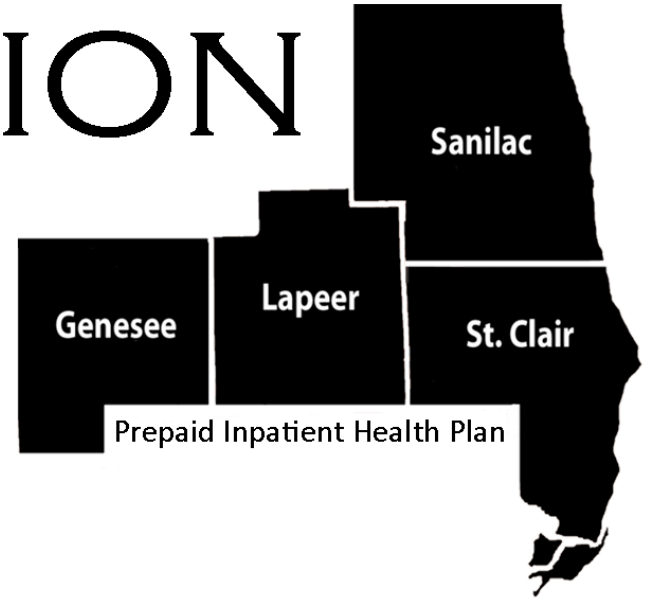
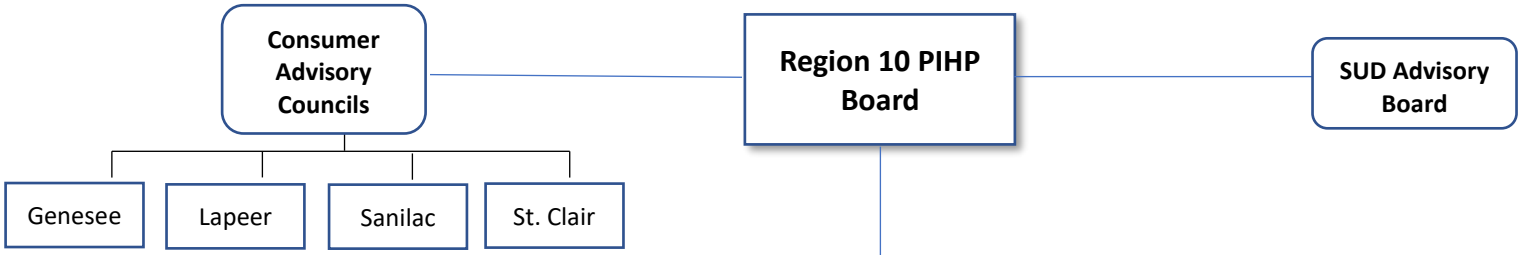
Region 10



QUALITY IMPROVEMENT PROGRAM & WORKPLAN

FY 2019 – Annual Report

REGION 10 QAPIP ORGANIZATIONAL STRUCTURE



Quality Improvement Committee

PIHP CEO (Chair)
PIHP Medical Director
PIHP CCO
PIHP COO
PIHP CIO
PIHP CFO
PIHP Admin Director/Compliance Officer
Committee Chairs

	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 Provid	√							√

Quality Management Fiscal Year (FY) 2019 Work Plan (October 1, 2018 – September 30, 2019)

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
QI Program Structure - Annual Evaluation	• **Submit 2018 QI Program Evaluation to "Quality Improvement Committee" and the Region 10 PIHP Board by December 1, 2018.**	• **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.** • **After presentation to the "Quality Improvement Committee" the Annual Evaluation will be presented to the Region 10 PIHP Board for discussion and approval.**	**Pattie Hayes** **QI Department** **QI Program Standing Committees**	**Goal Met: ☒ Yes ☐ No** **Quarterly Updates:** **Q1 Summary: The FY18 QI Program Annual Report was presented and approved by QIC and the PIHP Board at October's meetings. No further actions needed.** **Q2 Summary: No new updates** **Q3 Summary: No new updates.** **Q4 Summary: No new updates** **Evaluation: Completed.** **Barrier Analysis: No barriers.** **Next Steps: Objective to be continued into the following FY.** **Continue Objective(s)?** **☒ Yes ☐ No**

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
QI Program Structure - Program Description	• **Submit 2019 QI Program Description to "Quality Improvement Committee" and the Region 10 PIHP Board by December 1, 2018.**	• **Review the previous year's QI Program and make revisions to meet current standards and requirements.** • **Include changes approved through committee action and analysis.** • **Include signature pages, Work Plan, Evaluation, Policies and Procedures and attachments.**	**Pattie Hayes** **QI Department** **QI Program Standing Committees**	**Goal Met:** ☒ **Yes** ☐ **No** **Quarterly Update:** **Q1 Summary: FY2019 QI Program Description was reviewed and approved by QIC and PIHP Board at the October meetings.** **Q2 Summary: Updates were made to the QI Program to better align with QAPIP requirements and EQR standards. Reviewed and approved at QIC and PIHP Board March meetings.** **Q3 Summary: No new updates** **Q4 Summary: No new updates** **Evaluation: Completed.** **Barrier Analysis: No barriers.** **Next Steps: Objective to be continued into the following FY.** **Continue Objective(s)?** ☒ **Yes** ☐ **No**

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
QI Program Structure - Annual Work Plan	• **Submit 2019 QI Program Description to the "Quality Improvement Committee" and the Region 10 PIHP Board by December 1, 2018.** • **Develop the 2019 QI Program Work Plan standard by December 1, 2018.** • **Present the work plan to committee by December 1, 2018.**	• **Utilize the annual evaluation in the development of the Annual Work Plan for the upcoming year.** • **Prepare work plan including measurable goals and objectives.** • **Include a calendar of main project goal and due dates**	**Pattie Hayes** **QI Department** **QI Program Standing Committees**	**Goal Met: ☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary: FY2019 QI Workplan was reviewed and approved by QIC and PIHP Board at the October meetings.** **Q2 Summary: No new updates** **Q3 Summary: No new updates** **Q4 Summary: No new updates** **Evaluation: Completed** **Barrier Analysis: No barriers** **Next Steps: Objective to be continued into the following FY. Additional goals may be added throughout the current year as needed following goal approval process.** **Continue Objective(s)?** **☒ Yes ☐ No**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
Aligned System of Care	**The goals for 2019 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.**	• **Monitor utilization of the PIHP Clinical Practice Guidelines.** • **Review Evidence-Based Practices to promote standardized clinic operations across the provider network.** • **Monitor and advise on ESC activities to encourage CMHSP a) employment targets, b) standardized employment services data and reports formats and c) share and learn opportunities.** • **Identify and promote aligned network practices in utilizing the CC360 system, e.g. access to and working knowledge of CC360, entry of relevant case record notes for PIHP/CMH/MHP interactive care plans.**	**Tom Seilheimer** **Improving Practices Leadership Team (IPLT)**	**Goal Met:** ☒ **Yes** ☐ **No** **Quarterly Update:** **Q1 Summary:** **Discussed potential updates/language alignments to the policy in connection to UM Redesign and Parity implementation;** **no fidelity reviews or reports coming due at this time, but discussed BDHHA's fidelity initiatives regarding BTPRC and LOCUS; November ESC identified CMHSP employment baselines and targets and supported Charting the Life Course training; discussed CC360 webinar/training on CC360 PIs and the increasing use of CC360 within the Interactive Care Plans project.** **Q2 Summary:** **The policy update in preparation for the HSAG audit was approved for QIC and Board approval. EBP updates have been noted; Sanilac has scheduled a LOCUS fidelity review for later this FY, and Lapeer is in discussions with the MIFAST/LOCUS review team; the IPLT LOCUS implementation plan will be updated for April review. Lapeer and St. Clair have implemented employment targets, Sanilac is still finalizing baselines, and GHS has begun contract discussions with its employment services providers to begin community-based employment options. All members have expressed interest in pursuing local**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				opportunities to utilize the 'Charting the Life-Course' care management manual in connection to promoting community-based employment readiness. **CC360 webinar/training on CC360 PIs and the increasing use of CC360 within the Interactive Care Plans project have been discussed.** **Q3 Summary:** **No updates on CPGs for the quarter. LOCUS implementation plan follow-up task completed; CMHSP LOCUS training leaders / implementation coordinators list was updated; St. Clair recently enrolled another staff in the MIFAST LOCUS training, and Lapeer and Sanilac confirmed their MIFAST fidelity review participation, to take place by the end of this fiscal year.** **Reviewed and discussed ESC's documents and recommendations on the Charting the Life Course curriculum.** **Reported increased lag in posting encounter claims data was further discussed in terms of the IPLT Chair's recent outreach to the CC360 Data Administrator; follow up is planned in terms of gathering local examples warranting further investigation.** **Q4 Summary:** **CPG Annual Evaluation Report in-progress and scheduled for next meeting.** **Lapeer's MIFAST review of its IDDT was presented, noting**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				progress as well as shared issues regarding sustainability; the LOCUS EOY Survey will be sent next week in preparation for the October meeting. **CMH employment baselines and targets have been completed; share-and-learn discussions continue regarding promotion of community-based employment opportunities and partnered activities with MRS offices.** **Multi-year implementation activities with CC360 were concluded, noting local objectives met and further monitoring of CC360 utilization taking place within the Care Integration workgroup.** **Evaluation: Progress.** **Barrier Analysis: No Barriers.** **Next Steps: Implement FY 2020 Annual Plan.** **Continue Objective(s)?** **☒ Yes ☐ No**
Healthcare Integration / Care Coordination	**The goals for 2019 Reporting Year are as follows:** • **Align network healthcare integration / care coordination processes for persons served to ensure quality and safety of clinical care and quality of service.**	• **Assist in aligning network care integration processes for persons with Medicaid Health Plans, including shared case record operations.**	**Tom Seilheimer** **Improving Practices Leadership Team (IPLT)**	**Goal Met:** **☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary:** **Discussed care manager activities and complex case management issues; explored ways to address various operational issues; also reviewed the MHP worksheets guiding goal development and discussed strategies to increase case manager participation.** **Q2 Summary:**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				Case consultation taking place as planned among all the participants and opportunities for expanded participation have also been discussed; a policy update has also been reviewed as forwarded for QIC and Board approval. **Q3 Summary:** **13 active cases and 22 new cases are being recommended for the group's next meeting; monthly ICP Notes are being added by CMH into CC360. Intro and Guidelines document has been updated; all CMHSPs have participated at the last meeting, which is a first-time accomplishment.** **Q4 Summary:** **CMH participation in the Care Integration workgroup varies, but across the current caseload of 10 ICPs, all are regularly involved, and new referrals being scheduled.** **Evaluation: Progress.** **Barrier Analysis: No Barriers.** **Next Steps: Continue Annual Workplan into next FY.** **Continue Objective(s)?** **☒ Yes ☐ No**
Home & Community Based Services	**The goals for 2019 Reporting are as follows:** • **Monitor network implementation of the Home and Community Based Services transition to ensure quality of clinical care and service.**	• **Monitor and advise on CMHSP network'' ongoing efforts to complete Home and Community-Based Services transition.**	**Tom Seilheimer** **Christy Koons** **Improving Practices Leadership Team (IPLT)**	**Goal Met:** **☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary: HCBS Informational page was put on Region 10 website. Moving forward with B survey beginning in 2019 and out of compliance letters should be mailed out early 2019. All CAPs for the C survey in all four counties should be**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update

Heightened Scrutiny Cases		
	HSW Non-Residential	HSW Residential
Genesee	32	140
Lapeer	5	17
Sanilac	0	22
St. Clair	1	11
PIHP Total	38	190

B3 Survey	Out of Compliance	Heightened Scrutiny Cases
GHS	102	71
Lapeer	139	9
Sanilac	12	7
St. Clair	20	11
PIHP Total	273	98

C Survey	Final CAP Approved	CMH Site Visits/Desk Audits	Final Approval/ Remaining
HSW Non-Residential			
Genesee	223	223	223/0
Lapeer	13	13	13/0
Sanilac	37	37	37/0
St. Clair	17	17	17/0
PIHP Total	290	290	290/0
HSW Residential			
Genesee	99	99	99/0
Lapeer	4	4	4/0
Sanilac	9	9	9/0
St. Clair	61	61	61/0
PIHP Total	173	173	173/0

complete early 2019. HS Site visits will begin early 2019 as well. Numbers have not changed since November.

Q2 Summary:
Region 10 has 100% of the non-residential CAPS complete and 100% of the residential CAPS complete for the C Survey. B Survey out of compliance letters will be sent out in June. Heightened Scrutiny cases for the C-Survey were emailed a notification and guidance was emailed on how to be removed from the list.

Q3 Summary: Region 10 reached 100% completion for C-Survey. Timeline for B-survey determined OOC letters to be all out by July 15, 2019. All CAPs to be completed by April 15, 2020. B-3 changing to I services, will fall under the HSW site review process going forward. MDHHS is continuing its work on Heightened Scrutiny validation. They have offered a webinar for HS CMH leads to help streamline the process. They are starting with a document review and then move to site review. Reviews will occur regionally. MI-DDI has updated its education outreach material. 100% of the out of compliance B-surveys letters have been sent out to providers. Providers have 30 days to respond with a corrective action plan. B survey Corrective Action Plans are starting to come in and are being reviewed. Once they are received by the PIHP we have 30

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				days to approve or disapprove them and notify the provider. **Q4 Summary:** **The validation process for Heightened Scrutiny cases for the B surveys is in place. The next round of surveys is scheduled for January. DDI will be sending out Full Comprehensive surveys for those providers who completed a Provisional survey through 7/31/19. Once the survey process is caught up MDHHS will assign this process to the PIHPs.** **Evaluation: Progress.** **Barrier Analysis: No Barriers.** **Next Steps: Continue Annual Workplan into next FY.** **Continue Objective(s)?** **☒ Yes ☐ No**
Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	**The goals for FY2019 Reporting are as follows:** • **To review and monitor the safety of clinical care.**	• **Review critical incidents to ensure adherence to data and reporting standards and to monitor for trends to improve system of care.** • **To provide sentinel event monitoring and analysis and ensure follow-up as necessary.**	**Tom Seilheimer** **Sentinel Event Review Committee**	**Goal Met:** **☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary:** **The two clinical advisories to be issued by the Medical Director have been completed; three sentinel events have been received from St. Clair CMHSP and have been reviewed as per compliance with policy timeframes, thus far no systems or compliance issues have been identified; the 4Q/EOY CI Report was reviewed and there were no systems issues identified.** **Q2 Summary:** **The 1Q CI Report was reviewed, with no network issues identified; a recommendation to further**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				evaluate a St. Clair trend is in-process. **The St. Clair SE case has been brought to appropriate closure; the current trend of Lapeer having as-yet no SEs reported has been assigned for follow-up to assess for and address any apparent systems reporting issues.** **PIHP contracts with CMH/SUD Treatment Providers were updated to align with PIHP policies.** **Q3 Summary:** **SE received from Lapeer was reviewed and noted as not meeting criteria per its payer status; Chair will review this finding with Lapeer as part of the follow up SE training to take place 5/10/19. One SE received from St. Clair; all reporting tasks and time frames are in compliance; continue monthly monitoring.** **CMHSP Mid-Year Mortality Reports were reviewed, with no systems issues identified; the follow-up SE and Mortality Report training at Lapeer CMHSP was completed by the SERC Chair.** **One sentinel event reported from St. Clair was monitored and brought to closure, with RCA activities completed and systems improvement activities ongoing.** **Q4 Summary:** **Trends are being monitored, with no immediate issues noted; the Medical Director is conducting outreach with the CMHs to further assess and encourage Narcan training across residential service systems; 3Q CI report discussed and identified no systems or**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				provider issues. No Sentinel Events have been reported for review. **Evaluation: Progress.** **Barrier Analysis: No Barriers.** **Next Steps:** **Continue Annual Workplan in next FY, with an additional objective for monitoring unexpected deaths review process.** **Continue Objective(s)?** **☒ Yes ☐ No**
Employment Services	**The goals for FY2019 Reporting are as follows:** • **To monitor and advise on Employment Services activities as the CMHSPs**	• **Encourage and support CMHSP progressive employment services practices.** • **Develop and pursue employment targets pertaining to competitive employment (community-based) and compensation (minimum wage or higher).** • **Utilize standardized employment services data and report formats.** • **Provide share and learn opportunities as such may pertain to employment targets and collaborative**	**Tom Seilheimer** **Employment Services Committee**	**Goal Met:** **☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary:** **November ESC identified CMHSP employment baselines and targets; supported Charting the Life Course training and discussed MRS/CMH collaborative field successes; discussed a share and learn for the January meeting regarding St. Clair's IPS 1Q report/format.** **Q2 Summary:** **GHS has begun contract discussions with its employment services providers to begin community-based employment options.** **Lapeer and St. Clair have implemented employment targets, Sanilac is still finalizing baselines. All members have received the International IPS quarterly reporting shell documents, sent by St. Clair; Sanilac and Lapeer have adapted the documents to their local purposes. All members have**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
		practices. e.g. MRS.		**expressed interest in pursuing local opportunities to utilize the 'Charting the Life-Course' care management manual in connection to promoting community-based employment readiness; all members have discussed their various challenges and successes in dealing with their local MRS offices.** **Q3 Summary:** **GHS has entered a contract with Peckham, Inc. a progressive community-based job search / job support organization for persons with I/DD; this will expand their service options beyond sheltered employment.** **Sanilac has not yet completed its targets; will follow up at the next ESC meeting. Share and learn discussions and documents distribution have been accomplished per the prior meeting.** **Lapeer success stories in working with MRS have been shared; noting the value of embedding MRS staff and developing a strong relationship to encourage MRS taking a stronger Recovery focus in its vocational rehabilitation model.** **Reviewed and discussed ESC's documents and recommendations on the Charting the Life Course curriculum; also engaged in share-and-learn discussions of case successes in transition from sheltered to community-based employment.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				No updates on report formats, as this has been thoroughly discussed at prior meetings. **Q4 Summary:** **Employment-related webinars and conference information has been shared among members; some members are scheduled to attend the IPS Summit and the Employment First Conference.** **CMH employment baselines and targets have been completed, with progress reported.** **Share-and-learn discussions continue regarding promotion of community-based employment opportunities.** **Partnered activities with MRS offices.** **Evaluation: Progress.** **Barrier Analysis: No Barriers.** **Next Steps: Continue Annual Workplan into next FY.** **Continue Objective(s)?** **☒ Yes ☐ No**
Michigan Mission Based Performance Indicator System (MMBPIS)	**The goals for FY2019 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** • **Provide status updates to relevant committees such as QMC, PIHP CEO, PIHP Board** • **Review quarterly**	**Pattie Hayes / Lauren Bondy** **QI Department** **Quality Management Committee (QMC)**	**Goal Met:** **☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary:** **Performance Indicators for FY18 Q4 were submitted to MDHHS on 12/26/18. The PIHP met the set performance standards for every PI. Lapeer CMH did not meet the standard for PI 2 – DD Adults. Sanilac CMH did not meet the standard for PI 3 – DD Children,**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update

	FY18 Q4	FY19 Q1	FY19 Q2	FY19 Q3
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%				
1.1 Children	100%	99.75%	99.48%	100%
1.2 Adults	99.83%	99.91%	99.65%	99.91%
Ind. 2 – Percentage of new persons receiving a face-to-face assessment with a professional within 14 calendar days of non-emergency request for service. Standard = 95%				
2 PIHP Total	99.61%	99.20%	98.51%	98.99%
2.1 MI-Children	99.59%	100%	99.48%	99.15%
2.2 MI-Adults	100%	99.78%	99.60%	100%
2.3 DD-Children	98.91%	99.04%	100%	99.24%
2.4 DD-Adults	96.15%	100%	98.04%	100%
2.5 SUD	99.68%	98.59%	97.46%	98.40%
Ind. 3 – Percentage of new persons starting any needed on-going service within 14 days of non-emergent face-to-face assessment with professional. Standard = 95%				
3 PIHP Total	98.68%	98.85%	97.53%	99.00%
3.1 MI-Children	99.55%	99.58%	97.44%	98.39%
3.2 MI-Adults	98.66%	99.37%	99.80%	99.58%
3.3 DD- Children	97.09%	99.08%	99.23%	100%
3.4 DD-Adults	100%	100%	98.25%	100%
3.5 SUD	98.56%	98.20%	95.74%	98.61%
Ind. 4 – Percentage of discharges from psychiatric inpatient unit / SUD Detox unit that were seen for follow-up care within 7 days. Standard = 95%				
4a.1 Children	100%	100%	100%	97.89%
4a.2 Adults	98.80%	96.73%	98.90%	99.42%
4b SUD	100%	100%	100%	96.43%
Ind. 10 – Percentage of readmissions of children and adults to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less				
10.1 Children	10.10%	15.11%	11.85%	11.03%
10.2 Adults	10.66%	9.58%	10.94%	10.91%

MMBPIS data

PI 10 – Children and Adults. St. Clair CMH did not meet the standard for PI 3 – MI Adults and DD Children. Corrective Action Plans have been received.

Q2 Summary:
Performance Indicators for FY19 Q1 were submitted to MDHHS on 3/28/19. The PIHP met the set performance standards for all PIs except PI 10. GHS did not meet the standard for PI 10 – Children. Lapeer CMH did not meet the standard for PI 2 – DD Children, PI 3 – MI Children and DD Children, and PI 4 – Adults. Corrective action plans have been received and reviewed.

Q3 Summary:
Performance Indicators for FY19 Q2 were submitted to MDHHS on 6/27/19. The PIHP met the set performance standards for all PIs. Lapeer CMH did not meet the standard for PI 2 – DD Adults, PI 3 – DD Adults, and PI 10 – Children. Sanilac CMH did not meet the standard for PI 3 – MI Children and PI 4 – Adults. St. Clair CMH did not meet the standard for PI 10 – Children. Corrective action plans have been received and reviewed.

Q4 Summary:
Performance Indicators for FY19 Q3 were submitted to MDHHS on 9/26/19. The PIHP met the set performance standards for all PIs. Sanilac CMH did not meet the standard for PI #4 – Adults. Corrective action plans have been received and reviewed.

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				Evaluation: Progress. **Barrier Analysis: No barriers.** **Next Steps: Continue with Annual Plan.** **Continue Objective(s)?** **☒ Yes ☐ No**
Members' Experience	**The goals for FY2019 Reporting are as follows:** • **Complete the member satisfaction survey by August 2019.**	• **Conduct regional consumer satisfaction survey** • **Conduct MDHHS annual consumer satisfaction survey** • **Develop interventions to address areas for improvement based on FY2019-member satisfaction survey**	**Pattie Hayes/Christy Koons QI Department** **Quality Management Committee (QMC)**	**Goal Met:** **☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary:** **The regional consumer satisfaction survey is conducted annually during the summer. As the administration date nears, work on this task will begin.** **Q2 Summary:** **QMC has agreed to add questions on accessibility, availability, quality of care, and an overall satisfaction question to the surveys to better align with EQR requirements.** **Survey is updated with new questions; CMHs agreed to conduct the survey earlier this year, with all data to be sent to PIHP by July 31st. All populations will be surveyed.** **Q3 Summary:** **Data template for the 2019 regional survey has been sent out to the CMHs along with the survey questions. The data is due back to the PIHP by July 31st. SUD survey was opened on April 15th and will close May 3rd. Data will be due on May 17th. SUD customer satisfaction survey was completed with over 600 responses to the 3**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				open ended questions and a total of 685 surveys taken. The CMHs are working on their customer satisfaction surveys and will have the results to the PIHP by July 31st. In June St. Clair had 263 surveys completed, GHS has mailed out there 100 random survey's and is waiting for them to return, all others were completed. Lapeer is complete and will pull the report and will have it to the PIHP by the deadline. Sanilac is still conducting their survey's but will have the report by the deadline. **Q4 Summary:** **Annual Customer Satisfaction Survey was completed, and report is in development. QMC discussed survey results and other findings at length in September. The RSA survey will be conducted during the month of October in the region. No MDHHS survey was conducted in FY2019.** **Evaluation: Progress.** **Barrier Analysis: No barriers.** **Next Steps: Continue with Annual Plan.** **Continue Objective(s)?** **☒ Yes ☐ No**
State Mandated Performance Improvement Projects	**The goals for FY2019 Reporting are as follows:** • **Identify 2 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 adult consumers with schizophrenia or bipolar disorder who are taking an antipsychotic medication are receiving necessary and relevant diabetes screenings (specifically glucose or HbA1c**	• **HSAG report on PIP interventions and baseline** • **PIP Status updates to Quality Management Committee** • **QMC to consider selection of PIP**	**Tom Seilheimer** **Quality Management Committee (QMC)**	**Goal Met: ☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary:** **PIP 1 pre-baseline activities have been completed and shared to help align actual, annual baseline activities due in January; also completed share and learn activities regarding RCA and barrier analysis; PIP 2 data**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
	screenings) related to mental health medicines prescribed. This study topic aligns with the HEDIS measure "Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications."	**projects aimed at impacting error reduction, improving safety and quality**		**development is still in process.** **Q2 Summary:** **PIP 1 baseline analysis has been completed; continued share and learn activities regarding RCA and barrier analysis; all CMHSPs report they are working on their root cause and barrier analyses; in April the CCO will develop and distribute a standardized task/activity tracking tool, especially to ensure that tracking takes place regarding the implementation of systems improvement activities. PIP 2 data development has been completed and a provisional report has been generated.** **Q3 Summary:** **PIP 1 structured monthly reporting has been implemented, including improvement activities; required CMHSP PIP documents have been requested, in preparation for the July HSAG validation summary report. PIP 2 data analysis pertaining to its timeframe sampled data has been completed, and it was recommended that this data base may be used for its measurement-four analyses.** **Q4 Summary:** **PIP 1 HSAG validation summary report was submitted 7/08/19. Preliminary results from HSAG were shared with QMC. Discussion occurred regarding additional information needed from each CMH for the resubmission of PIP #1 to HSAG on 8/26. Discussed changes to PIP**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				#1 final report which was submitted to HSAG in August. PIP 2 data analysis pertaining to its timeframe sampled data has been completed, an updated report is pending, as CMHs continue with their CY 2019 improvement action plans. Data analysis conducted in September reveals that PIP #2 is approaching completion. In the next fiscal year, the group will discuss other PIP topics for focused review. **Evaluation: Progress.** **Barrier Analysis: No Barriers.** **Next Steps: Continue with Annual Workplan.** **Continue Objective(s)?** **☒ Yes ☐ No**
External Monitoring Reviews	**The goals for FY2019 Reporting are as follows:** • **To monitor and address activities pertaining to the PIHP HSW Program:** **a) Q.2.3. (ensure non-licensed, non-verified providers meet required qualification)** **b) Q.2.4. (ensure support and service providers receive required training)**	• **QMC members will follow up and report monthly on each CMHSPs follow up activities to ensure compliance with the MDHHS HSW requirements**	**Pattie Hayes Quality Management Committee (QMC)**	**Goal Met:** **☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary:** **CMHs are continuing to monitor all areas.** **Q2 Summary:** **CMHs are continuing to monitor all areas.** **The group discussed the need for additional HSW enrollment packets for the region and barriers CMHs experience in enrolling persons in HSW. All CMHs have stated that there are potential cases that can be enrolled into the HSW program; enrollment packets are being prepared to submit to PIHP.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				Q3 Summary: **CMHs are monitoring all areas. HSW numbers are as follows: 96.8% are complete there are 4 pending and 1 is waiting for more information, once those are approved the region will be at 97.5%As of May HSW, numbers are as follows: There are 641 enrollees and 3 applications are pending. This will put the Region at 98% slot utilization. The FY 20 program changes were discussed at the June meeting with all 4 CMH's.** **Q4 Summary:** **CMHs continue to report on their providers' ongoing activities to ensure compliance with HSW standards. The new HSW process is working well; annual RLA validation has been completed.** **Evaluation: Progress.** **Barrier Analysis: No barriers.** **Next Steps: Continue with Annual Plan.** **Continue Objective(s)?** **☒ Yes ☐ No**
Monitoring of Quality Areas	**The goals for FY2019 Reporting are as follows:** • **To explore and promote quality and data practices within the region.**	• **Monitor critical incidents** • **Monitor emerging quality and data initiative / issues and requirements** • **Monitor and address implementation of the Bonus System Performance**	**Pattie Hayes** **Quality Management Committee (QMC)**	**Goal Met: ☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary:** **Monthly critical incident reports were reviewed and discussed throughout the quarter. Emerging quality and data initiative/issues were reviewed and discussed. Performance Bonus reporting was discussed, and more information will be provided in Quarter 2.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
		Indicators		**Q2 Summary:** **HRA - Reminder to not change the NPI # from what the hospital submits on the claim. In the recent HRA payments, there were no erroneous NPI numbers found.** **G & A changes in EHR - Grievance and Appeals letters and changes were deployed in the MIX system.** **Codes - ABA code changes were discussed; all CMHs have updated their ABA codes accordingly.** **PIHP Contract Performance Metrics were reviewed / discussed.** **FUH was discussed;** **the most current discharge information is best for the performance bonus.** **Q3 Summary:** **Place of service (POS) was discussed and stressed that the code 21 be used for hospital discharge instead of code 99 as this code could mean the service took place anywhere. Follow-up on hospital discharge is an ongoing issue. Overnight services will be a new service provided in FY20. It is needed for safety reasons. MDHHS has requested an estimate of the number of people that may use the service. No issues for the end of Quarter 3. The PIHP was 100% for FY18 with no missing data.** **Q4 Summary:** **Electronic Visit Verification (EVV) update from CIO Forum was provided; CMHs were asked to survey their provider networks re: who currently uses an EVV system. Discussed MSA 19-20 (Enrollment Requirement for Prescribers) and**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				implications for networks. BH-TEDS reports continue to be provided; training on BH-TEDS was provided in September. 6-month MUNC report process was discussed. Discussed rounding rules changes to be issued by MDHHS 10/1/19. **Evaluation: Progress.** **Barrier Analysis: No barriers.** **Next Steps: Continue with Annual Plan.** **Continue Objective(s)?** **☒ Yes ☐ No**
Financial Management	**The goals for FY2019 Reporting are as follows to promote sound fiscal management of the region:** • **New Funding allocation methodology.**	• **Run parallel payment reports with new funding allocation methodology by 1/1/19**	**Richard Carpenter** **Finance Committee**	**Goal Met:** **☐ Yes ☒ No** **Quarterly Update:** **Q1 Summary:** **Risk Factors have been received and imported into MIX for parallel processing for Medicaid.** **Q2 Summary:** **Due to Audit preparation and completion required in March, no progress this month. No significant Progress this quarter due to year end and audit proprieties. Focus will shift back to goal in Q3.** **Q3 Summary: Discussion with MIX vendor initiated in April. In May the Region was still waiting on a update from MIX vendor on reports.** **Q4 Summary:** **No progress, waiting on MIX vendor to finalize report needed for funding allocation.** **Evaluation: Progress was made in**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				determining report needed and tech request submitted for report development. **Barrier Analysis: The barrier has been having the necessary report programmed into MIX; this is in progress with completion date tentatively scheduled for the next month. The goal is continued into FY20.** **Next Steps: Continue with annual plan.** **Continue Objective(s)?** **☒ Yes ☐ No**
Financial Management	**The goals for FY2019 Reporting are as follows to promote sound fiscal management of the region:** • **Risk-based payment methodology.**	• **Transition to risk-based payment methodology effective by 4/1/19**	**Richard Carpenter** **Finance Committee**	**Goal Met:** **☐ Yes ☒ No** **Quarterly Update:** **Q1 Summary:** **On Hold until parallel process is evaluated.** **Q2 Summary:** **No significant Progress this quarter due to year end and audit proprieties. Focus will shift back to goal in Q3.** **Q3 Summary:** **April and May on Hold until parallel process is evaluated.** **Q4 Summary:** **No progress until parallel process evaluated.** **Evaluation: This activity is on hold pending report development for funding allocation (see previous goal).** **Barrier Analysis: The barrier has been having the necessary report programmed into MIX; this is in progress with completion date**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				tentatively scheduled for the next month. The goal is continued into FY20. **Next Steps: Continue with annual plan.** **Continue Objective(s)?** **☒ Yes ☐ No**
Financial Management	**The goals for FY2019 Reporting are as follows to promote sound fiscal management of the region:** • **Target Rates for service codes**	• **Develop target service code rates for 5 service codes in each of the PIHP's funding streams (SPB3, HSW, HMP by 10/1/19**	**Richard Carpenter** **Finance Committee**	**Goal Met:** **☐ Yes ☒ No** **Quarterly Update:** **Q1 Summary:** **Focused discussion on Autism Rates and MDHHS rate caps. In discussions with CMHSP CFOs about regional rate cap** **Q2 Summary: No significant Progress this quarter due to year end and audit proprieties. Focus will shift back to goal in Q3.** **Q3 Summary:** **Referred to QAPIP Oversight for Autism Regional Rate Cap. No New update in May.** **Q4 Summary:** **Received FY18 data from MDHHS to start analyzing in August/September.** **Evaluation: Some progress was made.** **Barrier Analysis: The timing of rates (received in Q4) from State of Michigan as well as prioritizing other budget-related issues impacted achievement of this goal. It is continued into FY20.** **Next Steps: Continue with annual plan.** **Continue Objective(s)?** **☒ Yes ☐ No**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
Utilization Management	• **Ensure that monthly regional service utilization reports are generated (10/1/18 – 9/30/19).**	• **Monitor and advise on regional service utilization reports including new services implementation** • **Crisis Services, including psychiatric inpatient** • **Other community-based services (quarterly outlier-based CMHSP utilization review reports.**	**Tom Seilheimer** **Utilization Management (UM) Committee**	**Goal Met: ☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary:** **Monthly mobile intensive crisis stabilization services reports generated by GHS and St. Clair are being reviewed; Sanilac and Lapeer will confer with St. Clair regarding report capability; Sanilac now has service capacity but do not yet have service volume as yet to populate the monthly reports; Lapeer is still dealing with services capacity issues. All CMHSPs have been apprised of the six-month reporting due in January.** **Monthly crisis services reports were reviewed, with no services systems issues noted. No systems or utilization issues have been identified.** **Community-based UR reports were reviewed, with no service systems or utilization issues identified.** **Q2 Summary:** **Continuing to monitor CMHSP UM reporting on youth Mobile Crisis Unit (MCU); Lapeer reports progress on resolving its youth MCU staff capacity issues.** **Monthly reports reviewed; no recommendations.** **Quarterly reports reviewed; no recommendations.** **Q3 Summary:** **Crisis services reports reviewed revealed no significant or concerning trends. Continued UM**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				monitoring and contract management monitoring of Lapeer's ICSS implementation POC is taking place; monthly updates are being provided through UMC and as of June Lapeer is providing services and reports. **Quarterly delegated UR activities and reporting were submitted by GHS and Lapeer; Sanilac and St. Clair were not able to report as scheduled and were placed on the July agenda.** **Q4 Summary:** **Monitoring Lapeer's ICSS implementation has continued and has identified service activity and reporting processes in place; will now monitor per regular monthly crisis services reporting** **Crisis services reports reviewed revealed no significant or concerning trend; however, discussion of ICSS utilization noted fluctuations in service demand across all CMHs; reasons for potential under-utilization were also discussed along with methods to minimize this risk.** **Quarterly delegated UR activities and reporting were submitted and discussed, noting no significant systems or service delivery issues** **Evaluation: Progress.** **Barrier Analysis: No Barriers.** **Next Steps: Continue Annual Workplan into next FY.** **Continue Objective(s)?** **☒ Yes ☐ No**
Utilization	• **Provide periodic oversight on the use of restrictive and intrusive**	• **Monitor and**	**Tom**	**Goal Met: ☒ Yes ☐ No**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
Management	**behavioral techniques, physical management or contact with law enforcement use on an emergency basis.**	**advise on BTPRC data on use of Restrictive and Intrusive techniques, physical management or contact with law enforcement us on an emergency basis.** • **Evaluate reports per committee review / discussion of findings, trends, potential systems improvement opportunities, adherence to standards**	**Seilheimer** **Utilization Management (UM) Committee**	**Quarterly Update:** **Q1 Summary:** **All CMHSP reports indicate relatively low rates of restrictive technique utilization and use of emergency Physical Management.** **Q2 Summary:** **Quarterly reports reviewed in February with no issues identified to be addressed.** **Q3 Summary:** **Quarterly reports received and reviewed, with no systems issues identified.** **Q4 Summary:** **CMHs presented their reports, noting no systems or service issues Committee discussion also covered potential areas of concern: St. Clair is monitoring the IPOS of one person who had two PM events; GHS identified four PM events that were further assessed to be isolated and resolved; Lapeer is closely monitoring one behavioral individual at his residential placement; Sanilac is closely monitoring one case where retrogression was recently evident in that person's RT behavior plan.** **Evaluation: Progress.** **Barrier Analysis: No Barriers.** **Next Steps: Continue Annual Workplan into next FY.** **Continue Objective(s)?** **☒ Yes ☐ No**
Utilization Management	• **Conduct Utilization Review (per revisions contingent upon the completion of the UM Redesign Work Group)**	• **SUD site review audits per SUD UR Schedule, and outlier-**	**Tom Seilheimer** **Utilization**	**Goal Met:** **☒ Yes ☐ No** **Quarterly Update:**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
		based case record selection methodology. • Targeted case record review of community-based services per CMHSP delegation agreements. • Explore feasible opportunities for additional outlier-based UR (linked to high-cost and / or high-risk)	Management (UM) Committee	**Q1 Summary:** The UMC SUD subcommittee has developed the SUD UR case record selection method (random selection of MAT cases) and contingent UR schedule. No CMHSP delegation issues have been received by UMC regarding the need for targeted UR during 1Q. Opportunities for additional outlier-based UR (linked to high-cost and / or high-risk) are being discussed as-needed, with no specific recommendations as yet emerging. **Q2 Summary:** SUD UR form is completed; in process of finalizing the UR review schedule, to begin in April. Quarterly reports were reviewed in March, with no service utilization issues noted, and applicable per-case POCs addressed. No CMHSP delegation issues have been received by UMC regarding the need for targeted UR during 2Q. **Q3 Summary:** SUD UR has been progressing as scheduled and will be completed by August. Findings have been favorable and applicable POCs have been completed and received. launched; program schedule will be monitored in connection the DM claims verification review schedule, to minimize review burden onto programs. No major service system or delivery issues have been identified. **Q4 Summary:**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				SUD UR is completed; EOY report in-process. GHS and Sanilac identified marginal service utilization issues, all of which have been addressed in terms of per-case POCs; no service systems issues identified; St. Clair and Lapeer did not submit their reports as scheduled but will submit at the October UMC. **The SUD EOY report will help inform current plans to develop a statistically based outlier case review selection method.** **Evaluation: Progress.** **Barrier Analysis: No Barriers.** **Next Steps: Continue Annual Workplan into next FY.** **Continue Objective(s)?** **☒ Yes ☐ No**
Utilization Management	• **Promote aligned care management activities across key areas of network operations.**	• **Promote aligned care management activities across key areas of network operations a) Access Management System access sites, b) Service Authorization Guidelines Continuum of Care pilot project.**	**Tom Seilheimer** **Utilization Management (UM) Committee**	**Goal Met:** **☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary:** **Access Management System End of Year report was reviewed at the November meeting; UMC discussion noted the achievements in meeting the continued marginal increases in service volume and in meeting customer services performance indicators; it also endorsed ongoing activities regarding operational alignments between the two Access sites. Service Authorization Guidelines Continuum of Care draft documents are being developed in preparation for the March UM pilot.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				Q2 Summary: **No new activities to report regarding Access operations, as per pending Mid-Year Report; extensive work is now taking place for Pilot Project implementation scheduled for May - July.** **Q3 Summary:** **AMS M-Y Report was presented and discussed; no systems issues identified; improvement opportunities regarding recommended aligned program disruption protocols were supported.** **Ongoing monthly updates on the Pilot Project have taken place; Pilot trainings and webinars have been completed; Pilot activities and communications systems have commenced.** **Q4 Summary:** **Pending EOY reporting cycle; report scheduled for the November UMC.** **Evaluation: Progress.** **Barrier Analysis: No Barriers.** **Next Steps: Continue Annual Workplan into next FY.** **Continue Objective(s)?** **☒ Yes ☐ No**
Corporate Compliance	• **Compliance with 42 CFR 438.608 Program Integrity requirements. 9/30/19**	• **Review requirements** • **Identify and document responsible entities.** • **Identify and document supporting evidence / practice.**	**Kristen Potthoff** **Corporate Compliance Committee**	**Goal Met:** **☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary:** **Ongoing work in the areas of planning, policy, process, monitoring and program evaluation.** **Facilitated first tri-annual meeting**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
		• Ongoing policy review • Review PIHP plan updates. • Make recommendations on updates (e.g. policy, contract language, etc..).		with CMH Compliance Officers. Celebrated National Compliance & Ethics Week. Began process of sending quarterly communications to all PIHP staff and Provider Network from "Compliance Office" on related educational topic areas / reminders. Completed PIHP Annual Report and presented to Regulatory Compliance Committee. Q2 Summary: PIHP Code of Conduct finalized and made available on PIHP website. Reviewed PIHP Corporate Compliance Program Policy and made revision recommendations (currently out for Provider and PIHP staff review). Held 2nd Tri-Annual CMH Compliance Officers meeting. Q3 Summary: PIHP Corporate Compliance Program Policy revised and posted on PIHP website. Q4 Summary: FY20 PIHP Corporate Compliance Plan reviewed and approved. August: Held 3rd Tri-Annual CMH Compliance Officers meeting. Review and approval of FY20 Committee Goals. Reviewed updated policies: HIPAA Privacy & Security Measures, HIPAA Privacy Measures – Protected Health Information and new policy: HIPAA Breach Notification. Evaluation: Progress. Barrier Analysis: No Barriers. Next Steps: Continue Annual

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				Workplan. **Continue Objective(s)?** ☒ **Yes** ☐ **No**
Corporate Compliance	• **Support reporting requirements (quarterly and ongoing) as defined by MDHHS, OIG, PIHP, etc. 9/30/19**	• **Ongoing review of reporting process**	**Kristen Potthoff** **Corporate Compliance Committee**	**Goal Met:** ☒ **Yes** ☐ **No** **Quarterly Update:** **Q1 Summary:** **Continued work with CMH and SUD Treatment Providers on reporting content. Continued work with OIG on reporting requirements clarification. Submitted first OIG quarterly report (November). Began draft PIHP guidance document.** **Q2 Summary: Continued work with OIG and Network Providers on completion of required reports. Submission of 1Q PIHP Program Integrity Report. Continued work on PIHP guidance document.** **Q3 Summary: Submission of 2Q PIHP Program Integrity Report. Continued work with the OIG and PIHP Provider Network on guidance documents.** **Q4 Summary:** **Continued work with the OIG and PIHP Provider Network on guidance documents.** **Submission of 3Q PIHP Program Integrity Report. Internal discussions regarding data mining requirements.** **Evaluation: Progress.** **Barrier Analysis: No Barriers.** **Next Steps: Continue with Annual Workplan.** **Continue Objective(s)?** ☒ **Yes** ☐ **No**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
Corporate Compliance	• **Review regional Corporate Compliance monitoring standards, reports and outcomes. 9/30/19**	• **Review Contract Monitoring results.**	**Kristen Potthoff** **Corporate Compliance Committee**	**Goal Met:** **☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary:** **Annual FY18 PIHP Corporate Compliance Report reviewed and approved. Reviewed Annual FY18 PIHP Contract Monitoring Summary.** **Q2 Summary: 1Q PIHP Contract Monitoring summary completed – no trends or significant concerns noted. 2Q PIHP Contract Monitoring in process.** **Q3 Summary: 2Q and Annual PIHP Contract Monitoring in process. No trends noted.** **Q4 Summary:** **2Q Contract Monitoring complete. No trends noted. Discussion regarding CMH summary reviews of Provider Network compliance in this area. Completed PIHP Compliance Awareness Survey.** **Evaluation: Progress** **Barrier Analysis: No Barriers** **Next Steps: Continue with Annual Workplan.** **Continue Objective(s)?** **☒ Yes ☐ No**
Provider Network	• **Address service capacity concerns and ensure resolution of identified gaps in the network based on Gap Analysis Reports.**	• **Review definition of network gap** • **Review CMH Gap Analysis Reports** • **Review SUD Network gaps** • **Review contract**	**Amanda Zabor** **Provider Network Committee**	**Goal Met:** **☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary:** **Discussion regarding ongoing Autism service concerns and SUD identified service gaps.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
		monitoring results • **Address cultural and linguistic needs of members** • **Review service capacity concerns identified (e.g. Autism, Mobile Intensive Crisis Stabilization)**		**Implemented review process for Service Capacity reporting requirement of CMHs.** **Q2 Summary:** **Continued review of CMH Service Capacity Reporting. PIHP Semi-Annual Report Submission to MDHHS on Mobile Children's Intensive Crisis Stabilization Services (ICSS) Report. Began review process for regional service gap definition. Discussion regarding ongoing Autism service concerns. 1Q PIHP Contract Monitoring completed – trends noted regarding insufficient information posted on CMH Provider Directories. CMH Plans of Correction in this area currently pending review.** **Q3 Summary:** **Continued review of CMH Service Capacity Reporting. Enhanced PIHP monitoring for Lapeer CMH ICSS Program. 2Q PIHP Contract Monitoring completed for CMH Providers. 2Q SUD Monitoring is almost complete. Work continues on the update of CMH Provider Directories to bring into compliance. CMH Plans of Correction regarding insufficiencies have been approved by the PIHP, with updates being requested when the PIHP conducts annual onsite monitoring this summer. Autism concerns are ongoing with some improvement noted with Lapeer CMH.** **June: After review of the Code of Federal Regulations, The PIHP has updated its Coordination of Care policy to enhance and strengthen**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				the language and has required the PIHP Provider Network to review and enhance their policies as well. This has been an area of discussion during annual onsite monitoring visits with the Provider Network, with revised provider policies being submitted to the PIHP for review. Annual onsite reviews continue with the Provider Network with general positive feedback received from the Providers regarding PIHP staff responsiveness and helpfulness. **Q4 Summary:** **Work continues on the update of CMH Provider Directories to bring into compliance. PIHP staff are working directly with 2 CMH Providers to improve Autism gaps, including weekly phone calls between PIHP Autism staff and CMH Autism staff. Mobile ICSS for Children reports are due to MDHHS on October 15, and Lapeer CMH has demonstrated much improvement in this area. The PIHP Provider Network Committee has established a region-wide definition for service gap.** **FY20 Goals were reviewed and approved by the Committee.** **Evaluation: Progress** **Barrier Analysis: No Barriers** **Next Steps: Continue with Annual Workplan.** **Continue Objective(s)?** **☒ Yes ☐ No**
Provider Network	• **Review Network Adequacy requirements and address compliance with standards.**	• **Review MDHHS standards and current Network**	**Amanda Zabor**	**Goal Met:** **☒ Yes ☐ No**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
		Adequacy • **Address Network Adequacy concerns**	**Provider Network Committee**	**Quarterly Update:** **Q1 Summary:** **Shared information received from MDHHS regarding standards and development. Requested feedback from CMH Providers on Network Adequacy identified programs. Submitted PIHP proposal to MDHHS on meeting standards.** **Q2 Summary: No update.** **Q3 Summary: We have not received any information from MDHHS; therefore, there is no update.** **Q4: Summary:** **The PIHP has received notification from MDHHS that they have reviewed the PIHP's proposed plan to implement Network Adequacy Standards and acknowledged that Region 10 PIHP has fulfilled the MDHHS expectation to submit a plan to effectuate the Network Adequacy Standards. MDHHS will monitor and assess progress towards meeting the standard with standards being analyzed for continuous quality improvement. Benchmarks will be recalibrated as needed with data justification.** **Evaluation: Progress.** **Barrier Analysis: No Barriers** **Next Steps: Continue with Annual Workplan.** **Continue Objective(s)?** **☒ Yes☐ No**
Provider Network	• **Ensure Provider Directories are updated monthly and provide MDHHS – required information for individuals served.**	• **Review MDHHS requirements** • **Address**	**Amanda Zabor Provider**	**Goal Met:** **☒ Yes ☐ No**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
		opportunities for reporting efficiency and effectiveness	**Network Committee**	**Quarterly Update:** **Q1 Summary:** **Discussed HSAG audit (of PIHP) results. Met with CMH Providers.** **Q2 Summary:** **Finalized HSAG CAP regarding PIHP Directory Updates and Provider Network monitoring. PIHP Directory updated and posted on PIHP website. Directory online posting machine-readable format clarification sent to CMH Network Providers and discussed. 1Q PIHP Contract Monitoring completed – trends noted regarding insufficient information posted on CMH Provider Directories. CMH Plans of Correction in this area currently pending review.** **Q3 Summary:** **Work continues on the update of CMH Provider Directories to bring into compliance. CMH Plans of Correction regarding insufficiencies have been approved by the PIHP, with updates being requested when the PIHP conducts annual onsite monitoring this summer.** **Q4: Summary:** **Work continues on the update of CMH Provider Directories to bring into compliance. The Region 10 PIHP Network Directory is also being updated monthly with appropriate checks taking place in areas of machine-readable format and Section 508 guidelines.** **Evaluation: Progress.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				Barrier Analysis: No Barriers. **Next Steps: Continue with Annual Workplan.** **Continue Objective(s)?** **☒ Yes☐ No**
Provider Network	• **Review most recent FY PIHP Contract Monitoring Results.**	• **Review FY Contract Monitoring Aggregate Report** • **Discuss trends and improvement opportunities**	**Amanda Zabor** **Provider Network Committee**	**Goal Met:** **☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary:** **Reviewed Annual Contract Monitoring Report for FY2018. Contract Monitoring Presentation reviewed at Board Retreat. Domain areas of continued compliance reviewed and incorporated into monitoring. Deemed status request from CMH Providers reviewed.** **Q2 Summary:** **Deemed status review complete and implemented for Annual Monitoring. 1Q PIHP Contract Monitoring completed with Plans of Correction currently pending review. 2Q PIHP Contract Monitoring tools developed. Annual PIHP Contract Monitoring tools developed and Network Provider on-site review schedule completed.** **Q3 Summary:** **2Q Contract Monitoring in process. 2Q Contract Monitoring with Plans of Correction for CMH Providers has been completed. 2Q SUD Monitoring and Plans of Correction are almost complete. Trends noted include weak language in provider policies as it relates to coordination of care.**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				PIHP staff are working with Provider staff to enhance language. Annual Onsite Contract Monitoring visits have begun and will be completed by August 6. June: Coordination of Care continues to be an area of discussion during annual onsite monitoring visits with the Provider Network, with revised provider policies being submitted to the PIHP for review. Annual onsite reviews continue with the Provider Network with general positive feedback received from the Providers regarding PIHP staff responsiveness and helpfulness. **Q4 Summary:** **Trends in non-compliance for CMH Providers include the Domains of Quality Improvement, Provider Network, Performance Measurement, and Customer Service.** **QUALITY IMPROVEMENT:** **Throughout FY19, while all CMH Providers are submitting the majority of HSW recertifications in a timely manner, 3 of the 4 CMH Providers are submitting some recertifications less than 14 days prior to recertification date.** **PROVIDER NETWORK:** **For Autism services, the number of eligible cases without a plan of service in WSA within 90 days of the eligibility date has dropped overall. However, it remains a concern for all 4 CMH Providers.** **PERFORMANCE MEASUREMENT:** **Throughout FY19, 3 of the 4 CMH**

<table>
<tr><th>Component</th><th>Goals/Timeframe/Analysis</th><th>Planned Activities</th><th>Responsible Staff/ Department</th><th>Status Update</th></tr>
<tr><td></td><td></td><td></td><td></td><td>Providers missed some quarterly performance indicator standards as set by MDHHS.

CUSTOMER SERVICE:
All 4 CMH Providers are working to bring their provider websites into compliance, which includes converting their websites and all documentation into a machine-readable file and format and improving their Provider Directories.

Evaluation: Progress.
Barrier Analysis: No Barriers
Next Steps: Continue with Annual Workplan.
Continue Objective(s)?
☒ Yes ☐ No</td></tr>
<tr><td>Grievances</td><td>• To review and analyze baseline grievance data for the region for FY2019.

<table><tr><th colspan="6">Reporting Period: FY2019</th></tr><tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th>Total</th></tr><tr><td>GHS</td><td>15</td><td>29</td><td>15</td><td>11</td><td>70</td></tr><tr><td>Lapeer</td><td>2</td><td>0</td><td>0</td><td>0</td><td>2</td></tr><tr><td>St. Clair</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>0</td><td>0</td><td>0</td></tr><tr><td>SUD / R10</td><td>2</td><td>3</td><td>2</td><td>1</td><td>8</td></tr><tr><td>TOTAL</td><td>19</td><td>32</td><td>17</td><td>12</td><td>80</td></tr><tr><th colspan="5">Most Common Grievance Subject/Topics:</th><th>Total</th></tr><tr><td colspan="5">Quality of Care</td><td>27</td></tr><tr><td colspan="5">Service Concerns/Availability</td><td>11</td></tr><tr><td colspan="5">Service Environment</td><td>7</td></tr><tr><td colspan="5">Other</td><td>4</td></tr><tr><td colspan="5">N/A - Left Blank</td><td>31</td></tr></table></td><td>• To track and trend internally the grievances on a quarterly basis.
• Identify consistent patterns related to member grievances.
• Develop interventions to address critical issues within the organization.</td><td>Dana Moore

Quality Improvement Committee</td><td>Goal Met: ☒ Yes ☐ No

Quarterly Update:

Q1 Summary: The CMHSPs are reporting monthly data to the G&A Manager and PIHP is tracking its own grievances in MIX module which allows for data organization and reporting. A final report format and decision on pertinent data will be complete in Q2.

Q2 Summary:
Q2 numbers have been reported in the chart to the left. There was a slight increase in overall number of grievances in Q2. Most common grievance subject remains quality of care, typically resulting in a request to change assigned case holder.</td></tr>
</table>

<table>
<tr><th>Component</th><th>Goals/Timeframe/Analysis</th><th>Planned Activities</th><th>Responsible Staff/ Department</th><th>Status Update</th></tr>
<tr><td></td><td></td><td></td><td></td><td>Q3 Summary: The Semi-Annual G&A report was presented to the R10 Board at the May meeting. June: Q3 numbers have been reported in the chart to the left. There was a significant decrease in the overall number of grievances in Q3.

Q4 Summary:
Grievance numbers from Q4 are listed in the table to the left. Total number of grievances is twelve (12). There was a slight decrease in overall number of grievances from Q3.

Evaluation: Progress.
Barrier Analysis: No Barriers identified.
Next Steps: Continue with Annual Plan.
Continue Objective(s)?
☒ Yes ☐ No</td></tr>
<tr><td>Appeals</td><td>• To review and analyze baseline appeals data for the region for FY2019.

<table>
<tr><th colspan="6">Reporting Period: FY2019</th></tr>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th>Total</th></tr>
<tr><td>GHS</td><td>34</td><td>41</td><td>34</td><td>20</td><td>129</td></tr>
<tr><td>Lapeer</td><td>5</td><td>1</td><td>0</td><td>0</td><td>6</td></tr>
<tr><td>St. Clair</td><td>2</td><td>1</td><td>2</td><td>0</td><td>5</td></tr>
<tr><td>Sanilac</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>SUD / R10</td><td>3</td><td>2</td><td>2</td><td>1</td><td>8</td></tr>
<tr><td>R10 Access</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>TOTAL</td><td>44</td><td>45</td><td>38</td><td>21</td><td>148</td></tr>
<tr><th colspan="5">Reason for Appeal:</th><th>Total</th></tr>
<tr><td colspan="5">Service Termination</td><td>100</td></tr>
<tr><td colspan="5">Service Denial</td><td>39</td></tr>
<tr><td colspan="5">Service Suspension</td><td>5</td></tr>
<tr><td colspan="5">Service Reduction</td><td>4</td></tr>
<tr><th colspan="5">Service at Issue: (Top 3 reported)</th><td></td></tr>
<tr><td colspan="5">Case Management/Support Coordination</td><td></td></tr>
<tr><td colspan="5">Respite</td><td></td></tr>
<tr><td colspan="5">ABA Therapy</td><td></td></tr>
</table>
</td><td>• To track and trend internally the appeals on a quarterly basis.
• Identify consistent patterns related to member appeals.
• Develop interventions to address critical issues within the organization.</td><td>Dana Moore

Quality Improvement Committee</td><td>Goal Met: ☒ Yes ☐ No

Quarterly Update:

Q1 Summary:
All appeals for Q1 have been entered in MIX module and a report generated. A final summary report format and decision on pertinent data will be completed in Q2.

Q2 Summary:
Appeal numbers from Q2 are listed in the table to the left. Total number of appeals for Q2 (45) was similar to Q1 (44). Case management/Supports coordination continues to be most common service effected.</td></tr>
</table>

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				Q3 Summary: **The Semi-Annual G&A report was presented to the R10 Board at the May meeting.** **June: Appeal numbers from Q3 are listed in the table to the left. Total number of appeals for Q3 thirty-seven (37) slight decrease from Q2. Case management/Supports coordination continues to be most common service effected.** **Q4 Summary:** **Appeal numbers from Q4 are listed in the table to the left. Total number of appeals for Q4 twenty-one (21) a decrease from Q3. An additional forty-six (46) cases were handled/resolved without opening a formal appeal.** **Evaluation: Progress.** **Barrier Analysis: No barriers identified.** **Next Steps: Continue with Annual Plan.** **Continue Objective(s)?** **☒ Yes ☐ No**
Credentialing / Privileging	**The goal for FY2019 Credentialing and Privileging is as follows:** • **Provide oversight of the credentialing process and policy to ensure quality of care and service.**	• **Complete privileging and credentialing reviews and approval process of Organizational Applications for CMH and SUD Providers.** • **Complete privileging and credentialing review and**	**Amanda Zabor** **Privileging and Credentialing Committee**	**Goal Met: ☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary: The committee met once during the 1st quarter of FY19. During this meeting policy and forms were discussed and additional review will occur within and between meetings in order to have further discussion on any needed updates within policy or revisions of forms used for P&C activities. These activities will be**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
		approval process of all applicable Region 10 staff. • **Maintain policies and procedures on privileging and credentialing inclusive of MDHHS and Medicaid Standards.**		**ongoing during FY19** **Q2 Summary:** **PIHP Credentialing & Privileging Policy review and recommendations for revision. PIHP Practitioner Application review and recommendations for revision. One (1) Organizational Provider Application update reviewed and approved. Seven (7) Flint Access Staff Practitioner Applications reviewed and approved for full re-credentialing. Committee Membership discussion. Committee goals review. Reviewed PIHP Annual Contract Monitoring record review methodology.** **Q3 Summary:** **PIHP Organizational Application reviewed and updated. PIHP Guidance Document for PIHP Committee Review of Applications in process. Committee Membership enhancement to include Chief Clinical Officer and data / quality staff.** **PIHP Guidance document for PIHP Committee Review continues to be developed. Committee discussion regarding PIHP Access Staff member training requirements. Committee discussion regarding credentialing timeframe alignment with previous NCQA application. The Committee continues to research Access Center Staff Training Requirements. Credentialing is a focus area for the September 2019 HSAG External Quality Review. Reminders for Credentialing renewals notices are being**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				prepared and sent to Practitioners and Organizations to ensure timely receipt from those needing to be re-credentialed and appropriate and thorough review by the Committee. The Committee continues to work on a guidance document to assist committee members with review of applications. **Q4: Summary:** **All Providers and Practitioners with expiring credentialing that were presented to the P & C Committee for credentialing were approved for the full credentialing period with the exception of Flint Odyssey House (FOH), who was granted provisional privileges (10.1.19 – 2.27.20) with a required Action Plan to be submitted which details the steps FOH is taking toward obtaining appropriate licensure for all facilities where the PIHP maintains a contract with FOH to provide services (e.g. Recovery Homes).** **FY20 Goals were reviewed and approved by the Committee.** **Evaluation: In Progress** **Barrier Analysis: No barriers identified** **Next Steps: Continuation** **Continue Objective(s)?** **☒ Yes ☐ No**

<table>
<tr><th>Component</th><th>Goals/Timeframe/Analysis</th><th>Planned Activities</th><th>Responsible Staff/ Department</th><th>Status Update</th></tr>
<tr>
<td>Autism Program</td>
<td>
A) 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.
<table>
<tr><th></th><th></th><th>1Q</th><th>2Q</th><th>3Q</th><th colspan="3">4Q</th></tr>
<tr><th></th><th></th><th>Dec</th><th>Mar</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th></tr>
<tr><td>GHS</td><td>Overdue List Total</td><td>73</td><td>93</td><td>111</td><td>136</td><td>113</td><td>129</td></tr>
<tr><td></td><td>≥90 (Days)</td><td>52</td><td>59</td><td>86</td><td>97</td><td>81</td><td>74</td></tr>
<tr><td></td><td>60-89</td><td>6</td><td>6</td><td>12</td><td>8</td><td>14</td><td>23</td></tr>
<tr><td></td><td>30-59</td><td>3</td><td>15</td><td>8</td><td>6</td><td>16</td><td>2</td></tr>
<tr><td></td><td>0-29</td><td>12</td><td>13</td><td>5</td><td>25</td><td>2</td><td>30</td></tr>
<tr><td>Lapeer</td><td>Overdue List Total</td><td>2</td><td>7</td><td>4</td><td>4</td><td>2</td><td>2</td></tr>
<tr><td></td><td>≥90</td><td>1</td><td>1</td><td>4</td><td>4</td><td>2</td><td>0</td></tr>
<tr><td></td><td>60-89</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td></td><td>30-59</td><td>1</td><td>2</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td></td><td>0-29</td><td>0</td><td>3</td><td>0</td><td>0</td><td>0</td><td>2</td></tr>
<tr><td>Sanilac</td><td>Overdue List Total</td><td>1</td><td>1</td><td>3</td><td>2</td><td>0</td><td>0</td></tr>
<tr><td></td><td>≥90</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td></td><td>60-89</td><td>0</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td></tr>
<tr><td></td><td>30-59</td><td>1</td><td>0</td><td>1</td><td>1</td><td>0</td><td>0</td></tr>
<tr><td></td><td>0-29</td><td>0</td><td>1</td><td>1</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>St. Clair</td><td>Overdue List Total</td><td>8</td><td>7</td><td>12</td><td>12</td><td>11</td><td>6</td></tr>
<tr><td></td><td>≥90</td><td>1</td><td>3</td><td>2</td><td>2</td><td>1</td><td>3</td></tr>
<tr><td></td><td>60-89</td><td>2</td><td>0</td><td>1</td><td>2</td><td>2</td><td>0</td></tr>
<tr><td></td><td>30-59</td><td>2</td><td>2</td><td>5</td><td>3</td><td>3</td><td>3</td></tr>
<tr><td></td><td>0-29</td><td>3</td><td>2</td><td>4</td><td>5</td><td>5</td><td>0</td></tr>
</table>
B) Autism benefit enrollees will receive one or more Family Behavior Treatment Guidance service per quarter.
</td>
<td>

Monitor persons on autism services overdue list total
Monitor completion of behavioral plans of care
Monitor service provision in specified areas
Monitor documentation submission to Waiver Support Application (WSA)
Monitor services (encounters) using the funding Source Bucket Report (FSBR)

</td>
<td>Lauren Bondy

Monitored by Quality Improvement Committee (QIC)</td>
<td>
Goal Met:
☐ Yes ☒ No

Quarterly Update:

Q1 Summary:
A) The FY19 Q1 data was pulled 1/2/19, which provides a baseline. Since the beginning of the fiscal year, Lapeer CMH, Sanilac CMH, and St. Clair CMH have shown consistent overdue list totals. GHS has shown a significant increase in the number of individuals overdue to begin services since the beginning of the fiscal year.
B) Data for FY18 Q4 has been recalculated using methodology which excludes individuals without a plan of service in WSA. This was prompted by a draft methodology document shared by the MDHHS Autism Team Data Analyst. Because this data was calculated using encounters on the FSBR, the measure will be recalculated in each upcoming quarter. GHS and Sanilac CMH demonstrated a compliance rate of 33%. Lapeer CMH demonstrated a compliance rate of almost 5%, which is a significant decrease from the previous quarter. St. Clair CMH demonstrated a compliance rate of almost 58%. No CMH met the standard.
C) Of all cases with a plan of service in WSA, GHS provided at least one ABA service to approximately 64% of enrollees. Because this data was calculated using encounters on the FSBR, the measure will be recalculated in each upcoming quarter. Lapeer CMH provided ABA services to
</td>
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</table>

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update

Percentage of individuals receiving ≥ 1 Family behavior Treatment Guidance service per quarter.
Data source: Waiver Support Application (WSA) and Funding Source Bucket Report (FSBR)

	FY18 4Q	FY19 1Q	FY19 2Q	FY19 3Q
Genesee	35.29%	45.87%	28.18%	18.70%
Lapeer	40.91%	4.76%	10%	4.55%
Sanilac	54.17%	37.50%	52%	90.48%
St. Clair	64.29%	80%	97.56%	89.13%

Standard: **100% of individuals will receive ≥ 1 Family Behavior Treatment Guidance Service per quarter, as measured using the FSBR report.**

C) Autism Benefit enrollees with an active plan of service will receive one or more ABA service per quarter.

Percentage of individuals receiving ≥ 1 ABA service per quarter.
Data source: Waiver Support Application (WSA) and Funding Source Bucket Report (FSBR)

	FY18 4Q	FY19 1Q	FY19 2Q	FY19 3Q
Genesee	85.71%	71.56%	69.09%	70.73%
Lapeer	90.91%	80.95%	70%	86.36%
Sanilac	100%	100%	92%	100%
St. Clair	90.48%	97.78%	100%	97.83%

Standard: **100% of individuals will receive ≥ 1 ABA service per quarter, as measured using FSBR report.**

almost 81% of enrollees. Sanilac CMH demonstrated a compliance rate of 100% and was the only CMH to meet this standard. St. Clair CMH demonstrated a compliance rate of almost 89%.

Q2 Summary:
A) As shown, the overdue totals for GHS and Lapeer CMH have increased. Both GHS and Lapeer CMH submit periodic service capacity report updates to the PIHP. Additionally, GHS has added a new ABA provider and created a new "Autism Benefit Administrator" to manage the Autism Benefit. This position will become the CMH Autism Coordinator. GHS continues to send monthly Autism referral reports to the PIHP to track referrals to ABA providers. CMHs have added new ABA providers to improve capacity. Lapeer CMH has added two new ABA providers for additional capacity. St. Clair CMH overdue totals have decreased. St. Clair CMH added a new ABA provider. Sanilac CMH overdue total remains consistent month to month.
B) Using WSA reports and updated FSBR reports, the percentages for all quarters have been recalculated. GHS, Lapeer CMH, and Sanilac CMH have not demonstrated improvement in increasing family training services. GHS plans to start a research project with the Michigan State University Autism Lab. The project will focus on implementation of family training. St. Clair CMH has demonstrated

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				consistent improvement and has the highest implementation of family training. This is a measure that will be included in the FY19 MDHHS semi-annual reports, which have not yet been received. C) Using WSA reports and updated FSBR reports, the percentages for all quarters have been recalculated. The percentage of enrollees with an active plan of service received one or more ABA service per quarter has consistently decreased quarter to quarter for both GHS and Lapeer CMH. Sanilac CMH and St. Clair CMH have consistently demonstrated compliance rates of 90% or higher, which does not meet the standard for this goal. PIHP staff will investigate this measure further to determine causes and identify possible solutions. **Q3 Summary:** **A) As shown, the overdue total for GHS has increased. GHS submitted the quarterly periodic service capacity report update to the PIHP on April 12, 2019. GHS reports a new "Autism Benefit Administrator" staff has been hired to manage the Autism Benefit. GHS has also entered into a contract with Helping Hand, an ABA provider, for adolescent Autism services. Additionally, GHS reports space has been identified for the development and operations of an adolescent Autism treatment center. Lapeer CMH and St. Clair CMH overdue totals have decreased. Sanilac CMH overdue total remains consistent month to month. This measure was**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				included on the first FY19 Biannual Autism Update Report from MDHHS. This report and the methodology were presented at the April IPLT meeting. Findings on the report indicate that Region 10's compliance with this measure was 46% in FY19 Q1 and 42% in FY19 Q2. The report also shows statewide totals for this measure, which were 57% for FY19 Q1 and 50% for FY19 Q2. According to the MDHHS report, Region 10 is below the statewide average for percentage of enrollees overdue to begin ABA services. **B) Using updated FSBR reports, the percentages for FY19 Q1 and Q2 have been recalculated. Sanilac CMH has slightly increased the percentage of family training provided from FY19 Q1 to Q2. GHS and Lapeer CMH have not demonstrated improvement in increasing family training services. GHS plans to start a research project with the Michigan State University Autism Lab. The project will focus on implementation of family training. St. Clair CMH has demonstrated consistent improvement and has the highest implementation of family training. This measure was included on the first FY19 Biannual Autism Update Report from MDHHS. This report and the methodology were presented at the April IPLT meeting. Findings on the report indicate that Region 10's compliance with this measure was 51% in FY19 Q1 and 49% in FY19 Q2. The report also shows statewide totals for this measure,**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				which were 65% for FY19 Q1 and 64% for FY19 Q2. According to the MDHHS report, Region 10 is providing family training at rates lower than the statewide average. Additionally, MDHHS calculations appear to be slightly higher than the PIHP's calculations. The PIHP Autism Coordinator will review the MDHHS methodology to identify any possible discrepancies in the logic and data. **C) Using updated FSBR reports, the percentages for FY19 Q1 and Q2 have been recalculated. The percentage of enrollees with an active plan of service who received one or more ABA service per quarter has consistently decreased quarter to quarter for Lapeer CMH. GHS has slightly decreased from FY19 Q1 to Q2. Sanilac CMH and St. Clair CMH have consistently demonstrated compliance rates of 90% or higher, which does not meet the standard for this goal. PIHP staff will investigate this measure further to determine causes and identify possible solutions.** **A) GHS overdue by 90+ days has increased. GHS total overdue to begin services is similar from April to May. GHS has added an ABA provider. GHS also has a new Autism Coordinator. This staff has been tasked with managing WSA and SharePoint. Lapeer CMH total overdue has decreased and over 90 days has increased. Sanilac CMH total overdue has increased but maintains zero enrollees overdue for 90+ days. St. Clair CMH total**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				overdue has increased, likely due to new enrollees. St. Clair CMH overdue for 90+ days has increased by 1. **B) No updates at this time. MDHHS report containing this measure will be presented at the PNC meeting on June 4, 2019.** **C) No updates at this time.** **June:** **A) GHS, SCMH, and SC CMH overdue totals have increased from Q2 to Q3. LCMH overdue total has decreased from Q2 to Q3. CMHs are currently working on completing capacity surveys which include a list of all active ABA providers. This continues to be a regional and statewide issue. Enrollment continues to increase. GHS and LCMH service capacity report updates are due on 7/15/19.** **B) FY19 Q2 data was recalculated and FY19 Q3 data was calculated using encounter data from 7/1/19. The percentage of enrollees receiving at least one family training service per quarter is below 10% for GHS and LCMH. SCMH has increased from Q2 to Q3. SC CMH has decreased from Q2 to Q3. SCMH and SC CMH have maintained over 50% during Q2 and Q3. This measure will be calculated during the Annual/Q3 PIHP's CMH site reviews and was previously calculated during Q1 for sample cases. Findings from the site reviews will be added to the Annual/Q3 contract monitoring tools. POCs will be requested if sample cases do not demonstrate**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				compliance with this standard. **C) FY19 Q2 data was recalculated and FY19 Q3 data was calculated using encounter data from 7/1/19. GHS and SC CMH have decreased from Q2 to Q3. LCMH and SCMH have increased fromQ2 to Q3. SCMH and SC CMH have maintained over 90% during the last four quarters. GHS is working on improving the process for submitted ABCAFs to the PIHP to be processed. PIHP Autism Coordinator will work with Admin Tech to research last plan and eval dates in WSA then request disenrollment's if appropriate.** **Q4: Summary:** **A) GHS overdue totals have been inconsistent during Q4. GHS is required to submit quarterly service capacity reports. GHS staff report they are working to expand the GHS Autism Center. "The expansion plan has been developed and currently a budget is being developed." The GHS VP of Clinical Operations reports a shortage of available workforce and service capacity. However, GHS reports improved referral tracking and a meeting scheduled with ABA providers to review capacity and develop a plan. The GHS Autism Coordinator also reported cleanup efforts to ensure WSA contains accurate and complete data. The LCMH overdue totals have decreased during Q4. The LCMH Autism Coordinator and support staff has been working with the PIHP Autism team to submit, process,**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				and approve the plans in WSA. SCMH now has no cases overdue for services. SC CMH overdue totals have decreased during Q4. The SC CMH Children's Program Supervisor is looking into the case overdue by 90+ days. **B) This data has been presented to each CMH Autism Coordinator and discussed at the FY19 4Q meetings. The PIHP CEO requested additional information from the GHS VP of Clinical Operations. The GHS Autism Coordinator stated she would gather more information from subcontract providers. The LCMH Autism Coordinator, Quality Improvement Coordinator, and CEO reported they may add this measure to their Quality Improvement Plan. The LCMH Autism Coordinator and Autism Case Manager reported they will work to improve family education on family training to ensure family participation. The SCMH Autism Coordinator requested detailed information on the cases without family training. The PIHP Autism Coordinator provided this information. The SC CMH Children's Program Supervisor reported family training should be 100% for all CMH center-based cases. It was also reported that subcontract providers are providing family training at least once a month. Family training may be added to SC CMH subcontract requirements. Additionally, the PIHP Autism Coordinator has worked with a PIHP Data Dept Administrative Coordinator to**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				develop a report for this measure. **C) This data has been presented to each CMH Autism Coordinator and discussed at the FY19 4Q meetings. A training on the Autism Benefit Case Action Form was completed with each CMH at the FY19 4Q meetings. The GHS and LCMH trainings included discussion on SharePoint and WSA management, which are areas identified as needing improvement for both GHS and LCMH. The GHS Autism Coordinator also reported cleanup efforts to ensure WSA contains accurate and complete data. The PIHP Autism Team set up weekly phone calls with the GHS Autism Coordinator to review any issues or questions related to SharePoint and WSA. The LCMH Autism Coordinator also reports cleanup efforts are taking place. Weekly phone calls have also been scheduled with the LCMH Autism Coordinator and support staff. There are no concerns with SCMH or SC CMH.** **Evaluation: Much progress has been made throughout the year to bring improvement to the ABA program within the region. Goals are continued into FY20.** **Barrier Analysis: Barriers have been identified within the network regarding service capacity, education of staff, efforts towards data completeness/accuracy.** **Next Steps: Continue with Annual Workplan.** **Continue Objective(s)?** **☒ Yes ☐ No**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
External Quality Review Corrective Actions	**Per the 2017-2018 External Quality Review Compliance Monitoring Report for Region 10 PIHP, corrective action plans (CAP) were needed in the following areas:** **Standard VI. Customer Service** **Standard VII. Grievance Process** **Standard IX. Subcontracts and Delegation** **Standard XIV. Appeals** **Standard XVII. Management Information Systems**	**The Subject Matter Expert Lead staff for each area will provide updates regarding the status of corrective action plan activities.**	**VI. Customer Service – Kristen Potthoff** **VII. Grievance Process – Dana Moore** **IX. Subcontracts and Delegation – Kristen Potthoff** **XIV. Appeals – Dana Moore** **XVII. Management Information Systems – Pattie Hayes**	**Goal Met:** **☒ Yes ☐ No** **Quarterly Update:** **Q1 Summary: Recommend addition of new goal to the QI Workplan** **Q2 Summary:** **Customer Service – Kim Prowse – Corrective Action has been submitted. No further action to report at this time pending Corrective Action feedback from HSAG.** **Grievance Process – Bob Esselink** **Corrective Actions have been completed. Updates to MIX/OASIS/CHIP have been completed.** **Subcontracts and Delegation – Kristen Potthoff** **Corrective Action has been completed. No further action needed at this time.** **Appeals – Bob Esselink** **Corrective actions have been completed. Updates to MIX / OASIS / CHIP have been completed.** **Management Information Systems – Pattie Hayes** **Corrective Action has been completed. No further action needed at this time.** **Q3 Summary:** **Customer Service –Kristen Potthoff** **No update** **Grievance Process – Kristen Potthoff** **No update**

Component	Goals/Timeframe/Analysis	Planned Activities	Responsible Staff/ Department	Status Update
				Subcontracts and Delegation – Kristen Potthoff **No update** **Appeals – Kristen Potthoff** **No update** **Management Information Systems – Pattie Hayes** **CAP completed. No update.** **Q 4 (July-Sept): Summary:** **No information has been received from MDHHS regarding approval of the CAP submitted for the EQR review of FY2018.** **Evaluation: Progress.** **Barrier Analysis: No Barriers.** **Next Steps: Continue with Annual Workplan.** **Continue Objective(s)?** ☒ **Yes** ☐ **No**

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As of 9.30.2019