REGION 10 QAPIP ORGANIZATIONAL STRUCTURE

Region 10 PIHP Board

Consumer Advisory Councils
- Genesee
- Lapeer
- Sanilac
- St. Clair

SUD Advisory Board

Quality Improvement Committee
- PIHP CEO (Chair)
- PIHP CCO
- PIHP CFO
- PIHP Admin Director / Compliance Officer
- Committee Chairs

Compliance Committee
- Region 10
- CMH Providers
- SUD Providers

Finance Committee
- Region 10
- CMH Providers
- SUD Providers

Improving Practices Leadership
- Region 10
- CMH Providers
- SUD Providers

Privileging and Credentialing
- Region 10
- CMH Providers
- SUD Providers

Provider Network Management
- Region 10
- CMH Providers
- SUD Providers

Quality Management
- Region 10
- CMH Providers
- SUD Providers

Sentinel Events Review
- Region 10
- CMH Providers
- SUD Providers

Utilization Management
- Region 10
- CMH Providers
- SUD Providers

*Behavior Mgmt. Treatment Plan Review
Quality Management Fiscal Year (FY) 2020 Work Plan (October 1, 2019 – September 30, 2020)

<table>
<thead>
<tr>
<th>Component</th>
<th>Goals/Timeframe</th>
<th>Planned Activities</th>
<th>Responsible Staff/Department</th>
<th>Status Update</th>
</tr>
</thead>
</table>
| Q1 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): Evaluation: Completed  
Barrier Analysis: No barriers  
Next Steps: Objective to be continued into the following FY.  
Continue Objective(s)? ☒ Yes ☐ No |
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| 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): 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): Evaluation: Completed  
Barrier Analysis: No barriers  
Next Steps: Objective to be continued into the following FY.  
Continue Objective(s)? ☒ Yes ☐ No |
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

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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):
Evaluation: Completed
Barrier Analysis: No barriers
Next Steps: Objective to be continued into the following FY.
Continue Objective(s)?
☒ Yes ☐ No

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 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
| 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 deaths review processes and ensure follow-up as deemed necessary. | Tom Seilheimer  
Sentinel Event Review Committee | and C Survey processes must be completed by 7-31-2020.  
Q 4 (July-Sept):  
Evaluation: Completed  
Barrier Analysis: No barriers  
Next Steps: Objective to be continued into the following FY. Continue Objective(s)?  
☐ 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 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):
Evaluation: Completed
Barrier Analysis: No barriers
Next Steps: Objective to be continued into the following FY.
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 | 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.  
MMBIPS #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):  
Evaluation: Completed  
Barrier Analysis: No barriers  
Next Steps: Objective to be continued into the following FY.  
Continue Objective(s)?  
☑ Yes ☐ No |
The goals for FY2020 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 MMBPIS data

<table>
<thead>
<tr>
<th>Michigan Mission Based Performance Indicator System (MMBPIS)</th>
<th>FY19 Q4</th>
<th>FY20 Q1</th>
<th>FY20 Q2</th>
<th>FY20 Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>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>
<td>1.1 Children</td>
<td>99.63%</td>
<td>99.73%</td>
<td>99.71%</td>
</tr>
<tr>
<td></td>
<td>1.2 Adults</td>
<td>99.83%</td>
<td>99.91%</td>
<td>100%</td>
</tr>
<tr>
<td>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%</td>
<td>2 PIHP Total</td>
<td>99.03%</td>
<td>99.18%</td>
<td>99.04%</td>
</tr>
<tr>
<td></td>
<td>2.1 MI-Children</td>
<td>100%</td>
<td>99.25%</td>
<td>99.22%</td>
</tr>
<tr>
<td></td>
<td>2.2 MI-Adults</td>
<td>100%</td>
<td>99.79%</td>
<td>99.18%</td>
</tr>
<tr>
<td></td>
<td>2.3 DD-Children</td>
<td>100%</td>
<td>100%</td>
<td>97.85%</td>
</tr>
<tr>
<td></td>
<td>2.4 DD-Adults</td>
<td>100%</td>
<td>100%</td>
<td>98.08%</td>
</tr>
<tr>
<td></td>
<td>2.5 SUD</td>
<td>98.19%</td>
<td>98.72%</td>
<td>99.09%</td>
</tr>
<tr>
<td>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%</td>
<td>3 PIHP Total</td>
<td>98.08%</td>
<td>98.51%</td>
<td>98.14%</td>
</tr>
<tr>
<td></td>
<td>3.1 MI-Children</td>
<td>99.44%</td>
<td>98.40%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>3.2 MI-Adults</td>
<td>99.36%</td>
<td>99.20%</td>
<td>99.05%</td>
</tr>
<tr>
<td></td>
<td>3.3 DD-Children</td>
<td>100%</td>
<td>100%</td>
<td>99.07%</td>
</tr>
<tr>
<td></td>
<td>3.4 DD-Adults</td>
<td>98.11%</td>
<td>100%</td>
<td>98.08%</td>
</tr>
<tr>
<td></td>
<td>3.5 SUD</td>
<td>96.90%</td>
<td>97.84%</td>
<td>96.87%</td>
</tr>
<tr>
<td>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>
<td>4a.1 Children</td>
<td>100%</td>
<td>97.53%</td>
<td>97.37%</td>
</tr>
<tr>
<td></td>
<td>4a.2 Adults</td>
<td>97.71%</td>
<td>96.67%</td>
<td>95.42%</td>
</tr>
<tr>
<td></td>
<td>4b SUD</td>
<td>98.88%</td>
<td>93.68%</td>
<td>92.13%</td>
</tr>
<tr>
<td>Ind. 10 – Percentage of readmissions of children and adults to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less</td>
<td>10.1 Children</td>
<td>8.05%</td>
<td>7.69%</td>
<td>7.21%</td>
</tr>
<tr>
<td></td>
<td>10.2 Adults</td>
<td>12.26%</td>
<td>14.15%</td>
<td>11.66%</td>
</tr>
</tbody>
</table>

Lauren Bondy
QI Department
Quality Management Committee (QMC)

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.

Q 4 (July-Sept):
Evaluation: Progress  
Barrier Analysis: None  
Next Steps: Continue  
Continue Objective(s)?  
☐ Yes  ☐ No
### Members’ Experience

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.
- Conduct regional consumer satisfaction survey
- Conduct MDHHS annual consumer satisfaction survey
- Develop interventions to address areas for improvement based on FY2020-member satisfaction survey

<table>
<thead>
<tr>
<th>Goal Met:</th>
<th>☐ Yes ☐ No</th>
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<thead>
<tr>
<th>Quarterly Update: Q 1: (Oct-Dec):</th>
<th>PIHP Quality staff are drafting the final report.</th>
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</thead>
</table>

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.

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.

<table>
<thead>
<tr>
<th>Lauren Bondy</th>
<th>QI Department</th>
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<tbody>
<tr>
<td></td>
<td>Quality Management Committee (QMC)</td>
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<tr>
<td><strong>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.</strong></td>
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</table>
| **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):**  
Evaluation: Progress  
Barrier Analysis: None  
Next Steps: Continue |
| Continue Objective(s)?  
☑ Yes ☐ No |
<table>
<thead>
<tr>
<th>State Mandated Performance Improvement Projects</th>
<th>The goals for FY2020 Reporting are as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify and implement 2 PIP projects that meet MDHHS standards:</td>
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<tr>
<td>Improvement Project #1</td>
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<tr>
<td>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.</td>
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<tr>
<td>Improvement Project #2</td>
<td></td>
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<tr>
<td>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.”</td>
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<tr>
<td>• HSAG report on PIP interventions and baseline</td>
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<tr>
<td>• PIP Status updates to Quality Management Committee</td>
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<td>• QMC to consider selection of PIP projects aimed at impacting error reduction, improving safety and quality</td>
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<tr>
<td>Tom Seilheimer</td>
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<td>Quality Management Committee (QMC)</td>
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<tr>
<td>Goal Met:</td>
<td>Yes No</td>
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<td>Quarterly Update:</td>
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<tr>
<td>Q 1: (Oct-Dec):</td>
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<tr>
<td>HSAG findings and remediation activities have been completed.</td>
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<td>PIP 1 and PIP 2 activities proceeding according to plans; remeasurement activities are scheduled for January.</td>
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<td>QMC is working within its PIP selection process.</td>
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<td>Q 2 (Jan-Mar):</td>
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<tr>
<td>(March meeting cancelled)</td>
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<td>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.</td>
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<td>Q 3 (Apr-June):</td>
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<tr>
<td>PIP 1 – final preparation is underway to submit the validation report in time before the due date.</td>
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<td>PIP 2 – CY 2019 data have been analyzed and will be reviewed at the July meeting.</td>
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<td>Q 4 (July-Sept):</td>
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<tr>
<td>Evaluation: Completed</td>
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<tr>
<td>Barrier Analysis: No barriers</td>
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<tr>
<td>Next Steps: Objective to be continued into the following FY.</td>
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<tr>
<td>Continue Objective(s)?</td>
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<td>☒ Yes ☐ No</td>
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</table>

New PIP selection process pending final QMC review/recommendation to QIC.
## 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

<table>
<thead>
<tr>
<th>Goal Met:</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>Lauren Bondy Quality Management Committee (QMC)</td>
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| 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): |
| Evaluation: Progress Barrier Analysis: None Next Steps: Continue 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):

Evaluation: Progress
Barrier Analysis: None
Next Steps: Continue
Continue Objective(s)?
☑ Yes ☐ No
<table>
<thead>
<tr>
<th>Financial Management</th>
<th>The goals for FY2020 Reporting are as follows to promote sound fiscal management of the region:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Evaluate funding allocation methodology.</td>
</tr>
<tr>
<td></td>
<td>• Determine appropriate risk factors to drive payment methodology.</td>
</tr>
<tr>
<td></td>
<td>• Create funding report in MIX based on appropriate risk factors.</td>
</tr>
<tr>
<td></td>
<td>• Present side-by-side comparison of funding under old and new methodology.</td>
</tr>
<tr>
<td></td>
<td>Richard Carpenter</td>
</tr>
<tr>
<td></td>
<td>Finance Committee</td>
</tr>
<tr>
<td>Goal Met:</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Quarterly Update:</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Q 2 (Jan-Mar): No progress in Q2 due to year end reporting requirements and COVID-19.</td>
</tr>
<tr>
<td></td>
<td>Q 3 (Apr-June): No update so far in Q3. Focus has been on revised revenue rates and DCW increases.</td>
</tr>
<tr>
<td></td>
<td>Q 4 (July-Sept):</td>
</tr>
<tr>
<td>Evaluation:</td>
<td>Progress</td>
</tr>
<tr>
<td>Barrier Analysis:</td>
<td>None</td>
</tr>
<tr>
<td>Next Steps:</td>
<td>Continue</td>
</tr>
<tr>
<td>Continue Objective(s)?</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>
| 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):
Evaluation: Progress
Barrier Analysis: None
Next Steps: Continue
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):  
Evaluation: Progress  
Barrier Analysis: None  
Next Steps: Continue  
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

<table>
<thead>
<tr>
<th>Goal Met:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### 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):
Evaluation: Progress
Barrier Analysis: None
Next Steps: Continue
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): Evaluation: Completed Barrier Analysis: No barriers Next Steps: Objective to be continued into the following FY. 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): Evaluation: Completed  
Barrier Analysis: No barriers  
Next Steps: Objective to be continued into the following 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 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):

Evaluation: Completed
Barrier Analysis: No barriers
Next Steps: Objective to be continued into the following FY.
Continue Objective(s)?
☑ Yes ☐ No
| Utilization Management | • 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 | Goal Met: ☒ Yes ☐ No  
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. |
<table>
<thead>
<tr>
<th>Q 3 (Apr-June):</th>
</tr>
</thead>
<tbody>
<tr>
<td>The April meeting was cancelled, and the May and June meetings were held via secure email.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>AMS semi-annual report was reviewed at the June meeting and approved as submitted.</td>
</tr>
<tr>
<td>The Quarterly Customer Involvement, Wellness/Healthy Communities reports will be reviewed as scheduled next quarter.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q 4 (July-Sept):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation: Completed Barrier Analysis: No barriers</td>
</tr>
<tr>
<td>Next Steps: Objective to be continued into the following FY.</td>
</tr>
<tr>
<td>Continue Objective(s)?</td>
</tr>
<tr>
<td>☒ Yes ☐ No</td>
</tr>
</tbody>
</table>
| 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:  
Quarterly Update:  
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):  
Evaluation: Completed Barrier Analysis: N/A  
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 Corporate Compliance Committee | Goal Met:  
□ Yes □ No  
Quarterly Update:  
Q 1 (Oct-Dec): 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): Evaluation: Completed Barrier Analysis: Data mining activity 2 has been delayed due to pandemic. Next Steps: Continue to monitor. Continue Objective(s)? □ Yes □ No |
<table>
<thead>
<tr>
<th>Corporate Compliance</th>
<th>• Review regional Corporate Compliance monitoring standards, reports and outcomes. 9/30/20</th>
<th>• Review contract monitoring results</th>
<th>Katie Forbes Corporate Compliance Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>Goal Met: □ Yes □ No</td>
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<td>Quarterly Update:</td>
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<td></td>
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<td></td>
<td>Quarterly Update:</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Q 3 (Apr-June): No updates</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Quarterly Update:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Q 4 (July-Sept): Evaluaion: Completed Barrier Analysis: None Next Steps: Continue to monitor. Continue Objective(s)?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>
| 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):  
Evaluation: Limited Progress  
Barrier Analysis: The COVID-19 pandemic has prevented additional progress on reviewing SUD Network Gaps, which vary across the region. CMH Providers report there is also a lack of appropriately qualified ABA Providers for CMH Providers to contract with. |
<table>
<thead>
<tr>
<th>Provider Network</th>
<th>• Review Network Adequacy requirements and address compliance with standards.</th>
<th>• Review MDHHS standards and current Network Adequacy • Address Network Adequacy concerns</th>
<th>Amanda Zabor Provider Network Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal Met:</td>
<td>Yes □ No □</td>
<td>Next Steps: Evaluate PIHP contract monitoring tools to add and enhance Autism standards for review. Continue review of SUD Network gaps. Encourage transparency with CMH Providers regarding ABA access to care. Continue Objective(s)? □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Quarterly Update:</td>
<td>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): No updates</td>
<td>Evaluation: Progress Barrier Analysis: None Next Steps: Wait further information from MDHHS. Continue Objective(s)? □ Yes □ No</td>
<td></td>
</tr>
</tbody>
</table>
| 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 | 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): Evaluation: Limited Progress  
Barrier Analysis: The COVID-19 pandemic has prevented additional progress on bringing CMH Provider Network Directories into compliance. Inconsistent Provider Network Directory formatting and information across the CMH Provider Network. Next Steps: Finish transition of duties from Provider Network Management to Customer Service who will then work with CMH Providers to identify barriers and solutions to bring Network Directories into compliance. Continue Objective(s)? |
<table>
<thead>
<tr>
<th>Provider Network</th>
<th>• Review most recent FY PIHP Contract Monitoring Results.</th>
<th>• Review FY Contract Monitoring Aggregate Report • Discuss trends and improvement opportunities</th>
<th>Amanda Zabor Provider Network Committee</th>
</tr>
</thead>
</table>

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):
Evaluation: Limited Progress
Barrier Analysis: The COVID-19 pandemic has hindered the FY2020 Semi-Annual Contract Monitoring and will result in changes to FY2020 Annual Onsite Monitoring.
Next Steps: Send Semi-Annual Contract Monitoring results to the CMH and SUD Providers during the first week of July, requesting corrective action on any items that did
not meet compliance. Begin the Annual Contract Monitoring Process, which will be completed through electronic means in FY2020.

Continue Objective(s)?
- Yes
- No

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.

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.

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**Grievances**

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

**Grievances:**

<table>
<thead>
<tr>
<th>Grievances:</th>
<th></th>
</tr>
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<tbody>
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<td></td>
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</tbody>
</table>

**Reporting Period: FY2020**

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>GHS</td>
<td>13</td>
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<td>4</td>
</tr>
<tr>
<td>Lapeer</td>
<td>2</td>
<td>2</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sanilac</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>n/r</td>
</tr>
<tr>
<td>St. Clair</td>
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<td>0</td>
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</tr>
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</tr>
<tr>
<td>PIHP</td>
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<td>TOTAL</td>
<td>16</td>
<td>22</td>
<td>0</td>
<td>2</td>
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</table>

**Reason for Grievance:**

<table>
<thead>
<tr>
<th>Reason for Grievance</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Matters</td>
<td>0</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>20</td>
</tr>
<tr>
<td>Service Concerns / Availability</td>
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</tr>
<tr>
<td>Service Environment</td>
<td>4</td>
</tr>
<tr>
<td>Suggestions / Recommendations</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
</tbody>
</table>
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):
Evaluation: Completed
Barrier Analysis: N/A
Next Steps: Continue to monitor.
Continue Objective(s)?
☒ Yes ☐ No
Appeals

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

<table>
<thead>
<tr>
<th>Reporting Period: FY2020</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>GHS</td>
<td>4</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Lapeer</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>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>St. Clair</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>PIHP</td>
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<tr>
<td>TOTAL</td>
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Reason for Appeal:

<table>
<thead>
<tr>
<th>Reason for Appeal</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grievance not resolved within allowed days</td>
<td>0</td>
</tr>
<tr>
<td>Requested not acted on within 14 days</td>
<td>0</td>
</tr>
<tr>
<td>Service Denial</td>
<td>11</td>
</tr>
<tr>
<td>Service not started within 14 days</td>
<td>0</td>
</tr>
<tr>
<td>Service Reduction</td>
<td>0</td>
</tr>
<tr>
<td>Service Suspension</td>
<td>2</td>
</tr>
<tr>
<td>Service Termination</td>
<td>5</td>
</tr>
</tbody>
</table>

- 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):
### Customer Service Inquiries:

**Reporting Period: FY2020**

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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<tr>
<td>GHS</td>
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<td>47</td>
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<td>138</td>
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<td>0</td>
<td>1</td>
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<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
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<td>0</td>
<td>3</td>
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<td>SUD</td>
<td>2</td>
<td>3</td>
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<td>TOTAL</td>
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<td>54</td>
<td>12</td>
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**Inquiry Resolution Categories:**

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<td>Listen/Support</td>
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<td>Referral to Access</td>
<td>41</td>
</tr>
<tr>
<td>Referral to Provider</td>
<td>3</td>
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<tr>
<td>PIHP Customer Service</td>
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</tr>
<tr>
<td>Rights Complaint</td>
<td>0</td>
</tr>
<tr>
<td>Pending</td>
<td>0</td>
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</table>

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

Evaluation: Completed
Barrier Analysis: N/A
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:  
  o Current Providers  
  o New Providers  
  o Existing Provider Renewals / Updates  
  o 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):  
Evaluation: Limited Progress  
Barrier Analysis: The COVID-19 pandemic has prevented additional progress on revising the P & C applications. 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]):  
  o Current Practitioners  
  o New Practitioners  
  o Existing Practitioner Renewals / Updates  
  o 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):  
Evaluation: Limited Progress  
Barrier Analysis: The COVID-19 pandemic has prevented additional progress on revising the P & C applications. 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):  
Evaluation: Progress |
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
- Monitor service provision in specified areas
- Monitor documentation submission to Waiver Support Application (WSA)
- Monitor services (encounters) using the funding Source Bucket Report (FSBR)

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

<table>
<thead>
<tr>
<th></th>
<th>FY19 4Q</th>
<th>FY20 1Q</th>
<th>FY20 2Q</th>
<th>FY20 3Q</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genesee</td>
<td>52.8%</td>
<td>30.5%</td>
<td>23.1%</td>
<td>46.5%</td>
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<tr>
<td>Lapeer</td>
<td>14.8%</td>
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<td>81.8%</td>
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<tr>
<td>St. Clair</td>
<td>94.2%</td>
<td>82.8%</td>
<td>84.7%</td>
<td>59.6%</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th></th>
<th>FY19 4Q</th>
<th>FY20 1Q</th>
<th>FY20 2Q</th>
<th>FY20 3Q</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genesee</td>
<td>81.9%</td>
<td>70.9%</td>
<td>67.8%</td>
<td>52.1%</td>
</tr>
<tr>
<td>Lapeer</td>
<td>77.8%</td>
<td>65.4%</td>
<td>69.6%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Sanilac</td>
<td>100.0%</td>
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<td>96.2%</td>
<td>81.5%</td>
</tr>
<tr>
<td>St. Clair</td>
<td>96.2%</td>
<td>91.4%</td>
<td>86.4%</td>
<td>64.9%</td>
</tr>
</tbody>
</table>

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

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.

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):

Evaluation: Progress
Next Steps: Continue Objective(s)?
☐ Yes ☐ No

| External Quality Review | 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 | The Subject Matter Expert Lead staff for each area will provide updates regarding the Compliance Monitoring: | Goal Met: ☐ Yes ☐ No
Quarterly Update: Q 1: (Oct-Dec): |
| Corrective Actions | Standard V. Utilization Management  
Standard XI. Credentialing  
Standard XVI. Confidentiality of Health Information | status of corrective action plan activities. | II. Quality Measurement and Improvement – Lauren Bondy  
V. Utilization Management – Kristen Potthoff  
XI. Credentialing – Kristen Potthoff  
XVI. Confidentiality of Health Information – Kristen Potthoff | 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. |

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.
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
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 4 (July-Sept):</td>
<td>Evaluation: Progress \nBarrier Analysis: None \nNext Steps: Continue \nContinue Objective(s)?</td>
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</table>
Region 10 PIHP Board Officers

CHAIRMAN
Lori Curtiss

VICE CHAIRMAN
Robert Kozfkay

SECRETARY
Wanda Cole

TREASURER
Edwin Priemer

Region 10 PIHP Board General Membership

Terry Bankert
Ronald A. Barnard
Niketa S. Dani
DeElla Johnson
Joyce Johnson
Gary Jones
Linda C. Keller
Elva Mills
Wayne W. Strandberg
Nancy Thomson
Bobbie Umbreit

As of 07.14.2020