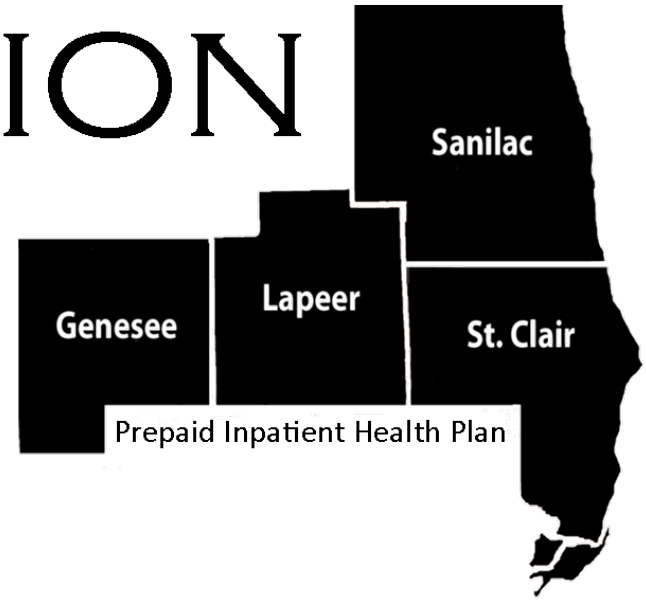
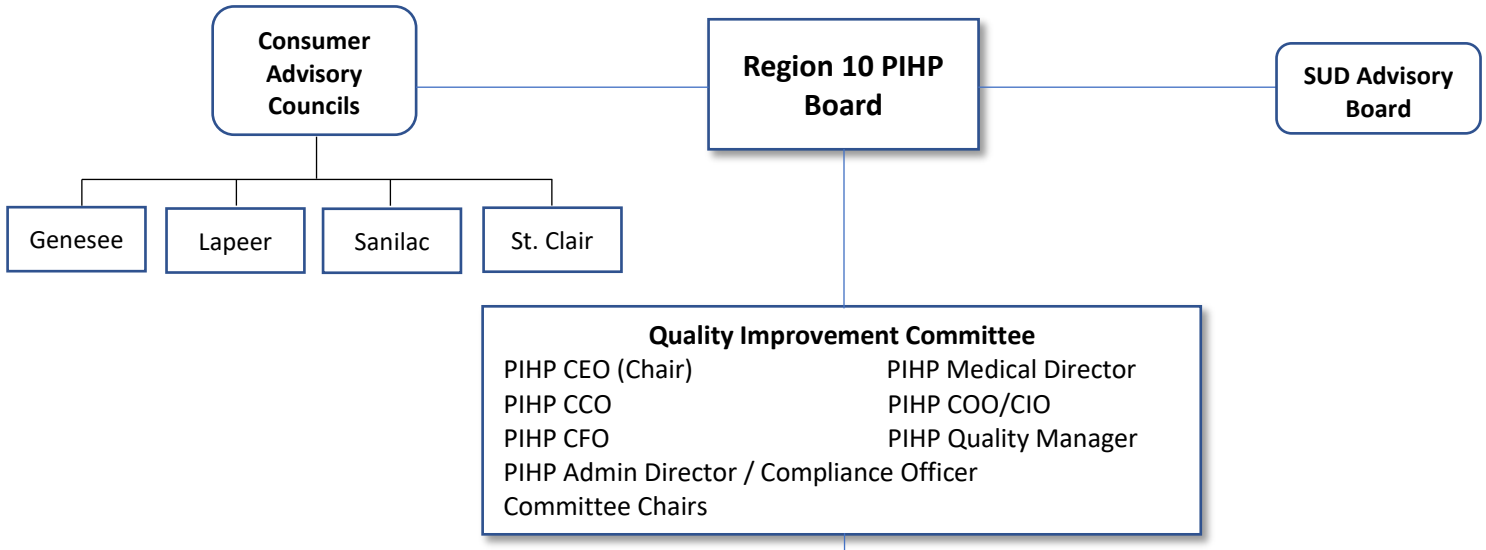
Region 10



QUALITY IMPROVEMENT PROGRAM & WORKPLAN

FY 2022 – Annual Report

REGION 10 QAPIP ORGANIZATIONAL STRUCTURE



	Compliance Committee	*Finance Committee*	*Improving Practices Leadership*	*Privileging and Credentialing*	*Provider Network Management*	*Quality Management*	*Sentinel Events Review*	*Utilization Management* **Behavior Mgmt. Treatment Plan Review*
Region 10	√	√	√	√	√	√	√	√
CMH Providers	√	√	√		√	√		√
SUD Providers	√							

Quality Improvement Fiscal Year (FY) 2022 Work Plan (October 1, 2021 – September 30, 2022)

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
QI Program Structure - Annual Evaluation	• Submit FY2021 QI Program Evaluation to Quality Improvement Committee and the Region 10 PIHP Board by 12/1/2021. o Present the Annual Evaluation to the Quality Improvement Committee. The Quality Improvement Committee will be responsible for providing feedback on the qualitative analysis, proposed interventions, and implementation plan. o After presentation to the Quality Improvement Committee, the Annual Evaluation will be presented to the Region 10 PIHP Board for discussion and approval.	Lauren Campbell / Hailey Dziegelewski Quality Management Department QI Program Standing Committees	**Quarterly Updates:** **Q 1 (Oct-Dec):** **The FY2021 QI Program Annual Report was presented and approved by QI Committee and the PIHP Board at the October meetings.** **Q 2 (Jan-Mar):** **No update** **Q 3 (Apr-June):** **No updates** **Q 4 (July-Sept):** **No updates** **Evaluation: This goal is met as Region 10 annually presents the Quality Improvement (QI) Program Annual Report to the QI Committee and the PIHP Board for approval and submits the QI Program Annual Report to the Michigan Department of Health and Human Services (MDHHS).** **Barrier Analysis: No barriers** **Next Steps: Objective to be continued into the following fiscal year.**
QI Program Structure - Program Description	• Submit FY2022 QI Program Description to Quality Improvement Committee and the Region 10 PIHP Board by 12/1/2021. o Review the previous year's QI Program and make revisions to meet current standards and requirements. o Include changes approved through committee action and analysis. o Include signature pages, Work Plan, Evaluation, Policies and Procedures, and attachments.	Lauren Campbell / Hailey Dziegelewski Quality Management Department QI Program Standing Committees	**Quarterly Updates:** **Q 1 (Oct-Dec):** **The FY2022 QI Program Description was reviewed and approved by QI Committee and the PIHP Board at the October meetings.** **Q 2 (Jan-Mar):** **No update** **Q 3 (Apr-June):** **No updates**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Q 4 (July-Sept): **No updates** **Evaluation: This goal is met as Region 10 prepared and revised the FY2022 Quality Improvement (QI) Program Description to meet current standards and requirements. Region 10 incorporated feedback provided by the Michigan Department of Health and Human Services (MDHHS).** **Barrier Analysis: No barriers** **Next Steps: In preparation for the FY2023 QI Program Description, Region 10 will enhance the description to incorporate more detail including emphasis on how the PIHP implements the required activities outlined within the QI Program Description per the Health Services Advisory Group's (HSAG) and MDHHS' recommendations. Other revisions and changes will be made to incorporate additional feedback.**

QI Program Structure - Annual Work Plan	• Submit FY2022 QI Program Workplan to the Quality Improvement Committee and the Region 10 PIHP Board by 12/1/2021.
	• Develop the FY2022 QI Program Work Plan standard by 12/1/2021.
	• Present the work plan to committee by 12/1/2021.
	  o Utilize the annual evaluation in the development of the Annual Work Plan for the upcoming year.
	  o Prepare work plan including measurable goals and objectives.
	  o Include a calendar of main project goal and due dates.
		Lauren Campbell / Hailey Dziegelewski
		
		QI Department
		
		QI Program Standing Committees
			<u>Quarterly Updates</u>:
			
			<u>Q 1 (Oct-Dec):</u>
			The FY2022 QI Program Workplan was reviewed and approved by QI Committee and the PIHP Board at the October meetings. Responsible staff revised for one Provider Network goal, the Home & Community Based Services goal, and the QI Program Structure goals. Also revised the QI Program Annual Evaluation goal to correct the fiscal year of the QI Program Evaluation.
			
			<u>Q 2 (Jan-Mar):</u>
			Responsible staff revised for the Home and Community Based Services, Provider Network, Privileging and Credentialing, the Autism Program, Opioid Health Home, Supports Intensity Scale, and for the Verification of Services goals. A Board member was added to the Region 10 PIHP Board General Membership list effective as of the February 18th Board meeting.
			
			<u>Q 3 (Apr-June):</u>
			Responsible staff revised for the External Monitoring Reviews goal, for the Supports Intensity Scale goal, and for the Provider Network goals and Committee Chairperson.
			
			<u>Q 4 (July-Sept):</u>
			During fourth quarter, the responsible staff listed for the Provider Network and Privileging and Credentialing goals were revised.
			
			<u>Evaluation:</u> This goal is met and will continue in FY2023.
			
			<u>Barrier Analysis:</u> No barriers
			
			<u>Next Steps:</u> In Preparation for the FY2023 QI Program Workplan, Region 10 will be enhancing the evaluation, measurement, and next step sections of each goal to include qualitative and quantitative write ups with specific action steps per recommendations from the Health Services Advisory Group (HSAG) and the Michigan Department of Health and Human Services (MDHHS). Quality Assessment & Performance Improvement Program (QAPIP) Committees and responsible staff for

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			each goal are reviewing and revising activity interventions within the goals to address areas requiring additional oversight and monitoring.
Aligned System of Care	The goals for FY2022 Reporting Year are as follows: • To promote an aligned system of care throughout the PIHP Provider Network to ensure quality and safety of clinical care and quality of service. o Monitor utilization of the PIHP Clinical Practice Guidelines. o Review Evidence-Based Practices and related fidelity review activities to promote standardized clinic operations across the provider network, e.g., IDDT, LOCUS.	Tom Seilheimer Improving Practices Leadership Team (IPLT)	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **The Annual Evaluation Report and Biennial Evaluation Report review are scheduled for approval at the February QI Committee meeting. These reports address updates on Clinical Practice Guidelines (CPG) and Employment Based Practices (EBP). The Level of Care Utilization System (LOCUS) annual implementation plan has been updated for FY2022. CMHs are encouraged to implement/expand periodic reporting to track/trend LOCUS utilization, such as decreasing over-ride rates, and increasing rater consistency.** **<u>Q 2 (Jan-Mar):</u>** **Clinical Practice Guideline (CPG) evaluation reports have been reviewed and approved, and IPLT subject matter expert feedback has been received to help inform the current CPC policy update. The LOCUS annual implementation plan is in place.** **<u>Q 3 (Apr-June):</u>** **Clinical Practice Guidelines policy has been updated and posted, including regional updates on Evidence-Based Practices. Region 10 LOCUS Implementation Plan mid-year status was discussed, and notes from the May State LOCUS Implementation Workgroup meeting were shared. Lapeer has applied for an IPS application and MiFAST fidelity assessment.** **<u>Q 4 (July-Sept):</u>** **Task development and collaborations on the Clinical Practice Guidelines (CPG) Annual Evaluation Report were discussed and follow-up activities were identified for further review and work to completion. Genesee Health System (GHS) implemented its Level of Care Utilization System (LOCUS) Dashboard. The Michigan Department of Health & Human Services (MDHHS) LOCUS State Implementation Plan report was reviewed and**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Community Mental Health (CMH) Providers were encouraged to participate as needed with the Michigan Fidelity Assistance Support Team (MiFAST) fidelity review and/or consultative processes. **<u>Evaluation:</u> This goal is met for FY2022. The FY2021 Biennial Evaluation Report and Annual Evaluation Report were completed, and report findings were integrated into the updated CPG Policy. The FY2022 Annual Evaluation Report is in-process toward completion, according to schedule. Regarding evidence-based practices (EBPs), GHS has implemented its LOCUS Dashboard, St. Clair initiated its Integrated Dual Disorders Treatment fidelity scale (IDDT) MiFAST review, Lapeer completed its MiFAST Individual Placement & Support (IPS) application process, and all CMHs have implemented their annual LOCUS implementation plans.** **<u>Barrier Analysis:</u> No barriers were identified during FY2022.** **<u>Next Steps:</u> This goal is identified by the Quality Improvement Committee as a continuation goal, and it will continue in FY2023. Specific next steps are as follows: Update the CPG policy contingent upon its annual evaluation report findings and recommendations; implement the FY2023 LOCUS implementation plan; ensure share-and-learn presentations with CMH MiFAST reports.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Employment Services	The goals for FY2022 Reporting Year are as follows: • Support progressive and safe community based CMHSP employment service practices throughout the regional Employment Services Committee (ESC). Facilitate share and learn discussions on: o CMHSP employment targets for competitive employment (community-based) and appropriate compensation (minimum wage or higher) o Standardized employment services data and report formats o In-service / informational materials o Community-based employment opportunities and collaborative practices, e.g., MRS o CMHSP successes addressing COVID-19 challenges in community-based employment	Tom Seilheimer Improving Practices Leadership Team (IPLT) & Employment Services Committee (ESC)	**Quarterly Updates:** **Q 1 (Oct-Dec):** **At the November Employment Services Committee (ESC) meeting, members participated in an Individual Placement Support (IPS) presentation which included a question-and-answer session with the MDHHS IPS fidelity consultant.** **Q 2 (Jan-Mar):** **GHS is looking into a dashboard format to track employment activities beyond the MMBPIS tracking; Lapeer has started an employment services steering committee along with plans to expand its part time employment specialists into full time, and IT discussions are underway regarding employment activity tracking; Sanilac conducts monthly case reviews for referral to MRS in terms of work orientation, skill development and a three-step readiness assessment across both MI and I/DD consumers; St. Clair reported on its IPS End of Year Report findings: 49% employment rate, 90% retention rate $11+ average wage rate, 29 hour average work week – all of which are either records or progressive findings, along with encouraging results with its Discovery Model. Group discussion also focused on the effectiveness of a shorter-term, strategic use of the Discovery Model, and the overall importance of Benefit to Work coaching to help expedite the process and to maintain placements.** **Q 3 (Apr-June):** **May Employment Services Committee (ESC) meeting notes were reviewed. Lapeer CMH has applied for an IPS application and MiFAST fidelity assessment. St. Clair CMH has launched its Discovery Model for its I/DD population. All CMHs report efforts promote safety and safe work environments.** **Q 4 (July-Sept):** **The Individual Placement Support (IPS) application process was discussed and Lapeer CMH was recognized**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			for its current accomplishments in this area. Michigan Mission-Based Performance Indicator System (MMBPIS) employment indicators were reviewed along with local efforts to increase these rates. Utilization Management (UM) Redesign activities were overviewed in connection with employment services, and employment in-service materials were shared. **<u>Evaluation:</u> This goal has been met for FY2022. At least one share-and-learn peer presentation was given at each quarterly meeting. Quarterly updates and discussion were also held on the Michigan Department of Health and Human Services (MDHHS) Recharging Employment quarterly meetings, and on the annual Benefit to Work Coaching in-service. The MDHHS IPS consultant also presented on IPS practices, in conjunction with St. Clair CMH presentation of its annual IPS evaluation report. All Community Mental Health (CMH) Providers reported setting local employment targets as informed by the MMBPIS tracking reports. All CMHs reported at least one field success story at each quarterly meeting. Genesee Health System (GHS) is working on an Employment Services Dashboard, and Lapeer CMH has completed its IPS application process.** **<u>Barrier Analysis:</u> Temporary barriers to community-based employment were reported in connection to COVID-19, but these had abated by end-of-year.** **<u>Next Steps:</u> This goal is identified by the Quality Improvement Committee as a continuation goal, and it will continue in FY2023. Specific next steps are as follows: expand work safety monitoring beyond pandemic issues; support Lapeer CMH's IPS implementation; ensure committee member use of the UM Redesign service authorization grid as it applies to skill building and employment services.**
Employment Services	The goals for FY2022 Reporting Year are as follows: • Celebrate safe community based CMHSP employment service practices. Facilitate share and learn discussions on:	Tom Seilheimer Improving Practices Leadership Team	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **At the November Employment Services Committee (ESC) meeting, members participated in an Individual**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ CMHSP successes addressing COVID-19 challenges in community-based employment	(IPLT) & Employment Services Committee (ESC)	**Placement Support (IPS) presentation which included a question-and-answer session with the MDHHS IPS fidelity consultant. Safety within community employment opportunities was also discussed.** **<u>Q 2 (Jan-Mar):</u>** **Meeting discussion noted that member participation has increased, presumably in connection with effective service engagement and COVID-19 prevention practices.** **<u>Q 3 (Apr-June):</u>** **May Employment Services Committee (ESC) meeting notes were reviewed. All CMHs report efforts to promote safety and safe work environment settings in the community.** **<u>Q 4 (July-Sept):</u>** **Employment in-service materials were discussed regarding state initiatives to encourage and increase skill building assistance encounters back to pre-pandemic levels, and to promote community-based employment opportunities as COVID-19 risks decrease.** **<u>Evaluation:</u> This goal is met for FY2022. All Community Mental Health (CMH) Providers reported activities being undertaken to increase skill building assistance encounters back to pre-pandemic levels and to promote community-based employment opportunities.** **<u>Barrier Analysis:</u> Temporary barriers to community-based employment were reported in connection to COVID-19, but these had abated by end-of-year.** **<u>Next Steps:</u> This goal is identified by the Quality Improvement Committee as a continuation goal, and it will continue in FY2023, as revised: Share and learn discussions in support of CMH successes addressing challenges in community-based employment, e.g., pandemic, community inclusion.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Home & Community Based Services	The goals for FY2022 Reporting are as follows: • Monitor CMHSP network implementation of the Home and Community Based Services (HCBS) Transition Plan to ensure quality of clinical care and service. o Monitor network completion of the FY2022 HCBS survey process, Heightened Scrutiny Out of Compliance, and Validation of Compliant Settings process o Monitor the provisional approval process	Lauren Campbell / Hailey Dziegelewski Improving Practices Leadership Team (IPLT)	**Quarterly Updates:** **Q 1 (Oct-Dec):** **The FY2022 Surveys were distributed during FY2022 Q1. 100% of the provider surveys distributed were completed. These surveys were required for providers to complete. The Heightened Scrutiny Out of Compliance process made progress during FY2022 Q1. Out of Compliance Notifications were sent to providers, Corrective Action Plans were submitted to the PIHP, reviewed and Corrective Action Plan approval notifications were sent to providers. Three (3) providers have not yet submitted their Plan of Correction. These are considered past due and PIHP HCBS Staff are working with CMH HCBS Leads to rectify this issue. The CMHs are working on validating settings that were initially determined to be compliant after completing the full HCBS survey. This validation work will be ongoing and is to be completed by July 2022. LCMH and SC CMH have completed this validation work. A new HCBS process was initiated by MDHHS in efforts to meet the requirements of the Final Rule. This process involves surveying settings that have not responded to any surveys that were sent during previous survey cycles. The PIHP will work closely with MDHHS, CMH Leads and providers to survey and bring these settings into compliance with the HCBS Final Rule. During FY2022 Q1, thirteen (13) Provisional Approval Requests were received and approved by the PIHP.** **Q 2 (Jan-Mar):** **All corrective action plans have been received and approved for the Heightened Scrutiny Out of Compliance Remediation. The next step in the Heightened Scrutiny Out of Compliance Remediation process is for CMH HCBS Leads to attest that corrective action plans have been implemented by providers due by May 2022.** **The PIHP HCBS Lead received four requests for the Region 10 Provisional Approval process. The initial compliance evaluation validation process has been completed so far by St. Clair CMH and Lapeer CMH.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The PIHP HCBS Lead coordinated with the CMH HCBS Leads to complete the Non-Responder Surveys by March 31. **Other project updates are pended to later this fiscal year or next fiscal year.** **<u>Q 3 (Apr-June):</u>** **Ongoing coordination with the CMH HCBS Leads has occurred to remediate the Heightened Scrutiny providers. MDHHS informed PIHP's that the second phase of the MDHHS Heightened Scrutiny Public Comment period has been posted on their website and will be posted for 30 days. After the 30-day review, the State and CMS will review public feedback and determine if Heightened Scrutiny providers can continue with HCBS Medicaid-funding services. This phase includes Region 10 providers.** **For the Non-Responder Survey Cycle, providers have been sent letters to include their Compliance Status and any action that is needed for either validation and/or remediation. Providers that have been issued corrective action plans (CAPs) have a due date to submit the CAPs of July 25th. This entire process is due by August 31, 2022.** **Provisional approval requests are ongoing. All other ongoing project updates are pended to later this fiscal year or next fiscal year.** **<u>Q 4 (July-Sept):</u>** **The Michigan Department of Health & Human Services (MDHHS) Public Comment Period closed on July 27th. For next steps, MDHHS will conduct their own review of the Heightened Scrutiny (HS) providers and send the providers they find compliant to the Centers for Medicare & Medicaid Services (CMS) for final determination.** **For the Non-Responder Survey Cycle, all Out-of-Compliance providers submitted their corrective action plans (CAPs) to the PIHP by Tuesday, July 26th. All validation work was received and reviewed by PIHP by deadline of September 17, 2022.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Statewide Transition Planning preparation work for consumers on Heightened Scrutiny has been ongoing. Region 10 staff met internally to discuss the PIHP's stance for transitioning consumers and how the PIHP can best support the provider network and consumers during this time. The approach is going to be looking at each individual consumer and any restrictions or health and safety concerns documented in their plans of service. Consumers must be transitioned prior to March 1, 2023. More information and direction to come on this process from MDHHS. **<u>Evaluation:</u> The PIHP has worked collaboratively to address gaps in processes for completing Home and Community Based Services (HCBS) provider surveys, remediation and validation work, and provisional approvals. PIHP HCBS Coordinator has sought technical assistance (TA) from MDHHS on outstanding questions and conducted several TA calls with Community Mental Health (CMH) Leads for process improvement opportunities. This goal is not quite met as Heightened Scrutiny (HS) providers are currently under review and transition planning steps will be continued into FY2023.** **<u>Barrier Analysis:</u> Timeline for transitioning HS consumers is not aligning with the six-month timeframe originally provided. MDHHS and CMS have not completed their final review of HS providers.** **<u>Next Steps:</u> This goal will carry over to FY2023. The PIHP HCBS Coordinator will continue working on implementing process improvement opportunities and support the CMHs during the Statewide Transition Planning process.**
Integrated Health Care	The goals for FY2022 Reporting are as follows: • Monitor CMHSP network implementation of the CMHSP/PIHP/MHP Integrated Health Care (IHC) Care Coordination Plan. o Assist in aligning network care integration processes for persons with Medicaid Health Plans, including	Tom Seilheimer Improving Practices Leadership Team (IPLT)	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **Twenty-four (24) Interactive Care Plans (ICPs) are open, with all CMHs participating. A racial/ethnic disparity reporting template is in development.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	shared case record operations and aligned network practices in utilizing the CC360 system.		**Q 2 (Jan-Mar):** **At the end of March, there were 18 interactive care plans open. All CMHs have been participating.** **Committee discussion regarding Supports Intensity Scale (SIS) implementation / continuation challenges were noted for feedback to the state evaluation and planning process. Discussion regarding SIS implementation has taken place to help inform current state workgroup planning activities.** **Q 3 (Apr-June):** **All members participate in the monthly meetings and new cases are being added. The new CareConnect360 feature regarding homelessness risk was further discussed and its regional utilization is being encouraged and monitored.** **Q 4 (July-Sept):** **Integrated Health Care (IHC) monthly meetings are proceeding as scheduled, with all designated entities participating. CareConnect360 homelessness risk reporting has been accessed and integrated into case record discussions.** **Evaluation: This goal has been met. Given the multi-year intent of this IHC plan, the Quality Improvement Committee (QIC) has forwarded this goal into FY2023.** **During FY2022, a total of 29 Interactive Care Plans were opened for shared members of the Community Mental Health (CMH) Providers and the six Medicaid Health Plans (MHPs). This is a slight decrease from the 31 Interactive Care Plans that were opened in FY2021. The count of Interactive Care Plans opened by CMH is as follows: Genesee Health System, 18; Lapeer CMH, 2; Sanilac CMH, 3; St. Clair CMH, 6.** **Also, during FY2022, a total of 35 Interactive Care Plans were closed as either "All goals met," "Ineligible/member lost coverage," "Member refuses coordinated care between the MHP/CMH," or "Some goals met." This year, 37% of the 30 care plans were closed as "All goals met."**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			This was an increase over FY2021 which saw 17% of care plans being closed as "All goals met." **<u>Barrier Analysis:</u> No barriers are identified.** **<u>Next Steps:</u> Given this project's multi-year plan, the QIC will continue this goal into FY2023.**
Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	The goals for FY2022 Reporting are as follows: • To review and monitor the safety of clinical care. o Review critical incidents, to ensure adherence to timeliness of data and reporting standards and to monitor for trends, to improve systems of care. o Monitor sentinel event review processes and ensure follow-up as deemed necessary. o Monitor unexpected deaths review processes and ensure follow-up as deemed necessary.	Tom Seilheimer Sentinel Event Review Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **Monthly Critical Incident (CI) reports and the FY2021 Q4 / end of year CI Report were reviewed, with no concerning trends identified. There were no sentinel events submitted for review. The FY2021 Q4 / end of year CI Report has been submitted to the QI Committee for review/approval. Substance Use Disorder (SUD) CI reporting is being systematized and integrated into the Sentinel Event Review Committee's (SERC) periodic CI monitoring/reporting system.** **<u>Q 2 (Jan-Mar):</u>** **Discussion has continued regarding Medical Director review of research on age and gender standardized mortality ratios by psychiatric diagnosis. Follow up discussion will assess the potential to inform regional trends with critical incidents and sentinel events. One CMH sentinel event was received for committee review. The SUD SE form has been disseminated to the SUD network. Work continues on policy updates. One sentinel event was received from St. Clair CMH. No concerning trends noted on the monthly CI reports.** **<u>Q 3 (Apr-June):</u>** **Critical incident (CI) monthly monitoring and quarterly monitoring identified no immanent issues; potential concerning trends are being monitored (see attached second quarter CI report). The CI Sentinel Event (SE) Policy update has been completed and follow-up discussion will take place in management team.** **<u>Q 4 (July-Sept):</u>**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			One sentinel event was submitted to the committee during the quarter, and its review is in-process. The new substance use disorder (SUD) critical incident (CI) Reporting System was disseminated, and the expansion of the Sentinel Event Review Committee (SERC) annual goals and policy updates were discussed. Mortality reporting is not due until the end of year reporting schedule. **<u>Evaluation:</u> This goal has been met. All applicable reports and data submissions were received from the network affiliates, for committee monitoring, analysis, and feedback. CI trends reveal continued variance across categories overall, with continued low rates in Hospitalization, Suicide, and Arrest. Continued elevations are noted in Emergency Medical Treatment (EMT) and Non-Suicide Death, mostly attributed to two Community Mental Health (CMH) Providers. Here, specific cases and other case trends have been analyzed to rule out service systems issues. Three sentinel events were received that, upon further committee evaluation, were found to not meet sentinel event (SE) criteria. Nevertheless, substance use submissions were timely and in compliance with all process time frames. Unexpected Deaths were reviewed as scheduled by monitoring affiliate mortality reports. Here, service systems issues were ruled out. SUD CI monitoring began mid-year, and no service systems issues have been identified. In response to the Health Services Advisory Group (HSAG) findings, the Risk Events reporting, and monitoring processes have been centralized under SERC, and will commence during FY2023 per CI SE policy update.** **<u>Barrier Analysis:</u> No barriers have been identified.** **<u>Next Steps:</u> Continue this plan into FY2023 according to CI SE policy updates and work plan addendum regarding Risk Events and Unexpected Deaths monitoring.**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr>
<td>Michigan Mission Based Performance Indicator System (MMBPIS)</td>
<td>The goals for FY2022 Reporting are as follows:

The goal is to attain and maintain performance standards as set by the MDHHS contract.

Report indicator results to MDHHS quarterly per contract.
Review quarterly MMBPIS data.
Improve performance with indicators without a set performance standard.
Provide status updates to relevant committees, such as QMC, PIHP CEO, PIHP Board.

<table>
<tr><th></th><th>FY21 Q4</th><th>FY22 Q1</th><th>FY22 Q2</th><th>FY22 Q3</th></tr>
<tr><td colspan="5">Ind. 1 - Percentage of persons receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95%</td></tr>
<tr><td>1.1 Children</td><td>99.64%</td><td>100%</td><td>99.73%</td><td>100%</td></tr>
<tr><td>1.2 Adults</td><td>99.81%</td><td>100%</td><td>100%</td><td>99.57%</td></tr>
<tr><td colspan="5">Ind. 2a – Percentage of new persons receiving a completed biopsychosocial assessment within 14 calendar days of non-emergency request for service. No standard</td></tr>
<tr><td>2a PIHP Total</td><td>63.98%</td><td>58.64%</td><td>54.88%</td><td>46.86%</td></tr>
<tr><td>2a.1 MI-Children</td><td>69.11%</td><td>66.80%</td><td>56.97%</td><td>50.80%</td></tr>
<tr><td>2a.2 MI-Adults</td><td>58.34%</td><td>51.83%</td><td>51.73%</td><td>44.46%</td></tr>
<tr><td>2a.3 DD-Children</td><td>75.00%</td><td>67.68%</td><td>63.71%</td><td>48.48%</td></tr>
<tr><td>2a.4 DD-Adults</td><td>76.74%</td><td>57.41%</td><td>54.43%</td><td>47.62%</td></tr>
<tr><td colspan="5">Ind. 2b - Percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders. No standard</td></tr>
<tr><td>2b SUD</td><td>68.52%</td><td>66.52%</td><td>67.84%</td><td>64.96%</td></tr>
<tr><td colspan="5">Ind. 3 – Percentage of new persons during the quarter starting any needed on-going service within 14 days of non-emergent face-to-face assessment with professional. No standard</td></tr>
<tr><td>3 PIHP Total</td><td>86.45%</td><td>91.25%</td><td>84.79%</td><td>84.14%</td></tr>
<tr><td>3.1 MI-Children</td><td>91.67%</td><td>95.19%</td><td>88.27%</td><td>89.82%</td></tr>
<tr><td>3.2 MI-Adults</td><td>83.07%</td><td>88.60%</td><td>79.25%</td><td>79.43%</td></tr>
<tr><td>3.3 DD-Children</td><td>89.76%</td><td>92.73%</td><td>96.79%</td><td>91.28%</td></tr>
<tr><td>3.4 DD-Adults</td><td>88.57%</td><td>84.31%</td><td>83.05%</td><td>78.69%</td></tr>
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</td>
<td>Lauren Campbell

Quality Management Committee (QMC)</td>
<td><u>Quarterly Updates:</u>

<u>Q 1 (Oct-Dec):</u>
Performance Indicators (PIs) for FY2021 Q4 were submitted to MDHHS on January 3, 2022. The PIHP met the set standard for every PI with a performance standard. St. Clair CMH did not meet the standard for PI 4a – Children. Lapeer CMH did not meet the standard for PI 4a – Adults. Corrective action plans have been received. Additionally, plans of improvement were received from all CMHs for PIs 2a and 3 which include analyses of noncompliant events. The plans of improvement submitted by the CMHs are relevant to the analyses completed and support efforts to improve individuals' access to care and services. Lastly, the PIHP continues to evaluate processes to determine where efficiencies are added.

As a reminder, the final total and rate for PI 2b are calculated by MDHHS using data submitted by the PIHP. The table to the left includes the PIHP's most recent estimate of the rate for PI 2b.

<u>Q 2 (Jan-Mar):</u>
Performance Indicators (PIs) for FY2022 first quarter were submitted to MDHHS on March 31, 2022. The PIHP did not meet the set performance standard for PI 4a – Adults and PI 4b. St. Clair CMH did not meet the standard for PI 4a – Children. Lapeer CMH did not meet the standard for PI 4a – Adults and PI 10 – Adults. Sanilac CMH did not meet the standard for PI 4a – Adults. Corrective action plans have been received from Lapeer CMH and Sanilac CMH and requested from St. Clair CMH.

<u>Q 3 (Apr-June):</u>
Performance Indicators (PIs) for FY2022 second quarter were submitted to MDHHS on June 30, 2022. The PIHP did not meet the set performance standard for PI 4b. St. Clair CMH did not meet the standard for PI 4a – Adults and PI 10 – Adults. Sanilac CMH did not meet the standard for PI 10 – Children.</td>
</tr>
</table>

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr><td></td><td>
<table>
<tr><td colspan="5">Ind. 4 – Percentage of discharges from a psychiatric inpatient unit / SUD Detox unit that were seen for follow-up care within 7 days. Standard = 95%</td></tr>
<tr><td>4a.1 Children</td><td>98.39%</td><td>95.77%</td><td>97.30%</td><td>97.73%</td></tr>
<tr><td>4a.2 Adults</td><td>96.69%</td><td>92.65%</td><td>95.67%</td><td>97.75%</td></tr>
<tr><td>4b SUD</td><td>95.31%</td><td>91.49%</td><td>85.71%</td><td>98.46%</td></tr>
<tr><td colspan="5">Ind. 10 – Percentage of readmissions of children and adults to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less</td></tr>
<tr><td>10.1 Children</td><td>6.90%</td><td>10.53%</td><td>5.26%</td><td>9.45%</td></tr>
<tr><td>10.2 Adults</td><td>11.45%</td><td>9.86%</td><td>11.46%</td><td>9.75%</td></tr>
</table>
</td><td></td><td><u>Q 4 (July-Sept):</u>
Performance Indicators (PIs) for FY2022 third quarter were submitted to the Michigan Department of Health & Human Services (MDHHS) on September 30, 2022. All Community Mental Health (CMH) Providers and the PIHP met the set standard for every PI with a performance standard.

<u>Evaluation:</u> This goal was not met during FY2022 reporting. The PIHP successfully reported indicator results to MDHHS, reviewed quarterly MMBPIS data, and provided status updates to relevant committees. However, there was not improved performance with indicators without a set performance standard.

<u>Barrier Analysis:</u> Barriers identified during root cause analyses for indicators 2a and 3 included staff capacity, individuals not showing for appointments or rescheduling appointments, unsuccessful outreach attempts to engage individuals in services, and transportation.

<u>Next Steps:</u> This goal will be continued for FY2023. The PIHP PI Team will revisit the expectations for quality improvement initiatives for PIs. The PIHP PI Team will also address feedback from the Health Services Advisory Group by preparing monthly updates. These updates will be reported through the External Quality Review Corrective Actions Quality Improvement Workplan goal.</td></tr>
<tr><td>Members' Experience</td><td>The goals for FY2022 Reporting are as follows:
• Conduct assessments of members' experience with services.
o Conduct annual regional customer satisfaction survey.
o Conduct the Recovery Self-Assessment survey.
o Conduct qualitative assessments (e.g., focus groups).
o Conduct other assessments of members' experience as needed.
o Develop interventions to address areas for improvement based on member satisfaction survey</td><td>Lauren Campbell / Jennifer Beier

Quality Management Committee (QMC)</td><td><u>Quarterly Updates:</u>

<u>Q 1 (Oct-Dec):</u>
The FY2021 RSA Survey Report was approved by the PIHP Board at its October meeting. During November, the PIHP Satisfaction Survey Policy review process was initiated. Additionally, the FY2021 Customer Satisfaction Survey Report was approved by the PIHP Board at its December meeting. Discussion continues with Quality Management Committee members regarding qualitative assessments, as well as a schedule for quantitative assessments.</td></tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Q 2 (Jan-Mar): **During the January QMC meeting, members discussed administration methods for the FY2022 Recovery Self-Assessment (RSA) Survey. Electronic methods of collecting responses, such as a quick response (QR) code, were discussed to avoid the low response rates reported for mailout surveys. The QMC members also discussed other available methods to ensure all individuals served will be able to participate in the survey. The FY2022 RSA Survey was administered during March.** **Q 3 (Apr-June):** **The FY2022 Recovery Self-Assessment (RSA) Survey Report was presented to the Quality Management Committee (QMC) in May. Minimal feedback was provided by QMC members. The QMC members discussed administration of the FY2022 Customer Satisfaction Survey. A workgroup meeting was held with CMH QMC representatives to discuss survey administration processes and preferences. The PIHP Survey Team will use the feedback from CMH QMC members and other PIHP subject matter experts to improve the survey process.** **Q 4 (July-Sept):** **In July, the FY2022 Recovery Self-Assessment (RSA) Survey Report was approved by the PIHP Board at its July meeting and was posted to the PIHP website. A copy of the RSA Survey Report was sent to the Community Mental Health (CMH) Providers and Substance Use Disorder (SUD) Treatment Providers for distribution to staff and individuals served. The PIHP participated in the FY2022 Health Services Advisory Group (HSAG) Compliance Review on July 12, 2022 where feedback was obtained regarding the PIHP's survey reporting. During August, each CMH began conducting the FY2022 Customer Satisfaction Survey. Surveys were administered from August 1, 2022 through September 2, 2022. The PIHP mailed out surveys on behalf of its SUD Provider network during the week of August 22, 2022. In**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			September, data collected by each CMH was submitted to the PIHP. All data is currently being analyzed to be included in the FY2022 Customer Satisfaction Survey Report. **<u>Evaluation:</u> The PIHP conducted assessments of members' experience by way of the RSA and Customer Satisfaction Surveys. The RSA survey showed that overall, a recovery-oriented system of care is in place throughout Region 10, as noted by scores and responses in a positive range. However, response rates for the RSA survey have declined during FY2022, with the total number of surveys completed at 549, which was a decrease of 39% from FY2021. Of the 549 surveys completed response counts from the three survey versions were as follows: Person in Recovery had 345 responses (decrease of 43% from FY2021), Provider had 148 responses (decrease of 32% from FY2021), and Administrator/Manager responses had 56 (decrease of 33% from FY2021).** **The Customer Satisfaction Survey was conducted, and responses were collected during FY2022, with the analysis and report creation still under way. For the FY2022 Customer Satisfaction Survey, the PIHP requested feedback from Quality Management Committee (QMC) members during a survey workgroup meeting. Feedback included survey population sample size and preferred survey administration methods. Response rates declined for the Customer Satisfaction Survey in FY2022. A total of 551 adult survey responses were collected, which was a decrease of 45% from FY2021. Of the adult surveys, 500 came from the CMHSPs (a decrease of 48% from FY2021) and 51 responses came from SUD (an increase of 29% from FY2021). A total of 130 survey responses were collected for the child survey, which was a decrease of 8% from FY2021.** **<u>Barrier Analysis:</u> While being mindful of safe Covid-19 practices along with CMH preferences, the sample size and survey administration methods may have produced reduced response rates from the CMHs for the Customer**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Satisfaction Survey. The SUD survey mail out conducted by the PIHP for the Customer Satisfaction Survey, while having a slight increase in responses over FY2021, also yielded a low response rate when compared to prior years of the survey. **<u>Next Steps:</u> The PIHP will utilize input from QMC members and other sources to improve survey administration processes and increase survey response rates. The PIHP will incorporate feedback received during the FY2022 Health Services Advisory Group (HSAG) Compliance Review to make improvements to future surveys and reporting. The PIHP will continue to share survey results with the CMHs and SUD Providers to make results available to persons served and to use survey findings as part of discussions during Consumer Advisory Council meetings.**
State Mandated Performance Improvement Projects	The goals for FY2022 Reporting are as follows: • Identify and implement two PIP projects that meet MDHHS standards: Improvement Project #1 Tobacco Cessation: the proportion of SMI adult Medicaid consumers identified as tobacco users who had at least one reported encounter during the CY for prescribed medications to assist in reducing or eliminating tobacco use. Improvement Project #2 The goal of this PIP is to ensure that children and adults within the region who are Medicaid beneficiaries will receive follow-up services within 30 days after discharge from a psychiatric inpatient hospital. This study topic aligns with the Performance Bonus Incentive Pool metric "Follow-up After Hospitalization for Mental illness within 30 Days", which applies performance standards for these two clinical cohorts. PIP performance targets have been set to exceed these performance standards. o Review HSAG report on PIP interventions and baseline	Tom Seilheimer Quality Management Committee (QMC)	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **The Performance Improvement Plan (PIP) 1 Final Validation Report from the Health Services Advisory Group (HSAG) was received, noting 100% compliance. PIP 2 implementation monitoring activities were discussed, and CMHs were provided a monitoring template to carry out this task. The proposed new PIP was discussed, and feedback was received in support of the proposal submission to MDHHS.** **<u>Q 2 (Jan-Mar):</u>** **PIP 1 has been phased out, per goal attainment and has been replaced by the new PIP 1: Racial/Ethnic Disparities in SUD Access. Initial PIP 2 data gathering, and analyses have been completed to provisionally inform CMHs on their PIP progress.** **<u>Q 3 (Apr-June):</u>** **Development of PIP 1 (disparities) is proceeding in conjunction with the HSAG PIP July 15 due date. Data analysis of PIP 2 (Follow-up After Hospitalization (FUH) – data Jan-Sep) reveals target percentages being met.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Provide / review PIP status updates to Quality Management Committee ○ QMC to consider selection of PIP projects aimed at impacting error reduction, improving safety and quality		**Q 4 (July-Sept):** **The Racial/Ethnic Disparities performance improvement project (PIP) was resubmitted to the Health Services Advisory Group (HSAG) per the initial review feedback. The Follow Up After Hospitalization (FUH) PIP annual findings were discussed in terms of evaluative feedback to Community Mental Health (CMH) PIP activities, and CMHs submitted their updated annual improvement plans.** **Evaluation: This goal is met. PIP 1 activities have been completed according to plan and confirmed by HSAG audit. PIP 2 activities have been completed according to plan and confirmed by HSAG audit. PIP 2 Measurement One analysis did not identify significant rate increases compared to baseline, but rates remained higher than the MDHHS incentive targets.** **Barrier Analysis: No barriers have been identified for PIP 1. One barrier has been identified for PIP 2 pertaining to a delay in receiving end of calendar year data from the MDHHS data warehouse. Region 10 is informed by MDHHS that it is aware of this issue and is working to address it.** **Next Steps: Given the multi-year implantation planning for both PIPs, this goal will be continued for FY2023. Specific next steps are as follows: implement PIP 1 improvement action plan; complete the PIP 2 FY2022 implementation monitoring evaluation and implement the PIP 2 FY2023 systems improvement plan.**
External Monitoring Reviews	The goals for FY2022 Reporting are as follows: • To monitor and address activities related to PIHP Waiver Programs (HSW, CWP, SEDW): ○ Follow up and report on activities to ensure compliance with the MDHHS HSW, CWP, and SEDW requirements. ○ Ensure both Professional and Aide staff meet required qualifications.	Lauren Campbell / Hailey Dziegelewski Quality Management Committee (QMC)	**Quarterly Updates:** **Q 1 (Oct-Dec):** **During Quality Management Committee (QMC) meetings, the PIHP Waiver Coordinator provided information regarding the PIHP Waiver Programs. Information included an overview of findings and highlights from the PIHP's FY2021 Waiver Clinical Case Record Reviews, trainings and technical assistance webinars hosted by MDHHS, and upcoming virtual**

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	○ Ensure compliance with person-centered planning and individual plan of service requirements, with additional focus on areas identified as repeat citations. ○ Discuss CMH, PIHP, and MDHHS Review findings and follow up on remediation activities.		**conferences. Additionally, information regarding Habilitation Supports Waiver (HSW) slot allocation was shared.** **<u>Q 2 (Jan-Mar):</u>** **During QMC meetings, the PIHP Waiver Coordinator shared information regarding upcoming conferences, MDHHS trainings, regional meetings, Waiver slot allocation, and the extended public health emergency. The new PIHP Waiver Coordinator asked about the CMHs' waiver case record review processes. All CMHs provided an update and reported their reviews are ongoing.** **<u>Q 3 (Apr-June):</u>** **MDHHS notified the PIHP that there indeed will be an upcoming desk/remote Full Site Review of Region 10's CWP, HSW, SEDW, and SUD services. This review will be conducted from Monday, August 15th through Friday, September 30th. MDHHS also informed PIHP that there are upcoming waiver trainings in the making and that the Supports Intensity Scale (SIS) Assessment will be required for individuals enrolled in the HSW and 1915(i) State Plan Amendment (SPA) beginning October 1, 2024.** **<u>Q 4 (July-Sept):</u>** **The Michigan Department of Health & Human Services (MDHHS) 1915(c) Waiver Site Review began on Monday, August 15th and ended on September 30th. Findings and citations will be shared with the Community Mental Health (CMH) Providers and discussed during upcoming Quality Management Committee (QMC) meetings.** **The Waiver for Children with Serious Emotional Disturbances (SEDW) and Children's Waiver Program (CWP) 101 in-person trainings have officially been scheduled for October 31st and November 1st. These will consist of a full day training at Blue Water Convention Center in Port Huron with MDHHS, the PIHP, and CMH attendance. PIHP asked that attendees return their registration forms into Region 10's Human Resource Department by Wednesday, October 12th.**

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			<u>Evaluation:</u> During QMC meetings, PIHP Waiver Coordinator addressed Habilitation Supports Waiver (HSW) slot utilization, the Public Health Emergency, and upcoming MDHHS Site Reviews and trainings. Through the fourth quarter, the HSW slot utilization stayed steady, averaging 93%. This is below the MDHHS and Federal threshold of 95%. In efforts to improve Region 10's performance, the PIHP Waiver Coordinator shared several HSW, SEDW, and CWP training opportunities and webinars for all staff involved in waiver activities. This goal is met, and performance activities will continue to be monitored. **<u>Barrier Analysis:</u> No barriers** **<u>Next Steps:</u> This objective will be continued into the following fiscal year. To enhance oversight of Region 10's slot performance, additional slot utilization and monitoring will be added to the goal and discussed during QMC meetings with the CMHs.**
Monitoring of Quality Areas	The goals for FY2022 Reporting are as follows: • To explore and promote quality and data practices within the region. o Monitor critical incidents. o Monitor emerging quality and data initiative / issues and requirements. o Monitor and address Performance Bonus Incentive Pool activities and indicators. o Monitor and address changes to service codes. o Review / analysis of various regional data reports. o Review / analysis of BH TEDS reports.	Lauren Campbell / Laurie Story-Walker Quality Management Committee (QMC)	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **The Behavioral Health Treatment Episode Data Set (BH-TEDS) completion rates were reviewed. BH-TEDS reporting for FY2022 began November 1st (due to the FY2022 specification changes). CHAMPS added a new edit for encounters that no longer allows a P.O. Box to be listed in the second address line for Provider Profiles. PCE updated the logic to include this edit. Discussions occurred regarding the service code and modifier changes effective October 1, 2021. CMHs had concern with the change in utilization of the Mental Health assessment code when using the 90791 Psychiatric Evaluation, master's level (previously reported as H0031), and was shared with MDHHS. All CMHs participated in the CMHA Telehealth Survey.** **CMHs were asked to remind staff to accurately answer the veteran fields. MDHHS project to review the list provided when the Medicaid ID in the admission record is different from the Medicaid ID in the discharge record.**

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			Some reasons may be due to an adoption or name change. MDHHS extended the due date to January 31, 2022. The CMHs will return their listing with findings to the PIHP no later the end of business day January 29, 2022. December 22nd is the last scheduled FY2021 encounter submission. CMHs will coordinate FY2021 encounters submission after that December 22, 2021, with the PIHP. **Monthly critical incident reports were reviewed. An issue with the PCE critical incident event reporting module was identified (and resolved) by PCE during October. Performance Bonus Incentive Pool (PBIP) reports were discussed. The PIHP prepared and submitted the final PBIP narrative on patient-centered medical homes.** **<u>Q 2 (Jan-Mar):</u>** **During QMC meetings, BH TEDS Completion Rates, I/DD designation field clarification, updated BH TEDs error codes and missing staff level modifiers were shared and reviewed with the membership.** **Monthly critical incident reports were reviewed. During the February QMC meeting, GHS reported that the PIHP's report was missing data. Follow up occurred after the meeting. Performance Bonus Incentive Pool (PBIP) reports were also discussed. The PIHP prepared a narrative summarizing the difference between the number of contacts made by the PIHP Veteran Navigator/Coordinator and the number of Veteran admissions recorded through BH-TEDS data.** **The PIHP also completed data validation activities for the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) measure and submitted findings to MDHHS.** **<u>Q 3 (Apr-June):</u>** **The MDHHS issued communications were reviewed with the Quality Management Committee (QMC) members that included the BH TEDS completion rates, Telemedicine reminders related to the Public Health Emergency (PHE) potential April end, Federal PHE**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			update, extending through July 15, 2022, April EDIT meeting minutes, quarterly updates to the SFY 2022 Behavioral Health Code Charts and Provider Qualifications chart and Support Intensity Scale (SIS-A) Assessment Tool. The PHE unwind webinar was discussed and information shared with others upon request. The FY2023 BH TEDS specifications and Error listing, Electronic Visit Verification (EVV) handouts were shared with members. CMHs should report any outstanding encounter issues to the PIHP. **Monthly critical incident reports were reviewed. Performance Bonus Incentive Pool (PBIP) activities were also discussed. It was shared that the PIHP did not receive the full PBIP withheld amount due to performance with two measures focused on reducing racial disparities.** **<u>Q 4 (July-Sept):</u>** **The updated SFY2022 Code Chart and Provider Qualifications document was posted to the Michigan Department of Health & Human Services (MDHHS) website. The Community Mental Health (CMH) Providers reported no challenges or barriers for encounter reporting. All CMHs reported no issues with encounter reporting. All are working on Encounter Quality Initiative (EQI) data comparisons and data cleanup for FY2022 Period 2. Behavioral Health Treatment Episode Data Set (BH TEDS) Completion rates were provided, along with the FY2023 BH TEDS specifications and Error Descriptions. Coordination of Benefit data will be included in the encounter for all subcontractors beginning October 1, 2022. The MDHHS plans to add this requirement to CMH direct-run services beginning FY2024.** **Monthly critical incident reports were reviewed. Performance Bonus Incentive Pool (PBIP) activities were also discussed. On July 26, 2022, the PIHP submitted a narrative to MDHHS which reported all four CMHs in the region are sending Admission Discharge Transfer (ADT) records. The PIHP also continued preparing for**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			the next narrative report focused on patient-centered medical home efforts. **<u>Evaluation:</u> The PIHP explored and promoted quality and data practices within the region. The PIHP will continue quality improvements efforts of BH TEDS and Encounter data.** **<u>Barrier Analysis:</u> Missing communication from data barriers/challenges the CMH may be experiencing.** **<u>Next Steps:</u> Goal will continue in FY2023 with oversight of Service Code changes, BH TEDS, and Encounter Reporting. The PIHP will also continue oversight of critical incident data and performance bonus incentive pool activities. For FY2023, the PIHP will add oversight of risk event data and reporting.**
Financial Management	The goals for FY2022 Reporting are as follows to promote sound fiscal management of the region: • Evaluate CMH Direct Run service rates to MDHHS expectations. o Evaluate Independent Rate Model (IRM) report and compare rates to CMH posted rates. o Evaluate root cause of significant variations by comparing IRM assumptions to CMH actual performance.	Richard Carpenter Finance Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **No updates** **<u>Q 2 (Jan-Mar):</u>** **The February Finance Committee meeting was focused on year end reports. CMHs are evaluating Independent Rate Model.** **<u>Q 3 (Apr-June):</u>** **CMHs have prepared a comparison of actual CMH data to appendix 4 & 6 of the Independent Rate Model (IRM). We will be reviewing the results in August and discussing options to move toward the IRM assumptions and/or provide feedback to MDHHS where assumptions may be unrealistic.** **<u>Q 4 (July-Sept):</u>** **The Community Mental Health (CMH) Providers have decided to evaluate internal rates as compared to the new Independent Rate Model (IRM) report issued in late August. We will compare the rates as report in the**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Encounter Quality Initiative (EQI) report due October 21st. **<u>Evaluation:</u> We continue to gather information to inform the analysis.** **<u>Barrier Analysis:</u> Timeliness of guidance and information about the IRM from MDHHS continues to hamper the progress for this goal.** **<u>Next Steps:</u> We will carry this goal forward into FY2023.**
Financial Management	The goals for FY2022 Reporting are as follows to promote sound fiscal management of the region: • Evaluate the effectiveness of Standardized Cost Allocation (SCA) implementation. o Review FY2022 Period 1 EQI (first report required with SCA) to verify compliance with SCA requirements. o Identify areas of inconsistency within the region that may need modification. o Identify concerns/feedback to MDHHS for areas the model could be improved.	Richard Carpenter Finance Committee	**<u>Quarterly Updates:</u>** **Q 1 (Oct-Dec):** **No updates** **<u>Q 2 (Jan-Mar):</u>** **The February Finance Committee meeting was focused on year end reports. Period 1 EQI is not due until May 31, 2022.** **<u>Q 3 (Apr-June):</u>** **No update for Standardized Cost Allocation (SCA) Implementation.** **<u>Q 4 (July-Sept):</u>** **Encounter Quality Initiative (EQI) report deadline was moved by MDHHS to October. We will use this report to evaluate and compare cost allocation practices going forward.** **<u>Evaluation:</u> We continue to gather information to inform the analysis.** **<u>Barrier Analysis:</u> Timeliness of guidance and information from MDHHS about the Standard Cost Allocation (SCA) continues to hamper the progress for this goal.** **<u>Next Steps:</u> We will carry this goal forward into FY2023.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
Utilization Management	The goals for FY2022 Reporting are as follows: • Provide oversight on CMHSP affiliate crisis services utilization. ○ Monitor and advise on PCE-based crisis service utilization reports (monthly).	Tom Seilheimer Utilization Management Committee (UM)	**Quarterly Updates:** **Q 1 (Oct-Dec):** **Monthly reports received with no systems issues identified.** **Q 2 (Jan-Mar):** **Crisis service utilization reports have been reviewed, with no service systems issues identified.** **Q 3 (Apr-June):** **Monthly monitoring reports and quarterly trending indicated no significant service systems issues.** **Q 4 (July-Sept):** **Monthly crisis services utilization reports were reviewed. Community Mental Health (CMH) representatives overviewed their findings and recommendations in connection with over and underutilization issues and/or trends. With the exception of CMHs tracking and addressing service underutilization with youth crisis stabilization services, no other issues were noted.** **Evaluation: This goal is met, as the committee has monitored and analyzed all required monthly reporting.** **Barrier Analysis: No barriers have been identified, but CMHSPs continue to work on their local community outreach and engagement activities.** **Next Steps: Given the ongoing responsibility of the Utilization Management (UM) Committee to provide oversight in this area of UM operations, this goal with be continued.**
Utilization Management	The goals for FY2022 Reporting are as follows: • Provide oversight on CMHSP affiliate Behavior Treatment Plan Review Committee (BTPRC) management activities over the use of restricted and intrusive behavioral techniques, emergency use of physical management, and 911 contact with law enforcement.	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Updates:** **Q 1 (Oct-Dec):** **Quarterly reports received with no systems issues identified.** **Q2 (Jan-Mar):**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Monitor and advise on BTPRC data spreadsheet reports: Evaluate reports per committee discussion of findings, trends, potential system improvement opportunities, and adherence to standards (quarterly).		**BTPRC reports have been reviewed, with no service systems issues identified.** **<u>Q 3 (Apr-June):</u>** **Quarterly monitoring reports indicated no service systems issues.** **<u>Q 4 (July-Sept):</u>** **Quarterly Behavior Treatment Plan Review Committee (BTPRC) and physical management (PM) utilization reports were reviewed. Community Mental Health (CMH) representatives overviewed their findings and recommendations in connection with clinical progress and potential risk issues. No service delivery issues were identified.** **<u>Evaluation:</u> This goal is met, as the committee has monitored and analyzed all required quarterly reporting.** **<u>Barrier Analysis:</u> No barriers have been identified.** **<u>Next Steps:</u> Given the ongoing responsibility of the Utilization Management (UM) Committee to provide oversight in this area of UM operations, this goal with be continued. As another next step, the UMC will provide monitoring and discussion of the Michigan Department of Health & Human Services (MDHHS) BTPRC fidelity monitoring system, once that system is put into place by the MDHHS.**
Utilization Management	The goals for FY2022 Reporting are as follows: • Ensure regional Utilization Review (UR). ○ PIHP UM Department to conduct UR: ▪ UR on SUD network provider programs (annually) ▪ UR on CMHSP OASIS-user affiliates (quarterly) ○ UMC to monitor and advise on delegated CMHSP (GHS) UR activity reports (quarterly).	Tom Seilheimer Utilization Management (UM) Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **Quarterly reports received with no systems issues identified.** **Q2 (Jan-Mar):** **BTPRC reports have been reviewed, with no service systems issues identified.** **<u>Q 3 (Apr-June):</u>** **Quarterly CMH utilization review (UR) was completed and reported at the June meeting, with outlier issues**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			identified and addressed. SUD UR case-finding and UR protocol updates have been completed and UR activities began in June. **<u>Q 4 (July-Sept):</u>** **Substance use disorder (SUD) utilization review (UR) is proceeding as scheduled and Community Mental Health (CMH) UR is proceeding as scheduled, with CMH reporting completed in September and SUD UR reporting in October.** **<u>Evaluation:</u> This goal is met, as the committee has completed its annual SUD UR activities, and reporting and its quarterly CMH UR activities and reporting, including Genesee Health System (GHS) UR.** **<u>Barrier Analysis:</u> No barriers have been identified.** **<u>Next Steps:</u> Given the ongoing responsibility of the Utilization Management (UM) Committee to provide oversight in this area of UM operations, this goal with be continued. As another next step, UMC will expand SUD UR to include concurrent UR per a stratified sampling methodology.**
Utilization Management	The goals for FY2022 Reporting are as follows: • Promote aligned care management activities across key areas of network operations. o Implement Centralized UM System (UM Redesign Project) o Complete implementation of the MDHHS Phase I Parity Compliance Plan (Milliman Care Guidelines Indicia System and Indicia Inter-Rater Reliability)	Tom Seilheimer Utilization Management (UM) Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **Quarterly CMH Utilization Review (UR) activities were completed. SUD UR is scheduled to begin by the end of the second quarter.** **<u>Q 2 (Jan-Mar):</u>** **Second quarter CMH Utilization Review (UR) has been completed. SUD UR case finding has begun, with UR to begin third quarter.** **<u>Q 3 (Apr-June):</u>** **OASIS redesign and service grid updates are proceeding. The semi-annual Indicia Inter-Rater Reliability (IRR) report was reviewed at Utilization Management Committee (UMC), indicating increased percentages and achieving above target.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Q 4 (July-Sept):</u> **OASIS and MIX redesign features have moved to test mode. The state Parity Work Group agreed to coordinate their Milliman Care Guidelines upgrades to the 26th Edition with the beginning of FY2023.** **<u>Evaluation:</u> This goal is met. The committee has completed its ongoing monitoring and evaluation of the UM Redesign activities and Parity Implementation Plan activities, as according to the UM Program FY2022 Annual Plan.** **<u>Barrier Analysis:</u> No barriers have been identified.** **<u>Next Steps:</u> Given the ongoing responsibility of the Utilization Management (UM) Committee to provide oversight in this area of UM operations, this goal with be continued. It is anticipated that Region 10 will launch its centralized automated UM system during early FY2023, for which UMC will provide oversight.**
Utilization Management	The goals for FY2022 Reporting are as follows: • Promote aligned care management operations across the regional Access Management System (AMS). o Monitor and advise on AMS reports (Mid-Year, End-of-Year)	Tom Seilheimer Utilization Management (UM) Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **The Access Management System (AMS) EOY Report was reviewed and approved for Quality Improvement Committee (QIC) review.** **<u>Q 2 (Jan-Mar):</u>** **The AME Semi-Annual Report is due in June.** **<u>Q 3 (Apr-June):</u>** **The Access Management System (AMS) Semi-Annual Report was reviewed and approved for Quality Improvement Committee (QIC) review – this report will be shared at the July QIC meeting.** **<u>Q 4 (July-Sept):</u>** **The Access Management System (AMS) End of Year Report is due in October. The AMS Mid-Year Report was reviewed and approved in June.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Evaluation:</u> This goal is met, given the committee review and approval process of these semi-annual reports. **<u>Barrier Analysis:</u> No barriers have been encountered.** **<u>Next Steps:</u> Given the ongoing responsibility of the Utilization Management (UM) Committee to provide oversight in this area of UM operations, this goal with be continued. For FY2023, AMS will be centralized to one site, and the UM Committee will provide oversight to this operation.**
Utilization Management	The goals for FY2022 Reporting are as follows: • Provide oversight on CMHSP affiliate community access / care management activities. o Monitor and advise on Customer Involvement, Wellness / Healthy Communities reports (quarterly)	Tom Seilheimer Utilization Management (UM) Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **Quarterly reports were reviewed with no systems issues identified.** **<u>Q 2 (Jan-Mar):</u>** **Reports have been reviewed, with extensive and appropriate activities taking place and with no service systems issues identified.** **<u>Q 3 (Apr-June):</u>** **Quarterly monitoring reveals a wide range of community activities regarding outreach, support, information, and collaborations with Public Health.** **<u>Q 4 (July-Sept):</u>** **Quarterly reports were reviewed, with Community Mental Health (CMH) Providers providing a wide range of community engagement activities and services.** **<u>Evaluation:</u> This goal is met, as the committee has monitored and analyzed all required quarterly reporting.** **<u>Barrier Analysis:</u> No barriers have been identified, but CMHSPs continue to work on their local community outreach and engagement activities.** **<u>Next Steps:</u> Given the ongoing responsibility of the Utilization Management (UM) Committee to provide**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			oversight in this area of UM operations, this goal with be continued.
Utilization Management	The goals for FY2022 Reporting are as follows: • Provide oversight on regional Adverse Benefit Determination (ABD) operations. o Monitor and advise on ABD reports: Access Management System, CMHSP affiliates, SUD network provider programs (quarterly).	Tom Seilheimer Utilization Management (UM) Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **Quarterly reports were reviewed, and activities are proceeding according to the Health Services Advisory Group (HSAG) Corrective Action Plan (CAP). Utilization Management Committee (UMC) oversight continues to encourage CMHs to discuss their findings and any issues.** **<u>Q 2 (Jan-Mar):</u>** **Quarterly ABD reports were reviewed, and no service systems issues were identified. A new quarterly reporting schedule was put into place.** **<u>Q 3 (Apr-June):</u>** **Affiliate quarterly tracking and trending activities identified no issues except for one CMH that had a delay in processing during one of the three months that has since been resolved.** **<u>Q 4 (July-Sept):</u>** **Quarterly adverse benefit determination (ABD) reports were reviewed. Community Mental Health (CMH) representatives overviewed their findings, recommendations, and local improvement activities. All reports indicate progress with reporting accuracy and timeliness.** **<u>Evaluation:</u> This goal is met, as the committee has monitored and analyzed all required monthly reporting.** **<u>Barrier Analysis:</u> No barriers have been identified, but CMHs continue to work on their local community outreach and engagement activities. All reports indicate progress with reporting accuracy and timeliness.** **<u>Next Steps:</u> Given the ongoing responsibility of the Utilization Management (UM) Committee to provide oversight in this area of UM operations, this goal with be**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			continued. For FY2023, ABD monitoring will also include ABD operations linked to the UM Redesign project.
Corporate Compliance	The goals for FY2022 Reporting are as follows: • Compliance with 42 CFR 438.608 Program Integrity requirements. o Review requirements o Identify and document responsible entities o Identify and document supporting evidence / practice o Policy review o Review PIHP Corporate Compliance Plan updates	Katie Forbes Corporate Compliance Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **The FY2022 Corporate Compliance Plan was updated on the PIHP website. The PIHP celebrated Annual Compliance and Ethics Week (November 7-13). PIHP staff participated in daily activities to promote awareness and education in the area of Compliance. Additionally, the Corporate Compliance Committee reviewed the Code of Federal Regulations (CFR) Program Integrity Requirements during the December committee meeting.** **<u>Q 2 (Jan-Mar):</u>** **The Corporate Compliance Committee discussed in the February Committee meeting Program Integrity requirements including ongoing discussion of policy language.** **<u>Q 3 (Apr-June):</u>** **The FY2023 PIHP Corporate Compliance Plan was approved by the Corporate Compliance Committee.** **<u>Q 4 (July-Sept):</u>** **The FY2023 PIHP Corporate Compliance Plan was approved by the PIHP Board. The Plan was emailed to PIHP and Network staff and is available on the PIHP website.** **<u>Evaluation:</u> The Corporate Compliance Committee has achieved the goal of maintaining compliance with Program Integrity requirements as evidenced by all policies and procedures being followed by Network and PIHP staff throughout the fiscal year. This includes four (4) submissions of the Program Integrity Report to the Office of Inspector General (OIG) displaying activities related to compliance with program integrity. Additionally, the FY2023 Corporate Compliance Program Plan was approved by the PIHP Board and is available on the PIHP website. Achievement of this goal has resulted in**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			ensuring that the quality of services rendered and billed within our Regional Network aligns with Program Integrity Requirements. This directly impacts the quality of services and delivery of services being provided to the consumers we service. **<u>Barrier Analysis:</u> None** **<u>Next Steps:</u> This goal will be continued in the next fiscal year to continue the monitoring of our region to ensure ongoing compliance with Program Integrity requirements.**
Corporate Compliance	The goals for FY2022 Reporting are as follows: • Support reporting requirements (quarterly and ongoing) as defined by MDHHS, OIG, PIHP, etc. o Review of reporting process	Katie Forbes Corporate Compliance Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **The FY2021 Q4 Program Integrity Report and Annual Contracted Entities Report were submitted to the Office of Inspector General (OIG). The PIHP has received a new MDHHS Program Integrity Report Template and Guidance Document. Verbal updates were provided to the Compliance Committee in the December meeting. Additionally, committee members identified areas related to fraud referrals where additional training would be beneficial. The Compliance Committee also reviewed the FY2021 Annual Complaint Summary to discuss findings and identify any trends throughout the fiscal year.** **<u>Q 2 (Jan-Mar):</u>** **The PIHP submitted the FY2022 Q1 Program Integrity Report to the Office of Inspector General (OIG).** **Additionally, the PIHP received the final version of the Program Integrity Report Template from the OIG. The revised Template and OIG Guidance Document were provided to the Corporate Compliance Committee for review. The Committee was notified that there will be continued discussion in the next Committee meeting and a training will be scheduled in the coming months on the Template.** **<u>Q 3 (Apr-June):</u>**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The FY2022 second quarter Quarterly Program Integrity Report was submitted to the Office of Inspector General (OIG). **The CMH & SUD Provider Network have received the new Program Integrity Report Template and new Fraud Referral Forms including implementation dates. Guidance documents from the OIG were also provided to Network staff. The PIHP Compliance also developed and provided the CMH and SUD Network a PowerPoint Training to provide additional guidance to the implementation of the new template. Additionally, individual meetings with each Provider to provide support in the area of Program Integrity Reporting will be scheduled in fourth quarter.** **PIHP Compliance staff also provided additional guidance and training on the required documentation for a fraud referral submission to the PIHP.** **<u>Q 4 (July-Sept):</u>** **The PIHP submitted the FY2022 Q3 Program Integrity Report to the Office of Inspector General (OIG).** **Region 10 PIHP compliance staff met individually with PIHP and Network staff to train on the new OIG Program Integrity Report Template which has an implementation date of FY2022 Q4. Additionally, the Corporate Compliance Committee reviewed and discussed the New OIG Program Integrity Report and the new OIG Fraud Referral Form during the August committee meeting.** **<u>Evaluation:</u> The goal of supporting reporting requirements by the Michigan Department of Health & Human Services (MDHHS), OIG, and PIHP has been met. The PIHP has educated and trained the PIHP and Network staff on new reporting requirements including the new OIG Program Integrity Report Template and OIG Fraud Referral Form. The PIHP submitting the FY2022 Q4 Program Integrity Report to the OIG with the new template which is sooner than the required implementation date. By achieving all reporting requirements, our PIHP and Providers are completing**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			ongoing monitoring internally and reporting to ensure that all Corporate Compliance reporting details are documented and reported to MDHHS. This also holds the PIHP and Provider Network accountable to ensure any areas of concern related to the quality of services provided and delivery of services are addressed and promptly reported to appropriate staff (e.g., fraud referrals). **<u>Barrier Analysis:</u> None** **<u>Next Steps:</u> The PIHP will continue to monitor this goal in the next fiscal year to ensure that we continue to achieve the expectations of monitoring and reporting as defined by the OIG and MDHHS.**
Corporate Compliance	The goals for FY2022 Reporting are as follows: • Review regional Corporate Compliance monitoring standards, reports, and outcomes. o Review regional PIHP contract monitoring results o Review current CMH Subcontractor contract monitoring process / content	Katie Forbes Corporate Compliance Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **The Compliance Subject Matter Expert (SME) completed record reviews for the MDHHS (5515) Consent to Share Behavioral Health Information Form. The PIHP Compliance Committee also reviewed the FY2021 Annual Corporate Compliance Contract Monitoring Summary Report.** **<u>Q 2 (Jan-Mar):</u>** **The Corporate Compliance Committee received notification of results of the FY2021 record reviews on the MDHHS Consent to Share Behavioral Health Information Form (5515) as part of Annual Contract Monitoring. All Plan of Corrections have been addressed and accepted by the PIHP. Additionally, the Committee discussed the FY2022 Monitoring Cycle and Timeline.** **<u>Q 3 (Apr-June):</u>** **The PIHP Compliance Subject Matter Expert provided support to Provider Network Staff to finalize the FY2022 Annual Contract Monitoring Tools.** **The Corporate Compliance Committee reviewed the FY2022 Annual Contract Monitoring schedule and discussed. The PIHP Compliance Subject Matter Experts**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			completed the Advanced Desk Audits and began reviewing Desk Audits for FY2022 Annual Contract Monitoring. Additionally, internal discussions with PIHP staff were conducted to initiate preliminary efforts towards the record reviews of the MDHHS (5515) Consent to Share Behavioral Health Information Form as part of the FY2022 Annual Contract Monitoring Cycle. **Q 4 (July-Sept):** **The PIHP Compliance Subject Matter Expert (SME) completed the FY2022 Annual Contract Monitoring through Plan of Corrections. Additionally, the MDHHS (5515) Consent to Share Behavioral Health Information Form record reviews have been initiated.** **Evaluation: The Corporate Compliance Committee was able to collaborate and review to ensure the successful completion of the FY2022 Annual Contract Monitoring Cycle. The review and completion of annual contract monitoring directly impacts the quality of services provided as any concerns related to services are reviewed and addressed. Contact Monitoring holds the PIHP Network accountable to ensure that policies and procedures are demonstrating all federal and contractual requirements to ensure optimal service for the individual served. In addition, record reviews include a specialized in-depth audit of records to ensure that individual records have appropriate documentation to support that the related policy and procedure is being appropriately followed for that area of the record review.** **The committee was unable to review the Community Mental Health (CMH) subcontract provider contract monitoring process. This goal is not achieved and will be continued in the next fiscal year for full achievement.** **Barrier Analysis: There have been several requirements initiated by the Office of Inspector General (OIG) including a new Program Integrity Report Template and Fraud Referral Form which have taken a significant increase in staff efforts across the Network. This has resulted in a limitation for time to address parts of this**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			goal. Due to this, the Corporate Compliance Committee was not able to get to the point of discussing and reviewing how the CMH Providers complete Contract Monitoring for their subnetwork providers. **<u>Next Steps:</u> The PIHP will continue this goal in the next fiscal year to ensure that the review and monitoring of the CMH contact monitoring of their subnetwork providers is achieved. In addition, the committee will also review and discuss the PIHP monitoring cycle for FY2023.**
Corporate Compliance	The goals for FY2022 Reporting are as follows: • Improve reciprocity and efficiency within the PIHP Provider Network. o Review MDHHS Network Management Reciprocity & Efficiency Policy o Create Regional Corporate Compliance Complaint Form (for complainant use) o Create Regional Corporate Compliance Complaint Summary Form (for Compliance Office use) o Create Regional HIPAA Breach Notification Letter Templates o Review PIHP and Provider Corporate Compliance webpage content	Katie Forbes Corporate Compliance Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **The Corporate Compliance Committee designated two members to draft a regional complaint form and regional complaint summary form. The Committee also discussed the regional MDHHS (5515) Consent to Share Behavioral Health Information form.** **<u>Q 2 (Jan-Mar):</u>** **The Corporate Compliance Committee collected a Complaint Summary Form from each Committee member in order to develop a drafted regional form. The Committee has drafted the regional Complaint Summary Form which will be reviewed for approval at the next committee meeting in May.** **Additionally, Committee members received the regional Compliance Training and Quiz to include in future trainings with staff.** **<u>Q 3 (Apr-June):</u>** **The PIHP provided the Network with a Regional Compliance Training for all staff as part of compliance training requirements.** **The Corporate Compliance Committee approved a regional Corporate Compliance Complaint Summary Form.** **<u>Q 4 (July-Sept):</u>**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The Corporate Compliance Committee discussed the development of a regional Corporate Compliance Complaint Form. Due to staff capacity, completion of this form was not completed. However, staff did email their versions of the form for committee review and potential enhancement to current forms. **<u>Evaluation:</u> The Corporate Compliance Committee successfully developed a regional Corporate Compliance Complaint Summary Form which has been implemented. Additionally, a regional training was implemented for staff trainings. By implementing regional trainings and forms, it develops a more consistent and comprehensive process for an individual to file a corporate compliance complaint and for the compliance department to initiate and complete and investigation. Furthermore, by ensuring consistent training in the area of corporate compliance, there is a consistent message and education provided for optimal consumer experience and protection (e.g., securing Protected Health Information) in the area of corporate compliance.** **Due to staff capacity, the committee was unable to review website content, develop a regional form for complainant use, or review HIPAA Breach Templates.** **<u>Barrier Analysis:</u> There have been several requirements initiated by the Office of Inspector General (OIG) including a new Program Integrity Report Template and Fraud Referral Form which have taken a significant increase in staff efforts across the Network. This has resulted in a limitation in time to address other areas including finishing part of this goal.** **<u>Next Steps:</u> Due to the increased and changing requirements of the OIG, the PIHP has removed this goal from FY2023 goals to focus on new reporting requirements. However, the Corporate Compliance Committee will continue to discuss ongoing policies and procedures for ensuring that there is a consistent method**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			and delivery for the Corporate Compliance Program Plan.
Provider Network	The goals for FY2022 Reporting are as follows: • Address service capacity concerns and ensure resolution of identified gaps in the network based on Gap Analysis Reports. o Review CMH Gap Analysis Reports. o Review SUD Network gaps and capacity concerns. o Review CMH capacity concerns identified (e.g., Autism, Mobile Intensive Crisis Stabilization).	Stephanie Heywood Provider Network Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **The PIHP continues to work towards empaneling a qualified and interested substance use disorder (SUD) provider to offer outpatient services specifically in Sanilac County. One (1) provider has expressed interest and is pursuing appropriate accreditation through CARF, as well as seeking ASAM Designations before formally applying to the PIHP.** **The PIHP has identified a gap in certain Prevention services specifically in the St. Clair County area. Outreach to current Prevention Providers in St. Clair County has occurred to determine the level of interest in providing these specific services. To date, three (3) Prevention Providers have indicated willingness to add services to their current offerings. An internal meeting with PIHP will be held the week of January 3 to determine next steps.** **PIHP PNM staff continue to work on identifying potential service gaps in the Network, especially as it relates to SUD. Regular meetings are taking place to discuss potential concerns and resolutions.** **The PIHP continues to work with the CMH Providers to close service gaps in the area of Autism services.** **<u>Q 2 (Jan-Mar):</u>** **Provider Network Management continued work with Sanilac CMH regarding the SUD Outpatient contract. The original anticipated effective date was April 1, 2022; however, work continues to ensure the PIHP has all necessary materials in place with a new anticipated effective date of May 1, 2022.** **<u>Q 3 (Apr-June):</u>** **Provider Network Management has received materials from Sanilac CMH for the SUD Outpatient contract.** **Provider Network Management has secured the ASAM Continuum materials, and the Sandusky location is open.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Provider Network Management has identified the CMHs that have a current Gap Analysis Report on file with Region 10 PIHP. Provider Network Management will continue to work with the CMHs which require an updated Gap Analysis report. **<u>Q 4 (July-Sept):</u>** **The PIHP has continued to receive Gap Analysis and Network Adequacy Reports from its Community Mental Health (CMH) Network.** **<u>Evaluation:</u> This goal has been met. The PIHP has identified and addressed service gaps within the Network resulting in improvements to access to services for members. Ongoing, the Provider Network Management team monitors CMH and Substance Use Disorder (SUD) Network service gaps.** **<u>Barrier Analysis:</u> Several PIHP Network Providers have noted concerns regarding staffing capacity due to the ongoing COVID 19 pandemic.** **<u>Next Steps:</u> Continue into FY2023. The Provider Network Management Team will review current PIHP Customer Service Team initiatives to address urgent Network service needs to incorporate efforts in future goal reporting.**
Provider Network	The goals for FY2022 Reporting are as follows: • Review Network Adequacy requirements and address compliance with standards. o Review MDHHS standards and current Network Adequacy. o Address Network Adequacy concerns.	Stephanie Heywood Provider Network Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **The PIHP is continuing work on the Network Adequacy Plan.** **<u>Q 2 (Jan-Mar):</u>** **PIHP staff were reassigned regarding the Network Adequacy Plan and work continued moving forward regarding this goal. Region 10 PIHPs Network Adequacy Plan was finalized and submitted to MDHHS on March 30, 2022.** **<u>Q 3 (Apr-June):</u>**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Provider Network Management staff continue to review current contract language pertaining to Network Adequacy Requirements. **<u>Q 4 (July-Sept):</u>** **PIHP Provider Network Management (PNM) staff continue to monitor Network Adequacy. The PIHP, through its Network Stabilization Program, has continued to provide both Staffing Stabilization and Staffing Recruitment funds to its substance use disorder (SUD) Network Providers. This information has been shared with the Region 10 PIHP Board on an ongoing basis.** **<u>Evaluation:</u> This goal has been met. Ongoing, the PIHP continues to monitor Michigan Department of Health & Human Services (MDHHS) standards and the current Network Adequacy. The PIHP successfully developed a Network Adequacy Plan and supported its substance use disorder (SUD) Network Providers with stabilization funding. This has resulted in improvements in the quality of health care and services for members.** **<u>Barrier Analysis:</u> MDHHS / PIHP contract has had multiple revisions in FY2022 including modifications to Network Adequacy Reporting requirements. Several PIHP Network Providers have noted concerns regarding staffing capacity due to the ongoing COVID 19 pandemic.** **<u>Next Steps:</u> Continue into FY2023. Continue review of MDHHS / PIHP contract to ensure PIHP Reporting requirements are met. Continue to review opportunities to provide stabilization funding to the PIHP network. The PIHP Provider Network Management team will continue to monitor both Community Mental Health (CMH) and SUD Networks Service Gaps.**
Provider Network	The goals for FY2022 Reporting are as follows: • Ensure Provider Directories are updated monthly and provide MDHHS-required information for individuals served. o Review MDHHS requirements o Address opportunities for reporting efficiency and effectiveness	Katie Forbes Provider Network Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **The PIHP Provider Directory Workgroup has been re-engaged. Each CMH Provider identified a participant for the Workgroup. PIHP staff met individually with each**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	o Identified staff participate in PIHP Provider Directory Workgroup		**participant to review Directories and identify areas requiring modifications. Due dates were given to each participant to submit their modified directories.** **<u>Q 2 (Jan-Mar):</u>** **PIHP Customer Service staff worked with each CMH Provider individually through the Provider Directory Workgroup to ensure that each Provider Directory is in compliance with current federal and contractual requirements. At this time, all four (4) CMH Providers are in compliance with their Provider Directory. PIHP Customer Service staff initiated a drafted plan for Network review to ensure ongoing compliance with the Provider Directories.** **<u>Q 3 (Apr-June):</u>** **PIHP Customer Service staff completed quarterly reviews of the CMH Provider Directories to ensure ongoing compliance with federal and contractual requirements. All four (4) CMH Providers were in compliance with the current contractual requirements.** **Through FY2022 External Quality Reviews, PIHP staff have identified additional requirements in the standard of Health Information Systems that relate to Provider Directories. Working sessions have been initiated to ensure that all requirements are addressed and met. Efforts will continue in fourth quarter.** **<u>Q 4 (July-Sept):</u>** **The PIHP Customer Service Department completed Q4 reviews of the Community Mental Health (CMH) Provider Directories to ensure all contractual and federal requirements are met. Any provider not complying with requirements was notified of immediate changes are required. Staff have also continued ongoing efforts to review and implement additional requirements following a recent external quality review.** **<u>Evaluation:</u> The PIHP Customer Service Department has developed a quarterly review of CMH Provider Directories to ensure ongoing compliance with**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			requirements. Additionally, staff have begun to review additional requirements identified following an external quality review. These efforts will continue in the next fiscal year. This goal is partially met. **<u>Barrier Analysis:</u> None** **<u>Next Steps:</u> Ongoing efforts to review new requirements and enhance the provider directory process for the PIHP and Network will continue in the next fiscal year.**
Provider Network	The goals for FY2022 Reporting are as follows: • Review most recent FY PIHP Contract Monitoring Results. o Review FY Contract Monitoring Aggregate Report o Discuss trends and improvement opportunities	Stephanie Heywood Provider Network Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **PIHP Provider Network Management staff are drafting the FY2022 Contract Monitoring Schedule, and also planning trainings for PIHP Subject Matter Experts (SMEs) in each department to focus on challenges and questions specific to subject matter, rather than just process.** **<u>Q 2 (Jan-Mar):</u>** **Provider Network Management staff have worked to prepare the Annual Contract Monitoring schedule / Team Calendar and finalize Subject Matter Expert Lists for FY2022. Areas of potential deemed status have not yet been confirmed. Content, formatting, and reference check reviews regarding the FY2022 Contract Monitoring Tools is closing. Provider Network Management staff are working to finalize any outstanding areas and are currently in the process of documenting changes that have been made to the tools for this fiscal year's upcoming review. Provider Network Management staff are currently preparing for the next cycle in the Contract Monitoring process, the upcoming Provider Performance Reviews.** **<u>Q 3 (Apr-June):</u>** **In April, Provider Network Management staff continued to prepare for FY2022 Contract Monitoring Virtual Audits, ensuring the contract monitoring tools were formatted and contained the necessary content.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Additionally, the team worked towards maintaining the Annual Contract Monitoring schedule/ Team calendar. **In May, Provider Network Management staff continued to work to ensure the Annual Contract Monitoring schedule/ Team calendar remained updated. Updates to the document included recording all dates and times of the upcoming virtual audit.** **In June, Subject Matter experts finalized the Contract Monitoring tools. CMH and SUD audits are anticipated to take place in July or early August.** **<u>Q 4 (July-Sept):</u>** **Provider Network Management staff worked with Subject Matter Experts to finalize the FY2022 Contract Monitoring tools. Virtual audits occurred for all Community Mental Health (CMH) Providers and SUD Providers, and the FY2022 Contract Monitoring evaluations were finalized and sent out to the Network Providers. The FY2022 Contract Monitoring Aggregate Report was presented to the Region 10 PIHP Board in September and approved. The Aggregate Report has also been posted to the PIHP website.** **<u>Evaluation:</u> This goal has been met. The FY2022 Contract Monitoring Aggregate Report has been finalized and opportunities for improvement have been identified. PIHP Network Providers were issued Plans of Correction for any areas found to not meet compliance. These PIHP oversight activities and issuance of Provider Action Plans have resulted in improvements to the quality of healthcare and services to members.** **<u>Barrier Analysis:</u> None.** **<u>Next Steps:</u> Continue into FY2023. PIHP Provider Network Management Department will meet regularly to review improvement opportunities for PIHP contract monitoring and evaluation oversight.**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr>
<td>Customer Service Inquiries</td>
<td>
The goals for FY2022 Reporting are as follows:

• To review and analyze baseline customer service inquiry data for the region for FY2022.
o To track and trend internally the customer service inquiries on a quarterly basis.
o Identify consistent patterns related to member customer service inquiries.
o Develop interventions to address critical issues within the organization.

<table>
<tr><th colspan="8">Reporting Period: FY2022</th></tr>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>July</th><th>Aug</th><th>Sept</th><th>Total</th></tr>
<tr><td>GHS</td><td>26</td><td>24</td><td>21</td><td>6</td><td>3</td><td>6</td><td>86</td></tr>
<tr><td>Lapeer</td><td>0</td><td>1</td><td>2</td><td>0</td><td>1</td><td>0</td><td>4</td></tr>
<tr><td>PIHP</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>Sanilac</td><td>0</td><td>1</td><td>1</td><td>0</td><td>0</td><td>0</td><td>2</td></tr>
<tr><td>St. Clair</td><td>1</td><td>1</td><td>2</td><td>1</td><td>0</td><td>0</td><td>5</td></tr>
<tr><td>SUD</td><td>5</td><td>8</td><td>5</td><td>1</td><td>0</td><td>2</td><td>21</td></tr>
<tr><td>TOTAL</td><td>32</td><td>36</td><td>31</td><td>8</td><td>4</td><td>8</td><td>119</td></tr>
<tr><th colspan="7">Inquiry Dispositions:</th><th>Total</th></tr>
<tr><td colspan="7">Appeal</td><td>24</td></tr>
<tr><td colspan="7">Grievance</td><td>4</td></tr>
<tr><td colspan="7">Referral to Access</td><td>25</td></tr>
<tr><td colspan="7">Rights Complaint</td><td>1</td></tr>
<tr><td colspan="7">Referral to Provider</td><td>39</td></tr>
<tr><td colspan="7">Other</td><td>26</td></tr>
<tr><td colspan="7">Pending</td><td>0</td></tr>
</table>
</td>
<td>Katie Forbes

Quality Improvement Committee</td>
<td>
<u>Quarterly Updates:</u>

<u>Q 1 (Oct-Dec):</u>
<u>Data</u>
There was a total of thirty-two (32) customer service inquiries which is a significant decrease from FY2021 Q1 which had fifty-one (51) inquiries.

In FY2022 Q1, three (3) of the inquiries resulted in an Appeal, one (1) resulted in a formal grievance, six (6) resulted in a referral to Access, fifteen (15) resulted in a referral to a Provider, four (4) fell in another category, and three (3) are currently pending.

<u>Trends</u>
Referrals to Access are down from FY2021 Q1 (25.5%) to FY2022 Q1 (18.75%) and referrals to a Provider are up from FY2021 Q1 (33.3%) to FY2022 Q1 (46.9%). One observation during the quarter is that collaboration from the Providers including intake staff at each CMH have resulted in a quicker connection back to services for the Consumer without requiring a referral to Access for screening.

<u>Q 2 (Jan-Mar):</u>
There was a total of thirty-five (35) customer service inquiries in Q2 which was a decrease from FY2021 Q2 which had forty-four (44).

<u>TRENDS</u>
CMH Network: 74%
SUD Network: 23%
PIHP Access: 3%
<u>DISPOSITION TRENDS</u>
• 23% of inquiries resulted in an appeal
• 29% of inquiries resulted in a referral to Access and/or Provider.
• 3% of inquiries resulted in a Grievance.
• 29% of inquiries were in an other category. Examples of other include supports following a State Fair
</td>
</tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Hearing, Consumer being unable to reach, or a referral to a community resource. • **16% are currently pending.** **<u>Q 3 (Apr-June):</u>** **There was a total of thirty (30) inquiries in third quarter which is a decrease from FY2021 third quarter which had forty-night (49).** **Top three (3) Inquiry Dispositions:** • **10 of the 30 (33.3%) resulted in a referral to Access** • **9 of the 30 (30%) resulted in a referral to a Provider.** • **4 of the 30 (13.3%) resulted in the opening of an Appeal.** **<u>Q 4 (July-Sept):</u>** **There was a total of twenty (20) customer service inquiries in Q4 which is a decrease from FY2021 Q4 which had thirty-five (35).** **Top Inquiry Dispositions:** • **7 of the 20 (35%) resulted in an appeal.** • **6 of the 20 (30%) resulted in Other (Examples of Other include unable to reach, community resources, or general education provided).** • **3 of the 20 (15%) resulted in a referral to a Provider.** • **3 of the 20 (15%) resulted in a referral to PIHP Access.** **<u>Evaluation:</u> PIHP Customer Service staff have successfully tracked internal customer service inquiry data and reviewed for trends. The PIHP has not identified any critical concerns that needed immediate interventions. This goal is met. The quality of health care and services has been improved by the inquiry process being monitored and tracked to ensure that all consumers have inquiry access, and their needs are being addressed.**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr><td></td><td></td><td></td><td><u>Barrier Analysis:</u> None

<u>Next Steps:</u> Customer Service staff will continue this goal in FY2023.</td></tr>
<tr><td>Appeals</td><td>The goals for FY2022 Reporting are as follows:

• To review and analyze baseline appeals data for the region for FY2022.
o To track and trend internally the appeals on a quarterly basis.
o Identify consistent patterns related to member appeals.
o Develop interventions to address critical issues within the organization.

<table>
<tr><th colspan="8">Reporting Period: FY2022</th></tr>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>July</th><th>Aug</th><th>Sept</th><th>Total</th></tr>
<tr><td>GHS</td><td>6</td><td>7</td><td>4</td><td>2</td><td>1</td><td>4</td><td>24</td></tr>
<tr><td>Lapeer</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>PIHP</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Sanilac</td><td>0</td><td>0</td><td>2</td><td>0</td><td>1</td><td>0</td><td>3</td></tr>
<tr><td>St. Clair</td><td>0</td><td>1</td><td>1</td><td>0</td><td>0</td><td>0</td><td>2</td></tr>
<tr><td>SUD</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>TOTAL</td><td>6</td><td>9</td><td>7</td><td>2</td><td>2</td><td>4</td><td>30</td></tr>
<tr><th colspan="7">Reason for Appeal:</th><th>Total</th></tr>
<tr><td colspan="7">Grievance not resolved within 90 days</td><td>0</td></tr>
<tr><td colspan="7">Grievance not resolved within allowed days</td><td>0</td></tr>
<tr><td colspan="7">Request not acted on within 14 days</td><td>0</td></tr>
<tr><td colspan="7">Service Denial</td><td>17</td></tr>
<tr><td colspan="7">Service not started within 14 days</td><td>0</td></tr>
<tr><td colspan="7">Service Reduction</td><td>3</td></tr>
<tr><td colspan="7">Service Suspension</td><td>0</td></tr>
<tr><td colspan="7">Service Termination</td><td>10</td></tr>
</table>
</td><td>Katie Forbes

Quality Improvement Committee</td><td><u>Quarterly Updates:</u>

Q 1 (Oct-Dec):
<u>Data</u>
There was a total of six (6) appeals which is a slight decrease from FY2021 Q1 which had seven (7) appeals. Five (5) of the appeals were due to a service denial and one (1) was related to a service reduction.

<u>Trends</u>
Service denial appeals have increased from FY2021 Q1 (71.5%) to FY2022 Q1 (83.3%).

<u>Q 2 (Jan-Mar):</u>
There was a total of nine (9) appeals in Q2 which was an increase from FY2021 Q2 which had four (4).

<u>TRENDS</u>
Of the nine (9) appeals, four (4) were for a service denial (44.5%), one (1) was for a service reduction (11%), and four (4) were for a service termination (44.5%).

CMH Network: 89%
SUD Network: 11%
PIHP Access: 0%

Approximately 89% of denials being appealed are either a service denial or service termination compared to 100% in FY2021 Q2.

<u>Q 3 (Apr-June):</u>
There were seven (7) appeals in third quarter which is an increase from FY2021 third quarter which had four (4). Of the 7 appeals:

<u>Reason for Appeal</u>
3 were for a service termination
4 were for a Service Denial</td></tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Appeal Outcome</u> **1 of the appeals was denied (PIHP Clinical Team agreed with the Adverse Benefit Determination (ABD) Notice).** **3 of the appeals were approved (PIHP Clinical Team overturned the ABD Notice and approved the requested service).** **3 of the appeals are still in the review process.** **<u>Q 4 (July-Sept):</u>** **There was a total of eight (8) appeals in Q4 which was an increase from FY2021 Q4 which had three (3).** **TRENDS:** **<u>Reason for Appeal</u>** **Of the eight (8) appeals, 4 (50%) were for a service denial, 1 (12.5%) was for a service reduction, and 3 (37.5%) were for a service termination.** **<u>Appeal Outcomes</u>** **4 of the 8 were approved (the PIHP Clinical Team overturned the Adverse Benefit Determination Notice and approved the requested service).** **3 of the 8 were denied (PIHP Clinical Team agreed with the Adverse Benefit Determination Notice).** **1 of the 8 was withdrawn at the consumer's request.** **<u>Evaluation:</u> PIHP Customer Service staff have successfully tracked appeal data and reviewed for trends. The PIHP has not identified any critical concerns that needed immediate interventions. This goal is met. The overall health care of consumers is improved due to the ongoing monitoring of the appeal system to ensure that the PIHP appeals process is aligning with requirements which allow the consumer a third-party review of a recent Adverse Benefit Determination (ABD) Notice.**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr><td></td><td></td><td></td><td><u>Barrier Analysis:</u> None

<u>Next Steps:</u> This goal will continue in FY2023.</td></tr>
<tr><td>Grievances</td><td>The goals for FY2022 Reporting are as follows:

• To review and analyze baseline grievance data for the region for FY2022.
o To track and trend internally the grievances on a quarterly basis.
o Identify consistent patterns related to grievances.
o Develop interventions to address critical issues within the organization.

<table>
<tr><th colspan="8">Reporting Period: FY2022</th></tr>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>July</th><th>Aug</th><th>Sept</th><th>Total</th></tr>
<tr><td>GHS</td><td>11</td><td>17</td><td>20</td><td>12</td><td>12</td><td>1</td><td>73</td></tr>
<tr><td>Lapeer</td><td>1</td><td>0</td><td>0</td><td>0</td><td>2</td><td>0</td><td>3</td></tr>
<tr><td>PIHP</td><td>0</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>Sanilac</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>St. Clair</td><td>0</td><td>0</td><td>2</td><td>0</td><td>1</td><td>0</td><td>3</td></tr>
<tr><td>SUD</td><td>1</td><td>1</td><td>1</td><td>0</td><td>0</td><td>0</td><td>3</td></tr>
<tr><td>TOTAL</td><td>13</td><td>18</td><td>23</td><td>13</td><td>15</td><td>1</td><td>83</td></tr>
<tr><th colspan="7">Reason for Grievance:</th><th>Total</th></tr>
<tr><td colspan="7">Interactions with Provider</td><td>3</td></tr>
<tr><td colspan="7">Quality of Care</td><td>48</td></tr>
<tr><td colspan="7">Access / Availability</td><td>21</td></tr>
<tr><td colspan="7">Service Environment</td><td>4</td></tr>
<tr><td colspan="7">Member Rights</td><td>1</td></tr>
<tr><td colspan="7">Other</td><td>6</td></tr>
</table>
</td><td>Katie Forbes

Quality Improvement Committee</td><td><u>Quarterly Updates:</u>

<u>Q 1 (Oct-Dec):</u>
There has been one (1) grievance reported which is a slight increase from FY2021 Q1 which had zero (0). The one (1) grievance is related to a quality-of-care concern.

The PIHP has not received CMH Grievance Data as Q1 data is not due until the 15th following the quarter. Updates will be provided as grievance data is collected from the CMH Providers.

<u>Q 2 (Jan-Mar):</u>
There was a total of fourteen (14) grievances in Q2. The PIHP will receive Q2 Grievance Data from the CMH Provider Network by April 15, 2022. This data will be reported in the May Quality Improvement Committee (QIC) Meeting.

<u>Q 3 (Apr-June):</u>
The PIHP received 1 grievance in third quarter thus far which was related to a Quality of Care complaint. The CMH Providers report grievances on the 15th following each quarter. Additionally updates on quarterly grievance data will be provided in August.

<u>Q 4 (July-Sept):</u>
There was a total of twenty-nine (29) grievances which is an increase from FY2021 Q4 which had eleven (11).

<u>Evaluation:</u> PIHP Customer Service staff have successfully tracked grievance data and reviewed for trends. The PIHP has identified critical issues in grievance records reviewed during the FY2022 Annual Grievance Record Reviews including incomplete documentation and poor follow up on grievances received. The PIHP will be issuing Plans of Corrections for any Provider that has issues identified. The monitoring of grievance data and records directly impact the quality of services provided</td></tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			including how our PIHP and Network receives and processes complaints of dissatisfaction from the consumers we serve. The PIHP will be continuing to monitor this during FY2023. This goal is considered met. **<u>Barrier Analysis:</u> None** **<u>Next Steps:</u> This will continue to be monitored through FY2023. The grievance process with the PIHP and Network will be reviewed for enhancement opportunities. The review and enhancement of the grievance process will improve the quality of care received for the consumers we serve including the process of how grievances are received and handled.**
Credentialing / Privileging	The goals for FY2022 Reporting are as follows: • Complete Privileging and Credentialing reviews and / or approval process of Organizational Applications for CMH and SUD Providers. o Review all Organizational Applications: ▪ Current Providers ▪ New Providers ▪ Existing Provider Renewals / Updates ▪ Provider Terminations / Suspensions / Probationary Status ▪ Provider Adverse Credentialing Determinations	Katie Forbes Privileging and Credentialing Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **One (1) Organizational Provider Privileging and Credentialing (P & C) application (Great Lakes Recovery Mission) was received for P & C Committee Review during FY2022 Q1. The Provider was issued full privileges.** **<u>Q 2 (Jan-Mar):</u>** **The Privileging and Credentialing (P&C) Committee reviewed and discussed Sanilac CMH, an existing provider, submitting an Organizational Additional SUD Location Form. Approval was not required as this is an already established Provider only adding a location.** **Q 3 (Apr-June):** **The Privileging and Credentialing Committee did not receive any Applications for Organizational Providers this quarter.** **<u>Q 4 (July-Sept):</u>** **The Privileging and Credentialing (P&C) Committee did not receive any additional applications for Organizational Providers. In August, the P&C Committee discussed New Paths Inc., an existing provider that submitted an additional location form.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Evaluation:</u> The Provider Network Management team successfully completed Privileging and Credentialing for Community Mental Health (CMH) and substance use disorder (SUD) Providers. Maintaining a network of Providers that serve our enrollees has resulted in maintaining the quality of health care and services for member. **<u>Barrier Analysis:</u> None.** **<u>Next Steps:</u> Continue into FY2023. The PIHP Provider Network Management Department will review the FY2022 Health Services Advisory Group (HSAG) Compliance Review recommendations and required action for additional improvement opportunities.**
Credentialing / Privileging	The goals for FY2022 Reporting are as follows: • Complete Privileging and Credentialing reviews and / or approval process of all applicable Region 10 staff. o Review all Practitioner Applications (includes PIHP Medical Director, Chief Clinical Officer, Clinical Manager, Access Clinicians [leased staff and direct hires]): ▪ Current Practitioners ▪ New Practitioners ▪ Existing Practitioner Renewals / Updates ▪ Practitioner Terminations / Suspensions / Probationary Status ▪ Practitioner Adverse Credentialing Determinations	Katie Forbes Privileging and Credentialing Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **No Individual Practitioner Privileging and Credentialing (P & C) applications were received for P & C Committee Review during FY2022 Q1.** **<u>Q 2 (Jan-Mar):</u>** **The P&C Committee did not receive any Individual Practitioner Privileging & Credentialing applications for review in Q2.** **<u>Q 3 (Apr-June):</u>** **In April, the Privileging and Credentialing (P&C) Committee reviewed an application for a PIHP Access Clinician (Port Huron location) and approved full privileges. Additionally, an application was received for a second PIHP Access Clinician (Port Huron location) which was also approved with full privileges.** **In May, the P&C Committee reviewed and approved a revision to the term date of an Access Clinician's previously approved application.** **There were no P&C applications submitted in the month of June.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Q 4 (July-Sept):</u> **The Privileging and Credentialing (P&C) Committee reviewed and approved a PIHP Access Clinician for full privileges. Additionally, an application was received for re-credentialing which was also reviewed and approved by the P&C Committee.** **<u>Evaluation:</u> This goal has been met. The Committee successfully completed Privileging and Credentialing application reviews for Region 10 staff, allowing our staff to provide services to our enrollees. This has resulted in maintaining the quality of health care and services for members.** **<u>Barrier Analysis:</u> None.** **<u>Next Steps:</u> Continue Goal into FY2023. The PIHP Provider Network Management Department will review the FY2022 Health Services Advisory Group (HSAG) Compliance Review recommendations and required action for additional improvement opportunities.**
Credentialing / Privileging	The goals for FY2022 Reporting are as follows: • Maintain a current and comprehensive policy on Privileging and Credentialing inclusive of MDHHS and Medicaid standards. o Review policy content. ▪ Review for alignment between policy and applications ▪ Revise and clarify language where needed	Katie Forbes Privileging and Credentialing Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **PIHP staff are reviewing policy for content, formatting, and alignment with state and federal standards.** **<u>Q 2 (Jan-Mar):</u>** **No updates** **<u>Q 3 (Apr-June):</u>** **No update for this Quarter.** **<u>Q 4 (July-Sept):</u>** **The Provider Network Management staff continue to monitor the Privileging and Credentialing Policy.** **<u>Evaluation:</u> The Provider Network Management team maintains a comprehensive policy on Privileging and Credentialing inclusive of Michigan Department of Health**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			& Human Services (MDHHS) and Medicaid Standards. As this PIHP Policy applies to both the PIHP and its Network Providers, this results in maintaining quality of healthcare and services for members. **<u>Barrier Analysis:</u> MDHHS Credentialing Policy (significant modifications) has not been finalized resulting in a delay of PIHP documentation updates.** **<u>Next Steps:</u> Continue Goal into FY2023. The PIHP will continue its review of the PIHP Credentialing and Privileging Policy for necessary revisions and improvements. The PIHP Provider Network Management Department will review the FY2022 Health Services Advisory Group (HSAG) Compliance Review recommendations and required action for additional improvement opportunities.**
Credentialing / Privileging	The goals for FY2022 Reporting are as follows: • Maintain current and comprehensive Privileging and Credentialing applications for Organizational Providers and Individual Practitioners inclusive of MDHHS and Medicaid standards. o Review application content: ▪ Clarify and streamline Organizational Provider Applications ▪ Clarify and streamline Individual Practitioner Applications ▪ Enhance Application Review Process	Katie Forbes Privileging and Credentialing Committee	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **PIHP staff are reviewing the Organizational Provider and Individual Practitioner applications for content, formatting, and alignment with state and federal standards.** **<u>Q 2 (Jan-Mar):</u>** **No updates** **<u>Q 3 (Apr-June):</u>** **During the April Privileging and Credentialing (P&C) committee meeting there was a discussion regarding potential enhancements to the P&C Application Review Process. Areas of review included current procedures related to ongoing monitoring of documentation within an application (e.g., licensure expiration dates, etc.) and application completion. Additional meetings were scheduled with P&C lead staff for continued efforts.** **<u>Q 4 (July-Sept):</u>** **The Provider Network Management team continues to update the Privileging and Credentialing (P&C)**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr><td></td><td></td><td></td><td>instructions document to streamline the Organizational and Individual Practitioner application as well as enhance the review process.

<u>Evaluation:</u> This goal has been met. The Committee successfully maintained current and comprehensive applications for Individual Practitioners and Providers within its Network. This resulted in maintaining the quality of health care and services for members.

<u>Barrier Analysis:</u> None.

<u>Next Steps:</u> Continue Goal into FY2023. The PIHP Provider Network Management Department will review the FY2022 Health Services Advisory Group (HSAG) Compliance Review recommendations and required action for additional improvement opportunities. Additionally, the PIHP Provider Network Management Department will review opportunities for improvement in oversight of Provider licensure checks, tracking of Organizational Provider Application submission dates, and enhancements to the PIHP Contract Monitoring Evaluation Tools.</td></tr>
<tr><td>Autism Program</td><td>The goals for FY2022 Reporting are as follows:
• Reduce the number of beneficiaries waiting to start ABA services, as measured by the number of persons on the overdue list and length of stay on the overdue list before beginning services.
o Monitor persons on autism services overdue list total
o Monitor completion of behavioral plans of care
o Monitor documentation submission to Waiver Support Application (WSA) and Microsoft Teams

<table><tr><th colspan="2"></th><th>FY22 1Q</th><th>FY22 2Q</th><th>FY22 3Q</th><th colspan="3">FY22 4Q</th></tr><tr><th colspan="2"></th><th>Dec</th><th>Mar</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th></tr><tr><td>Genesee</td><td>Overdue List Total</td><td>328</td><td>305</td><td>213</td><td>203</td><td>208</td><td>212</td></tr></table></td><td>Lauren Campbell

Monitored by Quality Improvement Committee (QIC)</td><td><u>Quarterly Updates:</u>

<u>Q 1 (Oct-Dec):</u>
The PIHP hosted the quarterly Autism Leads meeting in October. All four CMHs attended this meeting. The overdue totals for FY2022 Q1 were calculated. These calculations show GHS, LCMH and SC CMH have individuals waiting more than 90 days to begin ABA services.
These end of quarter calculations are current as of December 22, 2021. The quarter end reports were not available in the Waiver Support Application (WSA) due to a WSA timing error. Efforts were made by PIHP staff to complete these reports, however the WSA timing error continued to occur. MDHHS has been notified of this error, a response has yet to be received from MDHHS regarding this error.</td></tr>
</table>

Component	Goal/Activity/Timeframe							Responsible Staff/Department	Status Update & Analysis
		≥90 (Days)	214	253	173	155	146	148		**The totals for GHS do not match the information reported to Region 10 in GHS' monthly service capacity report. This is due to untimely data and document submission sent to the PIHP for input into the WSA.** **<u>Q 2 (Jan-Mar):</u>** **The PIHP hosted the quarterly Autism Leads meeting in January. All four CMHs attended the meeting. The overdue totals for the end of March and second quarter show GHS, Lapeer CMH, and St. Clair CMH have individuals waiting more than 90 days to begin ABA services. The PIHP Autism Coordinator designee will follow up with CMH Autism Coordinators at the next regional meeting which is scheduled for mid-April.** **The totals for GHS do not match information reported to Region 10 on GHS' periodic service capacity report. The PIHP continues to work with GHS to update the data within the Waiver Support Application (WSA). Additionally, the January monthly service capacity report from GHS indicated five of the ABA Providers are taking referrals.** **<u>Q 3 (Apr-June):</u>** **During April, the PIHP hosted the quarterly Autism Leads meeting. During the meeting, CMH Leads reported challenges with staffing. The overdue totals for the end of June show all CMHs have individuals waiting more than 90 days to begin Applied Behavior Analysis (ABA) services. This will be discussed at the July Autism Leads meeting.** **A decrease is noted for the number of individuals waiting to begin ABA services for GHS from the end of May to the end of June.** **<u>Q 4 (July-Sept):</u>** **The PIHP hosted Autism Leads meetings in July and September. The Community Mental Health (CMH) Autism Leads shared they are seeing an increase in the number of children presenting to CMH to be assessed for Autism and ABA services. During fourth quarter, the**
		60-89	54	12	0	12	28	8		
		30-59	42	21	12	28	25	24		
		0-29	18	19	28	8	9	32		
	Lapeer	**Overdue List Total**	**7**	**4**	**4**	**5**	**2**	**3**		
		≥90	2	1	2	1	0	0		
		60-89	2	1	0	0	0	1		
		30-59	1	1	0	2	1	1		
		0-29	2	1	2	2	1	1		
	Sanilac	**Overdue List Total**	**1**	**1**	**6**	**3**	**2**	**3**		
		≥90	0	0	1	0	0	1		
		60-89	0	0	0	2	0	1		
		30-59	0	0	3	0.	1	0		
		0-29	1	1	2	1	1	1		
	St. Clair	**Overdue List Total**	**15**	**11**	**10**	**17**	**18**	**17**		
		≥90	4	4	6	5	2	2		
		60-89	3	1	0	2	0	4		
		30-59	6	4	2	1	10	7		
		0-29	2	2	2	9	6	4		

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr><td></td><td></td><td></td><td>Genesee Health System (GHS) Autism Lead reported efforts continue to increase capacity with the provider network. The overdue totals for the end of September show GHS, Sanilac CMH, and St. Clair CMH all have individuals waiting more the 90 days to begin applied behavior analysis (ABA) services. The total number of individuals waiting over 90 days to begin ABA services has increased for the first time since January.

<u>Evaluation:</u> Throughout FY2022, there was not a consistent improvement in reducing the number of beneficiaries overdue to begin ABA services. At the conclusion of FY2022, there was a total of 235 beneficiaries overdue to begin ABA services.

<u>Barrier Analysis:</u> CMH Leads reported challenges with staffing and ABA provider network capacity.

<u>Next Steps:</u> The PIHP will continue to monitor overdue totals and network ABA Provider and services capacities. However, the PIHP's monitoring process may need to be modified if/when WSA is decommissioned.</td></tr>
<tr><td>Autism Program</td><td>The goals for FY2022 Reporting are as follows:
• Autism benefit enrollees will receive one or more Family Behavior Treatment Guidance service per quarter.
o Monitor service provision in specified areas
o Monitor services (encounters) using the funding Source Bucket Report (FSBR)

Standard: 100% of individuals will receive ≥1 Family Behavior Treatment Guidance Service per quarter, as measured using the FSBR report.
Percentage of individuals receiving ≥1 Family behavior Treatment Guidance service per quarter.
Data source: Waiver Support Application (WSA) and Funding Source Bucket Report (FSBR)
<table><tr><th></th><th>FY21 4Q</th><th>FY22 1Q</th><th>FY22 2Q</th><th>FY22 3Q</th></tr><tr><td>Genesee</td><td>47.1%</td><td>41.5%</td><td>52.5%</td><td>58.1%</td></tr><tr><td>Lapeer</td><td>96.0%</td><td>85.2%</td><td>95.7%</td><td>87.5%</td></tr></table></td><td>Lauren Campbell

Monitored by Quality Improvement Committee (QIC)</td><td><u>Quarterly Updates:</u>

<u>Q 1 (Oct-Dec):</u>
Percentages of Autism benefit enrollees receiving one or more Family Behavior Treatment Guidance service per quarter were calculated for FY2021 Q4 using updated encounter data. These calculations show LCMH, SCMH and SC CMH provided fewer Autism benefit enrollees with one or more Family Treatment Guidance service in FY2021 Q4 compared to FY2021 Q3. GHS shows an increase in the provision of one or more Family Treatment Guidance services to Autism benefit enrollees in FY2021 Q4 compared to FY2021 Q3.
The calculation for GHS was completed using updated encounter data and data from the Waiver Support Application (WSA). WSA data for GHS is not considered up to date. As GHS becomes current in their submissions to the PIHP these calculations will begin to accurately reflect the percentage of Family Treatment Guidance services GHS provides to Autism Benefit enrollees. The</td></tr>
</table>

Component	Goal/Activity/Timeframe				Responsible Staff/Department	Status Update & Analysis
	Sanilac	88.5%	88.9%	100%	91.7%	**standard for this goal is that 100% of Autism benefit enrollees will receive one or more Family Treatment Guidance services per quarter.** **<u>Q 2 (Jan-Mar):</u>** **Percentages of Autism benefit enrollees receiving one or more Family Behavior Treatment Guidance service per quarter were recalculated for FY2022 Q1 using updated encounter data. Percentages of Autism benefit enrollees receiving one or more Family Behavior Treatment Guidance service per quarter were calculated for FY2022 Q2 using available encounter data. An increase in the number of individuals receiving at least one Family Behavior Treatment Guidance service from FY2022 Q1 to FY2022 Q2 is demonstrated for Lapeer CMH and Sanilac CMH. The PIHP will recalculate as encounter data becomes available / more complete.** **PIHP Autism Team staff will continue to monitor and will discuss with CMH Autism Leads.** **<u>Q 3 (Apr-June):</u>** **The provision of Family Behavior Treatment Guidance was discussed with CMH Autism Leads during the quarterly meeting in April. Reminded CMH Autism Leads that this was an area of focus from MDHHS previously but is not monitored via contract monitoring.** **Percentages of Autism benefit enrollees receiving one or more Family Behavior Treatment Guidance service per quarter were recalculated for FY2022 second quarter using updated encounter data. An increase in the number of individuals receiving at least one Family Behavior Treatment Guidance service from FY2022 first quarter to FY2022 second quarter is seen for all CMHs. The PIHP will calculate third quarter as encounter data becomes available.** **<u>Q 4 (July-Sept):</u>** **Percentages of Autism benefit enrollees receiving one or more Family Behavior Treatment Guidance service per quarter were recalculated for FY2022 third quarter. A**
	St. Clair	72.2%	74.5%	83.3%	81.7%	

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			decrease in the number of individuals receiving at least one Family Behavior Treatment Guidance service from FY2022 second quarter to FY2022 third quarter is noted for all Community Mental Health (CMH) Providers except Genesee Health System. The PIHP Autism Team discussed discontinuing this goal at the end of the fiscal year due to changes to the program. **<u>Evaluation:</u> This goal was not met as not all Autism Benefit enrollees received one or more Family Behavior Treatment Guidance service per quarter. However, has been improvement in the number of (and consistency of) Autism Benefit enrollees receiving one or more Family Behavior Treatment Guidance service per quarter since FY2019, when this goal was first introduced.** **<u>Barrier Analysis:</u> The PIHP and CMHs have prioritized ABA Provider capacity and other program policy changes to continue providing Autism Benefit and Applied Behavior Analysis (ABA) services to eligible individuals and in alignment with the Michigan Medicaid Provider Manual.** **<u>Next Steps:</u> The PIHP will discontinue this goal. This was previously identified as one of the Michigan Department of Health & Human Services (MDHHS) ABA quality and system improvement indicators. However, oversight and monitoring of Family Behavior Treatment Guidance services has not been a priority effort. Moving forward, the PIHP will continue oversight of CMHs' ABA Provider Network capacity.**
Autism Program	The goals for FY2022 Reporting are as follows: • The documents and data submitted to the PIHP for Autism Benefit program enrollees will be complete and accurate. This will be evidenced by seamless use of Microsoft Teams by all CMHSPs, accurate submission of Autism Benefit Case Action Form (ABCAF) documents to the PIHP related to the Autism Benefit, increased understanding of timeframes for document and data submission, and accurate and timely processing of document submission by the PIHP.	Lauren Campbell Monitored by Quality Improvement Committee (QIC)	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **LCMH, SCMH and SC CMH consistently submit documents and data completely and accurately for Autism Benefit program enrollees. LCMH, SCMH and SC CMH staff seamlessly use Microsoft Teams and accurately submit required documentation to the PIHP. LCMH, SCMH and SC CMH also understand the timeframes for document and data submissions to the PIHP.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	○ Monitor documentation submission to Waiver Support Application (WSA) and Microsoft Teams		**Q 2 (Jan-Mar):** **During January, many Waiver Support Application (WSA) users encountered issues and errors with the application. These issues were brought to the MDHHS Leads' attention. During February and March, the PIHP Autism Team met with the GHS Autism Leads to discuss their plan to make all information in the WSA current. Missing and overdue plans and evaluations will be submitted to the PIHP and uploaded into WSA by May 1st. Lapeer CMH, Sanilac CMH, and St. Clair CMH continue to submit documents and data to the PIHP completely and accurately using Microsoft Teams.** **Q 3 (Apr-June):** **CMH Leads and designees continue to utilize the Waiver Support Application and Microsoft Teams to share documents and data with the PIHP for Autism Benefit enrollees. GHS specifically had a goal of catching up on missing and overdue plans and evaluations by May 1st. This goal was not met but GHS staff continue to upload plans of service and submit evaluation information.** **Q 4 (July-Sept):** **Community Mental Health (CMH) Leads and designees continue to utilize the Waiver Support Application (WSA) and Microsoft Teams to share documents and data with the PIHP for Autism Benefit enrollees. Communication regarding corrections or clarification needed occurs via Microsoft Teams between the PIHP and CMH Autism Leads/Designees. The Genesee Health System (GHS) Autism Lead reports adding a second staff to assist with case volume. GHS also reported work continued to address timely and accurate reporting.** **Additionally, the Michigan Department of Health & Human Services (MDHHS) hosted a meeting with PIHP Autism Leads and designees to initiate conversation regarding decommissioning of the WSA for the Autism Benefit. Communication from the new Manager overseeing Autism at MDHHS indicated the use of WSA will be transitioned to direct reporting by April 1, 2023.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Evaluation:</u> Overall, this goal was not met. Although Microsoft Teams was utilized by the PIHP and CMHs, there were still accuracy and timeliness concerns identified. As identified during FY2022 Annual Contract Monitoring, there were delays in the submission of initial evaluations, reevaluations, treatment plans, and disenrollments. CMHs will prepare corrective action plans if the timeliness standards have not been achieved. Additionally, GHS specifically had a goal of catching up on missing and overdue plans and evaluations by May 1st. This goal was not met, but GHS staff continue to upload plans of service and submit evaluation information. **<u>Barrier Analysis:</u> A barrier reported by CMHs is staff capacity.** **<u>Next Steps:</u> Continue this goal with modifications to adapt to changes to data reporting (i.e., WSA versus direct reporting).**
Standard Assessments	The goals for FY2022 Reporting are as follows: • Implementation and integration of the ASAM Continuum and GAIN I-Core into the SUD Treatment Provider Network. o Monitor ASAM Continuum/GAIN I-Core implementation throughout the region. o Provide ASAM Continuum/GAIN I-Core technical assistance to the SUD Provider Network. o Track and monitor training completion. o Evaluate implementation throughout Region 10.	Tayler Job Monitored by Quality Improvement Committee (QIC)	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **The ASAM Continuum (standardized SUD assessment for adult population) and GAIN I-Core (standardized SUD assessment for adolescent population) were implemented on October 1, 2021. Training completion is continuously being tracked and monitored to ensure appropriate SUD providers have access to the electronic health record (EHR) located in the MIX system. There is now a self-paced ASAM Continuum training available for completion at any time. We will continue to provide customer and technical support to the SUD Provider Network as needed.** **<u>Q 2 (Jan-Mar):</u>** **The ASAM Continuum and GAIN I-Core assessments were implemented on October 1, 2021. Our partners at ASAM have hosted three ASAM Continuum Advanced Skills Webinars over the last two months. These sessions were not mandatory, but recommended, as they were designed to respond to Provider questions and give the opportunity to discuss successes and challenges**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			experienced since beginning to use the Continuum. Training instructions and registration links were sent out to Providers in advance, and this information was also reported at the SUD Provider Network meeting. We will continue to provide customer and technical support to the SUD Provider Network as needed. **<u>Q 3 (Apr-June):</u>** **As of June 13, 2022, Sanilac County CMH has been onboarded as an SUD provider, at their Sandusky location. The Data team will continue to work with the Provider Network Management (PNM) team to onboard Sanilac CMH's Croswell location. MDHHS added Sanilac CMH to the Customer Relationship Management (CRM) system on July 6th. The PIHP has since sent their ASAM LOC application and is awaiting the submission of Croswell's ASAM questionnaire.** **<u>Q 4 (July-Sept):</u>** **Sanilac Community Mental Health (CMH) successfully submitted their American Society of Addiction Medicine (Sub Abuse Assessment; ASAM) Level of Care (LOC) questionnaire for the Croswell location and has been granted access to the ASAM Continuum assessment in the MIX system. The ASAM Continuum team offered an opportunity to interact with Continuum experts at their ASAM Continuum Office Hours on September 7th and will be offering another session on November 9, 2022. This will be the last opportunity for this year. Registration information was distributed to all Substance Use Disorder (SUD) Treatment Providers on October 4th.** **<u>Evaluation:</u> The ASAM Continuum (standardized SUD assessment for adult population) and the Global Appraisal of Individual Needs (GAIN) I-Core (standardized SUD assessment for adolescent population) were implemented on October 1, 2021. Self-paced ASAM Continuum training is available for staff to complete at any time. Additionally, a GAIN I-Core training course is offered once a month as needed. Training completion is continuously being tracked and monitored to ensure**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			appropriate MIX access/enrollment. Multiple ASAM Continuum trainings and Q&A webinars were held for additional support throughout the implementation process. Region 10 provided customer and technical support to successfully implement the ASAM Continuum and GAIN I-Core throughout the region. This goal has been met. **<u>Barrier Analysis:</u> None** **<u>Next Steps:</u> Due to this goal being met, the PIHP has removed the goal from the FY2023 QI Workplan but will continue to provide customer and technical support to the SUD Treatment Providers as needed.**
Opioid Health Home	The goals for FY2022 Reporting are as follows: • Development of the Opioid Health Home (OHH) model within Region 10. o Identify, enroll, and onboard potential Health Home Partner(s) (HHP). o Manage enrollment of OHH beneficiaries. o Development of continuous utilization and quality improvement program.	Kristen Potthoff / Josh Elsholz Monitored by Quality Improvement Committee (QIC)	**<u>Quarterly Updates:</u>** **<u>Q 1 (Oct-Dec):</u>** **The Opioid Health Home was implemented in October 2021 within Region 10. Region 10 continues to meet internally to discuss progress. There are currently 10 beneficiaries enrolled in the Opioid Health Home.** **<u>Q 2 (Jan-Mar):</u>** **The PIHP has created resource and guidance materials to support its OHH Provider. This information has been shared with the PIHP OHH Provider and training completed. The PIHP continues to enroll beneficiaries in the OHH (40 beneficiaries have been enrolled to date). The PIHP continues to work with its OHH Provider in establishing required billing and reporting procedures. MDHHS Media Campaign materials received from MDHHS and the PIHP has completed its review of these materials with an expected go live date coming soon. The PIHP has collaborated with MDHHS on an ongoing and frequent basis regarding guidance pertaining to this new benefit.** **<u>Q 3 (Apr-June):</u>** **The PIHP FY2022 Contract Monitoring Opioid Health Home (OHH) advance desk audit has been completed. A Methodology and Record Review Worksheet has been created to support Care Plan Reviews. PIHP OHH**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Coordinator access has been granted for CareConnect360 which will help to help identify potential beneficiaries for OHH benefits and training has begun on how to utilize this program. A staff member from Sacred Heart has been identified and enrolled in Collecting and Utilizing Social Determinants of Health Data for Health Homes training. Collaboration efforts with the Data team within the PIHP have resulted in reports being generated which will help identify beneficiaries who may be in lieu of recoupment for services not submitted. Continued work with Sacred Heart to ensure that all services are being billed correctly is ongoing. **<u>Q 4 (Jul-Sep):</u>** **The Opioid Health Home (OHH) Coordinator role was assigned to a new PIHP staff member on July 22, 2022. An additional 12 beneficiaries have been enrolled into the OHH for Region 10 PIHP in Quarter 4. Sacred Heart Rehabilitation Center has received an approved OHH application for a Port Huron Location and that was added to their FY2023 contract with a start date of October 1, 2022. Discussion with Biomed staff has begun with the possibility of contracting with their organization for OHH services with an emphasis on providing services in Flint, MI. The PIHP is working with Sacred Heart to ensure that the organization is uploading their documents into the WSA in a complete manner to ensure timely enrollment for those seeking services.** **<u>Evaluation:</u> All goals were met for FY2022 and there have been improvements in the quality of health care and services for Region 10 members by means of beginning the Opioid Health Care Program and subsequent expansion into St. Clair County. The total approved OHH enrollees for Region 10 PIHP at the end of FY2022 stands at 58 beneficiaries.** **<u>Barrier Analysis:</u> None**

<table>
<tr><th>Component</th><th>Goal/Activity/Timeframe</th><th>Responsible Staff/Department</th><th>Status Update & Analysis</th></tr>
<tr><td></td><td></td><td></td><td><u>Next Steps:</u> Continue with this goal for FY2023 with an emphasis on expansion of enrollment and onboarding of Health Home Partners.</td></tr>
<tr><td>Supports Intensity Scale</td><td>The goals for FY2022 Reporting are as follows:
Improve regional Supports Intensity Scale (SIS) assessment completion rate.
Monitor SIS assessment completion rates and number of assessments completed monthly.
Monitor regional SIS Assessor capacity.
Monitor SIS Assessors’ certification statuses and annual conflict-free agreements.
<table>
<tr><th></th><th>FY22 Q2</th><th>FY22 Q3</th><th colspan="3">FY22 Q4</th></tr>
<tr><th></th><th>3/2022</th><th>6/2022</th><th>7/2022</th><th>8/2022</th><th>9/2022</th></tr>
<tr><td>Genesee</td><td>24.5%</td><td>18.8%</td><td>16.5%</td><td>14.7%</td><td>12.3%</td></tr>
<tr><td># Assessments Completed</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Lapeer</td><td>76.7%</td><td>74.4%</td><td>70.5%</td><td>67.9%</td><td>63%</td></tr>
<tr><td># Assessments Completed</td><td>1</td><td>14</td><td>10</td><td>7</td><td>7</td></tr>
<tr><td>Sanilac</td><td>44.1%</td><td>37.9%</td><td>37.1%</td><td>35.3%</td><td>36.5%</td></tr>
<tr><td># Assessments Completed</td><td>11</td><td>3</td><td>1</td><td>3</td><td>3</td></tr>
<tr><td>St. Clair</td><td>27.8%</td><td>19.5%</td><td>17.9%</td><td>17.3%</td><td>16.5%</td></tr>
<tr><td># Assessments Completed</td><td>1</td><td>3</td><td>3</td><td>5</td><td>6</td></tr>
<tr><td>Total</td><td>31.4%</td><td>25.5%</td><td>23.5%</td><td>20.3%</td><td>20.3%</td></tr>
<tr><td># Assessments Completed</td><td>13</td><td>20</td><td>14</td><td>15</td><td>16</td></tr>
</table></td><td>Jennifer Beier

Monitored by Quality Improvement Committee (QIC)</td><td><u>Quarterly Updates:</u>

<u>Q 1 (Oct-Dec):</u>
Region 10 continues to monitor Supports Intensity Scale (SIS) assessment completion rates among the region. Sanilac CMH currently does not have a SIS assessor. St. Clair CMH and Lapeer CMH both have one SIS assessor. GHS has struggled to maintain SIS assessor capacity and has been working to prepare for upcoming SIS assessor trainings in which they hope to bring GHS staff to. Ongoing monitoring occurs via the outstanding plan of correction report to ensure GHS has plans in place to maintain SIS assessor qualifications.

<u>Q 2 (Jan-Mar):</u>
Updated completion rates and number of assessments completed were obtained from the TBD Solutions Explore SIS site. Sanilac CMH continues contracting with MORC to complete SIS assessments. GHS, Lapeer CMH, and St. Clair CMH each have one SIS assessor. GHS has struggled to maintain SIS assessor capacity and has been working to prepare for upcoming SIS assessor trainings. Ongoing monitoring occurs via the outstanding plan of correction report to ensure GHS has plans in place to maintain SIS assessor qualifications. Assessor training opportunities are shared with the SIS Supervisors at each CMH.

<u>Q 3 (Apr-June):</u>
Updated completion rates and number of assessments completed were obtained from the TBD Solutions Explore SIS site. Sanilac CMH continues contracting with MORC to complete SIS assessments. Lapeer CMH and St. Clair CMH each have one SIS assessor. The status of Genesee Health System’s SIS assessor is unclear at this time. However, GHS has not completed any assessments since February 2022. Ongoing monitoring occurs via the outstanding plan of correction report to ensure GHS has</td></tr>
</table>

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			plans in place to maintain SIS assessor qualifications. Assessor training opportunities are shared with SIS Supervisors at each CMH. **MDHHS intends to require the SIS for individuals with intellectual and developmental disability designations for the Habilitation Supports Waiver, 1915(i) State Plan Amendment, and specialized residential settings effective October 1, 2024.** **<u>Q 4 (July-Sept):</u>** **Region 10 continues to monitor Supports Intensity Scale (SIS) assessment completion rates among the region. During July through September 2022, per data from the Explore SIS Site (maintained by TBD Solutions), Region 10 had the lowest SIS completion rate among the PIHPs.** **From July through September, productivity increased slightly for Sanilac Community Mental Health (CMH) and St. Clair CMH. Productivity decreased slightly for Lapeer CMH during this time. Genesee Health System (GHS) has not completed a SIS assessment since February 2022. St. Clair CMH and Lapeer CMH each have one SIS Assessor. Sanilac CMH continues to contract with MORC to complete SIS assessments. GHS confirmed in August that they no longer have a SIS assessor, but plan to fill the position.** **The SIS Steering Committee meeting was held on August 11, 2022 where it was announced that the proposed implementation start date for the SIS-A 2nd Edition is October 1, 2023. The Region 10 Quarterly SIS Training hosted by MORC was held via Zoom on August 16, 2022 with attendance from Lapeer CMH and St. Clair CMH SIS assessors as well as PIHP SIS Leads.** **Data from the Explore SIS Site was presented at the monthly CEO meeting on September 12, 2022. Data included completion rates by CMH and completion rates by PIHP. This information was also presented during the monthly Improving Practices Leadership Team (IPLT) meeting on September 27, 2022.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			<u>Evaluation:</u> Region 10's overall SIS Assessment completion rate declined steadily since the beginning of the fiscal year. SIS Assessment completion rates have declined significantly over the fiscal year for GHS, Sanilac CMH, and St. Clair CMH. SIS Assessment completion rates have declined slightly for Lapeer CMH since the beginning of the fiscal year. **<u>Barrier Analysis:</u> SIS Assessor capacity throughout the PIHP continues to be a barrier. GHS currently does not have a SIS Assessor.** **<u>Next Steps:</u> The PIHP will continue to monitor SIS Assessor capacity throughout the region and continue tracking the number of assessments completed each month. The PIHP will begin tracking the percentage of overdue assessments each month through data available on the Explore SIS Site. The PIHP will consider adding CMH contract language in order to increase completion rates throughout the region and prepare for the upcoming requirements of the SIS Assessment for the 1915(I)SPA, Habilitation Supports Waiver, and specialized residential settings effective October 1, 2024.**
Verification of Services	The goals for FY2022 Reporting are as follows: • The PIHP will verify whether services reimbursed by Medicaid were furnished to members by affiliates (as applicable), providers, and subcontractors. o Conduct quarterly claims verification reviews. o Increase the sample size selected for quarterly claims verification reviews. o Prepare and submit an annual report including the claims verification methodology, findings, and actions taken in response to findings. o Update the PIHP Claims Verification Policy 04.03.02 to better reflect current processes. o Send EOB letters biannually during the fiscal year.	Jennifer Beier Quality Management & Data Management Departments	**Quarterly Updates:** **<u>Q 1 (Oct-Dec):</u>** **The PIHP submitted the Medicaid Verification report to MDHHS. The PIHP Claims Verification Policy 04.03.02 is currently being reviewed to enhance language. 1,438 Explanation of Benefits (EOB) letters were mailed in December (7.8%).** **Q 2 (Jan-Mar):** **The Quality Management Team pulled claims and encounters to conduct the FY2022 Q1 claims verification audit. The team is preparing emails to send to Providers to request supporting documentation. Additionally, the PIHP Claims Verification Policy 04.03.02 is currently being reviewed to enhance language.** **<u>Q 3 (Apr-June):</u>**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
	o Send Explanation of Benefits (EOB) letters to more than 5% of consumers receiving services.		**Requests for supporting documentation for the FY2022 first quarter claims verification reviews were sent to Providers in early April. Provider supporting documentation was reviewed by the PIHP. PIHP staff met multiple times to discuss the claims verification review processes before preparing preliminary letters for Providers or finalizing findings.** **Additionally, 1,469 Explanation of Benefit (EOB) letters were mailed in June (7.8%).** **<u>Q 4 (July-Sept):</u>** **During July, the PIHP worked to conclude the Verification of Medicaid Services for FY2022 Quarter 1. PIHP staff finalized the review of Provider supporting documentation for services selected for the quarter. PIHP staff met multiple times to discuss the claims verification review process. In August, PIHP staff began preparing preliminary letters to send to the Providers where insufficiencies were found. PIHP staff met to discuss the process for selecting claims to be reviewed in future quarters in order to include all Providers in the sample each quarter going forward. In September, preliminary letters and Plans of Correction were finalized for those Providers found to be out of compliance, as well as final letters for those Providers found in compliance. The process for selected claims to be reviewed for FY2022 Quarter 2 also began.** **<u>Evaluation:</u> Verification of Medicaid Services has not been completed per Region 10's proposed timeline for FY2022. The PIHP Claims Verification Policy 04.03.02 was not update during FY2022.** **<u>Barrier Analysis:</u> Verification of Medicaid services related activities were not completed timely due to training of new staff.** **<u>Next Steps:</u> Continue moving forward with the FY2022 Quarter 2 Verification of Medicaid Services. Update all PIHP process documents pertaining to claims verification.**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			Update the PIHP Claims Verification Policy in FY2023 to reflect current processes.
External Quality Review Corrective Actions	The goals for FY2022 Reporting are as follows: • Implement corrective action plans (CAPs) and address recommendations from External Quality Reviews. o Standard Leads will report CAP updates monthly to the External Quality Review Team / Quality Manager. o Recommendations resulting from the Performance Measure Validation (PMV) Review will be addressed by the Quality Manager and PIHP Performance Indicator Team. Following the 2021 External Quality Review of Region 10 PIHP, CAPs were needed for the following areas: o Standard I. Member Rights and Member Information o Standard III. Availability of Services o Standard IV. Assurances of Adequate Capacity and Services o Standard V. Coordination and Continuity of Care o Standard VI. Coverage and Authorization of Services Per the 2021 External Quality Review Performance Measurement Validation Report for Region 10 PIHP, it was recommended: o Region 10 PIHP work with the CMHs to add a level of validation for the review of compliant records for Indicators #1 and #3 and also consider talking with CMHs to update source code to identify any manually entered diagnosis dates within assessments to ensure alignment with the MDHHS PI Codebook (for cases when the diagnosis was completed after the assessment date). o Region 10 PIHP consider having ongoing discussions and review of the MDHHS Codebook specifications during meetings with CMHs, PIHP PI Team, and IT/system representatives.	**Compliance Monitoring:** Standard Leads & External Quality Review Team / Lauren Campbell **Performance Measure Validation:** Lauren Campbell	**Quarterly Updates:** **Q 1 (Oct-Dec):** **The FY2021 Health Services Advisory Group (HSAG) Compliance Review Final Report and corrective action plan (CAP) Template were received from HSAG. HSAG notified PIHPs that recommendations for "Met" elements will be incorporated into the FY2022 HSAG Compliance Review. Standard Leads prepared CAPs for "Not Met" elements and responses to recommendations for the "Met" elements. The responses to recommendations will not be submitted to HSAG but will be monitored monthly.** **The final CAP Template with Region 10 CAP responses was submitted to HSAG on December 1, 2021. A total of 13 CAPs were submitted to HSAG. Standard Leads also prepared status updates for each recommendation. The CAP and recommendation response updates will be shared with the PIHP QI Committee in January.** **The PIHP Performance Measurement Validation (PMV) Team met to review HSAG's recommendations and plan for action steps. Many action steps align with other performance indicator issues and recommendations. The PIHP Performance Indicator (PI) / PMV Team will continue working to improve PI processes and will also focus on remediating weaknesses and issues identified by HSAG. The PIHP PI Team continues to review PI processes and provide feedback and ideas for enhancements and revisions. PIHP Management Team members have also provided feedback regarding PI processes.** **Q 2 (Jan-Mar):** **The Health Services Advisory Group (HSAG) provided feedback to PIHPs on the corrective actions plans (CAPs) submitted in response to findings from the FY2021 Compliance Review. All corrective action plans were accepted by HSAG and MDHHS and did not require revisions. On March 31, the PIHP submitted a progress**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			report to HSAG to report the status of the SFY2021 Compliance Review CAPs. **Standard Leads continue to provide monthly status updates to address corrective action plans and recommendations from the FY2021 Compliance Review. The latest updates from Standard Leads indicate six (6) of the thirteen (13) corrective action plans have been completed.** **The PIHP Performance Indicator (PI) Team continued working to improve PI processes. The Quality Manager also began training with PIHP PI Team staff to learn more about PI processes. In preparation for the 2022 Performance Measure Validation (PMV) Review, the PIHP PMV Team attended a technical assistance webinar hosted by HSAG. The PIHP PMV/PI Team and Quality Management Committee (QMC) also revisited the 2021 PMV Final Report and findings. Ongoing discussion regarding PIs continues through QMC meetings.** **MDHHS shared the SFY2021 External Quality Review Technical Report with PIHPs in late March. The PIHP will review the report for overall findings, weaknesses, and recommendations.** **<u>Q 3 (Apr-June):</u>** **PIHP staff worked to prepare Compliance Review Tools and collect supporting evidence documents to submit to HSAG at the beginning of June for the SFY2022 Compliance Review. PIHP staff continue to prepare for the Compliance Review, which is scheduled for July 12th.** **Work continued on the SFY2021 corrective action plans and recommendations. Six (6) of the thirteen (13) corrective action plans have been completed.** **The 2022 Performance Measure Validation (PMV) Review occurred. The PIHP is following up on concerns noted regarding encounter submissions by CMHs.** **<u>Q 4 (July-Sept):</u>**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			The SFY2022 Compliance Review took place on July 12th. Health Services Advisory Group (HSAG) Auditors provided feedback and recommendations to the PIHP subject matter experts / Standard Leads. Although the draft SFY2022 Compliance Review Report has not yet been received from HSAG, Standard Leads have initiated work and discussion to address recommendations provided during the review. **Regarding the 2022 Performance Measure Validation (PMV) Review, the PIHP followed up on concerns noted regarding encounter submissions by Community Mental Health (CMH) Providers. These items will be added to FY2022 Annual Contract Monitoring.** **Additionally, during August, the PIHP received the draft 2022 PMV Review Report from HSAG. The team reviewed the report and provided feedback to HSAG by the deadline of September 9th. The PIHP Team will work to address identified weaknesses and HSAG's recommendations.** **Work continued on the SFY2021 corrective action plans and recommendations. Seven (7) of the thirteen (13) corrective action plans have been completed, while work continues for the remaining six (6) corrective action plans.** **<u>Evaluation:</u> Region 10 PIHP has initiated and implemented corrective actions in response to findings and recommendations provided during External Quality Reviews. However, although efforts continue, not all corrective action plans have been completed.** **<u>Barrier Analysis:</u> An identified barrier for Coordination and Continuity of Care corrective action plan is timing of the tech request (to amend the CMH Utilization Review Tool) to be sent to the electronic health record (EHR) project manager is contingent upon other EHR tech requests that also need to be sent.** **<u>Next Steps:</u> Continue this goal with modifications to include SFY2022 findings, recommendations, and**

Component	Goal/Activity/Timeframe	Responsible Staff/Department	Status Update & Analysis
			corrective actions. Additionally, the PIHP's internal process to collect regular updates on Compliance Review recommendations and corrective actions will be enhanced to include PMV Review recommendations and corrective actions.

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As of 10.01.2022