Quality Assurance & Performance Improvement
Utilization Management
2020 Program Evaluation

All SWMBH Business Lines

Evaluation Period: Medicaid (October 1, 2019- September 30, 2020)
Evaluation Period: MI Health Link (January 1, 2020 – December 31, 2020)

Reviewed by:

SWMBH Quality Management Committee: 1/28/21
SWMBH Regional Utilization Management Committee: 1/10/21
SWMBH MI Health Link Committee: 1/28/21
SWMBH Board Education: 2/12/21

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I. Introduction: Quality Assurance Improvement Program

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) has a documented Quality Assessment and Performance Improvement Program (QAPIP) that meets required federal regulations: the specified Balanced Budget Act of 1997 (BBA) as amended standards, 42 CFR § 438, requirements 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 ensure it meets 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 2019 through September 2020 for Medicaid Services and from January 2020 to December 2020 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 and other departmental plans. SWMBH's QAPIP promotes 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.

This evaluation period considered is from October 1, 2019, through September 30, 2020 (Medicaid) and January 1, 2020, to December 31, 2020 (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, this evaluation aims 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 and our partner Community Mental Health Service Programs (CMHSPs). The communication and relationship between SWMBH's different departments and CMHSPs are critical to the QAPI Department's success. 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 critical. 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 with developing and managing 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 and management for analyzing organizational performance, business modeling, strategic planning, quality initiatives, and general business operations, including developing and maintaining databases and 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. The Business Data Analyst will develop reports, summaries, recommendations, and visual representations based on the data.

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 collaborate with QAPI Director to ensure complete, accurate, and timely submission of clinical program data, including the 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 summarizes 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 various 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, this program's goal 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 to develop an annual QAPI plan. QAPI Department also works with other functional areas and external organizations/vendors 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
- Leads 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 liaison between different functional areas in the communication of audit and accreditation requirements and timelines.
- Responsible for communication, organization, and submission of annual Performance Bonus Improvement Program reports to MDHHS and Quality Withhold Measures to the Integrated Care Organizations (ICO's)

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 QAPI Program's day-to-day operations. 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 the central role that quality and data play in decision making, strategic planning, and defining tactical objectives throughout the Region.

Practitioner Involvement

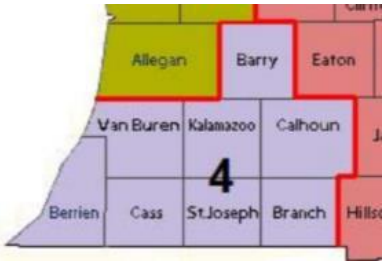
The QAPI has a full and active involvement of providers and Clinical Director involvement in the program. They attend Quality Management Committee meetings, MIHL Committee Meetings, Regional Utilization Management, and Clinical Practice Committee meetings and are available as needed to the QAPI team. 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. Go-to-Meeting or WebEx technology is offered to Regional Committee members and internal and external stakeholders if they cannot attend meetings in person.

Service Population and Eligibles Served:

The SWMBH region (4) has served nearly **26,724** unique consumers from October 1, 2019, to September 30, 2020, with 258,505 Medicaid Eligible in the Region.



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

IV. Evaluation of Quality Management Committee Structure

SWMBH has established the QMC to oversee and manage quality management functions and provide 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 quality policies. QMC is responsible for developing Committee goals, maintaining contact with other committees, identifying people, organizations, or departments that can further the QAPI Department and the QMC aims. 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 and 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 have all the same responsibilities when participating in committee work.

QMC Committee Commitments

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 quality policies. 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 cannot participate in meetings, they should notify the QMC Chairperson as soon as possible. QMC members should be engaged in performance improvement issues and bring challenges from their site to the SWMBH committee's attention 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 andprovider 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 2020. All meeting materials are accessible on the SWMBH portal before and after each meeting. During this review period, the focus and oversight of QMC were on the continued review of Quality activities, including Board Ends Metrics, Performance Improvement Projects, Annual survey trends and analysis, Analysis of quality in the BH TEDs reporting process, MMBPIS performance indicator review, Critical Incident data review, Jail Diversion data review, discussion and process for collection of the annual Performance Bonus Incentive Project (PBIP) and Regional Audit preparation efforts. The QMC uses NCQA approved and best practice measures to track action items and any follow-up items identified during the meetings.

2020 Quality Management Committee Goals

SWMBH took a different approach to the Department and Committee goal setting in 2020. Each Department and Regional Committee worked together to achieve the overarching Strategic Imperatives identified during the Board of Directors retreat on May 11, 2020. 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).* Also, please see the 2021-2022 Board Ends Metrics specific SWMBH Functional Area goals and targets.

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 Roles and Tasks

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 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 quality policies.
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 QM activities' results 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 advise the MHL Committee or a subcommittee that reports to the MHL Committee. The behavioral healthcare provider must have a doctorate and can 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 have all the same responsibilities 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 and identifying people, organizations, or departments that can further the QAPI Department and the committee's aims. 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 2020

- ✓ 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.
- ✓ Discussed the Improved MI Health Link (Dual Eligible) Consumer Satisfaction rates by 1.74% over the last year's results. All survey results exceeded State and National benchmarks for each category evaluated.
- ✓ 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.
- ✓ Review of access to care measures; including, provider availability and distance to care analysis.
- ✓ Discussion and efforts towards improvement of Transfer of Care and Hospital Follow-up metrics.

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	Director of QAPI or designated QAPI Specialist	As needed

	and review of results).		
	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

The MIBI Steering Committee was created in early 2019 to oversee business intelligence strategy, resources, and priorities. Monthly meetings occur and 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 Outcomes

The following sections represent the outcomes from the categories included in the 2020 QAPI and UM Plans

2020 Michigan Mission-Based Performance Indicator System Results (MMBPIS)

Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Michigan Mission-Based Performance Improvement System (MMBPIS) **The full 2020 – 2021 MMBPIS Specifications can be found here:** Link to new MMBPIS Reporting Codebooks	➢ MMBPIS Performance Standards will meet or exceed the State indicated benchmark for each of the (17) Performance Measures reported to State. ➢ In June of 2020, MDHHS restructured the language for indicators 2, 2b, and 3. The benchmarks for these indicators were also eliminated for this year. MDHHS plans to reintroduce benchmarks for the performance indicators in late 2021.	✓ 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 2019 – December 2020	QAPI Director QAPI Specialist Clinical Quality Director SUD Director	Quarterly Submissions to MDHHS: *Q1 - 3/31/20 *Q2 - 6/30/20 *Q3 - 9/30/20 *Q4 - 1/2/2021 CMHSPs submit monthly reports on the 25th of each month Via the FTP site. Annual on-site reviews for all (8) CMHSPs occurred in April-May 2020.

New 2020 Performance Indicators:

In April of 2020, MDHHS introduced and modified (3) new performance indicators. It took significant effort to get both Managed Care Systems (Streamline and PCE) in alignment with the identified reporting specifications outlined below. A data integrity workgroup was formulated to develop a spreadsheet that could be utilized to record the data from both systems. The data is audited monthly for accuracy and again before it is reported to MDHHS at the end of each quarter. The most recent data reports are reviewed during each Regional Quality Management meeting to identify trends or barriers in the areas of access to care and follow-up timeliness. Please find the specifications of the (3) new performance indicators below:

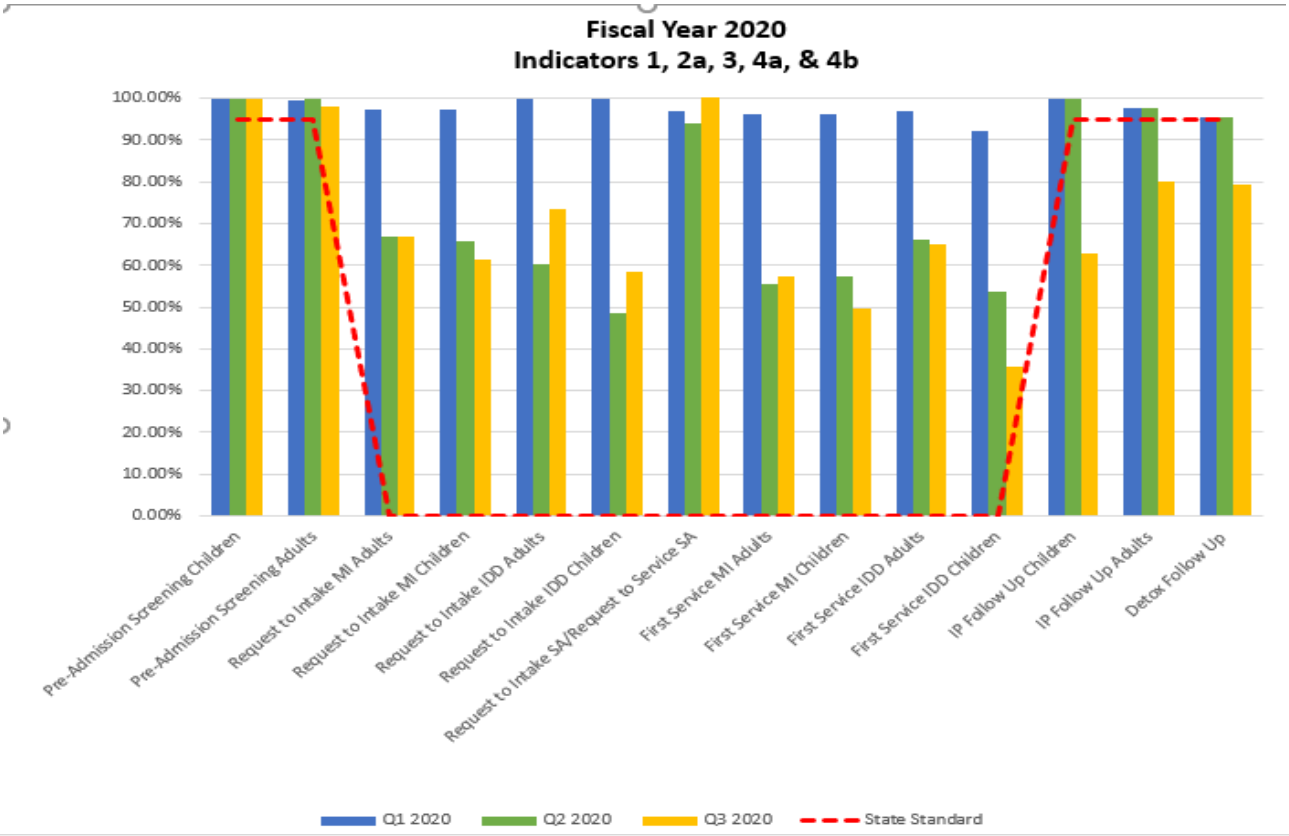
2. The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.
    a. No standard for 1st year of implementation – will use the information to determine a baseline.
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers
    e. Scope: MI adults, MI children, I/DD adults, and I/DD children

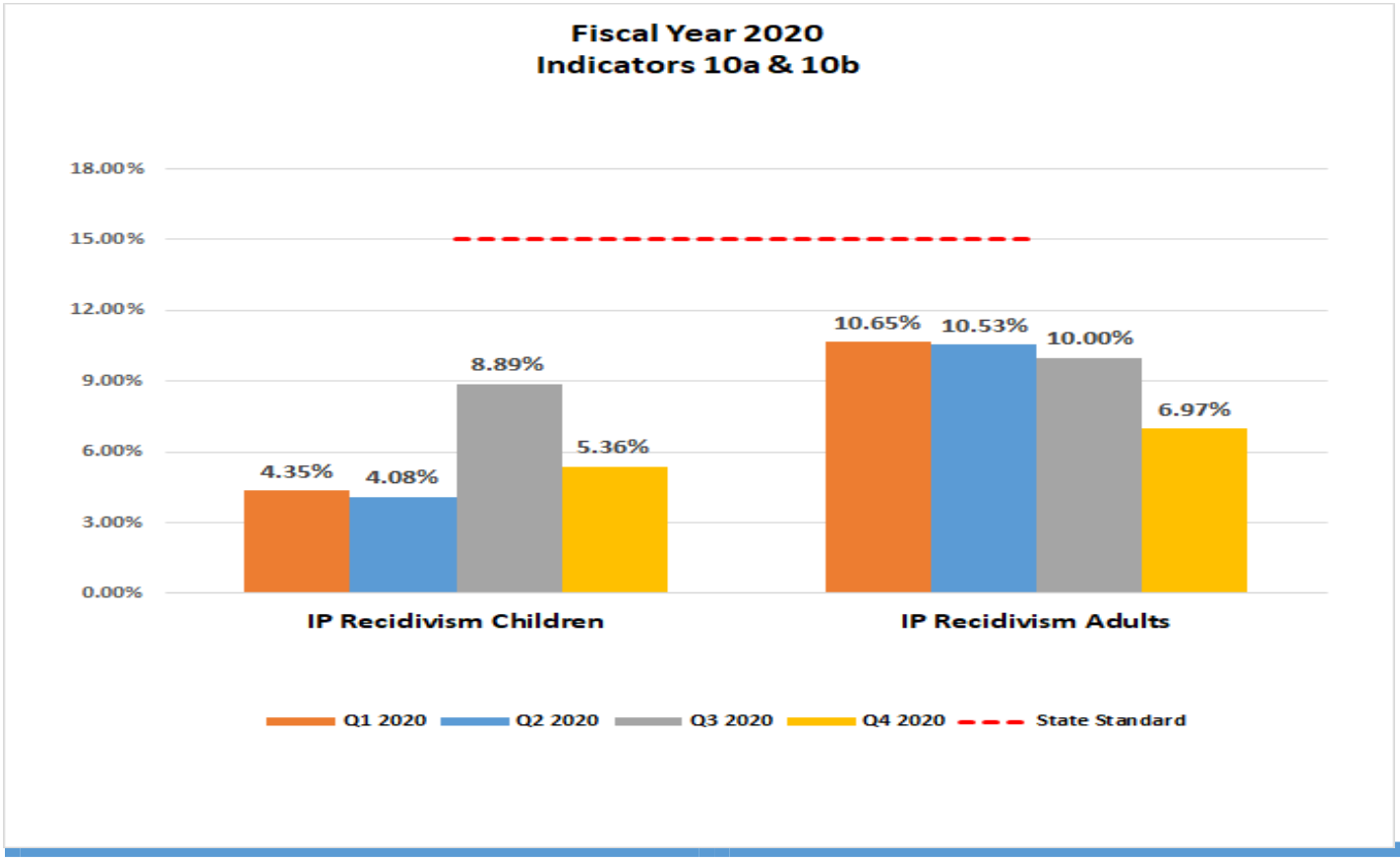
2. (b) The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders.

    a. No Standard for 1st year of implementation – will use the information to determine a baseline.
    b. Quarterly report
    c. PIHP for all Medicaid and non-Medicaid persons

3. Percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment.
    f. No Standard for 1st year of implementation – will use the information to determine baseline.
    g. Quarterly report
    h. PIHP for all Medicaid beneficiaries
    i. CMHSP for all consumers

    *Scope: MI adults, MI children, I/DD adults, and I/DD children


Fiscal Year 2020
Indicators 1, 2a, 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 Adults
Request to Intake MI Children
Request to Intake IDD Adults
Request to Intake IDD Children
Request to Intake SA/Request to Service SA
First Service MI Adults
First Service MI Children
First Service IDD Adults
First Service IDD Children
IP Follow Up Children
IP Follow Up Adults
Detox Follow Up
Q1 2020
Q2 2020
Q3 2020
State Standard


Fiscal Year 2020
Indicators 10a & 10b
18.00%
15.00%
12.00%
9.00%
6.00%
3.00%
0.00%
4.35%
4.08%
8.89%
5.36%
10.65%
10.53%
10.00%
6.97%
IP Recidivism Children
IP Recidivism Adults
Q1 2020
Q2 2020
Q3 2020
Q4 2020
State Standard

Performance Indicator Measurement Period: October 1, 2019, through September 30, 2020

Objective

State defined indicators aimed at measuring access, quality of service, and 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 85% for all performance indicators to achieve the MDHHS established benchmark for (4) quarters during FY 2020. The internal benchmark was lowered, to account for the (3) new performance indicators; that do not have established benchmarks tied to them yet.

Results

35/38 or 92.1% of total Performance Indicators in 2020 met the State Standard of 95%:

i. 1st Quarter = 15/16
ii. 2nd Quarter = 8/8
iii. 3rd Quarter = 6/7
iv. 4th Quarter = 6/7

MMBPIS Indicator #	*MMBPIS Performance Indicator*	*State Standard*	Q1 2020	Q2 2020	Q3 2020	Q4 2020
1a	*Pre-Admission Screening Children*	95%	100.00%	100.00%	100.00%	98.81%
1b	*Pre-Admission Screening Adults*	95%	99.39%	99.74%	98.10%	98.78%
2a(a)	*Request to Intake MI Adults*	95/0%	97.31%	67.82%	79.78%	69.26%
2a(b)	*Request to Intake MI Children*	95/0%	97.36%	65.60%	77.16%	69.09%
2a(c)	*Request to Intake IDD Adults*	95/0%	100.00%	60.42%	90.38%	76.92%
2a(d)	*Request to Intake IDD Children*	95/0%	100.00%	55.44%	80.65%	75.00%
2e/2b/3e	*Request to Intake SA/Request to Service SA*	95/0%	96.87%	97.43%	341	389
3a	*First Service MI Adults*	95/0%	96.31%	55.44%	66.26%	68.99%
3b	*First Service MI Children*	95/0%	96.08%	57.20%	71.94%	67.43%
3c	*First Service IDD Adults*	95/0%	96.77%	66.18%	76.27%	80.72%
3d	*First Service IDD Children*	95/0%	92.00%	53.85%	71.43%	73.17%
4a(a)	*IP Follow Up Children*	95%	100.00%	100.00%	100.00%	92.11%
4a(b)	*IP Follow Up Adults*	95%	97.66%	97.58%	97.08%	95.49%
4b	*Detox Follow Up*	95%	95.47%	95.42%	79.17%	97.17%
10a	*IP Recidivism Children*	15%	4.35%	4.08%	8.89%	5.36%
10b	*IP Recidivism Adults*	15%	10.65%	10.53%	13.24%	6.97%
	Overall Results		15/16	8/8	6/7	6/7

Identified Barriers

Covid-19 certainly presented its share of barriers to many of the CMHSP's follow-up processes. Many consumers proved difficult to reach during the Pandemic, which impacted some of the timeliness performance indicators. The other significant change with impact processes, were the elimination of exclusions and exceptions for indicators 2, 2b and 3. It took significant time, effort, and resources to accommodate the specification changes within the SWMBH and CMHSP systems. Another barrier that impacted performance was many CMHSP's struggled with staffing issues throughout the year, which led to missed performance indicators (i.e., opportunities to schedule inside a 14-day window are lost due to not having staff available to take on the assessment or service). Additionally, 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.

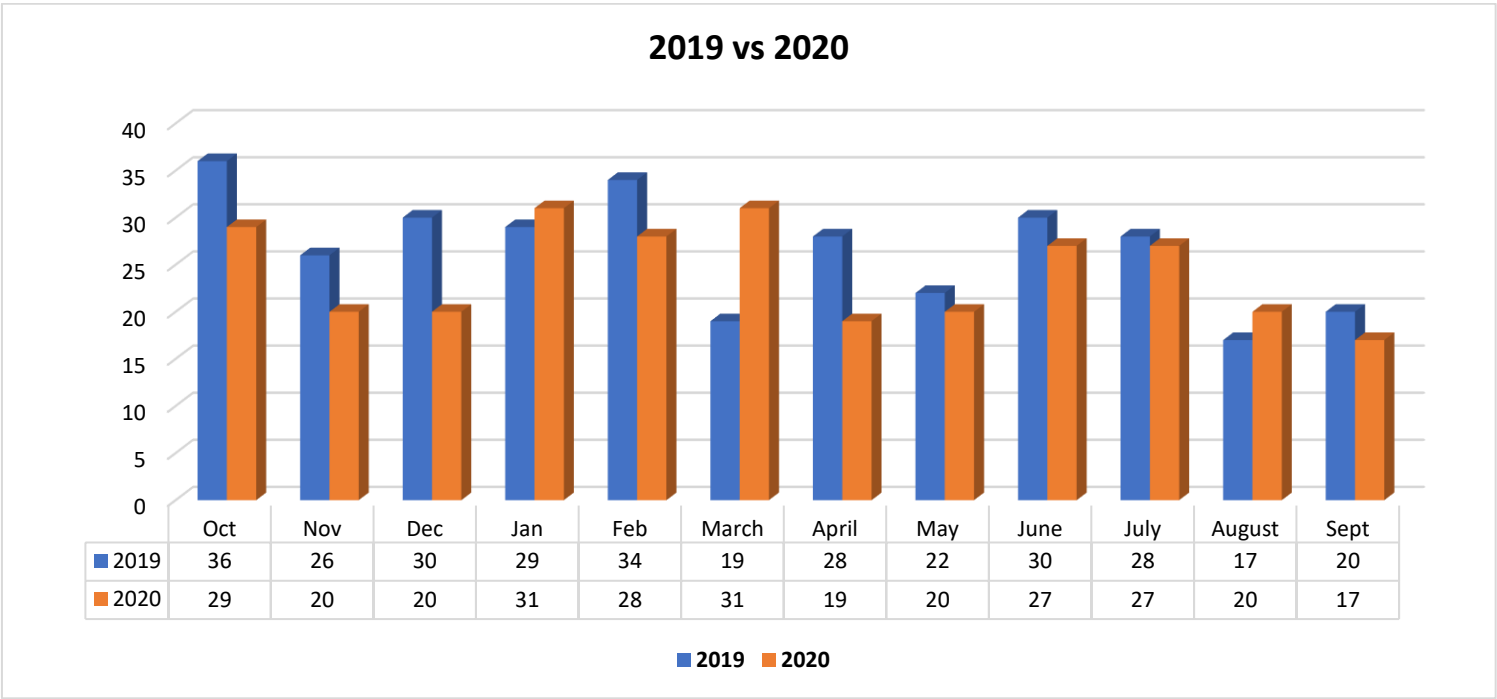
Recommendations

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. It is recommended that each CMHSP utilize the approved template to submit their monthly reports. The template has been modified to adapt to both Streamline and PCE operating systems. This will ensure validity and consistency with all data being reported. SWMBH has also implemented an internal audit process, in which we review 5%-7% of total cases through primary source verification to ensure accuracy, quality and data validity.

2020 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 2019 – September 2020	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 occurred in April-June 2020. Select Critical Incidents are selected for analysis.

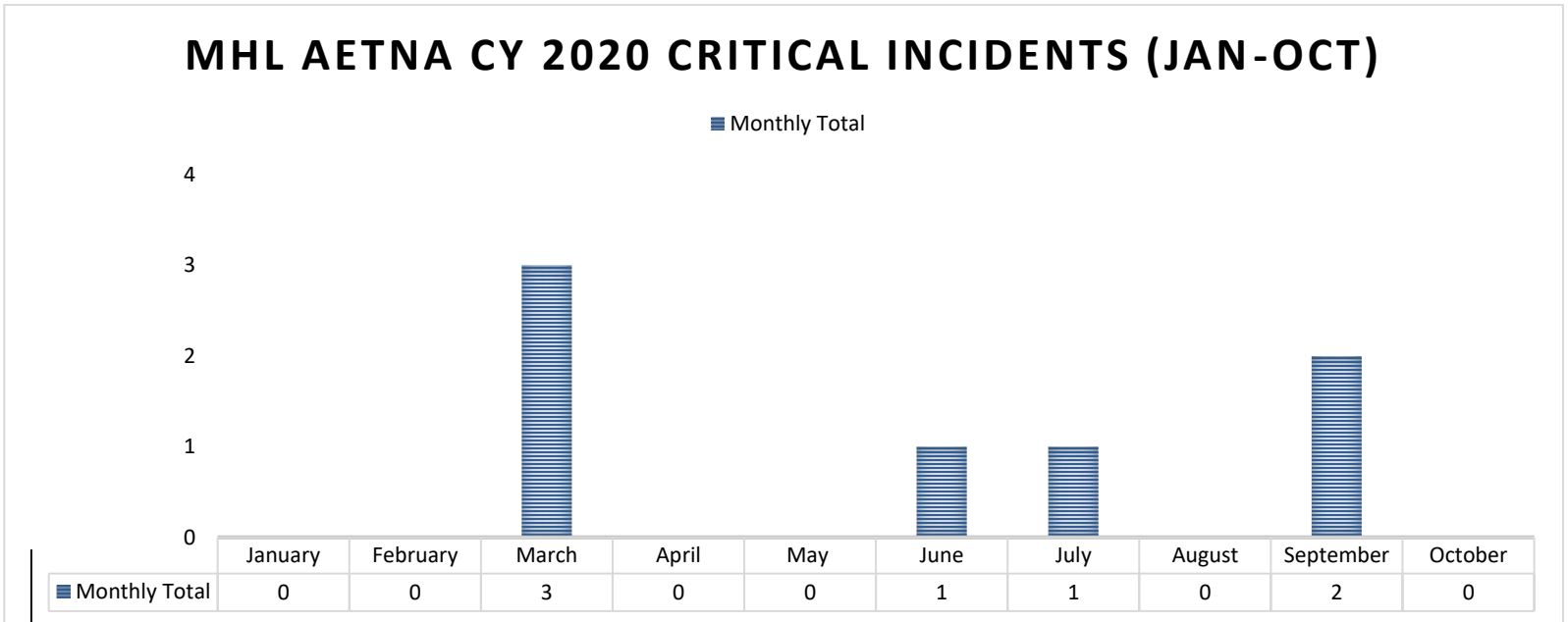
FY 2020 Critical Incidents (All Business Lines)



- Overall, for FY 20 there were 289 critical incidents (Down from 319 for FY 19). This was a difference of 30 events.
- The highest number of events occurring in January and March with 31 events.

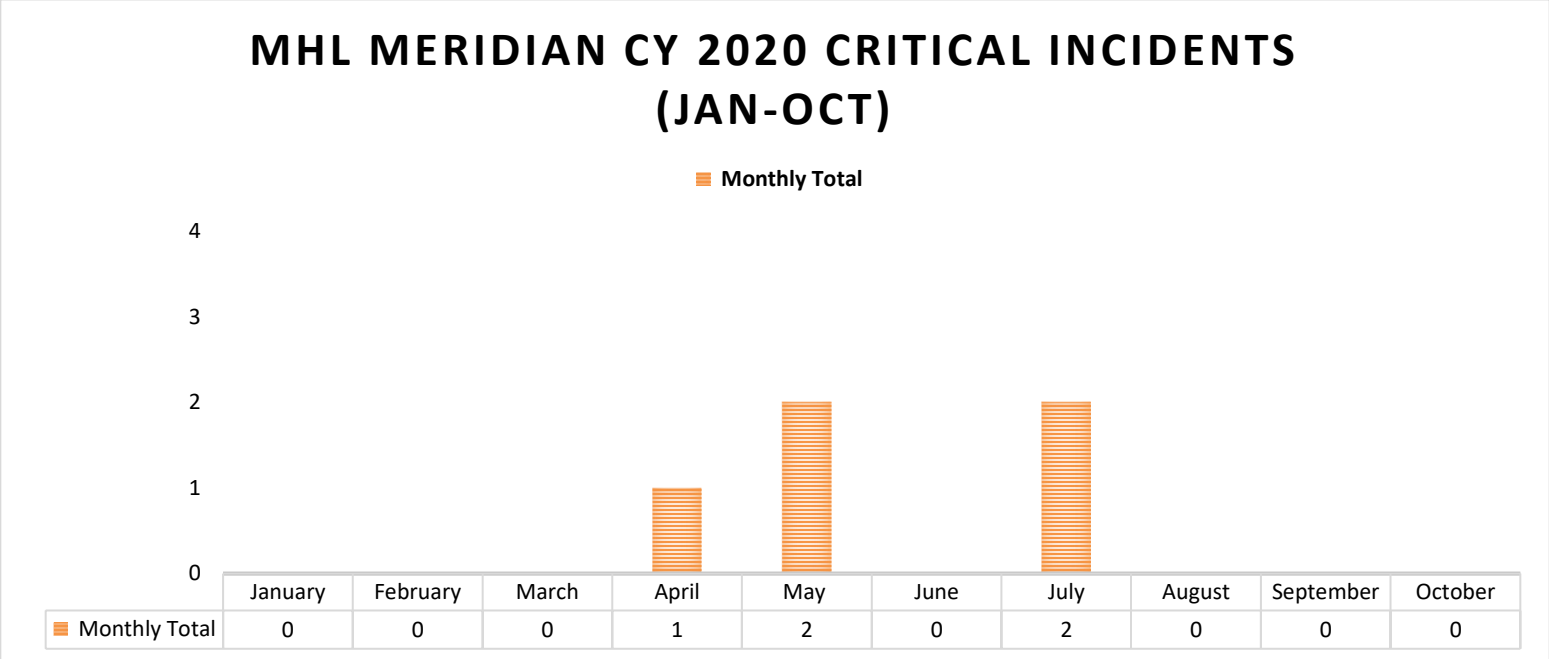
MI Health Link (Duals Demonstration Project) CY 2020 Critical Incidents

Aetna Health Plan



- ❖ Analysis: In CY 2020 there were a total of 7 critical incidents reported to SWMBH for enrolled Aetna Members
- ❖ No significant trends were noted for the 2020 reporting period.

Meridian Health Plan



	January	February	March	April	May	June	July	August	September	October
Monthly Total	0	0	0	1	2	0	2	0	0	0

- ❖ Analysis: In CY 2020, there were a total of 5 critical incidents reported to SWMBH for enrolled Meridian Members.
- ❖ No significant trends were noted for the 2020 reporting period.

Objective

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

Results

Improved reporting from CMHSPs—decrease in events reported in FY2020 due to the new implemented process in FY 19.

Identified Barriers

Covid-19 proved difficult for CMHSPs when it came to monthly reporting due to a variety of factors including remote work operations. Additionally, high turnover at one of the CMHSPs presented its own set of challenges.

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, please document this in the Event Reporting Submission sheet each month and send it to the Event Reporting Inbox. A CISE (Critical Incident & Sentinel Event) workgroup updated CISE training materials and disseminated it to the struggling CMHSPs. 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 has developed an analysis methodology to be include the creation of a dashboard on Tableau, however improvements still need to occur.

2020 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 2019 – September 2020	QAPI Specialist QAPI Director Data Analyst Director of Clinical Practices Regional Operations Committee	Quarterly

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 the number of interventions and the 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 to evaluate 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 spreadsheet's information fields did not include the length of time that interventions were used per person. Attachment P7.9.1 requires that the BTRCs review the number 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 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 were not reporting for non-waiver beneficiaries. A process has been established to begin collecting this information from CMHSPs.

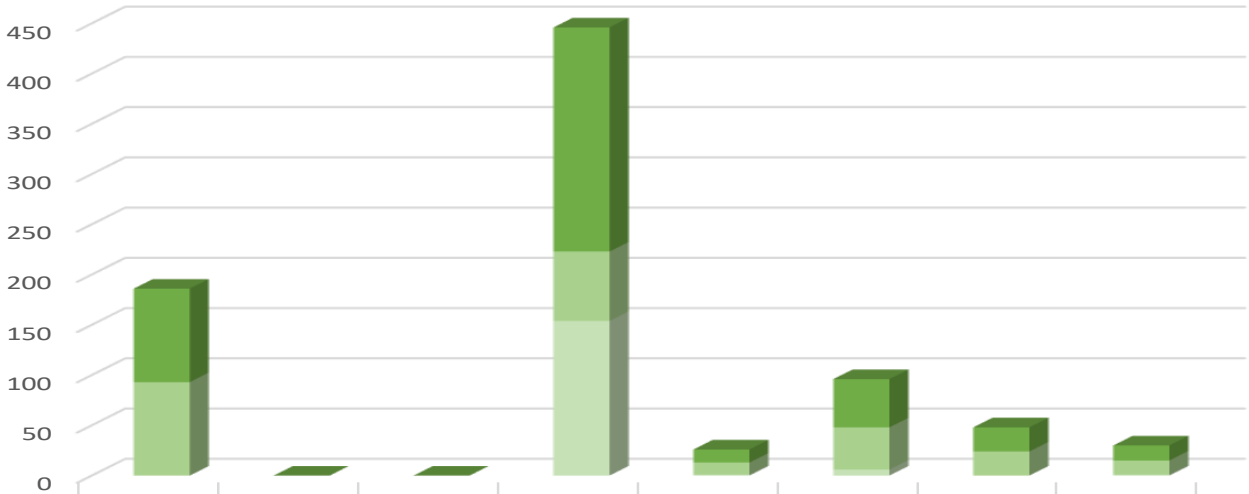
Recommendations

The PIHP must ensure that CMHSPs collect and analyze 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.

2020 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 2019 – September 2020	QAPI Specialist QAPI Director Director of Clinical Practices Director of Utilization Management	Annually or as needed

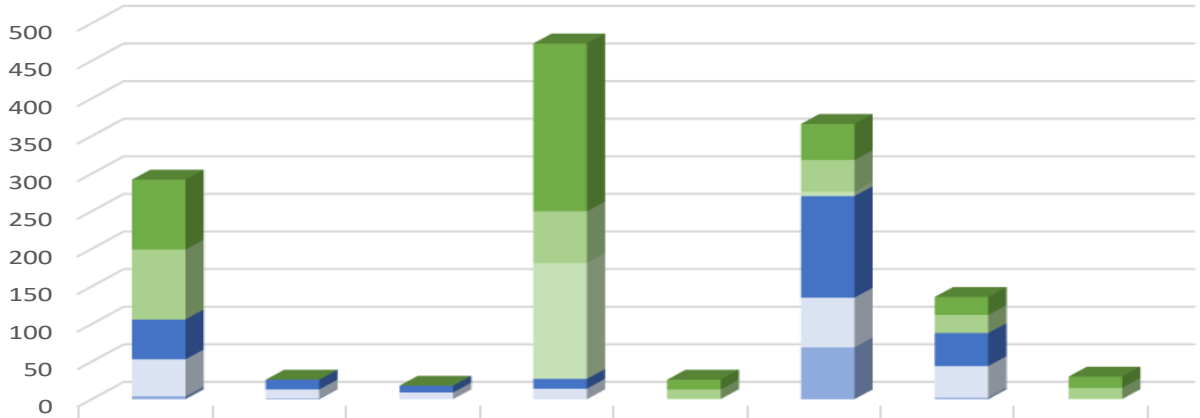
FY 2020 Jail Diversion Data



	Barry	Berrien	Cass	ISK	Pines	St. Joe	Summit Pointe	Van Buren
2020 Total	93	0	0	223	13	48	24	15
2020 Post Booking	93	0	0	69	12	42	24	14
2020 Pre-Booking	0	0	0	154	1	6	0	1

2020 Pre-Booking 2020 Post Booking 2020 Total

FY 2019 (B) Vs FY 2020 (G) Jail Diversion Data



	Barry	Berrien	Cass	ISK	Pines	St. Joe	Summit Pointe	Van Buren
2020 Total	93	0	0	223	13	48	24	15
2020 Post Booking	93	0	0	69	12	42	24	14
2020 Pre-Booking	0	0	0	154	1	6	0	1
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

2019 Pre 2019 Post 2019 Total 2020 Pre-Booking 2020 Post Booking 2020 Total

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, most 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 accurately, complete, and timely as required by MDHHS. Appropriate training and reporting from the jails' administrative staff seem to be an ongoing issue and reflects 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 continue to provide our Jail Diversion Educational PowerPoint for new providers and those CMHSPs that are showing signs of challenges.

2020 Annual Member Experience Analysis/Feedback

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 analyze 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 2020 - December 2020	QAPI Specialist QAPI Director Chief Administrative Officer Utilization Management Manager Director of Clinical Quality or Medical Director Consultant All Senior Leadership	Annually

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

MHSIP Results

- ❑ 2019 Aggregate Ave. Score: 93.09%
- ❑ 2020 Aggregate Ave. Score: 89.01%

-4.08% Percent Decrease in comparison to previous years score

(All Categories)

YSS Results

- ❑ 2019 Aggregate Ave. Score: 91.58%
- ❑ 2020 Aggregate Ave. Score: 90.51%

-1.07% Percent Decrease in comparison to previous years score

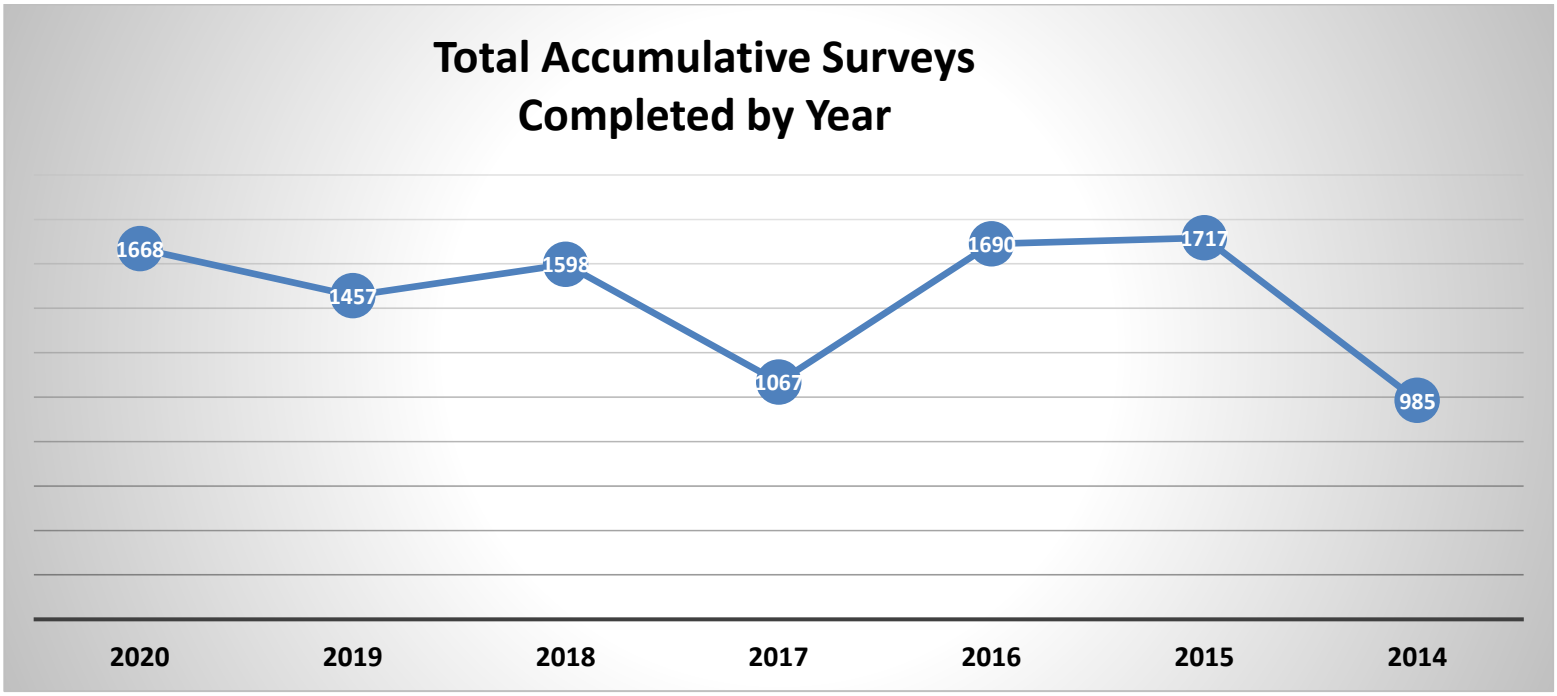
(All Categories)

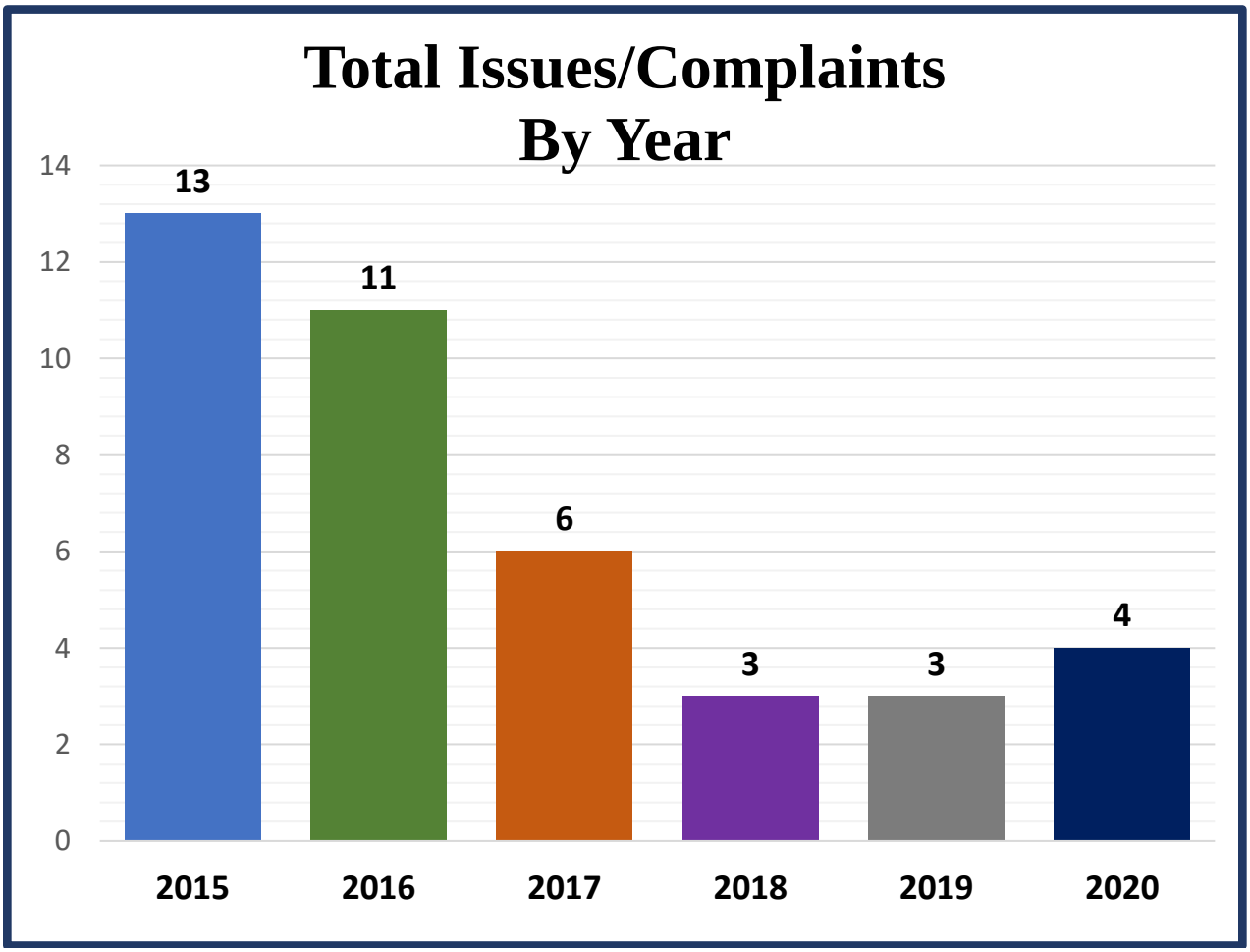
Overall Response Rates

- ❑ 2019 Response Rate: 36.4%
- ❑ 2020 Response Rate: 31.1%

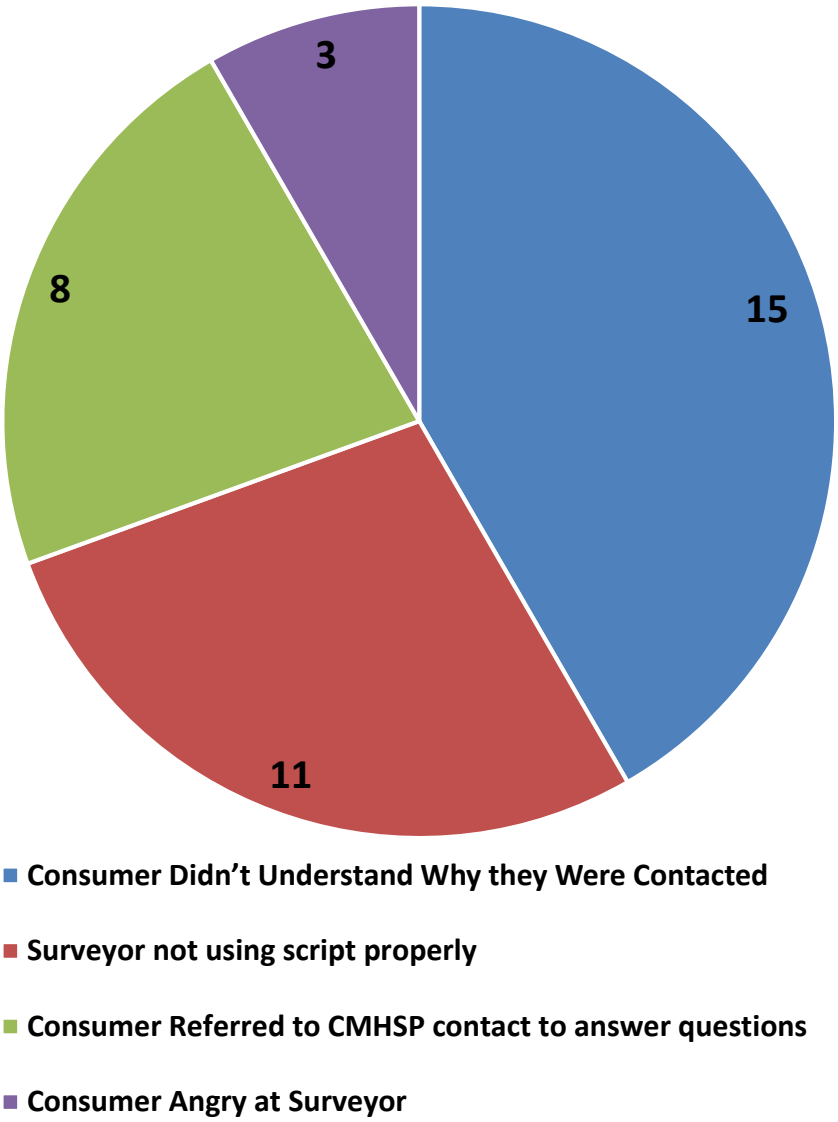
Overall Result

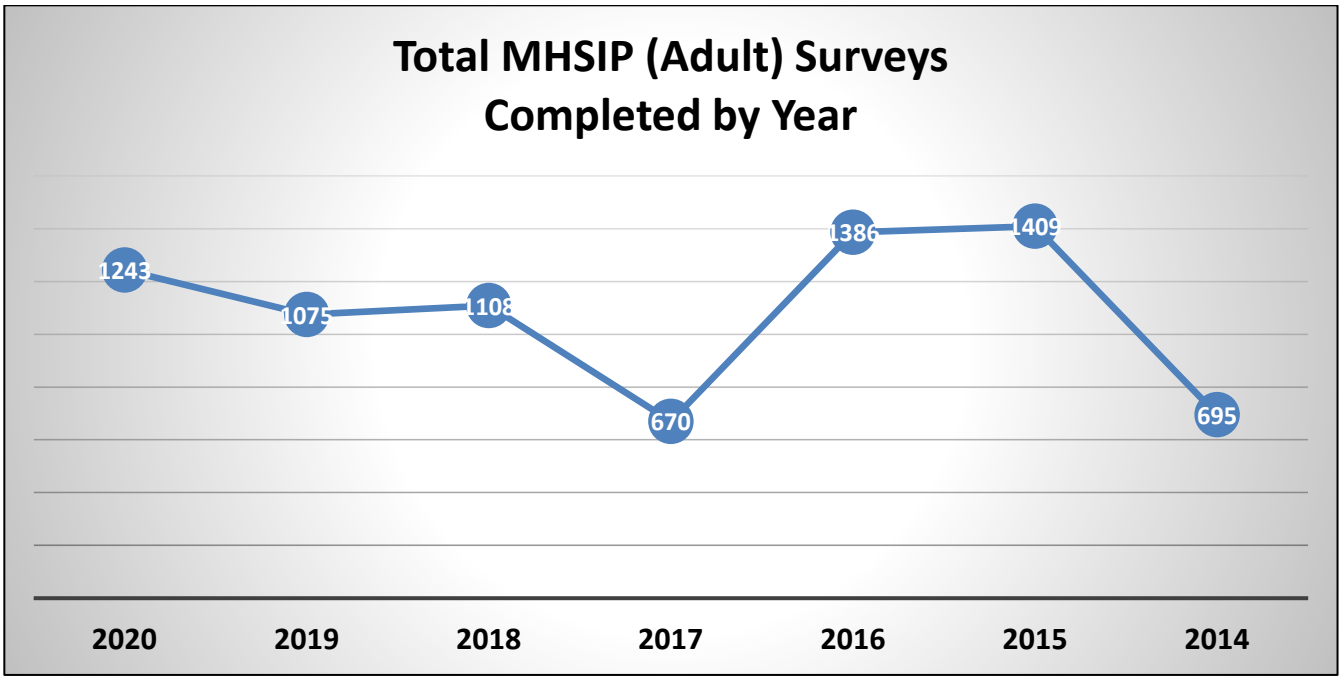
-5.15% Percent Overall Decrease (MHSIP + YSS)


Total Accumulative Surveys Completed by Year
1668
1457
1598
1067
1690
1717
985
2020
2019
2018
2017
2016
2015
2014

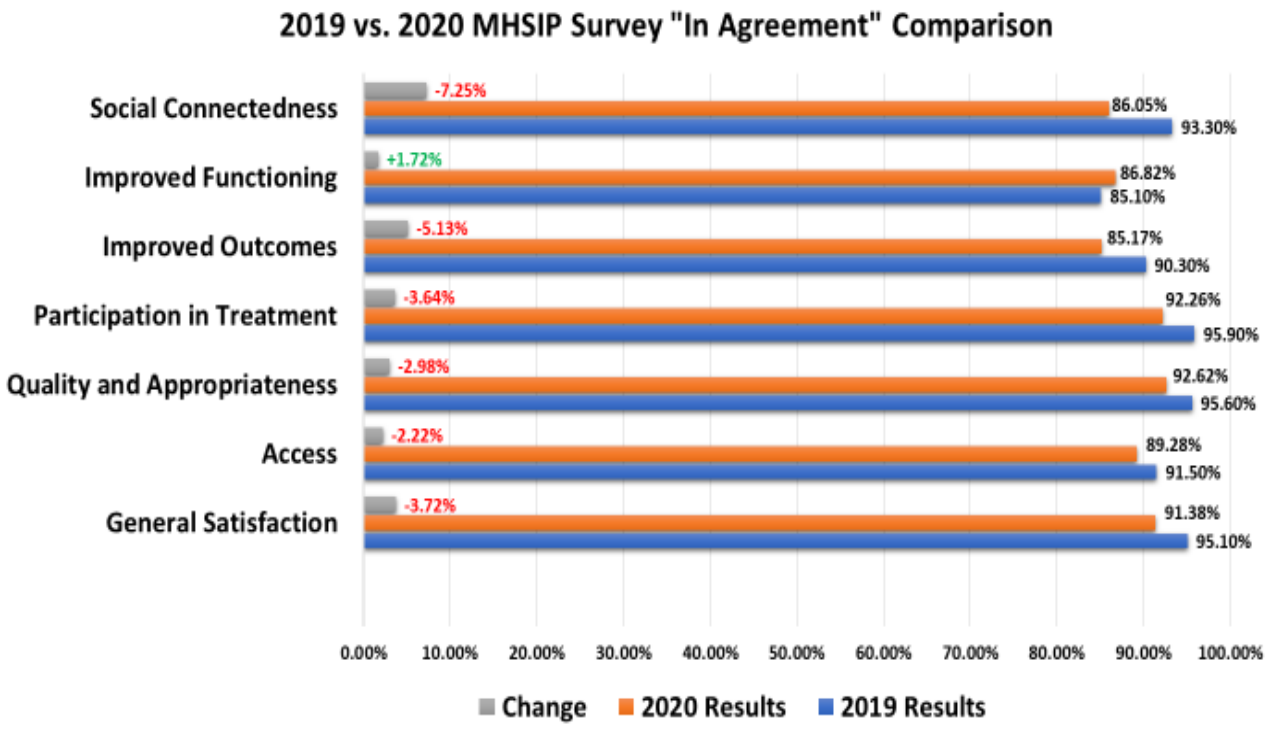

Total Issues/Complaints By Year
14
12
10
8
6
4
2
0
13
11
6
3
3
4
2015
2016
2017
2018
2019
2020

Reasons For Consumer Complaints or Confusion





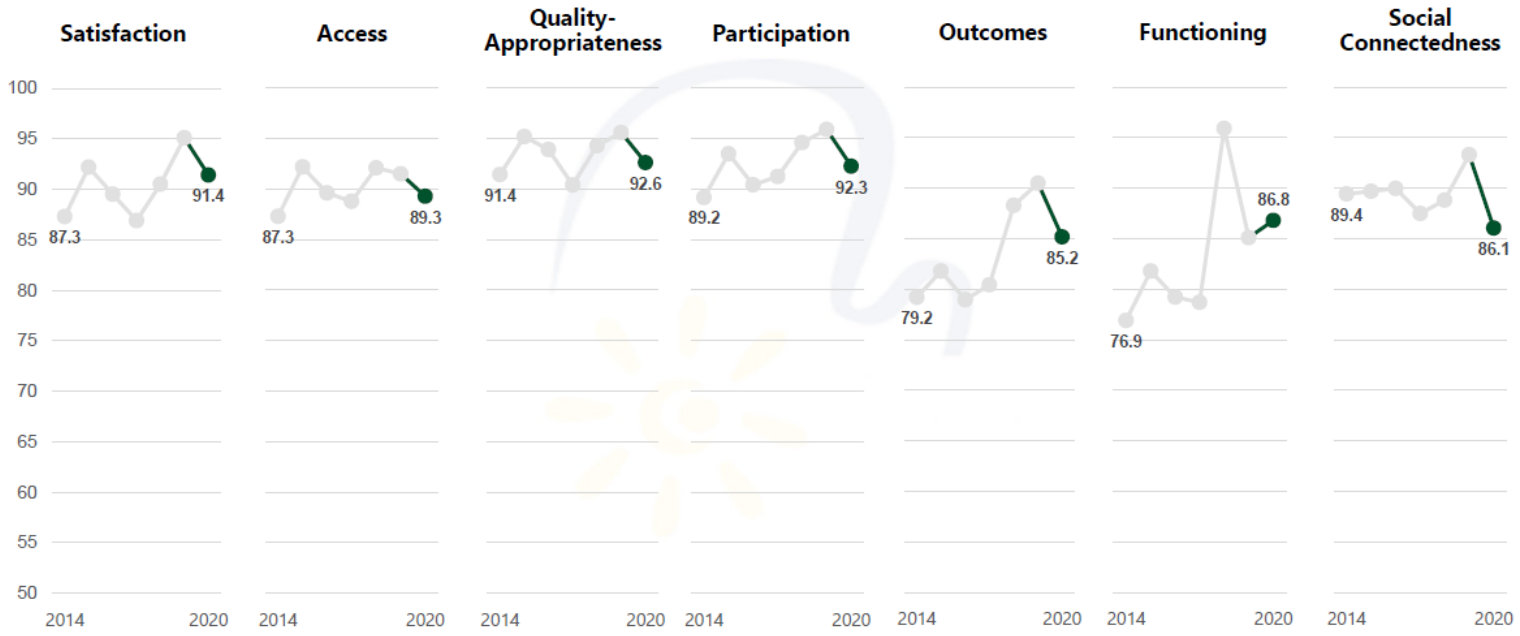
MHSIP (Adult) Satisfaction Survey "In Agreement" Comparison 2019 vs. 2020



2

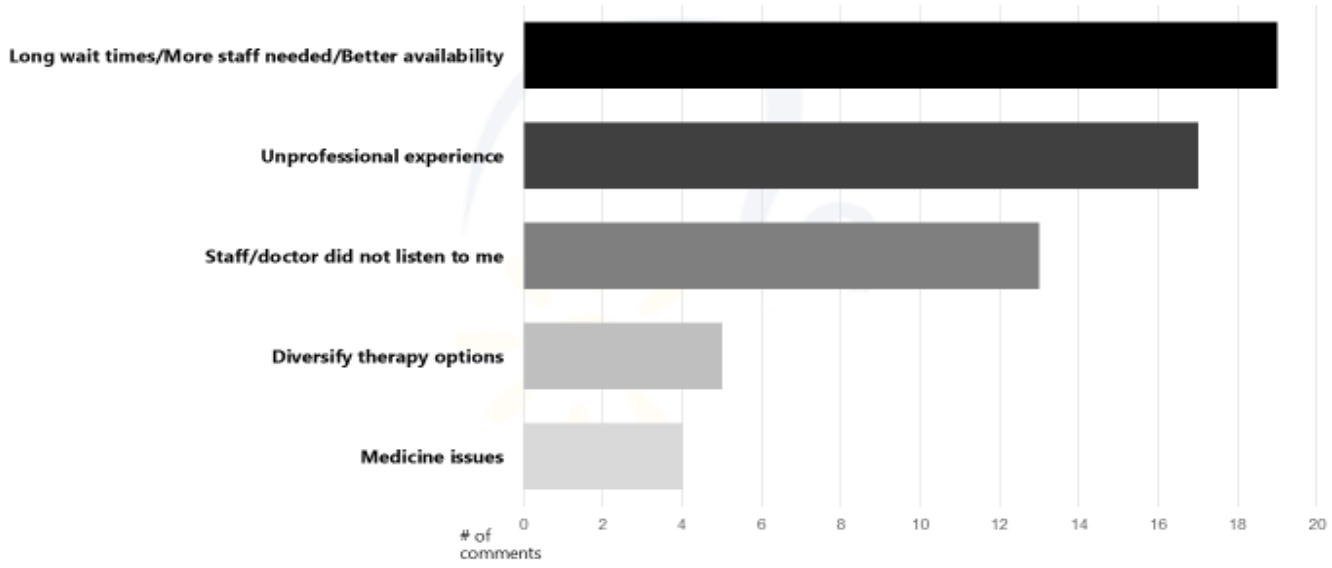
Overall, scores were lower across all constructs in 2020

MHSIP scores by year across each construct show that 2020 broke the trend of consecutive yearly improvement for most of the categories



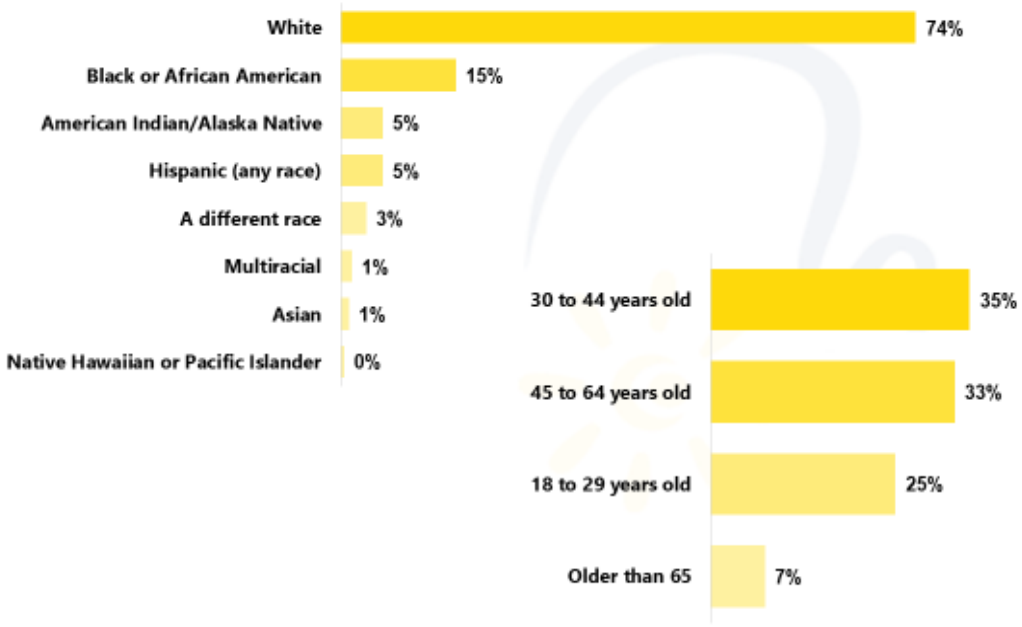
Opportunities for improvement in staffing, professionalism

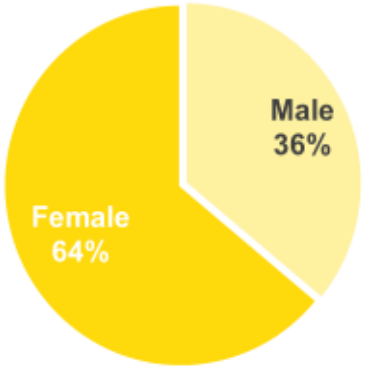
Of respondents to the MHSIP who were dissatisfied with services, reasons included long wait times, understaffed sites, & unprofessional experiences

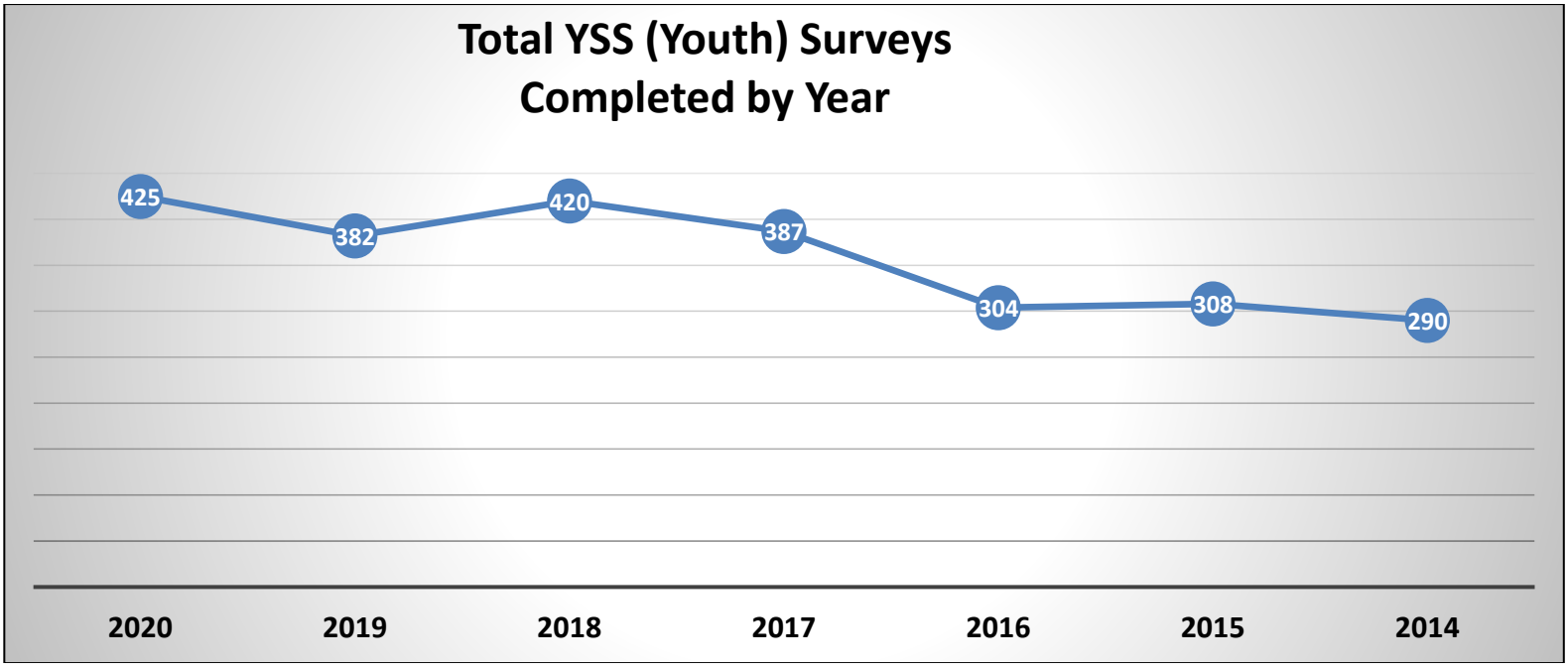


MHSIP 2020 survey takers were demographically diverse

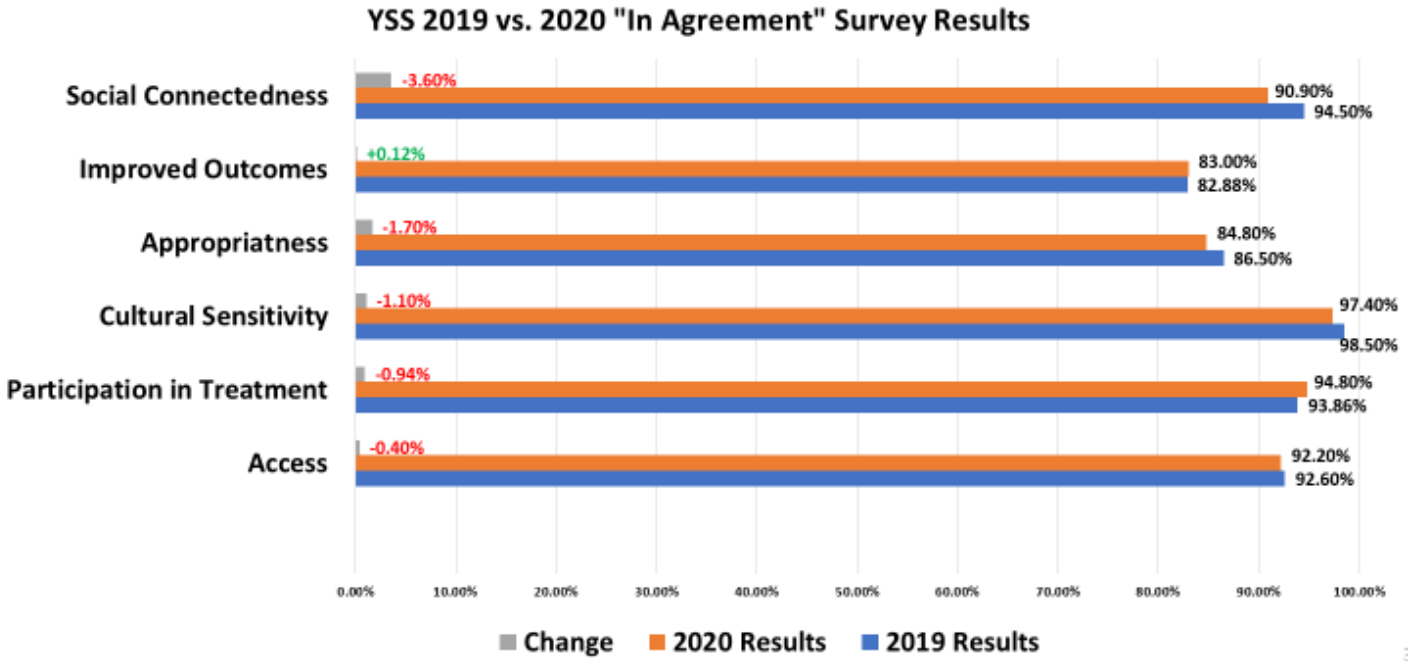
Many more women than men responded, but a diverse set nonetheless







YSS (Youth) Satisfaction Survey "In Agreement" Comparison 2019 vs. 2020



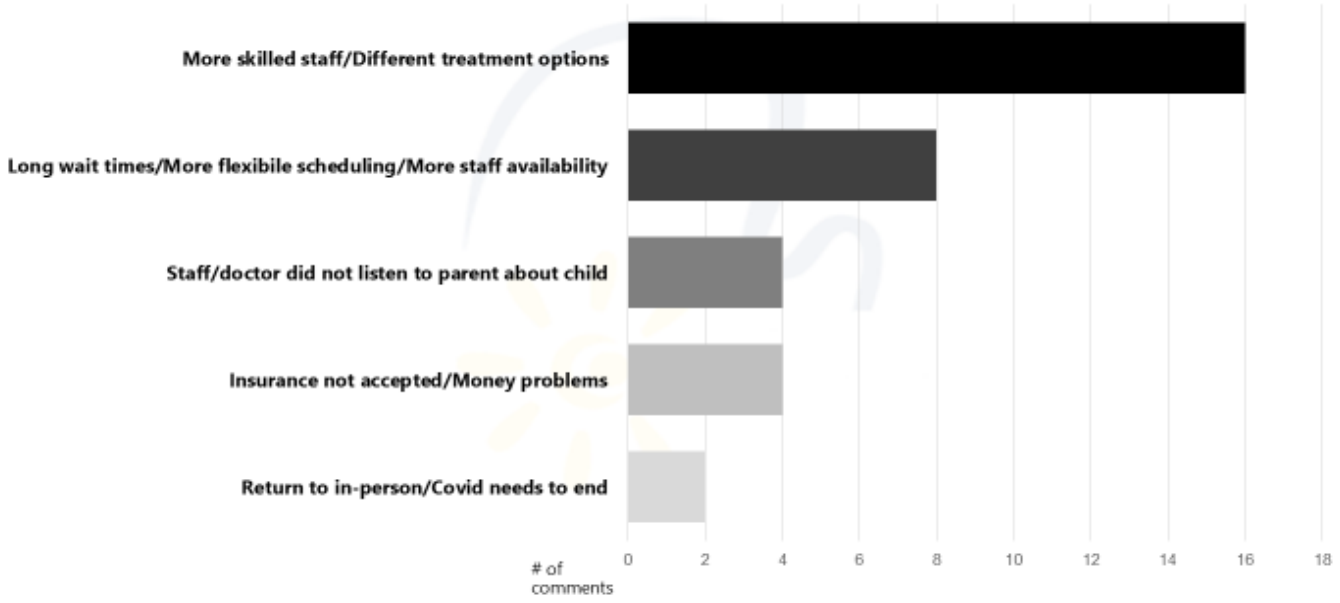
3

Overall, the prior year's scores were mostly maintained

YSS scores by year across each construct show that improvement has been steady for most constructs since 2014

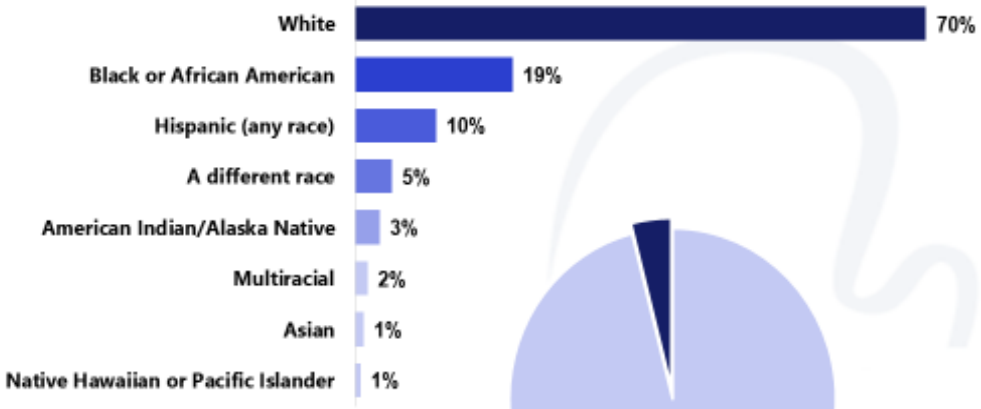
Opportunities for improvement in diversifying treatment, staffing

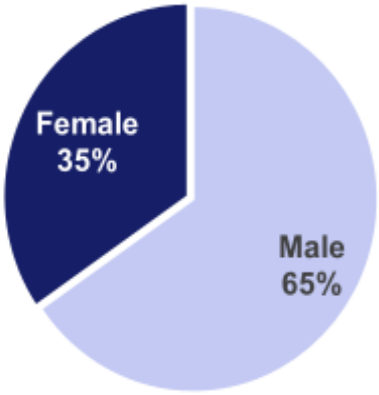
Of respondents to the YSS who were dissatisfied with services, frustrations included lacking staff skills & availability

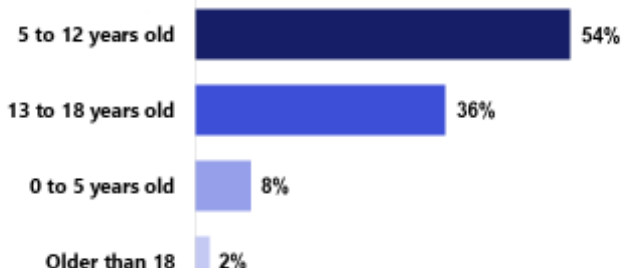


YSS 2020 survey takers were demographically diverse

Many more men than women responded, but a diverse set nonetheless







MHL Program
Overall, scores were lower across most constructs in 2020

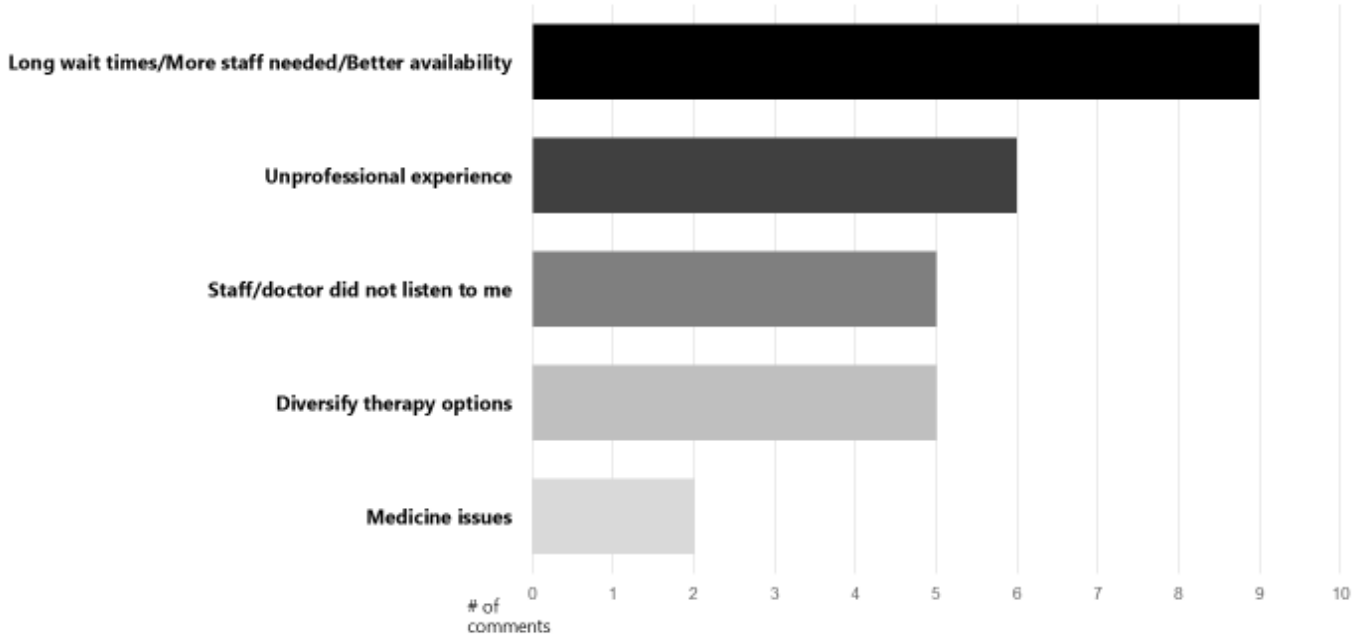
Enrolled Consumers (18 years of age or over) were eligible to complete the survey.

Kiaer Research SWMBH Consumer Satisfaction 2020 MHSIP Results

2020 surveys completed: 332
2019 surveys completed: 355
-23 from previous year

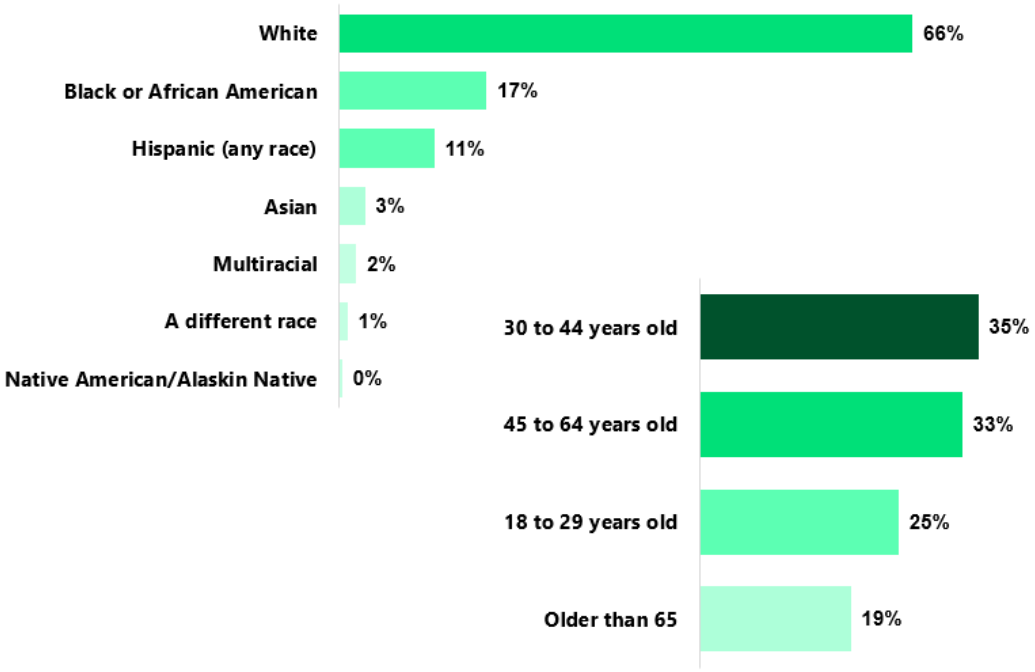
MHL Program
Opportunities for improvement in staffing, professionalism and access

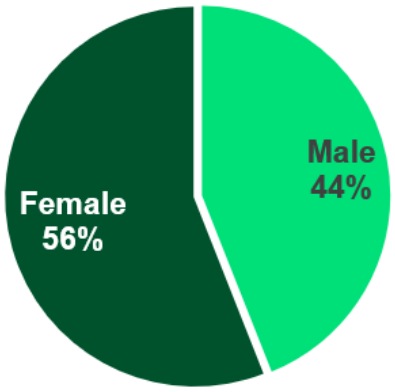
Of respondents to the MHSIP who were dissatisfied with services, reasons included long wait times to get an appointment, understaffed sites, unprofessional experiences & difficulties getting prescriptions refilled.



MHL Program 2020 survey takers were demographically diverse

Many more women than men responded, but a diverse set nonetheless





Survey methods employed in 2020

- A **call-to-IVR** phone method was used to lower interview costs of phone participants
- Response rates via phone were lower than past years, so a supplemental **email survey** was sent out, repeat takers were excluded
  - MHSIP: 734 phone, 509 web
  - YSS: 217 phone, 208 web
- These two methods largely reached different populations
  - **Just ~13% of email respondents** said they had completed the phone survey
- These leaner methods resulted in a **~33% project cost reduction** compared to prior years
- Data from both sources were cleaned and combined into one dataset

Recommendations for 2021 surveys

- Continue to use the **mixed-mode survey delivery** of email and phone
  - Perhaps **prioritize email** to further potential cost savings
- Let respondents **self-select** whether they should take the MHSIP, YSS, or both
  - Some MHSIP respondent comments suggested they had children receiving services
  - **Survey logic** can be used to increase accuracy and route respondents to the right questions
- Use a web survey platform that allows for **dynamic email display names**
  - Alchemer is one such platform – emails could come from "The designated CMHSP" rather than from "SWMBH – Survey Monkey" as they did this year
  - This would improve email response rates and further lower costs
- Consider **expanding demographic options** (nonbinary, trans, multiracial, etc.)
  - Respondents took the liberty of adding more precise identifiers in the comments
  - At least one respondent was deadnamed (old name used instead of trans name)

Recommendations for 2021 surveys (cont.)

- Consider **incentivizing** every respondent (i.e., $2 or $5 for anyone that completes)
  - Depending on the mode of delivery, this could make the survey more cost effective and more representative of the true consumer population
  - Another option is to incentivize counties that have lower population and higher uncertainty (Cass, Branch)
- Consider using a **different survey tool**
  - The MHSIP and YSS are relatively long surveys and have high attrition as a result
  - These tools may not provide the most useful information to help inform critical decisions at SWMBH
- **Change** the "percent agreement" scoring protocol
  - Currently, "neutral" survey options are split against the agreement percentage
  - In actuality, answering "neutral" to a question that says "I like the services we received here." might not be a good sign, or it could mean something benign
  - Proposed revision: Only "agree" or "strongly agree" should contribute toward the "percent agreement" scoring measures

2020 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 used to measure different aspects of customer satisfaction with public behavioral health services. The (6) measurements are social connectedness, outcomes, appropriateness, cultural sensitivity, participation in treatment, and access. THE YSS consists of 46 questions.

The primary objective with the 2020 survey period was to improve on the Improved Outcomes scores for the Youth population and Improved Functioning for the Adult population. Over the past (6) years of conducting this survey, those have been identified as our lowest scoring categories needing improvement.

Results

SWMBH realized a – *4.08% reduction in scores for the (adult-MHSIP) population* and a – *1.07% reduction in scores for the (youth – YSS) population*; translating into an overall – *5.15% reduction in overall scores* across all categories in each survey tool. Although, there was a significant reduction across most categories, SWMBH did realize an improvement in scores in the target areas of improvement of; Improved Functioning (adult + 0.12%) and Improved Outcomes (youth + 1.72%). SWMBH was happy to realize improvements in these particular categories, as we established Regional performance improvement projects around them. SWMBH also targeted those categories in its Board Ends Metrics "Key Performance Indicators", indicating that; Consumer Satisfaction Surveys collected by SWMBH during 2020 are at or above the SWMBH 2019 results; for the *Improved Functioning* (MHSIP survey) and *Improved Outcomes* (YSS survey). Again, these categories were selected as they have been the lowest-scoring categories measured over the past 6 years.

The 2020 survey project also achieved the goal of completing 2000 total surveys, for the Youth, Adult and MHL consumer populations: MHSIP: 1243 - YSS: 425 - MHL: 332.
Both the MHSIP-Adult survey and the YSS-Youth survey both saw an increase in surveys completed, in comparison to the previous year. The MHL survey did see a slight reduction of -17 surveys completed in comparison to the previous years. Both telephonic and electronic (Survey Monkey) methods were used to collect survey responses during the collection period (October – December 2020).

Identified Barriers

The 2020 survey process got off to a late start but picked up momentum quickly. The previous Vendor that SWMBH used to complete the telephonic portion of the surveys closed in September, which left us scrambling to find another Vendor to administer the telephonic portion of the survey. Luckily, SWMBH was referred to Kiaer Research, who was able to assist with the project. Unfortunately, this did not give us as much time to train the surveyors as we would have liked but feel this had a minimal impact on the overall survey results.
The primary barriers identified during the survey measurement period, were the effects of Covid-19 on just about every aspect of life and the participants unwillingness to participate in the survey. Our overall survey participation rates fell about 8% in comparison to previous years, which forced the surveyors to complete double the calls they had anticipated to meet targeted quotas.
The other significant barrier was the survey measurement period fell directly in the middle of a Presidential Election year. Consumers were less likely to answer their phones and participate, due to the number of political polling calls that were taking place during the same time.

Recommendations

SWMBH was aware that significant improvement in each survey category over the past 3 years was not sustainable. For this reason, 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 (6) years.

It is recommended that SWMBH review the consumer responses from the 2019 survey project and compare them to the consumer responses identified in the 2020 survey project. This will allow SWMBH to identify common denominators and trends in each of the past 2 survey measurement periods. SWMBH should target area's receiving the highest number of consumer responses, such as: 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, as potential performance improvement projects. 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. Our CMHSP partners will also be required to complete performance improvement projects, based on their specific results from the development of CMHSP tailored reports for all (8) Counties. The CMHSP's should discuss their individual survey results during internal Quality, Operations and Performance improvement workgroups and committees. CMHSP's will be asked to provide evidence of these discussions and proposed performance improvement plans/strategies to SWMBH for review and as evidence.

Summary of Finding

In summary, (2000) valid surveys were completed, resulting in a 25.4% response rate. The response rate was down significantly compared to 2019 results of 33.4% which just outside of being considered significant impact and still well ahead of the national average response rates. This response rate continues to be very good and attributed to the letters and advertisement efforts taken before the survey implementation. The current 2020 results show a decrease in overall "In Agreement" responses, but is not consider a significant decrease at (-5.15%). Agreement' ratings across most (MHSIP-adult) domain areas are also lower this year, netting an average 'In Agreement' score (MHSIP – adult) of 3.71 on a 5.0 scale (89.1%), compared to the 2019 average 'In Agreement' score of 3.89 (92%). Agreement ratings across (YSS – youth) domain areas are also lower this year, netting an average 'in Agreement' score (YSS-youth) of 3.94 on a 5.0 scale (91.6%), compared to the 2019 average 'In Agreement score of 3.99 (92.2%).

The Quality Department will continue to evaluate consumer survey participant feedback to identify common denominators and trends associated with the 2020 survey process. The current results tend to reflect (higher) than national trends for the respective MHSIP and YSS 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 a similar evaluation and validation process as Southwest Michigan Behavioral Health.

Improvement Measures

During the 2020 survey process and evaluation, it was identified that increased vendor oversight and monitoring needed to occur. In 2019 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 survey's purpose and how their responses will be used to improve programs and services.

Additionally, SWMBH Management was allowed to listen to surveyors (during active calls) to observe the consistency in scripts, and the survey protocol was being followed correctly. It was found that the 7 surveyors evaluated were using the appropriate scripts and techniques they had been educated on and 2 did not. 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.

2020 Recovery Self-Assessment – Person in Recovery (RSA-r) Survey

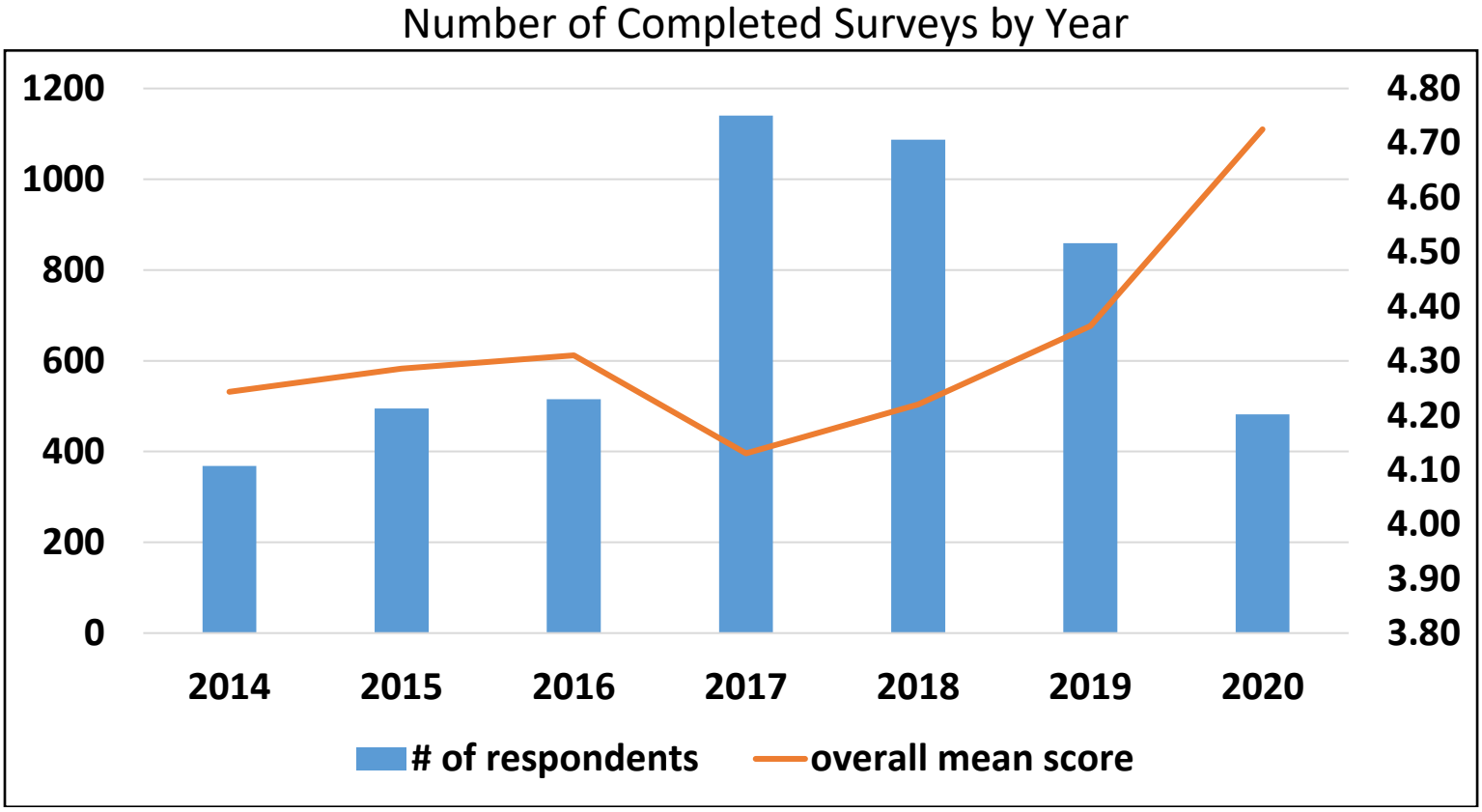
RSA-r Results Year Comparison

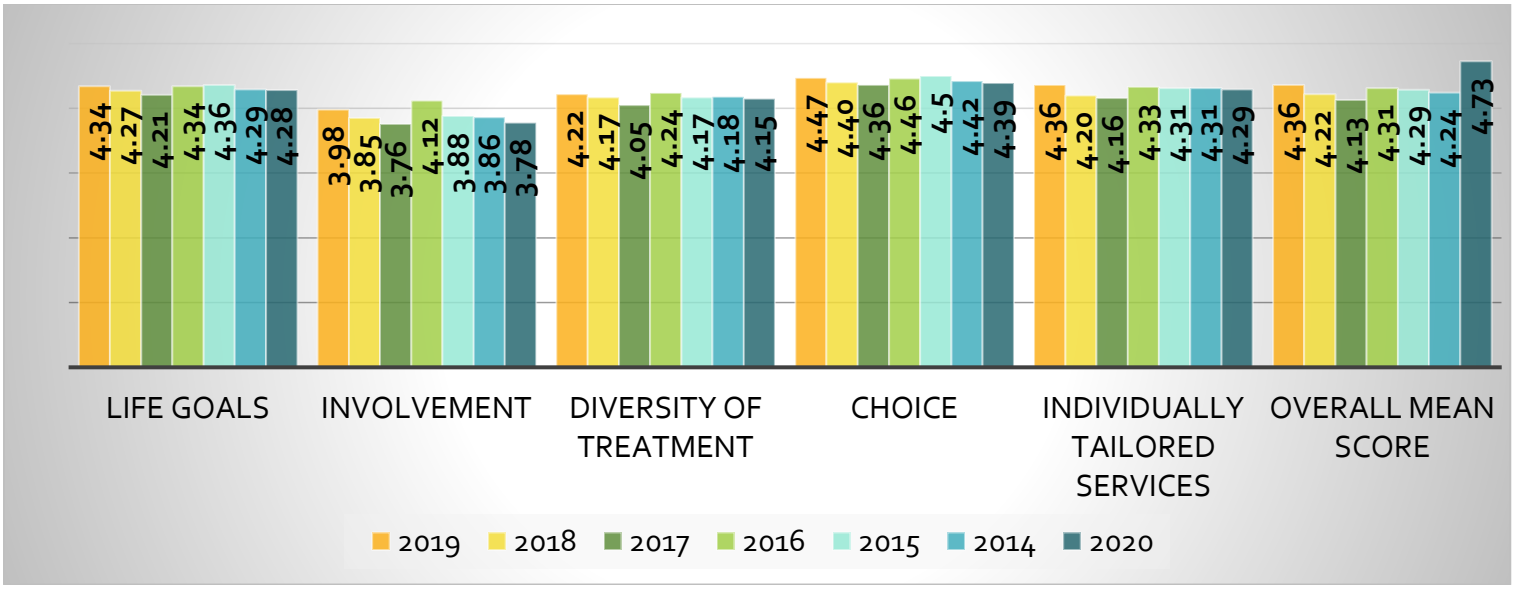
2020 Overall Mean Score: 4.73

(+0.37 increase from 2019 results)

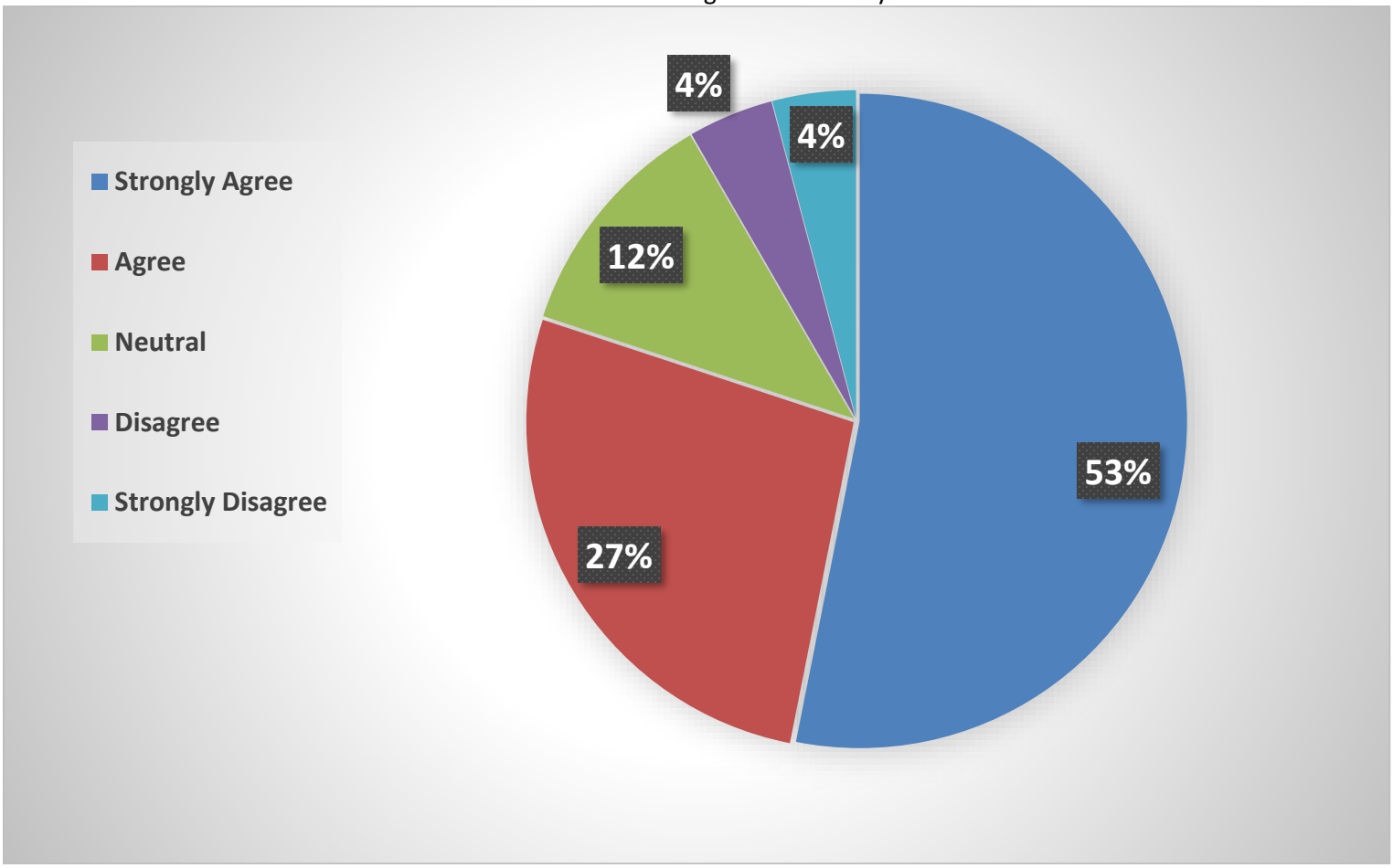
a. 2019 Overall Mean Score: 4.36
b. 2018 Overall Mean Score: 4.22
c. 2017 Overall Mean Score: 4.13
d. 2016 Overall Mean Score: 4.31
e. 2015 Overall Mean Score: 4.29
f. 2014 Overall Mean Score: 4.24

6 Year Average	Mean Score
Life Goals (Q3,Q7,Q8,Q9,Q12,Q16,Q17,Q18,Q28,Q31,Q32)	**4.33**
Involvement (Q22,Q23,Q24,Q25,Q29	**3.96**
Diversity of Treatment (Q14,Q15,Q20,Q21,Q26)	**4.22**
Choice (Q10, Q27, Q4, Q5, Q6)	**4.47**
Individually Tailored Services (Q11, Q13, Q19, Q30)	**4.30**

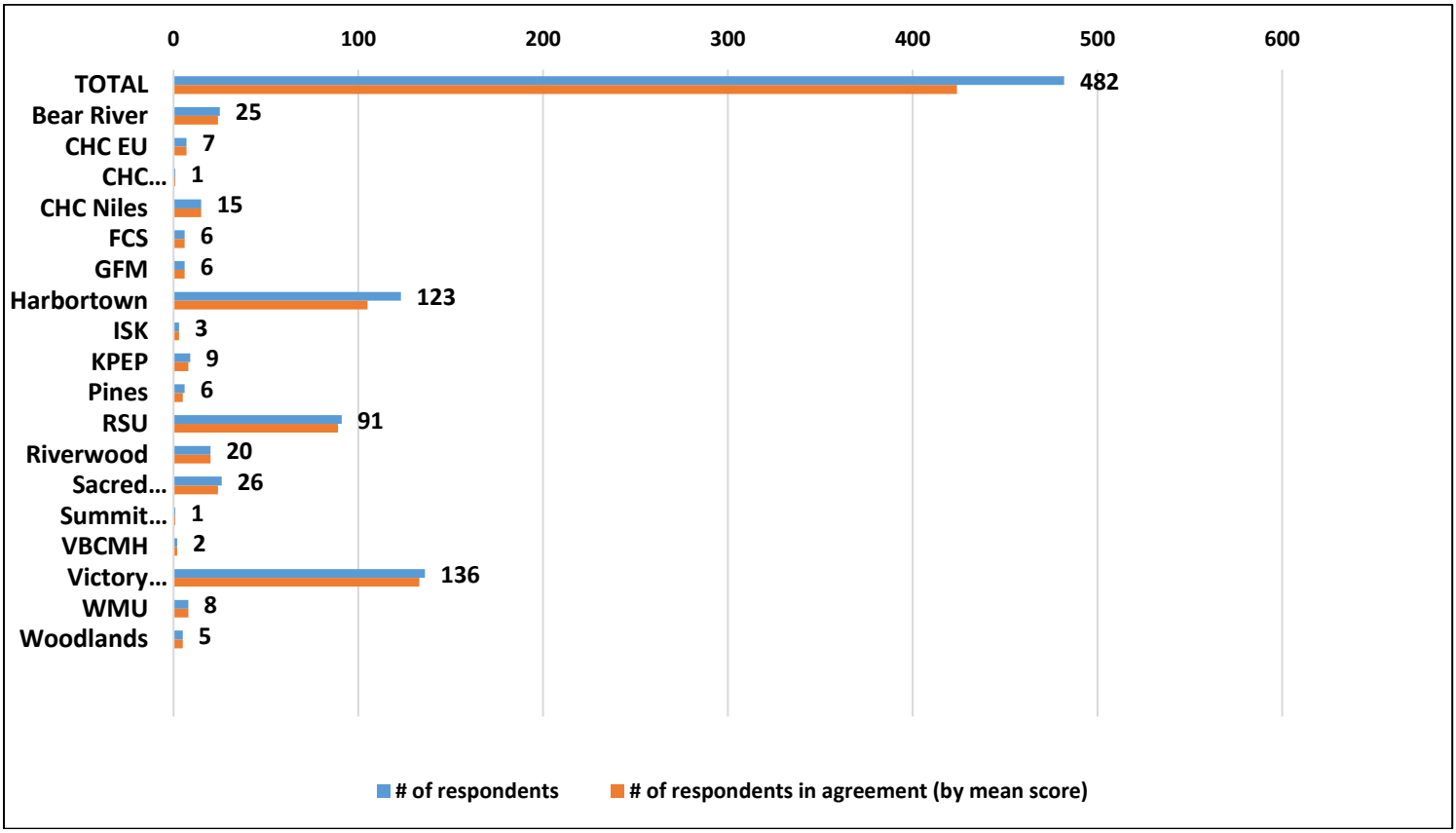




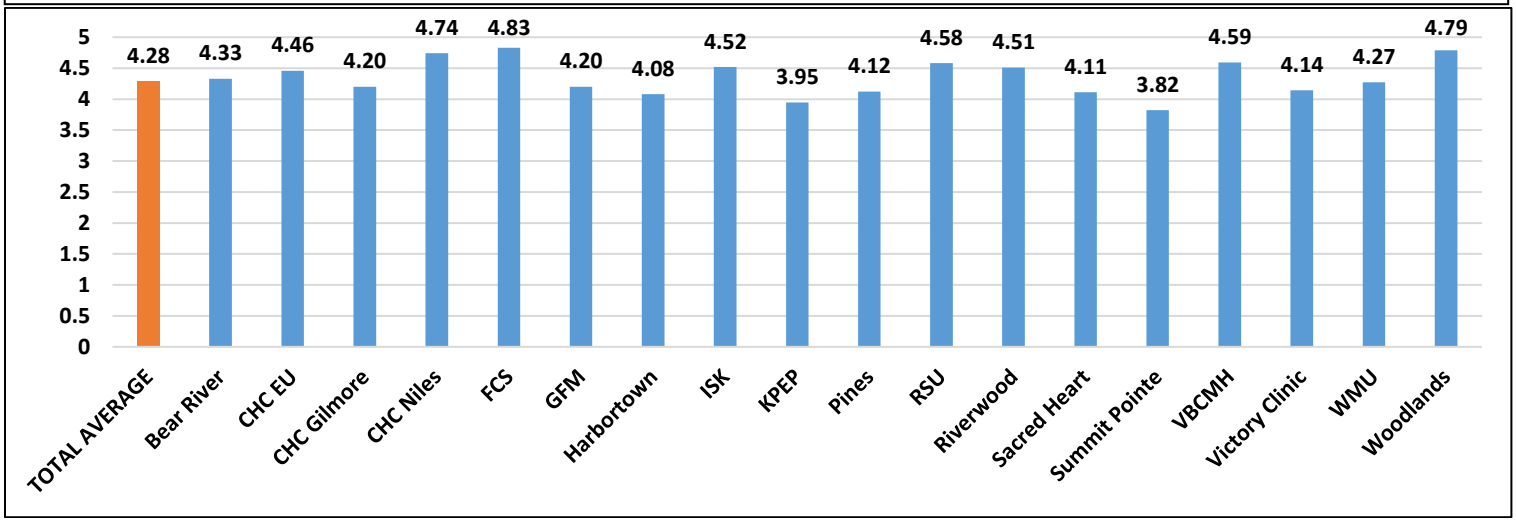
Consumer "In Agreement" Analysis



Surveys Completed by Provider

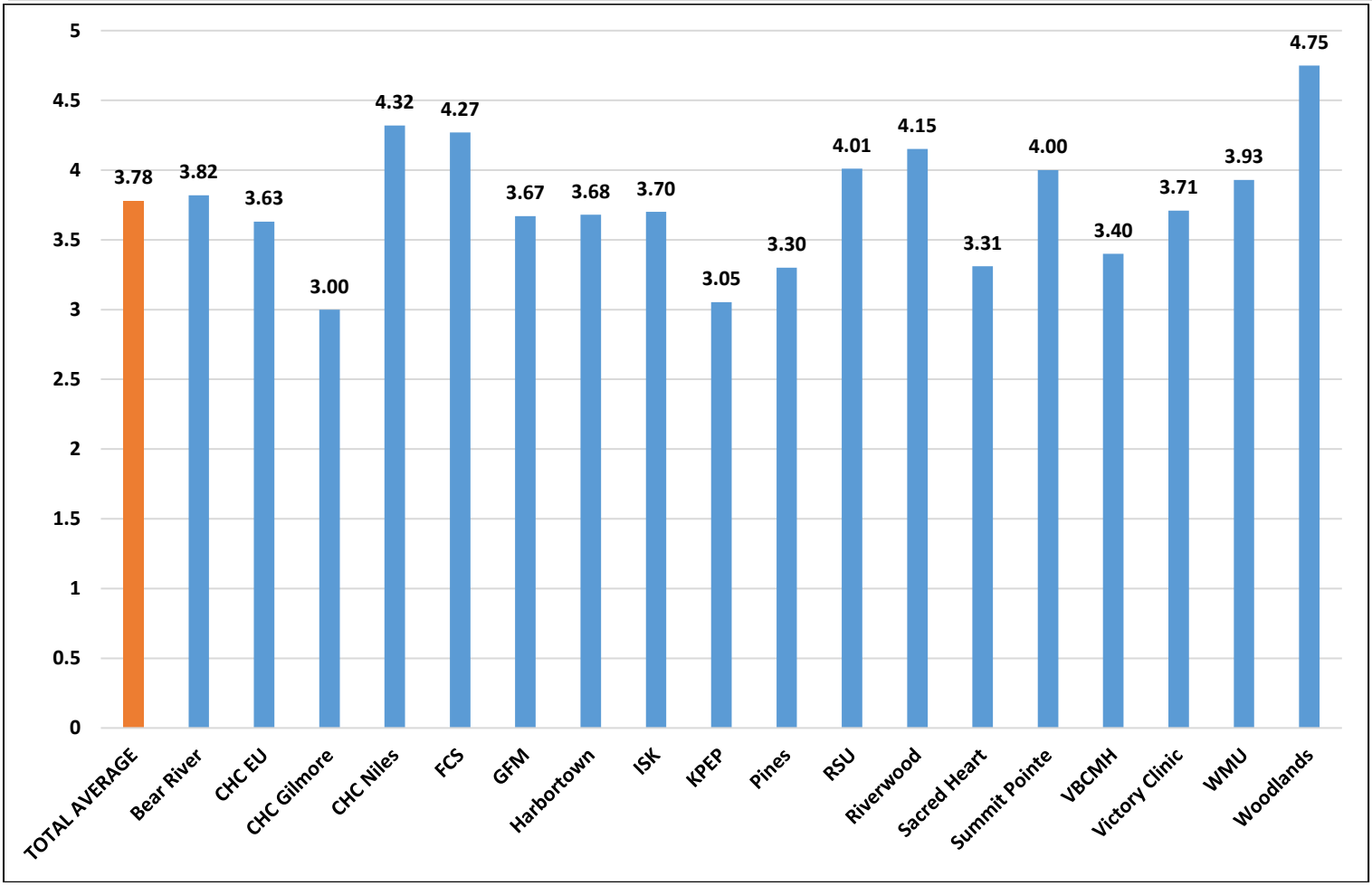


Life Goals 2020



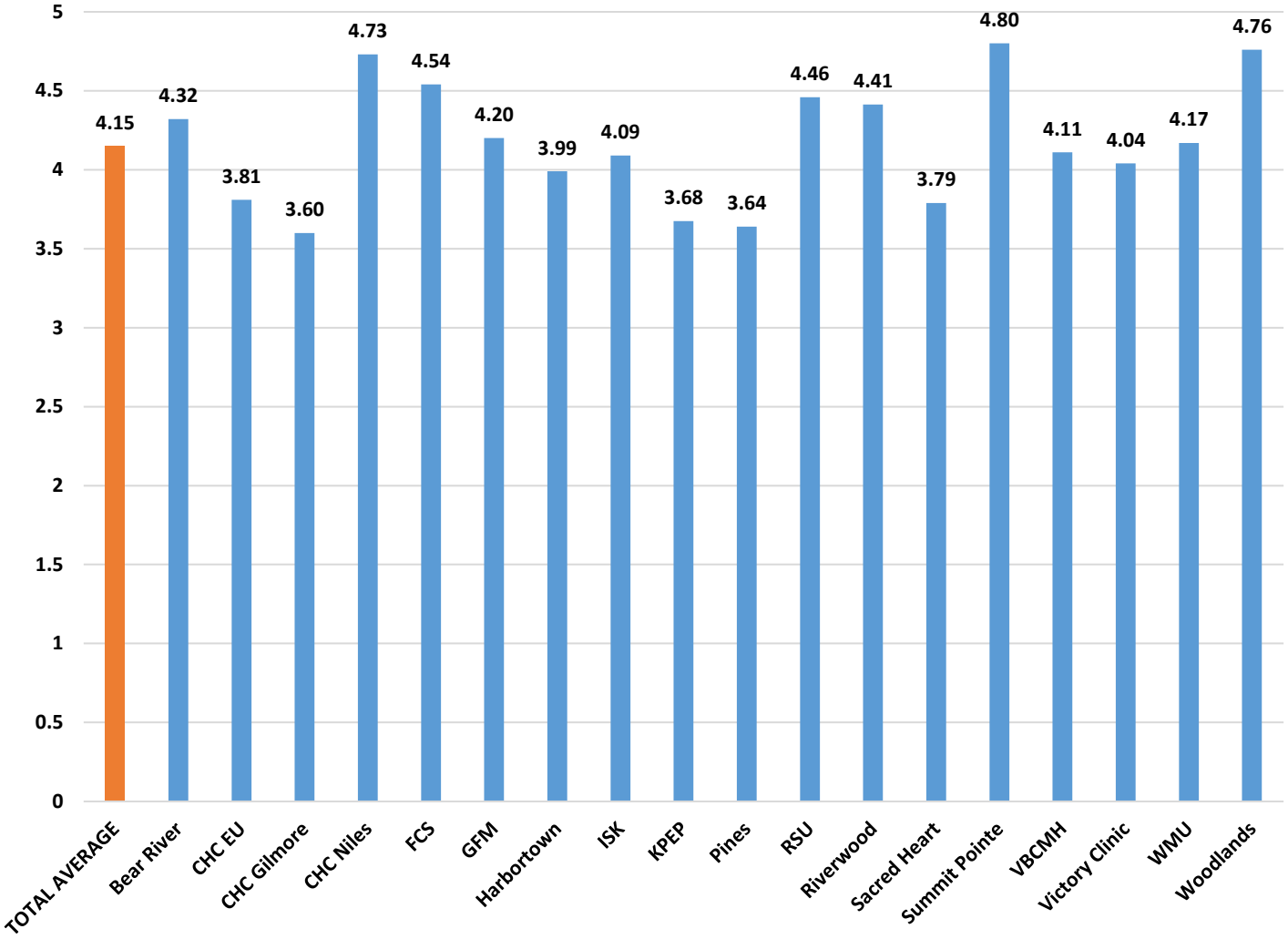
- **3. Staff encourage program participants to have hope and high expectations for their recovery.**
- **7. Staff believe in the ability of program participants to recover.**
- **8. Staff believe that program participants have the ability to manage their own symptoms.**
- **9. Staff believe that program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

Involvement 2020



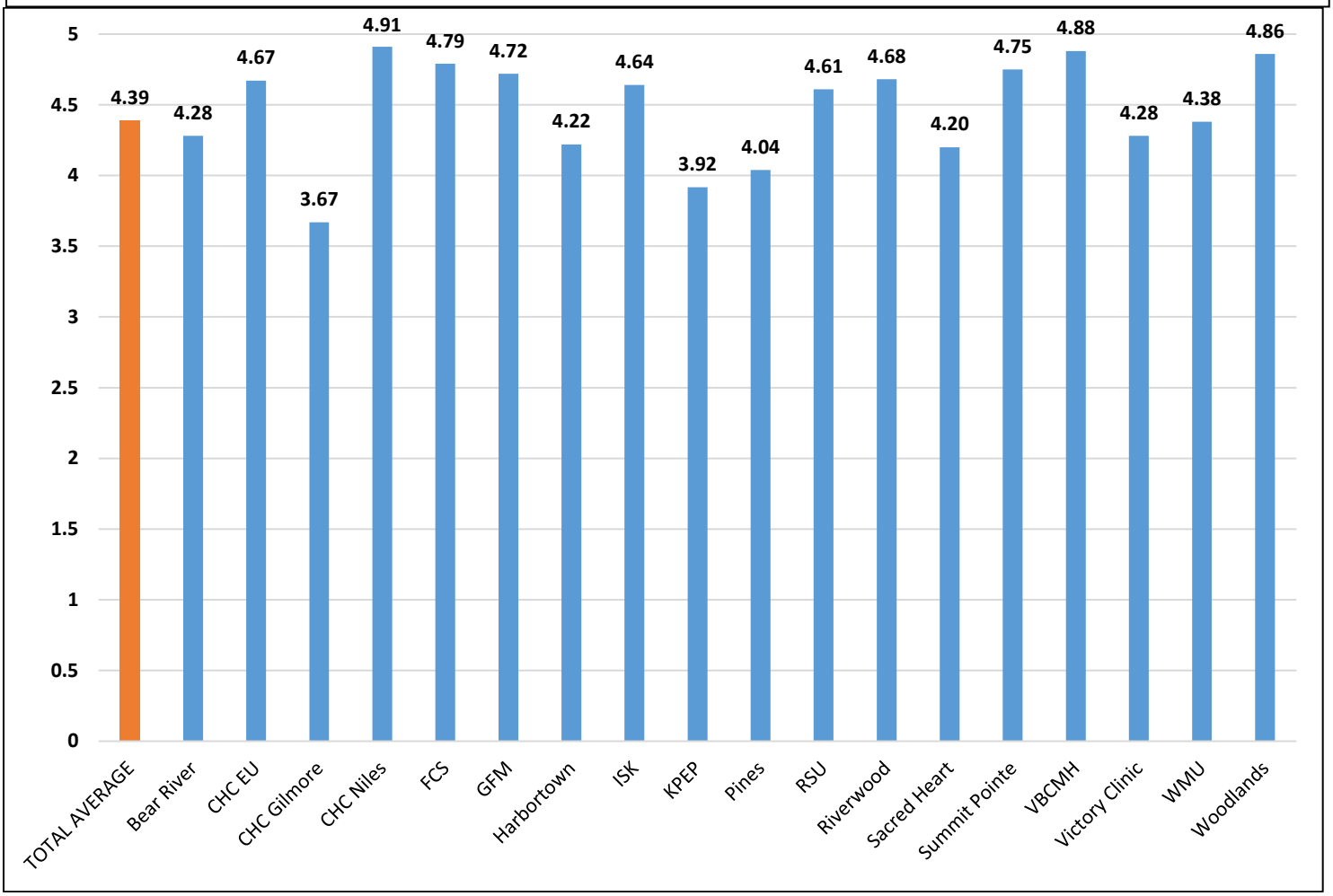
- **22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).**
- **23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.**
- **24. People in recovery are encouraged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

Diversity of Treatment 2020

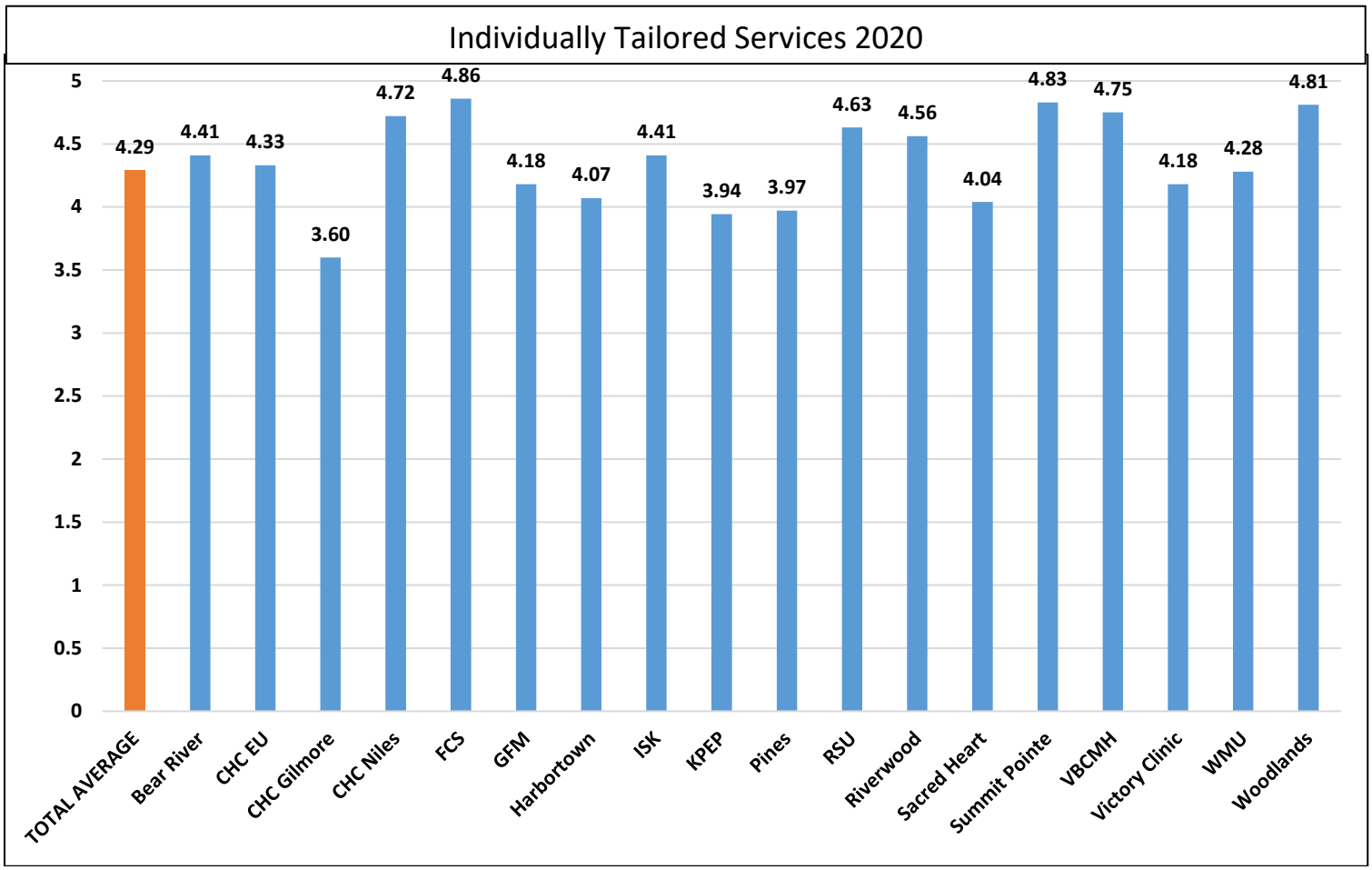


- **14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.**
- **15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.**
- **20. Staff actively introduce program participants to persons in recovery who 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.**

Choice 2020



- **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

RSA-r (Recovery Self-Assessment-revised) Survey was given to Medicaid & Block Grant SUD consumers to answer about the services they receive from their current provider. The survey consists of 32 questions and the answers were based on scale of 1-5 (1=strongly disagree to 5=strongly agree).
All questions were related to the following categories: Life Goals, Involvement, Diversity of Treatment, Choice, and Individually Tailored Services. The survey is 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 2020 RSA-r survey administration period was from 9/21/2020 to 11/23/2020.
For the 2020 process, SWMBH received total (482) surveys back, which was significantly less than what was seen with the 2019 response of (859) total surveys returned. (18) Different provider organizations participated in the 2020 survey process, which was 1 less than the 2019 participation; (19) provider organizations participated. SWMBH's analysis of the overall mean score *represented a +0.37 increase in comparison to 2019 scores*.
Consumers of substance abuse services complete the surveys, which were administered through their provider.

Identified Barriers

The current global pandemic influenced the number of surveys received. It also affected the Involvement category immensely, as providers were forced to close and turn to telehealth services. Additionally, providers were unable to offer services inviting their clients to get involved with their community due to the State of Michigan lockdown. Many of the other category scores were affected as well, including any questions that had to do with in-person treatment. Furthermore, the survey was released later in the year and over a holiday break whereby impacting the number of surveys received. Finally, the coding of the survey was done incorrectly which led to a lot of manual work – better coding needs to occur so that the surveys can be analyzed faster and more accurately.

Recommendations

The coding of the survey was done incorrectly which led to a lot of manual work and therefore a better coding needs to occur so that the surveys can be analyzed faster and more accurately. SWMBH is also making additional efforts to provide an easier to use electronic version of the survey to providers/consumers to complete during their office visits with their provider.

Sharing and Communication of Information To Consumers and Providers

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 2020 - December 2020	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

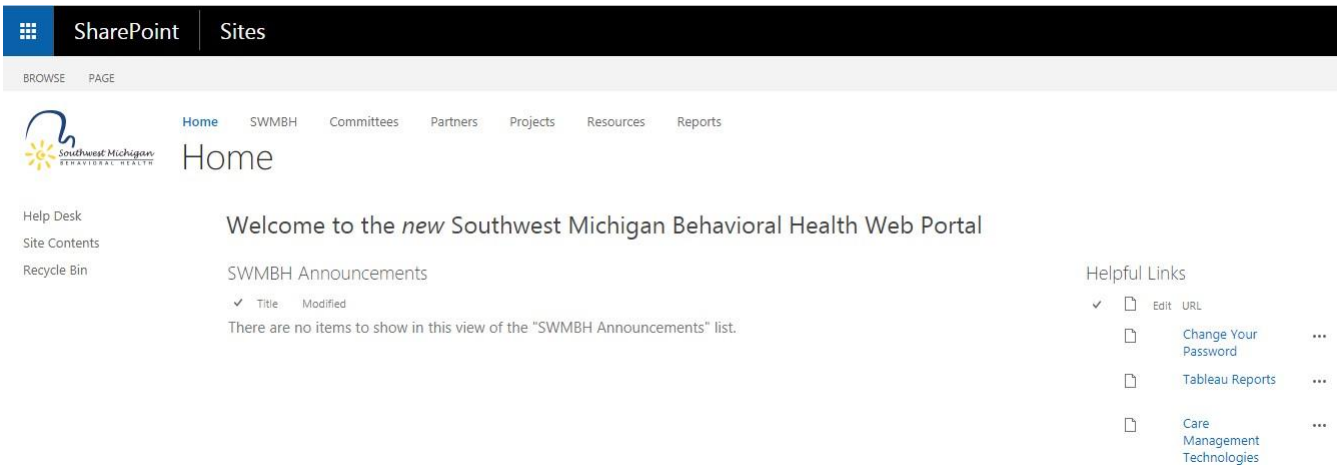
In late 2029 SWMBH formulated a website committee that meets monthly to discuss updates and proposed edits. Currently, each functional area has a designated team member who is responsible for implementing recommended updates. This process helps to keep information from getting outdated and ensures that 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. During 2020 to current, the SWMBH IT team continues to make improvements to the Portal. A recent improvement in 2020 now allows internal staff and CMHSP partners to reset their own passwords. This has saved significant IT time and resources.

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. Additionally, establishing permission levels for each access point is challenging and continue to take longer than anticipated thereby continuing to be a barrier.

Actions were taken to Improve Processes

In early 2020 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. Additionally, the user guide provides guidance on how to use each approved web-based communication tool, such as Zoom, Teams and Go-To-Meeting platforms.

During 2020 to current, the SWMBH IT team continues to make improvements to the Portal. A recent improvement in 2020 now allows internal staff and CMHSP partners to reset their own passwords. This has saved significant IT time and resources.

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. Additionally, explore the possibilities of creating navigation video tutorials for partners to access on resources such as SharePoint, SWMBH Website, Tableau, Provider Directory, Teams and Go-To-Meeting.

Communication with Physical Health and Behavioral Health Providers

Provider Communication Survey

Introduction:

- The survey was meant to assess information exchange and coordination of healthcare information between behavioral health (BH) and physical health (PH) providers.
- Findings will be used to guide planning of improvement initiatives and will be shared with interested stakeholders.

GOALS:

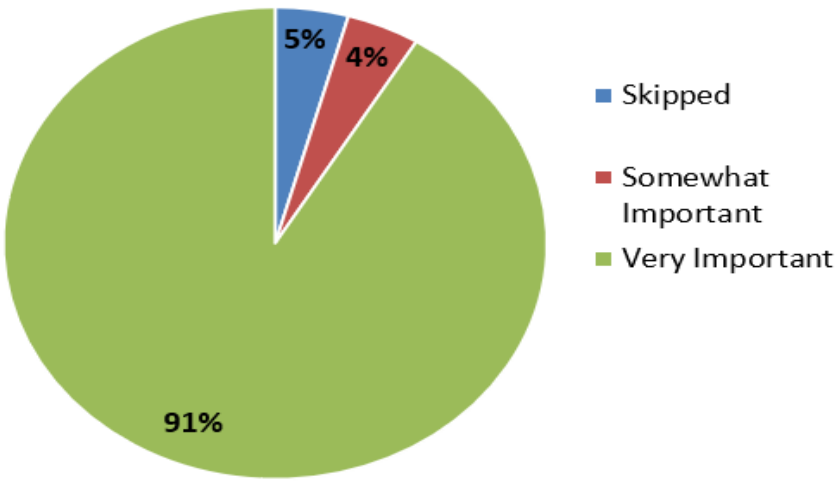
- Improve Patient Care through Provider Collaboration and Communication Strategy Enhancements.

Improve and Examine:

- Accuracy of the information
- Frequency of the information
- Sufficiency of the information
- Timeliness of the information

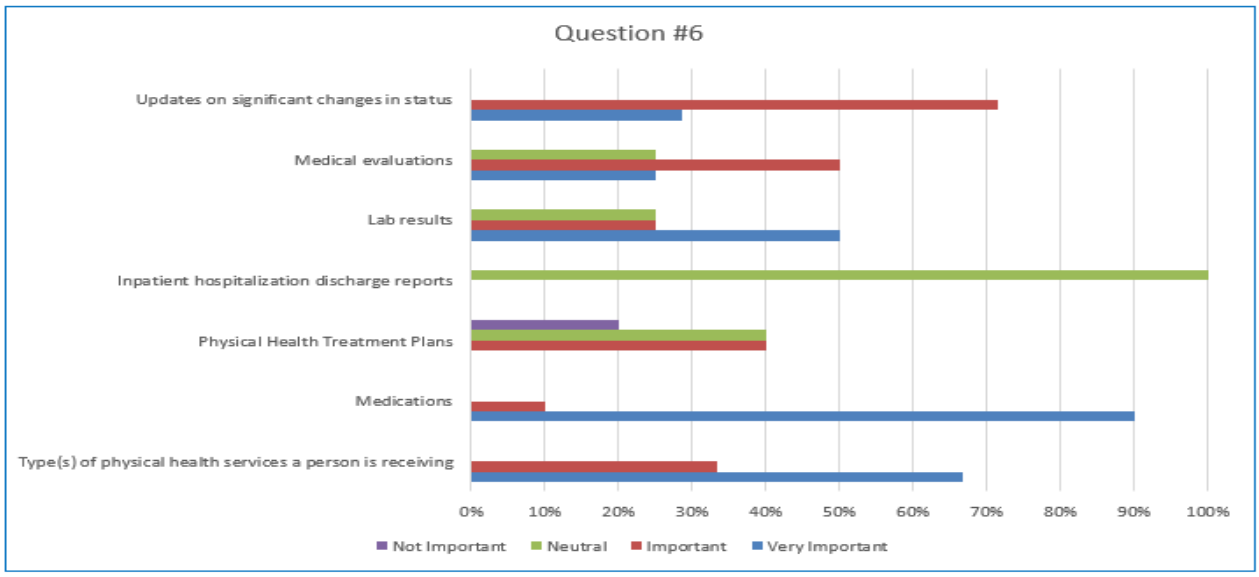
Provider Communication Survey

#4 Importance of Coordination of Patients' Behavioral Health Care



Provider Communication Survey Behavioral Health Providers

#6 Rate how important it is to you as a behavioral health provider to receive the following physical health treatment information regarding your members:



Provider Communication Survey Recommended Action to Improve Communication Between BH/PH Providers

Key Observations:

- 65% of BH Provider indicate they receive their patients PH information timely. (slide 38)
- 70% of BH Providers indicated there is PH information they needed but is not consistently provided. (slide 36)
- 34% of PH Providers felt they didn't have the information they needed to make referrals for BH treatment. (slide 24)
- 57% of PH Providers indicated they did not receive quality BH information on their patient in the past 6 months. (slide 9)

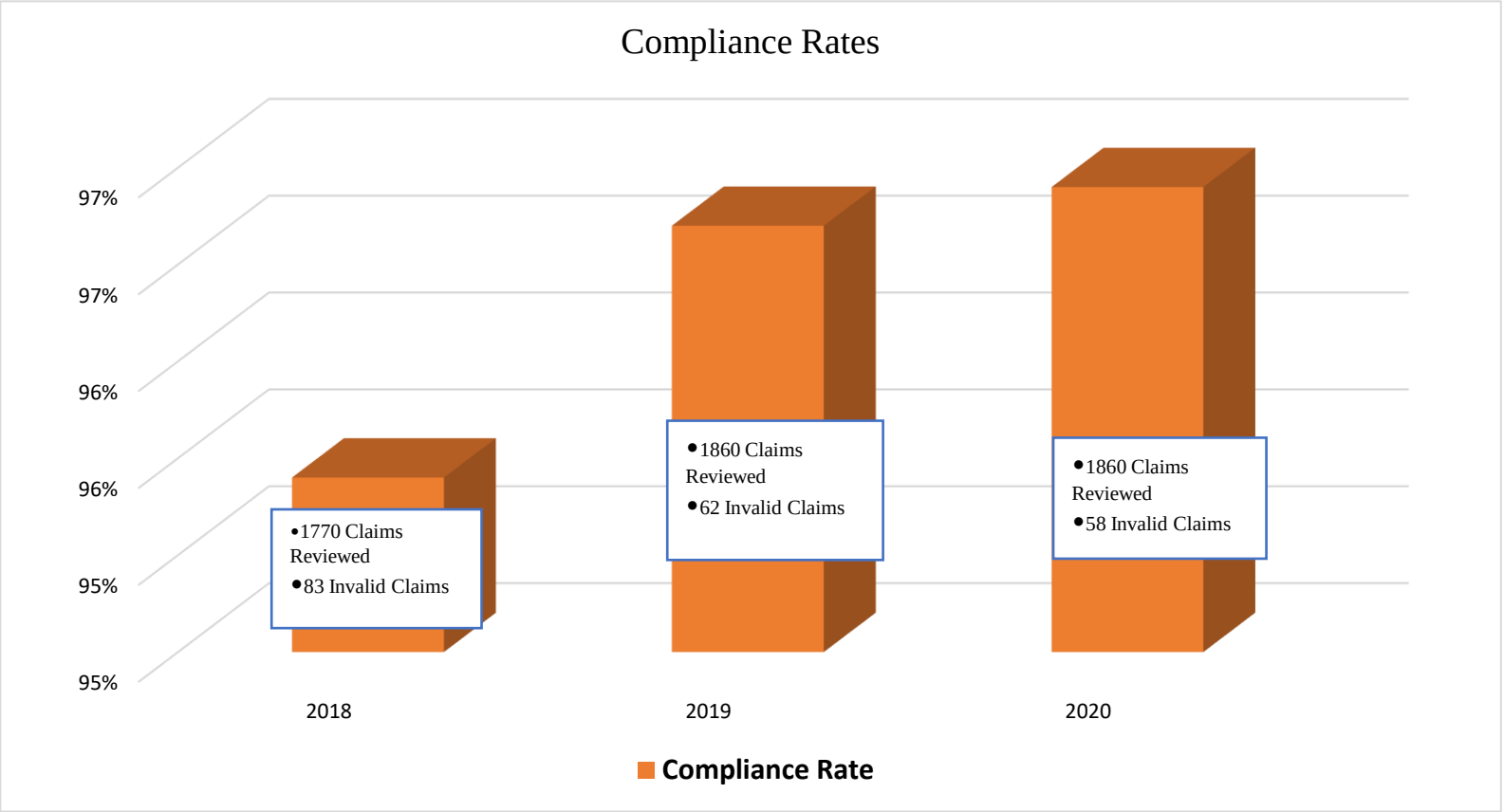
Next Steps:

- Access to electronic records for both BH/PH providers to determine what medications their patients are on.
- Formulate a check-list of critical BH/PH information Providers feel is most important to have in front of them, when treating their patients.

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 2019 – September 2020	QAPI Specialist QAPI Director Chief Compliance Officer	Annually

2020 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 was over 90%.This metric was removed from the 2020 Board Ends Metrics but is still closely being watched with routine analysis and presentations to the Regional Compliance Committee, Regional Operations Committee and the SWMBH Board.

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 2020 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:

ϖ. Was the person eligible for Medicaid coverage on the date of the service reviewed?
- **1 deficiency**

ϖι. Is the provided service eligible for payment under Medicaid?
- **0 deficiencies**

ϖιι. Is there a current treatment plan on file which covers the date of service?
- **23 deficiencies**

ϖιιι. Does the treatment plan contain a goal/objective/intervention for the service billed?
- **27 deficiencies**

ιξ. Is there documentation on file to support that the service was provided to the consumer?
- **27 deficiencies**

ξ. Was the service provided by a qualified practitioner and falls within the scope of the code billed/paid?
- **9 deficiencies**

ξι. 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.

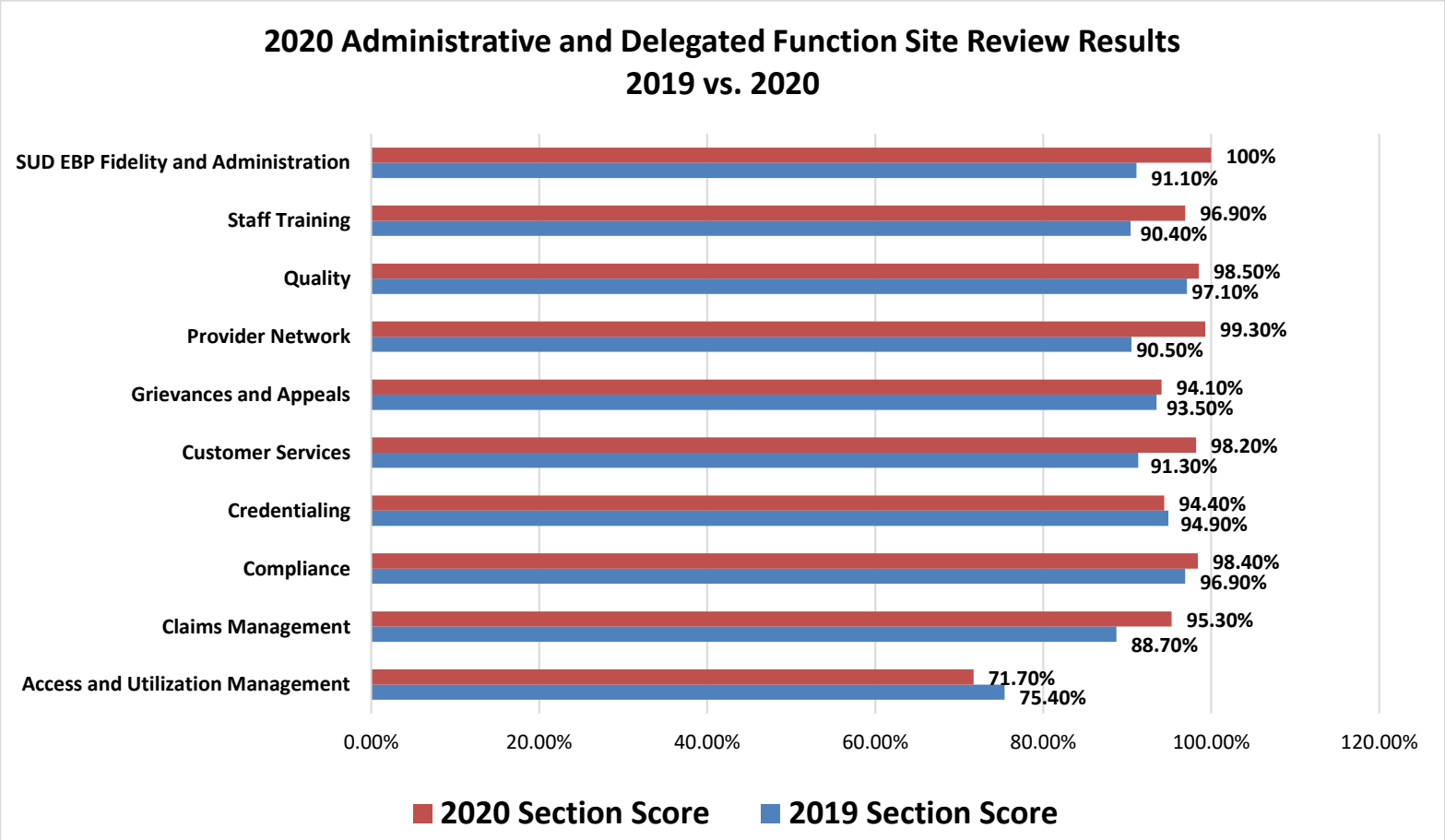
The deficiencies noted were regarding a treatment plan on file which covers the date of service and the treatment plan containing a goal/objective/intervention for the service billed. The majority of the deficiencies were due to the lack of timeliness in completing and validating the treatment plan with 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.

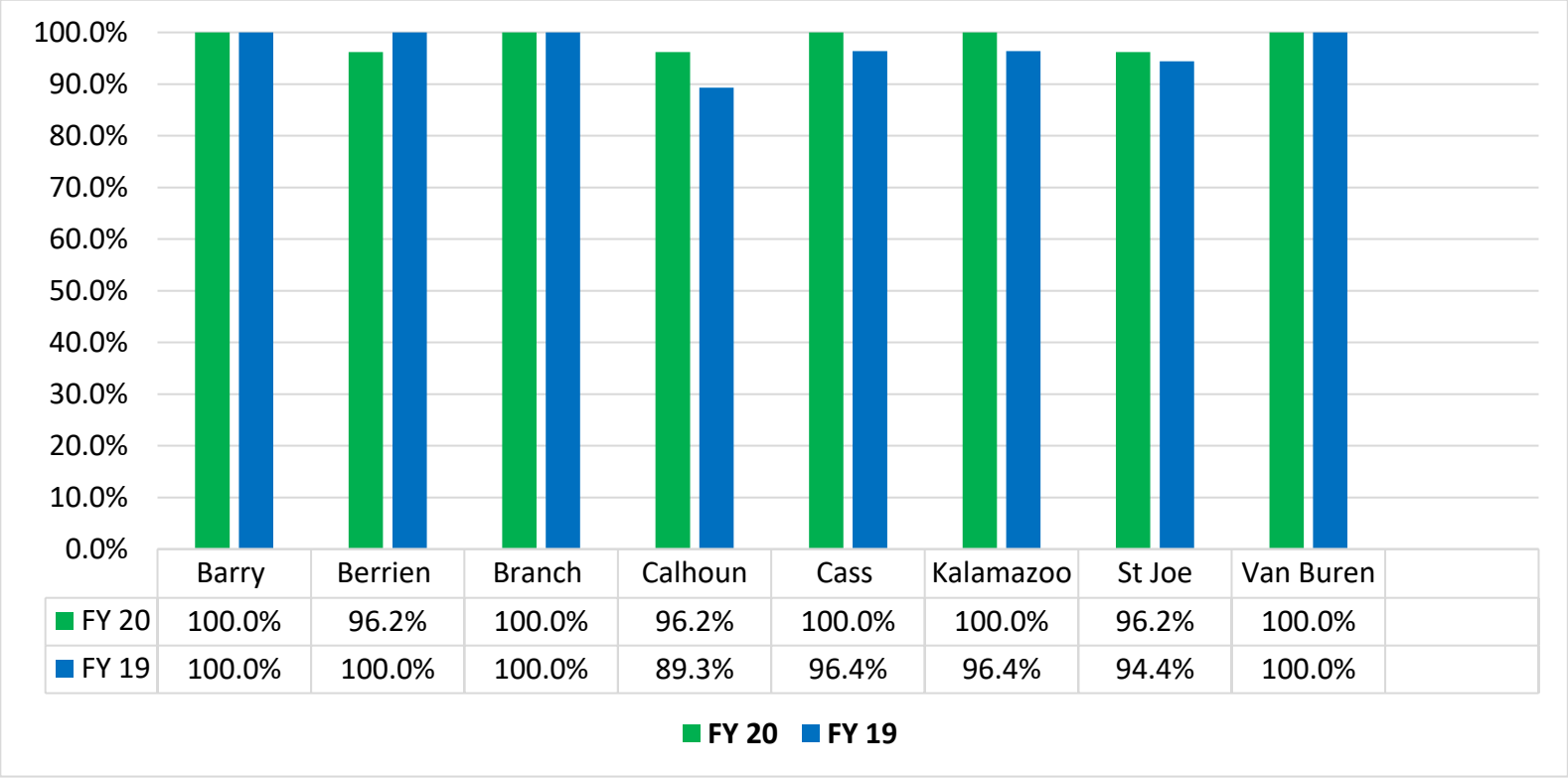
2020 Administrative and Delegated Function Site Review

Summary Score		
Standard	**2019 Section Score**	**2020 Section Score**
Access and Utilization Management	75.4%	71.7%
Claims Management	88.7%	95.3%
Compliance	96.9%	98.4%
Credentialing	94.9%	94.4%
Customer Services	91.3%	98.2%
Grievances and Appeals	93.5%	94.1%
Provider Network	90.5%	99.3%
Quality	97.1%	98.5%
Staff Training	90.4%	96.9%
SUD EBP Fidelity and Administration	91.1%	100%

- Red indicates Section Score decreased from 2019 Results.
- Green Indicates Section Score increased from 2019 Results.



2020 CMHSP Quality Program Review Results



	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St Joe	Van Buren
FY 20	100.0%	96.2%	100.0%	96.2%	100.0%	100.0%	96.2%	100.0%
FY 19	100.0%	100.0%	100.0%	89.3%	96.4%	96.4%	94.4%	100.0%

Results

Overall results show an improvement for 7/8 counties during the 2020 review process. However, 2/10 categories reviewed showed a decrease in the score, in comparison to 2019 site review scores. Those (2) categories are Access/UM and Credentialing. For purposes of this review, the overall quality review resulted in a +1.51% 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 -3.7% 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. The Credentialing review observed an overall .5% decrease across all categories measured. All other categories reviewed observed good improvements. It is important to note, that no categories observed a significant decrease in overall results in comparison to 2019 results.

Barriers

Covid-19 presented a significant barrier on completing the site reviews. Site reviews shifted to a remote virtual review, Opposed to the traditional on-site reviews the CMHSP's are used to. Overall, the process went very well.

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.
Additionally, SWMBH provide each CMHSP a Power Point summary of results before meeting with them for the Closing conference. This process worked very well and CMHSP's provided positive feedback. It also provided the CMHSP's a chance to formulate questions they had on each standard that was reviewed. SWMBH will plan to utilize this process improvement in 2021 and moving forward.

2020 SWMBH 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 monitoring/oversight for Regional performance indicators that are consistently out of compliance.	January 2020 – December 2020	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

2020 Health Services Advisory Group (HSAG) Performance Measure Validation Audit Results

The following report summarizes preliminary findings during the Health Services Advisory Group (HSAG) Performance Measure Validation Audit that took place on July 17, 2020, at Southwest Michigan Behavioral Health.

Results

*47/47 or **100%*** Of Total Elements Evaluated received a designation score of "Met," "Reportable," or "Accepted."

This meets the *successful completion of our 2020 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	10/10 – 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	10/10 – 100% Numerator and Denominator Elements Evaluated **"Met"** full compliance Standard.
Met **(new standard)**	11/11 – 100% New Indicator Readiness Review **"Met"** full compliance standards. (*PIHP's process to consolidate diversified files and to extract required information from the performance indicator repository are appropriate)*

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 the Chief Information Officer had extensive behavioral health backgrounds 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.

2020 Health Services Advisory Group (HSAG) External Quality Review Results

Audit Objectives

According to federal requirements located within the Code of Federal Regulations (CFR), 42 CFR §438.358, the state, its agent that is not a Medicaid prepaid inpatient health plan (PIHP), or an external quality review organization (EQRO) must conduct a review to determine a Medicaid PIHP's compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To comply with the federal requirements, the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration (BHDDA) contracted with Health Services Advisory Group, Inc. (HSAG) as its EQRO to conduct compliance monitoring reviews of the PIHPs.

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 – Summary of Results for the Three-Year Cycle of Compliance Reviews

Prior Years (SFY 2017–2018, SFY 2018–2019) and Current Year (SFY 2019–2020) Scores							
Compliance Monitoring Standard		Total # of Applicable Elements	Number of Elements				Total Compliance Score
			Prior Years		Current Year		
			M	*# CAPs*	*M*	*NM*	
I	QAPIP Plan and Structure	8	8	0	NA	NA	**100%**
II	Quality Measurement and Improvement	8	7	1	1	0	**100%**
III	Practice Guidelines	4	4	0	NA	NA	**100%**
IV	Staff Qualifications and Training	3	3	0	NA	NA	**100%**
V	Utilization Management	16	13	3	2	1	**94%**
VI	Customer Service	39	34	5	5	0	**100%**
VII	Grievance Process	26	21	5	5	0	**100%**
VI	Members' Rights and	13	13	0	NA	NA	**100%**

II	Protections						
IX	Subcontracts and Delegation	11	10	1	1	0	**100%**
X	Provider Network	12	12	0	NA	NA	**100%**
XI	Credentialing	9	5	4	3	1	**89%**

Prior Years (SFY 2017–2018, SFY 2018–2019) and Current Year (SFY 2019–2020) Scores							
Compliance Monitoring Standard		Total # of Applicable Elements	Number of Elements				Total Compliance Score
			Prior Years		Current Year		
			M	***# CAPs***	***M***	***NM***	
XII	Access and Availability	19	17	2	2	0	**100%**
XIII	Coordination of Care	11	11	0	NA	NA	**100%**
XIV	Appeals	54	47	7	7	0	**100%**
XV	Disclosure of Ownership, Control, and Criminal Convictions	14	14	0	NA	NA	**100%**
XVI	Confidentiality of Health Information	10	10	0	NA	NA	**100%**
XVII	Management Information Systems	12	12	0	NA	NA	**100%**
	Total	**269**	**241**	**28**	**26**	**2**	**99%**

M = *Met*; ***NM*** = *Not Met*; ***NA*** = *Not Applicable*

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a designation of *NA*. **Prior Years:** The total number of elements within each standard that achieved a score of *Met* or required a CAP in either the SFY 2017–2018 or SFY 2018–2019 reviews.

Number of Elements: The number of elements that required a CAP in either the SFY 2017–2018 or SFY 2018–2019 reviews that received a score of *Met* or *Not Met* during the SFY 2019–2020 CAP review.

Total Compliance Score: Elements that received a score of *Met* during the SFY 2019–2020 CAP review plus the elements that received a score of *Met* in either the SFY 2017–2018 or SFY 2018–2019 reviews were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Through the combined compliance review activities, **Southwest Michigan Behavioral Health** achieved full compliance in 15 of the 17 standards, demonstrating most program areas had the necessary policies, procedures, and initiatives in place to carry out the required functions of the contract. The remaining two standards have continued opportunities for improvement.

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 15/17 of the 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 2 Standards, Utilization Management and Credentialing, received corrective action plans that were *successfully met*.

Southwest Michigan Behavioral Health demonstrated compliance in 267 of 269 elements, with an overall compliance score of 99 percent, indicating that all program areas had the necessary policies, procedures, and initiatives in place to carry out required functions of the contract. In contrast, this was the highest score achieved out of the 10 Michigan PIHP's.

Next Steps and Follow-up

In consultation with MDHHS, HSAG is currently determining what the next Audit cycle will look like. SWMBH will continue to work with its CMHSP partners to strengthen its programs and service delivery models to maintain full compliance against contractual requirements and the Medicaid Managed Care regulations.

2019-2020 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.

STATE OF MICHIGAN
GRETCHEN WHITMER, GOVERNOR
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING
ROBERT GORDON, DIRECTOR

FROM: Belinda Hawks, Director
Division of Quality Management & Planning
Bureau of Community Based Services

SUBJECT: 1915(c) and Substance Use Disorder Site Review

On behalf of the site review team, I would like to thank you and your staff for the outstanding assistance provided during the site review on June 3, 2019 – June 28, 2019. As you know, the intent of this review was to provide an opportunity for training and consultation, and to provide you with feedback in meeting service delivery requirements for the 1915(c) waivers.

Enclosed are the HSW and SUD Reports. The SUD Protocol was fully compliant.

2020 Performance Bonus Incentive Program (PBIP) Results

Per MDHHS contractual obligations/requirements (section; 8.4.2.1.1 and 8.4.2.1.2) Southwest Michigan Behavioral Health has submitted its PBIP report on November 13, 2020, summarizing the efforts and performance in the areas of: Comprehensive Care, Patient Centered, Coordinated Care, Accessible Services and Quality and Safety of Care. The following represent the primary results of those reports, as reviewed by MDHHS.

This communication serves as the consultation draft review response to your PIHP regarding the FY2020 performance bonus, contract section 8.4.2. Scoring is based on PIHP/MHP Joint Metrics and PIHP-only deliverables. Your PIHP has earned full points in both areas.

FY20 Total .75 Performance Bonus Incentive		
	Total $ Available (.75 withhold)	**Total Withhold Unearned**
SWMBH	$ 2,066,079.90	$0.00

PIHP/MHP Joint Metrics

Joint metrics with the MHPs included 1) FUH measure performance, and 2) implementation of joint care management processes. The final Follow-up after Hospitalization for Mental Illness within 30 Days (FUH) measure rates for the 1/1/2019-12/31/2019 measurement period were posted in CC360 in July 2020. Points earned out of 65 total points available are displayed in the table below.

Follow-up after Hospitalization for Mental Illness within 30 days CY2019 (65 points)								
	Scored 6-20 Combos	Scored 6-20 Combos Meeting Standard	Scored 21-65 Combos	Scored 21-65 Combos Meeting Standard	Total Scored Combos	Points per Combo	Total Combos Meeting Standard	**Score (maximum = 65)**
SWMBH	2	2	6	6	8	8.13	8	**65**

Quarterly, beneficiaries for whom CC360 joint care plans have been developed are randomly selected for review by MDHHS staff. This review is used to score the implementation of joint care management processes portion of the performance bonus. Points earned out of 35 total points available are displayed in the table below.

Joint Care Management Processes (35 points)	
	Joint care mgmt processes Yes = 35, No = 0
SWMBH	35

Joint metric results are represented below in dollar amounts.

PIHP Joint MHP Metric Score (100 points)				
	Score	**Score Converted to Percentage**	**Joint Metric Total $ Available**	**Joint Metric Earned**
SWMBH	**100**	**100%**	$1,033,039.95	$1,033,039.95

MI Health Link and Integrated Care Organization Audit Results

Aetna Claims Delegation Audit

Review Period: 7/1/2020 through 9/30/2020

Summary of Claims Audit Results: 100% Compliance Score

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

SECTION V - OPERATIONAL and PERFORMANCE COMPLIANCE SUMMARY:

Operational Compliance By Section:	Compliance Level	Compliance Score
Section I - Claim Department Management:	Full	5
Section II - Claim Processing:	Full	5
Section III - Claim System Capabilities:	Full	5
Overall Operational Compliance:	**Full**	**15**
Performance Compliance - Section IV:	**Pass**	

Legend:
Operational Compliance
Full Compliance - Score 15
Significant Compliance - Score 11 - 14
Partial Compliance - Score 8 - 10
Minimal Compliance - Score 5 - 7
Non Compliance - Score Under 5
Performance Compliance
PASS / FAIL - Benchmark = 95%

Auditor Comments and Summary of Results:

b. The annual claims desk audit review was conducted and finalized on 11/18/2020
c. All of the claim documents reviewed were summitted by SWMBH through the Aetna FTP website.
d. There was always a SWMBH staff member available to answer questions, and they did a great job.
e. There were no issues noted, or findings pointed out during the review.
f. The next audit will be conducted during the 3rd quarter of 2021.

2020 Aetna Delegated Utilization Management Oversight Audit

Review Period: 1/16/2020 through 7/1/2020

Summary of Utilization Management Audit Results**: 100% Compliance**

CREDENTIALING AUDIT

Auditor: Loretta Coffman

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

UTILIZATION MANAGEMENT AUDIT

Auditor: Cheryl Ford

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

GRIEVANCE AND APPEALS AUDIT

Auditor: Rachel Godwin

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	Met
2. Meet timeframes for Appeals and Grievance as it applies to Providers	Met
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 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

2020 Meridian Delegated Credentialing Audit

Review Period: 1/1/2020 through 9/30/2020

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 2021.

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 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 QAPI Effectiveness Review/Evaluation findings 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 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, a sound level of care and care management practices, implementation of evidence-based clinical practices, promotion of recovery, self-determination, the 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, responsive to the community, family, and individual needs. The entry process must be transparent, readily available, and well known to all constituents. Information, assessment, referral, and linkage capacity must be readily and seamlessly accessible to be effective. 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 dollars and maximization of equity across beneficiaries. As a steward of managing taxpayer dollars, SWMBH is committed to identifying, developing, and using 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 improvement areas. 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 various member and stakeholder surveys to evaluate the UM Program's effectiveness. 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 and 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. 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, and MHL Plan members.

Behavioral Healthcare Practitioner Involvement

The SWMBH Utilization Management Program shall operate under the oversight of the SWMBH Medical Director and the 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

2020 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 the 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 2019 – September 2020	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 2020

Over and underutilization

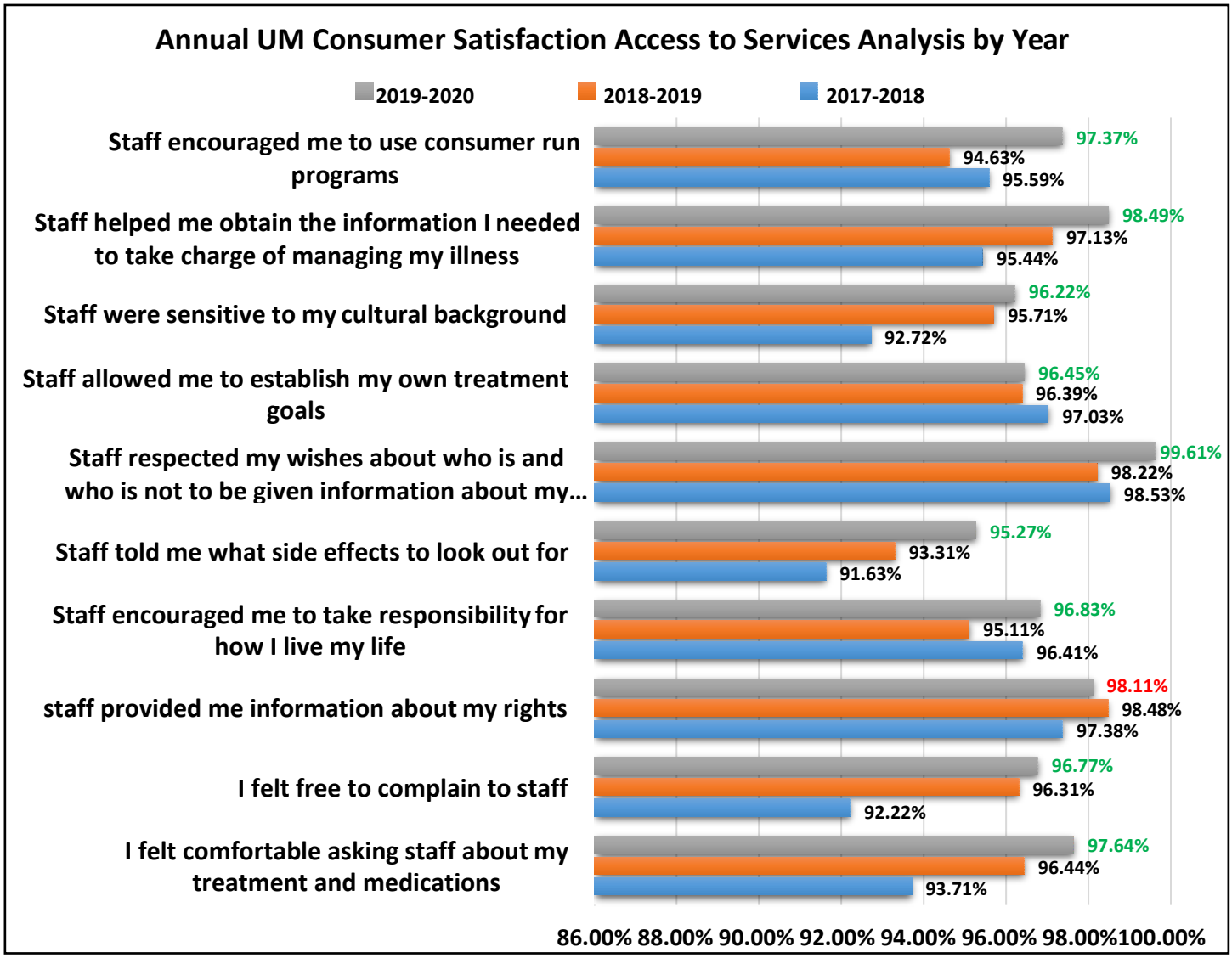
- Outlier Management
  - ✓ Tools for monitoring analyzing and addressing outliers. SWMBH's performance indicators, service utilization data, and cost analysis reports.
- Access Standards
- ❖ The percent of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom 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%)

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.

2020 UM Customer Survey Analysis

Survey Description: During November and December 2020, the Mental Health Statistic Improvement Project (MHSIP) survey was administered (through telephone interviews, Survey Monkey and random probability sampling) to 1243 consumers who received Mental Health authorization and support through Southwest Michigan Behavioral Health and Services through our CMHSP partners from April through August 2020. In observation, the current results – representing consumer feedback received from 332 consumers enrolled in the MI Health Link (Dual Eligible) program- 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 last 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.

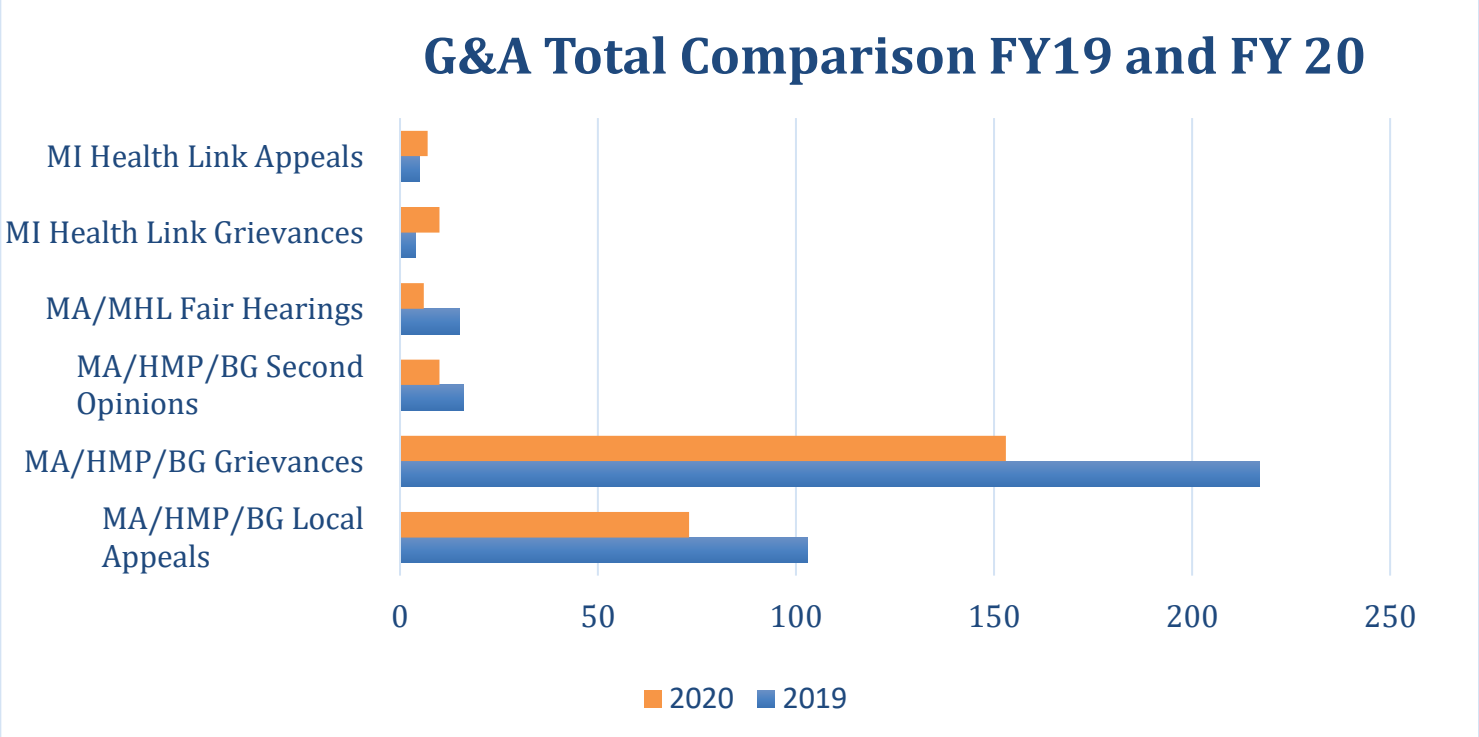
Monitoring the Customer Service Complaint Tracking System 2020

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 2019 – September 2020	QAPI Specialist QAPI Director Chief Compliance Officer and Director of Provider Network Management Customer Service Manager Chief Administrative Officer	Quarterly

2020 Grievances and Appeals

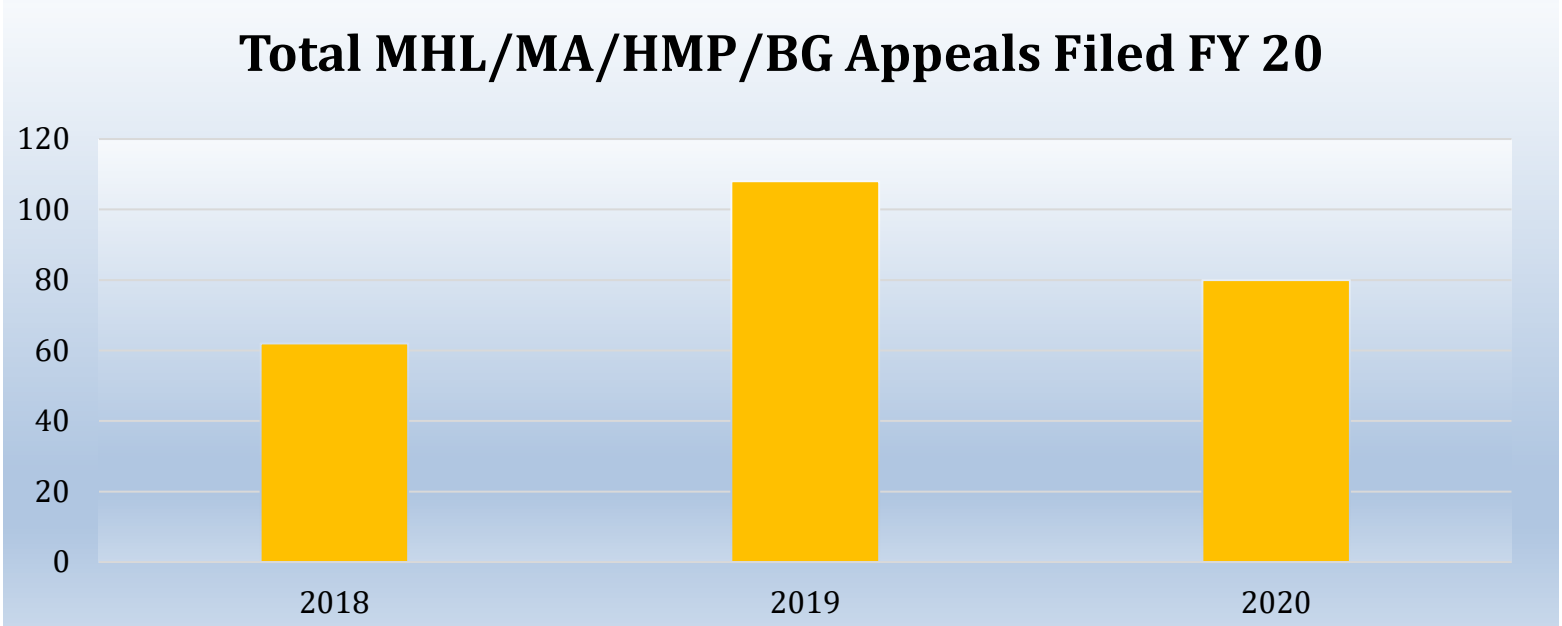
SWMBH REGIONAL GRIEVANCE TOTALS (*MHL/MA/HMP/BG*)
FY 2019 - 2020

Category	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Total
Access to Services	6	2	3	5	16
Attitude and Service	26	19	20	19	84
Quality of Care	16	14	6	14	50
Quality of Office Site	2	1	0	0	3
Grand Total	50	36	29	38	153



SWMBH REGIONAL APPEAL TOTALS (*MHL, MA, HMP, BG*)
FY 2019-2020

Category	**Qtr. 1**	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**	Total
Affirmed	9	13	9	7	38
Reversed	10	10	3	6	29
Split Resolution	1	1		1	3
Withdrawn/Dismissed	1	4	2	3	10
Grand Total	**21**	**28**	**14**	**17**	80

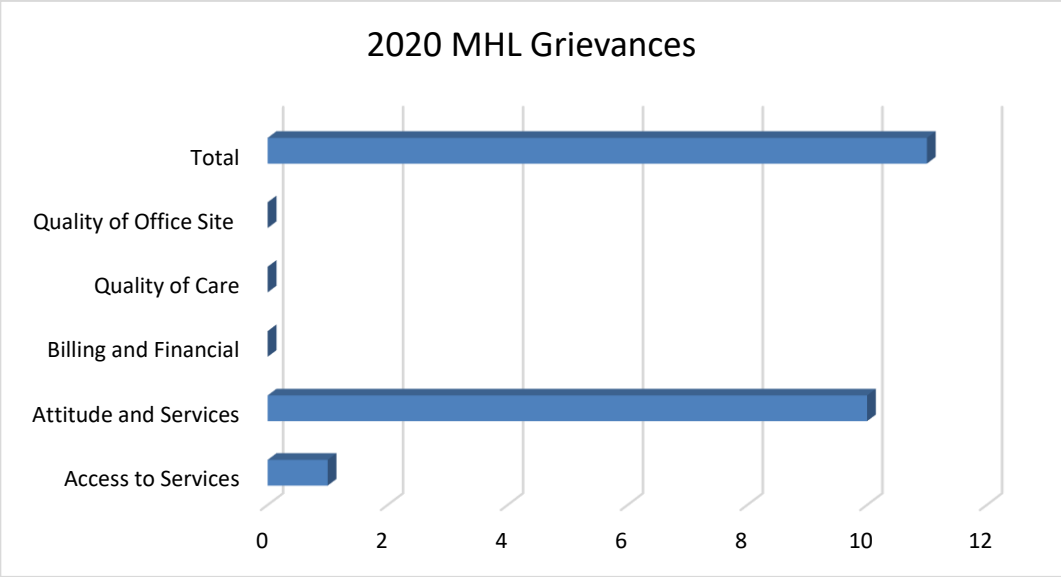


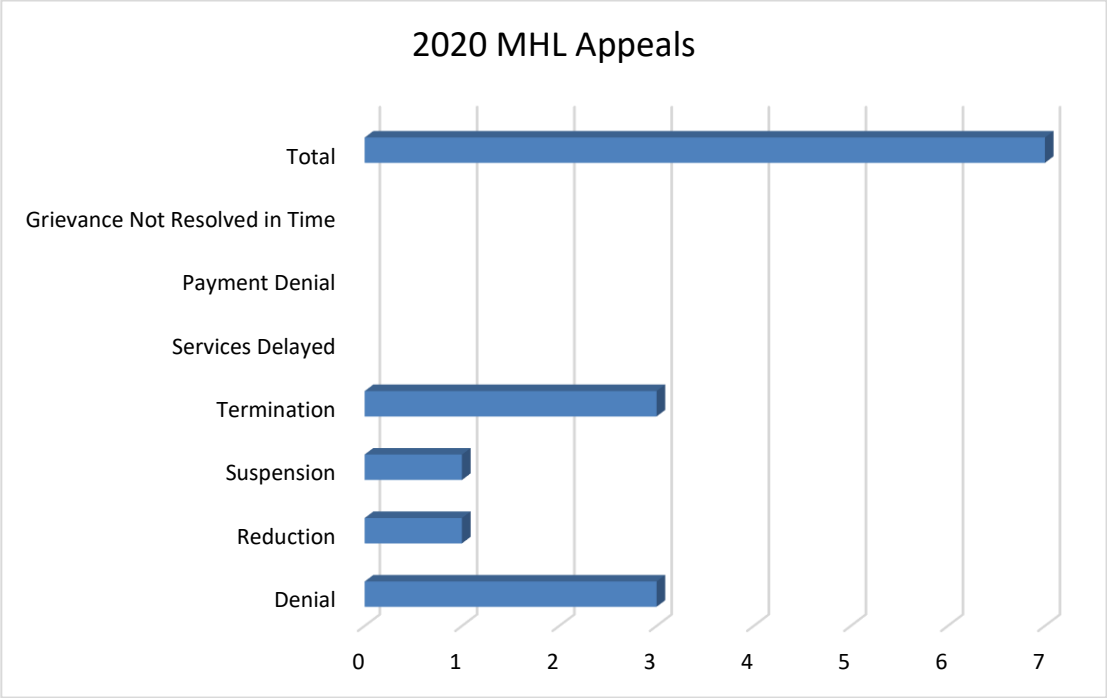
Goals for FY 2021

- Complete the NCQA Re-Accreditation successfully for Utilization Management and Rights and Responsibilities.
- Advance Directives – Create and update educational and training materials related to Advance Directives.
- Mediation Process: Ensure region is following mediation practices according to the Michigan Mental Health Code.
- Independent Facilitation: Collaborate and participate with TBD Solutions and Building Better Lives Project to increase awareness and availability of Independent Facilitators within the region by:
- Increase communication options to ensure access to customer service offices and functions throughout the region.

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 2019 – September 2020	QAPI Specialist QAPI Director Chief Compliance Officer Customer Service Manager Chief Operations Officer Provider Network Director	Quarterly

MI Health Link Analysis on Member Complaint Data





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.

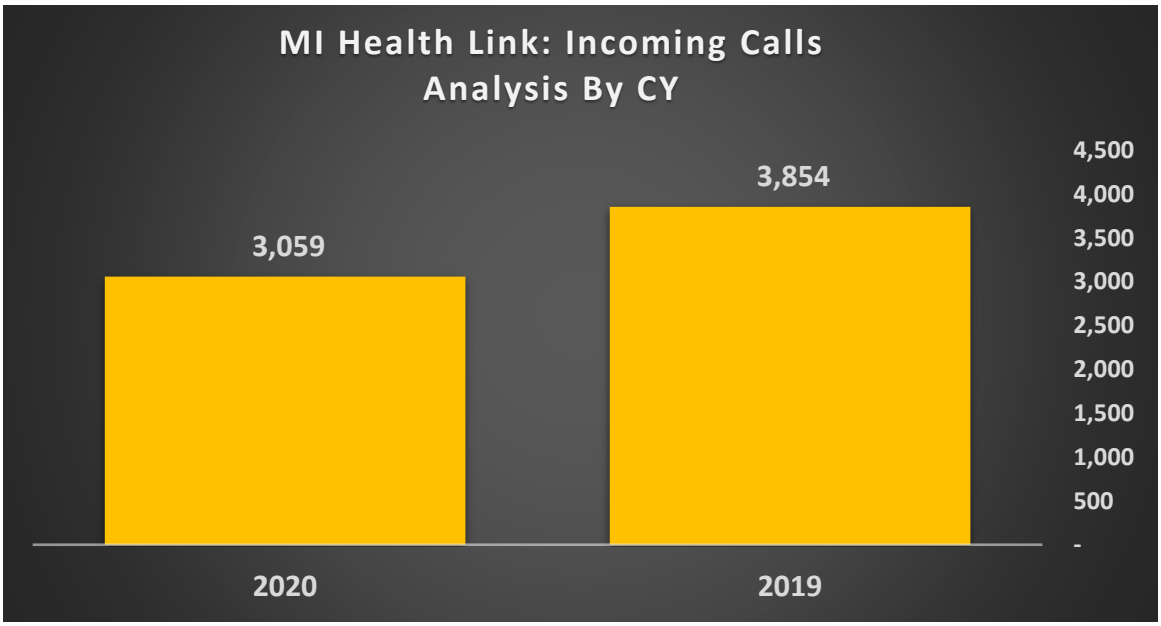
Providers administer the RSA-R survey. Several provider-based surveys required by NCQA exist between the mental health and primary care providers regarding how they receive collaborative information from each other. SWMBH also administers an online survey about access to care.

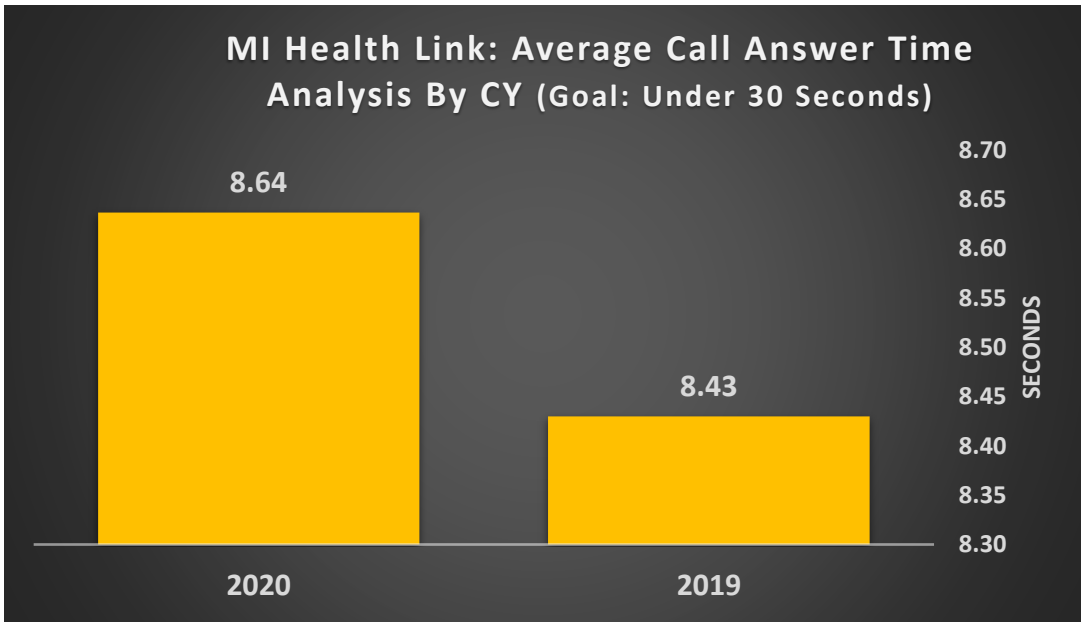
When surveys are completed, SWMBH follows a validation and review process with internal QAPI team members, Quality Management Committee, Regional Utilization Management and Clinical Practices Committee, and the Consumer Advisory Committee. Survey results, including narrative feedback, are given to each 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.

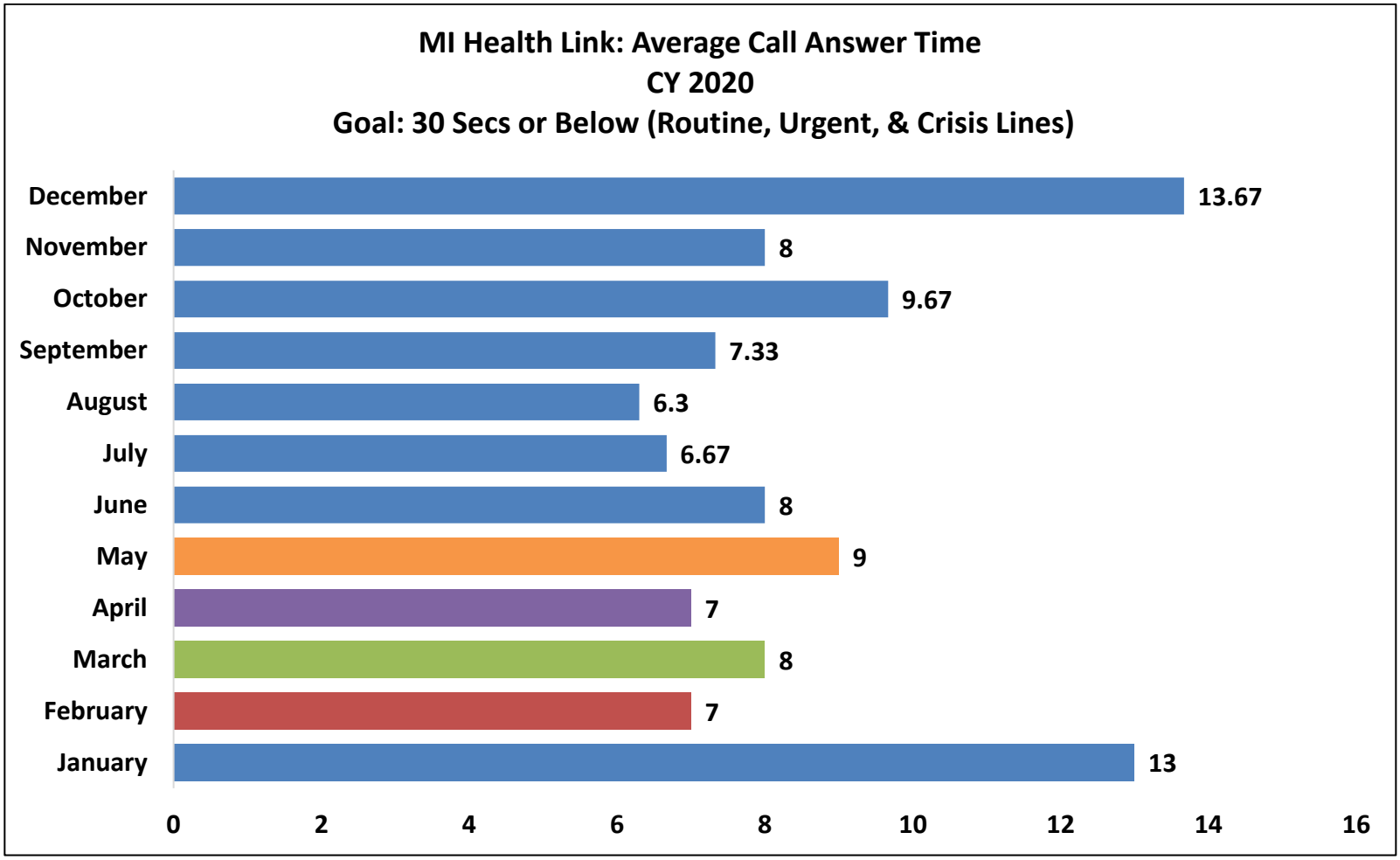
2020 Call Center Data Analysis

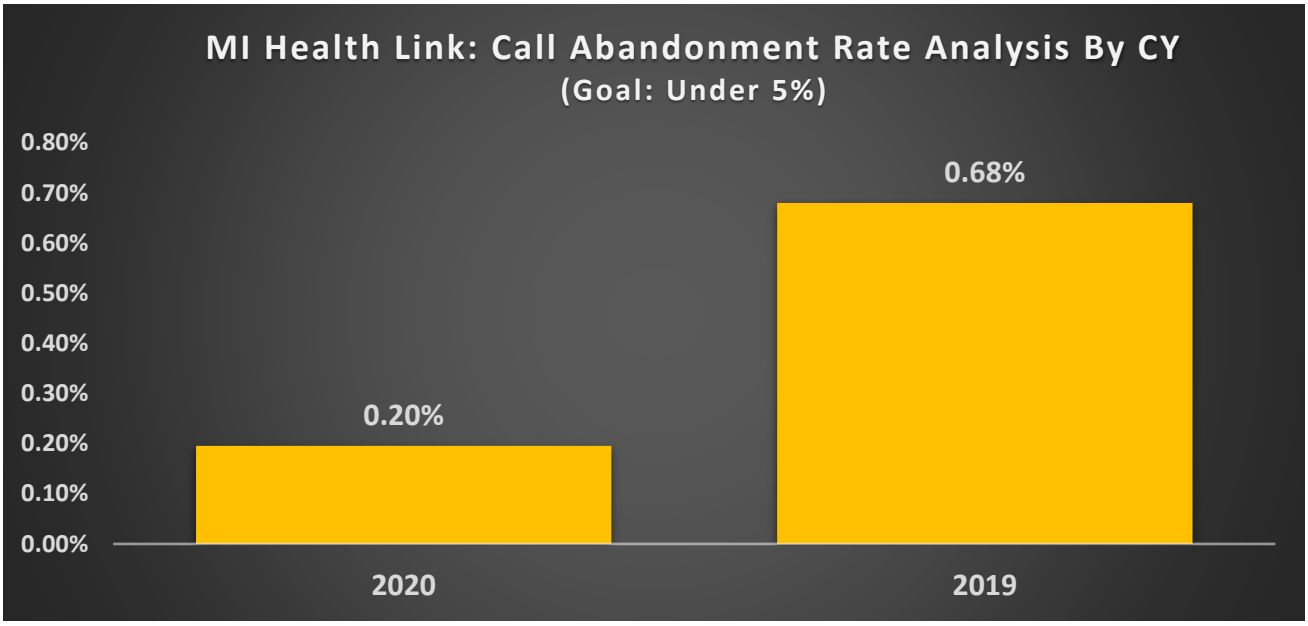
Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Call Center Monitoring (SWMBH reporting) for MI Health Link Business Line	➢ Ensure that a call center monitoring plan is in place ➢ Provide routine quality assurance audits. ➢ Random (live) Monitoring of calls for quality Assurance. ✓ Tracking 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 96.25% performance rate scoring criteria 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 2020 – December 2020	QAPI Specialist QAPI Director Customer Service Manager Chief Operations Officer Utilization Manager Director of Clinical Quality or Medical Director Consultant	Monthly

SWMBH 2020 MI Health Link Call Center Data Analysis




MI Health Link: Average Call Answer Time
Analysis By CY (Goal: Under 30 Seconds)
8.64
8.43
8.70
8.65
8.60
8.55
8.50
8.45
8.40
8.35
8.30
SECONDS
2020
2019


MI Health Link: Average Call Answer Time
CY 2020
Goal: 30 Secs or Below (Routine, Urgent, & Crisis Lines)
December
13.67
November
8
October
9.67
September
7.33
August
6.3
July
6.67
June
8
May
9
April
7
March
8
February
7
January
13
0
2
4
6
8
10
12
14
16



Objective

The Quality Improvement Department is primarily responsible for overseeing and managing 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 2020. Please find the current breakdown of call metric averages for 2020:

- Call Abandonment Rate: 0.20%
- Call Answer Time: 8.64 seconds
- Incoming Calls for 2020: 3059
- Total Number of Incoming Calls for 2019: 3,854

Identified Barriers

Evaluation of Call Monitoring and Calibration Process during vender transition.

Recommendations

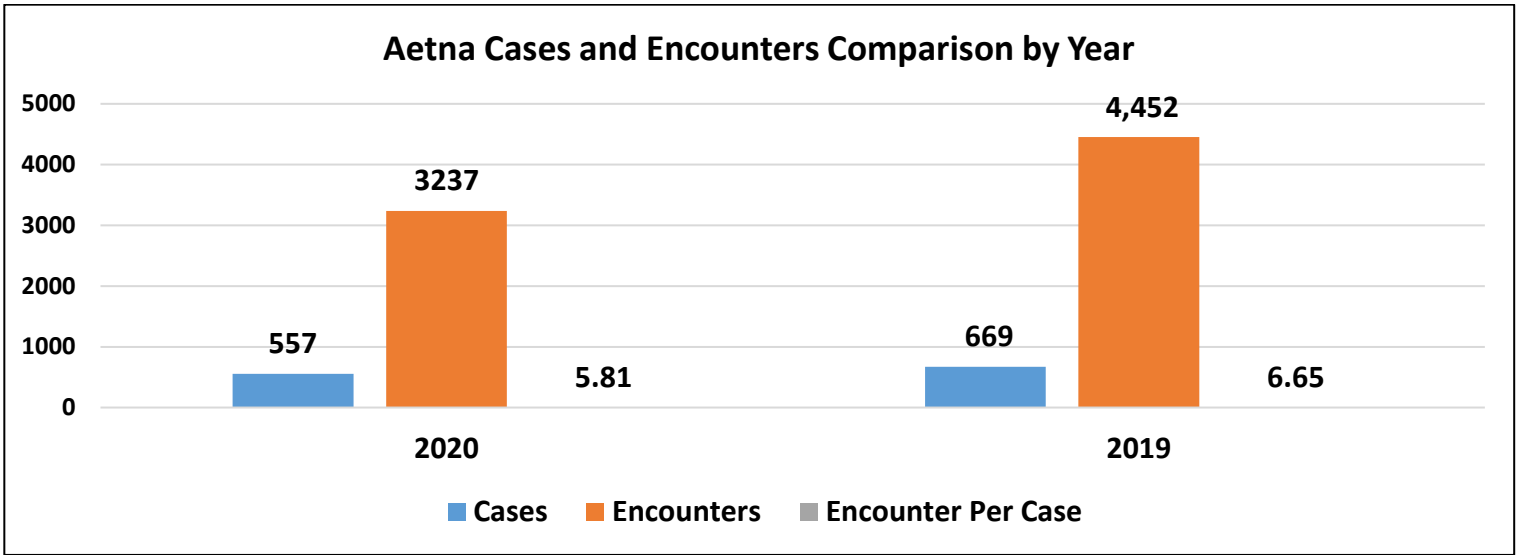
Calibration ensures that all SWMBH clinical staff, who have been deemed appropriate to engage in monitoring activities, can rate call center staff interactions consistently and fairly. Calibration will occur on an annual basis and/or when a new clinical staff member is designated to perform monitoring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

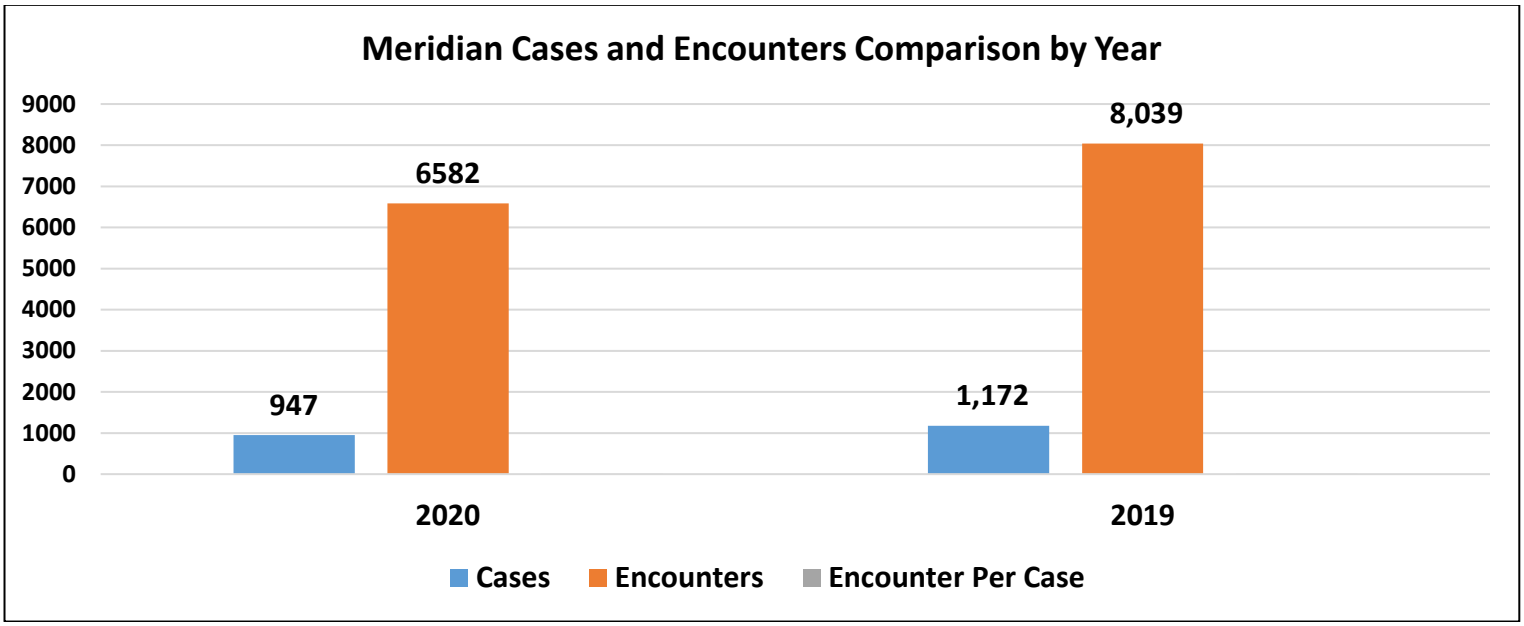
Enrollment and Eligibility Breakdown in the MI Health Link Demonstration

MI Health Link Enrollment by County (CY 2020):

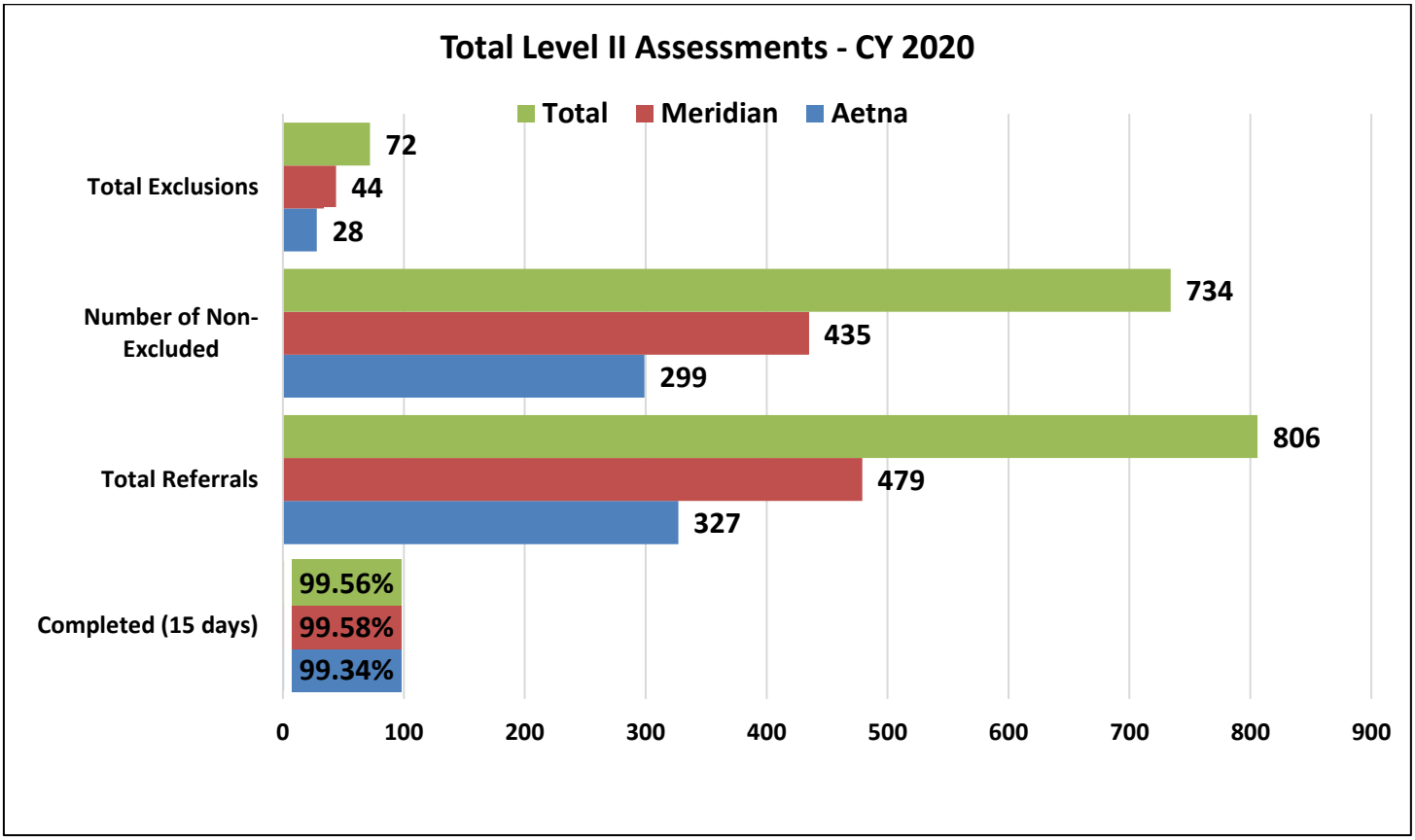
**Data includes MI Health Link Business Line for both Aetna and Meridian (ICO Partners) **
Data Snapshot taken 1/29/20

County Name	# Consumers Covered	# Consumers Served	# of Encounters
Kalamazoo	2,707	510	33,000
Berrien	2,154	196	13,000
Calhoun	2,097	329	10,300
Van Buren	1,179	168	6,900
St. Joseph	770	98	3,900
Cass	593	83	3,832
Branch	522	96	3,800
Barry	459	49	2,274
Total:	**10,481**	**1,529**	**77,006**

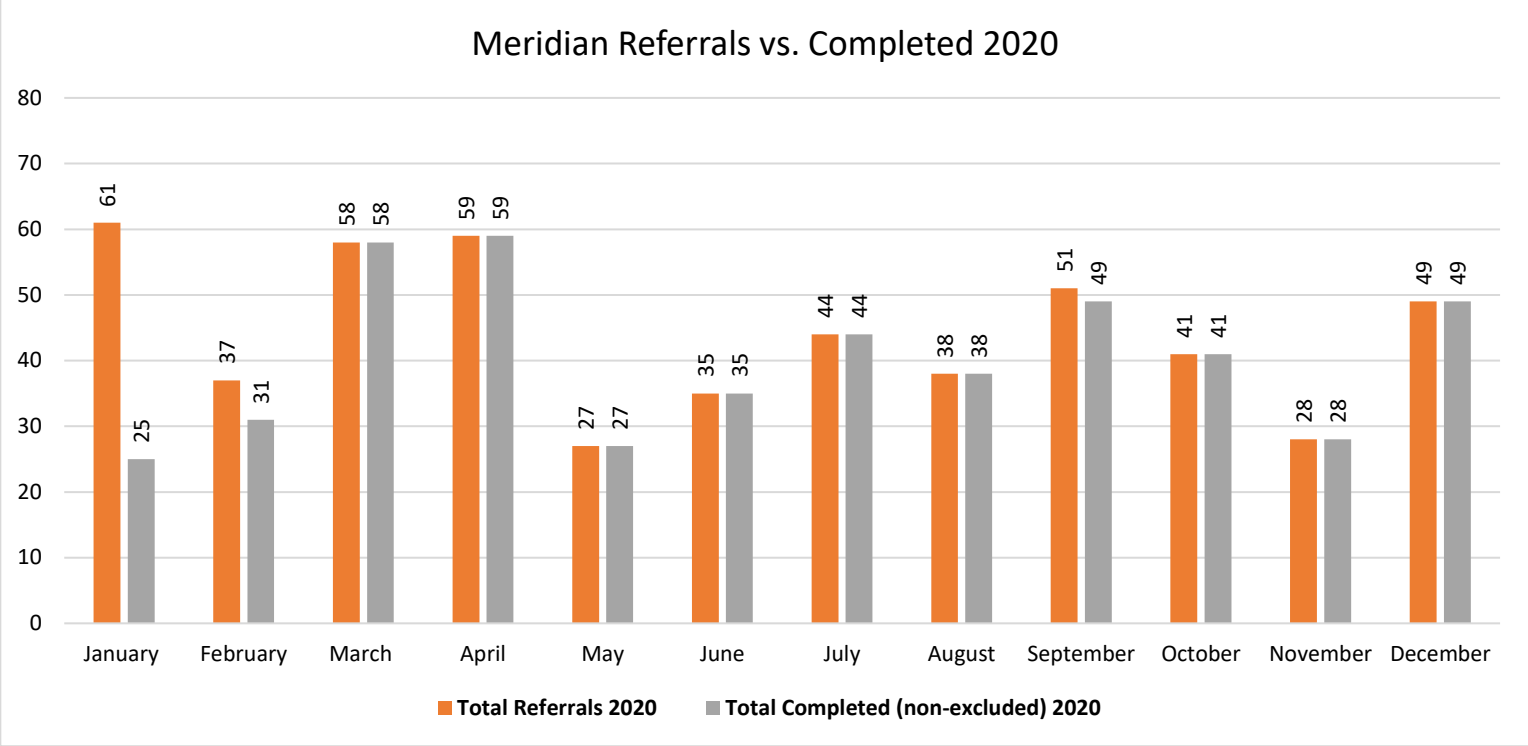

Aetna Cases and Encounters Comparison by Year
5000
4000
3000
2000
1000
0
557
3237
5.81
669
4,452
6.65
2020
2019
Cases
Encounters
Encounter Per Case

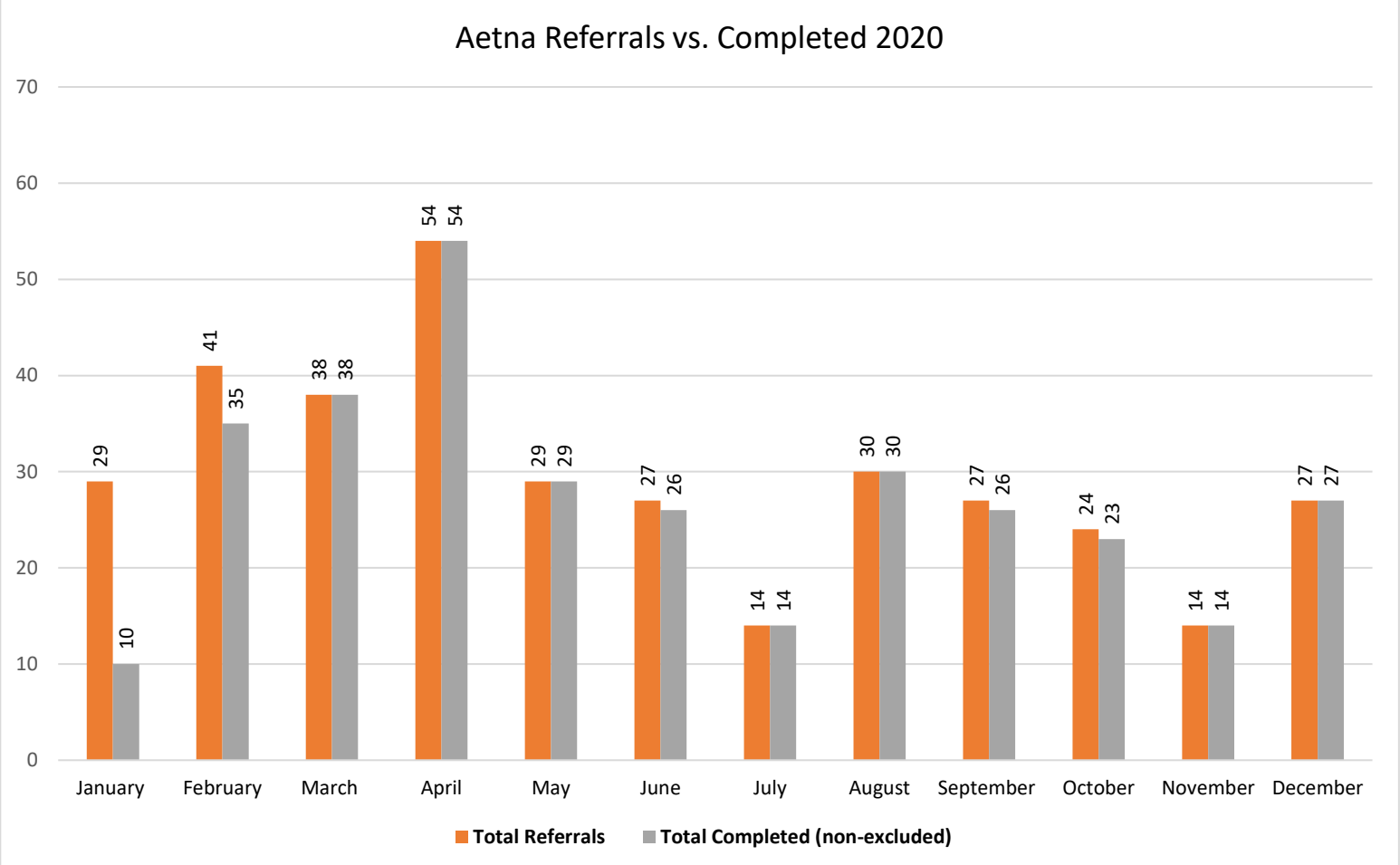

Meridian Cases and Encounters Comparison by Year
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
947
6582
1,172
8,039
2020
2019
Cases
Encounters
Encounter Per Case

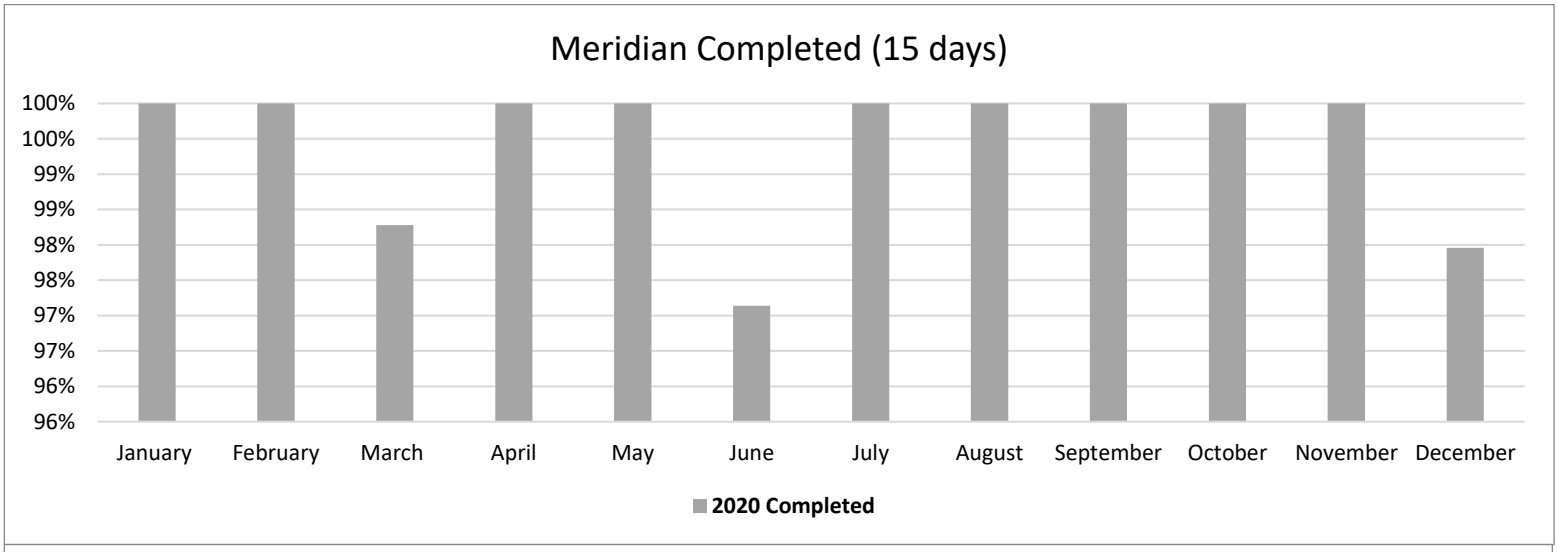
MI Health Link Level II Assessment Timeliness Report Analysis
January 1, 2020 – December 31, 2020

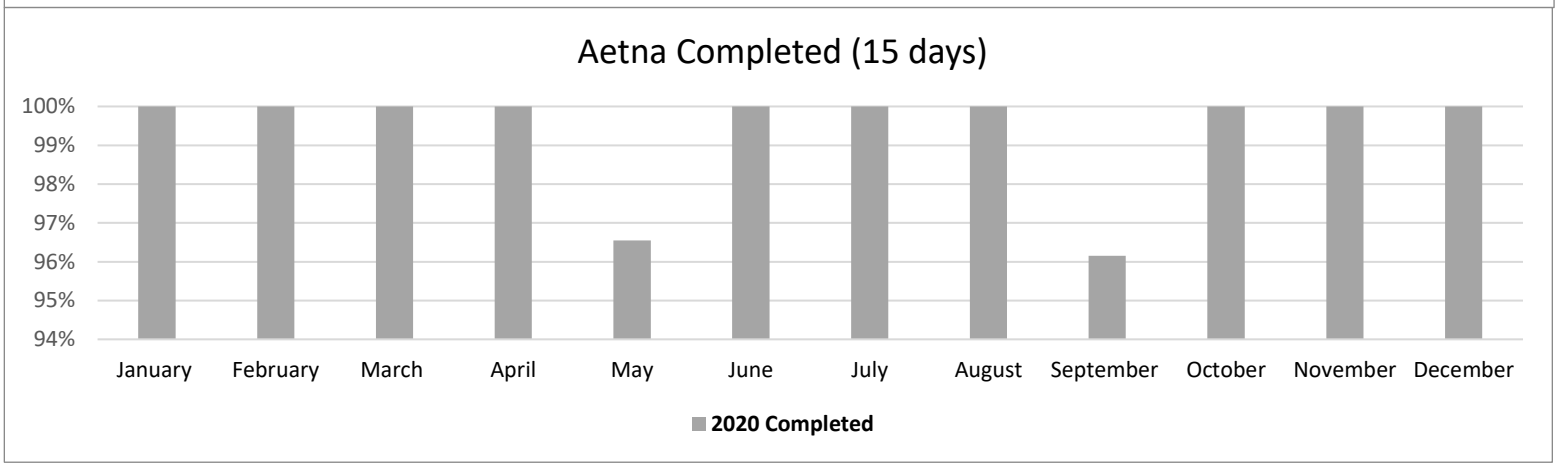


- **Target/Goals:** The MI Health Link Quality Performance Benchmark for the Level II Assessment Follow-up Timeliness Metric within (15 days) is 95% or above.


Meridian Referrals vs. Completed 2020
80
70
60
50
40
30
20
10
0
61
25
37
31
58
58
59
59
27
27
35
35
44
44
38
38
51
49
41
41
28
28
49
49
January
February
March
April
May
June
July
August
September
October
November
December
Total Referrals 2020
Total Completed (non-excluded) 2020


Aetna Referrals vs. Completed 2020
70
60
50
40
30
20
10
0
29
10
41
35
38
38
54
54
29
29
27
26
14
14
30
30
27
26
24
23
14
14
27
27
January
February
March
April
May
June
July
August
September
October
November
December
Total Referrals
Total Completed (non-excluded)





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 2020, 99% of consumers received an initial Level II Assessment within 15 days of a referral. 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 2020, 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.

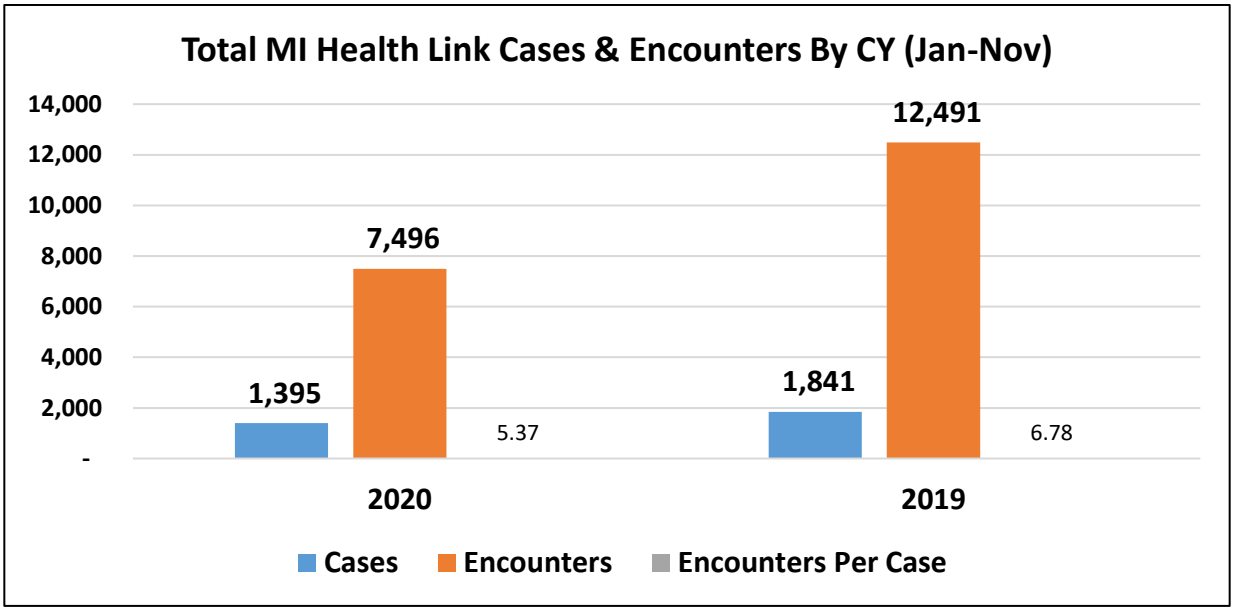
Recommendations

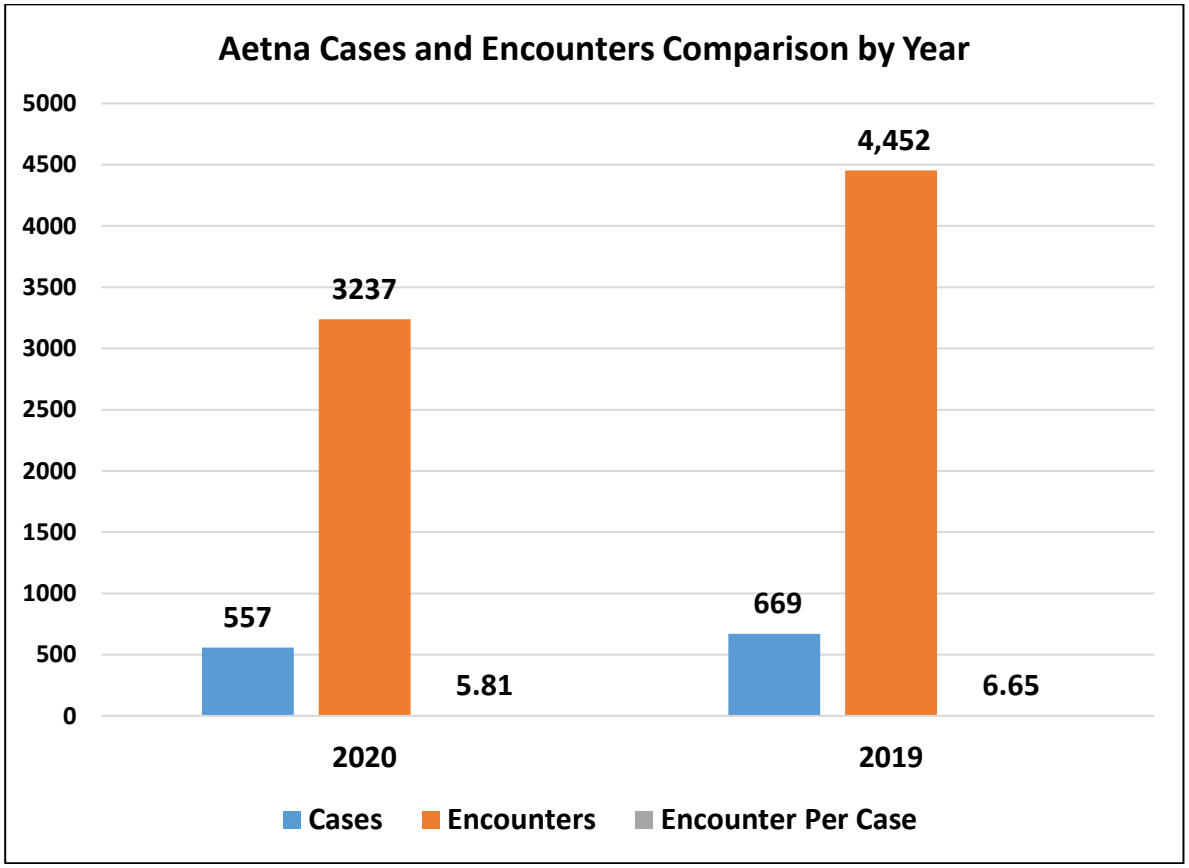
SWMBH is currently working on the redevelopment of the Level II report in SmartCare. This will improve the validity and accuracy of the report. This will also help capture our agreed-upon methodology for Level II Assessment exclusion categories with Integrated Care Organizations (ICO's). This will be 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 (CY 2020) of the top 10 MHL services out of the many services offered:

Detailed Exam – Moderate Complexity (99214)	1511
Individual Therapy 38-52 min (90834)	609
Telehealth origination site visit (Q3014)	498
Individual Therapy 52 or more min (90837)	404
Focused Exam Decision making (99212)	381
Psych Diagnostic with Meds (90792)	307
Expanded Exam low complexity (99213)	222
Psych Diagnostic no med service (90791)	181
Medication Administration or Review (96372)	180
Group/Adult/Child Therapy (90853)	59
Psychotherapy 60 min (90839)	51

- The graph above is the ICO Service Encounter Breakdown (CY 2020) for the top 10 MHL services delivered during the measurement period.
- Service dates (January 1, 2020 through December 31, 2020).
- The dashboard includes services provided to both Meridian and Aetna Plan Members.
- A total of 4,256 services were provided in CY 2019 and in CY 2020 4,403 services were provided. This equates to an increase of 147 total services in comparison to the previous year.
- The slight increase is services can be directly related to the impacts of Covid-19 and limited accessibility to in-person services. Due to access to in-person appointments, Telehealth visits had a 300% increase over the previous year's totals. This accounts for the total increase in consumer services.




Aetna Cases and Encounters Comparison by Year
5000
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3000
2500
2000
1500
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500
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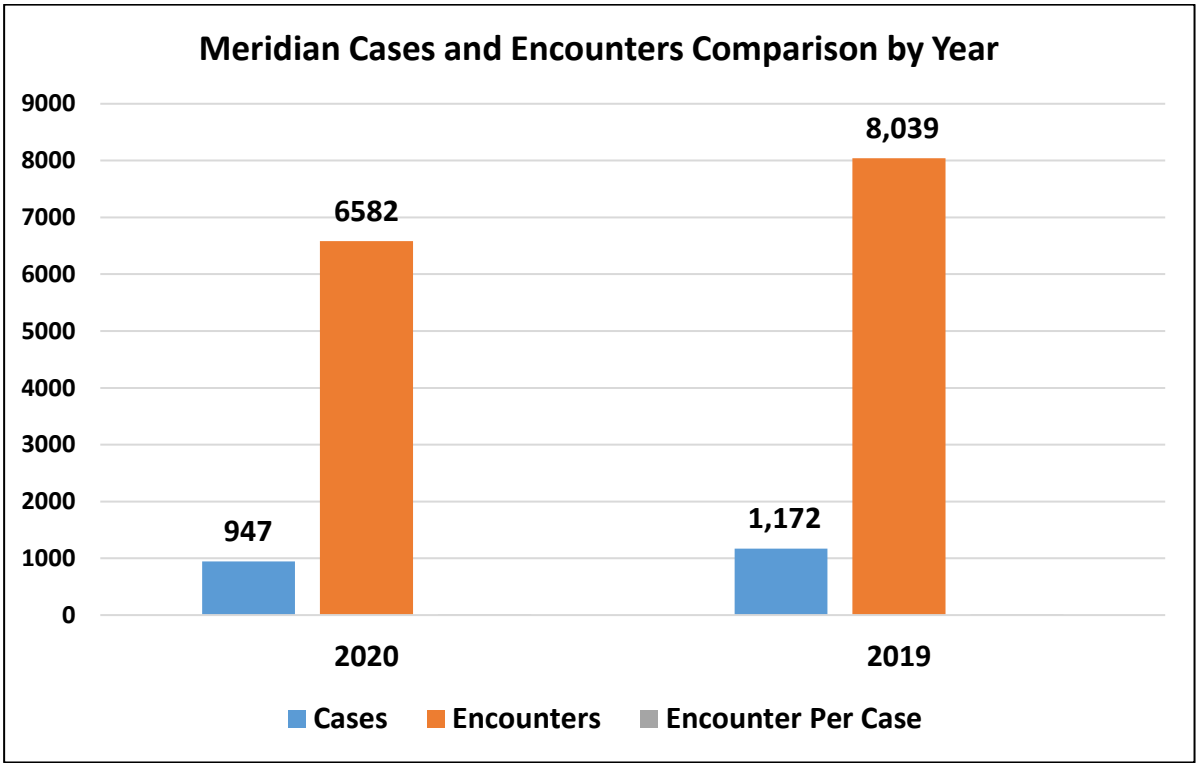
3237
5.81
669
4,452
6.65
2020
2019
Cases
Encounters
Encounter Per Case


Meridian Cases and Encounters Comparison by Year
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
947
6582
1,172
8,039
2020
2019
Cases
Encounters
Encounter Per Case

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:

ι. Regular and routine care appointments.
ιι. Urgent care appointments.
ιιι. After-hours care.
ιϖ. Member Services, by telephone.
ϖ. UM by telephone SWMBH Reporting:

- Care of non-life-threatening 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 non-urgent 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:

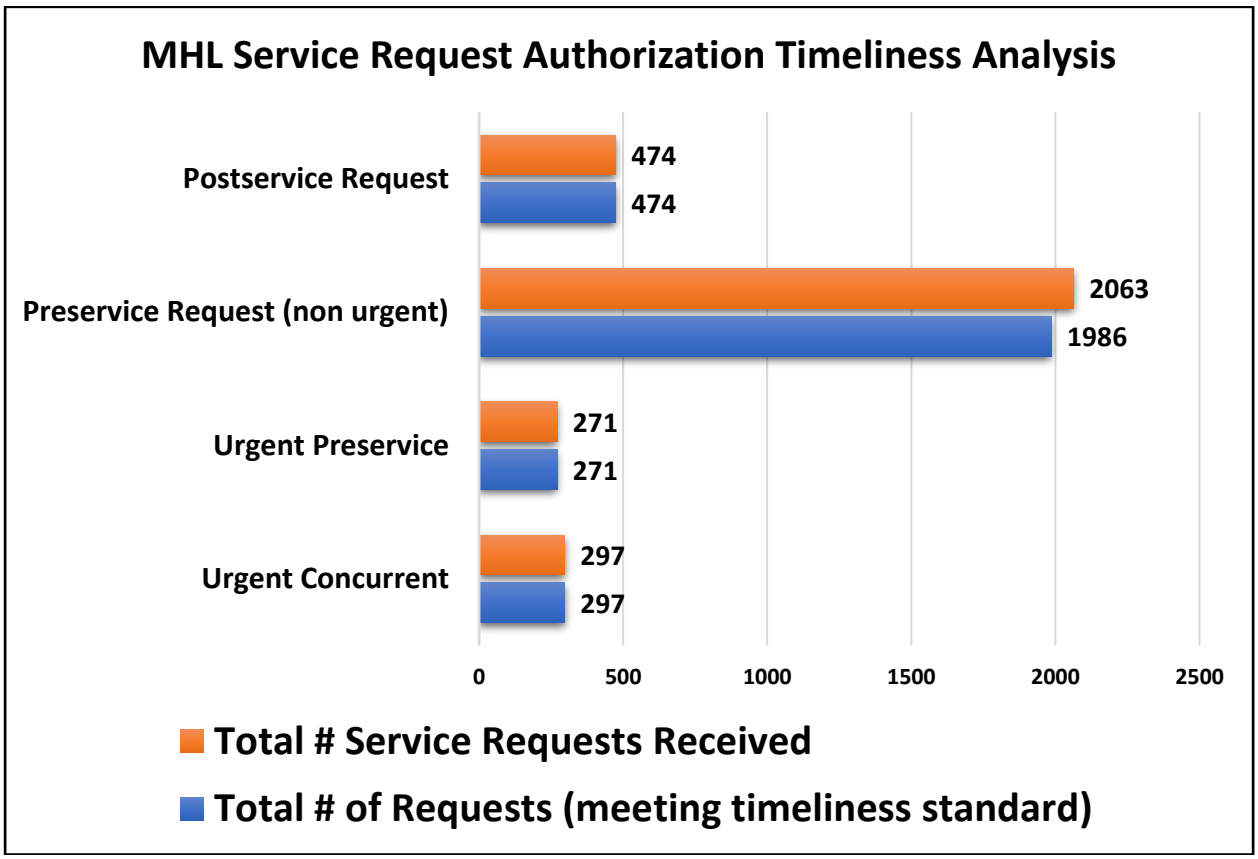
1. For urgent concurrent review, the organization makes decisions within 24 hours of receipt of the request.
2. For urgent pre-service decisions, the organization makes decisions within 72 hours of receipt of the request.
3. For nonurgent preservice decisions, the organization makes decisions within 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:

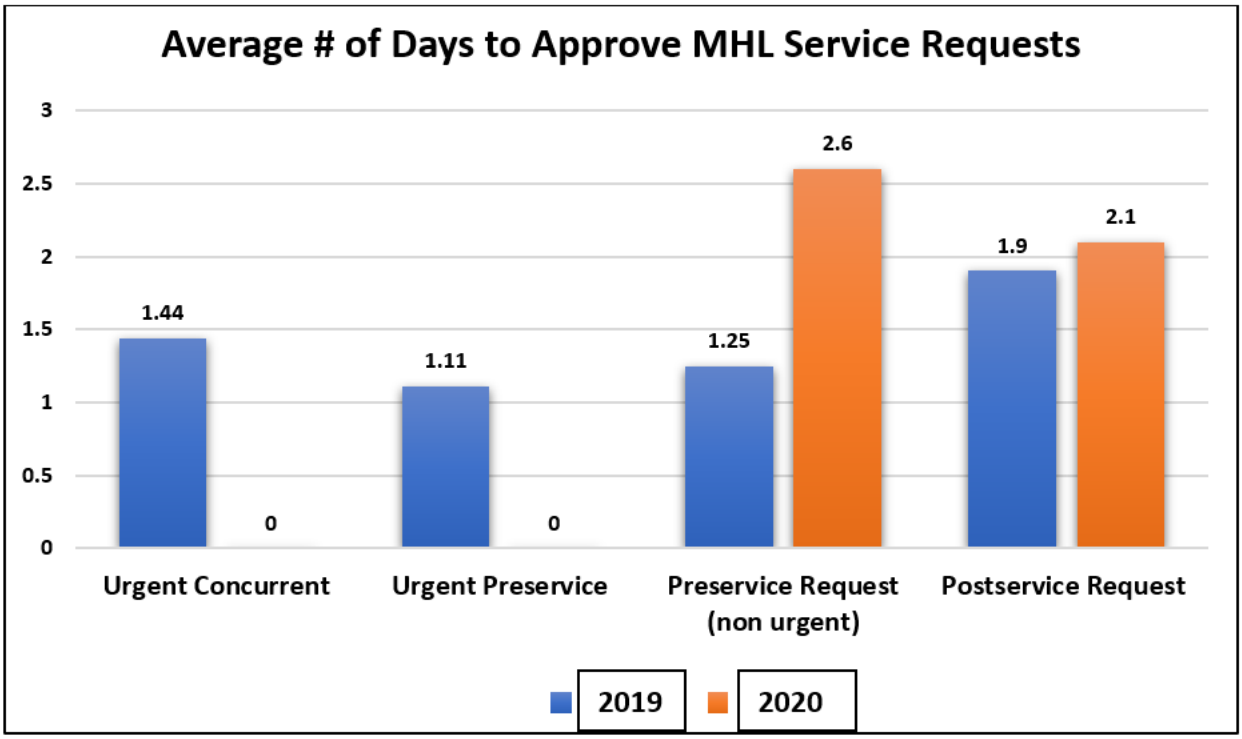
1. **Urgent request:** A request for care or services where the application of the time frame for making routine or non-life-threatening care determinations could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or in the opinion of a 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.
2. **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.
3. **Nonurgent request:** A request for care or services for which application of the time periods for deciding 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.
4. **Preservice request:** A request for coverage of care or services that the organization must approve in advance, in whole, or in part.
5. **Post-service request:** A request for coverage of care or services that have been received (e.g., retrospective review

2020 MI HEALTH LINK SERVICE AUTHORIZATION TIMELINESS ANALYSIS

Measurement Period: January 1, 2020 through December 31, 2020



MHL Service Request Timeliness Report	Urgent Concurrent (24 hours)	Urgent Preservice	Preservice Request (non-urgent)	Postservice Request
Total # of Requests (meeting timeliness standard)	297	271	1986	474
Total # Service Requests Received	297	271	2063	474
Timeliness Rate	100%	100%	96%	100%



Timeliness Categories and Standard Definitions:

Urgent Request	A request for care or services where application of the time frame for making routine or non-life-threatening care determinations could seriously jeopardize the life, health or safety of the member or others, due to the members psychological state or in the opinion of a practitioner with knowledge of the members medical or behavioral conditions.
Concurrent Request	A request for coverage of care or services made while a member is in the process of receiving the requested care or services, even if the organization did not previously approve the earlier care.
Nonurgent Request	A request for care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.
Preservice Request	A request for coverage of care or services that the organization must approve in advance, in whole or in part.
Postservice Request	A request for coverage of care or services that have been received (e.g., retrospective review).

Care Coordination

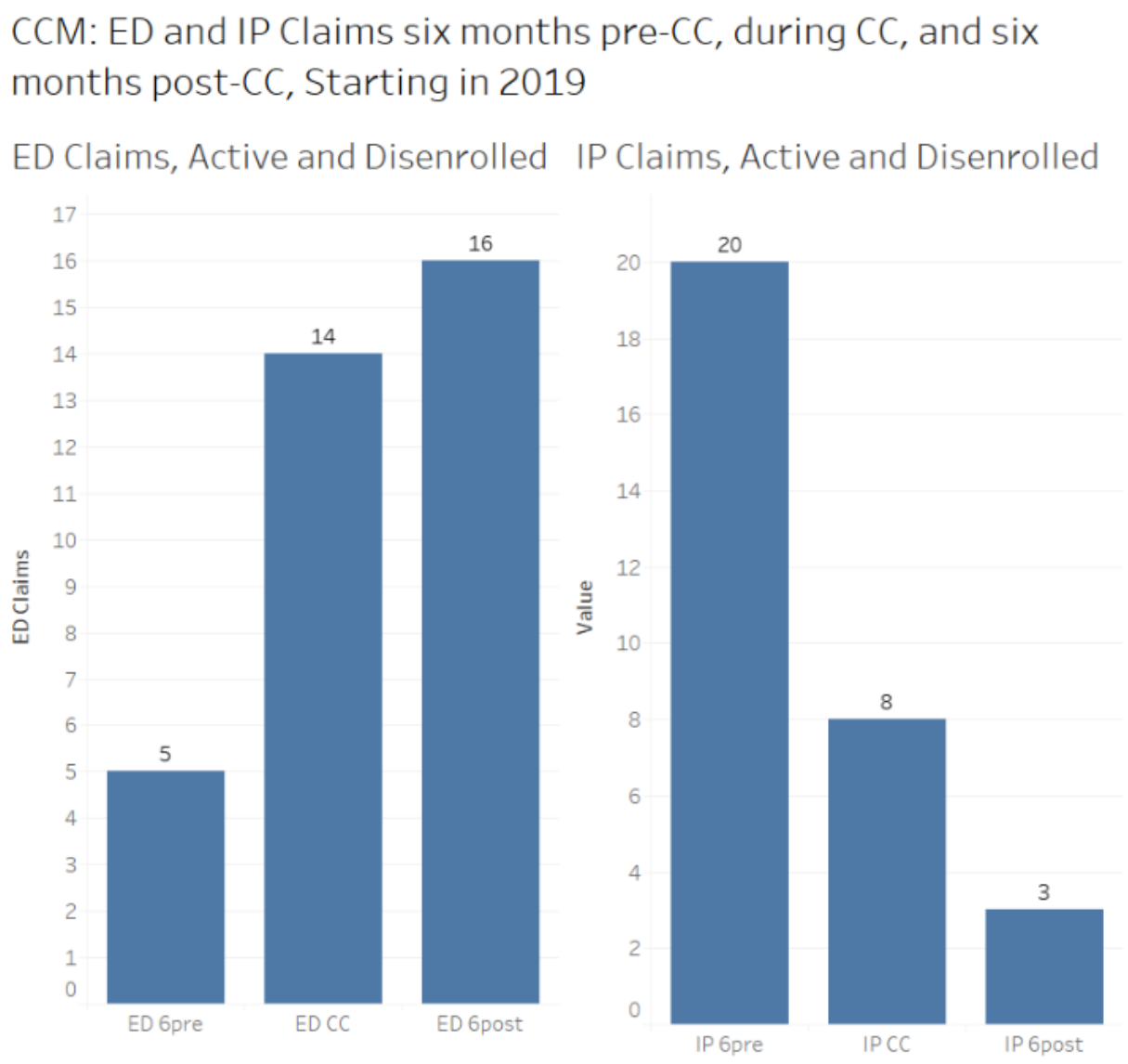
Objective	Goal	Deliverables	Dates	Lead Staff	Review Date
Coordination of Care	➢ Monitors for continuity and coordination of care members receive across the network and actions improve. ➢ Demonstrate re-measurement for selected interventions. ➢ Quantitative and causal analysis of data to identify improvement 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 2020 – December 2020	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

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:

1. 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.
2. 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.
3. 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 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:

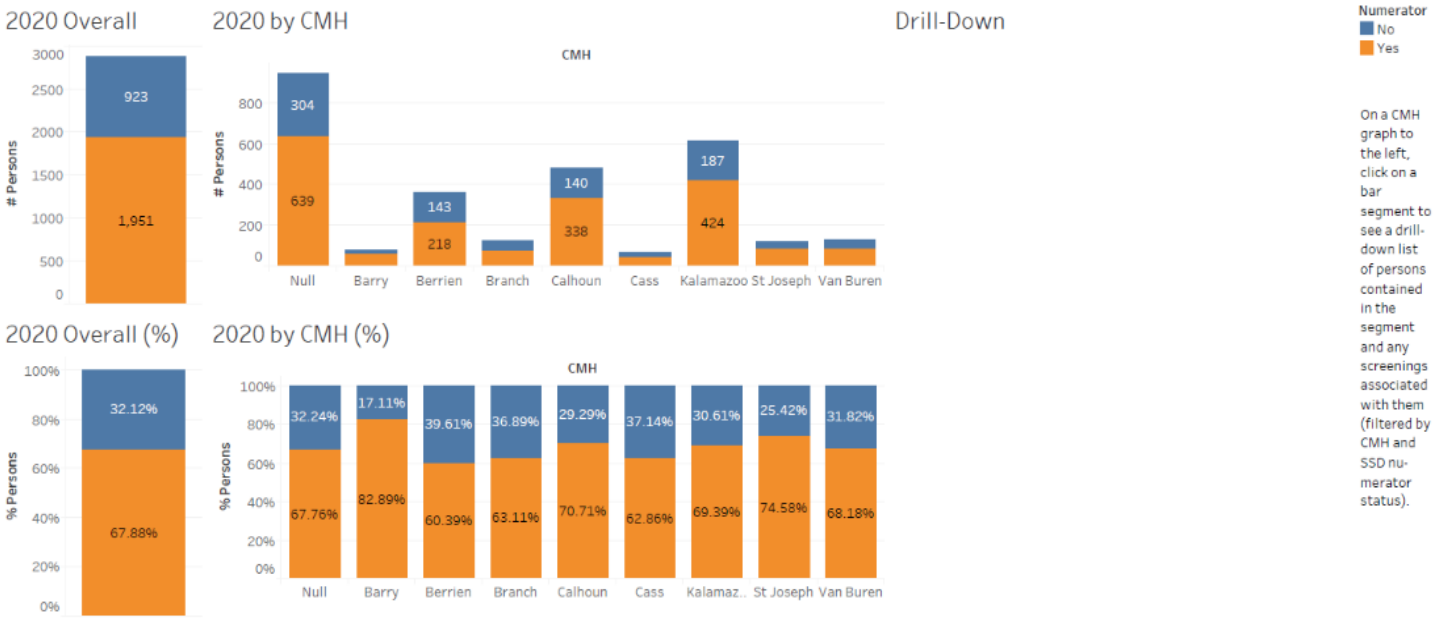
SWMBH utilizes ProAct (an application produced by CMT using Care Connect 360 data) to monitor behavioral health and physical health aspects of members served. CMT contains hundreds of reports measuring HEDIS metrics, inpatient and ER utilization, medication adherence, opioid alerts, and prescriber trends. 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 2020 is below. CMHs can export their data so they can identify and follow up with individuals who need a screen completed.

SSD: Diabetes Screenings for Persons with Bipolar Disorder or Schizophrenia Taking Antipsychotic Medications, CY 2020 So Far



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 FY2020.	
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	

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 Medicaid Health Plans (MHPs) in our region. We complete risk stratification, collaboration, update agendas, maintain, and share meeting minutes. Goals are to reduce ED utilization and inpatient admissions for individuals opened to Integrated Care Teams during FY20. There was a 67.9 % reduction in ER claims and a 78.4% reduction in inpatient days for the six months before ICT involvement versus six months post ICT involvement. In FY2020 SWMBH staff participated in 84 Integrated Care Team meetings with MHPs to coordinate care and encourage appropriate utilization of health services for consumers.

All-Cause Readmissions Joint MHP/PIHP Protocol Development

The MHPs and PIHPs meet monthly in their Collaboration Workgroup to discuss behavioral health and physical health care integration. 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 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 ensure compliance with MDHHS contractual requirements related to Integrated Care. As part of the workgroup's activities, protocols have been developed to ensure follow-up after hospitalization is completed timely. Optum developed a reporting feature in CC360 to allow for PIHPs to report all behavioral health inpatient admit and discharge information directing into CC360. This creates a timely communication channel with standards that are followed throughout the state. SWMBH has participated fully in the conversations, planning, and implementation of this. SWMBH also worked in collaboration with 3 other PIHPs and 3 MHPs to create a Plan All-Cause Recidivism (PCR) protocol. Along with the protocol, we advocated for changes to CC360 to help assist with risk stratification, including race. These changes were implemented based on agreement within the PIHP-MHP Workgroup. Unfortunately, and unexpectedly, PCR is no longer a measurement for FY21 as of July 2020. However, the CC360 changes will be beneficial for risk stratification in the future.

Aetna Transition of Care Calls

Aetna Population Health department offered SWMBH engagement in the transition of care meetings with Family Health Center. These 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 provide information and member outreach as needed. A Charter was developed to establish guidelines around Transition of Care calls, and Aetna will be developing measures to show the effectiveness of SWMBH's involvement in December 2020.

Evaluation of Improved Communication Efforts with Providers

2020 Provider Communication and Access to Services Survey Information

Provider Communication Survey:

This survey is meant to help identify and improve provider communication, access and follow-up with practitioners in the network.

Findings of this survey will be used to guide planning of improvement initiatives.

Survey responses were collected from November 7, 2020 through November 30, 2020.

GOALS:

Comparison of 2020 survey results with previous years results.

Examine and improve practitioner experience based on assessment of data:

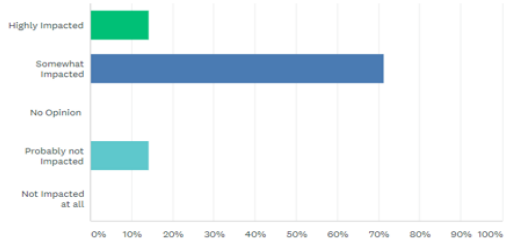
SWMBH and UM Business Processes:

- Communication
- Technical Assistance
- Timeliness of Care:
  - Access to Routine Appointments
  - Access to Urgent Appointments
  - Access to Emergency Appointments
- Identify Access to Care Barriers triggered by Covid-19 response efforts

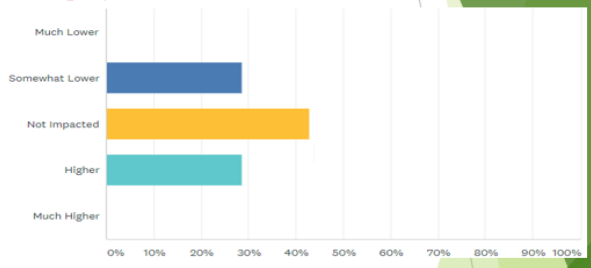
2

Additional Questions added for 2020 in regards to Covid-19 (3 Questions Total)

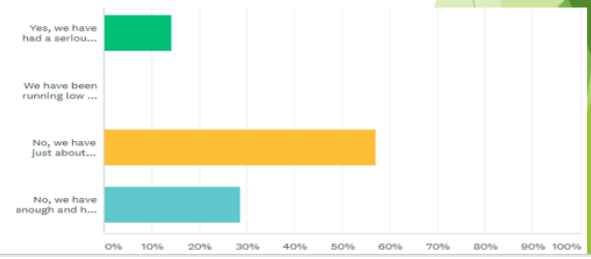
1. At any time during the past 6 months, do you feel that your patients access to care was impacted, due to the Coronavirus Pandemic?
   - 85.4% of providers indicated they felt services were highly or somewhat impacted as a result of Covid-19.



2. How do the past few months (September and October) patient visit volumes compare to your average number of monthly visits pre Covid-19?
   - 78% of providers indicated that their patient volumes were not impacted or higher, due to Covid-19.



3. In the past 3 months, has your location been able to maintain an adequate supply of Personal Protective Equipment (PPE) (e.g., masks, gloves, gowns, etc.)?
   - Only 14.2% of providers indicated they have had difficulties maintaining an adequate supply of (PPE).



2020 Regional Provider Communications Survey Analysis - Next Steps - Opportunities for Improvement

Summary of Finding:

Overall, there were 52 survey responses with 81% were in contract with SWMBH for MI Health Link Services, compared to the 76% in 2019. Providers types that responded to the survey included: CMH, SUD, SUD Residential/Detox, Outpatient Mental Health Therapy or Psychiatry, Inpatient Psychiatric Hospital, Specialized Residential, Community Based Services, and other. There were 18 questions total on the survey with topics covering: UM Process and Communication, Timeliness of Care, Areas of Technical Assistance Needed, and SWMBH Processes. 3 additional question related to Covid-19 Access and Preparedness were also added to this years survey.

This survey is meant to help identify and improve provider communication, access and follow-up with practitioners in the network. Survey responses were collected from November 7, 2020 through November 30, 2020. This is the third year this survey was completed and comparison data was used when available.

- Results: Highest Response Rate per Category
  - UM Process - "agree"
  - UM Communication - "Most of the time" satisfied
  - Timeliness of Care - "always"
  - In the different areas of technical assistance providers responded that the authorization services (27.39%) and reporting requirement (21.95%) (i.e. BH TEDS) require the most technical assistance, while 3.1% of providers said no technical assistance was needed.
  - Providers responded "good" to SWMBH Processes in all categories except for Authorization which had the same response percentage 27.03% for both neutral and good. Availability of data and reports also had the highest provider response rate of neutral at 32.43%.

2020 Regional Provider Communications Survey Analysis - Next Steps - Opportunities for Improvement

Improvement Measures:

On December 11, 2020 the MI Health Link Committee met and discussed the survey results and opportunities for Improvement Initiatives. The overall results were provider satisfaction with communication and access to services was very high.

- Ideas from MI Health Link Committee on Improvement Initiatives:
  - Ways we can improve communication and access to services:
    - Posting on website UM Business Process Flow Diagram of who and how to contact for which type of information and support
    - Training on Tableau and other Managed Business Intelligence resources for providers.
    - More education/information/resources on Duals Project including authorizations. Possibly provide Quarterly education on the MI Health Link program in the provider newsletter.
    - Focused education sessions (15-20 minutes) with providers on identified categories (authorizations, provider directory, techniqual assistance ect.)

Next Steps:

Although the survey had found that overall provider satisfaction with communication and access was very high, based on its analysis of the data, the Committee decided to choose to take some opportunities for improvement on communication and technology. The Committee decided on working on posting on the SWMBH website and Tableau Trainings (see below). Owners were assigned and will work on implementing and educating and then will update Committee in the next couple of months. To measure if the interventions have been successful another annual survey will be conducted. Before the next survey, the Committee will discuss and look at how to improve survey responses such as using focus groups or attending some provider meetings to increase responses collected or increasing how we notify or make aware of survey.

Identified Improvement Opportunities	Plan to Implement	Owner
• Posting on website UM Business Process Flow Diagram of who and how to contact for which type of information and support	Post on website	Beth Guisinger, UM - Randy Paruch, IT
• Business Intelligence Training/Resources	Set up a schedule of trainings for providers	Natalie Spivak, CIO or designee

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 implementing 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.

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 within 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 potentially reduce ED visits by 1 visit/county /day in Region 4

2020-2021 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

2020 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 2019 - September 2020	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 2020 Customer Satisfaction Survey Analysis and Results • SWMBH Grievance and Appeal Data Analysis • SWMBH 2020 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 their preferred language and have access to language support to represent themselves while SWMBH addresses their complaint(s).

2020 Cultural Competence Goals

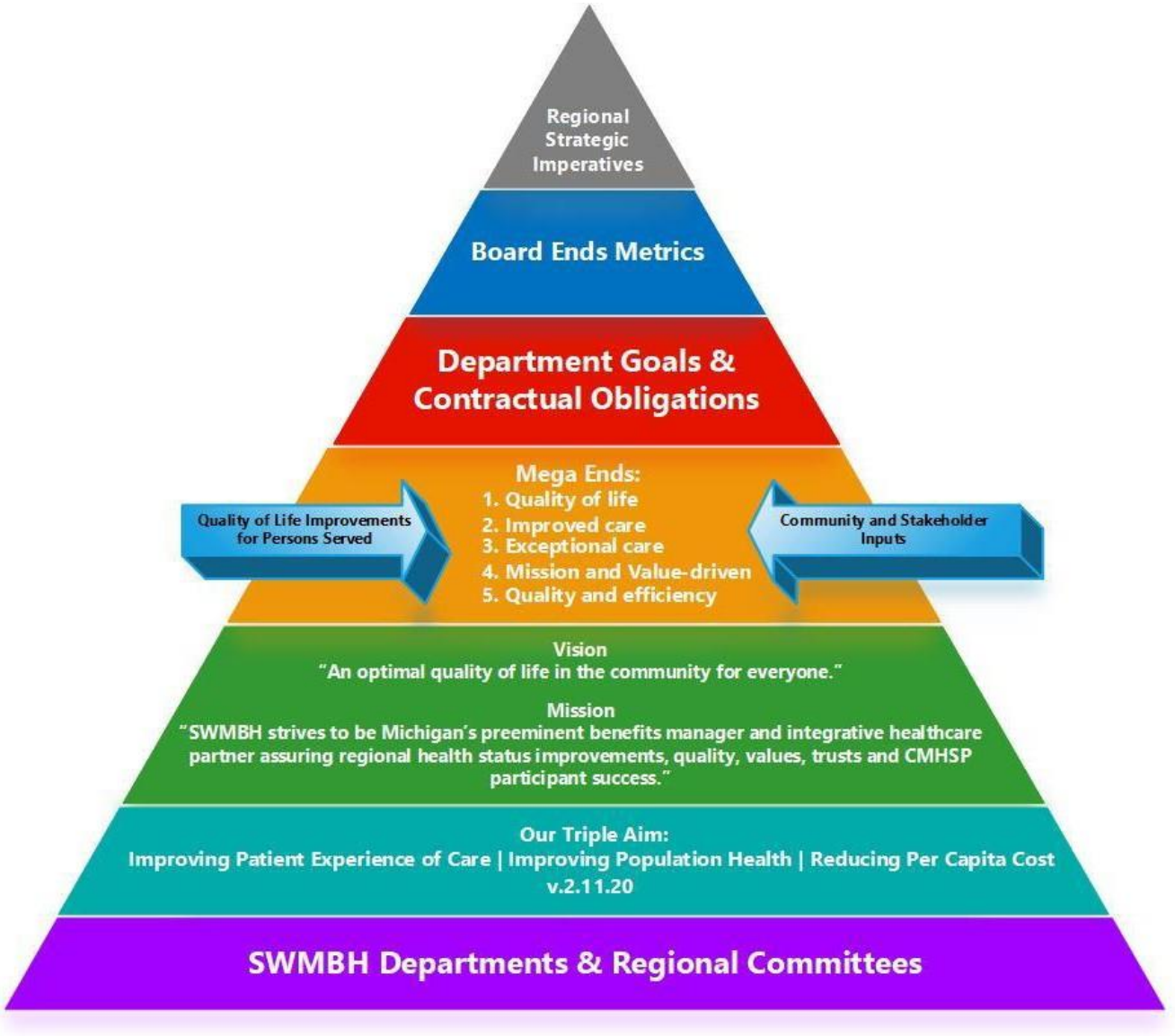
Goal	Source	Steps to take/Completion Date	Outcome	Responsibility
1. Implement Staff/Provider survey to gauge the Organizational level of Cultural Competence.	Network Adequacy Analysis – Population Race/Ethnicity Analysis	A. ACTION for the Cultural Competency Workgroup to research and identify tools to 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, our 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.

Attachment A: SWMBH 2020 Strategic Alignment – Annual Goal Planning



Attachment B: 2020-2022 Strategic Imperatives

Southwest Michigan Behavioral Health
2020-2022 Strategic Imperative Descriptions & Priorities

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

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

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

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 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

Integrated Health Care

- Michigan Health Endowment Fund 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

Revenue Maximization

- Assure 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/new business lines (upon request)

Cost Reductions in Medical Loss Ratio and Administrative Loss Ratio

- Support CMHSP cost reduction strategies (upon request)

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

Managed Care Functional Review

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

Proof of Value and Outcomes

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

Attachment C: SWMBH 2020 Board Ends Metrics

Summary of 2020 Board Ends Metrics

This document serves to summarize the achievement status of the Board Approved Metrics for completion in FY 2020 (*October 1, 2019 through September 30, 2020*).

- Current Ends Metrics Status: 10.75 of 13 achieved – 82.6%
- 9 Metrics Roll Over to 2021 for approval
  (*Please see detailed outcomes and status for each metric*)

Board Ends Metric	Metric Result	Board Approved Date	Points Earned
• 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** MDHHS Report Date: 12/3/19 Reported the following status: • Mental Health TEDS: 96.79% • Substance Abuse TEDS: 97.47% Measurement Period: (1/1/19 – 12/30/19)	1/10/2020	**1 point earned**
At least 18% of parents and/or caregivers of youth and young adults who are receiving Applied Behavior Analysis (ABA) for Autism 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.	**Metric Achieved** SWMBH Achieved a rate of 57% per Michigan Department of Health and Human Services (MDHHS) Metric Status Report on 10/29/2020	11/8/2019	**1 point earned**
PBIP Narrative Report	**Metric Achieved**		

Achieve 95% of Performance Based Incentive Program monetary award based on MDHHS specifications.	Report Submitted to MDHHS on 11/15/19 MDHHS confirmed on 2/1/2020 that SWMBH achieved 100% of possible bonus earnings ($1,313,811)	3/13/2020	**1 point earned**
PBIP Metrics Reports Achieve the following Joint expectations for the MHP's and SWMBH. There are 100 points possible for this bonus metric	**Metric Achieved** SWMBH submitted required reports for: Joint Care Management, Follow-up after Hospitalization, Plan All-Cause Readmissions and Emergency Department Visit for Alcohol and drug dependence SWMBH was notified by MDHHS on:1/13/2020 that it achieved 98.2% of possible bonus award earnings ($485,930)	3/13/2020	**1 point earned**
2019-2020 Customer Satisfaction Surveys collected by SWMBH are at or above the SWMBH previous year's results for the following categories: Mental Health Statistic Improvement Project Survey (MHSIP) tool. *(Improved Functioning)* Youth Satisfaction Survey (YSS) tools. *(Improved Outcomes)*	**Metric Achieved** SWMBH Achieved the following improvements for each survey tool: • MHSIP (adult): +3.9% • YSS (youth): +2.0%	3/13/2020	**1 point earned**
95% of Functional Assessment tool detailed sub-element scores (LOCUS, ASAM, CAFAS, SIS) are received electronically by SWMBH from CMHSPs by (4/15/20).	**Partial Metric Achieved** Significant Improvements Were Made in following Assessment tools: • LOCUS: 97.4% • CAFAS: 98.2% • SIS: 95.6% • ASAM: 94.1%	4/10/2020	**.75 point earned**
2019 Health Service Advisory Group (HSAG) External Quality Compliance Review (90% of Sections evaluated receiving a score of "Met").	**Metric Achieved** 74/82 or 90.24% of total elements evaluated achieved (full compliance)	6/12/2020	**1 point earned**

	*SWMBH ranked highest amongst all 10 Michigan PIHP's		
Achieve a (4 percentage point) improvement in the rate of Diabetes screenings for consumers with schizophrenia and bipolar disorder who are using antipsychotic medications.	**Metric Missed** Goal for 2019-2020 PIP: 80% Rate Achieved: 76.44% Metric Measurement Period: 1/1/20 – 12/31/20	6/12/2020	**0 points earned**
92% of MMBPIS Indicators will be at or above the State benchmark for 4 quarters for FY19.	**Metric Missed** 59/68 or 86.7% of indicators achieved the States benchmark target.	4/10/2020	**0 points earned**
SWMBH will achieve 95% of quality withhold performance measures identified in the Integrated Care Organization (ICO) contracts. (2 points possible) +1 Meridian - +1 Aetna	**Metric Achieved** **Meridian** Quality Withhold Achievement DY 1-3 (100%) **Metric Missed** **Aetna** Quality Withhold Achievement DY 3 (66%)	10/9/2020	**1 point earned**
2020 HSAG Performance Measure Validation Passed (95% of Critical Measures receiving a score of "Met")	**Metric Achieved** 47/47 or 100% of Standards Evaluated received a designation of "Met", "Accepted" or "Reportable".	9/11/2020	**1 point earned**
A. 97% of applicable MH served clients with an accepted encounter will have a matching and accepted BH TEDS record confirmed by MDHHS monthly status report. B. 97% of applicable SUD served clients with an accepted encounter will have a matching and accepted BH TEDS record confirmed by MDHHS monthly status report.	**Metric Achieved** The MDHHS June report showed SWMBH at MH=98.53% and SUD=97.21%. SWMBH dropped back on the August report: MH= and SUD= . We suspect the values for each will exceed 97% for our final MDHHS September report. Measurement Period: 1/1/20 – 7/1/20	10/9/2020	**1 point earned**

Regional Habilitation Supports (HSW) Waiver slots are full at 99% throughout the year. (October 2018-September 2019)	**Metric Achieved** 99.86% of HSW slots have been filed in FY 20, per the MDHHS status report. *SWMBH has been the best performing PIHP in the State for 3 consecutive years.	10/9/2020	**1 point earned**
Total Metrics Evaluated in 2019-2020 Merit calculation cycle: **(13)** 10.75/13 = 82.6%	**Total Metrics that achieved Board approved Targets:** **(10.75)**	**Total Points Possible: 14** **Total Points Earned: 10.75**	

Attachment D: MHL 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: 12/11/20
Next Charter Review Date: 12/11/21

Approved By: Jonathan Gardner, Director of Quality
Signature: _____
Date: 12/11/20

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:

- 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

- 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

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.
  NCQA, MBHO, QI 11 Clinical Measurement Activities / QI 12 Effectiveness of the QI Program

Member Rights and Responsibilities:

- Reviews and authorizes policies and materials that state SWMBHs commitment to treating members in a manner that respects their rights, and its expectations of members' responsibilities.
  NCQA, MBHO, RR 1 Statement of Members' Rights and Responsibilities
- Reviews and authorizes policies and procedures for thorough, appropriate and timely resolution of member complaints and appeals.
  NCQA, MBHO, RR2 Policies and Procedures for Complaints and Appeals
- Ensures the web-based provider directory is evaluated for understandability and usefulness to members no less than every 3 years.
  NCQA, MBHO, RR 4 Practitioner and Provider Directories, Element I Usability Testing
- Ensures the web-based provider directory contains the required information and is updated as required.
  NCQA, MBHO, RR 4 Practitioner and Provider Directories, Element A Practitioner Directory Data/Element B Practitioner Directory Updates

Relationship to Other Committees: The identified above sub committees will plan and coordinate as needed. The committees may also coordinate with the other SWMBH Regional Committees as needed.

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 the above sub committees, 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: Quality/UM/Clinical & Integrated Care

Membership Name	***Organization/County***	***Type of member (Ad hoc, standing, voting, alternate)***
Kelly Norris LMSW, CAADC Provider Network Specialist II	*SWMBH*	*Voting*
Gale Hackworth, PHD, LP	*Lighthouse Behavioral Health*	*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*
Estavanica Lovely, LMSW	*Delano Medical Group*	*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 2: Credentialing

Membership Name	***Organization/County***	***Type of member (Ad hoc, standing, voting, alternate)***

Kelly Norris *Provider Network Specialist II*	*SWMBH*	*Voting*
Gale Hackworth, PHD, LP	*Lighthouse Behavioral Health*	*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*
Estavanica Lovely, LMSW	*Delano Medical Group*	*Voting*
Sarah Green RN, BSN, MBA *Senior Integrated Healthcare Specialist*	*SWMBH*	*Voting*
Sarah Ameter *Manager of Customer Services*	*SWMBH*	*Voting*
Natalie Spivak *CIO*	*SWMBH*	*Voting*

Attachment 3: Member Rights and Responsibility

Membership Name	***Organization/County***	***Type of member (Ad hoc, standing, voting, alternate)***
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*
Beth Guisinger, LPC *Utilization Management and Call Center Manager*	*SWMBH*	*Voting*
Kelly Norris *Provider Network Specialist II*	*SWMBH*	*Voting*
Jonathan Gardner B.S, CHES, PTA *Director of Quality Assurance and Performance Improvement*	*SWMBH*	*Voting*
Courtney Juarez Quality Assurance Specialist	*SWMBH*	*Voting*
Moira Kean LLP, MA *Director of Clinical Quality*	*SWMBH*	*Voting*
Sarah Green RN, BSN, MBA *Senior Integrated Healthcare Specialist*	*SWMBH*	*Voting*

Attachment E: 2020 Quality Management Committee Charter

2021 Quality Management Committee Charter

☒ Southwest Michigan BEHAVIORAL HEALTH

☐☐☒ **SWMBH Committee** **SWMBH Workgroup:_____Duration:**

Quality Management Committee

(QMC) On-Going **Deliverable Specific**

Date Approved: 5/1/14

Last Date Reviewed: 11/19/20

Next Scheduled Review Date:11/18/21

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.* • *Assist the RITC Committee with management and oversight of the Data Exchange sub-workgroup related to regional strategic imperatives and CMH data submission quality and completeness.* • *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:	At least annually 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 F: 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 G: Regional Utilization Management Committee Charter

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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*
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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.
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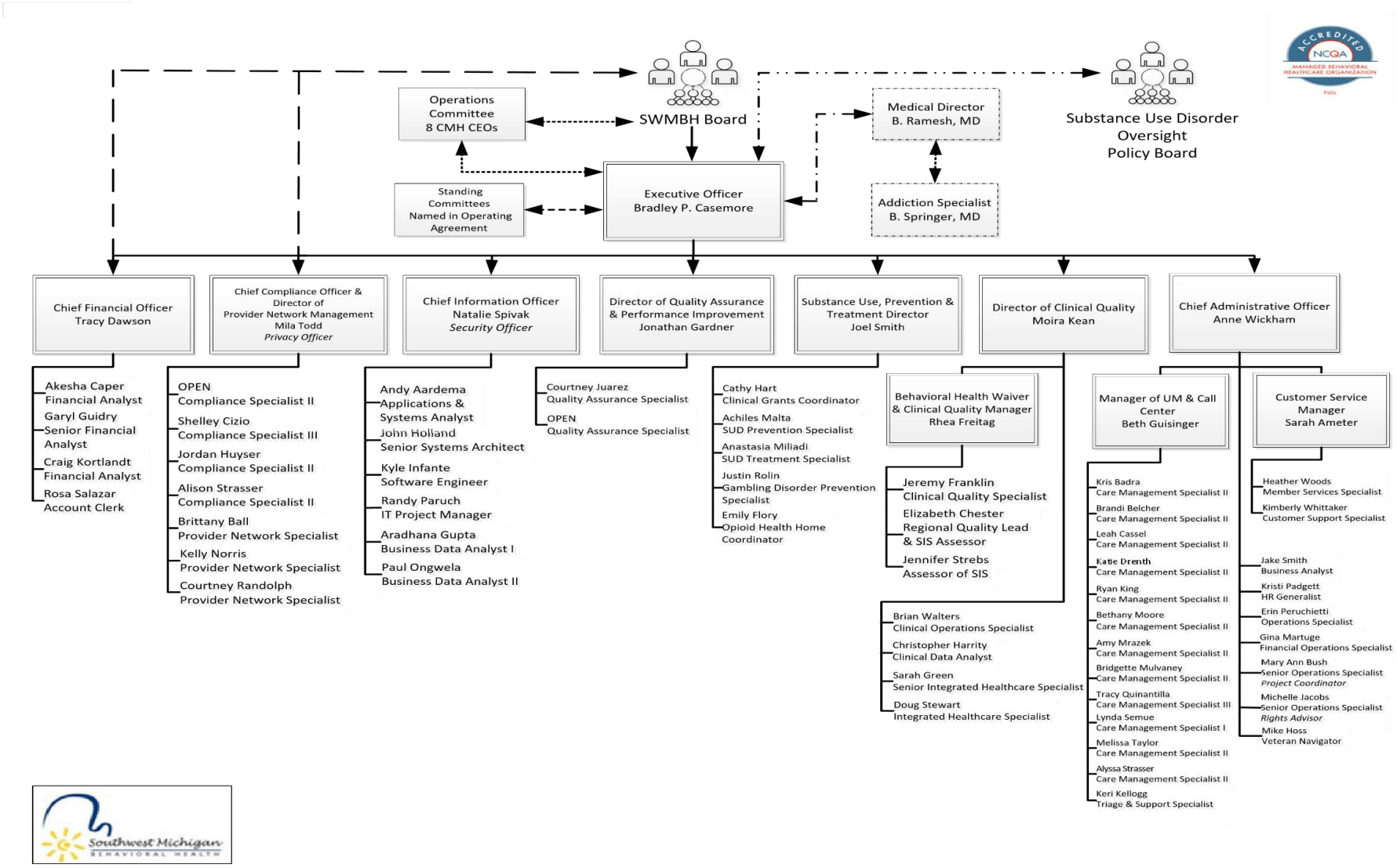
Jonathan Gardner	SWMBH	*Ad hoc*
Bangalore Ramesh	SWMBH	*Ad hoc*

Attachment H: SWMBH Organizational & Committee Structure Chart

Organizational Chart Revised 11/17/2020



Attachment I: Regional Utilization Management Committee Charter

Southwest Michigan BEHAVIORAL HEALTH

2021 Board Member Roster

Barry County

- Ruth Perino
- Robert Becker (Alternate)

Berrien County

- Edward Meny - Chair
- Randy Hyrns (Alternate)

Branch County

- Tom Schmelzer – Vice-Chair
- Jon Houtz (Alternate)

Calhoun County

- Patrick Garrett
- Kathy-Sue Vette (Alternate)

Cass County

- Vacant
- Mary Middleton

Kalamazoo County

- Erik Krogh
- Patricia Guenther (Alternate)

St. Joseph County

- Carole Naccarato
- Cathi Abbs (Alternate)

Van Buren County

- Susan Barnes - Secretary
- Angie Dickerson (Alternate)