Quality Assurance & Performance Improvement
Utilization Management
2019 Program Evaluation

All SWMBH Business Lines

Evaluation Period: Medicaid (October 1, 2018- September 30, 2019)
Evaluation Period: MI Health Link (January 1, 2019 – December 31, 2019)

Reviewed by:

SWMBH Quality Management Committee: 2/27/2020
SWMBH Regional Utilization Management Committee: 2/10/2020
SWMBH MI Health Link Committee: 2/20/2020
SWMBH Board Education: 4/10/2020

Table of Contents

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 outlined 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 2018 through September 2019 for Medicaid Services and from January 2019 to December 2019 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 reviewed and 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, 2018 through September 30, 2019 (Medicaid) and January 1, 2019 to December 31, 2019 (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 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 different 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.

Internal Staffing of the QAPI Department

The SWMBH QAPI Department is charged to develop and manage its program. This program plan outlines the current relationships and structures that exist to promote 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 two 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 works in conjunction with 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. The data analyses include statistical analyses of outcomes data to test for statistical significance of changes, mining large data sets, and conducting factor analyses to determine causes or contributing factors for outcomes or performance outliers; correlates analyses to assess 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, as needed, 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 allocated to quality management activities. Additionally, the outside departmental staff is listed with the percentage of their time allocated to quality activities.

Title	Department	Percent of time per week devoted to QM
Director of Quality Assurance and Performance Improvement	QAPI	100%
(2) Quality Assurance Specialist	QAPI	100%
Business Data Analyst I	QAPI	50%
Business Data Analyst II	QAPI	30%
Clinical Data Analyst	QAPI and PNM	20%
Manager of Utilization Management and Call Center	UM	20%

Director of Clinical Quality	PNM	20%
Chief Information Officer	IT	20%
Senior Systems Architect	IT	20%
Customer Service Manager	UM	15%
Behavior Health Waiver and Clinical Quality Manager	CQ	10%
Applications and Systems Analyst	IT	20%
Designated Behavioral Health Care Practitioner	UM/PN	20%
Chief Compliance and Administrative Officer	Com/Ops	15%

QAPI = Quality Assurance and Performance Improvement
PNM = Provider Network Management
UM = Utilization Management
IT = Information Technology
CQ= Clinical Quality

SWMBH will have appropriate staff to complete QAPI functions as defined in this plan. In addition to having 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:

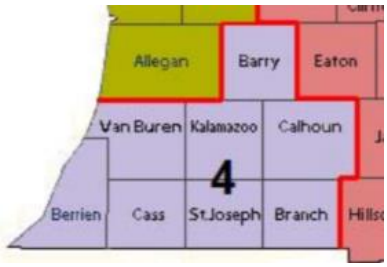
- Reviewing and submitting data to the state
- Creating and maintaining QAPI policies, plans, evaluations, and reports
- Implementation of regional projects and monitoring of reporting requirements
- Assisting in the development of Strategic Plans and Tactical Objectives
- Assisting in the development 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 participation 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 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 essential to the day-to-day operations of the SWMBH. Document management is also a crucial 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 essential Regional information and data. Tableau, dashboard visualization, and analysis software have become a critical part of our information and data sharing process with both external and internal stakeholders. This software allows access to real-time data, which is very important in our performance-based environment. The use of Go-to-Meeting or WebEx technology is offered to Regional Committee members, internal, and external stakeholders if they are not able to attend meetings in person.
It is important to note that during the reporting period, SWMBH transitioned its telecommunications and IT vendor from ITP to Secant Technologies. The transition will provide significant cost savings, increased phone/call analytics data, improved security, and additional on-site support.

Service Population and Eligibles Served:
The SWMBH region (4) has served nearly **26,489** unique consumers from October 1, 2018 to September 30, 2019



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 the region (FY'19): 258,912

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. Moreover, SWMBH values the input of all stakeholders in the improvement process. QMC spearheads the improvement process by fostering participant communication, ensuring mission alignment, and acting as subject matter experts 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 is required of all 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.

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 techniques 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, a 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 the 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 tasked 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. Quarterly, 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 regularly (at a minimum quarterly) to inform of quality activities, to demonstrate follow-up on all findings, and to approve required actions (e.g., 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 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. It is expected that committee members attend all meetings by phone or in person. If members are not able to participate in 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.
- To ensure CMHSP's have developed and are 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.

Quality Management Committee Key Accomplishments
The QMC met monthly during FY 2019. 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 the continued review of Quality activities, including Board Ends Metrics and Performance Improvement Projects. The QMC uses NCQA approved and best practice measures to track action items and follow-up's identified during meetings.

2019 Quality Management Committee Goals
SWMBH took a different approach to the Department and Committee goal setting in 2019. Each Department and Regional Committee worked together to achieve the overarching Strategic Imperatives that were identified during the Board of Directors retreat on May 11, 2019. These (7) Strategic Imperatives replaced the 2019 Regional Committee Goals. The following represent a list of those Strategic Imperatives: *(Please see attachment C for more details on completion of Strategic Imperatives)*

1. Public Policy and Legislative Education
2. Uniformity of Benefit
3. Integrated Health Care
4. Revenue Maximization and Diversification
5. Managed Care Functional Review
6. Improved Healthcare Information Exchange, Analytics and Business Intelligence
7. Proof of Value and Outcomes

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 jointly enrolled in 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 outlined 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 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 Executive Officer, committee chair and members, member needs, MI Health Link demonstration guidelines, including the Three-Way Contract, ICO-PIHP Contract, and NCQA requirements. The MHL Committee is accountable to the SWMBH EO. It is responsible for assisting SWMBH Leadership in meeting the Managed Care Benefit requirements within the MHL demonstration, the ICO-PIHP contract, and across all business lines of SWMBH. The Committee must provide evidence of review and thoughtful consideration of changes in its policies, procedures, work plan, and changes to its policies as needed. The Committee analyzes and evaluates the results of QM activities to identify required actions and make recommendations related to efficiency, improvement, and effectiveness. The Committee will meet regularly (at a minimum quarterly) to inform of quality activities, to demonstrate follow-up on all findings, and to approve required actions (e.g., QAPIP, QAPI & UM Effectiveness Review/Evaluation, and Performance Improvement Projects (PIPs). 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 participate in 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 the same responsibilities of members when participating in committee work.

Members of the committee will act as 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 liaisons, it is expected that committee members attend and are engaged in Performance Improvement issues, as well as bring challenges from their sites 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 2019 include:

- ✓ Preparations toward Achieving NCQA-MBHO Re-Accreditation
- ✓ Review Quarterly MHL enrollee statistics
- ✓ Completed and Ongoing QI Activities that address the 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 the QAPI program, including progress toward influencing network safe clinical practices
- ✓ Enhancing Practitioner Involvement with Quality initiatives and fundamental 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.

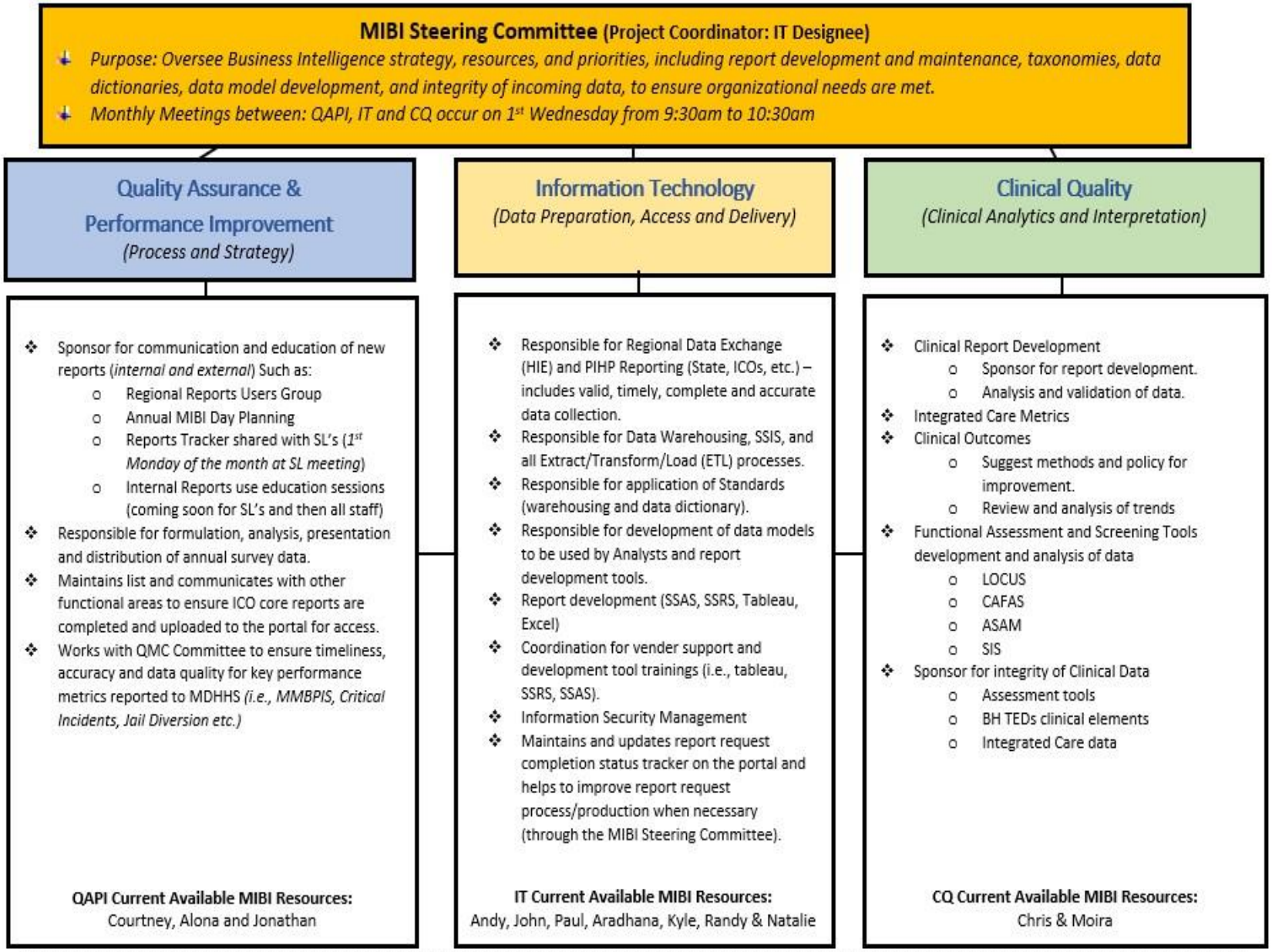
- ✓ Quarterly Review and analysis of grievances, appeals, and denials.
- ✓ Analysis of BH/PH Provider Communications Survey and Opportunities for improvement.
- ✓ Communication on critical findings from ICO/SWMBH audits and reviews.
- ✓ Review and understanding of NCQA-MBHO accreditation standards and 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	Monthly
UM	Grievances and Appeals	Customer Service Manager	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 the last meeting	Provider Network Specialist, or Director of Provider Network	Monthly
	Credentialing Applications for Committee Review	Provider Network Specialist, or Director of Provider Network	Monthly
	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	Quarterly, 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	Monthly
	Timeliness Monitoring	Director of QAPI or designated QAPI Specialist	Monthly
	NCQA Reports	Director of QAPI or designated QAPI Specialist	Quarterly
UM/Clinical	Collaborative Initiatives Meridian ICT Update	Manager of Utilization Management and Integrated Care Specialist	Monthly
	Complex Case Management	Manager of Utilization Management or Integrated Care Specialist	Monthly
	NCQA Measures	Director of Provider Network or Manager of Utilization Management	Monthly
	Policy and Procedure Review and Updates.	Manager of Utilization Management	As needed

Managed Information Business Intelligence Roles and Structure:

The MIBI Steering Committee was created in early 2019 to oversee business intelligence strategy, resources, and priorities. Monthly meetings occur, which include the Chief Information Officer, Director of Quality Assurance and Performance Improvement, and the Director of Clinical Quality. The (3) departments work very closely together, so key meeting objectives include data quality, data accuracy, data validation, report development, and prioritizing data related development projects and needs for SWMBH. The columns below describe the responsibilities of each functional area:


MIBI Steering Committee (Project Coordinator: IT Designee)
Purpose: Oversee Business Intelligence strategy, resources, and priorities, including report development and maintenance, taxonomies, data dictionaries, data model development, and integrity of incoming data, to ensure organizational needs are met.
Monthly Meetings between: QAPI, IT and CQ occur on 1st Wednesday from 9:30am to 10:30am
Quality Assurance & Performance Improvement
(Process and Strategy)
Sponsor for communication and education of new reports (internal and external) Such as:
Regional Reports Users Group
Annual MIBI Day Planning
Reports Tracker shared with SL's (1st Monday of the month at SL meeting)
Internal Reports use education sessions (coming soon for SL's and then all staff)
Responsible for formulation, analysis, presentation and distribution of annual survey data.
Maintains list and communicates with other functional areas to ensure ICO core reports are completed and uploaded to the portal for access.
Works with QMC Committee to ensure timeliness, accuracy and data quality for key performance metrics reported to MDHHS (i.e., MMBPIS, Critical Incidents, Jail Diversion etc.)
QAPI Current Available MIBI Resources:
Courtney, Alona and Jonathan
Information Technology
(Data Preparation, Access and Delivery)
Responsible for Regional Data Exchange (HIE) and PIHP Reporting (State, ICOs, etc.) – includes valid, timely, complete and accurate data collection.
Responsible for Data Warehousing, SSIS, and all Extract/Transform/Load (ETL) processes.
Responsible for application of Standards (warehousing and data dictionary).
Responsible for development of data models to be used by Analysts and report development tools.
Report development (SSAS, SSRS, Tableau, Excel)
Coordination for vender support and development tool trainings (i.e., tableau, SSRS, SSAS).
Information Security Management
Maintains and updates report request completion status tracker on the portal and helps to improve report request process/production when necessary (through the MIBI Steering Committee).
IT Current Available MIBI Resources:
Andy, John, Paul, Aradhana, Kyle, Randy & Natalie
Clinical Quality
(Clinical Analytics and Interpretation)
Clinical Report Development
Sponsor for report development.
Analysis and validation of data.
Integrated Care Metrics
Clinical Outcomes
Suggest methods and policy for improvement.
Review and analysis of trends
Functional Assessment and Screening Tools development and analysis of data
LOCUS
CAFAS
ASAM
SIS
Sponsor for integrity of Clinical Data
Assessment tools
BH TEDs clinical elements
Integrated Care data
CQ Current Available MIBI Resources:
Chris & Moira

Southwest Michigan
BEHAVIORAL HEALTH

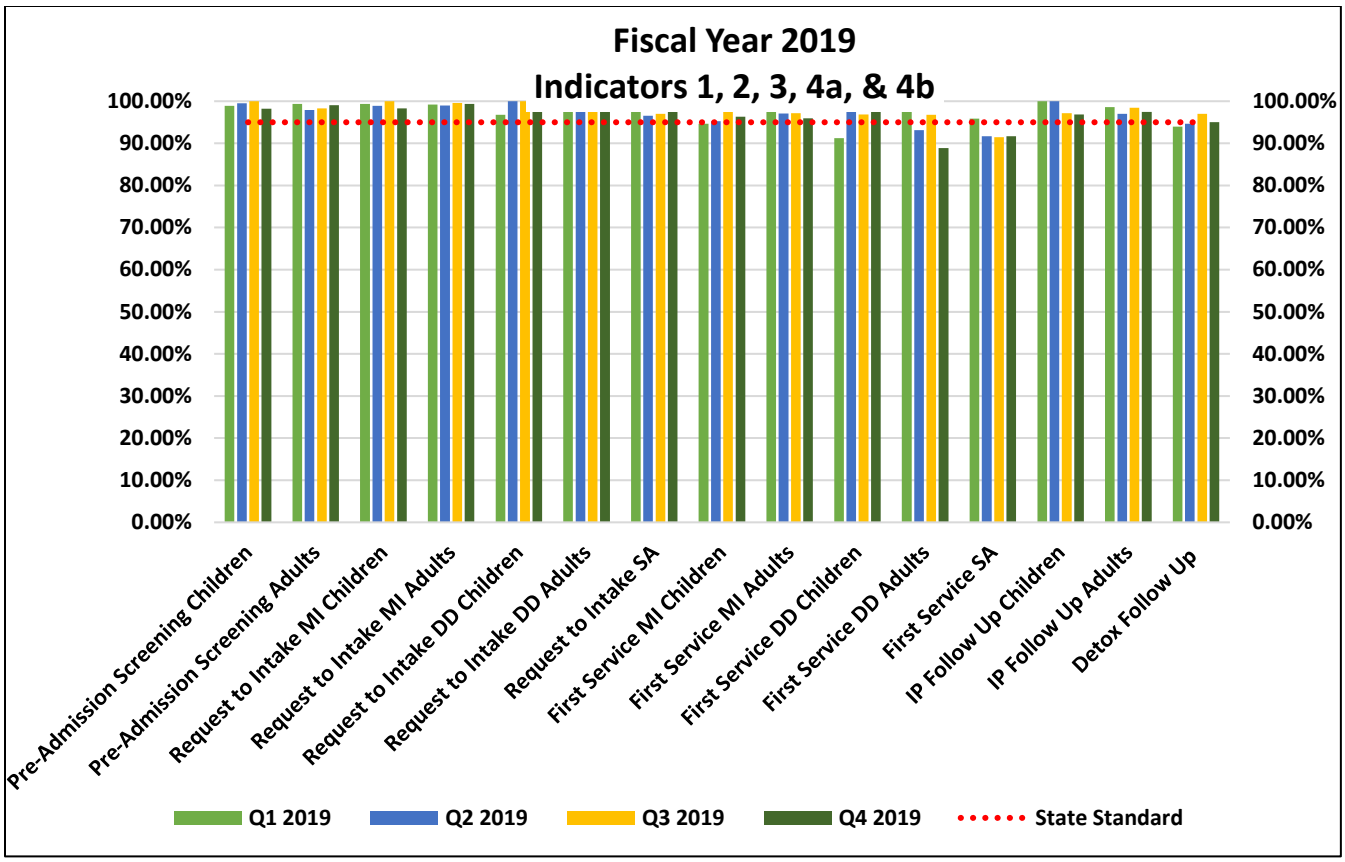
Quality Assurance Improvement Program Evaluation

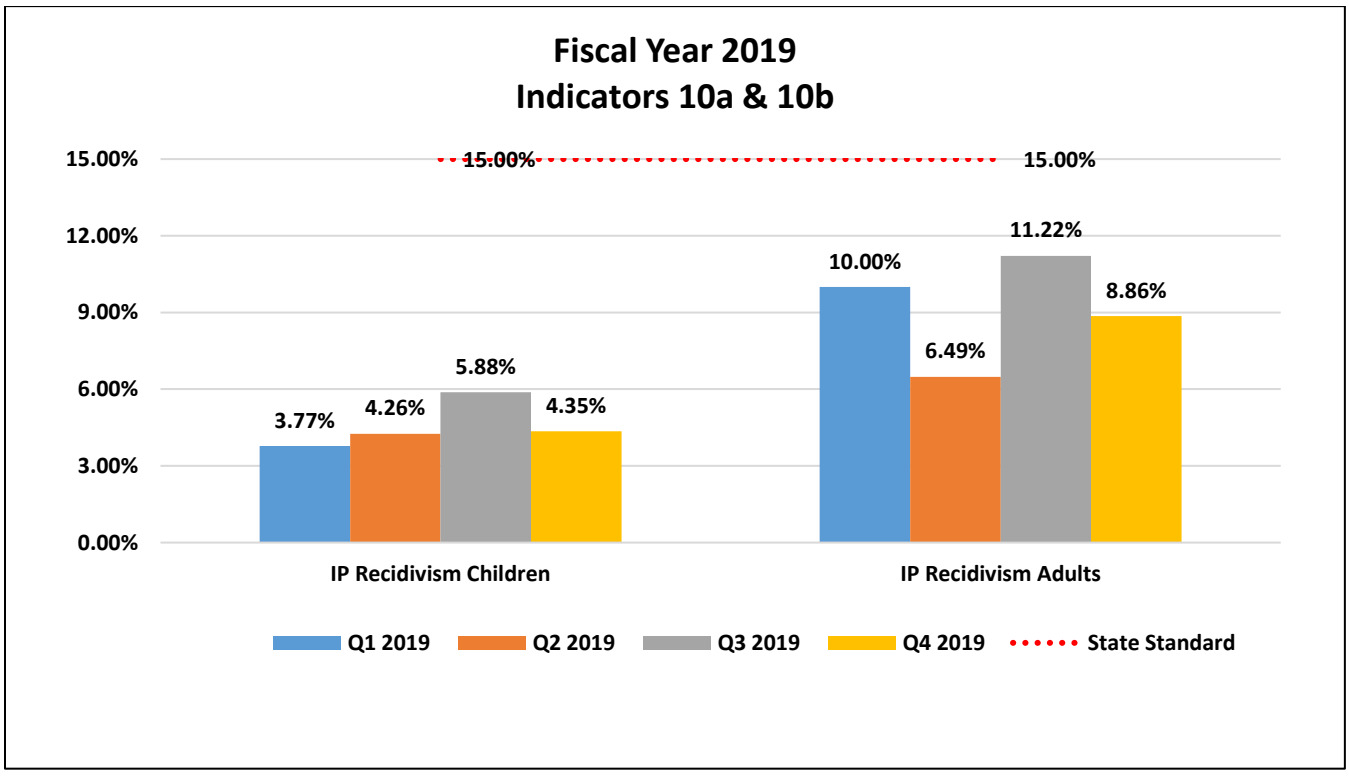
V. Quality Assurance Improvement Program Plan Evaluation

The following sections represent the outcomes, from the categories included in the 2019 QAPI and UM Plans

2019 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 quarterly. ✓ 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 benchmark. ✓ Ensure CMSHP Corrective Action Plans are achieved, and improvements are recognized.	October 2018 – December 2019	QAPI Director QAPI Specialist Clinical Quality Director SUD Director	Quarterly Submissions to MDHHS: *Q1 - 3/31/19 *Q2 - 6/30/19 *Q3 - 9/30/19 *Q4 - 1/2/20 CMHSPs submit monthly reports on the 25th of each month Via the FTP site. Annual on-site reviews for all (8) CMHSPs occur in April-May 2020.


Fiscal Year 2019
Indicators 1, 2, 3, 4a, & 4b
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
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 2019
Q2 2019
Q3 2019
Q4 2019
State Standard


Fiscal Year 2019
Indicators 10a & 10b
15.00%
12.00%
9.00%
6.00%
3.00%
0.00%
15.00%
15.00%
3.77%
4.26%
5.88%
4.35%
10.00%
6.49%
11.22%
8.86%
IP Recidivism Children
IP Recidivism Adults
Q1 2019
Q2 2019
Q3 2019
Q4 2019
State Standard

Performance Indicator Measurement Period: October 1, 2018 through September 30, 2019

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.

Target Goals:
The MDHHS benchmark for access and follow-up performance indicators is set at 95%. The SWMBH Board Ends Metric target was set at 92% for all performance indicators to achieve the MDHHS established benchmark for (4) quarters during FY 2019.

Results:
59/68 or 86.7% of total Performance Indicators in 2019 met the State Standard of 95%:

- 1st Quarter = 14/17
- 2nd Quarter = 14/17
- 3rd Quarter = 16/17
- 4th Quarter = 15/17

MMBPIS Performance Indicator	*State Standard*	Q1 2019	Q2 2019	Q3 2019	Q4 2019
Pre-Admission Screening Children	95.00%	98.93%	99.49%	100.00%	98.25%
Pre-Admission Screening Adults	95.00%	99.36%	97.90%	98.28%	99.08%
Request to Intake MI Children	95.00%	99.35%	98.87%	100.00%	98.26%
Request to Intake MI Adults	95.00%	99.21%	98.97%	99.55%	99.37%
Request to Intake DD Children	95.00%	96.77%	100.00%	100.00%	100.00%
Request to Intake DD Adults	95.00%	100.00%	100.00%	100.00%	100.00%
Request to Intake SA	95.00%	98.39%	96.55%	97.02%	97.58%
First Service MI Children	95.00%	94.61%	95.26%	97.72%	96.36%
First Service MI Adults	95.00%	97.91%	97.11%	97.16%	95.96%
First Service DD Children	95.00%	91.23%	100.00%	96.83%	100.00%
First Service DD Adults	95.00%	100.00%	93.10%	96.77%	88.89%
First Service SA	95.00%	95.83%	91.70%	91.43%	91.67%
IP Follow Up Children	95.00%	100.00%	100.00%	97.14%	96.88%
IP Follow Up Adults	95.00%	98.62%	97.01%	98.44%	97.49%
Detox Follow Up	95.00%	93.98%	94.64%	97.04%	95.05%
IP Recidivism Children	15.00%	3.77%	4.26%	5.88%	4.35%
IP Recidivism Adults	15.00%	10.00%	6.49%	11.22%	8.86%
Overall Results		14/17	14/17	16/17	15/17

Identified Barriers:
Many CMHSP's struggled with staffing issues throughout the year, which led to missed performance indicators (i.e., opportunities to schedule inside of a 14-day window are lost due to not having staff available to take on the assessment or service). Some CMHP's switched EMR's which hindered the ability to communicate information to SWMBH on a timely basis.

SWMBH distributed Corrective Action Plans (CAP's) asking for the identification of action to correct the missed indicator and turned them away if they did not include show proofs. When two or more indicators are missed, SWMBH implements a higher level of scrutiny, which requires the CMHSP's to submit monthly (and sometimes weekly) reports on their progress. CMHSPs are required to submit the MMBPIS tracking template monthly to ensure accuracy and outliers are being followed-up with on a timely basis. Quarterly data is compiled and sent to MDHHS on the last day of the 3rd month in each quarter.

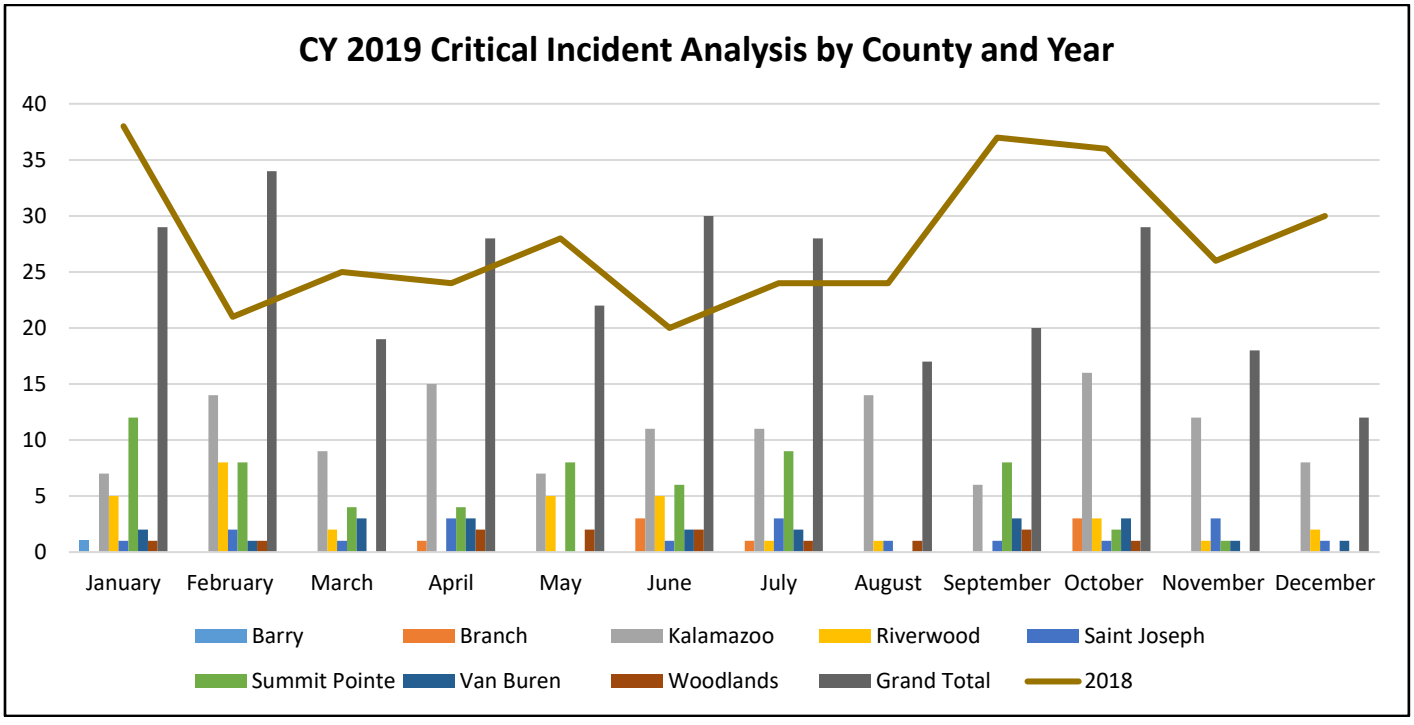
Improvement Efforts:
SWMBH sends CMHSP's appreciation letters upon meeting 100% of the State's performance indicators, which are directed at their CEO and shared at the Board meetings. SWMBH has also increased the frequency of analysis during QMC meetings, igniting conversation, and sharing best practices across the region. This process has helped identify trends early on. SWMBH has also developed dashboards in the tableau analytics system, that allow CMHSP's to access and flag cases that are approaching the end of the follow-up period.

Recommendations:
CMHSPs are required to submit the MMBPIS tracking template monthly to ensure accuracy and outliers are being followed-up with on a timely basis. Quarterly data is compiled and sent to MDHHS on the last day of the 3rd month in each quarter. MDHHS will be changing reporting specifications for indicators 2b, 3, and 4 in the 3rd Quarter of 2020. One of the primary changes will be the elimination of the exclusions and acceptations for the said indicators.

2019 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 qualifying 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 the 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 ▪ The arrest of a consumer that meets population standards	October 2018 – September 2019	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 analysis.

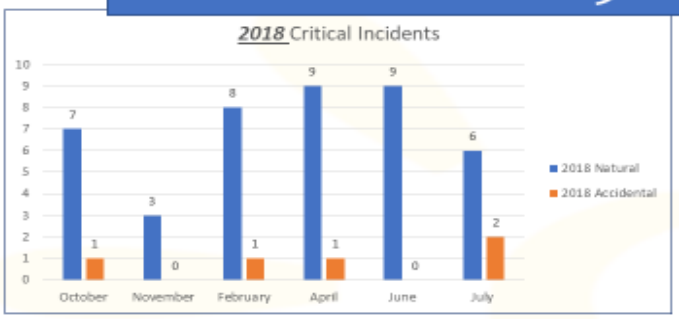
2019 Critical Incidents

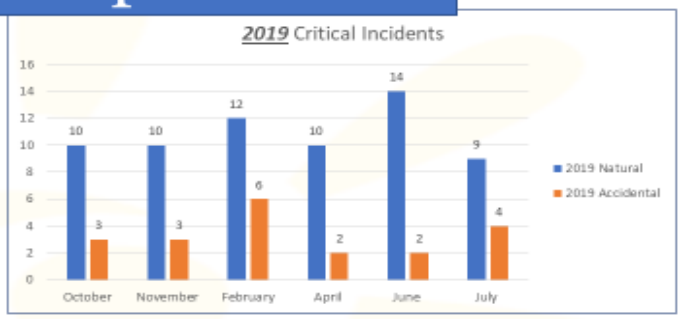


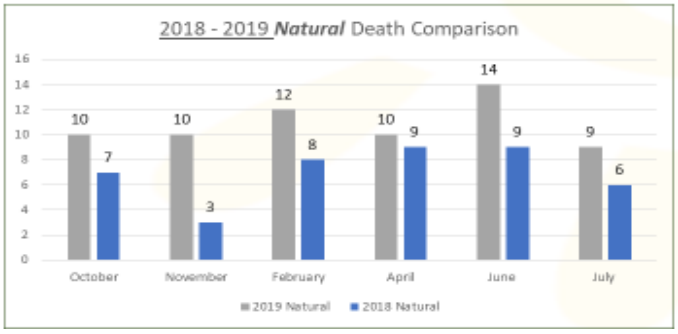
- ❖ Overall, for calendar year 2019 there were 287 critical incidents.
- ❖ The highest CI category being non-suicide death (141); the next top CI category is EMT due to injury/medication error (77).
- ❖ The lowest number of critical incidents was due to Suicide (8).

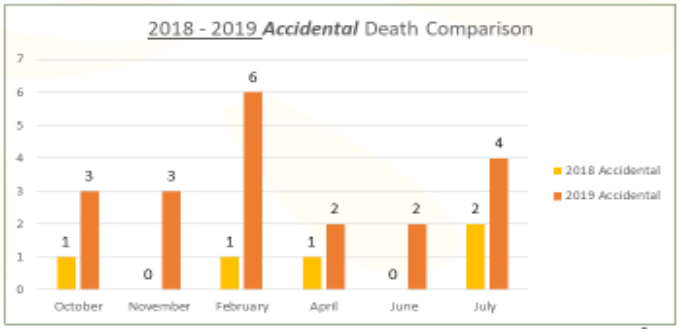
	FY 2019 - Q2			FY 2019 - Q3			FY 2019 - Q4			FY 2020 - Q1			Grand Total
	January	February	March	April	May	June	July	August	Septemb..	October	November	December	
Arrest	3	6	2	3	5	5	7	3	4	5	2	3	48
EMT due to Injury/Medication Error	6	7	9	12	6	8	6	8	4	6	4	1	77
Hospitalization due to Injury/Medication Er..	2	3	0	1	1	1	2	1	0	1	1	0	13
Non-Suicide Death	17	17	7	12	9	14	12	4	12	17	11	9	141
Suicide	1	1	1	0	1	2	1	1	0	0	0	0	8
Grand Total	29	34	19	28	22	30	28	17	20	29	18	13	287

2018 vs 2019 Comparison





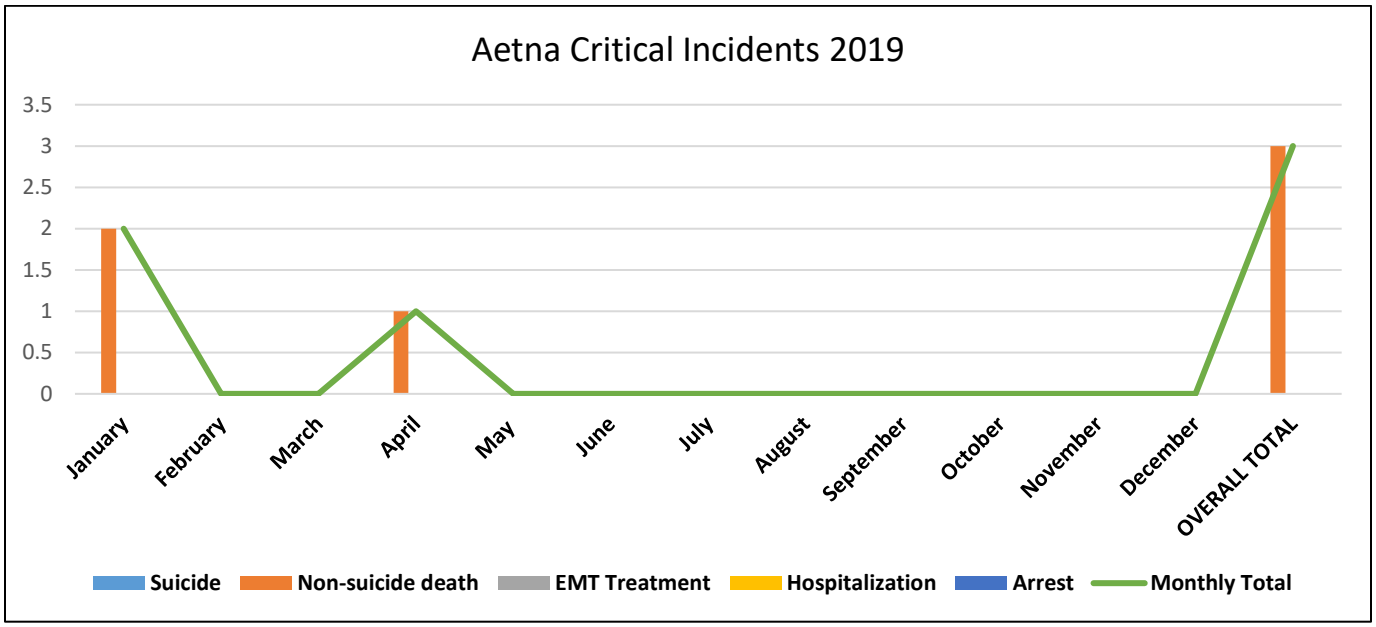




- ❖ The above data reflects months in which Natural and Accidental Deaths occurred, as well as a comparison by year.
- ❖ 2019 showed an increase of 23 Natural Deaths over the 2018 results.
- ❖ 2019 showed an increase of 15 Accidental Deaths over the 2018 results.

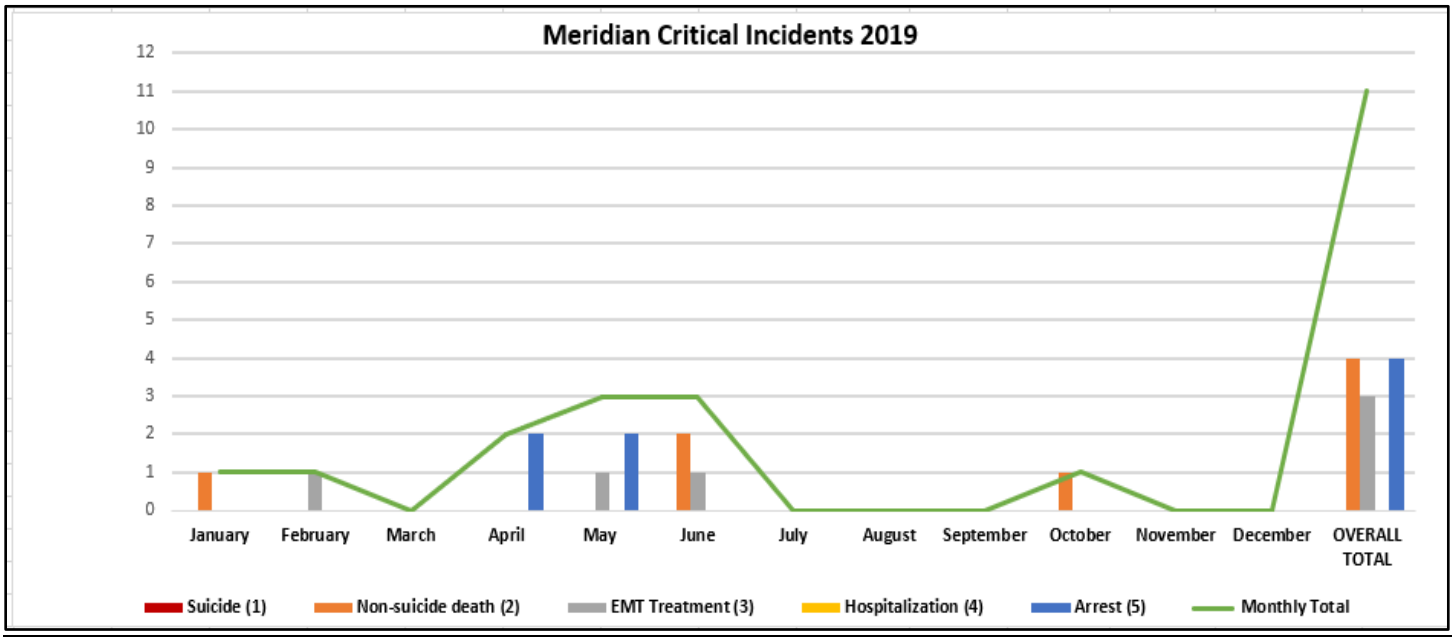
MI Health Link (Duals Demonstration Project) Critical Incidents

Aetna Health Plan



	2019-Q1			2019-Q2			2019-Q3			2019-Q4			
	January	February	March	April	May	June	July	August	September	October	November	December	OVERALL TOTAL
Suicide	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-suicide death	2	0	0	1	0	0	0	0	0	0	0	0	3
EMT Treatment	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospitalization	0	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	0
Monthly Total	2	0	0	1	0	0	0	0	0	0	0	0	3

- Analysis: In CY 2019 there was a total of (3) critical incidents reported to SWMBH for enrolled Aetna Members.
- A new reporting template will be implemented in 2020. The new template will allow both SWMBH and Aetna complete additional analysis, using the detailed data they receive.
- No significant trends were noted for the 2019 reporting period.



	2019-Q1			2019-Q2			2019-Q3			2019-Q4			
	January	February	March	April	May	June	July	August	September	October	November	December	OVERALL TOTAL
Suicide (1)	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-suicide death (2)	1	0	0	0	0	2	0	0	0	1	0	0	4
EMT Treatment (3)	0	1	0	0	1	1	0	0	0	0	0	0	3
Hospitalization (4)	0	0	0	0	0	0	0	0	0	0	0	0	0
Arrest (5)	0	0	0	2	2	0	0	0	0	0	0	0	4
Monthly Total	1	1	0	2	3	3	0	0	0	1	0	0	11

- Analysis: In CY 2019 there was a total of 11 critical incidents reported to SWMBH for enrolled Meridian Members.
- A new reporting template will be implemented in 2020. The new template will allow both SWMBH and Aetna to complete additional analysis, using the detailed data they receive.
- No significant trends were noted for the 2019 reporting period.

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 FY2019 due to the newly implemented process.

Identified Barriers:

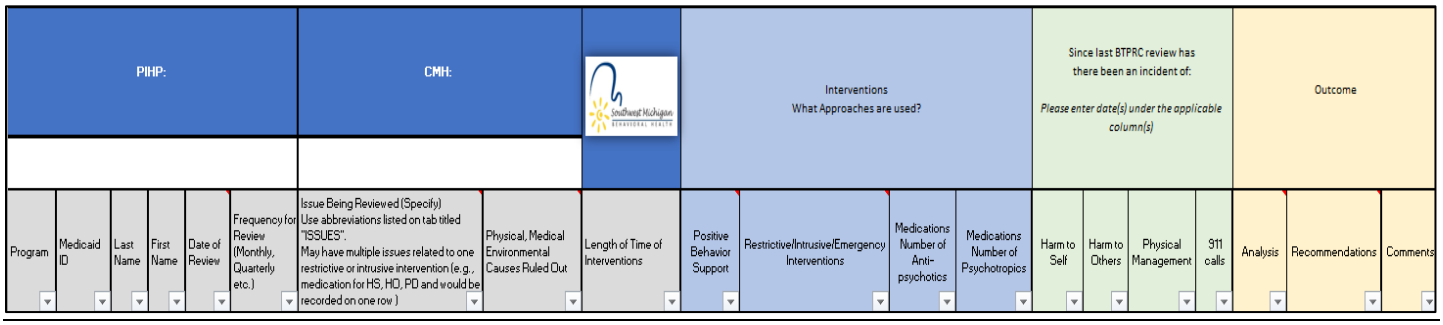
Per a recent Health Service Advisory Group (HSAG) External Quality Audit, it was determined that risk event analysis needs to be conducted on a more frequent basis during the Quality Management Committee (QMC) meetings. Also, a new policy regarding Sentinel event timeliness needs to be employed and communicated to SWMBH CMHSP partners.

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 significantly improved since FY 18. A CISE (Critical Incident & Sentinel Event) workgroup was created to update any current CISE training materials and also to 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.

2019 Behavioral Treatment Review Committee Data

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Behavioral Treatment Review Committee Data	➢ SWMBH collects information from CMHs and makes it 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 quarterly. ✓ 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 the care of "vulnerable" people.	October 2018 – September 2019	QAPI Specialist QAPI Director Data Analyst Director of Clinical Practices Regional Operations Committee	Quarterly



PIHP:						CMH:			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		
Program	Medicaid ID	Last Name	First Name	Date of Review	Frequency for Review (Monthly, Quarterly etc.)	Issue Being Reviewed (Specify) Use abbreviations listed on tab titled "ISSUES". May have multiple issues related to one restrictive or intrusive intervention (e.g., medication for HS, HD, PD and would be recorded on one row)	Physical, Medical Environmental Causes Ruled Out	Length of Time of Interventions	Positive Behavior Support	Restrictive/Intrusive/Emergency Interventions	Medications Number of Anti-psychotics	Medications Number of Psychotropics	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. 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:

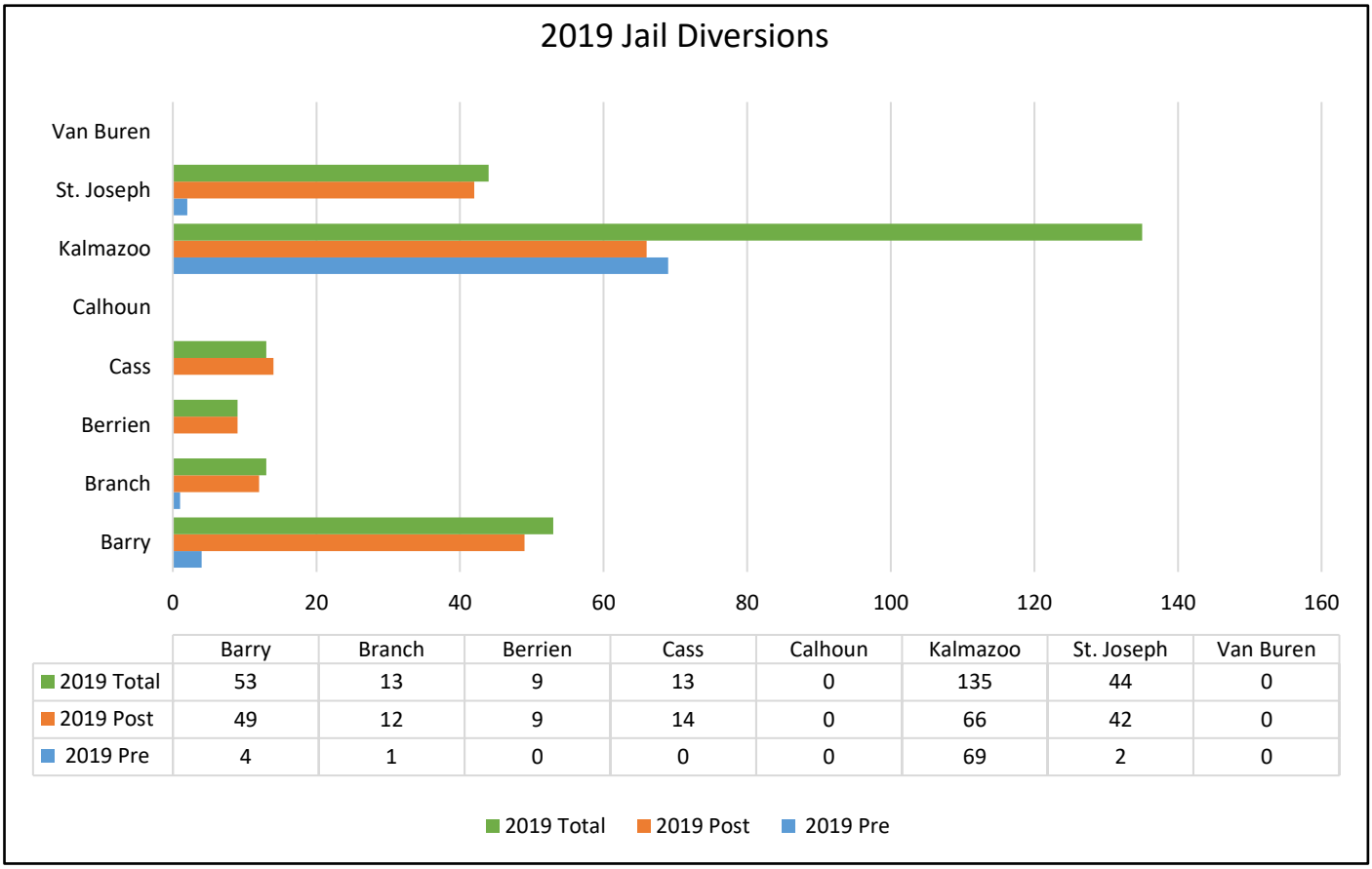
The SMMBH Quality Management Committee (QMC) minutes documented that the PIHP ensured that each affiliate submitted BTRC data via the BTPRC Data Spreadsheet. The SWMBH Operating Policy 3.3, Behavior Treatment Review Committee, listed the information required to be entered in the form. This information is reviewed quarterly during QMC meetings, and selected cases are selected for review during CMHSP site audits. The SWMBH clinical team reviews the appropriateness of interventions and length of service standards.

Identified Barriers:
CMHSPs are not reporting for non-waiver beneficiaries. A process has been established to begin collecting this information from CMHSP's during FY 2020.

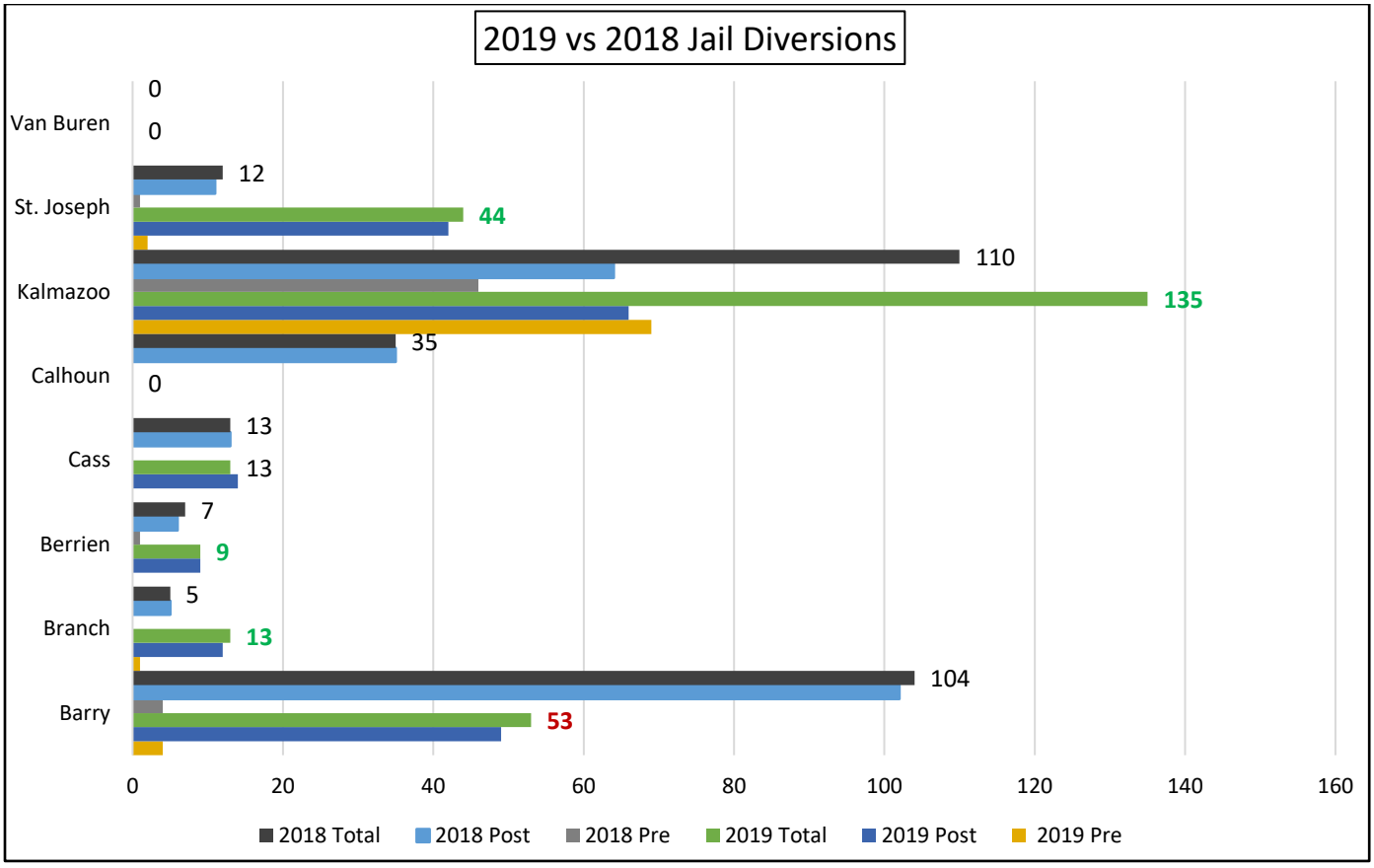
Recommendations:
The PIHP must ensure that CMHSPs are collecting and analyzing all data as required, including the length of time of interventions used per person. QMC will review data quarterly for potential identification of improvements, improved processes, and identification/analysis of any trends.

2019 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 shared with Regional Entities through the Operations Committee and Utilization Management Committee as needed.	October 2018 – September 2019	QAPI Specialist QAPI Director Director of Clinical Practices Director of Utilization Management	Annually or as needed



	Barry	Branch	Berrien	Cass	Calhoun	Kalmazoo	St. Joseph	Van Buren
2019 Total	53	13	9	13	0	135	44	0
2019 Post	49	12	9	14	0	66	42	0
2019 Pre	4	1	0	0	0	69	2	0



***Red signifies a decrease from last year**
***Green signifies an increase from the previous year**

Objective:
Collect, monitor, and report services designed to divert persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate.

Results:
The collection of diversion data from participant CMHSPs is due to SWMBH annually. As you can see, the majority of CMHSPs have had an increase in diversions over the past year. Affiliate input suggests administration at jails may be a factor in the utilization of jail diversion programs.

Identified Barriers:
Identified barriers include data being reported in an accurate, complete, and timely manner as required by MDHHS. Appropriate training and reporting from the administrative staff in the jails seems to be an ongoing issue and is reflective of the data collected and reported.

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. We will also update our Jail Diversion Educational Power Point and send to new providers, as reference on reporting expectations.

2019 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 customer experience and improved outcomes.	✓ Distribution and analysis of an annual customer satisfaction survey for members who have received multiple services during the survey 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 2019 - December 2019	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 Analysis

(MHSIP-Adult) and Youth Statistics Survey (YSS-Youth)

How Did We Do?

MHSIP Results

- 2019 Aggregate Ave. Score: 93.09%
- 2018 Aggregate Ave. Score: 90.63%

+2.46% Percent Improvement over 2018 Scores (All Categories)

YSS Results

- 2019 Aggregate Ave. Score: 91.58%
- 2018 Aggregate Ave. Score: 91.28%

+0.30% Percent Improvement over 2018 Scores (All Categories)

Overall Response Rates

- 2019 Response Rate: 36.4%
- 2018 Response Rate: 37.3%

Overall Result

+2.76% **Percent Overall Improvement (MHSIP + YSS)**

Survey Process and Preparation

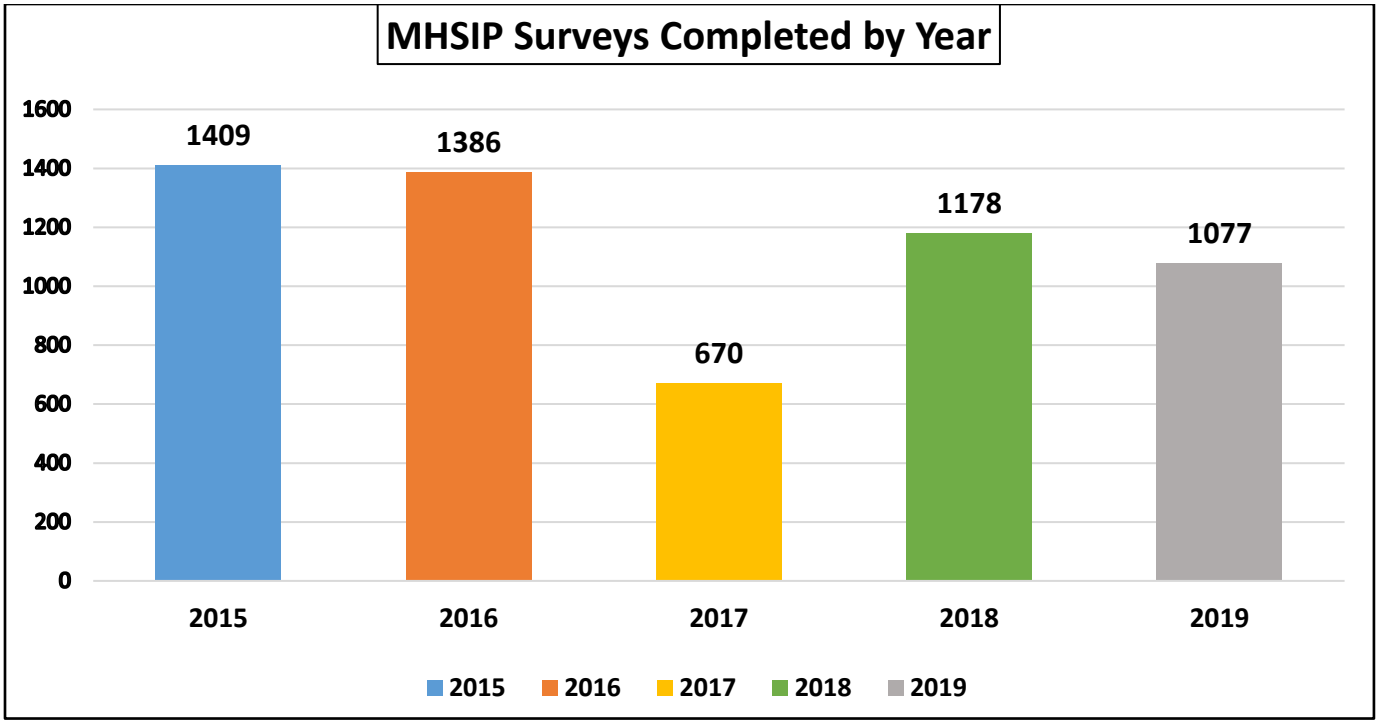
How the survey is conducted:

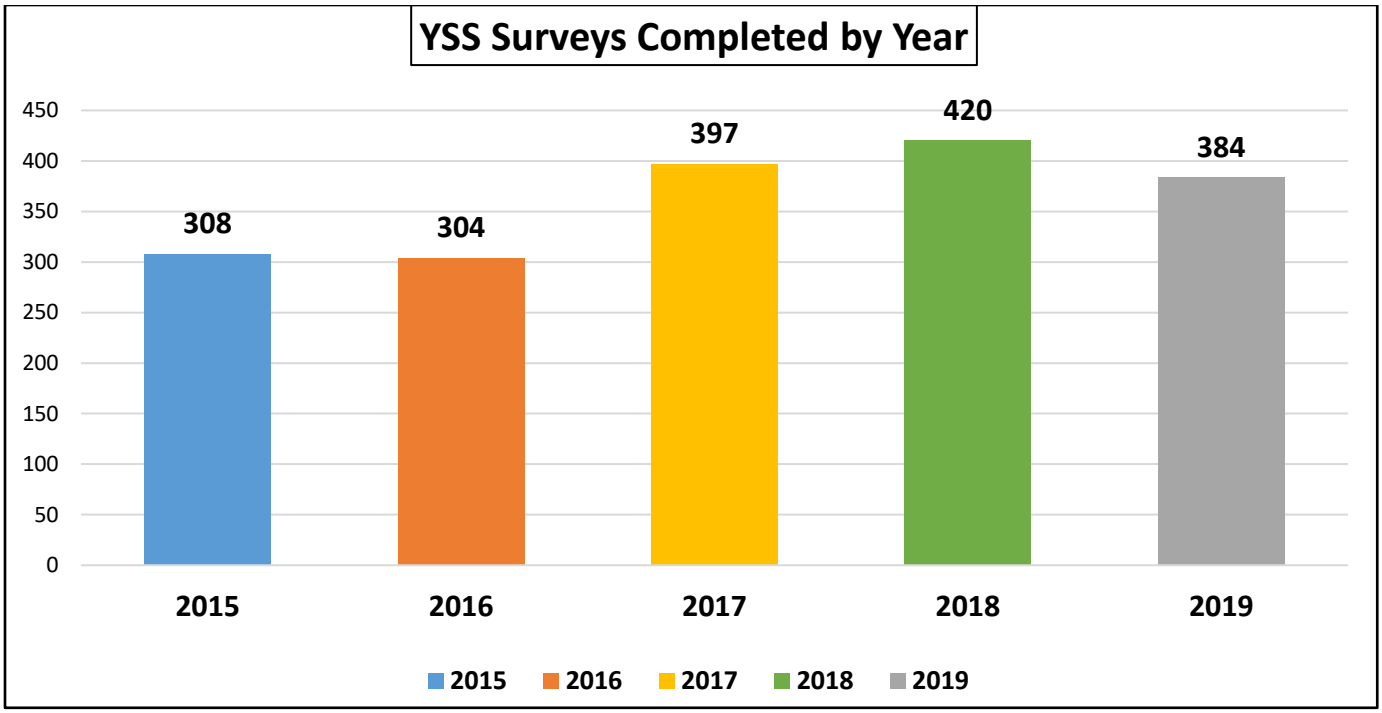
- Telephonically
- Using the following survey tools:
- Mental Health Statistics Improvement Program (MHSIP) – consumers 18 years + .
- Youth Services Survey (YSS) – under 18 years of age.

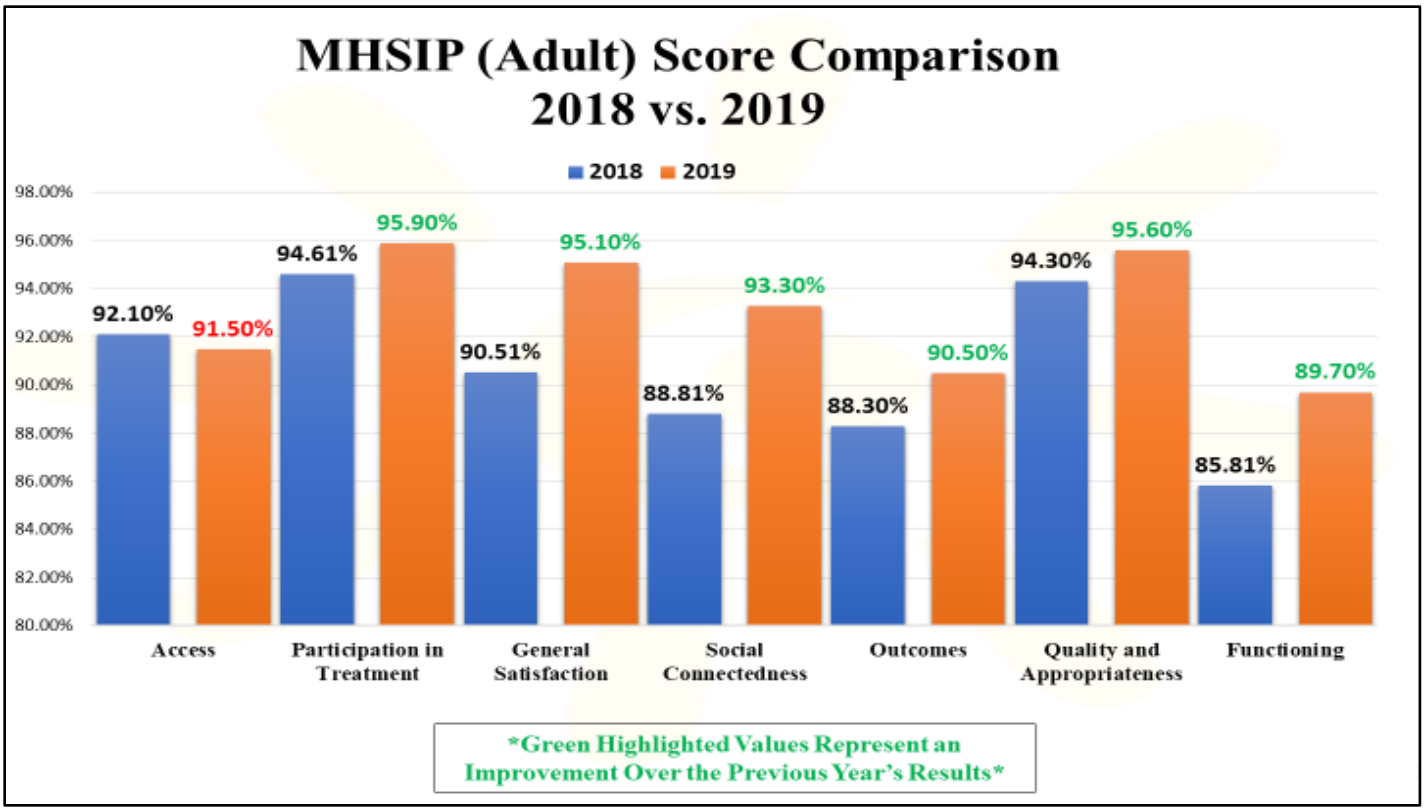
About the survey tools:

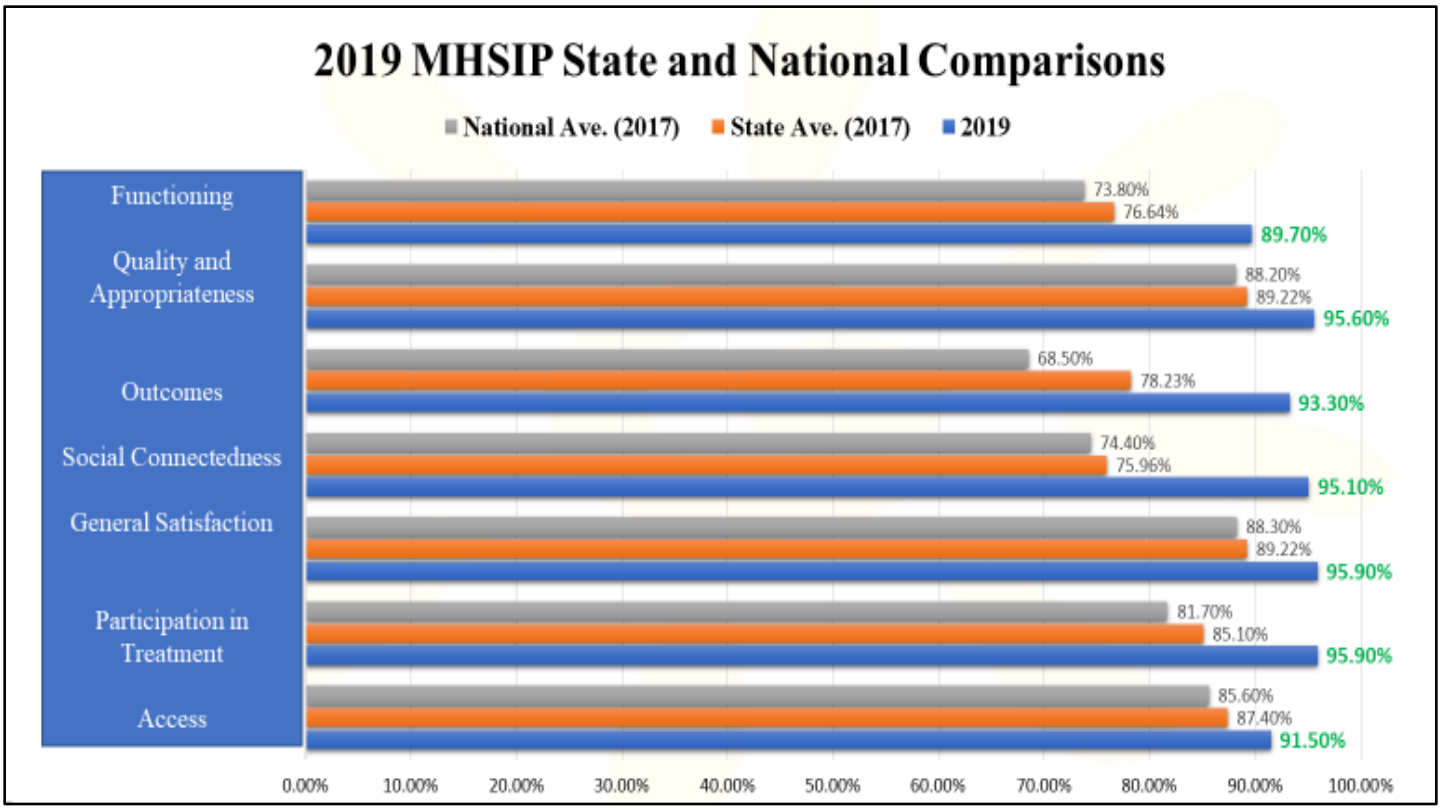
- Contractually obligated by MDHHS for SMWBH to utilize.
- Both offer a wide range of flexibility in the capturing of feedback.
- Offer comparison against other national and state results (currently implemented in 55 states).

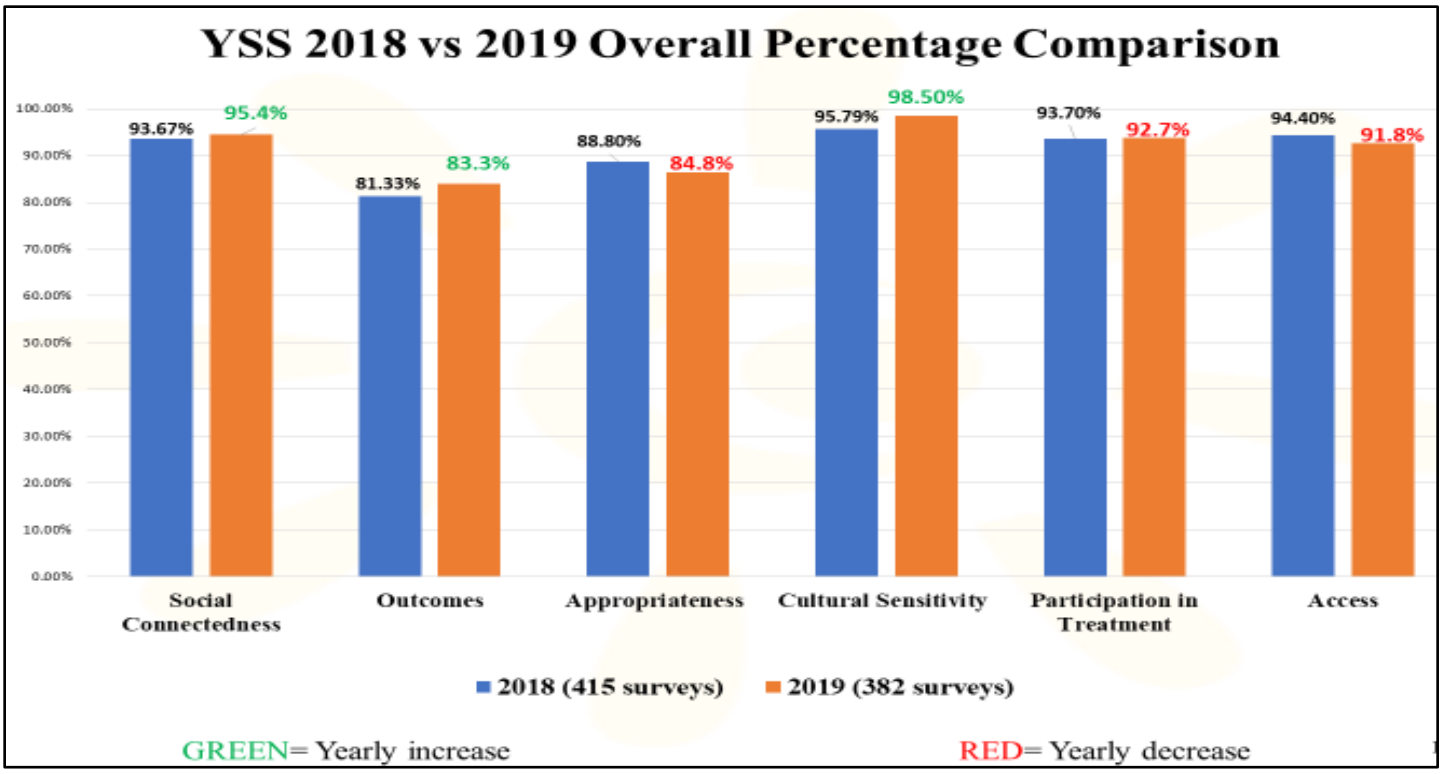
Complete survey results and consumer feedback can be found in the following slides

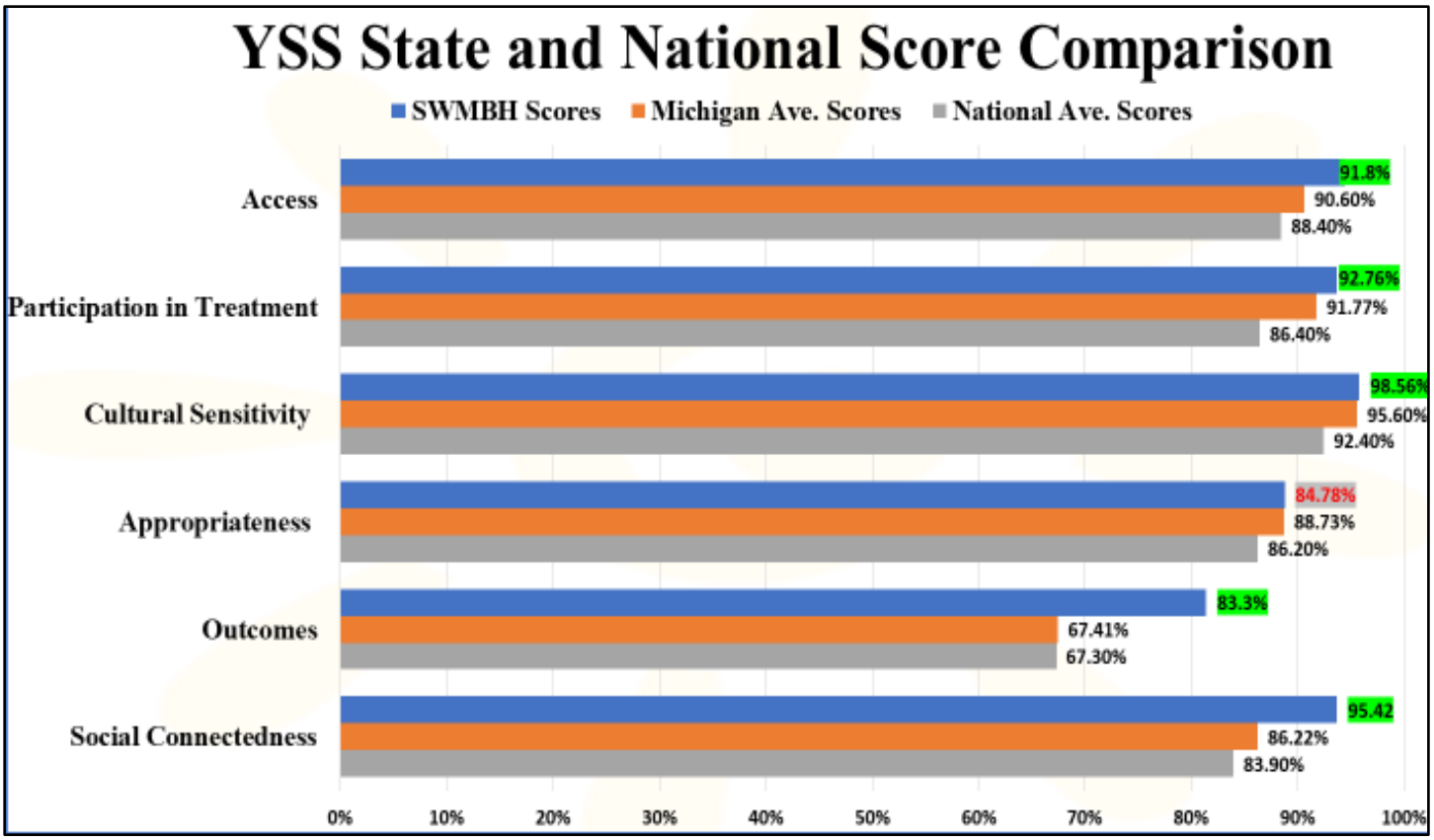

MHSIP Surveys Completed by Year
1600
1400
1200
1000
800
600
400
200
0
1409
1386
670
1178
1077
2015
2016
2017
2018
2019
2015 2016 2017 2018 2019


YSS Surveys Completed by Year
450
400
350
300
250
200
150
100
50
0
308
304
397
420
384
2015
2016
2017
2018
2019
2015 2016 2017 2018 2019

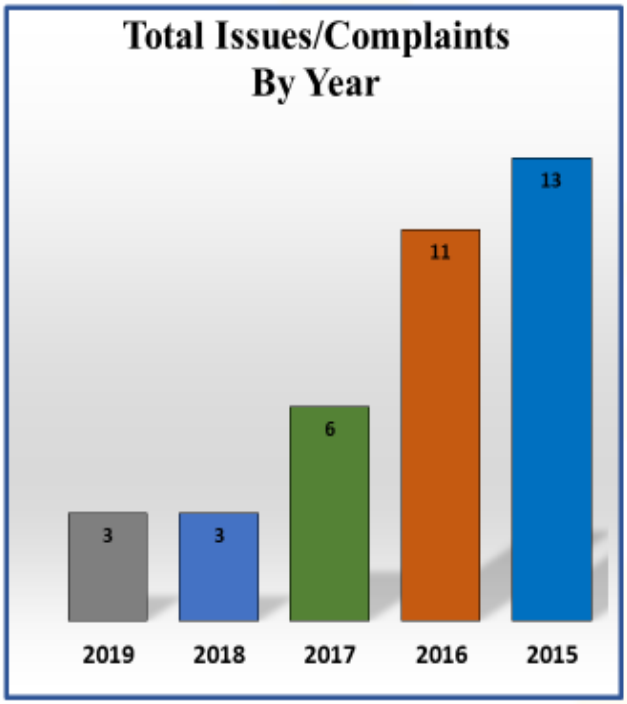

MHSIP (Adult) Score Comparison
2018 vs. 2019
2018
2019
98.00%
96.00%
94.00%
92.00%
90.00%
88.00%
86.00%
84.00%
82.00%
80.00%
92.10%
91.50%
94.61%
95.90%
90.51%
95.10%
88.81%
93.30%
88.30%
90.50%
94.30%
95.60%
85.81%
89.70%
Access
Participation in Treatment
General Satisfaction
Social Connectedness
Outcomes
Quality and Appropriateness
Functioning
Green Highlighted Values Represent an Improvement Over the Previous Year's Results


2019 MHSIP State and National Comparisons
National Ave. (2017)
State Ave. (2017)
2019
Functioning
73.80%
76.64%
89.70%
Quality and Appropriateness
88.20%
89.22%
95.60%
Outcomes
68.50%
78.23%
93.30%
Social Connectedness
74.40%
75.96%
95.10%
General Satisfaction
88.30%
89.22%
95.90%
Participation in Treatment
81.70%
85.10%
95.90%
Access
85.60%
87.40%
91.50%
0.00%
10.00%
20.00%
30.00%
40.00%
50.00%
60.00%
70.00%
80.00%
90.00%
100.00%

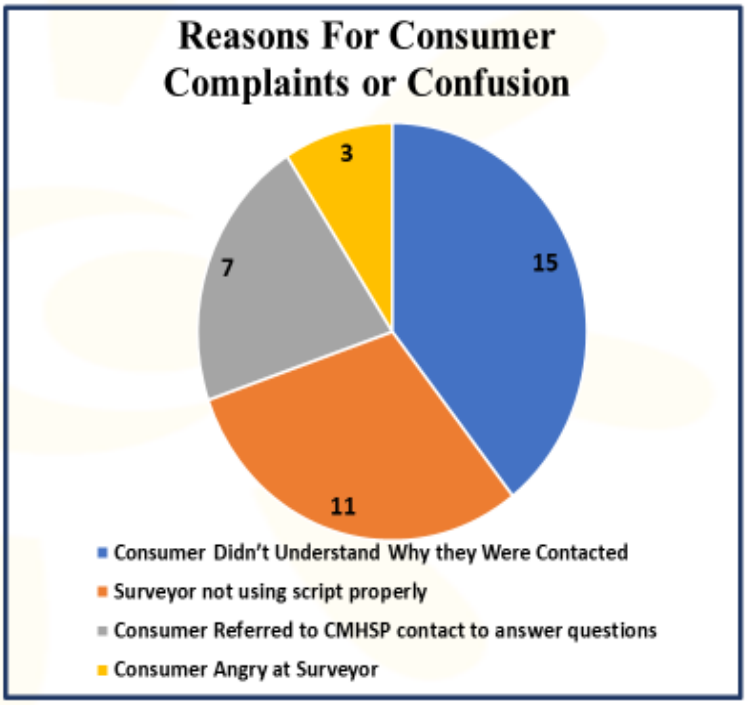

YSS 2018 vs 2019 Overall Percentage Comparison
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
93.67%
95.4%
81.33%
83.3%
88.80%
84.8%
95.79%
98.50%
93.70%
92.7%
94.40%
91.8%
Social Connectedness
Outcomes
Appropriateness
Cultural Sensitivity
Participation in Treatment
Access
2018 (415 surveys)
2019 (382 surveys)
GREEN= Yearly increase
RED= Yearly decrease


YSS State and National Score Comparison
SWMBH Scores
Michigan Ave. Scores
National Ave. Scores
Access
91.8%
90.60%
88.40%
Participation in Treatment
92.76%
91.77%
86.40%
Cultural Sensitivity
98.56%
95.60%
92.40%
Appropriateness
84.78%
88.73%
86.20%
Outcomes
83.3%
67.41%
67.30%
Social Connectedness
95.42
86.22%
83.90%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

Consumer Issues and Complaints

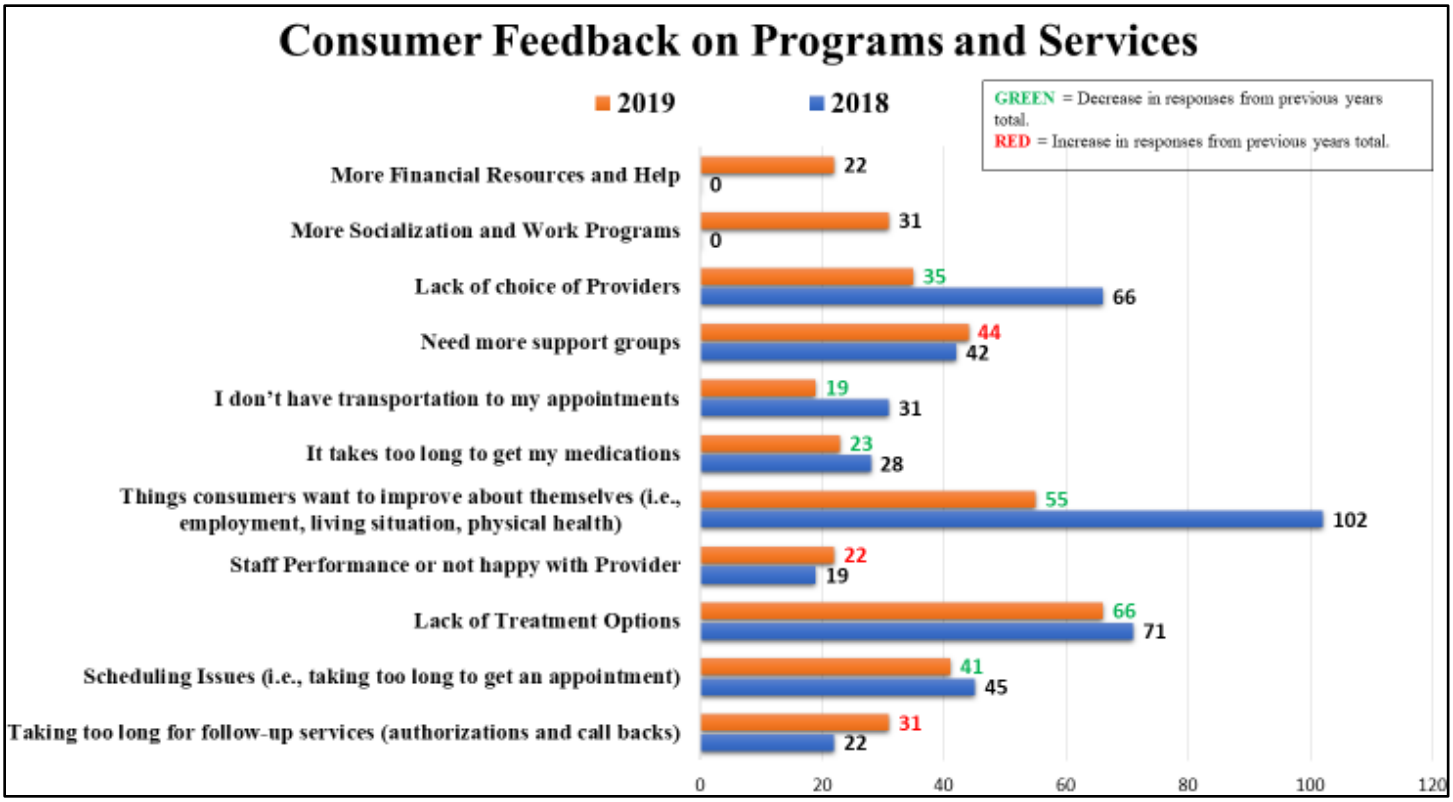


(3) Complaints during 2019



(36) Total Across All 5 Year's

Consumer Feedback on Programs and Services




Positive Feedback From Consumers Regarding Improved Outcomes
MY THERAPIST HELPED ME GET A REALATIONSHIP WITH MY FAMILY BACK
1
I CAN NOW LIVE INDEPENDTLY AND NOT HAVE TO RELY ON OTHERS
3
I FEEL COMFORTABLE IS SOCIAL SITUATIONS NOW
6
MY SOCIAL WORKER HELPED ME GO BACK TO WORK
6
THANKS TO MY THERAPIST, I HAVE NEVER FELT BETTER
2
I FEEL EMPOWERED TO MAKE MY OWN DECISIONS
3
GETTING MY MEDS RIGHT MADE A HUGE DIFFERENCE
5
MY THERAPIST TAUGHT ME HOW TO BE MY OWN ADVOCATE
2
I HAVE MY LIFE BACK
2
MY DOCTOR IS ALWAYS WILLING TO SEE ME AND IS UNDERSTANDING
5
WORK PROGRAMS ARE VERY HELPFUL
11
ACCESS TO MY DOCTOR AND THERAPIST IS VERY GOOD
13
GROUP THERAPY AND PEER SUPPORT GROUPS REALLY HELP
20
I LOVE MY THERAPIST AND INDIVIDUAL SESSIONS
21
MY SOCIAL WORKER IS EXCEPTIONAL
30
0
5
10
15
20
25
30
35


Direct Service Consumer Feedback and Opportunities for Improvement
MY THERAPIST NEEDS TO LISTEN BEFORE MAKING JUDGEMENTS
3
FRONT DESK AT CMHSPS SHOW NO EMOTION OR COMPASSION
4
MY CMHSP WONT GIVE ME A RIDE TO MY APPOINTMENTS
7
I WAITED LONGER THAN 2 WEEKS FOR A MED REFILL
7
THE LENGTH OF MY APPOINTMENTS ARE TO SHORT AND RUSHED
8
EASIER ACCESS TO TALK TO INDIVIDUALS INSTEAD OF A SWITCHBOARD WHEN YOU CALL
9
IT TAKES A LONG TIME FOR MY CMHSP TO ANSWER THE PHONE
11
0
2
4
6
8
10
12

2019 Consumer Satisfaction Survey Analysis and Opportunities for Improvement

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 an overall **+2.76% Percent Improvement** over the 2018 Results*. This met the Board Ends Metric target, which is indicated: Consumer Satisfaction Surveys collected by SWMBH during 2019 are at or above the SWMBH 2018 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 2019 survey project also resulted in a tie with the 2018 survey year, for the fewest consumer complaints (3). Total Number of Consumer Complaints by year: 2015 – (13); 2016 – (11) and 2017 – (6); 2018 – (3); 2019 – (3). The decrease in consumer complaints over the past 2 years is primarily attributed to 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 vendor; 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 2019 survey process got off to a late start but picked up momentum quickly. Due to the late start, this didn't give us as much time to train the surveyors as we would have liked. This is our second year working with the selected vendor, so we are still working through how to train surveyors while ensuring maximum efficiency. The QAPI Department has adjusted processes/schedules to begin the surveys earlier in 2020. We believe an earlier start will allow us to achieve a higher rate of samples and target a more validated sample size for each CMHSP. 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 vendor.

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 2020, through consumer feedback analysis, some access issues were identified as a trend. Specific issues included; waiting too long to see a provider, waiting too long for Rx refills, timeliness of answering phones at particular locations, and lack of transportation options to attend appointments. SWMBH will work through Regional Committees to develop a performance improvement plan and causal analysis, which targets improvement in timeliness of access to care for the consumers we serve. CMHSP's were also requested to complete performance improvement projects, based on their specific results from the development of CMHSP tailored reports for all (8) Counties. The CMHSP specific reports were delivered on 2/24/2020.

MI Health Link Satisfaction

MIHL Medicare Business Line
Consumer Satisfaction Survey Analysis

Core contractual deliverable to our Integrated Healthcare Partners
(Meridian & Aetna Health Plans)

- Measures concerns that are important to consumers, who are enrolled under Meridian or Aetna Health Plans, who received Mental Health or Substance Abuse Service Authorizations by Southwest Michigan Behavioral Health (SWMBH)

This includes:

- **Improved functioning**
- **Quality and Appropriateness**
- **Outcomes**
- **Social Connectedness**
- **General Satisfaction**
- **Participation in treatment**
- **Access**

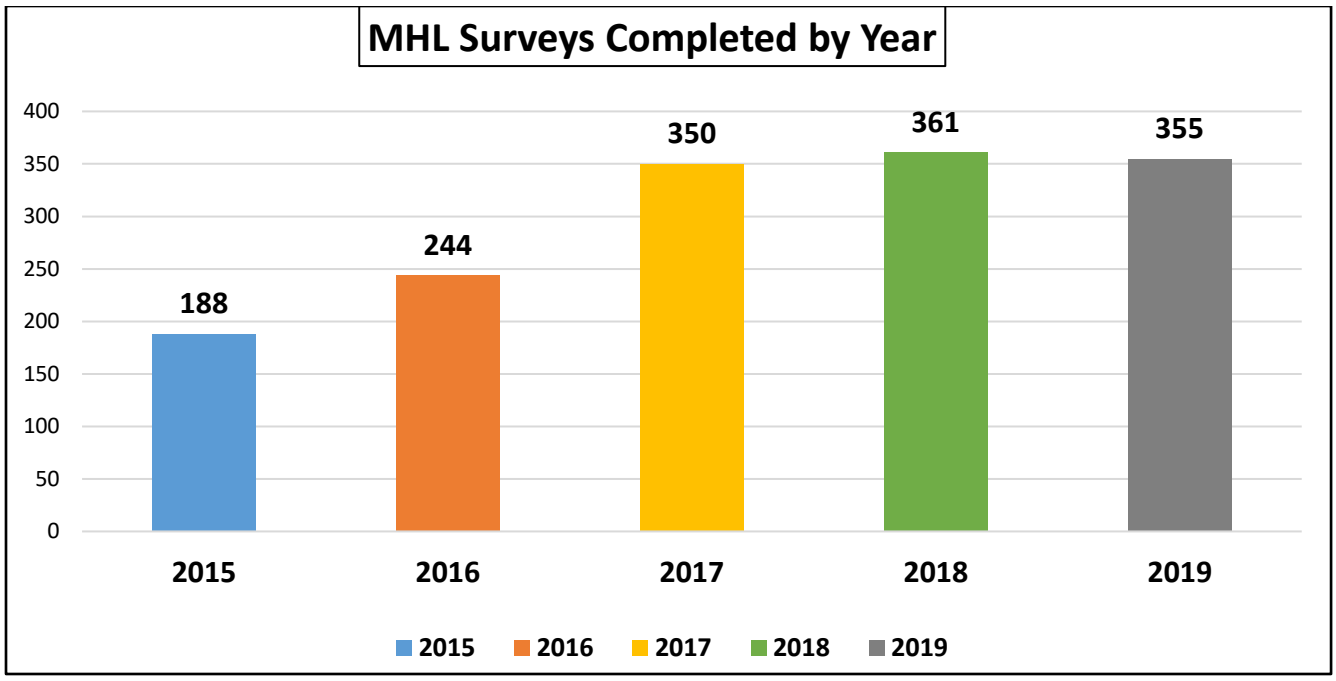
How Did We Do?

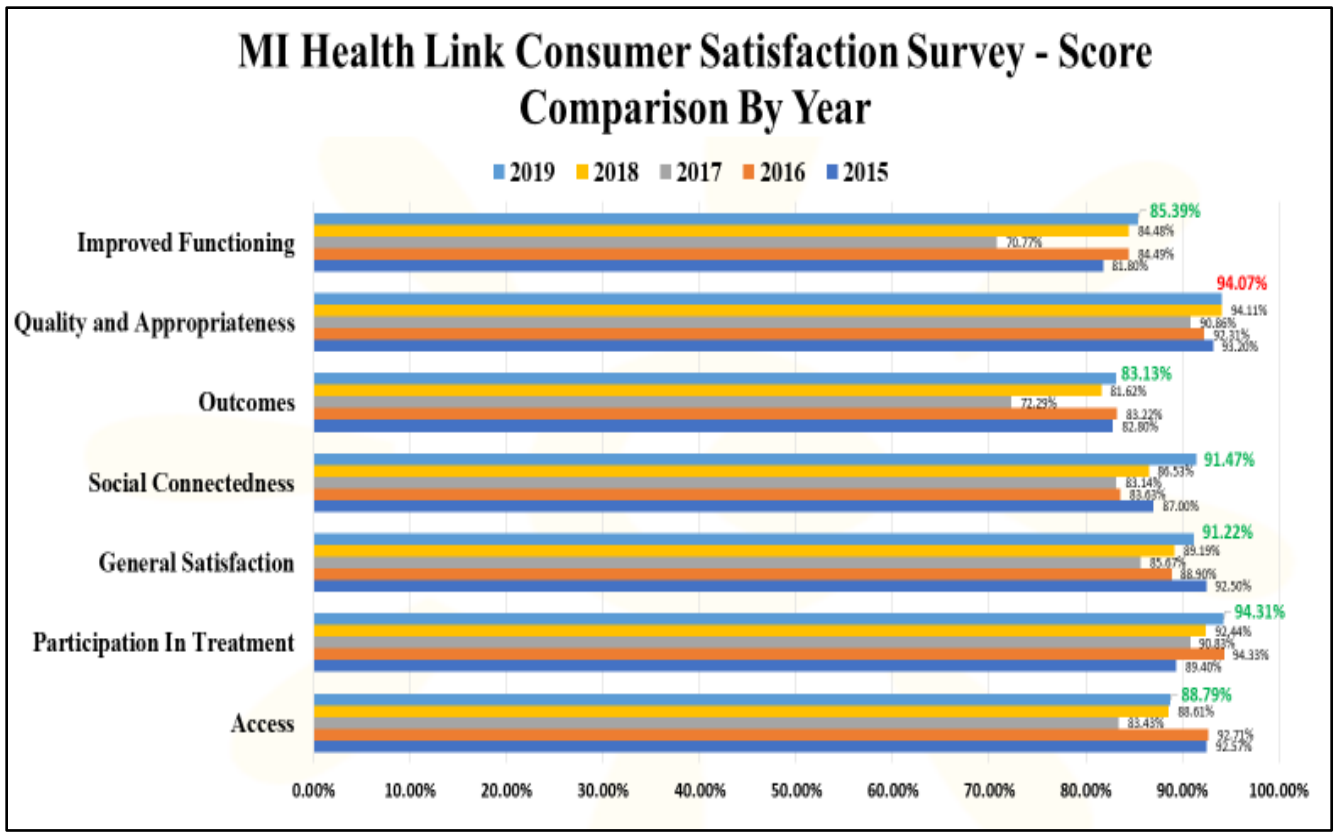
MIHL Results

- ❑2019 Aggregate Score: 89.8%
- ❑2018 Aggregate Score: 88.1%

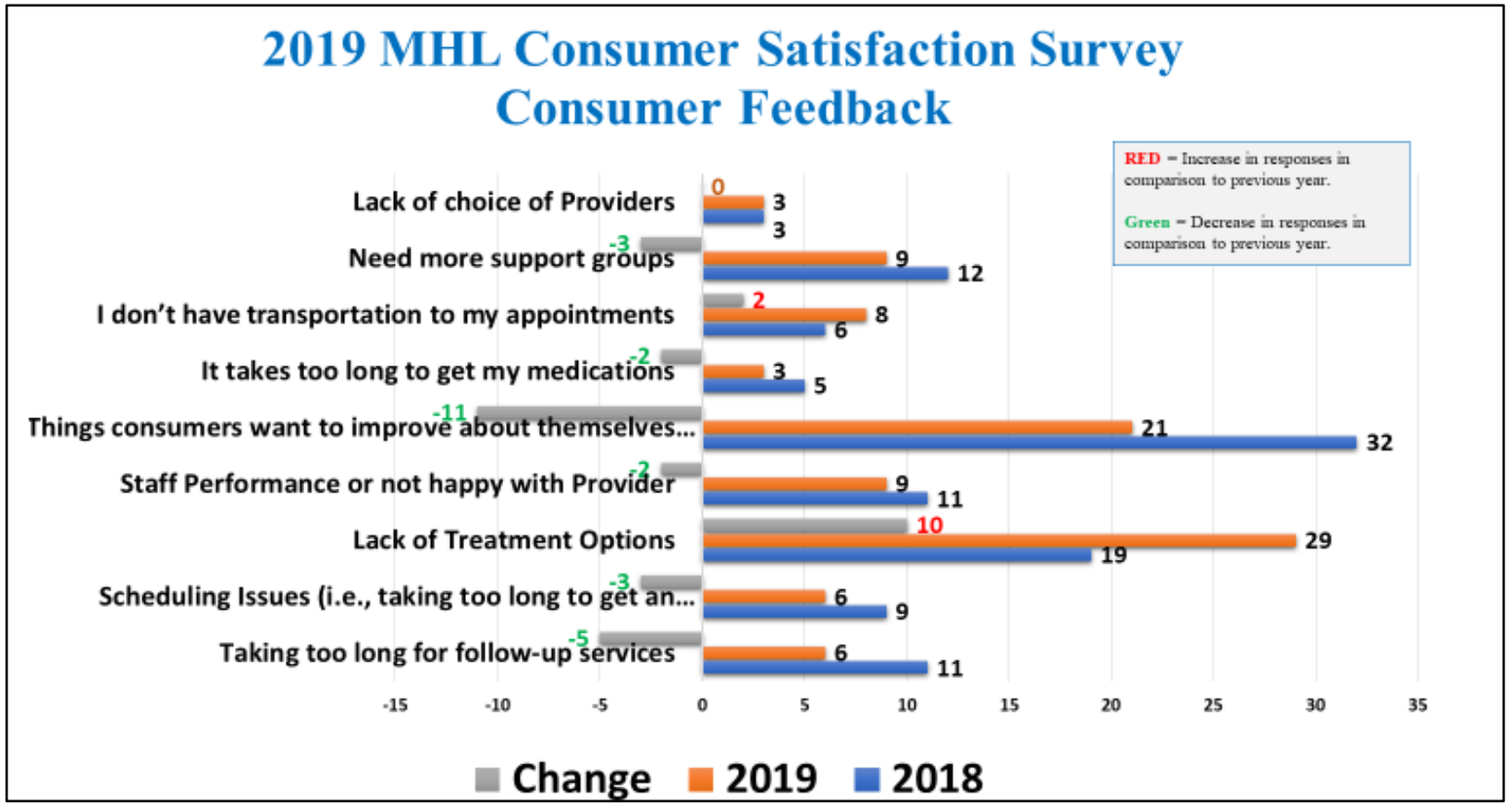
- ❑2019 Response Rate: 37.4%
- ❑2018 Response Rate: 39.7%

+1.7% Percent Improvement over 2018 Scores





*Improvement in (6 of 7) total categories was achieved during the 2019 survey period.



Summary of Finding:

In summary, (355) valid surveys were completed, resulting in a 37.4% response rate. The response rate was down a touch in comparison to 2018 results 42.9%, but was not considered significant, and still well ahead of the national average. This response rate is very good and attributed to the letters and advertisement efforts taken before the survey implementation. The current 2019 results are a significant improvement over the 2018 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 2018 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 2019 survey process. The current results tend to reflect national trends for the respective MHSIP survey tool domains. They tend to reflect results reported by [some] states that employ credible survey methods for MHSIP URS (SAMSHA) reporting (i.e., Oregon / Utah / Ohio / California…). These states have similar evaluation and validation processes as Southwest Michigan Behavioral Health.

Improvement Measures:

During the 2019 survey process and evaluation, it was identified that increased vendor oversight and monitoring needed to occur. In 2018 it was found that some surveyors were inconsistent using scripts and identified themselves incorrectly to consumers. This caused some confusion for the consumers in understanding the significance 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.

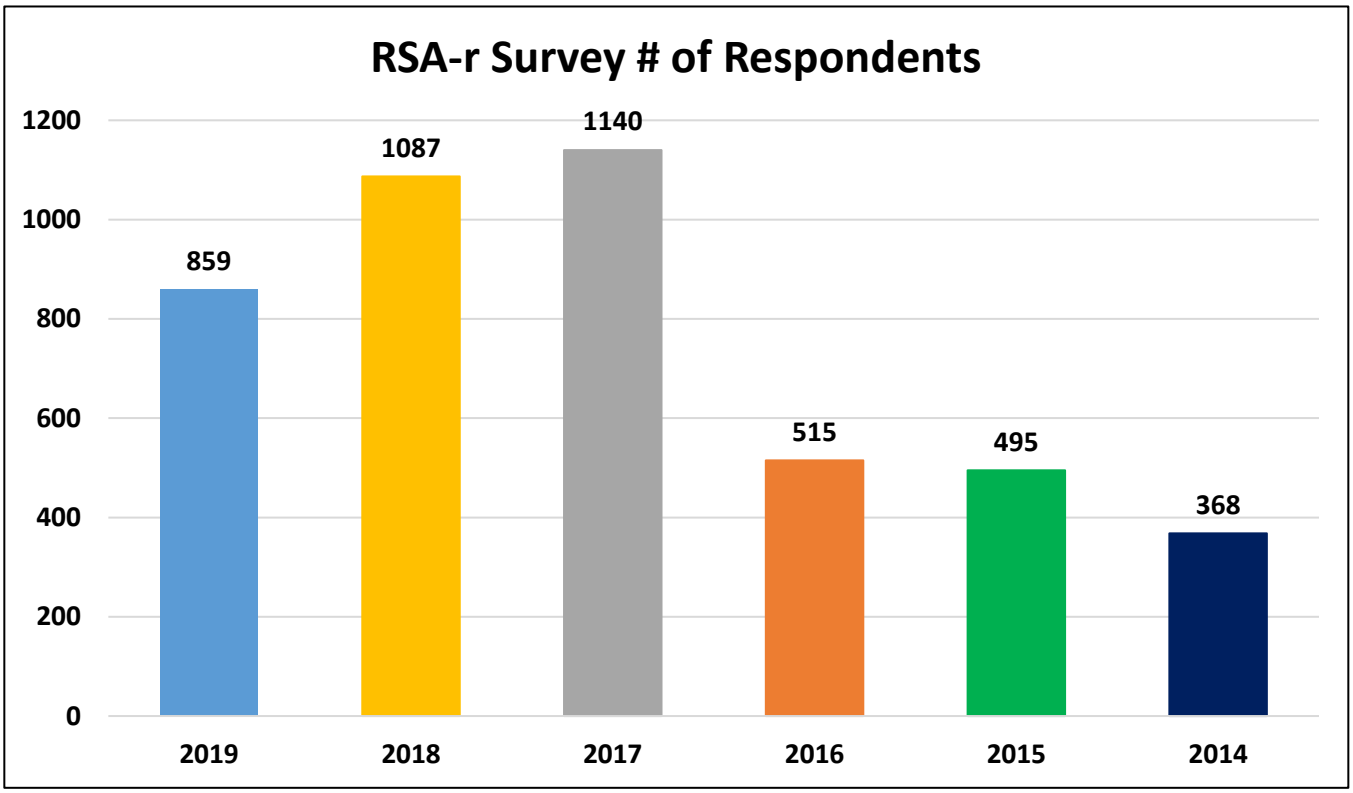
Additionally, SWMBH Management made (2) random visits to the vendor/survey location to observe the consistency in scripts and survey protocol was being followed correctly. It was found that the 4 surveyors evaluated were using the appropriate scripts and techniques they had been educated on. Consumer feedback and comments will be assessed to identify potential trends. Workgroups and Regional Committees will review the detailed data and formulate a performance improvement plan for categories with identified outliers.

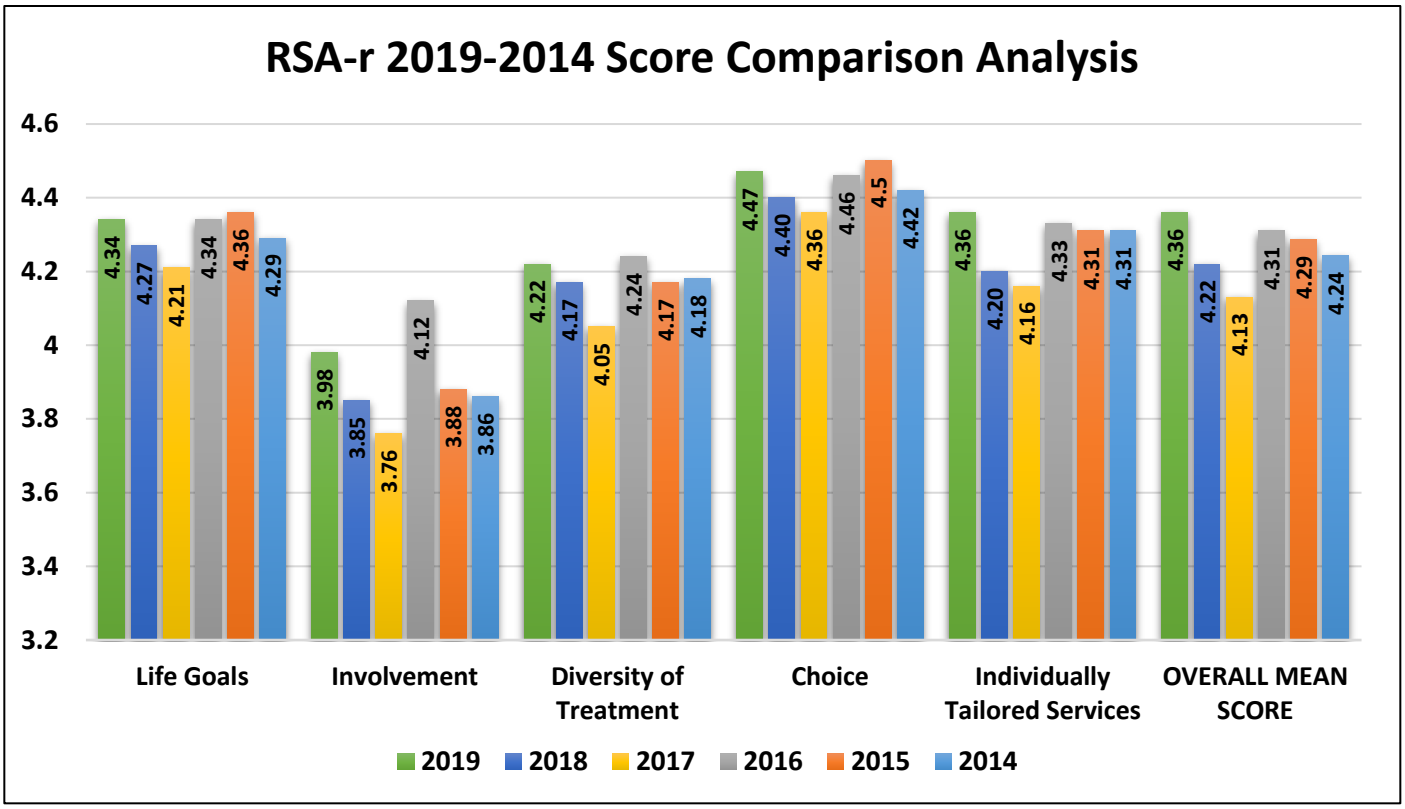
Recovery Self-Assessment – Person in Recovery (RSA-r) Survey

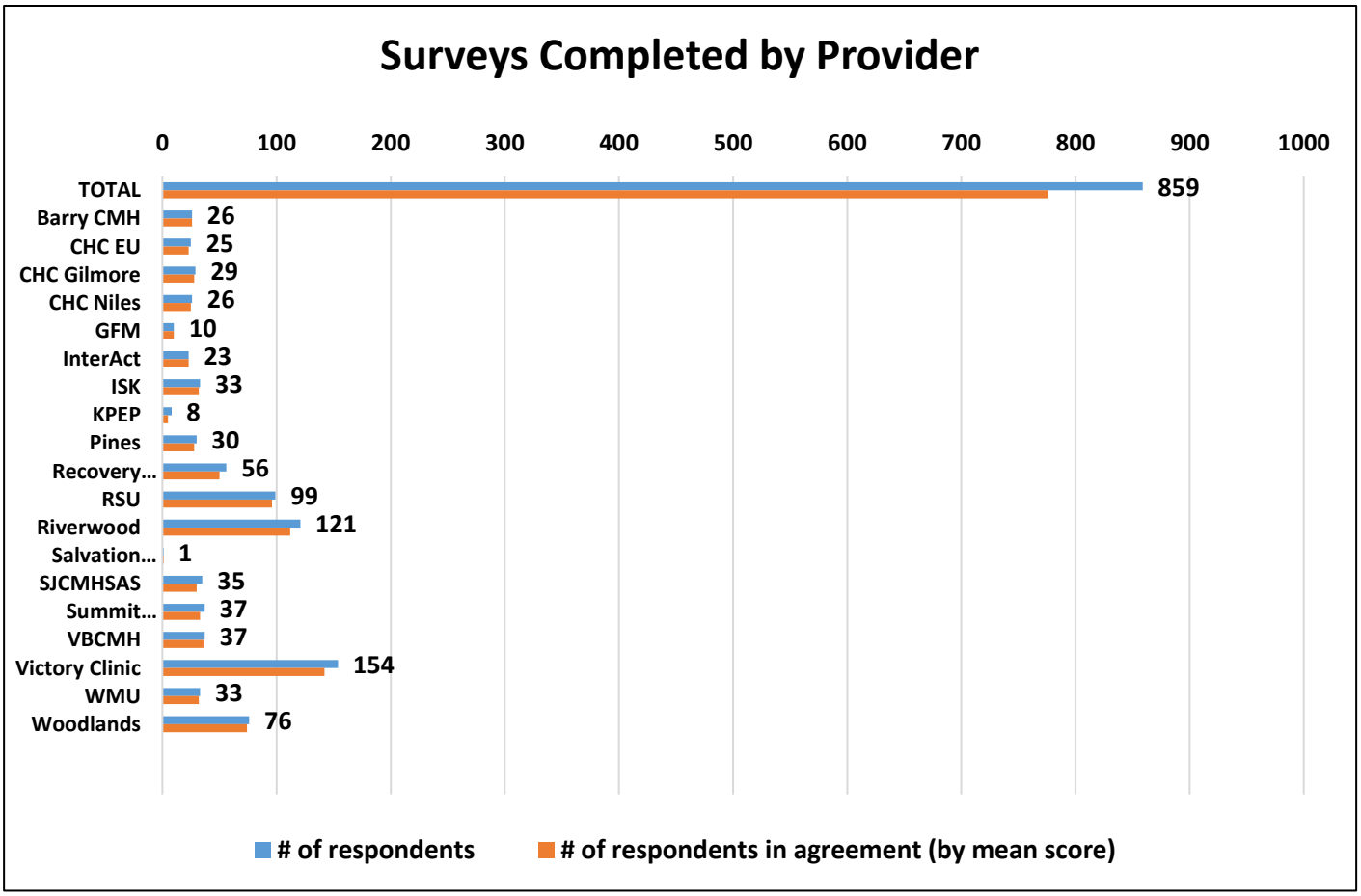
RSA-r Results Year Comparison

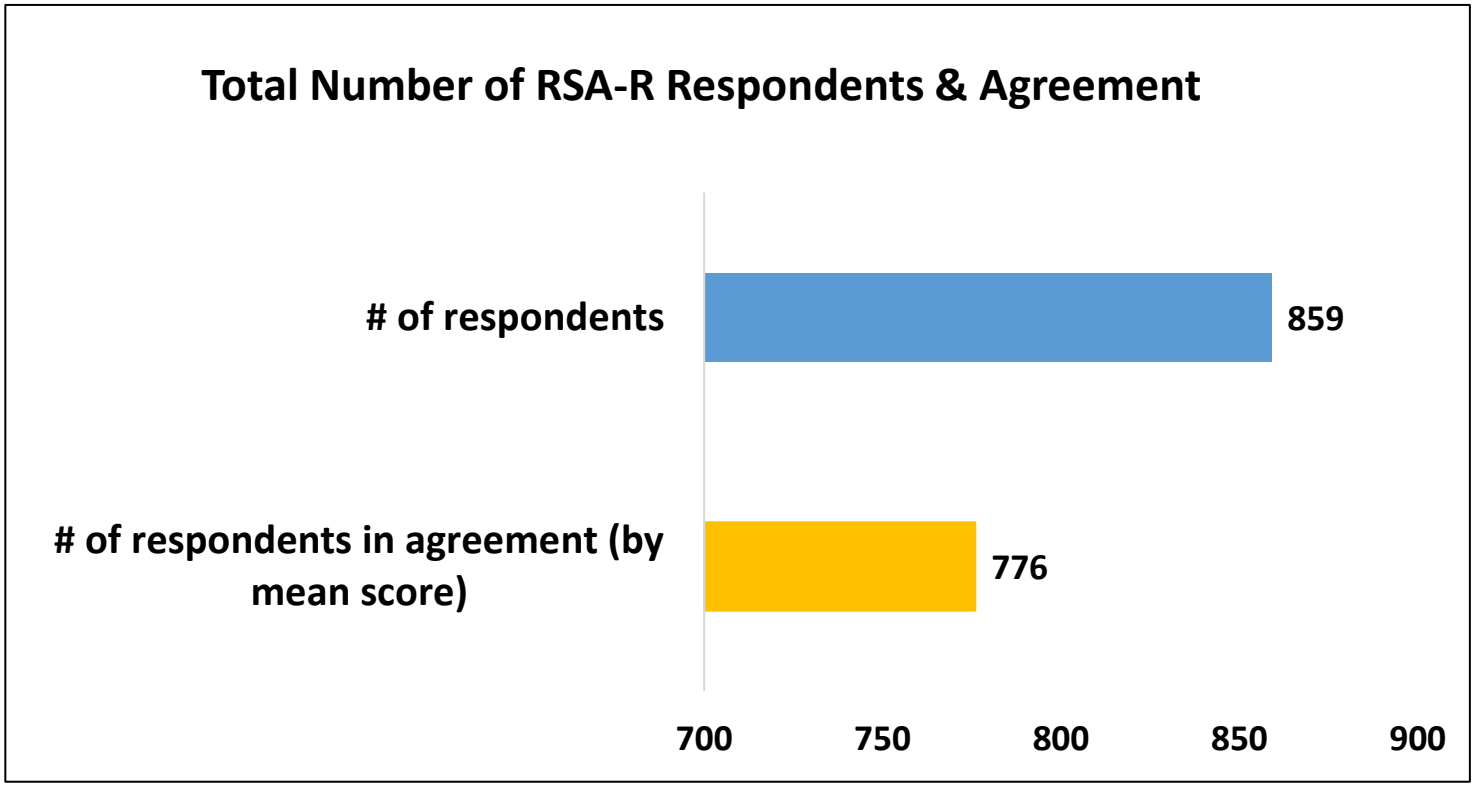
- ❑ 2019 Overall Mean Score: 4.36
  (+0.14 Percent increase from 2018)
- ❑ 2018 Overall Mean Score: 4.22
- ❑ 2017 Overall Mean Score: 4.13
- ❑ 2016 Overall Mean Score: 4.31
- ❑ 2015 Overall Mean Score: 4.29
- ❑ 2014 Overall Mean Score: 4.24

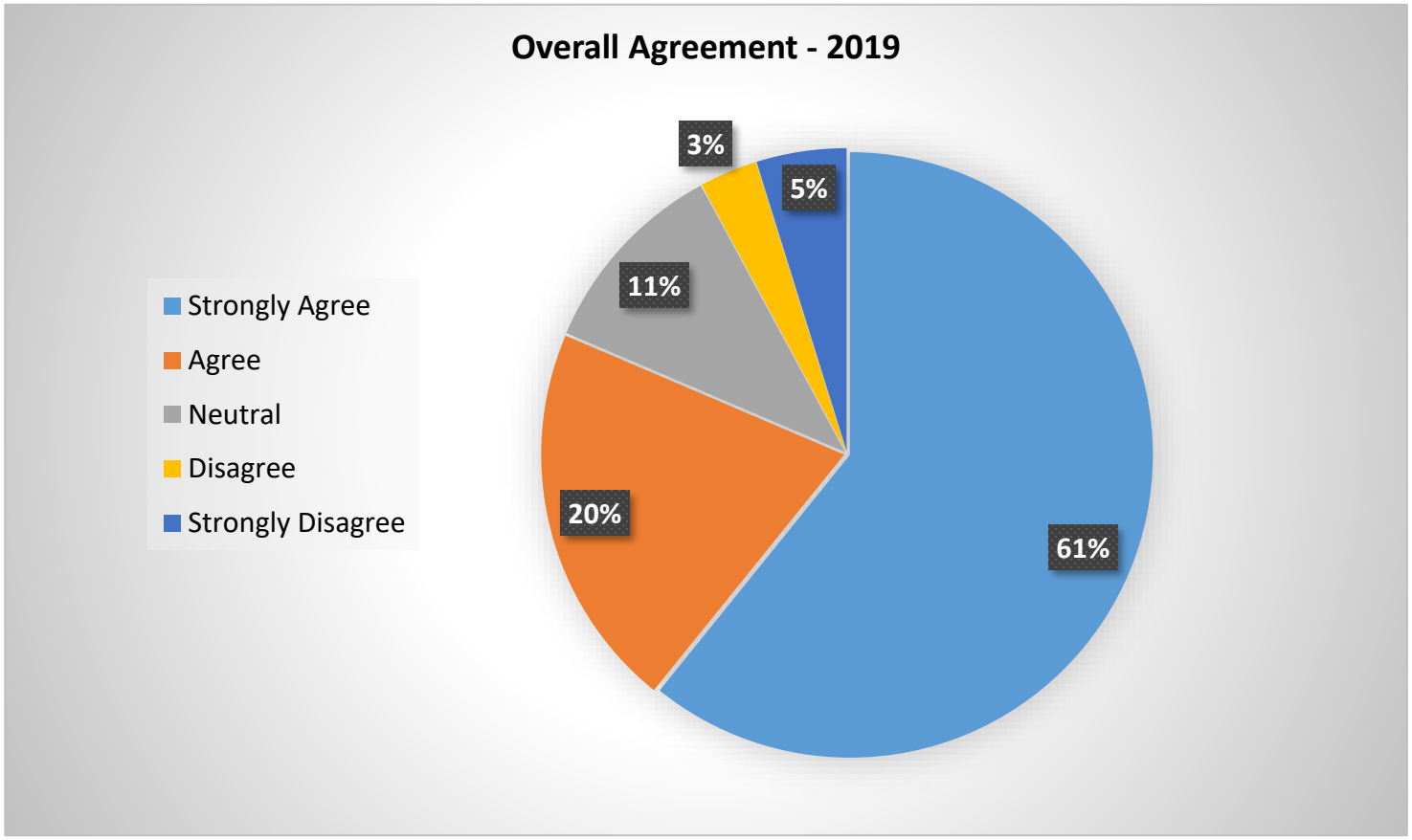
6 Year Average	Mean Score
Life Goals (Q3,Q7,Q8,Q9,Q12,Q16,Q17,Q18,Q28,Q31,Q32)	**4.30**
Involvement (Q22,Q23,Q24,Q25,Q29	**3.91**
Diversity of Treatment (Q14,Q15,Q20,Q21,Q26)	**4.17**
Choice (Q10, Q27, Q4, Q5, Q6)	**4.44**
Individually Tailored Services (Q11, Q13, Q19, Q30)	**4.28**

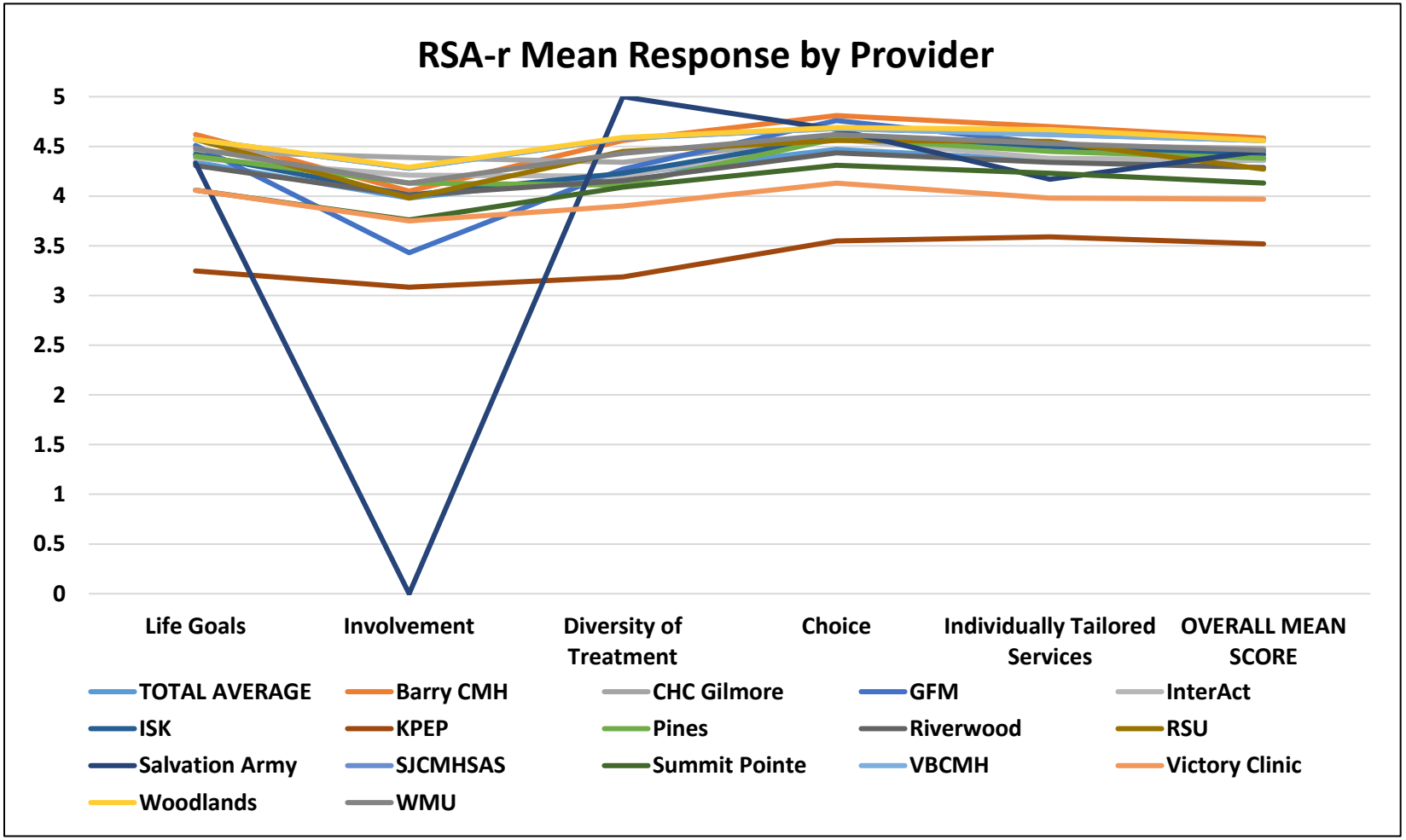


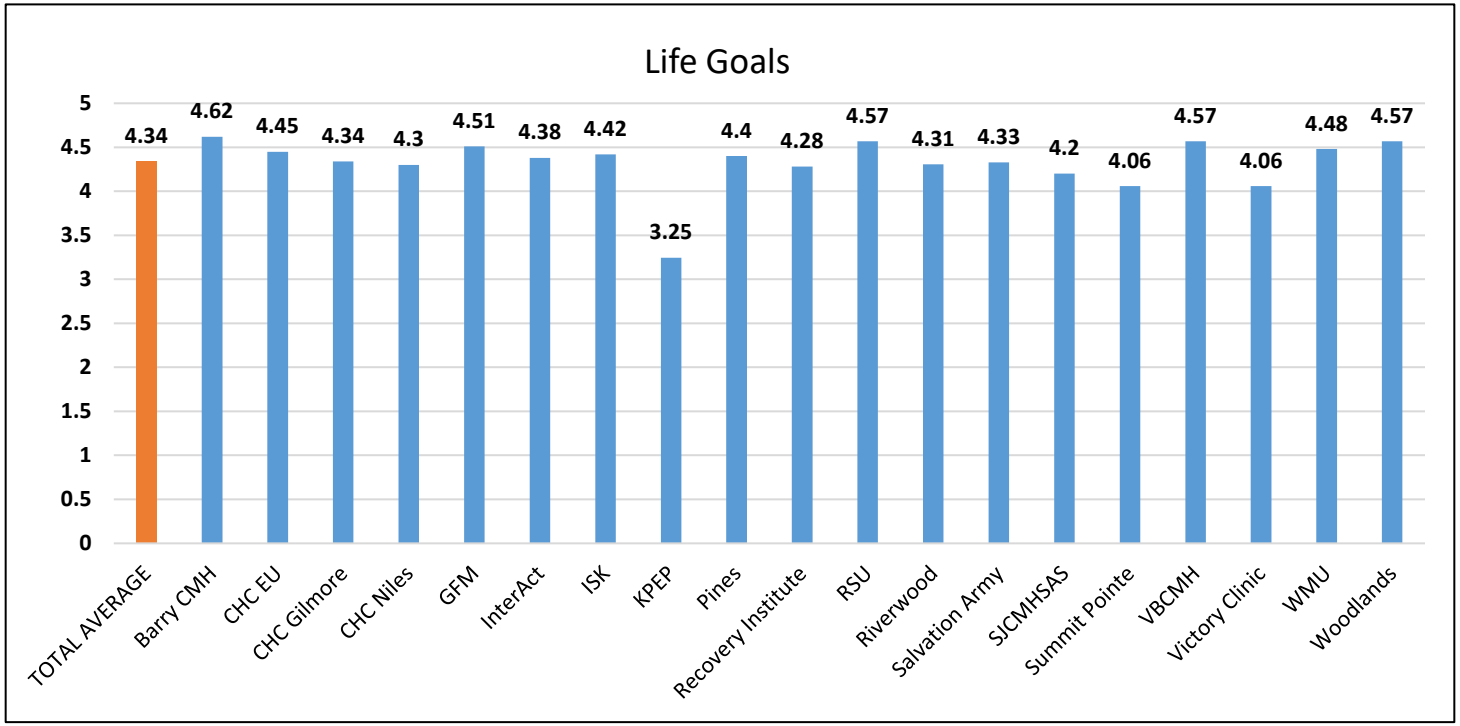

RSA-r 2019-2014 Score Comparison Analysis
4.6
4.4
4.2
4
3.8
3.6
3.4
3.2
4.34
4.27
4.21
4.34
4.36
4.29
3.98
3.85
3.76
4.12
3.88
3.86
4.22
4.17
4.05
4.24
4.17
4.18
4.47
4.40
4.36
4.46
4.5
4.42
4.36
4.20
4.16
4.33
4.31
4.31
4.36
4.22
4.13
4.31
4.29
4.24
Life Goals
Involvement
Diversity of Treatment
Choice
Individually Tailored Services
OVERALL MEAN SCORE
2019
2018
2017
2016
2015
2014


Surveys Completed by Provider
0
100
200
300
400
500
600
700
800
900
1000
TOTAL
Barry CMH
CHC EU
CHC Gilmore
CHC Niles
GFM
InterAct
ISK
KPEP
Pines
Recovery...
RSU
Riverwood
Salvation...
SJCMHSAS
Summit...
VBCMH
Victory Clinic
WMU
Woodlands
859
26
25
29
26
10
23
33
8
30
56
99
121
1
35
37
37
154
33
76
# of respondents
# of respondents in agreement (by mean score)

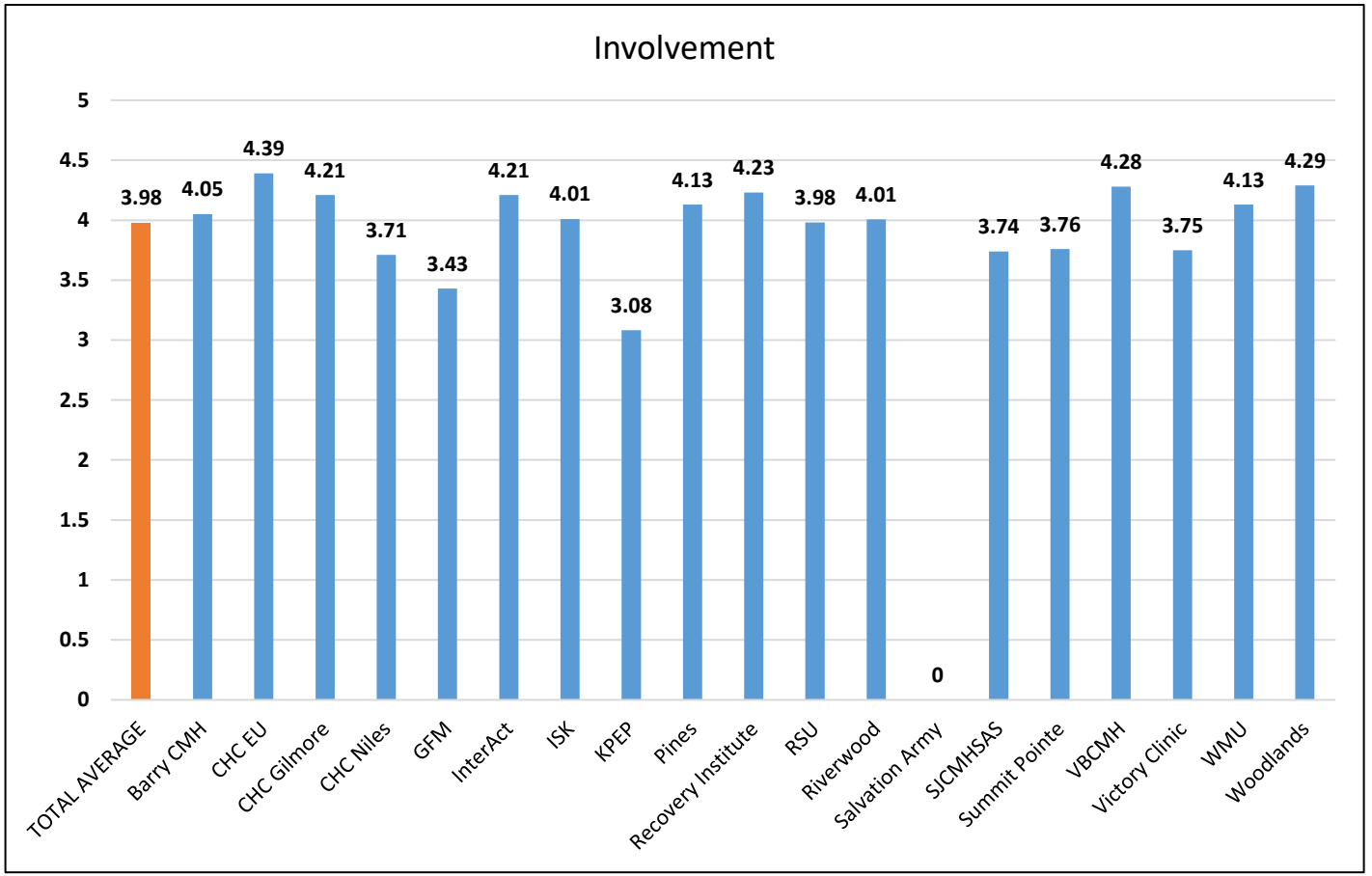

Total Number of RSA-R Respondents & Agreement
# of respondents
859
# of respondents in agreement (by mean score)
776
700
750
800
850
900


Overall Agreement - 2019
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
3%
5%
11%
20%
61%

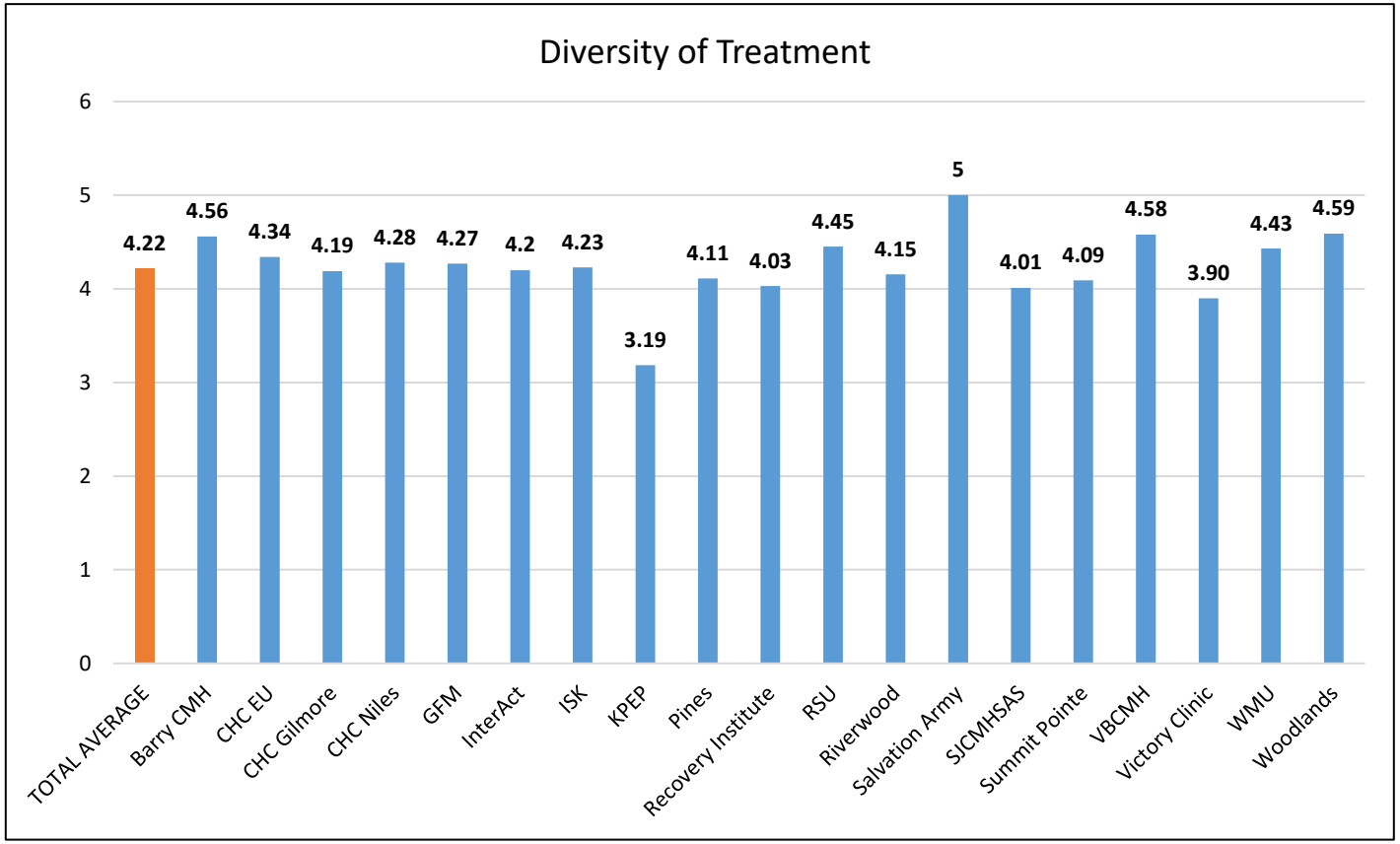

RSA-r Mean Response by Provider
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Life Goals
Involvement
Diversity of Treatment
Choice
Individually Tailored Services
OVERALL MEAN SCORE
TOTAL AVERAGE
Barry CMH
CHC Gilmore
GFM
InterAct
ISK
KPEP
Pines
Riverwood
RSU
Salvation Army
SJCMHSAS
Summit Pointe
VBCMH
Victory Clinic
Woodlands
WMU



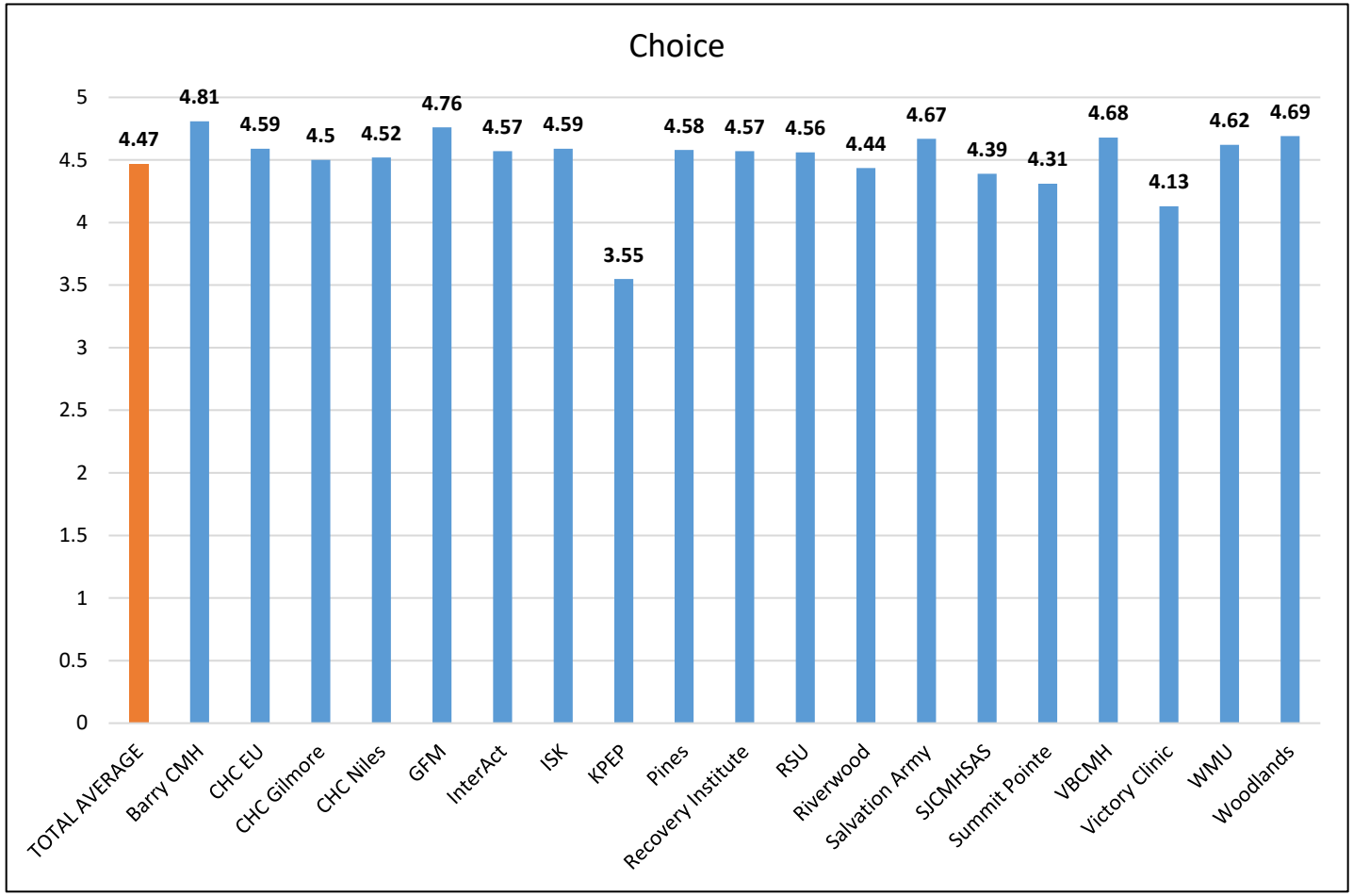
- 3. Staff encourage program participants to have hope and high expectations for their recovery.
- 7. Staff believe in the ability of program participants to recover.
- 8. Staff believe that program participants have the ability to manage their own symptoms.
- 9. Staff believe that program participants 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.



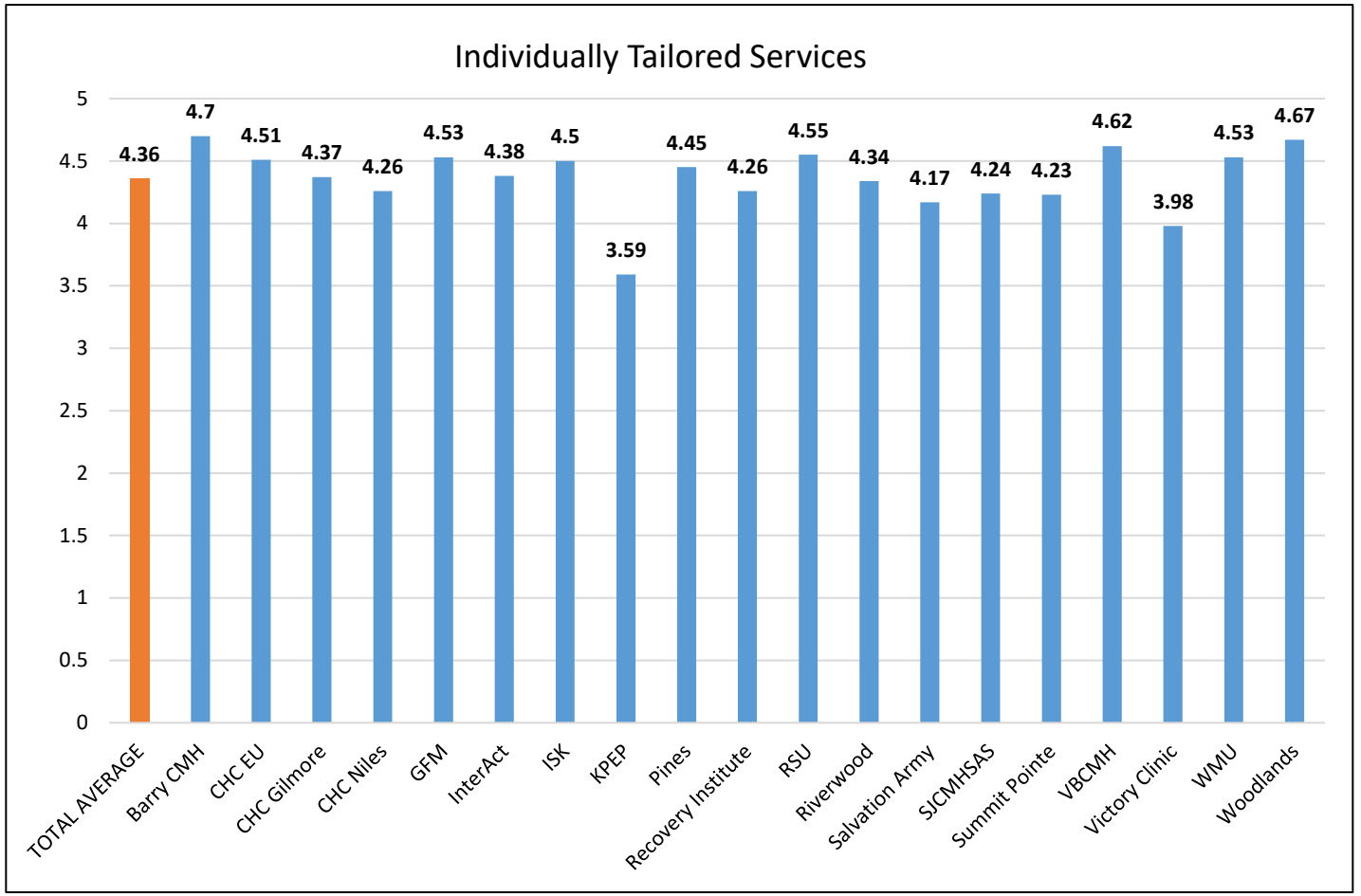
- 22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, and neighborhood watch/cleanup).
- 23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.
- 24. People in recovery are encouraged 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.



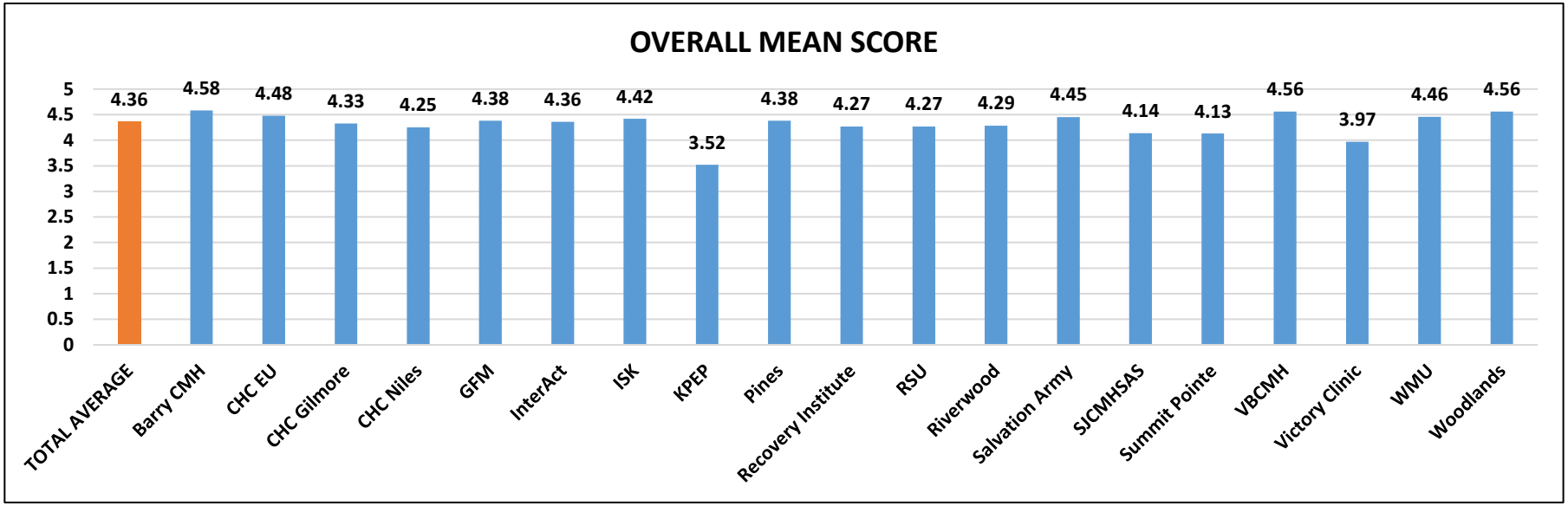
- 14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.
- 15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.
- 20. Staff actively introduce program participants to persons in recovery who can serve 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 32-question tool; designed to gauge the degree to which programs implement recovery-oriented practices. It is a reflective tool intended to identify strengths and target areas of improvement, geared toward improving consumer outcomes and treatment modalities.

Results:

The 2019 RSA-r survey administration period was from 9/23/2019 to 11/15/2019.

For the 2019 process, SWMBH received total (859) surveys back, which was a decrease from the 2018 response of (1087) total surveys returned. (19) Different provider organizations participated in the 2019 survey process, which was 3 less than the 2018 participation; (22) provider organizations participated. SWMBH's analysis of the overall mean score *represented a +0.14 increase in comparison to 2018 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, this was the second year in a row where the number of surveys received was less than the year before (not including a submission received with no paper surveys inside of the envelope). These are all areas of improvement for the survey next year.

Recommendations:

The QAPI Department explored utilizing Survey Monkey to automate the data entry system, which would save employee time and speed up the results/analysis process. The decision was made to make the electronic survey optional, and one provider chose to submit their results electronically. The results were that the electronic survey analysis was within +/- 1% of SWMBH's internal analysis, so this information will be used to plan for 2020's survey administration. QMC will also explore ways to improve scores in the Involvement category, which once again was the lowest score and has been the Regions' lowest score since 2015.

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 the QI program and results through newsletter, mailings, website, and member handbook and practitioner agreements. ✓ Provide member 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 resource and report delivery system.	January 2019 - December 2019	QAPI Specialist QAPI Director Chief Administrative Officer Manager of UM and Call Center Newsletter Editor Chief Information Officer	Quarterly

The SWMBH Website

http://www.swmbh.org

Process for Updating Website Content

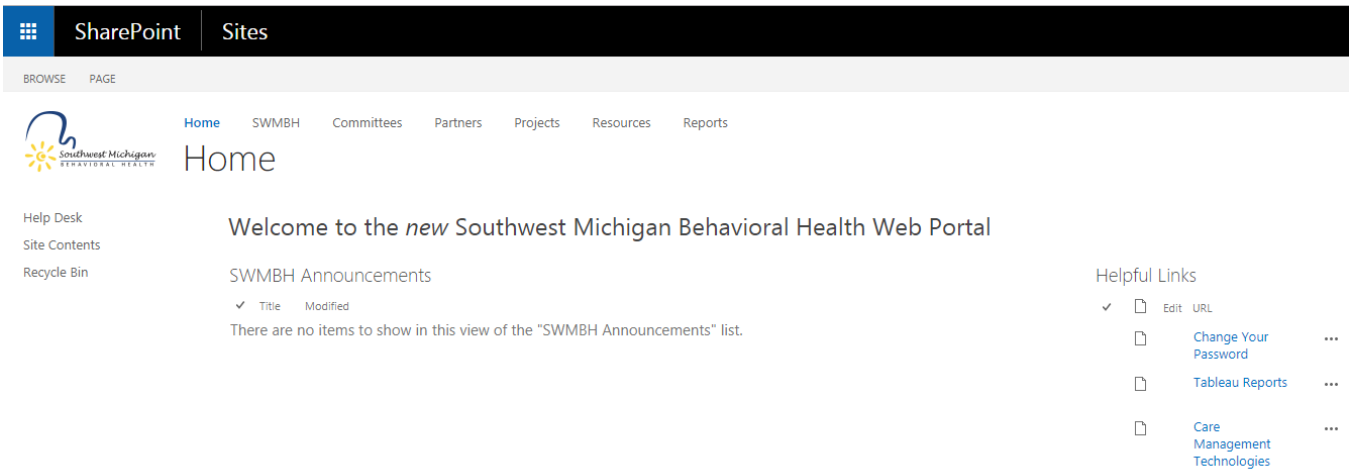
SWMBH formulated a website committee that meets monthly to discuss updates and proposed edits. Currently, each functional area has a designated team member who is responsible for implementing recommended updates. This process helps to keep information from getting outdated and ensures that members and community partners can access the most updated information possible.

Sharing of Information

SWMBH produces and distributes quarterly Member and Provider Newsletters. The Newsletter's primary focus is to keep members updated with the latest information regarding programs and services, and providers updated with the latest information on regulations, reports, and contractual requirements that affect our Region. Types of information the quality department shares on a routine basis include:

- Accreditation Standard Requirements
- Recent Consumer Satisfaction Survey Results
- Person in Recovery Survey Results (SUD)
- Mental Health and Physical Health Provider Communication Survey Results
- Critical Incident Analysis
- Jail Diversion Program Updates
- Performance Indicator Results and Updates
- Audit or Review Results
- Successes and Achievements
- Relevant State and National Data for Member/Provider Education

The SWMBH Portal



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 to the Portal 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. Additionally, 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. Consumers can also access the website to view customer handbooks, policies, and procedures.

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 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 on 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.

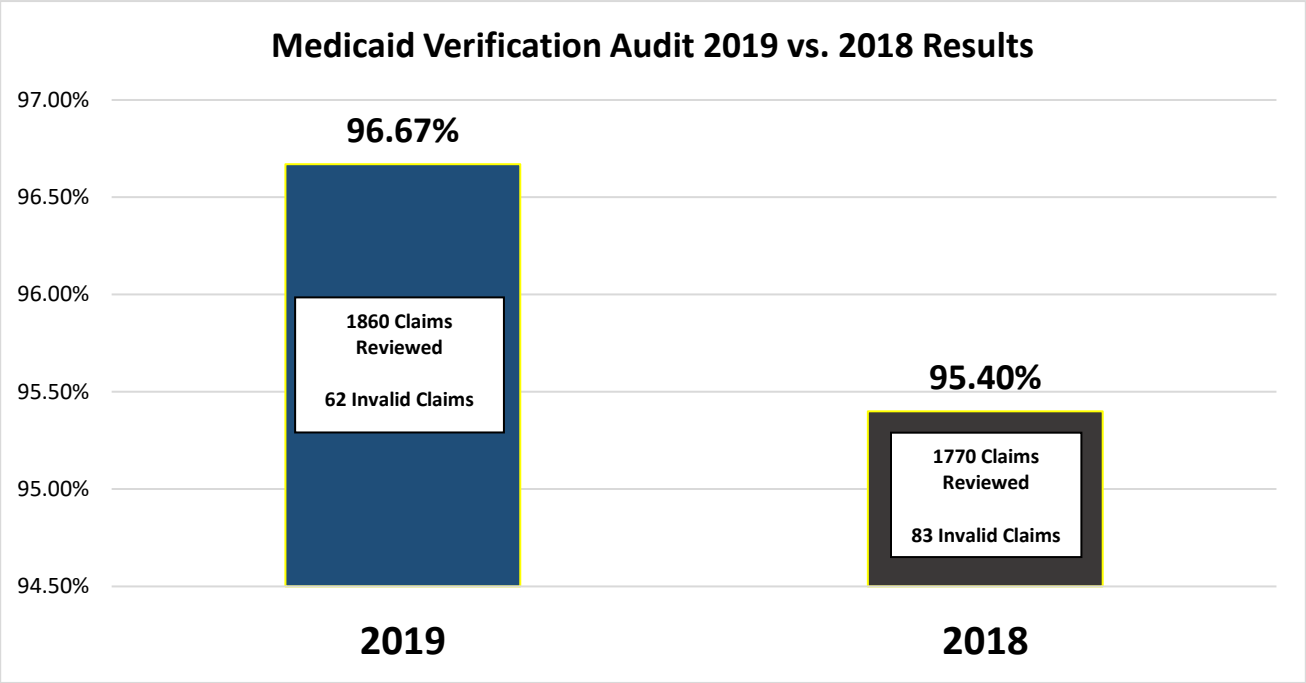
Actions were taken to Improve Processes:
In early 2019 a portal navigation user guide was developed to help users navigate and access resources more effectively. The users' guide helps break down the different sections of the portal and also provides education on how to access reports and other data readily available to them. This has alleviated a significant amount of help desk time and has been an excellent resource for new and existing team members.

Recommendations:
Hold a Regional Managed Information Business Intelligence Training for Internal and External Stakeholders twice annually. This will allow SWMBH 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 the 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 yearly QAPI Evaluation report. ✓ NCQA Clinical Practice Guidelines measure performance against at least (2) aspects of the (3) guidelines. (3) Clinical practice guidelines.	October 2018 – September 2019	QAPI Specialist QAPI Director Chief Compliance Officer	Annually

2019 Medicaid Verification Audit



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 2019 and 2018 Board Ends Metric target for Medicaid claims verification is over 90%.

Process:

- Reviews are conducted on an annual basis.
- The reviews are comprised of a combination of desk and on-site methods.
- Reviews include an evaluation of all delegated functions.
- Any functions that are not in full compliance with MDHHS, 42 CFR & 438 (Managed Care Regulations), and SWMBH requirements require a written corrective action plan to be submitted by the participant CMHSP and approved by SWMBH.
- SWMBH monitors select programs each year for program and staffing fidelity and adherence to MDHHS contractual requirements for specialty service programs.
- Requirements and sections reviewed not meeting 90% compliance require corrective action plans
- SWMBH staff work with CMHSP staff throughout the year to implement and ensure areas needing attention have been addressed.

Results:
SWMBH Compliance Department completed the annual Medicaid Verification review using the sampling methodology per the Office of Inspector General standards. Overall the result in 2019 was a 96.67% Medicaid claims compliance rate with 1860 total claims reviewed with 62 invalid claims identified. In 2018 the Medicaid claims verification compliance rate was 96.25% with 1,770 and 83 invalid claims identified. Overall, the result was a 1.27% improvement in the claims verification rate over the previous year's result.

The following are a detailed breakout of claim deficiencies identified:

- Was the person eligible for Medicaid coverage on the date of the service reviewed?
  - **1 deficiency**
- Is the provided service eligible for payment under Medicaid?
  - **0 deficiencies**
- Is there a current treatment plan on file which covers the date of service?
  - **23 deficiencies**
- Does the treatment plan contain a goal/objective/intervention for the service billed?
  - **27 deficiencies**
- Is there documentation on file to support that the service was provided to the consumer?
  - **27 deficiencies**
- Was the service provided by a qualified practitioner and falls within the scope of the code billed/paid?
  - **9 deficiencies**
- Was the appropriate amount paid (contract rate or less)?
  - **15 deficiencies**

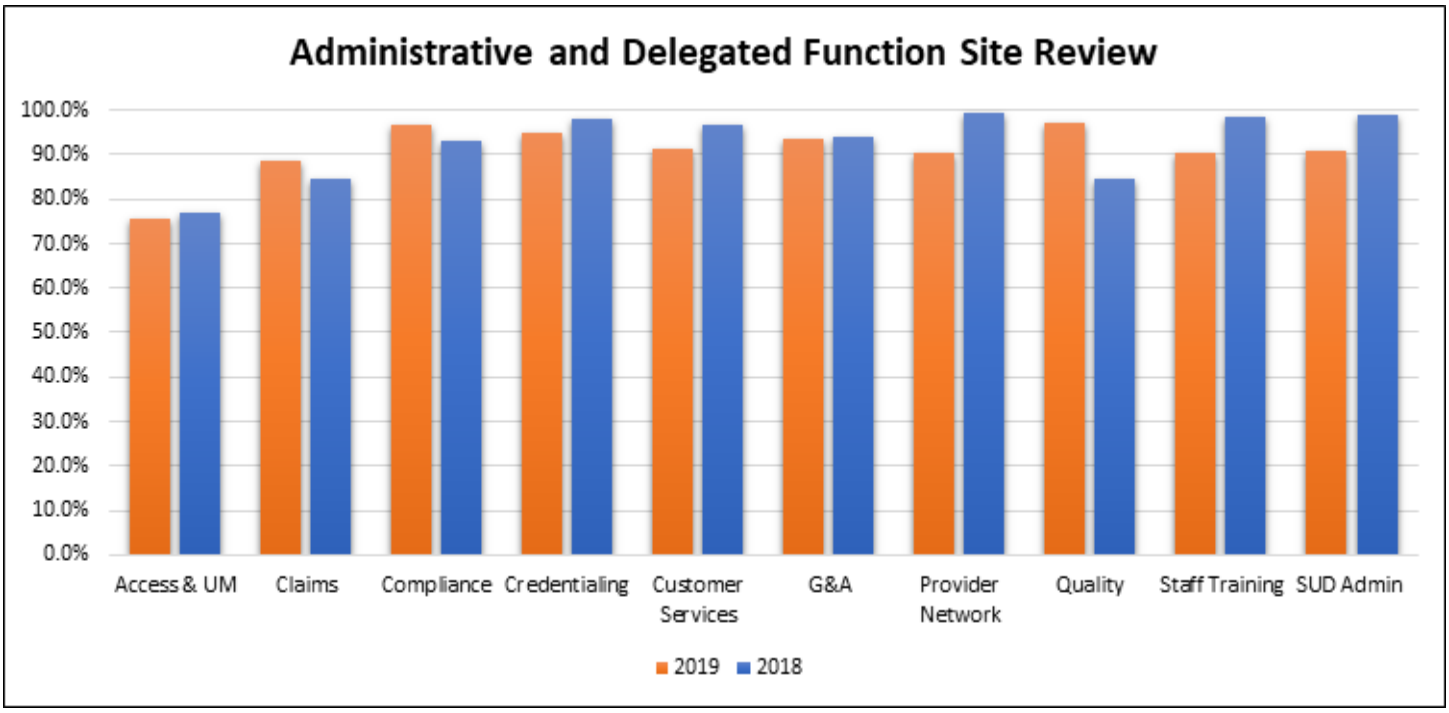
Identified Barriers:
None identified.

Recommendations:
No corrective action plans were required based on the standards set in the Medicaid Services Verification-Technical Requirements set by MDHHS.
The deficiencies noted were regarding a treatment plan on file which covers the date of service and the treatment plan containing a goal/objective/intervention for the service billed. The majority of the deficiencies were due to the lack of timeliness in completing and validating the treatment plan with a clinician signature before the provision of service and within 15 business days of the effective date of the plan (per MDHHS Treatment Planning/Person-Centered Planning Policy). SWMBH will continue to work with our CMHSPs and sub-contracted providers to address the timeliness of treatment planning and the signatures of the clinician validating the treatment plan. Additionally, SWMBH will continue to educate providers on the importance of specific and individualized goals/objectives/interventions for services contained within the treatment plan.
The deficiencies noted that despite documentation being supplied to support the service provided, many providers struggled with the MDHHS requirement of a provider signature and signature date on documentation. SWMBH has been working and will continue to work with CMHSPs and sub-contracted providers to ensure adherence to all MDHHS clinical records policies and requirements.

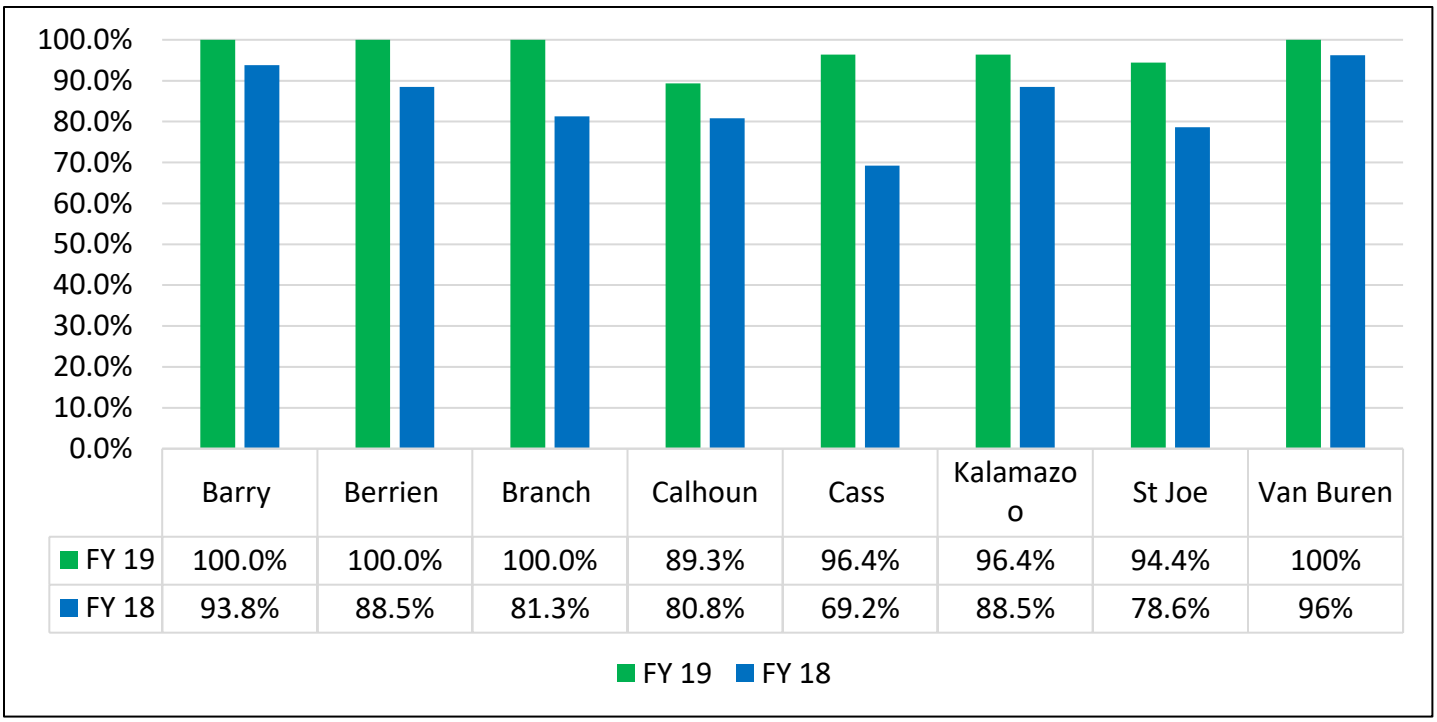
Administrative and Delegated Function Site Review

Summary Score		
Standard	**2019 Section Score**	**2018 Section Score**
Access and Utilization Management	75.4%	76.9%
Claims Management	88.7%	70.8%
Compliance	96.9%	80.5%
Credentialing	94.9%	98.2%
Customer Services	91.3%	96.8%
Grievances and Appeals	93.5%	94.2%
Provider Network	90.5%	86.9%
Quality	97.1%	84.6%
Staff Training	90.4%	98.5%
SUD EBP Fidelity and Administration	91.1%	99.0%

- Red indicates Section Score decreased from 2018.
- Green Indicates Section Score increased from 2018.



2019 CMHSP Quality Program Review Results



	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 19	100.0%	100.0%	100.0%	89.3%	96.4%	96.4%	94.4%	100%
FY 18	93.8%	88.5%	81.3%	80.8%	69.2%	88.5%	78.6%	96%

Results:
Overall results show an improvement for all counties (8) counties during the 2019 review process. However, 6/10 categories reviewed showed a decrease in the score, in comparison to 2018 site review scores. For purposes of this review, the overall quality review resulted in a +12.5% increase across all categories measured. This was directly attributed to an overall improvement in performance indicator compliance and timeliness reporting. The utilization management review observed an overall -1.5% decrease across all categories measured. This was attributed to lower scores in the timeliness of service approvals and quality of notification letters distributed to consumers.

Barriers:
No significant barriers to performance were observed for quality or utilization management during this review period.

Recommendations:
Per our on-site review and feedback SWMBH received during our last HSAG review, it is fully acknowledged that SWMBH needs to make remediations with our Adverse Benefit Decision documents (ABD).
HSAG recommends that the PIHP implement a quality auditing process to ensure that each notice of ABD is easily understood and written at the appropriate reading grade level for the PIHP's membership.
HSAG strongly recommends that the PIHP confirm all CMHSPs have implemented the State-mandated ABD template.
HSAG further suggests that the PIHP implement a quality auditing process to ensure that the language documented within the template is accurate and includes all required information per the requirements under this element.

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 organization's 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 promptly. ✓ 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 the level of monitoring/oversight for Regional performance indicators that are consistently out of compliance.	January 2019 – December 2019	All Functional Area Senior Leaders QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Administrative Officer Provider Network Director	Annually or audits as scheduled

2019 Health Services Advisory Group (HSAG) Performance Measure Validation Audit Results

The following report represents a summary of preliminary findings during the Health Services Advisory Group (HSAG) Performance Measure Validation Audit that took place on July 23, 2019, at Southwest Michigan Behavioral Health.

Results:
37/37 or 100% Of Total Elements Evaluated received a designation score of "Met," "Reportable," or "Accepted."

This meets the *successful completion of our 2019 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 was ***"Accepted"*** and met full compliance standards.
Reportable	12/12 – 100% 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	9/9 – 100% Numerator and Denominator Elements Evaluated **"Met"** full compliance Standard.

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 and Chief Information Officer had extensive backgrounds in behavioral health and all processes related to performance indicator (PI) and data reporting requirements. A Managed Information Business Intelligence Steering Committee was formed and is focusing on data integrity, data completeness, data structures/reporting, and reporting of key performance indicators.

Recommendations:
HSAG recommends that **Southwest Michigan Behavioral Health** and the CMHSPs employ an over-read or validation process to compare the original BH-TEDS record in the CMHSPs' documentation to the data entered into the PIHP's system after these data are manually entered, to account for any missing data that may have been captured during the initial assessment but not entered into the PIHP's system or if any data were keyed incorrectly. HSAG also recommends that the PIHP and the CMHSPs clearly define the processes for entering the data into PIHP's EMR with additional data quality and completeness checks beyond the state-specified requirements before the data are submitted to the State.

2019 Health Services Advisory Group (HSAG) External Quality Review Results

Audit Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within three years to determine the PIHPs' compliance with standards outlined in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To complete this requirement, HSAG, through its EQRO contract with the State of Michigan, performed compliance monitoring reviews of the 10 PIHPs with which the State contracts.

The review standards are separated into 17 performance areas. MDHHS has elected to review the full set of criteria over two review periods, as displayed in Table 1-1.

Table 1-1 – Standard Schedule of Review

2017–2018	2018–2019
Standard VI—Customer Service	Standard I—QAPIP Plan and Structure
Standard VII—Grievance Process	Standard II—Quality Measurement and Improvement
Standard IX—Subcontracts and Delegation	Standard III—Practice Guidelines
Standard X—Provider Network	Standard IV—Staff Qualifications and Training
Standard XII—Access and Availability	Standard V—Utilization Management
Standard XIV—Appeals	Standard VIII—Members' Rights and Protections
Standard XV—Disclosure of Ownership, Control, and Criminal Convictions	Standard XI—Credentialing
Standard XVII—Management Information Systems	Standard XIII—Coordination of Care
	Standard XVI—Confidentiality of Health Information

Table 1-2 – Audit Scores by Standard

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	8	0	0	100%
Standard II—Quality Measurement and Improvement	8	7	1	0	87%
Standard III—Practice Guidelines	4	4	0	0	100%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	13	3	0	81%
Standard VIII—Members' Rights and Protections	13	13	0	0	100%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	10	0	0	100%
Total	82	74	8	0	90%

Table 1-2 represents the scores for the (9) standards evaluated during the 2019 review period

Table 1-3 Scoring Methodology

Compliance Score	Point Value	Definition
Met	Value = 1 point	*Met* indicates "full compliance" defined as all of the following: • All documentation and data sources reviewed, including PIHP data and documentation, case file review, and systems demonstrations for a regulatory provision or component thereof, are present and provide supportive evidence of congruence. • Staff members are able to provide responses to reviewers that are consistent with one another, with the data and documentation reviewed, and with the regulatory provision.
Not Met	Value = 0 points	*Not Met* indicates "noncompliance" defined as one or more of the following: • Documentation and data sources are not present and/or do not provide supportive evidence of congruence with the regulatory provision. • Staff members have little or no knowledge of processes or issues addressed by the regulatory provisions. • For those provisions with multiple components, key components of the provision could not be identified and/or do not provide sufficient evidence of congruence with the regulatory provision. Any findings of *Not Met* for these components would result in an overall finding of "noncompliance" for the provision, regardless of the findings noted for the remaining components.
Not Applicable	No value	• The requirement does not apply to the PIHP line of business during the review period.

Audit Summary of Results

Southwest Michigan Behavioral Health achieved full compliance in six of the nine standards reviewed, demonstrating performance strengths and adherence to all requirements measured in the areas of QAPIP Plan and Structure, Practice Guidelines, Staff Qualifications, and Training, Members' Rights and Protections, Coordination of Care, and Confidentiality of Health Information. The remaining three standards have identified opportunities for improvement. The areas with the most significant opportunity for growth were related to Quality Measurement and Improvement, Utilization Management, and Credentialing, as these areas, received performance scores under 90 percent.

Southwest Michigan Behavioral Health demonstrated compliance in 74 of 82 elements, with an overall compliance score of 90 percent, indicating that most program areas had the necessary policies, procedures, and initiatives in place to carry out most required functions of the contract. In contrast, other areas demonstrated opportunities for improvement to operationalize the elements required by federal and state regulations. Detailed Standard scores are represented in table 1-2, and scoring methodology is detailed in table 1-3.

Next Steps and Follow-up:

Southwest Michigan Behavioral Health is required to submit to MDHHS a CAP for all elements scored *Not Met*. The CAP must be provided within 30 days of receipt of the final report. For each component that requires correction, the PIHP must identify the planned interventions to achieve compliance with the requirement(s), the individual(s) responsible for each intervention, and the timeline, including scheduled dates of completion for each intervention.

HSAG has prepared a customized template to facilitate **Southwest Michigan Behavioral Health**'s submission and MDHHS' review of corrective actions. The template includes each requirement for which HSAG assigned a performance score of *Not Met* and, for each requirement, HSAG's findings and recommendations to bring the organization's performance into full compliance with the requirement. Within 30 days after receipt of the final report, the CAP must be submitted to HSAG's secure file transfer protocol (SFTP) site, with an email notification to MDHHS and HSAG indicating that the CAP has been uploaded.

2019 MDHHS Substance Use Disorder Administrative Monitoring Protocol Audit

Results:

- **26/26 Standards Evaluated Received a Score of Full Compliance.**

Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration
Substance Use Disorder Administrative Monitoring Protocol
Page 2 of 12

PIHP Name: SWMBH	Date: June 4, 2019

	Requirement (citation)	Evidence To Support Compliance Requirement	Evidence Document Name and Location in Document (Page Number)	Compliance Rating 2= Full 1 = Partial 0= None	Comments/Findings
2) Annual Evaluation of SUD Services	The PIHP must annually evaluate and assess substance use disorder services in the department-designated community mental health entity in accordance with the guideline established by the Department. MDHHS/PIHP Contract Boilerplate, 1.0 Statement of Work, Item 7, Page 69	Copies of policies and procedures Monitoring tool Copies of reports findings Evidence of making reports available to public	Provider Network Policy, Member Newsletter, Memo on Making reports Available to Public, Review Tools, Prevention Site Reviews for Van Buren and Barry CMHs, Treatment Site Reviews for HTC, BCCCH, VBCMH, CHC, Site Review Schedule	26/26 Standard Evaluated Received a Score of Full Compliance (2 = Full).	Use of Site Metrics and Clinical Quality Review is exemplary. String Evidence of full Compliance. Metrics scorecard is also made available to public.

MI Health Link and Integrated Care Organization Audit Results

Aetna Claims Delegation Audit

Review Period: 7/1/2019 through 9/30/2019

Summary of Claims Audit Results: 100% Compliance

Medicare Advantage / Standard Delegation - Claim Audit Results										
OVERALL RESULTS				30	30	100%	30	100%	30	100%
Product Line	Product Description	Deal Type	Universe / Unit Description	Total Claims Audited	Turn-Around Time Compliance		Payment / Denial Accuracy		Coding Accuracy	
					#	%	#	%	#	%
Medicare	MMP	BH Clm	Member Denials	NR	NR	NR	NR	NR	NR	NR
Medicare	MMP	BH Clm	Paid Claims - Contracted	30	30	100%	30	100%	30	100%
Medicare	MMP	BH Clm	Paid Claims - Non-Contracted	NR	NR	NR	NR	NR	NR	NR
Medicare	MMP	BH Clm	Provider Denials	NR	NR	NR	NR	NR	NR	NR
Medicare	MMP	BH Clm	Provider Disputes	NR	NR	NR	NR	NR	NR	NR

Auditor Comments and Summary of Results:

- ✓ The annual claims desk audit review was conducted and finalized on 11/18/2019
- ✓ All of the claim documents reviewed were summitted by SWMBH through the Aetna FTP website.
- ✓ There was always a SWMBH staff member available to answer questions, and they did a great job.
- ✓ There were no issues noted, or findings pointed out during the review.
- ✓ The next audit will be conducted during the 3rd quarter of 2020.

Aetna Delegated Utilization Management Oversight Audit

Review Period: 1/16/2019 through 7/1/2019

Summary of Utilization Management Audit Results: 100% Compliance

Criteria	Level of Compliance [Full/Significant/Partial/Minimal/Non-Compliant]
1. UM 1 UTILIZATION MANAGEMENT STRUCTURE	Full
2. UM 2 CLINICAL CRITERIA FOR UM DECISIONS	Full
3. UM 3 COMMUNICATION SERVICES	Full
4. UM 4 APPROPRIATE PROFESSIONALS	Full
5. UM 5 TIMELINESS OF UM DECISIONS	Full
6. UM 6 CLINICAL INFORMATION	Full
7. UM 7 DENIAL NOTICES	Full
8. UM 11 SATISFACTION WITH UM PROCESS	Full
9. UM 12 EMERGENCY SERVICES	Full
10. UM15 SUBDELEGATION OVERSIGHT	NA
Total Percentage of Compliance = 100%	**Total Level of Compliance:** Full

Summary of Case Management Audit Results: 100% Compliance

Criteria	Level of Compliance [Full/Significant/Partial/Minimal/Non-Compliant]
1. QI 7 Complex Case Management	NA
2. QI 12 Delegation of QI	NA
3. UM 8 Policies for Appeals	Met
4. UM 9 Appropriate Handling of Appeals	Met
5. RR 2 Policies and Procedures fo Complaints and Appeals	Met
Total Percentage of Compliance = 100%	**Total Level of Compliance:** Full

Summary of Credentialing Audit Results: 100% Compliance

Criteria	Level of Compliance [Full/Significant/Partial/Minimal/Non-Compliant]
I. Policy and Procedure Review	Full
II. Credentialing Committee	Full
III. Credentialing Verification (File Audit)	Full
IV. Recredentialing Cycle Length	Full
V. Practitioner Office Site Quality	NA
VI. Ongoing Monitoring	Full
VII. Notification to Authorities and Practitioner Appeal Rights	Full
VIII. Organizational Providers Credentialing and Recredentialing (File Audit)	Full
IX. Evaluation of Sub-Delegated Credentialing	Full
Total Percentage of Compliance = 100 %	**Total Level of Compliance:** Full

Summary of Grievance and Appeals Audit Results: 100% Compliance

Criteria	Level of Compliance [Full/Significant/Partial/Minimal/Non-Compliant]
UM 8: Policies for Appeals	Full
UM 9: Appropriate Handling of Appeals	Full
RR 2: Policies and Procedures for Complaints and Appeals	Full
Total Percentage of Compliance = 100 %	**Total Level of Compliance:** Full
CMS Criteria	
1. Meet timeframes for Appeals and Grievance as it applies to Members	NA – no member appeals
2. Meet timeframes for Appeals and Grievance as it applies to Providers	NA – no provider appeals
Total Percentage of Compliance = 100 %	**Total Level of Compliance:** Full

Meridian Delegated Credentialing Audit

Review Period: 1/1/2019 through 9/30/2019

Thank you for allowing Meridian to review your organization's credentialing program in support of the Annual Delegation oversight audit. We had a few updates from the Center for Medicare & Medicaid Services (CMS) regarding provider updates and compliance. Please update your policies to reflect any of the new changes (if applicable). **You are approved for delegated credentialing**. You may anticipate your next audit in October 2020.

The audit results are as follows:

The assessment process consisted of a review of the following measures:

1. Credentialing and re-credentialing policies and procedures
2. Credentialing list
3. Recredentialing list
4. Evidence of ongoing monitoring of sanctions and limitations
5. Credentialing files: 5
6. Recredentialing files: 5

The results of the assessment yielded the following scores:

Measure	Score
Health care professional credentialing file audit	100%
Health care professional re-credentialing file audit	100%
Policies and procedures review	100%
Overall Score	100%

Utilization Management Program Evaluation

VI. Utilization Management Program Evaluation

Utilization Management Program Description

On at least an annual basis, the QAPIP is evaluated. The QAPI & UM Effectiveness Review/Evaluation document is a companion document to the yearly QAPIP and will be completed at the end of the fiscal year, or shortly after that. 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 particular focus on patient safety and risk assessment and performance related to clinical care and service. Progress toward the previous year's project plan goals is also evaluated. The SWMBH QM department completes the evaluation and identifies the accomplishments and any potential gaps during the last year's QM activities. When a gap is identified and addressed during that year, it will be reported in the QAPI Effectiveness Review/Evaluation, and other deficiencies 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 expected 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 – 2020 MBHO Accreditation Standards: UM 1 A-D, 2 A-C, 3, 4 A-B, D-F, 6 B
UM and Quality Management Regional Committee Charter
MHL UM and QAPI Committee Charters

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 for ensuring 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 critical aspects of the utilization management plan is to monitor population health effectively 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 evidence-based clinical practices, promotion of recovery, self-determination, involvement of peers, cross-collaboration, outcome monitoring, and discharge/transition/referral follow-up.

Values

SWMBH intends to operate a high-quality utilization management system for behavioral health and substance abuse services, which is responsive to the community, family, and individual needs. The entry process must be transparent, readily available, and well known to all constituents. To be effective, information, assessment, referral, and linkage capacity must be readily and seamlessly accessible. The level of care and care management decisions must be based on medical necessity and evidenced-based wellness, recovery, and best practice. SWMBH is committed to ensuring the use of evidence-based services with member matching that drives outcomes/results/value for taxpayer dollar and maximization of equity across beneficiaries. As a steward of managing taxpayer dollars, SWMBH is committed to the identification, development, and use of lesser cost supportive services (e.g., Assistive Technology, Certified Peer Supports, and Recovery Coaches, etc.) while meeting the service needs of members in the region. SWMBH recognizes that access to services is critical to successful recovery and outcomes at both the individual and service management levels. Maximizing Access to service depends upon appropriate utilization throughout all aspects of the level of care and care management decision-making process.

Evaluation

The UM program is reviewed at least annually to determine if the Fiscal Year goals have been achieved and what areas for improvement there are. The MHL UM and Quality Management committees are involved in this review and implementing any improvement activities throughout the provider network. The Quality Management unit, led by a senior-level administrative staff, conducts a variety of member and stakeholder surveys to evaluate the effectiveness of the UM Program. As part of the QAPI process and development of the UM Program plan, MHL cross-functional committees and the CAC review population health data, stakeholder survey data in relation to medical necessity criteria, policy, procedure, and clinical protocols/criteria. They provide input on trends and specific data to inform the decision making regarding approving the use of medical necessity criteria, system clinical changes and training, and best practice implementation. The purpose of the annual evaluation is to identify any Best Practices that could be incorporated into the UM program, as well as continue to improve on the care provided to SWMBH members. The specific evaluation is contained in and conducted as part of the Quality Assurance, and Performance Improvement plan as UM is designated in our MDHHS contract as a subset of QAPI.

Additionally, Inter-rater reliability will be evaluated annually. All clinical professionals making medical necessity determinations and utilization management decisions will be tested yearly to validate consistent application and understanding of uniform benefit, clinical protocols, and medical necessity criteria. All evaluation data is reviewed by members of the MHL UM committee consisting of the Medical Director, Senior-level masters licensed clinical staff, masters or higher practitioners as well as MHL Plan members.

Behavioral Healthcare Practitioner Involvement

The SWMBH Utilization Management Program shall operate under the oversight of the SWMBH Medical Director and Manager of Utilization Management and Call Center. The Medical Director and the Manager of Utilization Management and Call Center 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 the UM program remains current and appropriate, QAPI evaluated:

UM Program Structure

- **2019 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 the 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.
    - ✓ Those evaluators that score under 90% will be provided with additional education and be retested.

Uniformity of Benefits	➢ Perform analysis on the consistency of Inter-rater Reliability Testing to ensure uniformity of benefit. ➢ Complete analysis on Level of Care Guidelines and examine outliers/trends.	✓ Perform analysis on tool scores relative to medically necessary level of care (LOC). ✓ Identify and schedule reports on functional assessment tool scores. ✓ Ensure functional assessment data related to the LOCUS, SIS, CAFAS, and ASAM are being received in the SWMBH data warehouse.	October 2018 – September 2019	Manager of UM and Call Center Director of Clinical Quality Clinical Data Analyst Director of QAPI QAPI Specialist	Quarterly

Inter-Rater Reliability Results for SWMBH 2019

Date & Case	# of Raters	% Matching Medical Necessity Criteria	Comments
11/1/18 Gregg Locus 20 LOC 4	10	50% - 5/10 Outpatient 40% - 4/10 Detox/Residential	Range 16-23 LOC 2-5
1/3/19 Arthur Locus 17 LOC 3	10	90% 9/10 – Outpatient Meds & CSM or therapy	Range 16-18 LOC 2 & 3
4/30/19 Esther Locus 15 LOC 5	11	82% - 9/11 Outpatient Psych Eval and Medication Management	
11/4/19 Jane Locus	10	100% - 10/10 Outpatient Psych Services and Medication Evaluation	
2/13/20 Taylor	11	91% - 10/11 Detox Residential or IOP	

- **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%)

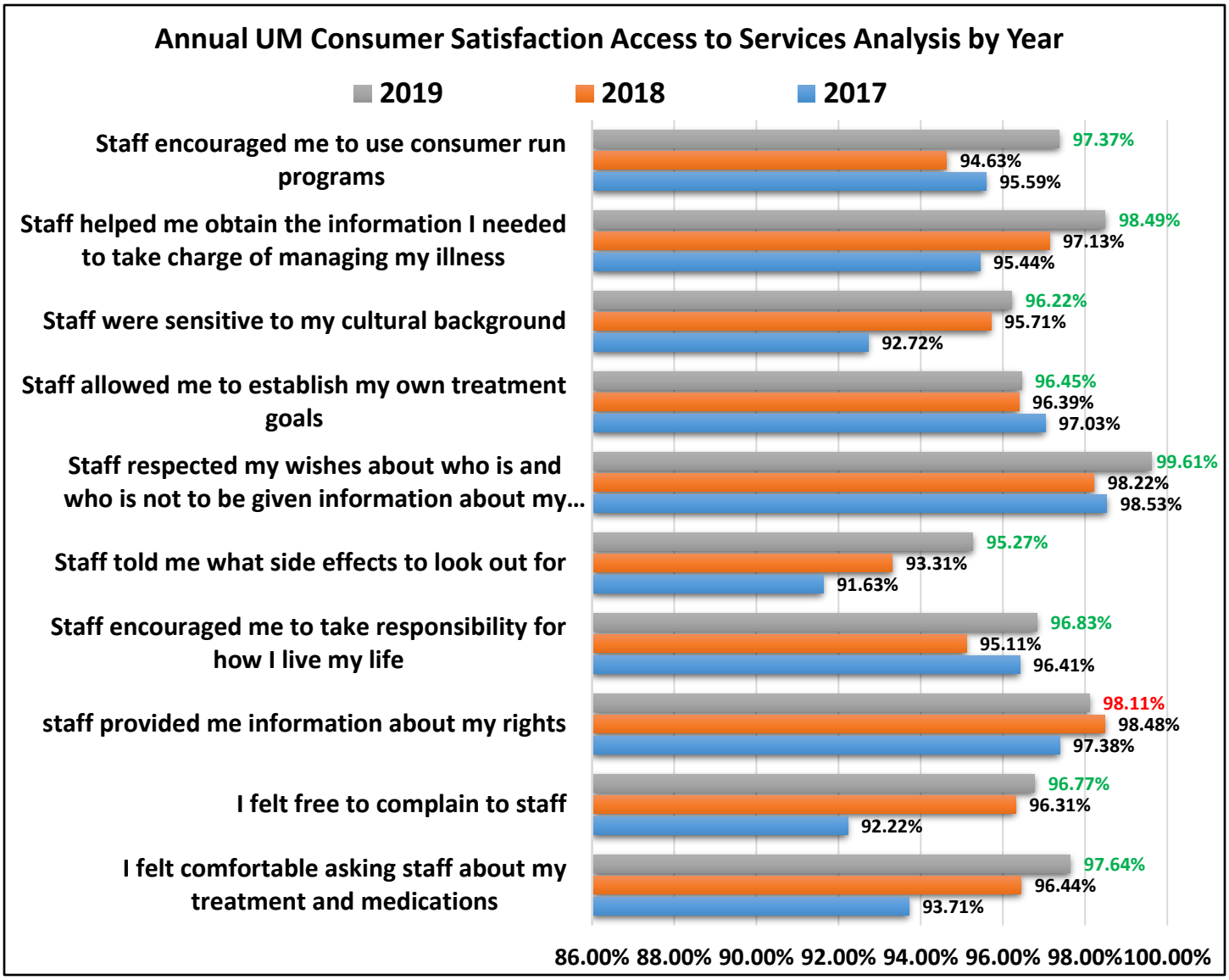
❖ The percent of discharges from a psychiatric inpatient unit who are seen for follow up care within seven days (Standard=95%)

❖ The percent of discharges from a substance abuse detox unit who are seen for follow-up care within seven days (Standards=95%)

- **59/68 Total Performance Indicators in 2019 met the State Standard of 95%**
- **86.76% of indicators achieved the State indicated benchmark of 95%**
  - **1st Quarter = 14/17**
  - **2nd Quarter = 14/17**
  - **3rd Quarter = 16/17**
  - **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.

UM Customer Survey Analysis



Survey Description: During the months of November and December 2019, the Mental Health Statistic Improvement Project (MHSIP) survey was administered (through telephone interviews and random probability sampling) to 1458 consumers who received Mental Health authorization and support through Southwest Michigan Behavioral Health and Services through our CMHSP partners from April through August 2019. In observation the current results – representing consumer feedback received from 355 consumers who are enrolled in the MI Health Link (Dual Eligible) program and engaged with Southwest Michigan Behavioral Health Utilization Management staff to receive services. **Green** values represent an improvement over the previous year's score, while **Red** values represent a decrease in comparison to the previous year's score.

Analysis and Observations: Overall results are much improved in comparison to the previous 2 years. Although there was a slight decrease of (-.37%) in the category of "*staff provided me information about my rights*", no significant variations were identified.

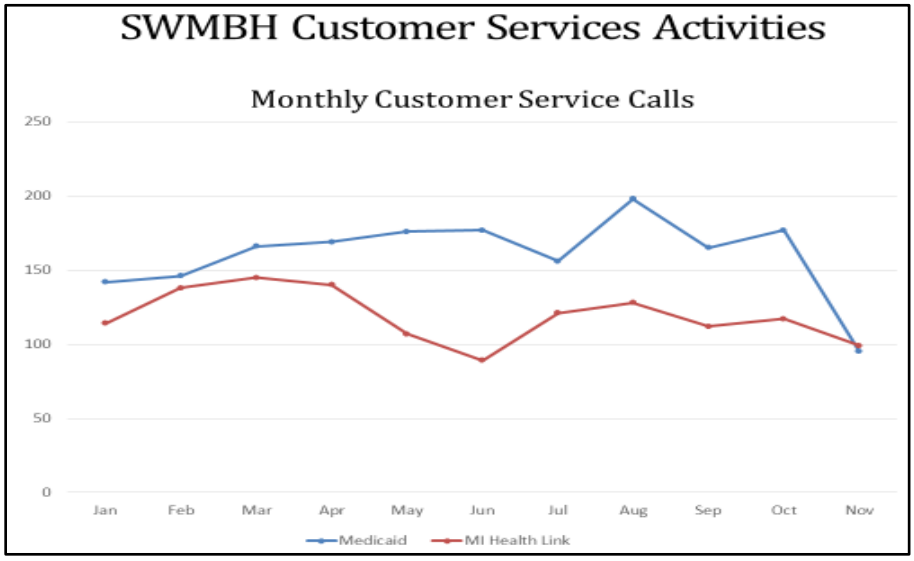
Opportunities for Improvement and Next Steps: The consumer responses received, will be evaluated by UM staff, QAPI staff and Regional Committees to identify any common denominators, or trends in responses. If significant trends are identified in a particular category, then an improvement plan will be formulated. However, the initial score analysis is consistently positive with no significant variance in scores indicated for this survey period.

Monitoring the Customer Service Complaint Tracking System 2019

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 report 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 2018 – September 2019	QAPI Specialist QAPI Director Chief Compliance Officer and Director of Provider Network Management Customer Service Manager Chief Administrative Officer	Quarterly

2019 Calls and Access Analysis

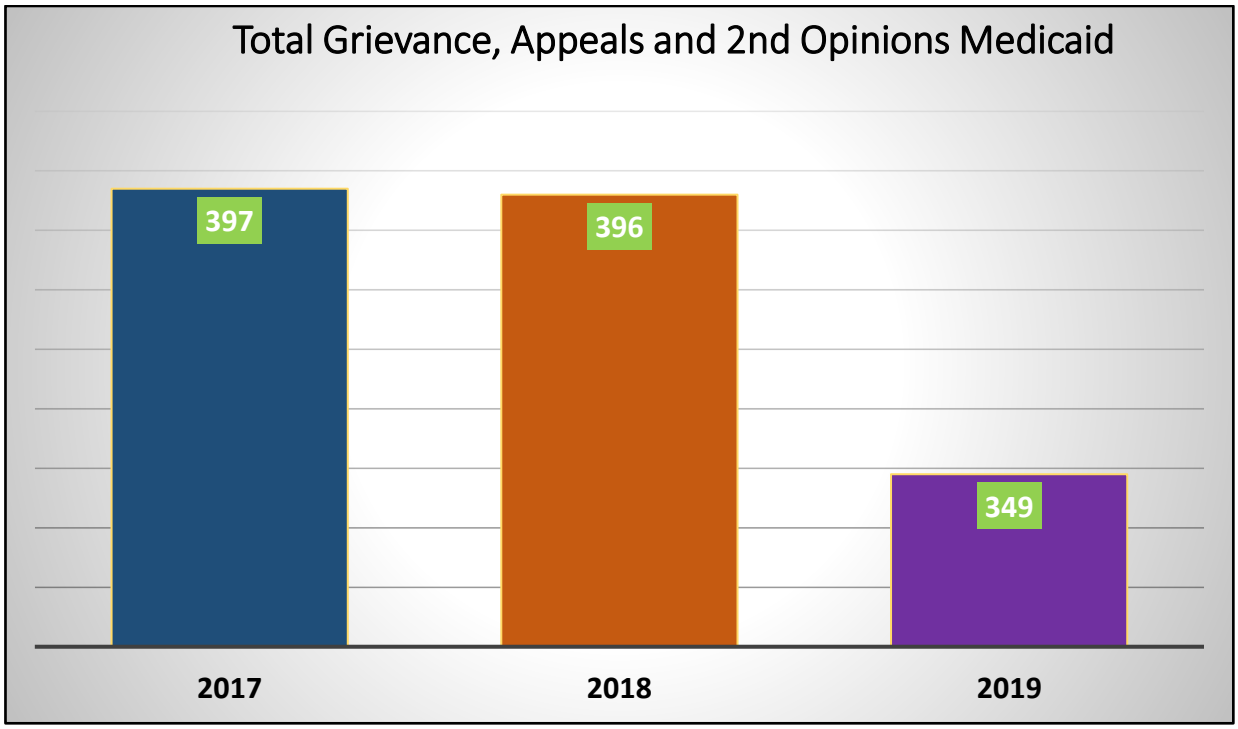
Customer Service Information: (Measurement Period: October 1, 2018 – September 30, 2019)



In FY 19 Customer Service fielded 3071 phone calls
Medicare Customer Service Line: 1761 calls
MHL Member Service Line: 1310
Completed 800 follow up calls
692 members were discharged from Substance Use Disorder Residential Settings
108 members were discharged from Inpatient Psychiatric setting

2019 Grievances and Appeals

In FY 19, Customer Service Managed/provided oversite of 360 grievances and appeals:
❖ MA/HMP/BG Appeals reported: **103**
❖ MA/HMP/BG Grievances reported: **217**
❖ MA/MHL Fair Hearings reported: **15**
❖ MA/HMP/BG Second Opinions reported: **16**
❖ MI Health Link Grievances reported**: 4**
❖ MI Health Link Appeals reported: **5**



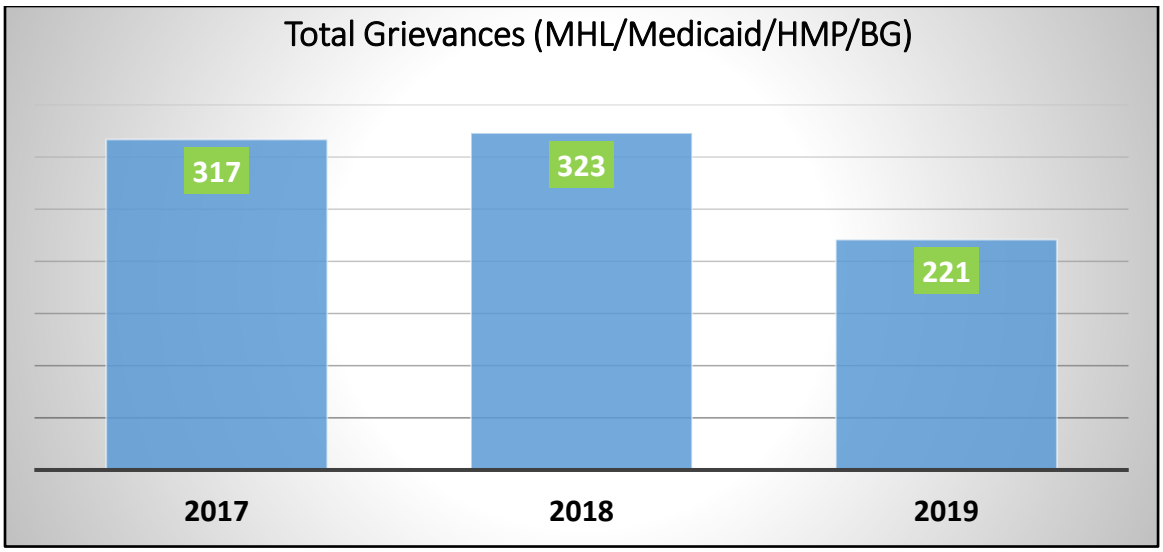
FY 2020 Goals:

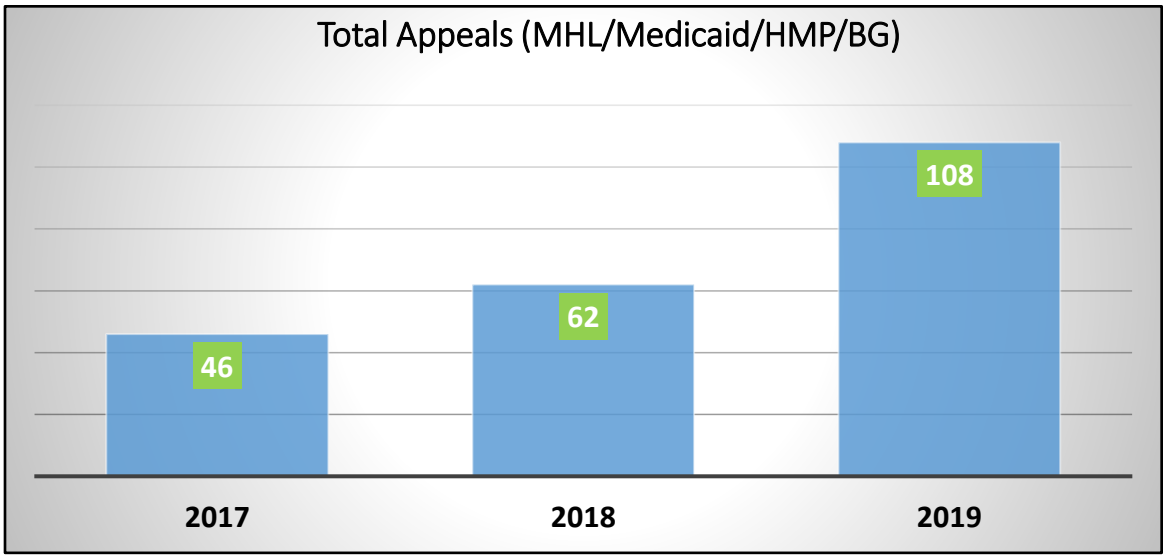
- Complete the Health Services Advisory Group 2020 audit with 90% or higher compliance for Customer Services, Grievances, and Appeals.
- Review and update regional processes for MHL and SUD Adverse Benefit Determinations
    - To ensure effective and efficient communication and notification of rights to members
    - Define what is being sent by whom, why and when
- Define and implement a regional process to notify members of denials of payment
    - This is in response to 2019 HSAG audit
    - Templates and method will be developed for both MI Health Link and Medicaid

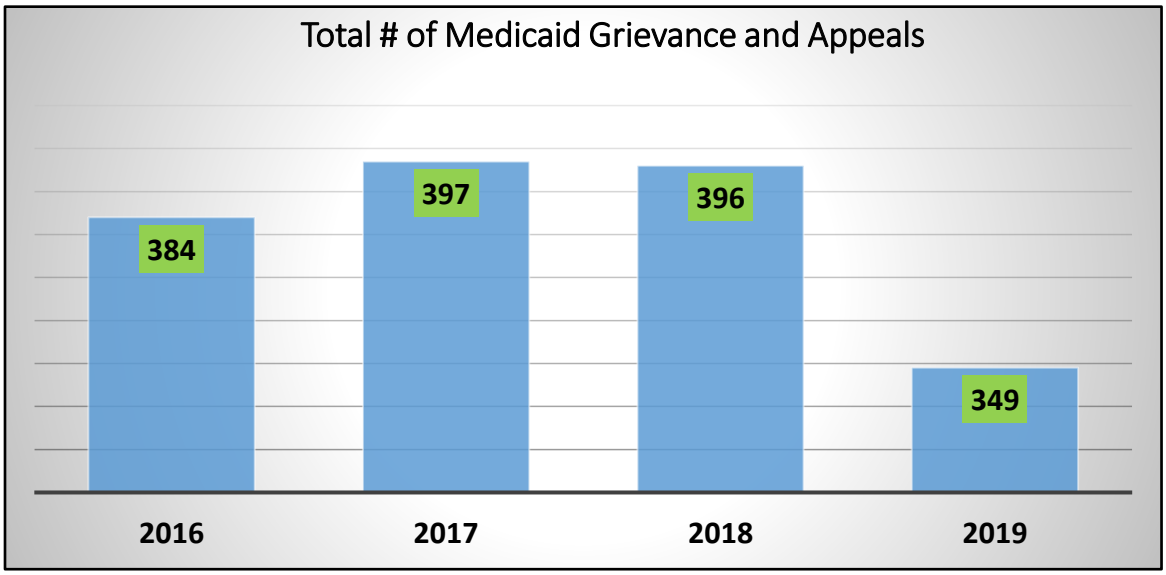
Southwest Michigan Behavioral Health						
Customer Grievance and Appeal Data FY 2019						
SWMBH REGIONAL TOTAL (MA/HMP/BG)						
Activity	**Outcome**	**Q1**	**Q2**	**Q3**	**Q4**	**Total Events:**
Local Appeals Including Termination Reduction Suspension of current services and Denial of additional services	Withdrawn	1				**1**
	Decision Upheld/Affirmed	18	22	22	6	**68**
	Decision Overturned	5	7	9	7	**28**
	Settled/Resolved	2		2	2	**6**
Access 2nd Opinions	Withdrawn		4			**4**
	Decision Upheld/Affirmed	2	2	1	2	**7**
	Decision Overturned		1	1	1	**3**
	Settled/Resolved					**0**
Hospital 2nd Opinions	Withdrawn					**0**
	Decision Upheld/Affirmed			1	1	**2**
	Decision Overturned					**0**
	Settled/Resolved					**0**
	Decision Affirmed	2			2	**4**
	Decision Overturned			1		**1**
	Settled/Resolved					**0**
Grievances	Withdrawn	3	1	3	1	**8**
	Settled/Resolved	57	61	55	44	**217**
TOTAL Events:		**90**	**98**	**95**	**66**	**349**

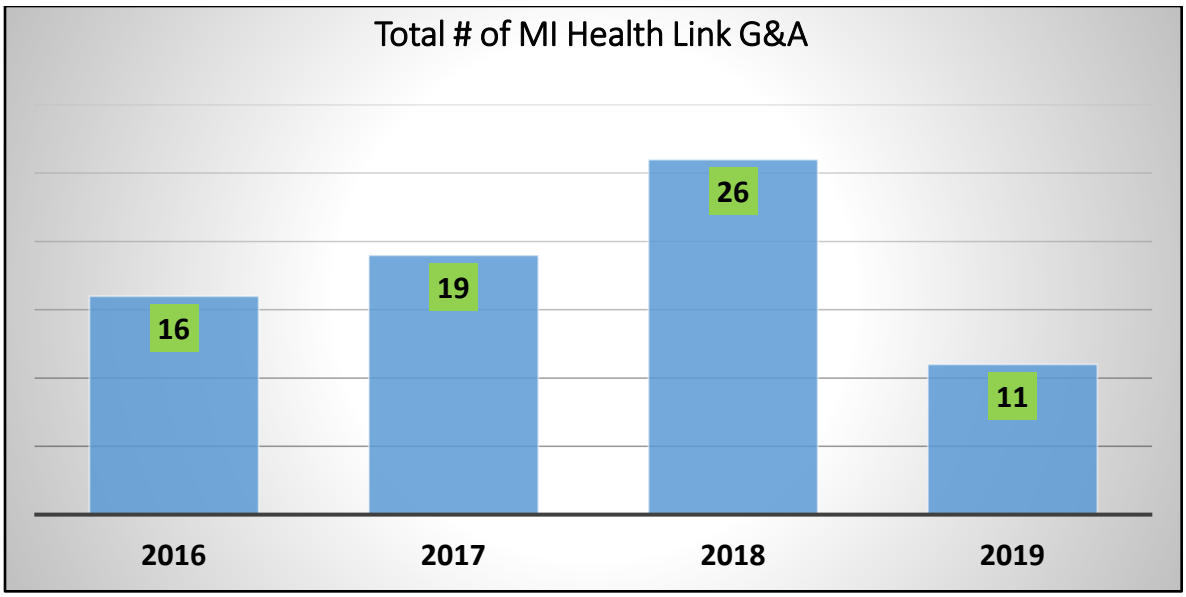
Southwest Michigan Behavioral Health						
Customer Grievance and Appeal Data CY January 2019 – December 2019						
SWMBH REGIONAL TOTAL (MHL)						
Activity	**Outcome**	**Q1**	**Q2**	**Q3**	**Q4**	**Total Events:**
Local Appeals Including Termination Reduction Suspension of current services and Denial of additional services	Withdrawn					**0**
	Decision Upheld/Affirmed	2	1			**3**
	Decision Overturned	1	1			**2**
	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			1		**1**
	Settled/Resolved		1	3	0	**4**
	Recipient Rights Referral					**0**
TOTAL Events:		**3**	**4**	**4**	**0**	**11**

✓ A decrease of 15 Grievance and Appeals has been observed in comparison to the previous year (2019 vs. 2018)


Total Grievances (MHL/Medicaid/HMP/BG)
317
323
221
2017
2018
2019


Total Appeals (MHL/Medicaid/HMP/BG)
46
62
108
2017
2018
2019


Total # of Medicaid Grievance and Appeals
384
397
396
349
2016
2017
2018
2019



Causal Analysis of 2019 Grievance and Appeals

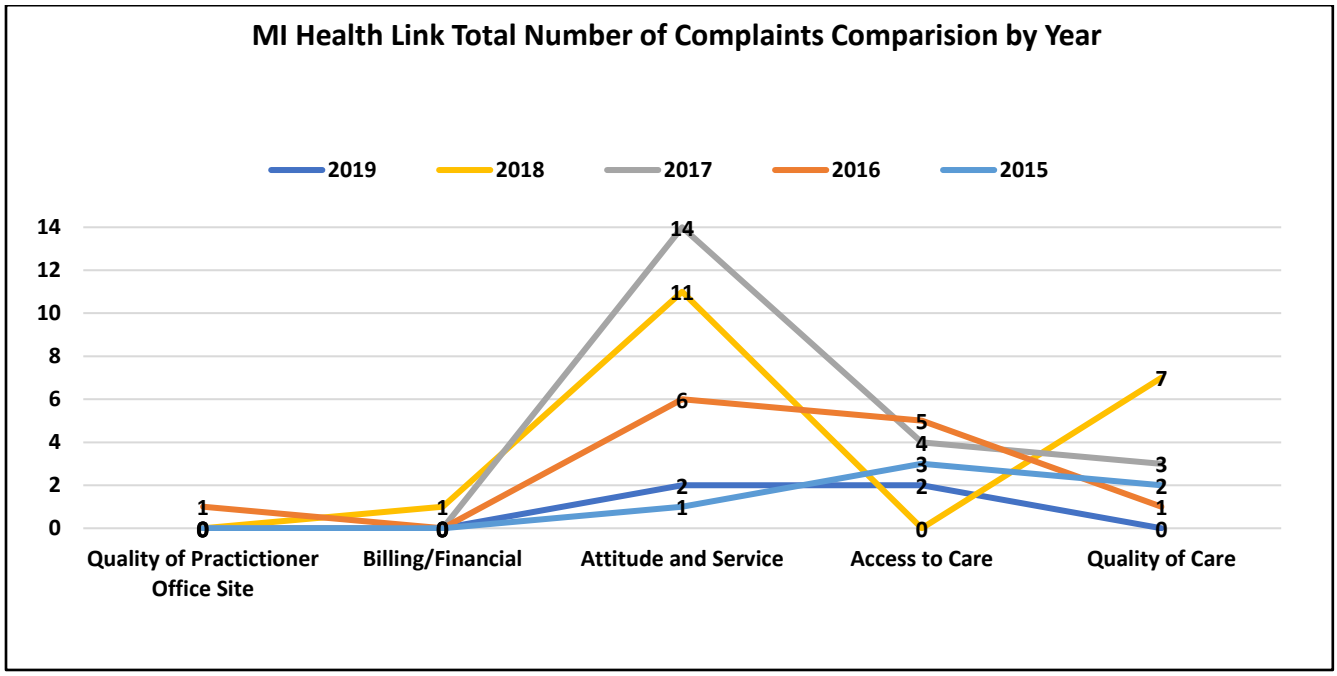
- The total number of Medicaid Grievance, and Appeals, and 2nd Opinions for FY 2019 was 349, (47) less than 2018 total of 396. This translates into an overall decrease of (-12.37%).
- There was also a decrease in the total number of Grievances (MHL/Medicaid/HMP/BG) from 323 in 2018 to 221 in 2019. This translates into a significant decrease of (31.57%) in total Grievances for FY 2019.
- The total number of MHL Grievance, Appeal, and 2nd Opinions was (11) for 2019, which is a (-57.69%) decrease from 2018 (26).

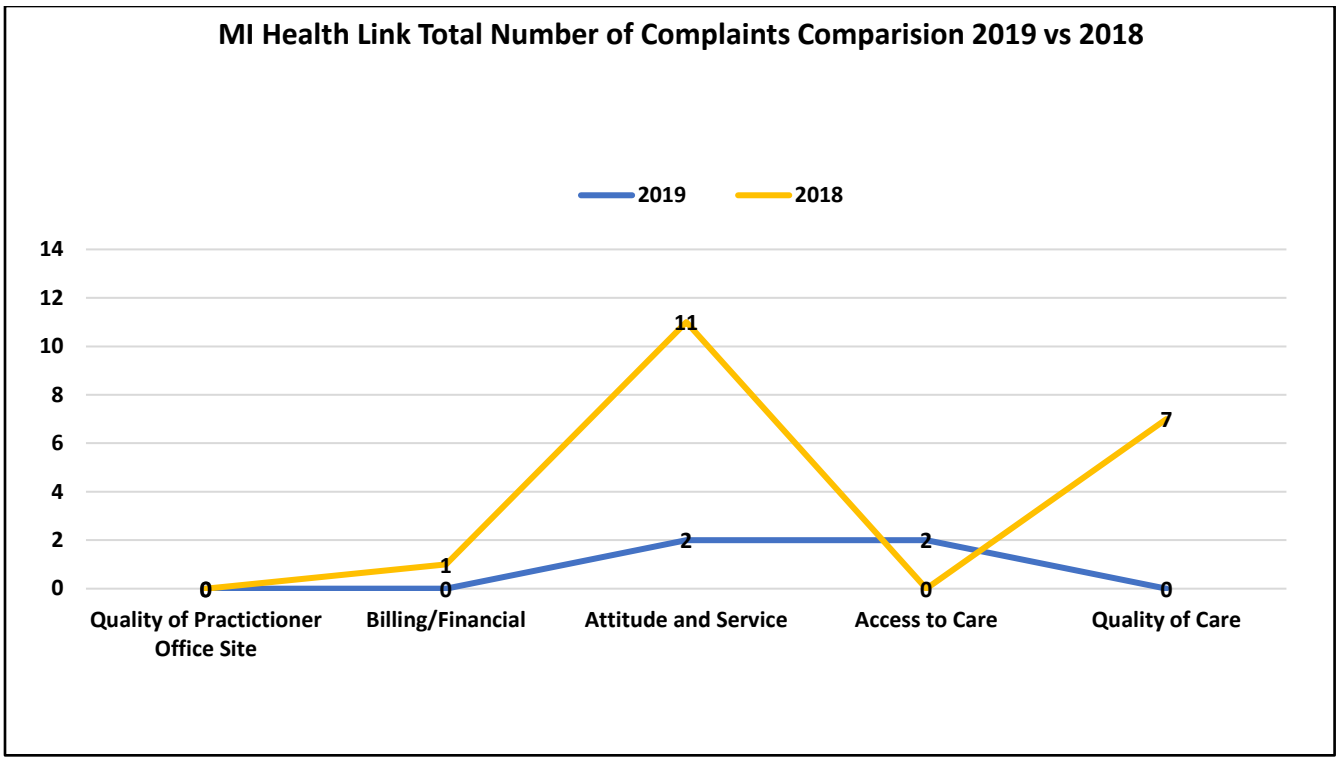
As shown in the above results, a significant improvement was observed with both total Medicaid and MI Health Link Grievance and Appeals totals. This data analysis has been reviewed by internal Quality and Customer Services Workgroups, as well as Regional Quality Assurance and Customer Service Committees. Many of the improvements have been attributed to improved processes at the local and administrative levels. Updated forms, policies, and guidance documents have significantly decreased overall customer inquiries into the Grievance or Appeals processes, as they are not more familiar with their options.

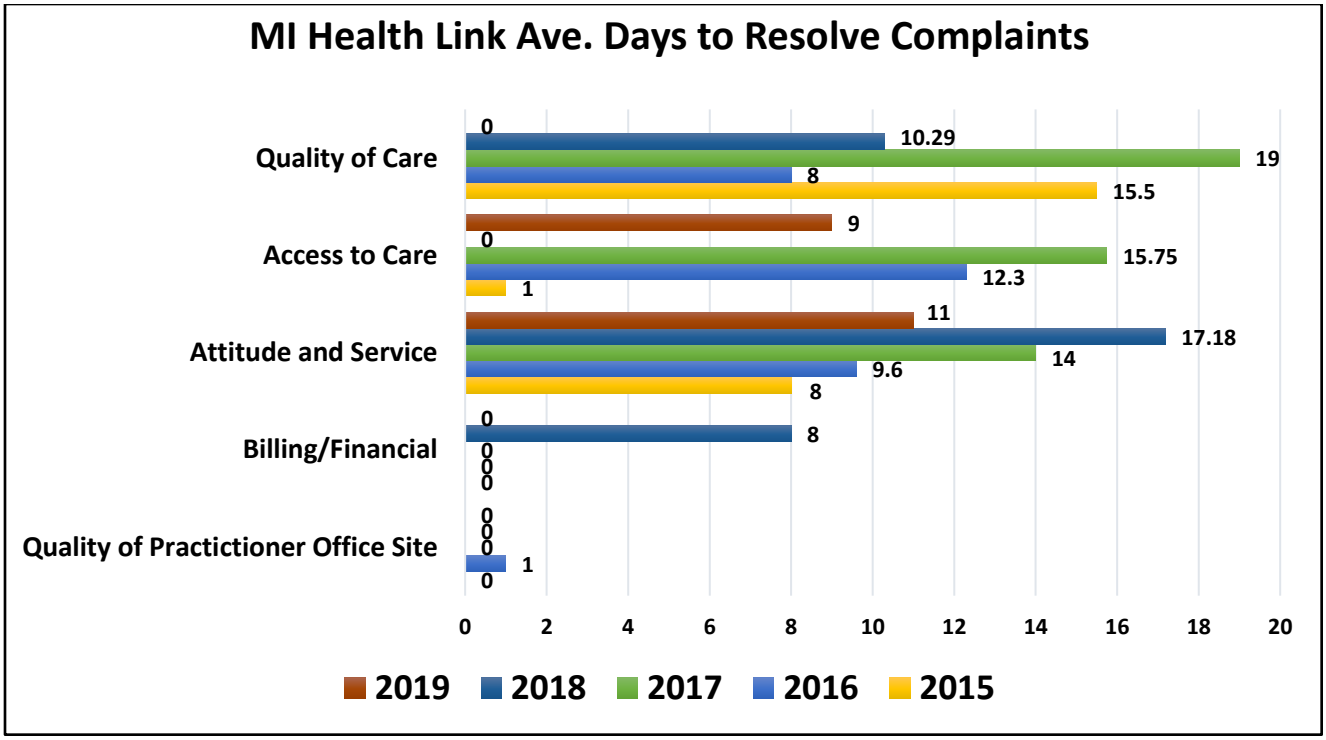
Additionally, It has been determined by the Regional Customer Services Committee that; if a consumer attempts to re-engage in services after being supplied an adequate action notice, within the given timeframe (12 days), services will continue without interruption and the incident is not tracked as an open appeal. If the consumer attempts to reengage after a given timeframe or if problematic issues are 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. Before 2018, 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 the timeframe.
The Regional Customer Services Committee and the Regional Quality Assurance and Performance Improvement Committee will continue to review Grievance and Appeals data quarterly and follow-up on any trends that are identified.

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 report 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 2018 – September 2019	QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Provider Network Director	Quarterly

2019 MI Health Link Complaints




MI Health Link Total Number of Complaints Comparision 2019 vs 2018
2019
2018
14
12
10
8
6
4
2
0
0
1
11
0
2
2
0
7
0
Quality of Practictioner Office Site
Billing/Financial
Attitude and Service
Access to Care
Quality of Care


MI Health Link Ave. Days to Resolve Complaints
Quality of Care
0
10.29
19
8
15.5
Access to Care
9
0
15.75
12.3
1
Attitude and Service
11
17.18
14
9.6
8
Billing/Financial
0
8
0
0
0
Quality of Practictioner Office Site
0
0
0
1
0
0
2
4
6
8
10
12
14
16
18
20
2019
2018
2017
2016
2015

MI Health Link Qualitative Analysis on Member Complaint Data

Complaints & Grievances- A casual and trend analysis has been completed and reviewed during the regional MHL Committee meeting to, 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	2019 (10,673) MEMBERS	2018 (9,586) MEMEBRS	2017 (11,179) MEMBERS	2016 (8,024) MEMBERS	2015 (5,186) MEMBERS
QUALITY OF CARE	0/0	3/0.313	3/0.268	1/0.125	2/0.386
ACCESS	2/0.187	0/0	4/0.358	5/0.623	3/0.578
ATTITUDE/SERVICE	2/0.187	11/1.148	14/1.252	6/0.784	1/0.193
BILLING/FINANCIAL	0/0	1/0.104	0/0	0/0	0/0
QUALITY OF PRACTITIONER OFFICE SITE	0/0	0/0	0/0	1/0.125	0/0
TOTAL	2/0.187	15/1.565	21/1.879	13/1.869	6/1.157

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 Utilization Management. The Medical Director also participated.

Results:
There were 2 complaints each for the Access and Attitude and Service Categories.

Identified Improvement Opportunities:

- Owners of the building were notified to create a handicap accessible ramp to the building.
- Improve telephone communication skills with education and with the creation of 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 the 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 6-7 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.

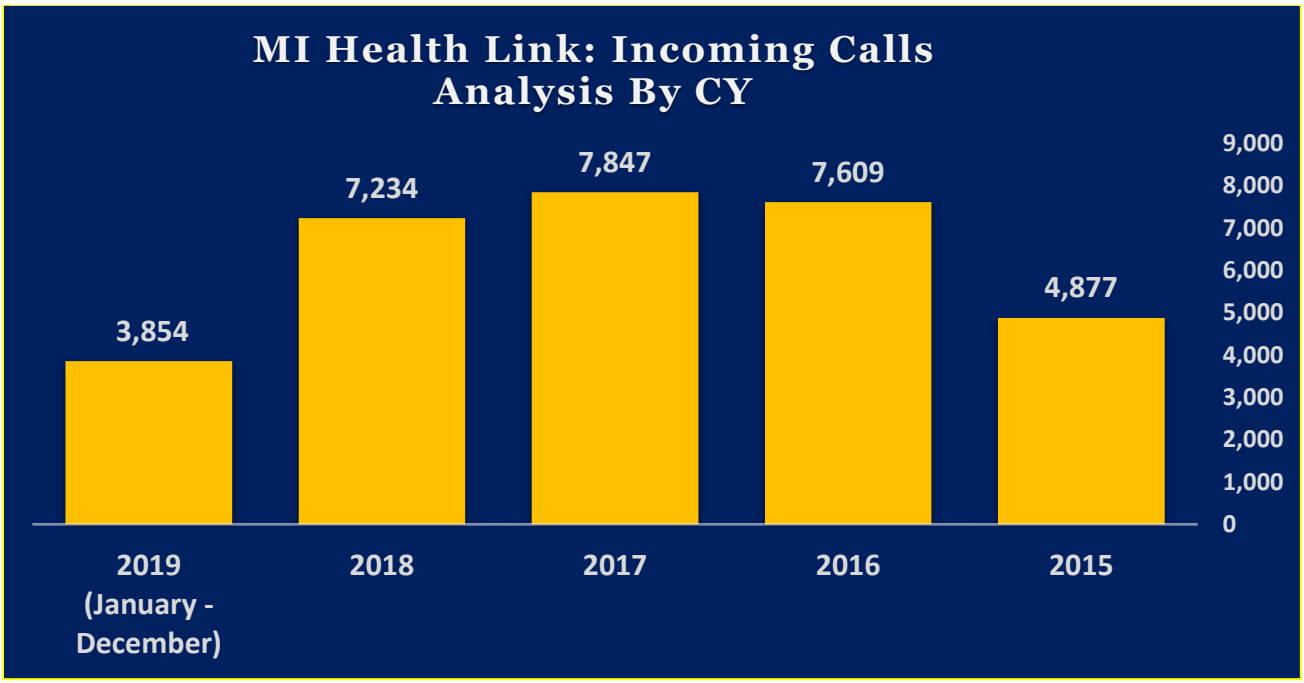
Providers administer the RSA-R survey. Several provider-based surveys required by NCQA exist between the mental health and primary care providers regarding how they receive collaborative information from each other. SWMBH also administers an online survey about access to care.

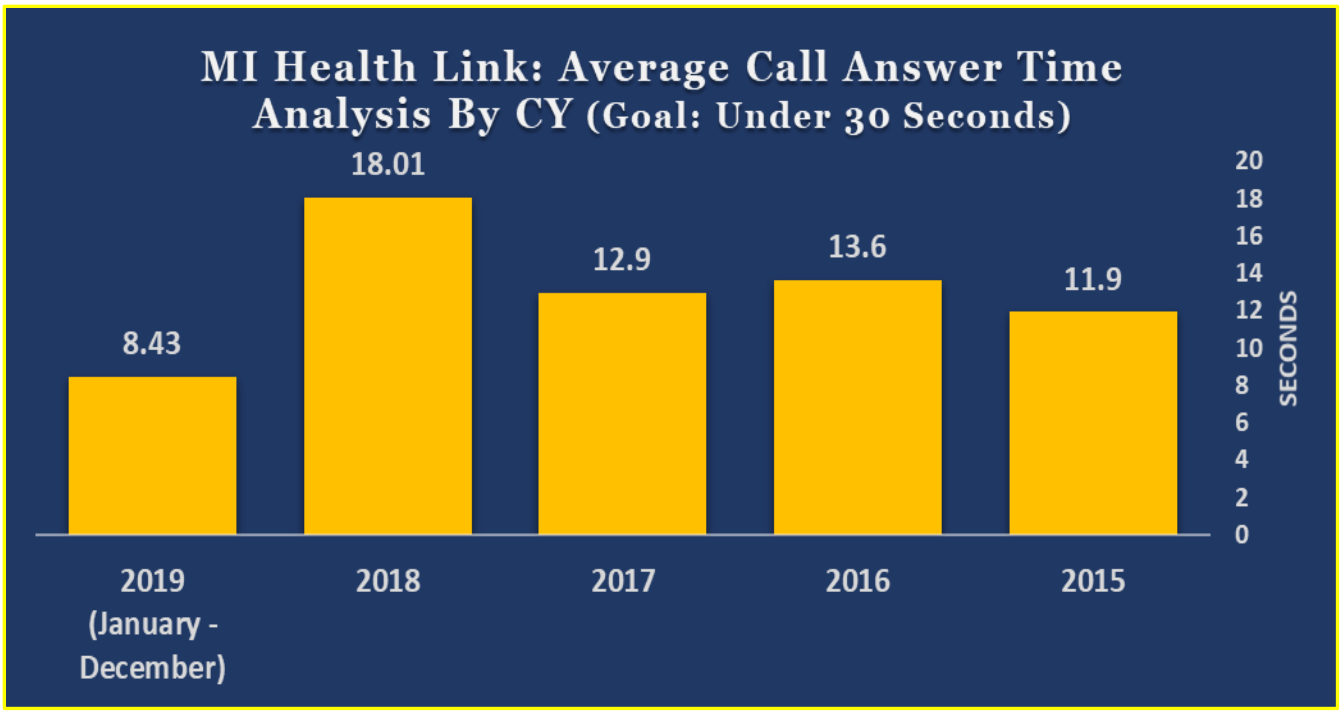
When surveys are completed, SWMBH follows a validation and review process with internal QAPI team members, Quality Management Committee, Regional Utilization Management and Clinical Practices Committee, and the Consumer Advisory Committee. Survey results, including narrative feedback, are given to each 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 would conduct a follow-up survey following the prescribed program adjustments and interventions.

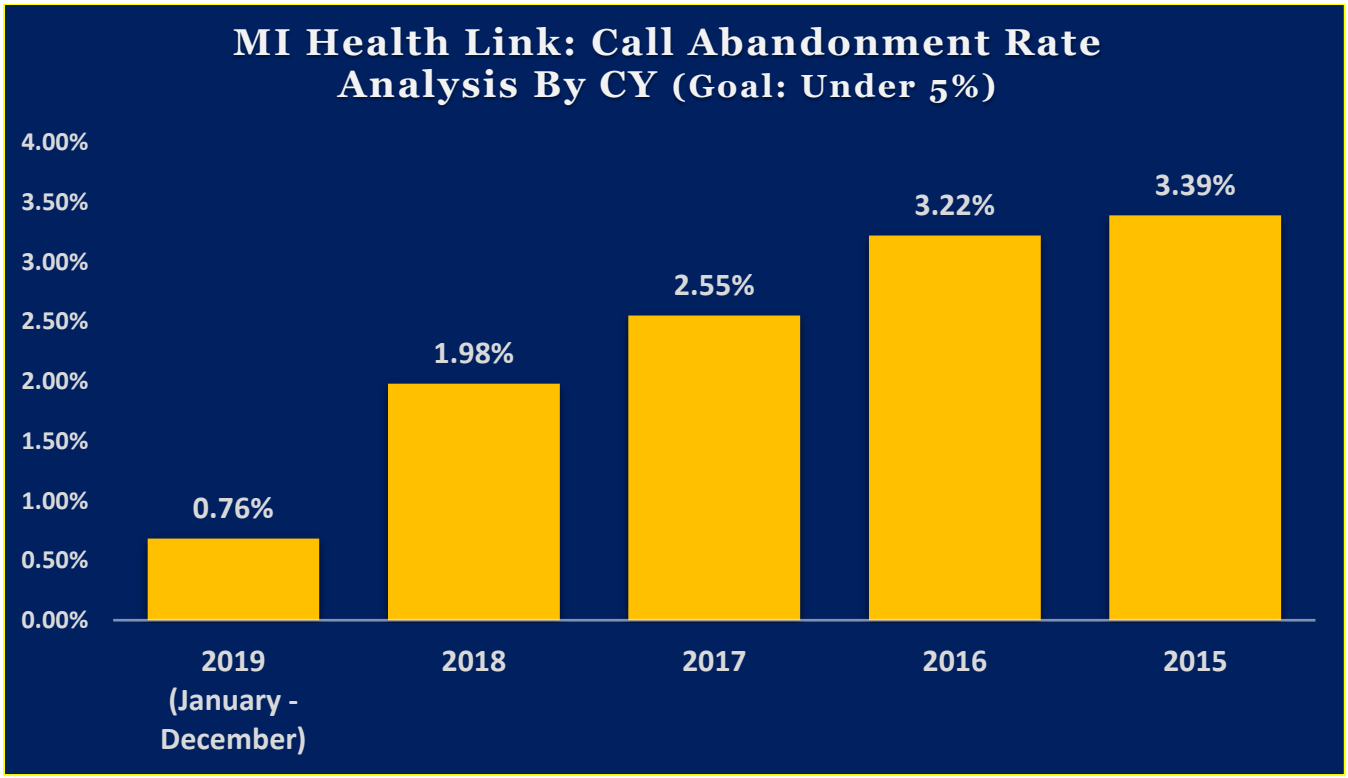
2019 Call Center Data Analysis

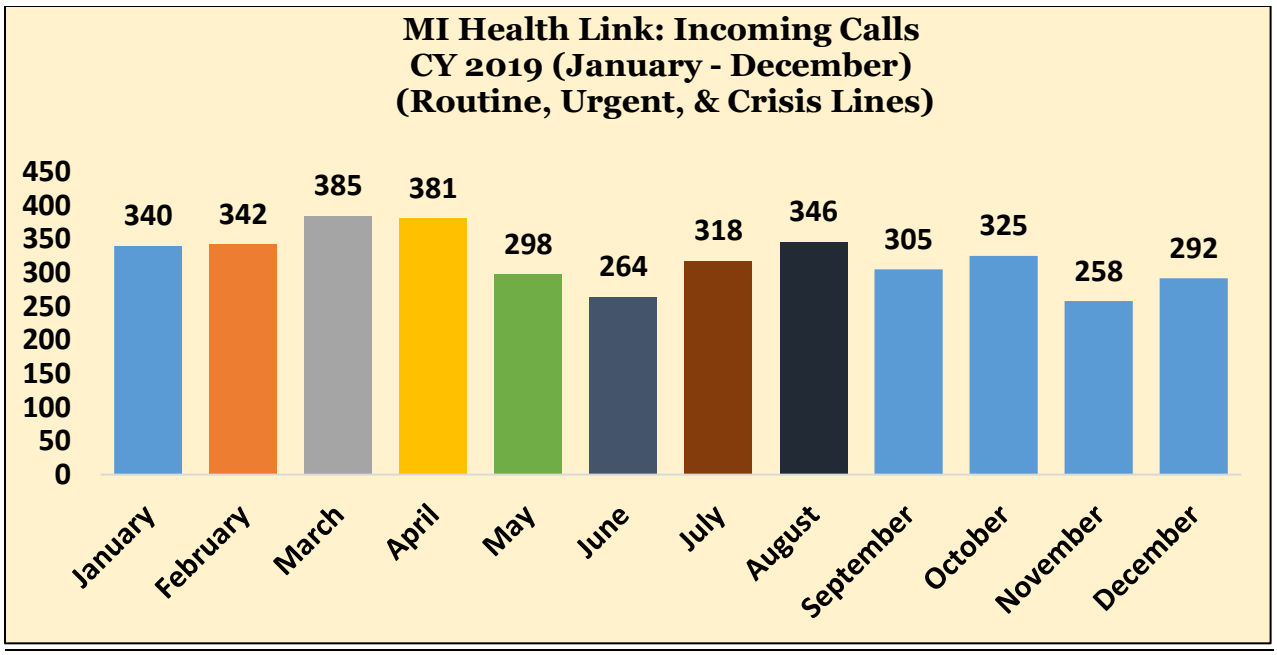
Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Call Center Monitoring (SWMBH reporting) for MI Health Link Business Line	➢ Ensure that a call center monitoring plan is in place ➢ Provide routine quality assurance audits. ➢ Random (live) Monitoring of calls for quality Assurance. ✓ Tracking 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 the scoring criteria of 96.25% performance rate is completed and evaluated. (*not required)* ✓ Achieve a call abandonment rate of 5% or less. ✓ Monitor the number of calls received for each service line. ✓ The 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 2019 – December 2019	QAPI Specialist QAPI Director Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant	Monthly

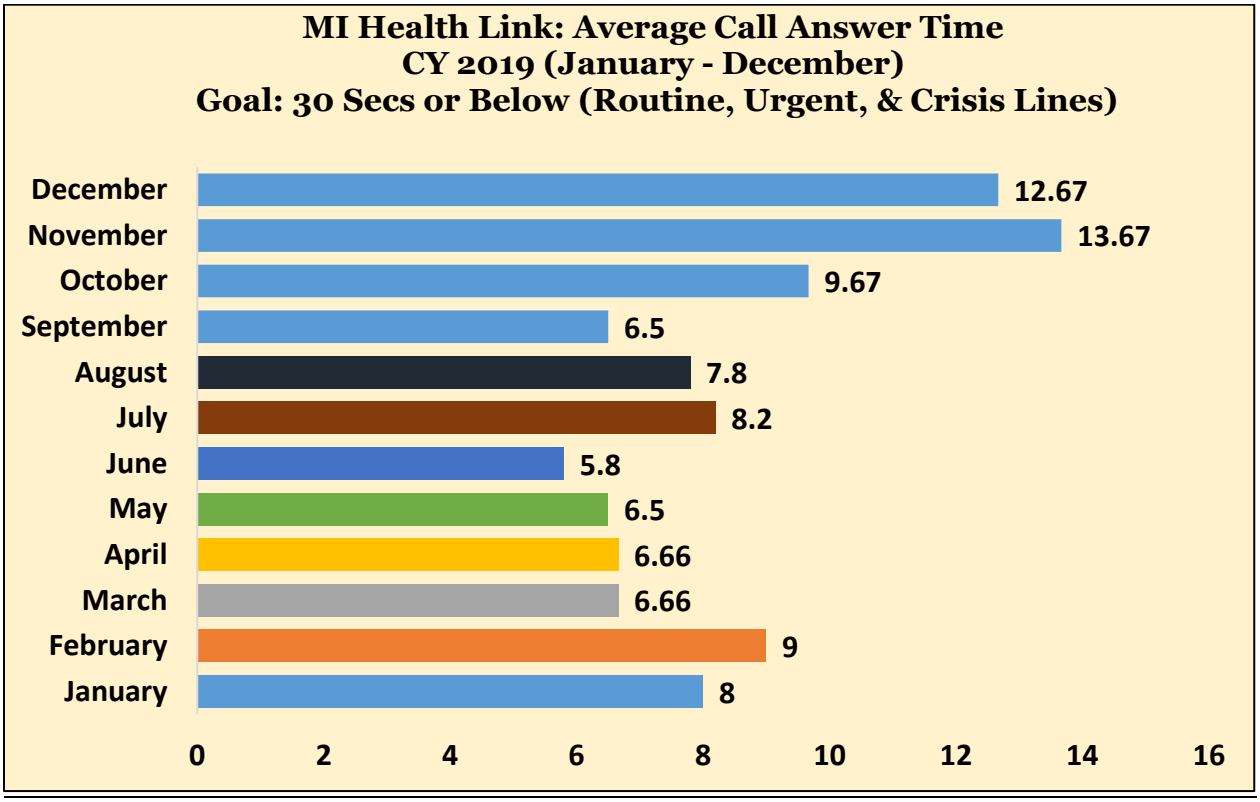
SWMBH 2019 MI Health Link Call Center Data Analysis

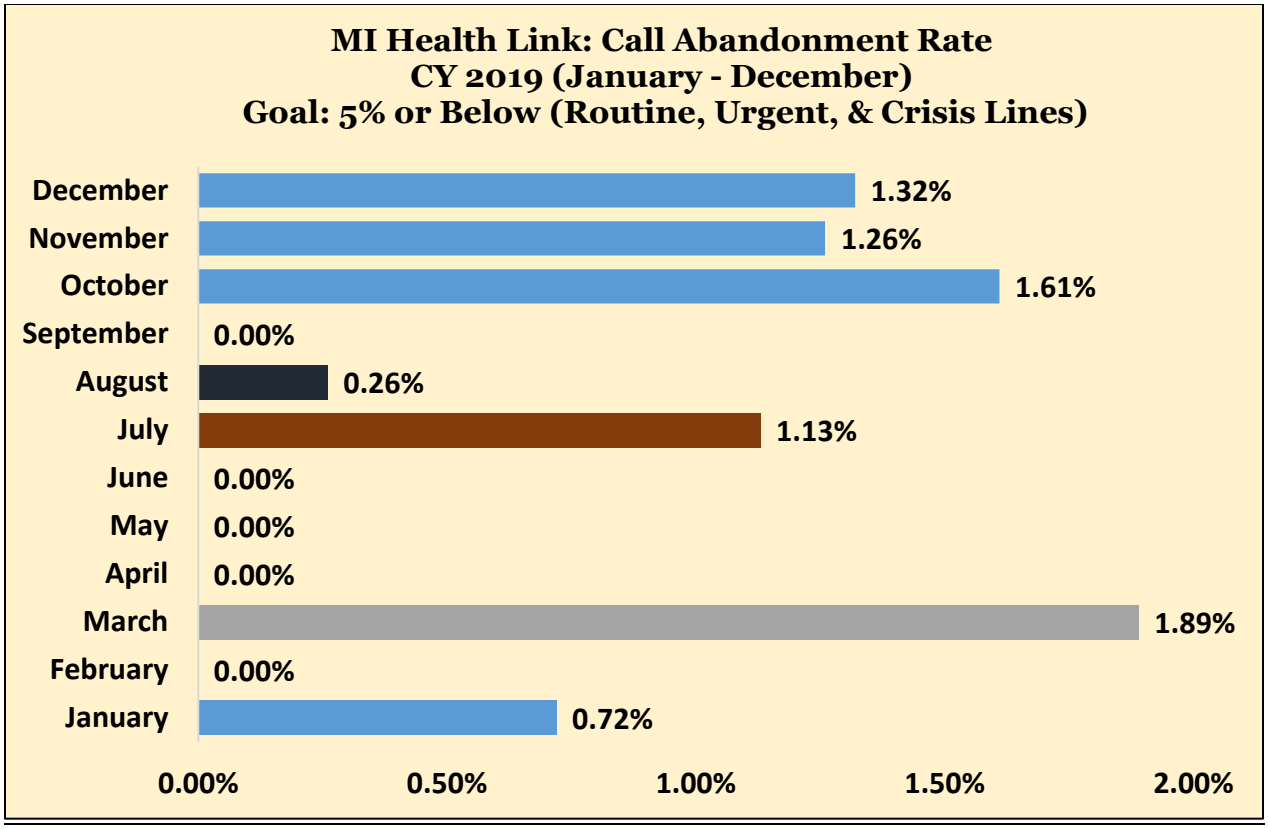



MI Health Link: Average Call Answer Time
Analysis By CY (Goal: Under 30 Seconds)
8.43
18.01
12.9
13.6
11.9
20
18
16
14
12
10
8
6
4
2
0
SECONDS
2019 (January - December)
2018
2017
2016
2015


MI Health Link: Call Abandonment Rate
Analysis By CY (Goal: Under 5%)
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
0.76%
1.98%
2.55%
3.22%
3.39%
2019 (January - December)
2018
2017
2016
2015


MI Health Link: Incoming Calls
CY 2019 (January - December)
(Routine, Urgent, & Crisis Lines)
450
400
350
300
250
200
150
100
50
0
340
342
385
381
298
264
318
346
305
325
258
292
January
February
March
April
May
June
July
August
September
October
November
December


MI Health Link: Average Call Answer Time
CY 2019 (January - December)
Goal: 30 Secs or Below (Routine, Urgent, & Crisis Lines)
December
November
October
September
August
July
June
May
April
March
February
January
12.67
13.67
9.67
6.5
7.8
8.2
5.8
6.5
6.66
6.66
9
8
0
2
4
6
8
10
12
14
16



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 procedures 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 allowed 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 2019. Please find the current breakdown of call metric averages for 2019:

- Call Abandonment Rate: **0.76%**
- Call Answer Time: **8.43 seconds**
- Average Incoming Calls per Month: **321 Calls**
- Total Number of Incoming Calls for 2018: **3,854**

Identified Barriers:

Evaluation of Call Monitoring and Calibration Process during vender transition.

Recommendations:

Calibration ensures that all SWMBH clinical staff, who have been deemed appropriate to engage in monitoring activities, can rate call center staff interactions consistently and fairly. Calibration will occur on an annual basis and/or when a

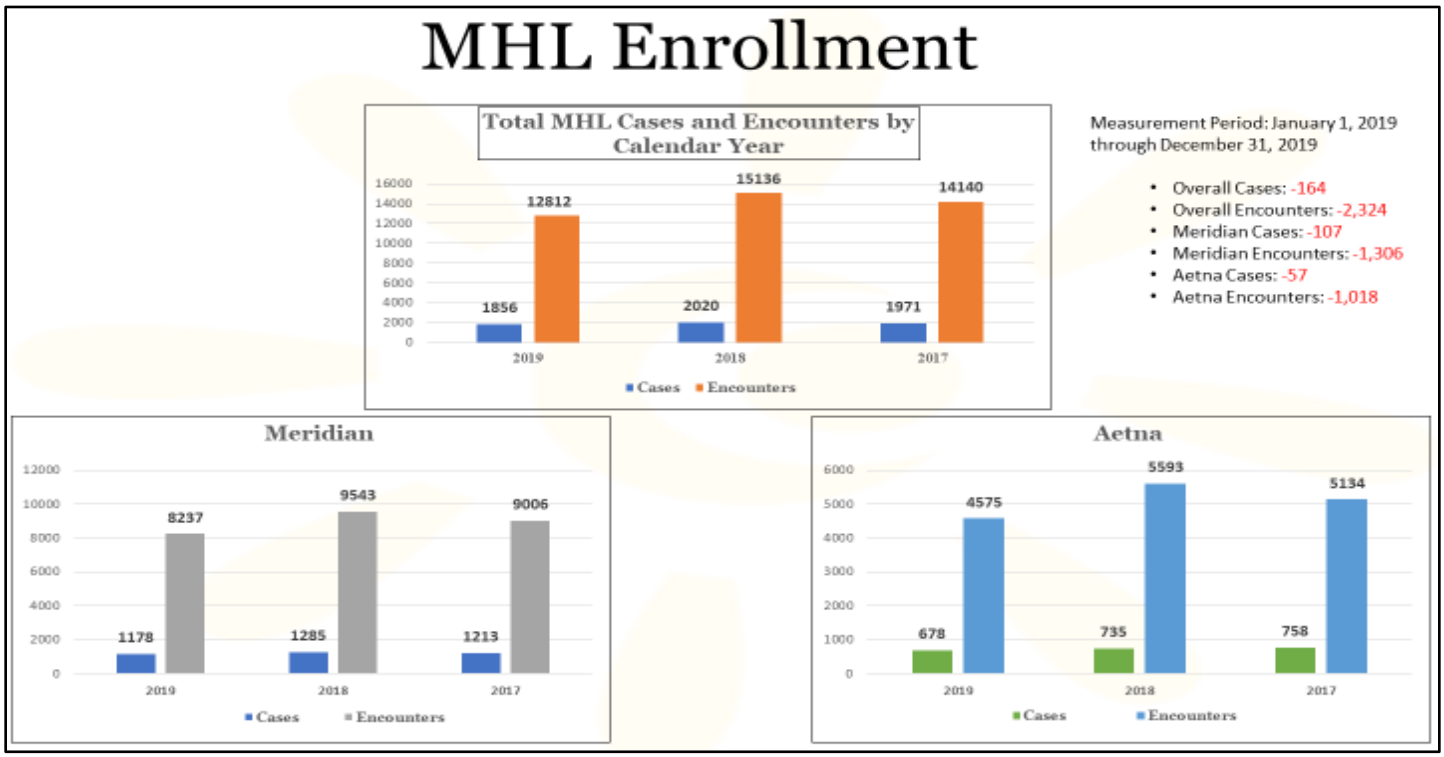
new clinical staff member is designated to perform monitoring activities. During each calibration session, multiple evaluators will independently score the same call center staff interaction.

Enrollment and Eligibility Breakdown in the MI Health Link Demonstration

MI Health Link Enrollment by County (CY 2019):

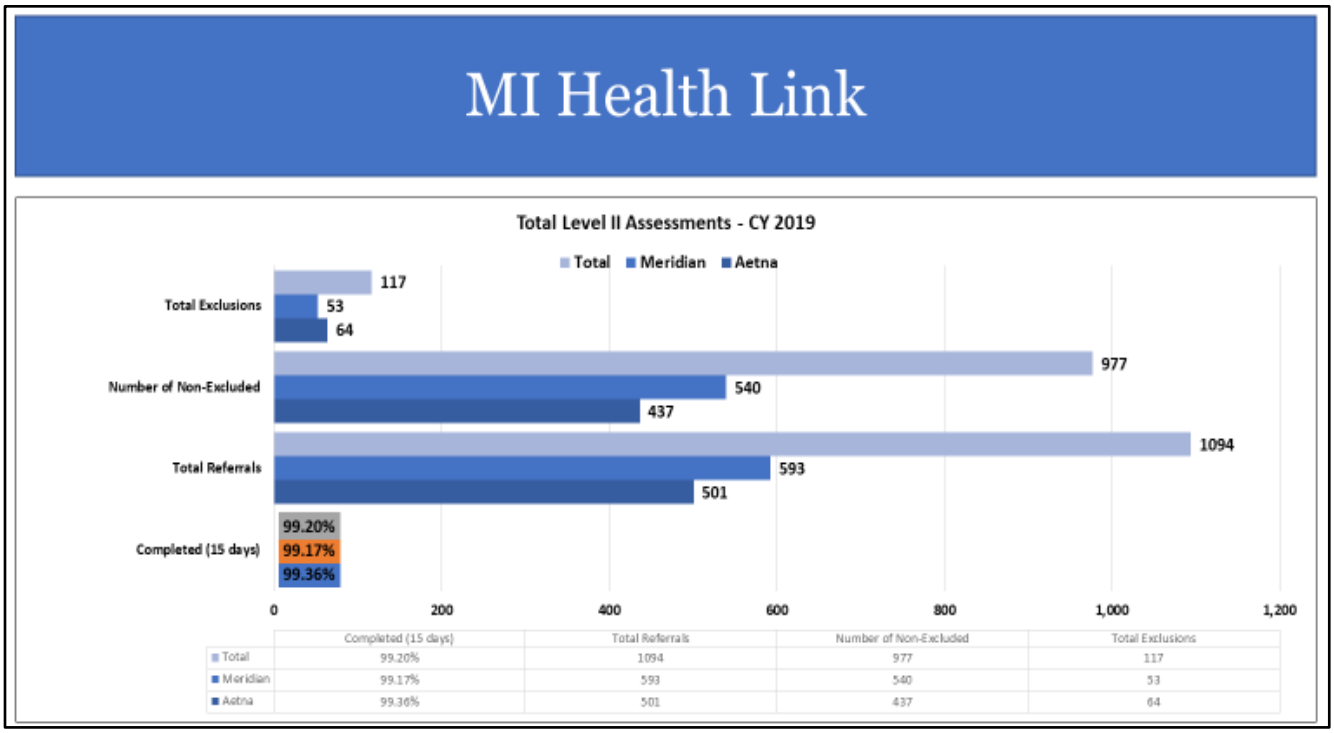
**Data includes MI Health Link Business Line for both Aetna and Meridian (ICO Partners) **
Data Snapshot taken 1/27/20

County Name	# Consumers Covered	# Consumers Served	# of Encounters
Kalamazoo	2,653	388	35,900
Calhoun	2,337	277	14,000
Berrien	2,237	166	9,031
Van Buren	1,133	135	7,700
St. Joseph	785	77	4,086
Cass	577	72	5,400
Branch	512	71	4,200
Barry	439	66	1,300
Total:	**10,673**	**1,252**	**81,617**

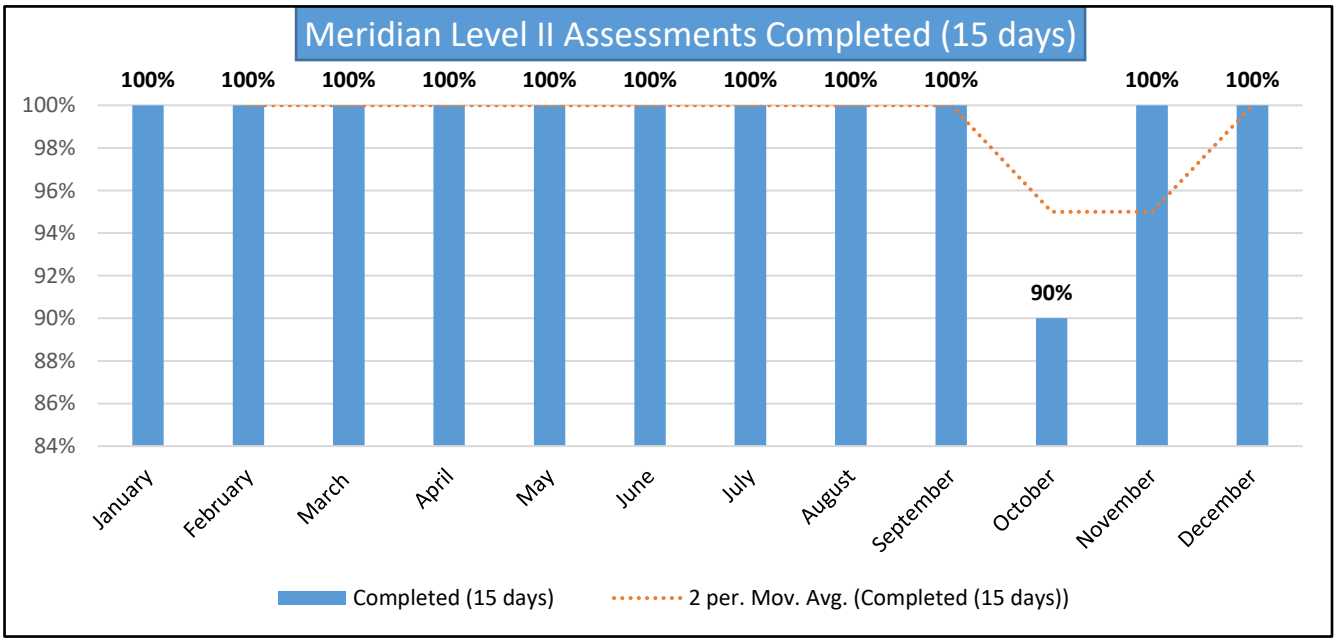


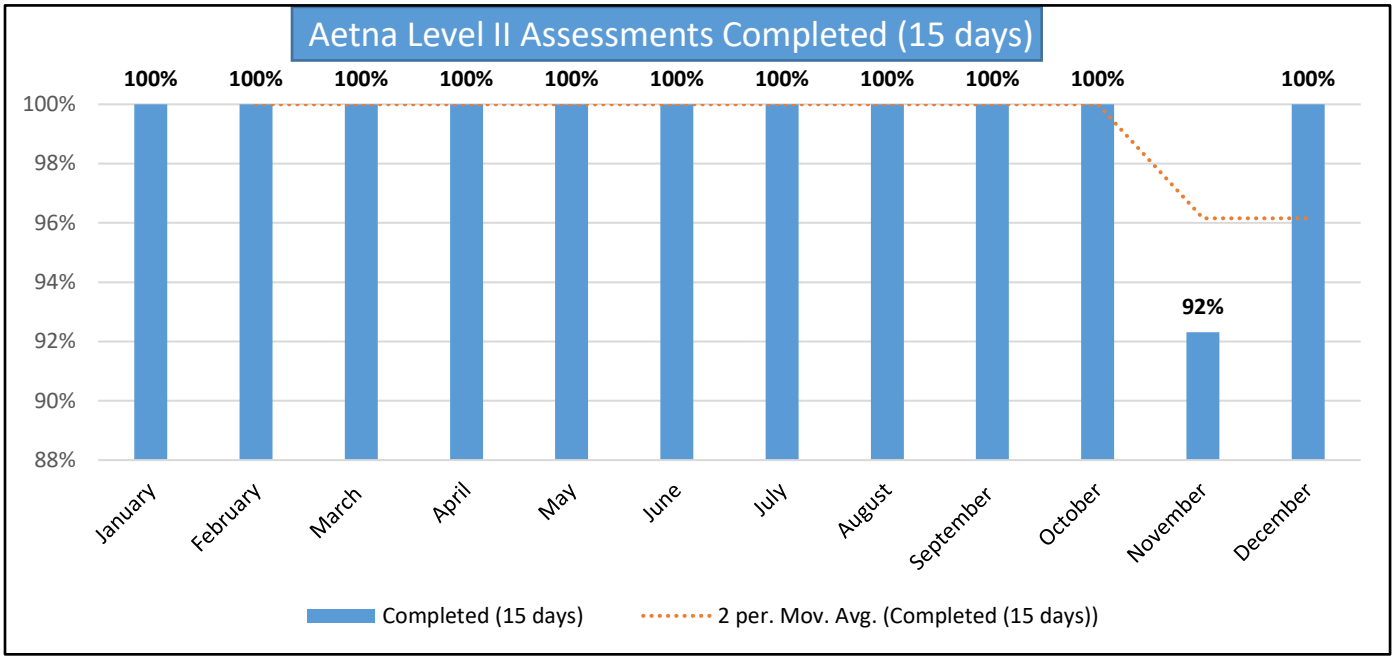
MI Health Link Level II Assessment Timeliness Report Analysis

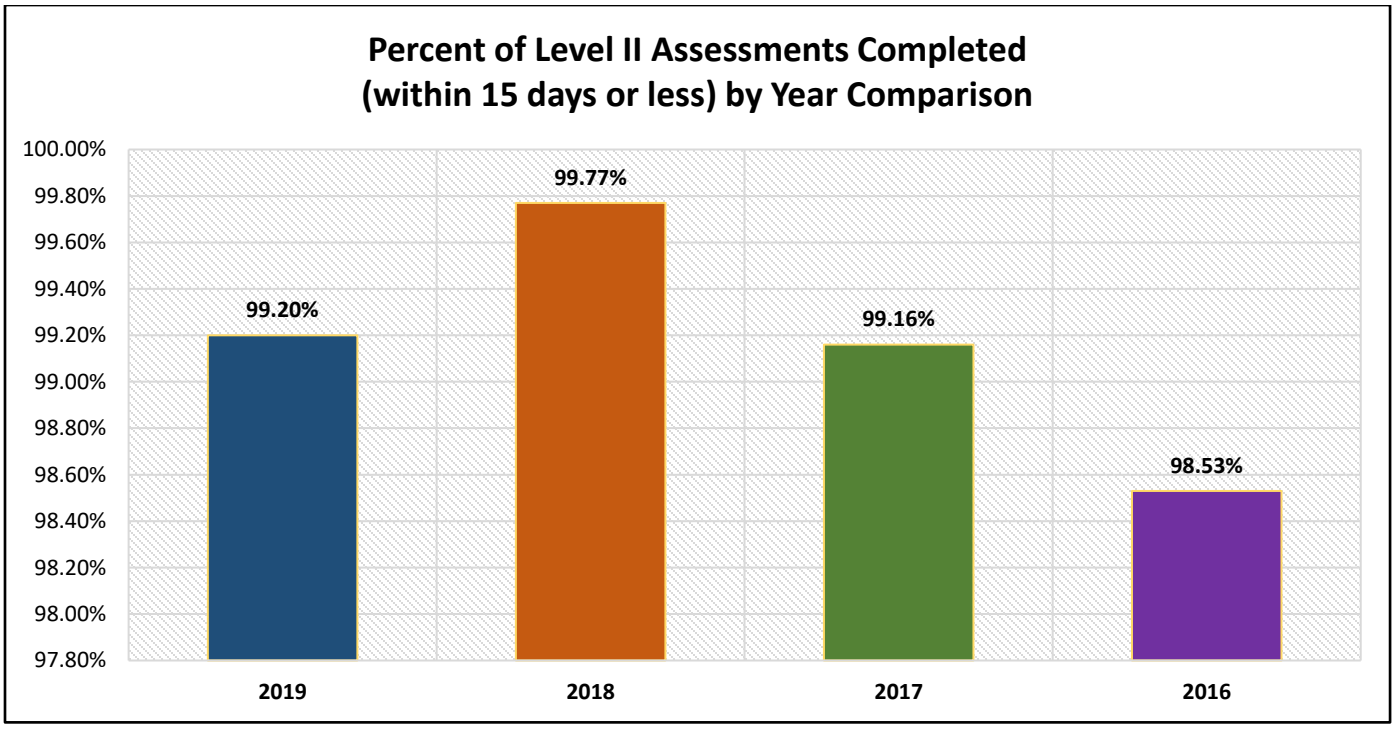
January 1, 2019 – December 31, 2019

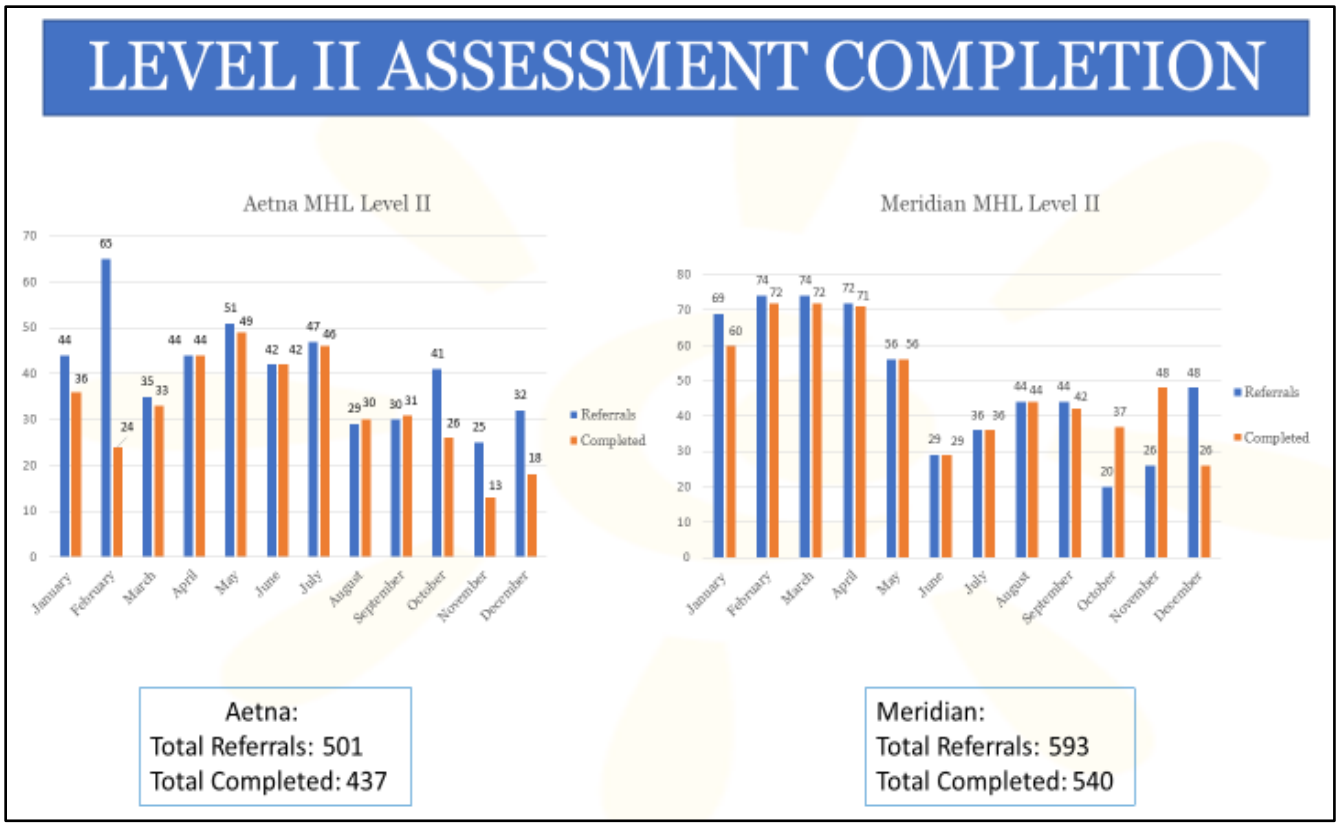


- **Target/Goals:** The MI Health Link Quality Performance Benchmark for the Level II Assessment Follow-up Timeliness Metric within (15 days) is 95% or above.
- During CY 2019 99.20% of Level II Assessments achieved the Timeliness Standard of follow-up within (15 days or less).




Aetna Level II Assessments Completed (15 days)
100%
98%
96%
94%
92%
90%
88%
100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 92% 100%
January
February
March
April
May
June
July
August
September
October
November
December
Completed (15 days)
2 per. Mov. Avg. (Completed (15 days))


Percent of Level II Assessments Completed
(within 15 days or less) by Year Comparison
100.00%
99.80%
99.60%
99.40%
99.20%
99.00%
98.80%
98.60%
98.40%
98.20%
98.00%
97.80%
99.20%
99.77%
99.16%
98.53%
2019
2018
2017
2016



Objective:

The analysis measures are the 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 2019, 99.20% of consumers received an initial Level II Assessment within 15 days of a referral. This was a 0.61% decrease compared to 2018 and a 0.04% increase from 2017. Review Level II Assessment analysis and exclusion determinations are reviewed during MHL Committee Meetings, on a quarterly schedule. If outliers are identified, a corrective action plan may be implemented.

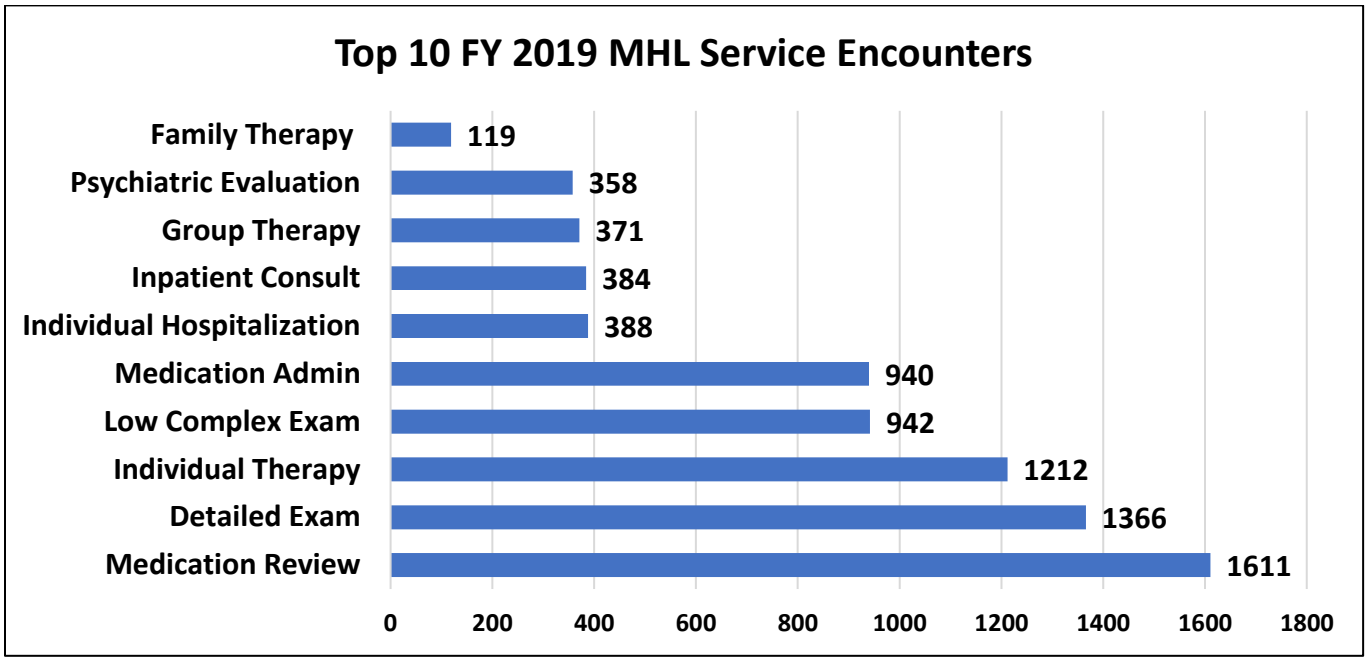
Identified Barriers:

In May of 2019, the Call Center/UM staff were very short-handed and going through a transitional phase of training those newly hired. There were also some system changes regarding how the event was captured in the EHR. This required additional training/education to staff and updates to report logic.

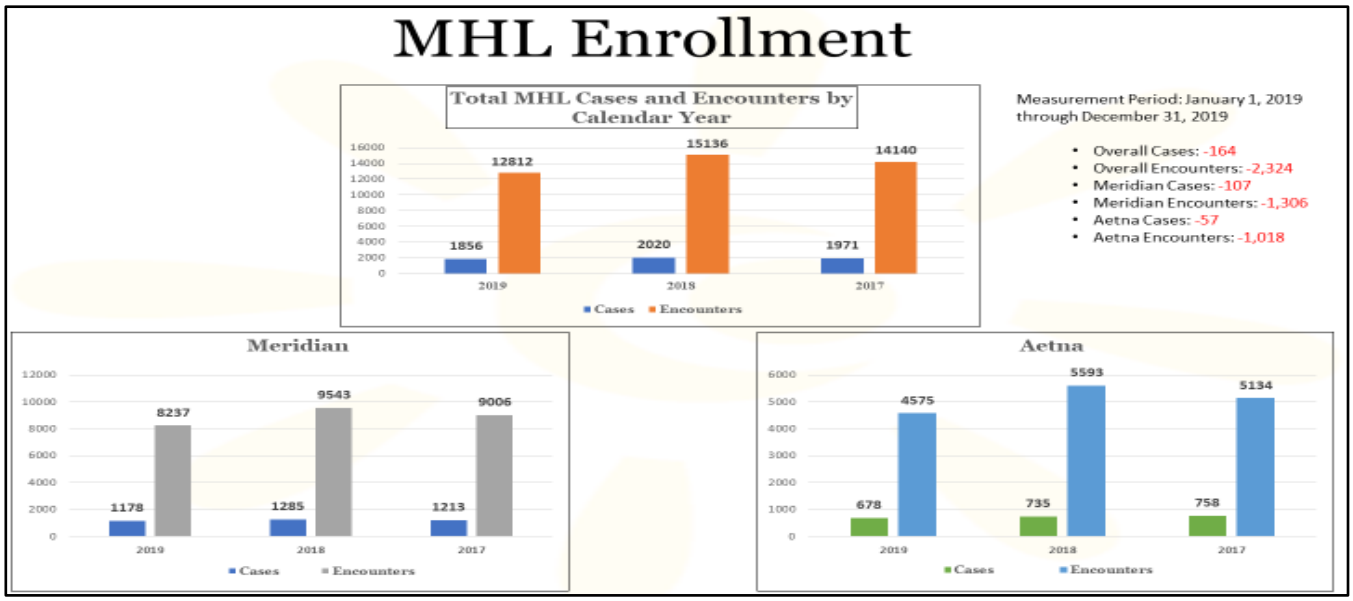
Recommendations:

SWMBH is currently working on the redevelopment of the Level II report in SmartCare. This will improve the validity and accuracy of the report. This will also help capture our agreed-upon methodology for Level II Assessment exclusion categories with Integrated Care Organizations (ICO's). This will be very helpful when we are negotiating our established quality withhold measures at the end of the contract year.

The graph below is the ICO Service Encounter Breakdown (FY 2019) of the top 10 MHL services out of the many services offered:



- ❖ The graph above is the ICO Service Encounter Breakdown (FY2019) of the top 10 MHL services out of the many services offered.
- ❖ Service Dates (October 1, 2018 through September 30, 2019).
- ❖ Dashboard Includes Services Provided to both Aetna and Meridian Plan Members.
- ❖ A total of 7691 provider services were administered during FY 2019.



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 a pre-screen process at the hospital and crisis line calls. Standards: 3 hours to complete the pre-screening process, and the 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 the 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 the risk of experiencing an emergent situation if support/service is not given	Within 72 hours of request; prior authorization required; if services are denied/ appealed and deemed urgent, Expedited Appeal needed within 72 hours of denial
ROUTINE/PRESERVICE NONURGENT	At the 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 the request

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

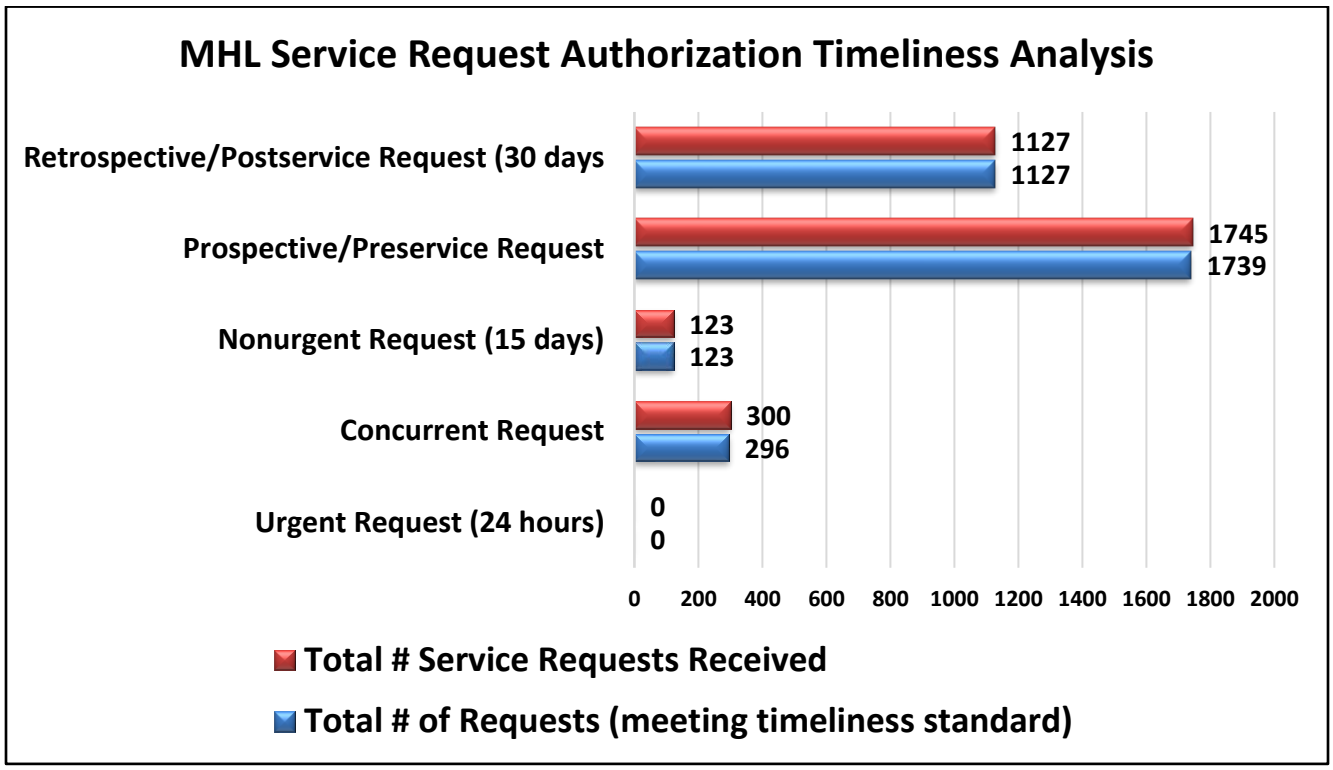
1. For urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request.
2. For urgent pre-service decisions, the organization makes decisions within 72 hours of receipt of the request.
3. For nonurgent preservice decisions, the organization makes decisions within 15 calendar days of receipt of the request.
4. For post-service decisions, the organization makes decisions within 30 calendar days of receipt of the request.

Timeliness Categories:

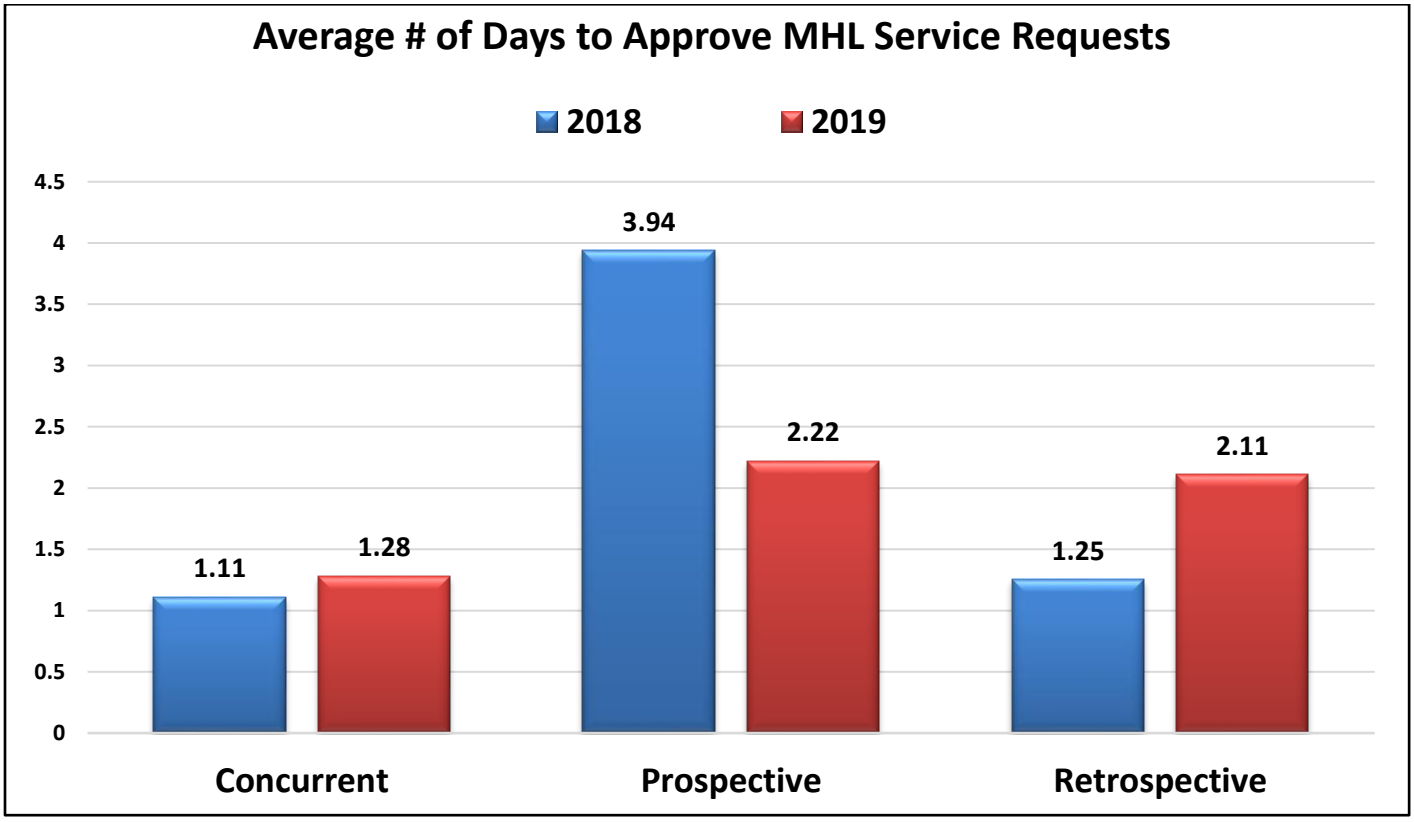
- **Urgent request:** A request for care or services where the application of the time frame for making routine or non-life threatening care determinations could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner 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.
- **Post-service request:** A request for coverage of care or services that have been received (e.g., retrospective review).

2019 MI Health Link Service Authorization Timeliness Analysis

Measurement Period: January 1, 2019 through December 31, 2019
NCQA Standard UM-5C



MHL Service Request Timeliness Report	Urgent Request (24 hours)	Concurrent Request	Nonurgent Request (15 days)	Prospective/Preservice Request	Retrospective/Post service Request (30 days
Total # of Requests (meeting timeliness standard)	0	296	123	1739	1127
Total # Service Requests Received	0	300	123	1745	1127
Timeliness Rate	N/A	98.60%	100%	100%	100%



Analysis and Observations:

Overall, the timeliness performance met or exceeded standard and department requirements.

At this time, no corrective action plans are warranted for this measurement period, as each category has maintained satisfactory compliance.

The MHL Committee will continue to review the timeliness measures quarterly to identify and remediate any potential trends, outliers, or delayed decisions. Timely service authorization and delivery are essential to the consumers we serve so that they can achieve improved outcomes.

Care Coordination

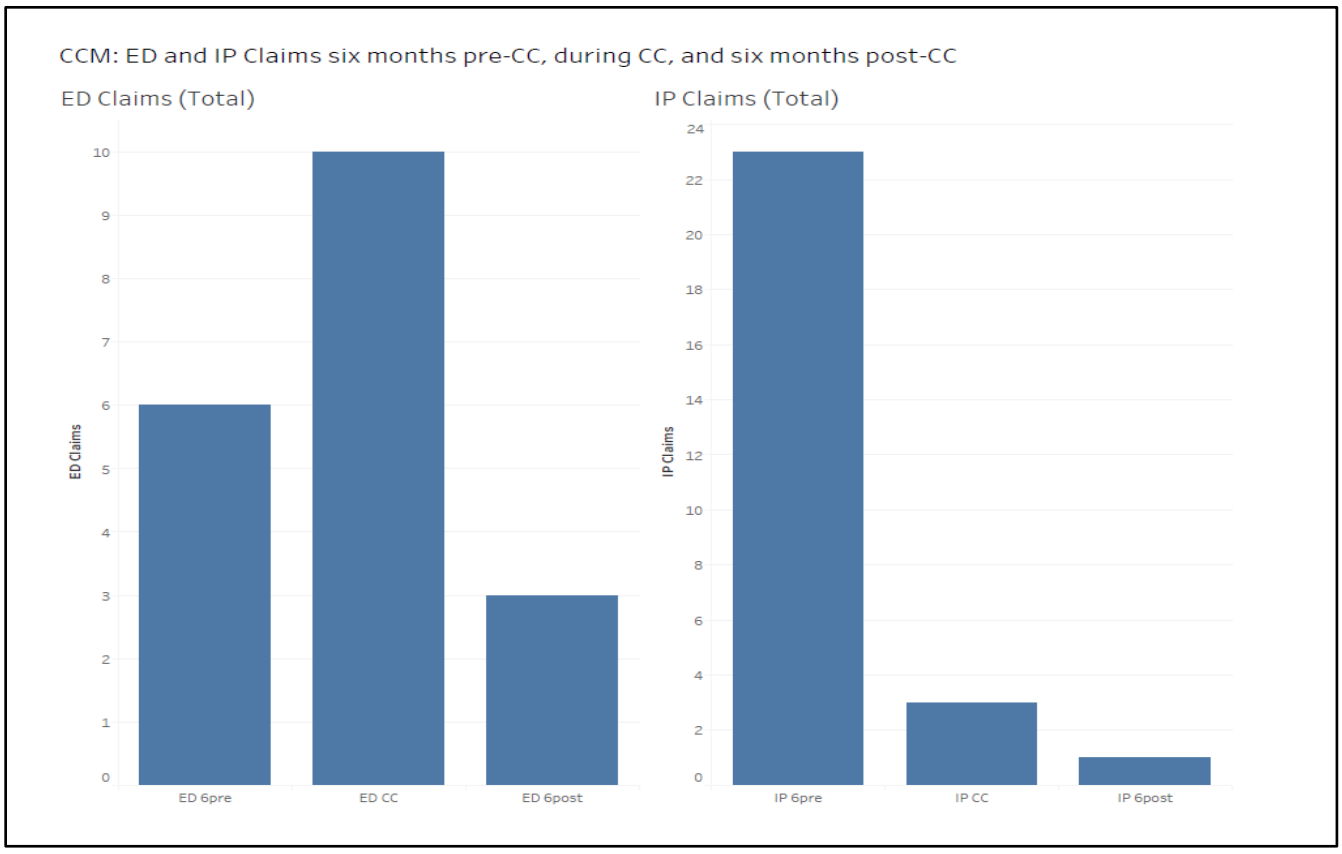
Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Coordination of Care	➢ Monitors for continuity and coordination of care members receive across the network and actions improve. ➢ Demonstrate re-measurement for selected interventions. ➢ Quantitative and causal analysis of data to identify improvement 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 analyze the appropriate use of psychotropic medications. ✓ Measure and analysis of services/programs for consumers with severe and persistent mental illness. ✓ Develop and 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 the BH prescreening process and reduce IP admissions. ✓ Increase outreach to veterans and Military Families that are not currently receiving services.	January 2019 – December 2019	Senior Integrated Healthcare Specialist QAPI Director Chief Operations Officer Utilization Management Manager Director of Clinical Quality or Medical Director Consultant	Quarterly

Complex Case Management Coordination and Overview

In 2019, the Integrated Care Team revised and updated the Complex Case Management Process. A workflow was created, beginning at risk stratification and ending with the closure of the member from the program.
The workflow, having been streamlined, has created consistency and efficiency of care, communication, and collaboration that is being provided to members. Some important updates include:

- SWMBH sends an initial packet to the member's home upon identification to notify them of the program and that someone from SWMBH will be reaching out. The result of this has been that members are likely to answer the phone when we call if they are aware, we are going to be outreaching them to help support them.
- SWMBH meets members where they are in the community. The Integrated Healthcare Specialist has made visits to public locations (McDonald's), an inpatient hospital setting, and a homebound patient's home this year. With this flexibility and person-centered focus, the CCM program was able to establish and build relationships that resulted in member improvement and graduation from the program as well as member engagement in other services such as psychiatric care and outpatient therapy.
- SWMBH's Integrated Healthcare Specialist works with members to create person-centered plans and update plans according to their personal needs. Progress notes and closure letters are provided to each member throughout the process based on their needs.

All of these factors and the rest of the workflow process have created a consistent environment where member's needs are addressed timely, hospitalizations are decreased, and member engagement with ambulatory care is improved.



2019-member emergency department (ED) and inpatient (IP) claims pre-, during, and post- complex case management involvement. Note decreased ED and IP claims six months post-graduation from CCM.

Patient-Centered Care:

The overall goal of Complex Case Management (CCM) is to help members move towards optimum health, improved functional capability, and a better quality of life by focusing on their own health goals. The member selects the health goals that they wish to address, and a SWMBH RN will help facilitate the identification of steps needed and the community support available to meet the patient-centered goals.

Complex Case Management is available to members who have a variety of co-morbid behavioral health, physical conditions, and needs. Complex Case Management offers SWMBH members the opportunity to talk with a Registered Nurse to assess physical and behavioral health needs; establish member-centered goals to address needs; identify barriers and solutions to help achieve goals and identify additional available community resources.

The purpose of Complex Case Management is to help organize and coordinate services for members with complex physical and behavioral health conditions. A SWMBH RN will work through physical and behavioral health obstacles or barriers with members on a 1:1 basis. The RN will help the member to navigate confusing multiple service pathways and secure necessary physical health, behavioral health, and community services.

The criteria for enrollment include, but is not limited to one or more severe and persistent mental illness (SPMI) Behavioral Health diagnoses and at least one of the following criteria:

- Recent (2 in the past six months) inpatient admissions (IP) to the hospital
- High Emergency Department (ED) User
- Four or more chronic medical diagnoses
- A combination of IP admissions/high ED use along with a less severe mental illness

Furthermore, the criteria for SUD/Withdrawal Management/Residential Treatment includes two or three withdrawal management or residential SUD treatments in the past twelve months in conjunction with two or three chronic medical conditions.

Those members identified for enrollment in CCM are contacted via phone to schedule a time to talk with the RN. This is done via telephone or in-person to learn about the CCM program. Additionally, a SWMBH RN is available to meet members during a psychiatric inpatient stay to educate them about the CCM program and assess their eligibility and interest.

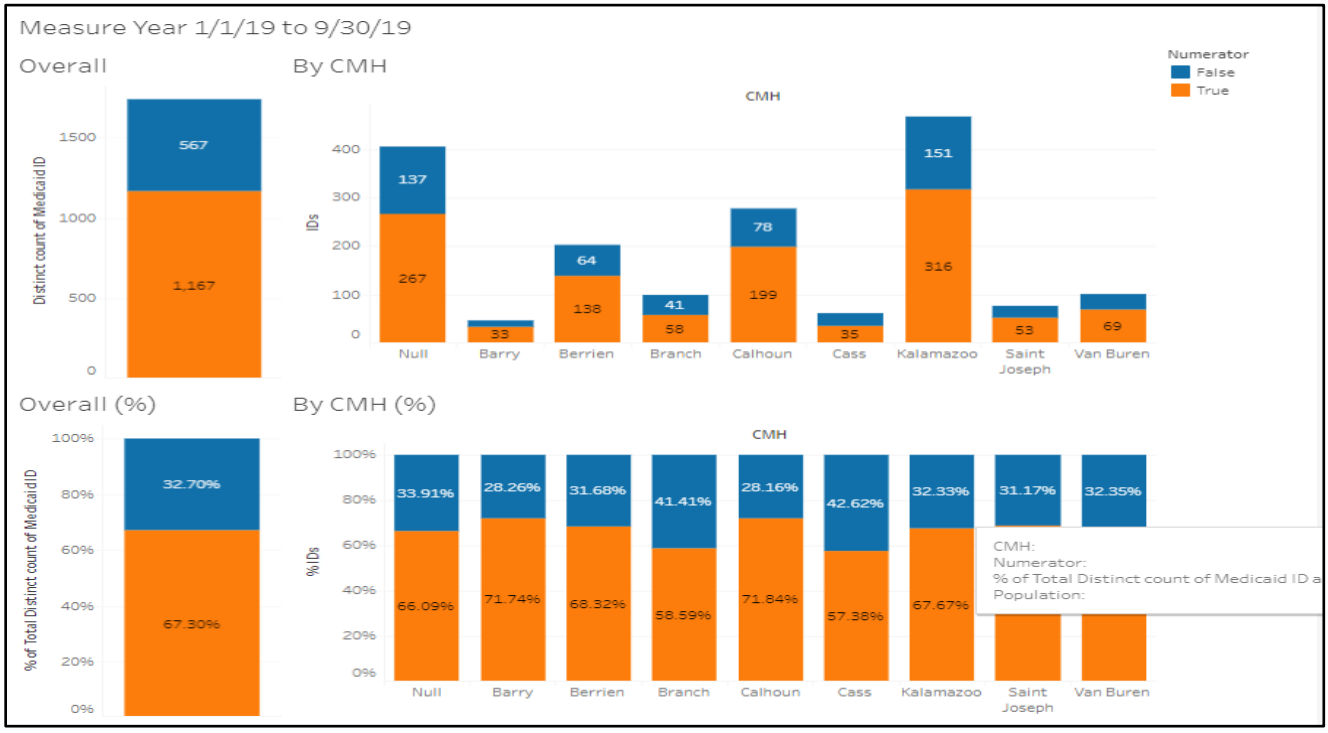
Care Management Technologies (CMT) ProAct Application:

SWMBH utilizes ProAct (an application produced by CMT using Care Connect 360 data) to monitor behavioral health and physical health aspects of members served. CMT contains hundreds of reports measuring HEDIS metrics, inpatient and ER utilization, medication adherence, opioid alerts, and prescriber trends. Each CMHSP has at least one identified clinical or quality professional trained in CMT to monitor these measures. CMT reports are utilized at the PIHP to provide a comprehensive health status of complex case management customers, to identify regional and local trends, and to drive decision-making for regional clinical initiatives.

Diabetes Screening for People with Schizophrenia and Bipolar Disorder who are Using Antipsychotic Medications (PIP):

Southwest Michigan Behavioral Health (SWMBH) has a Performance Improvement Project (PIP) in place to improve the proportion of members with schizophrenia or bipolar disorder taking an antipsychotic medication who are screened for

diabetes. SWMBH's PIP on diabetes screening was validated by HSAG this year. We submitted our baseline measurement (the 2018 calendar year), which was a rate of 76.6%. Our remeasurement one goal is 80%. SWMBH worked with our regional CMH partners to ensure that each CMH has a process set up internally to ensure that members taking antipsychotics are screened annually for diabetes. Educational materials for CMHs and customers were developed and distributed. Reports have been made available for CMHs to monitor their performance. A screenshot of year-to-date progress for 2019 is below. CMHs can export their data so they can identify and follow up with individuals who need a screen completed.



MEASURE	
The percentage of beneficiaries ages 18 to 64 with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement period.	
MINIMUM STANDARD	
This measure will be informational only for FY2019.	
ELIGIBLE POPULATION	
Age	Ages 18 to 64 as of the last day of the measurement period (December 31).
Continuous Enrollment	During the measurement year.
Allowable gap	As of the last day of the measurement period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for two months [60 days] is not considered continuously enrolled).
Anchor Date	December 31 of the measurement period.

Event/Diagnosis	Identify beneficiaries with a diagnosis of schizophrenia or bipolar disorder from either: 1) at least one acute inpatient encounter, or 2) at least two visits on different dates of service in an outpatient, intensive outpatient, partial hospitalization, ED, or non-acute inpatient setting, during the measurement period.
Exclusions	Beneficiaries identified as having diabetes, beneficiaries who had no antipsychotic medications dispensed during the measurement period, and beneficiaries in hospice are excluded from the eligible population.
ADMINISTRATIVE SPECIFICATIONS	
Denominator	The eligible population.
Numerator	A glucose test (Glucose Tests Value Set) or an HbA1c test (HbA1c Tests Value Set) performed during the measurement period, as identified by claim/encounter.
DATA ELEMENTS	

Data is extracted from the Medicaid Data Warehouse.

Please refer to the *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2018 Reporting:*
https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf
NCQA's Medication List Directory (MLD) of NDC codes for Antipsychotic Medications, Antipsychotic Combination Medications, and Diabetes Medications can be found at http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2018/hedis-2018-ndc-license/hedis-2018-final-ndc-lists.

PROCESS

The plan-specific percentages will be electronically transmitted to each PIHP.

MEASUREMENT FREQUENCY

Annually

Care Coordination Efforts

Integrated Care Team Meetings and Communications with Health Plans:

SWMBH began monthly Integrated Care Team (ICT) meetings in August 2016. SWMBH's Integrated Care Team continues to schedule and facilitate monthly meetings with each of the seven different MHPs in our region. We complete risk stratification, collaboration, update agendas, maintain, and share meeting minutes. As of 9/30/2019, there were a total of 128 SWMBH Coordinated Care Plan (CCP) Members. In CC360, 45 members had an open CCP; 69 had a CCP status of completed, and 14 had canceled CCPs. Of those 69 completed:

- 32 met all goals
- 13 had some goals met
- 23 lost coverage
- 1 refused participation

All-Cause Readmissions Joint MHP/PIHP Protocol Development:

The MHPs and PIHPs meet monthly in their Collaboration Workgroup to discuss the integration of behavioral health and physical health care. A protocol for prevention of All-Cause Readmissions is being developed (a sub-workgroup co-chaired by SWMBH and HAP Midwest has been assigned to this task; the group has met minimally monthly from May through November 2019 and has drafted risk stratification criteria to identify individuals at highest risk for readmission, based on published research and data analysis regarding potentially preventable readmissions). We will be developing guidance for PIHP / MHP support during care transitions with implementation anticipated in early 2020. Ultimately, this guidance/protocol will create a consistent and collaborative effort between all PIHPs and MHPs to decrease potentially avoidable readmissions.

We include individuals at high risk of readmission in PIHP/MHP ICT meetings to ensure that individuals are connected to community resources and outpatient care. These interventions have been highly effective. The positive results can be attributed to outreach and education regarding resources and disease processes, supporting participant engagement with providers, and communication/collaboration between the member, caregivers, behavioral health and medical health providers, and health plans to decrease gaps in care and bring awareness to member's needs.

Updates to CC360 to Support Implementation of SSD and COPD PIHP/MHP Joint Care Management Protocols:

SWMBH participates monthly in the MHP and PIHP Collaboration Workgroup to support the integration of behavioral health care and physical health care, and to ensure compliance with MDHHS contractual requirements related to Integrated Care. As part of the workgroup's activities, protocols have been developed to ensure that individuals taking antipsychotic medications (who have been diagnosed with Bipolar Disorder or Schizophrenia) have annual diabetes screening, and to ensure that spirometry testing is used in the initial diagnosis of COPD. SWMBH assisted in the development of upgrades to the Joint Care Management reports available in CC360 for identifying members who fall in the targeted populations for the protocols. The upgrades assist in identifying individuals who are the responsibility of the MHP or the PIHP.

Aetna Transition of Care Calls:

Aetna Population Health department offered SWMBH engagement in the transition of care meetings with four entities (Borgess, Intercare, Family Health Center, and Lakeland Network). These weekly or monthly coordination calls consist of a collaboration of high risk, high utilization members. SWMBH Integrated Care staff outreach community mental health sites and providers to provide an update on the utilization of PIHP services and provided information and member outreach as needed. We engaged in updates from October 1, 2019, to December 31, 2019. We began attending meetings in January 2019 and engaged weekly until June 2019 when Aetna discontinued meetings due to staffing changes.

- There was a total of thirty-seven (37) Transition of Care meetings attended by an Integrated Healthcare Specialist in 2019.

MI Health Link Process Improvements:

SWMBH Integrated Care staff identified inefficiency in the biweekly inpatient and cold call Integrated Care Team (ICT) process. SWMBH staff recreated the process to include increased collaboration, increased efficiency, and decreased risk of oversight of a member. The process was discussed with Aetna and Meridian personnel, and there was an agreement in the process.

The process includes

- SWMBH identification of behavioral health admissions and cold calls
- SWMBH notification to ICOs of admissions and cold calls
- ICO confirmation of agenda
- In-meeting collaboration and discussion of possible treatment plan needs
- Continued review through follow-up with a scheduled provider and/or greater than 30 days past discharge date
- Discussion of other members as needed
- SWMBH provides meeting minutes as requested by ICO

Within one month of implementation of the process, biweekly MI Health Link ICTs ran efficiently, ICOs expressed buy-in in the process, and member collaboration became more efficient. Overall, this is positively affecting the collaboration and care the member is receiving.

- Coordination of care between medical and behavioral healthcare providers
- The 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

Additional 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 3 months

- 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

2019-2020 Customer Service Priorities and Goals

SWMBH Customer Service		
Priorities	**Goals**	**Service Activities**
• Welcome and orient individuals to services and benefits available, as well as 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 complaints 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 the 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 a *Welcoming* atmosphere for customers of SWMBH network. • Promote Customer Voice to be heard throughout SWMBH business activities. • Assist with all complaints, grievances, or appeals filed with the 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

2019 Cultural Competence Plan

Cultural Competence Strategies

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Serving Culturally and Linguistically Diverse Members	➢ The Quality Department will work with other SWMBH Departments to address the Cultural and Linguistic needs of its membership.	✓ Ensure that Cultural Competency policies are being followed. ✓ Review the Cultural Competency Plan on an annual basis to address any identified barriers to care. ✓ Work with RCP and RUM Committee to reduce health care disparities in clinical areas. ✓ Work with Provider Network to improve network adequacy to meet the needs of underserved groups. ✓ Work with Provider Network to perform analysis on the network adequacy report and support the identification of culturally diverse provider resources. ✓ Improve Cultural Competency materials and communication. ✓ Review of Annual Cultural Competency Policies and Plan. ✓ Annually review and update Cultural Competency Goals and work plan. ✓ Annually review CMHSP partner Cultural Competency Plans.	October 2018 - September 2019	QAPI Specialist QAPI Director Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant All Senior Leadership Director of Provider Network SWMBH Cultural Committee Chair Person	Annually

Personnel

Business Practice – to promote Competency	Source	Outcome
A. SWMBH actively recruits a 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. The SWMBH hiring process includes the 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 the 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 the training. The monitored process is to occur annually.	• SWMBH Policy 3.7 – Cultural and Linguistic Competency • SWMBH Cultural Competency and Diversity Training (PowerPoint 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 common 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 the *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 Culturally 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 • Network Adequacy Analysis – Population Race/Ethnicity Analysis	To ensure provider network performance meets SWMBH standards.
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, there 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	The evaluation is performed to identify if SWMBH workforce continues to be reflective of the demographics of the 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't identify their primary language, SWMBH can direct the 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/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 2019 Customer Satisfaction Survey Analysis and Results • SWMBH Grievance and Appeal Data Analysis • SWMBH 2019 QAPI – UM 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 into Spanish.
O. Customer access to Grievance and Appeal processes is aided by translated documents, assistance to all customers, and available interpretation at all steps. Customers can identify Authorized Representatives to represent them.	• SWMBH Policy 2.14 – Grievance and Appeals • Network Adequacy Assessment of cultural, ethnic, racial and linguistic needs	Customers will have processes explained to them in preferred language and have access to language support to represent themselves while SWMBH addresses their complaint(s).

2019 Cultural Competence Goals

Goal	Source	Steps to take/Completion Date	Outcome	Responsibility
1. Implement Staff/Provider survey to gauge the Organizational level of Cultural Competence.	Network Adequacy Analysis – Population Race/Ethnicity Analysis	A. ACTION for the Cultural Competency Workgroup to research and identify tools to utilize (By June 2020).	SWMBH to utilize data for future planning and movement of the organization along the 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 a needs assessment, and use data to improve outcomes.
2. Utilize feedback from Customers related to Cultural Competency of the 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 existing tools provide questions regarding customer opinion of Competency and if not - Identify tool(s) to add to surveys to collect data (By October 2020) 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 the organization along the path of Competence. Specifically, are customers identifying that SWMBH can 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 2020 Network Adequacy Plan/Report. ACTION an analysis and improved outcome measures will be documented in a 2020 Member Services Newsletter and the 2020 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 the data collection process (By October 2020) C. SWMBH to add CMHSP Cultural Competency plan/needs review to the 2020 CMHSP site review tool.	SWMBH to utilize data for future planning and movement of the organization along the 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 the 2020 All-Staff meeting. B. ACTION to provide at least 1 Cultural educationally focused article to the SWMBH newsletter during 2020. C. ACTION to evaluate and promote new Culturally 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.

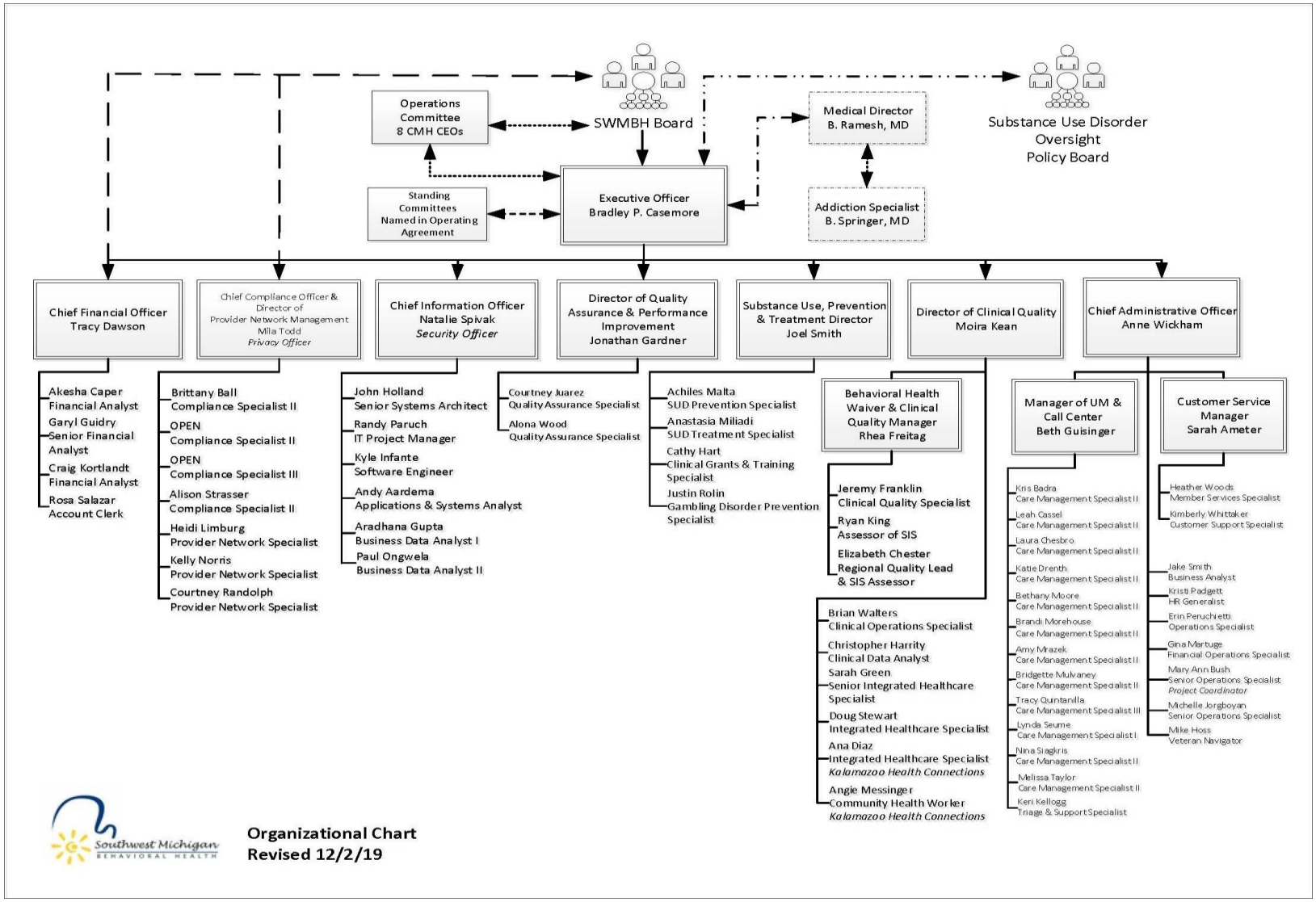
Interventions Attempted

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 backgrounds 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.

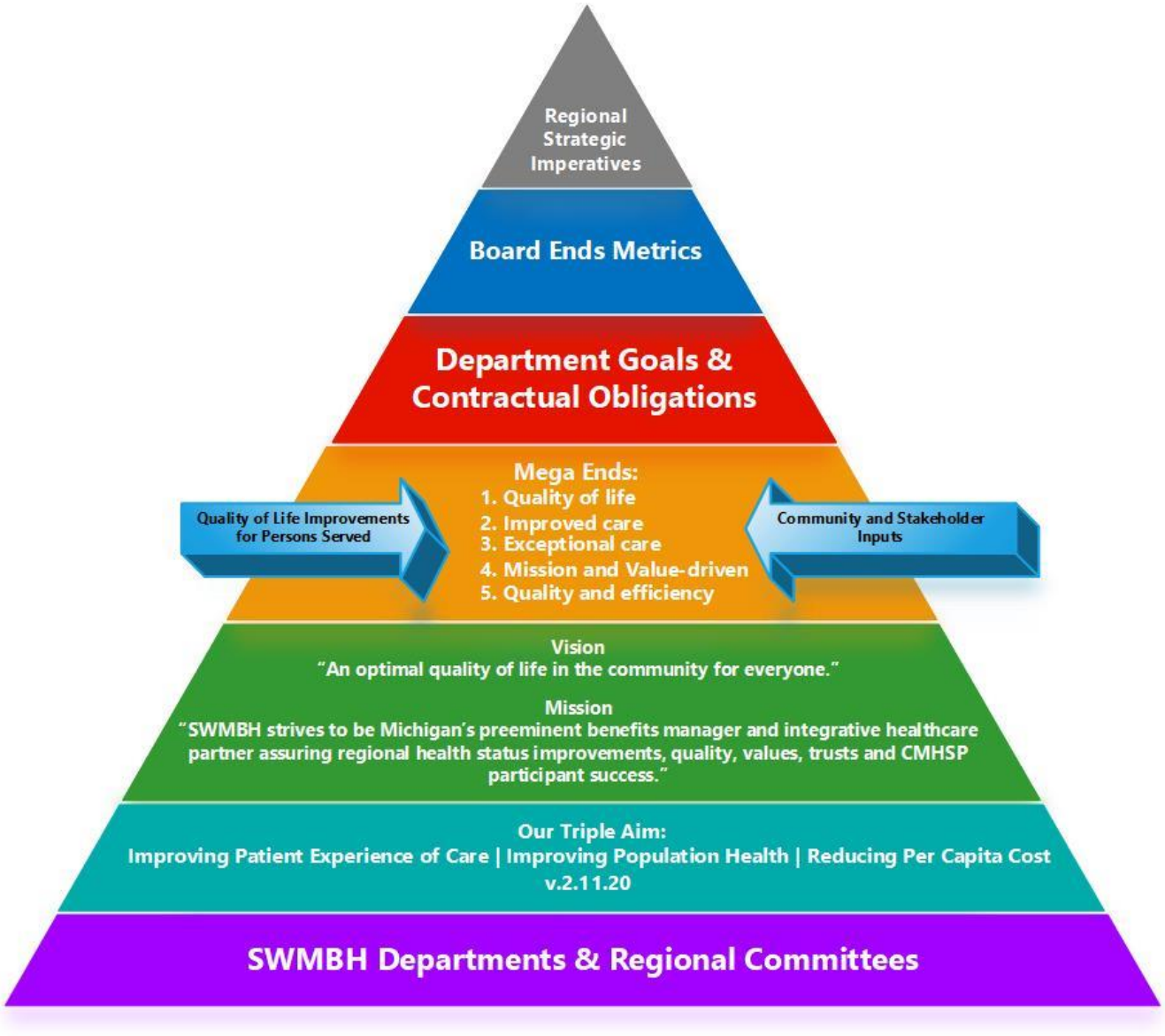
We did not set a specific goal regarding the short-term recruitment of Spanish-speaking clinicians, as our current availability of Spanish-speaking clinicians (1.6% of network clinicians) is only about 2 percentage points lower than the overall population of Spanish-speaking individuals in our region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

VII. Attachments

Attachment A: Southwest Michigan Behavioral Health Organizational Chart



Attachment B: SWMBH 2019 Strategic Alignment – Annual Goal Planning



Attachment C: 2020-2022 Strategic Imperatives

1) Public Policy Legislative Education

- Inform legislators of Michigan statutory changes necessary for publicly led Specialty Integrated Plan
- Inform executive branch of Michigan regulatory changes necessary for publicly led Specialty Integrated Plan
- Inform legislators of potential negative impacts of Reforms on CMHSPs.
- Inform Legislators of key Behavioral Health and SUD issues
- Hold public policy & legislative education events

2) Uniformity of Benefits

- Ensure that persons served receive objectively appropriate services across all specialty populations
- Automate Level of Care Guidelines and Utilization Management processes

➢ Use the Level of Care Guidelines (LOCG) for service authorization consistency

- Consistent use, attached to Assessment Tool scores
- Embedded in EMR and MCIS
- Update LOCG Tables and business processes as necessary and indicated

➢ Consistent Use of Assessment Tools

- CMHSPs and Providers submit scores in detail as discrete data fields
- Real-time, accessible analytics, and reporting
- Identification of outliers and trends for over- and under-utilization monitoring

3) Integrated Health Care

- Michigan Health Endowment Fund Grant success
- Extend MI Health Link with Integrated Care Organizations beyond 12/31/2020
- Multi-agency Performance Improvement Projects
- Improve CMHSP and PIHP communications with primary physical health providers
- Improve SWMBH communications with Medicaid Health Plans

4) Revenue Maximization/Diversification

- Assure the capture of Performance Bonus Incentive Pool funds
- Continue assertive efforts internally and externally to maximize regional capitation funds
- Assess SWMBH opportunities for Grants, alternative funding streams, and expanded or new business lines
- Assess CMHSP opportunities for Grants, alternative funding streams, and expanded or new business lines, upon request

➢ Cost reductions in Medical Loss Ratio and Administrative Loss Ratio

- Support CMHSP cost reduction strategies upon request

5) Improve Healthcare Information Exchange, Analytics and Business Intelligence

- Improve Health Information Exchange systems
- Improve healthcare data analytics capabilities
- Regional individual access to industry-standard management information tools

6) Managed Care Functional Review

- Build consistency, replicability, and scalability for all managed care functions

7) Proof of Value and Outcomes

- Create, monitor and publish proofs of clinical and administrative performance
- Maintain NCQA MBHO Accreditation
- Consider other NCQA Accreditations and/or Certifications
- Assure Program Integrity

Attachment D: SWMBH 2019 Board Ends Metrics

Summary of 2019 Board Ends Metrics

(Completion within the Review Period)

Results:

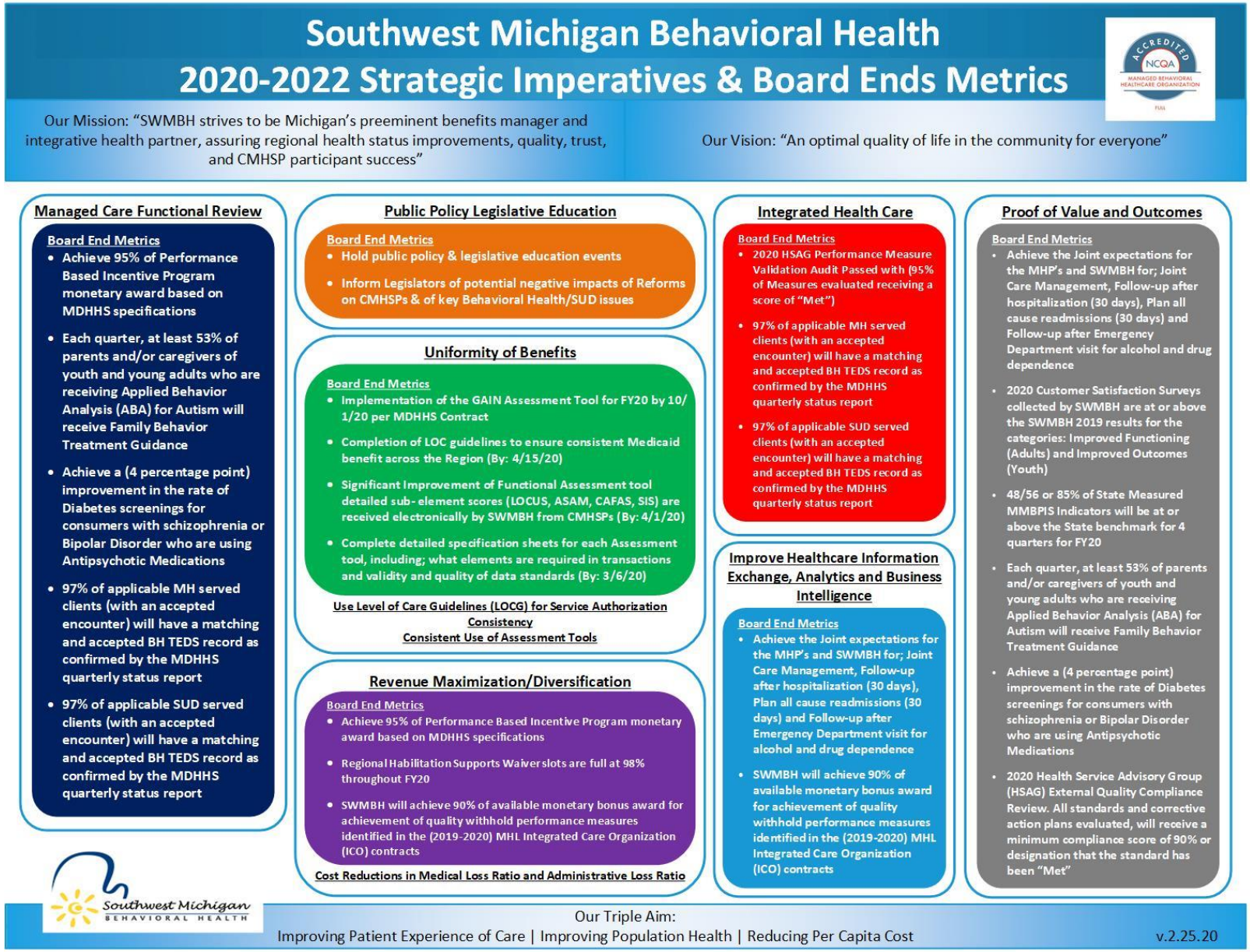
***14/15 Board Metrics Achieved within the Review Period**

Board Ends Metric	Metric Result	Board Approved Date
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." (January 2018 - March 2019)	**Metric Achieved** Formal Assessment Completed by TBD Consulting.	6/14/2019
SWMBH will achieve 95% of quality withhold performance measures identified in the Integrated Care Organization (ICO) contracts. (January 2018 - December 2018)	**Metric Achieved** Demonstration Year 1-2 Quality Withholds were Completed with Aetna at 95%.	1/11/2019
Regional Habilitation Supports (HSW) Waiver slots are full at 99% throughout the year. (October 2018-September 2019)	**Metric Achieved** 99.9% of HSW slots have been filed in FY 19. SWMBH has been the best performing PIHP in the State for 3 consecutive years. ***+1 Bonus Point*** *for achieving (20) additional slots.*	10/11/2019
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, utilizing the MHSIP and YSS Survey tools (January 19 - December 2019)	**Metric Achieved** **MHSIP Improved Function** 18=85.8% 19=89.7% **+3.9%** **YSS Improved Outcomes** 18=81.3% 19=83.3% **+2.0%** Overall (all categories measured) ***+2.76%*** *Improvement*	3/13/2020

Medicaid Administrative Loss Ratio for the region is (< 10.0%) (October 18 – September 19)	**Metric Achieved** Result: 9.1% and a (.07%) improvement over 2018 results.	3/8/2019
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, 2018)	**Metric Achieved** Percent of scores and files received for each Level of Care Tool: LOCUS: 98.6% ASAM: 85.1% CAFAS: 95.6% SIS: 88.8%	11/9/2018
SWMBH to "Establish and implement an inclusive formal Regional public policy, legislative education program." (By: October 2018)	**Metric Achieved** Legislative Event list available upon request.	11/9/2018
2019 HSAG Performance Measure Validation Passed (95% of Critical Measures receiving a score of "Met")	**Metric Achieved** 37/37 or 100% of Standards Evaluated received a designation of "Met", "Accepted" or "Reportable".	11/8/2019
SWMBH will ensure the following Customer Service and Grievance and Appeals contractual requirements and HSAG corrective actions are achieved at 100% compliance:	**Metric Achieved** All provider directories are using link to SWMBH directory on website. All CMHSPs are using Approved HSAG grievance resolution letters as of 7/1/19.	11/8/2019
• 95% of MH reportable encounters will have a matching and accepted BH TEDS record as confirmed by the MDHHS quarterly status report. • 95% of SUD reportable encounters will have a matching and accepted BH TEDS record as confirmed by the MDHHS quarterly status report.	**Metric Achieved** As of 1/1/2020 MH = 96.79% SUD = 97.47%	3/13/2020
At least 18% of parents and/or caregivers of youth and young adults who are receiving Applied Behavior Analysis (ABA) for Autism	**Metric Achieved** 57% per Michigan Department of Health and Human Services (MDHHS) Metric	1/10/2020

will receive Family Behavior Treatment Guidance at least once per quarter. This service supports families in implementing procedures to teach new skills and reduce challenging behaviors.		
PBIP Narrative Report Achieve 95% of Performance Based Incentive Program monetary award based on MDHHS specifications.	**Metric Achieved** SWMBH achieved **98.20%** of possible bonus award earnings $1,799,741	3/13/2020
PBIP Metrics Reports Achieve the following Joint expectations for the MHP's and SWMBH. There are 100 points possible for this bonus metric in FY2019:	**Metric Achieved** Joint PIHP/MHP Reports received 93 out of a possible 100 points. PCR and FUA metrics received 50 out of 50 possible score.	3/13/2020
2019 Health Service Advisory Group (HSAG) External Quality Compliance Review (90% of Sections evaluated receiving a score of "Met").	**Metric Achieved** SWMBH achieved 74/82 Standards evaluated achieving an overall score of 90.24%.	3/13/2020
92% of MMBPIS Indicators will be at or above the State benchmark for 4 quarters for FY 19.	**Metric Missed** Indicators Met at the MDHHS benchmark: 59/68 = 86.76%	3/13/2020

Attachment E: 2020-2022 Alignment of Strategic Imperatives & Board End Metrics



Attachment F: 2020 MI Health Link Committee Charter

☒ **MI Health Link**

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

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

Charter Effective Date: 6/1/15

Charter last Review Date: 12/17/19

Next Review Date: 12/17/2020

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, and contractual obligations and tasks. MI Health Link Committees ensure a care management quality control program is maintained at all times and that the 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. The committee 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. 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.
Accountability:	The committee is one method of participant communication, alignment, and advice to SWMBH. The committee tasks are determined by the committee chair and members, member needs, MI Health Link demonstration guidelines including the Three-Way Contract, the ICO-PIHP Contract and NCQA requirements. Each committee is accountable to the SWMBH Executive Officer and is responsible for assisting SWMBH Leadership to meet the Managed Care Benefit requirements within the MI Health Link demonstration, the ICO-PIHP contract, and across 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; QI 2: Program Operations: QI Committee Responsibilities, Element A.* • 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 1: Program Structure; 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 6: Member Experience; 9: Complex Case Management, Member Experience with Case Management, Element I (Factor 1); UM 10 Experience with the UM Process.* • Review of current status and upcoming MHL audits • Review of demonstration year quality withhold measures **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). Aetna Contract-Attach C4; Meridian Contract.* • 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). Aetna Contract; 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). Aetna Contract; Meridian Contract.* • 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; Meridian Contract* • 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). Aetna Contract & Meridian Contract* • Ensures reporting of practitioner suspension or termination to the appropriate authorities. *NCQA, MBHO, CR 6: Notification to Authorities and Practitioner Appeal Rights, Actions Against Practitioners, Element A (Factor 2); NCQA, MBHO, CR 6: 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 6: Notification to Authorities and Practitioner Appeal Rights, Element A (Factor 4); CR 6: 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: o 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) Aetna Contract & Meridian Contract* o 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). Aetna Contract& Meridian Contract* • Ensures annual audits of practitioner complaints to determine if there are complaints alleging discrimination. *NCQA, MBHO, CR 5: Ongoing Monitoring, Ongoing Monitoring and Intervention: Element A (Factor 3). Aetna Contract; Meridian Contract.* **Utilization Management Committee:** • Reviews and authorizes policies and procedures. *NCQA, MBHO, UM 1: Utilization Management Structure, UM Program Description Element A.* • 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; Meridian Contract.
- 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.; Meridian Contract.
- Ensures annual written description of the preservice, concurrent urgent and non-urgent and postservice 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. Aetna Contract; Meridian Contract-Attach C.
- 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); Meridian Contract
- Ensures the organization:
  - 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). Aetna Contract; Meridian Contract-Attachment C.
  - 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). Aetna Contract; Meridian Contract.
  - 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). Aetna Contract; Meridian Contract.
  - Involves appropriate practitioners in developing, adopting and reviewing criteria.
    NCQA, MBHO, UM 2: Clinical Criteria for UM Decisions, UM Criteria Element A (Factor 4). Aetna Contract; Meridian Contract-Attachment C.
  - 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; Meridian Contract

Cultural Competency Management Committee:

- Has written policies, procedures and plan for promoting and ensuring a culturally competent, sensitive and inclusive environment.
- Conducts an annual review of the Network Adequacy Report to ensure that the data covers all members' language, race and ethic needs as well as ensure that there is data available for practitioner race, ethnic background and language skills. There will be a

	comparison of the two data sets to determine if the provider network is enough to meet its members' needs, identify areas of improvement and set interventions if needed. Will review internal and provider organizational systems to determine level of compliance with the Culturally & Linguistic Appropriate Services (CLAS) standards and other pertinent requirements for MI Health Link. *NCQA, MBHO, QI 4: Availability of Practitioners and Providers.* **Integrated Care/Clinical Quality Committee:** • Ensures the organization approves and adopts clinical practice guidelines and promotes them to practitioners. *NCQA, MBHO, QI 10: Clinical Practice Guidelines-Element A; 2: Program Responsibilities, QI Committee Responsibilities, Element A.* • Monitors the continuity and coordination of care that members receive across the behavioral healthcare network and takes action, as necessary, to improve and measure the effectiveness of these actions. • The organization collaborates with relevant medical delivery systems to monitor, improve and measure the effectiveness of actions related to coordination between behavioral and medical care. *NCQA, MBHO, CC 1 & 2: Collaboration between Behavioral Healthcare and Medical Care Aetna Contract-Attachment C.2; Meridian Contract* • Ensures assessment of population health needs, including social determinants and other characteristics of member population, is completed annually, and the CCM program is adjusted accordingly. *NCQA, MBHA, QI 9A: Complex Case Management, Population Assessment* • Ensures member survey results feedback is reviewed and follow-up occurs as appropriate. *NCQA, MBHO, QI 9J: Complex Case Management, Experience with Case Management* • The organization demonstrates improvements in the clinical care and service it renders to members. *QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program* • Monitors performance for all HEDIS/NQF measurements minimally annually. *NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program* • Selects 3 or more clinical issues for clinical quality improvements annually. Ensures that appropriate follow up interventions are implemented to improve performance in selected areas. *NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program* • Approves developed logic for calculating HEDIS measure and ensure it follows HEDIS specifications. o *NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program*
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 Executive Officers 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)***
Kelly Norris *Provider Network Specialist II*	*SWMBH*	*Voting*
Dr. Bangalore K. Ramesh D.O., Psychiatrist (Medical Director/ Practitioner/Provider)	*Western Michigan University*	*Voting*
Beth Guisinger, LPC *Utilization Management and Call Center Manager*	*SWMBH*	*Voting*
Jonathan Gardner BS, CHES, PTA *Director of Quality Assurance and Performance Improvement*	*SWMBH*	*Voting*
Moira Kean LLP, MA *Director of Clinical Quality*	*SWMBH*	*Voting*
Stephanie Lagalo, LMSW, CAADC, CCS (Practitioner and Provider)	*Western Michigan University* *Interact of Michigan (Contract)*	*Voting*
Sarah Green RN, BSN, MBA	*SWMBH*	*Voting*

Senior Integrated Healthcare Specialist		
Sarah Ameter *Manager of Customer Services*	*SWMBH*	*Voting*
Natalie Spivak *CIO*	*SWMBH*	*Voting*

Attachment 2: - Quality/UM/Clinical

Membership Name	***Organization/County***	***Type of member (Ad hoc, standing, voting, alternate)***
Kelly Norris LMSW, CAADC *Provider Network Specialist II*	*SWMBH*	*Voting*
Dr. Bangalore K. Ramesh D.O., *Psychiatrist (Medical Director/ Practitioner/Provider)*	*Western Michigan University*	*Voting*
Beth Guisinger, LPC, CAADC *Utilization Management and Call Center Manager*	*SWMBH*	*Voting*
Jonathan Gardner BS, CHES, PTA *Director of Quality Assurance and Performance Improvement*	*SWMBH*	*Voting*
Moira Kean LLP, MA *Director of Clinical Quality*	*SWMBH*	*Voting*
Stephanie Lagalo, LMSW, CAADC, CCS (Practitioner and Provider)	*Western Michigan University* *Interact of Michigan (Contract)*	*Voting*
Sarah Green, R.N, B.S.N, M.B.A *Integrated Healthcare Specialist*	*SWMBH*	*Voting*
Sarah Ameter *Manager of Customer Services*	*SWMBH*	*Voting*
Courtney Juarez *Quality Assurance Specialist*	*SWMBH*	*Voting*
Chris Harrity, MHSA *Clinical Data Analyst*	*SWMBH*	*Voting*

Attachment 3: - Cultural Competency Management Committee

Membership Name	***Organization/County***	***Type of member (Ad hoc, standing, voting, alternate)***
Achiles Malta *Prevention Specialist*	*SWMBH*	*Voting* *Committee Chair*

Jonathan Gardner B.S, CHES, PTA *Director of Quality Assurance and Performance Improvement*	*SWMBH*	*Voting*
Moira Kean LLP, M.A. *Director of Clinical Quality*	*SWMBH*	*Voting*
Sarah Ameter *Manager of Customer Services*	*SWMBH*	*Voting*
Kimberly Whittaker *Consumer Advisory Committee Rep*	*SWMBH*	*Voting*
Open for Consumer Participation	*Open*	*Open*

Attachment G: 2020 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: **12/19/19**

Next Scheduled Review Date: **12/17/20**

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 at a minimum on a quarterly 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 primary task of the QM Committee is to review, monitor and make recommendations related to the listed review activities with the QAPI Program/Plan* • *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.* • *Work with the RITC Committee to create sub-workgroups, as needed, to facilitate regional initiatives or address issues/problems as they occur.*

Relationship to Other Committees:	As needed, there will be planning and coordination with the other Operating Committees including: • 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 and discussions. Members should also bring relevant quality related challenges from their site to the attention of the SWMBH committee for possible project creation and/or assistance. Membership shall include: 1. Appointed participant CMH representation 2. Member of the SWMBH Customer Advisory Committee with lived experience 3. SWMBH staff as appropriate 4. Provider participation and feedback

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 and 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 will lose the right to participate in the voting structure for that meeting.
Deliverables:	The Committee will support SWMBH Staff in the: • Annual Quality Work Plan development and review • QAPI Evaluation development and review • Michigan Mission-Based Performance Indicator System (MMBPIS) regional report • Event Reporting Dash Board • Regional Survey Development and Analysis • Completion of Regional Strategic Imperatives or goals, assigned to the committee • Completion, feedback and analysis on any Performance Improvement Projects assigned to, or relevant to the committee

Attachment H: Regional Utilization Management Committee Charter

☒ **SWMBH Committee: Regional *Utilization Management Committee* (RUM)**
Duration: ☒ **On-Going**

Charter Effective Date: 2/12/18 (reviewed at RUM)
Revision Dates: 2/11/19. 1/13/20

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 Medicaid Managed Care Benefit requirements within the Balanced Budget Act, Parity, the PIHP contract, and across all business lines of SWMBH. The committee is to provide their expertise as subject matter experts.
Committee Purpose:	*In the context of the overall functionality of the PIHP's Utilization Management Program, the Regional **Utilization Management (RUM) Committee** is the PIHP's designated committee that reviews and provides input to SWMBH for the Regional Utilization Management Program and assisting with the review and/or development of:* 1. *The Annual UM Program Plan* 2. *UM, service determination and utilization review policies, procedures and protocols* 3. *Service determination/authorization and level of care criteria* 4. *Service Use Encounter (SUE) report* 5. *Over/under utilization reports* 6. *Outlier Management reports* 7. *RUM work plan/committee goals* *The RUM Committee is charged with making efficient, effective, and innovative recommendations for:* 1. *monitoring and ensuring the uniformity and consistent application of standardized assessment tools and level of care, service determination and eligibility criteria at a local care management level*

	2. *using assessment tool, level of care and utilization data to track service provision to customers,* 3. *implementation of level of care and care management practices,* 4. *identification of services gaps and training needs* *The **Utilization Management Program** assures that statutory and contractual state and federal regulatory requirements are met in a cost effective and timely manner. To ensure this standard is achieved and/or surpassed, programs are consistently and systematically monitored and evaluated. There are four basic management techniques deployed within the utilization management program with reports and data reviewed by RUM Committee:* 1. *Access and Eligibility* 2. *Level of Care Assessment/Service Support* 3. *Service Determination/Outlier Management* 4. *Utilization Review/Care Management* *The RUM is responsible for holding themselves and each organization in the region accountable for:* 1. *Proper use of assessment tools, level of care guidelines and medical necessity criteria* 2. *Timely and accurate collection and reporting of assessment and utilization data to SWMBH* 3. *Uniformity of benefit* 4. *Installation, use and revision of level of care guidelines and medical necessity criteria* 5. *EMR/MCIS authorization (278) application, documentation, and submission to SWMBH*
Relationship to Other Committees:	At least annually there will be planning and coordination with the other Operating Committees. • Regional Finance Committee • Regional Quality Management Committee • Regional Provider Network Management Committee • Information Technology • Regional Customer Services Committee • Regional Compliance Coordinating Committee • Regional Clinical Committee The RUM utilizes the Regional Clinical Committee to address population specific issues and issues such as high utilization or high risk. The SWMBH Medical Director will also be available for consultation to the committee.
Membership:	The Operating Committee appoints their CMH participant membership who should be the senior manager responsible for utilization and local care management. The SWMBH EO appoints the committee Chair. • Members of the committee will act as conduits and liaisons to share information reviewed or decided on in the committee. This includes

	keeping relevant staff, providers and local committees informed and abreast of regional information, activities, and recommendations. • Members are representing the regional needs related to Utilization Management. 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. RUM is a PIHP Committee consisting of UM, Quality, Information Technology and clinical leadership representatives from each of the eight Community Mental Health Service Programs, customers/individuals with lived experience and SWMBH staff. RUM representatives are experienced administrative and clinical professionals with specialty representation for Child and Adolescent Serious Emotional Disturbance, Intellectual/Developmental Disabilities, Adults with Serious and Persistent Mental Illness, and Substance Abuse and Addiction. Ongoing consultation and ad hoc representation from the SWMBH Medical Director is available to the committee.
Decision Making Process:	The RUM 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 of one vote per CMH 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 Utilization Management Program Plan* • RUM assigned priorities • Regional Level of Care Guidelines (review or update) • Regional UM Policies and Procedures Review

Attachment 1:

Membership Name	*Organization/County*	*Type of member (Ad hoc, standing, alternate)*
Emily Whisner	Barry	*Standing*
Jill Bishop	Barry	*Standing*
Tammy Winchell	Branch d/b/a Pines	*Standing*
Jennifer Poole	Berrien d/b/a Riverwood	*Standing*
Anne Cornell	Berrien d/b/a Riverwood	*Standing*
Natalie Tenney	Calhoun d/b/a Summit Pointe	*Standing*
Mary Munson	Cass d/b/a Woodlands	*Standing*
David Gamble	Cass d/b/a Woodlands	*Standing*
Jane Konyndyk	Kalamazoo	*Standing*
Beth Ann Meints	Kalamazoo	*Standing*
Sheila Hibbs	Kalamazoo	*Standing*
Jarrett Cupp	St. Joseph	*Standing*
Liz Courtney	Van Buren	*Standing*
Mary Green	Van Buren	*Standing*
Kyleen Gray	Van Buren	*Standing*
Mike Horein	Van Buren	*Standing*
Anne Wickham, Chair	SWMBH	*Standing,*
Leah Cassel, Recorder	SWMBH	*Standing*
Moira Kean	SWMBH	*Standing*
Natalie Spivak	SWMBH	*Ad Hoc*
Jonathan Gardner	SWMBH	*Ad hoc*
Bangalore Ramesh	SWMBH	*Ad hoc*

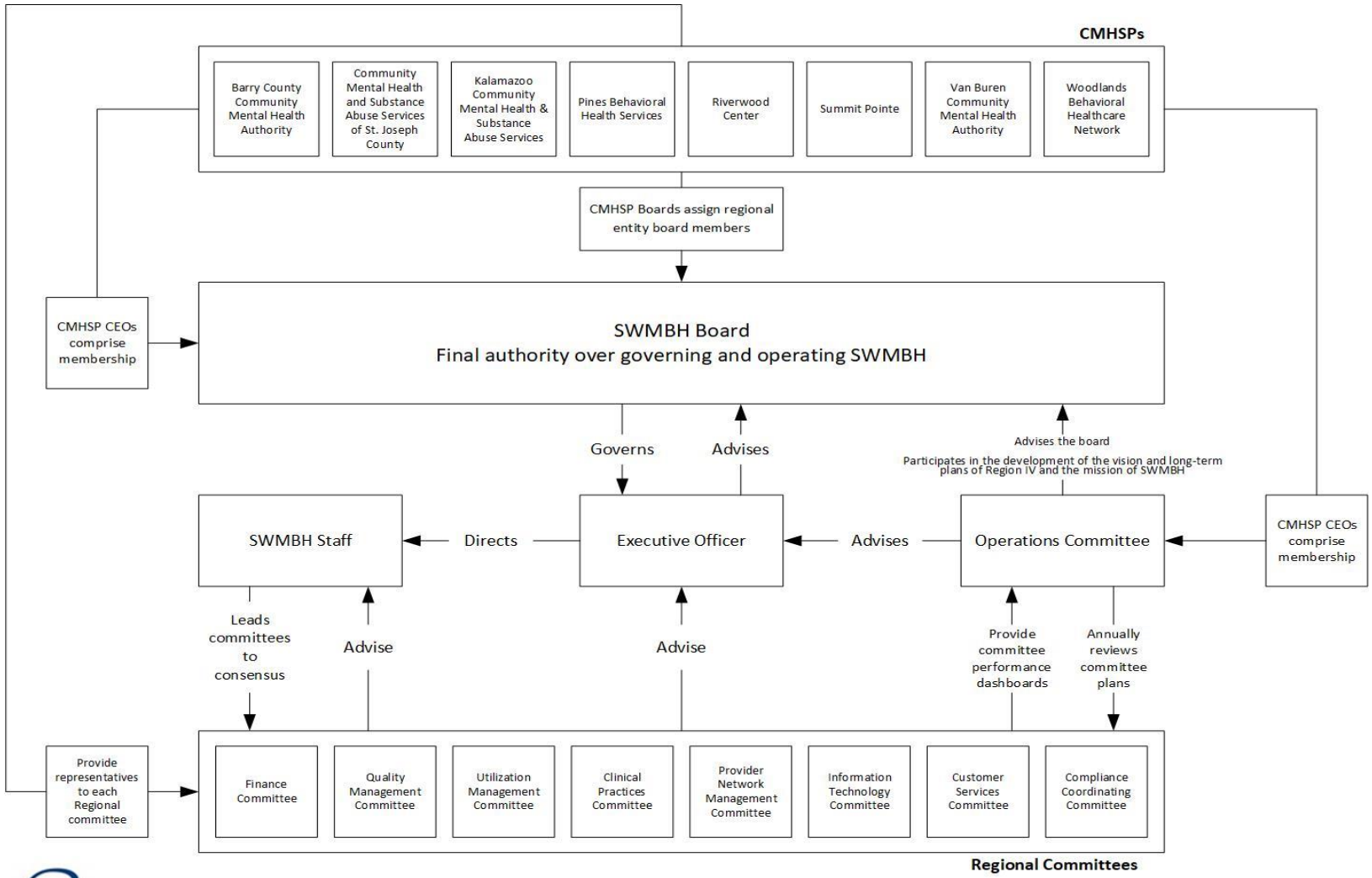
Attachment I: Regional Utilization Management Committee Goals

Regional Utilization Management Committee

FY 2019 Goals & Timelines

Strategic Imperative	*Goal* and Timeline for Completion (Sub Goals to be completed quarterly)	Brief Description	Responsible Leader
Parity & Utilization Management Normalization to Assure Uniform Benefit **Goal: Implement MCG software & updated level of care guidelines to ensure Consistent Medicaid Benefit across the Region with all services.**	2nd Quarter (Jan, Feb, March) • Establish MCG implementation teams (by: Nov 28)	• Phase 1- Use MCG Guidelines for LOC determination at each CMHSP and SWMBH (inpatient)	Gale
	• Implementation team completes a project plan (by: January 31)		Gale
	• Training all applicable UM-CMHSP and UM- SWMBH staff on new Medical Necessity Criteria (within: 30 days from time of URL/notification)		Beth (SWMBH) Gale (Regional)
	• RUM reviews LOCUS guidelines during Nov mtg. (by: November 30)		Moira
	• All CMHSPs install updated LOC guidelines (by: December 31)		Moira

Attachment J: SWMBH Organizational & Committee Structure Chart



SWMBH Organizational and Committee Structure
Updated 3/19/19

Attachment K: 2020 Board Member Roster

2020 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

- Michael McShane
- Vacant

Kalamazoo County

- Vacant
- Patricia Guenther (Alternate)

St. Joseph County

- Vacant
- Cathi Abbs (Alternate)

Van Buren County

- Susan Barnes - Secretary
- Angie Dickerson (Alternate)