QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

Annual Plan FY2023

Prepared by LRE Chief Quality Officer: February 10, 2023
Reviewed by LRE Executive Team: February 16, 2023
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*Due to inclement weather, LRE's Board of Directors did not meet in February 2023.

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I. INTRODUCTION

Lakeshore Regional Entity ("LRE") is a regional entity 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 outlines requirements for the annual QAPIP ("Quality Assessment and Performance Improvement Program") 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] It also describes how these functions are accomplished and the organizational structure and responsibilities relative to these functions.

II. PURPOSE

In addition to meeting contractual requirements, the QAPIP intends to outline functional requirements and provide guidance for operationalizing these requirements, including but not limited to:

1. Evaluating and enhancing, if appropriate, LRE's Quality Improvement ("QI") Processes and Outcomes.
2. Monitoring and evaluating the systems and processes related to the quality of clinical care and non-clinical services that can be expected to affect the health status, quality of life, and satisfaction of persons served by each Member CMHSP.
3. Identifying and prioritizing opportunities for performance improvement.
4. Creating a culture that encourages stakeholder input and participation in problem solving.

III. QUALITY IMPROVEMENT AUTHORITY AND ORGANIZATIONAL STRUCTURE

The LRE Board of Directors, which serves as LRE's Governing Board, reviews and approves the QAPIP on an annual basis thereby giving authority for the implementation of this QAPIP and all the components necessary for continuous quality improvement.

A. Governing Body

1. ***Membership:*** The LRE 15-member Governing Board includes three representatives from each of the five (5) Member CMHSP Boards of Directors. Currently, LRE Governing

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

Board has two (2) vacancies, one in OnPoint CMH (f/k/a Allegan CMH) and one in West Michigan CMSHP, which the CMHSP Boards of Directors are taking strides towards appointment to the LRE Governing Board.

2. ***Responsibilities:*** The LRE Governing Board is responsible for monitoring, evaluating, and making improvement to care including, but are not limited to:

    a. ***Oversight of the QAPIP:*** This includes documented evidence that the Governing Board has approved the overall QAPIP and QI Plan.

    b. ***QAPIP Progress Reports:*** The LRE Governing Board routinely receives written reports from the Chief Quality Officer describing performance improvement initiatives undertaken, the actions taken, and the results of those actions.

    c. ***Annual QAPIP Review:*** The LRE Governing Board formally reviews a written report on the operation of the QAPIP, at least annually.

    d. ***Adopting and Communicating Process and Outcome Improvement:*** The LRE Governing Board adopts the QAPIP via Board Motions and communicates the process and outcome improvement to stakeholders via Board of Directors meeting minutes, which are published on the LRE website for public consumption. LRE also publishes the QAPIP and QAPIP Annual Effectiveness Review on its website and provides electronic copies to all Member CMHSPs for distribution via its Newsletter to the provider network.

    e. ***Reporting Accountability:*** Following review and approval by the LRE Governing Body, the LRE CQO submits the QAPIP, QAPIP Annual Effectiveness Review, and MDHHS Governing Body Form to MDHHS on or before February 28th each year.

B. Organizational Structure

In Fiscal Year 2022, LRE reorganized its organization structure and added the role of Chief Quality Officer ("CQO") thereby enhancing LRE's organization structure to support the implementation, management, and oversight of the QAPIP. LRE's new organization structure allows for the clear and appropriate administration and evaluation of the QAPIP. Exhibit A.

C. Designated Senior Official

The LRE Chief Executive Officer ("CEO") has delegated to the Chief Quality Officer ("CQO") the responsibility for submitting a regional QAPIP to the LRE Board of Directors for final approval. LRE CEO also provides regular QAPIP updates to the Operations Advisory Council, which includes all Member CMHSP CEOs, where applicable. In addition, if issues or barriers to

operational effectiveness are identified, these are escalated to the Operations Advisory Council and/or the LRE Board of Directors for input, resolution and/or awareness.

The LRE CQO has day-to-day administrative management and oversight of the QAPIP and is responsible for keeping the LRE CEO informed of region-wide quality improvement activities and performance improvement projects. The LRE CQO also provides periodic updates to the Operations Advisory Council and LRE Board of Directors.

D. Regional Operations Advisory Teams

LRE's overall structure supports the management and oversight of the QAPIP and all components necessary for its implementation. Exhibit B.

To facilitate the implementation and management of the QAPIP, LRE created the Quality Improvement Regional Operations Advisory Team ("QI ROAT"), which consists of representation from LRE, Member CMHSPs, and other stakeholders. The QI ROAT is responsible for regularly reviewing all activities within the QAPIP. The QI ROAT members also collaborate with one another and between ROATs when any systemic or performance issues are identified to resolve said issues as efficiently and effectively as possible.

For Fiscal Year 2023, LRE created the LRE Quality Improvement Council ("LRE QIC"), which consists of the LRE Executive Team, with the charter being to regularly review all managed care functions, including all QAPIP activities, with internal stakeholders and, when necessary, external stakeholders such as the LRE Governing Board, Member CMHSPs, ROAT members, providers, etc.

IV. ACTIVE PARTICIPATION OF CONSUMERS AND PROVIDERS

LRE recognizes the importance of stakeholder input and its role in improving quality, customer experiences, and outcomes. Consumers and families are valued contributors into the Quality Improvement process. LRE supports an active Consumer Advisory Panel. There is a bi-directional feedback and input loop between LRE ROATs and the Consumer Advisory Panel to ensure consumer engagement on quality initiatives. There are multiple opportunities for consumers, or guardians, to respond to satisfaction surveys. Customer Services staff responds to any complaint, request for feedback, or request for assistance regardless of the means collected. LRE's website includes a link to allow interested parties to provide feedback on any areas of concern at any time.

Provider agency involvement is also important to the LRE Quality Improvement process. There are regular quarterly meetings open to all regional provider organizations, which allows an opportunity to share information and consider recommendations for quality improvement.

V. QUALITY MANAGEMENT SYSTEM

LRE's Quality Management System combines the traditional aspects of quality assurance and adds the elements of continuous quality improvement by utilizing the Plan-Do-Study-Act process (Attachment C).

The Quality Management System helps LRE achieve its mission, realize its vision, and live its values. It protects against adverse events, and it provides mechanisms to bring about positive change. Continuous quality improvement efforts assure a proactive and systematic approach that promotes innovation, adaptability across the region, and a passion for achieving best practices.

The *Quality Management System* includes:

1. Predefined quality standards,
2. Formal assessment activities,
3. Measurement of outcomes and performance, and
4. Strategies to improve performance that is below standards.

The various aspects of the Quality Management System are not mutually exclusive to just one category. The below table identifies the more common standards, assessment activities, measurements, and improvement strategies used by the LRE's Quality Management System.

QUALITY MANAGEMENT SYSTEM			
Quality Standards	**Assessment Activities**	**Performance Measurements**	**Improvement Strategies**
• Federal/State Rules/Regulations • Stakeholder Expectations • MDHHS/PIHP Contract • Provider Contracts • Practice Guidelines • Evidence Based Practices • Network Standards • Accreditation Standards • Network Policies/ Procedures • Delegation Agreement • Clinical Documentation Standards	• Quality Monitoring Reviews • Accreditation Surveys • Credentialing • Risk Assessment/ Management • Utilization Reviews • External Quality Reviews (HSAG) • Stakeholder Input • Sentinel Events • Critical Incident Reports • Documentation Reviews • Medicaid Verification of Service Reviews • Performance Improvement Projects • Critical Event Reporting	• MMBPIS Reports • Audit Reports • External Quality Reviews (HSAG) • MDHHS Site Reviews • Outcome Reports • Benchmarking • Grievance & Appeals	• Corrective Action Plans • Improvement Projects • Improvement Workgroups • Strategic Planning • Practice Guidelines • Organizational Learning • Administrative and Clinical Staff Training • Cross Functional Work Teams • Reducing Process Variation

VI. PERFORMANCE INDICATORS

A. Michigan Mission Based Performance Indicator System

LRE measures its performance using standardized indicators based on the systemic, ongoing collection, and analysis of valid and reliable data. Specifically, LRE utilizes the performance measure established by MDHHS, meaning the Michigan Mission Based Performance Indicator System ("MMBPIS") in the areas of access, efficiency, and outcomes, which LRE reports to MDHHS on a quarterly basis.

LRE takes great strides to ensure its Member CMHSPs MMBPIS data is valid and reliable. For every reporting quarter, LRE reviews each Member CMHSP's MMBPIS data and, while considering each submitted consumer's arc of treatment, selects samples for a quality check. Each Member CMHSP then submits its proofs for each sample selected to demonstrate compliance with the MMBPIS Code Book. Once LRE is confident its Member CMHSPs' MMBPIS data is valid and reliable, LRE directs each Member CMHSP to finalize its MMBPIS data, and LRE then aggregates the MMBPIS data for submission to MDHHS.

LRE utilizes its QAPIP to assure that each Member CMHSP meets the minimum MMBPIS performance thresholds set forth by MDHHS. On a quarterly basis, LRE aggregates, analyzes, and reviews the MMBPIS data with the MMBPIS Workgroup and QI ROAT while paying special attention to outliers and negative trends. This collaboration also seeks to identify possible causes for any outliers or negative trends. If a Member CMHSP is out of compliance in any given quarter, LRE issues a Corrective Action Plan ("CAP") and monitors the CAP through to remediation and validation ensuring quality improvement in access, efficiency, and outcomes.

B. Key Performance Indicators

LRE utilizes PowerBI to review its HEDIS® Key Performance Indicator ("KPI") Dashboard, with data sourced from the by Zenith Technology Services – ICDP – Integrated Care Delivery Platform, on a quarterly basis. LRE distributes and discusses the KPI Dashboard via the QI ROAT. Since February 2021, LRE has added two additional "slicers" to its KPI Dashboard PowerBI, the 1) Member CMHSP and 2) race/ethnicity categories in an effort to better understand the data on a Member CMHSP and race/ethnicity basis, which is necessary for the 2022 Race/Ethnicity Disparity PIP as directed by MDHHS.

VII. 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 the choosing of LRE and must be submitted to MDHHS along with the QAPIP.

LRE encourages all stakeholders to regularly submit improvement recommendations through local QI processes. During QI ROAT, LRE asks each Member CMHSP for ideas for performance improvement projects. LRE also relies upon LRE staff, ROATs, Workgroups, providers, consumers, etc. to generate ideas for potential PIPs.

LRE utilizes the Plan-Do-Study-Act process (Exhibit C) when conducting all PIPs to facilitate a statistically significant improvement that is sustainable over time.

For PIPs required by the state, LRE submits recommendations through the Operations Advisory Council. All identified PIPs will be reported through the QI ROAT, to the Operations Advisory Council and Consumer Advisory Panel.

For Fiscal Year 2023, LRE is conducting two PIPs centered on improving the HEDIS® Follow-up After Hospitalization. LRE's research suggests that an increase in the FUH metric can improve outcomes, decrease suicides, decrease recidivism, and increase satisfaction.

A. FUH Metric: Improve FUH Data Distribution, Submission, and Tracking

Upon transitioning FUH reporting from Beacon Health Options back to LRE, LRE determined it was necessary to standardize the process for distributing FUH data to the Medicaid Health Plans, submitting FUH data to MDHHS, and following up with consumers within the FUH population. This PIP intends to improve quality of care and outcomes for all consumers within the FUH population through ongoing collaboration with Medicaid Health Plans and standardized processes for the distribution, submission, and tracking of FUH data.

B. FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites

In accordance with MDHHS mandate, the LRE must choose a PIP centered on decreasing the race/ethnicity disparity in Region 3. LRE's MDHHS mandated PIP is whether targeted interventions result in significant improvement (over time) in the number of members who identify as African American/Black that receive follow-up within 30 days after an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm when compared to those similarly situated members who identify as White, meaning a decrease in the racial disparity between the two measurement groups, during the measurement period, without a decline in performance for the White members.

One risk is that LRE's interventions may raise the FUH metric for all races and may not improve the race disparity between African Americans/Blacks and White, but this is a risk that LRE is willing to accept given the positive impact that follow-up care after psychiatric hospitalization appears to provide to its members.

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

Beginning October 1, 2022, MDHHS requires all critical incidents, sentinel events, and unexpected deaths be reported via the Customer Relationship Management ("CRM") platform. LRE will utilize the required field in the CRM platform to identify the provider and exact place where a critical incident occurs. LRE will analyze this data with an eye towards protecting one of its most vulnerable populations, which is the specialized residential consumers.

LRE collects, aggregates, and analyzes all critical incidents and risk events on a quarterly basis. LRE CIRE Workgroup also reviews all sentinel events and unexpected deaths, and immediately reportable events on a monthly basis. LRE's analyses of the critical incidents, risk events, sentinel events, unexpected deaths, and immediately reportable events endeavor to determine what, if any, action is needed to remediate any problem or situation, prevent the occurrence of additional events and incidents, and ensure compliance with reporting requirements.

LRE reports these findings, outliers, and trends to QI ROAT, and, when necessary, to the Operations Advisory Council, on a quarterly basis via the LRE's Critical Incidents Monitoring Report, Risk Event Monitoring Report, Sentinel Event|Unexpected Death Timeliness Report, and Mortality Report. LRE also reports Event Reporting and Notifications to its Governing Board annually.

A. Critical Incidents

LRE captures data on critical incidents for mental health and SUD consumers, which are defined as:

1. Suicide
2. Non-Suicide Death
3. Emergency Medical Treatment due to Injury or Medication Error ("EMT")
4. Hospitalization due to Injury or Medication Error ("Hospital"),

5. Arrest of Consumer,
6. Death of Unknown Cause,
7. MAT Medication Error,
8. SUD Medication Error, and
9. Seriously Challenging Behavior.

LRE requires each Member CMHSP to submit its Critical Incidents by the 15th of each month. LRE reports to MDHHS the following Critical Incidents to MDHHS within sixty (60) days after the end of the month, except for Suicides which are reportable within thirty (30) days, in which the incident occurred for individuals who, at the time of the incident, were actively receiving services:

Service	Suicide (01)	Death (02)	EMT (03)	Hospital (04)	Arrest (05)	Death of Unknown Cause (06)	MAT Med Error (07)	SUD Med Error (08)	Serious Challenging Behaviors (09)
ACT	●	●				●			
CLS	●	●				●			
Case Management	●	●				●			
Homebased	●	●				●			
Support Coordination	●	●				●			
Wraparound	●	●				●			
Any other Service	●	●				●			
SUD Services	●	●				●	●		
Hab Waiver	●	●	●	●	●	●			
SED Waiver	●	●	●	●	●	●			
Child Waiver	●	●	●	●	●	●			
Living Situation									
Specialized Residential	●	●	●	●	●	●	●		
Child Caring Institution	●	●	●	●	●	●	●		
SUD Residential	●	●	●	●	●	●	●	●	●

B. Risk Events

LRE also captures data on events that put individuals at risk of harm, which are defined as:

1. Harm to Self,
2. Harm to Others,
3. Police Calls by Staff under Certain Circumstances,
4. Emergency Use of Physical Management, and
5. Two or More Unscheduled Admissions to a Hospital within a 12-month Period.

LRE requires each Member CMHSP to submit its Risk Event by the 15th of each month. LRE requires Member CMHSPs to report the following Risk Events to LRE within sixty (60) days after the end of the month in which the event occurred for individuals who, at the time of the event,

were actively receiving services:

Service	Harm to Self	Harm to Others	Police Calls	Physical Management	Hospitalization
Supports Coordination	●	●	●	●	●
Case Management	●	●	●	●	●
ACT	●	●	●	●	●
Home-Based	●	●	●	●	●

C. Sentinel Events and Unexpected Deaths

LRE reports sentinel events and unexpected deaths consistent with MDHHS contract requirements. Member CMHSPs, per contract, must notify LRE within 24 hours of learning of an Unexpected Death or possible Sentinel Event. Member CMHSPs have three (3) business days after the occurrence of a Critical Incident to determine if it is a Sentinel Event. If the Critical Incident is classified as a Sentinel Event, the Member CMHSP then has two (2) subsequent business days to commence a Root Cause Analysis ("RCA") of the event. LRE established that RCAs must be completed within 45 days.

The LRE CIRE Workgroup, which includes LRE's Medical Director, reviews all unexpected deaths of persons receiving specialty supports and services at the time of their death including medical examiner's reports, death certificates, and RCAs inclusive of findings and recommendations. The LRE CIRE Workgroup also aggregates all mortality data into the LRE Mortality Report to identify possible trends related to all deaths and address any issues related to quality of care.

D. Immediate Event Notification

LRE reports all Immediately Reportable Events to MDHHS according to contract and as follows:

1. Any death that occurs because of suspected staff member action or inaction or any death that is the subject of a recipient rights, licensing, or police investigation is reported to MDHHS within 48 hours of either the death, the PIHPs receipt of notification of the death, or the PIHPs receipt of notification that a rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information:

    a. Name of Beneficiary,
    b. Beneficiary ID Number (Medicaid, MiChild),
    c. Consumer I (CONID) if there is no Beneficiary ID Number,

d. Date, Time, and Place of Death (if a licensed foster care facility, include the license number),
e. Preliminary Cause of Death, and
f. Contact Person's Name and Email Address.

2. Relocation of a consumer's placement due to licensing suspension or revocation within five (5) business days of relocation.
3. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours within five (5) business days of relocation.
4. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement within five (5) business days of knowledge.
5. Any changes to the composition of the provider network organizations that negatively affect access to care within seven (7) days of any change.

IX. BEHAVIOR TREATMENT REVIEW

Member CMHSPs collect and submit Behavior Treatment/HAB Waiver data to LRE quarterly. The regional Behavior Treatment Committee ("BTC"), with representation from each Member CMHSP and LRE, convenes quarterly to review and analyze the CMHSP BTR/HAB Waiver data. The committee ensures submitted data is correct and complete and reviews the data for any trends or areas of concern. Where intrusive or restrictive techniques have been approved for use and/or where physical management or 911 calls to law enforcement in an emergency have occurred, the BTC conducts quarterly analysis of the data submitted by Member CMHSPs to identify trends and subsequent actions that may need to be taken to reduce the potential for future events. The LRE Physical Management Episode Tracking Report is reviewed quarterly by both the LRE Behavior Treatment Committee and the QI ROAT. This report allows for the review of the physical management data including the number of interventions and length of time the interventions were used per individual. LRE adheres to the provisions outlined in the MDHHS Technical Requirements for Behavior Treatment Plans Policy and the current MDHHS-PIHP Contract.[2]

X. CUSTOMER SATISFACTION ASSESSMENT

LRE requires its Member CMHSPs to deploy, at least annually, the Regional Customer Satisfaction Survey ("Survey") in a way that is representative of the individuals served, including individuals receiving long-term supports and services ("LTSS"), such as consumers receiving

[2] MDHHS, Behavioral Health and Developmental Disabilities Administration, Technical Requirement for Behavior Treatment Plans (michigan.gov).

case management and supports coordination as well as other services and supports being rendered.

The LRE Survey includes a section specifically designed for individuals within the LTSS population in addition to questions on telehealth experiences given the new modality of service delivery due to the Public Health Emergency.

The LRE Survey also provides space for individuals filling out the survey to provide comments. LRE requires Member CMHSP Customer Services staff to follow-up on any negative comments or less than desirable Survey score.

Member CMHSPs submit the Survey data to LRE and LRE aggregates and analyzes the data via a PowerBI Dashboard to identify strengths, areas for improvement, and make recommendations for action and follow up, as appropriate. LRE reviews and reports the Survey findings to the QI ROAT and Customer Services ROAT quarterly as well as the LRE Governing Board annually to improve services, processes, communication, and overall customer satisfaction.

XI. 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 ia LRE and CMHSP websites, LRE newsletter, and ROAT reviews and education.

LRE along with its Member CMHSPs developed and approved an Inter-Rater Reliability Process ensuring that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. LRE reviews all Audit Summary results in the Clinical ROAT and Utilization Management ROAT.

LRE monitors the use of established guidelines as part of its Member CMHSP Site Reviews.

XII. 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. LRE Policy # 4.4: Organizational Credentialing and Recredentialing outlines the guidelines and responsibilities for credentialing and re-credentialing provider staff and agencies.

LRE conducts Organizational Credentialing to assure each organization maintains necessary licensure and meets basic expectation for contracting. LRE requires each organization to

complete a Credentialing Application and provide proofs, such as state licensures, insurance certificates, W-9 or IRS letter, NPI enumerator documentation, accreditation certificates, fidelity bonding certificate, disclosure of ownership and controlling interest statement, etc. LRE also conducts OIG, SAM, MDHHS checks to ensure organizational providers are not excluded from doing business with LRE or its Member CMHSPs.

LRE also conducts credentialing and recredentialing for any individual or professional staff with which it directly contracts.

LRE delegates the credentialing of individual and professional staff to its Member CMHSPs. LRE oversees the Member CMHSPs' credentialing/recredentialing efforts in two ways. Quarterly, MDHHS requires LRE to submit credentialing reports for both Organizational and Individual Providers. In turn, LRE requires each Member CMHSP to submit credentialing/recredentialing data on a quarterly basis. LRE then aggregates and analyzes the credentialing/recredentialing data. LRE may, at times, collaborate with CMHSPs to ensure data integrity. Once assured the credentialing/recredentialing data is integrous, LRE submits LRE's credentialing/recredentialing data to MDHHS. Secondly, LRE also provides oversight of appropriate credentialing/ qualifications by auditing a sample of credentialed staff during its Member CMHSP Site Reviews. If LRE finds gaps in a Member CMHSP's credentialing/recredentialing efforts, LRE assigns the Member CMHSP a plan of correction. These findings are reported to LRE Executive Team, CMHSP Leadership, Provider Network ROAT, Clinical ROAT, Utilization Management ROAT, and the Quality Improvement ROAT.

LRE is attempting to incorporate quality measures into its recredentialing process by considering the extent an organization or a practitioner has been grieved, has received a less than desired Survey score, has fallen below performance indicator thresholds, which could include CMHSP Site Review results for clinical and credentialing audits, or has experienced a rise in critical incident or sentinel events. Prior to being able to implement such quality measures into the recredentialing process, LRE requires reprogramming of its EMR. Currently, LRE is developing the technical requirements for such reprogramming.

XIII. STAFF TRAINING AND DEVELOPMENT

LRE and its Member CMHSPs ensure that consumers are served by staff with adequate training, competencies, and qualifications. This function is performed across the region with materials and processes that are developed to be uniformly compliant with regulations but using procedures developed by the Member CMHSPs.

LRE requires its Member CMHSPs to identify staff training needs and provide in-service training, continuing education, and staff development activities. A regional Training Workgroup is responsible for the development of staff training and education standards to support reciprocity and efficiencies across the region.

During CMHSP Site Reviews, LRE annually audits each Member CMHSPs' adherence to LRE policies and procedures related to staff possessing the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:

1. Educational Background,
2. Relevant Work Experience,
3. Cultural Competence,
4. Certification, Registration, and Licensure as Required by Law, and
5. Training of New Personnel Regarding their Responsibilities, Program Policy and Staff Development Activities.

LRE monitors corrective action plans to ensure that the plans are implemented, and provider and agency staff are meeting training requirements.

In addition, LRE Policy 4.2 Provider Network and Contract Management describes mechanism for monitoring and assessing compliance with contract, state, and federal requirements of service providers.

XIV. MEDICAID SERVICES VERIFICATION

MDHHS requires all PIHPs to submit an annual report, due December 31, covering the claims/encounters verification process for the prior fiscal year and must describe the PIHP's Medicaid Services Verification methodology and summarize the audit results, which must contain the following required elements:

1. Population of providers,
2. Number of providers tested,
3. Number of providers put on corrective action plans,
4. Number of providers on corrective action for repeat/continuing issues,
5. Number of providers taken off corrective action plans,
6. Population of claims/encounters tested (units & dollar value),
7. Claims/Encounters tested (units & value), and
8. Invalid claims/encounters identified (units & dollar value).

LRE established a written policy and procedure for monitoring and evaluating the claims/encounters submitted by its Member CMHSPs ensuring compliance with federal and state regulations as well as the MDHHS Medicaid Verification Process technical requirements.[3]

LRE's policy and procedure consider conflicts of interest, validation of claims/encounters data, sampling methodology, audit criteria, review and reporting standards, recoupment procedures,

[3] MDHHS, Behavioral Health and Developmental Disabilities Administration, Medicaid Services Verification (michigan.gov).

corrective action plan procedures, and documentation standards, as required by the MDHHS Medicaid Verification Process policy.

In January 2022, LRE increased the frequency of its Medicaid Services Verification audits from semi-annually to quarterly and increased the sampling size across all service types. Additionally, LRE revised its report template for the Medicaid Claims/Encounters Verification Process Annual Report.

LRE's dedicated staff conducts all Medicaid Services Verification audits to verify that adjudicated claims for services rendered are sufficiently supported by clinical documentation.

XV. 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 under-utilization as well as over-utilization. LRE leverages PowerBI Dashboards to the review and analysis under and over utilization. LRE also conducts Utilization Reviews that include the review and monitoring of individual consumer records, specific provider practices, and system trends. UM data is aggregated and reviewed by the UM ROAT to identify trends and make service improvement recommendations. Findings are reported to the LRE CEO and Operations Advisory Council.

XVI. OVERSIGHT OF PROVIDER NETWORK

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. The LRE CMSHP Site Review process is a systematic and comprehensive approach to monitor, benchmark, and improve the quality of care and delivery of mental health and substance use disorder services.

During the CMHSP Site Review Process, LRE evaluates the Member CMHSPs' and external providers' compliance is the areas of

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

As a result of the CMHSP Site Reviews, LRE is able 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.
7. Ensure CAP remediation by providers.
8. Identify systemic, regional issues and develop improvement plans to improve quality of care and delivery of services.

If LRE requires a CAP, the Member CMHSP or provider has 30 days to respond. LRE either approves the CAP as written or denies it and requests more information and/or recommends additional changes. LRE has a process to review the CAP during the following year's CMHSP Site Review.

B. MDHHS Site Reviews

LRE participates in site reviews conducted by MDHHS to monitor CMHSP member performance. Upon completion of the MDHHS Site Review a CAP report, MDHHS provides LRE with its findings. When LRE receives the CAP report, it distributes to all applicable stakeholders for CAP development.

To best address local concerns, each Member CMHSP drafts CAPs for all citations for which the Member CMHSP has been identified as being out of compliance. LRE ensures that CAPs and remedial actions are implemented. LRE may rely upon Workgroups and consult with ROATS to address systemic issues that are identified by the MDHHS reviewers.

C. External Quality Reviews

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. HSAG's stated objective for the EQR is to provide meaningful information that MDHHS and the LRE can use for

1. Evaluating the quality, timeliness, and access to mental health and substance abuse care furnished by the LRE.
2. Identifying, implementing, and monitoring system interventions to improve quality.
3. Evaluating one of the two performance improvement projects of the LRE.
4. Planning and initiating activities to sustain and enhance current performance processes.

D. Facilities Reviews

LRE conducts annual Facilities Reviews for all contracted, 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 works hand-in-hand with providers to develop CAPs for non-compliant findings and assists providers in remediating these findings as efficiently as possible. LRE utilizes the aggregate data from these Facilities Reviews to determine what trainings and tools are needed at the provider level to improve the quality of care of and delivery of services to consumers.

XVII. LONG TERM SERVICES AND SUPPORTS

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 FY22, 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").[4] 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 ensuing LRE assesses the quality and appropriateness of care furnished to individuals receiving

[4] 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.

LTSS.[5]

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, LRE has contracted with an agency to conduct SIS training for all interested parties in Region 3, which will only strengthen LRE's commitment to ensuring individuals receiving LTSS receive quality, appropriate care over the long-term.

Finally, LRE has created a Personal Emergency Response System Workgroup encouraging independence among all consumers, including those receiving LTSS.[6]

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[5] 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.

[6] LRE co-leads a Regional Emergency Response System Workgroup initiated by Lynne Doyle Ottawa CMH, CEO.

XVIII. FISCAL YEAR 2023 QAPIP WORKPLAN

FY 2023 LRE QAPIP Goals and Work Plan: October 1, 2022 - September 30, 2023

QAPIP Component	Goal / Opportunity	Objectives (Specific Actions to be taken)	Responsible Party	Deadline
Performance Measures	LRE will meet and maintain the performance standards as set by the MDHHS / PIHP Contract.	1. CMHSPs will consistently meet all MDHHS MMPBIS 95% Standards for Indicator 1, 4a, & 4b, and the less than 15% Standard for Indicator 10. 2. LRE will require Plans of Correction from each CMHSP for each Indicators not meeting MDHHS Standards.	CQO Monitored By: 1. MMBPIS Workgroup 2. QI ROAT	Ongoing
Performance Measures	LRE will show improvement in the percentage of new individuals receiving a psychosocial assessment within 14 days of a non-emergent request and of new individuals starting on-going treatment following the psychosocial assessment	1. LRE QI Staff will closely monitor data CMHSPS submit for Indicators 2 and 3 analyzing out of compliance codes looking for trends. and improvement opportunities. 2. LRE MMBPIS training is scheduled for January 2023. Data codes will be reviewed and discussed for the purpose of a regionwide understanding of code definitions. This will improve the ability of LRE QI Staff to monitor and accurately trend the MMBPIS data. 3. Add CAP provision for any downward trend for more than 2 quarters in a row. 4. Integrate MDHHS Performance Indicator Thresholds, once established.	CQO Monitored By: 1. MMBPIS Workgroup 2. QI ROAT	9/30/2023
Performance Improvement Projects	LRE will implement two PIP projects that meet MDHHS Standards. Formal PIP: FUH Metric: Decrease in Racial Disparity between Whites and African American/ Blacks Baseline Data for FY2022: submitted to HSAG July 2022 FUH_ Adults and Children who identify as African American/Black: 60.2% FUH_Adults and Children who identify as While: 70.9%	1. The objective for the PIP is that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African-Americans/ Blacks) will demonstrate a significant increase over the baseline rate without a decline in performance to the comparison subgroup (Whites). 2. LRE will develop improvement strategies and interventions to impact this performance indicator outcomes and achieve significant improvememt. 3. LRE will work with the five CMHSPs within Region 3 to implement agreed upon interventions	CQO Monitored By: 1. QI ROAT	9/30/2023
Performance Improvement Projects	LRE will implement two PIP projects that meet MDHHS Standards. 2nd PIP: FUH HEDIS Measure: The percentage of discharges for patients 6 years of age or older who were hospitalized for treatment of selected mental illness or intentional self harm diagnoses and who had follow-up visit with a mental health provider within 30 days of discharge. Baseline FUH Data: TBD	1. LRE will develop workflows for ADT data dissemination, follow-up after discharge, and CMHSP weekly data submission requirements. LRE will also develop an FUH error report for dissemination to and remediation by its CMHSPs at least bi-monthly. 2. The objective for the PIP is to demonstrate a significant increase over the baseline rate for all consumers to which FUH applies. 3. LRE will develop improvement strategies and interventions to impact this performance indicator outcomes and achieve significant improvememt. 4. LRE will work with the five CMHSPs within Region 3 to implement agreed upon interventions.	Provider Network Staff (#1) CQO (#2-#4) Monitored By: 1. FUH Workgroup (#1) 2. UM/Clinical ROAT (#1) 3. QI ROAT (#2-#4)	9/30/2023
Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Management	Ensure contractual requirements are being met in Sentinel Events, Critical Incidents, and Risk Events.	LRE will 1. Analyze and monitor CIRE data to ensure data completeness, accuracy, and timeliness. 2. Determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. 3. Monitor CMHSPs for follow-up of remediations efforts with providers, as needed.	CQO Monitored By: 1. CIRE Workgroup 2. QI ROAT	Ongoing

Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Management	LRE delegates the process of review and follow-up of sentinel events to the CMHSP. LRE will continually monitor the five regional CMHSP's sentinel event and unexpected death processes ensuring timeliness of reporting, completion of RCAs and follow up as required per contract.	LRE will monitor the following: 1. CMHSPs will notify the LRE of a possible sentinel event / unexpected death within 24 hours of their knowledge of event. 2. CMHSPs have 3 business days to determine if the event is a sentinel event. 3. CMHSPs have 2 business days to commence an RCA if the event was determined to be a possible sentinel event / unexpected death. 4. CMHSPs have 48 ours to submit the completed unexpected death/ SE form to the LRE following completion of the RCA. 5. LRE will follow-up to ensure remediation of issues found through the RCA within 90 days following receipt of the RCA.	CQO (#1-#4) Provider Network Staff (#5) Monitored By: 1. CIRE Workgroup 2. QI ROAT	Ongoing
Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Management	LRE will review and monitor CIRE events by type of incident and facility incident occurred.	MDHHS is implementing a new CIRE process using MiCAL/CRM for FY23. 1. LRE will develop a new process for submitted the CIRE data to MDHHS by 3/31/2023. 2. CMHSPs will consistently submit their CIRE data to LRE by the 15th of reporting month. 3. LRE IT will develop a Power BI report for CIRE data by 8/30/2023. 4. LRE will monitor CIRE data using the Power BI report looking for trends with incident types and /or facilities by 8/30/2023. Previous to the development of the Power BI, LRE will continue to monitor through Excel processes.	IT Staff (#1) CQO (#2-#4) Monitored By: 1. CIRE Workgroup 2. QI ROAT	9/30/2023
Critical Incidents, Sentinel Events, Unexpected Deaths, and Risk Management	LRE will monitor mortality data over time.	1. LRE QI Staff will review mortality data looking for trends in the causes of natural deaths and unexpected deaths. (suicide, accidental, homicide) 2. Mortality data report trends and issues will be discussed quarterly at the CIRE Workgroup and semi annually at the QI ROAT.	CQO Monitored By: 1. CIRE Workgroup 2. QI ROAT	Ongoing
Behavior Treatment Review	LRE will review and analyze behavior treatment review committee physical management data by individual and length of time for each instance of physical management used in an emergency behavioral crisis.	1. CMHSPs will submit physical management data for every instance of physical management used in an emergency behavioral health crisis to the LRE at least quarterly. This data will be reported by: • individual (separately for each instance), • include demographics of population, • Hab Waiver: Yes/No, • Behavior Plan: Yes/No, and • Time per instance will be reported in minutes and seconds. 2. LRE QI Staff will aggregate physical managment data quarterly. • quarterly data will be reviewed for trends, issues, and performance improvement opportunities. • quarterly reports and analysis will be reviewed and discussed by Behavior Treatment Workgroup and QI ROAT. 3. LRE QI Staff will work with IT staff to have the Phyical managment data in Power Bi by 9/30/2023	CQO (#1-#2) IT Staff (#3) Monitored By: 1. LRE Behavior Treatment Workgroup 2. QI ROAT	9/30/2023

Member Experience with Services	LRE will complete quantitative and qualitative assessments of member experiences with its services.	1. Implementation of the LRE Satisfaction Survey process has been delegated to the CMHSPs within Region 3. CMHSPs will collect satisfaction survey data using the LRE Satisfaction Survey. CMHSPs will submit satisfaction survey data vai FastLane. 2. Customer Services Staff will run quarterly satisfaction survey reports using Power BI. 3. Customer Services Staff will review the quarterly satisfaction survey data, analyzing for trends/ issues. Customer Services Staff will present quarterly reports to CS ROAT and QI ROAT. 4. Customer Services Staff will review all survey comments and follow up with the individual who completed the survey. Follow up will be documented and reviewed for trends / issues. 5. Annually, LRE will collect information from CMHSPs on any focus groups held during the year and the results/ findings from the group.	Customer Services Staff Monitored By: 1. CQO 2. QIC 3. Customer Services Workgroup 4. QI ROAT	9/30/2023
Grievance and Appeals	Provider grievances, appeals and NABD's will be compliant with MDHHS Standards and Policy.	1. Establish policy and procedure to conduct quarterly grievance, appeals, and NABDs audit at the CMHSP level to ensure compliance with Federal regulations and State reqirements.	Customer Services Staff Monitored By: 1. CQO 2. QIC 3. Customer Services Workgroup 4. QI ROAT	9/30/2023
Practice Guidelines	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.	1. CPGs will be reviewed and updated two times a year by the LRE Medical Director and the Clinical / UM Department staff. 2. CPG information will be disseminated to the provider network through various educational opportunities as well as links to the LRE CPGs via CMHSP and LRE Websites. 3. Disseminate the Clinical Practice Guidelines to its Regional Provider Network via LRE newsletter at least annually.	UM Staff Monitored By: 1. CQO 2. QIC 3. Clinical ROAT 4. QI ROAT	9/30/2023
Credentialing and Re-Credentialing	Enhance the credentialing/recredentialing process through successful implementation of the MDHHS CRM Universal Credentialing Module.	QAPIP Standards require that credentialing data be regularly reviewed 1. A credentialing data report will be developed by January 2023. 2. QI with LRE Credentialing Staff will review and monitor the credentialing data report monthly to identify trends and areas of concern. 3. Credentialing data report will be presented to the QI ROAT quarterly to discuss trends and areas of concerns. 4. Identified trends and areas of concern will be discussed with Provider Network Managers and a improvement plan to address and work on these with the Providers and CMHSPs will be developed as needed.	Credentialing Staff Monitored By: 1. QIC 2. QI ROAT	4/1/2023
Credentialing and Re-Credentialing	Develop specifications for developing a credentialing/recredentialing module within LIDS and reports with the assistance of PCE Systems that complies with MDHHS Provider Credentialing Policy.	1. Work with Stakeholder to identify unmet needs related to Master Provider Database. 2. Interface with PCE to ensure tranfer of technical requirements to functional module.	IT Staff CQO Monitored By: 1. Credentialing Staff 2. QI ROAT	9/30/2023
Credentialing and Re-Credentialing	Develop a process for integrating grievances, appeals, performance indicators, critical incidents, etc. into the recredentialing process.	1. Establish procedures to integrating grievances, appeals, performance indicators, critical incidents, etc. into the recredentialing process.	CQO Monitored By: 1. QIC 2. Credenialing Staff 3. QI ROAT	9/30/2023

Credentialing and Re-Credentialing	Develop a process for tracking, reporting, and monitoring Credentialing & Recredentialing Efforts. Organizational: # applications, # approvals, # denials/basis for denials, # revoke/basis for revocation, # closed/basis for closure, # of consumer affected by revocation/closures, timeliness of approvals/denials. Individual: Site Review data analysis - trainings, credentialing, first aid, etc. - trends/outliners - what did LRE do to support the CMHSPs/Provider Network when negative trends/outliers were found, timeliness of approvals/denials.	QAPIP Standards require that credentialing data be regularly reviewed 1. A credentialing data report will be developed by January 2023. 2. QI with LRE Credentialing Staff will review and monitor the credentialing data report monthly to identify trends and areas of concern. 3. Credentialing data report will be presented to the QI ROAT quarterly to discuss trends and areas of concerns. 4. Identified trends and areas of concern will be discussed with Provider Network Managers and a improvement plan to address and work on these with the Providers and CMHSPs will be developed as needed.	CQO Monitored By: 1. QIC 2. Credenialing Staff 3. QI ROAT	9/30/2023
Credentialing and Re-Credentialing	LRE will monitor the CMHSPs credentialing/recredentialing through the annual site review process. LRE will monitor its Organizational credentialing/recredentialing via internal audits. <u>Background:</u> LRE received recommendation from HSAG that the PIHP use the information it obtains through its ongoing monitoring of quality data and member concerns Ii.e. grievances, appeals, etc.) as part of the re-credentialing decision -making process.	1. FY23 Credentialing Site Review Tools will be updated in order to better reflect measurement and tracking of member CMHSP's re-credentialing of individual practitioners. a. <u>For Individual Provider Re-credentialing:</u> LRE will modify its FY23 Credentialing Site Review Tools to require CMHSP to utilize FY22 and FY23 quarter-to-date grievance reports during the re-credentialing of individual providers. 2. <u>For Organization Re-credentialing:</u> LRE will utilize FY22 and FY23 quarter-to-date grievance reports during re-credentialing of providers. 3. Update all relevant policies, procedures, forms, checklists, etc.	Credentialing Staff QI Staff Monitored By: 1. QIC 2. QI ROAT	Ongoing
Verification of Services	The LRE will complete Medicaid Verification of services reimbursed by Medicaid as required by MDHHS Contract.	LRE will: 1. Complete quarterly Medicaid Verification Reviews based on a sample of Medicaid paid claims from each of the five regional CMHSPs and their larger providers. 2. Complete quarterly Medicaid Verifications reports with analysis of findings. (reviewed by the QI ROAT). 3. Prepare and submit an annual Medicaid Verification report to MDHHS that includes claim verification methodology, findings, and actions taken in response to findings.	CQO Monitored by 1. MEV Staff 2. QI ROAT	Ongoing
Utilization Management	LRE will continue to establish and develop mechanisms to detect over/under utilization of services across its provider network by leveraging Information Technology to develop Power Bi Dashboards which will provide real-time highly quantitative date and service utilization reports by 10/1/2023.	1. Reports will be developed to review the lower 15% and the upper 15% using claims and authorization data for HLOC and SIS/Community Living Supports. 2. LOCUS dashboards will be developed to identify outliers for scores of 14 and below as well as scores of 20 and higher.	UM Staff Monitored by: 1. UM/Clinical ROAT 2. CQO	9/30/2023
Oversight of Provider Network	LRE will ensure CMHSP Site Review Tools comply with Federal regulations and State requirement.	1. Review 42 CFR 438 monthly to ensure Federal reglations have not changed and if they do, document such changes so as to incorporate in the CMHSP Site Review Tools for the following audit year.	CQO	Ongoing

Long Term Services and Supports (LTSS)	LRE will monitor services and supports for individuals receiving Long Term Services and Supports (LTSS)	1. A section of the LRE Satisfaction Survey has questions specifically for individuals receiving LTSS. Surveys questions will be aggregated and monitored quarterly using the Power BI platform. Survey data will be analized for trends and issues. Any issues found will be addressed. 2. LRE QI staff complete an annual CMHSP Site Review of each of the five CMHSPS in Region. 3. Clinical chart reviews are completed as part of this process.-, including specific Waiver Review Questions. Waiver questions will be aggregated by question and reviewed/analyzed for trends and issues. These trends /issues will be addressed with the responsible CMH with a required CAP with individualized remediation required. 4. QI I Staff complete annual facility reviews of specialized residential facilities. Specialized Residential facilities will be reviewed and monitored for HCBS required Standards. 5. Incorporate LTSS into UM Plan.	CQO UM Staff Monitored By: 1. UM ROAT 2. Clinical ROAT 3. QI ROAT	Ongoing

XIX. MDHHS GOVERNING BODY FORM

Governing Body Form

To be completed by the PIHP and submitted to MDHHS along with its annual QAPIP submission no later than February 28th of each year.

Name of PIHP		
Lakeshore Regional Entity		
List of members of the Governing Body (add additional rows as needed)		
Name	**Credentials**	**Organization** (if applicable)
1. Mark DeYoung	LRE Board Chair, Allegan County Commissioner, Allegan CMH Board Chair	OnPoint CMH (f/k/a Allegan CMH)
2. Linda Garzelloni	LRE Board Co-Chair, Retired CEO Hackley Community Care,	HealthWest
3. Jane Verduin	LRE Board Secretary, Physical Health Provider	West Michigan CMH
4. Alice Kelsey	LRE Board Member	OnPoint CMH (f/k/a Allegan CMH)
5. Janet Thomas	LRE Board Member, Lawyer, HW Board Chai	HealthWest
6. Patricia Gardner	LRE Board member, Kent County Judge	Network180
7. Stan Stek	LRE Board Member, Kent County Commissioner, N180 Board Member	Network180
8. Jack Greenfield	LRE Board member, Retired Provider Network (MOKA	Network180
9. Sara Hogan	LRE Board Member, Director of Administration (Benjamin's Hope) Provider Network,	Ottawa CMH
10. Richard Kanten	LRE Board Member, LRE OPB	Ottawa CMH
11. Susan Meston	LRE Board Member, Teacher/Principal	Ottawa CMH
12. Ron Bacon	LRE Board Member, WM CMH Board Member	West Michigan CMH

13. Ron Sanders	LRE Board Member	West Michigan CMH
Changes to membership during the past year: **Directors no longer on LRE Board:** Peg Driesenga, John Snider, Matt Fenske, Shaun Raleigh, Jacquie Johnson, Steven Gilbert, Dawn Rodgers-DeFouw		
Date the Governing Body approved the annual QAPIP (prior SFY QAPIP evaluation, current SFY QAPIP description, and current SFY QAPIP work plan)*		
Date:		
Dates the Governing Body received routine written reports from the QAPIP (during the prior SFY; add additional rows as needed)*		
Date:		
Date:		
Date:		
Date:		
MDHHS Feedback		

*The PIHP should be prepared to submit Governing Body meeting minutes and written reports to MDHHS upon request.

XX. ACRONYMS

BBA – Balanced Budget Act

BTC – Behavior Treatment Committee

BTP – Behavior Treatment Plan

CAP – Corrective Action Plan

CAFAS – Child and Adolescent Functional Assessment Scale

CEO – Chief Executive Officer

CIRE – Critical Incidents & Risk Events

CQO – Chief Quality 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

EQR– External Quality Review / External Quality Review Organization

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

HMP – Healthy Michigan Plan

ICO – Integrated Care Organization

I/DD – Intellectual/Developmental Disability

IPOS – Individual Plan of Service

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

MHL – MI Health Link Demonstration Program

MHP – Medicaid Health Plan

MI – Mental Illness

MMBPIS – Michigan Mission Based Performance Indicator System

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

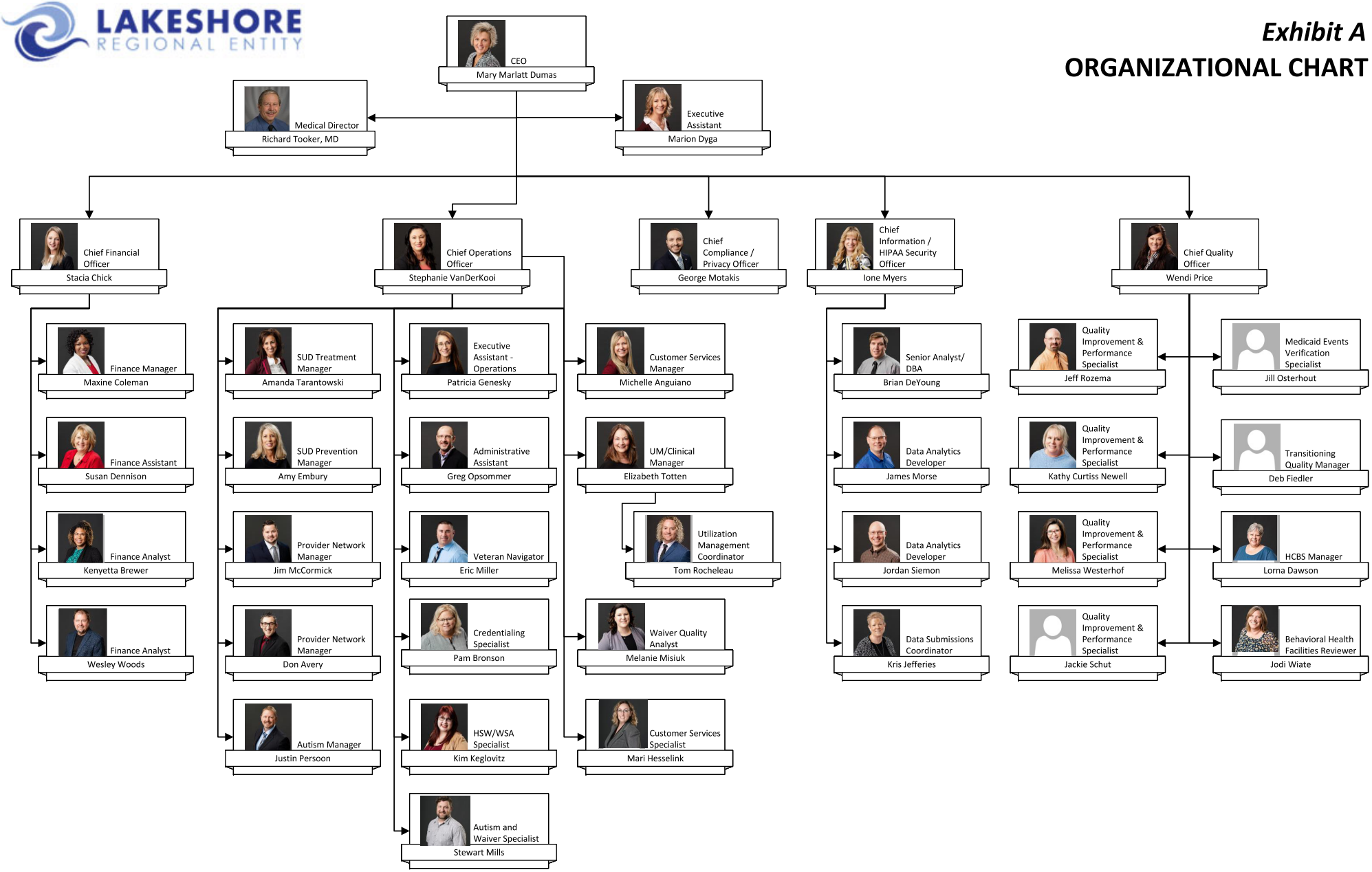
ROAT – Regional Operations Advisory Team

Survey – Customer Satisfaction Survey

UM – Utilization Management

LAKESHORE REGIONAL ENTITY

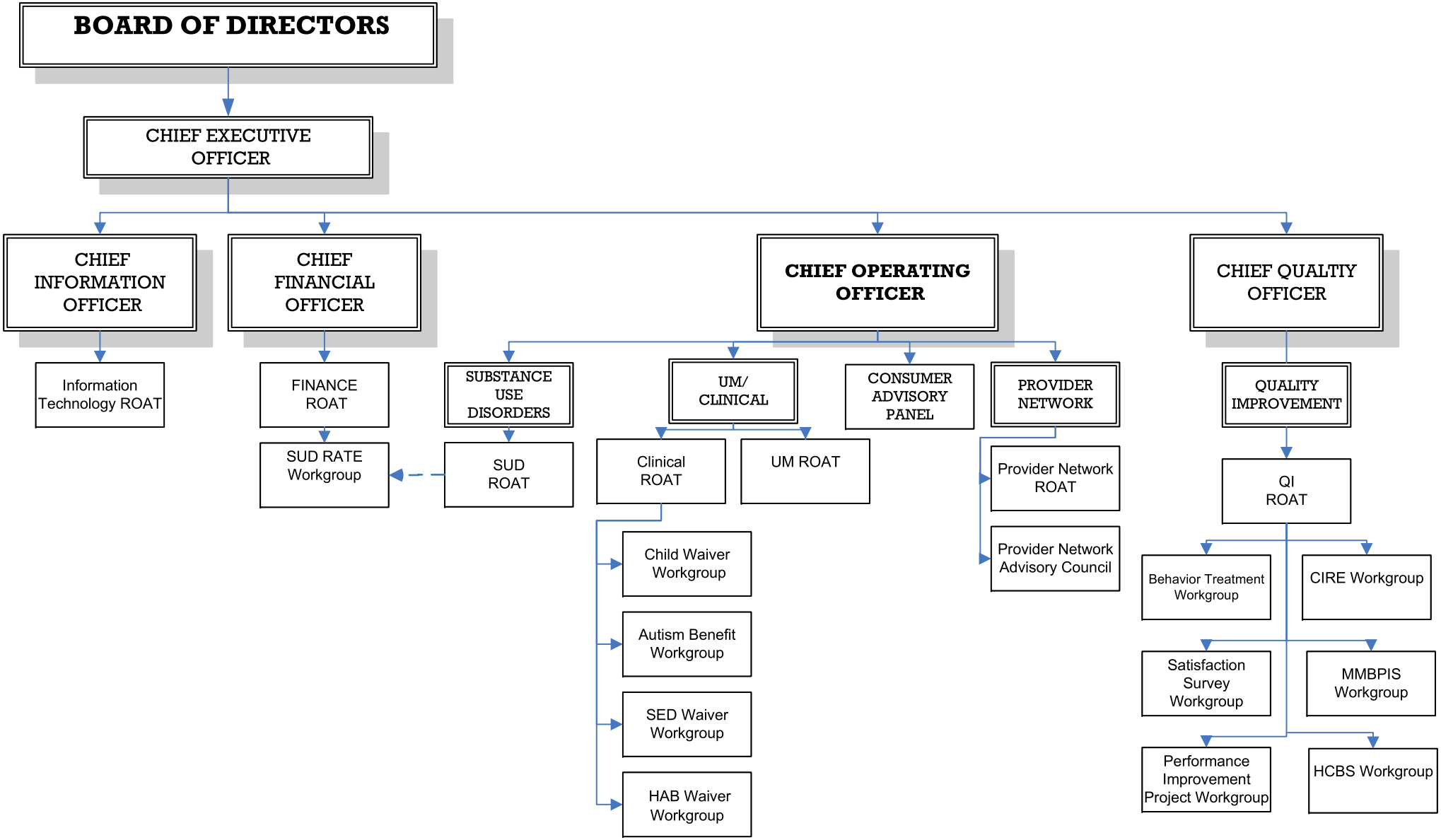
Exhibit A
ORGANIZATIONAL CHART



LAKESHORE REGIONAL ENTITY

Exhibit B

ROAT STRUCTURE



The Plan-Do-Study-Act (PDSA) process is a problem-solving approach commonly used in quality control efforts. It is oftentimes referred to as the Deming Cycle. There are four steps to the process and the process can be repeated indefinitely until the desired outcome is achieved:

1. ***Plan:*** design (or revise) a process to improve results

2. ***Do:*** implement the plan and measure its performance

3. ***Study:*** measure and evaluate the results and determine if the results meet the desired goals

4. ***Act:*** decide if changes are needed to improve the process. If so, then start the process over.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

FY22 QAPIP Annual Effectiveness Review

Prepared by LRE Chief Quality Officer: February 10, 2023
Reviewed by LRE Executive Team: February 16, 2023
Reviewed by LRE Board of Directors: March 22, 2023*
Submitted to MDHHS: February 27, 2023

*Due to inclement weather, LRE's Board of Directors did not meet in February 2023.

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I. INTRODUCTION

Lakeshore Regional Entity ("LRE") is a regional entity 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 QAPIP ("Quality Assessment and Performance Improvement Program") 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 2022 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
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 FY22 QAPIP Review 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 FY22 MMBPIS Goal is 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 aggregate for FY22, LRE met or exceeded its goal for all MMBPIS Indicators with established thresholds, except for Indicator 4a for children, which returned a compliance rate of 93.2%, 1.8% below the established threshold (Attachment A).

Indicator #	Indicator Description	Population Group	# Quarters MDHHS Standards Met	% of Quarters MDHHS Standards Met	LRE Annual Average Score Per Indicator
1	**Pre-admission Screening Disposition 3 hours or less**	Child	4 out of 4	100%	99.0%
		Adult	4 out of 4	100%	98.4%
2	**Request to Assessment within 14 days** *Note: In April 2020, MDHHS revised this indicator and no longer allows exceptions. 95% Standard removed.*	MI Child			66.2%
		MI Adult			64.1%
		DD Child			71.2%
		DD Adult			53.2%
		LRE Total			64.7%
3	**Assessment to Start of Ongoing Services within 14 days** *Note: In April 2020, MDHHS revised this indicator and no longer allows exceptions. 95% Standard removed.*	MI Child			63.2%
		MI Adult			63.6%
		DD Child			69.4%
		DD Adult			69.9%
		LRE Total			64.5%
4a	**Follow-up Within 7 Days of Inpatient Discharge**	Children	1 out of 4	25%	93.2%
		Adults	4 out of 4	100%	95.9%
4b	**Follow-up Within 7 Days of SUD Discharge**	SUD	3 out of 4	75%	97.3%
10	**Inpatient Recidivism**	Children	3 out of 4	75%	10.8%
		Adults	4 out of 4	100%	9.6%

Table 1. LRE FY22 MMBPIS Performance

On a quarterly basis, LRE met or exceeded the established thresholds 82.1% of the time, which is down from FY21 and on par with FY19 and FY20.

LRE FY22 MMBPIS Performance Indicators 1, 4a, 4b, 10				
	FY19	**FY20**	**FY21**	**FY22**
# of Indicators Met	56/76	46/52	28/28	23/28
% of Indicators Met	**73.6%**	**88.5%**	**100%**	**82.1%**

Table 2. LRE Longitudinal Trend – Indicators 1, 4a, 4b, & 10

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

LRE analyzed the data for the three Indicators that fell below the established thresholds for any given quarter in FY22 and determined the following:

1. *Indicator 4a for Children.* LRE fell below the 95% threshold for three out of four quarters (Q2 92.1%, Q3 89.1%, Q4 93.3%) with 14 out of 162 cases being out of compliance for these quarters. LRE determined that the out of compliance cases were due to Staff Canceling (1), Lack of Staff/Wait List (9), Failure to Schedule Timely (4). Staffing concerns continue to plague Region 3. For those cases where staff cancelled or staff failed to timely schedule the follow-up appointment, Member CMHSPs, as part of the corrective action plans, have trained and re-educated staff of the 7-day follow-up appointment requirement.

2. *Indicator 4b.* LRE fell below the 95% threshold for in FY22 Q2, 94.8%, with 5 out of 96 cases being out of compliance during this quarter. LRE determined that the out of compliance cases were due to Failure to Schedule Timely (5). For these cases, Member CMHSPs, as part of the corrective action plans, have trained and re-educated staff of the 14-day follow-up appointment requirement.

3. *Indicator 10 for Children.* LRE rose above the 15% threshold for FY22 Q2, 18.3%, with 11 out of 60 cases being out of compliance count during this quarter. After reviewing each out of compliance case through an arc of treatment lens, LRE determined that for four of these readmissions, parents/guardians either chose not to utilize Member CMHSP services post-discharge (2) or the consumer did not keep the follow-up appointment (2), which was scheduled within the 7-day standard. For the remaining seven cases, LRE assessed that in each case, Member CMHSPs scheduled timely follow-up appointments post-discharge, consumers attended the follow-up appointments, consumers engaged in services, but these consumers did readmit for medical necessity.

2. Indicators 2a and 3

LRE analyzed the data for Indicators 2a and 3, which do not have established thresholds, on an aggregate, annual basis to determine if performance declined over time. *Graph 1.*

LRE determined that over the past four quarters, Indicators 2a and 3 have declined over time and then analyzed the FY22 data for reasons for the decline. *Table 3.*

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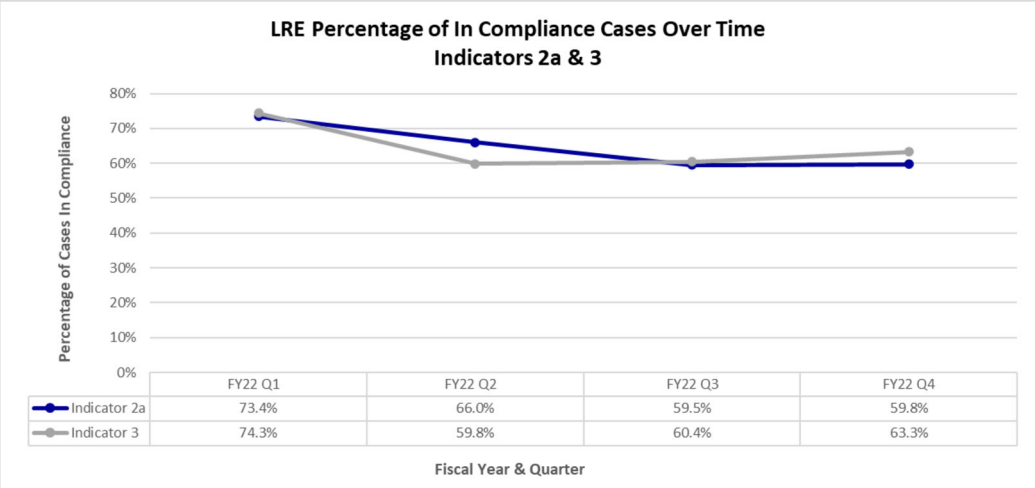


Graph 1. LRE FY22 Trend – Indicators 2a & 3

2a Exception Code	2a Exception Code Description	Count	%
NS	No Show	429	24%
SI	Staff issues or resource shortage	409	23%
CD	Client Choice of Date	166	9%
SY	System Issue	154	9%
RC	Rescheduled by client	150	8%
DI	Documentation Issue - no explanation or missing	127	7%
CC	Client Canceled	100	6%
UR	Unable to reach client to schedule within timeframe	77	4%
OT	Other	50	3%
CX	Cleint Choice not to use CMHSP/PIHP Services	36	2%
RS	Rescheduled by staff	24	1%
CP	Client Choice - agency or therapist	21	1%
NR	Client Not Reachable to schedule ever	17	1%
SC	Staff canceled	17	1%

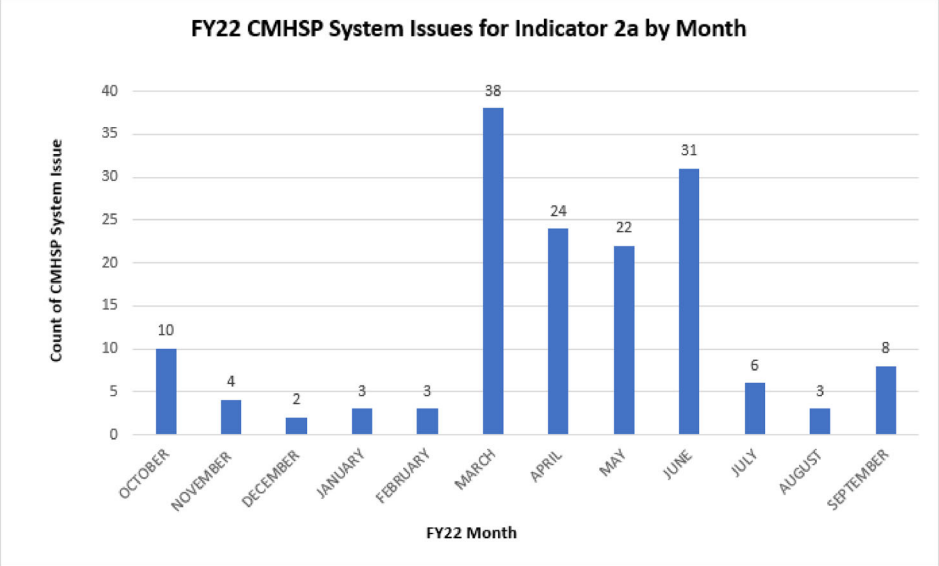
Table 3. Exception Codes for Non-Compliant Cases – Indicator 2a

i. Indicator 2a

LRE attributes the decline in Indicator 2a to two primary codes Consumer Did Not Show Up for Appointment (24%) and Staff Shortages (23%), which contributed greatly, almost 50%, to the overall reason for out of compliance cases for Indicator 2a. LRE's analysis also found that Client's Choice of Appointment Date (9%), CMHSP System Issue (9%), and Appointment Rescheduled by Consumer (8%) contributed another 26% to the out of compliance cases.

The LRE QI ROAT discusses the trending of Indicator 2a data and the out of compliance codes contributing to the decline in the Indicator 2a compliance rate. The LRE QI ROAT bifurcates the out of compliance codes into those that the Member CMHSPs have the ability to influence and those that cannot be included by Member CMHSP intervention.

Based on its review, the QI ROAT agrees that the single out of compliance code that can be influenced by Member CMHSP intervention is the CMHSP System Issue. Further investigation into this code found that a single Member CMHSP's contributed primarily to the out of compliance cases for Indicator 2a due to the fact that the Member CMHSP's implemented a new electronic medical record ("EMR"). LRE can confirm that over time, as the Member CMHSP finalized its implementation of its new EMR, the impact of the CMHSP System Issue code on out of compliance cases for Indicator 2a have lessened. *Graph 2.*



Graph 2. Impact of CMHSP System Issue - Indicator 2a

ii. Indicator 3

LRE attributes the decline in Indicator 3 to three primary codes Staff Shortages (27%), Consumer Did Not Show Up for Appointment (20%), and Documentation Issues – no explanation or missing (10%), which contributed greatly, almost 60%, to the overall reason for out of compliance cases for Indicator 3. Table 4. LRE's analysis also found that Client's Choice of Appointment Date (9%) also contributed to the out of compliance cases.

As with Indicator 2a, the LRE QI ROAT discusses the trending of Indicator 3 data and the out of compliance codes contributing to the decline in the Indicator 3 compliance rate.

Based on its review, the QI ROAT agrees that the single out of compliance code that can be influenced by Member CMHSP intervention is the Documentation Issue. LRE found that the majority of documentation issues are generated by three Member CMHSPs. LRE monitors quarterly MMBPIS submissions for improvement in Documentation Issues.

3 Exception Code	3 Exception Code Description	Count	%
SI	Staff issues or resource shortage	381	27%
NS	No Show	274	20%
DI	Documentation Issue - no explanation or missing	143	10%
CD	Client Choice of Date	125	9%
SY	System Issue	83	6%
RC	Rescheduled by client	82	6%
UR	Unable to reach client to schedule within timeframe	80	6%
CC	Client Canceled	78	6%
CX	Client Choice not to use CMHSP/PIHP Services	36	3%
NR	Client Not Reachable to schedule ever.	34	2%
OT	Other	32	2%
RS	Rescheduled by staff	18	1%
SC	Staff canceled	18	1%
CP	Client Choice - agency or therapist	10	1%
CT	Client Canceled - due to Transportation	1	0%

Table 4. Exception Codes for Non-Compliant Cases – Indicator 3

LRE. in collaboration with its Member CMHSPs. work diligently to find solutions to staff shortages and will continue to do so in Fiscal Year 2023.

LRE partially achieved its FY22 MMBPIS Goal.

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's FY22 Performance Improvement Projects Goal to identify two PIPs that meet MDHHS' expectation for the next 3 years. For Fiscal Year 2023, LRE is conducting two PIPs centered on improving the HEDIS® Follow-up After Hospitalization. (Attachments B & C). LRE's research suggests that an increase in the FUH metric can improve outcomes, decrease suicides, decrease recidivism, and increase satisfaction.

A. FUH Metric: Improve FUH Data Distribution, Submission, and Tracking

After transitioning Managed Care Functions from Beacon Health Options back to LRE in June 2022, LRE determined it was necessary to standardize the process for distributing FUH data to the Medicaid Health Plans, submitting FUH data to MDHHS, and following up with consumers

within the FUH population.

LRE created a cross-functional FUH Workgroup that includes Provider Network Management, Information Technology, Utilization Management, and all Member CMHSPs to develop the technical requirements for reporting tools and processes/procedures to improve timeliness for FUH. Currently, LRE's FUH reporting process is highly manual.

To date, the FUH Workgroup has developed an error report that LRE runs and reviews weekly with feedback distributed to Member CMHSPs, if applicable. The FUH Workgroup is also standardizing procedures for complex FUH reporting issues such as when Member CMHSPs do not receive discharge paperwork in a timely manner from the in-patient facility, which can be 2-3 days.

The FUH Workgroup meets weekly and has developed an FUH Roadmap that guides activities and produces intentional planning by all FUH Workgroup members.

B. FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites

In accordance with MDHHS mandate that LRE chose a PIP centered on decreasing the race/ethnicity disparity in Region 3, LRE's race/disparity PIP is whether targeted interventions result in significant improvement (over time) in the number of members who identify as African American/Black that receive follow-up within 30 days after an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm when compared to those similarly situated members who identify as White, meaning a decrease in the racial disparity between the two measurement groups, during the measurement period, without a decline in performance for the White members.

LRE created a PowerBI Dashboard that utilizes Region 3's FUH data and applies filters that allow LRE to monitor FUH with and without a race/ethnicity lens by Member CMHSP. LRE continues to monitor FUH metrics while the FUH Workgroup solidifies a standardized process for Member CMHSP reporting to the LRE and the distribution of data to MHPs.

LRE continues developing interventions for deployment across Region 3 during the first measurement period, which runs from January 1, 2023 to December 31, 2023.

LRE has achieved its FY22 PIP Goal.

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

LRE's FY22 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 meeting contractual requirements. LRE has achieved its FY22 goal through timely and accurate reporting of its critical incidents to MDHHS for the entirety of Fiscal Year 2022. LRE developed a tool used to monitor Member CMHSP timeliness of reporting sentinel events and unexpected deaths to LRE. This tool, along with training, has improved timeliness and review standards as LRE entered FY23.

Midway through FY22, as a result of MDHHS' implementation of its Customer Relationship Management ("CRM") platform, LRE established a secondary goal to develop a comprehensive Critical Incident and Risk Event reporting module in collaboration with PCE Systems, LRE's EMR vendor, that interfaces with MDHHS' CRM. It should be noted that LRE has utilized MDHHS' CRM when reporting FY23 Q1 critical incidents, sentinel events, and unexpected deaths, albeit through manual entry.

Beginning October 1, 2022, MDHHS requires all critical incidents, sentinel events, and unexpected deaths be reported via MDHHS' CRM, which interfaces with PCE Systems for data transfer. LRE does not utilize PCE Systems for its Critical Incident reporting because the PCE Systems is not programmed to manage Risk Event data along side the Critical Incident data. LRE has commissioned PCE Systems to enhance its Critical Incident module to include the ability to handle Risk Event data seamlessly. When PCE Systems completes the necessary programming, LRE will test it to ensure it meets LRE's technical requirements. Since LRE does not currently utilize PCE Systems for Critical Incident reporting, LRE hand-entered the FY23 Q1 critical incidents, sentinel events, and unexpected deaths into MDHHS' CRM. While a laborious process, LRE identified opportunities for enhancements to MDHHS' CRM and shared these enhancements with MDHHS during a collaboration meeting. LRE is well on its way of reaching its goal of developing a comprehensive Critical Incident and Risk Event reporting module.

A. Critical Incidents

For FY22, LRE experienced a total of 365 critical incidents, which is a decrease of 26 compared to FY21. (Attachment D). During FY22, LRE reviewed and discussed Critical Incidents with QI ROAT quarterly.

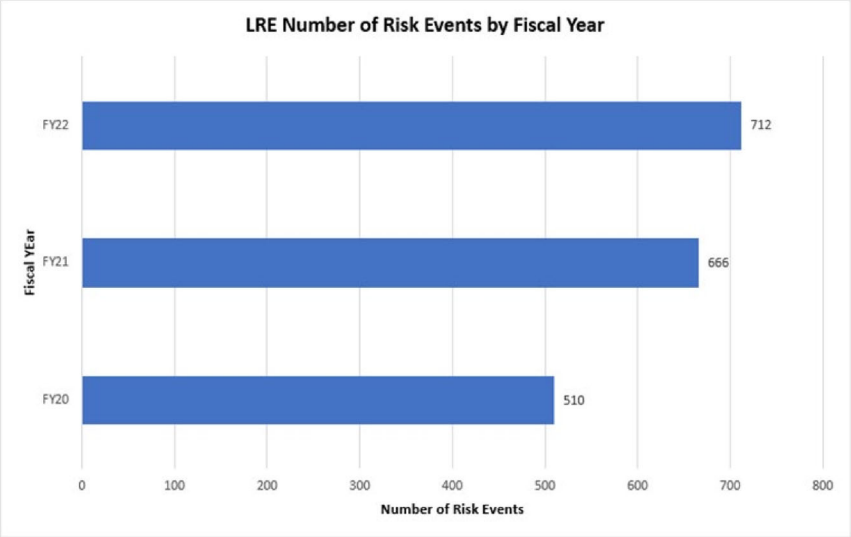
LRE analyzed the critical incident data and determined the following when comparing FY22 to FY21:

1. Suicides increased by 5 to a total of 13.
    a. Member CMHSPs experienced the following suicide counts:
        i. HealthWest: 2
        ii. OnPoint: 1
        iii. Ottawa: 1
        iv. Network 180: 4
        v. West Michigan: 4
2. Accidental Deaths decreased from 22 to 18.
3. Homicides increased to 1.
4. Injuries Requiring Emergency Medical Treatment increased by 3 to 183.
5. Medication Errors Requiring Emergency Medical Treatment decreased from 5 to 3.
6. Injuries Requiring Hospitalization decreased from 12 to 8.
7. Medication Errors Requiring Hospitalization remained unchanged at 1.
8. Arrests increased by 6 to 23.

In considering residential treatment providers in its Critical Incident analysis, LRE determined that for those incidents for which it has provider specific data no provider trends could be derived from the data.

B. Risk Events

For FY22, LRE experienced a total of 712 risk events, which is an increase of 46 compared to FY21. (Attachment E). LRE has experienced an increase in risk events for three years in a row. Graph 3.



Graph 3. LRE Longitudinal Trend – Risk Events

LRE analyzed the risk event data and determined the following when comparing FY22 to FY21:

1. Self Harm decreased by 4 to a total of 79.
2. Harm to Others decreased from 14 to 10.
3. Emergency Use of Physical Management increased by 54 to 394.
4. Police Calls by Staff Under Certain Circumstances decreased from 188 to 164.
5. Two or More Unscheduled Admissions to a Hospital within a 12-month Period increased by 30 to 68.

During FY22, LRE reviewed Risk Events with QI ROAT quarterly and specifically discussed the rationale for the increase in risk events for three straight fiscal years. Based on LRE's analysis and the QI ROAT's review and discussion, LRE determine that a single Member CMHSP primarily contributed to the increase in Risk Events for FY22 and the Member CMHSP acknowledged that the increase in the Emergency Use of Physical Management and Police Calls by Staff Under Certain Circumstances were related to one consumer. That specific Member CMHSP has developed protocols to reduce these two Risk Events for the one consumer.

C. Sentinel Events and Unexpected Deaths

In FY22, LRE experienced 40 Sentinel Events and Unexpected Deaths. Upon analysis, LRE determined that the three categories dominating the Region's Unexpected Deaths relate to 1) Overdose resulting in Accidental Death (28%), 2) Accidental (20%), and 3) Suicide (20%). Table 5. LRE also determined that the most vulnerable population serviced as it relates to Sentinel Events and Unexpected Deaths is the Mentally Ill Adult population (50%). Table 6.

LRE FY22 Sentinel Event & Unexpected Death by Category

Category	Count	%
Overdose Resulting in Accidental Death	11	28%
Accidental	8	20%
Suicide	8	20%
Potential Sentinel Event	3	8%
Other Sentinel Event	3	8%
Medication Error	2	5%
Choking	1	3%
Fall	1	3%
Vehicle Accident	1	3%
Homicide	1	3%
Fall	1	3%
Grand Total	**40**	

Table 5. LRE FY22 SE|UD by Category

LRE FY22 Sentinel Event & Unexpected Death by Population

Population	Count of	%
MIA	20	50%
SUD	5	13%
IDD	4	10%
MIA/SUD	4	10%
DDA	2	5%
DDA/Hab	2	5%
IDD/DDA	2	5%
None	1	3%
Grand Total	**40**	

Table 6. LRE FY22 SE|UD by Population

In FY22, LRE also reviewed the Sentinel Events|Unexpected Deaths timeliness and reporting standards and evaluated its Member CMHSP performance related to these standards. LRE developed a Sentinel Events|Unexpected Deaths timeliness reporting tool, revised its Sentinel Events|Unexpected Deaths reporting template, and created a Regional training on Critical Incidents, Risk Events, Sentinel Events, and Unexpected Deaths. (Attachment F). LRE also

revised its Mortality Report. One weakness of the Mortality Report is the lag time in requesting and receiving a death determination. LRE anticipates MDHHS' CRM platform will assist Region 3 in having better visibility to Sentinel Events and Unexpected Deaths in FY23.

LRE has achieved its FY22 Event Reporting and Notifications Goal.

VI. BEHAVIOR TREATMENT REVIEW

LRE's FY22 Behavior Treatment Review Goal is 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.

In FY22, LRE determined that its Member CMHSPs conducted 781 BTRs for an average of 150 consumers with the vast majority of these reviews relating to 1) Harm to Self (36%), 2) Harm to Others (35%), and 3) Property Damage (19%).

LRE conducts quarterly reviews with the Behavior Treatment Workgroup. Member CMHSPs are reporting Progressing or Stable status for 54% of consumers with BTPs and Regression or No Change for 22% for the same population. Table 7.

Effectiveness of Behavior Treatment Plan	Count	%
Stable	268	34%
Progress	152	20%
New Request	145	19%
Regression	83	11%
No Change	83	11%
Improperly Implemented	29	4%
Not Implemented	19	2%

Table 7. FY22 LRE – Effectiveness of Behavior Treatment Plans

Member CMHSPs are also reporting that each Member CMHSP's Behavior Treatment Review Committee is recommending continuation of existing BTPs almost 90% of the time with only 4% of BTPs being recommended for updates. Table 8.

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

Recommendations for Behavior Treatment Plans	Count	%
Continued	689	88%
New Plan Approved	39	5%
Update Approved	30	4%
Discontinued	11	1%
Interim Plan Approved	6	1%
Continued with Recommendations	4	1%
New Plan with Recommendations	2	0%
No Plan	2	0%
Interim Plan Approved with Recommendations	0	0%
New Plan Not Approved	0	0%

Table 8. FY22 LRE – Recommendations for Behavior Treatment Plans

LRE has achieved its FY22 Behavior Treatment Reviews Goal.

VII. CUSTOMER SATISFACTION ASSESSMENT

LRE's FY22 Customer Satisfaction Assessment Goal was to deploy the Regional Customer Satisfaction Survey ("Survey"), which was revised in FY21 according to recommendations received from Health Services Advisory Group ("HSAG"), and create in PowerBI Dashboard to maximize data analysis and transparency. Attachment G.

In FY22, LRE's Member CMHSPs received 1,917 complete Surveys for all services types, populations, and races/ethnicities. Of the 1,917 completed Surveys, 1,495 Surveys were for 30 identified providers and 422 completed Surveys did not identify the provider by name.

The results for LRE's FY22 Survey, which is based on a scale of 1 to 6 with 6 being "Strongly Agree," are as follows:

Member CMHSP	FY22 Overall Survey Score
HealthWest	n/a
OnPoint	5.1
Ottawa	5.2
Network 180	5.3
West Michigan	5.0
LRE	***5.3***

Table 9. FY22 LRE – Survey Results

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

a. *Access and Availability.* Consumers agree that service locations and hours promote access and availability of services (5.3). Consumers mildly agree that the services being offered are what they need/want (3.9).

2. *Quality of Services.* Consumers agree that they feel included in the Person Centered

Planning ("PCP") process as well as supported and accepted by staff (5.2 ➔ 5.4)

3. *Long Term Services.* Consumers agree that they are satisfied with case management services (4.8). Consumer mildly agree that they are satisfied with their current housing situation (4.4).
4. *Experience with Telehealth.* Consumers mildly disagree that their telehealth experiences were satisfactory (3.4).
5. *Outcomes.* Consumers agree that their services helped them and that they are satisfied with their services (5.3).

Generally, consumers appear satisfied with the access to services, quality of services, and service outcomes. LRE admits that consumers appear less than satisfied with their telehealth experiences, current housing situations, and choices of services. LRE will continue to gather, monitor, and analyze Survey measures in FY23 to see if these less than satisfied Survey measures repeat for FY23.

LRE has achieved its FY22 Customer Satisfaction Assessment Goal.

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 FY22 Clinical Practice Guidelines Goal was to develop an Inter-Rater Reliability process between LRE and its Member CMHSPs to ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. LRE in collaboration with its Member CMHSPs approved an Inter-Rater Reliability Process.

LRE monitors the use of established guidelines as part of its Member CMHSP Site Reviews.

LRE has achieved its FY22 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.

LRE's FY22 Credentialing Goal was to develop a process for tracking and reporting Credentialing findings. Due to MDHHS' implementation of a Universal Credentialing System, LRE revised

its original FY22 Credentialing Goal to successfully implement the Universal Credentialing System in Region 3.

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 Member CMHSP staff in an effort to support a seamless transition starting in FY23.

Through the FY22 Audit, HSAG identified two improvements necessary to ensure the highest quality of care and services for consumers. HSAG recommended that LRE 1) integrate quality measures into its recredentialing process and 2) ensure credentialing/recredentialing proofs were primary source verified.

LRE has embarked on developing a Master Provider Database for Region 3 providers which will support incorporating quality measures into its recredentialing process. Quality measures may include the extent an organization or a practitioner has been grieved, has received a less than desired Survey score, has fallen below performance indicator thresholds, which could include CMHSP Site Review results for clinical and credentialing audits, or has experienced a rise in critical incident or sentinel events. Prior to being able to implement such quality measures into the recredentialing process, LRE requires reprogramming of its EMR. Currently, LRE is developing the technical requirements for such reprogramming.

LRE has changed its process for verifying credentialing/recredentialing proofs and now only accepts primary source verified documents.

In FY22, LRE and its Member CMHSPs credentialed 337 providers and recredentialed 201 providers.

Provider Type	Initial Credentialing	Recredentialing
Organization	104	72
Individual	233	138

Table 10. FY22 LRE – Credentialing Efforts

LRE has achieved its FY22 Credentialing Goal.

X. MEDICAID SERVICES VERIFICATION

LRE's FY22 Medicaid Services Verification Goal was to develop and implement a revised Medicaid Verification Process that comports with MDHHS Medicaid Services Verification technical requirements.[2]

[2] MDHHS Medicaid Verification Process Policy, Behavioral Health and Developmental Disabilities Administration, Medicaid Services Verification (michigan.gov), Section V. Reporting, p. 3, revised July 29, 2020.

LRE established and published a written policy for monitoring and evaluating the claims/encounters submitted by its Provider Network for Medicaid and Healthy Michigan Plan recipients ensuring compliance with federal and state regulations as well as the MDHHS Medicaid Services Verification technical requirements.

A. Non-SUD Services

During Fiscal Year 2022, LRE performed Medicaid Services Verification audits on 7,186 non-SUD claims/encounters totaling $1,474,378.90 Medicaid dollars. LRE determined that $6,301.78, or 0.43%, was subject to recoupment.

Audit Period	*Total Medicaid Dollars*	*Amount Recouped*	*% Recoupment*
FY 22 Quarter 1	$670,348.10	$318.07	0.05%
FY 22 Quarter 2	$460,237.88	$4,748.68	1.03%
FY 22 Quarter 3	$273,021.00	$1,062.59	0.39%
FY 22 Quarter 4	$343,519.90	$172.44	0.05%
Total	**$1,474,378.90**	**$6,301.78**	**0.43%**

For Fiscal Year 2022, LRE's Medicaid Services Verification audit efforts encompassed 7,186 claims/encounters across 30 different service types, 1,565 consumers, and five distinct population groups for 80 unique providers.

In Fiscal Year 2022, 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/providers 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.

In Fiscal Year 2022, Region 3 providers performed well during the LRE Medicaid Services Verification audits. Overall, LRE audited a total of 7,186 claims/encounters and found a total of 39 non-compliant claims/encounter. Of these 39 claims/encounters, the following issues were found:

REASON FOR NON-COMPLIANCE	*COUNT*	*CAUSE*	*OUTCOME*
Claim/Encounter was Double Billed	16	CMHSP Implemented New EMR/Billing Process	Recoupment
Insufficient Documentation	7		Recoupment
Missing Documentation	12	Documentation found in 8 of 12 cases	Recoupment of 4
Services not in IPOS	4	Crisis Services	Recoupment

One CMHSP mistakenly double billed 15 claims/encounters, which were immediately recouped. The CMHSP stated that the double billing was attributed to the implementation of a new EMR and billing process that has since been resolved with the EMR vendor.

LRE recouped all funds related to the seven (7) claims/encounters where documentation was insufficient to support the claim/encounter. For the 12 claims/encounters where no documentation could be located, CMHSPs/Providers were able to locate missing documentation that supported the service in eight (8) of the 12 claims/encounters; LRE recouped funds for four (4) remaining claims/encounters. Finally, LRE recouped funds for the four (4) claims/encounters where the services provided were not included in the IPOSs.

B. SUD Services

During Fiscal Year 2022, LRE performed Medicaid Services Verification audits on 159 SUD claims/encounters totaling $21,990.80 Medicaid dollars. LRE determined that $38.50, or 0.18%, was subject to recoupment.

Audit Period	*Total Medicaid Dollars*	*Amount Recouped*	*% Recoupment*
FY 22 Oct 2021 - Jun 2022	$21,990.80	$38.50	0.18%
Total	**$21,990.80**	**$38.50**	**0.18%**

For Fiscal Year 2022, LRE's Medicaid Services Verification audit efforts for SUD Services encompassed 159 claims/encounters across 15 different service types, 69 consumers, and two distinct population groups for 23 unique providers.

LRE issued one CAP due to the fact that one SUD Treatment provider stated it could not retrieve clinical documentation due to a "glitch" in its EMR. Prior to FY22, LRE did not 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.

For FY22, Region 3 SUD providers performed above expectations during the LRE Medicaid Services Verification audits. Overall, LRE audited a total of 159 encounters and found a total of 7 non-compliant claims/encounters. Of these 7 claims/encounters, the following issues were found:

REASON FOR NON-COMPLIANCE	*COUNT*	*CAUSE*	*OUTCOME*
Missing Documentation	5	No Cause Given	Recoupment
Missing Documentation	2	"Glitch" in EMR - CAP issues	Paid by GF

LRE has achieved its FY22 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 under-utilization as well as over-utilization.

LRE's FY22 Utilization Management Goal was to develop PowerBI Dashboards and reports for reviewing and analyzing under and over utilization.

LRE, in collaboration with its Member CMHSP and the FUH Workgroup has developed four Utilization Management PowerBI Dashboards to identify under and over utilization quickly and efficiently: Higher Level of Care ("HLOC"), Level of Care Utilization System ("LOCUS"), Supports Intensity Scale/Community Living Supports ("SIS/CLS"), and Follow-up After Hospitalization for Mental Illness ("FUH"). LRE reviews the reports with the UM and Clinical ROATs monthly ensuring consumers are matched with services and supports that meet their level of care needs thereby providing each consumer the opportunity to overcome barriers and maximize outcomes.

LRE has achieved its FY22 Utilization Management Goal.

XII. OVERSIGHT OF PROVIDER NETWORK

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 FY22 CMHSP Site Review Goals were to 1) develop Site Review tools that comport with federal, state, and regional regulations and requirements within LRE's EMR and 2) deploy the new CMHSP Site Review tools and process.

LRE created entirely new Site Review tools in the following categories and deployed them in LRE's EMR:

1. Desk Audits for Administration of Managed Care Functions
2. Program Specific Audits.
3. Clinical Chart Audits.
4. Credentialing Audits.
5. Training Audits.

LRE also continued to conduct validation audits for the following:

1. MMBPIS
2. Critical Incidents
3. Risk Events
4. Medicaid Services Verification
5. Behavior Treatment Plans

During the CMHSP Site Review Process, LRE evaluates the Member CMHSPs' and external providers' compliance in the areas of

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

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

LRE FY22 CMHSP Site Review: Scores by Member CMHSP					
CMHSP Site Review Audit Type	**HealthWest**	**On Point**	**Ottawa**	**Network 180**	**West Michigan**
Desk Audit. Administration of Managed Care Functions	93.40%	91.90%	97.30%	98.40%	99.00%
Program Specific Standards	96.40%	96.30%	95.90%	98.60%	96.90%
Non-Waiver/Autism Clinical Charts	92.70%	95.10%	95.00%	98.20%	96.60%
Non-Waiver/Non-Autism Staff Training	89.60%	95.10%	99.70%	98.10%	97.10%
Non-Waiver/Non-Autism Staff Credentialing	95.20%	96.40%	95.80%	92.60%	97.70%
Autism Clinical Charts	95.90%	95.10%	90.10%	91.90%	88.40%
Autism Training/HR	91.60%	91.60%	95.50%	96.10%	98.30%
SEDW Clinical Charts	97.40%	89.30%	62.90%	91.00%	90.00%
SEDW Training/HR	79.30%	96.00%	94.60%	96.40%	82.70%
HSW Clinical Charts	88.80%	96.50%	93.90%	95.90%	78.50%
HSW Training/HR	89.20%	78.10%	88.30%	92.00%	88.60%
CWP Clinical Charts	93.80%	92.60%	90.30%	95.60%	81.40%
CWP Training/HR	90.80%	91.20%	86.20%	89.50%	70.70%
MEV Validation	99.50%	100%	99.90%	100%	100%
MMBPIS Validation	99.00%	100%	100%	100%	100%
CIRE Validation	95.50%	100%	95.50%	100%	93.50%
Comprehensive Score	**93.00%**	**93.70%**	**93.90%**	**95.90%**	**94.80%**

Member CMHSPs performed well given the breath and depth of changes to the Site Review tools. Due to the changes of its CMHSP Site Review tools, LRE could not complete a longitudinal trend for CMHSP Site Review performance.

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 has achieved its FY22 CMHSP Site Review Goal.

B. MDHHS Site Reviews

LRE's FY22 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 Member CMHSP level. LRE is now working to validate CAP remediation efforts at the Member CMHSP level.

LRE has achieved its FY22 MDHHS Site Review Goal.

C. External Quality Reviews

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 FY22 HSAG Audit Goals were to 1) integrate 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 conducts its Audit in three parts:

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

1. Performance Measurement Validation

For FY22, HSAG validated LRE's Performance Measurements and found:

1. No concerns with LRE's receipt and processing of eligibility data.
2. No major concerns with how LRE received and processed claim/encounter data for submission to MDHHS.
3. Lakeshore had sufficient oversight of its five affiliated CMHSPs.

HSAG commended LRE on the following strengths:

1. Lakeshore demonstrated appropriate oversight, implementation, and monitoring of CAPs that had been implemented with its CMHSPs throughout the measurement period.
2. Lakeshore deployed significant data quality improvement mechanisms throughout the prior year, investing in a data warehouse and more real-time monitoring of its data through Power BI technology. The PIHP demonstrated strength in its efforts to maintain closer oversight of its data, including CMHSP-reported data, through the use of the new Power BI dashboards, ensuring ongoing monitoring of data completeness and accuracy.

HSAG also noted two opportunities for LRE to improve:

1. While Lakeshore has strong CMHSP oversight processes in place, HSAG observed some individual user error in documentation of system data, which could potentially result in errors in reporting.
2. After reviewing the final BH-TEDS data submitted by MDHHS, HSAG noted 13 Lakeshore member records with discrepant employment and minimum wage BH-TEDS data.

2. Performance Improvement Projects Validation

FY22 is a baseline development year for both of LRE's PIPs.

HSAG approved LRE's race/ethnicity PIP titled FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites. LRE will determine whether targeted interventions result in significant improvement (over time) in the number of members who identify as African American/Black that receive follow-up within 30 days after an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm when compared to those similarly situated members who identify as White, meaning a decrease in the racial disparity between the two measurement groups, during the measurement period, without a decline in performance for the White members.

3. Compliance Review

In July 2022, HSAG conducted it Compliance Review of LRE. LRE's SMEs prepared HSAG tools and proofs.

LRE scored as follows:

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VII—Provider Selection	16	16	13	3	0	**81%**
Standard VIII—Confidentiality	11	11	9	2	0	**82%**
Standard IX—Grievance and Appeal Systems	38	38	33	5	0	**87%**
Standard X—Subcontractual Relationships and Delegation	5	5	3	2	0	**60%**
Standard XI—Practice Guidelines	7	7	6	1	0	**86%**
Standard XII—Health Information Systems	12	11	9	2	1	**82%**
Standard XIII—Quality Assessment and Performance Improvement Program	30	30	26	4	0	**87%**
Total	**119**	**118**	**99**	**19**	**1**	**84%**

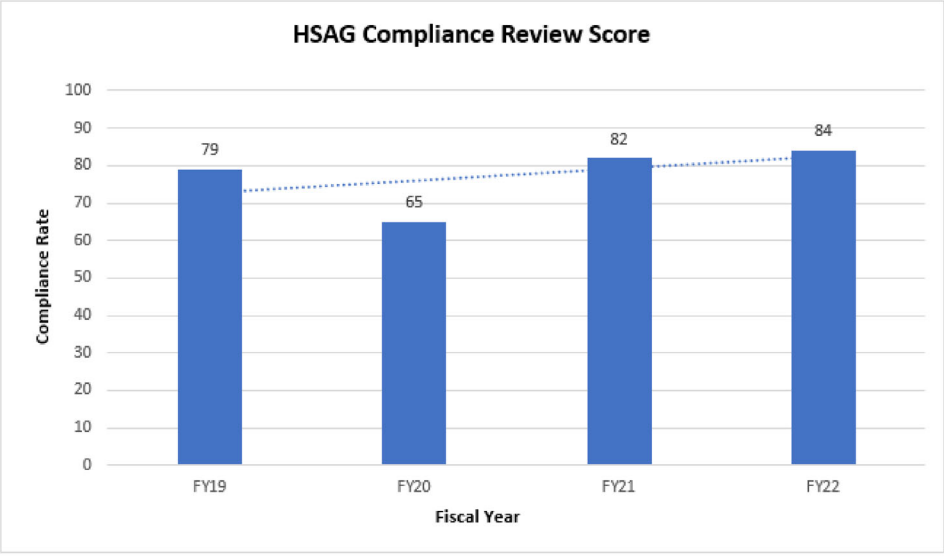
M = Met; NM = Not Met; NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

While LRE failed to score above an 87% on any given Compliance Review Standard, LRE's FY22 performance surpassed that of the last three years as shown below:



Graph 6: LRE Longitudinal Trend – HSAG Compliance Review Scores

LRE has achieved its FY22 HSAG Goals.

D. Facilities Reviews

LRE also maintains oversight of its Provider Network by conducting annual Facilities Reviews for all contracted, 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 FY22 Facilities Review Goals were to 1) incorporate audit questions regarding the Home and Community Based Services ("HCBS") Final Rule into the Facilities Review tool and 2) and launch Facilities Review tools within LRE's EMR.

LRE revised its Facilities Review tool by incorporating audit questions pertaining to the HCBS Final Rule to mitigate risk to the Provider Network as it relates to Heightened Scrutiny settings. LRE has completed Facilities Reviews for all settings on the HCBS Heightened Scrutiny list as dictated by MDHHS.

In FY22, LRE conducted approximately 225 Facilities Reviews and determined that providers required education and training regarding the HCBS Final Rule. Table

Audit Section	Audit Question	Percent
HCBS	13b. If restrictions affect other members of the home, each resident in the home has documentation of the restriction in the IPOS documenting how they can overcome the restriction	50%
Facility Review	11. Odor-Free	67%
HCBS	6. All bedrooms have appropriate keyed locks (individually keyed, non-locking against egress)	88%
HCBS	12b. If restrictions exist, the individual(s) in the home requiring a restriction has documentation of health/safety rationale in the IPOS.	89%
HCBS	13a. If there are residents with a Behavior Management Plan are the restriction(s) documented in the Behavior Management Plan and are all staff trained?	91%
Health and Safety Review	1. Freezer temperature < 0 degrees	94%
HCBS	3. Home is free from locked gates outside the home.	94%
Health and Safety Review	2. Refrigerator temperature < 40 degrees	95%
HCBS	2. Home is free of Lock/Alarms on exterior doors	95%
Health and Safety Review	11p. Is there a Checklist to monitor bag routinely reviewed (at least quarterly), initialed/dated))	95%

Table 11. LRE FY22 Facilities Reviews

The most common out of compliance element is the lack of documentation in IPOSs for restrictions contrary to the HCBS Final Rule. LRE issued CAPS for all elements found to be out of

compliance. LRE has also developed HCBS trainings and conducted many Region-wide training sessions with Member CMHSP, providers, and clinical staff.

LRE's efforts related to Facilities Reviews ensures consumers are placed in settings that are healthy and safe with minimal barriers, unless a restriction is deemed medically necessary or appropriate.

Where applicable, LRE collaborates with its Member CMHSP and LARA Licensing.

LRE has achieved its FY22 Facilities Review Goal.

XIII. LONG TERM SERVICES AND SUPPORTS

LRE's FY22 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 FY22, 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").[3] 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 ensuing LRE assesses the quality and appropriateness of care furnished to individuals receiving LTSS.[4]

LRE also ensures all individuals, including those receiving LTSS, receive a LOCUS/CAFAS upon

[3] 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.

[4] 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.

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, LRE has contracted with an agency to conduct SIS training for all interested parties in Region 3, which will only strengthen LRE's commitment to ensuring individuals receiving LTSS receive quality, appropriate care over the long-term.

Finally, LRE has created a Personal Emergency Response System Workgroup encouraging independence among all consumers, including those receiving LTSS.[5]

LRE has achieved its FY22 Long Term Services and Supports Goal.

[5] LRE co-leads a Regional Emergency Response System Workgroup initiated by Lynne Doyle Ottawa CMH, CEO.

XIV. ACRONYMS

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

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

EQR– External Quality Review / External Quality Review Organization

EMR – Electronic Medical Record

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

IPOS – Individual Plan of Service

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

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

RE – Risk Event

ROAT – Regional Operations Advisory Team

SE – Sentinel Event

SIS/CLS – Supports Intensity Scale/Community Living Supports

SME – Subject Matter Expert

Survey – Customer Satisfaction Survey

UD – Unexpected Death

UM – Utilization Management