Quality Assessment and Performance Improvement Program Description, Program Evaluation FY2022, and Program Work PLAN FY 2023

Approved By	Date
Compliance and Quality Committee (QOC)	January 3, 2023
Internal Operations Committee (OOC)	January 11, 2023
Board of Directors	January 25, 2023

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INTRODUCTION

The Northern Michigan Regional Entity (NMRE) is the Medicaid specialty prepaid inpatient health plan (PIHP) for the five Community Mental Health Services Programs (CMHSPs) serving the northern lower peninsula of Michigan. The member Boards are: AuSable Valley Community Mental Health Authority (AVCMH serving Iosco, Ogemaw, and Oscoda counties, Centra Wellness Network (CWN) serving Benzie and Manistee counties, North Country Community Mental Health Authority (NCCMH) serving Antrim, Charlevoix, Charlevoix, Emmet, Kalkaska, and Otsego counties, Northeast Michigan Community Mental Health Authority (NEMCMH) serving Alcona, Alpena, Montmorency, and Presque Isle counties, and Northern Lakes Community Mental Health Authority (NLCMH) serving Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, and Wexford Counties. The managed care activities are the responsibility of the NMRE.

AUTHORITY

The Quality Assessment and Performance Improvement Program (QAPIP) is reviewed and approved on an annual basis by the NMRE Governing Board. Through this process, the Governing Board gives authority for the implementation of the plan and all its components. This authority is essential to the effective execution of the plan.

Consistent with the structure of NMRE and the governance structure of its Board of Directors, this authority is discharged through the Chief Executive Officer (CEO) of the NMRE. In turn, the CEO discharges authority though the Compliance Director.

DEFINITIONS

Beneficiary: A person served by the publicly funded behavioral health and substance use disorder system or their representative (also Member).

Community Mental Health Services Program (CMHSP): For the purposes of this document, a CMHSP member is one of the following: AuSable Velley Community Mental Health Authority, Centra Wellness Network, North Country Community Mental Health Authority, Northeast Michigan Community Mental Health Authority, or Northern Lakes Community Mental Health Authority.

Michigan Department of Health and Human Services (MDHHS): A principal department of state of Michigan, headquartered in Lansing, that provides public assistance, child and family welfare services, and oversees health policy and management.

Network Provider: Any provider that receives Medicaid funding directly or indirectly to order, refer, or render covered services pursuant to the Specialty Supports and Services Contract between the State of Michigan and the NMRE, it's member CMHSPs, and/or its Substance Use Disorder (SUD) Provider Panel.

Northern Michigan Regional Entity (NMRE): The NMRE is one of 10 prepaid inpatient health plans (PIHPS) in the state of Michigan. The NMRE covers Region 2, the twenty-one counties at the tip of Michigan's lower peninsula (Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon, and Wexford).

NMRE Internal Operations Committee (IOC): An NMRE internal committee comprised of key leadership staff.

NMRE Operations Committee (Ops): An NMRE regional committee comprised of the top-level executive staff (CEO/Executive Director) of the NMRE and its five member CMHSPs.

NMRE Quality and Compliance Oversight Committee (QOC): A regional quality improvement committee, comprised of NMRE staff and quality and compliance leaders from the five member CMHSPs. Additional members may be appointed, as appropriate, including members from the NMRE SUD Provider Panel and service recipients (primary or secondary).

Prepaid Inpatient Health Plan (PIHP): The ten organizations in Michigan responsible for managing Medicaid services related to behavioral health, intellectual/developmental disabilities, and substance use disorders.

Quality Assessment and Performance Improvement Program (QAPIP): A data driven and proactive approach to quality improvement. The QAPIP is used to ensure services are meeting quality and performance standards.

MISSION & VISION

Mission

Develop and implement sustainable, managed care structures to efficiently support, enhance, and deliver publicly funded behavioral health and substance use disorder services.

Vision

A healthier regional community living and working together.

PURPOSE

As the PIHP for the twenty-one county region, the NMRE's mission guides quality improvement activities. The QAPIP is intended to serve several functions, including but not limited to.

- Serve as the quality improvement structure for the managed care activities of the NMRE as the PIHP for the twenty-one county area.
- Provide oversight of the CMHSPs' quality improvement structures and ensures coordination with PIHP activities, as appropriate.
- Provide leadership and coordination for the PIHP Performance Improvement Projects (PIPs).

- Coordinate with the regional Compliance Coordinator and Regional Compliance Committee for verification of Medicaid claims submitted.
- Describe how these functions will be executed within the NMRE's organizational structure.

This written plan describes how these functions will be accomplished. It also describes the organizational structure and responsibilities relative to these functions.

GOVERNANCE

The NMRE has a fully operational QAPIP that meets the conditions specified in its Specialty Supports and Services Contract with the State.

The NMRE Governing Board/Board of Directors reviews and approves the QAPIP on an annual basis. Through this process, the Governing Board gives authority for the implementation of the QAPIP and all its components. The Governing Board receives routine updates on the QAPIP, as well as a year-end effectiveness review.

STRUCTURE

1. Provider/Beneficiary Involvement
   The involvement of provider and beneficiary representatives is essential to the effectiveness of the QAPIP; this involvement is sought, encouraged, and supported at several levels including:

   a. The NMRE Governing Board includes beneficiaries as members.
   b. The NMRE Consumer Advisory Panel (Regional Entity Partners) provides input on various managed care activities.
   c. The regional Quality and Compliance Oversight Committee (QOC) is comprised of staff from the NMRE and its member CMHSPs.
   d. Each member CMHSP operates a Consumer Advisory Committee and includes beneficiary representatives on its Governing Board and on various committees.

2. NMRE Internal Operations Committee
   The NMRE Internal Operations Committee (IOC) has the central responsibility for the implementation of the QAPIP. Committee membership consists of key NMRE staff including but not limited to:

   a. Chief Executive Officer
   b. Chief Information Officer/Operations Director
   c. Chief Financial Officer
   d. Compliance Director
   e. Clinical Services Director
   f. Substance Use Disorder (SUD) Grant Director

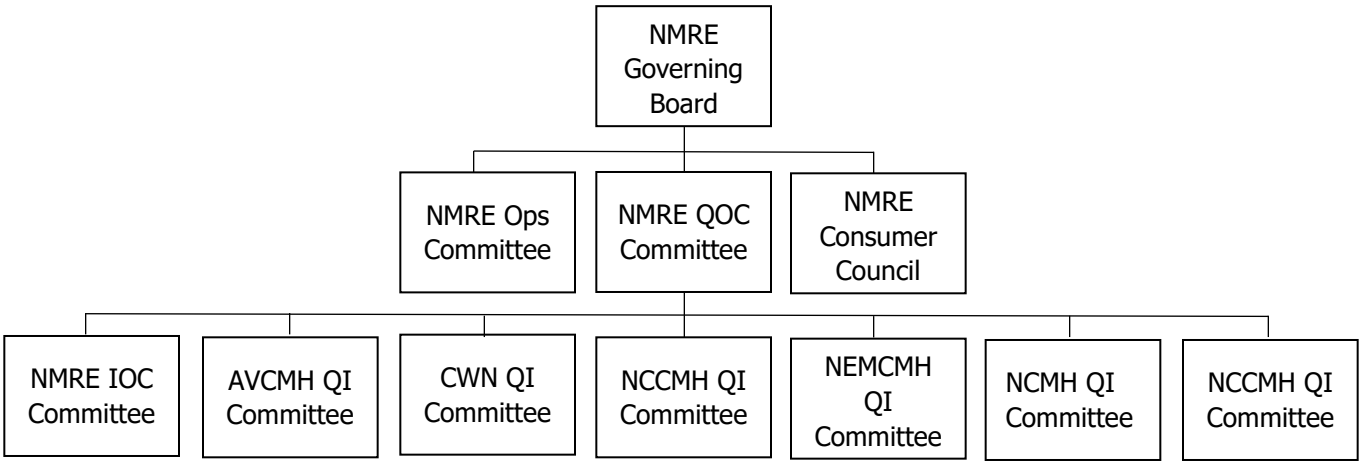
g. Human Resources Director

3. NMRE Quality and Compliance Oversight Committee
   The regional Quality and Compliance Oversight Committee (QOC) has the responsibility for ensuring that network providers have appropriate quality improvement structures and activities necessary to meet federal and state requirements. This group provides the primary link between the quality improvement structures of network providers and the NMRE. To create this link, the CEO of each member CMHSP appoints representatives to serve as members of the committee.

4. CMHSP Quality Improvement Committees
   Each member CMHSP has a Quality Improvement process to address quality issues within its operations that meets the requirements of MDHHS and the NMRE.

5. Accountability
   Because one of the tenants of quality improvement and a key element of a successful team in accountability, the success of the NMRE's QAPIP is dependent on the success of its parts. Employees and/or agents of the NMRE and its network providers must be accountable to beneficiaries, coworkers, various committees, and their primary employer for the quality and integrity of their work.

   The following table displays the reporting accountability of the various components of the quality improvement system.



RESPONSIBILITIES

Each of the components of the QAPIP structure have specific responsibilities. These various tasks, when taken in whole, ensure that the NMRE and its network providers are administering quality services, effectively managing and protecting available resources, protecting the rights of beneficiaries, and identifying opportunities to improve.

1. NMRE Internal Operations Committee (IOC)
   The NMRE IOC has the lead role within the NMRE in implementing the QAPIP, beginning with the quality, effectiveness, and efficiency of the managed are activities. The NMRE IOC also has responsibility for the following.

   a. Claims Verification
   The verification of Medicaid claims is required both by federal regulations and the Specialty Supports and Services Contract with the State. The primary responsibility for this activity, as specified in the NMRE Medicaid Encounter Verification Policy and Procedure is assigned to the Compliance Director.

   b. Practice Guidelines
   The process of developing, reviewing, adopting, and disseminating practice guidelines as specified in the NMRE Practice Guidelines Policy and Procedure is assigned to the NMRE Provider Network Manager. The NMRE IOC has the responsibility for ensuring that the policy and procedure is implemented appropriately. Practice Guidelines are posted on the NMRE.org website.

   c. Sentinel Events, Critical Incidents, and Risk Events
   The primary responsibility for the review of sentinel events, critical incidents, and risk events falls to NMRE network providers and residential treatment providers. The NMRE IOC and QOC analyze data sent by network providers quarterly to identify trends and implement plans of correction as appropriate to reduce the potential for future events. These reviews will be completed in accordance with MDHHS definitions and reporting requirements the NMRE's Critical Incident, Risk Events, Sentinel Events and Death Reporting policy.

   d. Death Reporting
   All unexpected deaths of Medicaid beneficiaries who, at the time of their death, were receiving specialty supports and services will be reviewed in accordance with the NMRE Critical Incident, Risk Event, Sentinel Event, and Death Reporting Policy and Procedure and the NMRE's Specialty Supports and Services Contract with the State.

   e. Credentialing
   The NMRE credentials organizational providers. Each network provider completes its own credentialing of staff. The NMRE ensures that credentialing is completed in a manner consistent with the NMRE Credentialing Policy and Procedure, MDHHS Credentialing and Recredentialing document dated July 29, 2020, and the NMRE's Specialty Supports and Services Contract with the State.

f. Utilization Management

The NMRE has a Utilization Management Plan that identifies:

i. Strategies for ensuring beneficiary eligibility criteria
ii. Strategies for evaluating medical necessity and service authorization decisions.
iii. Mechanisms to identify the correct under- and over-utilization of services.
iv. Procedures to conduct prospective, concurrent, and retrospective authorization reviews.

Collaboratively, NMRE and CMHSP designated staff are responsible to:

i. Provide oversight to ensure that each CMHSP has policies and procedures that comply with State and federal requirements related to UM.
ii. Develop, monitor and track key performance indicators to include identification of over/under utilization patterns and/or deviation from expected results across the region.
iii. Engage in studies of specific populations or sets of services based on identified factors or criteria. These may include populations or services with high risk, high costs, and presence of negative outliers or outcomes, or significant variance in utilization patterns.
iv. Act as the representative for the region on any Utilization Management initiatives across the state.

g. Provider Monitoring

The NMRE monitors its network providers at least annually, including CMHSPs, the SUD Provider Panel, inpatient psychiatric hospital units, and other contracted providers, as needed. Monitoring includes a review of delegated functions, services and supports provisions, and compliance with administrative requirements including credentialing and staff training. As appropriate, targeted monitoring activities for people identified as "vulnerable" are also conducted. When a network provider is found to be out of compliance with contract requirements, appropriate corrective action is required.

2. NMRE Quality and Compliance Oversight Committee (QOC)

The NMRE regional QOC acts as the NMRE's primary connection to the quality improvement activities of its network providers. This committee, the Regional Customer Services Committee, and the regional Consumer Advisory Committee (Regional Entity Partners) are the vehicles from which the NMRE receives beneficiary input.

a. Coordination with Network Provider Structures

The NMRE recognizes that quality improvement is best addressed by the individual involved in the systems to be improved. As such, those best equipped to improve the various functions of the NMRE's provider network are those within the provider organizations. The NMRE supports the existing quality improvement structures of its network providers though the NMRE retains the responsibility for ensuring that federal and state regulatory requirements and the quality improvement provisions of the NMRE's Specialty Supports and Services Contract with the State are met.

b. Performance Indicators

MDHHS has established performance indicators for CMHSPs and PIHPs. Each member CMHSP and the SUD Provider Panel report relevant performance indicator data to the NMRE. The NMRE IOC and QOC monitor these data quarterly and over time. When a standard is not met for two consecutive quarters, the NMRE requests a corrective action plan from the provider. This information includes persons served by the PIHP, whether for mental health, intellectual/developmental disability, or substance use conditions. The QOC monitors the PIHP's performance in this area. These reports are also shared quarterly with the NMRE's Governing Board.

c. Member Satisfaction

The NMRE QOC, Customer Services Committee, and SUD Provider meetings are responsible for ensuring that surveys are administered to beneficiaries to measure their degree of satisfaction with services, including those for mental health, intellectual/developmental disabilities, and substance use disorders, including long-term supports and services. Surveys are conducted in a way that results can be measured over time. The NMRE investigates areas of dissatisfaction when the data indicates a systemic concern with a particular provider. Survey findings are shared with the NMRE Governing Board, the NMRE regional Consumer Advisory Committee (Regional Entity Partners), network providers, and will be posted to the NMRE.org website.

d. Performance Improvement Projects

In accordance with federal regulations and the NMRE's Specialty Supports and Services Contract with the State, the NMRE conducts at least two Performance Improvement Projects (PIPs) each year. The MDHHS mandates the topic of one of the two PIPs. The NMRE regional QOC selected the topic for the additional PIP(s). The NMRE OOC reviews PIP data at least quarterly. The NMRE Compliance Director reports on the PIPs in accordance with the timeline established by MDHHS.

e. Analysis of Behavior Treatment Data

At least quarterly, the NMRE regional Behavior Treatment Plan Review Committee (BTPRC) reviews and analyzes data from network providers in which intrusive or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis to identify trends and any subsequent action that needs to be taken to reduce the potential for future events. Data includes the number of interventions and the length of time the interventions were used per individual. The NMRE adheres to the provisions outlined in the MDHHS Technical Requirement for Behavior Treatment Plans dated July 29, 2020, and the NMRE's current Specialty Supports and Services Contract with the State.

3. Compliance Director

The NMRE Compliance Director is a senior staff person responsible for the implementation of the NMRE's QAPIP. On an annual basis, the Compliance Director works with various committees to conduct an effectiveness review of the QAPIP and the previous fiscal year's workplan. The effectiveness review includes an analysis to determine whether members experienced any improvement in their quality of healthcare and services due to the QAPIP.

The effectiveness review is shared with the NMRE Governing Board, network providers, and upon request, to members and MDHHS. The effectiveness review is used to inform the current year's QAPIP and Workplan.

4. Member CMHSP Quality Improvement Committees
   Each member CMHSP must maintain an appropriate quality improvement program that meets the requirements of federal regulations and national accreditation. Each CMHSP submits summary reports of quality improvement activities, minutes of Quality Improvement Committee meetings, and Quality Improvement Plans to the NMRE. The NMRE monitors all quality improvement program activities to ensure they are consistent with the standards and requirements of managed care, as specified in federal regulations and the NMRE's Specialty Supports and Services Contract with the State.

   Substance Use Disorder (SUD) services are delivered through a network of contracted provider organizations (SUD Provider Panel). No managed care functions are delegated to SUD providers. To ensure adequate representation of SUD service in the NMRE's quality improvement activities, the NMRE SUD Grant Director is an integral member of various committees.

Approval Signature



NMRE Chief Executive Officer

2/8/23

Date

FY22 QAPIP Program Evaluation

A. Performance Improvement Projects (PIPs)

1. Increase the percentage of individuals enrolled in Opioid Health Home (OHH) services.

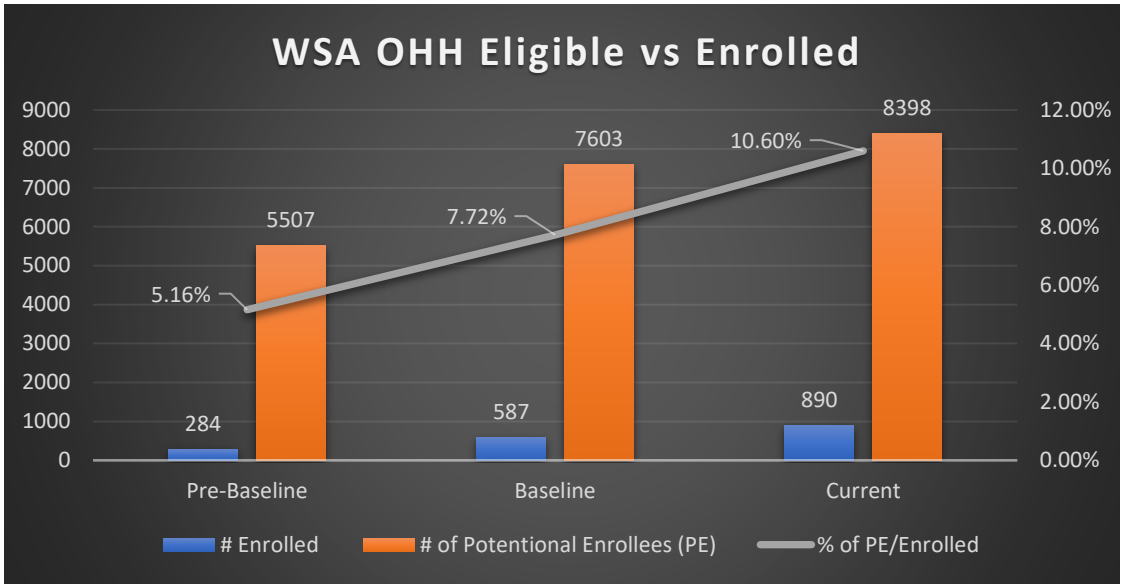
   OHH provides comprehensive care management and coordination services to Medicaid beneficiaries with an opioid use disorder. For enrolled beneficiaries, the OHH functions as the central point of contact for directing patient-centered care across the broader health care system. Beneficiaries work with an interdisciplinary team of providers to develop an individualized recovery care plan to best manage their care. The model also elevates the role and importance of peer recovery coaches and community health workers to foster direct empathy and connection to improve overall health and wellness. In doing so, this attends to a beneficiary's complete health and social needs. Participation is voluntary, and enrolled beneficiaries may opt out at any time.

   Goals

   a. Increase access to Medication Assisted Treatment (MAT) and integrated behavioral, primary, and recovery-centered services for beneficiaries with Opioid Use Disorder
   b. Decrease opioid overdose deaths
   c. Decrease opioid-related hospitalizations
   d. Increase utilization of peer recovery coaches
   e. Increase the "intangibles" of health status (e.g., the social determinants of health)

   Initial Data

Time Period	Running Date	# Enrolled	# of Potential Enrollees (PE)	% of PE/Enrolled
Pre-Baseline	<= 9/30/2020	284	5,507	5.16%
Baseline	<= 9/30/2021	587	7,603	7.72%
Current	<= 9/30/2022	890	8,398	10.60%



Based on data at submission, the is a .8 percent increase in the OHH enrollment rate. The increase reflects a slight improvement in enrollment.

Positive interventions

a. Provider Network expansion: There has been an increase in the provider network which led to subsequent increase in enrollment.

b. Current providers have increased participation resulting in an increase in enrollment. Some of the things that providers have done differently are:

    i. Hire more staff. Providers have hired more staff in critical areas such as care coordinators to help maintain and expand enrollment.

    ii. Become more engaged in the process by attending meetings with the NMRE and investing more in the program.

c. The NMRE has done the following to increase enrollment:

    i. Provide monthly meetings with providers. These monthly meetings have helped to keep providers more engaged and motivated

    ii. Monthly meetings have provided opportunities for additional education to providers.

Challenges

The major challenge here is staffing capacity.

a. Staffing inconsistency due to high turnover
b. When providers lose critical staff, they are almost starting over because they will have to either slow down or put a halt on new enrollment, hire new staff, train new staff before they can get back on track.

2. Behavioral Health Home (BHH) – Improve the percentage of individuals who are enrolled in the Behavioral Health Home program from 3.56% to 5% by the end of FY2023.

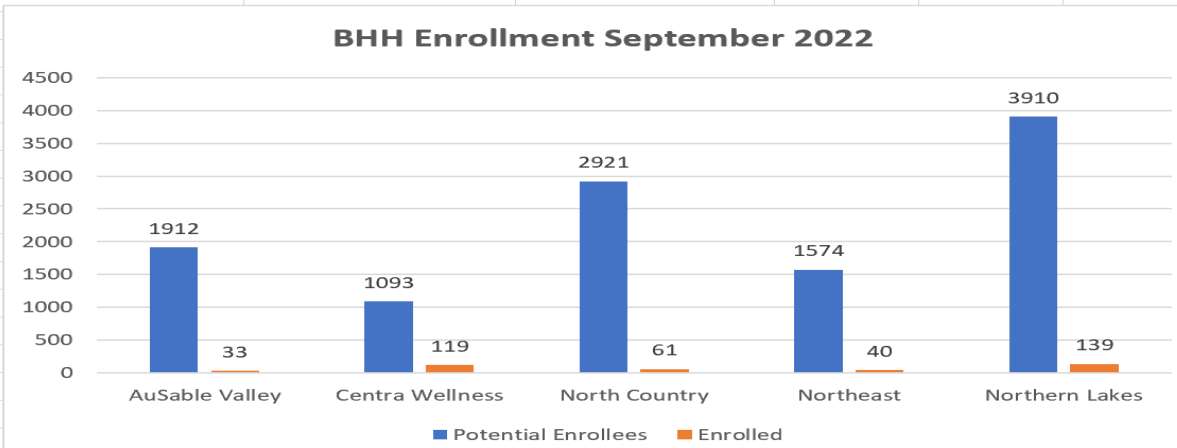
   Goals

   a. Improve care management for beneficiaries with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED).

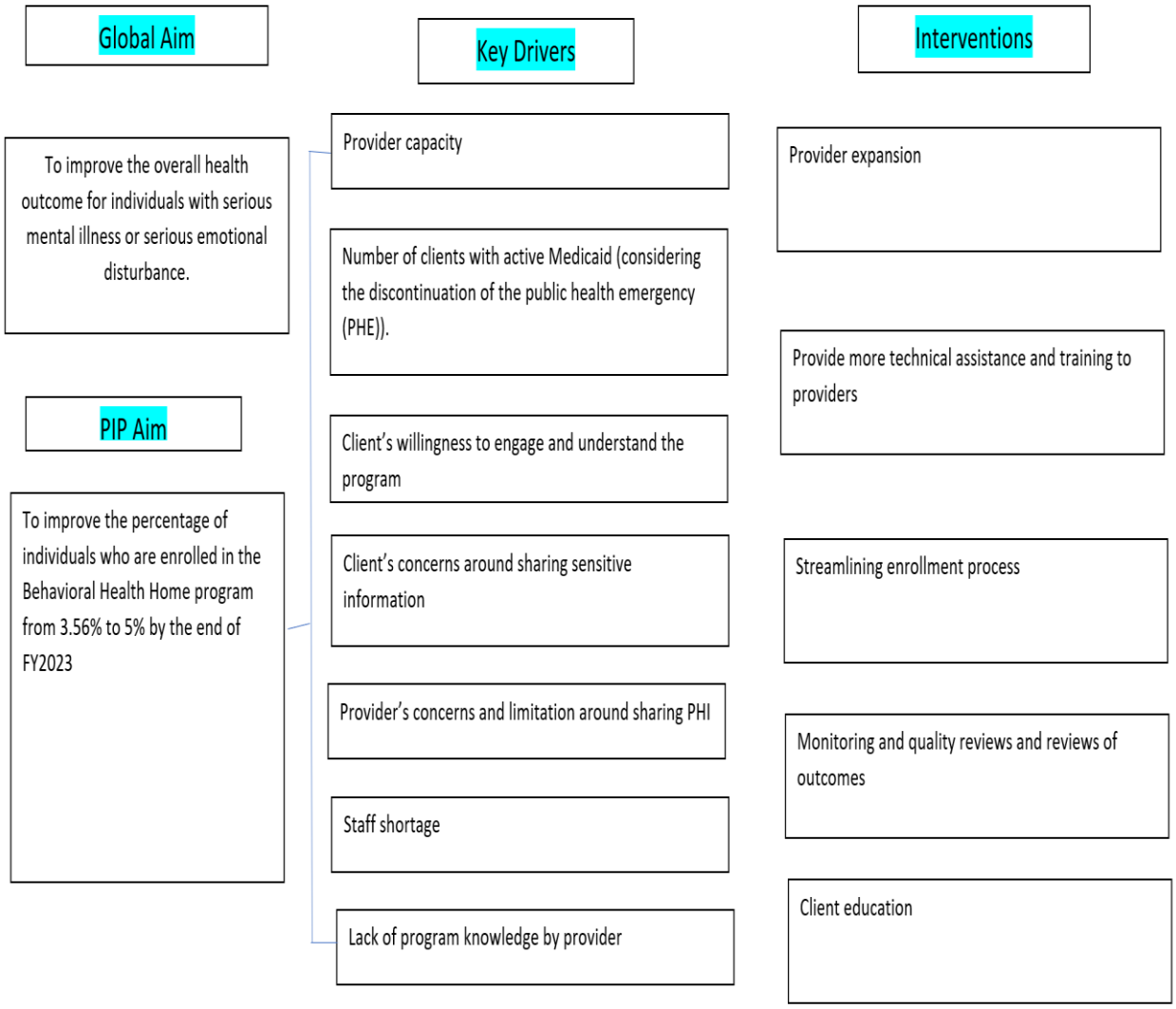
   b. Improve care coordination between physical and behavioral services.

   c. Improve care transitions between primary care, specialty services and inpatient settings.

	Potential Enrollees	Enrolled	%
AuSable Valley	1912	33	1.73%
Centra Wellness	1093	119	10.89%
North Country	2921	61	2.09%
Northeast	1574	40	2.54%
Northern Lakes	3910	139	3.55%
	11410	**392**	**3.44%**



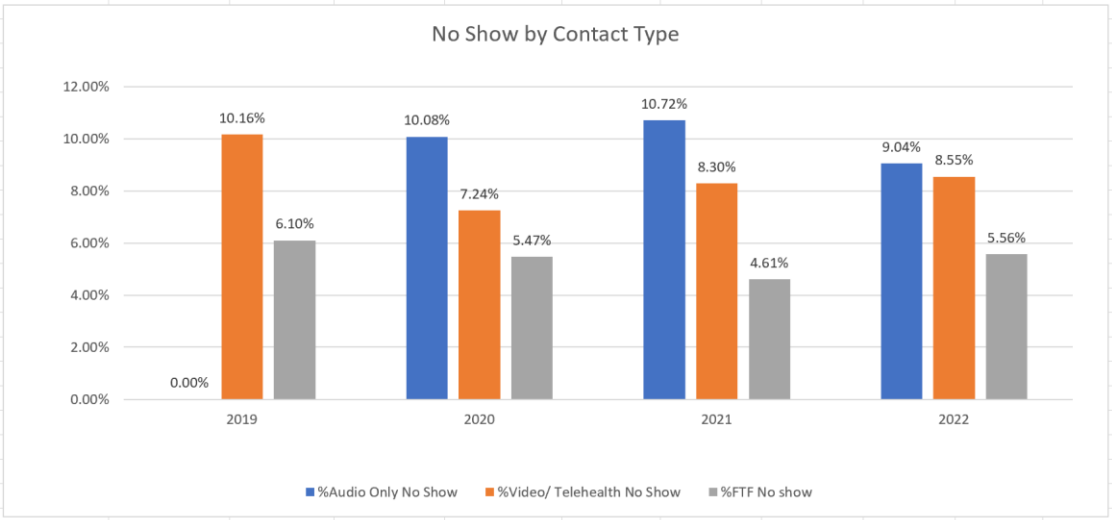
Key Driver Diagram for Behavior Health Home



3. Decrease no-show/missed appointment rate for psychiatric services.

Region Wide No-Show Data

	Total Appointments Scheduled	Total No Show	%Total No Show	Audio Only Scheduled	Audio Only No Show	%Audio Only No Show	Video/ Telehealth Scheduled	Video/ Telehealth No Show	%Video/ Telehealth No Show	FTF Scheduled	FTF No Show	%FTF No show
2019	225018	12562	**5.58%**	1	0	**0.00%**	9544	970	**10.16%**	189718	11570	**6.10%**
2020	229678	17083	**7.44%**	90485	9120	**10.08%**	22052	1597	**7.24%**	116071	6351	**5.47%**
2021	235344	17050	**7.24%**	82605	8854	**10.72%**	32134	2666	**8.30%**	119595	5519	**4.61%**
2022	194798	12533	**6.43%**	26889	2432	**9.04%**	23456	2005	**8.55%**	145362	8081	**5.56%**



Next Steps

a. Discussion on challenges from various boards

b. Boards sharing success ideas

c. Review common goal

B. Site Reviews

1. HSAG Compliance Review

The FY 2022 compliance review is the second year of the three-year cycle of compliance reviews that commenced in FY 2021. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance review for Michigan PIHPs consists of 13 program areas referred to as standards. MDHHS requested that HSAG conduct a review of the first six standards in Year One (FY 2021), and a review of the remaining seven standards in Year Two (FY

2022). In Year Three (FY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the FY 2021 and FY 2022 compliance reviews. The standards that were reviewed in FY22 are comparable to the standards reviewed in 2019. Although the FY22 standards were much more elaborate, there was still 8% increase in 2022 compared to the outcome from 2019. The practice guidelines had the lowest score, and some process changes have been put in place to mitigate this situation. There was a significant improvement in the Confidentiality standard and additional processes will be implemented to maintain this standard.

The FY 2021 compliance review CAP was approved, and the CAP implementation is in progress. The FY2022 CAP have been submitted and pending feedback.

2019 HSAG Compliance Review

Standard	Total # of Applicable Elements	Number of Elements			Total Compliance Score
		Met	*Not Met*	*NA*	
Standard I—QAPIP Plan and Structure	8	5	3	0	63%
Standard II—Quality Measurement and Improvement	8	4	4	0	50%
Standard III—Practice Guidelines	4	3	1	0	75%
Standard IV—Staff Qualifications and Training	3	3	0	0	100%
Standard V—Utilization Management	16	9	7	0	56%
Standard VIII—Members' Rights and Protections	13	11	2	0	85%
Standard XI—Credentialing	9	5	4	0	56%
Standard XIII—Coordination of Care	11	11	0	0	100%
Standard XVI—Confidentiality of Health Information	10	6	4	0	60%
Total	82	57	25	0	70%

2022 HSAG Compliance Review

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	12	4	0	75%
Standard VIII—Confidentiality[1]	11	11	10	1	0	91%
Standard IX—Grievance and Appeal Systems	38	38	32	6	0	84%
Standard X—Subcontractual Relationships and Delegation	5	5	4	1	0	80%
Standard XI—Practice Guidelines	7	7	4	3	0	57%
Standard XII—Health Information Systems	12	11	9	2	1	82%
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	21	9	0	70%
Total	119	118	92	26	1	78%

2. NMRE Site Review

The NMRE conducts regional CMH site reviews biannually where year one is a full review and year two is a review of the Corrective Action Plan (CAP) implementation. Fiscal year 2022 was a full review year for the NMRE's site review. The NMRE requested random sample of evidence from the CMHSPs. It was a Hybrid review where part was a deck review and NMRE staff went on site for separate piece.

Results Summary					
TOOL	OVERALL SCORE				
	AVCMHA	CWN	NCCMHA	NEMCMHA	NLCMHA
DMC	100%	99.4%	99.7%	97.9%	97.6%
Program Specific	97.37%	97.9%	97.4%	92.6%	95.8
Clinical Records	97.85%	98.2%	97.4%	96.6%	95.0%
Training			88.5%	85.4%	92.0%

Site Review Observations:

a. Most of the missing documentation; trainings were from 2020.

b. Most of the missing documents; trainings were from AFC Homes.

c. Unable to see a clear or separate training between the various specialties such as customer service, cultural competency, etc.

d. Some Boards did not have a training grid which would make it easy to identify the various roles and trainings.

e. National Practitioner Databank (NPDB) checks need to be incorporated in the initial verifications of clinical staff.

f. The CMHSPs are currently working on the CAPs for the FY2022 site review.

3. MDHHS Review

   The NMRE team worked with the CMHSPs and MDHHS to complete the initial 2022 (c) Waiver (HSW, CWP, SEDW) review; this review occurs every other year. There were no outstanding trends among the five CMHSPs reviewed; however, there was a need for a technical assistance call with the five CMHSPs to clarify certain areas.

4. SUD Program Review

   The NMRE conducts SUD Providers site reviews biannually where year one is a full review and year two is a review of the Corrective Action Plan (CAP) implementation. The 2022 compliance review for SUD providers was a CAP review from 2021 full review. This year the NMRE requested evidence of CAPs that were activated as a result of the 2021 NMRE site review. The region was determined to be substantially compliant with the CAPs.

C. Satisfaction Surveys

1. The survey tool was revised to capture more meaningful data.
2. The following satisfaction surveys were completed:
   a. SUD Residential
   b. MH Outpatient
   c. Detox
   d. Methadone
3. The Customer service Support Specialist and the Compliance Director:
   a. Reviewed the surveys for trends and identified areas for improvement.

b. Identified underperforming providers and reached out to them to implement a CAP and provide technical assistance.

c. Followed up with the CAP through to completion.

4. Survey results are disseminated/communicated as follows:

   a. Shared with the individual providers

   b. Shared and discussed at the SUD Director's meeting

   c. Shared and discussed at the Compliance and Quality Committee meeting

   d. Share with the Board of Directors

5. The following challenges to the survey process were identified:

   a. Low participation

   b. Lack of communication between staff and administration resulted in low participation

   c. Not all clients have returned to inpatient service

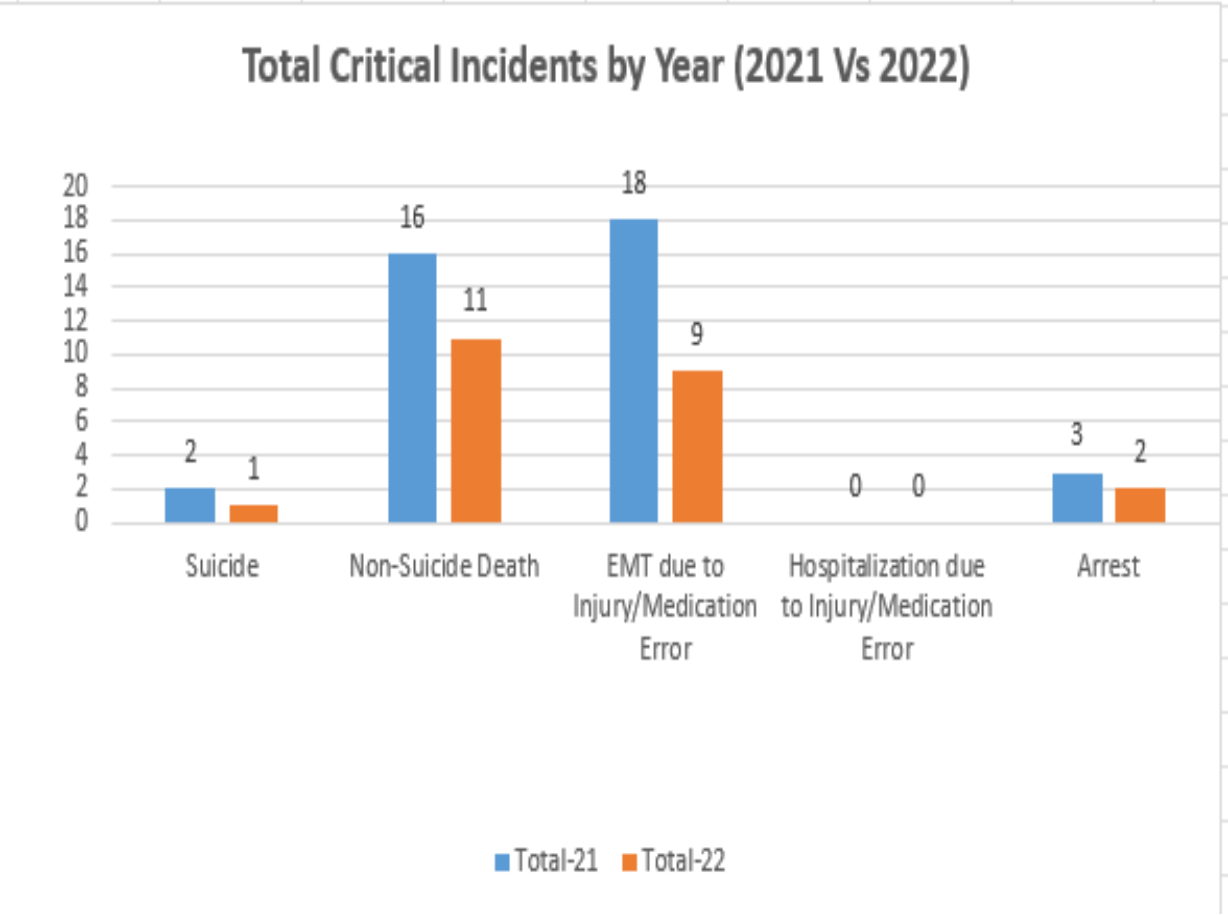
   d. Completed surveys are not returned timely

D. Events Data

1. Critical Incidents

   Critical Incidents data was broken down by months and by year. March of 2022 had the highest number of incidents reported, however, there was no trend around this occurrence. Non—suicide death was the highest category in 2022. It was determined that the impact of COVID was the major cause of the increase in reported deaths. EMT due to injury/Medication error came second. This came with no surprise because Region 2 continues to experience a significant level of staff shortage and high turnover. Overall, there was a total of 106 critical incidents reported in 2022, a 29% decrease from 2021.

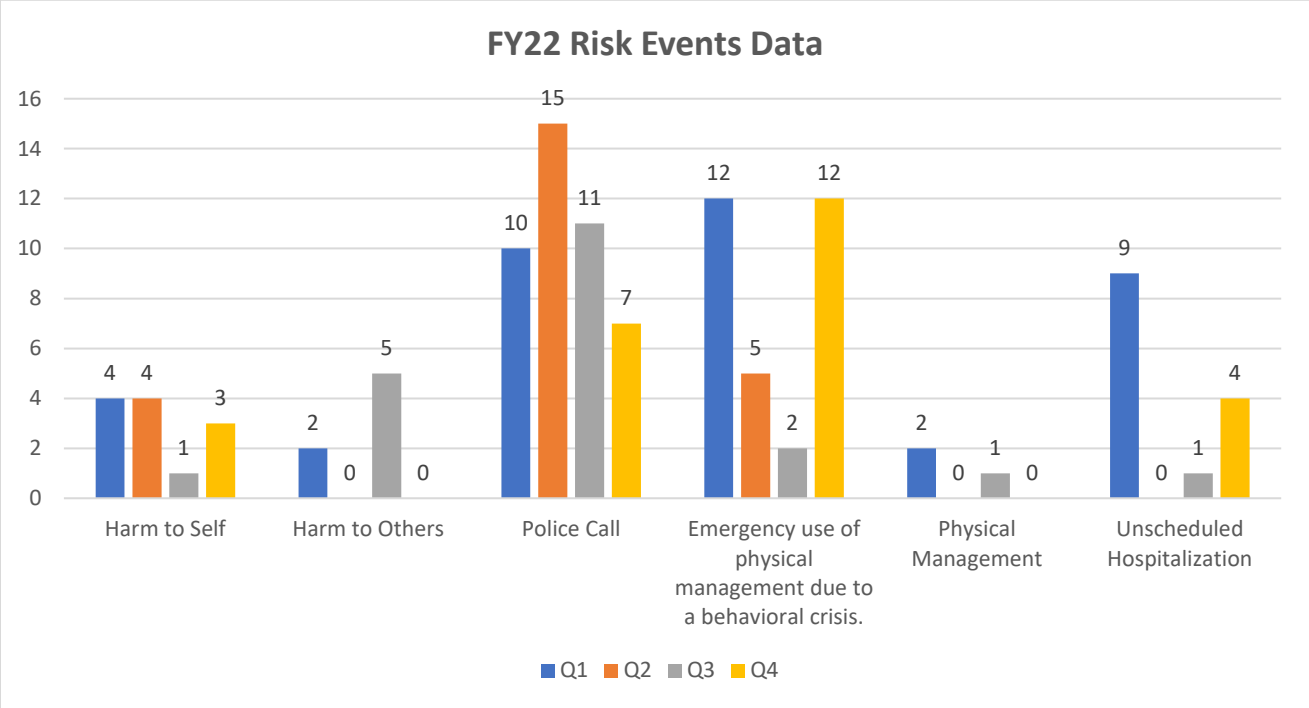

Incidents by months
9
8
7
6
5
4
3
2
1
0
1 0 0 0 1 1
5 4 5 4 6 3
8 3 7 1 3 5
0 0 0 0 0 0
2 1 1 1 0 0
Suicide
Non-Suicide Death
EMT due to Injury/Medication Error
Hospitalization due to Injury/Medication Error
Arrest
21-Apr
22-Apr
21-May
22-May
21-Jun
22-Jun



2. Risk Events Data

   Risk events data was reviewed by quarter as opposed to FY2021 vs. 2022 because 2022 was the first year with full data. Police calls remained consistently high due to increasing cases with chronic behavioral issues with either less staffing or insufficiently trained staff due to the staff shortage and staff turnover in the region. Emergency use of physical management due to behavioral crisis came in second. This is again attributed to the high staff turnover and staff shortage. This doesn't allow staff to be properly trained before they fully assume their duties.

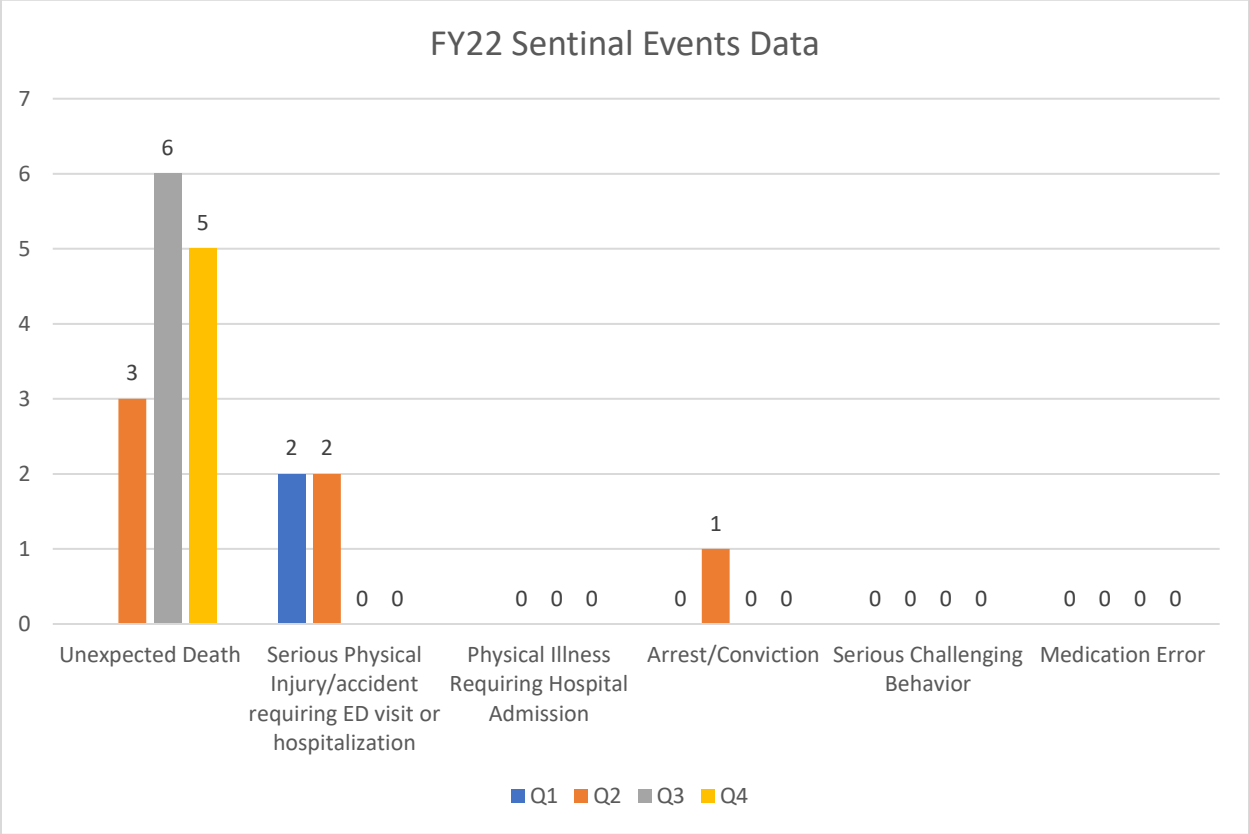
Event Type	Q1	Q2	Q3	Q4
Harm to Self	4	4	1	3
Harm to Others	2	0	5	0
Police Call	10	15	11	7
Emergency Use of Physical Management Due to a Behavior Crisis	12	5	2	12
Physical management	2	0	1	0
Unscheduled Hospitalization	9	0	1	4



3. Sentinel Events Data

Sentinel events data was reviewed by quarter as opposed to FY2021 vs. 2022 because 2022 was the first year with full data. Suicidal death was the highest sentinel event reported; unfortunately, there was no identified trend. The cause of death and location varied; however, it was determined that there is a need for enhanced crisis planning and the ongoing use of crisis plans. It was also observed that there was an increase in substance use disorders and lack of training to properly identify SUD and high-risk individuals. Some of the CMHSPs have created an SUD committee to address this need. Motivational Interviewing training is also being pursued.

Event Type	Q1	Q2	Q3	Q4
Unexpected Death		3	6	5
Serious Physical Injury/Accident Requiring ED Visit or Hospitalization	2	2	0	0
Physical Illness Requiring Hospital Admission		0	0	0
Arrest/Conviction	0	1	0	0
Serious Challenging Behavior	0	0	0	0
Medication Error	0	0	0	0



E. Performance Indicators

Performance indicator data was shared with all the PIHPs and the Substance Use Disorder (SUD) Directors for their review. During QOC and the SUD Directors meetings this data was presented and discussed. During these meetings, the NMER highlighted areas of success and discussed areas with deficiencies. It was discovered that there were certain situations when a client went back into the hospital prior to 7 days after discharge. The system may or may not update; this will require a manual adjustment. It was also revealed that hospitals sometimes do not schedule the follow-up visit before a client leaves that hospital. Once the client leaves the hospital, it is sometimes difficult to reach them prior to the 7-day window. The CMHSPs will work with the hospitals to mitigate this situation. For SUD access to care

within 7 days, due to staff shortage, it is sometimes not possible to have availability for an intake. SUD providers continue to explore other options, such as telehealth.

Table 1 – Access – Timeliness/Inpatient Screening

Population	Emergency Referral	# < 3 Hours	% < 3 Hours
Children	180	179	99.44%
Adults	770	761	98.83%
Total	**950**	**940**	**98.95%**

Table 2a – Access – Timeliness/First Request

Population	New Clients	# In 14 Days	% In 14 Days
MIC	353	195	55.24%
MIA	910	498	54.73%
DDC	77	59	76.62%
DDA	33	20	60.61%
Total	**1,373**	**772**	**56.23%**

Table 2b – Access – Timeliness/First Request - Substance Use Disorder

Population	Admissions	Expired	# In 14 Days	% In 14 Days
SA	Calculated	217	Calculated	%

Table 3 – Access – Timeliness/First Service

Population	New Clients Start Services	# In 14 Days	% In 14 Days
MIC	229	162	70.74%
MIA	515	330	64.08%
DDC	70	52	75.71%
DDA	22	14	63.64%
Total	**836**	**559**	**66.87%**

Table 4a – Access – Continuity of Care

Population	# Discharges	Exceptions	Net Discharges	# 7 Days	% 7 Days
Children	59	14	45	45	100%
Adults	228	80	148	145	97.97%
Total	**287**	**94**	**193**	**190**	**98.45%**

Table 4b – Access – Continuity of Care - Substance Use Disorder

Population	# Discharges	Exceptions	Net Discharges	# 7 Days	% 7 Days
SA	255	102	153	145	94.77%

Table 6 – Outcomes – Inpatient Recidivism

Population	# Discharges	Exceptions	Net Discharges	# Readmit in 30 Days	% Readmit in 30 Days
Children	59	0	59	4	6.78%
Adults	228	1	227	26	14.45%
Total	**287**	**1**	**286**	**30**	**10.49%**

F. Utilization Management (UM) Committee

A Regional UM Committee was formed in 2022. The purpose of this committee is to provide oversight and perform utilization management functions to control costs and minimize risk while assuring quality care. The UM Plan establishes a framework for oversight and guidance of the Medicaid program by ensuring consistent application of program/service eligibility criteria, and in decisions involving the processing of requests for initial and continued authorization of services. Individuals and or entities that conduct utilization management activities must sign an attestation stating that compensation cannot be structured to provide incentives to the individual or entity to deny, limit, or discontinue medically necessary services to any recipient.

The committee accomplished the following:

1. Reviewed the current UM processes for all the CMHSPs and SUD services
2. Discussed authorization decision making process to make sure that services are not being denied unnecessarily.
3. Other areas reviewed included:
    a. Service denials
    b. Telehealth
    c. Out-of-state placements
    d. Respite program
    e. 14-day compliance
    f. Intake and first services

G. Behavior Treatment Plan Review Committee (BTRC)

A regional Behavior Treatment Plan Review (BTPR) Committee was formed in 2022. The committee will quarterly review and analyze data from the CMHSPs' Behavior Treatment Review Committees where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plans and that have been approved during person-centered planning by the beneficiary or his/her guardian, may be used with beneficiaries. Data will include numbers of interventions and length of time the interventions were used per person.

In FY22, the committee accomplished the following:

1. Developed and approved the Behavior Treatment Review Committee (BTRC) Policy
2. Reviewed and approved the BTRC data collection template

3. Reviewed BTRC data from all five CMHSPs.

Once the data was reviewed, it was evident that more training was required. Some reports missed important details such as length of time of the intervention. Additional training will be provided to improve this process.

H. Network Adequacy

The NMRE has used Power BI to build reporting structures to measure mileage and drive time from its CMSHPs contracted inpatient psychiatric locations and Substance Use Disorder providers by ASAM level, and will continue this methodology for the CMHSPs' full array of service locations in FY2023. The NMRE has used the data reported in Power BI to project time/distance data required in the PIHP/MDHHS contracted Network Adequacy Standards by rural distance standards. In addition, the NMRE will use the updated data to provide adequacy reporting for the following enrollee-to-provider ratios:

Adult Services

- Assertive Community Treatment teams
- Psychosocial rehabilitation (Clubhouses)
- Opioid Treatment Programs (OTP)
- Crisis residential beds

Pediatric Services

- Home-Based regional FTEs
- Wraparound regional FTEs
- Crisis residential beds

The NMRE's QAPIP Report is reviewed and updated annually with input from various stakeholders and approved by the Governing Board. The NMRE's Board of Directors, the Operations Committee, the Internal Operations Committee (IOC) and the Compliance and Quality Oversight Committee (QOC) are responsible for the evaluation of the effectiveness of the QAPIP. This Annual Effectiveness Review includes analyses of whether there have been improvements in the quality of healthcare and services for recipients due to quality assessment and improvement activities and interventions carried out by the NMRE. The analysis considers trends in service delivery and health outcomes over time and includes monitoring of progress on performance goals and objectives. Information on the effectiveness of the QAPIP will be provided to network providers and to recipients upon request. This annual analysis will be provided to the MDHHS annually no later than February 28th.

The NMRE publishes its QAPIP Report that provides a summary of accomplishments and highlights from the previous Fiscal Year as well as key information that will identify whether current systems and processes are providing desired outcomes. This report is shared with the NMRE Board of Directors, Provider Network, Regional Consumer Council, and other interested stakeholders.

The NMRE posts this document on the website https://www.nmre.org. Copies of this document can be made available to stakeholders upon request.

FY23 QAPIP Program WORKPLAN

Goal #1

The NMRE will conduct Performance Improvement Projects (PIPs) that achieve ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction.

Objective #1

The NMRE QOC will continue to collect data, conduct ongoing analysis, and coordinate with providers to improve the number of individuals enrolled in the Opioid Health Home (OHH) program through September 30, 2023. The NMRE will collect data and conduct analysis in preparation for Measurement 1 to show evidence of enrollment improvement from the baseline by September 30, 2024.

Objective #2

The NMRE QOC will collect data and conduct analysis for Behavioral Health Home (BHH) enrollment. The NMRE will strive to improve the percentage of individuals who are enrolled in the Behavioral Health Home program from 3.56% to 5% by September 30, 2024.

Objective #3

The NMRE QOC will collect data and conduct analysis for no-show/missed psychiatric appointments. The goal is to decrease the regional no-show/missed appointment rate for psychiatric services by the end of FY2024.

Goal #2

The NMRE QOC, as part of the QAPIP, will continue to review and follow-up on sentinel events and other critical incidents and events that put people at risk of harm.

Objective #1

The NMRE will provide training to staff on the type of data to collect and the population involved in this data collection.

Objective #2

The NMRE will review the reporting process and requirements for critical incidents, risk events, sentinel events, and behavioral treatment reporting with the state and providers to reduce underreporting by 09/30/23.

Objective #3

The NMRE will continue to collect events and Behavior Treatment Review Committee (BTRC) data quarterly, analyze trends, and implement necessary interventions.

Objective #4
Annually, the NMRE will check to see if interventions are improving patient safety. This will be done by reviewing the data submitted which will include the number of events.

Goal #3

The NMRE will conduct quantitative and qualitative assessments (such as surveys, focus groups, phone interviews) of members' experiences with services. These assessments will be representative of persons served, including long-term supports and services (i.e., individuals receiving case management, respite services, or supports coordination) and the services covered by the NMRE's Specialty Supports and Services Contract whit the State. Assessment results will be used to improve services, processes, and communication.

Objective #1
The NMRE will incorporate consumers receiving long-term supports or services (LTSS) (e.g., persons receiving case management, respite services or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

Objective #2
The NMRE will expand its process of collecting members' experiences with services to identify and investigate sources of dissatisfaction.

Objective #3
The NMRE will conduct separate Substance Use Disorder (SUD) surveys, including the Detox and Methadone surveys, to identify specific member experiences.

Objective #4
The NMRE will identify and provide possible recommendations to resolve areas of dissatisfaction on an ongoing basis.

Objective #5
The NMRE will outline systemic action steps to follow-up on the findings from survey results on an ongoing basis.

Objective #6
The NMRE will share survey results with providers, the regional Quality and Compliance Oversight Committee (QOC), the Internal Operation Committee (IOC), network providers, Board of Directors, the Regional Consumer Council (Regional Entity Partners), and post copy to the NMRE.org website.

Goal #4

The NMRE will monitor its network providers at least annually.

Objective #1
The NMRE will conduct site review annually for all contracted service providers by 9/30/2023.

Objective #2
The NMRE will monitor and follow-up on corrective action plans to ensure Corrective Action Plans (CAPs) are being implemented as stated by network providers.

Objective #3
The NMRE QOC will receive regular updates from providers regarding the progress of their Quality Improvement Workplans and CAPs.

Objective #4
The NMRE will perform quarterly audits to verify Medicaid claims/encounters submitted within the provider network. This will include verifying data elements from individual claims/encounters to ensure proper codes are used and proper documentation is in place.

Goal #5
The reginal Behavioral Treatment Plan Committee (BTRC) will conduct quarterly reviews and review data analyses from the CMH providers where intrusive, or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis.

Objective #1
The NMRE will monitor that only techniques permitted by the MSHHS Technical Requirements for Behavior Treatment Plans and that have been approved during person-centered planning by the members or their guardians have been used with members through its annual site reviews by 9/30/2023.

Objective #2
The NMRE regional BTRC will be tasked with reviewing data to ensure that only techniques permitted by the MSHHS Technical Requirements for Behavior Treatment Plans and that have been approved during person-centered planning by the members or their guardians have been used.

Objective #3
The NMRE regional BTRC will monitor behavior treatment data quarterly, including the numbers of interventions and length of time the interventions were used per person.

Objective #4
The NMRE regional BTRC will review analyses of data from each CMHSP behavior treatment committee review process quarterly.

Objective #5
The NMRE QOC will review meeting minutes from the BTRC quarterly to assure that its reviews of data are accurate and complete.

Goal #6

The NMRE will establish regional HEDIS measures to demonstrate the effectiveness of improvements in the quality of health care and services for members as a result of the NMRE quality assessment and improvement activities and interventions carried out by the NMRE provider network.

Objective #1

The NMRE will provide HEDIS measure reports to the NMRE QOC on a regular basis.

Objective #2

The NMRE will collect and review data for the HEDIS measures tied to the Performance Bonus Incentive Pool to receive full payment.

- Follow-up after hospitalization (FUH) for mental illness within 30 days.
- Follow-up after (FUA) emergency department visit for Alcohol and Other Drug Dependence.

Objective #3

The NMRE will collect and review data for the HEDIS measures tied to the Performance Bonus Incentive Pool to receive full payment with the CMHSPs and identify interventions to improve these outcomes.

Objective #4

The NMRE OOC will continue to monitor the impact of the changes with FUH and FUA data. FUH and FUH are being calculated using the unaltered HEDIS specifications; this means that certain service coded that applied to these measures will no longer qualify.

Goal #7

The NMRE will implement the Supports Intensity Scale (SIS) Assessment in the region. SIS is a strengths-based, comprehensive assessment tool that measures an individual's support needs in personal, work-related, and social activities to identify and describe the types and the intensity of the supports an individual requires.

Objective #1

The NMRE will provide education to providers around the MDHHS contractual requirement to complete the statewide standardized assessment tool for individuals aged 16 and older1 with an intellectual/developmental disability (I/DD) as a primary or secondary diagnosis who receive services provided by Medicaid through the Behavioral Health System.

Objective #2

The NMRE will ensure that consumers and stakeholders are provided educational materials related to the SIS Assessment process.

Objective #3

The NMRE will develop and implement a process for staff to identify all declined SIS Assessments.

Objective #4
The NMRE will develop and implement a process to continue to engage, at least annually, individuals who did not participate in the SIS Assessment to increase their understanding of the benefits of this process and how the results will be used.

Goal #8
The Compliance Director will continue to provide quarterly updates to QOC, network providers, the Governing Board, and other stakeholders regarding routine QAPIP activities.

Objective #1
QAPIP activities will be reviewed and evaluated by QOC.

Objective #2
The QAPIP update report will be shared with the Governing Board quarterly.

Objective #3
QAPIP activities will be shared with consumers through the regional Consumer Council (Regional Entity partners) and other stakeholders through committees and posting to the NMRE.org website.

Goal #9
The NMRE and its network providers will implement a process to adopt and adhere to practice guidelines established by American Psychiatric Association (APA) and Michigan Department of Health and Human Services (MDHHS). The NMRE will also develop and adopt additional regional practice guidelines.

Objective #1
The NMRE, in collaboration with its network providers, will review and adopt practice guidelines established by APA and MDHHS.

Objective #2
The NMRE, in collaboration with its network providers and stakeholders, will develop and adopt additional regional practice guidelines as they relate to the services provided pursuant to the NMRE's Specialty Supports and Services Contract with the State.

Objective #3
The NMRE will disseminate adopted practice guidelines to all affected providers, members, and potential members as needed.

Objective #4
The NMRE will publish adopted practice guidelines on the NMRE.org website to be accessible to all interested stakeholders.

Goal #10

The NMRE will update Sub-contractual Relationships and Delegation Agreements to include the recommendation from HSAG during the compliance review.

Objective #1

The NMRE will ensure that in future agreements there is specific language around "the right to audit records for the past 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later".

Goal #11

The NMRE will update its credentialing standards to align with its Specialty Supports and Services Contract with the State and federal regulations.

Objective #1

The NMRE will update its annual monitoring tools, as applicable, to ensure evidence is collected in policy, procedure, and practice regarding its delegation review of member concerns, grievances, appeal information, or quality issues during periods of individual practitioner recredentialing.

Objective #2

Since CMHSPs have recently taken over running all staff in a monthly third-party exclusion check, the NMRE will annually and periodically ensure that the CMHSPs processes for exclusions checks are maintained each month and verify their processes for validation of the reports.

Objective #3

The NMRE will create a new monitoring tool specific to organizational credentialing and recredentialing using the HSAG tool as an example. The NMRE will ensure all standards in the MDHHS Credentialing and Recredentialing Guidelines are reviewed. The NMRE will further ensure that evidence of credentialing decision and accreditation or ongoing quality assessment, and timeframes, are reviewed.

Objective #4

The NMRE will host a series of Credentialing Roundtables for the region with the intension of educating the staff that do the actual individual credentialing. This will allow the NMRE to drive a series of interactive meetings that allow the CMHSPs to discuss their processes as a group and review the following in an organized manner:

a. The NMRE's Specialty Supports and Services contract with the State's credentialing and recredentialing standards (including timeline and all credentialing application requirements),
b. HSAG's monitoring tool requirements,
c. NMRE's monitoring tool requirements,
d. CAP document and noted deficiencies,
e. MDHHS credentialing report requirements, and
f. Localized CMHSP practices that are responsible for deficiencies and recommended changes for "best practice."