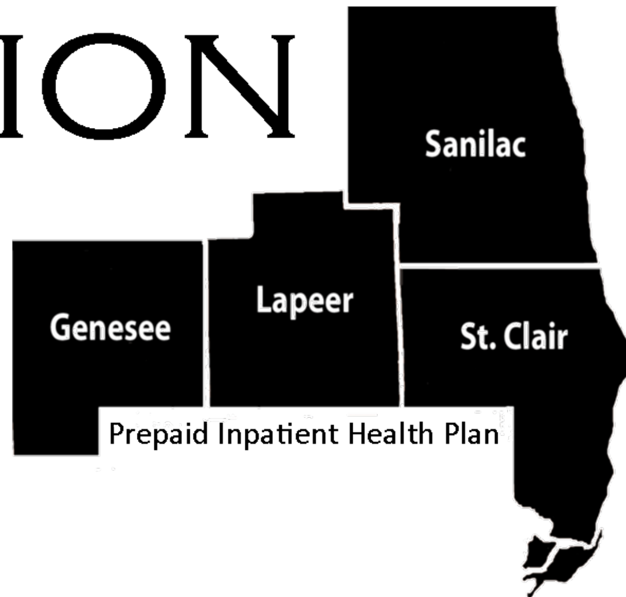
REGION

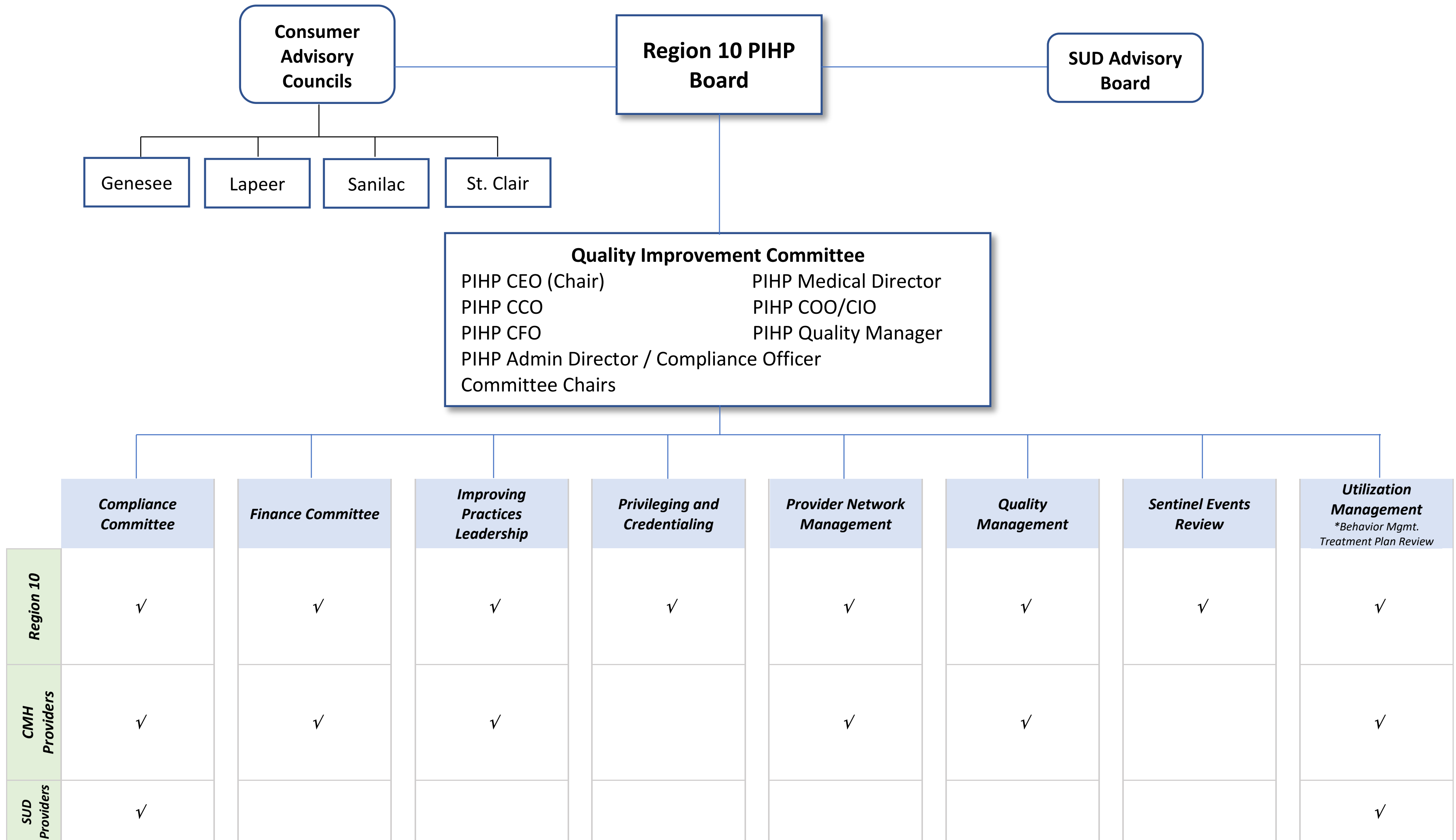
10



QUALITY IMPROVEMENT PROGRAM & WORKPLAN

FY 2020 – 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 Management Fiscal Year (FY) 2020 Work Plan (October 1, 2019 – September 30, 2020)

Component	Goals/Timeframe	Planned Activities	Responsible Staff/Department	Status Update
QI Program Structure - Annual Evaluation	• Submit FY2019 QI Program Evaluation to Quality Improvement Committee and the Region 10 PIHP Board by 12/1/19.	• 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 / Lauren Bondy QI Department QI Program Standing Committees	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1 (Oct-Dec):** **The FY2019 QI Program Annual Report was presented and approved by QIC and the PIHP Board at the October meetings. No further action needed.** **Q 2 (Jan-Mar):** **No update** **Q 3 (Apr-June):** **No update** **Q 4 (July-Sept):** **No update** **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 FY2020 QI Program Description to Quality Improvement Committee and the Region 10 PIHP Board by 12/1/19.	• 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 / Lauren Bondy QI Department QI Program Standing Committees	**Goal Met:** ☒ **Yes** ☐ **No** **Quarterly Update:** **Q 1: (Oct-Dec):** **FY2020 QI Program Description was reviewed and approved by QIC and the PIHP Board at the October meetings.** **Q 2 (Jan-Mar):** **No update** **Q 3 (Apr-June):** **No update** **Q 4 (July-Sept):** **No update** **Evaluation: Completed** **Barrier Analysis: No barriers** **Next Steps: Objective to be continued into the following FY.** Continue Objective(s)? ☒ Yes ☐ No

QI Program Structure - Annual Work Plan	• Submit FY2020 QI Program Work Plan to the Quality Improvement Committee and the Region 10 PIHP Board by 12/1/19.	• 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 / Lauren Bondy QI Department QI Program Standing Committees	**Goal Met:** ☒ **Yes** ☐ **No** **Quarterly Update:** **Q 1: (Oct-Dec):** **FY2020 QI Workplan was reviewed and approved by QIC and the PIHP Board at the October meetings.** **Q 2 (Jan-Mar):** **Revised responsible staff name for the Grievance and Appeal goals. New goal added to address EQR CAPs. Revised responsible staff name for the Corporate Compliance goals.** **Q 3 (Apr-June):** **Revised responsible staff name for the QI Program Structure, Michigan Mission Based Performance Indicator System, Members' Experience, External Monitoring Reviews, Monitoring of Quality Areas, and External Quality Review Corrective Actions goals.** **Q 4 (July-Sept):** **Revised responsible staff name for the Provider Network Provider Directory goal.** **Evaluation: Completed** **Barrier Analysis: No barriers** **Next Steps: Objective to be continued into the following FY.** Continue Objective(s)? ☒ Yes ☐ No

Aligned System of Care	The goals for FY2020 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 and related fidelity review activities to promote standardized clinic operations across the provider network, e.g. IDDT, LOCUS. • Monitor and advise on ESC activities to encourage CMHSP a) employment targets, b) standardized employment services data and report formats, and c) share and learn opportunities. • 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:** **Q 1: (Oct-Dec):** **Clinical Practice Guidelines annual evaluation report was reviewed and approved, noting clinical fidelity and effectiveness on each of the three EBPs evaluated (HBS, BHT, MAT); the CPG Bi-Annual Evaluation Report was reviewed and approved to be forwarded with its recommendations, to QIC; the BHDDA EBP Implementation Survey was discussed to ensure CMHSP completion and regional review.** **Findings from the regional LOCUS EOY Implementation Survey were reviewed; Lapeer's LOCUS fidelity review results and Sanilac's ACT fidelity review results were presented and discussed, noting fidelity successes and sustainability challenges; Sanilac's LOCUS fidelity review is rescheduled for December.** **Updates on CMHSP community-based employment opportunities and partnered activities with MRS were discussed as share-and-learn; discussed and distributed the BHDDA document, *The Inclusive Talent Pool.*** **18 ICPs in-place; a new case record selection process has been implemented utilizing a CC360 risk stratification list.** **C-survey and B-survey activities in-process per plan; Heightened Scrutiny work continues, and updates from the CMHA conference were discussed.**

		and aligned network practices in utilizing the CC360 system. • Monitor and advise on the CMHSP network's work on the continuation and remediation plans addressing Home and Community-Based Services transition.		**Q 2 (Jan-Mar):** **(March meeting cancelled)** **No CPG updates. Committee discussed Sanilac's LOCUS MIFAST report, also noting state-wide improvement opportunity trends with implementation and outcomes monitoring; LOCUS MIFAST reviews were finalized for St. Clair (May) and GHS (June); the FY 2020 R10 LOCUS Implementation Plan was updated and approved. There were no ESC activities to report for March. Status of ICM cases are noted in connection to February status report. The February survey timeline has moved to April; Heightened Scrutiny review process for R10 will be scheduled soon.** **Q 3 (Apr-June):** **April meeting was cancelled, and the May June meetings were held via secure email.** **No CPG updates. LOCUS MIFAST reviews were rescheduled for St. Clair and GHS. There were no ESC activities to report due to meeting cancellation, but the next meeting has been scheduled for July. Status of ICM cases are noted as well as increased access to telehealth; increased rate in post-meeting documentation with the two-day timeframe was noted. HCB services transition – the new round of surveys has been scheduled for July. June PISC meeting materials were distributed.** **Q 4 (July-Sept):**

				Committee selected CPGs for EOY report, which is scheduled for review at the October meeting. **Committee has been kept apprised of the BHDDA LOCUS Implementation Workgroup. GHS completed its LOCUS MIFAST review in August, and St. Clair rescheduled its review for February.** **ESC met in July and September focusing on how programs are dealing with COVID-19 challenges to service provision, and its annual goals were approved.** **18 ICPs are in place; documentation activities have been timely; members identify service engagement and service provision challenges posed by COVID-19. Other details and committee discussion are noted in the separate section, below.** **Annual goals were approved.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue with annual plan** Continue Objective(s)? ☒ Yes ☐ No
Home & Community Based Services	The goals for FY2020 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 Improving Practices Leadership Team (IPLT)	**Goal Met:** ☒ **Yes** ☐ **No** **Quarterly Update:** **Q 1: (Oct-Dec):** **C-survey and B-survey activities in-process per plan; Early completion is expected; DHHS due date is 4-2020, this portion of the survey process will be completed by 2-2020; Heightened Scrutiny work continues, and updates from the CMHA conference were**

C/Exit Survey	CAP Approved (# of individuals)	Attestation Received (# of settings)	Compliance Letter Sent
GHS	36/36	20/20	20
Lapeer	5/5	1/1	1
Sanilac	4/4	3/3	3
St. Clair	N/A	N/A	N/A

B3 Survey	CAP Approved (# of individuals)	Attestation Received (# of settings)	Compliance Letter Sent
GHS	45/45	14/14	14
Lapeer	108/108	4/4	4
Sanilac	5/5	5/5	5
St. Clair	14/14	5/5	5

discussed. Heightened Scrutiny review date remains TBD.

Q 2 (Jan-Mar):
B and C Survey processes were projected to be completed prior to the April 2020 deadline. This deadline has been extended to 7-15-2020. Region 10 will have this completed prior to the new deadline. New round of surveys will capture settings that were provisionally approved and survey errors from last survey round. These surveys were to be distributed in May 2020 however they will be delayed due to the current pandemic. Heightened Scrutiny work in Region 10 has not yet been scheduled, remains TBD.

Q 3 (Apr-June):
The new round of surveys has been scheduled for July. New round of surveys will capture settings that were provisionally approved and survey errors from last survey round. The B and C Survey processes must be completed by 7-31-2020.

Q 4 (July-Sept):
The B and C Survey processes were completed by Region 10 on 7-15-2020, this was ahead of the deadline imposed by DHHS. The new round of surveys was distributed on 7-6-2020, the surveys must be completed by 8-14-2020. This round of surveys was distributed to settings that were provisionally approved and those surveys that had errors during the last survey round. There were several concerns shared by regions, providers and CMH's about survey completion during this survey round. There are many factors that may contribute to

				incomplete surveys from providers. These include layoffs, staff working from home, limited access to email and the surveys initiating from an unknown email address causing concern from providers. DHHS stated at 8-21-2020 PIHP HCBS Leads Meeting that a discussion would take place internally at DHHS to address the concerns listed above. MI-DDI is currently working on data cleaning for this survey round. DHHS has given permission to resend surveys that were not completed due to the impact of COVID-19. Final reports on compliant settings and needed corrective action plans for this round of surveys will be forthcoming. **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue with annual plan** Continue Objective(s)? ☒ Yes ☐ No
Event Reporting (Critical Incidents, Sentinel Events & Risk Events)	The goals for FY2020 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 systems of care. • Monitor sentinel event review processes and ensure follow-up as deemed necessary. • Monitor unexpected	Tom Seilheimer Sentinel Event Review Committee	**Goal Met:** ☒ **Yes** ☐ **No** **Quarterly Update:** **Q 1: (Oct-Dec):** **Critical Incident monitoring reveals broad continuation of trends; two CIs were followed-up to assess for accurate reporting and appropriate program response. The CI 4Q Report was presented and discussed, and favorable decreases were noted across most categories; also, discussion about SE reporting systems, and outreach will be made to two CMHSPs to ensure their systems are operational.** **Three sentinel events received from St. Clair; all complied with policy tasks and report timeframes; two**

		deaths review processes and ensure follow-up as deemed necessary.		**brought to closure with one presenting a relevant systems improvement activity; and one remains in-process, pending Medical Director review.** **Mortality reports for EOY revealed CMHSP tracking and trending along with development of systems improvement recommendations.** **Q 2 (Jan-Mar):** **(March meeting cancelled)** **Monitoring continues, no untoward trends have been identified; a retrospective study was completed and reviewed regarding the SUD CI reporting systems and related sentinel events reports systems; systems issues and improvement opportunities were discussed, and follow-up activities were identified. No sentinel events have been reported.** **Q 3 (Apr-June):** **Meetings were held in Teams.** **CI monitoring continues, no untoward trends have been identified; No sentinel events have been reported. Next report on unexpected deaths is scheduled for end-of-year.** **Q 4 (July-Sept):** **The 3Q Report reviewed at the August meeting indicated that, across CI categories, trends for all CMHSPs are consistent with baseline FY2019 and previous FY2020 quarters, with the exception of an upward trend in non-suicide deaths. SERC will monitor for potential trends or factors such as the COVID-19 pandemic, contributing to this increase. Also**

				recommended to continue to improve and monitor critical event reporting from SUD provider programs. **One SE was reported by St. Clair and it will be further reviewed by SERC at the October meeting.** **Mortality reporting is pended to its semi-annual reporting schedule.** **Annual goals were approved.** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue with annual plan** Continue Objective(s)? ☒ Yes ☐ No

Employment Services	The goals for FY2020 Reporting are as follows: • To monitor and advise on Employment Services activities as the CMHSPs	• Encourage and support CMHSP progressive employment services practices. • Support to CMHSP pursuit of local employment targets pertaining to competitive employment (community-based) and compensation (minimum wage or higher). • Explore additional opportunities to utilize standardized employment services data and report formats. • Provide share and learn opportunities as such may pertain to employment targets and collaborative practices, e.g. MRS.	Tom Seilheimer Employment Services Committee	**Goal Met:** ☒ **Yes** ☐ **No** **Quarterly Update:** **Q 1: (Oct-Dec):** **Sanilac, St. Clair and Lapeer have established employment targets; GHS has a contract with Peckham, Inc. Per the recent BHDDA EBP Survey, GHS and Lapeer have expressed interest in IPS implementation.** **Updates on CMHSP community-based employment opportunities and partnered activities with MRS were discussed as share-and-learn; discussed and distributed the BHDDA document, *The Inclusive Talent Pool.*** **Q 2 (Jan-Mar):** **(March meeting cancelled)** **Sanilac reported consumer and family enthusiasm for its community-based employment initiatives launched in October. MMBPIS #8 and #9 findings were discussed in connection to informing CMH PI targets for 2020. SCCMH IPS annual report is rescheduled for the next meeting. Sanilac reported on new collaborative cases with MRS.** **Q 3 (Apr-June):** **No meetings could be scheduled. The next meeting has been scheduled for July.** **Q 4 (July-Sept):** **ESC met in July and September focusing on how programs are dealing with COVID-19 challenges to service provision, and its annual goals were approved.**

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<td>Annual goals were approved.

Evaluation: Progress
Barrier Analysis: No barriers
Next Steps: Continue with annual plan
Continue Objective(s)?
☒ Yes ☐ No</td>
</tr>
<tr>
<td>Michigan Mission Based Performance Indicator System (MMBPIS)</td>
<td>The goals for FY2020 Reporting are as follows:
The goal is to attain and maintain performance standards as set by the MDHHS contract.
<table>
<tr><th></th><th>FY19 Q4</th><th>FY20 Q1</th><th>FY20 Q2</th><th>FY20 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>99.63%</td><td>99.73%</td><td>99.71%</td><td>100%</td></tr>
<tr><td>1.2 Adults</td><td>99.83%</td><td>99.91%</td><td>100%</td><td>99.89%</td></tr>
<tr><td colspan="5">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% (No standard effective FY20 Q3)</td></tr>
<tr><td>2 PIHP Total</td><td>99.03%</td><td>99.18%</td><td>99.04%</td><td>76.54%</td></tr>
<tr><td>2.1 MI-Children</td><td>100%</td><td>99.25%</td><td>99.22%</td><td>83.96%</td></tr>
<tr><td>2.2 MI-Adults</td><td>100%</td><td>99.79%</td><td>99.18%</td><td>72.42%</td></tr>
<tr><td>2.3 DD-Children</td><td>100%</td><td>100%</td><td>97.85%</td><td>91.07%</td></tr>
<tr><td>2.4 DD-Adults</td><td>100%</td><td>100%</td><td>98.08%</td><td>78.13%</td></tr>
<tr><td>2.5 SUD</td><td>98.19%</td><td>98.72%</td><td>99.09%</td><td>N/A</td></tr>
<tr><td colspan="5">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% (No standard effective FY20 Q3)</td></tr>
<tr><td>3 PIHP Total</td><td>98.08%</td><td>98.51%</td><td>98.14%</td><td>92.93%</td></tr>
<tr><td>3.1 MI-Children</td><td>99.44%</td><td>98.40%</td><td>100%</td><td>94.19%</td></tr>
<tr><td>3.2 MI-Adults</td><td>99.36%</td><td>99.20%</td><td>99.05%</td><td>91.61%</td></tr>
<tr><td>3.3 DD- Children</td><td>100%</td><td>100%</td><td>99.07%</td><td>98.18%</td></tr>
<tr><td>3.4 DD-Adults</td><td>98.11%</td><td>100%</td><td>98.08%</td><td>96.77%</td></tr>
<tr><td>3.5 SUD</td><td>96.90%</td><td>97.84%</td><td>96.87%</td><td>N/A</td></tr>
<tr><td colspan="5">Ind. 4 – Percentage of discharges from 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>100%</td><td>97.53%</td><td>97.37%</td><td>100%</td></tr>
<tr><td>4a.2 Adults</td><td>97.71%</td><td>96.67%</td><td>95.42%</td><td>97.54%</td></tr>
<tr><td>4b SUD</td><td>98.88%</td><td>93.68%</td><td>92.13%</td><td>100%</td></tr>
</table>
</td>
<td>Report indicator results to MDHHS quarterly per contract
Provide status updates to relevant committees such as QMC, PIHP CEO, PIHP Board
Review quarterly MMBPIS data</td>
<td>Lauren Bondy

QI Department

Quality Management Committee (QMC)</td>
<td>Goal Met: ☒ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec):
Performance Indicators for FY19 Q4 were submitted to MDHHS on 12/26/19. The PIHP met the set performance standard for every PI. Sanilac CMH did not meet the standard for PI 3 – DD Adults and PI 10 – Children. St. Clair CMH did not meet the standard for PI 4 – Adults. Corrective Action Plans have been received.

Q 2 (Jan-Mar):
Performance indicators for FY2020 Q1 were submitted to MDHHS on 4/1/2020. The PIHP did not meet the set performance standard for PI 4b. Sanilac CMH did not meet the standard for PI 3 – MI Children. St. Clair CMH did not meet the standard for PI 10 – Adults. Corrective Action Plans have been received.

Q 3 (Apr-June):
Performance Indicators for FY2020 Q2 were submitted to MDHHS on 6/30/2020. The PIHP did not meet the set performance standard for PI 4b. GHS did not meet the standard for PI 4a – Adults. Lapeer did not meet the standard for PI 3 – DD Adults. St. Clair did not meet the standard for PI 3 – DD Children.</td>
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<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>8.05%</td><td>7.69%</td><td>7.21%</td><td>8.45%</td></tr>
<tr><td>10.2 Adults</td><td>12.26%</td><td>14.15%</td><td>11.66%</td><td>16.17%</td></tr>
</table>

<table>
<tr><td></td><td>FY19 Q4</td><td>FY20 Q1</td><td>FY20 Q2</td><td>FY20 Q3</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>N/A</td><td>N/A</td><td>N/A</td><td>67.38%</td></tr>
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<td>Q 4 (July-Sept):
A revised PI Codebook was developed with an effective date of April 1, 2020. Significant changes include the population(s) captured, new definitions for PI #2 and PI #3 with a new PI #2b, removal of exceptions for PI #2 and PI #3, and removal of the 95% standard for PI #2 and PI #3. The new PI #2b is calculated by MDHHS using data submitted by the PIHP. A table has been added to represent the PIHP's calculation of the new PI #2b using MDHHS' methodology.

Performance Indicators for FY2020 Q3 were submitted to MDHHS on 9/30/2020. The PIHP did not meet the set performance standard for PI 10 – Adults. GHS did not meet the standard for PI 10 – Adults. Lapeer did not meet the standard for PI 10 – Children. Sanilac did not meet the standard for PI 4a – Adults and PI 10 – Adults.

Evaluation: Progress
Barrier Analysis: No barriers
Next Steps: Continue with annual plan
Continue Objective(s)?
☒ Yes ☐ No</td>
</tr>
<tr>
<td>Members' Experience</td>
<td>The goals for FY2020 Reporting are as follows:

Conduct assessments of members' experience with services

Complete the member satisfaction survey by August 2020.
Conduct the Recovery Self-Assessment survey.
Conduct other assessments of members' experience as needed.

</td>
<td>
Conduct regional consumer satisfaction survey
Conduct MDHHS annual consumer satisfaction survey
Develop interventions to
</td>
<td>Lauren Bondy

QI Department

Quality Management Committee (QMC)</td>
<td>Goal Met: ☐ Yes ☒ No

Quarterly Update:
Q 1: (Oct-Dec):
The FY2020 Recovery Self-Assessment survey was conducted during a two-week period in October 2019. The survey has been closed. PIHP Quality staff are drafting the final report.</td>
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		address areas for improvement based on FY2020-member satisfaction survey		**The FY2019 Customer Satisfaction Survey was presented and approved by the PIHP Board during the December 2019 meeting.** **The FY2020 Customer Satisfaction Survey process has been discussed during QMC meetings. Recommendations for FY2020 survey implementation are an earlier timeframe, include individuals receiving long-term services and supports (LTSS), add an optional question for individual contact information, reorder the list of questions on the survey, ensure the same methodology is used for CMH and SUD providers, and show satisfaction percentages by SUD provider.** **Q 2 (Jan-Mar):** **PIHP Quality staff presented the draft report for the FY2020 RSA Survey during the February QMC meeting. Information from the QMC discussion was added to the survey report. The final draft of the report is being shared with the PIHP CCO and Clinical Manager for additional recommendations or enhancements to the report.** **The FY2020 Customer Satisfaction Survey process has been discussed during QMC meetings and internally with PIHP Quality and SUD Provider Network staff. PIHP staff are preparing the survey template and communication for CMHSPs and SUD Treatment Providers. It was originally discussed that the survey would be administered during April 2020. Due to the COVID-19 pandemic, it was**

				agreed by QMC members (via email) to postpone the administration of the customer satisfaction survey. During the February QMC meeting, members discussed qualitative assessments and how assessment results are shared with the providers and individuals served. **Q 3 (Apr-June):** **The FY2020 RSA Survey Report was reviewed and approved by the PIHP Board during the May meeting.** **Due to the COVID-19 pandemic, administration of the FY2020 Customer Satisfaction Survey has been delayed. CMHs and PIHP staff report interest in completing surveys using a mail-out method. When complete, CMHs will submit data to the PIHP to aggregate and report.** **Q 4 (July-Sept):** **The Customer Satisfaction Survey was administered by CMHs. Methods include mailout and telephonic. CMHs began submitting data to the PIHP to be aggregated and included in a regional report. The PIHP collected narratives from CMHs regarding their survey methodology for inclusion in the regional report. The FY2020 Customer Satisfaction Survey has not yet been administered to individuals receiving SUD services. PIHP staff continue work on a mailout survey for individuals served by SUD Providers.** **Evaluation: Progress** **Barrier Analysis: The Customer Satisfaction Survey process for individuals served by SUD Providers has not yet been finalized.**

				Next Steps: **Continue with annual plan** Continue Objective(s)? ☒ Yes ☐ No
State Mandated Performance Improvement Projects	The goals for FY2020 Reporting are as follows: • Identify and implement 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 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."	• HSAG report on PIP interventions and baseline • PIP Status updates to Quality Management Committee • QMC to consider selection of PIP projects aimed at impacting error reduction, improving safety and quality	Tom Seilheimer Quality Management Committee (QMC)	**Goal Met: ☒ Yes ☐ No** **Quarterly Update:** **Q 1: (Oct-Dec):** **HSAG findings and remediation activities have been completed.** **PIP 1 and PIP 2 activities proceeding according to plans; remeasurement activities are scheduled for January.** **QMC is working within its PIP selection process.** **Q 2 (Jan-Mar):** **(March meeting cancelled). PIP 1 CY data submitted for analysis, rechecking data submissions for possible data veracity issues; annual plans have been updated. PIP 2 CY data through June 2019 are available and have been gathered; descriptive analytics have been completed; significance testing will be completed by June 2020 when the full CY data set becomes available; affiliates will continue PIP 2 until decided otherwise. PIP selection process has been completed and the recommendation is pending management team review/approval before notifying QMC and routing to QIC.** **Q 3 (Apr-June):** **PIP 1 – final preparation is underway to submit the validation report in time before the due date.** **PIP 2 – CY 2019 data have been analyzed and will be reviewed at the July meeting.**

				New PIP selection process pending final QMC review/recommendation to QIC. **Q 4 (July-Sept):** **PIP 1 – HSAG validation report consultation meeting with HSAG was completed and its updated version was resubmitted.** **PIP 2 – There was follow up discussion of the CY 2019 data and it was agreed to discontinue this PIP based on the QIC approval of the new PIP.** **New PIP selection was officially launched per QIC approval. RCA and BA activities have begun. The FUH PIP will become the new PIP 2.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue with annual plan** Continue Objective(s)? ☒ Yes ☐ No

External Monitoring Reviews	The goals for FY2020 Reporting are as follows: • To monitor and address activities pertaining to the PIHP Waiver Programs (HSW, CWP, SEDW): a) Ensure non-licensed, non-verified providers meet required qualification b) Ensure support and service providers receive required training on IPOS	• QMC members will follow up and report monthly on each CMHSPs follow up activities to ensure compliance with the MDHHS HSW requirements	Lauren Bondy Quality Management Committee (QMC)	**Goal Met:** ☒ **Yes** ☐ **No** **Quarterly Update:** **Q 1: (Oct-Dec):** **CMHs reported that on-going monitoring in these areas continues to occur. GHS reported they are currently conducting an audit. Lapeer CMH reported that monitoring will begin after January 1, 2020 and new staff have been hired to assist with monitoring.** **Q 2 (Jan-Mar):** **CMHs reported that on-going monitoring in these areas continues to occur. GHS reported they lost a staff involved in this project, but they were replaced. Lapeer CMH reported that monitoring was initiated, and a new staff have been hired to assist with monitoring. MDHHS will be conducting a site review this year.** **Q 3 (Apr-June):** **CMHs reported that on-going monitoring in these areas continues to occur. GHS reported a position has been filled and auditing has resumed. Lapeer CMH reported that a quarterly list was sent out for review. MDHHS will be conducting a site review this year.** **Q 4 (July-Sept):** **CMHs reported that on-going monitoring in these areas continues to occur. Lapeer CMH reports they are continuing monitoring through peer review and provider monitoring. GHS reports the two new auditors are doing quarterly audits, which are going well.**

				The MDHHS Site Review is scheduled for September 1, 2020 – October 7, 2020. Supporting documentation was collected and submitted to MDHHS. During September, MDHHS Auditors had phone conferences with each CMH and the PIHP Site Review Team. Final findings are expected in October during the Exit Conference. **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue with annual plan** Continue Objective(s)? ☒ Yes ☐ No

Monitoring of Quality Areas	The goals for FY2020 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 Indicators • Review / analysis of various regional data reports • Review / analysis of BH TEDS reports	Lauren Bondy Quality Management Committee (QMC)	**Goal Met:** ☒ **Yes** ☐ **No** **Quarterly Update:** **Q 1: (Oct-Dec):** **Monthly critical incident reports were reviewed; each CMH confirmed its data. The following quality / data issues were discussed: code list changes, encounter reporting, BH-TEDS reporting, EDIT meeting updates, and FY19 year-end reporting. Performance Bonus reporting was discussed and the final FY2019 Narrative was provided.** **Q 2 (Jan-Mar):** **Monthly critical incident reports were reviewed; each CMH confirmed its data. EDIT meeting information was shared along with the notification of a new MUNC template on the MDHHS website. The following quality / data issues were discussed: Database Security Application (DSA) requests, BH-TEDS data cleanup, and the HMP Work Rules list.** **Q 3 (Apr-June):** **The April QMC meeting was cancelled. The May QMC meeting was conducted via email. The final FY2020 1st Qtr. MMB Performance Indicator Report and FY2020 RSA Survey Report were shared as handouts. Written updates were shared on the customer satisfaction survey process, qualitative assessments of members' experience with services, and performance improvement projects. CMHs were asked to provide a narrative response of the proposed process developed to conduct qualitative assessments (i.e. focus groups) of member experiences**

				with services. The June QMC meeting occurred via Microsoft Teams. Monthly critical incident reports were reviewed; each CMH confirmed its data. The following quality / data issues were discussed: BH-TEDS, Database Security Application (DSA) Access, and LOCUS Reporting. **Q 4 (July-Sept):** **Monthly critical incident reports were reviewed; each CMH confirmed its data. The following quality / data issues were discussed: BH-TEDS, LOCUS Reporting, address changes in the EHRs, and service code changes.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue with annual plan** Continue Objective(s)? ☒ Yes ☐ No

Financial Management	The goals for FY2020 Reporting are as follows to promote sound fiscal management of the region: • Evaluate funding allocation methodology.	• Determine appropriate risk factors to drive payment methodology. • Create funding report in MIX based on appropriate risk factors. • Present side-by-side comparison of funding under old and new methodology.	Richard Carpenter Finance Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **The funding allocation methodology has been imported to MIX and the committee has taken a first look at a payment comparison analysis for FY19.** **Q 2 (Jan-Mar):** **No progress in Q2 due to year end reporting requirements and COVID-19.** **Q 3 (Apr-June):** **No update so far in Q3. Focus has been on revised revenue rates and DCW increases.** **Q 4 (July-Sept):** **Progress has been made with Kristy to create detail reports needed to evaluate the effectiveness of the new methodology. These reports will be summarized and shared with CMHSP CFOs.** **Evaluation: Behind schedule but now progressing again.** **Barrier Analysis: Reporting barrier has been removed** **Next Steps: CMHSP CFO review and acceptance.** Continue Objective(s)? ☒ Yes ☐ No

Financial Management	The goals for FY2020 Reporting are as follows to promote sound fiscal management of the region: • Implement risk-based payment methodology.	• Identify any barriers to the new risk-based funding model • Modify funding model to eliminate barriers or reduce them to an acceptable level. • Implement new risk-based funding as primary funding mechanism	Richard Carpenter Finance Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **The evaluation of the funding allocation methodology is a prerequisite of this goal. No progress in Q1.** **Q 2 (Jan-Mar):** **No progress in Q2 due to year end reporting requirements and COVID-19.** **Q 3 (Apr-June):** **No update so far in Q3. Focus has been on revised revenue rates and DCW increases.** **Q 4 (July-Sept):** **No progress on this goal pending the finalization of the evaluation goal.** **Evaluation: N/A** **Barrier Analysis: Waiting for completion of Evaluation goal.** **Next Steps: Continue with annual plan** Continue Objective(s)? ☒ Yes ☐ No

Financial Management	The goals for FY2020 Reporting are as follows to promote sound fiscal management of the region: • Bring Service Code Rates within acceptable variance of State-wide average rates.	• Identify significant codes for evaluation • Review variations from state-wide average and identify causes as applicable • Design and implement strategies to move service costs toward the state-wide average where appropriate.	Richard Carpenter Finance Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **The committee has received an analysis of cost per code comparing state-wide average, Region 10 average, and each individual CMHSP. CFOs have been tasked to identify variations that warrant additional discussion/analysis by the group.** **Q 2 (Jan-Mar):** **No progress in Q2 due to year end reporting requirements and COVID-19.** **Q 3 (Apr-June):** **No update so far in Q3. Focus has been on revised revenue rates and DCW increases.** **Q 4 (July-Sept):** **Development of the Independent Rate Model (IRM) group at MDHHS and the development of a standard fee schedule makes this goal** **Evaluation: Goal no longer relevant for the business needs of Region 10 or CMHSPs** **Barrier Analysis: New State projects has superseded this project** **Next Steps: Recommended elimination of this goal** Continue Objective(s)? ☐ Yes ☒ No

Financial Management	The goals for FY2020 Reporting are as follows to promote sound fiscal management of the region: • Bring Service utilization within acceptable variance of State-wide average.	• Identify significant services for evaluation • Review variations from state-wide average and identify significant gaps in service availability, how services are authorized, or how services are delivered • Design and implement strategies to move service utilization toward the state-wide average where appropriate.	Richard Carpenter Finance Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **The committee has received an analysis of cost per case and units per case comparing state-wide average, Region 10 average, and each individual CMHSP. CFOs have been tasked to identify variations that warrant additional discussion/analysis by the group.** **Q 2 (Jan-Mar):** **No progress in Q2 due to year end reporting requirements and COVID-19.** **Q 3 (Apr-June):** **No update so far in Q3. Focus has been on revised revenue rates and DCW increases.** **Q 4 (July-Sept):** **Development of the Independent Rate Model (IRM) group at MDHHS and the development of a standard fee schedule makes this goal** **Evaluation: Goal no longer relevant for the business needs of Region 10 or CMHSPs** **Barrier Analysis: New State projects has superseded this project** **Next Steps: Recommended elimination of this goal** Continue Objective(s)? ☐ Yes ☒ No

Utilization Management	• Ensure that monthly regional service utilization reports are generated (10/1/19 – 9/30/20).	• Monitor and advise on regional Crisis service utilization reports (monthly PCE-based reports), including new services implementation	Tom Seilheimer Utilization Management (UM) Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Crisis services reports are being monitored; no service utilization issues are thus far suggested by the data.** **Q 2 (Jan-Mar):** **(March meeting cancelled). Monthly crisis services reports have been reviewed through February, with no issues identified or recommendations.** **Q 3 (Apr-June):** **The April meeting was cancelled, and the May and June meetings were held via secure email.** **Crisis services reports were reviewed, noting no concerning trends.** **Q 4 (July-Sept):** **Crisis services reports were reviewed; community-based crisis services appear to be trending slightly downward in connection to COVID-19 issues, but thus far no concerning trends are noted, as programs have continued implementing service outreach and service provision workarounds.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue with annual plan** Continue Objective(s)? ☒ Yes ☐ No

Utilization Management	Provide periodic oversight on the use of restrictive and intrusive behavioral techniques, physical management or 911 contact with law enforcement use on an emergency basis.	Monitor and advise on BTPRC data on use of Restrictive and Intrusive techniques, physical management or contact with law enforcement use on an emergency behavior basis; evaluate reports per committee review / discussion of findings, trends, potential systems improvement opportunities, adherence to standards.	Tom Seilheimer Utilization Management (UM) Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Quarterly BTPRC and PM services reports are being monitored; no service utilization or care issues are thus far suggested by the data.** **Q 2 (Jan-Mar):** **(March meeting cancelled), Quarterly BTPRC reports have been reviewed, with a late submission from GHS to be received for the next UMC meeting; thus far, no issues identified or recommendations.** **Q 3 (Apr-June):** **The April meeting was cancelled, and the May and June meetings were held via secure email.** **Reports were reviewed, noting no concerning trends.** **Q 4 (July-Sept):** **Quarterly reports were reviewed and a marginal decrease in activity was noted, due to COVID-19 constraints. Also, BTPRC activities were briefly interrupted, but thus far no service issues have been identified.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue with annual plan** 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 outlier-based case record selection methodology • Targeted case record review of community-based services per outlier-based case record selection methodology, per CMHSP delegation agreements • Explore feasible opportunities for additional outlier-based UR linked to high-cost and / or high-risk	Tom Seilheimer Utilization Management (UM) Committee	**Goal Met:** ☒ **Yes** ☐ **No** **Quarterly Update:** **Q 1: (Oct-Dec):** **FY 2019 EOY UR Report was reviewed and approved. SUD programs met overall compliance targets, and per-case corrective actions have been completed; findings will in-part inform FY 2020 SUD UR planning, which is in-process.** **CMHSP UR reports were reviewed in December, and the EOY UR Report was thereby updated. Findings indicate broad compliance to service utilization standards, and per-case corrective actions have been completed.** **Feasible opportunities for additional outlier-based UR linked to high-cost and / or high-risk have been discussed in connection with within UM Redesign (e.g. CLS, skill-building).** **Q 2 (Jan-Mar):** **(March meeting cancelled). SUD outlier reports are under development, with an anticipated 3Q implementation. Community based UR is pending quarterly reporting cycle. Discussions continue to take place within the ongoing UM Redesign project.** **Q 3 (Apr-June):** **The April meeting was cancelled, and the May and June meetings were held via secure email.** **SUD UR has begun in June as per annual plan.**

				CMH UR June reports received from GHS, Lapeer and St. Clair; no service utilization issues reported. Sanilac's report is not yet received and has been placed on the July Agenda. **No discussion regarding additional areas of UR.** **Q 4 (July-Sept):** **SUD UR was completed as scheduled; POCs have been reviewed and an annual report is submitted for QIC review and approval. CMH UR was completed as scheduled, and the EOY report is expected to be reviewed at the October meeting. Other UR opportunities have been identified and are noted in the FY 2021 UM Program Plan Description.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue with annual plan** Continue Objective(s)? ☒ Yes ☐ No

Utilization Management	• Promote aligned care management activities across key areas of network operations.	• Implement Centralized UM System • Promote aligned care management activities across Access Management System Access sites • Monitor and advise on community access care management activities: Quarterly Customer Involvement, Wellness/Healthy Communities reports	Tom Seilheimer Utilization Management (UM) Committee	**Quarterly Update:** **Q 1: (Oct-Dec):** **The Pilot Project Evaluation Report has been reviewed and approved by the committee. Work is ongoing with the TBDS consultants in aspects of implementation planning. GHS Orientation meetings have begun, and the OASIS PCE user group has been closely monitored.** **Access EOY Report was reviewed and approved by committee, endorsing continued opportunities to align operations across both Access sites; annual trends reveal increased Access requests and screens, continued low rates of second opinions and high rates of consumer satisfaction.** **Community access care management activities and Quarterly Customer Involvement, Wellness/Healthy Communities reports have been reviewed; discussion highlighted various activities CMHSPs are doing to ensure local community outreach and anti-stigma education.** **Q 2 (Jan-Mar):** **(March meeting cancelled). UM Redesign work proceeds, per updated task and implementation dates. Pending AMS semi-annual report cycle. Quarterly reporting presented and discussed, noting a wide range of community support and outreach activities.** **Q 3 (Apr-June):** **The April meeting was cancelled, and the May and June meetings were held via secure email.**

				UM Redesign work proceeds, per updated task and implementation dates, although CMHSPs have not yet completed their implementation tasks with PCE. A meeting has been scheduled with the CMH OASIS users on July 14th. **AMS semi-annual report was reviewed at the June meeting and approved as submitted.** **The Quarterly Customer Involvement, Wellness/Healthy Communities reports will be reviewed as scheduled next quarter.** **Q 4 (July-Sept):** **UM Redesign activities continue; CMH OASIS User Group meeting are being regularly held, and thus far PCE redesign activities are on track. Final designs are underway for the UM Department to conduct centralized CMH UR beginning 1Q FY 2021.** **The FY 2021 UM Program Plan is submitted to QIC for review and approval.** **EOY report pending.** **Quarterly reports were reviewed, noting various and intensive efforts to address COVID-19 service engagement and delivery issues as well as community support and collaborations.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue with annual plan**

				Continue Objective(s)? ☒ Yes ☐ No

Corporate Compliance	• Compliance with 42 CFR 438.608 Program Integrity requirements. 9/30/20	• Review requirements • Identify and document responsible entities • Identify and document supporting evidence / practice • Ongoing policy review • Review PIHP plan updates • Make recommendations on updates	Katie Forbes Corporate Compliance Committee	**Goal Met:** ☒ **Yes** ☐ **No** **Quarterly Update:** **Q 1: (Oct-Dec):** **Reviewed FY2019 Annual Corporate Compliance Report. Reviewed PIHP (new) HIPAA Breach Notification Policy. PIHP Corporate Compliance & Ethics Week celebration. MDHHS / PIHP contract negotiations on hold for area of Program Integrity.** **Q 2 (Jan-Mar):** **MDHHS/PIHP contract negotiations update: MDHHS/OIG is withdrawing current language proposed in area of Program Integrity. MDHHS will remove from FY20 items. Training provided to SUD Providers on reporting expectations.** **Q 3 (Apr-June):** **No updates** **Q 4 (July-Sept):** **FY21 Corporate Compliance Plan reviewed and approved by PIHP Board.** **Corporate Compliance & Ethics Week Committee started weekly meetings to prepare activities for Compliance & Ethics Week in November.** **Evaluation: Completed** **Barrier Analysis: None** **Next Steps: Continue to monitor** Continue Objective(s)? ☒ Yes ☐ No
Corporate Compliance	• Support reporting requirements (quarterly and ongoing) as defined by MDHHS, OIG, PIHP, etc. 9/30/20	• Ongoing review of reporting process	Katie Forbes	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):**

			Corporate Compliance Committee	**Submitted PIHP 4Q Report and Annual Contracted Entities Report to the OIG. Reviewed updated OIG and PIHP guidance for reporting categories. Completed internal PIHP meeting to review current data mining activities.** **Q 2 (Jan-Mar):** **Submitted PIHP Q1 Report and Annual Contracted Entities Report to the OIG. Reviewed updated OIG and PIHP guidance for reporting categories. Completed internal PIHP meeting to review current data mining activities. PIHP has current data mining project in motion with 1 current activity planned for Q2 reporting.** **Q 3 (Apr-June):** **Submitted PIHP Q2 Report to the OIG (included data mining activity).** **Q 4 (July-Sept):** **Submitted PIHP Q3 Report to the OIG. PIHP staff provided additional training to PIHP staff and Provider Network that participate in the OIG Program Integrity quarterly reporting requirements. Training included a review of the report template and guidance document to ensure completion is consistent and accurate. PIHP has submitted first data mining activity with second activity in motion.** **Evaluation: Completed** **Barrier Analysis: None** **Next Steps: Continue to monitor** Continue Objective(s)? ☒ Yes ☐ No

Corporate Compliance	• Review regional Corporate Compliance monitoring standards, reports and outcomes. 9/30/20	• Review contract monitoring results	Katie Forbes Corporate Compliance Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Reviewed FY19 Annual PIHP Contract Monitoring results for the Corporate Compliance standards.** **Q 2 (Jan-Mar):** **Completed recommendations for FY20 Semi-Annual Contract Monitoring performance standards and completed initial subject matter expert reviews.** **Q 3 (Apr-June):** **No updates** **Q 4 (July-Sept):** **FY20 Annual Contract Monitoring preliminary reviews have been completed for Provider Network (CMH and SUD).** **Evaluation: Completed** **Barrier Analysis: N/A** **Next Steps: Continue to monitor** 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 Address cultural and linguistic needs of members. Review capacity concerns identified (e.g. Autism, Mobile Intensive Crisis Stabilization).	Amanda Zabor Provider Network Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Work continues on the update of the CMH Provider Directories to bring into compliance. This will be an area of focus for FY2020. PIHP PNM staff and Autism staff are working together to improve CMH service gap reporting requirements as it relates to Autism. PIHP staff is looking at ways to improve the Mobile ICSS for Children reporting process. SUD Network gaps are being reviewed.** **Q 2 (Jan-Mar):** **CMH Contract Performance Objectives have been amended to include enhanced reporting requirements for CMH Providers who maintain a gap in service capacity for Autism services.** **Preliminary discussions are taking place with PIHP staff regarding the review of the PIHP SUD Network and any service capacity gaps.** **Q 3 (Apr-June):** **No updates** **Q 4 (July-Sept):** **The PIHP has issued a Request for Proposal (RFP) for SUD Opioid Treatment Provider (OTP) Services due to a gap in dispensing/dosing Methadone, Suboxone, and other treatment medications in St. Clair, Sanilac, and Lapeer counties. The successful bidder(s) will be located in the Port Huron area. The RFP is open until the beginning of October.** **The PIHP is seeing a need for residential services for adolescent**

				females. At this time, the need outweighs the availability of services. **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue facilitation of the RFP. Review recommendations by PIHP Leadership for SUD Residential options for adolescent females.** Continue Objective(s)? ☒ Yes ☐ No
Provider Network	• Review Network Adequacy requirements and address compliance with standards.	• Review MDHHS standards and current Network Adequacy • Address Network Adequacy concerns	Amanda Zabor Provider Network Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec): No further information has been received from MDHHS.** **Q 2 (Jan-Mar):** **No update.** **Q 3 (Apr-June):** **No updates** **Q 4 (July-Sept):** **The PIHP has hired an Administrative Coordinator for the Provider Network Management Department. The coordinator will be reviewing MDHHS standards and our current Network Adequacy once she is fully trained. No updates have been received from MDHHS.** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Waiting for further information from MDHHS. Continue training new PIHP staff.** 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 opportunities for reporting efficiency and effectiveness	Katie Forbes / Amanda Zabor Provider Network Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Provider Network Directory improvements are a focus area for FY20. PIHP staff will be working with Provider staff to bring directories into compliance.** **Q 2 (Jan-Mar):** **Work continues by PIHP staff to gather information and identify barriers and solutions to bring Network Directories into compliance across all CMH Providers.** **Q 3 (Apr-June):** **The responsible staff / department is being changed to Katie Forbes in the Customer Services Department. Staff from both the Provider Network Management Department and Customer Services Department met to discuss the transition.** **Q 4 (July-Sept):** **The PIHP has initiated monthly workgroup meetings that focus on compliance within directories. Two meetings have been conducted with full CMH engagement and participation. Workgroup meetings are scheduled through January 2021 with the goal of full compliance by January 2021.** **Evaluation: Completed** **Barrier Analysis: None** **Next Steps: Continue to monitor** 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:** **Q 1: (Oct-Dec):** **The aggregate report has been shared with the Provider Network Committee. FY20 Contract Monitoring preparation has begun.** **Q 2 (Jan-Mar):** **The PIHP has modified its formal Contract Monitoring frequency from three (3) standard evaluation periods to two (2) standard evaluation periods: Semi-Annual and Annual.** **The PIHP has enhanced the comprehensiveness of its Contract Monitoring evaluation tools regarding performance standards and interpretive guidelines.** **Work continues on revising the PIHP Provider Network Policies.** **The FY2020 Semi-Annual Monitoring Cycle for CMH and SUD Providers is underway.** **Q 3 (Apr-June):** **No updates** **Q 4 (July-Sept):** **The Semi-Annual Contract monitoring cycle is complete with corrective actions in place. The Annual Contract Monitoring Process is well underway, with Desk Audit requests out to Providers. PNM staff will be reviewing training and P & C records electronically this fiscal year rather than in person.** **Evaluation: Progress** **Barrier Analysis: Due to ongoing pandemic concerns, in person**

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<tr>
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<td>monitoring will not be taking place during the Annual Monitoring cycle.
Next Steps: Continue Monitoring Process.
Continue Objective(s)?
☒ Yes ☐ No</td>
</tr>
<tr>
<td>Grievances</td>
<td>
• To review and analyze baseline grievance data for the region for FY2020.

Grievances:
<table>
<tr><th colspan="8">Reporting Period: FY2020</th></tr>
<tr><th rowspan="2"></th><th rowspan="2">Q1</th><th rowspan="2">Q2</th><th rowspan="2">Q3</th><th colspan="3">Q4</th><th rowspan="2">Total</th></tr>
<tr><th>Jul</th><th>Aug</th><th>Sep</th></tr>
<tr><td>GHS</td><td>13</td><td>18</td><td>5</td><td>5</td><td>2</td><td>n/r</td><td>43</td></tr>
<tr><td>Lapeer</td><td>2</td><td>2</td><td>0</td><td>0</td><td>0</td><td>1</td><td>5</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>0</td><td>0</td><td>0</td><td>n/r</td><td>0</td></tr>
<tr><td>SUD</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>PIHP</td><td>1</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td><td>2</td></tr>
<tr><td>TOTAL</td><td>16</td><td>22</td><td>6</td><td>5</td><td>2</td><td>1</td><td>52</td></tr>
<tr><th colspan="7">Reason for Grievance:</th><th>Total</th></tr>
<tr><td colspan="7">Financial Matters</td><td>0</td></tr>
<tr><td colspan="7">Quality of Care</td><td>27</td></tr>
<tr><td colspan="7">Service Concerns / Availability</td><td>20</td></tr>
<tr><td colspan="7">Service Environment</td><td>4</td></tr>
<tr><td colspan="7">Suggestions / Recommendations</td><td>0</td></tr>
<tr><td colspan="7">Other</td><td>1</td></tr>
</table>
</td>
<td>• To track and trend internally the grievances on a monthly basis.
• Identify consistent patterns related to member grievances.
• Develop interventions to address critical issues within the organization.</td>
<td>Katie Forbes

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

Quarterly Update:
Q 1: (Oct-Dec): The FY19 Annual G & A Report was completed and presented to Management Team in December. It will also be presented at the January CEO and Board meetings.

Grievance numbers reported to date for Q1 are listed in the table to the left. Total number of grievances for Q1 is twelve (12). Not all grievance data for Q1 has been reported. There was no change in the number of grievances reported for FY19 Q4 which was also twelve (12).

Q2: (Jan-Mar):
The FY19 Annual G & A Report was presented to the January CEO and Board meetings.

Grievance numbers reported to date for Q2 are listed in the table to the left. Total number of grievances for Q2 is twenty-three (23). All grievance data for Q2 has been collected. There was a decrease in the number of grievances reported from FY19 Q2 which was twenty-eight (28).

Semi-Annual Grievance Record Reviews were completed. Providers issued review results; no follow up action necessary.</td>
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				Q 3 (Apr-June): **Grievance numbers reported to date for Q3 are listed in the table to the left. Total number of grievances for Q3 is six (6). Not all grievance data for Q3 has been reported. There is a decrease in the number of grievances reported from FY19 Q3 which was fifteen (15). Customer Service staff are continuing to work with Providers on all requirements and timeframes for grievance reporting.** **Q 4 (July-Sept):** **Grievance numbers reported to date for Q4 are listed in the table to the left. Total number of grievances for Q4 is eight (8). Not all grievance data for Q4 has been reported. There has been a decrease in the number of grievances reported from FY19 Q4 which was twelve (12). Customer Service staff are continuing to work with Providers on all requirements and timeframes for grievance reporting.** **Evaluation: Completed** **Barrier Analysis: None** **Next Steps: Continue to monitor.** Continue Objective(s)? ☒ Yes ☐ No

Appeals

- To review and analyze baseline appeals data for the region for FY2020.

Appeals:

Reporting Period: FY2020							
	Q1	**Q2**	**Q3**	**Q4**			**Total**
				Jul	**Aug**	**Sep**	
GHS	4	10	0	0	0	2	16
Lapeer	0	0	0	0	0	0	0
Sanilac	0	1	0	0	0	0	1
St. Clair	0	0	0	0	0	1	1
SUD	0	0	0	0	0	0	0
PIHP	3	0	0	0	0	1	4
TOTAL	7	11	0	0	0	4	22

Reason for Appeal:	**Total**
Grievance not resolved within allowed days	0
Requested not acted on within 14 days	0
Service Denial	14
Service not started within 14 days	0
Service Reduction	0
Service Suspension	2
Service Termination	6

- To track and trend internally the appeals on a monthly basis.
- Identify consistent patterns related to member appeals.
- Develop interventions to address critical issues within the organization.

Katie Forbes

Quality Improvement Committee

Goal Met: ☒ Yes ☐ No

Quarterly Update:
Q 1: (Oct-Dec): The FY19 Annual G & A Report was completed and presented to Management Team in December. It will also be presented at the January CEO and Board meetings.

Appeal numbers from Q1 are listed in the table to the left. Total number of appeals for Q1 seven (7) a decrease from Q4 (21). An additional sixty-eight (68) customer service inquiries were handled/resolved in Q1 without opening a formal appeal. This is an increase from FY19 Q4 forty-six (46).

Q2 (Jan-Mar):
The FY19 Annual G&A Report was presented at the January CEO and Board meetings.

Appeal numbers from Q2 are listed in the table to the left. Total number of appeals for Q2 eleven (11) a decrease from FY19 Q2 forty-five (45). An additional fifty-four (54) customer service inquiries were handled/resolved in Q2 without opening a formal appeal. This is a decrease from FY20 Q1 which was sixty-nine (69). A decrease in appeals was expected as the PIHP has enhanced communication with Providers on resolving customer inquiries prior to initiating a formal appeal.

Q 3 (Apr-June):
Appeal numbers from Q3 are listed in the table to the left. Total number of appeals for Q3 is zero (0) a decrease

Customer Service Inquiries:

Reporting Period: FY2020							
	Q1	Q2	Q3	Q4			Total
				Jul	Aug	Sep	
GHS	61	47	30	9	16	12	175
Lapeer	0	1	0	3	0	0	4
Sanilac	1	0	1	0	0	0	2
St. Clair	2	1	0	0	0	2	5
SUD	2	3	1	0	1	0	7
PIHP	3	2	0	2	0	1	8
TOTAL	69	54	32	14	17	15	201

Inquiry Resolution Categories:	Total
Appeal	7
Grievance	2
Listen/Support	5
Other	17
Referral to Access	58
Referral to Provider	12
PIHP Customer Service	96
Rights Complaint	1
Pending	3

from FY19 Q3 thirty-seven (37). An additional thirty-two (32) customer service inquiries were handled/resolved in Q3 without opening a formal appeal. This is a decrease from FY20 Q2 which was fifty-four (54). A decrease in appeals was expected as the PIHP has enhanced communication with Providers on resolving customer service inquiries prior to initiating a formal appeal.

Q 4 (July-Sept):
Appeal numbers from Q4 are listed in the table to the left. Total number of appeals for Q4 is four (4) a decrease from FY19 Q4 which was twenty-one (21). An additional forty-six (46) customer service inquiries were handled/resolved in Q4 without opening a formal appeal. This is an increase from FY20 Q3 which was thirty-two (32). A decrease in appeals was expected as the PIHP has enhanced communication with Providers on resolving customer service inquiries prior to initiating a formal appeal process. FY20 is the first year we are tracking customer service inquiry data.

Evaluation: Completed
Barrier Analysis: None
Next Steps: Continue to monitor
Continue Objective(s)?
☒ Yes ☐ No

Credentialing / Privileging	• Complete Privileging and Credentialing reviews and approval process of Organizational Applications for CMH and SUD Providers.	• Review all Organizational Applications: ○ Current Providers ○ New Providers ○ Existing Provider Renewals / Updates ○ Provider Terminations / Suspensions / Probationary Status	Amanda Zabor Privileging and Credentialing Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **All organizational applications are current and complete. Flint Odyssey House was granted full privileges following PIHP Management Review.** **Q 2 (Jan-Mar):** **During FY2020 2Q P & C Committee meetings, organizational application updates for St. Clair CMH, Holy Cross Services, and Flint Odyssey House were approved. All organizational applications remain current and complete.** **Q 3 (Apr-June):** **No updates** **Q 4 (July-Sept):** **During FY2020 4Q, the P & C Committee approved an organizational application for Great Lakes Recovery Center. An application update for New Paths was approved by the Committee, and Salvation Army was re-credentialed with full privileges of 2 years granted. Timely notification was sent to all Providers. Organizational applications remain current and complete.** **Evaluation: Progress** **Barrier Analysis: The P & C Organizational application is not as organized and user friendly as it could be.** **Next Steps: PIHP staff will continue to meet regarding improving forms, process and procedure for P & C**

				organizational application review and approval. Continue Objective(s)? ☒ Yes ☐ No

Credentialing / Privileging	• Complete Privileging and Credentialing reviews and approval process of all applicable Region 10 staff.	• 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	Amanda Zabor Privileging and Credentialing Committee	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **All practitioner applications are current and complete. In December, one leased staff application will be reviewed by the P & C Committee for approval.** **Q 2 (Jan-Mar):** **During FY2020 2Q P & C Committee meetings, practitioner application approvals included GHS Access Staff members Carrie Corlew-Thayer and Heather Hale. All practitioner applications remain current and complete.** **Q 3 (Apr-June): During FY2020 3Q, the P & C Committee reviewed and approved (electronically) a practitioner application for R10 Chief Clinical Officer Dr. Tom Seilheimer. All practitioner applications remain current and complete.** **Q 4 (July-Sept):** **During FY2020 4Q, there were two (2) practitioner applications reviewed by the P & C Committee, with full recredentialing terms of 2 years granted to each practitioner. Practitioner applications remain current and complete.** **Evaluation: Progress** **Barrier Analysis: The P & C Practitioner application is not as organized and user friendly as it could be.** **Next Steps: PIHP staff will continue to meet regarding improving forms, process and procedure for P & C**

				practitioner application review and approval. Continue Objective(s)? ☒ Yes ☐ No
Credentialing / Privileging	• Maintain policies and procedures on Privileging and Credentialing inclusive of MDHHS and Medicaid standards.	• Review policy content. • Development of Guidance Document. • Enhance Review of Application Evaluation Process.	Amanda Zabor Privileging and Credentialing Committee	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **The P & C policy will be reviewed during FY20 for accuracy and any needed revisions. The guidance document continues to be developed.** **Q 2 (Jan-Mar):** **The PIHP issued a contract amendment for SUD Provider contracts to enhance credentialing language to include provisions regarding written notification of adverse credentialing decisions and ensuring an appeal process for adverse credentialing decisions is communicated.** **The PIHP is revising its Credentialing and Privileging Policy to enhance areas regarding the requirements to provide written notification of adverse credentialing decisions to Organizations and Practitioners with information that an appeal process is available for adverse credentialing decisions.** **Q 3 (Apr-June): During FY2020 3Q, the PIHP Management Team approved updates to the P & C policy, which included information regarding the requirements to provide written notification of adverse credentialing decisions to Organizations and Practitioners with information that an appeal process is available for adverse credentialing decisions.**

				Q 4 (July-Sept): **PIHP staff completed a PowerPoint training for the CMH and SUD Provider Networks regarding the requirements for privileging and credentialing written policies and procedures, organizational and individual practitioner credentialing file requirements, and adverse credentialing determination notifications. The PowerPoint was shared with the entire Network of Providers electronically with a review planned with each Provider via phone or video conference during the annual contract monitoring cycle. Additionally, the PIHP has hired an administrative coordinator in the Provider Network Management Department. One of the coordinator's priorities will be to review the PIHP P & C policy for updates, revisions, etc. once her training is completed.** **Evaluation: Progress** **Barrier Analysis: None** **Next Steps: Continue to review policy and procedures to identify areas for revisions, clarifications, and streamlining of information. Continue to train new PIHP staff.** Continue Objective(s)? ☒ Yes ☐ No
Autism Program	The PIHP will monitor and bring system-wide improvement to the ABA program. 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.	• Monitor persons on autism services overdue list total • Monitor completion of behavioral plans of care	Lauren Bondy Monitored by Quality Improvement Committee (QIC)	**Goal Met:** ☐ Yes ☒ No **Quarterly Update:** **Q 1: (Oct-Dec):** **A) The PIHP continues weekly phone calls with the GHS and LCMH Autism Coordinators to improve SharePoint and WSA management. The total number of GHS enrollees**

		FY20 1Q	FY20 2Q	FY20 3Q	FY20 4Q		
		Dec	Mar	Jun	Jul	Aug	Sep
GHS	**Overdue List Total**	**122**	**122**	**124**	**122**	**129**	**130**
	≥90 (Days)	115	114	122	117	117	118
	60-89	4	4	1	0	1	4
	30-59	3	3	0	1	4	7
	0-29	0	1	1	4	7	1
Lapeer	**Overdue List Total**	**1**	**3**	**5**	**2**	**3**	**6**
	≥90	0	0	3	0	1	1
	60-89	1	0	0	1	0	1
	30-59	0	1	2	0	1	1
	0-29	0	2	0	1	1	3
Sanilac	**Overdue List Total**	**4**	**3**	**3**	**3**	**0**	**2**
	≥90	0	1	3	1	0	0
	60-89	2	0	0	0	0	0
	30-59	1	1	0	0	0	0
	0-29	1	1	0	2	0	2
St. Clair	**Overdue List Total**	**7**	**4**	**4**	**4**	**6**	**10**
	≥90	0	0	4	3	1	1
	60-89	1	1	0	0	0	0
	30-59	4	3	0	0	1	2
	0-29	2	0	0	1	4	7

B) Autism benefit enrollees will receive one or more Family Behavior Treatment Guidance service per quarter.

Percentage of individuals receiving ≥1 Family behavior Treatment Guidance service per quarter.

- Monitor service provision in specified areas
- Monitor documentation submission to Waiver Support Application (WSA)
- Monitor services (encounters) using the funding Source Bucket Report (FSBR)

overdue by 90+ days has not consistently improved. Two new ABA Providers' information was sent to all CMHs. GHS was directed to follow up with each provider by January 17, 2020. It has been recommended to update the PIHP – CMH FY2020 Contract Attachment P.8.9.1: Performance Objectives to increase the GHS provider service capacity plan update from quarterly to monthly. PIHP Autism Team staff and PIHP Provider Network Management Team staff are meeting to prepare recommendations for an improved provider service capacity plan process. Lapeer CMH, Sanilac CMH, and St. Clair CMH have no cases overdue by 90+ days following the end of the quarter.

B) Reports have been developed to calculate compliance with this standard and identify cases out of compliance. A formal process for running and validating these reports will be developed. This standard will be considered for contract monitoring. The PIHP Autism Team will discuss and prepare recommendations for follow-up with CMHs using the data and individual-level detail data.

C) Reports are being developed to calculate compliance with this measure and identify cases out of compliance. PIHP Autism staff will follow up with the GHS and LCMH Autism Coordinators during weekly phone calls to review the open cases without ABA services to determine if WSA data is up to date and discuss if case closure is appropriate.

Data source: Waiver Support Application (WSA) and Funding Source Bucket Report (FSBR)				
	FY19 4Q	**FY20 1Q**	**FY20 2Q**	**FY20 3Q**
Genesee	52.8%	30.5%	23.1%	48.6%
Lapeer	14.8%	15.4%	30.4%	45.5%
Sanilac	81.8%	85.7%	46.2%	66.7%
St. Clair	94.2%	82.8%	84.7%	70.2%

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)				
	FY19 4Q	**FY20 1Q**	**FY20 2Q**	**FY20 3Q**
Genesee	81.9%	70.9%	67.8%	52.4%
Lapeer	77.8%	65.4%	69.6%	72.7%
Sanilac	100.0%	100.0%	96.2%	85.2%
St. Clair	96.2%	91.4%	86.4%	80.7%

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

Q 2 (Jan-Mar):
A) All CMHs have cases waiting to begin ABA services. Information for an ABA Provider interested in expanding in Region 10 was shared with CMH Provider Network / Contract and Autism contacts. The PIHP's process for monitoring provider service capacity is being reviewed and discussed among Autism Team staff and Provider Network Management staff. Additionally, PIHP staff are working to enhance the process for CMH provider service capacity reporting which is a contract requirement for both GHS and LCMH. LCMH continues recruitment for ABA Program staff. GHS posted an RFP for Autism Behavioral Health Services with a focus on after-school, home-based services. The GHS Autism Center started an after-school program to serve individuals waiting. Additionally, GHS reports fewer cases waiting to begin services than calculated by the PIHP. PIHP staff will ask GHS Autism staff what methodology GHS uses for calculating overdue totals.

B) Percentages for FY2020 1Q and 2Q were recalculated using new encounter data. CMHs have not demonstrated consistent improvement in providing one or more Family Behavior Treatment Guidance service per quarter. PIHP Autism Coordinator planned to share this data with CMH Autism Coordinators and designees during FY2020 2Q meetings. However, due to the COVID-19 pandemic, these meetings have been postponed. After reviewing the data with CMH Autism

				Coordinators and designees, the individual cases without a Family Behavior Treatment Guidance service will be securely emailed for CMHs to review. **C) Percentages for FY2020 1Q and 2Q were recalculated using new encounter data. CMHs have not demonstrated consistent improvement in providing one or more ABA service per quarter for Autism Benefit enrollees with an active plan of service. PIHP Autism Coordinator planned to share this data with CMH Autism Coordinators and designees during FY2020 2Q meetings. However, due to the COVID-19 pandemic, these meetings have been postponed. After reviewing the data with CMH Autism Coordinators and designees, the individual cases without an ABA service will be securely emailed for CMHs to review.** **Q 3 (Apr-June):** **A) The directives and protocols during the COVID-19 pandemic impacted ABA service delivery, as well as the completion of documentation and data entry in WSA. MDHHS indicated notes, amendments, and paperwork for Autism cases could wait until further guidance was provided. Due to these factors, it is assumed the data for Q3 is not an accurate representation of the number of individuals waiting to begin ABA services. Additionally, GHS reports the process of bringing on three new ABA Providers has been initiated.**

				B) Percentages for FY2020 3Q were calculated. It is likely the provision of Family Behavior Treatment Guidance services was impacted by the COVID-19 pandemic. This data will be analyzed further when more complete encounter data is available. **C) Percentages for FY2020 3Q were calculated. The provision of ABA services was impacted by the COVID-19 pandemic. This data will be analyzed further when more complete encounter data is available.** **Q 4 (July-Sept):** **A) MDHHS has provided guidance on service delivery, documentation, and data entry. Submissions and approval of plans in WSA was restarted. It continues to be assumed that the data is not an accurate representation of the number of individuals waiting to begin ABA services. GHS has confirmed 3 new contracted ABA providers. GHS also reports that one of their current providers anticipates tripling service capacity. Two of the new providers have begun accepting referrals.** **B) Percentages for FY2020 3Q were calculated. It is likely the provision of Family Behavior Treatment Guidance services was impacted by the COVID-19 pandemic. This data will be analyzed on an ongoing basis as more complete encounter data is available.** **C) Percentages for FY2020 3Q were calculated. The provision of ABA services was impacted by the COVID-19 pandemic. This data will be**

				analyzed on an ongoing basis as more complete encounter data is available. **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Objective to be continued into the following FY.** Continue Objective(s)? ☒ Yes ☐ No
External Quality Review Corrective Actions	Per the 2018-2019 External Quality Review Compliance Monitoring Report for Region 10 PIHP, corrective action plans (CAPs) were needed in the following areas: Standard II. Quality Measurement and Improvement Standard V. Utilization Management Standard XI. Credentialing Standard XVI. Confidentiality of Health Information Per the 2019 External Quality Review Performance Measurement Validation Report for Region 10 PIHP, it was noted that cases reported as exceptions did not have the necessary exception documentation to meet the exclusion criteria. Based on these findings, it was recommended the PIHP incorporate more stringent checks to ensure that exception criteria are followed.	The Subject Matter Expert Lead staff for each area will provide updates regarding the status of corrective action plan activities.	**Compliance Monitoring:** II. Quality Measurement and Improvement – Lauren Bondy V. Utilization Management – Kristen Potthoff XI. Credentialing – Kristen Potthoff XVI. Confidentiality of Health Information – Kristen Potthoff **Performance Measurement Validation:** Lauren Bondy	**Goal Met:** ☒ Yes ☐ No **Quarterly Update:** **Q 1: (Oct-Dec):** **Q 2 (Jan-Mar):** **Compliance Monitoring:** **Quality Measurement and Improvement – Pattie Hayes – To address corrective action needed, the PIHP will work to develop a regional process for qualitative assessments of member experiences, including a process to share assessment results with providers and persons receiving services. The PIHP will also ensure that surveys are administered to at least 100 persons from each CMHSP who receive LTSS or HCBS services. Monitoring will be enhanced to address CMH presentation of survey response to members who receive LTSS / HCBS.** **Utilization Management – Kristen Potthoff – Updated Adverse Benefit Determination (ABD) Notice updated and implemented (PIHP and CMH levels); draft annual Contract Monitoring Tool updated; regional tracking mechanism created to address authorization and Notice timelines.**

				Credentialing – Kristen Potthoff – SUD Provider contract language enhancements complete; draft annual Contract Monitoring Tool updated. **Confidentiality of Health Information – Kristen Potthoff – HIPAA Breach Notification written procedures and letter templates created; HIPAA Breach Notification Policy created and posted; SUD Provider contract language enhancements complete; draft annual Contract Monitoring Tool updated.** **Performance Measurement Validation:** **Pattie Hayes – HSAG recommendations were that the PIHP should incorporate more stringent checks to ensure exception criteria are followed. The process for reviewing SUD Performance Indicators and exceptions was examined in depth beginning in late FY2019. More stringent PI review criteria and follow-up practices have been implemented to ensure compliance with MDHHS Performance indicator calculation specifications.** **Q 3 (Apr-June):** **Compliance Monitoring:** **Quality Measurement and Improvement – Lauren Bondy – The PIHP is working on development of a regional process for qualitative assessments of member experiences with services in conjunction with the Quality Management Committee. The PIHP has developed a process to ensure that providers and persons receiving services are informed of the assessment results. Monitoring will be**

				enhanced to address CMH presentation of survey response to members who receive LTSS / HCBS. **Utilization Management – Kristen Potthoff – No update** **Credentialing – Kristen Potthoff – No update** **Confidentiality of Health Information – Kristen Potthoff – No update** **Performance Measurement Validation:** **Lauren Bondy – The new process for reviewing SUD Performance Indicators and exceptions continues.** **Q 4 (July-Sept):** **Compliance Monitoring:** **Quality Measurement and Improvement – Lauren Bondy – Annual contract monitoring tools updated to ensure enhanced monitoring.** **Utilization Management – Kristen Potthoff – Annual Contract Monitoring tools updated and finalized. ABD Notice Tracking Log completed and shared with Provider Network. Draft Utilization Management Policy modifications in process.** **Credentialing – Kristen Potthoff – Annual Contract Monitoring tools updated and finalized. Credentialing Policy modifications complete. Provider Training materials completed.**

				Confidentiality of Health Information – Kristen Potthoff – Annual Contract Monitoring tools updated and finalized. **Performance Measurement Validation:** **Lauren Bondy – The process for reviewing SUD Performance Indicators and exceptions continues.** **Evaluation: Progress** **Barrier Analysis: No barriers** **Next Steps: Continue with annual plan** Continue Objective(s)? ☒ Yes ☐ No

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As of 9.30.2020