COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

Performance Improvement Plan

2024-2025

Contents

Mission Statement

Community Mental Health of Ottawa County partners with people with mental illness, intellectual/developmental disabilities and substance use disorders and the broader community to improve lives and be a premier mental health agency in Michigan.

I. PURPOSE

The purpose of the Community Mental Health of Ottawa County (CMHOC) Performance Improvement Plan is to follow a process of assessment, strategy development, stakeholder input, plan implementation, results review, and change using the cycle of continuous quality improvement (CQI). CMHOC will seek to improve outcomes for those receiving services.

Continuous quality improvement is based on the following assumptions:

1. Persons working on behalf of the organization seek to provide high quality services.
2. In nearly all situations, improvement can be made by analyzing processes and systems for completing work.
3. Persons served will be involved in defining the quality of services.
4. Decisions are based on reliable data.

The Performance Improvement Plan addresses the requirements of the Michigan Department of Health and Human Services (MDHHS), CARF standards, Lakeshore Regional Entity, and other federal requirements through the implementation of organization-wide, systematic, and performance-based activities.

II. GOALS

1. Target improvements at all levels including management, administration, and programs. Dimensions of care such as access, efficient assessments, coordination of services, timeliness, safety, respect, effectiveness, appropriateness, and continuity will be included.
2. Involves people served and those who care for them in assessing and improving satisfaction with outcomes and services.
3. Develops performance indicators to assure services are effective, safe, respectful, and appropriate.
4. Tracks key performance indicators, comparing performance to statewide and/or nationwide data, when available.
5. Assures providers of service fulfill their contractual or employment obligations in accordance with applicable regulatory and accreditation standards.
6. Assures providers of service are competent and capable of providing services through a system of competency evaluation and credentialing.
7. Assures providers can accommodate individual needs of the people served by the organization.

8. Assures performance indicators and Quality Improvement activities impact all populations served by the agency, including but not limited to populations such as persons served over a long period of time, older adults, children, non-English speakers, and those served with intellectual/developmental disabilities.

III. PLAN REQUIREMENTS

The Performance Improvement Plan will meet the following requirements:

1. Meet the minimum performance standards as set by the Michigan Department of Health and Human Services (MDHHS), CARF, the Lakeshore Regional Entity, Federal Standards and awarded grant requirements. Failure to meet the standards for one quarter will result in an initiation of a performance improvement project and in-depth analysis.
2. Develop internal standards for performance when these standards are not set by MDHHS, CARF, the Lakeshore Regional Entity, federal standards, and/or awarded grant requirements.
3. Performance improvement projects will sustain improvement in significant aspects of clinical and non-clinical services.
4. Carry out monitoring and review activities to assure that systematic problems are identified and corrected.
5. Meet all MDHHS requirements for grievances and appeals and maintain an active member services function.
6. Maintain a record of all performance improvement projects and provide follow-up data to assure improvements are demonstrated and maintained.
7. Performance improvement activities in the clinical area will strive to improve prevention, acute, chronic, high-volume, high-risk services, providing a whole person approach to health care services as well as any process that may be relevant to service improvement.
8. Performance improvement activities in non-clinical processes may include such areas as availability, accessibility, cultural competency, quality of providers, processes regarding billing and authorizations, appeals, grievances, and complaints.
9. Identify performance improvement initiatives through a regular process of data gathering, analysis, and prioritization which considers prevalence, need, risks, and the interest of persons served in pursuing the project.
10. Assure whole person wellness promotion occurs for persons served.
11. Review all sentinel events and implement action items based on these reviews.
12. Implement a utilization management function that clearly identifies criteria for services with the agency, publicizes these to those individuals currently and potentially receiving services, and reviews trends in access and service utilization.
13. Carry out performance projects as required by State, Federal and awarded grant guidelines.

IV. RESPONSIBILITIES

A. The CMHOC Board will annually approve the Performance Improvement Plan. The Board will also periodically review QI data and information.
B. The Chief Executive Officer (CEO) will assure a QI system is in place. The CEO will review recommendations from the Leadership Group and authorize any subsequent action plans.
C. The Medical Director or designee shall provide consultation to any committee that requires medical consultation. The Medical Director or designee will serve as an ad hoc member of the Leadership Group and

will assure psychiatric representation is available for the Pharmacology & Therapeutics/Medication Committee, Utilization Management Committee, and the Behavioral Treatment Review Committee, as needed.

D. The Chief Operating Officer (COO) will be responsible for the implementation and ongoing functions of the QI system. The COO will serve as a member of the Leadership Group and will provide facilitation and data analysis within the QI system. This includes the ongoing development of the QI Plan and evaluation of the QI system.
E. The Leadership Group will serve as the organization's QI Committee, reviewing data and setting implementation steps based on recommendations and data from the various QI standing committees.
F. Managers and Staff will participate on QI standing committees and performance improvement groups. Managers will authorize appropriate staff to perform these functions prior to staff participating in a committee or improvement group.
G. CMHOC staff may make recommendations for change by bringing quality issues to their direct supervisor or the QI Department for evaluation. Quality and performance initiatives may also start based on findings in process and data quality monitoring such as Medicaid Verification. Staff will serve on QI standing committees and performance improvement groups if approved by their direct supervisor.
H. Contractual agencies will be evaluated based on the performance standards stated in their contracts. They will be provided a regular means of communicating issues to CMHOC such as the Provider Network Council (PNC) which meets bi-annually or by submitting issues via a help desk portal system.

V. STRUCTURE

The CMHOC Board meets monthly and receives quarterly reports regarding the agency's performance on indicators in the Michigan Mission Based Performance Indicator System (MMBPIS). Additional performance indicators and data, as well as consumer satisfaction data, may be presented to the CMHOC Board or its subcommittees by the CEO on a regular basis. The structure of the QI system is graphically depicted in Appendix A, "Management/Performance Improvement Structure."

Leadership Group serves as the agency's quality improvement committee. QI standing committees will regularly report to Leadership Group with findings and recommendations. The duties and responsibilities of Leadership Group include:

1. Receive regular reports from the committees and act on recommendations and findings.
2. Review reports generated by performance improvement groups (ad hoc work groups).
3. Review and evaluate all employee generated suggestions for QI.
4. Annually review and approve the Quality Improvement Plan and structure.
5. Annually review the committee structure to assure comprehensive QI process.
6. Analyze the root cause analyses of sentinel events.
7. Assure plans for improving systems are in place and effectively implemented, monitored, and communicated.
8. Identify training needs of the organization related to QI.
9. Recommend priorities for action based on data and recommendations.
10. Maintain a log that tracks status on all actions taken.
11. Maintain guidelines on communication and conflict resolution within the organization and model these expectations.
12. Assure any work groups assigned by the Leadership Group understands its role and function clearly.

The Quality Improvement Unit is responsible for the following:

1. Presents a Performance Improvement Plan to the Leadership Group and the CMH Board on an annual basis for approval.
2. Provides consultation and support to QI standing committees and to the Leadership Group in their role as the Performance Improvement Committee.
3. Assures QI data is regularly presented to the Leadership Group.
4. Completes all state required performance indicator reports.
5. Completes all state required customer satisfaction surveys and reports data.
6. Assures a credentialing process is operational.

VI. QI STANDING COMMITTEES

QI standing committees include CMHOC staff and may include persons served by the organization or persons who care about them such as family members, guardians, and advocates. The QI standing committees are established to evaluate and monitor the quality of important aspects of care.

Behavior Treatment Review Committee – The committee reviews restrictive, intrusive, or aversive behavior plans, whether developed by CMHOC operated or contracted programs, and psychotropic medications prescribed for behavioral control purposes. The committee also educates staff regarding behavior issues, as specified in the Behavior Treatment Review Committee Operating Manual; See appendix J: "Behavior Treatment Review Committee Manual" for full details. The committee provides recommendations for staff seeking interventions for challenging cases. The committee meets monthly and reports semi-annually to the Leadership Team

Clinical Case Review Committee – This committee serves as a review body and determines dispositions within the mental health and intellectual/developmental disability systems related to requests from treatment teams to transfer consumers to a higher level of care; transfers between treatment teams at the same or lower level of care, should third-party involvement be required; and team assignment for new consumers when the initial disposition is unclear.

Pharmacology & Therapeutics/Medication Committee – The committee monitors the utilization of medications in CMHOC operated and contractual programs. The committee reviews significant medication errors, assures compliance with internal and external standards and policies, aids programs for the purpose of developing procedures, and revises CMHOC policies and procedures regarding medication. Record reviews are completed monthly by prescribers, pharmacists and nurses, independent of the monthly committee meeting. The committee meets monthly and reports to the Leadership Team semi-annually.

Utilization Management Committee – The committee monitors the utilization of resources to assure services are clinically necessary, effective, and provided in the most cost-effective manner. Regular data reports will be reviewed, and adjustments will be made in the organization based on the data. The committee meets monthly and consists of the Leadership Team and the Information and Technology Department. The Committee reports to the CMHOC Board of Directors semi-annually.

Compliance Committee – This committee provides oversight of the compliance functions of the organization, reviews compliance incidents and data, and oversees policy and procedure development in privacy, security, and compliance. The committee develops a Corporate Compliance Plan, and an annual Risk Management Plan which covers a variety of risk factors such as programmatic, financial, or health and safety. The committee meets monthly and reports to the Leadership Team quarterly.

Consumer Advisory Meeting (CAM) – The Consumer Advisory Meeting is a place to provide input and feedback to the CMHOC CEO and COO. The CAM is where consumers, guardians, and families can ask questions about CMHOC programs and process. The CAM meets quarterly.

Health and Safety Committee – The committee oversees efforts across the organization, assuring that effective safety, emergency preparedness, and security issues are addressed. The committee meets quarterly and reports to the Leadership Team semi-annually.

Information Technology Committee – The committee addresses data system implementation issues, clinical and IT workflows, reviews performance indicators, and identifies data and reporting needs. This committee meets monthly and reports to the Leadership Team annually.

Health Information Management Committee – This committee develops and implements CMHOC's move to an electronic medical record (EMR), identifies trends and needs related to clinical documentation, and monitors compliance with documentation standards. This committee meets monthly and reports to the Leadership Team semi-annually.

CMH Personnel and Training Committee – The committee develops an annual Staff Training Plan, Accessibility Plan, and a Cultural Competency Plan. The committee will monitor credentialing requirement process. Meetings will be held on a bi-monthly basis and the plans will be presented to the Leadership Team on an annual basis.

Recipient Rights Advisory Committee – This committee, mandated by the Mental Health Code, helps to ensure that every individual receiving CMHOC services has certain protected rights. The committee will meet quarterly, and it is the responsibility of the Director of Recipient Rights for reports and data presentation.

Provider Network Council – This committee will address any CMHOC provider network issues related to contractual changes, CMHOC Provider Portal issues, Provider Performance and Compliance issues, as well as any other CMHOC provider concerns such as billing changes. This committee will also hold quarterly or semi-annual meetings with the CMHOC provider network to provide CMHOC updates and communicate changes.

CMHOC Fiscal Services Team – This department will address and provide any accounting and budgeting services for CMHOC. This department will monitor financial management, centralized procurement, budget administration, billing, fixed asset accounting, and debt management. The CMHOC Finance Manager will participate on the CMHOC Leadership Team and report updates and improvements regularly.

Access Center Team – This department connects callers with the most appropriate services and resources as quickly and efficiently as possible and ensure that all eligible consumers receive timely, appropriate, and high-quality services while preventing unnecessary, inappropriate, and ineffective utilization of resources. This department assists individuals seeking assistance for mental health and substance use disorders to obtain needed information, services, and resources in a manner that is customer friendly, timely, and accurate. Access Center staff members welcome all individuals by demonstrating empathy and providing opportunity for the person presenting to describe their situation, problems, and functioning difficulties. The Director of Access and Connections participates on the CMHOC Leadership Team and report updates and improvements regularly.

VII. CRITICAL INCIDENTS

A. Critical incidents will be reported consistent with MDHHS contract requirements.
B. Critical incidents that meet criteria as sentinel events will result in a full review, analysis, and semiannual report by CMHOC to MDHHS and the Lakeshore Regional Entity compliance point-person. The review will meet requirements as defined by MDHHS and specified in CMHOC Policy 1.03, Sentinel Events. The results of root cause analysis, with recommendations for change, will be presented to Leadership Team for information and further action if necessary.
C. The Quality Improvement Unit will provide support and facilitation to the review process.
D. The Compliance Committee will maintain a log of all recommendations, assuring actions are taken to complete all plans.
E. Persons involved in the review will have the proper expertise and credentials for the specific event being reviewed. The Medical Director, or other assigned medical professional, will participate in the process and review all results when appropriate.
F. CMHOC will report all applicable deaths to the State per the MDHHS Contract Attachment C 6.5.1.1 and will assure all deaths, subsequent to leaving a state facility within a 6-month period, will be properly reported.

VIII. INVOLVEMENT OF PERSONS SERVED

CMHOC will assure persons served will be offered input and involvement into the performance improvement system through the following mechanisms:

1. Primary consumers of mental health services serve on the CMHOC Board of Directors.
2. CMHOC consumers participate in the Consumer Advisory Meetings.
3. Satisfaction surveys are completed according to the following frequency:
    a. Persons served with mental illness or emotional disturbance – annually.
    b. Persons served with intellectual/developmental disabilities (includes parents and guardians) – annually.
    c. Post discharge satisfaction surveys – monthly.
    d. Satisfaction with CMHOC and/or contractual provider services – completed during contract review, pre-planning and treatment planning process.
    e. Assertive Community Treatment (ACT) and Home-Based services satisfaction as mandated by MDHHS.
    f. Progress note documentation or quarterly outcome measures in the electronic medical record as required.
4. Persons served will always be given the opportunity to directly contact a representative of CMHOC as part of the satisfaction process.
5. When specific issues are discovered, special efforts may be utilized such as targeted consumer interviews or focus groups.
6. Involvement of persons served will be solicited to address issues relating to quality, availability, and accessibility of services.
7. CMHOC will seek to improve representation of people served in quality improvement participation, policy setting, as well as employment and volunteer opportunities.
8. CMHOC will communicate information on satisfaction, performance indicators, and needs assessment to consumers and stakeholders.
    a. The Consumer Advisory Meeting will receive this information for discussion and be given the opportunity to make recommendations to the CMHOC CEO and CMHOC Leadership Team.

b. Data will be provided to the CMHOC Board of Directors on a regular basis. Performance Indicator data will be presented at least quarterly.
c. Findings and analysis will be made available on the CMHOC website (www.miottawa.org/cmh). Periodically, information will be made available in agency lobbies and offices.

X. PROBLEM SOLVING TECHNIQUES/REMEDIAL ACTIONS

The Leadership Team will identify issues that require additional effort to resolve and improve. A "Work Group"/Committee Charge Form" (see Appendix C) will be completed that specifies the scope of expectation for any group sanctioned by the Leadership Team.

CMHOC will use ASPIRE to Excellence, a system put in place by the accreditation body CARF for their 2008 standards, as its problem-solving model. This will be used for performance improvement groups, which are time-limited groups designed to address areas needing improvement. All staff will be encouraged to identify quality issues.

Problem Solving Process:

1. **A**ssess the environment
2. **S**et strategy
3. **P**ersons served (provide input into design and delivery of quality services)
4. **I**mplement the plan
5. **R**eview Results
6. **E**ffect change

QI staff provides support to the QI system by serving as facilitators to the committees and performance improvement groups. This includes using QI tools and methods to assist groups in problem identification and plan development.

In addition to using ASPIRE, CMHOC will also utilize the Ottawa County Creativity Playbook. The Creativity Playbook is a repository of information designed to promote collaboration and innovation in the workplace. It consists of both KATA and Design Thinking plays. The Design Thinking plays can be followed as a full process or individual as needed to help teams get "unstuck".

XI. CREDENTIALING, PRIVILEGING, AND COMPETENCY OF STAFF

CMHOC maintains a complete system for credentialing and competency that includes CMHOC staff and contractual staff. Practices relating to these functions are explained in detail in CMHOC policies 9.02, Credentialing and 9.14, Competency and Performance Evaluation.

CMHOC adheres to the following procedures for the selection and ongoing management of staff. For more detail, refer to the aforementioned policies.

1. Selection: CMHOC follows Ottawa County guidelines for staff selection. Prior to hiring the following actions are taken:

a. Ottawa County Human Resources completes the criminal background check on all prospective employees.
b. Ottawa County Human Resources verifies from the source, the educational status of the applicant.
c. Ottawa County Human Resources completes reference checks of the applicant prior to hire.
d. CMHOC verifies from the source licensing status of professional staff and assures that no adverse actions have been taken against the professional, including conducting Recipient Rights checks.

2. Maintenance: CMHOC has the following procedures in place for review of staff competency:
   a. Ottawa County Human Resources maintains job descriptions for every county employee.
   b. CMHOC has a more detailed function and ability description specifying expectations for each position.
   c. CMHOC maintains a list of licenses with expiration dates and assures licensing is up to date and no adverse actions have been taken against the individual's license.
   d. Annually, all supervisory staff is required to complete an evaluation of staff as specified in CMHOC Policy 9.14, Competency and Performance Evaluation.
   e. Annually, the Leadership Team identifies core priorities for the organization that specifies the expectations for agency staff.
   f. CMHOC will assure all credentialing and re-credentialing requirements within the Lakeshore Regional Entity are met.

In addition to the above requirements, CMHOC will assure all Licensed Independent Practitioners (LIPs) are approved by the Medical Director or designee, and the CEO or designee, prior to starting services at CMHOC. This will include a review of experience and references, in addition to compliance and licensure verification included in CMHOC Policy 9.02, Credentialing. CMHOC will maintain documentation of all training and supervision of non-licensed staff.
CMHOC's Personnel and Training Committee will monitor compliance with credentialing requirements by reviewing summary information on both LIP and non-LIP positions consistent with CMHOC Policy 9.02, Credentialing.

CMHOC will assure staff are properly oriented and trained to complete their job functions. Completion of all necessary and required training will be tracked by the Training Center, and documentation of compliance will be maintained by assigned administrative staff. Initial and ongoing training requirements will be documented in an annual Training Plan. The CMHOC Personnel and Training Committee will assure the annual Training Plan is completed.

XII. CLINICAL PRACTICE GUIDELINES

CMHOC works with the LRE to implement the use of Clinical Practice Guidelines (CPGs) in service provision. CPGs are available to assist practitioners and members in making decisions about appropriate health care for specific clinical circumstances. CMHOC endorses CPGs that have been adopted by the American Psychiatric Association. CMHOC adopted the American Psychiatric Association CPGs in concert with the Lakeshore Regional Entity and its Member CMHSPs through the Clinical ROAT and Utilization Management ROAT. CMHOC disseminates the CPGs via its website and communications from the Lakeshore Regional Entity.

CMHOC, in collaboration with the Lakeshore Regional Entity, developed and approved an Inter-Rater Reliability Process ensuring the decision for utilization management, member education, coverage of services, and other

areas to which the guidelines apply are consistent with the guidelines. CMHOC is monitored on the use of established guidelines as part of the Lakeshore Regional Entity Site Reviews.

XIII. CULTURAL COMPETENCE

CMHOC will annually evaluate programs for access and treatment trends of ethnic/minority groups. The evaluation will analyze all current activities designed to assure equitable access and effective treatment to persons with cultural barriers to receiving services. An annual Cultural Competency Plan will be developed and periodic training to CMHOC staff will be provided based on the organizational assessment.

XIV. UTILIZATION MANAGEMENT SYSTEM

A. All persons requesting services will be evaluated by the agency's Access Center using standardized, approved admission criteria. The Access Center will maintain an Access Manual.
B. Practice guidelines for admission and ongoing services will be reviewed and approved by CMHOC Leadership prior to being implemented.
C. The agency will maintain a Utilization Management Committee which reviews trends in service utilization, outcomes, and costs on a regular basis. The Utilization Management Committee will also review organization Key Performance Indicators which may include financial, organizational, and/or clinical indicators.
D. CMHOC will develop and regularly update a Utilization Management Plan.

XV. PERFORMANCE IMPROVEMENT COMMUNICATION/TRAINING

CMHOC will develop and maintain an orientation process for all new staff on agency policy and procedural requirements. CMHOC will assure that decisions and actions are communicated to all appropriate staff. When a decision is made by the Leadership Group, an implementation plan will identify the responsible individual to inform staff and carry out the decision. Implementation of decisions can occur at the team level, QI Committee level and/or even agency-wide level. CMHOC will leverage Leadership members and their staff to communicate and provide information on agency updates, initiatives, and performance on indicators within the agency. Training in QI for all staff is completed during the orientation process.

XVI. CLAIMS VERIFICATION OF MEDICAID SERVICES

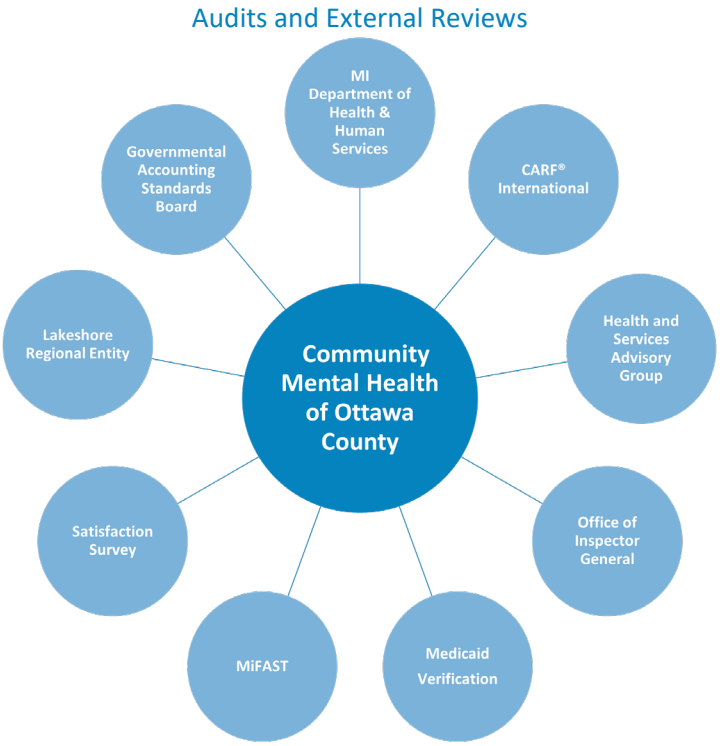
CMHOC and the PIHP will conduct an audit of all internal and external programs to assure claims billed under Medicaid have met standards as identified by the Lakeshore Regional Entity, MDHHS, and federal standards. Data will be provided to the Lakeshore Regional Entity as requested. Findings will be presented to CMHOC's Compliance Committee. Immediate recommendations may be made to CMHOC Leadership. Claims found to be deficient will result in a required plan of correction. Restitution will be sought for those claims when necessary.

XVII. 2024 PERFORMANCE IMPROVEMENT REVIEW

The Quality Improvement system and Performance Improvement Plan is reviewed on an annual basis. The CEO will assure Performance Improvement Plan is presented to CMHOC Board of Directors for review and approval annually. The Summary Review 2024 highlights the performance and quality improvement initiatives of CMHOC.

CHMOC Performance and Quality Improvement, External Reviews and Audits

This review outlines the major audits and external reviews Community Mental Health of Ottawa County (CMHOC) participates in. However, this list is not inclusive of all monitoring activities in which CMHOC engages to ensure quality of services, efficient operations, and adherence to all state and Prepaid Inpatient Health Plan (PIHP) requirements.



CARF® International

CMHOC is accredited by CARF® International, an external agency evaluating the organization on specific standards. The accreditation review is completed every 1, 2 or 3 years depending on the results of the review. If CMHOC receives full marks, CARF® does not come back for the next 3 years. However, if there are significant issues and findings, CARF® may award a 1 or 2- year accreditation, resulting in more frequent reviews. Since beginning CARF® accreditation, CMHOC has consistently received a 3-year accreditation. CMHOC was evaluated by CARF® in the spring of 2023 and awarded the CARF® accreditation through June 30, 2026.

CARF® is by far the most comprehensive review. Standards reviewed include areas such as Leadership, Performance Improvement, Person Centered Planning, Risk Management, Performance Measure and Management, Legal Requirements, and Strategic Planning. A total of 30 standards are reviewed, with each

standard having between 20 to 30 sub-section requirements. The review is conducted onsite or virtually for a full week by two to three CARF® reviewers.

External Reviews

Lakeshore Regional Entity Site Review

The Lakeshore Regional Entity (LRE) conducts an annual review of all the Community Mental Health Service Programs (CMHSP) with which they contract. The LRE performs a desk audit of CMHOC policies, best practices, and procedures to ensure compliance with contractual obligations. There are a total of 21 standards reviewed ranging from Person Centered Planning, medical record documentation, use of S.M.A.R.T. goals in treatment plans, Health Information Systems, Financial Management, Services, Governance, etc. Each standard may include anywhere from 20 to 30 subsections that require documented proof.

Example: Member Rights standards is Standard 1 and has subsections 1.1 - 1.23.

Site review Scores:

FY21	FY22	FY23	FY24
92.93%	93.59%	93.90%	94%

Michigan Department of Health and Human Services (MDHHS) Waiver Audit

- MDHHS performs an audit of the LRE and regional CMHSPs annually on a set of standards. A 10% sampling of medical records across the region are reviewed.
- The Substance Use Disorder (SUD) audit is a PIHP/regional audit by MDHHS and is an administrative review, no medical records are reviewed.
- Children's Waiver Program (CWP), Serious Emotional Disturbance (SED) Waiver, and Habilitation Supports Waiver (HSW) are directly audited by MDHHS in the fall of 2024.
- An Autism Benefit review of the CMHSPs was completed by MDHHS in 2019. After that year MDHHS switched to auditing the region as a whole rather than individual CMHSPs.

MDHHS Certified Community Behavioral Health Clinic Demonstration Certification

MDHHS requires all Certified Community Behavioral Health Clinic (CCBHC) Demonstration sites to complete an application to become certified. CMHOC completed the certification application which included 34 standards that all needed to be met in order to become certified. The application is reviewed by MDHHS and a consultant used by MDHHS. On August 25, 2023, CMHOC was notified we were fully certified as a CCBHC. The review team thoroughly reviewed CMHOC's application materials and determined our clinic meets all the requirements of a CCBHC which includes 34 standards with 3-15 subsections each. CMHOC will complete another application in the summer of 2024 to be re-certified as a CCBHC by MDHHS.

Health and Services Advisory Group (HSAG)

The HSAG audit is a review of the PIHP, CMHSPs must comply with all the standards and requirements of HSAG. HSAG is the independent external reviewer retained by MDHHS to review the PIHP. There are two major components to the HSAG audit, Performance Measures Validation (PMV) and the HSAG Compliance audit. For the PMV, HSAG reviews how data integration and controls are established to measure the Michigan Mission Based Performance Indicator System measures. MMBPIS Indicators are outcome measures required by the MDHHS for all CMHSP's. They measure the timeliness of inpatient screenings, access to care, start of ongoing services, follow up after inpatient and detox discharges, and track inpatient recidivism and are measured based

on the target percentage determined by the State of MI. HSAG reviews all the programming, reporting associated with arriving at the numerator and denominators for each of the indicators.

List of standards include (Compliance)
The Quality Assessment and Performance Improvement Plan (QAPIP); Structure, Quality Measurement and Improvement; Practice Guidelines; Staff qualifications and training; Utilization Management; Customer Service; Grievance and Appeals Process; Members' Rights and Protections; Subcontracts and Delegation; Provider Network; and Credentialing.

Performance Measure Validation results

- 2022-2023 – 13/13 of the PMV standards met.
- 2021-2022 – 13/13 of the PMV standards met.
- 2020-2021 – 11/13 of the PMV standards met (2 were not applicable).

HSAG Compliance Review results
The compliance review is a three-year cycle, half of the 13 standards reviewed in Year 1 (2021), the second in year two (2022) and all of the unmet standards are reviewed in Year 3 (2023).

- Year 1 – Standards 1 to 6 reviewed. Of the six standards, 53 were met regionally and 12 were not (82% total compliance score). Results for the next standards due to the PIHP in October 2022.
- Year 2 – Standard 7-13 reviewed. Of the 7 standards, 99 were met regionally and 19 were not met (84% compliance score.
- Year 3 – Standards 1-13 reviewed. Of the 13 standards, 152 were met regionally, 31 were not met and 1 was N/A (83% total compliance score)

LRE and CMHSP Medicaid Verification

The LRE conducts Medicaid verification reviews of a sample of claims derived from encounters submitted. The review involves verification of service, costs and proper documentation. If issues are identified, then the appropriate steps are followed to resolve issues. The LRE now conducts a quarterly review of services across the region and works with CMHSPs to resolve findings.

In addition to the LRE completing Medicaid Verification, CMHOC also conducts an internal review of providers and their services. CMHOC conducts a random sample of providers, including external and internal, and reviews the services provided to ensure proper documentation is in place. If there are findings, a larger sample is pulled and reviewed. CMHOC will purposefully include new providers to the panel for review to ensure the provider is following the appropriate billing procedures and billing accurately.

Office of Inspector General Report Quarterly Review

The Office of Inspector General (OIG) requires the PIHP to submit data mining activities to review potential areas where overpayment may have occurred. The LRE developed an OIG report that includes a series of data points looking at these potential areas of overpayment. Each quarter the LRE sends this report for review and the CMHSPs further investigates the results published in the report. Some of the data reviewed includes inpatient codes overlapping with other codes and over threshold or duplicate services.

MIFAST Reviews

The overall purpose of the Michigan Fidelity Assistance Support Team (MIFAST) is to provide technical assistance moving the publicly funded behavioral health system forward in ascertaining the degree to which an evidence-based program has been implemented and is functioning for both fidelity and efficacy.

MIFAST audits are requested by the CMHSP or PIHP. CMHOC requested and participated in a MiFAST consultative audit of the Assertive Community Treatment (ACT) Program in September 2023. This audit reviewed the fidelity of the ACT program, this program provides flexible and mobile team-based care 24/7/365 to adults with serious mental illness. The ACT is an evidence-based practice, researched and in use since the 1970's, it has a positive effect in using fewer hospital services and increasing housing stability and service satisfaction. The results of the recent consultative audit of the CMHOC ACT team received an average score of 4.2/5. The reviewers identified areas where the team could improve including training, implementing Illness Management Recovery or Seeking Safety Groups, and addressing staffing shortages. The review looked at 3 area standards with 51 sub-standards which included assessment, individualized treatment, penetration rate, training, multi-disciplinary team composition, motivational interviewing, group treatment, and team approach.

Satisfaction Surveys

The standard consumer satisfaction surveys are completed annually, and results are presented to the Board showing the results for CMHOC along with the rest of our partners in the Lakeshore Regional Entity. The Quality Improvement (QI) department sends the survey out to the different populations we serve. The Satisfaction Survey was developed regionally and was updated several times in the last several years per HSAG recommendation. Any findings of immediate concern found during the survey are quickly addressed when a consumer requests to be notified. The results of the 2023 Satisfaction Survey can be found here. Other surveys performed by CMHOC are discharge surveys, where staff follow up with consumers who have been discharged from services and the annual needs assessment which requires, we conduct a stakeholder survey every other year.

Internal Reviews and Monitoring

Utilization Management (UM) Committee

The UM Committee meets monthly to review a matrix of reports. The reports reviewed include productivity reports, cost per service, state and local psychiatric placements, length of impatient stay, outcome data from Adult Needs and Strengths Assessment (ANSA), the Child and Adolescent Function Assessment Scale (CAFAS), Spenddown Report, Utilization (High Utilizers), and other data integrity reports. Reports are reviewed monthly, quarterly, semi-annually or annually. Committee members follow up on decisions made during the meeting. This could include data reviews in the Electronic Medical Record or further review of findings from the reports presented.

Michigan Mission Based Performance Improvement System (MMBPIS)

MMBPIS Indicators are outcome measures required by the State of MI. They measure the timeliness of inpatient screenings, access to care, start of ongoing services, follow up after inpatient and detox discharges, and track inpatient recidivism. The dashboard displays the target percentage determined by the State of MI compared to CMHOC's data, which is broken out by fiscal quarter, indicator, and treatment population (MI Adult, MI Child, DD Adult, DD Child, SUD). These indicators also give us the ability to measure how effective we are at getting people services compared to other CMH's across the state. The dashboards are available here for review.

Quality Improvement Committee

a. The Performance Improvement Plan is presented annually to the CMHOC Board of Directors.
b. The Performance Improvement Plan is reviewed and updated by Leadership annually. Leadership uses the plan to develop, compile and review various committee and department goals and objectives for the year.
c. CMH Quality Improvement workgroup activities – ad hoc committees formed to review and work on continuous improvement initiatives.
d. Continuous Improvement initiatives:
    i. BH TEDS using KATA
    ii. MMPBIS using KATA
    iii. Family Support Subsidy using Innovators Compass
e. Plan of Correction activities – The Compliance Coordinator compiles and collates all findings from reviews and audits and develops various plans of corrections. The process involves working with teams to implement change, modify and improve processes, develop or create needed policies, etc.

CMH Fiscal Audit

The CMH Fiscal audit is now part of the County Fiscal audit. While this audit looks at financial controls in place to adhere to GAAP (Generally Accepted Accounting Principles) GAAP and GASB (Governmental Accounting Standards Board) standards, data is also pulled to review financial accuracy similar to Medicaid verification.

XVIII. MANAGEMENT & PERFORMANCE IMPROVEMENT STRUCTURE