The Annual Summary and Evaluation of the Quality Assessment and Performance Improvement Program (QAPIP)

This evaluation compiles the quality assessment and performance improvement projects created by the Community Mental health Partnership of Southeast Michigan (CMHPSM) – Region 6 Pre-Paid Inpatient Health Plan (PIHP)

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I. Overview

Background. The Community Mental Health Partnership of Southeast Michigan (CMHPSM) is a region of four Community Mental Health Services Programs (CMHSPs), including Lenawee Community Mental Health Authority (LCMHA), Livingston County Community Mental Health Authority (LCCMHA), Monroe Community Mental Health Authority (MCMHA) and Washtenaw County Community Mental Health (WCCMH). Annually, the CMHPSM designs a Quality Assessment and Performance Improvement Program (QAPIP) to assure high quality services across the region. The Clinical Performance Team (CPT), comprised of appointed staff and consumers from each of the four counties, provides oversight of the QAPIP.

The QAPIP establishes a framework for quality and accountability for the safety of consumer care through the work of standing committees, ad hoc teams, and performance measures. The QAPIP establishes processes that promote ongoing systematic evaluation of important aspects of service delivery. The program promotes sustained performance improvement, the safety of consumers through the delivery of services, and addresses PIHP and provider compliance with state standards.

II. QAPIP Structure

A. CMHPSM Board

The CMHPSM Board is responsible for overseeing the QAPIP by performing the following functions:

- Review and approve the QAPIP Plan.
- Review and approve an annual report on the operation of the QAPIP.
- Receive periodic written reports of the activities of the QAPIP, including performance improvement projects (PIPs), actions taken, and the results of those actions.
- Following approval, the Board submits the written annual QAPIP Plan to MDHHS for approval. The submission includes a list of all the members of the Board.

B. Clinical Performance Team (CPT)

The QAPIP is managed by the CMHPSM Clinical Performance Team (CPT). Membership includes consumers, clinical staff, PIHP staff, and performance improvement staff from each of the CMHSPs within the region. A CMHSP Chief Executive Officer (CEO) from the Regional Operations Committee (ROC) also serves on the committee.

CPT responsibilities include performing the following:

- systematically gather information from various stakeholders
- define performance standards
- evaluate performance and/or gaps
- complete root cause analyses
- develop interventions
- implement interventions
- evaluate effectiveness of the interventions

- examine the capacity to support and sustain improved performance

The Integrated Health Care workgroup (IHC) was created by the CPT to carry out specific Performance Improvement Projects (PIPs) and report back to the CPT on a regular basis. Performance improvement projects are based on state requirements and the population health needs of the community. To assess population health needs, CMHPSM collaborates with the state, regional providers and members to carry out initiatives such as the Consumer Experiences project and the Recovery Self-Assessment project. Most QAPIP tasks are carried out by staff from each CMHSP and by Electronic Health Record Operations Committee (EOC) Liaisons.

CMHPSM staff (at CPT and EOC) provide leadership and support for data collection, analysis and report writing, compliance needs, and training. The CPT meets monthly to review progress on PIPs, and to ensure clear and consistent communication to staff, consumers, and stakeholders. After meetings are held, CPT Liaisons communicate the progress of PIPs to their staff, local Boards, consumers, and community stakeholders. Communication efforts include posting PIP plans on local websites, newsletters, internal communications boards, staff meetings, and community meetings.

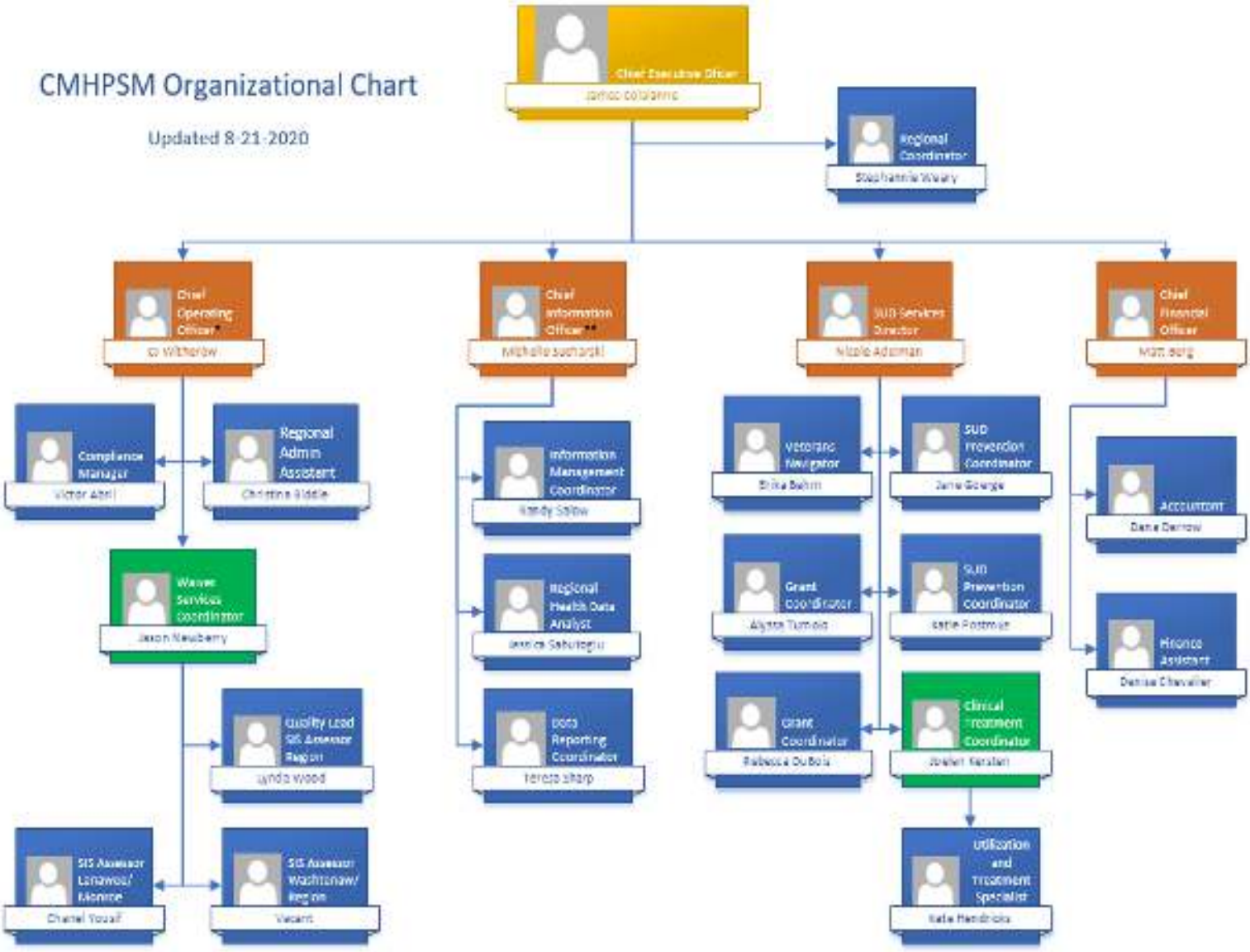
The CPT reviews the annual QAPIP Plan and may make revision suggestions. The Regional Operations Committee (ROC) then reviews and approves the plan before it is brought to the Regional Board. The ROC is made up of the four CMHSP Executive Directors, the CMHPSM Substance Use Disorder Director, and the CMHPSM CEO.

C. Committees and Workgroups

The QAPIP is implemented using various groups and teams including but not limited to the following:

- Clinical Performance Team
  - Integration of Health Care Workgroup (IHC)
- Regional Consumer Advisory Committee
- Utilization Review Committee
- Electronic Health Record Operations (EOC) Committee
- Customer Services Committee
- Network Management Committee
- Compliance Committee

The CPT is responsible for general oversight of the QAPIP. The Chief Operations Officer, and the Compliance and Quality Officer are responsible for the PIHP oversight of QAPIP Implementation. See CMHPSM Organizational Chart below.



III. Performance Improvement Projects

A. ADT Project (PIP Chosen by CMHPSM)

Summary: During FY 14, the region developed and implemented a PIP study to improve the quality of integrated clinical care provided for consumers transitioning in and out of inpatient settings. The purpose is to support consumers who are transitioning in and out of inpatient settings, reduce avoidable re-admissions, improve overall consumer access to a continuum of care, and improve health outcomes. This is accomplished by using admission, discharge and transfer (ADT) alerts received via a Health Information Exchange (HIE) that identify consumers who are experiencing a transition in care. Based on the ADT alerts, a clinical protocol is followed directing clinical staff to contact consumers either face to face or by phone/letter and provide support and/or encouragement for follow up with any discharge recommendations.

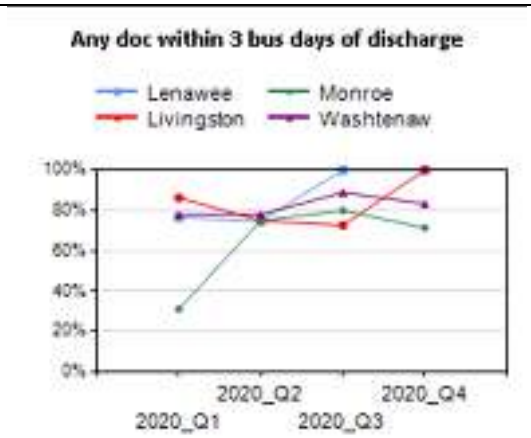
Goals: The work group goals for FY 20 were:

1. ADT alerts per consumer served will be greater than prior quarters.
2. Continue to refine the regional protocol regarding how to respond to ADT alerts.
3. Continue to assess the extent to which the regional protocol is followed.
4. To achieve significant improvement from baseline data.
5. Use of ADT data to inform outcomes with the Shared Metric of "Follow Up After Hospitalization".
6. Continue to work through Health Information Exchange barriers and errors.
7. Explore an information exchange relationship with ProMedica (the largest health care provider for Lenawee and Monroe Counties).
8. Increase coordination with other Health Plans to receive more accurate and timely ADT alerts.

Barriers: While Health Information Exchange errors and technology barriers are being addressed, issues such as the accuracy of how hospitals enter their data remains a barrier to our region receiving a significant increase in ADTs. Improvements have been made to the electronic health record to better identify and document when an ADT follow-up has occurred. The ADT data available relies on the hospitals compliance with and properly coding the ADTs they send. Hospitals based in other states (with locations in Michigan) cannot provide ADT data in the Michigan Health Information Exchange (MIHN), and MIHN has control and authority of contracting with hospital systems to be on the MI Health Information Exchange. CPT is also looking to for ways to increase cooperation with hospitals and mental health plans to improve this ADT data.

Status Report: Below is a comparison of FY19 and FY20 on this indicator. The table includes rate of follow up within 3 business days after a discharge alert between 10/1/2018 through 9/30/2019 compared with 10/1/2019 through 9/30/2020.

Rate of follow up within 3 days after receiving a discharge alert		
	2019	**2020**
Lenawee	88%	100%
Livingston	85%	100%
Washtenaw	82%	83%
Monroe	43%	71%
Regional	**82%**	**88%**



County Rates per Quarter : Overall performance of regional partners has improved this past year. Lenawee CMHSP's rates for each quarter in 2020 were 76%, 75%, 100% and 100%. Livingston CMHP's rates were 86%, 75%, 73% and 100%. Monroe CMHP's rates were 31%, 75%, 80% and 71%. Washtenaw CMHSP's rates were 78%, 78%, 89% and 83%. Performance was dependent on to the participation of hospitals and the HIE they use, as hospitals based in other states (with locations in Michigan) cannot provide ADT data in the Michigan Health Information Exchange. The CPT committee and ADT workgroup reviews data sets, identifies barriers and proposes solutions to improve rates.

For FY 21 the CPT Committee will determine revisions to the ADT project that need to be addressed based on the "Shared Metrics Projects Between the CMHPSM, CMHSPs and Michigan Medicaid Health Plans."

B. Consumers with Schizophrenia and Diabetes who had an HbA1c and LDL-C Test

Summary: Research identifies individuals with schizophrenia are at greater risk and higher prevalence rates for diabetes. Individuals with diabetes also have a greater increased risk for cardiovascular disease. Drawing HbA1c and LDL-C tests for individuals with schizophrenia and diabetes helps determine whether an individual (s) has abnormal lab value(s), which would assist in comprehensive assessment and treatment planning. Treatment planning would include informing the patient about lab values and strategies to reduce the risk of diabetes/cardiovascular disease with interventions such as: information and referral to primary care, care coordination with primary care and health plans, transportation to appointments, addressing blood pressure and lipid control, disease self-management, taking and managing medications, self-monitoring of glucose and blood pressure, smoking cessation, weight management, physical activity, healthy eating and coping skills. Providing lab monitoring and treatment as specified above could improve consumer health, functional status and satisfaction.

Goals: The PIHP's targeted interventions for Medicaid eligible patient(s) with schizophrenia and diabetes will result in an increase in the proportion of those patients receiving a HbA1c and LDL-C test during the report period. **The target rate of achievement was set at 71.6% of completed**

lab rates. The Integrated Health Work Group worked toward the following goals in FY20 and into FY 21:

1) The PIHP's targeted interventions for Medicaid eligible patient(s) with schizophrenia and diabetes will result in an increase in the proportion of those patients receiving a HbA1c and LDL-C test during the report period.
2) Labs will be entered as discrete fields into the regional electronic health record and/or collected from Michigan Health Information Network (MiHIN) lab feed and/or CC360 claims data.
3) The baseline measurement was 8/1/2017 to 7/31/2018. The FY19 (remeasurement 1) data period is 5/1/2019-4/30/2020.
4) The FY20 (remeasurement 2) data period is 5/1/2020-4/30/2020.
5) Incorporate updated barriers and interventions developed by the Integrated health Workgroup for Remeasurement Period 2.
6) Prepare for the Health Services Advisory Group (HSAG) - External Quality Review (EQR) for study methodology validation.

The 2018 HEDIS technical specification were used as the guide during the life of the study.

Status Report:

FY20		Q1	Q2	Q3	Q4
ALL	All known dates	65% (98/151)	68% (103/152)	65% (92/141)	65% (92/141)
Len	All known dates	85% (23/27)	81% (22/27)	92% (23/25)	87% (20/23)
Liv	All known dates	71% (12/17)	88% (14/16)	87% (13/15)	76% (13/17)
Mon	All known dates	56% (19/34)	60% (18/30)	59% (17/29)	52% (15/29)
Was	All known dates	60% (44/73)	62% (49/79)	54% (39/72)	61% (44/72)

Lenawee CMHSP's rates for each quarter were 85% (QI), 81% (QII), 92% (QIII) and 87% (QIV). Livingston CMHSP's rates for each quarter were 71% (QI), 88% (QII), 87% (QIII) and 76% (QIV). Monroe CMHP's rates were 56% (QI), 60% (QII), 59% (QIII) and 52% (QIV). Washtenaw CMHSP's rates for each quarter were 60% (QI), 63% (QII), 54% (QIII) and 61% (QIV). Total PIHP performance was 65%,(QI), 68% (QII), 65% (QIII), and 65% (QIV).

Comparison: Solely for reference, our PIHP's performance with Remeasurement period 1was compared to performance on a state and national level. Findings show 2.51-5/1% variation, with overall percentages having declined on the state level during the pandemic year.

PIHP Baseline	Remeasurement 1 (2020)	State level (2020)	National Medicaid HMO Level (2019)
65.60%	65.80%	68.31%	70.70%

The CPT committee and Integrated Health workgroup reviewed data sets, identified barriers, and proposed solutions to improve rates. The rate reached a high in March 2020 at **69%**. Beginning April 2020, however, the number began to drop due to the COVID-19 pandemic that brought a variety of barriers to consumers being able to get labs completed. We are currently in our second remeasurement period and new interventions to address these barriers are being designed by the Integrated Health Workgroup. This PIP will sunset at the end of FY21 and the state will be assigning a new PIP for FY22.

C. Medication Labs

Background: This project focused on increasing medication labs entered into the electronic health record for Medicaid and Non-Medicaid consumers prescribed an antipsychotic psychotropic medication and who have received two medication reviews. Such psychotropic medications may contribute to various metabolic syndromes such as cardiovascular disease and type II diabetes. When prescribers have access to these lab values, this may further inform their prescribing practices and provides information to community health care providers to promote integrated health. The labs included HbA1c, Glucose, LDL Cholesterol, HDL Cholesterol, Total Cholesterol, and Triglycerides.

Data was sent to each of the region's CMHSPs per prescriber to help with focused intervention efforts. Clinical team members such as supports coordinators, therapists, nurses, and peers, as well as contracted community providers, assist consumers with getting these labs completed where needed. Examples of assistance may include verbal prompting, coordination of appointments, increasing access to and partnerships with labs, transportation to appointments and obtaining written consent to release and/or exchange information between the laboratories and the prescribers. The chart below depicts the percentage of Medicaid consumers with completed labs for FY 20, as this data was used to support and inform the state required PIP of "Consumers with Schizophrenia and Diabetes who had an HbA1c and LDL-C Test".

Status Report: The established baseline to be met was 44.8%. While some CMHSPs exceeded this baseline during FY20, overall PIHP performance did not reach baseline.

	2020_Q1	2020_Q2	2020_Q3	2020_Q4
CMH	**44%** (1656/3745)	**44%** (1600/3672)	**38%** (1341/3559)	**34%** (1194/3500)
Len	67% (409/608)	65% (386/593)	59% (346/586)	59% (351/597)
Liv	27% (161/598)	33% (196/589)	32% (181/560)	34% (188/548)
Mon	32% (246/767)	29% (212/733)	23% (162/701)	18% (129/700)
Was	47% (840/1772)	46% (806/1757)	38% (652/1712)	32% (526/1655)

Lenawee CMHSP's rates for each quarter were 67%, 65%, 59% and 59%. Livingston CMHP's rates for each quarter were 27%, 33%, 32% and 34%. Monroe CMHSP's rates were 32%, 29%, 23% and 18%. Washtenaw CMHSP's rates for each quarter were 47%, 46%, 38% and 32%.

Barriers. The CPT committee and Integrated Health workgroup reviewed data, identified barriers, and proposed solutions to improve rates. Like the PIP Project (increasing the percentage of consumers with schizophrenia and diabetes who have completed HbA1c and LDL-c labs), the rate began to drop at the end of Q2 due to the COVID-19 pandemic that brought a variety of barriers to consumers being able to get labs completed. For example, barriers to getting labs completed include certain businesses/medical services not being as available, individuals fears of COVID-19 exposure in getting labs done or being out in the community, and needing to manage overall life changes brough on by the pandemic. One CMHSP that acquired a lab provider to be on site, however that resource made the decision to close that service.

IV. MMBIS Indicators

MDHHS indicators are established in the MDHHS PIHP contract and reported by the CMHPSM, with the values of improving access to services and reducing inpatient recidivism. Data is cleaned monthly, aggregated, and reported quarterly to MDHHS. Most indicators are held to the required thresholds of 95% or above, except inpatient discharges re-admitted within 30 days, which is below 15%. The chart below specifies the indicators, the State set threshold; and the region and/or

local CMHSP(s) compliance. Highlighted percentages mean that a corrective action plan was required for the respective indicator in that quarter.

Scores with an asterik (*) indicate data completion is pending and the percentage is an estimate only.

Indicators	**Target**	**QI**	**Q2**	**Q3**	**Q4**
Indicator 1: % of Pre-Admission Screens for Psychiatric Inpatient Care All Children	95%	99.41%	98.62%	100%	97.60%
Indicator 1: Adults	95%	99.37%	98.39%	98.38%	98.24%
Indicator 2: % Initial Assessment within 14 days of Request MI Child	95%	98.84%	97.26%	74.38%	72.22%
Indicator 2: (MI Adult)	95%	98.80%	99.17%	71.61%	60.55%
Indicator 2: (DD Child)	95%	96.15%	100.00%	84.21%	84.29%
Indicator 2: (DD Adult)	95%	100.00%	100.00%	92.31%	53.85%
Indicator 2: (SUD)	95%	94.53%	91.75%	67.18%	78.68%*
Indicator 3: % Start Services Within 14 Days of Assessment MI Child	95%	97.92%	97.67%	79.22%	86.30%
Indicator 3: (MI Adult)	95%	96.89%	91.91%	79.79%	79.71%
Indicator 3: (DD Child)	95%	96.15%	100.00%	76.92%	92.98%
Indicator 3 (DD Adult)	95%	92.86%	94.12%	77.78%	75.00%
Indicator 3: (SUD)	95%	96.37%	96.84%	merged with Indicator 2-SUD	merged with Indicator 2-SUD
Indicators	**Target**	**QI**	**Q2**	**Q3**	**Q4**
Indicator 4a: % of Discharges from Psych Inpatient Seen within 7 Days Child	95%	100.00%	100.00%	92.00%	97.62%
Indicator 4a: Adult	95%	91.03%	97.32%	98.31%	91.55%
Indicator 4b: % SUD Discharges	95%	99.12%	97.00%	97.01%	96.94%

from Detox Seen Within 7 Days					
Indicator 10: % Inpatient Discharges Readmitted Within 30 Days Child	15% or less	10.00%	6.45%	24.24%	11.11%
Indicator 10: % Adult	15% or less	9.71%	5.44%	13.69%	9.84%

The data was reviewed by Clinical Performance Team. Strengths, opportunities for improvement and root cause analyses were completed. For any indicators where thresholds are not met, a corrective action plan (CAP) is required to addresses systemic issues, including a projected timeframe for expected improvements, which may have contributed to low scores. CAPs were required if an individual CMHSP was out of compliance for any quarter. If this occurred, the CAP was due within 30 days and monitored by the CMHPSM. Some reductions in performance were related to COVID-19 related barriers.

V. Regional Customer Services: Consumer Experience with Services and Supports

Over the past six fiscal years the Performance Improvement program has improved the consumer satisfaction survey process to obtain reliable feedback from consumers and their families and/or guardians to be used to improve services across the region. This included capturing feedback about service environment, dignity and respect, timeliness of returning phone calls and appointments, understanding what was said by CMH staff, CMH helping to achieve consumer goals, CMH staff follow up about consumer physical health needs, consumer ability to complain or disagree with staff, and consumers deciding what is important to work on with CMH staff.

For FY 20 the goals were to expand data analysis that incorporated other aspect of consumers experience with services and supports, make revisions to the customer satisfaction survey, and administer the surveys to all populations served, specifying population-specific data for those receiving LTSS and HCBS waiver services.

In addition to satisfaction surveys, for FY20 the following aspects of analyzing consumer experience with services and supports was expanded upon:

1. Review of consumer appeals data for consumers served by the CMHSPM system.
2. Review of consumer grievance data for consumers served by the CMHSPM system.
3. Review of the most current National Core Indicators for the state of Michigan, and whether there were any trends that would apply to our region for which recommendations could be made to improve consumer experience in those areas.

These additional indicators of consumer experience were also incorporated in the QAPIP portion of Regional Customer Service Committee's review for FY21. Review and recommendations of these data sets includes reporting to and partnership with the Regional Consumer Advisory Committee.

Consumer Satisfaction Survey

Methods

The Regional Customer Services Committee conducts annual satisfaction surveys through a combination of face to face and phone surveys. In FY 2019-2020, due to the COVID-19 pandemic, there was a significant shift in the provision of services, wherein the state allowed for expansion of services that could be provided and billed for with the use of telehealth. There were also COVID-19 related limitations to conducting satisfaction surveys that resulted in surveys needing to be conducted more so by phone. CMHPSM therefore decided to conduct a survey related to consumer's experiences with telehealth services, to better understand how consumers were adjusting to service delivery changes related to the pandemic, and to plan for any limitations with telehealth and/or expansion options based on consumers' experiences with telehealth services.

Results were reviewed at the February Regional Customer Service Committee Meeting and recommendations will be shared with the CPT Committee at their March 2021 meeting.

Consumer Telehealth Satisfaction Survey Measurement and Results

A total of 404 consumers were surveyed across the region. Results varied and between those who found benefit to telehealth and those were dissatisfied, with a slightly greater number of positive feedback. Feedback became more positive over time as the system worked out barriers and acclimated to technology needs in the transition.

Positive feedback included being able to attend appointments more easily for those who've had transportation issues, the overall convenience and flexibility, feeling safer from potential exposure to COVID-19.

Negative feedback included not always having the technology to participate (wifi, cell phones, computers), the burnout of most meetings, school, etc being remote, and concerns from privacy on their home.

CMH	Lenawee	Livingston	Monroe	Washtenaw
QUESTION 1 - Due to COVID-19 ___ Has moved almost all of our (CMH direct) services to telehealth. Telehealth includes providing services using a telephone, smart phone or computer. Telehealth can also be provided using video conferencing which are meetings conducted using video and/or audio to communicate. Have you been provided telehealth services?				
• **YES**	34	64	133	15
• **NO**	00	04	01	1
QUESTION 2 - What telehealth technology have you used? Select all that apply.				
• **Video Conference**	33	36	31	11

• **Telephone** • **Email** • **Other**	22 03 00	56 17 04	143 00 08	09 03 02
QUESTION 3 - What do you like about using telehealth? Please explain. **All comments were collected in narrative form, specified by county**				
QUESTION 4 - If available, how likely would you be to use telehealth services instead of in-person services? • **Very Likely** • **Likely** • **Unlikely** • **Very Unlikely**	 11 08 10 05	 23 28 08 09	 56 48 24 06	 04 05 02 01
QUESTION 5 - Which of the following would be reasons you might not want to use telehealth technologies? Select all that apply. • **Privacy/Security** • **Internet/computer** • **Concerns** • **Prefer to meet with someone in person** • **Quality of Care** • **No issues using Telehealth** • **Uncomfortable using telehealth for sharing personal issues** • **Other**	 01 07 03 11 04 09 01 09	 02 07 00 20 05 40 01 05	 04 16 00 31 09 73 04 55	 02 04 00 06 03 05 01 00
QUESTION 6 - What parts of telehealth do you wish could remain even after COVID-19 is no longer a concern? Select all that apply • **Telephone calls from my treatment team.** • **Video conferencing with my treatment team.** • **Person Centered Planning meetings using video conferencing.** • **Other**	 13 13 08 09	 49 20 13 09	 See below	 09 09 04 02
QUESTION 6a - What parts of telehealth do you wish could remain even after COVID-19 is no longer a concern? Select all that apply • **Medication Management** • **Case Management** • **Outpatient Therapy** • **Peer Supports** • **Group Therapy** • **Person Centered Planning Meetings**	See above	See above	 95 122 27 16 04 44	See above

• **Day Program Activities** • **None of the above** • **Other**			15 05 13	
QUESTION 7 - What CMH program are you currently involved in? • **MI-A** • **I/DD TEAM 1** • **I/DD Team 2** • **I/DD** • **MI-A ARS** • **MI CIP** • **SED: Home-Based** • **SED: PIP** • **SED: FCM** • **DD-1** • **MI-A ARS** • **ARS** • **DD** • **Parent Support Program**	DNA	 23 16 02 04 05 01 03 01 01 02 05 02 01 03	DNA	DNA
QUESTION 8 - If you prefer face to face appointments, where would you prefer your case management and/or therapy appointment to take place? • **Home** • **Office** • **Community** • **Other**	DNA	DNA	49 32 11 42	DNA
QUESTION 9 - If you receive both therapy and case management, would you prefer these services to be provided by the same person? **52 – Yes** **18 – No** **64 – Other**	DNA	DNA	 52 18 64	DNA

Limitations

- The ability to reach people and have a high response rate in using web-based or phone surveys.
- The newness of telehealth for consumers
- Staffing and accessibility limitations related to the COVID-19 pandemic, including those whose health were affected directly or indirectly by the pandemic, and a disinterest in doing phone surveys.

Improvement Planning

During FY 21, the Regional Customer Services Department will develop and implement a plan to improve consumer education about how to file a complaint, and will implement a new survey that will be more accessible to consumers and addresses some of the feedback/issues raised in the FY20 survey results.

CMHPSM FY20 Appeals Data

Method

As consumers and guardians have the right to appeal when a negative action is being taken with their services, the data collected for appeals can be a useful indicator of customer service-related areas for improvement. Consumer appeals data is maintained and monitored by the Fair Hearings Officers and regional representatives of the CMHPSM Utilization Management/ Review Committee. In FY20 this committee partnered with Regional Customer Services and the Regional Consumer Advisory Committee to review what appeals data is collected quarterly, and what data would be meaningful for their analysis of consumer experiences. Based on that process the data elements below were identified and a summary report for FY20 was developed.

County	Number of Suspensions or Reductions
Number of Appeal Requests	Number of Terminations
Number of Expedited Appeals requested	Medicaid/Non-Medicaid Specify if HSW, CWP, or ABA(autism)
Number of Expedited Appeals Denied	Number of Local Appeals
Number of Cases Where Actions & Date of Notice within correct time frames	Number of State Level Hearing/Appeals
Number of Notices Out of Compliance with Timeframes Service(s) Involved	Number of Internal/Local Appeal Timeframes Met
Number of Appeals Per the Service (Won't match # of Appeals as 1 appeal can involve multiple services)	Number Upheld
	Number Reversed
	Number Withdrawn/ Dismissed
Number of Denials	Trends

Results

For FY20 a total of 58 appeals were requested, and of those 32 were upheld, 11 were reversed (in favor of the consumer) and 15 were withdrawn/dismissed, which includes if an agreement was reached that was satisfactory for the consumer or the consumer no longer wished to appeal. All but one case complied with timeframes and requirements related to ensuring consumers' appeal rights are upheld, and the factors related to the one case were corrected by the CMHSP. There was a decline in appeal requests as the COVID-19 pandemic continued, some of which attributed to state directives that the pandemic was not a viable legal reason to change services. There has been a long-standing history of no appeal requests in the SUD system.

Limitations:
The Regional Customer Services and the Regional Consumer Advisory Committee requested the data include any issues with specific providers related to this appeals data, how the lack of SUD appeals will be addressed with SUD providers, and more information in the trends section on any aspects of the process that consumers may need more assistance or information with in navigating the appeals process.

Improvement Planning
The data report will be revised to include the factors identified in limitations and the Regional Customer Services and the Regional Consumer Advisory Committee will continue to review this data for any improvement projects in FY21.
The PIHP will roll out a grievance and appeals training program and plan for FY21 and include compliance with these processes in the FY21 PIHP review of SUD providers.

CMHPSM FY20 Grievances Data

Method
Consumers and guardians have rights to file grievances when they are dissatisfied with any aspects of their services and supports. Customer Services staff at each CMHSP respond to grievances, and the Regional Customer Services Committee maintains and monitors this data.

Results
The following is an analysis of grievances per county, noting if trends have been observed by Regional Customer Services staff.

	Lenawee	Livingston	Monroe	Washtenaw
Total Grievances	69	30	69	70
• Medicaid	68	26	66	65
• Non-Medicaid	01	02	01	03
• Unknown	00	02	02	02
Grievance Type				
• Accommodation	02	00	00	04
• Financial	02	00	05	03
• Provider Choice	50	06	00	05
• Quality of Care	07	15	30	18
• Service Concerns/availability	05	08	28	27
• Service Timeliness	01	00	00	00
• Service environment	01	00	02	03
• Recommendations/suggestions	00	00	00	00
• Other	00	00	03	08
• Blank	01	01	01	02

The global pandemic impacted many elements of care. The largest number of grievances involved service concerns/availability that we worked to impact for those we serve. Areas of concern were inability to attend vocational programming or have in home ABA services due to stay-at-home orders and inability to ensure social distancing at vocational sites leading to individuals having some barriers in returning to the service when the order was lifted. Work was done to ensure care was provided when it was safe to do so, and transition plans where needed. Provider stability will need to be a focus as COVID-19 pandemic risks carry into FY21.

Limitations

- Due to the COVID-19 pandemic, the ability to resolve provider related grievances was limited at times due to pandemic related restrictions.
- There was also a question of whether consumers had sufficient access to file a grievance based on the pandemic and the reduction in attending in person appointments, although Customer Services staff remained accessible both by phone and in office.

Improvement Planning

As the pandemic spanned most of FY20 and has continued into FY21, ways to keep the grievance process accessible to consumers/guardians.

Risks with provider stability will be explored in conjunction with local provider network managers and the Regional Network Management Committee.

National Core Indicators Data (NCI) for Michigan

The National Core Indicators (NCI) program is a voluntary effort by state developmental disability agencies to track their performance using a standardized set of consumer and family/guardian surveys with nationally validated measures. The effort is coordinated by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). The most recent survey result available are from 2018-19, in which a total of 46 states, the District of Columbia and 22 sub-state entities participated, including Michigan.

Method

The NCI is an in-Person Survey is completed with 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 survey instrument includes a "Background Information Section", which gathers data about the consumer from agency records, and an in-person survey that is conducted face-to-face with the person receiving services. The in-person survey is composed of two sections: Section I includes subjective questions that can only be answered by the person receiving services from the state. Section II includes objective, fact-based questions that can be answered by the person or, if needed, a proxy respondent who knows the person well.

Areas of life and service experiences included in the survey are: Residential Designation, Choice and Decision-Making, Work, Self-Direction, Community Inclusion, Participation and Leisure, Relationships, Satisfaction, Service Coordination, Access (op community), Health, Wellness, Safety, Rights and Respect. A series of questions in each area are asked that address levels of independence, empowerment, support, and satisfaction.

Results

The NCI conducts the analysis and reports outcomes data. Averages are "weighted" to reflect the states' relative population and sample sizes. Weights were created using the state's number of valid surveys and its total survey-eligible population. This way, a state that provides services to a larger number of people but uses a sample similar in size has data proportional to its service population.

The NCI report is an extensive document, therefore for the purposes of this evaluation the outcomes data for Michigan can be found here:
https://www.nationalcoreindicators.org/states/MI/report/2017-18/

In analyzing Michigan 2018/2019 compared to the national measures Michigan's performance was either at or above performance compared to national report. Areas of opportunity in general seemed most prevalent in the following areas under the category of **Work:**

- People have support to find and maintain community integrated employment.
- Has a paid community job; individual, group and/or in a business that primarily hires people with disabilities (with or without publicly funded supports)
- Receives paid time off (for example, paid vacation and/or sick time) at paid community job
- Does not have paid community job and would like a job in the community
- Having volunteer opportunities

Limitations

- The Michigan NCI data is extensive and there is a need for more familiarity and study of the data as this is the committee's first experience is reviewing the data.
- The data is not broken down by PIHP region or county and as such is more of a generalization, therefore it is difficult to ascertain any specific opportunities for improvement in our region.
- The data set is three years old, therefore it's unclear if these areas of work remain currently relevant.
- The COVID-19 pandemic has resulted in a significant loss of jobs in the community, and a risk of exposure to COVID-19 in community employment, therefore more analysis is needed with the possible need for more long-term planning.

Improvement Planning

For FY 21 the Regional Customer Services Committee will pursue the following ways to improve the analysis of this data:

The data analysis will be brought to the Regional Consumer Advisory Council for feedback and potential areas for performance improvement.

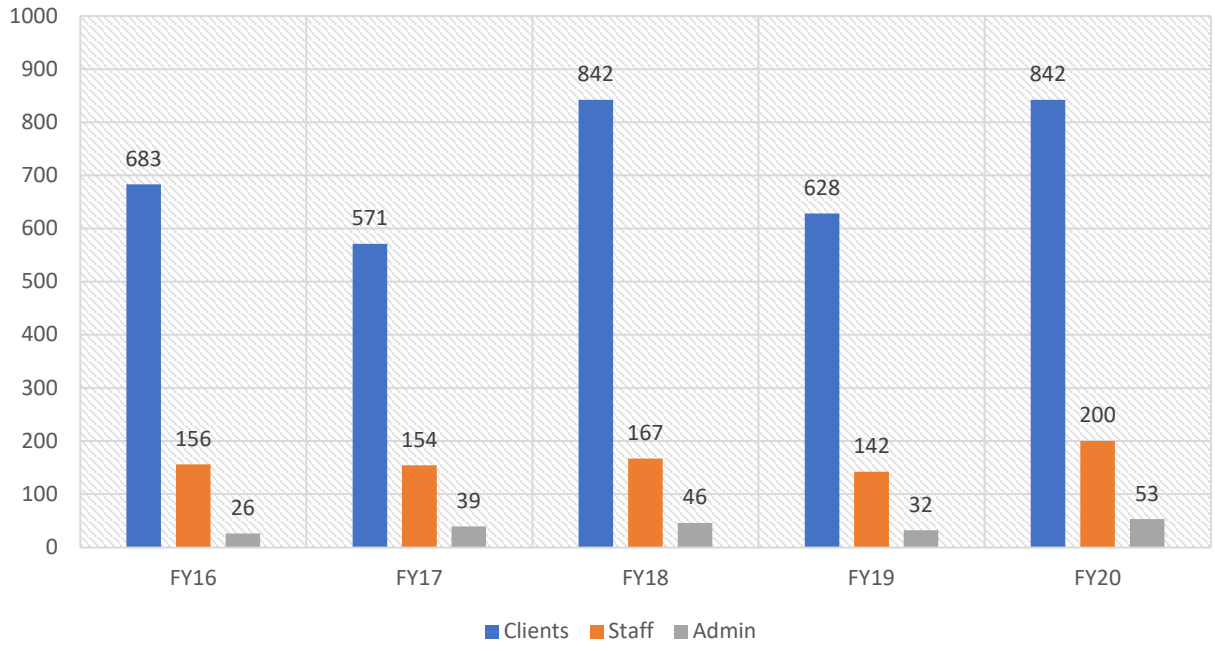
The region will explore the new MDHHS employment database launched in FY21 that may better provide regional local data about work experiences that can inform potential areas for performance improvement.

VI. Recovery Self-Assessment

During FY 20, the CMHPSM distributed the Recovery Self-Assessment-Revised survey (RSA-R) (O'Conell, Tondora, Croog, Evans, &Davidson, 2005) to the contracted providers in its four-county region that use the Recovery Oriented System of Care (ROSC) model. The counties that the survey was distributed to included: Lenawee, Livingston, Monroe, and Washtenaw. The CMHPSM wanted to accurately assess and measure the effectiveness of substance-use disorder (SUD) and community mental health (CMH) providers in the implementation of recovery focused services from the perspective of consumers, provider staff, and administrative staff.

This is the fifth year that the RSA has been used in CMHPSM's region and comparisons were made between the data from 2016 to 2020. The FY20 survey was updated from previous years to better reflect the validated survey that the local Recovery Self-Assessment Survey (RSA) is based on. As a result, some questions were added/moved to different domains. Subsequent annual survey comparisons will use the FY20 survey results as the baseline period.

In 2020, there was a total of 1,095 participants in this analysis. See the table below for information about respondents by year. Respondents by Year



Measurement

The Recovery Self-Assessment Survey (RSA) was designed with the intent to accurately gain feedback from consumers, provider staff, and administrators. The survey is designed to be administered in 3 separate versions: Consumers, Provider Staff and Administrators. Each survey was broken down into five domains: 1. Life Goals, 2. Involvement, 3. Diversity of Treatment Options, 4. Choice and 5. Individually Tailored Services. Each survey question contained an answer choice based on a 5-point Likert Scale:

1 = Strongly Disagree 2 = Disagree 3 = I am neutral	4 = Agree 5= Strongly Agree NA = Not Applicable	DK = Don't Know Additionally, the survey contained a comment box.

Method

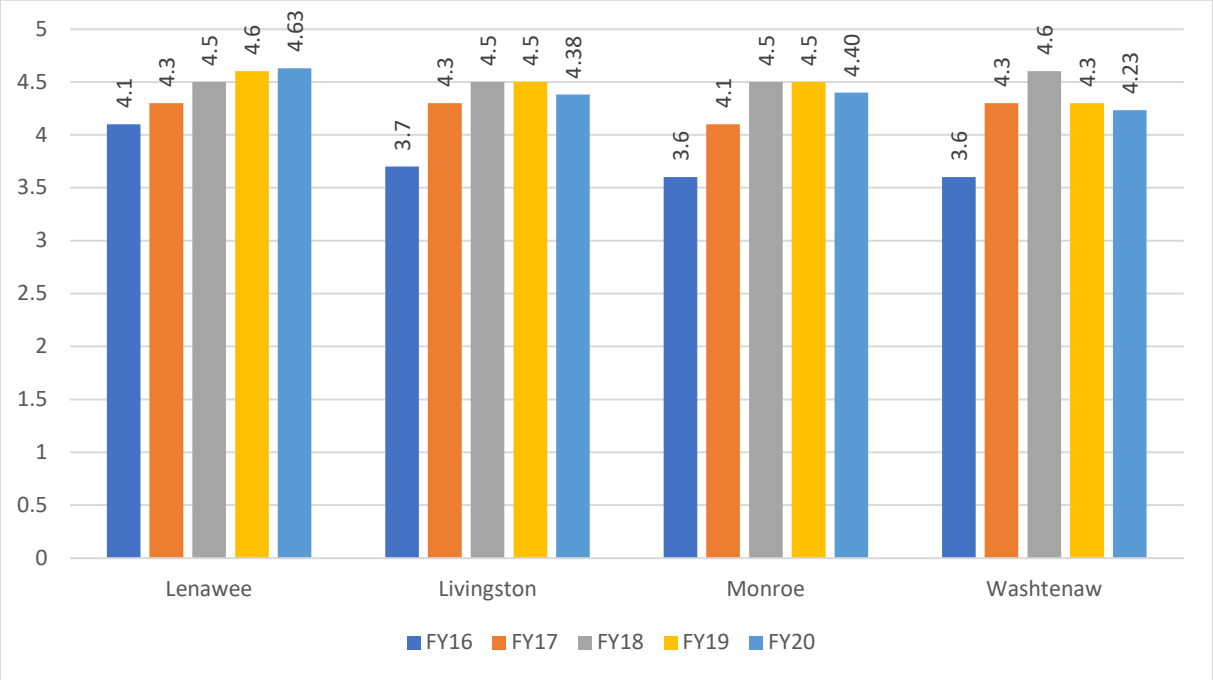
The RSA was distributed to Administrators, Provider Staff, and Consumers both electronically and in paper form using the Survey Monkey Software. After the survey period had closed, the surveys were analyzed using Microsoft Excel.

Consumer Participants

Provider Agencies	# of Client Respondents
Access	2
Ann Arbor Treatment Center	2
Catholic Charities (Lenawee)	31
Catholic Charities of Southeast MI (Monroe)	16
Complete Counseling Services	3
Dawn Farm	24
Hegira Health	1
Home of New Vision	38
Key Development Services	6
Lenawee County Community Mental Health Authority	36
Livingston County Catholic Charities	7
Livingston County Community Mental Health Authority	69
McCullough-Vargas	5
Monroe County Community Mental Health Authority	155
Parkside for Families	7
Passion of Mind Healing Center	360
Paula's House	7
Salvation Army Harbor Light	18
St. Joe's Greenbrook	1
unanswered	6
Washtenaw County Community Mental Health	48
Total	842

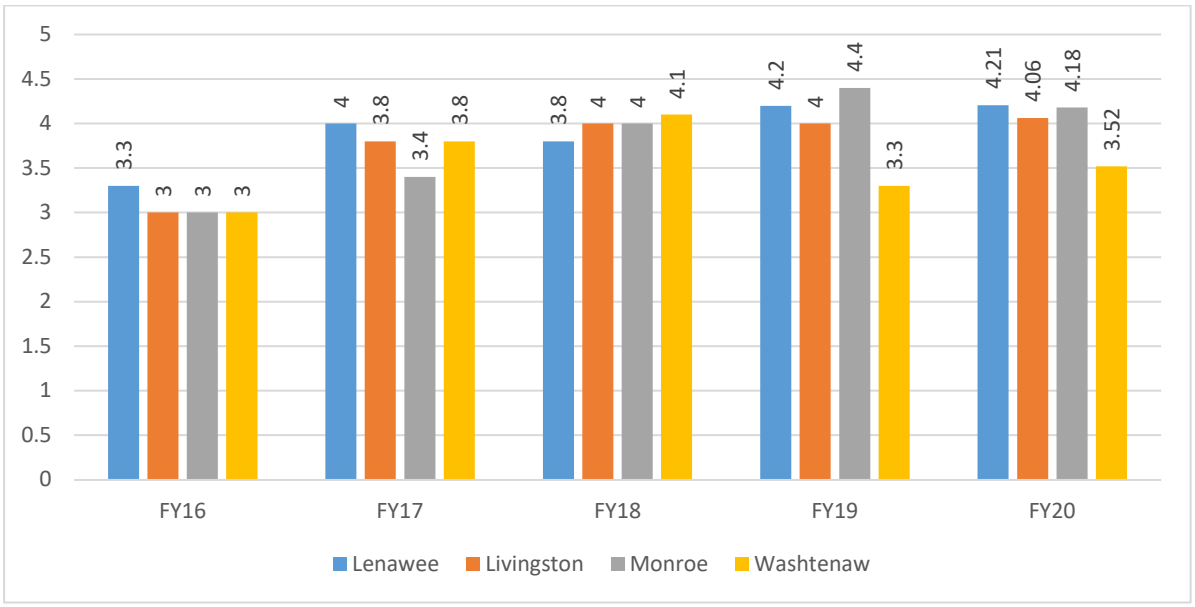
Consumer Responses by County 2016-2020:

Client Version Life Goals FY16-FY20



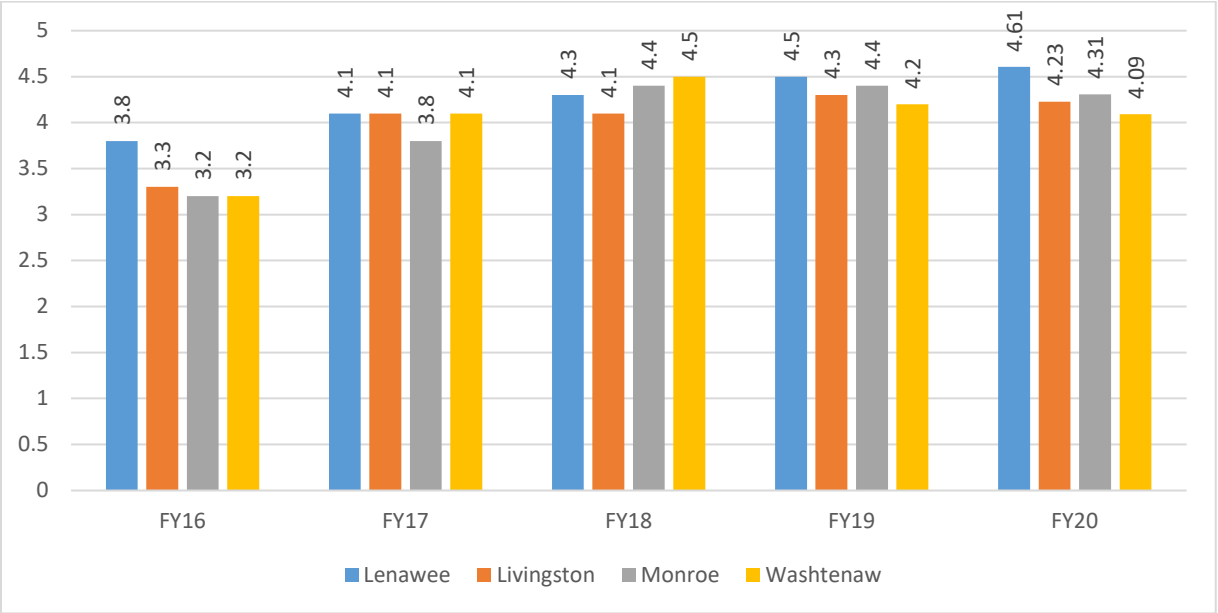
"I am happy with my recovery, this was the best place for me to come."

Client Version Involvement FY16-FY20



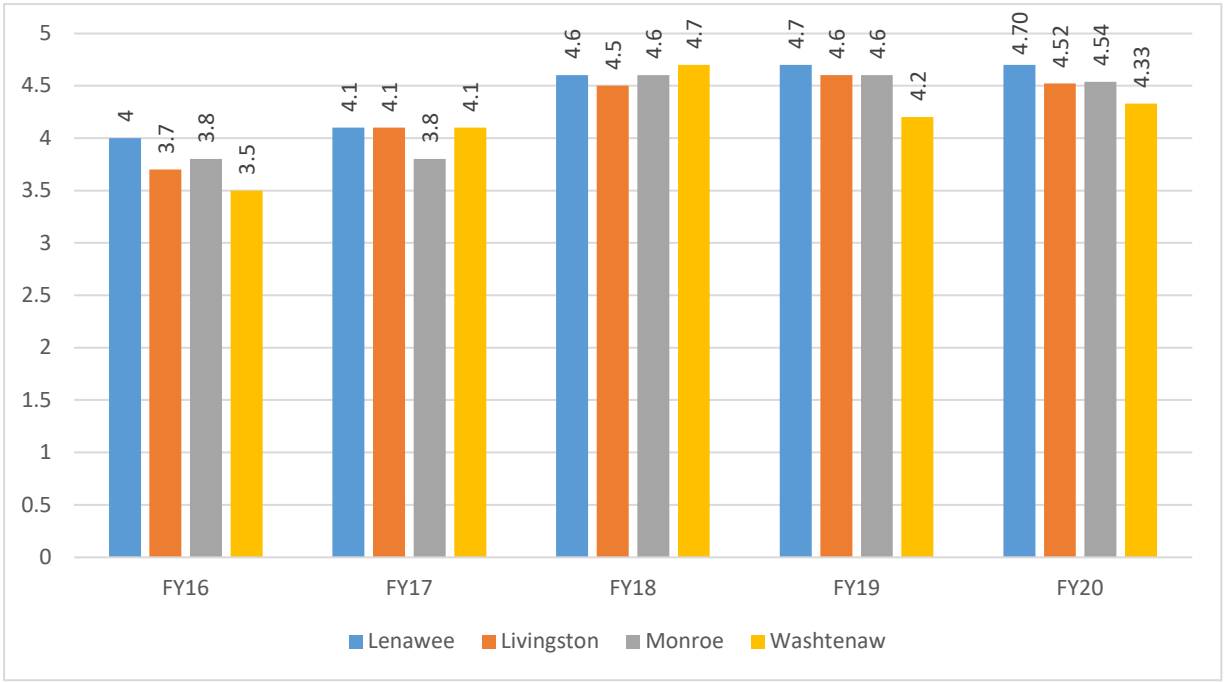
"The staff is very caring and knowledgeable. This helps greatly in recovery."

Client Version Diversity of Treatment Options FY16-FY20



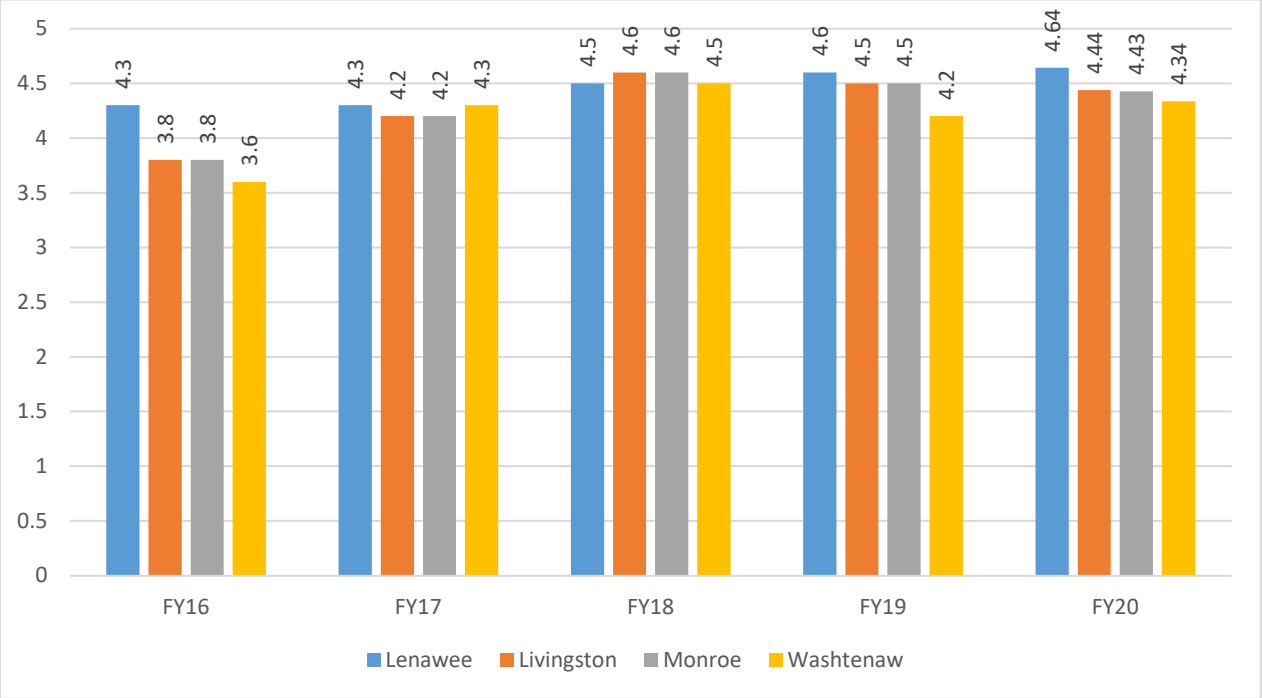
"Thank you for all of the help especially during the pandemic. I lost my job and you guys made me comfortable knowing I would not be kicked out because I could not pay my rent. Everyone was so helpful and understanding."

Client Version Choice FY16-FY20



"This program has helped me so much, also has made me a better person. I also feel a lot better about myself and my future."

Client Version Individually Tailored Services FY16-FY20



"I am treated with respect and kindness and am comfortable with all treatment team."

Considerations

Across the region, consumer ratings remained comparable to previous years in the four counties—relatively high, with averages of most questions wavering between agree and strongly agree on the 5-point Likert scale. The Involvement domain scored the lowest in all four counties on all three survey versions.

Consumers responses to several questions indicated that improvements can be made to clinical practice to meet client needs. Region wide trends are as follows: In the Life Goals domain, clients in all counties disagreed most with the statement "Staff help me to find jobs". Clients in all counties disagreed most with "I am encouraged to attend agency advisory boards and/or management meetings if I want" within the Involvement domain. In the Diversity of Treatment Options domain, clients from three out of four counties (Lenawee, Livingston, and Washtenaw) scored the statement "I am given opportunities to discuss my sexual needs and interests when I wish" lowest. Clients from three out of four counties (Lenawee, Monroe, and Washtenaw) disagreed most with "Staff regularly ask me about my interests and the things I would like to do in the community" in the Individually Tailored Services domain.

Each county is working with their respective RSA results to develop a county-specific plan to address the report responses.

Limitations

- Many of the surveys were completed in paper form, and therefore required manual input. Manual input was completed by provider agencies, which may contribute to some level of variance.
- When using a Likert Scale configuration, some answers may have been given a 1 rating (strongly disagree) when the participant may have intended to record a 5 (strongly agree) and vice versa. However, it is difficult to assess the prevalence of this phenomenon.
- Some of the surveys were submitted with responses which included the same answer for every question. For example, a score of 5 was given for every question. For these types of surveys, data was still collected and therefore overall data was potentially skewed.
- Missing responses to questions also posed as an issue amongst clients, staff, and administrators threatening the validity of the data.
- *The COVID-19 public health crisis may have impacted the number of respondents and/or perception of services due to providers possibly not seeing as many individuals in person as in past years. The numbers of respondents were expected to be lower, but were higher than past years.*
- *The 2020 RSA was based more closely on the Yale Survey Tool, resulting in several questions being moved between domains, and one new section being added. These are noted with "*" in each table. As a result, year to year percentages are not comparable.*

Improvement Planning

During FY 21, Co-Occurring Administrators Group will be reviewing this data and will determine whether there will be an improvement plan.

VII. Shared Metrics Projects Between the CMHPSM, CMHSPs and the Michigan Medicaid Health Plans (MHPs) Joint Metrics

A. Care Coordination for High Consumer utilizers project

The Care Coordination for High Consumer Utilizers Project was continued from last year. The following activities occurred during FY 20:

- The Regional Data Coordinator facilitated monthly meetings with the CMHSPs and the Medicaid Health Plans (e.g. Aetna, Blue Care Complete, Meridian, Molina, McLaren, and United) regarding consumers with the highest utilization via the Stratification Report. Persons that may have been present included the Data Coordinator, CMHSP Clinical Administrators, Supervisors, Supports Coordinators and Registered Nurses. Additionally, Medicaid Health Plan staff were also present (Care Managers, Supervisors and Clinical Administrators). Examples of diagnoses include the following: schizophrenia, borderline personality disorders, generalized anxiety, depression, diabetes, hypertension, heart disease, obesity, and seizures.
- Care coordination activities were recorded into the electronic health record and the CC360 file.
- The CMHPSM continued to evaluate the needs for reports to capture care coordination and utilization of services.

- The region used data from the reports to analyze trends.

CMHPSM received a full score of 100 and the full financial bonus incentive for FY20.

B. Performance Bonus Joint MHP/PIHP Metrics

During FY20, Medicaid Health Plans (MHPs) and Prepaid Inpatient Health Plans (PIHPs) had the opportunity to review and validate measure data for two performance measures: **Follow-up after hospitalization for Mental Illness (FUH) and Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA**). Event-level data was provided by MDHHS for both measures through the 6/30/20 measurement period. CMHPSM submits to MDHHS, a Shared Metrics Data Validation Narrative to demonstrate participation in these validation activities. The report also includes findings of efforts to review and validate data, noting discrepancies found that impact the measure results, as well as actions taken to address data issues (as needed). Below is a summary of the findings for these two performance measures:

1. Follow-up after Hospitalization for Mental Illness (FUH)

Summary. This project monitors follow up after hospitalization for individuals (aged 6 and older) with a mental illness or harm diagnosis. CPT and EOC explore ways to improve performance with the following goals:

1. Collect, review, and evaluate the timeliness of outcome data.
2. intervene on a local level to address any barriers to timely data.
3. Ensure adherence to project protocols.
4. Consult data exchange vendors such as PCE and/or MiHIN (health highway data exchange vendor) and Medicaid Health Plans.

Indicator. The PIHP shares performance on this metric with Medicaid Health Plans. The indicator is the percentage of discharges for individuals age six and older, who were hospitalized for mental illness or intentional self-harm diagnoses, and who had a follow-up visit with a mental health practitioner within 30 days of discharge. The PIHP also plans to reduce disparities between an index group and at least one minority group. The measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2019 with July 1, 2020-June 30, 2021.

Status report:

While the CMHPSM performed above the benchmark for all four quarter in FY 19 and FY20, this is a joint metric shared with the Medicaid Health Plans (MHPs) and the PIHP did not receive a full score/full incentive due to a lower percentage performance by one of the MHPs.

CMHPSM FY19	**Standard**	**Q1 (Oct-Dec)**	**Q2 (Jan-March)**	**Q3 (Apr.- June)**	**Q4 (July-Sept)**
Children	70% (6-17yrs)	78.59%	80.69%	81.69%	81.53%
Adults	58% (>=18yrs)	64.97%	63.91%	64.73%	64.36%

Follow-up after Hospitalization for Mental Illness within 30 days CY2019 (65 points)								
	Scored 6-20 Combos	Scored 6-20 Combos Meeting Standard	Scored 21-65 Combos	Scored 21-65 Combos Meeting Standard	Total Scored Combos	Points per Combo	Total Combos Meeting Standard	Score (maximum = 65)
CMHPSM	4	3	4	4	8	8.13	7	57

The CMHPSM performed above the benchmark for all quarters that have been finalized in FY20.

CMHPSM FY20	Standard	Q1 (Oct-Dec)	Q2 (Jan-March)	Q3 (Apr.- June)
Children	70% (6-17yrs)	82.09%	78.78%	76.43%
Adults	58% (>=18yrs)	64.62%	62.75%	63.43%

2. Follow up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

Summary. Event-level detail for FUA was provided to health plans quarterly through 6/30/2020. MHPs and PIHPs received denominator events only. MHPs were to review denominator events against their own emergency department claims and document any members who received numerator compliant follow-up services. PIHPs were also to document any members who received numerator compliant follow-up services.

The CMHPSM does not have access to substance use disorder (SUD)-related claims, therefore the CMHPSM was unable to compare internal calculations to the State's denominator. In the analysis, we assume that the State's denominator is the gold standard.

Indicator. The PIHP shares performance on this metric with Medicaid Health Plans. The indicator here looks at "members 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow up visit within 30 days". This measure is informational only. The measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2019 with July 1, 2020-June 30, 2021. The following table shows the overall FUA percentages through 6/30/2020 for CMHPSM compared with Michigan Medicaid:

Measure	CMHPSM	Medicaid total	Report Ending Date
FUA	29.70	28.56	Q1 (12/31/19)
FUA	29.59	28.44	Q2 (3/31/2020)
FUA	28.71	27.44	Q3 (6/30/2020)

VIII. PIHP-Only Performance Bonus Measures

MDHHS holds the CMHPSM to nationally recognized quality measures. In FY20, MDHHS incentivized CMHPSM to improve standards in the following two "pay for performance measures". The Initiation and Engagement of alcohol and other drug abuse or dependence

treatment (IET) measure was informational only. The Behavioral Health Treatment Episode Data Set (BHTEDS) and Veteran Services Navigator (VSN) was incentivized through a pay for performance program.

A. IET: Initiation and Engagement of alcohol and other drug abuse or dependence treatment

Summary. This project monitors the percent of beneficiaries ages 18 to 64 with a new episode of alcohol or other drug abuse (AOD) or dependence during the measurement period who initiated or engaged in treatment (measuring access to SUD treatment).

Status Report. This project is informational only for FY 20 and FY21. The CMHPSM has begun to track, and trend overall percentages, and statistically significant disparities in racial or ethnic groups. The measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2019 with July 1, 2020-June 30, 2021.

The IET project has two indicators:

1. Initiation of AOD treatment (IET-14): Percentage of beneficiaries who initiated treatment through an admission AOD, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.

IET-14 Overall Percentage

CMHPSM	Medicaid total	Report Ending Date
37.75	39.65	Q1 (12/31/19)
38.67	39.77	Q2 (3/31/2020)
41.90	40.46	Q3 (6/30/2020)

2. Engagement of AOD treatment (IET-34): Percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit.

IET-34 Overall Percentage

CMHPSM	Medicaid total	Report Ending Date
16.38	16.73	Q1 (12/31/19)
16.68	16.50	Q2 (3/31/2020)
19.16	16.53	Q3 (6/30/2020)

B. BHTEDS: Behavioral Health Treatment Episode Data Set and Veteran Services Navigator

Summary. MDHHS requires that CMHPSM submit the Behavioral Health Treatment Episode Data Set (BHTEDS) as part of reporting services provided directly by the CMHSPs, collected at admission and discharge. In FY 20, the CMHPSM was incentivized to improve and maintain data quality on BHTEDS military and veteran fields through a pay for performance program. This project aims to use BHTEDS to identify consumers eligible for services through the Veteran's Administration by verifying elements required for military/veteran status.

Status report. The CMHPSM received full incentive points for BHTEDS and Veteran Services Navigator metrics in FY20.

IX. Critical Incident Data Review

CMHPSM reviews quarterly critical, sentinel, and risk event data to look for trends, compliance with the policy procedures and timeframes, use of root cause analyses where applicable, determine educational opportunities, and potential performance improvement projects.

Critical incidents included in the data review include:

Suicide
Non-suicide Death (unexpected)
Accident Requiring an ER Visit or hospitalization
Emergency Medical Treatment due to Injury or Medication Error
Hospitalization due to Injury or Medication Error
Hospitalization from a Physical Illness
Arrest of Consumer
Serious Challenging Behaviors

No trends were identified in FY20 that resulted in any recommendations for performance improvement projects.

X. Compliance and Quality Reviews

Summary. The Code of Federal Regulations (CFR), 42 CFR §438.358 requires the state conduct an external quality review organization (EQR) by a third party to determine PIHPs' compliance with Medicaid Managed Care Rules (42 CFR §438—Managed Care Subpart D and 42 CFR §438.330). To comply with the federal requirements, the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration (BHDDA) contracted with Health Services Advisory Group, Inc. (HSAG), as its EQR organization to conduct compliance monitoring reviews of the PIHPs. Thus HSAG completes an annual compliance review of the region, which includes three components: 1) Compliance Monitoring of Standards, 2) Validation of Performance Measures and 3) Validation of Performance Improvement Projects.

The Michigan Department of Health and Human Services (MDDHS) PIHP contract also requires state reviews of the PIHPs' compliance with 1915(c) Home and Community Based Services Waiver Rules, Autism services, the Habilitation Supports Waiver (HSW), Children's Waiver (CWP), and Children's SED Waiver (SEDWP) programs.

Due to the COVID-19 pandemic there were no state reviews in FY20. As part of the last site review, the region was instructed is to complete quarterly credentialing audits.

A. EQR Compliance Monitoring Review of Standards

Summary. HSAG performed a remote review of the CMHPSM. For FY 20, MDHHS selected for HSAG to audit the PIHP's corrective actions on the full set of standards evaluated in the previous two years (2017-18 and 2018-19). The full set of standards are derived from federal Medicaid

managed care regulations and the associated MDHHS contract requirements and include the following categories:

Standard I—Quality Assessment and Performance Improvement Program Plan and Structure Standard II—Performance Measurement and Improvement Standard III—Practice Guidelines Standard IV – Staff Qualifications and Training Standard V – Utilization Management Standard VI – Customer Service Standard VII – Enrollee Grievance Process Standard VIII – Coordination of Care Standard IX – Subcontracts and Delegation	Standard X – Provider Network Standard XI – Credentialing Standard XII – Access and Availability Standard XIII – Coordination of Care Standard XIV – Appeals Standard XV – Disclosure of Ownership, Control, and Criminal Convictions Standard XVI – Confidentiality of Health Information Standard XVII – Management Information Systems

Status Report. The results of the EQR FY20 review, which covered the FY18 and FY19 CAPs, was 100% on 16 out of 17 standards. Credentialing had a score of 78%. The total overall score was 99%. This is a 22% overall score increase from the previous year's review. The final compliance report from HSAG was received in November, with follow-up Technical Assistance meetings in December. The CMHPSM will be held to the corrective action plan for the credentialing standard in future reviews.

B. EQR Validation of Performance Measures: Information Systems Capabilities Assessment Tool (ISCAT)

Summary. The Centers for Medicare & Medicaid (CMS) requires that states, through their contracts with the PIHP's measure and report on performance to assess the quality and appropriateness of care and services provided to members. The purpose of performance measure validation is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state specifications and reporting requirements. HSAG conducted the performance measure validation for FY20, validating data collection and reporting processes used to calculate performance indicator rates. Validation of Performance Measures tested the capability of the regional information systems. The CMHPSM and each CMHSP were assessed in the following areas:

- Organizational Structure and Reporting Entities
- Evaluation of System Compliance
- Overview of Data Integration and Control Procedures
- Primary Source Verification
- Service Data Preparation and Processing for Quality Improvement Data Processing and Preparation
- Encounter Data Preparation and Specifics Regarding the Flow of Data
- Enrollment and Eligibility

Status Report. HSAG fully validated the CMHPSM's data integration, data control, performance improvement documentation, validation results, eligibility and enrollment data system, medical

services data system (claims and encounters), behavior health treatment episode data set/data production, PIHP's oversight of CMHSPs, PIHP's actions related to previous recommendations and areas for improvement from last year and performance indicators being in compliance with State specifications and the rate can be reported.

C. EQR Validation of Performance Improvement Projects (PIPs)

Summary. To validate the state required PIP projects, the HSAG conducts reviews that require the CMHPSM to complete a PIP Summary Report regarding the Patient(s) with Schizophrenia and Diabetes who had an HbA1c and LDL-C Test During the Report Period indicating the following information:

- Topic of Study
- Definition of Study Topic
- Use of a Representable and Generalizable Study Population
- Selection of the Study Indicators
- Use of Sound Sampling Techniques
- Reliably Collect Data
- Data Analysis and Interpretation of Results
- Inclusion of Improvement Strategies and Barrier Analysis

Status report. HSAG assessed the validity and reliability of the results based on the Centers for Medicare and Medicaid Services (CMS) validation protocols and determined that the State and key stakeholders can have high confidence in the reported performance improvement project findings.
In FY20, CMHPSM met all the applicable critical elements of the evaluation except for achieving a statistically significant improvement over the baseline.

XI. Enhanced Compliance Monitoring

A. PIHP Compliance Review of the CMHSPs

Summary. A strong compliance and program integrity system is a critical component of managed care systems. All PIHPs are required to comply with 42 CFR 438.608 Program Integrity Requirements. Designation of a PIHP Compliance Officer, development and implementation of region wide policies and procedures which comply with federal and state laws, training, clear lines of communication with the Compliance Officer, discipline and enforcement, internal monitoring and auditing and prompt responses to detected offenses are key elements of compliance and program integrity.

The following modifications to the CMHPSM Monitoring of CMHSPs took place for FY 20:

A. The review was completed remotely and by desk audit. Based on past auditing practices, it appears a desk audit administrative review of delegated functions for each of the CMHSPs is completed every two years, with the last one completed FY18, meaning another administrative review of delegated functions would be completed this

FY20. Due to the COVID-19 pandemic the CMHPSM desk audit of delegated functions was waived and will be completed in FY21, to reduce undue resource / administrative burden on the CMHSPs.

B. A random sample of 5 cases per population was pulled for review for each CMHSP. These populations were: Adults with MI, Adults with CI/IDD, HSW, Children with CI/IDD (including autism and CWP), and Children with SED (including SEDW).
C. A sample of staff who billed for services was pulled based on the random case sample list, and their provider qualifications/credentialing files were reviewed.

A Zoom meeting was completed with applicable CMHA staff to review findings of clinical case review, findings of provider qualifications, and a review of the CMHSP's performance with PI indicators (MMBIS, PIP study), including whether the CMHSP has implemented CAPs in the past fiscal year, successes, challenges, plans for improvement in the coming fiscal year.

Results

Summary of Clinical Compliance Review Findings

Standards were scored 0 (not met), 1 (partially met), and 2 (met), with an overall standard score of 1.80 or less requiring the submission of a corrective action plan (CAP). In areas where a CAP was required, it appeared the CMHSPs had the policies, procedures, and understanding of practices in place to meet the contractual requirements of these standards. The majority of these findings appeared to be related to staff documentation and training needs of those practices.

CMHSP Staff Qualifications Findings

All CMHSPs had scores of full compliance with no findings in this area.

Review of PI Data

For this fiscal year, a baseline review of the MMBPIS indicators was completed with all CMHSPs as follow up from corrective actions provided to the Regional Clinical Performance Team (CPT) to assess the successful implementation of those corrective actions. PI Data results for QI and QII of FY20 were reviewed with staff. As the state changed data cleaning analysis standards mid-year the review addressed whether the CMHSPs completed their corrective action plans as written. All CMHSPs were compliant in this area.

B. FY20 PIHP Substance Use Disorder (SUD) Prevention Provider Monitoring

All CMHPSM funded prevention programs are monitored on a continuous basis. Typically desk audits are conducted every other year (FY19) and program observations occur on the other years (FY20). Program observations were not able to occur during FY20 due to the COVID-19 health crisis. While the health crisis impacted the ability for CMHPSM prevention staff to conduct program observations as intended, consultations and technical assistance were provided to promote the continuation of effective prevention services.

Due to the COVID-19 health crisis in the spring, and the associated impact on prevention services, the CMHPSM required providers to complete a Continuation Action Plan Form to gauge how prevention services could continue during the pandemic. This form was required based on their previously approved FY20 EBI Implementation and Evaluation Plan. Additionally, the MDHHS OROSC provided a guidance document for providing and reporting virtual SUD prevention activities, as well as allowable indirect activities during the COVID-19 pandemic.

The mid-year point allowed for a more in-depth analysis based on a variety of factors including: the amount of time for program implementation, the submission of Evidenced-based Initiative (EBI) Implementation and Evaluation Planning Forms, EBI Program Assessment/Fidelity Forms, and Coalition Community Sector Checklists (where applicable). Prevention programs are reviewed from multiple perspectives: financial, contractual, Michigan Prevention Data System (MPDS) entries, programming, and progress on planned activities in relationship to outcomes.

For those areas that did not produce the results anticipated, a 'course correction' was required. The CMHPSM considers the ramifications of the pandemic and promotes the rectification of program implementation to enhance the opportunity for successful efforts within the respective targeted community. Thus, feedback and consultation are provided where necessary.

C. FY20 PIHP Substance Use Disorder Treatment Monitoring

The following modifications to the CMHPSM Monitoring of SUD Providers took place for FY 20:

Reviews were completed remotely and by desk audit due to safety precautions required by the COVID-19 pandemic.

Based on past auditing practices, it appears an administrative and policy review, as well as a clinical record review of all requirements has been is completed annually with the last one completed FY19. Due to the COVID-19 pandemic and limited provider resources, an administrative and policy review and a full clinical record review was waived for FY20 and will be completed the next fiscal year, to reduce undue resource/ administrative burden on SUD providers.

The FY 20 review of SUD providers entailed the following:

a) A review of the provider's corrective action plan (CAP) from last fiscal year to ensure all areas have been addressed. If no CAP was required by the provider this aspect of the review will not be applicable.
b) A risk review of clinical cases related to COVID-19 and telehealth services was completed remotely for all SUD providers in the CMHPSM region. A random sample of cases were pulled from claims data between March 2020 and July 2020, with cases reviewed to include indicators on whether telehealth services were correctly coded/billed, met the definition of the service billed, met documentation

requirements, meet access standards for priority populations vs. routine services, an individualized client-centered treatment/recovery plan was are developed within 30 days after admission, and was modified for any changes in service provision and allowable telehealth services, services were provided as written in the plan, and staff who billed for the services met state and federal provider requirements,

c) A review of provider compliance and performance with the new IET state PI indicators effective April 26, 2020.

A minimum of five charts were randomly selected from provider admission lists for people who received services within the identified indicators.

Results: Fifteen (15) SUD providers reviewed by PIHP staff. For providers based in other regions, CMHPSM requested the monitoring reports conducted by the PIHP of that region.
The majority of findings were related to providing all evidence of staff qualifications, and SUD provider performance with SUD access PI data. SUD PI indicators will be changing for FY21 and the region already has plans in place and preliminary data that shows meeting required state thresholds in this area.
SUD providers showed overall compliance with accurately documenting and billing for the implementation of telehealth services that was a new factor of service provision for FY20.

Next Steps: The clinical review tools will be revised to update any new contract requirements, correct any review items that were not relevant and ensure the flow of tool captures the intent of the clinical review. The FY 21 review will be conducted during quarter three and quarter four. Providers who need to address providing clearer evidence of staff qualifications will be required to address this in corrective action plans.

D. Modernization of the Region's Electronic Health Record

For over a decade, the region has been in a contractual relationship with Peter Chang Enterprises (PCE) as vendor for the electronic health record (EHR). The CMHPSM Chief Information Officer (CIO) and the Electronic Health Record Operations Committee (EOC) are the primary parties responsible for managing the electronic health record in conjunction with PCE. These groups identify regional needs, prioritize those needs, and identifies system problems, with local solutions developed the EHR vendor. In FY 18/19 the region achieved the goal to further modernize the electronic health record. Since that time, regional electronic record goals have centered around system enhancements and optimization. For FY 20 the following system enhancements and optimizations have been identified:

- Regional sub-committees modified forms with review and approval by the Regional Implementation Team.
- During FY20 EOC was able to implement approximately 34 system enhancements into our regional EHR.
- System enhancements included updating clinical forms and documentation to align with clinical workflow and regulatory needs.
- Upgraded substantial system modules such as the Community Living Supports Module, Grievance and Appeals Module, Letters Module, and Performance Indicators Module.
- Increased operational supports within the EHR through the addition of a supervisor dashboard.
- Reviewed all user role security and privacy groups with modifications as indicated.
- Implemented increased system validations to increase user documentation of required fields.
- Increased visual prompts to support completeness of encounter data requirements.
- Addition of NOMS clinical documentation and reporting components.
- Implementation of system bi-directional interface and training for use of state required Milliman Care Guidelines (MCG) and Indicia level of care documentation for authorization of urgent/emergent services such as psychiatric inpatient, partial hospitalization.
- Continued review and implementation of clinical, revenue, and operations local custom reports using clinical and revenue EHR data.

Closing Statement

The annual QAPIP evaluation is a partial representation of the expansive performance improvement initiatives throughout the CMHPSM region. Continuous improvement and development of new/enhanced areas for improvement is a vital part of the CMHPSM as a learning

organization. The goal of continuous improvement is an ongoing aspect of all operations across the region, that incorporates input from consumers, employees, directors, providers, and community partners to ensure quality and performance improvement is an inherent part of all aspects of services, programs and supports provided to those we serve.

Respectfully Submitted,

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