MSHN

Mid-State Health Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Plan FY2023

Prepared By: MSHN Quality Manager – 11/29/2022

Reviewed and Approved By: Quality Improvement Council – 12/2022

Reviewed By: MSHN Leadership – 12/14/2022

Reviewed By: MSHN Operations Council – 12/19/2022

Reviewed and Approved By: MSHN Board –

Contents

I. OVERVIEW/MISSION STATEMENT

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 Authority, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network , Huron County Community Mental Health Authority, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, Shiawassee Health and Wellness, The Right Door and Tuscola Behavioral Health Systems. In January 2014, MSHN entered into its first contract with the State of Michigan for Medicaid funding, and entered into subcontracts with the CMHSPs in its region for the provision of Mental Health, Substance Use Disorder, and Developmental Disabilities services. The contract was expanded in 2014 to include an expanded Medicaid benefit, the Healthy Michigan Plan. As of October 1, 2015, MSHN took over the direct administration of all public funding for substance use disorder (SUD) prevention, treatment and intervention within the region and expanded the provider network to include SUD providers. Beginning in FY22 Michigan was identified as a Certified Community Behavioral Health Clinic Demonstration State. October 1, 2021, MSHN became responsible for the PIHP requirements related to CCBHC. Three CMHSP Participants within the MSHN region have received the certification to become a Certified Community Behavioral Health Clinic (CCBHC), CEI, The Right Door, and SCCMH. Lifeways currently has an expansion grant directly with Substance Abuse and Mental Health Services Administration (SAMHSA). MSHN will adhere to contractual and policy requirements related to CCBHC.

The mission of MSHN is to ensure access to high-quality, locally delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members. The vision of MSHN is to continually improve the health of our communities through the provision of premiere behavioral healthcare and leadership.

II. SCOPE OF PLAN

The scope of MSHN's QAPIP is inclusive of all CMHSP participants, substance use disorder providers and their respective provider networks, and Certified Behavioral Health Clinics (CCBHC) within the MSHN Region.

Performance monitoring covers all important organizational functions, 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.

III. DEFINITIONS/ACRONYMS

BTPRC: Behavior Treatment Plan Review Committee reviews, approves, or disapproves any plans that propose to use restrictive or intrusive intervention, with as defined in the Technical Requirement for Behavior Treatment Plans.

Behavioral Health: An individual with a mental illness, intellectual developmental disability and/or substance use disorder or children with a serious emotional disturbance.

CMHSP: Community Mental Health Services Program is a program operating 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.

CIRS: Critical Incident Reporting System includes events required to be monitored and reported to MDHHS and the process in which this is completed. The current critical incidents categories include suicide death; non-suicide death; arrest of consumer; emergency medical treatment due to injury or medication error; and type of injury. Subcategories include injuries that resulted from the use of physical management; hospitalization or emergency treatment due to injury or medication error; emergency medical treatment of hospitalization due to injury related to the use of physical management.

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

EQR: External Quality Review is conducted quarterly by CMS and MDHHS.

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

CQS: Comprehensive Quality Strategy provides a summary of work done to assess and improve the quality of care and services provided and reimbursed by Michigan's Medicaid programs, in accordance with State and Federal laws and regulations. The CQS provides a framework to accomplish its overarching goals of designing and implementing a coordinated and comprehensive system to proactively drive quality across Michigan Medicaid managed care programs.

MEV: Medicaid Event Verification is a process which verifies services reimbursed by Medicaid.

MMBPIS: Michigan Mission Based Performance Indicator System includes domains for access to care, adequacy and appropriateness of services provide, efficiency (administrative cost vs. service costs), and outcomes (employment, housing inpatient readmission).

MDHHS CQS: Michigan Department of Health and Human Services Comprehensive Quality Strategy

MDHHS: Michigan Department of Health and Services

PIP: Performance Improvement Projects must be conducted to address clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes.

PIHP: Prepaid Inpatient Health Plan is a managed care organization responsible for administering specialty services for the treatment of mental health, intellectual and developmental disabilities and substance use disorders in accordance with the 42 CFR part 401 et al June 14, 2002, regarding Medicaid managed care, Medicaid regulations, Part 438, MHC 330.1204b.

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 subcontractors.

QAPI: Quality Assessment Performance Improvement

QM/QA/QI: Quality Manager/Assurance/Improvement

QAPIP: Quality Assessment and Performance Improvement Program includes standards in accordance with the Guidelines for Internal Quality Assurance Programs as distributed by the Health Care Financing Administration Medicaid Bureau guide to states in July of 1993, the Balanced Budget Act of 1997, Public Law 105-33, and 42 Code of Federal Regulations (CFR)438.358 of 2002.

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

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

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

Stakeholder: A person, group, or organization that has an interest in an organization, including consumer, family members, guardians, staff, community members, and advocates.

Subcontractors: Refers to an individual or organization that is directly under contract with CMHSP and/or SRE to provide services and/or supports.

SUD Providers: Refers to substance use disorder (SUD) providers directly contracted with MSHN to provide SUD treatment and prevention services.

Veteran Navigator (VN): The role of the Veteran Navigator is to listen, support, offer guidance, and help connect Veterans to services they need.

Vulnerable Person: An individual with a functional, mental, physical inability to care for themselves.

IV. PHILOSOPHICAL FRAMEWORK

The MSHN utilizes the National Healthcare Reform Framework the "Quintuple Aim". For MSHN, the quintuple aim includes five strategic priorities: "Better Health", "Better Care", "Better Value", "Better Provider Systems" and new beginning with the MSHN FY22 Strategic Plan, "Better Equity". MSHN organizes and empowers a network of publicly funded community partnerships essential to ensure quality of life while efficiently and effectively addressing the complex needs of the most vulnerable citizens in our region.

The MSHN Quality Assessment and Performance Improvement Program (QAPIP) provides a structure for quality improvement in alignment with the MSHN Strategic Plan through performance monitoring. Additionally, the MSHN QAPIP aligns with the quality assessment and performance improvement program interventions as identified in the Michigan Department of Health and Human Services (MDHHS) Comprehensive Quality Strategy (CQS). Responsibilities of the quality management program are outlined in the QAPIP Plan.

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 provider network 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.

V. ORGANIZATIONAL STRUCTURE AND LEADERSHIP

a) Structure

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

b) Governance

Board of Directors

The MSHN's Board of Directors employs the Chief Executive Officer (CEO), sets policy related to quality management, and approves the PIHP's QAPIP, including quality management priorities as identified in this plan. The QAPIP Plan is evaluated and updated annually, or as needed, by the MSHN Quality Improvement Council.

Through the Operations Council, Substance Use Disorder Oversight Policy Board and MSHN CEO, the MSHN's Board of Directors receives quarterly progress reports through the Balanced Score Card and MSHN Department Reports. Additionally, the Board of Directors receives an Annual Quality Assessment and Performance Improvement Program Report evaluating the effectiveness of the

quality management program and recommending priorities for improvement initiatives for the next year. The report describes quality management activities, performance improvement projects, and actions taken to improve performance. After review and approval of the Annual Quality Assessment and Performance Improvement Program inclusive of a list of the Board of Directors', the QAPIP Plan and Report is submitted to the Michigan Department of Health and Human Services (MDHHS) as required by February 28, 2023.

Chief Executive Officer

MSHN's CEO is hired/appointed by the PIHP Board and is the designated senior official with responsibility for ensuring implementation of the regional QAPIP. The MSHN CEO has designated the Quality Manager as the chair of the MSHN Quality Improvement Council, and a member of the MDHHS Quality Improvement Council. In this capacity, the Quality Manager under the direction of the Chief Compliance and Quality Officer, is responsible for the development, review, and evaluation of the Quality Assessment and Performance Improvement Plan 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 ensuring ongoing monitoring and compliance with its MDHHS contract including provision of quality improvement plans as required.

Medical Director

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

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

c) Components

Recipients

MSHN continues the legacy of its founding CMHSP Participants by promoting and encouraging active consumer involvement and participation within the PIHP, the respective CMHSPs and their local communities. Recipients of services participate in the QAPIP through involvement on workgroups, process improvement teams, advisory boards, and Quality Improvement (QI) Councils at the local and regional level. Recipients provide input into policy and program development, performance indicator monitoring, affiliation activities/direction, self- determination efforts, QI projects,

satisfaction findings, consumer advocacy, local access and service delivery, and consumer/family education, etc. In addition to the participation of recipients of services in quality improvement activities, MSHN and the CMHSP Participants/ SUD Providers strive to involve other stakeholders including but not limited to providers, family members, community members, and other service agencies whenever possible and appropriate. Opportunities for stakeholder participation include the PIHP governing body membership; PIHP Quality Improvement Council; PIHP Customer Services Committee; Consumer Advisory activities at the local, regional, and state levels; completion of satisfaction surveys; participation on quality improvement work teams or monitoring committees; and focus group participation. Stakeholder input will be utilized in the planning, program development, and evaluation of services, policy development, and improvement in service delivery processes.

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

- Implementation of Compliance Monitoring activities as outlined in the MSHN Corporate Compliance Plan
- 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. Communication related to standards and requirements will occur through policy and procedure development, constant contact, training, committees/councils, and the MSHN website.

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.

Communication of Process and Outcomes

A quality structure identifies clear linkages and reporting structures. The MSHN Quality Improvement Council (QIC), in coordination with the CMHSP Participants and SUD Providers through regional committees and councils, is responsible for monitoring and reviewing performance measurement activities including identification and monitoring of opportunities for process and outcome improvements. Consumers and stakeholders receive reports on key performance indicators, consumer satisfaction survey results, and performance improvement (PI) projects through the Operations Council, Consumer Advisory Council meetings. Final performance and quality reports are available to the stakeholders and the general public through the MSHN website, and as requested. The Board of Directors receives periodic and an annual report on the status of organizational performance.

d) MSHN Provider Network

MSHN Councils and Committees are responsible for providing recommendations and reviewing regional policy regarding related managed care operational decisions. Each council/committee develops and annually reviews and approves a charter that identifies the following: Purpose, Decision Making Context and Scope, Defined Goals, Monitoring, Reporting and Accountability, Membership, Roles and Responsibilities Meeting Frequency, Member Conduct and Rules, and Upcoming Goals supporting the MSHN Strategic Plan. The Operations Council approves all council/committee charters. Each council/committee guides the Operations Council, who advises the MSHN CEO. These recommendations are considered by the Operations Council on the basis of obtaining a consensus or simple majority vote of the twelve 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.

CMHSP Participant/SUD Provider staff have the opportunity to participate in and to support the QAPIP through the following activities:

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

Quality Improvement Council

A quality representative from each CMHSP is appointed by the CMHSP CEO to participate in the MSHN Quality Improvement Council. Primary and/or secondary consumer representatives are appointed through an application process. Substance Use Disorder (SUD) Treatment Providers are represented on the Council by MSHN SUD Staff on an as needed basis.

Regional Medical Directors

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

SUD Oversight Policy Board

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

SUD-Advisory Councils

The MSHN SUD provider network utilizes work groups to serve in an advisory capacity to MSHN to represent SUD providers and to offer input regarding SUD policies, procedures, strategic planning, quality improvement initiatives, monitoring and oversight processes, and to support MSHN's focus on evidence-based, best practice service and delivery to persons served. Each SUD provider work group is specific to a Level of Care (LOC) and functional area including, Women's Specialty Services, Medication Assisted Treatment, Residential, Recovery Housing, and Outpatient work groups.

Regional Consumer Advisory Council (RCAC)

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

Operations Council (OC)

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

Finance Council (FC)

The FC will 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 FC 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.

Information Technology Council (ITC)

The ITC was 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.

Clinical Leadership Committee (CLC)

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

Regional Medical Directors Committee (RMDC)

The RMDC was established to advise the MSHN Chief Medical Officer (CMO), the MSHN Chief Executive Officer (or designee), the MSHN Chief Behavioral Health Officer (CBHO), and the OC concerning the behavioral health operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the

CMO, CEO (or designee), CBHO, and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Utilization Management Committee (UMC)

The UMC was established to assure effective implementation of the Mid-State Health Network's UM Plan and to support compliance with requirements for MSHN policy, the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract and related Federal & State laws and regulations.

Compliance Committee (CC)

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

Customer Services Committee (CSC)

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

Provider Network Management Committee (PNMC)

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

Regional Equity Advisory Committee for Health (REACH)

To address MSHN's strategic priority of better equity, MSHN has established a Regional Equity Advisory Committee for Health (REACH), an advisory body comprised of Region 5 stakeholders and community partners from historically marginalized populations with lived experience. REACH goals are 1) to ensure attention to issues of equity, including reducing health disparities in access and delivery of quality behavioral health and substance use disorder (SUD) prevention, treatment and recovery programs; 2) to inform development and review of MSHN policies, procedures and practices through the lens of diversity, equity and inclusion (DEI); 3) to incorporate a trauma-informed perspective that accounts for historical and racialized trauma; 4) to address stigma and bias that may impact health outcomes.

VI. PERFORMANCE MANAGEMENT

Performance Management is defined as "a forward-looking process used to set goals and regularly check progress toward achieving those goals. In practice, an organization sets goals, looks at the actual data from its performance measures, and acts on results to improve the performance toward its goals."[1] MSHN utilizes the Balanced Score Card (BSC) to provide a comprehensive view of the organizational performance.

a) Establishing Performance Measures

MSHN encourages the use of objective and systematic forms of measurement. MSHN utilizes performance measurement to monitor system performance, promote improved performance, identify opportunities for improvement and best practices, and to ensure compliance with PIHP contract requirements and State and Federal processes and requirements.

Performance measures are developed through the regional committees/councils and align with the MSHN strategic priorities of Better Health, Better Care, Better Value, Better Provider System, and Better Equity.

The measures established can be clinical and non-clinical, have clear expectations, promote transparency, and are accountable through ongoing monitoring. Information is a critical product of performance measurement that facilitates performance improvement, and priorities for risk reduction. Data must be systematically aggregated and analyzed to become actionable information. Data is used for clinical decision-making, and organizational decision-making (e.g., strategic planning and day-to-day operations).

The PIHP quality management program uses but is not limited to the following means for identification of system issues and opportunities for improvement through performance measurement:

- growth areas identified from performance summaries and reports.
- stakeholder feedback from providers and member experiences.
- oversight and monitoring reviews from external and internal processes.
- appeals/grievance, customer service complaints.

Once an opportunity is identified a quality improvement process may be initiated.

b) Prioritizing Measures

Measures are chosen by MSHN leadership in collaboration with MSHN committees, councils, and work groups based on the needs of the organization, with consideration given to the following three factors:

Focus Area: Clinical, high volume or high-risk services; continuity and coordination of care, or Non-Clinical include but are not limited to appeals, grievance, trends, and patterns of substantiated member rights complaints as well as access to, and availability of services that can be expected to have a

[1] (U.S. Department of Health & Human Services, Health Resources & Services Administration. Performance Measurment and Management, 2011)

beneficial effect on health outcomes and individual satisfaction. Qualitative and quantitative assessment; internal performance.

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, accreditation requirement and/or clinical standards of cares.

c) Data Collection, Analysis, and Reporting

The purpose of data collection is to monitor performance, identify growth areas, and monitor the effectiveness of interventions. A description of the measure is written and may include, but is not limited to the following:

- Baseline
- Standard/Target/Goal
- Data collection timeframe, and remeasurement periods
- Frequency of data analysis
- Population/sample
- Data source
- Consistent data collection techniques.
- Strategies to minimize inter-rater reliability concerns and maximize data validity.
- Measure Steward

Additionally, if a sampling method is used, the population from which a sample is pulled, and appropriate sampling techniques to achieve a statistically reliable confidence level are included in the project/study description. The default confidence level for MSHN performance measurement activity is a 95% confidence level with a 5% margin of error.

Data is aggregated at a frequency appropriate to the process or activity being studied. Statistical testing and analysis are used as appropriate to analyze and display the aggregated data. PIHP data is analyzed over time to identify patterns and trends and are compared to established performance targets and/or externally derived benchmarks when available. Performance targets are set through established contract requirements and/or externally derived benchmarks. If there is no set performance target, baseline data should be considered prior to setting a target.

Baseline data is data that is collected for a period of time, typically up to one year, prior to establishing a performance target. Historical data, when available may be used for baseline. When collecting baseline data, it is important to establish a well- documented, standardized, and accurate method of collecting the data and set ongoing frequencies to review the data (monthly, quarterly, etc.).

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

Targets may be defined by a set percentage for achievement to meet the outcome being measured or a percentage increase/decrease change to be achieved. When establishing performance targets, the following should be considered (as defined in the Health Resources and Service Administration (HRSA) Quality Tool Kit):

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

The data is reviewed at the established intervals by the appropriate council, committee, or workgroup, in collaboration with QIC. The data is analyzed for undesirable patterns, trends, or variations in performance. In some instances, it may be necessary to complete further data collection and analysis to isolate the causes of poor performance or excessive variability, proceeding with performance improvement action steps until the performance target is met.

d) Performance Improvement Action Steps

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

- Develop a step-by-step action plan, limiting the number of variables impacted.
- Implement the action plan, preferably on a small or pilot scale initially, and
- Study the data to check for expected results.
- Modify or develop interventions to obtain expected result.

The process of measurement, data collection, data analysis and action planning are repeated until the desired level of performance/improvement is achieved. Sustained improvement is sought for a reasonable period (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 ensure the desired level of quality is being maintained, as appropriate, unless the measure(s) mandated by external entities such as the MDHHS require further measurement and analysis.

When the established minimum performance targets or requirements are not met, CMHSP Participants/SUD Providers may need to submit a quality improvement plan that includes the following:

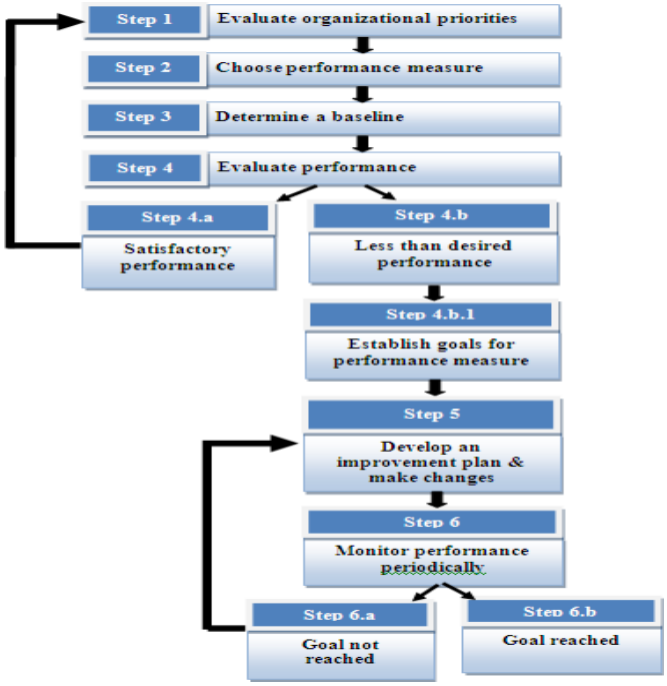
- Causal factors that caused the variance (directly and/or indirectly)
- Interventions that will be implemented to correct the variance
- Timelines for when the action will be fully implemented
- How the interventions will be monitored

- Any other actions that will be taken to correct undesirable variation

The appropriate MSHN staff, council, committee, workgroup, etc. will monitor the implementation and effectiveness of the quality improvement plan (QIP). The effectiveness of the QIP will be monitored based on the re-measurement period identified.

In some instances, region wide quality improvement efforts may be developed based on the patterns and trends identified through data analysis, in lieu of provider level improvement plans. Region wide efforts will be reviewed for effectiveness at established intervals within the appropriate MSHN council, committees, workgroups.

Process Map of Performance Management Pathway (defined by HRSA)



e) Performance Indicators[2]

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in access, efficiency, and outcomes. Pursuant to its contract with MDHHS, MSHN is responsible for ensuring that it's CMHSP Participants and Substance Use Disorder Providers are measuring performance using standardized performance indicators and participate in the Michigan Mission Based Performance Improvement System (MMBPIS).

When minimum performance targets or requirements are not met, CMHSP participants/SUD providers develop a quality improvement plan documenting causal factors, interventions, implementation timelines, and any other actions taken to correct undesirable variation. The plan will be reviewed by the designated MSHN content expert to ensure sufficient action planning. Regional trends are identified and discussed at the QIC or relevant committee/council for regional planning

[2] Quality-Michigan Mission Based Performance Indicator System

efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified.

f) Performance Improvement Projects[3]

MDHHS requires the PIHP to complete a minimum of two performance improvement projects per waiver renewal period. The QIC chooses performance improvement projects based on the methodology described in section VI Performance Management of this document which includes but is not limited to the analysis of data, analysis of process, satisfaction, and/or outcome trends that may have an impact on the quality of service provided. Once chosen, a recommendation is made to the MSHN Operations Council for approval. The PIP is presented to relevant committees and councils for collaboration during the duration of the PIP. One of the two is chosen by the department based on Michigan's Quality Improvement Council recommendations. This project is approved by MDHHS and subject to validation by the external quality review (EQR) organization, requiring the use of the EQR's form. In alignment with the MDHHS Comprehensive Quality Strategy, MDHHS has elected the focus of the PIP topic for FY22-FY25 to include the reduction of existing racial or ethnic disparities in access to healthcare or health outcomes. MSHN has approved the following Non-clinical Performance Improvement Project to address access to services for the historically marginalized groups within the MSHN region:

Study Topic - Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population.

Study Question - Do the targeted interventions reduce or eliminate the racial or ethnic disparities between the black/African American population and the white population who have received a medically necessary ongoing service within 14 days of completing a biopsychosocial assessment?

The second or additional PI project(s) is chosen by the PIHP. MSHN QIC has recommended and MSHN Operations Council has approved the following Non-clinical Performance Improvement Project to ensure time access to treatment:

Study Topic - The racial or ethnic disparities between the black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated.

Study Questions - Do the targeted interventions reduce or eliminate the racial or ethnic disparities in the penetration rate between the black/African American penetration rate and the index (white) penetration rate?

Performance is reviewed as outlined in the performance improvement project description. The summary is submitted to the external quality review organization for a validation review, and to MDHHS through the QAPIP Annual Report and upon request.

VII. STAKEHOLDER EXPERIENCE/ENGAGEMENT [4]

MSHN values the opinions of consumers, their families, and other stakeholders as 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, and organizations providing services to consumers are surveyed by MSHN at least annually using

[3] Quality-Performance Improvement

[4] Quality-Consumer Satisfaction Survey Policy

a standardized survey or assessment tool. The tools vary in accordance with service population needs, 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.

Surveys used to assess stakeholder and member experiences include but are not limited to the following:

- Mental Health Statistics Improvement Program (MHSIP)-Adults with a Mental Health illness
- Youth Satisfaction Survey (YSS) Youth with a Severe Emotional Disturbance
- Substance Use Disorder Satisfaction Survey-Individuals with a substance use disorder
- Home and Community Based Services Survey-Individuals receiving Long Term Supports and Services
- Provider Network Survey-Organizations who contract with MSHN
- Committee/Council Survey-Provider representatives on MSHN committees/ councils
- National Core Indicator Survey-Individuals receiving LTSS
- Supports Intensity Scale- Individuals receiving LTSS
- Appeals and Grievance Data, and customer complaints

The aggregated results of the surveys and/or assessments are collected, analyzed, and reported by MSHN to the QI Council, Regional Consumer Advisory Council, and other relevant committees/councils, who identify strengths, areas for improvement and make recommendations for action and follow up as appropriate. Regional benchmarks and/or national benchmarks are used for comparison when available. The data is used to identify best practices, demonstrate improvements, or identify growth areas. The QI Council determines action for improvements. The findings are incorporated into program improvement action plans as appropriate. The CMHSP participant/SUD providers take action on individual cases, as appropriate, to identify and investigate sources of dissatisfaction and determine appropriate follow-up.

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

VIII. ADVERSE EVENTS

Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrant a PIHP review. A subset of the adverse events will qualify as "reportable events" according to the MDHHS Critical Event Reporting System. These include MDHHS defined sentinel events, critical incidents, and risk events. MSHN also ensures that each CMHSP participant/SUD provider has a system in place to monitor these events, utilizing staff with appropriate credentials for the scope of care, and reporting or follow up within the required timeframes.

MSHN submits and/or reports required events to MDHHS including events requiring immediate notification as specified in the MDHHS PIHP FY23 contract and the Critical Incident Reporting and Event Notification Policy.

MSHN delegates the responsibility of the review and follow-up of sentinel events, critical incidents, and other risk events that put people at risk of harm to the CMHSP participants and SUD providers. Risk events are monitored by the providers and include actions taken by individuals receiving services as defined by MDHHS, that may cause harm to self or others, and have had two or more unscheduled admissions to a medical hospital within 12 months. CMHSP Participants report suicide deaths, non-suicide deaths, arrests, emergency medical treatment and/or hospitalization for injuries and medication errors for required populations as defined by MDHHS.[5] Additionally, subcategories reported for deaths include accidental/unexpected and homicide. Subcategories for emergency medical treatment and hospitalizations include those injuries from the use of physical management. SUD Providers, including but not limited to residential providers, review and report deaths, injuries requiring emergency medical treatment and/or hospitalization, serious behavioral issues, medication errors, physical illness requiring hospitalization, and arrests and/or convictions as defined by MDHHS.[6] All MSHN providers are responsible to review critical incidents to determine if the incident is sentinel within three days of the occurrence. Once appropriately qualified and credentialed staff identify an incident as sentinel, a root cause analysis/investigation is to commence within 2 business days of the identification of the sentinel event. Following completion of a root cause analysis, or investigation, the CMHSP will develop and implement either a plan of action to address immediate safety issues, an intervention to prevent further occurrence or recurrence of the adverse event, or documentation of the rationale for not pursuing an intervention. The plan shall address the staff and/or program/committee responsible for implementation and oversight, timelines, and strategies for measuring the effectiveness of the action. [7]MSHN providers are responsible to report any death that occurs as a result of staff action or inaction, subject to recipient rights, licensing, or police investigation within 48 hours of the death or receipt of the notification of the death and/or investigation.

MSHN provides oversight and monitoring of the CMHSP participant/SUD provider processes for reporting sentinel events, critical events, events requiring immediate notification to MDHHS, and monitoring of risk events. In addition, a quarterly analysis of the events, identified patterns or trends, the completion of identified actions, and recommended prevention strategies for future risk reduction is reviewed with the relevant committees and councils. The goal of reviewing these events is to focus the attention of the CMHSP participant/SUD providers 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.

IX. CLINICAL QUALITY STANDARDS

a) Utilization Management [8] -

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.

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[5] Quality-Critical Incidents

[6] Quality-Critical Incident Review for SUD Providers

[7] Quality-Sentinel Events

[8] Utilization Management Plan

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

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

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

Utilization review functions are delegated to CMHSP Participants in accordance with MSHN policies, protocols, and standards. This includes local-level prospective, concurrent and retrospective reviews of authorization and utilization decisions and/or activities regarding level of need and level and/or amount of services, consistent with PIHP policy, standards, and protocols. A Regional Utilization Management Committee comprised of each CMHSP Participant assists in the development of standards and reviews/analyzes region-wide utilization activity and trends.

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

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

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

MSHN has mechanisms to identify and correct under-and over-utilization of services as well as procedures for conducting prospective, concurrent, and retrospective reviews. MSHN ensures through policy and monitoring of the CMHSP Participants/SUD Providers that qualified health professionals supervise review decisions and any decisions to deny or reduce services are made by health care professionals who have appropriate clinical licensure and expertise in treating the beneficiary's condition. Through policy and monitoring of CMHSP Participants/SUD Providers, MSHN shall ensure that reasons for treatment decisions are clearly documented and available to persons

served; information regarding all available appeals processes and assistance through customer services is communicated to the consumer; and notification requirements are adhered to in accordance with the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services.

b) Practice Guidelines[9]

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

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

Practice guidelines will be monitored and evaluated through data analysis and MSHN's site review process to ensure CMHSP participants and SUD providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization. Additionally, information regarding evidenced based practices is reported through the annual assessment of network adequacy. Fidelity reviews shall be conducted and reviewed as part of the local quality improvement program or as required by MDHHS.

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

c) Oversight Of "Vulnerable People"

MSHN assures the health and welfare of the region's service recipients through service delivery by establishing standards of care for individuals served. MSHN defines vulnerable people as individuals who have functional limitation and/or chronic illnesses. Each CMHSP Participant/SUD Provider shall have processes for addressing and monitoring the health, safety and welfare of all individuals served.

MSHN ensures that long term supports, and 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 assesses the quality and appropriateness of care furnished by monitoring of population health through data analytics software to identify adverse utilization patterns and to reduce health disparities, and by conducting individual clinical

[9] Service Delivery-Clinical Practice Guidelines and Evidence Based Practices

chart reviews during program specific reviews to ensure assessed needs are addressed and in the individual's treatment plan and during transitions between care settings.

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 participants and SUD Providers that are unable to demonstrate acceptable performance may be subject to additional PIHP oversight and intervention.

d) Cultural Competence

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

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

With MSHN's added strategic priority in its FY22-23 strategic plan of "better equity," MSHN is seeking to expand its scope of activity beyond cultural competence with an added focus on actively seeking to address implicit bias and to reduce health disparities.

e) Behavior Treatment[10]

MSHN delegates the responsibility for the collection and evaluation of data, and the evaluation of the effectiveness of the Behavior Treatment Committee by stakeholders to each local CMHSP Behavior Treatment Review Committee. Behavior treatment data is reviewed as part of the each CMHSP Quality Program. Only those (restrictive and/or intrusive) techniques that are included in the individual's plan of service and contained in a Behavior Treatment plan that addresses all standards will be reviewed and approved by the BTPRC prior to plan implementation. Data is collected, reviewed, and reported to MSHN 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. Data shall include numbers of interventions and the length of time the interventions were used per person. By asking the behavior treatment committees to track this data, it provides important oversight to the protection and safeguard of vulnerable individuals including those receiving long term supports and services.

MSHN provides oversight through analysis of the data on a quarterly basis to address any trends and/or opportunities for quality improvements. MSHN also uses this data during the delegated managed care site reviews to ensure accurate reporting and adherence to the Behavioral Treatment Standards[11] by each CMHSP. MSHN also conducts clinical chart reviews for those with recommended restrictive and/or intrusive interventions, in addition to the annual review of BTPRC policy and

[10] Quality-Behavior Treatment Plan Review Committee

procedures. The clinical chart reviews address each of the behavior treatment standards and overall compliance is determined based on implementation of those standards. This data is available to MDHHS upon request.

f) Trauma

MSHN and its Provider Network shall adopt a trauma informed culture including the following: values, principles, and development of a trauma informed system of care ensuring safety and preventing re-traumatization. In compliance with the MDHHS Trauma Policy MSHN has delegated the responsibility to the network providers to ensure development of a process for screening and assessing each population for trauma. Providers shall adopt approaches to address secondary trauma for staff and utilize evidenced based practices or evidence informed practice to support a trauma informed culture. An organizational assessment shall be completed to evaluate the extent to which the organizations policies are trauma informed. Organizational strengths and barriers, including an environmental scale to ensure the building and environment does not re-traumatize will be identified and utilized for improvement efforts. The assessment should occur every three years.

Consistent with MSHN's broader agenda to address racial disparities and cultural competence, efforts around being trauma-informed will necessarily be expanded to incorporate competency and awareness around racialized and historical trauma for certain demographics that have historically faced discrimination, marginalization, and violence.

X. PROVIDER STANDARDS

a) Provider Qualifications [12][13]

MSHN has established written policy and procedures, in accordance with MDHHS's Credentialing and Re-Credentialing Processes, 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, in accordance with the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes chart.

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

MSHN policies and procedures are established to address the selection, orientation, and training of directly employed or contracted staff. PIHP employees receive annual reviews of performance and competency. Individual competency issues are addressed through staff development plans. MSHN is responsible for ensuring that each provider, employed and contracted, meets all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements, including relevant work

[12] Provider Network-Provider Network Credentialing/Re-Credentialing

[13] Provider Network-Non-licensed Provider Qualifications

experience and education, and cultural competence. The CMHSP Participants/SUD Providers are likewise responsible for the selection, orientation, training and evaluation of the performance and competency of their own staff and subcontractors.

b) Medicaid Event Verification [14]

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

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

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

c) Financial Oversight

MSHN has established written policies and procedures to ensure appropriate financial management. MSHN will conduct a financial oversight review of the SUD provider network. The review will be based on eight standards used to assure regulatory compliance by reviewing the following: Certified Public Accountant (CPA) Audit, compliance with previous corrective action; financial management policies and procedures; documents to ensure proper segregation of duties; evidence to support the Financial Status Report (FSR) billing; verification of board approved sample financial reports; and evaluation of Risk Management Plan. Information obtained from the review will be used to identify focus areas for improvement efforts, in accordance with the oversight monitoring corrective action process.

All CMHSP Participants and 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.

d) Provider Monitoring and Follow-Up [15][16]

MSHN uses a standard written contract to define its relationship with CMHSP Participants/SUD Providers that stipulates 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

[14] Quality-Medicaid Event Verification

[15] Quality-CMHSP Participant Monitoring & Oversight

[16] Quality-Monitoring & Oversight of SUD Service Providers

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. SUD Providers, however, must first obtain written authorization from MSHN in order to subcontract any portion of their agreement with MSHN. 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 support reciprocity by developing regionally standardized contracts, provider performance protocols, maintain common policies, and evaluate common outcomes to avoid duplication of efforts and reduce the burden on shared contractors. 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. CMHSPs Participants/SUD Providers that are unable to demonstrate acceptable performance may be required to provide corrective action, may be subject to additional PIHP oversight and interventions, and may be subject to sanctions imposed by MSHN, up to and including contract termination.

e) External Reviews[17]

The PIHP is subject to external reviews through MDHHS and/or an external quality reviewer contracted by MDHHS to ensure quality and compliance with all regulatory requirements. MSHN collaborates with MDHHS and the external quality reviewer to provide relevant evidence to support compliance. In accordance the MDHHS-PIHP, all findings that require improvement based on the results of the external reviews are incorporated into the QAPIP Priorities for the following year. An action plan will be completed that includes the following elements: improvement goals, objectives, activities, timelines, and measures of effectiveness in response to the findings. The improvement plan will be available to MDHHS upon request.

(2020) What are Long-Term Supports and Services (LTSS) (https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/ltss-overview)

(2021). Medicaid Managed Specialty Supports and Services Contract

(2021). Medicaid Managed Specialty Supports and Services Contract Quality Assessment and Performance Improvement Technical Requirement

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

[17] Quality-External Quality Review

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

(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.

XI. Quality Assessment and Performance Improvement Program Priorities (QAPIP) FY2023

The QAPIP priorities shall guide quality efforts for FY23. Figure 1 provides the QAPIP Priorities and Quality Work Plan for FY23. The FY23 QAPIP Priorities include completion of required elements of the QAPIP, and growth areas based on QAPIP review of effectiveness and external quality and/or compliance reviews. QAPIP activities are aligned with the MSHN Strategic Plan contributing to Better Health, Better Care, Better Provider Systems, and Better Equity for the individuals we serve.

Figure 1. QAPIP Priorities and Work Plan

MDHHS Performance Indicators	Objectives/Activities	Assigned Lead/Committee	Frequency/ Due Date
MSHN will meet or exceed the MMBPIS standards for Indicators as required by MDHHS.	Complete quality checks on data prior to submission through affiliate uploads in REMI. (Verify Medicaid Eligibility, Data Accuracy)	CMHSP Participants	3/15/2023 6/15/2023 9/15/2023 12/10/2023
	Complete performance summary reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees' councils.	QIC	10/27/2022 1/27/2023 4/28/2023 7/28/2023
	Complete primary source verification of submitted records during the DMC review.	MSHN-QM	Annually
	Ensure accuracy of data through REMI validations, and increased sample for those that had findings during external reviews.	MSHN-QM	Annually
MSHN will demonstrate an increase in compliance with access standards for the priority populations.	Establish a mechanism to monitor access requirements for priority populations.	MSHN-QM MSHN-UCM Director	1/27/2023

Performance Improvement Projects	Objectives/Activities	Assigned Lead/ Committee	Frequency/ Due Date
PIP 1: Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population.	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils. Submit PIP 1 to HSAG as required for validation.	MSHN-QM QIC	3/31/2023 6/30/2023 9/30/2023
PIP 2: The racial or ethnic disparities between the black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated.	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations). Review with relevant committees/councils. Submit to MDHHS upon request.	MSHN-QM QIC	1/27/2023 4/28/2023 7/28/2023
Quantitative and Qualitative Assessment of Member Experiences	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**
MSHN will obtain a qualitative and quantitative assessment of member experiences for all representative populations, including members receiving LTSS, and take specific action as needed, identifying sources of dissatisfaction, outlining systematic action steps, monitoring for effectiveness, and communicating results.	Develop proposal for the administration of qualitative and quantitative assessment of member experience, and provider satisfaction for the region.	MSHN-Quality Manager, Customer Services Manager	3/31/2023
	Implement standard survey/assessment for all populations (SUD, CCBHC, MH, SED, IDD) that provides meaningful and actionable data.	QIC, MSHN Quality Manager	6/30/2023
	Document and CMHSP / Provider Network action steps for improvement in the QIC action plan	CMHSP participants	9/30/2023
	Complete member experience annual report with causal factors, interventions, and feedback provided from relevant committees/councils.	QIC, MSHN Quality Manager	8/30/2023
Quantitative and Qualitative Assessment of Member Experiences	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**
MSHN will demonstrate full compliance with the completion of a SIS assessment in accordance with the MDHHS required guidelines. (1x every three years)	Review internal report for compliance rate, identify causal factors and interventions for not meeting the standard. (How many have received a SIS within 3 years. How many meet the criteria for the completion of a SIS assessment.)	MSHN-CBHO CLC	Quarterly
MSHN will meet or exceed the standard for Appeals and Grievance resolution in accordance with the MDHHS standards.	Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations).	MSHN-Customer Services Manager CSC	Quarterly

Event Monitoring and Reporting	Objectives/Activities	Assigned Lead/ Committee	Frequency/ Due Date
MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported, and followed up on as specified in the PIHP Contract.	Establish standard data element for mortality reviews	MSHN QM, QIC	4/30/2023
	Establish standard data elements/form for a Root Cause Analysis	MSHN QM, QIC	4/30/2023
	Develop Dashboard for tracking and monitoring timeliness	MSHN QM, QIC	4/30/2023
	Develop training documents, including policies/procedures based on the new requirements and process for reporting	MSHN QM, QIC	2/28/2023
	Develop control charting with upper and lower control limits	MSHN QM, QIC	2/28/2023
	Complete the CIRS Performance Reports (including standards, trends, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence) quarterly.	MSHN QM, QIC	3/23/2023 6/22/2023 9/22/2023 12/15/2023
Medicaid Event Verification	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**
MSHN will meet or exceed a 90% rate of compliance of Medicaid delivered services in accordance with MDHHS requirements.	Complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.	MSHN-MEV Auditor	See annual schedule
	Complete The MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement.	MSHN-CQCO MSHN MEV Aud.	12/31/2022 12/31/2023
Utilization Management Plan	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**
MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements	Complete/review the MSHN Utilization Management Plan.	MSHN-UCM Dir.	2023
	MSHN to complete performance summary quarterly reviewing under / over utilization, medical necessity criteria, and the process used to review and approve provision of medical services. Identify CMHSPs/SUDPs requiring improvement and present/provide to relevant committees/councils.	MSHN-UCM Director	Quarterly/ Annually
	Utilize uniform screening tools and admission criteria. LOCUS, CAFAS, MCG, ASAM, SIS, DECA	MSHN-UCM Director	Quarterly/ Annually
MSHN will demonstrate full compliance with timeframes of service authorization decisions in accordance with the MDHHS requirements.	Oversight of compliance with policy through primary source verification during Delegated Managed Care Reviews.	MSHN-UCM Dir.	Annually
	Monitor REMI process for tracking timeliness of authorization decisions, developing improvement plans	MSHN-UCM Director	Quarterly/ Annually
MSHN will meet or exceed the standard for compliance with the adverse benefit determination notices completed as required.	Oversight of compliance in accordance with the 42 CFR 438.404 with during Delegated Managed Care Reviews.	MSHN-Customer Service Manager	Annually

Practice Guidelines	Objectives/Activities	Assigned Lead/ Committee	Frequency/ Due Date
MSHN will demonstrate an increase in the implementation of Person-Centered Planning and Documentation in the IPOS	Establish a Person-Centered Planning QI Team to review process steps to identify efficiencies.	MSHN-QM/QIC	1/31/2023
	MSHN will coordinate a regional training to address Person Centered Planning and the development of the Individual Plan of Service.		1/31/2023
MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (Standard-95%)	Monitor compliance with standards. DMC	MSHN Waiver Administrator, CLC	Annually
	Implement Behavior Treatment Training Modules	MSHN Waiver Administrator, CLC	1/31/2023
MSHN will demonstrate an increase in fidelity to the Evidenced Based Practice-Assertive Community Treatment Michigan Field Guide, on average minutes per week per consumer.	Complete a quarterly utilization summary of the average minutes per week/per consumer that will include the identification of barriers, interventions, and progress. Explore adding to the Program Specific DMC	MSHN-UCM Director UMC	Quarterly
Oversight of "Vulnerable People"/Long Term Supports and Services	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**
MSHN will assess the quality and appropriateness of care furnished to members (vulnerable people) receiving LTSS.	Analyze performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) for community integration and assessment of care between settings.	MSHN-CBHO	Annually/ Quarterly
Behavior Treatment	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**
The percentage of emergency physical interventions per person served during the reporting period will decrease from previous year.	Develop BTPR Module Specifications/Development (subgroup)	CLC/QIC	6/30/2023
	Develop control charting with upper and lower control limits for track and trend data.	QIC	2/28/2023

Provider Monitoring	Objectives/Activities	Assigned Lead/ Committee	Frequency / Due Date
MSHN will be in compliance with PIHP Contract Requirements.	Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN-QAPI	Annually
	Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews.	Relevant committees	9/30/2023
MSHN will demonstrate an increase in compliance with the External Quality Review (EQR)-Compliance Review.	Implement corrective action plans for areas that were not in full compliance, and quality improvement plans for recommendations. See CAP for specific action steps. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN QM	9/30/2023
MSHN will demonstrate full compliance with the EQR-Performance Measure Validation Review.	Implement quality improvement plans for recommendations provided by the external quality review team. Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.	MSHN-QM-QIC MSHN-CIO-ITC	9/30/2023
MSHN will demonstrate an increase in compliance with the MDHHS 1915 Review.	Monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.	MSHN-Waiver Managers, CBHO	9/30/2023
Provider Qualifications	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency / Due Date**
Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements.	Complete Primary Source Verification utilizing the Credentialing Report submitted to MDHHS	Leadership/ PNM	Quarterly
	Require individual remediation for records that are not in full compliance with the credentialing requirements, and additional monitoring for those CMHSPs that have a compliance rate of =<90%.	Leadership/ PNM	Annually
	Primary Source Verification and review of the credentialing/recredentialing policy and procedure will occur during the DMC review. Providers who score less than 90% on the file review will be subject to additional review of credentialing and re-credentialing records.	Leadership/ PNM	Annually
	Include primary source verification for professionals that have/require the designation of Qualified Intellectual Disability Professional (QIDP).	QIC/PNM	Annually
Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.	Develop regional guidelines for training documentation consistent with MDHHS expectations.	QIC	1/31/2023
	Continue to update the training grid as required.	QIC/PNM	1/31/2023

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

Figure 2. FY23 Performance Measures

Strategic Priority	Indicator	Committee/ Council	FY22
	Michigan Mission Based Performance Indicator System (MMBPIS)		
Better Care	MSHN will meet or exceed the standard for indicator 1: Percentage of Children who receive a Prescreen within 3 hours of request (>= 95% or above)	QIC	97.75%
Better Care	MSHN will meet or exceed the standard for indicator 1: Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95% or above)	QIC	98.90%
Better Care	Indicator 2. a. Effective on and after April 16, 2020, the percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children. (No Standard)	QIC	62.35%
Better Care	Indicator 3: Effective April 16, 2020, percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). (No Standard)	QIC	62.44%
Better Care	MSHN will meet or exceed the standard for indicator 4a1: Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%)	QIC	97.36%
Better Care	MSHN will meet or exceed the standard for indicator 4a2: Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%)	QIC	95.72%
Better Care	MSHN will meet or exceed the standard for indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%)	QIC/SUD	97.34%
Better Care	MSHN will meet or exceed the standard for indicator 10a: Re-admission to Psychiatric Unit within 30 Days-Children (standard is <=15%)	QIC	4.04%
Better Care	MSHN will meet or exceed the standard for indicator 10b: Re-admission to Psychiatric Unit within 30 Days-Adults (standard is <=15%)	QIC	10.24%

Strategic Priority	Performance Improvement Projects	Committee/ Council	CY22
Better Care	PIP 1– Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the black/African American population and the white population.	QIC	Gap year, Data not available
Better Care	PIP 2- Reducing or eliminating the racial or ethnic disparities between the black/African American minority penetration rate and the index (white) penetration rate.	QIC	Gap year, Data not available
Strategic Priority	**Event Monitoring and Reporting**	**Committee**	**FY22**
Better Care	The rate of critical incidents, per 1000 persons served will demonstrate a decrease from previous year.(CMHSP) (excluding deaths)	QIC	8.561
Better Care	The rate, per 1000 persons served, of Non-Suicide Death will demonstrate a decrease from previous year. (CMHSP)(Natural Cause, Accidental, Homicidal)	QIC	6.405
Better Care	The rate, per 1000 persons served, of Suicide Death will demonstrate a decrease from previous year. (CMHSP)	QIC	.384
Better Care	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from previous year. (SUDP)	QIC/SUD	1.535
Strategic Priority	**Behavior Treatment**	**Committee/ Council**	**FY22**
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (Standard-95%)	CLC	72%
Better Care	The percent of emergency physical interventions per person served during the reporting period will decrease from previous year.	QIC	0.91%
Strategic Priority	**Stakeholder and Assessment of Member Experiences**	**Committee/ Council**	**FY22**
Better Care	Percentage of consumers indicating satisfaction with SUD services. (Standard 80%/3.50)	QIC	95%/4.62
Better Care	Percentage of children and/or families indicating satisfaction with mental health services. (Standard 80%)	QIC	87%
Better Care	Percentage of adults indicating satisfaction with mental health services. (Standard 80%)	QIC	82%
Better Care	Percentage of individuals indicating satisfaction with long term supports and services.(Standard 80%)	QIC	82%
Better Provider System	MSHN will demonstrate full compliance with the completion of a SIS assessment in accordance with the MDHHS required guidelines. (1x every three years) (Baseline) MDHHS expectation 85% by 9/30/2023	CLC	52.56%

Strategic Priority	Member Appeals and Grievance Performance Summary	Committee/ Council	FY22
Better Care	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service. (Standard 95%)	UMC	93.94%
Better Care	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal. (Standard 95%)	CSC	96.71%
Better Care	The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance. (Standard 95%)	CSC	95.12%
Strategic Priority	**Clinical Practice Guidelines**	**Committee/ Council**	**FY22**
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (95% Standard) see Section IV. e	CLC	72.2%
Better Care	MSHN's ACT programs will demonstrate a fidelity for average minutes per week per consumer (120 minutes).	UMC	2/7
Strategic Priority	**Staff Qualifications**	**Committee/ Council**	**FY22**
Better Provider	Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. MDHHS Review	Leadership	FY22 88%
Better Provider	Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements. MDHHS Review	Leadership	FY22 89%
Strategic Priority	**Medicaid Event Verification**	**Committee/ Council**	**FY22**
Better Care	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service date and time matching the claim date and time of the service. CMHSP/SUD.	CCC	CMHSP: 98.44% SUD: 97.21%
Better Care	Medicaid Event Verification review demonstrates improvement of previous year results with the documentation of the service provided falls within the scope of the service code billed.	CCC	CMHSP: 91.26% SUD: 94.28%

Strategic Priority	Priority Measures-	Committee/ Council	FY22
Better Value	Reduction in number of visits to the emergency room for individuals in care coordination plans between the PIHP and MHP (Target 100%)	UM / IC	78%
Better Care	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%)	UM	100%
Better Care	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan. (Standard 100%)	UM	85%
Better Care	Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth. (Standard 0% decrease over previous fy)	UM	+10%
Better Value	Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages (Standard <=5%)	UM	1%
Better Care	MSHN will be in full compliance with the Adverse Benefit Determination notice requirements.	CSC	95%
Better Care	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization.	CLC	94.90%
Better Care	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (Standard 95%)	CLC	93%
Better Care	MSHN's CMHSP partners will report completing at least one community education activity on fetal alcohol spectrum disorder (FASD). (Standard 50%)	CLC	42%
Better Care	MSHN's provider network will demonstrate 95% compliance with trauma-competent standard in the site review chart tool. (Standard 100%)	CLC	100%
Better Health	MSHN will demonstrate improvement from previous reporting period (79%) of the percentage of patients 8-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Diabetes Screening Report (Data Source-ICDP) Michigan 2020-84.43%	QIC	81.74%
Better Health	MSHN will demonstrate an increase from previous measurement period in the percentage of individuals 25 to 64 years of age with schizophrenia or bipolar who were prescribed any antipsychotic medication and who received cardiovascular health screening during the measurement year. Cardiovascular Screening (Data Source-ICDP) Michigan 2020-73.16%,	CLC	43.1%
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. (Data Source-ICDP) Michigan 2020-44.44%	CLC	76.27%
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation	CLC	96.04%

	Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. (Data Source-ICDP) Michigan 2020 54.65%		
Better Care	Plan All-Cause Readmissions-The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (<=15%) (Data Source-ICDP) Michigan 2020 9.09%	UM	10.88%
Better Care	The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%) (Data Source – ICDP) Michigan 2020 82.49%	UM	86.35%
Better Care	The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%) (Data Source-ICDP) Michigan 2020 89.64%	UM	95.19%

Strategic Priority	Joint Metrics	Committee/ Council	FY22
Better Care	Percent of care coordination cases that were closed due to successful coordination (Standard-<= to 50%)	UMC / IC	93%
Better Value	Reduction in number of visits to the emergency room for individual in care coordination. (Standard 100%)	UMC / IC	78%
Better Care	J.2 The percentage of discharges for adults (18 years or older) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. FUH Report, Follow-Up After Hospitalization Mental Illness Adult (Standard-58%) Data Source ICDP	QIC	60.99%
Better Care	J.2 The percentage of discharges for children (6-17 years) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. Follow-Up After Hospitalization Mental Illness Children (Standard-70%) Data Source ICDP	QIC	74.06%
Better Care	J.2 Racial/ethnic group disparities will be reduced. (*Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) *Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children)*	QIC	0
Better Care	J.3 Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Standard 27%) based on CY21	UMC / IC	26%*
Better Care	J.3 Reduce the disparity BSC Measures for FUA. *Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use.*	UMC	2*

	Certified Behavioral Health Clinic (CCBHC) Performance Measures	Committee / Council	FY22*
Better Care	Follow-Up After Hospitalization for Mental Illness ages 18+ (adult age groups) (FUH-BH-A) Standard-58%	QI	New
Better Care	Follow-Up After Hospitalization for Mental Illness ages 6-17 (child/adolescents) (FUH-BH-A) Standard- 70%	QI	New
Better Health	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-BH) Standard 58.50%	QI	New
Better Care	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH) Standard I-42.5%; E-18.5%	QI	New
Better Health	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A) Standard 13%	QI	New
Better Health	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C) Standard 23.9%	QI	New
Better Health	Depressions Remission at Twelve Months (DEP-REM-12)	QI	New
Better Care	Preventative Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI_SF)	QI	New
Better Care	Preventative Care and Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	QI	New
Better Care	Preventative Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	QI	New
Better Care	Screening for Depression and Follow-Up Plan. Age 18 and older (CDF-AD)	QI	New
Better Care	Time to initial Evaluation (I-EVAL)	QI	New
Better Care	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-BH)	QI	New
Better Care	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are using Antipsychotic Medications (SSD)	QI	New
Better Care	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	QI	New
Better Care	Follow-Up Care for Children Prescribed ADHD Medication (ADD-BH)	QI	New
Better Health	Housing Status (HOU)	QI	New
Better Care	Patient Experience of Care Survey (PEC)	QI	New
Better Care	Youth/Family Experience of Care Survey (Y/FEC)	QI	New
Better Health	Plan All-Cause Readmission Rate (PCR-AD)	QI	New
Better Care	Antidepressant Medication Management (AMM-AD)	QI	New

*CCBHC measures are currently being validated to ensure accuracy