



Quality Assurance and Performance Improvement Program (QAPIP) Fiscal Year 2025 Plan


All SWMBH Medicaid Business Lines

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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.

II. Purpose

The QAPIP Plan delineates the features of the SWMBH Quality Management program. The QAPIP promotes high quality health care services and outcomes for beneficiaries through systematic monitoring of key performance elements, integrated with system-wide approaches to continuous quality improvement.

The SWMBH QAPIP spans across clinical and non-clinical service delivery within the network as well as the benefit management processes within SWMBH. Populations served by SWMBH and the CMHSPs within the region include eligible individuals and their families who experience mental illnesses, developmental disabilities, and substance use disorders.

Additional purposes of the QAPIP are to:

- Monitor, evaluate, and drive process improvement throughout the system and the region.
- Develop and implement efficient and effective processes to monitor and evaluate service delivery, quality, integration of care, beneficiary satisfaction, and data integrity, while promoting the timely identification and resolution of quality-of-care issues.
- Promote and support best practices that guide optimal benefits in service areas of accessibility, acceptability, value, impact, and risk-management for all beneficiaries.
- Monitor and report the results of ongoing performance monitoring to ensure performance standards and other requirements are met.
- Meet the needs of internal and external stakeholders and provide performance improvement leadership to other departments and throughout the region. Stakeholders are defined as a person, group, or organization that has an interest in the organization, including beneficiaries, family members, guardians, staff, community members, advocates, etc.

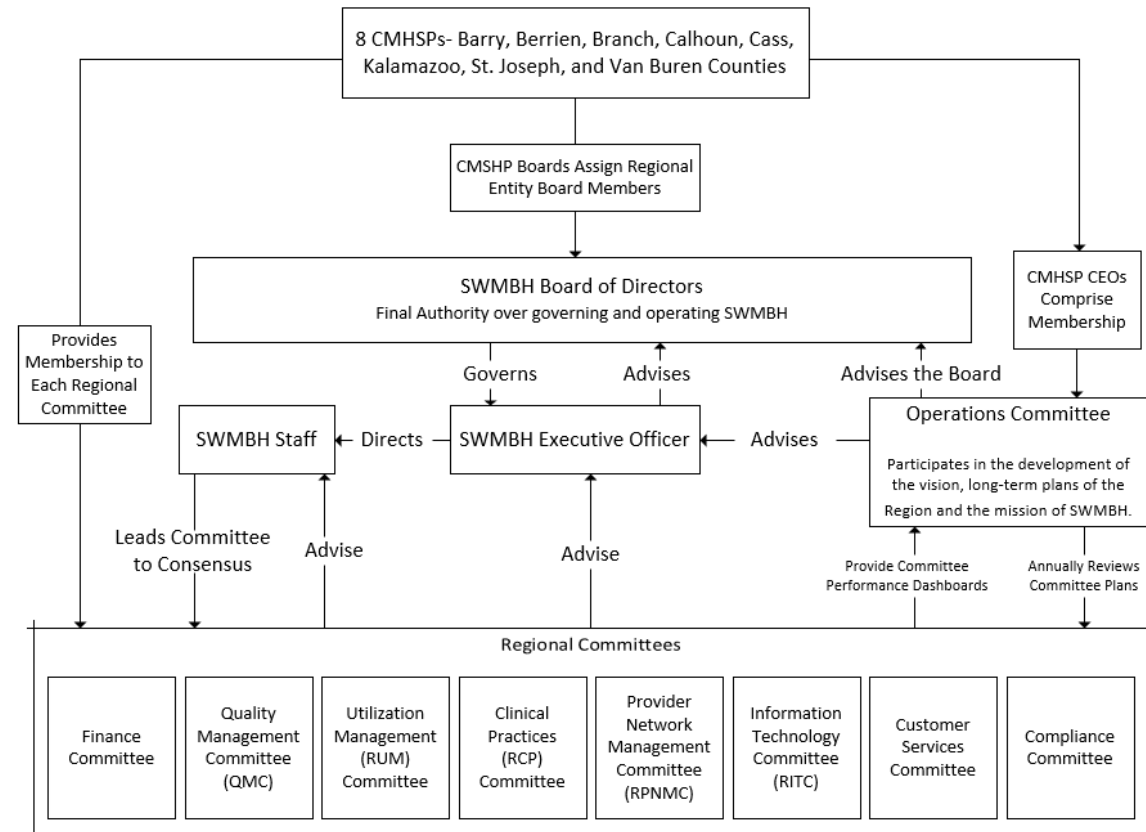
III. QAPIP Authority

The QAPIP is accountable to the SWMBH Board of Directors which acts as the governing body and is a PIHP Regional Entity (see Attachment B – SWMBH Board Roster). Responsibilities of the Board for monitoring, evaluating, and making improvements to care include:

- Oversight of the QAPIP- the Board must approve the overall QAPIP and Plan annually.
- QAPIP Progress Reports- the Board receives written reports related to performance improvement projects undertaken, the actions taken, and the results of those actions.

- Annual QAPIP Review- the Board formally reviews a written report on the operation of the QAPIP no less than annually.
- Submission of the QAPIP Plan and Evaluation to MDHHS by the contractually defined due date each year. The report includes a list of the Board Members.

In addition to the review by the SWMBH Board and SWMBH EO, the QAPIP Plan and Evaluation are taken to the SWMBH Operations Committee to facilitate the development and management of quality assurance and improvement initiatives throughout the Region. The SWMBH Operations Committee consists of the CEO, or their designee, for each of the eight CMHSPs in the region and advises the SWMBH Board.



IV. Guiding Principles

The Board Ends serve as the guiding principles for the development of annual Board Ends Metrics, SWMBH Agency Metrics, Regional Committee Goals, SWMBH Department Goals, and Regional Strategic Objectives set forth by the SWMBH Board. In October 2024, the SWMBH Board adopted a revised set of Board Ends, which directs SWMBH towards the benefits to be produced, for whom, and at what cost reflecting the organization's vision and reason for being. Developing revised Board Ends included multiple contacts with each of the eight CMHSP Boards to ensure their values are expressed through the Board Ends.

Board Global End: As a benefits manager of state and federal funds, SWMBH exists to assure that member agencies and providers create sustainable programs and provide specialty services so that persons in the SWMBH region have access to appropriate resources and experience improvements in their health status and quality of life, optimizing self-sufficiency, recovery, and family preservation. Quality services are provided while minimizing costs through efficient stewardship of human, financial, and technology resources available and use of shared knowledge.

- Member CMHSP boards, EOs, and staff value the partnership with SWMBH, and experience the relationship as collaborative, transparent, responsive, and reciprocal.
- Member CMHSPs are aware of environmental disruptors and trends and benefit from SWMBH's regional and statewide regulatory and public relations advocacy impacting the Mental Health Community.
- Member CMHSPs have the resources needed to address their communities' individualized needs, successfully access appropriate resources and successfully meet contractual obligations (*including managed care functions*).
- Member CMHSPs and other providers assure and monitor ready access to appropriate programs and services for their consumers and contribute accurate data so SWMBH can create aggregated, comprehensive, and comparative regional results which supports access to maximum funding available.
- The SWMBH regional partners align with best practice, learning from each other, collaborating, sharing resources, and benefitting from lessons learned.

V. Quality Organizational Structure

The general oversight of the development and implementation of the QAPIP is given to SWMBH's Quality Management and Clinical Outcomes Department. The Director of Quality Management and Clinical Outcomes is the designated senior official responsible for overseeing the department and QAPIP implementation. The Quality Management and Clinical Outcomes Department is additionally staffed with a Quality and Performance Improvement Manager, Clinical Quality Specialists, Clinical Data Analysts, a Clinical Projects Specialist, and SWMBH's Integrated Care Team. Together, the department monitors and evaluates the overall effectiveness of the QAPIP, assesses its outcomes, provides periodic reporting on the program (including Performance Improvement Projects), and chairs and facilitates the Quality Management Committee (QMC) and Regional Clinical Practices (RCP) Committee. Additionally, the Director of Quality Management and Clinical Outcomes collaborates on many of the QAPIP goals and objectives with the SWMBH Senior Leadership team and with SWMBH Regional Committees including QMC, RCP, Regional Information Technology (RIT) Committee, Regional Utilization Management (RUM) Committee, Regional Provider Network Management Committee (RPNMC), and the Regional Compliance Committee.

SWMBH also has access to the Medical Director to support and advise the department in meeting the QAPIP deliverables. The Medical Director provides supervision and oversight of all SWMBH clinical functions to include Utilization Management, Customer Services, Integrated Care, Provider Network, Substance Use Prevention and Treatment, and other clinical initiatives. The Medical Director also provides clinical expertise and programmatic consultation to the Quality Management and Clinical Outcomes Director to ensure complete, accurate, and timely submission of clinical quality program data.

VI. Communication

To effectively adopt and communicate process and outcome improvements, SWMBH utilizes a structured approach that ensures continuous evaluation, transparency, and collaboration across all levels of the organization and region. By using this structured approach, SWMBH ensures that improvements are adopted effectively, and the results are communicated transparently to everyone involved, fostering a culture of continuous improvement. Key mechanisms include:

- **Data Monitoring and Analysis:** SWMBH places a strong emphasis on the use of data to guide treatment and decision-making. By leveraging both quantitative and qualitative data, SWMBH continuously monitors the information, identifies trends, and tailors interventions to meet individual, organizational, and regional needs. This data-driven approach allows SWMBH to improve the effectiveness of services,

ensure that improvement efforts are targeted, and provide measurable outcomes that inform decisions. SWMBH is committed to integrating research, beneficiary feedback, and clinical insights to ensure that every aspect of care is grounded in the best available information.

- **Stakeholder Involvement:** Input from beneficiaries, families, and other internal and external stakeholders is integral to the process. SWMBH engages those groups through surveys, committee meetings, and other collaborative discussions to ensure that improvements align with regional needs and goals.
- **Transparent Communication Channels:** SWMBH provides ongoing education and training for the region to ensure there is understanding of any new or updated processes and the rationale behind changes. SWMBH also uses various communication tools (member and provider newsletters, meetings, and SWMBH’s website) to share progress and outcomes with all stakeholders. This ensures that everyone is aware of the improvements, their rationale, and the impact on service delivery and care.
- **Regular Feedback Loops:** After implementing improvements, SWMBH establishes continuous feedback loops to monitor progress. This includes regular check-ins, meetings, and ongoing monitoring to track outcomes, ensure understanding, and gather input from those directly involved in the process.
- **Performance Metrics:** Clear and measurable performance indicators are used to measure and assess the effectiveness, efficiency, and outcomes of specific processes, initiatives, or interventions. These metrics are communicated regularly to all stakeholders to demonstrate progress and inform future strategies.

The Quality Management and Clinical Outcomes Department interacts with all other departments within SWMBH as well as with the CMHSPs, which is a critical component to the success of the QAPIP. At least annually, the Quality Management and Clinical Outcomes Department shares the QAPIP Plan and Evaluation, beneficiary satisfaction survey results, and other relevant information in newsletter articles and on the SWMBH website for stakeholders to review.

VII. Participation of Providers and Individuals in the QAPIP Processes

Providers and beneficiaries serve as members of SWMBH’s Regional committees, sub-groups, and workgroups as appropriate. Committee and group members are expected to attend all meetings virtually, by phone, or in person. If members cannot attend a meeting, they are expected to send an alternative in their place. Members hold the responsibility of communicating all relevant information discussed during the meetings (and included in meeting materials and minutes) back to the appropriate individuals and/or departments within their organizations. Members who cannot attend meetings are made aware of process and outcome improvements discussed through meeting recordings, meeting minutes, and/or other materials (PowerPoint presentations, etc.) that are made available to the full committee following the meeting.

SWMBH additionally hosts a Customer Advisory Committee (CAC) which is made up of beneficiaries actively receiving services, with representation from all CMHSPs. During CAC meetings information is shared and feedback and discussion are requested and encouraged. CAC members also attend various regional committees which affords SWMBH the opportunity to involve beneficiaries in quality management and improvement efforts.



FY 2025 Quality Assurance and Performance Improvement Program Descriptions & Work Plan

A. Performance Measures

a) Michigan Mission Based Performance Indicator System (MMBPIS)

Description

SWMBH utilizes performance measures established by MDHHS in the areas of access, efficiency, and outcome measures. SWMBH is responsible for ensuring that its CMHSPs and SUD Providers are measuring performance through the MMBPIS per the contract with MDHHS. SWMBH maintains a dashboard tracking system to monitor individual CMHSP and Regional progress on each indicator throughout the year.

Each CMHSP is responsible for reviewing and submitting valid and reliable performance indicator data to SWMBH via the SWMBH Commons by the 25th of every month for analysis. SWMBH promotes data integrity by using electronic controls within the spreadsheets used for reporting MMBPIS data. SWMBH has a Clinical Quality Specialist dedicated to reviewing the data to ensure it is complete and accurate, based on the MMBPIS PIHP Code Book, prior to submission to MDHHS. SWMBH submits the data to MDHHS quarterly as established in the contract schedule. When State-indicated benchmarks are missed or other issues are identified, SWMBH requests the CMHSPs and/or SUD Providers to complete a Corrective Action Plan (CAP). SWMBH Subject Matter Experts (SMEs) also review performance indicator compliance and are incorporated in approval of MMBPIS-related CAPs. The PIHP ensures the action plans are achieved and improvements are recognized. Status updates are given, and regional trends are identified and discussed at relevant committees such as QMC, RUM, RCP and Operations Committee for further planning and coordination. SWMBH also participates in the MDHHS Quality Improvement Council (QIC) and associated sub-workgroups and communicates any changes with indicator measurements or reporting to stakeholders.

SWMBH utilizes the QAPIP to assure it achieves minimum performance levels on performance indicators as established by MDHHS as defined in the contract and analyzes the causes of statistical outliers when they occur. Oversight and monitoring are conducted by SWMBH through the monthly review of reports and analysis by the Quality Management Committee. The administrative and delegated function CMHSP site reviews occur annually. The SWMBH Quality Management and Clinical Outcomes (QMCO) Department completes a review of MMBPIS Performance Indicator (PI) data, primary source verification documentation and protocols during this annual site audit, CAPs may be requested from any CMHSPs with a site review score of two or less for each PI related standard.

FY25 Goals

In late FY24, MDHHS introduced their plans for a quality overhaul- a three-year roll-out strategy to implement new behavioral health quality measures that align with other state and national requirements (termed BH Quality Transformation) and reported that MMBPIS will be sunset at the end of FY25. SWMBH goals will remain for the final year of MMBPIS measures, that the PIHP will meet or exceed the MDHHS-indicated benchmark for each of the access and follow-up MMBPIS performance measures in the table below. Benchmarks that became effective in FY24 for indicators 2 and 3 remain in place for one additional year. SWMBH continues the non-clinical PIP in FY25 related to increasing indicator 3 outcomes as this benchmark, and goal of the PIP, was not achieved in FY24.

MMBPIS Indicators	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Indicator 1 - Percentage of Children who receive a Prescreen within 3 hours of request (>= 95%).	QMCO	QMC	Quarterly
Indicator 1 - Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95%).	QMCO	QMC	Quarterly
Indicator 2a - Percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service by four sub-populations: MI-adults, MI-children, I/DD-adults, I/DD-children (>=62%).	QMCO	QMC	Quarterly
Indicator 2e - Percentage of new persons during the quarter receiving a face-to-face service for treatment or support within 14 calendar days of a non-emergency request for service for persons with substance use disorders (>=68.2%).	QMCO, SUD	QMC, SUD Directors Workgroup	Quarterly
Indicator 3 - Percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment by four sub-populations: MI-adults, MI-children, I/DD-adults, and I/DD-children (>=72.9%).	QMCO	QMC	Quarterly

Indicator 4a(a) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%).	QMCO	QMC	Quarterly
Indicator 4a(b) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%).	QMCO	QMC	Quarterly
Indicator 4b - Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%).	QMCO, SUD	QMC, SUD Directors Workgroup	Quarterly
Indicator 10a - Re-admission to Psychiatric Unit within 30 Days-Children (<=15%).	QMCO	QMC	Quarterly
Indicator 10b - Re-admission to Psychiatric Unit within 30 Days- Adults (<=15%).	QMCO	QMC	Quarterly

b) Performance Bonus Incentive Program (PBIP)

Description

Contract quality withholds are established by MDHHS to support initiatives as identified in the MDHHS Comprehensive Quality Strategy. The quality withhold program is called the Performance Bonus Incentive Program (PBIP). The Criteria for the PBIP payments will include, but is not limited to, assessment of performance in quality of care, access to care, and administrative functions. PBIP withhold monies will be distributed as follows:

- Contractor-only Pay for Performance Measures: 45% of withhold
- Contractor Narrative Report: 25% of withhold
- MHP/Contractor Joint Metrics: 30% of withhold

FY25 Measures

Contractor-only Pay for Performance (P4P) Measures

Measure	Description	Deliverable
Implement data driven outcomes measurement to address social determinants of health. (18% of the P4P Measures)	Analyze and monitor BHTEDS records to improve housing and employment outcomes for persons served. Measurement period is prior fiscal year. Use most recent update or discharge BHTEDS record during the measurement period, look back to most recent prior update or admission record.	SWMBH will conduct an analysis and submit a narrative report of findings and project plans aimed at improving outcomes, no longer than two pages, by July 31, 2025. Narrative must address beneficiary changes in employment and housing and actions taken to improve housing and employment outcomes.
Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD). (9% of the P4P Measures)	Percentage of adults aged 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.	Region 4 will be measured against a minimum standard of 62%. Measurement period will be calendar year (CY) 2024.

<p>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). (18% of the P4P Measures)</p>	<p>The percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: 1. Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis. 2. Engagement of AOD Treatment: The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or Medication Assisted Treatment (MAT) within 34 calendar days of the initiation visit.</p>	<p>Region 4 will be measured against a minimum of 40% at initiation and 14% at engagement. Points will be divided evenly between Initiation and Engagement measures. Measurement period will be CY24.</p>
<p>PA 107 of 2013 Sec. 105d (18): Increased participation in patient centered medical homes. (25% of total withhold)</p>	<p>Narrative report summarizing participation in patient-centered medical homes (or characteristics thereof). Points for Narrative Reports will be awarded on a pass/fail basis, with full credit awarded for submitted narrative reports, without regard to the substantive information provided. The State will provide consultation draft review response to the Contractor by January 15th. The Contractor will have until January 31st to reply to the State with information.</p>	<p>SWMBH must submit a narrative report of no more than 10 pages by November 15th, 2025, summarizing prior FY efforts, activities, and achievements of SWMBH and CMHSPs to increase participation in patient-centered medical homes. The specific information to be addressed in the narrative is below: 1. Comprehensive Care 2. Patient-Centered 3. Coordinated Care 4. Accessible Services 5. Quality & Safety</p>

MHP/Contractor Joint Metrics

Measure	Description	Deliverable
<p>Implementation of Joint Care Management Processes. (10% of the Joint Measures)</p>	<p>Collaboration between entities for the ongoing coordination and integration of services.</p>	<p>Each Medicaid Health Plan and SWMBH will continue to document joint care plans in CC360 for beneficiaries with appropriate severity/risk, who have been identified as receiving services from both entities.</p> <p>Risk stratification criteria is determined in writing by the SWMBH-MHP Collaboration Work Group in consultation with the State. SWMBH must demonstrate joint care planning specific to child and adult populations. SWMBH must document joint care plans in CC360 for at least 25% of qualified adult Enrollees.</p>

<p>Follow-up After Hospitalization (FUH) for Mental Illness within 30 Days using HEDIS (Healthcare Effectiveness Data and Information Set) descriptions. (10% of the Joint Measures)</p>	<p>The percentage of discharges for beneficiaries six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 days.</p>	<p>1. Region 4 must meet set standards for follow-up within 30 days for each rate (ages 6-17 and ages 18 and older). Region 4 will be measured against an adult minimum standard of 58% and a child minimum standard of 79%. Measurement period will be CY23. The points will be awarded based on MHP/SWMBH combination performance measure rates.</p> <p>2. Data will be stratified by race/ethnicity and provided to plans. Region 4 will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of CY23 with CY24. The points will be awarded based on Region 4 performance measure rates.</p> <p>The points for overall standard (item 1 above) will be awarded based on MHP/ Region 4 combination performance measure rates. The points for reducing racial/ethnic disparities (item 2 above) will be awarded based on individual MHP or Region 4 performance over time. The total potential points will be the same regardless of the number of MHP/PIHP combinations for a given entity or number of racial/ethnic comparisons.</p>
<p>Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment. (5% of the Joint Measures)</p>	<p>Adult beneficiaries who had new SUD episodes that result in treatment initiation and engagement.</p> <p>1. Initiation of AOD Treatment: The percentage of beneficiaries who initiate treatment within 14 calendar days of the diagnosis.</p> <p>2. Engagement of AOD Treatment: The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 calendar days of the initiation visit</p>	<p>1. Region 4 will be measured against an initiation (IET 14) minimum standard of 40% and an engagement (IET 34) minimum standard of 14%. Measurement period will be calendar year 2024.</p> <p>2. Data will be stratified by race/ethnicity and provided to plans. Region 4 will be incentivized to reduce the disparity between the index population and at least on minority group (if necessary, minority groups will be combined to achieve a sufficient numerator/denominator). Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2023 with calendar year 2024.</p> <p>The points for the overall standard (item 1 above) will be awarded based on MHP/PIHP combination performance measure rates. The points for reducing racial/ethnic disparities (item 2 above) will be awarded based on individual MHP or Region 4 performance over time. The total potential points will be the same regardless of</p>

		the number of MHP/PIHP combinations for a given entity or number of racial/ethnic comparisons.
Follow-Up After (FUA) Emergency Department Visit for Alcohol and Other Drug Dependence. (5% of the Joint Measures)	Beneficiaries 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence (AOD) that had a follow-up visit within 30 days.	Data will be stratified by the State by race/ethnicity and provided to SWMBH. Region 4 will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of CY23 with CY24. The points will be awarded based on Region 4 performance measure rates. The total potential points will be the same regardless of the number of MHP/PIHP combinations for Region 4.

B. Performance Improvement Projects (PIPs)

Description

MDHHS requires SWMBH to conduct and submit performance improvement projects (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 Medicaid beneficiaries in PIHPs must be tracked, analyzed, and reported annually. SWMBH’s QAPIP includes affiliation-wide performance improvement projects that achieve thorough ongoing measurement and intervention, and demonstratable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and individual satisfaction. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that SWMBH serves.

Each year, one PIP is reviewed by the Health Services Advisory Group (HSAG). 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 (QI) strategies and activities conducted by the PIHP during the PIP.

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

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

There are currently two primary Performance Improvement Projects that SWMBH has targeted for FY25:

1. Reducing Racial Disparities in Follow-Up After Emergency Department Visits (ED) for Alcohol and Other Drug Use (AOD). This is a high-risk service area, where improved continuity and coordination of care is needed; this project serves as the clinical PIP.
2. Increase the percentage of new persons starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (MMBPIS Indicator 3); this project serves as the non-clinical PIP.

The details of each of the two identified PIPs can be found below.

FY25 PIPs

PIP	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
<p>Performance Improvement Project #1 (Clinical)</p> <p>Reducing Racial Disparities in Follow-Up After Emergency Department Visits (ED) for Alcohol and Other Drug Use (AOD).</p> <p>Goal: “To eliminate the statistically significant disparity between African American/Black and White rates of follow up after Emergency Department (ED) visits for alcohol and other drug use, from baseline (2021) to remeasurement 1 (2023) and 2 (2024), without a corresponding decrease in White follow up rates.”</p> <p>Monitoring: Remeasurement 2 (2024) results will be available in June 2025. SWMBH will assess performance on the following measures to determine whether the region met the PIP goal for 2024:</p> <ol style="list-style-type: none"> 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. <p>In FY25, SWMBH will collaborate with the Project ASSERT teams in the three largest counties to increase referrals from EDs and to follow-up on referrals when individuals present to the ED for substance use needs, with specific attention to the Black/African American population.</p>	<p>QMCO</p>	<p>Regional Clinical Practices (RCP) Committee and Regional Quality Management Committee (QMC)</p>	<p>Bi-Annual</p>

<p>Performance Improvement Project #2 (Non-Clinical)</p> <p>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).</p> <p>Goal: In FY25, SWMBH and its provider network will continue efforts to increase the percentage of new persons starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment. The goal is to reach the MDHHS set benchmark of 72.9%.</p> <p>Monitoring: Quarterly, the PIHP will complete continuous analysis of regional outcomes, reasons for non-compliance and the mean number of days to service per CMHSP-submitted MMBPIS data.</p> <p>By the end of FY25 Q1, SWMBH will complete individual meetings to discuss specific barriers and actions taken to improve access and timeliness with the 3 CMHSPs that had the lowest rates per FY24 Q4 outcomes. Best practices found in these consultations will be shared and discussed with the region during QMC/RCP meetings.</p> <p>By the end of FY25, the PIHP will review the data and evaluate the effectiveness of the interventions and improvement strategies suggested to determine if the goal was met, and in preparation for revised access measures included in the BH Quality Transformation.</p>	<p>QMCO</p>	<p>Regional Clinical Practices (RCP) Committee and Regional Quality Management Committee (QMC)</p>	<p>Annually and Quarterly</p>
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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 SWMBH 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

Specialized 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.

A sentinel event is an unexpected occurrence involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase “or risk thereof” includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (JCAHO, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event. A root cause analysis (RCA) (JCAHO) or investigation (per the Centers for Medicare and Medicaid Services (CMS) approval and MDHHS contractual requirements) is "a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998). 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 an 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 administrative and delegated function 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 presentations and 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 via email to mdhhs-bhdda-contracts-mgmt@michigan.gov and additionally reports the SE in the BH CRM.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will report any SUD Sentinel Event that occurs at a contracted residential treatment provider via email to MDHHS and in the BH CRM within 24 hours.	QMCO	Through submission to MDHHS via email and in the BH CRM	As SUD SEs Occur
The rate for the region, per 1000 persons served, of suicide deaths will demonstrate a decrease from the previous year.	QMCO	QMC	Quarterly
The rate for the region, per 1000 persons served, of unexpected deaths due to overdose will demonstrate a decrease from the previous year.	QMCO	QMC	Quarterly

D. Behavioral Treatment Review

Description

MDHHS requires data to be collected based on the definitions and requirements within the MDHHS Technical Requirement Behavioral Treatment Plans policy and the MDHHS Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans policy. 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 monitoring and collecting and analyzing data to each local CMHSP Behavior Treatment Review Committee (BTRC). Each BTRC reviews and approves or disapproves behavior treatment plans (BTPs) that propose the use of restrictive or intrusive interventions, as defined by the technical requirement. Each CMHSP is required to submit their BTRC data to SWMBH quarterly. SWMBH focuses on and analyzes data related to intrusive and restrictive techniques, physical management, and/or incidents resulting in 911 calls for emergency behavioral crisis. The data submitted includes the numbers of interventions and length of time the interventions were used per person. Monitoring this data is important for the oversight and protection of vulnerable individuals, including those receiving long term supports and services (LTSS). The data is made available to MDHHS upon request. SWMBH provides oversight by analyzing the data on a quarterly basis to identify and address any trends or opportunities for improvement. Based on the analysis, SWMBH requests the behavior plans on an individual level as needed to review further. The criteria for further review may include, but is not limited to, those with restrictive and/or intrusive interventions, 911 calls, self-injurious behavior, hospitalizations, harm from physical management, etc. During the annual CMHSP Site Reviews SWMBH completes an audit of the data and a sample of behavior treatment plans to ensure accurate reporting and adherence to the Behavior Treatment Review Standards by each CMHSP.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will complete a quality review of at least 4 behavior treatment plans per CMHSP for FY24.	QMCO	QMC	Quarterly
The region will achieve 90% or higher on the Behavior Treatment Plan section of the non-SUD clinical file review tool for the annual CMHSP Site Review.	QMCO	CMHSP Administrative and Delegated Function Site Review, Clinical File Review Tool	Annually

E. Member Experience with Services

a) Customer Satisfaction Survey

Description

SWMBH’s Quality Management and Clinical Outcomes Department administers an annual Customer Satisfaction Survey on behalf of the region. The primary objective of the survey is to identify opportunities for improvement at the CMHSP and PIHP levels, and to improve outcomes in comparison to the previous year results. SWMBH ensures the incorporation of beneficiaries receiving long-term supports or services (LTSS), case management services, CCBHC services, and Medicaid services into the review and analysis of the survey results obtained from quantitative and qualitative methods. Respondents are asked to identify the type of services and supports they, or the individual the respondent is completing the survey on behalf of, are receiving which allows for the identification of beneficiaries receiving LTSS. CMHSPs are also required to identify target populations (e.g. CCBHC) within their sample provided for the survey, and responses are tracked and analyzed based on that information.

SWMBH utilizes a hybrid Mental Health Statistics Improvement Program (MHSIP), Youth Surveillance Survey (YSS), and the Experience of Care and Health Outcomes (ECHO) Survey. All adopted survey methods and categories are certified as best practice survey tools to gauge beneficiary experience of care and were approved by MDHHS. Prior to implementation, survey tools are evaluated to ensure required data is collected from beneficiaries and their guardians/family where appropriate. SWMBH’s Consumer Advisory Committee members also provide feedback on the survey process, questions and content, and the distribution plan during standing committee meetings. During 2025, the SWMBH Quality Management and Clinical Outcomes Department plans to collect beneficiary survey responses throughout the year with the goal of achieving at least 2100 completed surveys. Surveys will be accessible electronically to beneficiaries via postings with quick-response (QR) codes and tablets in the CMHSP waiting/lobby areas, through the SWMBH website, by text message, and by email. Additionally, CMHSPs will offer the survey on paper if requested. CMHSPs are responsible for having a systematic approach to enter the paper survey responses they receive into the electronic survey collection tool.

The survey provides space for individuals completing it to provide comments on their services which allows for deeper analysis and qualitative assessment. Respondents have the option to request CMHSP follow-up within the survey, which generates an automated response to the applicable CMHSP, and CMHSP Customer Services staff are responsible to follow-up with those requests.

At the conclusion of the survey project, a full analysis report is produced, providing qualitative and quantitative analysis for each of the Adult and Youth survey categories measured. The quantitative analysis includes a review of the numerical data, and the qualitative analysis includes a review of the comments and additional information respondents provide. Starting in 2025, SWMBH plans to provide further analysis of service delivery and health outcomes from year-to-year as anonymous IDs are now optionally assigned to each participant to track

respondents’ answers over time. The results and survey analysis are shared with internal/external stakeholders which includes SWMBH’s Regional Clinical Practices Committee, Utilization Management Committee, the Operations Committee, Customer Advisory Committee, Quality Workgroups, and the Board of Directors. The results are also shared via the SWMBH website, newsletters, within the annual QAPIP Evaluation, etc.

The QAPIP Evaluation outlines the results of the survey project, identifies any barriers, and provides recommendations for improvement for the following years’ survey project. The effects of activities implemented to improve satisfaction, from the previous year’s recommendations, are evaluated and discussed during the Regional QMC meeting. The survey analysis addresses issues of quality and availability of services. Sources of beneficiary dissatisfaction are identified and each CMHSP is required to develop improvement plans, specific to the findings/results/analysis from their locations. Systemic steps will be outlined to follow up on the findings.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Achieve at least 1500 completed MHSIP surveys and 600 completed YSS surveys by making the survey more available/accessible utilizing email, text, QR code, mobile device, tablet, and paper survey.	QMCO	QMC	Annually
The FY25 MHSIP (adult) survey will see an improvement of the region’s overall score for the lowest scoring domain in the FY24 survey (Outcomes and Functioning).	QMCO	QMC, RCP, CAC	Annually
The FY25 YSS (youth) survey will see an improvement of the region’s overall score for the lowest scoring domain in the FY24 survey (Outcomes).	QMCO	QMC, RCP, CAC	Annually

b) Recovery Self-Assessment, Person in Recovery version (RSA-r) Survey

Description

SWMBH’s Quality Management and Clinical Outcomes Department, in conjunction with the SUD Department, administers the Recovery Self-Assessment Survey, Person in Recovery version (RSA-r) to Medicaid and SUD Block Grant beneficiaries within the region. The primary objective of the survey is to improve scores in comparison to the previous year’s results and identify opportunities for improvement in SWMBH’s recovery-oriented care. At the conclusion of the survey project, a full analysis report is produced, providing qualitative and quantitative analysis for each of the six subcategories measured (Life Goals, Involvement, Diversity of Treatment, Choice, Individually Tailored Services, Inviting Space). The results and survey analysis are shared with internal and external stakeholders including the SWMBH Consumer Advisory Committee, RCP, the Regional Operations Committee, QMC, and the SUD Program Director’s Workgroup. Feedback strategies are implemented as appropriate. The results are also shared via SWMBH website, newsletters, the annual QAPIP Evaluation, and other SWMBH annual publications.

The Evaluation Report outlines the results of the survey project, identifies any barriers, and provides recommendations for improvement for the following year’s survey project. The effects of activities implemented to improve satisfaction, from the previous year’s recommendations, are evaluated and discussed during the QMC and the SUD Directors Subgroup meetings. The survey analysis addresses issues of quality and availability of care. Sources of beneficiary dissatisfaction are identified. SWMBH requests that participating SUD and CMHSPs review results internally and develop improvement plans, specific to the findings/results/analysis from their locations. Systemic steps are outlined to follow up on the findings.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Increase survey participation compared to the previous year, as evidenced by more participating providers and/or more completed surveys.	QMCO, SUD	QMC, SUD Directors Subgroup	Annually
Achieve at least 90% consumer satisfaction with SUD services as indicated by survey results.	QMCO, SUD	QMC, SUD Directors Subgroup	Annually

F. Verification of Medicaid Services

Description

SWMBH’s Program Integrity and Compliance department performs the Medicaid Services Verification review to verify whether services reimbursed by Medicaid were furnished to beneficiaries by its Participant CMHSPs, providers, and subcontractors. This review is performed pursuant to MDHHS-PIHP Master Contract Section (1)(C)(4) and in conformity with the MDHHS Medicaid Verification Process technical requirement. SWMBH performs this review after the end of each Fiscal Year Quarter, typically within 30 days depending on the accepted encounter volume, to have real time results and an opportunity to effectuate change quickly. SWMBH submits its findings from this process to MDHHS annually and provides follow up actions that were taken because of the findings. SWMBH also presents the findings to the Board of Directors.

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

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

FY25 Goal

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
The overall Medicaid claims verification of services compliance rate for SWMBH will be above 90%.	Compliance	SWMBH Corporate Compliance Committee, Regional Compliance Committee	Monthly/Every Other Month

G. Provider Network

a) Provider Network Adequacy Evaluation

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 contract.

MDHHS contracts with HSAG to conduct the annual performance measures and included network adequacy validation activities, 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.

FY25 Goal

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

b) 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.

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).

FY25 Goal

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will complete or ensure completion of site reviews for the region (for Participant CMHSPs, SUD Providers, and Network Providers), and areas of non-compliance will require a corrective action plan.	All SWMBH Departments; Participant CMHSPs	Site Review Tools and CAP Documents	Annually

H. Credentialing and Re-Credentialing

Description

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

- QI Data Check
 - Compliance fraud/waste/abuse (F/W/A) or other billing issues
 - Customer Services issues (in addition to formal Grievances/Appeals)
 - Utilization Management issues/concerns

SWMBH directly performs credentialing for the following in its network:

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

SWMBH delegates, under Delegation memorandum of understanding (MOUs), credentialing activities to its Participant CMHSPs for the following:

- CMHSP network providers, other than those listed above.

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

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

Monitoring Activities – Non-licensed Providers

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

Through the annual site review process SWMBH ensures, regardless of funding mechanism:

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

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will provide training and technical assistance to participant CMHSP staff responsible for completing credentialing.	Provider Network	RPNMC	Annually
The credentialing and re-credentialing requirements will be reviewed for each CMHSP during the Administrative and Delegated Function Site Reviews.	Provider Network	Delegated Admin Function Review Tool	Annually

I. Clinical Practice Guidelines

Description

SWMBH reviews, disseminates, and implements clinical practice guidelines that are consistent with the regulatory requirements of the MDHHS Specialty Services Contract and Medicaid Managed Care rules. SWMBH and its Medicaid subcontracted provider network 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 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 the 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.

SWMBH's adopted practice guidelines 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
- Employment Works! Policy

Practices Guidelines are adopted, developed, and implemented by the Regional RCP Committee, which consists of representatives from SWMBH and the eight CMHSPs in Region 4. The group works together to decide which guidelines are most relevantly matched to the individuals in the region by eliciting responses from CMHSP representatives who are close to the issues. The group ensures 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 Administrative and Delegated Function Site Review process to ensure Participant CMHSPs and SUD providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization via measures agreed upon by leadership across the region.

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

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will evaluate the region's effectiveness in demonstrating the Person-Centered Planning Practice Guideline during the Administrative and Delegated Function Site Reviews.	QMCO	Clinical Quality Review Tool	Annually
SWMBH, with the CMHSPs, will develop improvement strategies to address any deficiencies and identify goals to improve the Person-Centered Planning Process in FY25.	QMCO	RCP	Quarterly

J. Care Management Program

Description

SWMBH provides a robust care management program to all Medicaid beneficiaries with behavioral health needs who require intensive care management, including but not limited to, child and adult beneficiaries who have significant behavioral health issues and complex physical comorbidities.

The purpose of SWMBH's care management program is to help beneficiaries gain optimal health outcomes, improve functional capacity, and support whole-person recovery. Care management includes but is not limited to care planning, preventative health education, patient communication, medication management, risk stratification, and population management. Care coordination between behavioral and physical health providers is an essential component of care management involving the organization, coordination, and communication of healthcare services for beneficiaries.

SWMBH works with the MHPs to own joint care management responsibilities with shared MHP beneficiaries, consistent with MDHHS policy and contractual direction. Monthly integrated care team (ICT) meetings are held with the MHPs represented in Region 4 to address the needs of beneficiaries with multiple or complex conditions as well as high ED use and inpatient (IP) admissions. Mutually shared beneficiaries are identified through risk stratification conducted in CareConnect 360 (CC360). An Integrated Healthcare Specialist provides comprehensive assessment of the beneficiary's condition, determination of available benefits and resources, and development and implementation of a care management plan with patient-centered goals, monitoring, and follow-up in conjunction with the MHP care management teams. An integrated care plan is created in CC360 to monitor care coordination activities and health outcomes.

Transition of care monitoring is a key component of care management that focuses on closely monitoring and supporting beneficiaries as they move between different care settings, such as moving from an inpatient admission to the community, ensuring a smooth transition and minimizing potential complications by providing coordinated care during a critical period in a beneficiary's care. Discharge planning is an integral part of treatment. Consideration of the continuum of care and long-term recovery needs of the member should direct transition planning. Transition of care monitoring intends to improve quality of care, improve outcomes and control costs by assuring plan coordination in which primary and specialty mental health, SUD, and healthcare providers inform each other regarding their treatment of an individual and collaboration regarding the needs of the beneficiary.

To further bolster performance measures including FUH and FUA, SWMBH employs grant funded Transition Navigators. The SWMBH UM department identifies beneficiaries not actively engaged in services with a CMHSP,

Certified Community Behavioral Health Clinic (CCBHC), or SUD treatment program that, if not otherwise engaged in aftercare, would have a high risk of readmission following an IP admit or ED visit. Transition Navigators conduct outreach to promote treatment engagement, eliminate barriers to engagement, link beneficiaries to resources as needed, and provide health education.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will create an audit system to track the number of complex cases identified by risk stratification delineated by MHP, the number of cases presented for discussion in monthly ICT meetings, and the volume of cases having a care plan in CC360. This will aid SWMBH to meet or exceed the benchmark expectation that 25% of complex beneficiaries identified through risk stratification will also have a joint care plan created or updated in CC360.	QMCO (Integrated Care)	ICT meetings, RCP, SWMBH Departmental Meetings	Quarterly
SWMBH will create a care coordination procedure detailing use of CC360 risk stratification to identify enrollees 18 and under, shared by both PIHP and MHP, who have significant behavioral health issues and complex physical care needs.	QMCO (Integrated Care)	RCP and shared via Provider Newsletter	Annually
SWMBH will establish a care coordination procedure to facilitate plan-level referrals between both PIHP and MHP which follows the agreed upon workflow created in the PIHP-MHP Referral Subgroup.	QMCO (Integrated Care)	RCP, RUM	Annually

K. Long-Term Services and Supports (LTSS)

Description

LTSS 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 HCBS Waivers as recipients of LTSS. HCBS is defined as Home and Community Based Services which provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted population groups such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses. 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 and its network serves beneficiaries receiving LTSS through the following HCBS Waivers:

- Children’s Waiver Program (CWP)
- Waiver for Children with Serious Emotional Disturbances (SED)
- Habilitative Supports Waiver (HSW)
- 1915 (i)SPA

Additionally, SWMBH identifies beneficiaries who receive the following services as LTSS recipients:

- Care Coordination/Targeted Care Management
- Respite Services
- Community Living Supports (to promote participation in the community)
- Home Modifications
- Nursing Services
- Personal Emergency Response Systems
- Family and Non-Family Training
- Enhanced Pharmacy
- Overnight Health and Safety Supports

SWMBH is dedicated to ensuring the quality and appropriateness of care to all beneficiaries. People receiving LTSS are some of the region’s most vulnerable individuals, therefore, additional analyses of the quality and appropriateness of care for the LTSS populations in Michigan are warranted by both quantitative and qualitative means. The quality, appropriateness, availability, and accessibility of care furnished to beneficiaries receiving LTSS is quantitatively and qualitatively assessed using an analysis of adult and youth (MHSIP and YSS) satisfaction surveys. SWMBH’s Quality Management and Clinical Outcomes (QMCO) Department incorporated a question in the annual surveys to identify individuals who received LTSS in FY23. This has allowed for a separate analysis of the LTSS population.

The CMHSP Clinical Quality File Review Tool that is utilized in Region 4 annually, includes items to monitor the quality and appropriateness of care for beneficiaries receiving LTSS. For reference, some of the items from the SWMBH annual CMHSP site review tool are:

- In the event there has been a significant change (for example: inpatient admission, inpatient discharge, medication change, significant adverse event, significant change in services, termination of services or death) there is evidence of coordination of care with the primary care physician.
- If the member is a recipient of LTSS, there is an assessment of care between settings.
- Needs, priorities, and a professional analysis of service needs and recommendations are documented.
 - All identified needs are included and addressed in the Individual Plan of Service (IPOS).
- Level of Care (LOC) is appropriately evaluated and identifies a functional deficit requiring intervention/treatment. LOC assessment is completed annually and when there is significant change in individual's status.
- The IPOS is individualized based upon assessment of the beneficiary’s needs and preferences. The plan (or assessment) describes their strengths, abilities, plans, hopes, interests, preferences and natural supports.
 - Health/safety risks are identified.
 - Beneficiary choice is documented.
 - Natural supports that will be used to assist the beneficiary in being able to accomplish goals and objectives are identified.

- The plan contains clear, concise, and measurable statements of the objectives the beneficiary will be attempting to achieve.
- Individuals are provided with ongoing opportunities to provide feedback on supports and services they are receiving, perceived barriers or strengths during treatment, and their progress towards goal attainment.
 - May be documented in progress notes and/or periodic reviews.
- Services and interventions identified in the IPOS are provided as specified –
 - Goals and objectives are measurable.
 - The plan specifies the type, amount, scope, duration, frequency, and timeframe for implementing services.
 - The individual has received all services as authorized in the plan.
 - If services are not being utilized as planned, and an appropriate reason for the lack of service provision is not present in the documentation, the IPOS has been amended. (Lack of provider is not an acceptable reason for not providing a medically necessary service.)

Aggregated annual audit outcomes are regularly monitored and analyzed by the QMCO 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.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will use the Customer Satisfaction Survey results to assess the quality, appropriateness, availability, and accessibility of care of beneficiaries receiving LTSS. Improvement areas will be identified based on the analysis of the results in Q4 of FY25.	QMCO	QMC, RCP	Annually
SWMBH will evaluate the number of Respite encounters utilized to establish a baseline of LTSS Respite service utilization. SWMBH will provide education to increase awareness of the benefit of Respite services through Regional Committees and using the member newsletter by providing a description of Respite services, and featuring a beneficiary success story from using Respite supports, by Q4 of FY25.	QMCO	RCP, RUM, RPNMC, and shared via Member Newsletter	Annually

L. Utilization Management (UM)

Description

The purpose of the UM 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, SED and Child Waivers, LTSS recipients (defined in LTSS section of the QAPIP), and SUD Community Grant resources

of the Plan while ensuring uniformity of benefit. SWMBH is responsible for monitoring the provision of delegated UM managed care administrative functions related to the delivery of behavioral health and substance use disorder services to beneficiaries enrolled in Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports, SED and Child Waiver, LTSS recipients, and SUD Community Grant. SWMBH is responsible to ensure adherence to UM related statutory, regulatory, and contractual obligations associated with the MDHHS Medicaid Specialty Services and SUD contracts, Medicaid Provider Manual, mental health and public health codes/rules and applicable provisions of the Medicaid Managed Care Regulations, the Affordable Care Act and 42 CFR. The PIHP must ensure services identified in 42 CFR §438.210(a)(1) must be furnished in an amount, duration, and scope for the same services furnished to beneficiaries under Fee for Service (FFS) Medicaid, as set forth in §440.230, and for beneficiaries under the age of 21, as set forth in subpart B of part 441.

The UM program consists of functions that exist solely to ensure that the right person receives the right service at the right time for the right cost with the right outcome, while promoting recovery, resiliency, integrated and self-directed care. The most important aspects of the UM 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 UM 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 detox, residential and MAT/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. The 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 (IRR) testing is conducted annually for any SWMBH clinical staff making medical necessity determinations through the centralized care management or outlier management processes.

Determination of Medical Necessity

Treatment under the beneficiary's behavioral health care benefit plan is based upon a person-centered process and meets medical necessity criteria/standards before being authorized and/or provided. Medical necessity criteria for Healthy Michigan Plan and Medicaid for mental health, IDD, and substance abuse

supports and services and provider qualifications are found in the MDHHS Medicaid Provider Manual. For the purposes of utilization control, SWMBH ensures all services furnished can reasonably achieve their purpose and the services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the beneficiary's ongoing need for such services and supports. SWMBH utilizes the MCG medical necessity criteria for Inpatient. Levels of Care, service utilization expectations, changes (if any) in the MDHHS Medicaid criteria or professional qualifications requirements, and UM standards are reviewed annually by the RUM Committee with final approval by the SWMBH Medical Director.

Services selected based upon medical necessity criteria are:

1. Delivered in a timely manner, with an immediate response in emergencies in a location that is accessible to the beneficiary.
2. Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner.
3. Provided in the least restrictive appropriate setting; (inpatient and residential treatment shall be used only when less restrictive levels of treatment have been unsuccessful or cannot be safely provided).
4. Delivered consistent with national standards of practice, including standards of practice in community psychiatry, psychiatric rehabilitation and in substance abuse, as defined by standard clinical references, generally accepted practitioner practice or empirical practitioner experience.
5. Provided in a sufficient amount, duration, and scope to reasonably achieve their purpose – in other words, are adequate and essential.
6. Provided with consideration for and attention to integration of physical and behavioral health needs.

Process Used to Review and Approve the Provision of Medical Services

1. Review decisions are made by qualified medical professionals. Appropriately trained behavioral health practitioners with sufficient clinical experience and authorized by the PIHP or its delegates shall make all approval and denial determinations for requested services based on medical necessity criteria in a timely fashion. A required service will not be arbitrarily denied or reduced by amount, duration, or scope based solely on a diagnosis, type of illness, or condition of the beneficiary.
2. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the beneficiary's medical, behavioral health, and/or long-term services and supports needs.
3. Efforts are made to obtain all necessary information, including pertinent clinical information, and consulting with treating physician as appropriate.
4. The reasons for decisions and the criteria on which decisions are made are clearly documented and available to the beneficiary and provider.
5. Well-publicized and readily available appeals mechanisms for both providers and beneficiaries exist. Notification of a denial includes a description of how to file an appeal and on which criteria the denial is based.
6. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
7. There are mechanisms to evaluate the effects of the program using data on beneficiary satisfaction, provider satisfaction or other appropriate measures.
8. Utilization management functions that are delegated to a CMHSP may not be sub-delegated without prior approval and pre-delegation assessment by SWMBH.

Review Process

A Prospective Review involves evaluating the appropriateness of a service prior to the onset of the service. A Concurrent Review involves evaluating the appropriateness of a service throughout the course of service

delivery. Retrospective Review involves evaluating the appropriateness of a service after the services have already been provided. Determinations are made within the previously identified timeframes.

UM staff obtain review information from any reasonably reliable source. The purpose of the review is to obtain the most current, accurate, and complete clinical presentation of the beneficiary’s needs and whether the services requested are appropriate, sufficient, and cost-effective to achieve positive clinical outcomes. Only information necessary to make the authorization admission, services, length of stay, frequency and duration is requested.

Access Standards

- The percentage of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. (MMBPIS #1, Standard = 95%)
- The percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. (MMBPIS #2, Standard = >62%)
- The percentage of new persons receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with a SUD. (MMBPIS #2e, Standard = 68.2%)
- The percentage of new persons starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. (MMBPIS #3, Standard = 72.9%)
- The percentage of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (MMBPIS #4a, Standard = 95%)
- The percentage of discharges from a substance abuse withdrawal management (detox) unit who are seen for follow-up care within seven days. (MMBPIS #4b, Standard = 95%)
- Achieve a call abandonment rate of 5% or less.
- Average call answer time 30 seconds or less.

Level of Intensity of Service Determination

Level of Intensity	Definition	Expected Decision/Response Time
Emergent-Psychiatric	The presence of danger to self/others; or an event(s) that changes the ability to meet support/personal care needs including a recent and rapid deterioration in judgment	Within 3 hours; Prior authorization not necessary for the screening event. Authorization required for an inpatient admission within 3 hours of request
Urgent – Psychiatric	At risk of experiencing an emergent situation if support/service is not given	Within 72 hours of request; prior authorization required; if services are denied/appealed and deemed urgent, Expedited Appeal required within 72 hours of denial
Routine	At risk of experiencing an urgent or emergent situation if support/service is not given	Within 14 days; Prior authorization required
Retrospective	Assessing appropriateness of medical necessity on a case-by- case or aggregate basis after services were provided	Within 30 calendar days of request

Post-stabilization	Covered specialty services that are related to an emergency medical condition and that are provided after a beneficiary is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the beneficiary's condition	Within 1 hour of request
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Coordination and Continuity of Care

SWMBH is committed to ensuring each beneficiary receives services designed to meet each individual special health need as identified through a functional assessment tool and a Biopsychosocial Assessment. The screening and assessment process contains mechanisms to identify needs and integrate care that can be addressed with specialty behavioral health and substance abuse treatment services as well as integrated physical health needs and needs that may be accessed in the community including, but not limited to, employment, housing, financial assistance, etc. The assessment is completed or housed in a uniform managed care information system with collection of common data elements which also contains a functional assessment tool that generates population-specific level of care guidelines. To assure consistency, the tools utilized are the same version across the SWMBH region and include the Level of Care Utilization System (LOCUS) for Adults with Mental Illness or Co-Occurring Disorder, CAFAS (Child and Adolescent Functional Assessment Scale) for Youth with Serious Emotional Disturbance, and the ASAM-PPC (American Society for Addiction Medicine-Patient Placement Criteria) for persons with a SUD. Effective March 2023, MDHHS made the decision not to renew the contract to continue use of the SIS (Supports Intensity Scale) as a level of care assessment tool for individuals with Intellectual and Developmental Disabilities. Components of the assessments generate a needs list which is used to guide the treatment planning process. Assessments are completed by appropriate clinical professionals. Treatment plans are developed through a person- centered planning process with the beneficiary’s participation and with consultation from any specialists providing care to the beneficiary.

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 Policy Access Management). SWMBH ensures that the Access Standards are met, including MMBPIS.
2. Clinical Protocols: To ensure Uniform Benefit for beneficiaries, consistent functional assessment tools, medical necessity, level of care, and regional clinical protocols have been or will be identified and implemented for service determination and service provision (see Policy Clinical Protocols and Practice Guidelines).
3. Service Authorization: Service Authorization procedures will be efficient and responsive to beneficiaries while ensuring sound benefits management principles consistent with health plan business industry standards. The service determination/authorization process is intended to maximize access and efficiency on the service delivery level, while ensuring consistency in meeting federal and state contractual requirements. Service authorization utilizes level of care principles in which intensity of service is consistent with severity of illness.
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 will be utilized to ensure utilization management standards are met, such as appropriate level of care

determination and medically necessary service provision and standard application of Uniformity of Benefit (see Policy Utilization Management).

The SWMBH UM 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 UM 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 UM functions.

The Utilization Review process uses monthly review of outlier management reports and annual review with specialized audit tools that monitor contractual, statutory, and regulatory requirements. The reports and UR tool speak to ensuring intensity of service matching level of care with services and typical service utilization as well as any additional external audit findings. Should any performance area be below the established benchmark standard, the Utilization Review process requires that a CAP be submitted to address any performance deficits. SWMBH clinical staff monitor the implementation of the CAPs. The outlier management process and subsequent reports to manage it, including Over and underutilization and uniformity of benefit, are based on accurate and timely assessment data and scores of agreed tools and service determination transactions being submitted to the SWMBH warehouse, implementation of level of care guidelines and development of necessary reports for review.

Outlier Management

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

1) Outlier Definition

"Outlier" is generally defined as significantly different from the norm. SWMBH defines "outlier" in relation to UM as follows: A pattern or trend of under- or over-utilization of services (as delivered or as authorized), compared to the typical pattern of service utilization. Over or under- utilization trends can be identified at a variety of comparative levels, including but not limited to the population, CMH, state, service type, or provider levels.

2) Outlier Identification

Multiple tools are available to SWMBH for monitoring, analyzing, and addressing outliers. SWMBH's Performance Indicator Reports (MDHHS required performance standards), service utilization data, and cost analysis reports are available to staff and committees for review and comparison of overall performance. The service use analysis reports are developed to allow detailed analysis of resource utilization at macro and micro levels. Outlier reviews are organized to focus extreme outliers in contrast to regionally normative

patterns. Specific outlier reports are available and generated in the MCIS and reviewed by SWMBH Utilization Management to provide adequate oversight of service utilization and potential issues of uniformity of benefit.

3) Outlier Management Procedures

1. As outliers are identified, protocol driven analysis will occur at SWMBH and the regional committee level to determine whether the utilization is problematic and in need of intervention. Data identified for initial review will be at aggregate levels for identification of statistical outliers. Additional information will be accessed as needed to understand the utilization patterns and detail.
2. Identified outliers are evaluated to determine whether further review is needed to understand the utilization trend pattern. If warranted, active communication between the SWMBH staff and the regional committee or the CMHSP will ensure understanding of the utilization trends or patterns.
3. If the utilization trends or patterns are determined to require intervention at the CMHSP or the individual level, collaborative corrective action plans are jointly discussed with the CMHSP by SWMBH staff with defined timelines for completion.

Data Management

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

Management/monitoring of common data elements are critical to identify and correct overutilization and underutilization as well as identify opportunities for improvement, patient safety, call rates, Access standards and beneficiary quality outcomes. A common Managed Care Information System with Functionality Assessment and Level of Care Tool scores drives Clinician/Local Care Manager/Central Care Manager review and action of type, amount, scope, duration of services. As such there is a need for constant capture and analyses of beneficiary level and community level health measures and maximization of automated, data-driven approaches to UM and to address population health management.

The purpose of data management is to evaluate the data that is collected for completeness, accuracy, and timeliness and use that data to direct individual and community level care. As part of data management, Levels of Care for beneficiaries can be assigned. This work allows beneficiaries to be assigned categories of expected services and addresses a uniform benefit throughout the region. It is a goal of UM to identify the levels of care and subsequent reports to manage utilization and uniform benefit.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
<p>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 through the Annual CMHSP Clinical Quality Site Review Process.</p> <p>SWMBH will identify and/or develop relevant UM Reports to share with the Region to help monitor utilization and uniform benefit using data informed practices.</p>	<p>UM, QMCO</p>	<p>RUM, RCP</p>	<p>Annually and Quarterly</p>

<p>SWMBH will ensure regional IRR audits are completed for consistent application and understanding of authorization of uniform benefits and medical necessity benefit criteria.</p> <ul style="list-style-type: none"> IRR monitoring will continue during the annual site review process to ensure it is being completed to ensure consistent application and use of the LOCUS. <p>The LOCUS tableau report will be utilized to review trends by assessor by CMHSPs and discussed quarterly in Regional Committees</p>	<p>UM, QMCO</p>	<p>RUM, RCP</p>	<p>Annually and Quarterly</p>
<p>SWMBH will review Service Authorization Denial files for trends, ongoing through the end of FY25.</p> <ul style="list-style-type: none"> Service authorization denial trends will be reviews quarterly. <p>CMHSPs and SWMBH will complete quarterly denial monitoring meetings.</p>	<p>UM, Customer Services</p>	<p>RUM, Regional Customer Service Committee</p>	<p>Quarterly</p>

M. Customer Services

Description

SWMBH’s Customer Services Department provides a welcoming environment and orientation to services which includes providing 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. That includes helping beneficiaries with the grievance and appeal (G&A) process. Customer Services is able to track and report patterns of problems for each organization, regionally, and evaluate 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.

SWMBH also employs a Veteran Navigator within the Customer Services Department, and their role is to listen, support, offer guidance, and help connect Veterans to services they need. The Veteran Navigator facilitates and attends community outreach events throughout the region to increase awareness and connection to services.

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Regional Customer Service Committee will ensure all member facing materials meet state and federal requirements, including updates to 1557 by end of FY25. This will include but not limited to all brochures, SWMBH and CMH websites, informational materials, privacy practices, intake paperwork such as consent to treat, all letters and notices provided to members, and 1557 training.	Customer Services	Regional Customer Service Committee	Quarterly
Plan and implement Conflict-Free Access and Planning (CFAP) requirements to Customer Service such as notices and letters for members as well as any informational materials in FY25. <ul style="list-style-type: none"> ▪ Review guiding documents from MDHHS when released for customer service (member materials/documents), grievance appeal, veteran navigator, and access requirements. ▪ Identify any oversight and monitoring requirements and create and implement any tracking tools. 	Customer Services	Regional Customer Service Committee	Quarterly
Committee will review Grievance and Appeal files for trends, ongoing through the end of FY25. <ul style="list-style-type: none"> ▪ Committee will review G&A trends quarterly. ▪ CMHSPs and SWMBH will complete quarterly G&A monitoring meetings. ▪ Review the Managed Care Program Annual Report (MCPAR) data for trends by the end of March 2025. 	Customer Services	Regional Customer Service Committee	Quarterly

N. Integrated Health Initiatives

Description

Health Home models aim to improve the health and well-being of individuals served by using comprehensive and integrated approaches to care. In Region 4, the Certified Community Behavioral Health Clinic (CCBHC), Substance Use Disorder Health Home (SUDHH), and Behavioral Health Home (BHH) models are represented. Each of these models, though different, converge to provide comprehensive mental health and substance use disorder care, coordination between behavioral and physical health, as well as address areas of social need, support service delivery across the lifespan, and improve access to services through interdisciplinary care teams and flexible funding structures.

CCBHC

Effective 10/01/24, seven of the eight CMHSPs within Region 4 are participating as CCBHC demonstration sites. 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 9 core services are:

1. Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
2. Screening, assessment, and diagnosis, including risk assessment.

3. Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
4. Outpatient mental health and substance use services.
5. Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
6. Targeted case management.
7. Psychiatric rehabilitation services.
8. Peer support and counselor services and family supports.
9. Intensive, community-based mental health care for beneficiaries of the armed forces and veterans, particularly those beneficiaries and veterans located in rural areas.

CCBHC General Requirements

SWMBH must adhere to the CCBHC contractual and policy requirements from MDHHS. CCBHCs must meet the requirements indicated in CCBHC certification. SWMBH and the CCBHCs must adhere to the requirements of all Medicaid statutes, policies, procedures, rules, and regulations, and the CCBHC Handbook.

PIHP Requirements

SWMBH shares responsibility with MDHHS for ensuring continued access to CCBHC services. SWMBH is responsible for meeting minimum requirements, distributing payment, facilitating CCBHC outreach and assignment, monitoring, reporting on CCBHC measures, and coordinating care for all populations served by the CCBHC sites in their region (regardless of payor). SWMBH developed a MOU with all CCBHCs in the region and ensure access to CCBHC services for their enrollees. Contracts with CCBHCs permit authorizing agreements with Designated Collaborating Organization (DCO) entities and reflect the CCBHC scope of services. They also ensure compensation for CCBHC services equates to clinic-specific Prospective Payment System (PPS-1) rates and do not limit the CCBHC's ability to serve all populations with behavioral health needs per CCBHC eligibility requirements. SWMBH is responsible for understanding the CCBHC certification process requirements, including DCO credentialing. MDHHS recommends that PIHPs provide training and support on this process and help potential CCBHC sites to become certified.

SWMBH distributes data requests from MDHHS for quality metrics, cost reports, level of care data, reconciliation templates, etc. and validates and evaluates CCBHC data as well as communicates any discrepancies to MDHHS prior to submission. SWMBH utilizes Michigan claims and encounter data for the CCBHC population, and provides support related to Health Information Technology (HIT) including the Waiver Support Application, CC360, the PIHP Electronic Health Record (EHR) and Health Information Exchanges (HIEs). SWMBH works with CCBHCs to establish timelines for MDHHS reporting deadlines.

SWMBH provides access to CCBHC services through providers certified as a CCBHC. SWMBH panels CCBHCs to provide SUD services or assist the CCBHC to develop a DCO agreement with a SUD provider already on the PIHP panel. SWMBH honors intake, access, screening, and authorization for CCBHC services completed by a CCBHC demonstration provider when an individual seeks services at a CCBHC (i.e., calling the CCBHC directly or walk-ins). Timely access is provided to new and established recipients according to the CCBHC Handbook and SWMBH pays the CCBHC the full PPS rate for any first encounter.

SWMBH collaborates with CCBHCs who conduct a warm handoff to the PIHP during instances when a CCBHC is required to refer individuals to the PIHP access center. This may include:

- Individuals who require a service that is at a higher level of care than the nine core CCBHC services offered at the CCBHC or their contracted DCO, including SUD services.
- Individuals seeking access to services a CCBHC does not provide.
- Individuals seeking access to services offered through the 1915(c) waivers or 1915(i) services.
- PIHPs cannot require any prior authorizations or additional screening requirements beyond those noted above before an individual can access CCBHC services.

It should be noted that PIHP utilization management of CCBHC services is limited to retrospective review of approved/rendered services to confirm that the care was medically necessary. SWMBH cannot delegate retrospective reviews for CCBHC services to a CCBHC or CMHSP.

SWMBH utilizes RUM, QMC, and RCP to cover CCBHC topics and current metric status. The full list of specific Core Measures and other federal requirements are included in the CCBHC Handbook and measures associated with the Quality Bonus Payment (QBP) program are included below.

Measure Name	State or Clinic Reported	Steward	Benchmark	Award Methodology
HBD-AD: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control for Patients with Diabetes	State	NCQA	Rate is greater than or equal to the 25 th percentile of the CCBHC demonstration site average at year end for each sub-measure. HbA1c controlled HbA1c poorly controlled	10% of Eligible QBP
DEP-REM-6: Depression Remission at 6 months	Clinic	MN Community Measurement	Rate is greater than or equal to the 25 th percentile of the CCBHC demonstration site average at year end.	5% of Eligible QBP
I-SERV: Time to Services	Clinic	SAMHSA	Rate is greater than or equal to the 25 th percentile of the CCBHC demonstration site average at year end for each sub-measure: Time to Evaluation Time to Clinical Service Time to Crisis Response	15% of Eligible QBP
FUH-AD: Follow-Up After Hospitalization for Mental Illness, ages 18+	State	NCQA	30-day: 75% 7-day: 48%	15% of Eligible QBP
FUH-CH: Follow-Up After Hospitalization for Mental Illness, ages 6 to 17	State	NCQA	30-day: 88% 7-day: 60%	15% of Eligible QBP
IET-AD: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	State	NCQA	Initiation: 41% Engagement: 14%	10% of Eligible QBP
PCR-AD: Plan All-Cause Readmissions Rate	State	NCQA	10%	10% of Eligible QBP
SRA-A: Adult Major Depressive Disorder: Suicide Risk Assessment	Clinic	Mathematica	73%	10% of Eligible QBP
SRA-C: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Clinic	Mathematica	57%	10% of Eligible QBP

SUDHH and BHH

Both the SUDHH and BHH models provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. Beneficiaries eligible for SUDHH will have a qualifying diagnosis related to alcohol, stimulant, or opioid use disorder. Beneficiaries eligible for BHH must have a SMI or SED. The models are staffed with an interdisciplinary care team that addresses the beneficiary’s behavioral and physical health needs. Each model must provide six core health services:

1. Comprehensive Care Management
2. Care Coordination
3. Health Promotion
4. Comprehensive Transitional Care
5. Individual and Family Support
6. Referral to Community and Social Support Services

PIHP Requirements

PIHPs operating as the Lead Entity (LE), for both the SUDHH and BHH models, must:

- Have the capacity to evaluate, select, and support providers who meet the standards for Health Home Program (HHP)s including:
 - Identification of providers who meet the HHP standards
 - Provision of infrastructure to support HHPs in care coordination
 - Collecting and sharing member-level information regarding health care utilization and medications
 - Providing quality outcome protocols to assess HHP effectiveness
 - Developing training and technical assistance activities that will support HHPs in effective delivery of health home services
- Maintain a network of providers that support the HHPs to service beneficiaries with a substance use disorder (SUDHH) or serious mental illness and serious emotional disturbance (BHH).
- Reimburse HHPs for providing health home services
- The LE must be contracted with MDHHS to execute the enrollment, payment, and administration of the SUDHH and BHH with providers; MDHHS will retain overall oversight and direct administration of the LE; the LE will also serve as part of the Health Homes team by providing care management and care coordination services.

FY25 SUDHH Quality Metrics

Performance Measure Number	Measure Name and NQF # (if applicable)	Measure Steward	State Baseline	Allocation % of P4P Budget
1	Initiation and engagement of alcohol and other drug (AOD) dependence treatment (0004), Initiation of AOD treatment within 14 days	NCQA	TBD	50%
2	Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence (FUA-AD), Follow-up within 7 days after discharge	NCQA	TBD	30%
3	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	CMS	TBD	20%

FY25 BHH Quality Metrics

Performance Measure Number	Measure Name and NQF # (if applicable)	Measure Steward	Allocation % of P4P Budget
1	Follow up After Hospitalization (FUH-7)	NCQA	50%
2	Increase in Controlling High Blood Pressure (CBP-HH)	NCQA	20%
3	Access to Preventative/Ambulatory Health Services	NCQA	30%

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

FY25 Goals

Goal	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
SWMBH will achieve an overall compliance score of >90% during the 2025 HSAG Compliance Review.	QMCO, SWMBH Senior Leaders	QMC, SWMBH Senior Leadership Meetings, other Regional Committees	Annually
SWMBH will achieve an overall compliance score of >95% on the 2025 HSAG Performance Measure Validation (PMV) Audit.	QMCO, IT	QMC, SWMBH Senior Leadership Meetings, other Regional Committees	Annually
SWMBH will achieve an overall compliance score of >90% during the 2025 HSAG Network Adequacy Validation (NAV) audit.	Provider Network	RPNMC, SWMBH Senior Leadership Meetings, other Regional Committees	Annually
SWMBH will see a reduction in the number of repeat citations during the 2025 MDHHS Waiver Audit, compared to the 2023 audit results.	QMCO	QMC, RPC, other Regional Committees	Annually

P. Cultural Competency

Description

SWMBH is dedicated to ensuring that the supports and services provided throughout Region 4 demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all beneficiaries. Such commitment includes acceptance and respect for the cultural values, beliefs, and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

To effectively demonstrate such commitment to cultural competence and demonstrate compliance with the MDHHS/PIHP contract, SWMBH has the following five components in place:

1. Community Assessment
2. Policy and Procedure

3. Service Assessment and Monitoring
4. Ongoing Training
5. Culturally Contextual Services/Supports

Community Assessment

SWMBH uses the annual regional Network Adequacy assessment and consumer satisfaction surveys to assess for a culturally competent provider network and consumer involvement throughout the region. Languages spoken throughout the provider network are gathered through the Region's credentialing process.

At the county level, MDHHS requires each CMHSP to conduct a nominal Needs Assessment at least every two years. Michigan also launched as a CCBHC Demonstration state in 2021, and MDHHS requires all local CCBHC sites to complete 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, complete with root cause analysis and subsequent strategic planning.

Policy and Procedure

SWMBH Policy - Cultural & Linguistic Competency and SWMBH Procedure - SWMBH Cultural Competency Plan reflect SWMBH's values and practice expectations toward cultural competency. SWMBH has adopted the Culturally and Linguistically Appropriate Standards (CLAS) as general guidelines for the region. These policies apply to the entire SWMBH network.

Service Assessment and Monitoring

SWMBH is fully dedicated to improving health equity within Region 4, as evidence by adding the Health Equity Project Coordinator position that is entirely dedicated to reducing health equity disparities for minorities. It 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 FY25. The position facilitates a Regional Health Equity Focus Group consisting of representation from all 8 counties in the Region 4. The workgroup meets quarterly and helps to identify regional and county barriers. Likewise, the workgroup participants bring advice from frontline partnerships for further coordination and support, provide feedback on trainings and anti-stigma campaign efforts. Cultural competency is further assessed and monitored through current PBIP, CCBHC, MMBPIS, and other metrics geared toward ensuring cultural competence and fairness in service delivery.

Training

SWMBH requires ongoing training to assure that staff are aware of, and able to effectively implement cultural competency policies and procedures. SWMBH requires all provider-level staff that are in-network to have cultural competency training and SWMBH reviews that requirement as part of the Staff Training File Review in the annual administrative and delegated function site review process. SWMBH Policy - Cultural & Linguistic Competency and SWMBH Procedure SWMBH Cultural Competency Plan are trained annually during a Quality Management Committee meeting. SWMBH has likewise begun offering the following trainings free of charge to all provider agencies in Region 4: Social work Ethics and Pain Management, Implicit Bias, and Human Trafficking.

Culturally Contextual Services/Supports

SWMBH strives to ensure that supports and services are provided within the cultural contexts for all beneficiaries. SWMBH's community-sponsored events are selected by the Community Outreach Committee, which is dedicated to finding opportunities to better reach underserved and minority populations.

FY25 Goals

Goals	Responsible Department	Where Progress Will Be Monitored	Frequency of Monitoring
Further develop trainings in 2025 by adding a mixture of free-to-attend virtual trainings and in-person health equity conferences in the region.	QMCO (Integrated Care)	Integrated Care Team Meetings	Monthly
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	Regional Customer Services Committee, RPNMC, RCP	Annually
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.	Provider Network	Regional Customer Services Committee, RPNMC, RCP	Annually

ATTACHMENT A – VALUE FRAMEWORK

Value Framework

Our Mission

“SWMBH strives to be Michigan’s preeminent benefits manager and integrative healthcare partner, assuring regional health status improvements, quality, value, trust, and CMHSP participant success”.

Mega Ends

Quality of Life	Improved Health	Exceptional Care	Mission and Value-Driven	Quality and Efficiency
Persons with Intellectual Developmental Disabilities, Serious Mental Illness, Autism Spectrum Disorder, Serious Emotional Disturbances and Substance Use Disorders in the SWMBH region see improvements in their quality of life and maximize self-sufficiency, recovery and family preservation.	Individual mental health, physical health and functionality are measured and improved.	Persons and families served are highly satisfied with the care they receive.	CMHSPs and SWMBH fulfill their agencies’ missions and support the values of the public mental health system.	The SWMBH region is a learning region where quality and cost are measured, improved and reported.

Triple Aim

Improving Patient Experience of Care | Improving Population Health | Reducing Per Capita Cost

Our Vision

“An optimal quality of life in the community for everyone”.



2025 Board of Directors Roster

Barry County

- Lorraine Lindsey
- Robert Becker (Alternate)

Berrien County

- Edward Meny
- Nancy Johnson (Alternate)

Branch County

- **Tom Schmelzer, Vice-Chair**
- Jon Houtz (Alternate)

Calhoun County

- **Sherii Sherban, Chair**
- Kathy-Sue Vette (Alternate)

Cass County

- Louie Csokasy
- Jeanne Jourdan (Alternate)

Kalamazoo County

- Erik Krogh
- Karen Longanecker (Alternate)

St. Joseph County

- **Carol Naccarato, Secretary**
- Cathi Abbs (Alternate)

Van Buren County

- Tina Leary
- Angie Dickerson (Alternate)