Quality Assurance and Performance Improvement Program (QAPIP) FY23 Evaluation

All SWMBH Medicaid Business Lines

Evaluation Period: October 1, 2022 - September 30, 2023

Reviewed by:
SWMBH Board of Directors
Operations Committee
Quality Management Committee

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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 Quality Management (QM) 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.

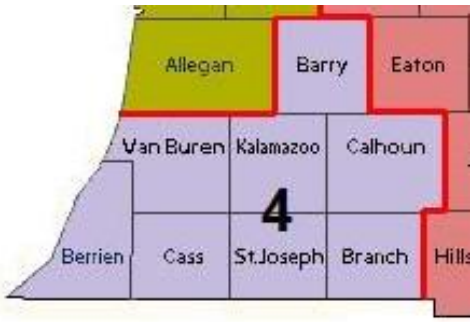
This annual evaluation includes improvement initiatives undertaken by SWMBH from October 2022 through September 2023 for Medicaid Services and the status of QAPIP Plan goals. The formulation of the QAPIP goals includes incorporating numerous federal, state, and accreditation principles. This includes 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 QM 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 SWMBH's QAPIP Evaluation and approve the QAPIP Plan on an annual basis.

Service Population and Eligible Members Served

SWMBH (Region 4) served 32,425 unique members from October 1, 2022, to September 30, 2023, with 299,029 Medicaid Eligible in the Region.

Members 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 (I/DD)



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.

SWMBH has completed the Annual QAPIP Evaluation Report and incorporated recommendations received from MDHHS and HSAG. SWMBH utilized the NCQA 'Best Practice' evaluation standards and has provided the following elements for each functional area evaluated:

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

A. Michigan Mission Based Performance Indicator System (MMBPIS)

Description

Each Community Mental Health Service Program (CMHSP) was responsible for reviewing and submitting valid and reliable performance indicator data to SWMBH each month in FY23 for analysis. SWMBH promoted data integrity by using electronic controls within the spreadsheets used for reporting MMBPIS data. SWMBH has a QAPI Specialist dedicated to the oversight and monitoring of the data to ensure it is complete and accurate, based on the MMBPIS PIHP and CMHSP Code Book, prior to submission to MDHHS. SWMBH submitted the data to MDHHS quarterly in FY23 as established in the contract schedule. SWMBH utilized the QAPIP to assure it achieved minimum performance levels on performance indicators as established by MDHHS and defined in the contract and analyzed causes of negative statistical outliers when they occurred. When State-indicated benchmarks were missed, or other issues are identified, SWMBH requested that the CMHSPs and/or Substance Use Disorder (SUD) Providers complete a Corrective Action Plan (CAP). The PIHP ensured the action plans were achieved and improvements were recognized. Status updates were given, and regional trends were identified and discussed at relevant committees for further planning and coordination. SWMBH also participated in the MDHHS Performance Indicator Workgroups and communicated changes with indicator measurement or reporting to internal and external stakeholders. Additional oversight and monitoring occurred in the annual CMHSP Site Reviews where the SWMBH QM Department analyzed progress and trends with MMBPIS Performance Indicator data, primary source verification documentation, and protocols. SWMBH analyzed and communicated results to the CMHSPS and requested CAPs as needed. These efforts ensured improvements in the quality of health care and services for members, service delivery, and health outcomes over time.

FY23 Goals

SWMBH will meet or exceed the MDHHS-indicated benchmark for each of the access and follow-up MMBPIS performance measures (Indicators 1, 4 and 10). SWMBH's Board Ends Metrics target in FY23 was that 85% of MMBPIS Indicators will achieve the State-indicated benchmark for four consecutive quarters for FY23. An additional target is set for Indicator 3a, b, c, and d to achieve a 3% combined improvement (through FY23, all four quarters) over the FY22 baseline.

Goal	Responsible Department	Where Progress Was Monitored	Frequency of Monitoring
Indicator 1 - Percentage of Children who receive a Prescreen within 3 hours of request (>= 95%).	QM	QMC	Monthly
Indicator 1 - Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95%).	QM	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 4 sub-populations: MI-adults, MI-children, IDD-adults, IDD-children).	QM	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 SUDs.	QM	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 4 sub-populations: MI-adults, MI-children, IDD-adults, IDD-children).	QM	QMC	Monthly

Indicator 4a (a) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%).	QM	QMC	Monthly
Indicator 4a (b) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%).	QM	QMC	Monthly
Indicator 4b - Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%).	QM	QMC	Monthly
Indicator 10a - Re-admission to Psychiatric Unit within 30 Days-Children (standard is <=15%).	QM	QMC	Monthly
Indicator 10b - Re-admission to Psychiatric Unit within 30 Days- Adults (standard is <=15%).	QM	QMC	Monthly

FY23 Identified Barriers and Analysis

Notable barriers for Region 4 included, but are not limited to, staffing shortages, access to services in rural areas, and communication from healthcare partners outside the CMHSP system. Exclusions and exceptions for indicators 2a, 2e, and 3 were eliminated in FY20 and continued to impact the length of time to treatment after request for service. Benchmarks remained unset for these indicators in FY23, however, as anticipated, were announced by MDHHS and will be effective beginning FY24. In anticipation of the new benchmarks for access and timeliness to appointments and with the decrease in performance from FY22 to early FY23 (see Year to Year Indicator 3 Comparison below), SWMBH's Provider Network Department established a regional Workgroup with representation from all CMHSPs to further review MMBPIS indicator 3. Some barriers to timely appointments with CMHSP consensus were clinical and psychiatric staffing shortages. CMHSPs openly discussed what incentives they have offered to attract and hire clinicians. Member engagement was discussed at most QMC meetings and PIHP MHP Workgroups to brainstorm and troubleshoot barriers that were identified in the region.

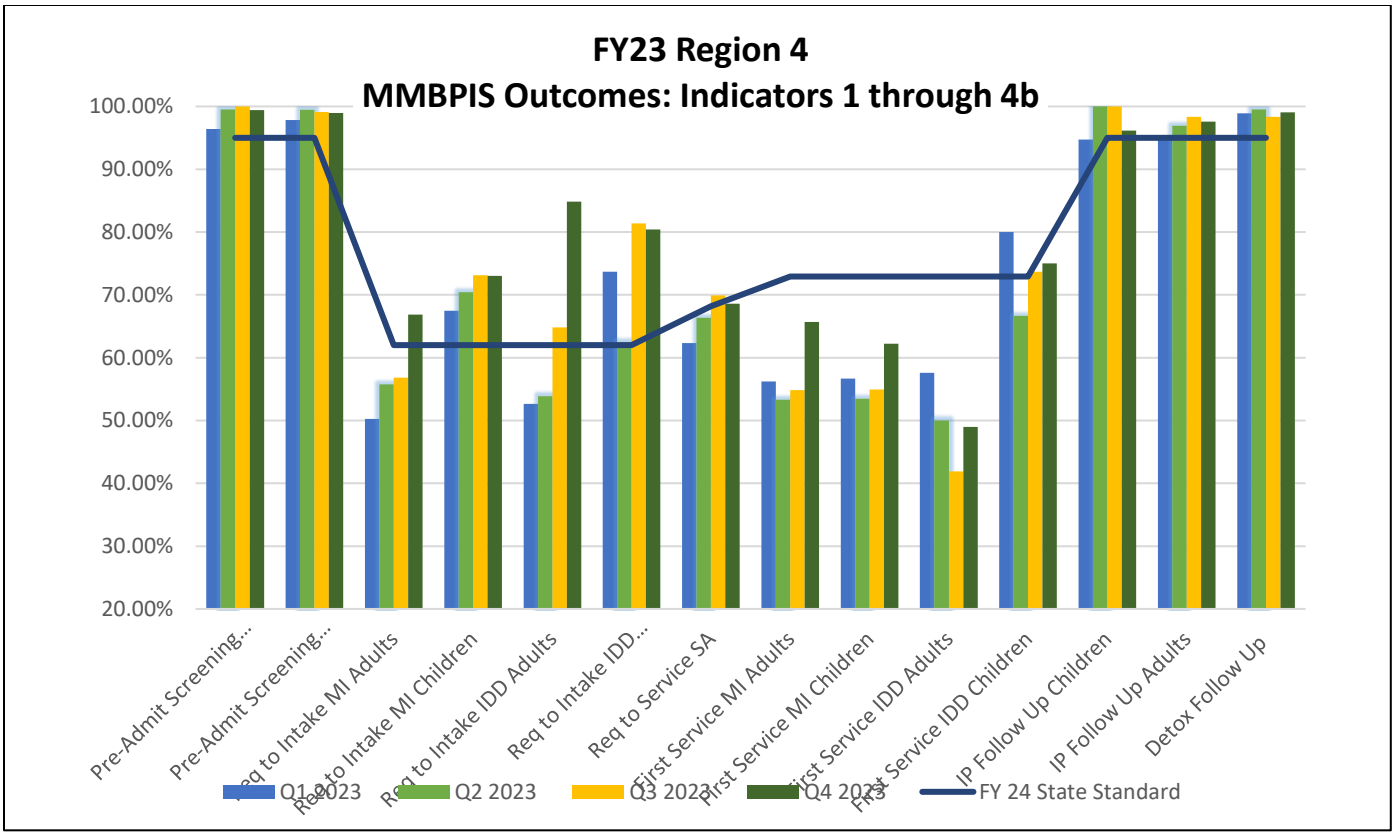
Improvement Efforts Made in FY23

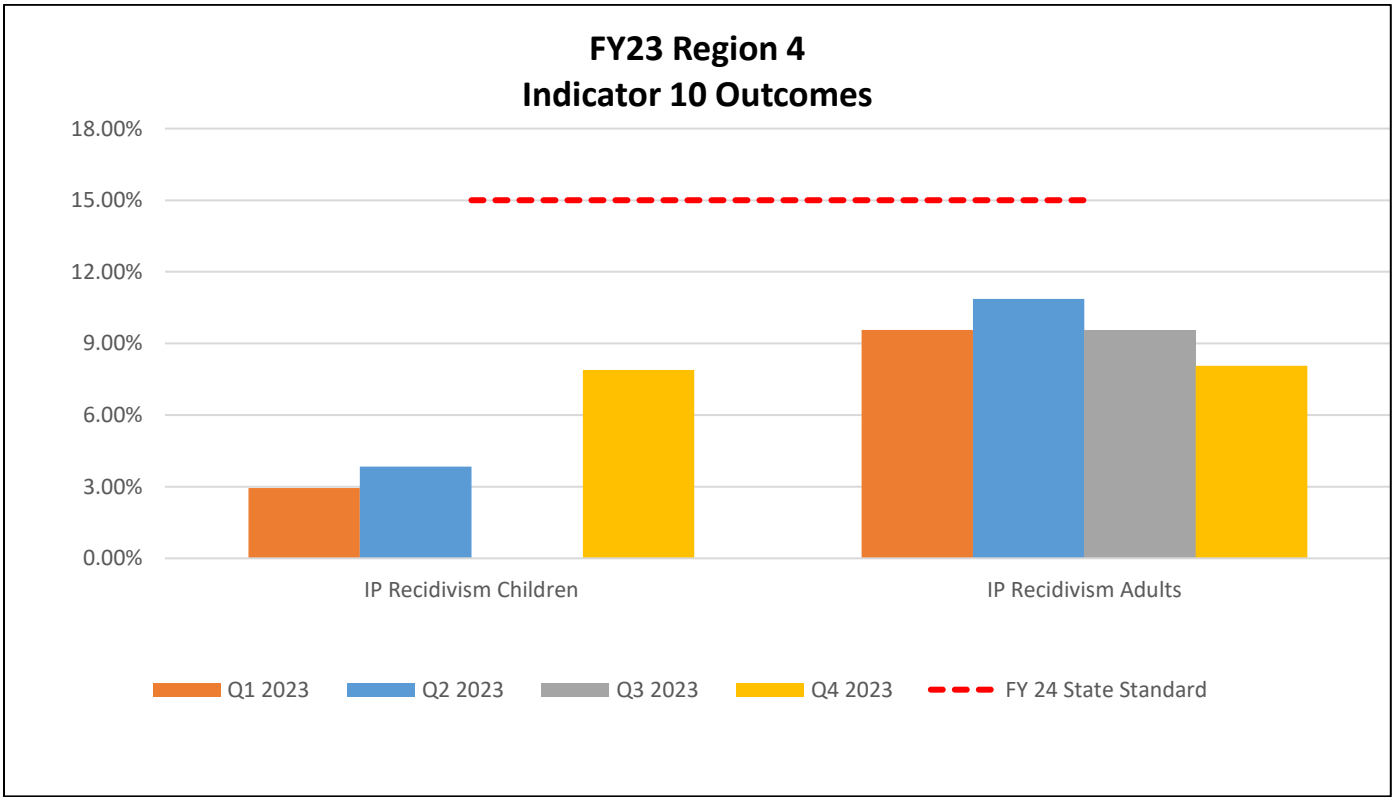
During the FY23 Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) audit, the need for additional analysis and validation of PIHP-reported expired requests was identified. This validation process engages CMHSPs and SUD providers to accurately identify missing Behavioral Health Treatment Episode Data Set (BH TEDS) admission records. Updates were also made to the PIHP indicator 4b report to better align with the PIHP Reporting Codebook. SWMBH met one of two Board Ends Metrics associated with MMBPIS Performance Measures, missing regional benchmarks only twice in FY23 (met 92.9% of 85% goal, 26/28) which was an improvement from FY22. In anticipation of the new benchmarks in FY24, SWMBH increased the frequency of analysis of indicators 2a, 2e and 3 during QMC and the SUD Directors meetings and in the above-mentioned Regional Workgroup, igniting discussion and sharing best practices across the region. A consistent approach in counting the IPOS pre-planning meeting as the first service while maintaining the integrity of the IPOS process was established in the fourth quarter of FY23 and an increase in outcomes resulted. SWMBH continued to send CMHSPs appreciation letters upon meeting 100% of the State's performance indicators. SWMBH also distributed CAP requests to address any indicators not meeting the state benchmark. Proof of action was likewise required to ensure implementation. A systematic approach to engage Clinical and Quality subject matter experts at the PIHP and CMHSP levels were established in FY23 as part of the data review and CAP approval process.

FY23 Results

Indicator	FY22	FY23	Eval Score	Recommendations
1 - Percentage of Children who receive a Prescreen within 3 hours of request (>= 95%).	99.40%	98.86%	5	The goal was met, will stay the same and be monitored through FY24.
1 - Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95%).	99.26%	98.88%	5	The goal was met, will stay the same and be monitored through FY24.
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-adult, MI-child, IDD-adult, IDD-child.	73.15%	66.85%	3	MDHHS benchmarks were established for FY24 based on FY22 performance. This goal will be monitored through the upcoming FY.
2e - 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.	65.19%	66.83%	3	MDHHS benchmarks were established for FY24 based on FY22 performance. This goal will be monitored through the upcoming FY.
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-adult, MI-child, IDD-adult, and IDD-child).	64.08%	56.78%	3	MDHHS benchmarks were established for FY24 based on FY22 performance. This goal will be monitored through the upcoming FY. Due to low indicator performance, a non-clinical PIP was also established to affect this indicator—see further details below in Section B.
4a(a) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%).	98.71%	98.01%	4	The goal was met, will stay the same and be monitored through FY24.
4a(b) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%).	95.85%	96.98%	4	The goal was met, will stay the same and be monitored through FY24.
4b - Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%).	97.93%	98.98%	4	The goal was met, will stay the same and be monitored through FY24.
10a - Re-admission to Psychiatric Unit within 30 Days-Children (standard is <=15%).	4.83%	3.37%	4	The goal was met, will stay the same and be monitored through FY24.
10b - Re-admission to Psychiatric Unit within 30 Days- Adults (standard is <=15%).	10.85%	9.50%	4	The goal was met, will stay the same and be monitored through FY24.

MMBPIS Indicator #	MMBPIS Performance Indicator	FY24 State Standard	Q1 2023	Q2 2023	Q3 2023	Q4 2023
1a	Pre-Admit Screening Children	95%	96.39%	99.51%	100.00%	99.39%
1b	Pre-Admit Screening Adults	95%	97.85%	99.45%	99.11%	98.97%
2a(a)	Req to Intake MI Adults	62%	50.23%	55.75%	56.84%	66.85%
2a(b)	Req to Intake MI Children	62%	67.47%	70.40%	73.11%	73.05%
2a(c)	Req to Intake IDD Adults	62%	52.67%	53.85%	64.84%	84.83%
2a(d)	Req to Intake IDD Children	62%	73.68%	62.50%	81.40%	80.43%
2e	Req to Service SA	68.2%	62.34%	66.35%	69.90%	68.57%
3a	First Service MI Adults	72.9%	56.24%	53.33%	54.84%	65.70%
3b	First Service MI Children	72.9%	56.68%	53.44%	54.95%	62.23%
3c	First Service IDD Adults	72.9%	57.58%	50.00%	41.89%	48.99%
3d	First Service IDD Children	72.9%	80.00%	66.67%	73.68%	75.00%
4a(a)	IP Follow Up Children	95%	94.74%	100.00%	100.00%	96.15%
4a(b)	IP Follow Up Adults	95%	94.80%	96.91%	98.34%	97.57%
4b	Detox Follow Up	95%	98.92%	99.52%	98.36%	99.07%
10a	IP Recidivism Children	15%	2.94%	3.85%	0.00%	7.89%
10b	IP Recidivism Adults	15%	9.57%	10.87%	9.57%	8.06%
	Overall Results		5/7	7/7	7/7	7/7


FY23 Region 4
MMBPIS Outcomes: Indicators 1 through 4b
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
Pre-Admit Screening...
Pre-Admit Screening...
Req to Intake MI Adults
Req to Intake MI Children
Req to Intake IDD Adults
Req to Intake IDD...
Req 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 2023
Q2 2023
Q3 2023
Q4 2023
FY 24 State Standard


FY23 Region 4
Indicator 10 Outcomes
18.00%
15.00%
12.00%
9.00%
6.00%
3.00%
0.00%
IP Recidivism Children
IP Recidivism Adults
Q1 2023
Q2 2023
Q3 2023
Q4 2023
FY 24 State Standard

B. Performance Improvement Projects (PIPs)

Description

MDHHS requires that the PIHP conduct and submit PIPs annually to meet the requirements of the Medicaid Managed Care rules, 42 CFR Part 438. According to the managed care rules, the quality of health care delivered to 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 quality improvement 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

The State of Michigan requests that each PIHP select a PIP topic to address healthcare disparities. The specific topic was selected through the analysis of SWMBH performance and utilization trends, which assessed for the presence of racial and ethnic disparities impacting service delivery and health outcomes over time. 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 the Centers for Medicare & Medicaid Services (CMS) Core Set/Healthcare Effectiveness Data and Information 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).

In FY23 there were 3 Performance Improvement Projects that SWMBH targeted for progress. 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 PIP)
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 alcohol and other drug (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.
3. SWMBH selected a non-clinical PIP related to the Annual Customer Satisfaction Survey scores in the *'Improved Outcomes'* category for adults and the *'Improved Functioning'* category for Youth. The identified categories were the 2 lowest scoring categories over the past 5 years.

FY23 Goals

PIP	Responsible Department	Where Progress Was Monitored	Frequency of Monitoring
Performance Improvement Project #1 To reduce racial disparities in follow-up after Emergency Department visits for AOD abuse or dependence (FUA-30). Monitoring: 1. 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. 2. 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 Practices (RCP) and QMC	Bi-Annual
Performance Improvement Project #2 The percentage of adolescents and adults with a new episode of AOD abuse or dependence who received the following: 1. Initiation of AOD Treatment, the percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis (IET-14). 2. 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 (IET-34). 3. SWMBH will participate in DHHS planned data validation activities and meetings. SWMBH will be provided IET data files by 1/31/23 and have 120 calendar days to return the completed validation template to MDHHS.	Clinical Quality	RCP and QMC	Bi-Annual
Performance Improvement Project #3 SWMBH selected a non-clinical PIP related to the Annual Customer Satisfaction Survey Scores in the '*Improved Outcomes*' category for adults and the 'I*mproved Functioning*' category for Youth. The identified categories were the 2 lowest scoring categories over the past 5 years. The target categories that have been targeted for improvement during the FY23 survey period are: 1. Access and Timeliness to Care 2. Expanding Treatment, Program and Group Therapy options.	QM	QMC	Bi-Annual

Performance Improvement Project #1 – Reduce racial disparities in follow-up after ED visits for alcohol and other drug dependence.

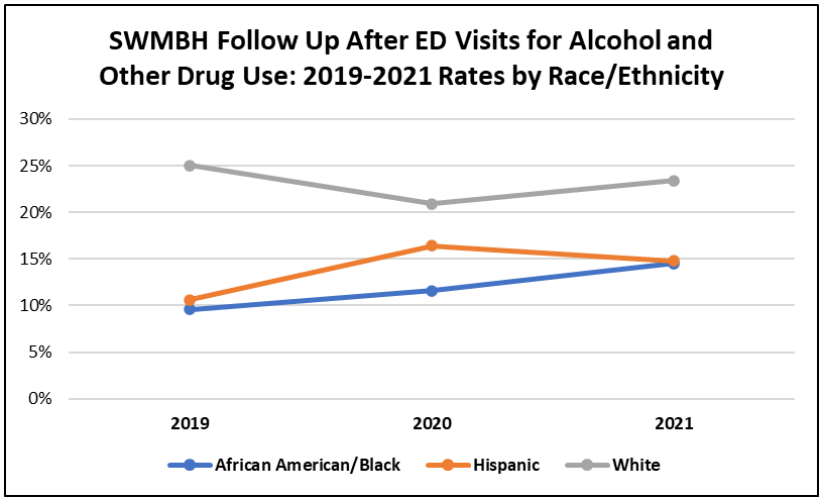
Topic Selection and Historical Results

The State of Michigan requires that each PIHP select a performance improvement project topic to address healthcare disparities. The 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 ED 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.



PIP Performance Measures

1. 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.
2. 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 CY21 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 Access and Quality of Care

During CY23, SWMBH established encounter reporting for services delivered by peers embedded in EDs in Kalamazoo County. This ensured that SWMBH received credit for these follow up services in the metric, and allowed for easier monitoring and identification of issues (like access or network capacity difficulties). Calhoun County was the next provider of ED follow up services to begin reporting encounters. Peer ED follow up services were established in Branch County, and a contract for these services was put in place in Van Buren County, but services have not been started there due to staffing challenges. SWMBH also hired a Health Equity Grant Coordinator in CY23 who coordinated focus groups to understand and address gaps in service access, implemented an anti-stigma campaign to encourage mental health and substance use treatment in non-white populations, and hosted provider trainings related to health equity and welcoming concepts. These interventions are on-going and will result in county-specific action plans to be put in place to address identified gaps in access to care. Barriers to successful interventions have included difficulty hiring for the peer ED outreach position in Van Buren County, and challenges establishing encounter reporting for peer ED follow up in counties outside of Kalamazoo. An ongoing challenge with the PIP has been that the region depends on local EDs to inform the provider network when someone in the ED requires substance-use-related follow up. EDs are not incentivized to assist PIHPs with this project. SWMBH and the CMHSPs met with local EDs to increase awareness of racial and ethnic disparities in ED follow-up for substance use, but inconsistencies remain in the number of referrals received.

Evaluation of the Effectiveness of the Interventions Based on the Performance of Measures

SWMBH evaluated the effectiveness of the interventions using Plan-Do-Study-Act (PDSA) cycles. For the first major intervention, reporting of peer follow up services, SWMBH monitors the proportion of services that the Project ASSERT partners report in their net cost reports, that also have a state-reported encounter each month. SWMBH assisted providers with problem-solving issues that arose. For the stigma campaign and provider

trainings, SWMBH used pre and post testing to assess impact. The community member and provider focus groups that the health equity project coordinator hosted identified ways to increase health equity and decrease barriers to treatment. The coordinator will continue to work with CMHSPs and providers to implement changes in FY24, and SWMBH will monitor how many of the proposed changes are successfully implemented. The next official PIP remeasurement periods are CY23 and CY24, when SWMBH will evaluate whether the interventions overall have decreased or eliminated the disparity. Results for CY23 will be available in mid CY24.

Planning and Initiation of Activities for Increasing or Sustaining Improvement

Through the course of the project, SWMBH will continue to assess the success of the 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 SWMBH's second PIP is the CMS Adult Core Set quality metric, Initiation and Engagement of Alcohol and Other Drug Treatment (IET). The 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 Initiation of Alcohol and Other Drug Treatment, and IET-34 Engagement of Alcohol and Other Drug Treatment.

1. **IET-14**: Beneficiaries 13 years or older with a new episode of 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.

IET-34: Beneficiaries 13 years or older who engaged in treatment and had two or more additional 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 FUA, FUH, and IET. A statistically significant disparity between White and African American/Black measure performance was found for IET-34 for CY21, 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 CY21 lags significantly behind Michigan Medicaid overall IET-14 performance. SWMBH's IET-14 rate for CY21 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 CY21

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.

- 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 CY21 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., CY21) 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 is responsible for the PIP's outcomes. 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 Behavioral Health (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 CMHSPs, EDs, and Project ASSERT.
- Improve CMHSP workforce diversity by collaborating with local universities to recruit more non-White students into social work.

During CY23, several of these interventions were implemented. SWMBH hired a Health Equity Grant Coordinator, who coordinated an anti-stigma campaign, the delivery of equity-focused trainings, and focus groups on access barriers. Project ASSERT encounter reporting was established in Kalamazoo County but has not yet begun in other counties. In addition, each of the 8 CMHSPs have been asked to develop and implement their own improvement plans to address IET-14 performance and IET-34 racial and ethnic disparities, since most people receiving substance use treatment through the provider network do so through the CMHSPs. Some of the interventions at the CMHSPs include peer follow up calls and arranging transportation for individuals receiving substance use treatment.

Evaluation of the Effectiveness of the Interventions Based on the Performance of Measures

SWMBH evaluated the effectiveness of the interventions using Plan-Do-Study-Act (PDSA) cycles. For reporting of peer follow up services, SWMBH monitored the proportion of services that the Project ASSERT partners report in their net cost reports, that also have a state-reported encounter each month. SWMBH assisted providers with problem-solving issues that arose. For the stigma campaign and provider trainings, SWMBH used pre and post testing to assess impact. The community member and provider focus groups that the health equity project coordinator will host will identify ways to increase health equity and decrease barriers to treatment. The

coordinator will continue to work with CMHSPs and providers to implement changes, and SWMBH will monitor how many of the proposed changes are successfully implemented.

Planning and Initiation of Activities for Increasing Improvement

The project is being retired as a formal PIP and will be replaced with a non-clinical PIP in 2024 to improve rates on 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. IET is a Performance Bonus Incentive Program (PBIP) measure and therefore has high visibility in the region, with frequent monitoring and discussion in regional committees.

Performance Improvement Project #3 – Customer Satisfaction Survey

Topic Selection and Implementation of Interventions

SWMBH identified customer satisfaction as a region-wide area needing improvement and selected a non-clinical PIP to address the lowest scoring categories. Regionally, the Outcomes and Functioning construct was identified as the lowest scoring category for both Youth and Adults and targeted areas of improvement during the FY23 survey period were Access and Timeliness to Care and Expanding Treatment, Program and Group Therapy options. SWMBH provided the FY22 Customer Satisfaction Survey results to each CMHSP and required them to develop CAPs specific to their individual results. Of the eight CMHSPs, over half included goals related to expanding services and groups in FY23. At the request of the CMHSPs, SWMBH also added access to real-time survey data for the CMHSPs to review results and implement changes throughout the year. MMBPIS performance indicators 2a and 3 data and outcomes were also used to measure progress in Access and Timeliness to Care. While an increase occurred in indicator 2a from Q1 to Q4, a slight decrease was seen in indicator 3 in the same timeframe. Due to low performance and newly established state benchmarks, the non-clinical PIP chosen for FY24 is specifically related to Indicator 3 and access to services after the biopsychosocial assessment.

Evaluation of the Effectiveness of the Interventions

FY23 MHSIP (Adult) “In agreement” scores for the Outcomes and Functioning construct improved in comparison to FY22 (78.6 to 81.0) while YSS (Youth) scores in the same construct decreased (75.5 to 73.0). “In agreement” scores for the Access construct increased for adults this year (85.4 to 87.7) and slightly decreased for Youth (83.6 to 81.9). The changes in youth scores from FY22 to FY23 were not statistically significant. See graphics provided in Section E: Member Experience- Customer Satisfaction Surveys. While this goal was removed in the FY24 plan, SWMBH required each CMHSP to set specific goals based on individual areas of improvement once internal qualitative and quantitative analysis was completed. Combined regional improvement efforts will continue to be monitored during regional committees and specifically reviewed between the CMHSP and SWMBH Quality representatives at least bi-annually.

FY23 Results

Goal	FY23	Eval Score	Recommendations
Performance Improvement Project #1 To reduce racial disparities in follow-up after Emergency Department (ED) visits for alcohol and other drug abuse or dependence. Monitoring: 1. 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. 2. The percentage of White beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence.	Met FY23 goal of implementing interventions for the PIP.	**3**	The disparity between Black/African American and White follow up from ED for AOD rates did not change significantly from 2021 to 2022. In FY23, we were still in intervention planning and implementation stages. We expect to see a decrease in disparities in the first remeasurement period (2023), which will be reported in FY24.
Performance Improvement Project #2 The percentage of adolescents and adults with a new episode of alcohol or other drug abuse or dependence who received the following: 1. Initiation of AOD Treatment, the percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis. 2. 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. SWMBH will participate in DHHS planned data validation activities and meetings. SWMBH will be provided IET data files by 1/31/23 and have 120 calendar days to return the completed validation template to DHHS.	Met FY23 goals of implementing interventions for the PIP and participating in the IET data validation process.	**3**	The IET metric rates did not change significantly. In FY23, we were still in the intervention planning stages. We expect to see an increase in rates in FY24. This measure will be monitored as agency metrics and PBIP next year rather than as a Performance Improvement Project. The IET data validation process is complete and SWMBH received full credit for participation.

Performance Improvement Project #3 SWMBH will select a Performance Improvement Metric related to the Annual Customer Satisfaction Survey Scores in the '*Improved Outcomes*' category for adults and the '*Improved Functioning*' category for Youth. The identified categories have been the 2 lowest scoring categories over the past 5 years. The target categories that have been targeted for improvement during the FY23 survey period are: 1. Access and Timeliness to Care, Expanding Treatment, Program and Group Therapy options.	Partially Met	**3**	Regionally, the Outcomes (and Functioning) construct remains the lowest scoring category for both Youth and Adults. FY23 MHSIP (Adult) "In agreement" scores for the Outcomes and Functioning construct improved in comparison to FY22 (78.6 to 81.0) while YSS (Youth) scores in the same construct decreased (75.5 to 73.0). "In agreement" scores for the Access construct increased for adults this year (85.4 to 87.7) and slightly decreased for Youth (83.6 to 81.9). The changes in youth scores from FY22 to FY23 were not statistically significant. While this goal was removed in the FY24 plan, SWMBH required each CMHSP to set specific goals based on individual areas of improvement once internal qualitative and quantitative analysis was reviewed. Combined regional improvement efforts for improvement will continue to be monitored during regional committees.

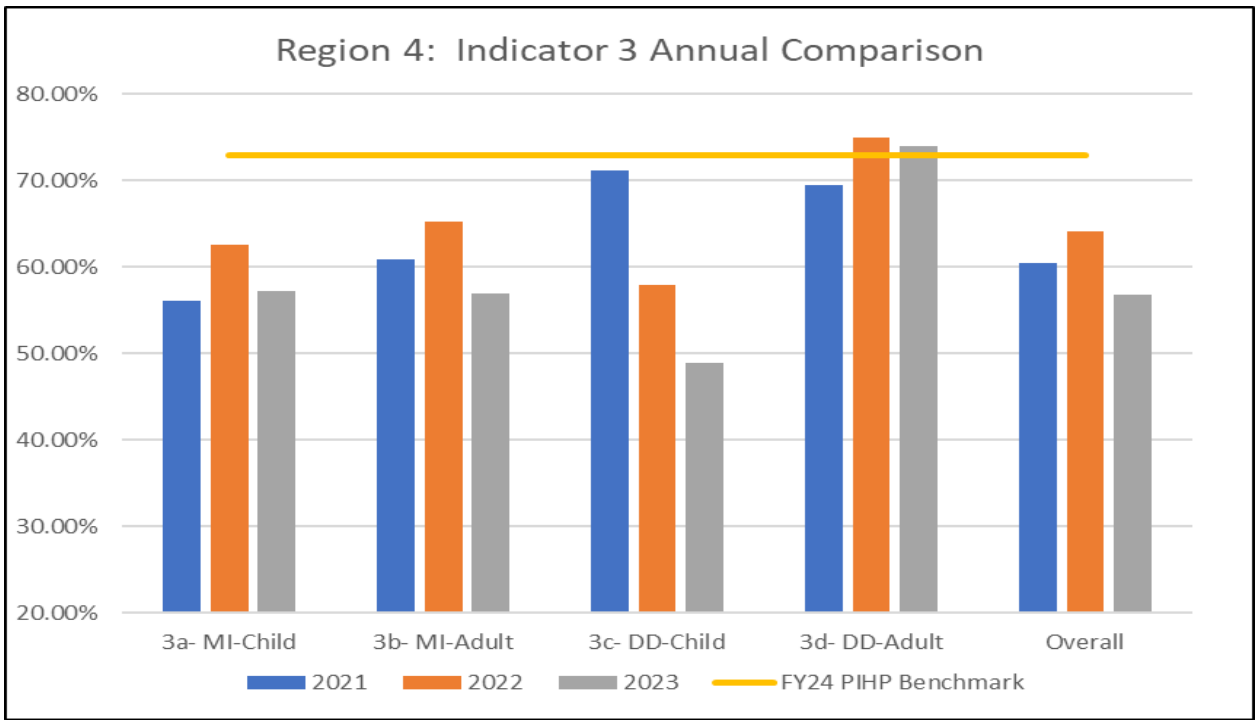
Non-Clinical Performance Improvement Project to start in FY24 – Improve access and timeliness of new persons starting a service by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children.

Topic Selection

A new non-clinical PIP was chosen for FY24, to improve access and timeliness of new persons starting a service by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children, which is MMBPIS indicator 3. In October 2023, MDHHS published benchmarks for MMBPIS indicator 3 in the revised MMBPIS Codebook version 6. This topic was chosen because it affects a large number of people and has a great impact on the quality of services. Medicaid enrollees have a right to timely access to care, and timely access is a predictor of greater satisfaction with services. As described in detail in Section A, SWMBH tracks and monitors data for all the MMBPIS indicators with established benchmarks. Since the benchmarks were defined for MMBPIS indicator 3, SWMBH has monitored and analyzed regional performance with this metric. In doing so, SWMBH established the cumulative baseline results for FY23 of 56.78%. The established MMBPIS CAP process for indicators falling below the benchmarks has not improved regional performance as it is still below the state benchmark of 72.9%. The goal of improving performance for MMBPIS indicator 3 is to improve access and timeliness of services with new persons starting a service with four subpopulations: MI-adults, MI-children, IDD-adults, and IDD-children.

Measurement of Performance Using Objective Quality Indicators and Baseline Results

In FY24, SWMBH and its provider network will increase the percentage of new persons starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment from the FY23 baseline rate of 56.78% to at least 72.9% in the remeasurement period using MDHHS's MMBPIS standards to measure the indicator. MMBPIS data is collected from each CMHSP monthly. SWMBH has a Quality Specialist dedicated to reviewing the MMBPIS data submissions to ensure they are complete and accurate, based on the MMBPIS PIHP and CMHSP Code Book. The SWMBH QM Department also completes primary source verification documentation during the annual CMHSP Site Reviews.



FY24 Indicator 3 Cumulative Outcomes by CMHSP and Subcategory

#3 - Ax to 1st service	MIC	Served	%	MIA	Served	%	DDC	Served	%	DDA	Served	%
SWMBH	2033	1162	57.16%	4355	2480	56.95%	508	248	48.82%	150	111	74.00%
Barry	31	29	93.55%	215	146	67.91%	23	14	60.87%	10	10	100.00%
Berrien	85	66	77.65%	884	470	53.17%	167	64	38.32%	32	25	78.13%
Branch	47	27	57.45%	555	325	58.56%	25	25	100.00%	20	18	90.00%
Calhoun	20	3	15.00%	437	192	43.94%	38	12	31.58%	14	3	21.43%
Cass	35	27	77.14%	116	75	64.66%	43	21	48.84%	13	11	84.62%
Kalamazoo	124	49	39.52%	1367	621	45.43%	141	60	42.55%	33	23	69.70%
St. Joe	76	74	97.37%	539	495	91.84%	33	31	93.94%	16	16	100.00%
Van Buren	28	18	64.29%	242	156	64.46%	38	21	55.26%	12	5	41.67%
Overall	7046	4001	56.78%									

Implementation of Interventions to Achieve Improvement in Access and Quality of Care

In FY24 SWMBH will complete a causal barrier analysis to evaluate factors contributing to the FY23 baseline of 56.78%. SWMBH will meet with each CMHSP to review local barriers, processes, and better understand local strategies that may be used to drive performance improvement efforts. Interventions will be identified and implemented to address the barriers in access and timeliness of services, related to MMBPIS indicator 3. The interventions will be utilized to increase the FY24 percentage to 72.9%. Remeasurement will occur in FY25 and will include Q3 and Q4 of FY24.

C. Event Reporting – Critical Incidents

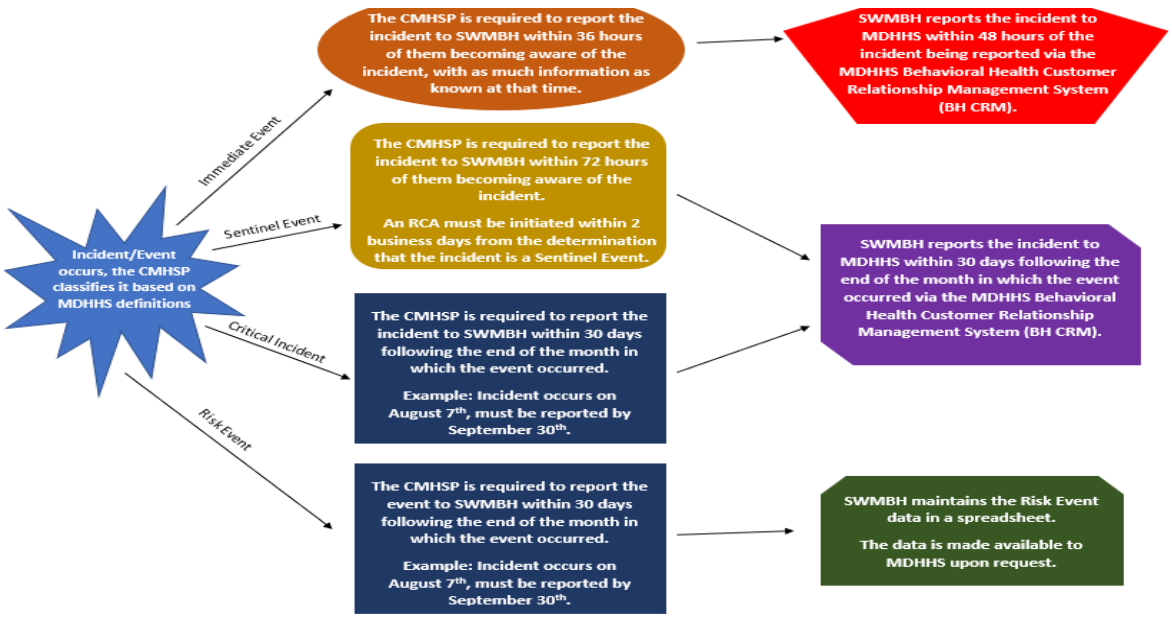
Description

SWMBH's process for identifying, reporting, and following up on incidents and events that put individuals at risk of harm is outlined in policy 03.05 Incident Event Reporting and Monitoring. The five reportable critical incidents for members are defined by MDHHS as suicide, non-suicide death, hospitalization due to injury or medication error, emergency medical treatment (EMT) due to injury or medication error, and arrest. Hospitalization or EMT due to an injury is further classified to include whether the injury resulted from physical management. Residential treatment providers prepare and file incident reports to the contracted CMHSP when incidents occur. The CMHSPs are responsible for reviewing and classifying the incident reports and submitting the reportable incidents to SWMBH as outlined in policy. SWMBH is then responsible for reporting qualifying incidents to MDHHS in a timely manner, as defined in the contract language, via the MDHHS Behavioral Health Customer Relationship Management System (BH CRM). SWMBH is also responsible for ensuring that MDHHS requests for further information, details related to the remediation of an incident, or any other requests are responded to timely. SWMBH delegates the responsibility of the process for the identification, review, and follow-up of immediate events, sentinel events (SEs), critical incidents (CIs), and risk events (REs) to its eight contracted CMHSPs and SUD Providers (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). The CMHSPs and SUD providers have 3 business days after an incident occurs to determine if it is a sentinel event, and two subsequent business days to commence a root cause analysis of the event if it determined to be a sentinel event. The CMHSPs work with the residential treatment provider, when applicable, to complete a root cause analysis (RCA). All unexpected deaths (UDs) are classified as SEs 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 reviews a random sample of SEs during the annual CMHSP Site Reviews to ensure that all unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, are reviewed and the review includes:

- Screens of individual deaths with standard information (e.g., coroner's report, death certificate).
- Involvement of medical personnel in the mortality reviews. SWMBH ensures that individuals involved in the review of SEs have the appropriate credentials to review the scope of care (e.g. deaths or serious medical conditions involve a review by a physician or nurse).
- Documentation of the mortality review process, findings, and recommendations.
- Following completion of a RCA, or investigation, the CMHSP or SUD Provider developed and implemented either a plan of correction or an intervention to prevent further occurrence or recurrence of the adverse event, or documented the rationale of why corrective actions were not needed.
- Use of mortality information to address quality of care.

SWMBH requires that all CMHSPs and SUD Providers notify SWMBH within 36 hours of an immediate event that is subject of a recipient right, licensing, and/or police investigation. SWMBH reports those events to MDHHS within 48 hours via the BH CRM. Following an immediate event notification, SWMBH additionally submits to the MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within 1 year of the individual's discharge from a State-operated service. SWMBH analyzes CIs, SEs, and REs at least quarterly during the regional QMC meetings. The REs reviewed minimally include those that put individuals at risk of harm including 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 (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period. The quantitative data and the qualitative details of specific incidents or patterns of events are reviewed and discussed to remediate the problem or situation and prevent the occurrence of similar additional incidents or events in the region. Documentation of the review and discussion is maintained the meeting PowerPoint presentation and minutes which are saved on the SWMBH Commons and available to all QMC members. It is the expectation that members that cannot attend the meetings will review the PowerPoint presentation and the minutes, and that all members communicate information from the meetings to the appropriate people within their organizations.



FY23 Goals

Goal	Responsible Department	Where Progress Was Monitored	Frequency of Monitoring
SWMBH will submit any SUD Sentinel Event that occurs at a contracted residential treatment provider in the new CRM when the SE occurs.	QM	Through submission to MDHHS in the new CRM	As SEs Occur
The rate for the region, per 1000 persons served, of suicide deaths will demonstrate a decrease from the previous year.	QM	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.	QM	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.	QM	QMC	Monthly
The rate for the region, per 1000 persons served, of individuals who are arrested will demonstrate a decrease from the previous year.	QM	QMC	Monthly

FY23 Identified Barriers

One barrier that was identified in FY23 is related to requesting and obtaining death certificates to determine the cause of death for accurate reporting and RCA. Many CMHSPs reported long delays in obtaining the death certificates or being unable to obtain them after numerous attempts. This resulted in CMHSPs being required to make a best judgement determination on the cause of death, which could not be done for six incidents because the deaths were identified from obituaries and no further information is known or has been able to be obtained. Another barrier that was identified is related to the coding of risk events and the variance in incident report writing by residential treatment providers and classification by the CMHSPs specifically related to suicide and homicide threats/gestures/attempts.

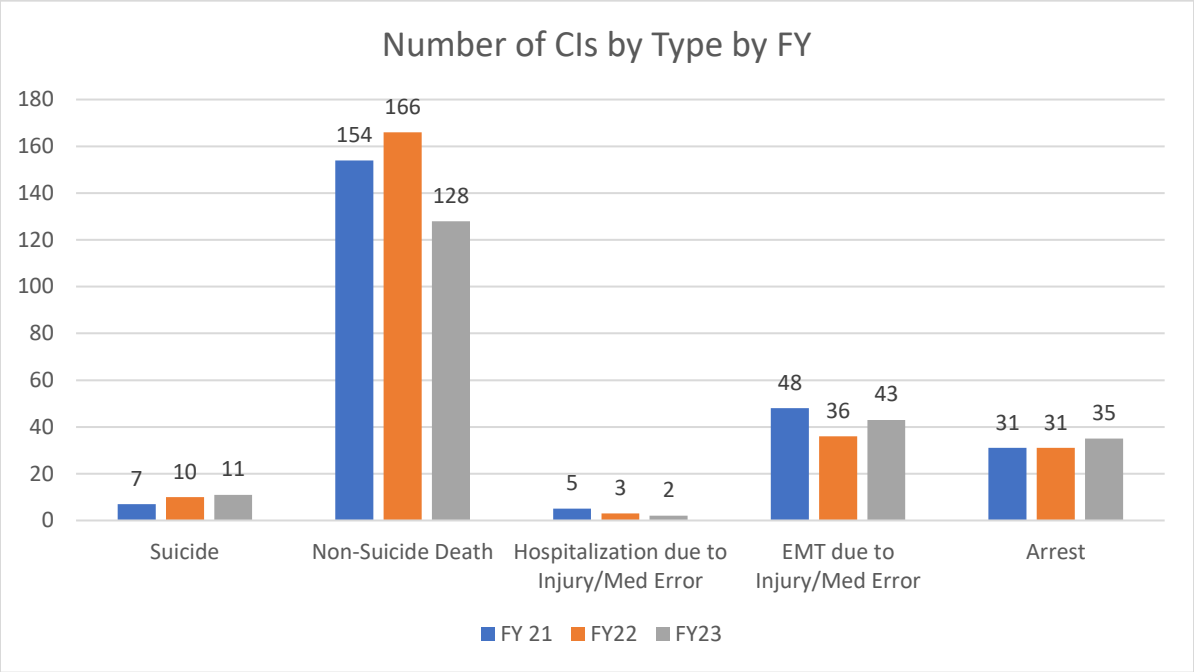
Improvement Efforts Made in FY23

Beginning in FY23 MDHHS required all incidents to be reported through the BH CRM. SWMBH modified the process for CMHSPs to submit their data monthly, requiring some additional information, and the way SWMBH communicates the data to MDHHS. SWMBH's policy was updated to reflect those changes and the CMHSPs were asked to update their policies. SWMBH presented the critical incident data in additional meeting such as the Customer Advisory Committee and to the IDD workgroup, which allowed for the data to be reviewed with a focus on the IDD population, and to members for their input and feedback. SWMBH also provided education and guidance to the CMHSPs throughout the fiscal year related to incidents.

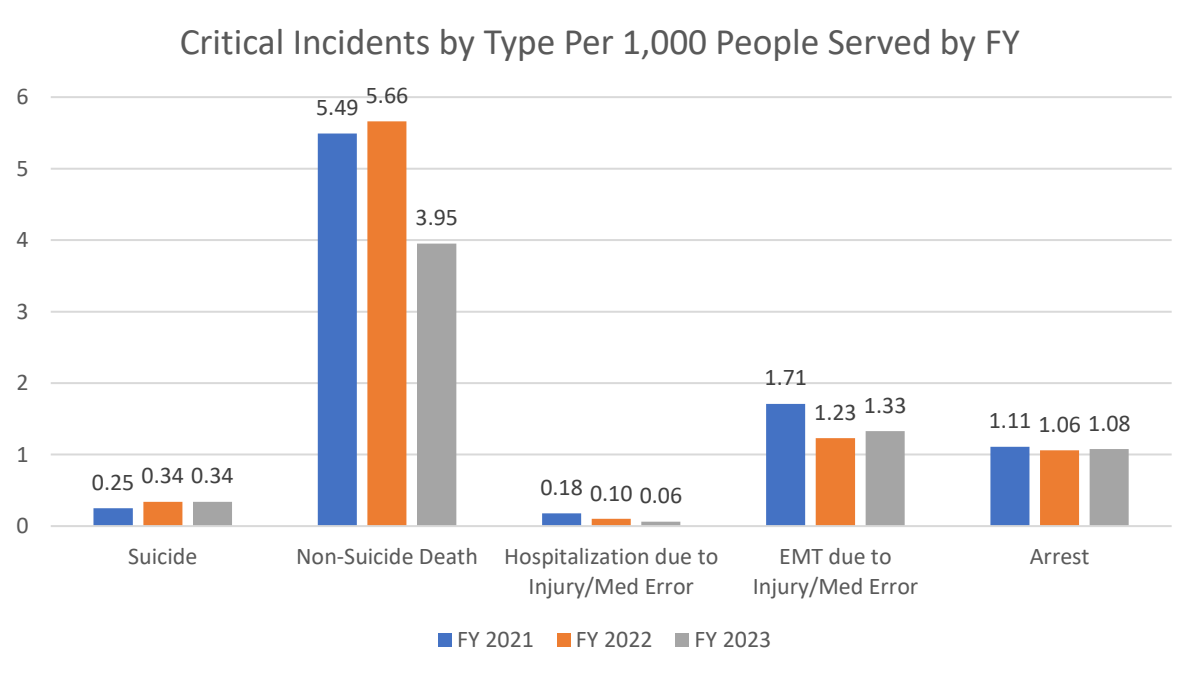
FY23 Results

Goal	FY22	FY23	Eval Score	Recommendations
SWMBH will submit any SUD Sentinel Event that occurs at a contracted residential treatment provider in the new CRM when the SE occurs.	N/A	None to Report	**N/A**	No SUD Sentinel Events were reported in FY23. The process for reporting and the goal will remain the same for FY24.
The rate for the region, per 1000 persons served, of suicide deaths will demonstrate a decrease from the previous year.	0.34	0.34	**3**	The goal was not met, but the rate did not increase. The goal will stay the same and be monitored through FY24.
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.	0.10	0.06	**5**	The goal was met and will stay the same and be monitored through FY24.
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.	1.23	1.33	**2**	The goal was not met. It will stay the same and be monitored through FY24.
The rate for the region, per 1000 persons served, of individuals who are arrested will demonstrate a decrease from the previous year.	1.06	1.08	**3**	The goal was not met, but the rate did not increase significantly. The goal will stay the same and be monitored through FY24.

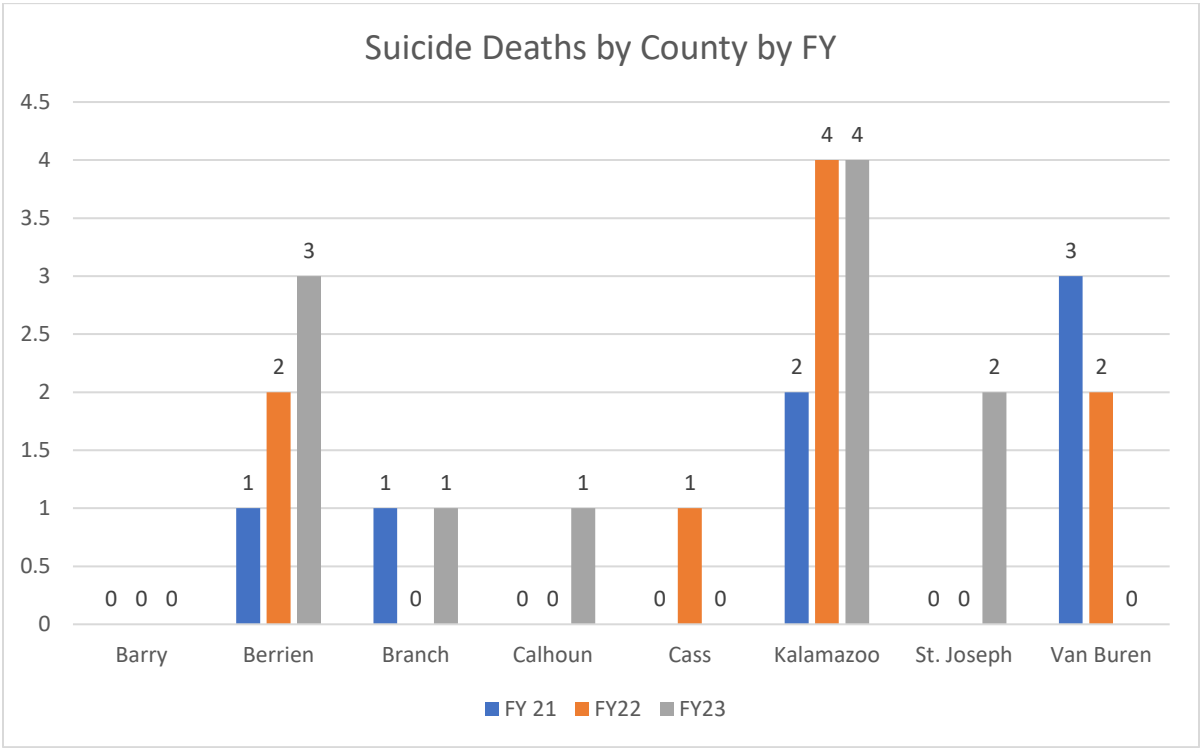
Quantitative Analysis of SWMBH's CIs, SEs, UDs, and REs

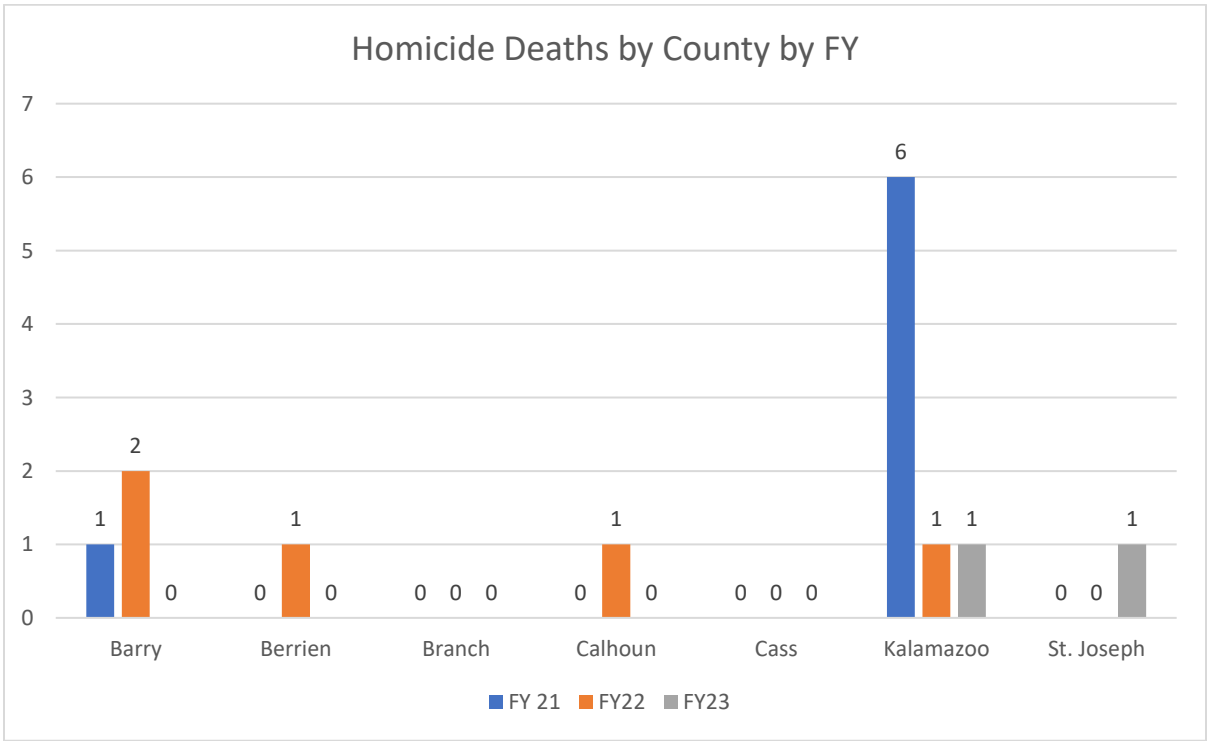


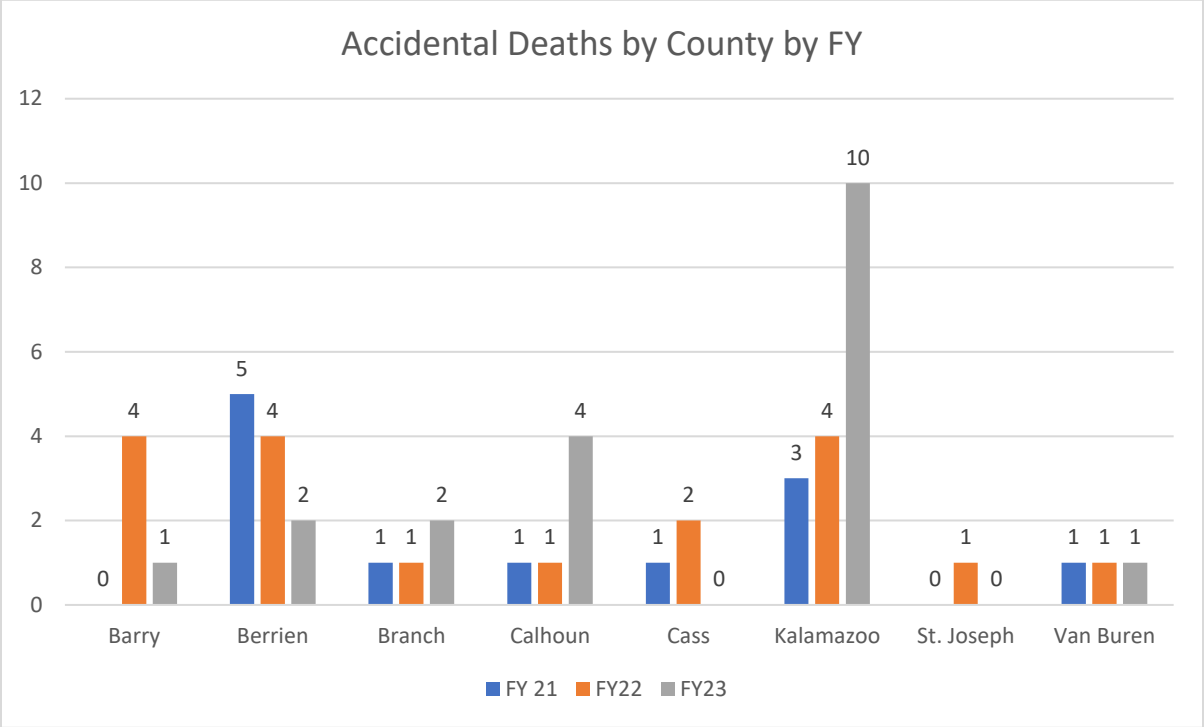
No injuries resulting from physical management were reported in FY23.



Aggregation of Unexpected Death Mortality Data (Sentinel Events)



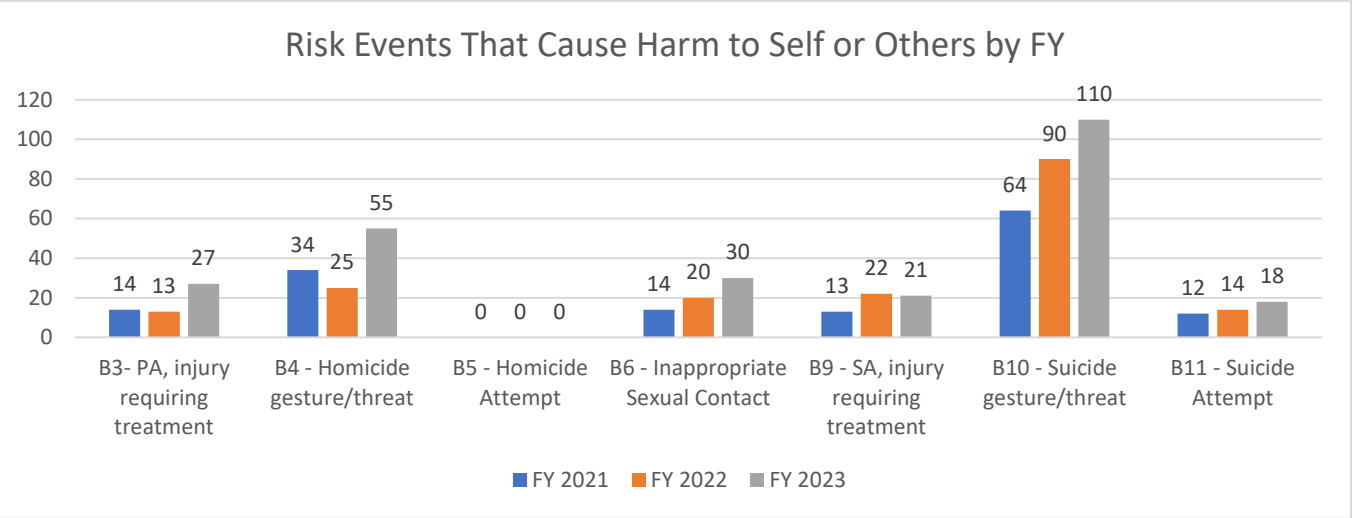




COD	FY21	FY22	FY23
Overdose/Drug Related	4	9	8
Car Accident	2	3	0
Hit by Car/Train	2	2	1
Fire	1	0	0
Medical (choking, fall, etc.)	0	2	4
Random Occurrence	0	0	1
Unknown	2	2	6

No unexpected deaths were reported in FY23 resulting from an undiagnosed condition.

Risk Events (RE)



Risk Event Hospitalizations (H8)

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. While the processes vary slightly by CMHSP, hospital discharges are tracked and Case Managers (if applicable) or other identified staff follow up with the member, residential treatment provider, etc. SWMBH communicated with each CMHSP individually on a quarterly basis related to members with multiple hospitalizations to determine why the members were hospitalized and also to ensure appropriate follow up occurred following discharge.

SUD Residential Treatment Providers – Sentinel Events

No sentinel events occurred in FY23 at the SUD residential treatment providers that SWMBH contracts with.

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

SWMBH presented the analysis of the data to QMC monthly and identified regional trends and asked the CMHSPs to review the RCAs that were completed for their SEs at least quarterly. The qualitative discussion of the trends and RCAs leads to improvements in the quality of health care and services for members, service delivery, and health outcomes over time in the region. Some examples (not an exhaustive list) of the qualitative discussions from QMC meetings in FY23 included:

- Multiple Sentinel Event overdose deaths in the region- identification of a new, more dangerous form of Fentanyl in the region called Parafluorofentanyl. Discussion also occurred related to communicating to members the dangers of using again once they have been in sobriety for a period of time (tolerance).
- Planned leaves of absence (LOA)- discussion of ensuring the primary caretaker has information about medication, physical care needs, etc. and that environment concerns are discussed to ensure safeguards are in place prior to the LOA.
- Documentation of phone calls/communication with members- ensuring there is documentation of follow up of missed appointments.
- Trend of Critical Incident medication errors- identified gaps in communication across shifts and with the training of new staff.
- Trends in risk event specific to the I/DD population- higher rates of physical aggression, inappropriate sexual contact, self-injury, and repeated hospitalization. Hospitalizations are likely due to the commonly co-occurring medical conditions that population is impacted by.

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 QAPIP Technical Requirement attached to the PIHP/CMHSP contract. Only techniques that are permitted by the Technical Requirement and have been approved during person-centered planning may be used. SWMBH delegates the responsibility for collecting and analyzing data to each local CMHSP Behavior Treatment Review Committee (BTRC), including the evaluation of the effectiveness of the BTRC by stakeholders. Each CMHSP is also required to submit their BTRC data to SWMBH on a quarterly basis. SWMBH focuses on and analyzes data related to intrusive and restrictive techniques, physical management, and/or incidents resulting in 911 calls for emergency behavioral situations. The data submitted includes the numbers of interventions and length of time the interventions were used per person. Monitoring this data is important for the oversight and protection 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 on an individual level 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 incidents. During the CMHSP Site Reviews SWMBH completes an audit of the data to ensure accurate reporting and adherence to the Behavior Treatment Review Standards by each CMHSP. Additionally, SWMBH evaluates each CMHSP BTRC process annually and participates in at least one BTRC meeting for each CMHSP each year.

FY23 Goals

Goal	Responsible Department	Where Progress Was Monitored	Frequency of Monitoring
The percentage of individuals who have an approved Behavior Treatment Plan, per 1,000 people served, will decrease from the previous year.	Clinical Quality	Regional Clinical Practices Committee	Quarterly
The number of behaviors being addressed in a BTP per person will decrease from the previous year.	Clinical Quality	Regional Clinical Practices Committee	Quarterly
The percent of emergency interventions (911 calls and physical management) will decrease from the previous year.	Clinical Quality	Regional Clinical Practices Committee	Quarterly

FY23 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 and impacted the BTRC process in FY23. SWMBH worked collaboratively with the CMHSPs to train the newly appointed staff on the expectations for collection and submission of the data.

Improvement Efforts Made in FY23

SWMBH provided data driven guidance to each CMHSP throughout FY23. A position was added to SWMBH's QM and Clinical Outcomes Department to act as the subject matter expert for behavior treatment monitoring. The position was charged with ensuring accurate and complete collection and analysis of the data trends for the purpose of quality improvement. A BTRC Workgroup was formed in FY23 to collaboratively update the behavior treatment plan monitoring process within the region. The Workgroup analyzed data trends within each CMHSP, streamlined tracking documentation, and produced a new behavior treatment monitoring process.

FY23 Results

Goal	FY23	Eval Score	Recommendations
The percentage of individuals who have an approved Behavior Treatment Plan, per 1,000 people served, will decrease from the previous year.	Not Met- Increased by 10 people	**2**	SWMBH will do a quality review of at least 6 behavior treatment plans per CMHSP for FY24.
The number of behaviors being addressed in a BTP per person will decrease from the previous year.	Not Met – Increased by 442 behaviors being addressed	**2**	Rate for the region will be 90% or higher on the *Behavior Treatment Plan* section of the annual CMHSP audit.
The percent of emergency interventions (911 calls and physical management) will decrease from the previous year.	Met – Decreased by 8 incidents	**4**	Implement a regional evaluation of the committee's effectiveness for each CMHSP BTRC.

E. Member Experience with Services – Customer Satisfaction Surveys

Description

During FY23 SWMBH contracted with Kiaer Research to administer customer satisfaction surveys based on the Mental Health Statistics Improvement Program (MHSIP) and Youth Surveillance Survey (YSS). Survey responses were collected throughout CY23 to meet the SWMBH Departmental goal of achieving 2000 completed surveys. Surveys were made accessible to members via QR codes and tablets available in CMHSP common areas, through the SWMBH website, or by paper copy. Kiaer Research sent the survey to members via text message and email. The survey's main objective is to collect member on services and to identify sources of dissatisfaction. CMHSPs are required to develop improvement plans, specific to the findings/results/analysis from their locations for the purpose of systemic improvements. SWMBH added mechanisms to capture responses inclusive of individuals receiving LTSS, case management services, Certified Community Behavioral Health Clinics (CCBHC) services, and Medicaid services. A full analysis report was produced by Kiaer Research, providing qualitative and quantitative analysis for each of the Adult and Youth survey categories measured. The results and analysis are shared with relevant stakeholders, committees, and the Board of Directors. SWMBH informs providers, members, and other stakeholders, by sharing the survey results via the SWMBH website and provider and member newsletters. The SWMBH Consumer Advisory Committee (CAC) was consulted for feedback on survey processes and distribution.

FY23 Goals

Goal	Responsible Department	Where Progress Was Monitored	Frequency of Monitoring
Achieve at least 1000 completed MHSIP surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper.	QM	QMC	Quarterly
Achieve at least 500 completed YSS surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper survey.	QM	QMC	Annually
Achieve a minimum of 300 completed surveys for each CCBHC site, utilizing MDHHS questions, criteria, and results/analysis reporting guidance.	QM	QMC and CCBHC Data and Reporting Workgroup	Annually
Evaluate the effects of activities implemented to improve satisfaction, from the previous year's recommendations.	QM	QMC, CAC, RCP, and Region UM (RUM)	Bi-Annual
Ensure that CMHSP develops improvement plans, specific to their findings/results/analysis.	QM	QMC, CAC, CPC, and RUM	Bi- Annual
Present and receive feedback from the SWMBH CAC on survey process, questions, content, and distribution plan.	QM	QMC and CAC	Annually

FY23 Identified Barriers and Analysis

For some CMHSPs, member phone numbers and e-mail addresses provided to SWMBH for distribution of the survey were inaccurate or unavailable because the information in the CMHSP electronic health record was either not provided or had been changed. Several survey revisions took place in FY23, and some respondents took the previous version of the survey, but the data was compiled altogether. Due to the timing of the annual customer satisfaction survey project, the final survey analysis and recommendations were not available to SWMBH until well into FY24. In summary, 1903 valid surveys were completed, resulting in the highest cumulative completion

rate since 2014. Response rates for MHSIP (Adult) improved over FY22 rates, while the YSS (Youth) response rate decreased in comparison. Most surveys were completed via e-mail or text invitation, while in-office responses (QR code, tablet, or paper version) accounted for just under 20% for both MHSIP and YSS surveys. The FY23 MHSIP survey results reflected an improvement in satisfaction for all constructs compared to FY22. The FY23 YSS survey results did not reflect a statistically significant difference in overall satisfaction rates compared to FY22 results. Qualitative data was captured via robust respondent comments while quantitative data was captured via a numbered scale on the surveys in FY23. Additional barriers included the inability to consistently classify surveys as CCBHC or not depending on how the survey was completed.

Improvement Efforts Made in FY23

Of the eight CMHSPs, over half included goals related to expanding services and groups in FY23. Improving Social Connectedness was also emphasized by three CMHSPs in region 4. Further evaluation of activities implemented in FY23 will occur during early FY24 between SWMBH and each CMHSP. Around 700 surveys were disqualified from the FY22 survey due to invalid submissions resulting from bot interference. In response, reCAPTCHA, a bot-catching mechanism, was successfully employed to protect the FY23 survey from fraudulent responses. It was likewise determined that the survey's reading level was out of compliance with ADA standards in that it was above a 6th grade reading level. Further investigation revealed that the descriptive text required revision e.g. "Please indicate your agreement or disagreement with each of the following statements" was changed to "Please tell us whether you agree or disagree". Lastly, demographic questions were added, and participants were prompted to identify their primary living arrangement and associated CMHSP.

Recommendations for the FY24 Survey

- Focus on increasing YSS response rates.
- Continual quality improvement in terms of gathering demographic data.
  - Including, but not limited to living situation, race/ethnicity, LTSS, employment, and gender, length of time receiving services, type of services received (unique to each CMHSP),
- Consider utilizing a unique ID question to track respondents over time.
- Better align survey timing with the fiscal year.
  - This will allow for better resolution of issues and quick referrals for respondents in crisis.

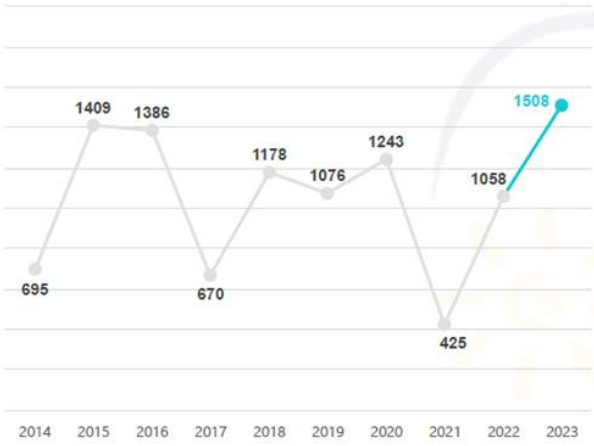
FY23 Results

Goal	FY23	Eval Score	Recommendations
Achieve at least 1000 completed MHSIP surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper.	Met- 1508 Completed Surveys	5	This goal was met and will continue to be monitored in FY24.
Achieve at least 500 completed YSS surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper survey.	Partially Met- 395 Completed Surveys	3	The completion goal was not met, but it was made more available/accessible. A regional focus will be put into obtaining more YSS surveys in FY24.
Achieve a minimum of 300 completed surveys for each CCBHC site, utilizing MDHHS questions, criteria, and results/analysis reporting guidance.	ISK- 191 surveys Pivotal- 167 surveys	5	While the FY23 QAPIP goal states each CCBHC will complete 300 surveys, specifications state "reaching out to 300 members per CCBHC site". Sample size met this specification. This goal was met, will continue to be monitored in FY24.
Evaluate the effects of activities implemented to improve satisfaction, from the previous year's recommendations.	In Process	4	This goal will continue to be monitored in FY24.
Ensure that CMHSP develops improvement plans, specific to their findings/results/analysis.	In Process	4	This goal will continue to be monitored in FY24.
Present and receive feedback from the SWMBH CAC on survey process, questions, content, and distribution plan.	Met	5	This goal will continue to be monitored in FY24.

Highest number of responses ever recorded for 2023 MHSIP

In-office responses (via QR code or paper survey) accounted for 292 (19.3%) of MHSIP responses

MHSIP # of responses, 2014-2023



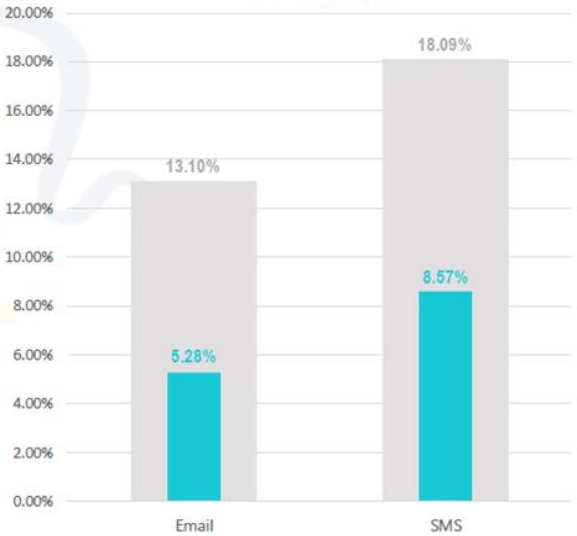
MHSIP response rate by medium
2022 vs. 2023

YSS total responses and response rates dipped in 2023

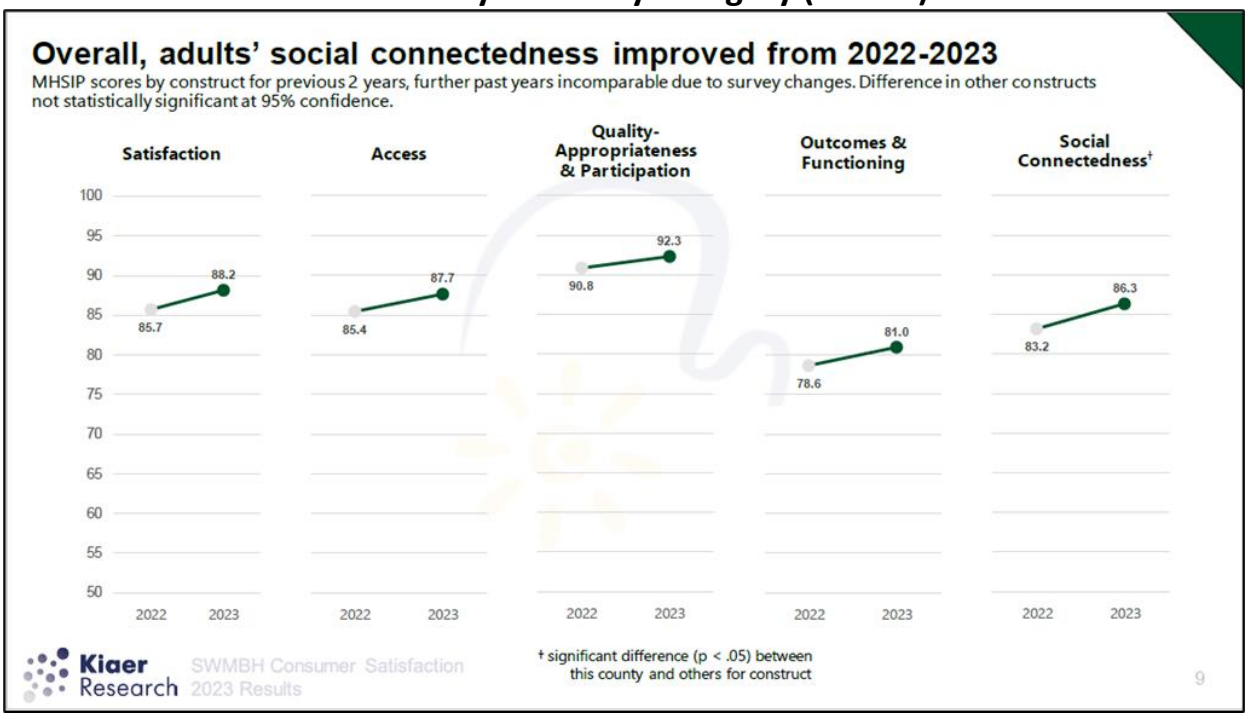
In-office responses (via QR code or paper survey) accounted for 73 (18.5%) of YSS responses

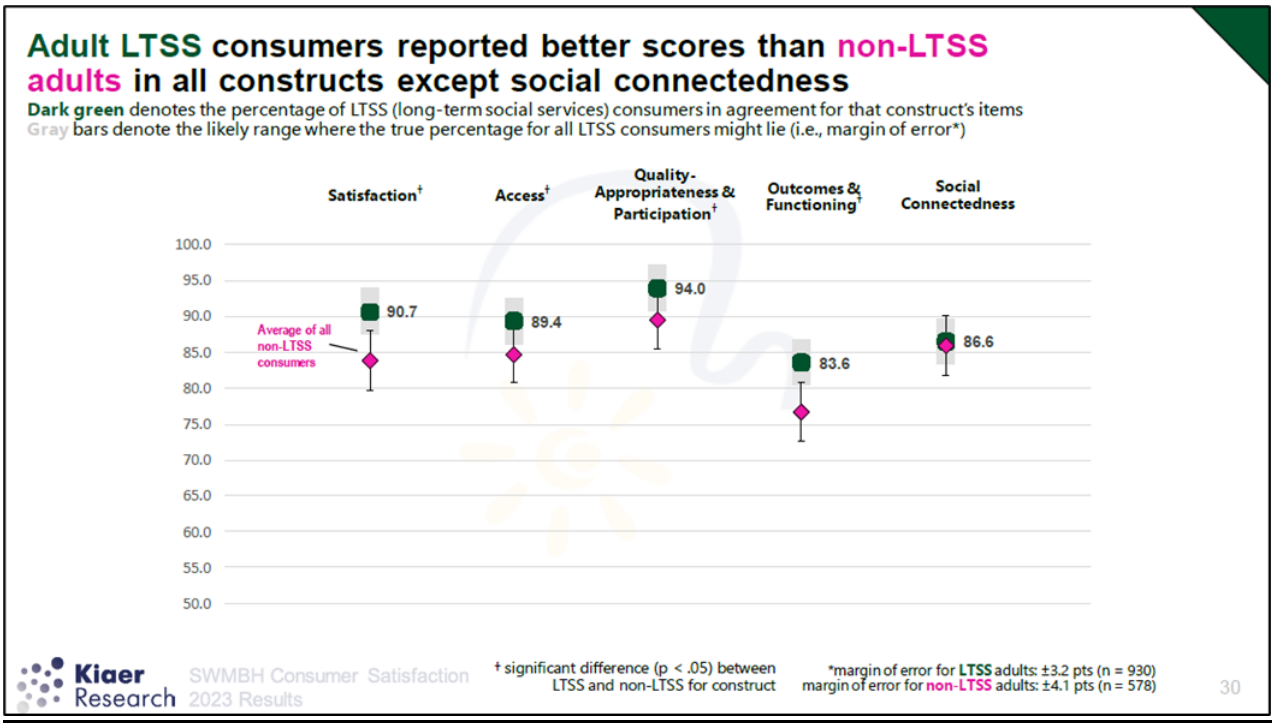
YSS # of responses, 2014-2023

YSS response rate by medium
2022 vs. 2023



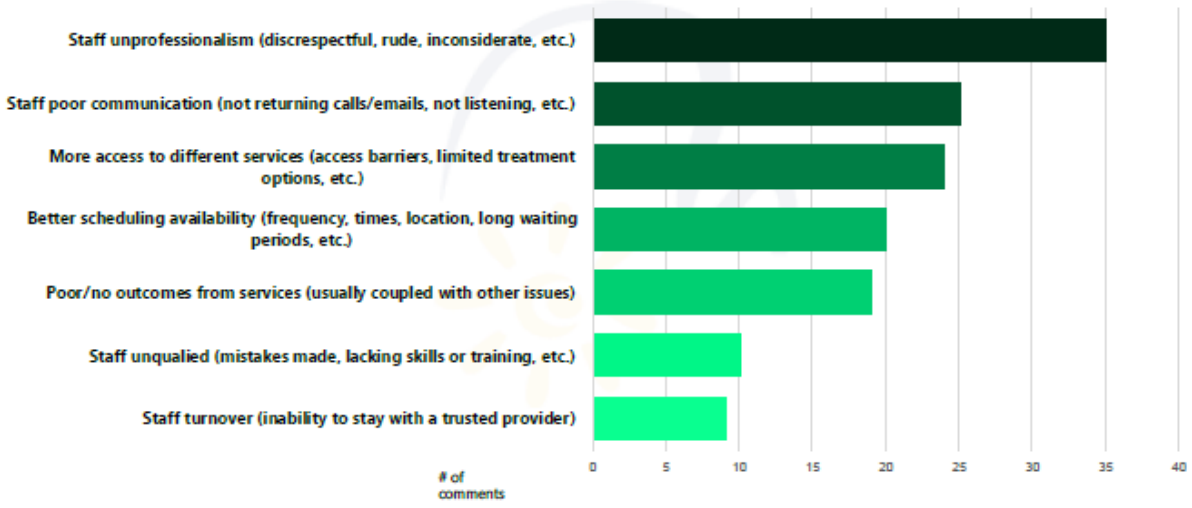
Adult Survey Scores by Category (MHSIP)





Opportunities for improvement in staff conduct, more access

Of respondents to the MHSIP who were *dissatisfied* with services, staff conduct was cited most frequently. Respondents also desired better access and availability of services.



Consumers had life-changing accounts of benefit from their CMHSPs

"I love the care I get from Pivotal and the many services I receive is amazing **I couldn't have asked for better**."

"I was able to **rebuild my relationship** with **my parents** as well as **my children.**"

"Less anxiety, less depression, zero meds, less anger, **more patience**."

"They helped me **get into hospital immediately** because I was in danger. Their follow up after the hospital was **extremely helpful**. I love my therapist and I feel like my psychiatrist **really hears me** when I voice my concerns about medication."

"Overall the services I receive at Riverwood Center in so many words **saved my life** to this day! For that I'm grateful."

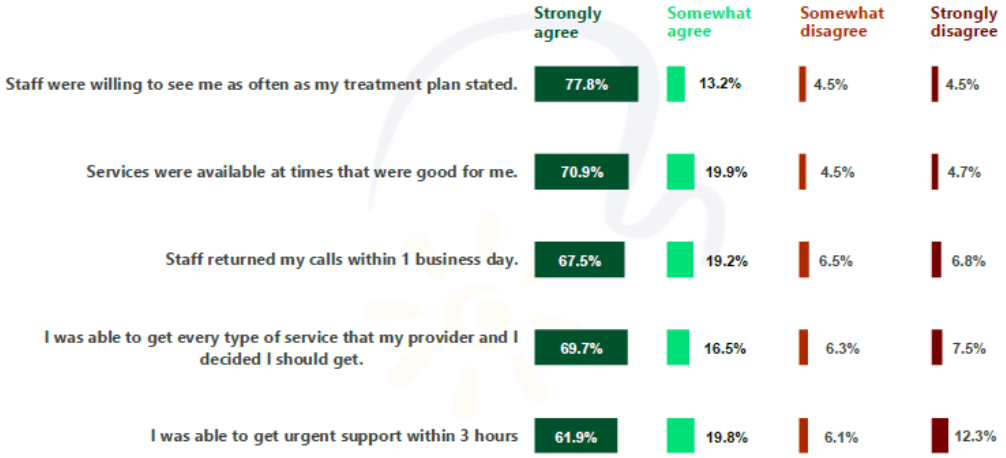
"**I am alive today** because of the wonderful people at Barry County Mental Health…I'm still here and am **enjoying time with my grandchildren** because of the people at BCMH."

"100% you **saved my life,** I thank God for you and pray this helps others."

"The respect and support I received help me to **live a better quality of life**...Thanks to all the staff that showed so much **love and respect.** I will be **forever so grateful** to all of you!!!!"

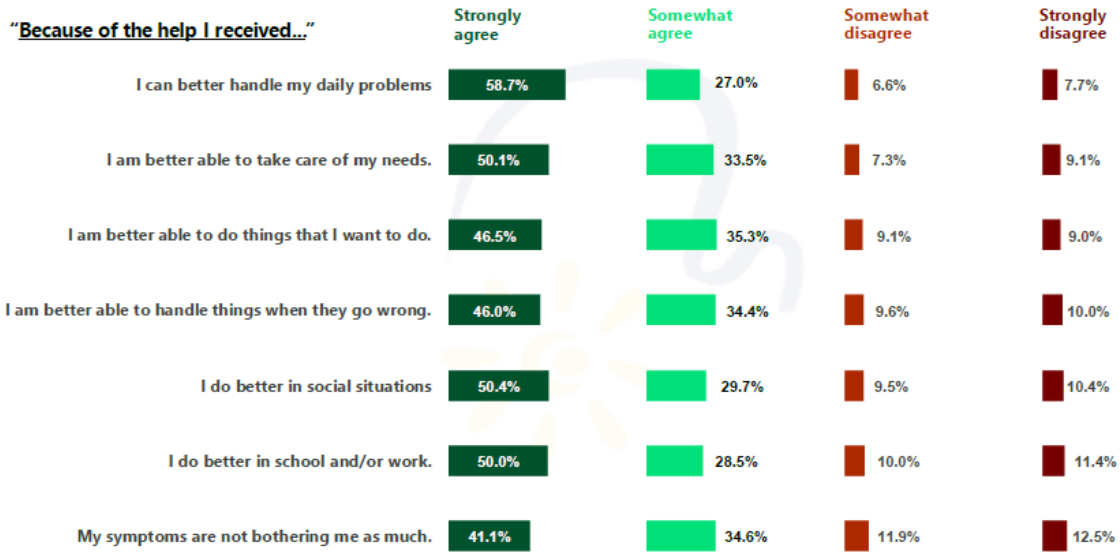
Majority of consumers had good access to services

Treatment plan adherence and the timing of services were the most approved items.

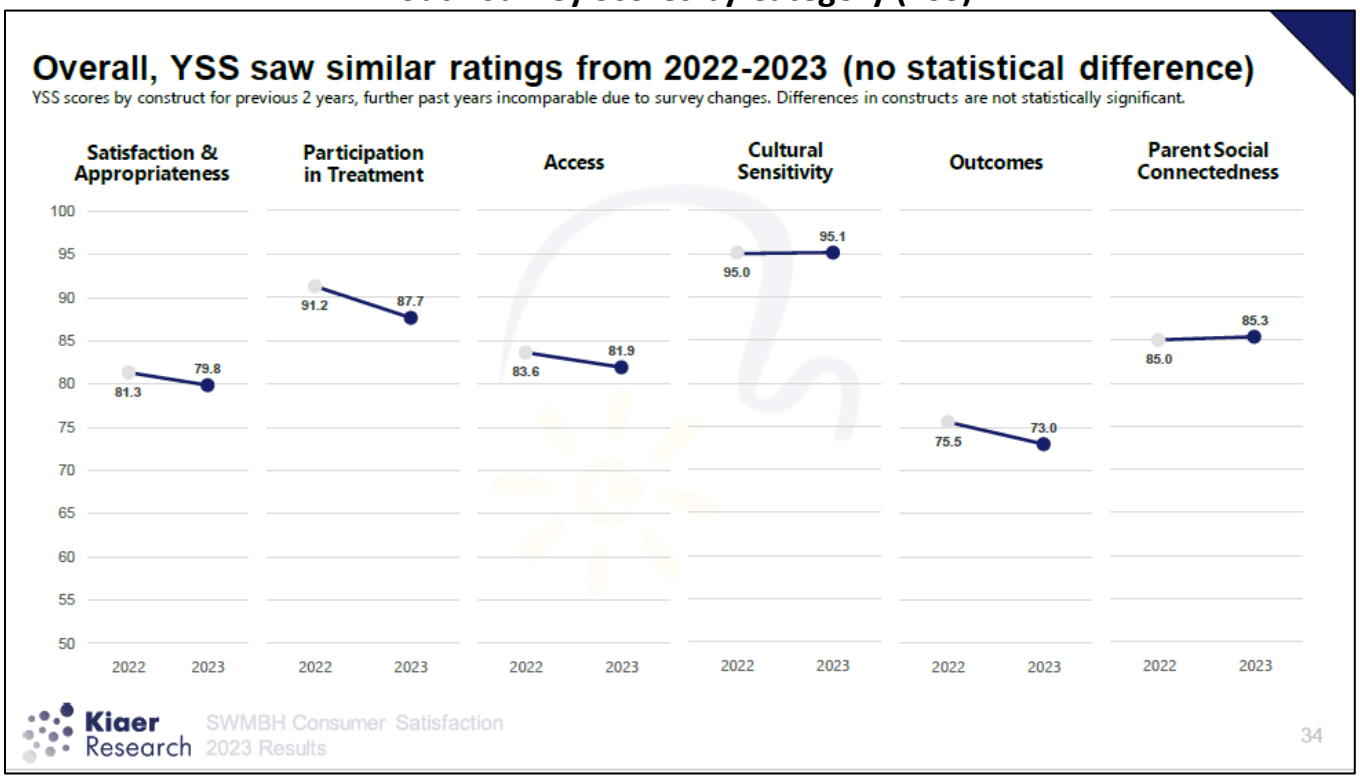


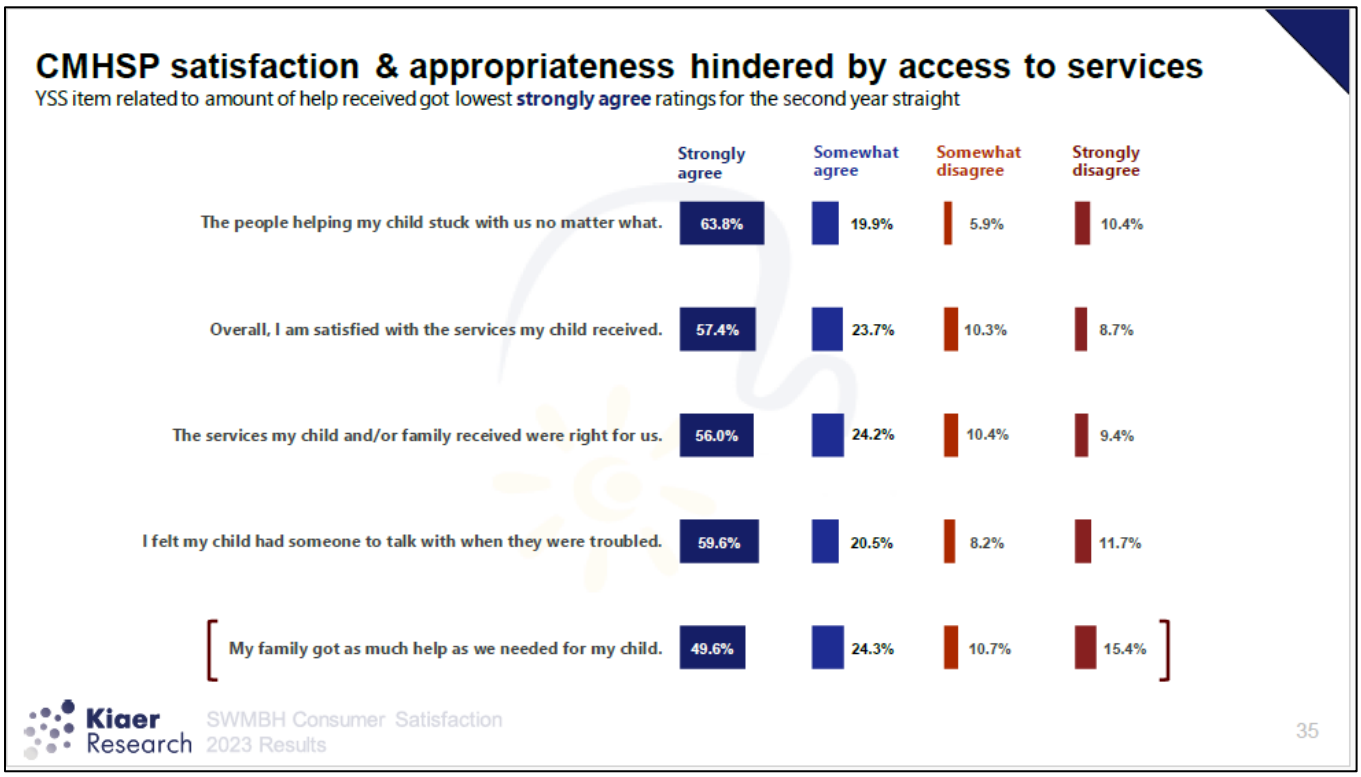
Consumer outcomes & functioning relatively consistent across all items

Nearly one in four **disagreed** that their "symptoms [were] not bothering me as much" – highest on all O&F items.



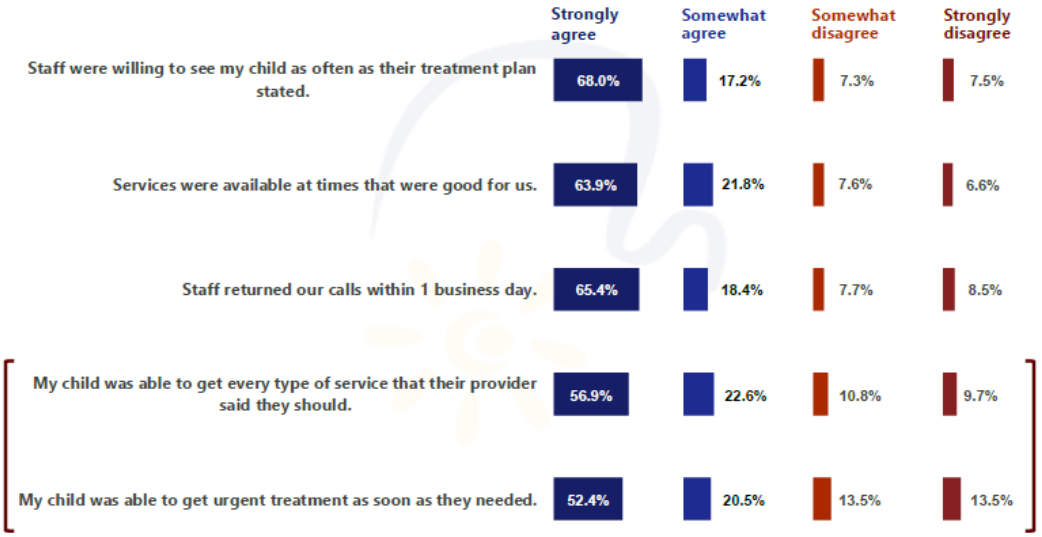
Youth Survey Scores by Category (YSS)





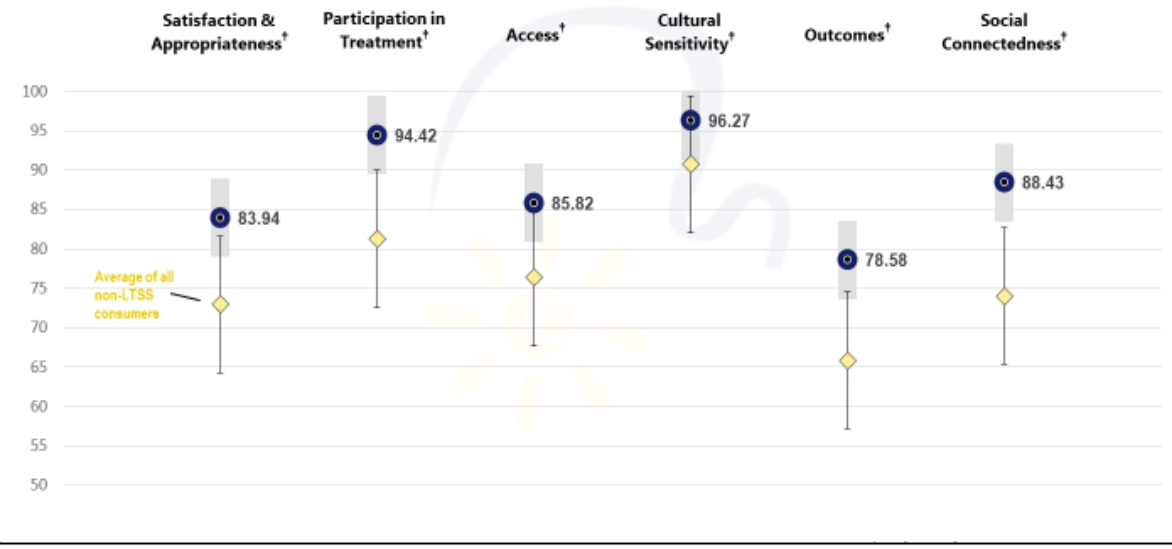
Most access ratings were strong, some weaker

Less **agreement** with items related to receiving different types of services and urgent treatment.



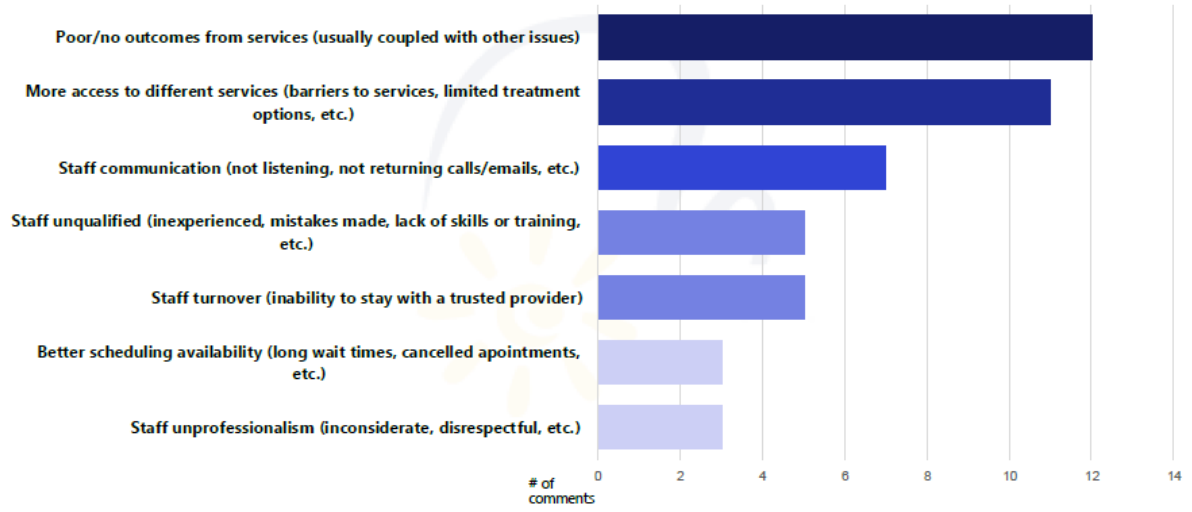
Youth LTSS consumers report better scores than non-LTSS youth across the board

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*)



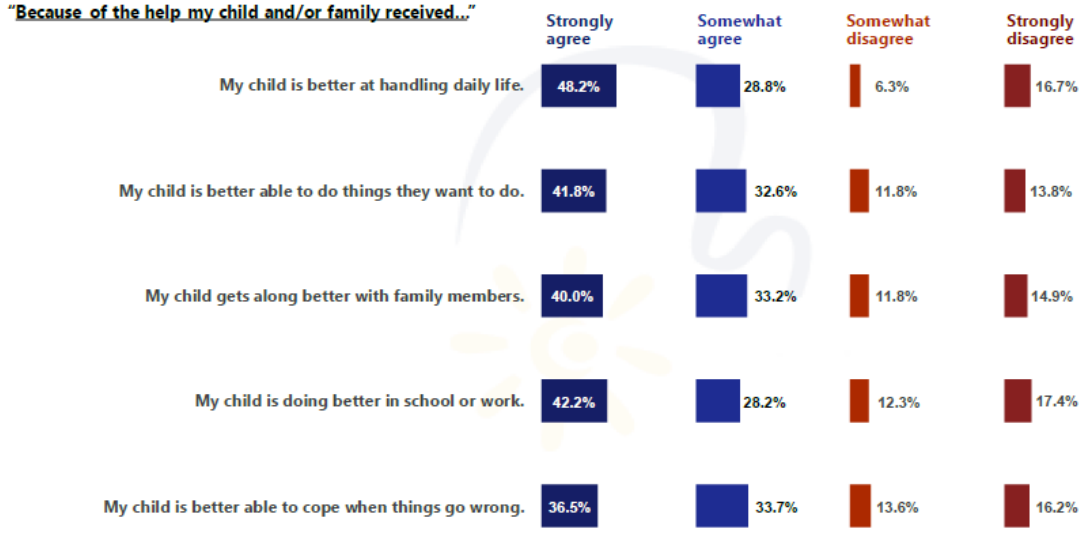
Opportunities for improvement in granting more access to services

Comments emphasized the inability for their children to receive services as a driver of poor outcomes.



Outcomes for youth consistent, but not stellar

For close to 1 in 4 respondents, their child saw no improvement across the different outcome measures



Positive highlights from the YSS comments section

"Our therapist has been **really in tune** with my child's actions and feelings. She has helped him learn to look at his actions and find a better way to resolve an issue the next time."

"Everyone has been great! ISK, Family Services, ASK, KRESA, KCC and Total Spectrum. Because of these services my grandsons **quality of life** (and mine) **has increased**. Thank you!!!"

"Because of the help I am not only able to **get my child's needs met** educationally but also emotionally. He has had more opportunities to go places a child loves, interact and enjoy trips, and be able to **be a happy child**. He has progressed so well especially in verbal communication. You have given me as a parent **confidence, assurance, and self esteem** in my choices for my child."

"The **support** and **complete understanding** is so appreciated. It's comforting to know **there is someone there** in times of crisis if needed. My daughter has gained so much **confidence and independence** through services offered here."

"To know I am **not alone**, and to have all the **resources**, and **guidance** we need. To have a caring person and **great listener** to help us and be a friend and a familiar face. To know no question is never a bad one and does get answers. They are **absolutely wonderful** to have in our area!"

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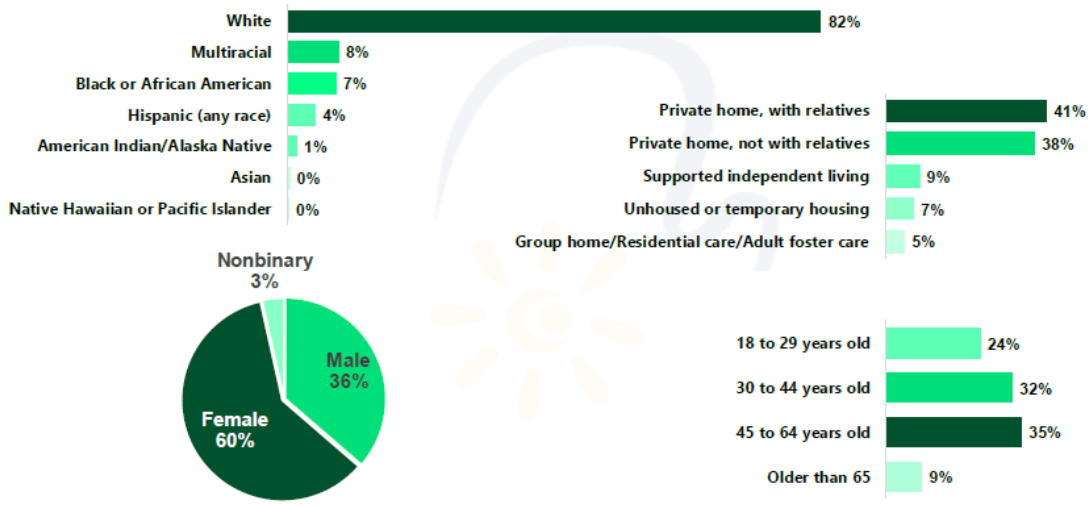
Survey Diagnostics, Analytics, and Recommendations

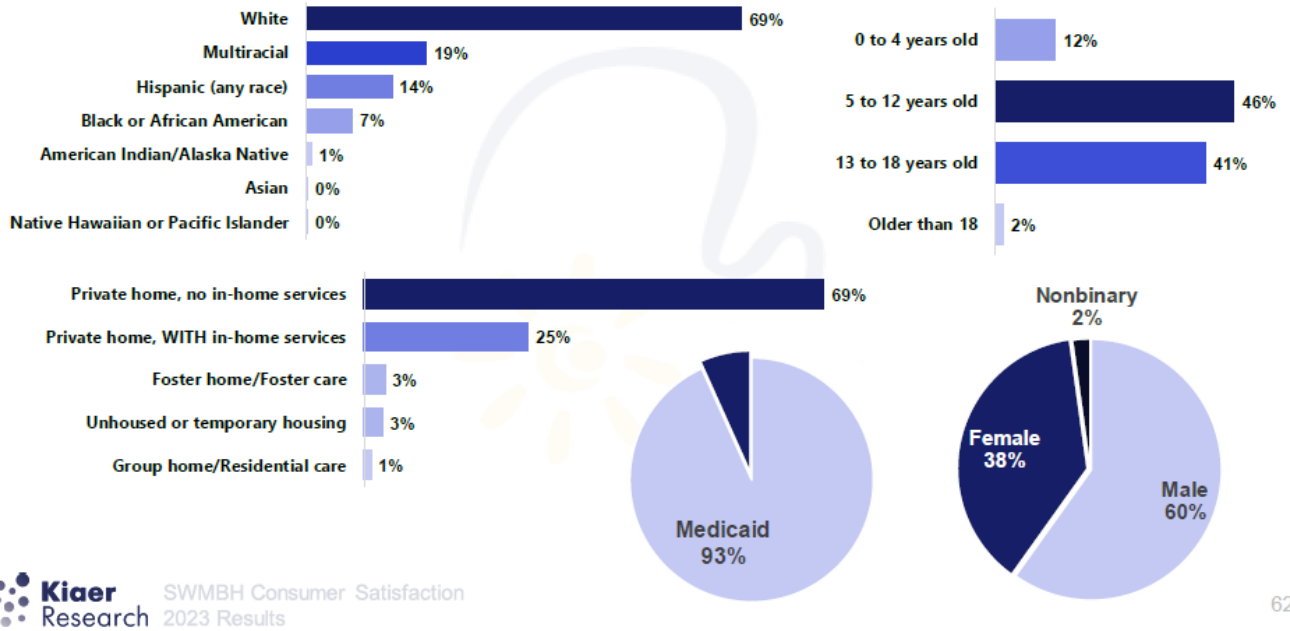
MHSIP 2023 respondents similar in makeup to prior years

In 2023, a new question about living situation was asked, though it may be tweaked in future surveys.



YSS 2023 youth represented were more diverse than in 2022

More Hispanic youth were represented and more non-Medicaid youth were represented.



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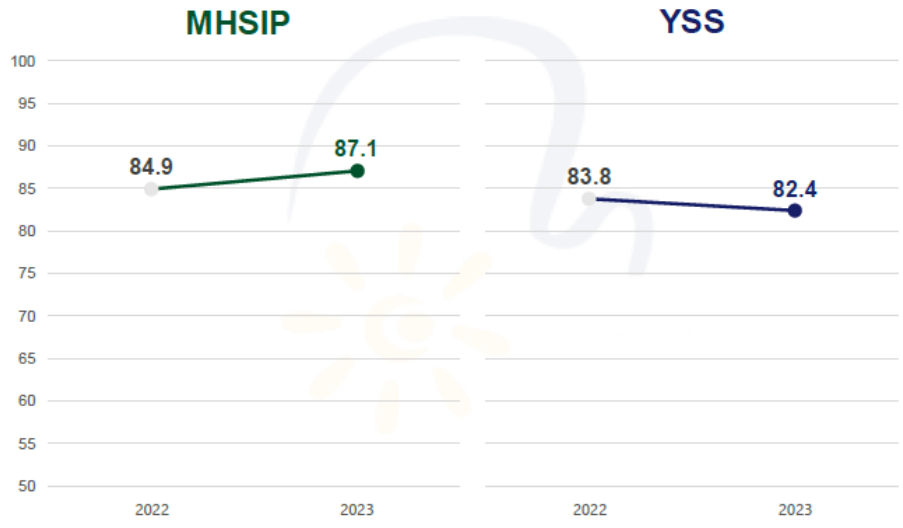
Total aggregate average score dipped for YSS, lifted for MHSIP in 2023

While 2022 had similar scores for MHSIP and YSS, 2023 has a nearly 5-pt difference between the two



F. Member Experience with Services – RSA-r Survey

Description

The Recovery Self-Assessment-revised (RSA-r) Survey was offered to Medicaid & Block Grant SUD members to capture satisfaction with the services they receive, and to identify sources of dissatisfaction with their current provider. The survey consists of 32 questions and the answers were based on a scale of 1-5. 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 member outcomes and treatment modalities.

FY23 Goals

Goal	Responsible Department	Where Progress Was Monitored	Frequency of Monitoring
Increase the number of surveys completed compared to the previous year.	QM	QMC and SUD Directors Subgroup	Annually
Improve scores in at least four out of five survey categories from previous year's results.	QM	QMC and SUD Directors Subgroup	Annually
Revise the survey to collect SUD service program type to enable further analysis and process improvement of recovery-oriented care.	QM	QMC and SUD Directors Subgroup	Annually

FY23 Identified Barriers and Analysis

The formats in which the RSA-r survey was administered proved to be a barrier in FY23. For example, electronic survey participation increased in FY23, accounting for only 22% of completed surveys. The majority of surveys were completed via paper which resulted in heightened processing time and margin for manual entry error.

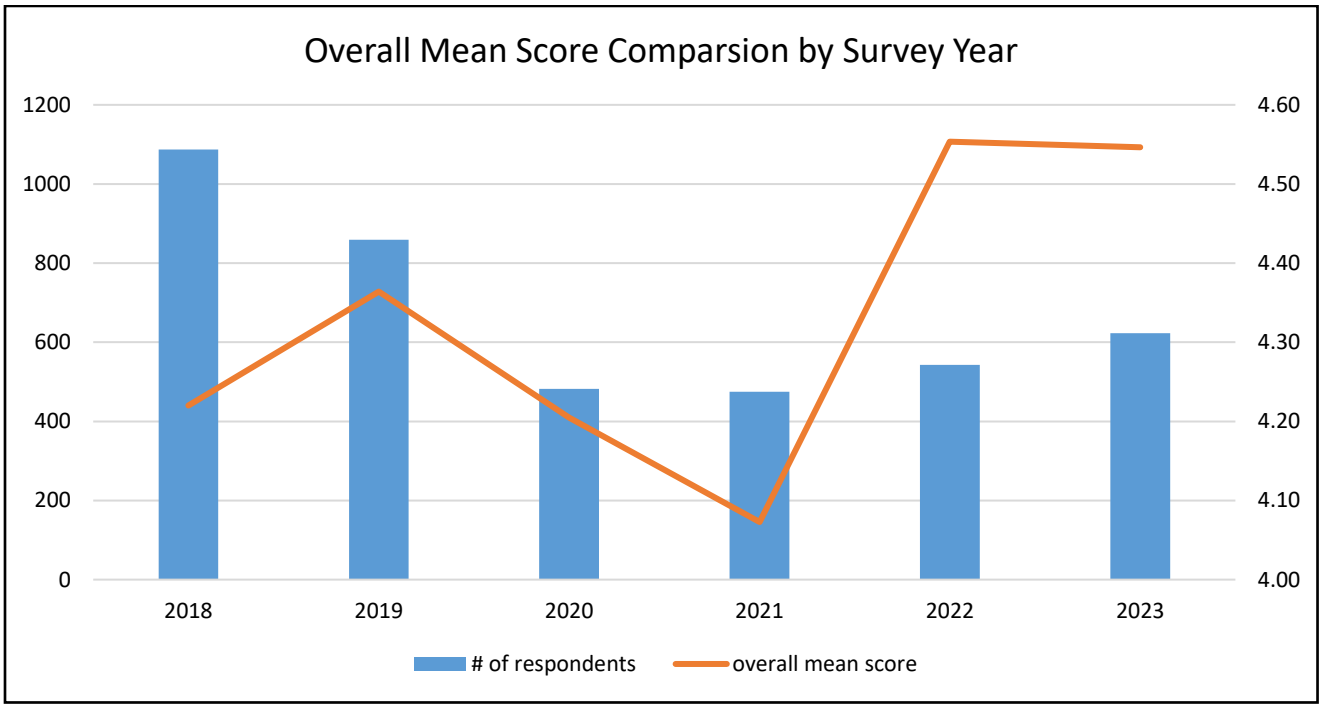
Improvement Efforts Made in FY23

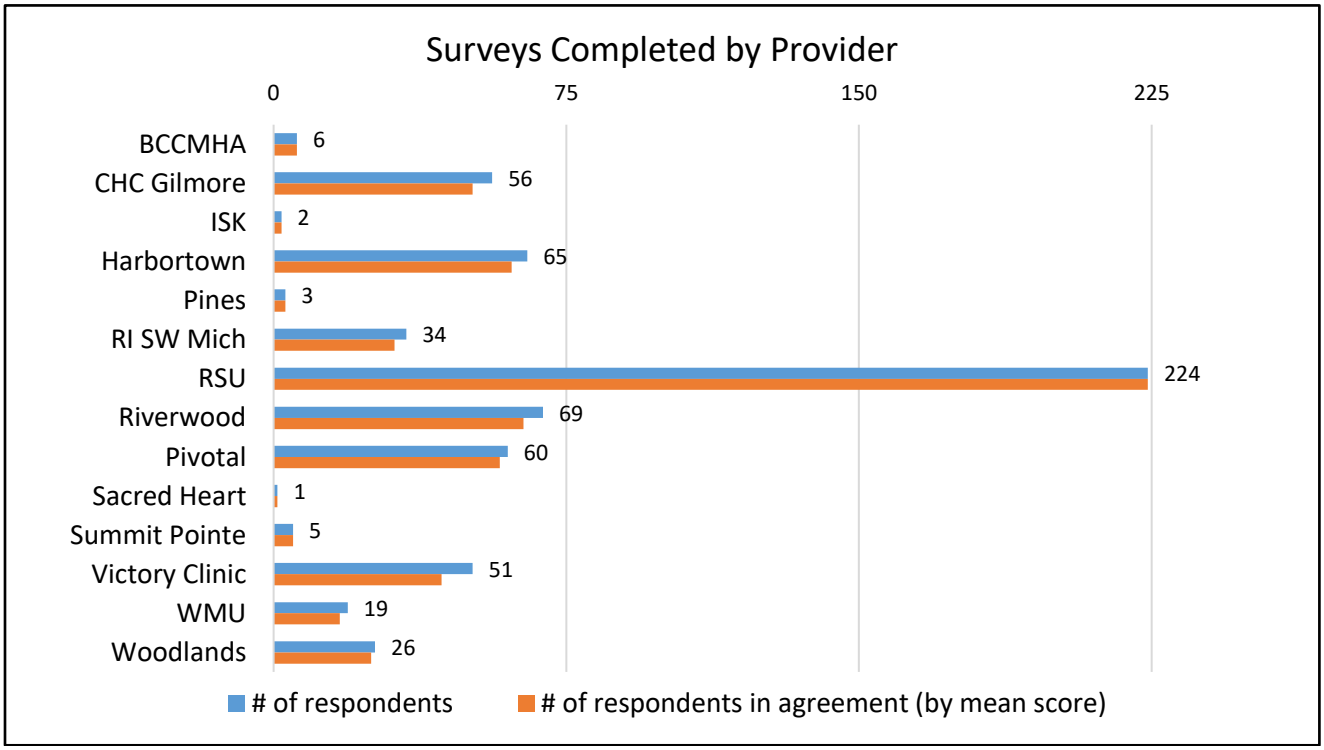
Important dates for the survey process were communicated in a timelier fashion to multiple regional committees resulting in increased awareness and participation. SWMBH consulted with the SUD Provider network to determine the most relevant data points to be used for trend identification and analysis, and the development of quality improvement efforts. SUD provider action plans submitted to SWMBH based on FY22 results were revisited and interventions were evaluated as part of the FY23 individual provider summaries. The mean scores for the questions under each subcategory were provided to the region. CAPs were requested from the SUD Providers for analysis and follow up will occur in FY24. These efforts help ensure improvements in the quality of health care and services for members, service delivery, and health outcomes over time.

FY23 Results

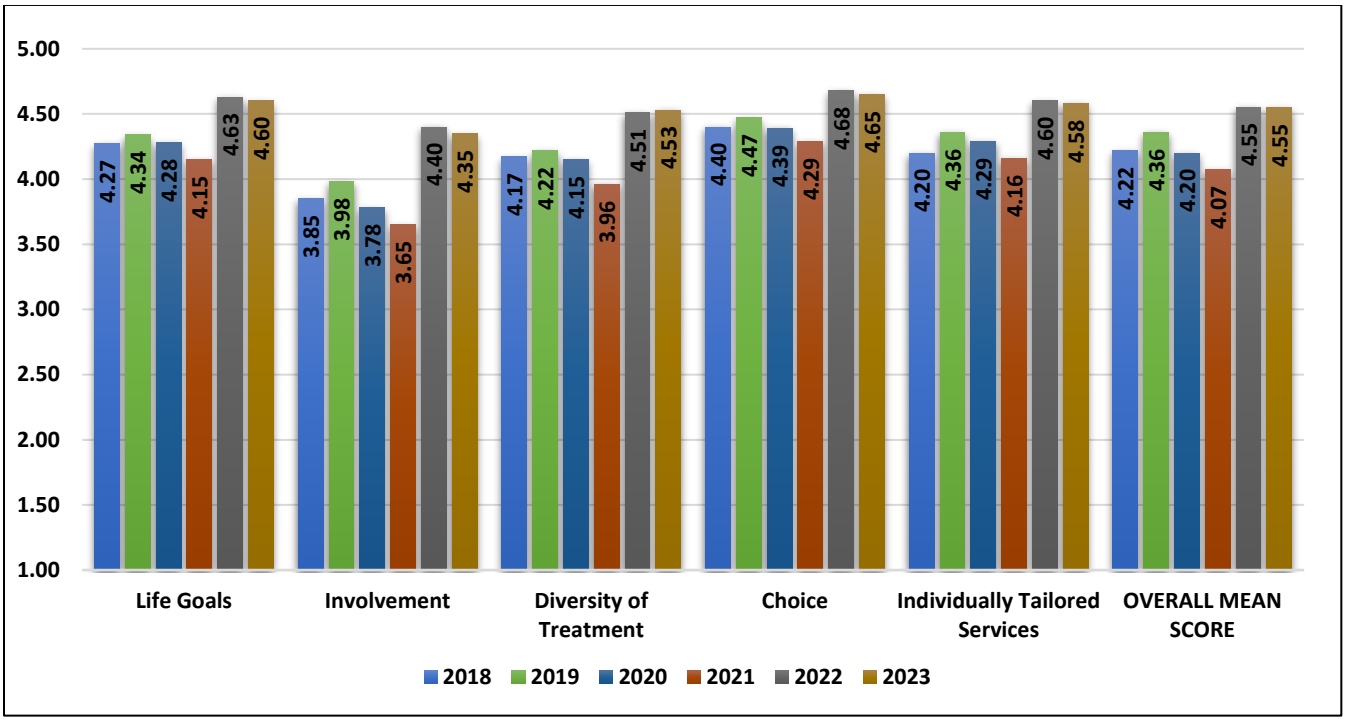
Goal	FY22	FY23	Eval Score	Recommendations
Increase the number of surveys completed compared to the previous year.	543 surveys	623 surveys	**5**	Goal met in FY23, will continue in FY24.
Improve scores in at least four out of five survey categories from previous year's results.	N/A	Not met	**2**	Goal not met in FY23, however, there was no change in overall mean score compared to FY22.
Revise the survey to collect SUD service program type to enable further analysis and process improvement of recovery-oriented care.	N/A	Partially met	**3**	SWMBH consulted with the SUD Provider network to determine the most relevant data points and decided against collecting the service program type. SWMBH provided the mean score for each question under each subcategory to allow for further analysis.

RSA-r Survey Results
FY23 Overall Mean Score: 4.55

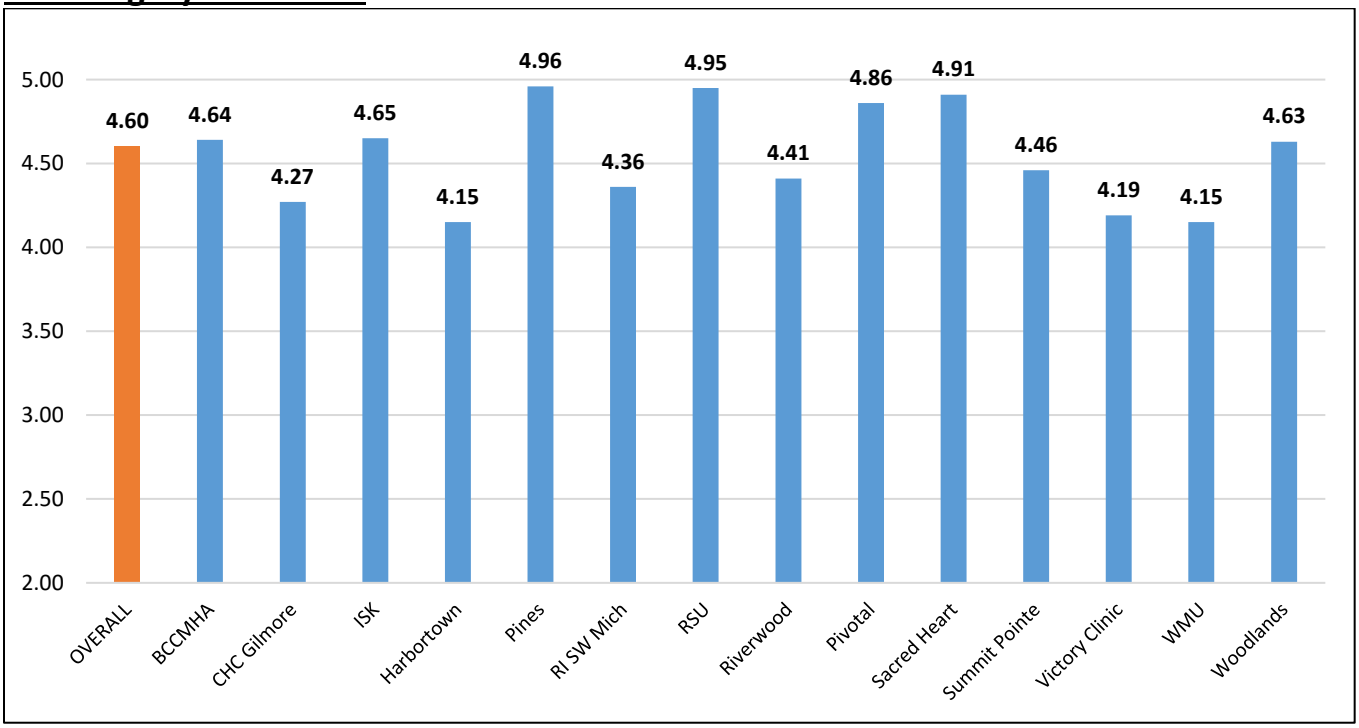




SWMBH Mean Response by Subcategory
Year to Year Comparison



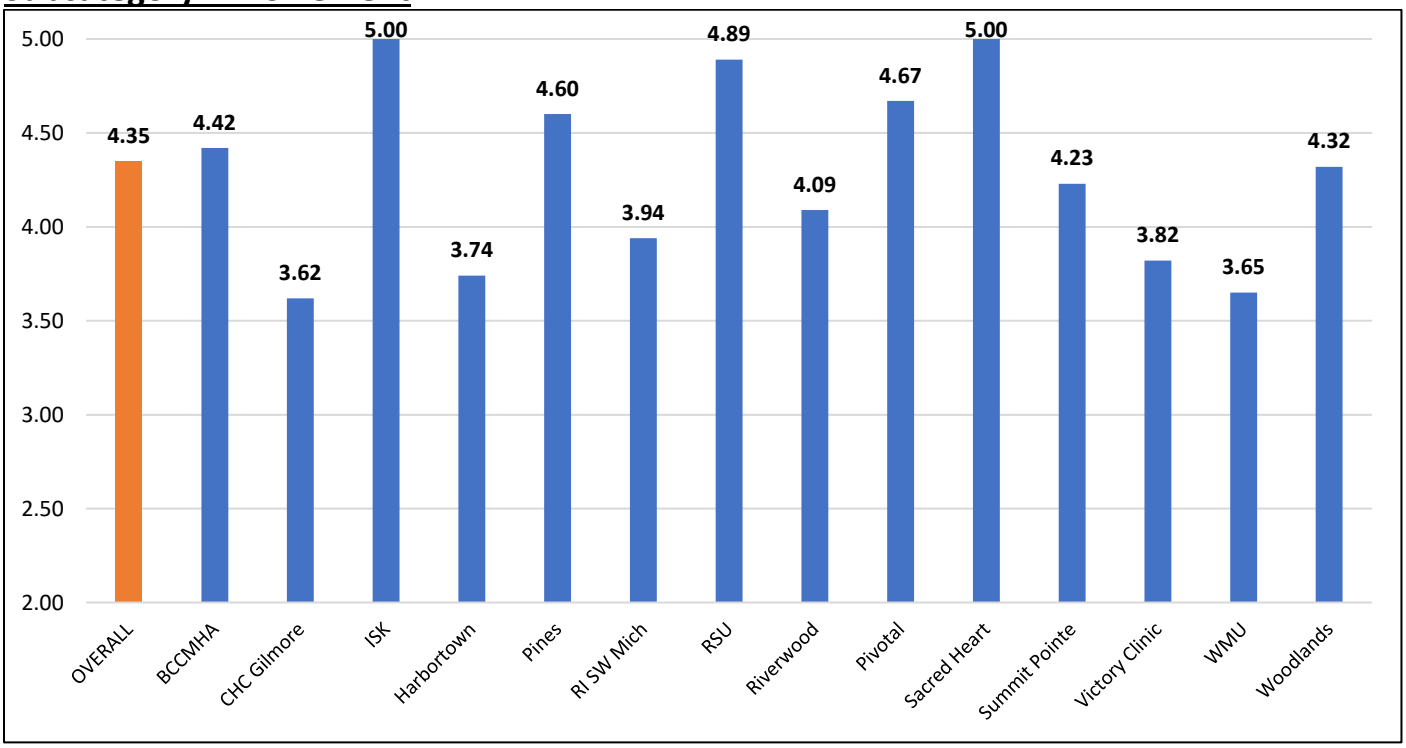
Subcategory: Life Goals



The SWMBH average was 4.60 for the Life Goals subcategory in FY23. The average decreased from 4.62 in FY22 however, this change is not statistically significant. Also, the regional average in FY23 was still higher than the six-year average mean for this subcategory (4.38). The table below includes questions associated with the Life Goals Subcategory as well as the mean score for each question.

Question	Mean Score
3. Staff encourage program participants to have hope and high expectations for their recovery.	4.71
7. Staff believe in the ability of program participants to recover.	4.79
8. Staff believe that program participants have the ability to manage their own symptoms.	4.59
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.	4.67
12. Staff encourage program participants to take risks and try new things.	4.44
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).	4.67
17. Staff routinely assist program participants with getting jobs.	4.26
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.	4.49
28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.	4.60
31. Staff are knowledgeable about special interest groups and activities in the community.	4.61
32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	4.63

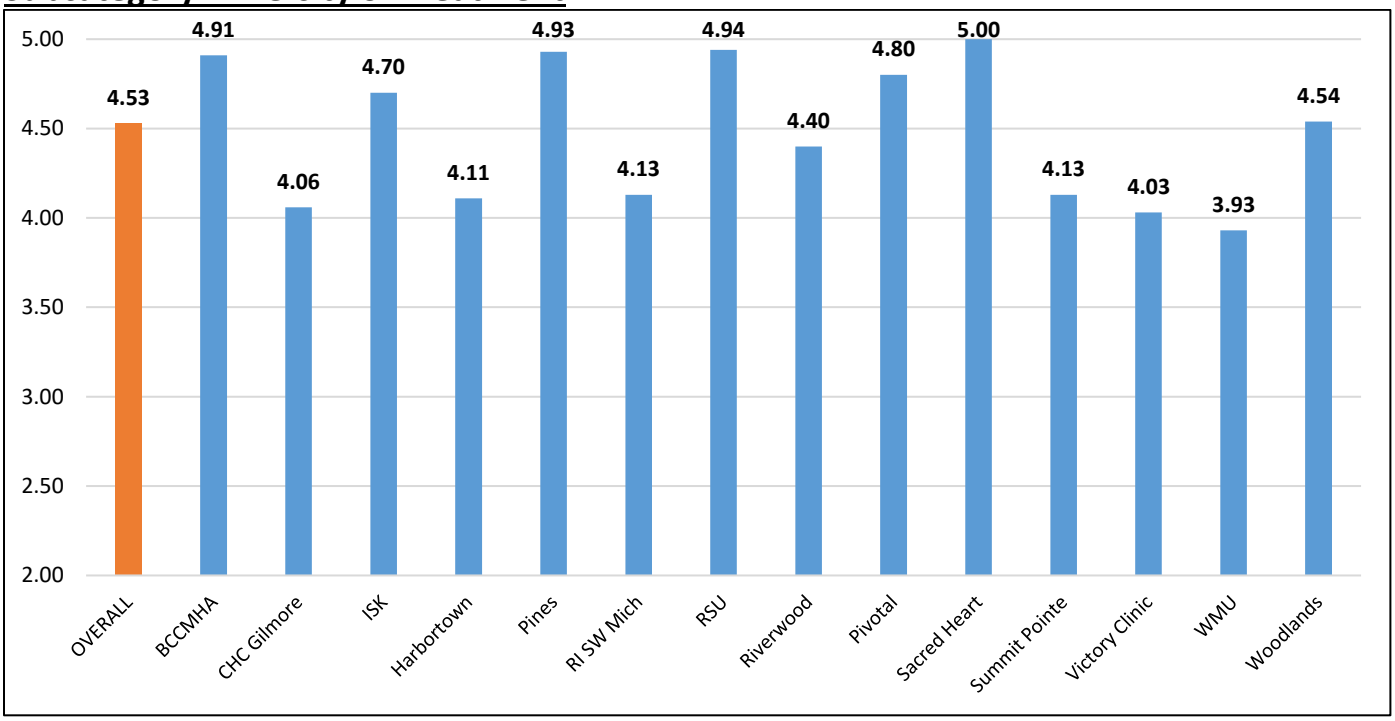
Subcategory: Involvement



The SWMBH average was 4.35 for the Involvement subcategory in FY23 which was a slight decrease in score from the previous year at 4.40. The table below includes questions associated with the Involvement Subcategory and the mean score for each question.

Question	Mean Score
Q22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).	4.39
Q23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.	4.28
Q24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.	4.53
Q25. People in recovery are encouraged to attend agency advisory boards and management meetings.	4.19
Q29. Persons in recovery are involved with facilitating staff trainings and education at this program.	4.29

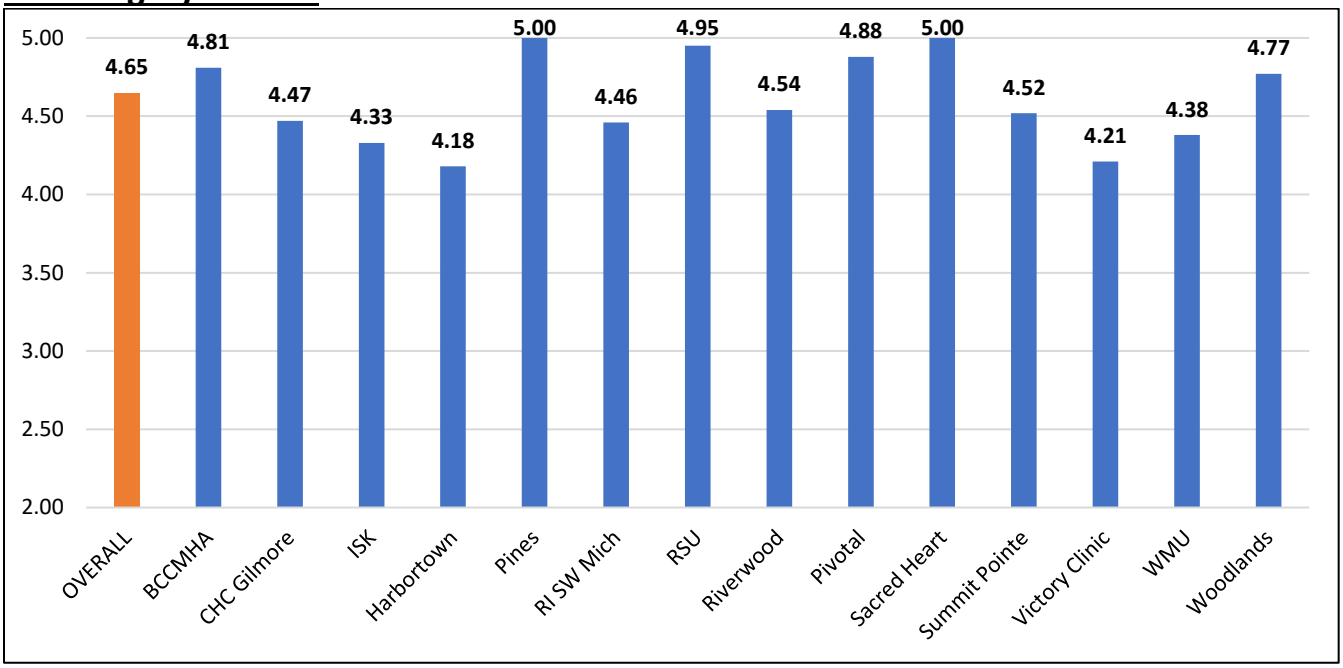
Subcategory: Diversity of Treatment



The SWMBH average was 4.53 for the Diversity of Treatment subcategory in FY23. This was the only category average that increased from the previous year's score as FY22 was 4.50. The table below includes questions associated with the Involvement Subcategory and the mean score for each question.

Question	Mean Score
Q14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.	4.62
Q15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.	4.32
Q20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.	4.51
Q21. Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.	4.65
Q26. Staff talk with program participants about what it takes to complete or exit the program.	4.53

Subcategory: Choice

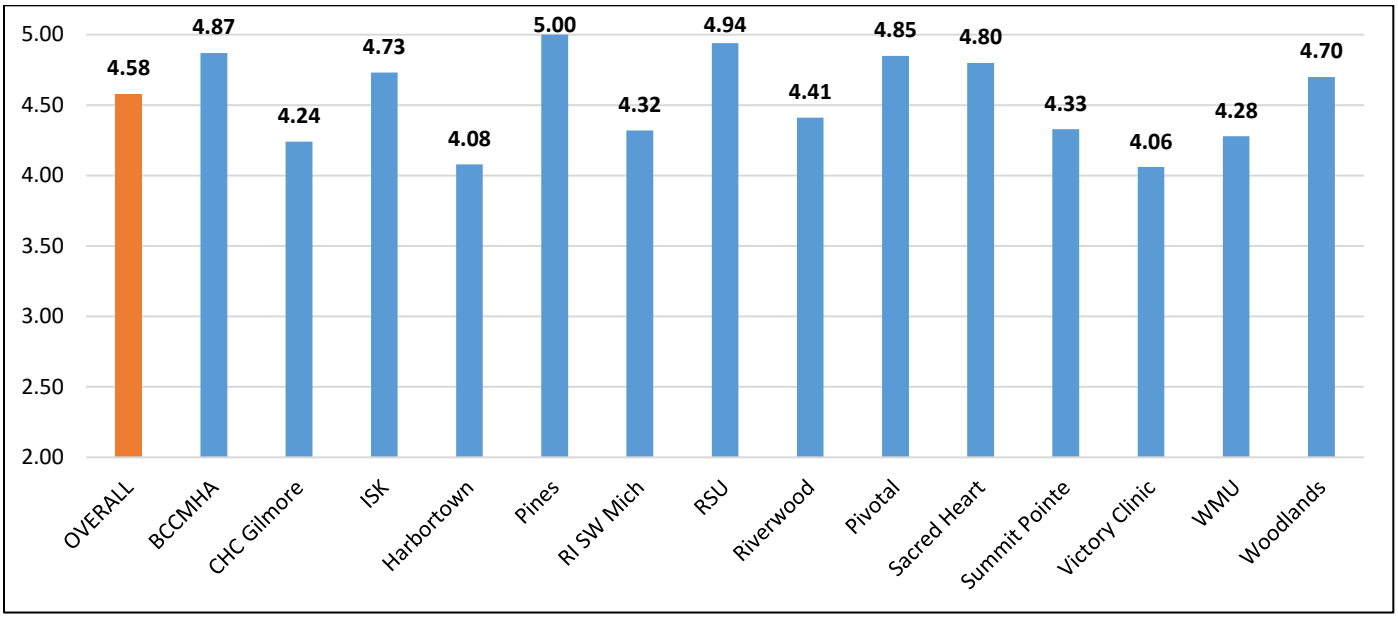


The SWMBH average this year decreased slightly from 4.68 in FY22 to 4.65 for the Choice subcategory; however, was the highest scoring of the five subcategories.

The table below includes questions associated with the Choice Subcategory and the mean score for each question.

Question	Mean Score
Q4. Program participants can change their clinician or case manager if they wish.	4.59
Q5. Program participants can easily access their treatment records if they wish.	4.59
Q6. Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.	4.72
Q10. Staff listen to and respect the decisions that program participants make about their treatment and care.	4.71
Q27. Progress made towards an individual's own personal goals is tracked regularly.	4.62

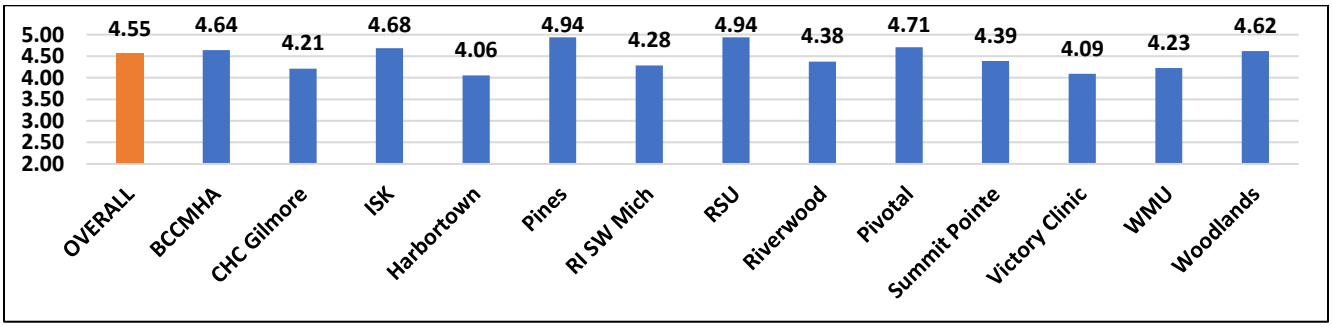
Subcategory: Individually Tailored Services



The SWMBH average was 4.58 for the Individually Tailored Services subcategory in FY23.
The table below includes questions associated with the Individually Tailored Services Subcategory and the mean score for each question.

Question	Mean Score
Q1. Staff welcome me and help me feel comfortable in this program.	4.70
Q2. The physical space of this program (e.g. the lobby, waiting rooms, etc.) feels inviting and dignified.	4.46
11. Staff regularly ask program participants about their interests and the things they would like to do in the community.	4.50
13. This program offers specific services that fit each participant's unique culture and life experiences.	4.54
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).	4.63
Q30. Staff listen, and respond, to my culture, ethnicity, lifestyle, and interests.	4.65

Overall Mean Score by Provider



G. Provider Experience – Communication and Access to Services Survey

Description

SWMBH ensures members access to behavioral health services in accordance with the MDHHS contracts and relevant Medicaid Provider Manual and Mental Health Code requirements. SWMBH directly, or through delegated function to the CMHSPs or SUD Providers acting on its behalf, is responsible for the overall network's utilization management (UM) system. Each CMHSP or SUD Provider is accountable for carrying out delegated UM functions and/or activity relative to the people they serve through directly operated or contracted services. All service authorizations are based on medical necessity decisions that establish the appropriate eligibility relative to the identified services to be delivered. To ensure SWMBH is meeting the needs/obligations of the delegated providers, SWMBH conducts a Provider Communications and Access to Services Survey. The results/data from the annual survey process are reviewed in applicable Regional Committees and internally for the development of trainings and/or improvement opportunities. The survey is designed to evaluate and improve practitioner experience base on the assessment of data from the following categories:

- SWMBH and UM Business Processes
- Communication
- Timeliness of Care (authorization of Routine, Urgent and Emergency Services)
- Technical Assistance
- Etc.

FY23 Goal

Goal	Responsible Department	Where Progress Was Monitored	Frequency of Monitoring
Administer the Provider Communications and Access to Services Survey and obtain at least 35 responses.	QM	QMC and RUM Committees	Annually

FY23 Identified Barriers

The largest barrier to completing the Provider Communications and Access to Services Survey in FY23 was getting providers to participate in the completion of the survey. The timeframe for completing the survey was extended two additional months to try to increase participation, but only 27 responses were received. Additionally, once the survey results received and the analysis began another barrier that was identified was the responses were not easily classified into the type of provider that provided the responses to be able to effectively implement corrective actions.

Improvement Efforts Made in FY23

A new survey platform was utilized in FY23, Microsoft Forms, which allowed SWMBH to develop the survey in a way that flows better for the survey taker. The new platform also allowed SWMBH to monitor the results in real time to work to improve the response rate.

FY23 Results

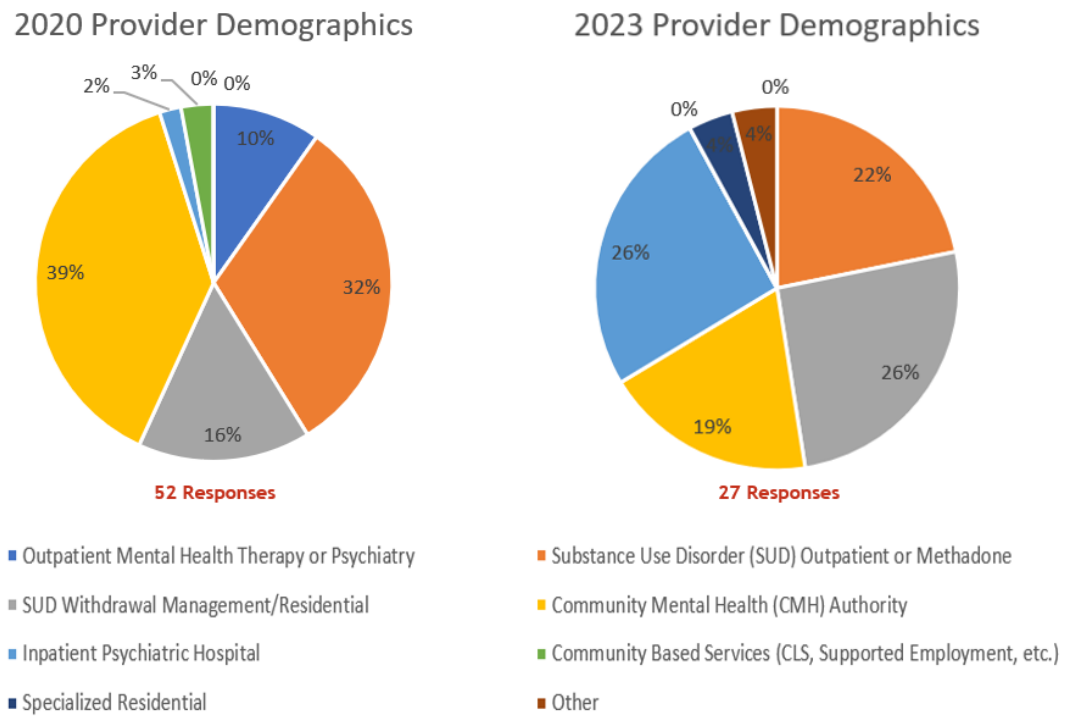
Goal	FY23	Eval Score	Recommendations
Administer the Provider Communications and Access to Services Survey and obtain at least 35 responses.	27 Responses	**3**	The goal of 35 responses was not met, however 27 responses containing valuable feedback were received.

Each SWMBH Senior Leader was provided the results of the survey and asked to review the data that was relevant to their Department for the development of trainings and/or improvement opportunities and to Review relevant data and proposed improvement efforts in applicable Regional Committee meetings.

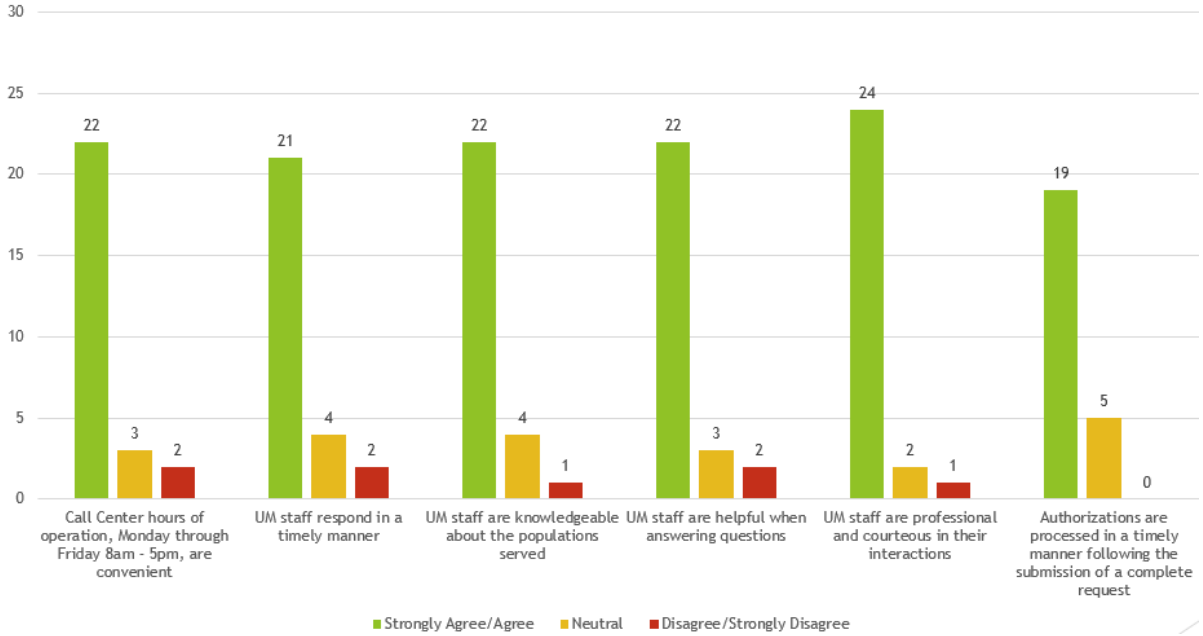
Some specific actions that were developed are outlined below:

- Communications Protocols have been reviewed and revised and after approval from other Senior Leaders will be sent out to all staff and reviewed at the next All Staff meeting.
- The Provider Support concerns were reviewed with the SWMBH Business Analyst, and a succession plan/backup is being developed for when the Business Analyst is on PTO, as the current plan was determined to be inadequate and may be what leads to some of the delays. The plan will entail ensuring that there is one or more SWMBH staff that are trained to respond to provider requests that are submitted via email to the providersupport@swmbh.org email address.
- In future surveys the questions or format of the survey should be changed based on the provider type to gain a better understanding of the areas needing improvement.
- Ideas to improve participation in the survey include obtaining e-mail addressed from the UM Director and the Provider Network team to extend the survey to more individuals and looking at other ways to contact people outside of e-mail as many people had left the organizations or were on leave when the e-mail was sent.
- Other areas such as availability of data and reports and credentialing have been discussed at various Regional Committee meetings as not enough specific information was provided in the survey comments to implement changes.

Survey Responses and Provider Demographics



2023 UM Specific Questions



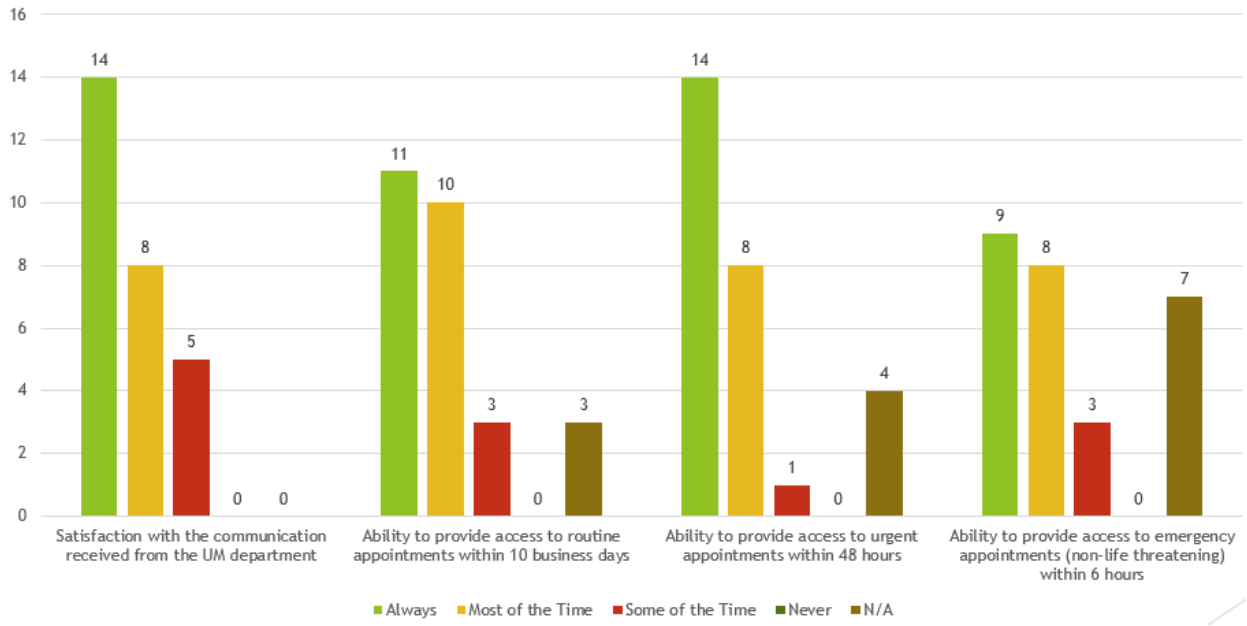
UM Specific Questions Comparison

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Call Center hours of operation are convenient	2020 36% 2023 26%	2020 34% 2023 56%	2020 9% 2023 11%	2020 3% 2023 7%	2020 5% 2023 0%
UM staff respond in a timely manner	2020 25% 2023 26%	2020 37% 2023 52%	2020 15% 2023 15%	2020 2% 2023 4%	2020 7% 2023 4%
UM staff are knowledgeable about the populations served	2020 27% 2023 41%	2020 39% 2023 41%	2020 14% 2023 11%	2020 2% 2023 7%	2020 7% 2023 0%
UM staff are helpful when answering questions	2020 25% 2023 41%	2020 41% 2023 41%	2020 11% 2023 11%	2020 2% 2023 7%	2020 6% 2023 0%
UM staff are professional and courteous in their interactions	2020 34% 2023 59%	2020 36% 2023 30%	2020 9% 2023 7%	2020 4% 2023 4%	2020 5% 2023 0%
Authorizations are processed timely following a complete request	2020 27% 2023 41%	2020 43% 2023 30%	2020 9% 2023 19%	2020 0% 2023 0%	2020 5% 2023 0%

Percentages were rounded and N/A responses were included but not reported here.

The 2023 responses show an increase of over 10% in the combined Strongly Agree/Agree responses for each question, except for Authorizations which were comparable to 2020.

2023 Communication & Timeliness of Care



Communication & Timeliness of Care Comparison

	Always	Most of the Time	Some of the Time	Never
Satisfaction with the communication received from the UM department	2020 29% 2023 52%	2020 43% 2023 30%	2020 20% 2023 19%	2020 2% 2023 0%
Ability to provide access to routine appointments within 10 business days	2020 49% 2023 41%	2020 36% 2023 37%	2020 0% 2023 11%	2020 0% 2023 0%
Ability to provide access to urgent appointments within 48 hours	2020 39% 2023 52%	2020 28% 2023 30%	2020 11% 2023 4%	2020 0% 2023 0%
Ability to provide access to emergency appointments within 6 hours	2020 36% 2023 33%	2020 11% 2023 30%	2020 14% 2023 11%	2020 5% 2023 0%

Ability to Provide Always or Most of the Time in 2023

➡ 78%

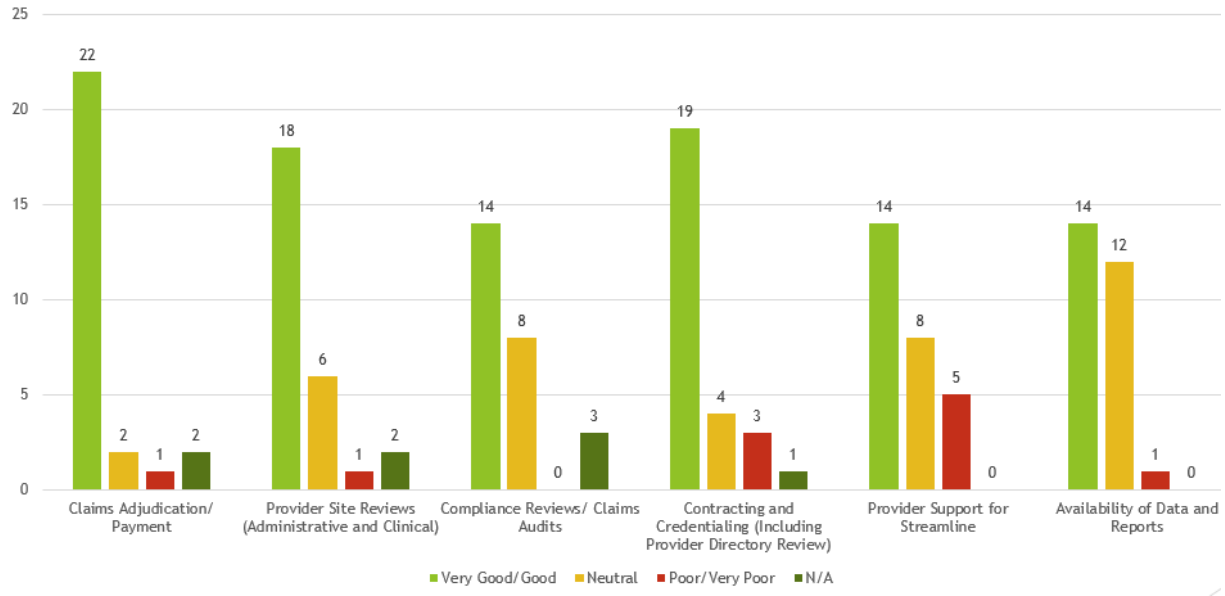
➡ 82%

➡ 63%

Percentages were rounded and N/A responses were included but not reported here.

2023 Areas of Technical Assistance Needs

2023 SWMBH Processes



SWMBH Processes Comparison

	Very Good	Good	Neutral	Poor	Very Poor
Claims Adjudication/ Payment	2020 16% 2023 41%	2020 30% 2023 41%	2020 16% 2023 7%	2020 8% 2023 4%	2020 3% 2023 0%
Provider Site Reviews (Administrative and Clinical)	2020 19% 2023 26%	2020 30% 2023 41%	2020 22% 2023 22%	2020 2% 2023 4%	2020 5% 2023 0%
Compliance Reviews/ Claims Audits	2020 16% 2023 15%	2020 35% 2023 44%	2020 30% 2023 30%	2020 8% 2023 0%	2020 0% 2023 0%
Contracting and Credentialing (Including Provider Directory Review)	2020 33% 2023 15%	2020 34% 2023 56%	2020 12% 2023 15%	2020 4% 2023 11%	2020 1% 2023 0%
Provider Support for Streamline	2020 16% 2023 15%	2020 30% 2023 37%	2020 19% 2023 30%	2020 14% 2023 11%	2020 5% 2023 7%
Availability of Data and Reports	2020 11% 2023 15%	2020 22% 2023 37%	2020 32% 2023 44%	2020 11% 2023 4%	2020 5% 2023 0%

Percentages were rounded and N/A responses were included but not reported here.

Areas with noted room for improvement include Contracting and Credentialing, Provider Support for Streamline, and the Availability of Data and Reports.

H. Verification of Medicaid Services

Description

SWMBH's Program Integrity and Compliance Department performed the Medicaid Services Verification review to verify whether services reimbursed by Medicaid were furnished to members by its CMHSPs, providers, and subcontractors. This review was performed pursuant to MDHHS-PIHP Master Contract Section (1)(C)(4) and in conformity with the MDHHS Medicaid Verification Process technical requirement. SWMBH performed this review immediately after the end of each Fiscal Year Quarter to have real time results and an opportunity to effectuate change quickly. SWMBH submitted its findings from the process to MDHHS and provided follow up actions that were taken because of the findings. These efforts helped ensure improvements in the quality of health care and services for members, service delivery, and health outcomes over time. For completing the fiscal year verification of sampled Medicaid claims, SWMBH used the random number function of the Office of Inspector General's (OIG) statistical software package, RAT-STAS, and conduced quarterly audits of service encounters for each CMHSP and reviewed claims from contracted substance use disorder (SUD) providers and non-SUD providers subcontracted with CMHSPs. SWMBH utilized a standardized verification tool, which included the following elements against which all selected encounters and claims were 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 member?
6. Was the provider qualified to deliver the services provided?
7. Is the appropriate claim amount paid (contracted rate or less)?

FY23 Goal

Goal	Responsible Department	Where Progress Was 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

FY23 Identified Barriers and Analysis

CMHSPs and providers were cooperative and responsive to SWMBH's review process. The only barrier to performing the review was the timeliness of claims and encounter data. SWMBH performed 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 persisted. As a result, claims and encounter data were monitored following the end of each Fiscal Year quarter until the volumes were averaged, then samples were pulled. If the CMHSP experienced difficulty in submitting encounter data, or an SUD provider did not submit claims promptly, claims and encounter volumes were affected. To account for this, SWMBH monitored encounter and claims submission volumes prior to pulling quarterly samples and contacted SWMBH IT and/or the affected CMHSP when issues are identified, and remediation was necessary.

Improvement Efforts Made in FY23

Based on the FY23 overall compliance rate of 92.03% and given that all samples reviewed achieved a compliance rate greater than or equal to 90%, a formal CAP was not required; however, SWMBH continued the efforts described in the Medicaid Services Verification Report, to improve service claim processes congruous with Medicaid requirements. In addition to the Medicaid Services Verification Review, SWMBH performed a region wide annual comprehensive qualitative and administrative analysis, designed to provide ongoing feedback to both CMHSPs and network providers.

FY23 Results

Goal	FY22	FY23	Eval Score	Recommendations
The overall Medicaid claims verification compliance rate for Region 4 will be above 90%.	94.64%	92.03%	5	Continue to monitor.

SWMBH's 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 1,833 claims/encounters, representing 22,165 units and $1,880,781.06, were audited for FY23. Of those audited, 1,687 were verified to be a valid service reimbursable by Medicaid, for an overall FY23 compliance rate of 92.03%. 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? **8 deficiencies (Medicaid was secondary payor)**
- Is there a current treatment plan on file which covers the date of service? **8 deficiencies**
- Does the treatment plan contain a goal/objective/intervention for the service billed? **4 deficiencies**
- Is there documentation on file to support that the service was provided to the member? **119 deficiencies**
- Was the service provided by a qualified practitioner and falls within the scope of the code billed/paid? **2 deficiencies**
- Was the appropriate amount paid (contract rate or less)? **1 deficiency**

FISCAL YEAR	MEDICAID SERVICES VERIFICATON RESULTS
FY21	95.27%
FY22	94.67%
FY23	92.03%

SWMBH is committed to improving the effectiveness and efficiency of the PIHP accountabilities in Medicaid fraud and abuse prevention. Given the FY23 findings, ongoing education and training will be provided with an emphasis on documentation standards, proper reporting of face-to-face service start and stop times, treatment planning timeliness, and required modifiers (U-modifiers and provider-qualification modifiers specifically). As a result of the anticipated staff training, efforts to continuously improve in this area will be ongoing. In FY24, SWMBH will continue a concerted focus to enhance regional data mining efforts and continue to monitor and educate providers on treatment plan timeliness, proper recording of face-to-face service start and stop times, accurate use of provider qualifications modifiers, and service documentation standards. Additionally, SWMBH will continue closely monitoring the reporting of in-home Community Living Support claims for the proper use of modifiers, start and stop times, and only billing face-to-face services.

I. Provider Network Adequacy

Description

SWMBH completed an evaluation of the adequacy of the FY23 provider network during the first quarter of the applicable fiscal year, assessing provider network adequacy and accessibility according to the most current MDHHS Network Adequacy Standards. The areas that were assessed included enrollee-to-provider ratios, crisis residential beds-to-enrollee ratios, time and distance standards, SUD services based on American Society of Addiction Medicine Level of Care (ASAM LOC), timely appointments, languages spoken, cultural competence, and physical accessibility. Each section contained a regional analysis and identified opportunities for improvement that were addressed throughout the fiscal year. These efforts help ensure improvements in the quality of health care and services for members, service delivery, and health outcomes over time, and the report was submitted to MDHHS for review and feedback.

FY23 Goal

Goal	Responsible Department	Where Progress Was Monitored	Frequency of Monitoring
SWMBH will complete an evaluation of provider network adequacy and accessibility according to the most current MDHHS Network Adequacy Standards. The report will be submitted to MDHHS by the MDHHS-required due date.	Provider Network	SWMBH Assessment of Medicaid Network Adequacy Report	Annually

FY23 Identified Barriers and Analysis

Following the completion of the FY23 Provider Network Adequacy Report, SWMBH convened a Network Adequacy Remediation Workgroup to prioritize and strategize around identified deficiencies. The Workgroup identified a MMBPIS indicator where the Region would benefit from explicit guidance to ensure consistency across CMHSPs as well as accuracy in the data reported. The Workgroup also identified challenges in determining staff counts and the corresponding ratios for children's services – Homebased and Wraparound – and recommended further review of how to identify only those members who may be eligible for the service to more accurate calculate clinician to member ratios.

Improvement Efforts Made in FY23

On behalf of the Region, SWMBH worked to secure a contract with Pineway for Children's Crisis Residential services, which greatly improved the Region's time and distance access for this service. During the FY23 HSAG review process, HSAG reviewers indicated an overall satisfaction with SWMBH's FY23 Network Adequacy Report but suggested that SWMBH include a section on languages spoken in future reports. That was recommendation will be incorporated into the FY24 Report. The FY23 Network Adequacy Remediation Workgroup made a recommendation to QMC regarding the MMBPIS indicator referenced in the "Barriers" section above, and the Regional QMC collaborated and provided explicit guidance.

FY23 Results

Goal	FY23	Eval Score	Recommendations
SWMBH will complete an evaluation of provider network adequacy and accessibility according to the most current MDHHS Network Adequacy Standards. The report will be submitted to MDHHS by the MDHHS-required due date.	Met	**5**	Continue to monitor.

The FY23 Network Adequacy Report was submitted to MDHHS by the required due date. HSAG recommendations regarding languages spoken were included in the FY24 Report. SWMBH performs the Network Adequacy evaluation during the first Quarter of the Fiscal Year to evaluate the current Fiscal Year's network, identify deficiencies, and effectuate change before the next fiscal year cycle. This poses some challenges with MDHHS reporting as the MDHHS report is required for the prior fiscal year. SWMBH has communicated with MDHHS and will submit all required information to MDHHS as part of the MDHHS-required report.

J. Administrative and Delegated Function Site Reviews

Description

SWMBH either directly performed or ensured that the CMHSPs performed annual monitoring of all provider agencies within the network. This monitoring occurred through the annual Site Review process, during which standardized tools were used to evaluate CMHSPs' and contracted providers' (both SUD and non-SUD) compliance with administrative requirements and clinical service quality.

CMHSP Site Reviews

SWMBH performed annual Site Reviews of the 8 CMHSPs in Region 4. These reviews analyzed each CMHSP's administrative processes and procedures in the following functional areas: Access and UM, 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 included 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 performed a Clinical Quality (non-SUD) clinical record review of CMHSP directly operated services that was focused on a specific population or service (consistent across all CMHSPs). The population or service focus was determined by SWMBH's Clinical Quality Department based on several factors which included State or PIHP-audit results, member complaints, or other identified concerns. SWMBH also performed an SUD Clinical Quality clinical record review of CMHSP 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 performed annual Site Reviews for each of the contracted SUD providers. These reviews consisted of a review of an analysis of 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 performed a clinical file review as part of the annual Site Review process.

Subcontracted Providers

For non-SUD network providers that are contracted with one or more of SWMBH's CMHSPs, SWMBH ensured that monitoring was performed annually either by SWMBH or by a CMHSP. SWMBH directly performed 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 performed annual monitoring of the remaining network provider types. SWMBH's Regional Provider Network Management Committee (RPNMC) annually reviewed standardized subcontracted provider review tools which were used for completion of subcontracted provider Site Reviews to ensure

consistency and foster reciprocity. The RPNMC also maintained a spreadsheet of all shared providers, subcontracted providers that are contracted with more than one CMHSP and assigned a responsible CMHSP to perform the annual Site Review each year, to reduce the burden on shared providers. Completed reviews were uploaded to SWMBH's Portal so they were accessible to all CMHSPs.

Network provider Site Reviews consisted of a review of each provider's administrative operations and included 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 were qualified to perform the services being delivered and/or perform their job functions (for unlicensed/direct-care staff).

FY23 Goal

Goal	Responsible Department	Where Progress Was Monitored	Frequency of Monitoring
SWMBH will complete Site Reviews for the region (for CMHSPs, SUD Providers, and Subcontracted Providers), and areas of non-compliance will require a corrective action plan.	All SWMBH Departments and CMHSPs	Site Review Tools and CAP Documents	Annually

FY23 Identified Barriers and Analysis

CMHSPs and network providers were collaborative and responsive to the Site Review process. It was confirmed during the FY23 CMHSP Site Review process that quarterly file reviews would be more effective at identifying and remediating deficiencies timely.

Improvement Efforts Made in FY23

SWMBH completed its move to a cloud-based portal, named "SWMBH Commons". SWMBH Commons was used for the FY23 CMHSP Site Reviews, as well as functioning as a repository for network provider Site Review and credentialing reciprocity documentation to be shared amongst CMHSPs. SWMBH received positive feedback from CMHSPs about the functionality and ease of use of SWMBH Commons for these purposes. Following the FY23 CMHSP Site Review process, SWMBH implemented quarterly file reviews for Denials, 2nd Opinions, Grievances and Appeals. Quarterly reviews have allowed for faster identification and remediation of deficiencies.

FY23 Results

Goal	FY23	Eval Score	Recommendations
SWMBH will complete Site Reviews for the region (for Participant CMHSPs, SUD Providers, and Subcontracted Providers), and areas of non-compliance will require a corrective action plan.	Met	5	Continue to monitor.

FY23 Overall Sections by CMHSP								
Section	**Barry**	**Berrien**	**Branch**	**Calhoun**	**Cass**	**Kalamazoo**	**St. Joseph**	**Van Buren**
Access and Utilization Management	96.4%	89.3%	95.8%	100%	95.5%	96.4%	90.9%	100%
Claims Management	100%	100%	100%	100%	93.8%	87.5%	100%	87.5%
Compliance	100%	100%	100%	100%	100%	100%	100%	94.4%
Credentialing	97.1%	97.9%	100%	97.9%	97.1%	97.2%	100%	96.5%
Customer Services	93.8%	90.6%	93.8%	100%	93.8%	96.9%	87.5%	100%
Grievances and Appeals	90.5%	88.1%	95.2%	95.2%	92.9%	95.2%	97.6%	97.6%
Provider Network	95.5%	95.5%	100%	100%	95.5%	100%	100%	95.4%
Quality and Performance Improvement	100%	78.1%	100%	81.3%	100%	100%	100%	100%
Staff Training	92.9%	78.3%	87.5%	93.5%	80.4%	100%	70.6%	97.2%
SUD EBP Fidelity and Administration	100%	100%	100%	100%	100%	100%	100%	100%
Clinical Administration	100%	94.4%	87.5%	88.9%	93.3%	100%	88.9%	88.9%
Overall	96.9%	92%	96.3%	96.1%	94.8%	97.6%	94.1%	96.1%

Overall Sections by Year Data is a combined average score for each section from all eight CMHSP Site Reviews.		
Section	**FY22 Scores**	**FY23 Scores**
Access and Utilization Management	84.9%	95.5%
Claims Management	88.3%	96.1%
Compliance	96.4%	99.3%
Credentialing	95.2%	98%
Customer Services	93.7%	94.6%
Grievances and Appeals	90.3%	94%
Provider Network	94.9%	97.7%
Quality and Performance Improvement	89.6%	94.9%
Staff Training	94.2%	87.6%
SUD EBP Fidelity and Administration	96.3%	100%
Clinical Administration	88.2%	92.7%

FY23 Clinical Quality Sections by CMHSP								
Sections	**Barry**	**Berrien**	**Branch**	**Calhoun**	**Cass**	**Kalamazoo**	**St. Joseph**	**Van Buren**
Physician Coordination	100%	81.6%	94.4%	95.9%	96.3%	98.9%	82.4%	92.7%
Assessment	100%	95.6%	92.7%	93.9%	96.9%	92.3%	92.2%	92.6%
Treatment Plan/PCP	96.6%	93.8%	90.1%	84%	98.9%	87%	85.9%	92.9%
Progress Notes	96.6%	94.2%	94.6%	94.6%	98.2%	90.6%	86%	95.6%
Periodic Review	95%	88.7%	83.8%	91.1%	95%	82.9%	88%	91.1%
Behavior Treatment Planning	N/A	100%	100%	75%	N/A	N/A	N/A	100%
Overall	97.4%	92.2%	90.8%	89.3%	97.4%	89.2%	87.2%	93%

Clinical Quality Sections by Year Data is a combined average score for each section from all eight CMHSP Site Reviews.		
Section	**FY22 Scores**	**FY23 Scores**
Physician Coordination	73%	92.8%
Assessment	95.6%	94.5%
Treatment Plan/PCP	86.8%	91.2%
Progress Notes	90.4%	93.8%
Periodic Review	77%	89.5%
Behavior Treatment Planning	N/A	93.8%

FY23 SUD Clinical File Sections by CMHSP								
Section	**Barry**	**Berrien**	**Branch**	**Calhoun**	**Cass**	**Kalamazoo***	**St. Joseph**	**Van Buren**
Physician Coordination	86.4%	92.9%	81%	76.9%	100%	100%	96.4%	95%
Assessment	97.4%	90.6%	42.6%	26.9%	89.7%	75%	86.2%	96.3%
Treatment Plan/PCP	88.1%	88.8%	76.6%	89%	100%	78.6%	90%	100%
Progress Notes	98.2%	88.5%	90.9%	83.3%	100%	100%	92%	98.3%
Discharge/BH TEDS	100%	95.7%	70%	53.1%	100%	100%	91.7%	100%
MDOC	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Women's Specialty Services	N/A	100%	100%	N/A	100%	N/A	100%	N/A
Overall	93.4%	90.9%	71.7%	62.5%	97.3%	86.8%	91.6%	98.5%

*For Kalamazoo- only one SUD funded member was eligible for the sample during the period reviewed.

SUD Clinical File Sections by Year Data is a combined average score for each section from all eight CMHSP Site Reviews.		
Section	**FY22 Scores**	**FY23 Scores**
Physician Coordination	72.4%	91.1%
Assessment	88%	75.6%
Treatment Plan/PCP	88.7%	88.9%
Progress Notes	96.2%	93.9%
Discharge/BH TEDS	81%	88.8%
MDOC	N/A	100%
Women's Specialty Services	97.6%	100%

K. Credentialing and Re-Credentialing

Description

SWMBH either directly performed or ensured that the CMHSPs and network providers performed 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) ensured that organizations, physicians, and other licensed health care professionals were qualified to perform their services. SWMBH utilized standardized credentialing and re-credentialing applications throughout the Region to ensure consistent application of required standards and the applications are periodically reviewed by the RPNMC. These efforts help ensure improvements in the quality of health care and services for members, service delivery, and health outcomes over time.

SWMBH utilized a checklist to assist in processing credentialing applications. The checklist included, among other things, 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 performed credentialing for the following in the network:

- Applicable SWMBH employees/contractors (individual credentialing)
- 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 performed organizational credentialing of each Specialized Residential Site, on behalf of the Region.

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

- CMHSP network providers, other than those listed above.

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

- Compliance with SWMBH or CMHSP organizational re-credentialing activities, including provider timely submission of credentialing applications and proofs; and
- Provider completion of individual practitioner credentialing of directly employed/contracted staff.

Monitoring Activities - Licensed/Credentialed Staff

SWMBH and the CMHSPs monitored compliance with credentialing requirements through the annual Site Review process. Each Site Review included 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 CMHSPs required 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 CMHSPs monitored to ensure licensed professionals were qualified to perform their services. While it is not "credentialing", when SWMBH received a request from a provider to have a clinician added to the billing system as a rendering provider, SWMBH performed basic screening checks including exclusions screening and licensure verification to ensure

that the clinician was only assigned billing rights to service codes they were qualified to deliver.

Monitoring Activities – Non-licensed Providers

SWMBH and the CMHSPs monitored non-licensed provider staff qualifications through the annual Site Review process. Standardized Site Review tools for all provider types included a Staff Training file review, which evaluated whether a sample of the provider's staff completed all required trainings within required timeframes. Standardized Site Review tools that were specific to providers employing non-licensed staff (example - Ancillary and Community Services tool) included review elements that evaluate the provider's process for ensuring non-licensed direct care staff met the minimum qualifications to perform their jobs as articulated in the Medicaid Provider Manual.

Through the annual Site Review process SWMBH ensured, regardless of funding mechanism:

- Staff (licensed or non-licensed) possessed the appropriate qualification as outlined in their job descriptions, including the qualifications for the following:
  - Education background
  - Relevant work experience
  - Cultural competence
  - Certification, registration, and licensure as required by law (where applicable)

FY23 Goals

Goal	Responsible Department	Where Progress Was Monitored	Frequency of Monitoring
SWMBH will provide training and technical assistance to participant CMHSP staff responsible for completing credentialing.	Provider Network	Provider Network Team Meeting Minutes	Annually
The credentialing and re-credentialing requirements will be reviewed for each CMHSP during the administrative and delegated Site Reviews.	Provider Network	Site Review Tools	Annually

FY23 Identified Barriers

During SWMBH's preparation for the FY23 HSAG EQR Audit, it was identified that there are continued opportunities for improvement in the quality of credentialing application processing. SWMBH is still weighing the potential benefits of quarterly credentialing file reviews against the added administrative burden associated with more frequent monitoring.

Improvement Efforts Made in FY23

SWMBH's CMHSP Site Review Tool was modified for FY23 to mirror HSAG's review tool and was divided into separate Credentialing and Recredentialing file reviews. SWMBH reviewed MDHHS credentialing standards with CMHSPs on 02/17/23, provided training to CMHSP staff on 03/17/23 and again on 10/20/23.

FY23 Results

Goal	FY22	FY23	Eval Score	Recommendations
SWMBH will provide training and technical assistance to participant CMHSP staff responsible for completing credentialing.	N/A	Met – Training occurred on 02/17/23, 03/17/23, and 10/20/23	**5**	SWMBH will re-evaluate the need for continued training following the FY24 CMHSP Site Review results from the Credentialing and Recredentialing file reviews.
The credentialing and re-credentialing requirements will be reviewed for each CMHSP during the administrative and delegated Site Reviews.	Combined Average from 8 FY22 CMHSP Site Reviews 95.2%	Combined Average from 8 FY23 CMHSP Site Reviews 98%	**5**	Continue to monitor.

L. Clinical

Description

SWMBH reviewed, disseminated, and implemented clinical practice guidelines that are consistent with the regulatory requirements of the MDHHS Specialty Services Contract and Medicaid Managed Care rules. SWMBH and its Medicaid subcontracted provider network has adopted these guidelines and assured that information related to the guidelines was made available to members and providers. It is policy that the employees of SWMBH, CMHSPs, and the provider network adhere to MDHHS practice guidelines when making decisions about utilization management, member education, coverage of services, and other areas.

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.
- Adopted in consultation with contracting providers and staff who utilize the protocols and guidelines.
- Reviewed and updated periodically as needed, with final approval by the Medical Director and/or Director of Quality Management and Clinical Outcomes.
- Disseminated to all applicable providers through provider orientation/the provider manual and to members upon request.
- Posted on the SWMBH website.
- Referenced in the provider and member handbooks.
- Published in the provider and member newsletters.

SWMBH's adopted practice guidelines include:

- Inclusion Practice Guideline
- Housing Practice Guideline
- Consumerism Practice Guideline
- Personal Care in Non-Specialized Residential Settings Practice Guideline
- Family-Driven and Youth-Guided Policy and Practice Guideline
- Employment Works! Policy
- School-to-Community Transition Guideline
- Person-Centered Planning Practice Guideline

Practices Guidelines were adopted, developed, and implemented by the SWMBH Regional Clinical Practices (RCP) Committee, which consists of representatives from SWMBH and the eight CMHSPs in Region 4. This group worked together to decide which guidelines were most relevantly matched to the individuals in this region by eliciting responses from CMHSP representatives. They ensured that the essence and intention of these guidelines were filtered through the behavioral health system via meaningful discussion, policy, procedure, training, and auditing/monitoring, and data trend analysis for process improvement efforts. 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 guideline measures.

Information and outcomes regarding evidence-based practices were reported from RCP, down to local clinical meetings at the county level. Audits were 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 were likewise 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.

FY23 Goals

Goal	Responsible Department	Where Progress Was Monitored	Frequency of Monitoring
Monitoring for the Employment Works! Practice Guideline will be added to the CMHSP annual Site Review tool for FY23. It is expected that there is clear documentation that employment has been discussed with all members at least annually. The intended outcome is described in the Michigan Employment First Executive Order No. 2015-15 which "recognizes that competitive employment within an integrated setting is the first priority and optimal outcome for persons with disabilities, regardless of level or type of disability; …"	Clinical Quality	Site Review Tools	Annually
Information sharing about Practice Guidelines, and SWMBH's commitment to Practice Guidelines, will be added to the SWMBH Provider Newsletter at least once/year.	Clinical Quality	Provider Newsletter	Annually
Fill two new positions in the Clinical Quality Department by 3/1/23. These positions will focus on the continuous monitoring and evaluation of numerous clinical compliance, best practices and evidenced base practices, including but not limited to Practice Guidelines.	Clinical Quality	Human Resources	By 3/1/23

FY23 Identified Barriers and Analysis

SWMBH has adopted the Clinical Practice Guidelines as required and outlined in the PIHP contract and identified by MDHHS and HSAG. There were some regional deficiencies identified in FY23 in the implementation and documentation of the Person-Centered Planning Practice Guideline which SWMBH began addressing in FY23 and will continue to address in FY24.

Improvement Efforts Made in FY23

In FY23, RCP reviewed each of the adopted Practice Guidelines and noted in the meeting minutes that each one has been reviewed, discussed, and adopted. Additionally, a policy attachment to accompany the SWMBH Practice Guideline Policy was written in FY23. The policy attachment outlines the requirements and timeframe for which adoption of the Clinical Practice Guidelines are expected.

The quality of services delivered and adherence to the adopted Practice Guidelines were assessed during the FY23 CMHSP Site Reviews. Baseline data was gathered to determine if there was clear documentation that employment had been discussed with members at least annually. The verification that employment was discussed annually was added to the annual Site Review tool to monitor and analyze trends. Data driven performance improvement efforts were implemented to increase the quality of the Person-Centered Planning Process. Trends were tracked, monitored, and disseminated regionally in several committees. The updated charter for RCP includes goals to improve the Person-Centered Planning Process and clinical documentation.

FY23 Results

Goal	FY23	Eval Score	Recommendations
Monitoring for the Employment Works! Practice Guideline will be added to the CMHSP annual Site Review tool for FY23. It is expected that there is clear documentation that employment has been discussed with all members at least annually. The intended outcome is described in the Michigan Employment First Executive Order No. 2015-15 which "recognizes that competitive employment within an integrated setting is the first priority and optimal outcome for persons with disabilities, regardless of level or type of disability; …"	Met	**5**	The Site Review tool was updated to include verification that employment was discussed annually with members. In FY24 it is recommended to evaluate the region's effectiveness in demonstrating the Person-Centered Planning Practice Guideline.
Information sharing about Practice Guidelines, and SWMBH's commitment to Practice Guidelines, will be added to the SWMBH Provider Newsletter at least once/year.	Met	**3**	This will be added as an annual expectation to ensure ongoing communication with providers and members.
Fill two new positions in the Clinical Quality Department by 3/1/23. These positions will focus on the continuous monitoring and evaluation of numerous clinical compliance best practices and evidenced base practices, including but not limited to Practice Guidelines.	Met	**5**	It was determined that only one FTE was necessary to accomplish the goal of providing more departmental oversight of clinical performance and improvement.

M. Long-Term Services and Supports (LTSS)

Description

LTSS is defined as 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 its 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 its 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

The Centers for Medicare & Medicaid Services (CMS) worked closely with MDHHS to create a sustainable, person-driven long-term support system in which people with disabilities and chronic conditions have choice, control, and access to a full array of quality services and assure optimal outcomes, such as independence health and quality of life. SWMBH is dedicated to ensuring the quality and appropriateness of care to all its members. However, persons receiving LTSS are some of the region's most vulnerable citizens; therefore, additional analyses, both quantitative and qualitative, of the quality and appropriateness of care for the LTSS populations in Michigan are warranted. The quality, availability, and accessibility of care furnished to members receiving LTSS was quantitatively assessed using an analysis of new LTSS sections and breakouts of the existing MHSIP and YSS surveys. SWMBH's QM Department incorporated a question to the annual MHISP and YSS surveys to identify individuals who received LTSS in FY23. This will allow for a separate analysis of the LTSS population in FY24. Additional questions may be developed to assess accessibility in FY24.

The CMHSP Site Review tool that has been adopted by all 8 CMHSPs in Region 4 included items to monitor the appropriateness of care of members receiving LTSS. For reference, these items in the CMHSP Site Review tool stated:

- In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or

death) there is evidence of coordination of care with the PCP. This should include minimally – making available the primary assessment, treatment plan updates, changes in level of care, med changes etc. to the PCP. Actual contact (phone or in person) with the physician is also counted/encouraged. If documentation of refusal is present as outlined above: this item is not applicable. Appropriate releases for exchange of information must be present if SUD information I shared. There is documented evidence of ongoing contact between the primary clinician and the ancillary provider.

- Clinical analysis and interpretive summary of the member's identified needs and priorities, and a professional opinion of service needs and recommendations are recorded.
- Level of Functioning/Daily Living is appropriately evaluated and identifies a functional deficit requiring intervention/treatment. LOC assessment completed annually and when there is significant change in individual's status.
- The psychosocial assessment clearly identifies the member's strengths and barriers (may also be addressed in the plan of service).
- Plan is individualized based upon assessment of the member's needs and preferences. The plan (or assessment) describes his/her strengths, abilities, plans, hopes, interests, preferences and natural supports.
- All needs identified in the assessment are addressed or deferred (including health/safety risks); needs not identified in the assessment are not included in the plan.
- The treatment plan identifies natural supports that will be used to assist the member in being able to accomplish goals and objectives.
- Plan contains clear, concise, and measurable statements of the objectives the member will be attempting to achieve.
- Individuals are provided with ongoing opportunities to provide feedback on supports and services they are receiving, perceived barriers or strengths during treatment, and their progress towards goal attainment. (May be documented in Progress notes and/or Periodic Reviews.)
- Services and intervention identified in the IPOS are provided as specified in the Plan - including measurable goals/objectives, the type, amount, scope, duration, frequency, and timeframe for implementing. Individual has received all services authorized in plan. If services are not being utilized as planned, and an appropriate reason for the lack of service provision is not present in the documentation, the IPOS has been amended. (Lack of provider is not an acceptable reason for not providing a medically necessary service.)

Aggregated annual audit outcomes were regularly monitored and analyzed by the Clinical Quality and QM Departments at both the CMHSP and PIHP levels, and used to inform the annual provider training that was offered to the LTSS provider network. A future addition will be to develop a regional approach to assess care between settings.

FY23 Goals

Goal	Responsible Department	Where Progress Was Monitored	Frequency of Monitoring
Identify method to obtain LTSS status in MHSIP and YSS surveys, add questions related to accessibility in the FY23 surveys, and establish baseline LTSS survey results assessing the quality, availability, and accessibility of care. The Annual Quality Evaluation report will also include results of any efforts to support community integration for members using/engaged in LTSS.	Clinical Quality/QAPI	Clinical Quality	Annually

Add the topic of LTSS to at least two regional clinical meeting agendas to educate the Region 4 Network on how the LTSS population is defined, and how it can be better supported according to HSAG guidance.	Clinical Quality	Clinical Quality	Annually
Add information about LTSS to the provider newsletter once/year for the purpose of further educating the Region 4 Network and bring attention to the population.	Clinical Quality	Clinical Quality	Annually PRA
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.	Clinical Quality	Clinical Quality	Annually

FY23 Identified Barriers and Analysis

SWMBH has sought guidance from MDHHS about the assessment of LTSS care between settings to clarify all requirements of this expectation. There is still a need to identify a more comprehensive regional approach to assess care between settings. SWMBH is prepared to implement the CMS LTSS Quality Measure set once MDHHS adopts and communicates them. Having an established quality measurement would provide some of the needed guidance. Also, the National Core Indicator (NCI) survey data already being collected by MDHHS cannot be used regionally to help the PIHPs assess the quality of and satisfaction with services provided to the region's LTSS recipients.

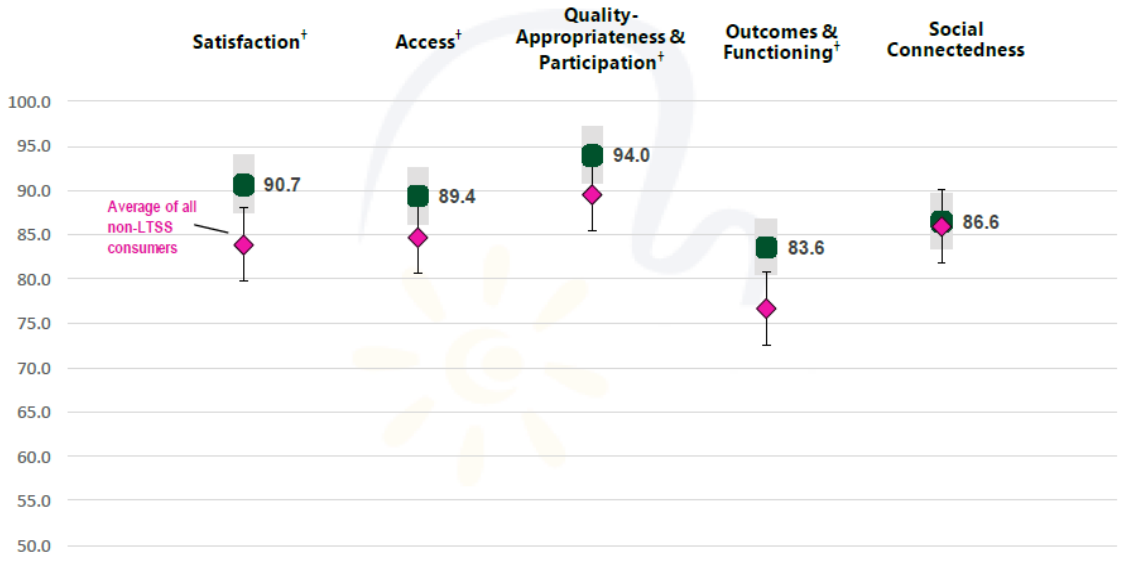
Improvement Efforts Made in FY23

Aggregated annual CMHSP Site Review outcomes were monitored and analyzed by clinical and quality assurance departments at both the CMHSP and PIHP levels and used to evaluate community integration efforts and assess quality of care. A comparative analysis was done to evaluate trends between FY22 and FY23. The results of the biennial MDHHS waiver audit results were also analyzed to evaluate trends in the region and reviewed against the CMHSP Site Review results to better inform performance improvement efforts. During the FY23 CMHSP Site Reviews, the service utilization trends were evaluated to ensure that services are being delivered in the appropriate amount, scope, and duration as specified in the Person-Centered Plan. The clinical file reviews, as a part of the annual CMHSP Site Reviews, evaluated whether a level of care assessment was completed at least annually and when there was a significant change in a member's life, which can include a change in setting for LTSS recipients. CMHSPs that performed under the 90% threshold according to the SWMBH review tool were required to implement corrective action plans in these areas. Systemic remediation efforts regarding the utilization of services were implemented in collaboration with the CMHSPs and cross functionally with several SWMBH Departments. There was more education and discussion about LTSS services and how to identify LTSS recipients in FY23.

The following slides demonstrate age, race and LTSS comparison results from the Customer Satisfaction Surveys (MHSIP and YSS), which were administered in FY23. An analysis of results revealed that Adult and Youth LTSS members report better satisfaction scores than non-LTSS members across the board.

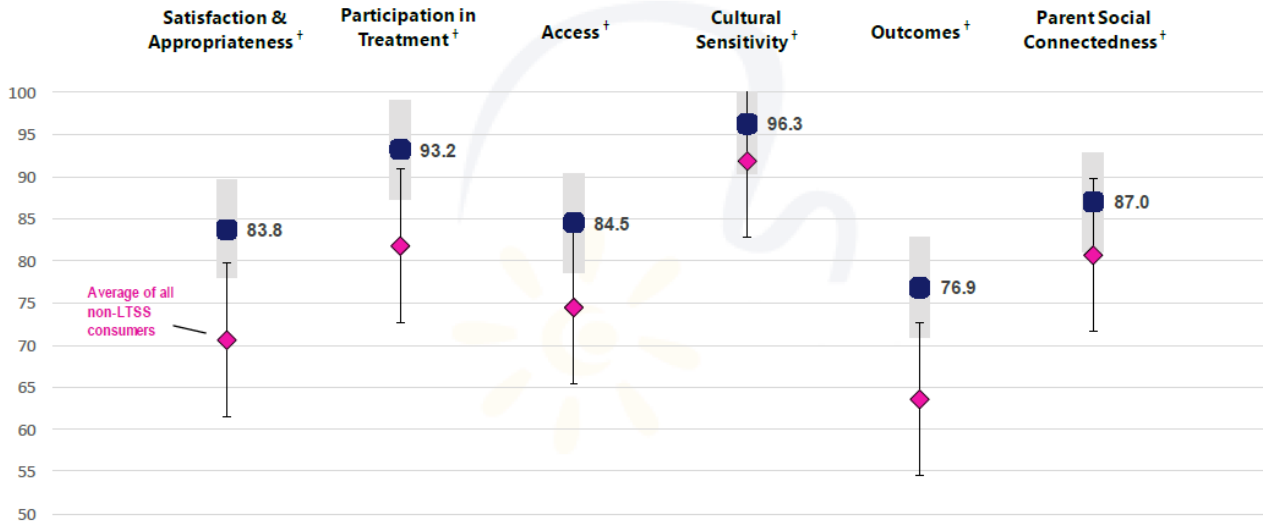
Adult LTSS consumers reported better scores than non-LTSS adults in all constructs except social connectedness

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 families report better satisfaction, participation, access, and outcomes for the 2023 YSS

Dark blue 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*)



FY23 Results

Goal	FY23	Eval Score	Recommendations
Identify method to obtain LTSS status in MHSIP and YSS surveys, add questions related to accessibility in the FY23 surveys, and establish baseline LTSS survey results assessing the quality, availability, and accessibility of care. The Annual Quality Evaluation report will also include results of any efforts to support community integration for members using/engaged in LTSS.	Met	**4**	Expand on the identification of LTSS respondents to qualitatively and quantitatively assess member satisfaction of LTSS services. SWMBH will use the Member Experience Satisfaction Survey results and the information from the Waiver Audit Interviews to assess the quality, availability, and accessibility of care of members receiving LTSS.
Add the topic of LTSS to at least two regional clinical meeting agendas to educate the Region 4 Network on how the LTSS population is defined, and how it can be better supported according to HSAG guidance.	Met	**4**	SWMBH will maintain the topic of LTSS at least once per year at several committees to help with regional awareness about LTSS services, populations and how to identify LTSS recipient grievances and/or appeals to help monitor and assess quality of LTSS services.
Add information about LTSS to the provider newsletter once/year for the purpose of further educating the Region 4 Network and bring attention to the population.	Met	**3**	SWMBH will maintain the topic of LTSS annually in the provider newsletter to help with regional awareness about LTSS services, populations and how to identify LTSS recipient grievances and/or appeals to help monitor and assess quality of LTSS services.
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.	Partially Met	**3**	There is still a need to identify a more comprehensive regional approach to assess care between settings. During the CMHSP Site Reviews clinical cases are reviewed to evaluate whether a new level of care assessment was completed at least annually and when there is a significant change in a member's life, which can include a change in setting for LTSS recipients. Part of the clinical file review includes a review that services are provided as specified in the plan.

N. Utilization Management (UM)

Description

The purpose SWMBH's UM Program is to maximize the quality of care provided to members while effectively managing the Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, Serious Emotional Disturbances (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. SWMBH is responsible to ensure adherence to Utilization Management related statutory, regulatory, and contractual obligations associated with the MDHHS 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.

Coordination and Continuity of Care

Throughout FY23 SWMBH was committed to ensuring each member receives services designed to meet each individual special health need as identified through a functional assessment tool and a Biopsychosocial Assessment. Components of the assessments generated a needs list which were used to guide the treatment planning process.

SWMBH assured 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 Members, 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 members 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 FY23 SWMBH Utilization Management Plan is designed to maximize timely local access to services for members while providing an outlier management process to reduce over and underutilization (financial risk) for each CMHSP and the SUD 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.

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 members 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 CMHSPs.

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, CMHSP, 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 occurred at SWMBH and the regional committee level to determine whether the utilization is problematic and in need of intervention. Data identified for initial review was 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.

FY23 Goals

Goal	Responsible Department	Where Progress Was 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
Identify the levels of care and subsequent reports to manage utilization and uniform benefit.	UM, Clinical Quality	RCP	Quarterly
Ensure regional Inter-rater reliability (IRR) audits are completed for consistent application and understanding of authorization of uniform benefits and medical necessity benefit criteria. Create IRR training and distribute regionally.	UM	RUM	Annually Due by 6/30/23
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 Service	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	CMHSP Site Review Tools	Annually

FY23 Identified Barriers and Analysis

Clinical and direct care working shortages with ongoing staff turnovers continued to present a problem throughout Region 4. Historical knowledge of the public behavioral health system was hindered by staff turnover. Communication delays across departments presented barriers throughout the region and within the PIHP and CMHSPs. SWMBH recognizes these barriers and is working collaboratively with CMHSPs and internally to improve communication and outcomes as they relate to UM.

Improvement Efforts Made in FY23

In coordination with other PIHPs, a state-wide Utilization Management Committee was formed to improve collaboration across the state and to share successful ideas and processes. SWMBH's UM Director took the lead on these efforts and the SWMBH Commons SharePoint is now home to a statewide depository for all communication and documents shared across the region. In addition, the Regional UM Committee also has a Regional UM folder for the sharing and distribution of UM documents, including meeting agendas and minutes, inter-rater reliability tools, and other helpful documents the region can share with one another to remove duplication of work efforts across the region.

FY23 Results

Goal	FY22	FY23	Eval Score	Recommendations
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 FY24.
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 stay the same and be monitored through FY24. Level of care thresholds were finalized and implemented into CMHSP EHRs. RUM will continue to review data trends to identify outliers. New Level of Care tools will be adopted to replace the SIS and CAFAS. These will need to be reviewed and updated again FY25 or FY26, depending on data available.
Identify the levels of care and subsequent reports to manage utilization and uniform benefit.	N/A	Met	3	The goal was met and will continue to be monitored in FY24.
Ensure regional Inter-rater reliability (IRR) audits are completed for consistent application and understanding of authorization of uniform benefits and medical necessity benefit criteria. Create IRR training and distribute regionally.	Met	Met	5	Regional IRR Tracking documents were created and distributed to RUM Committee. IRR tracking will continue in FY24. Verification of IRR audit plan was moved from Clinical Quality to UM.
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.	25%	65.2%	3	SWMBH training and ongoing assistance has dramatically increased the quality of the ABD notices. Annual Site Reviews increased the score to 62.5%; however, the file reviews were completed prior to the training. Quarterly file reviews began FY23 Q3, and the percentage increased to 78.75%.
Emergent and non-emergent cases will be periodically monitored to ensure compliance with standards.	Met	Met	4	The score increased from 81.25% compliance to 100% at the annual Site Review. This will continue to be monitored in FY24 to ensure the timeliness standards are met.
SWMBH will achieve a call abandonment rate of 5% or less.	0.2%	0.19%	5	The goal was met and will continue to be monitored in FY24.
SWMBH will achieve an average call answer time 30 seconds or less.	98.67%	99.03%	5	The goal was met and will continue to be monitored in FY24.

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 FY24.
Evaluate CMHSP call reports during Delegated Administrative Function Site Reviews.	100%	93.75%	**5**	The goal was met and will continue to be monitored in FY24.

SWMBH FY23 Inter-Rater Reliability Results

Date & Case	# of Raters	% Matching Medical Necessity Criteria (MNC)	ASAM Variances (# outside of one Level of Care)
March 2023 – "Tom"	11	100%	0
May 2023 – "Brandy"	12	100%	0

O. Customer Services

Description

SWMBH's Customer Services Department provides a welcoming environment and orientation to services, including providing information about benefits and available provider network. Customer Services provides information about how to access behavioral health, substance use disorders, primary health, and other community resources. Customer Services assists members with obtaining information about how to access Due Processes when benefits are denied, reduced, suspended, or terminated while overseeing grievances and appeal (G&A) processes and track/report patterns of problems for each organization and regionally including over/under service utilization.

SWMBH delegates some Customer Service functions including Due Processes, and Grievances and Appeals to the CMHSPs. As such, a Memorandum of Understanding (MOU) between SMWBH and each CMHSP is implemented to specify the delegated functions and expectations of the CMHSP. Adherence to the MOU is crucial to ensure all members have access to customer services that meet federal and state requirements, while ensuring the services are provided in a uniform manner throughout Region 4 for continuity of care.

FY23 Goals

Goal	Responsible Department	Where Progress Was Monitored	Frequency of Monitoring
Implement HSAG Corrective Action Plans and Recommendations to ensure contractual and federal requirements are met.	Customer Services	Regional Customer Service Committee	Annually
Update and Improve Advance Directives and Due Process materials/trainings in partnership with Building Better Lives project.	Customer Services	Regional Customer Service Committee	Annually
Review Grievance and Appeal files regionally for analysis of trends related to service utilization.	Customer Services	Regional Customer Service Committee	Semi-Annually

FY23 Identified Barriers

Goal 1:

- CMHSPs note system limitations for data input in PCE system which impacts the overall readability of system-generated notices and letters (ABDs, G&A letters).
- CMHSPs noted barriers and gaps in understanding related to MDHHS interpretation of the federal standards. This required additional outreach to MDHHS regarding definitions and expectations.

Goal 2:

- This goal did not have precedence in FY23 due to unexpected project needs and requirements (implementation of regional ABDs, G&A trainings, implementation of quarterly regional monitoring, implementation of iSPA, several CMHSPs becoming CCBHCs, etc.)
- Building Better Lives project has been discontinued and gap analysis was not completed.
- There are pending changes in draft update to the G&A Technical Requirement which impact Due Process materials and rights for G&A.

Goal 3:

- CMHSPs noted limitations related to system capabilities for pulling data from their EHR.
- One CMHSP completed the transition between EHR systems this year (from Streamline to PCE).
- CMHSPs noted barriers related to data transfer and margin for human error when inputting data into MDHHS specific templates.
- CMHSPs noted barriers and gaps in understanding related to MDHHS required fields for reporting. This required additional outreach to MDHHS and research to define required reporting fields.

Improvement Efforts Made in FY23

Goal 1:

- Completed regional training regarding G&A, and ABD requirements, including specific corrective action plan and recommendations from HSAG reviews to ensure a consistent regional approach.
- Reviewed and updated SWMBH policies and procedures related to ABDs, G&A.
- Initiated quarterly monitoring of G&A records to ensure accuracy of documentation and content of investigations/reviews.
- Initiated quarterly monitoring of G&A acknowledgment and resolution letters to ensure use required templates and inclusion of contractually mandated content.

Goal 2:

- SWMBH will continue to monitor Advance Directive materials through annual Site Reviews to ensure materials meet state and federal requirements.
- Due Process materials will be updated per the MDHHS G&A Technical Requirement updates.

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.
- The Regional Customer Services Committee reviewed G&A data and summary of trends at least quarterly.

FY23 Results

Goal	FY23	Eval Score	Recommendations
Implement HSAG Corrective Action Plans and Recommendations to ensure contractual and federal requirements are met.	Met	**5**	The goal will be revised for FY24 to reflect ongoing quarterly monitoring of G&A files to ensure contractual delegated functions are met at each CMHSP.
Update and Improve Advance Directives and Due Process materials/trainings in partnership with Building Better Lives project.	Not Met	**3**	The goal will be discontinued. CMHSPs and SWMBH will work informally to improve processes and customer access to information about these topics. This will not be a formal goal as the Building Better Lives project has been discontinued.
Review Grievance and Appeal files regionally for analysis of trends related to service utilization.	Partially Met	**4**	The goal will be revised for FY24 to reflect the ongoing monitoring of G&A files for trends overall. It was determined that review of service utilization is better captured under the Utilization Management Department, rather than Customer Services going forward.

During FY23, there were several significant system-changes across SWMBH's region. Four more CMHSPs have been working to become CCBHCs. All CMHSPs have been transitioning eligible customers to the iSPA waiver. There are also state-wide projects that are likely to have a strong system impact, including but not limited to, HCBS Conflict Free Access/Planning and pending updates to G&A Technical Requirement within FY24. CMHSPs expressed interest in reviewing the requirements of their delegated functions and how these are applied given the system updates and pending changes. Regional review of delegated functions will be prioritized as a goal in FY24.

FY23 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	16	0.08	6	0.03	20	16	25
ACCESS AND AVAILABILITY	16	0.08	2	0.01	23	16	17
INTERACTION WITH PROVIDER OR PLAN	128	0.63	51	0.25	149	128	14
MEMBER RIGHTS	9	0.04	8	0.04	11	9	10
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	1	0.00	1	0.00	1	1	13
SAFETY/RISK MANAGEMENT	1	0.00	1	0.00	2	1	19
SERVICE ENVIRONMENT	7	0.03	1	0.00	19	7	29
OTHER	2	0.01	0	0.00	4	2	64
Total	180	0.89	70	0.35	229	180	16

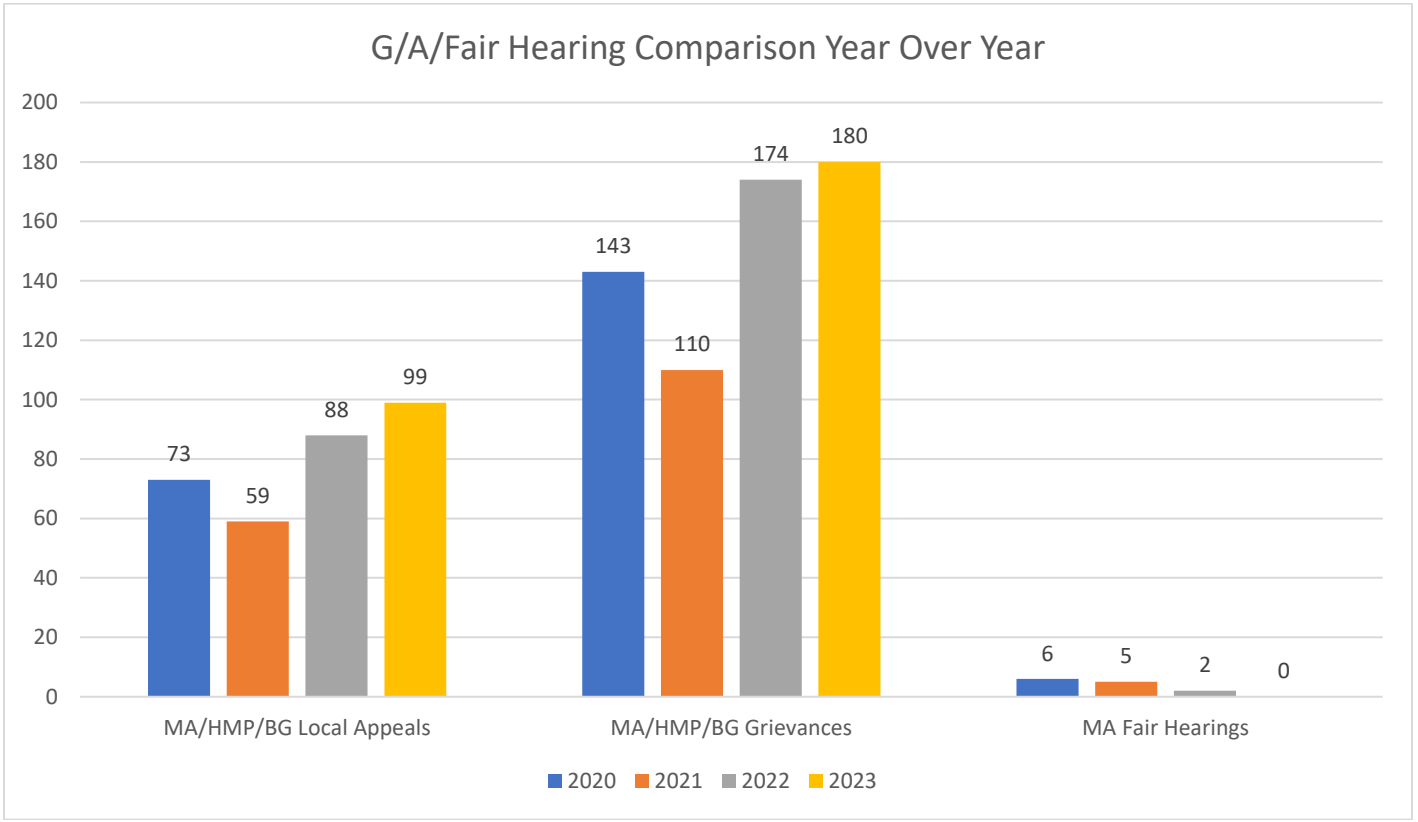
*Field will display "#DIV/0!" if there are no reported cases per category.

FY23 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	0.19	38	0	0	0	100%	0%
NOT A PIHP-COVERED BENEFIT	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
CLINICAL DOCUMENTATION NOT RECEIVED	1	0.00	0	1	0	0	0%	100%
TREATMENT/SERVICE PLAN GOALS MET	1	0.00	1	0	0	0	100%	0%
MEMBER NOT ELIGIBLE FOR SERVICES	2	0.01	2	0	0	0	100%	0%
MEMBER NON-COMPLIANT WITH TREATMENT/SERVICE PLAN	4	0.02	4	0	0	0	100%	0%
FAILURE OF THE PIHP/CMHSP/SUD PROVIDER TO RENDER A DECISION TIMELY	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
OTHER	3	0.01	3	0	0	0	100%	0%
NOT APPLICABLE	50	0.25	49	0	1	0	100%	0%
Total	99	0.49	97	1	1	0	99%	1%

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

	Count	Percentage
Appeals	99	
Appeals Upheld	46	46%
Appeals Overturned	50	51%
Appeals Partially Upheld/Overturned	3	3%


G/A/Fair Hearing Comparison Year Over Year
200
180
160
140
120
100
80
60
40
20
0
73
59
88
99
143
110
174
180
6
5
2
0
MA/HMP/BG Local Appeals
MA/HMP/BG Grievances
MA Fair Hearings
2020
2021
2022
2023

P. Certified Community Behavioral Health Clinics (CCBHC)

Description

In October 2020, MDHHS began participating in a two-year demonstration with the 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 CMHSPs and 3 non-profit behavioral health entities, together serving 18 Michigan counties. On 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 Prospective Payment System (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 had two participating CCBHCs at the beginning of FY23 including Pivotal (formerly known as Community Mental Health and Substance Abuse Services of St. Joseph County) and Integrated Services of Kalamazoo (ISK). Othe CMHSPs in Region 4 have made movement toward becoming a CCBHC in FY24. Two CMHSPs within the region had a CCBHC Expansion Grant in FY23 and 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/member 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.

FY23 Goals

Goal	Responsible Department	Where Progress Was Monitored	Frequency of Monitoring
Track QBP measures and CCBHC-Reported Measures at least quarterly. Report to all CCBHC subgroups.	QM, Clinical Quality, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly, and as needed
Based on status of QBP and CCBHC-Reported Measures, analyze and document clinical pathways, and if needed, revise to improve QBP measures.	QM, Clinical Quality, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly
Establish and document the criteria that will be used to validate the measures routinely submitted to MDHHS and update process as needed.	QM, CCBHC Coordinator	CCBHC Subgroup Meetings	Due by 1/31/23, and as needed
PIHPS will collect, validate clinic-reported data templates and either make available or submit to MDHHS per the schedule outlined in CCBHC Handbook.	QM, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly and Annually by 3/31/2023 (DY1) 3/31/2024 (DY2)
Document and track stages of readiness for mandatory CCBHC Evidence Based Practices (EBP). Additional documentation of how and why CCBHCs self-scored to get a regional operational definition.	Clinical Quality, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly and by 06/2023 for documentation
Respond to all financial requests to MDHHS related to CCBHC Finance by stated deadlines (agenda, forms, handbook versions) and following all conversations and communications with MDHHS, report back to workgroup at the next scheduled meeting.	Finance, CCBHC Coordinator	CCBHC Subgroup Meetings	Monthly
Document year-end financial reporting, reconciliation, and cost settlement processes as soon as able to ensure 2023 processes are efficient and in compliance with MDHHS expectations.	Finance, CCBHC Coordinator	CCBHC Subgroup Meetings	Quarterly

Maintain current frequency of subgroup meetings to continue close collaboration with current CCBHC sites.	Finance, CCBHC Coordinator	CCBHC Subgroup Meetings	Monthly
Develop written guidelines and process maps to support new regional CCBHC sites.	QM, Clinical Quality, Finance, CCBHC Coordinator	All CCBHC Subgroup Meetings	Due June 2023

FY23 Identified Barriers and Analysis

Final Demonstration Year One (DY1) Quality Bonus Payments (QBP) metric outcomes were made available to SWMBH by MDHHS in May 2023 and indicated that both ISK and Pivotal missed the benchmark for the SAA-AD measure, making them ineligible for the 5% Quality Bonus Payment. Before the final DY2 data pull, the identified population for QBP measures was to include those enrolled and seen by the CCBHCs. The actual populations used were individuals eligible for CCBHC, regardless of whether they had been enrolled. In addition, it was discovered that for the SAA-AD measure, some extended-release medications were not included in the data pull. The understanding of the financial rate setting of unique PPS-1, the flow of supplemental funds, and CCBHC's financial impact on the Medicaid funding in the region was not fully understood prior to and during the first demonstration year. These constraints, along with lack of clarity in the MDHHS created CCBHC handbook of the PIHP role prevented SWMBH from providing commentary or input into the cost reports submitted by the initial two Region 4 CCBHCs.

Improvement Efforts Made in FY23

In response to the change in population for Quality Bonus Payments (QBP) measures, both CCBHCs within SWMBH's region expanded the population for whom they identified as being included in the SAA-AD metric. By doing this, both CCBHCs have increased the population for which they monitor and work directly with to enhance medication compliance. A presentation was given to the Operations Committee and SWMBH's Board demonstrating the flow of funds from traditional Medicaid to CCBHC block grant and the flow of supplemental revenue. SWMBH was also able to provide support and technical assistance for the four regional CMHSPs that applied and were accepted to participate in the demonstration beginning 10/2023.

FY23 Results

Goal	FY22	FY23	Eval Score	Recommendations
Track QBP measures and CCBHC-Reported Measures at least quarterly. Report to all CCBHC subgroups.	N/A	Met	**4**	The goal was met and will continue to be monitored in FY24. Subgroups consolidated in FY23 per CCBHCs recommendation.
Based on status of QBP and CCBHC-Reported Measures, analyze and document clinical pathways, and if needed, revise to improve QBPs.	N/A	Met	**4**	The goal was met and will continue to be monitored in FY24.
Establish and document the criteria that will be used to validate the measures routinely submitted to MDHHS and update process as needed.	N/A	Partially Met	**3**	This goal was partially met in FY23 as criteria and a process was established for data validation but not documented until FY24. This goal was removed in the FY24 plan to consolidate where possible.
PIHPS will collect, validate clinic-reported data templates and either make available or submit to MDHHS per the schedule outlined in CCBHC Handbook.	N/A	Partially Met	**4**	This goal was partially met as FY22 (DY1) clinic-reported data was submitted timely during FY23. FY23 (DY2) clinic-reported data is due 3/31/2024. This goal will continue to be monitored in FY24.
Document and track stages of readiness for mandatory CCBHC Evidence Based Practices (EBP). Additional documentation of how and why CCBHCs self-scored to get a regional operational definition.	N/A	Partially Met	**4**	Regional EBP workgroup formed in late FY23. CCBHCs are at various stages of implementation with expected differences between Cohort 1 and Cohort 2. Both cohorts are working collaboratively in the regional workgroup to prioritize specific EBPs to support not only fidelity but also EHR improvements for better evidence of implementation. SWMBH will monitor progress in FY24 as a member of this workgroup.
Respond to all financial requests to MDHHS related to CCBHC Finance by stated deadlines (agenda, forms, handbook versions) and following all conversations and communications with MDHHS, report back to workgroup at the next scheduled meeting.	N/A	Met	**5**	This goal was met and removed from the FY24 plan to consolidate where possible.
Document year-end financial reporting, reconciliation, and cost settlement processes as soon as able to ensure 2023 processes are efficient and in compliance with MDHHS expectations.	N/A	Partially Met	**4**	This goal was partially met as the due date for completion of FY23 reporting is 2/29/2024. This goal was removed from the FY24 plan in efforts to consolidate where possible.

Maintain current frequency of subgroup meetings to continue close collaboration with current CCBHC sites.	N/A	Met	**5**	This goal was met and removed from the FY24 plan to consolidate where possible.
Develop written guidelines and process maps to support new regional CCBHC sites.	N/A	Met	**4**	This goal was met and is ongoing into FY24 as four new CCBHCs were added to the demonstration from Region 4 effective October 2023.

DY2 Metric Results

Metric Name	State or CCBHC Reported Measure	Bench-mark	ISK QBP Results	St. Joe QBP 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%**	**69.93%**	**80.44%**
Major Depressive Disorder: Suicide Risk Assessment (SRA-A) **	**CCBHC**	**12.50%**	**49.70%**	**92.15%**
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%**	**59.89%**	**60.76%**

Follow up after Hosp for Mental Illness, ages 21+ (FUH) **	**State**	**58%**	**76.25%**	**73.49%**
Follow up after Hosp for Mental Illness, ages 6-21 (FUH) **	**State**	**70%**	**96.88%**	**92.10%**
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%**	**33.65%**	**35.00%**

****Quality Bonus Payment**

Reported QBP results in the DY2 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 3/31/24. The QBP results above are sourced from Relias, CCBHC Medical Records Data, or SWMBH internal Tableau reports and were used by the PIHP during DY2 to monitor current CCBHC metric status and implement process improvement where necessary. SWMBH's preliminary analysis of this data indicated both ISK and Pivotal met all QBP metrics and will be eligible for payment, however, the MDHHS results used to determine eligibility for QBP payment was not available in time for this report.

Q. External Quality Monitoring and Audits

Description

The SWMBH QM Department is responsible for the coordination, organization, submission, and responses related to all external audit requests. External auditing includes any requests from MDHHS, HSAG, CMS, and other organizations as identified by the SWMBH Board. Audit results were reviewed, analyzed, and shared with relevant SWMBH regional committees and the SWMBH Board. Regional and internal CAPs were developed for reviews/audits that did not achieve specified benchmarks or established targets. The SWMBH QM Department is responsible for working with all SWMBH functional areas to ensure CAPs are developed, reviewed, and submitted in a complete and timely manner.

FY23 Goals

Goal	Responsible Department	Where Progress Was Monitored	Frequency of Monitoring
SWMBH will demonstrate an improvement in overall compliance scores (*90% or top 2 scoring PIHP's*) during the FY23 HSAG External Quality Review (EQR).	QM	QMC, SWMBH Senior Leadership Meetings and other Regional Committees	Annually
SWMBH will demonstrate a minimum of (90% compliance score) on the annual HSAG Performance Measure Validation Review (PMV).	QM	QMC, SWMBH Senior Leadership Meetings and other Regional Committees	Annually
SWMBH will demonstrate an improvement in compliance and number of Corrective Action Plans during the bi-annual MDHHS 1915 (SEDW, CWP, HSW, HCBS, Autism) review.	QM and Clinical Quality	QMC, CPC and other Regional Committees as necessary	Annually
SWMBH will demonstrate Full Compliance with MDHHS Substance Use Disorder Administrative Protocols/Review.	QM and SUD	QMC, SUD workgroup and Board	Annually
SWMBH will demonstrate Full Compliance with the MDHHS 1915c Administrative Protocols/Review.	QM Lead with other SWMBH Functional Areas to Assist	QMC, SWMBH Senior Leadership	Annually
SWMBH will demonstrate assurances of adequate capacity and services for the region, in accordance with the MDHHS Network Adequacy Standards.	Provider Network	Regional Provider Network, Compliance Committee, and RUM	Annually

FY23 Identified Barriers and Analysis.

No specific barriers were identified in FY23 HSAG EQR or PMV audits. There were notable barriers for the MDHHS 1915c Waiver audit due to the enormous breadth and depth of the audit, as well as pacing. The audit spanned several weeks and was of great administrative burden to both the CMHSPs and PIHP. The pacing of the audit was likewise a barrier. More than once, preliminary audit results were either incomplete, incorrect, or received after the preliminary findings meeting with MDHHS. Furthermore, there was notable pushback from some CMHSPs in terms of coming into compliance with MDHHS' prescriptive requirements for the Waiver Audit CAPs.

Improvement Efforts Made in FY23

SWMBH made multiple internal process improvements in FY23 around planning, hosting, and following up after external monitoring audits. All items identified as Not Met or with a recommendation during the FY21 and FY22 HSAG EQR were compiled and analyzed by the SWMBH QM Department, then communicated with department leads during an audit season kickoff meeting. Subsequent department-specific meetings were held as needed to ensure each item deemed to be Not Met or with recommendations during past audit cycles were brought into compliance. A new tracking system for HSAG EQR results was likewise created and employed. These efforts resulted in excellent HSAG EQR results for FY23, which included resolving 32 of the 33 "Not Complete" findings accumulated during FY21 and FY22. The SWMBH QM Department is currently analyzing outcomes from all previous audits to plan for continued success in FY24. SWMBH scored 100% again in FY23 on the HSAG PMV audit. This is a sustained improvement from FY21 when performance indicator data was found to be "not reportable" and other elements were determined to be unmet. SWMBH attributes this success to revising the MMBPIS reporting template to assist in catching event date and exception errors made during CMHSP data entries. SMWBH also continued validation of Indicator 4B data (BH TEDS Detox Admissions and Discharges records) with further review and training for providers of substance use services where necessary.

The SWMBH QM Department also employed a new process during preparation for the MDHHS 1915c Waiver Audit in FY23 whereby all the documents that were submitted by the CMHSPs were pre-audited for completion, readability and relevance prior to compiling and uploading for them for the audit. This additional step caught simple mistakes prior to the audit and resulted in a much smoother audit process for all. The SWMBH QM Department likewise pre-audited the CMHSPs' corrective action plans and proofs prior to sending them to MDHHS. SWMBH worked with MDHHS and the CMHSPs to resolve the audit. SWMBH is designing a survey to gain feedback from the CMHSPs to determine further process improvements that SWMBH can make for this audit in FY25. Repeat citations have been reviewed during regional meetings with the CMHSPs and will continue to be a focus.

SWMBH once again demonstrated compliance in FY23 with the MDHHS Substance Use Disorder Administrative Protocols/Review. All items received a score of full compliance except for one item requiring a policy update, which was completed on 9/15/23 and submitted to MDHHS for approval. SWMBH has remained consistent over the years with its success on this audit. Improvement efforts included prompt follow up on any recommendations made by MDHHS during this audit.

FY23 Results

Metric	FY22	FY23	Eval Score	Recommendations
SWMBH will demonstrate an improvement in overall compliance scores (*90% or top 2 scoring PIHP's*) during the FY23 HSAG EQR.	80%	97%	**5**	SWMBH met 32 of 33 Standards (97%) that were audited during FY23, which was year 3 in the HSAG EQR Audit cycle. SWMBH Project Management launched a new tracking system and process for preparing SWMBH for this audit. Recommend continuing and developing the same tracking and process in FY24 for continued success.
SWMBH will demonstrate a minimum of (90% compliance score) on the annual HSAG Performance Measure Validation Review (PMV).	100%	100%	**5**	SWMBH scored 100% once again in FY23 for HSAG PMV. Recommend following through in FY24 with the recommendations and interventions as described in #2 of the FY23 Annual EQR TR follow up response, and the FY23 PMV Final Audit results. Recommend continued focus on training for SUD providers, continue to refine internal processes.
SWMBH will demonstrate an improvement in compliance and number of Corrective Action Plans during the bi-annual MDHHS 1915 (SEDW, CWP, HSW, HCBS, Autism) review.	N/A	50%	**2**	The FY21 MDHHS 1915 Waiver Audit resulted in 101 CAPs, while the FY23 MDHHS 1915 Waiver Audit resulted in 106 CAPs. While the total number of CAPs did not decrease, the amount of time that it took for final approval of the CMHSP CAP documents did decrease, demonstrating improvement in the area of compliance compared to previous audits. There is still room for improvement with the MDHHS 1915 Waiver Audit and SWMBH is making concerted efforts to decrease CAPs while improving compliance across Region 4 in FY25.
SWMBH will demonstrate Full Compliance with MDHHS Substance Use Disorder Administrative Protocols/Review.	N/A	92%	**4**	SWMBH met 13 out of 13 standards on the MDHHS SUD Administrative Audit in FY22 for a score of 100%. 12 out of 13 SUD Administrative Standards evaluated in FY23 received a Score of Full Compliance for a score of 92%. All items received a score of full compliance in FY23 except for one item requiring a policy update, which was completed on 9/15/23 and submitted to MDHHS for full approval.
SWMBH will demonstrate Full Compliance with the bi-annual MDHHS 1915c Administrative Protocols/Review.	N/A	50%	**3**	The FY21 MDHHS 1915c Administrative Protocols/Review Audit resulted in 6 CAPs, while the FY23 MDHHS 1915c Administrative Protocols/Review Audit resulted in 3 CAPs. Thus, full compliance was not achieved per the goal. However, it is noted that the number of CAPs were reduced by half from FY21 to FY23. Recommend continued focus on the administrative protocols in FY25.
SWMBH will demonstrate assurances of adequate capacity and services for the region, in accordance with the MDHHS Network Adequacy Standards.	N/A	100%	**5**	SWMBH regularly analyzes audit results and uses them to inform business practices, including but not limited to assuring adequate capacity and services for the region.

HSAG FY23 EQR Audit Results

The state fiscal year SFY23 compliance review was the third year of the three-year cycle of compliance reviews that commenced in SFY21.

FY23 Summary of Findings

There were 33 Not Met Standards from the previous HSAG EQR audits that occurred in FY21 and FY22 that were audited for compliance in FY23. The following table demonstrates how SWMBH met 32 out of 33 Standards during the FY23 review of standards and elements that required a corrective action plan in FY21 and FY22.

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Member Rights and Member Information	3	3	**0**
Standard III—Availability of Services	1	1	**0**
Standard IV—Assurances of Adequate Capacity and Services	3	3	**0**
Standard V—Coordination and Continuity of Care	2	2	**0**
Standard VII—Provider Selection	4	4	**0**
Standard VIII—Confidentiality	1	1	**0**
Standard IX—Grievance and Appeal Systems	5	5	**0**
Standard XI—Practice Guidelines	2	2	**0**
Standard XII—Health Information Systems[1]	2	1	**1**
Standard XIII—Quality Assessment and Performance Improvement Program	10	10	**0**
Total	**33**	**32**	**1**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

[1]This standard includes a comprehensive assessment of the PIHP's IS capabilities.

All Standards from the 3-year cycle were resolved aside from Standard XII – Health Information Systems, Element 7 (API) which was scored as *Not Complete* in FY23, indicating that SWMBH did not implemented a Fast Healthcare Interoperability Resources (FHIR)-based Patient Access Application Programming Interface (API) meeting all requirements of 42 CFR §431.60. A technical assistance call was not required as the PIHPs are in discussions with MDHHS regarding the applicability of the API requirements. SWMBH took the recommendations made by HSAG seriously and will continue to work with MDHHS on this matter of relevancy.

HSAG FY23 PMV Audit Results

The following table represents how SWMBH has scored with the HSAG Performance Measure Validation (PMV) Audit over the past 5 years.

Fiscal Year	PMV Result
FY19	100%
FY20	97%
FY21	90%
FY22	100%
FY23	100%

FY23 Summary of Findings

Southwest Michigan Behavioral Health's Health Services Advisory Group (HSAG) Performance Measure Validation Audit took place on July 12, 2023. The primary goal of the audit was 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. SWMBH scored 100% again in FY23 on the HSAG PMV audit. This is a sustained improvement since FY21 when performance indicator data was found to be "not reportable" and other elements were determined to be unmet.

Strengths

SWMBH continued to work diligently with the 8 CMHSPs in Region 4 to ensure state-indicated benchmarks were being met. SWMBH did this by consistently providing timely reporting to the CMHSPs to ensure they were aware of their progress in meeting State thresholds. Since 2021, SWMBH has taken additional strides to better report BH-TEDS data. SWMBH directly deployed additional validation checks within their system to strengthen the completeness of the data being entered. 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.

SWMBH continued to improve its processes in FY23 by revising the MMBPIS reporting template to assist in catching event date and exception errors made during CMHSP data entries. SMWBH likewise continued validation of Indicator 4B data (BH TEDS Detox Admissions and Discharges records) with further review and training for providers of substance use services where necessary.

MDHHS FY23 SUD Administrative Audit

SWMBH met 13 out of 13 standards on the MDHHS SUD Administrative Audit in FY22 for a score of 100%. 12 out of 13 SUD Administrative Standards evaluated in FY23 received a Score of Full Compliance for a score of 92%. The following item required a policy update, which was completed on 9/15/23 and submitted to MDHHS.

The PIHP shall assure that, for any subcontracted treatment or prevention service, each subcontractor maintains service availability throughout the fiscal year for persons who do not have the ability to pay. MDHHS/PIHP Contract Boilerplate, section 19.1, Page 77	Copies of policies and procedures Encounter and TEDS reporting	✓ SWMBH Policy 1.07 Substance Abuse Block Grant Use for Treatment Services. ✓ SWMBH Encounter Tracking and Reporting Summary (BG Encounter report) ✓ BH TEDS Admissions Report	1	Email sent to Joel for further documentation of requirement. SWMBH needs to have an internal policy that outlines this requirement. While it is clear that this is the practice based on evidence provided, it needs to be documented. SWMBH updated policy 01.07 Substance Abuse Community-Block Grant Authorized Use for Treatment Services on 9/15/23. A copy of the updated policy has been provided.

FY23 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

Final PBIP results for FY23 are not yet available from MDHHS.

Summary of Interventions in Key PBIP Areas

Comprehensive Care and Complex Case Management Progress

SWMBH's Integrated Care Team (ICT) facilitates monthly meetings including staff from SWMBH, Medicaid Health Plan (MHP), CMHSP and primary care physician 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 ED 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. OHH consists of a team of Nurse Care Managers, Peer Recovery Coaches and Community Health Workers who provide comprehensive care management, care coordination, health promotion, transitional care, individual and family support, and referrals to community services. For FY23, OHH was expanded to allow members with Medicaid in all eight SWMBH counties to be eligible and a new Health Home Provider, Harbortown Treatment Center in Berrien county, joined the other three providers. Because of these changes, during FY23, OHH enrollment averaged approximately 486 members each month, 690 unique members received services, and over 12,500 OHH services were provided.

Year	Average OHH enrollment/month	# of members receiving OHH services	Total # of OHH services provided
FY22	352	525	Nearly 8,000
FY23	486	690	Over 12,000

Coordination of Care

SWMBH staff have access to the SWMBH Medical Director, Dr. Perry Westerman, a psychiatrist for member-specific consultation via phone and ad hoc meetings at any time. Members brought for discussion with Dr. Westerman have typical diagnoses of a Severe and Persistent Mental Illness (SPMI) and chronic physical health conditions. There is often a recent history of inpatient psychiatric admissions with difficult to treat symptomology. After reviewing clinical diagnoses, presenting behaviors, and treatment history, Dr. Westerman can provide recommendations on viable next steps for the member's treatment regimen. Difficult cases or members with complex needs are taken to Dr. Westerman 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 ED 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. These metrics track progress on quality bonus metrics and identify areas where intervention is needed. SWMBH and CMHSP leadership can use Population Performance to identify regional and local population health trends, and drive decision-making for regional clinical initiatives.

Accessibility of Services

The goal of Complex Case Management (CCM) is to help members move toward optimum health, improved functional capability, and quality of life improvement by focusing on their own health goals. The members select the health goals that they wish to address. After that, a SWMBH Registered Nurse (RN) helps facilitate the identification of steps needed and recommends community supports available to assist in meeting 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 RN 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.

R. Cultural Competency

Description

SWMBH is dedicated to ensuring that the supports and services provided throughout Region 4 demonstrate an ongoing commitment to linguistic and cultural competence to ensure equitable access and meaningful participation for all members. Such commitment includes acceptance and respect for the cultural values, beliefs and practices of 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. To effectively demonstrate such commitment to cultural competence, SWMBH has the following five components in place:

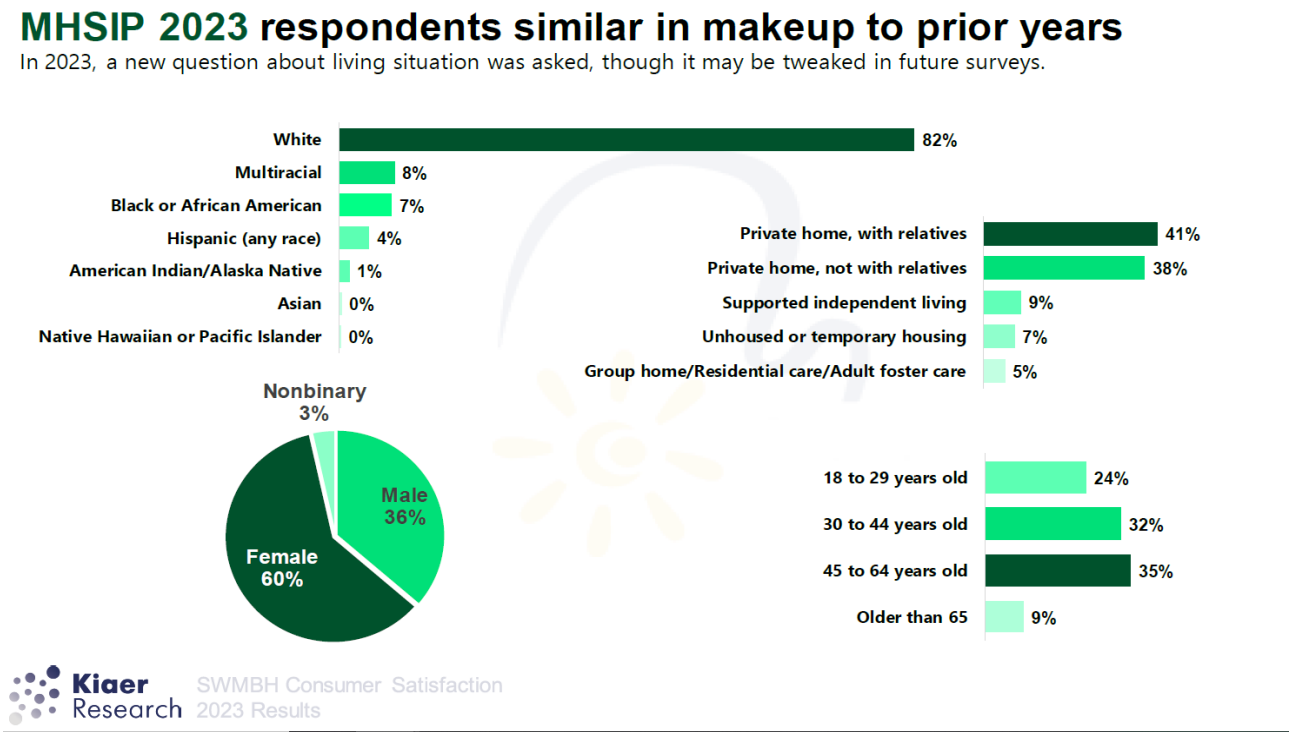
1. **Community Assessment**

SWMBH used the annual regional Network Adequacy Assessment and Customer Satisfaction Surveys to assess the cultural competence of its provider network and member involvement throughout the region. Languages spoken throughout the provider network are gathered through the Region's credentialing process. At the county level, MDHHS requires each CMHSP to conduct a nominal Needs Assessment at least every two years. MDHHS required all local CCBHC sites to have a Needs Assessment. These community health needs assessments provide current demographic data and involve extensive stakeholder surveys spanning both provider agencies and persons served. The CMHSPs analyze stakeholder survey responses alongside data points for a combined qualitative and quantitative view of cultural competence and needs in each county. These data points were discussed, analyzed, and organized via county level workgroups and presentations. Community needs assessments were used to create a foundational equity framework that is specific to the county level, complete with root cause analysis and subsequent strategic planning.

MHSIP and YSS Survey responses and demographics

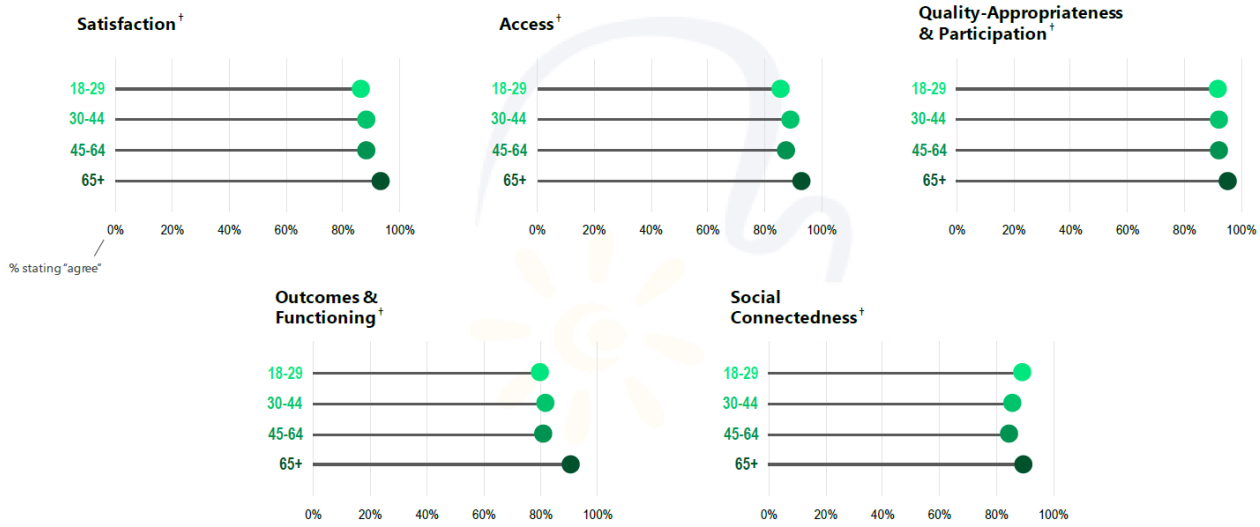
During the Annual Customer Satisfaction Survey Process, SWMBH completed an analysis of respondence. This helped SWMBH identify what percentage of each demographic population was receiving services, as well as other factors identified in the analysis below. SWMBH used this information to target services, programs and implement interventions to decrease disparities amongst minority groups.

The following graphics depict overarching themes and outcomes from the FY23 Mental Health Statistics Improvement Plan (MHSIP) survey, as they relate to cultural components:



Age: Those 65 and up had higher ratings than other age groups

Although, construct ratings were generally similar between groups.



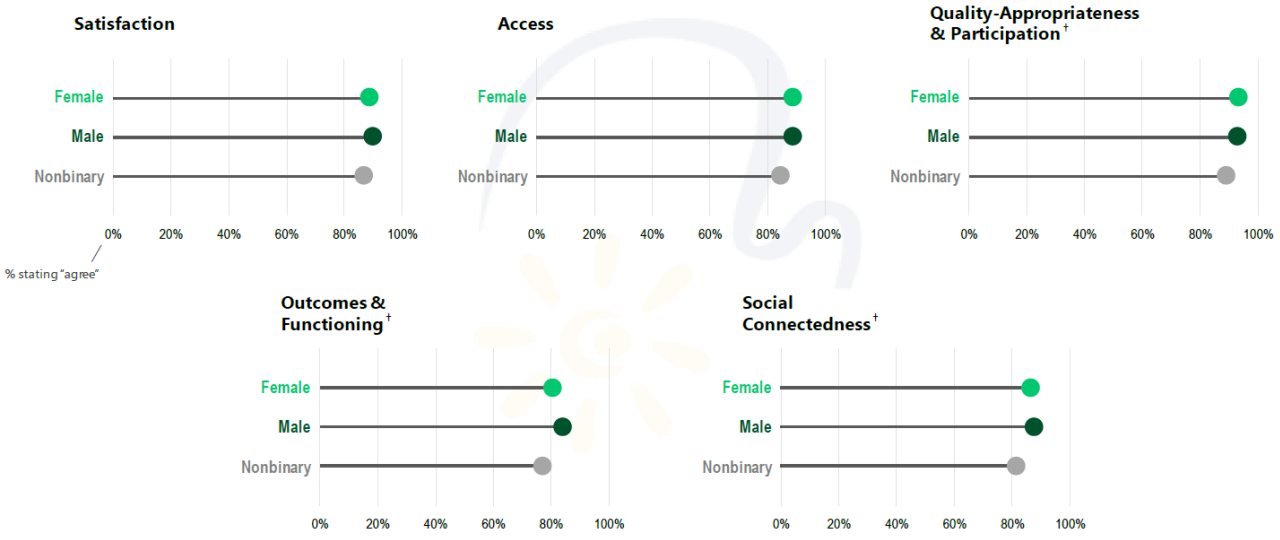
Kiaer Research SWMBH Consumer Satisfaction 2023 Results

† statistically significant difference ($p < .05$) found between groups

18-29 n = 321 45-64 n = 563
30-44 n = 432 65+ n = 123

Gender: Nonbinary consumers reported lower quality-appropriateness & participation, outcomes, and social connectedness

Meanwhile, male consumers rated both outcomes and social connectedness slightly higher than female consumers.
The next page documents qualitative data from LGBTQIA+ consumers.



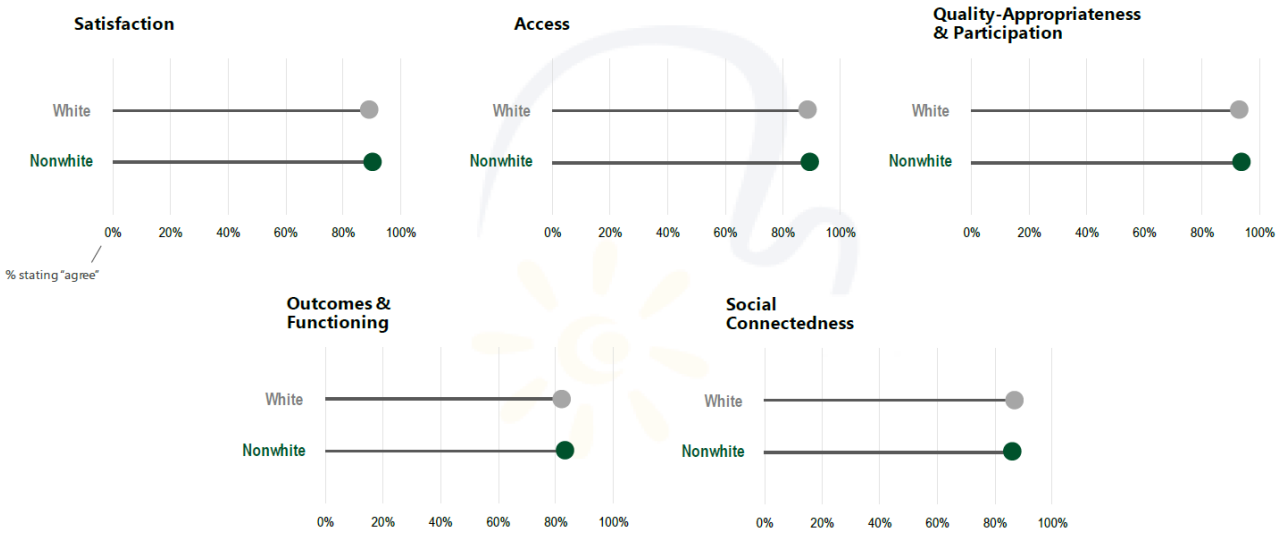
Kiaer Research SWMBH Consumer Satisfaction 2023 Results

† statistically significant difference ($p < .05$) found between groups

Female n = 846 Nonbinary n = 49
Male n = 511

Race: Not much difference in ratings by race

"Nonwhite" category comprises any race other than White, including Black/African American, Asian, Native American, Native Hawaiian/Pacific Islander, or any mix of races. This aggregation was done mostly due to small sample sizes.

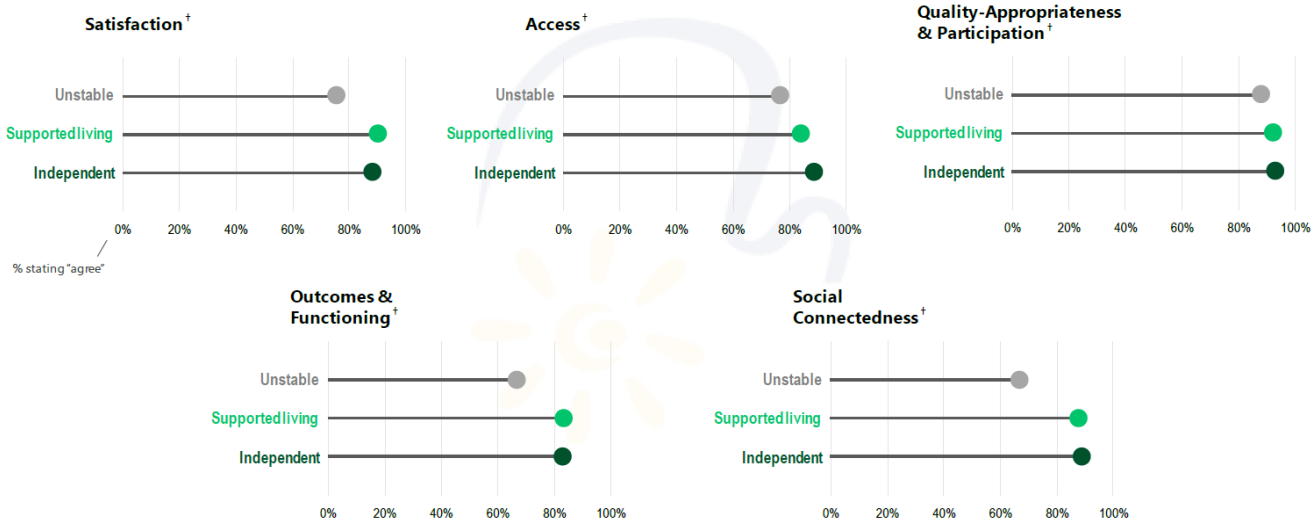


Kiaer Research SWMBH Consumer Satisfaction 2023 Results

White n = 1,108
Nonwhite n = 245

Living situation: Those with unstable housing had lower ratings, especially in access, outcomes & functioning, & social connectedness

Those in supported living had worse access ratings than those living independently ($p < .05$). "Unstable" was indicated if the respondent reported living in a shelter, motel/hotel, vehicle, etc. "Supported living" included AFC, a group home, or other supported independent living. "Independent" included all other living situations.



Kiaer Research SWMBH Consumer Satisfaction 2023 Results

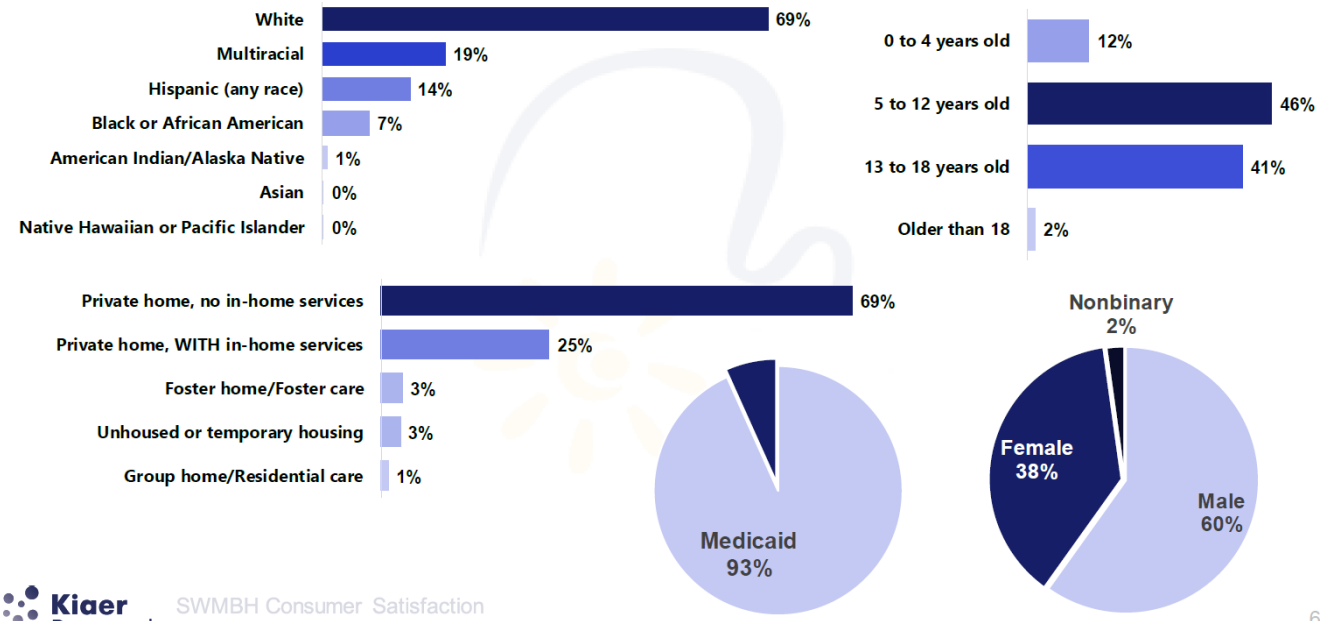
† statistically significant difference ($p < .05$) found between groups

Unstable n = 80
Supported living n = 150
Independent n = 867

The following graphics depict overarching themes and outcomes from the FY23 Youth Services Survey for Families (YSS) survey, as they relate to cultural components:

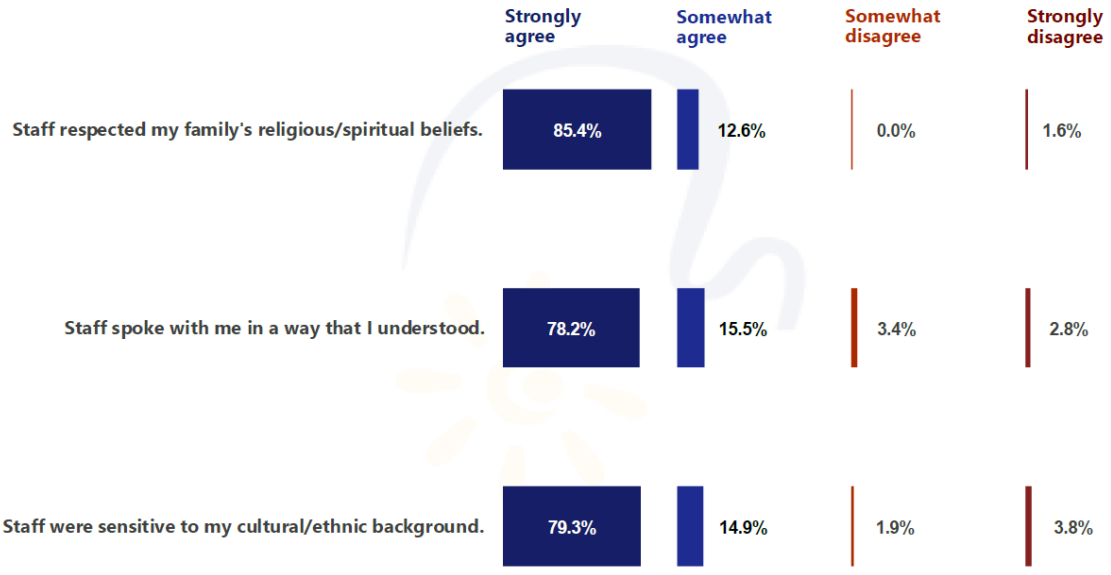
YSS 2023 youth represented were more diverse than in 2022

More Hispanic youth were represented and more non-Medicaid youth were represented.



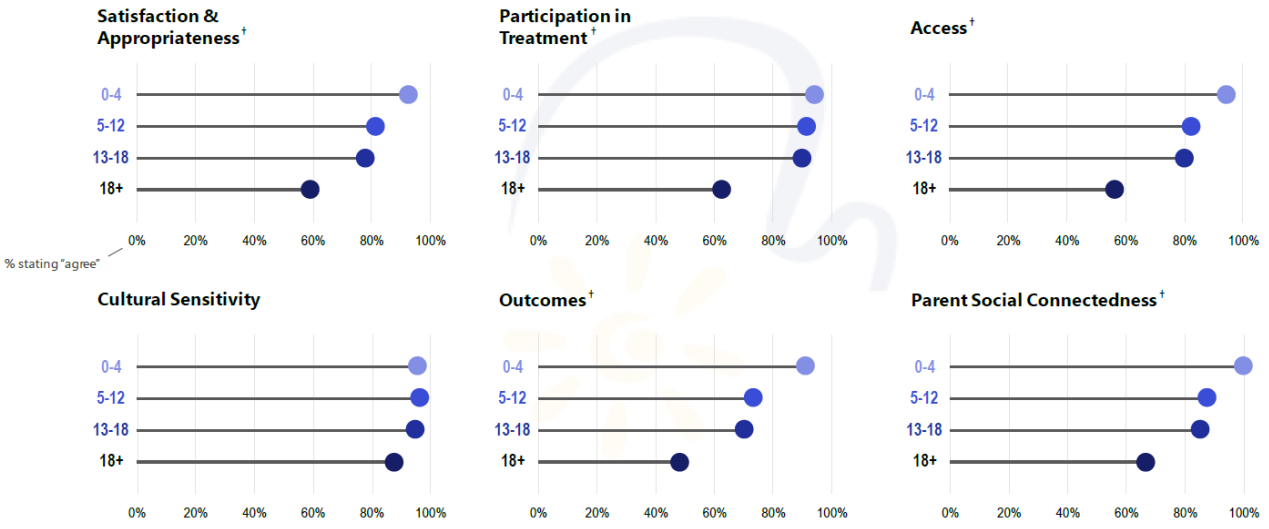
CMHSP cultural sensitivity received near perfect ratings

A majority of YSS respondents gave the cultural sensitivity items **strongly agree** ratings



Generally, the older the youth, the lower the survey scores

YSS survey completers with children **over 18** (n = 6) reported lower scores because the child was no longer in their care.



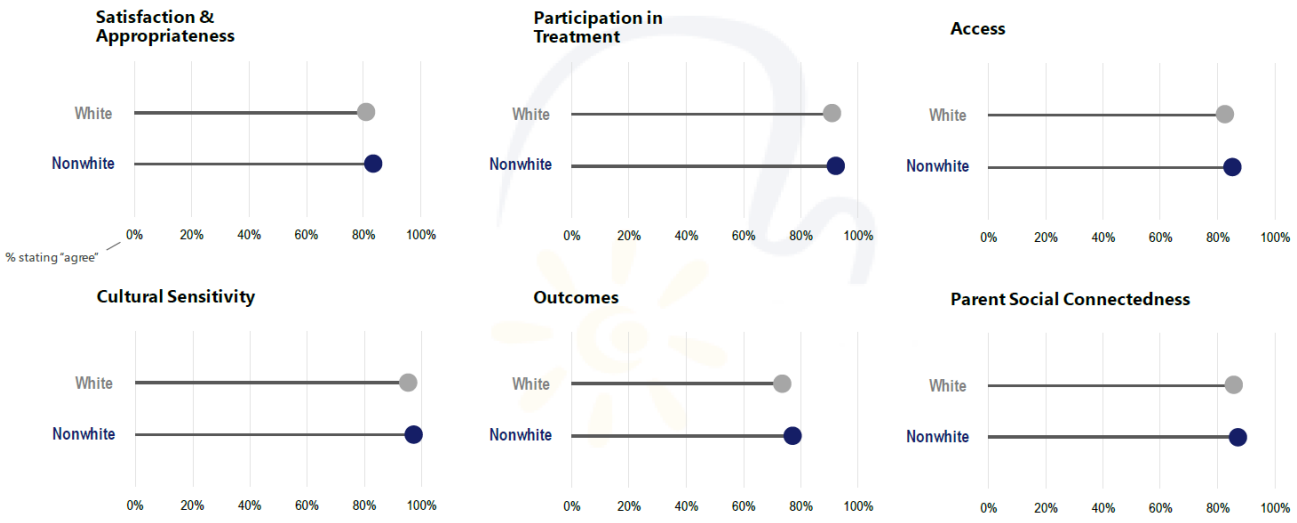
Kiaer Research SWMBH Consumer Satisfaction 2023 Results

† statistically significant difference ($p < .05$) found between groups

0-4 n = 44 13-18 n = 153
5-12 n = 174 18+ n = 6

Youth scores similar for each race in 2023 YSS

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



Kiaer Research SWMBH Consumer Satisfaction 2023 Results

White n = 245
Nonwhite n = 111

2. Policy and Procedure

SWMBH Policy 03.07 Cultural & Linguistic Competency and SWMBH Procedure 03.07A 2023 SWMBH Cultural Competency Plan reflect SWMBH's values and practice expectations toward cultural competency. SWMBH has adopted the Culturally and Linguistically Appropriate Standards (CLAS) as general guidelines for the region. These policies apply to the entire SWMBH network. The following excerpt from 2023 SWMBH Cultural Competency Plan provides additional details regarding SWMBH's commitment to cultural competency.

Personnel

Business Practice – to promote Competency	Source	Outcome
SWMBH actively recruits workforce of diverse backgrounds through the candidate selection process.	• SWMBH Position Descriptions • SWMBH Policy 3.7 – Cultural and Linguistic Competency • SWMBH Policy 4.7 – Competitive Employment • Network Adequacy Analysis – Population Race/Ethnicity Analysis	To promote a workforce that is reflective of the community and individuals served.
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.
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.
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

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.
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.
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.
SWMBH annually/internally evaluates demographic data of network and individuals served through the Network Adequacy review.	• 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
SWMBH encourages members to identify their need for language support services via the use of "I Speak" tools at service sites or via telephone contacts. Annual CMHSP Site Reviews check to ensure the "I Speak" cards were shared.	• SWMBH Policy 6.5 Limited English Proficiency • SWMBH Network Adequacy Plan	When members can identify their primary language, SWMBH can direct support necessary to provide support and services.
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 members and individuals seeking services.
Via the Person-Centered Planning process, SWMBH (and all contracted providers) encourages discussion of the importance of	• SWMBH Policy 4.5 – Person and Family Centered Planning	To ensure members are receiving services suited to their individual needs.

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 maintains a competent provider panel of interpreters and translators.	• SWMBH Policy 4.1 – Access Management Program Description	To ensure members can receive educational materials and supportive services in their preferred language.
SWMBH will utilize the network adequacy report and feedback generated from annual customer satisfaction surveys to evaluate any changing cultural/linguistic needs of the community.	• SWMBH FY23 Customer Satisfaction Survey Analysis and Results • SWMBH FY23 Grievance and Appeal Data Analysis • SWMBH FY23 QAPI Evaluation of Services	SWMBH can modify printed materials as language thresholds change and can target workforce training needs to new community needs.
SWMBH educational materials are written in simple language and provided in preferred languages to customers.	• SWMBH Customer Handbook • SWMBH UM Policy	Community members and customers will have access to information in commonly used languages. Vital documents are translated in to Spanish.
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	Members will have processes explained to them in preferred language and have access to language support to represent themselves while SWMBH addresses their complaint(s).

3. Service Assessment and Monitoring

SWMBH used several methods to assess and monitor culturally competent services including but not limited to targeted items on the annual CMHSP and provider Site Reviews, and addition of a new Health Equity Project Coordinator position. The Health Equity Project Coordinator is a grant funded position that planned and developed regionwide programming to increase the access and participation of minority populations in behavioral health services. From this position, a Regional Health Equity Focus Group was formed, consisting of representation from all 8 counties in Region 4. The workgroup worked collectively to identify regional and county barriers, frontline partners for further coordination and support, provide feedback to training and campaign efforts. Cultural competency was further assessed and monitored according to current PBIP, CCBHC, MMBPIS and other metrics geared toward ensuring cultural competence and fairness in service delivery. Metrics that center around underserved populations were reviewed by SWMBH's internal Health Equity Performance Improvement Project (PIP) work group monthly, to ensure up to date monitoring. For example, the PIP workgroup helped to create a pathway for encounter data to reflect interventions for the FUA metric. Meetings were held with select hospitals in the region to improve education and awareness of health disparities. Quarterly meetings have taken place with SWMBH and Medicaid Health Plans (MHP) to monitor fluctuations more closely in performance measures and identify interventions pertaining to disparities. SWMBH and the Provider Network have demonstrated commitment to linguistic and cultural competence that ensures access and meaningful participation for all members 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.

4. Training

Throughout FY23, SWMBH required ongoing training to assure staff are aware of and able to effectively implement cultural competency policies and procedures. SWMBH required all provider agency and CMHSP staff that are in-network to have cultural competency training and reviewed this item as part of the Staff Training File Review in the annual Site Review process. SWMBH Policy 03.07 Cultural & Linguistic Competency and SWMBH Procedure 03.07A 2023 SWMBH Cultural Competency Plan are likewise trained annually during a Quality Management Committee meeting. Through the SWMBH Health Disparities Grant, representatives from each CMHSP in the region attended Advancing Health Equity in Public Health Training hosted by Michigan Public Health Institute (MPHI). Finally, SWMBH began offering the following trainings free of charge to all provider agencies in Region 4: Ableism 101 and 102, Disability and Healthcare Equity Training, Disability and Intersectionality Training, and Implicit Bias Training. In FY24, a health equity lecture series and symposium will be offered.

5. Culturally Contextual Services/Supports

During FY23, the SWMBH Community Engagement Committee participated 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 FY23 evaluation period include:

- Mental Health and Wellness Expo at Kellogg Community College
- North Burdick Block Party
- Kalamazoo Pride 2023
- Veteran's Night at The Growlers
- Family Health Center Back to School Bash
- Veteran's/First Responders Day
- Kalamazoo Veteran's Stand Down
- Recovery Festival in Bronson Park
- Benton Harbor Veteran's Stand Down
- Gryphon Place Suicide Prevention Walk
- St. Joseph Veterans Stand Down and Project Connect
- Kalamazoo County Project Connect
- Van Buren Project Connect
- Battle Creek Veteran's Stand Down
- Great Lakes Autism Center Truck or Treat

FY23 Identified Barriers and Analysis

Some identified barriers during this evaluation period included:

- Difficulty in obtaining data/survey responses from some minority groups.
- Difficulty to obtain member input/guidance on some aspects of the Regional Cultural Competency efforts. In response, SWMBH partnered with Michigan Public Health Institute (MPHI) to conduct peer professional interviews in the region to understand and obtain data on present day and historic barriers preventing the community from accessing and/or engaging with the behavioral health system and will also highlight successes.
- MDHHS intended to create a new procedural document with updated standards for use in FY24, but ultimately decided that was a lofty goal and unrealistic. Recommend MDHHS add guidelines surrounding the additional considerations section of the current procedural document for network adequacy analysis. Ideas include timely appointments, language, cultural competence, and physical accessibility.

- Difficulty finding qualified, culturally competent staff in some counties or lack of Black, Indigenous, Multiracial, and other People of Color (BIMPOC) provider representation. SWMBH supported the region through bringing CMHSPs together for discussions around sharing resources and staff.
- Other barriers in providing culturally competent care as identified in the regional health equity focus group include, stigma, mistrust in the behavioral health system, lack of transportation, lack of affordable housing, language barriers, misinformation about services, and internet/technology availability.

Improvement Efforts Made in FY23 toward Cultural Competency

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 frequent and additional access to provider health equity, cultural and implicit bias training.
- Revisions were made to the reading level of the satisfaction surveys to bring them into compliance with ADA standards.
- Increased scope and efforts for collecting provider cultural background information during the credentialing application process, which translated to the online provider panel.
- Launched the Anti-Stigma Campaign, "Flip the Script on Mental Health", which acknowledges stigmatized beliefs, while influencing and encouraging BIMPOC populations to engage with behavioral health. The campaign was implemented with radio and social media advertisements.
- Added Veterans week celebration including daily training and awareness.
- Added Martin Luther King Junior Day as an observed, paid holiday.
- Sponsored the upcoming Northside Ministerial Alliance MLK Day magazine with "Flip the Script on Mental Health" messaging.
- SWMBH had a booth at Kalamazoo Pride for the first time in FY23.
- Increased emphasis on Juneteenth through staff education and awareness. Adding Juneteenth as a paid holiday in FY24.
- One of HSAG's recommendations in FY23 was to evaluate language spoken by providers vs. enrollees for FY24. This topic has already been discussed at a SWMBH/CMHSP Network Adequacy Remediation Plan Workgroup and is planned for FY24.
- SWMBH began offering the following trainings free of charge to all provider agencies in Region 4: Ableism 101 and 102, Disability and Healthcare Equity, Disability and Intersectionality, Implicit Bias Training.
- Health Equity Performance Improvement Project (PIP) Workgroup.
- SWMBH revised the Facility/Office Accessibility section in the Organization Credentialing Application to capture whether providers have accommodations for disabilities.
- Previously, SWMBH's Online Provider Directory had a search option "Accessibility for Disabilities" with a drop-down menu for "Yes", "Unknown", and "No". SWMBH's IT Department added a Free Text option to add in the accessible features each site(s) include. SWMBH's Provider Network Department ensures this is up to date as Providers submit new and/or recredentialing applications.

FY23 Results

Goal	FY23	Eval Score	Recommendations
Implement an annual staff/provider Cultural Accelerator survey to gauge organizational level of internal and external Cultural Competence.	100%	**5**	This was completed more than annually during FY23. Doesn't measure cultural competency. Recommend remove this as a goal for next year
Perform and utilize analysis on feedback received from members during the annual Customer Satisfaction and Recovery Services Surveys.	100%	**5**	Survey results were received, and regional committees both reviewed and discussed outcomes on both a county-specific and regional level.
Promote continued Education throughout the organization and community by participating in or contributing to local organizations and public events.	100%	**5**	Include # of events, etc. Added Pride. Added Veterans Week activities. Anti-stigma campaign with training around disability awareness and accessibility. In FY24, a health equity lecture series and symposium will be offered.
Complete an annual Network Adequacy analysis, which will identify deficiencies and interventions for providers' cultural competence as well as how the region collects and tracks languages spoken within the provider network.	100%	**5**	This was completed. One of HSAG's recommendations in FY23 was to evaluate language spoken by providers vs. enrollees for FY24. This topic has already been discussed at a SWMBH/CMHSP Network Adequacy Remediation Plan Workgroup and is planned for FY24. SWMBH believes capturing more Provider data regarding languages spoken, cultural competency and physical accessibility of office space will assist the Provider Network Departments at each CMHSP in ensuring the Region's Member's needs are being met in this capacity.
The Network Adequacy Plan, survey results and cultural competency plan will be shared with the SWMBH Board of Directors.	100%	**5**	Cultural Competency Plan was shared via the QAPI Eval in January 2023 and the Network Adequacy Plan was shared with the board in March 2023. Next year the goal will be to review and approve at the RPNM committee meeting.
Confirm during CMHSP annual Site Reviews, that each CMHSP has an active and current Cultural Competency Plan in place. Plans should include goals and targeted initiatives for the current year.	Partially Met	**5**	SWMBH reviewed each CMHSP's Quality Plans and made recommendations for the development of FY24 plans. SWMBH will evaluate contractual requirements to determine whether a cultural competency plan is required for the CMHSPs.

FY23 Board Ends Metrics Summary Report

This document serves to summarize the achievement status of the Board Approved Metrics for completion in FY 2023 (*October 1, 2022, through September 30, 2023*)

Current Ends Metrics Status: **22.5/19** achieved- **100%**
4 Metrics Roll Over to 2024 for approval
(*Please see detailed outcomes and status for each metric*)

2022 PBIP Narrative Report Achieve 95% of Performance Based Incentive Program monetary award based on MDHHS specifications. Possible Points: 1 point for successful completion.	**Metric Achieved** Qualitative narrative report sent to MDHHS, summarizing prior FY efforts, activities, and achievement of the PIHP and CMHSPs.	Scheduled Metric Board Report Date: January 14, 2023	2022 Rollover Metric **1 point earned**
Achieve 95% of Veteran's Metric Performance-Based Incentive Program monetary award based on MDHHS specifications. Possible Points: 1 point for successful completion.	**Metric Achieved** • VSN Data has been submitted and received through the DCH file transfer successfully. • Data Quality Narrative Report send and received by MDHHS	Scheduled Metric Board Report Date: January 14, 2023	2022 Rollover Metric **1 point earned**
Achieve 95% of Increased Data Sharing Performance Bonus Incentive Program (PBIP) monetary award based on MDHHS specifications. Possible Points: 1 point will be awarded.	**Metric Achieved** • ADT Narrative report was submitted to MDHHS and received	Scheduled Metric Board Report Date: January 14, 2023	2022 Rollover Metric **1 point earned**

Achieve Compliance on Follow-up After Hospitalization for Mental Illness within 30 days (FUH) for beneficiaries six year of age and older and show a reduction in disparity with one minority group. Possible Points: 1 point will be awarded. (½ point each, child and adult.)	**Metric Achieved** Plans will be measured against the adult minimum standard of 58% and child minimum standard of 70%. 2022 SWMBH Rates: • Adult: 68.6% • Child: 83.5%	Scheduled Metric Board Report Date: January 14, 2023	2022 Rollover Metric **1 point earned**
2022 Customer Satisfaction Surveys collected by SWMBH are at or above the SWMBH 2021 results for the following categories: Mental Health Statistic Improvement Project Survey (MHSIP) tool. *(Improved Functioning)* Youth Satisfaction Survey (YSS) tools. *(Improved Outcomes)* Possible Points: 2 points will be awarded.	**Metric Not Achieved** a. Adult – Improved Functioning: 83.6% (-1.5%) Decrease in comparison to 2021 result. b. Youth – Improved Outcomes: 75.5% (-1.8%) Decrease in comparison to 2021 result.	Metric Board Report Date: Presented and approved, April 14, 2014	2022 Rollover Metric **0 points earned**
2022 Health Service Advisory Group (HSAG) External Quality Compliance Review (90% of Sections evaluated receiving a score of "Met"). Possible Points: 1 point will be awarded.	**Metric Not Achieved** FY22 - 80% (94/119)	Metric Board Report Date: Presented and approved December 9, 2022	2022 Rollover Metric **0 points earned**
SWMBH will achieve 90% of available monetary bonus award for achievement of quality withhold performance measures identified in the (2022) MHL Integrated Care Organization (ICO) contracts. Possible Bonus Points: 1 point for successful completion.	**Metric Achieved** 90 % achieved with Meridian	Scheduled Metric Board Report Date: January 14, 2023	2022 Rollover Metric **1 point earned**

85% of Michigan Mission Based Performance Indicators achieve the State indicated benchmark for 4 consecutive quarters for FY22. Possible Points: 2 points total- (½ point each for 3*a-d)*	**Metric Partially Achieved** b. Indicator 3a, b, c, & d to achieve a 3% combined improvement through FY22 2021 2022 3a 56.02% 62.51% 3b 60.89% 65.19% 3c 71.07% 57.86% 3d 69.42% 75.00%	Metric Board Report Date: Presented and approved, January 13, 2023	2022 Rollover Metric **1.5 points earned**
SWMBH will meet or exceed the Behavioral Health Treatment Episode Data Set (BH TEDS) compliance benchmarks established by MDHHS for FY22. Possible Points: 1.5 points for successful completion (½ point each for *a-c)*	**Metric Achieved** a. MH: 99.65%- ½ point b. SUD: 97.53%- ½ point c. Crisis: 99.39%- ½ point	Metric Board Report Date: Presented and approved, February 10,2023	2022 Rollover Metric **1.5 points earned**

Achieve 95% of Veteran's Metric Performance -Based Incentive Program monetary award based on FY23 MDHHS specifications. Possible Points: 1 point for successful completion.	**Metric Achieved** a. Timely submission of Veteran Services Navigator collection form b. Submit BH TEDs data quality monitoring narrative report by 1/1/2023. c. Sent VSN – BH TEDs comparison narrative report by 7/1/2023.	Scheduled Metric Board Report Date: January 12, 2024	**1 point earned**

Achieve 95% of Increased Data Sharing Performance Bonus Incentive Program (PBIP) monetary award based on MDHHS specifications. Possible Points: 1 point for successful completion.	**Metric Achieved** Submitted a narrative report by 7/31/2023, listing CMHSP's sending ADT messages, and barriers for those who are not, along with remediation efforts and plans.	Scheduled Metric Board Report Date: January 12, 2024	**1 point earned**
Achieve Compliance on Follow-up After Hospitalization for Mental Illness within 30 days (FUH) for beneficiaries six year of age and older and show a reduction in disparity with one minority group. Possible Points: 1 point total (½ point each, child and adult.)	**Metric Achieved** 2023 SWMBH Rates: a. Adult: 65.95% Child: 78.42% c. No significant disparity for adults or children	Scheduled Metric Board Report Date: February 9, 2024	**1 point earned**
2023 CCBHC Program Customer Satisfaction Surveys collected by SWMBH represent an 85% First Year *"in agreement"* Satisfaction rate average across all categories measured. Possible Points: 1 point total (½ point each *a* and *b)*	**Metric Achieved** a. SWMBH administered 369 surveys for ISK and 279 surveys for St. Joe b. SWMBH completed an analysis for MDHHS and CCBHC locations, delivering results and identified areas/ opportunities for improvement	Metric Board Report Date: Presented and approved, August 11, 2023	**1 point earned**