Quality Assurance Performance Improvement and Utilization Management 2018 Program Evaluation

All SWMBH Business Lines

Evaluation Period: Medicaid (October 1, 2017- September 30, 2018)
Evaluation Period: MI Health Link (January 1, 2018 – December 31, 2018)

Reviewed/Approved by:

SWMBH Quality Management Committee: March 28, 2019
SWMBH Regional Utilization Management & Clinical Practices Committee: March 11, 2019
SWMBH Operations Committee: February 27, 2019
SWMBH Board Approval: April 12, 2019

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I. Introduction

Quality Assurance Improvement Program

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) has a documented Quality Assessment and Performance Improvement Program (QAPIP) that meets required federal regulations: the specified Balanced Budget Act of 1997 (BBA) as amended standards, 42 CFR § 438, requirements set forth in the PIHP contract(s), specifically Attachment P.6.7.1.1.

As part of Southwest Michigan Behavioral Health's (SWMBH) benefit management organization responsibilities, the SWMBH QAPI Department conducts an annual QAPI Evaluation to assure it is meeting all contractual and regulatory standards required of the Regional Entity, including its PIHP responsibilities.

This annual review will include: (1) Improvement initiatives undertaken by SWMBH from October 2017 through September 2018 for Medicaid Services and from January 2018 to December 2018 for MI Health Link Services (2) Resources used by the QAPI department and (3) The status of QAPI Plan objectives. The formulation of the QAPI goals and objectives includes: incorporating numerous federal, state and accreditation principles including: BBA standards, National Committee for Quality Assurance (NCQA) standards, MDHHS contract requirements and best practice standards. Additionally, more information related to the QAPIP standards can be found in SWMBH policies and procedures, along with other departmental plans. SWMBH's QAPIP serves to promote quality customer service and outcomes through systematic monitoring of key performance elements integrated with system-wide approaches to continuous quality improvement.

The QAPIP is approved annually by the SWMBH Board. The authority of the QAPI department and the Quality Management Committee (QMC) is granted by SWMBH's Executive Officer (EO) and Board. SWMBH's Board retains the ultimate responsibility for the quality of the business lines and services assigned to the regional entity. The SWMBH Board annually reviews and approves the QAPI Effectiveness Review/Evaluation throughout the year.

II. Reporting Period

This evaluation period considered is from October 1, 2017 through September 30, 2018 (Medicaid) and January 1, 2017 to December 31, 2018 (MHL) and provides summaries of activities and performance results for each of the QAPI Program/Plan and UM Program/Plan annual goals and objectives.

III. Overview of Resources

In continuing the development of a systematic improvement system and culture, the goal of this evaluation is to identify any needs the organization may have in the future so that performance improvement is effective, efficient and meaningful. This analysis also examined the current relationships and structures that exist to promote the performance improvement goals and objectives.

Communication

The QAPI Department interacts with all other departments within SWMBH as well as our partner Community Mental Health Service Programs (CMHSPs). The communication and relationship between SWMBH's other departments and CMHSPs is a critical component to the success of the QAPI Department. The QAPI Department works to provide guidance on project management, technical assistance and support data analysis to other departments and CMHSPs. Sharing of information with internal and external stakeholders through our Managed Information Business Intelligence system; through the SWMBH SharePoint site is key. The site offers a variety of interactive visualization dashboards that give real time status and analysis to the end user. The QAPI department also publishes newsletter articles and key information to the SWMBH website.

Internal Staffing of the QAPI Department

The SWMBH QAPI Department is charged with the purpose of developing and managing its program. This program plan outlines the current relationships and structures that exist to promote the performance improvement goals and objectives.

The QAPI Department is staffed with a Director of Quality Assurance and Performance Improvement, which oversees the QAPI Department (including four full time staff). The QAPI Department also may utilize outside contract consultant for specialty projects and preparation for accreditation reviews. The QAPI Director collaborates on many of the QAPI goals and objectives with the SWMBH Senior Leadership team and SWMBH Regional Committees, such as the; Quality Management Committee (QMC), Regional Information Technology Committee (RITC), Regional Utilization Management Committee (RUM), and the Regional Clinical Practices Committee (RCP).

The QAPI Department staff includes two Business Data Analyst positions. The Business Data Analyst plays a pivotal role in the QAPIP providing internal and external data analysis, management for analyzing organizational performance, business modeling, strategic planning, quality initiatives and general business operations including developing and maintaining databases, consultation and technical assistance. In guiding the QAPI studies, the Business Data Analyst will perform complex analyses of data including statistical analyses of outcomes data to test for statistical significance of changes, mining large data sets and performs factor analyses to determine causes or contributing factors for outcomes or performance outliers; correlates analyses to determine relationships between variables. Based on the data, the Business Data Analyst will develop reports, summaries, recommendations and visual representations.

SWMBH staff will include a designated behavioral health care practitioner to support and advise the QAPI Department in meeting the QAPIP deliverables. This designated behavioral health care practitioner will provide supervisory and oversight of all SWMBH clinical functions to include; Utilization Management, Customer Services, Clinical Quality, Provider Network, Substance Abuse Prevention and Treatment and other clinical initiatives. The designated behavioral health care practitioner will also provide clinical expertise and programmatic consultation and will collaborate with QAPI Director to ensure complete, accurate and timely submission of clinical program data including Jail Diversion and Behavioral Treatment Committee. The designated behavioral health care practitioner is a member of the Quality Management Committee (QMC).

Adequacy of Quality Management Resources

The following chart is a summary of the positions currently included in the QAPI Department, their credentials and the percentage of time devoted to quality management activities. Additional departmental staff are listed with the percentage of their time devoted to quality activities.

Title	Department	Percent of Time Per Week Devoted to QM
Director of Quality Assurance and Performance Improvement	QAPI	100%
(2) QAPI Specialist	QAPI	100%
Business Data Analyst I	QAPI	100%
Business Data Analyst II	QAPI	70%
Clinical Data Analyst	QAPI and UM	25%
Manager of Utilization Management	UM	40%
Director of Provider Network	PNM	20%
Chief Information Officer	IT	30%

Senior Software Engineer	IT	30%
Member Engagement Specialist	UM	20%
Waiver and Clinical Quality Manager	PNM	20%
Applications and Systems Analyst	IT	30%
Designated Behavioral Health Care Practitioner	UM/PN	40%
Chief Compliance and Operations Officers	Com/Ops	15%

QAPI = Quality Assurance and Performance Improvement
PN = Provider Network
UM = Utilization Management
IT = Information Technology

SWMBH will have appropriate staff to complete QAPI functions as defined in this plan. In addition to having the adequate staff, the QAPI Department will have the relevant technology and access to complete the assigned tasks and legal obligations as a managed benefits administrator for a variety of business lines. These business lines include: Medicaid, Healthy Michigan Plan, MiChild, Autism Waiver, MI Health Link (MHL) & Duals, SUD Block Grant, PA 2 funds and additional grant funding. To complete these functions needed resources include, but are not limited to:

- Access to regional data
- Software and tools to analyze data and determine statistical relationships

The QAPI Department is responsible for collecting measurements reported to the state and to improve and meet SWMBH's mission. In continuing the development of a systematic improvement system and culture, the goal of this program and plan is to identify any needs the organization may have in the future so that performance improvement is effective, efficient and meaningful. The QAPI Department monitors and evaluates the overall effectiveness of the QAPIP, assesses its outcomes, provides periodic reporting on the Program, including the reporting of Performance Improvement Projects (PIPs), and maintains and manages the Quality Management Committee (QMC) and MI Health Link QM Committees.

The QAPI Department collaborates with the Quality Management Committee (QMC) and the SWMBH Board in the development of an annual QAPI plan. QAPI Department also works with other functional areas and external organizations/venders like Streamline Solutions and the Health Service Advisory Group (HSAG) to review data collection procedures. These relationships are communicated with the EO and the SWMBH Board as needed. Other roles include:

- Reviewing and submitting data to the state
- Creating and maintaining QAPI policies, plans, evaluations and reports
- Implementation of regional projects and monitoring of reporting requirements
- Assisting in the development of Strategic Plans and Tactical Objectives
- Assisting in the development of the Boards Ends Metrics and other Key Performance Indicators
- Communications and Reporting to our Integrated Care Organizations
- Analysis of reports and data; to determine trends and recommendations for process improvements

Leadership involvement
Another significant strength of the QAPI program is the continuing involvement of SWMBH Senior Leadership at the highest level. The CEO and members of the Senior Leadership team are all active participants in the day to day operations of the QAPI Program. Their active involvement provides a clear message to all SWMBH and CMHSP team members regarding the importance of the active involvement and support of the activities. Newly hired team members are quickly introduced to the quality culture of SWMBH and to the central role that quality and data play in decision making, strategic planning and defining tactical objectives throughout the Region.

Practitioner Involvement
The QAPI has a strong active involvement of providers and Clinical Director involvement in the program. They attend Quality Management Committee meetings, MIHL Committee Meetings, Regional Utilization Management and Clinical Practice Committee meetings and are available as needed to the QAPI team. They are instrumental in establishing measures and setting goals for Regional performance targets.

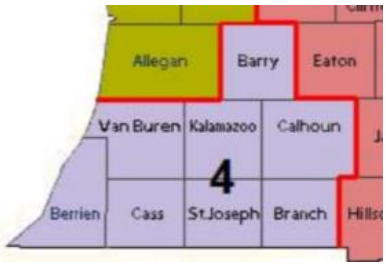
Physical Resources: Phones/Computers/Equipment
Due to the diverse geographical region, the phone system and internet/network capacities are important to the day-to-day operations of the SWMBH. Document management is also a key business practice that promotes effective workflow. As such SWMBH has developed and redesigned a portal for both internal and external entities to collaborate and access key Regional information and data. In late 2016 SWMBH was able to purchase a dashboard visualization and analysis software called Tableau that has become a critical part of our information and data sharing process with external and internal stakeholders. This software allows access to real time data that is very important in our performance based environment. The use of go-to-meeting or web-x technology is offered to Regional Committee members, internal and external stakeholders if they are not able to attend meetings in person.

Service Population and Eligibles Served:

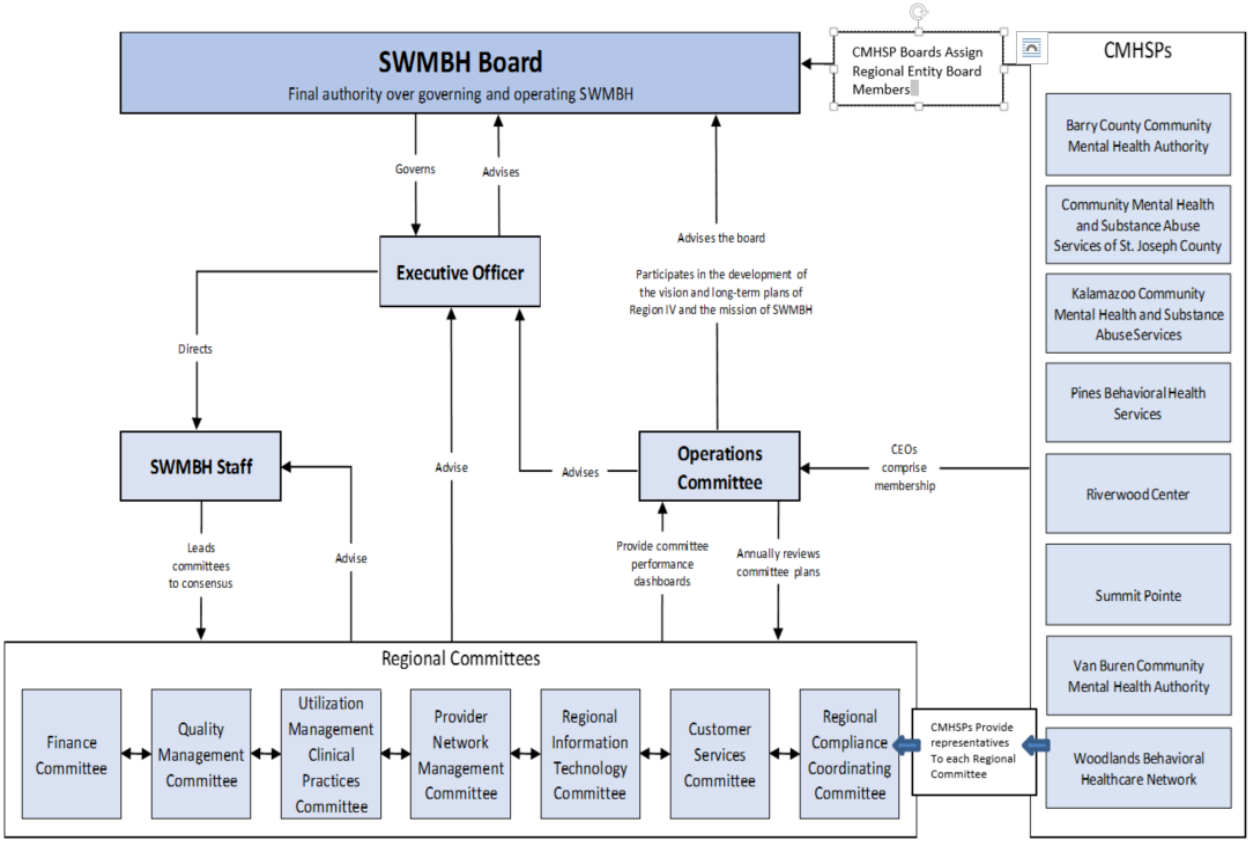
The SWMBH region (4) has served nearly **26,892** unique consumers from October 1, 2017 to September 30, 2018

- Persons served Include:
  - Adults with SPMI (Severe Persistent Mental Illness)
  - Adults with Developmental Disabilities
  - Adults with Substance Use Disorders
  - Children with SED (Severe Emotional Disturbance)
  - Children with Developmental Disabilities

- Medicaid or Healthy Michigan Plan (HMP) Eligible in region (FY'18): 239,763



IV. Evaluation of Quality Management Committee Structure



Quality Management (QMC) Committee Structure

SWMBH has established the QMC to provide oversight and management of quality management functions and providing an environment to learn and share quality management tools, programs, and outcomes. SWMBH values the input of all stakeholders in the improvement process and QMC is one method of participant communication, alignment, and advice to SWMBH. QMC allows regional input to be gathered regarding the development and management of processes and policies related to quality. QMC is responsible for developing Committee goals, maintaining contact with other committees, identifying people, organizations or departments that can further the aims of both the QAPI Department and the QMC. Cooperation with the QMC Program is required of all SWMBH staff, participants, customers and providers. QMC representatives are selected by their CMHSPs and required to communicate any information discussed during meetings or included in meeting minutes back to their CMHSPs.

CMHSPs are responsible for development and maintaining a performance improvement program within their respective organizations. Coordination between the participant and provider performance improvement programs and SWMBH's program is achieved through standardization of indicator measurement and performance review through the QMC.

In order to assure a responsive system, the needs of those that use or oversee the resources, (e.g. active participation of customers, family members, providers, and other community and regulatory stakeholders) are promoted whenever possible. Training on performance improvement technology and methods along with technical assistance is provided as requested, or as necessary.

Quality Management Committee (QMC) Membership

The QMC shall consist of an appointed representative from each participating CMHSP, representative(s) from the SWMBH Customer Advisory Committee (CAC) and SWMBH QAPI Departmental staff. All other ad hoc members shall be identified as needed and include provider representatives, IT support staff, Coordinating Agency staff and the SWMBH medical director and clinical representation. All QMC members are required to participate; however, alternates will also be named in the charter and will have all same responsibilities of members when participating in committee work.

***QMC Committee Commitments include*:**

1. Everyone participates.
2. Be passionate about the purpose
3. All perspectives are professionally Expressed and Heard
4. Support Committee and Agency Decisions
5. Celebrate Success

Decision Making Process

Quality Management is one of the core functions of the PIHP. The QMC is charged with providing oversight and management of quality management functions and providing an environment to learn and share quality management tools, programs and outcomes. This committee allows regional input to be gathered regarding the development and management of processes and policies related to quality. On a quarterly basis, QMC collaborates with the Regional Clinical Practices (RCP) and Regional Utilization Management (RUM) Committees on clinical and quality goals and contractual tasks.

The committee will strive to reach decisions based on a consensus model through discussion and deliberation. Further information on decision making can be found in the QMC charter. *(Please see Attachment L – QMC Charter for more details)*.

QMC Roles and Responsibilities

- QMC will meet on a regular basis (at a minimum quarterly) to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPIP, QAPI & UM Effectiveness Review/Evaluation, and Performance Improvement Projects (PIPs). Oversight is defined as reviewing data and approving projects.
- Members of the committee will act as conduits and liaisons to share information decided on in the committee. Members are representing the regional needs related to quality. It is expected that QMC members will share information and concerns with SWMBH QAPI staff. As conduits, it is expected that committee members attend all meetings by phone or in person. If members are not able to attend meetings, they should notify the QMC Chair Person as soon as possible. QMC members should be engaged in performance improvement issues, as well as bringing challenges from their site to the attention of the SWMBH committee for deliberation and discussion.
- Maintaining connectivity to other internal and external structures including the Board, the Management team, other SWMBH committees and MDHHS.
- Provide guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.
- Provide data review and recommendations related to efficiency, improvement and effectiveness.
- Review and provide feedback related to policy and tool development.
- The primary task of the QMC is to review, monitor and make recommendations related to the listed review activities with the QAPIP.
- The secondary task of the QMC is to assist the PIHP in its overall management of the regional QAPI functions by providing network input and guidance.

Quality Management Committee Key Accomplishments

The QMC met on a monthly basis during FY 2018. All meeting materials are accessible on the SWMBH portal before and after each meeting. The focus and oversight of QMC during this review period was on continued review of Quality activities including Board Ends Metrics and Performance Improvement Projects.

This year, instead of each Regional Committee being tasked with establishing (2) annual goals and reporting on them, the Board established (7) Strategic Imperatives. These (7) Strategic Imperatives will replace the 2019 Regional Committee Goals (*Please see attachment K to view the 7 Strategic Imperatives).*

2018 Quality Management Committee Goals (By: 12/30/2018)

✓ **Completed**

Implementation and oversight of a Regional Report Users and Analysis Group (By: 12/30/2018)

i. Determine who the members of the report users and analysis group will be.
ii. Send out calendar invites to selected report user group members.
iii. Formulate a charter, which defines the purpose and roles of the report users and analysis group.
iv. Determine schedule reports will be build and reviewed on, based on Regional priorities and needs.
v. Users Group to perform analysis, identify trends, improve function of reports.
vi. Users Group to present reports to relevant Regional Committees for feedback and use.

✓ **Completed**

Formulate a series of instructional videos/tutorials, which live on the SWMBH SharePoint Portal for SWMBH and CMHSP access (By: 12/30/2018)

i. Perform a gap analysis to identify Regional Education needs, based on current contractual/oversight obligations.
ii. Identify Training resources and software/tools we will use to create educational resources.
iii. Identify the list of Regional Trainings to be developed and prioritize them for development.
iv. Form sub-groups within QMC to put together materials/trainings and present trainings.
v. Test Access to the trainings/tutorials and ensure all CMHSP/SWMBH users have access to them.
vi. Present trainings to relevant Regional Committees or Internal SWMBH/CMHSP departments.
vii. Review Priority-Training Development List and make adjustment for ongoing development as necessary.
viii. Review Process and formulate ongoing report improvement and access strategies

1. 2019-2020 Target Goals will Include:

i. Review of Regional Critical Incident Reporting Procedures and Requirements.
ii. Review of Risk Event tracking, analysis and monitoring for consistency across all CMHSPs.
iii. Review of Regional Jail Diversion processes, training and State reporting measures.
iv. Review of Regional Grievance and Appeals tracking, notices, letters against HSAG and Managed Care guidelines.

Additional Accomplishments of the QMC during 2018 include:

- Consumer Satisfaction Survey Analysis and Outcomes (MHSIP and YSS tools).
- Reporting Phone System Data (*call abandonment rate, call answer times and total call volume*).
- Tracking and Reporting Critical Incidents (*development of new tracking form and reporting process*).
- Analysis and Improvement of MMBPIS Performance Indicator reporting and regional education.
- Review and Analysis of annual Grievance and Appeals data.
- Formulation of reports and Analysis to help with Identification of high-risk consumers.
- Review of Population Health Indicators, Analysis and Outcomes.
- Successful Completion of MDHHS Administrative site review for (HSW, SEDW and Home visits).
- Successful Completion of HSAG – Performance Measure Validation Audit.

MI Health Link Committee

On March 1, 2015, SWMBH became part of the Center for Medicare and Medicaid Services project titled the "MI Health Link (MHL) demonstration project" for persons with both Medicare and Medicaid. SWMBH contracts and coordinates with two Integrated Care Organizations within the region. The two ICOs identified for Region 4 are Aetna Better Health of Michigan and Meridian Health Plan. As such SWMBH is held to standards that are incorporated into this QAPIP that are sourced from The Michigan Department of Health and Human Services (MDHHS), CMS Medicare rules, NCQA Health Plan standards, and ICO contract arrangements. In addition to the MHL demonstration contract, it is required that each specialty PIHP have a documented QAPIP that meets required federal regulations: the specified Balanced Budget Act of 1997 as amended standards, 42 CFR § 438, requirements set forth in the PIHP contract(s), specifically MDHHS Attachment P.7.9.1, Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans, and MI Health Link (MHL) demonstration project contracts, Medicaid Provider Manual and National Council on Quality Assurance (NCQA). SWMBH will maintain a QAPIP that aligns with the metrics identified in the MHL ICO contract. SWMBH will implement BH, SUD and I/DD-oriented Health Care Effectiveness Data and Information Set (HEDIS) measures enumerated in the contract. This may include the implementation of surveys and quality measures, ongoing monitoring of metrics, monitoring of provider performance, and follow-up with providers as indicated.

The MHL Committee is charged with providing oversight and management of quality management functions and providing an environment to learn and share quality management tools, programs, and outcomes. This committee allows regional input to be gathered regarding the development and management of processes and policies related to quality. The committee is one method of participant communication, alignment, and advice to SWMBH.

The committee tasks are determined by the SWMBH EO, committee chair and members, member needs, MI Health Link demonstration guidelines including the Three-Way Contract, ICO-PIHP Contract and NCQA requirements. The MHL QMC is accountable to the SWMBH EO and is responsible for assisting the SWMBH Leadership to meet the Managed Care Benefit requirements within the MHL demonstration, the ICO-PIHP contract, and across all business lines of SWMBH. The MHL QMC must provide evidence of review and thoughtful consideration of changes in its policies and procedures and work plan and make changes to its policies where they are needed. Analyzes and evaluates the results of QM activities to identify needed actions and make recommendations related to efficiency, improvement, and effectiveness. The MHL QMC will meet on a regular basis (at a minimum quarterly) to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPI Program, QAPI Effectiveness Review/Evaluation, and Performance Improvement Projects. Oversight is defined as reviewing data and approving projects.

MI Health Link Committee Membership

The MHL Committee shall consist of the QAPI Department staff, a designated behavioral health care practitioner and ICO representatives. This designated behavioral health care practitioner shall have oversight of any clinical metrics and participates in or advising the MHL Committee or a subcommittee that reports to the MHL Committee. The behavioral healthcare provider must have a doctorate and may be a medical director, clinical director or, participating practitioner from the organization or affiliate organization. All other ad-hoc members shall be identified as needed and could include provider representatives, IT support staff, Coordinating Agency staff, and medical director and clinical representation. Members of the committee are required to participate; however, alternates will also be named in the charter and will have all same responsibilities of members when participating in committee work.

Members of the committee will act as conduits and liaisons to share information decided on in the committee. Members are representing the regional needs related to quality. It is expected that members will share information and concerns with SWMBH QAPI staff. As conduits it is expected that committee members attend and are engaged in Performance Improvement issues, as well as bringing challenges from their site to the attention of the SWMBH committee for possible project creation.

Decision Making Process

The committee will strive to reach decisions based on a consensus model through discussion and deliberation. Further information on decision making can be found in the MHL QMC charter. *(Please see Attachment F – MHL Committee Charter for more details)*. The MHL Committee is responsible for maintaining contact with other committees as well as identifying people, organizations, or departments that can further the aims of both the QAPI Department and the Committee. The MHL QAPI section of the Committee coordinates with the UM and Provider Network MHL Committees. The QAPI Director is a member of both the UM and Provider Network MHL Committees. The QAPI Director may call on other QAPI team members or CMHSP partners to participate in MHL Committee meetings as necessary.

MI Health Link Quality Committee Key Accomplishments during 2018 include:

- ✓ Achievement of Full NCQA MBHO Medicare Accreditation
- ✓ Review Quarterly MHL enrollee statistics
- ✓ Completed and Ongoing QI Activities that address quality and safety of clinical care and quality of service
- ✓ Trending of measures to assess performance in the quality and safety of clinical care and quality of service
- ✓ Analysis and evaluation of the overall effectiveness of QAPI program, including progress toward influencing network safe clinical practices
- ✓ Enhancing Practitioner Involvement with Quality initiatives and key performance measures.
- ✓ Monthly Analysis and reporting on; Call Center Metrics (*abandonment rate, average answer time, total calls per line and call volume analysis).*
- ✓ Quarterly Review and analysis of Critical Incidents, to help identify trends.
- ✓ Quarterly Review and analysis of grievances, appeals, and denials.
- ✓ Analysis of BH/PH Provider Communications Survey and Opportunities for improvement.
- ✓ Communication on key findings from ICO/SWMBH audits and reviews.
- ✓ Review and understanding of NCQA-MBHO accreditation standards and elements.
- ✓ Monthly updates and discussion on MIHL enrollment and eligibility data.

Functional Area	Objectives	Lead Staff	Review Date
Committee	Approve last month's MHL Committee Meeting minutes.	All Committee Members	Quarterly
UM	Grievances and Appeals	Member Engagement Specialist	Quarterly
Credentialing	Review and approval of MI Health Link policies and procedures.	Director of Provider Network	As needed
	Medical Director, Clean File Review Approvals Four clean file reviews since last meeting	Provider Network Specialist, or Director of Provider Network	Quarterly
	Credentialing Applications for Committee Review	Provider Network Specialist, or Director of Provider Network	Quarterly
	Practitioner Complaints	Provider Network Specialist, or Director of Provider Network	Quarterly
Quality	Policy and Procedure Review and Updates**.**	Director of QAPI or designated QAPI Specialist	As needed
	Annual Work plan Review (Quarterly).	Director of QAPI or designated QAPI Specialist	Bi-Annual as indicated by QAPI work plan
	Annual Reviews/Audits (Recommendations for Improvement and review of results).	Director of QAPI or designated QAPI Specialist	As needed
	Practitioner Participation and Clinical Practice Guideline Review.	Director of QAPI or designated QAPI Specialist	Quarterly
	Performance Measures for Site Audit	Director of QAPI or designated QAPI Specialist	As needed
	Causal Analysis	Director of QAPI or designated QAPI Specialist	Quarterly
	Call Center Monitoring	Director of QAPI or designated QAPI Specialist	Quarterly
	Timeliness Monitoring	Director of QAPI or designated QAPI Specialist	Quarterly
	NCQA Reports	Director of QAPI or designated QAPI Specialist	Quarterly
UM/Clinical	Collaborative Initiatives Meridian ICT Update	Director of Utilization Management or Integrated Care Specialist	Quarterly
	Complex Case Management	Director of Utilization Management or Integrated Care Specialist	Quarterly
	NCQA Measures	Director of Provider Network or Director of Utilization Management	Quarterly
	Policy and Procedure Review and Updates.	Director of Utilization Management or Manager of Utilization Management	As needed

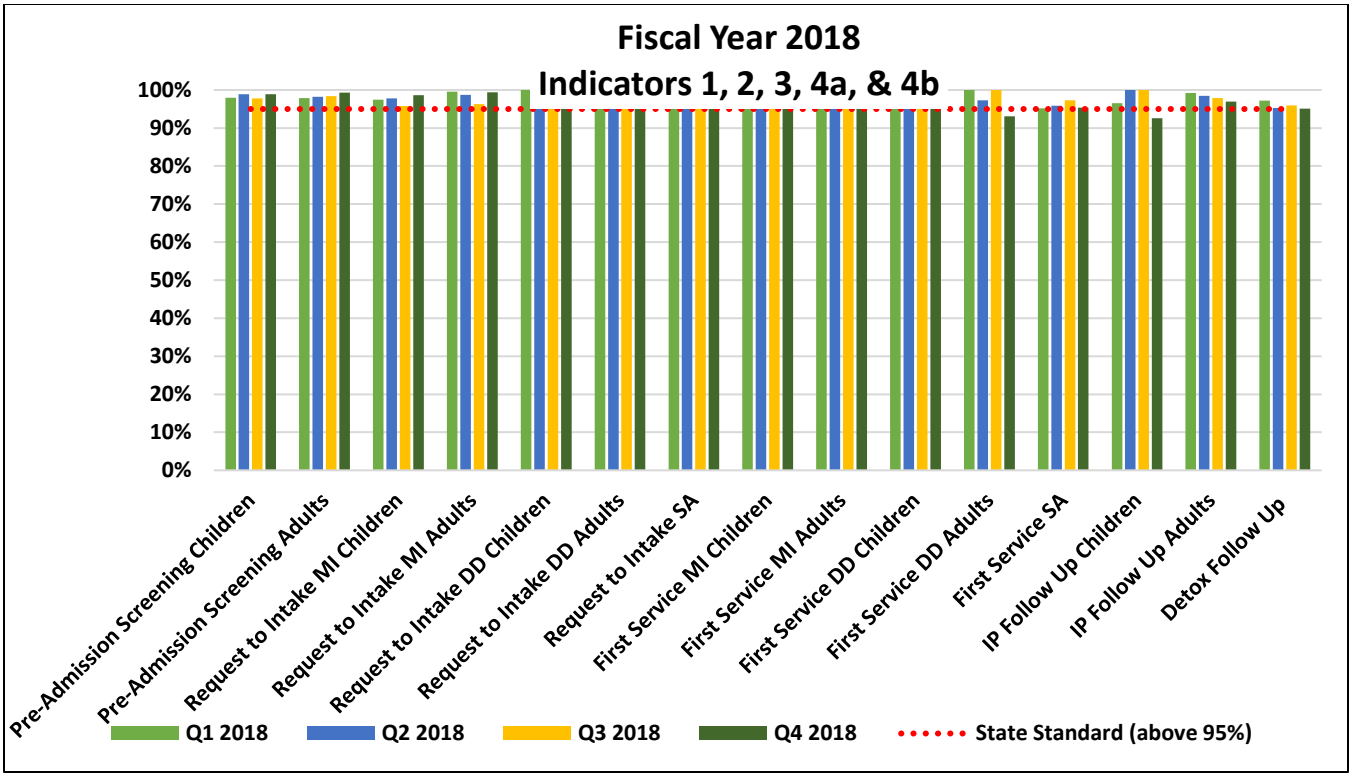
Quality Assurance Improvement Program Evaluation

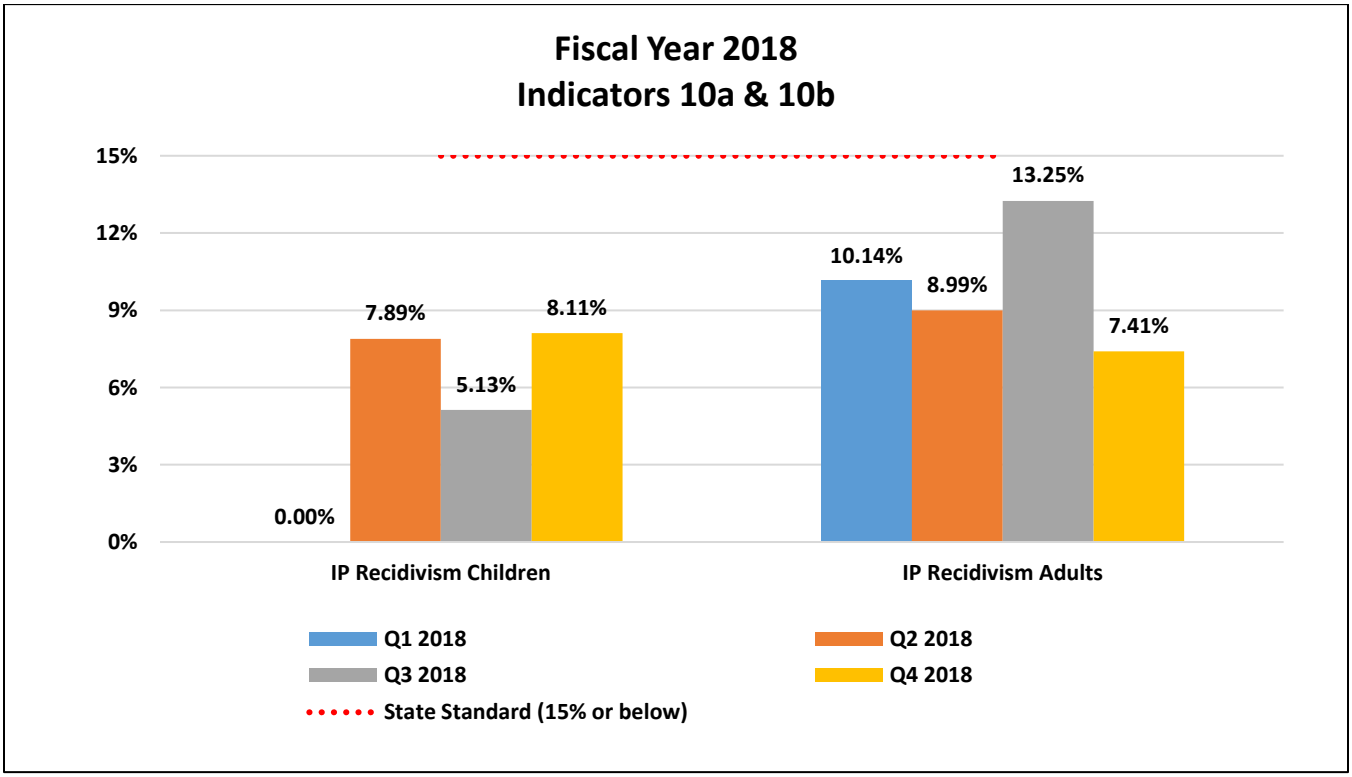
I. Quality Assurance Improvement Program Plan Evaluation

The following sections represent the outcomes, from the categories included in the 2018 QAPI and UM Plans

2018 Michigan Mission Based Performance Indicator System Results (MMBPIS)

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Michigan Mission Based Performance Improvement System (MMBPIS)	➢ MMBPIS Performance Standards will meet or exceed the State indicated benchmark, for each of the (17) Performance Measures reported to State.	✓ Maintain a dashboard tracking system to monitor progress on each indicator throughout the year (located on SWMBH Portal). ✓ Report indicator results to MDHHS on a Quarterly basis. ✓ Status updates to relevant Committees such as: QMC; RUM; RCP and Operations Committee. ✓ Ensure CMHSPs are submitting the approved template to the SWMBH FTP site on the 25th of each month. ✓ Ensure each CMHSP receives a Corrective Action Plan for any indicators that missed the State indicated bench mark. ✓ Ensure CMSHP Corrective Action Plans are achieved and improvements are recognized.	October 2017 – December 2018	QAPI Director QAPI Specialist Clinical Quality Director SUD Manager	Quarterly Submissions to MDHHS: *Q1 - 3/31/18 *Q2 - 6/30/18 *Q3 - 9/30/18 *Q4 - 12/30/18 CMHSPs submit monthly reports on the 25th of each month Via the FTP site. Annual on-site reviews for all (8) CMHSPs occur in June 2018.


Fiscal Year 2018
Indicators 1, 2, 3, 4a, & 4b
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Pre-Admission Screening Children
Pre-Admission Screening Adults
Request to Intake MI Children
Request to Intake MI Adults
Request to Intake DD Children
Request to Intake DD Adults
Request to Intake SA
First Service MI Children
First Service MI Adults
First Service DD Children
First Service DD Adults
First Service SA
IP Follow Up Children
IP Follow Up Adults
Detox Follow Up
Q1 2018
Q2 2018
Q3 2018
Q4 2018
State Standard (above 95%)


Fiscal Year 2018
Indicators 10a & 10b
15%
12%
9%
6%
3%
0%
0.00%
7.89%
5.13%
8.11%
10.14%
8.99%
13.25%
7.41%
IP Recidivism Children
IP Recidivism Adults
Q1 2018
Q2 2018
Q3 2018
Q4 2018
State Standard (15% or below)

Performance Indicator Measurement Period: October 1, 2017 through September 30, 2018

Objective:
State defined indicators that are aimed at measuring access, quality of service and provide benchmarks for the state of Michigan and all (10) PIHPs.

Results:
66/68 Total Performance Indicators in 2018 met the State Standard of 95%:

- 1st Quarter = 17/17
- 2nd Quarter = 17/17
- 3rd Quarter = 17/17
- 4th Quarter = 15/17

MMBPIS Indicator		Q1 2018	Q2 2018	Q3 2018	Q4 2018
Pre-Admission Screening Children	SWMBH	97.94%	98.91%	97.79%	98.86%
Pre-Admission Screening Adults	SWMBH	97.88%	98.23%	98.37%	99.32%
Request to Intake MI Children	SWMBH	97.43%	97.76%	95.75%	98.60%
Request to Intake MI Adults	SWMBH	99.52%	98.75%	96.24%	99.43%
Request to Intake DD Children	SWMBH	100.00%	97.37%	100.00%	100.00%
Request to Intake DD Adults	SWMBH	100.00%	100%	100.00%	100.00%
Request to Intake SA	SWMBH	97.04%	98.12%	97.36%	98.44%
First Service MI Children	SWMBH	95.67%	96.96%	96.82%	97.18%
First Service MI Adults	SWMBH	96.06%	96.61%	97.75%	97.10%
First Service DD Children	SWMBH	100.00%	100%	100.00%	100.00%
First Service DD Adults	SWMBH	100.00%	97.30%	100.00%	93.10%
First Service SA	SWMBH	95.21%	95.82%	97.30%	95.35%
IP Follow Up Children	SWMBH	96.55%	100.00%	100.00%	92.59%
IP Follow Up Adults	SWMBH	99.25%	98.48%	97.88%	96.98%
Detox Follow Up	SWMBH	97.24%	95.24%	95.97%	95.08%
IP Recidivism Children	SWMBH	0.00%	7.89%	5.13%	8.11%
IP Recidivism Adults	SWMBH	10.14%	8.99%	13.25%	7.41%
Overall Results	SWMBH	**17/17**	**17/17**	**17/17**	**15/17**

Identified Barriers:
MMBPIS data submission and process review due to changes in Managed Care Information Systems (MCIS). Also, the MMBPIS project manager left and was replaced in August 2018.

Recommendations:
Corrective action plans if CMHSPs do not meet State indicated benchmarks each quarter—additional 'stages' to remediation have been discussed and will likely be implement for FY2019. Due to changes in the MCIS, the region was tasked with updating the MMBPIS indicator submission process and came up with a new template that is currently in production. The template submission will likely be a short-term solution, but a long-term solution would be exploring a data exchange format or XML file transfers from the warehouse data.

CMHSPs are required to submit the MMBPIS tracking template on a monthly basis, to ensure accuracy and outliers are being followed-up with on a timely basis. Quarterly data is compiled and submitted to MDHHS on the last day of the 3rd month in each quarter.

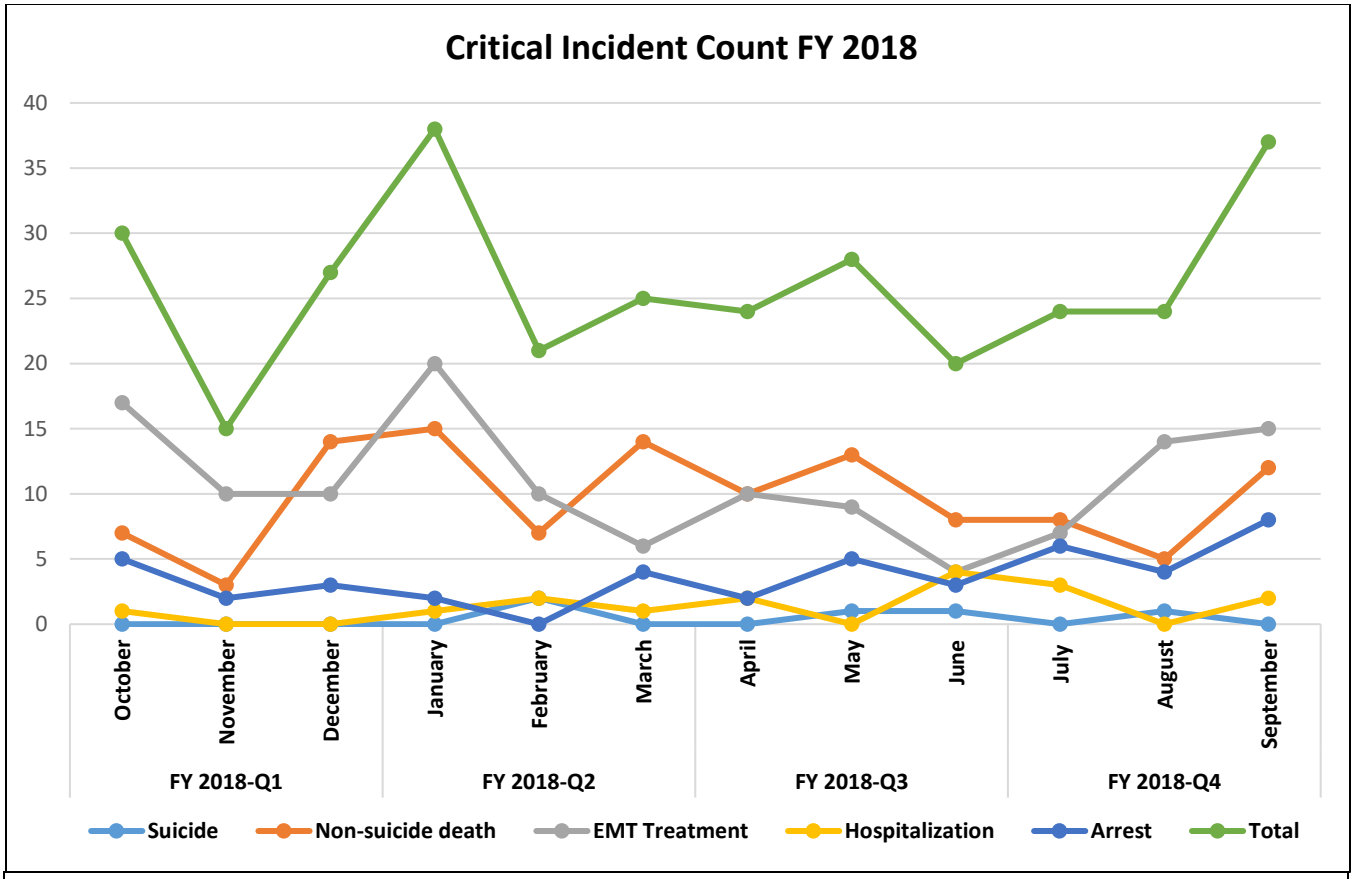
2018 Event Reporting

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Event Reporting (Critical Incidents, Sentinel Events and Risk Events)	➢ Event Reporting- trending report Adhere to MDHHS and ICO reporting mechanisms and requirements for qualified events as defined in the contract language. ➢ Ensure CMHSPs are submitting monthly reports. ➢ Development of educational materials and guidance on Sentinel and Immediate Event reporting.	✓ Event Reporting Quarterly reports to QMC; RUM, RCP, and MHL committees as part of process. ✓ Quarterly Reports of any qualified events to MDDHS including: ▪ Suicide ▪ Non-Suicide Death ▪ Emergency Medical Treatment Due to medication error ▪ Hospitalization due to injury or medication error ▪ Arrest of a consumer that meets population standards	October 2017 – September 2018	QAPI Director QAPI Specialist	Monthly Report Submission to QAPI Specialist with Sentinel and Immediate Events being reported within 48 hours to the event reporting email address: eventreporting@swmbh.org Annual on-site reviews for all (8) CMHSPs occur in June. Select Critical Incidents are selected for review.

2018 Critical Incident (CI) Analysis

CRITICAL INCIDENT COUNT														
	FY 2018-Q1			FY 2018-Q2			FY 2018-Q3			FY 2018-Q4				
	October	November	December	January	February	March	April	May	June	July	August	September	Total:	Average:
Suicide	0	0	0	0	2	0	0	1	1	0	1	0	5	1
Non-suicide death	7	3	14	15	7	14	10	13	8	8	5	12	116	23.2
EMT Treatment	17	10	10	20	10	6	10	9	4	7	14	15	132	26.4
Hospitalization	1	0	0	1	2	1	2	0	4	3	0	2	16	3.2
Arrest	5	2	3	2	0	4	2	5	3	6	4	8	44	8.8
Total	30	15	27	38	21	25	24	28	20	24	24	37	313	62.6

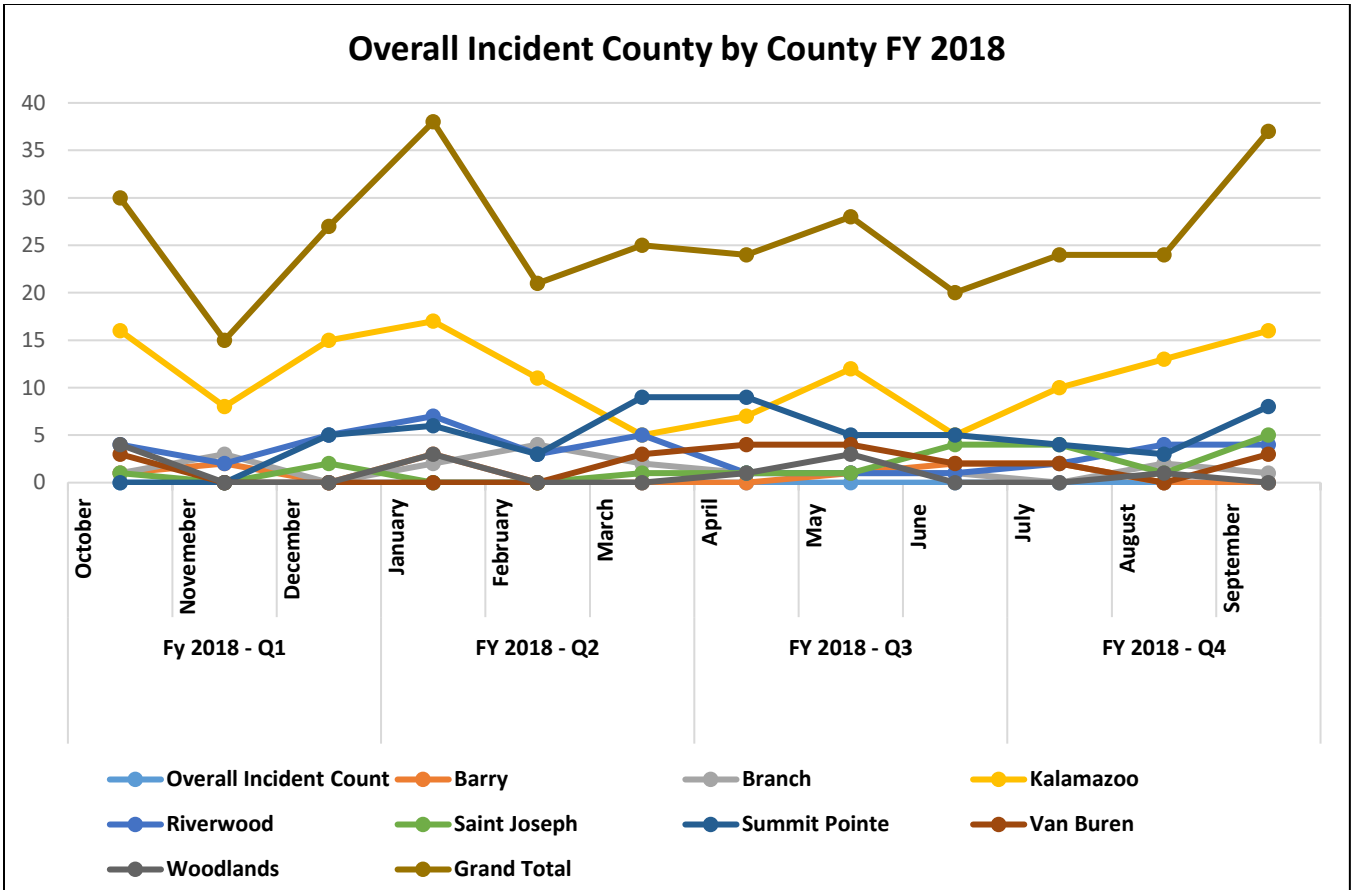
❖ This shows the overall number of Critical Incidents by category and month for FY 2018 (This dashboard can be found on Tableau). Below you can also see the visual of this information.



- Overall, there was a total of 313 Critical Incidents.
- The highest CI category being EMT due to injury/medication error (132); the next top CI category is Non-suicide death (116).
- The lowest number of Critical Incidents was due to Suicide.

	FY 2018 - Q1			FY 2018 - Q2			FY 2018 - Q3			FY 2018 - Q4		
Overall Incident Count	October	Novemeber	December	January	February	March	April	May	June	July	August	September
Barry	1	2	0	3	0	0	0	1	2	2	0	0
Branch	1	3	0	2	4	2	1	1	1	0	2	1
Kalamazoo	16	8	15	17	11	5	7	12	5	10	13	16
Riverwood	4	2	5	7	3	5	1	1	1	2	4	4
Saint Joseph	1	0	2	0	0	1	1	1	4	4	1	5
Summit Pointe	0	0	5	6	3	9	9	5	5	4	3	8
Van Buren	3	0	0	0	0	3	4	4	2	2	0	3
Woodlands	4	0	0	3	0	0	1	3	0	0	1	0
Grand Total	30	15	27	38	21	25	24	28	20	24	24	37

- This shows the overall Incident Count by county and month for FY 2018 (This dashboard can be found on Tableau). Below you can also see the visual of this information.



- Again, there was a total of 313 CI's, while the highest month of CI occurrence was January 2018 with 38 total. Of those 38 CI's in January 17 were from Kalamazoo alone.
- The lowest number of CI's occurred in November 2017 with only 15.

1000s Served	FY 2018-Q1			FY 2018-Q2			FY 2018-Q3			FY 2018-Q4		
	October	November	December	January	February	March	April	May	June	July	August	September
Barry	18.57	18.80	18.96	19.16	19.33	19.48	19.66	19.85	20.01	20.19	20.39	20.62
Branch	18.38	18.54	18.67	18.86	19.03	19.17	19.31	19.44	19.61	19.76	19.94	20.10
Kalamazoo	88.70	89.59	90.45	91.23	91.77	92.41	93.00	93.72	94.39	95.04	95.80	96.44
Riverwood	63.88	64.39	64.86	65.40	65.82	66.23	66.58	67.06	67.41	67.86	68.23	68.59
Saint Joseph	27.02	27.27	27.49	27.77	27.93	28.18	28.36	28.58	28.75	28.93	29.14	29.33
Summit Pointe	61.99	62.48	62.94	64.43	63.88	64.37	28.36	65.41	65.88	66.35	66.85	67.26
Van Buren	34.75	35.06	35.34	35.63	35.82	36.07	36.29	36.58	36.90	37.12	37.41	37.66
Woodlands	19.07	19.28	19.44	19.62	19.70	19.86	20.00	20.15	20.27	20.39	20.54	20.67

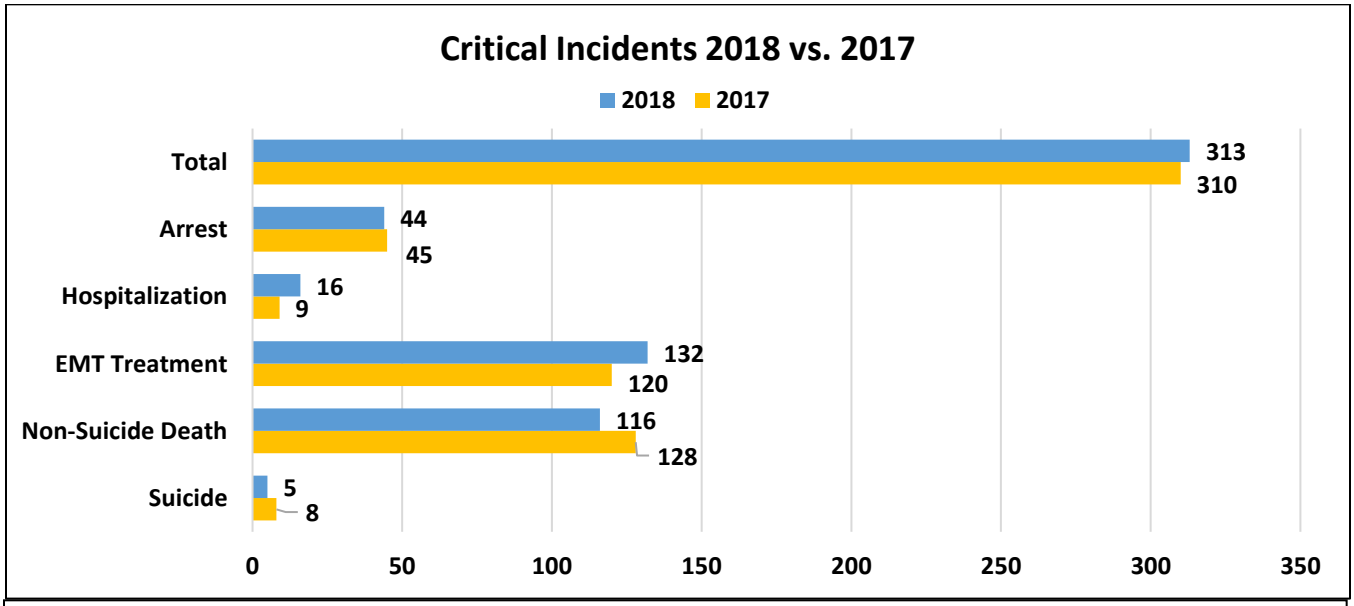
- 1000s Served – This table shows how many eligible members are served per 1000 (i.e. total eligible consumers divided by 1000). This table can also be found on the Critical Incident Dashboard in Tableau.

CRITICAL INCIDENTS PER 1000 SERVED												
	FY 2018-Q1			FY 2018-Q2			FY 2018-Q3			FY 2018-Q4		
	October	November	December	January	February	March	April	May	June	July	August	September
Barry	0.05	0.11	0.00	0.16	0.00	0.00	0.00	0.05	0.10	0.10	0.00	0.00
Branch	0.05	0.16	0.00	0.11	0.21	0.10	0.05	0.05	0.05	0.00	0.10	0.05
Kalamazoo	0.18	0.09	0.17	0.19	0.12	0.05	0.08	0.13	0.05	0.11	0.14	0.17
Riverwood	0.06	0.03	0.08	0.11	0.05	0.08	0.02	0.01	0.01	0.03	0.06	0.06
Saint Joseph	0.04	0.00	0.07	0.00	0.00	0.04	0.04	0.03	0.14	0.14	0.03	0.17
Summit Pointe	0.00	0.00	0.08	0.09	0.05	0.14	0.14	0.08	0.08	0.06	0.04	0.12
Van Buren	0.09	0.00	0.00	0.00	0.00	0.08	0.11	0.11	0.05	0.05	0.00	0.08
Woodlands	0.21	0.00	0.00	0.15	0.00	0.00	0.05	0.15	0.00	0.00	0.05	0.00

- Critical Incidents per 1000 Served – This table shows critical incidents per 1000 (i.e. overall incident count divided by 1000s served).

CRITICAL INCIDENTS PER 1000 SERVED BY TYPE (ALL)												
	FY 2018-Q1			FY 2018-Q2			FY 2018-Q3			FY 2018-Q4		
	October	November	December	January	February	March	April	May	June	July	August	September
Arrest	0.06	0.02	0.05	0.03	0.00	0.06	0.03	0.05	0.03	0.06	0.04	0.08
EMT Treatment	0.19	0.11	0.11	0.22	0.11	0.06	0.11	0.10	0.04	0.07	0.15	0.16
Hospitalization	0.01	0.00	0.00	0.01	0.02	0.03	0.02	0.00	0.06	0.03	0.00	0.03
Non-Suicide Death	0.08	0.03	0.15	0.16	0.08	0.15	0.11	0.14	0.08	0.08	0.05	0.12
Suicide	0.00	0.00	0.00	0.00	0.03	0.00	0.00	0.03	0.03	0.00	0.01	0.00
Total	0.34	0.16	0.31	0.42	0.24	0.30	0.27	0.32	0.24	0.24	0.25	0.39

- Critical Incident per 1,000 Served by Type (All) – This table shows each CI category and the number of incidents per 1,000 served by month and FY.

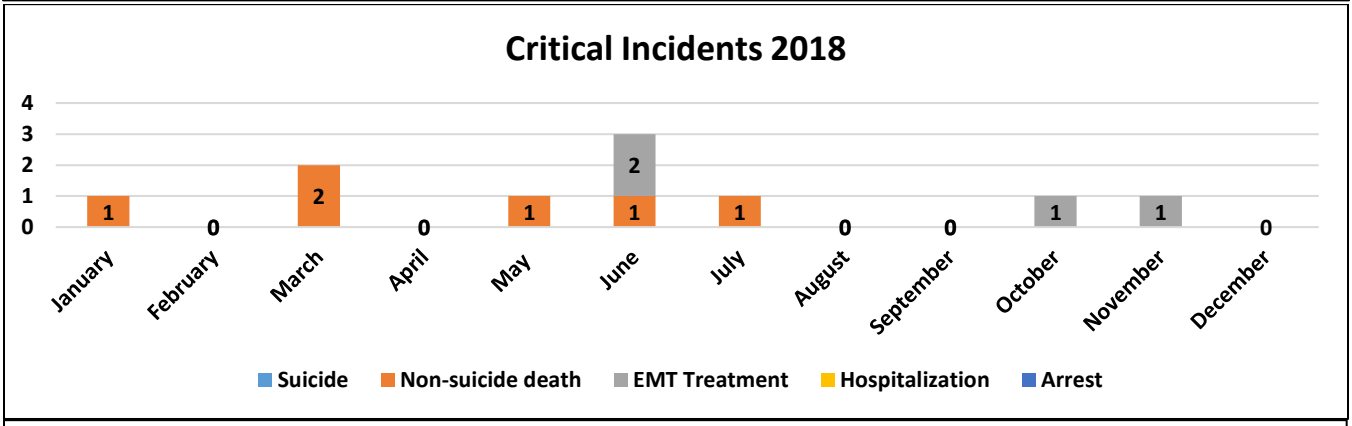


- Analysis: In CY 2018, there was a total of (313) Critical Incidents reported to SWMBH compared to (310) in 2017.

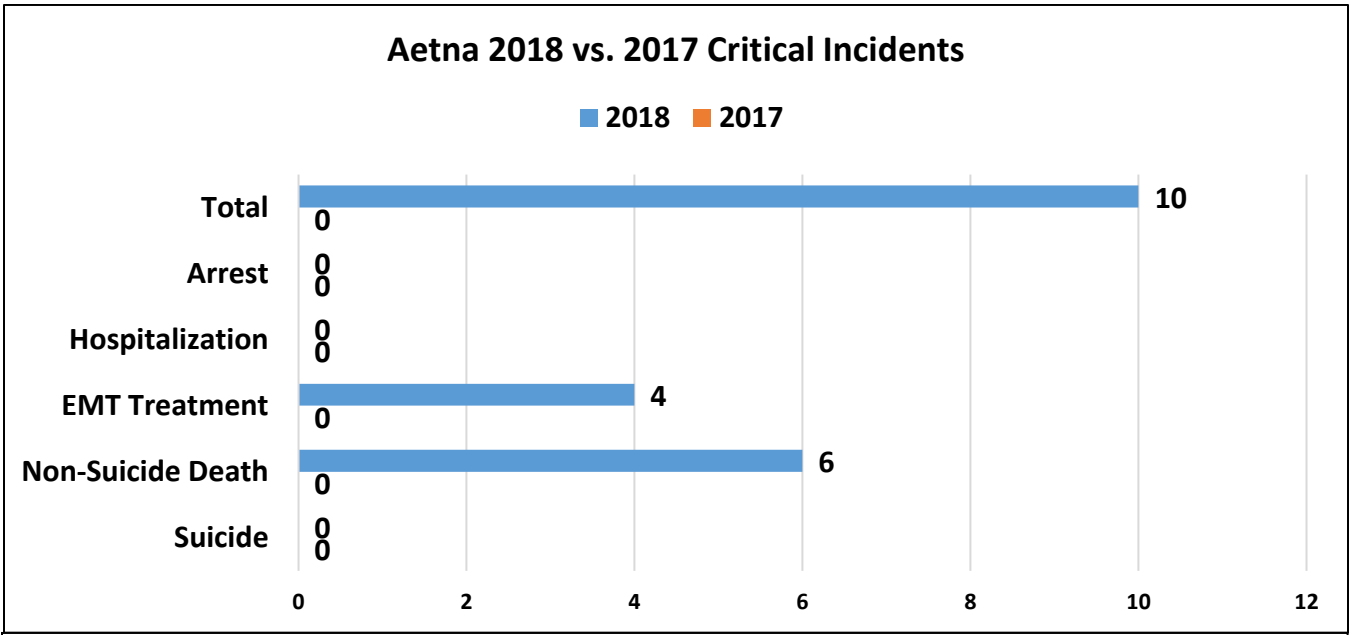
MI Health Link (Duals Demonstration Project) Critical Incidents

Aetna

	2018-Q1			2018-Q2			2018-Q3			2018-Q4		
	January	February	March	April	May	June	July	August	September	October	November	December
Suicide	0	0	0	0	0	0	0	0	0	0	0	0
Non-suicide death	1	0	2	0	1	1	1	0	0	0	0	0
EMT Treatment	0	0	0	0	0	2	0	0	0	1	1	0
Hospitalization	0	0	0	0	0	0	0	0	0	0	0	0
Arrest	0	0	0	0	0	0	0	0	0	0	0	0
Total	1	0	2	0	1	3	1	0	0	1	1	0



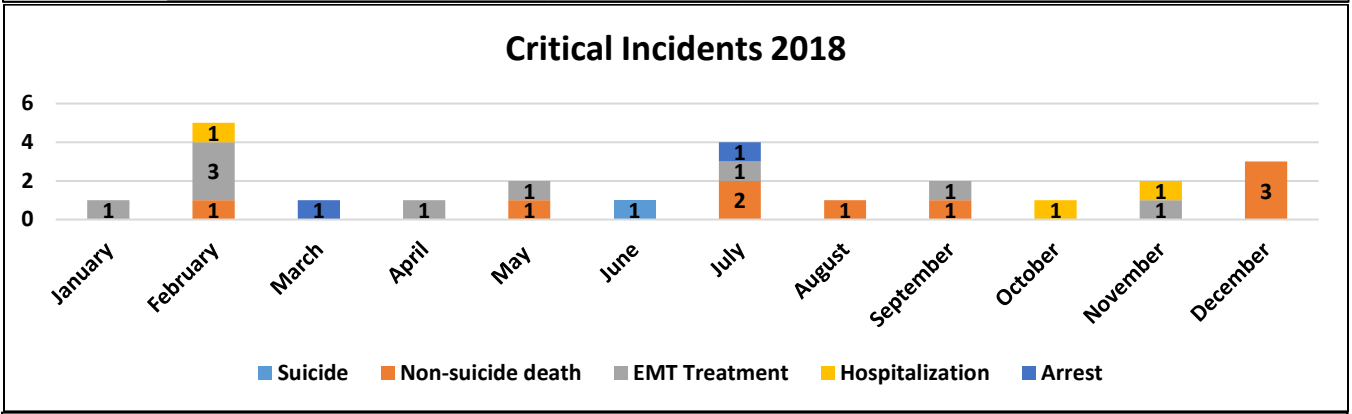
❖ Analysis: In CY 2018 there was a total of (10) Critical Incidents reported to SWMBH for enrolled Aetna Members.



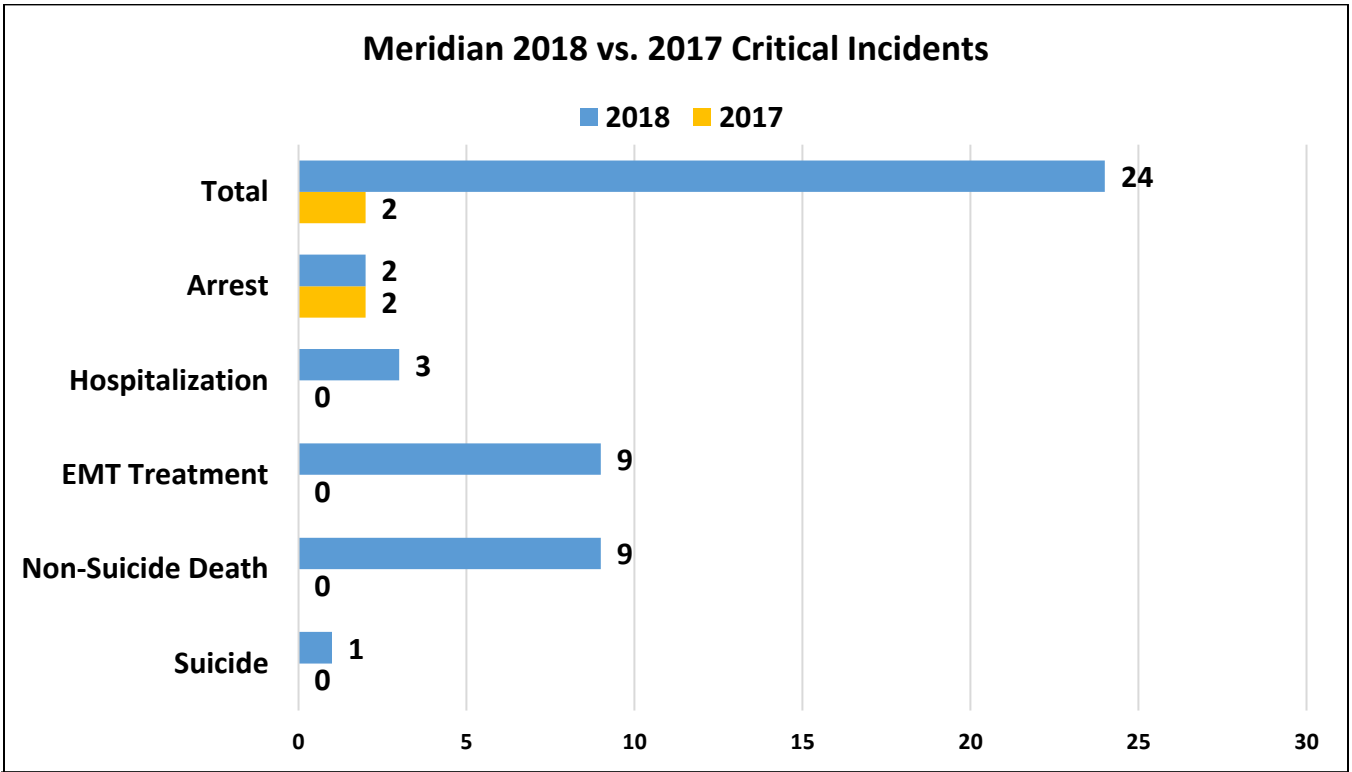
❖ Analysis: In CY 2017, there was a total of (0) Critical Incidents reported to SWMBH for enrolled Aetna Members as compared to (10) in 2018.

Meridian

	2018-Q1			2018-Q2			2018-Q3			2018-Q4		
	January	February	March	April	May	June	July	August	September	October	November	December
Suicide	0	0	0	0	0	1	0	0	0	0	0	0
Non-suicide death	0	1	0	0	1	0	2	1	1	0	0	3
EMT Treatment	1	3	0	1	1	0	1	0	1	0	1	0
Hospitalization	0	1	0	0	0	0	0	0	0	1	1	0
Arrest	0	0	1	0	0	0	1	0	0	0	0	0
Total	1	5	1	1	2	1	4	1	2	1	2	3



❖ Analysis: In CY 2018 there was a total of 24 Critical Incidents reported to SWMBH for enrolled Meridian Members.



❖ Analysis: In CY 2017, there was a total of (2) Critical Incidents reported to SWMBH for enrolled Meridian Members as compared to (24) in 2018.

Objective:
Collecting, reporting, and reviewing all deaths and unusual events or incidents of persons served.

Results:
Improved reporting from CMHSPs—increase in events reported in FY2018 due to the new implemented process.

Identified Barriers:
Risk event analysis needs to be conducted. Also, a new policy regarding Sentinel event timeliness needs to be employed.

Recommendations:
CMHSPs must fill out and send their Event Reporting Submission sheets to the SWMBH Event Reporting Inbox (eventreporting@swmbh.org) each month for reportable critical incidents and risk events. If there are no reportable events, then please document this in the Event Reporting Submission sheet each month and send it to the Event Reporting Inbox. Critical Incident reporting has improved greatly since FY 17. A CISE (Critical Incident & Sentinel Event) workgroup was created to update any current CISE training materials and to also add new helpful materials for new Providers, employees, etc. These documents are all housed in a central location on the new SWMBH Portal under Partners, Reporting Tools and Resources, Critical Incidents Educational Resources and Tools. Documents include: CISE Reporting Template, Critical Incidents Presentation, a webinar training with the Critical Incidents Presentation, Critical Incidents Process Map, Event Reporting Handbook, Risk Events Information, and Reporting Requirements by Service handout. Furthermore, with an updated risk event system the QAPI department should develop an analysis methodology. We currently created a dashboard on Tableau, but the analysis and improvement still need to occur.

2018 Behavioral Treatment Review Committee Data

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Behavioral Treatment Review Committee Data	➢ Information is collected by SWMBH from CMHs and available for review. ➢ The PIHP will continually evaluate its oversight of "vulnerable" consumers to identify opportunities for improving care.	✓ The QMC Committee will review the data collected from CMHs for trends and outliers on a quarterly basis. ✓ If trends are identified the QMC will collaborate with the Operations Committee and Regional Clinical Practices Committee to identify improvement strategies. ✓ The QMC Committee will formulate methods for improving care of "vulnerable" people.	October 2017 – September 2018	QAPI Specialist QAPI Director Data Analyst Director of Clinical Practices Regional Operations Committee	Quarterly

Interventions What Approaches are used?				Since last BTPRC review has there been an incident of: *Please enter date(s) under the applicable column(s)*					Outcome		
Positive Behavior Support	Restrictive/Intrusive/Emergency Interventions	Medications Number of Anti-psychotics	Medications Number of Psychotropics	Length of Time of Interventions	Harm to Self	Harm to Others	Physical Management	911 calls	Analysis	Recommendations	Comments

Objective:

The QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management has been used in an emergency situation. Data shall include numbers of interventions and length of time the interventions were used per person. As part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP), arrange for an evaluation of the committee's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates. Collected by SWMBH from the affiliates and available for review. The information fields on the spreadsheet did not include the length of time that interventions were used per person. Attachment P7.9.1 requires that the BTRCs review the numbers of interventions and length of time the interventions were used per person. Similarly, PIHP Contract Attachment P1.4.1 establishes elements that the BTRC committee must track and analyze; which includes No. 8, the length of time of each intervention.

Results:

The SMMBH Quality Management Committee (QMC) minutes documented that the PIHP ensured that each affiliate submitted BTRC data via the BTPRC Data Spreadsheet. The SWMBH Operating Policy 3.3, Behavior Treatment Review Committee, listed the information required to be entered in the form. It stated, as if this was optional, that additional elements could be identified by the CMH—which could include length of time of each intervention.

Identified Barriers:

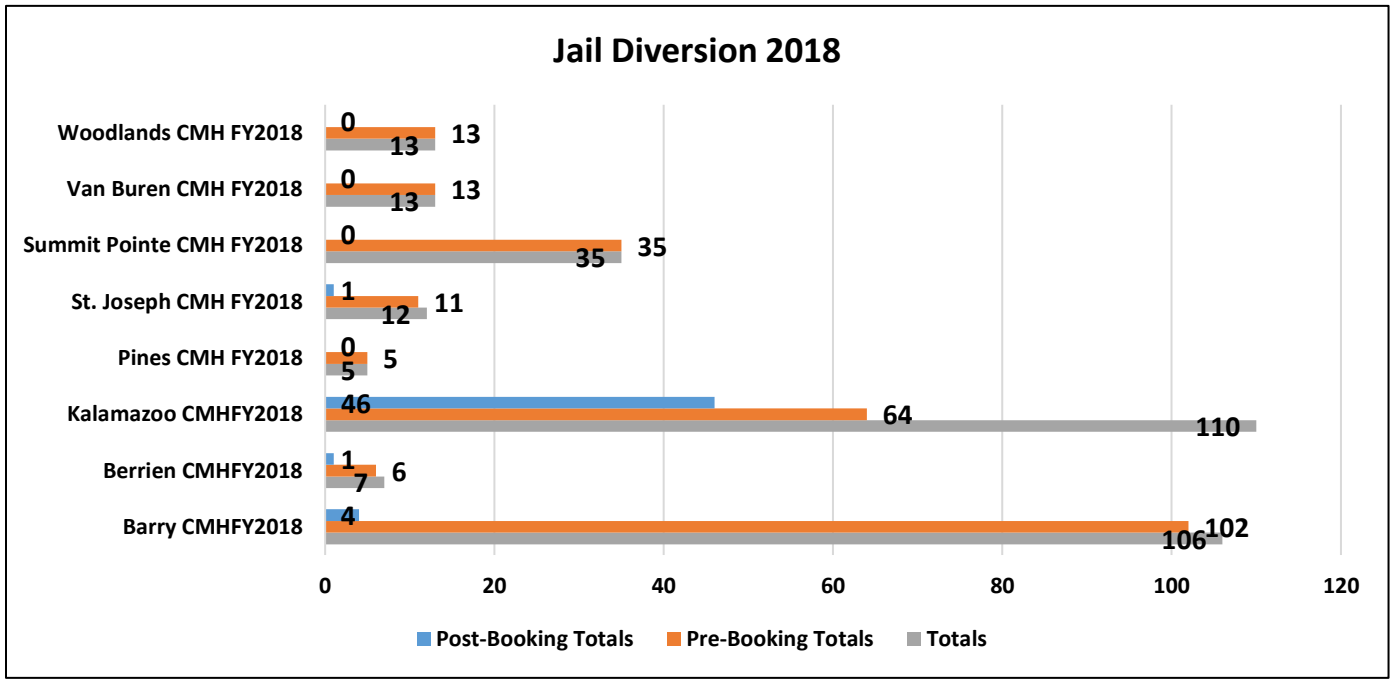
CMHSPs not reporting for non-waiver beneficiaries.

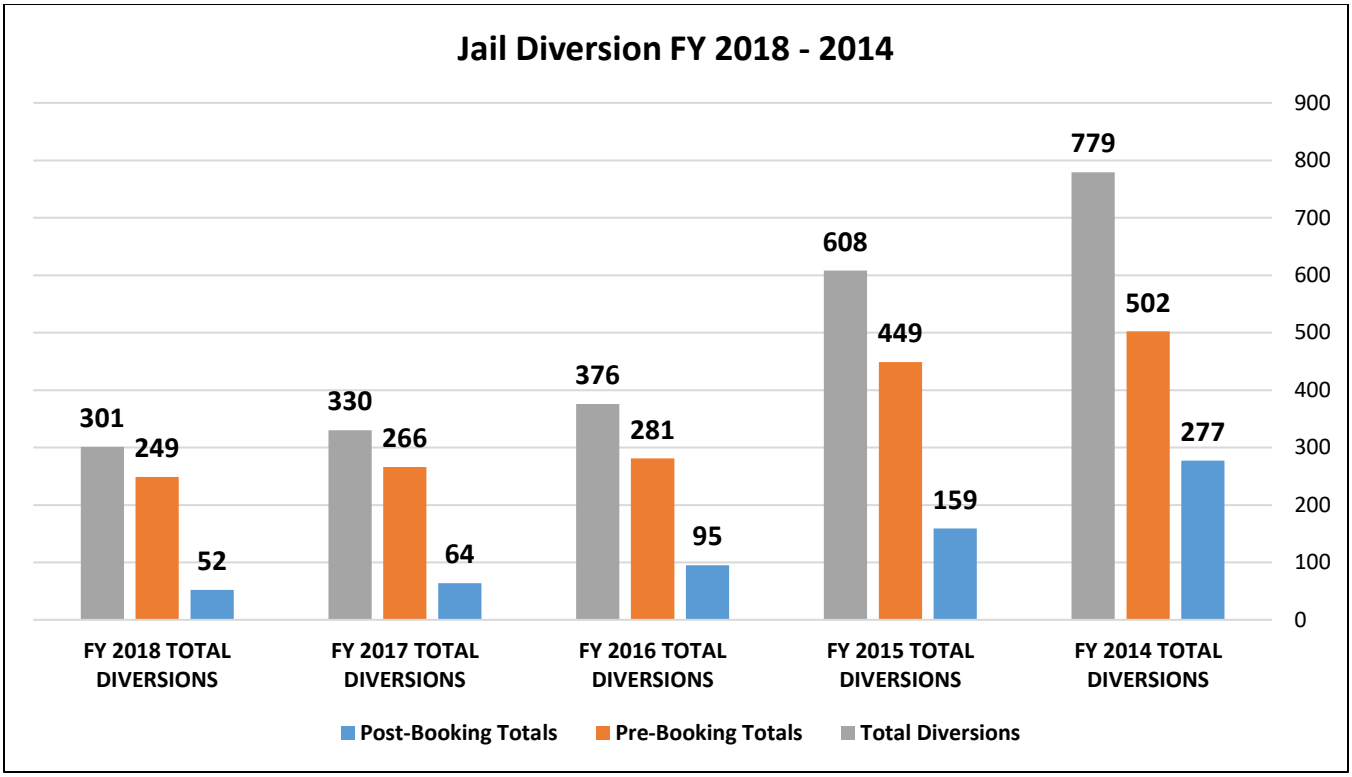
Recommendations:

The PIHP must ensure that CMHSPs are collecting and analyzing all data as required, including the length of time of interventions used per person. QMC will review data on a Quarterly basis for potential identification of improvements, improved processes and identification/analysis of any trends.

2018 Jail Diversion Data

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Jail Diversion Data Collection	• SWMBH collects and reports the number of jail diversions (pre-booking, and post booking) of adults with mental illness (MI), adults with co-occurring mental health and substance abuse disorders (COD), adults with developmental disabilities (DD), and adults with developmental disabilities and co-occurring mental health and substance abuse disorders (DD & COD).	✓ The QMC will evaluate data trends and specific CMHSP results. ✓ Jail Diversion data is shared at QMC, RUM, and RCP regional committees. ✓ Identified Trends and suggestions for policy change are share with Regional Entities through the Operations Committee and Utilization Management Committee as needed.	October 2017 – September 2018	QAPI Specialist QAPI Director Director of Clinical Practices Director of Utilization Management	Annually or as needed





Objective:
Collect, monitor and report on jail diversion data to help prevent incarceration of individuals with serious mental illness or developmental disability who encounter the criminal justice system.

Results:
Annual collection of data from participant CMHSP. As you can see; a declining trend is noted over the 5 years of data analysis. Affiliate input suggests administration at jails may be a factor in utilization of jail diversion programs. At least two CMHSPs have received additional grant funding to enhance their respective programs for which a higher level of participation is expected.

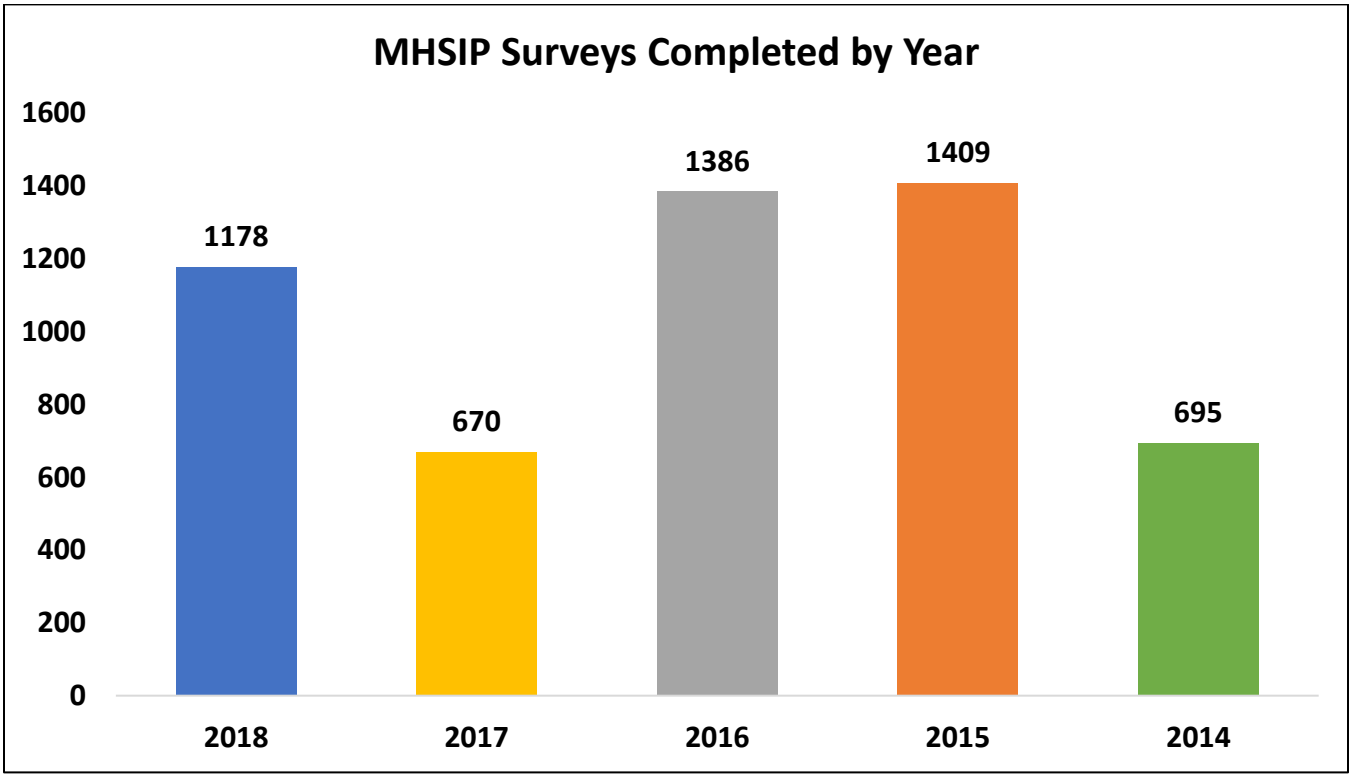
Identified Barriers:
Data reporting and discussion of issues on a consistent basis.

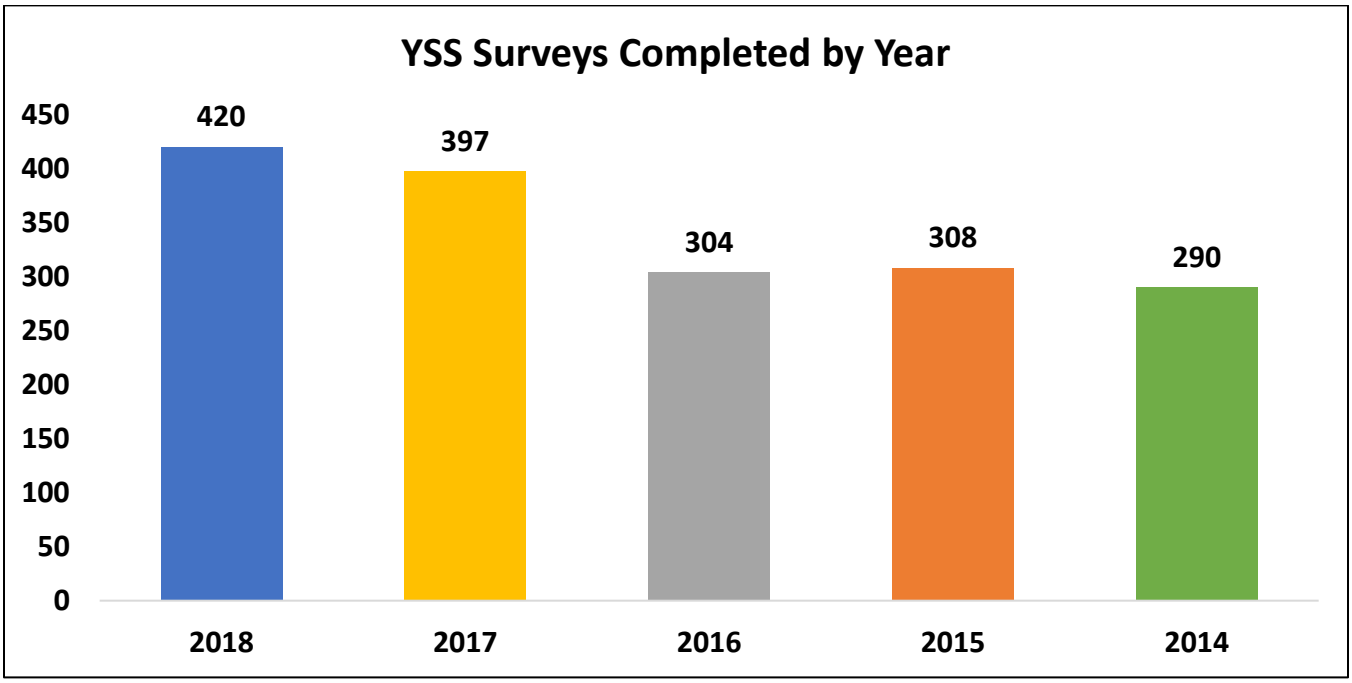
Recommendations:
Scheduling recurring discussion of jail diversion more frequently at QMC/RUM/RPC. Analysis of outcomes can be used to develop and target best practice interventions and strategies for improvement.
Being the first year of required TEDs submissions, MDHHS frequently changed reporting requirements, fields, logic and criteria. The constant changes made it difficult to establish consistency with reporting measures.

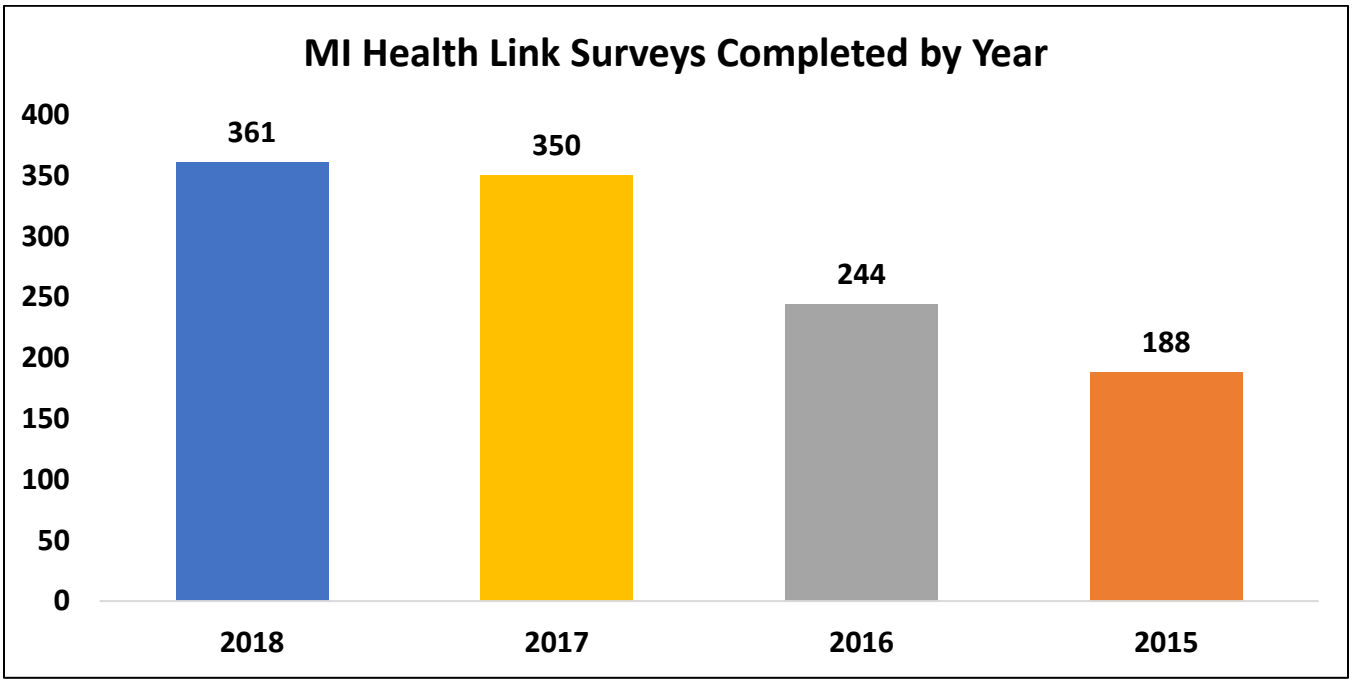
2018 Member Experience

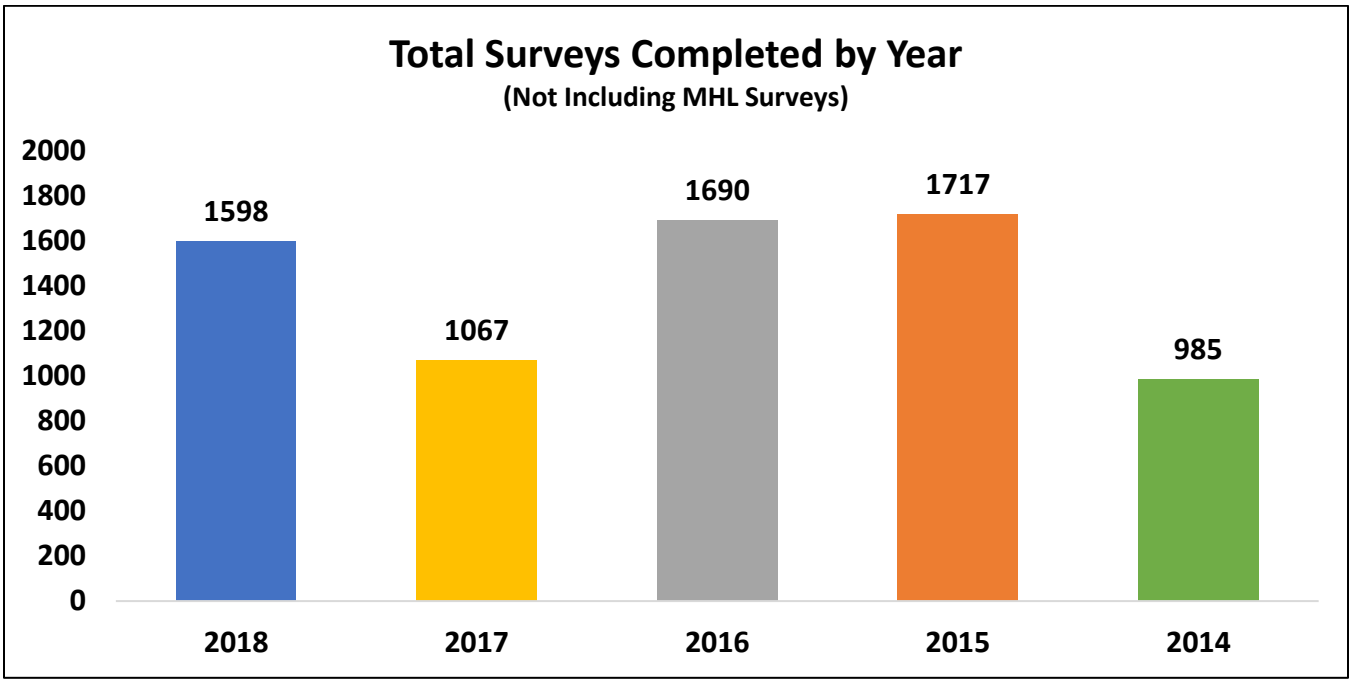
Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Member Experience	➢ Develop and evaluate the effectiveness of programs and initiatives, the QM department and QMC and MHL Committee analyzes data and customer input from various sources including customer surveys, audits, reported incidents and member or provider complaints. ➢ Data is used to identify trends and make improvements for the customer experience and improved outcomes.	✓ Distribution and analysis of an annual customer satisfaction survey for members who have received multiple services during the survey time period. ✓ Distribution, collection and analysis of annual Person in Recovery Survey (RSA-r). ✓ Medicaid Member Service Satisfaction Surveys. ✓ Medicare Member Service Satisfaction Surveys. ✓ MI Health Link – Dual Eligible Member Satisfaction Surveys. ✓ Complex Case Management Member Experience Survey. ✓ Distribution and analysis of MH and Physical Health provider communication satisfaction surveys. ✓ Causal analysis of grievance and appeal data broken into categories including: Quality of care, access, attitude and service, billing and financial issues and quality of practitioner office site. ✓ Member Grievance and Appeals data Complex Case Management. ✓ Grievance and Appeals data o Results are presented to the EO, Customer Advisory Committee, Operations Committee, QMC, MHL Committee, RCP, RUM, SWMBH Board and other stakeholders annually.	January 2018 - December 2018	QAPI Specialist QAPI Director Chief Administrative Officer Utilization Management Manager Director of Clinical Quality or Medical Director Consultant All Senior Leadership	Annually

Mental Health Statistics Improvement Program Survey (MHSIP) and Youth Statistics Survey (YSS)






MI Health Link Surveys Completed by Year
400
350
300
250
200
150
100
50
0
361
350
244
188
2018
2017
2016
2015


Total Surveys Completed by Year
(Not Including MHL Surveys)
2000
1800
1600
1400
1200
1000
800
600
400
200
0
1598
1067
1690
1717
985
2018
2017
2016
2015
2014

MHSIP Results

- ❑ 2018 Aggregate Score: 90.63%
- ❑ 2017 Aggregate Score: 86.28%

+4.43% Percent Improvement over 2017 Scores

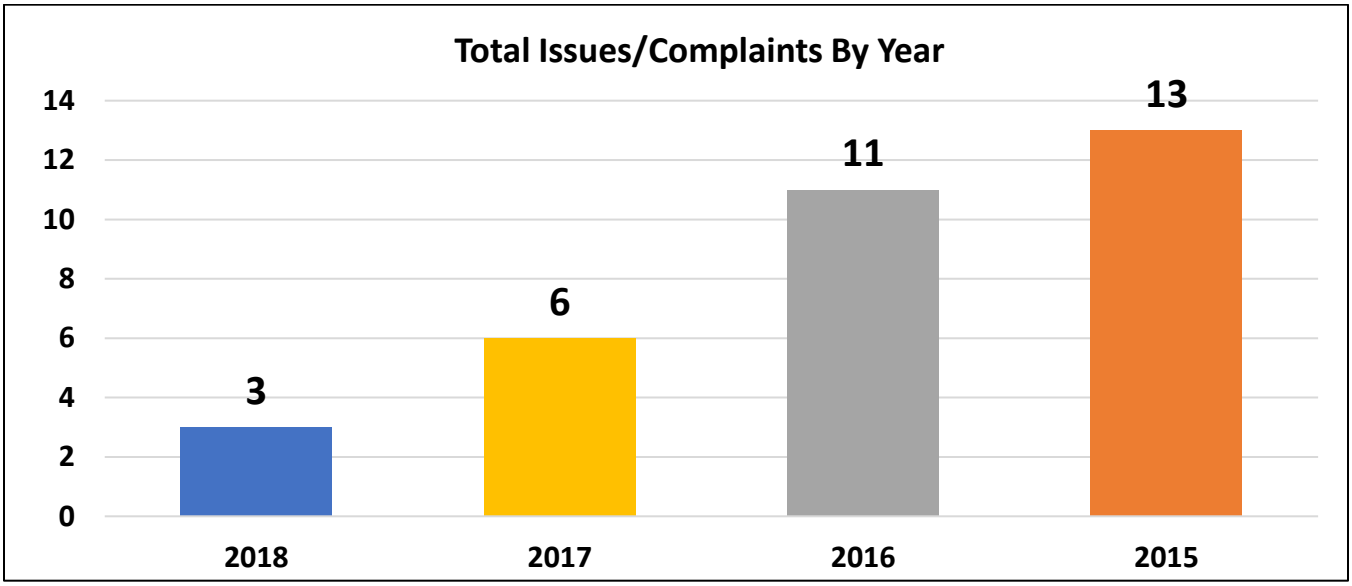
YSS Results

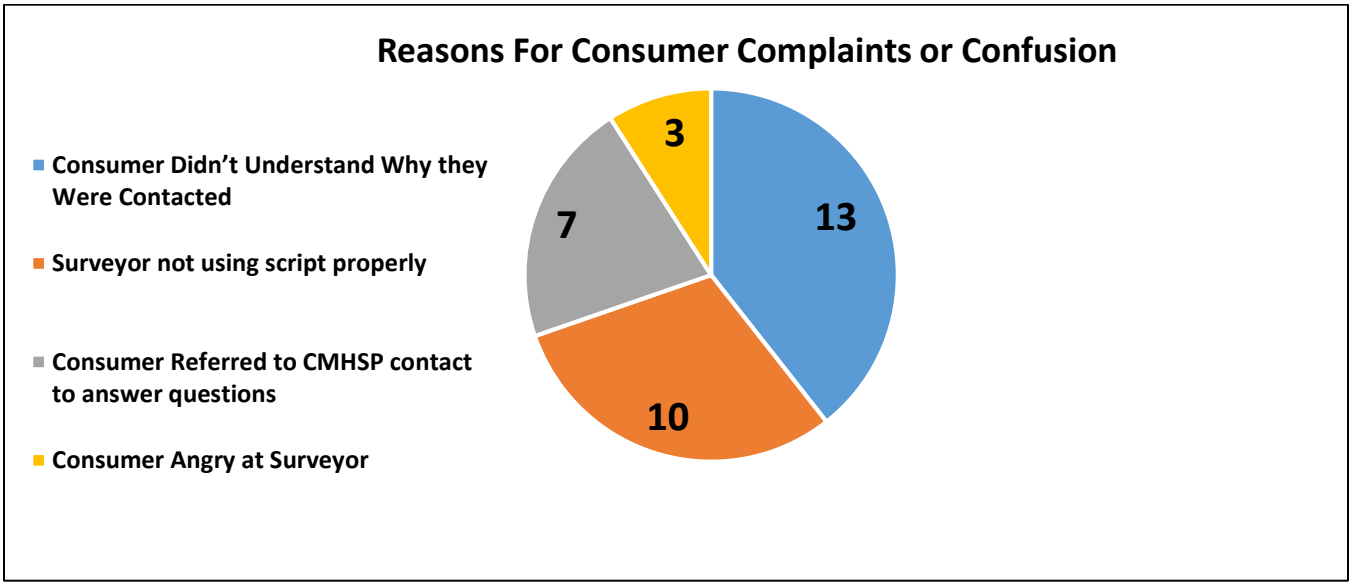
- ❑ 2018 Aggregate Score: 91.28%
- ❑ 2017 Aggregate Score: 88.90%

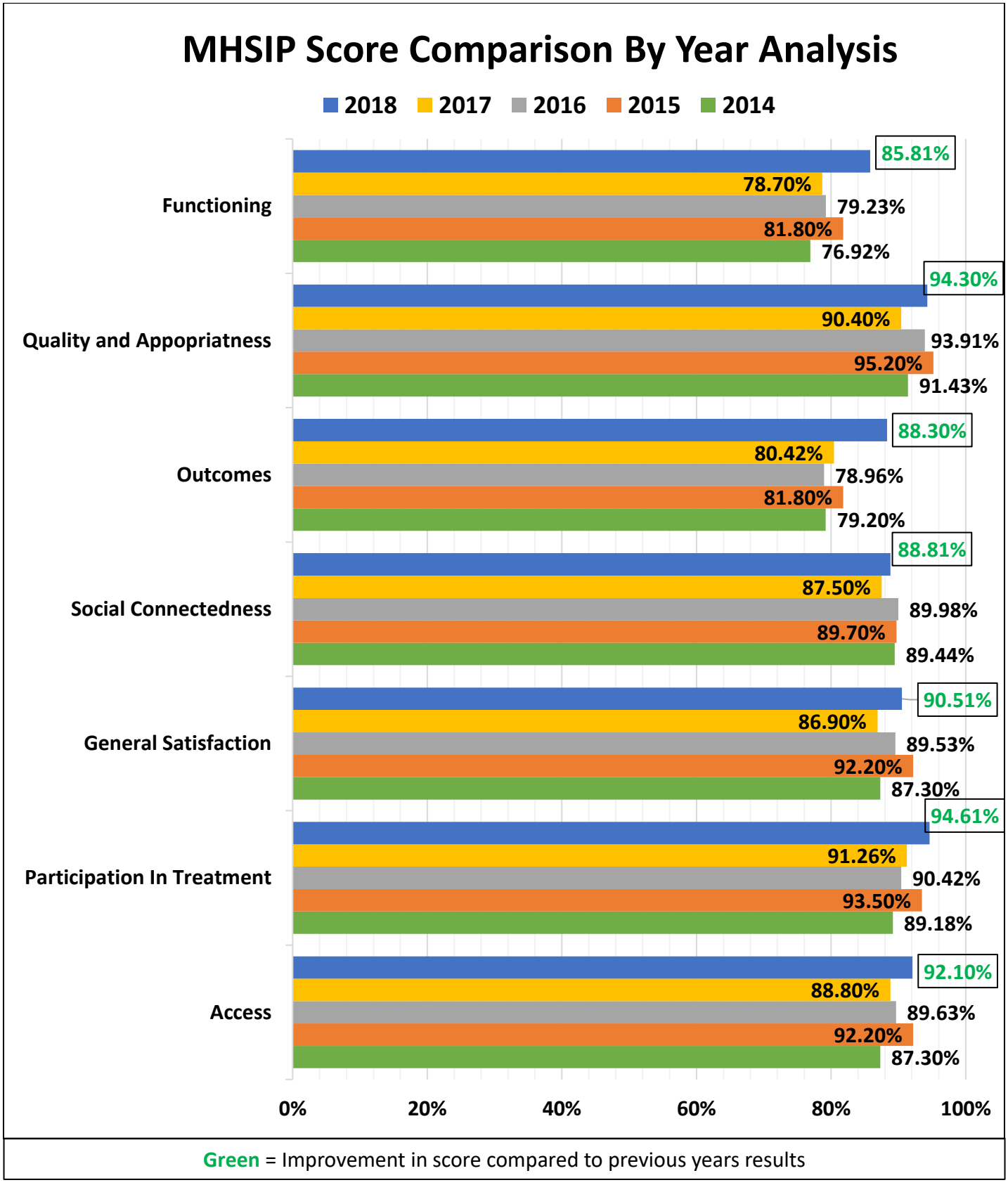
+2.38% Percent Improvement over 2017 Scores

Overall Result

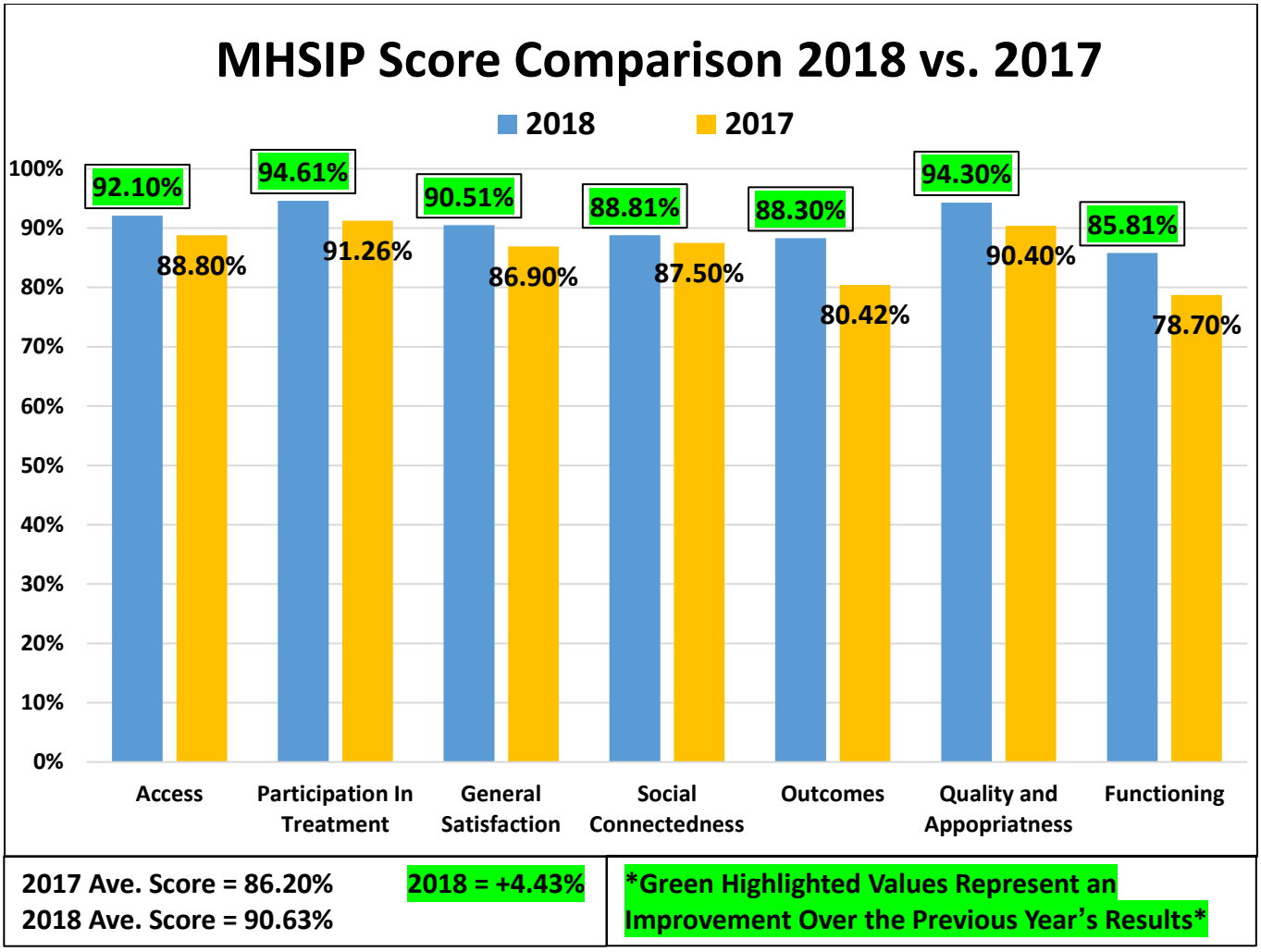
+6.81% Percent Improvement





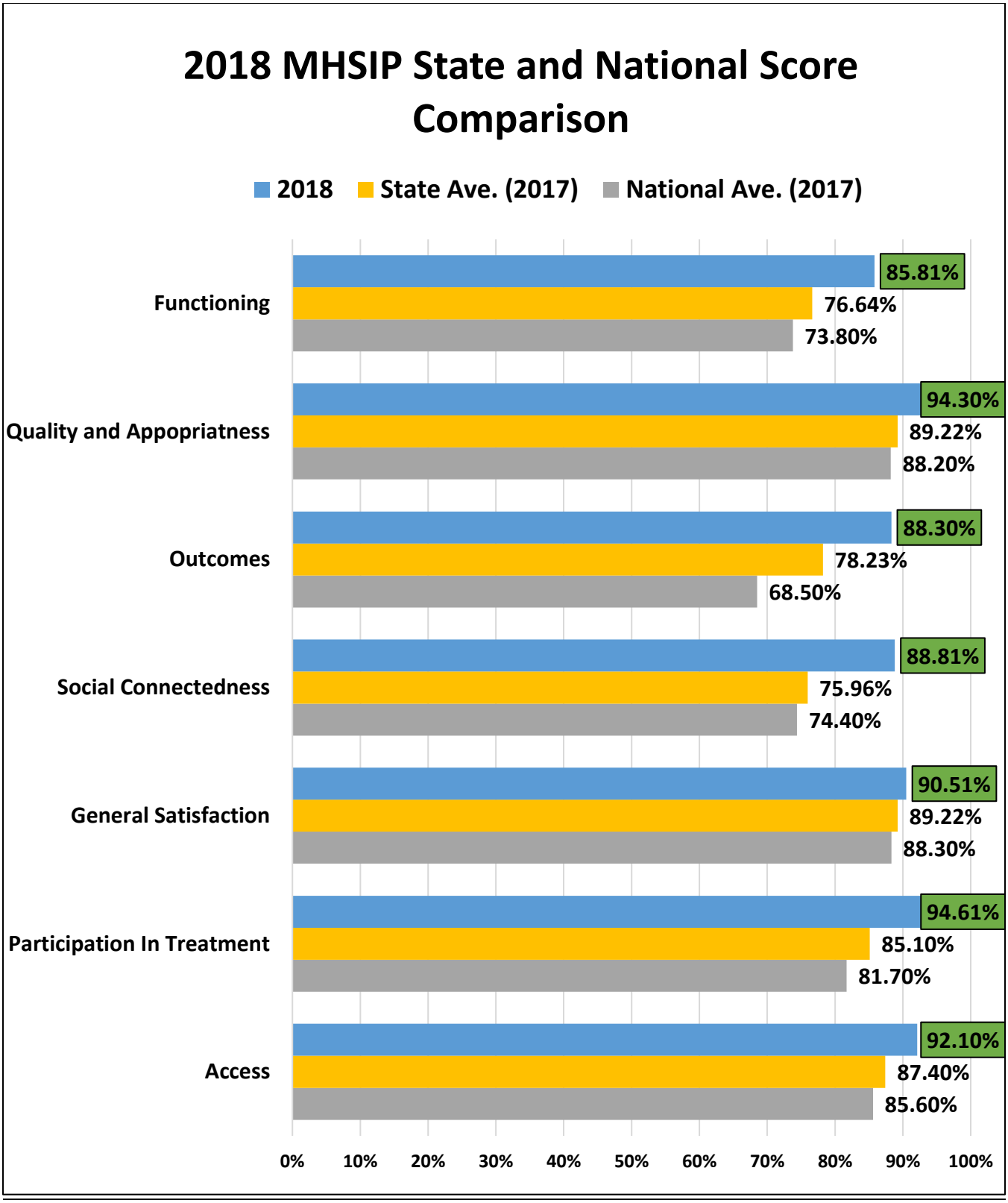


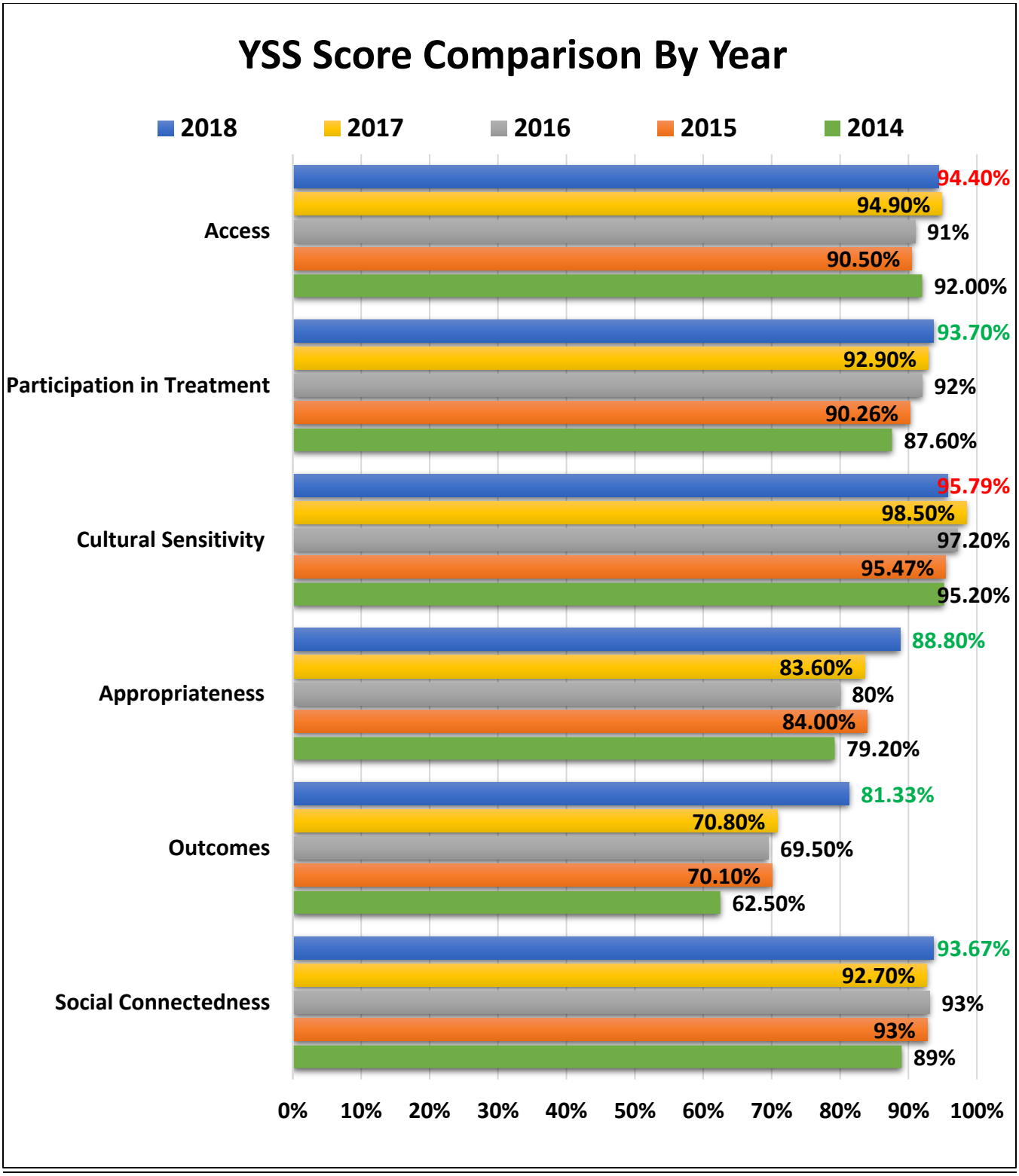
Green = Improvement in score compared to previous years results



2017 Ave. Score = 86.20%
2018 Ave. Score = 90.63%
2018 = +4.43%

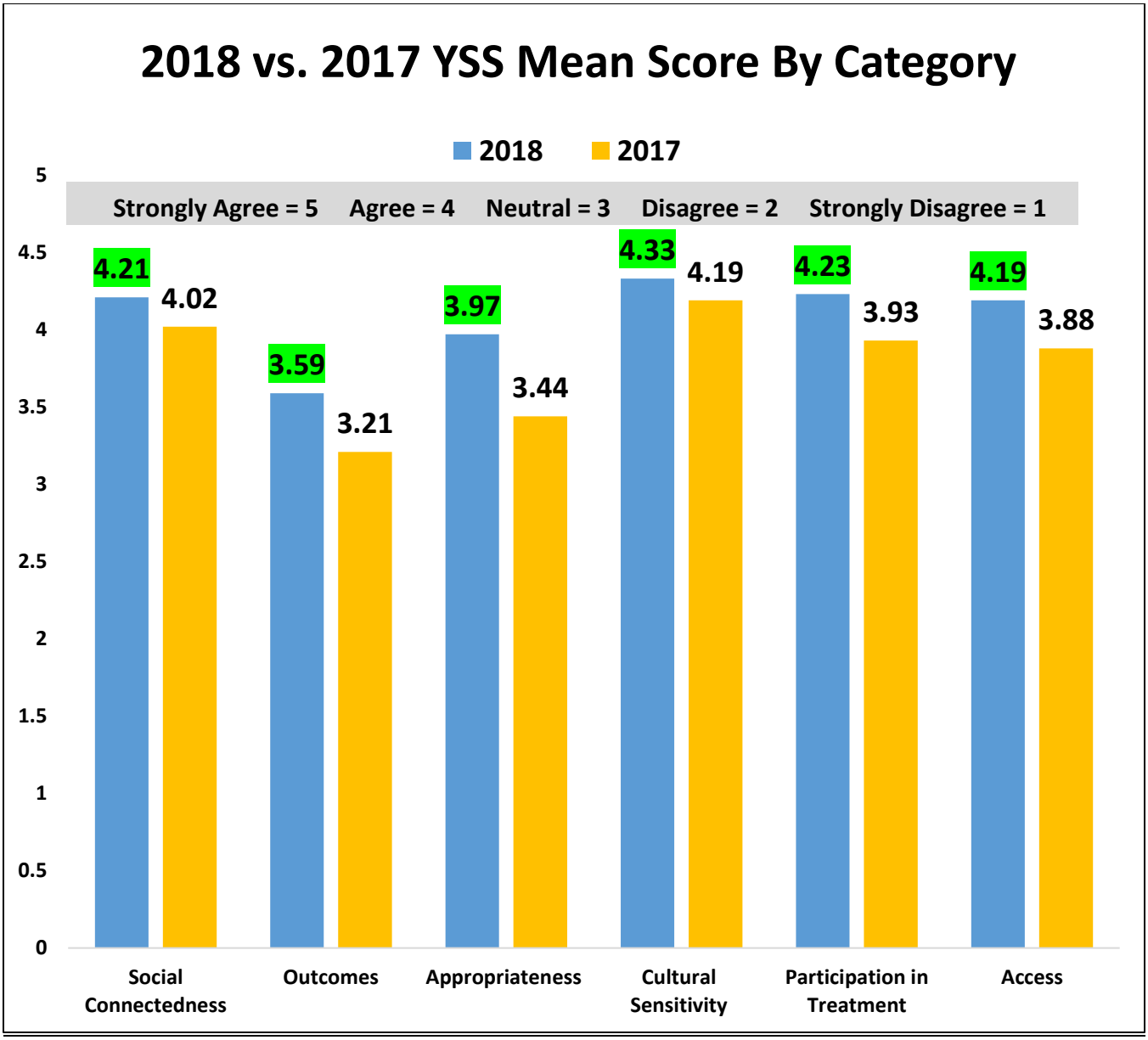
Green Highlighted Values Represent an Improvement Over the Previous Year's Results

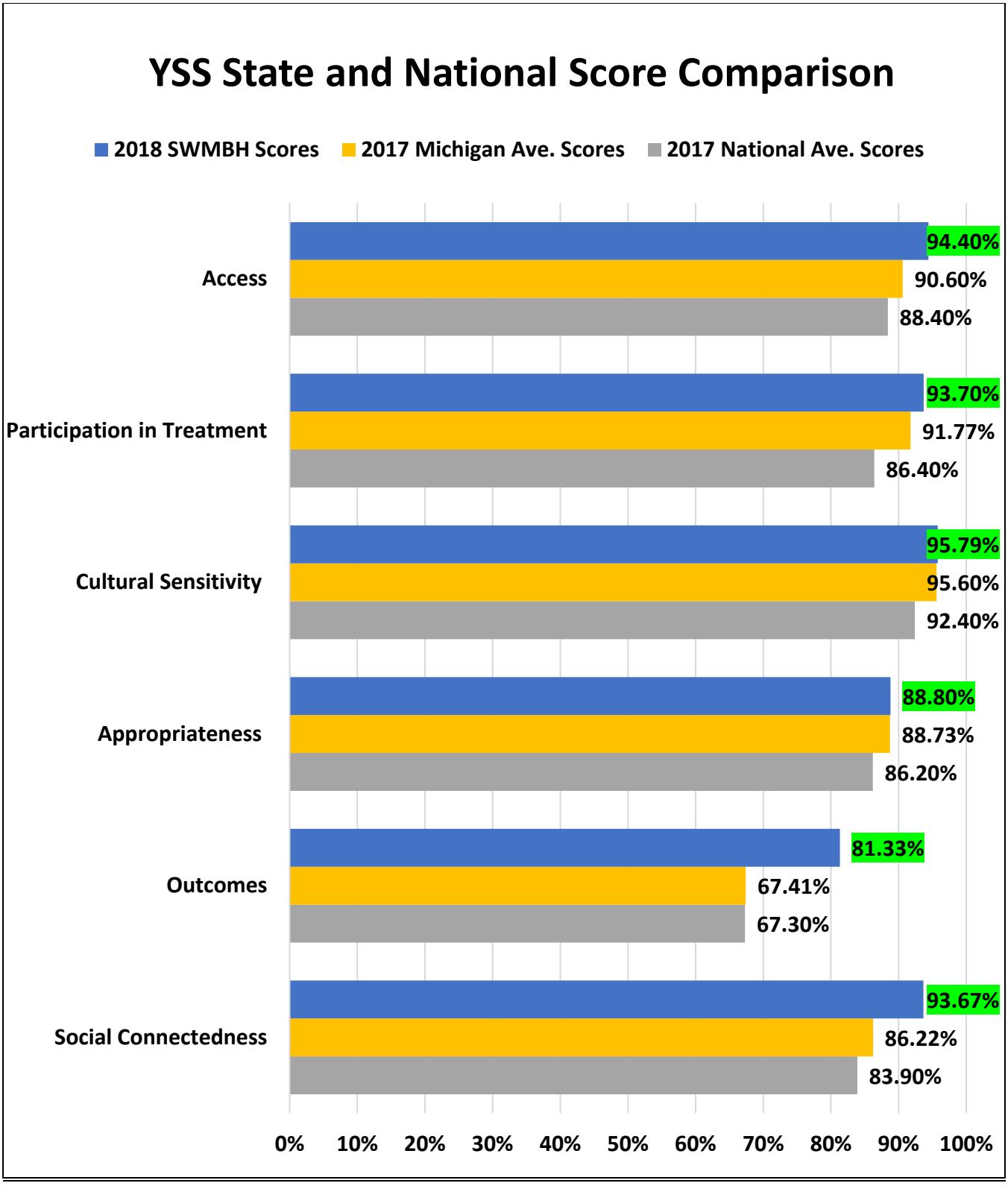

2018 MHSIP State and National Score Comparison
2018
State Ave. (2017)
National Ave. (2017)
Functioning
85.81%
76.64%
73.80%
Quality and Appopriatness
94.30%
89.22%
88.20%
Outcomes
88.30%
78.23%
68.50%
Social Connectedness
88.81%
75.96%
74.40%
General Satisfaction
90.51%
89.22%
88.30%
Participation In Treatment
94.61%
85.10%
81.70%
Access
92.10%
87.40%
85.60%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

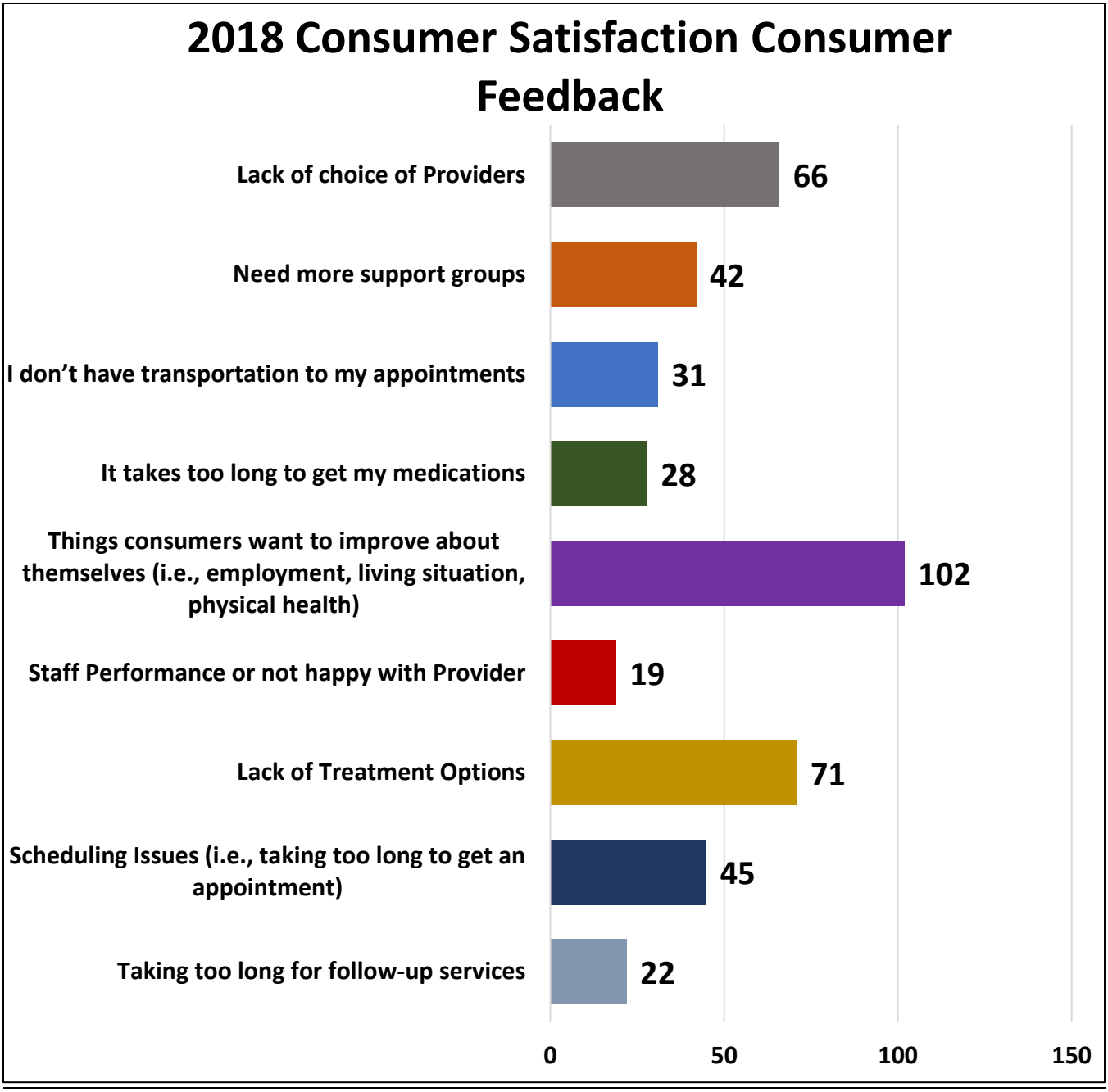


2018 Ave. Score = 91.28%
2017 Ave. Score = 88.90%
2018 = +2.38% Improvement

Green = Improvement in score compared to previous years results
Red = Decrease in score compared to previous year.


2018 vs. 2017 YSS Mean Score By Category
2018
2017
Strongly Agree = 5 Agree = 4 Neutral = 3 Disagree = 2 Strongly Disagree = 1
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
4.21
4.02
3.59
3.21
3.97
3.44
4.33
4.19
4.23
3.93
4.19
3.88
Social Connectedness
Outcomes
Appropriateness
Cultural Sensitivity
Participation in Treatment
Access


YSS State and National Score Comparison
2018 SWMBH Scores
2017 Michigan Ave. Scores
2017 National Ave. Scores
Access
94.40%
90.60%
88.40%
Participation in Treatment
93.70%
91.77%
86.40%
Cultural Sensitivity
95.79%
95.60%
92.40%
Appropriateness
88.80%
88.73%
86.20%
Outcomes
81.33%
67.41%
67.30%
Social Connectedness
93.67%
86.22%
83.90%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%



Objective:

The Mental Health Statistics Improvement Program (MHSIP) Consumer Surveys measure concerns that are important to consumers of publicly funded mental health services in (7) different areas including: access, participation in treatment, general satisfaction, social connectedness, quality and appropriateness, and outcomes. THE MHSIP consists of 44 questions.

A modification of the MHSIP survey for adults, the Youth Services Survey for Family (YSS-F) assesses caregivers' perceptions of behavioral health services for their children aged 17 and under.
The YSS creates (6) domains that are used to measure different aspects of customer satisfaction with public behavioral health services has (6) different measurements; social connectedness, outcomes, appropriateness, cultural sensitivity, participation in treatment, and access. THE YSS consists of 46 questions.

Results:

SWMBH achieved a +6.81% Percent Improvement over 2017 Results. This met the Board Ends Metric target, which is indicated: Consumer Satisfaction Surveys collected by SWMBH during 2018 are at or above the SWMBH 2017 results; for the *Improved Functioning* (MHSIP survey) and *Improved Outcomes* (YSS survey). These categories were selected, as they have been the lowest scoring categories measured over the past 4 years.

The 2018 survey process also resulted in fewer consumer complaints, then we have had in the 4 previous years. Total Number of Consumer Complaints by year: 2015 – (13); 2016 – (11) and 2017 – (6); 2018 – (3). The decrease in consumer complaints is primarily attributed to the better advertisement and communications regarding the survey before it begins. Letters are sent to all consumers who may be selected to take the survey, explaining why participation is important and their feedback will be used to improve programs and services. Additionally, the QAPI team implemented (2) audits on the survey vender; to ensure scripts were being followed correctly by the surveyors. This helped delivery and explanation to the consumers remain consistent and accurate. Furthermore, this year the QAPI team selected a new survey vendor that may have positively affected the results.

Identified Barriers:

The 2018 survey process got off to a late start and began in late November. The vender that was selected for the project decided to close their business, which left the Quality Department searching for a new vender at the last minute. Typically, the QAPI Department targets the survey process to begin in early October. This didn't give us as much time to train the surveyors as we would have liked. The QAPI Department has adjusted processes/schedules to begin the surveys earlier in 2019. The QAPI department has also adjusted processes, to only request the minimum information necessary from CMHSPs when identifying eligible survey participants. This will help eliminate exposure to Protected Health Information from SWMBH to the selected survey vender. Also due to the new survey vendor it took a little more time for them to understand the process and get the project started. The (3) complaints happened in the beginning of the survey process and were corrected quickly and efficiently to improve results.

Recommendations:

SWMBH is aware that significant improvement in each category measured in the survey is not sustainable every year. SWMBH has adjusted its Board Ends Metric to target identified categories that need the most improvement and have been our Regions lowest scores in the past (3) years.

In 2019, SWMBH will focus attention on improvement strategies for the following measures: Customer Satisfaction Surveys collected by SWMBH are at or above the SWMBH 2018 results; for the *Improved Functioning* (MHSIP survey) and *Improved Outcomes* (YSS survey) measurement categories. Opportunities for improvement include:

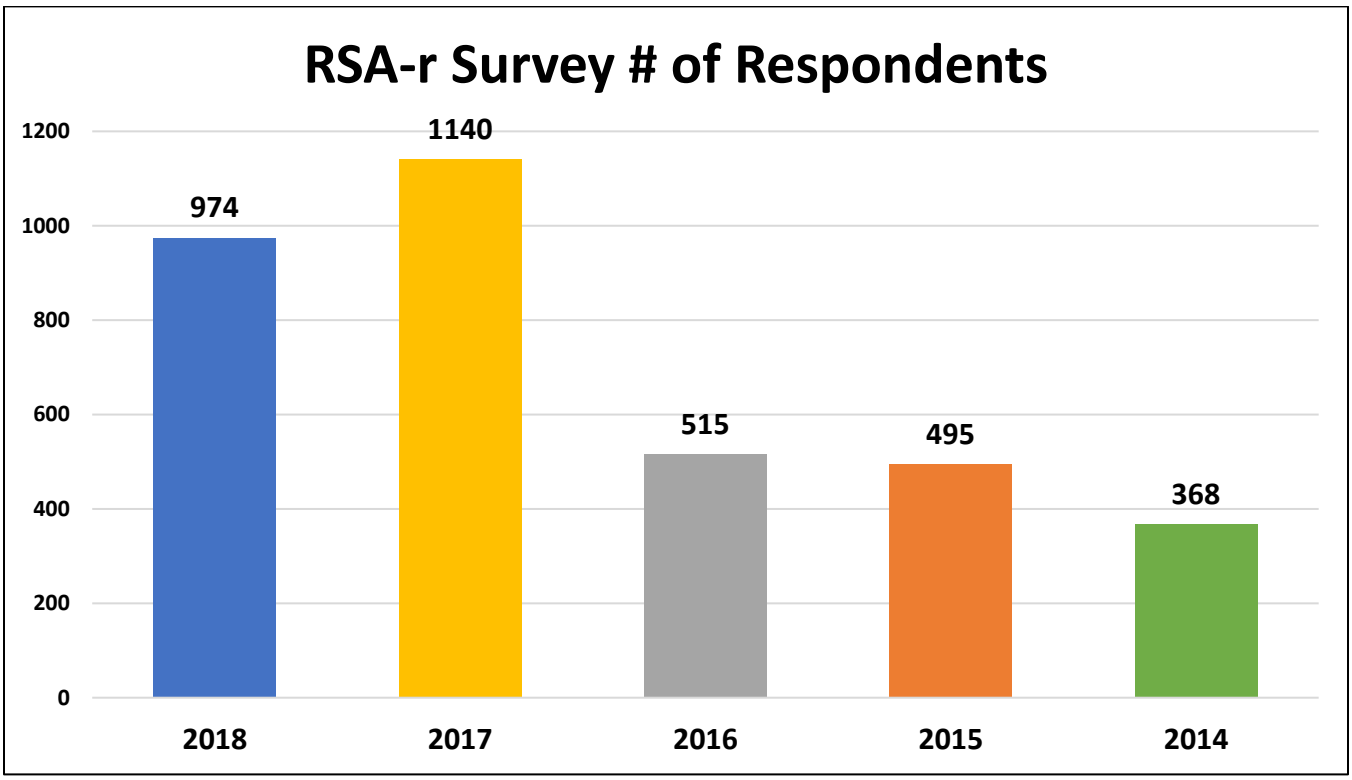
- Publish results widely (*i.e., newsletters, share with stakeholders and regional committees)*
- Develop CMHSP Specific Reports for all (8) Counties.
- Perform a Causal Analysis on Results for all (8) Counties.
- *Analysis and Evaluation of Comments Received by Customers*.
- Identify any Common Denominators or Patterns in Comments Received by Customers.
- Determine Course of Action to Address Customer Feedback and Concerns.
- Evaluate Improvement Strategies and Opportunities for Improvement through QM, RUM, RCP, and other Regional Committees for the 2019 Customer Satisfaction Survey Process.

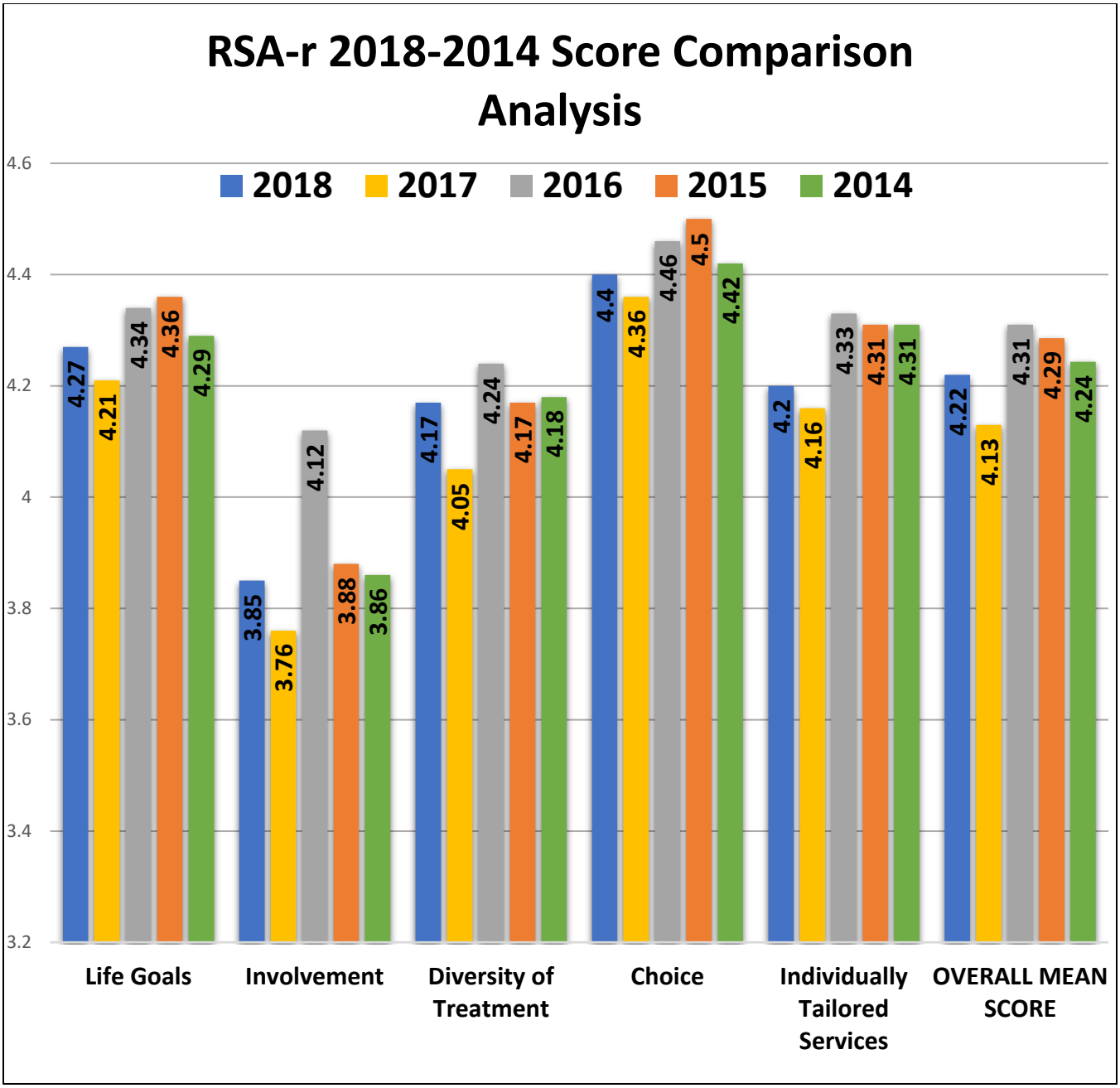
Recovery Self-Assessment – Person in Recovery (RSA-r) Survey

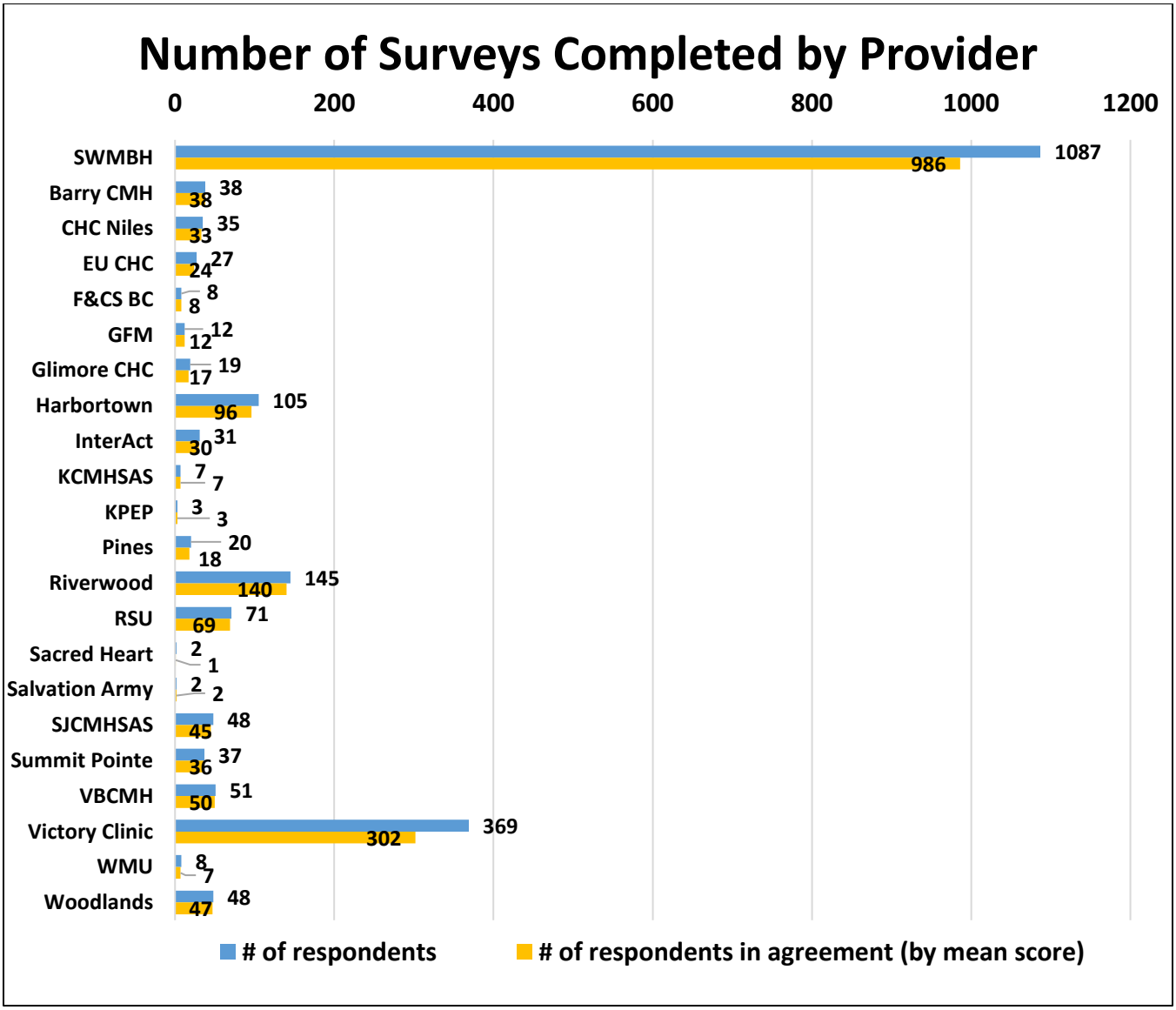
RSA-r Results Year Comparison

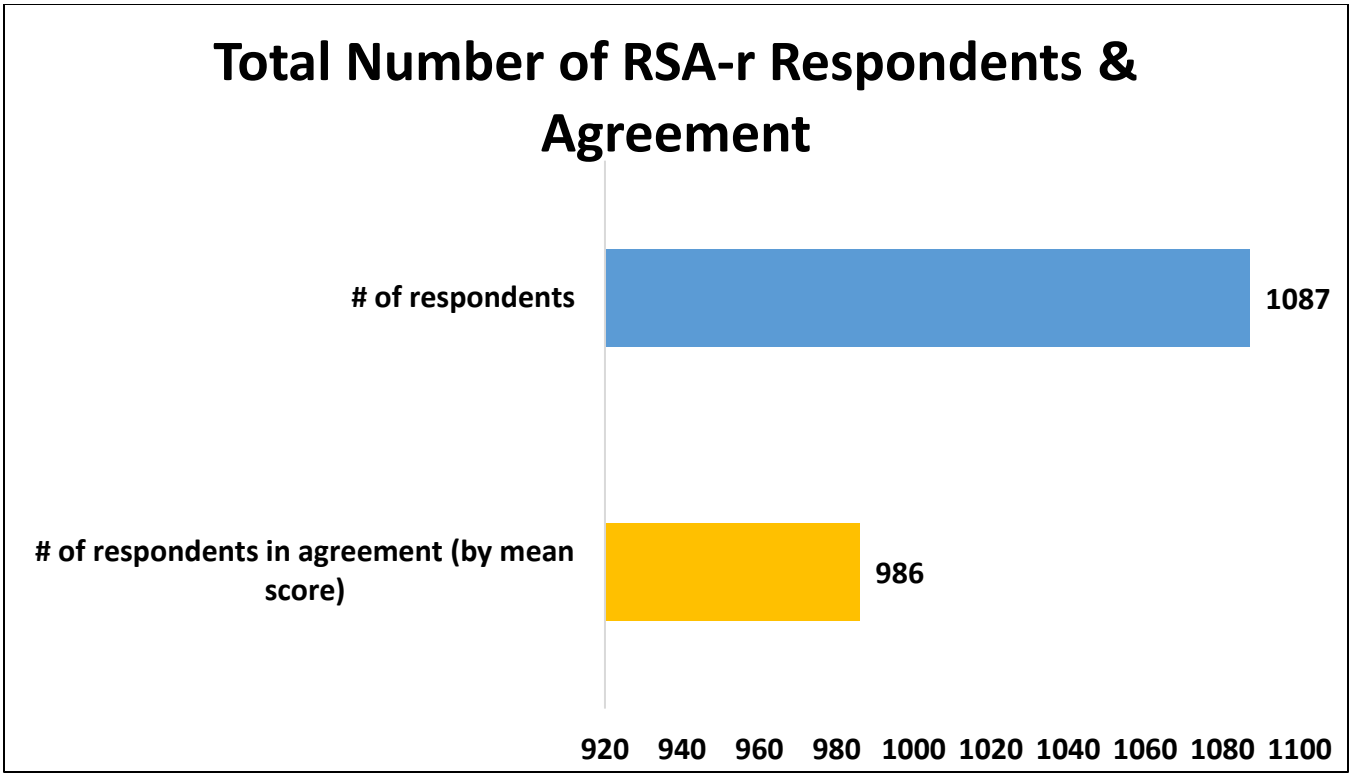
- ❑ 2018 Overall Mean Score: 4.22
  (+0.09 Percent increase from 2017)
- ❑ 2017 Overall Mean Score: 4.13
- ❑ 2016 Overall Mean Score: 4.31
- ❑ 2015 Overall Mean Score: 4.29
- ❑ 2014 Overall Mean Score: 4.24

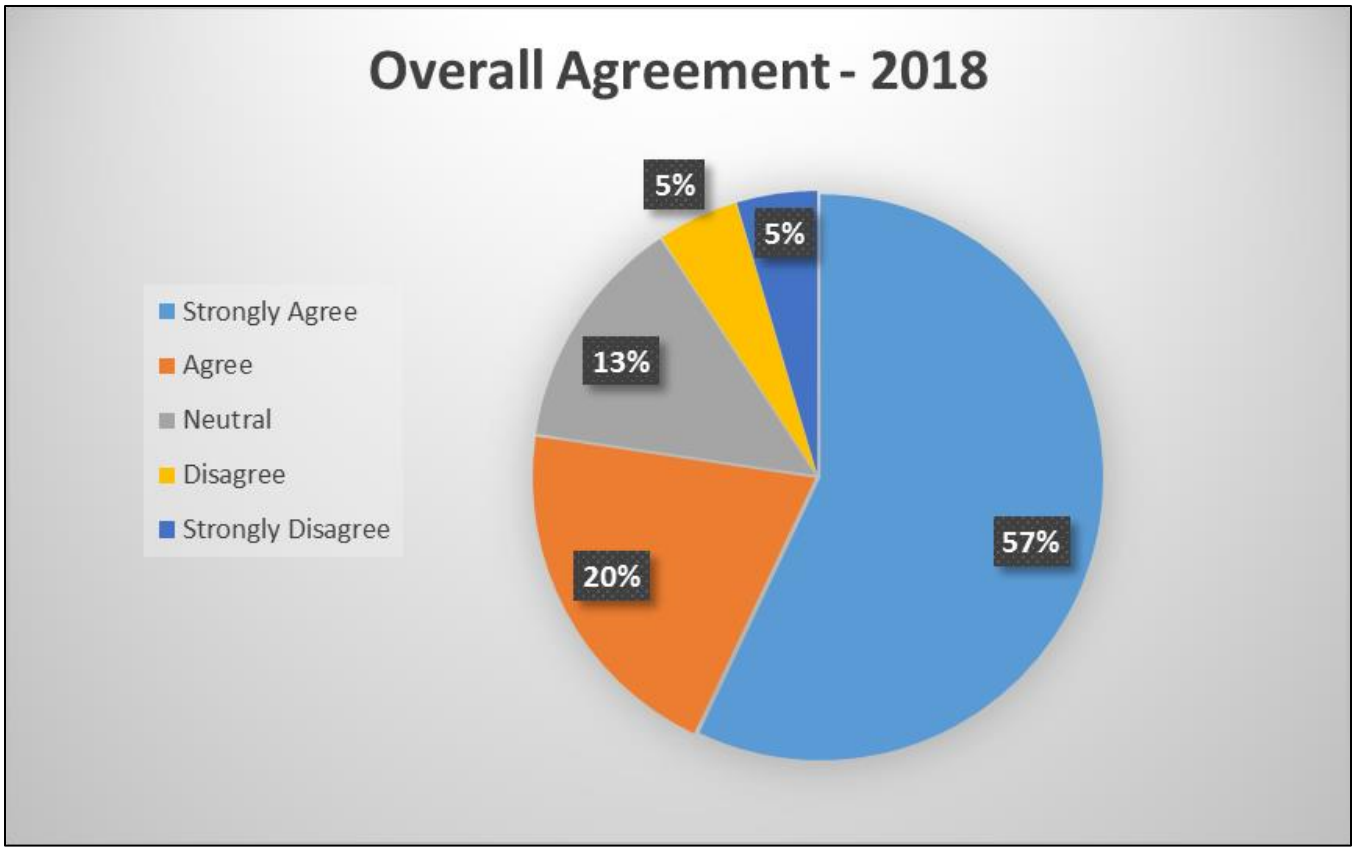
5 Year Average	Mean Score
Life Goals (Q3,Q7,Q8,Q9,Q12,Q16,Q17,Q18,Q28,Q31,Q32)	**4.294**
Involvement (Q22,Q23,Q24,Q25,Q29	**3.894**
Diversity of Treatment (Q14,Q15,Q20,Q21,Q26)	**4.162**
Choice (Q10, Q27, Q4, Q5, Q6)	**4.428**
Individually Tailored Services (Q11,Q13,Q19,Q30)	**4.262**

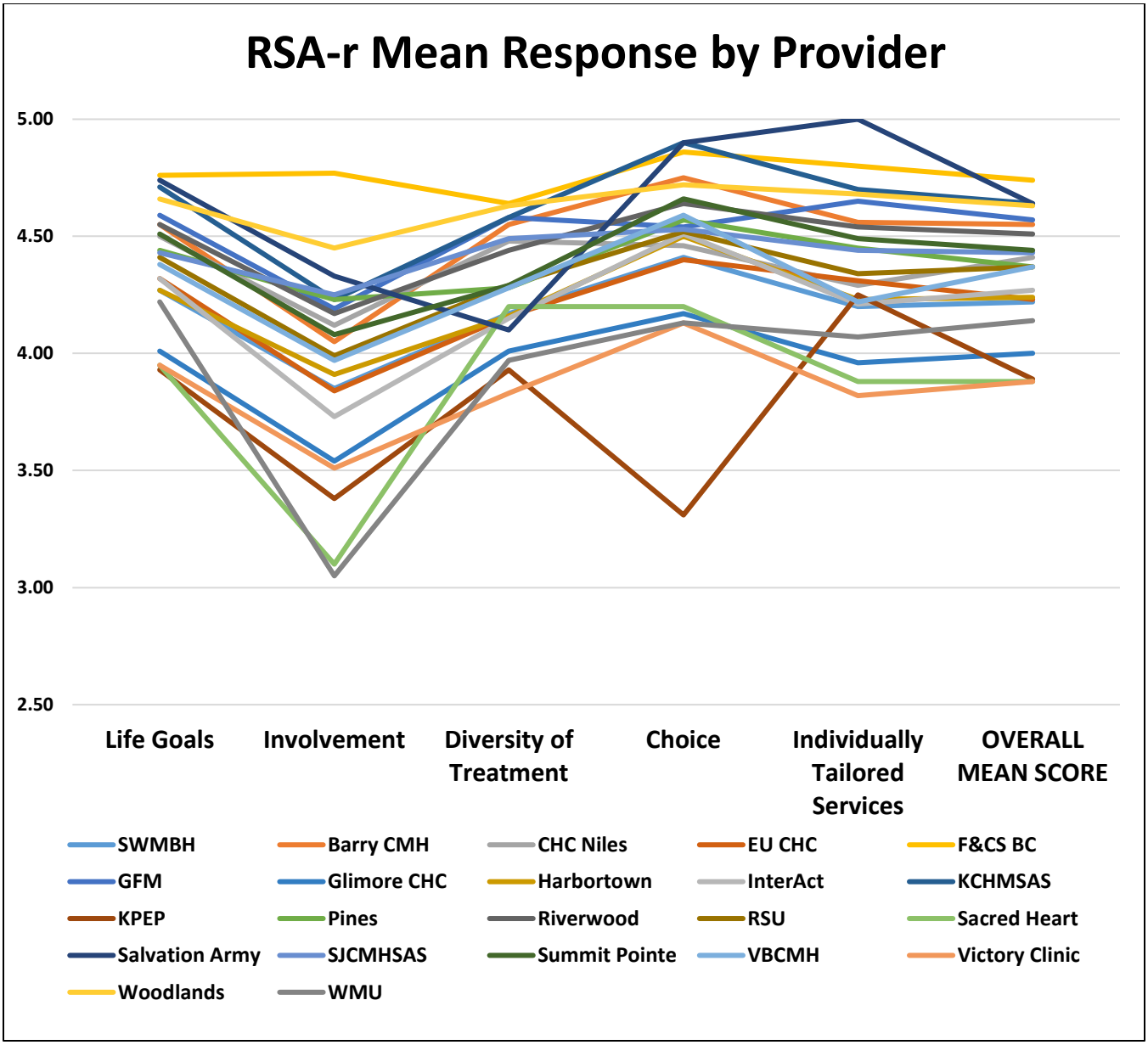


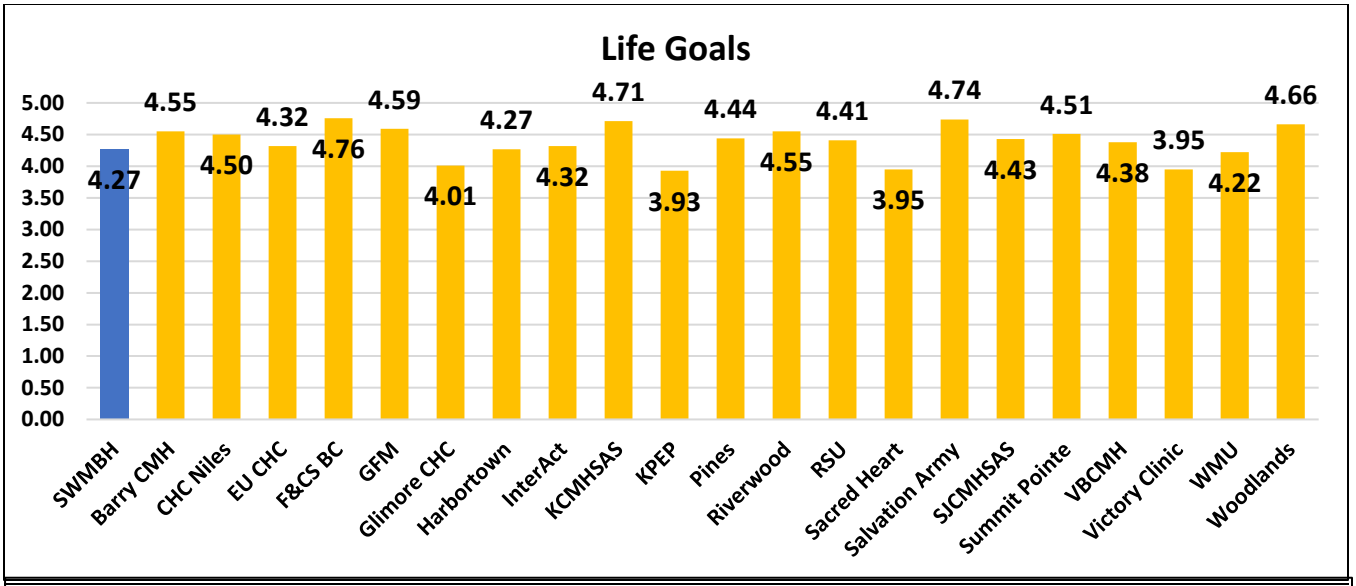

RSA-r 2018-2014 Score Comparison Analysis
2018
2017
2016
2015
2014
4.6
4.4
4.2
4
3.8
3.6
3.4
3.2
4.27
4.21
4.34
4.36
4.29
3.85
3.76
4.12
3.88
3.86
4.17
4.05
4.24
4.17
4.18
4.4
4.36
4.46
4.5
4.42
4.2
4.16
4.33
4.31
4.31
4.22
4.13
4.31
4.29
4.24
Life Goals
Involvement
Diversity of Treatment
Choice
Individually Tailored Services
OVERALL MEAN SCORE


Number of Surveys Completed by Provider
0
200
400
600
800
1000
1200
SWMBH
Barry CMH
CHC Niles
EU CHC
F&CS BC
GFM
Glimore CHC
Harbortown
InterAct
KCMHSAS
KPEP
Pines
Riverwood
RSU
Sacred Heart
Salvation Army
SJCMHSAS
Summit Pointe
VBCMH
Victory Clinic
WMU
Woodlands
1087
986
38
38
35
33
27
24
8
8
12
12
19
17
105
96
31
30
7
7
3
3
20
18
145
140
71
69
2
1
2
2
48
45
37
36
51
50
369
302
8
7
48
47
# of respondents
# of respondents in agreement (by mean score)

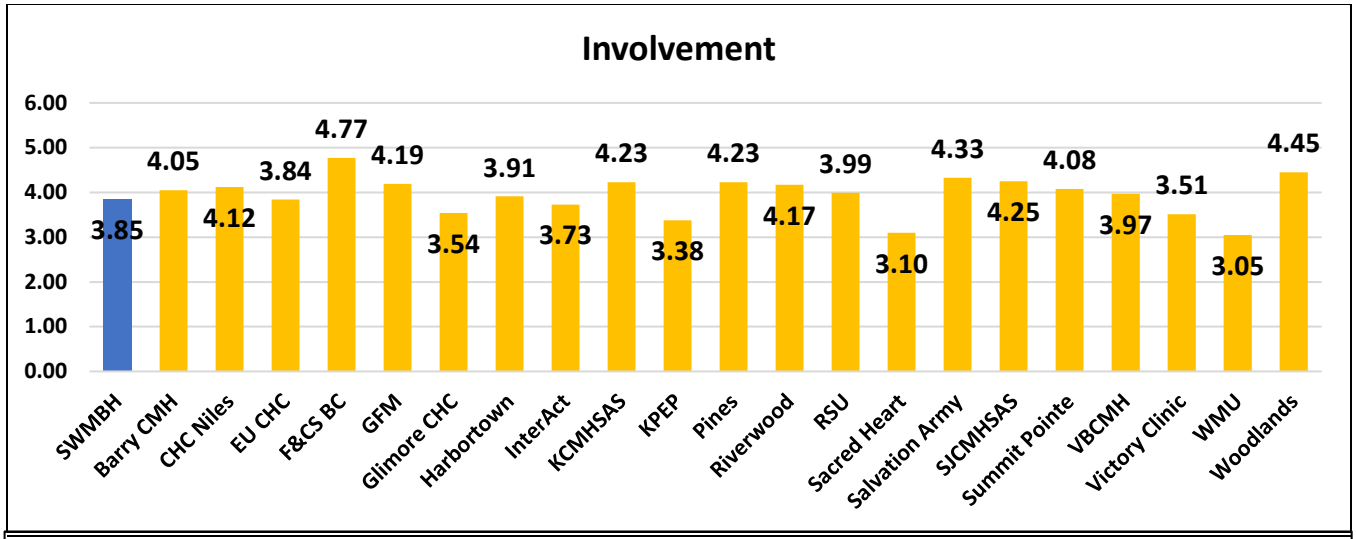

Total Number of RSA-r Respondents & Agreement
# of respondents
1087
# of respondents in agreement (by mean score)
986
920 940 960 980 1000 1020 1040 1060 1080 1100


Overall Agreement - 2018
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
5%
5%
13%
57%
20%

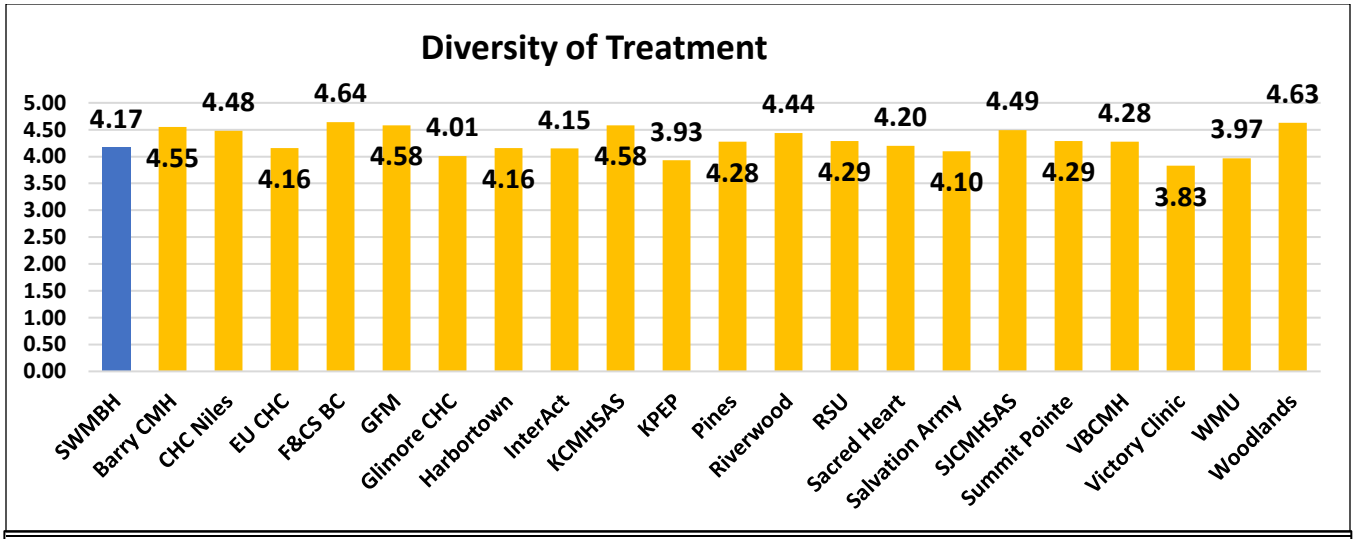

RSA-r Mean Response by Provider
5.00
4.50
4.00
3.50
3.00
2.50
Life Goals
Involvement
Diversity of Treatment
Choice
Individually Tailored Services
OVERALL MEAN SCORE
SWMBH
Barry CMH
CHC Niles
EU CHC
F&CS BC
GFM
Glimore CHC
Harbortown
InterAct
KCHMSAS
KPEP
Pines
Riverwood
RSU
Sacred Heart
Salvation Army
SJCMHSAS
Summit Pointe
VBCMH
Victory Clinic
Woodlands
WMU



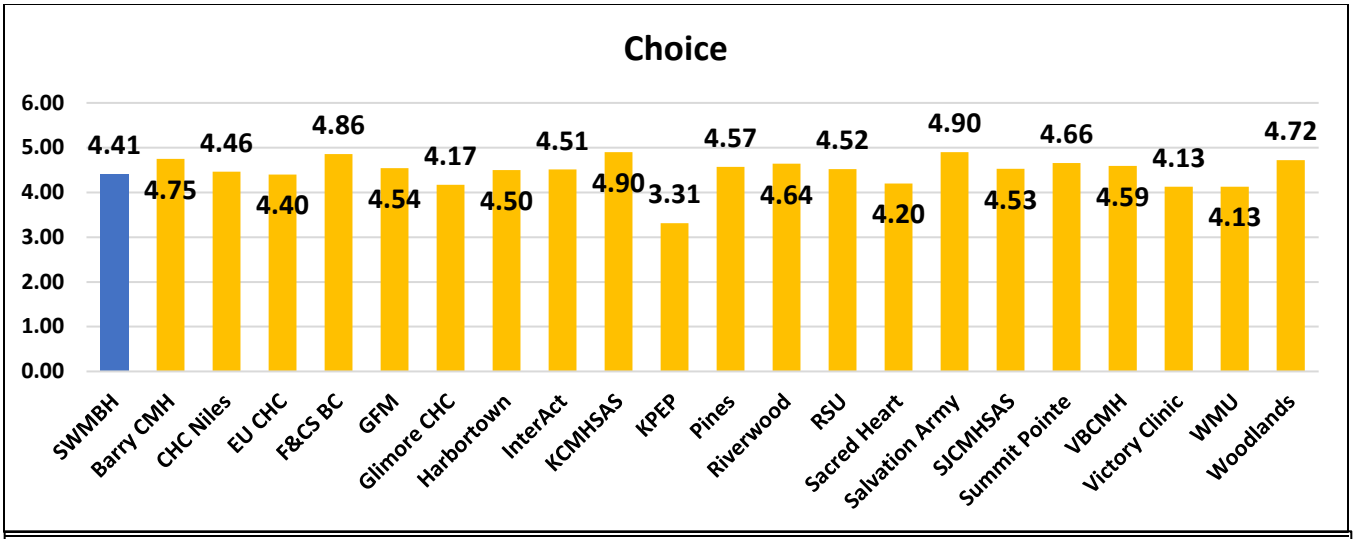
- 3. Staff encourage program participants to have hope and high expectations for their recovery.
- 7. Staff believe in the ability of program participants to recover.
- 8. Staff believe that program participants have the ability to manage their own symptoms.
- 9. Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.
- 12. Staff encourage program participants to take risks and try new things.
- 16. Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g. employment, education physical fitness, connecting with family and friends, hobbies).
- 17. Staff routinely assist program participants with getting jobs.
- 18. Staff actively help program participants to get involved in non-mental health/addiction related activities, such as church groups, adult education, sports, or hobbies.
- 28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.
- 31. Staff are knowledgeable about special interest groups and activities in the community.
- 32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.



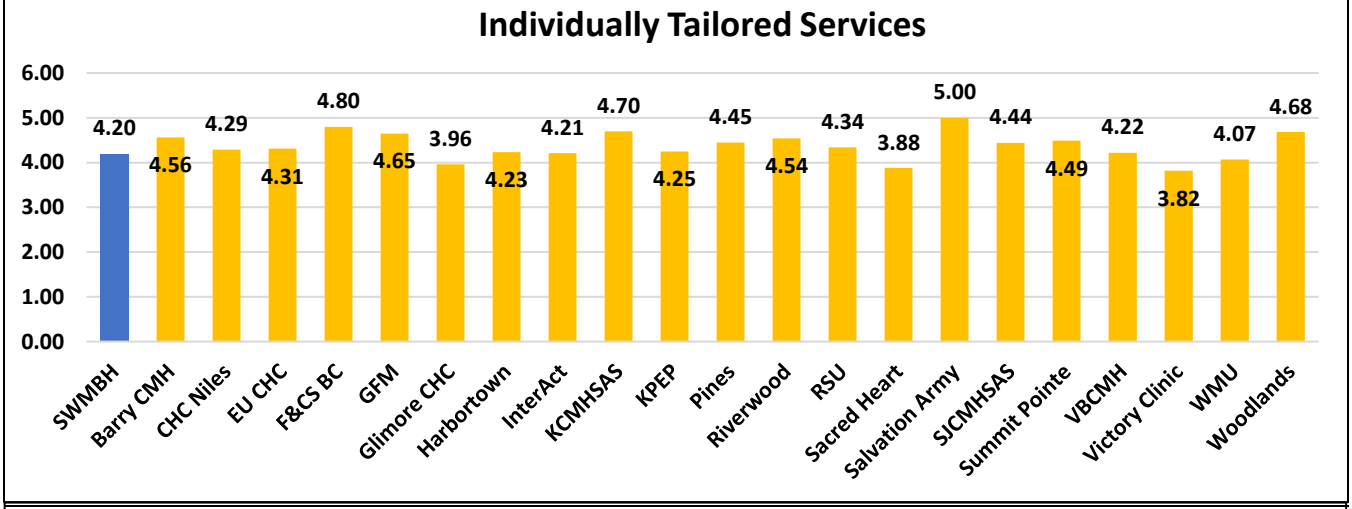
- 22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, and neighborhood watch/cleanup).
- 23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.
- 24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.
- 25. People in recovery are encouraged to attend agency advisory boards and management meetings.
- 29. Persons in recovery are involved with facilitating staff trainings and education at this program.



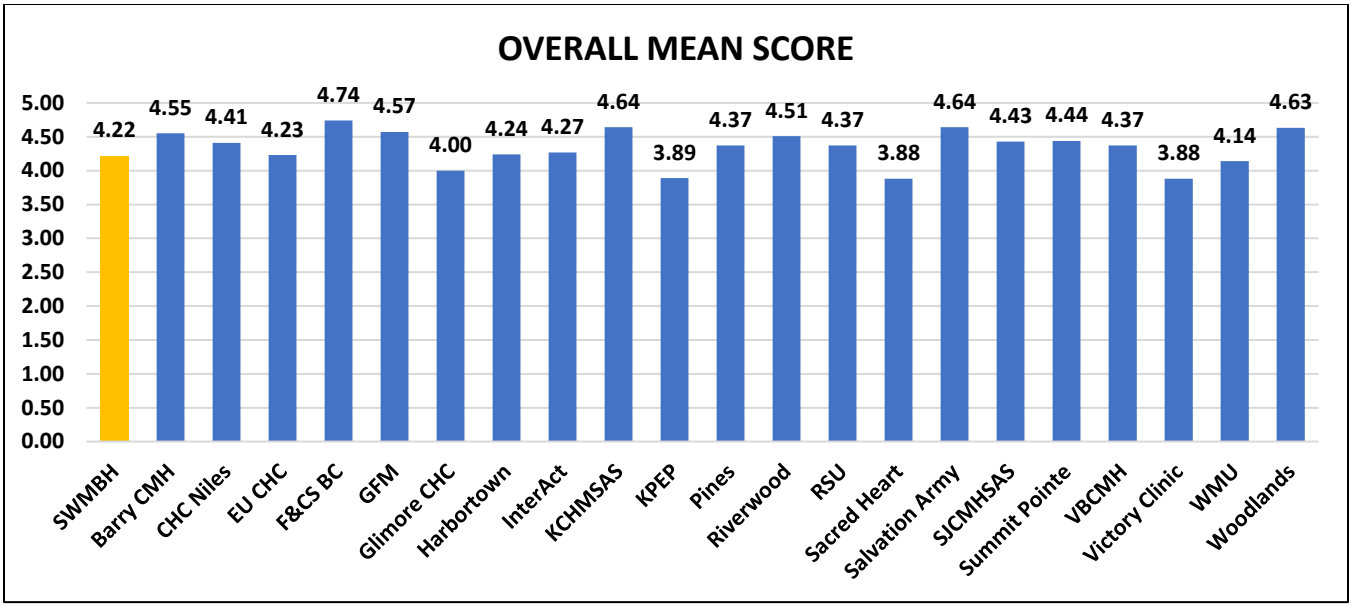
- 14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.
- 15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.
- 20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.
- 21. Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.
- 26. Staff talk with program participants about what it takes to complete or exit the program.



- 4. Program participants can change their clinician or case manager if they wish.
- 5. Program participants can easily access their treatment records if they wish.
- 6. Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.
- 10. Staff listen to and respect the decisions that program participants make about their treatment and care.
- 27. Progress made towards an individual's own personal goals is tracked regularly.



- 11. Staff regularly ask program participants about their interests and the things they would like to do in the community.
- 13. This program offers specific services that fit each participant's unique culture and life experiences.
- 19. Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer).
- 30. Staff at this program regularly attend trainings on cultural competency.



Objective:

The Recovery Self-Assessment – Person in Recovery Survey, is a 36-question tool; designed to gauge the degree to which programs implement recovery-oriented practices. It is a reflective tool designed to identify strengths and target areas of improvement, geared toward improving consumer outcomes and treatment modalities.

Results:

The 2018 RSA-r survey administration period was from: 9/24/2018 to 11/2/2018.
For the 2018 process; SWMBH received total (1087) surveys back, which was a decrease from the 2017 response of (1140) total surveys returned. (22) Different provider organizations participated in the 2018 survey process, which was eight more than the 2017 participation; (16) provider organizations participated. SWMBH's analysis of the overall mean score, *represented a +0.09 increase in comparison to 2017 scores*.
Consumers of substance abuse services complete the surveys, which were administered through their provider.

Identified Barriers:

The data entry process is manual and takes significant time to enter all provider organization results. Furthermore, when completing the surveys sometimes members would circle more than one response. In this instance, the lower score was entered when compiling the data. Also, the back of the surveys were not always filled out due to members not knowing that there were additional questions on the other side of the survey. These are all areas of improvement for the survey next year.

Recommendations:

The QAPI Department is exploring ways to automate the data entry system, to save employee time and speed up the results/analysis process. The QMC will be discussing possible methods of improving this process in 2019. The QMC will also explore ways to improve scores in the Involvement category, which has been the Regions lowest score since 2015. Lastly, the QMC will assess ways to improve the survey process to ensure each survey is completed to its entirety and further to identify strategies to ensure each consumer is only marking one answer per question.

MI Health Link Member Satisfaction Survey (MIHL)

MIHL Results Year Comparison

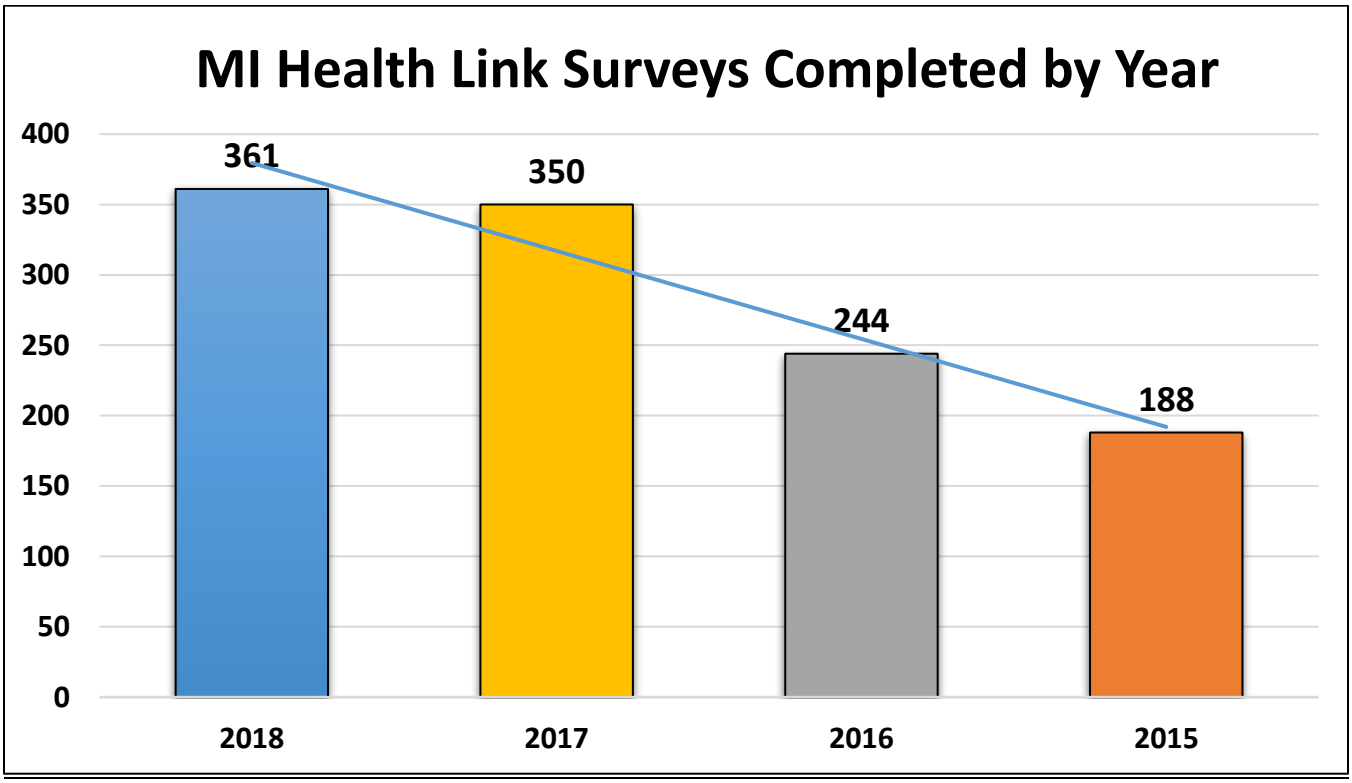
- ❑ 2018 Aggregate Ave Score = 88.14%
- ❑ 2018 National Ave Score: 80.07%
- ❑ 2017 Aggregate Ave Score = 82.43%

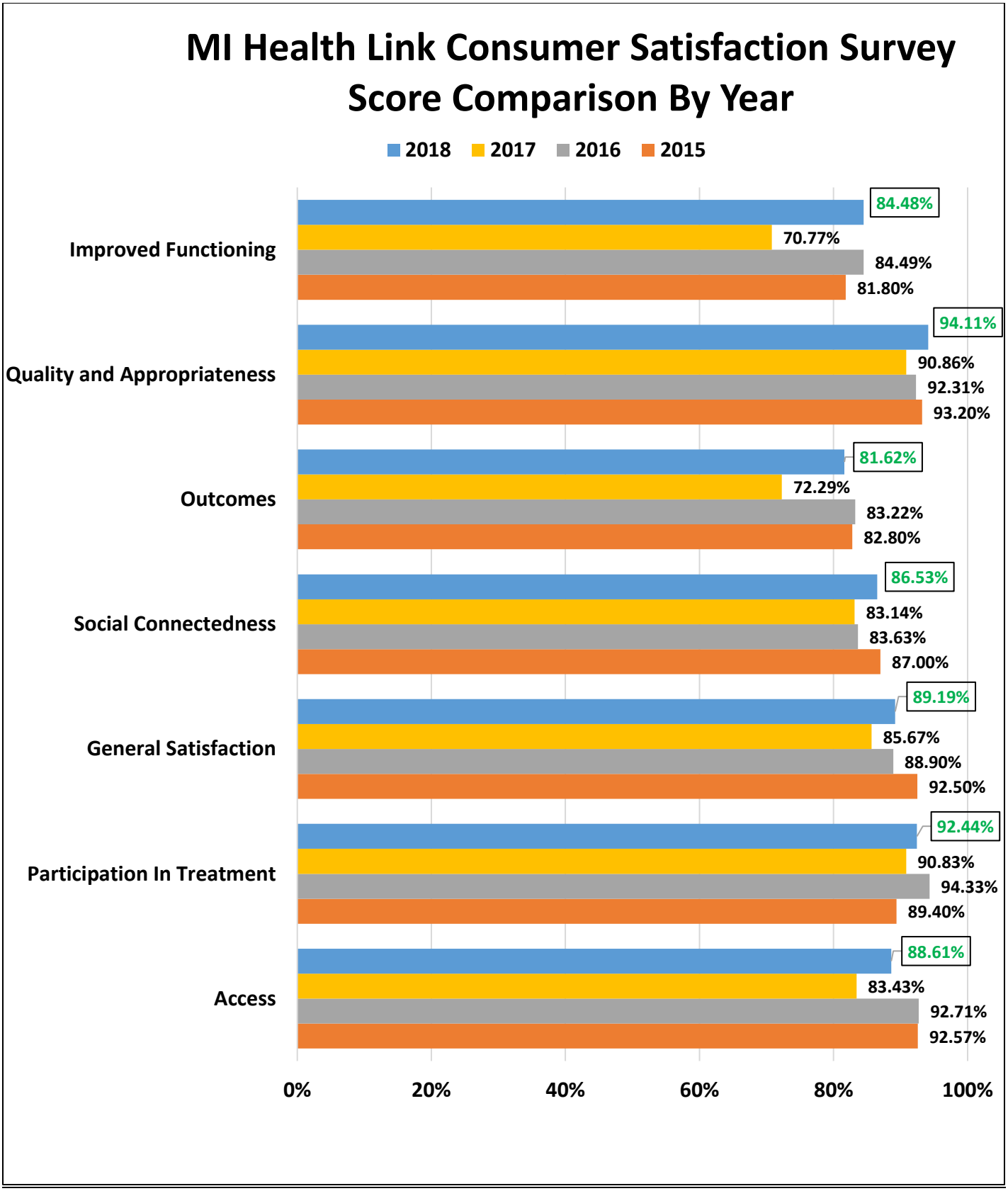
+5.71% Percent Improvement over 2017 Scores

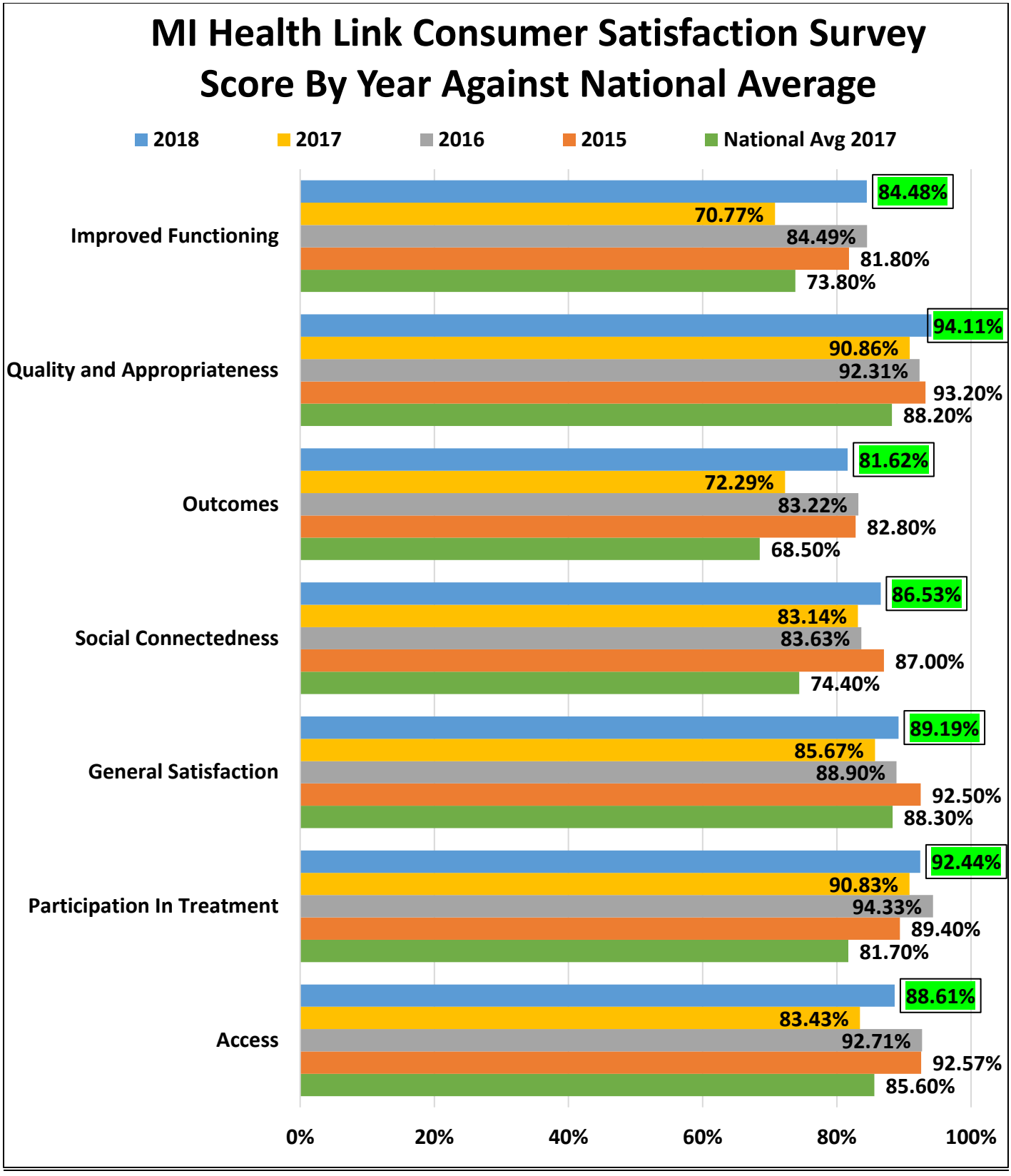
+8.07% Percent Improvement Over National Ave Scores

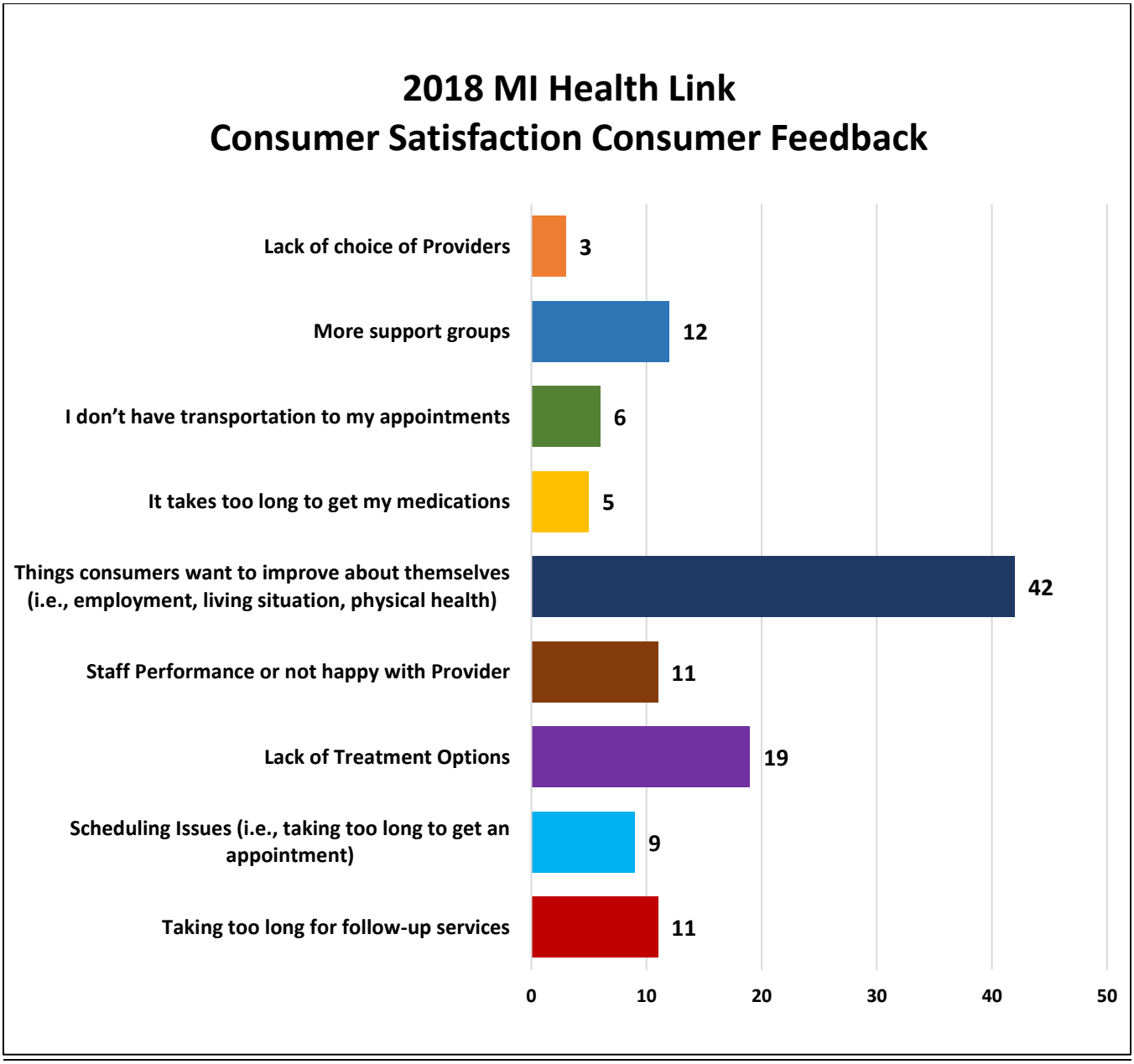
2018 Survey Responses

- ❑ 361 valid surveys were completed
- ❑ 841 total calls were made
- ❑ 42.9% response rate




MI Health Link Consumer Satisfaction Survey Score Comparison By Year
2018
2017
2016
2015
Improved Functioning
84.48%
70.77%
84.49%
81.80%
Quality and Appropriateness
94.11%
90.86%
92.31%
93.20%
Outcomes
81.62%
72.29%
83.22%
82.80%
Social Connectedness
86.53%
83.14%
83.63%
87.00%
General Satisfaction
89.19%
85.67%
88.90%
92.50%
Participation In Treatment
92.44%
90.83%
94.33%
89.40%
Access
88.61%
83.43%
92.71%
92.57%
0%
20%
40%
60%
80%
100%


MI Health Link Consumer Satisfaction Survey Score By Year Against National Average
2018
2017
2016
2015
National Avg 2017
Improved Functioning
84.48%
70.77%
84.49%
81.80%
73.80%
Quality and Appropriateness
94.11%
90.86%
92.31%
93.20%
88.20%
Outcomes
81.62%
72.29%
83.22%
82.80%
68.50%
Social Connectedness
86.53%
83.14%
83.63%
87.00%
74.40%
General Satisfaction
89.19%
85.67%
88.90%
92.50%
88.30%
Participation In Treatment
92.44%
90.83%
94.33%
89.40%
81.70%
Access
88.61%
83.43%
92.71%
92.57%
85.60%
0%
20%
40%
60%
80%
100%



Objective:

- MI Health Link is a program that joins Medicare and Medicaid benefits, rules and payments into one coordinated delivery system.
- MI Health Link health plans and current Michigan Pre-paid Inpatient Health Plans (PIHPs) receive payments to provide covered services.
- SWMBH:
    - Region 4 consist of Southwest Michigan: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren counties.
- The MIHL survey was conducted by calling SWMBH MI Health Link consumers.
- The MIHL survey measures concerns that are important to consumers of MI Health Link Services including: Improved Functioning, Quality and Appropriateness, Outcomes, Social Connectedness, General Satisfaction, Participation in Treatment, and Access.

In summary, (361) valid surveys were completed and (841) total calls were made, resulting in a 42.9% response rate. This response rate is very good and attributed to the letters and advertisement efforts taken before the survey implementation. The current 2018 results are a significant improvement over the 2017 results. The percentages of 'In Agreement' ratings across domain areas are also higher this year, netting an average 'In Agreement' score of 3.98 on a 5.0 scale, in comparison to the 2017 average 'In Agreement' score of 3.44. The Quality Department will continue to evaluate consumer survey participant feedback to identify common denominators and trends associated with the 2018 survey process.

The current results tend to reflect national trends for the respective MHSIP survey tool domains, and tend to reflect results reported by [some] states that employ credible survey methods for MHSIP URS (SAMSHA) reporting (i.e. – Oregon / Utah / Ohio / California…) which have similar evaluation and validation processes as Southwest Michigan Behavioral Health.

Speculatively, one hypothesis is that current performance differences may be related to sample variation – (though there are many potential factors that could come into play). With this, it may be interesting to compare the proportion of CMH-served vs Non-CMH served cases across specified survey time periods. Other factors that may have attributed to the improved survey scores may include: timing of study (i.e., the survey started earlier this year and avoided key Holiday times of Thanksgiving and Christmas); data collection processes; or new research crews hired by the new contracted survey vender we used to conduct this years survey.

Results:

- The Mental Health Statistics Improvement Program (MHSIP) Survey Tool Was Utilized.
- 361 MI Health Link Consumers Were Randomly Sampled in 2018 while, 350 MI Health Link Consumers Were Randomly Sampled in 2017.
- Average Score Comparison by Year:
  - 2018 Average Score = **88.14%.**
  - 2017 Average Score = **82.43%**
  - 2016 Average Score = **88.51%**
  - 2015 Average Score = **88.46%**

Identified Barriers:

During the 2018 survey process and evaluation, it was identified that increased vender oversight and monitoring needed to occur. In 2017 it was found that some surveyors were inconsistent using scripts and identified themselves incorrectly to consumers. This caused some confusion for the consumers and understanding the significant of their participation in the survey. Due to this finding, SWMBH sent out letters to all potential members who may be selected to receive a survey call. The letter informed the consumer of the purpose of the survey and how their responses will be used to improve programs and services. Additionally, SWMBH Management made (2) random visits to the vender/survey location to observe consistency in scripts and survey protocol was being followed correctly. It was found that the 4 surveyors evaluated were using the appropriate scripts and techniques they had been educated on.

Recommendations:

In follow up, a deeper dive into sample attributes may serve to illuminate potential reasons for the variation. Consumer feedback will be evaluated to identify potential trends and common denominators. Identified/realized trends will be acted on by internal SWMBH workgroups and Regional Committees (i.e. Quality Management Committee, Regional Utilization Management Committee and Consumer Advisory Committee) to improve processes, interventions and overall consumer outcomes.

2018 Sharing and Communication of Information

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Sharing and Communication of Information	➢ The Quality Department will demonstrate Sharing of information and communication through various internal and external resources to its membership and providers.	✓ Ensure availability of information about QI program and results through newsletter, mailings, web-site, and member handbook and practitioner agreements. ✓ Provide newsletter articles communicating QI performance results and satisfaction results for members and practitioners. ✓ Provide access to QMC and MHL meeting minutes and materials to internal customers. ✓ Access to the SWMBH website for various publications and Provider Directory. ✓ Access to the SWMBH SharePoint Portal for internal and external stakeholders, as a collaborative information sharing	January 2018 - December 2018	QAPI Specialist QAPI Director Chief Operations Officer Utilization Management Manager News Letter Editor Chief Information Technology Officer	Quarterly

SWMBH Website Redesign

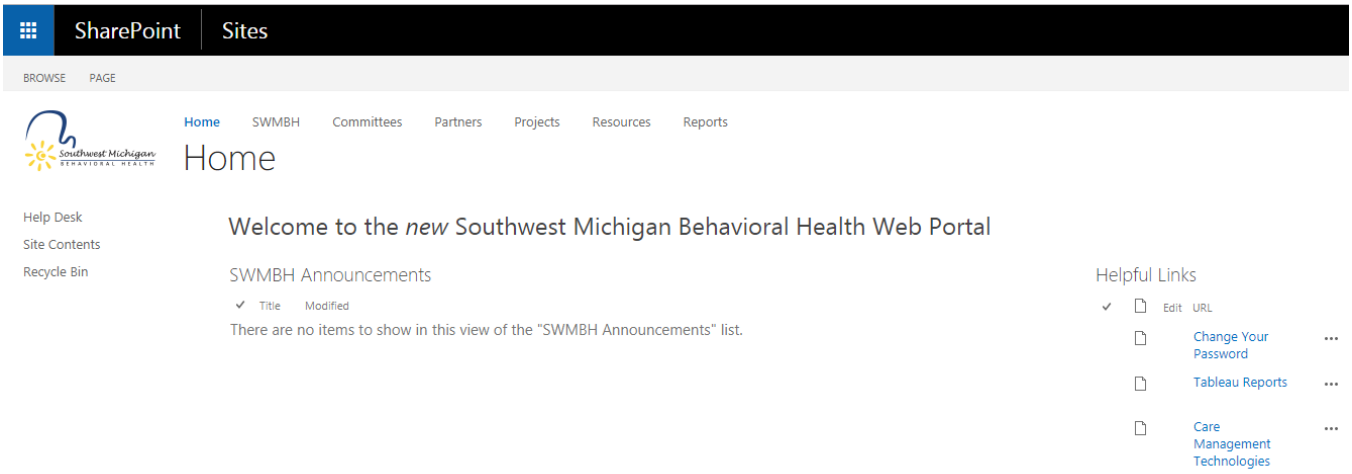
In 2017 SWMBH reorganized its website to make it easier for consumers, stakeholders and staff to navigate. Some of the new features of the improved website include: enhanced provider directory search function, access to member resources, and additional options for member customer service support. Consumers can also access the website to view customer handbooks, policies and procedures.

For more information on the SWMBH website, please visit the website by clicking the link below:

http://www.swmbh.org

SWMBH Portal – SharePoint Site

In 2018 a new SWMBH SharePoint Portal was created due to the switching of IT vendors. Many enhancements were added to the new SWMBH Portal to improve access to data and improve communications with internal and external stakeholders. Some of the primary features added include: Access for Integrated Care Organizations (ICOs) to view reports for dually enrolled consumers, the Tableau data analytics report inventory, access to Regional Committee documents and meeting information, a Reports tab of where all of the reports will be housed in a central location, and a new resources tab with all the Services Policy Manuals, Policies, and Attachments.



For more information on the SWMBH Portal, please visit the portal by clicking the link below:

https://portal.swmbh.org

Objective:

The Quality and Utilization Management Departments at SWMBH will use various methods to ensure the availability of accurate information to members, practitioners, CMHSPs, and internal customers via newsletters, mailings, SWMBH websites, member handbook, and practitioner agreements.

Results:

- A description of the QAPI Program is located on the SWMBH website and on the SWMBH Portal.
- Communication was made with the following groups:
  - Stakeholders
  - SWMBH Board
  - CMH staff and SWMBH staff
  - Others including State Representatives.
- Methods of sharing:
  - Provider Network and Member Services Newsletters
  - SWMBH Website
  - SWMBH SharePoint Site
  - Tableau Analytics and Visual Dashboards
  - SWMBH QM Reports
  - Regional and Internal Meetings
  - External Reports

Identified Barriers:

Training Internal and External Stakeholders how to access data sources, such as the SWMBH SharePoint Site and Tableau Visual Dashboard site. Establishing permission levels for each access point was challenging and took longer than anticipated.

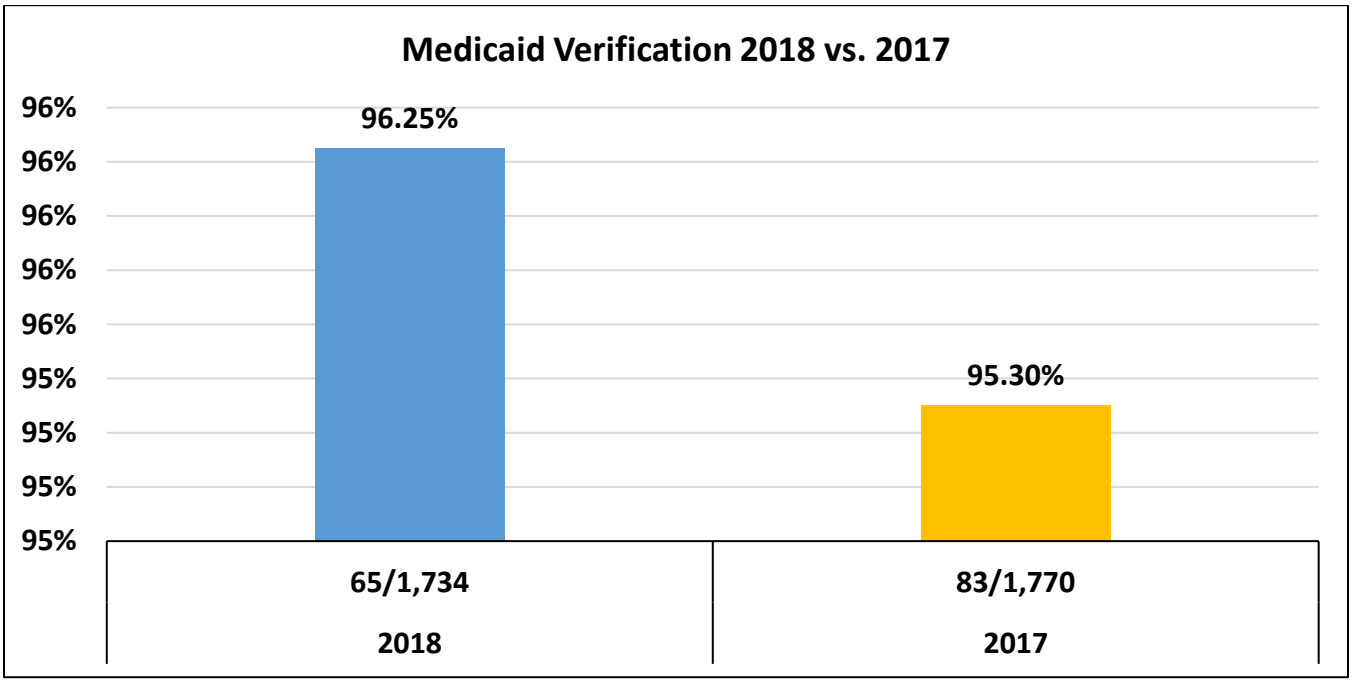
Recommendations:

Hold a Regional Managed Information Business Intelligence Training for Internal and External Stakeholders twice annually. This will give SWMBH the opportunity to show/demonstrate new tools and answer any questions Stakeholders have regarding data resources.

Medicaid Verification, Provider Network Audits and Clinical Guidelines

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Review of Provider Network Audits, Guidelines, and Medicaid Verification	➢ Review audits and reports from other SWMBH departments for continuous improvement opportunities.	✓ Annual report to QMC Committee on any findings or opportunities for improvement. ✓ Corrective Action Plans (CAP) developed, issued and tracked as needed. ✓ QAPI dept. will monitor its provider network on an annual basis to ensure systematic approaches to monitoring are occurring. Results are included in the QAPI annual Evaluation report. ✓ NCQA Clinical Practice Guidelines measure performance against at least (2) aspects of the (3) guidelines. (3) Clinical practice guidelines.	October 2017 – September 2018	QAPI Specialist QAPI Director Chief Compliance Officer	Annually

2018 Medicaid Verification



Objective:
Managed by the compliance department, this is a review of the Medicaid encounters submitted by the region to confirm that Medicaid funds were used appropriately. The 2017 and 2018 Board Ends Metric target for Medicaid claims verification is over 90%.

Results:
SWMBH Compliance Department completed the annual Medicaid Verification review using the sampling methodology in accordance with the Office of Inspector General standards. Overall the score in 2018 was 96.25% with 1,734 Claims were reviewed with a total of 1,669 claims verified to be a valid service reimbursable by Medicaid. A total of 65 claims were noted as having deficiencies and could not be verified during the review.

Identified Barriers:
None identified.

Recommendations:
No corrective action plans were required based on the standards set in the Medicaid Services Verification-Technical Requirements set by MDHHS.

2018 Site Reviews

2018 Provider Network CMHSP Site Reviews

Administrative and Delegated Function Site Review Summary Score		
Standard	**2018 Section Score**	**2017 Section Score**
Access and Utilization Management	**76.9%**	***90%***
Claims Management	**70.8%**	***78%***
Compliance	**80.5%**	***100%***
Credentialing	**98.2%**	***97%***
Customer Services	**96.8%**	***96 %***
Grievances and Appeals	**94.2%**	***96%***
Provider Network	**86.9%**	***95%***
Quality	**84.6%**	***92%***
Staff Training	**98.5%**	***95%***
SUD EBP Fidelity and Administration	**99.0%**	***98%***

- Red indicates Section Score decreased from 2017.
- Green Indicates Section Score increased from 2017.

2018 CMHSP Site Review –Quality

Standard	Total
The Participant has developed a written description of a Quality Improvement Plan that details improvement efforts for the current fiscal year.	*100%*
Within three business days of a critical incident the CMH has made a determination of whether it is a sentinel event. If the critical incident is classified as a sentinel event, the CMH has commenced a root cause analyses within 2 business days.	*50%*
All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include: 1. Screens of individual deaths with standard information (e.g., coroner's report, death certificate)	*80%*
All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include: 2. Involvement of medical personnel in the mortality reviews	*90%*
All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include: 3. Documentation of the mortality review process, findings, and recommendations	*100%*
All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include: 4. Use of mortality information to address quality of care	*90%*
The Participant has a BTPR that meets MDHHS technical requirements. The committee consists of at least a licensed Psychologist with specified training and experience in applied behavior analysis, licensed Physician / Psychiatrist and a representative from the office of Recipient Rights.	*100%*
The Participant is providing BTPR information and minutes to SWMBH QAPI Department that meet SWMBH policy requirements	*69%*
The BTPR committee has an established mechanism for expedited review of a proposed behavior treatment plan in emergent situations. "Expedited" means the plan is reviewed and approved in a short time frame such as 24 or 48 hours.	*100%*
MMBPIS indicators correctly identify individuals with Medicaid coverage.	*100%*
MMBPIS indicators correctly identify population.	*94%*
MMBPIS indicators correctly identify exception/exclusion type.	*69%*
MMBPIS indicators correctly identify exception/exclusion reason.	*56%*
Average Regional Score	**84%**

External Audit and Reviews Compliance

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
External Monitoring, Audits and Reviews	➢ The Quality Management Department will coordinate the reviews by external entities, including MDHHS, HSAG, ICO's, NCQA and other organizations as identified by the SWMBH board. ➢ The Quality Department will ensure that SWMBH achieves the goal/score established by the Board Ends Metrics, or meets the reviewing organizations expectations. ➢ The Quality Department will collect changes to contracts, managed care regulations and other contractual standards and provide education and resources to SWMBH and CMHSPs.	✓ The Quality Department will ensure all documentation is returned to the external monitoring agency in a timely manner. ✓ The Quality Department will notify other functional areas of reviews and ensure all arrangements and materials/documents are ready for review. ✓ The SWMBH QAPI Department reviews and approves plans of correction (CAPs) that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate and documented interval time. The QAPI Department may increase level of monitoring/oversight for Regional performance indicators that are consistently out of compliance.	January 2018 – December 2018	All Functional Area Senior Leaders QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Provider Network Director	Annually or audits as scheduled

National Committee for Quality Assurance (NCQA) – Managed Behavioral Healthcare Organization (MBHO) – Medicare Accreditation

On March 2, 2018 Southwest Michigan Behavioral Health (SWMBH) earned full Managed Behavioral Health Organization (MBHO) Accreditation for their MI Health Link Business Line from the National Committee for Quality Assurance (NCQA). NCQA is an independent 501(c) (3) not-for-profit organization dedicated to improving health care quality and has been a central figure in helping to elevate the issue of healthcare quality in the national agenda by driving improvement throughout the health care system.

Accreditation is a nationally recognized evaluation that consumers, providers, and regulators may use to assess managed NCQA behavioral health organizations (MBHOs). NCQA evaluates the implementation of evidence-based standards, measures, programs, and continuous quality improvement practices by organizations striving for excellence in administration and delivery of services. The NCQA review process includes rigorous on-site and off-site evaluations conducted by a team of physicians and managed care experts. A national oversight committee of physicians and behavioral health providers analyzes the team's findings and assigns an accreditation level based on the MBHO's performance compared to NCQA standards. For more information:
http://www.ncqa.org/programs/accreditation/managed-behavioral-healthcareorganization-mbho

2018 Health Services Advisory Group (HSAG) Performance Measure Validation Audit Results

The following report represents a Summary of preliminary finding during the Health Services Advisory Group (HSAG) Performance Measure Validation Audit that took place on July 18, 2017 at Southwest Michigan Behavioral Health.

Results:
40/41 or 97.56% Of Total Elements Evaluated received a designation score of "Met", "Reportable", or "Accepted".

This meets *successful completion of our 2017 Board Ends Metric*, which indicates: 95% of Elements Evaluated/Measured, shall receive a score of "Met".

The detailed results for each category and element evaluated can be found below:

Scoring Category	Performance Results
Accepted	3/3 – 100% Data Integration Elements Evaluated were ***"Accepted"*** and met full compliance standards.
Reportable	11/12 – 92.0% Performance Indicators Evaluated were ***"Reportable"*** and compliant with the State's specifications and the percentage reported.
Met	13/13 – 100% Data Integration and Control Elements Evaluated ***"Met"*** full compliance standards.
Met	13/13 – 100% Numerator and Denominator Elements Evaluated **s** full compliance Standards.

Data Integration, Control and Performance Indicator Elements Evaluated:

Standard	Scoring Criteria "Acceptable or "Not Acceptable"	Recommendation
1). Data Integration	Acceptable – 100%	Full Compliance
2). Data Control	Acceptable – 100%	Full Compliance
3). Performance Indicator Documentation	Acceptable – 100%	Full Compliance

PIHP Strengths

Southwest Michigan Behavioral Health experienced some staffing changes in the past year; however, newly hired staff members had extensive backgrounds in behavioral health and all processes related to performance indicator (PI) and data reporting requirements.

Several quality boards were formed with representatives from the PIHP and each affiliated CMHSP. These boards were focusing on data integrity and data completeness of performance measure indicators.

In addition, **Southwest Michigan Behavioral Health** continued to demonstrate robust oversight of its CMHSP. More specifically, prior to the CMHSP's new system implementation, the PIHP ensured that this new system captures and processes data accurately.

Southwest Michigan Behavioral Health also ensured that error messages received from the State related to submitted encounters or BH-TEDS files are incorporated into the transactional system as part of the internal system's data validation process.

HSAG PMV Recommendations:

- PIHP should create a snapshot of the summary and detail files submitted to the State.
- HSAG recommended additional quality control activities to ensure validity of the primary source verification.

Michigan Department of Health and Human Services (MDHHS) Autism Benefit and Substance Abuse Administrative Review

November 17, 2017

Brad Casemore
Southwest Michigan Behavioral Health
5250 Lovers Lane Suite 200
Portage, MI 49002

Re: Autism ABA Corrective Action Plan

Dear Mr. Casemore,

Thank you for submitting your region's corrective action plan (CAP) addressing required remediation for Applied Behavior Analysis (ABA) services covered by Medicaid. The CAP is in response to the site review conducted in July 2017 and has been approved by MDHHS. We appreciate the steps that are now being taken by your agency to address the findings outlined in your site review report.

MDHHS Autism Section will monitor implementation of the submitted CAP and evaluate effectiveness of system change with ongoing data collection through the ABA quality and system improvement letters provided quarterly, as well as, conduct a comprehensive on-site ABA review of your region in 2019. Autism staff will continue to collaborate with Southwest Michigan Behavioral Health to improve systems and increase access to quality care for individuals impacted by autism spectrum disorder.

Additionally, the MDHHS Contracts Division will utilize a variety of means to assure compliance with the contract requirements and the provisions of Section 330.1232b of Michigan's Mental Health Code, regarding Specialty Prepaid Inpatient Health Plans. This Division will pursue remedial actions and possible sanctions as needed to resolve outstanding contract violations and performance concerns with administration of the autism ABA benefit to eligible beneficiaries.

If you have any questions or would like to request additional assistance, please feel free to contact Morgan VanDenBerg, vandenbergm@michigan.gov or 517-335-2296

Utilization Management Program Evaluation

II. Utilization Management Program Evaluation

Utilization Management Program

On at least an annual basis, the QAPIP is evaluated. The QAPI & UM Effectiveness Review/Evaluation document is a companion document to the annual QAPIP and will be completed at the end of the fiscal year, or shortly thereafter. The QAPI & UM Effectiveness Review/Evaluation assesses the overall effectiveness of the QAPI and UM Programs including the effectiveness of the committee structure, the adequacy of the resources devoted to it, practitioner and leadership involvement, the strengths and accomplishments of the program with special focus on patient safety and risk assessment and performance related to clinical care and service. Progress toward the previous year's project plan goals are also evaluated. The SWMBH QM department completes the evaluation and identifies the accomplishments and any potential gaps during the previous year's QM activities. When a gap is identified and addressed during that year it will be reported in the QAPI Effectiveness Review/Evaluation, other gaps may be incorporated into the next year's QAPI plan. The findings within the QAPI Effectiveness Review/Evaluation will be reported to the QM Committee, Operations Committee, SWMBH EO, and SWMBH Board.

A Performance Improvement/Corrective Action Plan may be required for any area where performance gaps are identified. This describes a project improvement plan of action (including methods, timelines, and interventions) to correct the performance deficiency. A corrective action/performance improvement plan could be requested of a SWMBH department, CMHSP, or Provider Organization. When a provider within the network is required to complete such a plan, the Provider Network department will be involved and a notification of the needed action and required response will be given to the provider. A sanction may be initiated based on the level of deficiency and/or failure to respond to a Performance Improvement/Corrective Action Plan request.

References:

BBA Regulations, 42 CFR 438.240
MDHHS –PIHP Contract Attachment P 6.7.1.1 et al
SWMBH Quality Management Policies 3.1 and 3.2
NCQA – 2018 MBHO Accreditation Standards – QI 11B
Quality Management Committee Charter

The Utilization Management (UM) Program purpose is to maximize the quality of care provided to customers while effectively managing the Medicaid, MI Health Link Duals Demonstration project, Healthy Michigan Plan, 1115 Medicaid Waiver Expansion, Autism Benefit, Habilitation Supports Waiver and SUD Community Grant resources of the Plan while ensuring uniformity of benefit. SWMBH is responsible for monitoring the provision of delegated UM managed care administrative functions related to the delivery of behavioral health and substance use disorder services to members enrolled in Medicaid, Healthy Michigan Plan, 1115 Medicaid Waiver, Autism Benefit, Habilitation Supports Waiver and SUD Community Grant. SWMBH is responsible to ensure adherence to Utilization Management related statutory, regulatory, and contractual obligations associated with the Michigan Department of Health and Human Services (MDHHS) Medicaid Specialty Services and SUD contracts, MI Health Link demonstration project contracts, Medicaid Provider Manual, mental health and public health codes/rules and applicable provisions of the Medicaid Managed Care Regulations, the Affordable Care Act, 42 CFR and the National Council on Quality Assurance (NCQA).

The UM program consists of functions that exist solely to ensure that the right person receives the right service at the right time for the right cost with the right outcome while promoting recovery, resiliency, integrated and self-directed care. One of the most important aspects of the utilization management plan is to effectively monitor population health and manage scarce resources for those persons who are deemed eligible while supporting the concepts of financial alignment and uniformity of benefit. Ensuring that these identified tasks occur is contingent upon uniformity of benefit, commonality and standardized application of Intensity of Service/Severity of Illness criteria and functional assessment

tools across the Region, authorization and linkage, utilization review, sound level of care and care management practices, implementation of evidenced based clinical practices, promotion of recovery, self-determination, involvement of peers, cross collaboration, outcome monitoring and discharge/transition/referral follow-up.

Behavioral Healthcare Practitioner Involvement
The SWMBH Utilization Management Program shall operate under the oversight of the SWMBH Medical Director and Director of Utilization Management and Member Engagement. The Medical Director and Director of Utilization Management and Member Engagement will provide clinical and operational oversight and direction to the UM program and staff and ensure that SWMBH has qualified staff accountable to the organization affecting customers.

To determine if UM program remains current and appropriate, QAPI evaluated:

UM Program Structure

- **2018 UM Program Description, Plan & Policies**
  - ✓ In compliance with contractual, state and regulatory and accreditation requirements and with Established UM standards. SWMBH ensures compliance through Access and Eligibility, Clinical Protocols, Service Authorization and Utilization Management.
  - ✓ Program Description of processes, procedures and criteria necessary to ensure cost-effectiveness, achieving the best customer outcome for the resources spent.
  - ✓ Management information systems adequate to support the UM Program.
- **Committees**
  - Regional Utilization Management Committee (RUM)
    - ✓ RUM Committee held monthly meetings
  - Regional Clinical Practices Committee (RCP)
    - ✓ RCP Committee held monthly meetings
    - ✓ RUM and RCP Collaborative Meetings held Quarterly
  - MI Health Link Committee meetings
    - ✓ MI Health Link Committee meetings held Quarterly

UM program scope, processes, information sources used to determine benefit coverage and medical necessity.

- **SWMBH UM Decision-Making:**
  - Ensuring uniformity
  - Service determinations based on medical necessity criteria and benefits coverage information.
  - Application of functional assessment tools, evidenced based practices and medical necessity criteria.
    - ✓ UM screening and assessment process contains the mechanisms needed to identify the needs and integration of care.
    - ✓ Tools used: Level of Care Utilization System (LOCUS); CAFAS (Child and Adolescent Functional Assessment Scale); SIS (Supports Intensity Scale) and ASAM-PPC (American Society for Addition Medicine-Patient Placement Criteria).
  - UM decision-making including application of eligibility criteria and level of care guidelines.
  - ✓ Clinical Criteria
  - ✓ Availability of Criteria
  - ✓ Consistency of Applying Criteria
  - ✓ Inter-rater reliability (IRR audit)
    - ✓ Consistency in Applying Criteria-Interrater reliability testing: Evaluated the consistency with staff involved in UM apply criteria in decision making.

Inter-Rater Reliability Results for SWMBH 2018

Date & Case	# of Raters	% Matching MNC Medical Necessity Criteria	LOCUS points
3/1/18 Rod – Book 18- LOC 3	12	100%	Range 16-22, clinician Override to OP (what client will accept)
5/3/18 Jasmin Should use ASAM not LOCUS	11	82% = SUD residential (9/11)	Range scores 19-26 agreement on LOC for SUD
6/28/18 Sergio – Continuing stay review	10	80% Cont. IP Stay 2/10 suggested Crisis Residential	Range 20-26, LOCUS - LOC's 4 and 5
8/16/18 Crystal (Book 24- LOC 5)	10	80% Crisis Res. or Specialized residential	Range 18-24 LOC 3-5
11/1/18 Gregg (Book Locus 20 LOC 4 – COD MI and SUD	10	50% - 5/10 OP 40% - 4/10 Detox/Res	Range 16-23 LOC 2-5
1/3/19 Arthur Locus 17 LOC 3	10	90% 9/10 – OP Meds & CSM or therapy	Range 16-18 LOC 2 & 3

- **Over and underutilization**
  - Outlier Management
    - ✓ Tools for monitoring analyzing and addressing outliers. SWMBH's performance indicators, service utilization data and cost analysis reports.
  - Access Standards
- ❖ The percent of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours (Standard 95%)
- ❖ The percent of new persons receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for services (Standard=95%)
- ❖ The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional (Standard=95%)
- ❖ The percent of discharges from a psychiatric inpatient unit who are seen for follow up care within seven days (Standard=95%)
- ❖ The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days (Standards=95%)
  - **66/68 Total Performance Indicators in 2017 met the State Standard of 95%**
    - **1st Quarter = 17/17**
    - **2nd Quarter = 17/17**
    - **3rd Quarter = 17/17**
    - **4th Quarter = 15/17**

- **Adequate timely Access to Services:**
  - ✓ Telephone Access to Services & Staff during business and after hour's toll-free access/crisis line.
  - ✓ Face-to-Face evaluation by regional CMHSP
  - ✓ Crisis services through inpatient hospitals, mobile crisis teams and urgent care center
  - ✓ Achieved a call abandonment rate of 5% or less.
  - ✓ Average answer time of 30 seconds or less.

Monitor the Complaint Tracking System 2018

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Monitor the Complaint Tracking System for Providers and Customers	➢ Monitor Grievance, Appeals and Fair Hearing Data ➢ Monitor denials and UM decisions for trends related to provider complaints For all business lines	✓ At a minimum quarterly reports on customer complaints to the QMC Committee; MHL Committee; RUM Committee and RCP Committee are reviewed. ✓ Ensure proper reporting, monitoring and follow-up resolution of Grievance and Appeals data including: • Billing or Financial Issues • Access to Care • Quality of Practitioner Site • Quality of Care • Attitude & Service	October 2017 – September 2018	QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Provider Network Director	Quarterly

2018 Grievance and Appeals

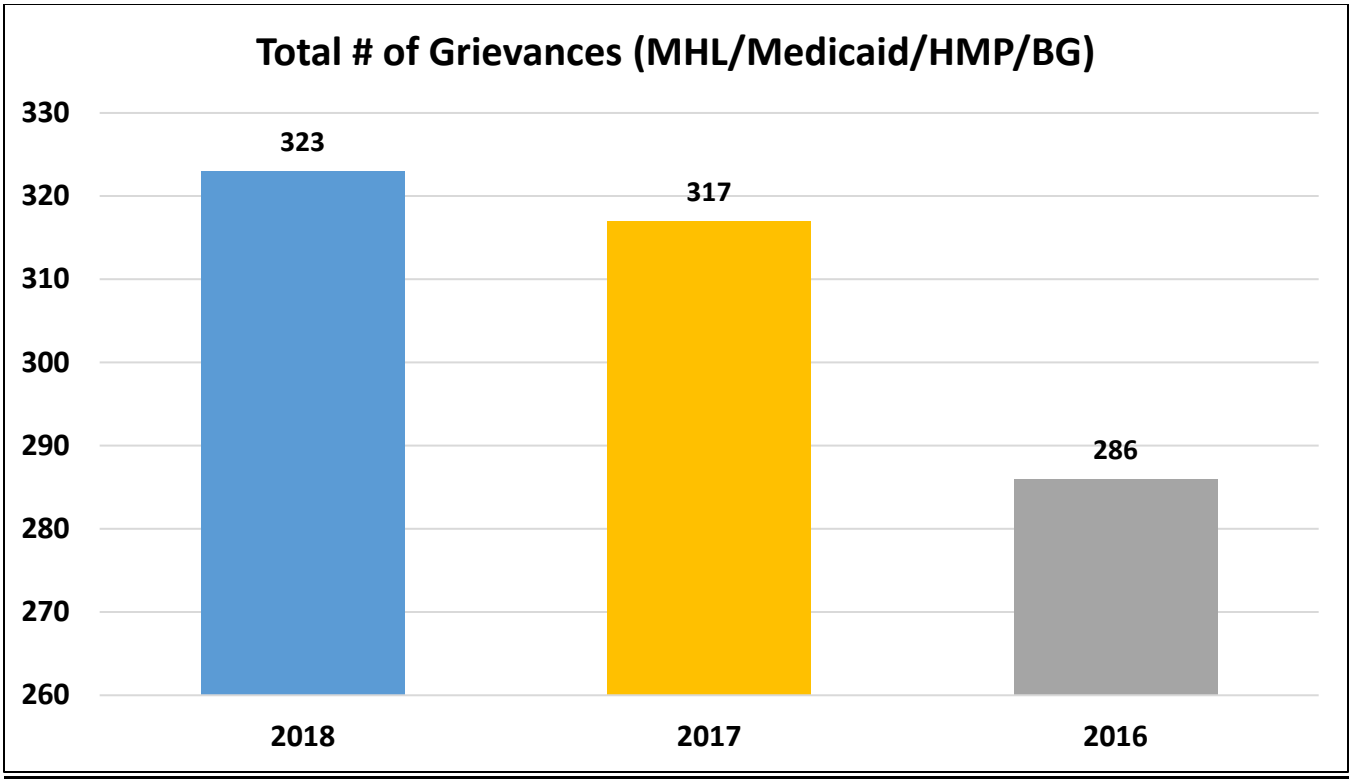
Customer Service Information: (Measurement Period: October 1, 2017 – September 30, 2018)

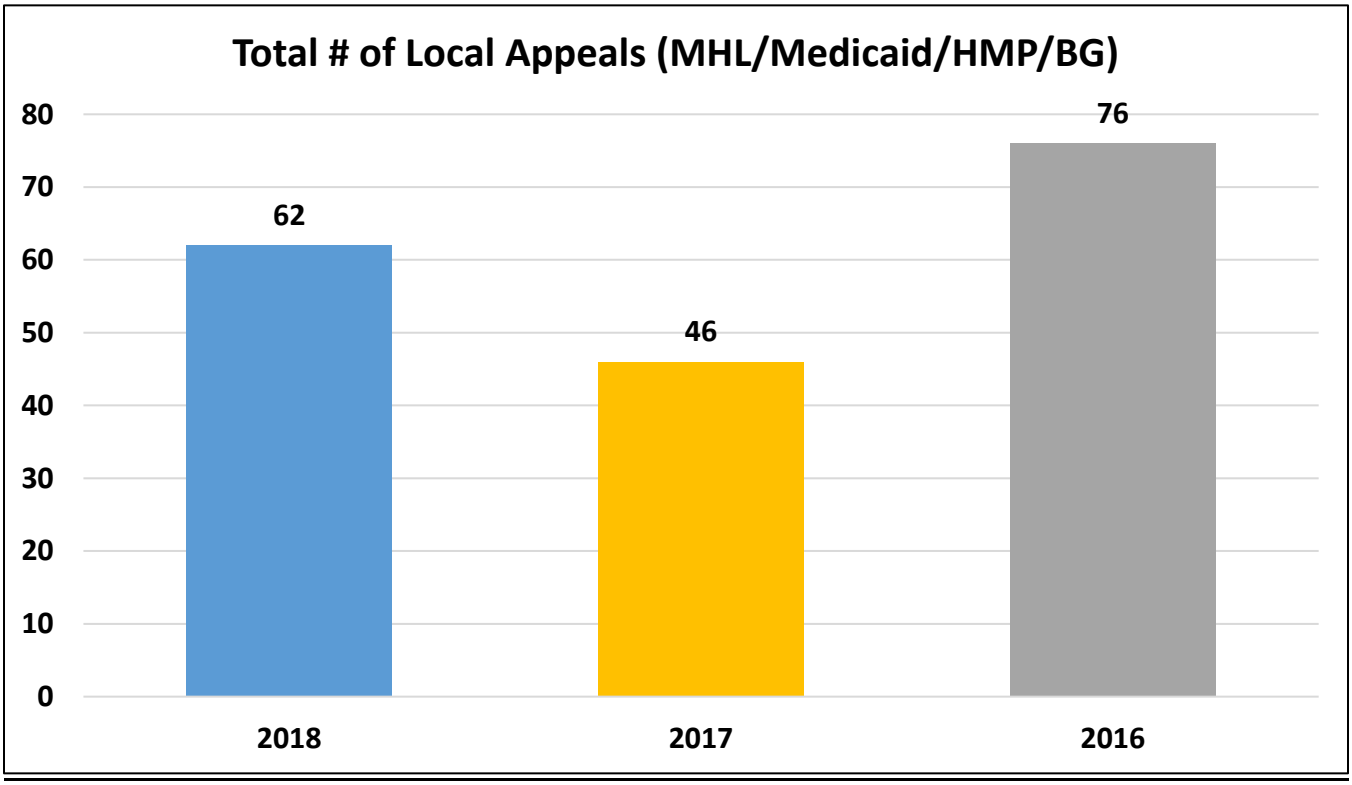
- ❖ In FY 18 Customer Service Fielded 4998 phone calls
- ❖ Completed 795 follow up calls
- ❖ 705 members were discharged form Substance Use Disorder Residential Settings
- ❖ 90 members were discharged from Inpatient Psychiatric setting

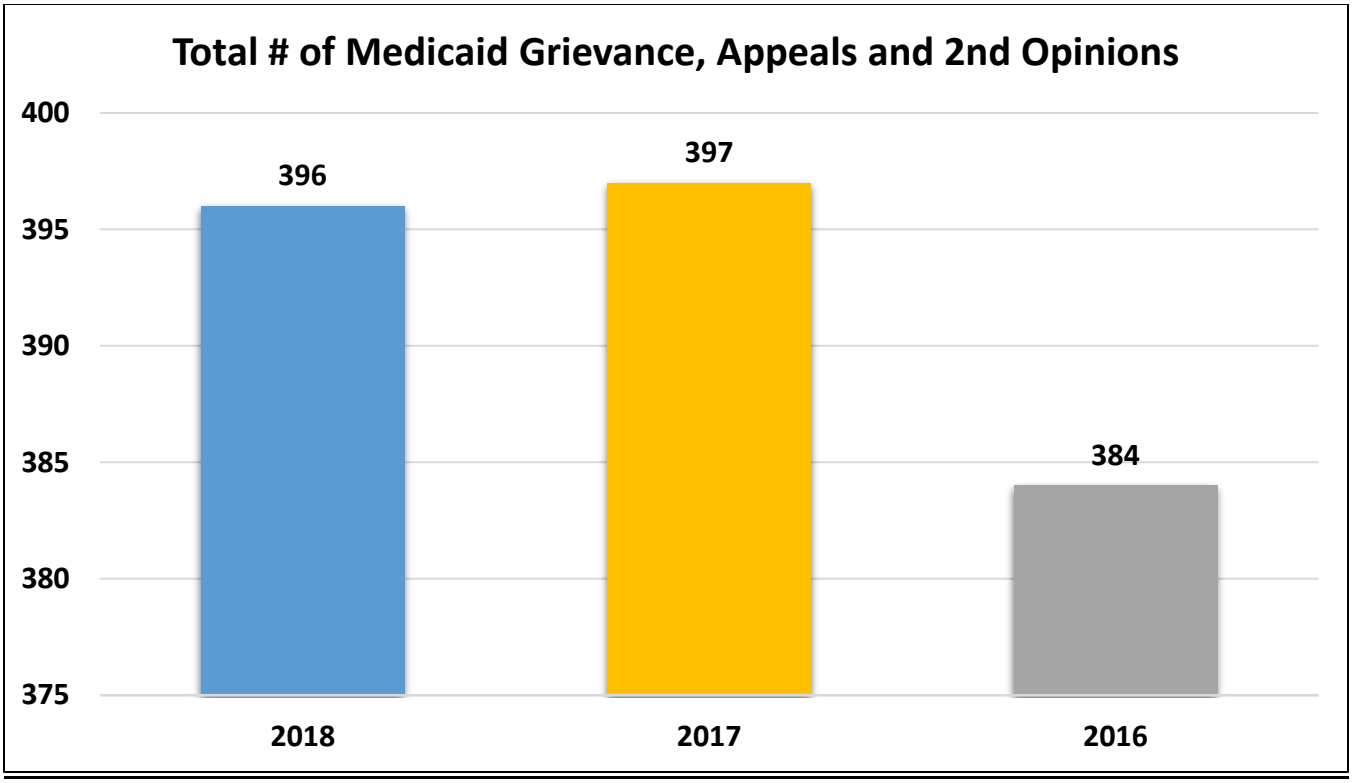
In FY 18 Customer Service Managed/provided oversite of 422 grievances and appeals:
❖ MA/HMP/BG Appeals reported: **57**
❖ MA/HMP/BG Grievances reported: **323***
❖ MA/HMP/BG/MHL Inquiries reported: **311**
❖ MA/MHL Fair Hearings reported: **11**
❖ MA/HMP/BG Second Opinions reported: **8**
❖ MI Health Link Grievances reported**: 20**
❖ MI Health Link Appeals reported: **5**

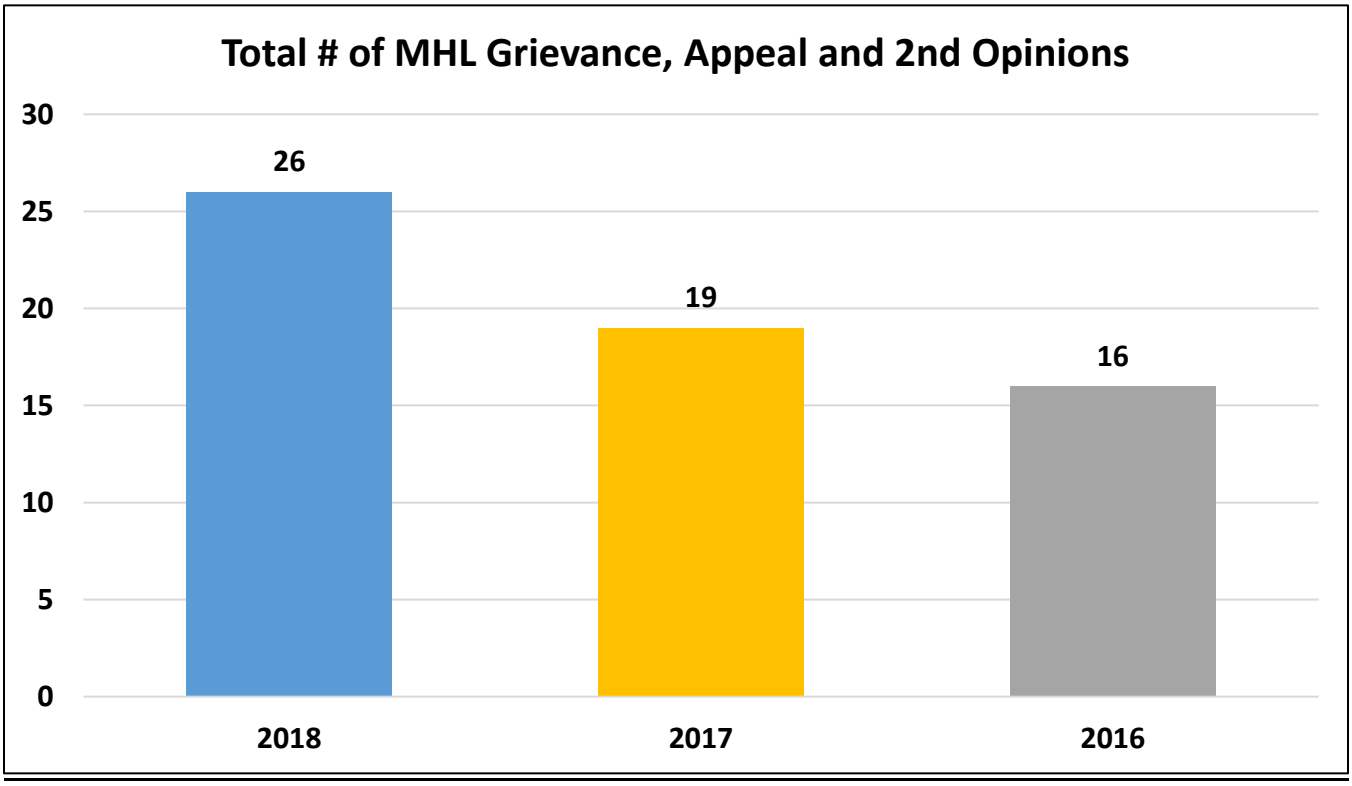
Southwest Michigan Behavioral Health						
Customer Grievance and Appeal Data FY 2017 - 2018						
SWMBH REGIONAL TOTAL (MA/HMP/BG)						
Activity	**Outcome**	**Q1**	**Q2**	**Q3**	**Q4**	**Total Events:**
Local Appeals Including: Termination Reduction Suspension of current services and Denial of additional services	Withdrawn		2	2		**4**
	Decision Upheld/Affirmed	11	7	5	9	**32**
	Decision Overturned	4	4	5	4	**17**
	Settled/Resolved			1	3	**4**
Access 2nd Opinions	Withdrawn					**0**
	Decision Upheld/Affirmed			1		**1**
	Decision Overturned	2				**2**
	Settled/Resolved					**0**
Hospital 2nd Opinions	Withdrawn					**0**
	Decision Upheld/Affirmed		1	2		**3**
	Decision Overturned	1	1			**2**
	Settled/Resolved					**0**
Administrative Medicaid (Fair) Hearing	Withdrawn			2		**2**
	Decision Affirmed	1		1		**2**
	Decision Overturned			1		**1**
	No Show	2		1		**3**
	Settled/Resolved					**0**
Grievances	Withdrawn	4	4	2	4	**14**
	Settled/Resolved	53	69	67	95	**284**
	Recipient Rights Referral	4	5	10	6	**25**
TOTAL Events:		**82**	**93**	**100**	**121**	**396**

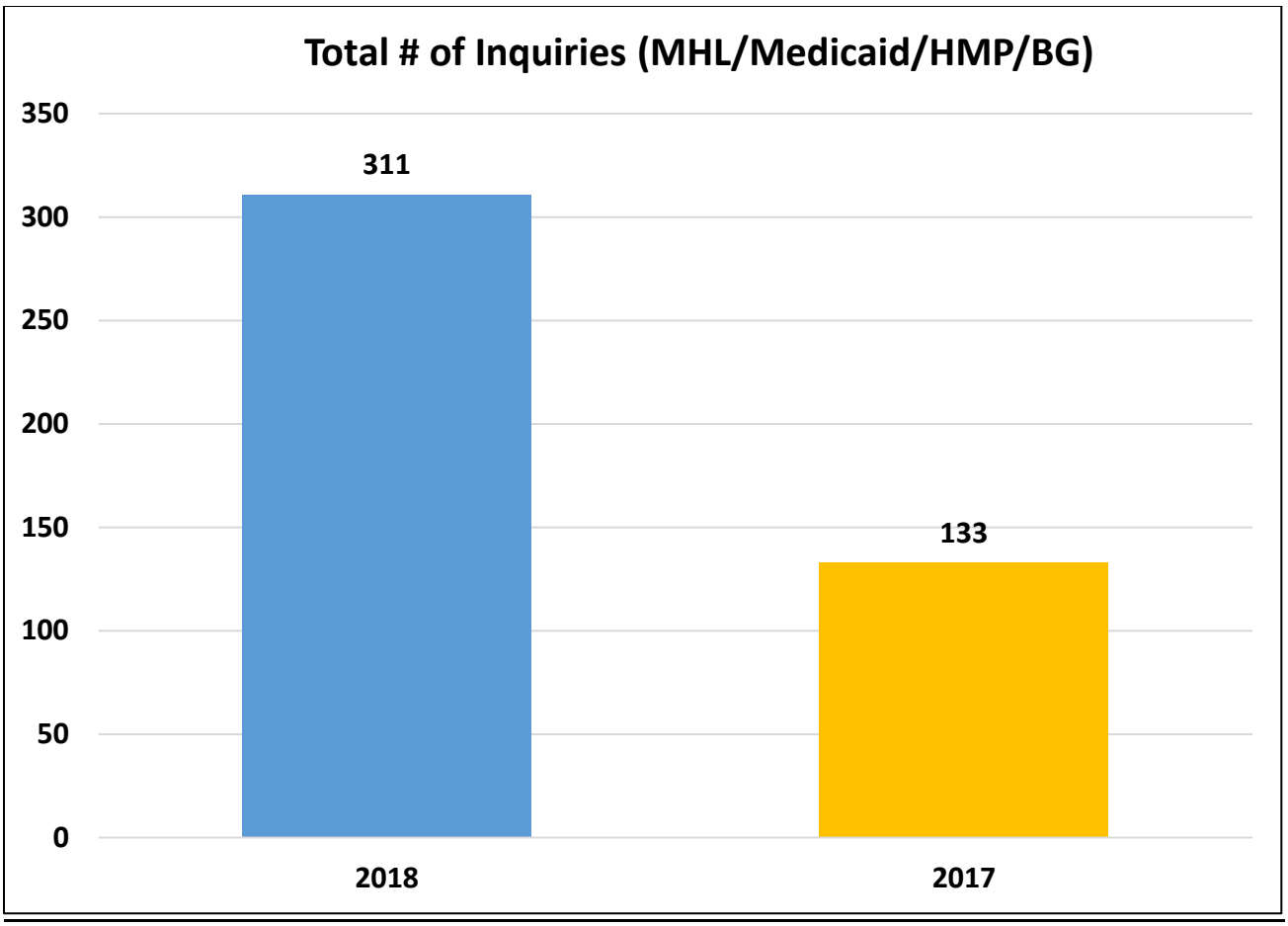
Southwest Michigan Behavioral Health						
Customer Grievance and Appeal Data FY 2017 - 2018						
SWMBH REGIONAL TOTAL (MHL)						
Activity	**Outcome**	**Q1**	**Q2**	**Q3**	**Q4**	**Total Events:**
Local Appeals Including: Termination Reduction Suspension of current services and Denial of additional services	Withdrawn					**0**
	Decision Upheld/Affirmed	3	1		1	**5**
	Decision Overturned					**0**
	Settled/Resolved					**0**
Access 2nd Opinions	Withdrawn					**0**
	Decision Upheld/Affirmed					**0**
	Decision Overturned					**0**
	Settled/Resolved					**0**
Hospital 2nd Opinions	Withdrawn					**0**
	Decision Upheld/Affirmed					**0**
	Decision Overturned					**0**
	Settled/Resolved					**0**
Administrative Medicaid (Fair) Hearing	Withdrawn					**0**
	Decision Affirmed	1				**1**
	Decision Overturned					**0**
	No Show					**0**
	Settled/Resolved					**0**
Grievances	Withdrawn					**0**
	Settled/Resolved	3		12	2	**20**
	Recipient Rights Referral					**0**
TOTAL Events:		**7**	**4**	**12**	**3**	**26**


Total # of Grievances (MHL/Medicaid/HMP/BG)
330
320
310
300
290
280
270
260
323
317
286
2018
2017
2016


Total # of Local Appeals (MHL/Medicaid/HMP/BG)
80
70
60
50
40
30
20
10
0
62
46
76
2018
2017
2016


Total # of Medicaid Grievance, Appeals and 2nd Opinions
400
395
390
385
380
375
396
397
384
2018
2017
2016


Total # of MHL Grievance, Appeal and 2nd Opinions
30
25
20
15
10
5
0
26
19
16
2018
2017
2016



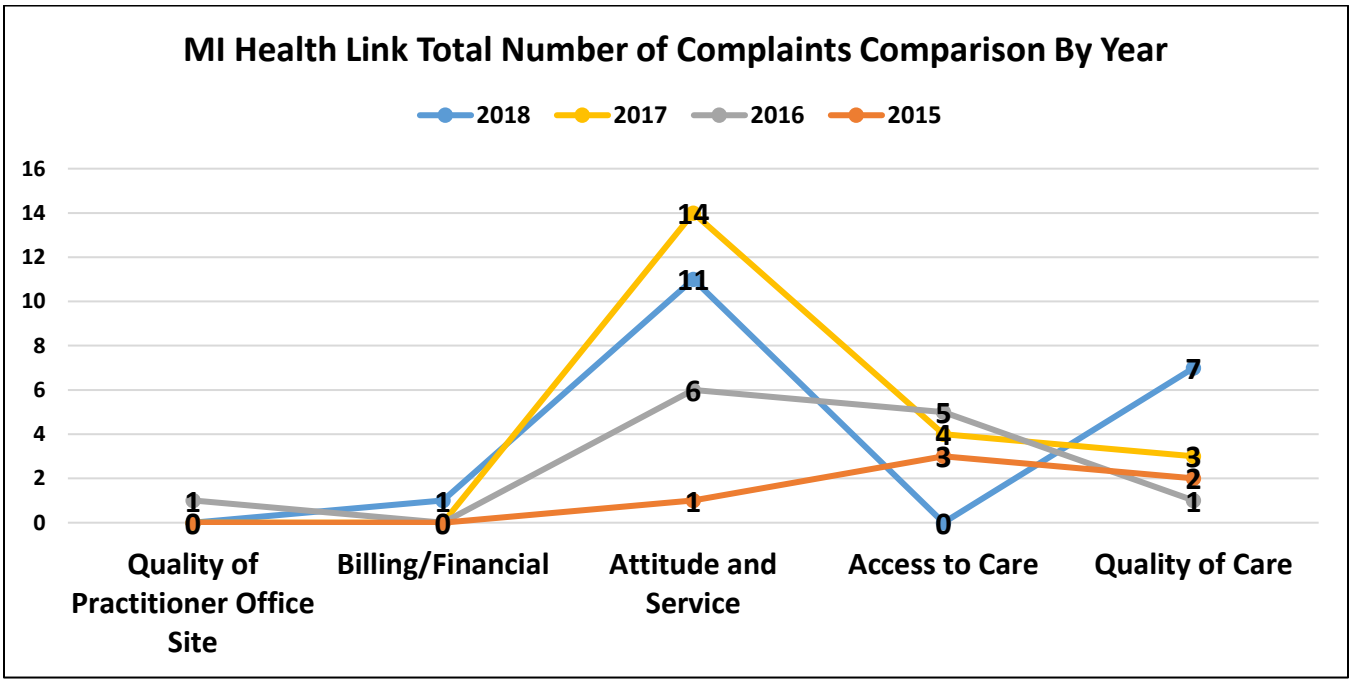
Causal Analysis of Grievance and Appeals

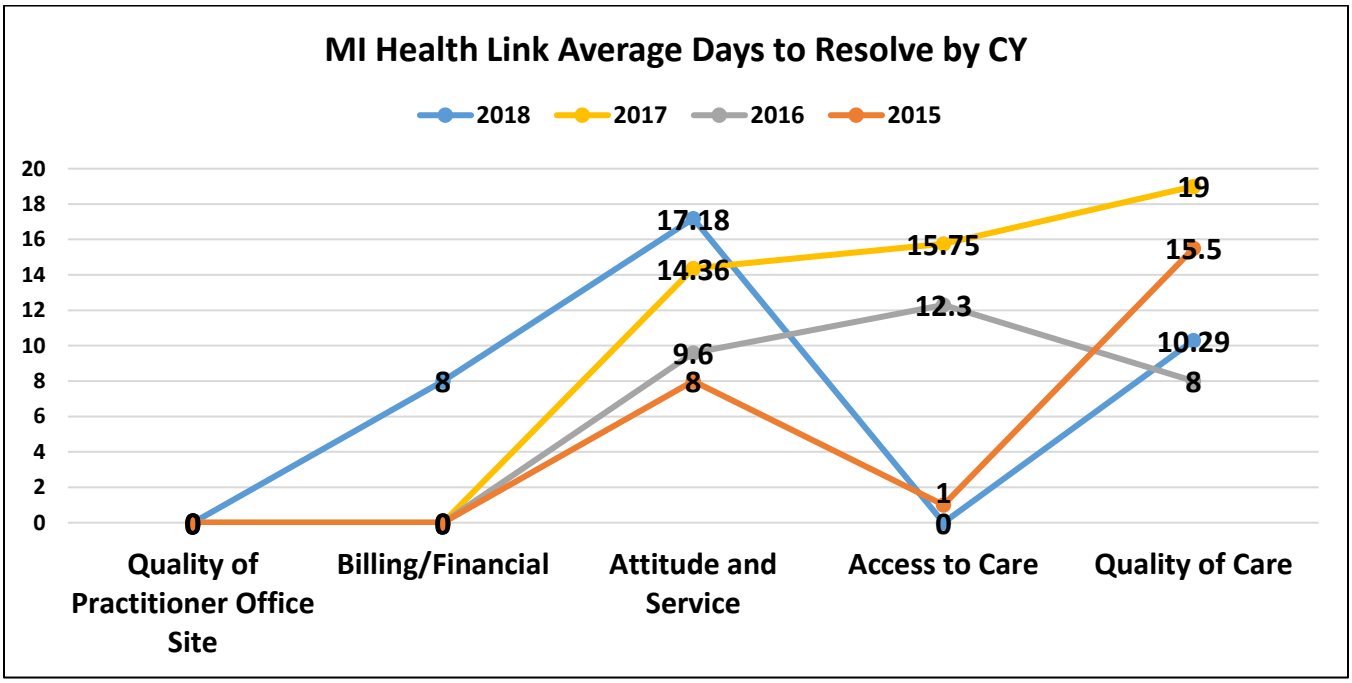
- The overall total number of grievances (MHL/Medicaid/HMP/BG) in 2018 was 323 which was a (+1.89%) increase from 2017 (317).
- There was also an increase in the total number of Local Appeals (MHL/Medicaid/HMP/BG) from 46 in 2017 to 62 in 2018 (+34.8%).
- The total number of Medicaid Grievance, and Appeals, and 2nd Opinions for FY 2018 was 396, (1) less than 2017 (-.25%) decrease.
- The total number of MHL Grievance, Appeal, and 2nd Opinions was (26) for 2018 which is a (+36.8%) increase from 2017 (19).
- The total number of Inquiries (MHL/Medicaid/HMP/BG) have increased from 133 in 2017 to 311 in 2018 (+133%).

It has been determined by the Regional Customer Services Committee that; if a consumer attempts to re-engage in services after being supplied an adequate action notice, within the given timeframe (12 days), services will continue without interruption and the incident is not tracked as an open appeal. If the consumer attempts to reengage after a given timeframe or if there are problematic issues surrounding the consumer and their services, an investigation will be conducted. When the investigation is performed, the incident is treated as a Local Level Appeal. Prior to 2016, anytime a consumer attempted to reengage in services after being supplied an adequate action notice, any attempt to reengage the consumer was considered a Local Level Appeal regardless of timeframe.

The Regional Customer Services Committee and the Regional Quality Assurance and Performance Improvement Committee will continue to review Grievance and Appeals data on a quarterly basis and follow-up on any trends that are identified.

2018 MI Health Link Complaints





MI Health Link Qualitative Analysis on Member Complaint Data

Complaints & Grievances- Casual analysis meeting to trend and analyze to access FY 2017 performance, identify opportunities for improvement and implement interventions.

The following table shows the aggregate complaint total and rate per 1,000 MHL members for the past three years

CATEGORY	2018 (9,586 MEMEBRS)	2017 (11,179 MEMBERS)	2016 (8,024 MEMBERS)	2015 (5,186 MEMBERS)
QUALITY OF CARE	3/0.313	3/0.268	1/0.125	2/0.386
ACCESS	0/0	4/0.358	5/0.623	3/0.578
ATTITUDE/SERVICE	11/1.148	14/1.252	6/0.784	1/0.193
BILLING/FINANCIAL	1/0.104	0/0	0/0	0/0
QUALITY OF PRACTITIONER OFFICE SITE	0/0	0/0	1/0.125	0/0
TOTAL	15/1.565	21/1.879	13/1.869	6/1.157

The following table shows complaints calculated by percentage of the above total for each category
Logic: Total Number of Complaint Category Divided by the Total Number of Complaints for the Year.

CATEGORY	2018	2017	2016	2015
QUALITY OF CARE	37%	14%	8%	33%
ACCESS	0%	19%	38%	50%
ATTITUDE/SERVICE	58%	67%	46%	17%
BILLING/FINANCIAL	5%	0%	0%	0%
QUALITY OF PRACTITIONER OFFICE SITE	0%	0%	8%	0%

Causal Analysis of MI Health Link Complaints

Objective:
SWMBH functional area departments held a causal analysis meeting with representatives from Member Services, Provider Relations, Quality Improvement and Claims departments. The Medical Director also participated.

Results:
There was one complaint under Quality of Practitioner Office Site, which was access to the building for handicapped individuals. Attitude and Service saw an increase in complaints in regard to telephone communication skill tips.

Identified Improvement Opportunities:

- Owners of Building notified to create handicap accessible ramp to building.
- Improve telephone communication skills by education and creating a Customer Service Phone Tip sheet for each Clinician. Suggestions included adopting a positive tone and answering the phone with a smile.
- MI Health Link Complaints and trends will be presented and discussed during MI Health Link Committee and Quality Committee monthly meetings.
- If trends are identified during reporting analysis, corrective action plans or other immediate actions may be taken to resolve the situation.

Consumer Involvement in Quality Assurance and Performance Improvement

The Annual Quality Plan and Evaluation is reviewed by the Regional Consumer Advisory Committee which includes 5-6 consumers. Consumer and provider input at the committee level is received through consumers who sit on the Regional Customer Services Committee, MI Health Link Committee, Quality Management Committee, and SUD Committees. This structure provides an opportunity for consumers and providers to review current analysis, trends and common denominators for programs and services and provide feedback on suggested opportunities for improvement.

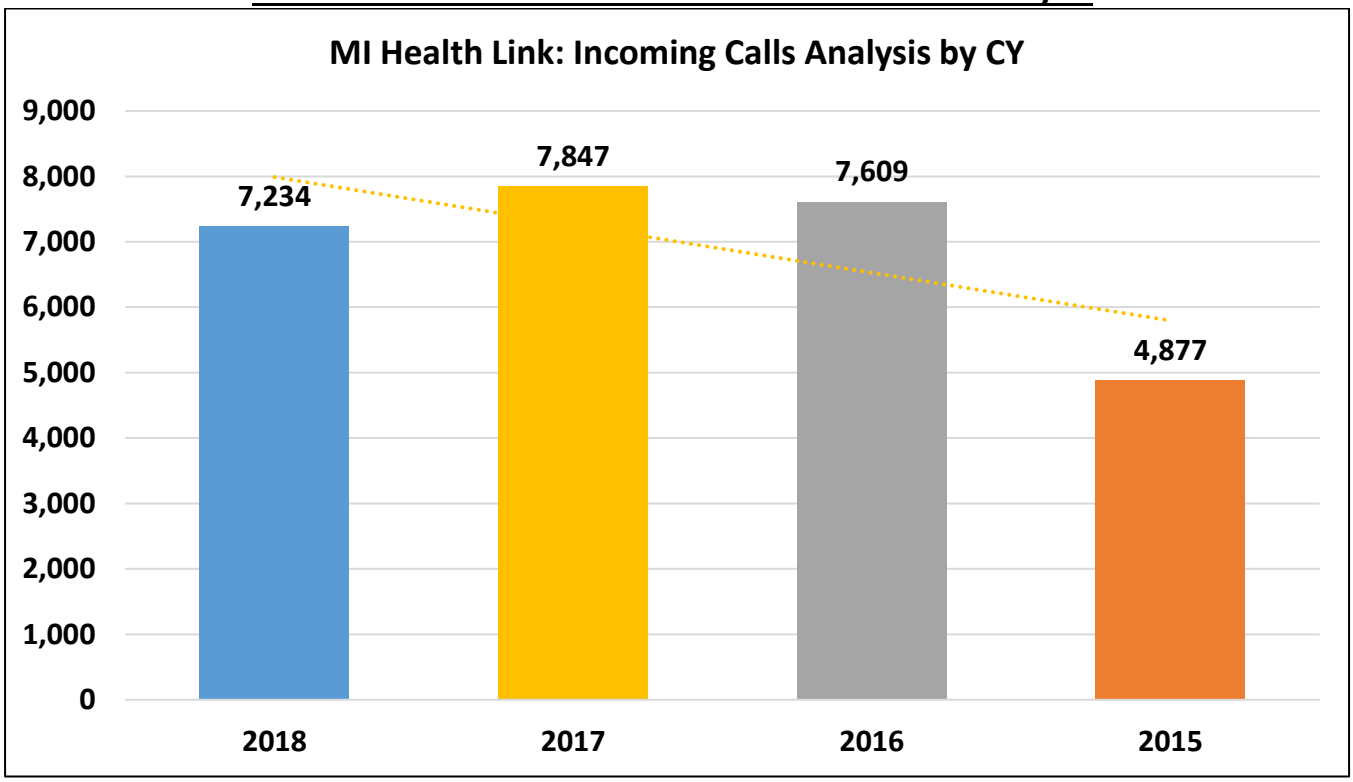
Input/Satisfaction Surveys
Consumer satisfaction is represented within the Quality Assurance and Performance Improvement Plan (QAPIP), Annual Quality Assurance Evaluation and through the annual Mental Health Statistics Improvement Program (MHSIP) and Youth Statistics Surveillance (YSS) surveys. The results and analysis reports are presented to the Quality Management Committee (QMC) and reflect overall SWMBH performance compared to state and national averages. Additionally, survey participant responses are reviewed and evaluated for trends. This consumer feedback is used by the QMC to improve processes and ultimately drive improvement in overall consumer outcomes.

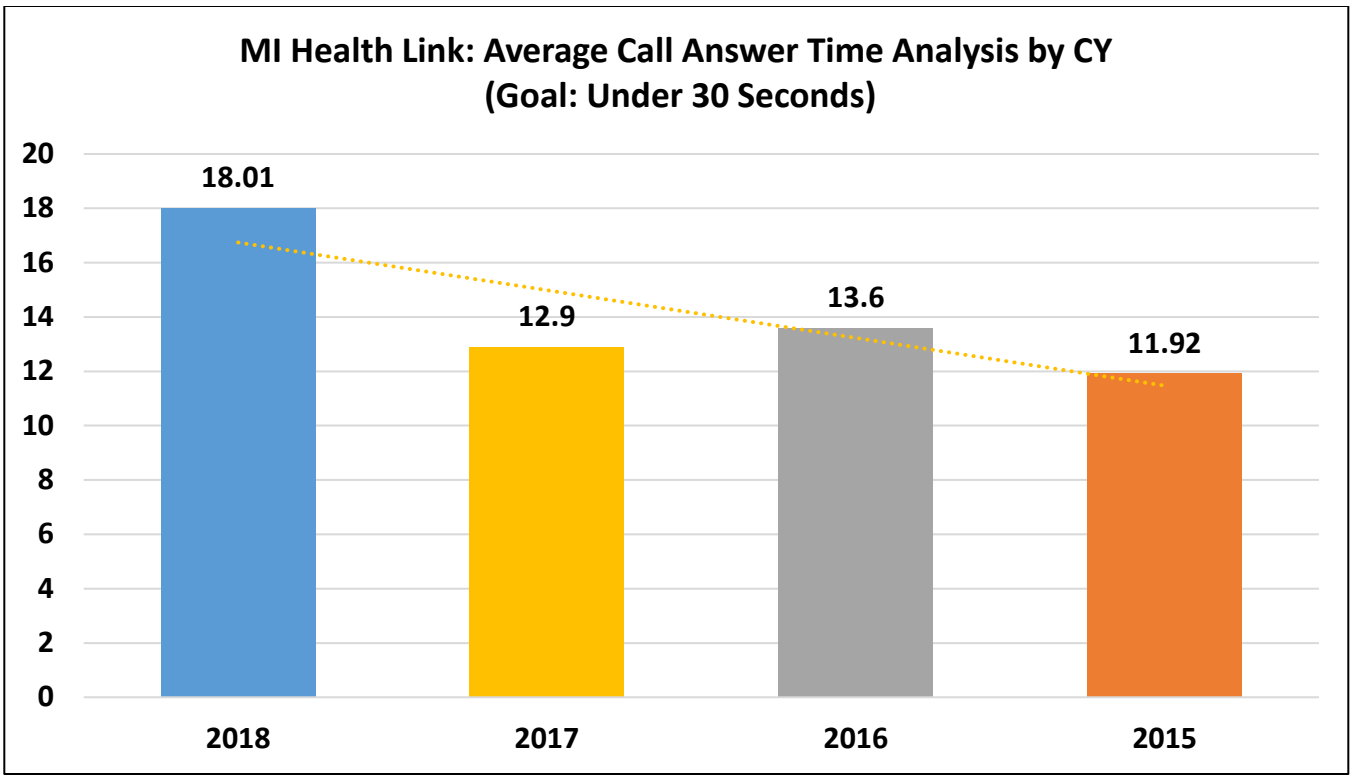
Providers administer the RSA-R survey. Several provider-based surveys required by NCQA exist between the mental health and primary care provider regarding how they receive collaborative information from each other. SWMBH also administers an online survey about access to care.
When surveys are completed, SWMBH follows a validation and review process with internal QAPI team members, Quality Management Committee, Regional Utilization Management and Clinical Practices Committee, and the Consumer Advisory Committee. Survey results, including narrative feedback, are to each committee, and the committees plan program adjustments, additional interventions and follow-up on significant concerns. If survey results were far below expectations, QAPI team members conduct a follow-up survey following the prescribed program adjustments and interventions.

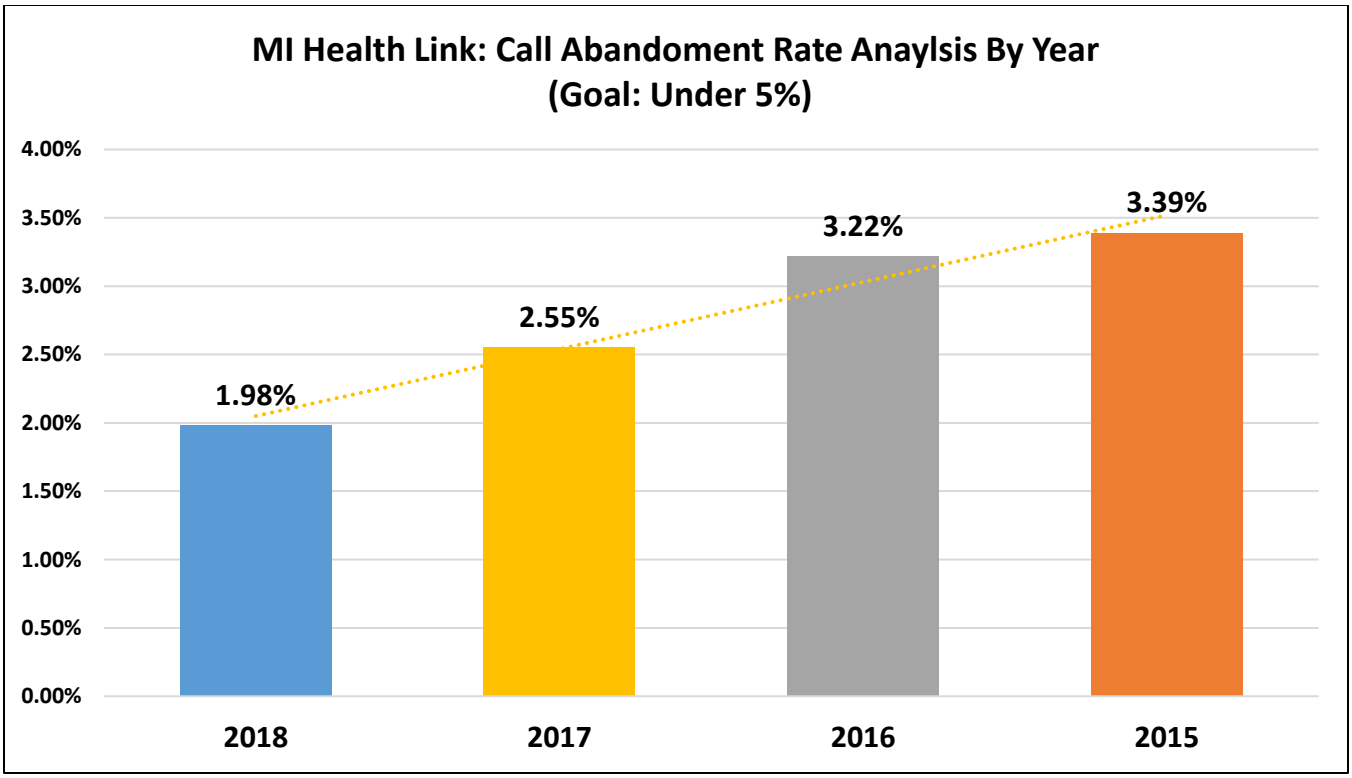
2018 Call Center Data Analysis

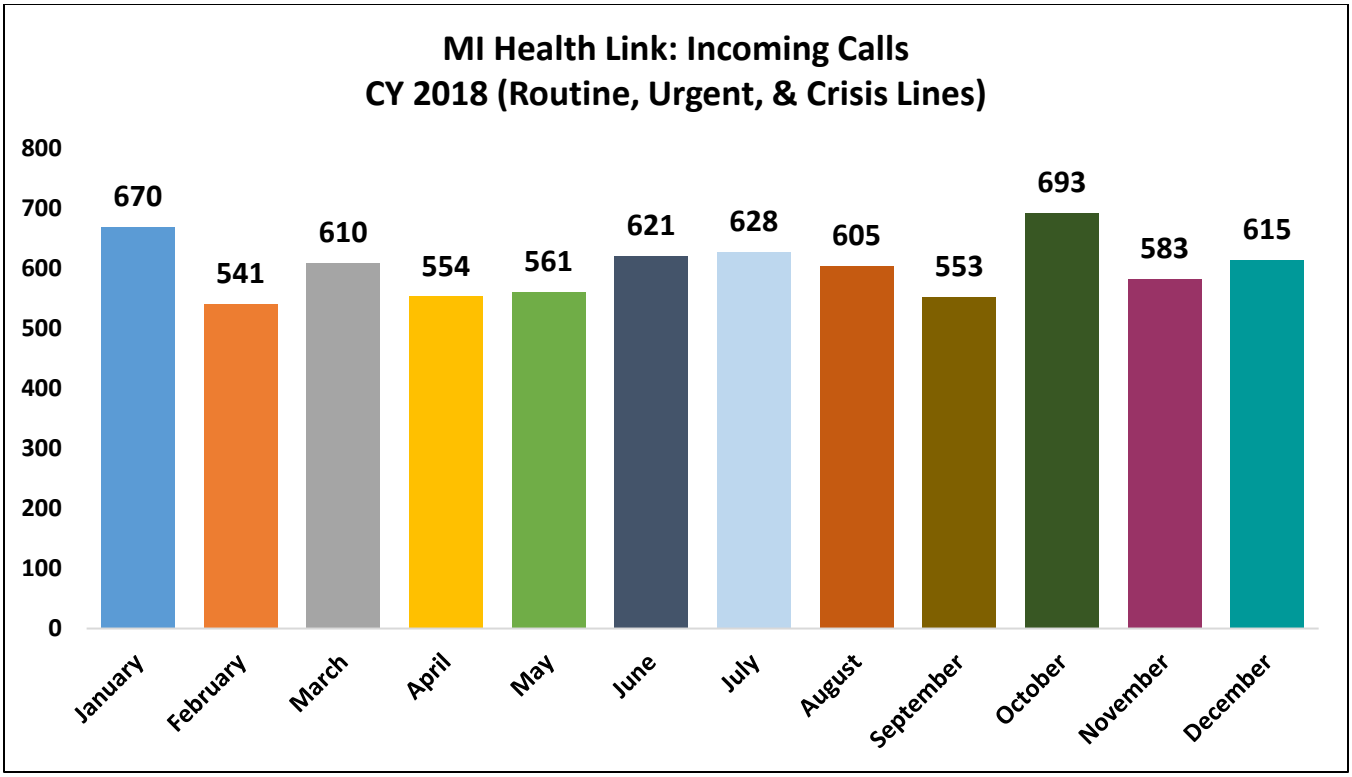
Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Call Center Monitoring (SWMBH reporting) for MI Health Link Business Line	➢ Ensure that a call center monitoring plan is in place ➢ Provide routine quality assurance audits. ➢ Random (live) Monitoring of calls for quality Assurance. ✓ Tracking and monitoring of all internal service lines (crisis, emergent, immediate and routine) ✓ Collect and analyze quarterly call reports submitted by CMHSPs	✓ A review of calls and agent performance to meet a scoring criteria of 96.25% performance rate is completed and evaluated. (*not required)* ✓ Achieve a call abandonment rate of 5% or less. ✓ Monitor number of calls received for each service line. ✓ Average answer time is confirmed as; 30 seconds or less. ✓ Service level standard of 75% or above. ✓ A minimum of 12 internal (UM) calls will be evaluated per month *(calls selected randomly across all available agents)*	January 2018 – December 2018	QAPI Specialist QAPI Director Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant	Monthly

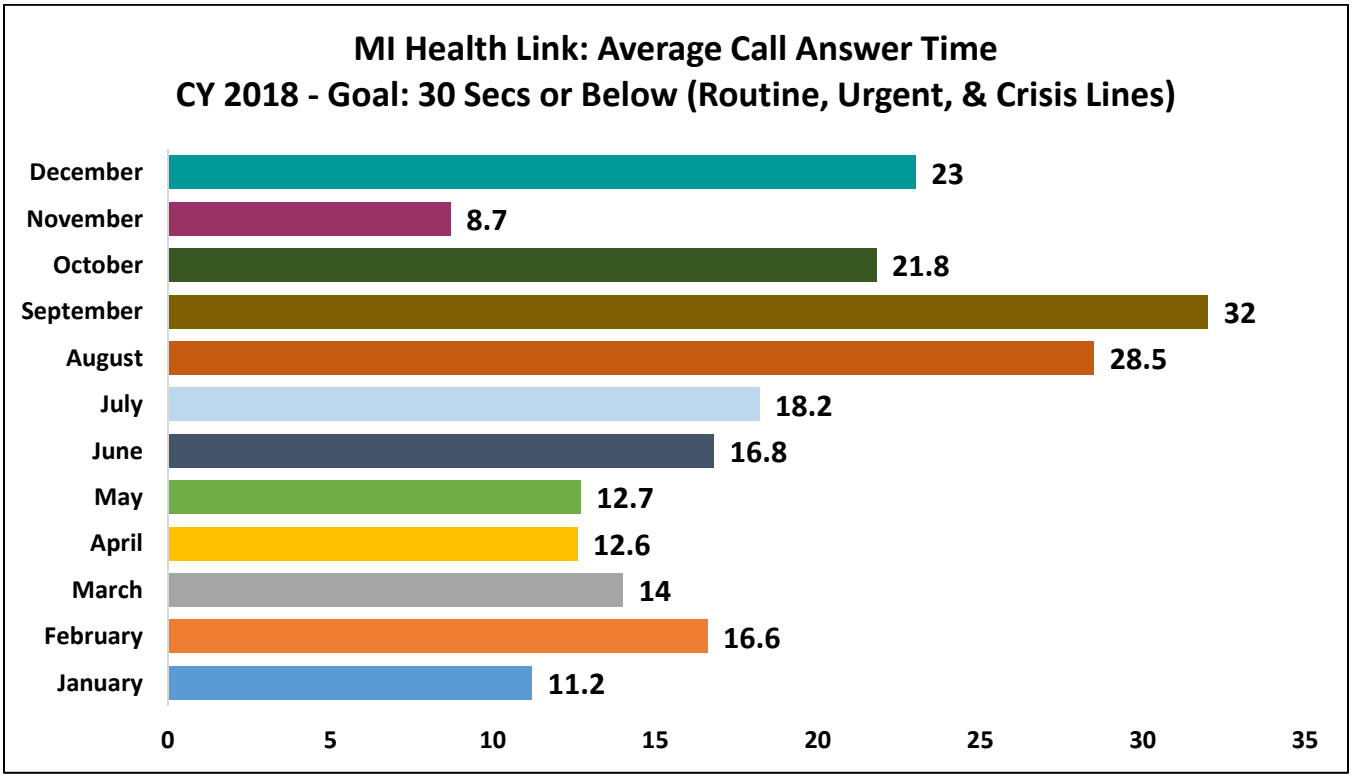
SWMBH 2018 MI Health Link Call Center Data Analysis

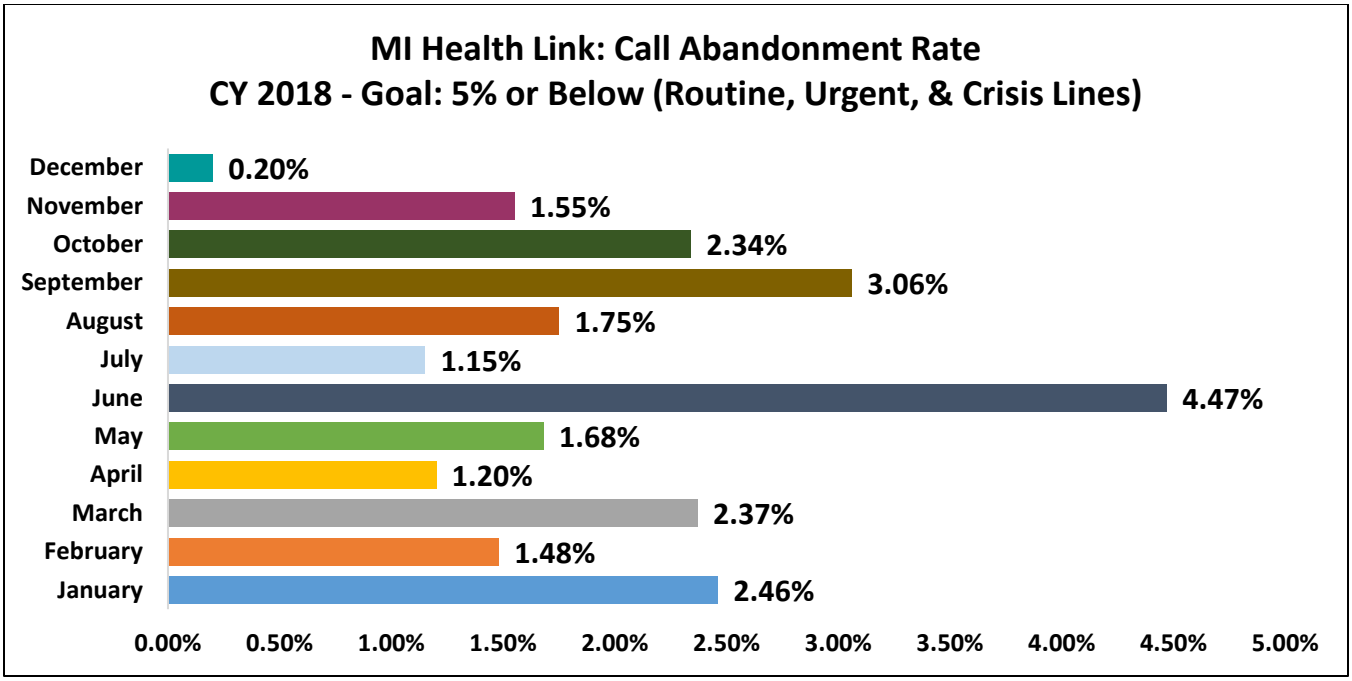



MI Health Link: Average Call Answer Time Analysis by CY
(Goal: Under 30 Seconds)
20
18
16
14
12
10
8
6
4
2
0
18.01
12.9
13.6
11.92
2018
2017
2016
2015


MI Health Link: Call Abandoment Rate Anaylsis By Year
(Goal: Under 5%)
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
1.98%
2.55%
3.22%
3.39%
2018
2017
2016
2015


MI Health Link: Incoming Calls
CY 2018 (Routine, Urgent, & Crisis Lines)
800
700
600
500
400
300
200
100
0
670
541
610
554
561
621
628
605
553
693
583
615
January
February
March
April
May
June
July
August
September
October
November
December


MI Health Link: Average Call Answer Time
CY 2018 - Goal: 30 Secs or Below (Routine, Urgent, & Crisis Lines)
December
November
October
September
August
July
June
May
April
March
February
January
23
8.7
21.8
32
28.5
18.2
16.8
12.7
12.6
14
16.6
11.2
0
5
10
15
20
25
30
35



Objective:

The Quality Improvement Department is primarily responsible for the oversight and management of all SWMBH quality programs and initiatives. The QI Department will appoint appropriate clinical SWMBH staff, deemed as appropriately trained in call auditing procedure and how to deliver constructive performance feedback to CM. The scores/evaluations are tracked over time so that call center staff can see progress, and senior leadership can identify trends and track ongoing improvements. Call center staff will receive evaluations upon completion of the monitoring form and be given the opportunity to ask questions, identify additional training needs and/or formulate a corrective action plan. Department supervisor(s) will be directly involved in situations in which employees receive negative performance feedback that may result in the activation of SWMBH's progressive discipline process and/or situations where call center staff continue to fail to improve call servicing skills.

Results:

All required call performance metrics stayed within acceptable ranges during 2018. Please find the current breakdown of call metric averages for 2018:

- Call Abandonment Rate: **1.98%**
- Call Answer Time: **18.01 seconds**
- Average Incoming Calls per Month: **603 Calls**
- Total Number of Incoming Calls for 2018: **7,234**

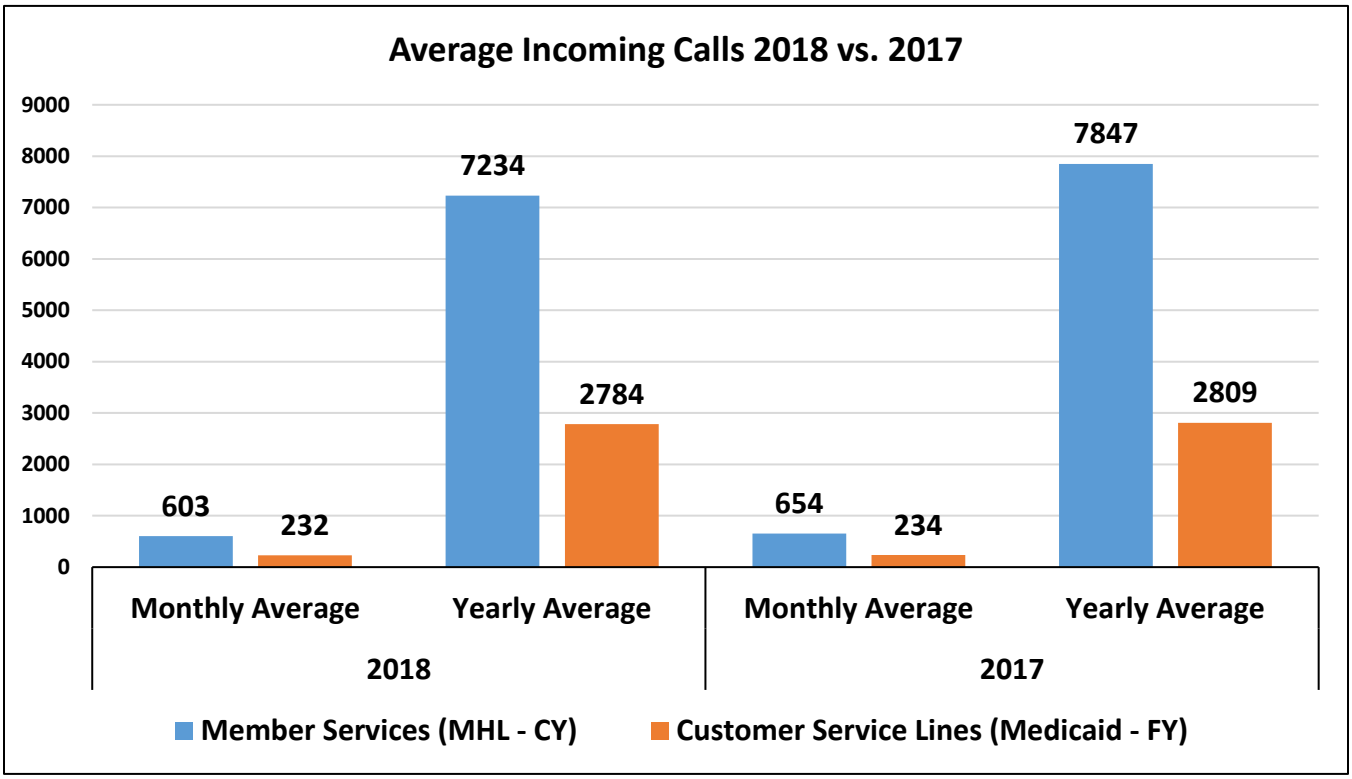
Identified Barriers:

Evaluation of Call Monitoring and Calibration Process.

Recommendations:

Calibration ensures that all SWMBH clinical staff, who have been deemed appropriate to engage in monitoring activities, rate call center staff interactions consistently and fairly. Calibration will occur on an annual basis and/or when new clinical staff are designated to perform monitoring activities. During each calibration session, multiple evaluators will independently score the same call center staff interaction.

2018 Annual Customer Service Call Analysis by Line



Enrollment and Eligibility Breakdown in the MI Health Link Demonstration

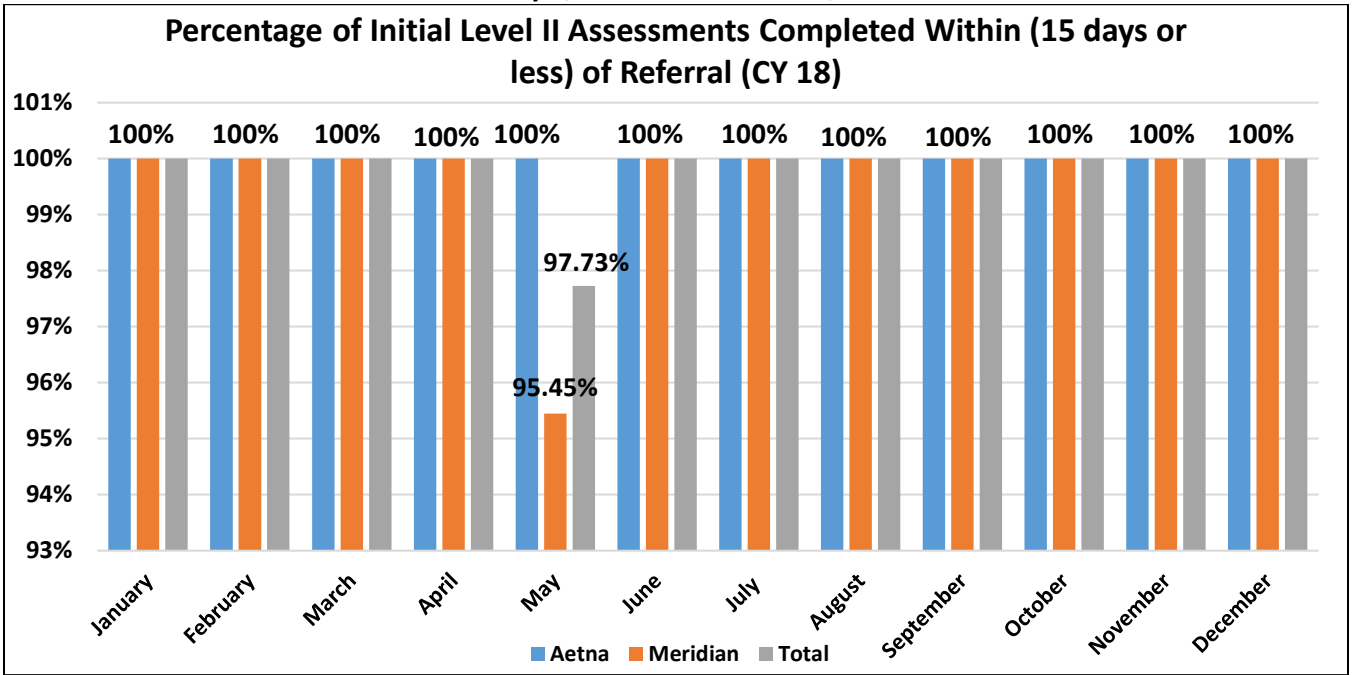
MI Health Link Enrollment by County (CY 2018):

**Data includes MI Health Link Business Line for both Aetna and Meridian (ICO Partners) **
Data Snapshot taken 1/23/19

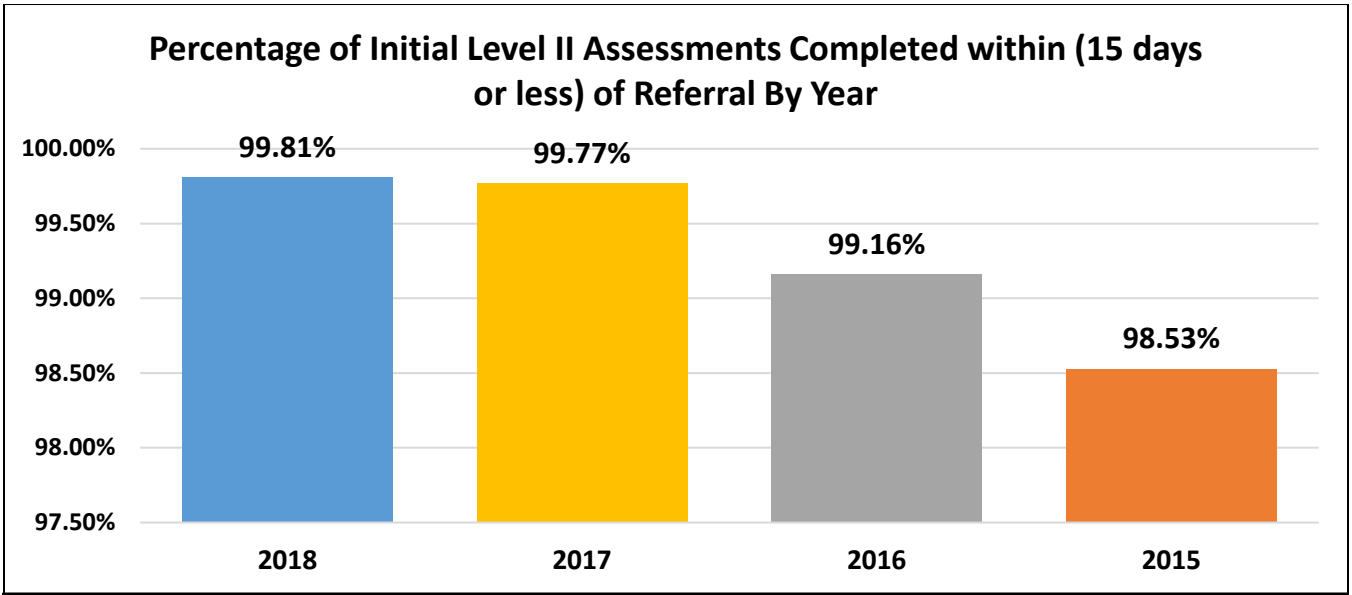
County Name	# Consumers Covered	# Consumers Served	# of Encounters
Kalamazoo	2,413	348	35,900
Berrien	2,097	166	14,000
Calhoun	1,932	282	9,031
Van Buren	1,053	135	7,700
St. Joseph	696	81	4,086
Cass	532	92	5,400
Branch	456	90	4,200
Barry	407	70	1,300
Total:	**9,586**	**1,264**	**81,617**

MI Health Link Level II Assessment Timeliness Report Analysis

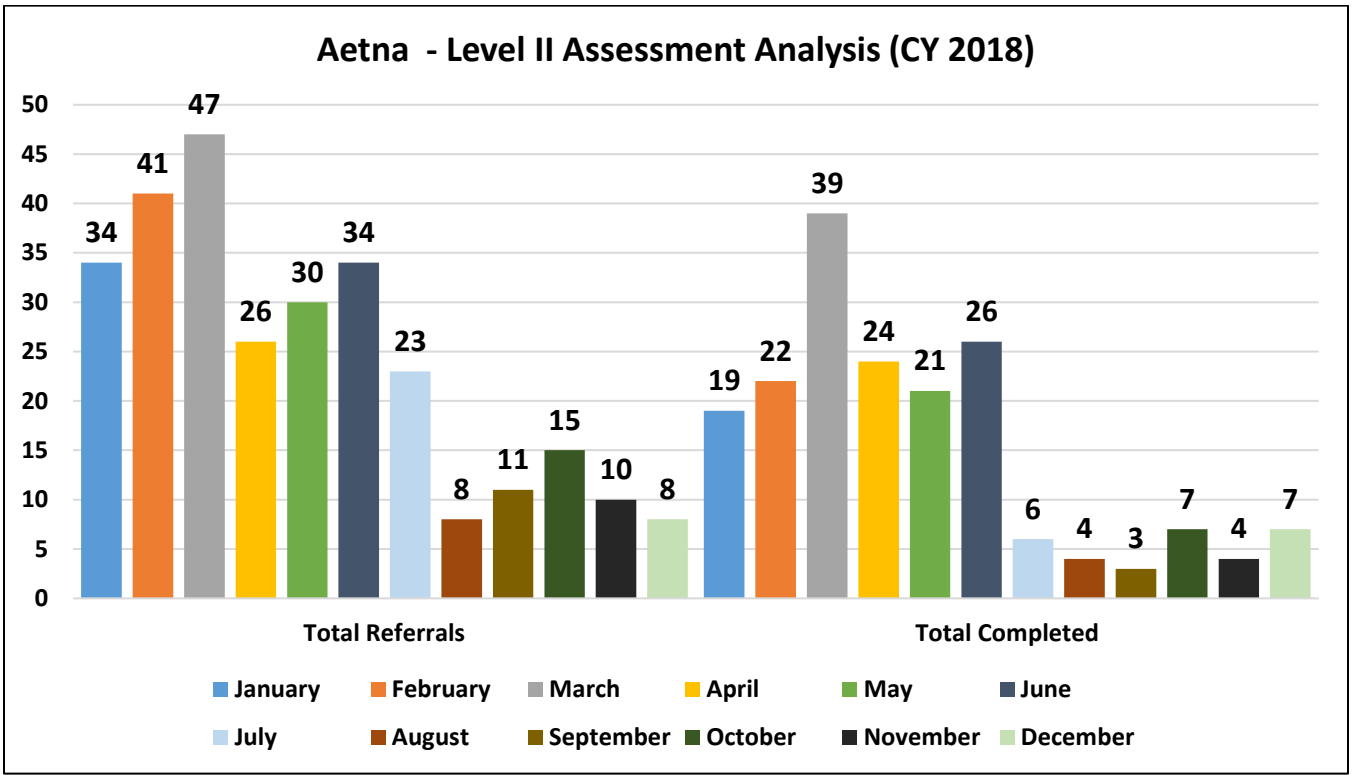
January 1, 2018 – December 31, 2018

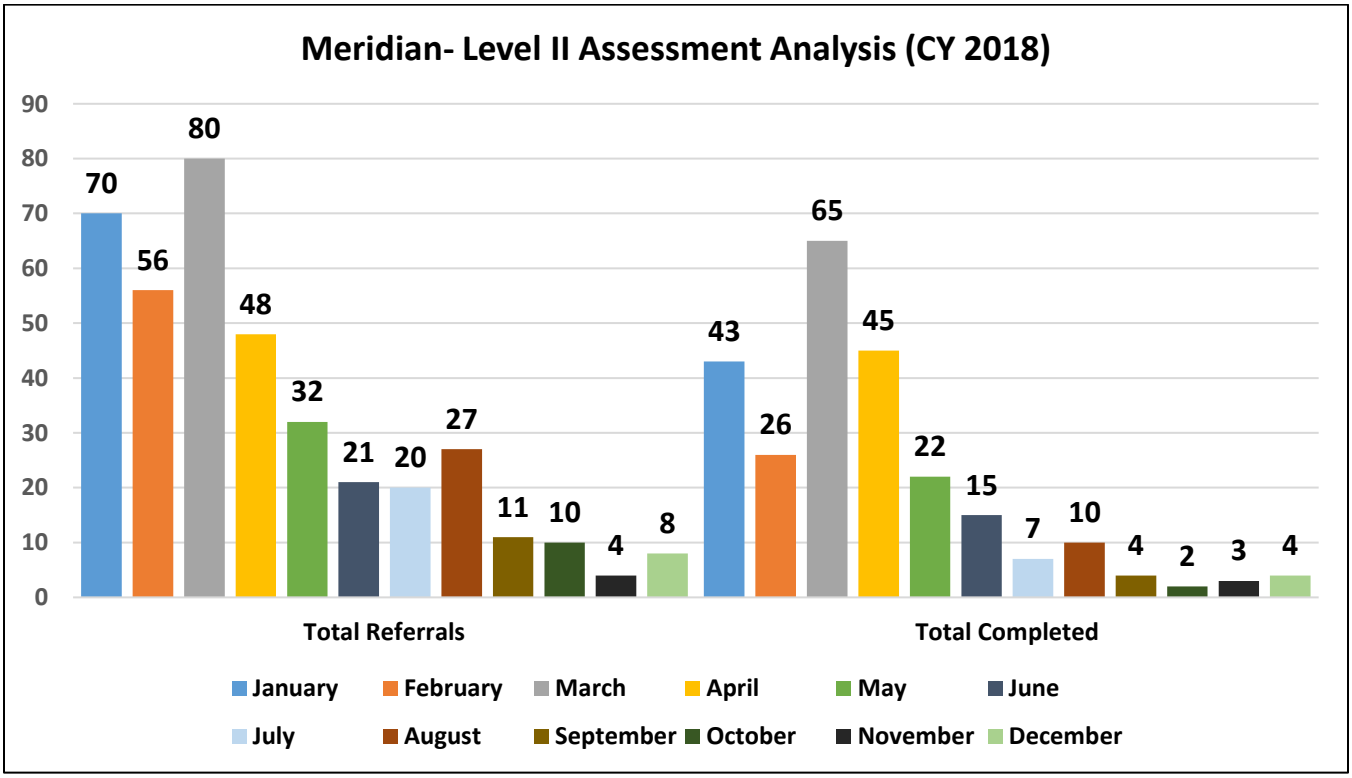


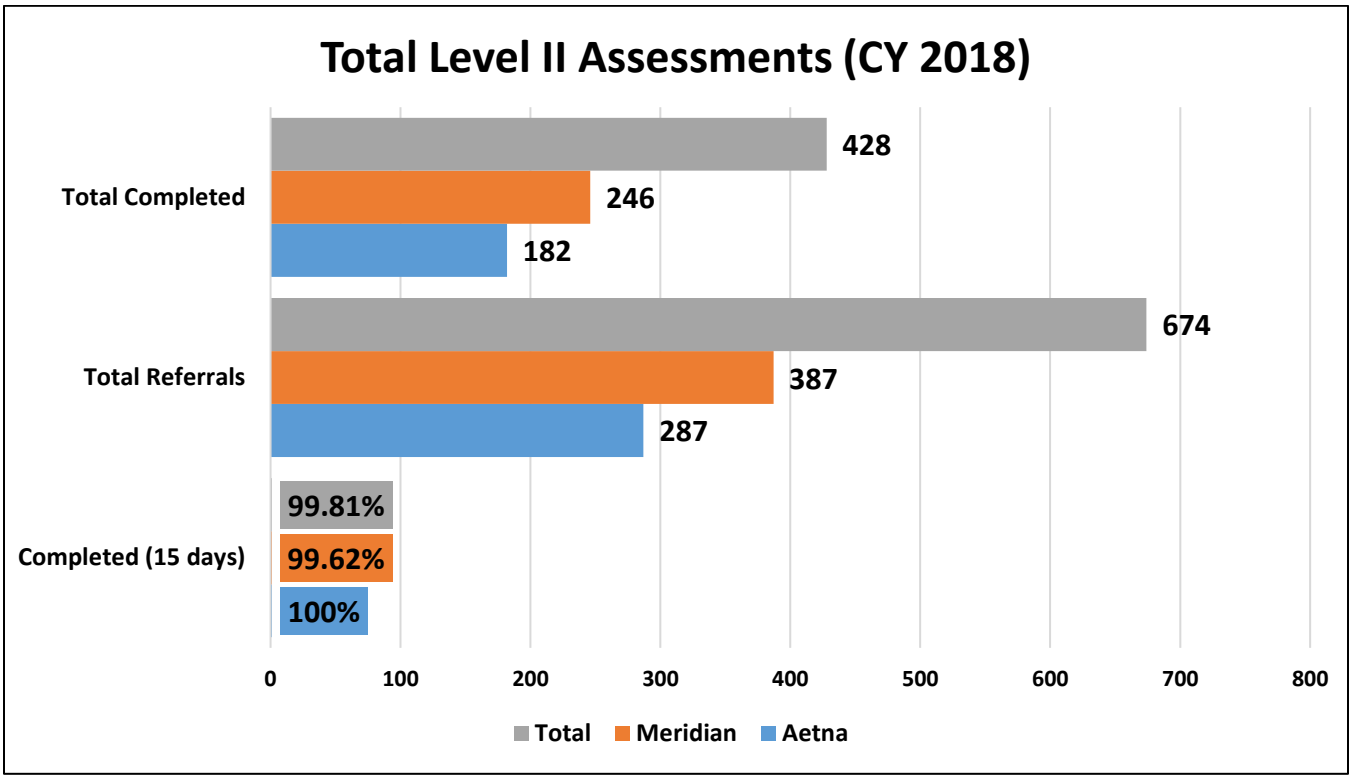
- **Target/Goals:** The MI Health Link Quality Performance Benchmark for the Level II Assessment Follow-up Timeliness Metric within (15 days) is 95% or above.
- In May 2018, 94.45% of Level II Assessments were completed creating an over total in 2018 of 99.81% of Level II Assessments achieved the Timeliness Standard of follow-up within (15 days).

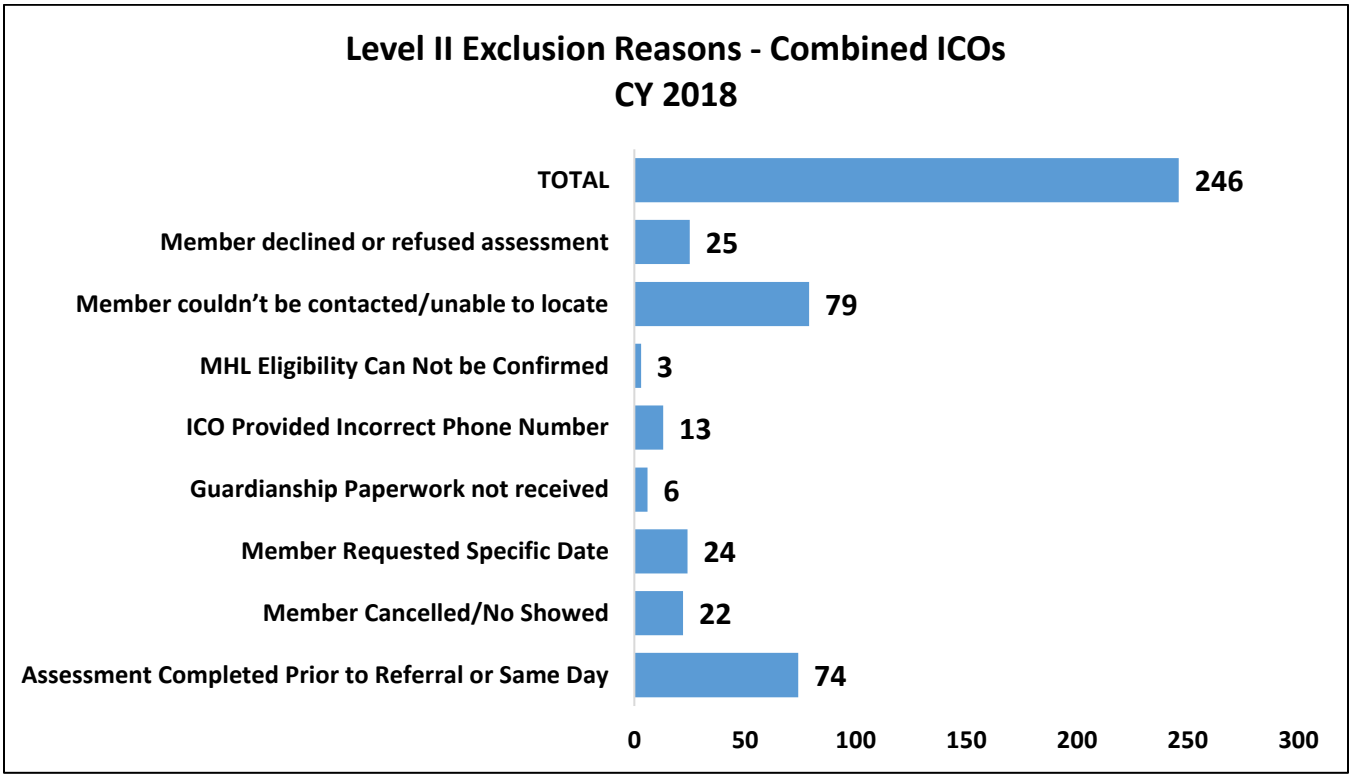


*2018 – 99.81% of referrals/appointments that have been scheduled within 15 days or less.
*2017- 99.77% of referrals/appointments that have been scheduled within 15 days or less.
*2016 - 99.16% of referrals/appointments that have been scheduled within 15 days or less.
*2015 – 98.53% of referrals/appointments that have been scheduled within 15 days or less.
*Report represents both Meridian and Aetna timeliness data.


Aetna - Level II Assessment Analysis (CY 2018)
50
45
40
35
30
25
20
15
10
5
0
34
41
47
26
30
34
23
8
11
15
10
8
19
22
39
24
21
26
6
4
3
7
4
7
Total Referrals
Total Completed
January
February
March
April
May
June
July
August
September
October
November
December


Meridian- Level II Assessment Analysis (CY 2018)
90
80
70
60
50
40
30
20
10
0
70
56
80
48
32
21
20
27
11
10
4
8
43
26
65
45
22
15
7
10
4
2
3
4
Total Referrals
Total Completed
January
February
March
April
May
June
July
August
September
October
November
December


Total Level II Assessments (CY 2018)
Total Completed
Total Referrals
Completed (15 days)
428
246
182
674
387
287
99.81%
99.62%
100%
0
100
200
300
400
500
600
700
800
Total
Meridian
Aetna


Level II Exclusion Reasons - Combined ICOs
CY 2018
TOTAL
Member declined or refused assessment
Member couldn't be contacted/unable to locate
MHL Eligibility Can Not be Confirmed
ICO Provided Incorrect Phone Number
Guardianship Paperwork not received
Member Requested Specific Date
Member Cancelled/No Showed
Assessment Completed Prior to Referral or Same Day
246
25
79
3
13
6
24
22
74
0
50
100
150
200
250
300

Objective:
The analysis measures; percentage of enrollees who completed a Level II Assessment within 15 days. The MI Health Link Quality Performance Benchmark for the Level II Assessment Follow-up Timeliness Metric is within (15 days) or 95% or above.

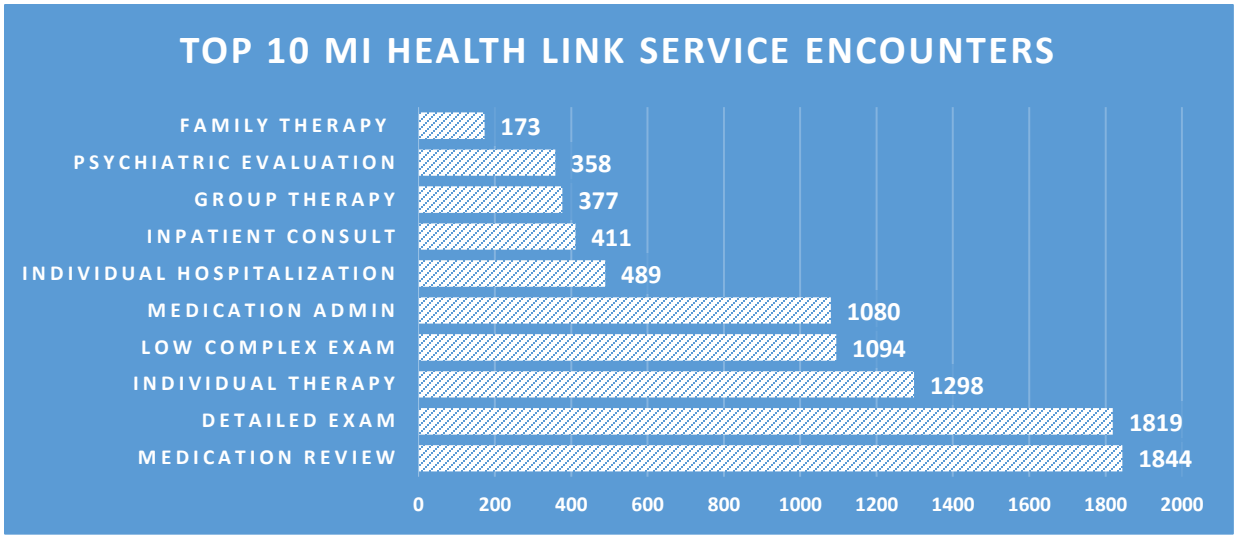
Results:
In 2018, 99.81% of consumers received an initial Level II Assessment within 15 days of a referral. This was a 0.04% increase compared to 2017 and a 0.65% increase from 2016.

Identified Barriers:
In May of 2018 the Call Center/UM staff were very short handed and going through a management transition. This led to the one Level II assessment not being followed up on (21/22 = 94.45%).

Recommendations:
SWMBH is currently working on the redevelopment of the Level II report in SmartCare. This will improve the validity and accuracy of the report.
Develop agreed upon methodology for Level II Assessment exclusion categories with Integrated Care Organizations.
Develop and agree upon a structured electronic referral and electronic Level II Assessment reporting mechanism (ICBR) or other.
Review Level II Assessment analysis and exclusion determinations during MHL Committee Meetings, on a quarterly schedule.

The graph below is the ICO Service Encounter Breakdown (FY2018) of the top 10 MHL services out of the many services offered:

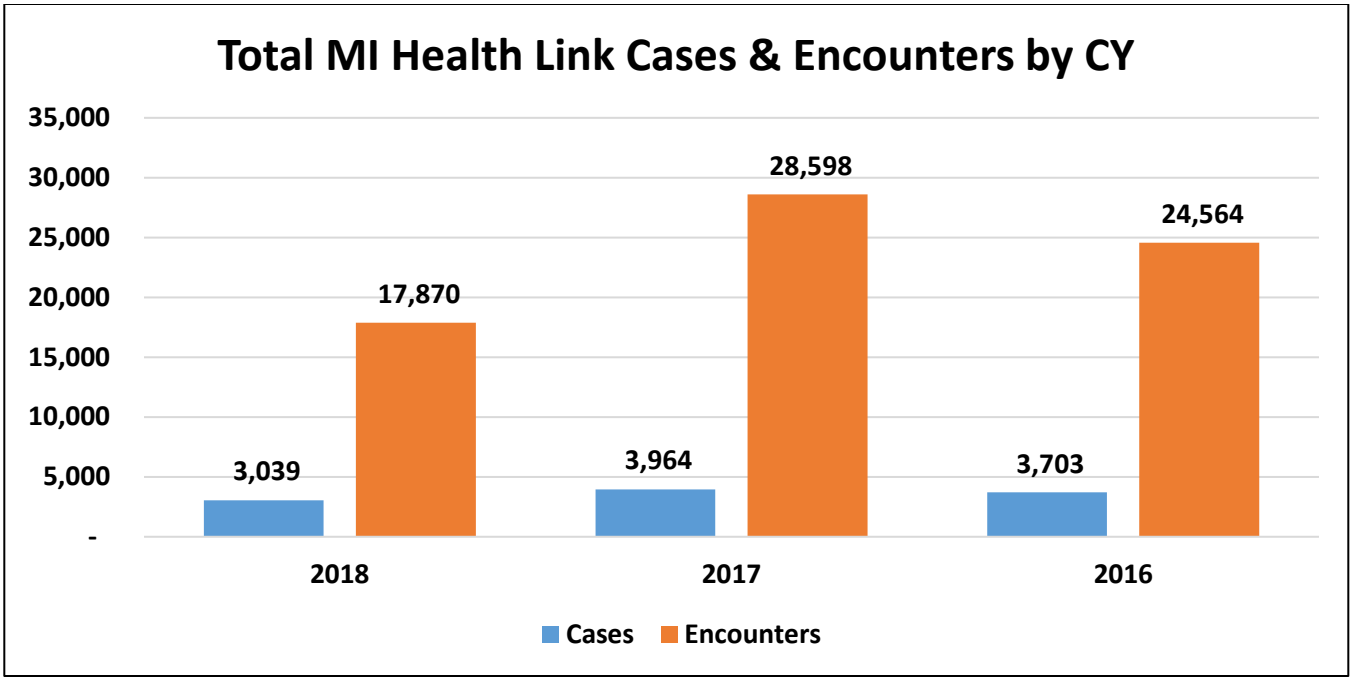
- Service Dates (October 1, 2017 through September 30, 2018)

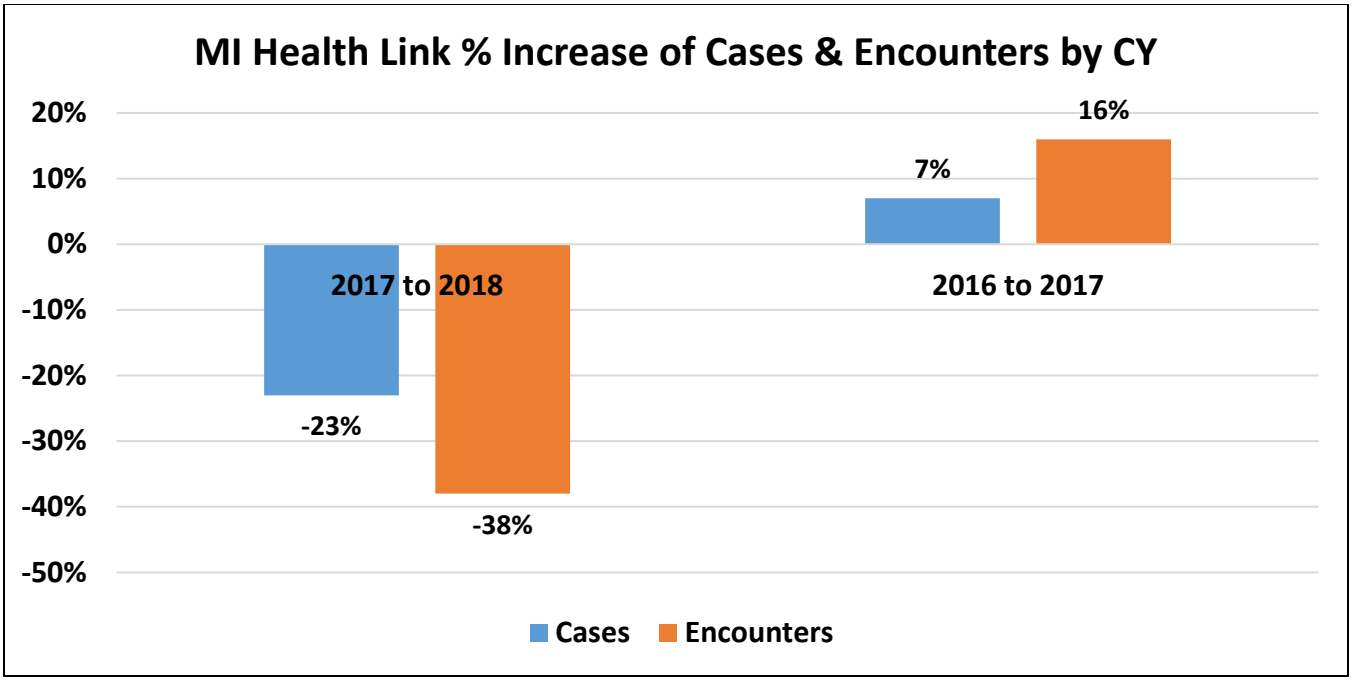


- Dashboard Includes Services Provided to both Aetna and Meridian Plan Members

Observations and Notes:

- A total of 17,870 consumer encounters occurred during CY 2018.





Observations and Notes:

- From CY 2017 to 2018 the total number of cases and encounters have decreased.
- **Encounters:** From 2017 to 2018: **-38%** (-10,728) and from 2016 to 2017: **+16%** (4,034).
- **Cases:** From 2017 to 2018: **-23%** (-925) and from 2016 to 2017: **+7%** (261).
- The decreases in cases and encounters from 2017 to 2018 are due to this being a CY measure not all the cases and encounters have been submitted for the year yet (i.e. October, November and December months).

Care Coordination

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Coordination of Care	➢ Monitors for continuity and coordination of care members receive across the network and actions improve. ➢ Demonstrate re-measurement for selected interventions. ➢ Quantitative and causal analysis of data to identify improvement opportunities. ➢ Collaboration with health plans to coordinate BH treatment for members.	✓ Use of Care Management Technology (CMT) and CC360 to measure: Exchange of information across the continuum of BH Services. ✓ Administration and analysis of Provider Survey on collaboration and coordination of care between behavioral healthcare and medical care. ✓ Measure and analysis of appropriate use of psychotropic medications. ✓ Measure and analysis of services/programs for consumers with severe and persistent mental illness. ✓ Develop an implement a procedure for Complex Care Management community Outreach to improve member engagement and coordination. ✓ Increase outreach and care coordination with regional ED to improve BH prescreening process and reduce IP admissions. ✓ Increase outreach to Veteran and Military Families that are not	October 2017 – September 2018	QAPI Specialist QAPI Director Customer Service Manager Chief Operations Officer Utilization Management Manager Director of Clinical Quality or Medical Director Consultant Director of Provider Network	Quarterly

Coordination of Care

- ❖ Coordination of care between medical and behavioral healthcare providers
- ❖ State mandate for Prepaid Inpatient Health Plans (PIHP)

Current Integrated Healthcare Goals:

1. Reduce the rate of ER use for chronic, non-emergent care
2. Reconnect patients to their PCP and CMH
3. Include patients in their coordination of care
4. Provide authorization for services as needed
5. Positively impact Population Health through coordination of care

Mental Illness Statistics

- ❖ Mood disorders (Major depression, dysthymic disorder and bipolar disorder) are the third most common cause of hospitalization in the US from age 18 to 44.
- ❖ Only 41% of adults with a mental health condition received mental health services in the past year.
- ❖ Suicide is the 10th leading cause of death in the U.S., the 3rd leading cause of death for people aged 10–24 and the 2nd leading cause of death for people aged 15–24.

PHIP Region 4 – High ED Use

- 96 patients had more than 6 ED visits during a 3 months period
- 36 of these patients have had PIHP contact – only about 1/3
- 6 to 17 visits per patient per 90 days
  - ➢ Up to once a week, per patient, for 90 days
- 701 total ED visits for these 96 patients = 87.6 visits over 90 days
  - ➢ Improved CMH/ED integration could potential reduce ED visits by 1 visit/county /day in Region 4

Medicaid ER to Hospitalization with and without Behavioral Health Diagnosis

Medicaid Consumers Only (June 1, 2017 – June 30, 2018)

	Total ER Visits (Behavioral and Non-Behavioral)			Behavioral ER Visits				Non-Behavioral ER Visits			
County	Total ER Visits	ER with No Hospital Admits	ER with Hospital Admits	Total ER Visits	ER with No Hospital Admits	ER with Hospital Admits	% with Hospital	Total ER Visits	ER with No Hospital Admits	ER with Hospital Admits	% ER with Hospital
All	202348	186163	16185	7487	5604	1883	25.15%	194861	180559	14302	7.34%
Barry CMH	9615	8812	803	332	249	83	25.00%	9283	8563	720	7.76%
Riverwood Center	39813	36715	3098	1003	780	223	22.23%	38810	35935	2875	7.41%
Pines Behavioral Health	11536	10726	810	377	254	123	32.63%	11159	10472	687	6.16%
Summit Pointe	35982	32771	3211	1279	991	288	22.52%	34703	31780	2923	8.42%
Woodlands Behavioral Health	10306	9607	699	243	200	43	17.70%	10063	9407	656	6.52%
KCMHSAS	54385	49824	4561	2798	2020	778	27.81%	51587	47804	3783	7.33%
CMHSAS-SJC	15285	14269	1016	423	349	74	17.49%	14862	13920	942	6.34%
Van Buren CMH	20778	19309	1469	582	467	115	19.76%	20196	18842	1354	6.70%

Quality and Value Evaluation

In order to **Improve Lives – and Prove It**, we are embarking on a multi-year, collaborative, systematic, and systemic effort to explicitly define, measure and publicly report on the areas below:

- Improving behavioral health
- Improving physical health
- Reducing avoidable behavioral and physical health service utilization
    - Avoid hospital readmissions
    - Avoid medical-surgical hospitalizations for ambulatory sensitive conditions
    - Avoid improper emergency department use
- Improving social functioning
    - Stable housing nights
    - Food stability
    - Increased work and school days
    - Avoid or reduce police contacts, criminal justice involvement and jail days

Drivers:

- Expert clinical assessment and proper documentation
- Common normed functional, level of care, utilization and outcomes Tools
- Clear evidence-based practice requirements, client matching, fidelity and fidelity monitoring
- Common Clinical Pathways, Clinical Protocols and Clinical Algorithms
- Shared Specialty Clinical Expertise
- Consumer Engagement
    - Self-Determination
    - Website Portal
    - Assistive Technology
- Consumer Supports
    - Peer Support Specialists
    - Recovery Coaches
    - Family and friends Supports
    - Social Determinants of Health Supports and Services
    - Quality of Care
    - Over or under utilization
    - Hospital Follow-Up

Strategic Plan Elements:

- Coordinated through, with and for local communities and customers
- Will look different in each county dependent on what the established programming elements already are
- Will be accomplished through a 12-18 month rollout during which new information will be consistently coming in.
- May involve coordination with Medicaid Health Plans, Medicare Integrated Care Organizations, Hospitals, PCP's and specialists as needed.
- Elements of involvement should include education, medical/behavioral cross training and care coordination when needed
- Data Analytics sent out to CMHSP's in usable report formats with technology support
- For identification/population assessment, stratification, prioritization
- Claims data and costs
- Pharmacy specific

Current State:

SWMBH Customer Service		
Priorities	**Goals**	**Service Activities**
• Welcome and orient individuals to services and benefits available and to the provider network. • Develop and provide information to members about how to access mental health, primary health, and other community services. • Provide information to members about how to access the various Rights processes. • Help individuals with problems and inquiries regarding benefits. • Assist people with and oversee local complaint and grievance processes. • Track and report patterns of problem areas for the organization. • Establish Policies and Procedures that meet and exceed all expectations set. • Manage Customer Services Committee Charter and membership to represent all of SWMBH member counties. • Create/Manage and Distribute the SWMBH Medicaid and MI Health Link Customer Handbooks. • Develop documents/Action Notices to communicate with customers regarding SWMBH-level service decisions. • Communicate with SWMBH Provider Network regarding CS office functions. • Develop marketing and member related communications	• Create and Maintain *Welcoming* atmosphere for customers of SWMBH network. • Promote Customer Voice to be heard throughout SWMBH business activities. • Provide assistance with all complaints, grievances, or appeals filed with CS office. • Collect and review aggregate data regarding customer grievances and appeals.	• Developed common training materials for SWMBH/Providers/CMHSPs. • Developed, updated and/or distributed SWMBH network customer/stakeholder educational materials including: ▪ 3 Members Newsletters ▪ 2 Provider Newsletters ▪ 1 Handbook ▪ Informational materials-SWMBH, Substance Use Disorder, Recovery Oriented Systems of Care, MI Health Link, VA Navigator, Complex Case Management, and Autism Services Brochures ▪ SWMBH and Recovery Oriented Systems of Care Marketing Materials ▪ MI Health Link Welcome Packet and orientation materials

2018 Provider CMHSP Access & UM Site Review

Standard	Total
The CMH maintains a log for the tracking of denials.	*81%*
Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, are made by health care professionals who have appropriate clinical expertise in treating the enrollee's condition.	*75%*
The CMH notifies the requesting provider, and gives the enrollee written notice of decisions to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.	*75%*
For standard authorization decisions, determination and notice is made as expeditiously as the enrollee's health condition requires but not exceeding 14 calendar days following receipt of the request for service.	*69%*
When an individual is determined ineligible for Medicaid specialty service and supports, he/she is notified both verbally and in writing of the right to request a second opinion.	*50%*
The Access system schedules and provides for a timely second opinion, when requested (3 days for inpt requests, excluding holiday and Sundays).	*67%*
Second opinion determinations are made by a qualified health care professional (in or out of network), at no cost to the customer.	*100%*
The Access System's telephone response system is answered by a live voice and demonstrates a welcoming environment.	*94%*
The Participant CMH is monitoring telephone answering rates and call abandonment rates. Corrective actions are made when call answering rates fall below 95%.	*88%*
The CMH has a written Utilization Management program description that meets MDHHS requirements and SWMBH policy.	*50%*
Compensation for utilization management activities is not structured so as to provide incentives for the individual to deny, limit or discontinue medically necessary services to enrollees.	*88%*
SWMBH level of care tables are utilized for UM decision making (10/1/16 and later); documentation to support medical necessity for exceptional treatment outliers is present when applicable.	*81%*
Consultation with SWMBH Central Care Management is obtained for inpatient psychiatric and crisis residential stays over 10 days in length, if included in MOU.	*67%*

Fiscal Year 2018 - 2019 FY Cultural Competence Plan

Cultural Competence Strategies

Personnel

Business Practice – to promote Competency	Source	Outcome
A. SWMBH actively recruits workforce of diverse backgrounds through the candidate selection process.	• SWMBH Position Descriptions • SWMBH Policy 3.7 – Cultural and Linguistic Competency • SWMBH Policy 4.7 – Competitive Employment • Network Adequacy Analysis – Population Race/Ethnicity Analysis	To promote a workforce that is reflective of the community and individuals served.
B. SWMBH hiring process includes utilization of "Guidelines to Explore Diversity in Job Interview" to determine an interviewees experience/willingness to support diversity and cultural competence as a SWMBH employee	• SWMBH Position Descriptions • SWMBH Policy 3.7 – Cultural and Linguistic Competency • SWMBH Policy 4.7 – Competitive Employment	To promote hiring of staff who embrace cultural competency as a work ethic.
C. SWMBH utilizes non-discrimination statements in all hiring and contracting searches.	• SWMBH Position Descriptions • SWMBH Annual Performance Review Form • SWMBH Policy 3.7 – Cultural and Linguistic Competency • SWMBH Policy 4.7 – Competitive Employment	SWMBH seeks to develop a workforce reflective of our community/individuals served.
D. SWMBH Personnel/Providers are required to follow training guidelines related to Cultural Competence and all other required topics of training. Monitored process to occur annually.	• SWMBH Policy 3.7 – Cultural and Linguistic Competency • SWMBH Cultural Competency and Diversity Training (Power Point Presentation) • SWMBH Cultural Competency and Diversity Attestation Form • Network Adequacy Analysis – Population Race/Ethnicity Analysis	SWMBH promotes workforce education in working with diverse populations. Spanish is the most prevalent non-English language spoken in the SWMBH 8-county region. According to the American Community Survey Aggregate Data, 5-Year Summary File, 2006–2010, 3.5% of the population in the SWMBH region speak Spanish
E. SWMBH reviews *Essential Functions* of each employee.	• SWMBH Position Descriptions • SWMBH Annual Performance Review Form • SWMBH Policy 3.7 – Cultural and Linguistic Competency	To ensure tasks and responsibilities remain accurate as well as provided in a Cultural Competent manner.
F. SWMBH promotes Cultural Competence practices in design, monitoring of contractual provider performance.	• SWMBH Member/Provider Handbook • SWMBH Site/Monitoring Reviews • SWMBH Cultural Competency Workgroup	To ensure provider network performance meets SWMBH standards.

	• Network Adequacy Analysis – Population Race/Ethnicity Analysis	
G. SWMBH maintains representation within the Recovery Oriented Systems of Care (ROSC) Community-Wide Collaboration, which explores Cultural Competency and barriers.	• ROSC Community Collaboration Meeting Minutes. • Network Adequacy Analysis – Population Race/Ethnicity Analysis	Based on needs, is a community-wide partnership to address/discuss Cultural issues and barriers to care.
H. SWMBH annually evaluates demographic data of network and individuals served through its Network Adequacy review (Attached on pg. 7-8).	• SWMBH Employee Satisfaction Surveys • SWMBH Policy 3.7 – Cultural Competency • SWMBH Policy 2.12 – Network Adequacy • SWMBH Policy 2.7 – Communication to Providers	Evaluation performed to identify if SWMBH workforce continues to be reflective of demographics of community/individuals served.

Individuals Served

Business Practice – to promote Competency	Source	Outcome
I. SWMBH encourages customers to identify their need for language support services via the use of "I Speak" tools at service sites or via telephone contacts.	• SWMBH Policy 6.5 Limited English Proficiency • SWMBH Network Adequacy Plan	When customers can identify their primary language, SWMBH can direct supports necessary to provide support and services.
J. SWMBH provides no-cost interpretation and translation as necessary for vital documents, during appointments, and telephone contacts.	• SWMBH Policy 4.3 – Authorization and Outlier Management	To engage in services, SWMBH offers free language assistance to customers and individuals seeking services.
K. Via the Person-Centered Planning process, SWMBH (and all contracted providers) encourages discussion of the importance of issues such as: culturally sensitive needs, gender or age specific needs, economic issues, spiritual needs/beliefs, and/or issues related to sexuality identity/orientation – in all treatment planning.	• SWMBH Policy 4.5 – Person and Family Centered Planning	To ensure customers are receiving services suited to their individual needs.
L. SWMBH maintains a competent provider panel of interpreters and translators.	• SWMBH Policy 4.1 – Access Management	To ensure customers can receive educational materials and supportive services in their preferred language.
M. SWMBH will utilize the community needs assessment process and feedback generated from annual customer satisfaction surveys to evaluate any changing cultural/linguistic needs of the community.	• SWMBH 2015 Customer Satisfaction Survey Analysis and Results • SWMBH Grievance and Appeal Data Analysis • SWMBH 2014-2015 QAPI Evaluation of Services	SWMBH can modify printed materials as language thresholds change and can target workforce training needs to new community needs.
N. SWMBH educational materials are written in simple language and provided in preferred languages to customers.	• SWMBH Customer Handbook • SWMBH UM Policy	Community members and customers will have access to information in commonly used languages. Vital documents are translated in to Spanish.
O. Customer access to Grievance and Appeal processes is aided by translated documents, assistance to all customers, and available	• SWMBH Policy 2.14 – Grievance and Appeals	Customers will have processes explained to them in preferred language and have access to language

interpretation at all steps. Customers can identify Authorized Representatives to represent them.	• Network Adequacy Assessment of cultural, ethnic, racial and linguistic needs	support to represent themselves while SWMBH addresses their complaint(s).

2018 - 2019 Cultural Competence Goals

Goal	Source	Steps to take/Completion Date	Outcome	Responsibility
1. Implement Staff/Provider survey to gauge Organizational level of Cultural Competence.	Network Adequacy Analysis – Population Race/Ethnicity Analysis	A. ACTION to Cultural Competency Workgroup to research and identify tool to utilize (By June 2019).	SWMBH to utilize data for future planning and movement of organization along path of Competence. Specifically, are their improvement opportunities for SWMBH policy/training	ACTION: SWMBH Cultural Competency Workgroup to work with internal/external stakeholders to complete needs assessment, and use data to improve outcomes.
2. Utilize feedback from Customers related to Cultural Competency of workforce.	Customer Satisfaction Surveys RSA-r Surveys Grievance and Appeals Data Network Adequacy Analysis – Population Race/Ethnicity Analysis Consumer Advisory Committee to review and provide feedback	A. ACTION to evaluate current customer survey tools to: Identify if current tools provide questions regarding customer opinion of Competency and if not - Identify tool(s) to add to surveys to collect data (By October 2019) B. The Consumer Advisory Committee and possibly other Regional Committees with consumer representation, will review current tools and protocols and provide feedback to improve processes.	SWMBH to utilize data for future planning and movement of organization along path of Competence. Specifically, are customers identifying that SWMBH is able to meet their individual needs through services.	ACTION Workgroup to work with QMC and CAC to identify tool(s). ACTION the Consumer Advisory Committee will review and provide input on the 2018 Network Adequacy Plan/Report. ACTION an analysis and improved outcome measures will be documented in a 2019 Member Services Newsletter and the 2019 Quality Assurance and Performance Improvement Plan.

3. Utilize outcome data to guide service design toward cultural competency	Network Adequacy Analysis Customer Satisfaction Survey Data Analysis RSA-r Survey Evaluation	A. ACTION to research SWMBH customer service outcomes based on populations of MIA, I/DD, and SED to B. Identify if customer demographics are part of data collection process (By October 2019) C. SWMBH to add CMHSP Cultural Competency plan/needs review to the 2019 CMHSP site review tool.	SWMBH to utilize data for future planning and movement of organization along path of Competence. Specifically, are outcomes impacted by cultural considerations?	ACTION Committee to work with QMC, RUM, and RCP to identify tool(s).
Goal	**Source**	**Steps to take/Completion Date**	**Outcome**	**Responsibility**
4. Promote continued education throughout the agency and community by participating in or contributing to an organization/event.	Cultural Diversity Training Curriculum	A. ACTION to present at 2019 All-Staff meeting. B. ACTION to provide at least 1 Cultural educationally focused article to SWMBH newsletter during 2019. C. ACTION to evaluate and promote new Cultural Competent educational opportunities for SWMBH staff/providers such as Lunch and Learns, and portal-based information.	A. To promote Workgroup activities and provide information to staff/providers regarding new ACTION plans. B. To enhance the Cultural Competency educational experiences for SWMBH staff.	A. ACTION B. ACTION C. ACTION Workgroup to work with HR and QMC to review and approve new training opportunities for staff/providers.

Interventions Attempted

SWMBH and its participant CMHs have attempted various methods to increase Hispanic/Latino clinician representation on our panel, including recruiting for positions in Hispanic/Latino cultural publications and at Hispanic/Latino community organizations. The overall available pool of clinicians with Hispanic/Latino background in our area is low, so these efforts have had minimal success. We have determined that we need a method to encourage behavioral health careers in the Hispanic/Latino population from very young ages. We are working with our local university to determine potential approaches to increasing Hispanic/Latino interest in the behavioral health field.

We did not set a specific goal regarding short-term recruitment of Spanish-speaking clinicians, as our current availability of Spanish-speaking clinicians (1.6% of network clinicians) is only about 2 percentage points lower than the overall population of Spanish-speaking individuals in our region (3.5%).

Access to Care and Timeliness of Services

Access Standards *(SWMBH policy 3.6)*
Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against standards for access to:

- Regular and routine care appointments.
- Urgent care appointments.
- After-hours care.
- Member Services, by telephone.
- UM by telephone SWMBH Reporting:
    - Care of non-life-threating emergency – defined as pre-screen process at hospital and crisis line calls. Standards: 3 hours to complete pre-screening process, and crisis line will be answered by a live person 24 hours a day.
    - Assessment – 14 calendar days
    - First Service- 14 calendar days

Level of Intensity Service and Decision Type

LEVEL OF INTENSITY/DECISION TYPE	DEFINITION	EXPECTED DECISION/ RESPONSE TIME
EMERGENT/PRESERVICE – PSYCHIATRIC	The presence of danger to self/others; or an event(s) that changes the ability to meet support/personal care needs including a recent and rapid deterioration in judgment	Within 3 hours of request; Prior authorization not necessary for the screening event. Authorization required for an inpatient admission within 3 hours of request.
URGENT CONCURRENT	A request for extension of a previously approved ongoing course of treatment with respect to which the application of the time periods for making nonurgent care determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, based on a prudent layperson's judgment; or in the opinion of a practitioner with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.	Within 24 hours of request; prior authorization required
URGENT PRESERVICE	At risk of experiencing an emergent situation if support/service is not given	Within 72 hours of request; prior authorization required; if services is denied/ appealed and deemed urgent, Expedited Appeal required within 72 hours of denial
ROUTINE/PRESERVICE NONURGENT	At risk of experiencing an urgent or emergent situation if support/service is not given	Within 14 calendar days of request; Prior authorization required
RETROSPECTIVE/POSTSERVICE	Accessing appropriateness of medical necessity on a case-by-case or aggregate basis after services were provided	Within 30 calendar days of request

The organization adheres to the following time frames for timeliness of UM decision making:

1. For urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request.

2. For urgent preservice decisions, the organization makes decisions within 72 hours of receipt of the request.
3. For nonurgent preservice decisions, the organization makes decisions within 15 calendar days of receipt of the request.
4. For postservice decisions, the organization makes decisions within 30 calendar days of receipt of the request.

Timeliness Categories:

- **Urgent request:** A request for care or services where application of the time frame for making routine or non-life threatening care determinations. Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
- **Concurrent request:** A request for coverage of care or services made while a member is in the process of receiving the requested care or services, even if the organization did not previously approve the earlier care.
- **Nonurgent request:** A request for care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.
- **Preservice request:** A request for coverage of care or services that the organization must approve in advance, in whole or in part.
- **Postservice request:** A request for coverage of care or services that have been received (e.g., retrospective review).

Legend:
***Numerator: The number of requests meeting the decision time frame**
***Denominator: The total number of requests**

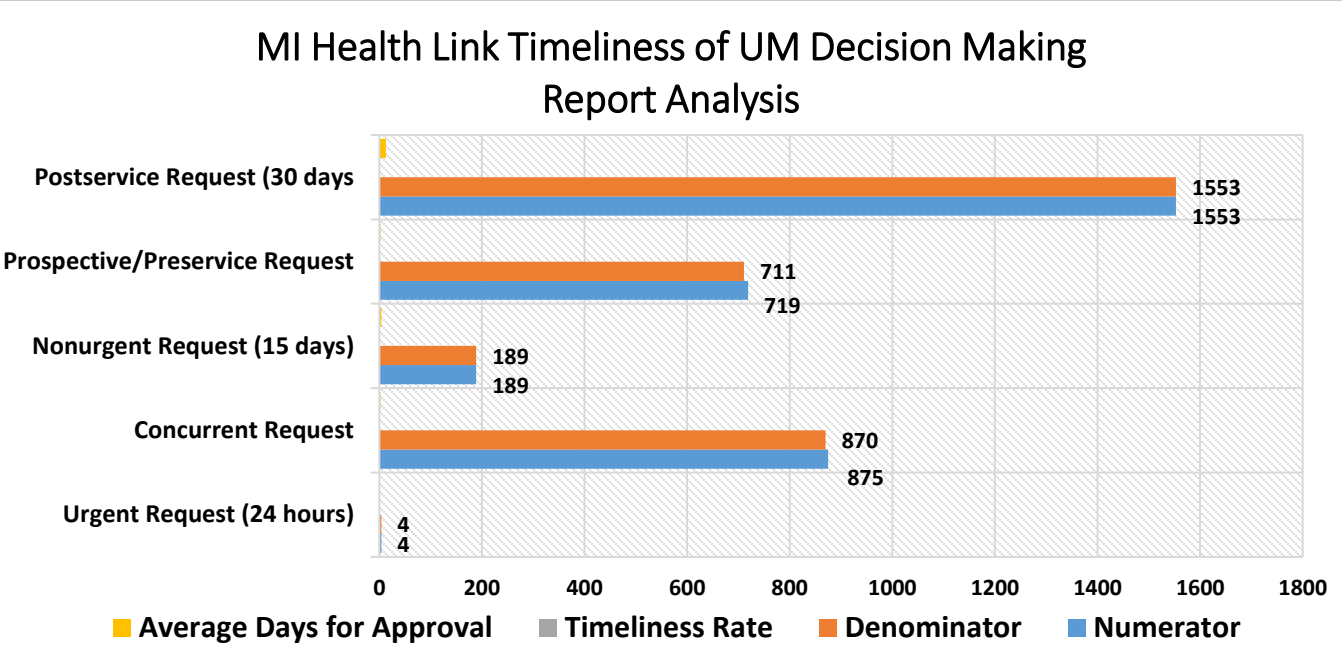
Analysis:

- **Overall, the timeliness requirements for all categories is being met. At this time, no corrective action plans/measures are suggested for this measurement period.**
- **The MHL Committee will continue to review the timeliness measure categories on a quarterly basis, to identify and remediate any potential trends in delayed decisions**

Timeliness Categories:

- ***Urgent request:*** A request for care or services where application of the time frame for making routine or non-life threatening care determinations:
- Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, ***or*** in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
- ***Concurrent request:*** A request for coverage of care or services made while a member is in the process of receiving the requested care or services, even if the organization did not previously approve the earlier care.
- ***Nonurgent request:*** A request for care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.
- ***Preservice request:*** A request for coverage of care or services that the organization must approve in advance, in whole or in part.
- ***Postservice request:*** A request for coverage of care or services that have been received (e.g., retrospective review).

Timeliness of UM Decision Making Analysis



- Measurement Period: January 1, 2018 through November 28, 2018.
- MI Health Link – Medicare Business Line.
- Mental Health and SUD Service Authorizations.

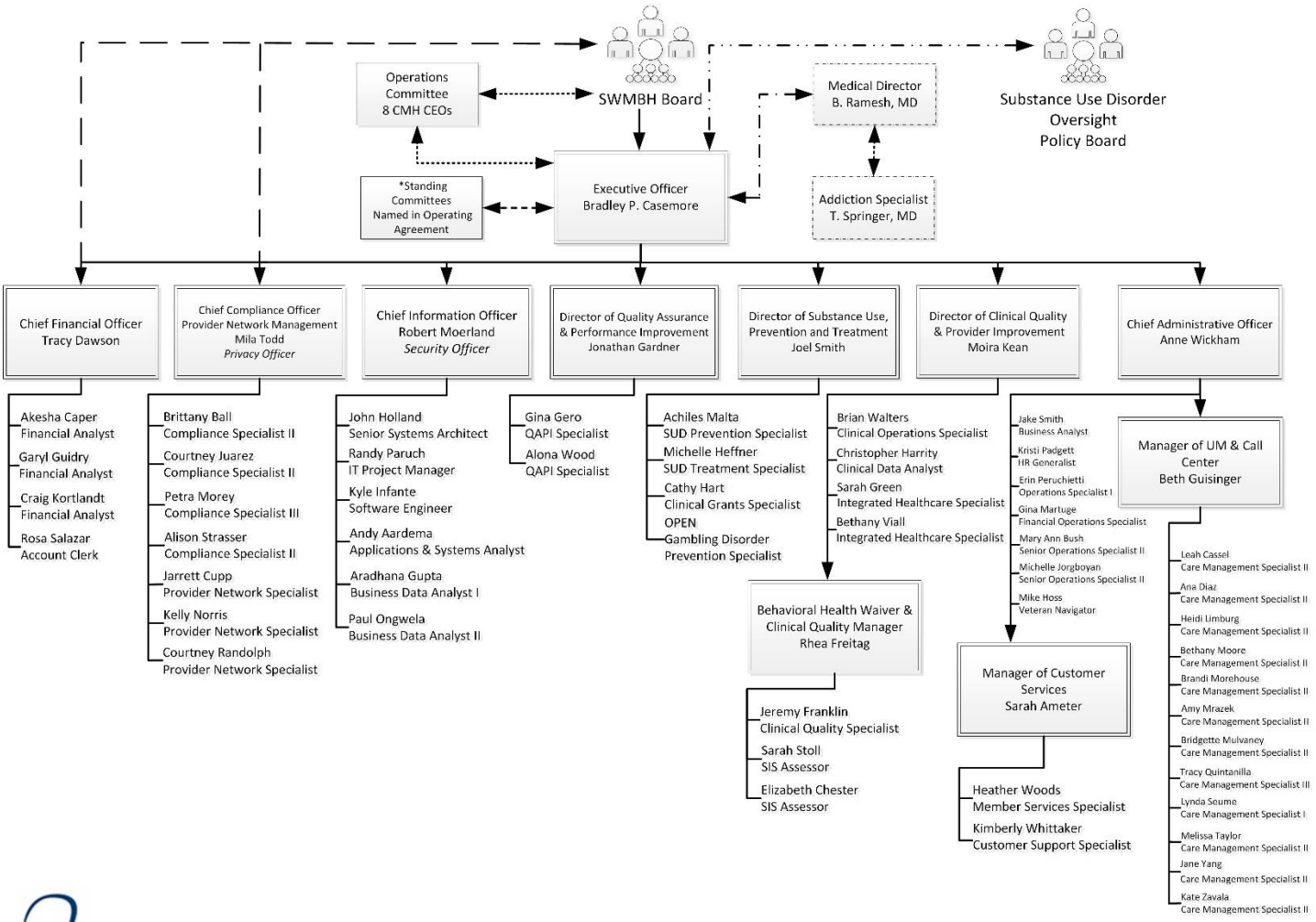
	Urgent Request (24 hours)	Concurrent Request	Nonurgent Request (15 days)	Prospective/Preservice Request	Post service Request (30 days)
Numerator	4	875	189	719	1553
Denominator	4	870	189	711	1553
Timeliness Rate	100%	99.40%	100%	99%	100%
Average Days for Approval	0.66	2.22	4.28	2.25	13.04

Analysis of Data

Overall, the timeliness requirements for all categories are being met. Currently, no corrective Action plans are suggested/necessary for this measurement period (October 1, 2017 through September 30, 2018). The MI Health Link and Regional Utilization Management Committees will continue to review the data and act on outliers if necessary.

III. Attachments

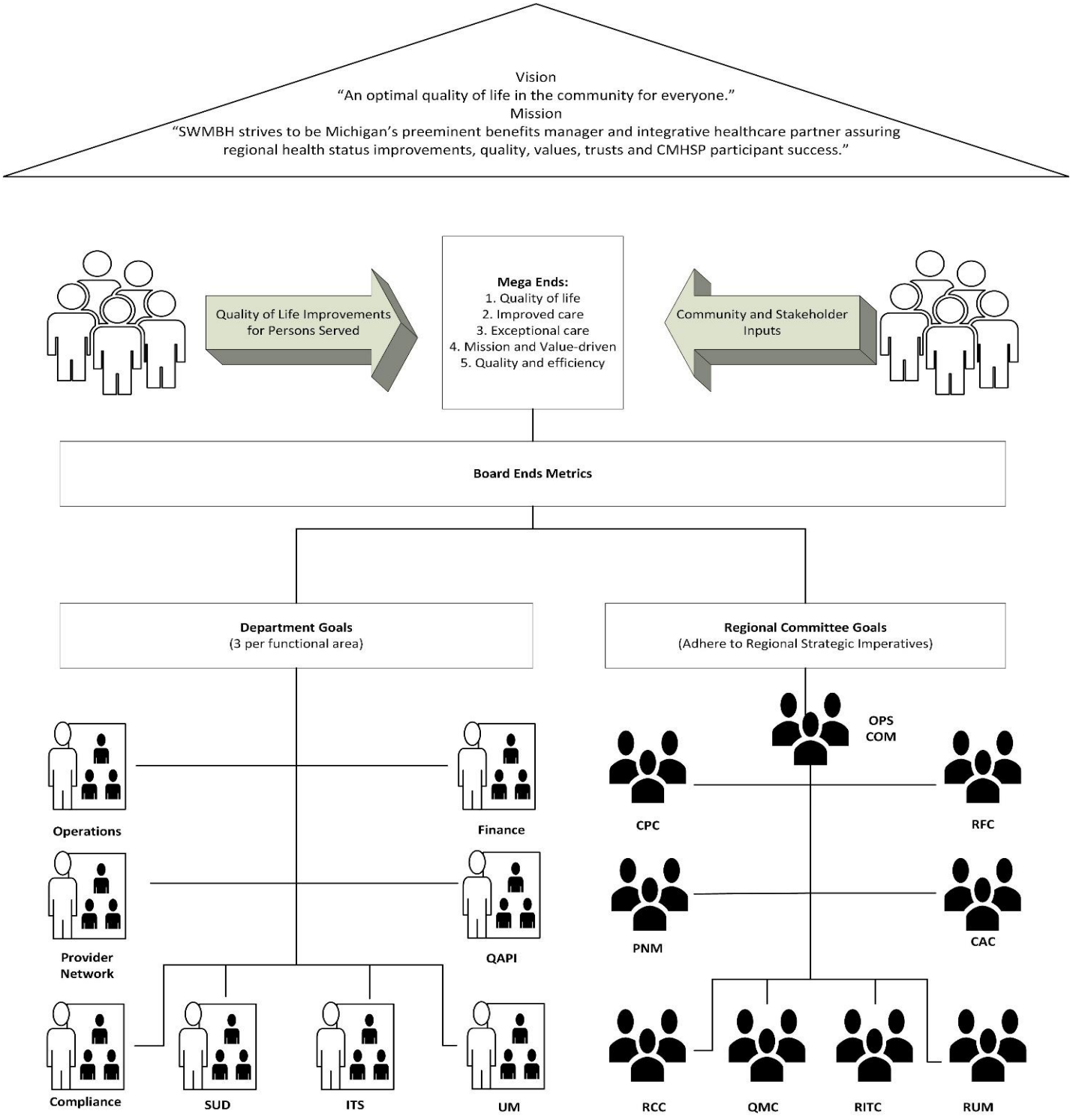
Attachment A: Southwest Michigan Behavioral Health Organizational Chart



Southwest Michigan Behavioral Health

Organizational Chart
Revised 2/20/19

Attachment B: SWMBH 2018 Strategic Alignment – Annual Goal Planning



Strategic Alignment – Annual Goal Planning
Revised 2/21/19

Attachment C: Strategic Plan Overview – Board End Metrics

Southwest Michigan Behavioral Health
2018-2021 Strategic Plan – Board Ends Metrics

Our Mission: "SWMBH strives to be Michigan's preeminent benefits manager and integrative health partner, assuring regional health status improvements, quality, trust, and CMHSP participant success"

Our Vision: "An optimal quality of life in the community for everyone"

- 1.2018 Health Service Advisory Group (HSAG) External Quality Compliance Review (90% of Sections evaluated receiving a score of "Met")
- 2.2018 HSAG Performance Measure Validation Audit Passed with (95% of measures evaluated receiving a score of "Met")
- 3.FY 2018 Medicaid Administrative Loss Ratio for the region is (< or = to 9.5%)
- 4.SWMBH will achieve all quality withhold performance measures identified in the Integrated Care Organization (ICO) contracts

- 92% of Michigan Mission-Based Performance Indicator System metrics will be at or above the State benchmark for 3 quarters for fiscal year 18.
- Regional Habilitation Supports Waiver slots are full at 99% throughout the year.
- SWMBH will apply for and achieve no less than (One Year) National Committee for Quality Assurance – Managed Behavioral Health Organization accreditation for the MI Health Link Duels Business Line.
  - SWMBH to implement and lead a multi-year, collaborative, systemic and systematic *Regional Values Outcome Project*, which primary objective will be to "*Improve Lives and Prove It*".
    - Per Board Directive: "Work with CMHs and contractors to assess and modify as appropriate regional managed care functions and roles to achieve greater efficiency and lower overall expenses."

- Collaboration between Medicaid Health Plans and Prepaid Inpatient Health Plan will demonstrate that joint care plans exist for members with appropriate severity/risk that have been identified as receiving services from both entities
- Follow-up after Hospitalization for Mental Illness within 30 days
- Completion of narrative and demonstration of SWMBH's participation in Patient Centered Medical Home initiative
- Improved Veterans' Needs and Services
- In Fiscal Year 18, at least 48% of persons with Autism Spectrum Disorders who have an Individual Plan of Service (IPOS) which includes Applied Behavioral Analysis services, will receive those services consistent with their plan (*>=75% units approved*)

- Fully utilize contractually obligated assessment tools for persons with Intellectual Developmental Disabilities (I/DD); Substance Use Disorders (SUD); Serious Mental Illness (SMI); Autism Spectrum Disorder (ASD) and Serious Emotional Disturbances (SED).
- 80% of members who have had an encounter during FY18, receive the appropriate assessment within the required timeframe
- SWMBH will develop and make available; Regional assessment reports in Tableau, with appropriate filters/analysis for each assessment tool

- Customer Satisfaction Surveys collected by SWMBH are at or above the SWMBH 2017 results
- SWMBH will complete the indicated Michigan Department of Health and Human Services (MDHHS) Home and Community Based Service (HCBS) reporting obligations with 95% success rate

Our Triple Aim:
Improving Patient Experience of Care | Improving Population Health | Reducing Per Capita Cost
v.1.24.18

Attachment D: SWMBH 2018 Board Ends Metrics

Summary of 2018 Board Ends Metrics

(Completion within the Review Period)

Results:

***14/15 Board Metrics Achieved within the Review Period**

Board Ends Metric	Result
SWMBH will complete the indicated MDHHS Home and Community Based Service (HCBS) reporting obligations with 95% success rate. (By: June 30, 2018)	**MET** **100%** of HCBS CAPs have been requested and approved by SWMBH
Regional Habilitation Supports Waiver slots are full at 99% throughout the year. (October 17 - September 18)	**MET** **99.9%** full FY 18 October 1st through September 30th *690 available slots per month
SWMBH will apply for and achieve no less than (One Year) NCQA MBHO Accreditation for the MI Health Link Duels Business Line. (By: April 2018)	**MET +1 Bonus Point** SWMBH Received notice of (full-3yr) Managed Behavioral Health Organization (MBHO) – Medicare Accreditation status on March 2, 2018
2018 HSAG Performance Measure Validation Audit Passed with (95% of Measures evaluated receiving a score of "Met") (By: September 30, 2018)	**MET** 37/37 Measures Evaluated were found to be in Full Compliance for a score of **100%**
92% of MMBPIS Indicators will be at or above the State benchmark for 3 quarters for FY 18. (October 17 – September 18)	**MET** 51/51 MMBPIS Indicators have met or exceeded the MDHHS established benchmark, resulting in: **100%** compliance for the first 3 quarters of 2018
SWMBH to "Establish and implement an inclusive formal Regional public policy, legislative education program." (By: September 30, 2018)	**MET** SWMBH held a large Legislative on 10/19/18 at the WMU Fetzer Center. Education and public policy involvement resulting in greater awareness of legislators about the values and results of the Michigan public behavioral health system and the specific needs of our Region was achieved
Customer Satisfaction Surveys collected by SWMBH are at or above the SWMBH 2016 results; for the *Improved Functioning* (MHSIP survey) and *Improved Outcomes* (YSS survey) measurement categories, utilizing the MHSIP and YSS Survey tools (By: December 31, 2017)	**MET** SWMBH achieved an overall improvement of **+1.3%** on the targeted categories.

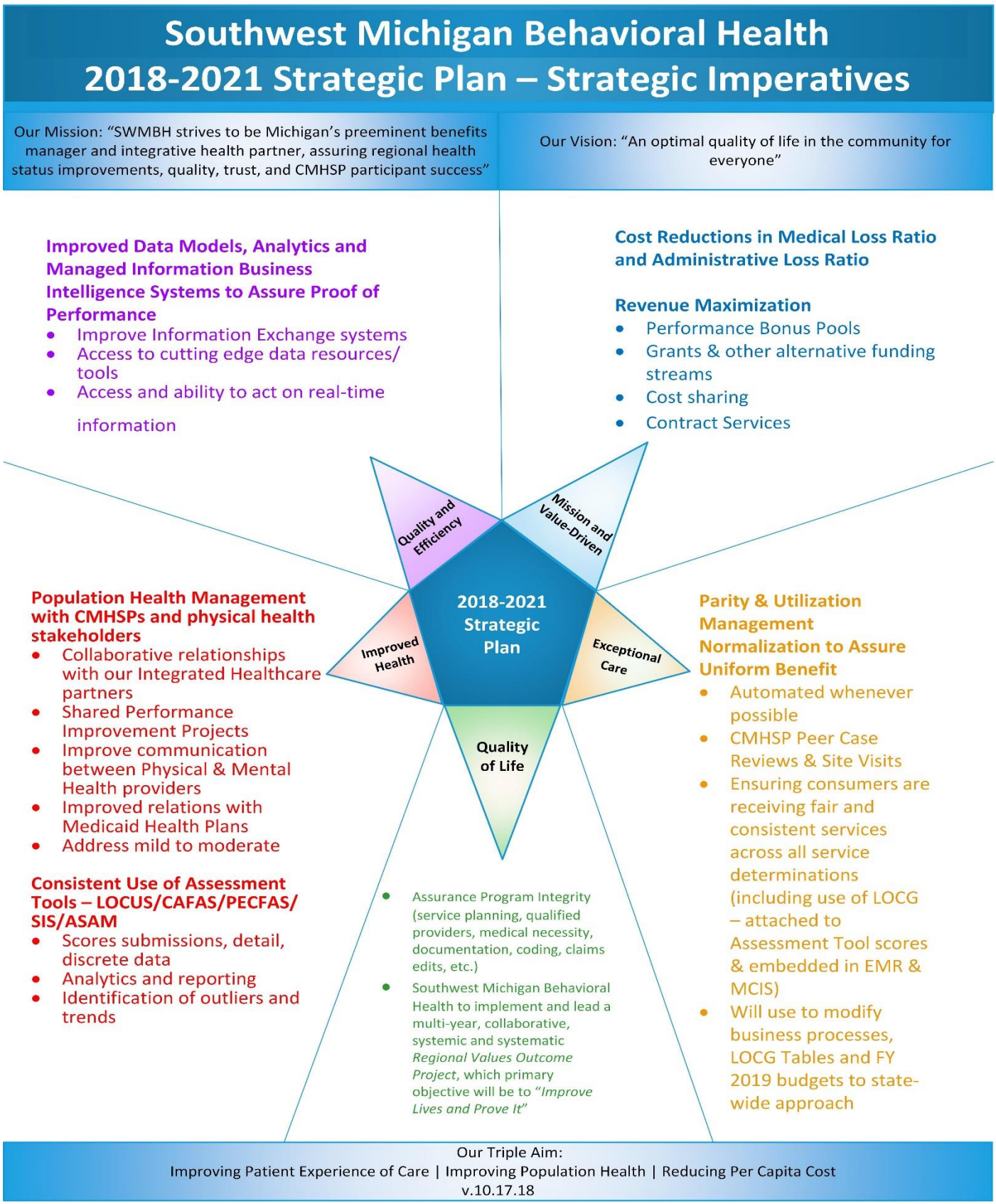
73.8% of consumers receiving an SUD assessment, will receive a minimum of (3) outpatient services within a (45 day) period; following their date of initial assessment. (By November 30, 2017)	**MET** **79.52%** of consumers received (3) outpatient services within (45 days) following their initial assessment. This is an 10.7% improvement over our baseline measure and 5.7% improvement over the metric target
70% of members (6) to (20) years of age and 58% of members (21) and older; who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner will receive follow-up within 30 days. (By December 31, 2017)	**MET** ***Children: 76.58%*** 110/139 ***Adults: 67.56%*** 1008/1332
Increase the use of recovery coaches by 20% over the 2016 baseline measure. (By October 31, 2017)	**MET** Measure was achieved at **37.22% improvement** over the baseline measure
The Regional Committees have developed and achieved 100% of their collective approved CY17 goals, as indicated by the SWMBH Regional Committee Goal tracking matrix. (By December 31, 2017)	**MET** Each of the (8) recognized Regional Committee has established and attested to completion of (2) new goals for 2017
Fully implement contractually obligated assessment tools for persons with Intellectual Developmental Disabilities (I/DD); Substance Use Disorders (SUD); Mental Illness (SMI) and Serious Emotional Disturbances (SED). Further analysis of data will be completed. (By: December 31, 2017)	**MET** Board Reviewed Metric and requested additional language of "85% of eligible members receive the appropriate assessment".
FY 2017 Medicaid Administrative Loss Ratio for the region is (≤ 10.0%) (By March 2018)	**MET** FY 2017 YTD Status ending 10/30/17: **9.5%**
FY 17 Medicaid Medical Loss Ratio meets standards as set by the Board. (85% - 87%) (By March 2018)	**NOT MET** FY 2017 YTD Status ending 10/30/17: **98.7%**

2018 Health Service Advisory Group (HSAG) External Quality Compliance Review (90% of Sections evaluated receiving a score of "Met"). (By: September 30, 2018)	**NOT MET** **(+1pt. for Full NCQA Accreditation)** 167/187 Elements "Met" Full Compliance 89% *Please see summary report for more details.

METRICS THAT WILL ROLL OVER INTO 2019 COMPLETION CYCLE

Fully utilize contractually obligated assessment tools for persons with Intellectual Developmental Disabilities (I/DD); Substance Use Disorders (SUD); Serious Mental Illness (SMI); Autism Spectrum Disorders (ASD) and Serious Emotional Disturbances (SED). A. 100% of assessment scores will be received as automated data file transfers to SWMBH at the domain and dimension level (By: 1/30/18) COMPLETE B. 85% of members who have had an encounter during FY18, receive the appropriate assessment within the required timeframe (By: 9/30/18) COMPLETE 1. LOCUS- Level of Care Utilization System Tool 2. SIS- Supports Intensity Scale Tool 3. CAFAS- Child/Adolescent Assessment Scale Tool 4. ASAM- American Society of Addiction Medicine Tool C. SWMBH will develop and make available; Regional assessment reports in Tableau, with appropriate filters/analysis for each assessment tool (By: 5/31/2018) COMPLETE	**COMPLETE** Approved during 11.9.18 Board Mtg. 100% of assessment , have received the scores are being received as automated data files 90.45% of members who have had an encounter appropriate assessment 72% was baseline measure on: 9.30.17 Regional assessment Reports that adhere to LOC tables are complete and available for view via Tableau Visual Analytics Tool.

Attachment E: SWMBH 2018-2021 Strategic Imperatives



Attachment F: 2018 MI Health Link Committee Charter

☒ **MI Health Link**

☒ **SWMBH Committees: Quality Management (QMC); Provider Network Credentialing (PNCC); Clinical and Utilization Management (CUMC)**

Duration: ☒ **On-Going** ☐ **Deliverable Specific**

Charter Effective Date: 6/1/15

Last Review Date: 1/30/2018

Approved By:

Signature: _____

Date: _____

Purpose:	SWMBH MI Health Link Committees are formed to assist SWMBH in executing the MI Health Link demonstration goals and requirements, NCQA requirements, as well as its contractual obligations and tasks.
Accountability:	The committee is one method of participant communication, alignment, and advice to SWMBH. The committee tasks are determined by the SWMBH EO, committee chair and members, member needs, MI Health Link demonstration guidelines including the Three-Way Contract, ICO-PIHP Contract and NCQA requirements. Each committee is accountable to the SWMBH EO, and is responsible for assisting the SWMBH Leadership to meet the Managed Care Benefit requirements within the MI Health Link demonstration, the ICO-PIHP contract, and across all business lines of SWMBH. The committee is to provide their expertise as subject matter experts.
Committees Purposes:	**Quality Management Committee:** • The QI Committee must provide evidence of review and thoughtful consideration of changes in its QI policies and procedures and work plan and make changes to its policies where they are needed. *NCQA, MBHO, QI 1: Program Structure; Quality Improvement Program Structure, Element A (Factor 4) & QI 2: Program Operations; QI Committee Responsibilities, Element A (Factor 1-4).* • Analyzes and evaluates the results of QI activities to identify needed actions and make recommendations related to efficiency, improvement, and effectiveness. Ensures follow-up as appropriate. *NCQA, MBHO, QI 2: Program Operations, QI Committee Responsibilities Element A (Factor 1, 2 & 5)* • Ensures practitioner participation in the QI program through planning, design, implementation or review. *NCQA, MBHO, QI 2: Program Operations, Element A QI Committee Responsibilities, Element A (Factor 3).* • Ensures discussion (and minutes) reflects: ○ Appropriate reporting of activities, as described in the QI program description. *NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 1).*

- Reports by the QI director and discussion of progress on the QI work plan and, where there are issues in meeting work plan milestones and what is being done to respond to the issues. *NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 7). QI 1: Annual Evaluation, Element B (Factor 3).*

- Ensures the organization describes the role, function and reporting relationships of the QI Committee and subcommittees. *NCQA, MBHO, QI 1: Program Structure, Quality Improvement Program Structure, Element A (Factor 1 & 4).*
- Ensures all MI Health Link required reporting is conducted and reviewed, corrective actions coordinated where necessary, and opportunities for improvement are identified and followed-up. *NCQA, MBHO, QI 2: Program Operations, QI Committee Responsibilities, Element A.*
- Ensures member and provider experience surveys are conducted and reviewed, and opportunities for improvement are identified and followed-up. *NCQA, MBHO, QI 9: Complex Case Management, Member Experience with Case Management, Element I (Factor 1).*
- Ensures the organization approves and adopts clinical practice guidelines and promotes them to practitioners. The appropriate body to approve the clinical practice guidelines may be the organization's QI Committee or another clinical committee. *NCQA, MBHO, QI 2: Program Responsibilities, QI Committee Responsibilities, Element A.*
- Ensures the organization approves and adopts preventive health guidelines and promotes them to practitioners in an effort to improve health care quality and reduce unnecessary variation in care. The appropriate body to approve the preventive health guidelines may be the organization's QI Committee or another clinical committee. *NCQA, MBHO, QI 10: Clinical Practice Guidelines, Adopting Relevant Guidelines, Element A.*
- The organization annually:
  - Documents and collects data about opportunities for collaboration. *NCQA, MBHO, CC 2: Collaboration between Behavioral Healthcare and Medical Care, Data Collection, Element A.*
  - Documents and conducts activities to improve coordination between medical care and behavioral healthcare. *NCQA, MBHO, CC 2: Collaboration between Behavioral Healthcare and Medical Care, Data Collection, Element A. Aetna Contract-Attachment C.2*
- Ensures the ICO and PIHP identify shared quality improvement measurement requirements and develop and implement related processes sharing results and undertaking correction and quality improvement activities. *Aetna Contract p. 33 (9.22)*
- Ensures a care management quality control program is maintained at all times. *Aetna Contract Attachment C.2*
- Ensures Call Center quality control program is maintained and reviewed, which should include elements of internal random call monitoring. *NCQA, MBHO, QI 5: Accessibility of Services, Assessment against Telephone Standards, Element B. Aetna Contract*

Credentialing Committee:

- Uses a peer review process to make credentialing and recredentialing decisions and which includes representation from a range of participating practitioners. *NCQA, MBHO, CR 2: Credentialing Committee, Element A (Factor 1). Meridian Contract. Aetna Contract-Attach C4.*
- Reviews the credentials of all practitioners who do not meet established criteria and offer advice which the organization considers. *NCQA, MBHO, CR 2: Credentialing Committee, Element A (Factor 2). Meridian Contract.*
- Implements and conducts a process for the Medical Director review and approval of clean files. *NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A (Factor 10); CR 2: Credentialing Committee, Element A (Factor 3). Meridian Contract.*

- Maintains meeting minutes. *NCQA, MBHO, CR 2: Credentialing Committee, Element A (Factor 2).*
- Reviews and authorizes policies and procedures. *NCQA, MBHO, CR 1: Credentialing Policies; CR 2: Credentialing Committee. QI 2: Program Responsibilities, QI Committee Responsibilities, Element A. Aetna Contract-Attach C4.*
- Ensures that practitioners are notified of the credentialing and recredentialing decision within 60 calendar days of the committee's decision. *NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 9). Meridian Contract*
- Ensures reporting of practitioner suspension or termination to the appropriate authorities. *NCQA, MBHO, CR 7: Notification to Authorities and Practitioner Appeal Rights, Actions Against Practitioners, Element A (Factor 2); NCQA, MBHO, CR 7: Notification to Authorities and Practitioner Appeal Rights, Reporting to the Appropriate Authorities, Element B. Aetna & Meridian Contracts.*
- Ensures practitioners are informed of the appeal process when the organization alters the conditions of practitioner participation based on issues of quality or service. *NCQA, MBHO, CR 7: Notification to Authorities and Practitioner Appeal Rights, Element A (Factor 4); CR 7: Notification to Authorities and Practitioner Appeal Rights, Practitioner Appeal Process: Element C (Factor 1). Meridian Contract.*
- Ensures the organization's procedures for monitoring and preventing discriminatory credentialing decisions may include, but are not limited to, the following:
    - Maintaining a heterogeneous credentialing committee membership and the requirement for those responsible for credentialing decisions to sign a statement affirming that they do not discriminate when they make decisions. *NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 7)*
    - Periodic audits of credentialing files (in-process, denied and approved files) that suggest potential discriminatory practice in selections of practitioners. *NCQA, MBHO, CR 1: Credentialing Policies, Practitioner Credentialing Guidelines, Element A: (Factor 7).*
- Ensures annual audits of practitioner complaints to determine if there are complaints alleging discrimination. *NCQA, MBHO, CR 6: Ongoing Monitoring, Ongoing Monitoring and Intervention: Element A (Factor 3). Aetna Contract.*

Clinical/Utilization Management Committee:

- Reviews and authorizes policies and procedures. *NCQA, MBHO, UM 1: Utilization Management Structure, UM Program Description Element A.*
- Ensures the PIHP and ICO conduct regular and ongoing collaborative initiatives that address methods of improved clinical management of chronic medical conditions and methods for achieving improved health outcomes. *NCQA, MBHO, CC 2: Collaboration Between Behavioral Healthcare and Medical Care, Opportunities for Collaboration, Element B. Aetna Contract, p. 22 (9.22)*
- Is involved in implementation, supervision, oversight and evaluation of the UM program. *NCQA, MBHO, UM 1: Utilization Management Structure, UM Program Description Element A. UM 1: Utilization Management Structure, Behavioral Healthcare Practitioner Involvement, Element B.*
- Ensures Call Center quality control program is maintained and reviewed, which should include elements of internal random call monitoring. *NCQA, MBHO, QI 5: Accessibility of Services, Assessment Against Telephone Standards, Element B. Aetna Contract*
- Maintains meeting minutes and ensures review of tools/instruments to monitor quality of care are in meeting minutes. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria, Element A. Aetna Contract-Attachment C.2*
- Ensures annual written description of the preservice, concurrent urgent and non-urgent and post service review processes and decision turnaround time for each. *NCQA, MBHO,*

	UM 5: Timeliness of UM Decisions, Timeliness of UM Decision Making, Element A & Notification of Decisions, Element B. Meridian Contract-Attach C. • Ensures a care management quality control program is maintained at all times. *Aetna Contract-Attach C.2* • Ensures at least annually the PIHP review and update BH clinical criteria and other clinical protocols that ICO may develop and use in its clinical case reviews and care management activities; and that any modifications to such BH clinical criteria and clinical protocols are submitted to MDCH annually for review and approval. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 5). Aetna Contract, p. 33-34 (9.27).* • Ensures PIHP shall render an authorization and communicate the authorized length of stay to the Enrollee, facility, and attending physician for all behavioral health emergency inpatient admissions in authorized timeframes. *Aetna Contract, p. 33 (9.25.3). Meridian Contract-Attachment C.* • Ensures the organization: o Has written UM decision-making criteria that are objective and based on medical evidence. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 1). Meridian Contract-Attachment C.* o Has written policies for applying the criteria based on individual needs. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 2).* o Has written policies for applying the criteria based on an assessment of the local delivery system. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 3).* o Involves appropriate practitioners in developing, adopting and reviewing criteria. *NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 4). Meridian Contract-Attachment C.*
Relationship to Other Committees:	These three committees will sometimes plan and likely often coordinate together. The committees may from time-to-time plan and coordinate with the other SWMBH Operating Committees.
Membership:	The SWMBH EO and Chief Officers appoint the committee Chair and Members. Members of the committee will act as conduits and liaisons to share information decided on in the committee. This includes keeping relevant staff and local committees informed and abreast of regional information, activities, and recommendations. Members are representing the regional needs related to Provider Network Credentialing; Quality Management and Clinical/Utilization Management as it relates to MI Health Link. It is expected that members will share information and concerns with the committee. As conduits it is expected that committee members attend and are engaged in issues, as well as bringing challenges to the attention of the SWMBH committee for possible project creation and/or assistance.
Decision Making Process:	The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. All regional committees are advisory with the final determinations being made by SWMBH. When consensus cannot be reached a formal voting process will be used. The group can also vote to refer the issue to the Operations Committee or another committee. Referral elsewhere does not preclude SWMBH from making a determination and taking action. Voting is completed through formal committee members a super majority will carry the motion. This voting structure may be used to determine the direction of projects, as well as other various topics requiring decision making actions. If a participant fails to send a representative either by phone or in person they also lose the right to participate in the voting structure on that day.

Attachment 1: - Credentialing

Membership Name	***Organization/County***	***Type of member (Ad hoc, standing, voting, alternate)***
Dr. Bangalore K. Ramesh D.O., Psychiatrist (Medical Director/ Practitioner/Provider)	Western Michigan University	*Voting*
Jonathan Gardner B.S, CHES, PTA Director of Quality Assurance and Performance Improvement	SWMBH	*Voting*
Moira Kean LLP, M.A. Director of Provider Network Management and Clinical Improvement	SWMBH	*Voting*
Jarret Cupp MA, LLPC Provider Network Specialist	SWMBH	*Voting*
Bethany Viall, RN (Practitioner) Integrated Healthcare Specialist	SWMBH	*Voting*
Beth Guisinger MA, LPC, CAADC Manager of UM and Call Center	SWMBH	*Voting*
Lori Ryland, PHD, BCBA-D, CAADC (Practitioner and Provider)	Skywood - Foundations Recovery Center (MH/SUD/Autism)	*Voting (as needed)*
Daniel Spencer Price, LLP, CAADC (Practitioner and Provider)	St. Joe CMH (SUD)	*Voting*
Stephanie Lagalo, LMSW, CAADC, CCS (Practitioner and Provider)	Interact of Michigan (MH/SUD)	*Voting*

Attachment 2: - Quality/UM/Clinical

Membership Name	***Organization/County***	***Type of member (Ad hoc, standing, voting, alternate)***
Dr. Bangalore K. Ramesh D.O., Psychiatrist (Medical Director/ Practitioner/Provider)	Western Michigan University	*Voting*
Robert Moerland MBA Chief Information Officer	SWMBH	*Voting*
Jonathan Gardner B.S, CHES, PTA Director of Quality Assurance and Performance Improvement	SWMBH	*Voting*

Moira Kean LLP, M.A. *Director of Provider Network Management and Clinical Improvement*	SWMBH	*Voting*
Jarrett Cup MA, LLP *Provider Network Specialist*	SWMBH	*Voting*
Bethany Viall, RN (Practitioner) *Integrated Healthcare Specialist*	SWMBH	*Voting*

Attachment 3: - Cultural Competency Management Committee

Membership Name	***Organization/County***	***Type of member (Ad hoc, standing, voting, alternate)***
Nancy Wallace, R.N., B.S, M.A *Integrated Healthcare Manager*	SWMBH	*Voting*
Dr. Bangalore K. Ramesh D.O., *Psychiatrist (Medical Director/ Practitioner/Provider)*	Western Michigan University	*Voting*
Kim Rychener LMSW, MSW *Director of UM and Member Engagement*	SWMBH	*Voting*
Tim Dubois MBA, PMP *IT Project Manager*	SWMBH	*Voting*
Jonathan Gardner B.S, CHES, PTA *Director of Quality Assurance and Performance Improvement*	SWMBH	*Voting*
Natalie Tenney LMSW, CAADC *Manager of UM and Call Center*	SWMBH	*Voting*
Scott VanKirk B.S. *Provider Network Specialist*	SWMBH	*Voting*
Bethany Viall, RN (Practitioner)	SWMBH	*Voting*

Attachment G: 2018 SWMBH Departmental Goals

The Following Represent SWMBH Department Goals that have been completed for the 2017 Calendar Year, utilizing the SMART Goal format

RESULTS: 23/24 Completed on time = 95.8%

SWMBH 2018 Department Goal Status Tracker

2018 SWMBH Department Goals Results

2018 SWMBH Department Goals	START Date	Completion Date	Functional Area	PERCENT COMPLETE
Utilization Management & Clinical Practices (Gale/Anne)				
Demonstrate knowledge and understanding of clinical decision criteria and a welcoming attitude	10/1/2017	9/30/2018	UM	N/A
Develop a comprehensive plan to streamline OP service determination processes across MHL MH/SUD and MA/HMP/BG/SUD business lines	10/1/2017	9/30/2018	UM	N/A
Develop and implement plan to improve the MHL psychiatric IP follow up to hospitalization process (requires confluence with Integrated Care)	10/1/2017	9/30/2018	UM	N/A
Quality Assurance and Performance Improvement (Jonathan)				
Design and produce (2) MMBPIS dashboards on Tableau for internal and external review	1/1/2018	10/30/2018	QAPI	100%
Formulate a series of instructional videos/tutorials, which live on the portal for SWMBH and CMHSP access	1/1/2018	10/30/2018	QAPI	100%
Improve categorization and organization of Tableau reports and dashboards	9/30/2018	12/30/2018	QAPI	100%
Finance (Tracy)				
Develop back up capabilities in 50% of the Department	1/1/2018	12/31/2018	Finance Dept	100%
Have Finance team handle the CAP process for the region to allow a smoother internal process and lower dependency and cost on consultants	1/1/2018	9/30/2018	Finance Dept	100%
SUD (Joel)				
Develop a provider report card which measures performance on NOM	10/1/2017	7/31/2018	SUD	100%

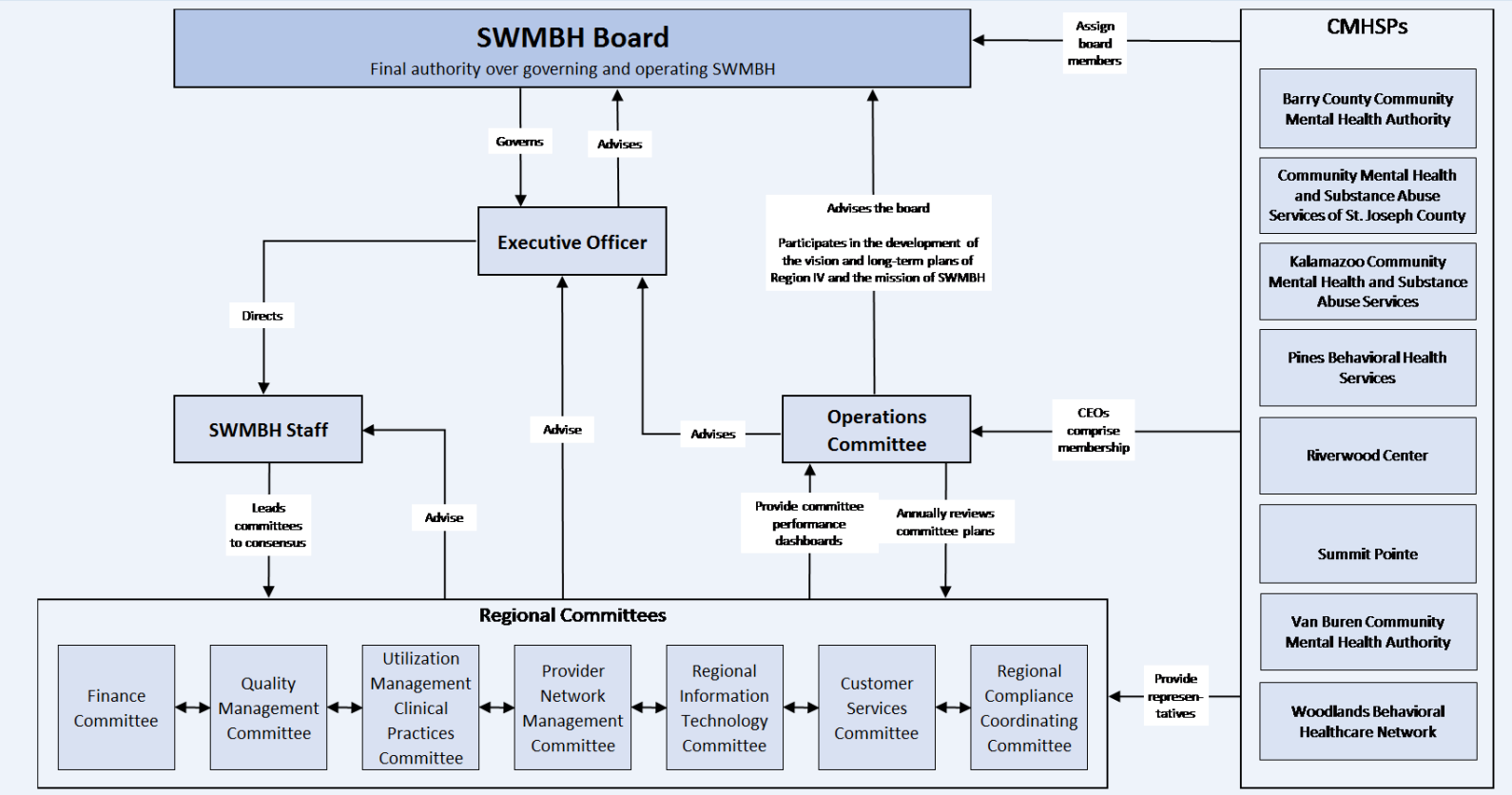
Develop an electronic multimedia curriculum for annual naloxone training refresher, including a proficiency test	10/1/2017	4/1/2018	SUD	**100%**
Develop and monitor metrics related to SUD treatment	10/1/2017	8/31/2018	SUD	**100%**
Provider Network Management (Moira)				
SWMBH will complete HCBS provider CAP process for HSW enrolled individuals	10/1/2017	12/31/2018	Provider Network	**100%**
Youth receiving ABA services will receive treatment in accordance with their IPOS	10/1/2017	9/30/2018	Provider Network	**80%**
SWMBH SUD administrative, clinical, and compliance reviews will be integrated	10/1/2017	12/31/2018	Provider Network	**100%**
Compliance (Mila)				
Create efficiencies in audit processes and performance for audits performed by Program Integrity & Compliance and Provider Network Management departments.	10/1/2017	9/30/2018	Compliance	**100%**
Develop a business process for implementing/utilizing data-mining reports requested from IT	10/1/2017	9/30/2018	Compliance	**100%**
Executive Officer (Brad)				
Maximization of revenue by preserving, diversifying, and expanding funding streams	10/1/2017	3/31/2019	EO	**100%**
Establish and implement an inclusive regional public policy and legislation education program	10/1/2017	2/28/2018	EO	**100%**
Increase efficiency by improving managed care functions	10/1/2017	3/31/2019	EO	**100%**
Operations (Anne)				
Implement claims clearinghouse	10/1/2017	6/1/2018	Operations	**100%**
Electronic open enrollment	1/1/2018	10/1/2018	Operations	**100%**
Integrated Care (Gale)				
To meet NCQA QI9, Element C, #6, increase the identification and engagement of MHL CCM members who meet inclusion criteria by 5% of baseline (engagement defined as successful completion of at least one meeting/assessment call).	10/1/2017	9/30/2018	Integrated Care	**100%**
Expand Integrated Care Coordination with ED staff through increased ED staff outreach in collaboration with CMH and ED staff.	10/1/2017	9/30/2018	Integrated Care	**100%**
Increase outreach and care coordination with Veteran and Military Families that are not currently receiving services	10/1/2017	9/30/2018	Integrated Care	**100%**
Information Technology Services (Rob)				
Re-evaluate ITP Contractual Services	10/1/2017	9/30/2018	ITS	**100%**
Development of Data-as-a-Service (DaaS)	10/1/2017	9/30/2018	ITS	**100%**

Attachment H: 2018-2019 SWMBH Regional Committee Goals

2018 - 2019 Regional Committee Goals	START Date	Completion Date	Mega End Category	Functional Area	PERCENT COMPLETE
Utilization Management & Clinical Practices (RUMCP) *Committees split mid-year*					
Develop processes to ensure consistent use and application of medical necessity criteria and LOC	1/1/2018	9/30/2019	Quality of Life	RUMCP	clinical practices on going
Develop and Implement a Regional Outlier Management Process	12/30/2017	9/30/2018	Improved Health	RUMCP	100%
Youth Receiving ABA services will receive treatment according to their plan	1/1/2018	11/30/2018	Quality of Life	RUMCP	100%
Select and Implement a nationally recognized medical necessity criteria for BH, MH and SUD across the Region	1/1/2018	9/30/2019	Quality of Life	RUMCP	clinical practices on going
Complete MDHHS Hab Waiver Home and Community Based Service Corrective Action Plan Process	1/1/2018	12/31/2018	Quality of Life	RUMCP	100%
Enhance use, oversight and monitoring of person-centered planning and availability of independent facilitators	1/1/2018	12/31/2018	Exceptional Care	RUMCP	100%
Information Technology Committee (RITC)					
Data Quality, Timeliness and Completeness	1/1/2018	9/30/2018	Quality & Efficiency	IT	100%
Regional Data Exchange (MCIS v.2.0)	1/1/2018	9/30/2018	Quality & Efficiency	IT	80%
TEDs Double Entry Process Improvement	1/1/2018	9/30/2018	Quality & Efficiency	IT	70%
Quality Management Committee (QMC)					
Implementation of a Regional Report Users and Analysis Group	1/1/2018	12/28/2018	Quality & Efficiency	QMC	100%
Formulate a series of instructional videos/tutorials, which live on the portal for SWMBH and CMHSP access	1/1/2018	10/30/2018	Quality & Efficiency	QMC	100%
Finance Committee (RFC)					
Revenue maximization by preservation and enhancement of funding streams and revenues	10/1/2017	3/15/2018	Quality & Efficiency	RFC	100%

Revenue diversification by exploring programs, services and funds that are not currently contracted by region	4/1/2018	12/31/2018	Quality & Efficiency	RFC	**100%**
Consumer Advisory Committee (CAC)					
Identify and implement opportunities for stakeholder awareness & education regarding customer services	1/1/2018	11/30/2018	Mission & Value Driven	CAC	**100%**
Assure implementation of a uniform regional grievance & appeal process	1/1/2018	4/30/2018	Exceptional Care	CAC	**100%**
Assure uniform application and adherence to the Enrollee Rights, Protections & Parity Managed Care Regulations	1/1/2018	9/30/2018	Exceptional Care	CAC	**100%**
Develop SWMBH/CMHSP Co-branded materials for health fairs and other community events	1/1/2018	4/30/2018	Mission & Value Driven	CAC	**100%**
Provider Network Management Committee (PNMC)					
Establish formal process for sharing credentialing information & for distribution for related activities	1/1/2018	12/31/2018	Quality & Efficiency	PNMC	**100%**
Implement Direct Care Wage Increase	1/1/2018	5/30/2018	Mission & Value Driven	PNMC	**100%**
Implement statewide inpatient psychiatric hospital monitoring reciprocity	1/1/2018	3/1/2019	Improved Health	PNMC	**100%**
Compliance Committee (RCC)					
Review and update Regional Compliance Training & Provide to RE CO Group for inclusion in drafting	1/1/2018	6/30/2018	Mission & Value Driven	RCC	**100%**
Request Clarification from EDIT/other State resources to issues related to overlapping billing, CLS, Respite, and ABA Services	1/1/2018	10/30/2018	Quality & Efficiency	RCC	**100%**

Attachment I: SWMBH Organizational & Committee Structure Chart



Attachment J: 2018 Board Member Roster

Southwest Michigan BEHAVIORAL HEALTH

2019 Board Member Roster

Barry County

- Robert Nelson
- Robert Becker (Alternate)

Berrien County

- Edward Meny - Vice-Chair
- Nancy Johnson (Alternate)

Branch County

- Tom Schmelzer - Chair
- Jon Houtz (Alternate)

Calhoun County

- Patrick Garrett
- Kathy-Sue Vette (Alternate)

Cass County

- Mary "May" Myers
- Karen Lehman (Alternate)

Kalamazoo County

- Moses Walker
- Patricia Guenther (Alternate)

St. Joseph County

- Timothy Carmichael
- Cathi Abbs (Alternate)

Van Buren County

- Susan Barnes - Secretary
- Angie Dickerson (Alternate)

Attachment K: 2018 Regional Strategic Imperatives

All Board Ends Metrics will be in alignment with 2019-2020 Board Approved Strategic Imperatives

1. Parity and Utilization Management Normalization to Assure Uniformity of Benefit.

2. Cost Reductions in Medical Loss Ratio.

3. Cost Reductions in Administrative Loss Ratio.

4. Improved Data Models, Analytics and Managed Information Business Intelligence Systems.

5. Development of Performance Based Care and Outcomes Metrics.

6. Integrated Care Management with CMHSP and Physical Health Stakeholders.

7. Revenue Maximization - Capture all possible and available revenue opportunities.

Attachment L: 2018 Quality Management Committee Charter

Quality Management Committee Charter

☒ **SWMBH Committee** **Quality Management Committee (QMC)** ☐ **SWMBH Workgroup:** _____
Duration: ☒ **On-Going** ☐ **Deliverable Specific**

Date Approved: **5/1/14**

Last Date Reviewed: **4/28/18**

Next Scheduled Review Date: **4/28/19**

Purpose:	Operating Committees can be formed to assist SWMBH in executing the Board Directed goals as well as its contractual tasks. Operating Committees may be sustaining or may be for specific deliverables.
Accountability:	The committee is one method of participant communication, alignment, and advice to SWMBH. The committee tasks are determined by the SWMBH EO with input from the Operations Committee. Each committee is accountable to the SWMBH EO, and is responsible for assisting the SWMBH Leadership to meet the Managed Care Benefit requirements within the Balanced Budget Act, the PIHP contract, and across all business lines of SWMBH. The committee is to provide their expertise as subject matter experts.
Committee Purpose:	• *The QMC will meet on a regular basis to inform quality activities and to demonstrate follow-up on all findings and to approve required actions, such as the QAPI Program, QAPI Effectiveness Review/Evaluation, and Performance Improvement Projects. Oversight is defined as reviewing data and approving projects.* • *The QMC will implement the QAPI Program developed for the fiscal year.* • *The QMC will provide guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.* • *The QMC will provide data review and recommendations related to efficiency, improvement, and effectiveness.* • *The QMC will review and provide feedback related to policy and tool development.*

	• *The secondary task of the QM Committee is to assist the PIHP in its overall management of the regional QM function by providing network input and guidance.* • *The primary task of the QM Committee is to review, monitor and make recommendations related to the listed review activities with the QAPI Program/Plan*
Relationship to Other Committees:	At least annually there will be planning and coordination with the other Operating Committees. • Finance Committee • Utilization Management Committee • Clinical Practices Committee • Provider Network Management Committee • Health Information Services Committee • Customer Services Committee • Regional Compliance Coordinating Committee
Membership:	The Operating Committee appoints their CMH participant membership to each Operating Committee. The SWMBH EO appoints the committee Chair. • Members of the committee will act as conduits and liaisons to share information decided on in the committee. This includes keeping relevant staff and local committees informed and abreast of regional information, activities, and recommendations. • Members are representing the regional needs related to Quality. It is expected that members will share information and concerns with SWMBH staff. As conduits it is expected that committee members attend and are engaged in issues, as well as bringing challenges from their site to the attention of the SWMBH committee for possible project creation and/or assistance. Membership shall include appointed participant CMH representation, a member of the SWMBH Customer Advisory Committee with lived experience, SWMBH staff as appropriate, and the CA Director.

Decision Making Process:	The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. All regional committees are advisory with the final determinations being made by SWMBH. When consensus cannot be reached a formal voting process will be used. The group can also vote to refer the issue to the Operations Committee or another committee. Referral elsewhere does not preclude SWMBH from making a determination and taking action. Voting is completed through formal committee members a super majority will carry the motion. This voting structure may be used to determine the direction of projects, as well as other various topics requiring decision making actions. If a participant fails to send a
	Representative either by phone or in person they also lose the right to participate in the voting structure on that day.
Deliverables:	• Annual Committee Work Plan The Committee will support SWMBH Staff in the: • *QAPIP* • *QAPI Evaluation* • *Michigan Mission-Based Performance Indicator System (MMBPIS) regional report* • *Event Reporting Dash Board*