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

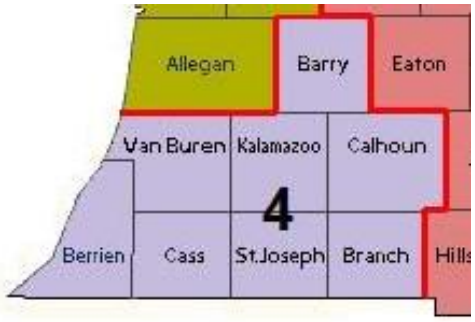
Physical Resources: Phones/Computers/Equipment

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

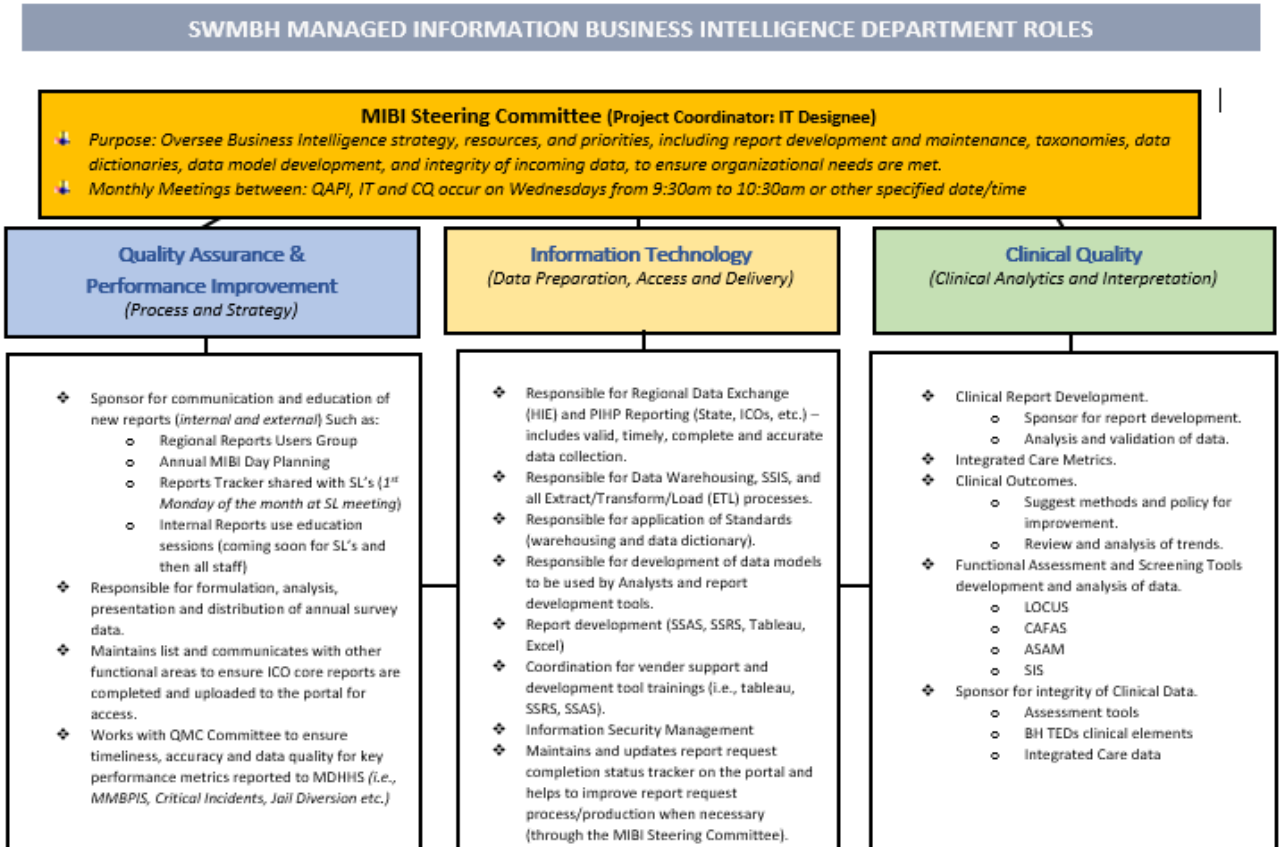
SWMBH (Region 4) has served nearly 29,360 unique consumers from October 1, 2021, to September 30, 2022, with 296,488 Medicaid Eligible in the Region.

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.



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

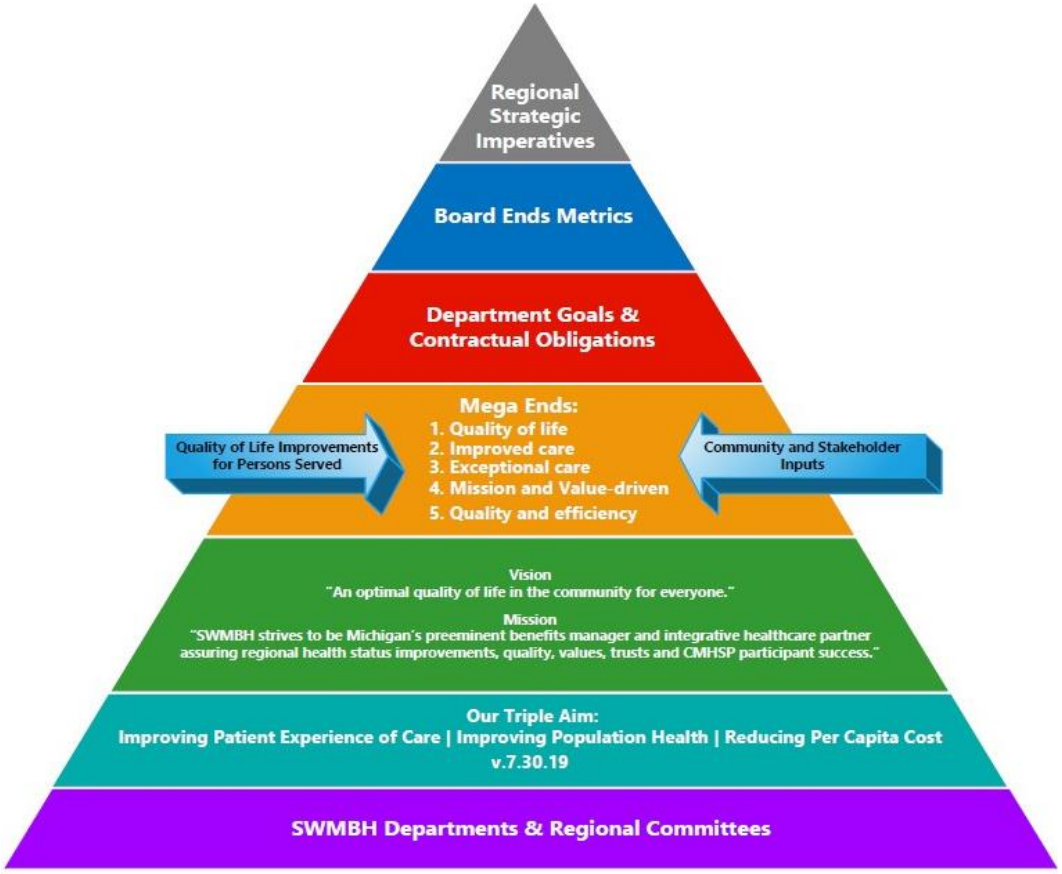
The committee will strive to reach decisions based on a consensus model through research, discussion, and deliberation. When consensus cannot be reached a formal voting process will be used and a super majority will carry the motion. This voting structure may be used to determine the direction of projects 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 (>= 95%).	Quality	QMC	Monthly
Indicator 1 - Percentage of Adults who receive a Prescreen within 3 hours of request (>= 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 (>= 95%).	Quality	QMC	Monthly
Indicator 4a (b) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%).	Quality	QMC	Monthly
Indicator 4b - Follow-Up within 7 Days of Discharge from a Detox Unit (>=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).

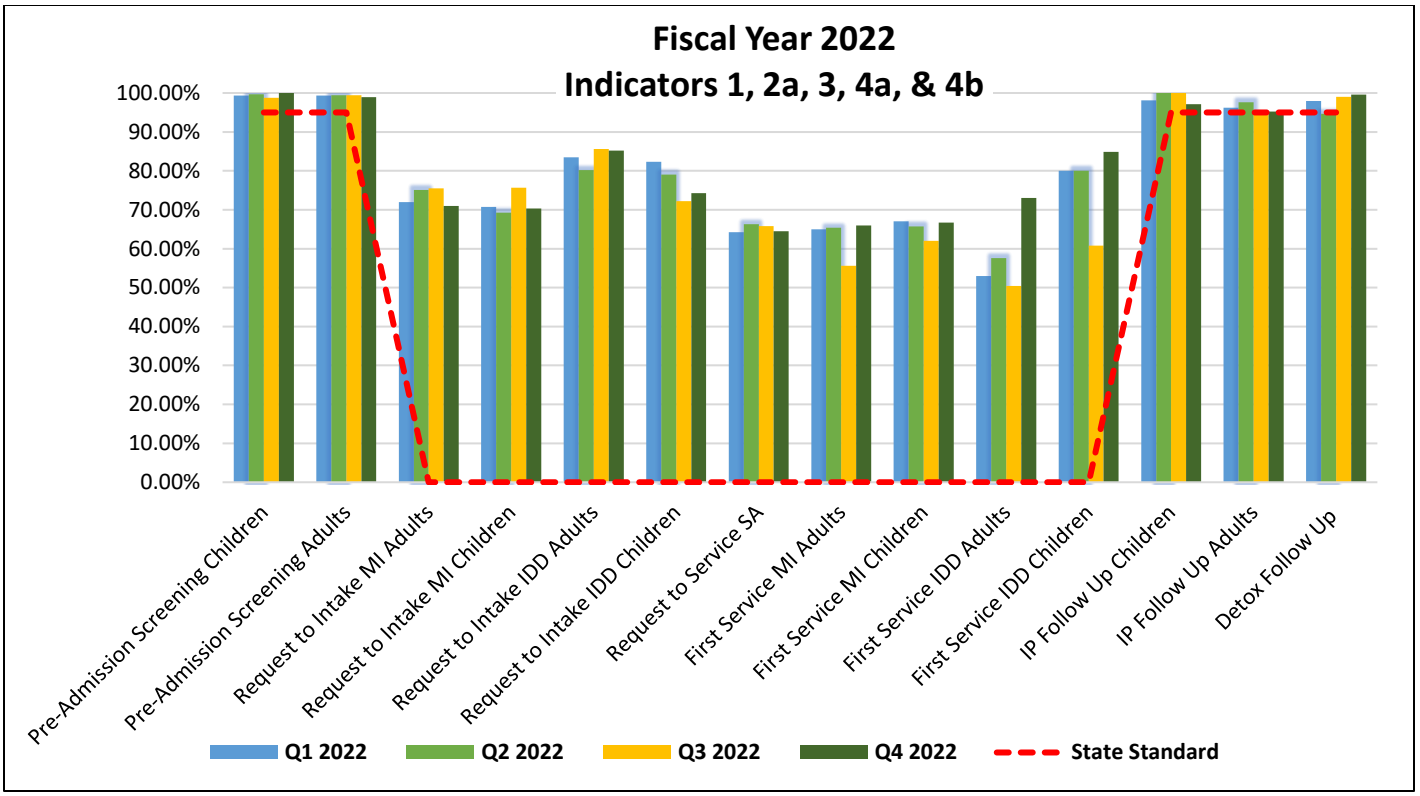
Improvement Efforts Made in FY22

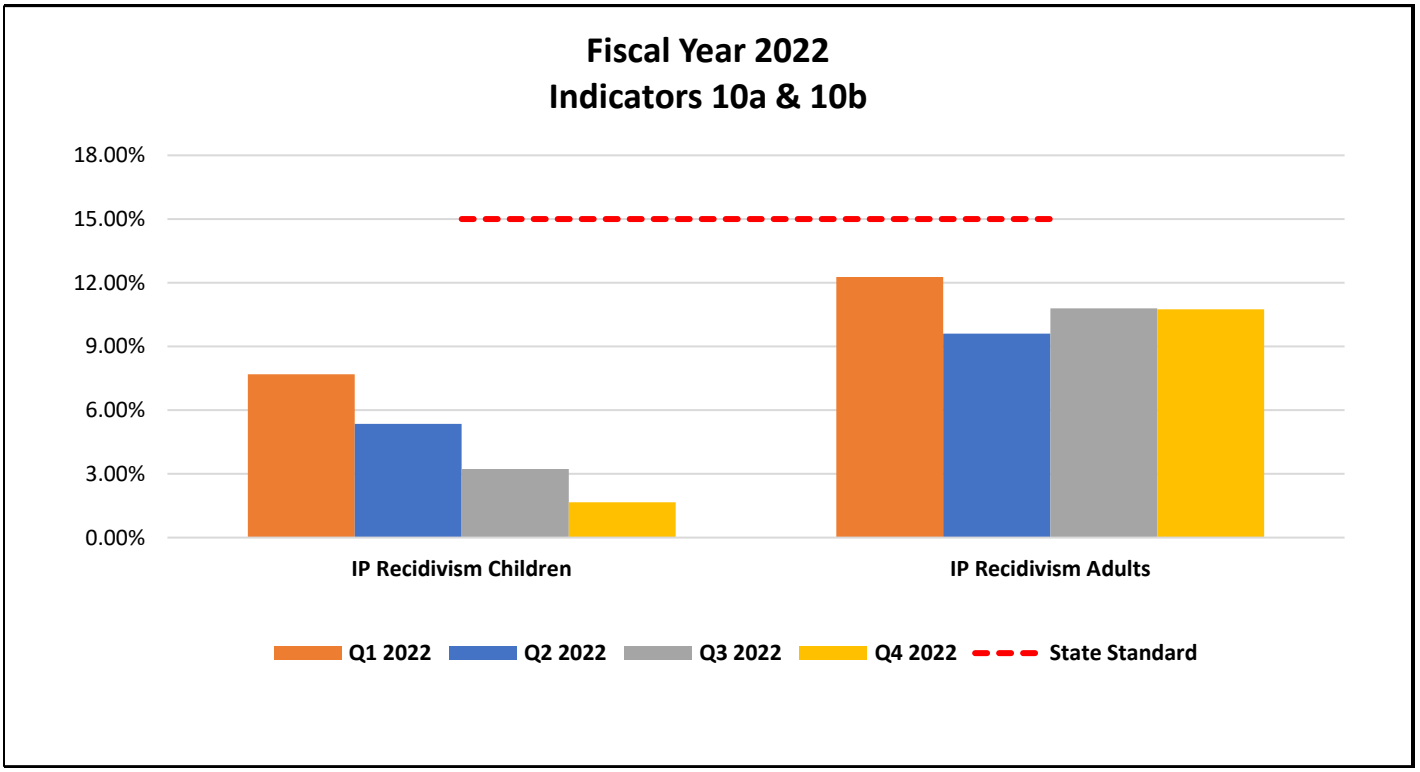
SWMBH continued to send CMHSPs appreciation letters upon meeting 100% of the State's performance indicators which are directed to their CEO. SWMBH also increased the frequency of analysis during QMC meetings, igniting discussion and sharing best practices across the region. This process has helped identify 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

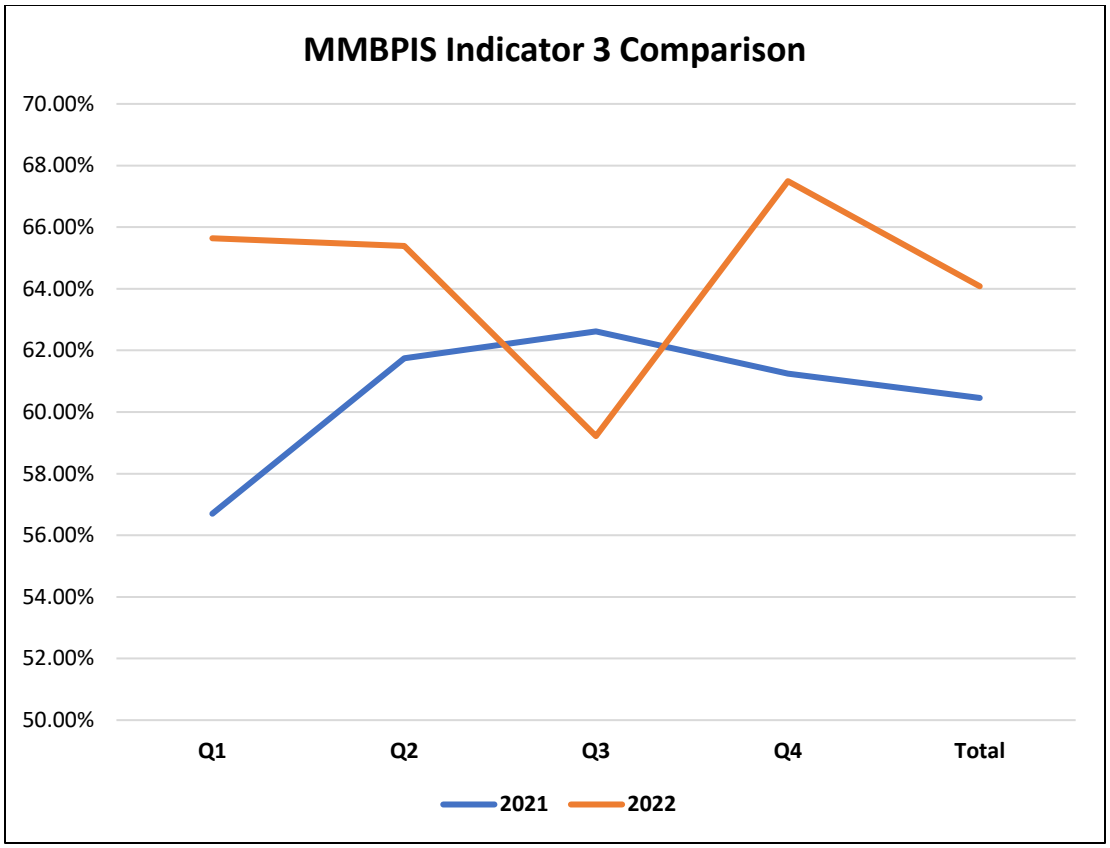
Indicator	FY21	FY22	Eval Score	Recommendations	Time Estimate
1 - Percentage of Children who receive a Prescreen within 3 hours of request (>= 95%).	99.32%	99.40%	**5**	The goal was met and will stay the same and be monitored through FY 2023.	 6-12 Mo.
1 - Percentage of Adults who receive a Prescreen within 3 hours of request (>= 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 (>= 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 (>= 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.

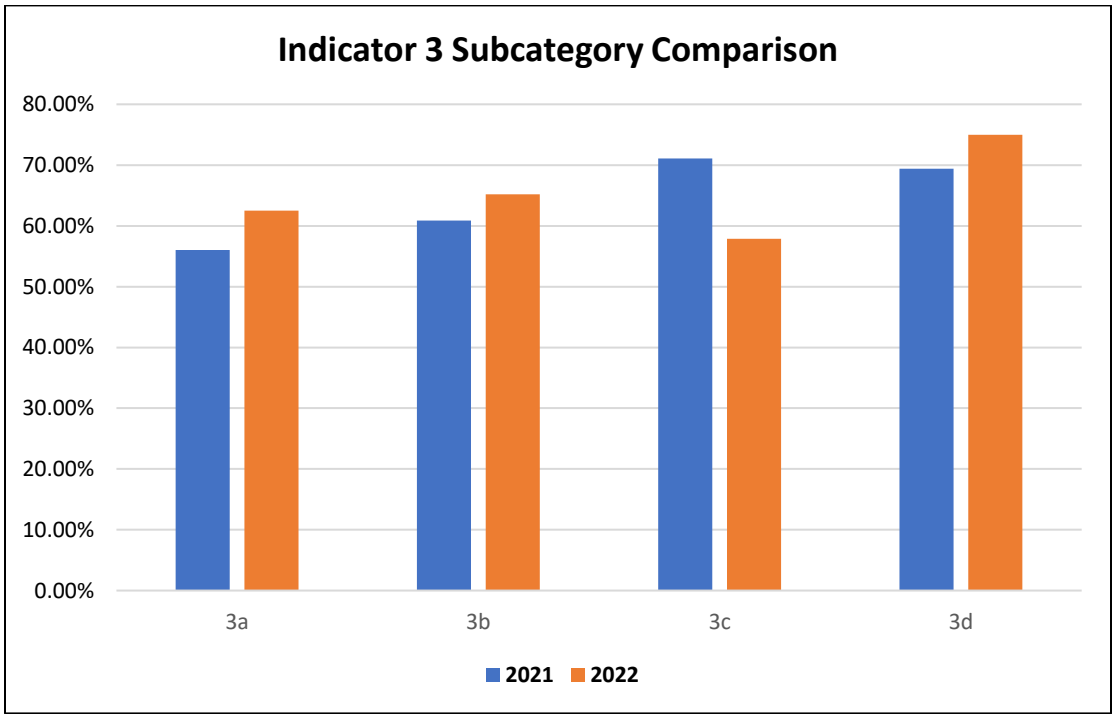
4b - Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%).	95.74%	97.93%	**4**	The goal was met and will stay the same and be monitored through FY 2023. The data collection process will be adjusted to improve efficiency and accuracy.	6-12 Mo.
10a - Re-admission to Psychiatric Unit within 30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


Fiscal Year 2022
Indicators 1, 2a, 3, 4a, & 4b
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Pre-Admission Screening Children
Pre-Admission Screening Adults
Request to Intake MI Adults
Request to Intake MI Children
Request to Intake IDD Adults
Request to Intake IDD Children
Request to Service SA
First Service MI Adults
First Service MI Children
First Service IDD Adults
First Service IDD Children
IP Follow Up Children
IP Follow Up Adults
Detox Follow Up
Q1 2022
Q2 2022
Q3 2022
Q4 2022
State Standard


Fiscal Year 2022
Indicators 10a & 10b
18.00%
15.00%
12.00%
9.00%
6.00%
3.00%
0.00%
IP Recidivism Children
IP Recidivism Adults
Q1 2022
Q2 2022
Q3 2022
Q4 2022
State Standard

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


MMBPIS Indicator 3 Comparison
70.00%
68.00%
66.00%
64.00%
62.00%
60.00%
58.00%
56.00%
54.00%
52.00%
50.00%
Q1
Q2
Q3
Q4
Total
2021
2022


Indicator 3 Subcategory Comparison
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
3a
3b
3c
3d
2021
2022

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
Performance Improvement Project #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. 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. Calendar year 2021 is baseline. Calendar year 2022 is the intervention development period. Calendar years 2023 and 2024 will be the remeasurement periods. Measures: a. 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. b. 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
Performance Improvement Project #2 1. Increase in SWMBH's initiation of treatment for substance use (IET-14) to 38.59% or above. 2. 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. 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. Measures: a. The overall IET-14 measure rate for SWMBH. b. 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.'			

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:

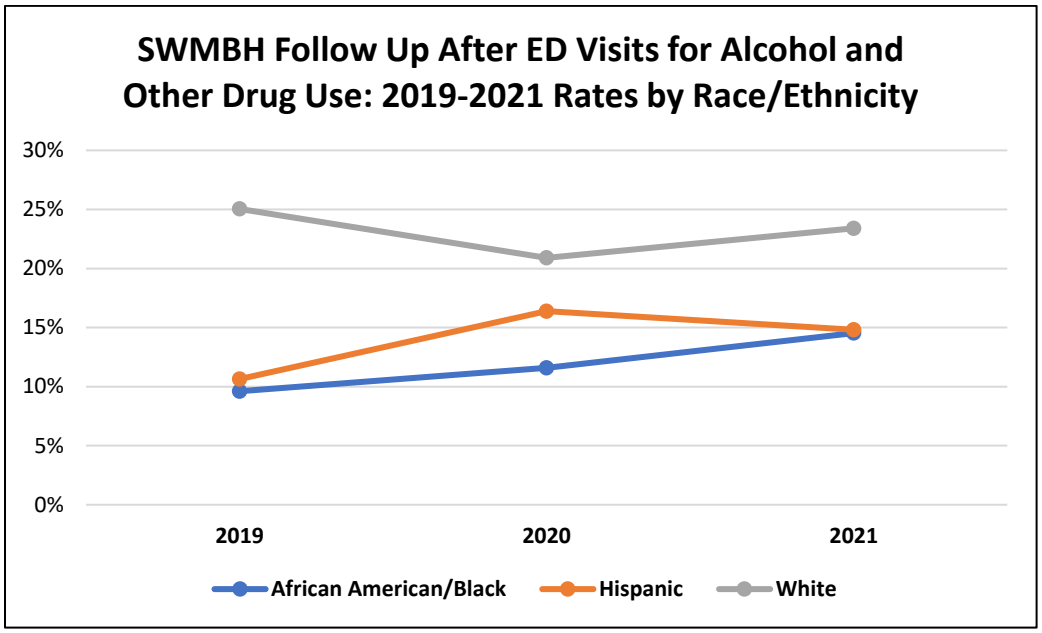
The goal of the project is to decrease the disparity between African American/Black and White rates of follow up after ED visits for alcohol and other drug use, from baseline to remeasurement 1, without a corresponding decrease in White follow up rates. Data will be stratified by race/ethnicity by MDHHS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

a. 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.

b. 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 ($X2$ (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 ($X^2 = 84.442$; $p < 2.2*10^{-16}$).

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.

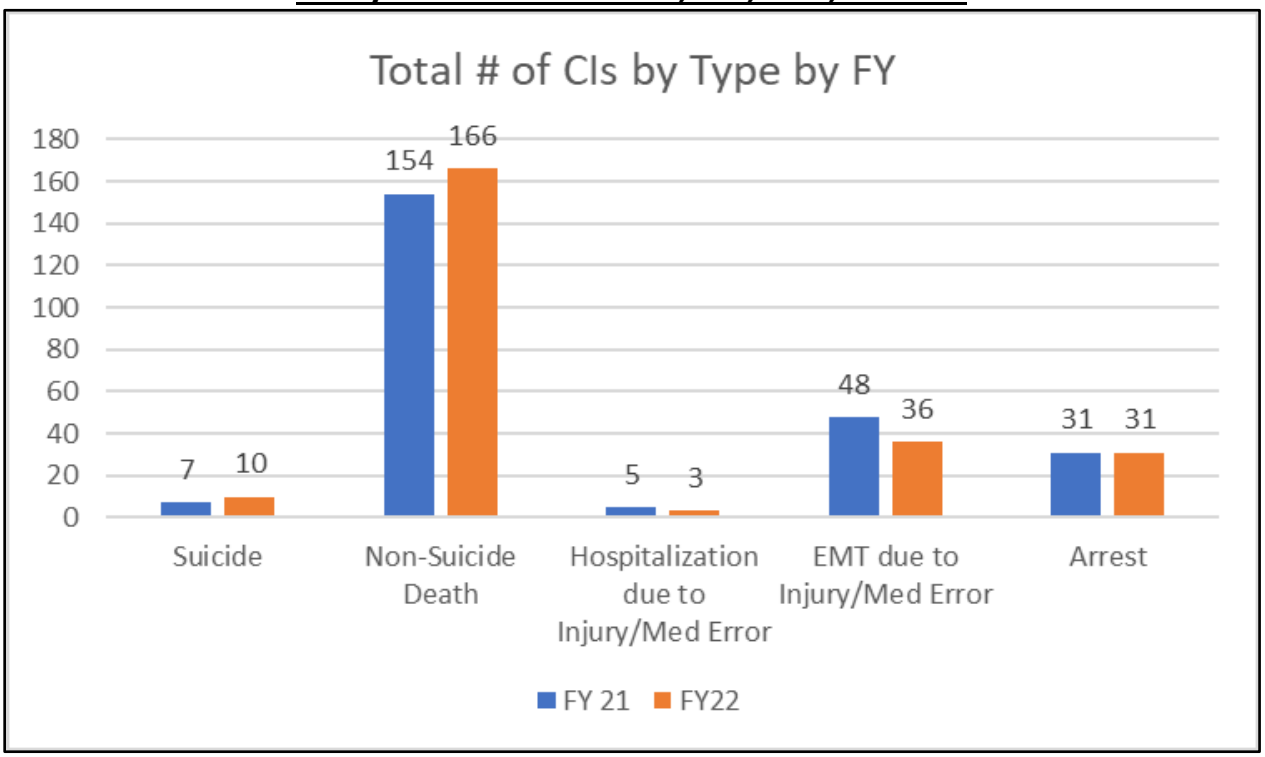
Improvement Efforts Made in FY22

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

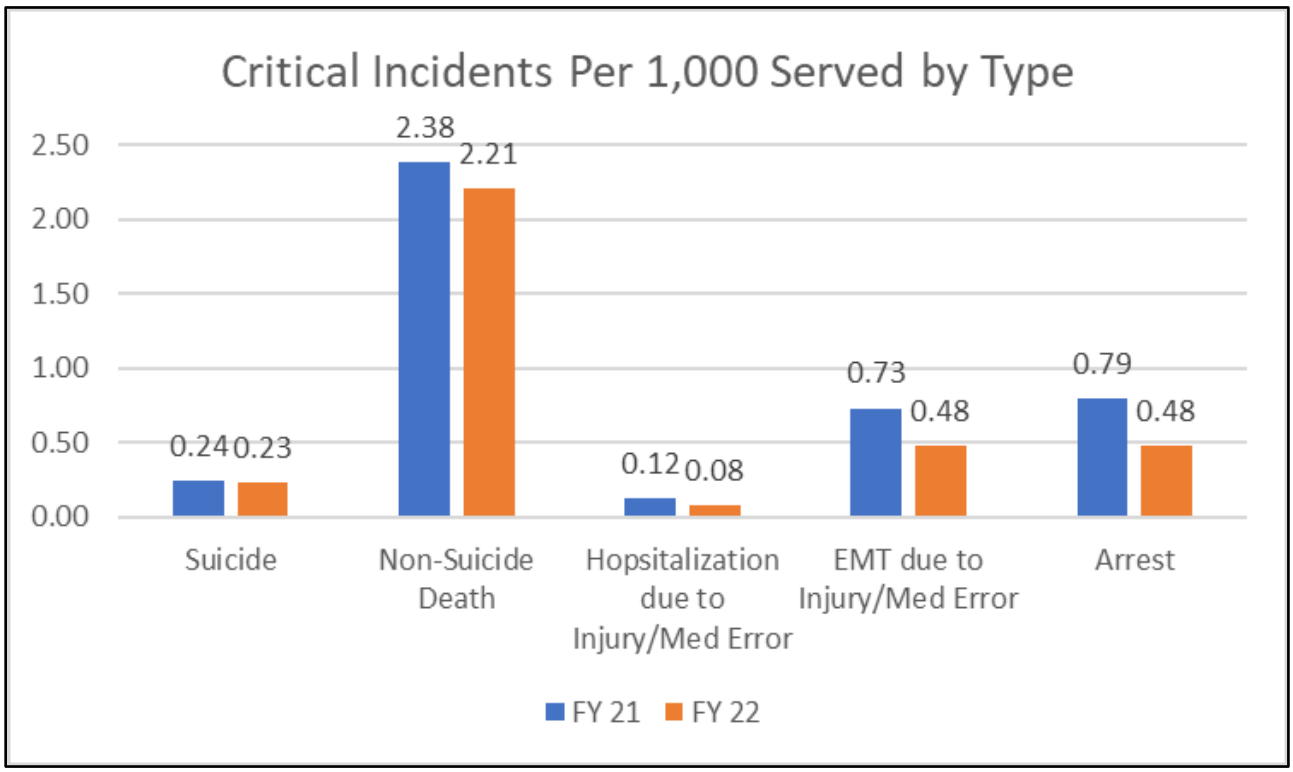
	Q1			Q2			Q3			Q4			Total
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Suicide	0.02	0.08	0.03	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.11	0.00	0.24
Non-Suicide Death	0.17	0.18	0.34	0.24	0.25	0.15	0.26	0.15	0.18	0.20	0.12	0.14	2.38
Hopsitalization due to Injury/Med Error	0.00	0.05	0.00	0.00	0.02	0.02	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

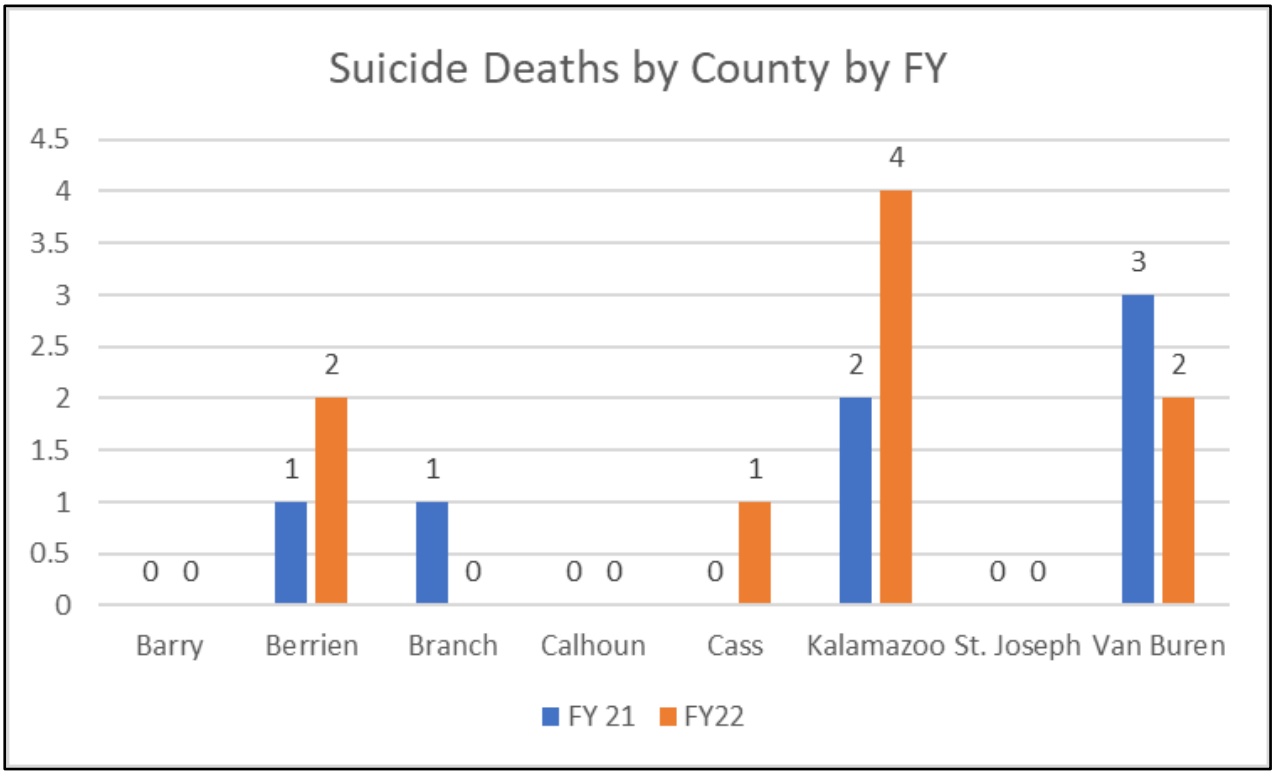
	Q1			Q2			Q3			Q4			Total
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Suicide	0.00	0.06	0.00	0.00	0.00	0.02	0.03	0.07	0.01	0.02	0.01	0.01	0.23
Non-Suicide Death	0.17	0.24	0.12	0.26	0.28	0.09	0.21	0.17	0.18	0.18	0.17	0.14	2.21
Hopsitalization due to Injury/Med Error	0.01	0.00	0.00	0.00	0.06	0.01	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

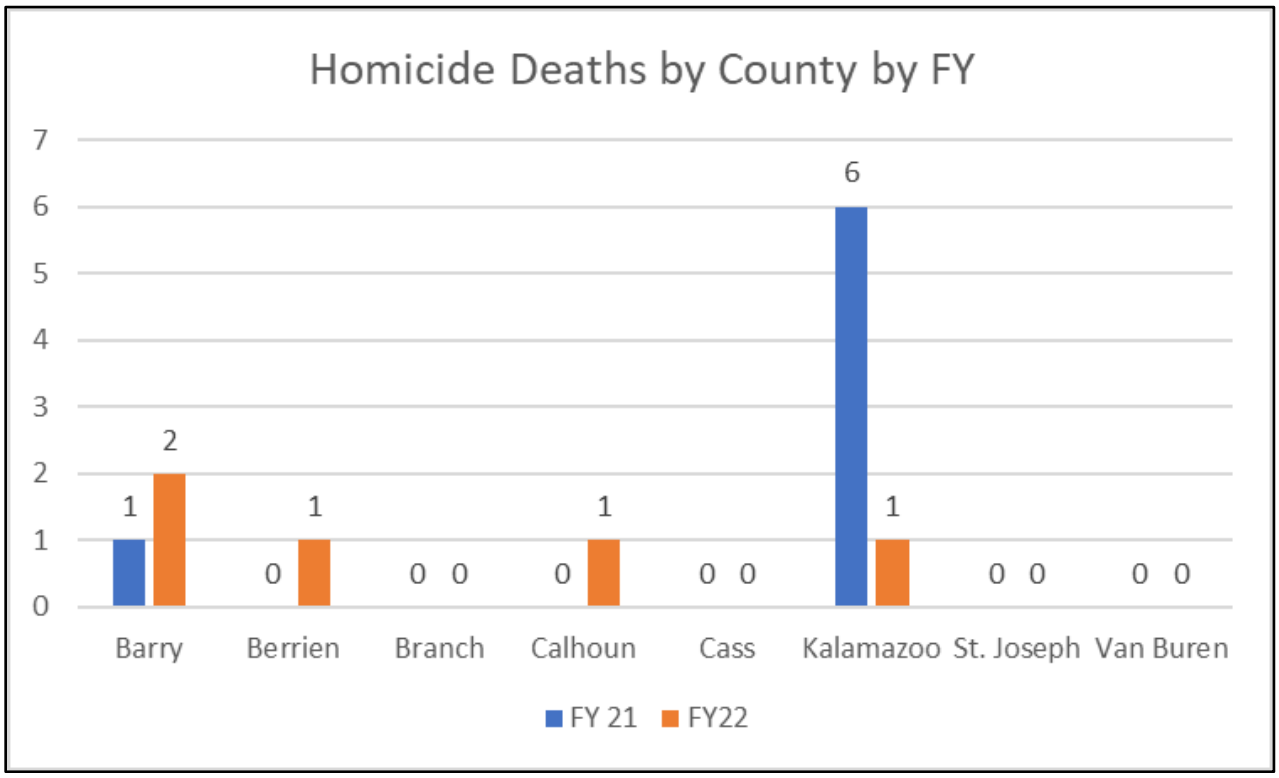
Critical Incident Per 1,000 Served by Type

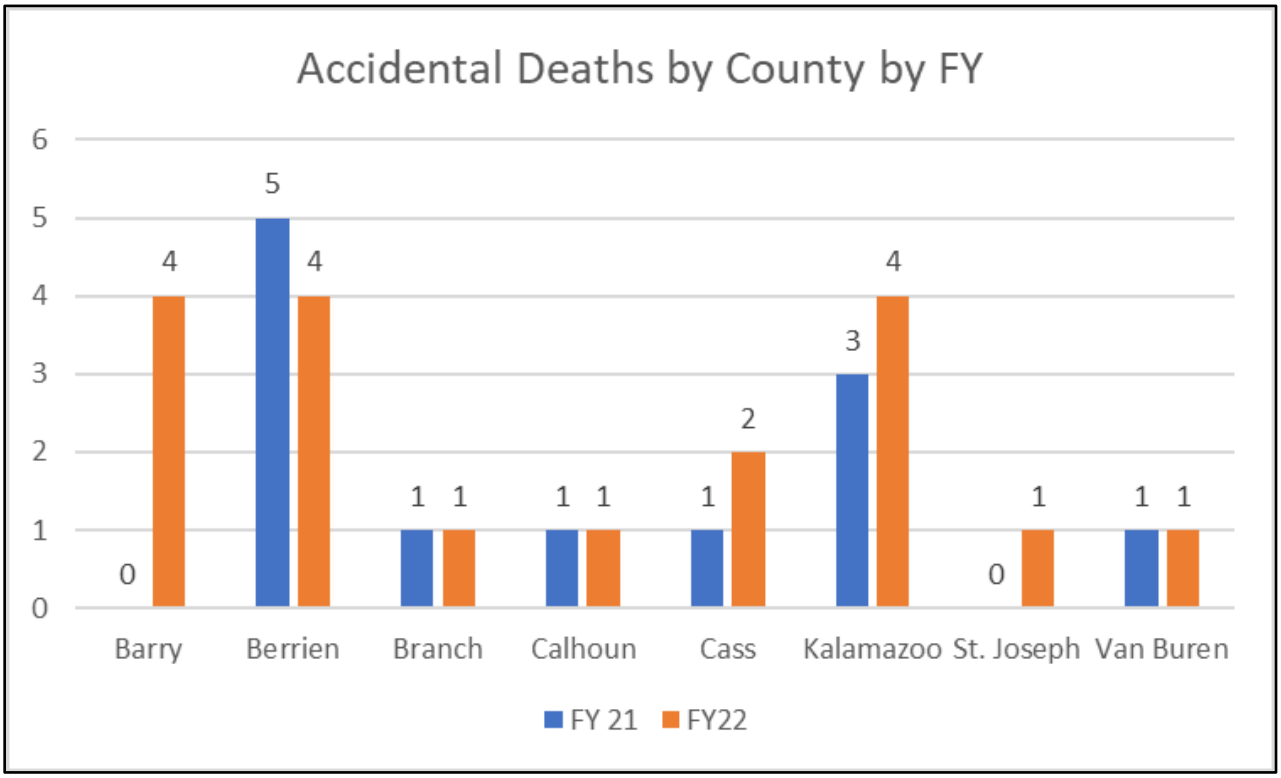
	FY 21	FY 22
Suicide	0.24	0.23
Non-Suicide Death	2.38	2.21
Hopsitalization due to Injury/Med Error	0.12	0.08
EMT due to Injury/Med Error	0.73	0.48
Arrest	0.79	0.48



Unexpected Deaths (Sentinel Events)



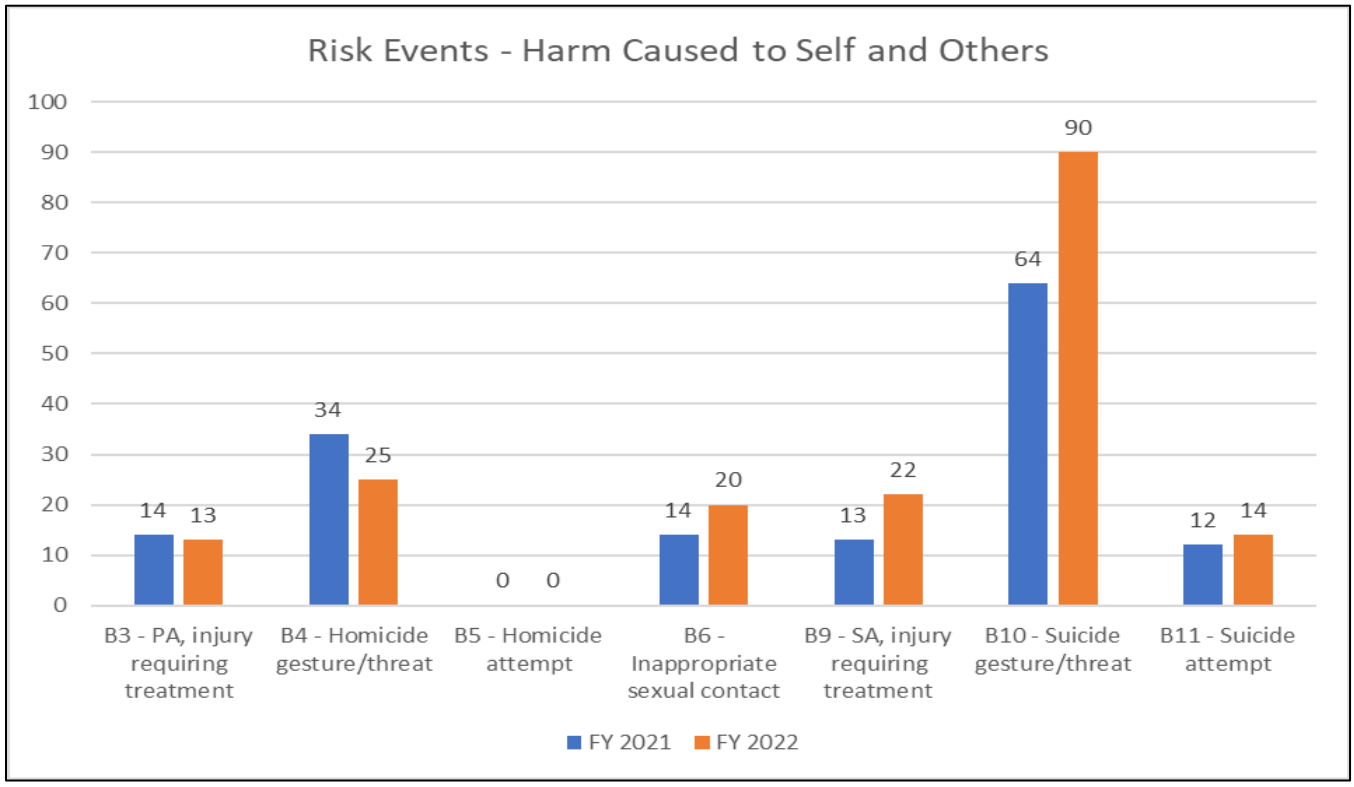

Homicide Deaths by County by FY
7
6
5
4
3
2
1
0
1
2
0
1
0 0
1
0 0
6
1
0 0
0 0
Barry
Berrien
Branch
Calhoun
Cass
Kalamazoo
St. Joseph
Van Buren
FY 21
FY22


Accidental Deaths by County by FY
6
5
4
3
2
1
0
0
4
5
4
1 1
1 1
1
2
3
4
0
1
1 1
Barry
Berrien
Branch
Calhoun
Cass
Kalamazoo
St. Joseph
Van Buren
FY 21
FY22

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 CMSHP 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 CMSHP 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 respondence) 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.	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.	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.	September 2022 September 2022 October 2022 January 2023

2.	Improve scores in Access and Outcomes Categories.	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.	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.	February 2023 March 2023 September 2022 July 2022

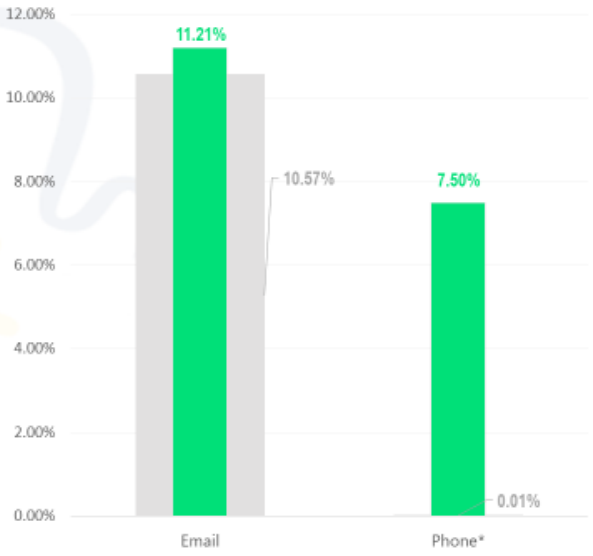
2022 CONSUMER SATISFACTION SURVEY RESULTS AND ANALYSIS

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

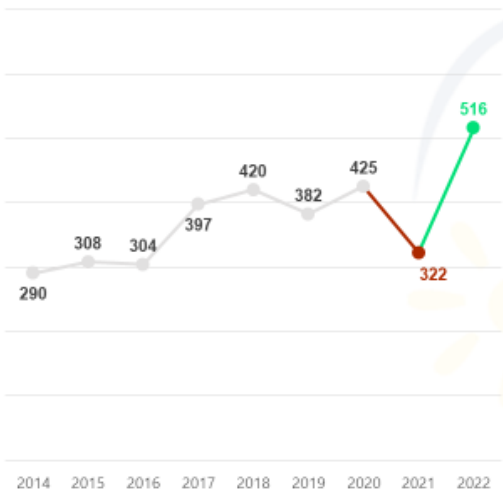
*direct calls in 2021, texts in 2022

4

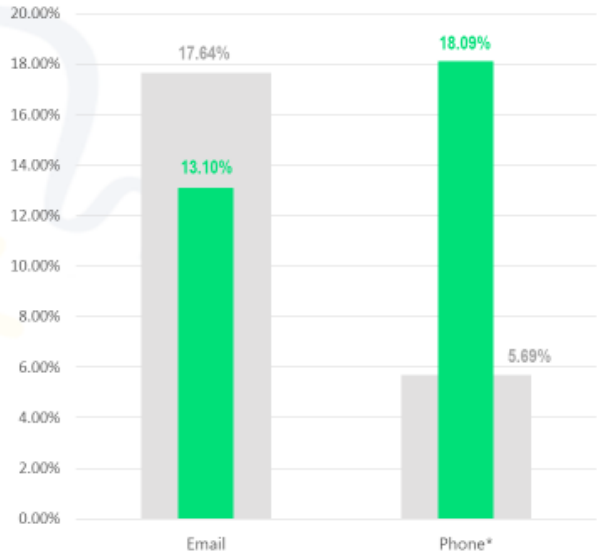
Response rates for the 2022 YSS reached highest point yet

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

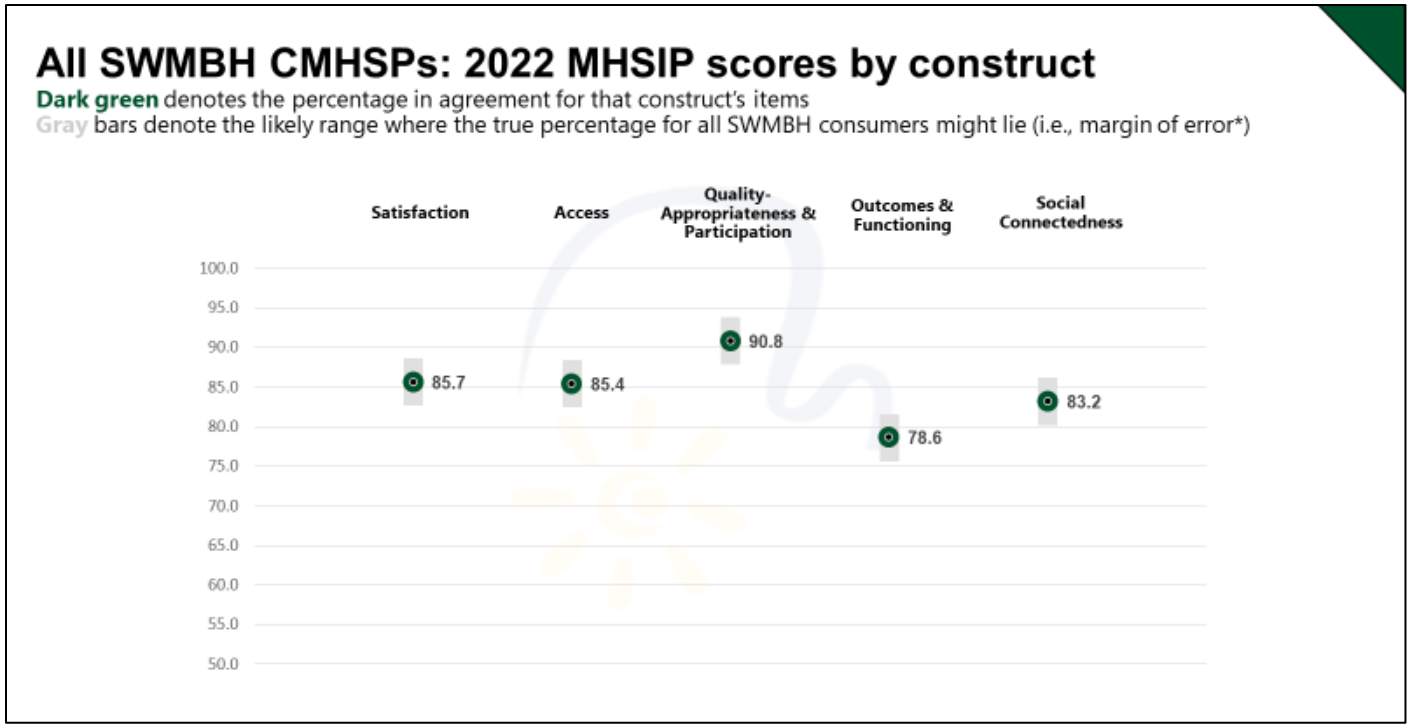


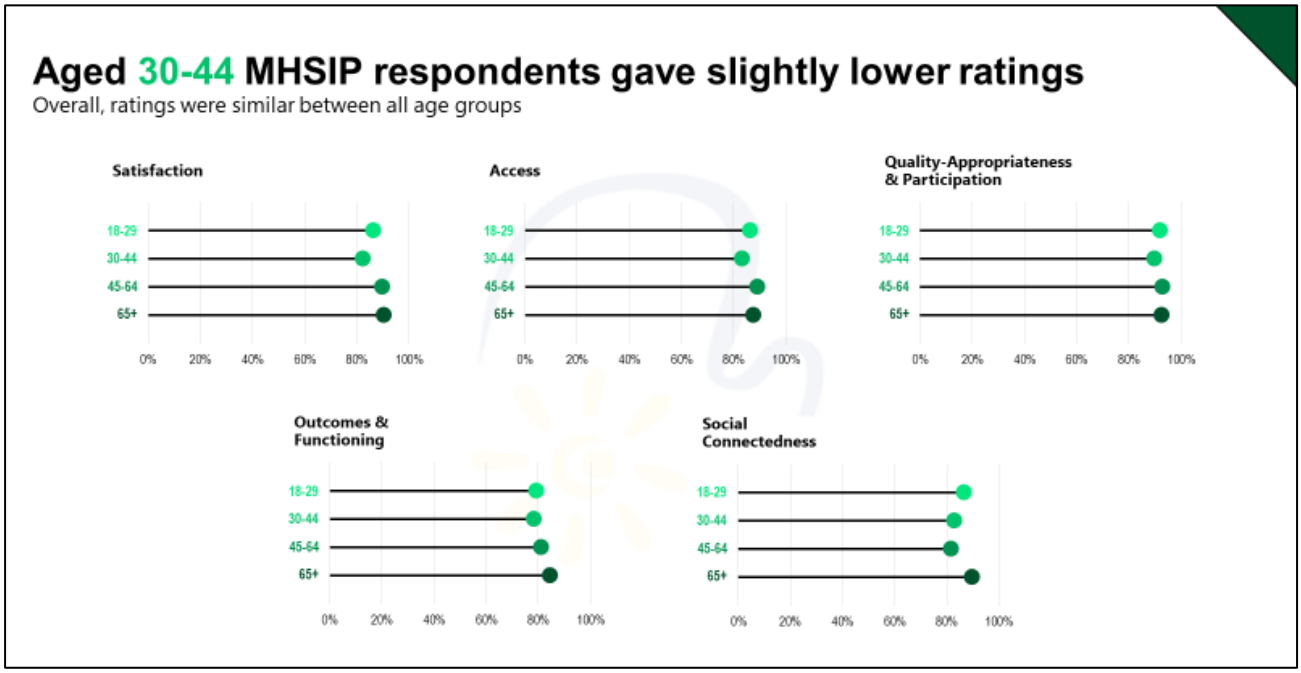
Kiaer Research SWMBH Consumer Satisfaction 2022 Results

*direct calls in 2021, texts in 2022

5

Adult Survey Scores by Category (MHSIP)





Adult consumers of color show slightly lower social connection ratings

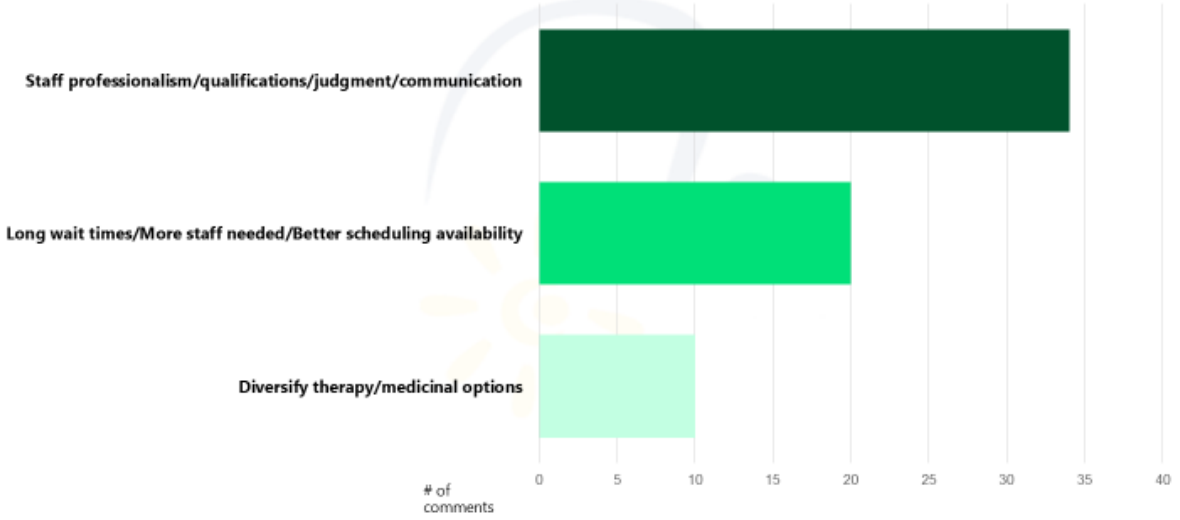
"Nonwhite" category comprises any race other than White, including Black/African American, Asian, Native American, Native Hawaiian/Pacific Islander, or any mix of races.

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*)

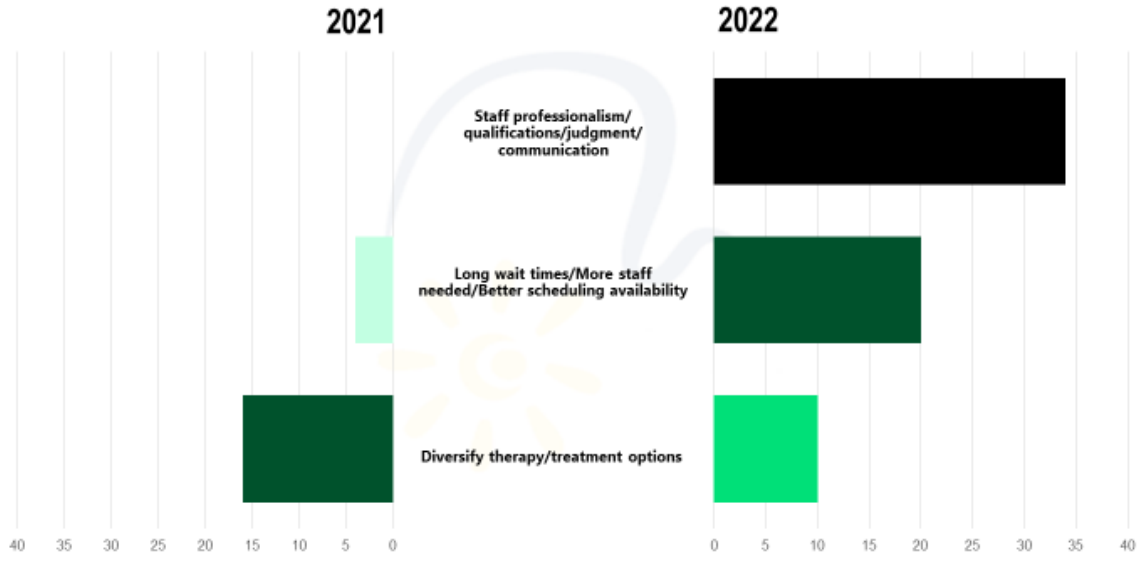
Opportunities for improvement in diversifying treatment options

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

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

"**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."

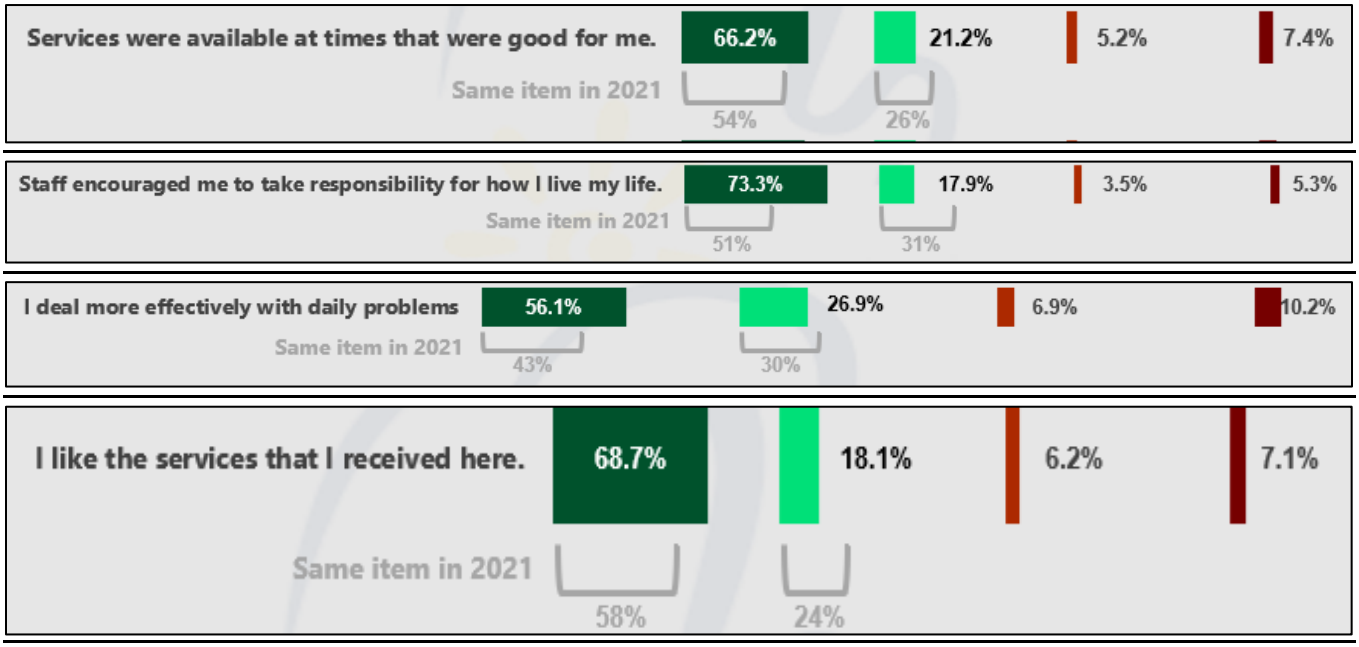
"The act team has totally helped me **transform my life**. I am so grateful."

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

"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.

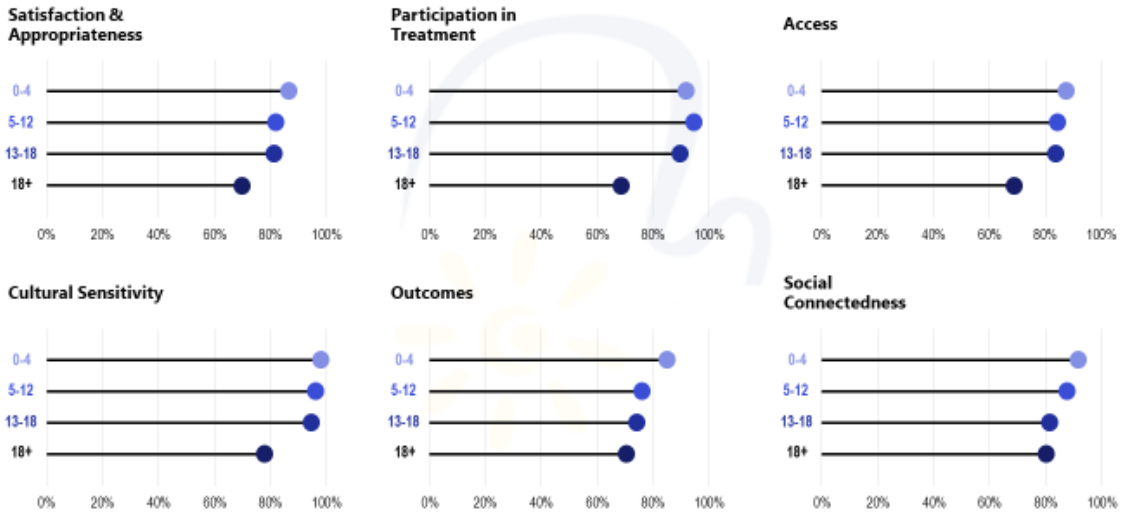
Youth Survey Scores by Category (YSS)

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*)

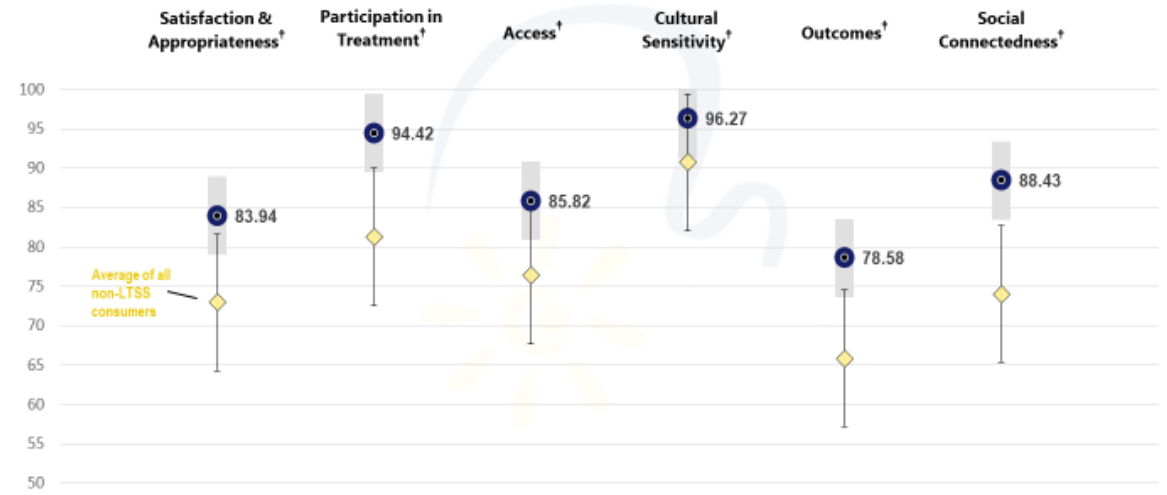
The older the youth, the lower the survey scores

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



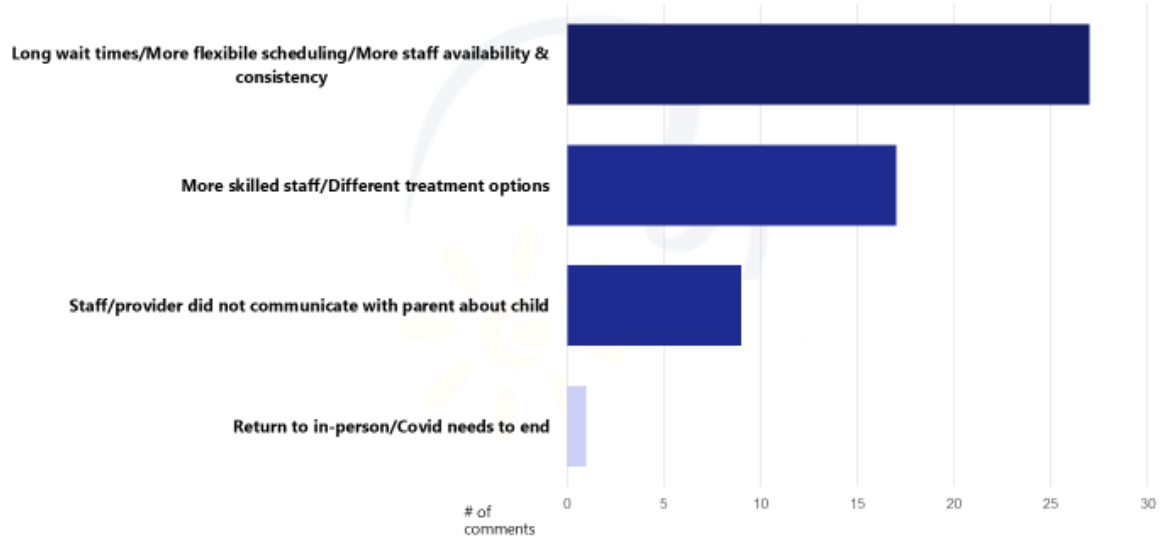
Youth LTSS consumers report better scores than non-LTSS youth across the board

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*)



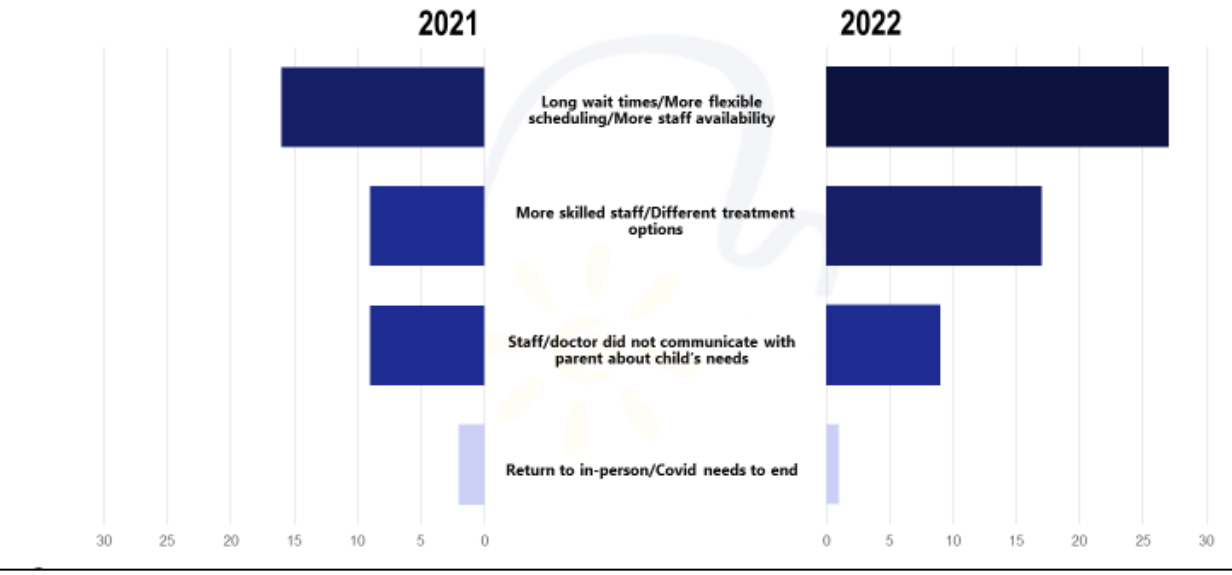
Opportunities for improvement in staffing, diversifying treatment

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"

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

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

"**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."

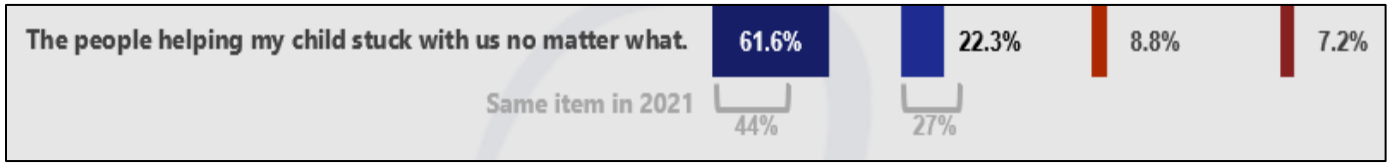
"Some sort of **respite** service for older kids and parents to have some time away in a safe manner."

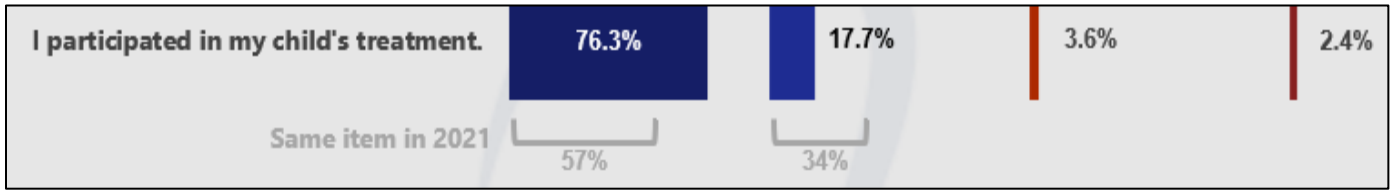
"Having a choice on where to receive **respite care** for my child."

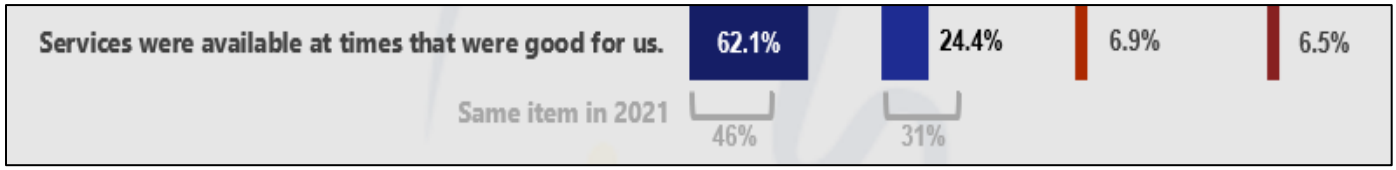
We needed **emergency support** we needed a **peer to peer** program, we need someone who can give us help with **respite**. We don't have family here so we don't have ppl to help us with that.

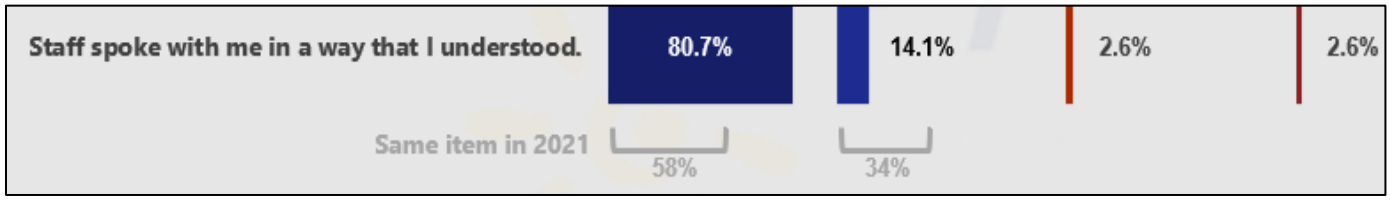
"More **in person gathering** with other families since covid is better than it was. Social interaction is key to my son/family as well as **other families** as well. Isolation is not good for mental health and social skills improvement."

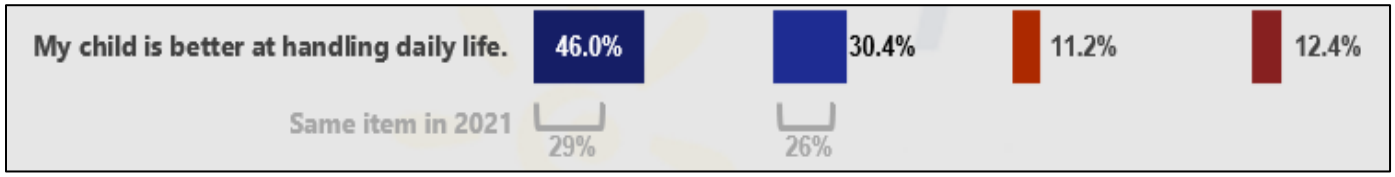
Youth Survey Questions that showed Significant Improvement



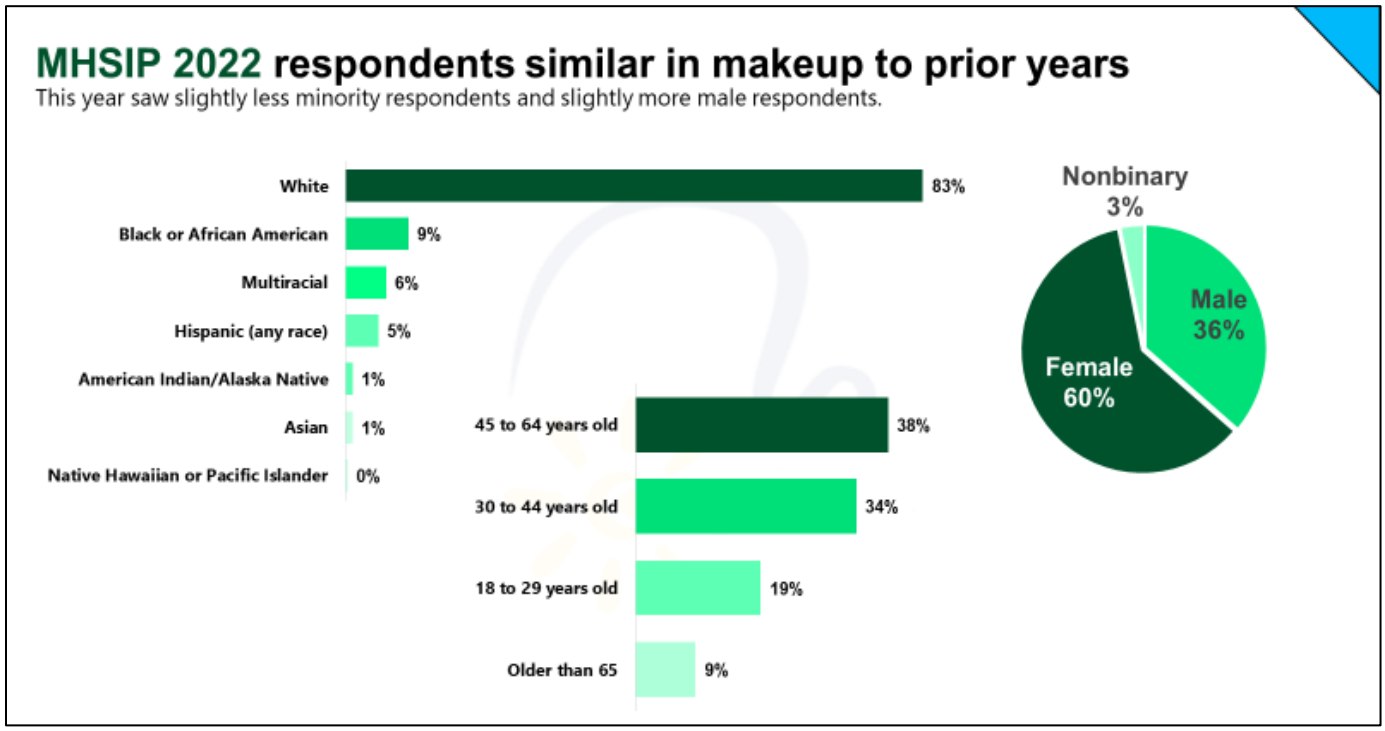


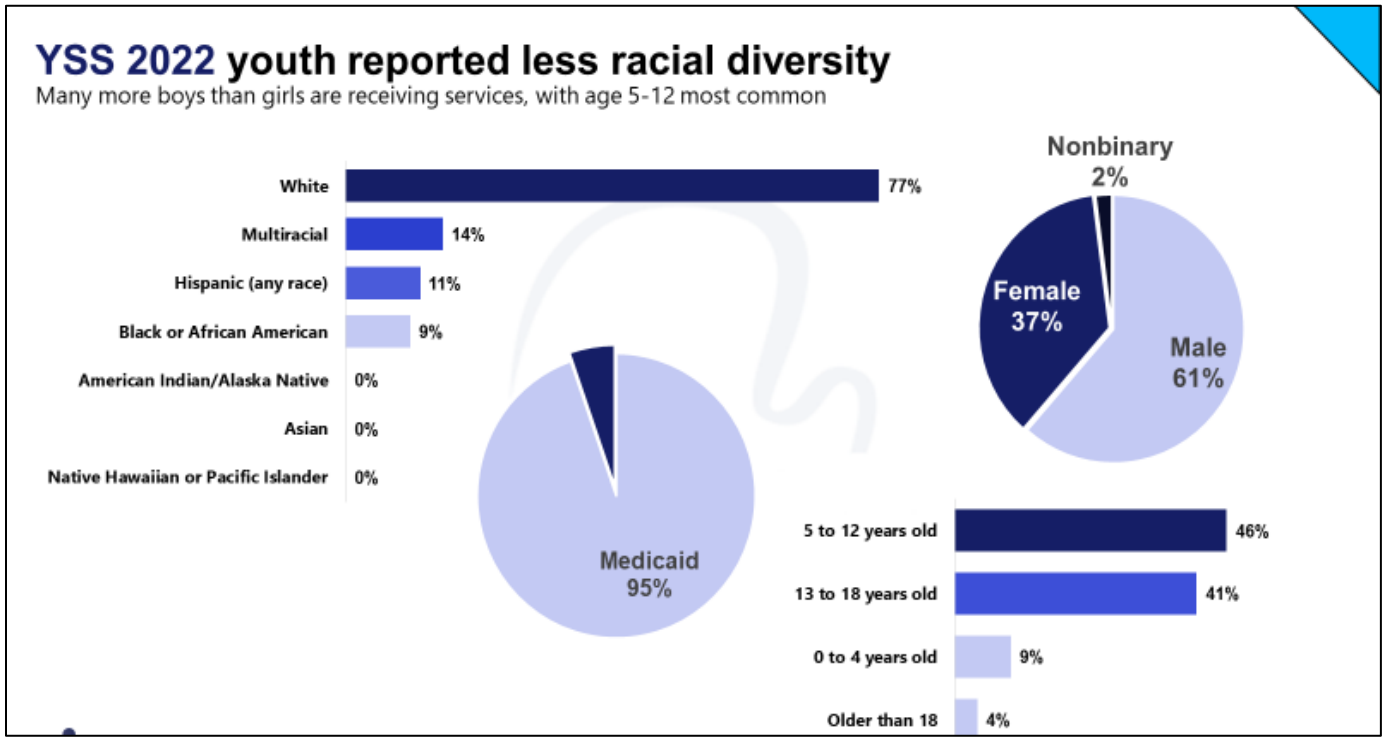






Survey Diagnostics, Analytics and Recommendations



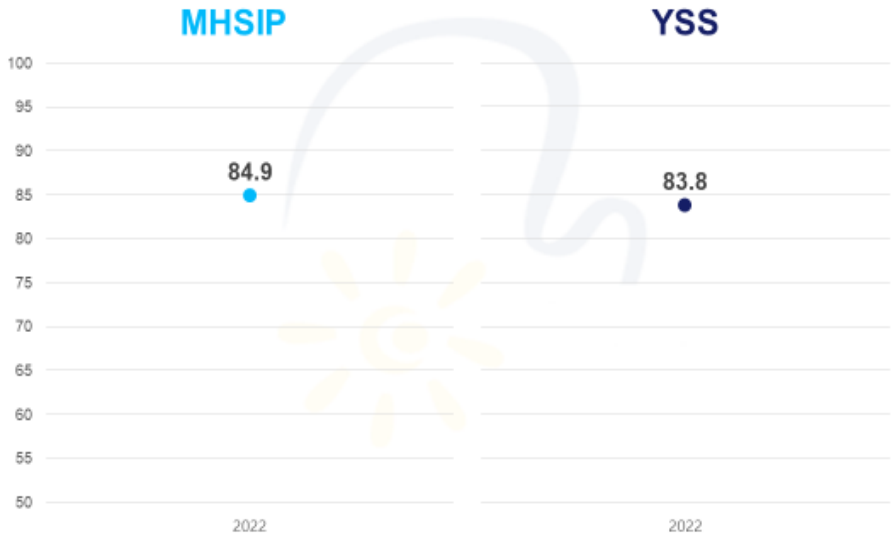


More youth than adults report having a case manager or service coordinator

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.

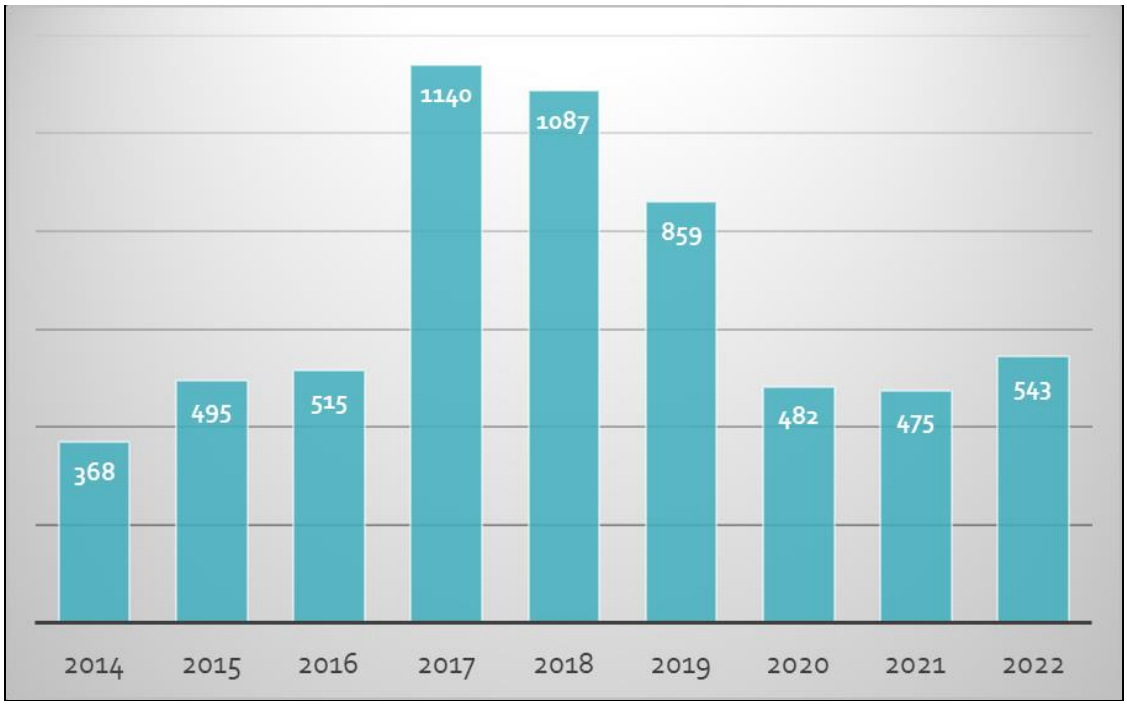
In 2022, SWMBH received a total of 543 completed surveys which was a 15% increase from 2021 but still significantly less than pre-pandemic participation. The number of participating provider organizations continued to decline in 2022 (down to 13 providers from 16 in 2021). SWMBH's analysis of the overall 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)

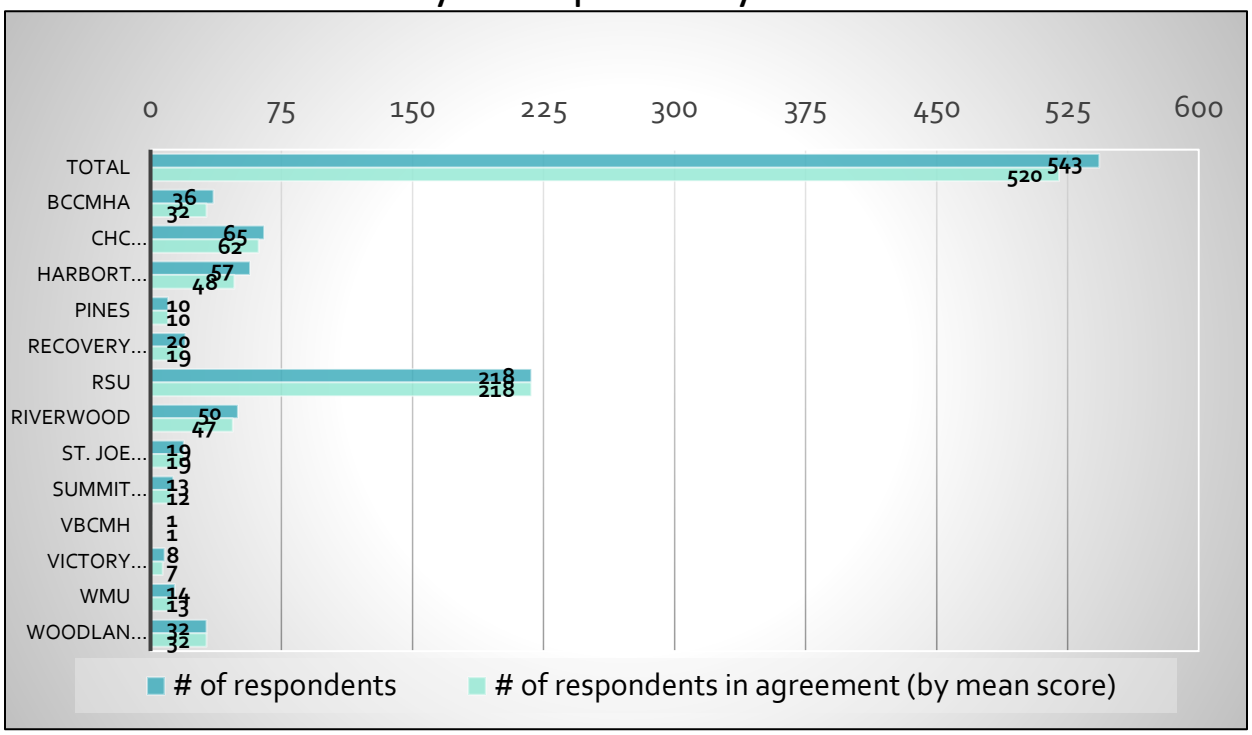
2021 Overall Mean Score 4.07
2020 Overall Mean Score: 4.20
2019 Overall Mean Score: 4.36
2018 Overall Mean Score: 4.22
2017 Overall Mean Score: 4.13
2016 Overall Mean Score: 4.31
2015 Overall Mean Score: 4.29
2014 Overall Mean Score: 4.24

9 Year Average	Mean Score
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

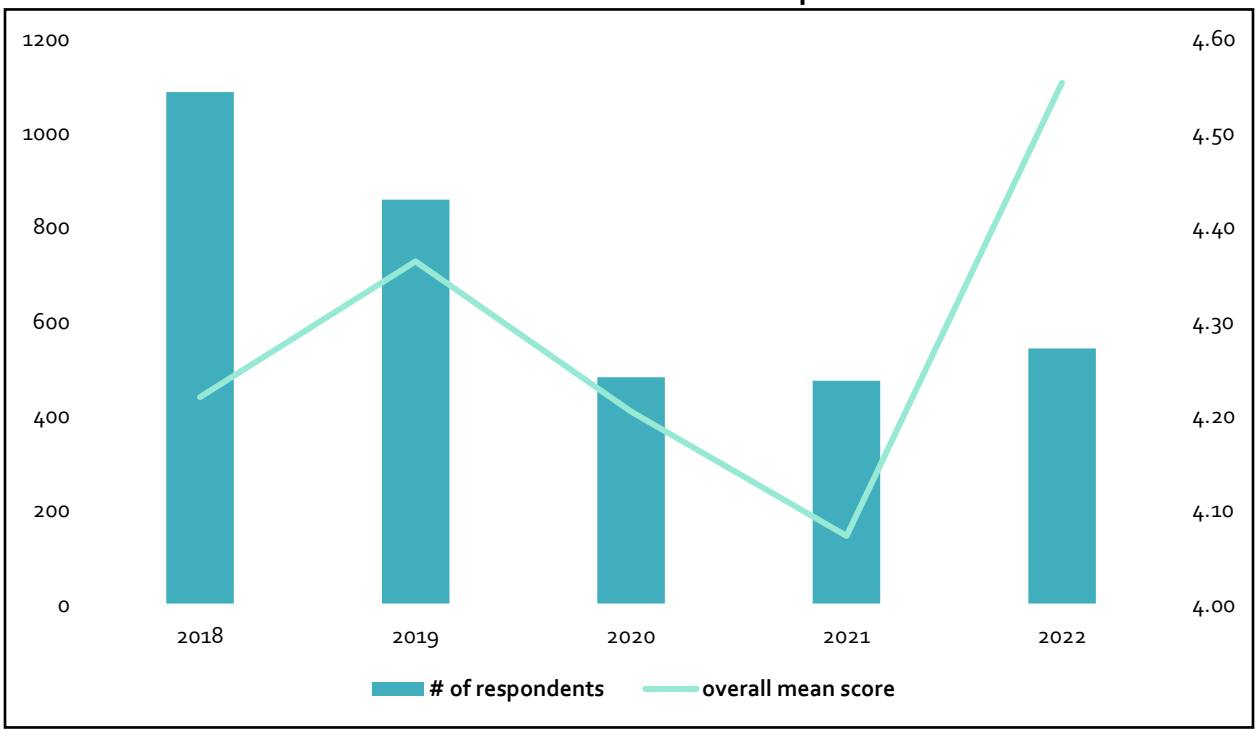
Number of Completed Surveys by Year



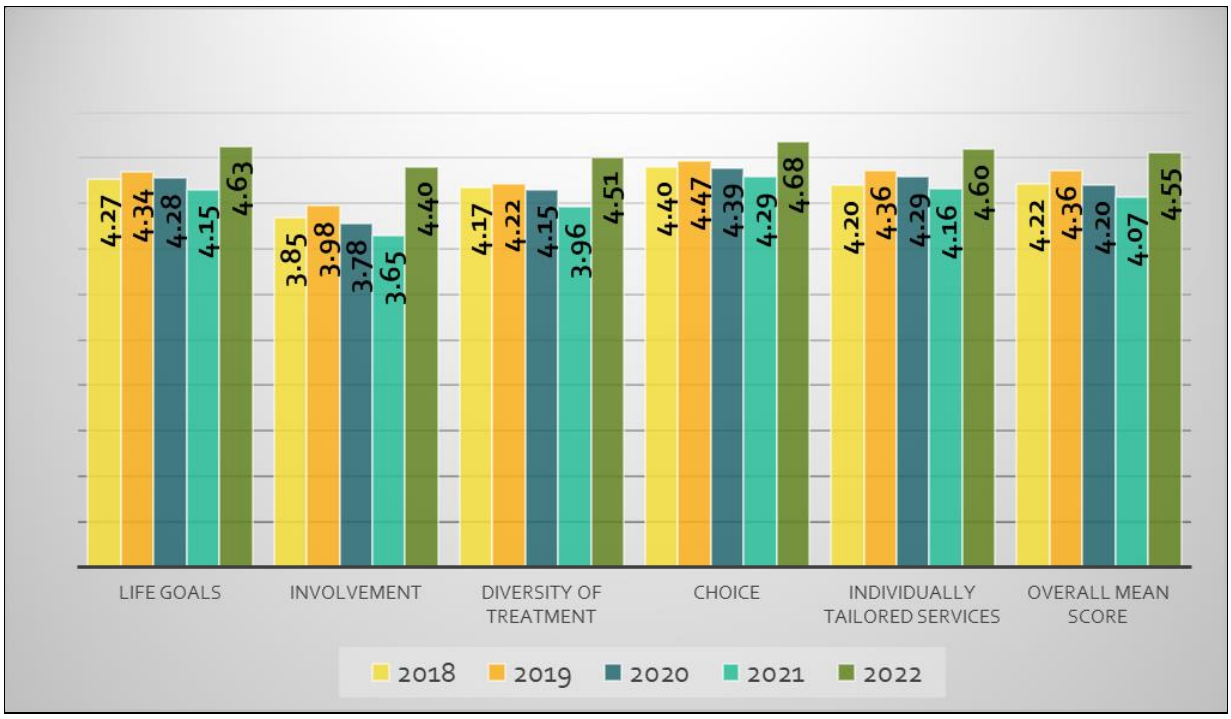
Surveys Completed by Provider



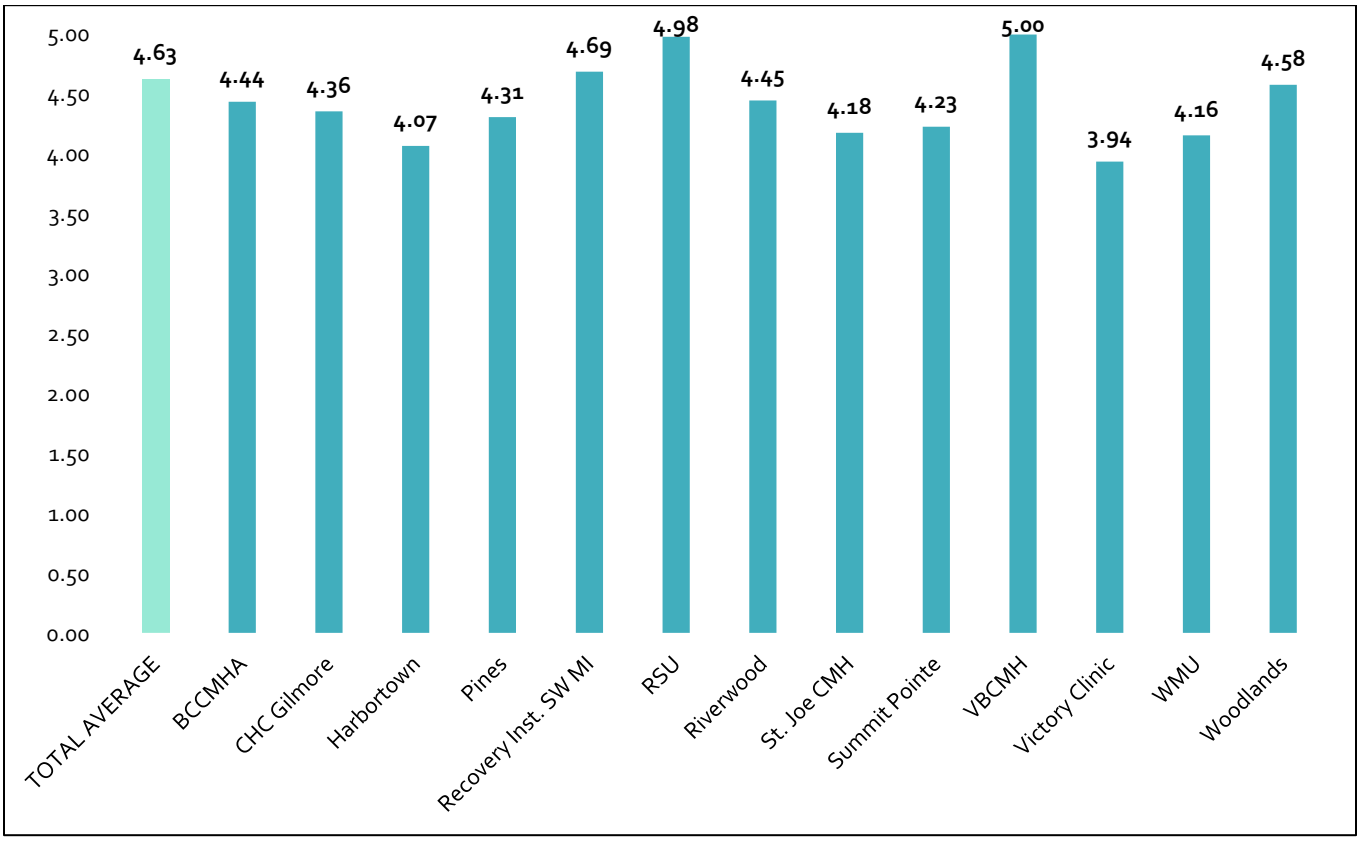
Overall Mean Score Comparison



Annual Mean Response by Subcategory



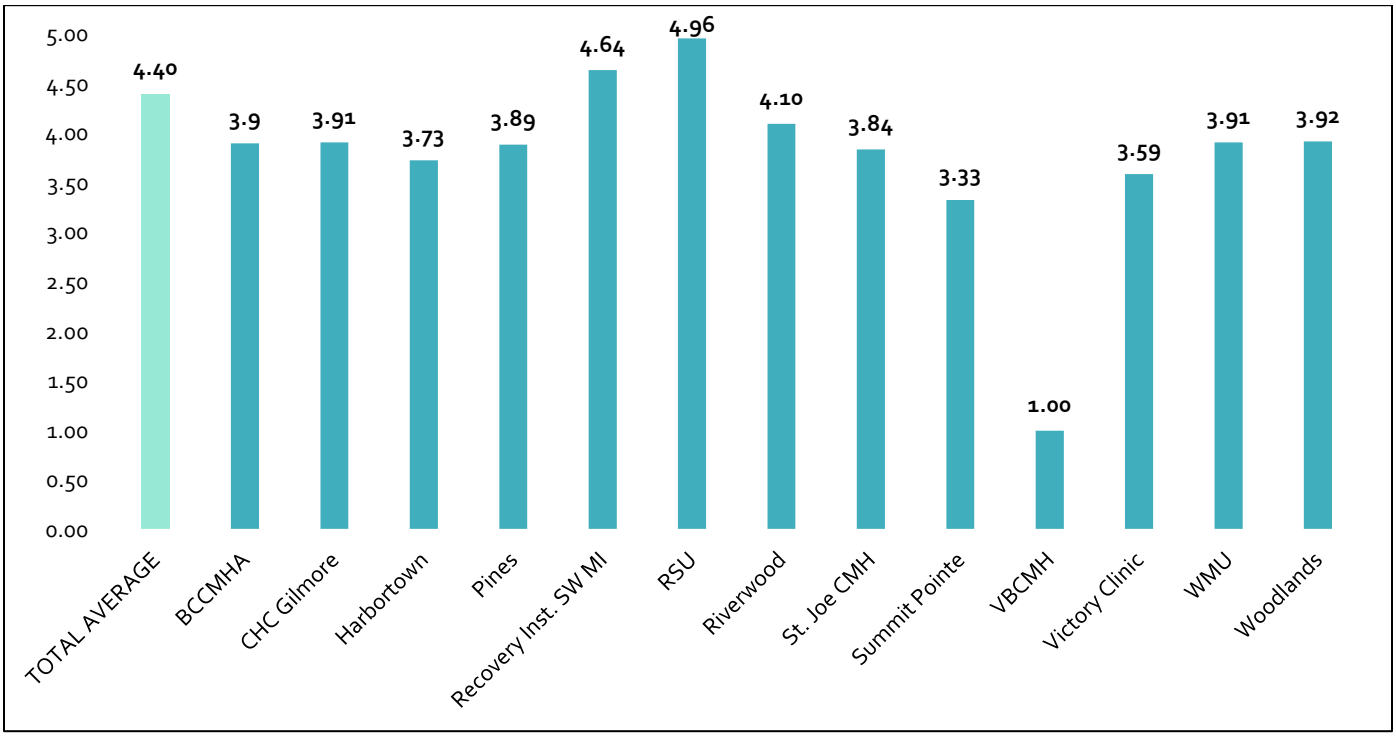
Subcategory: Life Goals



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.

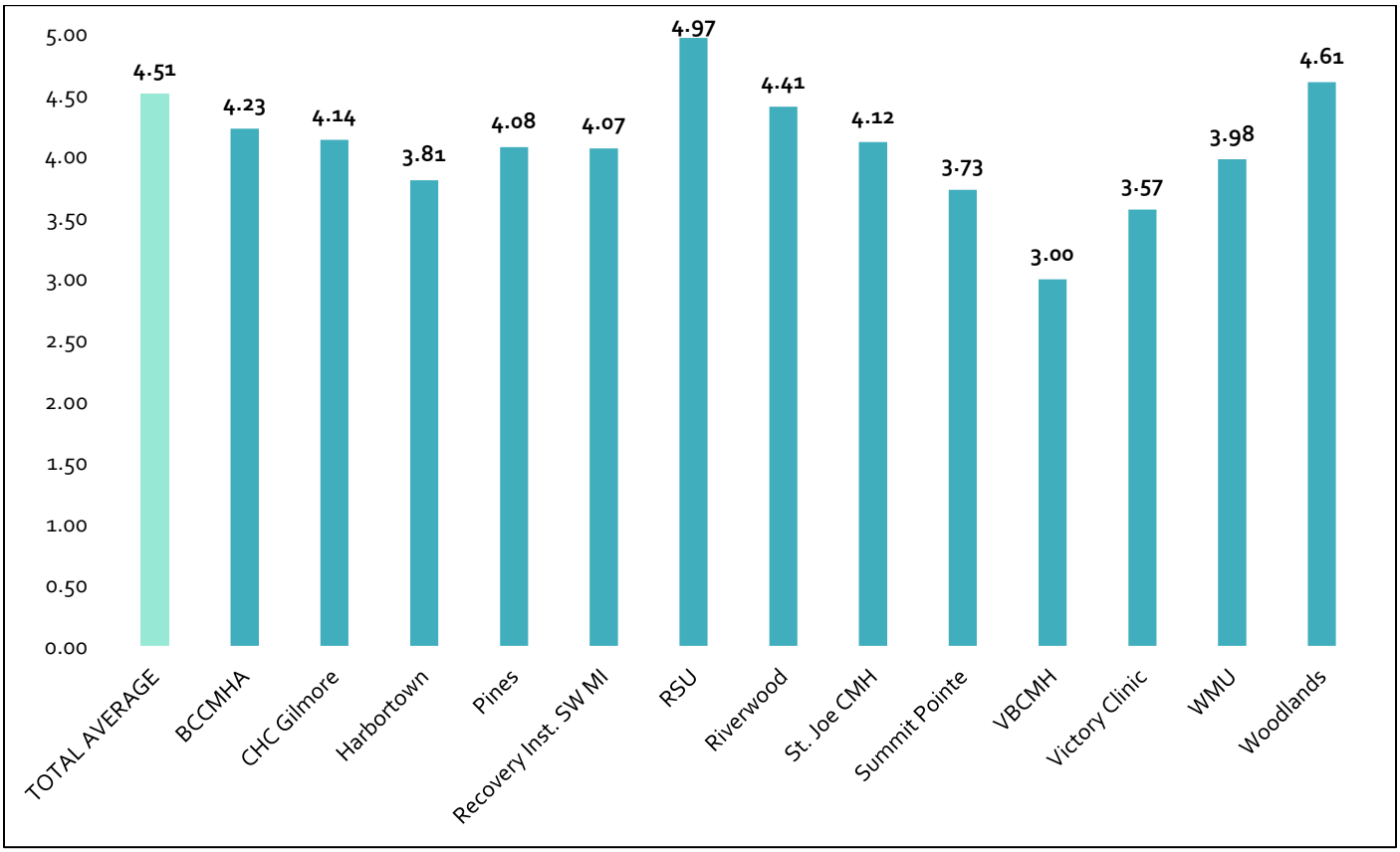
Subcategory: Involvement



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.

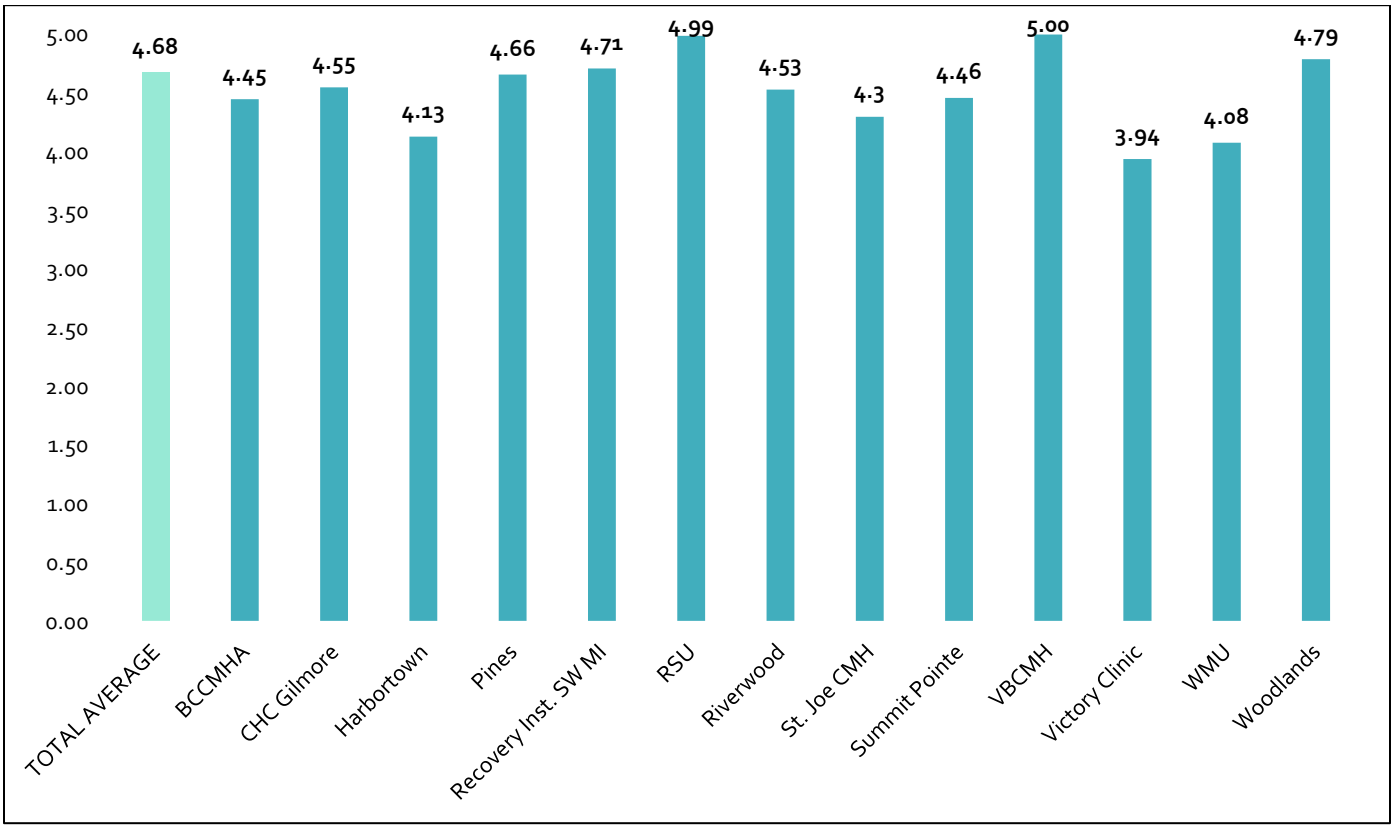
Subcategory: Diversity of Treatment



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.

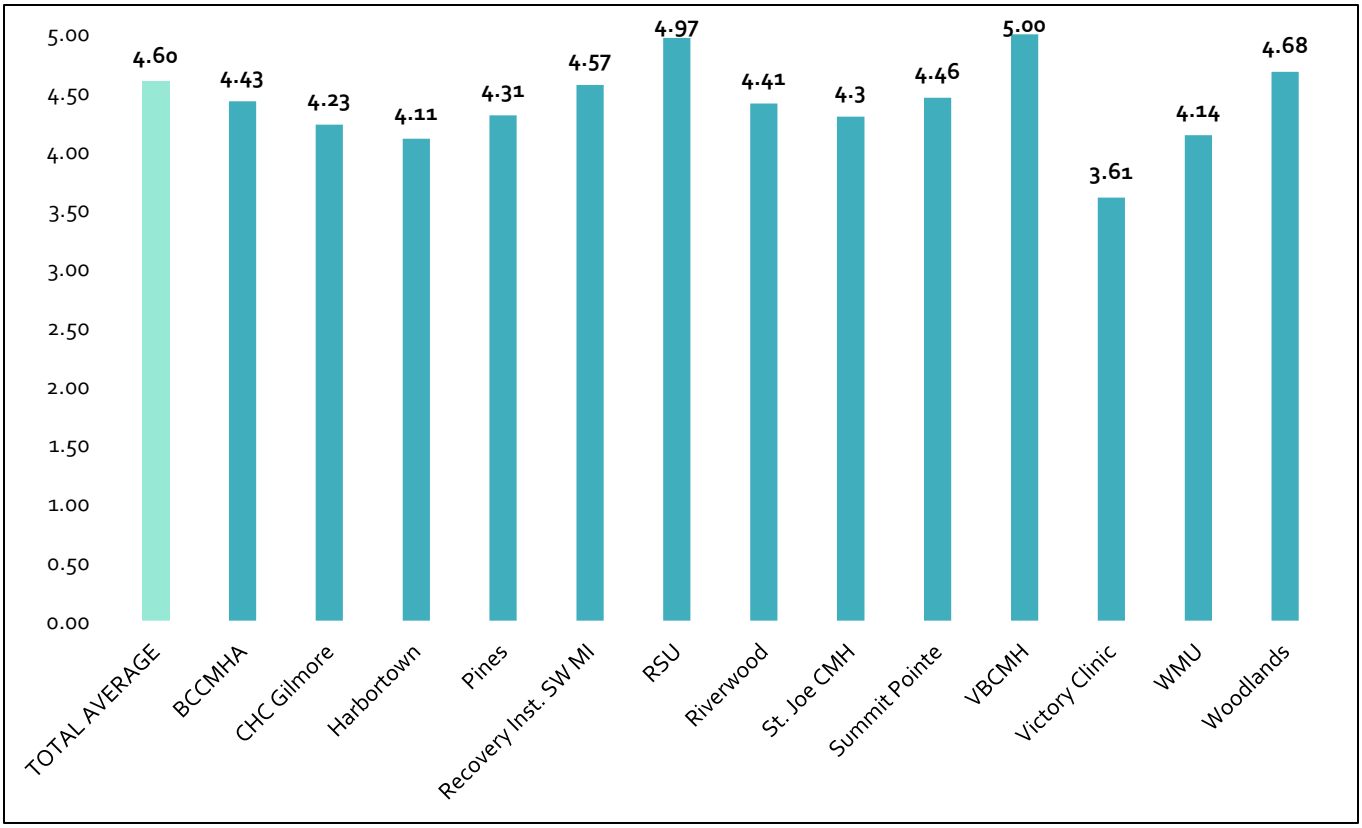
Subcategory: Choice



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 QAPIP 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.

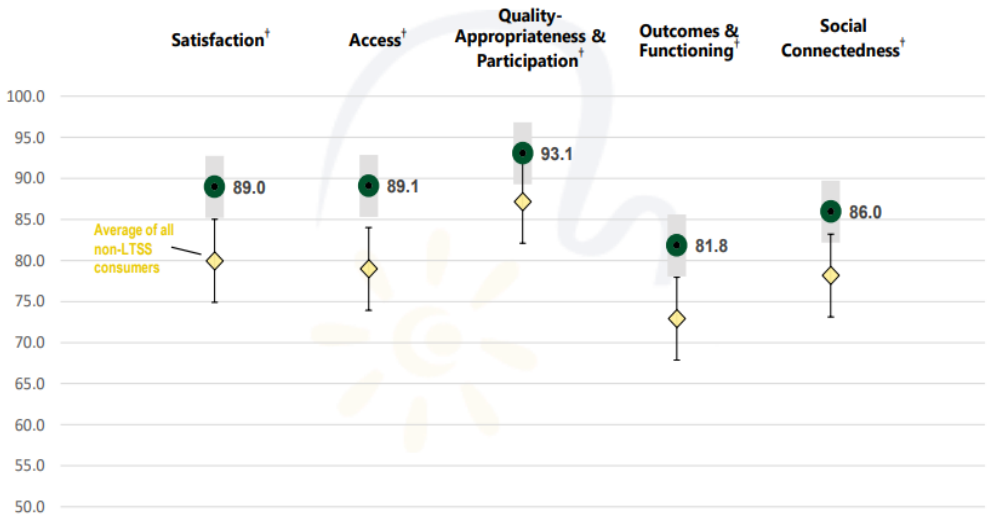
FY22 Results

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.

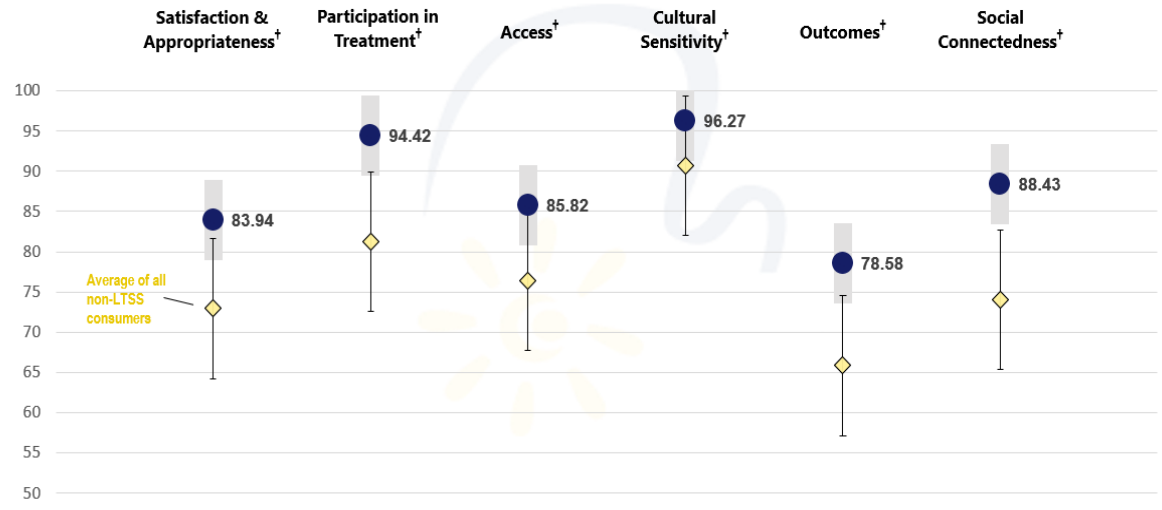
Adult LTSS consumers report better scores than non-LTSS adults across the board

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.

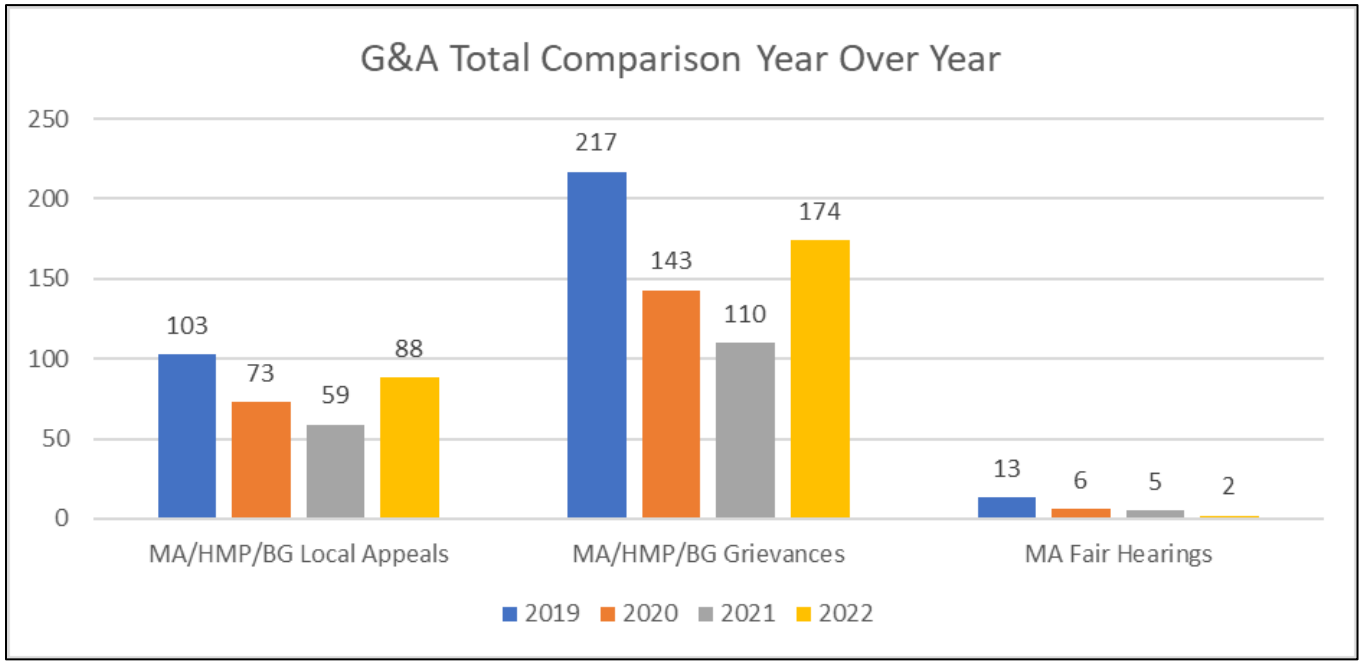
	Count	Percentage
Appeals	88	
Appeals Upheld	44	50%
Appeals Overturned	43	49%
Appeals Partially Upheld/Overturned	1	1%

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

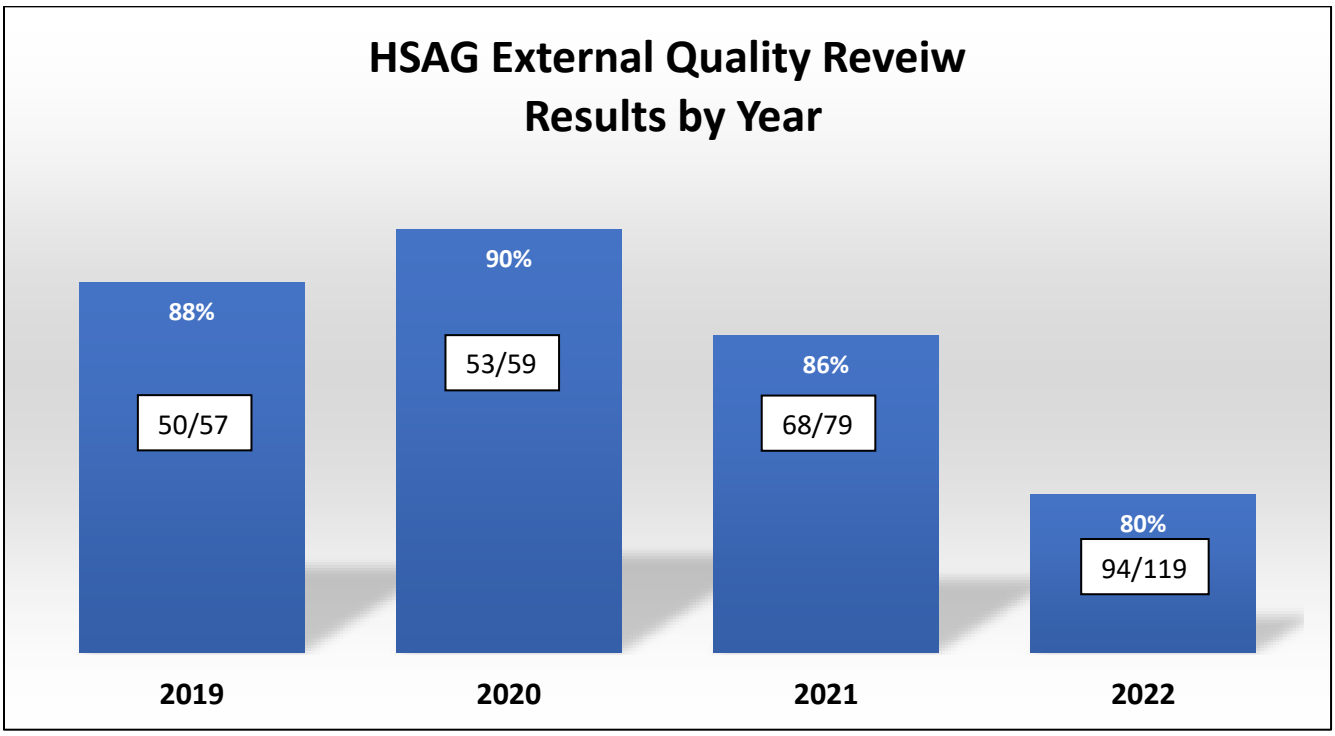
For any program areas requiring corrective action from audit completed in 2022, SWMBH conducted a review and analysis of the findings and submitted CAPs to bring the elements into compliance. CAPs were submitted within 30 days of receipt of the final report. For each element that required correction,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

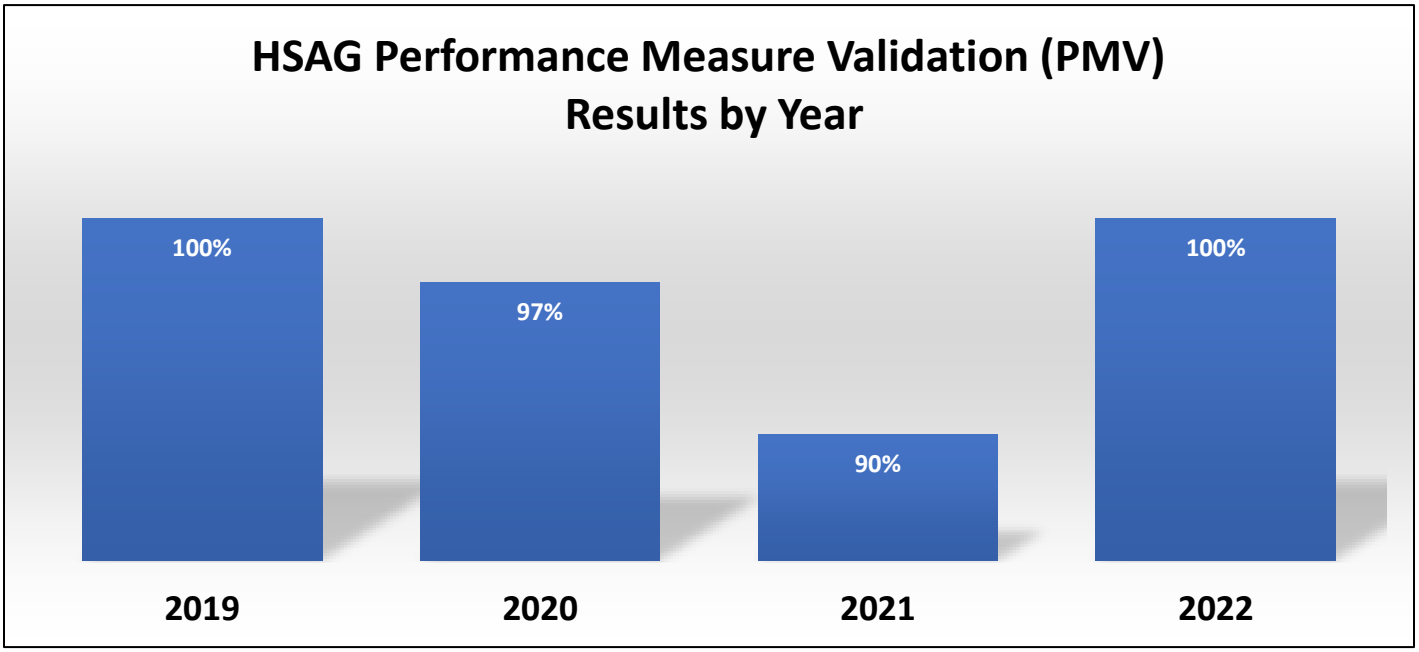
The table below represents an overview of the results of the SFY 2022 compliance review for Southwest Michigan Behavioral Health. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement 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 ***"Accepted"*** and met full compliance standards.
Reportable	**12/12** – 100% of Performance Indicators Evaluated were ***"Reportable"*** and compliant with the State's specifications and the percentage reported.
Met	**13/13** – 100% Data Integration and Control Elements Evaluated ***"Met"*** full compliance standards.
Met	**9/9** – 100% Numerator and Denominator Elements Evaluated **"Met"** full compliance standards.
37/37 or 100% Of Total Elements Evaluated received a designation score of "Met", "Reportable", or "Accepted".	

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	Copies of policies and procedures Monitoring tool Copies of reports findings Evidence of making reports available to public	✓ 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

<table>
<tr><th>Measure</th><th>Deliverables</th><th>Results</th></tr>
<tr>
<td>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).

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.</td>
<td>a. Due January 2022:
• 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.

. 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</td>
<td>METRIC ACHIEVED
<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><tr><td colspan="5">NARRATIVE REVIEW:</td></tr><tr><td colspan="5">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.</td></tr></table></td>
</tr>
</table>

<table>
<tr><th>Measure</th><th>Deliverables</th><th>Results</th></tr>
<tr><td></td><td>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</td><td></td></tr>
<tr><td>P.2. PA 107 of 2013 Sec. 105d (18): Increased data sharing with other providers (25 points)</td><td>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.</td><td>METRIC ACHIEVED
<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.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:
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></table></td></tr>
<tr><td>P.3. Initiation, Engagement and Treatment (IET) of Alcohol and Other Drug Dependence (50 points)</td><td>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.
Note: The State recognizes the Contractor does not have a full data set for analyses.</td><td>METRIC ACHIEVED
<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.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></table></td></tr>
</table>

<table>
<tr><th>Measure</th><th>Deliverables</th><th>Results</th></tr>
<tr><td>P.4. PA 107 of 2013 Sec. 105d (18): Increased participation in patient-centered medical homes (20% of total withhold)</td><td>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:
1. Comprehensive Care
2. Patient-Centered
3. Coordinated Care
4. Accessible Services
5. Quality & Safety</td><td>METRIC ACHIEVED
<table><tr><th></th><th>TOTAL WITHHOLD AMOUNT</th><th>TOTAL WITHHOLD UNEARNED AMOUNT</th><th>AVAILABLE POINTS</th><th>POINT EARNE</th></tr><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><tr><td colspan="5">NARRATIVE REVIEW:</td></tr><tr><td colspan="5">The idea of a Narcan vending machine is a great resource to avoid overdose death. The CCM prograı is beneficial when customers can work 1 on 1 with a nurse to navigate physical and behavioral healt issues. It is promising to see that BCCMHA partners with other medical providers, local courts and la enforcement, schools, and other human service providers to coordinate post-hospital aftercare. Th 100% hospital follow-up care is amazing. MDHHS likes that Riverwood meets consumers in the mo convenient manner via ‘remote’ or telehealth and same day appointments.</td></tr></table></td></tr>
</table>

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.

<table>
<tr><th>Category</th><th>Deliverables</th><th>Results</th></tr>
<tr><td>J.1. Implementation of Joint Care Management Processes (35 points)</td><td>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.</td><td>METRIC ACHIEVED
<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></td></tr>
<tr><td>J.2 Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days using HEDIS descriptions (40 points)</td><td>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.

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.</td><td>METRIC ACHIEVED
<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.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></table><table><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></td></tr>
</table>

<table>
<tr><th>Category</th><th>Deliverables</th><th>Results</th></tr>
<tr><td></td><td>The points will be awarded based on MHP/Contractor combination performance measure rates.

The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given entity.

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</td><td>
<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.2. 2 Follow-up after Hospitalization (FUH) within 30 days stratified by race/ethnicity.</td><td>$140,643.42</td><td>$0</td><td>20</td><td>20</td></tr>
</table>
J.2.1 – Medicaid Health Plan FUH-30-day combination metric
• Targets: 70% Child and 58% Adult:
• SWMBH missed one combination metric with Molina (53%) or 2.50pts.
</td></tr>
<tr><td>J3. Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence (25 points)</td><td>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.

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.

The points will be awarded based on MHP/Contractor combination performance measure rates.

The total potential points will be the same regardless of the number of MHP/Contractor combinations for a given entity.

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</td><td>
METRIC ACHIEVED

<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.3 Follow-up after (FUA) Emergency Department visit for Alcohol and Other Drug Dependency within 30 days stratified by race/ethnicity.</td><td>$175,804.28</td><td>$39,067.62</td><td>25</td><td>19.44</td></tr>
</table>
J.3. Follow-up after (FUA) 30-days Stratified by race/ethnicity
• 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.
</td></tr>
</table>

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

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

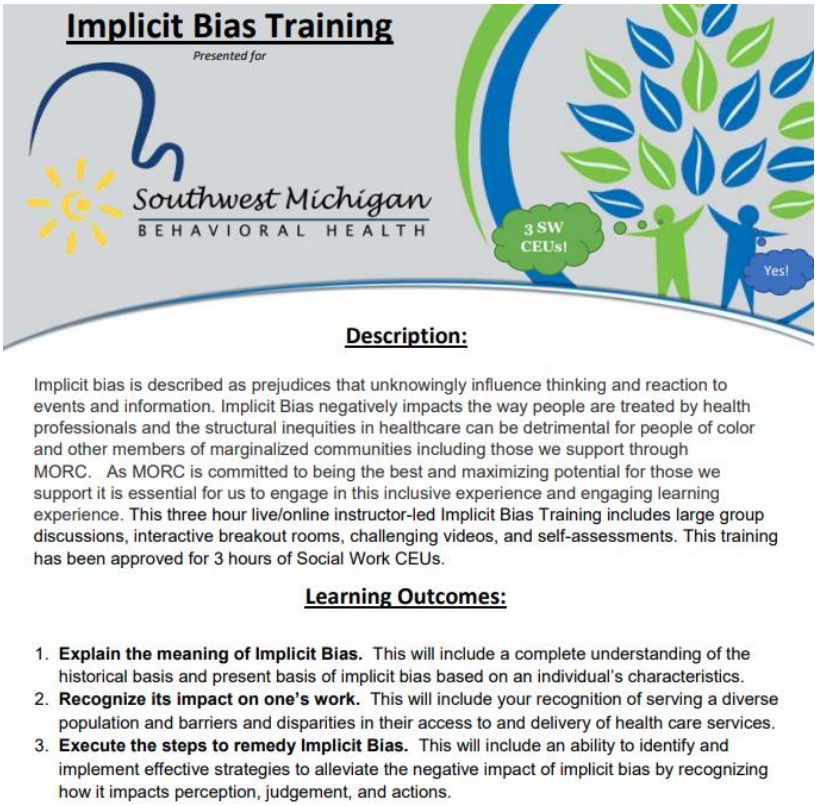
Opportunities for Improvement

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.



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.	• SWMBH Position Descriptions • SWMBH Policy 3.7 – Cultural and Linguistic Competency	To promote a workforce that is reflective of the community and individuals served.

	• 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	• SWMBH Position Descriptions • SWMBH Policy 3.7 – Cultural and Linguistic Competency • SWMBH Policy 4.7 – Competitive Employment	To promote hiring of staff who embrace cultural competency as a work ethic.
C. SWMBH utilizes non-discrimination statements in all hiring and contracting searches.	• SWMBH Position Descriptions • SWMBH Annual Performance Review Form • SWMBH Policy 3.7 – Cultural and Linguistic Competency • SWMBH Policy 4.7 – Competitive Employment	SWMBH seeks to develop a workforce reflective of 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.	• 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 2019are native Spanish speakers. 1.75% speak Arabic and .489% speak Chinese (including Mandarin, Cantonese), the next two most common languages
E. SWMBH reviews *Essential Functions* of each employee.	• SWMBH Position Descriptions • SWMBH Annual Performance Review Form • SWMBH Policy 3.7 – Cultural and Linguistic Competency	To ensure tasks and responsibilities remain accurate as well as provided in a Culturally Competent manner.
F. SWMBH promotes Cultural Competence practices in design, monitoring of contractual provider performance.	• SWMBH Member/Provider Handbook • SWMBH Site/Monitoring Reviews • SWMBH Cultural Competency Workgroup • Network Adequacy Analysis – Population Race/Ethnicity Analysis	To ensure provider network performance meets SWMBH standards.

G. SWMBH maintains representation within the Recovery Oriented Systems of Care (ROSC) Community-Wide Collaboration, which explores Cultural Competency and barriers.	• ROSC Community Collaboration Meeting Minutes. • Network Adequacy Analysis – Population Race/Ethnicity Analysis	Based on needs, 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).	• SWMBH Employee Satisfaction Surveys • SWMBH Policy 3.7 – Cultural Competency • SWMBH Policy 2.12 – Network Adequacy • SWMBH Policy 2.7 – Communication to Providers	Evaluation performed to identify if SWMBH workforce continues to be reflective of demographics of community/individuals served.

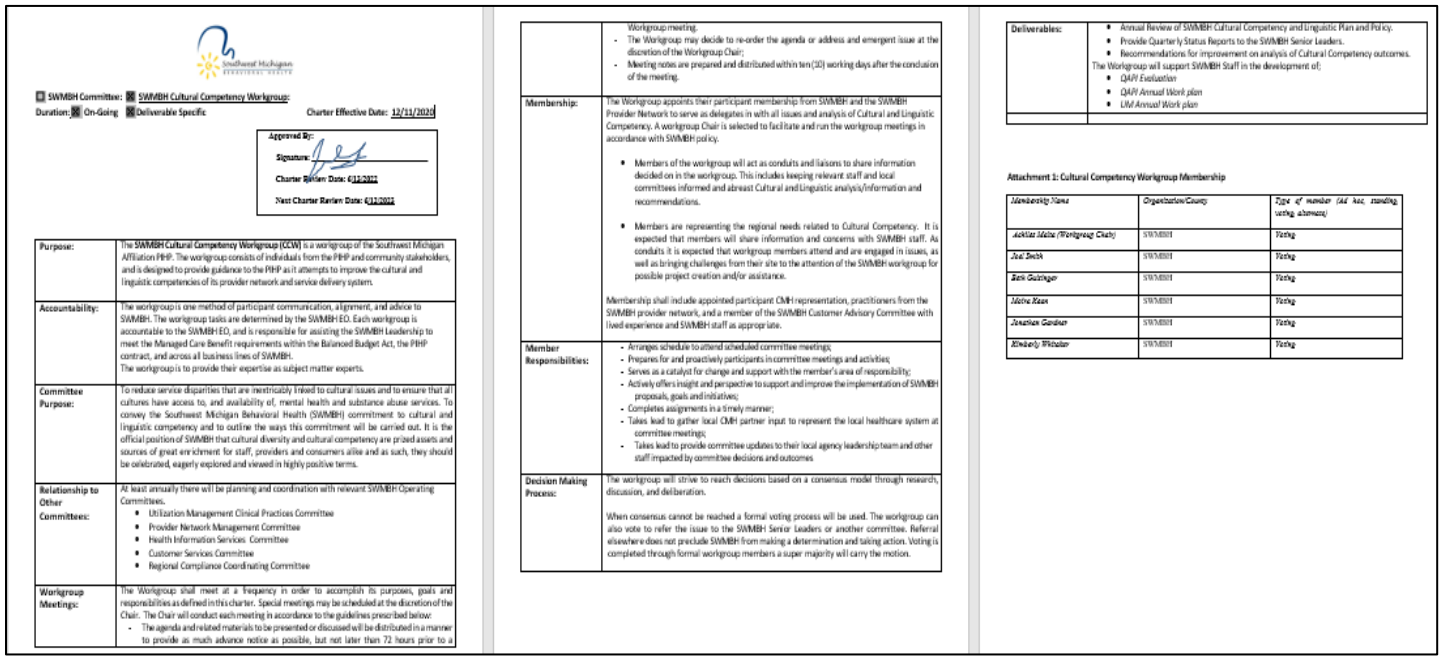
Individuals Served

Business Practice – to promote Competency	Source	Outcome
I. SWMBH encourages customers to identify their need for language support services via the use of "I Speak" tools at service sites or via telephone contacts.	• SWMBH Policy 6.5 Limited English Proficiency • SWMBH Network Adequacy Plan	When customers can identify their primary language, SWMBH can direct supports necessary to provide support and services.
J. SWMBH provides no-cost interpretation and translation as necessary for vital documents, during appointments, and telephone contacts.	• SWMBH Policy 4.3 – Authorization and Outlier Management	To engage in services, SWMBH offers free language assistance to customers and individuals seeking services.
K. Via the Person-Centered Planning process, SWMBH (and all contracted providers) encourages discussion of the importance of issues such as: culturally sensitive needs, gender or age specific needs, economic issues, spiritual needs/beliefs, and/or issues related to sexuality identity/orientation – in all treatment planning.	• SWMBH Policy 4.5 – Person and Family Centered Planning	To ensure customers are receiving services suited to their individual needs.
L. SWMBH maintains a competent provider panel of interpreters and translators.	• SWMBH Policy 4.1 – Access Management	To ensure customers can receive educational materials and supportive services in their preferred language.
M. SWMBH will utilize the community needs assessment process and feedback generated from annual customer satisfaction surveys to evaluate any changing cultural/linguistic needs of the community.	• SWMBH 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	• SWMBH Customer Handbook	Community members and customers will have access to

	provided in preferred languages to customers.	• 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.	• 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:



SWMBH Committee: ☒ SWMBH Cultural Competency Workgroup:
Duration: ☒ On-Going ☒ Deliverable Specific Charter Effective Date: 12/11/2020

Approved By:
Signature:
Charter Review Date: 4/12/2021
Next Charter Review Date: 4/12/2022

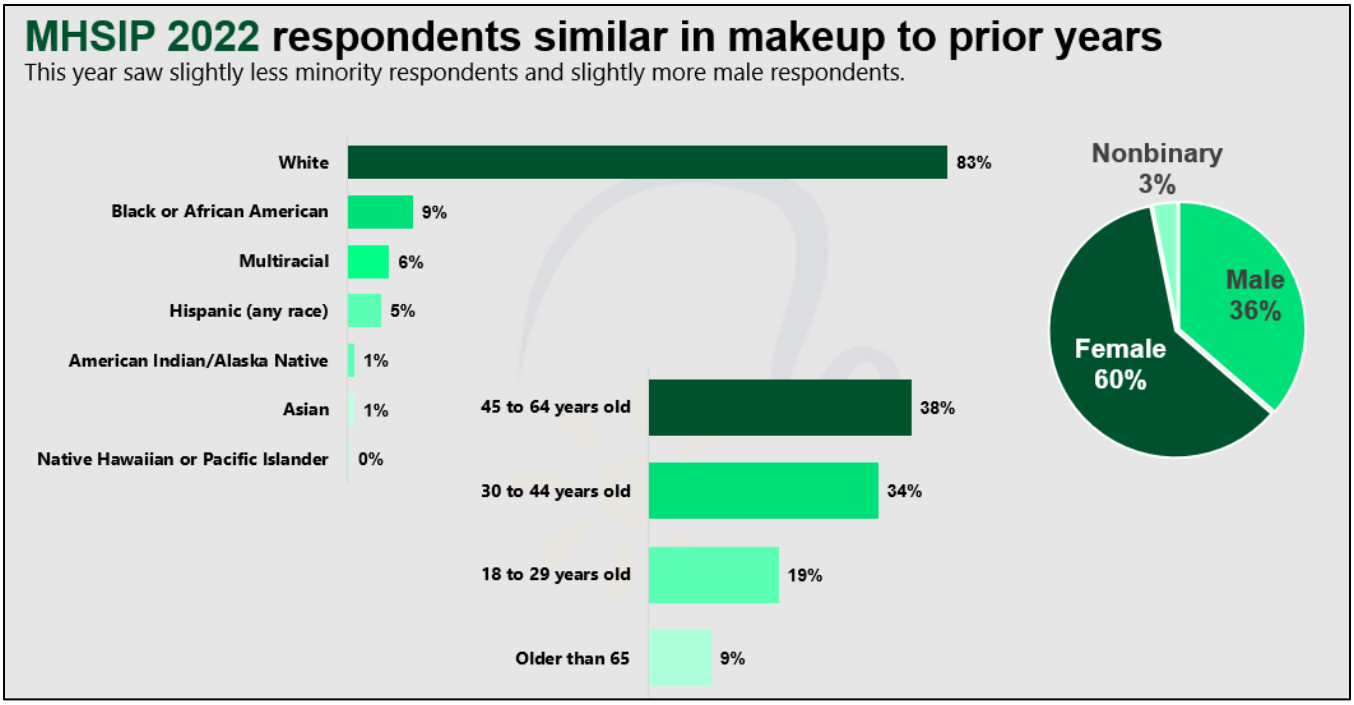
Purpose:	The SWMBH Cultural Competency Workgroup (CCW) is a workgroup of the Southwest Michigan Affiliation PIHP. The workgroup consists of individuals from the PIHP and community stakeholders, and is designed to provide guidance to the PIHP as it attempts to improve the cultural and linguistic competencies of its provider network and service delivery system.
Accountability:	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.
Committee Purpose:	To reduce service disparities that are inextricably linked to cultural issues and to ensure that all cultures have access to, and availability of, mental health and substance abuse services. To convey the Southwest Michigan Behavioral Health (SWMBH) 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.
Relationship to Other Committees:	At least annually there will be planning and coordination with relevant SWMBH Operating Committees. • Utilization Management Clinical Practices Committee • Provider Network Management Committee • Health Information Services Committee • Customer Services Committee • Regional Compliance Coordinating Committee
Workgroup Meetings:	The Workgroup shall meet at a frequency in order to accomplish its purposes, goals and responsibilities as defined in this charter. Special meetings may be scheduled at the discretion of the Chair. The Chair will conduct each meeting in accordance to the guidelines prescribed below: - The agenda and related materials to be presented or discussed will be distributed in a manner to provide as much advance notice as possible, but not later than 72 hours prior to a Workgroup meeting. - The Workgroup may decide to re-order the agenda or address and 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.
Membership:	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. • 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 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 conduits 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. 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.
Member Responsibilities:	- Arranges schedule to attend scheduled committee meetings; - Prepares for and proactively participants 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
Decision Making Process:	The workgroup 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. 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.
Deliverables:	• 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. The Workgroup will support SWMBH Staff in the development of; • QAPI Evaluation • QAPI Annual Work plan • UM Annual Work plan

Attachment 1: Cultural Competency Workgroup Membership

Membership Name	Organization/County	Type of member (ad hoc, standing, voting, observer)
Ashlee Mehe (Workgroup Chair)	SWMBH	Voting
Joel Smith	SWMBH	Voting
Beth Gutzinger	SWMBH	Voting
Mona Kaan	SWMBH	Voting
Jonathan Gardner	SWMBH	Voting
Kimberly Whitaker	SWMBH	Voting

Cultural Competency Analysis 2022 Survey Demographic

During the Annual Consumer Satisfaction Survey Process, SWMBH completes an analysis of respondence. 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.

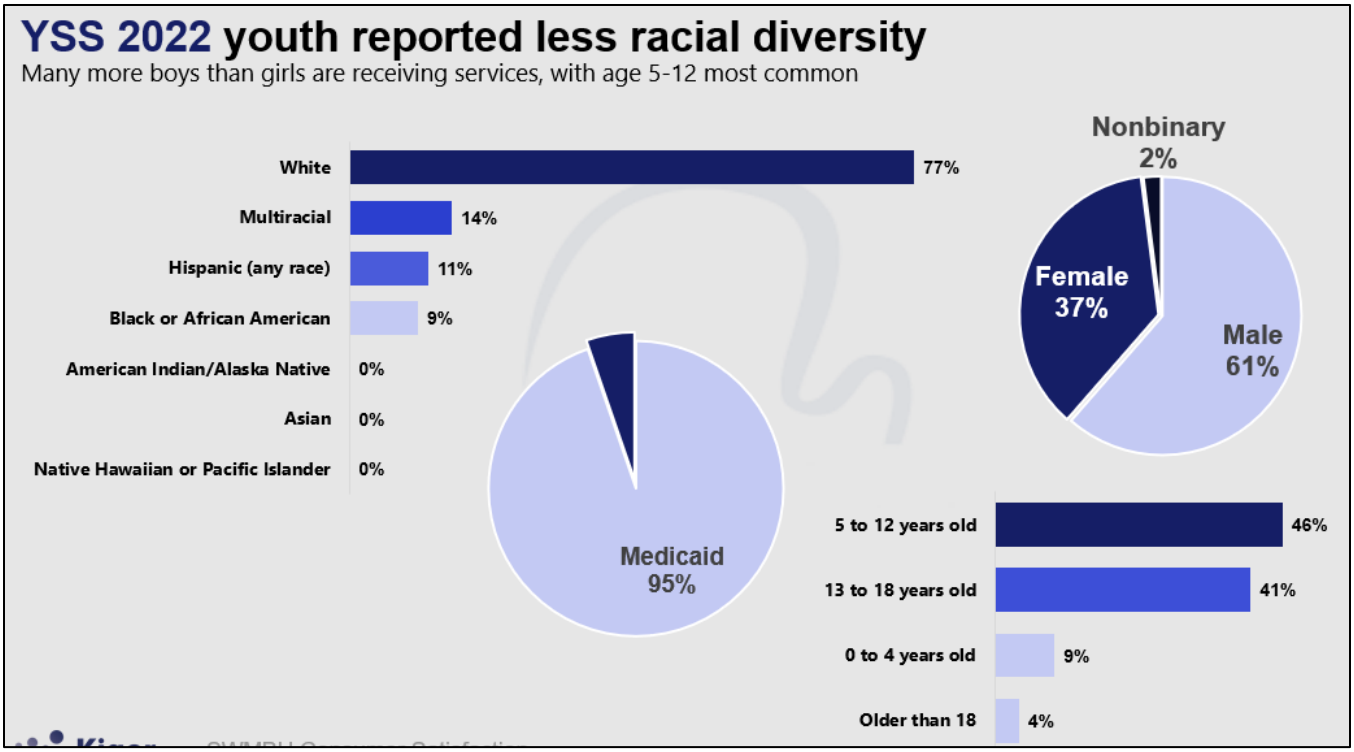


Respondent Comparison by Year (Adult Survey)

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.



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. *300* 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** ▪ FY 21 – 86% (56/65) ▪ FY 20 – 90.6% *SWMBH tied for 1st 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**

	Project is on schedule to be completed and live by 10/1/21. C. Automated processes for analyzing the ASAM data/results/reports are being developed and scheduled for completion by 2/11/21.		
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.	**Metric Achieved** • 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.	**Metric Achieved** Measurement Period Concludes on 12/30/21. Final Consultative Draft from MDHHS will be received by November/December 2021 Q1: 6/7 Q2: 7/7 Q3: 7/7 Q4:7/7 27/28 Indicators 'Met' the Indicated benchmark – **96.4%**	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.	**Metric Achieved** **Status as of 9/27/21:** • 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 (*contractually specified*) quality withhold performance measures, agreed upon by the Integrated Care Organizations (ICO's).	**Metric Achieved** 2020-2021 Rates: • 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.	**Metric Achieved** Notice provided by MDHHS on 1/19/2022 *VSN Data has been submitted and received through the DCH file transfer successfully. *Data Quality Narrative Report send and received by MDHHS on 7/1/21. **Final PBIP Results received in January 2022**	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.	**Metric Achieved** ✓ 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. **Final PBIP Results received in January 2022**	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.	**Metric Achieved** 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)	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.	**Metric Achieved** The final MDHHS – PBIP report indicated that; SWMBH received 35/35 points or 100% satisfying elements A and B This metric is largely based on combination calculations between the MHP and PIHP in CC360.	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:** • 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. • The MHSIP (adult) '*Improved Functioning'* category observed an improvement of +1.77% (*86.87%)* over the previous year's result (*85.1%). 1pt* • The YSS (youth) '*Improved Outcomes'* 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. a. 24/28 indicators meet the State Benchmark, throughout all FY22. 1pt. b. Indicator 3a,b,c & d achieve a 3% combined improvement (*through FY 22 all 4 Quarters*) over 2021 baseline (1/2 pt. each) 2pts	**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. SWMBH / PIHP Ave. A. 65% (56%) / 74% B. 66% (61%) / 73% C. 74% (69%) / 82% D. 75% (68%) / 79% **+6.5%** improvement from FY21 baseline to current FY22 results.	Board Presentation and Approval on January 13, 2023	**1 pt. earned**