MSHN

Mid-State Health Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Report FY2023

Prepared By: MSHN Quality Manager – 11/2023
Reviewed and Approved By: Quality Improvement Council – 12/2023
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Reviewed By: MSHN Operations Council – 12/18/2023
Reviewed and Approved By: MSHN Board –

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I. Introduction

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 MSHN 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. Effective January 2014, MSHN entered into its first contract with the State of Michigan for Medicaid funding, and entered into subcontracts with the CMHSPs in its region for the provision of Mental Health, Substance Use Disorder, and Developmental Disabilities services. The contract was expanded in 2014 to include an expanded Medicaid benefit, the Healthy Michigan Plan. The 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 Behavioral Health, 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. Effective 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.

The MSHN Quality Assessment and Performance Improvement Program (QAPIP) is reviewed annually for effectiveness. The evaluation includes a review of the components of the QAPIP to ensure alignment with the contract requirements, a review of the status of the QAPIP Workplan and impact on the desired outcome, and a committee/council annual review with accomplishments and goals for the upcoming year. The QAPIP Plan and associated QAPIP Work Plan was effective. Recommendations for the Annual QAPIP Plan, which includes a description of each activity and a work plan for the upcoming year, are included in the FY24 QAPIP Plan. The Board of Directors will receive the Annual QAPIP Report and approve the Annual QAPIP Plan for FY24. The measurement period for this annual QAPIP Evaluation is October 1, 2022, through September 30, 2023. The scope of MSHN's QAPIP is inclusive of all CMHSP Participants, the Substance Use Disorder Providers, and their respective provider networks in the MSHN region.

II. Performance Measurement and QAPIP Work Plan FY23 Review

MSHN monitors longitudinal performance through an analysis of regional trends. Performance is compared to the previous measurement period or other specifically identified targets. A status of "met" or "not met" is received. When minimum performance standards or requirements are "not met", CMHSP Participants/SUD Providers participate in a quality improvement process. The assigned committee/council in collaboration with other relevant committees/councils develop interventions designed to improve the performance of the measure. *Indicates data that has not been finalized. Based on performance and the performance measurement requirements, a recommendation is made to "continue", "discontinue", or "modify". Considerations for recommendations are based on changes in requirements and performance.

a) Michigan Mission Based Performance Indicator System

The Michigan Department of Health and Human Services (MDHHS), in compliance with Federal mandates, establishes measures in access, efficiency, and outcomes. Pursuant to its contract with MDHHS, MSHN is responsible for ensuring that its CMHSP Participants and Substance Use Disorder

Providers are measuring performance through The Michigan Mission Based Performance Indicator System.

Goal: MSHN will meet or exceed the MMBPIS Standards for the indicators as required by MDHHS.

Status: MSHN completed the objectives of the workplan. As a result, an increase in the accuracy of the data reported was demonstrated through the HSAG Performance Measure Validation. Established processes will further improve data accuracy over the next year. Access to services demonstrated the most challenge due to the workforce shortage and decreased appointment availability.

Barriers were identified and interventions were implemented. Beginning in FY24 a standard was applied to Indicator 2 and 3. MSHN has implemented a performance improvement project to address the performance of Indicator 3. The QAPIP was effective.

Attachment 2 MMBPIS Summary Report FY23

Strategic Priority	Michigan Mission Based Performance Indicator System (MMBPIS)	Committee	FY22	FY23	Status/ Recommendation
Better Care	Indicator 1: Percentage of Children who receive a Prescreen within 3 hours of request (>= 95% or above)	QIC	97.75%	98.40%	Met/Continue
Better Care	Indicator 1: Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95% or above)	QIC	98.90%	99.45%	Met/Continue
Better Care	Indicator 2. a. 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%	59.72%	No Standard/ Continue
Better Care	Indicator 2. E. The percentage of new persons during the quarter receiving a face to face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorder.	QIC/SUD	73.91%	*75.25%	No Standard / Continue
Better Care	Indicator 3: The 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%	62.14%	No Standard/ Continue
Better Care	Indicator 4a1: Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%)	QIC	97.36%	97.47%	Met/Continue
Better Care	Indicator 4a2: Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%)	QIC	95.72%	96.64%	Met/Continue
Better Care	Indicator 4b: Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%)	QIC/SUD	97.34%	97.87%	Met/Continue
Better Care	Indicator 10a: Re-admission to Psychiatric Unit within 30 Days-Children (standard is <=15%)	QIC	4.04%	9.20%	Met/Continue
Better Care	Indicator 10b: Re-admission to Psychiatric Unit within 30 Days- Adults (standard is <=15%)	QIC	10.24%	12.66%	Met/Continue

b) Performance Based Incentive Payment Measures

Performance incentives have been established to support initiatives as identified in the MDHHS comprehensive Quality Strategy. Data is currently available only through CY23Q1.

Attachment 3 FY23 Q2-Q3 Integrated Health Quarterly Report

Strategic Priority	Joint Metrics	Committee	CY22	CY23Q1	Status/ Recommendations
Better Care	J.2 a. 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 (Standard-58%) Data Source CC360	QIC	69.88%	70.92%	Met/Continue
Better Care	J.2 b. 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 CC360	QIC	87.87%	86.34%	Met/Continue
Better Care	J.2 c. 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	Not Available	Continue
Better Care	J.3 a. Follow up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (Standard 27%) based on CY21	UMC/IC	43.25%	44.26%	Met/Continue
Better Care	J.3 b. 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*	Not Available	Continue

The Certified Community Behavior Health Clinics review data quarterly to identify any areas of improvement needed and to share best practice with other CCBHCs within the region. The table below provides the performance of the Quality Bonus Payment measures. MDHHS has provided the finalized performance data for FY22. MSHN utilizes the Integrated Care Data Platform (ICDP) and Care Connect 260 to monitor performance throughout the year. The data in the table below is obtained from ICDP and has not been finalized by MDHHS.

CCBHC Quality Bonus Payments	Committee	FY22	FY23	Status/ Recommendations
Follow-Up After Hospitalization for Mental Illness (FUH -Adults) MSHN. Standard-58%	CCBHC QI	CEI: 68% Right Door: 91% SCCMHA: 79%	CEI: 62% Right Door: 61% SCCMHA: 70%	Met/Continue
Follow-Up After Hospitalization for Mental Illness (FUH-Child/Adolescents) MSHN. Standard 70%	CCBHC QI	CEI: 92% Right Door: 95% SCCMHA: 100%	CEI: 69% Right Door: 73% SCCMHA: 77%	Partial Met/Continue

Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) MSHN. Standard 58.5%	CCBHC QI	CEI: 55% Right Door: 73% SCCMHA: 71%	CEI: 59% Right Door: 95% SCCMHA: 57%	Partial Met/Continue
Initiation of Alcohol and Other Drug Dependence Treatment MSHN. Standard I-25%	CCBHC QI	CEI: 41% Right Door: 28% SCCMHA: 45%	CEI: 52% Right Door: 33% SCCMHA: 49%	Met/Continue
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Child) MSHN. Standard 12.5%	CCBHC QI	CEI: 27% Right Door: 19% SCCMH: 10%	CEI: 89% Right Door: 83% SCCMHA: 21%	Met/Continue
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Adults) MSHN. Standard 23.9%	CCBHC QI	CEI: 37% Right Door: 15% SCCMH: 31%	CEI: 75% Right Door: 74% SCCMHA: 78%	Met/Continue

c) Performance Improvement Projects

MDHHS requires the PIHP to complete a minimum of two performance improvement projects per waiver renewal period. MSHN has approved the two Non-clinical Performance Improvement Project to address access to services for the historically marginalized groups within the MSHN region for CY22 through CY25.

Status: Interventions to address the identified barriers have been identified and are in development. Effectiveness will be determined following the review of CY23 data, which will be available in March of 2024.

Attachment 4 PIP #1 Access-Reduction of Disparities Monitoring
Attachment 5 PIP #2 Penetration Rate CY21-CY23YTD

Strategic Priority	Performance Improvement Projects	Committee	CY21	CY22	CY23 YTD	Status/ Recommendations
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. Black/African American population White population	QIC	Baseline 65.04% 69.49%	53.72% 64.17%	61.31% 63.86%	Not Met/Continue
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. Black/African American population White population	QIC	Baseline 7.45% 9.51%	7.24% 9.04%	6.54% 8.36%	Not Met/Continue

d) Adverse Event Monitoring

Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrants PIHP review. Subsets of the adverse events will qualify as "reportable events" according to the MDHHS Critical Event Reporting System. These include MDHHS defined sentinel events which include unexpected deaths, critical incidents, and risk events.

Status: MSHN met the standards. The QAPIP was effective.

Attachment 6 MSHN Critical Incident Performance Summary
Attachment 7 MSHN Critical Incident Process Summary
Attachment 8 MSHN Critical Incident Performance SUDTP Report

	Event Monitoring and Reporting	Committee	FY22	FY23	Status/ Recommendations
Better Care	The rate of critical incidents per 1000 persons served will demonstrate a decrease from the previous year. (CMHSP) (excluding deaths)	QIC	8.561	7.41	Met/Continue
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	5.77	Met/Discontinue
Better Care	The rate, per 1000 persons served, of Suicide Death will demonstrate a decrease from previous year. (CMHSP)	QIC	0.384	.116	Met/Continue with the addition of unexpected deaths
Better Care	The rate, per 1000 persons served, of Sentinel Events will demonstrate a decrease from previous year. (SUDP)	QIC/SUD	1.535	.000	Met/Discontinue

e) Behavior Treatment

MDHHS requires data to be collected based on the definitions and requirements that have been set forth within the MDHHS Standards for Behavioral Treatment Review and the MDHHS Quality Assessment and Performance Improvement Program Technical Requirement attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract.

MSHN delegates the responsibility for the collection and evaluation of data to each local CMHSP Behavior Treatment Review Committee (BTRC), including the evaluation of effectiveness of the BTRC by stakeholders.

Status: MSHN did not meet each standard.

Attachment 9 MSHN Behavior Treatment Data

Strategic Priority	Behavior Treatment	Committee	FY22	FY23	Status/ Recommendations
Better Care	MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (Standard-95%)	CLC	72%	88%	Not Met/Continue
Better Care	The percent of emergency interventions per person served during the reporting period will decrease from previous year.	QIC	0.91%	0.93%	Not Met/Continue

f) Stakeholder and Assessment of Member Experiences

The aggregated results of the surveys and/or assessments, and other data were collected, analyzed, and reported by MSHN in collaboration with the QI Council, the Clinical Leadership Committee, the Customer Services Committee, and Regional Consumer Advisory Council, who identified areas for improvement and recommendations for action as appropriate. Regional benchmarks and/or national benchmarks were used for comparison. The findings were incorporated into program improvement action plans as needed. Actions are taken on survey results of individual cases, as appropriate, to identify and investigate sources of dissatisfaction and determine appropriate follow-up at the CMHSP Participant/SUD Provider level. The reports have been presented to the MSHN governing body, the Operations Council, Regional Consumer Advisory Council, CMHSP Participants and SUD Providers, and accessible on the MSHN website, Findings are also shared with stakeholders on a local level through such means as advisory councils, staff/provider meetings and printed materials.

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

Status: MSHN Met the standard by obtaining an 80% or higher.
MSHN in collaboration with the NCI Advisory Council will identity focus areas for FY24.

Attachment 10 MSHN Executive Summary Member Satisfaction FY2023 Annual Report
Attachment 11 National Core Indicator Summary

Strategic Priority	Stakeholder and Assessment of Member Experiences	Committee	FY22	FY23	Status/ Recommendations
Better Care	Percentage of consumers indicating satisfaction with SUD services. (Standard 80%/3.50)	QIC	95%	90%	Met/Continue
Better Care	Percentage of children and/or families indicating satisfaction with mental health services. (Standard 80%)	QIC	87%	81%	Met/Continue
Better Care	Percentage of adults indicating satisfaction with mental health services. (Standard 80%)	QIC	83%	80%	Met/Continue
Better Care	Percentage of individuals indicating satisfaction with long term supports and services.(Standard 80%)	QIC	83%	80%	Met/Continue
Strategic Priority	**Member Appeals and Grievance Performance Summary**	**Committee**	**FY22**	**FY23**	**Status/ Recommendations**

Better Care	Percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service. (Standard 95%)	UMC	93.94%	97.4%	Met/Continue
Better Care	The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal. (Standard 95%)	CSC	96.71%	98.85%	Met/Continue
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%	100%	Met/Continue

g) Clinical Practice Guidelines

MSHN supports and requires the use of nationally accepted and mutually agreed upon clinical practice guidelines including Evidenced Based Practices (EBP) to ensure the use of research -validated methods for the best possible outcomes for service recipients as well as best value in the purchase of services and supports.

Practice guidelines are monitored and evaluated through data analysis and MSHN's site review process to ensure CMHSP participants and SUDT providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization. Additionally, information regarding evidenced based practices is reported through the annual assessment of network adequacy.

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.

Status: MSHN did not meet the standard.

Attachment 12 ACT Utilization FY23
Attachment 9 Behavior Treatment Review Data

Strategic Priority	Clinical Practice Guidelines	Committee	FY22	FY23	Status/ Recommendations
Better Care	MSHN will demonstrate full compliance with the use of MDHHS required practice guideline. (PM) Inclusion, Consumerism, Personal Care in Non-Specialized Residential Settings, Family Driven and Youth Guided, Employment Works Policy and Practice Guidelines.	CLC	100%	100%	Met/Discontinue
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%	88%	Not Met/Continue

Better Care	MSHN's ACT programs will demonstrate fidelity for an average of minutes per week per consumer (85%/96 minutes-100%/120 minutes).	UMC	2/7	1/8	Not Met/Continue

h) Credentialing and Re-credentialing

MSHN has established written policy and procedures[1] in compliance with MDHHS's Credentialing and Re-Credentialing policy for ensuring appropriate credentialing and re-credentialing of the provider network. Whether directly implemented, delegated, or contracted, MSHN shall ensure that credentialing activities occur upon employment/contract initiation, and minimally every two (2) years thereafter. MSHN written policies and procedures[2] also ensure that non-licensed providers of care or support are qualified to perform their jobs, in accordance with the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes chart.

Credentialing, privileging, primary source verification and qualification of staff who are employees of MSHN, or under contract to the PIHP, are the responsibility of MSHN. Credentialing, privileging, primary source verification and qualification of CMHSP Participant/SUD Provider staff and their contractors is delegated to the CMHSP Participants/SUD Providers. MSHN monitors CMHSP Participant 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 updated the Credentialing review process in 2022 to include monitoring of the timeliness of decision making and credentialing activities for the CMHSP participants. Any CMHSP participants scoring less than 90% on the file review would be subject to additional review of credentialing and re-credentialing records.

Status: In 2023, six of the twelve CMHSPs scored under 90%. Staff qualifications are reviewed during the MDHHS Site Review and internally through the Delegated Managed Care Review. Based on the DMC review in FY23, improvement has been made. This will continue to be monitored until the MDHHS Site Review has been completed to allow for consistent comparisons.

Strategic Priority	Staff Qualifications	Committee	FY22	FY23	Status/ Recommendations
Better Provider	Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. FY22 MDHHS Review, FY23 DMC review	Leadership	88%	99%	Met/Continue
Better Provider	Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements. FY22 MDHHS Review, FY23 DMC Review	Leadership	89%	94%	Met/Continue

[1] Provider Network Credentialing/Recredentialing Policy and Procedure
[2] Provider Network Non-Licensed Provider Qualifications

i) Verification of Services

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

Data collected through the Medicaid Event Verification process is aggregated, analyzed, and reported for review. 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.

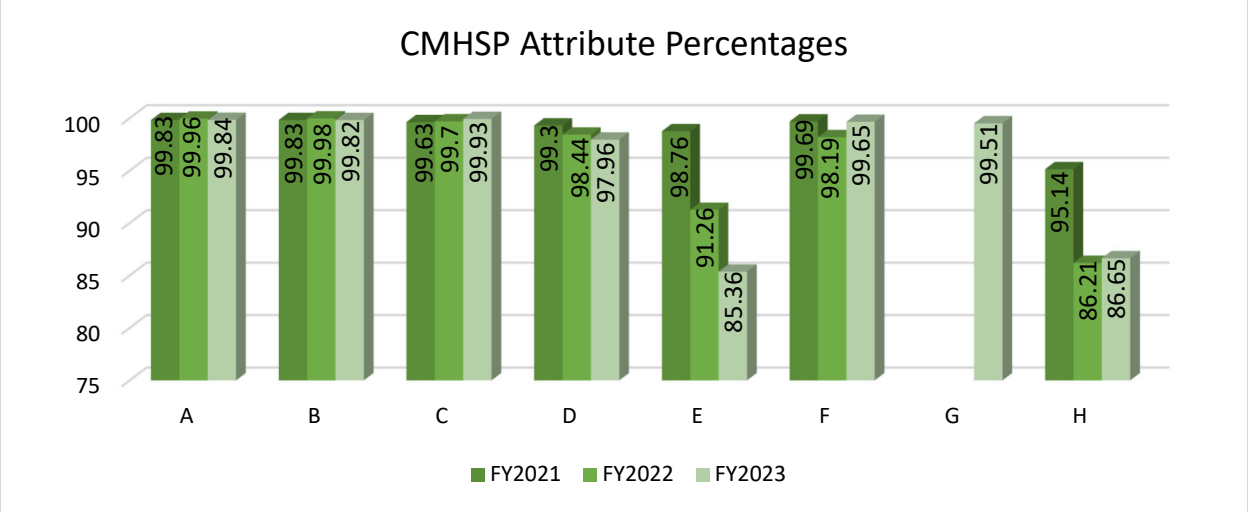
Process improvements implemented from previous MEV reviews included modifications to the forms for the claims review, summary report, plan of correction and data tracking to improve accuracy and ease of understanding how the data was represented. Improvements were also implemented to ensure proper and accurate reporting of information as part of the Office of Inspector General new reporting requirements for audit activities. The MEV forms continue to be standardized for consistency for each review. Additional improvements are being considered for FY2024 based on feedback received through the Provider network. One of the recommendations for improvement includes creating an MEV review guide for providers which would establish what documentation is required for each attribute and which findings will require voiding versus a plan of correction. The construction of this guide is currently underway.

Regionally the CMHSPs have shown slight improvements from FY2022 to FY2023 for the following attributes:

1. C: Service is included in the beneficiary's individual plan of service
2. F: Amount billed does not exceed contractually agreed upon amount
3. G: Amount paid does not exceed contractually agreed upon amount
4. H: Modifiers are used in accordance with the HCPCS guidelines

Note: FY23 Attributes F & G listed above were combined in FY22 under F.) Amount billed and paid does not exceed contractually agreed upon amount. Furthermore, Attribute H.) Modifiers are used in accordance with the HCPCS guidelines was Attribute G in FY22.

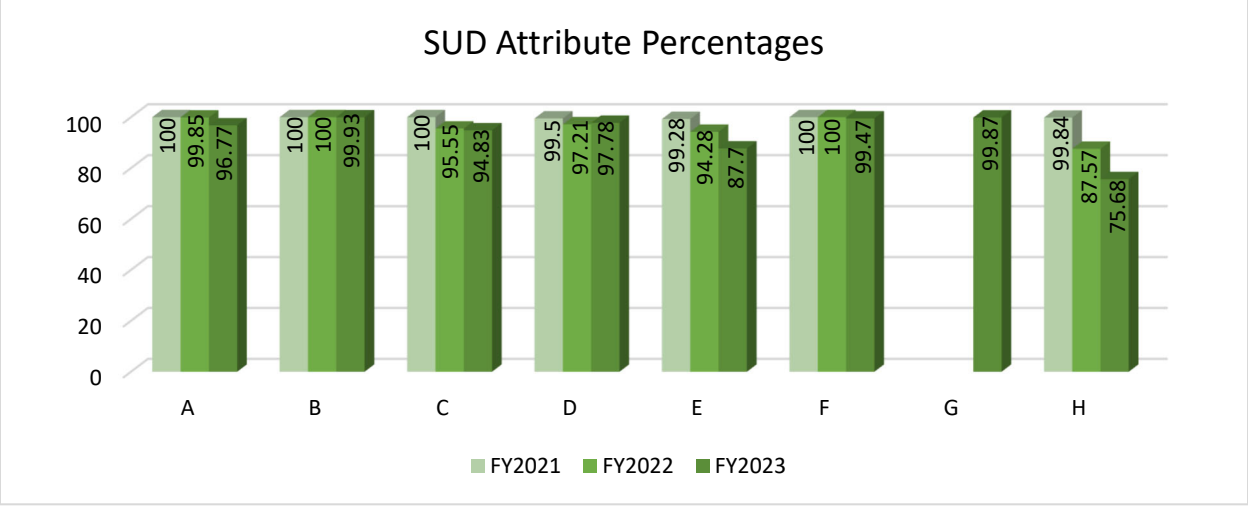
These improvements may be attributed to an increased focus on improving the quality of documentation, improved staff trainings, ongoing monitoring and oversight, and increased education and technical assistance provided by the Medicaid Event Internal Auditor during the review process. In addition, MSHN has safeguards in place to guard against duplicate and incomplete claims being submitted.



Regionally the SUD providers did not show significant improvements from FY2022 to FY2023. However, the SUD provider scores were already at a high level and most of the scores remained in the mid-high nineties. The attributes that had slight improvements from FY2022 to FY2023 were:

1. C: Service is included in the beneficiary's individual plan of service
2. D: Documentation of the service date and time matches the claim date and time of the service

This may be attributed to continued training and technical assistance provided by MSHN to the providers as part of the MEV site reviews. The SUD provider network is also improving their understanding of the required supporting documentation to show compliance with the attributes.



Note: The above chart does not include the same SUD providers from year to year but is representative of the region.

MSHN will continue to provide ongoing support to our provider network to ensure compliance with the attributes reviewed during the MEV site reviews. This will include training opportunities and identified quality improvements based on data trends.

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

- MSHN Compliance Committee (internal committee)
- Regional Compliance Committee (external committee consisting of members of the CMHSPs)
- MSHN Quality Improvement Council (external committee consisting of members of the CMHSPs)
- MSHN Operations Council (internal committee)

Councils and committees review and provide feedback for region-wide performance improvement opportunities. In addition, discussion and sharing regarding local improvement opportunities provides collaboration efforts to increase compliance.

Status: MSHN did not meet the goal as indicated below for FY23.

Strategic Priority	Medicaid Event Verification	Committee	FY22	FY23	Status/ Recommendations
Better Care	Medicaid Event Verification review demonstrates improvement of previous year results with the use of modifiers in accordance with the HCPCS guidelines.	CCC	CMHSP: 86.21% SUD: 87.57%	CMHSP: 86.65% SUD: 75.68%	Not Met/Continue

j) Utilization Management

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

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

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

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

MSHN ensures that screening tools and admission criteria are based on eligibility criteria established in

contracts 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 MDHHS/PIHP Contract.

Status: Effective/Continue

Attachment 13 MSHN Behavioral Health Quarterly Report
Attachment 14 FY23 Service Auth Denial Report
Attachment 3 FY23Q2-Q3 Integrated Health Quarterly Report

k) Long Term Supports and Services for Vulnerable Adults

MSHN ensures that long term supports, and services are consistently provided in a manner that supports community integration and considers the health, safety, and welfare of consumers, family, providers, and other stakeholders. MSHN assesses the quality and appropriateness of care furnished and community integration by monitoring of population health through data analytics software to identify adverse utilization patterns and to reduce health disparities, and by conducting individual clinical 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. In addition to the behavior treatment data, and adverse event data, MSHN monitors key priority measures as approved by Operations Council.

MSHN encourages community integration to occur more than once per week. Community integration is discussed with individuals at a minimum during the time of the person-centered planning to ensure their wants and desires are noted during the planning process. Documentation of community integration has been seen regularly during oversight reviews. Currently, there is not a systemic issue related to community integration as evidenced by the site review results.

Status: Met/Continue

Attachment 13 MSHN Behavioral Health Quarterly Report

Strategic Priority	Priority Measures	Committee	FY22	FY23	Status/ Recommendations
Better Value	Reduction in number of visits to the emergency room for individuals in care coordination plans between the PIHP and MHP (Target 100%)	UM/ IC	78%	Not Available	/Continue
Better Care	Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%)	UM	100%	100%	Met/Continue
Better Care	Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan. (Standard 100%)	UM	85%	70.1 68.2%	Not Met/Continue Explore options for more accurate monitoring.
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%	-	Unknown, unable to monitor after March. Discontinue
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%	1%	Met/Continue
Better Care	MSHN will be in full compliance with the Adverse Benefit Determination notice requirements.	UM	95%	95%	Met/Continue
Better Care	MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization.	CLC	93.50%	94%	Not Met/Continue
Better Care	Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (Standard 95%)	CLC	93%	87%	Not Met/Continue
Strategic Priority	**Priority Measures**	**Committee**	**FY22**	**FY23**	**Status/ Recommendations**
Better Health	MSHN will demonstrate improvement from previous reporting period 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%	81.42%	Not Met/Continue
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	CLC	43.10%	48.65%	Met/Discontinue- will utilize cardiovascular monitoring measure.

	during the measurement year. Cardiovascular Screening (Data Source-ICDP)				
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%	76.96%	Met/Continue
Better Health	The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. (Data Source-ICDP) Michigan 2020 54.65%	CLC	96.04%	96.84%	Met/Continue
Better Care	Plan All-Cause Readmissions-The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (<=15%) (Data Source-ICDP) Michigan 2020 9.09%	UM	10.88%	13.64%	Met/Continue
Better Care	The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%) (Data Source – ICDP) Michigan 2020 82.49%	UM	86.35%	87.46%	Met/Continue
Better Care	The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%) (Data Source-ICDP) Michigan 2020 89.64%	UM	95.19%	95.59%	Met/Continue

l) Provider Monitoring and External Reviews

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.

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.

The following external reviews were completed for FY23:

- HSAG Performance Measure Validation Review-Received a status of "Reportable"
- HSAG Compliance Review-Corrective Action Follow up from 2021 and 2022. All CAPs were accepted except Standard XII-Health Information Systems 7. Application Programming Interface.
- HSAG Performance Improvement Project-Received a status of "Met" the PIP received 100% validation.
- MDHHS Waiver Review- 90 Day Follow up was completed.
  MSHN filed an appeal for standards P.5.1 and P.5.2 which were not found to be in full compliance.

Status: Effective/Continue
The findings and recommendations will be incorporated into the QAPIP Performance Measures and Work Plan for FY24.

Strategic Priority	Provider Monitoring	Committee	FY22	FY23	Status/ Recommendations
Better Provider	Provider surveys demonstrate satisfaction with REMI enhancements - Provider Portal (SUD Network) (Standard >=3.50)	Leadership	3.60	3.73	Met/Discontinue
Better Provider	SUD providers satisfaction demonstrates 80% or above with the effectiveness and efficiency of MSHN's processes and communications (SUD Network) (Standard >= 3.50)	Leadership	3.95	4.09	Met/Continue
Better Provider	MSHN will demonstrate an increase in compliance with the External Quality Review-Compliance Review. Comprehensive Score for FY21 and FY22. (Next measurement is FY25)	QIC/CLC	87%	NA	Met/Continue

m) Quality Priorities and Work Plan FY23

Organizational Structure and Leadership	Objectives/Activities	Assigned Lead	Frequency/ Due Date	Status/ Recommendations
MSHN will have an adequate organizational structure with clear administration and evaluation of the QAPIP	To develop in collaboration with the QIC the annual QAPIP evaluation and QAPIP plan. (QAPIP Description, QAPIP Work Plan and Organizational Chart of the QAPIP).	Quality Manager	11.30.2023	Complete/Continue
	Development of a process to monitor the progress of the quality workplan performance measures inclusive of other departments designated responsibilities in the QAPIP.	Quality Manager	9.30.2023	Complete/Continue Recommend development of standard templates for use in organizational performance improvement projects and QI plan.
Governance	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status/ Recommendations**
Board of Directors will approve the QAPIP Plan and Report	To submit the annual QAPIP Plan and Report to the Board. (Attachment 17-MSHN Governing Board Form)	MSHN Deputy Director	1.1.2023 1.31.2024	Complete/Continue
Board of Directors review QAPIP Progress Reports	To submit QAPIP progress reports to the Board. (Balanced Scorecard Review, Quarterly Department Reports)	MSHN Deputy Director	Quarterly	Complete/Consider agenda item related to MSHN Performance and indicate any discussion
QAPIP description, associated work plan, and list of members of the Governing Body will be submitted to Michigan Department of Health and Human Services annually by February 28th	To submit the Board approved QAPIP Report and Plan to MDHHS. (via MDHHS FTP Site)	MSHN Quality Manager	1.31.2023 1.31.2024	Complete/Continue
Include the role of recipients of service in the QAPIP	QAPIP Description, and Organizational Chart of the QAPIP.	MSHN Quality Manager	1.31.2023 1.31.2024	Complete/Continue

Mechanisms for Communication of Process and Outcome Improvements	Objectives/Activities	Assigned Lead	Frequency/ Due Date	Status/ Recommendations
The QAPIP Plan and Report will be provided annually to network providers and to members upon request.	Distribute the completed Board approved QAPIP Effectiveness Review (Report) through committee/councils, MSHN Constant Contact, and email. Post to the MSHN Website. Ensure CMHSP contractors receive the QAPIP.	MSHN Quality Manager	2.28.2023 2.28.2024	Complete/Continue
Guidance on Standards, Requirements, and Regulations	Complete MSHN Contract Monitoring Plan and Medicaid Work Plan, post updates to MSHN Website, and distribute through committee/councils, MSHN Constant Contact.	MSHN Leadership	As needed, minimum annually	Complete / Continue
Consumers & Stakeholders receive reports on key performance indicators, consumer satisfaction survey results and performance improvement projects	Present reports on Consumer Satisfaction Survey Results, Key Priority Measures, MMBPIS, Behavior Treatment Review Data, Event Data, Quality policies/procedures and Customer Service Reports to RCAC.	MSHN Customer Services Manager	Quarterly	Complete/Continue
Performance Measurement and Quality reports are made available to stakeholders and general public	Upload to the MSHN website the following documents: QAPIP Plan and Report, Satisfaction Surveys, Performance Measure Reports; MSHN Scorecard, and MSHN Provider Site Review Reports, in addition to communication through committees/councils.	Leadership	Quarterly	Complete/Continue
MDHHS Performance Indicators	**Objectives/Activities**	**Assigned Lead**	**Frequency/ Due Date**	**Status/ Recommendations**
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/Continue
	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/Continue

	Complete primary source verification of submitted records during the DMC review.	MSHN-QM	Annually	Complete/Discontinue Recommend completing primary source during external review and prior to Quarterly submission to MDHHS.
	Ensure accuracy of data through REMI validations, and increased sample for those that had findings during external reviews.	MSHN-QM	Annually	Complete/Discontinue
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	Complete/Continue
Performance Improvement Projects	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
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	Quarterly 6/30/2023 6/30/2024	Complete/Continue
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 with QAPIP Evaluation and/or upon request.	MSHN-QM QIC	Quarterly 2/28/2024	Complete/Continue

Quantitative and Qualitative Assessment of Member Experiences	Objectives/Activities	Assigned Lead/ Committee	Frequency/ Due Date	Status/ Recommendations
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	3/31/2023	Not complete/Continue
	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	Not complete/Continue. Recommend MHSIP be used for SUD
	Document and CMHSP / Provider Network action steps for improvement in the QIC action plan	CMHSP participants	9/30/2023	Complete/Continue
	Complete member experience annual report with causal factors, interventions, and feedback provided from relevant committees/councils.	QIC, MSHN Quality Manager	8/30/2023	Complete/Continue
Quantitative and Qualitative Assessment of Member Experiences	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
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	Discontinued by MDHHS
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	Completed/Continue
Event Monitoring and Reporting	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored,	Establish standard data element for mortality reviews	MSHN QM, QIC	4/30/2023	Complete/Discontinue
	Establish standard data elements/form for a Root Cause Analysis	MSHN QM, QIC	4/30/2023	Complete/Discontinue

reported, and followed up on as specified in the PIHP Contract.	Develop Dashboard for tracking and monitoring timeliness	MSHN QM, QIC	4/30/2023	In Progress/Continue
	Develop training documents, including policies/procedures based on the new requirements and process for reporting	MSHN QM, QIC	2/28/2023	In Progress/Continue
	Develop control charting with upper and lower control limits	MSHN QM, QIC	2/28/2023	In Progress/Continue
	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	Complete/Continue Recommend continuing a process improvement report and performance report.
Medicaid Event Verification	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
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/Continue
	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	Complete/Continue
Utilization Management Plan	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
MSHN will establish a Utilization Management Plan in accordance with the MDHHS requirements	Complete/review the MSHN Utilization Management Plan.	MSHN-UCM Dir.	2023	Complete/Continue
	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	Complete/Continue
	Utilize uniform screening tools and admission criteria. LOCUS, CAFAS, MCG, ASAM, SIS, DECA	MSHN-UCM Director	Quarterly/ Annually	Complete/Continue. SIS was discontinued.

				MichiCans and MiCAS will be implemented
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	Complete/Continue
	Monitor REMI process for tracking timeliness of authorization decisions, developing improvement plans	MSHN-UCM Director	Quarterly/ Annually	Complete/Continue
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	Complete/Continue
Practice Guidelines	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
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	In progress/Continue
	MSHN will coordinate a regional training to address Person Centered Planning and the development of the Individual Plan of Service.		1/31/2023	Not complete/Modify to include provision of resources
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	Completed/Continue
	Implement Behavior Treatment Training Modules	MSHN Waiver Administrator, CLC	1/31/2023	Complete/Discontinue
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	Complete/Continue

Oversight of "Vulnerable People"/Long Term Supports and Services	Objectives/Activities	Assigned Lead/ Committee	Frequency/ Due Date	Status/ Recommendations
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	Complete/Continue
Behavior Treatment	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
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	Not Started/Continue
	Develop control charting with upper and lower control limits for track and trend data.	QIC	2/28/2023	In Progress/Continue
Provider Monitoring	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
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	Complete/Continue
	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	Complete/Continue
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	Complete/Continue

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	Complete/Continue
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	Complete/Continue
Provider Qualifications	**Objectives/Activities**	**Assigned Lead/ Committee**	**Frequency/ Due Date**	**Status/ Recommendations**
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	Not Complete/Discontinue
	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	Complete/Continue with modifications
	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	Not complete/Continue with modifications
	Include primary source verification for professionals that have/require the designation of Qualified Intellectual Disability Professional (QIDP).	QIC/PNM	Annually	In Progress/Continue
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	Complete/Discontinue
	Continue to update the training grid as required.	QIC/PNM	1/31/2023	Complete Discontinue

III. MSHN Councils Annual Reports FY23

Team Name: Mid-State Health Network Operations Council

Team Leader: Joe Sedlock, MSHN Chief Executive Officer

Report Period: 10.01.2022 through 9.30.2023

Purpose of Council or Committee: The MSHN Board has created the Operations Council 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.[3]

A. Past Year Accomplishments. FY23

- Reviewed and approved the FY22 Operations Council Annual Report
- Supported the forming of the 1915(i) Workgroup
- Reviewed and approved the FY22 QAPIP Annual Report
- Reviewed and approved the FY23 QAPIP Plan
- Supported MSHN position to appeal citations for the use of service ranges language in plans of service.
- Encouraged and supported MSHN in approaching MDHHS to offer to work together on special populations issues.
- Discussed and reviewed the Operating Agreement in regard to the local funds for OHH and BHH.
- Planned for the FY2024-2025 Strategic Plan Process
- Requested MSHN/region to look for opportunities to do more advocacy with MDHHS regarding how the state determines State Hospital placement.
- Supported the proposal to MSHNs Board of Directors to extend the Provider Staffing Crisis Stabilization Program thru the end of FY23.
- Supported MSHN and SWMBH collaboration in dialogue with MDHHS to assist with improving access for Children in Child Welfare.
- Reviewed and supported the Service Authorization Denial Summary and Procedure
- Reviewed MSHN Strategic Plan
- Examined Regional Savings Estimates-CMHSP regional partners to take a closer watch on current budget and expenditures. May need to develop regional strategy and/or regional cost containment plans.
- Discussed and reviewed the CFAP resolution
- Collaboration on issues raised by DHHS regarding Children's Access Issues
- Reviewed the FY22 Network Adequacy Addendum report
- Reviewed and approved FY24 ABA Contract
- Reviewed and approved FY24 Financial Management Services Contract
- Reviewed and approved the MSHN/CMHSP FY24 Medicaid Subcontract
- Reviewed and approved FY24 MSHN Training Grid
- Reviewed the FY23 budget amendment and the FY24 budget
- Monthly reviews of MDHHS disenrollment reports

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

- Supported MSHN to advocate with MDHHS to correct technological problems in the Customer Relationship Management (CRM) system and EGrAMS.
- Reviewed and approved the Ops Council Charter annual review
- Reviewed BCBS and Medicare Advantage services for Crisis Stabilization, Urgent Care and Mobile Crisis to encourage CMHSPs to consider participating.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Relating to conflict free access and planning, advocate for system reform changes that comply with the federal rule that are in the best interests of beneficiaries, their families and supporters, and the communities served by the public behavioral health system.
Work with MDHHS and other stakeholders to improve access to the services and supports of the public behavioral health system, including regional penetration rate monitoring.
Ensure effective and efficient regional operations and consider centralization of functions where efficiencies can be obtained.
As a region and as individual entities: address, reduce, and eliminate health disparities.
Address funding adequacy especially in light of ongoing workforce shortages and provider stabilization requirements
Monitor and expand Behavioral Health Homes, Opioid Health Homes and Certified Community Behavioral Health Clinics in the MSHN region
Continue to educate MDHHS and other stakeholders on the governmental (non-commercial) nature of the public behavioral health system and work to avoid shaping the system to function like a private health plan
Work with MDHHS to establish a practical vision for use of the State CRM and work toward implementation

Team Name: Finance Council
Team Leader: Leslie Thomas, Chief Financial Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Finance Council shall make recommendations to the Mid-State Health Network (MSHN) Chief Finance Officer (CFO), Chief Executive Officer (CEO) and the Operations Council (OC) to establish all funding formulas not otherwise determined by law, allocation methods, and the Entity's budgets. The Finance Council may advise and make recommendations on contracts for personnel, facility leases, audit services, retained functions, and software. The Finance Council may advise and make recommendations on policy, procedure, and provider network performance. The Council will also regularly study the practices of the Entity to determine economic efficiencies to be considered.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- FY 2022 Audits received unqualified opinions and clean Compliance Examinations.
- FY 2022 Fully funded Internal Service Fund and Savings of $47.8 M – both together total 14.4% of the 15% target which is an accomplishment.
- Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
•FY 2023 Favorable fiscal and compliance audit: CMHSP and PIHP fiscal audits are performed between December 2023 and February 2024. The audits will be available to the PIHP once they are reviewed by their respective Board of Directors. The goal is to have all fiscal CMHSP reports by April 2024 and compliance exams by June 2024. A favorable fiscal audit will be defined as those issued with an unqualified opinion. A favorable compliance audit will be defined as one that complies in all material aspects with relevant contractual requirements.
•Meet targeted goals for spending and reserve funds: Determination will be made when the FY 2023 Final Reports due to MDHHS March 31, 2024, are received from the CMHSPs to the PIHP. The goal for FY 2023 will be to spend at a level to maintain MSHN's anticipated combined reserves to 15% as identified by the board. This goal does not override the need to ensure consumers in the region receive medically necessary care.
•Work toward a uniform costing methodology: The PIHP CFO will participate in a Statewide workgroup initiated by MDHHS and Milliman to establish standard cost allocation methods. Regionally, Finance Council will review rates per service and costs per case for service codes identified in the Service Use and Analysis report suite. Finance Council will evaluate if action is needed based on State comparisons.
•Improve accuracy of interim reporting and projections in order to plan for potential risk related to use of reserve funds.
•If applicable, develop regional and local cost containment strategies to align projected revenue and expenses.

Team Name: Information Technology Council
Team Leader: Steven Grulke, MSHN CIO
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The MSHN IT Council (ITC) is established to advise the Operations Council (OC) and the Chief Executive Officer (CEO) and will be comprised of the Chief Information Officer (CIO) and the CMHSP Participants information technology staff appointed by the respective CMHSP CEO/Executive Director. The IT Council will be chaired by the MSHN CIO. All CMHSP Participants will be equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Representation from each CMHSP Participant at all Meetings.
    - There was a 95% attendance rate during FY23 ITC Meetings. 100% attendance occurred in 6 meetings. Participation remains active as we are a highly collaborative group, sharing expertise and project strategies.
- Successfully submit MDHHS required data according to MDHHS requirements regarding quality, effectiveness and timeliness.
    - We exceeded 95% compliance standard for submitting BH-TEDS with all three transaction types: Mental health, substance use, and crisis records. (M, A, Q transactions).
- Several initiatives that ITC assisted with during FY23 are:
    - COB changes in 2023

- MCG Indicia Upgrades
- Foster Care Served Numbers for CMHSA advocacy to MDHHS
- CRM Module Implementation
- MDHHS Medicaid Redetermination – ongoing
- Detailed files for updated EQI
- Withdrawal Management BH-TEDS Adjustments – MDHHS
- Addition of the 'TF' Modifier in EHRs for mild to moderate CCBHC designation
- EVV advocacy along with CMHSA

- Facilitate health information exchange (HIE) processes:
  - Continued pilot process with MDHHS and MiHIN for Substance Use Disorder eConsent in MI Gateway. MSHN is ahead of all other pilots in this implementation.
- Goals Established by Operations Council:
  - Improvements with balanced scorecard reporting
  - Continue trending COVID-19 and telehealth reports (ended in May with emergency orders)
- Meet external quality review requirements:
  - Health Services Advisory Group (HSAG) conducted a review for MDHHS and evaluated performance measures and information systems capabilities. Both areas were successful and approved, with 1 compliance finding.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Representation from each CMHSP Participant at all Meetings
Successfully submit MDHHS required data according to MDHHS requirements regarding quality, effectiveness and timeliness.
Collaborate to develop systems or processes to meet MDHHS requirements (e.g. BH-TEDS reporting, Encounter reporting).
Work on outcome measure data management activities as needed.
Improve balanced scorecard reporting processes to achieve or exceed targeted amounts for IT.
Transition health information exchange (HIE) processes to managed care information system, when appropriate, to gain efficiencies in data transmissions.
Meet IT audit requirements (e.g., EQRO).

Team Name: Quality Improvement Council
Team Leader: Sandy Gettel Quality Manager
Report Period Covered: 10.01.2022-9.30.2023
Purpose of Council or Committee:
The Quality Improvement Council has been established to advise the Operations Council and the Chief Executive Officer concerning quality improvement matters. The Quality Improvement Council will be comprised of the Quality Manager, the CMHSP Participants' Quality Improvement staff appointed by each respective CMHSP Participant Chief Executive Officer/Executive Director, consumer representatives appointed through an application process, and a MSHN SUD staff representing Substance Use Disorder services as needed. The Quality Improvement Council will be chaired by the Quality Manager. All CMHSP Participants will be equally represented on this council.

Annual Evaluation Process

A. Past Year Accomplishments FY23 (10.1.2022 through 9.30.2023)

- Completed and submit a MSHN Board approved QAPIP Plan and Report to MDHHS by the required due date (February 28th, 2023)
- Approved the Quality policies and procedures ensuring they are in compliance with regulatory requirements and have been communicated to the providers.
- Developed regional guidelines for training documentation consistent with MDHHS
- Completed Member Experience Annual Survey
- Achieved the performance standards for each areas within the QAPIP, participating in quality improvement efforts as identified:
    - Behavior Treatment Review-Provide Data to BTPR Workgroup
    - Michigan Mission Based Performance Indicator System (MMBPIS)-Collaborated with MDHHS for recommended revisions and standards for Indicator 2, 3 and other indicators. Executed a targeted remediation based on external results of primary source verification. Developed process for Medicaid eligibility verification prior to submission. Added validation step prior to submission.
    - Develop standardized elements/form for mortality reviews and root cause analysis.
    - Achieve a Performance Improvement Project Validation from the External Quality Reviewers

B. Upcoming Year's Goals FY24 (10.1.2023 through 9.30.2024)

Goal	Objectives/Activities	Frequency/ Due Date
Submit Board approved QAPIP Plan, Evaluation and Workplan by 2/28/2024	• Collaborate with other committees/councils to complete an annual effectiveness review with recommendations to be incorporated into the MSHN regional report. • Collaborate with committees/councils to develop regional QAPIP workplan. • Review/revise QAPIP Plan to include new regulations	Annually 2/28/2024
Improve health outcomes for those served in the region.	• Review regional key performance indicators. • Review regional performance (BSC/Dashboard) • Develop/identify regional improvement strategies used to identify barriers and interventions. • Analyze outliers and establish process for quality improvement in collaboration with committee/councils.	Annually Quarterly Annually- Annually

	• Monitor the effectiveness of interventions	Quarterly
Establish effective quality improvement programs for CCBHC, health homes.	• Identify regional key performance indicators. • Develop/modify data platforms/reports for performance monitoring. • Establish performance monitoring schedule. • Develop/identify regional improvement strategies.	Annually Annually Annually Annually
Adhere to critical incident and event notification reporting requirements by developing an efficient and effective critical incident monitoring system	• Develop training documents and complete training outlining the requirements of reporting critical, sentinel, and risk events. • Validate / reconcile reported data through the CRM. • Improve timeliness of remediation response in the CIRS-CRM • Develop dashboard for tracking and monitoring timelines. • Establish electronic process for submission of sentinel events/ immediate notification, and remediation documentations.	Annually Quarterly Quarterly 2/28/2024 4/30/2024
Achieve full compliance for the MDHHS Review.	• Ensure corrective action plans are implemented to address deficiencies.	Annually
Improve member experience of care	• Complete an assessment/survey of member experience of care representative of all served, addressing issues of quality, availability, and accessibility of care. (MI, IDD, SUD, LTSS) • Identify sources of dissatisfaction • Increase response rate-streamline surveys and process. • Outline actions step for follow up. • Evaluate the effects of activities implemented to improve satisfaction. • Complete an RFP for administration and analysis by an external vendor.	Annually Annually Annually Annually Annually 6/30/2024
Achieve full compliance for the HSAG External Quality Review - Compliance	• Ensure corrective action plans and recommendations are implemented to address deficiencies.	Annually
Achieve Reportable Status for the HSAG External Quality Review – Performance Measure Validation	• Verify Medicaid Eligibility and data accuracy through primary source verification. • Validate data collection process, both administrative and manual. • Develop / modify ongoing training documents.	Quarterly Annually Annually
Achieve 100% Validation Status for the HSAG External Quality Review- Performance Improvement Project	Implement 2 PIPs • Validate data • Utilize quality tools to identify barriers and root causes • Implement interventions • Evaluate the effectiveness of interventions	 Annually Annually Annually Quarterly

b) MSHN Advisory Councils FY23 Annual Reports

Team Name: Consumer Advisory Council
Team Leader: Todd Koopmans, Chairperson; Dan Dedloff, MSHN Staff Liaison
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Consumer Advisory Council will be the primary source of consumer input to the MSHN Board of Directors related to the development and implementation of Medicaid specialty services and supports and Substance Use Disorder requirements in the region. The Consumer Advisory Council includes representatives from all twelve (12) Community Mental Health Services Program (CMHSP) Participants of the region.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Reviewed the changes to the FY23 MSHN Consumer Handbook
- Reviewed Quality Improvement Performance Measure Reports that included Performance Indicators, Behavior Treatment Review and Oversight, Critical Incidents, Grievance and Appeals, and Medicaid Fair Hearings
- Reviewed and provided feedback on the MSHN Satisfaction Survey results
- Reviewed and provided feedback on the MSHN Compliance Plan
- Reviewed and provided feedback on the 2023 MSHN Delegated Managed Care Reviews
- Reviewed and provided feedback on the 2024/2025 MSHN Strategic Plan
- Reviewed and provided feedback on the Quality Assessment and Performance Improvement Plan
- Reviewed and provided feedback on the MSHN Website Redesign
- Reviewed and provided feedback on MSHN Adverse Benefit Determination Training
- Education and discussion on Implicit bias, Health Disparities & MSHN Activities on Diversity, Equity, and Inclusion
- Education and discussion on Integrated Care
- Education and discussion on Michigan Medicaid Autism Benefit
- Education and discussion on HCBS Rule Updates
- Education and discussion on Conflict Free Access and Planning
- Collaboration with the Healthy Democracy Healthy People
- Education and discussion on the outcomes from the Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and Compliance reviews
- Reviewed and revised the RCAC Charter
- Discussion and feedback on MSHN Council/Committee Survey Results
- Discussed the Public Behavioral Health System Redesign and explored advocacy opportunities.
- Improved practices for ongoing communication between MSHN and local councils
- Ongoing discussion on ways to strengthen Person Centered Planning, Independent Facilitation, and Self Determination Implementation
- Reviewed and approved RCAC annual effectiveness report
- Continued online meetings through Zoom and added an in-person meeting option.
- Explore system improvements for services directed to youth

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Provide input on regional educational opportunities for stakeholders
Provide input for ongoing strategies for the assessment of primary/secondary consumer satisfaction
Review regional survey results, including SUD Satisfaction Survey and external quality reviews
Annual review and provide feedback on the QAPIP
Annual review and feedback on the Compliance Plan
Review of the MSHN FY24 Consumer Handbook
Review and advise the MSHN Board relative to strategic planning and advocacy efforts
Provide group advocacy within the region for consumer-related issues
Explore ways to improve Person Centered Planning, Independent Facilitation, and Self Determination Implementation
Improve communication between the Regional Consumer Advisory Council and the local CMH consumer advisory groups
Explore ways to get more consumers involved in the RCAC and local consumer councils
Public Behavioral Health System Redesign Advocacy
Improve access to peer support specialists through CMHSPs

c) MSHN Oversight Policy Board FY23 Annual Report

Team Name: Substance Use Disorder (SUD) Oversight Policy Board
Team Leader: Chairperson Steve Glaser, SUD Board Member
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Mid-State Health Network (MSHN) Substance Use Disorder (SUD) Oversight Policy Board (OPB) was developed in accordance with Public Act 500 of 2012, Section 287 (5). This law obliged MSHN to "establish a substance use disorder oversight policy board through a contractual agreement between [MSHN] and each of the counties served by the community mental health services program." MSHN/s twenty-one (21) counties each have representation on the OPB, with a designee chosen from that county. The primary decision-making role for the OPB is as follows:

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

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Received updates and presentations on the following:
    - MSHN SUD Strategic Plan
    - MSHN SUD Prevention and Treatment Services
- Approval of Public Act 2 Funding for FY22 & related contracts
- Approved use of PA2 funds for prevention and treatment services in each county
- Received presentation on FY23 Budget Overview
- Received PA2 Funding reports – receipts & expenditures by County
- Received Quarterly Reports on Prevention and Treatment Goals and Progress
- Received Financial Status Reports on all funding sources of SUD Revenue and Expenses
- Provided advisory input to the MSHN Board of Directors regarding the overall agency strategic plan and SUD budget
- Received written updates from Deputy Director including state and federal activities related to SUD
- Received updates on MDHHS State Opioid Response Site Visit Results
- Shared prevention and treatment strategies within region
- Received information and education on opioid settlement and strategies
- Provided input on the FY24-26 MSHN SUD Strategic Plan
-

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Approve use of PA2 funds for prevention and treatment services in each county
Improve communications with MSHN Leadership, Board Members and local coalitions
Orient new SUD OPB members as reappointments occur
Increase communication with local counties/coalitions regarding use of state and local opioid settlement funding
Monitor SUD spending to ensure it occurs consistent with PA 500
Revise and sign new Intergovernmental Agreement

d) MSHN Committee FY23 Annual Reports

Team Name: Clinical Leadership Committee
Team Leader: Todd Lewicki, MSHN Chief Behavioral Health Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The MSHN Operations Council (OC) has created a CLC to advise the Prepaid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) and the OC concerning the clinical operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CEO and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Address workforce shortage.
- 1915(i) service oversight transition to PIHP for annual eligibility authorizations.
- Regional input into Conflict Free Access and Planning.
- Address Wraparound services as appropriate.
- Complete appeal of service range issue with MDHHS and waiver versus non-waiver service use.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Regional input into Conflict Free Access and Planning.
Review and address need for increasing access to children's services, including acute care.
Review, report, and increase use of CRM/OPEN Beds.
Address crisis resources uniformly across the region.
Address implementation of 988/MiCAL.
Address psychiatric residential treatment facility (PRTF) as MDHHS begins implementation, as appropriate.
Advocate for crossover multi-discipline process for ICSS.
Convert region to use of the CANS.
Address Inpatient Access issues and emergency department boarding.
MSHN will identify the group most appropriate to address system reform objectives (including what, who, by when, related metrics (if any).
Establish and/or work with providers to increase specialized housing options within the region.
Continue advocacy around conflict free access and planning consistent with MSHN Board adopted resolution.

Team Name: Regional Medical Directors Committee (RMDC)
Team Leader: Zakia Alavi, MD, MSHN Chief Medical Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
As created by the MSHN Operations Council (OC), the RMDC functions to advise the MSHN Chief Medical Officer (CMO), the MSHN Chief Executive Officer (or designee), the MSHN Chief Behavioral Health Officer (CBHO), and the OC concerning the behavioral health operations of MSHN and the region. Respecting that the needs of individuals served, and communities vary across the region, it will inform, advise, and work with the CMO, CEO (or designee), CBHO, and OC to bring local perspectives, local needs, and greater vision to the operations of MSHN so that effective and efficient service delivery systems are in place that represent best practice and result in good outcomes for the people served in the region.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Review and input into the behavioral health home initiative.
- Continued attention to Behavior Treatment Plan Review Committee feedback on medication guidelines.
- Addressed controlled substance prescription law and shared feedback with MDHHS.
- Reviewed planned updates and gave feedback to PCE prescriber module.
- Input into Population health and Integrated Care Plan and Quarterly Reports.
- Addressed staffing status for psychiatry.
- Continued input into Conflict Free Access and Planning discussion.
- Discussed DEI initiative.
- Reviewed critical incident report.
- Reviewed telemedicine bulletin MMP 23-10 and processes.
- Review and input into regional crisis residential service.
- Review and input into data, including MSHN performance improvement projects, health equity analysis.
- Review RMDC survey responses.
- Reviewed possibility of writing standards regarding nurse practitioners and physician's assistants.
- Reviewed issue of worker burnout.
- Reviewed and provided input into clinical care pathways relating to the CMH work when someone goes to the emergency room.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Address youth access to CMH services.
Continued input into behavior treatment processes.
Ongoing input into population health and integrated care.
Return to OpenBeds process conversation and define further.
Incorporate medical point of view into resource decisions, care decisions, increasing collaborative efforts. (Includes grant opportunities). Provide input into clinical leadership processes, improve linkages with CLC.
Improve collaboration with MDHHS around processes related to CMH functions (i.e., determination of hospitalization).

Team Name: Utilization Management Committee

Team Leader: Skye Pletcher, Chief Population Health Officer, MSHN

Report Period: 10.01.2022 through 9.30.2023

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

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- 1915(i) service oversight transition to PIHP for annual eligibility authorizations.
- Regional input into Conflict Free Access and Planning.
- Advocacy and appeal with MDHHS for the use of service ranges in person centered plans for waiver and non-waiver services.
- Regional monitoring of timely service authorization decisions and issuance of adverse benefit determination notices, as appropriate.
- Regional monitoring of acute service utilization using MCG Behavioral Health Guidelines and achieved >95% adherence to medical necessity criteria

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
NEW - Regional input into Conflict Free Access and Planning.
NEW - Address inpatient access issues and emergency department boarding.
NEW – Review regional process for addressing in-region COFR arrangements
NEW – Implementation of MichiCANS and MiCAS
CONTINUE - Establish performance improvement priorities identified from monitoring of delegated utilization management functions.
CONTINUE - Recommend improvement strategies where adverse utilization trends are detected.
CONTINUE - Recommend opportunities for replication where best practice is identified.
CONTINUE - Address succession planning for UMC members relative to skill set needed by committee members.
CONTINUE - Continued analysis of differences in amount/scope/duration of services received by individuals enrolled in waivers and non-waiver individuals.

Team Name: Regional Compliance Committee
Team Leader: Kim Zimmerman, Chief Quality and Compliance Officer
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
The Compliance Committee will be established to ensure compliance with requirements identified within MSHN policies, procedures, and compliance plan; the Michigan Department of Health and Human Services Prepaid Inpatient Health Plan Contract; and all related Federal and State laws and regulations, inclusive of the Office of Inspector General guidelines and the 42 CFR 438.608.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Revised and approved the 2023 MSHN Compliance Plan
- Provided feedback and approval for the FY2022 Annual Compliance Summary Report
- Reviewed and updated the committee charter.
- Reviewed HSAG Compliance Site Review Findings – Developed plan of correction for findings specific to compliance standards
- Reviewed Compliance Section for Managed Care Program Annual Report (MCPAR)
- Provided feedback on MEV site review process and updates.
- Reviewed proposed revisions to the 42 CFR Part 2 to ensure regional compliance.
- Consensus on use of signatures within the Electronic Health Records
- Reviewed results council/committee surveys- implemented changes based on feedback.
- Provided feedback on 2024-2025 MSHN Strategic Plan
- Updated Privacy Notice to ensure compliance with federal and state standards and developed consistent distribution processes.
- Medicaid Policy Updates: Telehealth compliance and end of public health emergency
- Reviewed the revised FY2023 OIG Quarterly Report changes, guidance documents, fraud referral form, and submission requirements.
- Ongoing review of 21st Century Cures Act for compliance with standards
- Ongoing review of CMH Patient Access Rule and InterOp Station for compliance with standards
- Reviewed trends in the OIG Quarterly Reports for needed systemic changes, etc.
- Reviewed information provided at the PIHP Compliance Officers meetings and MSHN Compliance Committee meetings.
- Provided consultation on local compliance related matters.
- Reviewed and provided feedback on MSHN compliance policies and procedures.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Identify compliance related educational opportunities including those aimed at training compliance officers
Review methods of assessing risks and findings for detection of fraud and abuse for potential improvements and efficiencies

Team Name: Provider Network Committee
Team Leader: Leslie Thomas, MSHN CFO
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: PNMC is established to provide counsel and input to Mid-State Health Network (MSHN) staff and the Operations Council (OC) with respect to regional policy development and strategic direction. Counsel and input will typically include: 1) network development and procurement, 2) provider contract management (including oversight), 3) provider qualifications, credentialing, privileging and primary source verification of professional staff, 4) periodic assessment of network capacity, 5) developing inter- and intra-regional reciprocity systems, and 6) regional minimum training requirements for administrative, direct operated, and contracted provider staff. In fulfilling its charge, the PNMC understands that provider network management is a Prepaid Inpatient Health Plan function delegated to Community Mental Health Service Programs (CMHSP) Participants. Provider network management activities pertain to the CMHSP direct operated and contract functions.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Addressed findings from HSAG audit, specific to provider credentialing and recredentialing systems; revised policies and procedures.
- Established regionally approved and executed CRU agreement with FHPCC.
- Continued to refine and support the statewide and intra-regional provider performance monitoring protocols resulting in improved provider performance and administrative efficiencies.
- Established and continued with an intra-regional provider performance monitoring protocol for ABA/Autism provider network; continued regional provider performance monitoring for Fiscal Intermediary and Inpatient Psychiatric Services.
- Establish relevant key performance indicators for the PNMC scorecard.
- Continued to monitor and refine regional provider directory to ensure compliance with managed care rules.
- Reviewed, revised, and issued regional contracts for Autism/ABA, Inpatient Psychiatric, and Fiscal Intermediary Services.
- Improved and continued coordination with regional recipient rights officers to support contract revisions.
- Continued implementation of statewide training reciprocity plan within the MSHN region.
- Development and continued support of regional training coordinators workgroup to support implementation.
- Completed and rolled out regional web-based provider application.
- Provided input into PCE Provider Management Module enhancements.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Address recommendations from the 2023 assessment of Network Adequacy as it relates to provider network functions; update the Assessment of Network Adequacy to address newly identified needs;
Develop an action plan to address repeat findings related to provider credentialing and recredentialing process requirements through training/technical assistance and monitoring; monitoring and oversight of CMHSPs demonstrate improvement in credentialing and credentialing systems;
Establish relevant key performance indicators for the PNMC scorecard;

Monitor and implement Electronic Visit Verification as required by MDHHS;
Initiatives to support reciprocity: •Contracting: ✓ Develop regionally standardized boilerplate and statement of work for: Therapeutic Camps, Community Living Supports, Residential, Vocational; Independent Facilitation Procurement: ✓ Fully implement the use of a regional web-based provider application; ✓ Publish provider selection processes on MSHN web; •Monitoring: ✓ Fully implement specialized residential reciprocity provider monitoring plan; ✓ Training: ✓ All CMHSPs will have 100% of applicable trainings vetted in accordance with the training reciprocity plan;
Advocate for direct support professionals to support provider retention (e.g. wage increase; recognition)
Develop and implement regionally approved process for credentialing/re-credentialing reciprocity
Develop regionally standardized boilerplate and statement of work for: CLS / Specialized Residential Services

Team Name: Customer Services Committee
Team Leader: Dan Dedloff, Customer Service & Rights Manager
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The Customer Services Committee was formed to draft the Consumer Handbook and to develop policies related to the handbook, the Regional Consumer Advisory Council (RCAC), and Customer Services. The Customer Services Committee (CSC) will continue as a standing committee to assure the handbook is maintained in a compliant format, and to support development and implementation of monitoring strategies to assure regional compliance with CS standards. This committee will be supported by the Chief Compliance and Quality Officer and will report through the Quality Improvement Council (QIC).

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Reviewed, revised, facilitated publication of, and completed regional distribution for the MSHN FY23 Consumer Handbook
- Facilitated publication and electronic regional distribution of the MSHN FY23 Consumer Handbook: Spanish language version for each of the 12 CMHSP and the MSHN SUD Provider Handbook
- Reviewed, analyzed and reported regional customer service information for:
    - Grievances
    - Appeals
    - Medicaid Fair Hearings
    - Recipient Rights
- Defined what would be considered a cultural competency request (CCR) to support network adequacy.
- Reviewed the FY22 HSAG Compliance Review results and collaborated to develop the HSAG corrective action plan.
- Reviewed and provided feedback on the Mid-State Health Network (MSHN) 2024/2025 Strategic Plan.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Conduct an annual review and revise the MSHN Consumer Handbook to reflect contract updates and regional changes
Continue reporting and monitoring Customer Service information
Continue to explore regional Customer Service process improvements
Continue to develop, where applicable, MSHN standardized regional forms
Continue to identify Educational Material/Brochures/Forms for standardization across the region
Complete the bi-annual review, update, and approval of the MSHN Customer Service Policies and Procedure.
Develop and distribute an Adverse Benefit Determination Frequently Asked Questions document.

Team Name: Regional Equity Advisory Committee for Health (REACH)
Team Leader: Shelly Milligan (REACH Facilitator); Dani Meier, Chief Clinical Officer (MSHN Lead)
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:

REACH is an advisory body of community stakeholders established for the following purposes:

- 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.
- Inform development and review of MSHN policies, procedures and practices through the lens of diversity, equity and inclusion (DEI).
- Incorporate a trauma-informed perspective that accounts for historical and racialized trauma.
- Address stigma and bias that may impact health outcomes.

Annual Evaluation Process:

A. Past Years Accomplishments. FY23

- REACH assisted with review of "Better Equity" strategic priority as MSHN updated its FY24-25 MSHN Strategic Plan.
- REACH assisted with review of MSHN's updates to its FY24-26 SUD strategic plan, in particular, the goals related to reducing health disparities was shared with REACH for their review.
- REACH participated in preparation and planning for MSHN's *Equity Upstream* Spring Lecture series. Several REACH members participated in various capacities in the actual trainings.
- REACH was part of preparation and planning for MSHN's *Equity Upstream* Learning Collaborative (LC) and continues to support direction and strategies related to LC activities.
- REACH members are and will be assisting with mechanisms to engage community members in seeking feedback from impacted minority communities who are underrepresented in our treatment population.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
1. Increase data sharing around equity activities and reducing health disparities
2. Support community engagement to inform Learning Collaborative activities
3. Review LC Action Plans relative to impacting health disparities
4. Support for IDEA Workgroup's internal review of MSHN policies, hiring, etc.

e) MSHN Workgroups FY22 Annual Reports

Team Name: Autism Benefit Workgroup
Team Leader: Tera Harris, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of the Autism Benefit Workgroup: The Autism Benefit Workgroup was established to initiate and oversee coordination of the autism benefit for the region. The Autism Benefit Workgroup is comprised of the MSHN Waiver Coordinator, the Community Mental Health Service Provider (CMHSP) autism benefit staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director, and other subject matter experts as relevant. The Autism Benefit Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented on this workgroup.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Helped MSHN region transition to and ensure understanding of post-pandemic policies.
- Developed a monitoring system to address timely service delivery.
- Encouraged attendance and participation in Michigan Autism Council and Autism Alliance of Michigan meetings.
- Served as advocates for the region while working to inform and collaborate with newly formed MDHHS autism section.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Table 3

Goal	Objectives/Activities	Frequency/Due Date
Improve and develop solutions to ensure timely service delivery as evidenced by an increase in network provider capacity including, but not limited to, qualified licensed practitioners (to complete comprehensive diagnostic evaluation) and Applied Behavior Analysis providers (to carryout treatment).	1. Outreach to providers within the state to increase opportunities for autism benefit enrollees to participate in medically necessary services. 2. Share list of available providers with the region as well as regional results of ongoing monitoring of current providers. 3. CMHSP representatives will connect with available providers in consideration of additional contracts.	Frequency: throughout the fiscal year. Due date: 9/30/2024
Adjust to code changes and new policy language.	1. Become aware of and understand the changes that are implemented by MDHHS. 2. Advocate for stabilization of policy to support quality service delivery. 3. Inform network and stakeholders when policy changes are proposed	Frequency: throughout the fiscal year. Due date: 9/30/2024

	and initiated.	
Ensure regional representation at quarterly MSHN Autism Workgroups.	1. MSHN to continue to send workgroup meeting invitations and agendas in a timely manner to encourage attendance. 2. Follow-up with CMHSPs that do not have consistent representation at quarterly workgroup meetings.	Frequency: throughout the fiscal year. Due date: 9/30/2024

Team Name: Children's Waiver Program (CWP) Workgroup
Team Leader: Tera Harris, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of the CWP Workgroup: The CWP Workgroup was established to initiate and oversee coordination of the CWP for the region. The CWP Workgroup is comprised of the MSHN Waiver Coordinator, the Community Mental Health Service Provider (CMHSP) CWP staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director, and other subject matter experts as relevant. The CWP Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Completed two separate CWP 101 trainings (10.04.2022 and 10.18.2022), with virtual options, in partnership with MDHHS (141 attendees total).
- Ensured full implementation of corrective action plan related to MDHHS and MSHN CWP findings.
- Helped MSHN region transition to and ensure understanding of post-pandemic policies.
- Demonstrated continued improvement on DMC reviews as evidenced by increased compliance scores (FY21 average chart review score 93.98%; FY23 average chart review score 98.53%).

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Table 2
Goal
Increase network provider capacity including, but not limited to, specialty services (recreation therapy, art therapy, and music therapy), CLS, and respite.
Prepare for upcoming MDHHS Home and Community Based Waiver Review to occur in 2024.
Begin to introduce and familiarize the region with the MichiCANS assessment system during the soft launch period with the required full implementation set for October 2024.
Continue to increase attendance rates at quarterly workgroup meetings to ensure all CMHSPs are adequately informed and have the resources available to enroll and maintain a youth in the CWP.

Team Name: Home and Community-Based Services (HCBS) Workgroup
Team Leader: Kara Hart, Home & Community Based Services Waiver Administrator
Report Period Home and Community-Based Services (HCBS) Workgroup**:** 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
The HCBS Workgroup was established to initiate and oversee coordination of the HCBS program for the region. The HCBS Workgroup is comprised of the Waiver Administrator (Adults), Waiver Coordinators, and the Community Mental Health Service Provider (CMHSP) HCBS staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The Waiver Administrator chairs the HCBS Workgroup, and the Waiver Coordinators facilitate. All CMHSPs are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Completed site visits and data cleanup regarding the 2020 HCBS Final Rule Survey Data.
- Surveyed, assessed, and remediated, when necessary, individuals/providers for HCBS Compliance.
- Facilitated discussion on the expectations and concerns relating to the MDHHS Community Transition Program (MCTP) releasing individuals into HS facilities.
- Provided information regarding HCBS Final Rule and their intersection with the BTP process.
- Allowed for the discussion of complex cases and the barriers to placing individuals of high needs.
- Provided updates regarding HCBS sites determined to be Heightened Scrutiny.
- Provided ongoing updates regarding MDHHS role changes and structural shifts as it relates to HCBS.
- Provided support, guidance, and reminders regarding the WSA.
- Reviewed best practice strategies to address potential barriers to attaining full HCBS resolution.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Establish a monitoring process to ensure HCBS settings within the Mid-State Health Network region maintain positive HCBS compliance status.
Continue to remediate and validate HCBS survey responses and provisional approval data as it becomes available from MDHHS.
Work to resolve identified conflicts between HCBS compliance and licensing (LARA) recommendations to ensure site and case compliance with MDHHS guidelines and expectations.
Continue to provide clear guidance on MDHHS guidelines and expectations for the provisional approval process.

Team Name: Habilitative Supports Waiver Workgroup
Team Leader: Victoria Ellsworth, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee: The HSW Workgroup was established to initiate and oversee coordination of the HSW program for the region. The HSW Workgroup is comprised of the Waiver Coordinator and the Community Mental Health Service Provider (CMHSP) HSW staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director. The HSW Workgroup is chaired by the Waiver Coordinator. All CMHSP's are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Identified potential candidates for enrollment in the HSW to increase slot allocation.
- Distributed monthly HSW reports and monthly overdue and coming due data.
- Tracking and reporting on reason for and number of HSW recertification pend backs from both MHSN and MDHHS.
- Worked through continued challenges related to monitoring initial HSW applications and recertifications for restrictive and intrusive technique and/or Behavior Treatment Plans.
- Received information provided by MDHHS and successfully implemented changes.
- Continued to implement adjustments related to service delivery and administrative tasks due to COVID-19 pandemic.

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Ensure full implementation of corrective action related to MDHHS and MSHN HSW findings.
Demonstrate improvement on DMC review scores for HSW program specific standards and clinical charts.
Achieve a minimum 95% utilization of allocated HSW slots for the region.
Eliminate monthly unsubmitted/past due HSW recertifications based on established due dates from MSHN and MDHHS.
Increase the timeliness of responses to concerns related to initial HSW applications and recertification reviews to align with the 15-day protocol requested by MDHHS.
Ensure transition, as appropriate, from HSW to 1915(i) for all cases that are being disenrolled or going into inactive status.
Prepare for the upcoming MDHHS Home and Community Based Waiver Review set to occur in 2024.

Team Name: Serious Emotional Disturbance Waiver (SEDW) Workgroup
Team Leader: Tera Harris, Waiver Coordinator
Report Period: 10.01.2022 through 9.30.2023
Purpose of Council or Committee:
The SEDW Workgroup was established to initiate and oversee coordination of the SEDW for the region. The SEDW Workgroup is comprised of the MSHN Waiver Coordinator, the Community Mental Health Service Provider (CMHSP) SEDW staff appointed by the respective CMHSP Chief Executive Officer (CEO)/Executive Director, and other subject matter experts as relevant. The SEDW Workgroup is chaired by the MSHN Waiver Coordinator. All CMHSPs are equally represented.

Annual Evaluation Process:

A. Past Year Accomplishments. FY23

- Increased overall enrollments by six percent (from August 2022-August 2023). This included one CMHSP that did not have enrollees, adding one enrollee. Eleven out of 12 CMHSPs now have enrollees.
- Completed two separate SEDW 101 trainings (10.03.2022 and 10.17.2022), with virtual options, in partnership with MDHHS (154 attendees total).
- Helped MSHN region transition to and ensure understanding of post-pandemic policies.
- Completed full implementation of corrective action plan related to MDHHS and MSHN SEDW findings.
- Held regional Wraparound consultation with Heather Valentiny (MDHHS) on July 6, 2023 (35 attendees).

B. Upcoming Years Goals. FY24 (10.1.2023 through 9.30.2024)

Goal
Increase network provider capacity including but not limited to, specialty services (recreation therapy, art therapy, and music therapy), CLS, and respite, as appropriate.
Begin to introduce and familiarize the region with the MichiCANS assessment system during the soft launch period with the required full implementation set for October 2024.
Review and respond to system changes as influenced by Michigan Intensive Child and Adolescent Service Array (MICAS).
Prepare for upcoming MDHHS Home and Community Based Waiver Review to occur in 2024.

IV. Definitions/Acronyms

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

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

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

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

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

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

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

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

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

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

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

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

Acronyms

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

VII. Attachments

Attachment 01 MSHN QAPIP Communication

Attachment 02 MMBPIS Performance Summary FY23Q3

Attachment 03 FY23 Q2-Q3 Integrated Health Quarterly Report

Attachment 04 PIP #1 Access-Reduction of Disparities Monitoring

Attachment 05 PIP #2 Penetration Rate CY21-CY23Q3

Attachment 06 MSHN Critical Incident Performance Report FY23

Attachment 07 MSHN Critical Incident Process Improvement Summary FY23Q3YTD

Attachment 08 MSHN Critical Incident Performance Report SUDTP FY23

Attachment 09 MSHN Behavior Treatment Review Data FY23

Attachment 10 MSHN Executive Summary member Experience of Care 2023 Annual Report

Attachment 11 National Core Indicator Summary

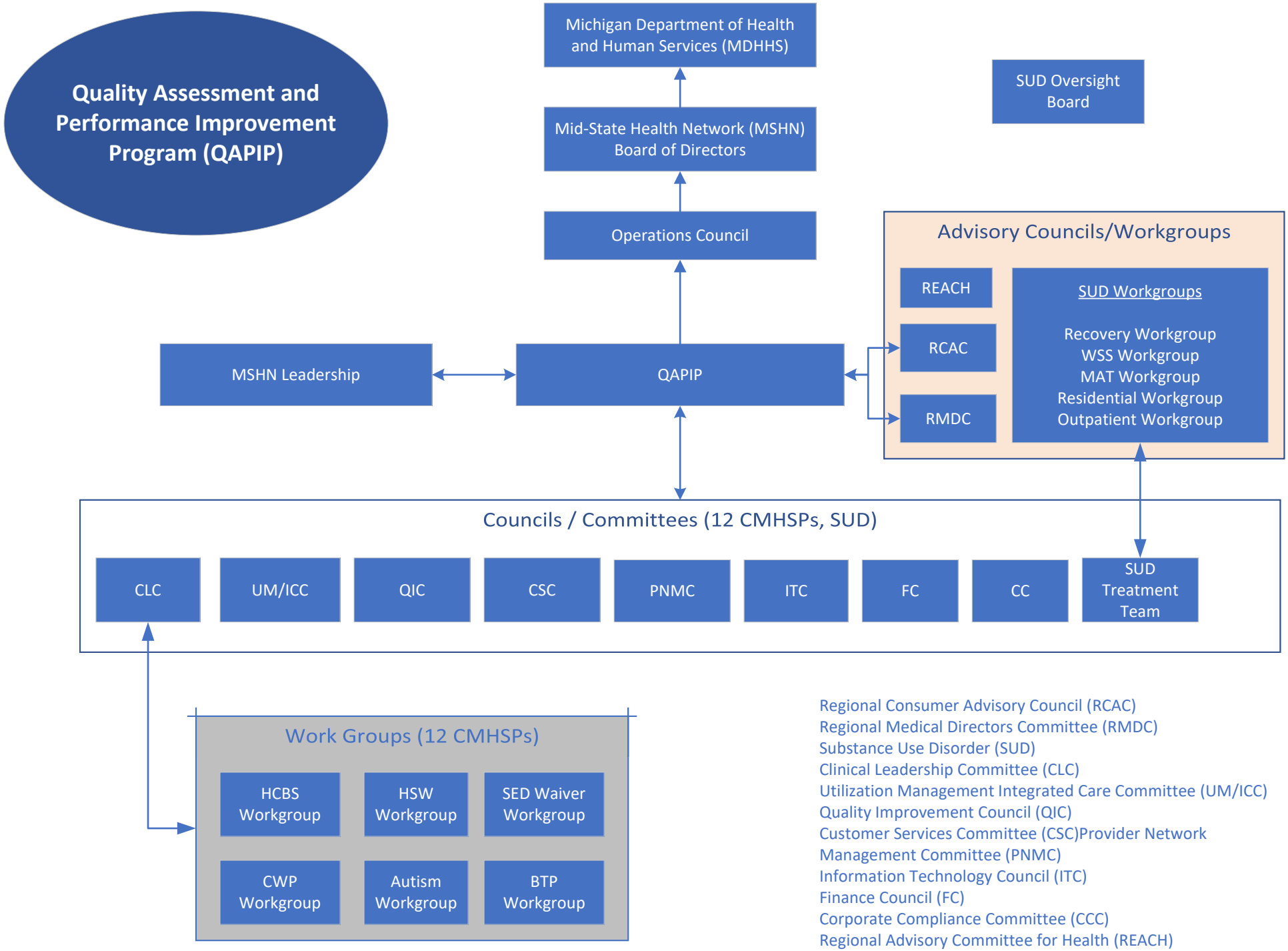
Attachment 12 ACT Utilization FY23

Attachment 13 Behavioral Health Department Quarterly Report FY23Q4

Attachment 14 FY23 Service Auth Denial Report Final

Attachment 15 MSHN 2023 QAPI Compliance Summary Report

Attachment 16 MSHN Governing Body Form



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

Revised 2.1.2022

Contents

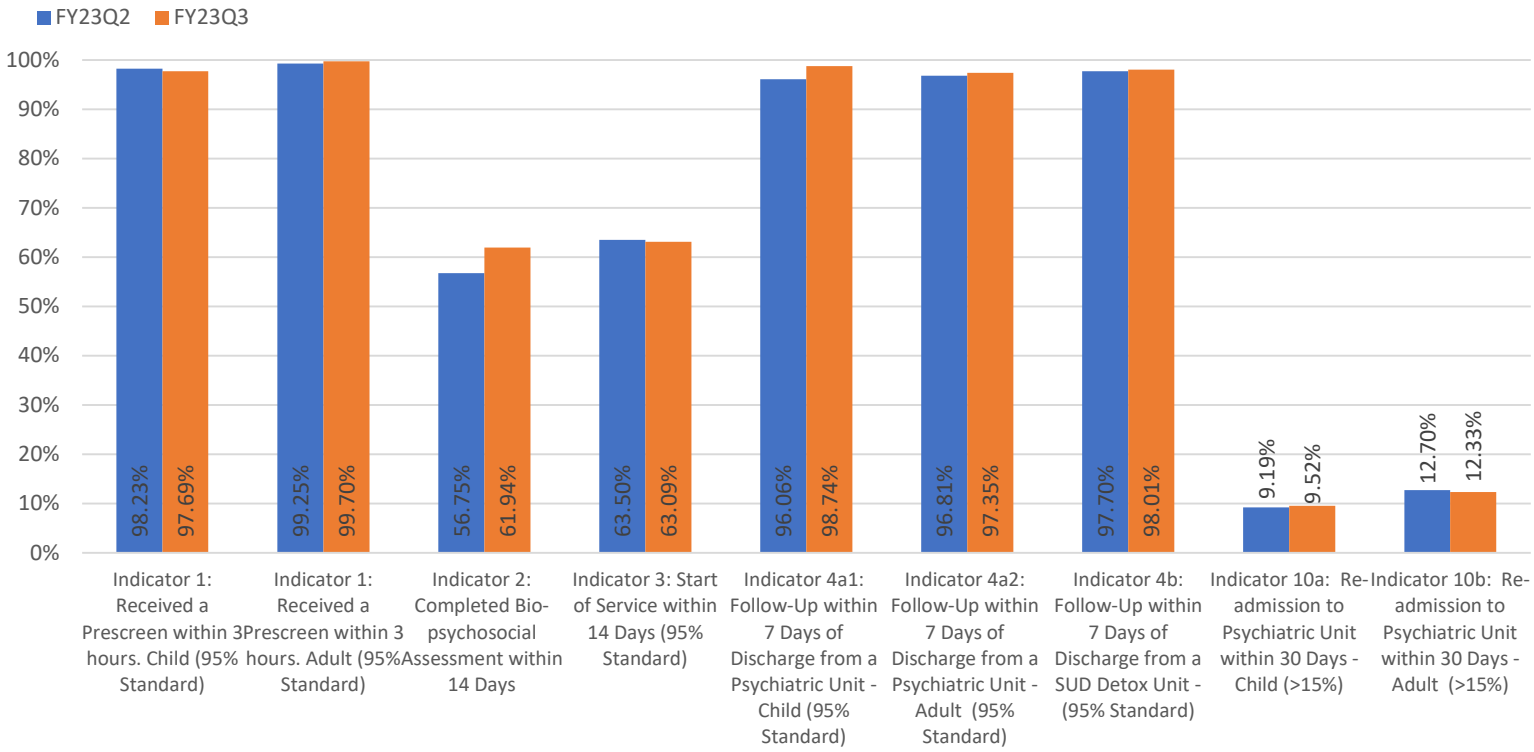
Executive Summary

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

Goal: MSHN will meet or exceed the MMBPIS standards for Access (Indicators 1 and 4) and Outcomes (Indicator 10). MSHN met the goal for FY23Q3.

The most recently finalized PIHP MMBPIS Report indicates that in FY23Q2 MSHN demonstrated performance above the State of Michigan for seven of the twelve indicators, performing in the top five for five of the twelve indicators (Figures 1a-7b). This is a decrease from the previous quarter where MSHN performed above the State of Michigan and in the top five for nine of the twelve indicators.

Figure 1. MSHN MMBPIS performance rate for Access Indicators 1, 4, and Outcome Indicators for FY23Q2.



The following providers demonstrated performance below the standard for FY23Q3:
(*Indicates Denominator under 30)
Indicator 1: CEI, The Right Door, *MCN, *Newaygo
Indicator 4: *The Right Door, Lifeways, *NCMH, *SHW, *TBHS, *ATS, *Healthsource, *Salvation Army
Indicator 10: *NCMH, SHW, *TBHS

Data Analysis

The MMBPIS data collected is based on the definition and requirements that have been set forth within the Michigan Mission Based Performance Indicator System (MMBPIS) Code Book FY20, and the Reporting Requirements within the PIHP contract. Additional instructions are available in the REMI Help documents and the MMBPIS Project Description. Exclusions and/or exceptions are allowed for Indicator 4 and 10.

Access

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

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

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

Indicator 2e: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders. (Effective 4/1/2020 No Standard the 1st 2 Years).

MSHN submits the number of expired requests from individuals who requested and were approved for SUD treatment, however never received a service. This information is submitted to MDHHS for inclusion into the calculation of Indicator 2b. MSHN had 482 expired requests during FY23Q1.

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

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

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

Additional information related to those identified as "exceptions" is found in Figures 7-10.

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

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

Outcomes

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

Individuals who chose not to use PIHP services were identified as an "exception" for this measure.

Figure 2. PIHP and CMHSP Indicator 1,4, and 10 performance rate FY23Q3

	#1 - Pre-Admission Screening		#4 - Hospital Discharges F/U		#10 - Inpatient Recidivism	
Affiliate / CMH	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Adult**
Bay-Arenac	100.00%	100.00%	100.00%	100.00%	8.11%	14.15%
CEI	94.09%	99.18%	100.00%	98.99%	13.33%	11.86%
Central MI	100.00%	99.74%	*100.00%	98.88%	*11.11%	11.30%
Gratiot	100.00%	98.92%	*100.00%	100.00%	*0.00%	14.71%
Huron	*100.00%	100.00%	*100.00%	*100.00%	*0.00%	*0.00%
Ionia	93.18%	100.00%	*100.00%	*85.19%	*0.00%	13.89%
LifeWays	100.00%	99.63%	*100.00%	94.44%	13.16%	13.76%
Montcalm	*94.74%	100.00%	*100.00%	100.00%	*0.00%	8.33%
Newaygo	*94.12%	100.00%	*77.78%	*100.00%	*16.67%	*0.00%
Saginaw	100.00%	100.00%	*100.00%	100.00%	6.67%	12.20%
Shiawassee	*100.00%	100.00%	*100.00%	*84.21%	*0.00%	16.67%
Tuscola	*96.30%	100.00%	*100.00%	*94.44%	*0.00%	*16.00%
Total/PIHP:	**97.69%**	**99.70%**	**98.74%**	**97.35%**	**9.52%**	**12.33%**

*Indicates denominator under 30. Red indicates the standard was not met. **No eligible records

Figure 2a. PIHP and CMHSP Indicator 2 and 3 performance rate FY23Q3

	#2a - 1st Request Timeliness					#3 - 1st Service Timeliness				
Affiliate / CMH	**MI / Child**	**MI / Adult**	**DD / Child**	**DD / Adult**	**Total**	**MI / Child**	**MI / Adult**	**DD / Child**	**DD / Adult**	**Total**
Bay-Arenac	69.07%	63.67%	65.12%	*66.67%	65.23%	61.96%	65.26%	86.49%	*66.67%	66.77%
CEI	86.25%	84.30%	9.38%	*66.67%	78.13%	62.83%	55.85%	97.60%	*77.78%	66.46%
Central MI	63.97%	75.16%	*75.00%	*75.00%	71.63%	69.64%	74.51%	*61.90%	*75.00%	72.63%
Gratiot	68.25%	64.35%	*72.73%	*66.67%	66.15%	59.57%	81.58%	*90.00%	*66.67%	74.26%
Huron	50.00%	72.73%	*100.00%	*100.00%	65.22%	56.00%	*51.02%	*100.00%	*0.00%	51.95%
Ionia	67.35%	70.00%	*75.00%	*87.50%	69.81%	42.22%	62.21%	*75.00%	*55.56%	56.18%
LifeWays	56.11%	56.80%	*40.00%	*81.25%	56.53%	20.57%	38.43%	*12.50%	*50.00%	32.09%
Montcalm	77.38%	77.36%	*89.66%	*88.89%	79.00%	55.41%	72.18%	90.32%	*100.00%	70.20%
Newaygo	55.56%	43.83%	**	*75.00%	48.44%	41.79%	67.33%	**	*50.00%	56.90%
Saginaw	11.97%	20.44%	2.56%	*40.00%	16.35%	61.76%	62.42%	68.42%	*66.67%	63.41%
Shiawassee	57.45%	52.94%	*66.67%	*33.33%	54.81%	81.25%	67.65%	*50.00%	*100.00%	74.71%
Tuscola	31.58%	24.10%	*0.00%	*75.00%	27.78%	93.10%	*88.89%	**	*100.00%	90.53%
Total/PIHP:	**61.13%**	**63.84%**	**42.74%**	**71.91%**	**61.94%**	**56.82%**	**63.68%**	**81.85%**	**65.91%**	**63.09%**

*Indicates denominator under 30. **No eligible records

Figure 3. MSHN longitudinal data Indicators 1, 2, 3, 4, 10 performance rates.

	Population	FY22Q2	FY22Q3	FY22Q4	FY23Q1	FY23Q2	FY23Q3
Indicator 1: Percentage who received a Prescreen within 3 hours of request 95% Standard	Children	98.00%	98.53%	97.22%	99.32%	98.23%	97.69%
	Adults	98.77%	98.74%	99.15%	99.42%	99.25%	99.70%
***Indicator 2: Percentage who have had a completed Bio-psychosocial Assessment within 14 Days. No Standard**	MI Child	63.78%	63.92%	63.39%	59.14%	57.13%	61.13%
	MI Adults	61.38%	60.10%	61.62%	62.95%	58.27%	63.84%
	DD Child	58.58%	55.29%	55.19%	49.21%	40.98%	42.74%
	DD Adult	63.46%	67.59%	74.76%	57.29%	49.18%	71.91%
	Total	62.08%	61.24%	62.13%	60.81%	56.75%	61.94%
Indicator 3: Percentage of who had a Medically Necessary Service within 14 Days. No Standard	MI Child	60.24%	56.03%	64.36%	56.86%	61.01%	56.82%
	MI Adults	67.56%	61.66%	63.65%	59.47%	62.85%	63.68%
	DD Child	75.24%	71.94%	78.34%	77.16%	81.42%	81.85%
	DD Adult	72.60%	63.04%	69.79%	61.90%	61.62%	65.91%
	Total	65.53%	60.53%	65.12%	59.53%	63.50%	63.09%
Indicator 4: Percentage who had a Follow-Up within 7 Days of Discharge from a Psychiatric Unit/SUD Detox Unit (95% Standard)	Children	98.97%	96.30%	97.80	97.25%	96.06%	98.74%
	Adults	95.75%	96.49%	97.25%	95.60%	96.81%	97.35%
	MSHN SUD	99.37%	97.16%	96.74%	97.83%	97.78%	98.01%
Indicator 10a: Percentage who had a Re-admission to Psychiatric Unit within 30 Days (>15% Standard)	Children	5.60%	2.68%	10.45%	8.75%	9.19%	9.52%
	Adults	10.42%	8.87%	9.66%	13.01%	12.70%	12.33%

Out of Compliance/Exception Data

MSHN completes an analysis of those records that were "out of compliance" and those that were identified as "exceptions. Exceptions are allowed for Indicators 4 and 10. Indicators 2 and 3 do not allow for exceptions. If an individual does not meet the timelines as required, the record is considered to be "out of compliance". The reasons for "out of compliance" can be found in Figure 5.

Figure 4. Indicator 4, 10 MSHN and the Provider Network exception rate.

	Indicator 4							Indicator 10					
	FY22Q2	FY22Q3	FY22Q4	FY23Q1	FY23Q2	FY23Q3		FY22Q2	FY22Q3	FY22Q4	FY23Q1	FY23Q2	FY23Q3
BABH	31.78%	30.00%	36.27%	36.42%	19%	29.37%		0.00%	0.00%	0.00%	0.65%	0.00%	1.38%
CEI	45.76%	49.50%	34.72%	45.88%	0%	30.85%		31.14%	30.90%	31.02%	33.74%	28.81%	21.16%
CMHCM	12.50%	27.27%	56.86%	25.24%	12%	25.56%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
GIHN	15.38%	16.22%	21.60%	16.13%	0%	4.55%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
HBH	33.33%	37.93%	6.67%	44.00%	0%	25.93%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
The Right Door	12.00%	12.50%	32.35%	15.38%	0%	23.26%		0.00%	2.78%	0.00%	0.00%	0.00%	0.00%
Lifeways	44.77%	48.89%	15.38%	36.57%	31%	42.79%		2.91%	0.00%	1.54%	2.86%	0.00%	1.30%
MCN	18.42%	19.44%	47.18%	21.05%	0%	20.00%		0.00%	0.00%	0.00%	0.00%	0.00%	6.98%
Newaygo	4.76%	37.50%	14.81%	26.67%	**	20.00%		0.00%	0.00%	0.00%	0.00%	**	0.00%
Saginaw	34.51%	34.48%	5.26%	33.85%	0%	43.24%		0.00%	0.00%	0.00%	0.66%	0.00%	0.51%
SHW	31.25%	33.33%	38.24%	32.14%	32%	34.38%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
TBHS	18.18%	28.57%	18.18%	12.50%	100%	32.14%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
MSHN	**33.18%**	**37.05%**	**28.57%**	**34.02%**	**20.63%**	**34.76%**		**10.68%**	**11.40%**	**10.04%**	**10.65%**	**8.42%**	**6.91%**
4b MSHN-SUD	50.77%	49.86%	46.36%	45.07%	39.51%	41.91%		**No eligible records					

Figure 5. Out of Compliance and Exception Reasons

	Ind. 2 Request to Assessment			Ind. 3 Assessment to Service			Ind. 4 FU after Psych Inpatient/Detox Discharge			Ind. 10 Readmission		
Out of Compliance / Exception Reasons	**FY23 Q1**	**FY23 Q2**	**FY23 Q3**	**FY23 Q1**	**FY23 Q2**	**FY23 Q3**	**FY23 Q1**	**FY23 Q2**	**FY23 Q3**	**FY23 Q1**	**FY23 Q2**	**FY23 Q3**
Total # Out of Compliance or Exception	1537	2039 /418	1673 /353	1262	1283	1312	339/ 155	300/ 152	386/ 149	118	147	93
Consumer canceled/no showed for an appointment	349	361/ 13	370/ 4	399	346	386	196/19	200/12	259/10			
Consumer rescheduled an appointment	202	208/ 9	158/ 20	105	114	84	16/4	20/1	12/0			
Consumer requested an appointment outside of 14/7 calendar days/Consumer refused an appointment offered within 14/7 Calendar Days	406	550/ 51	383/ 35	256	197	155	5/45	0/44	4/21			
No appointments available within the required timeframe	426	481/ 1	520/ 2	257	121	209	3/0	0/0	0/0			
Consumer chose not to pursue services	25	68/0	38/0	26	45	38	27/46	46/ 56	43/68	5	6	3
Staff cancel/reschedule	38	14/ 3	1/39	38	27	22	2/0	2/0	1/0			
Unable to be reached	9	2	13/2	11	2	14	0/0/	0	0/0			
Assessment determined not eligible for specialty mental health services	1	1		15	40	10	0/0	0/0	0/0			
Consumer chose not to use CMHSP/PIHP services/ chose provider outside of network	5	21	10	43	4	9	65/30	8/28	45/45	113	141	89
Unable to complete assessment due to emergent need	4	1	2			2	0/0	3/0	0/5			
Other (autism consumer, missing disability designation, rapid access, documentation, referred out for services)		13	90		3	149	0/0	0/1	0/0			1
Blank	72	1/ 341	65/ 287	27	384	234	0/3	21/ 10	17/4			

Follow Up to Data Analysis

Prioritize out of compliance / exception reasons, and identify causal factors with interventions to reduce or eliminate the barriers.

Improvement Strategies			**Evaluation Process**		
The number of individuals seen within the required timeframe will demonstrate an increase.			Review annual data for progress.		
Indicator	**Barrier /Causal Factors**	**Intervention**	**Start Date**	**Who**	**Status of Progress**
2/3	Scheduled outside of the required timeframes -No appointments available within required timeframe	Consumer are provided services through mobile response stabilization services until scheduled appointment.	FY23	SCCMHA	New
		Rebuild Workforce and increase staffing levels.	FY23	SCCMHA	New
		Utilize additional staff to ensure seen within 14 days.	FY23	GIHN	New
		Contracting with an outside agency.	FY23	SHW	New
		Postings, outreach to colleges, interns Recruitment-billboards, commercials, job fairs.	FY23	CEI	New
		Paying for Masters-additional education.	FY23	CEI	New
		Business cards with QR codes.	FY23	NCMH	New
		Incentives for staff referrals	FY23	The Right Door	New
2/3	Scheduled outside of the required timeframes -Process not followed	Education / Training staff.	FY23	BABH, Lifeways	New
		Development of procedure and policy with specific actions and timelines to track post hospital follow ups, and follow up with consumer and provider	FY23	Lifeways	New
2/3	Consumer No Show/ Canceled	Utilize peers for increased engagement	FY23	HBH	New
4	Lack of Care Coordination	Develop/improve discharge planning process with internal staff and hospital	FY22 FY22 FY22	The Right Door HBH Lifeways	Effective Effective Improvement
		Training including but not limited to coordination process and ensuring appropriate releases are in place for community treatment	FY22 FY22 FY23	GIHN Lifeways CMHCM	Effective Improvement New
	Staff Cancel	Process developed to ensure supervisors are aware of crisis, hospital discharge appointment to ensure follow up with another clinician in the event of an unexpected staff absence.	FY23	Saginaw	New

10	Lack of appropriate supervised housing.	Work collaboratively with MDHHS and community treatment providers for coordination, approvals and development	FY23	CMHCM	New
		Utilize/ develop crisis stabilization units and crisis residential as a step down	FY23	CEI MCN	New New
4/10	Process may not have been followed or be adequate to address the needs of individuals	Review each case for any process variation and develop appropriate action steps	FY23	NMCH	New
		Training on the access requirements and process. This may include documentation of exceptions etc.	FY23 FY22 FY22 FY23	BABH SCCMHA GIHN SUD Providers	New Effective Improvement New

Prepared by: Sandy Gettel, MSHN Quality Manager **Date:** 10/3/2023
Reviewed by: MSHN QIC **Date:** 10/26/2023
Distributed to SUD Treatment: **Date**: 10/27/2023

Attachment 1: Substance Use Disorder Treatment Providers Data FY23Q3

*Indicates denominator under 30

Provider	2e Expired Requests	2b Timeliness- (Unofficial Results)	4b Withdrawal Management Follow Up
MSHN	**476**	**87.03%**	**98.01%**
Access Lifeways CMH	12		
Access Montcalm Care Network	1		
Addiction Treatment Services	0	100.00%	*92.31%
Arbor Circle Counseling	1	*100.00%	
Bear River Health	46	93.85%	100.00%
Catholic Charities of Jackson Lenawee and Hillsdale Counties	8	82.86%	
Catholic Charities of Shiawassee and Genesee	0	*59.09%	
Catholic Human Services	0	*73.33%	
Cherry Street Service	0	100.00%	
CMH for Clinton, Eaton Ingham Counties	45	97.97%	100.00%
Cristo Rey Community Center	19	37.50%	
DOT Caring Centers	7	92.31%	*100.00%
Family Services & Children's Aid	1	96.77%	
Flint Odyssey House	26	96.70%	*100.00%
Great Lakes Recovery Centers	1	*88.89%	
Harbor Hall, Inc.	0	95.38%	
HealthSource Saginaw	0	*100.00%	*77.78%
Henry Ford Allegiance Health	28	79.80%	*100.00%
KPEP	0	*100.00%	
LifeWays	0	*84.62%	
List Psychological Services	19	80.46%	
McCullough Vargas & Associates	14	73.68%	

Meridian Health Services	21	96.34%	*100.00%
Michigan Therapeutic Consultants	1	97.44%	
Mid-Michigan Recovery Services	58	63.13%	
Mindful Therapy	0	*100.00%	
New Paths, Inc.	0	*100.00%	
North Kent Guidance Services, LLC	3	*100.00%	
Our Hope Association	1	*91.67%	
Pinnacle Recovery Services	0	76.67%	
Professional Psychological & Psychiatric Services	0	*87.50%	
Randy's House of Greenville	0	*100.00%	
Recovery Pathways	32	90.38%	
Sacred Heart Rehabilitation Center	10	83.33%	*100.00%
Saginaw Odyssey House, Inc.	11	79.59%	
Saginaw Psychological Services	3	86.67%	
Salvation Army	0	*100.00%	*90.00%
Samaritas	8	88.89%	
Sunrise Centre	7	86.67%	*100.00%
Ten Sixteen Recovery Network	49	82.31%	
The Right Door for Hope, Recovery and Wellness	8	80.00%	
Victory Clinical Services - Battle Creek	0	*100.00%	
Victory Clinical Services - Jackson	4	*88.89%	
Victory Clinical Services - Lansing	10	*76.92%	
Victory Clinical Services - Saginaw	16	81.25%	
WAI-IAM	0	98.33%	
Wedgwood Christian Services	6	78.57%	

Appendix A: PIHP MMBPIS Comparison Report Final State Data

FY23Q2 Final State Data

An analysis was completed using the most recent finalized report, comparing MSHN performance to other PIHPs and the State of Michigan. In addition to the indicators that are calculated and reviewed quarterly by MSHN, the following indicators calculated by MDHHS were included:

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

The most recent finalized MMBPIS-PIHP Performance Indicator Final Report indicates that in FY23Q2 MSHN demonstrated performance above the State of Michigan for seven of the twelve indicators, performing in the top five for five of twelve indicators (Figures 1a-7b). The data demonstrates areas of focus should be psychiatric inpatient admissions/readmissions (Indicator 10), follow up care (Indicator 4), and timely engagement (Indicator 3). MSHN demonstrated the third highest penetration rate in Michigan for Medicaid recipients receiving a PIHP service.

Figure 1a: PIHP Comparison Data for Access Indicator 1

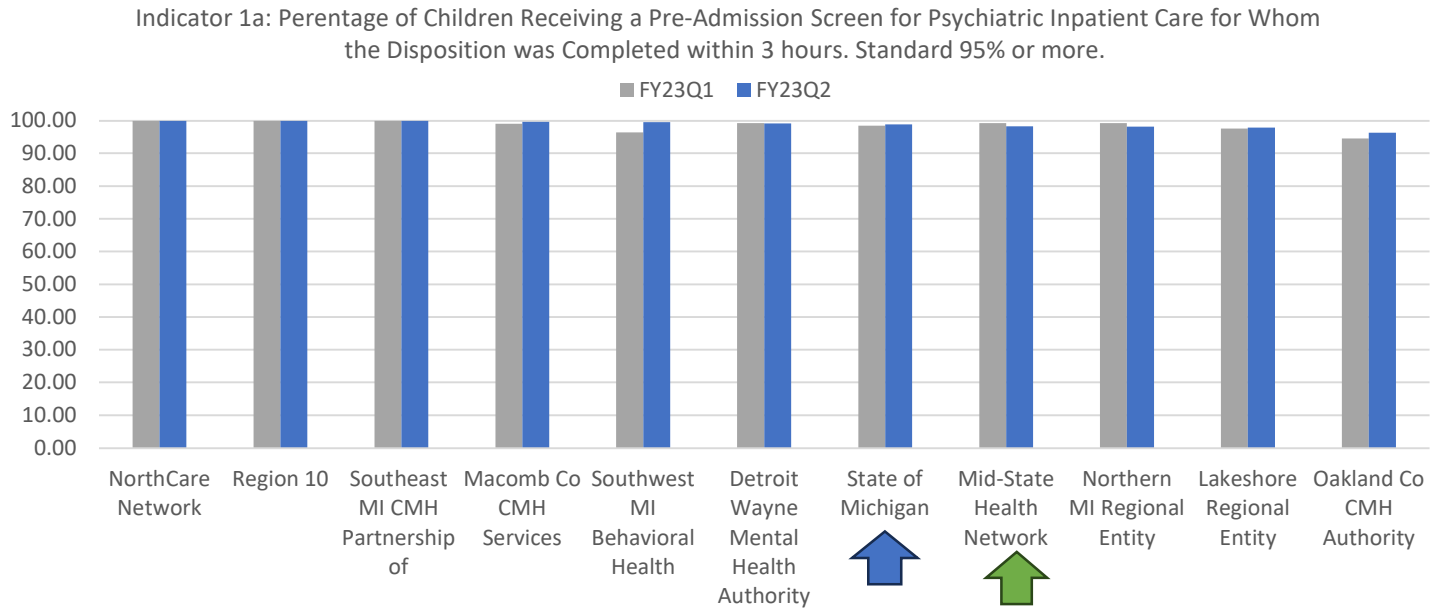


Figure 1b: PIHP Comparison Data for Access Indicator 1

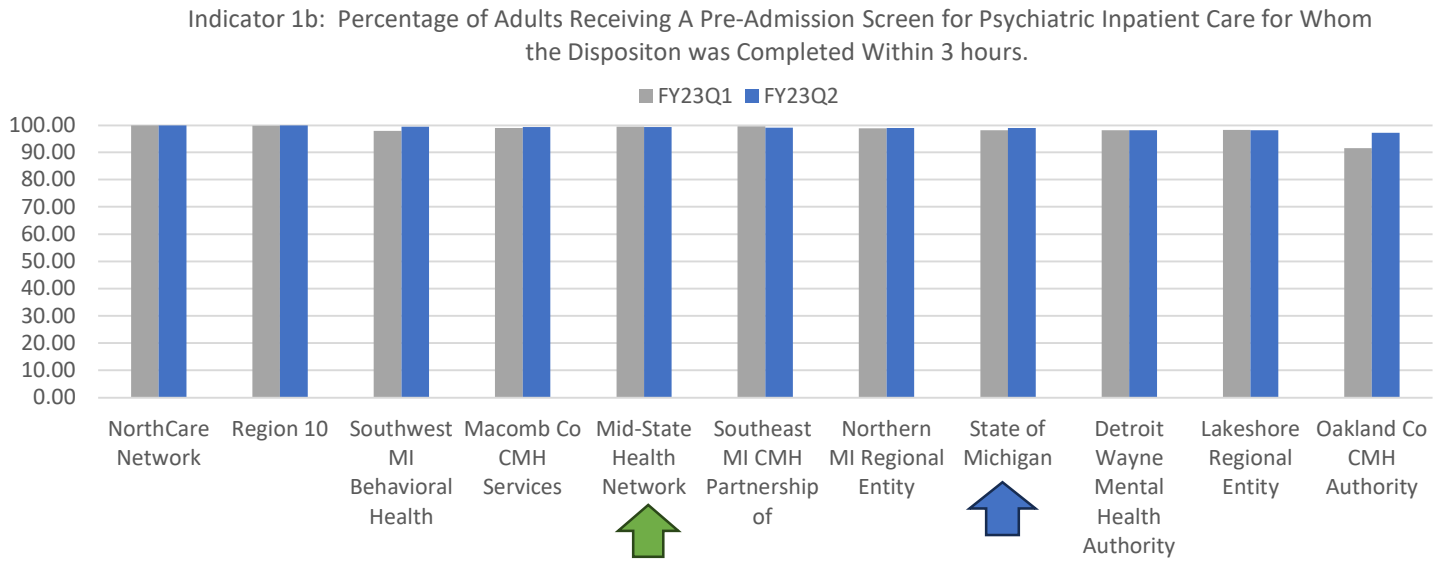


Figure 2: PIHP Comparison Data for Access Indicator 2

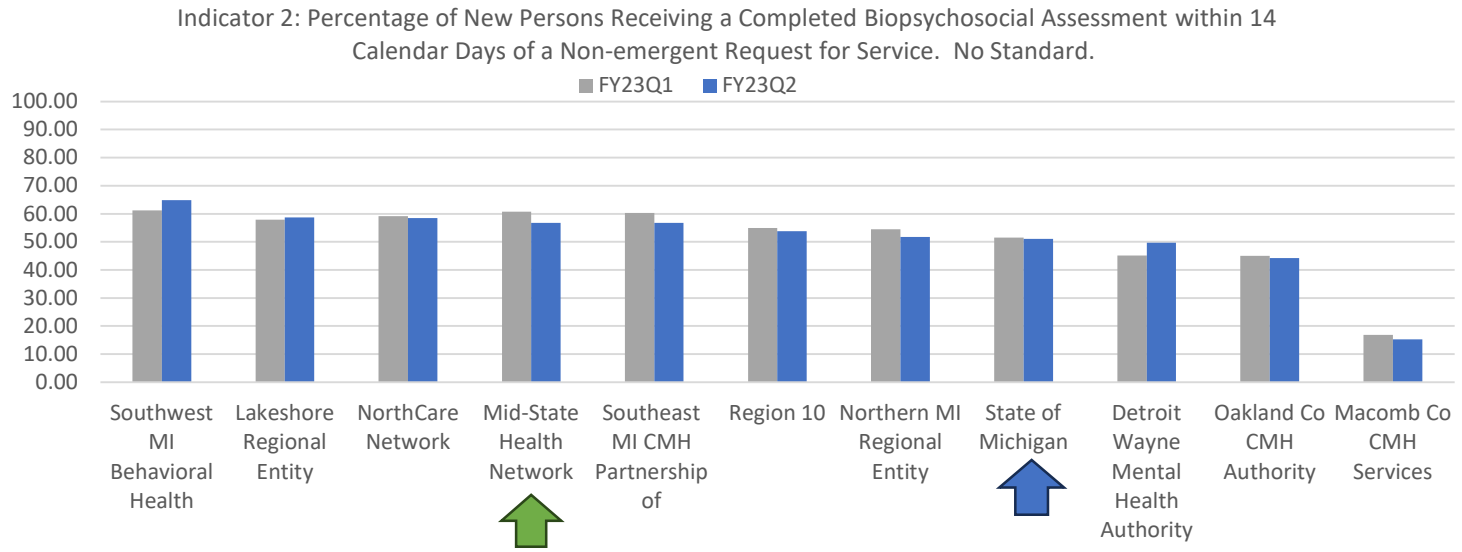


Figure 2b: PIHP Comparison Data for Access Indicator 2e

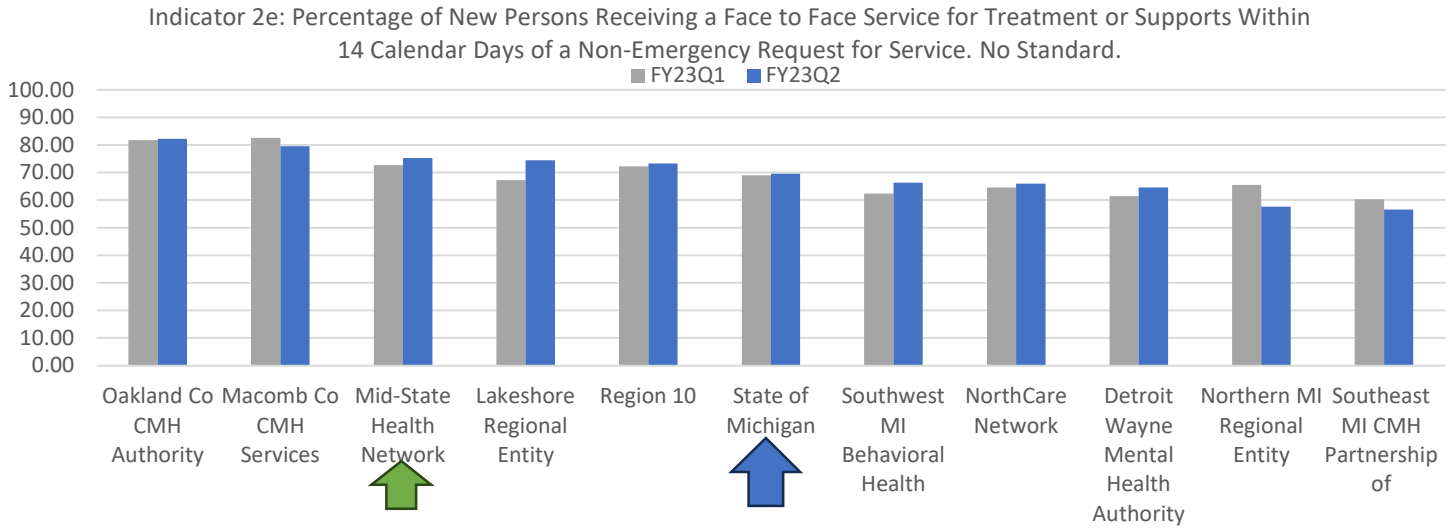


Figure 3: PIHP Comparison Data for Access Indicator 3

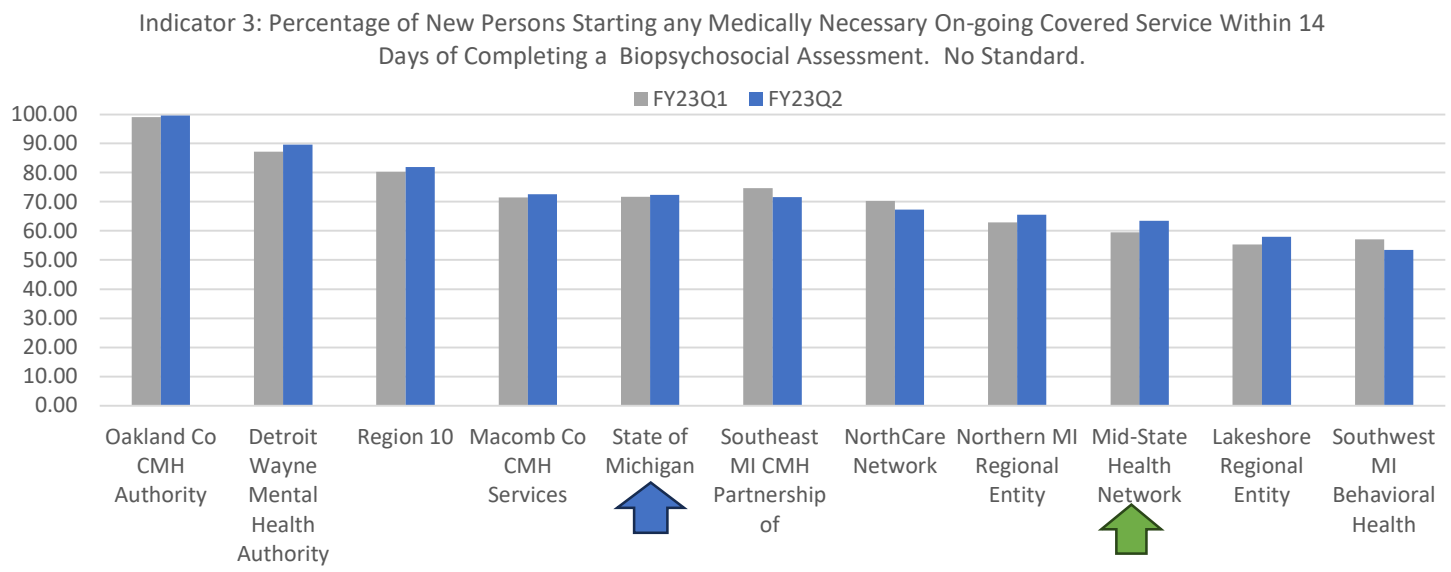


Figure 4a: PIHP Comparison Data for Access Indicator 4a1

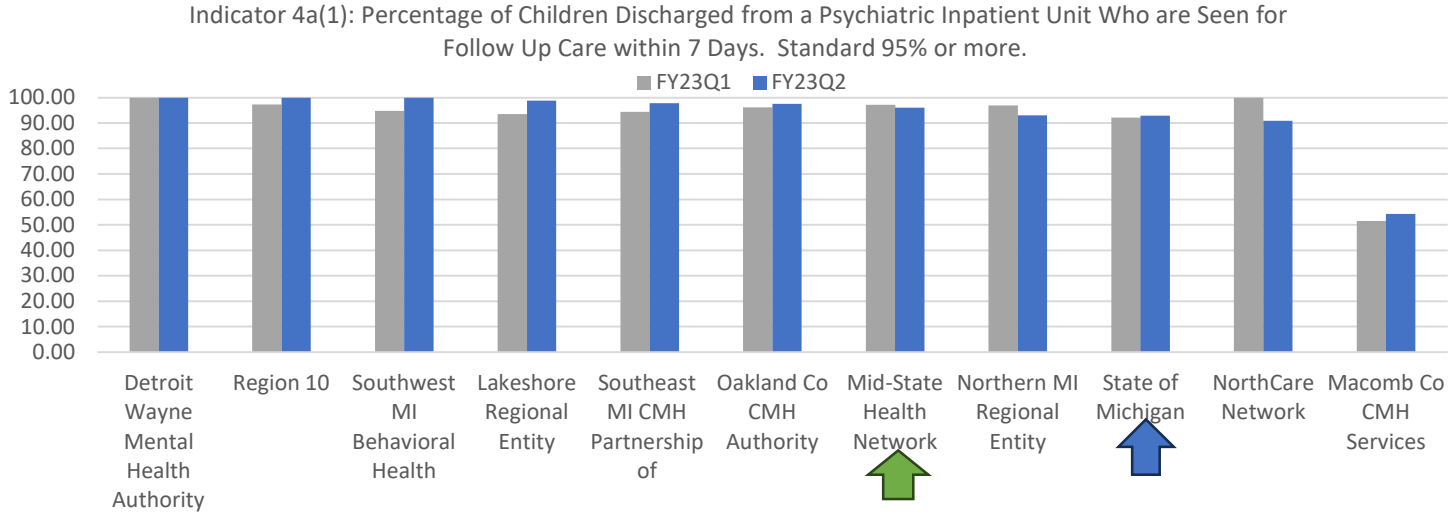


Figure 4b: PIHP Comparison Data for Access Indicator 4a2

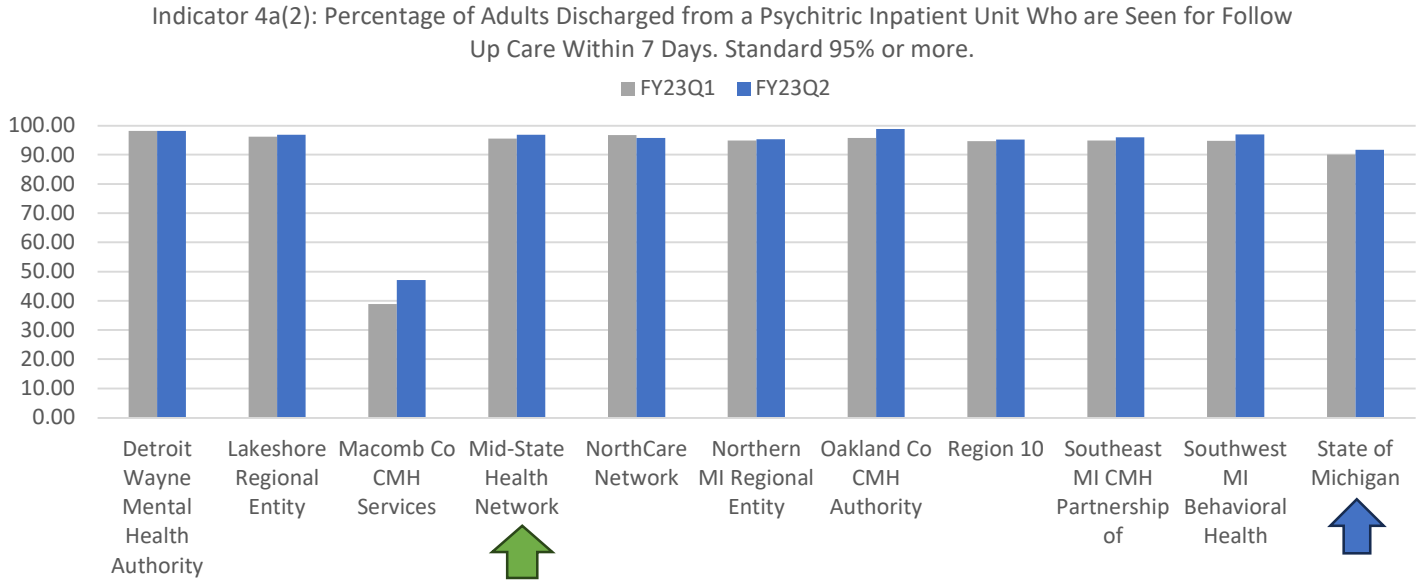


Figure 4c: PIHP Comparison Data for Access Indicator 4b.

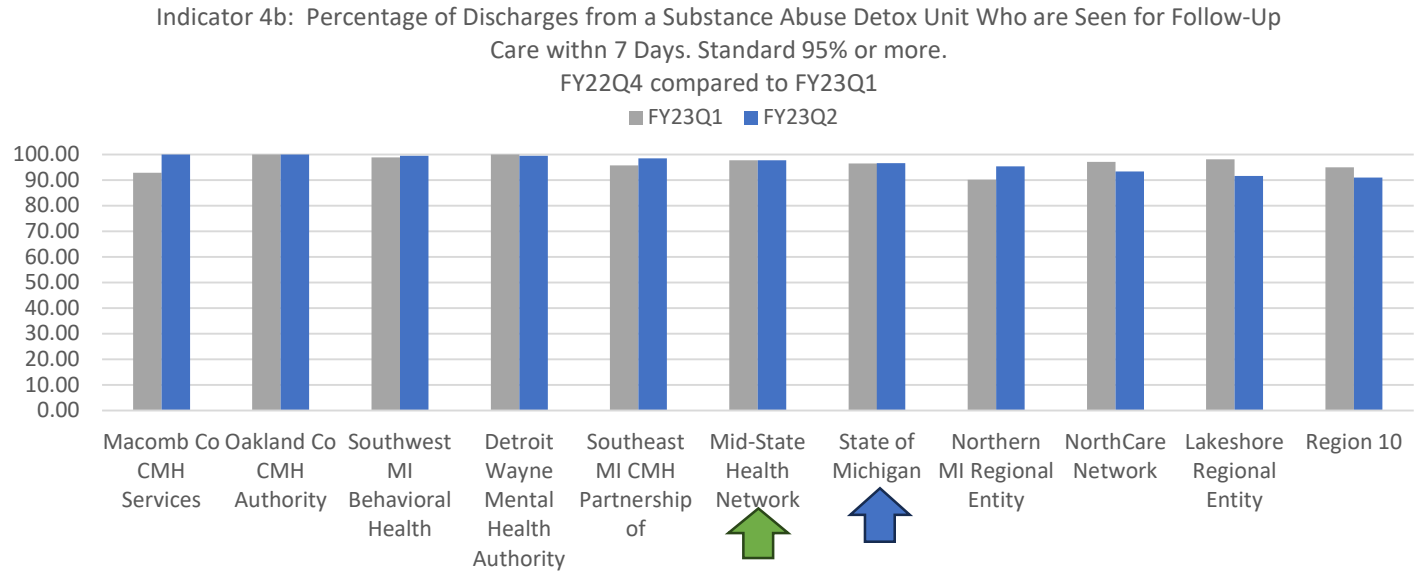


Figure 5: PIHP Comparison Data for Access Indicator 5

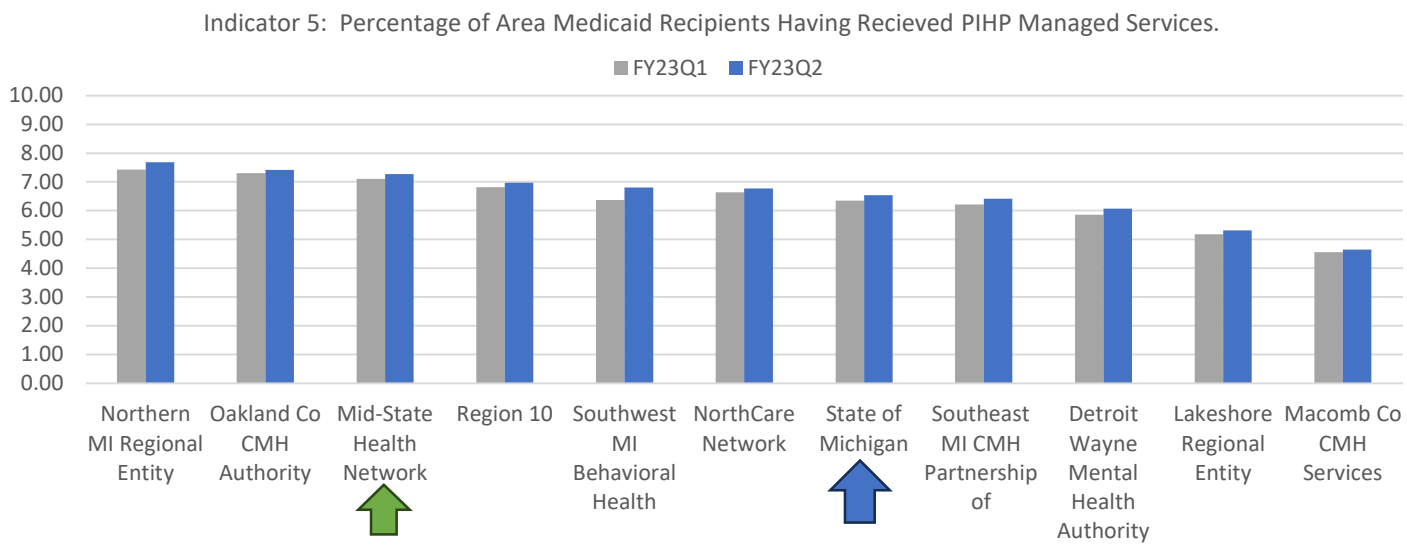


Figure 6: PIHP Comparison Data for Access Indicator 6

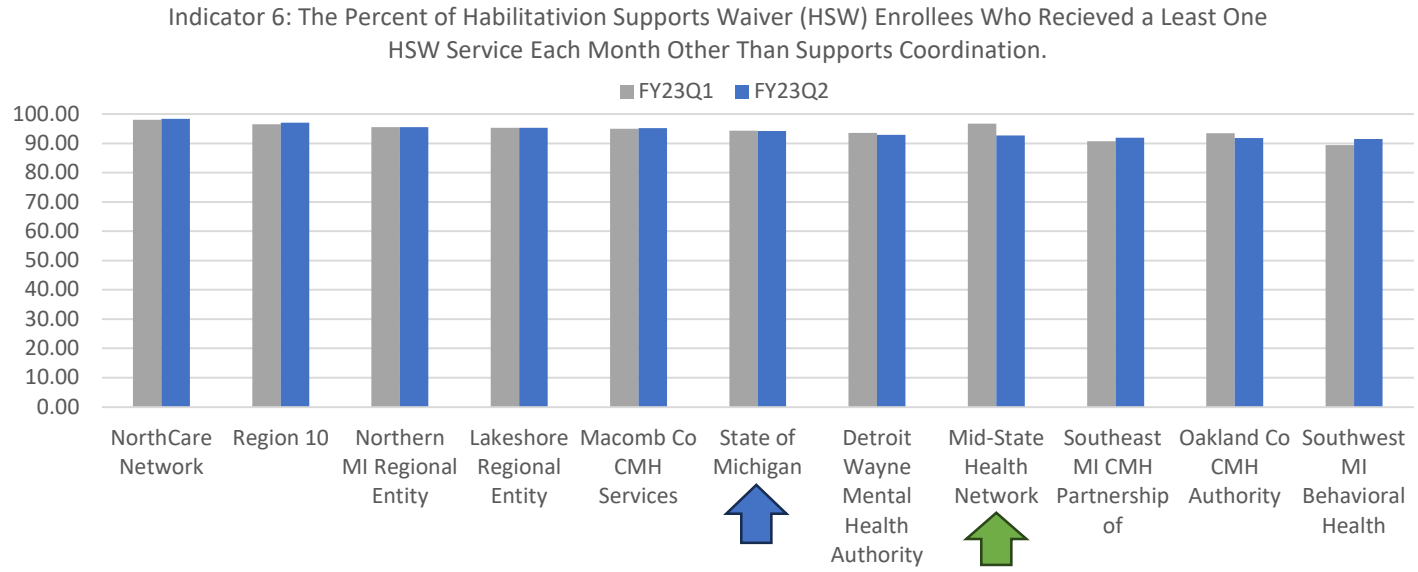
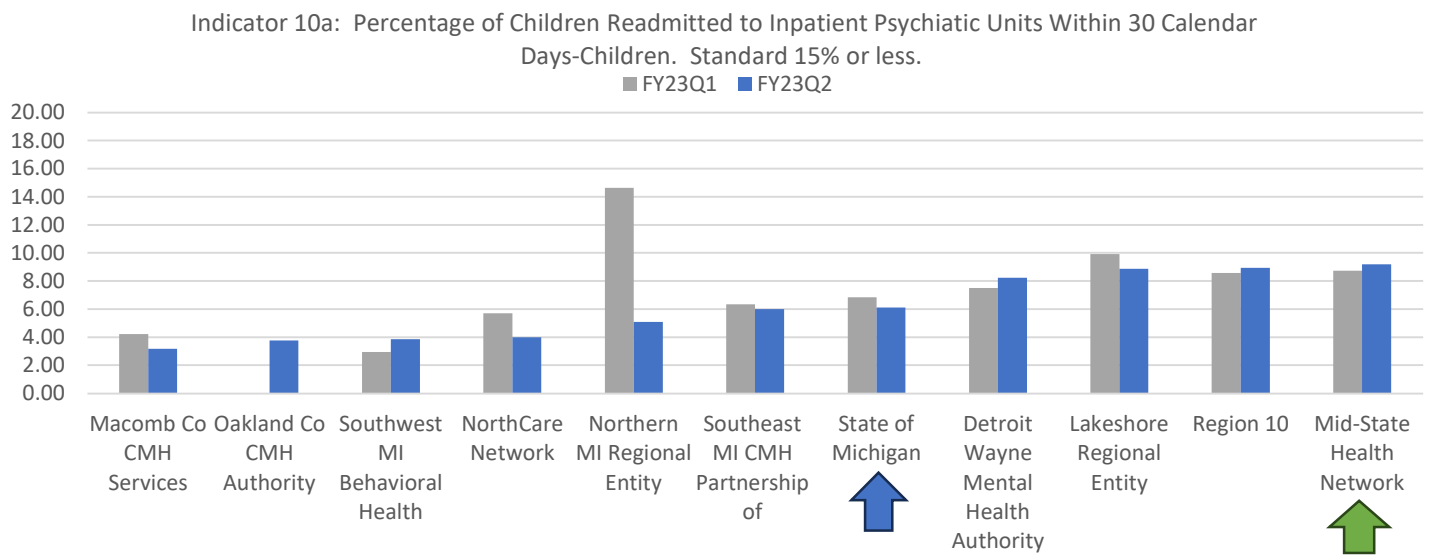
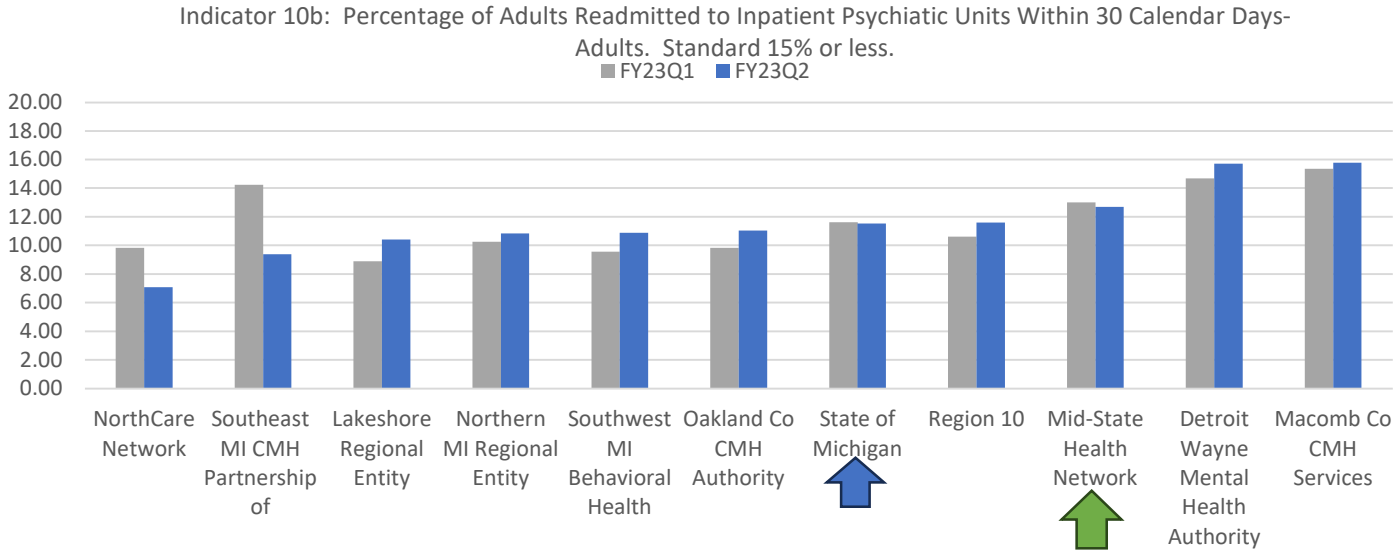


Figure 7a: PIHP Comparison Data for Outcome Indicator 10



MSHN had the highest number (185) of reported child admissions for psychiatric inpatient units in the State of Michigan. Seventeen of those admissions were readmitted within 30 days.

Figure 7b: PIHP Comparison Data for Outcome Indicator 10



Integrated Health Quarterly Report

January 2023 – June 2023 (FY23 Q2-Q3)

Prepared by: Director of Utilization & Care Management

Table of Contents

Background & Purpose

Mid-State Health Network (MSHN) is committed to increasing its understanding of the health needs of individuals within its 21-county service region and finding innovative ways to achieve the goals of better health, better care, better value, better provider systems, and better equity by utilizing informed population health and integrated care strategies. MSHN and its regional partners have a number of specific population health and integrated care initiatives underway during FY23 as detailed in the MSHN 2020-2022 Population Health and Integrated Care Plan (midstatehealthnetwork.org). The primary objectives of this quarterly report are as follows:

1. Monitor adherence to the MSHN Population Health & Integrated Care Plan
2. Report progress toward MDHHS-PIHP contractual integrated health performance requirements
3. Describe other current population health and integrated care initiatives that support MSHN Strategic Priorities of Better Health, Better Care, Better Provider Systems, Better Value, Better Equity
4. Provide additional recommendations as necessary regarding organizational needs in the areas of population health and integrated care

Michigan Department of Health and Human Services (MDHHS)-Prepaid Inpatient Health Plan (PIHP) Contractual Integrated Health Performance Requirements

FY23 PIHP-Only Pay for Performance Measure(s)

Note: Please refer to Attachment A: FY23 Performance Bonus Incentive Pool (PBIP) Contractual Requirements & Deliverables

A. Identification of beneficiaries who may be eligible for services through the Veteran's Administration

MSHN submitted the Veteran's Narrative report on 7/1/2023 covering FY23 Q1-Q2. MSHN continues to perform at a high-level for the completion and accuracy of the Military Fields in the BH-TEDS data, with an error rate of only 1.65%.

B. Increased data sharing with other providers (sending ADTs through Health Information Exchange)

Metric complete; All 12 CMHSPS in the region are fully functional and sending ADTs.

C. **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)**
MSHN submitted the required IET data validation project to MDHHS on 4/26/2023. MSHN had an overall match rate of 98.57%, meaning that MSHN data had a very high rate of accuracy when compared with the data provided by MDHHS.
Additionally, MSHN began publishing provider-specific IET performance metrics on the MSHN website as of April 2023. SUD providers were informed during the March 2023 SUD Provider meeting of MSHN's plans to publish the data for the purpose of improved transparency and accountability. MSHN also began holding a quarterly SUD data workgroup to discuss the metrics as well as improvement strategies. Participation in the data workgroup is optional for SUD providers.

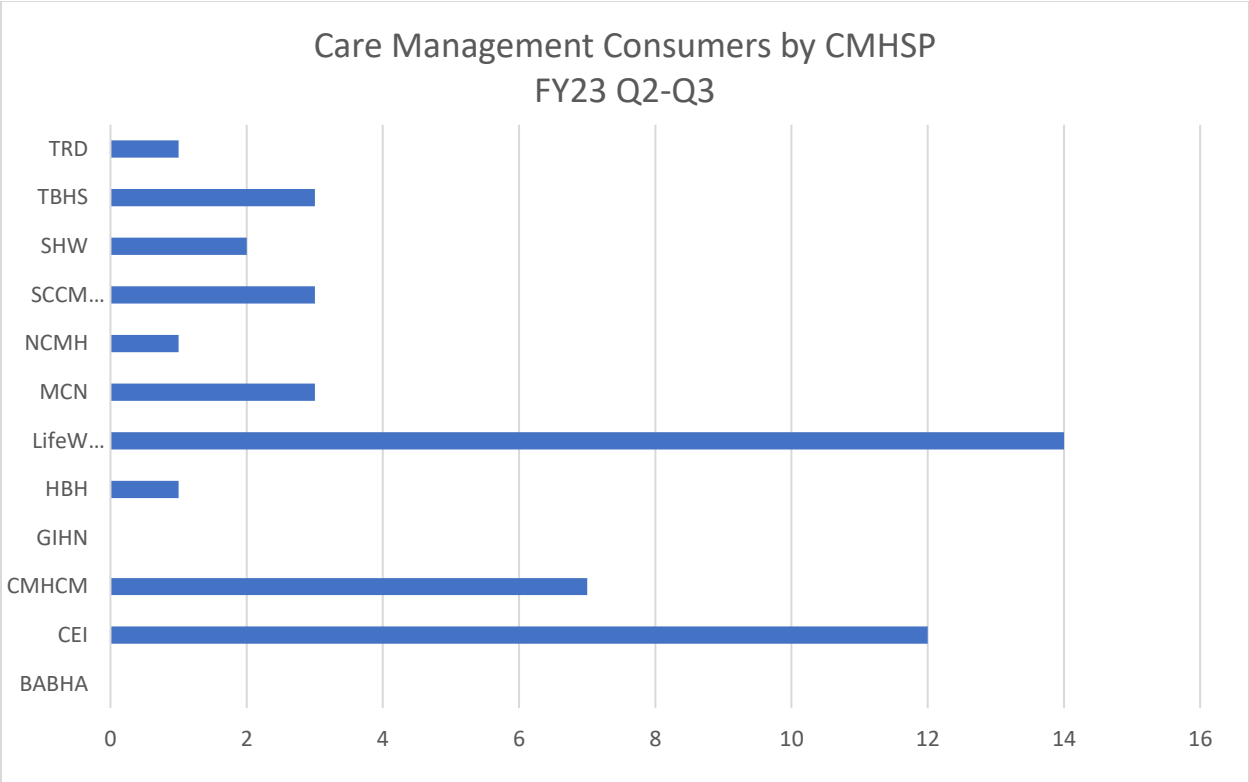
D. **Increased Participation in Patient-Centered Medical Homes Narrative Report**
No deliverables due during FY23 Q2 – Q3.

FY23 Medicaid Health Plan (MHP)/PIHP Joint Metrics

Note: Please refer to Attachment A of this report for a full copy of the FY23 Performance-Based Incentive Pool (PBIP) contract requirements and deliverables

A. **Implementation of Joint Care Management Processes**
MSHN continues to participate in monthly care coordination meetings with each of the 8 Medicaid Health Plans (MHP) that operate within the PIHP's 21-county region. Joint care plans are developed to strengthen coordination between payors and providers in order to meet the needs of members with multiple chronic physical health and behavioral health conditions. MSHN had open care plans for 47 individuals during FY23 Q2-Q3. The distribution of individuals with open care plans among CMHSPs is represented in Figure 1 below.

Figure 1: Number of Consumers involved in Joint Care Management Process with Medicaid Health Plans by CMHSP



B. Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days

The FY23 performance bonus for FUH is based on the time period of January 1, 2022- December 31, 2022 (calendar year 2022). MSHN Quality Improvement Council (QIC) provides a quarterly report on this performance measure and participates in quality improvement activities when adverse trends are identified. The following summary indicates performance during calendar year 2022:

- As a region, MSHN had a rate of 69.88% follow up for adults, exceeding the MDHHS required performance benchmark of 58%
    - MSHN combined performance with each of the 8 Medicaid Health Plans surpassed the 58% benchmark rate for adults
- As a region, MSHN had a rate of 87.87% follow up for children, exceeding the MDHHS required performance benchmark of 70%
    - MSHN combined performance with each of the 8 Medicaid Health Plans surpassed the 70% benchmark rate for children
- There were no racial disparities between the White population and Hispanic or American Indian populations, however there was a racial disparity between the White population and African American/Black population.

C. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)
During FY23 MSHN and its CMHSP participants will work to reduce or eliminate disparities in the rates of follow-up after an emergency visit related to alcohol or substance use between White individuals and individuals belonging to racial/ethnic minority groups. The measurement period for FY23 is January 1, 2022 – December 31, 2022 (calendar year 2022).

Follow up rates for all groups increased significantly in 2022 over 2021, as summarized below:

Race/Ethnicity	2021	2022	% Change
White	28.78%	46.28%	**+17.50%**
African American/Black	15.90%	31.25%	**+15.35%**
Hispanic	20.25%	40.76%	**+20.51%**
American Indian	21.43%	43.75%	**+22.32%**

During 2022 there was a racial disparity between the White population and African American/Black population, even though there was significant improvement in the rates of follow up between both groups.

Integrated Health Initiatives

Certified Community Behavioral Health Centers (CCBHC) and Health Homes

The Certified Community Behavioral Health Center (CCBHC) statewide demonstration pilot launched on October 1, 2021. Three CMHSPs in the MSHN region are currently participating in the CCBHC demonstration pilot including CEI CMH, Saginaw CMH, and The Right Door. The table below depicts total regional enrollment of CCBHC beneficiaries through the end of FY23 Q3:

CCBHC Site	Medicaid Enrolled	Non-Medicaid Enrolled	Total Enrolled
CEI CMH	9,587 (88%)	1,150 (12%)	10,737
Saginaw CMH	3,505 (98%)	69 (2%)	3,574
The Right Door	2,784 (75.5%)	682 (24.5%)	3,466
Total Region	**13,975 (88%)**	**1,901 (12%)**	**15,876**

MDHHS has not provided any guidance for the ratio of Medicaid to Non-Medicaid enrollment for CCBHC services, however statewide across all CCBHC demonstration sites the ratio averages 18% Non-Medicaid to 82% Medicaid. Non-Medicaid enrollment within the MSHN region varies significantly between CCBHC sites, ranging from 2% to 24.5%. MSHN and its CCBHC partners should evaluate the ratio of Medicaid to

Non-Medicaid enrollment given that one of the primary objectives of CCBHCs is to expand access to services for uninsured or underinsured individuals.

Additionally, LifeWays has applied to join the CCBHC demonstration pilot in FY24 and has begun participating in regional CCBHC meetings to prepare for future implementation.

Behavioral Health Homes

The Behavioral Health Home (BHH) initiative launched in the MSHN region beginning on May 1, 2023. Five CMHSPs are currently participating in the Behavioral Health Home initiative including Saginaw CMH, Newaygo CMH, Montcalm Care Network, Shiawassee Health & Wellness, and CMH for Central MI. CMHSPs in the MSHN region may choose to join the BHH initiative at any time. MSHN has established a BHH Certification Process to ensure that new BHH providers meet the Health Home Partner Standards established by MDHHS. The table below depicts total regional enrollment of BHH beneficiaries through the end of FY23 Q3:

BHH Site	**Total Enrolled**
Saginaw CMH	92
Newaygo CMH	0*
Montcalm Care Network	14
Shiawassee Health & Wellness	0*
CMH for Central MI	28
Total Region	**134**

**Newaygo CMH and Shiawassee Health & Wellness have not begun enrolling individuals in BHH at this time. Both are finalizing elements of the BHH program prior to beginning to serve beneficiaries. It is estimated that both BHH sites will begin serving beneficiaries during FY23 Q4.*

Additionally, Bay-Arenac Behavioral Health, Huron Behavioral Health, and Gratiot Integrated Health Network have expressed interest in potentially joining the BHH initiative in FY24 and have begun participating in regional BHH meetings to prepare for future implementation.

Opioid Health Homes

The Opioid Health Home (OHH) initiative launched in the MSHN region beginning on October 1, 2022. Currently Victory Clinical Services in Saginaw is the only OHH provider in the MSHN region. The table below depicts total regional enrollment of OHH beneficiaries through the end of FY23 Q3:

OHH Site	**Total Enrolled**
Victory Clinical Services – Saginaw	207
Total Region	**207**

Additionally, several other agencies have expressed interest in contracting with MSHN to become an Opioid Health Home Partner in FY24. MSHN will be holding an OHH informational meeting for all interested providers during Q4. The focus of the informational meeting will be to provide an overview of the OHH initiative and information regarding requirements to become a Health Home Partner. MSHN maintains an open SUD provider panel and will consider contracting with interested OHH partners that meet the minimum requirements.

Other Population Health and Integrated Care Initiatives

Health Equity & Social Determinants of Health (SDOH)

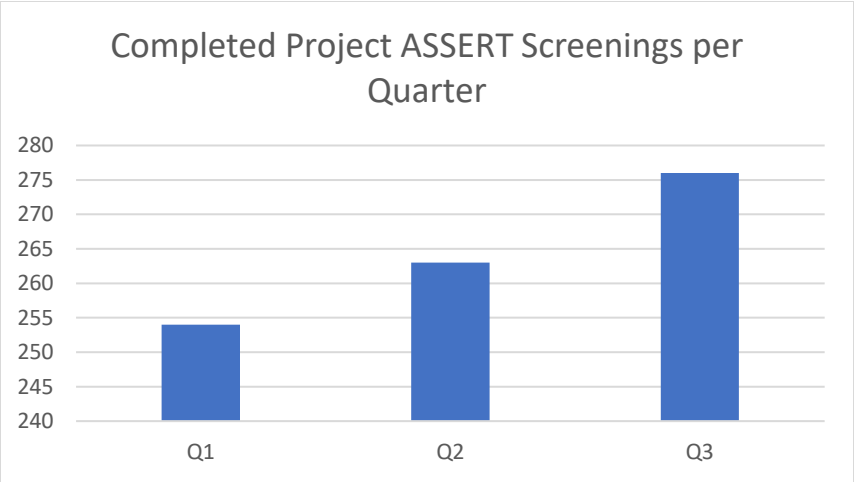
During FY 23 Q2-Q3 MSHN endeavored in a number of tasks toward understanding and addressing issues related to health equity and social determinants of health:

- Developed and hosted the "Equity Upstream" Virtual Lecture Series & Learning Collaborative to reduce racial & ethnic disparities in opioid overdose deaths with national experts to illuminate different perspectives on the landscape of SUD health disparities with an overview of epidemiological trends in the overdose epidemic, as well as what's known about *why* disparities exist (systemic racism, implicit bias, access issues, mistrust of the medical system, cultural issues specific to communities of color, etc.).
- CCBHC, OHH, and BHH providers are required to screen for Social Determinants of Health (SDOH). MSHN is currently exploring options for a regional approach to screening for SDOH

SUD Value Based Purchasing (VBP)

MSHN seeks to increase both the total number of Project ASSERT encounters that occur in hospital Emergency Departments (ED) and the overall rate of follow-up contacts after a person has been to the hospital ED for a drug or alcohol-related concern. The VBP pilot will explore innovative payment strategies that incentivize Project ASSERT providers to increase the rate of follow-up care for individuals who have experienced an ED visit for alcohol or other drugs. MSHN held initial meetings with all Project ASSERT providers during Q1 to review objectives for a VBP Pilot and explore provider willingness to participate. Contract amendments were approved by the MSHN Board of Directors during Q2 and MSHN began hosting joint meetings with Project ASSERT providers on a monthly basis during Q3.

Figure 2: Number of Completed Project ASSERT Screenings per Quarter in FY23



MSHN will evaluate feasibility to scale this pilot project (and potentially others) in future years so that all SUD providers may have an opportunity to earn bonus incentive payments based on meeting or exceeding established performance benchmarks by type of service provided.

Summary & Next Quarter Focus:

Highlights for FY23 Q2-Q3 included:

- Developed and implemented a Behavioral Health Home certification process
- Implementation of BHH on 5/1/2023 with total enrollment of over 134 beneficiaries by 6/30/2023
- Developed draft policy and procedure for health home services, including: New Health Home Provider Policy and Care Plan Monitoring Procedure
- Completed racial/ethnic disparities analysis for MHP/PIHP joint performance metrics (FUH and FUA) with finalized 2022 data provided by MDHHS.
- Conducted FY24 Integrated Health Expansion planning with a focus on expanding CCBHC, BHH, and OHH services in the region

Next Quarter Focus:

- Conduct OHH Informational meeting for potential new OHH partners for FY24
- Increase beneficiary enrollment in all initiatives – CCBHC, BHH, OHH
- Implement new health home care plan monitoring process with BHH providers during FY24 Q4
- Finalize integrated health staffing plan for FY24 to ensure sufficient MSHN staffing for successful monitoring and oversight of the regional integrated health initiatives to meet federal and state requirements.

Project Description:

MDHHS provided a broad focus for the PIP that aligned with the Michigan Comprehensive Quality Strategy. PIHPs are to identify existing racial or ethnic disparities within the region(s) and populations served and determine its plan-specific topic and performance indicator(s). Mid-State Health Network (MSHN) conducted a review of data to identify existing racial or ethnic disparities. The topic was chosen to improve access and engagement with services addressing any racial disparities that exist during the onset of treatment. The MSHN Quality Improvement Council, through consensus chose the following 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 without a decline in the index population rate.

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 covered service within 14 days of completing a biopsychosocial assessment without a decline in performance for the White population? Once the disparity has been statistically eliminated, the elimination of the disparity will need to be maintained throughout the life of the project.

Study Indicators:

Indicator 1: The percentage of new persons who are black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

Numerator: Number (#) of black/African American individuals from the denominator who received a medically necessary ongoing covered services within 14 calendar days of the completion of the biopsychosocial assessment.

Denominator**:**

Number (#) of black/African American individuals who are new and who have received a completed Biopsychosocial Assessment within the Mid State Health Network region and are determined eligible for ongoing services.

Indicator 2: The percentage of new persons who are white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment.

Numerator: Number (#) of white individuals from the denominator who started a medically necessary ongoing covered service within 14 calendar days of the completion of the biopsychosocial assessment.

Denominator**:** Number (#) of white individuals who are new and have received a completed a biopsychosocial assessment within the measurement period and have been determined eligible for ongoing services.

The records submitted for the MMBPIS reporting to MDHHS will be used for both denominators.

Data Source and Collection Method: (Manual/Administrative/Hybrid, Frequency of committee review)
The PIP will utilize administrative data for the analysis. The population includes all Medicaid individuals, adult and children, who are new to services and have received a Biopsychosocial Assessment by the PIHP.
The biopsychosocial must have been completed within the measurement period.
The African American/ Black and the white race and ethnicity will be obtained through the race/ethnicity field included in the 834 file. The 834 file is used to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy to a payer.
The PIHP Michigan Mission Based Performance Indicator System (MMBPIS) Codebook FY20 (Attachment 2) is being utilized to identify the eligible population. See the R5_MSHN_MI2021-22_PIHP-PIOP Val_Re Submission Form for more specific information.

Figure 1: Timelines for reporting

Time Period of Report Cumulative data compared to baseline	**Data Due to MSHN** (if applicable)	**Date Reviewed in Committee/Council**	**Date Due to MDHHS** (if applicable)
CY21 Baseline	NA	May/June	June 30th 2022
CY22 (1/1/2022-12/31/2022)	NA	April/May/June	June 30th 2023
CY23Q2 (1/1/2023-06/30/2023)	March	August	NA
CY23 (1/1/2023-12/31/2023)	TBD	April/May/June	June 30th 2024
CY24Q2 (1/1/2023-06/30/2023)	March	August	NA
CY24 (1/1/2024-12/31/2024)	TBD	April/May/June	June 30th 2025

Data Analysis:(Compare each period to CY2021
Figure 2: Longitudinal data of those who received a medically necessary service within 14 days of a completed biopsychosocial assessment.

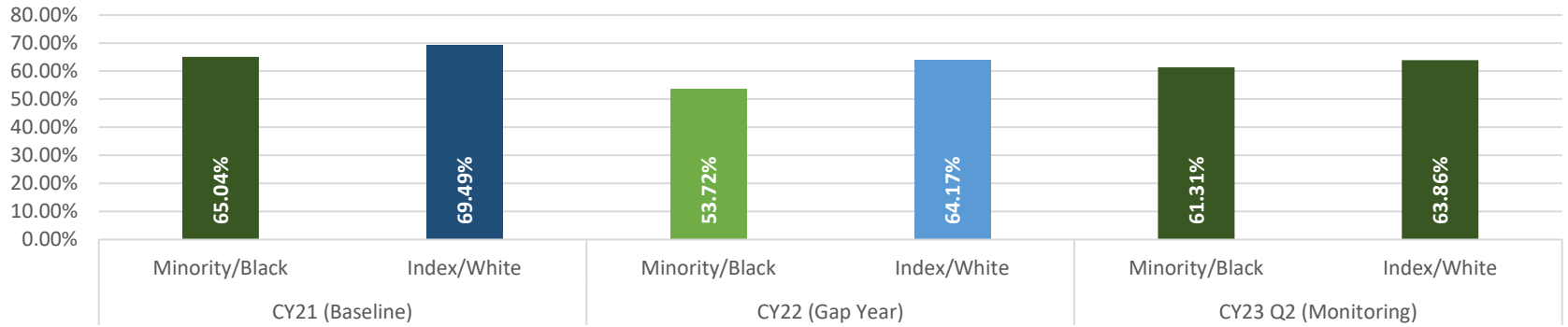


Figure 3: Performance for each measurement period with testing when applicable

Indicator 1 Title: The percentage of new persons who are black/African American and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment						
Measurement Period	**Indicator Measurement**	**Numerator**	**Denominator**	**Percentage**	**Mandated Goal or Target, if applicable**	**Statistical Test Used, Statistical Significance, and *p* Value**
01/01/2021–12/31/2021	Baseline	852	1310	65.04%	N/A for baseline	Fisher's Exact Test Statistically lower than the index white group p-value=0.0015
01/01/2022-12/31/2022	Gap Year	729	1357	53.72%	=>68.48%	
01/01/2023 - 3/31/2023	Monitoring	439	716	61.31%	=>68.48%	
01/01/2023 - 6/30/2023	Monitoring					
01/01/2023 – 9/30/2023	Monitoring					
01/01/2023–12/31/2023	Remeasurement 1				=>68.48%	
01/01/2024–12/31/2024	Remeasurement 2					
Indicator 2 Title: The percentage of new persons who are white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment						
Time Period	**Indicator Measurement**	**Numerator**	**Denominator**	**Percentage**	**Mandated Goal or Target , if applicable**	**Statistical Test, Statistical Significance, and *p* Value**
01/01/2021-12/31/2021	Baseline	5655	8138	69.49%	N/A for baseline	Reference
01/01/2022-12/31/2022	Gap Year	5994	9341	64.17%	=>69.49%	
01/01/2023 - 3/31/2023	Monitoring	3163	4953	63.86%	=>69.49%	
01/01/2023 - 6/30/2023	Monitoring					
01/01/2023 – 9/30/2023	Monitoring					
01/01/2023–12/31/2023	Remeasurement 1				=>69.49%	
01/01/2024–12/31/2024	Remeasurement 2					

Follow Up to Data Analysis:

Factors affecting the validity of the baseline and future remeasurement findings:

- Individuals who were unsure about their race/ethnicity or responded with unknown.
- Changes in utilization of telehealth services from CY2021 to CY2023
- Modifications to the specification documents (MMBPIS)
- Modification of the race and ethnicity field within the 834
- The termination of the public health emergency (PHE). The PHE expired at the end of the day May 11, 2023. Michigan has begun the unwinding phase. Medicaid policies have been developed to "unwind" policies that were implemented during the pandemic. Table 1 identifies specific action and policies that are impacted.

Figure 4: MDHHS Policy Impact Analysis Grid

PHE Temporary Bulletin	PHE Unwind Policy Action	Impact on Project
MSA 20-13	MMP 23-10	Telemedicine utilization (include summary of trends)
MSA 20-19	MMP 23-30	The number of enrollees whose data has been included within the baseline data.
MSA 20-28	MMP 22-38	The number of enrolled providers and individuals qualified who are available to provide services.
MSA 20-12	MMP 23-20	The number of those who have completed an assessment and consented to additional treatment through verbal communication.

The factors identified will be assessed at times of the said changes. Processes will be put in place to ensure minimal, if any, impact on the data used for the project. No other factors that might threaten the comparability of the measurement periods were identified.

Findings:

The rate of access to services for Index/White population group has demonstrated a downward trend from the baseline year as indicated in the Figure 1. The Black/African American population group increased from CY22. Attachment 1 includes the CMHSP counts and rates of those who qualify for inclusion in this project. The area within MSHN that has the largest Black/African American population group is CEI (275) Saginaw (225), Lifeways (87), CMCMH (52), and BABH (38). Interventions are focused primarily in those areas to have the largest impact.

Recommendations:

Implement interventions identified through the Fishbone Diagram.
Develop a standard report for ongoing monitoring.

Figure 5: Barrier Intervention Grid

Priority Ranking	Barrier Description	Intervention Description	Initiation Date	Status	Intervention Type
1	Workforce shortage-Lack of qualified - culturally competent clinicians resulting in limited available appointments within 14 days.	• Recruit student interns and recent graduates from colleges and universities with diverse student populations. • Utilize external contractors to provide services.	10/1/2022	New	Provider Intervention
2	No shows-lack of appointment follow up	• Implement appointment reminder system. • Implement/modify process for coordination between providers (warm hand off)	10/1/2022	New	Provider Intervention
3	Minority Groups are not aware of services offered	• Identify and engage with partner organizations that predominantly serve communities of color. (examples: faith- based/religious groups, community recreation centers, tribal organizations, etc) • Distribute CMHSP informational materials to individuals through identified partner organizations within communities of color.	10/1/2023	New	Provider
4	Lack of insight into what resources and community partners are available to address disparities.	• Identify survey/assessments/data sources to evaluate resources/community partners to address disparities within the local community. • Conduct assessment/survey to clearly identify community partners and resources available to address disparities within communities that demonstrate a significant disparity.	10/1/2023	New	Provider Intervention
5	Workforce shortage-Lack of qualified - culturally competent clinicians resulting in limited available appointments within 14 days.	• Conduct feasibility study to collect information from CMHSPs and SUD Providers regarding specific cultural competency requests.	12/31/2022	New	System
6	Insufficient data to identify Social Determinants of Health (SDOH) such as inadequate Housing, food insecurity, transportation needs, employment/income	• Develop system to effectively collect SDOH for individuals served. • Develop system to regionally analyze SDOH and develop action steps.	6/1/2024 11/1/2024	New New	Provider System

Attachment 1

	CY21			CY22			CY23Q2		
	In-Compliance	Grand Total	Rate	In-Compliance	Grand Total	Rate	In Compliance	Grand Total	Rate
Bay-Arenac									
Black (Non-Hispanic)	41	69	59.42%	38	64	59.38%	24	38	63.16%
White (Non-Hispanic)	560	820	68.29%	649	897	72.35%	328	476	68.91%
Unknown	67	103	65.05%	53	74	71.62%	84	121	69.42%
CEI									
Black (Non-Hispanic)	254	500	50.80%	279	574	48.61%	178	275	64.73%
White (Non-Hispanic)	746	1320	56.52%	764	1477	51.73%	509	772	65.93%
Unknown	118	232	50.86%	130	231	56.28%	151	228	66.23%
Central MI									
Black (Non-Hispanic)	39	59	66.10%	74	105	70.48%	40	52	76.92%
White (Non-Hispanic)	1076	1471	73.15%	1681	2250	74.71%	789	1070	73.74%
Unknown	104	145	71.72%	125	173	72.25%	180	235	76.60%
Gratiot									
Black (Non-Hispanic)	7	11	63.64%	9	13	69.23%	6	8	75.00%
White (Non-Hispanic)	374	463	80.78%	373	474	78.69%	185	245	75.51%
Unknown	21	27	77.78%	22	28	78.57%	28	37	75.68%
Huron									
Black (Non-Hispanic)	1	3	33.33%		3	0.00%	1	2	50.00%
White (Non-Hispanic)	126	177	71.19%	143	240	59.58%	74	122	60.66%
Unknown	14	19	73.68%	14	20	70.00%	12	27	44.44%
Ionia									
Black (Non-Hispanic)	8	12	66.67%	5	10	50.00%	4	9	44.44%
White (Non-Hispanic)	399	555	71.89%	443	716	61.87%	270	487	55.44%

Unknown	45	71	63.38%	34	55	61.82%	50	90	55.56%
LifeWays									
Black (Non-Hispanic)	87	155	56.13%	33	141	23.40%	26	87	29.89%
White (Non-Hispanic)	568	1011	56.18%	270	894	30.20%	161	535	30.09%
Unknown	93	174	53.45%	29	125	23.20%	64	196	32.65%
Montcalm									
Black (Non-Hispanic)	15	16	93.75%	13	19	68.42%	8	12	66.67%
White (Non-Hispanic)	438	604	72.52%	477	717	66.53%	287	415	69.16%
Unknown	49	70	70.00%	57	73	78.08%	37	57	64.91%
Newaygo									
Black (Non-Hispanic)	14	18	77.78%	15	20	75.00%	2	4	50.00%
White (Non-Hispanic)	361	497	72.64%	377	574	65.68%	150	268	55.97%
Unknown	46	69	66.67%	63	80	78.75%	61	94	64.89%
Saginaw									
Black (Non-Hispanic)	373	453	82.34%	252	395	63.80%	147	225	65.33%
White (Non-Hispanic)	554	683	81.11%	317	513	61.79%	203	301	67.44%
Unknown	77	93	82.80%	43	65	66.15%	52	98	53.06%
Shiawassee									
Black (Non-Hispanic)	9	10	90.00%	4	6	66.67%	3	4	75.00%
White (Non-Hispanic)	239	305	78.36%	269	334	80.54%	98	141	69.50%
Unknown	22	31	70.97%	16	18	88.89%	21	29	72.41%
Tuscola									
Black (Non-Hispanic)	4	4	100.00%	7	7	100.00%	0	0	
White (Non-Hispanic)	214	232	92.24%	231	255	90.59%	109	121	90.08%
Unknown	26	30	86.67%	28	30	93.33%	37	41	90.24%

Attachment 2

PIP Team

Project Sponsor (Provide/Approve Resources)

- Amanda Ittner-Deputy Director

Process Owner (Person responsible for continued implementation/maintenance of the project)

- Paul Duff-Integrated Care Coordinator

Quality Improvement Experience (Formal training or experience with QI initiatives)

- Sandy Gettel-Quality Manager
- QIC

Technical/Clinical Expertise-(Subject matter experts relative to the project)

- Technical-Joe Wager/Ron Meyer
- Clinical-Skye Pletcher Chief Population Health Officer
- Integrated Care/UM

Consumer Experience (Person who represents the consumer point of view)

- Dani Meier Chief Clinical Officer
- REACH

Knowledge of Process/System- (Person who are impacted-include differing perspectives)

-

MSHN
Mid-State Health Network

Quality Improvement Council
Penetration Rate-Reduction of Disparities

Project Description:

The Performance Improvement Project (PIP) was chosen by the PIHP based on the needs of the population served, previous measurement and analysis of process, satisfaction, and/or outcome trends that may have an impact on the quality of service provided. Mid-State Health Network (MSHN) conducted a review of data to identify existing racial or ethnic disparities. The Non-clinical Performance Improvement Project will address access to services for the largest historically marginalized group, Black/African American, within the MSHN region. The identification of barriers for access to services for this group will result in action, ensuring all Black/African American individuals served have the same opportunities to be healthy both mentally and physically. The MSHN Quality Improvement Council, through consensus, recommended this topic to Operations Council for approval. Operations Council supported the PIP topic for 2022-2025. The goal of the indicator is to reduce or eliminate racial or ethnic disparities between the African American/Black minority penetration rate and the index (white) penetration rate.

Study Question 1:

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 of those who are eligible for Medicaid services?

Study Indicators:

Numerator: The number of unique Medicaid eligible individuals who are black/African American and have received a PIHP managed service. (CMHSPs Combined)

Numerator: The number of unique Medicaid eligible individuals who are white and have received a PIHP managed service. (CMHSPs Combined)

Denominator**:**

The number of unique Medicaid eligible individuals within the Mid State Health Network region. (CMHSPs Combined)

Data Source and Collection Method: (Manual/Administrative/Hybrid, Frequency of committee review)

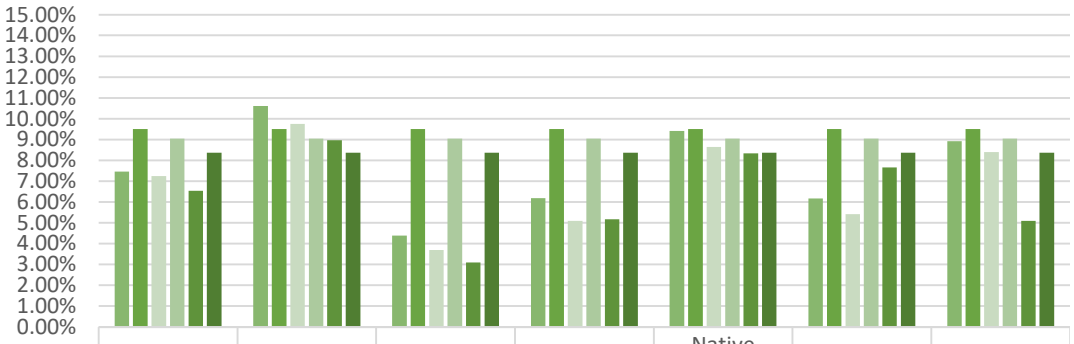
The PIP will utilize administrative data for the analysis. The data source will be a standard report within REMI which includes a programmed pull from claims/encounters and the 834 eligibility files. The estimated percentage of reported administrative data completeness at the time the data are generated is 95% complete.

Time Period of Report	Data Due to MSHN	Date Reviewed in Committee	Date Due to MDHHS
CY21 Baseline	NA	August	NA
CY22 (1/1/2022-12/31/2022)	NA	March	NA
CY23Q2 (1/1/2023-06/30/2023)	NA	August	NA
CY23 (1/1/2023-12/31/2023)	NA	March	NA

Data Analysis: (Compare each period to CY2021)

Measurement Period		Rate	Numerator	Denominator	Test used if applicable
CY21 Baseline	Index-White	9.51	35,532	373,783	
	Minority-African American/Black	7.45	5,236	70,267	
CY22	Index-White	9.04	34,891	385,878	
	Minority-African American/Black	7.24	5,241	72,377	
CY23Q3	Index-White	8.36	31731	379,529	
	Minority-African American/Black	6.54	4743	72,518	
CY23	Index-White				
	Minority-African American/Black				

Figure 1: MSHN-CMHSP Penetration Rates



	African American/ Black	American Indian/ Alaska Native	Asian American	Hispanic	Native Hawaiian & Other Pacific Islander	Unknown	Total
CY 21Minority Penetration Rate	7.45%	10.61%	4.39%	6.19%	9.40%	6.17%	8.92%
CY21 Index/White Penetration Rate	9.51%	9.51%	9.51%	9.51%	9.51%	9.51%	9.51%
CY22 Minority Penetration Rate	7.24%	9.75%	3.70%	5.08%	8.64%	5.42%	8.40%
CY22 Index/White Penetration Rate	9.04%	9.04%	9.04%	9.04%	9.04%	9.04%	9.04%
CY 23Q3 Minority Penetration Rate	6.54%	8.96%	3.09%	5.16%	8.33%	7.65%	5.09%
CY 23Q3 Index/White Penetration Rate	8.36%	8.36%	8.36%	8.36%	8.36%	8.36%	8.36%

Follow Up to Data Analysis:

Improvement Strategies					
Barrier Priority Ranking	**Barrier Description**	**Intervention Initiation Date (MM/YY)**	**Intervention Description**	**Intervention Status**	**Member, Provider, or System Intervention**
4	Lack of insight into what resources and community partners are available to address disparities.	10/1/2023	• Identify survey/assessments/data sources to evaluate resources/community partners to address disparities within the local community. • Conduct assessment/survey to clearly identify community partners and resources available to address disparities within those communities that demonstrate a significant disparity.	New	Provider Intervention
2	No shows-lack of appointment follow up	10/1/2022	• Implement appointment reminder system. • Implement/modify process for coordination between providers (warm hand off)	New	Provider Intervention

1	Workforce shortage-Lack of qualified -culturally competent clinicians resulting in inadequate limited available appointments within 14 days.	10/1/2022	• Recruit student interns and recent graduates from colleges and universities with diverse student populations. • Utilize external contractors to provide services.	New	Provider Intervention
5	Workforce shortage-Lack of qualified -culturally competent clinicians resulting in limited available appointments within 14 days.	12/31/2022	• Conduct feasibility study to collect information from CMHSPs and SUD Providers regarding specific cultural competency requests.	New	System
3	Minority Groups are not aware of services offered	10/1/2023	• Identify and engage with partner organizations that predominantly serve communities of color. (examples: faith-based/religious groups, community recreation centers, tribal organizations, etc) • Distribute CMHSP informational materials to individuals through identified partner organizations within communities of color.	New	Provider
6	Insufficient data to identify Social Determinants of Health (SDOH) such as inadequate Housing, food insecurity, transportation needs, employment/income challenges	6/1/2024 11/1/2024	• Develop system to effectively collect SDOH for individuals served. • Develop system to regionally analyze SDOH and develop action steps.	New New	Provider System

Best Practice (Share process/experience)	**Who**

Any Additional Follow Up/Attachments:
Attachment 1: MSHN Penetration Rate Comparisons
Attachment 2: CMHSP Penetration Rate FY23Q3

Completed by: Sandy Gettel Quality Manager **Date**: 11/14/2023
Reviewed/Approved by: Click or tap here to enter text. **Date:**

Attachment 1

CY2021	Total Population	Total Consumers Served	CY 21 Minority Penetration Rate	CY21 Index/White Penetration Rate
CMHSPs Combined				
African American / Black	70267	5236	7.45%	9.51%
American Indian / Alaska Native	7078	751	10.61%	9.51%
Asian American	3147	138	4.39%	9.51%
Hispanic	29710	1838	6.19%	9.51%
Native Hawaiian & Other Pacific Islander	553	52	9.40%	9.51%
Unknown	40486	2497	6.17%	9.51%
Total (all race/ethnicity combined)	487464	43489	8.92%	9.51%
White	373783	35532	9.51%	9.51%
CY2022	**Total Population**	**Total Consumers Served**	**CY22 Minority Penetration Rate**	**CY22 Index/White Penetration Rate**
CMHSPs Combined CY22				
African American/ Black	72377	5241	7.24%	9.04%
American Indian/Alaska Native	7545	736	9.75%	9.04%
Asian American	2976	110	3.70%	9.04%
Hispanic	472	24	5.08%	9.04%
Native Hawaiian & Other Pacific Islander	579	50	8.64%	9.04%
Unknown	39411	2136	5.42%	9.04%
Total (all race/ethnicity combined)	518303	43555	8.40%	9.04%
White (Non-Hispanic)	385878	34891	9.04%	9.04%
CY23Q3	**Total Population**	**Total Consumers Served**	**CY22 Minority Penetration Rate**	**CY22 Index/White Penetration Rate**
CMHSPs Combined CY23Q3				
African American/ Black	72518	4743	6.54%	8.36%
American Indian/Alaska Native	7175	643	8.96%	8.36%
Asian American	4234	131	3.09%	8.36%
Hispanic	36475	1883	5.16%	8.36%
Native Hawaiian & Other Pacific Islander	660	55	8.33%	8.36%
Total (all race/ethnicity combined)	531169	40651	7.65%	8.36%
Unknown	36393	1852	5.09%	8.36%
White (Non-Hispanic)	379529	31731	8.36%	8.36%

Attachment 2

MSHN
Mid-State Health Network

Quality Improvement Council
Penetration Rate-Reduction of Disparities

Organization	Total Population	Total Served	Penetration Rate
CMHSPs Combined	**1068153**	**81689**	**7.65%**
African American/ Black	**72518**	**4743**	**6.54%**
American Indian/Alaska Native	7175	643	8.96%
Asian American	4234	131	3.09%
Hispanic	36475	1883	5.16%
Native Hawaiian & Other Pacific Islander	660	55	8.33%
Total (all race/ethnicity combined)	531169	40651	7.65%
Unknown	36393	1852	5.09%
White (Non-Hispanic)	**379529**	**31731**	**8.36%**
Bay-Arenac	**81788**	**8816**	**10.78%**
African American/ Black	**1991**	**225**	**11.30%**
American Indian/Alaska Native	545	59	10.83%
Asian American	123	2	1.63%
Hispanic	2674	219	8.19%
Native Hawaiian & Other Pacific Islander	35	2	5.71%
Total (all race/ethnicity combined)	40714	4394	10.79%
Unknown	2014	139	6.90%
White (Non-Hispanic)	**33692**	**3776**	**11.21%**
CEI	**275288**	**16329**	**5.93%**
African American/ Black	**30555**	**1711**	**5.60%**
American Indian/Alaska Native	1822	134	7.35%
Asian American	2908	66	2.27%
Hispanic	13608	568	4.17%
Native Hawaiian & Other Pacific Islander	222	14	6.31%
Total (all race/ethnicity combined)	136928	8115	5.93%
Unknown	11498	510	4.44%
White (Non-Hispanic)	**77747**	**5211**	**6.70%**
Central MI	**179116**	**16234**	**9.06%**
African American/ Black	**3140**	**297**	**9.46%**
American Indian/Alaska Native	2120	183	8.63%
Asian American	321	22	6.85%
Hispanic	3436	233	6.78%
Native Hawaiian & Other Pacific Islander	135	16	11.85%
Total (all race/ethnicity combined)	89134	8087	9.07%
Unknown	4987	265	5.31%
White (Non-Hispanic)	**75843**	**7131**	**9.40%**
Gratiot	**28254**	**2973**	**10.52%**
African American/ Black	**298**	**33**	**11.07%**
American Indian/Alaska Native	168	34	20.24%
Asian American	43	4	9.30%
Hispanic	1099	84	7.64%
Native Hawaiian & Other Pacific Islander	11	1	9.09%
Total (all race/ethnicity combined)	14073	1480	10.52%
Unknown	597	49	8.21%
White (Non-Hispanic)	**11965**	**1288**	**10.76%**

Organization	Total Population	Total Served	Penetration Rate
Huron	**18523**	**1872**	**10.11%**
African American/ Black	**96**	**10**	**10.42%**
American Indian/Alaska Native	88	13	14.77%
Asian American	17	2	11.76%
Hispanic	328	23	7.01%
Native Hawaiian & Other Pacific Islander	3	0	0.00%
Total (all race/ethnicity combined)	9227	934	10.12%
Unknown	374	19	5.08%
White (Non-Hispanic)	**8390**	**871**	**10.38%**
Ionia	**37122**	**4056**	**10.93%**
African American/ Black	**363**	**32**	**8.82%**
American Indian/Alaska Native	190	28	14.74%
Asian American	41	4	9.76%
Hispanic	1070	93	8.69%
Native Hawaiian & Other Pacific Islander	21	1	4.76%
Total (all race/ethnicity combined)	18486	2024	10.95%
Unknown	1159	81	6.99%
White (Non-Hispanic)	**15792**	**1793**	**11.35%**
LifeWays	**141717**	**10671**	**7.53%**
African American/ Black	**8687**	**586**	**6.75%**
American Indian/Alaska Native	758	69	9.10%
Asian American	258	9	3.49%
Hispanic	2850	143	5.02%
Native Hawaiian & Other Pacific Islander	52	4	7.69%
Total (all race/ethnicity combined)	70302	5301	7.54%
Unknown	6240	363	5.82%
White (Non-Hispanic)	**52570**	**4196**	**7.98%**
Montcalm	**46975**	**4516**	**9.61%**
African American/ Black	**362**	**48**	**13.26%**
American Indian/Alaska Native	287	31	10.80%
Asian American	36	2	5.56%
Hispanic	1016	75	7.38%
Native Hawaiian & Other Pacific Islander	20	3	15.00%
Total (all race/ethnicity combined)	23377	2253	9.64%
Unknown	1411	68	4.82%
White (Non-Hispanic)	**20466**	**2036**	**9.95%**
Newaygo	**39358**	**3497**	**8.89%**
African American/ Black	**408**	**40**	**9.80%**
American Indian/Alaska Native	265	37	13.96%
Asian American	43	4	9.30%
Hispanic	1415	76	5.37%
Native Hawaiian & Other Pacific Islander	9	0	0.00%
Total (all race/ethnicity combined)	19590	1742	8.89%
Unknown	858	55	6.41%
White (Non-Hispanic)	**16770**	**1543**	**9.20%**

Organization	Total Population	Total Served	Penetration Rate
Saginaw	**153105**	**10340**	**6.75%**
African American/ Black	**26597**	**1795**	**6.75%**
American Indian/Alaska Native	616	53	8.60%
Asian American	347	13	3.75%
Hispanic	8158	343	4.20%
Native Hawaiian & Other Pacific Islander	128	11	8.59%
Total (all race/ethnicity combined)	76108	5138	6.75%
Unknown	5141	222	4.32%
White (Non-Hispanic)	**36010**	**2765**	**7.68%**
Shiawassee	**46174**	**2477**	**5.36%**
African American/ Black	**357**	**26**	**7.28%**
American Indian/Alaska Native	253	10	3.95%
Asian American	76	2	2.63%
Hispanic	668	33	4.94%
Native Hawaiian & Other Pacific Islander	23	0	0.00%
Total (all race/ethnicity combined)	23003	1235	5.37%
Unknown	1174	46	3.92%
White (Non-Hispanic)	**20620**	**1125**	**5.46%**
Tuscola	**38038**	**2359**	**6.20%**
African American/ Black	**376**	**31**	**8.24%**
American Indian/Alaska Native	195	15	7.69%
Asian American	40	2	5.00%
Hispanic	664	41	6.17%
Native Hawaiian & Other Pacific Islander	10	4	40.00%
Total (all race/ethnicity combined)	18925	1175	6.21%
Unknown	1270	56	4.41%
White (Non-Hispanic)	**16558**	**1035**	**6.25%**

Attachment 3

PIP Team

Project Sponsor (Provide/Approve Resources)

- Amanda Ittner-Deputy Director

Process Owner (Person responsible for continued implementation/maintenance of the project)

- Paul Duff-Integrated Care Coordinator

Quality Improvement Experience (Formal training or experience with QI initiatives)

- Sandy Gettel-Quality Manager
- QIC

Technical/Clinical Expertise-(Subject matter experts relative to the project)

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- Clinical-Skye Pletcher Chief Population Health Officer
- Integrated Care/UM

Consumer Experience (Person who represents the consumer point of view)

- Dani Meier Chief Clinical Officer
- REACH

Knowledge of Process/System- (Person who are impacted-include differing perspectives)

-

Quality Assessment Performance Improvement Program
Quality Improvement Council – Critical Incidents

Overview

Mid-State Health Network values the safety of the individuals served within the MSHN Provider Network. The Quality Assessment and Performance Improvement Program(QAPIP) outlines a process for monitoring and reviewing adverse events that put individuals served at risk. The review and monitoring of adverse events will assist in identifying the underlying causes and implementing changes to prevent recurrence and increase the safety of the individual served.

Adverse Events include any event that is inconsistent with or contrary to the expected outcomes of the organization's functions that warrant additional review. A subset of the adverse events will qualify as "reportable events" in accordance with the Michigan Department of Health and Human Services (MDHHS) Critical Incident and Event Notification Technical Requirement. MDHHS defined events include sentinel events, critical incidents, and risk events.

MSHN ensures that the MSHN Provider Network has a system in place to monitor these events and utilize staff with appropriate credentials for the scope of care, for review and/or follow up within the required timeframes. The following bullets outline the responsibilities of both the MSHN region and the MSHN Provider Network.

- 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. Beginning in FY23 the reporting system transitioned to the Behavioral Health (BH) Customer Relationship Management System (CRM) from the MPHI PIHP Warehouse.
- 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 MSHN Provider Network.
- The MSHN Provider Network is responsible for reviewing critical incidents to determine if the incident is sentinel. 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.
    - The Community Mental Health Service Program (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.[1] 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.
- The MSHN Provider Network, based on the root cause analysis/ investigation, 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

[1] Quality-Critical Incidents

program/committee responsible for implementation and oversight, timelines, and strategies for measuring the effectiveness of the action. [2]

- The MSHN Provider Network is 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.
- The CMHSP Participants monitor risk events 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.
- MSHN provides oversight and monitoring of the MSHN Provider Network 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 MDHHS BH CRM currently does not have reporting functions. The source of the information in this report is from MSHN REMI Critical Incident Standard Report. Changes in the events that are reported through the critical incident reporting system are indicated below in red font for additions and strike through font for deletions.

The following events are reported by the CMHSP Participants for population subsets based on event.

- Deaths-Suicide (All)
- Non-Suicide- Subsets of deaths include natural cause, accidental, homicidal.
- Unknown Cause of Death (New FY23)-Any death that cannot be determined as suicide or natural cause without additional information. This event type can be updated when cause of death is confirmed.
- Emergency Medical Treatment-Subsets include medication error and injury.
- Hospitalization- Subsets include medication error and injury.
- Arrest

This performance summary will be used to

- review performance
- identify areas of improvement

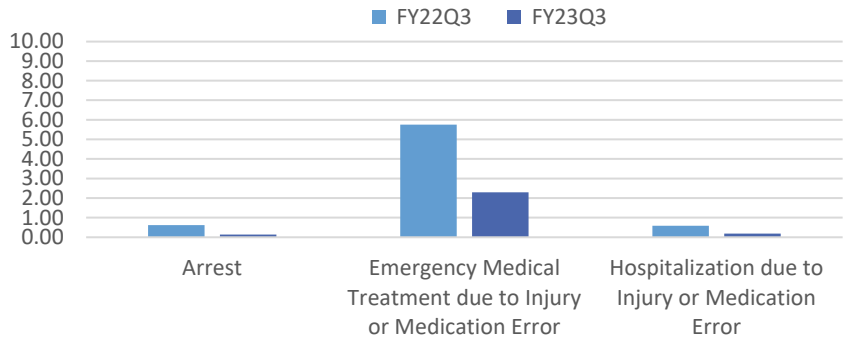
[2] Quality-Sentinel Events

Performance Summary

Outcome Goals:

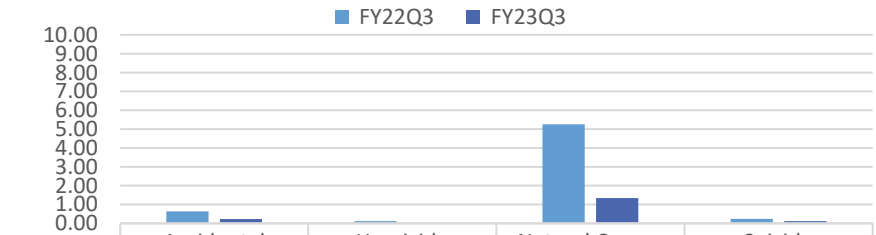
1. MSHN will demonstrate a decrease in the rate of critical incidents, excluding deaths from the previous year. Critical Incidents include an arrest, emergency medical treatment/hospitalization for an injury or medication error for individuals who are receiving a waiver service.

Figure 1: CIRS-Critical Events excluding Deaths.Cumulative rate per 1000 unique consumers served.



2. MSHN will demonstrate a decrease in the rate of Suicide Deaths and Non-Suicide Deaths from the previous year.
   The non-suicide deaths are broken down into three sub types which include: death of unknown cause, accidental, homicidal, natural cause.

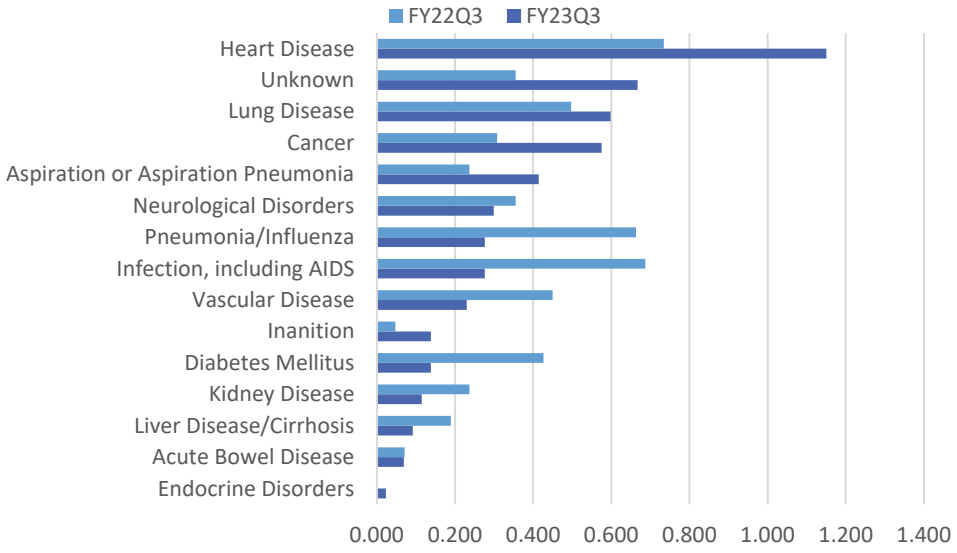
Figure 2: CIRS-Deaths. Cumulative Rate per 1000 unique consumers served.



	Accidental	Homicide	Natural Causes	Suicide
FY22Q3	0.639	0.118	5.258	0.237
FY23Q3	0.232	0.000	1.343	0.116

Natural cause deaths are those that have been diagnosed and treatment has been received. The leading cause of death was heart disease followed by lung disease and cancer. The largest decreases in rate were pneumonia/influenza, infection including AIDS, and diabetes mellitus.

Figure 3: CIRS-Natural Cause Death. Rate per 1000 unique consumers served FY23Q3 (cumulative).



Barriers:

- CMHSPs are requesting death certificates to verify the cause of death for accurate reporting and interventions. This has resulted in a delay in reporting, and additional cost. County offices are charging different amounts for the request of a death certificate.
- CMHSPs are required to make a Best Judgement determination if a cause of death cannot be determined by a medical examiner within 90 days after the event. A best judgment determination may not be possible due to limited information available to the medical directors.

Recommendations:

Performance

- MSHN to identify shifts in data using control limits, that require additional analysis. *Status: Initiated.*
- MSHN QIC and CMHSPs should review unexpected and accidental deaths to identify specifically the cause of death such as drug related, accidental overdose, or any other cause that may benefit from an intervention. *Status: In Progress. The new reporting system includes a category for overdose deaths for SUDTP. A recommendation has been made to include this category for the CMHSP Participants in addition to the SUDTP.*
- Review with regional medical directors for additional insight and recommendations related to death data. *Status: Initiated*

Prepared by: Sandy Gettel, Quality Manager **Date:** 10/20/2023
Distributed to: MSHN QIC **Date:** 10/26/2023

Attachment 1

MSHN
Mid-State Health Network

Quality Assessment Performance Improvement Program
Quality Improvement Council – Critical Incidents

Table 1. Number of Critical Event Types YTD per CMHSP (FY23Q3)

FY23Q3 YTD	MSHN	BABH	CEI	CMHCM	GIHN	HBH	Right Door	LifeWays	MCN	NCMH	SCCMHA	SHW	TBHS
Arrest	**26**	**1**		**5**			**1**	**3**	**7**		**7**	**2**	
Death of Unknown Cause	**3**		**1**	**1**							**1**		
Emergency Medical Treatment	**277**	**20**	**61**	**44**	**10**	**6**	**2**	**44**	**13**	**8**	**46**	**11**	**12**
Injury	273	19	61	44	10	6	2	44	13	8	43	11	12
Medication Error	4	1									3		
Hospitalization	**16**	**1**	**1**	**9**				**2**	**2**		**1**		
Injury	16	1	1	9				2	2		1		
Non-Suicide Death	**255**	**27**	**47**	**48**	**4**	**9**	**14**	**33**	**10**	**11**	**42**	**9**	**1**
Accidental	34	4	6	3			4	5			10	2	
Homicide	1		1										
Natural Causes	220	23	40	45	4	9	10	28	10	11	32	7	1
• Acute Bowel Disease	3	1	1					1					
• Aspiration/Aspiration Pneumonia	18	2	7	6	2				1				
• Cancer	25	6	1	4			3		2	2	6	1	
• Diabetes Mellitus	6		6										
• Endocrine Disorders	1			1									
• Heart Disease	50	5	5	10	2		1	14	1		9	3	
• Inanition	6			1				3			2		
• Infection, including AIDS	12	3	2	3			1				3		
• Kidney Disease	5			1							4		
• Liver Disease/Cirrhosis	4			1			2				1		
• Lung Disease	26	2	6	5		1		4	2	2	4		
• Neurological Disorders	13	1		6			1	1		1	1	1	1
• Pneumonia/Influenza	12	2	3	2		1			1		2	1	
• Unknown	29		5	4		7	2	4	3	4			
• Vascular Disease	10	1	4	1				1		2		1	
Serious Challenging Behaviors(SUD Only)	**1**		**1**										
Suicide	**9**		**1**	**3**				**1**	**1**		**3**		
Overdose Death	2			1							1		
Suicide	7		1	2				1	1		2		
Grand Total	**587**	**49**	**112**	**110**	**14**	**15**	**17**	**83**	**33**	**19**	**100**	**22**	**13**

Data Pull Dates FY20, FY21 9/15/2022; FY22 11/16/2022; FY23 3/24/2023; FY23Q3 10/19/2023

Quality Assessment Performance Improvement Program
Quality Improvement Council – Critical Incidents Process Improvement Summary

Problem:
Beginning in FY23 the Critical Incident Reporting System transitioned to the Behavioral Health (BH) Customer Relationship Management System (CRM) from the MPHI PIHP Warehouse. The CMHSP participants submit required events, event subtypes, and event subtype qualifiers through REMI Affiliate Uploads utilizing a webservice based on the specifications provided by MDHHS. Job Aides have been provided with instructions on how to directly enter data into the BHCRM-Critical incident Reporting System. The MDHHS Critical incident Reporting and Event Notification has not yet been updated to include new Event Types, guidance documents have been removed from the MDHHS website, and the MDHHS BH CRM currently does not have reporting functions. MDHHS continues to work to identify and improve technical issues and functionality of the BH CRM. The source of the information in this report is from MSHN REMI Critical Incident Standard Report. Changes in the events that are reported through the critical incident reporting system are indicated below in red font for additions and strike through font for deletions.
The following incidents are reported by the CMHSP Participants:

- Deaths-Suicide
- Non-Suicide- Subsets of deaths include natural cause, accidental, homicidal.
- Management, ACT, Home-Based, and Wraparound.
- Unknown Cause of Death (New FY23)-Any death that cannot be determined as suicide or natural cause. This event type can be updated when cause of death is confirmed.
- Emergency Medical Treatment-Subsets include medication error and injury.
- Hospitalization- Subsets include medication error and injury.
- Arrest

Aim: MSHN in coordination with the CMHSP Participants will reduce the number of failed submissions, events submitted outside of the required timeframes, and remediations completed outside of the required timeframes from year 1(FY23) to year 2(FY24).

Interventions: See attachment 2 for full list of barriers and ongoing interventions with status.

- Validate/reconcile the submitted data.
  Action:
  - Update overdose deaths. (CMHSP upload new record, PIHP request edit and make change)
  - Request a validation in REMI to reject Serious Challenging Behaviors. Include in policy/procedure.
- Monitor failed and successful submissions.
  Action:
  - Discuss options with MDHHS/PCE for updating the Failed status once it has been resolved.
  - Request validation in REMI to reject natural Cause Deaths with sub type qualifier-Unknown.
  - Report Natural Cause Deaths as Death of Unknown Cause-which allows for updates to be made through the web service.
- Monitor reporting timelines.
  Action:
  - MSHN to develop timeliness dashboard report in REMI. *Status: Planning. Timestamps are present in the new reporting system to track updates made to death reporting etc. this has significantly decreased the timeliness issues.*

Data Pull Dates FY20, FY21 9/15/2022; FY22 11/16/2022; FY23 3/24/2023; FY23Q3 10/19/2023

- Monitor remediations and remediation timelines and,
  Action: Develop a process to ensure remediations are provided within the required timeframe.
  - The PIHP to forward the request to the CMHSP via email. (On hold) Currently default email is set to the contact person.
  - Provide CMHSPs access.(Pilot 2 CMHSPs) GIHN, CEI
  - Develop form for CMHSPs to submit remediation following the submission of the events.
  - Currently, the events are uploaded nightly. Consider a less frequent schedule for submission.

Measures:

Validation and Reconciliation

Figure 1: Count of Events Submitted to MDHHS-The events in red font were not allowable events for the populations or timeframes indicated below and require follow up.

MSHN Event Types/Subtypes	FY22	FY23Q1	FY23Q2	FY23Q3	FY23Q4	FY23
Arrest	**37**	**13**	**8**	**6**	**8**	**35**
Death of Unknown Cause (New FY23Q1)	**NA**	**1**		**3**	**5**	**9**
Emergency Medical Treatment	**332**	**84**	**93**	**99**	**94**	**370**
Injury	**326**	**83**	**91**	**98**	**92**	**364**
During physical management	2	2	0	0	1	3
Not during physical management	322	81	89	97	90	357
Unknown if during physical mgmt.	2	0	2	1	1	4
Medication Error	**6**	**1**	**2**	**1**	**2**	**6**
Hospitalization	**32**	**3**	**5**	**8**	**8**	**24**
Injury	**31**	**3**	**5**	**8**	**8**	**24**
Medication Error	**1**	**0**	**0**	**0**	**0**	**0**
Non-Suicide Death	**300**	**91**	**89**	**69**	**60**	**309**
Overdose Death (New FY23)	NA	4	2	1	1	8
Accidental	**33**	**9**	**8**	**10**	**4**	**31**
Homicide	**9**	**0**	**1**	**0**	**2**	**3**
Natural Causes	**258**	**78**	**78**	**58**	**53**	**267**
Acute bowel disease	4	1	1	1	0	3
Aspiration or Aspiration pneumonia	12	7	7	4	4	22
Cancer	20	7	12	6	15	40
Diabetes mellitus	21	3	2	1	2	8
Heart Disease	37	19	18	13	6	56
Inanition	2	1	2	3	3	9
Infection, including AIDS	31	**7**	**2**	**3**	**3**	**15**
Kidney disease	11	3	1	1	1	6
Liver disease/cirrhosis	9	1	1	2	2	6
Lung Disease	24	10	7	8	7	32
Neurological disorders	15	4	3	6	6	19
Pneumonia/Influenza	29	0	9	2	2	13
Unknown	24	12	9	5	1	27
Vascular Disease	19	3	3	3	1	10
Overdose Death (New FY23)	NA	**4**	**2**	**1**	**1**	**8**
Suicide	**18**	**4**	**1**	**5**	**2**	**12**
Overdose Death (New FY23)	NA	**0**	**1**	**1**		**2**
Suicide	18	4	0	4	2	10
Serious Challenging Behaviors (SUD Only)	NA	**1**	**0**	**0**	**3**	**4**

Data Pull Dates FY20, FY21 9/15/2022; FY22 11/16/2022; FY23 3/24/2023; FY23Q3 10/19/2023

Quality Assessment Performance Improvement Program
Quality Improvement Council – Critical Incidents Process Improvement Summary

Failed and Successful Submissions

Figure 2: The number of events with a submission status of failed have not been accepted into the MDHHS CIRS.

FY23 YTD	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Failed	**6**	**9**	**7**	**3**	**4**	**3**	**3**	**3**		**4**	**5**	**8**	**55**
Death of Unknown Cause							1						1
EMT due to Injury or Med. Error										1	1		2
Non-Suicide Death	6	9	7	3	4	3	2	3		3	4	8	52
Successful	**60**	**61**	**53**	**67**	**54**	**59**	**79**	**52**	**43**	**62**	**65**	**53**	**708**
Arrest	6	1	1	1	2	3	2	3	3	7	4	2	35
Death of Unknown Cause					1	2	1	2	1			1	8
EMT due to Injury or Med. Error	26	33	34	38	27	34	43	24	27	30	33	19	368
Hospitalization due to Injury or Med. Error		5		4	3	1	6	2		1		2	24
Non-Suicide Death	27	22	18	22	20	17	26	20	9	22	25	29	257
Serious Challenging Behaviors									3		1		4
Suicide	1			2	1	2	1	1		2	2		12
Grand Total	**66**	**70**	**60**	**70**	**58**	**62**	**82**	**55**	**43**	**66**	**70**	**61**	**763**

Reporting Timelines

MSHN will report events within the required timeframes.

Figure 3: The number of events and percentage of events reported within the required timeframe.

Reporting Status	FY22	FY23Q1	FY23Q2	FY23Q3	FY23Q4	FY23 YTD
	88%	**84%**	**90%**	**89%**	**96%**	**90%**
Outside of Required Timelines	**90**	32	20	21	7	**80**
Within Required Timelines	**646**	165	176	169	173	**683**
Grand Total	**736**	**154**	**172**	**190**	**180**	**763**

Remediation Timelines

The number of remediations required to be submitted, the number submitted within the required timeframe, and the number closed(no additional follow up needed). Remediation is required to be submitted based on timeliness of reporting, initiated by the department, or based on the specific event.

Figure 4. Count of Required Remediations

Remediations	FY23YTD
Total Required	104
Total Submitted	80
Total Closed	2

Prepared by: Sandy Gettel, Quality Manager **Date: 10/20/2023**
Distributed to: MSHN QIC **Date:** 11/6/2023

Data Pull Dates FY20, FY21 9/15/2022; FY22 11/16/2022; FY23 3/24/2023; FY23Q3 10/19/2023

MSHN
Mid-State Health Network

Quality Assessment Performance Improvement Program Quality Improvement Council – Critical Incidents Process Improvement Summary

Table 1. Reporting Timeliness YTD of Submitted Events (FY23Q3)

	Yes	No	Grand Total	Rate
MSHN				
FY20	648	56	704	92%
FY21	683	94	777	88%
FY22	**641**	**78**	**719**	**89%**
FY23	**683**	**80**	**763**	**90%**
BABH				
FY20	72	4	76	95%
FY21	63	4	67	94%
FY22	63	1	64	98%
FY23	65	5	70	93%
CEI CMH				
FY20	72	10	82	88%
FY21	129	54	183	70%
FY22	118	48	166	71%
FY23	83	45	128	65%
CMHCM				
FY20	135	8	143	94%
FY21	130	2	132	98%
FY22	146	2	148	99%
FY23	153	7	160	96%
GIHN				
FY20	29	0	29	100%
FY21	15	7	22	68%
FY22	8	6	14	57%
FY23	17	1	18	94%

	Yes	No	Grand Total	Rate
HBH				
FY20	2		2	100%
FY21	6	1	7	86%
FY22	0	2	2	0%
FY23	9	1	10	90%
The Right Door				
FY20	6	4	10	60%
FY21	10	0	10	100%
FY22	7	0	7	100%
FY23	21	1	22	95%
LifeWays CMH				
FY20	83	17	100	83%
FY21	110	17	127	87%
FY22	120	17	137	88%
FY23	91	19	110	83%
MCN				
FY20	28	0	28	100%
FY21	23	2	25	92%
FY22	15	0	15	100%
FY23	44	0	44	100%
NCMH				
FY20	9	9	18	50%
FY21	3	4	7	43%
FY22	11	2	13	85%
FY23	21	0	21	100%

	Yes	No	Grand Total	Rate
SCCMHA				
FY20	138	1	139	99%
FY21	132	1	133	99%
FY22	115	0	115	100%
FY23	126	1	127	99%
SHW				
FY20	30	0	30	100%
FY21	35	0	35	100%
FY22	20	0	20	100%
FY23	26	0	26	100%
TBHS				
FY20	44	3	47	94%
FY21	27	2	29	93%
FY22	18	0	18	100%
FY23	27	0	27	100%

Methodology: Yes=Reported outside of the required timelines. Required timelines for the purposes of this report are as follows: Emergency Medical Treatment, Hospitalization, Arrests reported outside of 60 days past the end of the month in which the event occurred. *Additional considerations for timeliness of deaths such as suspected suicide.

Table 2. Number of Critical Event Types YTD per CMHSP (FY23Q3 10/20/2023)

Bay-Arenac	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23	7/23	8/23	9/23
Arrest	0	0	0	1	0	0	0	0	0	0	0	0
Death of Unknown Cause	0	0	0	0	0	0	0	0	0	0	2	0
Emergency Medical Treatment	5	2	1	1	2	0	4	0	5	3	0	6
Hospitalization	0	0	0	0	1	0	0	0	0	1	0	0
Non-Suicide Death	3	3	6	5	4	1	0	4	1	2	3	1
Total:	**8**	**5**	**7**	**7**	**7**	**1**	**4**	**4**	**6**	**6**	**5**	**7**

CEI	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23	7/23	8/23	9/23
Death of Unknown Cause	0	0	1	0	0	0	0	0	1	0	0	0
Emergency Medical Treatment	6	10	5	3	6	9	6	6	8	10	0	0
Hospitalization	0	0	0	0	0	0	1	0	0	0	0	0
Non-Suicide Death	2	6	7	4	7	8	4	4	4	5	3	0
Serious Challenging Behaviors	0	1	0	0	0	0	0	0	0	0	0	0
Suicide	1	0	0	0	0	0	0	0	0	0	0	0
Total:	**9**	**17**	**13**	**7**	**13**	**17**	**11**	**10**	**13**	**15**	**3**	**0**

Data Pull Dates FY20, FY21 9/15/2022; FY22 11/16/2022; FY23 3/24/2023; FY23Q3 10/19/2023

MSHN
Mid-State Health Network

Quality Assessment Performance Improvement Program
Quality Improvement Council – Critical Incidents Process Improvement Summary

Central MI	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23	7/23	8/23	9/23
Arrest	2	2	0	0	0	0	0	1	0	0	1	0
Death of Unknown Cause	0	0	0	0	0	0	0	1	0	2	0	0
Emergency Medical Treatment	1	4	1	4	3	5	7	9	10	14	6	4
Hospitalization	1	0	1	0	3	0	2	1	1	1	0	0
Non-Suicide Death	6	5	7	4	5	6	5	6	4	9	5	2
Serious Challenging Behaviors	0	0	0	0	0	0	0	0	0	0	0	3
Suicide	0	1	0	1	0	0	0	0	1	1	0	0
Total:	**10**	**12**	**9**	**9**	**11**	**11**	**14**	**18**	**16**	**27**	**12**	**9**

Gratiot	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23	7/23	8/23	9/23
Arrest	0	0	0	0	0	0	0	0	0	0	0	1
Emergency Medical Treatment	0	1	0	1	0	1	2	1	4	0	1	0
Non-Suicide Death	1	0	0	0	2	0	0	1	0	1	0	1
Total:	**1**	**1**	**0**	**1**	**2**	**1**	**2**	**2**	**4**	**1**	**1**	**2**

Huron	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23	7/23	8/23	9/23
Emergency Medical Treatment	0	0	0	0	0	0	0	0	0	1	3	3
Non-Suicide Death	0	2	1	0	0	0	0	0	0	0	0	0
Total:	**0**	**2**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**3**	**3**

Ionia	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23	7/23	8/23	9/23
Arrest	0	0	1	0	0	0	0	0	0	0	0	0
Death of Unknown Cause	0	0	0	0	0	0	0	0	0	0	0	1
Emergency Medical Treatment	0	0	0	1	1	0	0	0	0	0	0	0
Hospitalization	0	0	0	0	0	0	0	0	0	1	0	0
Non-Suicide Death	0	2	2	6	1	0	2	0	1	1	2	0
Total:	**0**	**2**	**3**	**7**	**2**	**0**	**2**	**0**	**1**	**2**	**2**	**1**

LifeWays	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23	7/23	8/23	9/23
Arrest	2	0	0	0	0	0	0	0	1	0	1	1
Emergency Medical Treatment	7	7	3	4	1	8	7	3	4	8	1	5
Hospitalization	0	0	0	0	0	0	1	1	0	1	1	0
Non-Suicide Death	4	4	3	3	7	2	4	2	4	4	4	0
Suicide	0	0	0	0	0	0	0	0	1	0	0	0
Total:	**13**	**11**	**6**	**7**	**8**	**10**	**12**	**6**	**10**	**13**	**7**	**6**

Montcalm	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23	7/23	8/23	9/23
Arrest	1	1	0	2	0	1	1	1	0	0	0	1
Emergency Medical Treatment	0	2	2	1	1	1	3	3	0	2	1	2
Hospitalization	0	0	0	0	1	0	0	1	0	0	0	0
Non-Suicide Death	2	0	2	2	0	1	2	0	1	0	0	4
Suicide	0	0	0	0	0	0	1	0	0	0	0	0
Total:	**3**	**3**	**4**	**5**	**2**	**3**	**7**	**5**	**1**	**2**	**1**	**7**

Data Pull Dates FY20, FY21 9/15/2022; FY22 11/16/2022; FY23 3/24/2023; FY23Q3 10/19/2023

Quality Assessment Performance Improvement Program
Quality Improvement Council – Critical Incidents Process Improvement Summary

Newaygo	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23	7/23	8/23	9/23
Emergency Medical Treatment	0	0	0	0	4	4	0	0	0	1	0	0
Non-Suicide Death	0	2	1	3	0	2	3	0	0	0	0	1
Total:	**0**	**2**	**1**	**3**	**4**	**6**	**3**	**0**	**0**	**1**	**0**	**1**

Saginaw	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23	7/23	8/23	9/23
Arrest	1	1	1	2	1	0	0	0	1	1	1	0
Death of Unknown Cause	0	0	0	0	0	0	0	0	1	0	0	0
Emergency Medical Treatment	3	6	7	10	7	5	3	3	2	3	10	0
Hospitalization	0	0	1	0	0	0	0	0	0	0	0	0
Non-Suicide Death	5	5	7	5	3	5	2	6	4	5	6	0
Suicide	0	1	0	0	0	0	1	1	0	0	1	0
Total:	**9**	**13**	**16**	**17**	**11**	**10**	**6**	**10**	**8**	**9**	**18**	**0**

Shiawassee	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23	7/23	8/23	9/23
Arrest	0	0	0	1	0	0	0	0	1	1	0	0
Emergency Medical Treatment	1	1	0	0	4	1	2	1	1	1	1	0
Hospitalization	0	0	0	0	0	0	0	0	0	1	0	0
Non-Suicide Death	1	0	1	1	2	0	2	1	1	0	0	0
Total:	**2**	**1**	**1**	**2**	**6**	**1**	**4**	**2**	**3**	**3**	**1**	**0**

Tuscola	10/22	11/22	12/22	1/23	2/23	3/23	4/23	5/23	6/23	7/23	8/23	9/23
Emergency Medical Treatment	1	1	0	1	4	0	4	1	0	0	1	7
Hospitalization	0	0	0	0	0	0	0	0	0	1	1	0
Non-Suicide Death	0	0	0	0	0	0	1	0	0	1	0	0
Total:	**1**	**1**	**0**	**1**	**4**	**0**	**5**	**1**	**0**	**2**	**2**	**7**

Attachment 2

Priority	Issue	Intervention	Assigned to	Status
High	Notifications for remediation or additional information are not sent to the PIHP consistently. They are sent to the contact person listed on the incident. The contact person may not have access to the CRM. The chatter is not visible to the PIHP when sent to another person.	• Email MDHHS • Provide CMHSPs access.(Pilot 2 CMHSPs) GIHN, CEI • Request the contact person to default to the Critical Incident Lead of each CMHSP. Can PCE default to a certain individual for the contact person for the CMHSP submissions? • Develop form for CMHSPs to submit remediation information manually or through REMI. Include in the notes of the submission? Test with a CMH(BABH, SCCMH). Tested with SCCMHS-Notes are not included in the submission to the PIHP/REMI. Form created to obtain remediation information.	PIHP CMHSP PIHP PIHP	Resolved-Complete Complete In Progress Complete
Medium	Job Aides indicate Remediations are due within 7 days of submission. It appears as though this was changed to 30 days in May/June 2023.	• CMHSPs to complete in the CRM PILOT • The PIHP to forward the request to the CMHSP via email. Email option changed in CRM. Defaults to the listed contact person on the submitted record. Sent email to MDHHS 10/29/2023. • Develop form and process for CMHSPs complete and submit to PIHP for direct entry into the CRM fields. Form created to obtain remediation information.	CMHSP PIHP CMHSP/PIHP	Complete In Progress Complete
High	Staff are not marking the potential suicide check box. The check box is required in the CRM to extend the time frame for reporting, however, it was not listed as a required field by MDHHS and is not built into the EMR as a required field.	• Check with PCE (Dmitriy/Nikki) to ensure it is available to the CMHSPs. Add validation to REMI that rejects if it is not marked for the unknown deaths	PIHP	In Process
High	Natural Cause Deaths - unknown are not able to be updated in the CRM through the web service developed. The CMHSP submissions are flagged as failed submission in REMI (PIHP viewing only).	• Include the direction from MDHHS which indicates all unknown deaths should be reported as an Event Type of Unknown Cause of Death. (Email dated 6/8/2023) in	PIHP	In Process

Data Pull Dates FY20, FY21 9/15/2022; FY22 11/16/2022; FY23 3/24/2023; FY23Q3 10/19/2023

	No notification is sent to the PIHP when there is a failed submission. The PIHP needs to manual check each submission to the CRM in REMI and communicate with the CMH as needed. A request to edit the specific record needs to be made to MDHHS through the CRM. MDHHS has to make the change. The request Revisions option in the CRM does not work. Once approved, PIHP need to update in the CRM. The failed submission status does not change, but the event type does. If the CMHSPs do not update the cause of death MDHHS request it to be uploaded. PIHP staff have no way of downloading/exporting the unknown deaths to track or send to the CMHSP for follow up. Staff capacity limits this function. (**report as Cause of Death Unknown**)	procedure. Has been added, but will not be finalized until Documentation received from MDHHS. • Provide education /policy of how to report unknown cause of deaths see above • Utilize PCE standard report for tracking unknown deaths • Advocate for MDHHS to remove Natural cause death - unknown or change logic. Sent email to MDHHS 10/29/2023 • Develop process to monitor CRM Submissions for Failed status • Discuss options for updating the status in REMI when a change has been made with PCE. Currently manually tracking.	PIHP CMHSP PIHP PIHP PIHP	In Process In Process In Process In Process In Process
High	CMHSPs are required to make a Best Judgement determination if a cause of death cannot be determined by 90 days after the event. Not all Medical Directors are comfortable with the best judgement determination without enough documentation to support the determination.	• MSHN to discuss “Best Judgement Determinations “ with the Regional Medical Directors group to identify potential solutions.	PIHP	Status: Planning, will attend next RMD meeting .
High	Submissions failed due to the Suspected Suicide/Overdose field not being completed. This was not identified as a required field during development (see above)	• Include in procedure for submissions. • Discuss with PCE changing this to a required field when event type Death of Unknown Cause is used.	PIHP PIHP	Complete but not finalized Started
Medium	Submission fail due to No Medicaid ID for Non SUD Events	• Clarify with MDHHS that non Medicaid is not required to be submitted Sent email to MDHHS 10/30/2023	PIHP	In Process

Low	Updates made but no record in the tracking in CRM (I incident)	• Follow up with MDHHS. Lifeways 116742	PIHP	Not started
Low	The previous requirements indicated if after 90 days … MDHHS is using 90 days as the current required timeframe for the cause to be submitted.	• Explore with MDHHS updating the requirements to reflect current expectations Sent email 10/30/2023	PIHP	In Process
High	The MDHHS contract does not include the changes in the requirements for reporting critical incidents. What is allowed in the CRM is inconsistent with what is included in the contract. No updated document is attached to the contract with the new reported events identified for the population groups. This has resulted MDHHS requesting changes in the submissions and the CMHSP and PIHP having to update and resubmit events.	• Continue to work with MDHHS to obtain clarification and provide contract changes and technical guidance documents. Communicate with MSHN Leadership Email MDHHS – last email indicates will be sent by 10/4/2023. As of 10/26/2023 has not been received. MDHHS QIC-Referred to the document that will be sent. Still not received. • Update policy/procedures and contracts once new requirements have been received via contract updates etc, Draft policy/procedure complete. Waiting for final documents.	PIHP PIHP	Waiting for the new requirements to be published prior to finalizing a revised policy and procedure In Progress
Medium	Contract submission deadline for immediately reportable events is business days. The CRM uses calendar days.	• MDHHS update requirements to reflect current expectations	PIHP	Resolved/Complete
High	Notification in the CRM are no longer able to be viewed, they have disappeared.	• Email MDHHS.	PIHP	Resolved/Complete for only current.
High	No process developed for the CMHSPs to communicate / upload documentation related to the remediation or requests for additional information within the CRM.	• Develop procedure with form to include fields consistent with the CRM for the PIHP to direct enter.	PIHP	Complete
Medium	Edits can only be made in the CRM. Resulting in a potential discrepancy between the CRM and the CMHSP EMR.	• Discuss option with PCE/MDHHS	PIHP	Planning
Medium	No reports or exports are available in the CRM to assist with follow up and tracking	• Advocate for MDHHS to develop export or reporting function in CRM	PIHP PIHP	Waiting Completed

		• Request report form MDHHS on current submissions and remediations required.		
Medium	No alerts or dashboard tracking for timeliness or follow up	• MSHN to develop timeliness dashboard report in REMI. Sandy to develop specifications.	PIHP	Planning
Medium	PCE report in REMI does not use the same identifiers as the CRM Identifying info in the CRM: • Medicaid ID • DOB • Name CRM-created IDs • ID number • IR number • CS-number • MiCAL CI Number (combines the ID and IR number) (Is it possible to add the CS, REM, Medicaid number to the REMI report)	• Sandy to request/discuss changes from PCE to the PCE/REMI standard report to be consistent with the CRM.	PIHP	Planning
Medium	Remediations cannot be downloaded or sent to the CMHSPs for follow up. It is a manual process within the CRM based on each individual record, not systemic issues. CRM modified email to default to the contact person on the submitted record only.	• Pilot – Provide access for 2 CMHSPs to have access for follow up of remediation. • Request made to MDHHS to allow emails to others Sent email to MDHHS 10/30/2023	CMHSP/PIHP PIHP	In Process In Process
High	CRM removed PIHP viewing of CMHSP remediations.	• Communicate with MDHHS to restore PIHP viewing permissions. Email sent to MDHHS-SN/LD.	PIHP	Complete
Medium	Remediation Job Aid indicates remediations are due 7 days from the date it was submitted.	• Notifications are not received that a remediation is due • The due date varies from 7 to 30 days Dec 2022 it was 7 days • Changed to 30 days after May. Job Aides should be updated.	PIHP MDHHS	Complete. Job aides have not been updated yet.

low	The date reported on the CS and the remediation are different. Remediation 'date reported" is always one day later	• Sent email to MDHHS		In Progress
High	Immediate reportable events are manually entered into the CRM by the PIHP. Duplicate process with critical incidents.	MSHN to develop a procedure for reporting events that require "immediate notification " to MDHHS.		Completed.

Quality Assessment Performance Improvement Program
Substance Use Disorder Residential Providers
Critical Incidents FY23

Summary of Project

The data collected is based on the definition and requirements that have been set forth within the Sentinel Event/Critical Incident Reporting System (CIRS) attached to the PIHP contract and available on the MDHHS Website. MSHN has included Recovery Housing to those providers required to report critical incidents. Effective FY23Q1 MDHHS implmented the BH CRM for submission of Incidents. The changes are indicated in bold. MSHN continues to utilize the Provider Portal Dashboard Sentinel Event Document Submission process for obtaining the information to enter into the BH CRM.

The following incidents are reviewed by the Substance Use Residential Providers and Recovery Housing providers to determine if the event is sentinel or not sentinel. Those events that are determined to be sentinel require a root cause analysis to be completed and a plan of action developed, or documentation as to why an action plan was not needed. Changes related to the types of incidents reported for FY23Q1 are included below. *Indicates required events to be reviewed for sentinel and reported by the Substance Abuse Residential Providers. Twenty-four hour detox is included in the required reporting population.

- *Death: That which is not by natural cause or does not occur as a natural outcome to a chronic condition (e.g. terminal illness) or old age.
- *Unexpected deaths: Deaths that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.
    - Deaths as a result of staff action or inaction, or subject to a recipient rights investigation, licensing, or police investigation requires additional information to be submitted to the Quality Manager or designee at MSHN within 36 hours of the notification of an investigation for reporting to MDHHS (MSHN must report to MDHHS within 48 hours of the notification of an investigation occurring).
- *Injury -Injury by accident resulting in a visit to an emergency room, medi-center and urgent care clinic/center and/or admissions to hospital
- *Physical illness resulting in admission to a hospital **(not included in the BH-CRM effective FY23Q1**): Does not include planned surgeries, whether inpatient or outpatient. It also does not include admissions directly related to the natural course of the person's chronic illness, or underlying condition. For example, hospitalization of an individual who has a known terminal illness in order to treat the conditions associated with the terminal illness is not a sentinel event.
- *Serious challenging behaviors: Behaviors not already addressed in a treatment plan and include significant (in excess of $100) property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence that result in death or loss of limb or function to the individual or risk thereof. All unauthorized leaves from residential treatment are not sentinel events in every instance) Serious physical harm is defined by the Administrative Rules for Mental Health (330.7001) as "physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient."
- *SUD Medication errors and **MAT Medication errors (new event type as of FY23):** Mean a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage which resulted in death or loss of limb or function or the risk thereof. It does not include instances in which consumers have refused medication.
- Administration of Narcan: Reported within 48 hours to MSHN. This event is not required to be reported to MDHHS.

- *Sentinel Event: An "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, 'or risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome." (JCAHO, 1998)

This data is to be reported and reviewed as part of the MSHN Quality Assessment and Performance Improvement Program (QAPIP). MSHN will analyze the data to address any trends and/or opportunities for quality improvements.
The critical incident reporting system is trend data; therefore, no external exists. MSHN utilizes a linear trend over a minimum of 4 reporting periods. The trend is used to identify any areas requiring further analysis to improve the safety of the individuals we serve. This is done by reviewing quarterly data to identify causal factors contributing to an increase rate contributing to an upward trend. The expectation is that each provider and/or MSHN will implement interventions to improve safety, thereby changing the direction of the trend. Substance Use Residential Providers are required to review critical incidents to determine if they are sentinel. If sentinel, a root cause analysis must be completed, with the determination of actions steps to prevent reocurrance. MSHN must analyze the data quarterly for patterns and/or trends. Quality improvement efforts should be implemented for relevant areas. Based on the number of events reported as critical versus sentinel the numbers are beginning to be reported more as expected. Accuracy will be better determined during the DMC, primary source verification.

Data Analysis
Goal: The rate, per 1000 people served, of Sentinel Events will demonstrate a decrease from the previous year.

The cumulative rate of sentinel events per 1000 persons served for FY23 is 000.0 for individuals receiving 24-hour detox, and residential long/short term services. Those identified as sentinel are required to be submitted to MDHHS. Figure 1 demonstrates the number of events reported by the 24-hour Residential and/or Withdrawal Management and the Recovery Housing providers. The recovery housing are collected for monitoring of safety and are not required to be reported to MDHHS. Figure 2 demonstrates the critical events reviewed to determine if they are sentinel or not sentinel, and if action was identified. Once a critical event is determined to be sentinel, a root cause analysis is completed, and action steps are identified to prevent recurrence. If no action is identified the rational as to why no action was identified should be documented.

Figure 1: MSHN counts of events reported by 24 hour residential, withdrawal management programs, and recovery housing.

	FY22		FY23	
	Critical	Sentinel	Critical	Sentinel
Total	**56**	**2**	**102**	**4**
Accident with hospital or EMT admit	5	1	3	0
Administration of Narcan	2	0	1	1
Arrest or conviction	0	0	0	0
Behavioral episode	15	0	14	0
Death of recipient	3	3	0	0
Medication errors	0	0	0	0
Physical illness hospital admit	31	1	9	0

Figure 2: MSHN 24 hour residential, withdrawal management, and recovery housing rate of critical, sentinel, and action per 1000.

MSHN Critical Events	**FY22**	**FY23**
Critical Event Reviewed	21.366	38.87
Sentinel Event	0.763	1.520
MSHN Death of Recipient	**FY22**	**FY23**
Critical Event Reviewed	1.445	0.381
Sentinel Event	1.445	0.381
MSHN Accidents requiring emergency room visits and/or admissions to hospitals	**FY22**	**FY23**
Critical Event Reviewed	1.908	3.040
Sentinel Event	0.381	0.000
MSHN Physical illness requiring admissions to hospitals	**FY22**	**FY23**
Critical Event Reviewed	11.828	14.100
Sentinel Event	0.381	0.000
MSHN Arrest or conviction of recipients	**FY22**	**FY23**
Critical Event Reviewed	0.000	1.524
Sentinel Event	0.000	0.381
MSHN Serious challenging behaviors	**FY22**	**FY23**
Critical Event Reviewed	5.723	18.292
Sentinel Event	0.000	0.381
MSHN Medication errors	**FY22**	**FY23**
Critical Event Reviewed	0.000	0.381
Sentinel Event	0.000	0.000
Administration of Narcan	**FY22**	**FY23**
Critical Event Reviewed	0.763	1.143
Sentinel Event	0.000	0.381

Recommendations:

- MSHN to develop a dashboard through Power BI or REMI to increase efficiency of reporting and allow for self-monitoring. Status: *New, On hold.*
- Transition to the use of Data Entry into REMI allowing scheduled submissions to MDHHS BH CRM. *Status: New, On hold.*
- MSHN to review a sample of critical incidents during SUD Delegated Managed Care reviews consistent with the SUD Oversight Policy. *Status: Completed/Continue.*
- MSHN to continue to work with Providers to reconcile the data and ensure the correct process is used for reviewing and reporting. Each sentinel event should result in a root cause analysis with identified action to prevent reoccurrence. If no action plan is implemented, rationale should be documented. *Status: Completed.*
- SUD Treatment should review serious challenging behaviors, and physical illness at provider locations requiring hospitalization.

Prepared by: Sandy Gettel, Quality Manager **Date:** 11/14/2023

Attachment 1

MSHN
Mid-State Health Network

Quality Assessment Performance Improvement Program
Substance Use Disorder Residential Providers
Critical Incidents FY23

FY23	Qtr1			Qtr2			Qtr3			Qtr4			FY23		
MSHN	Critical Incident	Sentinel Event	Action Required	Critical Incident	Sentinel Event	Action Required	Critical Incident	Sentinel Event	Action Required	Critical Incident	Sentinel Event	Action Required	Critical Incident	Sentinel Event	Action Required
Bear River Health - Boyne Falls	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**0**
Behavioral episode	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Physical illness hospital admit	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Bear River Health - Gaylord	**0**	**0**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**0**	**6**	**0**	**0**
Accident with hospital admit	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0
Medication errors	0	0	0	1	0	0	0	0	0		0	0	1	0	0
Physical illness hospital admit	0	0	0	3	0	0	0	0	0	1	0	0	4	0	0
Bear River Health - Walloon Lake	**17**	**0**	**0**	**27**	**0**	**0**	**0**	**0**	**0**	**18**	**0**	**0**	**62**	**0**	**0**
Accident with hospital admit	1	0	0	1	0	0	0	0	0	3	0	0	**5**	0	0
Behavioral episode	8	0	0	16	0	0	0	0	0	10	0	0	**34**	0	0
Physical illness hospital admit	8	0	0	10	0	0	0	0	0	5	0	0	**23**	0	0
Flint Odyssey House	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**0**
Arrest or conviction	0	0	0	0	0	0	2	0	0	0	0	0	2	0	0
House of Commons	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**
Administration of Narcan	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0
Meridian Health Services - Men's	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**
Behavioral episode	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0
Mid-Michigan Recovery Services - Outpatient	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**0**
Death of Recipient	0	0	0	0	0	0	1	1	1	0	0	0	1	1	0
***Randy's House of Greenville**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**2**	**0**	**0**
Arrest or conviction	0	0	0	0	0	0	1	1	0	0	0	0	1	1	0
Behavioral episode	0	0	0	0	0	0	1	1	0	0	0	0	1	1	0
***Saginaw Odyssey House, Inc. - Warren Ave.**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**
Arrest or conviction	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0
Saginaw Psychological Services -	**0**	**1**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**0**
Administration of Narcan	1	1	1	0	0	0	1	0	0	0	0	0	2	1	1
The Recovery Center	**2**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**3**	**0**	**0**
Behavioral episode	2	0	0	0	0	0	1	0	0	0	0	0	3	0	0
***WAI-IAM**	**5**	**0**	**0**	**1**	**0**	**0**	**7**	**0**	**0**	**6**	**0**	**0**	**18**	**0**	**0**
Accident with hospital admit	2	0	0	0	0	0	0	0	0	0	0	0	2	0	0
Behavioral episode	3	0	0	1	0	0	1	0	0	3	0	0	7	0	0
Physical illness hospital admit	0	0	0	0	0	0	6	0	0	3	0	0	9	0	0

Title of Measure: Behavior Review Data

Summary of Project: The study is required by the Michigan Department of Health and Human Services (MDHHS). The data collected is based on the definition and requirements that have been set forth within the Standards for Behavioral Treatment Review attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract.

MSHN delegates the responsibility for the collection and evaluation of data to each local CMHSP Behavior Treatment Review Committee (BTRC), including the evaluation of effectiveness of the BTRC by stakeholders. Data will be collected and reviewed quarterly by the CMHSP where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. This data is to be reviewed as part of the CMHSP Quality Improvement Program (QIP) and reported to the PIHP. MSHN monitors to ensure the local CMHSP BTRC follows the requirements outlined within the Standards for Behavior Treatment Review Committees. The following measures are trend data; therefore, no external standard exists. The trend is used to identify any areas requiring further analysis to improve the safety of the individuals we serve. This is done by reviewing quarterly data to identify causal factors contributing to undesirable patterns. CMHSP and/or MSHN will implement interventions to improve safety, thereby changing the direction of the trend. The expectation is that each year will demonstrate improvement from the previous year.

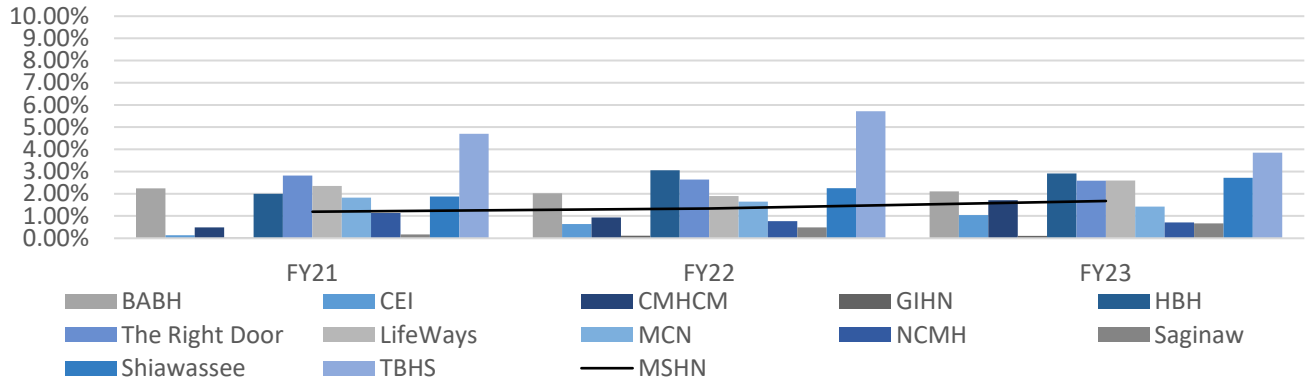
Data Analysis

Goal 1: The proportion of individuals with a restrictive and/ or intrusive behavior treatment plan will be monitored quarterly to address causal factors for positive or negative change**.**

Numerator: The total number of plans with restrictive and intrusive interventions reviewed during the reporting period.

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

Figure 1. Percent of Individuals served who have a Behavior Treatment Plan with Intrusive/Restrictive interventions.



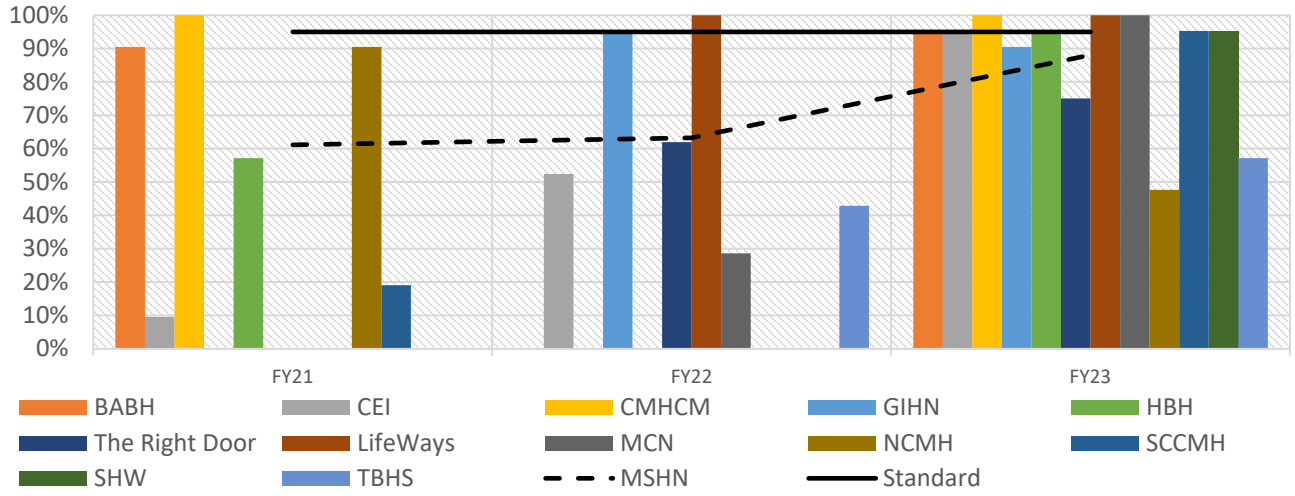
Goal 2: MSHN will ensure behavioral treatment plans are developed in accordance with the Standards for Behavior Treatment Plan Review Committees.

Study Question 2: Have the targeted interventions been effective in increasing the percentage of compliance with the Behavioral Treatment Standards.

Numerator: The number of Behavior Treatment standards meeting full compliance through the monthly delegated managed care reviews.

Denominator: The total number of Behavior Treatment Standards reviewed through the monthly delegated managed care reviews.

Figure 2. Percentage of Behavioral Treatment Plan Standards Met (Cumulative)



Goal 3: The percentage of emergency interventions per person served during the reporting period will demonstrate a decrease from the previous measurement period.

Study Question 3: Has the proportion of incidents in which the use of emergency intervention decreased over time (Figure 3)?

Numerator: The total number of emergency interventions reviewed during the reporting period. (Total # of physical management, and 911 call for behavioral assistance)

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

Figure 3. The percentage of emergency interventions used per person served for MSHN

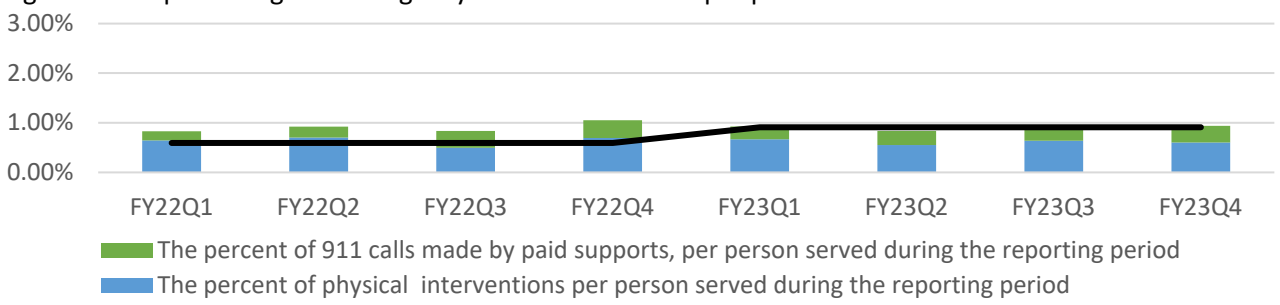
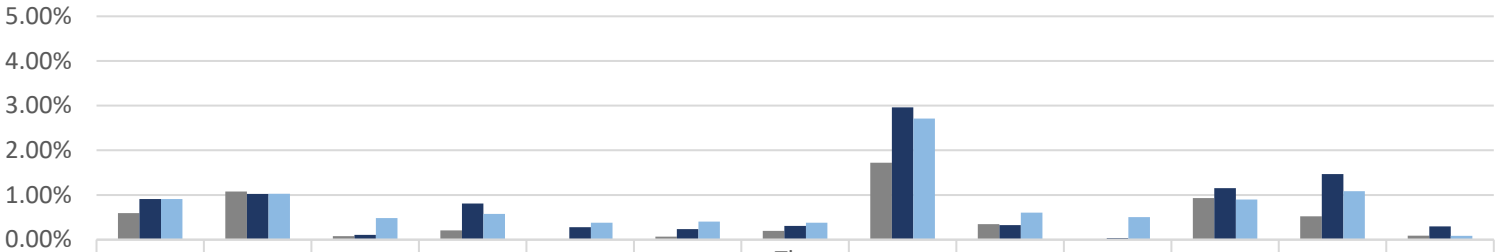


Figure 3a. The percentage of emergency intervention per person served for each CMHSP Participant



	MSHN	BABH	CEI	CMHCM	GIHN	HBH	The Right Door	LifeWays	MCN	NCMH	SCCMHA	SHW	TBHS
FY21	0.59%	1.08%	0.08%	0.21%	0.00%	0.07%	0.20%	1.72%	0.35%	0.00%	0.93%	0.52%	0.09%
FY22	0.91%	1.02%	0.11%	0.81%	0.28%	0.24%	0.31%	2.96%	0.32%	0.04%	1.15%	1.47%	0.30%
FY23	0.91%	1.03%	0.48%	0.58%	0.38%	0.40%	0.38%	2.71%	0.61%	0.50%	0.90%	1.09%	0.09%

Figure 4. The number of approved Behavior Treatment Plans, physical interventions (PI), 911 calls for behavioral assistance occurring during FY23 compared to FY22
(BTP-Behavior Treatment Plan, PI-Physical intervention)

	FY21			FY22			FY23		
	Ave. # BTPs	**# of PI**	**# 911 Calls**	**Ave. # BTPs**	**# of PI**	**# 911 Calls**	**Ave. # of BTPs**	**# of PI**	**# 911 Calls**
MSHN	362.5	531	193	423.75	811	346	532.5	779	372
BABH	70.75	131	6	67.25	129	7	74.5	134	11
CEI	7.25	0	18	35.5	3	21	61.5	27	87
CMHCM	28.75	39	11	56.25	150	46	106	91	52
GIHN	0.25	0	0	1	8	2	1	13	3
HBH	14.75	1	1	22.5	7	0	23.5	12	1
The Right Door	32.5	2	7	36.25	0	17	42	6	19
LifeWays	106	255	56	79.75	387	111	106.5	334	108
MCN	25	10	9	24.75	16	3	23.25	24	16
NCMH	14	0	0	10.75	1	1	10.25	20	9
SCCMH	7	71	85	19	75	105	26.25	90	52
SHW	17.5	19	0	22.25	28	30	24	27	12
TBHS	38.75	3	0	48.5	7	3	37	1	2

Conclusions:

Goal 1: The proportion of individuals with a restrictive and/ or intrusive behavior treatment plan will be monitored quarterly to address causal factors for positive or negative change. The percent of individuals served who have a behavior plan that include intrusive or restrictive interventions for FY23 has demonstrated an increase from FY22. The variance in the data relates to three main categories which are addressed in the recommendations and included in ongoing discussion with regional BTPRC.

Barriers/Causal Factors

1. The number of plans may be attributed to the increased monitoring and oversight from MDHHS and MSHN as it relates to the monthly review of HSW re-certification; and increased monitoring of the Individual plans of Service, Behavior Treatment Plans and home visits where unreported restrictions are identified; and more accurate identification and oversight of restrictions, and regional BTPRC training.
2. The incorporation of the individuals receiving the autism benefit into the CMHSP BTRC process. MSHN and our CMSHPs have worked to review and ensure that Applied Behavioral Analysis plans written for individuals enrolled in the Michigan Medicaid Autism Benefit also meet all requirements if restrictive and/or intrusive methods are recommended.
3. Medications that are prescribed outside of standard dosage or treatment for the individual's diagnosis or condition, must be addressed by the committee quarterly. This does not necessarily require a BTP, but these reviews are likely to lead to the creation of a BTP in order to adequately address the standards.

Goal 2: MSHN will ensure behavioral treatment plans are developed in accordance with the Standards for Behavior Treatment Plan Review Committees. (95% Standard)
MSHN met the standard for FY23Q4 with a 95% compliance rate. An increase was demonstrated from FY22 (63%) to FY23 (88%).

Goal 3: The percentage of emergency interventions per person served during the reporting period will demonstrate a decrease from the previous measurement year.
MSHN demonstrated an increase in the average emergency interventions in FY23 (.93%) compared to the average in FY22 (.91%). The standard was not met, however, and continues to be below 1.0%.
Variance of numbers/rate may be a result of the inconsistency of reporting interventions. The interventions are to be reported per incident, not episode.
QIC in collaboration with the BTP Work group determined interventions would be reported per incident, and will develop a process to ensure data integrity through primary source verification.

Barriers/Causal Factors:

1. Limited availability of care.
2. The reduction in inpatient hospital options for individuals with IDD and Autism.
3. Workforce shortage and staff turnover.
4. Transitions of care-limited staffing and higher level of care placements.
5. Behavior plans not being followed consistently.
6. Instances of physical management in the family home may not get reported even when Medicaid paid supports are present.
7. Work required to ensure standards addressed when long-term restrictions have found to be in place.
8. Out of county placements where different levels of monitoring and oversight occur.
9. The occurrence of overarching restrictive and intrusive techniques with providers who serve individuals with challenging needs.

Recommendations:

- Continue to provide support in collaboration with the Regional Medical Directors and local Behavior Treatment Review Committees as it relates to oversight/monitoring of medications when prescribed outside of standard dosage or treatment for the individual's diagnosis or condition (i.e., for behavioral control).
  1. CMHSPs to share current processes with one another.
  2. MSHN BTR Workgroup Chair/members will consult with Medical Directors as needed.
  3. BTP training will be made available as requested by MSHN staff and/or CMHSP BTP Leads.
  4. BTRCs will encourage conversations within Committee Members, including assigned Physician/Psychiatrist.

- Evaluate and monitor the development of the streamlined data collection process for restrictive and intrusive interventions, emergency physical interventions, and 911 calls.
  1. MSHN BTR Workgroup Members will have a clear understanding of definitions and expectations for data collection.
  2. MSHN BTR Workgroup will upload required data within the specified time frame.
  3. MSHN quality manager will work with IT/PCE to coordinate a more streamlined approach to data submission in REMI.

- Continue efforts to create Behavior Treatment monitoring templates and modules into PCE for consistency, compliance, and tracking purposes.
  1. BTR Workgroup members will share documentation and processes for consistent monitoring and tracking purposes.
  2. CMHSPs will identify ways to incorporate standards into their EMR.
  3. CMHSPs will share progress on EMR development of BTP standards.

- Improve overall compliance of BTP reviews resulting in a regional average of 95% standards fully compliant for cases reviewed.
  1. MSHN will continue to review BTP charts through the Delegated Managed Care Review and also through the MDHHS 2024 Site Review.
  2. MSHN will offer individual training to CMHSPs as needed/requested.
  3. MSHN will make regional BTPRC Training recording accessible to providers and stakeholders.

Completed Date: 11/17/2023

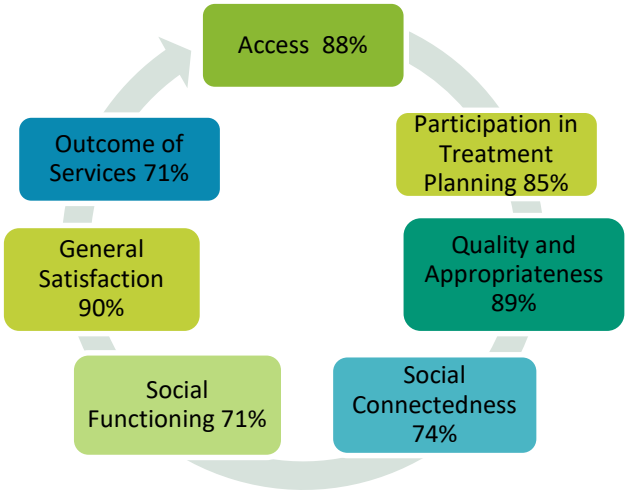
Quality Assessment and Performance Improvement Program
2023 Annual Member Perception of Care Report

Executive Summary

The Mid-State Health Network (MSHN) Quality Assessment and Performance Improvement Program, as required by the Michigan Department of Health and Human Services (MDHHS), annually administers a survey to a representative group of individuals served. MSHN, in collaboration with the Community Mental Health Services Program (CMHSP) and their contracted providers, Substance Use Disorder Treatment Providers (SUDTP), and the Michigan Developmental Disabilities Institute (MIDDI) through contract with the Michigan Department of Health and Human Services (MDHHS) utilized the following survey/assessments to obtain feedback related to the perception of care for a representative sample of all served within the MSHN region:

Survey Findings

Adults receiving services for a mental illness and/or an intellectual developmental disability.



Key Points:

- *MSHN's standard is for 80% to agree with the statements in the survey.*
  - *The Perception of Outcomes of Services, Social Connectedness, and Social Functioning did not meet the standard, however all improved form FY22.*
  - *Access, Treatment Planning, Quality and Appropriateness, and General*

Distribution:

- *18225 served during the timeframe.*
- *2819 completed a survey.*
- *15.47% response rate.*

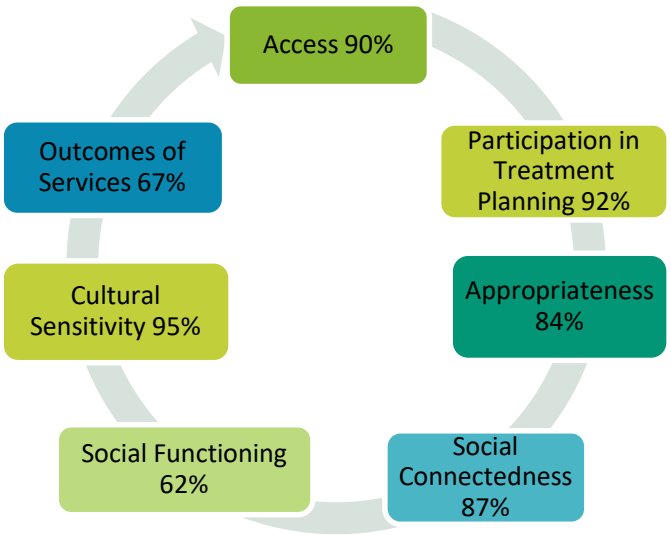
Youth receiving services for a serious emotional disorder and/or an intellectual developmental disability.

Key Points:

- *MSHN's standard is for 80% to agree with the statements in the survey.*
- *The Perception of Outcomes of Services and Social Functioning did not meet the standard.*
- *Outcomes of Services increased from FY22.*
- *Appropriateness decreased by 8 percentage points.*
- *Access decreased by 6 percentage points.*

Distribution:

- *6881 served during the timeframe.*
- *1041 completed the survey.*
- *15% response rate.*



Adults and adolescents receiving services for a substance use disorder.

Key Points:

- *Greater than 3.50 indicates a positive response.*
- *All areas were more than 3.50.*
- *Each question and focus area decreased from previous year.*
- *Coordination of Care had the largest decrease.*

Distribution:

3916 served during the timeframe.

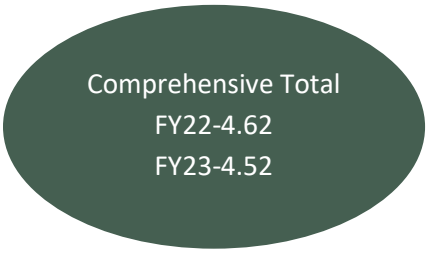
1866 completed a survey.

48% response rate.

Scale:

1-Strongly Disagree ⟶ *5-Strongly Agree*

Subscales	2022	2023
Welcoming Environment	4.64	4.56
Information on Recipient Rights	4.57	4.48
Cultural /Ethnic Background	4.69	4.59
Treatment Planning/Progress Towards Goals	4.69	4.58
Coordination of Care/Referrals to Other Resources	4.60	4.48



Recommendations/ Follow-up

- Distribute the Perception of Care Report to the providers through relevant committee/council for development of local improvement plan, identification of barriers, and development of interventions, with measures of effectiveness for the following areas:
  - MHSIP and YSS-Social Functioning
  - MHSIP and YSS-Outcomes of Services
  - MHSIP-Social Connectedness
    - ✓ *Status: Continue and ongoing. Interventions were not effective for the YSS in demonstrating improvement.*
- QIC in collaboration with relevant MSHN committees/council will establish a regional quality improvement plan to address the low response rates.
  - ✓ *Status: The FY22 response rates for MSHN demonstrated an increase from FY21. (Adults-15% to 22%; children 15% to 21%). The FY23 response rates decreased to 15%*
- MSHN and CMHSPs will identify regional barriers, relevant regional interventions, with measures of effectiveness.
  - ✓ *Status: QIC will continue to utilize the QIP template in the QIC action plan for development of interventions and monitoring of effectiveness.*
- Distribution methods will be explored to determine the most effective method. The consumer advisory council indicated most preferred method is face to face then phone.
  - ✓ *Status: Evaluate the distribution method and consider returning to face to face distribution as was prior to the pandemic.*
- Surveys will be streamlined to decrease survey fatigue.
  - ✓ *Status: A regional workgroup will be developed to determine the most efficient and effective methods of feedback and distribution.*

Attachment 1 MSHN Member Satisfaction Survey Adults with a Mental Illness and/or an Intellectual Developmental Disability.

Attachment 2 MSHN Member Satisfaction Survey for Children with a Severe Emotional Disturbance and/or an Intellectual Developmental Disability

Attachment 3 MSHN Member Satisfaction Survey for Individuals Receiving Substance Use Treatment.

Mid-State Health Network (MSHN), inclusive of the Community Mental Health Service Program (CMHSP) Participants, participates in the National Core Indicator (NCI) Survey in Michigan. The effort is coordinated by the National Association of State Directors of Developmental Disability Service and the Human Services Research Institute. The Michigan Developmental Disabilities Institute in collaboration with the Michigan Department of Health and Human Services conducts the survey in Michigan.
The NCI is an in-person survey offered to all adults with IDD age 18 and older receiving at least one paid service (in addition to case management) from the state DD service system. The in person survey includes background information provided by a professional working with the individual, subjective information received by the person receiving services, and fact based information provided by the person receiving services or a proxy who knows the person well. [1]

The NCI report provides a comparison of the responses from Michigan and forty-six other states. This summary highlights the strengths and growth areas of the performance data. The national performance is an average of all participating states. In the absence of a specific standard the national performance is used to gauge improvement efforts. Strengths are determined by those illustrating a higher favorable percentage than the national percentage or demonstrating an increase from the previous survey. Growth areas are determined by those illustrating a lower favorable percentage than the national percentage, and or a decrease from the previous survey.

<u>Choice and Decision Making</u>
Strengths
- Chose or had some help in choosing day program or workshop. (66%)
- Chooses or has help deciding how to spend free time. (97%)
- Has enough choice in how to spend free time. (98%)
- Has enough choice in the daily schedule. (95%)
- Chooses or has had help deciding what to buy or has set limits on what to buy with their spending money. (95%)

Growth Areas
- Choose or had some input in choosing their housemates if not living in the family home, or chose to live alone. (40%)
- Chose or had some input in choosing where they live if not living in the family home. (54%)
- Can change their case manager/service coordinator if wants to. (76%)
- Chooses or had some help in choosing where they work. (80%)
- Chose staff or were aware they could request staff change. (64%)
- Can change their case manager/service coordinator if wants to. (76%)

<u>Self-Direction/Self Determination</u>
Strengths
- Frequency with which the person gets information about budget/services. Every three months. (83%)

Growth Areas
- Hires or manages staff (among those using a self-directed support option). (81%)

[1] 2018-2019 MI NCI IPS State Report pg. 9

- Has enough help deciding how to use their individual budget/services (among those using a self-directed support option). (Decreased to 75%)
- Can make changes to individual budget/services if needed (among those using a self-directed support option). (63%)
- Gets information about how much money is left in budget/services (among those using a self-directed support option). (74%)
- Information about budget/services is easy to understand (among those using a self-directed supports option and who report they receive information about how much money is left in budget/services). (64%)

Community Inclusion, Participation and Leisure

Strengths

- Went out for entertainment at least once in the past month. (44%)
- Went shopping at least once in the past month. (70%)
- Went out on errands at least once in the past month. (76%
- Went to restaurant or coffee shop at least once in the past month. (65%)
- Participates as a member in community group. (29%)
- Able to go out and do the things they like to do in the community. (75%)
- Has enough things likes to do when at home. (87%)

Growth Areas

- Went out to religious service or spiritual practice at least once in the past month. (21%)
- Went away on vacation in the past year. (23%)
- Gets help to learn new things. (73%)

Relationships

Strengths

- Has friends who are not staff or family members. (84%)
- Has best friend. (74%)
- Wants help to meet or keep in contact with friends. (55%)
- Has friends and can see their friends when they want. (71%)
- Has other ways of talking, chatting, or communicating with friends when cannot see them. (87%)
- Can see or communicate with their family when they want or chooses not to (among those who do not live in the family home). (84%)

Growth Areas

- Often feels lonely. (12%)
- Can go on a date or is married or living with partner. (71%)

Satisfaction

Strengths

- Likes home and where he lives. (91%)
- Wants to live someplace else. (22%)
- Likes paid community job. (91%)
- Wants to work someplace else. (18%)

Growth Areas

- Services and Supports help person live a good life. (91%)

Service Coordination and Access

Strengths

- Has met or spoken with case manager/service coordinator. (95%)
- Able to contact case manager/service coordinator when wants. (88%)
- Staff come and leave when they are supposed to. (93%)
- Took part in last service planning meeting, or had opportunity and chose not to. (94%)
- Talked about learning new things at last service planning meeting. (80%)
- Remembers what was in his service plan of those who report having or maybe having a service plan. (73%)
- Of those who say they want to learn to perform ADLs more independently, the percentage who have a goal in the service plan to increase independence or improve function or skill performance in ADLS. (92%)

Growth Areas

- Has a way to get places need to go. (92%)
- Has a way to get places when wants to do something outside of home. (83%)
- Staff have right training to meet persons needs. (91%)
- Case manager/service coordinator asks person what s/he wants. (85%)
- Understood what was talked about at last service planning meeting. (72%)
- Person was able to choose services they get as part of service plan. (68%)
- Has a way to get places need to go (88%)
- Service plan includes things that are important to person. (85%)
- Of those who say they want a paid job in the community (and do not currently have one), the percentage who have community employment as a goal in the service plan. (28%)
- Knows who to ask if s/he wants to change something about services. (80%)

Health/Medication/Wellness

Strength

- Has a primary care doctor or primary care practitioner. (98%)
- Has completed a physical exam in past year. (88%)
- Has had pap test in past three years. (55%)
- Has had mammogram in past two years. (70%)
- Had a flu vaccine in the past year. (80%)
- Has a behavior plan. (20%)
- Exercises or does physical activity at least once per week for more than 10 minutes at a time. (80%)

Growth Areas

- Exercises or does physical activity at least once per week that makes the muscles in arms, legs, back, and/or chest work hard. (30%)for 10 minutes or more at a time. (73%)
- Had a dental exam in the past year. (68%)
- Had an eye exam or vision screening in the past year. (39%)
- Had a hearing test in the past five years. (45%)

Rights and Respect

Strengths

- Others let person know before entering home. (92%)
- Can lock bedroom if wants. (66%)

- Others let person know before coming into persons room. (85%)
- Has a place to be alone in the home. (97%)
- There are rules about having friends or visitors in the home . (46%)
- Has a key to the home. (50%)
- Can be alone with friends or visitors at home. (89%)
- Can stay at home if others in the house go somewhere (if not living alone). (44%)
- Can use phone and internet when wants. (94%)
- Has voted in local, state, or federal election, or had the opportunity and chose not to. (40%)

Growth Areas

- Staff treat person with respect. (93%)
- Has attended a self-advocacy group, meeting, conference or event or had the opportunity and chose not to. (21%)

Safety

Growth Areas

- Has someone to talk to if ever feels afraid or scared. (90%)
- There is at least one place where the person feels afraid or scared (in home, day program, work, walking in the community, in transport, and/or other place). (19%)

Next Steps

The results will be reviewed further by the MSHN Quality Improvement Council, the Waiver Workgroups, and the Regional Consumer Advisory Council considering the growth areas identified above.
Work with NCI Advisory Council to identify priority areas for Michigan.
Growth areas will be further investigated to determine any barriers or causal factor contributing to the outcome.
A quality improvement plan will be established to address those areas that have been identified as a priority by relevant committees/councils.

Michigan National Core Indicator (NCI) In Person Report (IPS) 2020-2021
https://www.nationalcoreindicators.org/upload/core-indicators/MI_IPS_state_508.pdf
March 21, 2022
https://www.nationalcoreindicators.org/upload/core-indicators/2020-21_NCI-IDD_IPS_COVID_Supplement_Report.pdf

Completed by: Sandy Gettel Quality Manager Date: 10/31/2023
Distributed to: MSHN QIC, Clinical Leadership Date: 11/21/2023

Assertive Community Treatment (ACT) Utilization FY23

Background

The Michigan Medicaid Provider Manual contains the following requirement for the provision of ACT services:

"The total number of contacts averages 120 minutes of face-to-face time each week for each beneficiary. Higher frequency with shorter visits is most effective and is determined and adjusted as needed within the flexibility identified in the Individual Plan of Service (IPOS) and case notes. Clearly documented clinical rationale is provided in exception cases where an average of 120 minutes for each beneficiary is clinically inappropriate."

The MSHN regional Utilization Management committee reviews claims/encounter data to monitor fidelity to this requirement and to ensure that services are delivered in the appropriate amount, scope, duration, and frequency for individual recipients' needs.

Service Utilization Summary

Regional ACT (H0039) service utilization data is being monitored to evaluate if services are currently being delivered to fidelity. Average weekly contact per consumer was calculated using the methodology as described in the *Michigan Field Guide to ACT*.

Average Minutes Per Week/Per Consumer

CMHSP	Q1	Q2	Q3	Q4
BABHA	35	40	46.25	37.5
CEI	52.5	60	76.25	80
CMHCM	45	48.75	50	48.75
Huron	67.5	81.25	80	75
Lifeways	73.75	81.25	82.5	93.75
Saginaw	100	111.25	110	102.5
Shiawassee	66.25	31.25	70	48.75
Tuscola	5	57.5	73.75	65

Highlighted Field= 85% - 100% fidelity to model (96-120 average minutes per week/per consumer)

Date of UM Committee Review: 11/16/2023

Committee Discussion & Response to Data:

- Saginaw shared best practices for how their ACT teams ensure consistently high average face-to-face times weekly. ACT teams are persistent in daily outreach attempts for individuals who miss appointments. Closely monitor cases where length of stay in ACT program is >6 months to ensure it remains the most appropriate level of care for the individual's needs and level of functioning. Emphasis on short-term high-intensity services until the individual is able to achieve a more stable level of functioning in community.
- Request to include count of persons served per CMHSP in subsequent reports as low population served can skew average for small/rural CMHSPs.
- CEI and CMHCM indicated they plan to share this data with ACT supervisors and gather feedback about factors that contribute to their rates of average weekly time per consumer.

Recommendations & Next Steps:

A. Identify Barriers - possible staffing issues, lack of engagement by persons served, other factors.
B. CMHSPs will validate data and notify MSHN if any inconsistencies are found.
C. Quarterly data monitoring by UM Committee

Next Review: February 2024

MSHN
Mid-State Health Network

MSHN Behavioral Health (CMH) Department Quarterly Report

July 2023-September 2023 (FY23 Q4)

Prepared by: Todd Lewicki, PhD, LMSW, MBA, Chief Behavioral Health Officer

Table of Contents

I. Introduction

The Behavioral Health (CMH) Department at Mid-State Health Network consists of several functions that oversee and support contractual obligations with the Michigan Department of Health and Human Services (MDHHS) and Community Mental Health Services Programs (CMHSPs). Pre-Paid Inpatient Health Plans (PIHPs) such as Mid-State Health Network (MSHN), have the responsibility to oversee the waiver services for eligible beneficiaries. MSHN is responsible for the provision of certain enhanced community support services for those beneficiaries in the service areas who are enrolled in Michigan's 1915(c) and 1915(i) Home and Community Based Services Waiver for children and adults with intellectual and developmental disabilities (IDD), children and youth with severe emotional disturbance (SED), and adults with serious mental illness (SMI). MSHN oversees the following 1915(c) waivers: The Children's Waiver Program (CWP), the Habilitation Supports Waiver (HSW), and the Waiver for Children with Serious Emotional Disturbance (SEDW). The 1915(i) State Plan Amendment (SPA) covers all ages and populations.

The Autism Benefit is provided under Michigan's Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) services. MSHN is responsible for the provision of specialty services Medicaid benefits and makes these benefits available to beneficiaries referred by a primary EPSDT screener, to correct or ameliorate a qualifying condition discovered through the screening process. The EPSDT is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The Autism Benefit is for children under 21 years of age and focuses on behavioral health treatment services (BHT) and applied behavioral analysis (ABA) evidence-based practice services.

MSHN Home and Community-Based Services Rule Transition (HCBS) efforts developed because on January 16, 2014, the Centers for Medicare & Medicaid Services (CMS) released the Home and Community Based Services (HCBS) Final Rule (CMS 2249-F/2296-F). The HCBS Final Rule specifies requirements for programs offering HCBS under the 1915(c), 1915(i), 1915(k), and 1115 authorities of the Social Security Act. These requirements aim to improve the quality of the lives of individuals, allowing them to live and receive services in the least restrictive setting possible with full integration in the community. MSHN must ensure that its provider network of CMHSPs and their sub-contracted providers are compliant with the HCBS Rule.

The Conflict Free Access and Planning workgroup is an MDHHS workgroup made up of participants from the PIHPs, CMHSPs, providers, and stakeholders. The Conflict Free Access and Planning workgroup was intended to explore how to implement processes in the service system that create firewalls, or separations between access and planning functions, and direct service functions. This has resulted in the workgroup needing to review four potential options for addressing conflict free processes. Any of the four options will conceivably and fundamentally alter the CMHSP structure and many CMHSP and PIHP Boards of Directors have issued resolutions opposing these options.

Following CMS' guidance, Michigan transitioned all the specialty behavioral health services and supports previously covered under 1915(b)(3) authority to a 1115 Behavioral Health Demonstration and 1915(i) HCBS state plan benefit effective October 1, 2019. Michigan developed the HCBS benefit to meet the specific needs of its behavioral health and developmental disabilities priority populations that were previously served through the Managed Specialty Services & Supports 1915(b1)(b3) waiver authorities within Federal guidelines. Beginning 10/1/2023, the 1915(i) State Plan Amendment (SPA) began to

operate concurrently with the 1115 Demonstration, which ensures the provision of behavioral health community-based services and evaluation/re-evaluation of eligibility function through Michigan's managed-care contract with the regional Prepaid Inpatient Health Plans (PIHP).

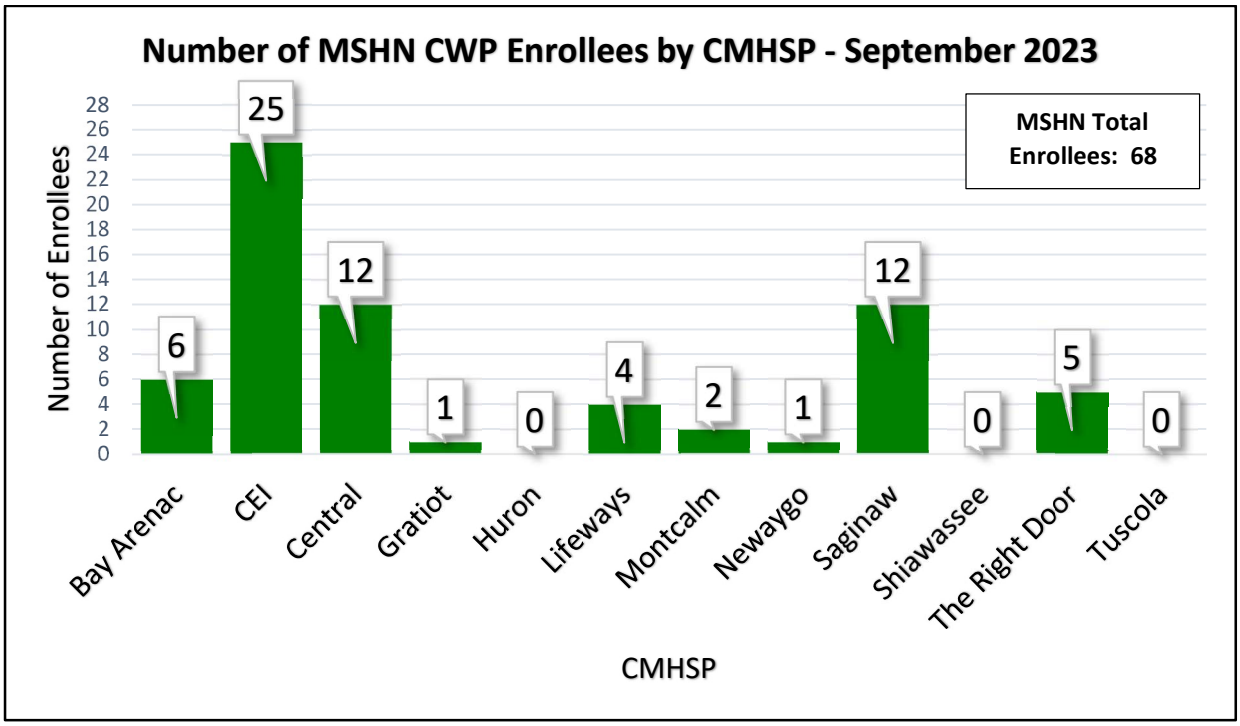
The Clinical Leadership Committee (CLC) consists of the clinical leaders of each CMHSP and MSHN. The MSHN Operations Council (OC) has created the CLC to advise the Prepaid Inpatient Health Plan's (PIHP) Chief Executive Officer (CEO) and the OC concerning the clinical operations of MSHN and the region.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

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

II. Waivers

A. Children's Waiver Program (CWP)

At the end of the third quarter (Q3) of Fiscal Year 2023 (FY23), Mid-State Health Network's (MSHN) Children's Waiver Program (CWP) had a total of 69 enrollees, which was a decrease of 4 compared to the number of enrollees at the end of FY23 Q2.

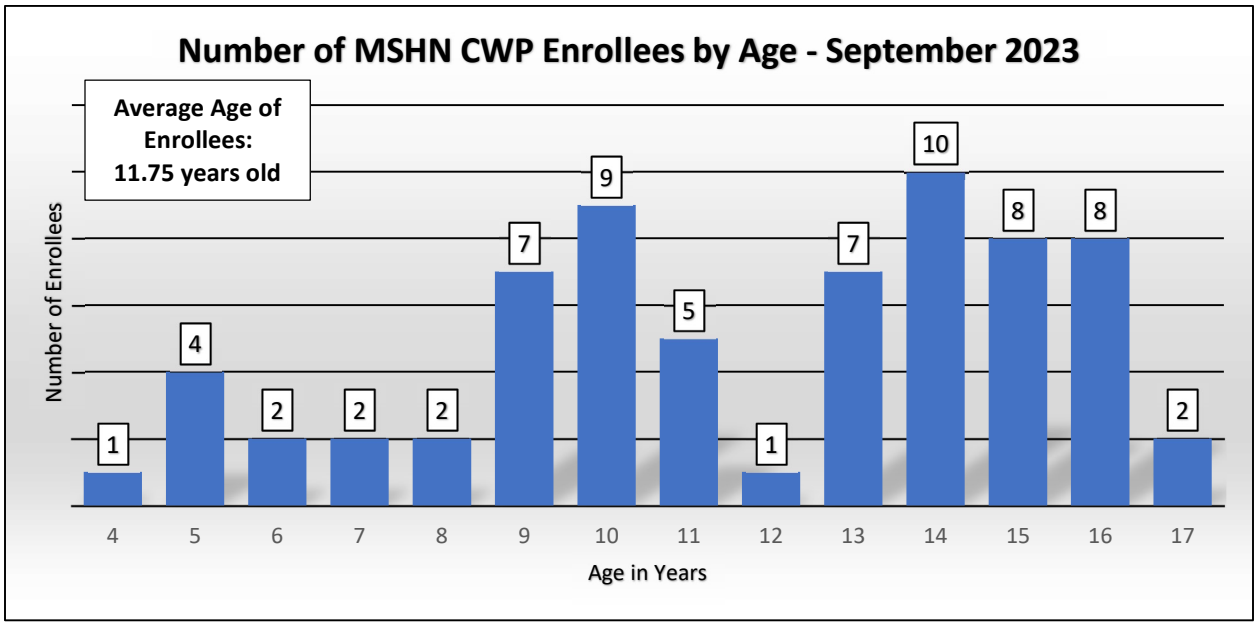


Mid-State Health Network's (MSHN) Children's Waiver Program (CWP) had a total of 68 individuals enrolled in September 2023. This amount remained the same from August 2023. Enrollment in the CWP has fluctuated slightly over the past fiscal year, from 72 in September of 2022, to 68 in September of 2023. CEI had the highest percentage of enrollees for September 2023 at 37%.

Currently, there are no applications pending for individuals who have been invited to participate in the CWP (but does not yet have an open case). There are presently three individuals on the Weighing List.

CWP Age-Related Data and Data Trends

In September 2023, the average age of individuals enrolled in the CWP was **11.75 years old**. MSHN had no age-offs. Individual reports with age-off data will be provided to each CMHSP when the individual is within 90 days of aging off the CWP (at age 18).



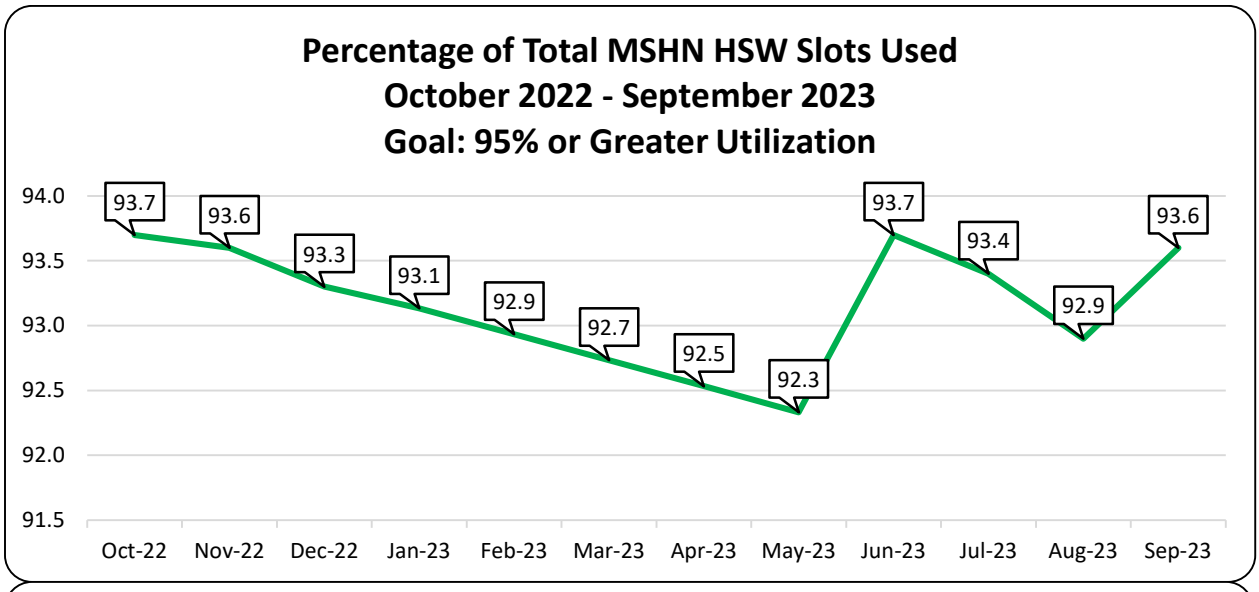
Summary

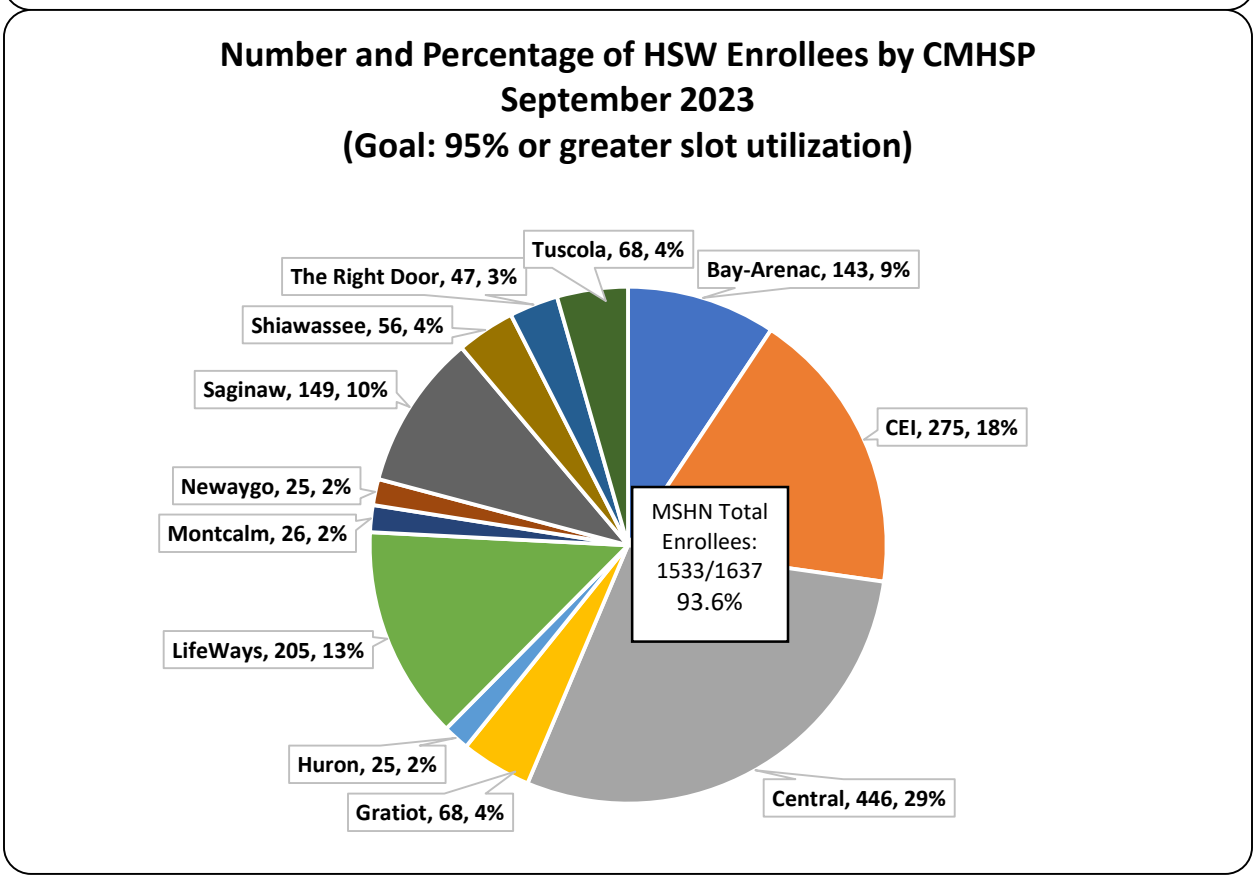
Enrollment in the CWP is down seven slots at end of FY23. The overall average age of enrollees has also increased slightly by three months. All cases in MDHHS or PIHP Waiver Support Application (WSA) work queues have been removed. Individual reports of overdue cases are provided to each CMHSP.

B. Habilitation Supports Waiver (HSW) Program

HSW Slot Utilization and Data Trends

While MSHN continued to be below the 95% slot utilization standard set by Michigan Department of Health and Human Services (MDHHS), there has been minor progress this past quarter, rising .2% from start of FY23Q4. For FY23, the HSW benefit roughly held even for the year, losing only .1%, or 1.6 slots. MSHN has a slot allocation of 1,637 slots. At the end of September, 1,533 slots, or 93.6%, were being utilized. This is a .7% increase since the end of FY23 Q3. The following charts represent the slot utilization distributions over the last 12 months, and among CMHSPs. MSHN will continue under corrective action by MDHHS. MSHN's goal is to attain a minimum 97% slot utilization.





Updates

Disenrollments and Data Trends

There was a total of 13 disenrollments ending FY23Q4 across the region. The reasons for disenrollment were due to consumer death 54% (7), voluntary disenrollment 31% (4), and nursing home 15% (2). MSHN reviews each voluntary disenrollment to better understand trends and address issues of education and concern.

New Enrollments and Data Trends

To end FY23Q4, MSHN had a total of 26 new enrollments across the region. The increase of enrollments over disenrollments continued this quarter with a positive balance of 13. This is a 2 to 1 enrollment to disenrollment pace which is helping to revive the slot utilization percentage closer to the 95% minimum.

Trends Related to Pended Cases

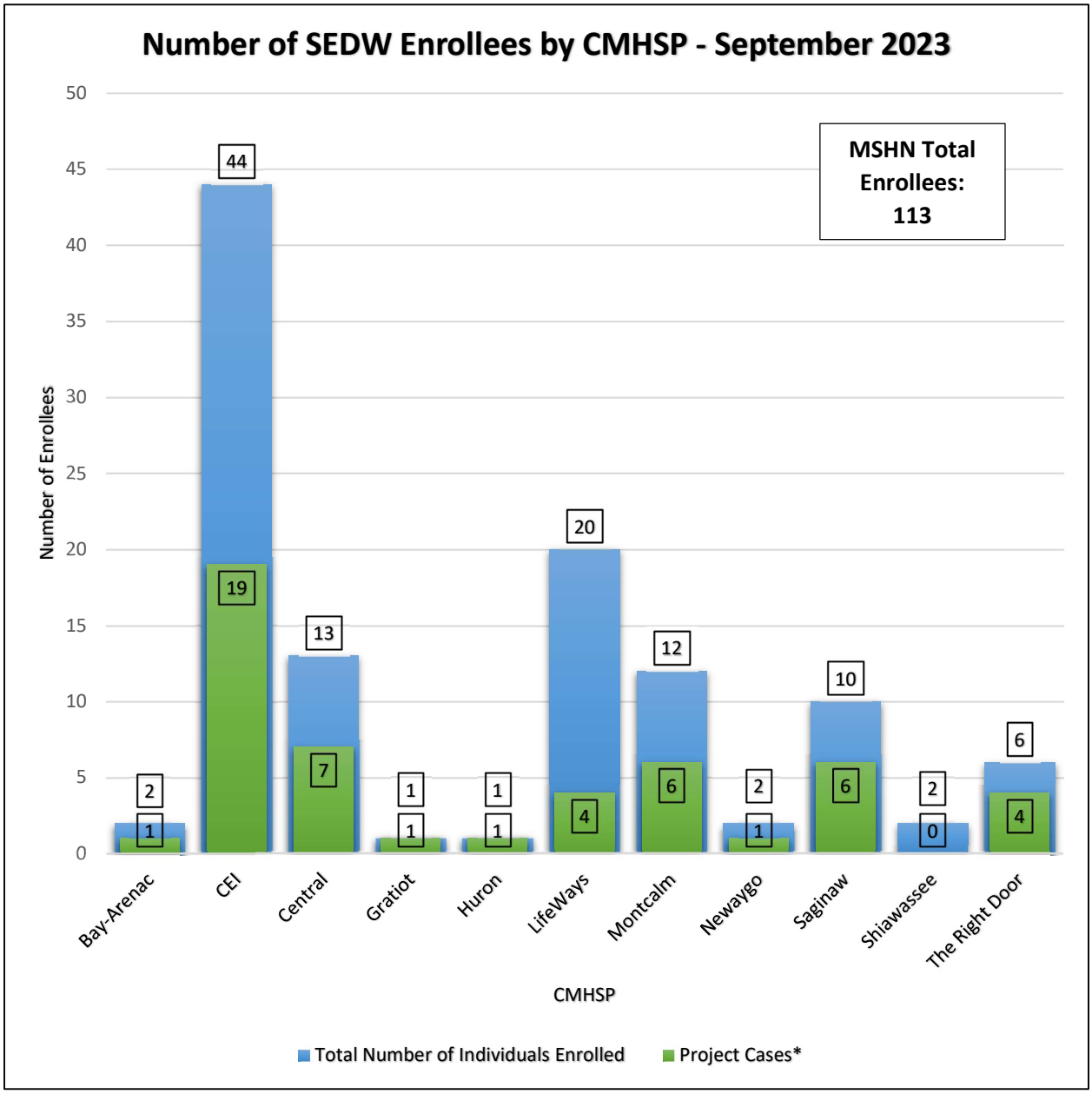
MSHN receives HSW recertification files each month from CMHSPs that have cases coming due for recertification submission to MDHHS. MSHN must review these cases and ensure that they meet criteria for recertification. When MSHN sends the files to MDHHS, their responsibility is to complete their review and to finalize approval of the recertification for the year. MSHN sends back recertifications that do not meet standards. MDHHS has advised MSHN to ensure that all submitted recertifications should meet the standards for approval and will be returned if they do not.

The CMHSPs have cited pended cases as a major reason for not wanting to submit new initial applications, citing the paperwork is prohibitive. Often, the reason MSHN must pend a case back continues to be due to lack of clarity around measurable goals and objectives in the plan. The other reasons were due to needing a copy of the behavior treatment plan, consent or IPOS addendum are missing signatures, IPOS start date not correct in WSA, and demographics does not match consent. MSHN shares this data to ensure that the CMSHPs can address improvements in these areas. MSHN will also organize trainings as indicated to help maximize efficiencies.

Summary

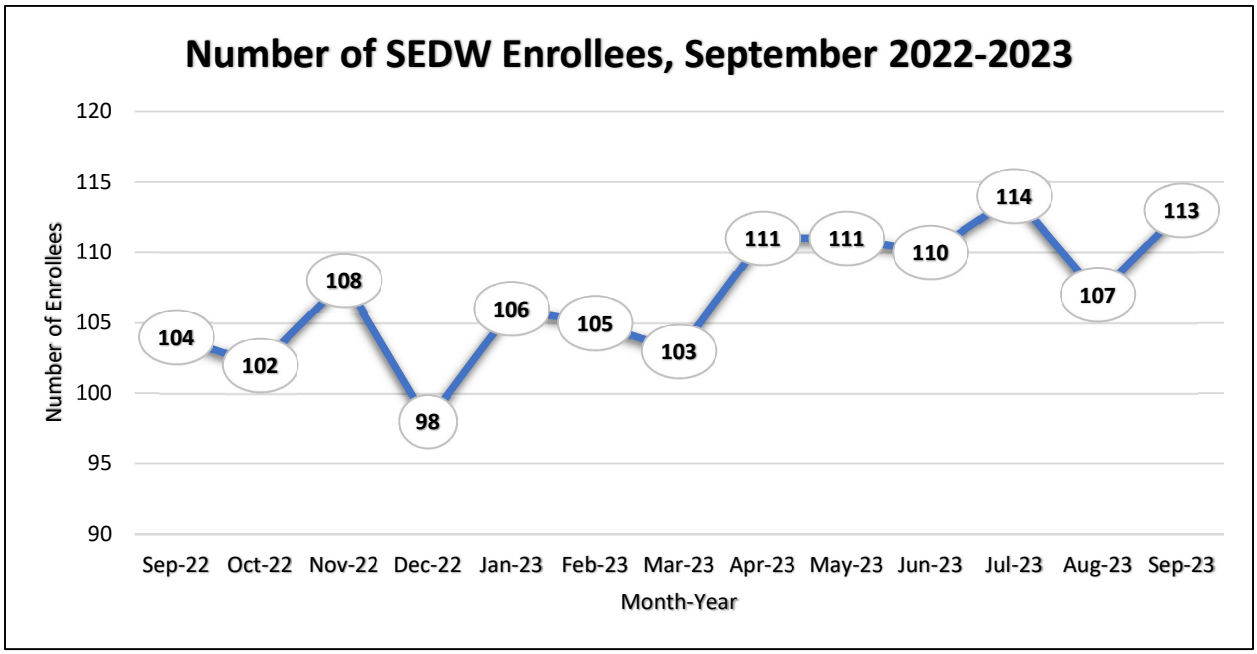
Mid-State Health Network's (MSHN) Habilitation Supports Waiver program ended FY23 Q4 with 1,533 enrollees, which was a 0.07% change from the third quarter of the fiscal year 23. The slot utilization rate at the end of the second quarter was 93.7% meaning MSHN continued to fall below compliance with the 95% slot utilization standard set by Michigan Department of Health and Human Services (MDHHS) but has continued a mostly upward trend. The region experienced 13 disenrollments and 26 new enrollments throughout the fourth quarter. The biggest reason for disenrollment throughout the fourth quarter was death of the recipient (54%).

C. Waiver for Children with Serious Emotional Disturbance (SEDW)



* "Project Cases" are children with open foster care cases through Michigan Department of Health and Human Services (MDHHS) and children adopted out of the Michigan Child Welfare System. Project Cases are counted as a part of the total number of enrollees for each Community Mental Health Service Program (CMHSP).

As of September 2023, Mid-State Health Network's (MSHN) Serious Emotional Disturbance Waiver (SEDW) program had a total of **113 enrollees**, of which there were **50 Project Cases (44%)**.



Currently, 11 of the 12 CMHSPs in MSHN's region have at least 1 child/family on the SEDW compared to the previous quarter, where only 8 CMHSPs had at least one SEDW case. The region added a total of 3 new cases to the SEDW compared to FY23Q3 but dropped 1 case from the beginning of FY23Q4. MSHN will continue to work with its network to ensure that each CMHSP has the knowledge and guidance to facilitate implementation of the SEDW benefit for potential candidates and enrollees.

Table 1:
SEDW Enrollment Numbers by CMHSP

CMHSP	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Bay-Arenac	2	1	1	0	1	2	2
CEI	39	40	42	44	46	41	44
Central	13	16	14	14	17	14	13
Gratiot	0	1	1	1	1	1	1
Huron	0	0	0	0	0	1	1
LifeWays	20	21	20	19	19	18	20
Montcalm	17	16	16	15	15	14	12
Newaygo	1	1	1	2	2	2	2
Saginaw	5	8	8	7	5	7	10
Shiawassee	0	0	0	0	1	1	2
The Right Door	6	7	8	8	7	6	6
Tuscola	0	0	0	0	0	0	0
Total	**103**	**111**	**111**	**110**	**114**	**107**	**113**

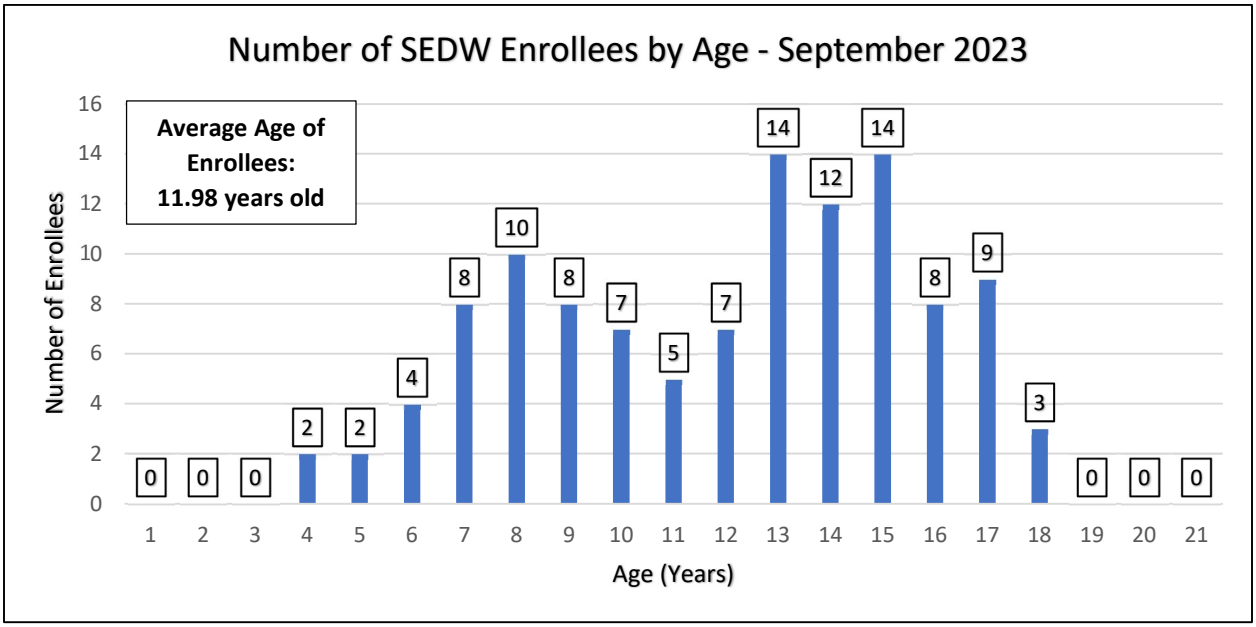
Table 2: SEDW Reason for Disenrollment

Reason for Disenrollment	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Age Off	0	0	0	0	0	0	0
Deceased	0	0	0	0	0	0	0
Moved out of State	0	1	1	0	0	0	0
Not Eligible	3	2	2	4	2	2	0
Other	0	0	0	0	0	0	0
Parent Declined	0	0	0	0	0	0	0
Reject	0	0	0	0	0	0	0
Res. Place 45 Day no Return	0	0	1	0	1	3	2
Voluntary Withdrawal	4	0	1	1	0	5	0
Withdraw	0	0	0	0	0	1	0
Total	**7**	**3**	**5**	**5**	**3**	**11**	**2**

Table 3: SEDW Total Disenrollment per CMHSP

CMHSP	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Bay-Arenac	0	1	1	0	0	0	0
CEI	3	1	1	1	0	4	0
Central	0	0	0	1	0	3	1
Gratiot	0	0	0	0	0	0	0
Huron	0	0	0	0	0	0	0
LifeWays	3	0	1	1	1	1	0
Montcalm	0	1	1	1	0	1	1
Newaygo	0	0	0	0	0	0	0
Saginaw	1	0	1	1	2	0	0
Shiawassee	0	0	0	0	0	0	0
The Right Door	0	0	0	0	0	2	0
Tuscola	0	0	0	0	0	0	0
Total	**7**	**3**	**3**	**5**	**3**	**11**	**2**

MSHN has added the two disenrollment tables (i.e., Reason for Disenrollment and Total Disenrollments by CMHSP) above to reflect the changes over the past year and to show disenrollment trends by CMHSP. Disenrollment data captured here includes the dates on which the disenrollments were finalized at the CMSHP. Often, MSHN receives notification of disenrollments with some delay. In these circumstances, the overall enrollment numbers are impacted but that specific disenrollment may not be captured in the report month. The current data indicates that the primary reason for disenrollment is reported to be "**Res. Place 45 Day No Return**." MSHN will review the data related to disenrollment at SEDW workgroup meetings and discuss the eligibility requirements to improve waiver enrollment.



At the end of FY23Q4, the average age of individuals enrolled in the SEDW was **11.98 years old**.

Summary

Total enrollees once again decreased at the end of FY23Q4 to 113, or a drop of one case. The drop noted in FY23Q4 is in contrast to the end of FY23Q2, which puts the end of FY23 up by 10 cases, and 11 over the whole year. Since September 2021, SEDW utilization has dropped 37 cases, from a high of 150. This means that potentially useful and intensive community services have not been utilized where they could have been and thus potentially leading to increased services of even higher intensity.

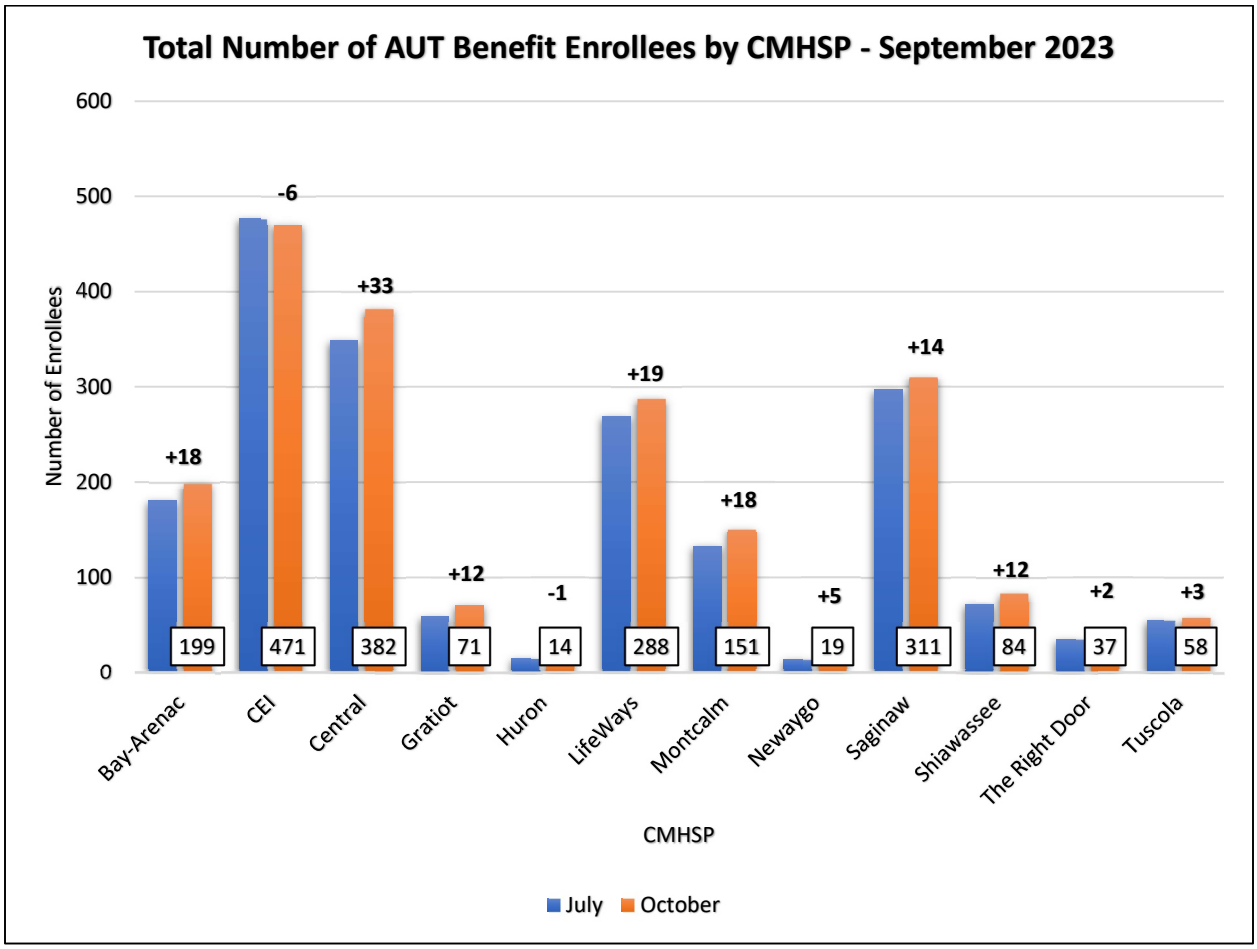
III. Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

A. Autism Benefit

Table 1:

Total Number of AUT Benefit Enrollees by CMHSP

CMHSP	Oct-22	Jan-23	Apr-23	Jul-23	Oct-23
Bay-Arenac	152	169	180	181	199
CEI	446	470	477	477	471
Central	339	348	345	349	382
Gratiot	61	55	57	59	71
Huron	19	19	18	15	14
LifeWays	254	249	256	269	288
Montcalm	112	125	133	133	151
Newaygo	12	12	12	14	19
Saginaw	269	278	285	297	311
Shiawassee	66	68	71	72	84
The Right Door	34	30	33	35	37
Tuscola	53	53	56	55	58
Total	**1817**	**1876**	**1923**	**1961**	**2085**



Mid-State Health Network's (MSHN) Autism Benefit enrollment data for September 2023 is shown in *Table 1: Total Number of AUT Benefit Enrollees by CMHSP* and subsequent chart. Enrollment numbers have **increased by 124** since July 1, 2023 (FY23, Q3). 10 of MSHN's 12 Community Mental Health Service Programs (CMHSPs) (Bay-Arenac, Central, Gratiot, LifeWays, Montcalm, Newaygo, Saginaw, Shiawassee, The Right Door and Tuscola) have experienced continued enrollment growth within that period.

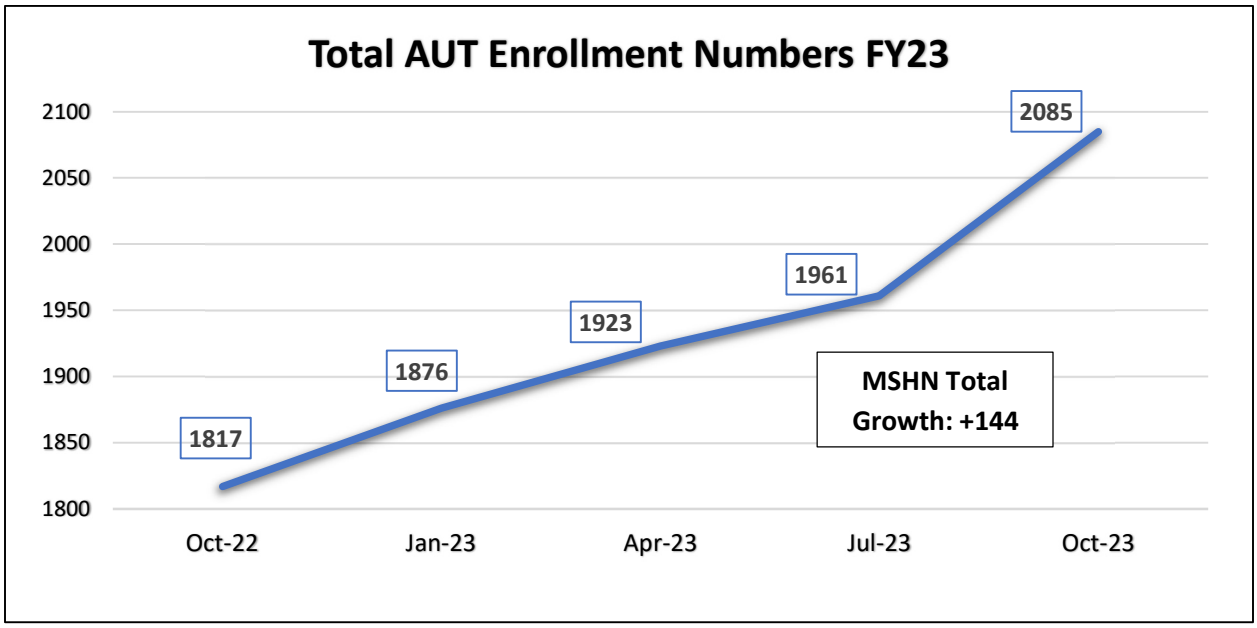


Table 2:*Total Pending AUT Benefit Enrollees*

CMHSP	Oct-22	Jan-23	Apr-23	Jul-23	Oct-23
Bay-Arenac	21	11	19	32	40
CEI	39	21	23	19	67
Central	51	55	60	50	74
Gratiot	4	13	17	23	20
Huron	0	0	0	0	0
LifeWays	11	29	28	22	28
Montcalm	9	14	8	13	10
Newaygo	0	4	2	0	0
Saginaw	32	28	32	46	56
Shiawassee	8	7	10	11	21
The Right Door	1	5	7	19	17
Tuscola	0	0	0	1	0
Total	**176**	**187**	**206**	**236**	**333**

Table 2: Total Pending AUT Benefit Enrollees depicts the number of individuals who have presented at each CMHSP requesting (but still waiting for) an autism evaluation. Positive changes indicate an increase in referrals and those still waiting for an assessment. Negative changes indicate CMHSP movement – having testing done for individuals and making diagnostic decisions (either qualifying or non-qualifying). This data could be used to inform CMHSPs about provider capacity issues as it relates to Qualified Licensed Practitioners (QLPs).

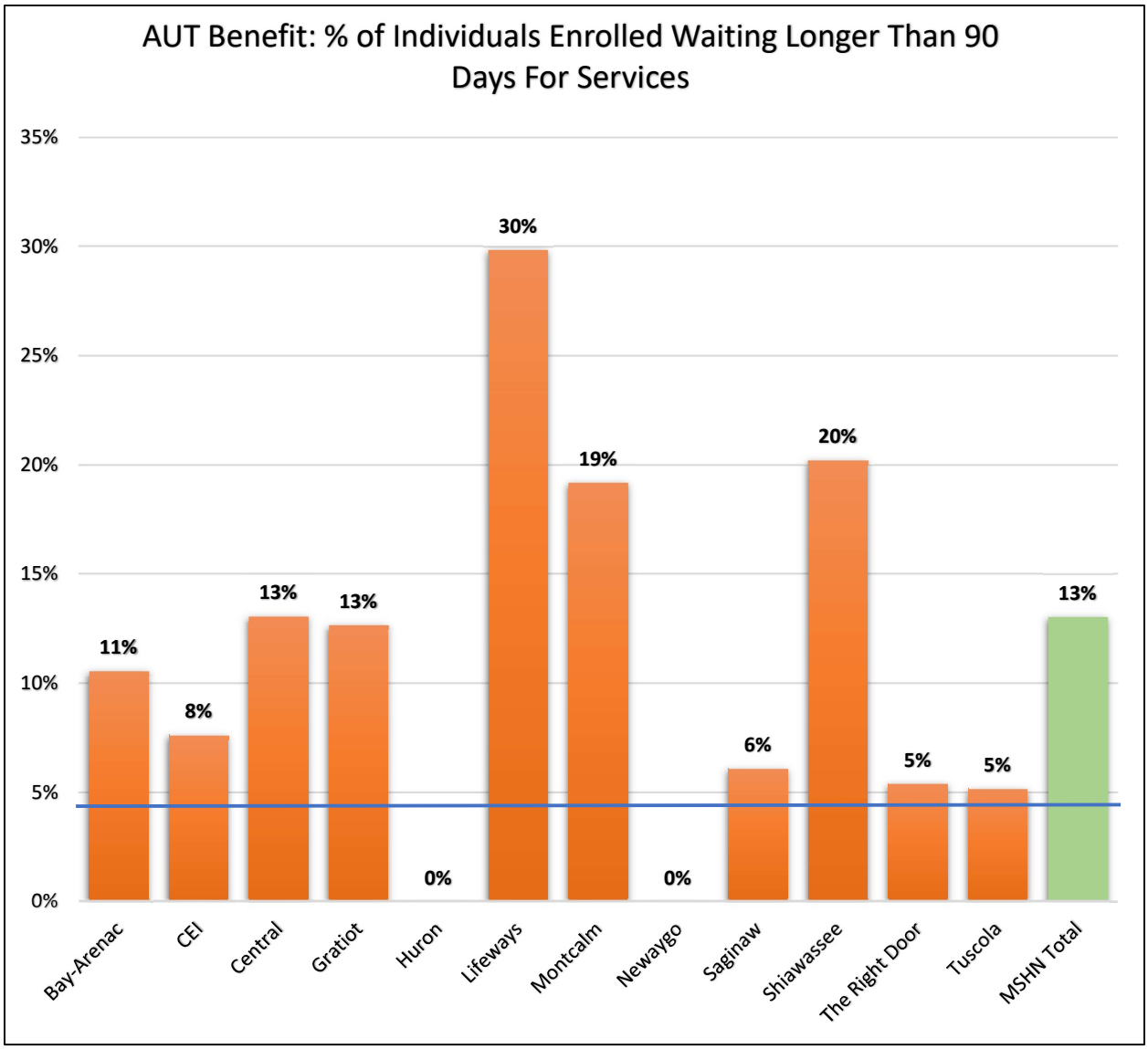
Table 3:
Reason for Disenrollment

Reason	Oct-22	Jan-23	Apr-23	Jul-23	Oct-23
Approved/Declined	11	4	7	12	16
Met TX. Goals	9	5	6	6	16
Out of State	3	0	0	1	0
No Medicaid	0	0	0	0	4
Age Off	1	4	0	0	1
Voluntary D/E	24	9	15	16	33
Other	0	0	2	7	8
Re-Eval did not meet med. nec. criteria	0	0	0	1	1
Total	**48**	**22**	**30**	**43**	**79**

The top reason for disenrollment in September 2023 was from **Voluntary Disenrollment**. CMHSPs are required to provide information when voluntarily disenrolling. Typically, families voluntarily disenroll after they feel progress has been made, they are transitioning to other services, or they no longer feel that ABA is beneficial.

Table 4:*Total Number of Individuals Enrolled and Waiting Longer than 90 days for Services*

CMHSP	Oct-22	Jan-23	Apr-23	Jul-23	Oct-23
Bay-Arenac	5	13	11	25	21
CEI	24	37	36	45	36
Central	10	21	12	35	50
Gratiot	3	3	3	5	9
Huron	3	2	2	0	0
LifeWays	35	39	37	76	86
Montcalm	24	28	31	48	29
Newaygo	0	0	0	0	0
Saginaw	6	10	2	17	19
Shiawassee	6	6	7	15	17
The Right Door	2	0	0	1	2
Tuscola	0	0	0	6	3
Total	**120**	**159**	**141**	**273**	**272**



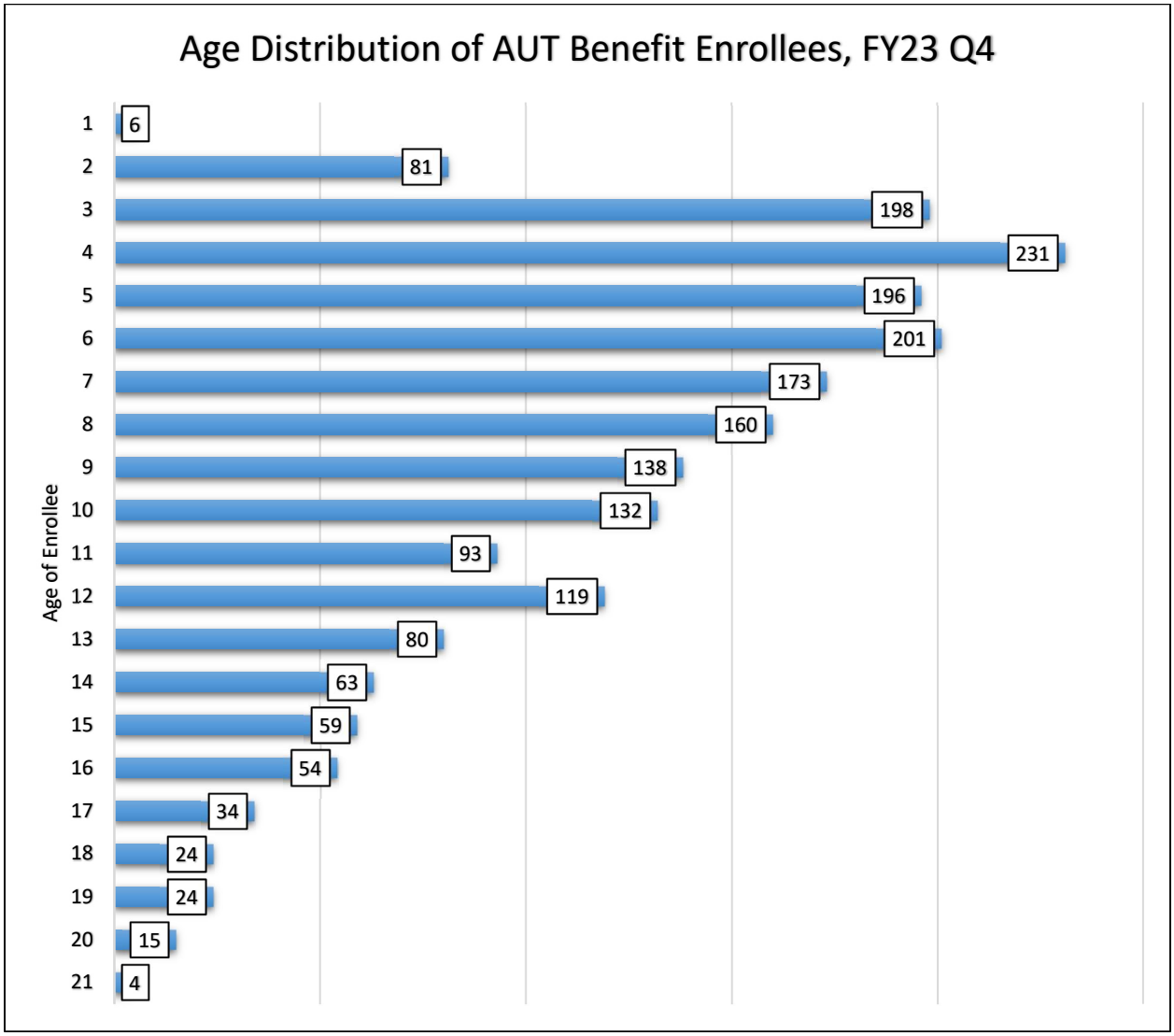
MSHN currently has an average of **13%** of its enrolled population waiting longer than 90 days to start services. 4 of the region's 12 CMHSPs have **less than or equal to 5%** of their enrolled population waiting longer than 90 days. The Clinical Leadership Committee of the MSHN region has established a goal that 95% of individuals served should receive ABA services within 90 days of established eligibility. MSHN will continue to work with the region to address issues related to service delays with a focus on increasing network capacity to ensure that all individuals receive services within 90 days of program eligibility. This data could be used to inform CMHSPs about provider capacity issues as it relates to the provision of ABA services.

Table 5: *New Evaluations by Classification*

Classification	Oct-22	Jan-23	Apr-23	Jul-23	Oct-23
Qualified	57	75	75	106	160
Not Qualified	34	43	26	46	70
Total	**91**	**118**	**101**	**152**	**230**

Overdue Re-evaluations Greater Than 30 Days

As of September 1, 2021, re-evaluations are only required once every three years. House Bill 4059, enacted on March 30, 2022, eliminates the requirement for re-evaluations entirely, however, the current expectation remains that re-evaluations will be completed every three years until policy is changed. MSHN will continue to provide guidance as implementation rules to House Bill 4059 become available, and policy is updated as a result. MSHN continues to emphasize the importance of quality and comprehensive initial autism evaluations to ensure eligibility is accurately determined.



The average age of individuals receiving AUT services for September 2023 was **8.10 years old**. The average age of individuals found to have a qualifying evaluation in Q4 was 7 years old. In recent Autism workgroup meetings, MSHN has highlighted this information, as well as the group of individuals that will age out of the benefit in coming months. MSHN has encouraged CMHSP leads to consider enrollment in other programs as appropriate, such as the Habilitation Supports Waiver (HSW) as a potential option for continued service.

Important WSA Updates:

The WSA was decommissioned for AUTISM only on April 1, 2023. MSHN has established a new data gathering process through the MSHN Autism Workgroup. The preceding data was the product of that work.

IV. Home and Community-Based Services Rule Transition (HCBS)

A. HCBS FY23Q3 Updates:

Purpose

On March 17, 2014, the Centers for Medicare and Medicaid Services (CMS) published a new set of rules for the delivery of Home and Community Based Services through Medicaid waiver programs. Through these rules, the Centers for Medicare and Medicaid Services aim to improve the experience of individuals in these programs by enhancing access to the community, promoting the delivery of services in more integrated settings, and expanding the use of person-centered planning.

In response, the Michigan Department of Health and Human Services is developing a statewide transition plan to bring its waiver programs into compliance with the new regulations while continuing to provide vital services and supports to Michigan citizens. The Department is committed to an inclusive process partnering with people receiving services, their allies, health care providers, and other organizations to create a transition plan that serves the best interests of the people of Michigan while also meeting requirements from the Centers for Medicare and Medicaid Services.

Current Projects

2020 Survey Remediation and Validation

This project is from 2020 surveys that were being resurveyed because they did not respond to the 2018 surveys. MSHN first began reviewing and cleaning this data with CMHSP leads in December 2022. MSHN received cleaned data from MDHHS in late April 2023. The 2020 surveys are now in their final stages of validation and remediation. There were approximately 157 unique individuals across 77 settings. All surveys must be remediated and validated by November 2023.

STATUS: In progress, site visits are being scheduled and all steps to be completed by November 2023.

Survey Process- Q1 2023

MDHHS has indicated that Qualtrics will no longer be used for surveying activity. The focus will be on reviewing settings/providers annually and a biennial process with beneficiaries. Each PIHP will be responsible for all settings within their region. The surveys completed in April 2023 will be the last round of the traditional survey process.

STATUS: Surveys closed, awaiting next steps from MDHHS.

Heightened Scrutiny CMS Review

No new updates in this section. MDHHS expects that nearly all sites will be dropped off the heightened scrutiny list.

STATUS: MDHHS, in the July 28, 2023, HCBS Leads meeting that CMS indicates that it will be at least one year before they review these settings.

Provisional Applications

The MSHN team continues to complete provisional approvals as indicated. Some reviews require involvement of MDHHS due to the perceived restrictive nature of the setting or provider.

Ongoing Monitoring and Evaluation

Following the completion of the initial HCBS Rule Transition compliance requirement of March 17, 2023, CMS and MDHHS have tasked the 10 PIHPs with annual monitoring and evaluating network providers for continued compliance. MDHHS is working on a process that will guide the PIHP/CMHSP system in ensuring that providers remain in compliance with the HCBS Final Rule. MSHN is also reviewing how it will implement ongoing monitoring in its region. This will include assessment of provider compliance and individual beneficiary experience, on-site reviews, virtual reviews, and desk audits.

Important Upcoming Dates

- **November 2023**
  2020 Survey Validation and Remediation completion due to MDHHS

V. Conflict Free Access and Planning

A. Summary

The MDHHS Conflict Free Access and Planning (CFAP) has been meeting for approximately a year and a half. Its purpose has been to explore models of operation that would align the service system to be in compliance with federal conflict free case management. MDHHS has noted an interest in moving away from the use of safeguards as the major contributor to compliance, to the more rigid approach of using "firewalls." These firewalls are intended to clearly separate major CMHSP functions so that access and planning and direct service provision are make to be separate, with no potential for financial conflict, the perceived primary reason for interest in firewalling these functions.

There are multiple ways to provide feedback, anyone can also use the CFAP email to MDHHS, Mdhhs-ConflictFreeAccess@michigan.gov.

A workgroup meeting was held in September 2023 where the up to date results of feedback gathered from multiple stakeholders was shared. There were over 3,000 lines of feedback to code. The coding yield a top five most important categories according to the stakeholders, including Access, Continuity, Autonomy, Viability, and Stringency. The top three relate directly to the beneficiary's experience and the final two relate to system design. MDHHS did not push for a decision on one of the four options, rather indicating that due to the feedback they were continuing to get, they would likely be discussing an alternate plan with the CFAP workgroup. The timeline for any kind of implementation has been put on hold until all feedback is in and a fully informed decision can be made.

VI. 1915i State Plan Amendment (SPA)

A. Summary

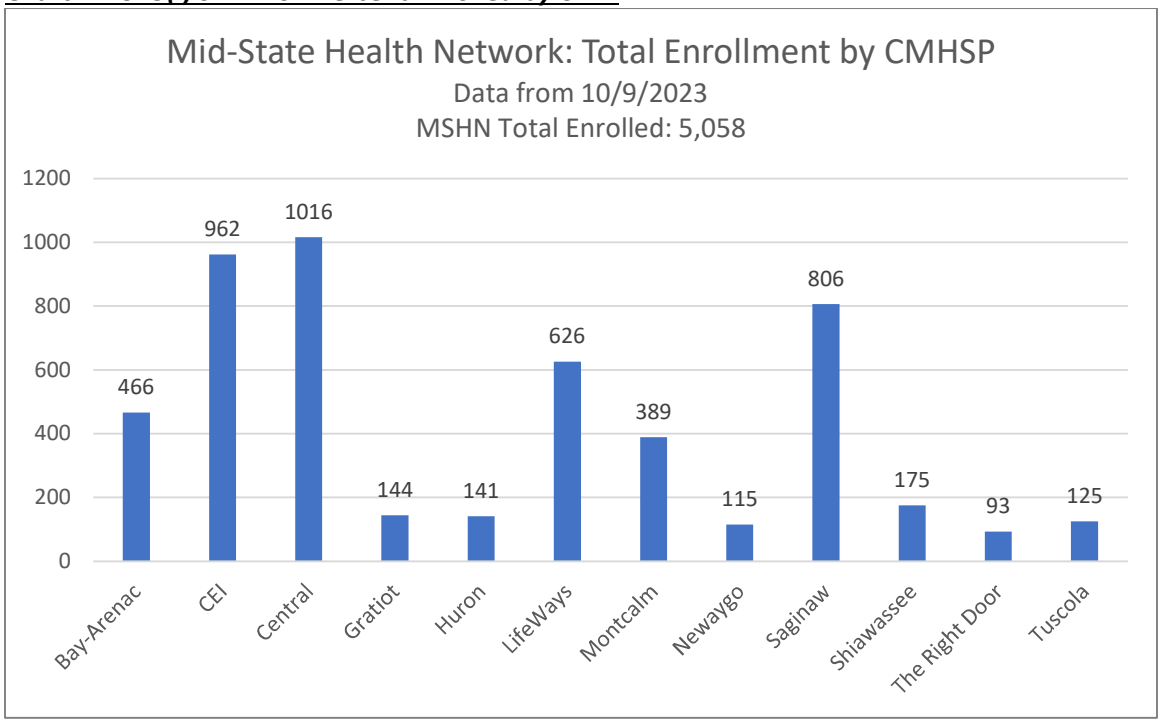
Following CMS' guidance, Michigan transitioned all the specialty behavioral health services and supports currently covered under 1915(b)(3) authority to a 1115 Behavioral Health Demonstration and 1915(i) HCBS state plan benefit effective October 1, 2019. Michigan developed the HCBS benefit to meet the specific needs of its behavioral health and developmental disabilities priority populations that were previously served through the Managed Specialty Services & Supports 1915(b1)(b3) waiver authorities within Federal guidelines.

The 1915(i)SPA benefit includes Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Family Support & Training, Fiscal Intermediary, Housing Assistance, Respite Care, Skill-Building Assistance, Specialized Medical Equipment & Supplies (formerly known as Assistive Technology), Supported/Integrated Employment, and Vehicle Modification (formerly known as Assistive Technology). The 1915(i)SPA benefit does not include Goods and Services.

B. Regional Issues

Upon MDHHS' initial deadline of 10/1/23, the PIHP's regional enrollment progress was 99.63% complete (range 98.17% - 100%), with a total of 4,896 enrolled individuals. On Monday, 10/2/23 the PIHP received a list from MDHHS of 460 additional individuals potentially needing to be enrolled, with a new deadline for these additional enrollments of Friday, 10/6/23. Of these 460 individuals, 93% were able to be accounted for by the designated CMHSP within MDHHS's given timeline: 301 were found to not be receiving services via the 1915(i)SPA and thus not needing to be enrolled, 126 were identified as receiving services and have since been enrolled, and 33 individuals were not accounted for by the designated CMHSP. The table below reflects enrollment data as of Monday, 10/9/23 that incorporates these additional individuals.

Chart 1: *1915(i) SPA WSA Percent Enrolled by CMH*



The PIHP continues to focus heavily on supporting CMHSPs with adjusting their policies, procedures, and systems to meet the previously mentioned CMS requirements now in place. Although the shift to having individuals open in the WSA prior to receiving any 1915(i)SPA services was a known and expected one, this is still a significant change to how CMHSP services that use the WSA typically function. CMHSPs continue to work to identify ways to best meet this requirement, and efforts at the PIHP to support these necessary adjustments are ongoing as well.

Moving forward, it will also be necessary to identify individuals coming due for their annual re-evaluation required to continue to receive services and to then conduct those evaluations in a timely manner. This data is able to be tracked in the WSA system and will be reported to the CMHSPs in the PIHP's monthly 1915(i)SPA Workgroup as well as in this report in future versions.

Chart 2: *1915(i) SPA WSA Percent Enrolled by PIHP (10-18-2023)*

ISP Enrollment Data

	Region 1 North Care	Region 2 NMRE	Region 3 LRE	Region 4 SWMBH	Region 5 MSHN	Region 6 CMHPSM	Region 7 DWIHN	Region 8 OCHN	Region 9 Macomb	Region 10	TOTALS
NEW PROJECTION	922	1609	3354	2497	5056	1104	6855	3378	1766	3150	29691
Point in Time Enrollment 10/18/23	922	1579	2572	2509	5086	1027	6833	3362	1758	2969	28617
% of completed enrollments	100.0%	98.1%	76.7%	100.5%	100.6%	93.0%	99.7%	99.5%	99.5%	94.3%	96.4%

Chart 2 above reflects the final total by MDHHS for all PIPHs following the conlcusion of the enrollment of all regional beneficiairies.

VII. Crisis Residential Services

MSHN continues work with Family Health Psychiatric and Counseling Center (FHPCC), to establish crisis residential services in Alma, MI for MSHN service recipients experiencing a mental health crisis. This work has been ongoing. The FHPCC site has been focused on completing the licensing requirements, posting for a program manager, completing the fire safety inspection, and starting renovations. The official name of the new crisis residential center is Healthy Transitions and is on target for a late December open.

MDHHS Service Authorization Denials Report – Mid-State Health Network (MSHN)

Report Timeframe: FY23 All Quarters

Background:
MDHHS requires PIHPs to submit a quarterly service authorization denials report on behalf of the region. The report must contain all initial service authorization denials, not denials of previously authorized services (ie: terminations, suspensions, reductions, second opinions, etc). The goal of the report is to ensure that service authorization decisions are occurring within the required timeframes of 14 days for standard requests and 72 hours for expedited requests, and to ensure that Medicaid beneficiaries are receiving a Notice of Adverse Benefit Determination each time a service is denied.

Due Dates:
Q1 – Feb 1
Q2 – May 1
Q3 – Aug 1
Q4 – Nov 1

Benchmark:
MDHHS has not set a performance benchmark for this report at this time. At this time MDHHS is monitoring the data and providing feedback on a quarterly basis if adverse trends are identified such as authorization decisions not being made within required timeframes and ABD notices not being provided to consumers within required timeframes.

Quarter	% of Authorization Decisions Made Timely – Standard	% of Authorization Decisions Made Timely - Expedited
1	93.5%	51.6%
2	97.1%	60.2%
3	97.9%	94.5%
4	97.4%	91.6%

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CMH	Q1 Compliance Rate	Q2 Compliance Rate	Q3 Compliance Rate	Q4 Compliance Rate
BABHA	97%	99.4%	98.21%	100.0%
CEI-CMH	100%	100.0%	100.00%	99.3%
CMHCM	91.6%	97.9%	98.74%	98.2%
GIHN	100%	98.7%	100.00%	100.0%
HBH	100%	72.5%	100.00%	97.4%
Lifeways	92.3%	95.0%	94.94%	79.7%
MCN	82.3%	100.0%	98.21%	97.9%
NCMH	14.3%	35.7%	86.67%	81.8%
SCCMHA	96.8%	100.0%	96.77%	100.0%
SHW	87.4%	84.4%	95.15%	97.0%
TBH	84.0%	90.2%	85.42%	89.7%
TRD	95.2%	95.2%	100.00%	100.0%

ABD Reason	ABD Sub-Reason	Number of Services Denied	Number of Services Denied Per 100 Members	Number of Decisions Made Timely-Standard	Number of Decisions Made Untimely-Standard	Number of Decisions Made Timely-Expedited	Number of Decisions Made Untimely-Expedited
ELIGIBILITY		**4485**	**11.76**	**4164**	**122**	**179**	**20**
	CLINICAL ELIGIBILITY CRITERIA NOT MET	3877	10.16	3556	97	199	42
	MEDICAID ELIGIBILITY CRITERIA FOR SMI, IDD, SED, OR SUD NOT MET	293	0.77	291	2	0	0
	MHP RESPONSIBLE FOR SERVICE	7	0.02	5	2	0	0
	OTHER RESOURCES ARE AVAILABLE	316	0.83	271	11	4	30

ABD Reason	ABD Sub-Reason	Number of Services Denied	Number of Services Denied Per 100 Members	Number of Decisions Made Timely-Standard	Number of Decisions Made Untimely-Standard	Number of Decisions Made Timely-Expedited	Number of Decisions Made Untimely-Expedited
	MEMBER LIVES OUTSIDE OF PIHP SERVICE AREA	49	0.13	42	6	1	0
	MEMBER RESIDING IN AN INSTITUTION	9	0.02	9	0	0	0
	OTHER	1	0.00	24	1	0	0
DELAY		**91**	**0.24**	**86**	**5**	**0**	**0**
	AUTHORIZATION DECISION NOT MADE WITHIN REQUIRED TIMEFRAME	76	0.20	68	8	0	0
	OTHER	17	0.04	17	0	0	0
MEDICAL NECESSITY		**1017**	**2.67**	**873**	**53**	**30**	**61**
	CLINICAL DOCUMENTATION PROVIDED DOES NOT ESTABLISH MEDICAL NECESSITY	915	2.40	833	51	5	52
	OTHER	1	0.00	1	0	0	0
OTHER		**50**	**0.13**	**45**	**5**	**0**	**0**
	SERVICE(S) IS NOT COVERED BY MEDICAID	11	0.03	9	2	0	0
	OTHER	25	0.07	24	1	0	0
Total	**Total**	**5643**	**14.79**	**5168**	**185**	**209**	**81**

Date Reviewed by UM Committee: 11/16/2023

Regional Response to Data:

- Noted improvement in the rate of timely ABDNs for expedited service authorization requests. CMHs have improved their processes for providing ABDN at the time of inpatient hospital screenings to ensure that timeliness standards are met.
- Greatest barrier identified by CMHs is significant staff turnover and ensuring that new case managers have a good understanding of the timeliness standards. CMHs are focused on ensuring initial and ongoing training for staff.
- Overall strong regional performance during FY23

MSHN

Mid-State Health Network

Delegated Managed Care Quality Assurance Review Summary Report Fiscal Year 2023

Contents

CMHSP Delegated Managed Care Review (DMC)

MSHN conducted full Delegated Managed Care (DMC) reviews for nine of the twelve (9/12) Community Mental Health (CMH) agencies within the region in FY23Q2 – Q4. Full reviews include a full programmatic review of policies, procedures, and sample files and charts.

MSHN conducted three of twelve (3/12) interim Delegated Managed Care reviews for CMH's within the region during FY23Q1. Interim reviews ensure that all approved corrective action from the previous review has been implemented. In addition, the interim reviews include a review of any new standards identified from contractual or regulatory changes and additional review of charts and files (as applicable) to ensure compliance. Interim reviews are not scored and not reflected in the tables below.

Scores below represent the nine (9) full reviews completed by MSHN during FY23Q2-Q4.

Delegated Managed Care Review Tool

Includes review of 199 standards. The focus of this section is to ensure compliance with requirements. Overall compliance for this timeframe is 95%.

Table 1: Delegated Managed Care Tool

Sections	# Of Standards	FY23 Q2 – Q4 Results
Information Customer Service	12	97%
Enrollee Rights and Protections	9	100%
24/7/365 Access	18	88%
Provider Network Sub-Contract Providers	14	100%
Service Authorization and UM	7	99%
Grievance and Appeals	19	96%
Person Centered Planning	30	90%
Coordination of Care/Integration	6	96%
Behavior Treatment Plan Review Committee	21	94%
Consumer Involvement	3	100%
Provider Staff Credentialing	22	93%
Compliance	7	99%
Ensuring Health and Welfare	16	97%
Information Technology	9	100%
Trauma Informed Care	6	99%

Scores represent January 1- September 30 , 2023.

Program Specific (PS) Non-Waiver Review Tool

Includes review of fifty-eight (58) standards. The focus of this section is to ensure compliance with requirements. Overall compliance for this timeframe is 93%.

Table 2: Program Specific Non-Waiver Tool

Sections	# Of Standards	FY23 Q2-Q4 Results
ACT	6	83%
Self-Directed Services	8	97%
Peer Delivered and Operated (Drop In)	2	100%
Home-Based Services	10	88%
Clubhouse	7	100%
Crisis Residential	10	98%
Targeted Case Management	4	97%
Autism/ABA	4	81%
Children's Intensive Stabilization Services	7	98%

Scores represent January 1- September 30, 2023.

Program Specific (PS) Waiver Review Tool

Includes review of forty (40) standards. The focus of this section is to ensure compliance with requirements. Overall compliance for this timeframe is 95%.

Table 3: Program Specific Waivers Tool

Sections	# Of Standards	FY23 Q2-Q4 Results
Habilitation Supports Waiver	6	95%
Home and Community Based Services	14	92%
Children's Waiver Program	9	99%
Severe Emotional Disturbances Waiver	11	95%

Scores represent January 1- September 30, 2023

Clinical Chart Review Tool

Includes review of seventy-eight (78) standards. The focus of this section is to ensure compliance with requirements. MSHN reviews 5-8 charts for each CMH. MSHN selects one chart per program for review. Overall compliance for this timeframe is 93%.

Table 4: Clinical Chart Review Tool

Clinical Chart Standards	# Of Standards	FY23 Q2-Q4 Results
Intake/Assessment	13	97%
Pre-Planning	10	91%
PCP/IPOS	21	94%
Documentation	2	100%
Customer Service	5	97%
Delivery and Evaluation	3	80%
Program Specific Service Delivery	17	93%
Discharge/Transfers	4	80%
Integrated Physical/Mental Health Care	3	97%

Scores represent January 1- September 30, 2023

Encounters and BHTEDs Review

Includes a sample review of professional encounters and institutional encounters to ensure compliance in addition to a review of CMHSP business processes related ethnicity, workforce, and Medicare ID numbers.

Table 5: Encounters and BHTEDs Business Process Review Tools

Encounters and Business Processes	FY23 Q2-Q4 Results
Encounters Sample Review	100%
BH-TEDS Sample Review	100%
BHTEDS/Encounters Business Processes	100%

Scores represent January 1- September 30, 2023

Strengths

- CMHs within the MSHN region have worked diligently to ensure compliance with behavior treatment standards and outcomes reflect a 20% increase since 2021.
- CMHs successfully implemented required changes in the EMR system related to ethnicity, workforce, and Medicare ID collection.
- There were many instances in the charts reviewed across all CMHs where reviewers noted the ways in which the CMH staff had gone above and beyond to ensure that each individuals hopes, dreams, and goals were met including helping to find independent housing, ways to ensure transportation and access to outings, and bringing in outside resources to provide additional opportunities for individuals to be successful.

Areas for Improvement

All review findings require corrective action. QAPI shares all review scores and review information within the department quarterly report. The reports are shared with all departments and those departments determine if further action is needed, beyond corrective action, and address as necessary.

- Chart reviews indicate services are not being provided in amount, scope, and duration they are authorized for across the region.
- Regionally, there is significantly low compliance with ensuring ACT consumers receive 120 minutes of weekly face to face contact.
- When reviewing grievance and appeals, the language in the narrative sections were often times not at a 6.9 grade reading level.

SUDSP Treatment Provider Delegated Function Reviews

QAPI completed eleven (11) full reviews and six (6) interim reviews in FY2023.

Interim reviews include a review of any new standards identified for the year and review to ensure implementation of approved corrective action from the previous review. Only chart reviews and new standards are scored during an interim reviews.

Full reviews include consumer chart reviews, sample files to verify processes, policies, and procedures. Each provider review is inclusive of all provider sites within the MSHN Region. For providers that are located outside of the MSHN region, MSHN honors the monitoring and auditing conducted by the PIHP in the region where the providers are located.

Delegated Functions Tool Results

Table 6: FY23 SUD Delegated Functions Scores

Sections	# Of Standards	Results
Access and Eligibility	4	84%
Information and Customer Service	17	96%
Enrollee Rights and Protections	14	95%
Grievance and Appeals	19	93%
Compliance	11	95%
Quality	5	86%
Individualized Treatment & Recovery Planning & Documentation	13	88%
Coordination of Care	4	83%
Provider Staff Credentialing	22	94%
IT Compliance/IT Management	1	100%
Trauma Informed Care	6	93%
Total Overall	**116**	**93%**

Program Specific Results

The Program Specific tool includes a review of specific services and is applicable to all providers.

Table 7: FY23 SUD Program Specific Scores

Sections	# Of Standards	Results
Residential	2	75%
Peer Recovery Support Services	1	75%
Women's Specialty Services	3	83%
Medication Assisted Programs	10	100%
Recovery Residences	9	92%
Total Overall	**25**	**89%**

Consumer Chart Review Results

Table 8: FY23 SUD Chart Review Scores

Sections	# Of Standards	Results
Screening, Admission, Assessment	5	73%
Treatment/Recovery Planning	10	72%
Progress Notes	4	69%
Coordination of Care	4	60%
Discharge/Continuity of Care	3	59%
Residential	4	64%
Medication Assisted Treatment	15	54%
Women's Designated	2	68%
Recovery Housing	4	59%
Total Overall	**51**	**68%**

**Scores include interim chart reviews in addition to full chart reviews.*

Strengths

- There has been improvement with providers verifying primary source documentation related to staff licenses and credentials.
- Provider charts indicated 90% compliance with using evidence-based practices in the records reviewed.

Areas for Improvement

All review findings require corrective action. QAPI shares all review scores and review information within the department quarterly report. The reports are shared with all departments and those departments determine if further action is needed, beyond corrective action, and address as necessary.

- Periodic reviews were often not completed or completed but missing required elements.
- Clinical chart reviews continue to show challenges with meeting coordination of care requirements.
- Record reviews indicate that screening children for FASD is not always completed.

Governing Body Form

To be completed by the PIHP and submitted to MDHHS along with its annual QAPIP submission no later than February 28th of each year.

Name of PIHP		
Mid-State Health Network		
List of members of the Governing Body (add additional rows as needed)		
Name	**Credentials**	**Organization** (if applicable)
1. Brad Bohner	2025	LifeWays CMHA
2. Joe Brehler	2025	CEI CMH
3. Phillip Moore	2024	Shiawassee Health & Wellness
4. Michael Ciezniewski	2023	Saginaw County Community Mental Health
5. Ken DeLaat	2026	Newaygo County Mental Health
6. David Griesing	2024	Tuscola Behavioral Health
7. Dan Grimshaw	2026	Tuscola Behavioral Health
8. Tina Hicks	2024	Gratiot Integrated Health
9. John Johansen	2024	Montcalm Care Network
10. Jeanne Ladd	2024	Shiawassee Health & Wellness
11. Pat McFarland	2026	Bay Arenac Behavioral Health
12. Deb McPeek-McFadden	2024	The Right Door for Hope, Recovery & Wellness
13. Ken Mitchell	2025	CEI CMH
14. Gretchen Nyland	2025	The Right Door for Hope, Recovery & Wellness
15. Irene O'Boyle	2026	Gratiot Integrated Health
16. Kurt Peasley	2024	Montcalm Care Network
17. L. Joseph Phillips	2026	CMH for Central Michigan
18. Tracey Raquepaw	2025	Saginaw County CMHA
19. Kerin Scanlon	2025	CMH for Central Michigan
20. Ed Woods	2024	LifeWays CMHA

21. Bob Pawlak	2025	Bay Arenac Behavioral Health
22. Richard Swartzendruber	2026	Huron Behavioral Health
23. Beverly Wiltse	2026	Huron Behavioral Health
24. Susan Twing	2025	Newaygo County Mental Health

Date the Governing Body approved the annual QAPIP (prior SFY QAPIP evaluation, current SFY QAPIP description, and current SFY QAPIP work plan)*
Date: 1/10/2023,
Dates the Governing Body received routine written reports from the QAPIP (during the prior SFY; add additional rows as needed)*
Date: 9/12/2023
Date: 5/9/2023
Date: 1/10/2023
Date 11/1/2022
Date
Date
MDHHS Feedback
Click or tap here to enter text.

*The PIHP should be prepared to submit Governing Body meeting minutes and written reports to MDHHS upon request.