QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

FY23 QAPIP Annual Effectiveness Review

Prepared by LRE Chief Quality Officer: February 23, 2024
Reviewed by LRE Executive Team: February 26, 2024
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I. INTRODUCTION

Lakeshore Regional Entity (LRE) is a regional entity, designated as Region 3, under Section 1204(b) of the Michigan Mental Health Code and responsible for the financial and administrative management of Behavioral Health, Mental Health and Substance Use Disorder Services for adults and children who reside in one of our seven (7) county areas: Kent, Muskegon, Ottawa, Oceana, Lake, Mason, and Allegan.

This document fulfills the evaluation requirement for the annual Quality Assessment and Performance Improvement Program (QAPIP) as set forth in the PIHP/MDHHS Medicaid Managed Specialty Supports and Services Program Contract Attachment and the MDHHS Policy - QAPIP for Specialty Prepaid Inpatient Health Plans.[1]

II. PURPOSE

In addition to meeting contractual requirements, the Fiscal Year 2023 (FY23) Annual QAPIP Review evaluates LRE's performance on each QAPIP component ensuring that LRE is monitoring all QAPIP components as well as deploying Quality Improvement (QI) Processes when performance improvement is required.

Specifically, LRE monitors and evaluates each the following QAPIP components, at a minimum:

1) Michigan Mission Based Performance Indicator System (MMBPIS)
2) Performance Improvement Projects (PIPs)
3) Critical Incidents (CI)
4) Risk Events (RE)
5) Sentinel Events (SE)
6) Unexpected Deaths (UD)
7) Immediate Event Notifications
8) Behavior Treatment Reviews (BTR)
9) Consumer Experience Assessment
10) Clinical Practice Guidelines (CPGs)
11) Credentialing
12) Staff Training and Development
13) Medicaid Services Verification (MEV)
14) Utilization Management (UM)
15) Oversight of Provider Network
16) Long Term Services and Supports (LTSS)

LRE's Annual FY23 QAPIP Annual Effectiveness Review (AER) will discuss each component one at a time.

[1] MDHHS, BH and DD Administration, Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans (michigan.gov).

III. PERFORMANCE INDICATORS

A. Michigan Mission Based Performance Indicator System

Michigan Department of Health and Human Services (MDHHS) mandates compliance with established measures related to access, efficiency, and outcomes. MDHHS' established measures are known as the Michigan Mission Based Performance Indicator System (MMBPIS).

LRE MMBPIS data to MDHHS quarterly, which consist of the following 20 metrics, also known as indicators:

	MMBPIS INDICATORS		
Indicator #	***Description***	***Threshold***	***Populations***
Indicator 1	Percentage Who Received a Prescreen within 3 Hours of Request	≥ 95%	Child/Adult
Indicator 2a	Percentage of New Persons during the Quarter Receiving a Completed Biopsychosocial Assessment within 14 Calendar Days of a Non-emergency Request for Service	None	MI Child/Adult DD Child/Adult Total
Indicator 2e	Percentage of New Persons during the Quarter Receiving a Face-to-Face Service for Treatment or Supports within 14 Calendar Days of a Non-emergency Request for Service for Persons with Substance Use Disorders	None	SUD
Indicator 3	Percentage of New Persons During the Quarter Starting any Medically Necessary On-going Covered Service within 14 days of Completing a Non-emergent Biopsychosocial Assessment	None	MI Child/Adult DD Child/Adult Total
Indicator 4a	Follow-Up within 7 Days of Discharge from a Psychiatric Unit	≥ 95%	Child/Adult
Indicator 4b	Follow-Up within 7 Days of Discharge from a from a SUD Detox Unit	≥ 95%	SUD
Indicator 5	% of Area Medicaid Having Received PIHP Managed Services	None	All
Indicator 6	% of HSW Enrollees in Quarter who Received at Least 1 HSW Service Each Month other than Support Coordination	None	All
Indicator 10	Re-admission to Psychiatric Unit within 30 Days	≤ 15%	Child/Adult

LRE's FY23 MMBPIS goal was to meet or exceed all MMBPIS Indicators for which MDHHS has established a threshold. On April 1, 2020, MDHHS eliminated thresholds for Indicators #2 and #3. For Indicators #2 and #3, LRE trends the data ensuring that any decline in performance is analyzed and discussed during QI ROAT to understand the root cause for any decline in performance and determine improvement opportunities.

In FY23, LRE is pleased to announce that it has deployed a comprehensive Microsoft® Power BI Dashboard for the MMBPIS Indicators, which has improved efficiencies in data analysis and reporting.[1] LRE also makes its MMBPIS Microsoft® Power BI Dashboard available to any CMHSP staff, as appropriate.

[1] LRE's MMBPIS PowerBI Dashboard printout is available upon request. Please make your request via email: marionm@lsre.org.

In FY23, LRE achieved its goal of meeting or exceeding all MMBPIS Indicators on an aggregate annual basis. (Table 1).

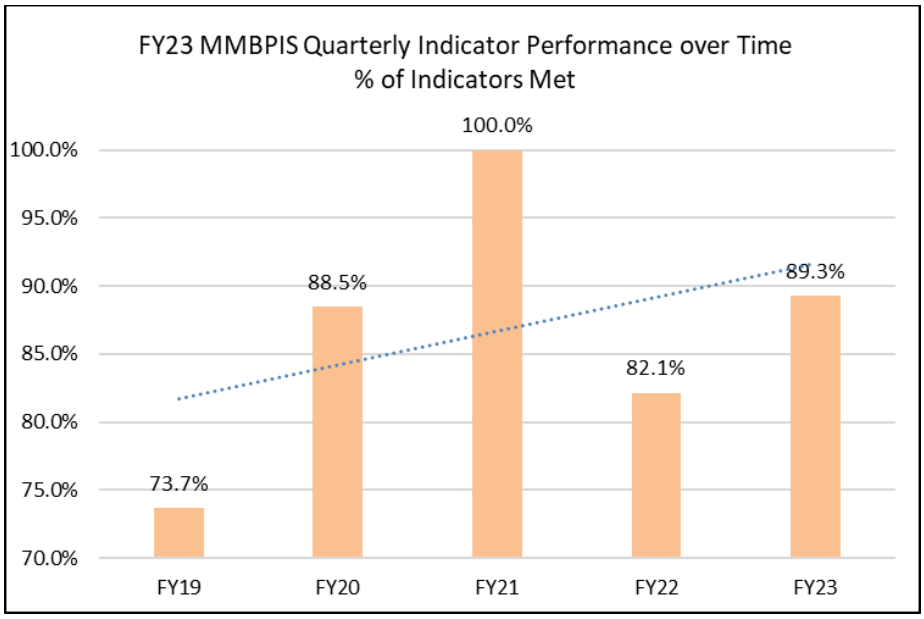
FY23 LRE Annual MMPBIS Performance by Indicator							
	Indicator 1-Adult	Indicator 1-Child	Indicator 4a-Child	Indicator 4a Adult	Indicator 4b-SUD	Indicator 10-Child	Indicator 10-Adult
	Avg	Avg	Avg	Avg	Avg	Avg	Avg
LRE Total	98.2%	98.1%	95.3%	96.9%	97.1%	8.9%	10.2%
MMBPIS Threshold	95.0%	95.0%	95.0%	95.0%	95.0%	15.0%	15.0%

Table 1.

Overall, LRE met or exceeded its quarterly MMBPIS goal 25 out of 28 times, or 89.3%, throughout FY23, which is more than a 7% improvement over FY22. (Table 2; Graph 1).

FY23 MMBPIS Quarterly Indicator Performance over Time					
	FY19	FY20	FY21	FY22	FY23
# of Indicators Met	56	46	28	23	25
Total # of Indicators	76	52	28	28	28
% of Indicators Met	73.7%	88.5%	100.0%	82.1%	89.3%

Table 2.



Graph 1.

1. Indicators 1, 4a, 4b, and 10

In FY23, LRE met or exceeded its goal for all MMBPIS Indicators with established thresholds on a quarterly basis, except for Indicator 4a for children in quarters 1 (Q1) and 3 (Q3), which returned compliance rates of 93.5% and 92.9%, respectively, and Indicator 4b in quarter 2 (Q2), which returned a compliance rate of 91.7%. (Table 3).

FY23 LRE Quarterly MMPBIS Performance by Indicator

Report Period / Indicator	FY23 Q1 N Count	FY23 Q1 Percent Met	FY23 Q2 N Count	FY23 Q2 Percent Met	FY23 Q3 N Count	FY23 Q3 Percent Met	FY23 Q4 N Count	FY23 Q4 Percent Met	MMBPIS Threshold
#1 - Pre-Admission Screening	**2158**	**98.1 %**	**2482**	**98.1 %**	**2298**	**97.9 %**	**2184**	**98.6 %**	**95.0 %**
Adult	1626	98.2 %	1825	98.1 %	1809	97.8 %	1808	98.4 %	**95.0 %**
Child	532	97.6 %	657	97.9 %	489	98.4 %	376	99.5 %	**95.0 %**
#2A - 1st Request Timeliness	**1450**	**57.9 %**	**1524**	**58.7 %**	**1405**	**55.5 %**	**1398**	**54.4 %**	
DD / Adult	71	66.2 %	90	62.2 %	103	58.3 %	77	57.1 %	
DD / Child	94	60.6 %	92	52.2 %	83	50.6 %	100	56.0 %	
MI / Adult	664	55.6 %	733	51.7 %	702	51.9 %	739	50.9 %	
MI / Child	621	58.9 %	609	67.7 %	517	60.7 %	482	58.9 %	
#3 - 1st Service Timeliness	**1317**	**55.3 %**	**1296**	**57.9 %**	**1166**	**64.0 %**	**1234**	**60.0 %**	
DD / Adult	74	59.5 %	72	63.9 %	88	64.8 %	80	65.0 %	
DD / Child	92	64.1 %	92	62.0 %	73	60.3 %	84	58.3 %	
MI / Adult	531	56.3 %	537	60.0 %	546	66.1 %	616	60.6 %	
MI / Child	620	52.6 %	595	54.8 %	459	61.9 %	454	58.6 %	
#4a - Hospital Discharges F/U	**356**	**95.5 %**	**370**	**97.3 %**	**387**	**96.9 %**	**369**	**96.5 %**	**95.0 %**
Adult	263	96.2 %	286	96.9 %	303	98.0 %	289	96.5 %	**95.0 %**
Child	93	93.5 %	84	98.8 %	84	92.9 %	80	96.3 %	**95.0 %**
#4b SUD - Detox Follow-Up	**103**	**98.1 %**	**96**	**91.7 %**	**101**	**98.0 %**	**107**	**100.0 %**	**95.0 %**
#10 - Inpatient Recidivism	**503**	**9.1 %**	**556**	**10.1 %**	**532**	**11.1 %**	**528**	**9.3 %**	**15.0 %**
Adult	382	8.9 %	432	10.4 %	419	11.9 %	426	9.4 %	**15.0 %**
Child	121	9.9 %	124	8.9 %	113	8.0 %	102	8.8 %	**15.0 %**

Table 3.

Indicator 4a – Child. LRE analyzed why Region 3 fell short of its FY23 quarterly MMBPIS goal for Indicator 4a – Child in Q1 and Q3.

One caveat to be aware of is that the quarterly sample size for Indicator 4a – Child is generally very low and only a few, generally one to three for Region 3, out of compliance case(s) can result in a CMHSP falling below the 95% threshold, which is what occurred in every instance for FY23 Q1 and Q3. (Table 4).

FY23 LRE MMBPIS Indicator 4a - Child Cases

	Q1			Q3		
	Total # of Cases	**Total # of Out of Compliance Cases**	**% of Indicators Met**	**Total # of Cases**	**Total # of Out of Compliance Cases**	**% of Indicators Met**
HealthWest	18	1	94.4%	5	2	60.0%
OnPoint	8	1	87.5%	20	1	95.0%
Ottawa	6	0	100.0%	5	2	60.0%
N180	54	3	94.4%	43	0	100.0%
West Michigan	7	1	85.7%	11	1	90.9%
Region 3	93	6	93.5%	81	6	92.6%

Table 4.

In FY23 Q1, LRE determined that while CMH of Ottawa County (CMHOC) achieved a 100% compliance rate for Indicator 4a – Child, all other Member Community Mental Health Services Programs (CMHSPs) fell below the 95% compliance threshold for this standard.[2]

[2] In FY23 Q1 for Indicator 4a - Child, OnPoint, HealthWest, Network180, and West Michigan returned compliance rates of 87.5%, 94.4%, 94.4%, and 85.7%, respectively.

In FY23 Q3, LRE established that Network180 (N180) and HealthWest (HW) achieved compliance rates of 100% and 95%, respectively; however, the remaining CMHSPs fell below the 95% compliance threshold.[3]

LRE issues Corrective Action Plans (CAPs) for each instance when a CMHSP failed to achieve a MMBPIS compliance threshold. For Indicator 4a – Child, each CMHSP conducted a Root Cause Analysis (RCA) and determined the cause for the non-compliance, which identified the following reasons for the non-compliance: 1) Hospital Discharged Early without Notice, 2) Lack of Properly Credentialed Staff to Perform Follow-Up, and 3) Hospital and CMHSP Staff Training Issues. Each CMHSP remediated the causes for non-compliance.

Indicator 4b. LRE analyzed why it fell short of its FY23 quarterly MMBPIS goal for Indicator 4b in Q2. Similar to Indicator 4a – Child, the quarterly sample size for Indicator 4b is generally very low and only a handful of out of compliance case(s) can result in a CMHSP falling below the 95% threshold, which is also what occurred in FY23 Q2 (Table 5).

FY23 LRE MMBPIS Indicator 4b Cases			
	Q2		
	Total # of Cases	Total # of Out of Compliance Cases	% of Indicators Met
HealthWest	10	1	90.0%
OnPoint	5	0	100.0%
Ottawa	23	2	91.3%
N180	46	5	89.1%
West Michigan	12	0	100.0%
Region 3	86	7	91.9%

Table 5.

In FY23 Q2, LRE determined that while OnPoint and West Michigan (WM) achieved a 100% compliance rate for Indicator 4b, but all other Member Community Mental Health Services Programs (CMHSPs) fell below the 95% compliance threshold for this standard.[4]

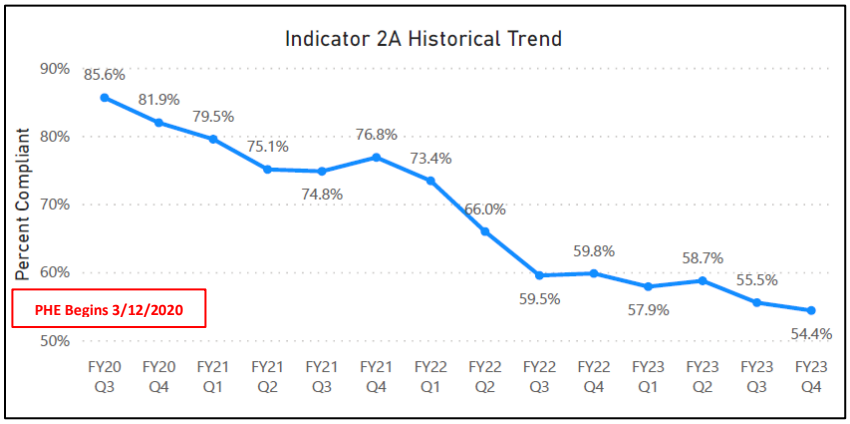
LRE issues Corrective Action Plans (CAPs) for each instance when a CMHSP failed to achieve a MMBPIS compliance threshold. For Indicator 4b, each CMHSP conducted a Root Cause Analysis (RCA) and determined the cause for the non-compliance, which identified the following reasons for the non-compliance: 1) SUD Detox Provider did not Schedule Timely Follow-up Appointment, 2) SUD Detox Provider did not Follow Discharge Protocols, and 3) SUD Detox Provider Training Issues. Each CMHSP remediated the causes for non-compliance.

[3] In FY23 Q3 for Indicator 4a - Child, OnPoint, Ottawa, and West Michigan returned compliance rates of 60.0%, 60.0%, and 90.9%, respectively.

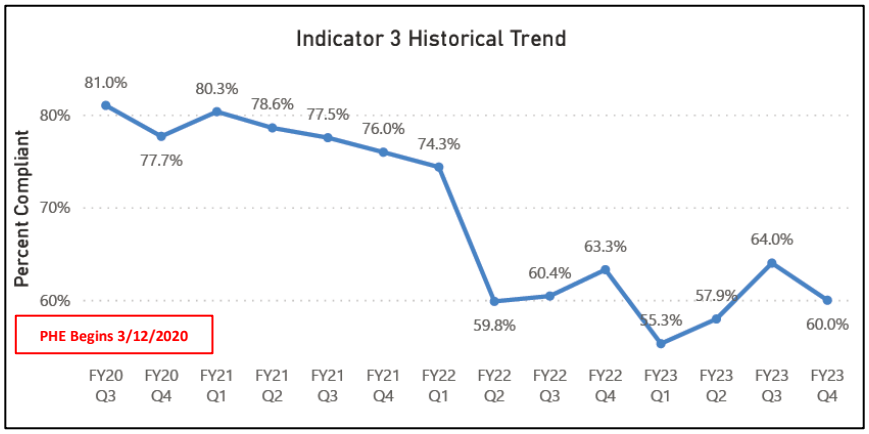
[4] In FY23 Q2 for Indicator 4b, HealthWest, Ottawa, and N180 returned compliance rates of 90.0%, 91.3%, and 89.1%, respectively.

2. Indicators 2a and 3

LRE analyzed the data for Indicators 2a and 3, which do not have established MMBPIS compliance thresholds, on an aggregate, annual basis to determine if performance declined over time. (Graphs 2 & 3).

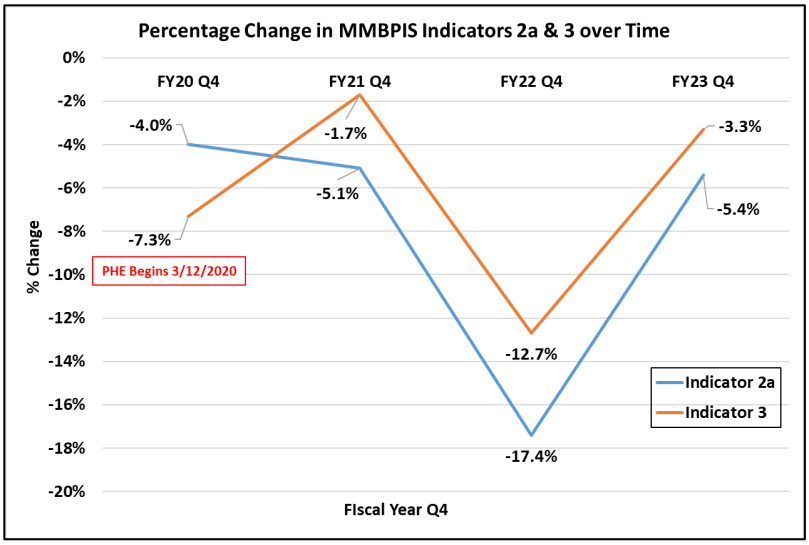


Graph 2.



Graph 3.

Since FY22 Q4, LRE determined that Indicators 2a and 3 have declined significantly since the beginning of the COVID-19 Public Health Emergency (PHE). Specifically, Region 3 has declined 31.3% and 21.0% for Indicators 2a and 3, respectively, since FY20 Q3. LRE's longitudinal analysis appears to indicate that the rate of decline for Indicators 2a and 3 may have slowed in FY23 with a significant rebound from FY22. (Graph 4).



Graph 4.

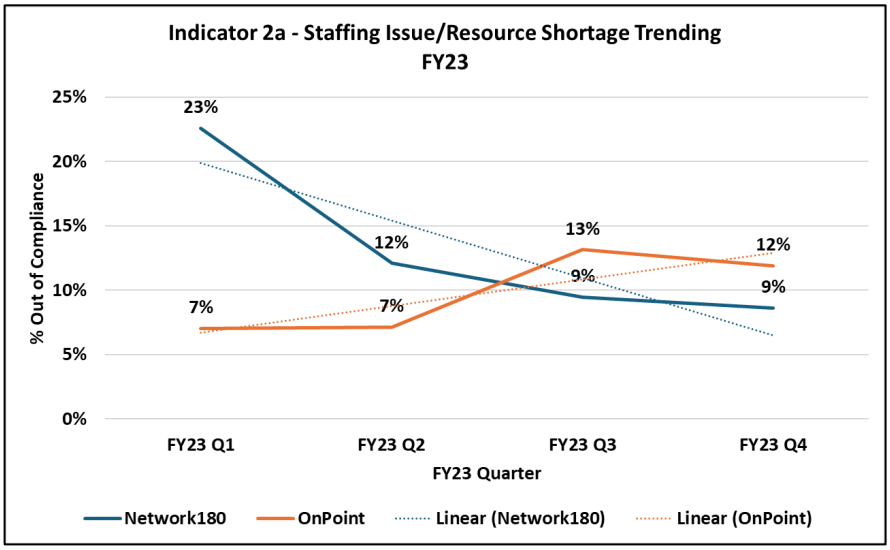
i. Indicator 2a

In FY23, LRE attributes the decline in Indicator 2a to two primary exception codes: 1) Staff Issue/Resource Shortage – 25% and 2) Consumer No Show – 20%. (Table 6).

LRE MMBPIS Indicator 2a Year over Year Trend				
MMBPIS Exception Code	**FY21**	**FY22**	**FY23**	**FY23 v FY22**
Staffing Issue/Resource Shortage	33%	23%	25%	↗
Client No Show	34%	24%	20%	↘
Client Choice of Date	8%	9%	9%	→
Client Choice not to Use CMHSP	2%	2%	9%	↗
Rescheduled by Client	8%	8%	8%	→
Client Canceled	5%	6%	8%	↗
Unable to Reach w/in Timeframe	1%	4%	5%	↗
Systems Issue	1%	9%	4%	↘
Documentation Issue	3%	7%	4%	↘

Table 6.

While N180 contributed 13% to the FY23 Staff Issue/Resource Shortage code, N180 has deployed hiring, retention, and workflow process initiatives demonstrating an overall decrease of 14% in FY23; however, during the same period, OnPoint experienced a 5% increase in FY23. (Graph 5).



Graph 5.

The LRE QI ROAT agrees that the exception codes that can be influenced by CMHSP intervention are Client No Show, System Issue, and Documentation Issue. In FY23, LRE and its CMHSPs deployed informal efforts surrounding these three codes by improving outreach processes, retraining staff on access processes, and reiterating documentation expectations, which resulted in a 12% aggregate decrease in these three codes. (Table 6).

LRE's analysis also found that the codes 1) Client's Choice of Appointment Date (9%, same as FY22), 2) Client's Choice not to Use CMHSP (9%, increase of 7% over FY22), and 3) Appointment Rescheduled by Consumer (8%, same as FY22), and Client Canceled (8%, increase of 2% over FY22), which can rarely be influenced by CMHSP intervention, contributed another 26% to the exception cases. (Table 6).

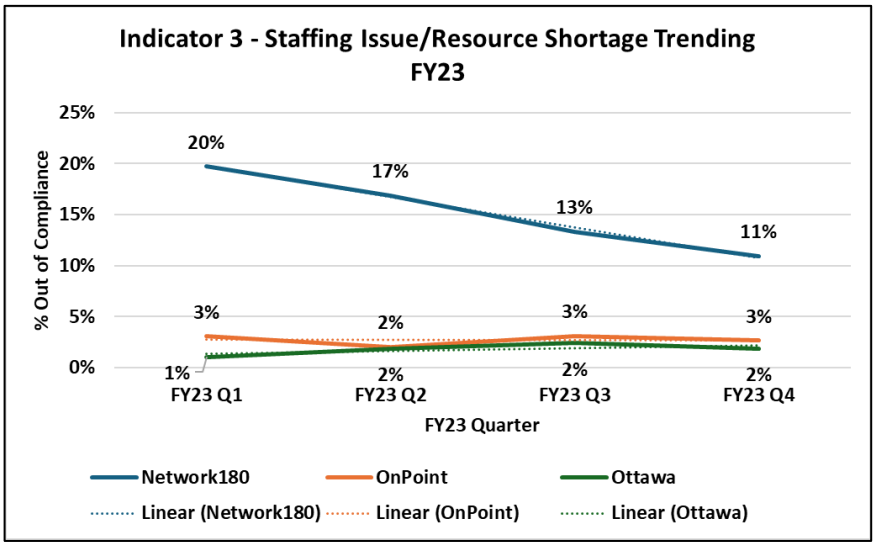
ii. Indicator 3

In FY23, LRE attributes the decline in Indicator 3 to two primary exception codes: 1) Staff Issue/Resource Shortage – 22% and 2) Consumer No Show – 19%. (Table 7).

While N180 contributed 14% overall to the FY23 Staff Issue/Resource Shortage code, N180 has deployed hiring, retention, and workflow process initiatives demonstrating an overall decrease of 9% in FY23. (Graph 6).

LRE MMBPIS Indicator 3 Year over Year Trend				
MMBPIS Exception Code	**FY21**	**FY22**	**FY23**	**FY23 v FY22**
Staffing Issue/Resource Shortage	16%	27%	22%	
Client No Show	23%	20%	19%	
Systems Issue	5%	6%	16%	
Client Choice of Date	10%	9%	8%	
Documentation Issue	10%	10%	7%	
Unable to reach w/in timeframe	3%	2%	7%	
Rescheduled by Client	9%	6%	5%	
Client Canceled	3%	6%	4%	
Client choice not to use CMHSP	4%	3%	4%	

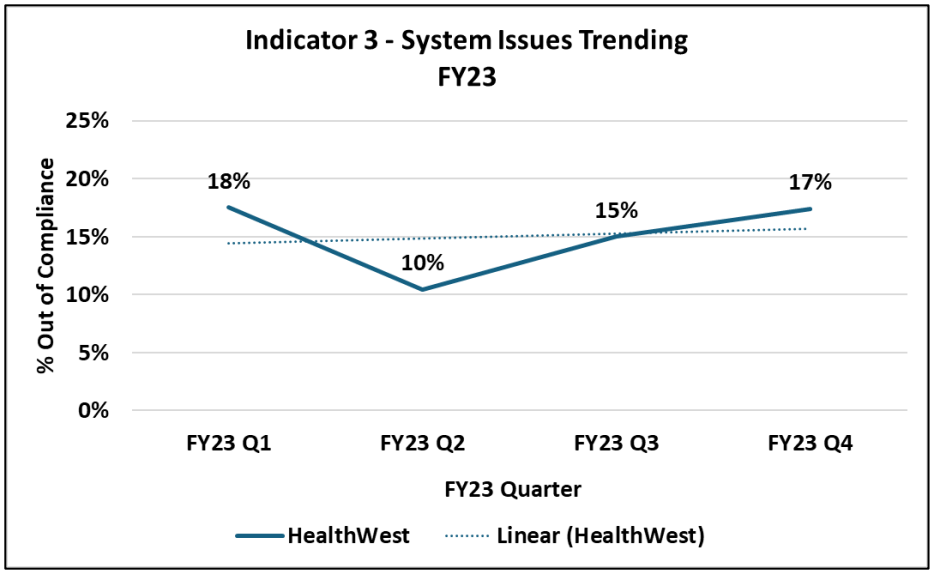
Table 7.



Graph 6.

LRE's analysis also found that the exception codes 1) Client's Choice of Appointment Date (8%, decrease of 1% over FY22), 2) Appointment Rescheduled by Consumer (5%, decrease of 1% over FY22) Client Canceled (4%, decrease of 2% over FY22), 3) Client's Choice not to Use CMHSP (4%, increase of 1% over FY22), which can rarely be influenced by CMHSP intervention, contributed another 21% to the exception cases. (Table 7).

Unfortunately, in FY23, any efforts to improve Client No Show and Documentation Issues, totaling a 4% decrease over FY22, were offset due to continued Systems Issues, which increased by 10% over FY22 to 16%. (Graph 7). LRE continues monitoring quarterly MMBPIS submissions for improvement in System Issues.



Graph 7.

In FY24, MDHHS has established compliance threshold for Indicators 2a and 3. On the other hand, MDHHS has also announced the sunsetting of the MMBPIS Indicators starting October 1, 2025, with an eye towards adopting National standards, such as NCQA, HEDIS®, etc. LRE and its CMHSPs agree that Region 3 must continue to strive to meet the MMBPIS compliance thresholds for all indicators since metrics relating to access, outcomes, recidivism, etc. will continue to be a part of MDHHS Quality Program.

LRE partially achieved its FY23 MMBPIS Goals.

IV. PERFORMANCE IMPROVEMENT PROJECTS

LRE conducts performance improvement projects (PIPs) that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and individual satisfaction.

LRE is required to conduct at least two PIPs each fiscal year. One of the two PIPs is mandated by MDHHS and is reviewed and evaluated by HSAG for compliance with the PIP requirements. The second PIP may be of LRE's choosing and must be submitted to MDHHS along with the QAPIP.

LRE is conducting two PIPs centered on improving the HEDIS® Follow-up After Hospitalization – 30 Day Quality Metric:[5]

1) FUH Metric: Decrease in Racial Disparity between Whites and African Americans/Blacks.
2) FUH Metric: Aggregate Improvement in Follow-Up after Hospitalization for Mental Illness Across Region 3.

[5] LRE has provided comprehensive PIP documentation to the LRE Board of Directors, HSAG, and MDHHS on multiple occasions since October 1, 2022, as such these are not included in this report; however, each are available upon request. Please make your request via email: marionm@lsre.org.

For FY23, LRE's primary PIP goals were two-fold: 1) Receive HSAG validation on the race/disparity PIP and 2) Develop a predictive model utilizing Zenith Technology Solutions (ZTS) data ensuring data integrity parallels MDHHS' data from the CC360 data warehouse.

Due to the significant interplay between both PIPs, LRE reports those aspects that are the same or similar between both PIPs and will highlight any deviation, as required, when considering the race/ethnicity disparity PIP.

A. LRE FUH PIPs - GENERALLY

LRE considered how best to operationalize its FY22 PIPs. LRE agreed that a two-pronged approach was the best course of action. On the front-end, LRE focused on ensuring that the FUH data it submits to MDHHS on a weekly basis is accurate, complete, and timely. This proactive approach ensures that quality FUH data is available to both the LRE and the Medicaid Health Plans (MHPs) ensuring quality of care for consumers post-discharge. LRE's approach then pivots to the back-end of the FUH process ensuring that FUH is completed timely, meaning within 30-days post-discharge, with the appropriate professional and identifying when follow-up did not occur and determining the root cause for non-compliance.

To deploy its two-pronged approach, LRE engaged two workgroups: 1) FUH Workgroup and 2) PIP Workgroup.

FUH Workgroup:

The FUH Workgroup's purpose was to understand how data is being submitted; monitor data accuracy, completeness, and timeliness; identify opportunities for efficiency gains; and monitor CMHSP progress towards submitting 100% accurate, complete, and timely data.

In July 2022, LRE resumed the FUH Data Reporting process from the previous managing organization. On average, LRE was spending fifteen hours per week reviewing and editing Member CMHSP file submissions prior to LRE's upload into CC360 due to inaccurate, incomplete, and untimely data. LRE identified many data errors and rejections and realized the process of collecting and uploading the data needed improvement. Upon further research, LRE learned that there was a lack of standardized procedures by the CMHSPs that was also impacting timely and accurate reporting.

From July 2022 to November 2022, LRE engaged in numerous iterations of data mining to quantify the source of the errors and determine how best to identify, remove, and track the errors. Through its efforts, LRE realized that CMH stakeholder involvement was critical to developing a common understanding of Regional FUH improvement goals; identifying current data collection procedures; and developing the data processing methods needed to improve the FUH data accuracy and completeness.

In November 2022, LRE held a meeting with its CMHSPs to discuss its findings related to the FUH data and the group collectively agreed to create the FUH Workgroup.

In December 2022, LRE, in collaboration with its CMHSPs, launched a FUH Workgroup led by one of LRE's Provider Network Managers with membership consisting of LRE Leadership, IT, and Clinical staff and CMHSP IT and Clinical staff.

From December 2022 through February 2023, the FUH Workgroup met at least six times and utilized brainstorming and voting to develop the Key Driver Diagram with the PIP Workgroup, Process Map, Road-Map, and Project Plan to outline the current process and identify the barriers preventing CMHSPs from submitting accurate, complete, and timely FUH data. The FUH Workgroup identified process improvements and prioritized them based on the logical sequence of events, length of time for each improvement to be made and resource availability, especially IT staff workloads, needed to complete the improvement.

During this time, the FUH Workgroup developed and revised the standardized FUH Technical Specification, FUH Procedure, FUH Error Report, HLOC Authorization Data Integrity Reports PowerBI Dashboard, and FUH Compliance Report until each were complete and ready for deployment. The FUH Workgroup established a key improvement to the FUH process requiring CMHSPs to upload FUH data two times per week instead of once per week.

LRE deployed the new FUH Technical Specification on April 3, 2023. On or around July 3, 2023, the FUH Workgroup made slight changes to the FUH Technical Specification and Error Report due to the start of Medicaid redeterminations by MDHHS, which impacted what consumers should be reported in the FUH Data. On July 30, 2023, the FUH Workgroup finalized the FUH Procedure. In addition to these improvements, LRE deployed the Value Based Incentive Program with Inpatient Providers to encourage these providers to begin discharge planning upon admission and ensure a follow-up appointment is scheduled within 7 days of discharge.

Overall, the FUH Workgroup efforts have resulted in the following improvements:

1) LRE staff spends 60 minutes a week instead of 900 minutes (15 hours) – a 93% efficiency gain in IT resource availability,
2) A significant reduction in CMHSP data errors.
3) Increased availability of FUH data to MHPs – MHPs have reported data is received more timely and more actionable for them as a result.
4) Improved relationships with CMHSPs.

LRE conducts ongoing monitoring by using the FUH Error Reports and FUH Compliance Reports and meets with CMHSPs that may be trending in a negative direction.

PIP Workgroup:

Secondly, LRE deployed the PIP Workgroup led by LRE's Chief Managed Care Officer (CMCO) with membership consisting of the LRE Quality and IT staff and ad hoc membership of LRE Clinical Staff, CMHSP Quality, Access, and Clinical staff.

As with the FUH Workgroup, the PIP Workgroup utilized brainstorming and voting to develop the Key Driver Diagram with the FUH Workgroup. The PIP Workgroup meets weekly to discuss barriers, progress, and next steps with a focus on ensuring data sources are accurate, identifying a no-show/cancelation without rescheduling policy and procedure, developing training and outreach tools, and developing predictive models to overcome the ***6-month CC360 data lag and allow for more real-time data mining***.

ZTS DATA INTEGRITY, POWERBI DASHBOARDS, AND PREDICTIVE MODELS:

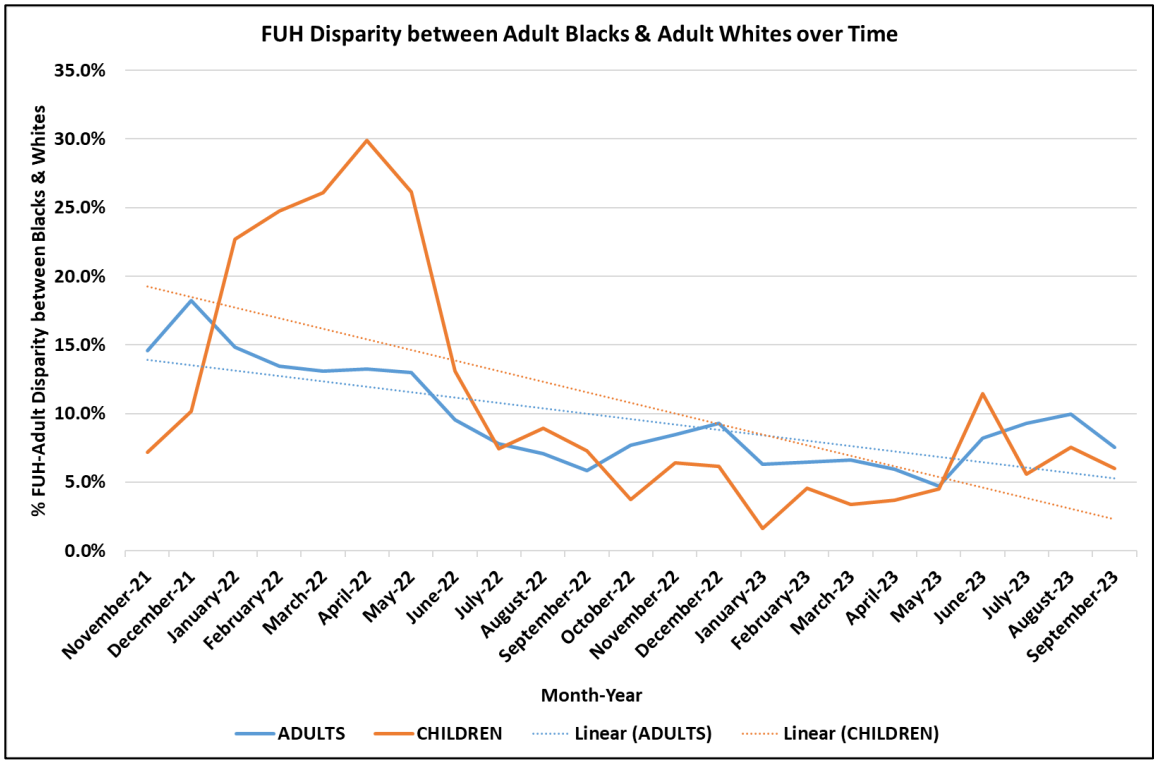
In early January 2023, the PIP Workgroup identified several programming modifications that needed to be made to the ZTS data source, which included:

1) Race Corrections: Due to the MDHHS' race coding issue that LRE identified in August 2020 and MDHHS corrected in September 2023.
2) Facility Name: Remap all NPIs to correctly named facilities so that reports return the Inpatient (IP) facility name and not N/A.
3) Incorporate the HEDIS® Aggregate FUH 2021 Averages, which are now available.
4) Update the HEDIS® FUH data identifying what, if anything, changed that may impact the Baseline measurement from 2021.

Once ZTS implemented these programming modifications, LRE completed its PowerBI Dashboard development, resumed its development of predictive models, and engaged in data mining facilitating follow-up on non-compliant cases at the granular level while developing interventions for those areas identified as systemic issues either by Region, CMHSPs, or IP Provider. In May 2023, LRE began developing its MMBPIS|FUH PowerBI Dashboard, which was completed in August 2023 after ZTS made the necessary programming modifications.

As of September 30, 2023, LRE determined, by way of its ZTS FUH-30 Predictive Model, that LRE has decreased the FUH-30 race disparity between blacks and whites as follows:

1) FUH-30 Adults: Decrease of 6.2%, and
2) FUH-30 Children: Decrease of 1.2%. (Graph 8).



Graph 8.

MHP COLLABORATION REGARDING FUH AND PIP:

Starting in May 2023, LRE began meeting with MHPs to introduce LRE's PIP and develop opportunities for 1) cycle-time improvements concerning getting FUH data into the MHP's hands as soon as possible post discharge and 2) development of joint training materials. LRE also recommended the standardization of all FUH data uploads days and times as well as all MHP data download days and times to the PIHP-MHP Workgroup, which was heard but not adopted, in an effort to reduce the cycle time of FUH data distribution to MHPs. LRE will recommend its position again if the data mining determines that LRE's move to uploading twice per week to CC360, versus once per week as done prior to April 3, 2023, improves FUH compliance rates among MHPs serving Region 3 consumers.

LRE and Meridian have made the most progress by conducting FUH Training and developing joint training materials for CMHSP and MHP staff. LRE continues its engagement with MHPs to effectuate improvement in the HEDIS® FUH 30-day metric, including Priority Health, which is the largest MHP in Region 3.

HSAG VALIDATION OF LRE FY23 PIP SUBMISSION:

In August 2023, HSAG validated LRE's PIP submission. (Table 8).

Appendix B: State of Michigan 2022-23 PIP Validation Tool
Decrease in Racial Disparity Between Whites and African Americans/Blacks
for Region 3 - Lakeshore Regional Entity

Performance Improvement Projects

Table B–1—2022—23 PIP Validation Tool Scores
for *Decrease in Racial Disparity Between Whites and African Americans/Blacks*
for Region 3 - Lakeshore Regional Entity

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total Partially *Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
1. Review the PIP Topic	2	2	0	0	0	1	1	0	0	0
2. Review the PIP Aim Statement(s)	1	1	0	0	0	1	1	0	0	0
3. Review the Identified PIP Population	1	1	0	0	0	1	1	0	0	0
4. Review the Sampling Method	7	0	0	0	7	2	0	0	0	2
5. Review the PIP Indicator(s) of Performance	2	2	0	0	0	1	1	0	0	0
6. Review the Data Collection Procedures	4	3	0	0	1	2	1	0	0	1
7. Review Data Analysis and Interpretation of Results	3	*Not Assessed*				1	*Not Assessed*			
8. Assess the Improvement Strategies	6	6	0	0	0	3	3	0	0	0
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	4	*Not Assessed*				0	*Not Assessed*			
Totals for All Steps	**30**	**15**	**0**	**0**	**8**	**12**	**8**	**0**	**0**	**3**

Table B–2—2022—23 PIP Validation Overall Score
for *Decrease in Racial Disparity Between Whites and African Americans/Blacks*
for Region 3 - Lakeshore Regional Entity

Percentage Score of Evaluation Elements *Met**	**100%**
Percentage Score of Critical Elements *Met* **	**100%**
Validation Status***	***Met***

* The percentage score for all evaluation elements *Met* is calculated by dividing the total number *Met* by the sum of all evaluation elements *Met, Partially Met,* and *Not Met.* The Not Assessed and Not Applicable scores have been removed from the scoring calculations.
** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met, Partially Met,* and *Not Met.*
*** Validation Status: See confidence level definitions on next page.

Table 8.

Other interventions can be found in LRE's Key Driver Diagram+ that outlines prioritized barriers, interventions, progress to date, and next steps.[6]

LRE achieved its FY23 PIP Goals.

V. EVENT REPORTING AND NOTIFICATIONS

LRE requires each Member CMHSP with direct services as well as contracted, external providers to record, assess, and report critical incidents, risk events, sentinel events, unexpected deaths, and immediately reportable events (a/k/a immediate event notification) according to LRE policies and procedures. LRE reports critical incidents, risk events, sentinel events, unexpected

[6] LRE has provided comprehensive PIP documentation, including the KDD+, to the LRE Board of Directors, HSAG, and MDHHS on multiple occasions since October 1, 2022, as such these are not included in this report; however, each are available upon request. Please make your request via email: marionm@lsre.org.

deaths, and immediately reportable events in accordance with MDHHS contractual requirements.

LRE's FY23 Event Reporting and Notifications Goal is to report all critical incidents, sentinel events, and unexpected deaths to MDHHS in a timely and accurate manner, meaning by the 15th of each month thereby meeting contractual requirements. LRE's second Event Reporting and Notifications Goal was to operationalize MDHHS' Critical Incident Customer Relationship Management (CRM) platform.

LRE achieved its FY23 goal through timely and accurate reporting of its critical incidents to MDHHS, whether through manual entry or direct upload to the MDHHS CRM. LRE manually entered each critical incident into the CRM from October 2022 through March 2023. While LRE continues to work with MDHHS regarding the intricacies of the CRM, LRE finds the CRM to be an efficient platform and hopes MDHHS makes further improvements, such as reporting sentinel events via the CRM and enabling report printing directly from the CRM.

In FY23, LRE is pleased to announce that it has deployed a comprehensive Microsoft® Power BI Dashboard for the Critical Incidents, Risk Events, and Mortality Reports, which has improved efficiencies in data analysis and reporting.[7] LRE also makes its Critical Incidents, Risk Events, and Mortality Report Microsoft® Power BI Dashboard available to any CMHSP staff, as appropriate.

A. Critical Incidents

For FY23, LRE experienced a total of 459 critical incidents, which is an increase of 104 compared to FY22, which can be attributed to the newly defined reporting requirements related to the new MDHHS CRM reporting platform.

During FY23, LRE reviewed and discussed Critical Incidents with QI ROAT quarterly.

LRE analyzed the critical incident data and determined the following when comparing FY23 to FY22:

1) Suicides decreased by 5 to a total of 8.
2) Accidental Deaths increased from 19 to 22.
3) Homicides remained the same at 1.
4) Overdose Deaths increased from 0 to 2.
5) Natural Deaths decreased from 106 to 104.
    a. Vascular & Heart Disease: 29%
    b. Cancer: 12%
    c. Pneumonia/Influenza 12%
    d. Neurological Disorders: 11%
6) Injuries Requiring Emergency Medical Treatment increased by 94 to 270.
    a. HW: 37% caused by 3 unique consumers
    b. N180: 43% caused by 3 unique consumers
    c. WM: 33% caused by 3 unique consumers
7) Medication Errors Requiring Emergency Medical Treatment remained the same at 4.

[7] LRE's CIRE PowerBI Dashboard printout, SE|UD Report, and Mortality Report are available upon request. Please make your request via email: marionm@lsre.org.

8) Injuries Requiring Hospitalization increased from 12 to 19.
9) Medication Errors Requiring Hospitalization remained unchanged at 1.
10) Arrests increased by 4 to 27.

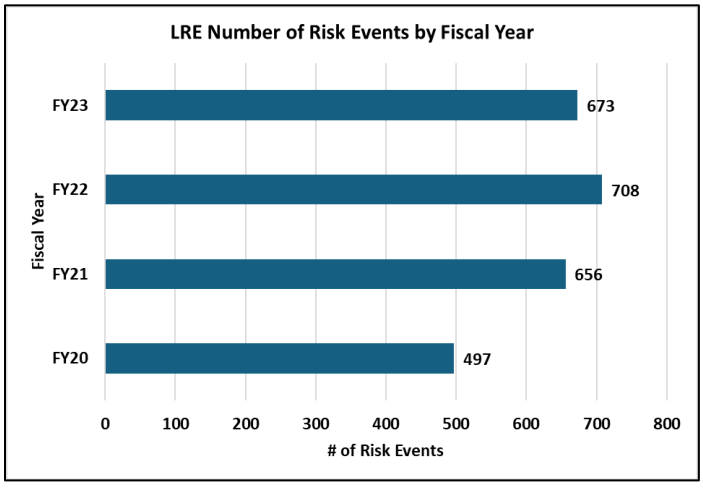
Critical Incidents in Specialized Residential Settings. When analyzing the Critical Incidents occurring only in Specialized Residential (SR) settings in FY23, LRE found the following:

Critical Incident in SR Settings	% of Total Critical Incidents by Category
Zero Suicides	0%
3 Accidental Deaths	14%
Zero Homicides	0%
45 Natural Deaths	42%
258 Injuries Requiring Emergency Medical Treatment	96%
4 Medication Errors Requiring Emergency Medical Treatment	100%
18 Injuries Requiring Hospitalization	95%
1 Medication Errors Requiring Hospitalization	100%
26 Arrests	96%

LRE also determined that 22% of Injuries Requiring Emergency Medical Treatment were occurring in three (3) unique settings and were due to 11 unique consumers requiring emergency medical treatment due to seizure related injuries and self-injurious behaviors. Due to the number of Injuries Requiring Emergency Medical Treatment in one Specialized Residential Setting, one consumer was discharged and admitted to a higher-level care setting.

B. Risk Events

For FY23, LRE experienced 673 risk events, which is a decrease of 35 compared to FY22. (Graph 9).



Graph 9.

LRE analyzed the risk event data and determined the following when comparing FY23 to FY22:

1) Self Harm increased by 73 to a total of 147.
2) Harm to Others increased from 25 to 36.
3) Emergency Use of Physical Management decreased by 75 to 315.
4) Police Calls by Staff Under Certain Circumstances decreased from 165 to 149.
5) Two or More Unscheduled Admissions to a Hospital within a 12-month Period decreased by 42 to 26.

During FY23, LRE reviewed Risk Events with QI ROAT quarterly and specifically discussed the cause for the increase in Self Harm and Emergency Use of Physical Management.

Based on LRE's analysis and the QI ROAT's review and discussion, LRE determined that three (3) CMHSPs contributed primarily to the increase in Self Harm incidents due to the following reasons:

1) A single consumer primarily contributed to the increase in Self Harm for FY23 having 37 Self Harm incidents, which is an increase of 18 from FY22.
2) One CMHSP increased in Self Harm incidents by 23 across 21 unique consumers who reported no Self Harm in FY22.
3) One CMHSP increased its Self Harm incidents by 10 for consumers who reported no Self Harm in FY22.

Concerning Emergency Use of Physical Management, LRE determined that three (3) CMHSPs contributed primarily to this Risk Event Category due to four (4) unique consumers, one in four of the Region 3 CMHSPs, accounted for 42% of the instances where Emergency Use of Physical Management was utilized in FY23. Region 3 CMHSPs have deployed comprehensive clinical reviews with the consumers and guardians to reduce the use of physical management on these four (4) unique consumers. In one clinical case that underwent a comprehensive clinical review, LRE has observed a decreased rate of 20% in the Emergency Use of Physical Management. In FY23, Region 3 increased slightly in the total time when using physical management from 3.85 minutes to 4.05 minutes, a 5% increase over FY22.

Risk Events in Specialized Residential Settings. When analyzing the Risk Events occurring only in Specialized Residential (SR) settings in FY23, LRE found the following:

Risk Events in SR Settings	% of Total Risk Event by Category
98 Self Harm	67%
32 Harm to Others	89%
99 Police Calls	66%
266 Emergency Uses of Physical Management	84%
21 Two or More Unscheduled Hospitalizations in 12 Months	81%

C. Sentinel Events and Unexpected Deaths

In FY23, LRE experienced 53 Sentinel Events and Unexpected Deaths (SE|UD), which is an increase of 13 over FY22. Upon analysis, LRE determined that the three categories dominating the Region 3's Unexpected Deaths relate to 1) Accidental Death (40%), 2) Suicide (15%), and 3) Overdose (9%). (Table 9).

LRE FY23 Sentinel Event & Unexpected Death by Category		
Category	**Count**	**%**
Accidental Death	21	40%
Suicide	8	15%
Overdose	5	9%
SE/serious injury	3	6%
Possible Sentinel Event	2	4%
Sentinel Event	2	4%
Suicide Attempt	2	4%
Unexpected Death	2	4%
Homicide	1	2%
Injury	1	2%
Other	1	2%
SE/Injury requiring hospitalization	1	2%
SE/Med Error requiring emergency medical	1	2%
Sentinel Event / Acidental Death	1	2%
Suspected Overdose	1	2%
Unknown	1	2%

Table 9.

LRE also determined that the most vulnerable population serviced as it relates to SE|UD is the Mentally Ill Adult population (51%). (Table 10).

LRE FY23 Sentinel Event & Unexpected Death by Population		
Population	**Count**	**%**
MIA	27	51%
MIA/SUD	8	15%
SUD	8	15%
DDA	4	8%
IDD	3	6%
IDD/MI/SUD	1	2%
MDOC	1	2%
MIA/DDA	1	2%

Table 10.

In FY23, LRE continued monitoring the SE|UD Timeliness and Review Standards and evaluated its Member CMHSP performance related to these standards. (Tables 11 & 12). Year over year, Region 3 CMHSPs improved the Timeliness Standards for notifying LRE and submitting the final review of SE|UD by 10% and 58%, respectively. For a second year in a row, Region 3 CMHSPs have completed the necessary Root Cause Analyses (RCAs) well below the Region 3 45-day standard. (Table 11).

In FY23, Region 3's CMHSPs improved performance in every Review Standard with improvements ranging from 17% to 75%, depending on the Review Standard. (Table 12).

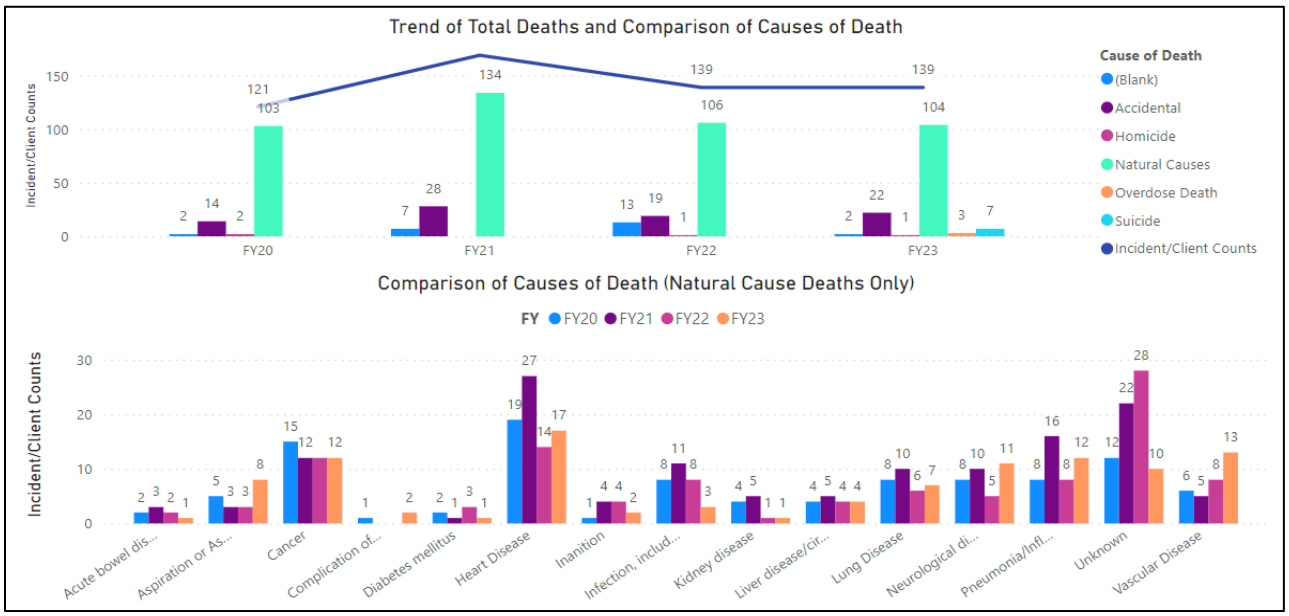
	TIMELINESS STANDARDS			
	# Days from knowledge of occurrence to LRE Notification **Standard: 24 hours**	# Days to Start RCA. **Standard: 3 days to determine if SE then 2 business days to commence RCA**	# Days to Complete RCA after started: **Standard: 45 Days**	# Days to Send LRE Completed Unexpected Death Form: **Policy states within 48 hours** **Data below in DAYS**
Target:	1	5	45	2
FY23 Average:	6	16	33	4
FY22 Average:	7	14	30	9
Change Year over Year:	10%	-15%	-11%	58%

Table 11.

	REVIEW STANDARDS					
	Health Care Professional Signature **Standard: MD/DO/RN Only**	Health Care Professional's Credentials **Standard: Credentials Present**	Health Care Professional Signature Date **Standard: Date Present**	Quality Improvement Personnel Signature **Standard: Appropriate Credentials**	Quality Improvement Personnel Credentials **Standard: Credentials Present**	Quality Improvement Professional Signature Date **Standard: Date Present**
Target:	100%	100%	100%	100%	100%	100%
FY23 Average:	92%	92%	91%	94%	85%	98%
FY22 Average:	74%	68%	77%	81%	48%	81%
Change Year over Year:	25%	36%	17%	17%	75%	22%

Table 12.

In FY23, LRE's review of its Mortality Report determined that Natural (75%) and Accidental Death (16%) continue to be the primary causes of death regardless of setting, meaning Specialized Residential versus non-Specialized Residential. (Graph 10).



Graph 10.

For all Natural Deaths in FY23, LRE determined that Heart and Vascular Disease, Cancer, Pneumonia & Influenzas, Neurological Disorders, and Aspiration or Aspiration Pneumonia contributed to 80% of the Natural Deaths in FY23. (Table 13).

FY23 LRE Mortality Report - Cause of Death				
	FISCAL YEAR			
Cause of Death	FY20	FY21	FY22	FY23
Heart Disease	18%	20%	13%	16%
Vascular Disease	6%	4%	8%	13%
Cancer	15%	9%	11%	12%
Pneumonia/Influenza	8%	12%	8%	12%
Neurological disorders	8%	7%	5%	11%
Unknown	12%	16%	26%	10%
Aspiration or Aspiration pneumon	5%	2%	3%	8%
Lung Disease	8%	7%	6%	7%
Liver disease/cirrhosis	4%	4%	4%	4%
Infection, including AIDS	8%	8%	8%	3%
Complication of treatment	1%	0%	0%	2%
Inanition	1%	3%	4%	2%
Acute bowel disease	2%	2%	2%	1%
Diabetes mellitus	2%	1%	3%	1%
Kidney disease	4%	4%	1%	1%

Table 13.

LRE anticipates MDHHS' CRM platform will assist Region 3 in having better visibility to Sentinel Events and Unexpected Deaths in FY24 with syncing to Critical Incidents to ensure a robust reconciliation process within the CRM platform.

LRE achieved its FY23 Event Reporting and Notifications Goals.

VI. BEHAVIOR TREATMENT REVIEW

LRE's FY23 Behavior Treatment Review Goal was to monitor and analyze Behavior Treatment Review (BTR) data to ensure consumers with behavior treatment plans (BTPs) are provided effective BTPs that gives each consumer the opportunity to maximum outcomes while minimizing barriers.

One caveat to be aware of is that LRE's FY23 Behavior Treatment Review data only includes those consumers on Habilitation Services Waiver who also have a Behavior Treatment Plan, which is a small percentage of the overall population served with Behavior Treatment Plans. As a result, for FY24, LRE pivoted to including comprehensive BTP, along with Individual Plans of Service, audits during FY24 LRE's CMHSP Site Reviews and Facilities Reviews/HCBS Physical Assessments.

In FY23, LRE determined that its CMHSPs conducted 526 BTRs for an average of 127 consumers per quarter with the vast majority of these reviews relating to 1) Harm to Self (35%) Harm to Others (33%), and 3) Property Damage (17%), which totals 85% and is similar to FY22.

LRE conducted its quarterly reviews with the Behavior Treatment Workgroup. CMHSPs reported Progressing or Stable status for 45% of consumers with BTPs, Regression for 6%, and No Change for 17% for the same population, which is similar to FY22. (Table 14)

Effectiveness of Behavior Treatment Plans		
Status	**Count**	**%**
Stable	144	27%
New Request	132	25%
Progress	93	18%
No Change	92	17%
Regression	33	6%
Improperly Implemented	20	4%
Not Implemented	12	2%

Table 14.

CMHSPs are also reporting that each CMHSP's Behavior Treatment Review Committee is recommending continuation of existing BTPs almost 81% of the time with 8% of BTPs being recommended for updates. (Table 15).

Recommendations for Behavior Treatment Plans		
Status	**Count**	**%**
Continued	424	81%
Update Approved	42	8%
New Plan Approved	28	5%
Discontinued	17	3%
Continued with Recommendations	8	2%
New Plan with Recommendations	4	1%
No Plan	2	0%
New Plan Not Approved	1	0%
Interim Plan Approved	0	0%
Interim Plan Approved with Recommendations	0	0%

Table 15.

LRE interprets the BTP and BTR data such that the CMHSPs are developing effective BTPs that reduce barriers and place consumers in positions to realize positive outcomes.

LRE achieved its FY23 Behavior Treatment Reviews Goal.

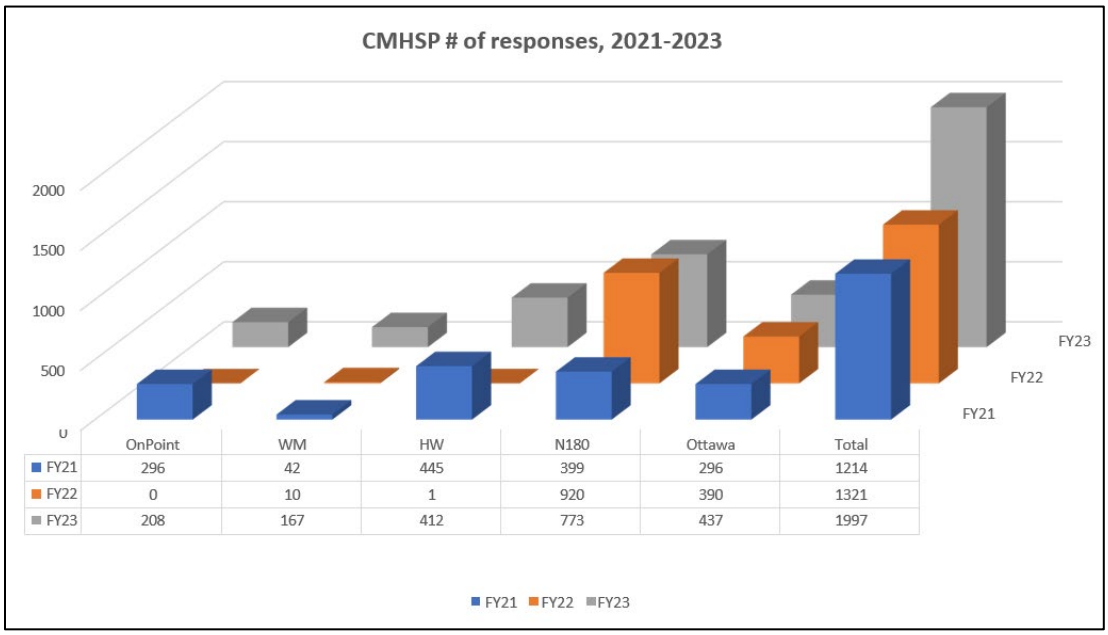
VII. CUSTOMER SATISFACTION ASSESSMENT [8]

LRE's FY23 Customer Satisfaction Assessment Goal was to revise and deploy the Regional Customer Satisfaction Survey (Survey) and create a MicroSoft® PowerBI Dashboard to maximize data analysis and transparency.

Prior to August 2022, the satisfaction survey was administered regionally by Beacon Health Options. At that time, there were no clear administrative guidelines regarding implementation or participation within the region, leading to:

1) Low participation
2) Lack of documentation
3) Data that showed little variation in satisfaction over multiple survey periods
4) Regional confusion on procedure

To address these issues, LRE created and implemented a Satisfaction Survey Workgroup comprised of LRE Customer Services staff, LRE IT department, and representatives from each CMHSP. This workgroup created and implemented the revised survey tool, LRE Policy 6.11, and LRE Procedure 6.11a to outline the requirements for administration, participation, follow-up, and response. In FY23, LRE's Member CMHSPs received 1,997 completed Surveys for all service types, populations, length of service, genders, and races/ethnicities, which is a 51% increase in participation, with all Region 3 CMHSPs participating and four out of five showing significantly improved participation. (Graph 11).



	OnPoint	WM	HW	N180	Ottawa	Total
FY21	296	42	445	399	296	1214
FY22	0	10	1	920	390	1321
FY23	208	167	412	773	437	1997

Graph 11.

LRE changed the scale of the FY23 Survey from a 6-point Likert scale with a N/A option to a 4-point Likert scale with a N/A option by removing the "Mildly Agree" and "Mildly Disagree" options

[8] LRE's Customer Satisfaction Assessment Report and PowerBI Dashboard printouts are available upon request. Please make your request via email: marionm@lsre.org.

to reduce confusion regarding the survey questions and clutter on the survey tool. LRE also revised survey questions to increase understanding, accessibility, and inclusion. LRE defines a satisfactory score at or above 3 for the 4-point Likert scale. LRE also added questions related to whether the survey respondent received information about rights, grievance, and appeals as well as whether the survey respondent knew how to file a grievance or appeal. LRE deployed a "Yes/No" choice option for questions related to rights, grievance, and appeals. LRE defines a satisfactory score at or above 80% for a "Yes/No" choice option. Any CMHSP receiving a less than satisfactory score must submit an Improvement Plan for each domain and questions to LRE. Finally, LRE removed the telehealth questions in the wake of the end of the COVID-19 Public Health Emergency.

In total, LRE's FY23 Survey is comprised of 14 questions corresponding to the following domains:

1) Access and Availability
2) Long-Term Supports and Services (LTSS)
3) Outcomes
4) Quality Measures

Based on the FY23 Survey results, LRE determined the following related to consumers' satisfaction levels for:

1) Access and Availability. Respondents reported overall satisfaction with access and availability regarding options for contact and the location/time of appointments. A notable portion of respondents reported they did not know what number to call when the office is closed. The regional average is 2.9, which does not meet the 3.0 threshold.
2) *Long Term Support & Services.* 199 survey respondents were identified as receiving LTSS. When their responses were separated from the other populations, all but one average score was equal to or within .1% of the non-LTSS populations. The data point regarding knowledge of numbers to call when the office is closed (After Hours #) may be lower in the LTSS population due to the living/staffing situations common to individuals receiving LTSS. The LTSS population reported slightly higher knowledge of how to file a grievance or an appeal than the non-LTSS population, as well as reflecting that they were given information about their rights.
3) *Quality of Services.* Respondents reported a high degree of satisfaction with their treatment team's efforts to connect them with community resources and supports and answer any questions they had. Many respondents reported feeling welcome when they entered their provider's office for services. Results varied among CMHSPs, but overall, Region 3 did not meet the 80% threshold for knowledge of the grievance and appeals processes. LRE Customer Services is working with the CMHSPs to provide more education about grievances and appeals to persons served.
4) Outcomes. Respondents reported a high degree of satisfaction with the overall service they received in Region 3, and the majority indicated that the services they received have improved their relationships with friends, family, and the community.

On the FY23 Survey, LRE contained an area that allowed respondents to leave a comment, suggestion, feedback, or other written response as well as a space for the respondent to leave

their name and phone number if they would like someone to call them to discuss their experience. LRE requires CMHSPs to make follow-up calls within four (4) days of request. CMHSP staff then documents each call in a call log that is reported to LRE for tracking purposes.

LRE achieved its FY23 Customer Satisfaction Assessment Goals.

VIII. CLINICAL PRACTICE GUIDELINES

LRE supports 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. LRE endorses CPGs that have been adopted by the American Psychiatric Association. LRE adopted the American Psychiatric Association CPGs in concert with Member CMHSPs through the Clinical ROAT and Utilization Management ROAT. LRE disseminates the CPGs via LRE and CMHSP websites, LRE newsletter, and ROAT reviews and education.

LRE's FY23 Clinical Practice Guidelines Goals were to ensure continued education and monitoring of Clinical Practice Guidelines while improving dissemination and education to the LRE Provider network. Adopt new/alternate practice guidelines as necessary. Specifically, LRE's FY23 CPG Objectives were that LRE will

1) Review, and if appropriate update, the CPGs two times a year with the LRE Medical Director and the Clinical / UM Department staff.
2) Disseminate the CPGs to the provider network through various educational opportunities as well as links to the LRE CPGs via CMHSP and LRE Websites.
3) Disseminate the CPGs to its Regional Provider Network via LRE newsletter at least annually.

LRE has reviewed the CPGs two times during FY23 with the LRE Medical Director, Clinical Director, UM ROAT, and Clinical ROAT. Upon conclusion of the collaborative review sessions, LRE disseminated the CPGs to the provider network via the ROAT meeting minutes, LRE Website and the LRE newsletter.

LRE achieved its FY23 Clinical Practice Guidelines Goal.

IX. CREDENTIALING

LRE ensures that services and supports are consistently provided by staff (contracted or directly operated), who are properly and currently credentialed, licensed, and qualified.

FY23 Credentialing Goals were as follows:

1) Enhance the credentialing/recredentialing process through successful implementation of the MDHHS CRM Universal Credentialing Module.
2) Develop a Credentialing/Recredentialing Module within LIDS, LRE's electronic health record (EHR).

3) Develop a process for tracking, reporting, and monitoring Credentialing & Recredentialing Efforts.
4) Integrate quality metrics and consumer concerns into LRE recredentialing processes.

LRE had to modify its original FY23 Credentialing Goals because MDHHS put a hold on the Universal Credentialing deploy and PCE Systems, LRE's EHR Vendor, is resource constrained relative to developing LRE's credentialing and recredentialing module in LIDS.

LRE has worked diligently as part of the MDHHS Universal Credentialing Workgroup by attending all meetings, contributing during meetings, and disseminating information from the meetings to LRE and CMHSP staff in an effort to support a seamless transition starting in FY23. Unfortunately, MDHHS has put a hold on the Universal Credentialing efforts.

In FY23, LRE developed a tracking process for its credentialing and recredentialing efforts, that tracks not only the number individual practitioners and organizational providers that are credentialed and recredentialed, but also tracks the timeliness of application approvals, timeliness of bi-annual recredentialing efforts, and rate at which application approvals close within 90 calendar days. (Table 14).

FY23 LRE Credentialing & Recredentialing Efforts				
	Q1	Q1-Q2	Q3	Q3-Q4
Total Individual Practitioners credentialed		104		120
Total Individuals recredentialed		81		144
Total Organizations credentialed	22	30	17	25
Total Organizations recredentialed	9	20	10	40
Individuals - average days from receipt of clean packet to approval		25.9		11.4
Organizations - average days from receipt of clean packet to Committee approval	16.1	16.6	16.6	17.5
100% of Individual Practitioners are recredentialed every 24 months 100% of the time		96%,		89%
100% of Organizations are recredentialed every 24 months at least 100% of the time	Met	95%	Met	100%
Individual Practitioner Applications - 100% will be processed in 90 calendar days from clean submission 100% of the time		99%		Met
Organizational Applications - 100% will be processed in 90 calendar days from clean submission 100% of the time	Met	Met	Met	Met
When temporary/provisional credentialing is approved, approvals do not exceed 150 days 100% of the time				

Table 14.

In FY22, LRE launched a Master Provider Database for Region 3 providers, which will support incorporating quality measures into its recredentialing process. Given PCE Systems resource constraints in FY23, LRE relied upon several MicroSoft® Power BI Dashboards to implement various quality metrics into the recredentialing process, such as critical incidents, risk events, sentinel events, unexpected deaths, customer satisfaction assessments, grievances, appeals, Site Review results related to clinical, credentialing, training, and Desk/Program Specific audits, and Facilility Reviews and HCBS Physical Assessments. LRE also modified its credentialing/ recredentialing checklist to ensure quality metrics are reviewed at recredentialing. Due to PCE

Systems resource constraints, LRE is developing the technical requirements for the Master Provider Database, which is in the final stages for delivery to and discussion with PCE Systems.

LRE achieved its FY23 Credentialing Goals.

X. MEDICAID SERVICES VERIFICATION

LRE's FY23 Medicaid Services Verification Goal was to continue monitoring Region 3 providers utilizing LRE's Medicaid Verification Process, which was revised in FY22 and comports with MDHHS Medicaid Services Verification technical requirements.

A. Non-SUD Services

During FY23, LRE performed Medicaid Services Verification audits on 9,712 claims/encounters totaling $2,673,803.56 Medicaid dollars. LRE determined that $8,877.37, or 0.33%, was subject to recoupment. (Table 15).

When compared to FY22, LRE increased the total Medicaid dollars and claims audited by approximately 82% and 35%, respectively, with an overall reduction in recoupment by 0.1%.

Audit Period	Total Medicaid Dollars	Amount Recouped	% Recoupment
FY23 Quarter 1	$628,151.00	$5,094.23	0.81%
FY23 Quarter 2	$749,418.80	$1,775.70	0.24%
FY23 Quarter 3	$667,218.61	$0.00	0.00%
FY23 Quarter 4	$629,015.15	$2,007.44	0.32%
Total	**$2,673,803.56**	**$8,877.37**	**0.33%**

Table 15.

For FY23, LRE's Medicaid Services Verification audit efforts encompassed 9,711 claims/encounters across 32 different service types (Table 16), 1,640 consumers, and five (5) distinct population groups (Tables 17 & 18) for 105 unique providers (Table 19).

Number of Audits Completed by Service Type							
ACT	795		Home Based	551		Residential CLS	397
Autism	437		Inpatient Hospital	2		Respite	79
Behavior Treat	119		Med Injections	194		Screening for Inpatient	90
CCBHC	108		Non-Family Training	1		Skill Building	129
Clinical Assessments	369		Nursing Services	83		Supported Employment	74
CLS (H2015)	990		Outpatient Services	1312		Supports Coord/ Case Management	1897
Clubhouse	16		Overnight CLS	8		Therapy: OP other-OT, PT, Massage	32
Crisis Assessments	91		Overnight Safety	1		Transport	6
Crisis Residential Hospitalization	55		Peer Support	128		Treatment Planning	387
Family Training	171		Personal Care	376		Wrap Around	152
Fiscal Intermediary	51		Psychiatric Services	623			

Table 16.

Number of Consumers by Population Group					
Population	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
	Oct – Dec 2022	Jan – Mar 2023	Apr – Jun 2023	Jul – Sept 2023	
MI Adult	151	201	140	134	626
MI Child	85	98	85	102	370
I/DD Adult	126	158	84	111	479
I/DD Child	46	46	42	31	165
Totals Reviewed	408	503	351	378	1640

Table 17.

Number of Encounters Completed by Population Group					
Population	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
	Oct – Dec 2022	Jan – Mar 2023	Apr – Jun 2023	Jul – Sept 2023	
MI Adult	1013	1225	850	619	3707
MI Child	493	562	553	467	2075
I/DD Adult	925	1073	558	514	3070
I/DD Child	287	280	183	109	859
Totals Reviewed	2718	3140	2144	1709	9711

Table 18.

Providers Audited by Service Type					
ACORN	Autism	Flatrock	Residential	Pendogani AFC	Residential
Adia AFC	Residential	Flatrock Manor	Residential	Pine Grove AFC	Residential
Agnus Dei AFC	Residential	Fox Counseling	OP	Pine Rest	OP
Amani AFC	Residential	Giddings AFC	Residential	Pioneer	CLS, Residential
American Homestead	Residential	Goodwill Industries	SB, SE	Pioneer Community Services	CLS, Residential
Arbor Circle	OP	Guardian Trac	FI	Positive Behavioral Supports	Autism
Autism Spectrum Therapies	Autism	Hansma AFC	Residential	Preferred Employment/Community	CLS, SE
Beacon Services	Residential	Harbor House	Residential	ProCare Unlimited	CLS
Beacon Specialized	Residential	Harbor House Ministries	Residential	Professional Rehabilitation Inc	Autism
Beacon Specialized & Support Services	Residential, CLS	Harbor Oaks Hospital Children	Inpatient	Ramsdell AFC	Residential
Benjamin's Home	Residential	Heritage Homes	Residential	RB Living Services	Residential
Bethany Christian	OP	Hernandez Home	Residential	Real Life Living Services	CLS
BHT Gusco	FI	HGA	Residential	Residential Opportunities	Residential
Brightside Living	Residential	HGA Virginia's House	Residential	Samaritas	OP
Camp Kidwell	Respite	Hope Discovery	Autism	Sandy's Country AFC	Residential
Case Management of Michigan	Supports Coordination	Hope Network	Autism, OP, CM. Psych	Second Story	OP
Castle Kingdom AFC	Residential	Ikaze Home AFC	Residential	Snug Harbor	CLS
Centria	Autism	IKUS/Indian Trails Camp	CLS, Respite	Sparks Behavioral Health	Psychology
Cherry Health	OP, CM,SUD	Indian Trails	CLS	Spectrum Community Services	OP, CM
Chrysalis Services	CLS	Kelly's Kare	CLS, Residential	Stuart Wilson	FI
Community Alliance	CLS	LA Benediction	Residential	Thresholds	OP
Community Living Services	Case Management	Lakeside Home Health	Respite	Thresholds Residential Services	Residential
Cornerstone AFC	Residential	Life Therapeutic Solution	CLS	Toni Ann Keglovitz	Health Services
Covenant Ability	Residential	Martha Guardado AFC	Residential	Trinity Home Health	OP, CLS
D.A. Blodgett	OP	McBride AFC	Residential	Turning Leaf	Residential
DA Blodgett	OP, CM, Home Based	Merakey	Autism	Visel Hilltop AFC	Residential
David's House Ministries	Residential	MOKA	CLS, Residential	Warren Sakshaug Group Home	Residential
Daybreak Adult Services	CLS	Morrells Family Home	Residential	Waypoints	Autism
Developmental Enhancements	Autism	Naile Boshnjaku	Residential	Wedgwood	OP, CM, wrap around
Dignified Care – Bergsma House	Residential	Norma Jeans AFC	Residential	Wedgwood Christian Services	OP
Easter Seals	OP	North Kent Guidance Services	OP	West MI Psych Services	OP
Evas AFC	Residential	Oasis Care Services AFC	Residential	Willow Brook AFC	Residential
Family Outreach	OP, CM	Orchard Hills Enterprises	Residential	Wilson & Wynn	Psychologist
Farragut Home	Residential	Pathfinders of Muskegon	CLS	Wrzesinski Specialized AFC	Residential
Fisher AFC	Residential	Paulson Home	Residential	Zawadi AFC	Residential

Table 19.

In FY23, LRE's Medicaid Services Verification audits found all CMHSPs/providers to be in substantial compliance with federal and state regulations. Therefore, LRE did not put any CMHSP/provider on corrective action plans. Because LRE does not currently have any CMHSPs/providers on Medicaid Services Verification corrective action plans, LRE did not take any providers off corrective action plans nor did LRE cite any provider for repeat/continuing issues. (Table 20).

STATUS OF CORRECTIVE ACTION PLANS - NON-SUD SERVICES	COUNT
Number of Providers Reviewed	105
Number of Claims/Encounters Reviewed	9,712
Number of Consumers Reviewed	1,640
Number of Service Types Reviewed	32
Number of Consumer Population Groups Reviewed	5
Number of Providers Put on Corrective Action Plans	0
Number of Providers on Correction Action for Repeat/Continuing Issues	0
Number of Providers Taken Off Correction Action Plans	0

Table 20.

In FY23, Region 3 providers performed well during the LRE Medicaid Services Verification audits. Overall, LRE audited a total of 9,711 claims/encounters and found a total of five (5) non-compliant claims/encounter. Of these five (5) claims/encounters, the following issues were found:

REASON FOR NON-COMPLIANCE	COUNT	CAUSE	OUTCOME
Provider not Qualified to Render Services	1	CMHSP Implemented New EMR/Billing Process	Recoupment
Insufficient Documentation	2	Lack of Start/Stop Times	Recoupment
Missing Documentation	2	Documentation not found	Recoupment

LRE recouped Medicaid funds related to the four (4) claims/encounters where documentation was insufficient to support the claim/encounter or missing. Finally, LRE recouped funds for the one (1) claim/encounter where the services provided by an individual provider with inappropriate credentials.

B. SUD Services

During FY23, LRE performed Medicaid Services Verification audits on 1,379 claims/encounters totaling $216,447.79 Medicaid dollars. LRE determined that $2,259.50, or 1.04%, was subject to recoupment. (Table 21).

Audit Period	Total Medicaid Dollars	Amount Recouped	% Recoupment
FY 23 Oct 2022 - Sept 2023	$216,447.79	$2,259.50	1.04%
Total	**$216,447.79**	**$2,259.50**	**1.04%**

Table 21.

For FY23, LRE's Medicaid Services Verification audit efforts for SUD Services encompassed 1,379 claims/encounters across 21 different service types (Table 22), 302 consumers, and one (1) distinct population group (Table 23) for 26 unique providers (Table 24).

Number of Audits Completed by Service Type			
Behavioral Health Counseling	12	Outpatient Services	112
Brief Screening	2	Peer Services	62
Case Management	139	Psychiatric Services	46
Clinical Assessments	21	Recovery Coach	27
Early Intervention	2	Recovery Coach/Peer Supports	71
Group Counseling/Therapy	24	Recovery Housing	7
Health Counseling	3	Recovery/Detox Residential	13
Injections/Health	1	Recovery/Peer Supports	14
Intense group therapy	15	Residential/Housing	18
Laboratory Drug Testing	44	Treatment Planning	8
Methadone Services	32		

Table 22.

	Number of Encounters Completed by Population Group	Number of Consumers Completed by Population Group
SUD Adult	1379	302
SUD Child	0	0
Total Reviewed	1379	302

Table 23.

Providers Audited by Service Type	
ACAC	Psychiatric, OP
Addiction Treatment Services	Residential, Crisis Residential
Arbor Circle	OP, Residential, Recovery
Bear River	Residential
Bear River Health	Residential
Catholic Charities	OP
Cherry Health	OP, SC, Methadone
Community Healing Center	OP, Residential, Crisis Res
Eastside	OP. Methadone
Family Outreach Center	OP, Recovery Coach
Great Lakes Recovery	Residential
Harbor Hall	OP, Residential
Healthwest	CMH
Mercy Life Counseling	OP
Network 180	CMH
OnPoint	CMH
Our Hope	Residential
Pine Rest	OP, Residential
Reach For Recovery	OP, Residential
Salvation Army	OP, Residential
Samaritas	OP, Psychiatric
Trinity Health	OP
Victory Clinic	OP, Methadone
Wedgwood	OP
West Michigan	CMH
West Michigan Treatment Center	OP, Methadone

Table 24.

In FY23, LRE's Medicaid Services Verification audits found all CMHSPs/providers providing SUD

services to be in substantial compliance with federal and state regulations. Therefore, LRE did not put any CMHSP/provider on corrective action plans. Because LRE does not currently have any CMHSPs/providers on Medicaid Services Verification corrective action plans, LRE did not take any providers off corrective action plans nor did LRE cite any provider for repeat/ continuing issues. (Table 25).

STATUS OF CORRECTIVE ACTION PLANS - SUD SERVICES	COUNT
Number of Providers Reviewed	26
Number of Claims/Encounters Reviewed	1379
Number of Consumers Reviewed	302
Number of Service Types Reviewed	21
Number of Consumer Population Groups Reviewed	1
Number of Providers Put on Corrective Action Plans	0
Number of Providers on Correction Action for Repeat/Continuing Issues	0
Number of Providers Taken Off Correction Action Plans	0

Table 25.

In Fiscal Year 2023, Region 3 SUD providers performed well during the LRE Medicaid Services Verification audits. Overall, LRE audited a total of 1,379 claims/encounters and found a total of four (4) non-compliant claims/encounters. Of these four (4) claims/encounters, the following issues were found:

REASON FOR NON-COMPLIANCE	COUNT	OUTCOME
Invalid IPOS at Date of Service	1	Recoupment
Provider not Qualified to Render Services	3	Recoupment

LRE recouped Medicaid funds related to the one (1) claim/encounter where the IPOS was expired. Finally, LRE recouped funds for the three (3) claims/encounters where the services provided by an individual provider with inappropriate credentials.

LRE achieved its FY23 Medicaid Services Verification Goal.

XI. UTILIZATION MANAGEMENT

At the LRE, Utilization Management (UM) is guided by LRE policy and procedure and an annual UM Plan. UM activities are conducted across the region to assure the appropriate delivery of services. Utilization mechanisms identify and correct underutilization as well as overutilization.

LRE's FY23 Utilization Management Goals were to 1) develop a MicroSoft® PowerBI Dashboards for Audits to improve efficiency and analysis of the CMHSP Site Review data that targets the under and over utilization of services, 2) expand auditing of continued stay reviews (CSR) beyond inpatient facilities to include crisis residential and partial outpatient settings and 3) include pre-admission screenings (PAS) as part of the continued stay review audits.

Over/Under Utilization via LRE Audits MicroSoft® PowerBI Dashboard.

LRE's Audits MicroSoft® PowerBI Dashboard allows LRE to data mine non-compliance at the question level. LRE's FY23 Clinical Audit Tool, Question 6.1b evaluates whether a provider has rendered services in the amount authorized in the IPOS. In FY23, LRE determined that all Region 3 CMHSP were not rendering services in the amount authorized on average 42% of the time. (Table 26).

FY23 LRE CMHSP Site Reveiws: Under/Over Utilization CMHSP Clincial Audit Tool - Question 6.1b		
CMHSP	**% Under/Over Utilization**	**% Compliant**
Allegan County CMH	47%	53%
CMH of Ottawa County	27%	73%
Healthwest	47%	53%
network180	49%	51%
West Michigan CMH	42%	58%
Grand Total	42%	58%

Table 26.

As part of the CMHSP Site Reviews, LRE issued CAPs to ensure services are rendered in the amount authorized in the IPOS, which are deemed to be medically necessary.

Expansion of Continued Stay Reviews (CSR). In FY22, LRE introduced for the first time a highly functional Interrater Reliability (IRR) program to Region 3. IRR serves to ensure the accuracy and consistency of the LRE's UM program, including access to care and coverage determinations. IRR also serves as a way to incorporate parity within our state/region, break down the inconsistencies of consumer experience across CMHPs, train and monitor use of medical necessity criteria and monitor its use for dispositions of higher level of care, and improve quality of care for the members we serve.

In FY23 Q2, LRE completed quarterly audits on a combination of adult and child consumer charts for Mental Illness (MI) Higher Level of Care (HLOC) according to the following protocol:

1) A minimum of 10 consumer charts are audited.
2) The number of charts audited per CMHSP is no less than three percent nor greater than 5 percent of the total number for the quarter.
3) Charts are randomly selected for consumers who were admitted/discharged during the quarter.
4) Randomly selected charts are identified using the Follow/Up to Hospitalization (FUH) report.
5) LRE staff will use regionally approved audit tools for pre-admissions screens and continued stay reviews.

6) LRE utilization department staff have been provided access to each CMHSP's EMR system to complete IRR audits.
7) Audit results are logged into the PAS/CSR Audit Summary Tool and the report shared with the Utilization Management ROAT.
8) LRE provides specific feedback on documentation that will be provided to the identified CMHSP lead(s).

In FY23, LRE conducted 590 CSR and PAS audits and found a total of three (3) instances of non-compliance, which resulted in compliance rates of 99.5% for both audit types. (Table 27).

FY23 UM - CSR & PAS AUDITS			
	# Audits	Non-Compliance	% Compliant
CSR	402	2	99.5%
PAS	188	1	99.5%

Table 27.

During the audits, LRE also identified improvement opportunities regarding CSR & PAS documentation. In FY23 Q1, LRE found that CMHSPs were not 1) including the mental health history in the first CSR, 2) updating discharge planning in the CSR, and 3) including documentation regarding the next CSR. LRE provided constructive feedback to CMHSPs resulting in corrective actions for these issues, which were not found in any of the remaining audits for FY23. (Tables 28 & 29).

	FY23 UM - PAS DOCUMENTATION IMPROVEMENT OPPORTUNITIES				
	PAS - No concerns	PAS does not contain DX	PAS Note only uploaded into EMR	PAS MCG 26th Edition not cited as reason for authorization	Upon admission, more than the standard of 3 days was authorized
PAS	34	9	14	104	3

Table 28.

	FY23 UM - CSR DOCUMENTATION IMPROVEMENT OPPORTUNITIES						
	CSR No Concerns	1st CSR does not contain mental health history	CSR does not contain psychosis assessment	CSR does not contain SI/HI documentation	CSR does not contain MCG 26th Edition criteria used for reason of authorization	CSR does not contain discharge planning update	CSR does not contain documentation regarding the focus for next review
CSR	60	13	32	72	87	21	13

Table 29.

LRE also found that CMHSPs were not citing the MCG 26th Edition criteria for authorization for neither PAS nor CSR. Again, LRE provided feedback to CMHSPs, which resulted in an overall quarterly decrease from 104 in Q1 to 39 in Q2 and 48 in Q3, which is a significant improvement quarter over quarter.

LRE achieved its FY23 Utilization Management Goals.

XII. OVERSIGHT OF PROVIDER NETWORK [9]

In FY23, LRE is pleased to announce that it has deployed two (2) comprehensive Microsoft® Power BI Dashboard for Audits, CAPs, and Encounter Look-Up, which has improved efficiencies in data analysis and reporting.[10]

A. CMHSP Site Reviews

LRE maintains oversight of its Provider Network by conducting annual CMHSP Site Reviews that ensure compliance with federal, state, and regional regulations and requirements.

LRE's FY23 CMHSP Site Review Goals were to 1) improve the cycle time for completing a CMHSP Site Review, 2) streamline the Corrective Action Plan process by leveraging technology, and 3) develop an actionable reporting template for CMHSPs.

CMHSP Site Review Cycle Time. In FY23, LRE improved the efficiency of the CMHSP Site Review process by reducing the Site Review Cycle Time from 19.5 weeks to 9.1 weeks, including any CAP development by the CMHSPs, which is a 114% reduction in cycle time.

CMHSP Site Review CAP Process. LRE reduced the average time for CMHSPs to enter CAP Responses into LIDS from 40 hours to zero hours by leveraging technology and pivoting from LIDS to MicroSoft® PowerBI Dashboards.

CMHSP Site Review Report Template: LRE developed an actionable reporting template for CMHSPs, which integrates the Audits MicroSoft® PowerBI Dashboard data, and will continue to improve the template in FY24.[11]

CMHSP Site Review Results. During the FY23 CMHSP Site Reviews, LRE completed the following audits:

1) 20 Desk Audits
2) 17 Program Specific Audits
3) 327 Credentialing & Training Audits
4) 164 Clinical Audits
5) 4 Critical Incident & Risk Event Audits
6) 2 Behavior Treatment Plan Audits

[9] Attachment A.
[10] LRE's MMBPIS PowerBI Dashboard printout is available upon request. Please make your request via email: marionm@lsre.org.
[11] LRE's CMHSP Site Review Report Template is available upon request. Please make your request via email: marionm@lsre.org.

During the CMHSP Site Review Process, LRE evaluates its CMHSPs' and external providers' compliance in the following areas:

1) Federal Regulations, State Requirements, and Regional Policies,
2) Contractual Obligations,
3) Delegated Managed Care Functions, and
4) Clinical Documentation Standards.

LRE conducted CMSHP Site Reviews for all five (5) of its CMHSPs with the following results:

FY23 LRE CMHSP SITE REVIEW RESULTS						
	CMHOC	HealthWest	network180	OnPoint	West Michigan	Region 3
Clinical	93.7%	94.9%	95.8%	90.1%	96.1%	94.1%
Credentialing/Training	96.4%	99.5%	96.9%	91.3%	91.3%	95.2%
Desk Audit	97.7%	96.3%	99.4%	88.8%	100.0%	94.9%
Program Specific	87.5%	88.0%	100.0%	94.7%	100.0%	94.9%
FY23 Comprehensive Total	**94.6%**	**95.4%**	**96.2%**	**90.5%**	**95.2%**	**94.4%**
FY22 Comprehensive Total	**93.9%**	**93.0%**	**95.9%**	**93.7%**	**94.8%**	**94.3%**

In FY23, CMHSPs performed similar overall to FY22.

LRE requires CAPs for each element found out of compliance, meaning "Not Met" or "Partially Met." LRE also requires individual and systemic remediation for any Autism and Waiver Clinical Chart and Credentialing Audit elements that required CAPs.

By way of its CMHSP Site Reviews, LRE maintains oversight of its Provider Network by utilizing the Site Review scores to:

1) Establish prioritized clinical and non-clinical priority areas for improvement.
2) Analyze the delivery of services and quality of care using a variety of audit tools.
3) Develop performance goals and compare findings with past performance.
4) Provide performance feedback through exit conferences and written reports.
5) Conduct targeted monitoring of consumers defined to be vulnerable by MDHHS.
6) Require improvements from providers via CAPs for areas that do not meet predetermined thresholds or are not compliant with defined standards.

LRE's CMHSP Site Review CAP process ensures improvements to quality of care and reduction of barriers through the CAP process and subsequent remediation validation.

LRE achieved its FY23 CMHSP Site Review Goals.

B. MDHHS Site Reviews

LRE's FY23 MDHHS Site Review Goal was to actively participate in the Site Review and oversee CAP development and remediation validation. LRE participated in the Site Review and monitored CAP development at the CMHSP level. LRE is now working to validate CAP remediation efforts at the CMHSP level.

LRE achieved its FY23 MDHHS Site Review Goal.

C. External Quality Reviews [12]

LRE participates in External Quality Reviews (EQRs), which are conducted by Health Services Advisory Group (HSAG) and required under The Balanced Budget Act of 1997 (BBA). Generally, HSAG evaluates the quality and timeliness of, and access to, health care services provided to consumers.

LRE's FY23 HSAG Audit Goals were to 1) continue integrating LRE Subject Matter Experts (SMEs) into the preparation of HSAG Compliance Review tools and proofs and 2) perform at least as well as years past.

HSAG conducted its Audit in three parts:

1. Performance Measurements Validation
2. Performance Improvement Projects Validation
3. Compliance Review

1. Performance Measurement Validation

For FY23, HSAG validated LRE's Performance Measurements.

HSAG commended LRE on the following strengths:

1) "Lakeshore continued to demonstrate strength in its efforts toward data quality improvement and CMHSP oversight through real-time monitoring using its Power BI technology dashboard. Lakeshore also integrated an Arc of Treatment Model and began monitoring CMHSP data on a larger scale by examining data by case numbers rather than specific indicators. By viewing data on a larger scale, Lakeshore was able to identify members who were present in more than one indicator and any trends within the Arc of Treatment Model, further ensuring ongoing monitoring of performance and data completeness and accuracy. [Quality]."
2) "In addition to reviewing the performance indicator submissions from the CMHSPs, Lakeshore implemented a new process that used reports to monitor quality and timeliness. Executive leadership at Lakeshore and CMHSP leads collaborated based on review of the reports and were able to address timeliness issues more efficiently. Lakeshore noted substantial improvements and consistency in obtaining timely data as a result of this new process. [Quality and Timeliness]."

[12] LRE has provided comprehensive documentation to the LRE Board of Directors, HSAG, and MDHHS on multiple occasions since October 1, 2022, as such these are not included in this report; however, each are available upon request. Please make your request via email: marionm@lsre.org.

HSAG also noted three (3) improvement opportunities for Region 3:

1) "Upon review of HealthWest's member-level detail file, HSAG identified three cases with completed biopsychosocial assessment dates that occurred prior to the non-emergency request for service dates for Indicator #2. [Quality]."
2) "Upon review of OnPoint's member-level detail file, HSAG identified one case with a completed biopsychosocial assessment date that occurred prior to the non-emergency request for service date for Indicator #2. [Quality]."
3) "Upon review of West Michigan's proof of service documentation provided, HSAG identified one case with an incorrect request date documented for Indicator #2. West Michigan noted that the correct request date reflected a greater-than-14-day difference between the non-emergency request date and completed biopsychosocial assessment date, which implies that this case should have received an out-of-compliance disposition instead of an in-compliance disposition. At HSAG's request, all reported cases were reviewed, and an additional five cases contained the same errors and should have been reported as out of compliance. [Quality]."

LRE and its CMHSPs worked together with the EHR vendors across Region 3 to operationalize the improvement opportunities found during HSAG's PMV Audit.

2. Performance Improvement Projects Validation

HSAG validated LRE's race/ethnicity PIP titled FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites. (See Section IV, pp. 10-15).

3. Compliance Review

In FY23, HSAG conducted its Compliance Review of LRE, which was a CAP remediation validation year for FY21 and FY22. LRE's SMEs prepared HSAG tools and proofs.

HSAG fully validated LRE's CAP remediation efforts for FY21 and FY22 except for two elements in the Health Information Systems Standard.

Specifically, HSAG determined that LRE failed to implement an Application Programming Interface (API), commonly known as a portal exchange, which typically would require LRE to attend a Technical Assistance Call (TAC) with HSAG and MDHHS. However, HSAG stated that "a technical assistance call is not required at this time as the PIHPs are in discussions with MDHHS regarding the applicability of the API requirements; however, the PIHP must proceed with fully implementing the Patient Access API to comply with all requirements of 42 CFR §431.60 and the CMS Interoperability and Patient Access Final Rule (CMS-9115-F)." LRE continues to work with MDHHS in determining the applicability of the API requirements.

Specifically, HSAG found the following:

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Member Rights and Member Information	2	2	**0**
Standard III—Availability of Services	2	2	**0**
Standard IV—Assurances of Adequate Capacity and Services	2	2	**0**
Standard V—Coordination and Continuity of Care	3	3	**0**
Standard VI—Coverage and Authorization of Services	3	3	**0**
Standard VII—Provider Selection	3	3	**0**
Standard VIII—Confidentiality	2	2	**0**
Standard IX—Grievance and Appeal Systems	5	5	**0**
Standard X—Subcontractual Relationships and Delegation	2	2	**0**
Standard XI—Practice Guidelines	1	1	**0**
Standard XII—Health Information Systems[1]	2	0	**2**
Standard XIII—Quality Assessment and Performance Improvement Program	4	4	**0**
Total	**31**	**29**	**2**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.

# of CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

# of CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

[1]This standard includes a comprehensive assessment of the PIHP's IS capabilities.

LRE achieved its FY23 HSAG Goals.

D. Facilities Reviews

LRE also maintains oversight of its Provider Network by conducting annual Facilities Reviews for all external providers to ensure compliance with the following requirements:

1. General Health and Safety Standards,
2. Emergency Procedures,
3. Medication Reviews,
4. Resident Funds Reviews,
5. Policies and Procedures, and
6. HCBS Final Rule.

LRE's FY23 Facilities Review Goals were to 1) continue educating providers on the Home and Community Based Services (HCBS) Final Rule and 2) conduct a time study to determine future full-time equivalent (FTE) needs for Facilities Reviews.

LRE conducted 32 HCBS Trainings with CMHSPs and the Provider Network bolstering the knowledge of and compliance with the HCBS Final Rule. LRE has noticed marked improvements in IPOS and BTP HCBS compliance at the majority of its CMHSPs.

During FY23, LRE increased the number of Facilities Reviews completed by over 300%, from 80 in FY21 to 325 in FY23 by hiring and diverting auditing staff, which provided the opportunity to reach more providers, review IPOSs and BTPs, and educate providers and CMHSPs on operationalizing the HCBS Final Rule in IPOSs and BTPs. LRE found the overall Facilities Review compliance rate for FY23 was 98.2%.

During FY23 Facilities Reviews, LRE improved compliance rates and quality of care by issuing 403 CAPs with 178, or 43%, related to HCBS non-compliance, of which 80, or 43%, were due to the use of locks/barriers and 60, or 34%, were due to non-compliant documentation standards. LRE resolved 398, or 98.8%, of the 403 CAPs from FY23 during FY23.

In FY23, LRE determined that in order to achieve its FY24 goal of conducting Facilities Reviews of all Region 3 settings, LRE requires the hiring of 2 FTEs for FY24. LRE hired two new staff; one started in January 2024 and the other starts in early March 2024, to assist with Facilities Reviews in FY24.

LRE achieved its FY23 Facilities Review Goals.

XIII. LONG TERM SERVICES AND SUPPORTS

LRE's FY23 Long Term Services and Supports Goal was to elucidate the avenues LRE explores to ensure consumers receiving Long Term Services and Supports are well represented in LRE's QAPIP efforts ensuring improved quality of care and maximum outcomes for consumers.

During the CMHSP Site Reviews, LRE ensures its sampling methodology used to select consumers for clinical chart audits is a representative cross-section of the overall distribution of service types provided in Region 3 by distinct consumer. For example, for FY23, LRE served almost 70% of its distinct consumer count with services defined by 1115 Pathway to Integration Waiver as Long-Term Services and Supports (LTSS).[13] Hence, when LRE selects its random sample for its clinical chart audits, most of the samples selected tether to individuals receiving LTSS. LRE's sampling methodology is the first step ensuring that LRE is able to assess the quality and appropriateness of care furnished to individuals receiving LTSS.

Secondly, LRE's Clinical Chart Audit Tool, which is used during CMSHP Site Reviews, is the mechanism used to assess the quality and appropriateness of care furnished to individuals receiving LTSS. Specifically, LRE's Clinical Chart Audit Tool contains sections on Person- Centered Planning (PCP), which allows LRE to assess member care between care settings, and Service Delivery, which allows LRE to compare the services received by the individual compared to the services identified in the individuals treatment/service plan.

LRE's Clinical Chart Audit Tool is compliant with MDHHS' PCP Guidelines Policy and the Medicaid Provider Manual ensuring LRE assesses the quality and appropriateness of care furnished to individuals receiving LTSS.[14] For FY24, LRE has modified its Clinical Chart Audit Tool to capture the LTSS population so that data can be analyzed specific to this population for comparison with the non-LTSS population to ensure equivalent delivery and quality of care.

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[13] 1115 Pathway to Integration defines Long-Term Services and Supports as Community Living Supports, Enhanced Medical Equipment and Supplies, Enhanced Pharmacy, Environmental Modification, Family and Support Training, Fiscal Intermediary, Goods and Services, Non-Family Training, Out-of-Home Non-Vocational Habilitation, Personal Emergency Response System, Prevocational Services, Skill Building Assistance, Specialty Services/Therapies (Music Therapy, Recreation Therapy, Art Therapy, and Massage Therapy), Supports and Service Coordination, Respite, Private Duty Nursing, Supported/Integrated Employment Services, Child Therapeutic Foster Care, Therapeutic Overnight Camping, Transitional Services.

[14] Person-Centered Planning section comports with the MDHHS Person-Centered Planning Guidelines Policy. MDHHS, Behavioral Health and Developmental Disabilities Administration, Person-Centered Planning Practice Guideline (michigan.gov). Service Delivery section comports with the Medicaid Provider Manual.

LRE also ensures all individuals, including those receiving LTSS, receive a LOCUS/CAFAS upon admission, annually, and when there has been a significant change in consumer's presentation. In an effort to improve visibility of LOCUS utilization, LRE has developed PowerBI Dashboards. Additionally, with the sundowning of the SIS, LRE has engaged in the soft launch of MichiCANS throughout Region 3, which will only strengthen LRE's commitment to ensuring individuals receiving LTSS receive quality, appropriate care over the long-term.

LRE also analyzes trends in service delivery and health outcomes for individuals receiving LTSS through its Customer Satisfaction Assessment (See Section VI, pp. 23-24). In FY23, LRE's Customer Satisfaction Assessment (Survey) found that approximately 10%, or 199, survey respondents were identified as receiving LTSS. When their responses were separated from the other populations, all but one average score was equal to or within .1% of the non-LTSS populations. The data point regarding knowledge of numbers to call when the office is closed (After Hours #) may be lower in the LTSS population due to the living/staffing situations common to individuals receiving LTSS. The LTSS population reported slightly higher knowledge of how to file a grievance or an appeal than the non-LTSS population, as well as reflecting that they were given information about their rights.

LRE's MicroSoft® PowerBI Dashboards for Critical Incidents, Risk Events, Physical Management, and Audits provide the ability to view individuals in Specialized Residential settings, which are the vast majority of individuals receiving LTSS.

Critical Incidents in Specialized Residential Settings. When analyzing the Critical Incidents occurring only in Specialized Residential (SR) settings in FY23, LRE found the following:

Critical Incident in SR Settings	% of Total Critical Incidents by Category
Zero Suicides	0%
3 Accidental Deaths	14%
Zero Homicides	0%
45 Natural Deaths	42%
258 Injuries Requiring Emergency Medical Treatment	96%
4 Medication Errors Requiring Emergency Medical Treatment	100%
18 Injuries Requiring Hospitalization	95%
1 Medication Errors Requiring Hospitalization	100%
26 Arrests	96%

LRE also determined that the 22% of Injuries Requiring Emergency Medical Treatment were occurring in three (3) unique settings and were due to 11 unique consumers requiring emergency medical treatment due to seizure related injuries and self-injurious behaviors. Due to the number of Injuries Requiring Emergency Medical Treatment in one Specialized Residential Setting, one consumer was discharged and admitted to a higher-level care setting.

Risk Events in Specialized Residential Settings. When analyzing the Risk Events occurring only in Specialized Residential (SR) settings in FY23, LRE found the following:

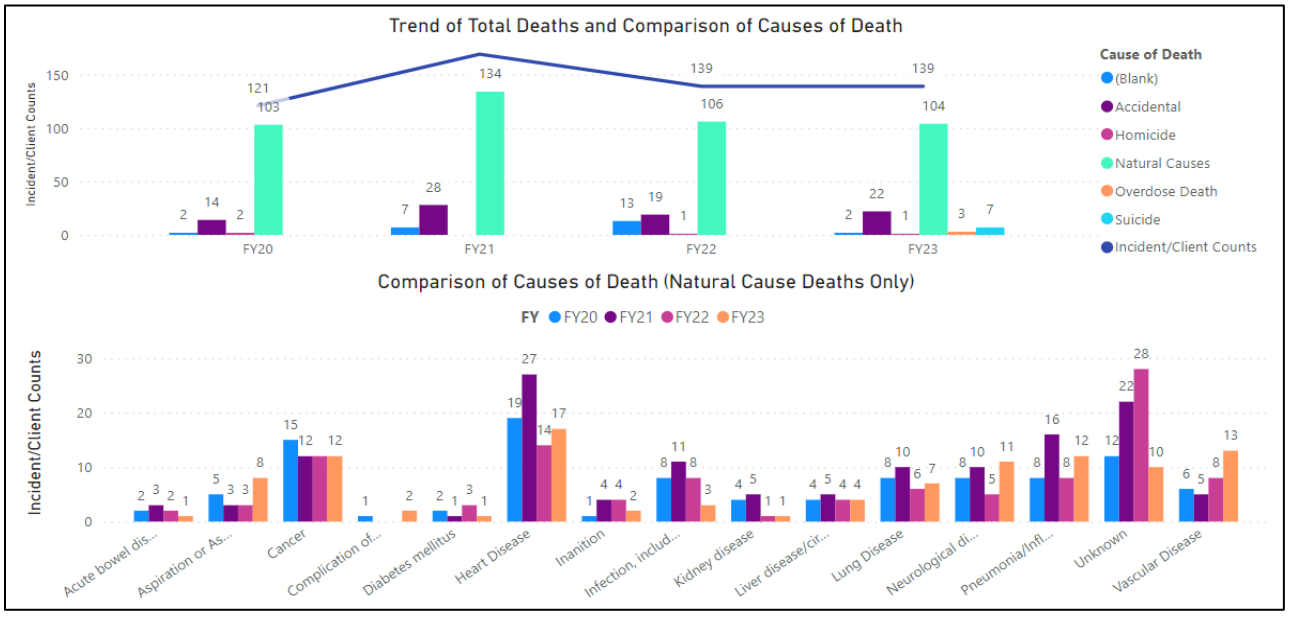
Risk Events in SR Settings	% of Total Risk Event by Category
98 Self Harm	67%
32 Harm to Others	89%
99 Police Calls	66%
266 Emergency Uses of Physical Management	84%
21 Two or More Unscheduled Hospitalizations in 12 Months	81%

Sentinel Events and Unexpected Deaths for Individuals in Specialized Residential Settings. LRE also determined that the most vulnerable population serviced as it relates to SE|UD is the Mentally Ill Adult, Mentally Ill with Co-occurring SUD, and SUD populations (81%) versus the I/DD population, which are typically found in Specialized Residential settings. (Table 30).

LRE FY23 Sentinel Event & Unexpected Death by Population		
Population	**Count**	**%**
MIA	27	51%
MIA/SUD	8	15%
SUD	8	15%
DDA	4	8%
IDD	3	6%
IDD/MI/SUD	1	2%
MDOC	1	2%
MIA/DDA	1	2%

Table 30.

Mortality Report for Individuals in Specialized Residential Settings. In FY23, LRE's review of its Mortality Report determined that Natural (75%) and Accidental Death (16%) continue to be the primary causes of death regardless of setting, meaning Specialized Residential versus non-Specialized Residential. (Graph 12).



Graph 12.

For all Natural Deaths in FY23, LRE determined that Heart and Vascular Disease, Cancer, Pneumonia & Influenzas, Neurological Disorders, and Aspiration or Aspiration Pneumonia contributed to 80% of the Natural Deaths in FY23. (Table 31).

FY23 LRE Mortality Report - Cause of Death				
	FISCAL YEAR			
Cause of Death	FY20	FY21	FY22	FY23
Heart Disease	18%	20%	13%	16%
Vascular Disease	6%	4%	8%	13%
Cancer	15%	9%	11%	12%
Pneumonia/Influenza	8%	12%	8%	12%
Neurological disorders	8%	7%	5%	11%
Unknown	12%	16%	26%	10%
Aspiration or Aspiration pneumon	5%	2%	3%	8%
Lung Disease	8%	7%	6%	7%
Liver disease/cirrhosis	4%	4%	4%	4%
Infection, including AIDS	8%	8%	8%	3%
Complication of treatment	1%	0%	0%	2%
Inanition	1%	3%	4%	2%
Acute bowel disease	2%	2%	2%	1%
Diabetes mellitus	2%	1%	3%	1%
Kidney disease	4%	4%	1%	1%

Table 31.

LRE achieved its FY23 Long Term Services and Supports Goal.

XIV. ACRONYMS

AER – Annual Effectiveness Review

API – Application Programming Interface

BBA – Balanced Budget Act

BTC – Behavior Treatment Committee

BTP – Behavior Treatment Plan

BTR – Behavior Treatment Review

CAP – Corrective Action Plan

CAFAS – Child and Adolescent Functional Assessment Scale

CEO – Chief Executive Officer

CI – Critical Incidents

CQO – Chief Quality Officer

CMCO – Chief Managed Care Officer

CMHSP – Community Mental Health Service Provider

CMS – Centers for Medicare and Medicaid Services

COO – Chief Operations Officer

CPG – Clinical Practice Guideline

CRM – Customer Relationship Management

CS – Customer Satisfaction

CSR – Continued Stay Review

EHR – Electronic Health Record

EQR– External Quality Review / External Quality Review Organization

EMR – Electronic Medical Record

FTE – Full-Time Equivalent

FUH – Follow-up After Hospitalization for Mental Illness

HSAG – Health Services Advisory Group (External Quality Review Organization contracted by MDHHS to conduct annual reviews of each PIHP)

HCBS – Home and Community Based Services

HIPAA – Health Insurance Portability and Accountability Act

HLOC – Higher Level of Care

HMP – Healthy Michigan Plan

ICO – Integrated Care Organization

I/DD – Intellectual/Developmental Disability

IP - Inpatient

IPOS – Individual Plan of Service

IRR – Interrater Reliability

KPI – Key Performance Indicator

LOCUS – Level of Care Utilization System

LTSS – Long Term Services and Supports

LRE – Lakeshore Regional Entity

MDHHS – Michigan Department of Health and Human Services

MHP – Medicaid Health Plan

MI – Mental Illness

MMBPIS – Michigan Mission Based Performance Indicator System

PAS – Preadmission Screening

PCP – Person Centered Planning

PIHP – Prepaid Inpatient Health Plan

PIP – Performance Improvement Project

QAPIP – Quality Assessment and Performance Improvement Plan

QIC – Quality Improvement Council

QI – Quality Improvement

RCA – Root Cause Analysis

RE – Risk Event

ROAT – Regional Operations Advisory Team

SE – Sentinel Event

SIS/CLS – Supports Intensity Scale/Community Living Supports

SME – Subject Matter Expert

SUD – Substance Use Disorder

Survey – Customer Satisfaction Survey

UD – Unexpected Death

UM – Utilization Management

LRE QUALITY ACCOMPLISHMENTS – FY23

Date: December 22, 2023

By: Wendi Price, CQO

LRE's Quality Accomplishments for FY23 include the following:

HSAG:

1. HSAG validated LRE's two Performance Improvement Projects (PIPs) upon first submissions for Year 1 and Year 2.
2. HSAG validated LRE's data collection and reporting processes via the PMV audit.
3. Since HSAG revised its compliance review standards in FY19, LRE received its highest audit score in FY23, which was driven by the engagement of subject matter experts from all relevant LRE departments as opposed to being managed by two LRE staff.
4. HSAG fully validated LRE's remediation efforts for audit years FY21 and FY22.

PROCESS EFFICIENCY GAINS:

1. LRE improved the efficiency of the CMHSP Site Review process by reducing the Site Review Cycle Time from 19.5 weeks to 9.1 weeks, including any CAP development by the CMHSPs, which is a 114% reduction in cycle time.
2. LRE reduced the average time for CMHSPs to enter Corrective Action Plans (CAP) Responses into LIDS from 40 hours to zero hours by leveraging technology and pivoting from LIDS to PowerBI Dashboards.
3. With MDHHS' launch of the CRM for critical incidents, LRE hand-entered all critical incidents into the CRM to minimize disruption to the CMHSPs until MDHHS solidified its technical requirements. LRE then developed a standardized CMHSP reporting template. LRE successfully operationalized the new critical incident reporting requirements in LIDS via the standardized CMHSP reporting template.
4. Master Provider Roadmap
5. LRE developed five new Quality PowerBI (PBI) Dashboards: Audits, MMBPIS, CIRE, Encounter look-up tool, and Behavior Treatment Plan Review Committee.
    a. The Audits PBI Dashboard allows for detailed aggregate data that enables LRE to pinpoint systemic issues at the CMHSP level related to clinical and credentialing processes and enables LRE to draft actionable reports for CMHSPs' remediation efforts.
    b. The Encounter look-up PBI Dashboard allows LRE to pull clinical and credentialing samples for CMHSP, SUD, and IP Site Reviews versus having the

CMHSPs and organizational providers pull samples, which reduces the administrative burden on CMHSPs and organizational providers.

6. LRE developed five new Quality PowerBI dashboards: Audits, MMBPIS, CIRE, Encounter look-up tool, which provides for faster access to data and improved data analysis related to systemic issues across Region 3 as well as at the CMHSP level.

IMPROVED QUALITY & COMPLIANCE:

1. LRE increased the number of Facilities Reviews completed by over 300%, from 80 in FY21 to 325 in FY23 by hiring and diverting auditing staff.
2. During FY23 Facilities Reviews, LRE improved compliance rates and quality of care by issuing 403 CAPs with 178, or 43%, related to HCBS non-compliance, of which 80, or 43%, were due to the use of locks/barriers and 60, or 34%, were due to non-compliant documentation standards. LRE resolved 398, or 98.8%, of the 403 CAPs from FY23.
3. LRE conducted 32 HCBS Trainings with CMHSP and the Provider Network bolstering the knowledge of and compliance with the HCBS Final Rule. LRE has noticed marked improvements in IPOS and BTP HCBS compliance at the majority of its CMHSPs. (See Attachment 1).
4. LRE's CMHSP Site Reviews resulted in an overall improvement in Credentialing Audits of over 3%.
5. LRE revised its QAPIP reporting template, and MDHHS' review of LRE's FY23 QAPIP and workplan resulted in the most favorable review ever garnered by LRE.

FY23 LRE HCBS Trainings

Date	Entity	Staff Type	Training Name
12/5/2022	Ottawa	Clinical	HCBS Final Rule Review Training
1/19/2023	WM	HCBS Leads	HCBS Final Rule Review/ IPOS requirements training
1/27/2023	WM	Clinical	HCBS Final Rule Review/ IPOS requirements training
2/23/2023	WM	Network Providers	HCBS Final Rule Review Training
2/27/2023	N180	Case Managers	HCBS Final Rule Review/ IPOS requirements training
2/27/2023	WM	Case Managers	HCBS Final Rule Review/ IPOS requirements training
3/2/2023	Region 3	Regional HCBS Leads	HCBS Final Rule Review Training
4/6/2023	Region 3	Regional HCBS Leads	HCBS Final Rule Review/ IPOS requirements training
4/21/2023	Region 3	Operations Council	HCBS Final Rule Review Training
5/23/2023	Ottawa	HCBS Leads	HCBS requirements for provisional approval, provisional consultation and review of HCBS Final Rule
6/5/2023	Ottawa	BTPRC Members	HCBS requirements for IPOS and BSP
6/21/2023	OnPoint	CLS	HCBS Final Rule Review/ IPOS requirements training
6/29/2023	Ottawa	Clinical	HCBS Final Rule Review/ IPOS requirements training
7/12/2023	Region 3	Customer Services	HCBS Final Rule Review/ IPOS requirements training
7/21/2023	LRE	Clinical	HCBS Final Rule Review/ IPOS requirements training
8/4/2023	Region 3	Clinical	HCBS Final Rule Review/ IPOS requirements training
8/10/2023	OnPoint	Contract Managers	HCBS Final Rule Review Training
8/28/2023	N180	Network Providers	HCBS Final Rule Review Training
9/6/2023	Hope Network	Compliance	HCBS Final Rule Review/ IPOS requirements training
9/18/2023	HealthWest	BTPRC Members	HCBS Final Rule Review/ IPOS requirements training
9/29/2023	OnPoint	Clinical	HCBS requirements for IPOS and BSP
10/10/2023	OnPoint	Network Providers	HCBS Final Rule Review Training
10/17/2023	N180	Clinical	HCBS Final Rule Review/ IPOS requirements training
10/23/2023	N180	Clinical	HCBS Final Rule Review/ IPOS requirements training
10/24/2023	N180	Clinical	HCBS Final Rule Review/ IPOS requirements training
10/24/2023	N180	Contract Managers	HCBS Final Rule Review/ IPOS requirements training
11/7/2023	N180	Independent Supports Coordinators	HCBS Final Rule Review/ IPOS requirements training
11/8/2023	N180	Independent Supports Coordinators	HCBS Final Rule Review/ IPOS requirements training
11/9/2023	N180	Supports Coordination	HCBS Final Rule Review/ IPOS requirements training
11/14/2023	Hope Network	Clinical	HCBS Final Rule Review/ IPOS requirements training
11/20/2023	WM	Network Providers	HCBS Final Rule Review Training
12/19/2023	N180	Supports Coordination	HCBS Final Rule Review/ IPOS requirements training

FY23 LRE HCBS Trainings by Entity

Entity	# Trainings by Entity
HealthWest	1
Hope Network	2
LRE	1
N180	10
OnPoint	4
Ottawa	4
Region 3	5
WM	5
Grand Total	**32**

FY23 LRE HCBS Trainings by Staff Type

Staff Type	# Trainings by Staff Type
BTPRC Members	2
Case Managers	2
Clinical	10
CLS	1
Compliance	1
Contract Managers	2
Customer Services	1
HCBS Leads	2
Independent Supports Coordinators	2
Network Providers	4
Supports Coordination	2
Regional HCBS Leads	2
Operations Council	1
Grand Total	**32**