Quality Assurance and Performance Improvement Program (QAPIP) Fiscal Year 2024 Evaluation Report

All SWMBH Medicaid Business Lines

Evaluation Period: October 1, 2023 - September 30, 2024

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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 Medicaid Managed Care rules, 42 CFR § 438, and requirements outlined in the PIHP/MDHHS contract.

Southwest Michigan Behavioral Health (SWMBH) uses the QAPIP Plan and Evaluation to assure all contractual and regulatory standards required of the Regional Entity, including its PIHP responsibilities and oversight of the eight Community Mental Health Service Partners (CMHSPs) in the region, are met. The QAPIP Plan describes the organizational structure for the SWMBH's administration and evaluation of the QAPIP, the elements, components, and activities of the QAPIP, the role of recipients of service in the QAPIP, the mechanisms used for adopting and communicating process and outcome improvement, and to implement improvement strategies to meet and exceed best practice performance levels.

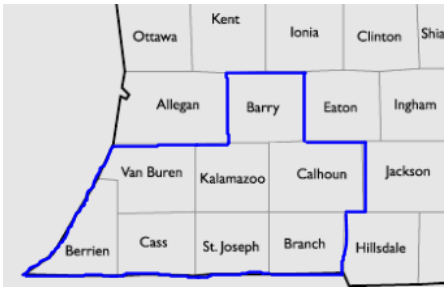
For SWMBH purposes, "beneficiary" includes all Medicaid eligible individuals (or their families) located in the defined service area who are receiving, or may potentially receive, covered services and supports. The following terms may be used interchangeably within this definition: member, customer, recipient, enrollee, individual, and person served.

This annual evaluation is comprised of initiatives undertaken by SWMBH and the Region from October 1st, 2023 through September 30th, 2024 for Medicaid Services and includes the status of FY24 QAPIP Plan goals. The formulation of the QAPIP goals includes incorporating numerous federal and state requirements and guidelines, 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 Quality Management and Clinical Outcomes Department and the Quality Management Committee (QMC) is granted by SWMBH's Executive Officer (EO). SWMBH's Board of Directors 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 Beneficiaries Served

SWMBH (Region 4) served 35,227 unique beneficiaries from October 1, 2023, to September 30, 2024, with 298,968 Medicaid Eligible in the Region.



Beneficiaries 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.

A. Performance Measures

Description

Each Community Mental Health Service Program (CMHSP) was responsible for reviewing and submitting valid and reliable performance indicator data to SWMBH for analysis each month in FY24. SWMBH promoted data integrity by using electronic controls within the spreadsheets used for reporting Michigan's Mission-Based Performance Indicator System (MMBPIS) data. SWMBH has a Clinical Quality Specialist dedicated to the oversight and monitoring of the data to ensure completion and accuracy per the MMBPIS Codebook prior to submission to MDHHS. SWMBH submitted quarterly outcomes to MDHHS per the FY24 contract schedule. The QAPIP was used to assure minimum benchmarks were achieved on performance indicators as established by MDHHS and analyzed causes of statistical outliers when they occurred. Status updates were given, and regional trends were identified and discussed regularly at QMC and other relevant committees for further planning and coordination. Additional oversight and monitoring occurred in the annual CMHSP Site Reviews where the SWMBH QM Department analyzed progress and trends with MMBPIS data, primary source verification documentation, and protocols. Results were analyzed and communicated to CMHSPS and Corrective Action Plans (CAPs) were requested, as appropriate. Additionally, when State-indicated benchmarks were missed, or other issues are identified, SWMBH requested that the CMHSPs and/or SUD providers complete a CAP. The PIHP ensured the CAPs were achieved and improvements were recognized. Appreciation letters were also sent to CMHSPs to provide recognition upon meeting 100% of the State's benchmarks each quarter. These efforts ensured improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes.

FY24 Identified Barriers and Analysis

MDHHS standards for indicators 2 and 3 became effective in FY24 and to monitor areas of improvement, these indicators were added to the CAP request process when quarterly benchmarks were not met. Beneficiary no shows/cancellations/requests outside the 14-day requirement for appointments were widespread barriers in meeting these access measures. SWMBH chose to focus on improving Indicator 3 outcomes for the FY24 Non-Clinical Performance Improvement Project (PIP) to further identify causal barriers and provide recommendations to improve access/timeliness. Additional details of this PIP can be found in the corresponding PIP section. Due to the lagging nature of MMBPIS performance indicator outcomes, and because these outcomes remain under the established benchmark of 72.9%, PIP efforts and full evaluation of recommendations for improvement will continue into FY25. During FY24, MDHHS announced a three-year rollout strategy for the Behavioral Health Quality Transformation to start in FY25, after which, the MMBPIS will be sunset. The transition to national core indicators will ultimately result in a comprehensive, better-defined system with more rigorous methodology that aligns with other state and national requirements. Details of the implementation and set standards have been slowly released by MDHHS, which has been a barrier in the ability to prepare for the overhaul.

Improvement Efforts Made in FY24

Issues with timely and accurate entry of Behavioral Health Treatment Episode Data Set (BH-TEDS) admissions in Smartcare by CMHSPs and SUD providers were further supported during the FY24 Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) audit; however, additional updates were made to PIHP reports to improve the identification of existing BH-TEDS errors and missing events affecting Indicator 2e. SWMBH continues to provide feedback to providers and encourages the use of the error reports during regional committee meetings to ensure records are processed accurately and timely. Additionally, MDHHS began providing SWMBH with quarterly detailed data used to calculate indicator 2e, which increased validation and analysis. SWMBH began to include Clinical and Quality subject matter experts at the PIHP and CMHSP levels in the CAP process in FY24, which led to additional collaboration with PIHP Utilization Management staff who routinely identify and review cases with frequent use of psychiatric inpatient services. It is anticipated that early identification could improve beneficiary level of care needs as well as aftercare outcomes.

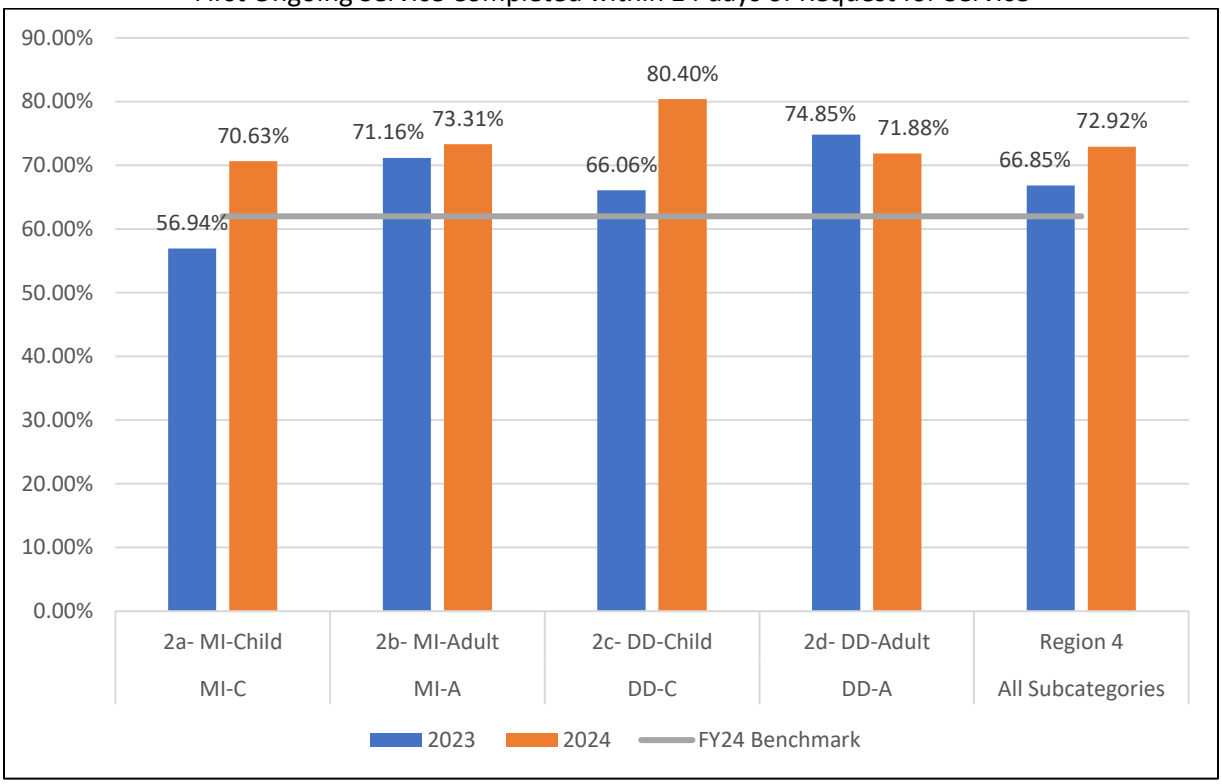
FY24 Results

Indicator	Where Progress was Monitored	Frequency of Monitoring	FY23	FY24	Eval Score	FY25 Recommendations
1 - Percentage of Children who receive a Prescreen within 3 hours of request (>= 95%).	QMC	Monthly	98.86%	99.67%	5	The goal was met, will stay the same and be monitored through FY25.
1 - Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95%).	QMC	Monthly	98.88%	99.72%	5	The goal was met, will stay the same and be monitored through FY25.
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 (>=62%).	QMC	Monthly	66.85%	72.92%	3	This goal was met, will stay the same and be monitored through FY25.
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 (>=68.2%).	QMC	Monthly	66.83%	65.97% *	3	It is anticipated that this goal will be met; however, MDHHS calculates this indicator and Q4 outcomes were not available for this report. 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) (>=72.9%).	QMC	Monthly	56.78%	59.21%	2	This goal was not met and will continue to be monitored through the upcoming FY. Due to low indicator performance, the non-clinical PIP to improve access and timeliness for new beneficiaries will continue through FY25.
4a(a) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%).	QMC	Monthly	98.01%	97.35%	4	The goal was met, will stay the same and be monitored through FY25.
4a(b) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%).	QMC	Monthly	96.98%	97.17%	4	The goal was met, will stay the same and be monitored through FY25.
4b - Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%).	QMC	Monthly	98.98%	98.11%	4	The goal was met, will stay the same and be monitored through FY25.
10a - Re-admission to Psychiatric Unit within 30 Days-Children (<=15%).	QMC	Monthly	3.37%	9.01%	4	The goal was met, will stay the same and be monitored through FY25.
10b - Re-admission to Psychiatric Unit within 30 Days- Adults (<=15%).	QMC	Monthly	9.50%	13.06%	4	The goal was met, will stay the same and be monitored through FY25.

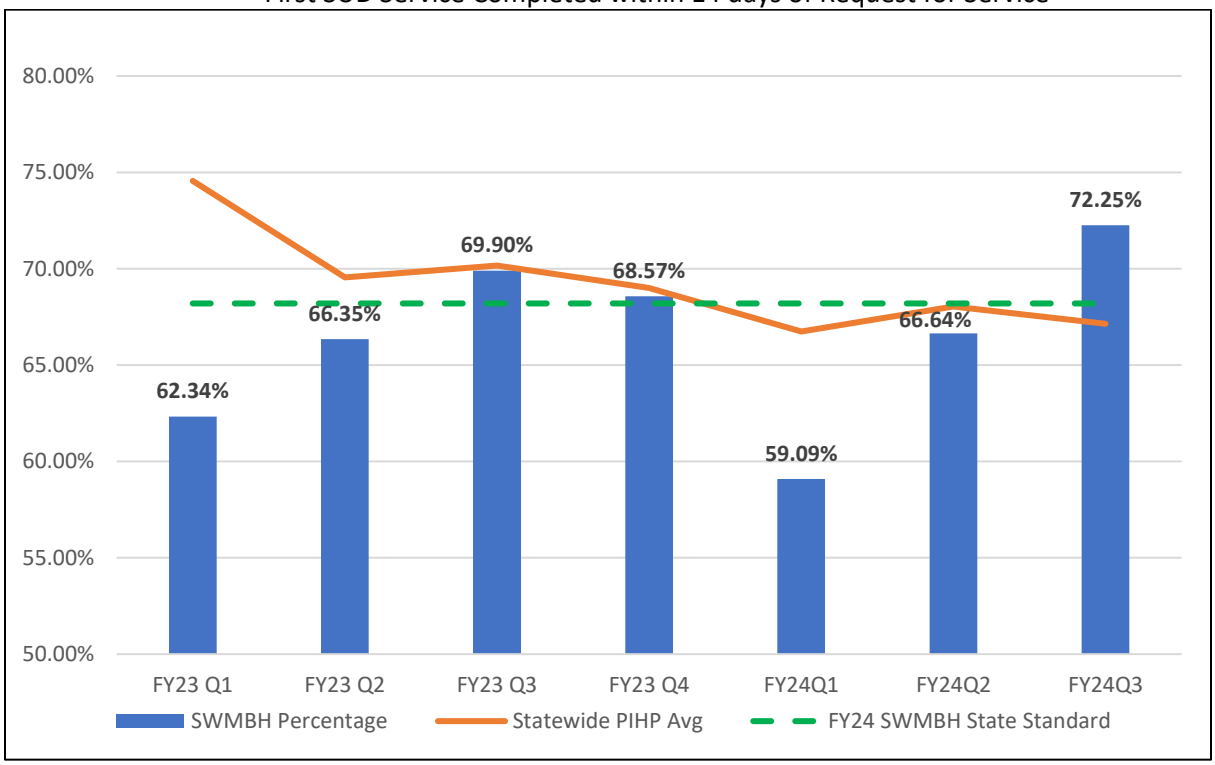
MMBPIS Indicator #	MMBPIS Performance Indicator	State Standard	Q1 2024	Q2 2024	Q3 2024	Q4 2024
1a	Pre-Admission Screening Children	95%	**99.57%**	**99.57%**	**100.00%**	99.52%
1b	Pre-Admission Screening Adults	95%	**99.52%**	**99.67%**	**99.79%**	99.89%
2a(a) MI-C	Request to Intake MI Children	62%	**61.77%**	**70.40%**	**71.10%**	79.21%
2a(b) MI-A	Request to Intake MI Adults	62%	**68.58%**	**70.92%**	**76.57%**	76.73%
2(c) DD-C	Request to Intake IDD Children	62%	**75.44%**	**78.79%**	**81.90%**	84.62%
2a(d) DD-A	Request to Intake IDD Adults	62%	**84.85%**	**50.00%**	**78.00%**	77.05%
2a Overall	**RFS to Intake within 14 days - All subcategories**	**62%**	**67.17%**	**70.79%**	**75.31%**	**77.82%**
2e	Request to Service SA	68.2%	**59.09%**	**66.64%**	**72.25%**	n/a
3a(a) MI-C	First Service MI Children	72.9%	**54.91%**	**61.36%**	**62.90%**	60.41%
3a(b) MI-A	First Service MI Adults	72.9%	**56.98%**	**63.58%**	**57.59%**	59.76%
3(c) DD-C	First Service IDD Children	72.9%	**46.28%**	**45.10%**	**45.30%**	55.12%
3a(d) DD-A	First Service IDD Adults	72.9%	**91.18%**	**71.79%**	**73.33%**	66.04%
3 Overall	**BPS Assessment to First Service within 14 days - All subcategories**	**72.9%**	**56.28%**	**62.06%**	**58.67%**	**59.80%**
4a(a)	IP Follow Up Children	95%	**96.20%**	**96.63%**	**98.57%**	98.44%
4a(b)	IP Follow Up Adults	95%	**96.62%**	**97.16%**	**98.89%**	95.75%
4b	Detox Follow Up	95%	**100.00%**	**96.33%**	**95.00%**	99.22%
10a	IP Recidivism Children	<15%	**7.89%**	**10.00%**	**11.21%**	6.80%
10b	IP Recidivism Adults	<15%	**12.59%**	**11.91%**	**16.32%**	11.03%

*Indicator 2e is calculated by MDHHS and Q4 outcomes are not available until the MMBPIS Consultative Draft is released.

SWMBH Quarterly Performance MMBPIS Indicator 2a
First Ongoing Service Completed within 14 days of Request for Service



SWMBH Quarterly Performance: MMBPIS Indicator 2e
First SUD Service Completed within 14 days of Request for Service



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 beneficiaries 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

In FY24 there were 2 Performance Improvement Projects that SWMBH targeted for progress. Those PIPs include:

1. Clinical: Reduce racial disparities in follow-up after Emergency Department (ED) visits for alcohol and drug use (AOD).
2. Non-Clinical: Improve access and timeliness of new persons starting a service by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children (MMBPIS Indicator 3).

Performance Improvement Project #1 (Clinical)– Reduce racial disparities in follow-up after ED visits for alcohol and other drug use (AOD).

Topic Selection and Historical Results

MDHHS 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 MMBPIS), and the Centers for Medicare and 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)). At the end of the analysis, SWMBH found clinically and statistically significant disparities in outcomes in the FUA-30 metric between the White and African American/Black beneficiaries. SWMBH reviewed the results with SUD providers in the region, and with clinical, substance use network, and quality leadership at SWMBH. In those discussions SWMBH obtained support for the project's focus, to reduce African American/Black disparities in follow-up after ED visits 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 beneficiary rates of follow up after ED visits for alcohol and other drug use, from baseline to remeasurement 1, without a corresponding decrease in White beneficiary 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 beneficiaries and African American/Black beneficiaries 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 SWMBH 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 2021 baseline rate of 30-day follow up after ED visits for alcohol and other drug abuse or dependence was 14.53% for African American/Black beneficiaries, compared to a rate of 23.39% for White beneficiaries. Using a chi-square test of independence, White beneficiaries were found to be significantly more likely than African American/Black beneficiaries 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.

Remeasurement 1 Results

SWMBH FUA-30 Rates by Major Racial/Ethnic Groups		Numerator	Denominator	Percent
Calendar Year 2023 (Remeasurement 1)	ALL RACES AND ETHNICITIES	621	1,631	38.07
	AFRICAN AMERICAN/BLACK	96	372	25.81
	HISPANIC	31	75	41.33
	WHITE	464	1,088	42.65

There were increases in the rates of ED follow up in 2023 (remeasurement 1) compared to 2021 (the project's baseline), with an overall follow up rate of 38.07% in 2023 compared to 20.97% in 2021. However, the statistically significant disparity between the African American/Black and White populations remained, with an African American/Black population rate of 25.81% compared to 42.65% for the White population. A chi-square test of independence resulted in a p value < 0.0001 (X^2 (1, N = 1460) = 32.54). This difference is significant at $p <$ .05. The increases in follow up rates can be attributed to increased attention to the metric and new interventions put in place in 2022 and 2023 by both behavioral health providers and hospitals. Unfortunately, this did not correspond with a decrease in disparities.

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 ensures that SWMBH receives credit for these follow-up services and allows for easier monitoring and identification of issues (like access or network capacity difficulties). In FY24, peer ED substance use follow-up services became available in Van Buren County. SWMBH has also met with ED and physician staff in the largest counties to share FUA health equity data and to discuss potential improvements.

SWMBH has had a Health Equity Grant Coordinator on staff since 2023. In FY24, this individual facilitated six focus groups with regional CMH staff to understand local drivers of inequity in behavioral health services and to address gaps in service access. These discussions are on-going and will result in county-specific action plans to address identified gaps in access to care. SWMBH also coordinates an anti-stigma campaign with radio and internet ads and billboards, to de-stigmatize mental health and substance use treatment in non-white populations. In FY24, streaming audio from SWMBH's anti-stigma campaign reached at least 20,000 unique users and videos reached at least 40,000 unique users each quarter. In FY24, SWMBH held ten online provider trainings and one in-person symposium to increase awareness of healthcare disparities, biases, and stigma.

Barriers to successful interventions have included difficulty hiring for the peer ED outreach position in Van Buren County, and challenges with 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 a beneficiary 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 evaluates the effectiveness of the interventions using Plan-Do-Study-Act (PDSA) cycles. For the first major intervention, peer follow up services, SWMBH monitors the racial/ethnic distribution of peer contacts, and the proportion of peer services reported as encounters. In FY24, SWMBH did not meet the goal of the racial/ethnic distribution of peer ED follow up contacts matching the racial/ethnic distribution of the FUA population. SWMBH did meet the goal of increasing the proportion of Project ASSERT (Alcohol and Substance Abuse Services, Education and Referral to Treatment) contacts reported as encounters.

For provider trainings, SWMBH uses evaluations and attendance to assess impact. In FY24, SWMBH met the goals of: 1) at least 75% of training participants agreeing that the trainings provided knowledge and tools to reduce healthcare disparities, 2) that each online training would have at least 25 participants, and 3) the symposium would have at least 75 participants.

For the marketing campaign, SWMBH monitors audio completion rate for streaming audio, and clickthrough rates for social media. In FY24, SWMBH met the goals of 1) streaming audio reaching at least 20,000 unique users quarterly with an audio completion rate of 95% or more, and 2) social media ads will reach at least 40,000 unique users quarterly with a clickthrough rate of at least 0.9%.

The training and marketing interventions have consistently reached their goals in reaching intended audiences and effectiveness of training but have not had a measurable impact on the study. The peer support interventions have faced challenges in staffing, receiving referrals (especially for the Black/African American population), and encounter reporting. Funding for this program has been reduced for FY25.

Planning and Initiation of Activities for Increasing or Sustaining Improvement

SWMBH has not yet achieved the improvements that were hoped to achieve with this project. 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 improvement can be achieved and sustained. In FY25, SWMBH will increase efforts to receive and follow up on referrals when beneficiaries present to the ED for SUD needs.

Performance Improvement Project #2 (Non-Clinical) – Improve access and timeliness of new persons starting a service by four sub-populations: MI-adults, MI-children, I/DD-adults, and I/DD-children (MMBPIS Indicator 3).

Topic Selection and Implementation of Interventions

A new non-clinical PIP was chosen for FY24, to improve access and timeliness of new beneficiaries starting a service by four sub-populations: MI-adults, MI-children, I/DD-adults, and I/DD-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 of the great impact on the quality of services for those new to services. As described in Section A, SWMBH tracked and monitored data for all 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 each quarter had not improved regional performance as indicator 3 remained below the state benchmark of 72.9%. The goal for improving MMBPIS indicator 3 is to expand access and timeliness of services with new persons starting a service with four subpopulations: MI-adults, MI-children, I/DD-adults, and I/DD-children.

Measurement of Performance Using Objective Quality Indicators and Baseline Results

In FY24, SWMBH and its provider network worked to increase the percentage of new beneficiary 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 was collected from each CMHSP monthly. SWMBH has a Clinical Quality Specialist dedicated to reviewing the MMBPIS data submissions to ensure they were complete and accurate per MMBPIS PIHP and CMHSP Code Book standards. The SWMBH QM Department also completed primary source verification documentation during the annual CMHSP Site Reviews.

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

In FY24, SWMBH conducted a survey will all regional CMHSPs to review the processes and flow of access to services and identify causal barriers contributing to the FY23 baseline of 56.78%. The survey indicated that barriers exist due to staffing shortages, the high frequency of beneficiary scheduling issues (beneficiary no shows, request for appointment outside of 14 days, rescheduled appointment, etc.), as these events are not excluded from the indicator. Beneficiaries seeking psychiatric or medication services only were affected by psychiatrist shortages and high no-show rates for psychiatric appointments as well. As suspected, the survey also identified variations between CMHSP intake to first on-going service processes and what each CMHSP counts as the initial biopsychosocial (BPS) assessment and the first service, which generated thoughtful discussion and clarification. CMHSPs that added pre-planning and peer support as same-day first service, as recommended by SWMBH, have shown improvements with indicator 3.

SWMBH utilized existing QMC meetings to routinely review indicator 3 outcomes and discuss the survey findings and causal barrier analysis with regional CMHSPs. In late FY24, the following recommendations were provided to CMHSPs by SWMBH in efforts to increase Indicator 3 to the MDHHS set benchmark:

- Complete the pre-planning meeting as first service (when appropriate).
- Reduce/simplify clinician workload with the use of technology (i.e., Eleos) or support staff.
- Consider the use of bachelor level staff if last completed assessment resulted in a diagnosis.
- Ensure multiple services occurring on the same day are captured in a reportable way, and ensure staff are appropriately trained on how to document those.
- Involve the use of peer supports to increase beneficiary engagement.
- Consider using nurses to complete health assessment or care coordination for pre-treatment planning for first service after the BPS assessment is completed.
- Consider use of contracted psychiatric services within the region when not available within individual CMHSP or when there are lengthy waits for psychiatric appointments.

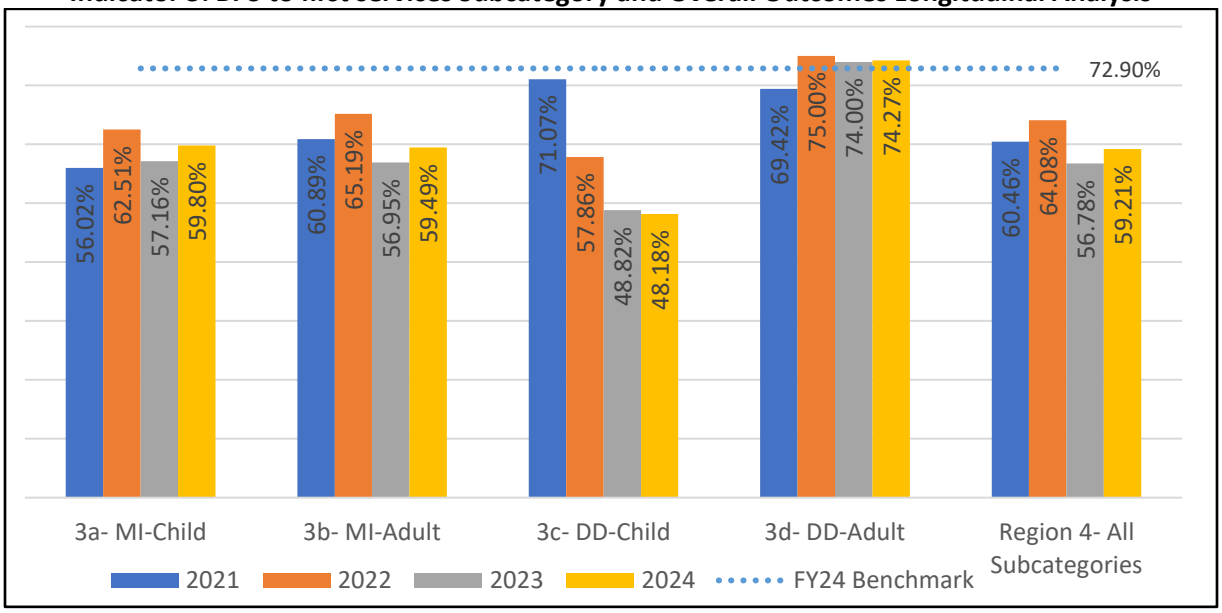
FY23 Indicator 3 Cumulative Outcomes by CMHSP and Subcategory (PIP Baseline)

	MIC	Served	%	MIA	Served	%	DDC	Served	%	DDA	Served	%	FY24 Den		FY24Q4 Overall
SWMBH	**2033**	**1162**	**57.16%**	**4355**	**2480**	**56.95%**	**508**	**248**	**48.82%**	**150**	**111**	**74.00%**	**7046**	**4001**	**56.78%**
Barry	170	129	75.88%	215	146	67.91%	23	14	60.87%	10	10	100.00%	418	299	71.53%
Berrien	384	205	53.39%	884	470	53.17%	167	64	38.32%	32	25	78.13%	1467	764	52.08%
Branch	226	133	58.85%	555	325	58.56%	25	25	100.00%	20	18	90.00%	826	501	60.65%
Calhoun	151	34	22.52%	437	192	43.94%	38	12	31.58%	14	3	21.43%	640	241	37.66%
Cass	124	76	61.29%	116	75	64.66%	43	21	48.84%	13	11	84.62%	296	183	61.82%
Kalamazoo	470	143	30.43%	1367	621	45.43%	141	60	42.55%	33	23	69.70%	2011	847	42.12%
St. Joe	368	349	94.84%	539	495	91.84%	33	31	93.94%	16	16	100.00%	956	891	93.20%
Van Buren	140	93	66.43%	242	156	64.46%	38	21	55.26%	12	5	41.67%	432	275	63.66%
Overall	**7046**	**4001**	**56.78%**												

FY24 Indicator 3 Cumulative Outcomes by CMHSP and Subcategory

	MIC	Served	%	MIA	Served	%	DDC	Served	%	DDA	Served	%	FY24 Den		FY24Q4 Overall
SWMBH	**2102**	**1257**	**59.80%**	**4772**	**2839**	**59.49%**	**467**	**225**	**48.18%**	**171**	**127**	**74.27%**	**7512**	**4448**	**59.21%**
Barry	164	146	89.02%	263	239	90.87%	24	19	79.17%	10	9	90.00%	461	413	89.59%
Berrien	371	173	46.63%	886	427	48.19%	138	23	16.67%	26	18	69.23%	1421	641	45.11%
Branch	210	104	49.52%	517	338	65.38%	30	22	73.33%	28	26	92.86%	785	490	62.42%
Calhoun	217	61	28.11%	515	213	41.36%	34	11	32.35%	24	5	20.83%	790	290	36.71%
Cass	94	59	62.77%	114	83	72.81%	32	26	81.25%	11	9	81.82%	251	177	70.52%
Kalamazoo	544	270	49.63%	1700	884	52.00%	149	73	48.99%	34	33	97.06%	2427	1260	51.92%
St. Joe	392	367	93.62%	562	501	89.15%	23	21	91.30%	18	17	94.44%	995	906	91.06%
Van Buren	110	77	70.00%	215	154	71.63%	37	30	81.08%	20	10	50.00%	382	271	70.94%
Overall	**7512**	**4448**	**59.21%**												

Indicator 3: BPS to first services Subcategory and Overall Outcomes Longitudinal Analysis



Analysis and FY25 Recommendations

Regional outcomes did not reach the 72.9% MDHHS benchmark for Indicator 3 as only 59.21% of adults/children received their first service within 14 days of their initial BPS assessment. However, regional outcomes indicated an increase over FY23's baseline performance in three of four population subcategories (I/DD- child subpopulation fell from 48.82% in FY23 to 45.59% in FY24). FY24 results indicate the potential for improvement within this subcategory, however, most of the CMHSPs have low denominators. Noted improvement in overall performance is expected to be slow due to the 90-day lag in reporting these quarterly outcomes to MDHHS, and the delay in seeing results following the implementation of interventions. This PIP will remain in place through FY25 and SWMBH will meet with each CMHSP with results below benchmark to review local barriers and processes, as well as strategies that may be used to drive further performance improvement in access and timeliness to services. Remeasurement will occur in FY25 though after which, MMBPIS will be sunset and SWMBH will transition to a new access to care measure which has yet to be defined by MDHHS.

FY24 Results

Goal	Where Progress was Monitored	Frequency of Monitoring	FY24	Eval Score	FY25 Recommendations
Performance Improvement Project #1 (Clinical) Reducing Racial Disparities in Follow-Up After Emergency Department Visits (ED) for Alcohol and Other Drug Use (AOD). Monitoring: Remeasurement 1 (2023) results will be available in June 2024. We will assess our performance on the following measures to determine whether we have met the PIP goal for 2023. 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.	Regional Clinical Practices Committee and Regional Quality Management Committee	Bi-Annual	Did not meet the FY24 goal of eliminating the disparity from 2021 to 2023.	**3**	The disparity between Black/African American and White beneficiary follow-up from ED for AOD rates did not change significantly from 2021 to 2023.
Performance Improvement Project #2 (Non-Clinical) Improve access and timeliness of new persons starting a service by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children (MMBPIS Indicator 3). Goals: ▪ Completion of a causal barrier analysis to evaluate factors contributing to the 2023 baseline of 56.78%. ▪ Development and implementation of interventions to address the barriers. ▪ Improve access to meet the MDHHS benchmark of 72.9%.	Regional Clinical Practices Committee and Regional Quality Management Committee	Annually and Quarterly	Partially Met	**2**	Goal was partially met as the causal barrier analysis completed and interventions were implemented in FY24. However, the FY24 overall Indicator 3 rate measures below 72.9% benchmark, at 59.21%. This was an improvement from FY23, and the PIP will continue in FY25.

C. Critical Incident, Sentinel Event, and Risk Event Management

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 Incident Event Reporting and Monitoring. The five reportable critical incidents for beneficiaries 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 or was due to a fall.

CMHSP Process

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. Risk Event data is made available to MDHHS upon request. 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.

SWMBH requires that CMHSPs notify SWMBH within 36 hours of an immediate event that is "newsworthy" and/or subject of a recipient right, licensing, and/or police investigation. SWMBH reports those events to MDHHS within 48 hours of PIHP notification 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.

The CMHSPs 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 (RCA) 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. 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 beneficiaries 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 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.

SUD Residential Treatment Provider Process

SWMBH holds contracts with SUD residential treatment providers for the region. SWMBH delegates the responsibility of the process for the identification, review, and follow-up of SUD SEs to those providers. If an SUD SE occurs, the provider is required to notify SWMBH of the incident immediately. SWMBH then reports those events to MDHHS within 24 hours of via by email to mdhhs-bhdda-contracts-mgmt@michigan.gov and additionally reports the SE in the BH CRM.

FY24 Identified Barriers

One barrier that was identified in FY23 and continued in FY24 is related to requesting and obtaining death certificates to determine the cause of death for accurate reporting and the 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 three incidents because detailed information is not available and the CMHSP has been unable to be obtain the death certificate. Another barrier that was identified at the end of the fiscal year was only 2 CMHSPs had reported any EMT incidents. Discussion occurred in the regional QMC meeting, and it was identified that CMHSPs had varying definitions of “injury” and needed clarification on the reporting requirements of EMT. Clarification was provided for both and SWMBH expects to see an increase in reported incidents in FY25. An additional barrier in FY24 was that obtaining guidance and answers to questions from MDHHS was very difficult. A Critical Incident PIHP Leads meeting was developed at the end of FY24 which is expected to help facilitate communication and act as an avenue to ask questions moving forward.

Improvement Efforts Made in FY24

SWMBH sought guidance from MDHHS where there were questions or when expectations were unclear in FY24 and then provided clarification and direction to the CMHSPs throughout the fiscal year related to incident and event reporting. MDHHS updated their Critical Incident, Event Notification, and SUD Sentinel Event Reporting Requirements policy at the end of FY24 and added the reporting of incidents and events for individuals on the 1915 iSPA, and SWMBH responded by updating the reporting template for CMHSPs to utilize. Additional training will be provided to CMHSPs and SUD providers in FY25, based on the MDHHS policy changes. SWMBH also continues to work on automating parts of incident reporting from the CMHSP PCE EHR system and hopes to go live with that process for all CMHSPs utilizing the PCE critical incident module in FY25.

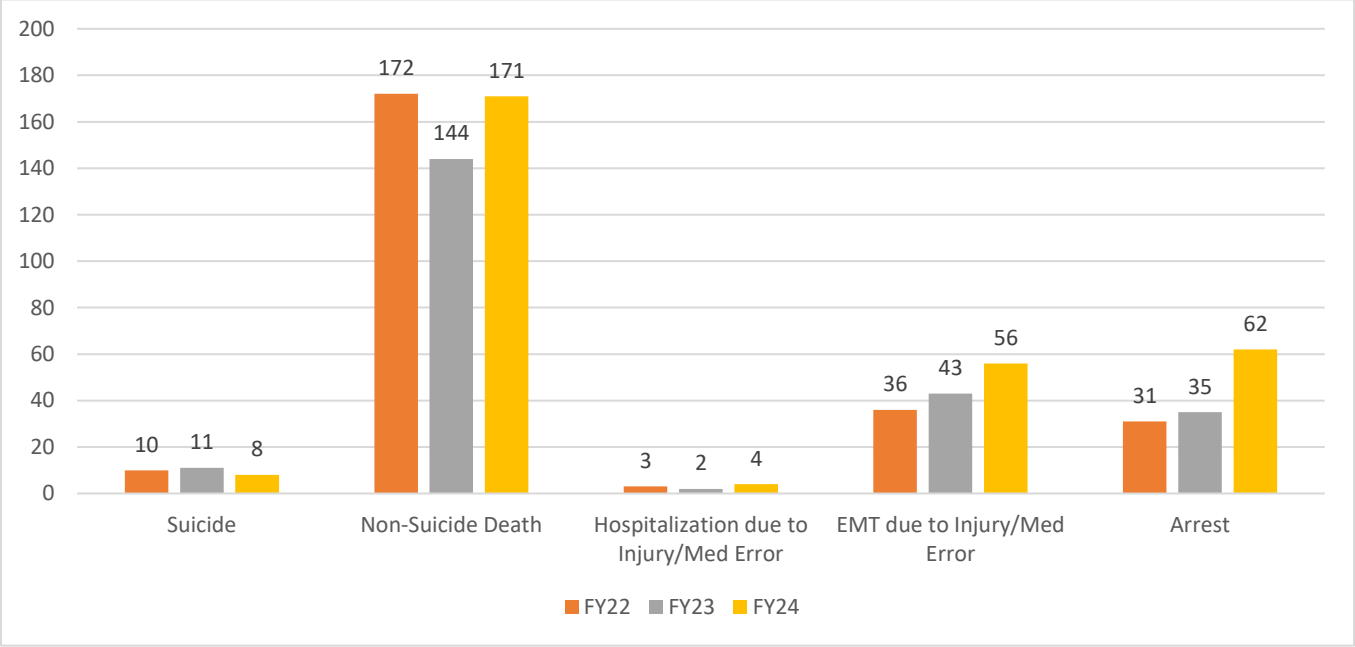
FY24 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY23	FY24	Eval Score	FY25 Recommendations
SWMBH will submit any SUD Sentinel Event that occurs at a contracted residential treatment provider in the new CRM when the SE occurs.	Through submission to MDHHS in the new CRM	As SEs Occur	None to Report	None to Report	N/A	No SUD Sentinel Events were reported in FY24. The process for reporting and the goal will remain the same for FY25.
The rate for the region, per 1000 persons served, of suicide deaths will demonstrate a decrease from the previous year.	QMC	Quarterly	0.34	0.23	5	The goal met and will stay the same and be monitored through FY25.
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.	QMC	Quarterly	0.06	0.11	3	The goal was not met, but the rate did not increase significantly. The data will continue in FY25, but the goal will be discontinued. SWMBH expects to see an increase in hospitalizations with the addition of the 1915 iSPA reporting groups.
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.	QMC	Quarterly	1.33	1.59	2	The goal was not met. The data will continue in FY25, but the goal will be discontinued. SWMBH expects to see an increase in hospitalizations with the addition of the 1915 iSPA reporting groups and the clarification of reporting requirements.
The rate for the region, per 1000 persons served, of individuals who are arrested will demonstrate a decrease from the previous year.	QMC	Quarterly	1.08	1.77	2	The goal was not met. The data will continue in FY25, but the goal will be discontinued. SWMBH expects to see an increase in hospitalizations with the addition of the 1915 iSPA reporting groups.
The rate for the region, per 1000 persons served, of individuals who caused harm to themselves (risk event codes B9, B10, and B11) will demonstrate a decrease from the previous year.	QMC	Quarterly	B9- 0.65 B10- 3.39 B11- 0.56	B9- 0.60 B10- 5.81 B11- 0.77	3	A decrease was seen in self-harm resulting in injury, but an increase was seen in suicide threats and attempts. The data will continue in FY25, but the goal will be discontinued.
The rate for the region, per 1000 persons served, of individuals who caused harm to others (risk event codes B3, B4, B5, and B6) will demonstrate a decrease from the previous year.	QMC	Quarterly	B3- 0.83 B4- 1.70 B5- 0.00 B6- 0.92	B3- 0.20 B4- 1.62 B5- 0.03 B6- 0.63	4	Decreases were seen in physical aggression resulting in injury, homicide threats, and inappropriate sexual conduct. An increase was seen with 1 homicide attempt. The data will continue in FY25, but the goal will be discontinued.

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

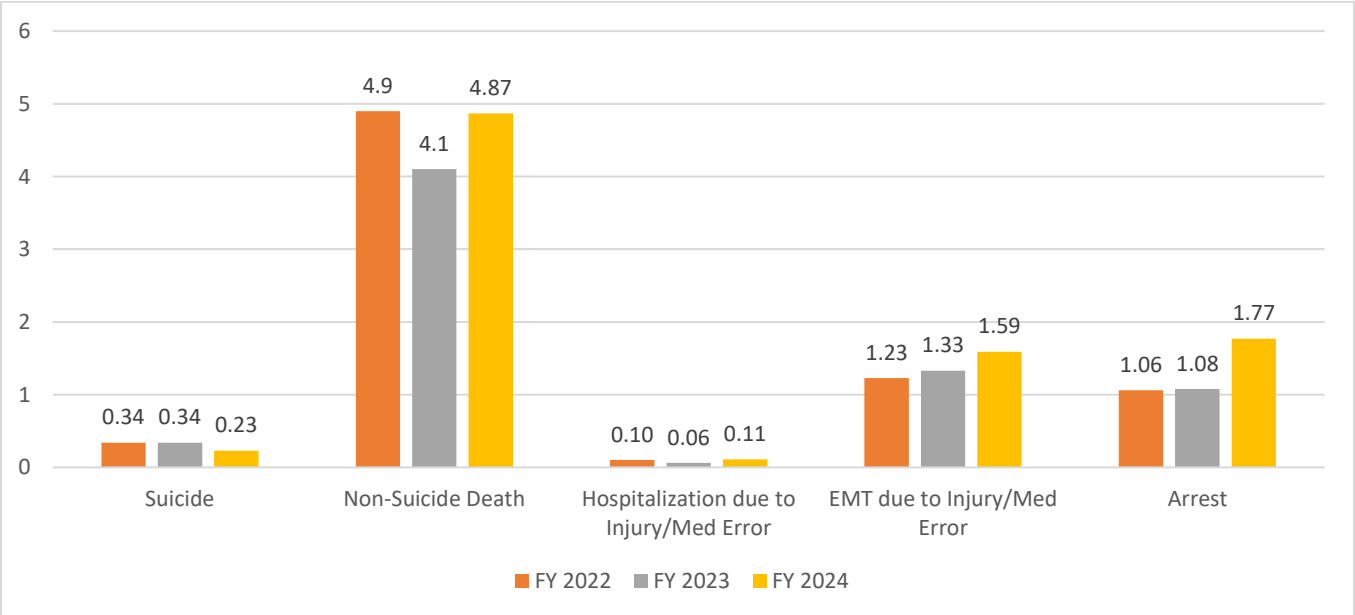
The graphs do not include incidents of Unknown Cause of Death.

Critical Incidents by Category by Fiscal Year



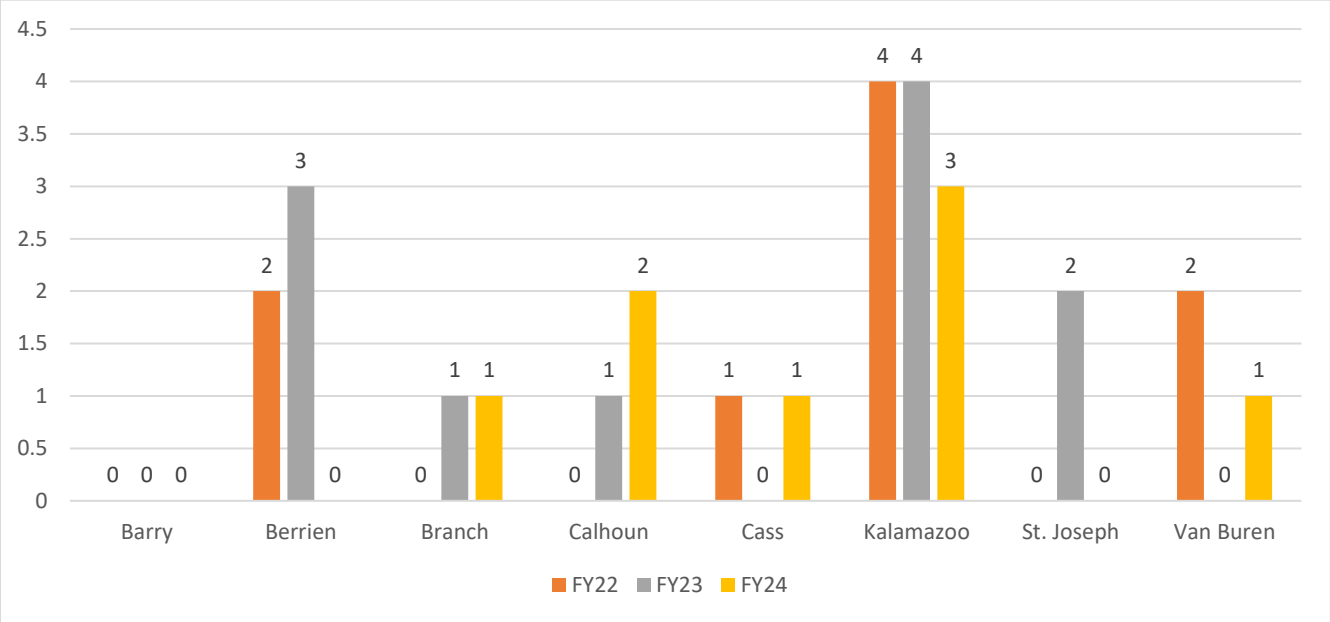
There was one injury resulting from physical management in FY24.

Critical Incidents Per 1,000 Served by Type FY24

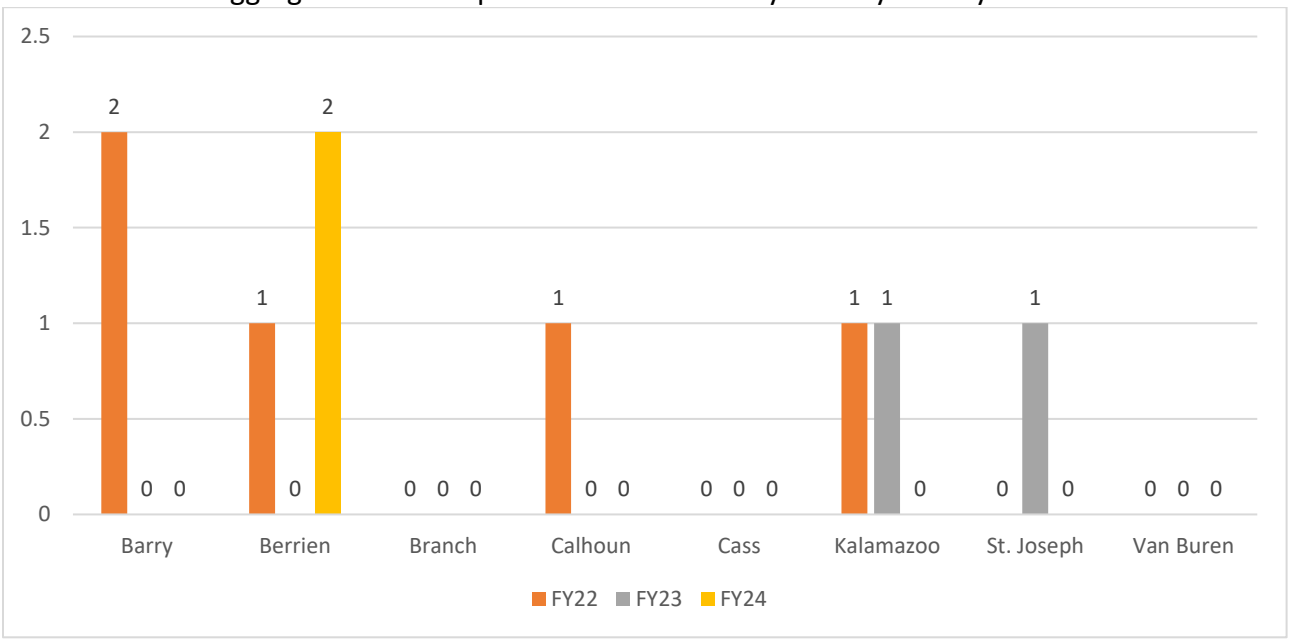


Aggregation of Unexpected Death Mortality Data (Sentinel Events)

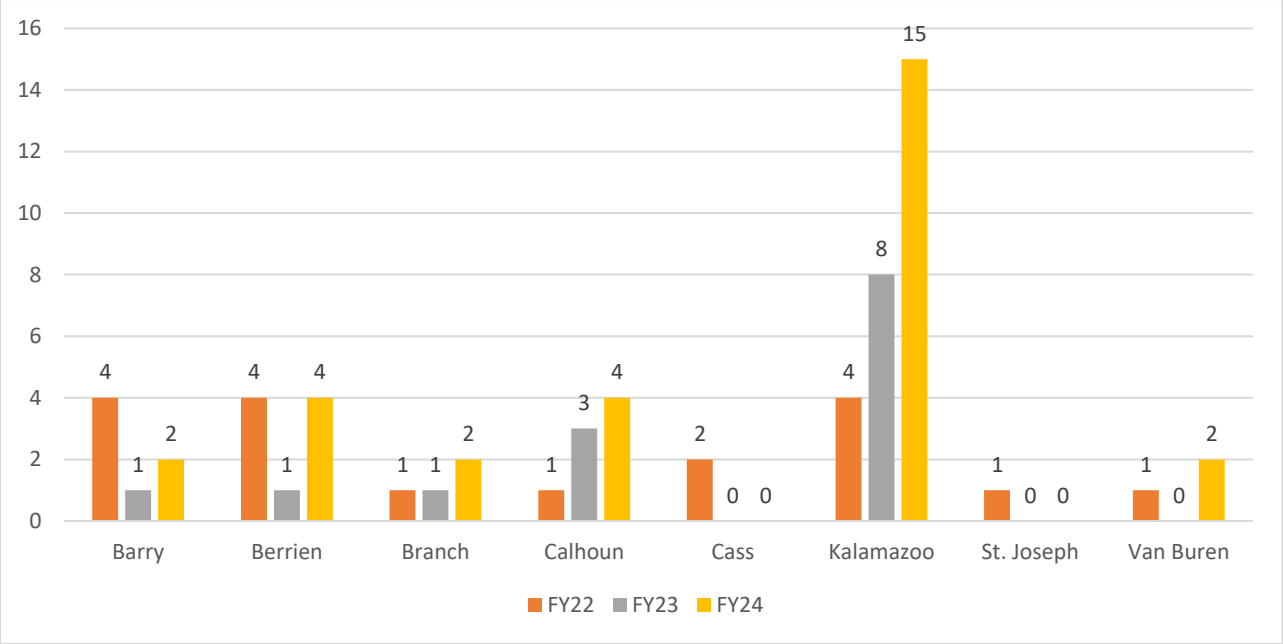
FY24 Aggregation of Unexpected Death Mortality Data by County - Suicides



FY24 Aggregation of Unexpected Death Mortality Data by County - Homicides



FY24 Aggregation of Unexpected Death Mortality Data - Accidental



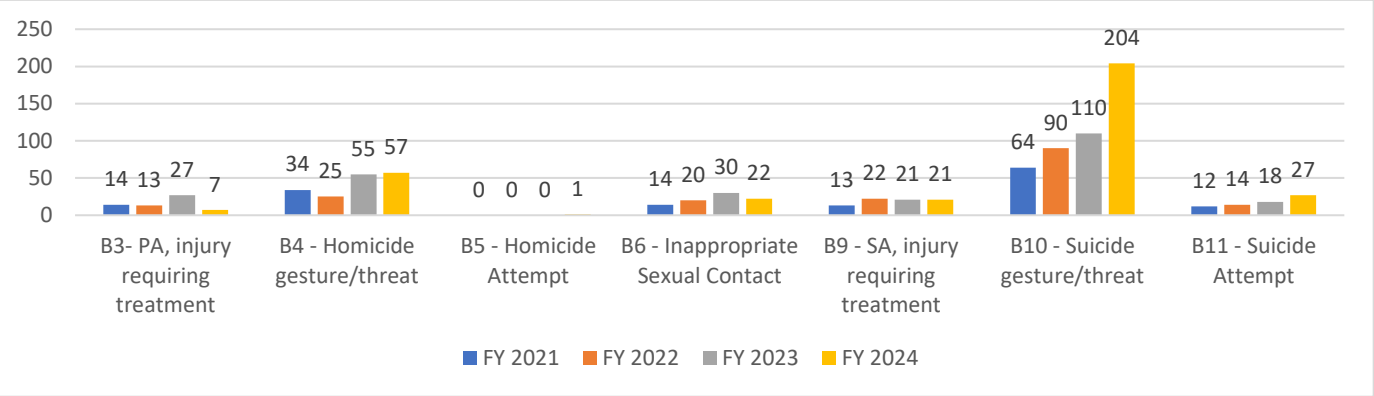
Unexpected Deaths Data by Category

COD	FY21	FY22	FY23	FY24
Overdose/Drug Related	4	9	8	16
Car Accident	2	3	0	1
Hit by Car/Train	2	2	1	3
Fire	1	0	0	1
Medical	0	2	4	6
Random Occurrence	0	0	1	0
Unknown	2	2	6	3

No unexpected deaths were reported in FY24 resulting from an undiagnosed condition or that were suspicious for possible abuse or neglect.

Risk Events (RE)

Risk Events That Caused Harm to Self or Others FY24



Risk Event Hospitalizations (Code H8)

The CMHSPs are delegated the responsibility of tracking and following up on beneficiaries 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 Holders follow up with the beneficiary, residential treatment provider, etc. SWMBH communicated with each CMHSP individually on a quarterly basis related to beneficiaries with multiple hospitalizations to determine why the beneficiaries were hospitalized and also to ensure appropriate follow up occurred following discharge. No patterns or improvement areas were identified in FY24.

SUD Residential Treatment Providers – Sentinel Events

No sentinel events occurred in FY24 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 critical incident data to QMC monthly and reviewed unexpected deaths, sentinel events, and risk events at least quarterly. The qualitative discussion of the trends and RCAs leads to improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes over time in the region. Some examples (not an exhaustive list) of the qualitative discussions from QMC meetings in FY24 included:

- Increase in Sentinel Event overdose deaths in the region- ideas presented to reduce ODs included updating informational brochures, providing safe use materials and supplies including test strips for testing Fentanyl to ensure it is not mixed with other substances, increasing access to Narcan, and ensuring that emergency contacts are identified (with beneficiary permission) to allow the CMHSPs to reach out if an individual stops engaging in services or has a sudden change. Improving communication with SWMBH if a beneficiary leaves SUD treatment or discharges early would help the CMHSPs with follow up. There are also other county and state initiatives focused on reducing ODs.
- Increase in arrests- CMHSPs attribute the increase due to officers being more willing to arrest individuals and take them to jail with the reduction of COVID-19 restrictions.
- Increase in police shooting deaths- CMHSPs discussed the programs and efforts to further develop partnerships with local law enforcement agencies, provide training, and assist with crisis situations.
- Trend of SEs resulting after beneficiaries no show and disconnect from services- focus has been placed on ensuring next appointments are scheduled and utilizing automated follow up after no shows.
- Increase in reported suicide gesture/threat and suicide attempt risk events- discussion was had around how risk events are coded and needing to ensure it is being done consistently. This will be an area of focus in FY25. SWMBH has also asked MDHHS for definitions and guidance on the coding of risk events to ensure incidents are coded similarly across CMHSPs.

D. Behavioral Treatment Review

Description

MDHHS requires data to be collected based on the definitions and requirements 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). Each CMHSP is also required to submit their BTRC data to SWMBH quarterly, which is made available to MDHHS upon request. SWMBH analyzes data related to intrusive and restrictive techniques, physical management, and/or incidents resulting in 911 calls for emergency behavioral situations to identify and address any trends or opportunities for improvement. 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. Based on the analysis, SWMBH requests the behavior treatment plans (BTPs) 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, etc. During the annual CMHSP Site Reviews SWMBH completes an audit of the data and a sample of BTPs to ensure accurate reporting and adherence to the Behavior Treatment Review Standards by each CMHSP.

FY24 Identified Barriers

SWMBH identified gaps in understanding of the requirements and the impacts of that to the BTRC process in FY24. SWMBH worked collaboratively with the CMHSPs to train staff on the expectations for collection and submission of the data. Changes to the technical requirements and billing codes have been a recent challenge for the CMHSPs. MDHHS no longer allows Licensed Master Social Workers and Licensed Professional Counselors to complete a functional behavior assessment which has left gaps in service as the CMHSPs are trying to navigate the shifting of duties in their agencies. Some CMHSPs are needing to find outside providers to assist while others are attempting to hire new staff while also remaining in their budget. A change in MDHHS's guidance regarding HCBS elements needing to be captured in an IPOS has been a system change and challenge for the region as well. New training for case managers on adding these elements to the IPOS has been a work in progress and SWMBH has been providing technical assistance to CMHSPs on how to meet the HCBS requirements.

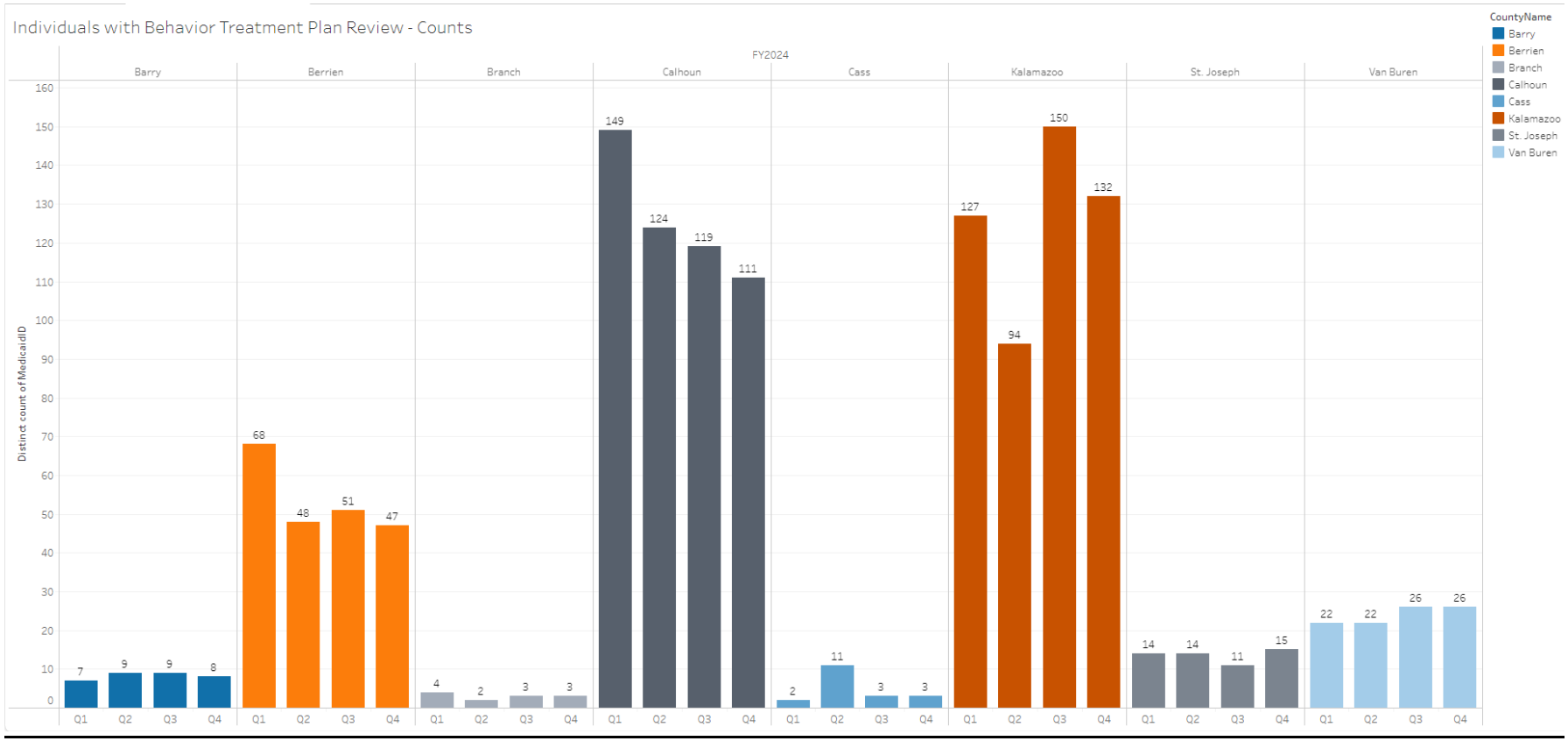
Improvement Efforts Made in FY24

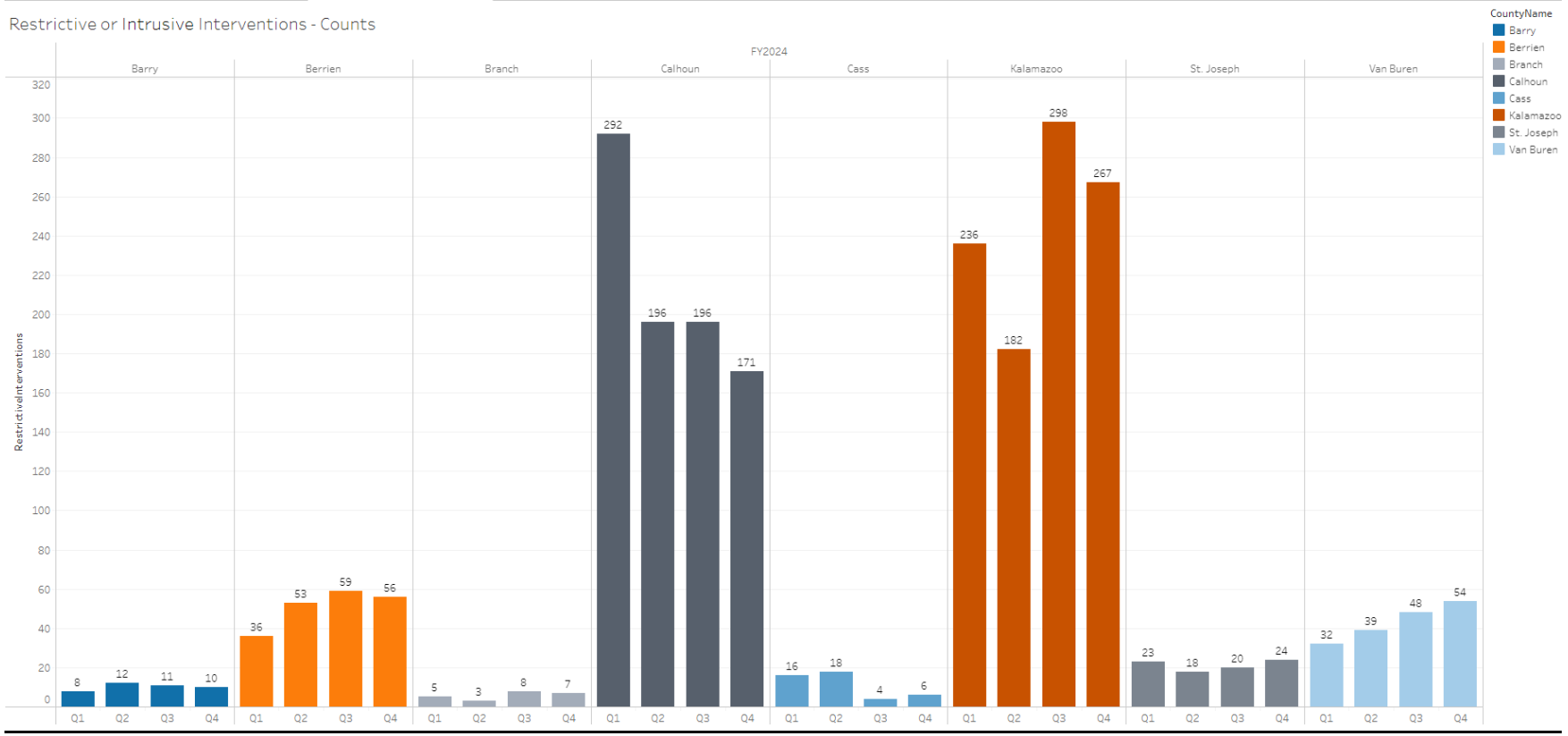
SWMBH provided data driven guidance to each CMHSP throughout FY24. One of SWMBH's Clinical Quality Specialists is charged with ensuring accurate and complete collection and analysis of the data trends for the purpose of quality improvement. A BTRC Workgroup was formed in FY23 to collaboratively update the behavior treatment plan monitoring process within the region. In FY24, the Workgroup analyzed data trends within each CMHSP, streamlined tracking documentation, and produced a new behavior treatment monitoring process. A new BTC Meeting Minutes form was developed and distributed to the region for use. This helped create a systematic approach to ensure that all required data and information is being captured. The regional form also assisted with time management as many BTRCs were reviewing multiple forms per beneficiary during their meetings. SWMBH's data analysts created reports utilizing the quarterly data that is being collected and analyzed from each CMHSP. SWMBH began presenting the data during the QMC meetings to discuss trends and opportunities for improvement in FY24. The quantitative and qualitative discussion of the trends leads to improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes over time in the region. During the FY24 CMHSP Site Reviews SWMBH completed an audit of the data to ensure accurate reporting and adherence to the Behavior Treatment Review Standards by each CMHSP. This is now its own review process, separated from the clinical file review, to better ensure that each standard is being met and allow for more thorough oversight of each behavior treatment plan reviewed.

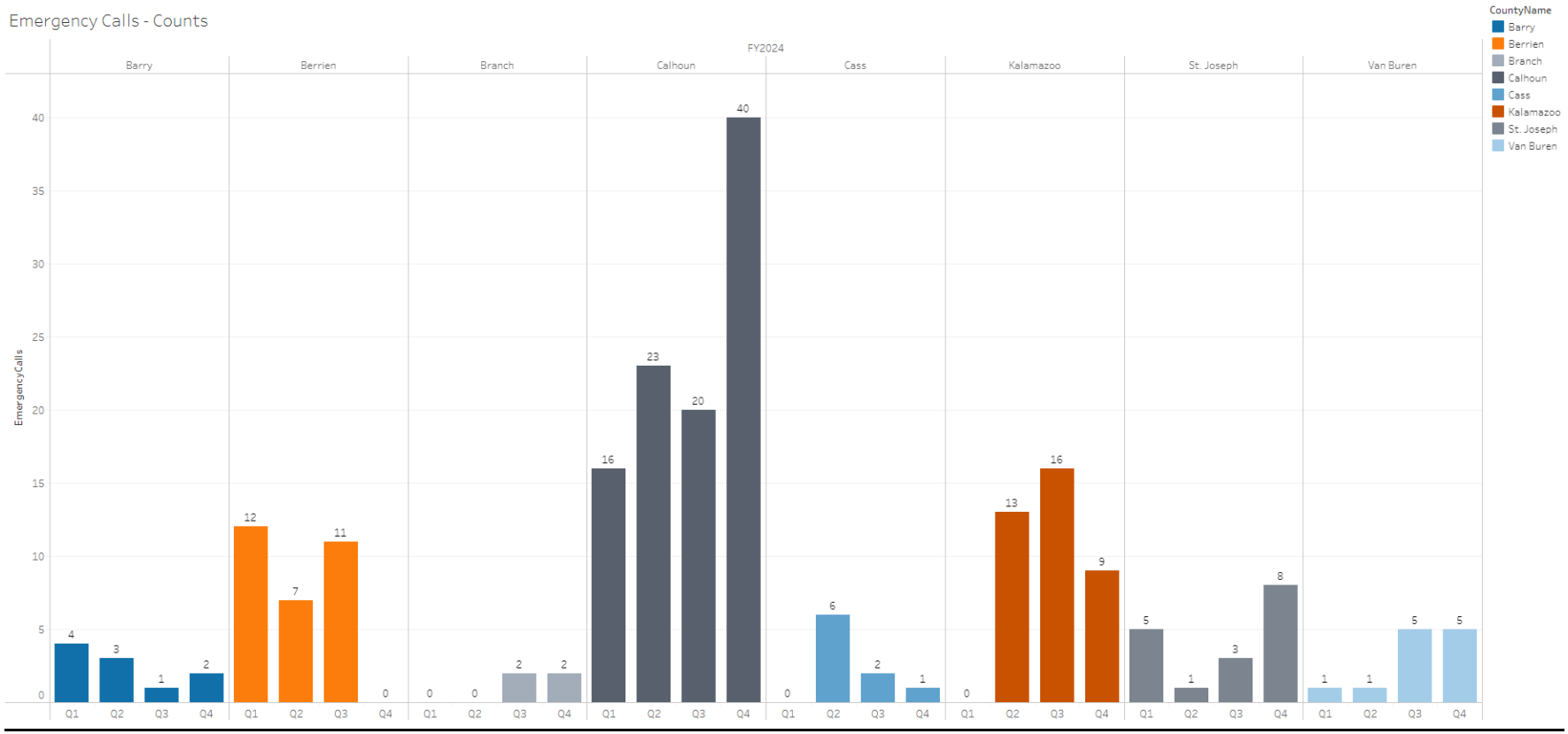
FY24 Results

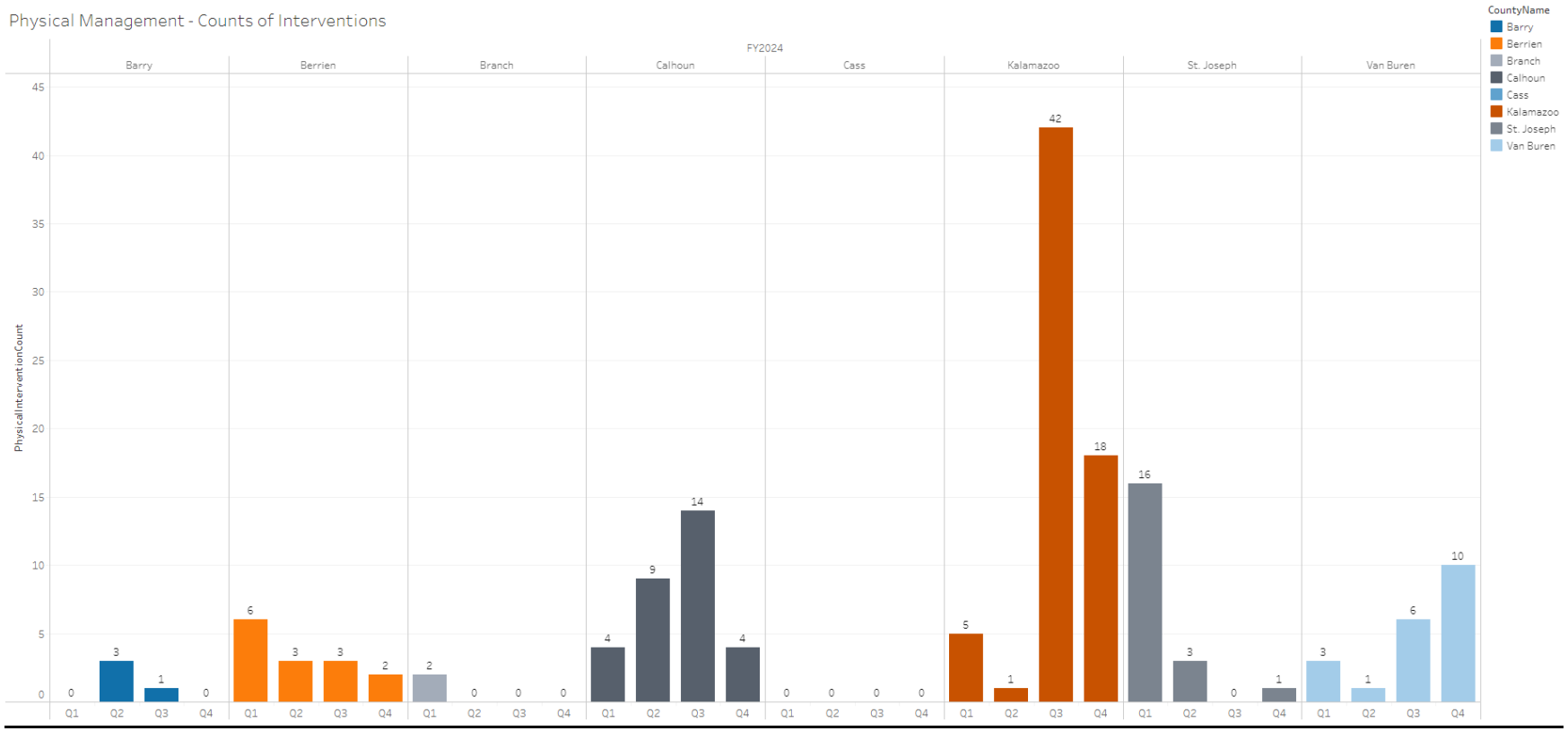
Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	Eval Score	FY25 Recommendations
SWMBH will complete a quality review of at least 6 behavior treatment plans per CMHSP for FY24.	RCP and QMC	Quarterly	Partially Met. A total of 58 behavior treatment plans were reviewed across the region but not at least 6 per CMHSP.	**3**	The goal will remain the same for FY25. SWMBH will continue to request behavior treatment plans for review based on trends or other identified questions or concerns.
The region will achieve 90% or higher on the Behavior Treatment Plan section of the annual CMHSP audit.	RCP and QMC	Annually	Not Met. Regional average score in the Behavior Treatment Planning Section was 85.74%	**3**	The goal will remain the same for FY25. SWMBH will continue to provide technical assistance to the region on low scoring areas and request CAPs as needed.
SWMBH will implement a regional strategy to evaluate the BTRC's effectiveness by Q4 of FY24.	RCP and QMC	Annually	The BTRC Workgroup worked on this initiative, however, this requirement was removed from the newest version of the technical requirements.	**N/A**	This goal will be discontinued as MDHHS indicated that this is no longer a requirement.

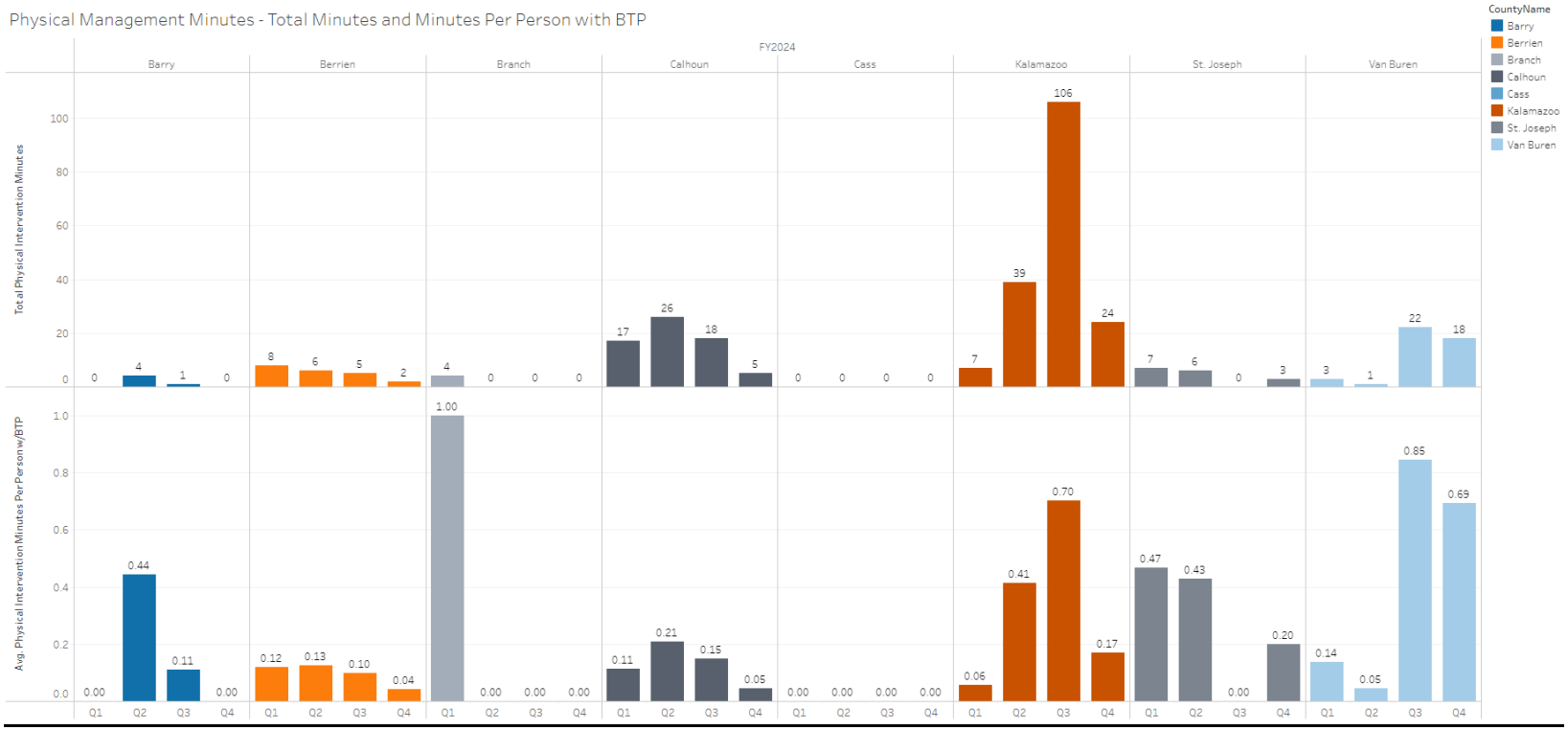
Quantitative Analysis of SWMBH's BTRC Data




Restrictive or Intrusive Interventions - Counts
FY2024
Barry
Berrien
Branch
Calhoun
Cass
Kalamazoo
St. Joseph
Van Buren
RestrictiveInterventions
0
20
40
60
80
100
120
140
160
180
200
220
240
260
280
300
320
Q1
Q2
Q3
Q4
8
12
11
10
36
53
59
56
5
3
8
7
292
196
196
171
16
18
4
6
236
182
298
267
23
18
20
24
32
39
48
54
CountyName
Barry
Berrien
Branch
Calhoun
Cass
Kalamazoo
St. Joseph
Van Buren


Emergency Calls - Counts
FY2024
Barry
Berrien
Branch
Calhoun
Cass
Kalamazoo
St. Joseph
Van Buren
EmergencyCalls
0
5
10
15
20
25
30
35
40
Q1
Q2
Q3
Q4
4
3
1
2
12
7
11
0
0
0
2
2
16
23
20
40
0
6
2
1
0
13
16
9
5
1
3
8
1
1
5
5
CountyName
Barry
Berrien
Branch
Calhoun
Cass
Kalamazoo
St. Joseph
Van Buren


Physical Management - Counts of Interventions
FY2024
Barry
Berrien
Branch
Calhoun
Cass
Kalamazoo
St. Joseph
Van Buren
PhysicalInterventionCount
CountyName
Barry
Berrien
Branch
Calhoun
Cass
Kalamazoo
St. Joseph
Van Buren
Q1
Q2
Q3
Q4



Qualitative Analysis of SWMBH's BTRC Data

SWMBH presented the analysis of the data to QMC monthly and identified regional trends and asked the CMHSPs to review the data at least quarterly. The qualitative discussion of the trends leads to improvements in the services for beneficiaries, service delivery, and the most appropriate interventions for beneficiaries. Some examples (not an exhaustive list) of the qualitative discussions from QMC meetings in FY24 included:

- Noting that some of the data from quarter 1 is incomplete due to a template reporting change occurred for quarter 2.
- Requested feedback on what the group would like to see and/or what additional information is requested.
- Trend of Individuals with a Behavior Treatment Plan – lower number of beneficiaries who have a behavior treatment plan for 4 out of 8 of our CMHSP's with 3 CMHSP's staying at the same count. With the requirement of including titration plans for current restrictions, we may see an even larger decrease in behavior treatment plans or total restrictions for beneficiaries in FY25.
- Trend in Emergency Calls (Count) – higher rates of 911 calls for 3 of the CMHSP's. The region did not provide discussion about why this occurred. The trend will continue to be monitored in FY25 and SWMBH will ask for additional information if the trend continues to try to identify causes and develop actions to address them.

E. Member Experience with Services – Customer Satisfaction Surveys

Description

During FY24 SWMBH contracted with Kiaer Research to administer the customer satisfaction surveys, utilizing revised versions of the Mental Health Statistics Improvement Program (MHSIP) and Youth Services Survey (YSS) as approved by MDHHS. Survey responses were collected throughout FY24 to meet the goal of achieving 2,100 completed surveys. Surveys were made accessible to beneficiaries via Quick Response (QR) codes and tablets available in CMHSP common areas, through the SWMBH and CMHSP websites and social media, or by paper copy. Additionally, each CMHSP provided SWMBH with a beneficiary sample with contact information. Kiaer Research sent the survey to these beneficiaries via email first, followed by Short Message Service (SMS) text. The survey's main objective was to collect beneficiary feedback on services and to identify sources of dissatisfaction. Mechanisms remained in place within the survey to capture responses inclusive of individuals receiving LTSS, case management services, Certified Community Behavioral Health Clinics (CCBHC) services, and other 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, beneficiaries, and other stakeholders, by sharing the survey results via the SWMBH website and within the provider and beneficiary newsletters. CMHSPs are provided individuals quantitative and qualitative (comments) results and are required to develop improvement plans, specific to the findings, results, and analysis from their locations for the purpose of systemic improvements. The SWMBH Customer Advisory Committee (CAC) is regularly consulted for feedback on the survey process and distribution methods.

FY24 Identified Barriers and Analysis

Overall, 2227 valid surveys were completed, resulting in the highest cumulative completion rate since 2014. Response rates for both MHSIP (Adult) and YSS (Youth) improved over FY23 rates. For both MHSIP and YSS, the percentage of surveys completed via email invitation went down compared to FY23 while those completed from SMS text increased; however, most surveys were completed via paper or QR code. The inability to consistently classify surveys as CCBHC/Non-CCBHC depending on the survey method remained this fiscal year. MHSIP results indicate that other than adults' Outcomes and Functioning, the difference in constructs from FY23 to FY24 were not statistically significant. MHSIP results indicated that for gender, male consumers reported higher scores than both groups (non-binary or transgender) in all contracts except Satisfaction and Quality Appropriateness, while nonbinary and transgender consumers reported lowest scores in Access and Social Connectedness. Statistically significant differences were seen in all constructs for LCBAP (lesbian, gay, bisexual, asexual or pansexual) consumers as their ratings were slightly worse than heterosexual/straight consumers. While FY24 YSS survey results did not reflect a statistically significant difference in overall satisfaction rates compared to FY23 results, satisfaction remained high. There were no major differences found in youth scores found between gender and sexual orientation. Demographics makeup for both 2024 MHSIP and YSS respondents compared to the year prior. Qualitative data was captured via robust respondent comments while quantitative data was captured via a numbered scale on the surveys in 2024.

Improvement Efforts Made in FY24

The survey implementation period shifted to better align with the fiscal year, allowing for more timely outcomes and analysis to stakeholders. To catch more urgent concerns and filter them to their CMHSPs, consumers were able to request follow-up directly within the survey. This allowed for better resolution of issues and quick referrals for respondents in crisis. To further enhance potential longitudinal analysis, questions were added to this year's survey that assigned anonymous IDs to track respondents' answers over time.

Additional demographic questions were available to capture the types of services participants received through their CMH, and further adjustments were made to capture employment status, sexual orientation and gender identity and primary living arrangements for both youth and adult participants, where appropriate. To increase YSS response rates, SWMBH offered either a guaranteed or lottery incentive to youth participants only. The perspective gained from this experiment was that providing a guaranteed incentive barely moved response rates compared to the lottery approach (10.2% to 9.3%) and with higher costs and minimal benefit, guaranteed incentives are not recommended for future surveys. CMHSPs were given access to real-time results for their participants via Alchemer.com, which allowed for more frequent review of outcomes and comments throughout the survey period. After review of FY23 survey outcomes, improving Social Connectedness remained a focus for almost all the CMHSPs in region 4. Over half of them included goals to improve customer engagement and communication by increasing consumer portal access and ways to communicate to providers within the portal, appointment reminders, and offering additional groups or peer services, for example. Further evaluation of the impact of activities implemented in FY24 will occur during early FY25 between SWMBH and each CMHSP. The quantitative and qualitative analysis and development of improvement plans based on the survey results leads to improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes over time in the region.

FY24 Results

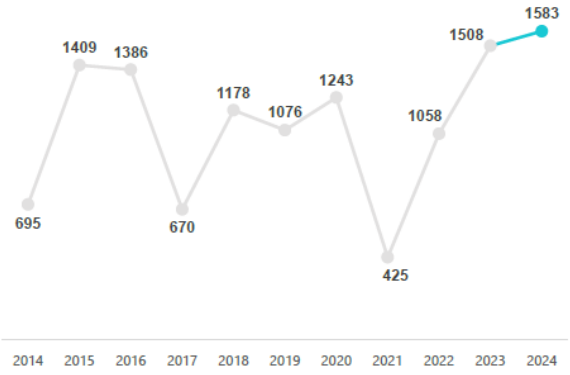
Goal	Where Progress Was Monitored	Frequency of Monitoring	FY23	FY24	Eval Score	Recommendations
Achieve at least 1500 completed MHSIP surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper.	QMC	Quarterly	1508 Completed Surveys	1583 Completed Surveys	**5**	This goal was met and will continue to be monitored in FY25.
Achieve at least 600 completed YSS surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper survey.	QMC	Quarterly	395 Completed Surveys	644 Completed Surveys	**5**	This goal was met and will continue to be monitored in FY25.
Evaluate the effects of activities implemented to improve satisfaction, from the previous year's recommendations.	QMC, RCP, and CAC	Annually	Met	Met	**4**	This process will continue in FY25 but will not be identified as a goal.
Ensure CMHSPs develop improvement plans specific to their survey findings/results/analysis.	QMC and CAC	Annually	Met	Met	**4**	This process will continue in FY25 but will not be identified as a goal.
Present and receive feedback from the SWMBH Beneficiary Advisory Committee on survey process, questions, content, and distribution plan.	QMC and CAC	Annually	Met	Met (Scheduled review in January 2025)	**5**	This goal was met, and the process will continue in FY25.

Survey Response Rates

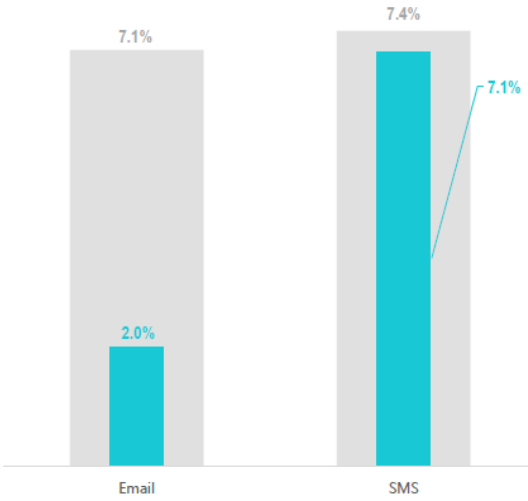
Highest number of responses ever recorded for 2024 MHSIP

Email response rate dropped 5 points to 2% in 2024, but SMS response rate held steady

MHSIP # of responses, 2014-2024

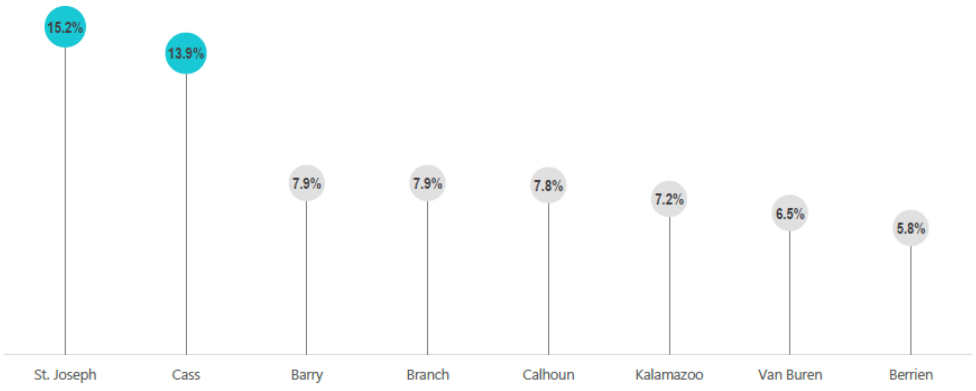


MHSIP response rate by medium
2023 vs. 2024



Pivotal's paper surveys nearly doubled their MHSIP response rate

In-office QR code, website link, and paper surveys accounted for 201 (12.7%) of total MHSIP responses. Pivotal submitted 160 of those 201 QR/paper surveys. Woodlands also saw a fairly high response rate relative to other CMHs.

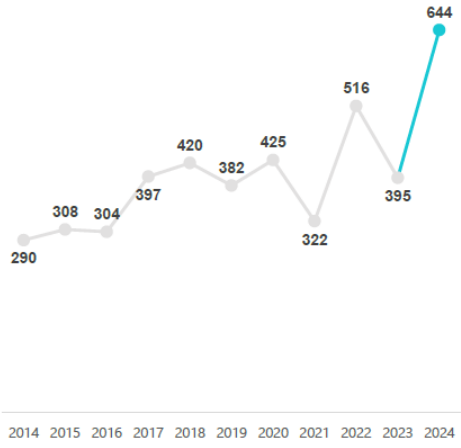


Response rate calculated as the number of completed MHSIP responses received divided by the number of contacts provided.

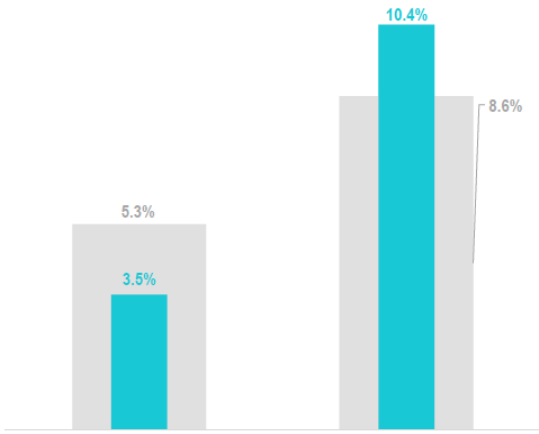
YSS number of responses hit highest ever recorded in 2024

Only 44 (6.8%) of total YSS responses came from in-office QR codes, paper surveys, and the website link.

YSS # of responses, 2014-2023

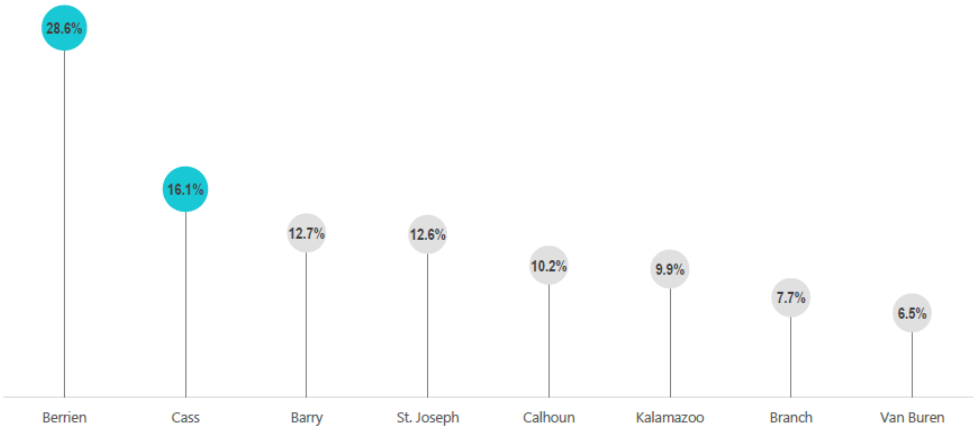


YSS response rate by medium
2023 vs. 2024



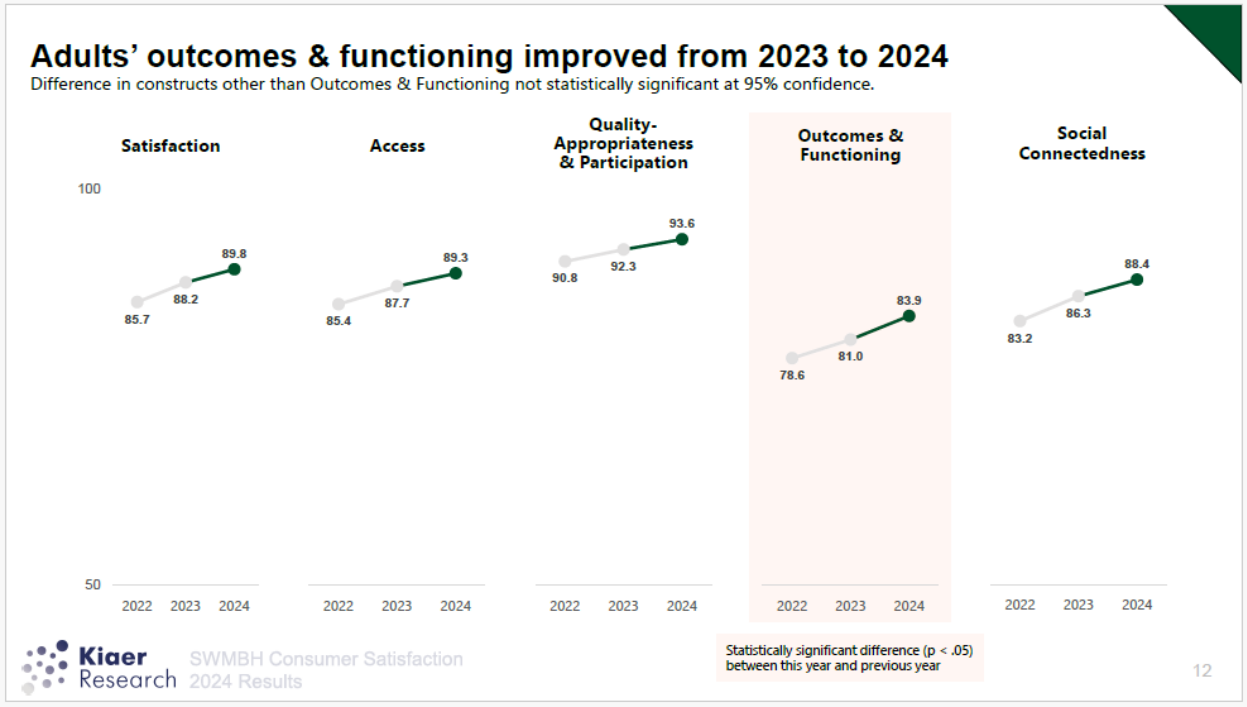
Riverwood had the highest YSS response rate by a fair margin

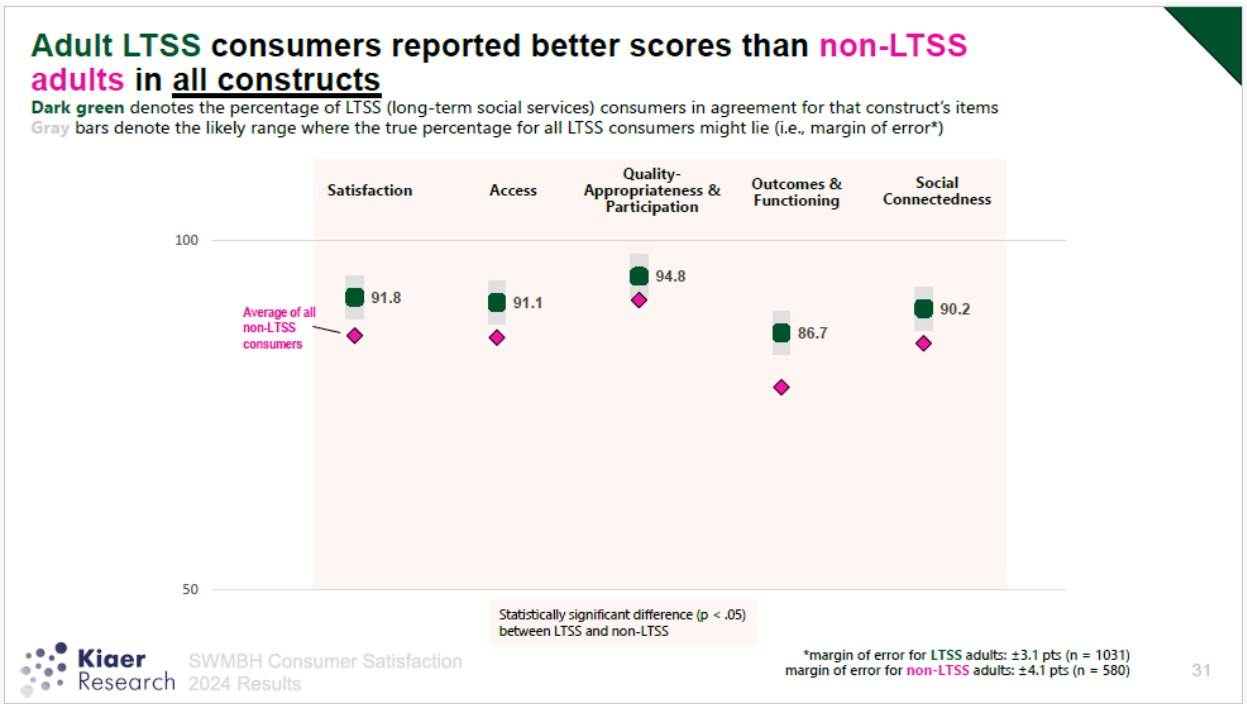
Woodlands also saw a relatively high response rate; Berrien and Cass had the two lowest number of YSS contacts provided (168 and 238 respectively), which may have increased their likelihood of responding to the survey



Response rate calculated as the number of completed YSS responses received divided by the number of contacts provided.

Adult Survey Scores by construct (MHSIP)





Opportunities for improvement in access to services, staff engagement with consumers,

Of MHSIP respondents who were *dissatisfied* with services, 5 major themes arose from qualitative feedback.

Access to services & continuity of care
45 comments

Lack of compassion & consumer-centered care
37 comments

Medication management issues
31 comments

Staff competency & turnover
26 comments

Lack of transparency & communication
19 comments

Consumers had life-changing accounts of benefit from their CMHSPs

"Seeing the people at Woodlands on a regular basis helped me be able to **set goals and manage my life** better. Even if I'm struggling I feel better knowing that **I have support if I need it** and **people I can trust** for advice."

"Helped me to be able to **live my life again**."

"It is good to have a check-in to remind me that **my life is improving**, even if it is bit by bit. **I'm extremely appreciative.**"

"I'm not being dramatic when I say this, but ISK **actually saved my life**…I can honestly say after nearly 3 decades, **my mental health hasn't been this under control** or handled like this before."

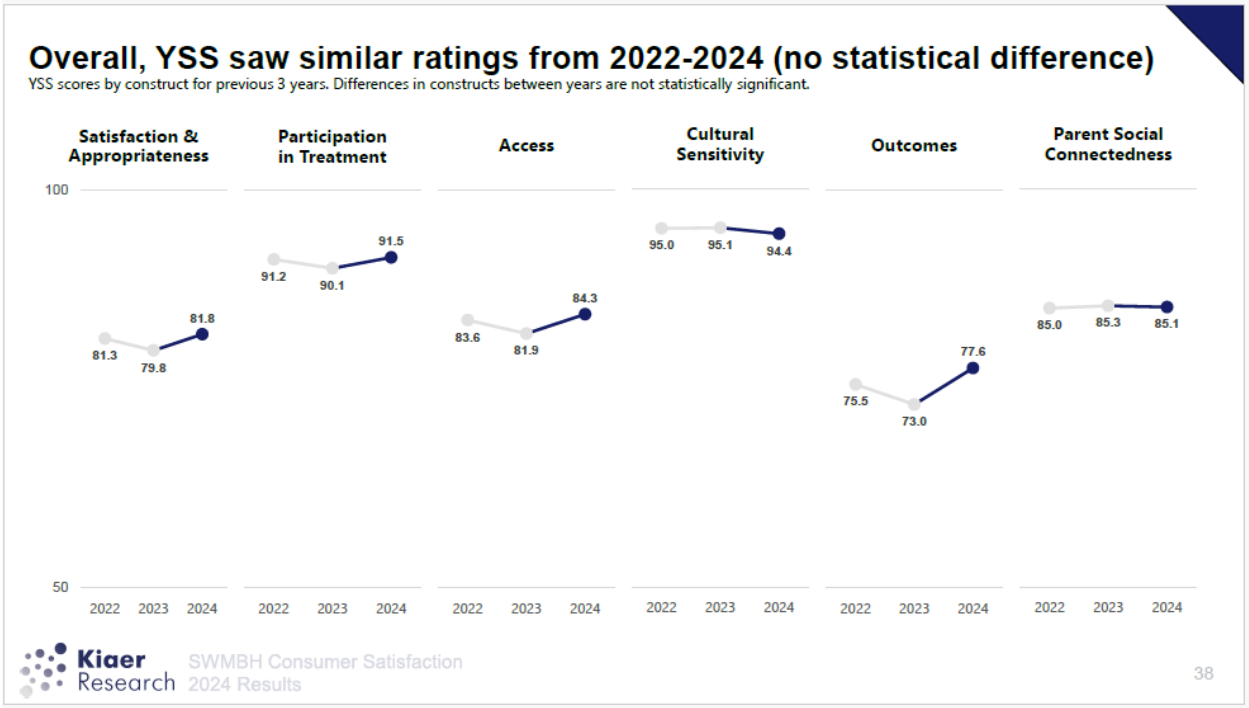
"The staff have helped me to **no longer be disabled** and to **live a normal life** working full time while continuing monthly treatment. I have been getting treatment for over 7 years and **plan to continue**."

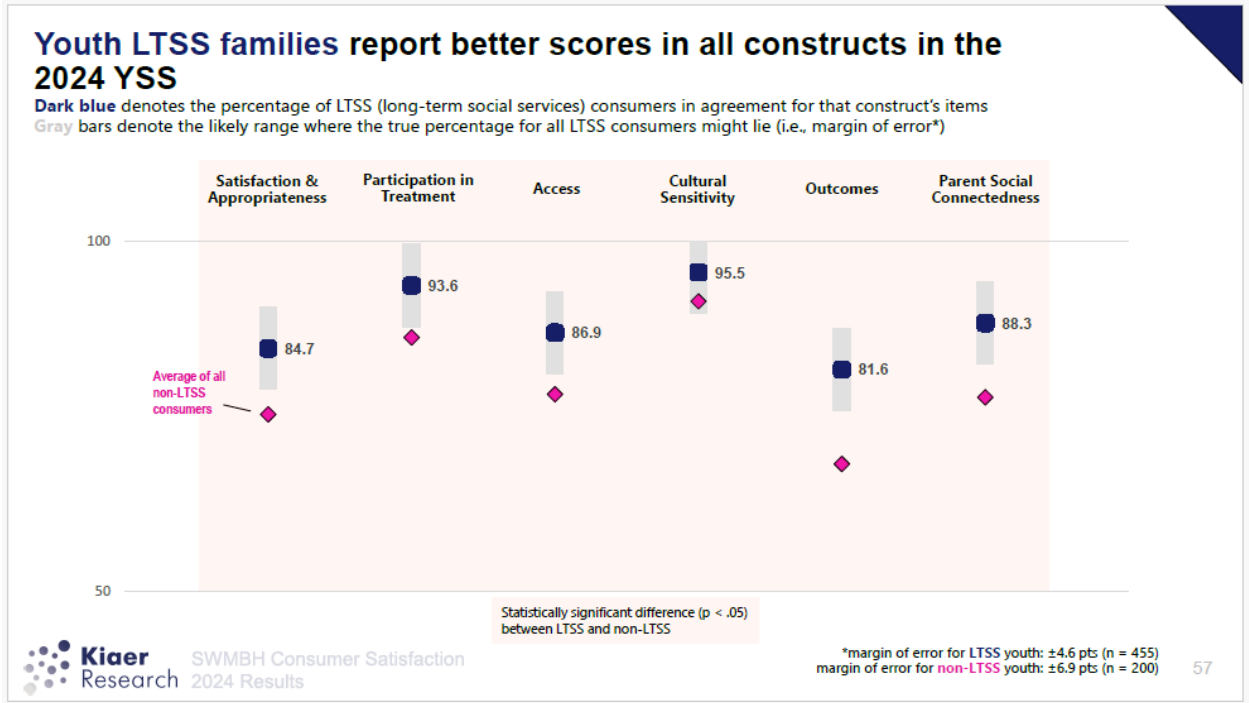
"I'm actually **accomplishing and achieving** my **name change goal** in my transgender journey."

"This has been a **life saving service**! They helped me realize I was in a DV situation and **supported me through the entire process** of getting myself and my children out of that situation... **literally saved our lives.**"

"My case manager is awesome. She has **helped me so much** in a short period of time. I now have **my own apartment**. I now have a **county ID card** and **Social Security card**. Those things are a big deal to me because I didn't have those things for a very very long time. **I would not have been able to do it without her**."

Youth Services Surveys by Construct (YSS)





Opportunities for improvement in access to services, staff engagement with consumers,

Of YSS respondents who were *dissatisfied* with services, 3 major themes arose from qualitative feedback.

Lack of reliable communication from staff
29 comments

Limited access to services
25 comments

Lack of specialized care/understanding of needs
18 comments

Positive highlights from the YSS comments section

"They really do research and **find things to help benefit you and your child's needs** they build a great relationship and **understand your kids needs and yours**. They **become family or a really great friend** to have along the way."

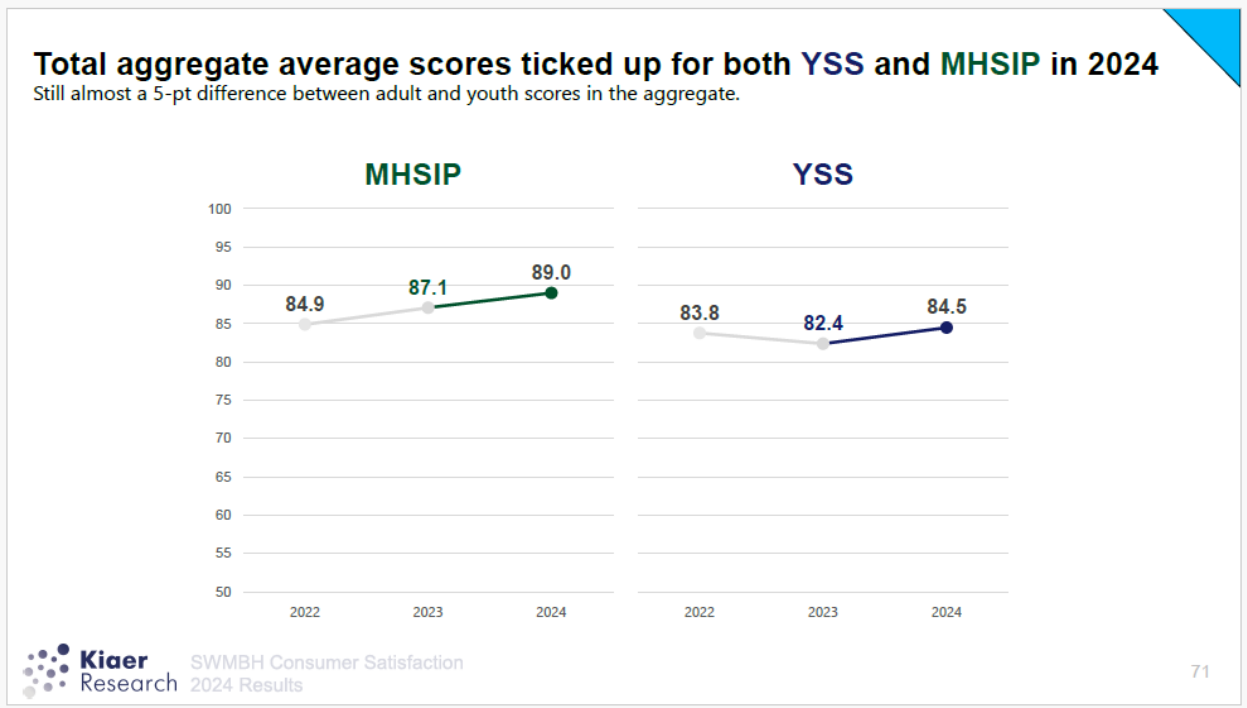
"With mental health there are many highs and lows. Our ISK "team" has been there to **support not just my daughter, but our family** through every step and **provided us the services that we never know existed** until they came into our lives. I'm **so thankful** for each and every one of them!"

"The councilor works around my work schedule and my child enjoys going now. My child knows if she is feeling like hurting herself **she can call Riverwood and someone will answer**. I'm **very grateful** for the staff and services that are provided. As a parent it's very hard to watch your child self harm and not know where to turn. Now **I'm less stressed and my daughter is doing amazing** it's like having my little girl back!"

"Our case manager is an absolute blessing. She **stood by our side** and **helped us fight the injustices** my son was experiencing in school. She helped guide me and was **present for every meeting**. She helped my son get into the right school so **he could thrive**."

"Our son is **coming back to the ray of light** he always has been, and **he's seeing himself that way** now too."

"The doctor is **amazing at talking to our child**. He always **includes him in the conversation** and **helps him understand** that this is a benefit having him on his meds. He is wonderful and that is **the reason we are still with Summit Pointe**."



F. Member Experience with Services – RSA-r Survey

Description

The Recovery Self-Assessment-revised (RSA-r) Survey was offered to Medicaid & Block Grant SUD beneficiaries to capture satisfaction with the services they receive from their current provider. Participation in the RSA-r survey through SWMBH is encouraged but optional for regional providers and some providers chose to not participate and to measure client satisfaction though alternative ways. The survey consisted of 32 questions and beneficiaries chose responses based on a 5-point Likert scale. The questions were grouped into to the following six categories: Life Goals, Involvement, Diversity of Treatment, Choice, Individually Tailored Services, and Inviting Spaces, the last being new to the FY24 analysis. The survey is designed to gauge the degree to which programs implement recovery-oriented practices and is a reflective tool for those in recovery to identify practices in their mental health and SUD services that improve or impede their recovery process.

FY24 Identified Barriers and Analysis

Survey participation continued to climb this year from 623 to 701 respondents, a 12% increase. For the second year in a row, the preferred survey method was completing the paper form (98%) and only 2% utilized Survey Monkey, which results in a large administrative lift for SWMBH to manually enter the surveys. Historically and in FY24, in-agreement calculations have included “Neutral/3” ratings, and this will be re-evaluated for the FY25 survey. Targeted areas of improvement based on FY23 results by some individual providers included Involvement and Diversity in Treatment. Mean scores for three of the five subcategories measured in FY23 decreased in FY24; however, only two were statistically significant—Diversity in Treatment and Individually Tailored Services. The Choice domain remains the highest scoring historically and had a significant increase in this domain in FY24. Two providers set goals to increase survey participation, and that was achieved for both.

Improvement Efforts Made in FY24

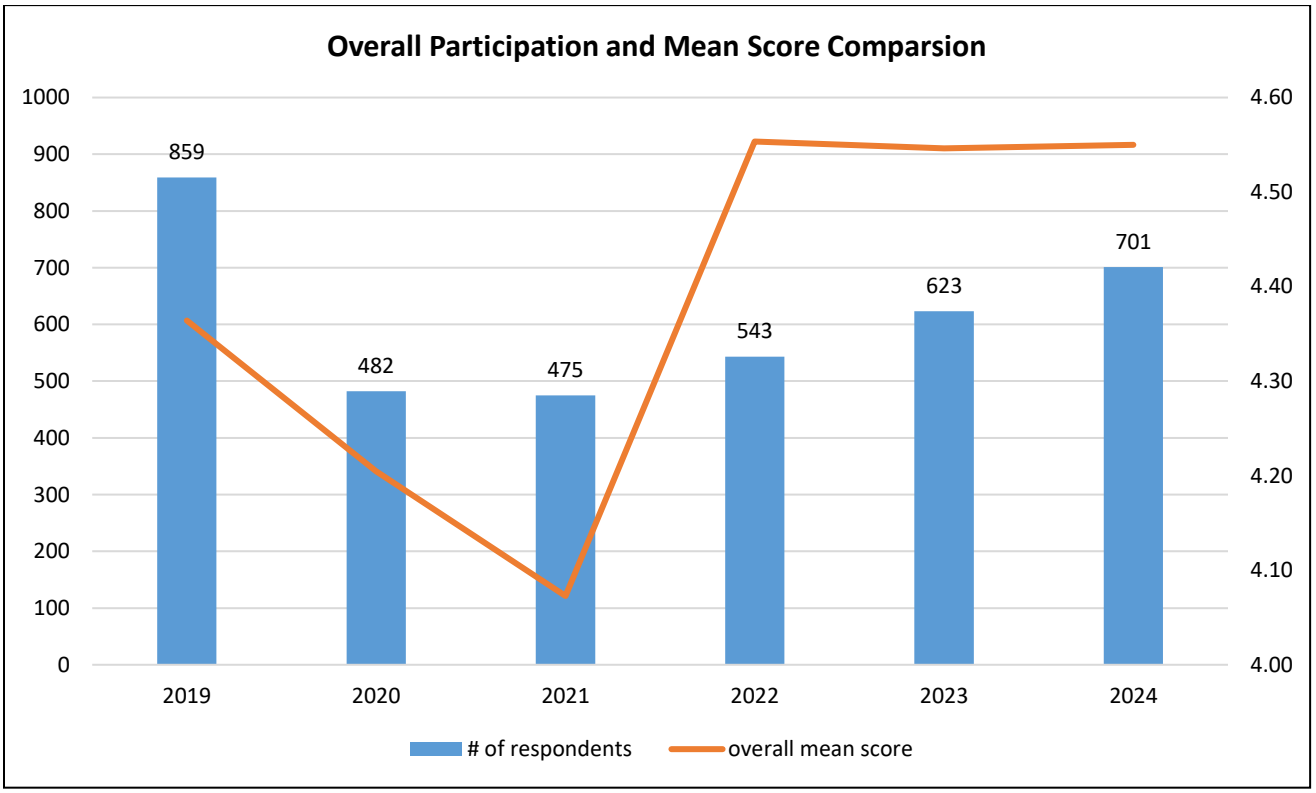
FY24 CMHSP and SUD provider CAPs specified efforts for improvement in survey participation, and the Involvement and Individually Tailored Service domains. The survey was implemented earlier in the year (August) to better align with the fiscal year ending and associated quality evaluations and plans. SWMBH consulted with the Regional SUD Director's Workgroup to determine the most relevant data points to be used for trend identification and analysis, and the development of quality improvement efforts. The mean scores for the questions under each subcategory were provided for additional comparison and analysis. While no changes to the questions were implemented, a sixth domain was added, Inviting Space, to align with the revised survey design. Improvement plans are requested from SUD Providers based on individual survey results which SWMBH reviews and will follow-up on in FY25. These efforts help ensure improvements in the quality of health care and services for members, service delivery, and health outcomes over time.

FY24 Results

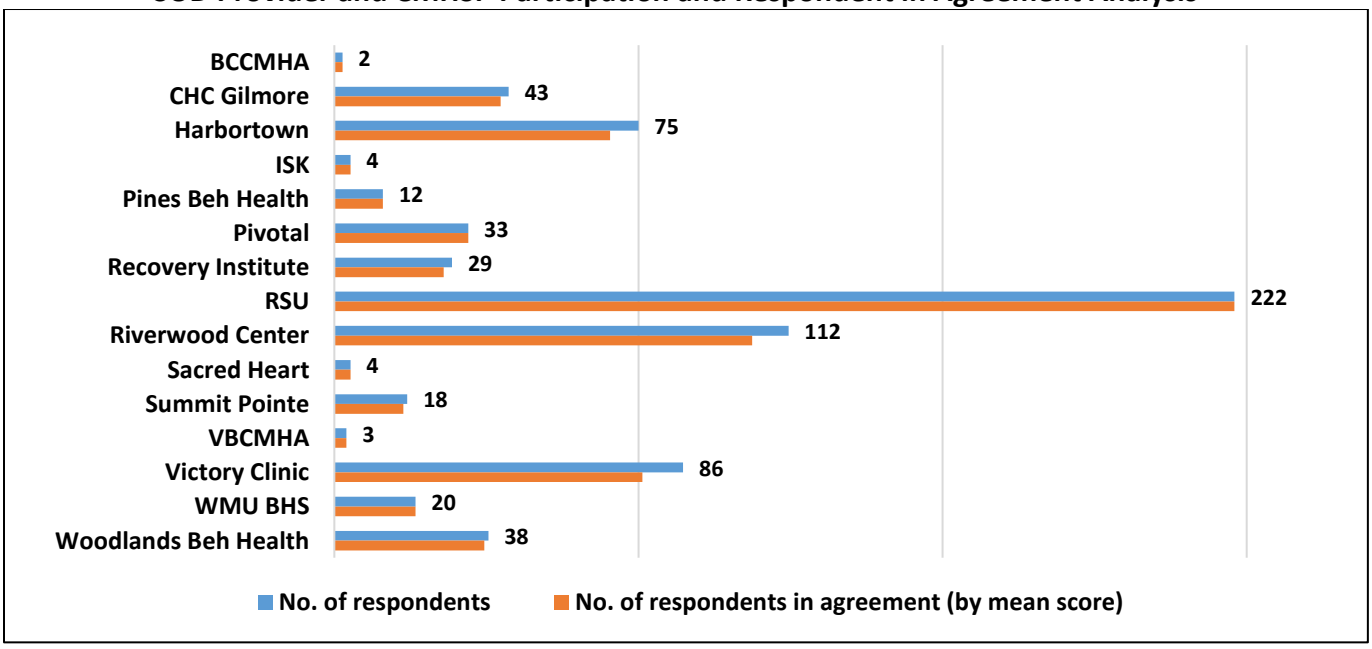
Goal	Where Progress Was Monitored	Frequency of Monitoring	FY23	FY24	Eval Score	FY25 Recommendations
Increase survey participation compared to the previous year as evidenced by more participating providers and/or more completed surveys.	QMC and SUD Directors Subgroup	Annually	623 surveys	701 surveys	**5**	Goal was met in FY24 and will continue in FY25.
Achieve 90% beneficiary satisfaction with SUD services as indicated by survey results.	QMC and SUD Directors Subgroup	Annually	N/A	Met	**4**	Goal met in FY24 and will continue to be monitored in FY25. PIHP will reevaluate in-agreement definition in the survey template.
Ensure participating CMHSPs and SUD Providers develop improvement plans specific to their survey findings, results, and analysis.	QMC and SUD Directors Subgroup	Annually	N/A	Met	**4**	Goal was met in FY24 as FY23 improvement plan efforts were evaluated in the FY24 Provider Summaries. FY24 provider improvement plans are due on February 15, 2025.

RSA-r Survey Regional Results

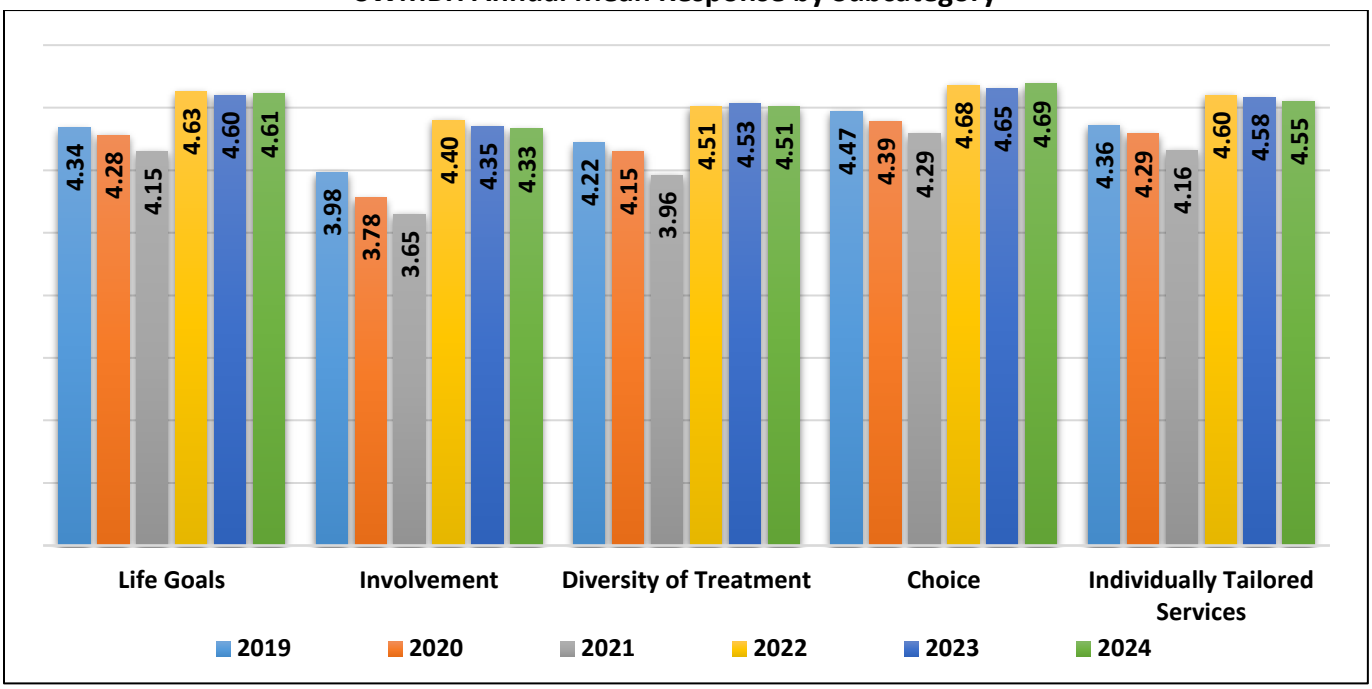
FY24 Overall Mean Score: 4.55



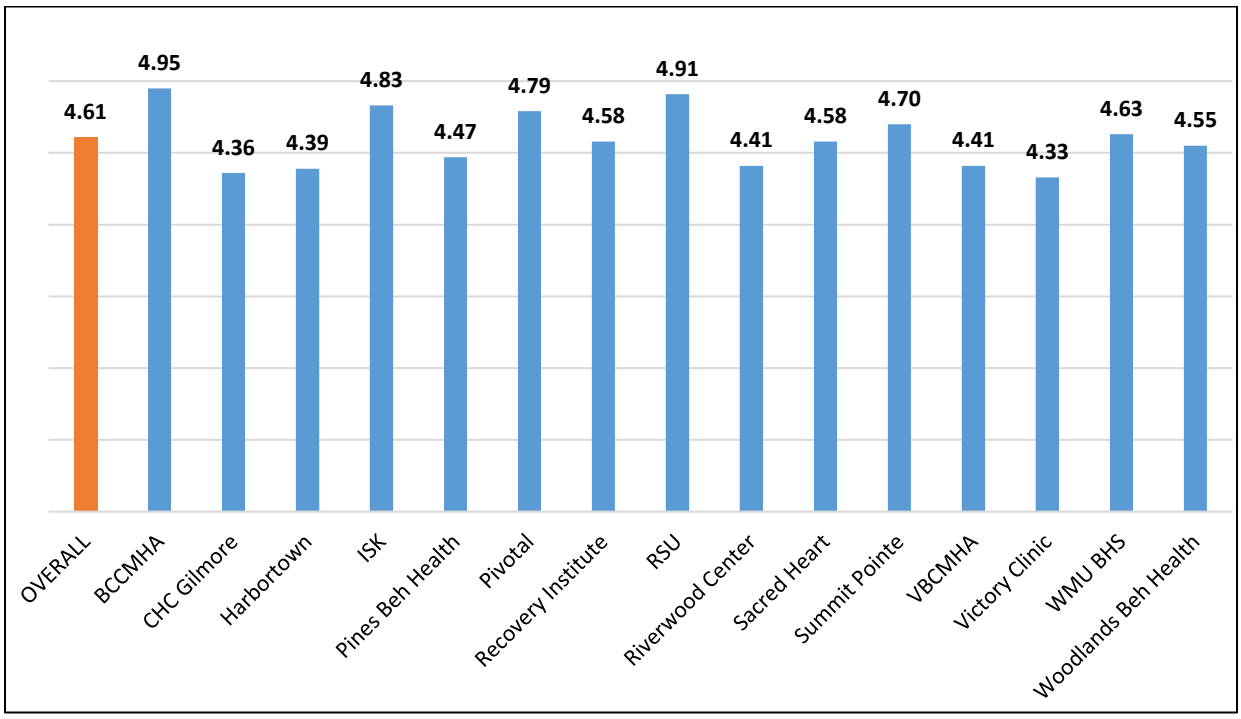
SUD Provider and CMHSP Participation and Respondent in Agreement Analysis



SWMBH Annual Mean Response by Subcategory



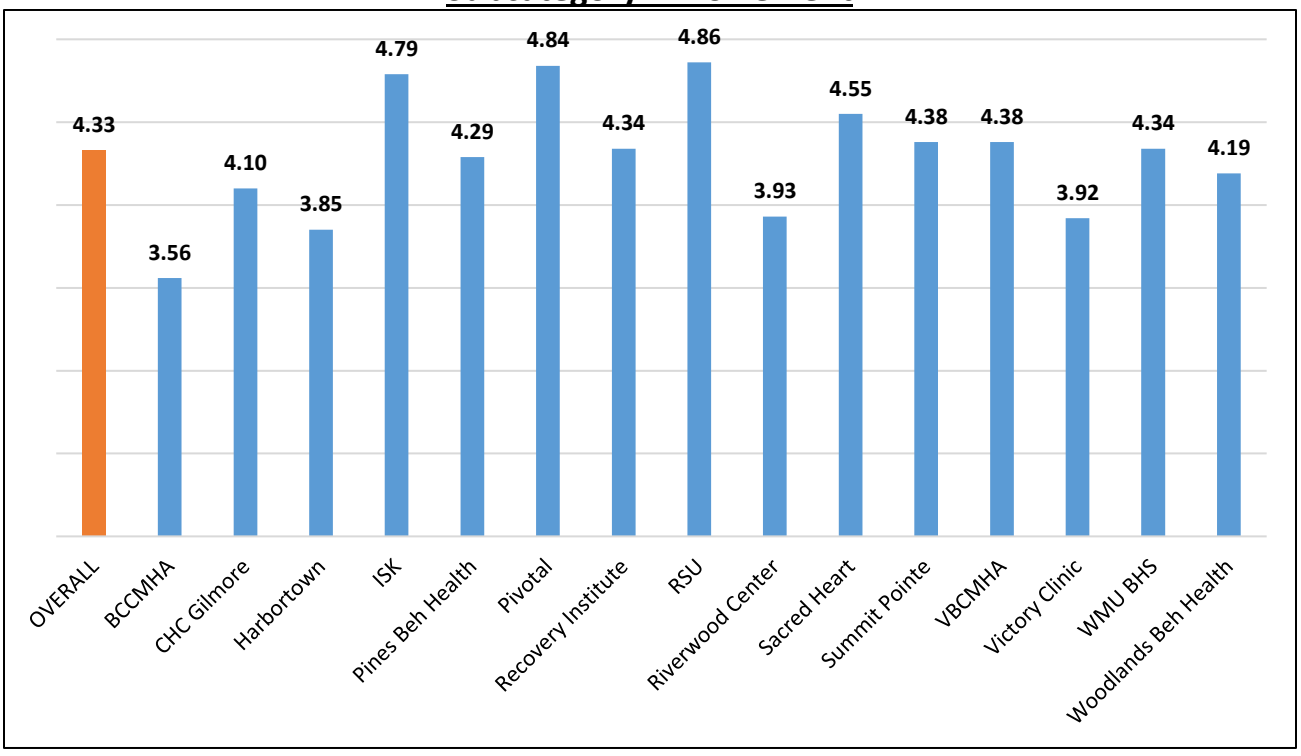
Subcategory: Life Goals



The SWMBH mean score for the Life Goals subcategory in FY24 increased to 4.61. The average increased from 4.60 in FY23, and this change is statistically significant. The table below includes questions associated with this domain as it measures how the provider encourages persons in recovery to pursue goals and interests.

Question	FY23 Mean Score	FY24 Mean Score
3. Staff encourage program participants to have hope and high expectations for their recovery.	4.71	4.78
7. Staff believe in the ability of program participants to recover.	4.79	4.83
8. Staff believe that program participants have the ability to manage their own symptoms.	4.59	4.65
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	4.71
12. Staff encourage program participants to take risks and try new things.	4.44	4.46
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	4.68
17. Staff routinely assist program participants with getting jobs.	4.26	4.31
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	4.44
28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.	4.60	4.59
31. Staff are knowledgeable about special interest groups and activities in the community.	4.61	4.58
32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	4.63	4.60

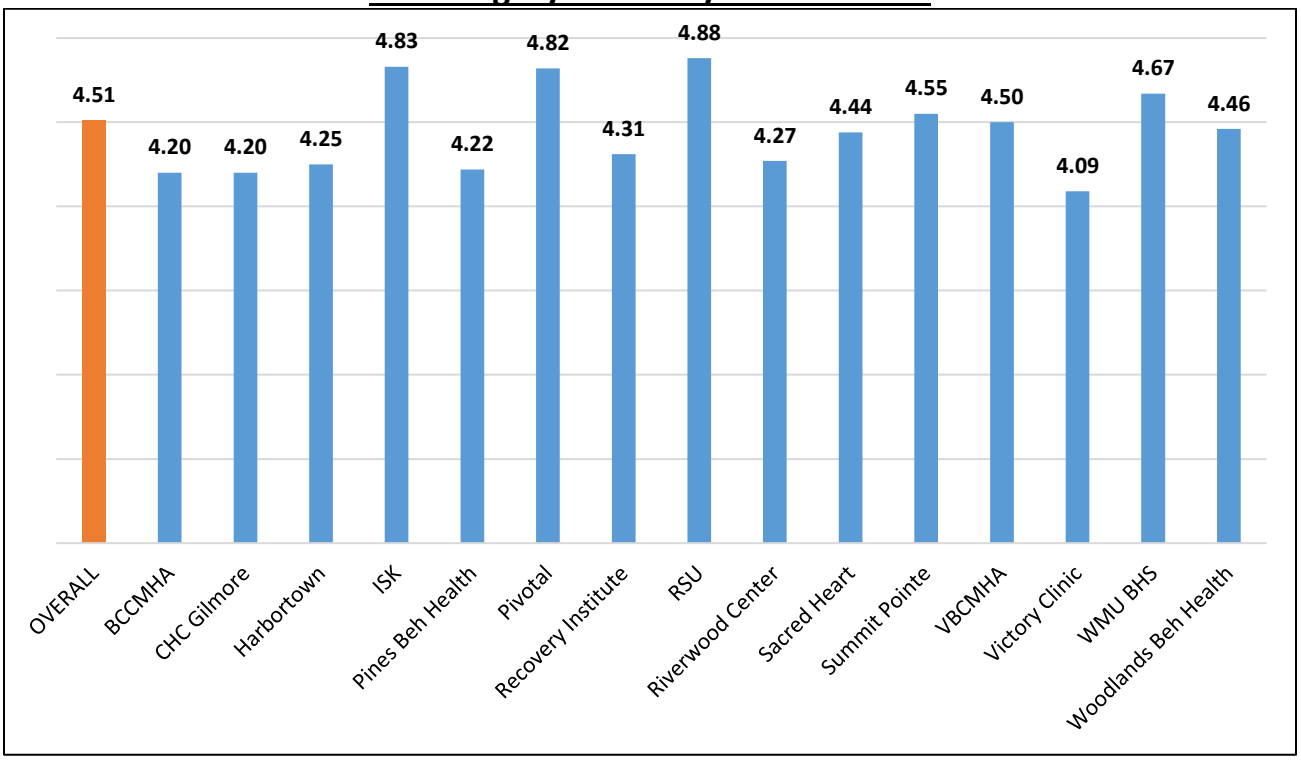
Subcategory: Involvement



The SWMBH average was 4.33 for the Involvement subcategory in FY24 which was a slight decrease in score from the previous year at 4.35, however, the difference is not statistically significant. This is historically the lowest scoring domain each year, but the five-year average remains lower, at 4.10, indicating improvement during this period. Providers mean scores for this category are included above. The table below includes questions associated with the Involvement subcategory as they measure how the provider involves the persons in recovery in their recovery process.

Question	FY23 Mean Score	FY24 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	4.35
Q23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.	4.28	4.25
Q24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.	4.53	4.46
Q25. People in recovery are encouraged to attend agency advisory boards and management meetings.	4.19	4.20
Q29. Persons in recovery are involved with facilitating staff trainings and education at this program.	4.29	4.34

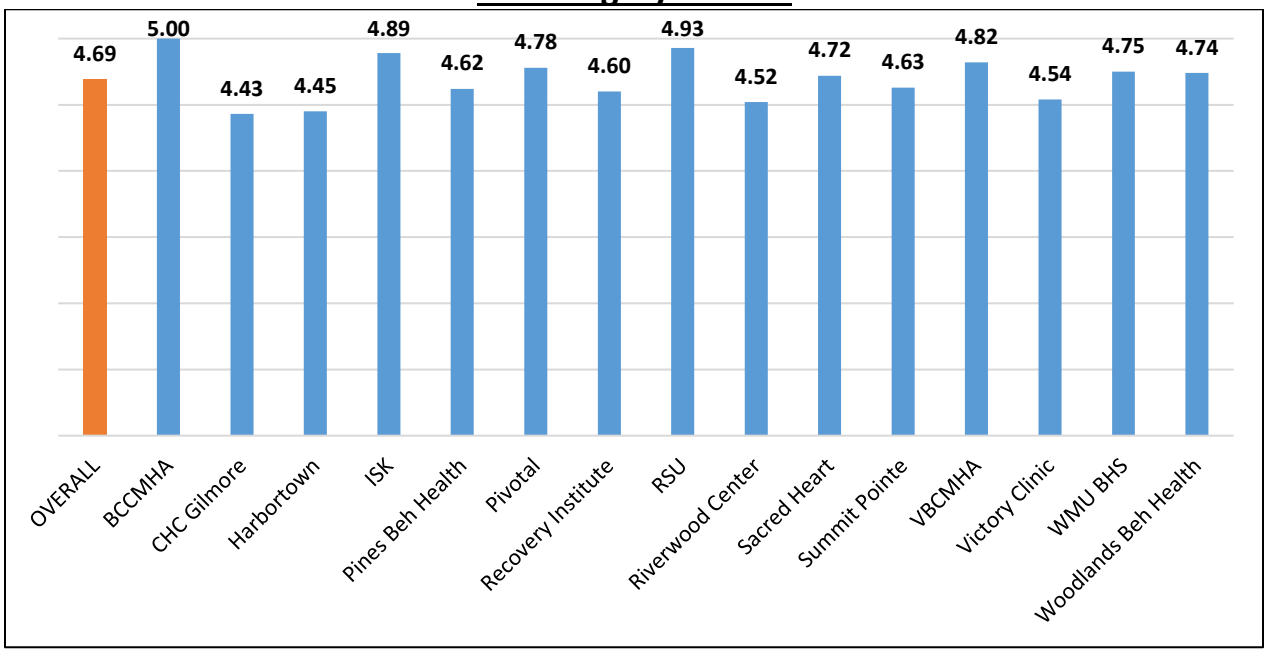
Subcategory: Diversity of Treatment



The SWMBH average returned to 4.51 in FY24 for the Diversity of Treatment subcategory as in FY23, the average was 4.53. This was a statistically significant decrease in FY24. The table below includes questions associated with the Involvement Subcategory and the mean score for each question for FY23 and FY24. These questions intend to measure how well the provider offers a range of treatment options and styles to cater to the needs and preferences of persons in recovery.

Question	FY23 Mean Score	FY24 Mean Score
Q14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.	4.62	4.58
Q15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.	4.32	4.39
Q20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.	4.51	4.44
Q21. Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.	4.65	4.60
Q26. Staff talk with program participants about what it takes to complete or exit the program.	4.53	4.49

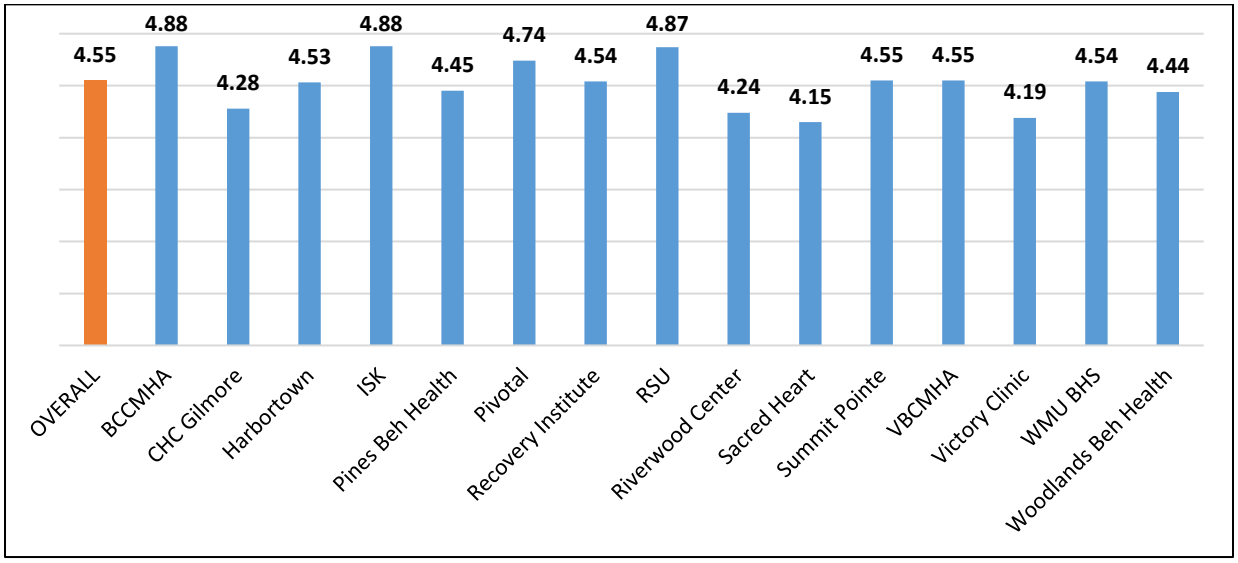
Subcategory: Choice



The Choice subcategory measures how the provider considers the preferences and choices of persons in recovery during their recovery process. The regional average increases this year to 4.69 (from 4.65). This subcategory continues to be the highest scoring. Questions associated with the Choice subcategory and the mean scores for the last two years are included below.

Question	FY23 Mean Score	FY24 Mean Score
Q4. Program participants can change their clinician or case manager if they wish.	4.59	4.66
Q5. Program participants can easily access their treatment records if they wish.	4.59	4.66
Q6. Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.	4.72	4.79
Q10. Staff listen to and respect the decisions that program participants make about their treatment and care.	4.71	4.71
Q27. Progress made towards an individual's own personal goals is tracked regularly.	4.62	4.61

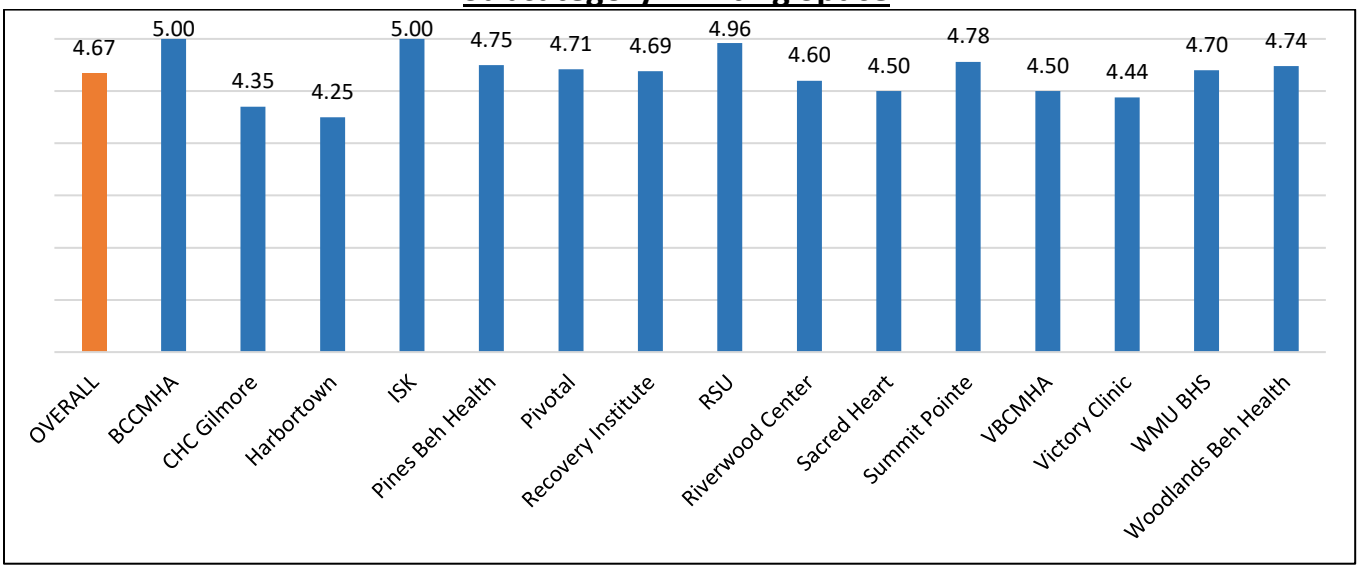
Subcategory: Individually Tailored Services



The Individually Tailored Services subcategory measures how the provider helps persons in recovery tailor their treatment programs to their individual needs. FY24 indicated a statistically significant decrease in this subcategory's mean score going from 4.58 to 4.55. The table below includes questions associated with this domain and the mean score for each question.

Question	FY23 Mean Score	FY24 Mean Score
11. Staff regularly ask program participants about their interests and the things they would like to do in the community.	4.50	4.58
13. This program offers specific services that fit each participant's unique culture and life experiences.	4.54	4.46
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	4.56
Q30. Staff listen, and respond, to my culture, ethnicity, lifestyle, and interests.	4.65	4.60

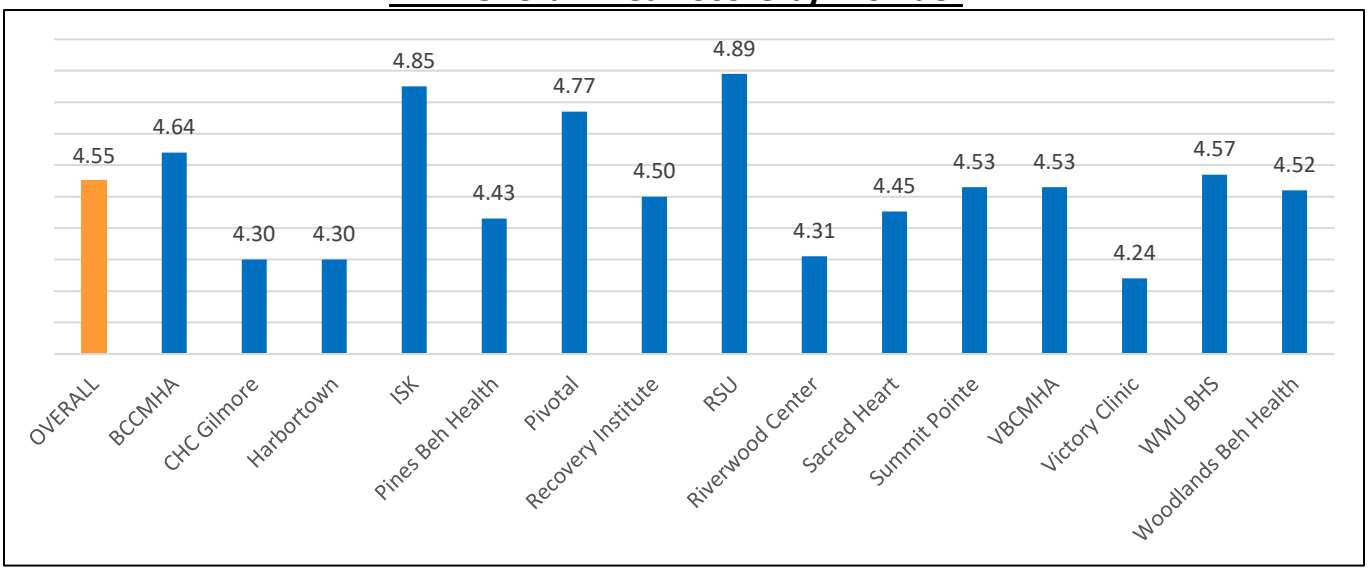
Subcategory: Inviting Space



The Inviting Space subcategory is intended to measure how welcoming the facility and its staff are to the individuals in recovery. While this subcategory is new to FY24, it is comprised of two questions that have always been included in the 32-question set but previously associated with the Individually Tailored Services domain. These questions and means scores are included below for both FY23 and FY24.

Question	FY23 Mean Score	FY24 Mean Score
Q1. Staff welcome me and help me feel comfortable in this program.	4.70	4.80
Q2. The physical space of this program (e.g. the lobby, waiting rooms, etc.) feels inviting and dignified.	4.46	4.54

FY24 Overall Mean Score by Provider



G. 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 beneficiaries 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 beneficiaries, 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 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 beneficiary?
6. Was the provider qualified to deliver the services provided?
7. Is the appropriate claim amount paid (contracted rate or less)?

FY24 Identified Barriers and Analysis

Given the overall compliance rate of 95.05% (which is a significant increase from FY23) and given that all samples reviewed achieved a compliance rate greater than or equal to 90%, a formal CAP was not required; however, SWMBH will continue the efforts to improve service claim processes. SWMBH identified opportunities for improvement which include the areas of coordination of benefits, rendering providers, treatment plan requirements, and proper billing and documentation of face-to-face service time reporting. SWMBH will provide ongoing education and training focused on those areas in FY25. The SWMBH Executive Officer, the Chief Compliance Officer, the SWMBH Corporate Compliance Oversight Committee and the SWMBH Leadership Team will also review the findings and identify any additional strategies needed to improve the findings.

Improvement Efforts Made in FY24

Over the course of FY24, SWMBH reviewed the service documentation and claims processing procedures of each participant CMHSP to ensure that both the applicable delegated and non-delegated functions follow Medicaid regulations and SWMBH policies.

Regarding the deficiencies noted pertaining Coordination of Benefits (COB), SWMBH is working with CMHSPs and contracted providers to ensure understanding of the COB requirements. SWMBH has added additional non-MSV audits for FY25 to better monitor our provider network in this area.

Regarding deficiencies noted for Treatment Plans, there were continued issues with ensuring Treatment Plans were completed/signed by the clinician in a timely manner. Additional deficiencies were noted for Inpatient Master Treatment Plans and the requirements for these plans when a customer is admitted for 72 hours or less. SWMBH Clinical Quality and Program Integrity/Compliance are working with CMHSPs to ensure Treatment Plans are clinically appropriate and include the required goals/objectives/interventions for all authorized services.

In addition to this Medicaid Services Verification Review, SWMBH performed a region wide annual comprehensive qualitative and administrative review process, designed to provide ongoing feedback to both participant CMHSPs and network providers.

SWMBH is committed to improving the effectiveness and efficiency of the PIHP accountabilities in Medicaid fraud and abuse prevention. In Fiscal Year 2025, SWMBH will continue a concerted focus to enhance regional data mining efforts and continue to monitor and educate providers on treatment plan requirements and timeliness, proper recording of face-to-face service start and stop times, proper billing of actual face-to-facetimes without rounding, accurate reporting of rendering providers, and Coordination of Benefits requirements. Additionally, SWMBH is expanding non-MSV and data-mining efforts to better monitor these deficiencies.

FY24 Results

Goal	FY23	FY24	Eval Score	Recommendations
The overall Medicaid claims verification compliance rate for Region 4 will be above 90%.	92.03%	95.05%	5	Goal was met in FY24 and will continue in FY25.

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 1,960 claims/encounters, representing 18,756 units and $1,894,521.88, were audited for FY24. Of those audited, 1,863 were verified to be a valid service reimbursable by Medicaid, for an overall FY24 compliance rate of 95.05 %. Results on each review element and deficiencies are detailed below:

1. Was the person eligible for Medicaid coverage on the date of the service reviewed? **0 deficiencies**
2. Is the provided service eligible for payment under Medicaid? **8 deficiencies**
3. Is there a current treatment plan on file which covers the date of service? **7 deficiencies**
4. Does the treatment plan contain a goal/objective/intervention for the service billed? **4 deficiencies**
5. Is there documentation on file to support that the service was provided to the beneficiary? **20 deficiencies**
6. Was the service provided by a qualified practitioner and falls within the scope of the code billed/paid? **2 deficiencies**
7. Was the appropriate amount paid (contract rate or less)? **0 deficiencies**

FISCAL YEAR	MEDICAID SERVICES VERIFICATON RESULTS
FY21	95.27%
FY22	94.67%
FY23	92.03%
FY24	95.05%

H. Provider Network

Description

SWMBH completes an evaluation of the adequacy of its current fiscal year's 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 are assessed include 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 contains a regional analysis and identifies opportunities for improvement that will be addressed throughout the fiscal year. The data from SWMBH's internal network adequacy analysis and opportunities for improvement report is then added to the MDHHS Network Adequacy Reporting Template and submitted to MDHHS by the required due date specified in Schedule E of the MDHHS-PIHP Agreement.

MDHHS contracts with HSAG to conduct the annual performance measures and included network adequacy validation activities in FY24 for the first time, ensuring all reported performance indicator rates are calculated following the state's measure specifications and reporting requirements, and that network standards, as defined by the state, were met.

SWMBH also maintains the Provider Directory on behalf of the region, which is located on SWMBH website. The CMHSPs submit new/update/delete request forms through SWMBH Commons when there has been a change to their network providers and SWMBH makes the change to the directory within 30 days.

FY24 Identified Barriers and Analysis

In FY23 SWMBH convened a Network Adequacy Remediation Workgroup, and the Workgroup identified challenges in determining staff counts and the corresponding ratios for children's services – Homebased and Wraparound, which continued to be barriers in FY24. MDHHS acknowledged the State-issued ratios and standards are being reviewed and revised, which MDHHS scheduled a meeting in Jan 2025 to further discuss. SWMBH will re-evaluate the network against new standards when those are available.

A barrier that existed related to the HSAG NAV audit was that little information or guidance was provided to SWMBH prior to the audit. At the time of the audit, it was unclear what the auditors would be reviewing or asking questions about, but SWMBH still performed well receiving a score of 100%.

In the FY24 HSAG EQR audit it was recommended that SWMBH include a printable version of the provider directory on SWMBH's website.

Improvement Efforts Made in FY24

Opportunities for improvement were identified in the Regional Provider Network Management Committee (RPNMC) and can be found in the FY24 SWMBH's internal network adequacy analysis and report. Evaluation of those opportunities for improvement are reviewed in the following fiscal year's report.

SWMBH's Provider Network team began developing a printable version of the provider directory in FY24 which will be made available to beneficiaries in FY25. SWMBH's Provider Network team conducted usability testing of the provider directory with SWMBH's Customer Advisory Committee (CAC) and changes were made to the directory based on feedback provided.

FY24 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY23	FY24	Eval Score	FY25 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.	SWMBH Assessment of Medicaid Network Adequacy Report	Annually	Met	Met	**5**	Continue to monitor.

The FY24 Network Adequacy Report was submitted to MDHHS by the required due date. 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 template as the MDHHS template 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.

I. Administrative and Delegated Function Site Reviews

Description

SWMBH either directly performs or ensures that its Participant CMHSPs perform annual monitoring of all providers in its network. This monitoring occurs through the annual site review process, during which standardized tools are used to evaluate Participant CMHSPs' and contracted providers' (both SUD and non-SUD) compliance with administrative requirements and clinical service quality. The oversight, monitoring, and corrective actions from the site reviews leads to improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes over time in the region.

Participant CMHSP Site Reviews

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

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

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

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

SUD Providers

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

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

Network Providers

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

- Autism Service Providers
- Crisis Residential Service Providers
- Inpatient Psychiatric Service Providers (utilizing the State Inpatient Reciprocity Tool and process)
- Financial Management Services (FMS) Providers

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

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

FY24 Identified Barriers and Analysis

CMHSPs and network providers were collaborative and responsive to the Site Review process. One barrier that was identified was the length of time the reviews take from start to finish, which is specifically lengthy for the file reviews and CAP processes. In FY24 the entire process took 8+ months for some CMHs and some sections where CAPs were not approved with the first submission and SWMBH requesting that training materials be reviewed and approved prior to implementation. SWMBH is re-evaluating the CMHSP Site Review process for FY25 in an attempt to reduce burden and actually affect change.

Improvement Efforts Made in FY24

SWMBH continues the use of the cloud-based portal, named "SWMBH Commons" for the FY24 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. This also allows for more oversight of the processes which is beneficial given the ongoing issues that have been identified. SWMBH is considering moving to quarter file reviews for SUD and Non-SUD clinical file reviews in FY25 or FY26.

FY24 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	Eval Score	FY25 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.	Site Review Tools and CAP Documents	Annually	Met	5	Continue to monitor.

FY24 Overall Sections by CMHSP								
Section	**Barry**	**Berrien**	**Branch**	**Calhoun**	**Cass**	**Kalamazoo**	**St. Joseph**	**Van Buren**
Access and Utilization Management	100%	85.7%	96.4%	85.7%	85.7%	86%	79%	96%
Claims Management	100%	100%	100%	62.5%	100%	100%	100%	100%
Credentialing	100%	100%	100%	94.7%	97.4%	100%	100%	100%
Recredentialing	100%	96.2%	100%	92.3%	100%	96.2%	100%	85.7%
Customer Services	100%	96.9%	90.6%	93.8%	96.9%	100%	90.6%	100%
Compliance	100%	100%	100%	100%	100%	100%	100%	100%
Grievances and Appeals	100%	92.9%	100%	100%	100%	92.9%	95.2%	100%
Provider Network	100%	100%	100%	100%	100%	100%	100%	100%
Quality	100%	100%	82.5%	97.5%	93.8%	97.5%	95%	100%
Staff Training	98%	100%	92.4%	90.8%	96.4%	94%	90.1%	98.3%
SUD EBP Fidelity and Administration	100%	100%	100%	100%	100%	100%	100%	100%
Overall	99.8%	97.4%	96.2%	92.4%	92.4%	96.8%	95%	98.7%

Overall Sections by Year Data is a combined average score for each section from all eight CMHSP Site Reviews.			
Section	**FY22 Scores**	**FY23 Scores**	**FY24 Scores**
Access and Utilization Management	84.9%	95.5%	89.3%
Claims Management	88.3%	96.1%	94.5%
Compliance	96.4%	99.3%	99%
Credentialing	95.2%	98%	96.3%
Recredentialing	N/A	N/A	96%
Customer Services	93.7%	94.6%	100%
Grievances and Appeals	90.3%	94%	97.6%
Provider Network	94.9%	97.7%	100%
Quality and Performance Improvement	89.6%	94.9%	95.8%
Staff Training	94.2%	87.6%	95%
SUD EBP Fidelity and Administration	96.3%	100%	100%
Clinical Administration	88.2%	92.7%	N/A

FY24 Clinical Quality Sections by CMHSP								
Sections	**Barry**	**Berrien**	**Branch**	**Calhoun**	**Cass**	**Kalamazoo**	**St. Joseph**	**Van Buren**
Care Coordination	92.7%	73.8%	95.4%	82.9%	87.2%	96.7%	98.7%	92.7%
Assessment	96.2%	91.4%	94.4%	92.1%	93.7%	92.5%	92.7%	95.3%
Treatment Plan/PCP	91.6%	87.8%	86.7%	83.7%	84.6%	88.7%	86.7%	90.5%
PCP Documentation Requirements	92.4%	92.5%	80.6%	82.5%	91.8%	87.5%	92.4%	88.9%
Behavior Treatment Planning	90.7%	89.7%	83.3%	81.5%	76.4%	88.9%	84.6%	90.7%
Overall	92.9%	88.6%	87.8%	85%	87.8%	90.2%	90.4%	91.72%

FY24 SUD Clinical File Sections by CMHSP								
Section	**Barry**	**Berrien**	**Branch**	**Calhoun**	**Cass**	**Kalamazoo**	**St. Joseph**	**Van Buren**
Physician Coordination	100%	92.9%	83.3%	66.7%	94.4%	100%	87.5%	83.3%
Assessment	76.8%	86.7%	87.1%	61.3%	91.3%	91.2%	87.9%	93.5%
Treatment Plan/PCP	80.9%	99.4%	84.7%	74.4%	99.2%	78%	86.7%	96.1%
Progress Notes	96.9%	97.5%	92.9%	81.3%	89.1%	87.5%	90%	96.9%
Discharge/BH TEDS	67.6%	97.7%	82.4%	100%	90%	100%	83.3%	84.6%
MDOC	66.7%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Women's Specialty Services	N/A	90.9%	100%	N/A	96.2%	N/A	83.3%	N/A
Overall	82.7%	95%	86.4%	74.5%	94.6%	86.6%	87.1%	94.2%

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**	**FY24 Scores**
Physician Coordination	72.4%	91.1%	88.5%
Assessment	88%	75.6%	84.5%
Treatment Plan/PCP	88.7%	88.9%	87.4%
Progress Notes	96.2%	93.9%	91.5%
Discharge/BH TEDS	81%	88.8%	88.2%
MDOC	N/A	100%	66.7%
Women's Specialty Services	97.6%	100%	92.6%

J. 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 beneficiaries, 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 Fraud/Waste/Abuse 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, Residential Opportunities Inc. (ROI), Turning Leaf, and Hope Network
    - SWMBH performed organizational credentialing of each Specialized Residential Site, on behalf of the Region.

SWMBH delegated, under Delegation Memorandums of Understanding (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 the Provider Network Monitoring section 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)

FY24 Identified Barriers

One barrier that occurred in FY24 was with the delay of the implementation of the universal credentialing process. MDHHS indicated it would be rolled out in FY24, but it had been delayed for over 6 months. Another barrier that was identified was with the credentialing report that is due to MDHHS quarterly. Staff turnover at the CMHSPs led to ongoing delays which SWMBH addressed through retraining and asking the CMHSPs to complete CAPs where there were repeated issues with timeliness.

Improvement Efforts Made in FY24

SWMBH provided training to the region related to credentialing and re-credentialing in the Regional Provider Network Management Committee (RPNMC) meeting on 10/20/24. MDHHS provided training on use of the BH CRM for credentialing for the region on 10/22/24, 10/28/24, and 10/30/24. On 11/13/24 a follow up meeting was held to help answer any remaining questions related to the BH CRM or the universal credentialing process. SWMBH also participates in MDHHS's universal credentialing workgroup. MDHHS updated their credentialing policy in the beginning of FY25 and SWMBH is working to update policy and the CMHSP Site Review tool and is planning to complete additional training for the region in FY25.

FY24 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY23	FY24	Eval Score	FY25 Recommendations
SWMBH will provide training and technical assistance to participant CMHSP staff responsible for completing credentialing.	Provider Network Team Meeting Minutes	Annually	Met – Training occurred on 02/17/23, 03/17/23, and 10/20/23	Met – Training occurred on 10/20/24, 10/22/24, 10/28/24, and 10/30/24	**5**	SWMBH is planning to provide continued training to the region in FY25 related to the MDHHS policy updates and implementation of universal credentialing.
The credentialing and re-credentialing requirements will be reviewed for each CMHSP during the administrative and delegated Site Reviews.	Site Review Tools	Annually	Combined Average from 8 FY23 CMHSP Site Reviews 98%	Combined Average from 8 FY23 CMHSP Site Reviews 96.3%	**5**	Continue to monitor.
SWMBH will develop and implement a quality performance improvement project designed to improve adherence to SWMBH and MDHHS credentialing requirements.	Site Review Tools, RPNMC	Annually	N/A	N/A	**N/A**	SWMBH decided to pursue a different non-clinical PIP in FY24, in anticipation of MDHHS changing the credentialing process.

K. Clinical Practice Guidelines

Description

SWMBH reviews, disseminates, and implements clinical practice guidelines that are consistent with the regulatory requirements of MDHHS Specialty Services Contract and Medicaid Managed Care rules. SWMBH and its Medicaid subcontracted provider network have adopted these guidelines. SWMBH assures that information related to the guidelines is made available to beneficiaries and providers.

It is policy that the employees of SWMBH, the CMHSPs, and the provider network must assure that decisions with respect to utilization management, beneficiary education, coverage of services, and other areas are consistent with the MDHHS Practice Guidelines, found here:
https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines

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 SWMBH beneficiaries.
- Are adopted in consultation with contracting providers and staff who utilize the protocols and guidelines.
- Are reviewed and updated periodically as needed, with final approval by the Medical Director and/or SWMBH's Director of Quality Management and Clinical Outcomes.
- Guidelines are disseminated to all applicable providers through provider orientation/the provider manual, and to beneficiaries upon request.
- Guidelines are posted on the SWMBH website and are referenced in the provider and member handbooks.
- Implementation of new guidelines and/or review of existing guidelines is published in the provider and member newsletters.
- Any decisions with respect to utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

All practice guidelines adopted for use are available on the SWMBH website and include:

- Inclusion Practice Guideline
- Person-Centered planning 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
- The Employment Works! Policy

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

Audits are conducted and reviewed as part of SWMBH's annual clinical audit process, or delegated to the CMHSPs, as required by SWMBH. Practice Guidelines and the expectation of their use are included in provider contracts. Practice guidelines are reviewed and updated annually or as needed and are disseminated to appropriate providers through relevant committees, councils, and/or workgroups.

FY24 Identified Barriers and Analysis

The FY24 CMHSP clinical site review findings showed that there continued to be some regional deficiencies in in the implementation and documentation of the Person-Centered Planning Process. The aggregate results for the region in the area of Person-Centered Planning Implementation was 87.55% in FY24, which was a decrease from FY23. It should be noted that the Clinical Quality CMHSP site review tool was updated, and the number of elements evaluated in the Person-Centered Planning Implementation section increased from 14 to 16. That said, there were several elements that had repeat citations from year to year. Any element that scored less than 90% required remediation and areas that had repeat citations included a quarterly monitoring plan.

Improvement Efforts Made in FY24

The Clinical Quality CMHSP site review tool was updated to better evaluate the effectiveness and implementation of the Person-Centered Planning process. The site review elements were assessed for clarity, content, purpose and were aligned with appropriate standards and regulations. All remediation approaches have been focused on systemic improvements across populations and service lines. The RCP Charter includes goals to improve the Person-Centered Planning Process and clinical documentation. Improvement strategies, resources, exemplary case examples, and best practices are shared in this committee to facilitate regional alignment with practice guidelines. These combined efforts have led to improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes over time in the region.

FY24 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	Eval Score	FY25 Recommendations
SWMBH will evaluate the region's effectiveness in demonstrating the Person-Centered Planning Practice Guideline and develop improvement strategies to address any deficiencies in FY24.	QMC, RCP, Site Review Tools	Quarterly	Met	**5**	The Clinical Quality CMHSP site review tool was updated to better evaluate the effectiveness and implementation of the Person-Centered Planning process. Any deficiencies resulted in corrective action plan development. As this is an area that continues to need regional improvement, this goal will continue in FY25.

L. Long-Term Services and Supports (LTSS)

Description

Long term services and supports refers to 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). 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 Home and Community Based Service (HCBS) Waivers as recipients of LTSS. SWMBH 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 is dedicated to ensuring the quality and appropriateness of care to all beneficiaries, however, persons receiving LTSS are some of the most vulnerable beneficiaries, 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 beneficiaries receiving LTSS is quantitatively assessed using an analysis of LTSS sections in the annual Customer Satisfaction Survey. SWMBH has incorporated survey questions that help to identify individuals who are receiving LTSS which allows for a separate analysis of the LTSS population.

The annual CMHSP site review tool that is utilized in Region 4 includes items to monitor the quality and appropriateness of care for beneficiaries receiving LTSS. Aggregated annual audit outcomes are regularly monitored and analyzed by the Quality Management and Clinical Outcomes Department at both the CMHSP and PIHP levels. Results are used to inform annual provider training that is offered to the LTSS provider network. Additional quality improvement training is provided at the CMHSP-level as needed or required. Future training topics will include developing a regional approach to assess care between settings. These combined efforts have supported community integration of LTSS beneficiaries and lead to improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes over time in the region.

FY24 Identified Barriers and Analysis

SWMBH has again sought guidance from MDHHS about the assessment of LTSS care between settings to clarify all requirements of this expectation. Establishing the best approach to assess care between settings is still an area with an opportunity for improvement. Additionally, SWMBH has sought guidance from MDHHS regarding a comprehensive list of all LTSS services and corresponding CPT codes. Having a consistent list would aid the region in identifying LTSS recipients and ensuring there is a consistent statewide understanding of LTSS services and oversight.

Improvement Efforts Made in FY24

Aggregated annual CMHSP Site Review outcomes were monitored and analyzed by the Clinical Outcomes and Quality Management department. A comparative analysis of the clinical file reviews was done to evaluate trends between FY23 and FY24. The results were used, in part, to evaluate community integration efforts and assess quality of care. Assessment of care between settings was a consultative item added to the annual CMHSP clinical quality site review tool in FY24 to help establish a better understanding of how CMHSPs are assessing and documenting that. During the FY24 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 evaluated whether a level of care assessment was completed at least annually and when there was a significant change in a beneficiary'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.

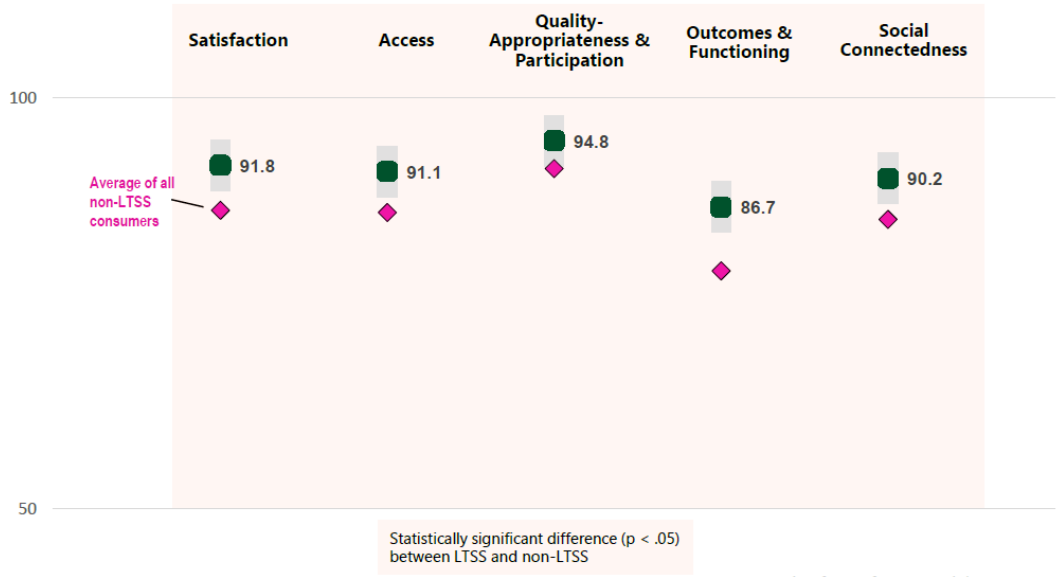
Year 1 of the 3-year HSAG External Quality Review (EQR) cycle includes 6 out of 16 elements within Standard V, Coordination and Continuity of Care, specifically related to the assessment, coordination, and quality of care for LTSS recipients. SWMBH received a score of 100% for Standard V in the FY24 audit.

While researching approaches to strengthen the quality and appropriateness of care for members receiving LTSS, SWMBH reviewed materials for a variety of sources that spoke about the role of unpaid caregiving in the lives of LTSS beneficiaries. Many beneficiaries are supported by family members who eventually burn-out or become injured. This has impacts on the beneficiary and the family, often resulting in the need for a higher level of care, and facility or institutional placement for the beneficiary. Considering those circumstances, respite supports were identified as a highly effective service, as they offered support for unpaid caregivers, reduced the risk of burn-out and injury, and were a cost-effective way to keep people served in their family homes in the community. Supported by several member organizations, including the MLTSS (Medicaid managed long-term services and supports) Health Plan Association a national strategy to support family caregivers identified five focus areas including; increase awareness of and outreach to family caregivers, advancing partnerships and engagement with family caregivers, strengthen services and supports for family caregivers, ensure financial and workplace security for family caregivers, and expanding data, research, and evidence-based practices to support family caregivers. It is recommended that SWMBH employ approaches to strengthen the use and awareness of respite services as an effort to address components of the national strategy in FY25.

The slides below demonstrate the results from the FY24 Customer Satisfaction Surveys for LTSS recipients. The MHSIP was used for adults and the YSS was used for youth.

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

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*)

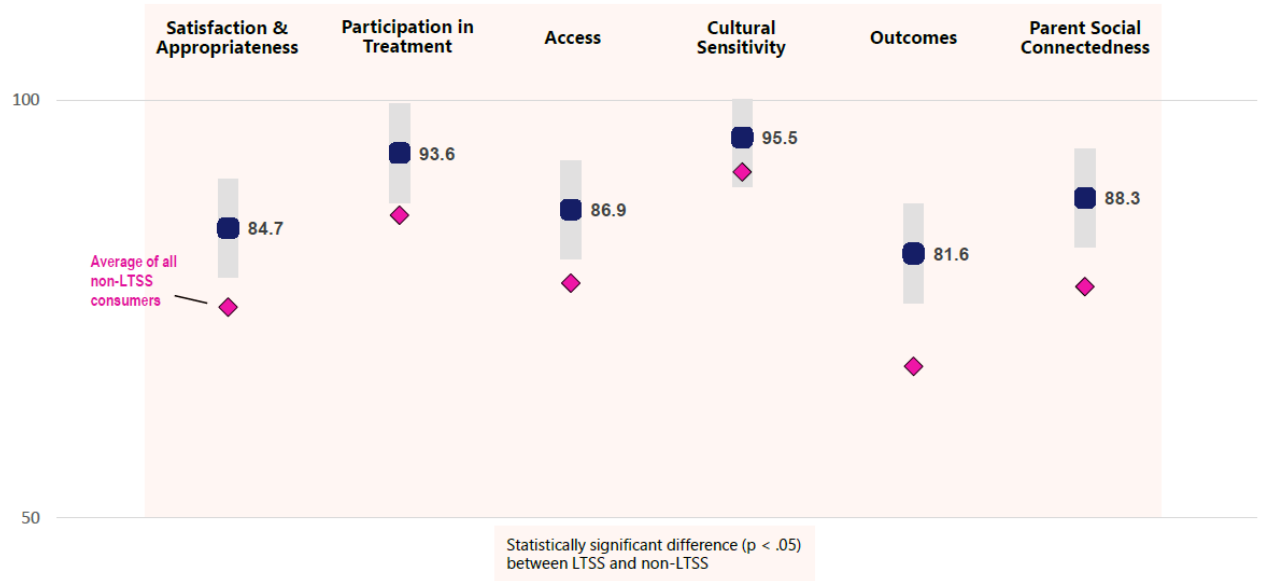


Kiaer Research SWMBH Consumer Satisfaction 2024 Results

*margin of error for **LTSS** adults: ±3.1 pts (n = 1031)
margin of error for **non-LTSS** adults: ±4.1 pts (n = 580)

Youth LTSS families report better scores in all constructs in the 2024 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*)



Kiaer Research SWMBH Consumer Satisfaction 2024 Results

*margin of error for **LTSS** youth: ±4.6 pts (n = 455)
margin of error for **non-LTSS** youth: ±6.9 pts (n = 200)

FY24 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	Eval Score	FY25 Recommendations
SWMBH will use the Beneficiary Experience Satisfaction Survey results and the information from the Waiver Audit Interviews to assess the quality, availability, and accessibility of care of beneficiaries receiving LTSS. Improvement areas will be identified based on the analysis of the results in Q3 of FY24.	QMC and RCP	Annually	Met	**5**	The Customer Satisfaction Survey results showed better scores in all constructs for adult and youth LTSS recipients compared to non-LTSS recipients. This goal will be kept in FY25 and SWMBH will continue to evaluate beneficiary satisfaction.

M. Utilization Management (UM)

Description

The purpose of the Utilization Management Program is to maximize the quality of care provided to beneficiaries while effectively managing the Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports Waiver, SED Waiver, Child Waiver, and SUD Community Grant resources of the Plan while ensuring uniformity of benefit. SWMBH is responsible for monitoring the provision of delegated UM managed care administrative functions related to the delivery of behavioral health and SUD services to beneficiaries enrolled in Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports Waiver, SED Waiver, Child Waiver Program, SUD Community Grant, and individuals accessing services at a designated CCBHC. SWMBH is responsible to ensure adherence to UM related statutory, regulatory, and contractual obligations associated with 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. Per 42 CFR §438.210(a)(1) the PIHP must identify, define and specify the amount, duration, and scope of each service must be furnished in an amount, duration, and scope for the same services furnished to members under Fee For Service (FFS) Medicaid, as set forth in §440.230, and for members under the age of 21, as set forth in subpart B of part 441.

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

Utilization Management Activities

Based on an annual review by SWMBH cross collaborative departments utilizing clinical and data model audits, an annual Utilization Management Program is developed, and UM oversight and monitoring activities are conducted across the region and provider network to assure the appropriate delivery of services. Participant CMHSP's are delegated most utilization management functions for mental health under their MOU and some CMHSP's are delegated UM functions for a limited scope of SUD services. SWMBH provides, through a central care management process, UM functions for all services delivered by SUD providers and all acute/high intensity SUD services inclusive of Withdrawal Management, Residential, and Medication for Opioid Use Disorder (MOUD)/Methadone. Based upon the UM Program review, annual audits, and report findings, modifications are made systemically through the UM annual work plan/goals and policy/procedure. Specific changes may be addressed through corrective action plans with the applicable CMHSP's, providers, or SWMBH departments.

Provider Network practitioners and participant CMHSP clinical staff review and provide input regarding policy, procedure, clinical protocols, evidence-based practices, regional service delivery needs, and workforce training. Each CMHSP is required to have their own utilization management/review process. SWMBH's Medical Director and a Physician board-certified in addiction medicine, meet weekly with SWMBH UM staff to review challenging cases, monitor for trends in service, and provide oversight of application of medical necessity criteria. Case consultation with the Medical Director, who holds an unrestricted license, is available 24 hours a day. SWMBH provides review of over and underutilization of services and all delegated UM functions. Inter-rater reliability testing is conducted annually for any SWMBH clinical staff making medical necessity determinations through the centralized care management or outlier management processes.

Coordination and Continuity of Care

SWMBH is committed to ensuring each beneficiary receives services designed to meet each individual specific health need as identified through a functional assessment tool and a Biopsychosocial Assessment. The screening and assessment process contains mechanisms to identify needs and integrate care that can be addressed with specialty behavioral health and SUD treatment services, as well as integrated physical health needs and needs that may be accessed in the community including, but not limited to, employment, housing, financial assistance, etc. The assessment is completed or housed in a uniform managed care information system with collection of common data elements which also contains a functional assessment tool that generates population-specific level of care guidelines. To assure consistency, the tools utilized are the same version across the SWMBH region and include the Level of Care Utilization System (LOCUS) for Adults with Mental Illness or Co-Occurring Disorder, Michigan Child and Adolescent Needs and Strengths (MichiCANS) for identifying the needs of the child/youth and family, and the American Society for Addiction Medicine-Patient Placement Criteria (ASAM-PPC) for persons with a substance use disorder. Effective March 2023, MDHHS made the decision not to renew the contract to continue use of the Supports Intensity Scale (SIS) as a level of care assessment tool for individuals with Intellectual and Developmental Disabilities. The decision was made by MDHHS to utilize the World Health Organization Disability Assessment Schedule (WHODAS); however, this is not planned to be implemented until October 1, 2025, for FY26. Components of the assessments generate a needs list which is used to guide the treatment planning process. Assessments are completed by appropriately trained and credentialed clinical professionals. Treatment plans are developed through a person-centered planning process with the beneficiary's participation and with consultation from any specialists providing care to the individual.

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

1. Access and Eligibility: To ensure timely access to services, SWMBH provides oversight and monitoring of local access, triage, screening, and referral (see SWMBH Policy - Access Management). SWMBH ensures that the Access Standards are met, including MMBPIS indicators.
2. Clinical Protocols: To ensure Uniform Benefit for beneficiaries, consistent functional assessment tools, medical necessity criteria, level of care tools, 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).
3. Service Authorization: Service Authorization procedures will be efficient and responsive to beneficiaries while ensuring sound benefit 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.
4. 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 is 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 SWMBH Policy - Utilization Management).

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

1. Management of identified high cost, high risk service outliers or those with under-utilized services.

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

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

The outlier management process and subsequent reports to manage it, including over- and under-utilization and uniformity of benefit, are based on accurate and timely assessment data and scores of agreed tools and service determination transactions being submitted to the SWMBH warehouse, implementation of level of care guidelines, and development of necessary reports for review. These combined efforts have led to improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes over time in the region.

FY24 Identified Barriers and Analysis

Throughout FY24, the Regional Utilization Management waited on multiple announcements that would impact the PIHPs and CMHSPs across the state related to the MDHHS directive regarding the HCBS Conflict Free Access and Planning (CFAP) for the state and the implications it could have in how managed care functions are delegated across the state. No clear guidance or implementation plan was provided in FY24, and the region continues to wait on direction. The MichiCANS did proceed and went live for use across the state beginning 10/01/24. Due to not receiving pertinent information passed on from the state, there was a fast turnaround time to modify and update the Level of Care Guidelines that was previously based on Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS) scores. Regional UM representatives volunteered to participate in a workgroup to collaborate with SWMBH's Clinical Quality staff to review data and previous established levels. The group was successful in getting new level of care thresholds distributed to the region for use in FY25. Adverse Benefit Determinations (ABDs) have continued to be an area needing improvement across the region.

Improvement Efforts Made in FY24

Quarterly denial file reviews were completed before and after the annual CMHSP site reviews. Three CMHSPs requested and were provided additional ABD trainings and the quarterly monitoring of those will continue. Throughout the quarterly denial file review process, it was discovered that there has been discrepancy across the region regarding documenting the correct service request date and time, as well as the date and time the written ABD notification was sent to the beneficiary. These issues have been addressed with the individual CMHSPs to ensure those deficiencies are remediated. MDHHS requested a PIHP lead for community access referrals for Intensive Community Transition Service (ICTS) and Psychiatric Residential Treatment Facilities (PRTF). These referrals required ongoing collaborative efforts for placement and ongoing discharge planning for appropriate community supports and services.

FY24 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY23	FY24	Eval Score	FY25 Recommendations
SWMBH will create a Utilization management Plan per MDHHS guidelines.	RUM	Annually	Met	Met	5	The goal was met. This is recommended to be removed for a FY25 UM Department Goal. This is a required document and consistently met without any concern.
SWMBH will aggregate and review UM data to identify trends and service improvement recommendations, identify best practice standards and thresholds, to ensure valid and consistent UM data collection techniques.	RUM and RCP	Monthly	Met	Met	5	Level of care thresholds were finalized for the MichiCANS implementation into CMHSP EHRs for the start of FY25. RUM will continue to review updated Tableau reports and work collaboratively with the SWMBH's Clinical Quality staff to assist with data validation, reviewing data, and resolving any identified concerns. This goal will be continued into FY25.
SWMBH will identify the levels of care and subsequent reports to manage utilization and uniform benefit.	RCP	Quarterly	Met	Met	5	SWMBH has reviewed and updated the LOC core service menu. Several reports have been developed to evaluate data related to UM practices in the region.
SWMBH will ensure regional inter-rater reliability (IRR) audits are completed for consistent application and understanding of authorization of uniform benefits and medical necessity benefit criteria.	RUM	Annually	Met	Not Met	2	5 of SWMBH's 8 CMHSPs did not provide adequate documentation to show proof of LOCUS IRR implementation, as required for the FY24 Annual Site Review. Those not meeting the standard were placed on Corrective Action Plans to ensure staff were meeting the minimum standard of LOCUS IRR testing. IRR monitoring will continue to be reviewed during the annual site review process to ensure it is being completed to ensure consistent application and use of the LOCUS. This goal will be continued into FY25.
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.	RUM and Regional Customer Service Committee	Quarterly, Annually	65.2%	62.5%	3	ABD Scores remained consistent across the region. Additional training was completed by SWMBH staff at the request of certain CMHSPs. Ongoing ABD monitoring will continue quarterly.

Emergent and non-emergent access to treatment will be periodically monitored to ensure compliance with timeliness standards.	RUM and Regional Customer Service Committee	Quarterly	Met	Met	**4**	The goal was met, the compliance and timeless standard were monitored throughout FY24 with a regional score of 87.5%
SWMBH will achieve a call abandonment rate of 5% or less.	Data submission to MDHHS	Quarterly	0.19%	0.13%	**5**	SWMBH's Call Center has consistently achieved call abandonment rates of less than 1%, well below the 5% required to meet NCQA standards.
SWMBH will achieve an average call answer time 30 seconds or less	Data submission to MDHHS	Quarterly	99.03%	99.49%	**5**	SWMBH's Call Center has continued to achieve call answer times of 30 seconds or less over 99% of the time, well above the NCQA timeliness standard required.
SWMBH will ensure a call center monitoring plan is in place and provide routine quality assurance audits.	QMC	Monthly	Met	Met	**5**	SWMBH Call Center Manager completed monthly staff call monitoring and provided staff feedback to anyone not scoring 100% for performance improvement efforts.
Evaluate CMHSP call reports during Delegated Administrative Function Site Reviews.	Site Review Tools	Annually	93.75%	Met	**4**	CMHSP Call reports are monitored as part of the annual administrative site review process. Any CMHSPs not obtaining abandonment rates of less than 5% or having call answer times of over 30 seconds less than 95% of the time were required to complete a root cause analysis as part of the require corrective action plan and monthly monitoring has continued to ensure the call time is improving and the deficiency is being remedied.

N. Customer Services

Description

SWMBH's Customer Services Department provides a welcoming environment and orientation to services. This includes providing beneficiaries with information about benefits, available providers in network, how to access behavioral health, substance use disorders, primary health, and other community resources. Customer Services assists beneficiaries with obtaining information about how to access their due process rights when services are denied, reduced, suspended, or terminated. This includes helping beneficiaries with the Grievance and Appeal (G&A) process. Customer Services tracks and reports patterns of problems for each organization, regionally, and evaluates over/under service utilization. SWMBH delegates Customer Service functions including due process, grievances, and appeals to the CMHSPs. As such, a MOU between SMWBH and each CMHSP is implemented. The MOU specifies the delegated functions and expectations of the CMHSP. Adherence to the MOU is crucial to ensure all beneficiaries have access to customer service rights. This ensures federal and state requirements are met, while ensuring the services are provided in a uniform manner throughout Region 4 for continuity of care.

FY24 Identified Barriers

Goal 1:

- Not all the areas identified for review were applicable to all the CMHSPs, such as CCBHC. As of FY24, the SWMBH region had 6 of the 8 CMHSPs were CCBHCs. Therefore, the information reviewed did not apply to all the CMHSPs. Conflict Free Access and Planning (CFAP) was another area slated to be reviewed, however, this program was not implemented in the fiscal year as expected.
- Not all CMHSPs have the same MOU agreement in place so the outlined expectations vary and how they are applied to the various programs.

Goal 2:

- Updates were made to the G&A Technical Requirement in the middle of the fiscal year. This impacted Due Process materials such as templates for letters, requirements such as ensuring a grievance or appeal is acknowledged in writing in 5 days, and rights for G&A.

Goal 3:

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

Improvement Efforts Made in FY24

Goal 1:

- Subject matter experts were invited to the Regional Customer Service Committee meeting to educate and provide information on the various programs as they relate to the MOU and expectations.
- Updates were made to the MOU template for Customer Service and Grievance and Appeals based on updates to the Code of Federal Regulations and the Grievance and Appeal Technical Requirement.
- All efforts were made to review documents and information from MDHHS as available such as the updated CCBHC Handbook and contract updates.

Goal 2:

- SWMBH updated the file review tool and created a summary report to provide to the CMHSPs, outlining the findings. This will allow for better tracking and trending of areas of opportunity for the CMHSP.
- SWMBH met with each CMHSP representative to review a sample of grievances and appeals quarterly and provide real time feedback regarding trends and up-coming requirement changes.

Goal 3:

- SWMBH and the regional CMHSPs reviewed trends in data quarterly at Committee meetings.
- Regional challenges and solutions were discussed regarding grievance and appeal trends.

FY24 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	Eval Score	FY25 Recommendations
Committee will review current MOU between SWMBH and CMHSPs and the application of the MOU delegated functions to the areas listed below by the end of FY24. (CCBHC, 1915 iSPA, CFAP, Managed Care Regulations/Contract, New MOU).	Regional Customer Service Committee	Annually	Met	**5**	This goal will be eliminated for FY25. SWMBH will continue to review and discuss delegated functions as applicable with various state programs and funding sources.
SWMBH will provide quarterly monitoring and feedback regarding Grievance and Appeal files to ensure contractual and delegated functions are met at each CMHSP at least 3 quarters by the end of FY24.	Regional Customer Service Committee	Quarterly	Met	**5**	This goal will be continued for FY25. SWMBH will continue to review and monitor the CMHSP grievance and appeal system through quarterly file reviews.
Committee will review Grievance and Appeal data for trends, ongoing.	Regional Customer Service Committee	Quarterly	Met	**5**	This goal will be continued for FY25. SWMBH will continue to review and monitor for trends from the CMHSP grievance and appeal system through quarterly file reviews.

During FY24 four CMHSPs transitioned to become CCBHCs, with one more in the planning stages for the adoption of the model in FY25. MDHHS has updated the quarterly grievance, appeal, and service authorization denial tools to reflect and capture CCHBC specific data. Going forward SWMBH will be responsible for reporting this Medicaid data to MDHHS. The G&A Technical Requirement was updated in FY24, including updating the state mandated letter templates. The region was required to implement those by October 1, 2024. SWMBH implemented the templates August 1, 2024, to identify and address any challenges before the CMHSPs implemented them. Monitoring and tracking of CMHSPs adherence to meeting state and federal regulations and accurate reporting of grievances and appeals will be a focus for FY25.

FY24 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	23	0.07	10	0.03	54	23	28
ACCESS AND AVAILABILITY	20	0.06	10	0.03	45	20	18
INTERACTION WITH PROVIDER OR PLAN	104	0.30	42	0.12	229	104	20
MEMBER RIGHTS	0	0.00	0	0.00	0	0	#DIV/0!
TRANSPORTATION	1	0.00	0	0.00	2	1	74
ABUSE, NEGLECT, OR EXPLOITATION	0	0.00	0	0.00	0	0	#DIV/0!
FINANCIAL OR BILLING MATTERS	1	0.00	0	0.00	2	1	3
SAFETY/RISK MANAGEMENT	0	0.00	0	0.00	0	0	#DIV/0!
SERVICE ENVIRONMENT	3	0.01	1	0.00	7	3	25
OTHER	2	0.01	2	0.01	4	2	12
Total	154	0.44	65	0.19	343	154	21

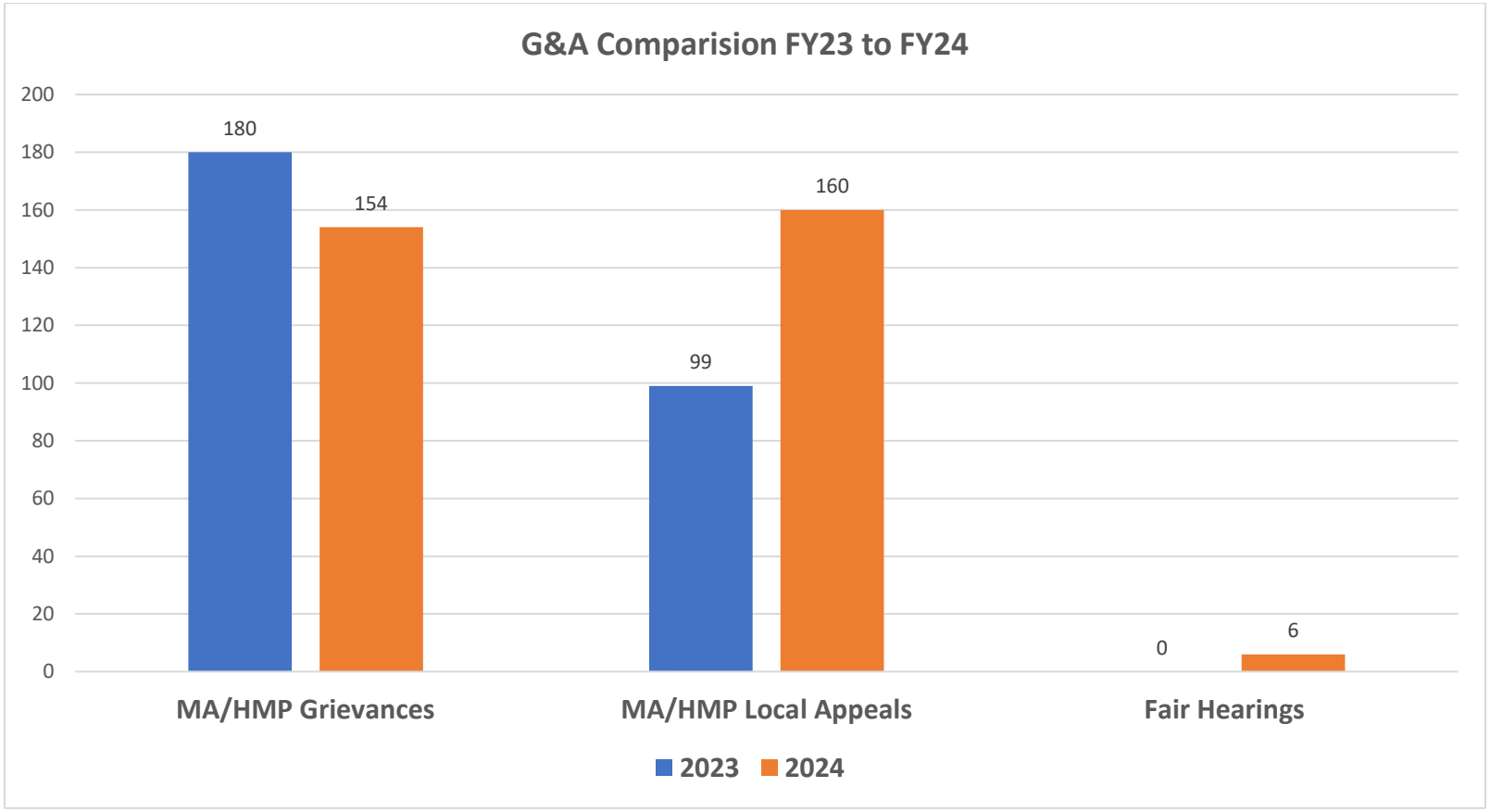
*Field will display "#DIV/0!" if there are no reported cases per category.

FY24 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	73	0.21	69	0	4	0	100%	0%
NOT A PIHP-COVERED BENEFIT	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
CLINICAL DOCUMENTATION NOT RECEIVED	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
TREATMENT/SERVICE PLAN GOALS MET	3	0.01	3	0	0	0	100%	0%
MEMBER NOT ELIGIBLE FOR SERVICES	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
MEMBER NON-COMPLIANT WITH TREATMENT/SERVICE PLAN	6	0.02	6	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	7	0.02	7	0	0	0	100%	0%
NOT APPLICABLE	71	0.20	68	0	3	0	100%	0%
Total	160	0.46	153	0	7	0	100%	0%

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

	Count	Percentage
Appeals	160	
Appeals Upheld	85	53%
Appeals Overturned	71	44%
Appeals Partially Upheld/Overturned	4	3%


G&A Comparision FY23 to FY24
200
180
160
140
120
100
80
60
40
20
0
180
154
99
160
0
6
MA/HMP Grievances
MA/HMP Local Appeals
Fair Hearings
2023
2024

O. Certified Community Behavioral Health Clinics (CCBHC)

Description

In October 2020, SWMBH had two participating CCBHCs- Pivotal (St Joseph County) and Integrated Services of Kalamazoo (ISK, Kalamazoo County). In October 2023 four additional CMHSPs joined from SWMBH's region- Barry County Community Mental Health Authority, Riverwood Center (Berrien County), Pines Behavioral Health (Branch County), and Summit Pointe (Calhoun County). In October 2024, Van Buren County Mental Health joined the CCBHC Demonstration as well. While some regional CMHSPs are also CCBHC Expansion Grant participants, SWMBH is not responsible for monitoring those requirements.

Core Services

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

- 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.
- Intensive, community-based mental health care for beneficiaries of the armed forces and veterans, particularly those beneficiaries and veterans located in rural areas.
- Crisis mental health services which in 2024, Behavioral Health Urgent Cares (BHUC) were added as a requirement under crisis receiving/stabilization services.

To account for providing these core requirements and the recommended evidence-based practices, the state continued the Prospective Payment System (PPS-1) reimbursement structure that finances CCBHC services at an enhanced daily clinic-specific rate to properly cover costs and offer greater financial predictability and viability.

PIHP Requirements

As the PIHP, SWMBH shared responsibility with MDHHS for ensuring continued access to CCBHC services. SWMBH was 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. SWMBH had a regional implementation governance structure for CCBHC with a steering committee of senior executives from SWMBH and CMHSPs and three sub-committees: IT data, clinical/quality, and finance. Each was led by a SWMBH director and CCBHC/CMHA representative, populated by current Medicaid CCBHC Demonstration CMHSPs with an open door to SAMHSA CCBHC CMHSPs. In the final quarter of FY24, with seven of eight regional CMHs being a part of the demonstration, the functions of these committees were moved to the regional committees as standard operations.

FY24 Identified Barriers and Analysis

After Demonstration Year (DY) 2 ended, MDHHS clarified that the state-reported measure data would be based on T1040 attribution (a CCBHC-specified billing code) instead of Waiver Support Application (WSA) enrollment/assignment as it originally was defined. Finalized DY2 Quality Bonus Payment (QBP) outcomes were released during FY24 and indicated that both ISK and Pivotal missed the benchmark for one of the six measures, Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD), for the second year in a

row, making them ineligible for the 5% QBP. Both CCBHCs were awarded redistributed QBP funds, however. SAA-AD measure technical specifications continued to prohibit the inclusion of extended-release injections in the numerator and was one identified barrier in meeting the measure benchmark. The understanding of the financial rate setting of the unique PPS-1 rate, the flow of supplemental funds, and CCBHC's financial impact on the Medicaid funding in the region was not fully understood until DY2. These constraints, along with the initial lack of clarity in the MDHHS-created CCBHC handbook of the PIHP's role allowed SWMBH to provide commentary but not input into the cost reports submitted by the initial two Region 4 CCBHCs. The transfer of funds from traditional Medicaid to CCBHC has resulted in five of the six operating their traditional Medicaid services/line of business at a loss.

The overlapping MDHHS-created CCBHC handbook changes made during FY24 caused a lack of clarity to what rules applied to FY24 vs. FY25. CCBHCs in Region 4 also prepared during this fiscal year to ensure compliance with the new SAMHSA CCBHC requirements, which includes BHUC.

Improvement Efforts Made in FY24

The lessons learned from the previous year assisted SWMBH, working in concert with ISK and Pivotal, to provide valuable support and technical assistance to the additional four regional CMHSPs that were new to the demonstration as of October 2023. Late in the fiscal year, the committees' structure was changed to gain meeting efficiency, and SWMBH began utilizing existing regional committees to review CCBHC-related topics.

The revised QBP fund distribution methodology was finalized in June 2024, and MDHHS eliminated the "all or nothing" approach. Effective for DY3 results, awards will be distributed proportionally for individual measures based on the weight assigned to each measure (see table below). If a CCBHC does not meet benchmarks for QBP measures, the potential distribution amount will be added to a QBP redistribution pool specific to each measure. Funds in the pool will be distributed equally to the clinics in the top 25% of performance on each measure. This change in methodology opens the QBP award earning potential for CCBHCs.

DY1-DY2 Metric Results

Metric Name	State or CCBHC Reported Measure	Bench-mark	ISK QBP Results		Pivotal QBP Results		DY3 Distribution weight
			DY1	DY2	DY1	DY2	
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	CCBHC	23.90%	36.1%	68.5%	74.90%	81.2%	.19
Major Depressive Disorder: Suicide Risk Assessment (SRA-A)	CCBHC	12.50%	68.89%	49.8%	68.89%	92.2%	.19
Adherence to Antipsychotic Meds with Schizophrenia (SAA-BH)	State	58.50%	53.61%	52.4%	52.70%	55.8%	.05
Follow up after Hosp for Mental Illness, ages 21+ (FUH)	State	58%	73.29%	70.1%	79.27%	73.1%	.19
Follow up after Hosp for Mental Illness, ages 6-21 (FUH)	State	70%	82.35%	90.0%	80.77%	89.1%	.19
Initiation and Engagement of Alcohol and other Drug Treatment (IET-BH) 14 day	State	25%	43.25	41.4%	39.46	38.8%	.19

DY3 QBP Metric Results will not be available to SWMBH for all six CCBHCs until 3/31/25.

FY24 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY23	FY24	Eval Score	FY25 Recommendations
Track QBP measures and CCBHC-Reported Measures at least quarterly. Report to all CCBHC subgroups.	CCBHC Subgroup Meetings	Bi-monthly, at minimum	Met	Met	**4**	The goal was met, and the process will continue in FY25.
Based on status of QBP and CCBHC-Reported Measures, analyze and document clinical pathways, and if needed, revise to improve QBPs.	CCBHC Subgroup Meetings	Quarterly	Met	Met	**4**	The goal was met, and the process will continue in FY25.
PIHPS will collect, validate clinic-reported data templates and either make available or submit to MDHHS per the schedule outlined in CCBHC Handbook.	CCBHC Subgroup Meetings	Quarterly & Annually by 3/31/2024 (DY2) 3/31/2025 (DY3)	Partially Met	Met	**4**	This goal was met as FY23 (DY2) clinic-reported data was submitted timely during FY24. FY24 (DY3) clinic-reported outcomes are due 3/31/2025. This process will continue in FY25; however, the measurement year will change to a calendar year vs. fiscal. Revised due dates are outlined in the CCBHC Handbook v2.0.
Develop written guidelines and process maps to support new regional CCBHC sites.	All CCBHC Subgroup Meetings	Annually	Met	Partially Met	**3**	This goal was partially met as QBP cheat sheets were maintained to assist CCBHCs with metric guidelines and tips for success. This goal will not continue.

P. External Quality Monitoring and Audits

Description

SWMBH 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. Audit results were reviewed, analyzed, and shared with relevant SWMBH regional committees and the SWMBH Board of Directors, as appropriate. Regional and internal CAPs were developed for reviews/audits that did not achieve specified benchmarks or established targets.

FY24 Identified Barriers and Analysis

One barrier that exists related to the HSAG EQR audit was with denials and adverse benefit determinations (ABDs). SWMBH has increased the amount of oversight and moved to quarterly audits, but the score in that section is reflective of the ongoing issues. Efforts will be focused on those areas to make improvements in FY25. A barrier that existed related to the HSAG NAV audit was that little information or guidance was provided to SWMBH prior to the audit. At the time of the audit, it was unclear what the auditors would be reviewing or asking questions about, but SWMBH still performed well receiving a score of 100%. No specific barriers were identified for the PMV audit or SUD site visit.

Improvement Efforts Made in FY24

SWMBH made multiple internal process improvements in FY24 around planning, hosting, and following up after external monitoring audits. Prior to the HSAG EQR audit the findings and recommendations were rereviewed from the applicable sections reviewed in FY21. Substantial effort was put into responding to the standards with thorough descriptions and providing supporting evidence. Similarly, for the HSAG PMV audit, the weaknesses that were identified in the FY23 audit were addressed through process changes, increased validation efforts, both of which were acknowledged as substantial improvements by the HSAG Review Team.

FY24 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY23	FY24	Eval Score	Recommendations
SWMBH will achieve an overall compliance score of >90% or top 2 scoring PIHPs during the 2024 HSAG External Quality Review (EQR).	QMC, SWMBH Senior Leadership Meetings and other Regional Committees	Annually	97%	89%	**4**	SWMBH met 76 of 85 Standards (89%) that were audited during FY24, which was year 1 in the HSAG EQR Audit cycle. The scores of all PIHPs have not been released at the time of this report. SWMBH will maintain the same goal for year 2 of the HSAG EQR Audit Cycle.
SWMBH will achieve an overall compliance score of >95% on the annual HSAG Performance Measure Validation Review (PMV).	QMC, SWMBH Senior Leadership Meetings and other Regional Committees	Annually	100%	PMV-100% NAV-100%	**5**	SWMBH scored 100% in FY24 for the HSAG PMV audit. SWMBH will review and implement strategies to address the recommendations made by the HSAG review team and will maintain the same goal for the FY25 HSAG PMV audit. Partnered with the PMV audit, HSAG also conducted the Network Adequacy Validation (NAV) Audit and SWMBH scored 100%.
During FY24, SWMBH will follow up on all recommendations from the FY23 Waiver Audit in preparation for improved scores in FY25. Systemic issues from the FY23 MDHHS Waiver Audit will be addressed during regional committees for systemic remediation and to prevent the likelihood of a repeat citation.	QMC, CPC and other Regional Committees as necessary	Annually	N/A	Met	**4**	Systemic issues were addressed in the Regional Clinical Practices Committee meetings, via e-mails, and in other communications throughout the year. SWMBH also addressed similar findings during the FY24 CMHSP Administrative and Delegated Function Site Reviews and CMHSPs were required to create and implement CAPs from those findings. SWMBH's next Waiver Audit will occur in FY25, and the goal will be to reduce the number of repeat citations compared to the FY23 audit.
SWMBH will achieve an overall compliance score of >95% on the MDHHS Substance Use Disorder Site Visit.	QMC, SUD workgroup and Board	Annually	92%	97%	**5**	The MDHHS SUD Site Visit in FY24 audited 49 standards, worth 2 points each for a total of 98 points possible. SWMBH received 95 points (missing 1 point on 3 standards) for a score of 97%.

HSAG FY24 EQR Audit Results

The state fiscal year SFY24 compliance review was the first year of the three-year cycle.

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	21	18	3	3	**86%**
Standard III—Availability of Services	20	18	18	0	2	**100%**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100%**
Standard V—Coordination and Continuity of Care	16	15	15	0	1	**100%**
Standard VI—Coverage and Authorization of Services	23	22	16	6	1	**73%**
Total	**94**	**85**	**76**	**9**	**9**	**89%**

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

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

HSAG FY24 PMV Audit Results

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

Fiscal Year	PMV Result
FY21	90%
FY22	100%
FY23	100%
FY24	100%

Strengths

HSAG's final report noted strengths within the Region including SWMBH's collaboration and process improvements across all of the CMHSPs, and improvement in data quality with all CMHSPs working in the same PCE-based EHR system which includes extensive data controls and validation steps.

Weaknesses

HSAG noted five weaknesses including the manual data entry errors resulting in incorrect BH TEDS data impacting Indicator #2e, an incorrectly reported exception for Indicator #10, misalignment between beneficiary-level detail data counts and MMBPIS reporting to MDHHS for Indicators 2, 2a, and 4, a case that was incorrectly reported as compliant when it should have been an exception for Indicator 4b, and Indicator #3's total rate fell below the 50th percentile benchmark. SWMBH will work to address all identified weaknesses in FY25.

HSAG FY24 NAV Audit Results

SWMBH participated in the HSAG NAV audit for the first time in FY24 and scored 100%.

Standard Type	Total "Met" elements	Total "Not Met" elements	Score	Validation Rating
PIHP-Time and Distance-Behavioral Health	19	0	100	High confidence

MDHHS FY24 SUD Site Visit

MDHHS audited 49 standards worth 2 points each for a total of 98 possible points. SWMBH received 95 points for a score of 97%. MDHHS determined that SWMBH was in compliance with the SUD/PIHP Compliance Protocol and has the necessary tools in place to manage, maintain, and report data from the provider network.

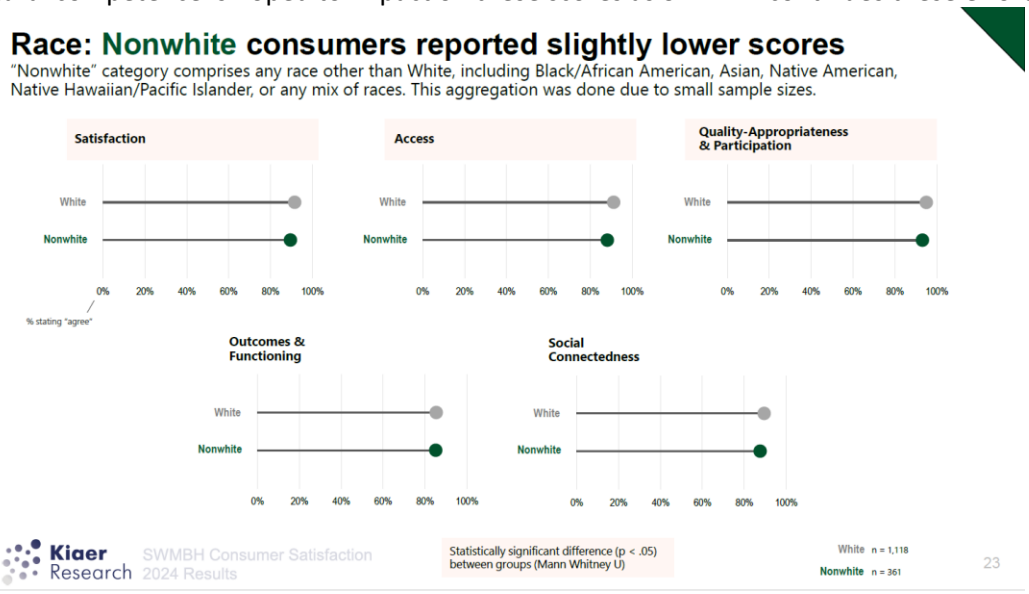
Q. Cultural Competency

Description

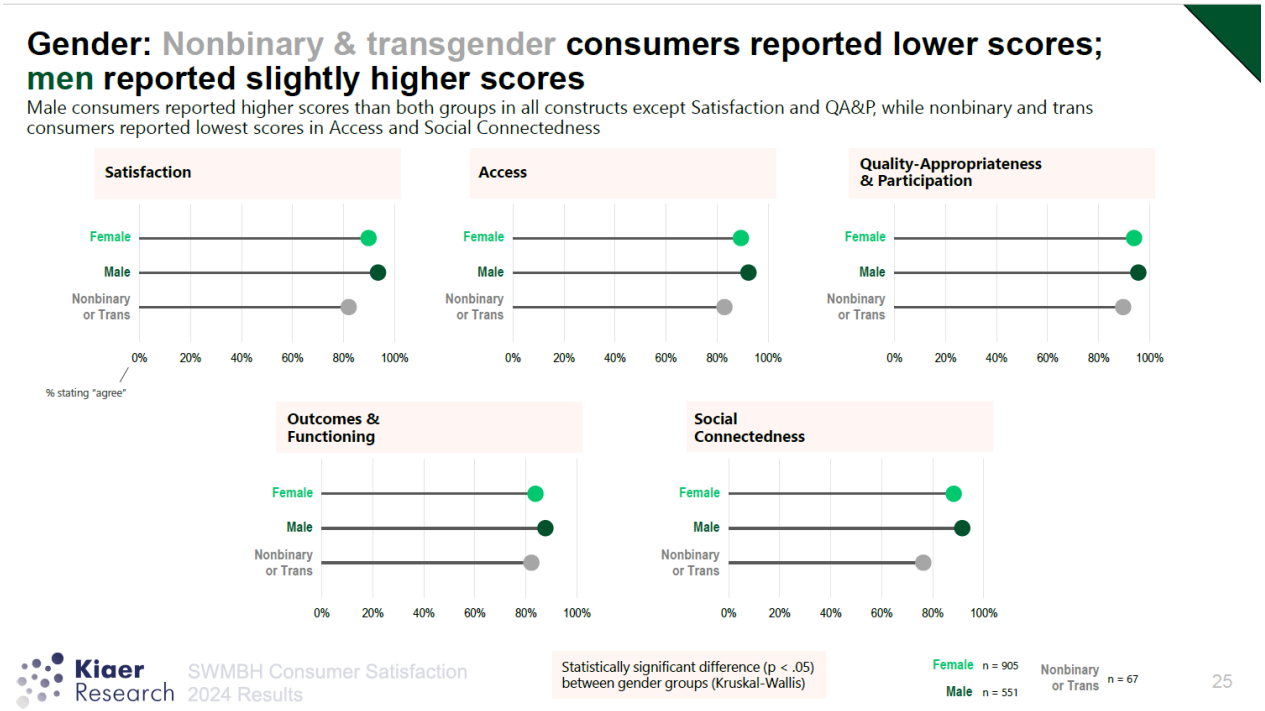
SWMBH remained dedicated to ensuring that the supports and services provided throughout Region 4 demonstrate an ongoing commitment to linguistic and cultural competence that ensured access and meaningful participation for all Members. Such commitment included acceptance and respect for the cultural values, 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 and demonstrate compliance with the MDHHS/PIHP contract, SWMBH had the following five components in place: Community Assessment, Policy and Procedure, Service Assessment and Monitoring, Ongoing Training, and Culturally Contextual Services/Supports.

Community Assessment

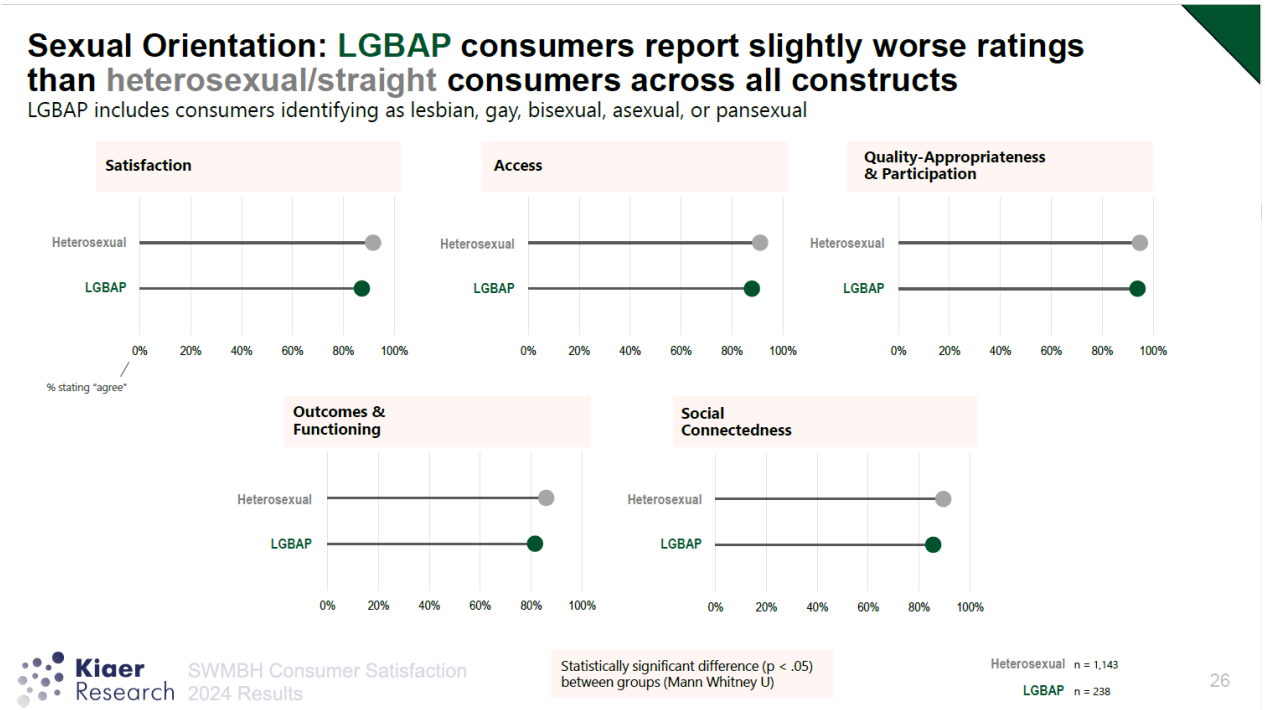
SWMBH used the annual regional Network Adequacy assessment the Customer Satisfaction Survey to assess for a culturally competent provider network and consumer involvement throughout the region. Results from the 2024 SWMBH Consumer Satisfaction Survey noted some areas for future improvement. Non-white consumers reported slightly lower scores overall, with areas such as Satisfaction, Access, Quality-Appropriateness & Participation having a statistically significant difference from white consumers in the region. Continued focus on improved cultural competence is hoped to impact on these scores as SWMBH continues these efforts.



Beneficiaries that identify as LGBTQIA+ also provided data on some areas in which cultural competence could be improved. Non-binary and transgender consumer reported lowers scores with each domain demonstrating a statistically significant difference in all areas with Access and Social Connectedness having the lowest scores.



Beneficiaries with sexual orientations such as lesbian, gay, bisexual, asexual, or pansexual (LGBAP) also reported statistically significant lower scores than heterosexual or straight beneficiaries in the region.



Languages spoken throughout the provider network were gathered through the Region's credentialing process. According to SWMBH's Provider Directory, Region 4 has a larger provider that speaks Hindi, Malayalam, Portuguese, Sinhalese, Spanish, Tanul, as well as American Sign Language and these languages are listed under each site, which resulted in higher percentages for the counties where the sites are located, as shown in the table below. Branch and St. Joseph Counties also have higher percentages as a larger provider with multiple sites reported Spanish as a secondary language at each site.

County	County Population % Spanish Speaking	# of Provider Sites with 1+ Spanish Speaking Clinician	% of Provider Sites with 1+ Spanish Speaking Clinician
Barry	1.6%	0	0.0%
Berrien	3.8%	9	17.0%
Branch	4.1%	12	50.0%
Calhoun	3.0%	4	6.3%
Cass	1.8%	0	0.0%
Kalamazoo	2.6%	2	1.4%
St. Joseph	6.3%	10	32.3%
Van Buren	8.2%	9	14.1%
Outside of Region 4	~	23	9.8%
SWMBH	3.9%	69	0.88%

SWMBH's credentialing application ensures data is being collected on physical accessibility of provider office locations. The accessible features of each site have been added to SWMBH's online Provider Directory and SWMBH updates them when notified of changes. SWMBH's online Provider Directory has a search option "Accessibility for Disabilities" with a drop-down menu for "Yes", "Unknown", and "No". The region completes site reviews of each in-network provider on an annual basis and monitors for accessibility and ensures there are business processes for the provision of adaptive equipment and/or environmental modifications.

At the county level, MDHHS requires that each CMHSP conduct a nominal Needs Assessment at least every two years. Michigan also launched as a CCBHC Demonstration state in 2021, and MDHHS will require 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 are discussed, analyzed, and organized via county level workgroups and presentations. Community needs assessments are used to create a foundational equity framework that is specific to the county level.

Policy and Procedure

SWMBH Policy 03.07 Cultural & Linguistic Competency and SWMBH Procedure 03.07A 2023 SWMBH Cultural Competency Plan continue to 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.

Service Assessment and Monitoring

SWMBH employs a Health Equity Project Coordinator position that is entirely dedicated to reducing health equity disparities for minorities. This is a grant funded position that will continue to plan and develop region wide programming to increase the access and participation of minority populations in behavioral health services. In FY24 this position facilitated a Regional Health Equity Focus Group that consisted of representation from all 8 counties in the Region 4. The workgroup met quarterly and helped to identify regional and county barriers. Likewise, the workgroup participants brought advice from frontline partnerships for further coordination and support, provided feedback on trainings and anti-stigma campaign efforts.

Cultural competency was further assessed and monitored according to current CCBHC, MMBPIS, and other metrics geared toward ensuring cultural competence and fairness in service delivery. Metrics that center around underserved populations are reviewed by SWMBH's internal Health Equity PIP work group quarterly, to ensure up to date monitoring. This group continued to expand its work in FY24, and report of these activities is covered in more detail in the PIP section of this report. 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 and quarterly meetings with Medicaid Health Plans (MHPs) to collaboratively monitor fluctuations in performance measures and identify interventions pertaining to disparities.

Training

SWMBH required ongoing training to assure that staff were aware of, and able to effectively implement cultural competency policies and procedures. SWMBH required all providers' staff, that were in-network, to have cultural competency training and reviewed this item as part of the Staff Training File Review of the annual site review process. The findings across the region for FY24 were as follows:

FY24 CMHSP Site Review	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St. Joseph Co	Van Buren
Cultural Competency Scores	100%	100%	85%	100%	100%	100%	95%	100%

Additionally, data on "Specialties & Cultural Competence" was collected in Organizational Credentialing packets, as well as in Individual Practitioner Credentialing Packets, to ensure SWMBH is collecting this data for in-network organizations.

SWMBH offered the following trainings that address aspects for cultural competence free of charge to all provider agencies in Region 4: Ableism 101 and 102, Disability and Healthcare Equity Training, Disability and Intersectionality Training, Person-Centered Thinking, Culture of Gentleness, Charting the Life Course, and Implicit Bias Training.

A virtual health equity education series was offered in 2024. The event included six speaker presentations with topics as follows: Health Communication 101, a two-part Bias and Community Engagement, Disability and Health Equity, Stigma in Mental Health, and African American Disparities in Behavioral Health. This virtual health equity series was geared towards providers in the region and free to attend. Post survey results showed at least 94% of surveyed participants agreed that they are more knowledgeable on the disparities of underserved populations after each speaker's presentation. Likewise, "Flip the Script: Creating a New Narrative", a full day anti-stigma symposium event was held on June 13, 2024, at the Western Michigan University Fetzer Center. This event was geared towards local behavioral health providers and free to attend. The event included 6 local speakers and topics including Racial Disparities in Black Mental Health, Stigma in the Faith-Based Community, Addressing Mistrust (TIP), General Stigma, Personal Peer Recovery, and Barriers to Mental and Behavioral Health Care. Post survey results showed that 98% of surveyed participants would attend another similar symposium event in the future and that 94% of surveyed participants agreed their knowledge on health disparities of underserved populations increased after attending the event.

Culturally Contextual Services/Supports

SWMBH strived to ensure that supports and services were provided within the cultural contexts to all beneficiaries. SWMBH's community-sponsored events were selected by the Community Outreach Committee and Engagement Committee, which is dedicated to finding opportunities to better reach underserved and minority populations. Through the Community Outreach and Engagement Committee, SWMBH sponsored, promoted, and participated in many community activities focused on attracting minorities and their allies. Events included but were not limited to: Kalamazoo Pride, Stand Down events geared towards Veterans and their families, Project Connect events geared towards the unhoused population, and Suicide Prevention and Recovery events in various counties. SWMBH employs a Veteran Navigator that provided Military Culturally Competency training to new hires, CMH staff, as well as community members and organizations.

FY24 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	Eval Score	Recommendations
Further develop trainings in 2024 by adding a health equity lecture series and symposium will be offered.	SWMBH's Integrated Care Team	Annually	100%	**5**	The symposium was held with respondent surveys indicated that participants cultural competency skills were increased through the participation in the symposium. A revised/ updated training goal will be included for FY25.
Promote continued education throughout the organization and 8-county region by participating in or contributing to local organizations and public events. Continue to seek culturally relevant, visible opportunities that attract minorities and their allies.	Customer Services, Provider Network and Clinical Practices Committees	Annually	100%	**5**	Events were increased and the cultural groups included racial and ethnic minorities, unhoused persons, veterans, and members of the LGBTQIA+ community. Recommend continuation of this goal to continue to engage with community in FY25.
SWMBH will evaluate language spoken by network providers vs. enrollees 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 Beneficiary's needs are being met in this capacity.	Customer Services, Provider Network and Clinical Practices Committees	Annually	100%	**5**	Survey results were received, and regional committees both reviewed and discussed outcomes on both a county-specific and regional level. Recommend to continue this goal in FY25.

FY24 SWMBH Agency Metrics

This document serves to summarize the Agency Metrics for completion in FY 2024

- 4 Metrics Rolled Over from 2023 to 2024
  (*Please see detailed outcomes and status for each metric*)

Agency Metric	Metric Deliverable	Metric Result
SWMBH will achieve the FY23 Initiation and Engagement State Specified benchmarks and participate in DHHS led data validation activities.	a. The PIHP must participate in DHHS planned and DHHS-provided data validation activities and meetings. PIHPs will be provided IET data files by January 31 each year, and within 120 calendar days, return their data validation template, completed, to DHHS. -met b. CCBHC Goal – Participating CCBHC sites achieve IET- 14-day metric at 25% and the IET-34-day metric at 18.5% per state indicated benchmarks. -met	**2023 Rollover Metric** Metric Achieved
SWMBH will submit a qualitative narrative report to MDHHS specific to Patient-Centered Care activities and programs throughout the PIHP region.	Submit a narrative report of no more than 10 pages by November 15, 2023 summarizing prior FY efforts, activities, and achievement of the PIHP and CMHSPs, specific to Patient-Centered Care activities and programs throughout the PIHP region.	**2023 Rollover Metric** Metric Achieved
2023 Customer Satisfaction Surveys collected by SWMBH are at or above the 2022 baseline results identified in (a & b) and performance improvement areas/plans are identified (c & d).	a. Mental Health Statistic Improvement Project Survey (MHSIP) tool. (Outcomes & Functioning – 2022 baseline: 78.6%) Result – 81% -met b. Youth Satisfaction Survey (YSS) tools. (Outcomes – 2022 baseline: 75.51%) Result- 73% -not met c. Work with the SWMBH Consumer Advisory Committee as Focus group to document, understand and act upon potential improvement efforts that impact overall Consumer Satisfaction. –met	**2023 Rollover Metric** Metric Partially Achieved
Michigan Mission Based Performance Indicator System (MMBPIS) Data, Tracking and Analysis	a. 24/28 indicators meet the State Benchmark, throughout all FY23 for 4 consecutive quarters. -met b. Indicator 3a,b,c & d achieve a 3% combined improvement (*through FY 23 all 4 Quarters*) over 2022 baseline -not met	**2023 Rollover Metric** Metric Partially Achieved

Implement data driven outcomes measurement to address social determinants of health	Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. Submit a 2-page narrative report and project plans aimed at improving outcomes: a. beneficiary changes in employment and housing b. actions taken to improve housing and employment outcomes	**2024 Metric** Metric Achieved
Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD) (10)	Percentage of Adults 18 and Older with Schizophrenia or Schizoaffective Disorder who were Dispensed and Remained on an Antipsychotic Medication for at Least 80 Percent of their Treatment Period a. participate in DHHS-planned and DHHS provided data validation activities and meetings	**2024 Metric** Metric Achieved
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) adolescents and adults	By September 1, 2024 provider action plans will be developed to improve this metric.	**2024 Metric** Metric Achieved
2024 Customer Satisfaction Surveys collected by SWMBH are at or above the 2023 baseline results	a. Mental Health Statistic Improvement Project Survey (MHSIP) tool. (Outcomes & Functioning – 2023 baseline: 81**%)** -met b. Youth Satisfaction Survey (YSS) tools. (Outcomes – 2023 baseline: 73**%)** -met	**2024 Metric** Metric Achieved
SWMBH will meet or exceed the Behavioral Health Treatment Episode Data Set (BH TEDS) compliance benchmarks established by MDHHS for FY23	a. 97% of applicable MH served clients (with an accepted encounter) will have a matching and accepted BH TEDS record, as confirmed by the MDHHS quarterly status report. -met b. 97% of applicable SUD served clients (with an accepted encounter) will have a matching and accepted BH TEDS record, as confirmed by the MDHHS quarterly status report. -met c. 97% of applicable Crisis served clients (with accepted encounter) will have a matching BH TEDS record, as confirmed by MDHHS quarterly status report. -met	**2024 Metric** Metric Achieved
2024 HSAG Performance Measure Validation (PMV) Audit Results	SWMBH will achieve score of at least 90% on the PMV for 2024.	**2024 Metric** Metric Achieved

2024 HSAG validated PIP- Reducing Racial Disparities in Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	a. The HSAG validation status of the PIP will me met -met b. The FY24 measurement of outcomes will show there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African American/Black beneficiaries) -not met c. The FY24 measurement of outcomes will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (White beneficiaries). -not met **14.53%-** 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. -not met **23.39%-** The percentage of White beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence. -not met	**2024 Metric** Metric Partially Achieved