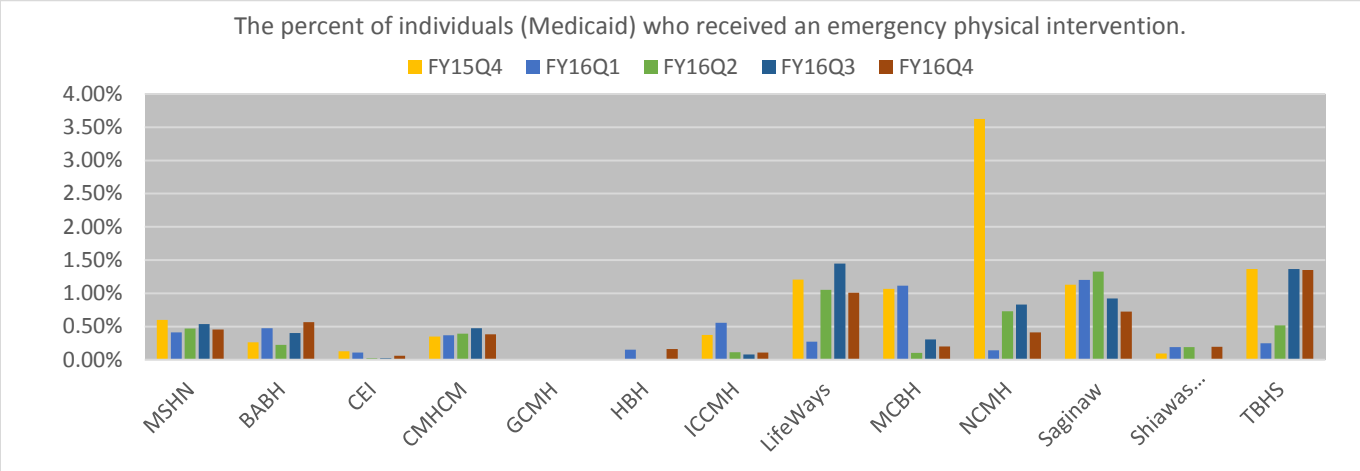


Figure 3

The top row for each CMHSP is the number of individuals who received more than one emergency physical intervention during the reporting period. The bottom row is the total number of individuals who received an emergency physical intervention during the reporting period.

	FY15Q3	FY15Q4	FY16Q1	FY16Q2	FY16Q3	FY16Q4
MSHN	**25**	**34**	**19**	**20**	**24**	**29**
	77	**65**	**46**	**53**	**48**	**60**
BABH	3	4	5	3	5	4
	7	6	8	4	6	7
CEI	0	0	0	0	0	3
	3	5	2	1	1	3
CMHCM	4	8	2	4	2	2
	13	22	10	9	6	9
GCMH	0	0	0	0	0	0
	0	0	0	0	0	0
HBH	0	0	0	0	0	0
	1	0	1	0	0	1
ICCMH (Right Door)	0	0	1	0	0	0
	0	2	1	1	1	1

LifeWays	6	8	1	3	8	10
	12	14	6	15	15	17
MCBH	1	2	3	0	0	0
	2	4	3	1	3	2
NCMH	2	2	0	3	1	1
	4	2	1	4	1	2
Saginaw	5	7	7	6	6	6
	13	11	10	12	10	9
Shiawassee	0	0	0	0	0	0
	1	1	2	2	0	2
TBHS	4	3	0	1	2	3
	5	4	2	4	5	7

FY15Q4

One hundred and sixty-one (161) emergency physical interventions were used during FY15Q4 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. A decrease in number of interventions was exhibited in each area except the area of "other". According to the distribution of interventions, the Wrap Hold category did have the highest percentage of interventions.

FY16Q1

One hundred and nine (109) emergency physical interventions were used during FY16Q1 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. A decrease in number of interventions was exhibited for supine hold, wrap hold and hands down interventions. However, there was a slight increase in the use of transport/escort and other/unidentified. According to the distribution of interventions, the Wrap Hold category did have the highest percentage of interventions.

FY16Q2

One hundred and twenty-five (125) emergency physical interventions were used during FY16Q2 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. A slight increase was noted in the interventions for use of supine hold, wrap hold and hands down interventions. However, there was a slight decrease of other/unidentified interventions and the percentage for use of transport/escort interventions remained the same as the previous quarter. According to the distribution of interventions, the Wrap Hold category continued to have the highest percentage of interventions.

FY16Q3

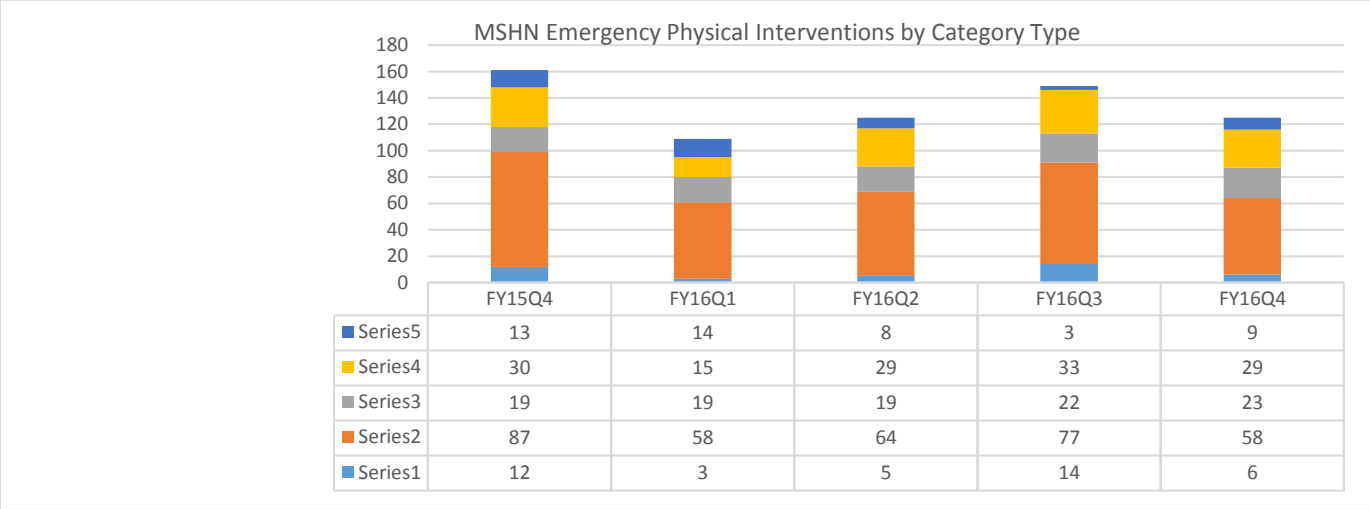
One hundred and forty-nine (149) emergency physical interventions were used during FY16Q3 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. An increase was noted across all identified interventions (supine hold, wrap hold, transports/escorts and hands down interventions). However, there was a slight decrease of other/unidentified interventions from the previous quarter. According to the distribution of interventions, the Wrap Hold category continued to have the highest percentage of interventions.

FY16Q4

One hundred and twenty-five (125) emergency physical interventions were used during FY16Q4 across the Mid-State Health Network Region. Figure 4 provides additional data on the types of interventions that were used. A decrease was noted for the use of supine hold and wrap hold, but a slight increase was noted for the transports/escorts, hands down and other/unidentified interventions from the previous quarter. According to the distribution of interventions, the Wrap Hold category continued to have the highest percentage of interventions.

Figure 4

Physical Intervention	**FY15Q3**	**FY15Q4**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
Supine Hold	(15)8%	(12)7%	(3) 3%	(5) 4%	(14) 9%	(6) 5%
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)	(113)57%	(87)54%	(58) 53%	(64) 51%	(77) 52%	(58) 46%
Transport/Escort (come along, CPI Transport, primary escort, 2 person escort, modified transport)	(31)16%	(19)12%	(19) 17%	(19) 15%	(22) 15%	(23) 18%
Hands down with resistance	(35)18%	(30)19%	(15) 14%	(29) 23%	(33) 22%	(29) 23%
Other/Unidentified	(5)3%	(13)8%	(14) 13%	(8) 6%	(3) 2%	(9) 7%
MSHN Total	(199)100%	(161)100%	(109) 100%	(125) 100%	(149) 100%	(125) 100%



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, 8 were reported to be outside of the 15-minute window, and 2 were reported as unknown. Follow up regarding the unreported and reported outside of the window is being completed at each CMHSP to ensure a process is in place to collect the length of time for each intervention.

Figure 5

Length of time of intervention	**FY15Q3**	**FY15Q4**	**FY16Q1**	**FY16Q2**	**FY16Q3**	**FY16Q4**
The total number of interventions within this time frame ≤ 5 minutes	87	74	58	66	80	61
The total number of interventions within this time frame 6-10 minutes	31	29	12	17	26	21
The total number of interventions within this time frame 11-15 minutes	41	31	10	17	29	25

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.

FY15Q4

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY15Q4 was .24% (65/26778). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY15Q4 was 65. Eleven CMHSP Participants utilized police assistance during this reporting period. This was an increase in the number of CMHSPs who utilized the police for behavioral assistance. It should be noted that police interventions are used primarily for individuals with a mental illness. Behavior Treatment plans are not developed for individuals who have a diagnosis of mental illness.

FY16Q1

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY16Q1 was .12% (33/26552). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY16Q1 was 33. Seven CMHSP Participants utilized police assistance during this reporting period. This was a decrease in the number of CMHSPs who utilized the police for behavioral assistance. It should be noted that police interventions are used primarily for individuals with a mental illness.

FY16Q2

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY16Q2 was .18% (49/26684). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY16Q2 was 49. Seven CMHSP Participants utilized police assistance during this reporting period. This was same number of CMHSPs 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.

FY16Q3

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY16Q3 was .25% (69/27827). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY16Q3 was 69. Ten CMHSP Participants utilized police assistance during this reporting period. This was an increase in the number of CMHSPs 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.

FY16Q4

As demonstrated in Figure 6, the rate of phone calls for police assistance per 100 consumers served for FY16Q4 was .24% (65/27627). The total number of reported incidents requiring phone calls for police assistance throughout MSHN during FY16Q4 was 65. Nine CMHSP Participants utilized police assistance during this reporting period. This was a decrease in the number of CMHSPs 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.

Figure 6

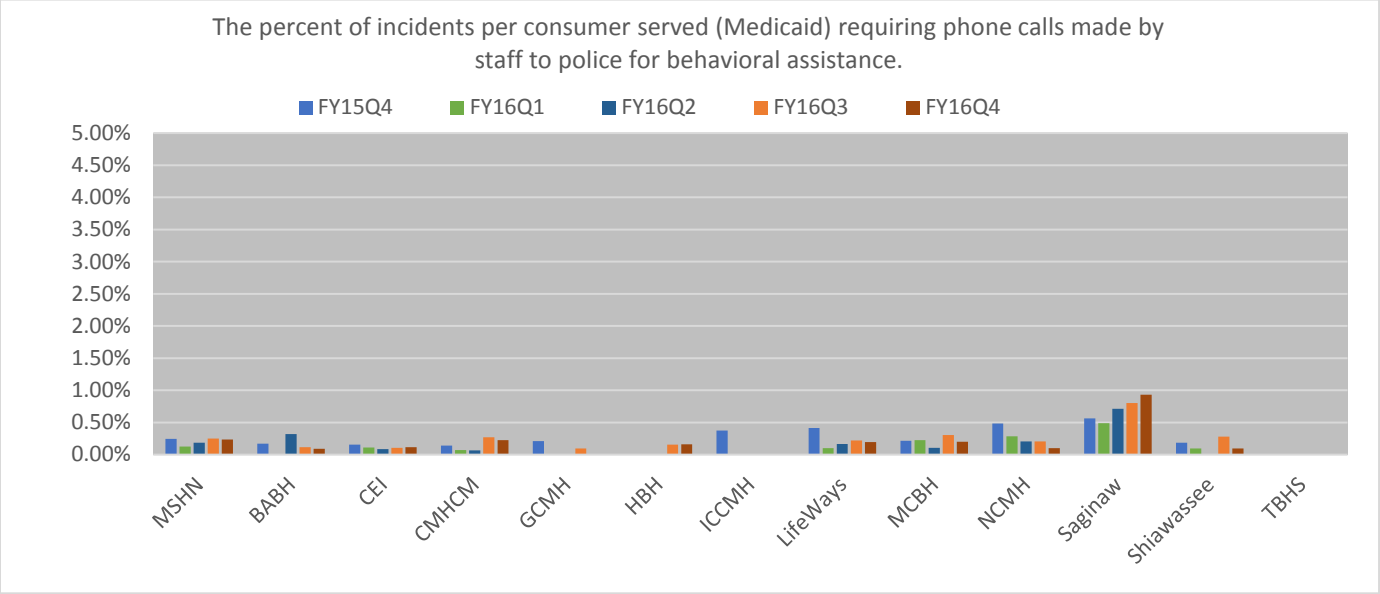
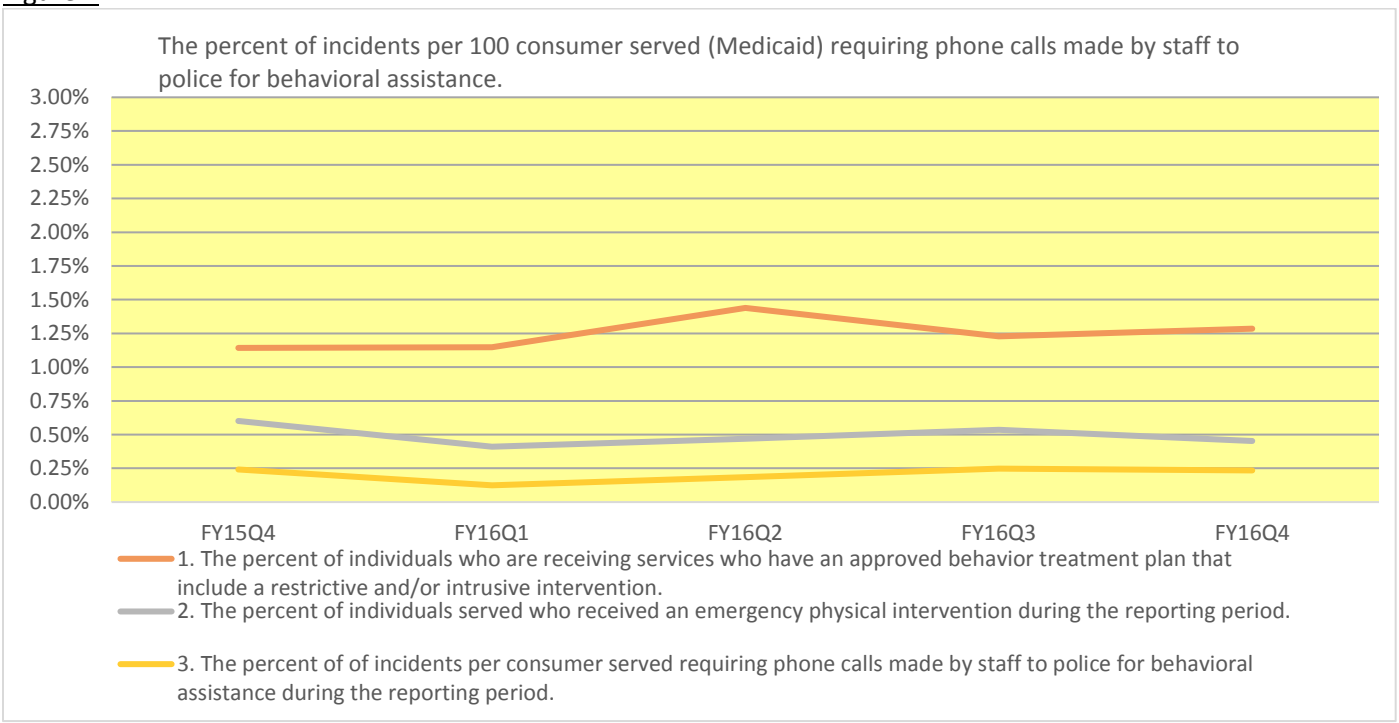


Figure 7



Conclusions:

Study Question 1: Has the proportion of individuals who have received a restrictive/intrusive intervention decreased over time? 1.44% (FY14Q2) compared to 1.28% (FY16Q4) of the individuals served have a Behavior Treatment Plan with Intrusive and/or Restrictive Interventions. This indicates that the proportion is slightly lower than first reported in FY14Q2. The percentage was showing a slow decrease between FY14Q3 through FY16Q1, then increased for FY16Q2, and then decreased again through FY16Q4.

Study Question 2: Has the proportion of individuals who have received physical intervention decreased overtime? .53% (FY14Q2) compared to .45% (FY16Q4) have received an emergency physical intervention. This indicates that a slight decrease has occurred. The PIHP has developed consistent definitions and reporting mechanisms that have assisted with the accuracy of the reporting. There had been an upward trend in the data beginning FY14Q3 through FY15Q2. Then beginning in FY15Q3 a downward trend started and went through FY16Q1 and then beginning in FY16Q2 there was a slight increase again through FY16Q3. Then FY16Q4 showed a slight decrease from the previous quarter. This will continue to be monitored to ensure that the trend continues down ward and interventions put in place have been effective.

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 .24% (FY16Q4) indicates a decrease in the proportion of incident in which the police have been called for police assistance with a behavioral incident. This downward trend began in FY14Q4 and continued through FY15Q3. Then beginning in FY15Q4 there were fluctuations each quarter with FY16Q4 showing a slight decrease.

Observation: FY16Q4 showed a slight decrease from FY16Q3 in the percentage of individuals served who received an emergency physical intervention and the percentage of phone calls made to police for behavioral assistance. For FY16Q4, the number of individuals who had an approved behavior treatment plan that included a restrictive and/or intrusive intervention was 355 which was an increase from FY16Q3 which was at 342. Overall, FY16Q4 reported good percentages, only showing a slight increase from FY16Q3 in one of the three areas being monitored.

Improvement Strategies:

Continue to monitor the number of plans. Monitor to see if there is a correlation between the number of plans decreasing and the number of phone calls to police or emergency physical interventions increasing.

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.

To continue to monitor the rate of phone calls to Police for staff assistance for each CMHSP. Each CMHSP should review for any trends with particular settings, explore alternative interventions, and take appropriate action to decrease as necessary without affecting the safety of the staff, community or the individuals served.

It is also recommended that each CMHSP ensure that interpretations and definitions are consistent across the region. CMHSPs will continue to work on reporting accuracies consistent with MSHN.

Analysis by: Kim Zimmerman, Director of Customer Service, Compliance and QI **Date:** November 2016

MSHN QIC Approved: November 17, 2016

II. Critical Incident Reports

MSHN Quarterly Critical Incident Report (FY 2016)

Data Submission Date: 10/31/2016

Board	Incident Type	Quarter 1 Totals (Oct-Dec)	Quarter 2 Totals (Jan-Mar)	Quarter 3 Totals (Apr-Jun)	Quarter 4 Totals (Jul-Sep)	FY Total (Oct-Sep)	FY Incidents Per 1000 Residents
Bay Arenac Behavioral Health	Suicide	0	0	1	0	1	0.0082
	Non-Suicide Death	11	5	10	9	35	0.2861
	EMT due to Injury/Medication Error	9	4	8	10	31	0.2534
	Hospitalization due to Injury/Medication Error	0	1	0	0	1	0.0082
Census: 122,319	Arrest	1	0	1	0	2	0.0164
	Total	**21**	**10**	**20**	**19**	**70**	**0.5723**
CMH Central Michigan	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	11	16	18	5	50	0.1806
	EMT due to Injury/Medication Error	24	34	35	43	136	0.4914
	Hospitalization due to Injury/Medication Error	1	2	2	3	8	0.0289
Census: 276,784	Arrest	4	6	6	5	21	0.0759
	Total	**40**	**58**	**61**	**56**	**215**	**0.7768**
CMHA CEI	Suicide	0	0	0	1	1	0.0021
	Non-Suicide Death	15	10	15	4	44	0.0942
	EMT due to Injury/Medication Error	26	17	10	8	61	0.1305
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
Census: 467,321	Arrest	0	0	0	0	0	0.0000
	Total	**41**	**27**	**25**	**13**	**106**	**0.2268**
Gratiot CMH	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	0	2	1	1	4	0.0953
	EMT due to Injury/Medication Error	0	2	2	1	5	0.1191
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
	Arrest	0	0	0	0	0	0.0000
Census: 41,968	**Total**	**0**	**4**	**3**	**2**	**9**	**0.2144**

Board	Incident Type	Quarter 1 Totals (Oct-Dec)	Quarter 2 Totals (Jan-Mar)	Quarter 3 Totals (Apr-Jun)	Quarter 4 Totals (Jul-Sep)	FY Total (Oct-Sep)	FY Incidents Per 1000 Residents
Huron Behavioral Health	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	2	0	2	1	5	0.1552
	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
Census: 32,224	Arrest	0	0	0	0	0	0.0000
	Total	**2**	**0**	**2**	**1**	**5**	**0.1552**
The Right Door (Ionia CMH)	Suicide	0	1	0	0	1	0.0156
	Non-Suicide Death	3	0	2	3	8	0.1249
	EMT due to Injury/Medication Error	1	0	0	0	1	0.0156
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
	Arrest	0	1	0	0	1	0.0156
Census: 64,073	**Total**	**4**	**2**	**2**	**3**	**11**	**0.1717**
Lifeways	Suicide	0	1	0	5	1	0.0048
	Non-Suicide Death	6	11	6	0	28	0.1356
	EMT due to Injury/Medication Error	3	13	5	0	21	0.10017
	Hospitalization due to Injury/Medication Error	0	1	0	0	1	0.0048
Census: 206,470	Arrest	1	2	1	5	4	0.0194
	Total	**10**	**28**	**312**	**610**	**55**	**0.2664**
Montcalm Behavioral Health	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	1	1	0	1	3	0.0475
	EMT due to Injury/Medication Error	4	5	1	6	16	0.2535
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
Census: 63,105	Arrest	2	1	2	1	6	0.0951
	Total	**7**	**7**	**3**	**8**	**25**	**0.3962**
Newaygo CMH	Suicide	1	0	1	0	2	0.0164
	Non-Suicide Death	5	0	2	0	7	0.1458
	EMT due to Injury/Medication Error	1	1	3	3	8	0.1667
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
Census: 48,001	Arrest	0	0	0	0	0	0.0000
	Total	**7**	**1**	**6**	**3**	**17**	**0.3542**

Board	Incident Type	Quarter 1 Totals (Oct-Dec)	Quarter 2 Totals (Jan-Mar)	Quarter 3 Totals (Apr-Jun)	Quarter 4 Totals (Jul-Sep)	FY Total (Oct-Sep)	FY Incidents Per 1000 Residents
Saginaw CMH	Suicide	1	0	0	0	1	0.0051
	Non-Suicide Death	3	14	9	7	33	0.1679
	EMT due to Injury/Medication Error	16	18	25	19	78	0.3969
	Hospitalization due to Injury/Medication Error	1	0	2	2	5	0.0254
Census: 196,542	Arrest	1	1	0	3	45	0.0254
	Total	**22**	**33**	**36**	**31**	**122**	**0.6207**
Shiawassee CMH	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	0	2	3	3	8	0.1161
	EMT due to Injury/Medication Error	0	0	3	0	3	0.0435
	Hospitalization due to Injury/Medication Error	0	0	0	0	0	0.0000
Census: 68,900	Arrest	0	0	0	0	0	0.0000
	Total	**0**	**2**	**6**	**3**	**11**	**0.1597**
Tuscola BH Systems	Suicide	0	0	0	0	0	0.0000
	Non-Suicide Death	0	1	1	0	2	0.0369
	EMT due to Injury/Medication Error	2	8	1	6	17	0.3133
	Hospitalization due to Injury/Medication Error	1	2	0	0	3	0.0553
Census: 54,263	Arrest	1	0	0	0	1	0.0184
	Total	**4**	**11**	**2**	**6**	**23**	**0.4239**
MSHN TOTALS	Suicide	2	2	2	1	7	0.0043
	Non-Suicide Death	57	62	69	39	227	0.1382
	EMT due to Injury/Medication Error	86	102	93	96	377	0.2296
	Hospitalization due to Injury/Medication Error	3	6	4	5	18	0.0110
Census: 1,641,970	Arrest	10	11	10	9	40	0.0244
	Total	**158**	**183**	**178**	**150**	**7669**	**0.4074**

III. Medicaid Event Verification Report

Pre-Paid Inpatient Health Plan

Medicaid Services Verification Methodology Report

Fiscal Year 2016

(October 1, 2015 – September 30, 2016)

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 2016 Deficiencies
B. Repeated Deficiencies

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 County Community Mental Health Services Authority, 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 County Community Mental Health Authority, The Right Door (Ionia County Community Mental Health), and Tuscola Behavioral Health Systems. Also within the PIHP region are 84 substance use disorder (SUD) treatment providers that include 12 treatment providers that have multiple service locations and 22 agencies that provide prevention services.

MSHN conducts oversight of the Medicaid claims/encounters submitted within the region by completing an onsite 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 84 SUD treatment providers, only the 60 providers that provided Medicaid eligible services and used Medicaid funding were included in the review. SUD disorder treatment providers that were in another PIHP region and had a MEV review completed in that region were not included in the MEV summary.

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. Sample selection for the CMHSP includes both the direct services provided by the CMHSP and the services provided at a contract provider of the CMHSP. Substance use providers with multiple locations with distinct site licenses were reviewed individually.

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 amount 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, Wraparound, and Behavior Treatment Plan. Substance Use Provider samples consisted of at

[1] Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 16 – Attachment P.6.4.1

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

The sample is 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 of 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 of the program types are not met with the 6% sample pulled, then the process will be ran again to select additional beneficiaries. This will be done until all the required program types are selected.

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, 2015 – September 30, 2016. Data presented in the below chart is relative to the 12 CMHSP's and 60 substance use disorder treatment providers reviewed during this time 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.) 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	99.81	100	100	99.81	81.35	100	100
CEI	100	100	99.45	98.36	76.3	100	100
CMHCM	100	99.92	99.77	99.84	85.85	100	100
Gratiot	100	100	98.8	98.81	68.92	99.6	95.74
Huron	100	100	100	100	90.07	100	100
Ionia	100	100	100	98.28	99.57	81.51	100
Lifeways	100	100	100	99.56	98.52	99.7	100
Montcalm	100	100	100	99.79	78.75	100	100
Newaygo	100	100	81.88	99.87	88.49	100	100
Saginaw	100	100	100	93.12	100	100	100
Shiawassee	100	100	98.28	99.22	93.1	100	100
Tuscola	100	100	100	99.54	99.77	100	100
MSHN Average	**99.98%**	**99.99%**	**98.18%**	**98.85%**	**88.39%**	**98.40%**	**99.65%**

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.

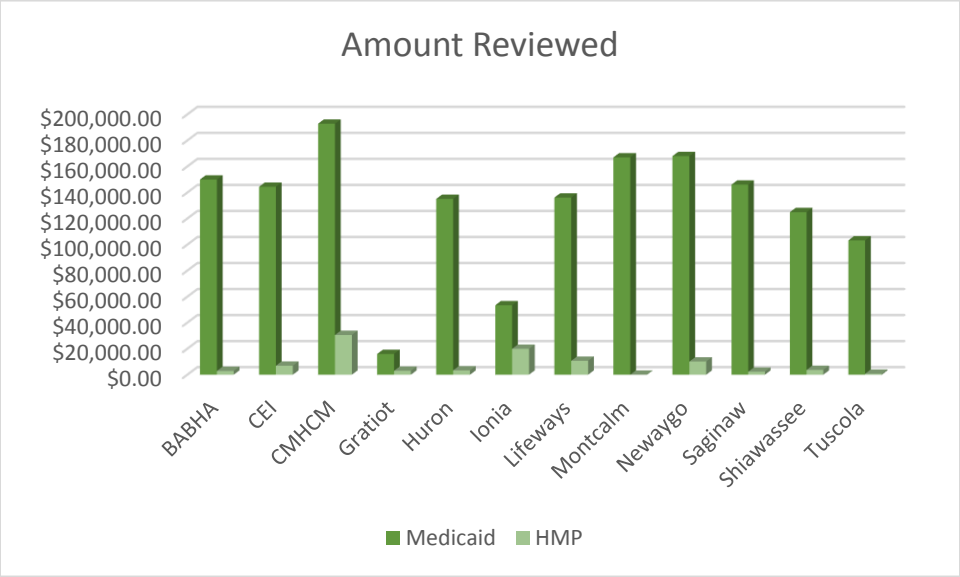
SUD

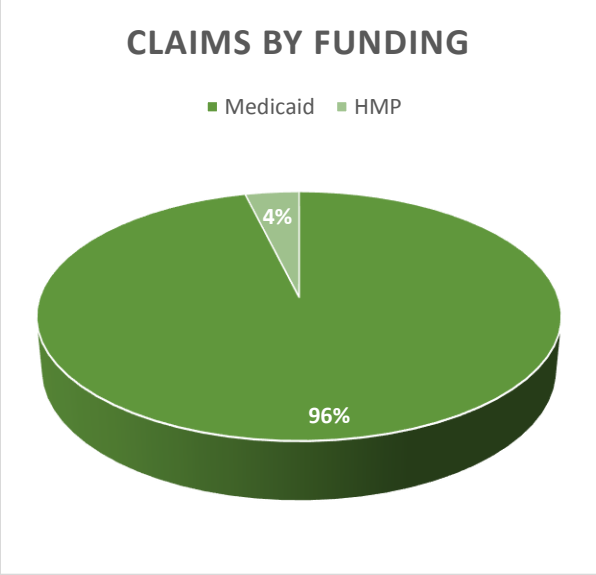
	A	B	C	D	E	F	G
SUD Providers	**99.94%**	**99.38%**	**99.95%**	**97.50%**	**98.55%**	**99.83%**	**98.83%**

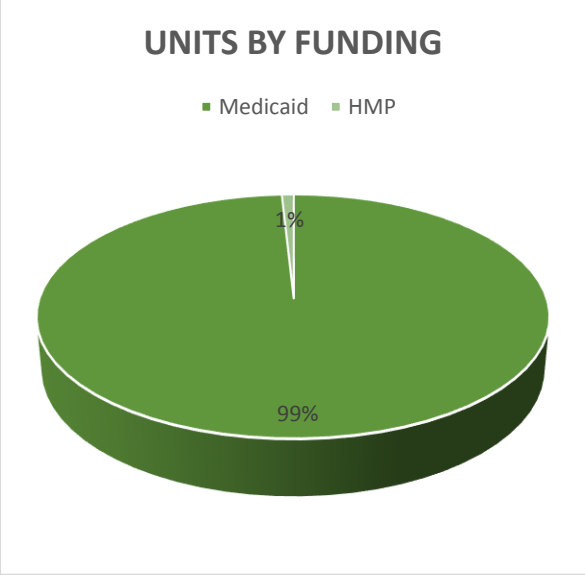
Summary of CMHSP Claims Reviewed by Funding Source:

In total 7,427 claims were reviewed. Of the 7,427 claims reviewed 7,142 of the claims were billed as Medicaid and 285 of the claims were billed using Healthy Michigan Plan Funding. The 7,427 claims included 79,938 units of service. Of the 79,983 units reviewed 79,248 were billed as Medicaid and 690 were billed as Healthy Michigan Plan. The dollar amount of the claims reviewed totaled $1,630,975.05. Of the $1,630,975.05 reviewed 1,536,820.66 was billed using Medicaid funding and $94,154.37 was billed using Healthy Michigan funding.

Note: Montcalm Care Network did not have any claims reviewed that were billed as Healthy Michigan Plan.

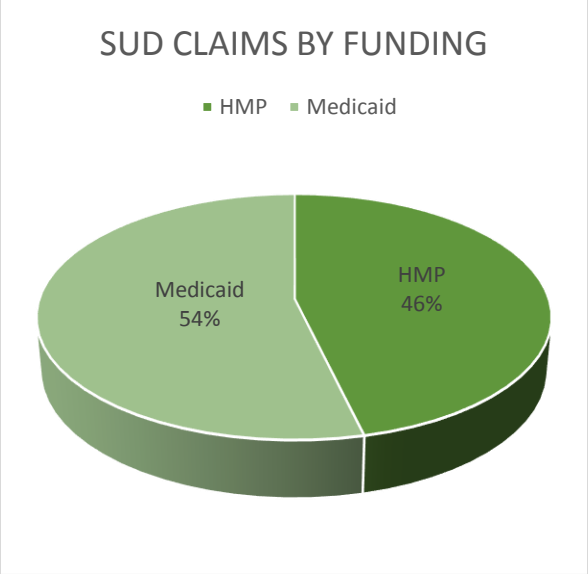


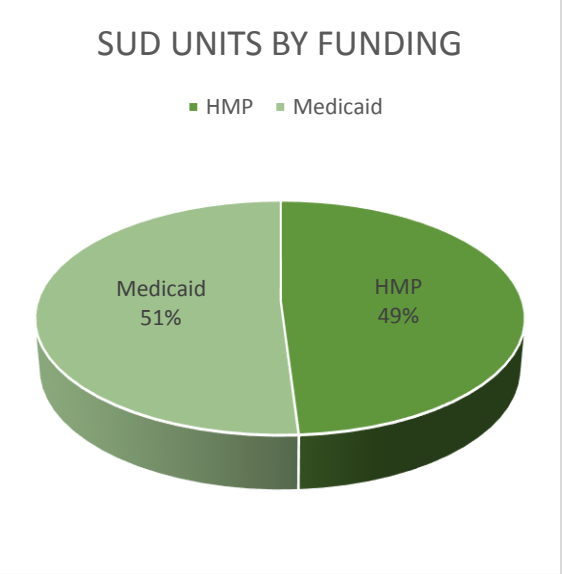




Summary of SUD Claims Reviewed by Funding Source:

In total 17,853 claims were reviewed. Of the 17,853 claims reviewed 8,260 of the claims were billed as Medicaid and 9,593 of the claims were billed using Healthy Michigan Plan Funding. The 17,853 claims included 27,043 units of service. Of the 27,043 units reviewed 13,795 were billed as Medicaid and 13,248 were billed as Healthy Michigan Plan. The dollar amount of the claims reviewed totaled $1,250,962.87. Of the $1,250,962.87 reviewed $678,210.61 was billed using Medicaid funding and $572,752.26 was billed using Healthy Michigan funding.





Deficiencies/Corrective Action

Fiscal Year 2016 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 in an effort to ensure system and process change.

Based on the MEV review for FY2016, 12 CMHSPs were placed on a plan of correction and 53 substance use disorder treatment providers were placed on a plan of correction. There were not any providers removed from a plan of correction during the 2016 MEV reviews, as the provider will be reviewed for compliance during FY2017.

The overall findings included a total of 1,482 claim lines identified as invalid claims/encounters based on one or more of the established review criteria. This included a total of 16,242 units of service and a total dollar amount of $197,753.51. Of the invalid claims/encounters, 1,081 claim lines of service were from reviews of CMHSPs direct and indirect services and 401 claim lines were from substance use disorder treatment providers. The total of invalid units included 14,643 units of service from CMHSPs and 1,599 units of service from substance use disorder providers. The total dollar amount of invalid claims identified included $170,781.11 for CMHSPs and $26,972.40 for substance use disorder treatment providers. All invalid claims were corrected based on MSHN's established process.

NOTE: This is the first year the MEV process has been completed directly by MSHN (previously a delegated function to the CMHSPs and the Sub Regional Entities) and 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 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

At this time, it would not be an accurate process to compare deficiencies from FY2015 to FY2016 as a secondary review of MEV process occurred in FY2015 and a primary review occurred in FY2016. Once reviews are completed for FY2017, MSHN will review the identify areas of repeat deficiencies.

However, a summary of the deficiencies identified by the CMHSPs during the FY2015 MEV review was used to compare to the deficiencies identified during the FY2016 MEV review completed by MSHN.

A review of the elements tested from the MEV reviews completed by each CMHSP during FY2015 indicated that 6 CMHSPs have repeated deficiencies. The deficiencies were services not identified in the

PCP (6 CMHSPs), billed services matching the documentation (6 CMHSPs), Medicaid eligibility (1 CMHSP), and the service being identified in the Medicaid Provider Manual (1 CMHSP).

Note: As FY2016 was the first year the MEV review was completed directly by MSHN for SUD treatment providers a comparison was unable to made.

Performance Improvement

Performance improvement over previous MEV results was not measured as each CMHSP and Sub-Regional Entity tested varying standards prior to the development of the Medicaid Event Verification Process identified by the state in FY2016. The standardized elements being evaluated across the region will be measured for improvement going forward.

There were some common findings identified during the MEV reviews completed during FY2016 that included the lack of documentation for per diem and 15-minute community living supports, personal care, and skill building. This finding led to the creation of new documentation standards/forms by many of the providers who were found out of compliance with the requirement. Another issue that contributed to some deficiencies being noted was a lack of appropriate documentation being available during the MEV review. MSHN provided education and clarification as to what supporting documentation is needed to complete the primary reviews as well as shared best practices among the provider network. These actions, along with process changes and improvements in automated system verifications, is expected to increase the validation results and show improvement in the quality of documentation during the reviews completed for FY2017.

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 second year of reviews and will focus on plans of corrections from previous reviews to ensure indicated quality improvement is 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.

IV. Performance Improvement Project – HEDIS

Diabetes Screening for Antipsychotics

MSHN PIP Report

Measure Definition

Certain medications used to treat psychiatric disorders may increase the risk of obesity and diabetes and thus CVD, where mortality is greater for this population. [1]

This baseline measure is modeled on the HEDIS measure "Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)" (see details at: NQF 1932), though it does not use the same measurement year timeframe.

The measure looks at the percentage of patients between 18 and 64 years of age with schizophrenia or bipolar disorder, who were dispensed a second-generation antipsychotic (SGA) medication and had a diabetes screening test during the measurement year[2]. The measure excludes patients with diabetes (determined either by diagnostic codes on claims or the presence of prescriptions for diabetic medications) to ensure that we are looking at screening and not ongoing monitoring.

Evaluation

HSAG evaluates the technical structure of the PIP to ensure that Mid-State Health Network designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., study question, indicator(s), population, sampling techniques, data collection methodology, and data analysis plan) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well Mid-State Health Network improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results). The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that any reported improvement in outcomes is related to a given PIP.

1American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, and North American Association for the Study of Obesity. (2004). Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes care, 27(2). Available at: http://care.diabetesjournals.org/content/27/2/596.full#sec-3

2 I.e. One or more glucose or HbA1c tests.

Study Topic/Indicator/Goal

PIP Topic	Study Indicator	Study Goal
Increasing Diabetes Screening for Consumers with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications.	*The indicator is the proportion of the eligible population having at least one diabetes screening completed in the measurement year.*	*To ensure that adult consumers with schizophrenia or bipolar disorder who are prescribed antipsychotic medication are receiving the necessary diabetes screenings because taking antipsychotic medications is associated with increased risk of developing diabetes.*

The study topic selected by Mid-State Health Network addressed CMS' requirements related to quality outcomes— specifically, the quality and accessibility of care and services.

Identified Barriers and Interventions

The identification of barriers in achieving the stated goal was completed through causal/barrier analysis. Each CMHSP reviewed their local baseline data and remeasurement period one data and provided feedback regarding the barriers to the PIHP using their local quality improvement process. The PIHP utilized the regional Quality Improvement Council to further identify region wide barriers to receiving a glucose test or an HbA1c test as well as the interventions to overcome the barriers. The process used for the causal/barrier analysis was brainstorming and the completion of a fishbone diagram.

Remeasurement Period One:

The common barriers identified within the region were:

- Behavioral Health services beneficiary not understanding the importance of having a primary care physician and maintaining regular appointments to address health care needs.
- Limited number of primary care physicians accepting Medicaid patients.
- Lack of awareness of benefit coverage for diabetes testing.
- Lack of coordination exists between behavioral health system and primary care physicians.

To assist with overcoming the identified barriers, MSHN implemented the following interventions:

- Provide education to consumers during the person-centered planning process and during face-to-face interactions about the importance of ongoing monitoring by a primary care physician.
- Community Mental Health agencies will coordinate with the consumer and primary care physician regarding the completion of testing.

Remeasurement Period Two:

During this remeasurement period another casual/barrier analysis was completed utilizing the regional Quality Improvement Council. It was determined that the interventions that were implemented during remeasurement period one were successful and therefore should continue into this period.

The following additional common barrier was identified:

- There is a lack of access to lab work completion data

To assist with overcoming the identified barrier, MSHN will implement the following intervention:

MSHN will utilize the ICDP database to run a care alert report that included data on the Diabetes Screening Key Performance Indicator (KPI) in real time. The care alerts include individuals who are currently open to the CMHSP and who have not had a diabetes screening completed within the past 12 months.

Remeasurement Period One Goal

Remeasurement period one covered the time period of October 01, 2014 through September 30, 2015. The goal was to show an increase of 1% over the baseline rate of diabetes screenings (Note: Not the same as a 1 percentage-point increase).

Note: The goal for this period was to increase to 75% from the baseline rate of 73.7%. The actual percentage achieved was 77.5%, which was 3.8 percentage points above the baseline rate.

Remeasurement Period Two Goal

Remeasurement period two covered the time period of October 01, 2015 through September 30, 2016. The goal is to show an increase of 1.5 percentage points and a 1 percent increase over remeasurement period one.

This goal will be measured during the next reporting period.

Explanation of Scoring

Each required activity is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable,* or *Not Assessed*.

HSAG looks at the following stages: Design, Implementation and Evaluation and Outcomes.

The Study Design looks at if MSHN designed a scientifically sound study supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design allowed for the successful progression to the next stage of the PIP process.

The Study Implementation and Evaluation looks to see if MSHN progressed to completing causal/barrier analysis using quality improvement tools and implementing interventions likely to impact outcomes. MSHN submitted and analyzed remeasurement period one data in this year's validation. For the next annual validation, study outcomes will be assessed by comparing Mid-State Health Network's remeasurement two results with remeasurement period one.

Results: (Review of 27 elements)

Name of Project/Study	Type of Annual Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
Increasing Diabetes Screening for Consumers with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications	Initial Submission	89%	100%	Met
	Resubmission	100%	100%	Met

Percentage Score of Evaluation Elements *Met*—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
Percentage Score of Critical Elements *Met*—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
Overall Validation Status—Populated from the PIP Validation Tool and based on the percentage scores.

Conclusion/Summary

The **Mid-State Health Network** PIP received a *Met* score for 100 percent of critical evaluation elements and for 100 percent of the overall evaluation elements in the Study Design and Implementation and Evaluation stages.

The performance of this PIP suggests a thorough application of the PIP design, appropriate analysis of the results (showing statistical significant improvement), and implementation of system interventions related to barriers identified through quality improvement processes.

Based on the validation of this PIP, HSAG's assessment determined high confidence in the results.

V. Performance Improvement Project – RAS

Overview of Mid-State Health Network Recovery Assessment Scale Summary Report FY2016

Consumer Outcome Measure

Introduction

The Recovery Assessment Scale (RAS) was developed as an outcome measure for program evaluations. Based on a process model of recovery, the RAS attempts to assess aspects of recovery with a special focus on hope and self-determination.

The tool is distributed to adult consumers with a diagnosis of mental illness to assess the perceptions of individual recovery. All items are rated using the same 5-point Likert scale that ranges from 1 = "strongly disagree" to 5 = "strongly agree."

The distribution period was January 1, 2016 through March 31, 2016 and this marks the second year of implementation.

The following overview of Mid-State Health Network's (MSHN) Recovery Assessment Scale 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 from 2,818 consumer's representing all 12 CMHSPs. 1,430 were Initial surveys, and 1,388 were Ongoing surveys. There were 558 respondents from Bay-Arenac Behavioral Health Authority (252 Initial, 307 Ongoing), 201 respondents from Community Mental Health Authority of CEI (35 Initial, 166 Ongoing), 746 respondents from CMH for Central Michigan (452 Initial, 294 Ongoing), 93 respondents from Gratiot County CMH (56 Initial, 37 Ongoing), 169 respondents from Huron Behavioral Health (79 Initial, 90 Ongoing), 292 respondents from Lifeways (177 Initial, 115 Ongoing), 133 respondents from Montcalm Care Network (123 Initial, 10 Ongoing), 64 respondents from Newaygo County CMH (61 Initial, 3 Ongoing), 222 respondents from Saginaw County CMH (78 Initial, 144 Ongoing), 165 respondents from Shiawassee County CMH (51 Initial, 114 Ongoing), 41 respondents from The Right Door (14 Initial, 27 Ongoing), and 134 respondents from Tuscola Behavioral Health System (53 Initial, 81 Ongoing) The survey results were aggregated and scored as outlined in the University of Sydney instructions.

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 to draw conclusions or make assumptions without further analysis.

MSHN Summary

The responses from the Recovery Assessment Scale survey were scored as a comprehensive total and into three separate domains. The comprehensive score measures how the system is performing as a whole, and the performance of three separate domains, and one uncategorized area:

- Personal Recovery
  - Questions 1, 3, 4, 5, 7, 8, 9, 10, 11, 15, and 17
    1: I have a desire to succeed
    3: I have goals in life that I want to reach.
    4: I believe I can meet my current personal goals.
    5: I have a purpose in life.
    7: I can handle what happens in my life.
    8: I like myself.
    9: If people really knew me, they would like me.
    10: Something good will eventually happen.
    11: I'm hopeful about my future.
    15: I know when to ask for help.
    17: I ask for help, when I need it.

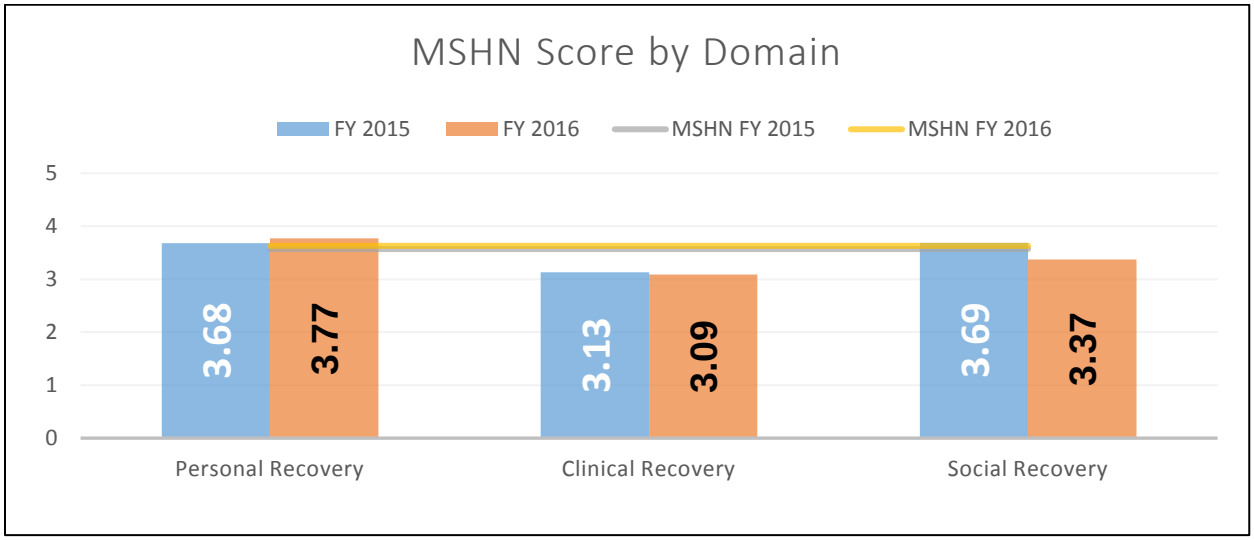
- Clinical Recovery
  - Questions 2, 13, and 14
    2: I have my own plan for how to stay or become well.
    13: My symptoms interfere less and less with my life.
    14: My symptoms seem to be a problem for shorter periods of time each time they occur.

- Social Recovery
  - Questions 6, 18, 19, and 20
    6: Even when I don't care about myself, other people do.
    18: I have people I can count on.
    19: Even when I don't believe in myself, other people do.
    20: It is important to have a variety of friends.

- Uncategorized Questions
  - Questions 12 and 16
    12: Coping with my mental illness is no longer the main focus of my life.
    16: I am willing to ask for help.

Figure 1 illustrates how MSHN's 12 CMHSPs scored themselves comprehensively and in the three separate domains. The MSHN comprehensive score for FY 2015 was 3.57, and for FY 2016 was 3.63.

Fig. 1 – MSHN Score by Domain



MSHN CMHSP Summary

The responses from the Recovery Assessment Scale survey were also analyzed by CMHSP, scored comprehensively, and by the separate domains.

Figure 2 illustrates how each CMHSP scored comprehensively in FY 2015 and FY 2016. The MSHN comprehensive score for FY 2015 was 3.57, and for FY 2016 was 3.63.

Fig. 2 – Comparison of CMHSP Comprehensive Score

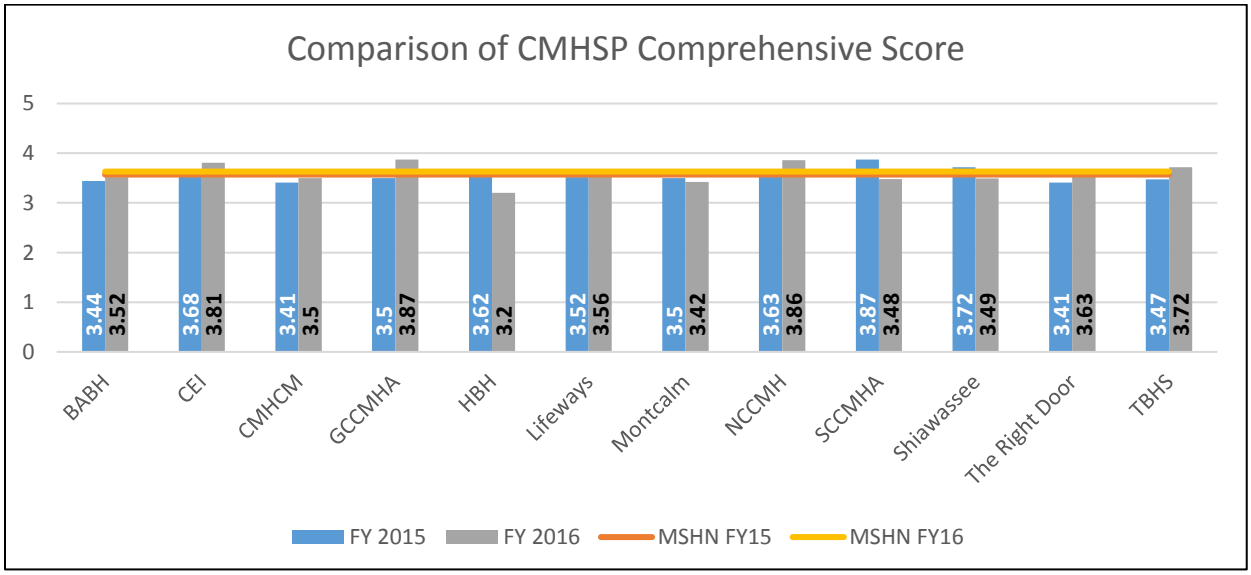


Figure 3 illustrates how ow each CMHSP scored comprehensively with Initial and Ongoing Recovery Assessment Scale survey responses for FY 2016. The MSHN comprehensive scores for the Initial surveys was 3.48, and 3.76 for the Ongoing.

Fig. 3 – Comparison of CMHSP Comprehensive Score between Initial and Ongoing survey responses.

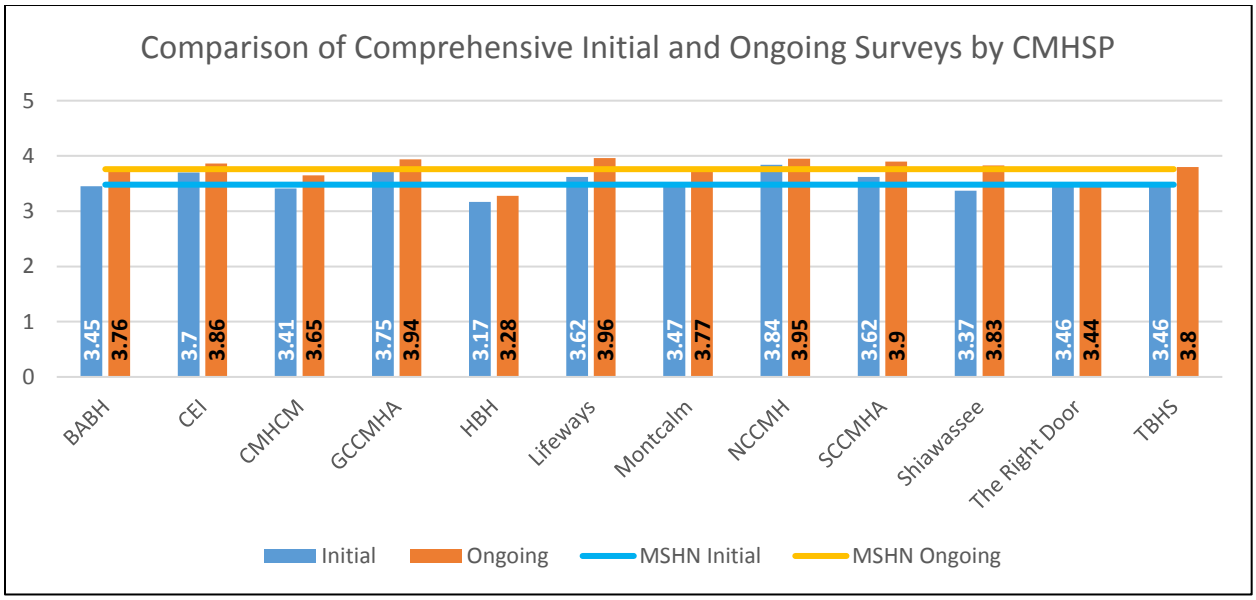


Figure 4 illustrates how each CMHSP scored in the Personal Recovery domain in both the Initial and Ongoing surveys. The MSHN score for the Personal Recovery domain for Initial surveys was 3.31, and 3.87 for Ongoing.

Fig. 4 – Comparison of CMHSP Personal Recovery Score

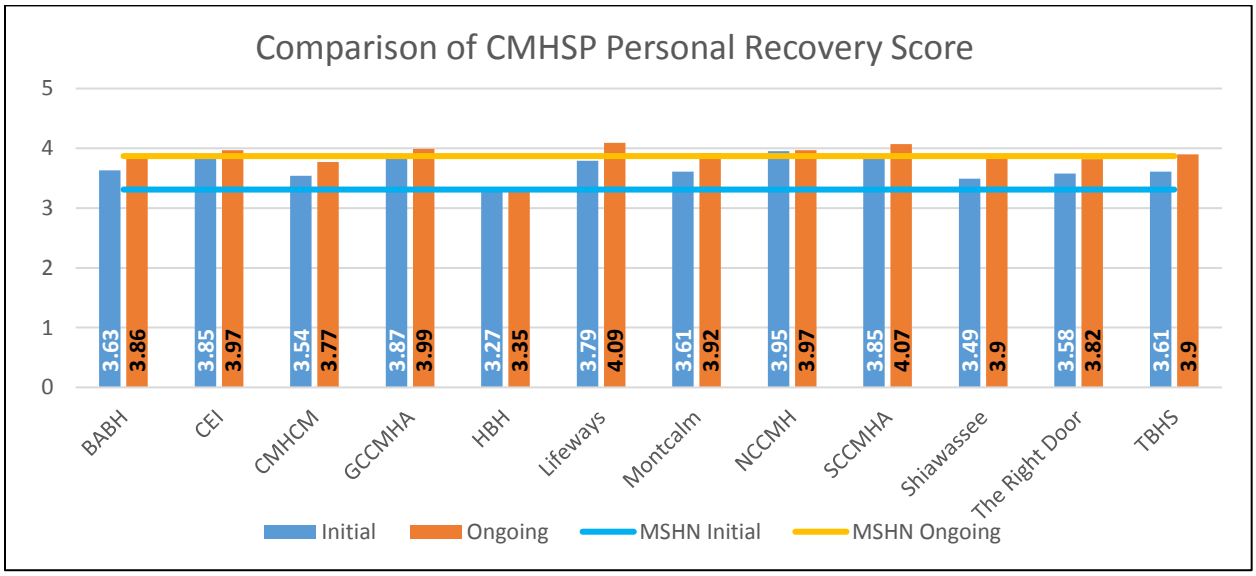


Figure 5 illustrates how each CMHSP scored in the Clinical Recovery domain in both the Initial and Ongoing surveys. The MSHN score for the Clinical Recovery domain for the Initial surveys was 2.82, and 3.37 for Ongoing.

Fig 5 – Comparison of CMHSP Clinical Recovery Score

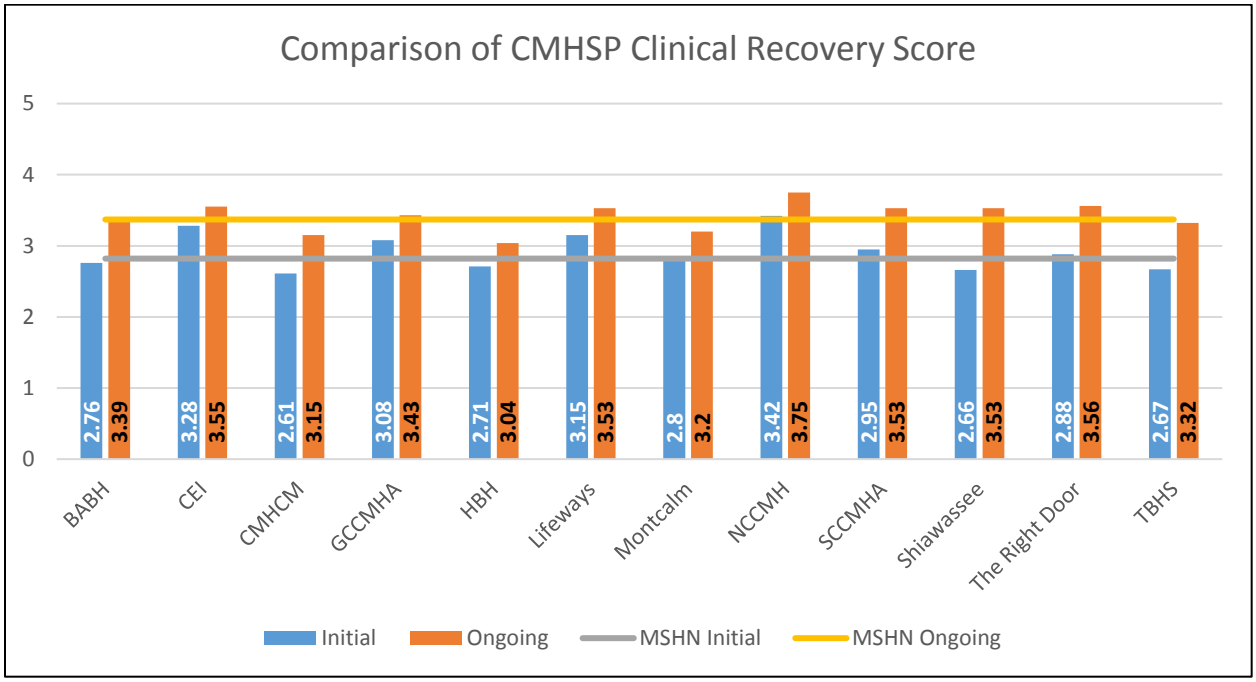
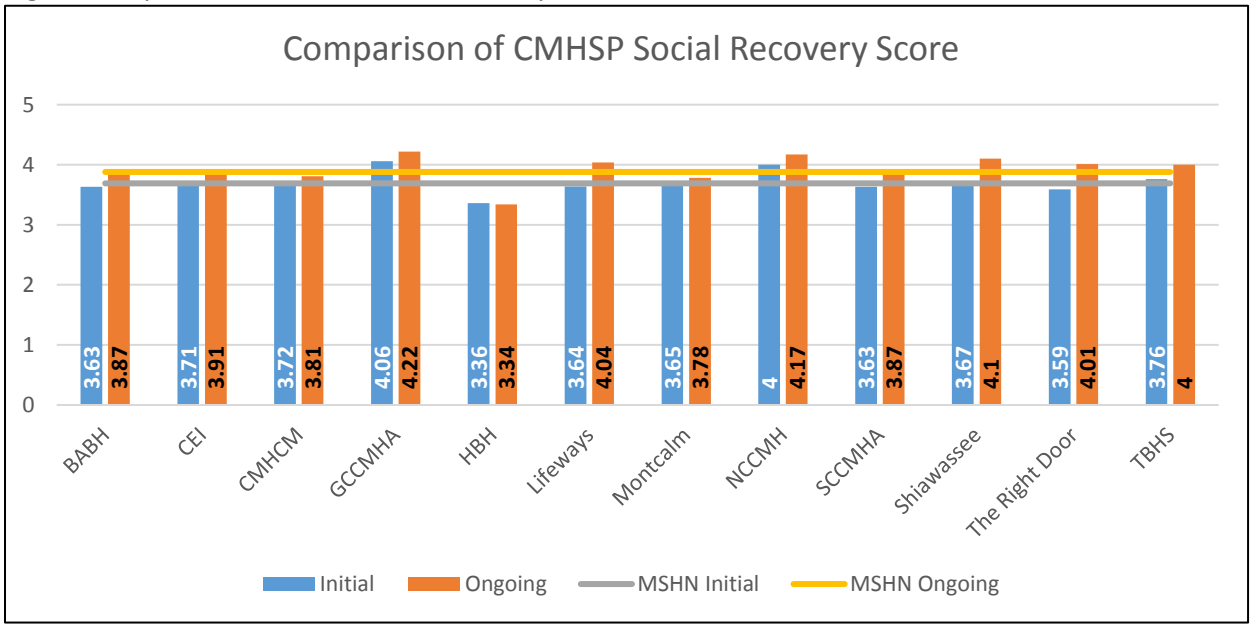


Figure 6 illustrates how each CMHSP scored in the Social Recovery domain in both the Initial and Ongoing surveys. The MSHN score for the Social Recovery domain for Initial surveys was 3.69, and 3.88 for Ongoing.

Fig 6 – Comparison of CMHSP Social Recovery Score



MSHN Recovery Assessment Scale Domain Response

The responses from the Recovery Assessment Scale survey were analyzed by domain questions and responses. This analysis was performed by each CMHSP.

Figure 7 illustrates how MSHN's 12 CMHSPs responded to the eleven Personal Recovery Domain questions. The questions included in this domain are as follows:

1: I have a desire to succeed
3: I have goals in life that I want to reach.
4: I believe I can meet my current personal goals.
5: I have a purpose in life.
7: I can handle what happens in my life.
8: I like myself.
9: If people really knew me, they would like me.
10: Something good will eventually happen.
11: I'm hopeful about my future.
15: I know when to ask for help.
17: I ask for help, when I need it.

Fig. 7 – MSHN - Personal Recovery Domain Response

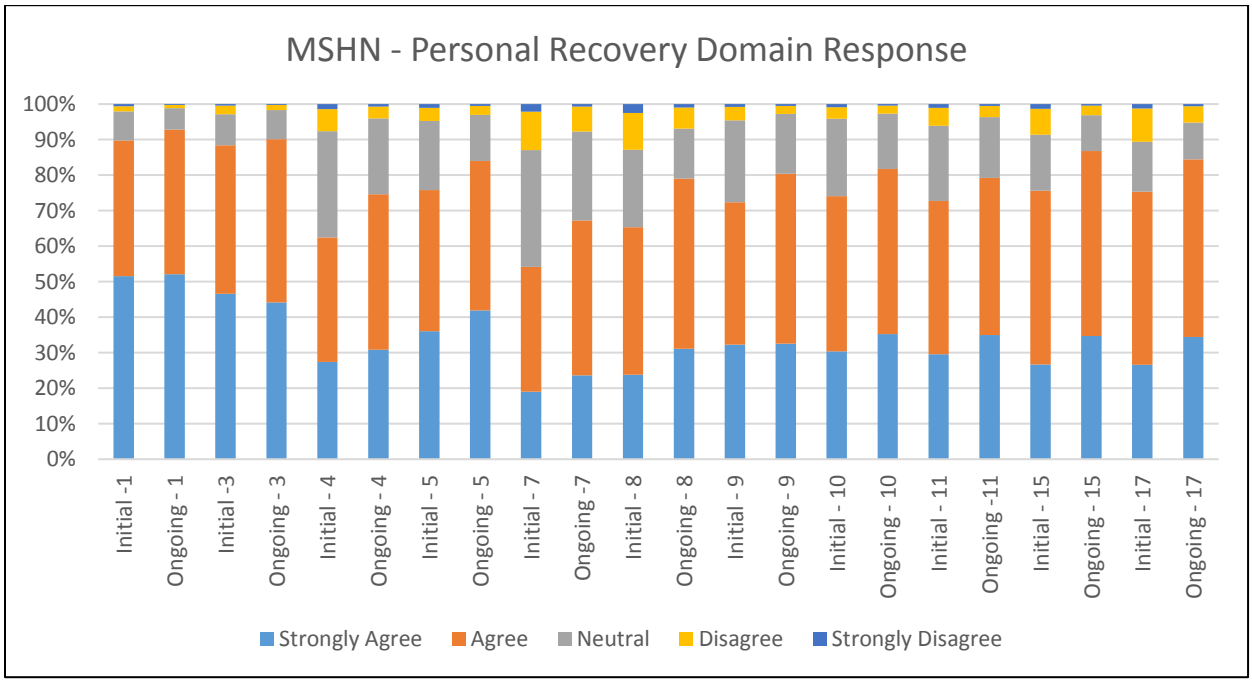


Figure 8 illustrates how MSHN's 12 CMHSPs responded to the three Clinical Recovery Domain questions. The questions included in this domain are as follows:

2: I have my own plan for how to stay or become well.
13: My symptoms interfere less and less with my life.
14: My symptoms seem to be a problem for shorter periods of time each time they occur.

Fig. 8 – MSHN – Clinical Recovery Domain Response

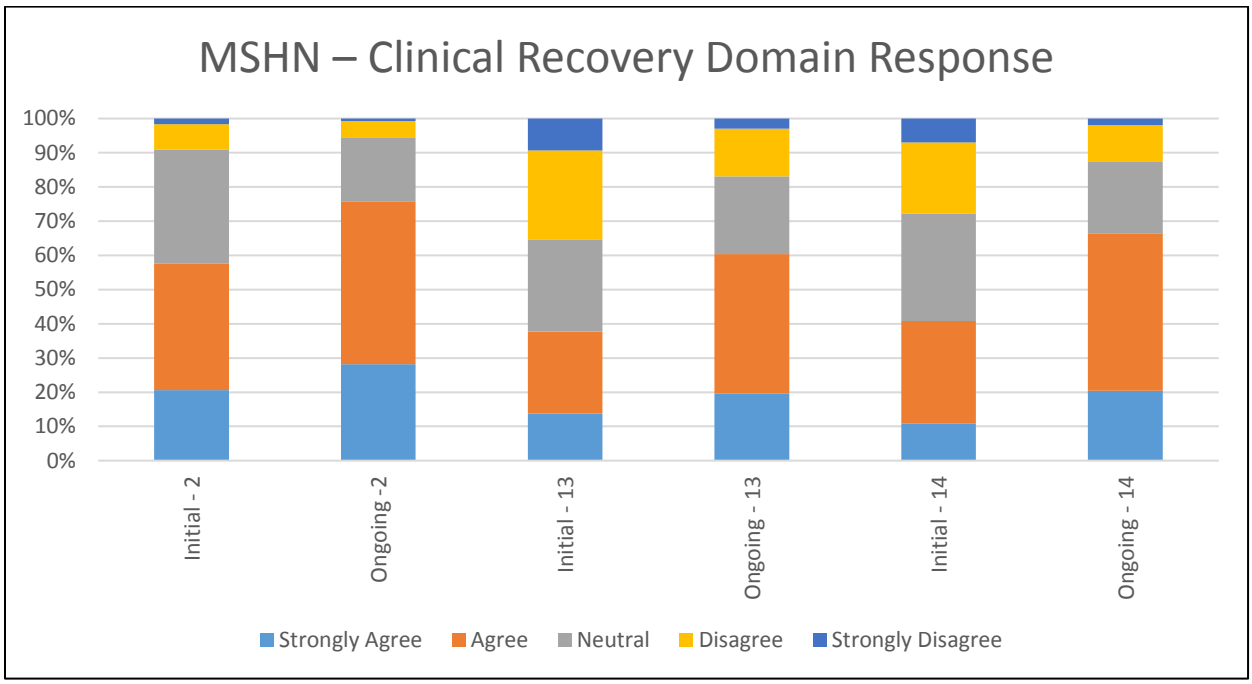


Figure 9 illustrates how MSHN's 12 CMHSPs responded to the four Social Recovery Domain questions. The questions included in this domain are as follows:

6: Even when I don't care about myself, other people do.
18: I have people I can count on.
19: Even when I don't believe in myself, other people do.
20: It is important to have a variety of friends.

Fig. 9 – MSHN – Social Recovery Domain Response

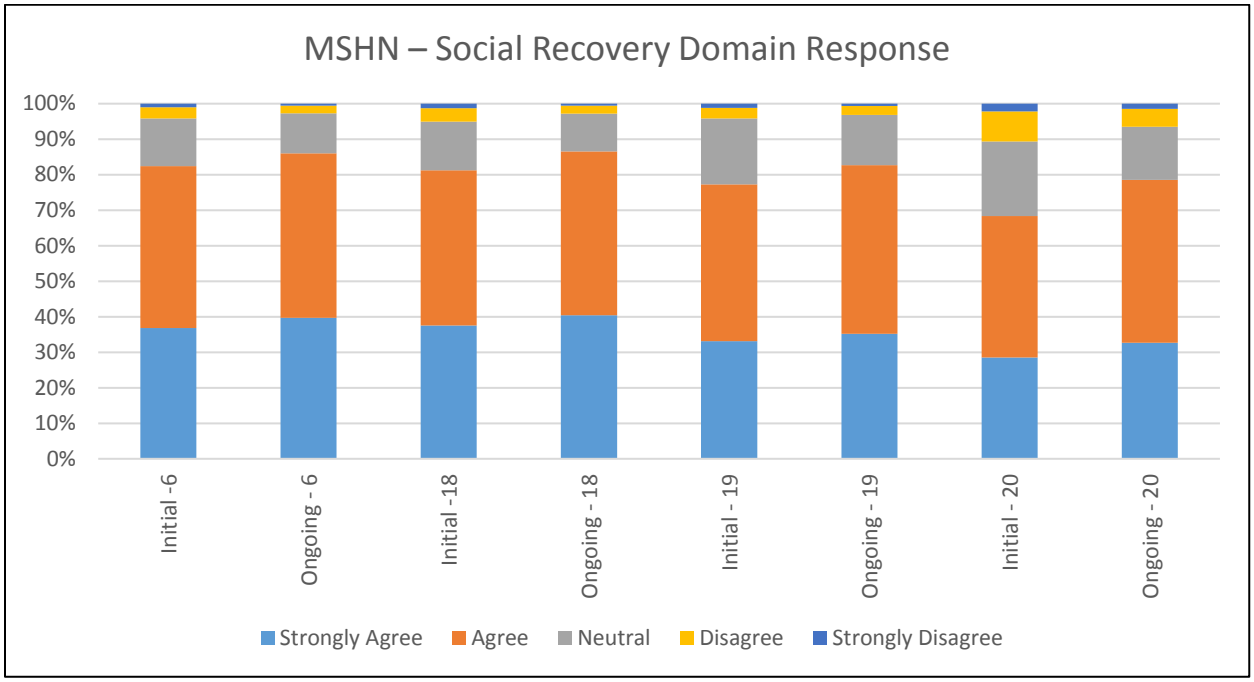
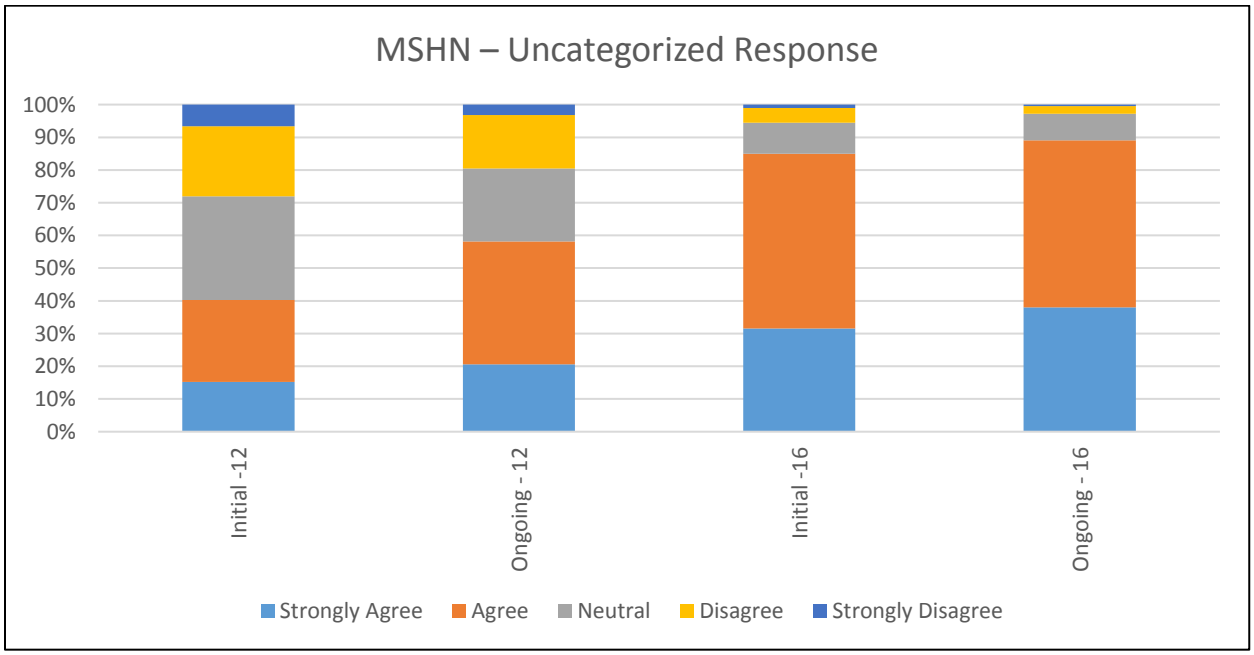


Figure 10 illustrates how all 12 CMHSPs responded to two uncategorized questions. The questions included are as follows:

12: Coping with my mental illness is no longer the main focus of my life.
16: I am willing to ask for help.

Fig. 10 – MSHN – Uncategorized Response



Conclusion:

The results in Figure 1 and 2 compare the FY2016 results to the FY2015 results.

Figure 1:
The FY2016 MSHN comprehensive results by domain identified a slight increase for the domain of personal recovery, but showed a slight decrease in the clinical and social recovery domains when compared to the results from FY2015.

Figure 2:
The FY2016 comprehensive scores by each CMHSP identified that eight (8) CMHSP's showed an improvement when compared to FY2015 results and four (4) showed a decrease.

Figures 3 through 10 contain results for the FY2016 surveys.

Figure 3:
The FY2016 CMHSP comprehensive scores comparing "initial" and "ongoing" survey scores identified that eleven (11) CMHSP's scored higher among the "ongoing" surveys and one (1) CMHSP showed a very slight decrease of 0.02% for the "ongoing" survey results.

Figure 4:
The FY2016 CMHSP results for the personal recovery domain identified that all twelve (12) CMHSP's scored a higher percentage for the "ongoing" survey than for the "initial" surveys.

Figure 5:
The FY2016 CMHSP results for the clinical recovery domain identified that all twelve (12) CMHSP's scored a higher percentage for the "ongoing" survey than for the "initial" surveys.

Figure 6:
The FY2016 CMHSP results for the social recovery domain identified that eleven (11) CMHSP's scored a higher percentage for the "ongoing" survey than for the "initial" surveys and only one (1) CMHSP scored lower on the "ongoing" survey but did so only by 0.02%.

Figure 7:
The MSHN scores for the personal recovery domain questions showed that most individuals responded with "strongly agreed" or "agreed" and the percentages for the "ongoing" surveys versus the "initial" surveys demonstrated a higher level of agreement. The question, "I can handle what happens in my life" had the highest combined percentage of 12.99% who responded with "disagreed" and/or "strongly disagreed" for the initial surveys.

Figure 8:
The clinical recovery domain question "I have my own plan for how to stay or become well" scored the highest for "strongly agreed" and "agreed" for the "ongoing" group. The question "My symptoms interfere less and less with my life" received the highest combined scores of "strongly disagreed" and 'disagreed" with the "initial" group. The percentages for those in the "ongoing" group scored higher in all domain questions versus those in the "initial" survey group.

Figure 9:
The social recovery domain question “I have people I can count on” scored the highest for “strongly agreed” and “agreed” for the “ongoing” group. The question “It is important to have a variety of friends” received the highest combined scores of “strongly disagreed” and ‘disagreed” with the “initial” group. The percentages for those in the “ongoing” group scored higher in all domain questions versus those in the “initial” survey group.

Figure 10:
This figure showed the result for the two “uncategorized” questions. The question “Coping with my mental illness is no longer the main focus of my life” had the highest combined responses for “strongly agreed” and “agreed” for the “ongoing” group. The question “I am willing to ask for help” received the highest combined score of “strongly disagreed” and “disagreed” for the “initial” group. Both questions showed a higher percentage among the “ongoing” group versus the “initial” group.

In summary, the survey results identified a higher percentage of satisfaction for those in the “ongoing” group versus those in the “initial” group. This is a positive trend that supports that MSHN and the CMHSP’s embrace a culture and provide services and supports that are founded in recovery.
The results will be reviewed further by the MSHN Quality Improvement Council to determine if there are any trends evident from FY15 to FY16 and if any regional improvement efforts can be made. Areas of improvement will be targeted toward below average scores (based on the regional average of all scores) in each of the domains and priority areas as identified through review by the Regional Advisory Council. Each CMHSP will also review their local results for analysis and identification of local improvement efforts.

Report Completed by: Mid-State Health Network **Date**: 06/2016

MSHN QIC Approved: 06/23/16

VI. Performance Improvement Project – RSA

Overview of Mid-State Health Network Recovery Self-Assessment Survey Summary Report FY2016

Provider Network Administrator Measure

Introduction

The Recovery Self-Assessment Survey (RSA) is a self-reflective tool designed to identify strengths and target areas of improvement as agencies and systems strive to offer recovery-oriented care.

The following overview of Mid-State Health Network's (MSHN) Recovery Self-Assessment 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 supervisors representing all CMHSP programs that provide services to adults with a Mental Illness diagnosis. There were a total of 81 respondents representing all 12 CMHSPs. The survey results were aggregated and scored as outlined in the Yale Program for Recovery and Community Health instructions.

The distribution period was January 15, 2016 through February 15, 2016 and this marks the second 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.

MSHN Summary

The responses from the Recovery Self-Assessment surveys were scored as a comprehensive total and separately as six subcategories. The comprehensive score measures how the system is performing as a whole, and the subcategories measures the performance of six separate parts:

- Invite – How welcoming the facility and its staff are to the client
    - Questions included
        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.).

- Choice – How the provider takes into account the client's preferences and choices during the recovery process
    - Questions included

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.

- Involvement – How the provider allows clients to become involved in the recovery process
  - Questions included
    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.

- Life Goals – How the provider encourages clients to pursue individual goals and interests
  - Questions included
    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.

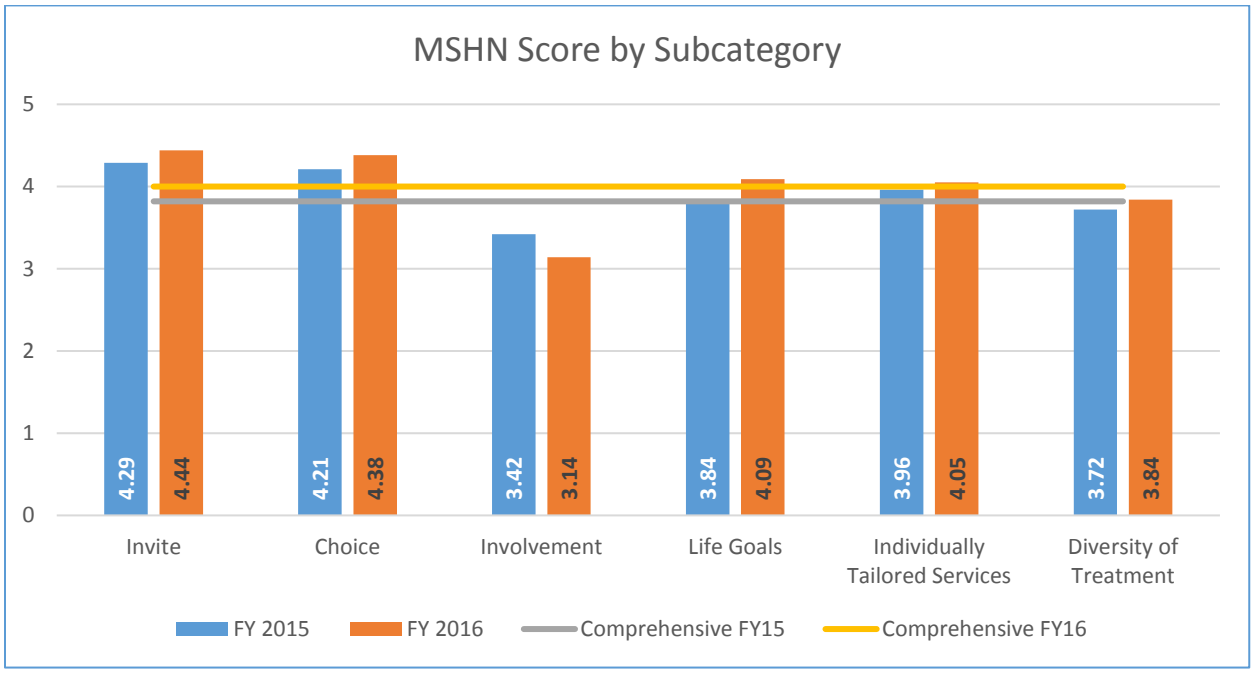
- Individually Tailored Services – How the provider helps clients tailor their treatment programs to their individual needs
    - Questions Included
        11. Staff regularly ask program participants about their interests and the things they would like to do in the community.
        13. This program 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, friend, clergy, or an employer).
        30. Staff at this program regularly attend trainings on cultural competency.

- Diversity of Treatment – How the provider offers a range of treatment options and style to cater to the client's needs and preferences
    - Questions Included
        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.

There were ten respondents from Bay-Arenac Behavioral Health Authority, eleven respondents from Community Mental Health Authority of CEI, thirteen respondents from Community Mental Health for Central Michigan, three respondents from Gratiot County Community Mental Health Authority, five respondents from Huron Behavioral Health, seven respondents from Lifeways Community Mental Health, six respondents from Montcalm Care Center, two respondents from Newaygo County Community Mental Health, eleven respondents from Saginaw County Community Mental Health, four respondents from Shiawassee County Community Mental Health, six respondents from The Right Door, and three respondents from Tuscola Behavioral Health System were aggregated for this overview.

Figure 1 illustrates how MSHN's twelve CMHSPs scored themselves comprehensively and in the six separate subcategories. The comprehensive score for FY 2015 was 3.82, and 4.00 for FY 2016.

Fig. 1 – MSHN Score by Subcategory



MSHN CMHSP Summary

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

Figure 2 illustrates how each CMHSP scored comprehensively. The MSHN average was 3.82 for FY 2015, and 4.00 for FY 2016.

Fig. 2 – Comparison of CMHSP Comprehensive Score

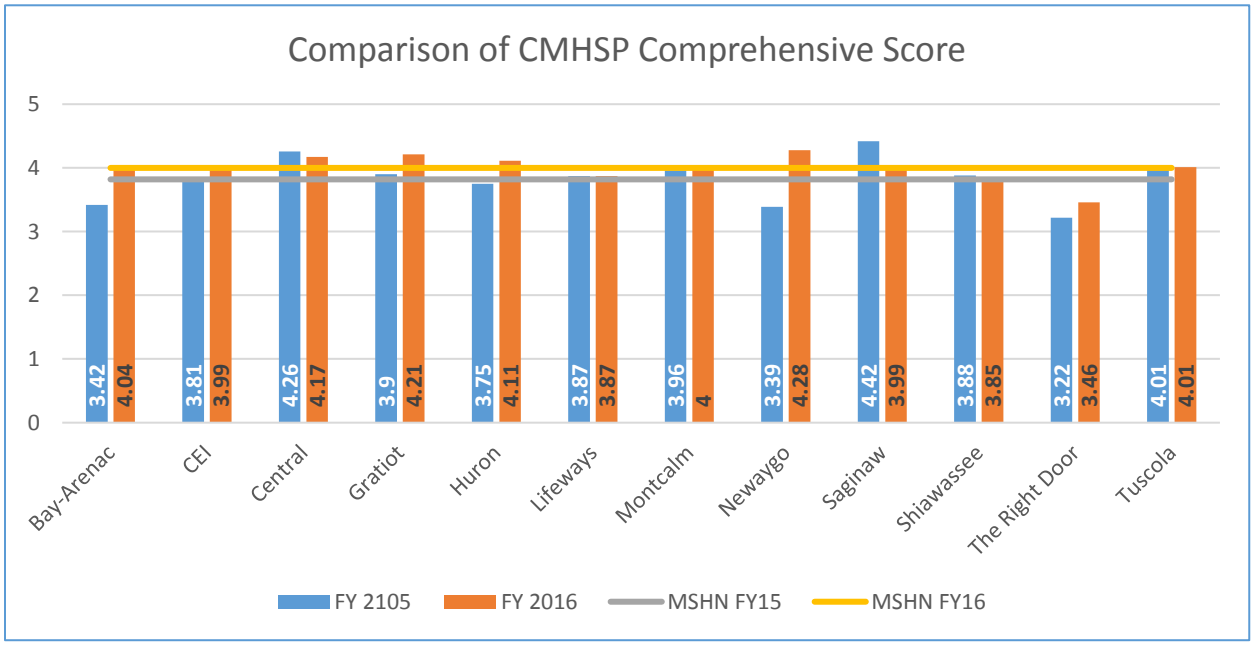


Figure 3 illustrate how each CMHSP scored in the Invite subcategory. The MSHN average was 4.29 for FY 2015, and 4.44 for FY 2016.

Fig. 3 – Comparison of CMHSP Invite Subcategory Score

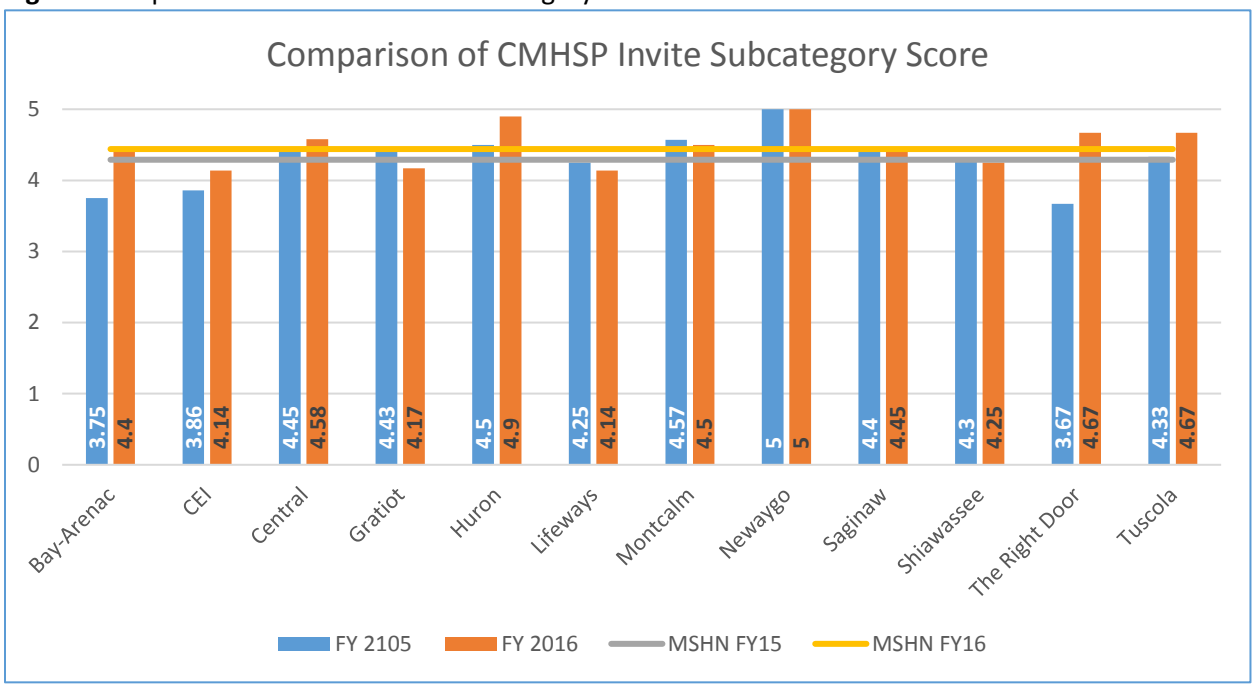


Figure 4 illustrates how each CMHSP scored in the Choice subcategory. The MSHN average for FY 2015 was 4.21, and 4.38 for FY 2016.

Fig. 4. – Comparison of CMHSP Choice Subcategory Score

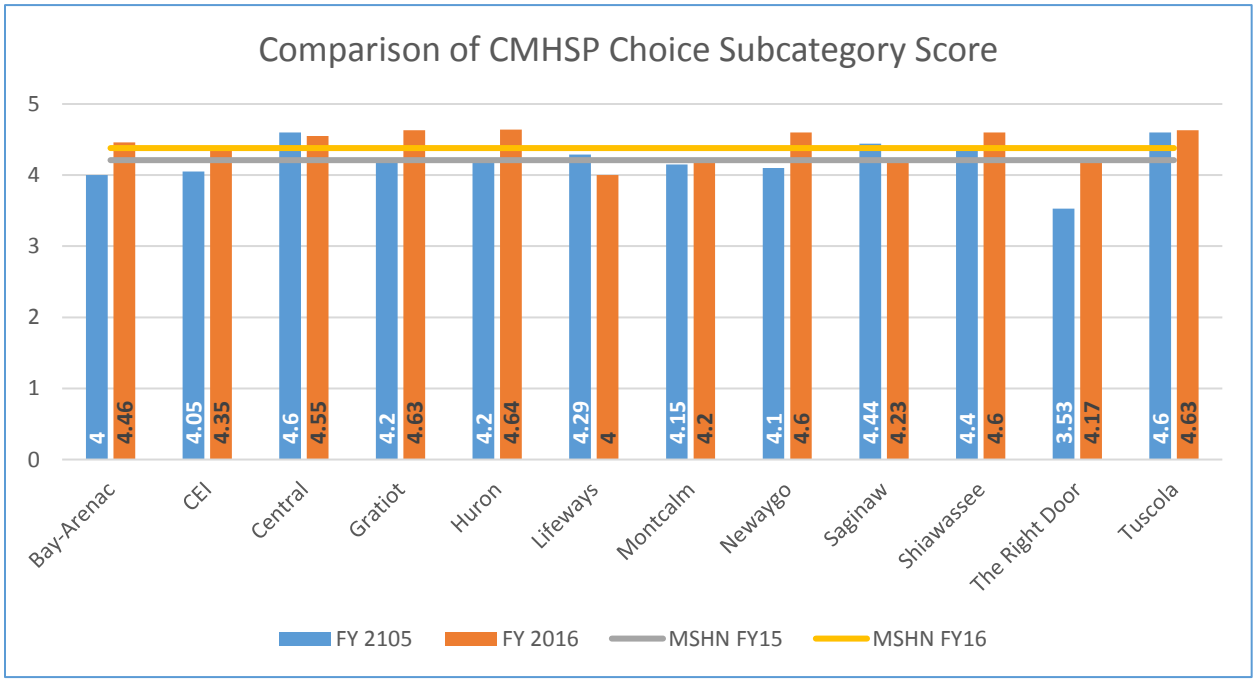


Figure 5 illustrates how each CMHSP scored in the Involvement subcategory. The MSHN average for FY 2015 was 3.42, and 3.14 for FY 2016.

Fig. 5 – Comparison of CMHSP Involvement Subcategory Score

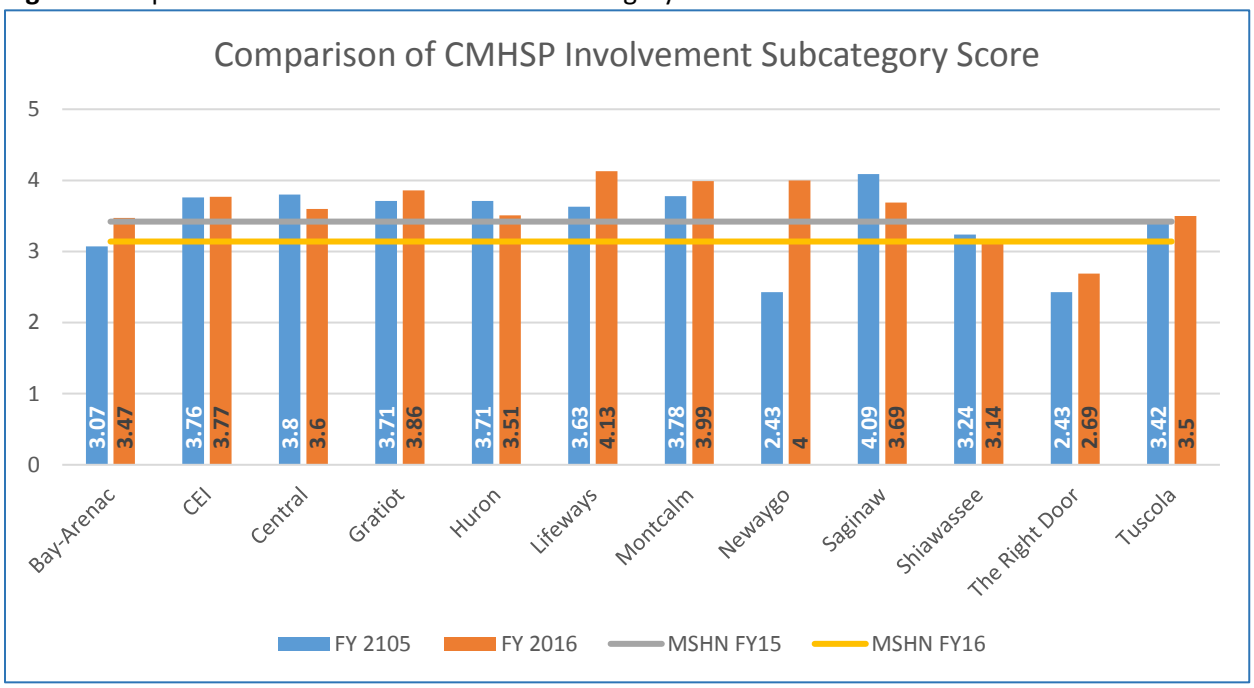


Figure 6 illustrates how each CMHSP scored in the Life Goals subcategory. The MSHN average for FY 2015 was 3.84, and 4.09 for FY 2016.

Fig. 6 – Comparison of CMHSP Life Goals Subcategory Score

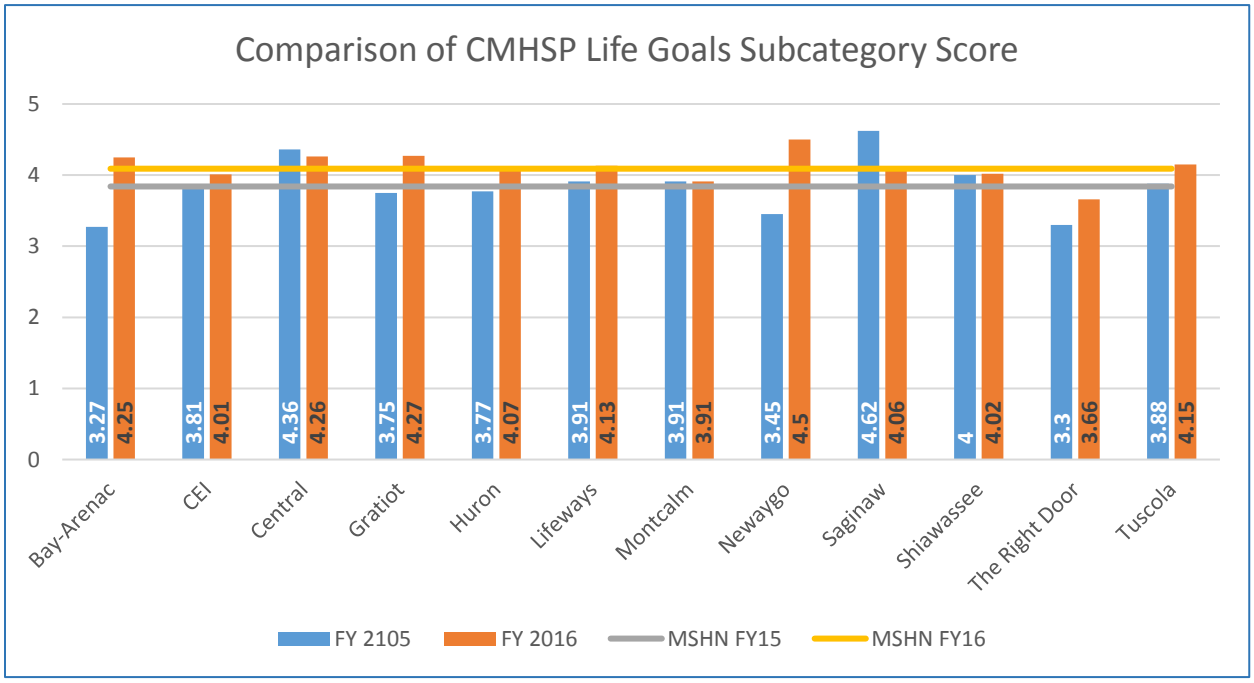


Figure 7 illustrates how each CMHSP scored in the Individually Tailored Services subcategory. The MSHN average for FY 2015was 3.96, and 4.05 for FY 2016.

Fig. 7 – Comparison of CMHSP Individually Tailored Services Subcategory Score

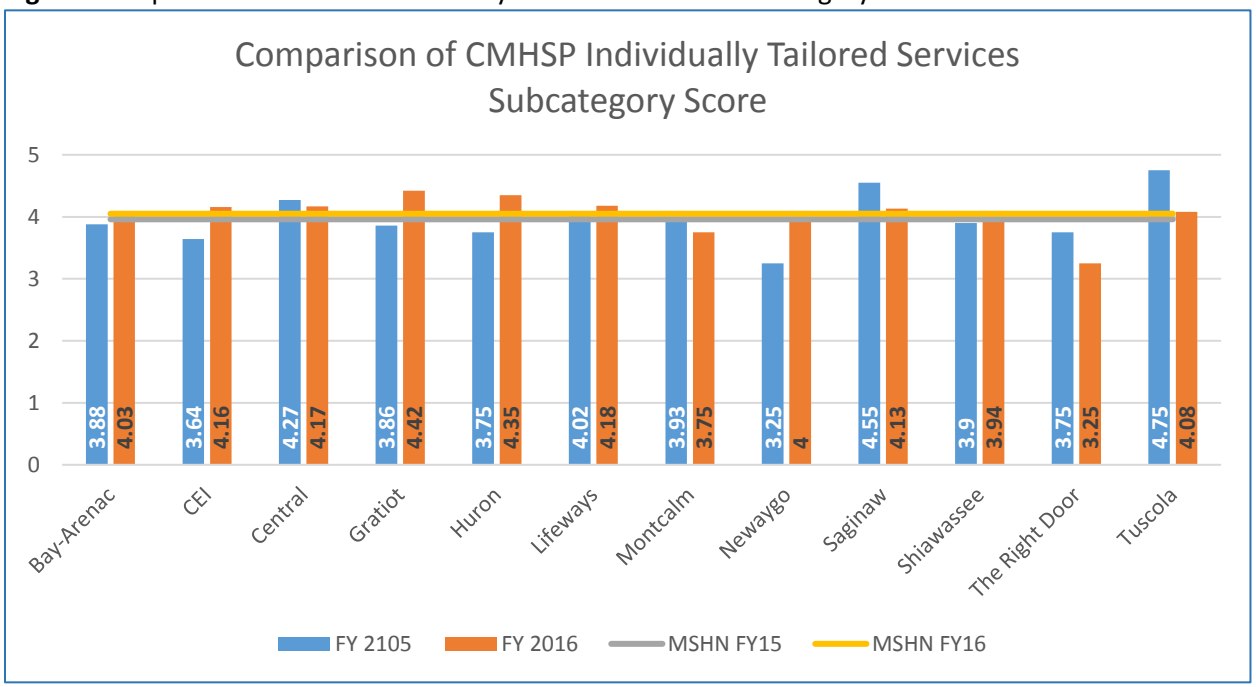
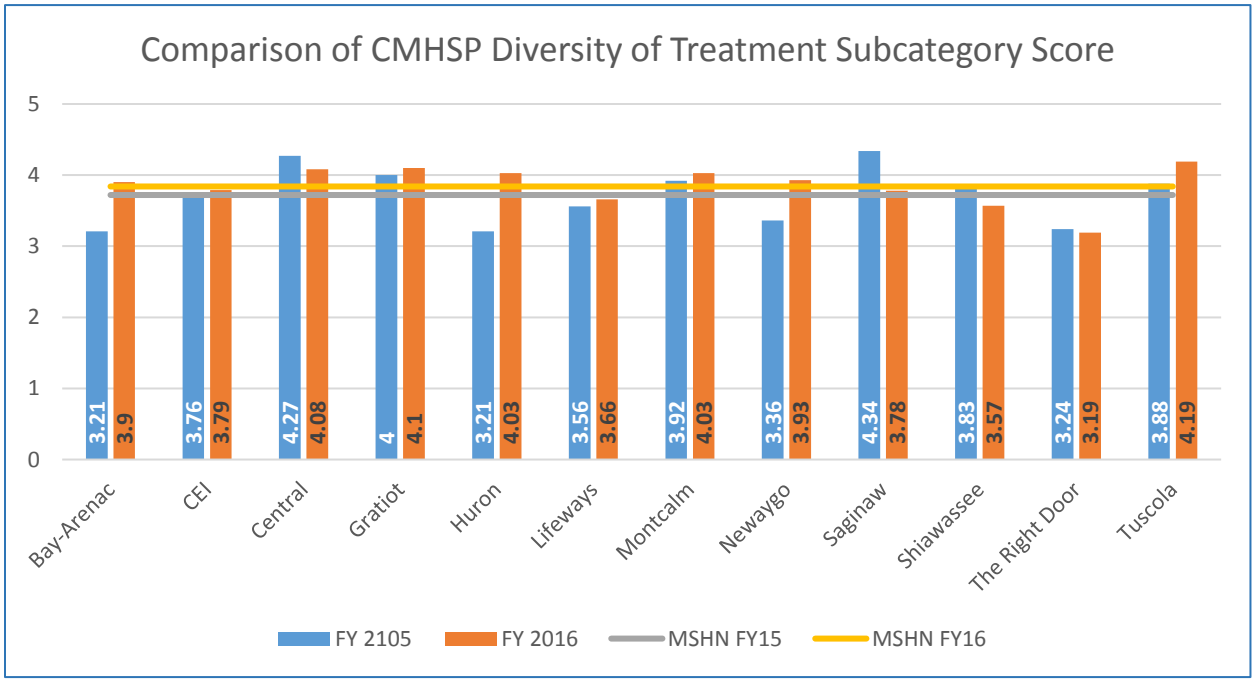


Figure 8 illustrates how each CMHSP scored in the Diversity of Treatment subcategory. The MSHN average for FY 2015 was 3.72, and 3.84 for FY 2016.

Fig. 8 – Comparison of CMHSP Diversity of Treatment Subcategory Score



MSHN Survey Response by Percentage

The Recovery Self-Assessment surveys were analyzed by subcategory questions and response. The not applicable and do not know responses were removed from the analysis. This analysis was performed by each CMHSP.

Figure 9 illustrates how all 12 CMHSPs responded to the two Invite subcategory questions for FY 2015 and FY 2016. 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.).

Fig. 9 – MSHN – Invite Subcategory Survey Response by Percentage

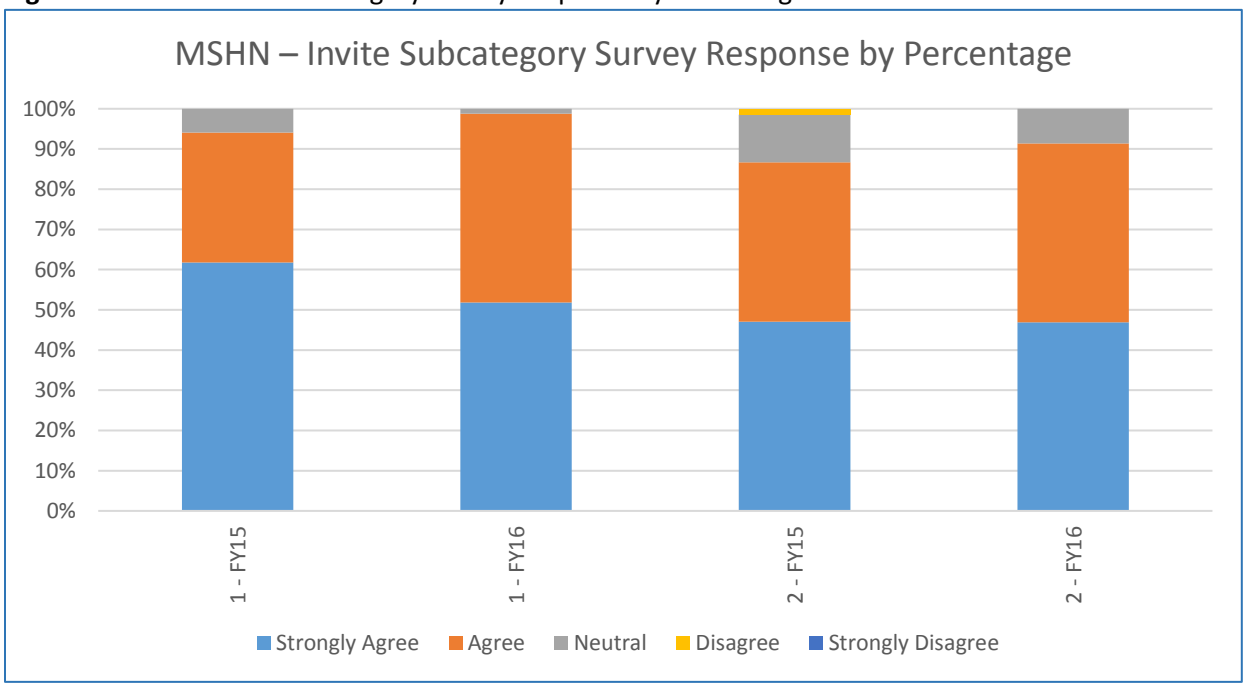


Figure 10 illustrates how all 12 CMHSPs responded to the 4 Choice subcategory questions. The questions included in the Choice subcategory are as follows:

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.

Fig. 10 – MSHN – Choice Subcategory Survey Response by Percentage

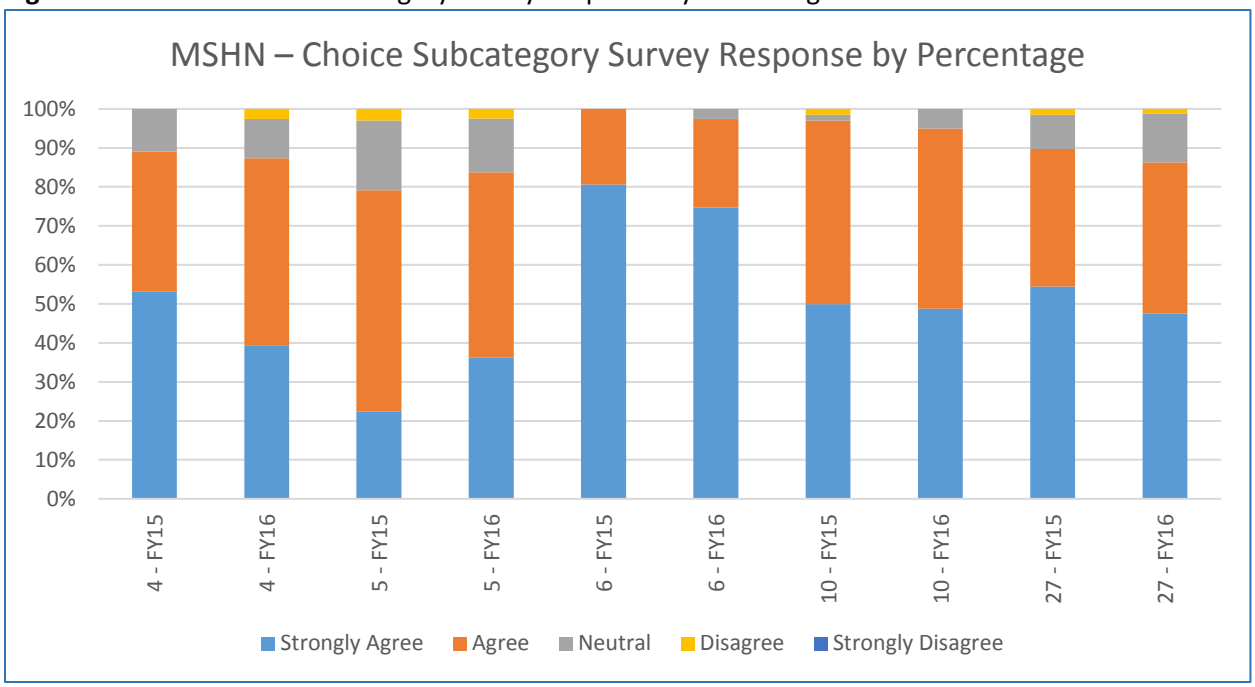


Figure 11 illustrates how all 12 CMHSPs responded to the 7 Involvement subcategory questions. The questions included in the Choice subcategory are as follows:

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.

Fig. 11 – MSHN – Involvement Subcategory Survey Response by Percentage

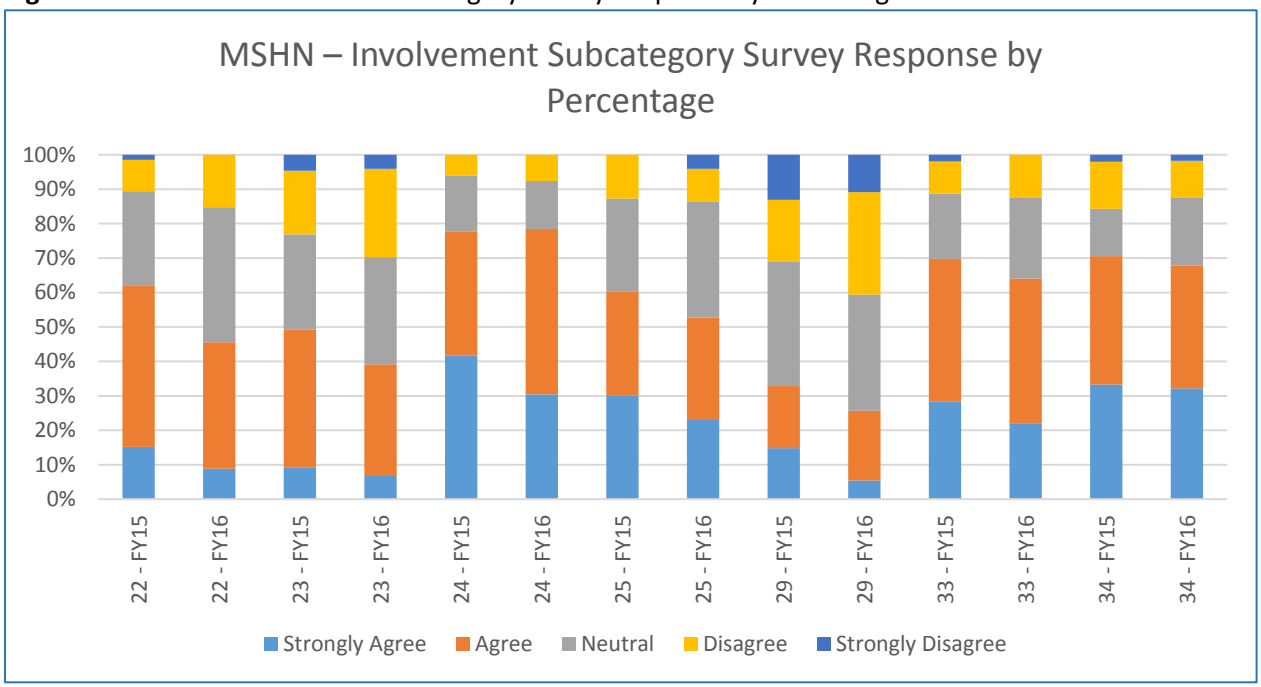


Figure 12 illustrates how all 12 CMHSPs responded to the Life Goals subcategory questions. The questions included in the Life Goals subcategory are as follows:

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.

Fig. 12 – MSHN – Life Goals Subcategory Survey Response by Percentage

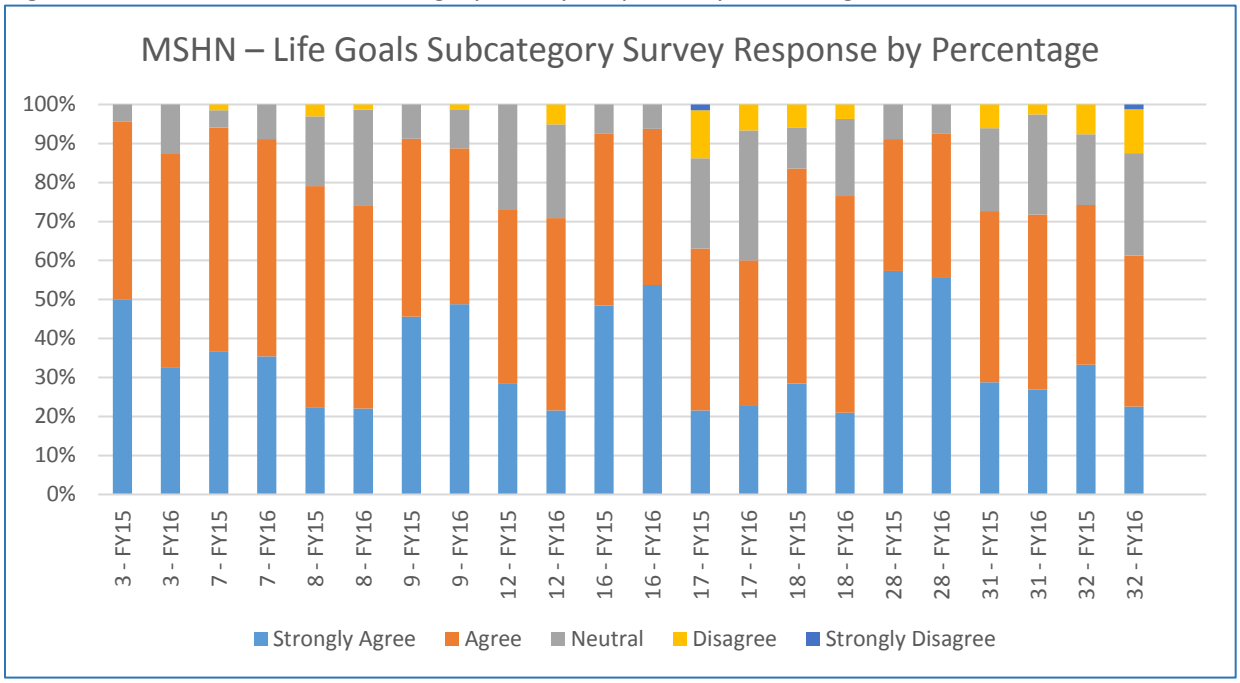


Figure 13 illustrates how all 12 CMHSPs responded to the 4 Individually Tailored Service subcategory questions. The questions included in the Individually Tailored Service subcategory are as follows:

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.

Fig. 13 – MSHN – Individually Tailored Service Subcategory Survey Response by Percentage

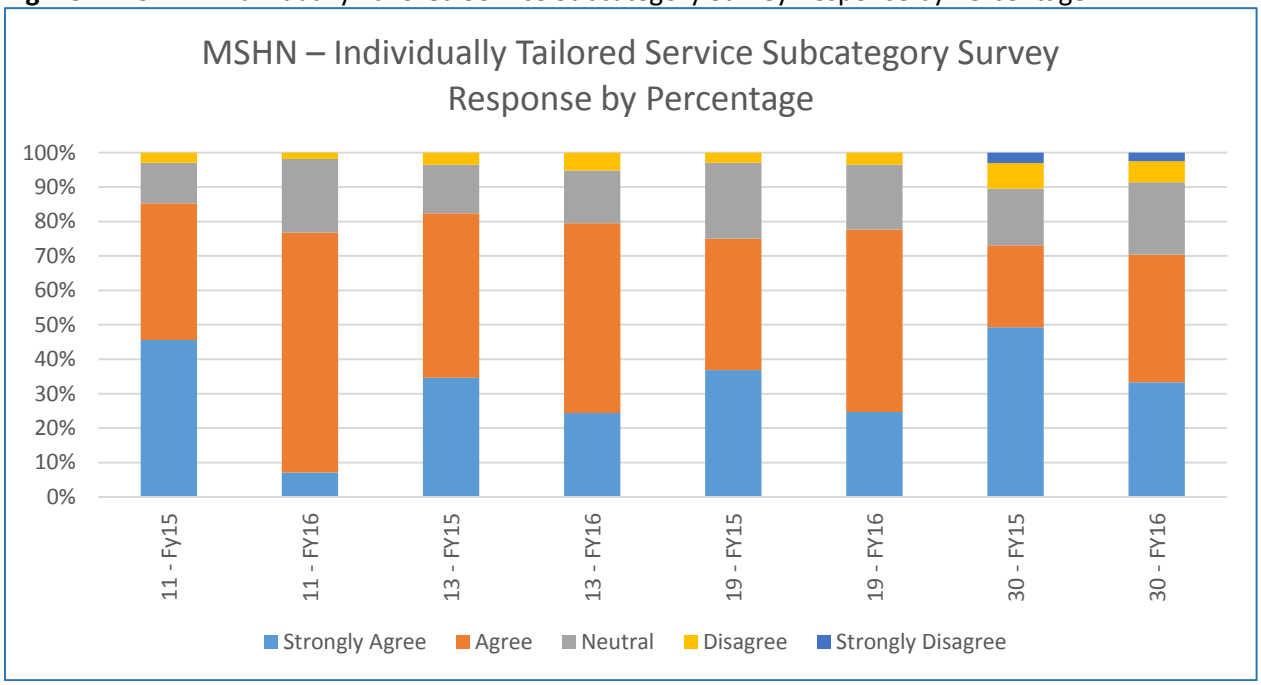
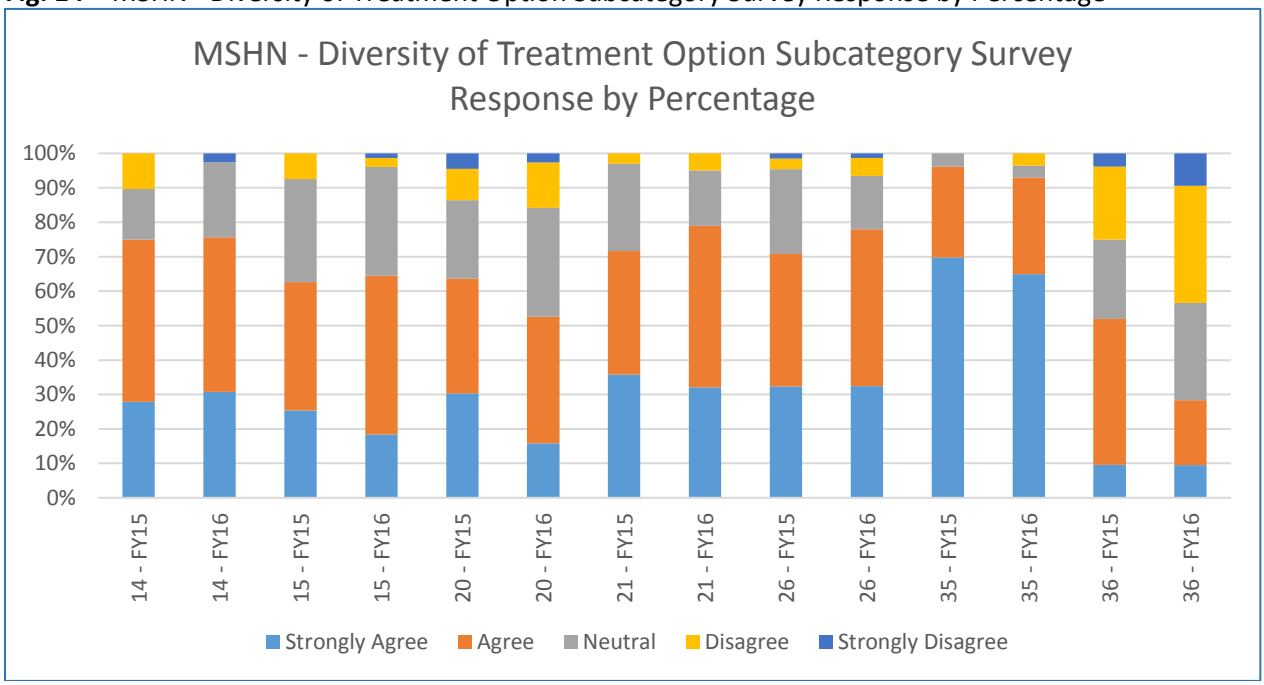


Figure 14 illustrates how all 12 CMHSP responded to the seven Diversity of Treatment Option subcategory questions. The questions included in Diversity of Treatment Option subcategory are as follows:

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.

Fig. 14 – MSHN - Diversity of Treatment Option Subcategory Survey Response by Percentage



Summary:

There was an increase of 11 participants who completed the survey from FY2015 (70) to FY2016 (81).

The survey consisted of 6 separate subcategories that included Invite, Choice, Involvement, Life Goals, Individually Tailored Services and Diversity of Treatment. The comprehensive scores of all 12 CMHSP's for five (5) of the subcategories showed a slight increase in satisfaction from FY15 to FY16 and those subcategories included: Invite, Choice, Life Goals, Individually Tailored Services and Diversity of Treatment. Only one (1) subcategory showed a slight decrease in satisfaction from FY15 to FY16 and that subcategory was Involvement. The comprehensive score for all subcategories for MHSN went from 3.82 in FY15 to 4.00 in FY16.

The comprehensive scores per each CMHSP also indicated that seven (7) CMHSP's showed a slight increase in scores from FY15 to FY16, 2 CMHSP's remained unchanged in their scores, and three (3) showed a slight decrease in scores from FY15 to FY16.

The subcategories showed the following changes in the MSHN average score when compared to FY 15 to FY16:

Invite: 0.15 increase
Choice: 0.17 increase
Involvement: 0.28 decrease
Life Goals: 0.25 increase
Individually Tailored Services: 0.09 increase
Diversity of Treatment: 0.12 increase

The subcategory of "Life Goals" showed the greatest increase in average score and the subcategory of "Involvement" showed the greatest decrease in the average score.

The results will be reviewed further by the MSHN Quality Improvement Council to determine if there are any trends evident from FY15 to FY16 and if any regional improvement efforts can be made. 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 Advisory Council. Each CMHSP will also review their local results in all subcategories for analysis and identification of local improvement efforts.

Report Completed by: Mid-State Health Network **Date:** 06/2016

MSHN QIC Approved: 06/23/16

VII. Consumer Satisfaction Reports – MHSIP

Quality Assessment and Performance Improvement Program
2015 Perception of Care Report
Assertive Community Treatment

Introduction

The Michigan Department of Health and Human Services (MDHHS) requires a survey be administered annually to programs identified by the Michigan Quality Improvement Council. The Michigan QI Council has chosen the Assertive Community Treatment program as one of the programs for 2015. The program completed the **Mental Health Statistics Improvement Program (MHSIP)** over a two-week period of time. MDHHS provides implementation guidelines and instructions to each Prepaid Inpatient Health Plan (PIHP). Each PIHP is to administer the survey within the time frame allotted by MDHHS. The survey results are returned to MDHHS via supplied excel workbook.

Each PIHP, in collaboration with the Community Mental Health Services Program (CMHSP) and their contracted providers, utilized the MHSIP to conduct a region wide perception of care survey to determine any areas that may be deficient within the region. The data obtained by each CMHSP was provided to Mid-State Health Network (MSHN) for regional analysis. The survey outcomes reported to the MSHN's Quality Improvement Council (QIC) for FY15 will be compared to the Baseline Perception of Care Report that was prepared of the 2014 data.

Survey Response Rates

Clinicians tracked who was given a survey with a tally form for each program. Consumers were given an option to decline answering the survey questions. Those consumers who declined were removed from the total number of surveys distributed. The response rates were calculated by dividing the number of surveys that were received by the number of surveys that were distributed. **Figure 1** indicates the return rate for each CMHSP where data was available prior to February 19th. Any surveys received after February 19th were not included in the results.

Figure 1

	2015				2014	2013
MHSIP-ACT	**Distributed**	**Received**	**Declined**	**Response Rates**	**Response Rates**	**Response Rates**
MSHN	503	**230**	0	46%	34%	41%
Bay-Arenac	29	**17**	0	59%	64%	41%
CEI	48	**22**	21	46%	13%	44%
Central MI	98	**27**	16	28%	21%	55%
Gratiot	**	**	**	**	**	*
Huron	19	**11**	10	58%	23%	18%
Ionia	**	**	**	**	*	50%
Lifeways	191	**82**	28	43%	37%	23%
Montcalm	25	**10**	2	40%	25%	26%
Newaygo	**	**	**	**	*	17%
Saginaw	40	**35**	5	88%	78%	85%

Shiawassee	20	**9**	2	45%	38%	45%
Tuscola	33	**17**	9	52%	50%	87%

*No Utilizers of ACT Services **No ACT Program

Methodology

The population type chosen was the Assertive Community Treatment (ACT) Team. The sample was a convenience sample of all who were scheduled to be seen within a pre-identified time frame. The Assertive Community Treatment (ACT) was given a choice of any two-week time frame between January 4th and February 5, 2016. All adult consumers within the ACT program will receive the MHSIP 44. The raw data was required to be received by MDHHS no later than March 11, 2016. MDHHS will prepare an analysis, which will include comparison data of PIHPs in Michigan and CMHSPs within each PIHP.

Consumers did have the option to decline participation. If a consumer declined, this was noted and removed from the number distributed.

There were two optional changes in the implementation process for FY2012. Based on discussions with Substance Abuse and Mental Health Services Administration (SAMHSA) and information from other states that implement the MHSIP, the MDHHS QIC decided that PIHPs can opt to assign numerical identifiers to the MHSIP in order to identify the respondents. The PIHP was to use the selected field in the data entry forms to inform MDHHS whether they have chosen to assign identifiers. These identifiers are for the PIHPs use only, and are not to be shared with MDHHS. MSHN did not require the use of identifiers for the survey.

Scoring

MHSIP – Seven domains are included in the survey. Each domain has multiple questions related to the domain topic. The domains are as follows: general satisfaction, access to care, quality of care, participation in treatment, outcomes of care, functional status, and social connectedness. Each question in the domain is required to have a response choice of 1 - 5 in order for the domain to be included in the sample. If one question is left blank, the responses of the remaining questions for that domain are excluded from the calculations of that domain. There are 6 response choices for each question within the domain, which are assigned a numeric value. Note that the number of responses included in the domain average and domain percentage of agreement could be less than that of each individual question as a result of the exclusion of unanswered questions when calculating the domain.

Strongly Agree=1	Agree=2
Neutral=3	Disagree=4
Strongly Disagree=5	Not Applicable=9

The mean of each individual question is calculated. Those less than or equal to 2.5 are considered to be "in agreement". The total number of respondents who were "in agreement" is then divided by the total respondents. The resultant number is then multiplied by 100 to provide a percentage.

Those questions that have a "Blank" or a response of "Not Applicable" were removed from the sample.

Data Analysis

Each survey was entered into an excel spreadsheet. The ACT program was categorized by numeric codes provided by MDHHS.

The results are analyzed as follows:

PIHP

- By Domain
- By Domain Line Item

CMHSP (Attachment A - MHSIP)

- By Domain
- By Domain Line Item

Survey Findings

MHSIP

Figure 2 demonstrates the percentage of agreement for each domain. Please refer to the scoring methodology above with questions related to the calculations. Those who responded to the survey indicated agreement at a decreased percentage compared to those who responded for the FY2014 survey. Each domain scored above the desired threshold of 80% except the "Perception of Outcome of Services", "Perception of Functioning", and "Perception of Social Connectedness". MSHN scored the highest in the "Perception of Participation in Treatment", "Perception of Access" and "General Satisfaction" domains in that order. Those who responded to the survey indicated:

a) Staff gave respondents the information needed to manage their illness (Survey Q19 – 88%, 186/212)
b) Staff gave Respondents information about their rights (Survey Q13 – 90%, 200/221)
c) Respondents were able to take responsibility for how to live their lives (Survey Q14 – 88%, 203/230)
d) Staff were sensitive to Respondents' cultural background (Survey Q18 – 81%, 165/203)
e) Staff respected Respondents' wishes about who to and not to give Respondents' information to (Survey Q16 – 88%, 191/218)
f) Staff believed Respondents could grow, change and recover (Survey Q10 – 88%, 198/226)
g) Staff encouraged Respondents to use consumer run programs (Survey Q20 – 84%, 179/213)
h) Respondents felt comfortable asking questions about their treatment (Survey Q11 – 89%, 204/230)
i) Staff were able to see Respondents at times that were good for Respondents (Survey Q7 – 87%, 197/227)
j) Staff returned calls within 24 hours (Survey Q6 – 90%, 198/221)
k) Respondents liked the services they received (Survey Q1 – 89%, 202/228)
l) Respondents would recommend the agency to a friend or family member (Survey Q3 – 83%, 189/228).

Figure 2

Adult Survey	General Satisfaction			Perception of Access			Perception of Quality and Appropriateness			Perception of Participation in Treatment			Perception of Outcome of Services			Perception of Functioning			Perception of Social Connectedness		
	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015
MSHN	86%	90%	**85%**	91%	92%	**86%**	89%	97%	**85%**	86%	94%	**84%**	73%	84%	**74%**	84%	73%	**75%**	84%	82%	**77%**
BABH	84%	71%	**84%**	92%	79%	**92%**	91%	89%	**86%**	92%	90%	**87%**	72%	50%	**76%**	96%	60%	**72%**	92%	73%	**73%**
CEI	79%	100%	**90%**	83%	100%	**89%**	82%	100%	**89%**	72%	100%	**90%**	73%	100%	**86%**	79%	88%	**82%**	94%	100%	**77%**
CMHCM	89%	86%	**73%**	98%	91%	**82%**	86%	95%	**78%**	90%	90%	**83%**	74%	92%	**66%**	83%	89%	**67%**	84%	68%	**74%**
HBH	89%	100%	**91%**	88%	86%	**89%**	89%	100%	**93%**	88%	100%	**95%**	83%	75%	**86%**	88%	67%	**82%**	100%	50%	**84%**
Ionia	100%			100%			100%			100%			100%			100%			67%		
Lifeways	86%	90%	**86%**	94%	97%	**83%**	89%	98%	**84%**	82%	97%	**82%**	82%	86%	**75%**	87%	71%	**75%**	78%	86%	**75%**
MCBH	100%	100%	**73%**	80%	100%	**69%**	100%	100%	**76%**	100%	100%	**65%**	50%	100%	**67%**	60%	80%	**68%**	100%	80%	**65%**
Newaygo	75%			100%			100%			100%			67%			33%			67%		
Saginaw	94%	95%	**92%**	88%	95%	**93%**	91%	100%	**89%**	85%	95%	**85%**	80%	92%	**77%**	90%	86%	**79%**	88%	95%	**87%**
Shiawassee	80%	100%	**78%**	90%	67%	**88%**	89%	100%	**84%**	80%	88%	**83%**	86%	67%	**70%**	100%	33%	**77%**	89%	100%	**83%**
TBHS	72%	90%	**86%**	85%	80%	**86%**	86%	78%	**88%**	81%	80%	**88%**	44%	57%	**66%**	68%	60%	**68%**	69%	60%	**68%**

Figure 3 provides a comparison of the percentage of those who responded with "agree-4" or "strongly agree-5" for each question within the domain. Please refer to the scoring methodology above with questions related to the calculations.

Figure 3

Adult – ACT Program	2013	2014	2015
General Satisfaction			
Q1. I like the services that I received.	87.6%	92%	**89%**
Q2. If I had other choices, I would still choose to get services from this mental health agency.	83.4%	84%	**83%**
Q3. I would recommend this agency to a friend or family member.	84.0%	91%	**83%**
Access			
Q4. The location of services was convenient.	82.7%	87%	**85%**
Q5. Staff were willing to see me as often as I felt it was necessary.	90.6%	89%	**88%**
Q6. Staff returned my calls within 24 hours.	85.8%	90%	**90%**
Q7. Services were available at times that were good for me.	88.3%	91%	**87%**
Q8. I was able to get all the services I thought I needed.	83.7%	87%	**84%**
Q9. I was able to see a psychiatrist when I wanted to.	79.8%	83%	**80%**
Quality/Appropriateness			
Q10. Staff believed that I could grow, change and recover.	86.9%	91%	**88%**
Q12. I felt free to complain.	79.4%	85%	**77%**
Q13. I was given information about my rights.	89.7%	91%	**90%**
Q14. Staff encouraged me to take responsibility for how I live my life.	87.7%	92%	**88%**
Q15. Staff told me what side effects to watch for.	78.4%	84%	**79%**
Q16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	86.8%	92%	**88%**
Q18. Staff were sensitive to my cultural/ ethnic background (e.g., race, religion, language, etc.).	82.1%	91%	**81%**
Q19. Staff helped me obtain the information I needed so that I could take charge of managing my illness and disability.	87.7%	90%	**88%**
Q20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	83.9%	93%	**84%**
Participation in Treatment Planning			
Q11. I felt comfortable asking questions about my treatment, services, and medication.	86.0%	93%	**89%**
Q17. I, not staff, decided my treatment goals.	79.5%	87%	**80%**
Outcomes			
Q21. I deal more effectively with daily problems.	80.4%	84%	**82%**
Q22. I am better able to control my life.	80.6%	82%	**79%**
Q23. I am better able to deal with crisis.	75.8%	79%	**77%**
Q24. I am getting along better with my family.	78.2%	74%	**76%**
Q25. I do better in social situations.	68.3%	70%	**78%**
Q26. I do better in school and/or work.	57.8%	61%	**60%**
Q27. My housing situation has improved.	68.6%	76%	**73%**
Q28. My symptoms are not bothering me as much.	70.8%	66%	**72%**

Functioning			
Q28. My symptoms are not bothering me as much.	70.8%	66%	**72%**
Q29. I do things that are more meaningful to me.	80.2%	75%	**75%**
Q30. I am better able to take care of my needs.	82.0%	79%	**81%**
Q31. I am better able to handle things when they go wrong.	73.7%	72%	**74%**
Q32. I am better able to do things that I want to do.	78.7%	77%	**72%**
Social Connectedness			
Q33. I am happy with the friendships I have.	84.9%	77%	**81%**
Q34. I have people with who I can do enjoyable things.	80.3%	79%	**82%**
Q35. I feel I belong in my community.	70.5%	70%	**70%**
Q36. In a crisis, I would have the support I need from family or friends.	81.1%	79%	**74%**

Recommendations/Improvement Opportunities

The results will be reviewed by the MSHN Quality Improvement Council and the Regional Consumer Advisory Council to determine possible region wide improvement efforts as well as identification of any trends that have occurred from year to year. The results will be compared to national averages as available. The areas of improvement will be targeted towards the domains with the lower average scores (based on the regional average of all scores) and those domains that have shown a decrease from the previous years. Each CMHSP will also review their local results for areas of improvement at the local level. It is also recommended that those with a low number of returned responses review their process and determine if additional action may need to be taken to impact the response rate. The low number of responses may result in an acceptable threshold based on the standard set or it may result in an unacceptable threshold. The low numbers may also impact the ability for the results to be generalized throughout the population.

Completed by: MSHN

Date: May 2016
Revised: June 2016

MSHN QIC Approved: 06/23/16

Attachment A

Adult Survey		MSHN	BABH	CEI	CMCMH	HBH	Lifeways	MCBH	Saginaw	Shiawassee	TBHS
General Satisfaction	**Domain Average %**	**85%**	**84%**	**90%**	**73%**	**91%**	**86%**	**73%**	**92%**	**78%**	**86%**
1. I like the services that I received.	% Agreement	**89%**	100%	95%	85%	91%	85%	80%	94%	89%	82%
	# Agree	202	17	20	23	10	69	8	33	8	14
	# Valid Respondents	228	17	21	27	11	81	10	35	9	17
2. If I had other choices, I would still choose to get services from this mental healthcare agency.	% Agreement	**83%**	82%	89%	63%	91%	84%	70%	94%	78%	88%
	# Agree	189	14	17	17	10	69	7	33	7	15
	# Valid Respondents	227	17	19	27	11	82	10	35	9	17
3. I would recommend this agency to a friend or family member.	% Agreement	**83%**	71%	86%	70%	91%	88%	70%	89%	67%	88%
	# Agree	189	12	18	19	10	71	7	31	6	15
	# Valid Respondents	228	17	21	27	11	81	10	35	9	17
Perception of Access	**Domain Average %**	**86%**	**92%**	**89%**	**82%**	**89%**	**83%**	**69%**	**93%**	**88%**	**86%**
4. The location of services was convenient.	% Agreement	**85%**	88%	90%	74%	100%	85%	56%	88%	100%	88%
	# Agree	191	15	18	20	11	68	5	30	9	15
	# Valid Respondents	224	17	20	27	11	80	9	34	9	17
5. Staff were willing to see me as often as I felt it was necessary.	% Agreement	**88%**	88%	90%	77%	100%	86%	70%	100%	89%	88%
	# Agree	198	15	19	20	10	70	7	34	8	15
	# Valid Respondents	225	17	21	26	10	81	10	34	9	17

6. Staff returned my calls within 24 hours.	% Agreement	**90%**	94%	89%	85%	80%	89%	80%	94%	100%	94%
	# Agree	198	16	17	23	8	70	8	31	9	16
	# Valid Respondents	221	17	19	27	10	79	10	33	9	17
7. Services were available at times that were good for me.	% Agreement	**87%**	100%	90%	93%	91%	81%	70%	94%	78%	82%
	# Agree	197	17	19	25	10	66	7	32	7	14
	# Valid Respondents	227	17	21	27	11	81	10	34	9	17
8. I was able to get all the services I thought I needed.	% Agreement	**84%**	94%	85%	77%	91%	81%	60%	94%	75%	88%
	# Agree	187	16	17	20	10	65	6	32	6	15
	# Valid Respondents	223	17	20	26	11	80	10	34	8	17
9. I was able to see a psychiatrist when I wanted to.	% Agreement	**80%**	88%	90%	84%	73%	73%	80%	88%	88%	76%
	# Agree	180	15	19	21	8	60	8	29	7	13
	# Valid Respondents	224	17	21	25	11	82	10	33	8	17
Perception of Quality and Appropriateness	**Domain Average %**	**85%**	**86%**	**89%**	**78%**	**93%**	**84%**	**76%**	**89%**	**84%**	**88%**
10. Staff believed that I could grow, change and recover.	% Agreement	88%	94%	90%	85%	100%	87%	80%	88%	78%	88%
	# Agree	198	16	18	22	11	71	8	30	7	15
	# Valid Respondents	226	17	20	26	11	82	10	34	9	17
12. I felt free to complain.	% Agreement	77%	76%	95%	63%	80%	79%	67%	82%	56%	76%
	# Agree	173	13	20	17	8	63	6	28	5	13
	# Valid Respondents	224	17	21	27	10	80	9	34	9	17

13. I was given information about my rights.	% Agreement	90%	94%	90%	77%	100%	90%	89%	94%	100%	94%
	# Agree	200	16	18	20	10	72	8	31	9	16
	# Valid Respondents	221	17	20	26	10	80	9	33	9	17
14. Staff encouraged me to take responsibility for how I live my life.	% Agreement	88%	82%	86%	78%	100%	89%	70%	94%	100%	94%
	# Agree	203	14	19	21	11	73	7	33	9	16
	# Valid Respondents	230	17	22	27	11	82	10	35	9	17
15. Staff told me what side effects to watch for.	% Agreement	79%	76%	95%	85%	91%	71%	70%	88%	78%	76%
	# Agree	179	13	19	22	10	58	7	30	7	13
	# Valid Respondents	226	17	20	26	11	82	10	34	9	17
16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	% Agreement	88%	93%	94%	85%	90%	85%	70%	88%	100%	94%
	# Agree	191	14	16	23	9	67	7	30	9	16
	# Valid Respondents	218	15	17	27	10	79	10	34	9	17
18. Staff were sensitive to my cultural/ethnic background (e.g., race, religion, language, etc.).	% Agreement	81%	87%	88%	77%	90%	78%	78%	79%	89%	88%
	# Agree	165	13	15	20	9	52	7	27	8	14
	# Valid Respondents	203	15	17	26	10	67	9	34	9	16

19. Staff helped me obtain the information I needed so that I could take charge of managing my illness and disability.	% Agreement	88%	80%	88%	73%	100%	88%	100%	94%	78%	94%
	# Agree	186	12	15	19	10	67	8	32	7	16
	# Valid Respondents	212	15	17	26	10	76	8	34	9	17
20. I was encouraged to use consumer run programs (support groups, drop-in centers, crisis phone line, etc.).	% Agreement	84%	93%	73%	84%	89%	86%	60%	88%	78%	82%
	# Agree	179	14	11	21	8	68	6	30	7	14
	# Valid Respondents	213	15	15	25	9	79	10	34	9	17
Perception of Participation in Treatment	**Domain Average %**	**84%**	**87%**	**90%**	**83%**	**95%**	**82%**	**65%**	**85%**	**83%**	**88%**
11. I felt comfortable asking questions about my treatment, services and medication.	% Agreement	89%	94%	91%	89%	100%	85%	70%	94%	100%	82%
	# Agree	204	16	20	24	11	70	7	33	9	14
	# Valid Respondents	230	17	22	27	11	82	10	35	9	17
17. I, not staff, decided my treatment goals.	% Agreement	80%	80%	88%	77%	90%	79%	60%	76%	67%	94%
	# Agree	172	12	15	20	9	62	6	26	6	16
	# Valid Respondents	216	15	17	26	10	78	10	34	9	17
Perception of Outcome of Services	**Domain Average %**	74%	76%	86%	66%	86%	75%	67%	77%	70%	66%
21. I deal more effectively with daily problems.	% Agreement	82%	87%	88%	72%	89%	83%	88%	82%	78%	76%
	# Agree	173	13	15	18	8	64	7	28	7	13
	# Valid Respondents	211	15	17	25	9	77	8	34	9	17
22. I am better able to control my life.	% Agreement	79%	80%	89%	64%	100%	76%	88%	85%	89%	71%
	# Agree	167	12	16	16	9	59	7	28	8	12

	# Valid Respondents	212	15	18	25	9	78	8	33	9	17
23. I am better able to deal with crisis.	% Agreement	77%	80%	94%	71%	90%	79%	60%	76%	78%	65%
	# Agree	167	12	16	17	9	63	6	26	7	11
	# Valid Respondents	216	15	17	24	10	80	10	34	9	17
24. I am getting along better with my family.	% Agreement	76%	86%	94%	60%	90%	82%	50%	74%	44%	71%
	# Agree	161	12	15	15	9	64	5	25	4	12
	# Valid Respondents	213	14	16	25	10	78	10	34	9	17
25. I do better in social situations.	% Agreement	78%	80%	82%	79%	89%	75%	88%	81%	75%	65%
	# Agree	160	12	14	19	8	57	7	26	6	11
	# Valid Respondents	206	15	17	24	9	76	8	32	8	17
26. I do better in school and/or work.	% Agreement	60%	58%	73%	63%	60%	64%	40%	56%	50%	50%
	# Agree	80	7	8	12	3	30	2	10	3	5
	# Valid Respondents	133	12	11	19	5	47	5	18	6	10

27. My housing situation has improved.	% Agreement	73%	71%	88%	61%	78%	77%	50%	79%	67%	56%
	# Agree	149	10	15	14	7	57	5	26	6	9
	# Valid Respondents	205	14	17	23	9	74	10	33	9	16
28. My symptoms are not bothering me as much. (Outcomes)	% Agreement	72%	67%	82%	58%	90%	66%	70%	82%	78%	76%
	# Agree	156	10	14	15	9	53	7	28	7	13
	# Valid Respondents	218	15	17	26	10	80	10	34	9	17
Perception of Functioning	**Domain Average %**	**75%**	**72%**	**82%**	**67%**	**82%**	**75%**	**68%**	**79%**	**77%**	**68%**
28. My symptoms are not bothering me as much. (Outcomes)	% Agreement	**72%**	67%	82%	58%	90%	66%	70%	82%	78%	76%
	# Agree	156	10	14	15	9	53	7	28	7	13
	# Valid Respondents	218	15	17	26	10	80	10	34	9	17
29. I do things that are more meaningful to me.	% Agreement	**75%**	71%	82%	64%	90%	79%	60%	79%	67%	65%
	# Agree	162	10	14	16	9	63	6	27	6	11
	# Valid Respondents	216	14	17	25	10	80	10	34	9	17
30. I am better able to take care of my needs.	% Agreement	**81%**	80%	89%	71%	80%	83%	80%	88%	89%	71%
	# Agree	176	12	16	17	8	66	8	29	8	12
	# Valid Respondents	216	15	18	24	10	80	10	33	9	17
31. I am better able to handle things when they go wrong.	% Agreement	**74%**	60%	82%	76%	80%	75%	60%	74%	78%	71%
	# Agree	159	9	14	19	8	59	6	25	7	12
	# Valid Respondents	216	15	17	25	10	79	10	34	9	17

32. I am better able to do things that I want to do.	% Agreement	**72%**	80%	76%	68%	70%	74%	70%	74%	75%	59%
	# Agree	155	12	13	17	7	58	7	25	6	10
	# Valid Respondents	214	15	17	25	10	78	10	34	8	17
Perception of Social Connectedness	**Domain Average %**	77%	73%	77%	74%	84%	75%	65%	87%	83%	68%
33. I am happy with the friendships I have.	% Agreement	81%	80%	72%	77%	100%	81%	70%	91%	100%	71%
	# Agree	173	12	13	20	9	62	7	29	9	12
	# Valid Respondents	213	15	18	26	9	77	10	32	9	17
34. I have people with who I can do enjoyable things.	% Agreement	82%	73%	78%	81%	78%	85%	70%	88%	89%	76%
	# Agree	178	11	14	21	7	67	7	30	8	13
	# Valid Respondents	217	15	18	26	9	79	10	34	9	17
35. I feel I belong in my community.	% Agreement	70%	80%	76%	56%	70%	71%	50%	85%	56%	59%
	# Agree	150	12	13	14	7	55	5	29	5	10
	# Valid Respondents	215	15	17	25	10	78	10	34	9	17
36. In a crisis, I would have the support I need from family or friends.	% Agreement	74%	60%	83%	83%	90%	66%	70%	82%	89%	65%
	# Agree	159	9	15	20	9	52	7	28	8	11
	# Valid Respondents	216	15	18	24	10	79	10	34	9	17

VIII. Consumer Satisfaction Reports – YSS

Quality Assessment and Performance Improvement Program
2015 Perception of Care Report
Home-Based Services Program

Introduction

The Michigan Department of Health and Human Services (MDHHS) requires a survey be administered annually to programs identified by the Michigan Quality Improvement (QI) Council. The Michigan QI Council has chosen the Home-Based Services program as one of the programs for 2015. The program completed the Youth Satisfaction Survey for Families (YSSF) over a two-week period of time. MDHHS provides implementation guidelines and instructions to each Prepaid Inpatient Health Plan (PIHP). Each PIHP is to administer the survey within the time frame allotted by MDHHS. The survey results are returned to MDHHS via supplied excel workbook.

Each PIHP, in collaboration with the Community Mental Health Services Program (CMHSP) and their contracted providers, utilized the YSSF to conduct a region wide perception of care survey to determine any areas that may be deficient within the region. The data obtained by each CMHSP was provided to Mid-State Health Network (MSHN) for regional analysis. The survey outcomes reported to MSHN's Quality Improvement Council (QIC) for FY15 will be compared to the Baseline Perception of Care Report that was prepared of the 2014 data.

Survey Response Rates

Clinicians tracked who was given a survey with a tally form for each program. Consumers were given an option to decline answering the survey questions. Those consumers who declined were removed from the total number of surveys distributed. The response rates were calculated by dividing the number of surveys that were received by the number of surveys that were distributed. **Figure 1** indicates the return rate for each CMHSP where data was available prior to February 19th. Any surveys received after February 19th were not included in the results.

Figure 1

	2015				2014	2013
YSSF Home-Based Services	Distributed	Received	Declined	Response Rates	Response Rates	Response Rates
MSHN	856	346	24	40%	22%	32%
Bay-Arenac	48	7	0	15%	28%	15%
CEI	96	60	2	63%	9%	37%
Central MI	114	47	4	41%	31%	24%
Gratiot	42	13	0	31%	42%	95%
Huron	13	5	0	38%	100%	10%
Ionia	63	22	0	35%	52%	*
Lifeways	273	90	5	33%	34%	15%
Montcalm	61	21	7	34%	32%	20%
Newaygo	24	5	0	21%	100%	*
Saginaw	10	3	0	30%	59%	13%
Shiawassee	35	14	5	40%	10%	43%

Tuscola	77	59	1	77%	*56%	56%

** May include individuals who have received services from the child case management program

* No data available

Methodology

The sample was a convenience sample of all who were scheduled to be seen within a pre-identified time frame. The Home-Based Services (HBS) survey population was given a choice of any two-week time frame in January 4th and February 5, 2016. The Youth, 17 years and younger, who are receiving services from the Home-Based Services program will receive the YSSF-36. The raw data was required to be received by MDHHS no later than March 11, 2016. MDHHS will prepare an analysis, which will include comparison data of PIHPs in Michigan and CMHSPs within each PIHP. Consumers did have the option to decline participation. If a consumer declined, this was noted and removed from the number distributed.

There were two optional changes in the implementation process for FY2012. Based on discussions with Substance Abuse and Mental Health Services Administration (SAMHSA) and information from other states that implement the YSSF, the MDHHS QIC decided that PIHPs can opt to assign numerical identifiers to the MHSIP in order to identify the respondents. The PIHP was to use the selected field in the data entry forms to inform MDHHS whether they have chosen to assign identifiers. These identifiers are for the PIHPs use only, and are not to be shared with MDHHS. MSHN did not require the use of identifiers for the survey.

Scoring

YSSF – There are six domains included in the survey. Each domain has several individual questions related to the domain topic. Each question in the domain is required to have a response choice of 1 - 5 in order for the domain to be included in the sample. If one question is left blank, the responses of the remaining questions for that domain are excluded from the calculations of that domain. The domains are as follows: quality and appropriateness (satisfaction with service), access to care, family participation in treatment planning, outcomes of care, cultural sensitivity of staff, and social connectedness. There are 5 response choices for each question within the domain, which are assigned a numeric value.

Strongly Agree=5
Agree=4
Neutral=3
Disagree=2
Strongly Disagree=1

The mean of each individual question is calculated. Those greater than or equal to 3.5 are considered to be “in agreement”. The total number of respondents who are “in agreement” is then divided by the total respondents. The resultant number is then multiplied by 100 to provide a percentage. Those questions that have a “blank” are removed from the sample.

Data Analysis

Each survey was entered into an excel spreadsheet. The HBS program was categorized by numeric codes provided by MDHHS.

The results are analyzed as follows:

PIHP

- By Domain
- By Domain Line Item

CMHSP (Attachment A - YSSF)

- By Domain
- By Domain Line Item

Survey Findings

The Youth Perception of Care Survey

Figure 2 demonstrates the percentage of agreement for each domain. Please refer to the scoring methodology above with questions related to the calculations. Those who responded to the survey indicated agreement consistent or at an increased percentage compared to those who responded for the 2014 survey. Each domain scored above the desired threshold of 80% except the "Perception of Outcomes of Services" and "Perception of Social Functioning". MSHN scored the highest in the "Perception of Cultural Sensitivity", "Perception of Access", "Perception of Participation in Treatment", "Appropriateness", and the "Perception of Social Connectedness" domains. This indicates:

a) The location of services are acceptable to the families who responded to the survey (Q8 - 97%, 334/346)
b) The times that services were available are acceptable to the families who responded to the survey (Q9 - 95%, 328/345)
c) Staff in the MSHN speak to the children in Home-Based services in a way they understand (Q14 - 99%, 342/346)
d) Staff in the MSHN treat the children with respect (Q12 - 98%, 339/346)
e) Staff respect the family's religious or spiritual beliefs (Q13 – 96%, 328/343)
f) Staff are sensitive to each person's cultural or ethnic background (Q15 - 95%, 317/332)
g) Families felt they were able to participate in their child's treatment (Q6 - 99%, 337/342)
h) Families felt they were able to choose their child's services (Q2 - 92%, 315/341)
i) Families felt they were able to choose their child's treatment goals (Q3 - 97%, 336/345).

The percentage of respondents who were in agreement with the survey questions for the domain "Perception of Outcomes of Services" was 60%, which was below the desired threshold of 80%.

The Respondents indicated:

a) Their child was better at handling their daily life (Q16 - 64%, 219/342).
b) Their child was better at coping when things go wrong (Q20 - 56%, 190/340).
c) Families indicated their child gets along better with friends and other people (Q18 - 61%, 208/340).
d) Families indicated their child gets along better with their family (Q17 - 63%, 216/342).
e) Their child was doing better in school and/or work (Q19 – 61%, 208/339).
f) Families indicated their child is able to do things that he/she wants to do (Q22 - 62%, 212/342).
g) Families indicated they were happy with their family life right now (Q21 - 55%, 188/341).

The percentages and respondent numbers for each CMHSP Participant is located in Attachment A.

Figure 2

Youth Survey	Appropriateness			Perception of Access			Perception of Cultural Sensitivity			Perception of Participation in Treatment			Perception of Outcome of Services			Perception of Social Connectedness			Perception of Social Functioning		
	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	*2013	2014	2015
MSHN	90%	92%	**90%**	98%	98%	**96%**	98%	99%	**97%**	95%	95%	**96%**	63%	65%	**60%**	92%	92%	**84%**		69%	**61%**
BABH	64%	80%	**93%**	93%	93%	**100%**	86%	100%	**100%**	46%	93%	**100%**	77%	53%	**67%**	77%	93%	**93%**		60%	**71%**
CEI	86%	93%	**86%**	99%	100%	**94%**	96%	100%	**96%**	55%	91%	**94%**	86%	73%	**71%**	86%	86%	**79%**		73%	**73%**
CMHCM	91%	92%	**85%**	100%	96%	**97%**	98%	100%	**98%**	59%	98%	**94%**	100%	55%	**49%**	100%	94%	**85%**		60%	**50%**
Gratiot	97%	100%	**92%**	97%	100%	**96%**	97%	100%	**96%**	81%	100%	**92%**	59%	79%	**59%**	94%	100%	**94%**		82%	**61%**
HBH	100%	79%	**83%**	100%	100%	**90%**	100%	100%	**100%**	0%	93%	**100%**	100%	57%	**51%**	100%	86%	**90%**		50%	**53%**
Ionia	93%	91%	**89%**	100%	96%	**100%**	100%	100%	**100%**	64%	96%	**98%**	93%	62%	**56%**	93%	91%	**87%**		71%	**59%**
Lifeways	90%	93%	**91%**	96%	97%	**96%**	97%	99%	**95%**	57%	96%	**96%**	90%	63%	**56%**	90%	97%	**83%**		66%	**55%**
MCBH	91%	87%	**85%**	100%	93%	**95%**	100%	100%	**96%**	64%	87%	**98%**	100%	71%	**61%**	100%	93%	**81%**		79%	**62%**
Newaygo	100%	100%	**80%**	100%	100%	**100%**	60%	100%	**95%**	100%	80%	**100%**	100%	40%	**66%**	100%	60%	**80%**		40%	**67%**
Saginaw	100%	90%	**94%**	100%	100%	**83%**	100%	100%	**100%**	100%	90%	**100%**	100%	70%	**62%**	100%	90%	**100%**		90%	**67%**
Shiawassee	100%	100%	**86%**	100%	100%	**93%**	100%	100%	**93%**	60%	100%	**90%**	100%	67%	**67%**	100%	67%	**70%**		67%	**68%**
TBHS	91%	94%	**98%**	97%	100%	**97%**	91%	97%	**99%**	75%	94%	**99%**	97%	74%	**64%**	97%	89%	**89%**		76%	**64%**

Figure 3 provides a comparison of the percentage of those who responded with "agree-4" or strongly agree-5" for each question within the domain. Please refer to the scoring methodology above with questions related to the calculations.

Figure 3

Youth – Home- Based Services	2015	2014	2013
Access			
Q8. The location of services was convenient for us.	**97%**	98%	96%
Q9. Services were available at times that were convenient for us.	**95%**	95%	96%
Participation in Treatment			
Q2. I helped to choose my child's services.	**92%**	90%	91%
Q3. I helped to choose my child's treatment goals.	**97%**	96%	98%
Q6. I participated in my child's treatment.	**99%**	97%	97%
Cultural Sensitivity			
Q12. Staff treated me with respect.	**98%**	100%	96%
Q13. Staff respected my family's religious/spiritual beliefs.	**96%**	94%	93%
Q14. Staff spoke with me in a way that I understand.	**99%**	99%	98%
Q15. Staff were sensitive to my cultural/ethnic background.	**95%**	93%	93%
Appropriateness			
Q1. Overall, I am satisfied with the services my child received.	**95%**	93%	92%
Q4. The people helping my child stuck with us no matter what.	**93%**	91%	91%
Q5. I felt my child had someone to talk to when she/he was troubled.	**92%**	90%	88%
Q7. The services my child and/or family received were right for us.	**92%**	88%	91%
Q10. My family got the help we wanted for my child.	**87%**	82%	86%
Q11. My family got as much help as we needed for my child.	**80%**	77%	80%
Outcomes			
Q16. My child is better at handling daily life.	**64%**	69%	65%
Q17. My child gets along better with family.	**63%**	67%	67%
Q18. My child gets along better with friends and other people.	**61%**	63%	65%
Q19. My child is doing better in school and/or work.	**61%**	65%	62%
Q20. My child is better able to cope when things go wrong.	**56%**	59%	58%
Q21. I am satisfied with our family life right now.	**55%**	61%	**56%**
Q22. My child is better able to do things he or she wants to do.	**62%**	66%	63%
Social Connectedness			
Q23. I know people who will listen and understand me when I need to talk.	**85%**	88%	88%
Q24. I have people that I am comfortable talking with about my child's problems.	**88%**	91%	88%
Q25. In a crisis, I would have the support I need from family or friends.	**81%**	80%	76%
Q26. I have people with whom I can do enjoyable things.	**81%**	87%	79%
Functioning			
Q16. My child is better at handling daily life.	**64%**	69%	65%
Q17. My child gets along better with family.	**63%**	67%	67%
Q18. My child gets along better with friends and other people.	**61%**	63%	65%
Q19. My child is doing better in school and/or work.	**61%**	65%	62%
Q20. My child is better able to cope when things go wrong.	**56%**	59%	58%
Q22. My child is better able to do things he or she wants to do.	**62%**	66%	63%

Recommendations/Improvement Opportunities

The results will be reviewed by the MSHN Quality Improvement Council and the Regional Consumer Advisory Council to determine possible region wide improvement efforts as well as identification of any trends that have occurred from year to year. The results will be compared to national averages as available. The areas of improvement will be targeted towards the domains with the lower average scores (based on the regional average of all scores) and those domains that have shown a decrease from the previous years. Each CMHSP will also review their local results for areas of improvement at the local level. It is also recommended that those with a low number of returned responses review their process and determine if additional action may need to be taken to impact the response rate. The low number of responses may result in an acceptable threshold based on the standard set or it may result in an unacceptable threshold. The low numbers may also impact the ability for the results to be generalized throughout the population.

Completed by: MSHN **Date:** May 2016
Revised: June 2016

MSHN QIC Approved: 06/23/16

Attachment A

Youth Survey		MSHN	BABH	CEI	CMHCM	Gratiot	HBH	Ionia	Lifeways	MCBH	NCMH	Saginaw	Shiawassee	TBHS
Appropriateness	Domain Average %	90%	93%	86%	85%	92%	83%	89%	91%	85%	80%	94%	86%	98%
1. Overall, I am satisfied with the services my child received.	% Agreement	95%	100%	95%	93%	100%	100%	100%	94%	86%	60%	100%	93%	100%
	# Agree	328	7	57	43	13	5	22	85	18	3	3	13	59
	# Valid Respondents	345	7	60	46	13	5	22	90	21	5	3	14	59
4. The people helping my child stuck with us no matter what.	% Agreement	93%	100%	90%	89%	92%	80%	91%	93%	95%	100%	100%	86%	98%
	# Agree	318	7	53	41	12	4	20	83	20	5	3	12	58
	# Valid Respondents	343	7	59	46	13	5	22	89	21	5	3	14	59
5. I felt my child had someone to talk to when she/he was troubled.	% Agreement	92%	86%	88%	83%	100%	80%	100%	92%	90%	80%	100%	86%	100%
	# Agree	315	6	53	38	13	4	22	82	19	4	3	12	59
	# Valid Respondents	344	7	60	46	13	5	22	89	21	5	3	14	59
7. The services my child and/or family received were right for us.	% Agreement	92%	100%	87%	91%	92%	100%	91%	90%	86%	80%	100%	93%	100%
	# Agree	316	7	52	42	12	5	20	81	18	4	3	13	59
	# Valid Respondents	345	7	60	46	13	5	22	90	21	5	3	14	59

10. My family got the help we wanted for my child.	% Agreement	87%	86%	83%	82%	85%	80%	82%	89%	81%	80%	100%	79%	100%
	# Agree	300	6	50	37	11	4	18	80	17	4	3	11	59
	# Valid Respondents	344	7	60	45	13	5	22	90	21	5	3	14	59
11. My family got as much help as we needed for my child.	% Agreement	80%	86%	75%	72%	85%	60%	73%	84%	71%	80%	67%	79%	92%
	# Agree	276	6	45	33	11	3	16	76	15	4	2	11	54
	# Valid Respondents	345	7	60	46	13	5	22	90	21	5	3	14	59
Perception of Access	**Domain Average %**	96%	100%	94%	97%	96%	90%	100%	96%	95%	100%	83%	93%	97%
8. The location of services was convenient for us.	% Agreement	97%	100%	93%	98%	100%	80%	100%	97%	100%	100%	100%	93%	97%
	# Agree	334	7	56	46	13	4	22	87	21	5	3	13	57
	# Valid Respondents	346	7	60	47	13	5	22	90	21	5	3	14	59
9. Services were available at times that were convenient for us.	% Agreement	95%	100%	95%	96%	92%	100%	100%	94%	90%	100%	67%	93%	97%
	# Agree	328	7	57	45	12	5	22	84	19	5	2	13	57
	# Valid Respondents	345	7	60	47	13	5	22	89	21	5	3	14	59
Perception of Cultural Sensitivity	**Domain Average %**	97%	100%	96%	98%	96%	100%	100%	95%	96%	95%	100%	93%	99%
12. Staff treated me with respect.	% Agreement	98%	100%	97%	100%	100%	100%	100%	96%	100%	100%	100%	93%	100%
	# Agree	339	7	58	47	13	5	22	86	21	5	3	13	59
	# Valid Respondents	346	7	60	47	13	5	22	90	21	5	3	14	59
13. Staff respected my family's religious/spiritual beliefs.	% Agreement	96%	100%	95%	98%	85%	100%	100%	94%	95%	80%	100%	93%	98%
	# Agree	328	7	56	45	11	5	22	84	20	4	3	13	58
	# Valid Respondents	343	7	59	46	13	5	22	89	21	5	3	14	59

14. Staff spoke with me in a way that I understand.	% Agreement	99%	100%	98%	100%	100%	100%	100%	98%	100%	100%	100%	93%	100%
	# Agree	342	7	59	47	13	5	22	88	21	5	3	13	59
	# Valid Respondents	346	7	60	47	13	5	22	90	21	5	3	14	59
15. Staff were sensitive to my cultural/ethnic back ground.	% Agreement	95%	100%	95%	95%	100%	100%	100%	93%	90%	100%	100%	93%	98%
	# Agree	317	7	57	42	13	4	21	79	18	5	3	13	55
	# Valid Respondents	332	7	60	44	13	4	21	85	20	5	3	14	56
Perception of Participation in Treatment	**Domain Average %**	96%	100%	94%	94%	92%	100%	98%	96%	98%	100%	100%	90%	99%
2. I helped to choose my child's services.	% Agreement	92%	100%	92%	86%	85%	100%	100%	90%	95%	100%	100%	86%	98%
	# Agree	315	7	54	38	11	5	22	81	20	5	3	12	57
	# Valid Respondents	341	7	59	44	13	5	22	90	21	5	3	14	58
3. I helped to choose my child's treatment goals.	% Agreement	97%	100%	93%	98%	92%	100%	95%	99%	100%	100%	100%	93%	100%
	# Agree	336	7	56	45	12	5	21	89	21	5	3	13	59
	# Valid Respondents	345	7	60	46	13	5	22	90	21	5	3	14	59
6. I participated in my child's treatment.	% Agreement	99%	100%	98%	98%	100%	100%	100%	99%	100%	100%	100%	93%	98%
	# Agree	337	7	59	45	13	5	22	87	21	5	3	13	57
	# Valid Respondents	342	7	60	46	13	5	22	88	21	5	3	14	58
Perception of Outcome of Services	**Domain Average %**	60%	67%	71%	49%	59%	51%	56%	56%	61%	66%	62%	67%	64%
16. My child is better at handling daily life.	% Agreement	64%	71%	77%	51%	69%	40%	59%	57%	62%	60%	67%	79%	71%
	# Agree	219	5	46	23	9	2	13	50	13	3	2	11	42

	# Valid Respondents	342	7	60	45	13	5	22	88	21	5	3	14	59
17. My child gets along better with family.	% Agreement	63%	86%	72%	56%	62%	20%	73%	57%	67%	60%	67%	71%	64%
	# Agree	216	6	43	25	8	1	16	50	14	3	2	10	38
	# Valid Respondents	342	7	60	45	13	5	22	88	21	5	3	14	59
18. My child gets along better with friends and other people.	% Agreement	61%	71%	73%	42%	69%	60%	59%	53%	71%	80%	67%	71%	64%
	# Agree	208	5	44	18	9	3	13	47	15	4	2	10	38
	# Valid Respondents	340	7	60	43	13	5	22	88	21	5	3	14	59
19. My child is doing better in school and/or work.	% Agreement	61%	71%	73%	45%	62%	80%	59%	59%	52%	80%	67%	57%	66%
	# Agree	208	5	44	20	8	4	13	51	11	4	2	8	38
	# Valid Respondents	339	7	60	44	13	5	22	87	21	5	3	14	58
20. My child is better able to cope when things go wrong.	% Agreement	56%	71%	70%	51%	50%	40%	55%	47%	43%	60%	67%	71%	60%
	# Agree	190	5	42	23	6	2	12	41	9	3	2	10	35
	# Valid Respondents	340	7	60	45	12	5	22	88	21	5	3	14	58
21. I am satisfied with our family life right now.	% Agreement	55%	43%	58%	41%	46%	40%	41%	61%	52%	60%	33%	64%	63%
	# Agree	188	3	35	18	6	2	9	54	11	3	1	9	37
	# Valid Respondents	341	7	60	44	13	5	22	88	21	5	3	14	59
22. My child is better able to do things he or she wants to do.	% Agreement	62%	57%	72%	56%	54%	80%	50%	60%	76%	60%	67%	57%	61%
	# Agree	212	4	43	25	7	4	11	53	16	3	2	8	36
	# Valid Respondents	342	7	60	45	13	5	22	88	21	5	3	14	59

Perception of Social Connectedness	**Domain Average %**	84%	93%	79%	85%	94%	90%	87%	83%	81%	80%	100%	70%	89%
23. I know people who will listen and understand me when I need to talk.	% Agreement	85%	100%	80%	83%	92%	100%	100%	85%	76%	80%	100%	71%	88%
	# Agree	294	7	48	39	12	5	22	76	16	4	3	10	52
	# Valid Respondents	345	7	60	47	13	5	22	89	21	5	3	14	59
24. I have people that I am comfortable talking with about my child's problems.	% Agreement	88%	100%	78%	94%	100%	100%	100%	85%	90%	100%	100%	71%	92%
	# Agree	305	7	47	44	13	5	22	76	19	5	3	10	54
	# Valid Respondents	345	7	60	47	13	5	22	89	21	5	3	14	59
25. In a crisis, I would have the support I need from family or friends.	% Agreement	81%	86%	78%	81%	92%	100%	86%	78%	81%	60%	100%	64%	86%
	# Agree	279	6	47	38	12	5	19	69	17	3	3	9	51
	# Valid Respondents	345	7	60	47	13	5	22	89	21	5	3	14	59
26. I have people with whom I can do enjoyable things.	% Agreement	81%	86%	78%	81%	92%	60%	62%	83%	76%	80%	100%	71%	88%
	# Agree	277	6	47	38	12	3	13	73	16	4	3	10	52
	# Valid Respondents	343	7	60	47	13	5	21	88	21	5	3	14	59
Perception of Social Functioning	**Domain Average %**	61%	71%	73%	50%	61%	53%	59%	55%	62%	67%	67%	68%	64%
16. My child is better at handling daily life.	% Agreement	64%	71%	77%	51%	69%	40%	59%	57%	62%	60%	67%	79%	71%
	# Agree	219	5	46	23	9	2	13	50	13	3	2	11	42
	# Valid Respondents	342	7	60	45	13	5	22	88	21	5	3	14	59
17. My child gets along better with family.	% Agreement	63%	86%	72%	56%	62%	20%	73%	57%	67%	60%	67%	71%	64%
	# Agree	216	6	43	25	8	1	16	50	14	3	2	10	38
	# Valid Respondents	342	7	60	45	13	5	22	88	21	5	3	14	59

18. My child gets along better with friends and other people.	% Agreement	61%	71%	73%	42%	69%	60%	59%	53%	71%	80%	67%	71%	64%
	# Agree	208	5	44	18	9	3	13	47	15	4	2	10	38
	# Valid Respondents	340	7	60	43	13	5	22	88	21	5	3	14	59
19. My child is doing better in school and/or work.	% Agreement	61%	71%	73%	45%	62%	80%	59%	59%	52%	80%	67%	57%	66%
	# Agree	208	5	44	20	8	4	13	51	11	4	2	8	38
	# Valid Respondents	339	7	60	44	13	5	22	87	21	5	3	14	58
20. My child is better able to cope when things go wrong.	% Agreement	56%	71%	70%	51%	50%	40%	55%	47%	43%	60%	67%	71%	60%
	# Agree	190	5	42	23	6	2	12	41	9	3	2	10	35
	# Valid Respondents	340	7	60	45	12	5	22	88	21	5	3	14	58
22. My child is better able to do things he or she wants to do.	% Agreement	62%	57%	72%	56%	54%	80%	50%	60%	76%	60%	67%	57%	61%
	# Agree	212	4	43	25	7	4	11	53	16	3	2	8	36
	# Valid Respondents	342	7	60	45	13	5	22	88	21	5	3	14	59

IX. Performance Indicators – MMBPIS

Summary Report

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

Reporting Period (month/year): FY16Q4

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).

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.

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 consumers are excluded from this count.

Indicator 3 indicates that those consumers who are in respite or medication only services may be excluded if they go beyond the 14-day window; other environmental circumstances also apply. See MDHHS 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 that document for any additional or more specific instructions.

Data Interpretation: (performance against targets and benchmark data)
Key: Green = Above the standard
Tan = Below the standard

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 99.77% compliance (440/441) of the **children** who requested a pre-screen received one within 3 hours, and 98.70% (2269/2299) of the **adults** who requested a prescreen received one (1) within 3 hours. All CMHSPs demonstrated performance above the standard of 95% for **children** and **adults**.

Indicator 2: Initial Assessment within 14 Days - Children/Adults (standard is 95% or above) – In Figure 1, MSHN exhibited a standard of 99.26% (3471/3497) for **all population groups**. Figure 1 exhibits each CMHSP's performance related to the specific population group. Eleven (11) CMHSPs demonstrated performance above the standard for **MI-Child** with one (1) CMHSP demonstrating performance below the standard for this indicator. All twelve (12) CMHSPs demonstrated performance above the standard for **MI-Adults**. Nine (9) CMHSPs demonstrated performance above the standard for **DD-Children** with one (1) CMHSP demonstrating performance below the standard and two (2) CMHSPs not having eligible individuals to report for this population. Eight (8) CMHSPs demonstrated performance above the standard for **DD-Adults** with one (1) CMHSP demonstrating performance below the standard and three (3) CMHSPs not having eligible individuals to report for this population. All applicable CMHSPs and SUD providers demonstrated performance above the standard for the **Substance Use Disorder (SUD)** population.

Figure 1

	Indicator 1		Indicator 2					
	% Children	% Adults	% MI-C	MI-A %	DD-C %	DD-A %	SA %	Total %
BABH	100.00%	99.01%	100.00%	99.01%	*	*		99.19%
CMH for Central MI	100.00%	98.43%	99.46%	99.77%	100.00%	100.00%		99.69%
CMHA CEI	99.26%	96.55%	99.36%	96.40%	75.00%	86.67%		96.77%
Gratiot CMH	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%
HBH	100.00%	100.00%	100.00%	100.00%	100.00%	*		100.00%
Lifeways	100.00%	99.53%	100.00%	98.67%	100.00%	100.00%		99.11%
Montcalm Care Network	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%
Newaygo CMH	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%
Saginaw CMH	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%
Shiawassee CMH	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%

The Right Door/Ionia	100.00%	100.00%	92.86%	98.00%	*	*		96.15%
TBHS	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%
MSHN	**99.77%**	**98.70%**	**99.41%**	**99.18%**	**96.92%**	**97.53%**	**99.55%**	**99.26%**

* Denotes no eligible consumers for that particular indicator for this reporting period (this excludes clients who are listed as exceptions).

Indicator 3: Start of Service within 14 Days (standard is 95% or above) – In Figure 2, MSHN demonstrated an average of 98.64% (2838/2877) for the total of **all population** categories for this measure. Figure 2 exhibits each CMHSP's performance related to the specific population group. Eleven (11) CMHSPs demonstrated performance above the standard for **MI-Child** with one (1) CMHSP performing below the standard for this indicator. Eleven (11) CMHSPs demonstrated performance above the standard for **MI-Adults** with one (1) CMHSP performing below standard for this indicator. Nine (9) CMHSPs demonstrated performance above the standard for **DD-Child** with three (3) CMHSPs not having any eligible individuals to report for this population. Ten (10) CMHSPs demonstrated performance above the standard for **DD-Adult** with two (2) CMHSPs not having any eligible individuals to report for this population. All applicable CMHSPs and SUD providers demonstrated performance above the standard for the **Substance Use Disorder (SUD)** population.

Indicator 4a: Follow-Up within 7 Days of Discharge from IP (standard is 95% or above) – In Figure 2, MSHN demonstrated a rate of 100.00% (85/85) for **children** with a diagnosis of mental illness. All twelve (12) CMHSPs demonstrated performance above the standard for this population. MSHN exhibited a 96.97% (448/462) for **adults** who have a diagnosis of mental illness. Ten (10) CMHSPs demonstrated performance above the standard with two (2) CMHSPs demonstrating performance below the standard for this population.

Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (standard is 95% or above) – MSHN demonstrated a 99.57% (230/231) standard for individuals who were seen within 7 days of discharge from a detox unit. Performance was above the standard for the **Substance Use Disorder (SUD)** population for this indicator.

Indicator 10: Re-admission to Psychiatric Unit within 30 Days (standard is 15% or less) – In Figure 2, MSHN demonstrated an 9.43% (10/106) for **children** who were re-admitted within 30 days of being discharged from a psychiatric hospitalization. Three (3) CMHSPs demonstrated performance above the standard, four (4) CMHSPs demonstrated performance below the standard, and five (5) CMHSPs did not have any eligible individuals to report for this population. MSHN exhibited an 11.88% (77/648) for **adults** who have a diagnosis of mental illness. Seven (7) CMHSPs demonstrated performance above the standard, three (3) CMHSPs demonstrated performance below the standard, and two (2) CMHSPs did not have any eligible individuals to report for this population.

Figure 2

	Indicator 3						Indicator 4a		4b	Indicator 10	
	% MI-C	% MI-A	% DD-C	% DD-A	% SA	Total	% Children	% Adults	% All	% Children	% Adults
BABH	90.48%	93.41%	*	100.00%		92.98%	100.00%	94.92%		17.65%	7.58%
CMH for Central MI	98.50%	97.54%	100.00%	100.00%		97.88%	100.00%	98.51%		9.09%	14.67%
CMHA CEI	95.18%	95.93%	100.00%	100.00%		95.73%	100.00%	96.25%		5.00%	12.43%
Gratiot CMH	95.00%	98.31%	100.00%	100.00%		97.06%	100.00%	100.00%		*	25.00%
HBH	100.00%	96.15%	*	*		97.14%	100.00%	100.00%		50.00%	13.33%
Lifeways	97.87%	100.00%	100.00%	100.00%		99.54%	100.00%	94.25%		10.00%	11.11%
Montcalm Care Network	100.00%	97.53%	100.00%	100.00%		98.35%	100.00%	100.00%		*	19.23
Newaygo CMH	100.00%	100.00%	100.00%	100.00%		100.00%	100.00%	100.00%		*	*
Saginaw CMH	100.00%	98.35%	100.00%	100.00%		98.94%	100.00%	97.53%		*	9.09
Shiawassee CMH	100.00%	100.00%	100.00%	100.00%		100.00%	100.00%	100.00%		25.00	27.78
The Right Door	95.00%	95.12%	*	*		95.08%	100.00%	100.00%		*	7.69%
TBHS	100.00%	100.00%	100.00%	100.00%		100.00%	100.00%	100.00%		33.33%	*
MSHN	**97.45%**	**97.65%**	**100.00%**	**100.00%**	**100.00%**	**98.64%**	**100.00%**	**96.97%**	**99.57%**	**9.43%**	**11.88%**

* Denotes no eligible consumers for that particular indicator for this reporting period (this excludes clients who are listed as exceptions).

Figure 3 shows a comparison of the performance indicator percentages starting in FY15 Quarter 1 to current. MSHN was within the established standards set by the state for each of the performance indicators. 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 3a

MMBPIS		FY15Q2	FY15Q3	FY15Q4	FY16Q1	FY16Q2	FY16Q3	FY16Q4
Indicator 1a & 1b: Pre-screen within 3 hours of request	Child	99.76%	99.54%	100.00%	99.60%	99.49%	99.02%	99.77%
	Adult	99.06%	99.11%	99.54%	99.69%	98.65%	98.97%	98.70%
Indicator 2: % of Persons Receiving an Initial Assessment within 14 calendar days of First Request	MI-Child	99.35%	98.63%	98.77%	99.82%	98.79%	98.72%	99.41%
	MI-Adult	99.50%	99.62%	99.39%	99.76%	99.45%	99.20%	99.18%
	DD-Child	97.96%	98.59%	100.00%	100.00%	98.44%	100.00%	96.92%
	DD-Adult	94.87%	98.91%	98.65%	100.00%	100.00%	98.82%	97.53%
	SA	97.39%	98.34%	100.00%	98.38%	96.37%	98.96%	99.55%
	Total	98.60%	98.96%	99.18%	99.42%	99.20%	99.02%	99.26%
Indicator 3: % of Persons Who Started Service within 14 days of Assessment	MI-Child	95.16%	97.15%	98.17%	96.60%	96.68%	96.83%	97.45%
	MI-Adult	96.98%	97.43%	97.84%	99.88%	97.96%	97.55%	97.65%
	DD-Child	97.37%	92.31%	98.15%	98.00%	95.74%	96.36%	100.00%
	DD-Adult	97.83%	93.85%	98.31%	100.00%	98.11%	96.36%	100.00%
	SA	100.00%	99.89%	100.00%	100.00%	100.00%	100.00%	100.00%
	Total	97.98%	98.08%	97.98%	97.49%	97.44%	98.32%	98.64%
Indicator 4a, and Indicator 4b: Persons seen within 7 days of Inpatient Discharge and Substance Abuse Detox	Child	98.11%	100.00%	98.81%	97.53%	100.00%	99.14%	100.00%
	Adult	98.54%	96.36%	98.52%	98.14%	98.32%	97.03%	96.97%
	SA	97.77%	95.10%	98.35%	100.00%	100.00%	100.00%	99.57%
Indicator 10: % of Discharges Readmitted to Inpatient Care within 30 days of Discharge	Child	9.92%	5.98%	10.42%	6.31%	11.90%	8.72%	9.43%
	Adult	9.56%	9.30%	9.43%	9.35%	8.26%	10.58%	11.88%
Below Standard								
Above 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.

Figure 4: Indicator 2 - Exception Report

Indicator 2	FY15Q2	FY15Q3	FY15Q4	FY16Q1	FY16Q2	FY16Q3	FY16Q4
BABH	7.49%	17.60%	17.47%	15.79%	17.27%	12.42%	20.13%
CMHCM	8.72%	8.81%	5.09%	5.82%	8.51%	7.55%	4.47%
CEI	13.79%	16.79%	10.10%	7.96%	11.22%	6.96%	6.29%
Gratiot	3.64%	3.61%	1.77%	6.67%	10.20%	4.10%	4.03%
HBH	1.28%	0%	4.55%	13.70%	3.41%	20.25%	15.09%
Lifeways	15.08%	12.98%	15.22%	9.76%	10.59%	8.12%	5.06%
Montcalm Care Network	4.70%	1.10%	4.55%	1.10%	1.55%	1.48%	2.06%
Newaygo	2.78%	.68%	0.74%	6.16%	4.95%	4.47%	3.39%
Saginaw	2.30%	1.36%	1.30%	2.59%	2.63%	2.90%	1.95%
Shiawassee	8.00%	0%	6.25%	5.41%	0.00%	6.67%	6.25%
The Right Door/Ionia	2.86%	5.81%	4.90%	10.42%	12.24%	10.49%	35.59%
TBHS	51.32%	43.01%	21.21%	10.11%	12.84%	20.00%	9.09%
CEI CA	NA	NA	NA	NA	NA	NA	NA
NIMSAS	NA	NA	NA	NA	NA	NA	NA
RCA	NA	NA	NA	NA	NA	NA	NA
Saginaw CA	NA	NA	NA	NA	NA	NA	NA
MSHN	**9.24%**	**9.39%**	**7.93%**	**7.13%**	**8.39%**	**7.55%**	**7.10%**

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	FY15Q2	FY15Q3	FY15Q4	FY16Q1	FY16Q2	FY16Q3	FY16Q4
BABH	3.97%	18.25%	15.00%	20.65%	24.00%	22.50%	22.45%
CMHCM	19.17%	19.66%	15.37%	16.77%	22.09%	23.77%	19.35%
CEI	11.22%	15.47%	28.11%	28.00%	35.37%	26.87%	27.24%
Gratiot	9.20%	10.81%	5.00%	9.09%	13.39%	12.50%	9.73%
HBH	33.85%	25%	20%	25.93%	19.05%	1.85%	28.57%
Lifeways	18.38%	20.50%	16.04%	16.81%	21.37%	20.52%	19.33%
Montcalm Care Network	11.57%	10%	16%	22.56%	16.36%	21.31%	20.39%
Newaygo	11.34%	11.93%	14.29%	11.40%	20.14%	10.29%	22.54%
Saginaw	16.24%	13.97%	13.28%	11.23%	21.08%	22.22%	22.31%
Shiawassee	15.15%	0%	8%	18.75%	10.81%	5.71%	8.00%
The Right Door/Ionia	23.26%	11.11%	12.82%	10.34%	17.95%	18.70%	45.05%
TBHS	25.42%	21.95%	7.50%	5.95%	6.98%	7.77%	8.96%
CEI CA	NA	NA	NA	NA	NA	NA	NA
NIMSAS	NA	NA	NA	NA	NA	NA	NA
RCA	NA	NA	NA	NA	NA	NA	NA
Saginaw CA	NA	NA	NA	NA	NA	NA	NA
MSHN	**13.27%**	**13.99%**	**13.22%**	**16.36%**	**21.29%**	**20.33%**	**21.77%**

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

Figure 6a: Indicator 4a – Exception Report

Figure 6a: Indicator 4a - Exception Report Indicator 4a	FY15Q2	FY15Q3	FY15Q4	FY16Q1	FY16Q2	FY16Q3	FY16Q4
BABH	4.27%	6.25%	5.56%	15.53%	7.55%	10.34%	10.84%
CMHCM	18.31%	22.22%	13.24%	14.67%	14.44%	18.89%	10.59%
CEI	41.86%	56.39%	63.39%	47.50%	46.48%	52.26%	51.53%
Gratiot	15.38%	0%	19%	9.09%	0.00%	14.29%	17.39%
HBH	21.05%	6.25%	0.00%	10.53%	14.29%	5.56%	35.29%
Lifeways	26.72%	21.35%	25.33%	17.78%	28.10%	21.74%	19.44%
Montcalm Care Network	11.76%	32.50%	37.14%	33.33%	18.18%	12.50%	31.03%
Newaygo	23.08%	18.75%	41.67%	30.00%	25.00%	11.11%	33.33%
Saginaw	16.33%	20.91%	26.77%	32.56%	25.64%	31.34%	25.00%
Shiawassee	18.75%	33.33%	0.00%	0.00%	0.00%	27.27%	19.05%
The Right Door/Ionia	47.37%	12.50%	25.00%	33.33%	18.75%	22.22%	15.38%
TBHS	33.33%	38.46%	32.14%	36.00%	37.50%	37.93%	41.67%
MSHN	**22.72%**	**26.21**	**24.08%**	**26.72%**	**25.37%**	**27.26%**	**28.53%**

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,

Figure 6b: Indicator 4b - Exception Report

Indicator 4b	FY15Q2	FY15Q3	FY15Q4	FY16Q1	FY16Q2	FY16Q3	FY16Q4
CEI	47.10%	50.59%	NA	NA	NA	NA	NA
CMHCM	NA	NA	NA	NA	NA	NA	NA
Riverhaven	34.21%	19.64%	NA	NA	NA	NA	NA
Saginaw	61.40%	40%	NA	NA	NA	NA	NA
MSHN	**45.09%**	**38.55%**	**44.34%**	**38.05%**	**44.34%**	**43.91%**	**41.07%**

Note: unable to obtain the data, as the FY15Q4, FY16Q1, FY16Q2, FY16Q3 and FY16Q4 processing was done by MSHN as a whole (44.34%, 38.05%, 44.34%, 43.91% and 41.07%) and not individually by the Sub-Regional Entities.

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

Figure 7: Indicator 10 - Exception Report

Indicator 10	FY15Q2	FY15Q3	FY15Q4	FY16Q1	FY16Q2	FY16Q3	FY16Q4
BABH	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
CMHCM	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
CEI	37.21%	50.38%	52.25%	4.17%	4.93%	0.00%	3.57%
Gratiot	0.00%	0.00%	0.00%	0.00%	0.00%	4.76%	4.17%
HBH	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%	0.00%
Montcalm Care Network	0.00%	0.00%	20.00%	0.00%	0.00%	0.00%	3.45%
Newaygo	0.00%	0.00%	4.00%	0.00%	0.00%	11.11%	33.33%
Saginaw	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Shiawassee	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%	0.00%	0.00%
TBHS	16.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
MSHN	**7.64%**	**8.76%**	**6.35%**	**0.67%**	**0.97%**	**1.05%**	**1.69%**

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)
		FY16Q1	FY16Q2	FY16Q3	
BABH	3a, 3b, 4a2, 10a	2a	3a, 3d	2d, 3b	1
CEI	2c, 2d	N/A	N/A	3a	1, 4, 10
CMHCM	NA	4a1	10a	NA	1, 2, 3
Gratiot	10b	1a, 3c	3b	4a2	2
HBH	10a	N/A	3b,10a,10b	10a	1, 2, 4
Lifeways	4a2	N/A	10a, 10b	3a, 3c, 10b	1, 2
MCN	10b	N/A	10a	3c, 3d	1, 2, 4
Newaygo	NA	N/A	3a	NA	1, 2, 4, 10
Saginaw	NA	N/A	3a, 3c	4a1	1, 2, 10
Shiawassee	10a, 10b	N/A	2a	2b	1, 3, 4
The Right Door	2a	2a, 3a	1a	1a, 10a	4
TBHS	10a	N/A	N/A	NA	1, 2, 3, 4

Note: The plans of correction (identified in the "interventions" column) 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.

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:** 12/16/16

MSHN QIC Approved: 01/26/17

X. Provider Network Monitoring Review

Monitoring and Auditing

Internal Audits

CMHSP Delegated Managed Care Functions & Program Specific Audits

The 2016 interim-year audit consisted of a review of corrective action plans established by CMHSP's and approved by MSHN in 2016, new standards review, and BH-TEDS reporting. CMHSP's provided supporting evidence to demonstrate implementation of the corrective action plan and compliance with the standards for which there were findings.

The new standards that went into effect for FY16 included staff training requirements, implementation of the 24/7/365 access standards, and autism/ABA requirements.

CEI in its capacity as the QI/BH-TEDS/Encounter contractor continues to audit the DD Proxy portion of the QI review. This year, they assessed each CMHSP's readiness for reporting BH-TEDS. Any findings and future plans the CMHSP's provided have been documented in the respective CMHSP final audit report.

As of November 14, 2016, MSHN staff completed twelve (12) reviews, with all CMHSP's showing substantial or full compliance with standards requiring follow-up from 2015, new standards for 2016, and BH-TEDS reporting.

In 2017, MSHN will conduct its biennial full review of all DMC and program specific standards.

SUD Delegated Managed Care Functions & Program Specific Audits

MSHN began conducting reviews of substance use disorder treatment and prevention providers in 2016 and is establishing baseline data. The review consists of delegated managed care functions as well as clinical chart reviews (treatment providers only) for program specific standards (i.e. outpatient, medication assisted treatment, and residential programs). With over sixty (60) provider agencies (some with multiple facilities) in MSHN's network, approximately half of the facilities are undergoing a full on-site review in 2016. As of November 14, 2016, twenty-nine (29) reviews were completed with another seven (7) scheduled to be completed by December 31, 2016. In 2017, the remaining facilities will undergo a full on-site review. Additionally, MSHN staff will conduct a follow-up of corrective action plans developed and approved in 2016.

Initial baseline data shows regional compliance scores as follows:

- Delegated Managed Care Standards – 73%
- Consumer Chart Standards – 72%
- Medication Assisted Treatment Program Specific Standards – 80%
- Residential Program Specific Standards – 80%
- Prevention Program Standards – 88%

Findings are issued and corrective action plans are required for standards that fall below 85% compliance. Corrective action plans will be reviewed during interim year reviews, unless the nature of the finding warrants a focused follow-up to ensure consumer safety. A common area of non-compliance is in the development of treatment/recovery plans and progress notes. MSHN's clinical team has conducted a regional training on treatment plan and progress note development and documentation.

MSHN honors the reciprocity of monitoring and evaluation conducted by other PIHP's for out-of-network providers. MSHN collects, reviews, and maintains current copies of annual site review reports and likewise, shares annual site review reports with other PIHP's.

XI. External Quality Reviews – MDHHS and HSAG

External Audits

MDHHS Habilitation Supports Waiver Site Visit Report: July 18th – August 26th

The Habilitation Supports Waiver (HSW) site review was conducted in coordination with the Waiver for Children with Serious Emotional Disturbance (SEDW) and the Children's Waiver Program (CWP). The SEDW and CWP is the responsibility of the CMHSP and therefore not included in the MSHN summary report. The HSW review was completed by the Michigan Department of Health and Human Services (MDHHS) for 2016 from July 18th through August 26th, 2016. This was a full site review to measure compliance with the service delivery requirements of the 1915 (c) waivers.

The 2016 site review included the review of beneficiary files, staff records and home visits.

Total Cases Reviewed (76)
Total Licensed Staff Records Reviewed (211)
Total Non-Licensed Staff Records Reviewed (827)
Total Home Visits (11)

Summary of the findings:

A. Administrative Procedures (5 Elements): 83%
B. Freedom of Choice (2 Elements): 98%
C. Implementation of Person Centered Planning (7 Elements): 96%
D. Plan of Service and Documentation Requirements (3 Elements): 98%
E. Behavior Treatment Plans and Review Committees (2 Elements): 50%
F. Staff Qualifications (4 Elements): 95%
G. Home Visits/Training/Interviews: Specific to Home

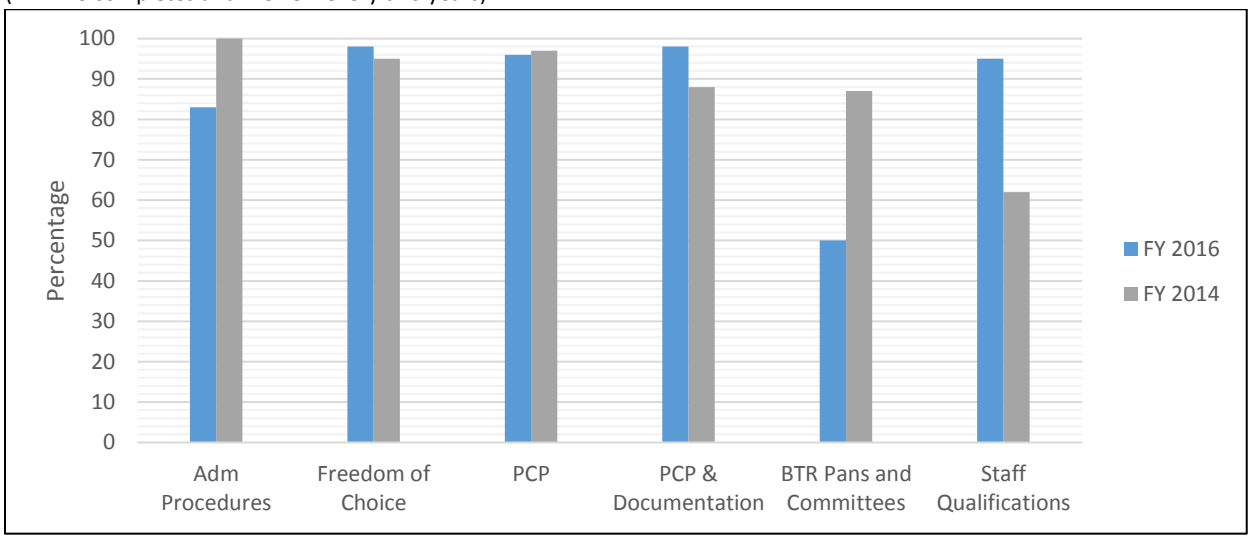
Note: The percentages were calculated by dividing the total number of charts that received a score of "yes" (full compliance) by the total number of charts that received a score of "no" (less than full compliance) for all elements in each section.

Next Steps:

MSHN is required to submit a plan of correction to MDHHS for any element that was identified as not being in "Full Compliance." MSHN submitted the plans of correction as required by October 20, 2016 and the plan of correction was approved as submitted. MSHN will continue to work with the regional Habilitation Supports Workgroup to ensure implementation of the corrective action plan.

Comparison of Results (Full Review) for FY2014 and FY2016:

(MDHHS completes a full review every two years)



MDHHS Substance Use Site Review Report: July 18th

The Michigan Department of Health and Human Services (MDHHS) completed a review at Mid-State Health Network (MSHN) on July 18, 2016 to determine compliance with the Substance Use Agreement with the Centers for Medicare and Medicaid Services. The purpose was to review compliance with established standards as well as serve as a quality improvement opportunity to provide technical assistance with the provision of SUD services. 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.

Summary of Compliance with Standards:

The following information identifies the standards that were reviewed and the score received.
(Scoring: 2 = Full Compliance; 1 = Partial Compliance; 0 = Non-Compliance)

1. Contracting – ***2***
2. Annual Evaluation of SUD Services – ***1***
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 – ***1***
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***

MSHN received an average compliance score of 1.85 which equates to 93% compliance for all standards reviewed.

Next Steps:
MSHN was required to submit a plan of correction to MDHHS for any standard that was identified as not being in "Full Compliance." MSHN submitted a plan of correction for standard 2 (Annual Evaluation of SUD Services) and standard 8 (Primary Care Coordination) as both received a score of "Partial Compliance." The submitted plan of correction was accepted by MDHHS.

For the two standards found to be in "partial compliance," MDHHS reviewed the annual site review findings for five (5) SUD provider agencies. MSHN was found to be in full compliance with the monitoring and review process, requiring plans of correction and making reports available for review. The partial compliance score was given due to the PIHP not completing the reviews of the entire provider network for FY16 at the time of the MDHHS site review.

MSHN will complete the current review cycle to ensure all SUD provider agencies receive an annual review and ensure ongoing monitoring of any required plans of correction.

This year is the first year MDHHS completed a SUD review of the PIHP. A year to year comparison for compliance with the standards will be completed during the next full review.

MDHHS – Health Services Advisory Group (HSAG) – Performance Measurement Validation Report: July 28th

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.

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). 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%**

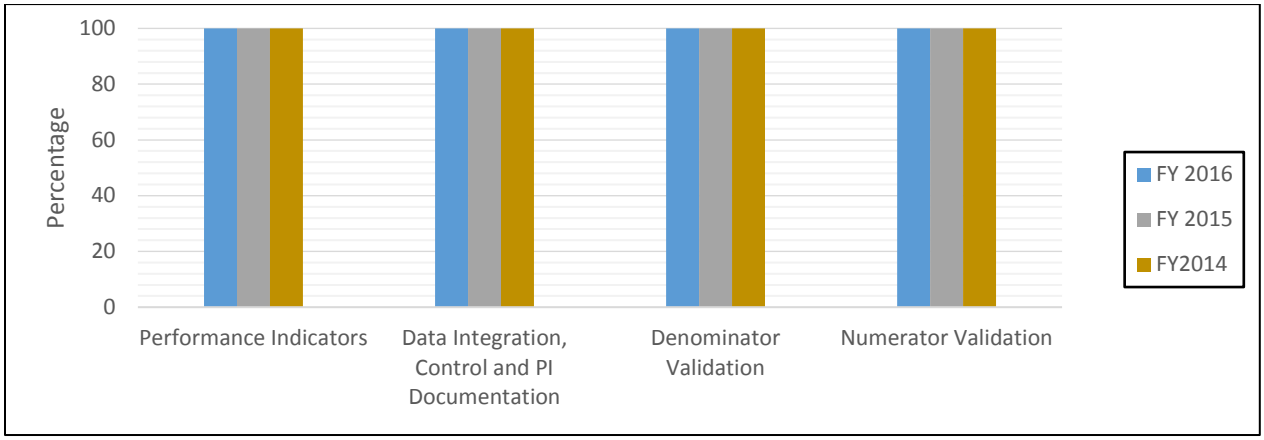
Compliance was assessed through a review of the following:

- 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%**

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.

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



MDHHS– Health Services Advisory Group – Compliance Monitoring Report: July 13th
The Compliance Monitoring Review is completed as a requirement of the Balanced Budget Act of 1997 (BBA), Public Law 105-33, which requires states conduct an annual evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with regulations, contractual requirements, and the state's quality strategy.

For the 2015–2016 compliance monitoring review, HSAG completed a follow up review assessing the PIHPs' compliance with federal regulations and contract requirements for the areas that required a plan of correction from the 2014-2015 review.

Summary of Findings:

The standards reviewed included:

Standard IX: Subcontracts and Delegation (1 Element Reviewed): **100%**
Standard XI: Credentialing (2 Elements Reviewed): **100%**
Standard XV: Disclosure of Ownership, Control, and Criminal Convictions (6 Elements Reviewed): **100%**

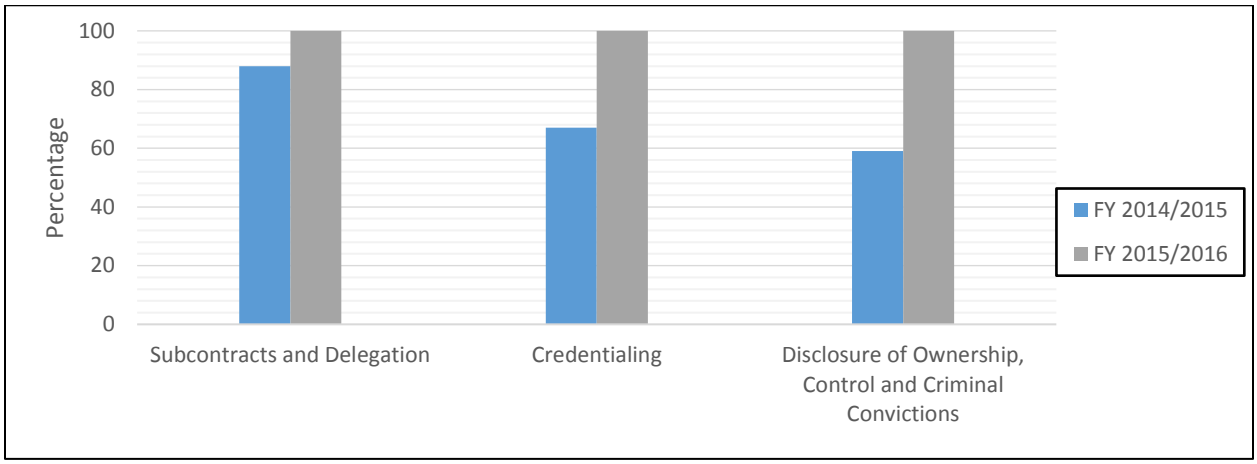
HSAG noted that MSHN showed strong performance by demonstrating full compliance in all standards reviewed and stated they were impressed by several of MSHN's forms and processes and noted the Disclosure of Ownership, Control and Criminal Convictions process as a best practice.

Next Steps:

MSHN is not required to submit a plan of correction as all standards were found to be in full compliance.

Comparison of FY2014/2015 and FY2015/2016 Results:

(HSAG completes a full review every other year for the Compliance Monitoring Review)



MDHHS – Health Services Advisory Group –Performance Improvement Project Report: Validation Year3: September 2016

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).

The PIP study topic is: *"Increasing Diabetes Screening for Consumers with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications*."

The FY2015-2016 PIP Summary Report analyzed the data for Remeasurement One Period (October 1, 2014 – September 30, 2015) and reviewed the identified barriers, interventions and goals that were established by MSHN for Remeasurement Two Period (October 1, 2015 – September 30, 2016).

Summary of Results:

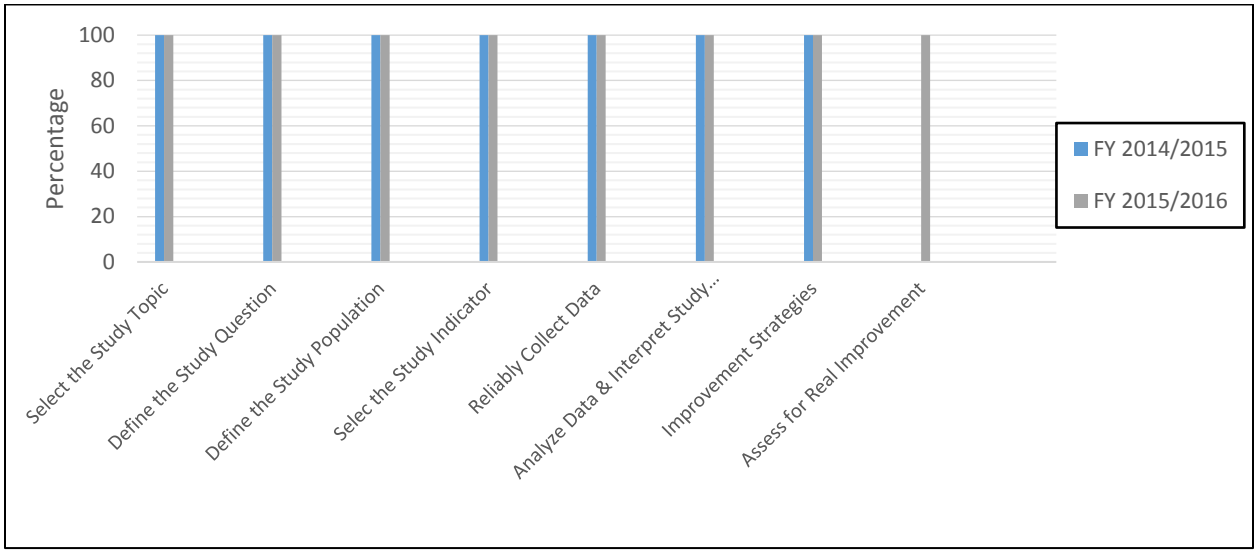
I. Select the Study Topic (2 Elements): **100%**
II. Define the Study Question(s) (1 Element): **100%**
III. Define the Study Population (1 Element): **100%**
IV. Select the Study Indicator(s) (3 Elements): **100%**
V. Use Sound Sampling Techniques (6 Elements): **N/A for this study topic**
VI. Reliably Collect Data (4 Elements): **100%**
VII. Analyze Data and Interpret Study Results (8 Elements): **100%**
VIII. Improvement Strategies (4 Elements): **100%**
IX. Assess for Real Improvement (4 Elements): **100%**
X. Assess for Sustained Improvement: **Not assessed for this year**

MSHN showed an increase from the Baseline Period of 73.7% to 77.5% for Remeasurement One Period. This demonstrated a statistically significant improvement of 3.8 percentage points above the baseline and exceeded the identified goal of reaching 75%.

Next Steps:

MSHN is not required to submit a plan of correction for the PIP. This project will continue to be implemented through FY2016/2017 to assess sustained improvement.

Comparison of FY2014/2015 and FY2015/2016 Validation Results:
(HSAG completes a full review each year for the PIP)



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

SECTION FOUR – EVALUATION AND PRIORITIES

I. 2016 Annual Effectiveness Review of QAPIP Goals and Objectives

2016 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	Quality Improvement Council
		Implement QAPIP	Met		Quality Improvement Council
	Guidance on Standards, Requirements & Regulations	Council & Committee review of MDHHS Contract and External Quality Review Requirements	Met		All Council & Committees
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		Quality Improvement Council
Communication of Process and Outcomes					
	QIC monitors performance measurement activity	Performance Measure Reports	Met	Enhance organizational quality & compliance	Quality Improvement Council
	Identify opportunities for process and outcome improvements	Recommendations included in PM Reports	Met		All Council & Committees
	Require corrective action plans for measures below regulatory standards and/or targets	Corrective action plan submissions & reviews	Met		Quality Improvement Council
	Regular reports to Councils, Committees, Board of Directors and Advisory Councils	Council & Committee Annual Reports	Met		All Council & Committees
	Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	RCAC Reports on Consumer Satisfaction Survey Results, Recovery Survey Assessments, HEDIS Measure, MMBPIS, BTR, and Customer Service Reports	Met	Increase the voice of MSHN's customers and key stakeholder	Regional Consumer Advisory Council
	Board of Directors receive annual report on status of organizational performance	MSHN Balanced Scorecard	Met	Enhance organizational quality & compliance	MSHN CEO
	Performance and Quality reports are made available to stakeholders and general public	MSHN website includes: QAPIP, Compliance Plan, MMBPIS, EQR Results	Met	Increase the voice of MSHN's customers and key stakeholder	MSHN Staff
Performance Measurement					
	Performance Indicators	MMBPIS Reports	Met	Improve Access to Care	Quality Improvement Council
	Performance Improvement Projects	PIP - RSA Report; PIP - HEDIS Report	Met	Assume increased responsibility for healthcare outcomes	Quality Improvement Council
Event Monitoring and Reporting					
	Critical Incident Reporting to MDHHS	Critical Incident Performance Reports	Met	Assume increased responsibility for healthcare outcomes	Quality Improvement Council
	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		Quality Improvement Council
	Oversight of CMHSP risk analysis and reduction	On-site reviews completed at CMHSP's in FY15; Follow up site reviews completed in FY16	Met		Quality Improvement Council
Behavior Treatment					
	Quarterly analysis of adherence to BTR Standards	BTR Performance Reports	Met	Improved behavioral health treatment/service outcomes	Quality Improvement Council

	Trends and patterns identified	BTR Performance Reports includes patterns and related improvement recommendations	Met		Quality Improvement Council & Behavior Treatment Plan Review Workgroup
Autism Waiver Monitoring					
	Monitor compliance with Autism Benefit program requirements	Quarterly Autism Reports; FY16 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
Quantitative and Qualitative Assessment of Member Experiences					
	Surveys analyzed	MHSIP & YSS Report	Met	Improved behavioral health treatment/service outcomes	Quality Improvement Council
	Surveys shared with QIC and RCAC	MHSIP & YSS Report shared with QIC and RCAC	Met	Increase the voice of MSHN's customers and key stakeholder	Quality Improvement Council & Regional Consumer Advisory Council
	Identified strengths and opportunities for improvement	FY15/16 completed regional surveys (MHSIP & YSS); comparison to baseline data (FY13) and FY14 data completed	Met	Improved behavioral health treatment/service outcomes	Quality Improvement Council & Regional Consumer Advisory Council
Practice Guidelines					
	CMHSP implementation of practice guidelines	Utilization Management Plan and Committee Report	Met	Improve access to care	Utilization Management Committee
		MSHN desk review verifications of local implementation; FY15 on-site reviews completed; FY16 follow up reviews completed	Met	Improve access to care	Utilization Management Committee
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; FY15 on-site review completed; FY16 follow up reviews completed	Met	Enhance organizational quality & compliance	Provider Network Committee
Medicaid Event Verification					
	Verifies delivery of services billed to Medicaid	PIHP Medicaid Event Methodology Report	Met	Public resources are used efficiently and effectively	Quality Improvement Council
	Results aggregated, analyzed and reported at QIC	FY16 MEV Report developed; QIC reviewed summary report results in October 2016	Met		Quality Improvement Council
	Opportunities identified for improvement	FY16 MEV Report reviewed by QIC in October 2016; Discussion on improvements to the process and review of trends of non-compliance	Met		Quality Improvement Council
	Reported annually to MDHHS	FY16 MEV Report sent to MDHHS	Met		MSHN Deputy Director
Utilization Management Plan					
	UM Committee develops standards for utilization	Utilization Management Plan and Committee Report	Met	Public resources are used efficiently and effectively	Utilization Management Committee
	Utilization activity and trends are reviewed and analyzed	Utilization Management Plan and Committee Report	Met		Utilization Management Committee
	Uniform screening tools and admission criteria	Utilization Management Committee – LOCUS has been selected	Met	Improved behavioral health treatment/service outcomes	Utilization Management Committee

	Identification of under-and-over utilization	Utilization Management Reports	Partial	Public resources are used efficiently and effectively	Utilization Management Committee
Provider Monitoring					
	CMHSP annual monitoring of provider subcontractors	Annual Compliance Report; Desk review of CMHSPs in FY14; Site review completed in FY15; Follow up reviews completed in FY16	Met	Enhance organizational quality & compliance	Quality Improvement Council & Provider Network Committee
	MSHN monitoring of CMHSPs and SUD Provider Network compliance	Annual Compliance Report; Desk review of CMHSPs and SUD Providers; Site review completed in FY15; and follow up reviews for FY16	Met		Quality Improvement Council & Provider Network Committee
Oversight of "Vulnerable People"					
	CMHSPs monitor health, safety and welfare of individuals served	95% Data Completeness Reports; Annual DMC site reviews	Met	Assume increased responsibility for healthcare outcomes	Quality Improvement Council
	Related concerns are acknowledged and action taken as appropriate	95% Data Completeness Reports - Includes reporting on actions; Annual DCM site reviews	Met		Quality Improvement Council

II. MSHN FY16 Strategic Plan Priorities & Objectives

Priority	Objective/Strategies	Goal/Measurement	Target Date	Status
Improve Access to Care	Based on the Assessment of Network Adequacy, establish expanded provider network to meet defined consumer needs.	1. All Healthy Michigan expanded SUD services are regionally available.	09.30.16	Met
		2. Establish network adequacy and competency to address areas of priority access improvement (ASD, Veterans, and corrections).	09.30.16	Discontinue: Part of Routine Operations
		3. All CMHSPs have established capacity for primary SUD access, screening, emergency and referral.	10.01.15	Met
		4. MSHN successfully negotiates regional inpatient contracts resulting in improved rates and performance results.	09.30.16	Partial: Ongoing
		5. With its regional CMHSP partners, MSHN develops improved regional crisis and inpatient capacity for targeted acute care needs	09.30.16	Partial: Ongoing
		6. Increase the number of consumers who participate in a person centered Medical Home.	06.30.15	Discontinued
	Establish regional strategies to engage more eligible beneficiaries in care.	1. Regionally define a penetration rate methodology that takes into consideration some of the uniqueness of the public behavioral health system (e.g. persons on spend down, MiChild, SED Waiver, etc.	01.01.16	Met
		2. Improve Medicaid penetration rates 10% over 2013 baseline.	09.30.16	Discontinued
		3. Increase persons served with primary substance use disorders over 2014 baseline	09.30.16	Discontinued
		4. Increase persons served in the Healthy Michigan Plan over 2014 baseline	09.30.16	Discontinued
		5. Fully implement the region's access and authorization practice guidelines to achieve a common benefit.	09.30.16	Met
		6. Regionally define and adopt best practices for documentation of medical necessity to assure people are receiving an appropriate scope, duration and intensity of care.	09.30.16	Met
	Through collaborative efforts with the MDOC and Community Corrections, expand service access and utilization for ex-offenders.	1. Assess current state of service needs.	03.31.16	Partial
		2. Define preferred partnership and implementation approach (Specific planning with MDOC regarding SUD service access for persons with HMP will be a FY16 contract requirement.).	03.31.16	Partial
		3. Monitor for increased access and service use. (Current national benchmarking indicates, per BHDDA, that Michigan's incarcerated population is comprised of 20% of individuals in jails and 22% in prison with mental illness. Nationwide the population ratio is 16% in jail and 17% in prison with mental illness.)	09.30.16	Partial
	Through collaborative efforts with the Veteran's Administration, expand service access and utilization for veterans.	1. Assess current state of service needs.	03.31.16	Partial
		2. Define target eligible and priority population to serve	03.31.16	Partial
		3. Define preferred partnership and implementation approach.	06.30.16	Partial
		4. Identify eligible veterans who may be appropriately served by the VA, make appropriate referral and assure transition and coordination of care.	07.31.16	Partial
		5. Monitor for increased access and service use.	09.30.16	Partial
	Expand service access and utilization for persons meeting Autism Spectrum Disorder diagnostic category.	1. Assess current state of service and need	01.01.16	Met
		2. Develop additional regional capacity	06.30.16	Met
		3. Monitor Performance	09.30.16	Discontinued: Part of Dashboard

	Address practice plan for conflict free case management services.	1. Research compliance requirements	12.31.16	Deferred pending stated policy release
		2. Develop network adequacy strategy	01.31.16	
		3. Establish necessary contracts and compliance standards	01.31.16	
		4. Complete any necessary procurement activities	03.31.16	
		5. Establish and implement regionally approved monitoring standards to access results and performance improvement needs across the region.	04.30.16	
		6. Monitor implementation and support CMHSP level performance improvement as indicated	09.30.16	
Demonstrate Improved Coordination of Behavioral Health and Primary Care	MSHN successfully implement SUD transition & 3-yr. Strategic Plan.	1. Adopt and deploy a regionally approved guideline for the best-practice implementation of Medication Assisted Treatment.	06.30.16	Met
		2. Establish and implement prevention strategies to reduce A1:L111 drinking, prescription and over-the counter drug abuse, and youth access to tobacco.	09.30.16	Met
		3. Implement and monitor SUD treatment services to: increase access to women's specialty service programs; reduce incidence of SUD over baseline; increase engagement, retention and completion of SUD treatment; and increase inter-agency coordination of SUD treatment.	09.30.16	Met
	Establish clear criteria and practices that demonstrate improved primary care coordination.	1. Establish and implement a regionally approved training curriculum that defines and provides strategies for the role of the primary clinician, case manager, supports coordinator in primary care coordination.	06.30.16	Discontinued: Replaced with updated strategy
		2. Health information exchange (HIE) occurs with other healthcare providers to assure appropriate integration and coordination of care.	09.30.16	
	Establish and successfully implement collaboration agreements and practices with regional Medicaid Health Plans.	1. Have a meaningful collaboration agreement with regional Medicaid Health Plans that include coordination priorities of the request for proposal and defined strategic for how they will be achieved.	01.31.16	Discontinued: Replaced with updated strategy
		2. Regional CMHSPs have at least one active collaboration and coordination of care project with a MHP.	09.30.16	
		3. MSHN acquires technical assistance to develop and deploy a regionally specific MHP targeted education/marketing effort that illustrates the value of the PIHP/CMHSP structure and provides evidence of the systems effectiveness.	12.31.15	Discontinued
		4. MSHN establishes a venue to regionally share MHP, FQHC, SIM projects, outcomes and learnings.	01.01.16	Ongoing
		5. Regionally engage in strategies for shared savings for improved population health outcomes	09.30.19	Not Due Yet
Increase the Voice of MSHN's Customers and Key Stakeholders	Implement regional educational opportunities and input sessions around new initiatives (i.e.: SIS, Autism, SUD integration)	1. Effectively implement improved trauma informed practices through a clearly defined learning communities.	09.30.16	Deferred: Not a Current Priority
		2. Strengthen peer health and recovery coaching strategies through ongoing learning community efforts	03.31.16	
		3. Establish regional opportunities for key stakeholder and provider meetings, input and communication.	06.30.15	
	Stakeholder input demonstrates effective, efficient and collegial operations.	1. Network Providers (CMHSP Participants) and their council/committee members report 95% satisfaction with input and planning processes.	09.30.16	Discontinued: Part of Dashboard
		2. Clearly define and implement ongoing strategies for the assessment of primary/secondary consumer satisfaction.	09.30.16	
		3. MSHN Regional Consumer Advisory Council reports satisfaction with their level of engagement and ability to influence MSHN's direction.	09.30.16	
		4. The MSHN Board reports improved satisfaction with regional communication.	09.30.16	

		5. MSHN has an established process for network providers to make complaints and appeals.	03.31.16	Met
		6. Provider Network Members report 80%+ satisfaction with the efficiency of MSHN's processes and communication.	09.30.16	Met
		7. Medicaid Health Plan report satisfaction with coordination of care and collaboration efforts.	09.30.16	Ongoing
Improved Behavioral Health Treatment/ Service Outcomes	Implement standardized assessment tools for defined sub-populations.	1. Regionally deploy a standardize assessment for persons with primary substance use disorders.	09.30.17	Deferred Pending System Development
		2. Regionally deploy a standardized assessment for persons with Mental Illness.	09.30.17	
		3. Assessment results demonstrate improvement over 2016 baseline.	09.30.17	
	Assessment of regional recovery strategies indicate performance improvement.	1. Recovery assessment demonstrates improvement over 2015 baseline.	09.30.16	Discontinued: Part of Dashboard
		2. Average regional consumer satisfaction ratings are 92% or higher.	09.30.16	
	The region has a trauma competent culture of care.	1. Audited EMRs demonstrate evidence of trauma screening and assessment.	09.30.17	Discontinued
		2. Identified history of trauma is effectively addressed as part of person-centered planning	09.30.17	Discontinued
		3. Site review assessment indicates widespread staff training consistent with a culture of trauma informed care.	09.30.17	Discontinued
	With BHDDA, implement required elements of the Home and Community Based Service - Final Rules with the goal of improving community living and consumer integrated living.	1. Support completion of MDHHS assessments and complete regional current state assessment of living situation and employment for the target population(s).	09.30.15	Ongoing
		2. Develop and implement practice improvement strategies for the MSHN provider network to comply with the new standards	09.30.17	Not due yet
		3. Trends in living situation and employment show progress toward integration and independence over time.	09.30.19	
		4. The MSHN region is fully compliant with HCBS Final Rules	09.30.19	
Assume Increased Responsibility for Healthcare Outcomes	MSHN health measures indicate improvements in health care status/outcomes for specific chronic conditions.	1. MSHN demonstrates regional improvement in persons screened for diabetes in accordance with HEDIS criteria.	09.30.16	Discontinued: Part of Dashboard
		2. In coordination with Medicaid Health Plans, MSHN demonstrates regional reduction in emergency department use for persons with co-occurring chronic health conditions and behavioral health diagnosis.	09.30.16	
		3. In coordination with Medicaid Health Plans, MSHN demonstrates regional reduction in "all-cause" inpatient readmissions for persons with co-occurring chronic health conditions and behavioral health diagnosis.	09.30.16	
		4. MSHN implements a regional strategy to monitor and affect incidence of opioid prescribing (pain medications) to assure alignment with best practice guidelines.	09.30.16	Partial
	Increase Provider Network use of available healthcare data.	1. Audited treatment records contain an objective(s) to improve the consumer's healthcare status.	09.30.16	Discontinued
		2. Audited EHR records demonstrate evidence of primary care coordination (including consideration of CC360 information).	09.30.16	Met
		3. Audited EMR name the primary care clinic or physician and show evidence of information sharing regarding relevant treatment information and conditions.	09.30.16	Discontinued
		4. Contracted CMHSPs used analytics to identify at least one local population health priority that drive evidence based interventions to improve behavioral and primary healthcare coordination and outcomes.	09.30.17	Discontinued: Replaced with updated strategy
	As necessary, consistent policies/ procedures are deployed across the region.	1. Results of HSAG External Quality Review improve over 2015 baseline.	09.30.16	Discontinue: Part of Routine Operations

Enhance Organizational Quality & Compliance		2. MSHN adopts and deployed a comprehensive credentialing/re-credentialing policy and process that are consistent with MDHHS standards and best practices.	12.01.15	Met
		3. Policy/procedure review to plan is met at target (annual review complete on time).	09.30.16	Discontinue: Part of Routine Operations
	Implementation of the QAPIP and the PIPs results in achievement of desired outcomes.	1. MSHN performance compared to statewide Fingertip (or Dashboard) baseline is at the State average or higher.	09.30.16	Discontinued: Part of Dashboard
	Increased compliance and performance of the Provider Network through sufficient oversight and monitoring.	1. Quality Review tools developed and implemented across SUD Provider Network	12.31.15	Met
		2. Demonstrated evidence of implementation of CMHSP DMC site review corrective action plans.	10.30.16	Discontinued: Part of Routine Operations
		3. Develop and implement second year site review process and procedure	12.31.15	Met
	MSHN adopts and deploys best practices for health information collection, retention, exchange and reporting.	1. The MSHN region successfully deployed Behavioral Health TEDS.	12.31.15	Met
		2. The electronic health and managed care record for substance use disorder services is integrated with provider network systems.	09.30.18	Ongoing
		3. MSHN and its regional providers create an Organized Health Care Arrangement in accordance with record security and confidentiality compliance requirements and best practices.	12.31.15	Met
		4. MSHN engages in health information exchange to support best practices in coordination of care.	09.30.16	Met
Public Resources Are Used Efficiently and Effectively	With other PIHPs, regional CMHSPs and MDHHS, adopt a consistent administrative cost model.	1. % of total PIHP administrative costs is at or below the MI average.	09.30.16	Discontinued: Part of Dashboard
		2. Implement use of a regional standardized calculation of medical loss ratio in accordance with federal Medicaid rules and the PIHP contract.	01.01.16	Revised and Ongoing
	Develop and Implement Regional Medicaid Event Verification Methodology	1. Provider Network MEV audits completed in accordance with new contractual guidance	09.30.16	Met
		2. Compliance with Medicaid Standards improves over baseline	09.30.17	Discontinued: Part of Dashboard
	Implement plan to achieve Board targets for restricted reserves.	1. Develop adjusted smoothing plan and identified service needs.	10.01.15	Ongoing
		2. Monitor performance to plan	Ongoing	Discontinue: Part of Dashboard
	Implementation of the region's utilization management plan demonstrates achievement of defined goals.	1. MSHN has utilization patterns that are within normal statistical limits when benchmarked against statewide benchmarks.	09.30.16	Met
		2. MSHN adopts a site review protocols for UM review that are consistent with the regionally adopted UM guidelines.	09.30.16	Met
		3. Audited medical EMRs demonstrate evidence of medical necessity consistent with regionally approved criteria and sufficient to support the scope duration and intensity of services authorized.	09.30.17	Met
Leadership & Public Policy Advocacy	Develop and implement a regional advocacy plan.	1. Communication related to regional advocacy efforts results in Board member satisfaction over 2014 baseline.	01.01.16	Ongoing
		2. The Board reports being informed of key funding actions and advocacy.	01.01.16	Ongoing
		3. MSHN Board members report strengthened advocacy efforts and skills.	01.01.16	Ongoing

	MSHN engages in proactive collaborative planning and communication with the MDHHS	1. MSHN leadership engages in planning efforts to provide system leadership and guide statewide planning.	Ongoing	Ongoing
		2. MSHN staff provide feedback and recommendations for improvement when MDHS planning falls outside of mutually agreed forums and/or without system input.	Ongoing	Discontinued
		3. MSHN leadership participates as a member of PIHP contract negotiation and monitoring activities to assure ongoing commitment to efficiency.	Ongoing	Discontinued: Part of Routine Operations
	MSHN develops and deploys a plan for regional accreditation.	1. Select an accreditation provider	03.01.16	Met
		2. Complete accreditation readiness plan	06.30.16	In Process
		3. Implement necessary changes/improvements to meet accreditation requirements	12.31.16	To be completed upon completion of readiness plan
		4. Apply for and complete accreditation review	01.01.17	Not Due Yet
		5. Prepare plan of correction in response to accreditation findings	09.30.17	Not Due Yet

III. QAPIP Priorities for Fiscal Year 2017 (Based on the FY17 MSHN Strategic Plan Priorities and Objectives)

2017 QAPIP Priorities			
Priority	**Measure**	**Strategic Planning Objective**	**Assigned Council / Committee**
Better Health			
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	Improve Population and Integrated Health Activities	Quality Improvement Council & IT Council
	2. Audited CMHSP participant records demonstrate evidence of primary care coordination (including consideration of CC360 information)		
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.	Improved Behavioral Health Treatment/Service Outcomes	Quality Improvement Council & UM Committee
Better 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.	Improve Access to Care	Quality Improvement Council, Clinical Leadership Committee & UM Committee
	2. All Healthy Michigan expended SUD services are regionally available		Quality Improvement Council & Clinical Leadership Committee
	3. MSHN will improve penetration of covered individuals in all eligibility categories, in part by defining a regional penetration rate analysis methodology that takes into consideration some of the uniqueness of the public behavioral health system.		Quality Improvement Council, Clinical Leadership Committee & UM Committee
	4. Fully implement the region's access and authorization practice guidelines to achieve a common benefit.		Quality Improvement Council & UM Committee
	5. Standardize practices for documentation of medical necessity to assure people are receiving an appropriate scope, duration and intensity of care.		Quality Improvement Council, Clinical Leadership Committee & UM Committee
	6. 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.		Quality Improvement Council
	7. Monitor compliance with Autism Benefit program requirements.		UM Committee

Better Care			
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	Improve the Role of MSHN Customers and Key Stakeholders	Quality Improvement Council
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.		Quality Improvement Council
MSHN will improve and integrate stakeholder and consumer input systems	1. Evaluate feasibility of survey consolidation and streamlining		Quality Improvement Council
MSHN implements its approved Quality Assessment and Performance Improvement Plan (QAPIP), and specific Performance Improvement Plans, to improve quality and care across the region	1. Quality review tools are developed and implemented across the Substance Abuse Prevention and Treatment (SAPT) provider network	Enhance Organizational Quality and Compliance	Quality Improvement Council, Clinical Leadership Committee, UM Committee & Provider Network Committee
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		Quality Improvement Council & Clinical Leadership Committee
Better Value			
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. 2. Audited medical records demonstrate evidence of consistently applied medical necessity criteria, consistent with regionally approved criteria and sufficient to support scope, duration and intensity of services. 3. Identification of under-and-over utilization	Public Resources are Used Efficiently and Effectively	UM Committee
MSHN develops and implements plan for PIHP accreditation	1. Implement necessary accreditation-related action plans regionally and within the PIHP.	Regional Public Policy Leadership Supports Improved Health Outcomes and System Stability	Quality Improvement Council
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.		Quality Improvement Council, IT Council & Provider Network
	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.		Quality Improvement Council

MSHN's Provider Network Management Systems are effective and efficient	1. MSHN publishes provider performance data to consumers and the public	Regional Public Policy Leadership Supports Improved Health Outcomes and System Stability	Quality Improvement Council & Provider Network

IV. MSHN Balanced Scorecard Report

MSHN FY16 - Operations Council's - Balanced Scorecard

Key Performance Areas	Key Performance Indicators	Actual Value (%)	Target Value	Performance Level	Target Ranges		
Consumer Health Outcomes	Enrollees living independently or in supported living arrangements (Note, now using BH-TEDS data)	85.9%	increase over 2015		72.3%	72.0%	70.0%
	Enrollees working or in supported employment arrangements (Note, now using BH-TEDS data)	17.2%	increase over 2015		12.3%	12.0%	11.5%
	Consumers are screened for diabetes	80.1%	increase over 2014		62.0%	61.9%	60.0%
	Enrollees receiving an annual primary care assessment	71.2%	increase over 2015		80.3%	80.0%	78.0%
	Emergency department visits	59,337	decrease from 2015		55,000	56,000	57,000
	Count of consumer assessed consistent with contract requirements for standardized assessment (SIS Assessments)	2,763	Stay on target		3196	3000	2600
	Behavioral Health IP readmissions within 30 days of discharge	1,729	decrease from 2015		850	895	950
	All cause IP readmissions within 30 days of discharge	3,442	decrease from 2015		3,300	3400	3,500

Key Performance Areas	Key Performance Indicators	Actual Value (%)	Target Value	Performance Level	Target Ranges		
Customer Focus	Consumer/family Satisfaction in person centered planning	89.5%	increase over 2015		95.0%	90.0%	85.0%
	Access& Timeliness Standards are Met (MMBPIS)	99.0%	100%		95.0%	94.9%	90.0%
	MSHN's Medicaid penetration rate	8.55%	increase over 2015		8.72%	8.70%	8.60%
	MSHN's Healthy Michigan Plan penetration rate	5.59%	increase over 2015		5.42%	5.40%	5.25%
	The number of enrollees served with Primary SUD	16,566	increase over 2015		8,355	8,000	7,500
	Count of inidividual and community primary prevention contacts in target areas of teenage drinking, over-the-counter and prescriptions, drug abuse, and tobacco	64,276	increase over 2015		41,733	41,500	40,000
	Inpatient visits per 1,000 enrollees	23	decrease from 2015		23	25	27
	CMHSP/Provider Network/Board/RCAC satisfaction with MSHN input & decision making process.	97.6%	increase over 2015		95.0%	94.9%	90.0%
Budget, Financial & Market	MSHN reserves (savings & ISF)	8.78% Total	7.5% (Board approved target)		≥ 7% and ≤ 8%	≥ 6.5% and < 7% or >8% and ≤ 8.5%	< 6.5% or > 8.5%
	% of PIHP Administrative Cost is equal to or less than the statewide PIHP average	Feb 17 (prev. 5.6%)	6.25%		≤6.25%	> 6.25% and < 8.5%	≥8.5%
	MSHN Medical loss ratio is within the MDHHS allowable target	Jan 17 (prev. 94.4%)	≥ 92.75%		≥ 92.75%	> 91.5% and < 92.75%	≤91.5%
	Performance Actual to Budget (%)	Jan 17 (prev. 97.4%)	≥ 90%		≥ 90%	> 85% and < 90%	≤ 85%

Key Performance Areas	Key Performance Indicators	Actual Value (%)	Target Value	Performance Level			
Workforce, Provider Network & Strategic Partnership Focus	MSHN Provider network demonstrates the full service array for Medicaid and HMP.	100%	100%		100%	-	99% ≥
	CMHSP's demonstrate an established 24-7-365 access services for individuals with primary SUD	100%	100%		100%	-	99% ≥
	MSHN has established an agreed upon performance improvement project with Medicaid Health Plans operating in the region	On target	increase over 2015		Ahead of target	On target	Behind target
	Number of evidenced based practices offered regionally	104 total (38-CMH; 66-SUD)	increase over 2015		> 99	99	99 >
	Network credentialing practices demonstrate compliance with MSHN policies and procedures	92% (11 of 12)	12		100%	-	99% ≥
	Number of learning communities within MSHN	5	increase over 2015		> 1	1	1 >
Process Effectiveness	MSHN strategic plan - progress to plan %	72%	84%		≥ 84%	84% > x > 74%	74% ≥
	Medical records reviewed showing evidence of trauma screening/assessment.	100%	increase over 2015		≥ 95%	95% > x > 90%	90% ≥
	Medical records demonstrate evidence of primary care coordination.	91%	increase over 2015		≥ 95%	95% > x > 90%	90% ≥
	Medical records demonstrated evidence of UM access and authorization consistent with regionally approved guidelines.	98%	increase over 2015		≥ 95%	95% > x > 90%	90% ≥
	Medicaid event verification demonstrates improvement over 2015 baseline (Note new PIHP process, FY 15 (97%) was a CMHSP process)	94%	increase over 2015		98%	96%	94%

					Target Ranges		
Key Performance Areas	Key Performance Indicators	Actual Value (%)	Target Value	Performance Level			
Leadership	Board perception of communication and advocacy efforts improve over 2014 baseline.	97%	2014 baseline		≥ 76.9%	76.9% > x > 71.9%	71.9% ≥
	Policy/procedure review to plan (%)	86%	≥ 90%		≥ 90%	90% > x > 80%	80% ≥
	MSHN Leadership represents the region in planning meetings with MDHHS as required to meet contract and strategic planning goals.	97%	2014 baseline		≥ 83.2%	83.2% > x > 78.2%	78.2% ≥
	MSHN achieves national accreditation % plan to target.	15%	On target		Ahead of target	On target	Behind target

SECTION FIVE –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 or not 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.

SECTION SIX –ATTACHMENTS

Attachment A: MSHN Monitoring Tools:

1. Delegated Managed Functions: **http://www.midstatehealthnetwork.org/docs/MSHN%20Delegated%20Functions%20Audit%20-%20Final%20Clean%20Version.pdf**