



Southwest Michigan Behavioral Health Board Meeting
Four Points by Sheraton, 3600 E. Cork St. Ct. Kalamazoo, MI 49001

April 14, 2023

9:30 am to 11:30 am

(d) means document provided

Draft: 4/5/23

- 1. Welcome Guests/Public Comment**
- 2. Agenda Review and Adoption (d) pg.1**
- 3. Financial Interest Disclosure Handling (M. Todd)**
 - None Scheduled
- 4. Consent Agenda**
 - a. February 10, 2023 SWMBH Board Meeting Minutes (d) pg.3
 - b. Consumer Advisory Committee Nomination (d) pg.6
- 5. Operations Committee**
 - a. February 1, 2023 Meeting Minutes (d) pg.7
 - b. Operations Committee Quarterly Report (C. Bullock) (d) pg.10
- 6. Ends Metrics Updates (*Requires motion)**

Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?

 - *2022 Annual Consumer Satisfaction Survey Results (J. Gardner) (d) pg.11
- 7. Board Actions to be Considered**
 - a. Bradley Casemore Employment Agreement
 - b. Policy Governance Assessment (S. Radwan) (d) pg.22
 - c. Retirement Plan Amendment (B. Casemore) (d) pg.42
 - d. Election of Officers
- 8. Board Policy Review**

Is the Board in Compliance? Does the Policy Need Revision?

 - a. BG-006 Annual Board Planning (d) pg.45
 - b. BG-001 Committee Structure (d) pg.47
- 9. Executive Limitations Review**

Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?

 - BEL-001 Budgeting (C. Naccarato) (d) pg.48

10. Board Education

- a. Fiscal Year 2023 Year to Date Financial Statements (G. Guidry) (d) pg.52
- b. Fiscal Year 2022 financial results (G. Guidry) (d) pg.61
- c. Fiscal Year 2022 Quality Assurance and Performance Improvement Program Evaluation (J. Gardner) (d) pg.66
- d. SWMBH Retirement Plans (C. Doerschler, J. Ingersoll) (d) pg.192
- e. Michigan Consortium for Healthcare Excellence Written Report (B. Casemore) (d) pg.198
- f. Health Services Advisory Group Technical Report (J. Gardner) (d) pg.202
- g. Fiscal Year 2023 Utilization Management Plan (B. Guisinger) (d) pg.204

11. Communication and Counsel to the Board

- a. May 12, 2023 Board Retreat Agenda and Location (d) pg.210
- b. Lakeshore Regional Entity Lawsuit (d) pg.211
- c. June 9, 2023 Draft Board Agenda (d) pg.212
- d. Board Member Attendance Roster (d) pg.214
- e. June Board Policy Direct Inspection – BEL-006 Investments (S. Sherban)

12. Public Comment

13. Adjournment

SWMBH adheres to all applicable laws, rules, and regulations in the operation of its public meetings, including the Michigan Open Meetings Act, MCL 15.261 – 15.275.

SWMBH does not limit or restrict the rights of the press or other news media.

Discussions and deliberations at an open meeting must be able to be heard by the general public participating in the meeting. Board members must avoid using email, texting, instant messaging, and other forms of electronic communication to make a decision or deliberate toward a decision and must avoid "round-the-horn" decision-making in a manner not accessible to the public at an open meeting.

Next Meeting

Board Planning Session

Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001

May 12, 2023

9:30 am – 3 pm

Southwest Michigan

BEHAVIORAL HEALTH

Board Meeting Minutes

February 10, 2023

Four Points Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001

9:30 am-11:30 am

Draft: 2/10/23

Members Present: Tom Schmelzer, Susan Barnes, Carol Naccarato, Ruth Perino, Louie Csokasy, Erik Krogh, Nancy Johnson

Members Absent: Edward Meny, Sherii Sherban

Guests Present: Bradley Casemore, Executive Officer, SWMBH; Michelle Jacobs, Senior Operations Specialist & Rights Advisor, SWMBH; Garyl Guidry, Chief Financial Officer, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Mila Todd, Chief Compliance Officer, SWMBH; Jonathan Gardner, Director of Quality Assurance and Performance Improvement, SWMBH; Courtney Dunsmore, Provider Network Specialist, SWMBH; Ric Compton, Riverwood Center; Cameron Bullock, St. Joseph County CMH; Richard Thiemkey, Barry County CMH; Jeanne Goodrich, Summit Pointe

Welcome Guests

Tom Schmelzer called the meeting to order at 9:30 am and introductions were made.

Public Comment

None

Agenda Review and Adoption

Motion Louie Csokasy moved to approve the agenda with one change of moving the Regional Utilization Plan to the March Board meeting.

Second Carol Naccarato

Motion Carried

Financial Interest Disclosure (FID) Handling

Mila Todd noted the names on the agenda, Sherri Sherban, Mary Green and Angie Dickerson, as presented and stated that no Board action is needed as no disclosures were made.

Consent Agenda

Motion Louie Csokasy moved to approve the January 13, 2023 Board meeting minutes as presented.

Second Susan Barnes

Abstain Nancy Johnson

Motion Carried

Operations Committee

None

Ends Metrics

Fiscal Year 2022 Behavioral Health Treatment Episode Data Set (BH TEDS)

Jonathan Gardner reported as documented. Discussion followed.

Motion Carol Naccarato moved that the data is relevant and compelling, the Executive Officer is in compliance and the Ends do not need revision.

Second Louie Csokasy

Motion Carried

Board Actions to be Considered

May 12, 2023 Board Meeting and May 12, 2023 Board Planning Session

Brad Casemore shared planning, process and details. Board members gave suggestions and voted to cancel the May Board meeting to focus solely on the planning session.

Motion Ruth Perino moved to cancel the May 12, 2023 Board meeting.

Second Louie Csokasy

Motion Carried

Board Policy Review

BG-007 Code of Conduct

Tom Schmelzer reported as documented.

Motion Erik Krogh moved that the Board is in compliance with Policy BG-007 Code of Conduct and the policy does not need revision.

Second Carol Naccarato

Motion Carried

Executive Limitations Review

None

Board Education

Fiscal Year 2023 Year to Date Financial Statements

Garyl Guidry reported as documented. Discussion followed.

Fiscal Year 2022 Program Integrity Compliance Report

Mila Todd reported as documented. Brad Casemore and Mila Todd summarized recent and ongoing experiences between SWMBH and the Office of Inspector General (OIG), including deeper, broader and more prescriptive input in SWMBH's operations and SWMBH's contractual obligations. Discussion followed.

Fiscal Year 2022 Medicaid Services Verification Report

Mila Todd reported as documented. Discussion followed.

Regional Committees

Brad Casemore reported as documented noting SWMBH Bylaws, Operating Agreement and guiding documents that ensure and explain the roles and responsibilities of regional committees. Discussion followed.

Communication and Counsel to the Board

Opioid Advisory Commission (OAC) and Opioid Settlement Funds

Brad Casemore reported as documented.

Substance Use Vulnerability Index

Brad Casemore reported as documented.

Roslund Prestage Audit Planning Letter

Brad Casemore reviewed the letter and the Board shared feedback.

March 10, 2023 SWMBH Draft Board Agenda

Brad Casemore noted the document in the packet for the Board's review.

Board Member Attendance Roster

Brad Casemore noted the document in the packet for the Board's review.

Intergovernmental Contract

Brad Casemore reviewed the history of the Intergovernmental Contract and summarized SWMBH's process and timeline for renewal of the contract which expires 12/31/23. Status of this renewal will be brought to the Board as needed/necessary.

Public Comment

None

Adjournment

Motion	Erik Krogh moved to adjourn at 10:47 am
Second	Susan Barnes
Motion Carried	



*Principal Office: 5250 Lovers Lane, Portage, MI 49002
Phone: 800-676-0423*

Date: February 28, 2023

Agenda Item

**Southwest Michigan Behavioral Health Customer Advisory Committee
Recommendation for Membership**

It is the recommendation of the Southwest Michigan Behavioral Health Executive Officer that the following individual be appointed to a one-year term ending September 30, 2024

Name	County
Kelli Nettleman	Branch

Southwest Michigan

BEHAVIORAL HEALTH

Operations Committee Meeting Minutes **Meeting: February 1, 2023 10:00am-11:30am** Draft: 2/2/23

Members Present

Jeannie Goodrich, Cameron Bullock, Ric Compton, Jeff Patton, Debbie Hess, Scott Williams, Richard Thiemkey

Guests present

Brad Casemore, CEO, SWMBH; Anne Wickham, Chief Administrative Officer, SWMBH; Garyl Guidry, Chief Financial Officer, SWMBH; Natalie Spivak, Chief Information Officer, SWMBH; Beth Guisinger, Director of Utilization Management, SWMBH; Jeanette Byypuneedi, Behavioral Health and Integrated Care Manager, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Leah Mitchell, Manager of UM and Call Center, SWMBH; John Ruddell, Woodlands BHN

Call to Order

Jeannie Goodrich began the meeting at 10:00 am.

Review and approve agenda

Agenda approved as presented.

Review and approve minutes from 10/26/22 Operations Committee Meeting

Minutes were approved by the Committee.

Fiscal Year 2022 Year to Date Financials

Garyl Guidry reported as documented and noted that Standard Cost Allocation should be complete by next month with all eight CMHSPs reporting actual numbers.

Ability To Pay (ATP) Administrative Rule

Garyl Guidry reviewed the recent State Legislature changes to the Mental Health Code regarding ATP to align Michigan with the Federal sliding scale fee. There are inconsistencies with how to calculate per member per month sessions. Internal meetings with MDHHS are ongoing and implementation is currently on hold.

Conflict Free Access and Planning (CFAP)

Brad Casemore reported as documented.

EDIT Feedback

Anne Wickham reviewed last October's EDIT meeting and complaints from CMHs around their input into EDIT meetings. Ed Sova of ISK and Anne Wickham of SWMBH represent the region on the Statewide EDIT meetings. Anne stated that she is always available to the CMHs for any input into the EDIT meetings. Jeannie Goodrich thanked Anne for her ongoing availability.

May Board Retreat

Brad Casemore noted the agenda in the packet for the group's review.

Joint Legislative Relations

Brad Casemore shared the recent Michigan House and Senate Committee appointments and stated that he is connecting with legislators to educate them on the public Behavioral Health System. Brad asked the group to work together to meet and work with legislators in our region.

Board Chair ask for Operations Committee information

Brad Casemore

Synchrony Health Services

Brad Casemore reported as documented.

2023 Operations Committee Planning

Brad Casemore asked the group for topics and ideas for 2023 planning. Jeff Patton would like Diversity, Equity and Inclusion (DEI) added to the 2023 planning.

Intergovernmental Contract Renewal

Brad Casemore reviewed the history of the Intergovernmental Contract and timeline for renewal of the contract which expires 12/31/23. This topic will be brought back to the Operations Committee as needed throughout this year.

2023 Operations Committee Meetings

Jeannie Goodrich reviewed the scheduled 2023 Operations Committee meetings. The group agreed to approve the meeting dates with the cancellation of the March 22, meeting.

Clinical Outcomes

Brad Casemore reported as documented and will bring this topic back to the March meeting for deeper discussion with Clinical Quality Director, Alena Lacey.

Provider Network Adequacy

Brad Casemore reported as documented.

Medicaid Services Verification Report

Brad Casemore reported as documented.

Fiscal Year 2022 Performance Bonus Incentive Program Results

Brad Casemore noted the report in the packet and stated that the numbers could change a little. A final report will be released in late February or early March.

Integrated Care Overview

Jeanette Byyapuneedi reported as documented.

2023 Utilization Management Plan

Beth Guisinger reported as documented.

MiCARE for the Bed Registry

Beth Guisinger reported as documented. Discussion followed.

Public Health Emergency (PHE) wind down

Brad Casemore stated that the Federal Government announced the end of the PHE on May 11, 2023 and Michigan Medicaid redeterminations will start on April 1, 2023. Fiscal Year 2024 revenue reflections will reflect Medicaid redeterminations. Anne Wickham discussed changes to the Telemedicine Policies and the effect these changes will have, curtailing the use of Telemedicine. The PIHPs and CMHs are waiting for the policy changes to be released.

Adjourned

Meeting adjourned at 11:30 am

DRAFT



**Operations Committee Board Report
Quarterly Report for February, March 2023
Board Date 4/14/23**

Action items:

- None

Discussion items:

- Multiple topics for information, review and updates are discussed at each meeting as we move to making recommendations for actions. Some recommendations are to SWMBH management, and some go to SWMBH Board. Much information and recommendations are taken by Operations members take back to their own CMH's. Some of the topics from this quarter included:
 - Reviewed year to date financial reports-and reviewed state level actions which impact financials
 - Reviewed Fiscal Year 2023 Contract Status/Updates
 - Reviewed Fiscal Year 2022 Performance Bonus Incentive Program developments
 - Opioid Health Homes (OHH) status
 - Reviewed Grant Updates/Status (Block Grant, Opioid Health Homes)
 - Reviewed and discussed various State and Milliman rate setting documents, Cost Allocation Workgroup updates including Standard Cost Allocation, new administrative rules, tiered rates and managed care delegation
 - Reviewed Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) and External Quality Reviews
 - Reviewed and discussed beginning Health Disparities Data
 - Reviewed MDHHS code changes
 - Discussion of CCBHC (Certified Community Behavioral Health Clinics) implementation and status
 - Discussion of Integrated Healthcare strategies
 - Discussion of Conflict Free Access and Planning and LOCUS MIFAST
 - Discussion of MiCARE Bed Registry
 - Discussion of MHL extraction
 - Discussion of 2022-2025 Strategic Plan and 2023-2024 Board Ends Metrics
 - Discussion of Opioid Settlement dollars and Opioid Advisory Commission
 - Discussion of Legislative Relations and Initiatives
 - Discussion of Intergovernmental Contract Renewal
 - Reviewed 2023 Regional Utilization Management Plan
 - Discussion of Public Health Emergency wind down
 - Discussed Annual Operating Agreement review
 - Discussed Annual Self-Evaluation process
 - Reviewed Fiscal Year 2022 Customer Survey Report

2022 Annual Consumer Satisfaction Survey Results and Analysis

Board Ends Metric:

PERFORMANCE METRIC DESCRIPTION	STATUS
<p>2022 Customer Satisfaction Surveys collected by SWMBH are at or above the 2021 results for the following categories:</p> <p>Metric Measurement Period: (4/1/22 - 8/30/22) Survey Period: (11/12/22 – 12/30/22) Metric Board Report Date: March 10, 2023</p> <p>A. Mental Health Statistic Improvement Project Survey (MHSIP) tool. <i>(Improved Functioning – baseline: 85.1%) 1 point.</i></p> <p>B. Youth Satisfaction Survey (YSS) tools. <i>(Improved Outcomes – baseline 77.3%) 1 point.</i></p> <p>C. Complete a series of Consumer oriented focus groups and work with the Consumer Advisory Committee to document, understand and act upon potential improvement efforts that impact overall Consumer Satisfaction.</p> <p>Measurement: Confirmation via selected survey vender of a valid process, survey data, and results report.</p> <p>Possible Points: 2 points will be awarded, 1 for each A & B.</p> <p><i>*Although the satisfaction survey tool changed, the survey results still represent an overall positive response and improvement in overall consumer ‘satisfaction’. The 2022 results will be utilized as baseline data, in comparison to 2023 survey results. Given the data presented, it is our recommendation that Board find the:</i></p> <p><i>“data relevant and compelling, the Executive Officer in Compliance and approve the 2023 Ends, as revised”.</i></p>	<p>Metric Achieved</p> <ul style="list-style-type: none"> Adult – Improved Functioning: 83.6% (-1.5%) Decrease in comparison to 2021 result. Youth – Improved Outcomes: 75.5% (-1.8%) Decrease in comparison to 2021 result. <p>Key Factors:</p> <ul style="list-style-type: none"> *The Survey Tool was changed in 2022, to shorten consumer response times (29min to 4min) *The new survey tool is a hybrid MHSIP/YSS/ECHO survey. *Neutral option was removed from survey tool. *Some survey categories were combined and question went through an ‘in agreement relevancy study’ to determine which questions are most relevant/actionable for improvement.

Survey Description

The QAPI Department has completed the 2022 annual Member Experience Satisfaction Survey. The primary objective of the survey is to improve scores in comparison to the previous year’s results and identify opportunities for improvement at the CMHSP and PIHP levels. During the 2022 survey project, SWMBH ensured the incorporation of individuals receiving long-term supports or services, case management services, CCBHC services, and Medicaid services into the review and analysis of the information obtained from quantitative and qualitative methods.

During FY22 Survey Project, SWMBH utilized a hybrid Mental Health Statistics Improvement Program (MHSIP), Youth Surveillance Survey (YSS) and the Experience of Care and Health Outcomes Survey (ECHO) to gauge member experience of care. During FY22 the SWMBH Quality Department’s goal was to collect 1500 completed surveys. The Region was able to reach that goal and achieved 1571 valid surveys, encompassing a validated survey process and consumer feedback from all eight of the CMHSPs. This was a tremendous improvement over the previous year’s survey completion volume of only 747 valid surveys.

In efforts to improve survey accessibility during FY22 and FY23, consumers could complete the survey via QR codes or tablets in the CMHSP lobby areas, through the SWMBH website, text message, email, or by paper copy.

The diverse options improved the response rates, and the targeted volume was achieved during FY22. The results of the annual survey are shared with MDHHS as a PIHP contractual obligation, the SWMBH Board of Directors, and Regional Committees (Operations Committee, Quality Management Committee, Consumer Advisory Committee, etc.) who have stake in the results/improvement efforts.

Improvement Efforts Made in FY22

During the 2022 survey project, the following significant improvement efforts were implemented:

The survey tool:

- Goal: Shorten the length of the survey by 30% to ease survey fatigue and increase response rates.
- A factor analysis was conducted to determine if any core survey items were redundant.
 - MHSIP tool was revised from 36 core items to 24 core items (in addition to open ended and demographic questions) while combining some constructs that were redundant.
 - YSS tool was revised from 26 core items to 23 core items (in addition to open ended and demographic questions).
- Item response options were changed from a 5pt scale with neutral option to a 4pt scale with no neutral option.
 - Previously, a “neutral” response was interpreted as a positive outcome.
 - The new scale forced respondents to respond either positively or negatively.
 - “Somewhat” labels were added to mid-scale positive and negative options, which offered a more accurate measure of overall satisfaction.







Priority population enhancements:

- New demographic questions were added for long-term support services and CCBHC to the survey. This allows responses to be filtered for those specialized populations and target performance improvement interventions as needed.
- A target of 300 completed surveys were established for the two CCBHC sites. ISK achieved this target at 386 and St. Joe fell short at 279.
- Data from each program (CCBHC, LTSS and CMHSP specific response) were cleaned and separated into distinct data sets and available to filter to identify common denominators or trends in responses.

Recommendations for 2023 Survey Project:

- Create a bot-catching mechanism or safe-guard technology to identify and stop fraudulent/ineligible responses. This could include including a CAPTCHA, trap/red herring questions, consistency checks, and/or other methods.
- Consider incentivizing every respondent.
 - Depending on the mode of delivery this could make the survey more cost effective and more representative of the consumer population.
 - Another option is to incentivize counties that have lower population and higher uncertainty (Cass/Branch/Barry) or underrepresented minorities.

FY22 Survey Goals and Results

Goal	FY21	FY22	Eval Score	Recommendations	Time Estimate
Identify a new (shorter) survey tool that meets 'Best Practice' standards and have approved by MDHHS for use during the 2022 survey period.	In progress	Complete	5	Monitor survey completion times and consumer feedback quality/quantity of questions. The FY21 completion time averaged 29 min. The FY22 completion time averaged 4.5 minutes.	 3-6 Mo.
Ensure that CMHSPs are reviewing the survey analysis with their internal workgroups and addressing identified areas needing improvement.	In progress	Complete	4	Each CMHSP is expected to formulate goals related to the survey results and submit them to SWMBH for review.	 3-6 Mo.
Incorporate additional questions into the survey to capture CCBHC and LTSS program participant responses.	In progress	Complete	4	Work with Clinical Quality Department to target LTSS questions and review responses to improve LTSS services and programs.	 3-6 Mo.
Expand survey access via different methods, such as email, text, phone, website, paper, tablet and QR code.	747 Complete Surveys	1571 Complete Surveys	4	The goal of 1500 completed surveys was achieved. The Quality Department will continue to formulate improvement efforts and recommendations through consumer feedback.	 6-12 Mo.
Improvement on overall "Improved Outcomes" for Youth respondents and "Improved Functioning" for adult respondents.	Youth: 77.3% Adult: 85.1%	Youth: 75.5% Adult: 83.6%	4	Ensure CMHSP's are reviewing consumer feedback, identify areas of improvement and target programs/services for improved "Outcomes/Functioning". It is important to note, that the survey questions did change from the previous year.	 A.S.A.P.
Focus on overall improvement across all survey categories in comparison to previous years results.	Youth: 81.5% Adult: 82.2%	Youth: 83.8% Adult: 84.9%	5	Overall, the Youth scores improved by 2.3% over the previous years result and the Adult scores improved by 2.7% over the previous years results. 2023 will provide a more accurate comparison in scores by year, since the same survey tools will be utilized for both the Youth and Adult participants.	 6-12 Mo.

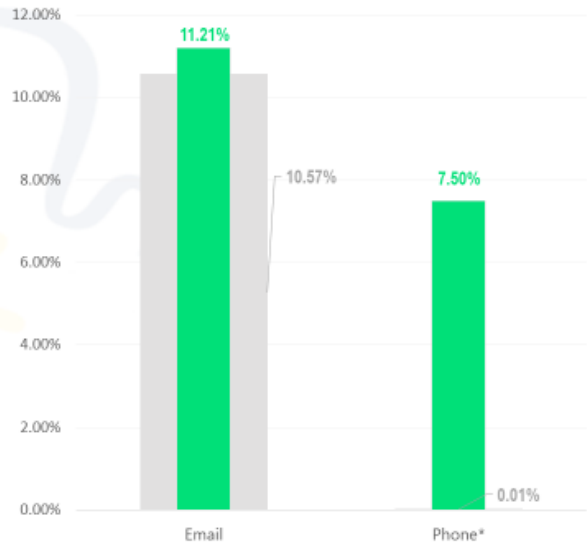
Response rates for the MHSIP rebounded in 2022

Switch to text message survey invitation for phones resulted in return to normalcy for sample size

MHSIP # of responses, 2014-2022



MHSIP response rate by medium
2021 vs. 2022



Kiaer
Research

SWMBH Consumer Satisfaction
2022 Results

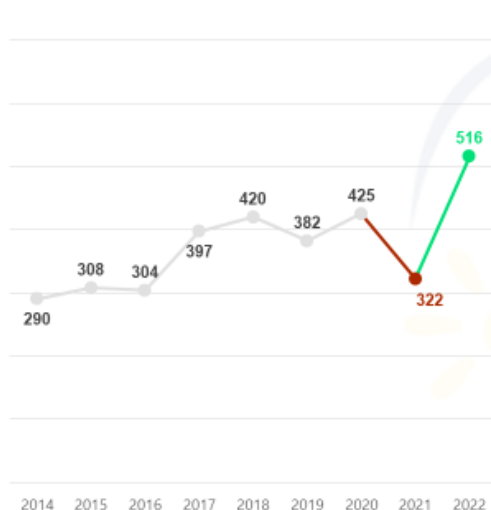
*direct calls in 2021,
texts in 2022

4

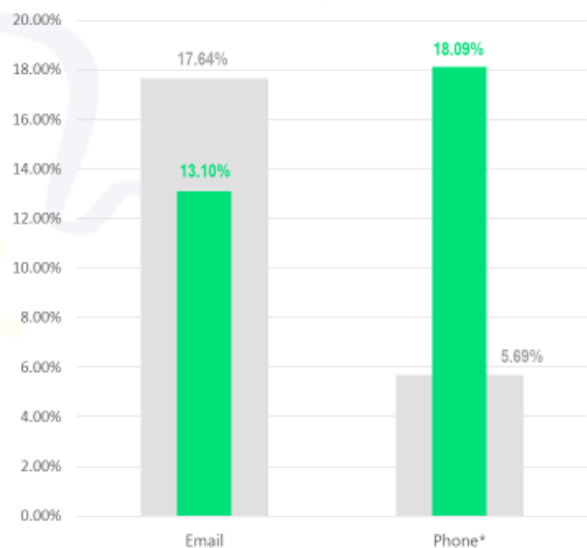
Response rates for the 2022 YSS reached highest point yet

Email response rates lowered while switching to SMS invitations more than tripled phone response rates

YSS # of responses, 2014-2022



YSS response rate by medium
2021 vs. 2022



Kiaer
Research

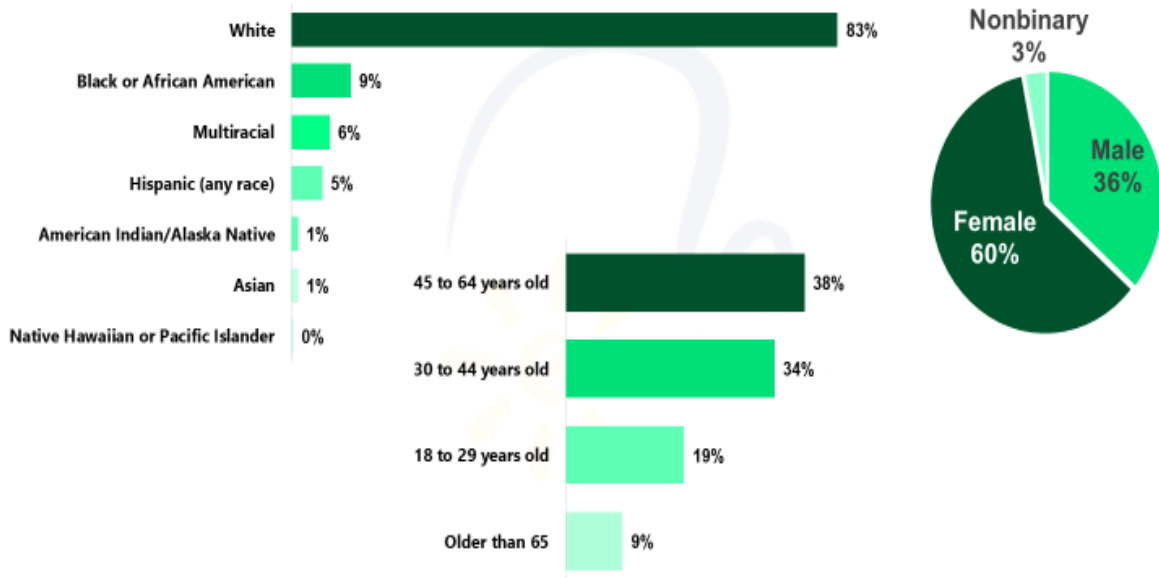
SWMBH Consumer Satisfaction
2022 Results

*direct calls in 2021,
texts in 2022

5

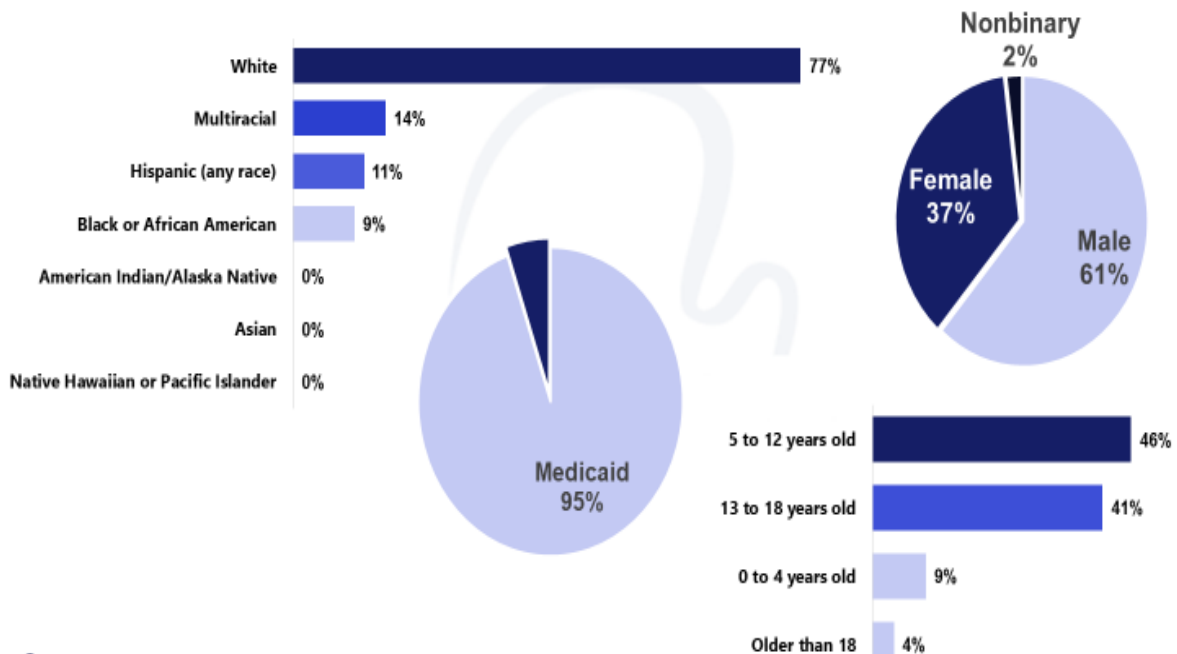
MHSIP 2022 respondents similar in makeup to prior years

This year saw slightly less minority respondents and slightly more male respondents.



YSS 2022 youth reported less racial diversity

Many more boys than girls are receiving services, with age 5-12 most common

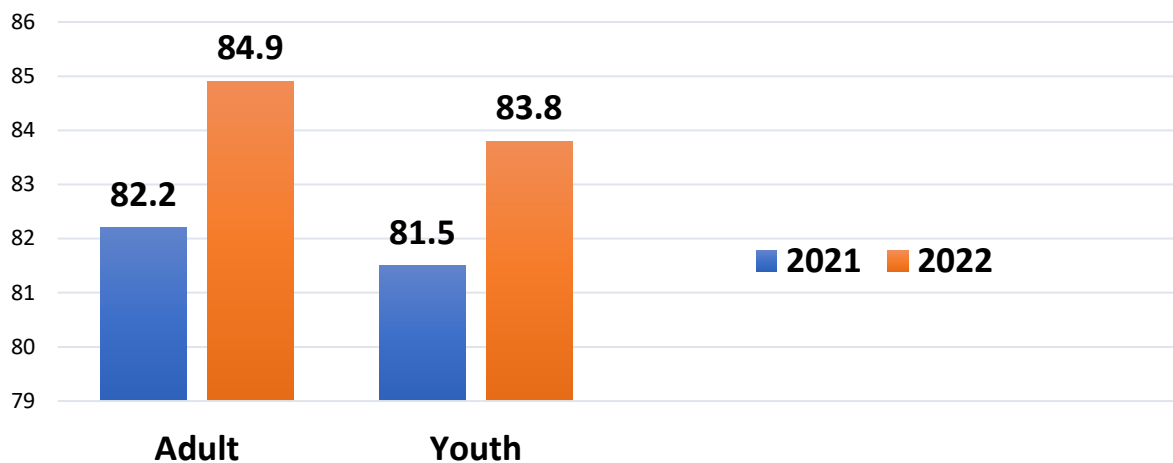


More youth than adults report having a case manager or service coordinator

Presence of case manager or service coordinator indicates consumer is receiving long term support services (LTSS)



'In Agreement' Overall Scores by Year (Adult and Youth Survey)



All SWMBH CMHSPs: 2022 MHSIP scores by construct

Dark green denotes the percentage in agreement for that construct's items

Gray bars denote the likely range where the true percentage for all SWMBH consumers might lie (i.e., margin of error*)



Adult LTSS consumers report better scores than non-LTSS adults across the board

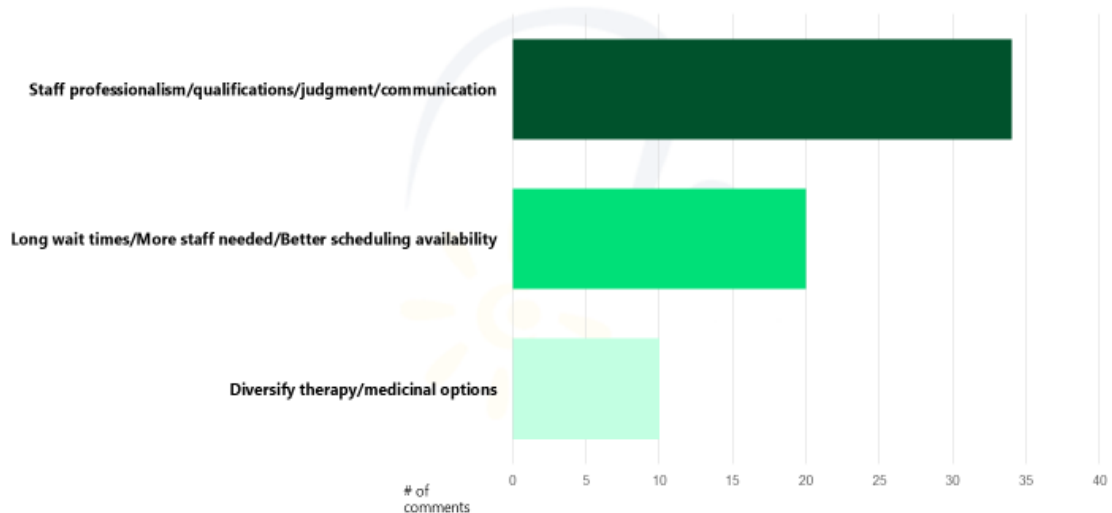
Dark green denotes the percentage of LTSS (long-term social services) consumers in agreement for that construct's items

Gray bars denote the likely range where the true percentage for all LTSS consumers might lie (i.e., margin of error*)



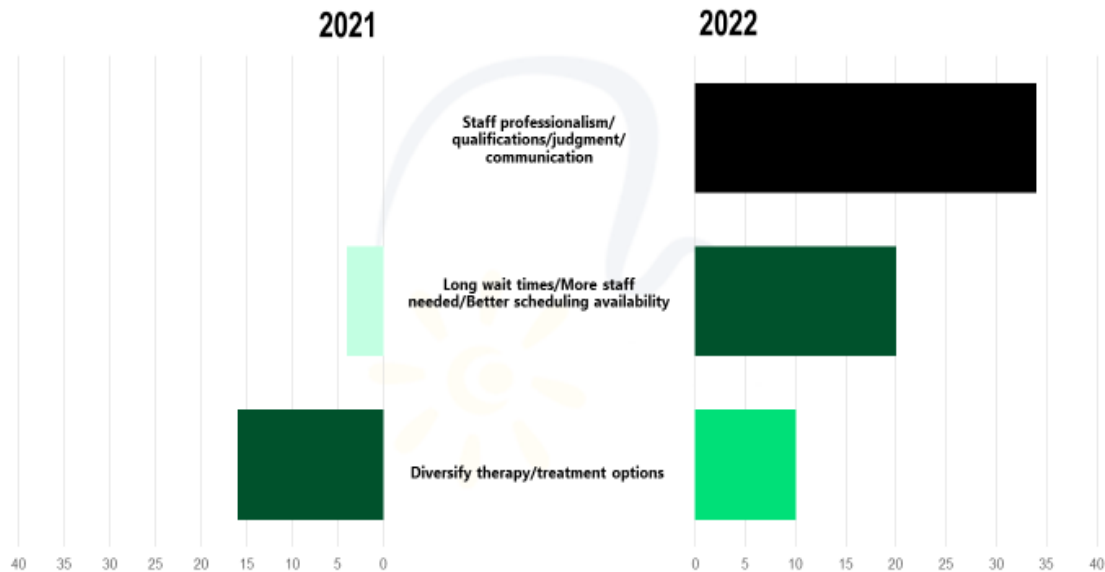
Opportunities for improvement in diversifying treatment options

Of respondents to the MHSIP who were dissatisfied with services, diversifying treatment options and having to wait to receive services were the most mentioned areas for improvement



2022 saw many complaints about staff professionalism and communication

Many comments discussed staff attitude, providers listening more, and better communication between different staff



Consumers had life-changing accounts of benefit from their CMHSPs

"Best place I ever been to, and best people too. Always smiling and says hello when I walk in. Never had to wait in the waiting room."

"Without these services I would not be here today. I am very grateful."

"The entire experience has been positive, professional, and helpful. I greatly appreciate the services provided. Thank you all very much."

"My therapist is the best, Renee has single handedly saved my life and made it better at almost every appointment."

"The act team has totally helped me transform my life. I am so grateful."

"Being placed back on my medication has made a huge turn around with my life including daily duties and wanting to get up and out of bed with a good start to my day instead of sad or depressed or just stuck."

"Yes, my counselor has helped me a lot in looking at things different, and I do feel better about myself."

Adult Survey Questions that showed Significant Improvement



*Improvement is in comparison to 2021 survey results.

All SWMBH CMHSPs: 2022 YSS scores by construct

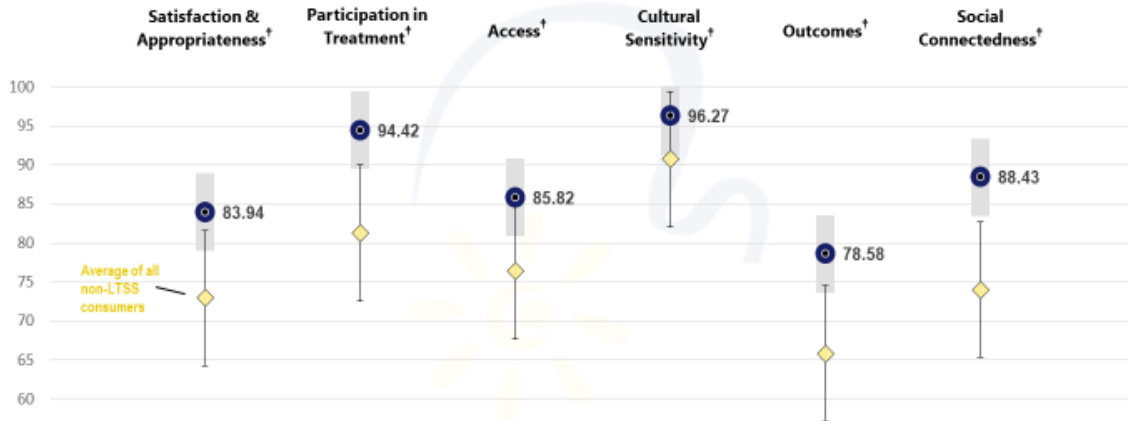
Dark blue denotes the percentage in agreement for that construct's items

Gray bars denote the likely range where the true percentage for all the county's consumers might lie (i.e., margin of error*)



Youth LTSS consumers report better scores than non-LTSS youth across the board

Dark green denotes the percentage of LTSS (long-term social services) consumers in agreement for that construct's items
Gray bars denote the likely range where the true percentage for all LTSS consumers might lie (i.e., margin of error*)



Different treatment options requested included...

"add **community living supports** and the **LINK** program back; increase frequency of outpatient therapy appointments"

"**Visits at home** when the kid refuses to go to the center."

"**Written crisis plans**, not the two page calming skills but actual directions from the team when in crisis."

"**Respite** (adequate respite) is a huge need of families with children that find themselves in need of CMH services. It would be nice for some funding to be allocated to regular, appropriate, and adequate respite. Camp Kidwell offers a great weekend service. Respite like the one they offer would be great."

"Would love to have services available. The only thing my child gets is case management and psychiatrist. There are no openings for **ABA**, **respite**, **CLS**, etc."

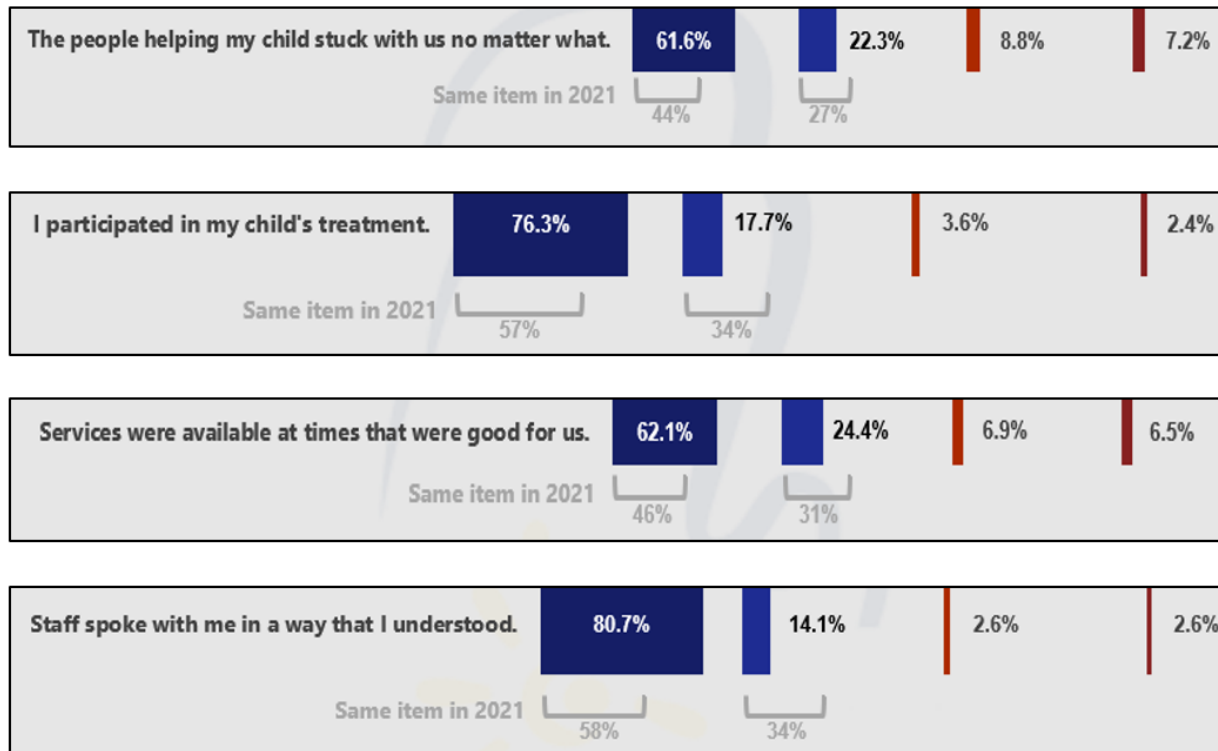
"Some sort of **respite** service for older kids and parents to have some time away in a safe manner."

"Having a choice on where to receive **respite care** for my child."

We needed **emergency support** we needed a **peer to peer** program, we need someone who can give us help with **respite**. We don't have family here so we don't have ppl to help us with that.

"More **in person gathering** with other families since covid is better than it was. Social interaction is key to my son/family as well as **other families** as well. Isolation is not good for mental health and social skills improvement."

Youth Survey Questions that showed Significant Improvement



Newly Proposed 2023 Board Ends Metric Language for 2023

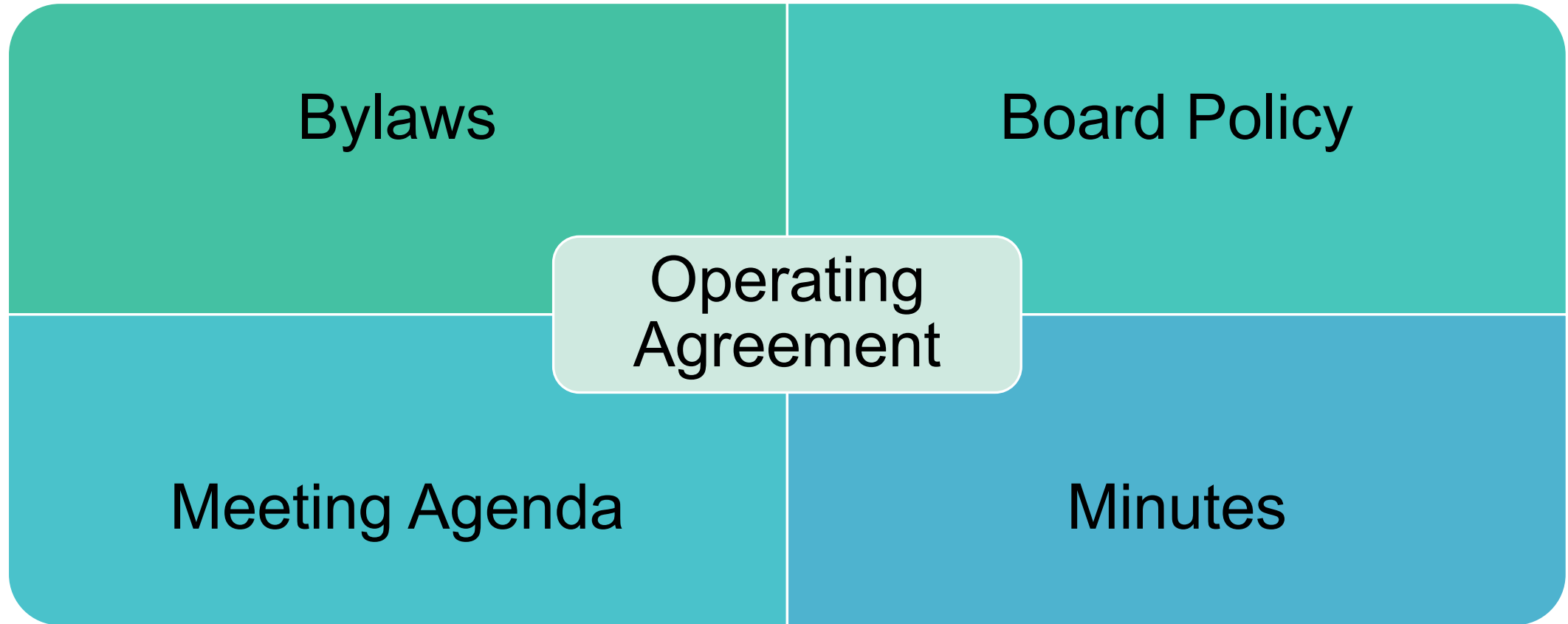
Strategic Imperative Category: Exceptional/Access to Care			
Persons and families served are highly satisfied with the services they receive.			
2023 Customer Satisfaction Surveys collected by SWMBH are at or above the 2022 baseline results identified in (a & b) and performance improvement areas/plans are identified (c & d).	<p>This metric is in direct alignment with <i>Section V</i> of the 2023 MDHHS-PIHP contract 'Member Experience with Services'</p> <ol style="list-style-type: none"> The survey methodology must include a quantitative assessment (e.g., surveys) of member experience with services. The methodology must include a qualitative assessment (e.g., focus groups) of member experience with services. 	<ol style="list-style-type: none"> Mental Health Statistic Improvement Project Survey (MHSIP) tool. (<i>Outcomes & Functioning</i> – 2022 baseline: 78.6%) 1 point. Youth Satisfaction Survey (YSS) tools. (<i>Outcomes</i> – 2022 baseline: 75.51%) 1 point. Work with the SWMBH Consumer Advisory Committee as Focus group to document, understand and act upon potential improvement efforts that impact overall Consumer Satisfaction. 1 point. Ensure that each CMHSP partner reviews site specific survey results and formulates Corrective Action Plans to drive identified or potential improvement areas. 	<p>Current Status:</p> <p>✓ On track to achieve metric.</p> <p>Survey Collection Period All of 2023, with analysis of results beginning in September 2023.</p> <p>Metric Board Report Date: February 9, 2024</p> <p>Notes: MDHHS permitted PIHP's to adopt a different survey tool during the 2022 process. SWMBH moved from the traditional MHSIP/YSS tools, to the hybrid MHSIP/YSS/ECHO tool. New baseline data was established in 2022 and average survey completion time was decreased from 29min to 5 min.</p>

Southwest Michigan Behavioral Health

GOVERNANCE REVIEW

Your Governance is One Whole System

Each document tells a part of the story



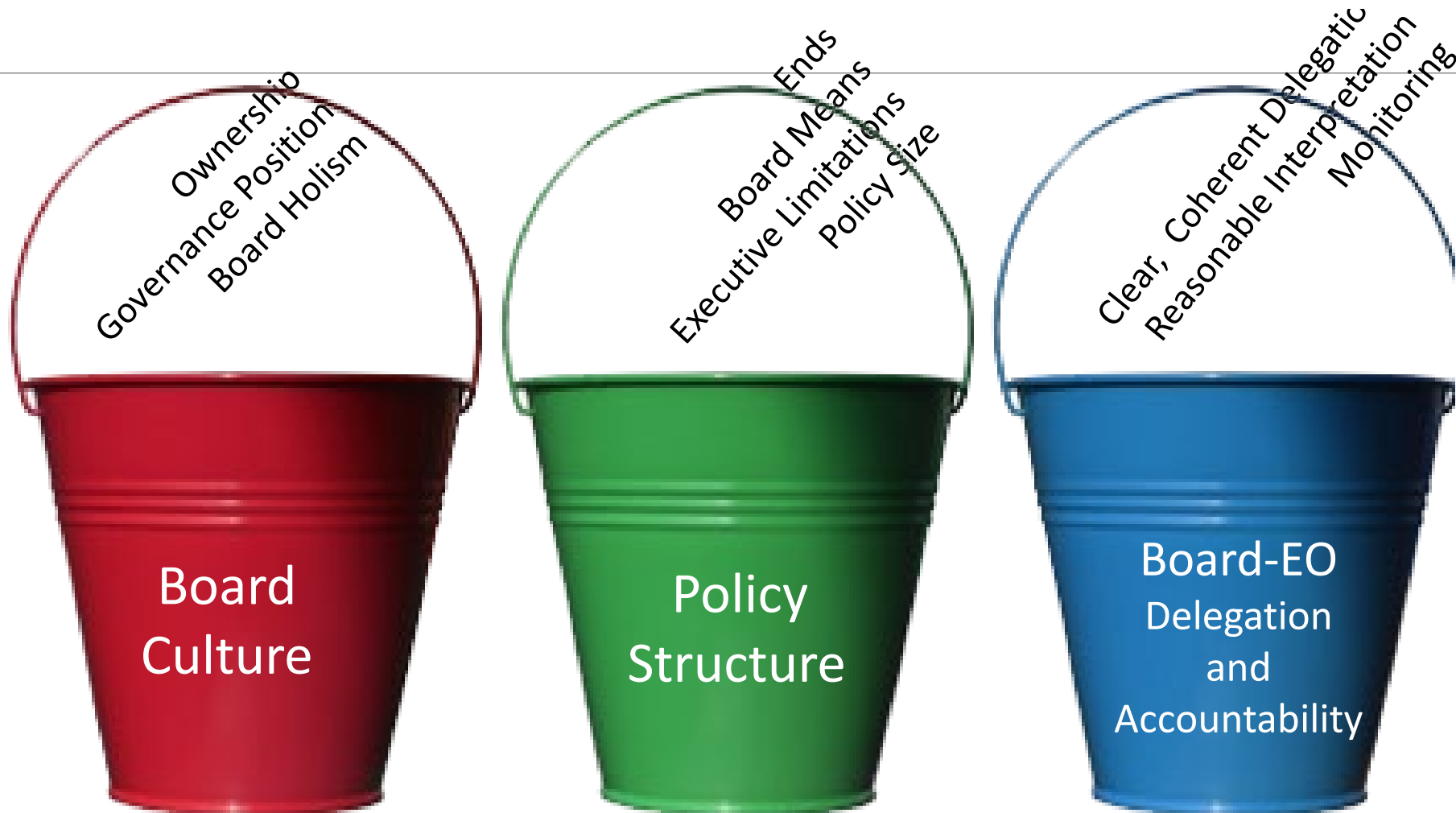
Policy Governance: A whole **Systems Approach for SWMBH**

Governing is seeing to it that the whole organization achieves what it should and avoids unacceptable situations.

Hold the whole as your primary concern.



10 Policy Governance Principles in Three Buckets of Concern All Embedded into Your Board Means Policies



To do Governance well...

1. The Board is accountable for its own job design, job products, job discipline, and job development.
2. The Board Chair is accountable to assure the **integrity** of governance which includes following the law, your bylaws, and Board policy.
3. Policies guide the decision-making processes and define the delegations to the EO.
4. To be the **informed voice and agent of the ownership**, policy needs to represent the values of the ownership.

Governing Document Audit Highlights

1. Global policies act as an umbrella policy to all of the lower level policies in the section.

- Each lower level policy further defines the global policy.

Example: Global Executive Limitations Policy (BEL-009)

The accountability of the EO's performance is based solely on achievement of the Ends and compliance with Executive Limitations, based on reasonable policy interpretations of the EO.

The Board does not define the interpretation of policy. The EO interprets and defines standards of achievement or compliance. The Board determines if that interpretation is reasonable.

Optimizing Your Governance Efforts



1. Board takes ownership of their own job and culture.
2. Board culture truly reflects the policies you have adopted.
 - Become aware of the connection between the words and your board practices.
 - Align the Board practices with your Board policies
3. Reformat policies to align with Policy Governance principles. (Consultant led project)
4. Engage with consultant to incrementally learn more deeply how to live the policy during your board meetings.



March 23, 2023

TO: Brad Casemore, CEO
SWMBH
FROM: Susan S. Radwan, Consultant
RE: Proposal for Policy Governance Assessment

Brad, thanks for your time last week to give me more context to understand why things are done in a particular way at SWMBH.

I have taken your comments and integrated them in the following documents:

- This proposal
- A revised version of the audit commentary
- A revised version of the PPT for the April 14 meeting to present during the 30 minutes I have on the current agenda.

Depending on the board's willingness, I propose a technical assistance plan for SWMBH Board and management for calendar year 2023.

The technical assistance would be specific to Policy Governance principles and practice with the board itself.

1. Share findings of the preliminary audit with the Executive Committee.

Meet with the Executive Committee and share observations and recommendations to close the gap between Policy Governance® principles, policies and practices.

2. Facilitate a Policy Governance® model review with the full board, potentially configured in bite-sized pieces.

For people new to Policy Governance, receiving the review of the principles in one session can be overwhelming. An initial training for the Board takes approximately 6-8 hours. With 4 hours focused the ten principles of the Policy Governance model, plus two-four hours focused on the job products of the board, specifically ownership linkage, policy development and assurance of performance (monitoring).

We can configure that training in a single day OR we can break it up over time. I like to teach the principles in three buckets: board culture, structure, and board-management delegation.

It is helpful for a group to learn about the 10 principles in one setting since the principles work together as a unit; however, for some, that is like drinking from the fire hose! If it is preferred, we could cover each "bucket" in conjunction with your regularly scheduled board meetings over time, extending the meeting time by an hour to 90 minutes. Followed by special sessions on ownership linkage, policy development and monitoring.

3. Consider coaching possibilities.

As you may recognize, Policy Governance® offers significant opportunities for the board to shape the future, based on its strategic exploration of relevant trends that may impact public education, the community, or the society in general. Often Boards miss the opportunity to do this work because of a general misunderstanding of its annual agenda planning. When the board creates their own annual plan of work for strategic exploration, it sets forth a substantive opportunity to look into the future, become an informed voice and agent of the ownership, and speak to relevant trends in its ends. Boards often find it helpful to have this session facilitated by a Policy Governance consultant.

I have facilitated sessions like this for many boards. On an annual basis, we can accomplish a number of things with a day long retreat. 1. Have a brief refresher on the model; 2. Conclude the previous year's plan of work and 3. Set forth a new annual plan of work. Additionally, I am often called in to conduct a PG orientation on the 10 principles when a new board member joins the group. That type of orientation can be on a virtual platform or through a pre-recorded video. This might be most helpful for your alternates on the board.

It is important for the board to recognize, however, that anytime you have a new board member, you have a new board. The dynamic of board changes with a new voice at the table. As a result, I am also a believer that the full board should engage in some sort of orientation process to get a sense of the new dynamic. Given the nature of your constituency board, perhaps holding an event that would include all members and alternates might be helpful.

Your Investment

The range of activities and timeframe for consulting will impact the overall cost. But let me paint a picture of what the overall cost will likely be. I allocate cost primarily on actual time spent with the client with the exception of document review. Mileage and other expenses are charged in addition to the consulting fee. Mileage to live events would be approximately \$86.5 per trip.

Phase 2: Engagement with the Executive Committee and Board <i>All live meetings will incur mileage expenses</i>	
1. Meet with the Executive Committee to discuss findings and next steps... <i>on site or Zoom</i>	\$600
2. Facilitate a review of the 10 Principles – Live Education in ½ day session OR conduct the basic training by zoom and record it for future onboarding of board members and alternates AND/OR	Live-\$1500 + expenses
Review of 10 Principles meeting by meeting (8 meetings-live) Combined with coaching the board meeting by meeting	\$600/mtg + Exp
3. Coaching on writing monitoring reports for senior staff 3 hr session, modeling operational definitions and brainstorming for appropriate for data tracks with metrics for success measures during the reporting period.	\$1500
4. Coaching Board meeting by meeting – live	\$600/meeting + Exp
5. Coaching Board Annually to create an annual plan of board work and review opportunities for governance improvements	\$2250 (6 hrs) + exp
Total possible investment for Phase 2 over eight months Payable with monthly invoicing or installments of your choice Fees would be based on actual work based on the client's desired configuration.	A range of \$9150 - \$12150 + Exp

SWMBH Governance Audit *revised*

applying the Policy Governance Principles

Submitted by Susan S. Radwan, Policy Governance Consultant

General Commentary

This governance audit involved the following reviews:

1. Review of the Policy Manual, with significant recommendations to reorder and revise the manual to align with the Principles of Policy Governance.
2. Review of the Bylaws to assure that the Board is adhering to the stated provisions.
3. Review of the Strategic Plan documentation to understand the Board's role in the development of the operational plan as well as understanding how Board policy drove the strategic imperatives.
4. Review of the Agendas for each meeting, assessing whether the Board fulfilling its differentiated role as designed in the Policy Governance Model.
5. Review of Minutes of each meeting in 2022 to understand the direction of some of the agenda items.
6. Review of Board packets for all 2022 Board meetings.

Each review conducted offered specific observations related to alignment with the Policy Governance model. This report contains commentary from each of the reviews listed. Because the Board packets, agendas and minutes follow a templated pattern, observations that apply to one item, generally apply to all like items.

Policy Governance is a systems approach to governing. To understand the system, the board needs access to see a whole and the inter-relationship of policies, the inter-relationship of all the Ends-related Metrics to assure the Ends as a whole are being achieved. In general, everything is fragmented.

- The policies are available only in a fragmented fashion and do not follow the formatting principles.
- Ends Metrics are presented in a fragmented form and not at all tied to the Ends policy language.

It appears that the staff members who are providing monitoring reports or who may have had a hand in the creation and archiving of the policy manual need to develop some understanding how their work is connected to the policy system and how the system works.

- The Monitoring approach needs to be tweaked so that a projection of results that the organization works to achieve is incorporated into the interpretation of policy. In is not evident that an interpretation of Ends exists with system-wide projected impacts on the consumer.

The Board does not appear to be engaged in delivering its own "job products".

- There is no indication that the Board is doing any ownership linkage activity to become the informed voice and agent of the Ownership as a collective body.
- There is no indication that the Board is doing any strategic exploration to advance the organization directionally, ultimately keeping Ends policies relevant.
- There is no indication that the Board has developed any policies in 2022. The only policy the board revised was the internal retirement policy plan.
 - There may be a need to right-size the EL policies, i.e. remove the limitation on real estate or on payroll since the process is systems driven.

- There is no indication that the board discusses as a whole body whether or not it is complying with its own Board Means policies. While all policies are being monitored by an individual, it appears that the board does not see this effort as a path for continuous improvement in governance.

SWMBH Bylaws Observations

Article IV: Regional Entity Board

4.1 General Powers. The business, property and affairs of the Regional Entity shall be managed by the Regional Entity Board in accordance with the Policy Governance Model as made explicit by Dr. John Carver www.carvergovernance.com.

*The board governs and delegates management of the operations to the EO. The provision would be more aligned with Policy Governance if it said **governed**, not managed.*

4.3 Appointment. *Since the Participant CMHSP Boards appoint members of the Regional Entity Board, it might be worthwhile for SWMBH to identify desirable criteria n appointed candidates. Governance research demonstrates that careful selection of Board members is the #1 concern of a high-performing board.*

4.5 Removal. *The Regional Entity Board is responsible for informing the relevant Participant board if there is a lack of participation or attendance by the Participant's appointed Board members. Does this really happen?*

4.12 Conflict of Interest Policy. *Members will annually disclose any conflicts of interest while serving on the Regional Entity Board. Completed; reported in April minutes.*

4.13 Compliance with Laws. *The provision requires that the Regional Entity shall develop such compliance policies and procedures to address applicable laws, such as Open Meetings and FOIA. While the Board Policy manual has a specific policy related to Open Meetings and FOIA, it seems a bit misguided and does not address the wider compliance with all relevant laws.*

4.14 Alternates/Designees. *In a well executed Policy Governance environment this provision poses many problems. The Board dynamic changes when even one board member changes. If you have alternates who are not following the train of thought on strategic issues OR do not understand the Policy Governance model, this provision disrupts the playing field significantly. The result is that the Board no longer governs because we have an uneven and uncommitted board. Because the EO is the only constant, the Board often loses the "right relationship" as the commanding authority, properly delegating to the EO. In Policy Governance, the Board's job is to be the informed voice and agent of the collective ownership.*

It is not clear what the role of the alternates is exactly. It appears their only role is to sit in the gallery to be informed of the operational reports.

6.5 Removal (of Officers): *Usually, the bylaws will give legitimate reasons for removal. The SWMBH bylaws do not. How would the board know whether they should invoke removal of an officer. There should be language such as no confidence, malfeasance, etc. It is also not clear that if an*

officer is removed, are they also removed from representing the Participant entity? Or are they only removed as an officer but remain on the board?

6.6 Chair: *In Policy Governance, the role of the Chair is to assure the integrity of governance which is beyond simply presiding over meetings. It means that the whole board comply with the fiduciary duties of care, loyalty and obedience. It also means that the Board operate in compliance with its bylaws and Board policies. Language should be added here to address assuring the integrity of governance.*

6.7 Vice Chair: *I do recommend that the Vice Chair be the champion of Board orientation so that all participants understand the model of governance that defines the culture of the Board.*

6.8 Secretary: *It is not enough that the minutes are recorded, but the Secretary shall assure the integrity of meeting documentation....in other words, accurately recorded in writing and preserved.*

Article IX. Reports. *The bylaws should indicate when the annual report is due to each participant.*

Article XI. Administration. *Most of the provisions in this section seems to belong in the Participant agreement. The detail of allocations is not about the rights of Participants, as the bylaws are intended to define.*

11.1.6 Accountability of Funds. *This provision should be in the Board Policy Manual not in the bylaws.*

11.1.2 Capital and Operating Costs. *Typo in line 6...principle should be principal.*

11.1.8 Risk Management. *This provision requires a Financial Risk Management Plan that is approved by the Regional Entity Board. Does it exist?*

11.2 Other Administration Activities. *This committee undermines the delegated authority of the EO in a Policy Governance world. It is appropriate that IF the EO wants to have a consultation committee, that would be acceptable, but it is at the request of the EO with a clear scope of concern defined.*

SWMBH Policy Observations

(See the Policy Manual Uninterrupted to demonstrate the Policy Manual as one whole document.)

1. Policies, as currently archived, fragment the nature of the policy manual which is an interdependent system. The Board cannot refer easily to relevant policies to guide their actions, nor can they easily see the interaction among the policies which is important as they review monitoring reports and bring new concerns to the board's attention.
2. The policy manual does not capture the umbrella nature of the Global Policies. For example, the Global Executive Constraint which is number BEL-009 is an umbrella to all other BEL policies. Anything not covered explicitly in the subsequent policies IS covered by the umbrella nature of this policy.
3. There is no added value in the purpose statement that heads up each policy. Recommend deletion.

4. What is identified as *Standards* are actually lower level policies to the broader statement. These policies are intended to be the Board's further interpretations of the language in the broader policy which in turn limit the range of EO interpretation.
5. In the Executive Limitations, the lead in statement says, "Accordingly, the Executive Officer may not...." However, in Executive Limitations, the lead in should be more like, "This includes but is not limited to..." This language allows for other interpretations of the language in the broader policy rather than limit it to the explicit lower level policies. Carver's original language in this place was, "Further, without limiting the scope of the foregoing by this enumeration, he or she shall not:..."
6. There is no need to repeat bylaws language in the policy manual. The Bylaws are a stand alone legal agreement between the members and the organization. The board should be as familiar with the bylaws as they are with the Board policy manual.
7. RE: Ends
 - Ends are never about what the organization itself, but rather they focus on the intended impacts on the beneficiaries.
 - Ends should begin with a global statement which encompasses all the lower level policies.
 - The Ends as identified are not clear about who is the direct beneficiary of SWMBH.
 - The Ends do not identify at what cost or what worth to the organization we achieve the Ends.

I recommend a reformatting to align with Policy Governance formatting. To illustrate:

Current Ends

1. Quality of Life

Persons with intellectual & developmental disabilities, serious emotional disturbance, autism spectrum disorders, serious mental illness, and substance use disorders in the SWMBH region see improvements in their quality of life and maximize self-sufficiency, recovery, and family preservation

2. Exceptional Care

Persons and families served are highly satisfied with the services they receive

3. Improved Health

Individual mental health, physical health and functionality are measured and improved •

4. Mission and Value Driven

CMHSPs and SWMBH fulfill their agencies' missions and support the value of the public behavioral health system

5. Quality and Efficiency

The SWMBH region is a learning agency where quality and cost are measured, improved, and reported

Ends (Proposed to align with PG Philosophy)

1.0 Global End

SWMBH is a fiduciary for state and federal funds that exists to assure that member agencies create environments where persons with intellectual & developmental disabilities, serious emotional disturbance, autism spectrum disorders, serious mental illness, and substance use disorders in the SWMBH region see improvements in their quality of life and maximize self-sufficiency, recovery, and family preservation, at the cost of efficient stewardship of resources available.

Furthermore, Member Agencies:

- 1.1 Assure that persons and families served are highly satisfied with the services they receive
- 1.2 Measure and track improvement for individual mental health, physical health and functionality

- 1.3 Fulfill their agencies' missions and support the value of the public behavioral health system
- 1.4 Learn from each other, the data collected and the metrics that are tracked and reported.

8. RE: Executive Limitations

- BEL-002 The purpose statement is the actual Financial Planning and Budgeting policy. The Financial Conditions and Activities policy governs the day-to-day transactions of the organization.
- RE: BEL-002.9. Executive Limitations policies NEVER needs to speak to Board authorization or approval. The nature of Executive Limitations is that they limit the unilateral authority of the EO. As a result, the EO cannot do anything beyond the statements without explicit board approval.
- BEL-005 Do these policies actually relate to Plan Member Treatment?
- BEL009 is the Global Policy but it is combined in an odd way with a board means policy. As the global policy it should be the first policy to appear in the Executive Limitations Section of policy. It acts as the umbrella to all successive ELs. All other ELs are further definitions of what the board deems as imprudent or unethical.
- BEL-010 re: MCHE is completely out of format with PG Principles. Most of this policy is about communication to the board. I am debating whether it belongs in the Board-Management Delegation Section OR to institute a new EL regarding Relationships with the External Environment. But I cannot locate any info about what this organization is or who it is intended to serve. I need more information to make a determination on where it goes.
 - In the uninterrupted policy manual, I put the reporting to the board provisions in Communication and Support to the Board and the budget of \$5000 belongs in Financial Conditions and Activities.

9. RE: BG-001 The policy as stated opens the door for the Board to appoint operational committees. Board committees are appointed to help the board do its own work. The EO, not the board, has the authority to appoint operational committees. When the board appoints operational committees, it undermines the accountability of the EO and violates the delegation of operations to the EO.

10. BG-002 Under what circumstances should the Board have access to the fiscal officer and Chief Compliance Officer. Let's be clear about that. It is clear that these positions report to the EO. What is the interest of the Board for them to have access?

11. BG-004 The policy as written violates the principles of Policy Governance, specifically regarding approving interpretations and adopting Ends Metrics. In practice, the board only accepts an interpretation and the metrics IF deemed reasonable. The metrics decisions are in the realm of the EO to choose what metrics will demonstrate that the system is working as interpreted. The EO "owns" these features as part of developing reasonable interpretations.

Eliminating that language leaves the policy without purpose since it is in the Board's job description to determine Ends.

12. BG-005 No need to say the Board will abide by the bylaws. We already cover that in board means policies. No need to quote verbatim from the bylaws.

13. BG-008 Orientation. It would be more important to offer a live remote briefing on Policy Governance which is the board's job than a briefing on functional areas which are operational and under the EO's control. The functional area type of briefing opens the door to undermining the EO's authority over operations and staff relationship with Board members.

14. BG-011 #7 & 8: Following the conflict of interest policy is covered under the Board's Code of Conduct. No need here.

15. BG-012 Open Meetings Act and Freedom on Information Act. We have already said in Board Code of Conduct that the board must act lawfully. This includes Open Meetings and FOIA. No need for this policy

in the Board Policy Manual. The bylaws requires that the Board create policies and procedures regarding lawful activity. I suggest that a policy be developed regarding a grievance against a Participating member who may be violating the law with procedures broadly covered in the Policy Manual.

16. There does not appear to be a global Governance Process Statement which defines the governing role of the board on behalf of its members.

I propose the following:

POLICY 3.0 The purpose of the Board who are stewards of funding available on behalf of Plan Members is to see to it that SWMBH achieves appropriate impacts for its direct beneficiaries at an appropriate value and to assure that the organization avoids unacceptable situations and risks.

Observations: SWMBH Strategic Plan 2023-2025

The plan has 11 Strategic Imperatives listed, but how do these relate to Ends. There should be a direct line between strategic initiatives and Ends. The choice of programs and services belongs to the EO, as the interpretation of Ends. When you tie the Strategic Imperatives directly to Ends, then the Board can see the priorities of allocations to achieve Ends.

As a point of best practice in Strategic Planning, the Plan should revolve around strategies, rather than a list of goals to achieve. Because disruptions over the next few years are inevitable, how will the priority strategies carry the organization forward, through the disruptions? The EO interpretation of the Ends can then identify the key success measures and metrics for achievement.

In Policy Governance, the EO owns the strategic plan, not the board. The strategic plan is operational in nature and under the scope of delegation from the Board to the EO.

The plan, developed by the operational team, should be directly tied to achieving progress on the Ends.

It is recommended, however, that the Board create its own Annual Plan of Work, defining a topic of shared concern for strategic exploration that could result in policy development, usually an Ends amendment.

Observations re: Minutes

Best practice in minutes recording is as follows:

1. There is no need to identify who made the motion and seconded it. Once seconded, the board owns the motion and consequently identification of the mover and seconder is superfluous.
2. The minutes should identify the exact motion made.
3. The range of discussion should be identified to communicate the sense that the board is complying with its fiduciary Duty of Care.

Embedded below is a chapter from “the Association Law Handbook” by Jerald Jacobs describing the modern approach to recording minutes.



Minutes of Meetings Article.pdf

March 2022 Minutes

When the Board is reviewing Monitoring reports, there are two questions for the board to answer: 1. Does the board accept the interpretation of the policy as reasonable? and 2. Does the data demonstrate compliance with the interpretation?

The concept of interpretation is an operational definition of the policy. In other words, how have we operationalized this policy inside our system? The EO also needs to give the rationale for why the board should see this as a reasonable application of the policy. Further, the interpretation includes the data track to be used to demonstrate that the system application is achieving organization-wide results. This data track may also need to be justified as to why the board should see it as a reasonable measure of performance in alignment with the policy interpretation. This is the interpretation that the board should determine as reasonable or not – for each lower level policy as well as the broadest policy.

Then, finally verifiable data, pulled from the data track, is presented to demonstrate performance in alignment with the interpretation.

The minutes do not show that the board questions the reasonability of the interpretation. They are only judging compliance. In Ends monitoring, the board should be assessing reasonable achievement of the Ends.

I note that the Policy BG-006 indicates that proposed Ends Metrics and final reports are proposed to the Board throughout the year, passed upon a Board- approved reporting calendar. My question is...what does the board do with that information? Do they pre-approve the metrics? If so, that would not be in alignment with Policy Governance. If the Board approves the proposed metrics, they own them, thus undermining the EO's ability to change the metrics as appropriate.

April 2022 Minutes

The Board found that the survey was adequate to show compliance with A and C. But what is the follow up when a piece of the report is NOT compliant? This presents a governance gap.

Remove National Committee on Quality Assurance (NCQA) as an Ends Metric

Belonging to an organization is not a metric that shows results. It is not an Ends Metric.

What is the process **to review if the board is in compliance with its own Board means** policies? I see that individuals give a report and make a recommendation for compliance. Is there any discussion in case others might see it differently?

- The Board's appointment of the Operational Committee does in fact violate BG-010. The Operational Committee is not helping the board do its work. It is designed to advise the EO. This is not in alignment with Policy Governance principles.

Board Education. What was the nature of the discussion that followed the presentation? A few bullet points would be advised to indicate the direction of the discussion.

It is noted that in the meetings of first quarter 2022, none of the meetings had 100% attendance. Is board attendance a problem? Is the presence of the all staff overwhelming to the board? Is attending the meetings a good use of staff time?

May 2022 Minutes

As noted, when you don't have a quorum, the board cannot make any decisions or take any votes. You can, however, present reports and hold discuss issues. But all decisions need to be made when there is a quorum.

June 2022 Minutes

What is the nature of the Conflict of Interest with Mr. Csokasy? Such conflicts could be mitigated by having an additional conflicts of interest policy wherein the Board member must declare the specific conflict in the context of a specific board agenda item.

To be clear about Conflicts of Interest, the real concern is when the board is addressing a matter of a contract and the individual who has a vested interest in that contract award is participating in the determination of who gets the contract. This situation is a violation of the Fiduciary Duty of Loyalty. IF the board actually has delegated operations, the EO is the one who makes that award decision. So the Executive Limitations policies may need a Conflicts of Interest policy to apply to the operational decision-makers as well as the board.

Motions made without a vote recorded in the minutes:

Audit Report Fiscal Year 2021

2022 Operations Committee Self-Evaluation Report

2022 Operations Committee Self-Evaluation Report

August 2022 Minutes

Same as above re: conflicts of interest

Board Actions to be Considered

Revised SWMBH Policy BEL-007 Compensation and Benefits

There is no indication in the minutes of what the revised policy is.

September 2022 Minutes

Resolution Honoring Representative Fred Upton

Brad Casemore reported as documented.

Motion Erik Krogh moved to adopt the resolution as presented.

Second Louie Csokasy

Motion Carried

What is the resolution? It should appear in the minutes.

Executive Limitations Review: *On what basis is this review occurring? Is the whole board reviewing the reports? Is there any discussion of the interpretation or data provided?*

BEL-002 Financial Conditions Louie Csokasy stated that he is actively working on the review of the policy and corresponding documents and asked to move this review to the October Board meeting. Board agreed.

BEL-004 Treatment of Staff Ruth Perino reported as documented. Motion Ruth Perino moved that the Executive Officer is in compliance with Policy BEL-004 Treatment of Staff and the policy does not need revision.

Second Tom Schmelzer

Motion Carried

BEL-009 Global executive Constraint Susan Barnes reported as documented. Motion Susan Barnes moved that the Executive Officer is in compliance with Policy BEL-009 Global Executive Constraint and the policy does not need revision. 3 Second Erik Krogh Motion Carried

Note: Monitoring process might have room for improvement. Has it ever been discussed that perhaps the whole board should be involved in monitoring rather than a single person?

Communication and Counsel to the Board

Could this policy be better served as a written report to the board rather than a verbal update?

Board Packets

Operations Committee Report: *What is the value of the minutes of that monthly report of the board? If it doesn't add value, why is it included?*

January 2022 Agenda

152 pages of content seems excessive for a monthly meeting. Is the whole board processing that much information? Has there been any discussion around whether the board packets demonstrate compliance with Policy BEL-008, Standard #6? "Present information in unnecessarily complex or lengthy form or in a form that fails to differentiate among information of three types: monitoring, decision preparation and other."

Ends Metrics Updates (*Requires motion)

Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?

The questions offered here are not complete. Critical to note is whether the Interpretation offered is reasonable, and whether the data shows compliance with the interpretation.

What is the purpose of the QAPIP Overview? Is it Board education? Is it related to policy in any way?

March 2022 Agenda

What board action is required for the budget updates, financial management plan, cost allocation plan or financial risk management plan. If anything, these should be under Communication and Counsel to the board. Because each of these reports are operational in nature, I fail to understand why the board needs to act on these reports. They are not framed as monitoring reports related to the BEL policies.

RE: Board Education – Does the staff or board determine what they need education on? The majority of these items are operational in nature...Board education could also be used for strategic exploration. For example, the House Dems Listening Tour report could be used by the Board to determine possibilities for Ends exploration.

Ends Metrics Updates:

Ends metrics should be focused on outcomes, not activity results. In the Opioid health Homes Program, what is the expected outcome? Your Ends interpretations should have a projected result, then the data should demonstrate that we achieved that result. Beware however, where possible, impacts should be the focus of projected results, not activity such as how many participants. Raw numbers mean nothing. What is the % of whole involved in treatment? What is the projection for retention in the program? What is the intended outcome of participation in the program? And how did we fare on that projection?

April 2022 Agenda

How do the Ends Metrics relate to the Ends? Where is the interpretation that demonstrates how it all connects together? You have five ends. Which of these does the survey relate to? It may be better to present all the Ends metrics in one integrated report, explicitly tying the data tracks and actual data to the Ends policies.

RE: Withdrawal from National Committee on Quality Assurance as an Ends Metric

*“*Given the current circumstances; with SWMBH’s withdraw from the MHL Demonstration Project. SWMBH is respectfully requesting that the Board allows/approves the removal of the above metric language from the approved 2022-2023 Board Ends Metrics.”*

The Board approving the metrics for Ends monitoring violates the principle of Any Reasonable Interpretation. The EO has the authority to change interpretations at any time. It is not the role of the Board to approve any interpretation. The role of the board is to examine the interpretation of Ends as reasonable or not. IF found to be reasonable, the Board ACCEPTS the interpretation as reasonable, followed by a determination of whether the Board finds the accompanying data to demonstrate achievement in alignment with the projections of performance included in the interpretation.

Board Education

Has the board asked for a financial report monthly? Unless the financial activity report or budget is on schedule for monitoring, the financial and budgeting reports are FYI for the board.

In general, if the board desires a monthly financial report, that ask should be identified in the Communication and Support to the Board policy. But the board should also be clear that they are not monitoring performance on the financials, it is merely an FYI, with no action required.

June 2022 Agenda

Resolution re: Retirement Savings Plan

In this resolution, the board appointed an operational committee to oversee the retirement plan, consisting of the CEO, the CFO, and the Chief Administrative Officer. This resolution violates the board policy on committee structure (BG-010) and the delegation of operations to the EO.

August 2022 Agenda

Autism – Applied Behavior Analysis Board Ends Metric

What is the justification for 53% of parents receiving training? Why should the board think 53% is a reasonable metric?

Policy Change on BEL-007

4. Establish or change retirement benefits so the retirement provisions:

- a. Cause unfunded liabilities to occur or in any way commit the organization to benefits that incur unpredictable future costs.
- b. Provide less than some basic level of benefits to all full-time employees. Differential benefits which recognize and encourage longevity are not prohibited.
- c. That are instituted without prior monitoring of these provisions.
- d. *Make revisions to Retirement Plan documents without prior Board approval.*
- e. *Implement employer discretionary contributions to staff without prior Board approval*

Comment: Neither policy d or e is necessary because the broader policy already prohibit plan changes unilaterally by the EO. Additionally, if there is a prohibition identified, the policy NEVER has to say “without board approval”. The fact that the EO is prevented from making those unilateral

decisions requires the board to waive the policy to make the changes...that can only be done by the Board.

Policy Number: BEL007 Monitoring Report

Policy Name: Compensation and Benefits Board and Report

Date: June 10, 2022

*In general the report is thorough, however, it lacks evidence of most statements. What evidence could be presented to prove that there is NO incidence of violation of the standards? Without evidence to prove the situation, you are asking the board simply to trust you. But the board needs to trust AND **VERIFY**.*

As has been experienced in the network, sometimes EOs make claims that cover up the reality. That is why evidence to prove compliance is so important.

In my opinion, there is a need to do some staff training on constructing monitoring reports that can present variable evidence of compliance to the board.

September 2022 Agenda

Ends Metrics: *What End does the Follow-up after Hospitalization for Mental Illness relate to? What was the projection? Does the data meet the projected outcome?*

Executive Limitations Review:

BEL-004 Standard #2: EO Response: No retaliation against any staff member has occurred for any reason including but not limited to an expression of dissent as evidenced by an absence of staff complaints to management, Human Resources or outside agencies in this regard. No staff member has been discriminated against in any shape or fashion for expressing an ethical dissent as evidenced by the absence of verbal or written complaints by staff either internal or to external agencies. Monthly staff meetings include a call for agenda items and views, and there is a HR-confidential question and issue submission process.

How would the board know if this is true? Monitoring reports need to provide evidence beyond the EO's words. The Board needs to be able to verify if these are true statements.

November 2022 Agenda

List of SWMBH 2022 Accomplishments and Successes

This is an impressive list, but how does this all tie in to Board policy?

December 2022 Agenda

11. Communication and Support to the Board

The EO reported on revised policies BEL-002 and BEL-010. Only the board has the ability to revise policies. It is not clear in the board packet what was revised or why the revision was necessary, but IF the EO did these revisions, that would be an overstep.

Southwest Michigan Behavioral Health

Resolutions of the Board of Directors

The board of directors (the “*Board*”) of Southwest Michigan Behavioral Health (“*SWMBH*”) hereby takes the following actions:

WHEREAS SWMBH maintains the Southwest Behavioral Health Retirement Savings Plan (the “*Plan*”), as previously amended; and

WHEREAS the Board desires to amend the Plan’s loan provisions to permit loans from the vested portion of all participant accounts;

RESOLVED that Board hereby approves the Fourth Amendment to the Retirement Savings Plan (the “*Amendment*”), in the form presented to the Board and attached hereto; and further

RESOLVED that the Chief Executive Officer and the Retirement Plan Committee are authorized and directed to take any and all actions they deem necessary or advisable to effect the foregoing resolutions.

The foregoing resolutions are dated _____, 2023, and were adopted at a meeting of the Board as of that date.

Certified

Edward Meny, Chair

SOUTHWEST MICHIGAN BEHAVIORAL HEALTH

To: SWMBH Board

From: Brad Casemore

Subject: Retirement Plan Amendment

Date: 03/10/23

This retirement plan amendment drafted by SWMBH plan counsel John Arendshorst simply permits staff to take loans from their retirement accounts. This clause was not included in original retirement plan documents nor is it in the recent amendment. It was identified to us by a staff member seeking to take such a loan. Such loans are wholly within retirement plan regulations.

Proposed motion: "To adopt the retirement plan amendment as presented."

Southwest Michigan Behavioral Health Retirement Savings Plan

4th Amendment

The Southwest Michigan Behavioral Health Retirement Savings Plan, as previously amended, is further amended as follows:

1. Section 6.7(a) is revised to read as follows:

(a) If approved by the plan administrator, participants may borrow money from the vested portion of their accounts. Loans are generally available for any purpose.

2. Section 6.7(c) is revised to read as follows:

(c) The principal amount of the loan may not be less than \$1,000 or more than any of the following amounts:

(1) the vested portion of the participant's account balance;

(2) if the vested portion of the participant's account balance is more than \$10,000 but not more than \$20,000, then \$10,000;

(3) if the vested portion of the participant's account balance is more than \$20,000 but not \$100,000, then 50% of the vested account balance; or

(4) if the vested portion of participant's account balance is more than \$100,000, then \$50,000.

These limitations will be determined and applied at the time the loan is made. The limitations in clauses (2), (3), and (4) will be applied by treating all plans maintained by the employer or any related employer as one plan. The \$50,000 limitation in clause (4) will be reduced by the highest outstanding loan balance during the one-year period ending on the day before the loan is made.

This amendment is dated and effective _____, 2023.

Employer

Southwest Michigan Behavioral Health

By _____

Bradley P. Casemore

Chief Executive Officer

Southwest Michigan

BEHAVIORAL HEALTH

Section: Board Policy – Board Governance/Management		Policy Number: BG-006	Pages: 1
Subject: Annual Board Planning Cycle		Required By: Policy Governance	Accountability: SWMBH Board
Application: <input checked="" type="checkbox"/> SWMBH Governance Board <input type="checkbox"/> SWMBH EO			Required Reviewer: SWMBH Board
Effective Date: 01.10.2014	Last Review Date: 4/8/22	Past Review Dates: 1.09.15, 2/12/16, 2/10/17, 1/12/18, 1/11/19, 4/12/19, 4/10/20, 4/9/21	

I. PURPOSE:

To organize the timing, process, content and outcomes of an annual planning process.

II. POLICY:

To accomplish its job, the Board will adopt an annual calendar which (a) completes a thorough review of Accomplishments/Ends annually, (b) continually improves its performance through attention to Board education and deliberation, (c) formally reviews all Board Policies, and (d) sets primary strategic imperatives for a following 12-18 month period.

III. STANDARDS:

- a. Completes a thorough review of Accomplishments/Ends annually;

Ends, Ends Interpretations and Ends Metrics are handled on both calendar years and fiscal years. Ends, Ends Interpretations and prospective Ends Metrics are proposed to Board no later than November and December of each year. They are first reviewed with the Operations Committee for advice and support.

Ends Metrics status and final reports are provided to the Board throughout the year, based upon a Board-approved reporting calendar. Ideally a majority of Ends Metrics are reported before or at the November Board meeting.

- b. Continually improves its performance through attention to Board education and deliberation;
- c. Formally reviews all Board Policies annually. [Please note, Board can make some or all policies more or less frequent.]

A prospective Board-approved calendar year events & activities calendar is proposed to the Board each December. It shall include: Board review calendar with Board Member assignments; required Board actions; Board-determined Board action; Ends Metrics Reporting; Executive Limitations, and Board-Staff Relationship Policy review.

- d. Sets primary strategic imperatives for a following 12-18 month period.

January- May Preparatory Strategic Planning Work

April-May: Environmental Scan and Strategic Imperatives Review with Board.

May- Board Retreat

July- 24-month Strategic Plan draft

- Mission
- Capital
- Market
- Growth
- Products
- Alliances

September- Budget Board review and approval.

Attachment: Calendar Year Board Calendar.

Southwest Michigan

BEHAVIORAL HEALTH

Section: Board Policy – Governance	Policy Number: BG-001	Pages: 1
Subject: Committee Structure	Required By: Policy Governance	Accountability: SWMBH Board
Application: <input checked="" type="checkbox"/> SWMBH Governance Board <input type="checkbox"/> SWMBH EO		Required Reviewer: SWMBH Board
Effective Date: 03.14.2014	Last Review Date: 1/14/22	Past Review Dates: 3.13.15, 3/11/16, 3/10/17, 3/9/18, 1/11/19, 1/10/20, 1/8/21

I. **PURPOSE:**

To define a SWMBH Board Committee.

II. **POLICY:**

A committee is a Board Committee only if its existence and charge come from the Board, regardless whether Board Members sit on the committee. Unless otherwise stated, a committee ceases to exist as soon as its work is complete.

III. **STANDARDS:**

1. The Board will charge the committee formed.

**Southwest Michigan Behavioral Health
Executive Limitations
Monitoring to Assure Executive Performance
BEL-001 Budgeting
April 14, 2023**

Policy Number: BEL-001
Policy Name: Budgeting
Board Date: April 14, 2023
Assigned Reviewer: Carol Naccarato

Policy:

Budgeting any fiscal year or the remaining part of any fiscal year shall not deviate from Board Accomplishments/Results/Ends priorities, risk fiscal jeopardy, or fail to be derived from a multi-year plan.

CEO Response: This report addresses fiscal year 2022 (October 1, 2021 to September 30, 2022) and the budget process for fiscal year 2023 (October 1, 2022 to September 30, 2023). Budgeting and financial reporting have been driven by adopted Board Ends Metrics, Board-reviewed assumptions, and fiscal parameters as well as Board directives from Board Planning Sessions.

Accordingly, the CEO may not allow budgeting which:

- 1. Contains too little information or omits information to enable credible projection of revenues and expenses, separation of capital and operational items, cash flow, and disclosure of planning assumptions.*

CEO Response: Fiscal year 2022, fiscal year 2023 budgeting and financial reporting each included as much information from the state as they would provide to enable credible projection and tracking of revenues. Expense projections include appropriate categories with specificity on the multiple SWMBH contracts and business lines and across the eight Participant CMHs. Capital and operational items were budgeted and reported as were cash flows.

SWMBH provided technical assistance and expectations guidance to the eight Participant CMHs throughout the FY2023 budget development process. Medicaid and Healthy Michigan eligibles trends and projections (which drive projected Medicaid and Healthy Michigan revenues) were made for fiscal year 2022 and fiscal year 2023.

Fiscal year 2022 Medicaid revenue actual receipts to budget projections were down \$11,342,638 a decrease of (-4.0%) noting that CCBHC revenues were highly unknown at the inception of the program by the actuary. The CCBHC

program continues to evolve in the rate setting process with MDHHS. Timely and more accurate information have been made available for budgeting purposes ongoing.

Healthy Michigan Plan fiscal year 2022 revenue receipts were up \$3,018,336 (6.7%) from budget, and up \$6,212,767 (14.9%) from fiscal year 2021.

Capital and operational items are detailed consistent with GAAP. Cash flows are projected and monitored. Budget documents, financial reports and accompanying materials disclose related planning assumptions which were reviewed with the Board in June 2021 for fiscal year 2022, and in July 2022 for fiscal year 2023.

Monthly fiscal year 2022 year to date financial reports have been provided to the Board monthly. All files are maintained within SWMBH Finance Department. Participant CMH CFOs and CEOs routinely review financial projections and results, as well as budget development materials.

Significant efforts by all have occurred to assure common cost allocations, per federal regulations, the SWMBH Board-approved Financial Risk Management and Cost Allocation Plans and MDHHS guidance.

2. *Plans the expenditures in any fiscal year of more funds than are conservatively projected to be received in that period.*

CEO Response: SWMBHs Board approved budget for fiscal year 2022 did not plan for the expenditures to be more than funds projected to be received. For fiscal year 2023 the approved budget did not plan for expenditures more than projected revenue.

3. *Provide less than is sufficient for board prerogatives, such as costs of fiscal audit, board development, board and committee meetings, and board legal fees.*

CEO Response: The fiscal year 2022 and 2023 budget included line items and sufficient amounts for Board prerogatives including costs of financial and compliance audit, board development, board and committee meetings and board legal fees.

4. *Endangers the fiscal soundness of future years or ignores the building of organizational capability sufficient to achieve future ends.*

CEO Response: The fiscal year 2022 actual performance is expected to be as anticipated. The improved results are due to the continuous efforts within the region to consider all areas of appropriate cost containment. SWMBH did not ignore the building of organizational capability sufficient to achieve Ends in future years and currently expects to be able to place funds into Medicaid Savings Risk

Corridor for a consecutive fiscal year. SWMBH has been active in several expense reductions, revenue maximization and funding advocacy efforts with some successes.

5. Cannot be shared with the board on a monthly basis.

CEO Response: The fiscal year 2022 and 2023 financial reports have been shared with the Board congruous with the Board's governing documents, and in format(s) approved or accepted by the Board. Throughout fiscal year 2022 and into 2023 monthly financial reports, critical assumptions, and threats to fiscal health were regularly shared with the Board.

The CEO provided this report and supporting materials to assigned Reviewer. CEO and CFO offered to meet with assigned Reviewer.

Supporting Documents

- Fiscal Year 2023 Budget Assumptions and Parameters
- Fiscal Year 2022 Board approved Budget
- Fiscal Year 2023 Board approved Budget

Southwest Michigan

BEHAVIORAL HEALTH

Section: Board Policy – Executive Limitations		Policy Number: BEL-001	Pages: 1
Subject: Budgeting		Required By: Policy Governance	Accountability: SWMBH Board
Application: <input type="checkbox"/> SWMBH Governance Board <input checked="" type="checkbox"/> SWMBH EO			Required Reviewer: SWMBH Board
Effective Date: 02.14.2014	Last Review Date: 3/11/22	Past Review Dates: 8.8.14, 11/13/15, 1/13/17, 1/12/18, 1/11/19, 1/10/20, 2/12/21	

I. PURPOSE:

II. POLICY:

Budgeting any fiscal year or the remaining part of any fiscal year shall not deviate from Board Accomplishments/Results/Ends priorities, risk fiscal jeopardy, or fail to be derived from multi-year plan.

III. STANDARDS:

Accordingly the Executive Officer may not allow budgeting which;

1. Contains too little information or omits information to enable credible projection of revenues and expenses, separation of capital and operational items, cash flow, and disclosure of planning assumptions.
2. Plans the expenditures in any fiscal year of more funds than are conservatively projected to be available for that period.
3. Provide less than is sufficient for board prerogatives, such as costs of fiscal audit, Board development, Board and Committee meetings, and Board legal fees.
4. Endangers the fiscal soundness of future years or ignore the building of organizational capability sufficient to achieve future ends.
5. Cannot be shared with the Board on a monthly basis.

	E	F	H	J	K	L	M	N	O	P	Q	R	S
1	Southwest Michigan Behavioral Health			Mos in Period									
2	For the Fiscal YTD Period Ended 9/30/2022		P12FYTD22	12									
3	(For Internal Management Purposes Only)												
4	INCOME STATEMENT												
5		TOTAL	Medicaid Contract	Healthy Michigan Contract	Autism Contract	Opioid Health Home Contract	CCBHC	MI Health Link	MH Block Grant Contracts	SA Block Grant Contract	SA PA2 Funds Contract	SWMBH Central	
6													
7	REVENUE												
18	Contract Revenue	352,504,579	219,684,799	48,276,854	20,715,860	1,575,733	47,659,349	5,152,523	-	7,265,021	2,174,440	-	
19	DHHS Incentive Payments	2,887,315	543,258	-	-	-	-	-	-	-	-	2,344,057	
20	Grants and Earned Contracts	1,024,753	-	-	-	-	-	-	1,024,753	-	-	-	
21	Interest Income - Working Capital	34,146	-	-	-	-	-	-	-	-	-	34,146	
22	Interest Income - ISF Risk Reserve	1,387	-	-	-	-	-	-	-	-	-	1,387	
23	Local Funds Contributions	1,289,352	-	-	-	-	-	-	-	-	-	1,289,352	
24	Other Local Income	-	-	-	-	-	-	-	-	-	-	-	
25													
26	TOTAL REVENUE	357,741,533	220,228,057	48,276,854	20,715,860	1,575,733	47,659,349	5,152,523	1,024,753	7,265,021	2,174,440	3,668,943	
27													
28	EXPENSE												
29	Healthcare Cost												
30	Provider Claims Cost	25,600,927	3,458,770	7,908,515	-	1,116,396	-	4,122,587	867,565	6,377,106	1,749,987	-	
31	CMHP Subcontracts, net of 1st & 3rd party	266,069,679	182,605,407	22,586,418	13,712,606	-	45,506,517	1,060,817	-	597,914	-	-	
32	Insurance Provider Assessment Withhold (IPA)	3,254,081	2,448,042	806,039	-	-	-	-	-	-	-	-	
33	Medicaid Hospital Rate Adjustments	5,047,196	2,797,256	2,249,940	-	-	-	-	-	-	-	-	
34	MHL Cost in Excess of Medicare FFS Cost	-	257,946	-	-	-	-	(257,946)	-	-	-	-	
35													
36	Total Healthcare Cost	299,971,883	191,567,421	33,550,911	13,712,606	1,116,396	45,506,517	4,925,458	867,565	6,975,021	1,749,987	-	
37	Medical Loss Ratio (HCC % of Revenue)	84.4%	87.0%	69.5%	66.2%	70.8%	95.5%	95.6%		96.0%	80.5%		
38													
40	Purchased Professional Services	433,065	-	-	-	-	-	-	-	-	-	433,065	
41	Administrative and Other Cost	9,852,482	(2,860)	-	-	-	-	-	193,780	-	-	9,663,100	
43	Depreciation	163,369	-	-	-	-	-	-	-	-	-	163,369	
44	Functional Cost Reclassification	-	-	-	-	-	-	-	-	-	-	-	
45	Allocated Indirect Pooled Cost	0	-	-	-	-	-	-	-	-	-	(1,537)	
46	Delegated Managed Care Admin	20,611,303	17,851,772	2,134,251	580,434	-	-	44,846	-	-	-	-	
47	Apportioned Central Mgd Care Admin	0	6,496,616	1,072,025	482,056	39,246	1,599,745	182,218	37,311	289,423	-	(10,198,640)	
48													
49	Total Administrative Cost	31,081,695	24,345,529	3,206,276	1,062,490	39,246	1,599,745	227,064	231,091	289,423	-	80,831	
50	Admin Cost Ratio (MCA % of Total Cost)	9.8%	11.3%	8.7%	7.2%	3.4%	3.4%	4.4%		4.0%	0.0%	3.1%	
51													
52	Local Funds Contribution	1,289,352	-	-	-	-	-	-	-	-	-	1,289,352	
53													
54													
55	TOTAL COST after apportionment	333,847,638	215,912,950	36,757,187	14,775,096	1,155,642	47,106,262	5,152,523	1,098,656	7,264,443	1,749,987	2,874,892	
56													
57	NET SURPLUS before settlement	23,893,894	4,315,107	11,519,667	5,940,764	420,092	553,087	-	(73,903)	577	424,452	794,050	
58	Net Surplus (Deficit) % of Revenue	6.7%	2.0%	23.9%	28.7%	26.7%	1.2%	0.0%	-7.2%	0.0%	19.5%	21.6%	
60	Prior Year Savings	17,316,484	16,894,122	422,362	-	-	-	-	-	-	-	-	
61	Change in PA2 Fund Balance	(424,452)	-	-	-	-	-	-	-	-	(424,452)	-	
62	ISF Risk Reserve Abatement (Funding)	(1,387)	-	-	-	-	-	-	-	-	-	(1,387)	
63	ISF Risk Reserve Deficit (Funding)	-	-	-	-	-	-	-	-	-	-	-	
64	Settlement Receivable / (Payable)	(7,268,724)	10,576,043	(10,930,247)	(5,940,764)	(420,092)	(553,087)	-	-	(577)	-	-	
65	NET SURPLUS (DEFICIT)	33,515,814	31,785,272	1,011,782	-	-	-	-	(73,903)	-	-	792,663	
66	HMP & Autism is settled with Medicaid												
67													
68	SUMMARY OF NET SURPLUS (DEFICIT)												
69	Prior Year Unspent Savings	-	-	-	-	-	-	-	-	-	-	-	
70	Current Year Savings	23,380,922	22,369,140	1,011,782	-	-	-	-	-	-	-	-	
71	Current Year Public Act 2 Fund Balance	-	-	-	-	-	-	-	-	-	-	-	
72	Local and Other Funds Surplus/(Deficit)	10,134,892	9,416,132	-	-	-	-	-	(73,903)	-	-	792,663	
73													
74	NET SURPLUS (DEFICIT)	33,515,814	31,785,272	1,011,782	-	-	-	-	(73,903)	-	-	792,663	
75													

	F	G	H	I	J	K	L	M	N	O	P	Q	R	
1	Southwest Michigan Behavioral Health			Mos in Period										
2	For the Fiscal YTD Period Ended 9/30/2022			12										
3	(For Internal Management Purposes Only)			ok										
4	INCOME STATEMENT			Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5														
6	Medicaid Specialty Services			HCC%	72.3%	78.2%	79.1%	83.0%	84.0%	80.0%	81.8%	84.0%	81.1%	
7	Subcontract Revenue	219,684,799	9,202,303	210,482,496	10,208,569	44,640,078	12,759,603	41,987,684	13,134,492	53,966,787	11,942,366	21,842,919		
8	Incentive Payment Revenue	543,258	398,707	144,551	15,885	52,949	-	-	20,121	-	31,240	24,357		
9	Contract Revenue	220,228,057	9,601,010	210,627,047	10,224,453	44,693,027	12,759,603	41,987,684	13,154,612	53,966,787	11,973,605	21,867,275		
10														
11	External Provider Cost	156,946,227	3,458,770	153,487,457	5,508,472	27,646,324	8,547,090	29,626,392	8,085,967	48,592,986	12,214,845	13,265,381		
12	Internal Program Cost	42,095,325	-	42,095,325	3,702,778	10,223,964	2,580,133	11,465,125	3,631,386	1,463,978	651,772	8,376,190		
13	SSI Reimb, 1st/3rd Party Cost Offset	(125,069)	-	(125,069)	-	-	-	(43,472)	-	(22,790)	-	(58,807)		
14	Insurance Provider Assessment Withhold (IPA)	5,245,298	5,245,298	-	-	-	-	-	-	-	-	-		
15	MHL Cost in Excess of Medicare FFS Cost	302,792	302,792	-	-	-	-	-	-	-	-	-		
16	Total Healthcare Cost	204,464,573	9,006,860	195,457,714	9,211,250	37,870,288	11,127,223	41,048,045	11,717,353	50,034,174	12,866,617	21,582,763		
17	Medical Loss Ratio (HCC % of Revenue)	92.8%		92.8%	90.1%	84.7%	87.2%	97.8%	89.1%	92.7%	107.5%	98.7%		
18														
19	Managed Care Administration	24,393,235	6,496,616	17,896,618	1,092,855	3,596,400	918,353	4,150,471	1,330,949	3,713,567	1,484,372	1,609,652		
20	Admin Cost Ratio (MCA % of Total Cost)	10.7%	2.8%	7.8%	10.6%	8.7%	7.6%	9.2%	10.2%	6.9%	10.3%	6.9%		
21														
22	Contract Cost	228,857,808	15,503,476	213,354,332	10,304,105	41,466,688	12,045,576	45,198,516	13,048,301	53,747,740	14,350,989	23,192,415		
23	Net before Settlement	(8,629,751)	(5,902,466)	(2,727,285)	(79,652)	3,226,339	714,027	(3,210,833)	106,311	219,046	(2,377,383)	(1,325,140)		
24														
25	Prior Year Savings	16,894,122	16,894,122	-	-	-	-	-	-	-	-	-		
26	Internal Service Fund Risk Reserve	-	-	-	-	-	-	-	-	-	-	-		
27	Contract Settlement / Redistribution	10,576,043	7,848,759	2,727,285	79,652	(3,226,339)	(714,027)	3,210,833	(106,311)	(219,046)	2,377,383	1,325,140		
28	Net after Settlement	18,840,414	18,840,414	0	-	-	-	-	-	-	-	-		
29														
30	Eligibles and PMPM													
31	Average Eligibles	175,652	175,652	175,652	9,538	33,259	10,351	33,874	10,301	45,897	14,428	18,004		
32	Revenue PMPM	\$ 104.48	\$ 4.55	\$ 99.93	\$ 89.33	\$ 111.98	\$ 102.72	\$ 103.29	\$ 106.42	\$ 97.99	\$ 69.16	\$ 101.21		
33	Expense PMPM	\$ 108.58	\$ 7.36	\$ 101.22	\$ 90.03	\$ 103.90	\$ 96.98	\$ 111.19	\$ 105.56	\$ 97.59	\$ 82.89	\$ 107.35		
34	Margin PMPM	\$ (4.09)	\$ (2.80)	\$ (1.29)	\$ (0.70)	\$ 8.08	\$ 5.75	\$ (7.90)	\$ 0.86	\$ 0.40	\$ (13.73)	\$ (6.13)		
35														
36	Medicaid Specialty Services													
37	Budget v Actual													
38														
39	Eligible Lives (Average Eligibles)													
40	Actual	175,652	175,652	175,652	9,538	33,259	10,351	33,874	10,301	45,897	14,428	18,004		
41	Budget	163,943	163,943	163,943	8,753	31,438	9,460	31,147	9,837	42,899	13,498	16,911		
42	Variance - Favorable / (Unfavorable)	11,709	11,709	11,709	785	1,821	891	2,727	464	2,998	930	1,093		
43	% Variance - Fav / (Unfav)	7.1%	7.1%	7.1%	9.0%	5.8%	9.4%	8.8%	4.7%	7.0%	6.9%	6.5%		
44														
45	Contract Revenue before settlement													
46	Actual	220,228,057	9,601,010	210,627,047	10,224,453	44,693,027	12,759,603	41,987,684	13,154,612	53,966,787	11,973,605	21,867,275		
47	Budget	258,113,929	17,386,803	240,727,126	12,646,870	46,139,698	13,688,936	46,173,983	14,127,177	63,845,997	19,376,730	24,727,735		
48	Variance - Favorable / (Unfavorable)	(37,885,872)	(7,785,793)	(30,100,079)	(2,422,417)	(1,446,671)	(929,333)	(4,186,299)	(972,565)	(9,879,211)	(7,403,125)	(2,860,459)		
49	% Variance - Fav / (Unfav)	-14.7%	-44.8%	-12.5%	-19.2%	-3.1%	-6.8%	-9.1%	-6.9%	-15.5%	-38.2%	-11.6%		
50														
51	Healthcare Cost													
52	Actual	204,464,573	9,006,860	195,457,714	9,211,250	37,870,288	11,127,223	41,048,045	11,717,353	50,034,174	12,866,617	21,582,763		
53	Budget	213,793,109	10,438,057	203,355,052	8,688,123	39,420,727	9,361,301	38,488,677	10,117,465	62,977,906	14,836,640	19,464,212		
54	Variance - Favorable / (Unfavorable)	9,328,536	1,431,198	7,897,338	(523,126)	1,550,439	(1,765,923)	(2,559,368)	(1,599,888)	12,943,732	1,970,023	(2,118,552)		
55	% Variance - Fav / (Unfav)	4.4%	13.7%	3.9%	-6.0%	3.9%	-18.9%	-6.6%	-15.8%	20.6%	13.3%	-10.9%		
56														
57	Managed Care Administration													
58	Actual	24,393,235	6,496,616	17,896,618	1,092,855	3,596,400	918,353	4,150,471	1,330,949	3,713,567	1,484,372	1,609,652		
59	Budget	23,526,609	8,806,696	14,719,913	881,756	2,910,446	731,904	2,130,106	1,059,855	5,095,446	748,002	1,162,398		
60	Variance - Favorable / (Unfavorable)	(866,626)	2,310,080	(3,176,706)	(211,100)	(685,954)	(186,449)	(2,020,365)	(271,094)	1,381,880	(736,370)	(447,254)		
61	% Variance - Fav / (Unfav)	-3.7%	26.2%	-21.6%	-23.9%	-23.6%	-25.5%	-94.8%	-25.6%	27.1%	-98.4%	-38.5%		

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Southwest Michigan Behavioral Health												
2	For the Fiscal YTD Period Ended 9/30/2022												
3	(For Internal Management Purposes Only)												
4	INCOME STATEMENT	Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA	
5													
62													
63	Total Contract Cost												
64	Actual	228,857,808	15,503,476	213,354,332	10,304,105	41,466,688	12,045,576	45,198,516	13,048,301	53,747,740	14,350,989	23,192,415	
65	Budget	237,319,718	19,244,754	218,074,964	9,569,879	42,331,173	10,093,205	40,618,783	11,177,320	68,073,352	15,584,643	20,626,609	
66	Variance - Favorable / (Unfavorable)	8,461,910	3,741,278	4,720,632	(734,226)	864,485	(1,952,371)	(4,579,733)	(1,870,981)	14,325,612	1,233,654	(2,565,806)	
67	% Variance - Fav / (Unfav)	3.6%	19.4%	2.2%	-7.7%	2.0%	-19.3%	-11.3%	-16.7%	21.0%	7.9%	-12.4%	
68													
69	Net before Settlement												
70	Actual	(8,629,751)	(5,902,466)	(2,727,285)	(79,652)	3,226,339	714,027	(3,210,833)	106,311	219,046	(2,377,383)	(1,325,140)	
71	Budget	20,794,211	(1,857,951)	22,652,162	3,076,992	3,808,524	3,595,731	5,555,200	2,949,857	(4,227,354)	3,792,088	4,101,125	
72	Variance - Favorable / (Unfavorable)	(29,423,962)	(4,044,516)	(25,379,447)	(3,156,643)	(582,185)	(2,881,704)	(8,766,032)	(2,843,546)	4,446,401	(6,169,471)	(5,426,265)	
73													
74													

	F	G	H	I	J	K	L	M	N	O	P	Q	R	
1	Southwest Michigan Behavioral Health			Mos in Period										
2	For the Fiscal YTD Period Ended 9/30/2022			12										
3	(For Internal Management Purposes Only)			ok										
4	INCOME STATEMENT			Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5														
75	Healthy Michigan Plan			HCC%	8.4%	11.9%	9.7%	12.9%	12.7%	8.0%	8.8%	13.0%	8.7%	
76	Contract Revenue			48,276,854	11,546,520	36,730,334	2,032,110	7,829,941	1,894,538	7,463,409	2,381,715	8,439,803	2,886,857	3,801,961
77														
78	External Provider Cost			21,166,371	7,908,515	13,257,856	573,008	1,725,763	846,168	3,444,715	524,701	3,348,145	1,564,487	1,230,869
79	Internal Program Cost			9,328,965	-	9,328,965	831,716	2,902,905	883,862	2,777,119	646,457	98,843	98,578	1,089,484
80	SSI Reimb, 1st/3rd Party Cost Offset			(403)	-	(403)	-	-	-	-	-	(403)	-	-
81	Insurance Provider Assessment Withhold (IPA)			3,055,979	3,055,979	-	-	-	-	-	-	-	-	-
82	Total Healthcare Cost			33,550,911	10,964,494	22,586,418	1,404,723	4,628,668	1,730,030	6,221,834	1,171,159	3,446,586	1,663,064	2,320,354
83	Medical Loss Ratio (HCC % of Revenue)			69.5%		61.5%	69.1%	59.1%	91.3%	83.4%	49.2%	40.8%	57.6%	61.0%
84														
85	Managed Care Administration			3,206,276	1,072,025	2,134,251	166,661	387,084	131,492	505,810	133,029	410,719	226,401	173,053
86	Admin Cost Ratio (MCA % of Total Cost)			8.7%	2.9%	5.8%	10.6%	7.7%	7.1%	7.5%	10.2%	10.6%	12.0%	6.9%
87														
88	Contract Cost			36,757,187	12,036,519	24,720,668	1,571,385	5,015,752	1,861,522	6,727,644	1,304,188	3,857,305	1,889,466	2,493,407
89	Net before Settlement			11,519,667	(489,998)	12,009,666	460,725	2,814,189	33,015	735,765	1,077,527	4,582,498	997,391	1,308,554
90														
91	Prior Year Savings			422,362	422,362	-	-	-	-	-	-	-	-	-
92	Internal Service Fund Risk Reserve			-	-	-	-	-	-	-	-	-	-	-
93	Contract Settlement / Redistribution			(10,930,247)	1,079,419	(12,009,666)	(460,725)	(2,814,189)	(33,015)	(735,765)	(1,077,527)	(4,582,498)	(997,391)	(1,308,554)
94	Net after Settlement			1,011,782	1,011,782	-	-	-	-	-	-	-	-	-
95														
96	Eligibles and PMPM													
97	Average Eligibles			75,820	75,820	75,820	3,848	14,898	3,586	13,866	4,549	21,871	5,928	7,275
98	Revenue PMPM			\$ 53.06	\$ 12.69	\$ 40.37	\$ 44.01	\$ 43.80	\$ 44.03	\$ 44.85	\$ 43.63	\$ 32.16	\$ 40.59	\$ 43.55
99	Expense PMPM			40.40	13.23	27.17	34.03	28.06	43.26	40.43	23.89	14.70	26.56	28.56
100	Margin PMPM			\$ 12.66	\$ (0.54)	\$ 13.20	\$ 9.98	\$ 15.74	\$ 0.77	\$ 4.42	\$ 19.74	\$ 17.46	\$ 14.02	\$ 14.99
101														
102	Healthy Michigan Plan													
103	Budget v Actual													
104														
105	Eligible Lives (Average Eligibles)													
106	Actual			75,820	75,820	75,820	3,848	14,898	3,586	13,866	4,549	21,871	5,928	7,275
107	Budget			67,368	67,368	67,368	3,409	13,500	3,191	12,191	4,051	19,238	5,239	6,549
108	Variance - Favorable / (Unfavorable)			8,452	8,452	8,452	439	1,398	395	1,676	498	2,633	688	726
109	% Variance - Fav / (Unfav)			12.5%	12.5%	12.5%	12.9%	10.4%	12.4%	13.7%	12.3%	13.7%	13.1%	11.1%
110														
111	Contract Revenue before settlement													
112	Actual			48,276,854	11,546,520	36,730,334	2,032,110	7,829,941	1,894,538	7,463,409	2,381,715	8,439,803	2,886,857	3,801,961
113	Budget			44,859,735	8,703,789	36,155,946	1,758,367	6,927,762	1,845,246	7,179,108	1,966,539	10,166,196	2,626,609	3,686,119
114	Variance - Favorable / (Unfavorable)			3,417,119	2,842,731	574,388	273,742	902,179	49,292	284,301	415,177	(1,726,392)	260,247	115,842
115	% Variance - Fav / (Unfav)			7.6%	32.7%	1.6%	15.6%	13.0%	2.7%	4.0%	21.1%	-17.0%	9.9%	3.1%
116														
117	Healthcare Cost													
118	Actual			33,550,911	10,964,494	22,586,418	1,404,723	4,628,668	1,730,030	6,221,834	1,171,159	3,446,586	1,663,064	2,320,354
119	Budget			32,188,319	7,304,898	24,883,421	1,513,264	4,704,925	1,360,952	5,987,956	1,363,378	5,588,043	2,179,053	2,185,848
120	Variance - Favorable / (Unfavorable)			(1,362,593)	(3,659,596)	2,297,003	108,541	76,257	(369,078)	(233,878)	192,220	2,141,458	515,989	(134,506)
121	% Variance - Fav / (Unfav)			-4.2%	-50.1%	9.2%	7.2%	1.6%	-27.1%	-3.9%	14.1%	38.3%	23.7%	-6.2%
122														
123	Managed Care Administration													
124	Actual			3,206,276	1,072,025	2,134,251	166,661	387,084	131,492	505,810	133,029	410,719	226,401	173,053
125	Budget			3,156,026	1,381,941	1,774,085	153,581	347,366	106,405	331,396	142,821	452,120	109,859	130,538
126	Variance - Favorable / (Unfavorable)			(50,249)	309,916	(360,165)	(13,081)	(39,717)	(25,088)	(174,415)	9,791	41,401	(116,542)	(42,515)
127	% Variance - Fav / (Unfav)			-1.6%	22.4%	-20.3%	-8.5%	-11.4%	-23.6%	-52.6%	6.9%	9.2%	-106.1%	-32.6%
128														
129	Total Contract Cost													
130	Actual			36,757,187	12,036,519	24,720,668	1,571,385	5,015,752	1,861,522	6,727,644	1,304,188	3,857,305	1,889,466	2,493,407
131	Budget			35,344,345	8,686,839	26,657,506	1,666,845	5,052,292	1,467,357	6,319,352	1,506,199	6,040,163	2,288,912	2,316,386

	F	G	H	I	J	K	L	M	N	O	P	Q	R	
1	Southwest Michigan Behavioral Health			Mos in Period										
2	For the Fiscal YTD Period Ended 9/30/2022			12										
3	(For Internal Management Purposes Only)			ok										
4	INCOME STATEMENT			Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5														
141	Autism Specialty Services			HCC%	5.1%	3.8%	10.1%	0.0%	0.0%	5.2%	7.5%	0.0%	6.1%	
142	Contract Revenue	20,715,860	(0)	20,715,861	1,095,021	3,784,980	1,153,210	3,939,709	1,115,782	5,929,041	1,664,270	2,033,848		
143														
144	External Provider Cost	13,255,371	-	13,255,371	-	4,811,642	-	-	761,090	6,063,626	-	1,619,014		
145	Internal Program Cost	457,235	-	457,235	452,740	4,373	-	-	-	-	-	123		
146	SSI Reimb, 1st/3rd Party Cost Offset	-	-	-	-	-	-	-	-	-	-	-		
147	Insurance Provider Assessment Withhold (IPA)	-	-	-	-	-	-	-	-	-	-	-		
148	Total Healthcare Cost	13,712,606	-	13,712,606	452,740	4,816,015	-	-	761,090	6,063,626	-	1,619,136		
149	Medical Loss Ratio (HCC % of Revenue)	66.2%	0.0%	66.2%	41.3%	127.2%	0.0%	0.0%	68.2%	102.3%	0.0%	79.6%		
150														
151	Managed Care Administration	1,062,490	482,056	580,434	53,715	-	-	-	86,451	319,513	-	120,756		
152	Admin Cost Ratio (MCA % of Total Cost)	7.2%	3.3%	3.9%	10.6%	0.0%	0.0%	0.0%	10.2%	5.0%	0.0%	6.9%		
153														
154	Contract Cost	14,775,096	482,056	14,293,040	506,454	4,816,015	-	-	847,540	6,383,139	-	1,739,892		
155	Net before Settlement	5,940,764	(482,056)	6,422,820	588,567	(1,031,035)	1,153,210	3,939,709	268,241	(454,098)	1,664,270	293,956		
156	Contract Settlement / Redistribution	(5,940,764)	482,056	(6,422,820)	(588,567)	1,031,035	(1,153,210)	(3,939,709)	(268,241)	454,098	(1,664,270)	(293,956)		
157	Net after Settlement	(0)	(0)	-	-	-	-	-	-	-	-	-		
158														
159														
160	Certified Community Behavioral Health Clin			HCC%		0.0%	0.0%	0.0%	0.0%	0.0%	24.6%	25.4%	0.0%	
161	Contract Revenue	47,659,349	15,026,675	32,632,674	-	-	-	-	-	-	27,126,458	5,506,216	-	
162														
163	External Provider Cost	-	-	-	-	-	-	-	-	-	-	-	-	
164	Internal Program Cost	25,136,376	-	25,136,376	-	-	-	-	-	-	19,991,231	5,145,145	-	
165	SSI Reimb, 1st/3rd Party Cost Offset	(431,665)	0	(431,665)	-	-	-	-	-	-	(397,200)	(34,465)	-	
166	Total Healthcare Cost	24,704,711	0	24,704,711	-	-	-	-	-	-	19,594,031	5,110,680	-	
167	Medical Loss Ratio (HCC % of Revenue)	51.8%	0.0%	75.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	72.2%	92.8%	0.0%	
168														
169	Managed Care Administration	1,599,745	1,599,745	-	-	-	-	-	-	-	-	-	-	
170	Admin Cost Ratio (MCA % of Total Cost)	6.1%	6.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
171														
172	Contract Cost	26,304,456	1,599,745	24,704,711	-	-	-	-	-	-	19,594,031	5,110,680	-	
173	Net before Settlement	21,354,893	13,426,929	7,927,964	-	-	-	-	-	-	7,532,427	395,536	-	
174	PPS-1 Supplemental Payment Difference	-	12,442,177	(12,442,177)	-	-	-	-	-	-	(12,210,051)	(232,126)	-	
175	Contract Settlement / Redistribution	(553,087)	(5,067,301)	4,514,214	-	-	-	-	-	-	4,677,624	(163,410)	-	
176	Net after Settlement	20,801,806	20,801,806	-	-	-	-	-	-	-	-	-	-	
177														
178														
179	SUD Block Grant Treatment			HCC%	0.2%	0.4%	0.4%	0.5%	0.0%	1.4%	0.0%	0.0%	0.2%	
180	Contract Revenue	7,265,021	6,688,086	576,935	37,755	195,296	28,267	-	60,955	111,957	78,969	63,736		
181														
182	External Provider Cost	6,377,314	6,377,106	207	-	-	207	-	-	-	-	-	-	
183	Internal Program Cost	597,707	-	597,707	47,840	182,812	68,532	31,754	208,364	-	339	58,066		
184	Insurance Provider Assessment Withhold (IPA)	-	-	-	-	-	-	-	-	-	-	-		
185	Total Healthcare Cost	6,975,021	6,377,106	597,914	47,840	182,812	68,739	31,754	208,364	-	339	58,066		
186	Medical Loss Ratio (HCC % of Revenue)	96.0%	95.4%	103.6%	126.7%	93.6%	243.2%	0.0%	341.8%	0.0%	0.4%	91.1%		
187														
188	Managed Care Administration	289,423	289,423	-	-	-	-	-	-	-	-	-	-	
189	Admin Cost Ratio (MCA % of Total Cost)	4.0%	4.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
190														
191	Contract Cost	7,264,443	6,666,529	597,914	47,840	182,812	68,739	31,754	208,364	-	339	58,066		
192	Net before Settlement	577	21,557	(20,979)	(10,084)	12,484	(40,472)	(31,754)	(147,409)	111,957	78,629	5,669		
193	Contract Settlement	(577)	(21,557)	20,979	10,084	(12,484)	40,472	31,754	147,409	(111,957)	(78,629)	(5,669)		
194	Net after Settlement	(0)	(0)	0	-	-	-	-	-	-	-	-	-	
195														

	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Southwest Michigan Behavioral Health												
2	For the Fiscal YTD Period Ended 9/30/2022												
3	(For Internal Management Purposes Only)												
4	INCOME STATEMENT												
5													
196													

1

Southwest Michigan Behavioral Health

2

For the Fiscal YTD Period Ended 9/30/2022

3

(For Internal Management Purposes Only)

Mos in Period

12

ok

4

INCOME STATEMENT

Total SWMBH

SWMBH Central

CMH Participants

Barry CMHA

Berrien CMHA

Pines Behavioral

Summit Pointe

Woodlands Behavioral

Integrated Services of Kalamazoo

St Joseph CMHA

Van Buren MHA

	F	G	H	I	J	K	L	M	N	O	P	Q	R	
1	Southwest Michigan Behavioral Health			Mos in Period										
2	For the Fiscal YTD Period Ended 9/30/2022			12										
3	(For Internal Management Purposes Only)			ok										
4	INCOME STATEMENT			Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5														
197	SWMBH CMHP Subcontracts													
198	Subcontract Revenue	343,601,883	42,463,583	301,138,300	13,373,455	56,450,295	15,835,617	53,390,802	16,692,944	95,574,046	22,078,677	27,742,463		
199	Incentive Payment Revenue	543,258	398,707	144,551	15,885	52,949	-	-	20,121	-	31,240	24,357		
200	Contract Revenue	344,145,141	42,862,290	301,282,851	13,389,339	56,503,244	15,835,617	53,390,802	16,713,065	95,574,046	22,109,917	27,766,820		
201														
202	External Provider Cost	197,745,282	17,744,391	180,000,891	6,081,480	34,183,729	9,393,466	33,071,106	9,371,758	58,004,757	13,779,332	16,115,263		
203	Internal Program Cost	77,615,608	-	77,615,608	5,035,072	13,314,055	3,532,527	14,273,998	4,486,208	21,554,052	5,895,833	9,523,863		
204	SSI Reimb, 1st/3rd Party Cost Offset	(557,137)	0	(557,137)	-	-	-	(43,472)	-	(420,393)	(34,465)	(58,807)		
205	Insurance Provider Assessment Withhold (IPA)	8,301,277	8,301,277	-	-	-	-	-	-	-	-	-		
207	MHL Cost in Excess of Medicare FFS Cost	302,792	302,792	-	-	-	-	-	-	-	-	-		
208	Total Healthcare Cost	283,407,822	26,348,460	257,059,362	11,116,552	47,497,783	12,925,992	47,301,633	13,857,965	79,138,416	19,640,700	25,580,320		
209	Medical Loss Ratio (HCC % of Revenue)	82.4%	61.5%	85.3%	83.0%	84.1%	81.6%	88.6%	82.9%	82.8%	88.8%	92.1%		
210														
211	Managed Care Administration	30,551,168	9,939,865	20,611,303	1,313,231	3,983,483	1,049,845	4,656,281	1,550,428	4,443,799	1,710,773	1,903,461		
212	Admin Cost Ratio (MCA % of Total Cost)	9.7%	3.2%	6.6%	10.6%	7.7%	7.5%	9.0%	10.1%	5.3%	8.0%	6.9%		
213														
214	Contract Cost	313,958,990	36,288,325	277,670,665	12,429,784	51,481,267	13,975,838	51,957,914	15,408,394	83,582,215	21,351,474	27,483,780		
215	Net before Settlement	30,186,151	6,573,965	23,612,186	959,556	5,021,977	1,859,780	1,432,887	1,304,671	11,991,831	758,443	283,040		
216														
217	Prior Year Savings	17,316,484	17,316,484	-	-	-	-	-	-	-	-	-		
218	Internal Service Fund Risk Reserve	-	-	-	-	-	-	-	-	-	-	-		
219	Contract Settlement	1,079,331	4,321,376	(3,242,044)	(959,556)	(5,021,977)	(1,859,780)	(1,432,887)	(1,304,671)	7,750,647	(130,781)	(283,040)		
220	Net after Settlement	48,581,966	28,211,825	20,370,141	-	-	-	(0)	-	19,742,478	627,663	0		
221														
222														
223														

	F	G	H	I	J	K	L	M	N	O	P	Q	R	
1	Southwest Michigan Behavioral Health			Mos in Period										
2	For the Fiscal YTD Period Ended 9/30/2022			12										
3	(For Internal Management Purposes Only)			ok										
4	INCOME STATEMENT			Total SWMBH	SWMBH Central	CMH Participants	Barry CMHA	Berrien CMHA	Pines Behavioral	Summit Pointe	Woodlands Behavioral	Integrated Services of Kalamazoo	St Joseph CMHA	Van Buren MHA
5														
224	State General Fund Services			HCC%	2.1%	5.6%	0.8%	3.6%	3.2%	5.4%	0.8%	1.2%	3.8%	
225	Contract Revenue				12,502,132	864,290	2,214,798	818,279	1,914,518	911,875	3,894,152	713,232	1,170,988	
226														
227	External Provider Cost				1,189,598	140,667	267,905	97,120	142,543	427,225	-	-	114,138	
228	Internal Program Cost				3,705,347	514,884	114,026	389,320	1,411,057	366,545	-	-	909,516	
229	SSI Reimb, 1st/3rd Party Cost Offset				-	-	-	-	-	-	-	-	-	
230	Total Healthcare Cost				4,894,945	655,551	381,931	486,439	1,553,600	793,770	-	-	1,023,654	
231	Medical Loss Ratio (HCC % of Revenue)				39.2%	75.8%	17.2%	59.4%	81.1%	87.0%	0.0%	0.0%	87.4%	
232														
233	Managed Care Administration				428,776	86,871	13,826	32,552	119,858	99,324	-	-	76,345	
234	Admin Cost Ratio (MCA % of Total Cost)				8.1%	11.7%	3.5%	6.3%	7.2%	11.1%	0.0%	0.0%	6.9%	
235														
236	Contract Cost				5,323,720	742,422	395,756	518,991	1,673,458	893,094	-	-	1,099,999	
237	Net before Settlement				7,178,412	121,868	1,819,042	299,288	241,060	18,781	3,894,152	713,232	70,989	
238														
239	Other Redistributions of State GF				(2,031,571)	-	(927,635)	(337,956)	(921,108)	-	98,732	56,396	-	
240	Contract Settlement				(251,719)	(77,262)	-	-	-	-	(52,147)	-	(122,310)	
241	Net after Settlement				4,895,121	44,606	891,407	(38,669)	(680,048)	18,781	3,940,737	769,628	(51,320)	
242														



For SWMBH Board
Fiscal Year 2022
Year End Results

FINAL FY 2022 RESULTS

- Total Revenue for fiscal year 2022.
 - \$357,741,533
- Total Healthcare Cost for fiscal year 2022.
 - \$299,971,833
 - Medical Loss Ratio, 84.4%
- Total Administrative Cost for fiscal year 2022.
 - \$31,081,695
 - Administrative Cost Ratio, 9.8%

FINAL FY 2022 RESULTS (cont'd)

- Net Surplus before settlement for fiscal year 2022.
 - \$23,893,894 (Prior Year Savings, PA2 Fund Balance, ISF Interest)
- Net Surplus for SWMBH for fiscal year 2022.
 - **\$33,515,814**

FY 2022 ACTUAL RESULTS & EFFECTS

- Actual FY 22 Internal Service Fund Balance \$23,380,921
- Actual FY 22 Medicaid Savings Funding \$23,380,922
- Total Risk Pool Actual \$46,761,843
- FY 22 DCW LAPSE \$7,268,147
- FY 22 LAPSE TO MDHHS \$14,212,672
- Ended the year positive

QUESTIONS?



Quality Assurance and Performance Improvement Program (QAPIP) FY 2022 Evaluation

All SWMBH Medicaid Business Lines

Evaluation Period: October 1, 2021 - September 30, 2022

Reviewed and Approved by:

SWMBH Board of Directors on: March 10, 2023

SWMBH Operations Committee on: February 22, 2023

SWMBH Quality Management Committee on: February 23, 2023

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SWMBH Quality Assurance and Performance Improvement Program (QAPIP)

I. Introduction

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

As part of Southwest Michigan Behavioral Health's (SWMBH) benefit management organization responsibilities, the SWMBH QAPI Department conducts an annual QAPIP Evaluation to evaluate whether all contractual and regulatory standards required of the Regional Entity, including the PIHP responsibilities, were met and to determine where improvement efforts should be focused over the following fiscal year.

This annual evaluation will include (1) improvement initiatives undertaken by SWMBH from October 2021 through September 2022 for Medicaid Services, (2) resources used by the SWMBH QAPI department, and (3) the status of QAPIP Plan objectives. The formulation of the QAPIP goals and objectives includes incorporating numerous federal, state, and accreditation principles. This includes 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 is designed to promote high quality customer service and outcomes by systematically monitoring key performance indicators integrated with system-wide approaches to continuous quality improvement efforts.

The authority of the SWMBH QAPI Department and the Quality Management Committee (QMC) is granted by SWMBH's Executive Officer (EO) and the Board of Directors. SWMBH's Board retains the ultimate responsibility for the quality of the business lines and services assigned to the regional entity, and they review and approve the SWMBH QAPIP Evaluation and QAPIP Plan on an annual basis.

II. 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 as well as the participant Community Mental Health Services Programs (CMHSPs). The communication and relationship between SWMBH's other departments and CMHSPs is a critical component to the success of the QAPIP. The QAPI Department works to provide guidance on project management, technical assistance, and support data analysis to other departments and CMHSPs. The sharing of information with internal and external stakeholders through the Managed Information Business Intelligence system and through the SWMBH SharePoint site is key. The site offers a variety of interactive visualization dashboards that give real time status and analysis to the end user. At least annually, the QAPI department shares information related to the QAPIP, survey results, and other relevant information in newsletter articles and on the SWMBH website for all stakeholders to review.

SWMBH QAPI Department

The general oversight of the development and implementation of the QAPI is given to SWMBH's QAPI Department. The QAPI Department is staffed with a QAPI Director who oversees the QAPI Department, two full time Quality Assurance Specialists, and a Strategic Initiatives Project Manager. The QAPI Department may also utilize an outside contract consultant for special projects as needed. 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 (RIT) Committee, Regional Utilization Management (RUM) Committee, and the Regional Clinical Practices (RCP) Committee.

The QAPI Department staff work closely with the SWMBH IT Department. The IT Department assists with 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, consultation, and technical assistance. The data analyses include statistical analyses of outcomes data to test for statistical significance of changes, mining large data sets, conducting factor analyses to determine causes or contributing factors for outcomes or performance outliers, and correlates the analysis to assess relationships between variables. In addition, the IT Department assists with the development of reports, summaries, and visual representations of the data.

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

Adequacy of SWMBH Quality Management Resources

The QAPI Department works collaboratively with many different functional areas. The following table outlines the positions within the QAPI Department and other departments that have quality related tasks, listed with the percentage of their time that is allocated to quality management (QM) activities.

Position Title	Department	Percent of Time Per Week Devoted to QM
Quality Assurance and Performance Improvement Director	QAPI	100%
Quality Assurance Specialists (2)	QAPI	100%
Strategic Initiatives Project Manager	QAPI	75%
Director of Clinical Quality	CQ	40%
Behavior Health & Integrated Care Manager	CQ	20%
Clinical Quality Specialists (3)	CQ	20%
Clinical Data Analyst	CQ	20%
Manager of Utilization Management and Call Center	UM	20%
Customer Service Manager	UM	20%
Chief Information Officer	IT	20%
Senior Systems Architect	IT	20%
Applications & Systems Analyst	IT	20%
Business Data Analysts (2)	IT	20%
Applications and Systems Analyst	IT	20%
Designated Behavioral Health Care Practitioner	UM/PNM	20%
Chief Compliance Officer & Director of Provider Network Management	Compliance/PNM	15%
Chief Administrative Officer	Operations	15%

CQ = Clinical Quality
UM = Utilization Management
IT = Information Technology
PNM = Provider Network Management

SWMBH will have appropriate staff to complete QAPI functions as defined in this plan. In addition to having adequate staff, the QAPI Department will have the relevant technology and access to complete the assigned tasks and legal obligations as a managed benefits administrator for a variety of business lines. These business lines include Medicaid, Healthy Michigan Plan, MiChild, Autism Waiver, SUD Block Grant, PA 2 funds, and other grant funding. To complete these functions, additional resources are utilized including access to regional data from the CMHSPs as well as software and tools to analyze the data to determine statistical relationships.

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

The QAPI Department works with other functional areas within the organization and external organizations/vendors such as Streamline Solutions and the Health Service Advisory Group (HSAG) to review processes and data collection procedures. These relationships are communicated to the EO and the SWMBH Board as needed. Other roles include:

- Reviewing and submitting data to the state per contractual requirements.
- Creating and maintaining QAPI policies, plans, evaluations, and other reports.
- Implementing regional projects and monitoring of reporting requirements.
- Assisting in the development of Strategic Plans and Tactical Objectives.
- Leading the development of the Boards Ends Metrics and other Key Performance Indicators.
- Analyzing reports and data to determine trends and making recommendations for process improvements.
- Functioning as the liaison between different functional areas in the communication of audit requirements and timelines.
- Communicating, organizing, and submitting the annual Performance Bonus Improvement Program (PBIP) reports to MDHHS.

Leadership Involvement

Another significant strength of the QAPI program is the continuing involvement of SWMBH Senior Leadership at the highest level. The CEO and senior leadership team members 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 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

SWMBH has a designated behavioral health care practitioner to support and advise the QAPI Department in meeting the QAPI deliverables, including setting goals and establishing regional performance measures and targets. The designated behavioral health care practitioner, as needed, provides supervisory and oversight of all SWMBH clinical functions including Utilization Management, Customer Services, Clinical Quality, Provider Network, Substance Abuse Prevention and Treatment, and other clinical initiatives. The designated behavioral health care practitioner also provides clinical expertise and programmatic consultation, and collaborates with the QAPI Director to ensure complete, accurate, and timely submission of clinical program data. The designated behavioral health care practitioner serves as a member of the Quality Management Committee (QMC), the Regional Utilization Management (RUM) Committee, and the Clinical Practice Committee.

Physical Resources: Phones/Computers/Equipment

Due to the diverse geographical region and remote work of many positions, 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 an effective workflow. SWMBH utilizes a SharePoint Site/Portal for internal and external entities to collaborate and access essential regional information and data. SWMBH also utilizes Tableau, a dashboard visualization and analysis software, for information and data sharing with stakeholders which allows access to real-time data. GoTo Meeting, WebEx, and Microsoft Teams technology is offered and utilized for meetings that cannot be attended in person.

Service Population and Eligible Consumers Served

SWMBH (Region 4) has served nearly 29,360 unique consumers from October 1, 2021, to September 30, 2022, with 296,488 Medicaid Eligible in the Region.

Consumers served include:

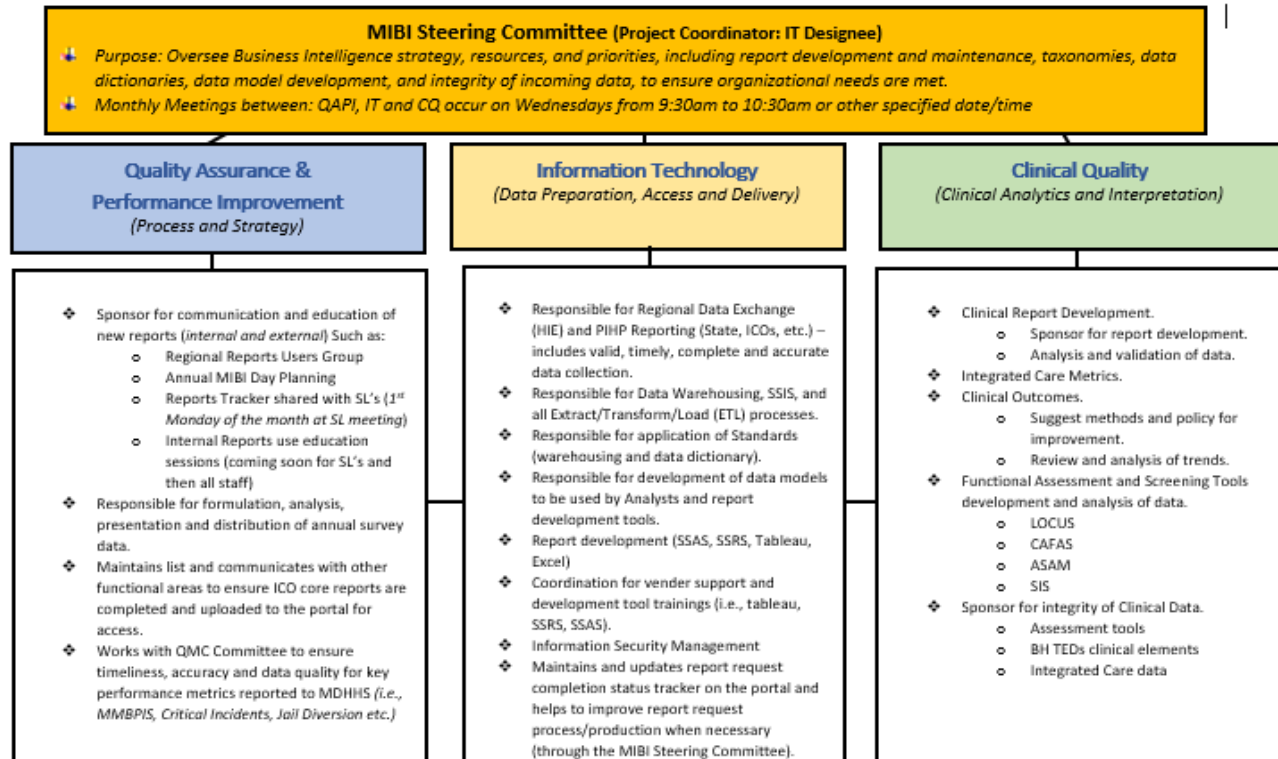
- Adults with Severe and Persistent Mental Illness (SPMI)
- Adults with Intellectual or Developmental Disabilities (I/DD)
- Adults with Substance Use Disorders (SUD)
- Children with Severe Emotional Disturbance (SED)
- Children with Intellectual or Developmental Disabilities



III. Managed Information Business Intelligence (MIBI) Steering Committee

In May of 2019, the Managed Information Business Intelligence (MIBI) Steering Committee was formed. The purpose of the committee is to 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. The Directors of QAPI, IT, and Clinical Quality meet on a monthly schedule to review prioritized and relevant data issues and policies. Since each department works cross functional with all available data sources, this meeting is a great way to minimize overlap and ensure identified tasks stay on track. The secondary purpose of the committee is to ensure all data sources and reports are in alignment with contractual requirements and exceeding metric benchmarks.

SWMBH MANAGED INFORMATION BUSINESS INTELLIGENCE DEPARTMENT ROLES



IV. Regional Quality Management Committee (QMC)

SWMBH has established the regional QMC to provide oversight and management of quality management functions and to provide an environment to learn and share quality management tools, programs, and outcomes. SWMBH values the input of all stakeholders in the improvement process, and QMC is one method of participant communication, alignment, and advice to SWMBH. QMC allows regional and member input to be gathered regarding the development and management of processes and policies related to quality. QMC is responsible for developing committee goals, maintaining contact with other committees, identifying people, organizations, or departments that can further the aims of both the QAPI Department and the QMC. Cooperation with the QMC Program is required of all SWMBH staff, participants, customers, and providers.

CMHSPs are responsible for the development and maintenance of a performance improvement program within their respective organizations. Coordination between the participant and provider performance improvement programs and SWMBH's program is achieved through standardization of indicator measurement and performance review through the QMC. To assure a responsive system, the needs of those that use or oversee the resources (e.g., active participation of members, families, providers, and other community and regulatory stakeholders) are promoted whenever possible. Training on performance improvement technology and methods, along with technical assistance, is provided as requested or as necessary.

QMC Membership

The QMC shall consist of an appointed representative from each participating CMHSP, representative(s) from the SWMBH Customer Advisory Committee (CAC), and SWMBH QAPI Departmental staff. All other ad hoc members shall be identified as needed, which may include provider representatives, IT support staff, Coordinating Agency staff, and the SWMBH medical director and clinical representation. The QMC will make efforts to maintain member representation, assist with review of reports/data, and provide suggestions for regional process improvement opportunities. All QMC members are required to participate, however, alternates will also be named in the charter and will have all the same responsibilities of members when participating in committee work.

QMC 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. Members share relevant information with their colleagues.
6. Celebrate success.

QMC Roles and Responsibilities

The 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, QAPIP Evaluation, and PIPs). Committee oversight is defined as reviewing data and approving projects. Committee members represent the regional needs related to quality. QMC members should be engaged in the discussion of performance improvement issues and bring challenges from their site to the SWMBH committee's attention for deliberation and discussion.

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 the overall management of the regional QAPI functions by providing network input and guidance. Additionally, the QMC is responsible for:

- Maintaining connectivity to other internal and external structures, including SWMBHs Board of Directors and Leadership Team, other regional committees, and MDHHS.
- Providing guidance in defining the scope, objectives, activities, and structure of the PIHP's QAPIP.
- Providing data review and recommendations related to efficiency, improvement, and effectiveness.
- Reviewing and providing feedback related to policy and tool development.
- Ensuring each CMHSP has developed and is maintaining a performance improvement program within their respective organizations.
- Ensuring coordination is achieved through standardization of indicator measurement and performance indicators.

QMC Decision Making Process

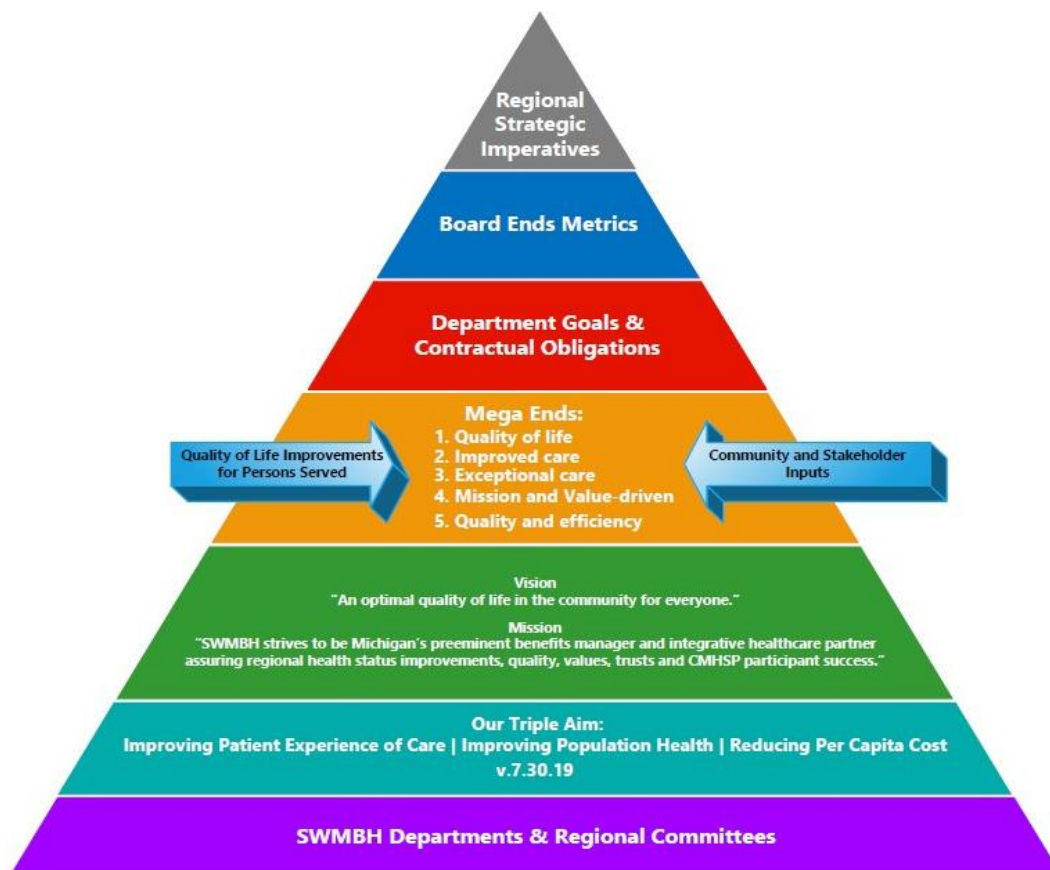
The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. When consensus cannot be reached a formal voting process will be used and a super majority will carry the motion. This voting structure may be used to determine the direction of projects or with other various topics requiring decision making actions. If a participant fails to send a representative to a meeting, they will forgo the right to participate in any votes that occur. All regional committees are advisory with the final determinations being made by SWMBH (see Attachment G – QMC Charter for more details).

FY 2022 Key Accomplishments

The QMC met monthly during FY 2022. All meeting materials were 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 and annual survey trends. The Quality Team and QMC also completed analysis on key contractual reporting metrics such as; MMBPIS performance indicators, Critical Incident data, Jail Diversion data, CMHSP site reviews and the BTRC process. Additionally, collecting data and producing/submission of reports for the annual Performance Bonus Incentive Project (PBIP), Opioid Health Homes Project (OHH) and CCBHC data reporting were very important and successful for the Region; ensuring we capture all available pay for performance funding streams.

V. SWMBH Board End Metrics

SWMBH's annual goals are established and approved by the Board of Directors on an annual basis. The annual set of 'key performance metrics are referred to as the "*Board Ends Metrics*" The results of the 2022 Board Ends Metrics can be found at the end of this report. SWMBH utilizes the following ladder method, to identify Regional Strategic Imperatives and Board Ends Metrics. The SWMBH vision and mission and Triple Aim are always considered when establishing the Annual Board Ends Metrics and Strategic Imperatives.



See the end of the evaluation for the 2022 Board Ends Metrics Summary Report.

VI. SWMBH 2022 Successes and Accomplishments Highlights

SWMBH 2022 Accomplishment Highlights

(Please see the full list of 2022 Accomplishments by clicking on the link below)

[The Latest News from Southwest Michigan Behavioral Health | Southwest Michigan Behavioral Health \(swmbh.org\)](#)

- SWMBH most recent 2021-2022 Consumer Satisfaction Survey showed significant improvements in important areas, such as; *'Improved Outcomes'* for Adults and *'Improved Functioning'* for Children.
- SWMBH has achieved an Unqualified Audit Opinion for FY 21, which means SWMBH was found to be in full compliance with managing resources. This also attests that; the auditors agree with the processes and the manner in which SWMBH handles and manages funds for all business lines.
- SWMBH conducted the annual Cultural Accelerator survey to measure employee engagement and staff satisfaction, showing a positive improvement in both areas for FY22.
- Completed 37 Trainings with a total attendance of 981- an increase of 647 training participants from last year. Topics included: SIS Assessment Orientation, Patients in Crisis: Life Threatening Risks of Opioids, Medical Marijuana, Vaping, safeTalk, Human Trafficking. Implicit Bias Training, Social Work Ethics Pain Management, Methamphetamine Prevention, Transgender Mental Health, Suicide Risk Assessment, Person Centered Thinking, EMDR, and Mindfulness.
- 99.7% of (710) available Habilitation Supports Waiver slots provided by the State have been filled for FY22 (from October 1, 2021 through September 30, 2022). SWMBH has continued to have the best HSW slot utilization rate throughout the State of Michigan over the past 5 years.
- SWMBH maintained 845 Autism Client Cases (up from 668 in 2021) and worked with CMHSPs to close out cases that had been left open unnecessarily to reflect proper enrollment numbers.
- Utilization Management completed 29,056 total authorizations for service; 17,839 Prospective Review Substance Use Disorder (SUD) events; 1,828 individuals who were admitted for psychiatric hospitalizations or crisis residential stays and 14,752 incoming SUD calls with an average phone queue time of 7 seconds or 98.68% of calls were answered in 30 seconds or less.
- SWMBH Veterans Service Navigator conducted meetings with approximately 120 new Veterans or Veteran Family Members (VFM) and participated in over 15 Veteran Community Events, providing education on services and programs available for Veterans to take advantage of.
- There was a 43.9 % reduction in ER claims and 73.3% reduction in inpatient episodes, for the six months prior to ICT involvement versus six months post ICT involvement. Overall, there were less ED claims this year than in years prior (*65.1% decrease*).
- SWMBH has trained 2,365 community members on the use/administration of naloxone. A total of 2,694 naloxone rescue kits have been distributed, resulting in 89 reversals by community members and 121 reversals by First Responders.
- SWMBH achieved a 96% Compliance Score on the Michigan Department of Health and Human Services 2021-2022 Performance Bonus Incentive Program (PBIP) Metrics, translating into a \$2,174,845 achieved bonus award for the Region.
- SWMBH performed very well on the most recent 2022 Health Service Advisory Group (HSAG) – Performance Measure Validation Audit; with 37 out of 37 total elements evaluated, receiving a designation score of “Met,” “Reportable” or “Accepted,” which represents 100% compliance.



FY22 Quality Assurance and Performance Improvement Program (QAPIP) Evaluation

How to Read This Report

SWMBH has adopted a rating system to evaluate the key performance indicators and QAPIP Plan objectives. Throughout the evaluation, a five-point scoring rubric is used to rate each evaluated component as follows:



1. A score of 1 or “Poor” indicates a critically unmet need that requires immediate follow-up.
2. A score of 2 or “Subpar” is given to an area that markedly needs improvement but does not necessarily require urgent, immediate attention.
3. A score of 3 or “Acceptable” is indicative of an area that minimally meets that area’s requirements.
4. A score of 4 or “Good” reflects an area that exceeds the acceptable requirements but may still contain room for minor improvements.
5. A score of 5 or “Excellent” is reserved for those areas that far exceed the acceptable requirements and need only very minor, if any, improvements.

Additionally, where recommendations are made throughout the evaluation rough time estimates are assigned to address and implement the recommendations. These are intended to serve as a rough guideline and are not intended to be used for detailed project planning. The rough time estimates are as follows:



SWMBH has completed the Annual Evaluation Report with recommendations received from MDHHS, HSAG and NCQA. SWMBH has adopted the NCQA ‘Best Practice’ evaluation standards and has provided the following elements for each functional area evaluated:

- Program Description
- Program Goals
 - Responsible Department(s)
 - Where Progress is Monitored
 - Frequency of Monitoring
- Identified Barriers
- Improvement Efforts

A. Michigan Mission Based Performance Indicator System (MMBPIS)

Description

SWMBH utilizes performance measures established by MDHHS in the areas of access, efficiency, and outcome measures. SWMBH is responsible for ensuring that the CMHSPs and Substance Use Disorder (SUD) Providers are measuring performance through the Michigan Mission-Based Performance Indicator System (MMBPIS) per the contract with MDHHS. SWMBH maintains a dashboard tracking system to monitor individual CMHSP and Regional progress on each indicator throughout the year.

Performance is monitored on a quarterly basis with submission to MDHHS. When minimum performance standards or requirements are not met, CMHSPs and/or SUD Providers will submit a form identifying causal factors, interventions, implementation timelines, and any other actions they will take to correct undesirable variation. Regional trends are identified and discussed at the QMC meetings for regional planning efforts and coordination. The effectiveness of the action plan will be monitored based on the re-measurement period identified. The evaluation of each indicator is based on a 1-to-5 scale where 1 is Poor and 5 is Excellent.

FY22 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 benchmark established for four quarters during FY 2022.

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Indicator 1 - Percentage of Children who receive a Prescreen within 3 hours of request ($\geq 95\%$).	Quality	QMC	Monthly
Indicator 1 - Percentage of Adults who receive a Prescreen within 3 hours of request ($\geq 95\%$).	Quality	QMC	Monthly
Indicator 2a - Percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children).	Quality	QMC	Monthly
Indicator 2b - 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.	Quality	QMC	Monthly
Indicator 3 - percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children).	Quality	QMC	Monthly
Indicator 4a (a) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children ($\geq 95\%$).	Quality	QMC	Monthly
Indicator 4a (b) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults ($\geq 95\%$).	Quality	QMC	Monthly
Indicator 4b - Follow-Up within 7 Days of Discharge from a Detox Unit ($\geq 95\%$).	Quality	QMC	Monthly

Indicator 10a - Re-admission to Psychiatric Unit within 30 Days-Children (standard is <=15%).	Quality	QMC	Monthly
Indicator 10b - Re-admission to Psychiatric Unit within 30 Days- Adults (standard is <=15%).	Quality	QMC	Monthly








FY22 Identified Barriers




COVID-19 presented barriers to many of the CMHSP's follow-up processes. CMHSPs reported issues with maintaining necessary staffing levels which led to lower results for timeliness and access performance indicators (i.e. opportunities to schedule inside a 14-day window are lost due to not having staff available to complete the assessment or service) as well as follow-up services after discharge from inpatient. The elimination of exclusions and exceptions in 2020 for indicators 2a, 2b, and 3 continued to impact performance indicator. Benchmarks remained unset, and exceptions and exclusions did not apply for these indicators but are expected to be in place for FY24. Three CMHSPs switched to a new EHR system and had trouble pulling MMBPIS data from the new system and converting it into the required reporting template during the first quarter of FY22. Of the five indicators with MDHHS-defined benchmarks, Indicator 4a(b) was missed regionally the most (7 out of 32 total benchmarks).

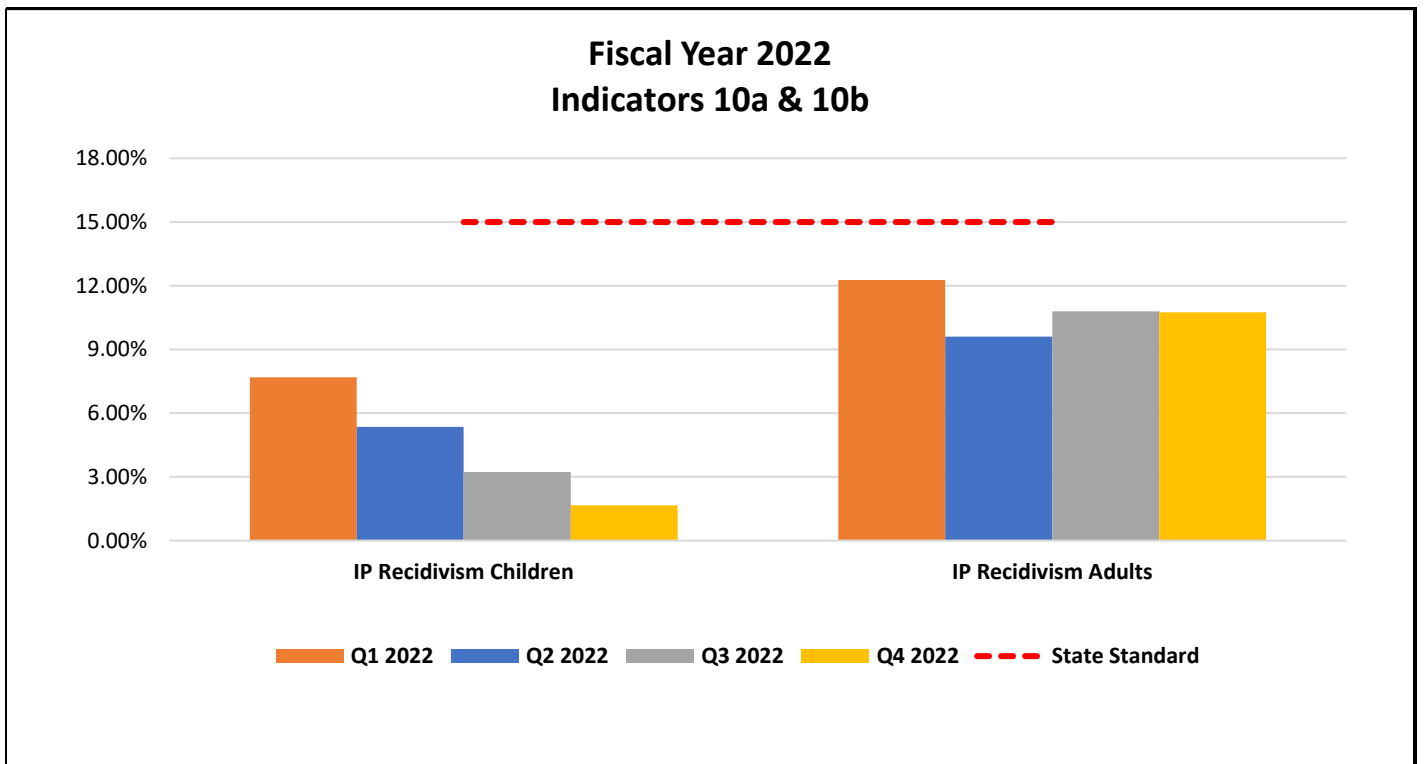
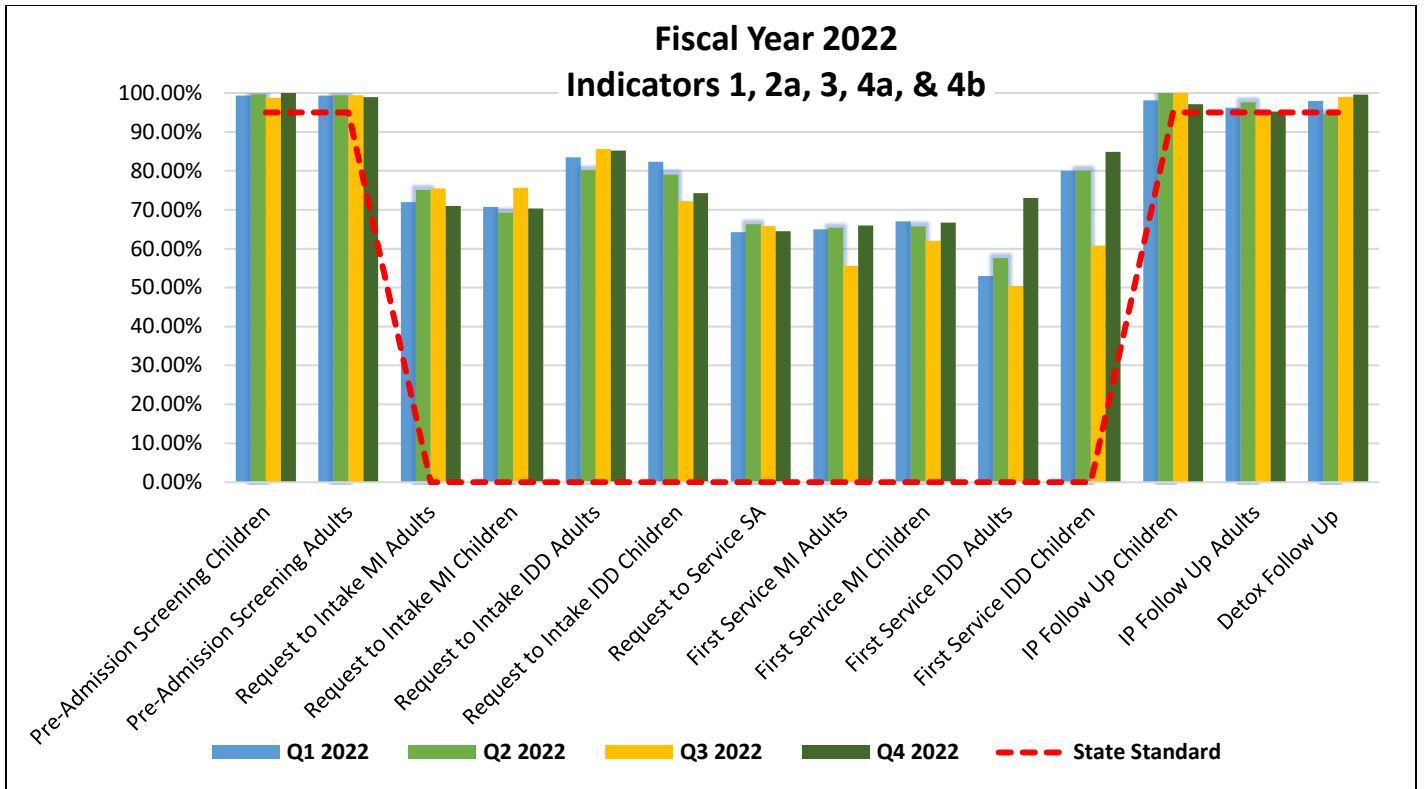
Improvement Efforts Made in FY22

SWMBH continued to send CMHSPs appreciation letters upon meeting 100% of the State's performance indicators which are directed to their CEO. SWMBH also increased the frequency of analysis during QMC meetings, igniting discussion and sharing best practices across the region. This process has helped identify trends early on. SWMBH conducted analysis of the CMHSP process for consumer assessment to first service (Indicator 3) in effort to identify best practice within the region and shared results with the regional Quality Committee. Improvements were seen in comparison to FY21 (see graphs below). SWMBH distributed Corrective Action Plan (CAP) requests to address any indicators not meeting the state benchmark. Proof of action was also required to ensure implementation of the actions. When two or more indicators were missed, SWMBH implemented a higher level of scrutiny which requires the CMHSPs to submit monthly (and sometimes weekly) reports on their progress. SWMBH had regularly scheduled meetings with two CMHSPs this year due to repeated MMBPIS compliance issues. Process analysis, improvement efforts, and status of the current quarter were discussed at each meeting. As the Indicator 4a benchmark continued to be missed, meetings continued with one CMHSP well into FY23 to ensure future improvement and success.

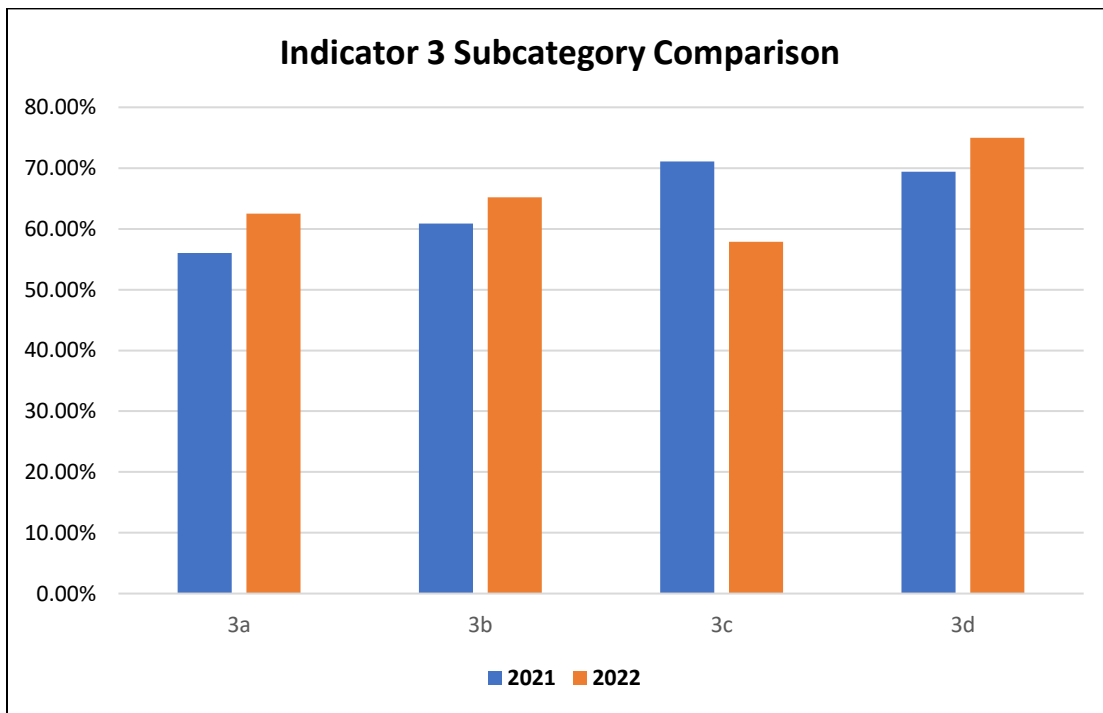
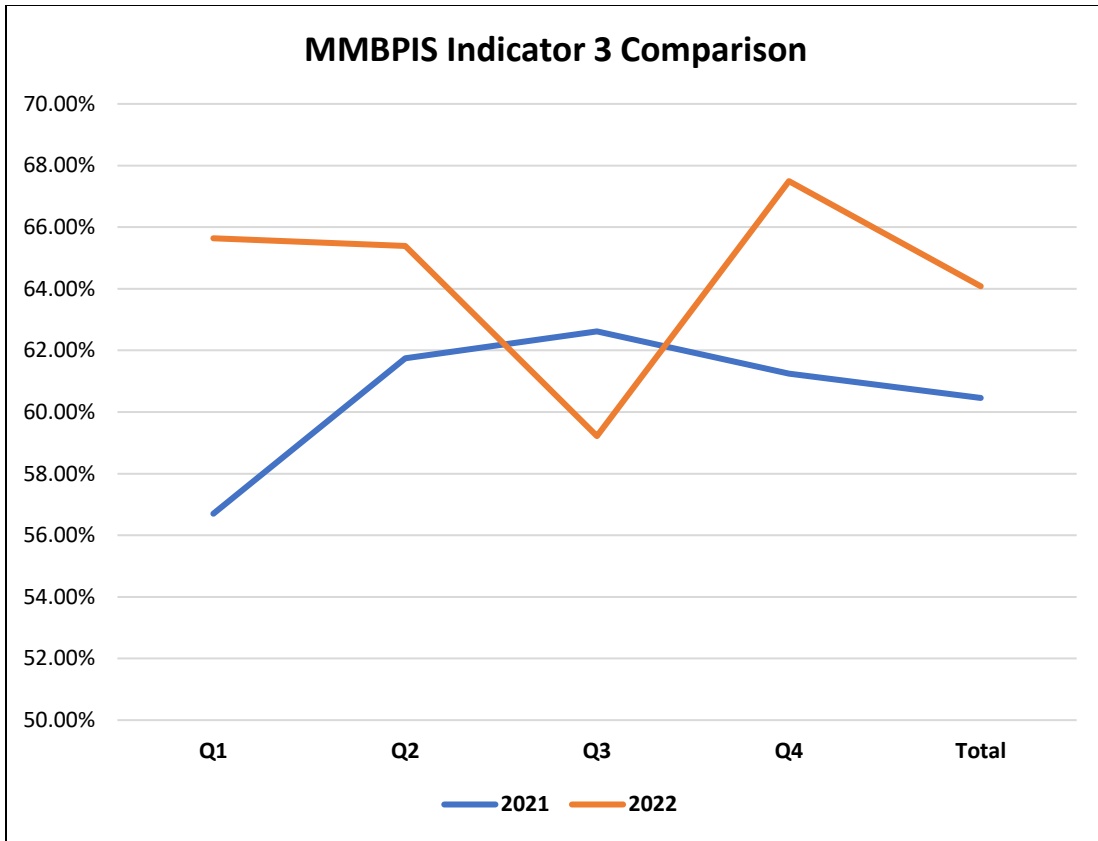
FY22 Results

Indicator	FY21	FY22	Eval Score	Recommendations	Time Estimate
1 - Percentage of Children who receive a Prescreen within 3 hours of request ($\geq 95\%$).	99.32%	99.40%	5	The goal was met and will stay the same and be monitored through FY 2023.	 6-12 Mo.
1 - Percentage of Adults who receive a Prescreen within 3 hours of request ($\geq 95\%$).	99.09%	99.26%	5	The goal was met and will stay the same and be monitored through FY 2023.	 6-12 Mo.
2a - Percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children).	67.31%	73.15%	N/A – No bench mark	MDHHS benchmarks will be established for FY 2024.	 6-12 Mo.
2b - 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.	68.78%	65.21%	N/A – No bench mark	MDHHS benchmarks will be established for FY 2024.	 6-12 Mo.
3 - percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children).	60.46%	64.08%	N/A – No bench mark	MDHHS benchmarks will be established for FY 2024.	 6-12 Mo.
4a(a) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children ($\geq 95\%$).	99.38%	98.71%	5	The goal was met and will stay the same and be monitored through FY 2023.	 6-12 Mo.
4a(b) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults ($\geq 95\%$).	98.24%	95.85%	4	The goal was met and will stay the same and be monitored through FY 2023. Most frequently missed benchmark by CMHSPs in FY22. Best practices will be identified in FY 2023 and shared with the region.	 6-12 Mo.

4b - Follow-Up within 7 Days of Discharge from a Detox Unit ($\geq 95\%$).	95.74%	97.93%	4	The goal was met and will stay the same and be monitored through FY 2023. The data collection process will be adjusted to improve efficiency and accuracy.	 6-12 Mo.
10a - Re-admission to Psychiatric Unit within 30 Days-Children (standard is $\leq 15\%$).	5.42%	4.83%	5	The goal was met and will stay the same and be monitored through FY 2023.	 6-12 Mo.
10b - e-admission to Psychiatric Unit within 30 Days- Adults (standard is $\leq 15\%$).	11.55%	10.85%	5	The goal was met and will stay the same and be monitored through FY 2023.	 6-12 Mo.



MMBPIS Indicator #	MMBPIS Performance Indicator	State Standard	Q1 2022	Q2 2022	Q3 2022	Q4 2022
1a	Pre-Admission Screening Children	95%	99.36%	99.64%	98.77%	100.00%
1b	Pre-Admission Screening Adults	95%	99.32%	99.42%	99.42%	98.89%
2a(a)	Request to Intake MI Adults	n/a	71.97%	75.08%	75.47%	70.99%
2a(b)	Request to Intake MI Children	n/a	70.75%	69.27%	75.63%	70.36%
2a(c)	Request to Intake IDD Adults	n/a	83.50%	80.17%	85.60%	85.19%
2a(d)	Request to Intake IDD Children	n/a	82.35%	79.07%	72.22%	74.29%
2e	Request to Service SA	n/a	401	351	420	430
3a	First Service MI Adults	n/a	64.99%	65.41%	55.64%	66.00%
3b	First Service MI Children	n/a	67.04%	65.68%	62.06%	66.75%
3c	First Service IDD Adults	n/a	52.94%	57.55%	50.39%	73.08%
3d	First Service IDD Children	n/a	80.00%	80.00%	60.78%	84.85%
4a(a)	IP Follow Up Children	95%	98.11%	100.00%	100.00%	97.14%
4a(b)	IP Follow Up Adults	95%	96.21%	97.60%	94.47%	95.27%
4b	Detox Follow Up	95%	97.93%	94.65%	99.03%	99.57%
10a	IP Recidivism Children	15%	7.69%	5.36%	3.23%	1.67%
10b	IP Recidivism Adults	15%	12.27%	9.61%	10.79%	10.76%
	Overall Results		7/7	6/7	6/7	7/7



B. Performance Improvement Projects (PIPs)

Description

MDHHS requires that the Prepaid Inpatient Health Plan (PIHP) conduct and submit performance improvement projects (PIPs) annually to meet the requirements of the Balanced Budget Act of 1997 (BBA), Public Law 105-33. According to the BBA, the quality of health care delivered to Medicaid members in PIHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that a PIHP serves.

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that the PIHP executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the QI strategies and activities conducted by the PIHP during the PIP.

The following are steps used to identify, implement, and evaluate the progress of a PIP.

Protocol Steps	
Step Number	Description
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood that Significant and Sustained Improvement Occurred

There were 2 primary Performance Improvement Projects that SWMBH has targeted for progress in 2022. Those PIPs include:

1. "A decrease in the disparity between African American/Black and White rates of follow up after ED visits for alcohol and other drug use, from baseline to remeasurement 1, without a corresponding decrease in White follow up rates." (HSAG)
2. The percentage of adolescents and adults with a new episode of alcohol or other drug abuse or dependence who received the following:
 - Initiation of AOD Treatment, the percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis.
 - Engagement of AOD Treatment, the percentage of beneficiaries who initiate treatment and who had 2 or more additional AOD services within 34 days of the initiation visit.

FY22 Goals

PIP	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
<p>Performance Improvement Project #1</p> <p>A decrease in the disparity between African American/Black and White rates of follow up after ED visits for alcohol and other drug use, from baseline to remeasurement 1, without a corresponding decrease in White follow up rates.</p> <p>Data will be stratified by race/ethnicity by MDHHS and delivered to PIHPs. The goal is to eliminate any statistically significant disparity between the African American/Black and White populations.</p> <p>Calendar year 2021 is baseline. Calendar year 2022 is the intervention development period. Calendar years 2023 and 2024 will be the remeasurement periods.</p> <p>Measures:</p> <ol style="list-style-type: none"> The percentage of African American/Black beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence. The percentage of White beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence. 	Clinical Quality	Regional Clinical Quality Committee and Regional Quality Management Committee	Bi-Annual
<p>Performance Improvement Project #2</p> <ol style="list-style-type: none"> Increase in SWMBH's initiation of treatment for substance use (IET-14) to 38.59% or above. Decrease in the disparity between White and African American/Black rates of engagement for substance use and dependence (IET-34), from baseline to remeasurement period 1, without sacrificing White/Caucasian measure performance. The aim is to eliminate any statistically significant disparity between the two groups. <p>Calendar year 2021 is Baseline. Calendar year 2022 is the intervention development period, and calendar years 2023 and 2024 will be Remeasurement periods 1 and 2.</p> <p>Measures:</p> <ol style="list-style-type: none"> The overall IET-14 measure rate for SWMBH. The IET-34 measure rate for the White/Caucasian SWMBH measure population; the IET-34 measure rate for the African American/Black SWMBH measure 	Clinical Quality	Regional Clinical Quality Committee and Regional Quality Management Committee	Bi-Annual

population; and the difference between these two rates, calculated as 'White Rate –African American/Black rate.'			
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Performance Improvement Project #1 – Reduce racial disparities in follow-up after ED visits for alcohol and other drug dependence.

Topic Selection and Historical Results:

In 2021, the State of Michigan requested that each PIHP select a new performance improvement project topic to address healthcare disparities. Our topic was selected through an evaluation of SWMBH performance and utilization data, assessing for the presence of racial and ethnic disparities. The evaluation included racial and ethnic stratifications of utilization rates of behavioral health services, access to medication-assisted opioid treatment, timely access to behavioral health services (measured by Michigan-specific performance metrics), and CMS Core Set/HEDIS quality metrics (including Follow-Up After Emergency Department Visit for Alcohol and other Drug Abuse or Dependence (FUA), Follow Up After Psychiatric Hospitalization (FUH), and Initiation and Engagement of Alcohol and other Drug Treatment (IET)).

At the end of this analysis, SWMBH found clinically and statistically significant disparities in outcomes in the FUA-30 metric between the White and African American/Black populations. We reviewed these results with substance use providers in the region, and with clinical, substance use network, and quality leadership at SWMBH. In those discussions we obtained support for the project's focus, to reduce African American/Black disparities in follow-up after emergency department visit for alcohol and other drug abuse or dependence.

Historical FUA-30 Rates by Major Racial/Ethnic Groups		Numerator	Denominator	Percent
Calendar Year 2019	ALL RACES AND ETHNICITIES	360	1,685	21.36
	AFRICAN AMERICAN / BLACK	32	333	9.61
	HISPANIC	5	47	10.64
	WHITE	281	1,122	25.04
Calendar Year 2020	ALL RACES AND ETHNICITIES	305	1,638	18.62
	AFRICAN AMERICAN / BLACK	38	328	11.59
	HISPANIC	10	61	16.39
	WHITE	238	1,139	20.90

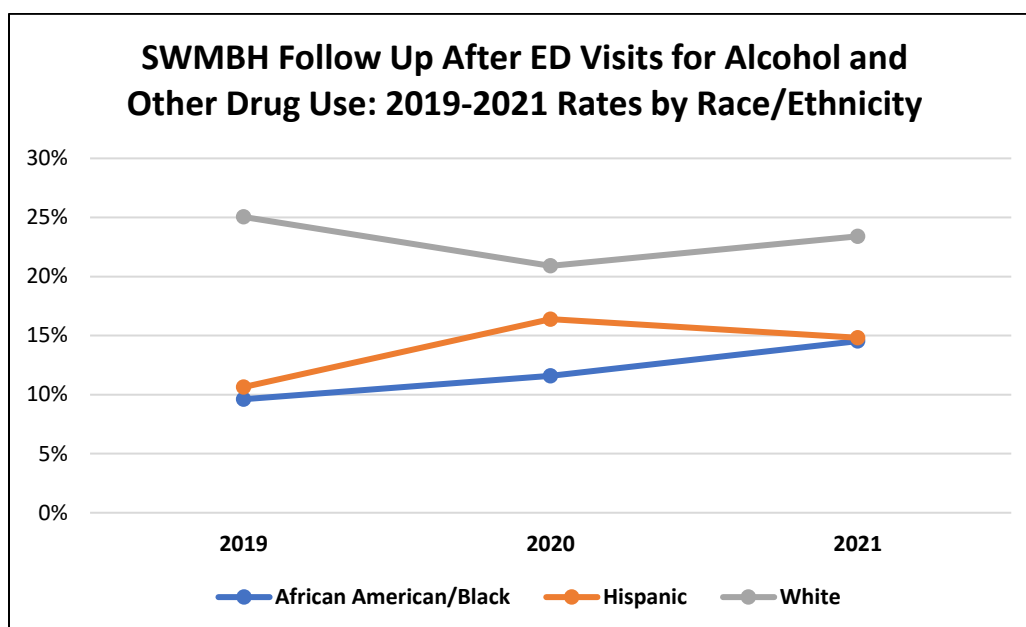
Measurement of performance using objective quality indicators:

The goal of the project is to decrease the disparity between African American/Black and White rates of follow up after ED visits for alcohol and other drug use, from baseline to remeasurement 1, without a corresponding decrease in White follow up rates. Data will be stratified by race/ethnicity by MDHHS and delivered to PIHPs. The specific aim is to eliminate any statistically significant disparity between the African American/Black and White populations.

The PIP Performance Measures are:

- The percentage of African American/Black beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence.
- The percentage of White beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence

For each measurement period, Pearson's chi-square test will be used to determine if a statistically significant difference remains between the proportions of White individuals and African American/Black individuals who receive a follow up service within 30 days of an ED visit for AOD. If there is no longer a statistically significant difference between the two populations, then we will have achieved the project's aim.



Baseline Results

SWMBH FUA-30 Rates by Major Racial/Ethnic Groups		Numerator	Denominator	Percent
Calendar Year 2021 (Project Baseline)	ALL RACES AND ETHNICITIES	369	1,760	20.97
	AFRICAN AMERICAN / BLACK	52	358	14.53
	HISPANIC	12	81	14.81
	WHITE	286	1223	23.39

The calendar year 2021 baseline rate of 30-day follow up after ED visits for alcohol and other drug abuse or dependence was 14.53% for African American/Black beneficiaries, compared to a rate of 23.39% for White beneficiaries. Using a chi-square test of independence, White individuals were found to be significantly more likely than African American/Black individuals to receive a follow up service for an ED visit for AOD in 2021, with a p value of .0003 ($\chi^2 (1, N = 1581) = 12.9$). This difference is significant at $p < .05$. The disparity in rates of follow up for the White and Hispanic populations was not statistically significant.

Implementation of interventions to achieve improvement in the access to and quality of care

Formal intervention is needed to address the persistent and significant disparity between African American/Black and White rates on FUA-30. SWMBH has formed a cross-functional team to identify barriers to equity in follow up services and to implement and monitor interventions. The primary drivers that we are working to address are reducing red tape and barriers to treatment, reducing stigma, increasing culturally competent care, addressing social determinants of health, and improving workforce diversity. The workgroup is prioritizing interventions within these domains. Interventions are selected based on feasibility and likely impact on the PIP goal.

We are currently working with providers to institute encounter reporting for services delivered by peers embedded in Emergency Departments. Often, follow up services occur that we do not receive credit for, because they are funded by net cost contracts. Encounter reporting will ensure that these services are counted in our metric and will allow for easier monitoring and identification of issues (like access or network capacity difficulties). SWMBH has also hired a Health Equity Grant Coordinator who will coordinate focus groups to understand and address gaps in service access, implement a stigma campaign, and host provider trainings related to health equity and welcoming concepts.

Many targeted interventions will be ongoing throughout 2023 and 2024. We plan to add at least one new withdrawal management level of care in our region. We are considering ways to increase African American/Black clinical or peer support staffing, such as through a fellowship pathway for Recovery Coaches. The new 24-hour crisis center in Calhoun and the future center in Kalamazoo county will be available for referrals from the ED. We will look for ways to use these crisis centers and other CMH/provider and emergency department communication pathways to increase equity in FUA-30.

Evaluation of the effectiveness of the interventions based on the performance of measures

We will evaluate the effectiveness of our interventions using Plan-Do-Study-Act (PDSA) cycles. For our first major intervention, reporting of peer follow up services, we will monitor the proportion of services that our Project ASSERT partners report in their net cost reports, that also have a state-reported encounter each month. We will assist providers with problem-solving issues that arise. For our stigma campaign and provider trainings, we will use pre and post testing to assess impact. The community member and provider focus groups that our health equity project coordinator will host will identify ways to increase health equity and decrease barriers to treatment. The coordinator will work with CMHs and providers to implement changes, and we will monitor how many of the proposed changes are successfully implemented.

The next official PIP remeasurement periods are calendar years 2023 and 2024, when we will evaluate whether our interventions overall have decreased or eliminated the disparity.

Planning and initiation of activities for increasing or sustaining improvement

Through the course of the project, we will assess the success of our interventions, and modify, add, or eliminate interventions as needed to ensure sustained improvement.

Performance Improvement Project #2 – Initiation and Engagement 14- and 34-day Follow-up

Topic Selection:

The topic selected for Southwest Michigan Behavioral Health's ('SWMBH') second PIP is the [CMS Adult Core Set](#) quality metric, [Initiation and Engagement of Alcohol and Other Drug Treatment](#), otherwise known as 'IET.' This measure assesses the percentage of individuals who, upon beginning a 'new' substance use treatment episode, received follow-up services within specific time intervals afterward.

IET is comprised of two related measures: IET-14, or 'Initiation of Alcohol and Other Drug Treatment,' and IET-34, or 'Engagement of Alcohol and Other Drug Treatment.'

1. **IET-14:** Beneficiaries 13 years or older with a new episode of alcohol or other drug (AOD) abuse or dependence during the measurement period who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.
2. **IET-34:** Beneficiaries 13 years or older who engaged in treatment and had two or more additional alcohol or other drug (AOD) abuse services or medication treatment within 34 days of the initiation visit. (A person who has not had an initiation visit – i.e., who is not in the measure numerator for IET-14 – cannot be in the measure denominator for IET-34.)

IET-14 and IET-34 were selected as PIP topics through an evaluation of SWMBH performance and utilization data, which assessed for the presence of racial and ethnic disparities. The evaluation included racial and ethnic stratifications of the following: utilization rates of behavioral health services, access to medication-assisted opioid treatment, timely access to behavioral health services (measured by Michigan-specific performance metrics), and CMS Core Set/HEDIS quality metrics (including Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)), Follow Up After Psychiatric Hospitalization (FUH), and Initiation and Engagement of Alcohol and Other Drug Treatment (IET)). A statistically significant disparity between White and African American/Black measure performance was found for IET-34 for calendar year 2021, motivating its selection as one of SWMBH's PIPs.

Furthermore, IET-14 and IET-34 measure data provided by the State of Michigan via Optum indicates that overall SWMBH IET-14 performance during calendar year 2021 lags significantly behind Michigan Medicaid overall IET-14 performance. SWMBH's IET-14 rate for calendar year 2021 is 32.9% (2227/6768 beneficiaries), whereas the rate for Michigan Medicaid overall is 38.59% (27186/70445 beneficiaries). SWMBH's overall performance on this measure is well short of the state's overall performance, justifying that IET-14 be selected as a topic for a PIP alongside IET-34.

Measurement of Performance Using Objective Quality Indicators:

The goals of this PIP are 1) to increase SWMBH IET-14 performance to 38.59% or above – the IET-14 performance rate for Michigan Medicaid overall during calendar year 2021; and 2) to decrease the disparity between African American/Black and White IET-34 rates, from baseline to remeasurement period 1, without a

decrease in White rates. Regarding Goal 2, the specific aim is to eliminate any statistically significant disparity between the two populations. For each measurement period, Chi-squared tests will be used to determine if a statistically significant disparity remains.

SWMBH's IET-14 rate for calendar year 2021 is 32.9% (2227/6768 beneficiaries), whereas the rate for Michigan Medicaid overall is 38.59% (27186/70445 beneficiaries). Per a Chi-squared test, this difference is significant at any commonly-used alpha level ($\chi^2 = 84.442$; $p < 2.2 \times 10^{-16}$).

IET-34 measure performance for SWMBH White and African American/Black groups during the Baseline period (i.e., calendar year 2021) is as follows:

SWMBH IET Rates by Racial/Ethnic Group		Group	Numerator (Events)	Denominator (Events)	Percent
Calendar Year 2021	IET-34	African American/Black	129	1490	8.66%
		White	513	4665	11.00%

During the baseline year, White IET-34 performance was 2.34% higher than African American/Black IET-34 performance. A Chi-squared test was used to determine that the IET-34 disparity is statistically significant at an alpha level of 0.05 ($p = 0.01164$).

Implementation of Interventions:

A cross-functional workgroup comprised of SWMBH personnel has convened throughout calendar year 2022 and 2023 to discuss barriers to appropriate follow-ups for substance-related healthcare, as well as approaches to reduce healthcare disparities. Interventions that have been suggested by the workgroup include the following:

- Trainings on social determinants of health, implicit biases, how to assess needs, welcoming concepts for SUDs and CODs, and trauma-informed care;
- Focus groups addressing trust in the BH/SUD system, improving social support for AOD treatment, and access barriers;
- Develop and disseminate outreach materials, especially for minority communities;
- Have Project ASSERT peers report encounters, and develop data sharing processes between CMHes, EDs, and Project ASSERT; and
- Improving CMH workforce diversity by collaborating with local universities to recruit more non-White students into social work.

SWMBH has hired a Health Equity Grant Coordinator, who will provide equity-focused trainings and coordinate focus groups on access barriers. Additionally, SWMBH plans to add at least one new withdrawal management level of care in Region 4.

Lastly, SWMBH is currently working with providers to institute encounter reporting for services delivered by peers embedded in EDs. Follow up services often occur that we do not receive credit for, because they are funded by net cost contracts. Encounter reporting will ensure that these services are counted in our metric and will allow for easier monitoring and identification of issues, such as access or network capacity difficulties.

Evaluation of the effectiveness of the interventions based on the performance of measures:







We will evaluate the effectiveness of our interventions using Plan-Do-Study-Act (PDSA) cycles. For our first major intervention, reporting of peer follow up services, we will monitor the proportion of services that our Project ASSERT partners report in their net cost reports, that also have a state-reported encounter each month. We will assist providers with problem-solving issues that arise. For our stigma campaign and provider trainings, we will use pre and post testing to assess impact. The community member and provider focus groups that our health equity project coordinator will host will identify ways to increase health equity and decrease barriers to treatment. The coordinator will work with CMHs and providers to implement changes, and we will monitor how many of the proposed changes are successfully implemented.

The next official PIP remeasurement periods are calendar years 2023 and 2024, when we will evaluate whether our interventions overall have decreased or eliminated the disparity.

Planning and initiation of activities for increasing or sustaining improvement:

Through the course of the project, we will assess the success of our interventions, and modify, add, or eliminate interventions as needed to ensure sustained improvement.

FY22 Results

Goal	FY21	FY22	Eval Score	Recommendations	Time Estimate
Plans will meet set standard for follow-up within 30 days for each rate (ages 6-17) and (18 and older). Plans will be measured against the adult minimum standard of 58% and child minimum standard of 70%. The measurement period was calendar year 2022.	Adult 67.1% Child 77.5%	Adult 68.6% Child 83.5%	5	This goal was met. If necessary, the goal will be revised for FY 2023 due to the potential changes in HEDIS or PBIP metric reporting by MDHHS. Ongoing monitoring will occur during Clinical and Quality Regional Committees.	 3-6 Mo.
The percentage of African American/Black beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence. The measurement will be a comparison of calendar year 2021 with calendar year 2022.	70.4%	71.3%	5	As indicated, a nearly full percent improvement was observed from the FY21 in comparison to the FY22 evaluation period. No immediate action is required, and the PIP will continue to be monitored throughout 2023-2024. Updates will be provided to MDHHS/HSAG as schedule requires.	 6-12 Mo.
The percentage of White beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence. The measurement will be a comparison of calendar year 2021 with calendar year 2022.	71.4%	68.3%	3	The initial metric measurement observed a decline from the FY21 result in comparison to the FY22 result. Additional data validation activities will occur, to ensure the most accurate data is available for continued analysis of this metric.	 3-6 Mo.
Initiation of AOD Treatment, the percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis.	32.95%	36.14%	4	The metric percentage continues to improve, so no immediate action is required. The metric will continue to be reviewed during Regional Clinical Committees and internal SWMBH data workgroups.	 3-6 Mo.
Engagement of AOD Treatment, the percentage of beneficiaries who initiate treatment and who had 2 or more additional AOD services within 34 days of the initiation visit.	10.49%	24.44%	5	The metric percentage continues to improve, so no immediate action is required. The metric will continue to be reviewed during Regional Clinical Committees and internal SWMBH data workgroups.	 3-6 Mo.
SWMBH participated in DHHS planned data validation activities and meetings. SWMBH was provided IET data files on 1/31/22 and had 120 calendar days to return the completed validation template to MDHHS.	Complete and verified by MDHHS in 2022 PBIP results		5	SWMBH will continue to participate in the DHHS planned data validation activities for the IET metric. This data and process will be discussed during internal SWMBH clinical data integrity meetings. SWMBH was awarded full points for this activity by MDHHS during the 2022 PBIP consultative results.	 6-12 Mo.

C. Event Reporting – Critical Incidents

Description

SWMBH's process for identifying, reporting, and following up on incidents and events is outlined in policy 03.05 Incident Event Reporting and Monitoring. The five reportable critical incidents are defined by MDHHS as suicide, non-suicide deaths, hospitalization due to injury or medication error, emergency medical treatment (EMT) due to injury or medication error, and arrests. Hospitalization or EMT due to an injury will be further classified to include whether the injury resulted from physical management. SWMBH is responsible for reporting qualifying incidents to MDHHS in a timely manner, as defined in the contract language.

SWMBH delegates the responsibility of the process for the identification, review, and follow-up of sentinel events, critical incidents, and risk events to the contracted CMHSPs and SUD Providers. All unexpected deaths (UDs) are classified as sentinel events and are defined as deaths resulting from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect, for members who at the time of their deaths were receiving specialty supports and services. SWMBH ensures that the CMHSP and SUD Providers have taken appropriate action to ensure that any immediate safety issues have been identified and addressed, including the proper identification of a sentinel event and the commencement of a root cause analysis. Following completion of a root cause analysis, or investigation, the CMHSP or SUD Provider is required to develop and implement either a plan of correction or an intervention to prevent further occurrence or recurrence of the adverse event, or to document the rationale of why corrective actions are not needed.

SWMBH analyzes critical incidents, sentinel events, and risk events at least quarterly during the regional QMC meetings. The risk events reviewed minimally include actions taken by individuals who receive services that cause harm to themselves, actions taken by individuals who receive services that cause harm to others, and two or more unscheduled admissions to a medical hospital (unrelated to a planned surgery or natural course of a chronic illness) within a 12-month period. The quantitative data and the qualitative details of specific incidents or events are reviewed and discussed to remediate the problems and prevent similar occurrences of additional incidents or events in the region. Documentation of the review and discussion is maintained the meeting PowerPoint presentation and minutes.

SWMBH contracts with four SUD residential treatment providers – Gilmore Community Healing Center (CHC), Freedom Recovery Center (FRC), Kalamazoo Probation Enhancement Program (KPEP), and Sacred Heart Center. These providers are required to prepare and submit a sentinel events data report semiannually to SWMBH that includes the number of sentinel events by event category, and plans of action or interventions, which occurred during the 6-month period. SWMBH aggregates the data and submits it to MDHHS by the designated due dates outlined in the contract requirements.

FY 2022 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will submit the SUD Sentinel Event report timely with a 100% completion rate biannually during the fiscal year.	Quality	Through submission to MDHHS via the DCH-File Transfer	Semiannual
The rate for the region, per 1000 persons served, of suicide deaths will demonstrate a decrease from the previous year.	Quality	QMC	Monthly
The rate for the region, per 1000 persons served, of individuals who were hospitalized due to an injury or medication error will demonstrate a decrease from the previous year.	Quality	QMC	Monthly
The rate for the region, per 1000 persons served, of individuals who received emergency medical treatment (EMT) for an injury or medication error will demonstrate a decrease from the previous year.	Quality	QMC	Monthly
The rate for the region, per 1000 persons served, of individuals who are arrested will demonstrate a decrease from the previous year.	Quality	QMC	Monthly






FY22 Identified Barriers

One barrier that was identified in FY22 was related to the classification of sentinel events and thus the completion of a root cause analysis. Questions were specifically raised about unexpected deaths and what should be considered a sentinel event. This barrier had the potential for impacting the quality of health care and services for members if incidents were misclassified and therefore interventions were not put in place to prevent recurrence of similar events. SWMBH clarified questions with MDHHS and reviewed the responses in the QMC meetings to ensure all CMHSPs understood the expectations moving forward.

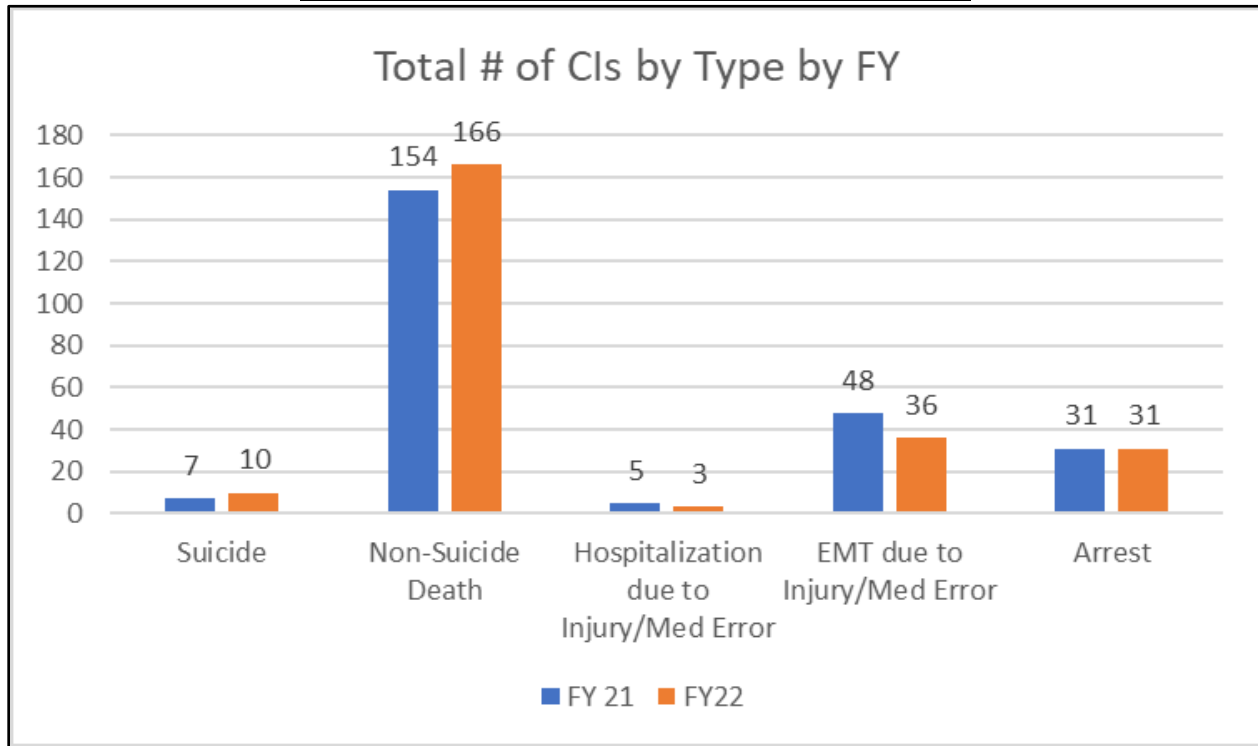
Improvement Efforts Made in FY22

The critical incident data is reviewed in the QMC meetings to help identify trends in the data across the region. The amount and detail of the data presented during the QMC meetings was improved. This included adding more data related to the types of incidents occurring, as well as aggregated information related to unexpected deaths and further classifying those considered accidental. This allowed for better discussion on regional trends and interventions the CMHSPs have taken related to critical incidents, sentinel events, and risk events to try to mitigate future risk. SWMBH also met individually (on a biweekly and transitioned to a monthly basis) with one CMHSP that scored poorly on the critical incident section of the 2022 Delegated Function Site Review. The meetings consisted of helping the CMHSP to revise their policy and process related to the review of incidents, identification of sentinel events, and completion of the root cause analysis process.

FY22 Results

Goal	FY21	FY22	Eval Score	Recommendations	Time Estimate
SWMBH will submit the SUD Sentinel Event report timely with a 100% completion rate biannually during the fiscal year.	100%	100%	5	This goal was met. It will be revised for FY 2023 due to the change in the SUD Sentinel Event reporting process, utilizing the new MDHHS BH CRM.	 6-12 Mo.
The rate for the region, per 1000 persons served, of suicide deaths will demonstrate a decrease from the previous year.	0.24	0.23	3	The goal was met and will stay the same and be monitored through FY 2023.	 6-12 Mo.
The rate for the region, per 1000 persons served, of individuals who were hospitalized due to an injury or medication error will demonstrate a decrease from the previous year.	0.12	0.08	3	The goal was met and will stay the same and be monitored through FY 2023.	 6-12 Mo.
The rate for the region, per 1000 persons served, of individuals who received emergency medical treatment (EMT) for an injury or medication error will demonstrate a decrease from the previous year.	0.73	0.48	4	The goal was met and will stay the same and be monitored through FY 2023.	 6-12 Mo.
The rate for the region, per 1000 persons served, of individuals who are arrested will demonstrate a decrease from the previous year.	0.79	0.48	4	The goal was met and will stay the same and be monitored through FY 2023.	 6-12 Mo.

Analysis of SWMBH's CIs, SEs, UDs, and REs

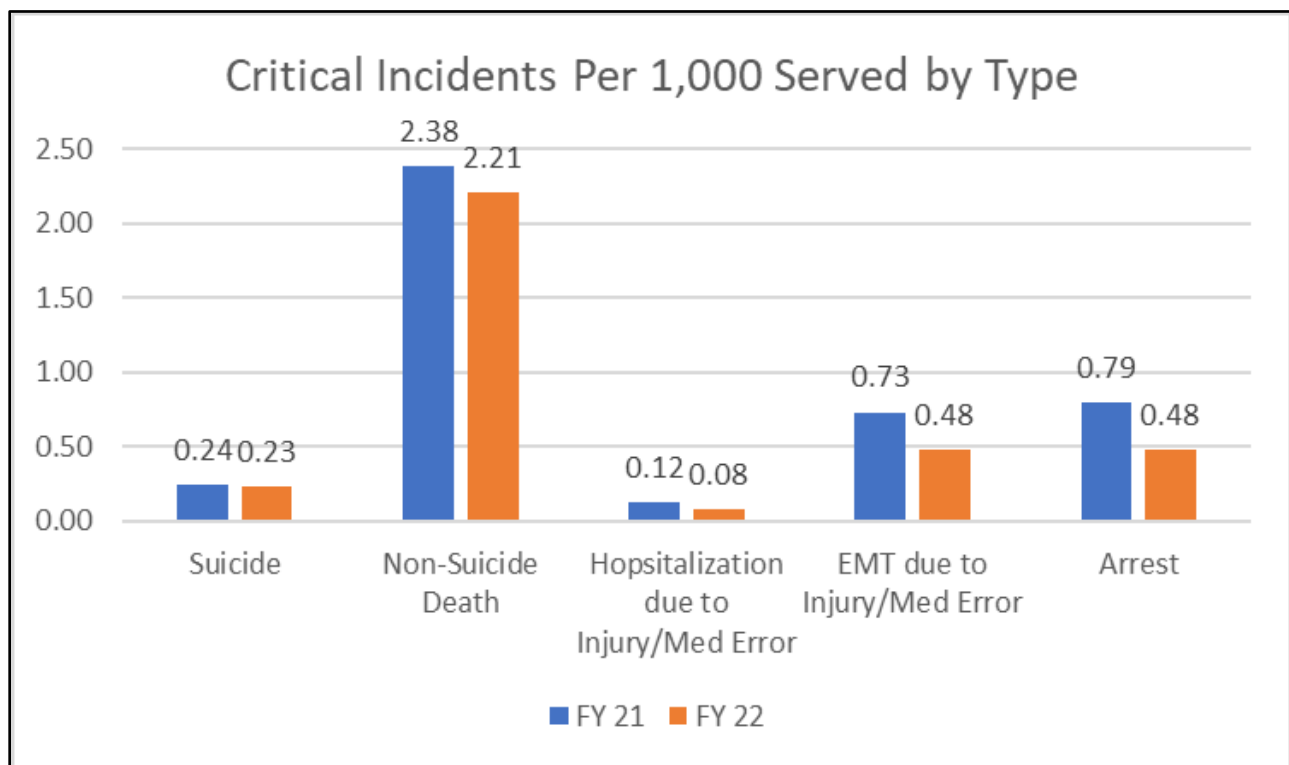


FY 2021 - Critical Incident Per 1,000 Served by Type													
	Q1			Q2			Q3			Q4			Total
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Suicide	0.02	0.08	0.03	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.11	0.00	0.24
Non-Suicide Death	0.17	0.18	0.34	0.24	0.25	0.15	0.26	0.15	0.18	0.20	0.12	0.14	2.38
Hopsitalization due to Injury/Med Error	0.00	0.05	0.00	0.00	0.02	0.02	0.00	0.01	0.02	0.00	0.00	0.00	0.12
EMT due to Injury/Med Error	0.15	0.03	0.05	0.03	0.06	0.14	0.11	0.01	0.03	0.07	0.04	0.01	0.73
Arrest	0.11	0.00	0.00	0.04	0.09	0.00	0.11	0.07	0.08	0.10	0.00	0.19	0.79

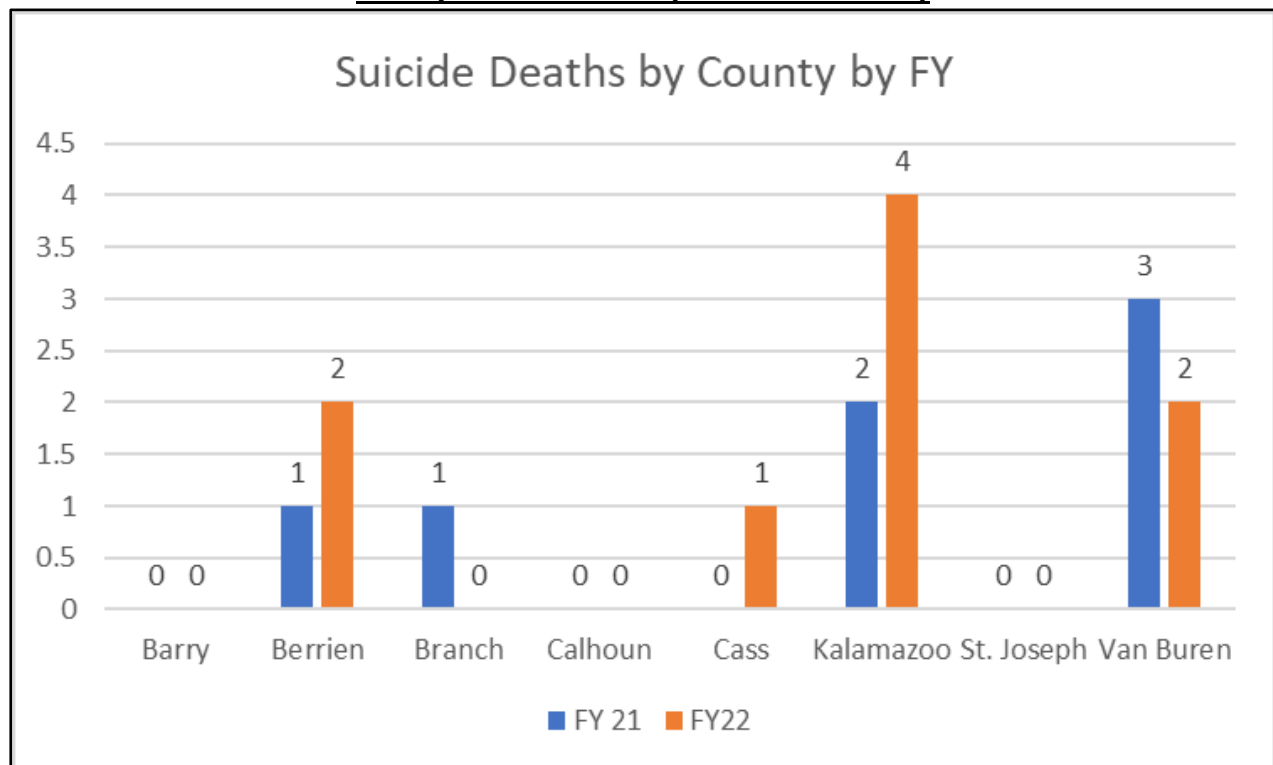
FY 2022 - Critical Incident Per 1,000 Served by Type													
	Q1			Q2			Q3			Q4			Total
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Suicide	0.00	0.06	0.00	0.00	0.00	0.02	0.03	0.07	0.01	0.02	0.01	0.01	0.23
Non-Suicide Death	0.17	0.24	0.12	0.26	0.28	0.09	0.21	0.17	0.18	0.18	0.17	0.14	2.21
Hopsitalization due to Injury/Med Error	0.01	0.00	0.00	0.00	0.06	0.01	0.00	0.00	0.00	0.00	0.00	0.00	0.08
EMT due to Injury/Med Error	0.06	0.03	0.04	0.01	0.04	0.03	0.03	0.05	0.03	0.06	0.04	0.06	0.48
Arrest	0.03	0.04	0.02	0.03	0.07	0.07	0.06	0.00	0.06	0.04	0.04	0.02	0.48

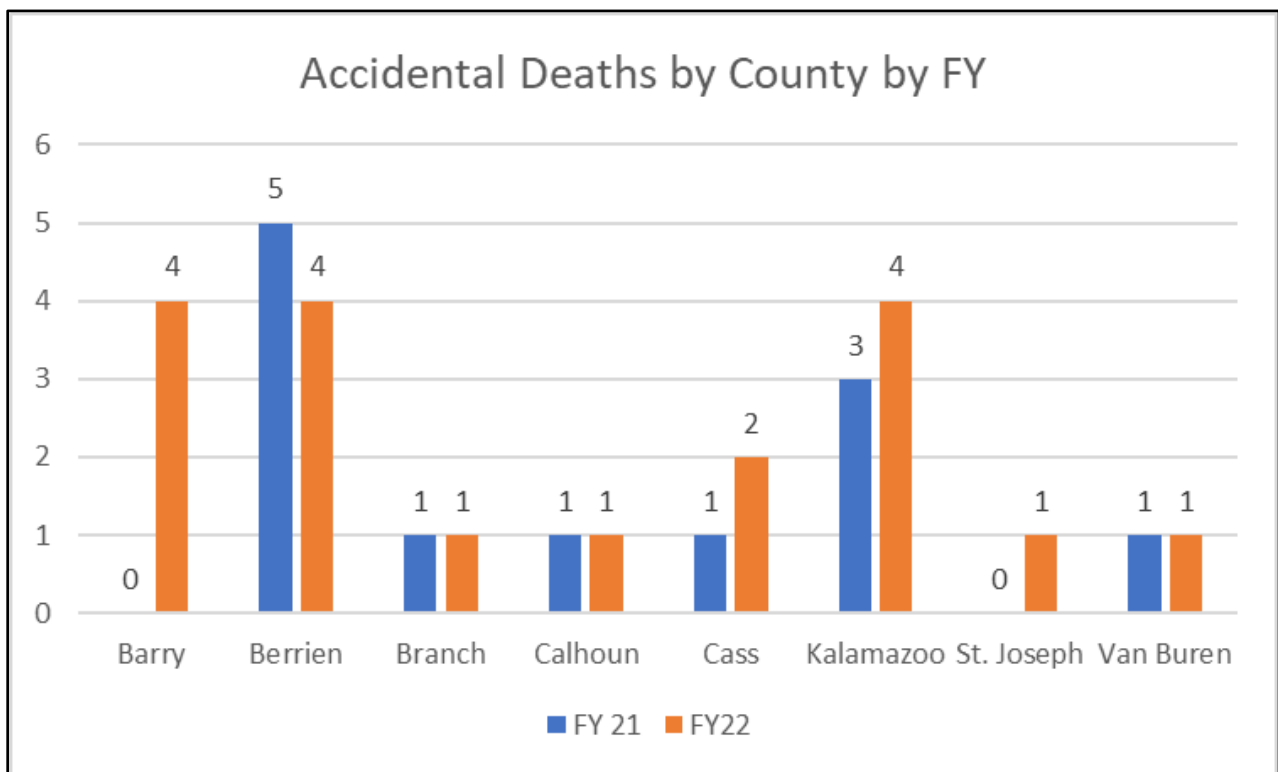
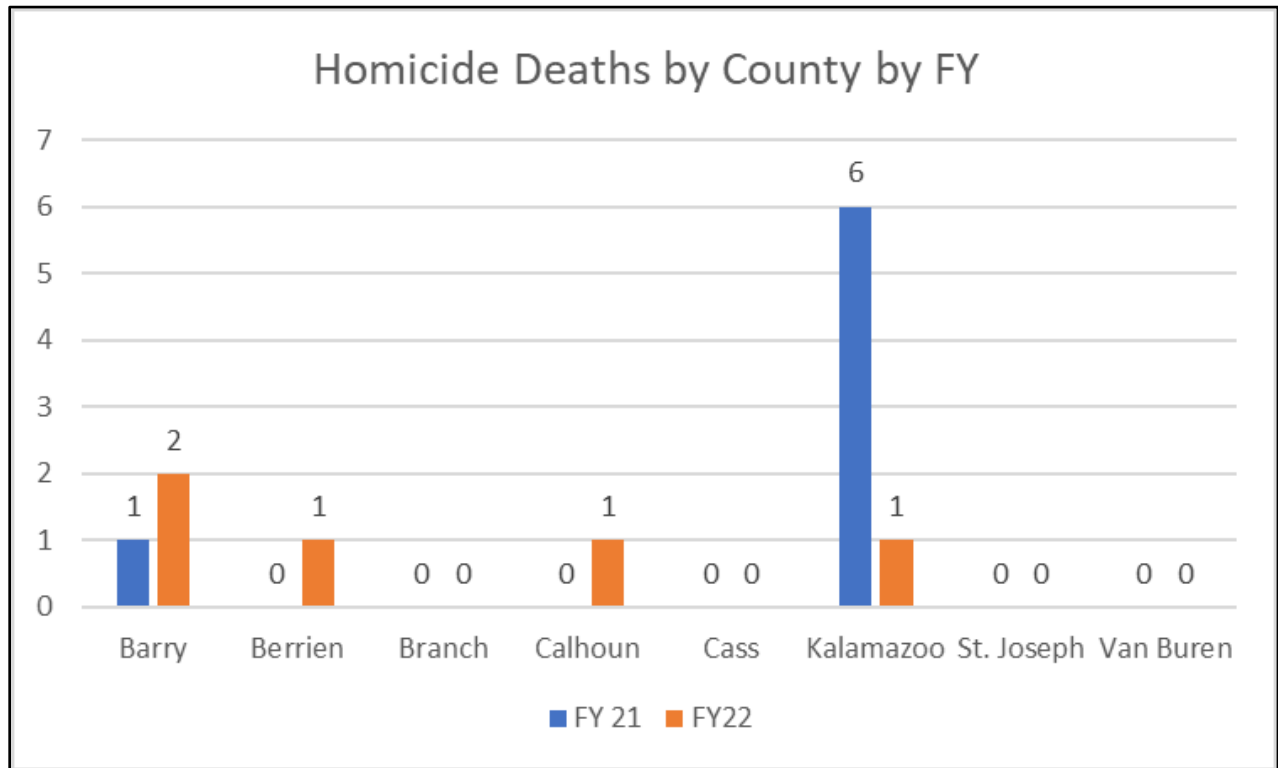
Critical Incident Per 1,000 Served by Type

	FY 21	FY 22
Suicide	0.24	0.23
Non-Suicide Death	2.38	2.21
Hopsitalization due to Injury/Med Error	0.12	0.08
EMT due to Injury/Med Error	0.73	0.48
Arrest	0.79	0.48



Unexpected Deaths (Sentinel Events)

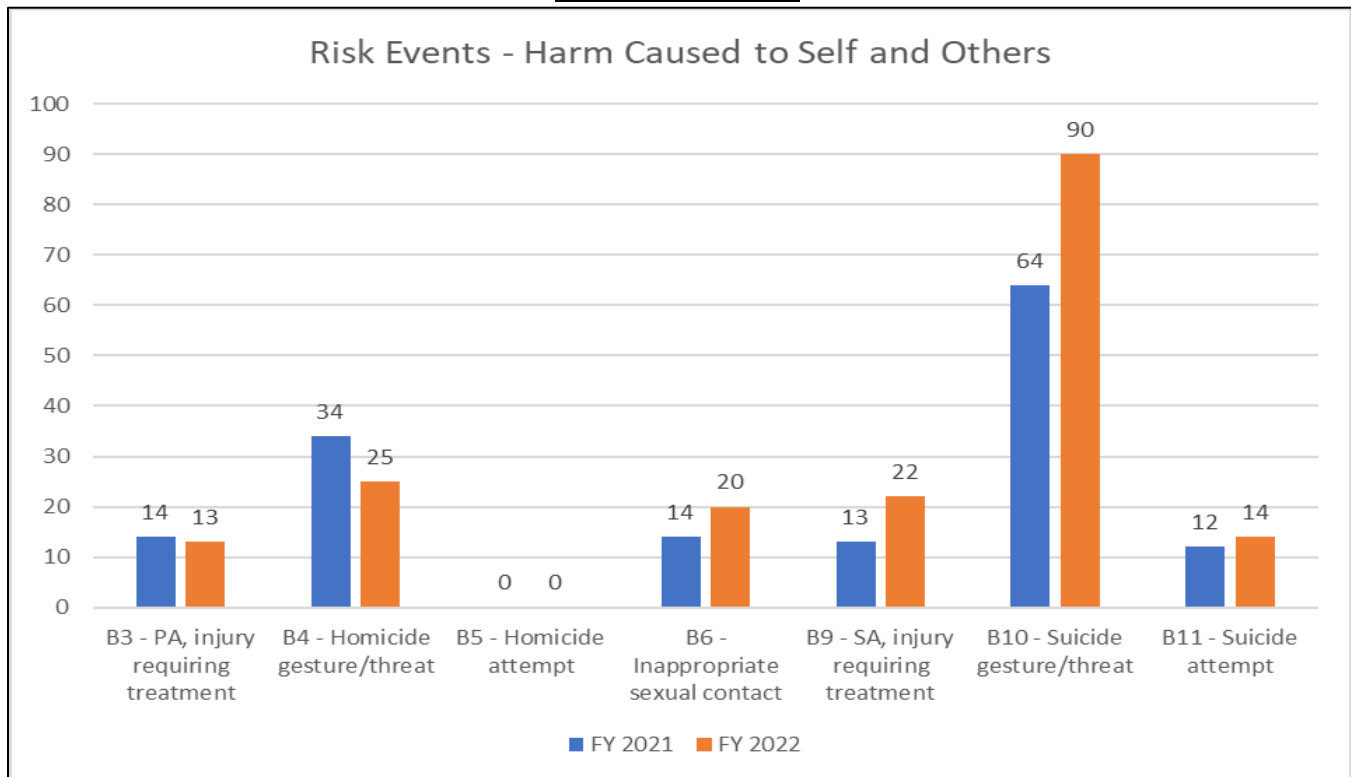




Aggregation of Unexpected Death Mortality Data - Accidental		
COD	FY 2021	FY 2022
Overdose	4	8
Drug Related/Other	0	1
Car Accident	2	3
Hit by Car/Train	2	2
Fire	1	0
Medical	0	2 (choking, fall)
Unknown COD	2	2

No unexpected deaths were reported in FY22 from an undiagnosed condition.

Risk Events (RE)



RE Hospitalizations

The CMHSPs are delegated the responsibility of tracking and following up on members who have two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness) within a 12-month period. SWMBH follows up with each CMHSP individually on a quarterly basis to ensure individuals with multiple admissions have appropriate follow up.

SUD Residential Treatment Providers

No sentinel events occurred in FY22 at the four residential treatment providers that SWMBH contracts with. The SUD Sentinel Event reports were submitted timely for both submissions to MDHHS in FY22.

D. Behavior Treatment Monitoring

Description

MDHHS requires data to be collected based on the definitions and requirements that have been set forth within the MDHHS Standards for Behavioral Treatment Review and the MDHHS Quality Assessment and Performance Improvement Program Technical Requirement attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract. Only the techniques permitted by the Technical Requirement for and have been approved during person-centered planning by the member or his/her guardian may be used with members. SWMBH delegates the responsibility for the collection and evaluation of data to each local CMHSP Behavior Treatment Review Committee (BTRC), including the evaluation of the effectiveness of the Behavior Treatment Review Committee by stakeholders. Each CMHSP is also required to submit their BTRC data to SWMBH on a quarterly basis where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. The data includes the numbers of interventions and length of time the interventions were used per person. Tracking this data provides important oversight to the protection and safeguard of vulnerable individuals, including those receiving long term supports and services (LTSS). The data is available to MDHHS upon request. SWMBH provides oversight by analyzing the data on a quarterly basis to identify and address any trends or opportunities for improvement. Based on the analysis, SWMBH requests the behavior plans for individuals as needed to review further. The criteria for further review may include, but is not limited to, those with restrictive and/or intrusive interventions, 911 calls, self-injurious behavior, hospitalizations, harm from physical management, and other critical incidents. SWMBH also utilizes the data during the administrative and delegated site reviews to ensure accurate reporting and adherence to the Behavior Treatment Review Standards by each CMHSP.

FY22 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Each CMHSP will have a Behavior Treatment Review Committee that meets the MDHHS technical requirements.	Quality	Quarterly Data Submissions and Delegated Function Site Reviews	Quarterly
Each CMHSP will submit their BTRC data timely, including the required elements, to SWMBH on a quarterly basis for analysis.	Quality	Quarterly Data Submissions and Delegated Function Site Reviews	Quarterly
Each CMHSP will have a process for expediting the review of a Behavior Treatment Plan in emergent situations which will be outlined in policy.	Quality	Delegated Function Site Reviews	Annually

FY22 Identified Barriers

In FY22 there was significant turnover of staff at the CMHSP level who were responsible for collecting and reporting the BTRC data to SWMBH, which led to gaps in understanding of the requirements. SWMBH worked collaboratively with the CMHSPs to train the newly appointed staff on the expectations for collection and submission of the data. No barriers were identified that impacted the quality of health care and services for members.

Improvement Efforts Made in FY22

Education was provided to the CMHSPs as the need was identified during the year. Additionally, the collection and analysis of the data was moved from SWMBH's Quality Department to the Clinical Quality Department to better align with the expertise of the departments and to improve the level of analysis of the data.

FY22 Results

Goal	FY22	Eval Score	Recommendations	Time Estimate
Each CMHSP will have a Behavior Treatment Review Committee that meets the MDHHS technical requirements.	8/8 CMHSPs Met This Requirement	5	The goal will be discontinued for FY23 but will continue to be monitored during the quarterly data submissions and during the delegated site reviews.	N/A
Each CMHSP will submit their BTRC data timely, including all of the required elements, to SWMBH on a quarterly basis for analysis.	4/8 CMHSPs Submitted All Data Timely	3	The goal will be discontinued for FY23 but will continue to be monitored during the quarterly data submissions and during the delegated site reviews.	N/A
Each CMHSP will have a process for expediting the review of a Behavior Treatment Plan in emergent situations which will be outlined in policy.	8/8 CMHSPs Met This Requirement	5	The goal will be discontinued for FY23 but will continue to be monitored during the delegated site reviews.	N/A

	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St. Joseph	Van Buren
The CMHSP has a BTRC that meets the MDHHS technical requirements.	X	X	X	X	X	X	X	X
The CMHSP submitted their BTRC data timely, including the required elements, to SWMBH quarterly in FY22.	4/4 quarters submitted timely	4/4 quarters submitted timely	0/4 quarters submitted timely	3/4 quarters submitted timely	4/4 quarters submitted timely	3/4 quarters submitted timely	0/4 quarters submitted timely	4/4 quarters submitted timely
The CMHSP has a process for expediting the review of BTPs in emergency situations.	X	X	X	X	X	X	X	X

E. Member Experience – Customer Satisfaction Surveys

Description

The QAPI Department has completed the 2022 annual Member Experience Satisfaction Survey. The primary objective of the survey is to improve scores in comparison to the previous year's results and identify opportunities for improvement at the CMHSP and PIHP levels. During the 2022 survey project, SWMBH ensured the incorporation of individuals receiving long-term supports or services, case management services, CCBHC services, and Medicaid services into the review and analysis of the information obtained from quantitative and qualitative methods.

During FY22 Survey Project, SWMBH utilized a hybrid Mental Health Statistics Improvement Program (MHSIP), Youth Surveillance Survey (YSS) and the Experience of Care and Health Outcomes Survey (ECHO) to gauge member experience of care. During FY22 the SWMBH Quality Department's goal was to collect 1500 completed surveys. The Region was able to reach that goal and achieved 1571 valid surveys, encompassing a validated survey process and consumer feedback from all eight of the CMHSPs. This was a tremendous improvement over the previous year's survey completion volume of only 747 valid surveys.

In efforts to improve survey accessibility during FY22 and FY23, consumers could complete the survey via QR codes or tablets in the CMHSP lobby areas, through the SWMBH website, text message, email, or by paper copy. The diverse options improved the response rates, and the targeted volume was achieved during FY22. The results of the annual survey are shared with MDHHS as a PIHP contractual obligation, the SWMBH Board of Directors, and Regional Committees (Operations Committee, Quality Management Committee, Consumer Advisory Committee, etc.) who have stake in the results/improvement efforts.

FY22 Goals

Primarily to improve on the Improved Outcomes scores for the Youth population and Improved Functioning for the Adult population. Over the past 7 years of conducting this survey, those have been identified as the lowest scoring categories needing improvement. Also, improvement against Statewide and National trends.

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Identify a new (shorter) survey tool that meets 'Best Practice' standards and have approved by MDHHS for use during the 2022 survey period.	Quality	QMC and Consumer Advisory Committee	Annually
Ensure that CMHSP Partners review the survey analysis with their internal workgroups and formulate PIPs for identified areas needing improvement.	Quality	QMC and Consumer Advisory Committee	Quarterly
Incorporate additional questions into the survey to capture CCBHC and LTSS program participant responses.	Quality	QMC and Consumer Advisory Committee and Clinical Practices Committee	Annually
Expand survey access via different methods, such as: email, text, phone, website, paper, tablet and QR code.	Quality	QMC and Consumer Advisory Committee	Quarterly
Improvement on overall "Improved Outcomes" for youth respondents and "Improved Functioning" for adult respondents.	Quality	QMC and Consumer Advisory Committee	Annually

FY22 Identified Barriers

Consumer phone numbers and e-mail addresses provided to SWMBH were not consistently accurate. It was identified that the information was not provided, had been changed, or was not updated in the CMHSP system. Also, during the survey process there were ineligible or fraudulent surveys submitted. SWMBH's survey vender, Kaier Research, identified that some surveys were submitted from IP addresses out of the country. Around 700 surveys were disqualified as they were identified as invalid/bot submissions which were completed in response to the incentive offered.

Improvement Efforts Made in FY22

During the 2022 survey project, the following significant improvement efforts were implemented:

The survey tool:

- Goal: Shorten the length of the survey by 30% to ease survey fatigue and increase response rates.
- A factor analysis was conducted to determine if any core survey items were redundant.
 - MHSIP tool was revised from 36 core items to 24 core items (in addition to open ended and demographic questions) while combining some constructs that were redundant.
 - YSS tool was revised from 26 core items to 23 core items (in addition to open ended and demographic questions).
- Item response options were changed from a 5pt scale with neutral option to a 4pt scale with no neutral option.
 - Previously, a "neutral" response was interpreted as a positive outcome.
 - The new scale forced respondents to respond either positively or negatively.
 - "Somewhat" labels were added to mid-scale positive and negative options, which offered a more accurate measure of overall satisfaction.






Priority population enhancements:

- New demographic questions were added for long-term support services and CCBHC to the survey. This allows responses to be filtered for those specialized populations and target performance improvement interventions as needed.
- A target of 300 completed surveys were established for the two CCBHC sites. ISK achieved this target at 386 and St. Joe fell short at 279.
- Data from each program (CCBHC, LTSS and CMHSP specific response) were cleaned and separated into distinct data sets and available to filter to identify common denominators or trends in responses.

Recommendations for 2023 Survey Project:

- Create a bot-catching mechanism or safe-guard technology to identify and stop fraudulent/ineligible responses. This could include including a CAPTCHA, trap/red herring questions, consistency checks, and/or other methods.
- Consider incentivizing every respondent.
 - Depending on the mode of delivery this could make the survey more cost effective and more representative of the consumer population.
 - Another option is to incentivize counties that have lower population and higher uncertainty (Cass/Branch/Barry) or underrepresented minorities.

FY22 Results

Goal	FY21	FY22	Eval Score	Recommendations	Time Estimate
Identify a new (shorter) survey tool that meets 'Best Practice' standards and have approved by MDHHS for use during the 2022 survey period.	In progress	Complete	5	Monitor survey completion times and consumer feedback quality/quantity of questions. The FY21 completion time averaged 28 min. The FY22 completion time averaged 6 minutes.	 3-6 Mo.
Ensure that CMHSPs are reviewing the survey analysis with their internal workgroups and addressing identified areas needing improvement.	In progress	Complete	4	Each CMHSP is expected to formulate goals related to the survey results and submit them to SWMBH for review.	 3-6 Mo.
Incorporate additional questions into the survey to capture CCBHC and LTSS program participant responses.	In progress	Complete	4	Work with Clinical Quality Department to target LTSS questions and review responses to improve LTSS services and programs.	 3-6 Mo.
Expand survey access via different methods, such as email, text, phone, website, paper, tablet and QR code.	747 Complete Surveys	1571 Complete Surveys	4	The goal of 1500 completed surveys was achieved. The Quality Department will continue to formulate improvement efforts and recommendations through consumer feedback.	 6-12 Mo.
Improvement on overall "Improved Outcomes" for Youth respondents and "Improved Functioning" for adult respondents.	Youth: 77.3% Adult: 85.1%	Youth: 75.5% Adult: 83.6%	4	Ensure CMHSP's are reviewing consumer feedback, identify areas of improvement and target programs/services for improved "Outcomes/Functioning".	 A.S.A.P.

In summary, 1571 valid surveys were completed, resulting in a favorable response volume in comparison to 2021 rates. The response rate was improved significantly compared to 2021 results where only 747 surveys were completed. Most of the surveys completed were done via e-mail or text. Direct telephonic method was not employed this year, due to the extremely low participation rate the previous year. The current 2022 results show an increase in overall "In Agreement" responses but cannot be validated, as the survey tool and questions did experience minor changes. Please see the detailed analysis represented in the graphs below, showing a significant improvement on isolated questions in comparison to 2021 scores. Agreement' ratings across most (MHSIP-adult) domain areas have proven lower during 2022, netting an average 'In Agreement' score (MHSIP – adult) of 76.6 in comparison to 86.1 the during the 2021 survey period. The decline in scores can be directly correlated to the removal of the neutral option on the survey tool. The current 2022. Agreement' ratings across most (YSS-Youth) domain areas have proven to be slightly lower during 2022, netting an average 'In Agreement' score (YSS – Youth) of 75.5 in comparison to 77.3 during the 2021 survey period. The decline in scores can be directly correlated to the removal of the neutral option on the survey tool.

Additionally, to ensure the 2022 Survey process was improved and prior year hurdles were avoided, the Regional Quality Committee formulated a 'SWMBH Customer Satisfaction Survey Improvement Plan to keep us on track with timelines and deliverables.

SWMBH Customer Satisfaction Survey Improvement Plan FY 2022

	GOALS	OBJECTIVES / ACTION STEPS	MEASURES/MILESTONES	Completion Date
1.	To improve annual consumer satisfaction survey response rate and number of completed surveys.	<ol style="list-style-type: none"> 1. Explore different survey tools. The MHSIP and YSS are outdated and take 30 minutes or more to complete. 2. Allow the selected survey tool to be accessed and taken by consumers all year, via SWMBH website or other platform. 3. Explore additional methods of survey completion and feedback, such as focus groups or listening sessions. 4. Offer incentives or drawing for those consumers who volunteer to complete the survey. 	<ol style="list-style-type: none"> 5. SWMBH has had dialog with MDHHS and has received approval to explore a new survey tool. SWMBH will convene a workgroup and solicit help from Kiaer Research to identify a new best practice and certified survey tool. 6. SWMBH will explore the feasibility of standing up the survey platform year around and formulate a secure tracking/review system. 1500 completed surveys is the target 7. SWMBH will contract with Kiaer Research or another vender to conduct a series of focus group sessions to gain valuable feedback from consumers. The target will be to; conduct 6 focus group session or engage 35 participants, constituting a valid sample from each CMHSP. 8. Drawings for 20 twenty-dollar gift cards. 	<p>September 2022</p> <p>September 2022</p> <p>October 2022</p> <p>January 2023</p>

2.	Improve scores in Access and Outcomes Categories.	<ol style="list-style-type: none"> 1. Take action to decrease wait times, improve provider availability and diversify therapy options. 2. Assess SWMBH website and social media campaign to promote information/programs/services available. 3. Participate in community events to provide information to the community. 4. Work with our CMHSP partners to create specific/targeted improvement plans, based on their CMHSP survey results. Access and Improved Outcomes should be targeted. 	<ol style="list-style-type: none"> 5. Results from follow-up satisfaction surveys and community needs assessment/focus group. Goal is to improve each category by 2 percentage points in comparison to the previous year's results. 6. Reports of increased knowledge of BH-SUD programs services/supports available within the region. Reported via focus groups or community needs assessment. 7. Devise a marketing campaign to educate consumers on benefits of participating in surveys/focus groups and how it translates into improving programs and services. 8. Each CMHSP to completed and submit a detailed improvement plan in the areas of Access and Outcomes. 	<p>February 2023</p> <p>March 2023</p> <p>September 2022</p> <p>July 2022</p>
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2022 CONSUMER SATISFACTION SURVEY RESULTS AND ANALYSIS

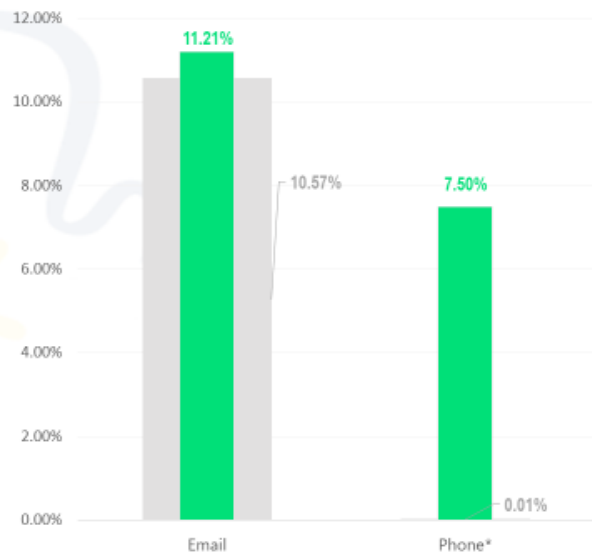
Response rates for the MHSIP rebounded in 2022

Switch to text message survey invitation for phones resulted in return to normalcy for sample size

MHSIP # of responses, 2014-2022



MHSIP response rate by medium
2021 vs. 2022



**Kiaer
Research**

SWMBH Consumer Satisfaction
2022 Results

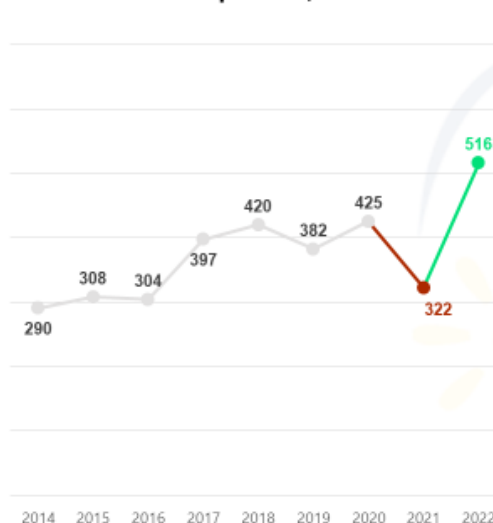
*direct calls in 2021,
texts in 2022

4

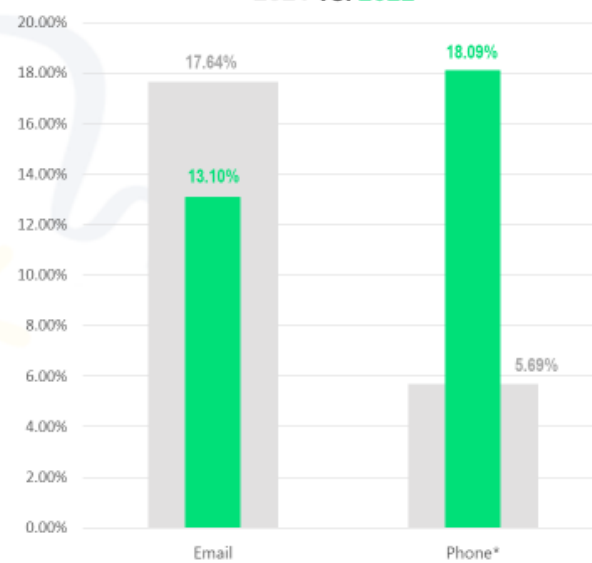
Response rates for the 2022 YSS reached highest point yet

Email response rates lowered while switching to SMS invitations more than tripled phone response rates

YSS # of responses, 2014-2022



YSS response rate by medium
2021 vs. 2022



**Kiaer
Research**

SWMBH Consumer Satisfaction
2022 Results

*direct calls in 2021,
texts in 2022

5

Adult Survey Scores by Category (MHSIP)

All SWMBH CMHSPs: 2022 MHSIP scores by construct

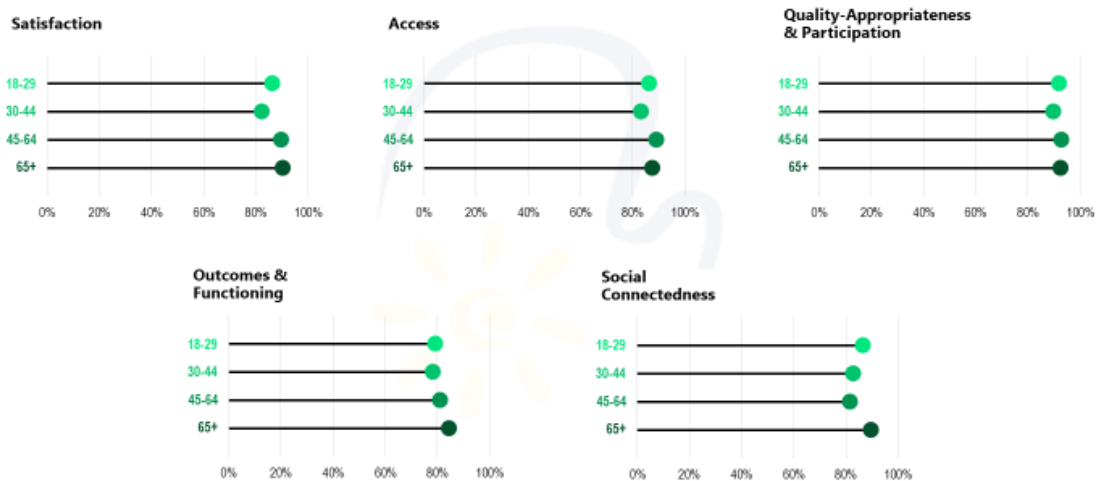
Dark green denotes the percentage in agreement for that construct's items

Gray bars denote the likely range where the true percentage for all SWMBH consumers might lie (i.e., margin of error*)



Aged 30-44 MHSIP respondents gave slightly lower ratings

Overall, ratings were similar between all age groups



Adult consumers of color show slightly lower social connection ratings

"Nonwhite" category comprises any race other than White, including Black/African American, Asian, Native American, Native Hawaiian/Pacific Islander, or any mix of races.



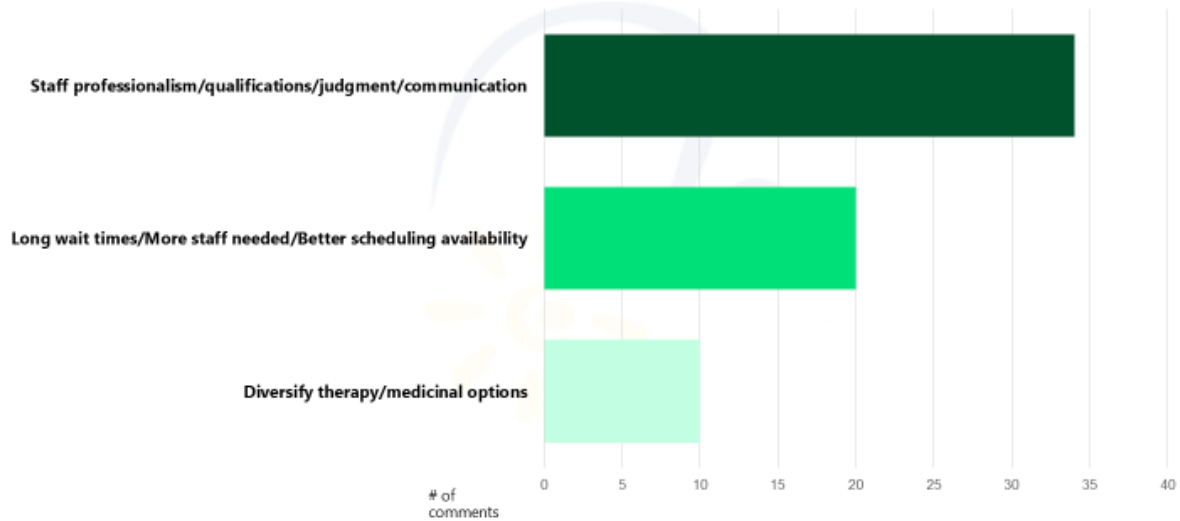
Adult LTSS consumers report better scores than non-LTSS adults across the board

Dark green denotes the percentage of LTSS (long-term social services) consumers in agreement for that construct's items
Gray bars denote the likely range where the true percentage for all LTSS consumers might lie (i.e., margin of error*)



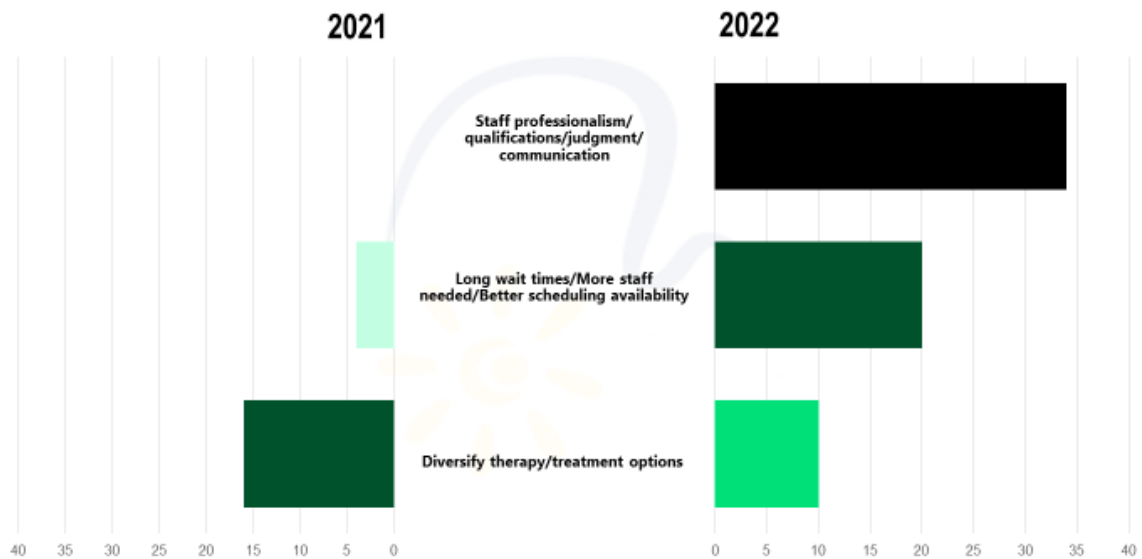
Opportunities for improvement in diversifying treatment options

Of respondents to the MHSIP who were dissatisfied with services, diversifying treatment options and having to wait to receive services were the most mentioned areas for improvement



2022 saw many complaints about staff professionalism and communication

Many comments discussed staff attitude, providers listening more, and better communication between different staff



Consumers had life-changing accounts of benefit from their CMHSPs

"**Best place** I ever been to, and **best people** too. **Always smiling** and says hello when I walk in. **Never had to wait** in the waiting room."

"My therapist is the best, Renee has single handedly **saved my life** and made it better at almost every appointment."

"Without these services **I would not be here** today. I am very grateful."

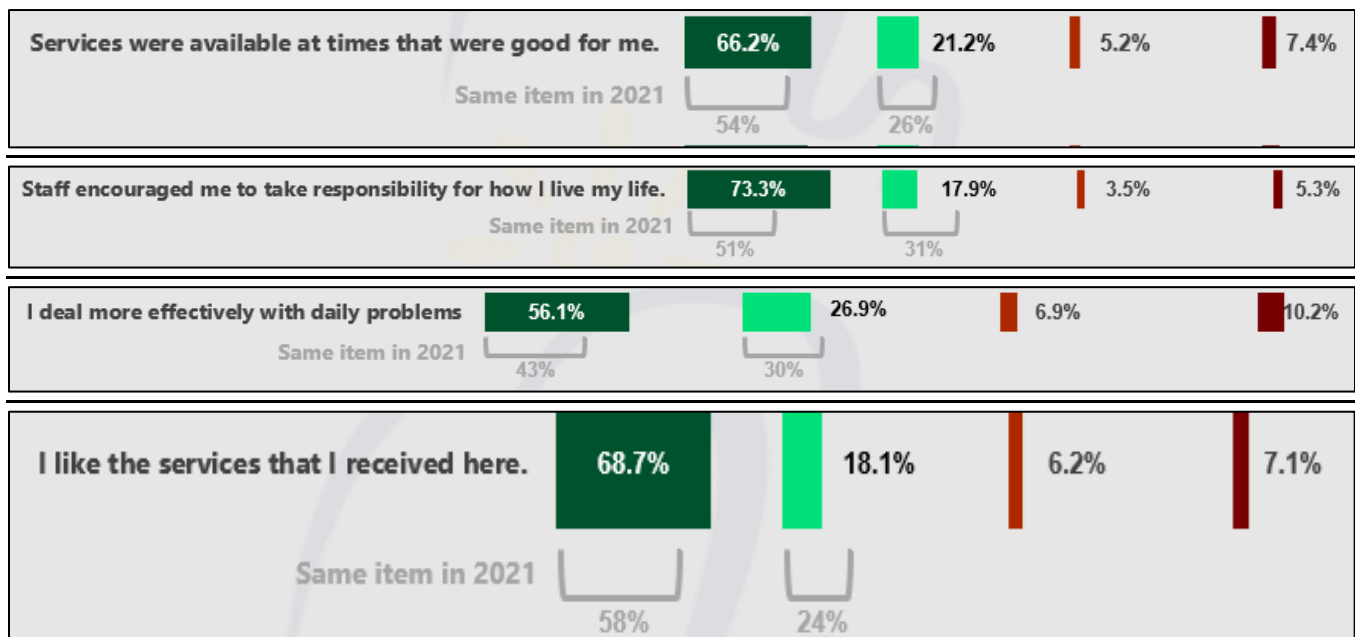
"The entire experience has been **positive, professional, and helpful**. I greatly appreciate the services provided. Thank you all very much."

"The act team has totally helped me **transform my life**. I am so grateful."

"Being placed back on my medication has made a **huge turn around with my life** including daily duties and wanting to get up and out of bed with a **good start to my day** instead of sad or depressed or just stuck."

"Yes, my counselor has helped me a lot in **looking at things different**, and I do **feel better about myself**."

Adult Survey Questions that showed Significant Improvement



*Improvement is in comparison to 2021 survey results.

Youth Survey Scores by Category (YSS)

All SWMBH CMHSPs: 2022 YSS scores by construct

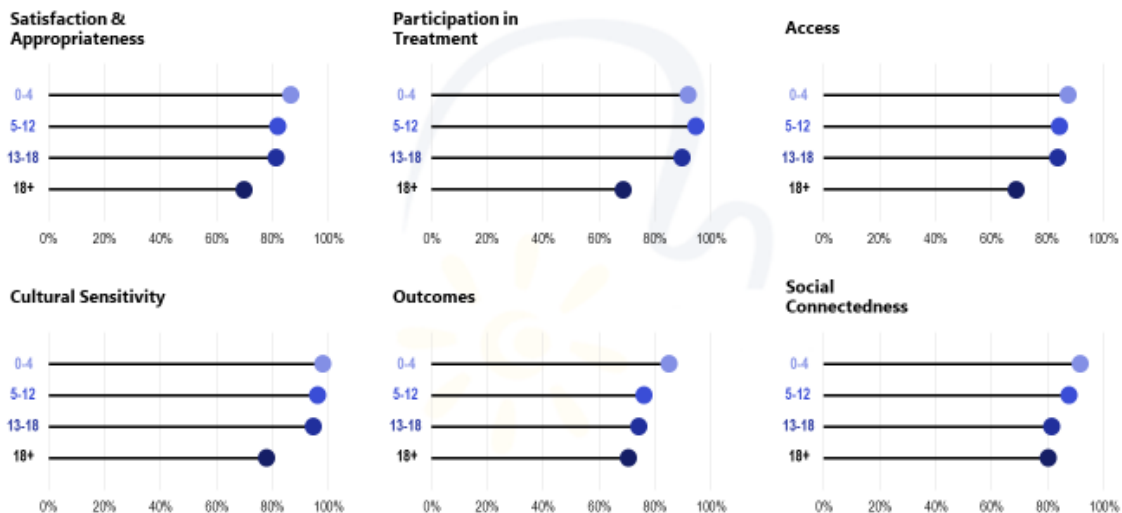
Dark blue denotes the percentage in agreement for that construct's items

Gray bars denote the likely range where the true percentage for all the county's consumers might lie (i.e., margin of error*)



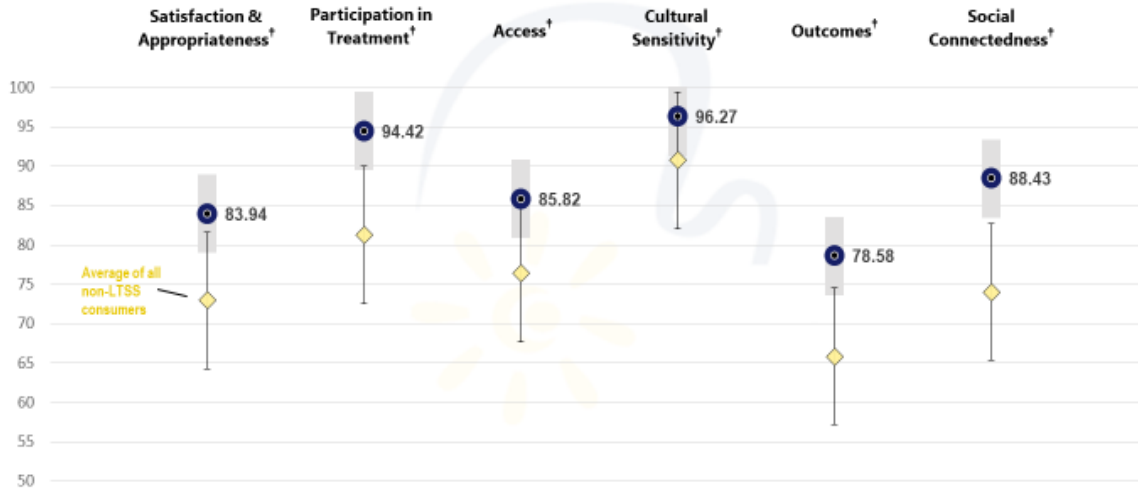
The older the youth, the lower the survey scores

YSS survey completers **over 18** reported lower scores, often because their child was no longer in their care.



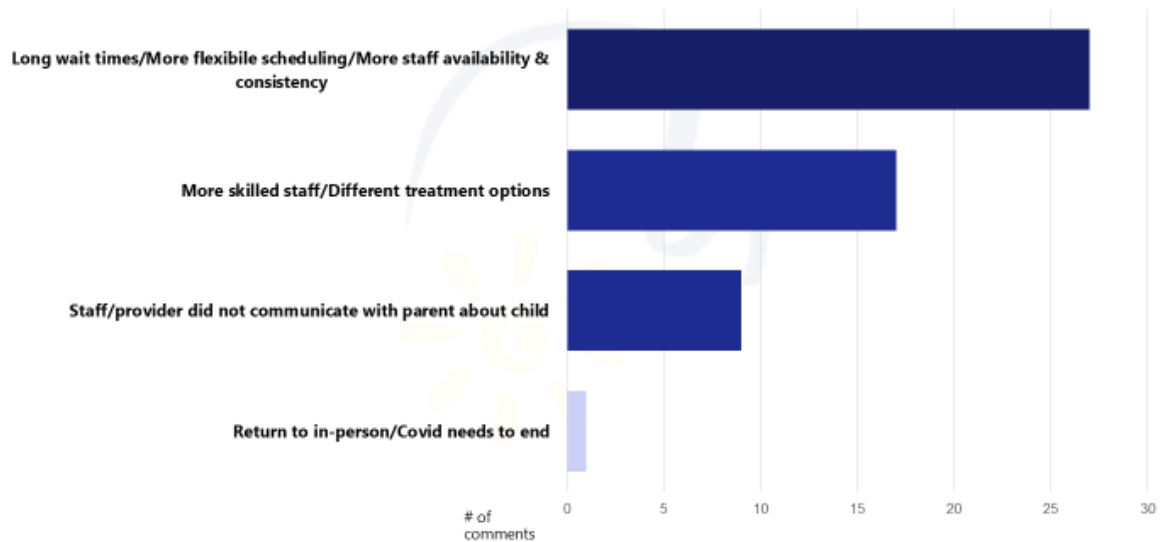
Youth LTSS consumers report better scores than non-LTSS youth across the board

Dark green denotes the percentage of LTSS (long-term social services) consumers in agreement for that construct's items
Gray bars denote the likely range where the true percentage for all LTSS consumers might lie (i.e., margin of error*)



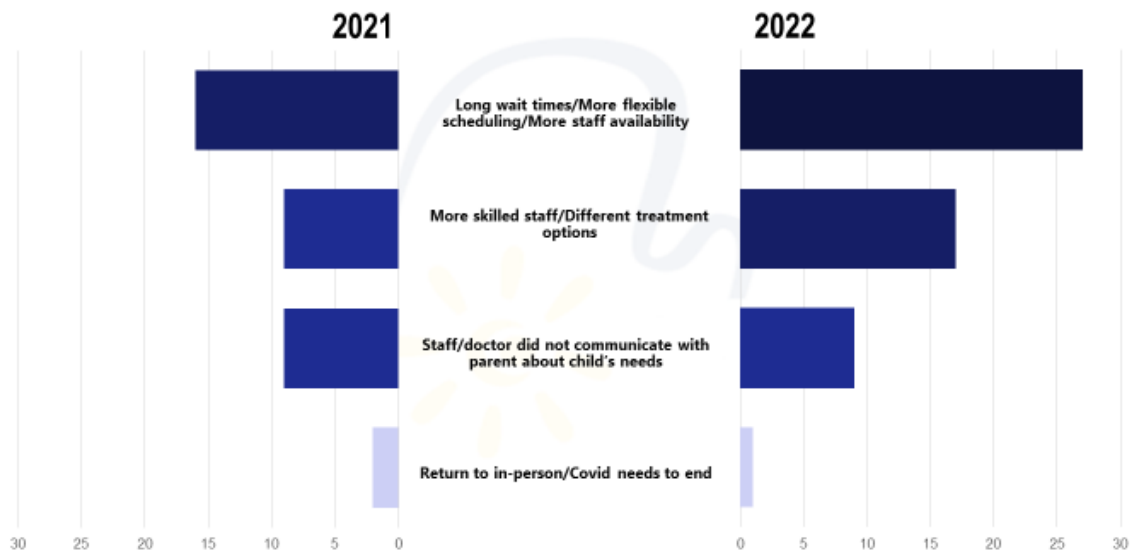
Opportunities for improvement in staffing, diversifying treatment

Comments mentioned staff consistency (i.e. turnover) and long wait times as a large detractor of service quality



Number of complaints increased in 2022, categories similar

This relates to the stories seen in the outcomes section of the YSS



Different treatment options requested included...

"add **community living supports** and the **LINK** program back; increase frequency of outpatient therapy appointments"

"**Visits at home** when the kid refuses to go to the center."

"**Written crisis plans**, not the two page calming skills but actual directions from the team when in crisis."

"**Respite** (adequate respite) is a huge need of families with children that find themselves in need of CMH services. It would be nice for some funding to be allocated to regular, appropriate, and adequate respite. Camp Kidwell offers a great weekend service. Respite like the one they offer would be great."

"Would love to have services available. The only thing my child gets is case management and psychiatrist. There are no openings for **ABA, respite, CLS**, etc."

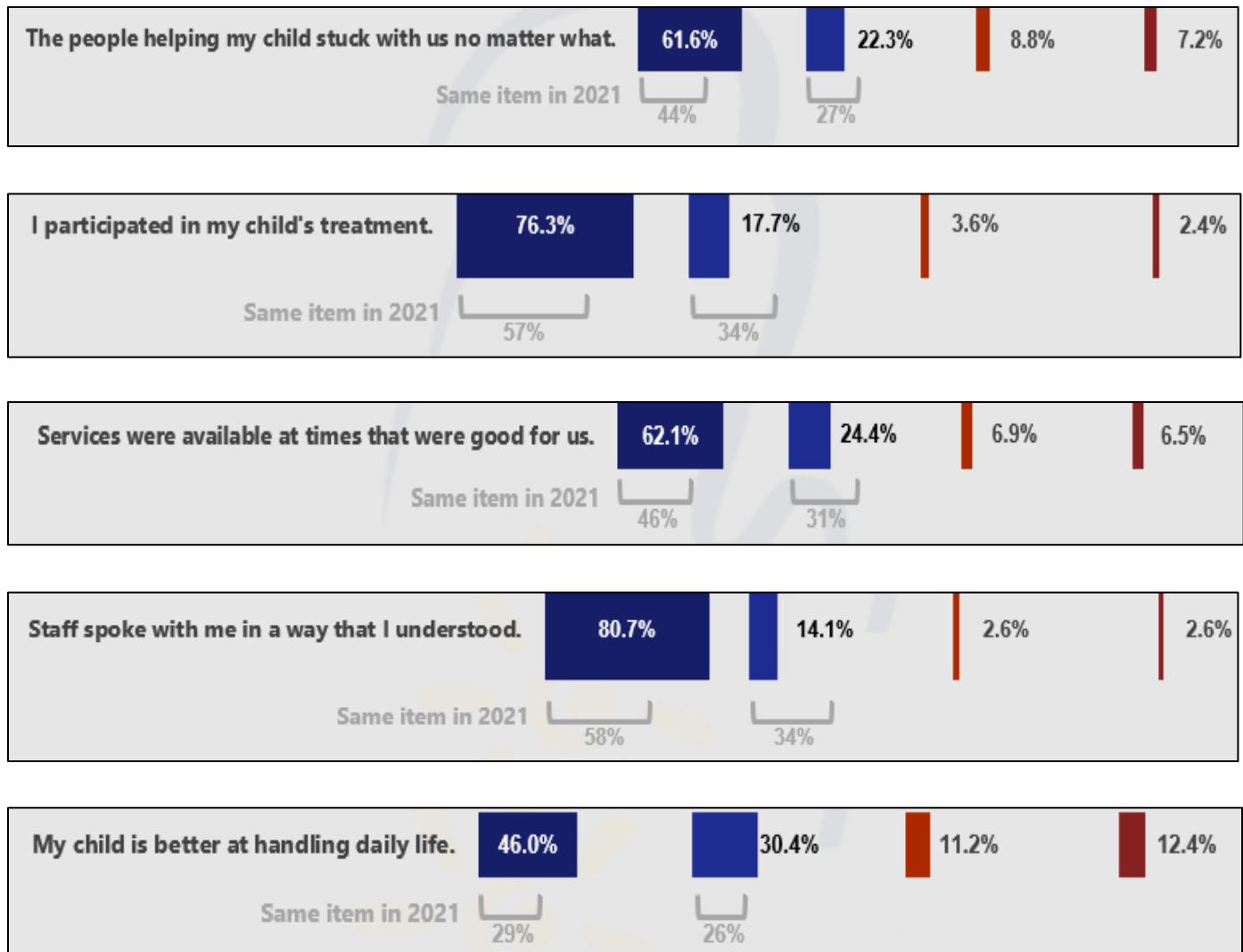
"Some sort of **respite** service for older kids and parents to have some time away in a safe manner."

"Having a choice on where to receive **respite care** for my child."

We needed **emergency support** we needed a **peer to peer** program, we need someone who can give us help with **respite**. We don't have family here so we don't have ppl to help us with that.

"More **in person gathering** with other families since covid is better than it was. Social interaction is key to my son/family as well as **other families** as well. Isolation is not good for mental health and social skills improvement."

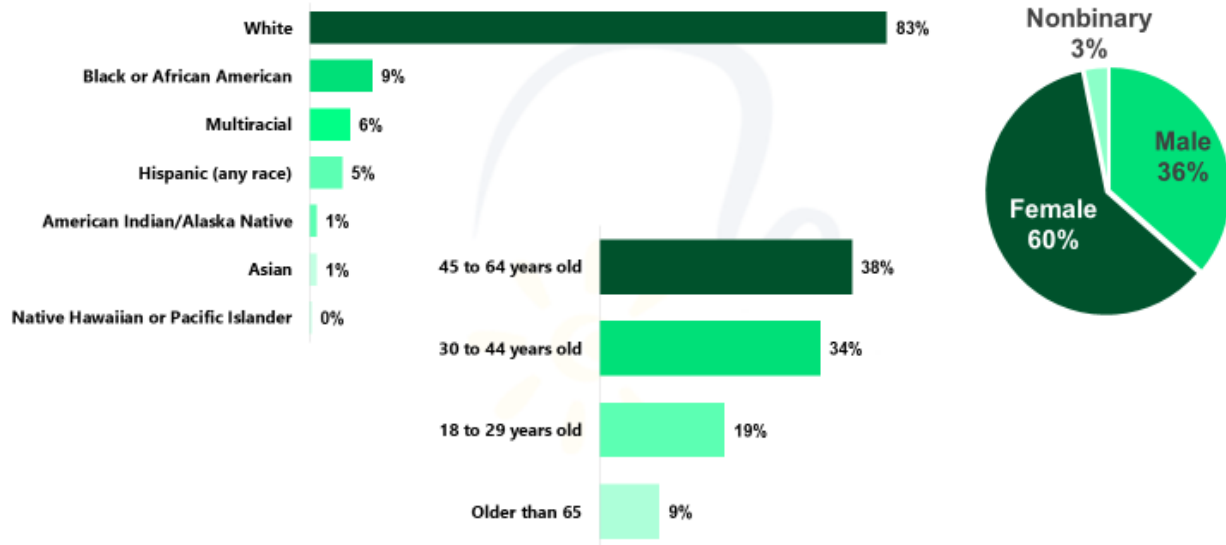
Youth Survey Questions that showed Significant Improvement



Survey Diagnostics, Analytics and Recommendations

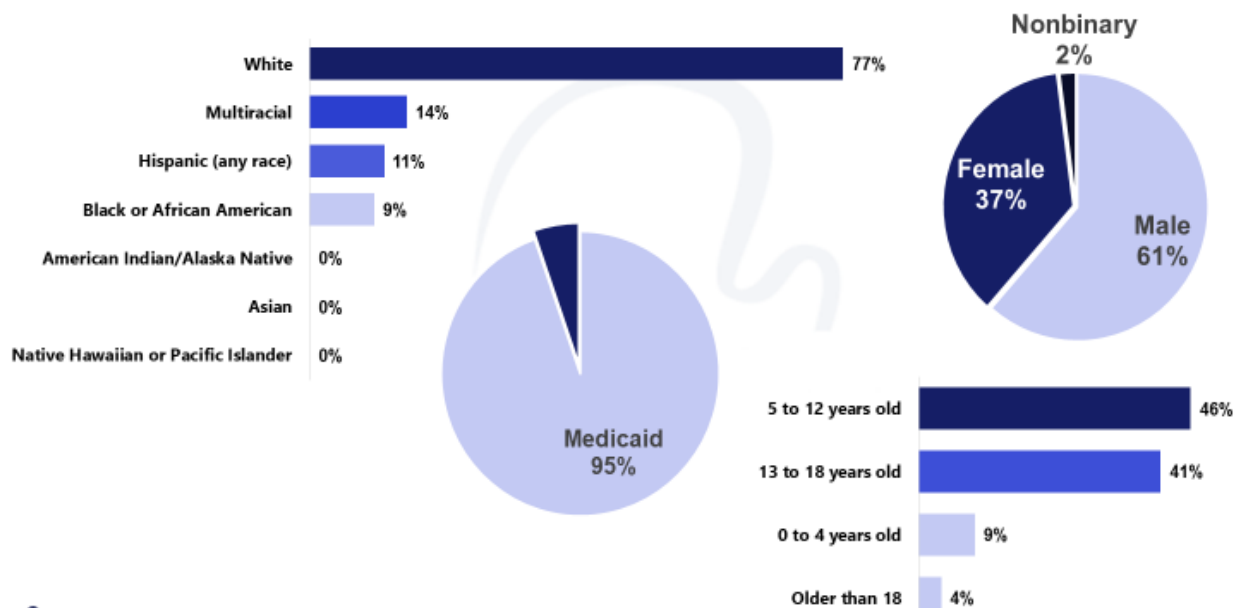
MHSIP 2022 respondents similar in makeup to prior years

This year saw slightly less minority respondents and slightly more male respondents.



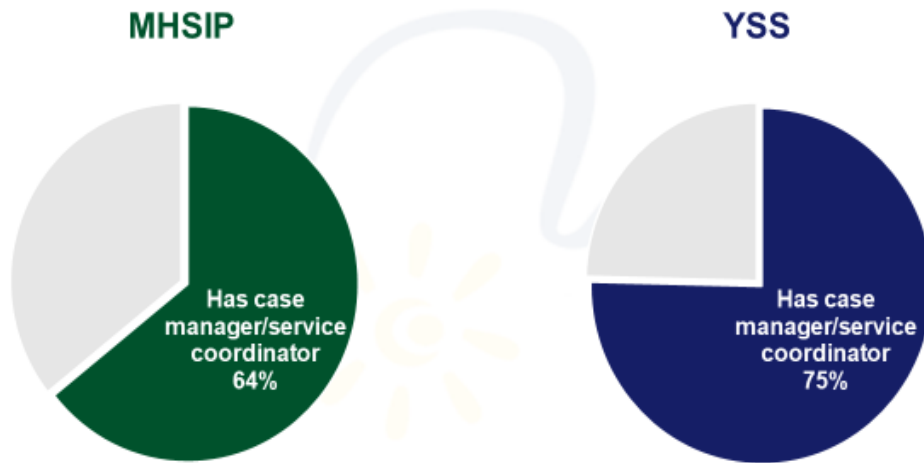
YSS 2022 youth reported less racial diversity

Many more boys than girls are receiving services, with age 5-12 most common



More youth than adults report having a case manager or service coordinator

Presence of case manager or service coordinator indicates consumer is receiving long term support services (LTSS)



Total aggregate average scores comparable across MHSIP and YSS in 2022

Single year reported rather than multi-year due to change in interpretation of aggregate positive scores in 2022



F. Member Experience – RSA-r Survey

Description

RSA-r (Recovery Self-Assessment-revised) Survey was given to Medicaid & Block Grant SUD consumers to answer questions about the services they receive from their current provider. The survey consists of 32 questions and the answers were based on a scale of 1-5 (1=strongly disagree to 5=strongly agree). All questions were related to the following five 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. Consumers receiving substance abuse services complete the surveys which were administered through their provider.

FY22 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Improve consumer access to the survey, to improve completion volume over the previous year's results.	QAPI	QMC and SUD Director's meeting as needed	Annually
Ensure that SUD providers review the survey analysis with their internal workgroups and formulate PIPs for identified areas needing improvement.	QAPI	QMC and SUD Director's meeting as needed	Annually
Improvement in overall mean score for all survey respondents.	QAPI	QMC and SUD Director's meeting as needed	Annually



FY22 Identified Barriers

Despite additional access to the electronic survey via QR code on posters available in SUD provider facilities, SWMBH saw a large decrease in electronic survey participation in 2022 (from 43% completed electronically in 2021 to 7% in 2022). Some providers expressed that depending on the SUD service setting, cell phones are not always allowed on the premises. Issues continued with participant understanding of the survey rating scale (1-5, 5 being the highest/best rating) with the use of the paper survey and further reformatting will occur during the next survey period.

Improvement Efforts Made in FY22

SWMBH added a QR code to the survey posters which were displayed in SUD provider organizations to increase the electronic access to Survey Monkey. With distribution of the 2021 individual provider results and analysis, SWMBH requested SUD providers review survey results with their internal workgroups and formulate a PIP based on areas needing improvement.

FY22 Results

Goal	FY21	FY22	Eval Score	Recommendations	Time Estimate
Improve consumer access to the survey, to improve completion volume over previous year's results.	477 completed surveys	543 completed surveys	4	Goal met and will be monitored in FY23. Evaluate survey delivery methods to ensure effectiveness of access appropriate for the SUD population.	 3-6 Mo.
Ensure that SUD providers review the survey analysis with their internal workgroups and formulate PIPs for identified areas needing improvement.	n/a	Partially met	3	Goal partially met will be monitored in FY23. Ensure SUD providers review on an annual basis. Consider a change in the survey distribution period.	 3-6 Mo.
Improvement in overall mean score for all survey respondents.	4.07 overall mean score	4.55 overall mean score	5	Goal met, will be monitored, and continued in FY23. Consider collection and further analysis based on SUD service type going forward.	

The 2022 RSA-r survey distribution period was from 10/7/2022 to 11/18/2022.

In 2022, SWMBH received a total of 543 completed surveys which was a 15% increase from 2021 but still significantly less than pre-pandemic participation. The number of participating provider organizations continued to decline in 2022 (down to 13 providers from 16 in 2021). SWMBH's analysis of the overall mean score represented a .48 increase in comparison to 2021 scores and an increase in all five survey categories. The category, Involvement, had the most significant change in results in 2022 with a 17% increase.

RSA-r Results Year Comparison
2022 Overall Mean Score: 4.55
(.48 increase from 2021 results)

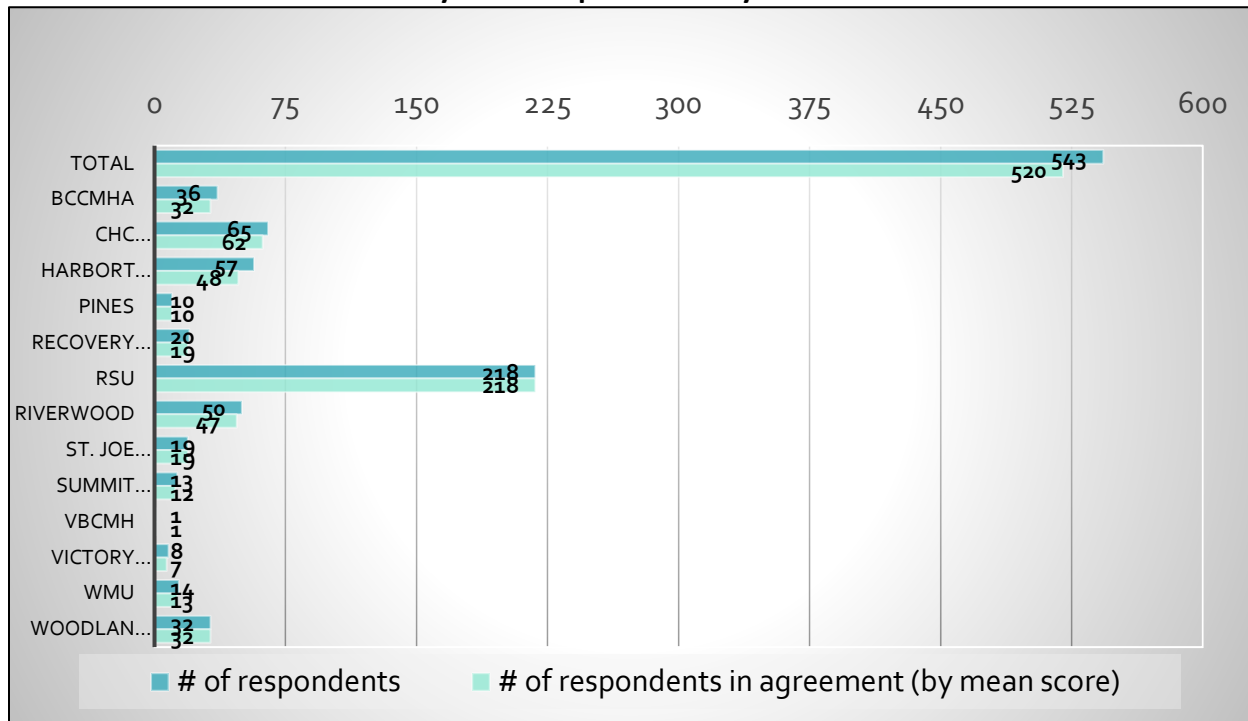
2021 Overall Mean Score 4.07
 2020 Overall Mean Score: 4.20
 2019 Overall Mean Score: 4.36
 2018 Overall Mean Score: 4.22
 2017 Overall Mean Score: 4.13
 2016 Overall Mean Score: 4.31
 2015 Overall Mean Score: 4.29
 2014 Overall Mean Score: 4.24

<u>9 Year Average</u>	<u>Mean Score</u>
Life Goals (Q3, Q7, Q8, Q9, Q12, Q16, Q17, Q18, Q28, Q31, Q32)	4.32
Involvement (Q22, Q23, Q24, Q25, Q29)	3.92
Diversity of Treatment (Q14, Q15, Q20, Q21, Q26)	4.18
Choice (Q10, Q27, Q4, Q5, Q6)	4.44
Individually Tailored Services (Q11, Q13, Q19, Q30)	4.30

Number of Completed Surveys by Year



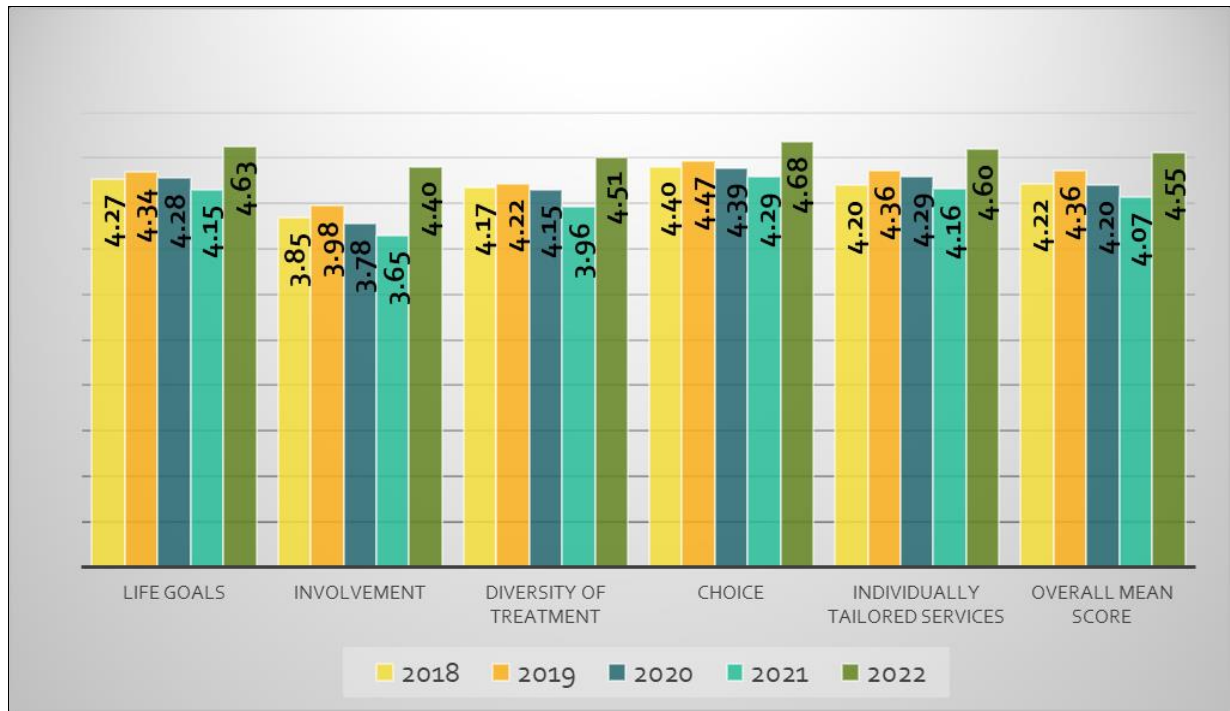
Surveys Completed by Provider



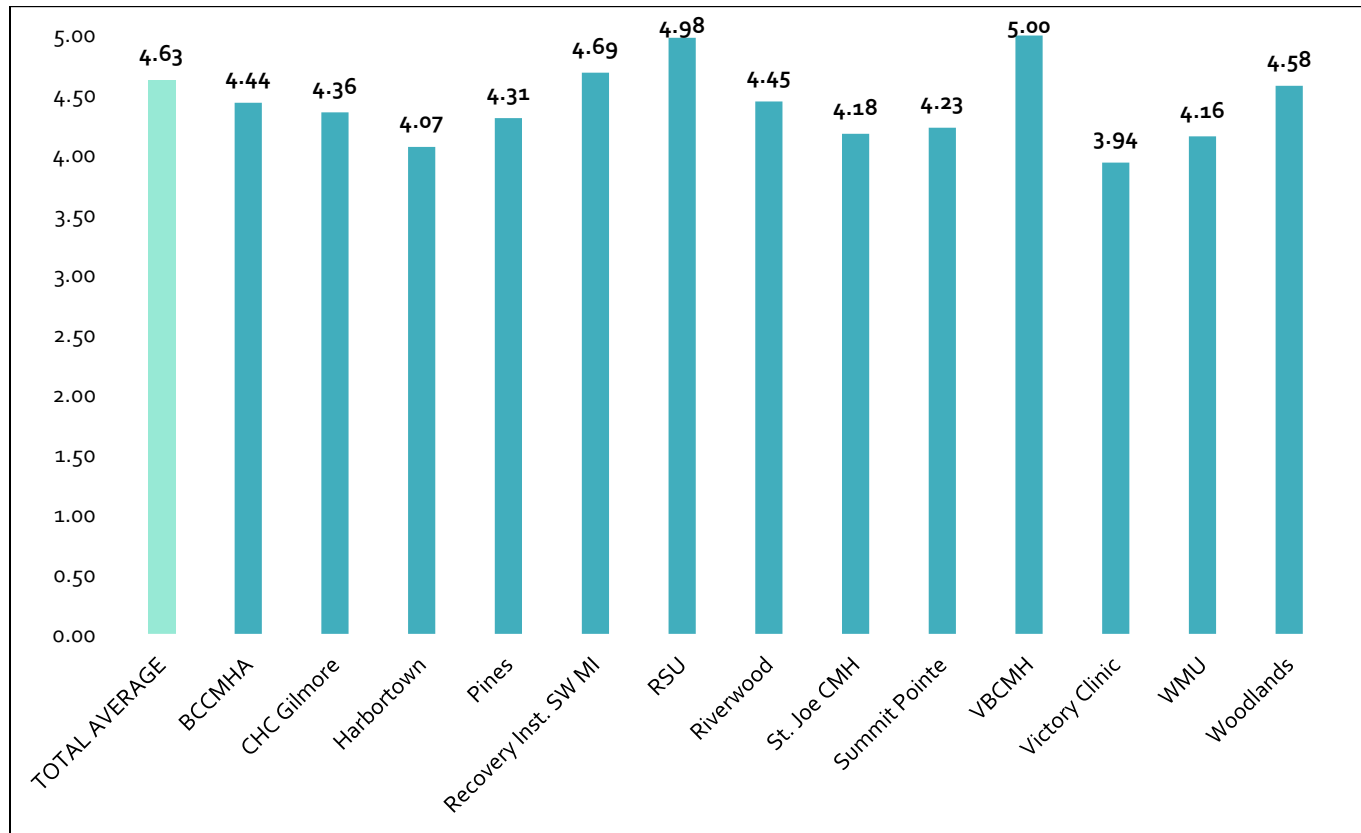
Overall Mean Score Comparison



Annual Mean Response by Subcategory



Subcategory: Life Goals

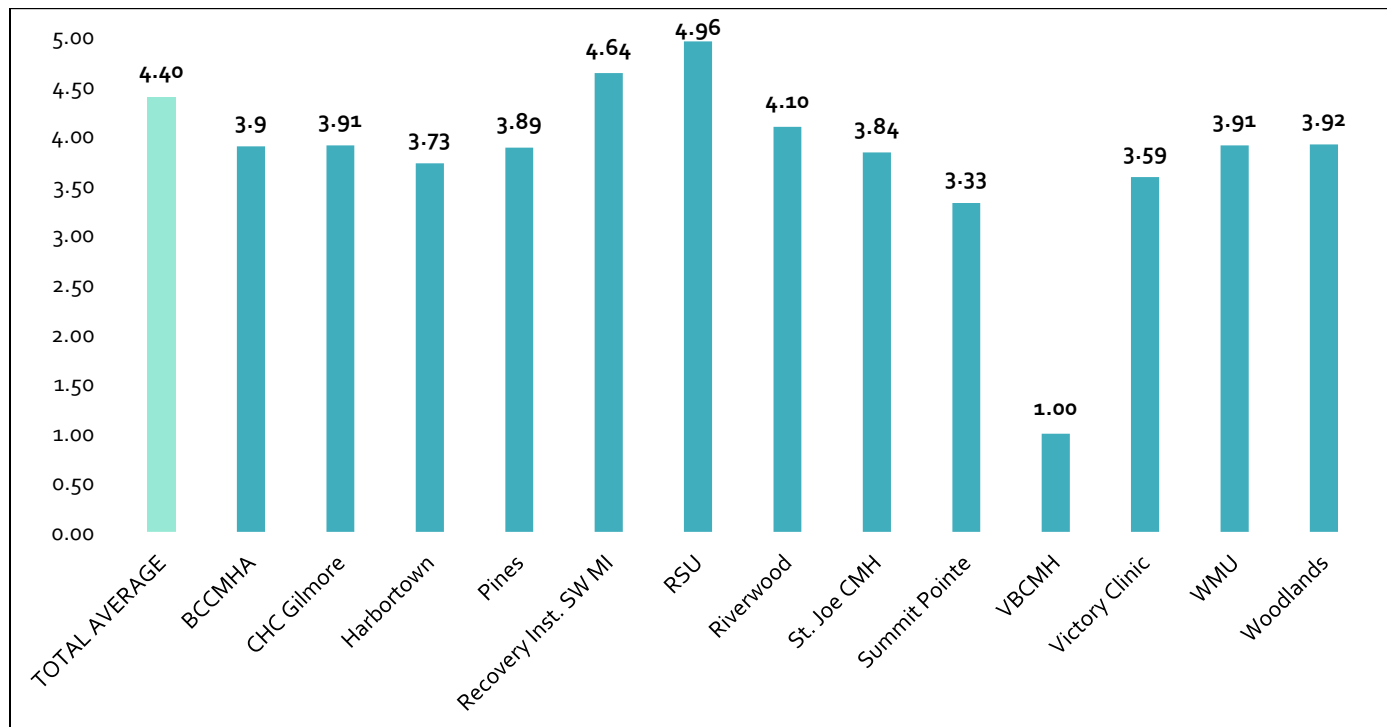


The SWMBH average was 4.63 for the Life Goals subcategory in FY22.

The Life Goals Subcategory included the following questions:

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

Subcategory: Involvement

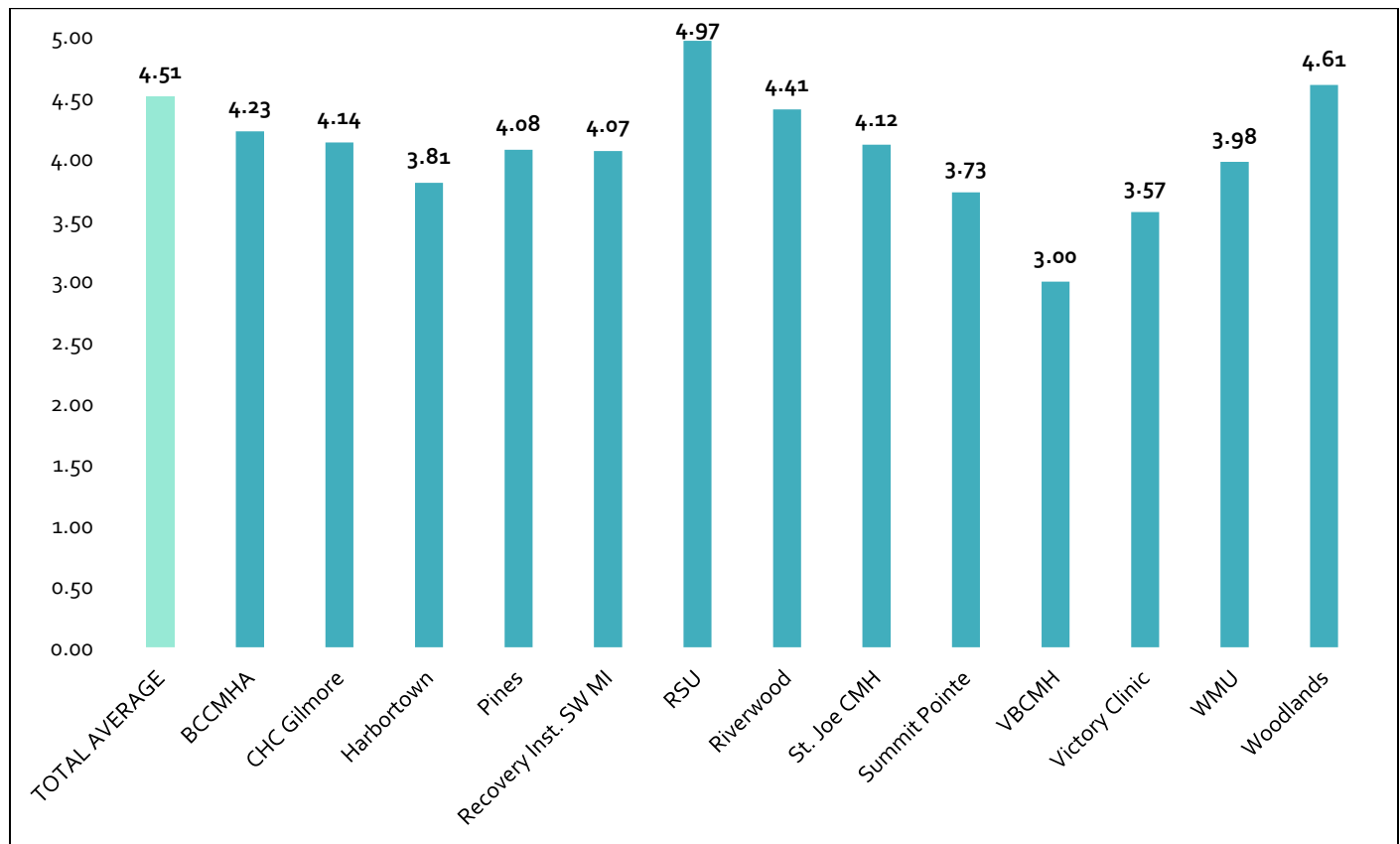


The SWMBH average was 4.40 for the Involvement subcategory in FY22. This subcategory showed the most improvement compared to the previous year's score of 3.65.

The Involvement Subcategory included the following questions:

- 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.

Subcategory: Diversity of Treatment

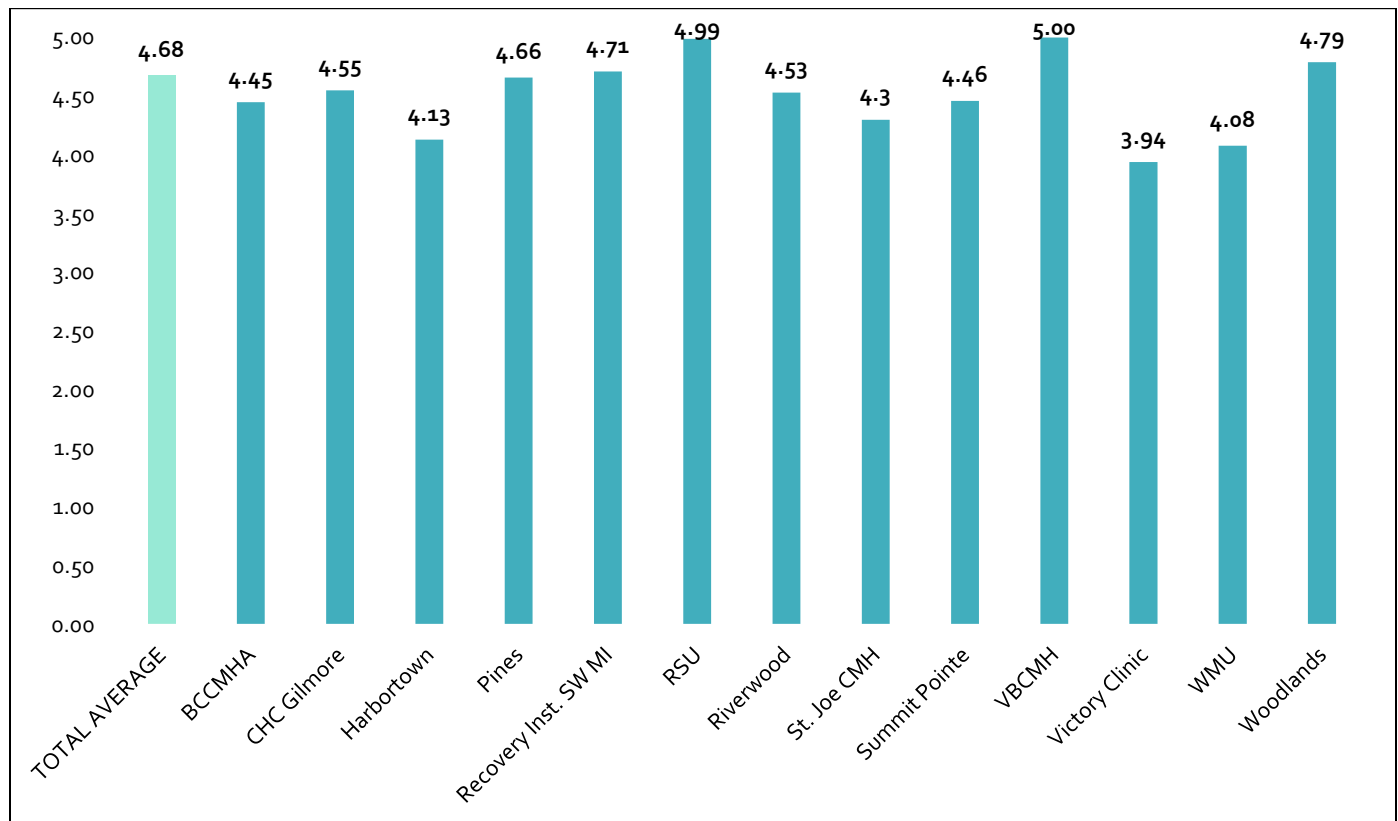


The SWMBH average was 4.51 for the Diversity of Treatment subcategory in FY22.

The Diversity of Treatment Subcategory included the following questions:

- 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.

Subcategory: Choice

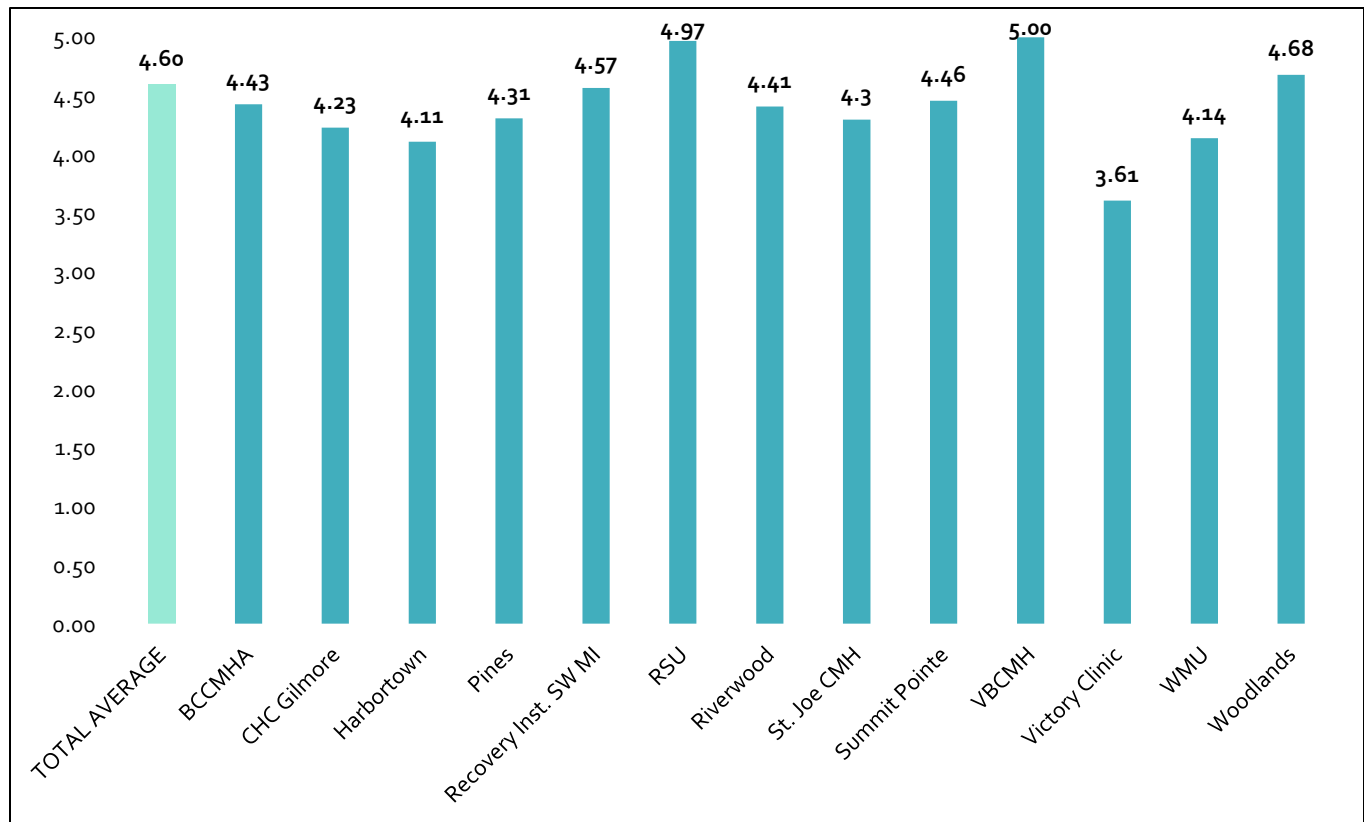


The SWMBH average was 4.63 for the Choice subcategory in FY22.

The Choice Subcategory included the following questions:

- Program participants can change their clinician or case manager if they wish.
- Program participants can easily access their treatment records if they wish.
- 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.

Subcategory: Individually Tailored Services



The SWMBH average was 4.60 for the Individually Tailored Services subcategory in FY22.

The Individually Tailored Services Subcategory included the following questions:

- 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 competence.

G. Verification of Medicaid Services

Description

SWMBH's Program Integrity and Compliance department performs the Medicaid Services Verification review to verify whether services reimbursed by Medicaid were furnished to members by the Participant CMHSPs, providers, and subcontractors. This review is performed pursuant to MDHHS-PIHP Master Contract Section (1)(C)(4) and in conformity with the MDHHS Medicaid Verification Process technical requirement. SWMBH performs this review immediately after the end of each FY Quarter to have real time results and an opportunity to effectuate change quickly. SWMBH submits the findings from this process to MDHHS annually and provides follow up actions that were taken because of the findings. SWMBH also presents the findings to the Board.

For completing the fiscal year verification of sampled Medicaid claims, SWMBH uses the random number function of the OIG statistical software package, RAT-STAS, and conducts quarterly audits of service encounters for each CMHSP and reviews claims from contracted substance use disorder (SUD) providers and non-SUD providers subcontracted with Participant CMHSPs. SWMBH utilizes a standardized verification tool, which includes the following elements against which all selected encounters and claims are evaluated:

1. Was the person eligible for Medicaid coverage on the date of service?
2. Is the code billed eligible for payment under Medicaid?
3. Was the service identified included in the beneficiary's individual plan of service/treatment plan?
4. Does the treatment plan contain a goal/objective/intervention for the service billed?
5. Is there documentation on file to support that the service was provided to the consumer?
6. Was the provider qualified to deliver the services provided?
7. Is the appropriate claim amount paid (contracted rate or less)?

FY22 Goal

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
The overall Medicaid claims verification compliance rate for Region 4 will be above 90%.	Compliance	SWMBH Compliance Committee and SWMBH Regional Compliance Committee	Monthly
		SWMBH Board of Directors	3x Annually


FY22 Identified Barriers

Participant CMHSPs and providers are cooperative and responsive to SWMBH's review process. The only potential barrier to performing this review is the timeliness of claims and encounter data. SWMBH performs this review quarterly to have a real-time perspective on the appropriateness of Medicaid billing and documentation occurring within the Region, and to be able to remediate identified issues before they have persisted. As a result, claims and encounter data is monitoring following the end of each Fiscal Year quarter until the volumes are average, then samples are pulled. If a Participant CMH experiences difficulty in submitting encounter data, or an SUD provider does not submit claims promptly, claims and encounter volumes are affected. To account for this, SWMBH Compliance Specialists monitor encounter and claims submission volumes prior to pulling quarterly samples. When issues are identified, Compliance contacts SWMBH IT and/or the affected Participant CMHSP to notify them of the observations related to encounter data volumes and identify any issues and necessary remediation.

Improvement Efforts Made in FY22

Based on the FY21 overall compliance rate of 95.32% and given that all samples reviewed achieved a compliance rate greater than or equal to 90%, a formal CAP was not required and was not submitted; however, SWMBH will continue the efforts described in the Medicaid Services Verification Report, submitted to MDHHS, in order to improve service claim processes congruous with Medicaid requirements.

FY22 Results

Goal	FY21	FY22	Eval Score	Recommendations	Time Estimate
The overall Medicaid claims verification compliance rate for Region 4 will be above 90%.	95.27%	94.64%	5	Continue to monitor.	 6-12 Mo.

SWMBH Compliance Department completed the annual Medicaid Verification review using the Random Number function of the OIG's statistical software package, RAT-STATS, SWMBH selected random samples of encounters and claims on a quarterly basis. A total of 1,848 claims/encounters were audited for FY22. Of those audited, 1,749 were verified to be a valid service reimbursable by Medicaid, for an overall FY22 compliance rate of 94.64%. Results on each review element and deficiencies are detailed below:

- Was the person eligible for Medicaid coverage on the date of the service reviewed? **0 deficiencies**
- Is the provided service eligible for payment under Medicaid? **0 deficiencies**
- Is there a current treatment plan on file which covers the date of service? **10 deficiencies**
- Does the treatment plan contain a goal/objective/intervention for the service billed? **0 deficiencies**
- Is there documentation on file to support that the service was provided to the consumer? **33 deficiencies**
- Was the service provided by a qualified practitioner and falls within the scope of the code billed/paid? **5 deficiencies**
- Was the appropriate amount paid (contract rate or less)? **3 deficiencies**

The 2019 and 2018 Board Ends Metric target for Medicaid claims verification was over 90%, which was successfully achieved in both years. This metric was removed from the 2020-2021 Board Ends Metrics but is still closely watched with routine analysis and presentations to the SWMBH Compliance Committee, Regional Compliance Committee, Regional Operations Committee and the SWMBH Board. As you can see by table below, SWMBH has maintained a compliance verification rate averaging 95.68% over the last 3 years.

FISCAL YEAR	MEDICAID SERVICES VERIFICATON RESULTS
FY2020	97.11%
FY2021	95.27%
FY2022	94.67%

H. CMHSP Administrative and Delegated Function Site Reviews

Description

Site Reviews

SWMBH either directly performs or ensures that the Participant CMHSPs perform annual monitoring of all providers in the network. This monitoring occurs through the annual site review process, during which standardized tools are used to evaluate Participant CMHSPs' and contracted providers' (both SUD and non-SUD) compliance with administrative requirements and clinical service quality.

Participant CMHSP Site Reviews

SWMBH performs annual Site Reviews of the Participant CMHSPs. These reviews consist of a review of each CMHSP's administrative processes and procedures in the following functional areas: Access and Utilization Management, Claims, Compliance, Credentialing, Customer Services, Grievances & Appeals, Provider Network, Quality, Staff Training, SUD EBP Fidelity and Administration, and Clinical Administration.

In addition to reviewing administrative processes, the annual site review process also includes file reviews for the following administrative functions:

- Denial File Review
- 2nd Opinion File Review
- Credentialing and Re-credentialing File Review
- Grievances File Review
- Appeals File Review
- MMBPIS and Critical Incident File Review
- Staff Training File Review

To monitor clinical service quality, SWMBH performs a Clinical Quality (non-SUD) clinical record review of CMHSP directly operated services that is focused on a specific population or service (consistent across all Participant CMHSPs). The population or service focus is determined annually by SWMBH's Clinical Quality Department based on several factors which may include State or PIHP-audit results, member complaints, or other identified concerns. SWMBH also performs an SUD Clinical Quality clinical record review of CMH SUD services.

SUD Providers

SWMBH does not allow for subcontracting of SUD services, and therefore directly holds each contract with the network SUD Providers. SWMBH directly performs annual site reviews for each of the contracted SUD providers. These reviews consist of a review of each SUD Provider's administrative operations and includes administrative file reviews of Credentialing and Re-credentialing, and Staff Training, to monitor SUD Provider completion of these activities in compliance with SWMBH Policies, and to ensure that staff are qualified to perform the services being delivered.

To monitor clinical service quality, SWMBH performs a clinical file review as part of the annual site review process.

Subcontracted Providers

For non-SUD subcontracted providers that are contracted with one or more of SWMBH's Participant CMHSPs, SWMBH ensures that monitoring is performed annually either directly by SWMBH or by a Participant CMHSP. SWMBH directly performs the annual site reviews for the following provider types:

- Autism Service Providers

- Crisis Residential Service Providers
- Inpatient Psychiatric Service Providers (utilizing the State Inpatient Reciprocity Tool and process)

SWMBH's Participant CMHSPs perform annual monitoring of the remaining subcontracted provider types. SWMBH's Regional Provider Network Management Committee (RPNMC) annually reviews standardized subcontracted provider review tools which are used for completion of subcontracted provider site reviews to ensure consistency and foster reciprocity. The RPNMC also maintains a spreadsheet of all "shared providers", subcontracted providers that are contracted with more than one Participant CMHSP and assigns a responsible Participant CMHSP to perform the annual site review each year, to reduce the burden on shared providers. Completed reviews are uploaded to SWMBH's Portal so they are accessible to all Participant CMHSPs.

Subcontracted provider site reviews consist of a review of each provider's administrative operations and includes administrative file reviews of Credentialing and Re-credentialing, and Staff Training, to monitor provider completion of these activities in compliance with SWMBH Policies, and to ensure that staff are qualified to perform the services being delivered and/or perform their job functions (for unlicensed/direct-care staff).

FY22 Goal

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will complete Administrative and Delegated Function Site Reviews of all 8 CMHSPs in the region and areas of non-compliance will require a corrective action plan.	All SWMBH Departments; Participant CMHSPs	Site Reviews	Annually


FY22 Identified Barriers

Participant CMHSPs and network providers are collaborative and responsive to the annual site review process. Some Participant CMHSPs have difficulty accessing the SWMBH Portal to upload shared provider site review results, making it more complicated for other Participant CMHSPs to secure those results which they accomplish via email. SWMBH is in the process of moving to a new cloud-based "portal" which will hopefully remediate this obstacle. Another finding that is more an opportunity for improvement than it is a "barrier" is the ability to accomplish more timely remediation of identified deficiencies. While SWMBH implement quarterly Corrective Action Plan monitoring (as detailed below), it is becoming increasingly clear that file reviews, both administrative and clinical, may be more effective at remediating deficiencies faster if performed on a quarterly basis instead of annually and then only the CAP monitored quarterly.

Improvement Efforts Made in FY22

During the FY22 CMHSP Site Review process, SWMBH implemented quarterly corrective action plan monitoring specific to each Participant CMHSP's site review scores. Quarterly CAP monitoring was implemented to monitor whether the accepted CAP is 1) actually implemented; and 2) sufficient to remediate the noted deficiencies. By way of example, Participant CMHSPs almost universally (with the exception of one) were non-compliant with Adverse Benefit Determination Notice content requirements. As a result, SWMBH's subject matter expert collaborated with a CMHSP representative who was selected by the SWMBH Operations Committee, to develop a remediation plan. SWMBH is performing quarterly monitoring into FY23 of Participant CMHSP ABD Notices to effectuate any needed changes promptly and ensure compliance. Another area where almost all Participant CMHSPs are receiving quarterly CAP monitoring is the SUD Clinical File Review. SWMBH's SUD subject matter experts are monitoring various standards for each Participant CMHSP by requiring quarterly samples from SUD clinical records.

FY22 Results

Goal	FY22	Eval Score	Recommendations	Time Estimate
SWMBH will complete Administrative and Delegated Function Site Reviews of all 8 CMHSPs in the region and areas of non-compliance will require a corrective action plan.	Met	5	Continue to monitor.	 6-12 Mo.

Summary Scores by Section			
Data is a combined average score for each section from all eight CMHSP site reviews.			
Section	2020 Scores	2021 Scores	2022 Scores
Access and Utilization Management	71.7%	92.8%	84.9%
Claims Management	95.3%	97.7%	88.3%
Compliance	98.4%	97.2%	96.4%
Credentialing	94.4%	94.4%	95.2%
Customer Services	98.2%	95.9%	93.7%
Grievances and Appeals	94.1%	97.5%	90.3%
Provider Network	99.3%	100%	94.9%
Quality and Performance Improvement	98.5%	90.2%	89.6%
Staff Training	96.9%	95.5%	94.2%
SUD EBP Fidelity and Administration	100%	98.6%	96.3%
Clinical Administration	N/A	N/A	88.2%

Clinical Quality Section Review 2022								
Sections	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St. Joseph	Van Buren
Physician Coordination	100%	54.7%	42.5%	83.3%	56.4%	78.6%	71.3%	100%
Assessment	97.9%	90.6%	99%	96.9%	90%	90.5%	100%	100%
Treatment Plan	97.3%	74.6%	89.8%	88.9%	72.9%	84.7%	92.9%	93%
Progress Notes	95.3%	92.2%	92.1%	88%	90%	83%	85.9%	96.9%
Periodic Review	85%	83.2%	75.7%	87.5%	36%	73.3%	75.7%	100%
Behavior Treatment Planning	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Overall	92.2%	76.7%	78.4%	86%	66.5%	79.5%	83.2%	94.2%

Clinical Quality Section Review 2022	
Sections	Combined Average for Each Section from All Eight CMHSPs
Physician Coordination	73%
Assessment	95.6%
Treatment Plan	86.8%
Progress Notes	90.4%
Periodic Review	77%
Behavior Treatment Planning	N/A
Overall Average	85%

SUD Clinical File Review Section 2022								
Sections	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St. Joseph	Van Buren
Physician Coordination	83.3%	41.7%	85.7%	62%	97.9%	69%	63.7%	75.7%
Assessment	99%	69.8%	94.8%	83%	100%	81.3%	84.4%	91.7%
Treatment Plan	75.8%	85.8%	91.1%	93%	96.9%	88.6%	91.3%	87.3%
Progress Notes	93.8%	95.3%	100%	93%	100%	97.9%	96.9%	92.9%
Discharge/BH TEDS	100%	94.4%	88.9%	47%	72.2%	100%	84.7%	63.4%
Women's Specialty Services	N/A	92.9%	N/A	N/A	100%	N/A	100%	N/A
Overall	92%	80.8%	92.6%	81.2%	96.2%	85.5%	88.2%	84.2%

SUD Clinical File Review Section	
Sections	2022 Combined Average for Each Section from All Eight CMHSPs
Physician Coordination	72.4%
Assessment	88%
Treatment Plan	88.7%
Progress Notes	96.2%
Discharge/BH TEDS	81%
Women's Specialty Services	97.6%
Overall Average	87.3%

I. Credentialing and Re-Credentialing

Description

SWMBH either directly performs or ensures that the Participant CMHSPs and network providers perform credentialing and re-credentialing in compliance with SWMBH's Credentialing and Re-credentialing Policies, which are annually approved by the SWMBH Board of Directors. The credentialing process (inclusive of re-credentialing) ensures that organizations, physicians, and other licensed health care professionals are qualified to perform their services. SWMBH utilizes standardized credentialing and re-credentialing applications throughout the Region to ensure consistent application of required standards. These applications are periodically reviewed by the Regional Provider Network Management Committee. SWMBH utilizes a checklist to assist in processing credentialing applications. The checklist includes the following components for re-credentialing files:

- QI Data Check
 - Compliance F/W/A or other billing issues
 - Customer Services issues (other than formal Grievances/Appeals)
 - Utilization Management issues/concerns

SWMBH directly performs credentialing for the following in the network:

- Applicable SWMBH employees/contractors (individual credentialing)
- Participant CMHSPs (organizational credentialing)
- SUD Providers (organizational credentialing)
- Autism Service Providers (organizational credentialing on behalf of the Region)
- Financial Management Service Providers (organizational credentialing on behalf of the Region)
- Crisis Residential Providers (organizational credentialing on behalf of the Region)
- Inpatient Psychiatric Service Providers (organizational credentialing on behalf of the Region)
- Large Specialized Residential Providers – Beacon, ROI, Turning Leaf, and Hope Network
 - SWMBH performs organizational credentialing of each Specialized Residential Site, on behalf of the Region.

SWMBH delegates, under Delegation MOUs, credentialing activities to the Participant CMHSPs for the following:

- CMHSP network providers, other than those listed above.

SWMBH includes credentialing requirements consistent with policies in the subcontracts with the Participant CMHSPs, SUD providers, and network providers via the CMH-provider subcontract boilerplate, for the following:

- Individual practitioner credentialing of directly employed/contracted staff.

Monitoring Activities - Licensed/Credentialed Staff

SWMBH and the Participant CMHSPs monitor compliance with credentialing requirements through the annual site review process. Each site review includes a file review of a sample of the provider's credentialing files. See "Provider Network Monitoring" for additional information on the annual site review process. Additionally, SWMBH and the Participant CMHSPs require clinician information for any clinician to be listed as a "rendering provider" in the applicable agency's billing system. This is another way SWMBH and the Participant CMHSPs monitor to ensure licensed professionals are qualified to perform their services. While it is not "credentialing", when SWMBH receives a request from a provider to have a clinician added to the billing system as a rendering provider, SWMBH performs basic screening checks including exclusions screening and licensure verification to ensure that the clinician is only assigned billing rights to service codes they are qualified to deliver.

Monitoring Activities – Non-licensed Providers

SWMBH and the Participant CMHSPs monitor non-licensed provider staff qualifications through the annual site review process. Standardized site review tools for all provider types include a Staff Training file review, which evaluates whether a sample of the provider’s staff completed all required trainings within required timeframes. Standardized site review tools that are specific to providers employing non-licensed staff (example - Ancillary and Community Services tool) include review elements that evaluate the provider’s process for ensuring non-licensed direct care staff meet the minimum qualifications to perform their jobs as articulated in the Medicaid Provider Manual.

FY22 Goal

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH providers will demonstrate an increase compliance with the MDHHS/SWMBH credentialing, recredentialing, and non-licensed provider staff qualification requirements.	Provider Network	Site Review Tools	Annually


FY22 Identified Barriers

Based on the HSAG External Quality Review completed in July 2022, there are opportunities for improvement in the quality of credentialing application processing. SWMBH received scores of “Met” on all administrative elements related to Credentialing and Re-credentialing. SWMBH received scores of “Not Met” on all file review elements related to this standard. SWMBH is currently working through a Corrective Action Plan that includes policy reviews, and training and written technical assistance to Participant CMHSP staff responsible for completing credentialing. SWMBH is also considering moving from an annual credentialing file review as part of the site review process, to quarterly credentialing file reviews. We believe more frequent oversight and monitoring will assist in identifying and remediating deficiencies faster and more thoroughly. With SWMBH’s exit from the MI Health Link program, it is anticipated that there will be staff resources and capacity sufficient to move toward a quarterly monitoring program.

Improvement Efforts Made in FY22

During FY22 there were changes made to the Regional Credentialing Applications and the Credentialing Checklist in order to ensure 1) credentialing timeframes are clearly tracked; 2) QAPI data is evaluated at the time of re-credentialing; 3) specific information on languages spoken and office accessibility features are gathered.

FY22 Results

Goal	FY21	FY22	Eval Score	Recommendations	Time Estimate
SWMBH providers will demonstrate an increase compliance with the MDHHS/SWMBH credentialing, recredentialing, and non-licensed provider staff qualification requirements.	Combined Average from 8 2021 CMHSP Site Reviews 94.4%	Combined Average from 8 2022 CMHSP Site Reviews 95.2%	5	Goal was met. Will continue to monitor and will provide additional training for the CMHSPs in 2023.	 6-12 Mo.

J. Clinical Practice Guidelines

Description

Southwest Michigan Behavioral Health (SWMBH) reviews, disseminates, and implements clinical practice guidelines that are consistent with the regulatory requirements of the Michigan Department of Health and Human Services (MDHHS) Specialty Services Contract and Medicaid Managed Care rules. SWMBH and the Medicaid subcontracted provider network has adopted these guidelines and assures that information related to the guidelines is made available to members and providers.

It is policy that the employees of Southwest Michigan Behavioral Health, Community Mental Health Service Providers (CMHSP), and the provider network must assure that decisions with respect to utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines found here: <https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines>

SWMBH's specific adopted practice guidelines include:

- Housing Practice Guideline
- Consumerism Practice Guideline
- Inclusion Practice Guideline
- Personal Care in Non-Specialized Residential Settings Practice Guideline
- Family-Driven and Youth-Guided Policy and Practice Guideline
- Employment Works! Policy

SWMBH's Clinical Protocols and Practice Guidelines meet the following requirements:

- Are based upon valid and reliable clinical evidence or a consensus of healthcare professionals in the field.
- Consider the needs of the SWMBH members.
- Are adopted in consultation with contracting providers and staff who utilize the protocols and guidelines.
- Are reviewed and updated periodically as needed, with final approval by the Medical Director and/or Director Clinical Quality.
- Are disseminated to all applicable providers through provider orientation/the provider manual and to members upon request. Guidelines are posted on the SWMBH website and are referenced in the provider and member handbooks.
- Any decisions with respect to utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Practices Guidelines are adopted, developed, and implemented by the SWMBH Regional Clinical Practices Committee, which consists of representatives from SWMBH and the eight CMHSPs in Region 4. This group works together to decide which guidelines are most relevantly matched to the individuals in this region by eliciting responses from CMHSP representatives who are close to the issues. They ensure that the essence and intention of these guidelines are filtered through the behavioral health system via meaningful discussion, policy, procedure, training, and auditing/monitoring. Practice guidelines are monitored and evaluated through SWMBH's site review process to ensure CMHSPs and SUD providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization via measures agreed upon by leadership across the region.

Information and outcomes regarding evidence-based practices is reported from the SWMBH Regional Clinical Practices Committee, down to local clinical meetings at the county level. Audits are conducted and reviewed as part of SWMBH's annual clinical audit process, or delegated to the CMHSPs, as required by SWMBH. Practice Guidelines and the expectation of their use are included in provider contracts. Practice guidelines are reviewed and updated annually or as needed and are disseminated to appropriate providers through relevant committees/councils/workgroups. All practice guidelines adopted for use are available on the SWMBH website.

FY22 Goal

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Specific Clinical Practice Guidelines will be adopted, well-communicated, reviewed, and updated according to HSAG requirements.	Clinical Quality	Regional Clinical Practices Committee	At Least Annually


FY22 Identified Barriers

SWMBH experienced staffing changes over the last 2 years. While the Practice Guidelines were reviewed and adopted regularly, there was room for improvement with documentation.

Improvement Efforts Made in FY22

In FY22, the Regional Clinical Practices Committee reviewed each of the adopted Practice Guidelines and noted in the meeting minutes that each one has been reviewed, discussed and adopted by the entire committee.

FY22 Results

Goal	FY21	FY22	Eval Score	Recommendations	Time Estimate
Specific Clinical Practice Guidelines will be adopted, well-communicated, reviewed, and updated according to MDHHS and HSAG requirements.	Partially Met	Partially Met	2	The Regional Clinical Practices Committee will continue to find new ways to communicate the adopted clinical practices guidelines and identify areas for improvement. A policy attachment will be written to clarify and define expectations around the adoption, communication and updating Practice Guidelines. Information sharing about Practice Guidelines, and SWMBH's commitment to Practice Guidelines, will be added to the SWMBH Provider Newsletter at least annually. Finally, elements of the Employment Works! Practice Guideline will be incorporated into the CMH annual site review tool for 2023.	 6-12 Mo.

K. Long-Term Services and Supports (LTSS)

Description

“Long term services and supports (LTSS)” means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting (42 CFR 438.2).

Long Term Services and Supports (LTSS) are provided to persons with disabilities who need additional support due to: (42 CFR §438.208(c)(1)(2)):

- Advancing age; **or**
- Physical, cognitive, developmental, or chronic health conditions; **or**
- other functional limitations that restrict their abilities to care for themselves; **and**
- Receive care in home and community-based settings or facilities such as nursing homes.

MDHHS identifies Medicare and Medicaid participants in HCBS Waivers as recipients of Long-Term Services and Supports (LTSS). Michigan currently hosts the following HCBS Waivers:

- Children’s Waiver Program
- MI Health Link Waiver
- Habilitative Supports Waiver
- Waiver for Children with Serious Emotional Disturbances (SED)
- 1915(i)- (formerly known as 1915(b)(3))
- 1115 Behavioral Health Demonstration

Southwest MI Behavioral Health manages funding for Michigan’s specialty behavioral health Medicaid population through delegation and contracting with the eight CMHSPs and their provider networks in Region 4. SWMBH and the network serves members receiving LTSS through the following HCBS Waivers:

- Habilitative Supports Waiver
- Waiver for Children with Serious Emotional Disturbances (SED)
- Children’s Waiver Program
- 1915(i)- (formerly known as 1915(b)(3))
- 1115 Behavioral Health Demonstration

SWMBH is committed to supporting full community integration for members using long-term supports and services (LTSS). Ensuring and improving community integration for members using LTSS is typically addressed at the local level by CMHSPs, provider agencies, advocates, and rights agencies. It is standard for every person to have a community integration goal in their Individualized Plan of Service (IPOS). Furthermore, all CLS providers (specialized residential and otherwise) are constantly audited by licensing, accreditation, the CMHSPs and SWMBH to determine that they are, in fact, providing appropriate and dynamic community integration opportunities with proper documentation. Community involvement is supplemented by various respite, skill building and supported employment services – all of which commonly have a community integration element.

FY22 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Ensure the incorporation of individuals receiving long-term supports or services (e.g., individuals receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods. Evaluate the effects of activities implemented to improve satisfaction.	QAPI and Clinical Quality	Customer Satisfaction Survey	Annually
Raise awareness across Region 4 about the LTSS population and work together to determine meaningful LTSS initiatives.	Clinical Quality	Regional Clinical Practices Committee	Ongoing as Needed
Evaluate the results of any efforts to support community integration for members using LTSS.	Clinical Quality	Regional Clinical Practices Committee	Annually

FY22 Identified Barriers




There was some clarification needed at the beginning of FY22 regarding HSAG and MDHHS' expectations regarding long-term services and supports, specifically about the requirements to survey and monitor the quality of LTSS. SWMBH has made strides toward incorporating LTSS oversight into processes, according to HSAG's recommendations.

Improvement Efforts Made in FY22

Long-Term Supports and Services was accurately defined, and the Clinical Quality Department worked cross-functionally to ensure that all HSAG requirements are met. This includes, but is not limited to:

- A formal LTSS section was added into the FY23 QAPI Plan and goals.
- To help monitor the quality of LTSS services, new departmental resources (FTEs) were allocated toward the quality monitoring of the LTSS population. The role has constant access to review service plans of individuals who reside in residential settings and receive LTSS services. This enhanced oversight will help to specifically address any issues with service plans and work directly with CMHSPs address any areas of concern.
- The Customer Satisfaction survey process was enriched in 2022 to ensure that the LTSS population was accurately captured for both the Youth and Adult populations, and data was analyzed. Survey questions will continue to be improved in 2023 so that community integration and satisfaction with providers are well-captured. There was an analysis of 2022 survey results which will be well-communicated across the region in 2023 to inform future LTSS initiatives.
- SWMBH continued to monitor CMH services via the annual CMH Site Review Tool, which included Long-Term Supports and Services.
- Aggregated annual audit outcomes were monitored and analyzed by clinical and quality assurance departments at both the CMHSP and PIHP levels and used to inform updates to the annual provider training, which was offered to the LTSS provider network. The provider training is held on an annual basis by CMHSP-level quality improvement departments.
- In 2022, SWMBH identified the need for a regional approach to assess care between settings. This need will inform 2023 goals around long-term supports and services.
- Southwest MI Behavioral Health is prepared to implement MDHHS's HCBS quality measures whenever they are specifically identified.

FY22 Results

Goal	FY21	FY22	Eval Score	Recommendations	Time Estimate
Ensure the incorporation of individuals receiving long-term supports or services (e.g., individuals receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods. Evaluate the effects of activities implemented to improve satisfaction.	N/A	Partially Met	2	Continue toward a method to obtain LTSS status in MHSIP and YSS surveys, add questions related to accessibility in the 2023 surveys, and establish baseline LTSS survey results assessing the quality, availability, and accessibility of care.	 3-6 Mo.
Raise awareness across Region 4 about the LTSS population and work together to determine meaningful LTSS initiatives.	N/A	Partially Met	3	LTSS population was discussed during regional meetings involving all 8 CMHSPs in 2022. SWMBH worked with other PIHPs, HSAG and MDHSS to clarify expectations regarding LTSS. For 2023, the topic of LTSS will be added to at least two regional clinical meeting agendas and the Provider Newsletter at least once/year to educate the Region 4 Network on how the LTSS population is defined, and how it can be better supported according to HSAG guidance.	 6-12 Mo.
Evaluate the results of any efforts to support community integration for members using LTSS.	N/A	Partially Met	2	SWMBH is identifying ways to support community integration for members using LTSS. SWMBH will research and develop a regional approach to assessing care between LTSS settings that expands on current PIHP activities by 12/31/23. It will include a comparison of services and supports received with those set forth in the member's treatment/service plan.	 6-12 Mo.

The following slides demonstrate age, race and LTSS comparison results from the Mental Health Statistics Improvement Program (MHSIP) and the Youth Services Survey (YSS), which were administered in 2022. An analysis of results reveals that Adult and Youth LTSS consumers report better satisfaction scores than non-LTSS consumers across the board.

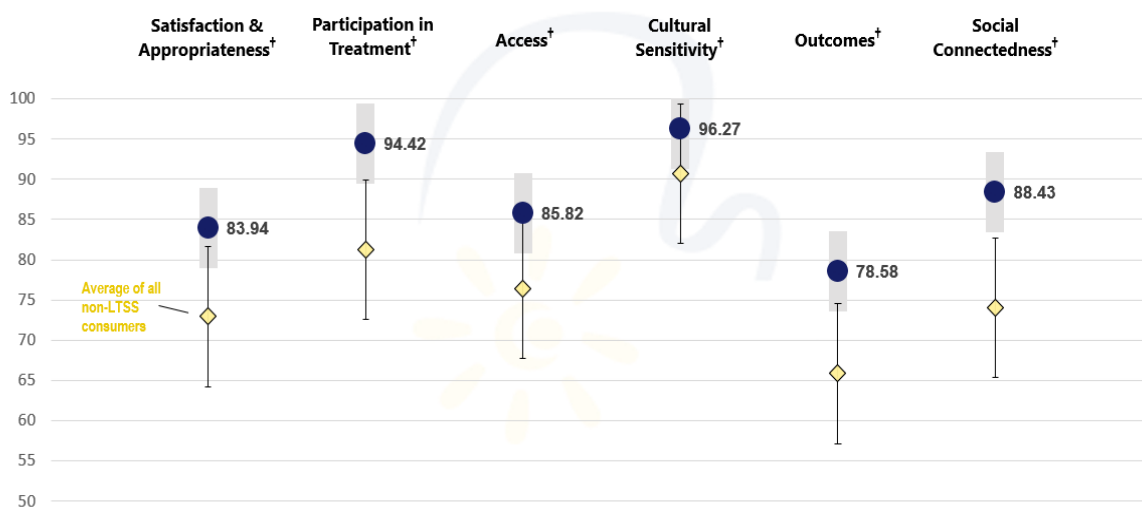
Adult LTSS consumers report better scores than non-LTSS adults across the board

Dark green denotes the percentage of LTSS (long-term social services) consumers in agreement for that construct's items
Gray bars denote the likely range where the true percentage for all LTSS consumers might lie (i.e., margin of error*)



Youth LTSS consumers report better scores than non-LTSS youth across the board

Dark green denotes the percentage of LTSS (long-term social services) consumers in agreement for that construct's items
Gray bars denote the likely range where the true percentage for all LTSS consumers might lie (i.e., margin of error*)



L. Utilization Management

Description

The purpose of the Utilization Management (UM) Program is to maximize the quality of care provided to customers while effectively managing the Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waivers 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, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waiver and SUD Community Grant. SWMBH is responsible to ensure adherence to Utilization Management related statutory, regulatory, and contractual obligations associated with the Department of Health and Human Services (DHHS) Medicaid Specialty Services and SUD contracts, Medicaid Provider Manual, mental health and public health codes/rules and applicable provisions of the Medicaid Managed Care Regulations, the Affordable Care Act and 42 CFR.

The utilization management 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. The most important aspects of the utilization management plan are to effectively monitor population health and manage scarce resources for those persons who are deemed eligible while supporting the concepts of financial alignment and uniformity of benefit. Ensuring that these identified tasks occur is contingent upon uniformity of benefit, commonality and standardized application of Intensity of Service/Severity of Illness criteria and functional assessment tools across the Region, authorization and linkage, utilization review, sound level of care and care management practices, implementation of evidenced based clinical practices, promotion of recovery, self-determination, involvement of peers, cross collaboration, outcome monitoring and discharge/transition/referral follow-up.

Coordination and Continuity of Care

SWMBH is committed to ensuring each customer receives services designed to meet each individual special health need as identified through a functional assessment tool and a Biopsychosocial Assessment. The screening and assessment process contains mechanisms to identify needs and integrate care that can be addressed with specialty behavioral health and substance abuse treatment services as well as integrated physical health needs and needs that may be accessed in the community including, but not limited to, employment, housing, financial assistance, etc. The assessment is completed or housed in a uniform managed care information system with collection of common data elements which also contains a functional assessment tool that generates population-specific level of care guidelines. To assure consistency, the tools utilized are the same version across the SWMBH region and include the Level of Care Utilization System (LOCUS) for Adults with Mental Illness or Co-Occurring Disorder, CAFAS (Child and Adolescent Functional Assessment Scale) for Youth with Serious Emotional Disturbance, SIS (Supports Intensity Scale) for Customers with Intellectual/ Developmental Disabilities, ASAM-PPC (American Society for Addiction Medicine-Patient Placement Criteria) for persons with a Substance Use Disorder. Components of the assessments generate a needs list which is used to guide the treatment planning process. Assessments are completed by appropriate clinical professionals. Treatment plans are developed through a person-centered planning process with the customer's participation and with consultation from any specialists providing care to the customer.

SWMBH ensures adherence to statutory, regulatory, and contractual obligations through four primary Utilization Management Functions:

- *Access and Eligibility.* To ensure timely access to services, SWMBH provides oversight and monitoring of local access, triage, screening, and referral (see Policy Access Management). SWMBH ensures that the Access Standards are met including MMBPIS.
- *Clinical Protocols.* To ensure Uniform Benefit for Customers, consistent functional assessment tools, medical necessity, level of care and regional clinical protocols have been or will be identified and implemented for service determination and service provision (see Policy Clinical Protocols and Practice Guidelines).
- *Service Authorization.* Service Authorization procedures will be efficient and responsive to customers while ensuring sound benefits management principles consistent with health plan business industry standards. The service determination/authorization process is intended to maximize access and efficiency on the service delivery level, while ensuring consistency in meeting federal and state contractual requirements. Service authorization utilizes level of care principles in which intensity of service is consistent with severity of illness.
- *Utilization Management.* Through the outlier management and level of care service utilization guidelines for behavioral health and outlier management, level of care service utilization guidelines and central care management processes for substance use disorders, an oversight and monitoring process will be utilized to ensure utilization management standards are met, such as appropriate level of care determination and medically necessary service provision and standard application of Uniformity of Benefit (see Policy Utilization Management).

The SWMBH Utilization Management Plan is designed to maximize timely local access to services for Customers while providing an outlier management process to reduce over and underutilization (financial risk) for each partner CMHSP and the substance use disorder provider network. The Regional Utilization Management Plan endorses two core functions:

1. Outlier Management of identified high cost, high risk service outliers or those with need under-utilizing services.
2. The Outlier Management process provides real-time service authorization determination and applicable appeal determination for identified service outliers. The policies and procedures meet accreditation standards for the SWMBH Health Plan for Behavioral Health services (Specialty Behavioral Health Medicaid and SUD Medicaid and Community Grant). Service authorization determinations are delivered real-time via a managed care information system or a telephonic review process (prospective, concurrent, and retrospective reviews). Outlier Management and level of care guideline methodology is based upon service utilization across the region. The model is flexible and consistent based upon utilization and funding methodology. Oversight and monitoring of delegated specialty behavioral health UM functions.

The Utilization Review (UR) process uses monthly review of outlier management reports and annual review with specialized audit tools that monitor contractual, statutory, and regulatory requirements. The reports and UR tool speak to ensuring intensity of service matching level of care with services and typical service utilization as well as any additional external audit findings (MDHHS, HSAG EQR, etc.). Should any performance area be below the established benchmark standard, the Utilization Review process requires that a Corrective Action Plan be submitted to address any performance deficits. SWMBH clinical staff monitor the implementation of the Corrective Action Plans.

The outlier management process and subsequent reports to manage it, including over and underutilization and uniformity of benefit, are based on accurate and timely assessment data and scores of agreed tools and service determination transactions being submitted to the SWMBH warehouse, implementation of level of care guidelines and development of necessary reports for review.

Outlier Management

An integral part of SWMBH's Performance Improvement Based Utilization Management Program is continued development and implementation of the outlier management methodology. This process is a key strategy for identifying and correcting over and underutilization of services. This strategy provides the foundation for systemic performance improvement focused by the PIHP versus intensive centralized utilization controls. The design encompasses review of resource utilization of all plan customers covered by the PIHP. The intent of the outlier management approach is to identify issues of material under-utilization or over-utilization and explore and resolve it collaboratively with involved CMHSP(s).

Outlier Definition

"Outlier" is generally defined as significantly different from the norm. SWMBH defines "outlier" in relation to UM as follows:

A pattern or trend of under- or over-utilization of services (as delivered or as authorized), compared to the typical pattern of service utilization. Over or under-utilization trends can be identified at a variety of comparative levels, including but not limited to the population, CMH, state, service type, or provider levels.

Outlier Identification

Multiple tools are available to SWMBH for monitoring, analyzing, and addressing outliers. SWMBH's Performance Indicator Reports (MDHHS required performance standards), service utilization data, and cost analysis reports are available to staff and committees for review and comparison of overall performance. The service use analysis reports are developed to allow detailed analysis of resource utilization at macro and micro levels. Outlier reviews are organized to focus extreme outliers in contrast to regionally normative patterns. Specific outlier reports are available and generated in the MCIS and reviewed by SWMBH Utilization Management to provide adequate oversight of service utilization and potential issues of uniformity of benefit.

Outlier Management Procedures

As outliers are identified, protocol driven analysis will occur at SWMBH and the regional committee level to determine whether the utilization is problematic and in need of intervention. Data identified for initial review will be at aggregate levels for identification of statistical outliers. Additional information will be accessed as needed to understand the utilization patterns and detail.

Identified outliers are evaluated to determine whether further review is needed to understand the utilization trend pattern. If further review is warranted, active communication between the SWMBH staff and the regional committee or the CMHSP will ensue to ensure understanding of the utilization trends or patterns.

Data Management

Data management and standardized functional assessment tools and subsequent reporting tools are an integral piece to utilization management and application of uniform benefit. Utilization mechanisms identify and correct under-utilization as well as over-utilization.

FY22 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will create a Utilization Management Plan per MDHHS guidelines.	UM	RUM	Annually
Aggregate and review UM data to identify trends and service improvement recommendations and identify Best Practice Standards and Thresholds to ensure valid and consistent UM data collection techniques.	UM, Clinical Quality, SUD	RUM, RCP	Monthly
Ensure Inter-rater reliability (IRR) audits are completed for consistent application and understanding of authorization of uniform benefits and medical necessity benefit criteria.	UM, Clinical Quality	RCP	Quarterly
SWMBH will meet or exceed the standard for compliance with Adverse Benefit Determination notices completed in accordance with the 42 CFR 438.404 and verify compliance during Delegated Managed Care Reviews.	UM and Customer Services	RUM, Regional Customer Service Committee	Annually (or Interim, as needed)
Emergent and non-emergent cases will be periodically monitored to ensure compliance with standards.	UM, Customer Services	Regional Customer Service Committee	Quarterly
SWMBH will achieve a call abandonment rate of 5% or less.	UM	Data submission to MDHHS	Quarterly
SWMBH will achieve an average call answer time 30 seconds or less.	UM	Data submission to MDHHS	Quarterly
Ensure a call center monitoring plan is in place and provide routine quality assurance audits.	UM	QMC	Monthly
Evaluate CMHSP call reports during Delegated Administrative Function Site Reviews.	UM	Site Review Tools	Annually


Identified Barriers





Across the region, there have been clinical and direct care working shortages and ongoing staff turnover. Due to problems related to staff retention, lack of training has been an identified barrier. Internal processes have been developed with a lack of understanding of the standards and guidelines that are required to be followed. Ongoing interrater reliability throughout region was inconsistent due to lack of time, staffing, and understanding of why it must be completed to ensure compliance and consistency to ensure parity across the state. Seven of eight CMHSPs within Region 4 had corrective action plans due to Adverse Benefit Determinations (ABDs) not meeting the federal regulations set by 42 CFR § 438.210 and 42 CFR § 438.404.

Improvement Efforts Made in FY22

In September 2022, SWMBH added the position of Director of Utilization Management (UM) and promoted the Manager of UM and Call Center to this role to provide additional regional oversight. In collaboration with the Customer Service department, there will be a region wide CMH training that will focus on improving the quality of the Adverse Benefit Determinations to address the recommendations made by Health Services Advisory Group (HSAG).

FY22 Results

Goal	FY21	FY22	Eval Score	Recommendations	Time Estimate
SWMBH will create a Utilization management Plan per MDHHS guidelines.	Met	Met	5	The goal was met, will stay the same and be monitored through FY 2023.	 6-12 Mo.
Aggregate and review UM data to identify trends and service improvement recommendations and identify Best Practice Standards and Thresholds to ensure valid and consistent UM data collection techniques.	Met	Met	5	The goal was met, will the stay the same and be monitored through FY23. Level of care thresholds were finalized and implemented into CMHSP EMRs. RUM will continue to review data trends to identify outliers.	 6-12 Mo.
Ensure Inter-rater reliability (IRR) audits are completed for consistent application and understanding of authorization of uniform benefits and medical necessity benefit criteria.	Met	Met	5	Goal was met and will continue in FY23. A plan to create IRR training and distribute regionally. Verification of IRR audit plan was moved from Clinical Quality to UM.	 6-12 Mo.
SWMBH will meet or exceed the standard for compliance with Adverse Benefit Determination notices completed in accordance with the 42 CFR 438.404 and verify compliance during Delegated Managed Care Reviews.	62.5%	25%	2	A training on ABD will be completed on 3 separate days in March 2023 based on HSAG recommendations from SFY2021 MDHHS-HSAG PIHP Compliance Review. Standard requirements were met; however, several recommendations were made based on identified errors in the file review that did not improve. Ongoing issues have been related to the EMR change and automated letters created within. SWMBH has been a part of ongoing collaboration with CMHSPs to assist with performance improvement to comply with standards.	 6-12 Mo.
Emergent and non-emergent cases will be periodically monitored to ensure compliance with standards.	Met	Met	4	The goal was met and will continue to be monitored in FY23. Standard requirements were met; however, several recommendations were made based on	 6-12 Mo.

				identified authorization timeliness errors in the file review of that did not improve. CAPs were submitted and the SWMBH ABD training to occur in March 2023 will also address improvement in this area.	
SWMBH will achieve a call abandonment rate of 5% or less.	0.23%	0.2%	5	The goal was met and will continue to be monitored in FY23.	 6-12 Mo.
SWMBH will achieve an average call answer time 30 seconds or less	98.19%	98.67%	5	The goal was met and will continue to be monitored in FY23.	 6-12 Mo.
Ensure a call center monitoring plan is in place and provide routine quality assurance audits.	Met	Met	5	Monthly call monitoring was completed and will continue to be monitored in FY23.	 6-12 Mo.
Evaluate CMHSP call reports during Delegated Administrative Function Site Reviews.	93.75%	100%	5	The goal was met and will continue to be monitored in FY23.	 6-12 Mo.

SWMBH 2022 Inter-Rater Reliability Results

Date & Case	# Of Raters	% Matching Medical Necessity Criteria (MNC)	ASAM Variances (# outside of one Level of Care)
April 2022- "Lucy"	12	100%	0
August 2022 – "Tiffany"	8	100%	0

M. Customer Service

Description

Customer Service provides a welcoming environment and orientation to services. Customer Service provides information about benefits and available provider network. Customer Service provides information about how to access behavioral health, substance use disorders, primary health, and other community resources. Customer Service assists members with obtaining information about how to access Due Processes when benefits are denied, reduced, suspended, or terminated. Customer Service oversees grievances and appeal process and tracks/reports patterns of problems for each organization and regionally including over/under service utilization.

FY22 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Identify alternative communication options to ensure access to customer service offices and functions throughout the region.	Customer Services	Regional Customer Service Committee	Annually
HSAG Metric – Complete the Health Services Advisory Group 2022 audit with 90% or higher compliance for Grievances and Appeals.	Customer Services	Regional Customer Service Committee	Annually
MDHHS Data reports – Ensure accurate and timely submission of regional data for Grievances, Appeals, and Denials ongoing.	Customer Services	Regional Customer Service Committee	Semi-Annually
Determine and implement regional procedures regarding Applied Behavioral Analysis (ABA) service denials.	Customer Services	Regional Customer Service Committee	Annually

FY22 Identified Barriers

For FY 22 Goal 1:

- The Regional Customer Service Committee identified that this goal did not have precedence in FY22 due to unexpected project needs and requirements (implementation of Mediation, increased monitoring in preparation for HSAG, etc.).

For FY 22 Goal 2:

- SWMBH noted the barrier of CMHSP staff turnover in their Customer Service departments, which resulted in knowledge gaps related to the state/federal requirements and system capabilities.
- The CMHSPs have consecutively been transitioning to a new electronic record system during the review period. There have been ongoing challenges with aligning state/federal requirements with the new system's capabilities.

For FY 22 Goal 3:

- CMHSPs noted barriers related to system capabilities for pulling data from their electronic record system (PCE and/or Smartcare).
- CMHSPs noted barriers related to data transfer and margin for human error when inputting data into MDHHS specific templates.

For FY 22 Goal 4:

- The processes for intake and evaluation of ABA cases vary by each CMHSP's staffing capabilities and limitations.

- Standards for ABA denials include cross-departmental functions and monitoring (ABA eligibility criteria, Adverse Benefit Determination requirements and timeframes, etc.).
- CMHSPs noted a barrier of the extensive testing process required for ABA and the restrictions for making decisions on services timely.
- CMHSPs noted a barrier of having a lack of qualified staff that are able to complete the various levels of testing in a timely manner.
- CMHSPs noted a barrier of the lack of follow through by customers/guardians when attempting to schedule intakes and evaluations for ABA services.

Improvement Efforts Made in FY22

For FY 22 Goal 1:

- CMHSPs report improvements with alternative communication efforts (such as electronic intake packets, releases of information, member information documents, etc.).

For FY 22 Goal 2:

- Reviewed templates for G&A letters to ensure compliance with MDHHS contract language.
- Reviewed G&A files to ensure timeliness was met.
- Reviewed G&A files to ensure that CFR 438.10 language requirements were met (e.g. simple language).
- Completed HSAG audit with 87% compliance for Grievance and Appeal standards.



For FY 22 Goal 3:

- CMHSPs were asked to submit data timely to SWMBH based on date/times established by SWMBH to ensure timely and accurate submission to MDHHS.
- SWMBH reviewed the quarterly data submissions prior to sending full regional report to MDHHS to ensure accurate and consistent data reporting.
- SWMBH met with each CMHSP to review their data trends no less than 2 times.
- The Regional Customer Services Committee reviewed the data and summary of trends at least quarterly.

For FY 22 Goal 4:

- Developed a written procedure detailing how ABA service denials would be processed.
- Created language guidance for Adverse Benefit Determinations (ABD) when ABA services are denied.
- The Regional Customer Services Committee discussed, reviewed, and evaluated implementation of the process/procedure and use of guidance language.

FY22 Results

Goal	FY22	Eval Score	Recommendations	Time Estimate
Identify alternative communication options to ensure access to customer service offices and functions throughout the region.	Not Met	2	The goal will be discontinued. Each CMHSP will determine how to best increase alternative communication options for customers in FY23.	N/A
HSAG Metric – Complete the Health Services Advisory Group 2022 audit with 90% or higher compliance for Grievances and Appeals.	Partially Met	3	The goal will be revised for FY23 to reflect the implementation of HSAG FY22 Corrective Action Plans and Recommendations.	 6-12 Mo.
MDHHS Data reports – Ensure accurate and timely submission of regional data for Grievances, Appeals, and Denials ongoing.	Partially Met	3	The goal will be revised for FY23 to reflect the increased monitoring of G&A files specific to utilization of services.	 6-12 Mo.
Determine and implement regional procedures regarding Applied Behavioral Analysis (ABA) service denials.	Met	4	The goal will be discontinued as it has been met and implemented. The data will continue to be monitored through the quarterly submission of denials from the CMHSPs in FY23.	N/A

FY22 Grievances

Grievance Category	Number of Cases Closed	Number of Cases Per 100 Members	Number of Cases Substantiated	Number of Cases Substantiated Per 100 Members	Number of Interventions	Number of Cases Resolved within 90 Calendar Days	Average Number of Days for Resolution*
QUALITY OF CARE	25	0.14	10	0.06	32	24	27
ACCESS AND AVAILABILITY	19	0.11	11	0.06	22	19	28
INTERACTION WITH PROVIDER OR PLAN	111	0.64	58	0.33	129	111	18
MEMBER RIGHTS	2	0.01	1	0.01	2	2	40
TRANSPORTATION	0	0.00	0	0.00	0	0	#DIV/0!
ABUSE, NEGLECT, OR EXPLOITATION	0	0.00	0	0.00	0	0	#DIV/0!
FINANCIAL OR BILLING MATTERS	2	0.01	0	0.00	4	2	31
SAFETY/RISK MANAGEMENT	1	0.01	1	0.01	1	1	2
SERVICE ENVIRONMENT	5	0.03	3	0.02	9	5	27
OTHER	9	0.05	1	0.01	10	9	13
Total	174	1.00	85	0.49	209	173	20

*Field will display “#DIV/0!” if there are no reported cases per category.

FY21 Grievances

Grievance Category	Number of Cases Closed	Number of Cases Per 100 Members	Number of Cases Substantiated	Number of Cases Substantiated Per 100 Members	Number of Interventions	Number of Cases Resolved within 90 Calendar Days	Average Number of Days for Resolution*
QUALITY OF CARE	25	0.15	7	0.04	31	25	34
ACCESS AND AVAILABILITY	19	0.12	5	0.03	26	19	24
INTERACTION WITH PROVIDER OR PLAN	62	0.38	14	0.09	69	62	14
MEMBER RIGHTS	0	0.00	0	0.00	0	0	#DIV/0!
TRANSPORTATION	0	0.00	0	0.00	0	0	#DIV/0!
ABUSE, NEGLECT, OR EXPLOITATION	0	0.00	0	0.00	0	0	#DIV/0!
FINANCIAL OR BILLING MATTERS	2	0.01	1	0.01	3	2	23
SAFETY/RISK MANAGEMENT	0	0.00	0	0.00	0	0	#DIV/0!
SERVICE ENVIRONMENT	1	0.01	0	0.00	1	1	10
OTHER	1	0.01	0	0.00	2	1	14
Total	110	0.68	27	0.17	132	110	20

*Field will display “#DIV/0!” if there are no reported cases per category.

FY22 Appeals

Reason for Adverse Decision on Appeal	Number of Cases Closed	Number of Cases Per 100 Members	Number of Decisions Made Timely-Standard	Number of Decisions Made Untimely-Standard	Number of Decisions Made Timely-Expedited	Number of Decisions Made Untimely-Expedited	Percent Timely-All Cases	Percent Untimely-All Cases
MEDICAL NECESSITY CRITERIA NOT MET	38	0.22	36	1	1	0	97%	3%
NOT A PIHP-COVERED BENEFIT	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
CLINICAL DOCUMENTATION NOT RECEIVED	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
TREATMENT/SERVICE PLAN GOALS MET	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
MEMBER NOT ELIGIBLE FOR SERVICES	3	0.02	2	1	0	0	67%	33%
MEMBER NON-COMPLIANT WITH TREATMENT/SERVICE PLAN	6	0.03	2	4	0	0	33%	67%
FAILURE OF THE PIHP/CMHSP/SUD PROVIDER TO RENDER A DECISION TIMELY	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
OTHER	1	0.01	1	0	0	0	100%	0%
NOT APPLICABLE	40	0.23	40	0	0	0	100%	0%
Total	88	0.50	81	6	1	0	93%	7%

*Field will display “#DIV/0!” if there are no reported cases per category.

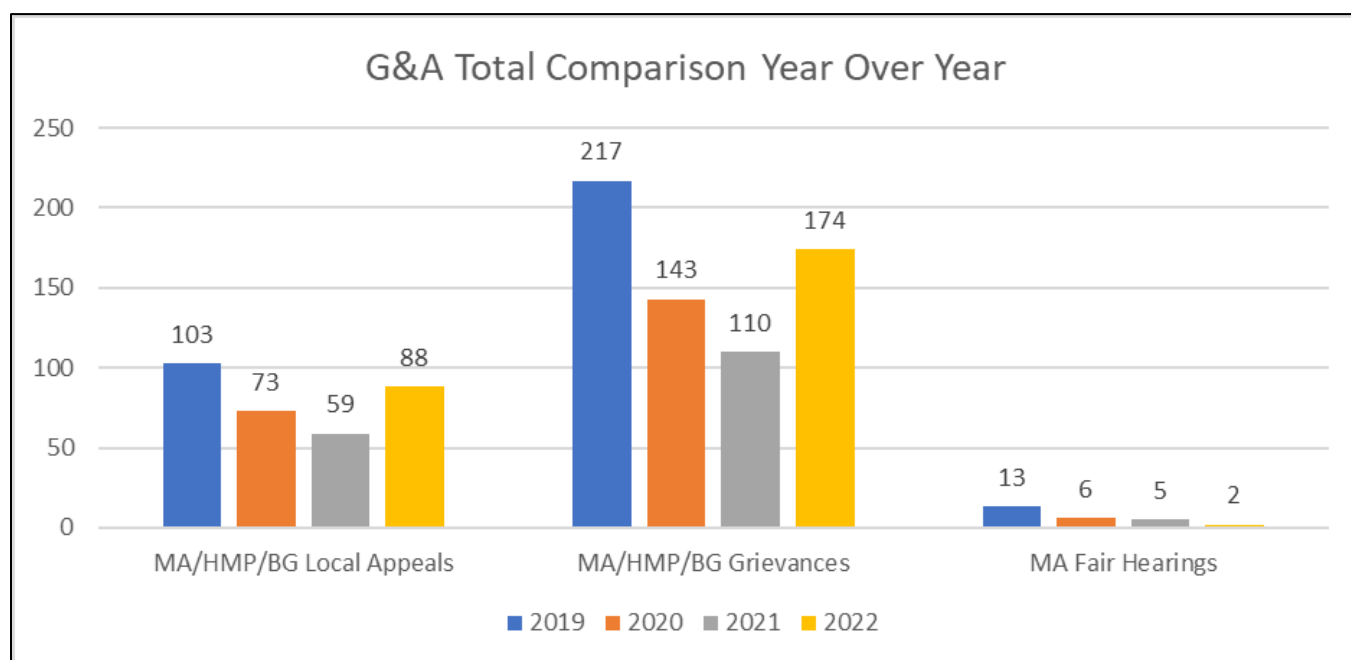
	Count	Percentage
Appeals	88	
Appeals Upheld	44	50%
Appeals Overturned	43	49%
Appeals Partially Upheld/Overturned	1	1%

FY21 Appeals

Reason for Adverse Decision on Appeal	Number of Cases Closed	Number of Cases Per 100 Members	Number of Decisions Made Timely-Standard	Number of Decisions Made Untimely-Standard	Number of Decisions Made Timely-Expedited	Number of Decisions Made Untimely-Expedited
MEDICAL NECESSITY CRITERIA NOT MET	33	0.20	33	0	0	0
NOT A PIHP-COVERED BENEFIT	0	0.00	0	0	0	0
CLINICAL DOCUMENTATION NOT RECEIVED	0	0.00	0	0	0	0
TREATMENT/SERVICE PLAN GOALS MET	0	0.00	0	0	0	0
MEMBER NOT ELIGIBLE FOR SERVICES	1	0.01	1	0	0	0
MEMBER NON-COMPLIANT WITH TREATMENT/SERVICE PLAN	7	0.04	6	1	0	0
FAILURE OF THE PIHP/CMHSP/SUD PROVIDER TO RENDER A DECISION TIMELY	0	0.00	0	0	0	0
OTHER	2	0.01	1	1	0	0
NOT APPLICABLE	16	0.10	16	0	0	0
Total	59	0.37	57	2	0	0

*Field will display "#DIV/0!" if there are no reported cases per category.

	Count	Percentage
Appeals	59	n/a
Appeals Upheld	31	53%
Appeals Overturned	26	44%
Appeals Partially Upheld/Overturned	2	3%



N. Certified Community Behavioral Health Clinics (CCBHC)

Description

In October 2020, MDHHS began participating in a two-year demonstration in the Centers for Medicare & Medicaid Services (CMS) CCBHC Demonstration when the federal CARES Act of 2020 authorized two additional states—Michigan and Kentucky—to join under Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA). Approved sites within Michigan included 11 Community Mental Health Services Programs (CMHSPs) and 3 non-profit behavioral health entities, together serving 18 Michigan counties.

June 25, 2022, the Bipartisan Safer Communities Act approved expansion of the CCBHC Demonstration enabling Michigan to extend the duration of the demonstration to 6 years, allow current Demonstration agencies to expand with new locations, and additional agencies to be brought on as a part of the demonstration. By July 1, 2024, up to ten additional states may also join the Demonstration, and by 2030, all states will have had the opportunity to join. This Act also Contains a “rule of construction” allowing States to continue to cover items and services in the CCBHC bundle under the authority of the State plan using the PPS rate.

The CMS CCBHC Demonstration requires certified sites to provide nine core services and Michigan CCBHCs have required and recommended evidence-based practices they must use.

Core Services: Screening, assessment, and diagnosis, including risk assessment; Patient-centered treatment planning or similar processes, including risk assessment and crisis planning; Outpatient mental health and substance use services; Outpatient clinic primary care screening and monitoring of key health indicators and health risk; Targeted case management; Psychiatric rehabilitation services; Peer support and counselor services and family supports; and Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas.

Required evidence-based practices (EBP): “Air Traffic Control” Crisis Model with MiCAL, Assertive Community Treatment (ACT), Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Infant Mental Health, Integrated Dual Disorder Treatment (IDDT), Motivational Interviewing (MI) for adults, children, and youth, Medication Assisted Treatment (MAT), Parent Management Training – Oregon (PMTO) and/or Parenting through Change (PTC), Screening, Brief Intervention, and Referral to Treatment (SBIRT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Zero Suicide.

Recommended EBPs: CCBHCs to choose EBPs to address trauma in adult populations, needs of transition age youth (such as the Transition to Independence Process [TIP] model), and chronic disease management; Dialectical Behavior Therapy for Adolescents (DBT-A), Permanent Supportive Housing, and Supported Employment (IPS model).

To account for these requirements, the state created a PPS reimbursement structure that finances CCBHC services at an enhanced payment rate to properly cover costs and offer greater financial predictability and viability. The PPS is integral to sustaining expanded services, investments in the technological and social determinants of care, and serving all eligible Michiganders regardless of insurance or ability to pay.

SWMBH currently has two participating CCBHCs (Community Mental Health and Substance Abuse Services of St. Joseph County and Integrated Services of Kalamazoo). While other CMHSPs within the region have CCBHC Expansion Grants, SWMBH is not responsible for monitoring these requirements.

PIHP Requirements

PIHPs share responsibility with MDHHS for ensuring continued access to CCBHC services. PIHPs are responsible for meeting minimum requirements, distributing payment, facilitating CCBHC outreach and assignment, monitoring and reporting on CCBHC measures, and coordinating care for eligible CCBHC recipients as described below.

SWMBH has a regional implementation governance structure for CCBHC with a steering committee of senior executives from SWMBH and CMHSPs and three sub-committees: clinical/client flow, data/reporting, and finance. Each is led by a SWMBH director and CCBHC/CMHA representative, populated by current Medicaid CCBHC Demonstration CMHSPs with an open door to SAMSHA CCBHC CMHSPs.

CCBHC Monitoring & Evaluation Requirements

CMS has defined reporting requirements and guidance for the CCBHC Demonstration. There are two broad sets of requirements – CCBHC Reported Measures and State Reported Measures. A state-lead measure is calculated by the state for each CCBHC, usually relying on administrative data. A CCBHC-lead measure is calculated by the CCBHC and sent to the state. The measures are not aggregated by the state. It is the goal of MDHHS to utilize administrative data as much as possible to avoid administrative burden on providers.

FY22 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
The Quality Department will help track and perform data analysis on identified Quality Bonus Payment (QBP) metrics.	Quality	CCBHC Data Workgroup	Monthly
Ensure that correct tracking mechanisms are in place to achieve pre-established benchmarks.	Quality	CCBHC Data Workgroup	Quarterly
Ensure that identified CCBHC-reported metrics are submitted timely and via correct methods.	Quality	CCBHC Data Workgroup	Bi-annually
Ensure correct forms and reporting methodologies are utilized.	Quality	CCBHC Data Workgroup	Bi-annually

DY1 Metric Results

Metric Name	State or CCBHC Reported Measure	Bench- mark	ISK QBP Preliminary Results	St. Joe QBP Preliminary Results
Time to Initial Evaluation (I-EVAL)	CCBHC	n/a	n/a	n/a
Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	CCBHC	n/a	n/a	n/a
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	CCBHC	n/a	n/a	n/a
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	CCBHC	n/a	n/a	n/a
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	CCBHC	n/a	n/a	n/a
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C) **	CCBHC	23.90%	36.03%	75.84%
Major Depressive Disorder: Suicide Risk Assessment (SRA-A) **	CCBHC	12.50%	73.62%	68.40%
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	CCBHC	n/a	n/a	n/a
Depression Remission at Twelve Months (DEP-REM-12)	CCBHC	n/a	n/a	n/a
Housing Status (HOU)	State	n/a	n/a	n/a
Patient Experience of Care Survey (PEC)	State	n/a	n/a	n/a
Youth Family Experience Survey (Y/FEC)	State	n/a	n/a	n/a
Follow up after ED Visit for MI (FUM)	State	n/a	n/a	n/a
Follow up after ED Visit for Alcohol and Drugs (FUA)	State	n/a	n/a	n/a
Plan All-Cause Readmission Rates (PCR-BH)	State	n/a	n/a	n/a
Diabetes Screening Schizophrenia/Bipolar using antipsychotics (SSD)	State	n/a	n/a	n/a
Adherence to Antipsychotic Meds with Schizophrenia (SAA-BH) **	State	58.50%	63.48%	70.37%
Follow up after Hosp for Mental Illness, ages 21+ (FUH) **	State	58%	85.24%	77.27%
Follow up after Hosp for Mental Illness, ages 6-21 (FUH) **	State	70%	86.67%	83.33%
Follow-up care for children prescribed ADHD meds (ADD)	State	n/a	n/a	n/a
Antidepressant Medication Management (AMM-BHH)	State	n/a	n/a	n/a
Initiation and Engagement of Alcohol and other Drug Treatment (IET-BH) **	State	14 day- 25%	40.24%	24.27%

****Quality Bonus Payment**

Reported Quality Bonus Payment (QBP) results in the DY1 Metric chart above are *preliminary and are not considered final as the majority are State-Reported Metrics and will not be supplied by MDHHS until after 3/31/23*. The QBP results above are sourced from Relias, CCBHC Medical Records Data or SWMBH internal Tableau Reports and were used by the PIHP during DY1 to monitor current CCBHC metric status and implement process improvement where necessary. SWMBH's preliminary analysis of this data indicated ISK met all QBP metrics and will be eligible for payment. St. Joe met all QBP metrics except for IET-BH (Initiation), missing the benchmark by only .73%; however, the MDHHS results used to determine eligibility for QBP payment was not available in time for this report.

FY22 Identified Barriers

Frequent revisions to metric definition and handbook policies occurred throughout the year. Final guidance from MDHHS was not provided until fourth quarter of the fiscal year regarding metrics.

MDHHS notified PIHPs and CCBHCs about removing allowable billing codes from the IET metric during the last quarter of the year. This drove staffing levels as well as clinical pathways changes.

In addition, Integrated Services of Kalamazoo (ISK) changed EMRs at the end of FY22. The previous EMR was not able to easily pull various data for required metrics.





Improvement Efforts Made in FY22

The data subgroup and clinical subgroup ensured metrics were approached both from a clinical pathways perspective while also ensuring data and encounter information was captured correctly.

For example, due to staff with different credentials using different code sets, clarifying peer recovery roles and responsibilities led to greater accuracy in capturing the contacts and care patients were being given.

The PIHP established a regional report in Tableau to monitor the status of IET metric, which is a state reported QBP metric. State driven metrics are driven by WSA enrollment and this process was simplified without losing the integrity of the process.

FY22 Results

Goal	FY22	Eval Score	Recommendations	Time Estimate
The Quality Department will help track and perform data analysis on identified Quality Bonus Payment (QBP) metrics.	Met	4	Monthly tracking established and reviewed regularly at CCBHC subgroup meetings. Continue in FY23 and review at internal Senior Leader meetings as necessary.	 6-12 Mo.
Ensure that correct tracking mechanisms are in place to achieve pre-established benchmarks.	Met	4	Monthly tracking established and reviewed at least monthly at CCBHC subgroup meetings. Continue in FY23.	 6-12 Mo.
Ensure that identified CCBHC-reported metrics are submitted timely and via correct methods.	Met	4	Mid-year reporting submitted timely by both CCBHCs to PIHP. Continue in FY23.	 6-12 Mo.
Ensure correct forms and reporting methodologies are utilized.	Met	4	PIHP validation occurred for mid-year and annual CCBHC-metric reporting. Continue in FY23.	 6-12 Mo.

N. External Quality Monitoring and Audits

Description

The SWMBH Quality Department is responsible for the coordination, organization, submission, and responses related to all external audit requests. External auditing includes any requests from Michigan Department of Health and Human Services (MDHHS), Health Service Advisory Group (HSAG), Centers for Medicaid Services (CMS), and other organizations as identified by the SWMBH Board. Audit results are reviewed and shared with relevant SWMBH regional committees and the SWMBH Board. Regional and internal corrective action plans are established for reviews/audits that do not achieve specified benchmarks or established targets. The SWMBH Quality Department is responsible for working with all SWMBH functional areas to ensure corrective action plans are developed, reviewed, and submitted timely.

FY22 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
The 2022 Health Service Advisory Group (HSAG) External Quality Compliance Review, all Standards and Corrective Action Plans evaluated will receive a score of 90% or designation that the Standard has been “Met”.	All Functional Areas	Senior Leadership meetings and QMC	Quarterly
The 2022 Health Service Advisory Group (HSAG) Performance Measure Validation (PMV) audit will be passed with 90% of Measures evaluated receiving a score of “Met”.	IT and Quality	Regional Data Exchange Workgroup and QMC	Bi-Annual or as needed
SWMBH will submit the annual ‘Performance Bonus Incentive Program’ reports/narrative receiving no less than 90% of possible points available.	All Functional Areas	Senior Leadership and QMC	Quarterly
SWMBH will adhere to and achieve no less than 90% compliance score on the annual MDHHS SUD Administrative Monitoring Protocol Audit.	All Functional Areas	Senior Leadership and QMC	Quarterly





FY22 Identified Barriers

Some barriers that occurred in FY22 included inconsistent communication to SWMBH of CMS/MDHHS guideline/contractual requirements/changes, staff turnover at MDHHS, the PIHP, and CMHSP’s, and the volume of oversight audits and staff time to dedicate to them.

Improvement Efforts Made in FY22

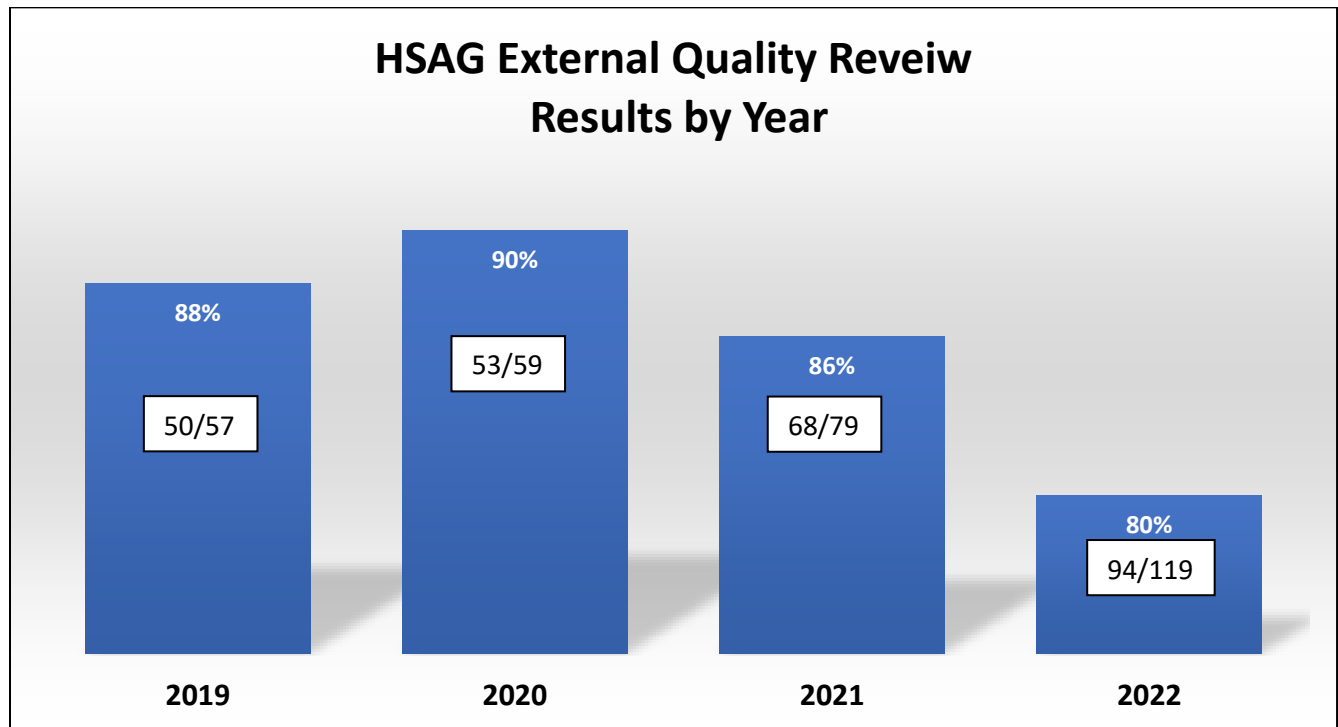
For any program areas requiring corrective action from audit completed in 2022, SWMBH conducted a review and analysis of the findings and submitted CAPs to bring the elements into compliance. CAPs were submitted within 30 days of receipt of the final report. For each element that required correction, SWMBH must identified interventions to achieve compliance. SWMBH created a new tracking system

FY22 Results

Metric	FY21	FY22	Eval Score	Recommendations	Time Estimate
The 2022 Health Service Advisory Group (HSAG) External Quality Compliance Review, all Standards and Corrective Action Plans evaluated will receive a score of 90% or designation that the Standard has been “Met”.	86%	80%	3	SWMBH should formulate a CAP/recommendation system, to track progress, timelines, and deliverables. The Quality Dept. will also review each CAP and Recommendation during relevant Regional Committee meetings and formulate work plans to meet compliance with identified CAPs and recommendations.	 1-3 Yr.
The 2022 Health Service Advisory Group (HSAG) Performance Measure Validation Audit will be passed with 90% of Measures evaluated receiving a score of “Met”.	98%	100%	5	This year’s audit was much improved and the recommendations from the previous year’s audit were fully implemented. SWMBH will continue to work to improve data quality and accuracy, by reviewing 7% of performance indicator samples during the annual site review process.	 3-6 Mo.
SWMBH will submit the annual ‘Performance Bonus Incentive Program’ reports/narrative receiving no less than 90% of possible points available.	91%	92.5%	4	SWMBH achieved the internal target of capturing 92.5% of available PBIP points this year. It is vital that SWMBH continues to cover each PBIP metric during Regional Committee meetings, so we can ensure full compliance in 2023. It is recommended that a schedule metric review dates/committee is formulated and shared. This will ensure SWMBH stays on target with deliverable and is quickly able to identify any barriers/negative data trends.	 0-3 Mo.
SWMBH will adhere to and achieve no less than 90% compliance score on the annual MDHHS SUD Administrative Monitoring Protocol Audit.	100%	100%	5	SWMBH achieved full compliance on the 2022 SUD Administrative audit during 2022. SWMBH should continue the SUD provider oversight practices and reviews during the annual on-site audits.	 6-12 Mo.

Health Service Advisory Group (HSAG) 2022 External Quality Review (EQR) Results

The graph below represents how SWMBH has scored over the past 4 years. It is also important to note, that the total number of standards/elements reviewed, have increased dramatically over the past 4 years. The numbers in each column, indicate the total number of elements evaluated for that year. Additionally, HSAG removed the “Partially Met” scoring designation in 2020, leaving only “Met” and “Not Met” as scoring designations.



2022 Summary of Findings

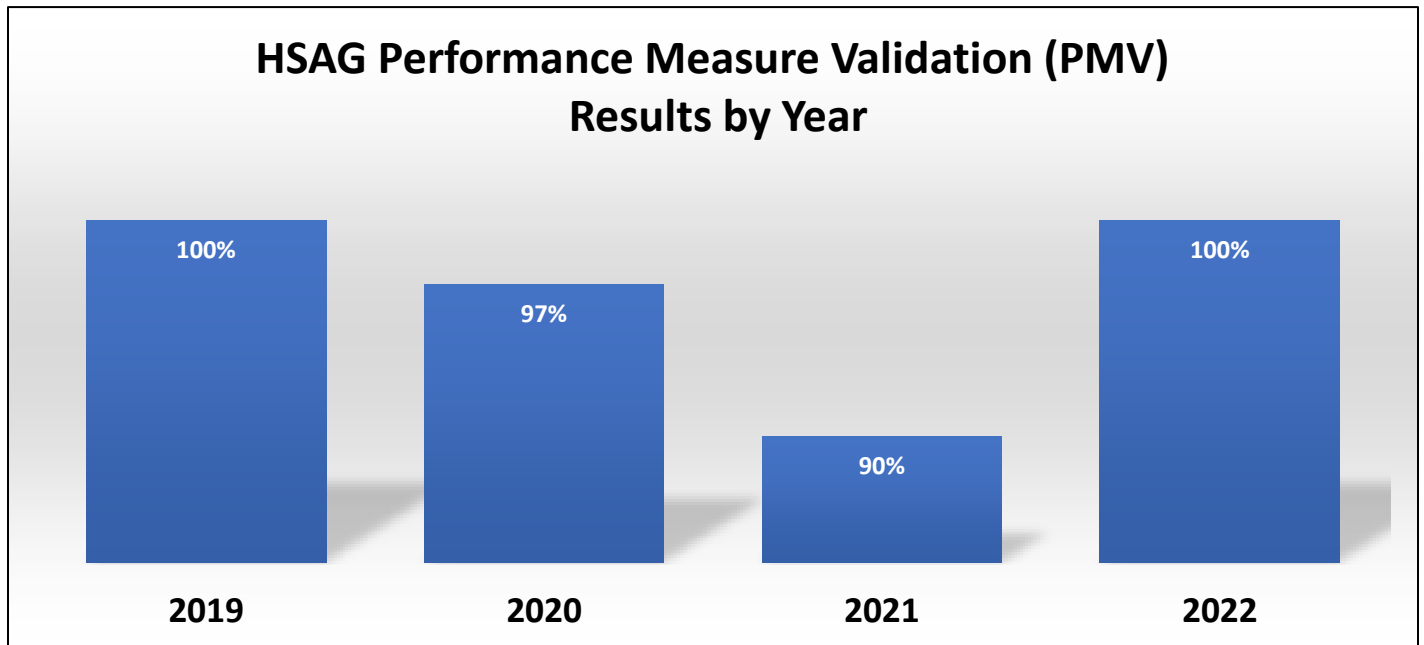
The table below represents an overview of the results of the SFY 2022 compliance review for Southwest Michigan Behavioral Health. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to Southwest Michigan Behavioral Health during the period covered by the review, HSAG used a *Not Applicable* (NA) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards. Refer to Appendix A for a detailed description of the findings.

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	NM	NA	
Standard VII—Provider Selection	16	16	12	4	0	75%
Standard VIII—Confidentiality ¹	11	11	10	1	0	91%
Standard IX—Grievance and Appeal Systems	38	38	33	5	0	87%
Standard X—Sub contractual Relationships and Delegation	5	5	5	0	0	100%
Standard XI—Practice Guidelines	7	7	5	2	0	71%
Standard XII—Health Information Systems	12	11	9	2	1	82%
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	20	10	0	67%
Total	119	118	94	24	1	80%

Southwest Michigan Behavioral Health achieved an overall compliance review score of 80 percent. Southwest Michigan Behavioral Health also achieved full compliance in one of the seven standards reviewed, demonstrating performance strengths and adherence to all requirements measured in the area of Sub contractual Relationships and Delegation. The remaining six standard(s) have identified opportunities for improvement. The area(s) with the greatest opportunity for improvement were related to Provider Selection, Grievance and Appeal Systems, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program, as these areas received performance scores below 90 percent. Detailed findings, including recommendations for program enhancements, are documented within the full report.

Health Service Advisory Group (HSAG) 2022 Performance Measure Validation (PMV) Audit

The graph below represents how SWMBH has scored over the past 4 years.



2022 Summary of Findings

The following section summarizes findings during the Health Services Advisory Group (HSAG) Performance Measure Validation Audit that took place on July 19, 2022, via Zoom at Southwest Michigan Behavioral Health. The primary goal of the audit is to evaluate; data control, data integration, data validation, encounter submission accuracy, BH TEDs validation, data accuracy, performance indicator accuracy and other methods of data exchange.

In FY21 39 elements were evaluated for compliance and in FY22 that went down to 37 elements, due to 2 performance indicators being removed from the audit tool.

Scoring Category	Performance Results
Accepted	3/3 – 100% Data Integration, Data Control and Performance Indicator Documentation Elements Evaluated were <i>“Accepted”</i> and met full compliance standards.
Reportable	12/12 – 100% of Performance Indicators Evaluated were <i>“Reportable”</i> and compliant with the State’s specifications and the percentage reported.
Met	13/13 – 100% Data Integration and Control Elements Evaluated <i>“Met”</i> full compliance standards.
Met	9/9 – 100% Numerator and Denominator Elements Evaluated <i>“Met”</i> full compliance standards.
37/37 or 100% Of Total Elements Evaluated received a designation score of <i>“Met”, “Reportable”, or “Accepted”</i> .	

Strengths

Southwest Michigan continued to diligently work with the CMHSPs on ensuring state-indicated benchmarks were being met. Southwest Michigan was providing timely reporting to the CMHSPs to ensure they were aware of their progress in meeting State thresholds. The PIHP’s CAPs helped document and institute direction to improve rates with individual CMHSPs. Southwest Michigan had also taken additional strides to better report BH-TEDS data. The PIHP directly deployed additional validation checks within their system to strengthen the completeness of the data being entered. All BH TEDS standards for Mental Health, Substance Use Disorder and Crisis have climbed over the 97% match rate, exceeding the MDHHS benchmark of 95%. Some of the additional checks were to create “stops” if a required field was not populated and provide additional drop-down designations in required fields to help create continuity in reporting. These additional checks were above and beyond the already 1,300 validation checks that were being done previously through automated validation. SWMBH has also improved the Performance Indicator data validation process, adding additional sample reviews and security protocols, locking the data after it has been loaded to the portal for submission.

MDHHS 2022 Substance Use Disorder Administrative Audit

26/26 SUD Standards Evaluated Received a Score of Full Compliance.

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	<p>Copies of policies and procedures</p> <p>Monitoring tool</p> <p>Copies of reports findings</p> <p>Evidence of making reports available to public</p>	<ul style="list-style-type: none"> ✓ SWMBH_2.13_Provider_Network_Monitoring ✓ SUD administrative review tools ✓ SUD Clinical Review tools ✓ Site Review Reports ✓ Website screen shot of available reports ✓ SWMBH Newsletter 	26/26 = Full Compliance	No findings. Reports are made completed and made public

2022 Performance Bonus Incentive Program (PBIP)

PBIP Description

The Performance Bonus Incentive Program is a set of key performance metrics, formulated by MDHHS for PIHP's as contract deliverables. PIHP's that are successful in achieving the established key performance metric benchmarks are eligible to earn funds set aside in the Bonus pool. The eligible bonus pool funds are equal to .75% of the PIHP annual negotiated contract with MDHHS. If some PIHP's are unsuccessful in achieving the established key performance metric benchmarks the PIHP's that have successfully achieved the metric benchmarks are eligible to capture those additional unclaimed funds. The PBIP metrics and benchmarks are established on an annual basis in consultation with PIHP representatives.

Summary of Results

Measure	Deliverables	Results										
<p>P.1. PA 107 of 2013 Sec. 105d (18): Identification of beneficiaries who may be eligible for services through the Veteran's Administration (25 points).</p> <p>The State acknowledges that not all Veterans interacted with by the Veteran Navigator and on the VSN will have a CMHSP contact and thus will not have a BH-TEDS file.</p>	<p>a. Due January 2022:</p> <ul style="list-style-type: none">a resubmission of October 1 through March 31 of FY21 comparison of the total number of individual veterans reported on BHTEDS and the VSN form.submission of April 1 through September 30 of FY21 comparison of the total number of individual veterans reported on BHTEDS and the VSN form.Narrative comparison of the above time periods, identifying any areas needing improvement and actions to be taken to improve data quality. <p>. b. The contractor must compare the total number of individual veterans reported on BHTEDS and the VSN during the October 1 through March 31 of FY22 and conduct a comparison. By July 1, the Contractor must submit a 1-2-page narrative report on findings and any actions taken to improve data quality. Timely submission constitutes metric achievement number of</p>	<div><p>METRIC ACHIEVED</p><table><tr><th></th><th>TOTAL WITHHOLD AMOUNT</th><th>TOTAL WITHHOLD UNEARNED AMOUNT</th><th>AVAILABLE POINTS</th><th>POINTS EARNED</th></tr><tr><td>P.1 Identification of beneficiaries who may be eligible for services through the Veteran's Administration.</td><td>\$263,706.41</td><td>\$0</td><td>25</td><td>25</td></tr></table><p>NARRATIVE REVIEW:</p><p>Report fulfills stated purpose; however, does not give specific/detailed information/results of data comparisons done between BHTEDS & Veteran Navigator Report. SWMBH continues very strong completion rates of these fields in BHTEDS.</p></div>		TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED	P.1 Identification of beneficiaries who may be eligible for services through the Veteran's Administration.	\$263,706.41	\$0	25	25
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P.2. PA 107 of 2013 Sec. 105d (18): Increased data sharing with other providers (25 points)	For multi-county PIHPs, two or more CMHSPs within a Contractor's service area, or the Contractor, will be submitting Admission Discharge and Transfer (ADT) messages to the Michigan Health Information Network (MiHIN) Electronic Data Interchange (EDI) Pipeline daily by the end of FY22. By July 31, the Contractor must submit, to the State, a report no longer than two pages listing CMHSPs sending ADT messages, and barriers for those who are not, along with remediation efforts and plans. In the event that MiHIN cannot accept or process Contractor's ADT submissions this will not constitute failure on Contractor's part.	<div>METRIC ACHIEVED</div> <table><thead><tr><th></th><th>TOTAL WITHHOLD AMOUNT</th><th>TOTAL WITHHOLD UNEARNED AMOUNT</th><th>AVAILABLE POINTS</th><th>POINTS EARNED</th></tr></thead><tbody><tr><td>P.2 Increased data sharing with other providers.</td><td>\$263,706.41</td><td>\$0</td><td>25</td><td>25</td></tr><tr><td colspan="5">NARRATIVE REVIEW:</td></tr><tr><td colspan="5">SWMBH reported that St. Joe, Barry and Calhoun CMHSPs implemented outbound ADTs by end of FY 2021. MDHHS looks forward to an update on ADT implementation news for Van Buren, Kalamazoo, Berrien, Cass and Branch County CMHSPs in the FY23 narrative.</td></tr></tbody></table>		TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED	P.2 Increased data sharing with other providers.	\$263,706.41	\$0	25	25	NARRATIVE REVIEW:					SWMBH reported that St. Joe, Barry and Calhoun CMHSPs implemented outbound ADTs by end of FY 2021. MDHHS looks forward to an update on ADT implementation news for Van Buren, Kalamazoo, Berrien, Cass and Branch County CMHSPs in the FY23 narrative.				
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P.3. Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence (50 points)	<div>1. The points will be awarded based on contractor participation in IET measure data validation work with MDHHS. Contractor will submit an IET data validation response file by March 31 in accordance with instruction provided by MDHHS.</div> <div>Note: The State recognizes the Contractor does not have a full data set for analyses.</div>	<div>METRIC ACHIEVED</div> <table><thead><tr><th></th><th>TOTAL WITHHOLD AMOUNT</th><th>TOTAL WITHHOLD UNEARNED AMOUNT</th><th>AVAILABLE POINTS</th><th>POINTS EARNED</th></tr></thead><tbody><tr><td>P.3 Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence.</td><td>\$527,412.83</td><td>\$0</td><td>50</td><td>50</td></tr></tbody></table>		TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED	P.3 Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence.	\$527,412.83	\$0	50	50										
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P.3 Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence.	\$527,412.83	\$0	50	50																		

Measure	Deliverables	Results										
P.4. PA 107 of 2013 Sec. 105d (18): Increased participation in patient-centered medical homes (20% of total withhold)	<p>The Contractor must submit a narrative report of no more than 10 pages by November 15th summarizing prior FY efforts, activities, and achievements of the Contractor (and component CMHSPs if applicable) to increase participation in patient-centered medical homes. The specific information to be addressed in the narrative is below:</p> <ol style="list-style-type: none">1. Comprehensive Care2. Patient-Centered3. Coordinated Care4. Accessible Services5. Quality & Safety	<div>METRIC ACHIEVED</div> <table><thead><tr><th></th><th>TOTAL WITHHOLD AMOUNT</th><th>TOTAL WITHHOLD UNEARNED AMOUNT</th><th>AVAILABLE POINTS</th><th>POINT EARNED</th></tr></thead><tbody><tr><td>P.4 Increased participation in patient-centered medical homes.</td><td>\$586,014.25</td><td>\$0</td><td>100</td><td>100</td></tr></tbody></table> <p>NARRATIVE REVIEW:</p> <p>The idea of a Narcan vending machine is a great resource to avoid overdose death. The CCM program is beneficial when customers can work 1 on 1 with a nurse to navigate physical and behavioral health issues. It is promising to see that BCCMHA partners with other medical providers, local courts and law enforcement, schools, and other human service providers to coordinate post-hospital aftercare. The 100% hospital follow-up care is amazing. MDHHS likes that Riverwood meets consumers in the most convenient manner via 'remote' or telehealth and same day appointments.</p>		TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINT EARNED	P.4 Increased participation in patient-centered medical homes.	\$586,014.25	\$0	100	100
	TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINT EARNED								
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MHP/Contractor Joint Metrics

Joint Metrics for the Integration of Behavioral Health and Physical Health Services

To ensure collaboration and integration between Medicaid Health Plans (MHPs) and the Contractor, the State has developed the following joint expectations for both entities. There are 100 points possible for this initiative. The reporting process for these metrics is identified in the grid below. Care coordination activities are to be conducted in accordance with applicable State and federal privacy rules.

Category	Deliverables	Results																																																			
J.1. Implementation of Joint Care Management Processes (35 points)	Each MHP and Contractor will continue to document joint care plans in CC360 for beneficiaries with appropriate severity/risk, who have been identified as receiving services from both entities. Risk stratification criteria is determined in writing by the Contractor-MHP Collaboration Work Group in consultation with the State.	<div>METRIC ACHIEVED</div> <table><tr><th></th><th>TOTAL WITHHOLD AMOUNT</th><th>TOTAL WITHHOLD UNEARNED AMOUNT</th><th>AVAILABLE POINTS</th><th>POINTS EARNED</th></tr><tr><td>J.1 Implementation of Joint Care Management Processes.</td><td>\$246,125.98</td><td>\$0</td><td>35</td><td>35</td></tr></table>		TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED	J.1 Implementation of Joint Care Management Processes.	\$246,125.98	\$0	35	35																																									
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J.1 Implementation of Joint Care Management Processes.	\$246,125.98	\$0	35	35																																																	
J.2 Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days using HEDIS descriptions (40 points)	<p>1. The Contractor must meet set standards for follow-up within 30 Days for each rate (ages 6-17 and ages 18 and older. The Contractor will be measured against an adult minimum standard of 58% and a child minimum standard of 70%. Measurement period will be calendar year 2021.</p> <p>2. Data will be stratified by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2020 with Calendar year 2021.</p>	<div>METRIC ACHIEVED</div> <table><tr><th colspan="2"></th><th>TOTAL WITHHOLD AMOUNT</th><th>TOTAL WITHHOLD UNEARNED AMOUNT</th><th>AVAILABLE POINTS</th><th>POINTS EARNED</th></tr><tr><td colspan="2">J.2.1 Follow-up after Hospitalization (FUH) within 30 days.</td><td>\$140,643.42</td><td>\$17,580.43</td><td>20</td><td>17.5</td></tr><tr><th>AGES</th><th>STANDARD</th><th>AET</th><th>BCC</th><th>HAR</th><th>MCL</th><th>MER</th><th>HAP MID</th><th>MOL</th><th>PRI</th><th>THC</th><th>UNI</th><th>UPP</th></tr><tr><td>6-20</td><td>70%</td><td>N/S</td><td>N/S</td><td>N/S</td><td>N/S</td><td>85</td><td>N/S</td><td>N/S</td><td>N/S</td><td>N/S</td><td>91</td><td>N/S</td></tr><tr><td>20-64</td><td>58%</td><td>69</td><td>N/S</td><td>N/S</td><td>71</td><td>73</td><td>N/S</td><td>53</td><td>62</td><td>N/S</td><td>69</td><td>N/S</td></tr></table>			TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED	J.2.1 Follow-up after Hospitalization (FUH) within 30 days.		\$140,643.42	\$17,580.43	20	17.5	AGES	STANDARD	AET	BCC	HAR	MCL	MER	HAP MID	MOL	PRI	THC	UNI	UPP	6-20	70%	N/S	N/S	N/S	N/S	85	N/S	N/S	N/S	N/S	91	N/S	20-64	58%	69	N/S	N/S	71	73	N/S	53	62	N/S	69	N/S
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Category	Deliverables	Results				
	<p>The points will be awarded based on MHP/Contractor combination performance measure rates.</p> <p>The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given entity.</p> <p>See MDHHS BHDDA reporting requirement website for measure specifications (query, eligible population, and additional details) and health equity scoring methodology, at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html</p>		TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
		J.2. 2 Follow-up after Hospitalization (FUH) within 30 days stratified by race/ethnicity.	\$140,643.42	\$0	20	20
		<p>J.2.1 – Medicaid Health Plan FUH-30-day combination metric</p> <ul style="list-style-type: none">Targets: 70% Child and 58% Adult:SWMBH missed one combination metric with Molina (53%) or 2.50pts.				

J3. Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (25 points)	<p>1. The Contractor must meet set standards for follow-up within 30 Days. The Contractor will be measured against a minimum standard of 27%. Measurement period will be calendar year 2021.</p> <p>2. Data will be stratified by the State by race/ethnicity and provided to plans. The Contractor will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2020 with calendar year 2021.</p> <p>The points will be awarded based on MHP/Contractor combination performance measure rates.</p> <p>The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given entity.</p> <p>See MDHHS BHDDA reporting requirement website for measure specifications (query, eligible population, and additional details) and health equity scoring methodology, at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html</p>	<p>METRIC ACHIEVED</p>				
			TOTAL WITHHOLD AMOUNT	TOTAL WITHHOLD UNEARNED AMOUNT	AVAILABLE POINTS	POINTS EARNED
	J.3 Follow-up after (FUA) Emergency Department visit for Alcohol and Other Drug Dependency within 30 days stratified by race/ethnicity.	\$175,804.28	\$39,067.62	25	19.44	

		<p>J.3. Follow-up after (FUA) 30-days Stratified by race/ethnicity</p> <ul style="list-style-type: none">SWMBH missed this metric, by not showing improvement over our 2020 baseline Black/White disparity index in comparison to 2021. The next round will be a comparison between 21-22.SWMBH will likely not see improvement in this PIP metric until the remeasurement/validation period in 2023, which is considered the “intervention” period.				
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Summary of Interventions in Key PBIP Areas:

Comprehensive Care

Complex Case Management Progress

SWMBH's Integrated Care Team (ICT) facilitates monthly meetings including staff from SWMBH, Medicaid Health Plan (MHP), Community Mental Health (CMH) and primary care physician (PCP) staff participating in care coordination with a shared goal of person-centered planning toward improved health outcomes. A SWMBH Integrated Care Specialist runs the risk stratification list utilizing Care Connect 360 for each MHP two weeks prior to the ICT meeting date. Targeted outcomes are reduction of chronic conditions and reduction of ED visits. Members are prioritized based on high emergency room (ER) use and high IP admissions, non-emergent ED use, SPMI diagnoses, and recent behavioral health and physical health claims. Meeting facilitation identifies members' needs and any barriers to meeting those needs; potential action items to address barriers are discussed. Participating stakeholders collaborate to provide behavioral health and medical updates in adherence to SWMBH, Michigan Mental Health Code and 42CFR, Part 2, protected health information guidelines. Identified members are tracked in ICT meetings until stable for 3 months (e.g., no chronic ED or IP visits), active and/or stable with behavioral care or discharged from behavioral health treatment.

Patient-Centered Care

In October of 2020, SWMBH implemented the Opioid Health Home (OHH) project in two of the largest counties in the region - Calhoun and Kalamazoo. Necessary patient-centered care through three Opioid Health Home locations have been provided throughout this time. Nurse Care Managers, peer recovery coaches and community health workers are an integral part of the Opioid Health Home care team who provide comprehensive care management, care coordination, health promotion, transitional care, individual and family support, and referrals to community services. During FY 22, OHH enrollment averaged about 352 customers each month, 525 unique customers received services, and almost 8,000 OHH services were provided.

Coordination of Care

SWMBH staff have access to the SWMBH Medical Director, Dr. Bangalore Ramesh, a psychiatrist for member-specific consultation via phone and ad hoc meetings at any time. Members brought for discussion with Dr. Ramesh are typically diagnosed with SPMI and multiple chronic physical health conditions and usually have a recent history of inpatient psychiatric admission with very difficult to treat symptomology. After reviewing diagnoses, presenting behaviors, and treatment history, Dr. Ramesh can provide consultation on viable next steps for the member's treatment regimen. Difficult cases or members with complex needs are brought to Dr. Ramesh for consultation.

Relias Population Health

SWMBH utilizes Relias's Population Performance platform to monitor behavioral and physical health status of members served, using Care Connect360 Medicaid service data. Population Performance contains reports measuring inpatient and emergency department utilization, medication adherence, prescribing trends, and Healthcare Effectiveness Data and Information Set (HEDIS) metrics. It can also identify individuals at risk for high inpatient and ED utilization, based on service history and chronic

conditions. SWMBH has added HEDIS metrics related to the Michigan CCBHC demonstration, and is developing care manager caseload monitoring capacities, so that care managers can view the comprehensive health status of their member population and identify individuals in need of individual outreach or support. SWMBH and CMH leadership can use Population Performance to identify regional and local population health trends, and drive decision-making for regional clinical initiatives.

Accessibility of Services

Complex Case Management (CCM) 's overall goal 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 Registered Nurse helps 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 various comorbid 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.

Complex Case Management aims to help organize and coordinate services for members with complex physical and behavioral health conditions. A SWMBH RN works through physical and behavioral health obstacles or barriers with members on a 1:1 basis. The RN helps the member navigate confusing multiple service pathways and secure 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.

Members identified for enrollment in CCM are contacted via phone to schedule a time to talk with the RN (via telephone or in-person) and learn about the CCM program. In addition, 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.

N. Cultural Competency

Description

The SWMBH Cultural Competency program is geared toward reducing service disparities that are inextricably linked to cultural issues and to ensure that all individuals have access to, and availability of, mental health and substance abuse services, to convey SWMBH's commitment to cultural and linguistic competency, and to outline the ways this commitment will be carried out. It is the official position of SWMBH that cultural diversity and cultural competency are prized assets and sources of great enrichment for staff, providers, and consumers alike and as such they should be celebrated, eagerly explored, and viewed in highly positive terms.

As part of SWMBH's Cultural Competency Plan, an annual Network Adequacy analysis is completed which ensures Network Adequacy standards are being achieved in the region related to cultural competency, provider availability, and access to services. The current Network Adequacy Plan evaluates the following categories, as required by MDHHS guidance: Enrollee to Provider Ratios, Assertive Community Treatment (ACT), Psychosocial Rehabilitation, Pediatric Enrollee Ratios, Home and Community Based Ratios, Wraparound by County, Crisis Residential, Time and Distance Analysis, SUD Treatment Organizations and Providers, Timely Appointments, Languages Spoken, Cultural Competence and Provider Trainings.

SWMBH and the Provider Network have demonstrated commitment to linguistic and cultural competence that ensures access and meaningful participation for all consumers who reside in the service area. Such commitment includes but is not limited to acceptance and respect for all cultural values, beliefs, and practices within the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

FY22 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH annually evaluates demographic data of Network and individuals served through the Network Adequacy Plan/Review.	Provider Network	SWMBH Cultural Competency Committee	Quarterly
Utilize data from Consumer Satisfaction Surveys and other sources of Consumer feedback to promote a Cultural Competency workforce and programs.	Quality Management and Member Services	SWMBH Cultural Competency Committee	Quarterly
Implement a Staff/Provider Survey to gauge Organizational level of Cultural Competence.	Human Resources	SWMBH Cultural Competency Committee	Quarterly
Promote continued education throughout SWMBH and community, by participating in local events.	Member Services	SWMBH Cultural Competency Committee	Quarterly
SWMBH actively recruits workforce of diverse backgrounds through the candidate selection process.	Human Resources	SWMBH Cultural Competency Committee	Quarterly

Network Adequacy Analysis

Time and Distance Analysis

MDHHS has specified minimum time and distance expectations for enrollees to access certain services. The Quest Analytics network adequacy software suite was used to calculate the average time and distance for SWMBH enrollees to access different types of providers. Quest Analytics classifies locations into rural, urban, or frontier based on zip code. MDHHS time and distance standards appropriate to enrollees' zip codes are applied when assessing time and distance. SWMBH's region contains both urban and rural zip codes.

For the majority of the services assessed, over 98% of SWMBH enrollees live within the time and distance standards set by MDHHS. There were two exceptions. 95.2% of adult enrollees live within the time and distance standards for Psychosocial Rehabilitation (Clubhouse). And 39.9% of child enrollees live within the standard time and distance for Crisis Residential services.

Adult Time and Distance Standards

Service	MDHHS Frontier Standard	MDHHS Rural Standard	MDHHS Urban Standard	SWMBH Enrollees: Percent with Access	SWMBH Enrollees: Average Distance to Closest Provider, Urban and Rural Zips
Assertive Community Treatment (ACT)	90 minutes/90 miles	60 minutes/ 60 miles	30 minutes/ 30 miles	100.0%	9.5 miles 10.6 mins
Psychosocial Rehabilitation (Clubhouse)	90 minutes/ 90 miles	60 minutes/ 60 miles	30 minutes/ 30 miles	95.2%	24.3 miles 27.2 mins
Opioid Treatment Programs	90 minutes/ 90 miles	60 minutes/ 60 miles	30 minutes/ 30 miles	100.0%	12.9 miles 14.7 mins
Crisis Residential	90 minutes/ 90 miles	60 minutes/ 60 miles	30 minutes/ 30 miles	98.2%	27.7 miles 33.5 mins
Inpatient Psychiatric	150 minutes/ 125 miles	90 minutes/ 60 miles	30 minutes/ 30 miles	100.0%	11.5 miles 12.8 mins

Pediatric Time and Distance Standards

Service	MDHHS Frontier Standard	MDHHS Rural Standard	MDHHS Urban Standard	SWMBH Enrollees: Percent with Access	SWMBH Enrollees: Average Distance to Closest Provider, Urban and Rural Zips
Home-based	90 minutes/ 90 miles	60 minutes/ 60 miles	30 minutes/ 30 miles	100%	8.6 miles 9.6 mins
Wraparound	90 minutes/ 90 miles	60 minutes/ 60 miles	30 minutes/ 30 miles	100%	8.6 miles 9.6 mins
Crisis Residential	90 minutes/ 90 miles	60 minutes/ 60 miles	30 minutes/ 30 miles	39.9%	60.4 miles 83.4 mins
Inpatient Psychiatric	330 minutes/ 355 miles	120 minutes/ 125 miles	60 minutes/ 60 miles	100%	11.9 miles 13.2 mins

Opportunities for Improvement

SWMBH recognizes the contracted adolescent/pediatric crisis residential providers are not within the Pediatric Time and Distance Standards and only 39.9% of SWMBH enrollees have access. On January 15, 2021, a local in-Region Provider closed their adolescent Crisis Residential program, which left a gap in SWMBH's services for a short time. SWMBH secured contracts with Beacon Home at Sandhurst in Lansing, MI and Samuel's House, part of Hope Network, in Grand Rapids, MI. These locations are both outside of SWMBH's region, however, have filled the service gap of adolescent crisis residential services. SWMBH already had an active adolescent crisis residential contract with Safe House, located in Warren MI, which is also outside of SWMBH's region.

Timely Appointments

SWMBH currently tracks timely appointments in accordance with MMBPIS Indicator 3: "Percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children)." Delay in the delivery of necessary services and supports may lead to exacerbation of symptoms and distress and poorer role functioning and disengagement from the system. The timely start of on-going services is critical to the engagement process, connecting the consumer to services and supports while the person is motivated towards treatment. The following table shares some overall figures for SWMBH's Region for Quarter 2 and 3 of 2022 as MMBPIS data for Q4 of 2022 and beyond hasn't been reported yet.

On-going Covered Service Timeliness Following Biopsychosocial Assessment

<i>MMBPIS Indicator #</i>	<i>MMBPIS Performance Indicator</i>	<i>State Standard</i>	<i>Q2 2022</i>	<i>Q3 2022</i>
<i>3a</i>	<i>First Service MI Adults</i>	<i>n/a</i>	65.41%	55.64%
<i>3b</i>	<i>First Service MI Children</i>	<i>n/a</i>	65.68%	62.06%
<i>3c</i>	<i>First Service IDD Adults</i>	<i>n/a</i>	57.55%	50.39%
<i>3d</i>	<i>First Service IDD Children</i>	<i>n/a</i>	80.00%	60.78%

Opportunities for Improvement

MDHHS stated in a meeting the week of December 5, 2022, that they plan to release the benchmarks in June 2023, which will then be effective for Fiscal Year 2024. SWMBH's Quality Department also confirmed it's in SWMBH's Board End Metrics to increase the overall percentages for these MMBPIS Indicators. The SWMBH Quality Department will continue to work through Regional Committees and Sub-workgroups to ensure the Regional improvement of this timeliness to service metric. Further analysis and reports on this metric and other performance indicators are kept in the SWMBH Tableau Data Analytics platform.

Languages Spoken

Languages spoken are gathered through the Region's credentialing process. According to SWMBH's Provider Directory, we do have a provider that speaks Hindi as well as Portuguese. SWMBH added an updated data collection form in the Individual Practitioner Credentialing Packet in 2021, which included the following statement:

"Please fill this out as it applies to you and/or your practice. These answers help our organization understand our network better to ensure we are meeting all the needs of our members."

When discussed at SWMBH's Regional Provider Network Management Committee Meeting on December 16, 2022, it was determined that this form should also be attached in the Organizational Credentialing Application as well in order for the Organization to report any additional languages spoken by staff members at their agency.

In addition to collecting the data, it will be SWMBH's responsibility to update the information in the Region's Provider Directory located on SWMBH's Website – www.swmbh.org under the "Find a Provider" tab on the Members Page – upon receipt from CMHSPs or directly from providers of any updates to languages spoken.

Regional Provider Language Analysis

Overall, about 2.80% of the clinicians in the SWMBH region speak Spanish. SWMBH provides translation services for all services. At least one local Spanish translator gets very positive reviews both from staff and customers. SWMBH assessed customer complaints regarding lack of accessible language preferences. There were no complaints regarding the Medicaid Business Line translation service for during the 2022 evaluation period.

County	County Population % Spanish Speaking	# Spanish Speaking Clinicians	% Spanish Speaking Clinicians	# Spanish Speaking Clinicians	% Spanish Speaking Clinicians
Barry	1.2%	0	0%	0	0%
Berrien	3.8%	0	0%	0	0%
Branch	3.0%	0	0%	0	0%
Calhoun	3.0%	0	0%	0	0%
Cass	1.8%	0	0%	0	0%
Kalamazoo	2.8%	5	3.7%	3	3.0%
St Joseph	6.1%	0	0%	0	0%
Van Buren	8.1%	1	6.7%	0	0%
Outside Region 4	~	2	8.7%	2	8.7%
SWMBH (including non- CMH-affiliated providers)	3.5%	8	2.8%	5	2.5%

The racial/ethnic makeup of the SWMBH region is primarily White (83.88%), with persons of Black or African American backgrounds (9.96%) and Hispanic/Latino ethnicity (5.82%) being the second and third most prevalent. This data has not changed much since 2020. SWMBH's provider network appears to, again, underrepresent the region's Black and Hispanic/Latino populations; Black personnel comprise 5.3% of the SWMBH provider network, while Hispanic or Latino personnel comprise 0.7% of it, when referencing the FULL Network: 2022 Data Chart. Black/African American personnel only comprise of 3% in the AVAILABLE Network for 2022. Keeping in mind 52.8% (which is down 2.1% from 2021) of SWMBH's practitioners did not report their own race/ethnicity, it was determined that it was difficult to assess whether or not the network requires any adjustments in this area.

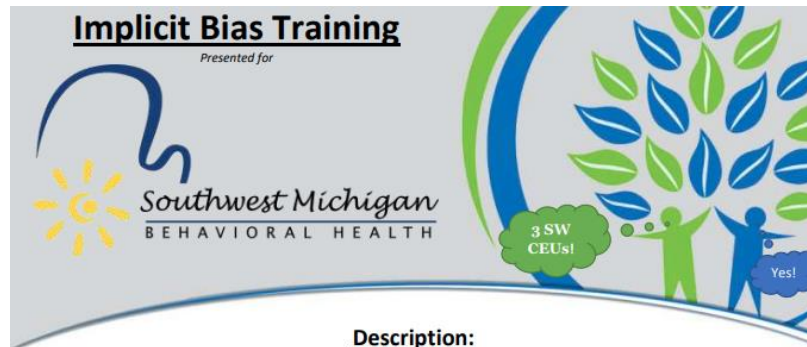
Opportunities for Improvement

SWMBH recognizes that over half of the FULL Network of practitioner's report "Other" or simply do not report their own Race/Ethnicity. This data is something SWMBH has been attempting to capture for two years now and would like to see more practitioners participate in answering this question either at Initial Credentialing, recredentialing or during the annual Network Adequacy Survey. SWMBH believes capturing more of the Practitioner Race/Ethnicity data will assist the Provider Network Department on ensuring SWMBH's Member's needs are being met in this capacity.

SWMBH would like to be able to present those Provider options to the member; however, currently, it is hard to do so with only half of the Practitioners reporting this data. SWMBH has also discussed the opportunity to offer Practitioners a training on Cultural Competency. This process has been added to the annual provider credentialing and cultural trainings.

Cultural Competence

SWMBH requires all provider's staff that are in-network to have cultural competency and Implicit Bias training and reviews this item as part of the Staff Training File Review in the annual site review process.



Description:

Implicit bias is described as prejudices that unknowingly influence thinking and reaction to events and information. Implicit Bias negatively impacts the way people are treated by health professionals and the structural inequities in healthcare can be detrimental for people of color and other members of marginalized communities including those we support through MORC. As MORC is committed to being the best and maximizing potential for those we support it is essential for us to engage in this inclusive experience and engaging learning experience. This three hour live/online instructor-led Implicit Bias Training includes large group discussions, interactive breakout rooms, challenging videos, and self-assessments. This training has been approved for 3 hours of Social Work CEUs.

Learning Outcomes:

1. **Explain the meaning of Implicit Bias.** This will include a complete understanding of the historical basis and present basis of implicit bias based on an individual's characteristics.
2. **Recognize its impact on one's work.** This will include your recognition of serving a diverse population and barriers and disparities in their access to and delivery of health care services.
3. **Execute the steps to remedy Implicit Bias.** This will include an ability to identify and implement effective strategies to alleviate the negative impact of implicit bias by recognizing how it impacts perception, judgement, and actions.

SWMBH Cultural Competency Workgroup

SWMBH established a Cultural Competency Plan, which is formulated and reviewed on an annual basis by the SWMBH Cultural Competency Workgroup. The Workgroup was established in 2020 and creates the business practices and goals for both personnel and Individuals serviced. The following represent the 2022 strategies and workplan:

Personnel

Business Practice – to promote Competency	Source	Outcome
A. SWMBH actively recruits workforce of diverse backgrounds through the candidate selection process.	<ul style="list-style-type: none"> • SWMBH Position Descriptions • SWMBH Policy 3.7 – Cultural and Linguistic Competency 	To promote a workforce that is reflective of the community and individuals served.

	<ul style="list-style-type: none"> • SWMBH Policy 4.7 – Competitive Employment • Network Adequacy Analysis – Population Race/Ethnicity Analysis 	
B. SWMBH hiring process includes utilization of “Guidelines to Explore Diversity in Job Interview” to determine an interviewees experience/willingness to support diversity and cultural competence as a SWMBH employee	<ul style="list-style-type: none"> • SWMBH Position Descriptions • SWMBH Policy 3.7 – Cultural and Linguistic Competency • SWMBH Policy 4.7 – Competitive Employment 	To promote hiring of staff who embrace cultural competency as a work ethic.
C. SWMBH utilizes non-discrimination statements in all hiring and contracting searches.	<ul style="list-style-type: none"> • 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 the community/individuals served.
D. SWMBH Personnel/Providers are required to follow training guidelines related to Cultural Competence and all other required topics of training. Monitored process to occur annually.	<ul style="list-style-type: none"> • SWMBH Policy 3.7 – Cultural and Linguistic Competency • SWMBH Cultural Competency and Diversity Training (Power Point Presentation) • SWMBH Cultural Competency and Diversity Attestation Form • Network Adequacy Analysis – Population Race/Ethnicity Analysis 	SWMBH promotes workforce education in working with diverse populations. Spanish is the most prevalent non-English language spoken in the SWMBH 8-county region. According to the American Community Survey Aggregate Data, 2020 ACS 5-Year Estimates Subject Table, 2.9% of the population in the SWMBH region in 2019 are native Spanish speakers. 1.75% speak Arabic and .489% speak Chinese (including Mandarin, Cantonese), the next two most common languages
E. SWMBH reviews <i>Essential Functions</i> of each employee.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • ROSC Community Collaboration Meeting Minutes. • Network Adequacy Analysis – Population Race/Ethnicity Analysis 	Based on needs, is a community-wide partnership to address/discuss Cultural issues and barriers to care.
H. SWMBH annually/internally evaluates demographic data of network and individuals served through the Network Adequacy review (Attached on pg. 7-8).	<ul style="list-style-type: none"> • SWMBH Employee Satisfaction Surveys • SWMBH Policy 3.7 – Cultural Competency • SWMBH Policy 2.12 – Network Adequacy • SWMBH Policy 2.7 – Communication to Providers 	Evaluation performed to identify if SWMBH workforce continues to be reflective of demographics of community/individuals served.



Individuals Served

Business Practice – to promote Competency	Source	Outcome
I. SWMBH encourages customers to identify their need for language support services via the use of “I Speak” tools at service sites or via telephone contacts.	<ul style="list-style-type: none"> • SWMBH Policy 6.5 Limited English Proficiency • SWMBH Network Adequacy Plan 	When customers can identify their primary language, SWMBH can direct supports necessary to provide support and services.
J. SWMBH provides no-cost interpretation and translation as necessary for vital documents, during appointments, and telephone contacts.	<ul style="list-style-type: none"> • SWMBH Policy 4.3 – Authorization and Outlier Management 	To engage in services, SWMBH offers free language assistance to customers and individuals seeking services.
K. Via the Person-Centered Planning process, SWMBH (and all contracted providers) encourages discussion of the importance of issues such as: culturally sensitive needs, gender or age specific needs, economic issues, spiritual needs/beliefs, and/or issues related to sexuality identity/orientation – in all treatment planning.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • SWMBH 2020 Customer Satisfaction Survey Analysis and Results • SWMBH 2020 Grievance and Appeal Data Analysis • SWMBH 2020 QAPI Evaluation of Services 	SWMBH can modify printed materials as language thresholds change and can target workforce training needs to new community needs.
N. SWMBH educational materials are written in simple language and	<ul style="list-style-type: none"> • SWMBH Customer Handbook 	Community members and customers will have access to

provided in preferred languages to customers.	<ul style="list-style-type: none"> SWMBH UM Policy 	information in commonly used languages. Vital documents are translated in to Spanish.
O. Customer access to Grievance and Appeal processes is aided by translated documents, assistance to all customers, and available interpretation at all steps. Customers can identify Authorized Representatives to represent them.	<ul style="list-style-type: none"> SWMBH Policy 2.14 – Grievance and Appeals Network Adequacy Assessment of cultural, ethnic, racial and linguistic needs 	Customers will have processes explained to them in preferred language and have access to language support to represent themselves while SWMBH addresses their complaint(s).

SWMBH Cultural Compliance Workgroup Charter

The SWMBH Cultural Competency Workgroup (CCW) is a workgroup of the Southwest Michigan Affiliation PIHP. The workgroup consists of individuals from the PIHP and community stakeholders and is designed to provide guidance to the PIHP as it attempts to improve the cultural and linguistic competencies of the provider network and service delivery system. The workgroup is one method of participant communication, alignment, and advice to SWMBH. The workgroup tasks are determined by the SWMBH EO. Each workgroup 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 workgroup is to provide their expertise as subject matter experts. These aspects as well as the membership criteria and responsibilities are provided in the SWMBH Cultural Compliance Workgroup Charter below:

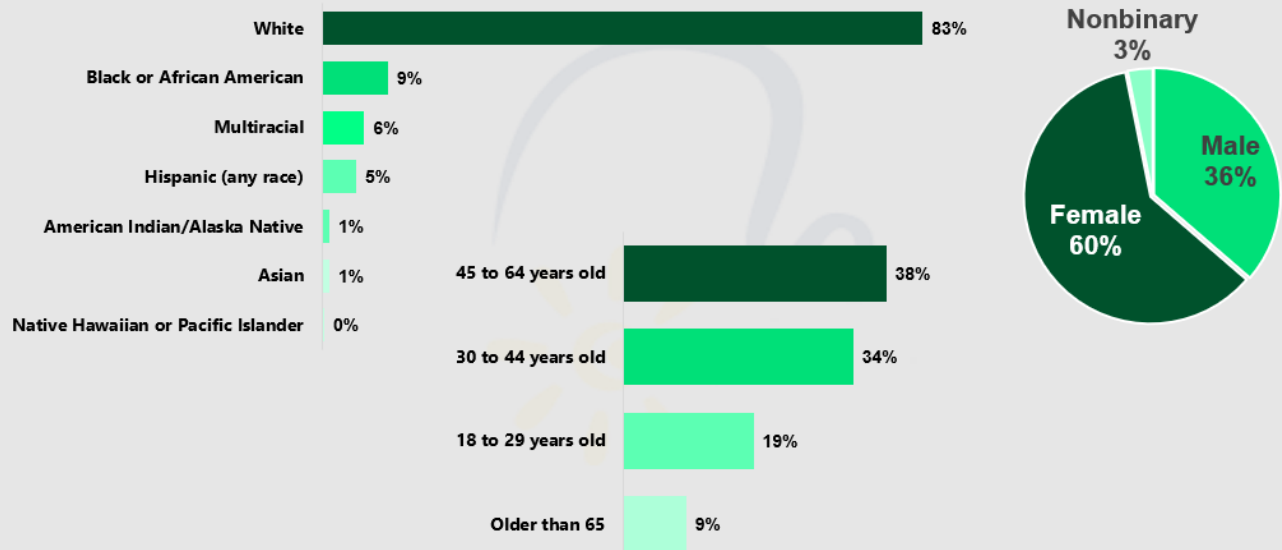
 <p>SWMBH Committee: SWMBH Cultural Competency Workgroup Duration: On-Going Deliverable Specific: Charter Effective Date: 12/11/2022</p> <p>Approved By:  Signature: _____ Charter Review Date: 6/11/2024 Next Charter Review Date: 6/11/2024</p>		<p>Workgroup meeting:</p> <ul style="list-style-type: none"> The Workgroup may decide to re-order the agenda or address an emergent issue at the discretion of the Workgroup Chair. Meeting notes are prepared and distributed within ten (10) working days after the conclusion of the meeting. <p>Membership:</p> <p>The Workgroup appoints their participant membership from SWMBH and the SWMBH Provider Network to serve as delegates in with all issues and analysis of Cultural and Linguistic Competency. A Workgroup Chair is selected to facilitate and run the workgroup meetings in accordance with SWMBH policy.</p> <ul style="list-style-type: none"> Members of the workgroup will act as conduits and liaisons to share information decided on in the workgroup. This includes keeping relevant staff and local committees informed and abreast of Cultural and Linguistic analysis/information and recommendations. Members are representing the regional needs related to Cultural Competency. It is expected that members will share information and concerns with SWMBH staff. As conducted it is expected that workgroup members attend and are engaged in issues, as well as bringing challenges from their site to the attention of the SWMBH workgroup for possible project creation and/or assistance. <p>Membership shall include appointed participant CMH representation, practitioners from the SWMBH provider network, and a member of the SWMBH Customer Advisory Committee with lived experience and SWMBH staff as appropriate.</p> <p>Member Responsibilities:</p> <ul style="list-style-type: none"> Arranges schedule to attend scheduled committee meetings Prepares for and proactively participates in committee meetings and activities Serves as a catalyst for change and support with the member's area of responsibility Actively offers insight and perspective to support and improve the implementation of SWMBH proposals, goals and initiatives Completes assignments in a timely manner Takes lead to gather local CMH partner input to represent the local healthcare system at committee meetings Takes lead to provide committee updates to their local agency leadership team and other staff impacted by committee decisions and outcomes <p>Decision Making Process:</p> <p>The workgroup will strive to reach decisions based on a consensus model through research, discussion, and deliberation.</p> <p>When consensus cannot be reached a formal voting process will be used. The workgroup can also vote to refer the issue to the SWMBH Senior Leaders or another committee. Referral elsewhere does not preclude SWMBH from making a determination and taking action. Voting is completed through formal workgroup members a super majority will carry the motion.</p>	<p>Deliverables:</p> <ul style="list-style-type: none"> Annual Review of SWMBH Cultural Competency and Linguistic Plan and Policy Provide Quarterly Status Reports to the SWMBH Senior Leaders Recommendations for improvement on analysis of Cultural Competency outcomes <p>The Workgroup will support SWMBH Staff in the development of:</p> <ul style="list-style-type: none"> QAPI Evaluation QAPI Annual Work plan LMH Annual Work plan <p>Attachment 1: Cultural Competency Workgroup Membership</p> <table border="1"> <thead> <tr> <th>Membership Name</th> <th>Organization/Group</th> <th>Type of member (Ad hoc, standing, voting, advisory)</th> </tr> </thead> <tbody> <tr> <td>Acklee Jelle (Workgroup Chair)</td> <td>SWMBH</td> <td>Standing</td> </tr> <tr> <td>Jae Smith</td> <td>SWMBH</td> <td>Standing</td> </tr> <tr> <td>Ben Seizinger</td> <td>SWMBH</td> <td>Standing</td> </tr> <tr> <td>John Xian</td> <td>SWMBH</td> <td>Standing</td> </tr> <tr> <td>Jessica Gordon</td> <td>SWMBH</td> <td>Standing</td> </tr> <tr> <td>Elizabeth Whitaker</td> <td>SWMBH</td> <td>Standing</td> </tr> </tbody> </table>	Membership Name	Organization/Group	Type of member (Ad hoc, standing, voting, advisory)	Acklee Jelle (Workgroup Chair)	SWMBH	Standing	Jae Smith	SWMBH	Standing	Ben Seizinger	SWMBH	Standing	John Xian	SWMBH	Standing	Jessica Gordon	SWMBH	Standing	Elizabeth Whitaker	SWMBH	Standing
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Cultural Competency Analysis 2022 Survey Demographic

During the Annual Consumer Satisfaction Survey Process, SWMBH completes an analysis of responsiveness. This helps SWMBH identify what percentage of each demographic population is receiving services, as well as other factors identified in the analysis below. SWMBH uses this information to target services, programs and implement interventions to decrease disparities amongst minority groups.

MHSIP 2022 respondents similar in makeup to prior years

This year saw slightly less minority respondents and slightly more male respondents.



Respondent Comparison by Year (Adult Survey)

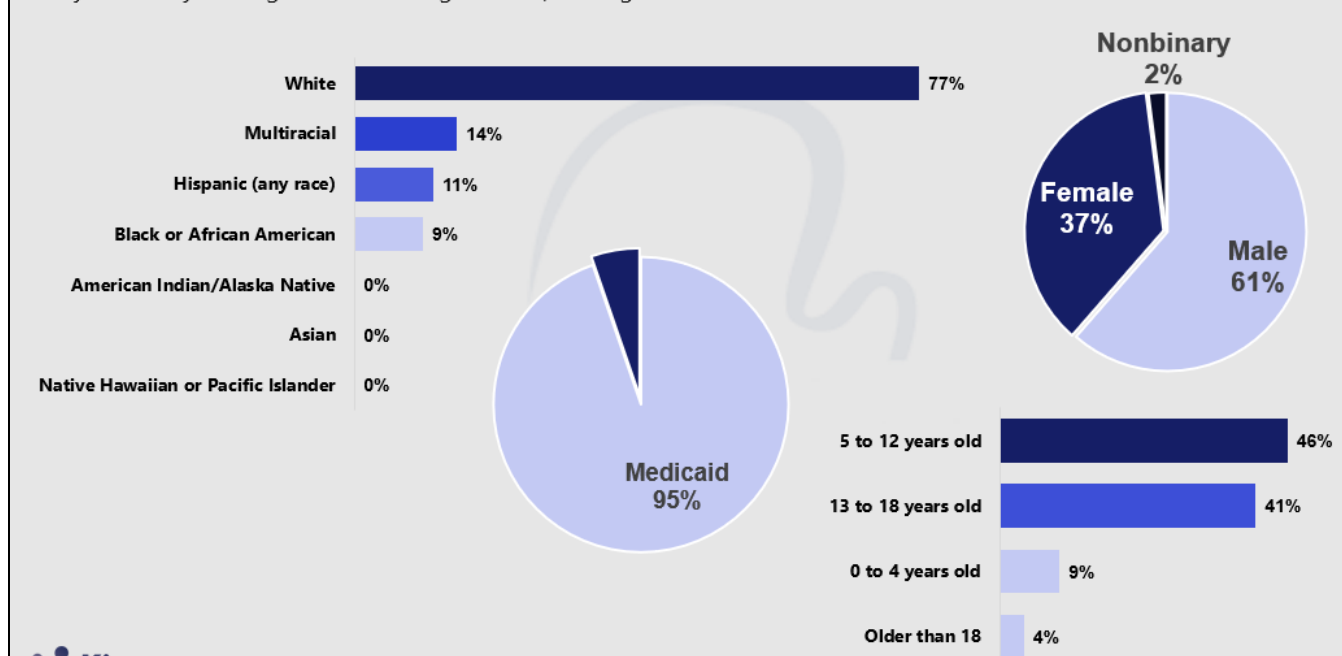
Respondent Groups	2021 Respondent Rate	2022 Respondent Rate	% Difference by Year
White	73%	83%	-10%
Black/Afr. American	12%	9%	-3%
Multicultural	4%	1%	-3%
Hispanic	9%	5%	-4%
Amer Indian/Alaska Native	1%	1%	0
Asian	1%	1%	0

Observations

During the 2022 survey process, the biggest difference in respondents for the 'Adult Survey' was with the White population response rate, coming in 10% lower than the previous year. The Black/African American rate dropped slightly at 3%, which was the same result for the Multicultural group at 3%. Further analysis will be completed to determine why response rates dropped within those response groups. This will also be discussed during Quality and Cultural workgroups throughout 2023.

YSS 2022 youth reported less racial diversity

Many more boys than girls are receiving services, with age 5-12 most common



Respondent Comparison by Year (Youth Survey)

Respondent Groups	2021 Respondent Rate	2022 Respondent Rate	% Difference by Year
White	79%	77%	-2%
Black/Afr. American	7%	9%	+2%
Multicultural	6%	14%	+8%
Hispanic	8%	11%	+3%
Amer Indian/Alaska Native	0%	0%	0
Asian	0%	0%	0

Observations

During the 2022 survey process, the biggest difference in respondents in the 'Youth Survey' was with the Multicultural group, showing an increase of 8% over the previous year. It is also important to note, that the Black/African American respondent group observed a 2% increase in response rates over the previous year and the Hispanic response group observed a 3% increase over the previous year. Further analysis will be completed to determine why response rates dropped within those response groups. This will also be discussed during Quality and Cultural workgroups throughout 2023.

Member Services Outreach Programs – Promoting Cultural Diversity within Communities Served

During 2022, the SWMBH Member Services Department participates in a variety of Community sponsored events throughout the Region, to promote programs, services and bring education to culturally diverse groups. Some of the activities that took place during the 2022 evaluation period include:

- Participated in Mental Health and Wellness Expo
- Wellness and Recovery Festival
- Walk A Mile Mental Health Summit
- Trunk or Treat for Great Lakes Autism Center
- Growlers baseball games to promote Substance Use Disorder, Prevention, Gambling, and Veteran Navigator programs.
- Participated in several Stand Down and Project Connect events throughout October

Identified Barriers

Some identified barriers during this evaluation period included:






- Difficulty in obtaining data/survey responses from some minority groups.
- Difficulty for the Cultural Compliance Workgroup to meet as frequently as needed and maintain participants.
- Difficulty to obtain Consumer input/guidance on some aspects of the Regional Cultural Competency efforts.
- Time restraints for SWMBH staff to be able to attend all Community events they would like to.
- Expenses and staff time associated with conducting Consumer and Staff surveys on an annual basis.

Improvement Efforts Made in FY22

Some identified improvement efforts during the evaluation period included:

- Editing the satisfaction survey tool, to include additional cultural demographic questions, that will help target improvement efforts with those minority groups.
- Offered more staff/provider collaborative activities to encourage networking and improve cultural awareness within the workplace.
- Offered more frequent and additional access to provider cultural and implicit bias trainings.
- Increased scope and efforts for collecting provider cultural background information during the credentialing application process, which translates to our online provider panel.

FY22 Results

Goal	FY21	FY22	Eval Score	Recommendations	Time Estimate
SWMBH annually evaluates demographic data of Network and individuals served through the Network Adequacy Plan/Review.	See data analysis	See data analysis	4	Although work on the 2023 Network Adequacy Plan is still being completed. It will be important to include further analysis and Regional plans to attract a culturally diverse array of providers. This will also include expanded provider cultural workforce training/education.	 6-12 Mo.
Utilize data from Consumer Satisfaction Surveys and other sources of Consumer feedback to promote a Cultural Competency workforce and programs.	See data analysis	See data analysis	4	Continue to complete analysis on consumer satisfaction demographic and cultural group response rates. Determine how to better target identified groups with low response rates and target groups that have been identified as part of Performance Improvement Projects (PIPs).	 3-6 Mo.
Implement a Staff/Provider Survey to gauge Organizational level of Cultural Competence.	73%	88%	3	SWMBH is always striving to improve internal and external cultural competence. Although staff cultural survey scores have improved (15%) over the previous year's result, SWMBH should continue to enhance staff/provider cultural education programs to improve overall consumer experiences. SWMBH also conducts a bi-annual Provider cultural survey, which is now recommended to be conducted on an annual basis.	 6-12 Mo.
Promote continued education throughout SWMBH and community, by participating in local events.	5 events	6 events	4	Although SWMBH continues to increase its community presence in local events, it is recommended that SWMBH improve media campaigns to target all demographics and cultural groups. This will help improve awareness and access to services/programs for underserved minority groups.	 3-6 Mo.
SWMBH actively recruits workforce of diverse backgrounds through the candidate selection process.	Compliant	Compliant	5	SWMBH has strong non-discriminatory practices/protocols and policy. The SWMBH workforce is representative of a diverse cultural and minority mix of professionals. SWMBH is in the process of improving the provider panel process, to ensure cultural and demographic information is available for each provider in the network.	 6-12 Mo.

FY 2022 Board Ends Metrics Summary Report

This document serves to summarize the achievement status of the Board Approved Metrics for completion in FY 2022 (*October 1, 2021, through September 30, 2022*).

- Current Ends Metrics Status: **16 of 19** achieved – **84.2%**
- 11 Metrics Roll Over to 2023 for approval
(Please see detailed outcomes and status for each metric)

SWMBH will achieve 225 enrollees for the Opioid Health Homes Program (OHH) during year 1 of implementation.	Metric Achieved A. 344 Enrollees in the OHH Program as of 9/17/21 B. <u>300</u> has been established as the OHH program retention value.	Board Presentation and Approval on January 14, 2022	1 point earned
2021 Health Service Advisory Group (HSAG) External Quality Compliance Review. All standards and corrective action plan evaluated will receive a score of 90% or designation that the standard has been "Met."	Not Completed Successfully <ul style="list-style-type: none"> ▪ FY 21 – 86% (56/65) ▪ FY 20 – 90.6% *SWMBH tied for 1 st of all (10) PIHP's for highest score.	Board Presentation and Approval on April 8, 2022	(Rollover metric) November 2021 Board Meeting presentation
2021 HSAG Performance Measure Validation Audit Passed with (95% of Measures evaluated receiving a score of "Met")	Not Completed Successfully 2021 Results: 34/38 (89.4%) of measures evaluated achieved full compliance.	Board Presentation and Approval on November 10, 2021	(Rollover metric) November 2021 Board Meeting presentation
Implementation of the "ASAM Continuum SUD Standardized Assessment Instrument" for FY21 by 10/1/2021 Per MDHHS Contract	Metric Achieved A. SWMBH has trained 154/166 (92.8%) clinicians to date. The trainings started the last week of July and concluded the second week on September. B. Streamline installed the ASAM Continuum interface into the production environment on 9/27/21.	Board Presentation and Approval on February 11, 2022	1 pt. earned

	<p>Project is on schedule to be completed and live by 10/1/21.</p> <p>C. Automated processes for analyzing the ASAM data/results/reports are being developed and scheduled for completion by 2/11/21.</p>		
Each quarter, at least 53% of parents and/or caregivers of youth and young adults receiving Applied Behavior Analysis (ABA) for Autism will receive Family Behavior Guidance. This service supports families in implementing procedures to teach new skills and reduce challenging behaviors.	<p>Metric Achieved</p> <ul style="list-style-type: none"> Q1: 60.5% (207/342) Q2: 59.7% (212/355) Q3: 58.2% (217/373) Q4: 54.7% (201/368) Ave. 58.27% 	Board Presentation and Approval on August 12, 2022	1 pt. earned
24/28 or 85% of Michigan Mission Based Performance Indicators achieve the State indicated benchmark for 4 consecutive quarters for FY 21.	<p>Metric Achieved</p> <p>Measurement Period Concludes on 12/30/21. Final Consultative Draft from MDHHS will be received by November/December 2021</p> <p>Q1: 6/7 Q2: 7/7 Q3: 7/7 Q4: 7/7</p> <p>27/28 Indicators 'Met' the Indicated benchmark – 96.4%</p>	Board Presentation and Approval on January 10, 2022	1 pt. earned
SWMBH will meet and exceed the Behavioral Health Treatment Episode Data Set (BH TEDS) compliance benchmarks established by MDHHS for FY21.	<p>Metric Achieved</p> <p>Status as of 9/27/21:</p> <ul style="list-style-type: none"> MH: 96.18% SUD: 98.45% Crisis: 97.68 	Board Presentation and Approval on January 14, 2022	1 pt. earned
SWMBH will achieve 90% of the available CY20-21 monetary bonus award to achieve (<i>contractually specified</i>) quality withhold performance measures, agreed upon by the Integrated Care Organizations (ICO's).	<p>Metric Achieved</p> <p>2020-2021 Rates:</p> <ul style="list-style-type: none"> Meridian: 100% Aetna 90% 	Board Presentation and Approval on February 11, 2022	1 pt. earned

Achieve 95% of Veteran's Metric Performance-Based Incentive Program monetary award based on MDHHS specifications.	<p>Metric Achieved</p> <p>Notice provided by MDHHS on 1/19/2022</p> <p>*VSN Data has been submitted and received through the DCH file transfer successfully.</p> <p>*Data Quality Narrative Report send and received by MDHHS on 7/1/21.</p> <p>Final PBIP Results received in January 2022</p>	Board Presentation and Approval on March 4, 2022	1 pt. earned
Achieve 95% of Increased Data Sharing Performance Bonus Incentive Program (PBIP) monetary award based on MDHHS specifications.	<p>Metric Achieved</p> <ul style="list-style-type: none"> ✓ ISK has successfully demonstrated the ability to submit ADT messages through the MIHIN pipeline. ✓ ADT Narrative report was submitted and received by MDHHS on 7/31.21. <p>Final PBIP Results received in January 2022</p>	Board Presentation and Approval on March 4, 2022	1 pt. earned
SWMBH will submit a qualitative narrative report to MDHHS receiving no less than 90% of possible points; by November 15, 2021, summarizing prior FY efforts, activities, and achievement of the PIHP and CMHSPs, specific to the identified areas.	<p>Metric Achieved</p> <p>SWMBH received full credit (40 points) or 100% on the submitted qualitative narrative report, as reflected on final results report delivered from MDHHS (Total amount earned: \$2,187,915.69)</p>	Board Presentation and Approval on April 8, 2022	1 pt. earned
Achieve 95% of possible points on collaboration between entities for the ongoing coordination and integration of services for shared MHL consumers.	<p>Metric Achieved</p> <p>The final MDHHS – PBIP report indicated that; SWMBH received 35/35 points or 100% satisfying elements A and B</p> <p>This metric is largely based on combination calculations between the MHP and PIHP in CC360.</p>	Board Presentation and Approval on March 8, 2022	1 pt. earned

Achieve Compliance on Follow-up After Hospitalization for Mental Illness within 30 days (FUH) and show a reduction in disparity with one minority group.	Metric Achieved Current SWMBH Rates: <ul style="list-style-type: none"> Adult: 68.13% Child: 77.51% 	Board Presentation and Approval on January 14, 2022	1 pt. earned
Regional Habilitation Supports (HSW) Waiver slots are full at 98% throughout the year. (10/1/21 – 9/30/22)	Metric Achieved 99.7% of HSW slots have been filed in FY 21, per the MDHHS status report. *SWMBH has been the best performing PIHP in the State for 4 consecutive years. SWMBH Maintains 610 Regional Slots.	Board Presentation and Approval on October 14, 2022	1pt. earned
2021 Customer Satisfaction Surveys collected by SWMBH are at or above the 2020 results for the identified categories.	Partially Achieved The Annual Satisfaction Survey Project was completed on 2/5/2022. <ul style="list-style-type: none"> The MHSIP (adult) ‘<i>Improved Functioning</i>’ category observed an improvement of +1.77% (86.87%) over the previous year’s result (85.1%). <i>1pt</i> The YSS (youth) ‘<i>Improved Outcomes</i>’ category observed a decrease of -4.05% (77.25%) under the previous year’s result (81.30%). Complete a study exploring other survey distribution methods and automation of results collection (focus groups) process. 1pt 	Board Presentation and Approval on March 8, 2022	2/3 possible points achieved
2022 HSAG Performance Measure Validation Audit Passed with (90% of Measures evaluated receiving a score of "Met")	Metric Achieved Draft report received on 8/27/22 2022 Results: 37/37 (100%) of measures evaluated achieved full compliance	Board Presentation and Approval on October 14, 2022	1 pt. earned

85% of Michigan Mission Based Performance Indicators achieve the State indicated benchmark for 4 consecutive quarters for FY 22.	Metric Achieved Measurement Period Concludes on 12/30/22. Final values represent data presented in the Final MDHHS Consultative Draft Report 26/28 or 92.8% of Indicators met the MDHHS indicated benchmarks. Q1: 7/7 Q2: 6/7 Q3: 6/7 Q4: 7/7 Indicator 3 FY21 Baseline Values: (%) value represents metric goal. <table><tr><td></td><td><u>SWMBH</u></td><td><u>PIHP Ave.</u></td></tr><tr><td>A.</td><td>65% (56%)</td><td>74%</td></tr><tr><td>B.</td><td>66% (61%)</td><td>73%</td></tr><tr><td>C.</td><td>74% (69%)</td><td>82%</td></tr><tr><td>D.</td><td>75% (68%)</td><td>79%</td></tr></table> +6.5% improvement from FY21 baseline to current FY22 results.		<u>SWMBH</u>	<u>PIHP Ave.</u>	A.	65% (56%)	74%	B.	66% (61%)	73%	C.	74% (69%)	82%	D.	75% (68%)	79%	Board Presentation and Approval on January 13, 2023	1 pt. earned
	<u>SWMBH</u>	<u>PIHP Ave.</u>																
A.	65% (56%)	74%																
B.	66% (61%)	73%																
C.	74% (69%)	82%																
D.	75% (68%)	79%																



Southwest Michigan Behavioral Health Board Meeting Friday, April 14th, 2023

Carl Doerschler, AIF®, CPFA, CMFC
Doerschler & Associates Wealth Management, LLC
carl@doerschlerandassociates.com
269-744-4180

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Doerschler & Associates Wealth Management, LLC
jill@doerschlerandassociates.com
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Overview

Service Providers:

- Vendor: Nationwide
- Administrator: Beene Garter
- Financial Advisors: Carl Doerschler and Jill Ingersoll at Doerschler & Associates Wealth Management, LLC
- Sponsored Retirement Plans:
 - 457(b) Deferred Compensation Plan
 - Employee Elective Deferrals
 - 401(a) Retirement Savings Plan
 - Employer Match
 - 401(a) Social Security Alternative
 - Social Security Alternative Contributions

Services Provided to SWMBH:

- Semi-Annual scheduled Fiduciary Review Meetings
- Co-Fiduciary 3(21) Advisory Services
- Consult with Investment Committee
- Prepare and maintain Investment Policy Statements (IPS)
- Recommend specific investments for each plan
- Prepare Investment Performance Reports
- Provide participant advice including enrollments and education
- Provide plan benchmarking analysis
- Assist with plan design consultation
- One-on-one education with each employee to discuss account contribution rates and investments
- Personal one-on-one enrollments for new employees

Statistics / Demographics

457(b) Plan

- Plan Balance as of 3/31/2023: \$2,583,551.71
- 2022 Average Rate of Return per Participant: (16.70%)
- Average annualized compounded growth rate per participant over the previous 6 years was 6.93%
- There are 67 participants eligible to participate. All 67 are participating for a 100% participation rate.

401(a) Plan – Employer Match

- Plan Balance as of 3/31/2023: \$2,385,698.33
- 2022 Average Rate of Return per Participant: (15.91%)
- Average annualized compounded growth rate per participant over the previous 6 years was 6.98%
- There are 67 participants eligible for the employer match, and all 67 are receiving the employer match.
- Employer match is \$1 for \$1 up to 5%

401(a) Plan - Social Security Alternative

- Plan Balance as of 3/31/2023: \$3,046,353.34
- 2022 Average Rate of Return per Participant: (17.27%)
- Average annualized compounded growth rate per participant over the previous 6 years was 6.02%
- There are 67 participants eligible to participate. 52 participants are contributing for a 78% participation rate.

Best Interest Practice Management



BEST INTEREST
CONTRACT RULE.



NO KNOWN CONFLICTS
OF INTEREST.



NO REVENUE SHARING
ARRANGEMENTS, SUCH
AS 12B-1, SUB-TA,
COMMISSIONS, OR
LOADS OR SALES
CHARGES.



DIVERSIFIED LINE-UP OF
INVESTMENTS.



BROAD RANGE OF
INVESTMENT OFFERINGS
INCLUDING VANGUARD
TARGET DATE FUNDS.



ALL INVESTMENTS MEET
OR EXCEED THE
STANDARDS SET FORTH
IN THE INVESTMENT
POLICY STATEMENTS
(IPS).



NO INVESTMENTS ON
THE "WATCH-LIST".

Historical Fee Benchmarking

- For 2019, the estimated cost savings for all three retirement plans was approximately \$10,800. This is based on \$4,000,284.95 in total plan assets with a 0.27% cost savings.
- For 2020, the estimated cost savings for all three retirement plans was approximately \$17,821. This is based on \$5,940,402.87 in total plan assets with a 0.30% cost savings.
- For 2021, the estimated cost savings for all three retirement plans was approximately \$22,679. This is based on \$7,315,949.26 in total plan assets with a 0.31% cost savings.
- For 2022, the estimated cost savings for all three retirement plans was approximately \$50,549. This is based on \$7,020,687.12 in total plan assets with a 0.72% cost savings.

	Nationwide (Inception - 2018)	Nationwide Prior 2019	Nationwide Prior 2020	Nationwide Prior 2021	Nationwide Current 2022
<u>Vendor Costs</u>					
Asset Based Fee	0.64%	0.47%	0.47%	0.47%	0.26%
<u>Weighted Average Expense Ratio</u>	<u>0.28%</u>	<u>0.28%</u>	<u>0.25%</u>	<u>0.24%</u>	<u>0.14%</u>
Total Vendor/Fund Annual Cost	0.92%	0.75%	0.72%	0.71%	0.40%
Financial Advisor Annual Fee	0.50%	0.40%	0.40%	0.40%	0.30%
Total (all-in) Fees	1.42%	1.15%	1.12%	1.11%	0.70%
Beene Garter TPA Costs:					
Conversion Fee	N/A	N/A	N/A	N/A	N/A
Document Fee	N/A - Attorney Drafted	N/A - Attorney Drafted	N/A - Attorney Drafted	N/A - Attorney Drafted	N/A - Attorney Drafted
Annual Administrative Fees	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500
	\$10 / participant	\$15 / participant	\$15 /participant	\$15 / participant	\$15 / participant



Questions and Answers



Michigan Consortium for Healthcare Excellence

**Executive Officer Board Report
April 14, 2023**

(1)

MCHE Activity

Ongoing Work Groups

- **Reciprocity: Direct Care Worker Training (all PIHPs)**
- **Reciprocity: Provider Reviews and Audits (all PIHPs)**
- **Statewide implementation of MCG Utilization Management solution (9 PIHPs)**



New Developments

- Joint contracting with TBD Solutions for a catalogue of known national, statewide and regional public behavioral health system performance measures and sources for purposes of enhancing PIHP collection and reporting of credible system performance reports
- Joint contracting with Wakely a Health Management Associates Actuarial firm for purposes of performing an objective review of MDHHS and Milliman Medicaid rate setting practices

Why Collaborate?

- Enhance public policy influence via collective consensus views and advocacy with executive branch
- Enhance collective and individual relations with Advocacy groups and individuals
- Share scarce resources
- Share operational and performance information for quality improvement and benchmarking
- Reduce provider burdens and provider administrative costs
- Reduce PIHP administrative costs
- Identify and pursue system opportunities

HSAG EQR 2021 – 2022 Compliance Review

HSAG calculated the Michigan Behavioral Health Managed Care program overall performance in each of the 13 performance standards reviewed during the current three-year compliance review cycle. Table 5-4 compares the statewide average compliance score with the compliance score achieved by each PIHP for the standards reviewed in SFY 2021 and SFY 2022. **Green font** is used to denote the highest-performing PIHP(s), while **red font** is used to denote the lowest-performing PIHP(s). For Standard II, since all PIHPs performed the same, no red or green font is shown.

Table 5-1—PIHP and Statewide Compliance Review Scores for SFYs 2021 and 2022

Standard ^{1, 2}	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	Statewide
I	84%	84%	89%	84%	84%	84%	84%	89%	84%	79%	85%
II ³	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
III	71%	100%	71%	86%	71%	71%	86%	71%	100%	86%	81%
IV	25%	50%	50%	25%	25%	25%	0%	50%	25%	25%	30%
V	93%	100%	79%	86%	93%	79%	79%	93%	79%	86%	86%
VI	82%	64%	73%	100%	91%	82%	64%	82%	73%	73%	78%
SFY 2021 Total	83%	86%	82%	86%	85%	80%	77%	86%	82%	80%	83%
VII	75%	75%	81%	75%	75%	75%	75%	75%	75%	75%	76%
VIII ³	100%	91%	82%	91%	91%	91%	91%	91%	82%	91%	90%
IX	79%	84%	87%	87%	84%	76%	84%	84%	89%	87%	84%
X	80%	80%	60%	100%	100%	80%	80%	40%	20%	100%	74%
XI	86%	57%	86%	71%	100%	86%	86%	100%	57%	100%	83%
XII ⁴	82%	82%	82%	82%	92%	82%	82%	82%	73%	82%	82%
XIII	90%	70%	87%	67%	93%	73%	83%	93%	67%	90%	81%
SFY 2022 Total	84%	78%	84%	80%	88%	78%	83%	85%	75%	87%	82%
Combined Total	84%	81%	83%	82%	87%	79%	81%	85%	77%	85%	82%

Standard I—Member Rights and Member Information
Standard II—Emergency and Poststabilization Services
Standard III—Availability of Services
Standard IV—Assurances of Adequate Capacity and Services
Standard V—Coordination and Continuity of Care
Standard VI—Coverage and Authorization of Services

Standard VII—Provider Selection
Standard VIII—Confidentiality
Standard IX—Grievance and Appeal Systems
Standard X—Subcontractual Relationships and Delegation
Standard XI—Practice Guidelines
Standard XII—Health Information Systems
Standard XIII—Quality Assessment and Performance Improvement Program

	Highest-performing PIHP(s) in each program area.
	Lowest-performing PIHP(s) in each program area.

The following table uses the same data to display a ranked comparison between all PIHPs for 2021, 2022, and their final combined scores. **Green font** is used to denote scores of 85% and above, while **yellow font** denotes scores of 80% - 84%, and **red font** is used to denote 79% and lower.

2021 Ranking	Region	2021 Total	2022 Ranking	Region	2022 Total	2021-2022 Combined Total Ranking	Region	Combined Total
1 st Place	Region 2	86%	1 st Place	Region 5	88%	1 st Place	Region 5	87%
1 st Place	Region 4	86%	2 nd Place	Region 10	87%	2 nd Place	Region 10	85%
1 st Place	Region 8	86%	3 rd Place	Region 8	85%	2 nd Place	Region 8	85%
2 nd Place	Region 5	85%	4 th Place	Region 1	84%	3 rd Place	Region 1	84%
3 rd Place	Region 1	83%	4 th Place	Region 3	84%	4 th Place	Region 3	83%
4 th Place	Region 3	82%	5 th Place	Region 7	83%	5 th Place	Region 4	82%
4 th Place	Region 9	82%	6 th Place	Region 4	80%	6 th Place	Region 2	81%
5 th Place	Region 6	80%	7 th Place	Region 2	78%	6 th Place	Region 7	81%
5 th Place	Region 10	80%	7 th Place	Region 6	78%	7 th Place	Region 6	79%
6 th Place	Region 7	77%	8 th Place	Region 9	75%	8 th Place	Region 9	77%



SWMBH Utilization Management Plan 2023

Board Education

2/10/2023

Purpose of Utilization Management Program

- SWMBH is required to assure Uniformity of:
 - Benefit
 - Adequate timely access to services
 - Application of functional assessments, evidence-based practices and medical necessity criteria.
 - UM decision-making that includes eligibility criteria, medical necessity criteria and level of care guidelines that is intended to drive positive outcomes for consumers.



Authority & Structure

- Utilization Management Program under the direction and approval of the SWMBH Medical Director
 - Reviews and approves the UM Plan on an annual basis
- Regional Utilization Management Committee
 - Provides input to the regional UM Plan and Policies and Level of Care Guidelines
 - Ensures services are provided by qualified staff
 - Develops, reviews and acts upon utilization data and reports.
 - Reviews data related to service utilization to improve population health



Access

Beneficiaries can access services through any of the following means:

- Telephone screening or walk-in during business hours to a CMHSP.
- Requesting substance use services from SWMBH during business hours or after- hours crisis or access line.
- ER's, mobile crisis units or urgent care centers
- Requesting services through local substance use providers either via phone or walk in.
- MDHHS has established contractual obligations that must be met for access to services for all populations.



Medical Necessity Criteria and Level of Care Guidelines

- Standardized functional assessments that determine clinical eligibility for specialty behavioral health services are required for all populations we serve.
- Implementation of LOCUS, ASAM Continuum and MCG medical necessity criteria.
- SWMBH has established regional Level of Care guidelines based on SWMBH historical utilization data for each identified level of care score
- Each Level of Care has a core set of services and the “likely” number of units of each service that would be appropriately authorized for that level.
- Requests for authorizations above or outside the guidelines require review by a utilization manager either at SWMBH or the CMHSP to determine medical necessity of the additional units or service.



Use of Data in UM

- Standardized data and SWMBH data warehouse
- Regional Utilization Management data reviews of over and under utilization
- Current focus is under-utilization, denied service authorizations (denial process, tracking, Adverse Benefit Determinations (ABDs), documentation), Interater Reliability (IRR)
- Identifies opportunities for improvement in quality of care, population health and access to services.
- MDHHS reports on Access standards, Appeals and Grievances have identified further opportunities.





Southwest Michigan Behavioral Health Board Retreat

Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001

May 12, 2023

Draft: 2/15/23

9:00 am-9:30 am	Continental Breakfast
9:30 am-9:45 am	Welcome, Introductions, Session Objectives and Participant Statements
9:45 am-12:00 pm	Susan Radwan, Policy Governance Consultant
12:30 pm - 1:15 pm	Lunch
1:15 pm – 2:30 pm	Jay Rosen, CEO, Health Management Associates
2:30 pm - 2:45 pm	Summary Discussion and Next Steps
3:00 pm	Adjourn

Invitees: Board Members and Board Alternates, CMH CEOs, Substance Use Disorder Oversight Policy Board Officers, Consumer Advisory Council Officers, select SWMBH Senior Leaders.

Focus Areas: Carver Policy Governance generally; Ends and Ends Metrics; Delegation, Oversight and Monitoring, Legislative outlook and future focuses for Behavioral Health

The week of 3/20/23 the judge in the case involving the Lakeshore Regional Entity (LRE) and MDHHS **ruled in favor of LRE on its use of its risk reserve and savings to cover the deficits of its member CMHs**. The article, in MIRS, describing this ruling is provided below.

Congratulations to LRE, its leadership, CMH members, and the thousands of persons who rely upon these CMHs and LRE for services and supports.

MIRS story: Medicaid Mental Health Manager Allowed To Use Surplus Funds To Pay CMHs' Deficit

A West Michigan Medicaid mental health management company can use its surplus to pay an estimated \$30 million deficit resulting from alleged underfunding by the state in 2018 and 2019.

Court of Claims Judge Douglas SHAPIRO held the Michigan Department of Health and Human Services' 2022 settlement agreement with Lakeshore Regional Entity supports Lakeshore's position that the state agreed it could use its internal service and surplus funds to pay the deficit that three of its community mental health (CMH) partners experienced.

That permission, Shapiro noted, is in Lakeshore's January 2022 risk management strategy plan.

"MDHHS simply argues that we should ignore the provisions of the Risk Management Strategy despite the fact that it was formally approved by the department," wrote Shapiro, who sits on the Michigan Court of Appeals.

MDHHS contracts with PIHPs, such as Lakeshore, for the administration of mental health services to eligible Medicaid beneficiaries. Lakeshore, in turn, contracts with entities, such as Muskegon County's CMH provider, HealthWest, to provide those services through CMHs.

Lakeshore alleges the state underfunded its services in 2018 and 2019, leaving three of its CMH partners with a combined estimated \$30 million shortfall (See "Muskegon Wants State To Pay \$12M Medicaid Tab," 2/15/23).

MDHHS argued it properly funded Lakeshore and any shortfall was due to mismanagement and it moved to terminate its contract (See "Judge Ponders Whether CMHs Can Recoup Past Deficits," 1/24/23).

The two sides, however, reached an agreement in January 2022, which Lakeshore says allowed them to use their Fiscal Year 2020 surplus – a projected estimate of \$50 million – and a portion of its ISF to pay the deficit, but the state disagreed.



Southwest Michigan Behavioral Health Board Meeting
Four Points by Sheraton, 3600 E. Cork St. Ct. Kalamazoo, MI 49001

June 6, 2023

9:30 am to 11:30 am

(d) means document provided

Draft: 3/21/23

- 1. Welcome Guests/Public Comment**
- 2. Agenda Review and Adoption (d)**
- 3. Financial Interest Disclosure Handling (M. Todd)**
 - None Scheduled
- 4. Consent Agenda**
 - April 14, 2023 SWMBH Board Meeting Minutes (d)
- 5. Operations Committee**
 - a. March 22, 2023 Meeting Minutes (D. Hess) (d)
 - b. April 26, 2023 Meeting Minutes (D. Hess) (d)
- 6. Ends Metrics Updates (*Requires motion)**

Is the Data Relevant and Compelling? Is the Executive Officer in Compliance? Does the Ends need Revision?

 - *Opioid Health Home Enrollee Retention (J. Gardner and J. Smith) (d)
 - *Fiscal Year 2022 Performance Bonus Incentive Program (J. Gardner) (d)
- 7. Board Actions to be Considered**
 - a. Operating Agreement (B. Casemore) (d)
 - b. Operations Committee Self-Evaluation (B. Casemore) (d)
 - c. Environmental Scan and Strategic Imperatives (B. Casemore) (d)
 - d. Budget Assumptions (G. Guidry) (d)
 - e. Staff Retention Bonus (B. Casemore) (d)
 - f. BEL-006 Investments
- 8. Board Policy Review**

Is the Board in Compliance? Does the Policy Need Revision?

 - a. BG-012 Open Meetings Act and Freedom of Information Act (d)
 - b. BG-010 Board Committee Principles (d)
 - c. Bg-011 Governing Style (d)
- 9. Executive Limitations Review**

Is the Executive Officer in Compliance with this Policy? Does the Policy Need Revision?

- BEL-006 Investments (S. Sherban) (d)

10. Board Education

- a. Fiscal Year 2023 Year to Date Financial Statements (G. Guidry) (d)
- b. Fiscal Year 2023 Mid-Year Contract Vendor Summary (G. Guidry) (d)
- c. External Audit Report Fiscal Year 2022 (G. Guidry) (d)
- d. Information Systems Update (N. Spivak) (d)
- e. Certified Community Behavioral Health Clinics (CCBHC) (E. Philander) (d)

11. Communication and Counsel to the Board

- a. Intergovernmental Contract Renewal Contract Status (B. Casemore)
- b. July 14, 2023 Draft Board Agenda (d)
- c. Board Member Attendance Roster (d)
- d. July Board Policy Direct Inspection – BEL-009 Global Executive Constraints (E. Meny)

12. Public Comment

13. Adjournment

SWMBH adheres to all applicable laws, rules, and regulations in the operation of its public meetings, including the Michigan Open Meetings Act, MCL 15.261 – 15.275.

SWMBH does not limit or restrict the rights of the press or other news media.

Discussions and deliberations at an open meeting must be able to be heard by the general public participating in the meeting. Board members must avoid using email, texting, instant messaging, and other forms of electronic communication to make a decision or deliberate toward a decision and must avoid "round-the-horn" decision-making in a manner not accessible to the public at an open meeting.

Next Board Meeting

Four Points by Sheraton, 3600 E. Cork St. Kalamazoo, MI 49001

July 14, 2023

9:30 am - 11:30 am

2023 SWMBH Board Member & Board Alternate Attendance												
Name:	January	February	March	April	May	June	July	August	September	October	November	December
Board Members:												
Ruth Perino (Barry)												
Edward Meny (Berrien)												
Tom Schmelzer (Branch)												
Sherii Sherban (Calhoun)												
Louie Csokasy (Cass)												
Erik Krogh (Kalamazoo)												
Carole Naccarato (St. Joe)												
Susan Barnes (Van Buren)												
Alternates:												
Robert Becker (Barry)												
Nancy Johnson												
Jon Houtz (Branch)												
Kathy-Sue Vette (Calhoun)												
Jeanne Jourdan (Cass)												
Karen Longanecker (Kalamazoo)												
Cathi Abbs (St. Joe)												
Angie Dickerson (Van Buren)												

as of 3/10/23

Green = present

Red = absent

Black = not a member

Gray = meeting cancelled