MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Quality Assessment Performance Improvement Program Evaluation

Year End Report FY 2023- QTR1 2024

Approval History:

Entity	Approval Date
Approved by MCCMH Board of Directors	02/28/2024

Contents

Introduction

The MCCMH Prepaid Inpatient Health Plan (PIHP) is required by the Michigan Department of Health and Human Services (MDHHS) to maintain a Quality Assessment and Performance Improvement Program (QAPIP). The final approval of the QAPIP lies with MCCMH's Governing Body, its Board of Directors. The previous QAPIP remains in effect until the new one is finalized. The final QAPIP will be disseminated to the Board, the Citizen Advisory Council, and the MCCMH provider network. The QAPIP will be posted on the MCCMH website and provided to the public upon request.

Board input and approval are necessary components of the QAPIP. The Board will receive quarterly progress reports on focus areas of the QAPIP through various presentations on the specific projects identified in the QAPIP. MCCMH's QAPIP Evaluation is not all inclusive as there are many improvement activities ongoing throughout the organization.

Organizational Quality Structure

The QAPIP is managed by the MCCMH Quality Committee. The Quality Committee ensures that MCCMH's Mission and strategic plan are interwoven with all policies and procedures throughout the network. The Committee oversees the various subcommittees and functions of the MCCMH QAPIP. The Committee identifies and addresses specific issues in need of remediation and reviews on-going activities of the various subcommittees. Grievances and appeals are tracked, and the trends reported to the Quality Committee. The Committee also reviews input from persons served utilizing satisfaction surveys, forums, and other forms of stakeholder input. All committee meeting minutes are continuously monitored and integrated into the overall Quality Improvement Program. Formal actions related to the QAPIP are taken to the Board at least annually through the QAPIP report.

The Committee's objectives are to improve quality, maximize clinical outcomes, reduce cost, and increase efficiency in service delivery. Through collaboration amongst the departments, the Quality Committee is responsible for oversight of ongoing implementation of quality indicators, processes and outcomes across Macomb County Community Mental Health as defined through the goals of the QAPIP.

QAPIP Work Plan Evaluation

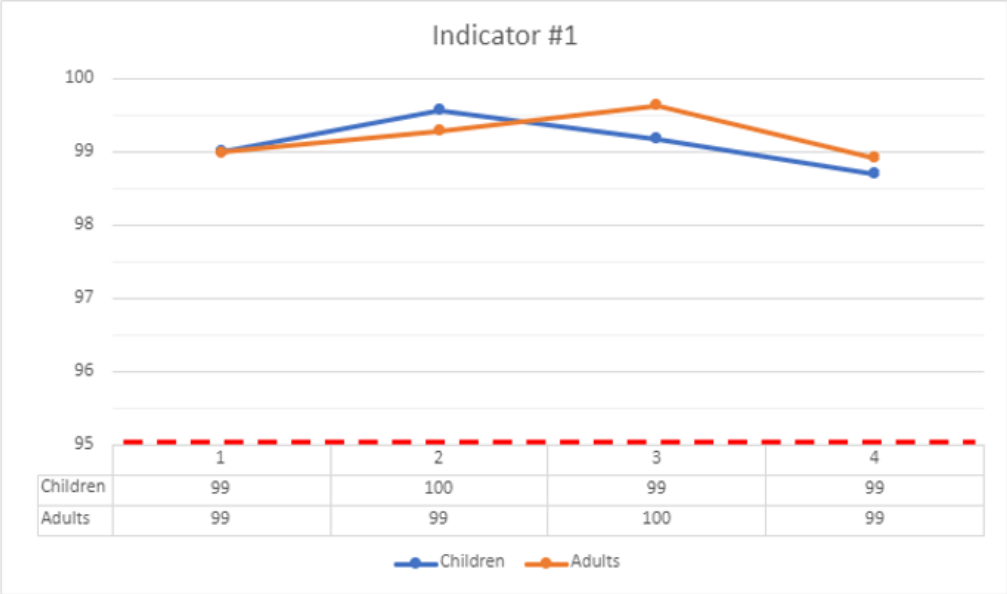
Key Performance Indicators

MCCMH works to ensure all Federal, State, and Local contractual obligations are met. MCCMH is responsible for oversight of established Key Performance Indicators (KPI) measures based upon Michigan's Mission-Based Performance Indicator System (MMBPIS) developed by MDHHS. Standards for performance measure compliance for FY23 were based on the MMBPIS Codebook. Indicator 1, 4a, and 4b have a standard of 95% or better and Indicator 10 has a standard of 15% of less. Revisions to the Reporting Codebook were made in preparation for FY24. Revisions included establishing PIHP specific benchmarks for Indicator 2, 2e, and 3. Standard percentiles were created based on the FY22 period and reported on an annual basis. The information and tables below depict MCCMH's FY 23 reported

indicator data, regional trends for areas considered out of compliance, and strategies to improve performance measures and overall access to care.

Performance Indicator Overview:

Indicator #1:
(95% Standard: Met)
The percentage of persons served during 2023 receiving pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. MCCMH consistently met this performance measure. In FY23, MCCMH exceeded the MDHHS performance measure standard of 95%, achieving 99-100% compliance score in this area for children and 99-100% compliance score for adults. The importance of meeting this standard ensures that those who are experiencing significant mental health concerns are receiving an appropriate screening and assessment to determine the appropriate level of care.

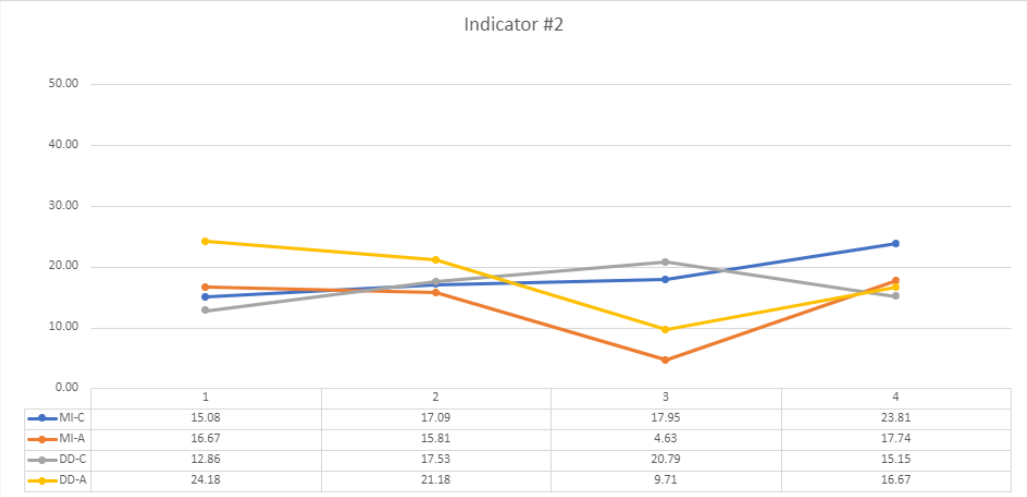


	1	2	3	4
Children	99	100	99	99
Adults	99	99	100	99

Indicator #2:
(No Set Standard for FY23)
The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 days of a non-emergency request for service. Based on internal tracking, MCCMH saw an overall decrease for Indicator #2 from FY22 at 21.01% to FY23 at 17.18%.

Based on region-wide trends, MCCMH continues to fall well below other PIHP's for this Indicator. MCCMH continued to work on network capacity related to appointment availability addressing initial and ongoing appointments. MCCMH also had a "ROCK" project throughout FY 2023 that focused specifically on access to care within MCCMH's network and targeted areas where there were gaps in service access.

Benchmarks for this Indicator were reassessed by MDHHS and presented during MDHHS's Quality Improvement Council (QIC) meeting in August 2023. Standard percentile benchmarks are PIHP specific based on FY22 reported data. Based on PIHP specific benchmarks, MCCMH is required to reach or exceed the 50th percentile for Indicator 2 beginning FY24.



	1	2	3	4
MI-C	15.08	17.09	17.95	23.81
MI-A	16.67	15.81	4.63	17.74
DD-C	12.86	17.53	20.79	15.15
DD-A	24.18	21.18	9.71	16.67

Indicator #2e:
(No Set Standard for FY23)
The 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 (SUD)

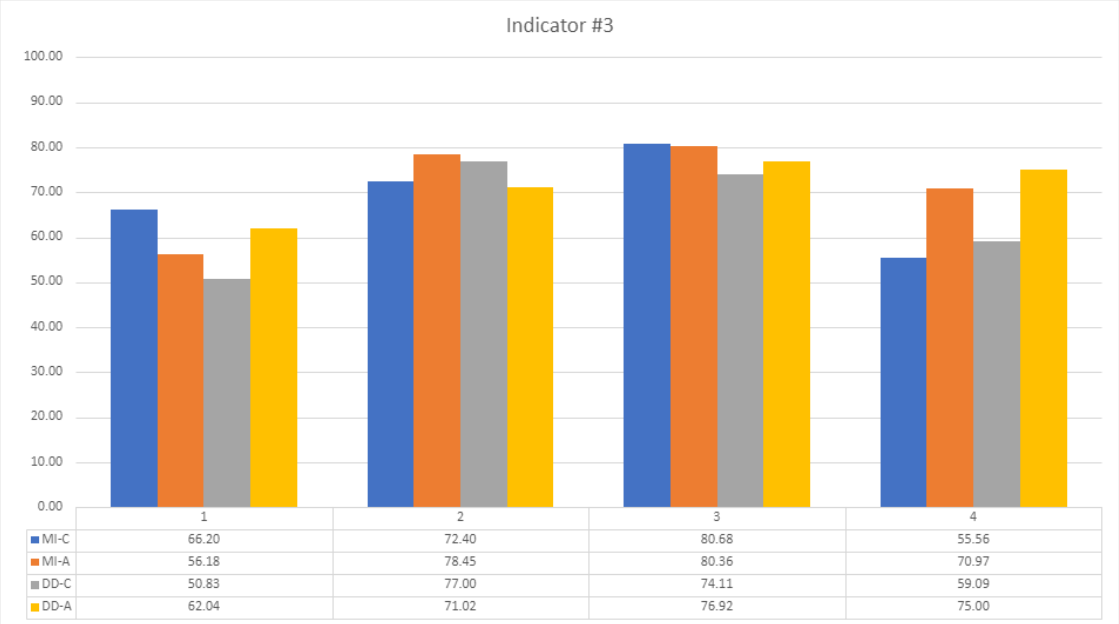
This indicator is calculated by BPHASA based on quarterly information reported to MDHHS by MCCMH.

Benchmarks for this Indicator were reassessed by MDHHS and presented during MDHHS's Quality Improvement Council (QIC) meeting in August 2023. Standard percentile benchmarks are PIHP specific based on FY22 reported data. Based on PIHP specific benchmarks, MCCMH was meeting and exceeding the newly established 75th percentile. PIHPs above the 75th percentile benchmark will be expected to maintain or exceed the performance level.

Indicator #3:
(No Set Standard for FY23)
The 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. Based on internal tracking, MCCMH saw an overall decrease for Indicator #3 from FY22 at 78.62% to FY23 at 70.64%.

Based on region-wide trends, MCCMH continues to fall below other PIHPs for this standard. MCCMH continued to work on network capacity related to appointment availability addressing initial and ongoing appointments.

Benchmarks for this Indicator were reassessed by MDHHS and presented during MDHHS's Quality Improvement Council (QIC) meeting in August 2023. Standard percentile benchmarks are PIHP specific based on FY22 reported data. Based on PIHP specific benchmarks, MCCMH data fell between the 50th and 75th percentile benchmark and are expected to reach or exceed the 75th percentile for Indicator 3 in FY24.



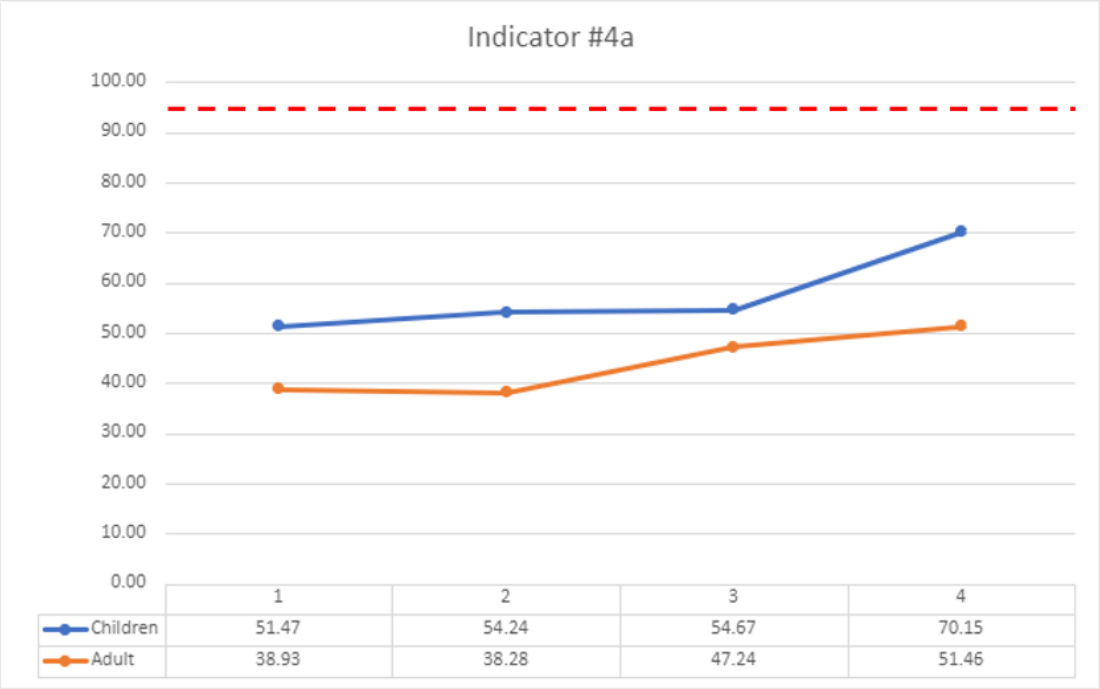
	1	2	3	4
MI-C	66.20	72.40	80.68	55.56
MI-A	56.18	78.45	80.36	70.97
DD-C	50.83	77.00	74.11	59.09
DD-A	62.04	71.02	76.92	75.00

Indicator #4a:

(95% Standard: Not Met)

The percentage of discharges from a psychiatric inpatient unit and were seen for follow-up care within seven (7) days. Based on internal tracking, MCCMH saw an overall increase for follow up appointments post hospitalization for children and adults for Indicator #4a from FY22 to FY23. Children FY22 39.26% Children FY23 57.63% and Adults FY22 42.41% Adults FY23 43.98%.

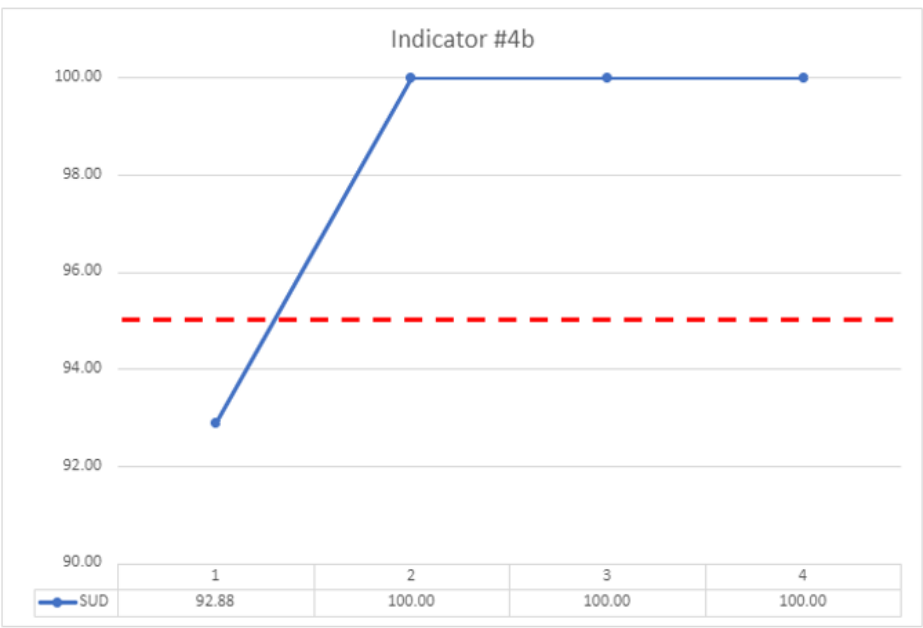
Based on region-wide trends, MCCMH continues to fall well below other PIHP's for this Indicator. Ongoing opportunities for improvement exist for MCCMH related to services post hospitalization. MCCMH's clinical Process Improvement Project (PIP) focuses on improving compliance with MDHHS' standard of follow-up appointments occurring within 7 days of discharge from an inpatient hospital setting. The clinical PIP identifies specific targeted improvement strategies to increase capacity for follow up appointments as well as identifying and understanding barriers for persons served following an inpatient hospitalization.



Indicator #4b:

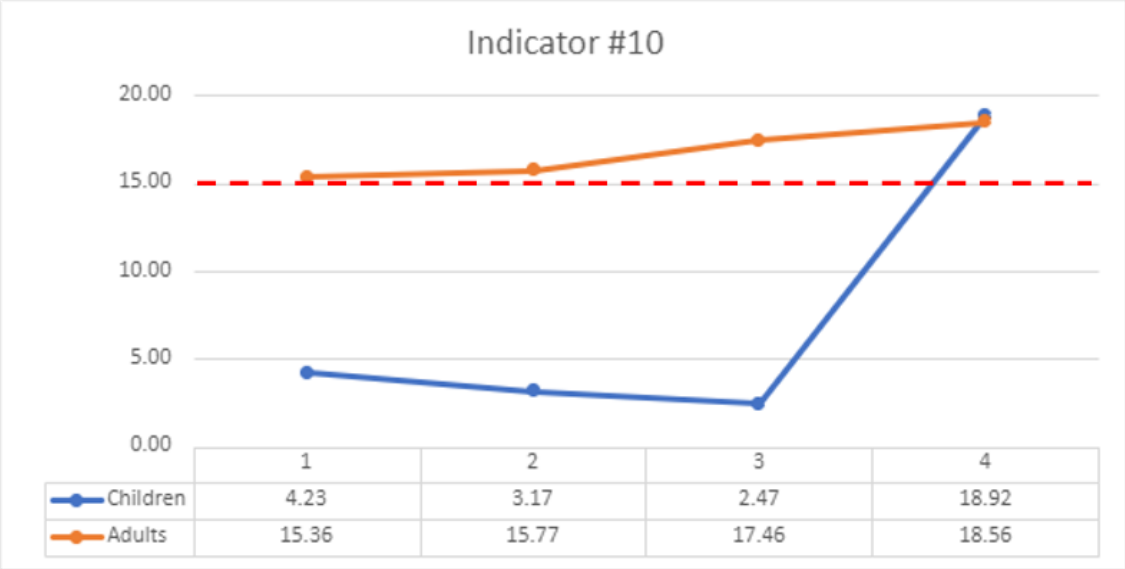
(95% Standard: Partially Met)

The percentage of discharges from a substance abuse detox and were seen for follow-up care within seven (7) days. Based on internal tracking, MCCMH saw an overall increase in compliance from FY22 at 96.04% to FY23 at 98.22%.



Indicator #10:
(15% or Less Standard: Partially Met)
The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. Based on internal tracking, MCCMH saw an overall decrease in recidivism for children and adults represented by Indicator #10 from FY22 to FY23. Children FY22 9.26% Children FY23 7.2% and Adults FY22 19.45% Adults FY23 16.79%.

Inpatient recidivism continues to be identified as an area for improvement for MCCMH. MCCMH Adults have been experiencing a steady increase in recidivistic cases from quarter to quarter and children saw a significant spike in recidivistic cases during Q4. Based on region-wide trends, MCCMH remains among one of the PIHPs with the highest recidivism rates for both children and adults. Ongoing efforts to address this area are occurring across MCCMH departments. Improvement initiatives specific to recidivism are occurring through ongoing case reviews and root cause analyses. Efforts to improve follow up after hospitalization are expected to also decrease recidivism.



FY 2023 Performance Measure Improvement Strategies Overview:

MCCMH internal performance goals were partially met throughout FY23. Below is a chart that depicts MCCMH's target improvement areas throughout FY23, and status based on completion and implementation.

Target Improvement Area	**Status**
Collect and monitor PI data on a weekly basis	Met
Implement monthly Provider Meetings	Met
Improve validation efforts based on PMV findings	Ongoing
Develop process improvement plans for negative trends and patterns	Ongoing
Enhance EMR reports to improve provider specific data reports	Ongoing
Meet MDHHS Standards	Not Met

FY 2024 Performance Measure Improvement Strategies:

MCCMH will work towards meeting or exceeding MDHHS benchmarks for each of the MMBPIS performance measures. For any areas that perform below the standard MCCMH will develop a workplan to address areas of deficiency to increase reported scores.

Areas to address include but are not limited to data improvements, performing primary source verification quarterly, implementing incentive-based incentives and all ongoing improvement areas. An important area of focus for MCCMH is to increase data awareness and visibility with its Provider Network by providing access to PI reports to assist in provider level improvement strategies to targeting KPI and overall access to care.

Performance Measure Activities

MCCMH conducts at least two Performance Improvement Projects every year. This past year, MCCMH worked on two Performance Improvement Projects aimed at addressing clinical and non-clinical aspects of care as approved by the state. Current Performance Improvement Projects include:

1. Increase percentage of adults receiving follow-up appointments and a reduction in racial disparity between Caucasian and African American persons served post inpatient psychiatric hospitalization.

2. Increase the number of MCCMH persons served enrolled in the MDHHS Habilitation Supports Waiver Program.

Clinical PIP:

For its clinical Performance Improvement Project, MCCMH received the 2022-2023 PIP Validation Report from HSAG in November 2023 for Validation Year 2 to which MCCMH received 100% validation on baseline data analysis.

MCCMH continues to implement its designated interventions to improve the equity and accessibility of follow-up care for both population groups. MCCMH continues to measure, assess, and analyze gathered information related to its clinical and non-clinical performance improvement plans to ensure engagement in continuous quality improvement.

MCCMH has utilized recommendations from the PIP Validation Report from HSAG throughout FY23 to guide organization wide initiatives and specialized workgroups. Based on recommendations from the report MCCMH has revisited its causal/barrier analysis on a quarterly basis to assess previously identified barriers and to determine if any new barriers exist. Quality-based tools and models have been developed to target specific interventions. Models utilized for analysis include fishbone diagrams, and the Focus-Plan-Do-Study-Act framework. MCCMH has also implemented an evaluation process to determine the effectiveness of each intervention through ongoing monitoring of data dashboards designed specifically to target success of each intervention. MCCMH's internal evaluation process includes two internal performance indicators to track performance for improvement over time.

- Indicator 1: the percentage of Caucasian adults discharged from a psychiatric inpatient unit who are seen for follow-up care within 7 calendar days.

- Indicator 2: the percentage of African American Adults discharged from a psychiatric inpatient unit who are seen for follow-up care within 7 calendar days.

Indicator data is pulled using claims data, MCCMH identified all members who meet PIP criteria, further separated by race, who received a billable clinical service within 7 calendar days of inpatient discharge. Qualifying follow-up service must be recorded as an approved service code provided by a professional.

Hospital Liaison Pilot Program:

MCCMH initiated a pilot program at the end of 2023 to define the process for the care coordination provided by the Hospital Liaisons with individuals admitted to the psychiatric unit. This pilot is currently implemented in one of MCCMH's contracted hospitals to track success of the program with the intent to implement throughout the network by the end of FY24.

The pilot programs intended target population includes individuals admitted to the hospital for inpatient psychiatric treatment who are not open and active with a primary clinical provider. MCCMH will assign the case in the EMR system to MCCMH Case Management within twenty-four (24) hours of admission, send an email to the MCCMH Hospital Liaison Team and the Hospital Liaison will contact the assigned Hospital social worker to begin discharge coordination.

Based on barrier analysis, transportation was identified as a significant barrier for follow up after hospitalization. The pilot program is structured to provide transportation to individuals who are willing to attend a follow up appointment on the same day of discharge.

MCCMH has built an internal tracker to track the progress of the pilot program. The tracker will help MCCMH to determine the success of the program and interventions. Data below represents information since the implementation of the pilot program.

Race/Ethnicity	#Discharged	#Appointment Kept	%		Accepted Transportation?
White	13	4	31%		0%
Black or African American	5	5	100%		60%
Hispanic or Latino	1	1	100%		0%
Total	19	9	47%		16%

During this period, 4 out of the 13 individuals discharged from this hospital who identified as white kept their appointment and none accepted transportation to the follow up appointment after discharge. All 5 individuals who identified as Black or African Americans who were discharged from the hospital kept their follow up appointment and 60% accepted transportation to the follow up appointment on the day of discharge.

MCCMH is preparing for remeasurement periods, which will occur during calendar years 2023 and 2024 to address causes and barriers identified through a continuous cycle of data

measurement and data analysis and assess the effectiveness of interventions. The table below depicts identified barriers, interventions, and status based on MCCMH progress towards implementation throughout FY23.

Barrier Priority Ranking	Barrier Description	Intervention Description	Intervention Status	Intervention Type
1.	Limited appointment availability with directly operated and contract service providers.	Increase number of available appointments at MCCMH North and East locations for individuals discharging from inpatient hospital settings.	Completed	Provider Intervention
		Update EMR calendar to accurately represent available appointments within the network.	In progress	System Intervention
2.	Outdated formalized processes for hospital discharges.	MCCMH Quality of Care ROCK Team will update the hospital liaison processes to engage consumers within 24 hours of admission and keep them engaged until after follow-up appointment.	In progress	Provider Intervention
		Managed Care Operations staff will improve coordination with the MCCMH Hospital Liaison Team for discharging members.	In progress	Provider Intervention
1.	Lack of communication with network on performance measure standards.	Issue a memo to provider network to remind providers of the required standard and detail MDHHS/PIHP requirements.	Not started	System Intervention
		Meet with providers to reiterate the importance of follow-up after an inpatient stay and provide space to further discuss challenges providers may be facing.	In progress	Provider Intervention
4.	Unidentified trends and barriers related to follow-up care.	Conduct a provider survey to identify network-wide barriers related to care coordination.	Completed	Provider Intervention
5.	Limited data visibility with network regarding MDHHS performance measures.	Develop dashboards for providers on compliance rates with MDHHS performance measures.	In progress	Provider Intervention
		Develop formalized processes with providers to review their current compliance rates.	In progress	Provider Intervention

Non-clinical PIP:

For its non-clinical Performance Improvement Project, MCCMH is targeting improving HAB enrollment across the Provider Network. MCCMH's average enrollment rate throughout FY23 fell below MDHHS's threshold for "Good Standing" of 97%. MCCMH has conducted internal efforts to develop a structured workplan to guide efforts to increase the number of HAB enrollments. Based on the most recent reports, MCCMH has a total of 494 allotted HAB slots and currently has 57 slots available that need to be filled. This places MCCMH well below the "Good Standing" threshold at 88% for slot maintenance.

Coordinated efforts between the Quality Department and Network Operations began in Q1 of FY23 to assess current and ongoing barriers impacting HAB enrollment. Systematic barriers included lengthy application process, provider program education and awareness, effective oversight of slot maintenance, disenrollment trends, and identification of eligible individuals.

Based on these identified barriers MCCMH has developed strategies to effectively approach barriers through specific and measurable interventions. MCCMH has been working on training materials to distribute to the network. MCCMH has also increased meetings with providers to provide education around the HAB waiver program and how to enroll new beneficiaries. This is an ongoing collaboration with providers to provide support to existing and new staff. Disenrollment trend analyses have also helped target specific reasons beneficiaries are no longer enrolled.

To increase ongoing oversight of slot maintenance, MCCMH created reports to share with providers identifying individuals who are currently utilizing HAB waiver services but are currently not enrolled in the program. This report has assisted providers to more easily identify potential beneficiaries to enroll in the program.

In addition, MCCMH has been meeting with individuals at the State level to further understand HAB waiver requirements and advocate ways to improve the enrollment process for providers.

MCCMH's focus for FY23 was to create a structured approach based on identified barriers to ensure the Provider Network has received more formal education and training on the benefits of HAB Waiver services. FY23 did not see an increase in HAB enrollment but based on the increased and targeted efforts, enrollment numbers are expected to increase during FY24. The table below depicts identified barriers, interventions, and status based on MCCMH progress towards implementation throughout FY23.

Barrier Priority Ranking	Barrier Description	Intervention Description	Intervention Status	Intervention Type
1.	Low enrollment in MDHHS' Habilitation Supports Waiver (HAB) was reported throughout FY 22	Review previous MDHHS reports to identify patterns and trends.	In Progress	System Intervention
		Contact Network Operations to discuss current challenges with enrollment numbers and identify any corrective action plans that have been implemented.	Completed	System Intervention
		Get access to MDHHS HAB enrollment platform for Quality representatives.	In Progress	System Intervention

		Run claims report and filter by service code to determine persons served who are not HAB recipients but utilize services that are available under the waiver.	In Progress	System Intervention
2.	Lack of network initiatives to improve enrollment numbers	Determine any previous or existing initiatives that were developed on this area.	Not started	System Intervention
		Gain deeper understanding of current state HAB workgroup and the scope of work it entails.	In Progress	System Intervention
3.	Lack of education at provider level regarding eligibility for HAB waiver services	Educate providers on MDHHS' enrollment criteria for HAB.	In Progress	Provider Intervention
		Develop training and resources on eligibility criteria and scope of services to share with network providers.	Not started	Provider Intervention
4.	Lack of monitoring processes to review eligibility and provision of appropriate services	Implement ongoing monitoring processes to evaluate the effectiveness of network initiatives.	Not started	System Intervention
5.	Lack of disseminated information to community regarding scope of HAB services	Develop informational pamphlet on services available under HAB waiver and how individuals can determine eligibility.	In progress	Member Intervention
6.	Lack of awareness related to the availability of HAB services in Macomb County	Distribute existing reports on waiver slot availability to MCCMH Leadership for further review and discussion.	In Progress	System Intervention
		Work with Children's Department to identify children transitioning from Children's Waiver Program (CWP) to encourage enrollment up until 6 months prior to 21st birthday.	Not started	Provider Intervention

Auditing and Monitoring Activities

MCCMH participated in the following external monitoring activities during FY23:

- 1915(c) Waiver Audit (MDHHS)
- Validation of Performance Measures for Region 9—Macomb County Community Mental Health (HSAG)
- Compliance Review for Region 9—Macomb County Community Mental Health (HSAG)
- Hospital Audits
- Residential Provider Audits

1915(c) Waiver Audit:

MDHHS performed their bi-annual 1915(c) Waiver Audit Site Review for FY23. The review consisted of a thorough review of administrative procedures, substance use disorder (SUD) Service Protocol, clinical documentation review, provider staff credentials, and client interviews for sample of those being serviced under a 1915(c) Waiver Service (HSW, CWP, SEDW).

MCCMH received full compliance in the Administrative Review and SUD Service Protocol sections. Areas identified with citations included Clinical Record Review and Provider Qualifications. MCCMH was responsible for creating corrective action plans (CAPs) to reflect individual and systemic remediation efforts that would be implemented with appropriate timelines. Developed CAPs were submitted and approved by MDHHS. MCCMH oversaw the implementation of the CAP for 90 days. MCCMH was able to effectively monitor and remediate all areas addressed in the CAP. MCCMH continues to monitor the areas of review through internal monitoring and audit activities to ensure continued compliance within the MCCMH Network.

HSAG Validation of Performance Measures (PMV):

The purpose of the Health Services Advisory Groups' (HSAG) Performance Measure Validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by MCCMH, as a PIHP, follows state specifications and reporting requirements.

The reporting cycle and measurement period specified for the review was for the first quarter of FY23, which began October 1, 2022, and ended December 31, 2022.

In preparation for the PMV Site Review, MCCMH submitted requested information including source code, its completed ISCAT, additional supporting documentation, and member-level detail files.

The PMV Virtual Review was conducted on July 18, 2023, and MCCMH received the final report in September 2023. MCCMH received the following validation findings:

- **Data Integration:** Acceptable
- **Data Control:** Acceptable
- **Performance Indicator Documentation:** Not Acceptable

Based on all validation activities, HSAG determined performance indicator specific findings and recommendations. MCCMH received *Reportable (R)* for all assessed indicators meaning the indicators were compliant with the State's specifications and the rate could be reported.

Strengths and weaknesses were identified by HSAG and assessed internally by MCCMH. MCCMH's Quality Department developed an ongoing workplan specific to PMV findings to ensure continuous improvement is targeted related to Performance Indicators. Improvement strategies are more specifically outlined in MCCMH's 2024 Workplan.

HSAG Compliance Review:

MCCMH engaged in its FY23 Compliance Review with HSAG. This was the third year of HSAG's three-year cycle of compliance reviews. These reviews focus on standards identified in 42 CFR 438.358(b) as well as requirements from MCCMH's PIHP contract. This year's compliance review consisted of a review of standards and elements that required a corrective action plan (CAP) during the SFY 2021 (Year One) and SFY 2022 (Year Two) compliance review activities. MCCMH required review in 11 of the 13 standards including 42 total CAP elements.

Following its Compliance Review in August 2023, 37 of the 42 CAP elements were successfully remediated and received a *Met* score. The 5 CAP elements that were considered *Not Met* were addressed by MCCMH during its final CAP submission. Of those 5 areas, 4 areas were *Accepted* or *Accepted with Recommendations* and 1 was considered *Not Accepted*. The CAP was considered closed by HSAG and concluded MCCMH's FY23 Compliance Review activity. MCCMH continues to internally monitor for internal compliance and has begun preparations for HSAG's 2024 Compliance Review. The chart below shows a breakdown of the reviewed standards and MCCMH's corrected CAP items.

Standard	Total CAP Elements	# of CAP Elements *Complete*	# of CAP Elements *Not Complete*
Standard I—Member Rights and Member Information	3	3	**0**
Standard IV—Assurances of Adequate Capacity and Services	3	3	**0**
Standard V—Coordination and Continuity of Care	3	2	**1**
Standard VI—Coverage and Authorization of Services	3	3	**0**
Standard VII—Provider Selection	4	4	**0**
Standard VIII—Confidentiality	2	2	**0**
Standard IX—Grievance and Appeal Systems	4	4	**0**
Standard X—Subcontractual Relationships and Delegation	4	4	**0**
Standard XI—Practice Guidelines	3	3	**0**
Standard XII—Health Information Systems[1]	3	1	**2**
Standard XIII—Quality Assessment and Performance Improvement Program	10	8	**2**
Total	**42**	**37**	**5**

Quality Hospital Audits:

MCCMH conducted its Fiscal Year 2023 Quality Hospital Audits for Behavioral Center of Michigan, Ascension Macomb-Oakland, and Harbor Oaks. An audit period from October 1, 2022, to March 31, 2023, was used and 5% of clinical charts from this period were reviewed. Charts were randomly selected and included length of stay outliers.

The Quality team conducted in-person site reviews in addition to the chart reviews. The site reviews included a facility tour, staff interviews, review of open cases, and discussion on the hospitals' experiences with MCCMH. Each hospital received a comprehensive written report once the audit process was complete. If a hospital scored below 95% compliant, they had thirty (30) calendar days to submit evidence to close their respective corrective action plan (CAP). Once a hospital audit report is finalized, MCCMH's Quality team uploads the report and supporting notices to the MDHHS Inpatient Reciprocity Group for other regions in Michigan to reference.

For the audit's period of review, MCCMH found the following average length of stay across its network, with consideration given to outlier cases that can be seen as accounting for a degree of data variance.

Total	**Number of Admissions**	**Average Length of Stay**
10/1/2022 – 3/31/2023	1442	9.70 Days
Outliers	**Number of Admissions**	**Average Length of Stay**
<10 Days	564	15.02 Days
<14 Days	234	20.28 Days
<20 Days	82	28.76 Days
<25 Days	41	35.66 Days

MCCMH's Quality Department aggregated findings from its hospital audits to identify patterns and developed targeted improvement initiatives to better support its provider agencies. Some examples of improvement initiatives include but are not limited to defining MCCMH's role in care coordination, disseminating clear care coordination processes, and clarifying and acting on residential placement needs. Improvement initiatives are regularly discussed and monitored through MCCMH's Quality Committee.

Residential Provider Audit:

During FY 2023, MCCMH's Quality Department updated its residential audit tool and re-launched its network wide residential audit processes. To maximize the efficiency and effectiveness of these audits, MCCMH's Quality Department is following a phase-out strategy for residential audits.

Since re-launching the residential audits in August 2023, MCCMH's Quality Department has completed Licensed Residential Audits for 26% of residential homes (36/138) and 19% of its

providers (12/63). MCCMH's Quality Administrators completed audits of the first two homes (1 provider) in August to test and validate the audit tool, and Quality Case Managers completed the next 34 audits of homes (11 providers).

Of the residential homes reviewed, 15 homes (42%) / 7 providers (63%) of the audited homes/providers had audit final report scores below a 95% compliance threshold. When providers are found to fall below this threshold, the Quality team works with the provider to develop a Corrective Action Plan (CAP) to remediate any areas of concern.

The two most common audit citations were as follows:

1. Individual Plan of Service: There must be a copy of the current, signed and dated Individual Plan of Service (IPOS) present in the person's case record - 45.73% of homes complied.

2. MCCMH Coordination of Care Form: There is evidence of Coordination of Care form completed - 53.70% of homes compliant.

The current compliance rate for residential homes audited is 93.8%. The Quality Department continues to partner with providers to highlight areas of strength as well as identify areas for improvement.

Total Audits			
63 Providers			
138 Homes			
Completed Audits			
Homes		Providers	
	36		12
	26%		19%
CAP Needed			
Homes		Providers	
	15		7
	42%		63%
CAP Completed			
Homes		Providers	
	11		6
	73%		86%

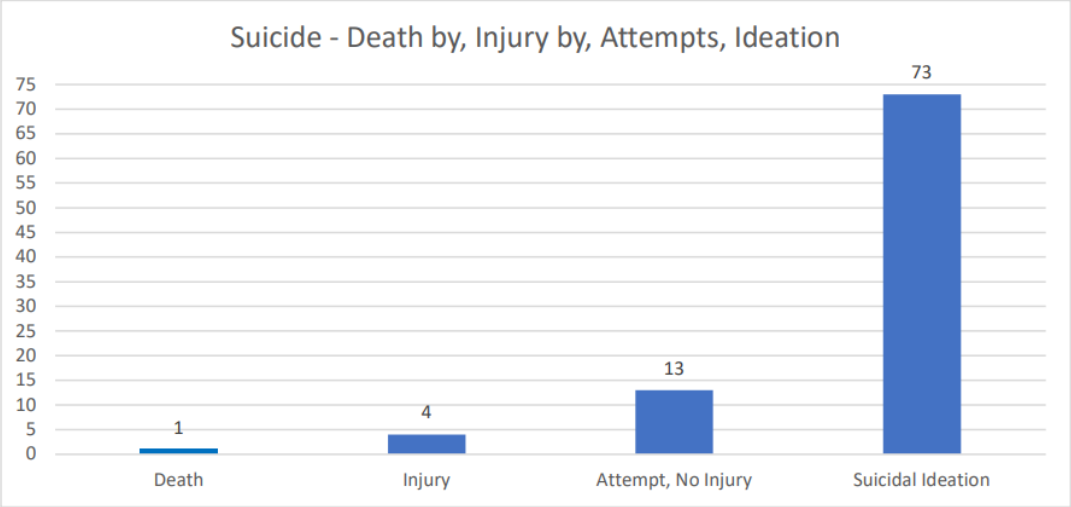
Events Data

Incident reports are required to be submitted to MCCMH by the provider network for all incidents considered unusual. Incidents are reported via fax or directly submitted using the portal in the electronic medical record keeping system. Those submitted through the fax line are uploaded to the MCCMH incident report module and reviewed by the Quality Department for data tracking purposes. Incident reports are coded, and critical/sentinel events are submitted to MDHHS in accordance with MDHHS reporting requirement. All sentinel events are reviewed by MCCMH's Critical Risk Management Committee (CRMC). Recipient Rights concerns are further reviewed by the Office of Recipient Rights. The Clinical Department reviews risk events and all codes related to suicide to further establish system-wide risk reduction strategies and direct initiatives for consumers with trending risk concerns including behavior treatment planning.

The Quality Department began electronically tracking all incident reports in June 2023. Data was reviewed from July through December of 2023, as data was consistently tracked and will most accurately depict all incidents received during these months. In total 2,778 incident reports were reported during the review period (July-December 2023). 378 of these reports were considered Critical, Sentinel, Risk Events, and/or immediately reportable, while 2,400 of the incidents were labeled "other" and while reviewed for Quality, Clinical, and Recipient Rights concerns, they would not be considered state reportable. This electronic tracking mechanism has improved visibility in trending data and allows MCCMH to develop appropriate strategies to mitigate risk, even those that fall outside of state reporting requirements. An example includes the Quality Department's ability to review recurring non-emergent falls for individuals and follow up with the provider agency with a Root Cause Analysis.

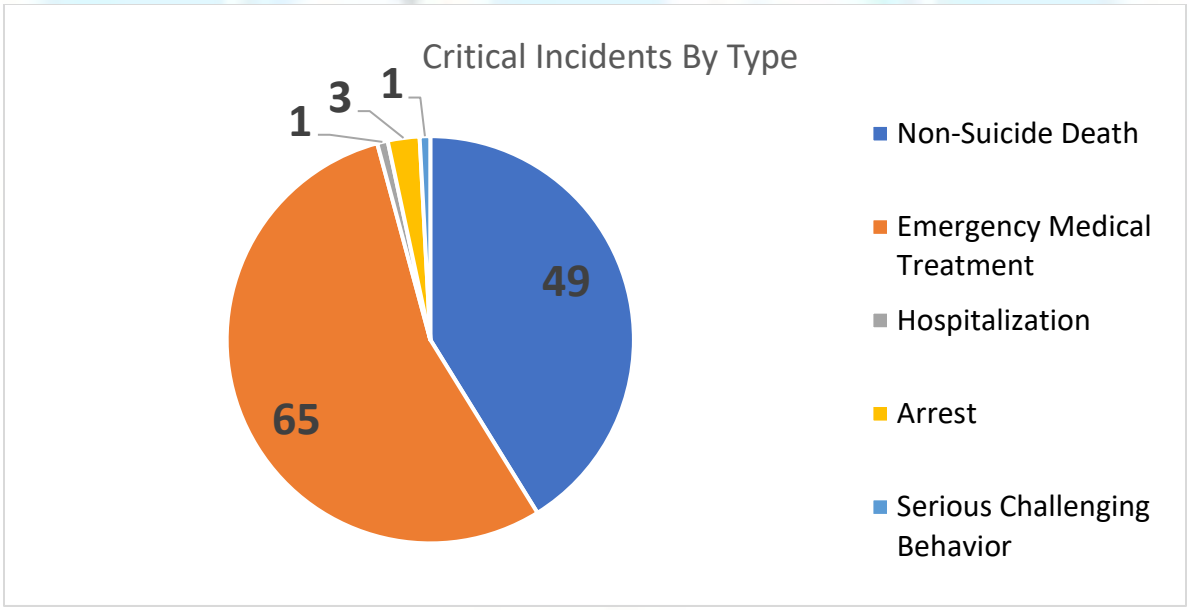
Suicide – Death, Injury, Attempts and Ideation

The Suicide - Death by, Injury by, Attempts, Ideation graph shows the number of deaths and injuries from suicide attempts from the last quarter. This data is used to support the "zero suicide initiative" and is reviewed by MCCMH's Clinical Department.



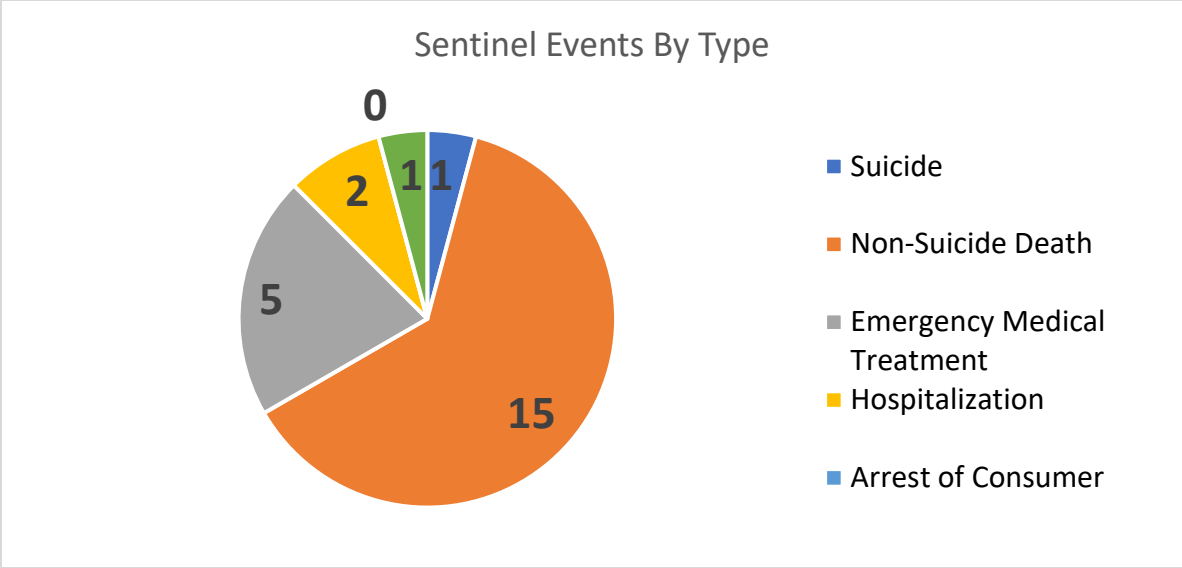
Critical Incidents by Type

The Critical Incidents by Type graph shows the number of Critical Incidents that were submitted from July-December 2023. The total number of Critical Incidents is calculated by adding up the incident reports submitted in MCCMH's electronic medical record (EMR) system. All critical events are reported to MDHHS.



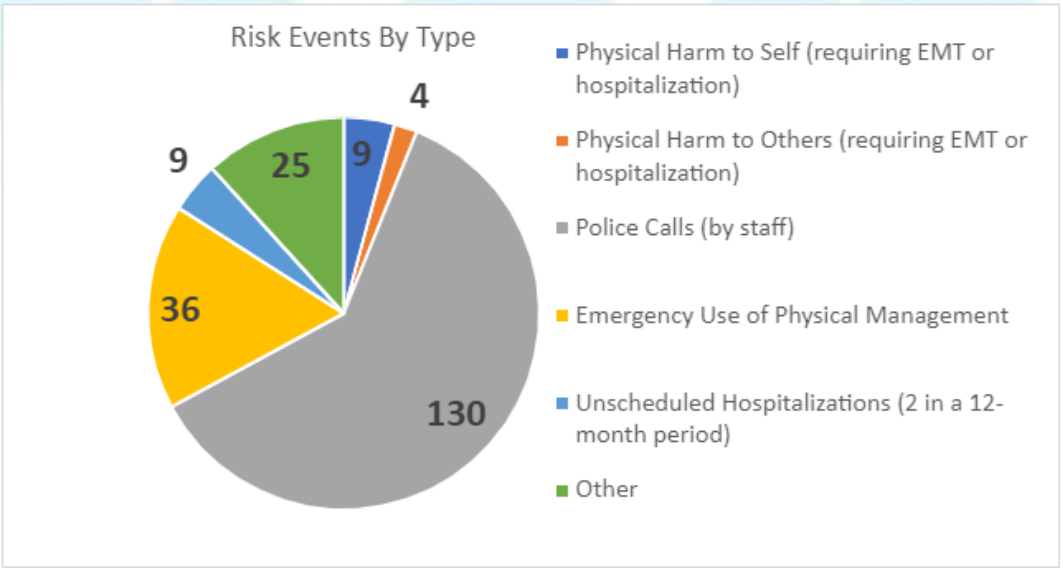
Sentinel Events by Type

The Sentinel Events by Type graph shows the number of Sentinel Events that were identified from July-December 2023. All Sentinel Events lead to a request for a Root Cause Analysis and are reviewed by the Critical Risk Management Committee (CRMC)



Risk Events by Type

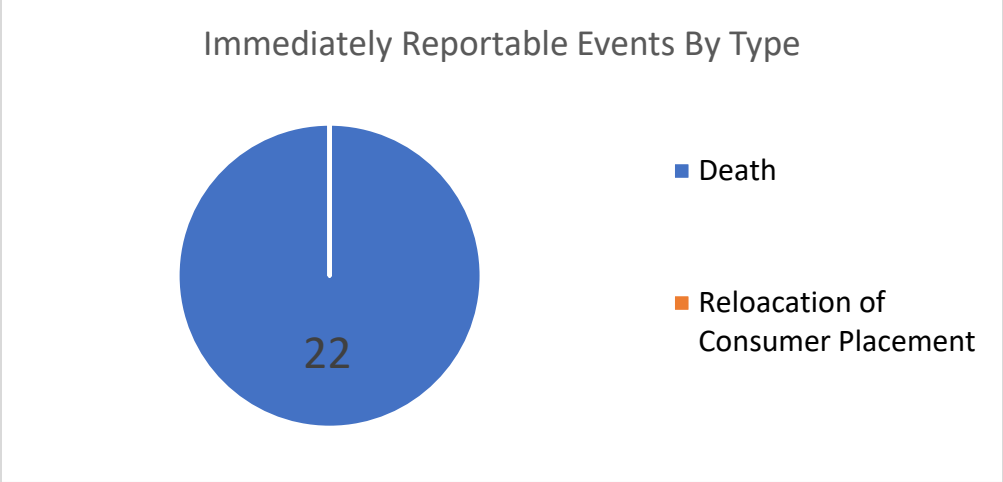
The Risk Events by shows the number of Risk Events that were identified from July to December of 2023. Risk events are reviewed by the clinical department to support the behavior treatment planning process and assist in mitigating further risk. The Behavior Treatment Plan Review Committee (BTPRC) also reviews the cases more frequently to help provide guidance on adjusting behavioral treatment plan, staff and other supports as needed to assure the success and safety of the individual served and effectiveness of the behavior treatment plan.



Immediately Reportable Events by Month

The Immediately Reportable Events by Month graph shows the number of Immediately Reportable Events that were identified from July to December of 2023. The data indicates all deaths that were a result of suspected staff action/inaction. Additional data was marked as

immediately reportable; however, it does not meet the criteria as defined by MDHHS. Training and support has been provided to improve accuracy of reporting.



Behavior Treatment Plan Review Committee (BTPRC).

During FY 2023, the BTPRC reviewed 524 duplicated behavior treatment plans where restrictive or intrusive interventions have been utilized. The BTPRC monitors for least restrictive interventions and makes sure health and safety are taken into consideration in limiting any rights of the individual's served. During this FY, emergency physical management was used 21 times; most of this was with the same individual. Where three or more instances of emergency physical management occurred in a 30-day period, the provider was asked to present in front of the BTPRC more frequently and revise the plan as appropriate or retrain staff if necessary. Other recommendations were made as the committee saw fit to assure quality of care for individuals served. A total of twenty-six 911 calls were made by staff to seek emergency intervention in cases where all other interventions failed, or staff were not properly trained or approved for the use of emergency physical management.

Quarterly training occurred on the BTPRC policy, process, and presentation available to all providers.

Utilization Management (UM)

The MCCMH UM Committee was re-structured and re-launched in FY 2023. The UM Committee's focus for FY 2023 was to determine the purpose and define the scope of this committee. The Committee charter was developed, reviewed, and implemented during Q3 of 2023. This included establishing the member list including identifying voting members, developing the structure of the meeting, and establishing a reporting schedule from the applicable MCCMH Departments and Programs.

The UM Committee reviews established data dashboards to assess timeliness of intake assessments, hospitalization rates, usage, and cost of services by service category, and other datasets to identify under- and over-utilization rates. Baseline utilization management data is reviewed on an ongoing basis to establish more comprehensive and valid over- and under-

utilization studies. These studies aim to ensure appropriate network capacity and adequacy for MCCMH's service region.

The Committee then proposes improvement strategies, as needed. As improvement strategies are operationalized, ongoing reports are presented to and discussed at the Quality Committee. The UM Committee reports quarterly to the MCCMH Quality Committee. The UM Committee meets monthly with a rotating reporting schedule with the focus on analyzing data, identifying opportunities for improvement, making recommendations for performance improvement, and providing approval on clinical and operational aspects of MCCMH's UM functions.

Clinical Practice Guidelines

MCCMH establishes Clinical Practice Guidelines based on the literature of related fields, collaboration with its partners, needs within the system, and best-practices as listed by the Substance Abuse and Mental Health Services Administration (SAMHSA).

MCCMH has adopted Clinical Practice Guidelines for Direct and Contract providers. The guidelines were established and guided by authoritative sources such as the American Psychiatric Association, but mainly established using Milliman Care Guidelines' (MCG) health criteria. MCG provides unbiased clinical guidance in making patient-centered care decisions, helping individuals get the right level of care and the right amount of care. MCCMH's current guidelines are:

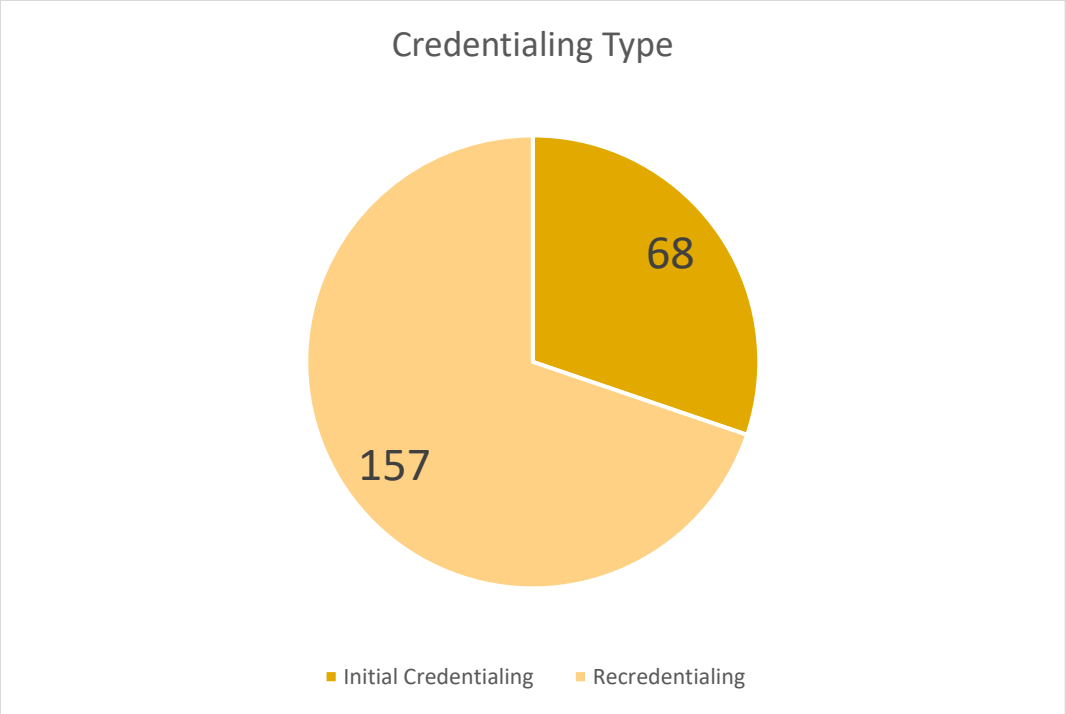
- Clinical Practice Guidelines - PTSD
- Clinical Practice Guidelines - ADHD Combined
- Clinical Practice Guidelines - ADHD and Disruptive Behavior Disorders
- Clinical Practice Guidelines - Bipolar Disorder
- Clinical Practice Guidelines - Major Depressive Disorder
- Clinical Practice Guidelines – Schizophrenia

Additional guidelines are added periodically and as needed to set standards of care.

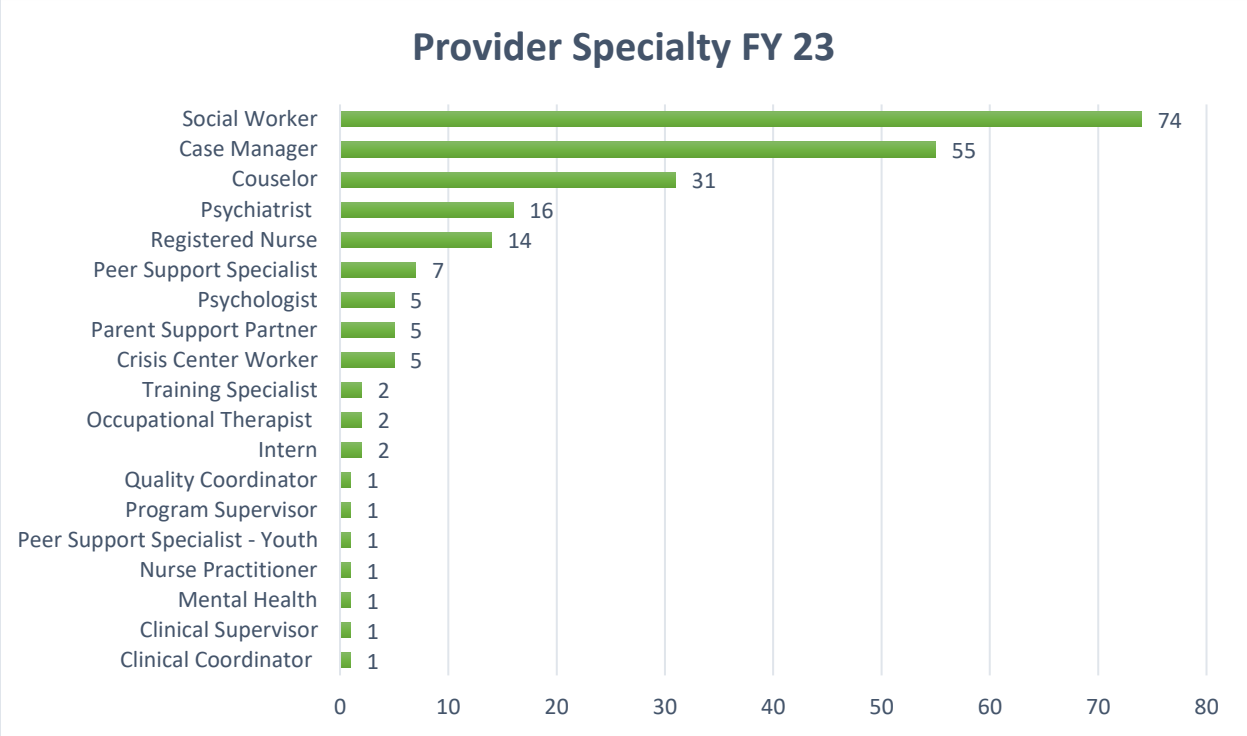
Clinical Practice Guidelines are reviewed and updated every two years. Throughout Q2 and Q3 of 2023, MCCMH's updated guidelines were presented to providers during network meetings where feedback was sought. After a period of review and feedback was given, the updated guides were formally adopted. Current Clinical Practice Guidelines are posted on MCCMH's website for ongoing reference and review.

Credentialing and Re-Credentialing Activities

In 2023, MCCMH credentialed and recredentialed 225 practitioners. Towards the end of FY23, the credentialing functionalities moved from MCCMH's Telent Engagement Department to the Quality Department. Given this transition, the Quality Department is working to revise and streamline credentialing processes to make such processes more manageable for both MCCMH and its providers. Performance data that MCCMH considers at the time of a provider's recredentialing includes but is not limited to grievances, performance indicators, utilization, appeals, member satisfaction, provider monitoring reviews, CIs, etc.).



The Provider Specialty graph represents a breakdown of the individual practitioners by the specialty type.



Verification of Billed Services

In accordance with the Balanced Budget Act of 1997, MCCMH developed a methodology for verifying that Medicaid services claimed by providers are delivered. Specifically, under the contract with MDHHS, this verification includes mental health services and substance use disorder services. Audits were conducted in accordance with MDHHS Guidelines for verification of Medicaid services and MCCMH Medicaid Verification Financial Audit Process guidelines. Audits verified the existence of appropriate clinical records for each claim in the sample selection, evaluated the reasonableness of clinical records associated with each claim, verified that services specified in the claim were part of the consumer's Individual Plan of Service and verified that services provided were included in Chapter III, Mental Health/Substance Abuse Section, of the Michigan Medicaid Provider Manual.

Summary reports of this verification of billed services were submitted to the MDHHS by December 31st, 2023.

Mental Health Services

Clinical records and payment documentation for a random sample of 16,563 claims, representing 1.9% of the population of claims and 3.8% of the dollar value of claims paid were reviewed in the audit period. The claims were classified under 80 vendors across the audit period of March 1, 2021, through February 28, 2023. The claims were reviewed for compliance with the Michigan Department of Health and Human Services Quality Assessment and Performance Improvement Program.

The review focused on three specific areas of compliance:

- Whether services claimed were listed in Chapter III of the Medicaid Bulletin
- Whether services were identified in the person-centered plan
- Verification of documentation that services claimed was provided.

MCCMH's Medicaid Encounter Verification audit results are as follows:

	Count	Dollars
Population	881,805	$177,599,113.31
Claims Audited	16,563	$6,827,982.08
Sample as % of Population	1.9%	3.8%
Error #1	0	$0
Error as % of Sample	0.0%	0.0%

Error #2	1	$472.33
Error as % of Sample	0.0%	0.0%
Error #3 Supporting documentation was missing	501	$84,062.53
Error as % of Sample	3.0%	1.2%

When a provider presented documentation concerns, MCCMH took immediate action to reduce risk for overpayment of Medicaid dollars and began a more extensive audit to review the provider. Based on the audit results, corrective active plans were implemented and referrals to the Office of the Attorney General were made, as needed.

Substance Use Disorder Services

Medicaid Billing Verification audits of contracted provider agencies were conducted during the period of March 1, 2022, through February 28, 2023. Billing Verification audits were also completed for non-Medicaid covered services.

This verification included a review of:

a. Whether services were listed in the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual.
b. Whether services were authorized by consumer/agency agreement.
c. Whether services were rendered as claimed.

Clinical records and payment documentation for 20,593 claims, classified under 21 vendors, for the period of March 1, 2022, through February 28, 2023, were randomly selected. The samples were selected representing 5.9% of cases (minimum of 5%) per vendor with 6.0% of total amounts paid per funding source (minimum of 5%).

The overall results of these audits are as follows:

	Count	Dollars
Population	365,698	**$14,889,034.34**
Claims Audited	20,593	$900,570.07
Sample as % of Population	5.6%	6.0%
Error #1	0	$0.00

Services claimed were not listed in the MDHHS Medicaid Provider Manual		
Error as % of Sample	0.0%	0.0%
Error #2 The services provided were not authorized by the consumer/agency agreement.	12	$3,040.21
Error as % of Sample	0.1%	0.3%
Error #3 Supporting documentation was missing	865	$28,073.62
Error as % of Sample	4.2%	3.1%

All providers audited accepted the audit process and findings and understood that the audits contributed toward meeting MCCMH-SUD record-keeping requirements. Records were available in a timely manner. MCCMH continues to work with providers to ensure quality clinical documentation and continues to provide guidance to agency personnel as questions arise. New service providers receive on-site training from MCCMH-SUD staff. MCCMH-SUD also offers onsite training to agencies that have had a change in billing staff, as needed. MCCMH-SUD's continued aim is to ensure high quality standards are met in the most cost-effective manner.

Provider Network Monitoring Activities

MCCMH developed a Network Adequacy Plan in Quarter 3 FY 2023 to address the needs and requirements of its system of care in accordance with MDHHS guidelines. MCCMH has monitoring processes in place to attend to its network's needs and adjust as necessary. The Network Adequacy Plan outlines specific steps MCCMH has taken to review its network, identifies various departments and stakeholders involved, and outlines provider contracting processes that support and ensure an appropriate provider network. MCCMH is supported by its directly operated programs as well as by expansive behavioral health and substance use disorder (SUD) networks. MCCMH contracts with providers over a two (2) year period to ensure covered services are available for persons served. Organizational Credentialing policies and processes that comply with pertinent standards from MDHHS, National Committee for Quality Assurance (NCQA), and other external entities were also updated and implemented throughout the network during FY2023.

Network Adequacy

MCCMH provides a comprehensive provider network of specialized services which are

geographically accessible to all individuals served in its community. In addition, MCCMH ensures supports are in place with the capacity to provide services sufficient in amount, scope, and duration to meet the needs of all eligible persons who may require specialty mental health benefits and/or substance use disorder services.

Mental Health:

MCCMH contracts with over 187 organizations to provide a wide variety of mental health services needed to adequately serve persons in Macomb County. Some of these services include, but are not limited to:

1. Autism Services/Applied Behavioral Analysis (ABA)
2. Crisis Residential Services (Adults and Children)
3. Targeted Case Management
4. Individual and Group Therapy for Children and Adults
5. Clubhouse Psychosocial Rehabilitation Programs
6. Peer Support Services
7. Assertive Community Treatment (ACT)
8. Community Living Supports (CLS)
9. Respite Services
10. Skill Building/Supportive Employment Services
11. Inpatient Psychiatric Services
12. Home Based Services
13. Speech Therapy
14. Occupational Therapy
15. Physical Therapy
16. Partial Hospitalization

Substance Use Disorder:

MCCMH contracts with a variety of providers who offer a comprehensive array of SUD Prevention, Treatment, and Recovery Programs to meet the substance use disorder needs of persons in Macomb County. Some of these services include, but are not limited to:

1. Withdrawal Management
2. Residential Treatment Services
3. Medication Assisted Treatment (MAT)
4. Intensive Outpatient Treatment
5. Outpatient Treatment
6. Opioid Health Home Services
7. Women's Specialty Services
8. Recovery Coaching
9. Recovery Housing

10. Prevention

MCCMH strives to provide all services needed to its community members and those served. This is not an all-inclusive list of Behavioral Health Care or substance use disorder services, which are offered within MCCMH's system of care. Throughout the impact of the COVID-19 Pandemic and the end of the Public Health Emergency (PHE), MCCMH has continued to support its provider network to ensure the maintenance and ability for individuals to receive medically necessary services in a timely manner.

To enhance the Provider Network Directory, MCCMH has developed an interactive map that is made available to the public on MCCMH's website. This map offers a comprehensive list of Provider Agencies throughout Macomb County. This functionality also includes search features by both by provider type and geographic area. Additionally, the map includes pop-up features for each provider that offer additional public information such as phone numbers, addresses, and services provided.

The following requests for proposals (RFPs) were released for FY23 to expand MCCMH's network adequacy:

RFP Topic	Release Date	Notes
Direct Support Professional (DSP) Training	October 2022	
Crisis Stabilization Services (December 2022) -	December 2022	This RFP was re-released because of changing requirements and needs from MDHHS. That's why you'll see this twice.
Marketing Services	December 2022	
Lobbying Services	June 2023	
Crisis Stabilization Unit	July 2023	

There were multiple other RFP releases for services prior to October 2022. These include but are not limited to ABA (April 2022), CLS & Respite (April 2022), Residential Jail Diversion (February 2022), and SRS (April 2022). This is why MCCMH does not have these critical services bids noted in FY23.

Member Satisfaction

MCCMH conducted its 2023 Member Satisfaction Survey for Adults and Children/Caregivers using Member Satisfaction Survey responses to meet the need of CCBHC Patient Experience reporting as well as align with MCCMH's QAPIP Workplan to assess member satisfaction and improve quality of care. Overall, 393 Adults and 137 Children/Caregivers participated in the survey.

Five of the seven improvement strategies from 2022 were implemented during the 2023 survey period. Improvement strategies implemented included: more demographic information collected

from participants, Primary Provider data was collected, layout of the survey and questions were revised, survey distribution efforts were improved (targeting Directly Operated Programs and designated collaborating organizations (DCOs) specifically) as well as promoting electronic and paper submission of survey data and aligning improvement strategies with MCCMH's QAPIP.

Survey Results—Adults:

Participants**:** 393 Adults

Demographics: An area for increased data collection included improving the amount of demographic information that was collected from respondents. Distinction of gender, age, provider, and recipients of Long-Term Services and Supports (LTSS) were added as demographic fields in response to previous data collection for 2022.

Insurance Type: Majority of respondents were recipients of Medicaid (43.77%) and dual enrolled Medicare/Medicaid (45.04%)

Race: Majority of respondents identified as White (78.27%) and Black/African American (14.76%)

Gender: Majority of respondents indicated that they most closely identify as Female (54.96%) and Male (39.69%)

Age: Age range of respondents varied and included 45 to 64 (34.61%), 30 to 44 (31.55%), 18 to 29 (19.34%) and 65+ (11.96%)

Provider: Majority of respondents indicated they are receiving services within MCCMH's directly operated programs: MCCMH-North (43 respondents), MCCMH-VDPS (42 respondents), MCCMH-West (41 respondents), MCCMH-East (18 respondents) totaling 144 respondents. Most responses from MCCMH's contract providers included MORC (79 respondents) and JOAK (32 respondents).

LTSS: LTSS data was measured if individuals had received Case Management services within the last 6 months. 91.60% of respondents stated they had worked with a Case Manager or Supports Coordinator within the last 6 months.

Table 1a

MHSIP—Domains	**Satisfied**	**Neutral**	**Dissatisfied**
General Satisfaction	78.89%	17.80%	1.57%
Access	64.86%	24.47%	2.12%
Quality of Appropriateness	75.76%	11.59%	2.33%
Participation in Treatment Planning	64.00%	24.53%	2.40%

Outcomes	61.34%	21.51%	4.16%
Functioning	55.77%	29.60%	3.32%
Social Connectedness	70.79%	20.03%	2.40%

Survey Results—Children/Caregivers:

Participants: 137 Children/Caregivers

Demographics: An area for increased data collection included improving the amount of demographic information that was collected from respondents. Distinction of gender, age, provider, and recipients of Long-Term Services and Supports (LTSS) were added as demographic fields in response to previous data collection for 2022.

Insurance Type: Majority of respondents were recipients of Medicaid (87.59%)

Race: Majority of respondents identified as White (62.04%) and Black/African American (20.44%)

Gender: Majority of respondents indicated that they most closely identify as Male (57.66%) and Female (39.42%)

Age: Age range of respondents varied and included 5 to 12 (52.55%), 13 to 17 (22.63%), 0 to 4 (10.95%) and Older than 18 (8.76%).

Provider: Majority of respondents indicated they are receiving services within our Direct services MCCMH-Children's Department (63 respondents)

LTSS: LTSS data was measured if individuals had received Case Management services within the last 6 months. 85.40% of respondents stated they had worked with a Case Manager or Supports Coordinator within the last 6 months.

Table 1b

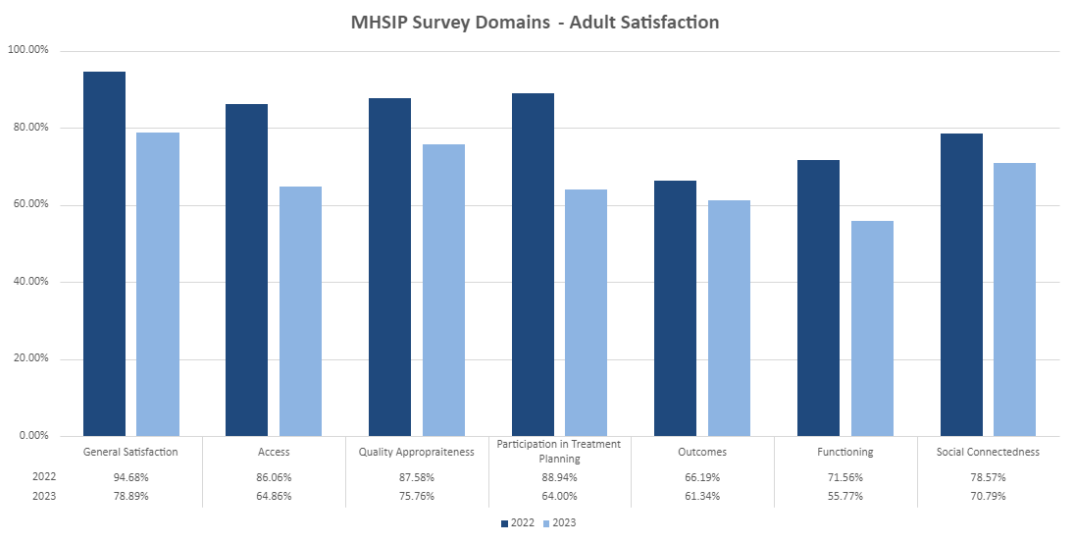
YSS-F—Domains	**Satisfied**	**Neutral**	**Dissatisfied**
General Satisfaction	88.35%	7.22%	1.14%
Access	87.79%	11.46%	1.53%
Cultural Sensitivity	92.39%	2.15%	0.78%
Participation in Treatment Planning	94.95%	1.77%	0.76%
Outcomes	66.15%	23.05%	6.38%
Functioning	69.53%	21.88%	4.69%

Social Connectedness	86.51%	9.13%	3.57%

Result Comparison:

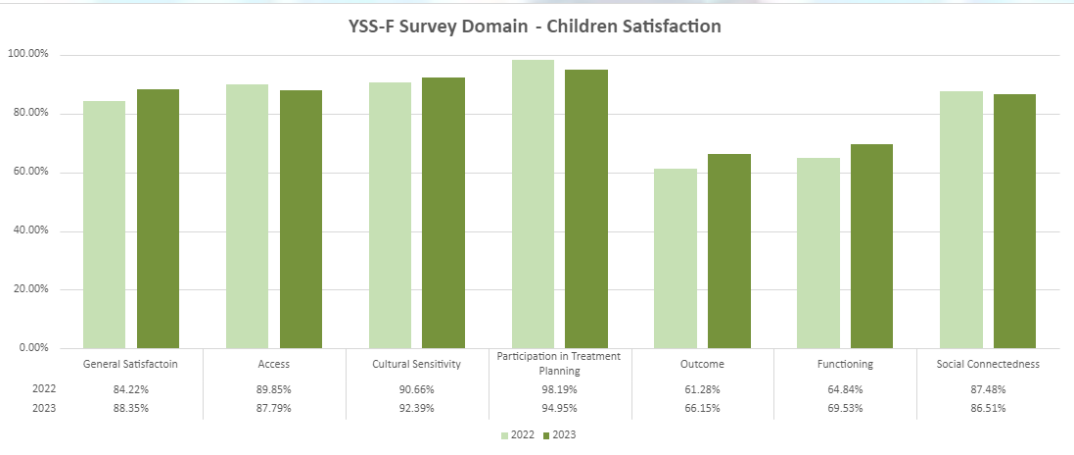
Table 2a and 2b represent Adult and Children/Caregivers satisfaction responses from 2022 and 2023.

Table 2a

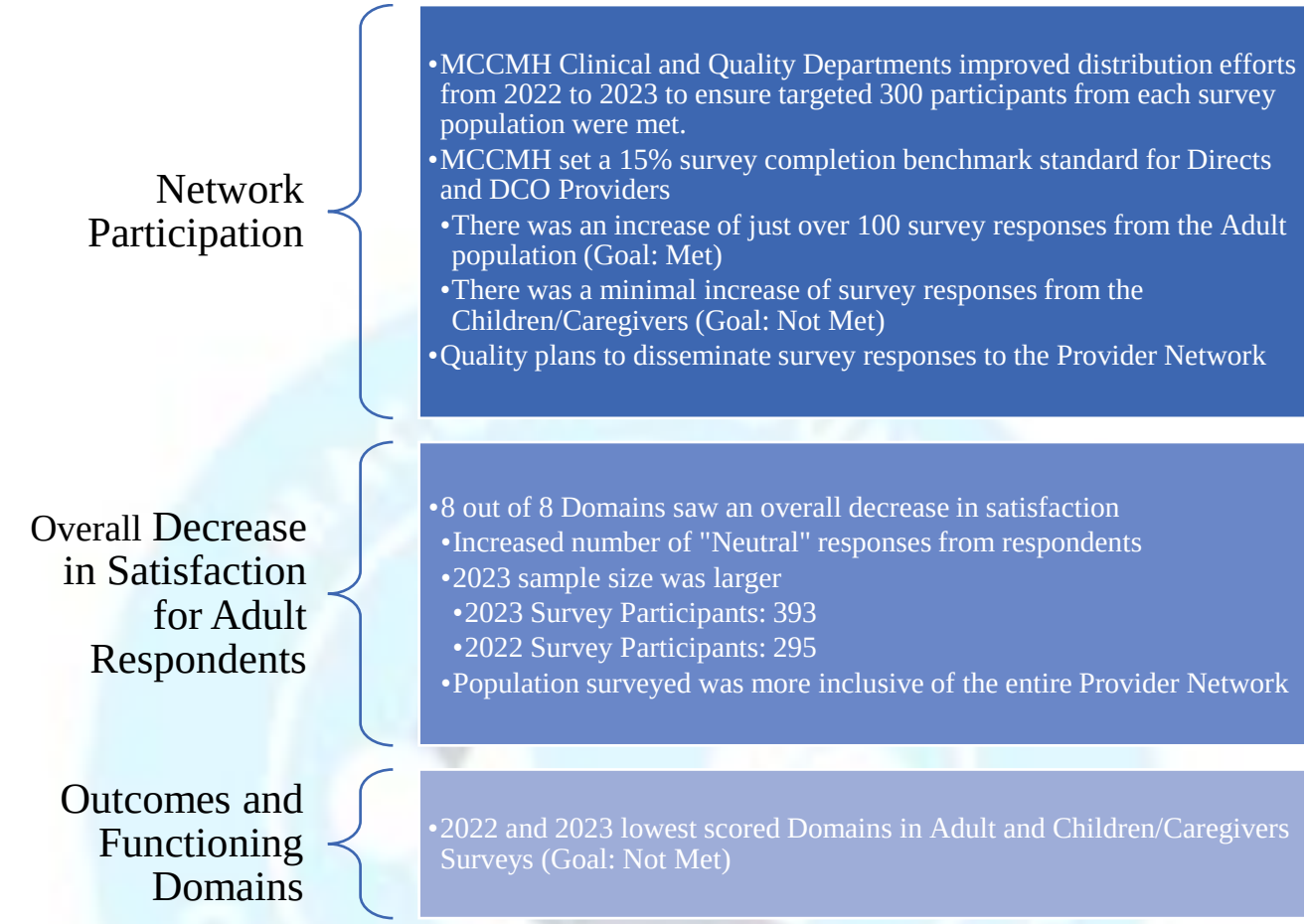


Greater number of "Neutral" responses from 2022-2023

Table 2b



Member Satisfaction Survey Analysis:



Vulnerable Individuals

MCCMH considers its entire population vulnerable individuals due to most individuals treated being severe mental illness (SMI) or serious emotional disturbance (SED). MCCMH created updates in the electronic medical record in FY 2023 to include the addition of physical health goals and SUD goal prompts which in turn compile an integrated care plan. The creation of a dashboard to measure the number of integrated care plans was started and steps were taken to validate the report.

LTSS Activities

MCCMH ensures individuals receiving long-term supports or services (e.g., individuals receiving case management or supports coordination) are incorporated in the review and analysis of information obtained from quantitative and qualitative methods. MCCMH continuously reviews care between care settings and compares services and supports received based on the individual's plan of service. Specific findings from MCCMH's Member Satisfaction Survey that was completed in FY2023 are described further in the Member Satisfaction Section of this report.

MCCMH continues to review, analyze, and monitor person-centered planning practices, IPOS reviews/amendments, and standardized assessment scores that support level of care such as the Level of Care Utilization System (LOCUS). This includes an assessment of care between care between care settings and a comparison of services and supports. LTSS members remain included as survey participants and members of the Consumer Advisory Councils.

Over the past year, MCCMH prioritized monitoring and improving continuity and coordination of care that persons served receive across the behavioral health network and has taken action to improve and measure the effectiveness of such improvement strategies. MCCMH has engaged in internal improvement workgroups surrounding network improvement and training of staff on person centered planning practices, periodic reviews of service, LOCUS and SIS assessments, specialized nursing assessments, behavioral assessments, and psychiatric evaluations. MCCMH has prioritized updates to Clinical Practice Policies that depict standards related to these areas to ensure compliance with current federal, state, and other external requirements to which MCCMH is held.

Person Served Rights

The goal to ensure the completion of all Office of Recipient Right's investigations within the mandated timeframes has been met thought the year. The Office of Recipient Rights has consistently exceeded contract requirements and expectations. Due to the importance of this goal and to ensure member' rights within MCCMH, this goal will continue.

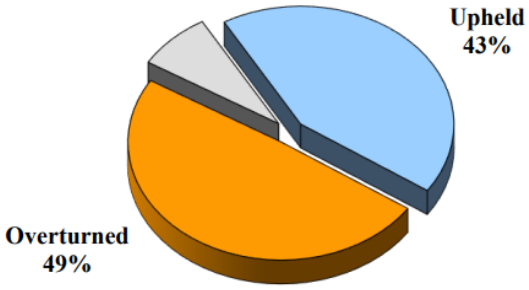
Grievances & Appeals

MCCMH oversaw a total of 63 appeals for 2023 which resulted in nearly 50% of the cases being overturned. This is an increase from the previous year where 34% of the appeals were overturned. The number of appeals from 2023 and 2022 remained similar. Community Living Services (CLS) appealed cases accounted for 35% of the total services appealed in 2023. The previous year, CLS appealed services accounted for only 14%.

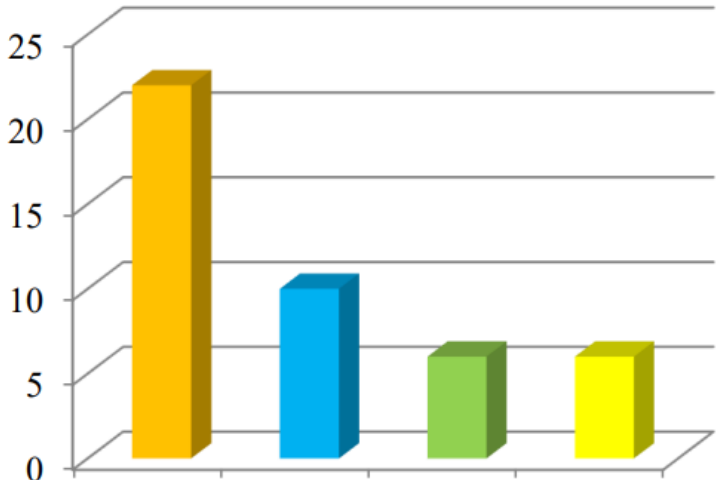
MCCMH had a total of 37 grievances for 2023 which resulted in a 57% substantiation rate. In 2022 there were 73 grievances, 68% of which were substantiated. MCCMH experienced nearly a 50% drop in total grievance in 2023 compared to 2022. 92% of the grievances in 2023 were related to Access and Availability compared to 77% of the cases being Access and Availability in 2022. There was a 15% increase of Access and Availability for 2023.

Grand Total of Appeals

Appeals Upheld	27
Appeals Overturned	31
Appeals Partially Upheld/Overturned	5
Total Appeals	**63**

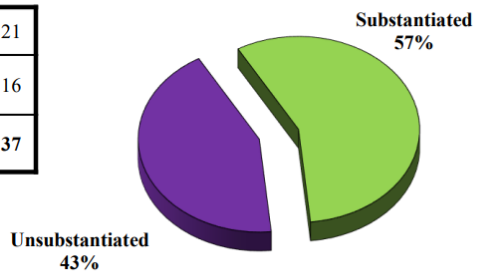


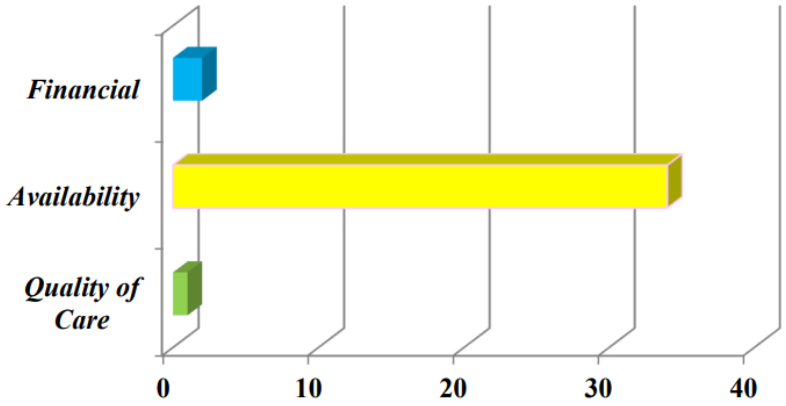
Top Four Appealed Services



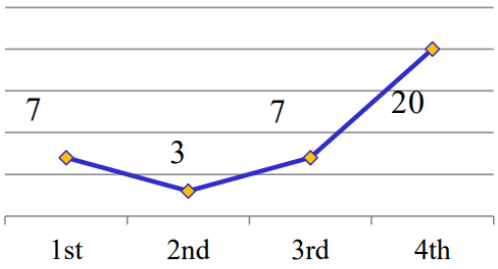
Grand Total of Grievances

Grievances Substantiated	21
Grievances Unsubstantiated	16
Total Grievances	**37**

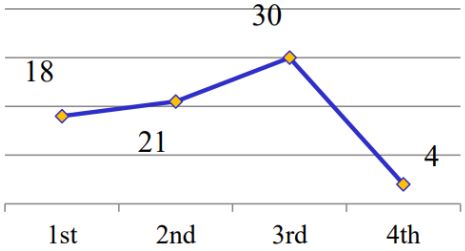




FY 2023 Grievances Per Quarter



FY 2022 Grievances Per Quarter



Customer Service Metrics and Key Performance Indicators (KPIs)

Customer Service staff assist callers that are seeking mental health services and/or substance use disorder treatment services. As well as those that have general questions regarding the services and supports provided by MCCMH and those requesting to file a grievance, appeal, or rights complaint regarding their services. During FY23 Customer Service handled 72,082 calls.

To support data driven decision making, MCCMH focuses on monitoring the following call center metrics: average time to answer, average wait time, abandonment rate and service level. As questions or service issues arise, the goal of call center staff is to answer all questions and address all needs without having to transfer the call whenever possible or connecting the caller directly to the subject matter expert that will be able to address their query.

MCCMH Customer Service Call Center Key Performance Indicators (KPIs):

1. Service Level: 90% of Customer Service calls shall be answered within 30 seconds.
2. Average Time to Answer: Our goal is to answer all incoming calls within 30 seconds.
3. Average Wait Time: No caller should be left on hold for longer than 2 minutes.
4. Abandonment Rate: The disconnection rate for all incoming calls should be less than 5%.
5. Requeues: A measure of agent availability. If an agent misses a call, it is requested and sent to the next available agent. The benchmark is for each agent to have less than 10 requeues per month.

Phone metrics for the Customer Service call center are also reported monthly to the MI Health Link Integrated Care Organizations (ICOs) for compliance purposes. The call center phone metrics have consistently met the benchmarks set forth by MI Health Link for the past 2 years.

Month	Average Wait Time (IN) <2 min.		Call Abandon Rate 5%	Average Speed to Answer 90% in <30 sec.	Total Calls
Oct-22	CSR	00:32	1.87%	84%	6,388
Nov-22	CSR	00:38	2.47%	80%	5,721
Dec-22	CSR	00:25	1.46%	87%	5,067
Jan-23	CSR	00:27	1.66%	84%	6,280
Feb-23	CSR	00:19	1.02%	89%	5,650
Mar-23	CSR	00:20	1.29%	89%	6,514
Apr-23	CSR	00:27	1.44%	86%	5,889
May-23	CSR	00:20	1.26%	86%	6,570
Jun-23	CSR	00:28	1.93%	83%	6,309
Jul-23	CSR	00:32	1.93%	81%	5,481
Aug-23	CSR	00:29	1.27%	83%	6,309
Sep-23	CSR	00:25	1.57%	83%	5,904
Total Calls FY23					72,082
FY 23 Average			1.60%	85%	6,007

Training Opportunities

The MCCMH Training Department increased the number of trainings hosted, both internally and externally, demonstrated by the 44% increase in individuals trained from 2022 to 2023. A variety of new training courses were created to fill deficits in clinical knowledge and to ensure effective services are provided to all populations served in Macomb County.

In 2023 the Training Department implemented an additional First Aid and CPR trainer and Nonviolent Crisis Intervention trainer, allowing us to offer this training to all providers in the MCCMH system. The Training Department worked closely with the Clinical Department to increase community outreach. This includes participating in the 2023 Macomb County Health Fair and hosting Mental Health First Aid trainings in which 80 people were trained, including MCCMH non-clinical staff and community partners.

The MCCMH Training Department actively participated in a training partnership with Oakland County Health Network (OCHN), by assisting OCHN in getting their Direct Support Professional (DSP) content ready and fully training their first nurse leading to OCHN's DSP training launch date of 10.01.23. By the end of 2023, we had two nurses able to provide testing and training to DSP's working with MCCMH individuals and increase the number of staff trained. MCCMH Training Department participated in the OCHN DSP Training Focus Group to increase the comprehension and accessibility of this training content for DSP's state-wide. The Training

Department continues to participate in the MDHHS State Training Guidelines Workgroup and MichiCANS Stakeholder Group.

The MCCMH Training Department worked to emphasize the importance of integrating primary and behavioral healthcare throughout all trainings. This is most apparent in the various updates made to the Person-Centered Planning training and the focus on writing integrated care goals. The department also offered two series of training courses to enhance the knowledge of our network of direct and contracted agencies in their continued need of Integrated Health education. These trainings include Healthy Sleep, Opioids & Overdose, Integrating Primary and Behavioral Health and SBIRT Training.

MCCMH adopted a "Zero-Suicide Philosophy" in 2022 with a goal to identify and implement evidence-based practices for clinical and non-clinical staff. This goal was met by sending Training Department staff to become certified trainers for Question, Persuade, Refer (QPR) and Assessing & Managing Suicide Risk (AMSR). The Training Department trained 60 non-clinical staff members in QPR and 172 clinical staff members in AMSR.

The training department brought in experts to train clinicians in Evidence-Based Practices including Prolonged Exposure Therapy, Integrated Dual Disorder Treatment, Introduction to Motivational Interviewing, Crisis Response and Intervention Training and Solution-Focused Brief Therapy. Training Department staff worked to create evidence-based skills refreshers including Principles & Applications of Cognitive Behavioral Therapy, Solution-Focused Brief Therapy and Grieving & Solution-Focused Support.

The Training Department arranged for local agencies to put on presentations about underserved populations in our community including the Deaf and Hard of Hearing population and informational sessions about Power of Attorney & Substituted Decision Making and 504 Behavior Plans & Individualized Education Plans.

Additional training topics that offered continuing education, substance use, and children's training hours include Behavior Treatment Plans, Children's Access to Technology, Collaborative Documentation, Military & Veterans Culture, The Right to Sex and Education for Individuals with Intellectual and Developmental Disabilities and Social Media and The Impact of Youth Development and Mental Health. The training department was also able to offer Human Trafficking and Implicit Bias trainings to assist clinical staff in meeting their licensure training requirements.

Policies and Procedures

During FY2023, MCCMH began contracting with the Policy Management Software, Logic Gate, to standardize and streamline policy review and approval lifecycles. Logic Gate's governance, risk, and compliance (GRC) software will help MCCMH ensure that all policies are up to date with the most recent regulations and external requirements.

Annual attestations have been built into MCCMH's new policy management system to help facilitate each policy being reviewed by the appropriate subject matter expert at MCCMH on at least an annual basis. MCCMH's policy management system also brings the functionality to run reports on policy reviews and updates to satisfy audit requests. MCCMH began building the policy

management system in July 2023 and over the last six months has developed the necessary workflows, permission sets, and logic behind each policy and coded such information into the system. MCCMH plans to roll out the new policy management system for agency-wide use in Q2 of FY 2024.

2023 Improvement Initiatives

MCCMH maintains short-term "Rock" projects to ensure agency-wide focus on identified strategic planning initiatives. The following areas remain strategic planning focus areas for MCCMH:

Access to Care

MCCMH has an improvement initiative to reduce average intake time to under two hours. Current objectives for this initiative include developing a patient portal that is available to all persons served, proposing intake changes to be incorporated into MCCMH's electronic medical record, collecting, and reporting average intake times (by intake section), improving workflows for BHTEDS/demographic information collection, and proposing improvements for access to intake for individuals with transportation obstacles.

Putting People First

MCCMH has been engaged in a one-year priority project to center its mission of putting people first. Its efforts include implementing measurement on evidence-based practices, establishing standards and metrics for person centered planning and staff supervision, and implementing a system for intervention. Current objectives for the project include piloting new vignettes for the person-centered planning training on both direct and contract providers for feedback and implementation; measuring evidence-based treatment outcomes; implementing specific updates to is EMR; and focusing on quantifiable measurement systems to ensure documented supervision between clinician and supervisor consider HIPPA and other legal considerations.

Diversity, Equity, and Inclusion (DEI)

The following areas delineate specific DEI initiatives that MCCMH worked on over FY2023:

DEI Steering Committee (DEISC): Throughout 2023, our DEI Steering Committee met quarterly to provide strategic guidance and ensure alignment with our DEI goals. Their insights and dedication have been instrumental in shaping our DEI initiatives.

Implicit Bias and Cultural Competency Revamp: Responding to valuable feedback from the Health Management Association (HMA) equity assessment, we initiated a revamp of our Implicit Bias and Cultural Competency training programs. This process involved incorporating insights from our sessions and external research to make these programs even more effective and engaging.

DEI Monthly Newsletters: MCCMH's DEI Monthly Newsletters were a significant success in 2023. They served as a vital communication tool, ensuring our entire organization was well-informed about DEI updates. MCCMH witnessed high employee engagement, which is a testament to the growing interest and commitment to DEI principles within its team.

Mystery Coffee Program: The Mystery Coffee Program was a unique initiative aimed at fostering connections and understanding among employees. It was heartening to see the growing interest and participation, as it aligns with MCCMH's goals of promoting inclusivity and a sense of belonging.

Culturally Affirming Lobby: The DEISC ROCK group successfully completed lobby assessments across the organization and presented recommendations to Leadership. Looking ahead to 2024, MCCMH is actively working on enhancing lobbies with culturally affirming and welcoming furniture, art, and literature. These efforts are aimed at creating spaces that are inclusive, ensuring that everyone who enters MCCMH facilities feels respected and valued.

Member Art Initiative: As an extension of the lobby assessment, MCCMH is launching the Member Art Initiative, a program designed to spotlight the diverse artistic talents within its community. This initiative will involve rotating artworks throughout all MCCMH locations. It offers a platform for local artists to exhibit their creations, enhancing spaces with cultural diversity and creativity.

Commission on Accreditation of Rehabilitation Facilities (CARF)

During FY 2023, MCCMH engaged in an accreditation re-survey to maintain its CARF Accreditation for its directly operated service programs. MCCMH received full accreditation status valid through June 30, 2026, for the following program(s)/service(s) surveyed:

Program(s)/Service(s) Surveyed

Assertive Community Treatment: Integrated: SUD/Mental Health (Adults)
Assessment and Referral: Integrated: IDD/Mental Health (Adults)
Assessment and Referral: Integrated: IDD/Mental Health (Children and Adolescents)
Assessment and Referral: Mental Health (Adults)
Assessment and Referral: Mental Health (Children and Adolescents)
Call Centers: Mental Health (Adults)
Call Centers: Mental Health (Children and Adolescents)
Case Management/Services Coordination: Integrated: IDD/Mental Health (Adults)
Case Management/Services Coordination: Integrated: IDD/Mental Health (Children and Adolescents)
Case Management/Services Coordination: Mental Health (Adults)
Case Management/Services Coordination: Mental Health (Children and Adolescents)
Community Integration: Psychosocial Rehabilitation (Adults)
Court Treatment: Mental Health (Adults)
Crisis Intervention: Mental Health (Adults)
Crisis Intervention: Mental Health (Children and Adolescents)
Integrated Behavioral Health/Primary Care: Comprehensive Care (Adults)
Intensive Family-Based Services: Mental Health (Children and Adolescents)
Outpatient Treatment: Mental Health (Adults)
Outpatient Treatment: Mental Health (Children and Adolescents)
Governance Standards Applied

CARF surveyors provided feedback that covered MCCMH areas for strength as well as areas for improvement. MCCMH's Quality Department developed a quality improvement plan (QIP) in response to CARF's feedback. The QIP covers the following areas: Performance Measurement and Management, Performance Improvement, Person Centered Planning, Transition and Discharge Planning, and Medication Use.

To improve in these areas MCCMH developed improved survey mechanisms, data review and analysis techniques, training curriculum, quality oversight processes, and standard operating processes. All improvement initiatives are tracked and monitored using a developed Microsoft Planner and progress made is discussed at monthly Quality Committee meetings.

National Committee for Quality Assurance (NCQA)

MCCMH continued preparation efforts to apply for National Accreditation for Quality Assurance (NCQA) accreditation. MCCMH has made significant progress to comply with NCQA's Managed Behavioral Health Organization standards through ongoing review and development of formalized documentation, reports, and case files.

MCCMH continues to collaborate with The Mihalik Group (TMG) for consultative advisement on appropriate adherence to NCQA standards and has scheduled bi-weekly meetings to ensure established timelines are being met. Current priority areas include the development of quality improvement (QI), care coordination (CC), and credentialing (CR) policies; utilization management (UM) criteria; UM system controls documentation; UM program description; UM appropriate professionals; credentialing system controls; appeals process flows; provider and practitioner directories; provider terminations; member experience reviews; and complex case management program development. The following image illustrates MCCMH's anticipated timeline to achieve NCQA accreditation: