MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Quality Assessment Performance Improvement Program Evaluation

Year End Report FY 2024

Approval History:

Entity	Approval Date
Approved by MCCMH Board of Directors	02/26/2025

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

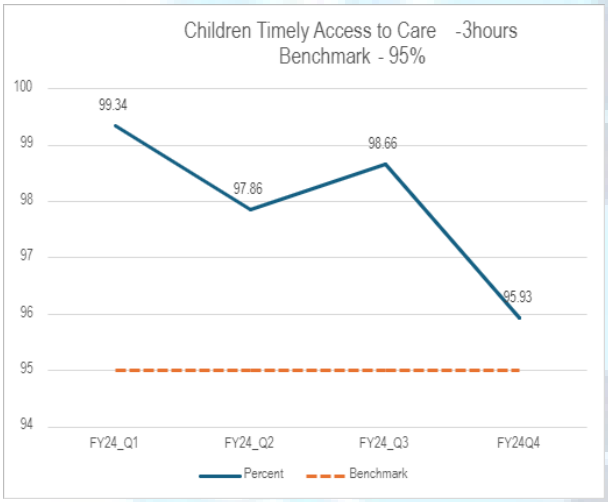
Key Performance Indicators

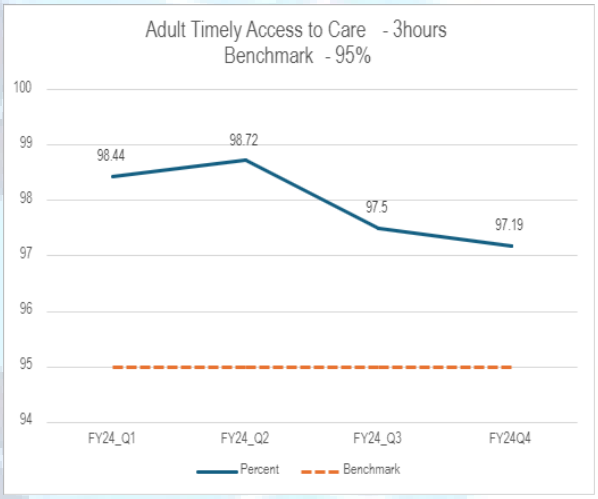
MCCMH works to ensure all Federal, State, and Local contractual obligations are met. MCCMH is responsible for oversight of established Key Performance Indicators (KPI) measures based upon Michigan's Mission-Based Performance Indicator System (MMBPIS) developed by MDHHS. Standards for performance measure compliance for FY23 were based on the MMBPIS Codebook. Indicator 1, 4a, and 4b have a standard of 95% or better. Indicator 10 has a standard of 15% or 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. For Indicator 2, MCCMH is required to meet the 50th percentile, in this case 57%

and 75th percentile for Indicator 3 which is 83.8 percent. The information and tables below depict MCCMH's FY 24 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:

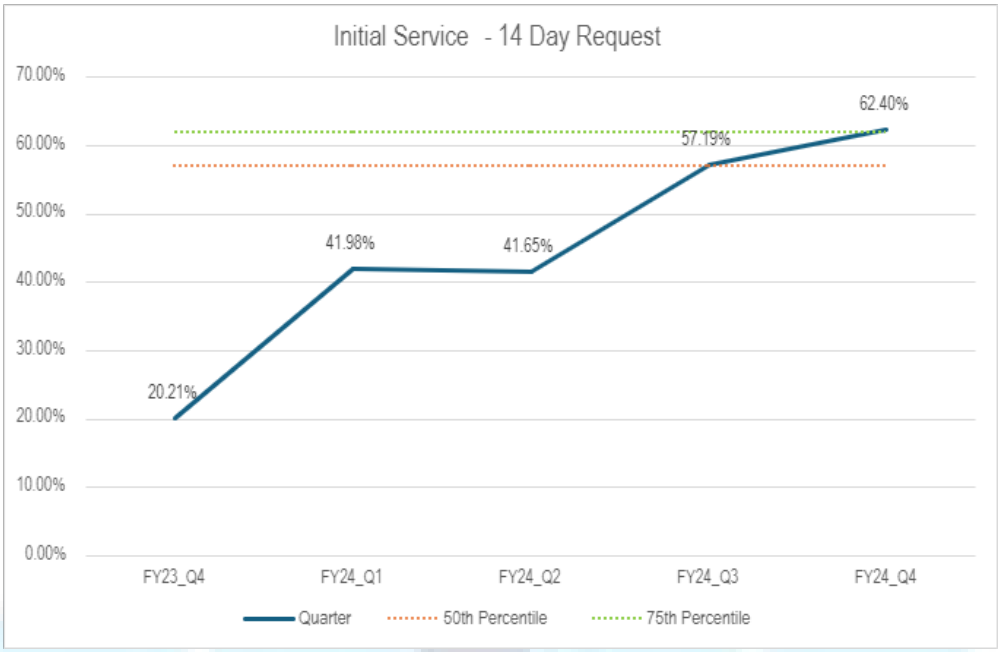
Indicator #1:
(Benchmark - 95%: Met)
The percentage of persons served during 2024 receiving pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three (3) hours. MCCMH consistently met this performance measure. MCCMH has continued to exceed the MDHHS performance measure standard of 95%, achieving 95.93% compliance score in this area for children and 97.19% compliance score for adults. The importance of meeting this standard ensures that those who are experiencing significant mental health concerns are receiving a timely screening and assessment to determine the appropriate level of care.





Indicator #2:
(Benchmark - 57%: Met)
The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within fourteen (14) days of a non-emergency request for service. Based on internal tracking, MCCMH saw consistent growth in this area.

MCCMH implemented multiple initiatives both internally and with its provider network to address access to care. MCCMH established a "ROCK", strategic initiative project, throughout FY 2024 that focused specifically on access to care. A workgroup was put in place to review the codebook and the logic to ensure data is being pulled as indicated in the codebook The Quality Department developed and provided training to MCCMH's provider network on the nature and scope of KPI standards and how to meet the standards. In addition, members of MCCMH's Leadership met one on one with providers to understand their individual challenges and work with them to overcome those challenges. MCCMH is now working to meet the 75th percentile in 2025.

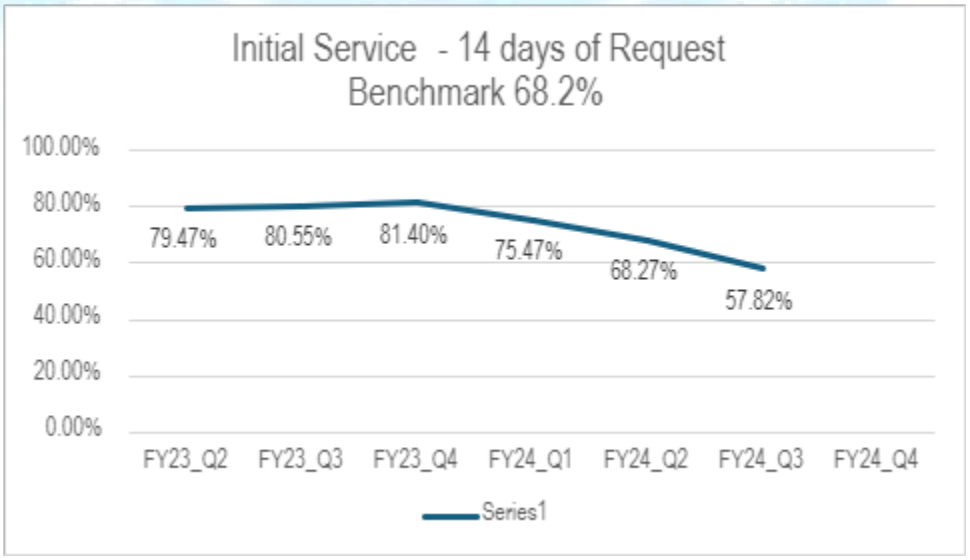


Indicator #2e:

(Benchmark - 68.2%: Not Met)

The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within fourteen (14) calendar days of a non-emergency request for service for persons with substance use disorders (SUD).

This indicator is calculated by MDHHS' Behavioral and Physical Health and Aging Services Administration (BPHASA) based on quarterly information reported to MDHHS by MCCMH. This indicator has seen a consistent downward trend across FY2024. However, MCCMH has reached out to MDHHS to obtain more details on how this data is being calculated and to identify ways to improve the data.



There are several factors influencing the data reported for this indicator. The most prominent factor is limited outpatient clinic capacity. MCCMH has taken the following steps to address the effects of limited outpatient clinic capacity:

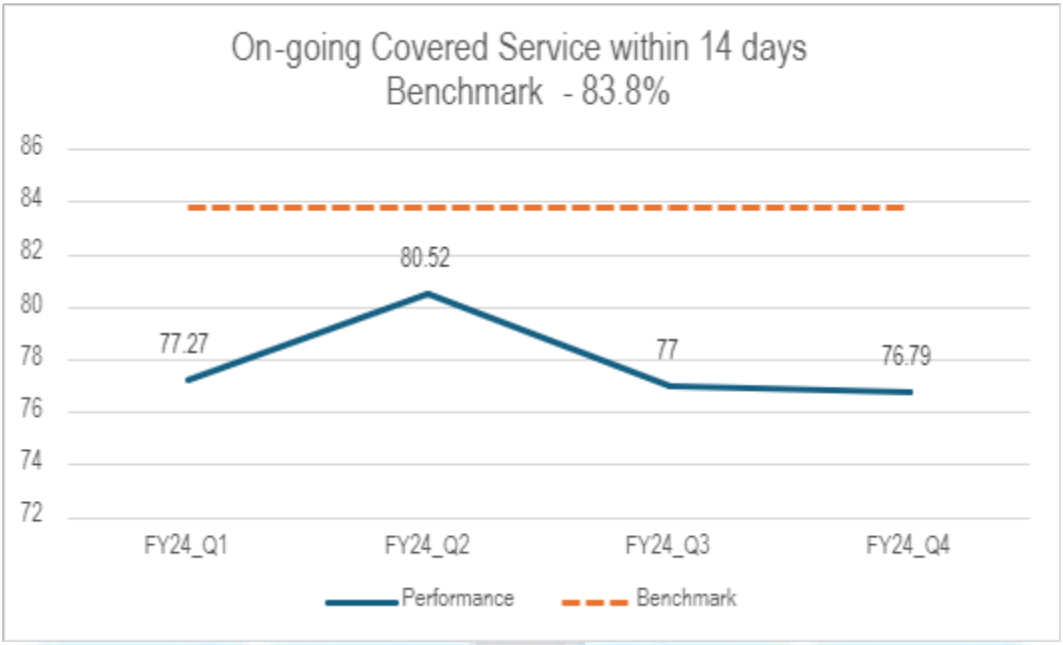
- Met with two (2) contracted providers who are not servicing our persons served despite being contracted for several years. The purpose of this meeting was to understand if the providers were not receiving referrals from MCCMH or if the providers had capacity issues. The end result was to collaborate and bridge any gaps that may exist.

- Added contracts for two (2) new outpatient providers through MCCMH's issuance of a request for proposal (RFP) process during FY2024.

- Requested timeliness to treatment data from MDHHS so MCCMH can analyze the data and see which providers are struggling with timeliness so we can provide additional technical assistance to them.

Indicator #3:
(Benchmark – 83.8% (75th percentile) - Not met)
The percentage of new persons during the quarter starting any medically necessary on-going covered service within fourteen (14) days of completing a non-emergent biopsychosocial assessment. Based on internal tracking, MCCMH has consistently seen a decrease in Q3 and Q4.

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. In 2024, MCCMH increased the number of available appointments at the North and East locations and also made available openings for walk-ins. Leadership has also been meeting with providers one on one to understand their challenges and identify possible solutions.



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 steadily improved in ensuring follow up appointments post hospitalization for children and adults for Indicator #4a for FY 2024.

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 seven (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.

MCCMH engaged in specific initiatives to address challenges and bridge barriers on racial disparity. Some of those initiatives include:

1. Integrated Outreach and Partnerships: In FY 2024, MCCMH continued to actively participate in community health fairs, workshops, and seminars to engage directly with underserved communities. These events serve as platforms for both disseminating information and forging partnerships with other organizations and community leaders.

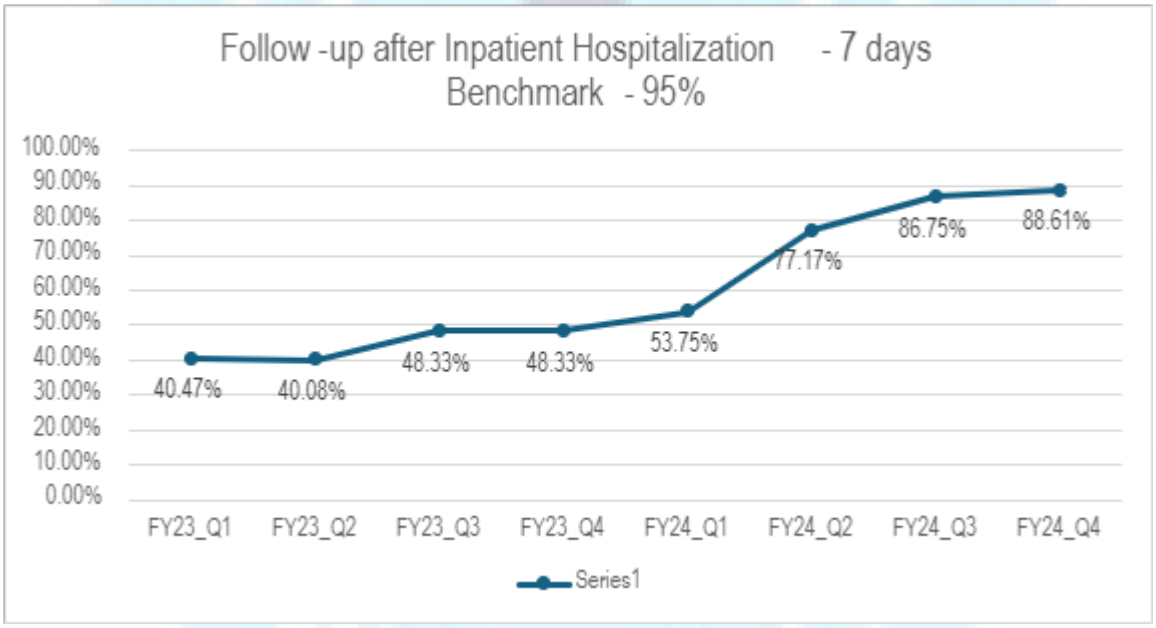
2. Cultural Competency and Implicit Bias Training: All team members undergo mandatory cultural competency training during orientation and implicit bias

training to ensure they are well-prepared to serve our diverse community respectfully and effectively.

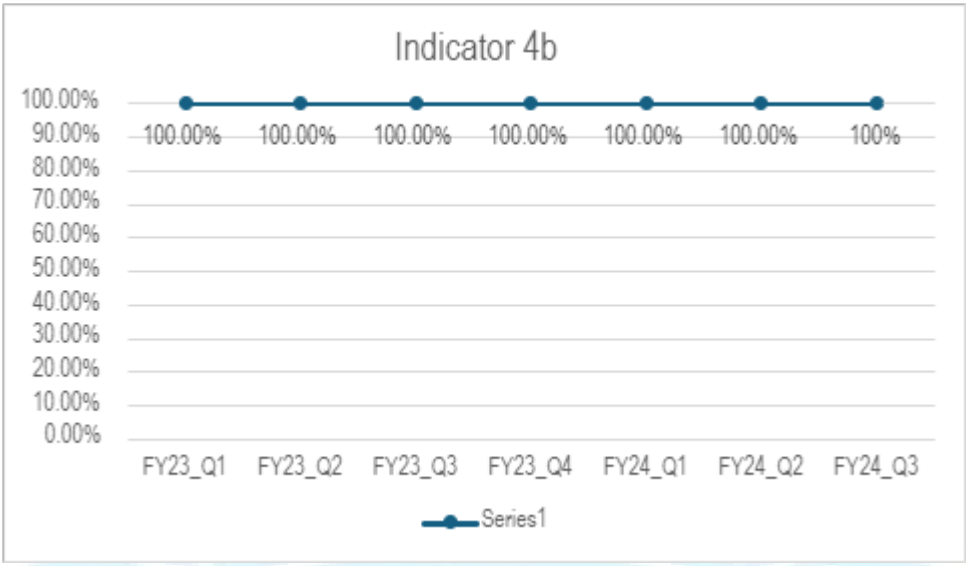
3. Service Delivery Revisions: MCCMH continuously reviews and adjusts service delivery models to ensure they are inclusive and accessible to all community members. This includes adjusting appointment scheduling, language services, and physical accessibility, ensuring our services are accommodating to everyone.

4. MCCMH Leadership has started meeting with targeted providers to consider adjusting their service delivery models by opening more walk-in appointments to ease accessibility.

5. Lastly, MCCMH has been holding monthly Quality Provider meetings to discuss challenges that exist around racial disparity and some of the interventions that can be put in place to address those challenges.



Indicator #4b:
(95% Standard: 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 has been at 100% for FY 2024.

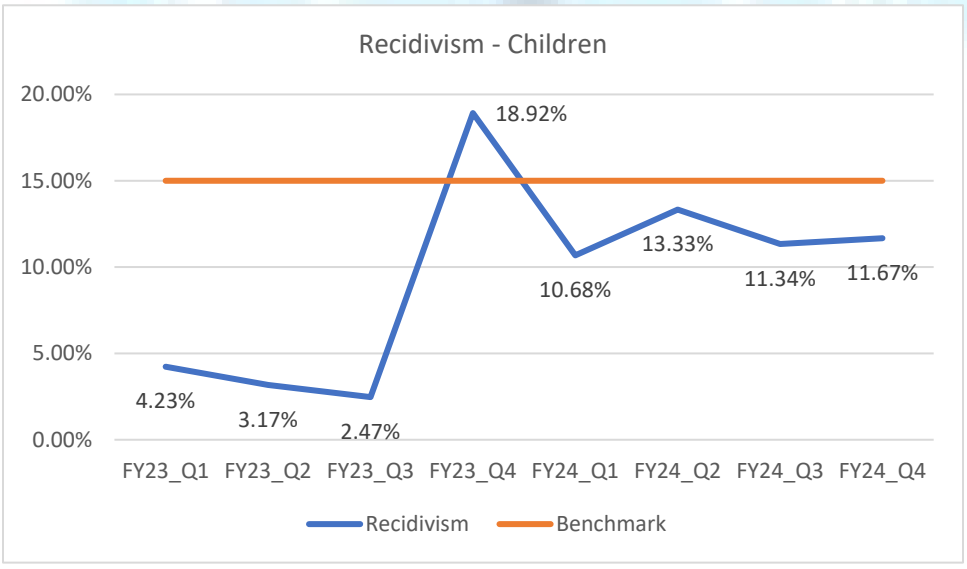


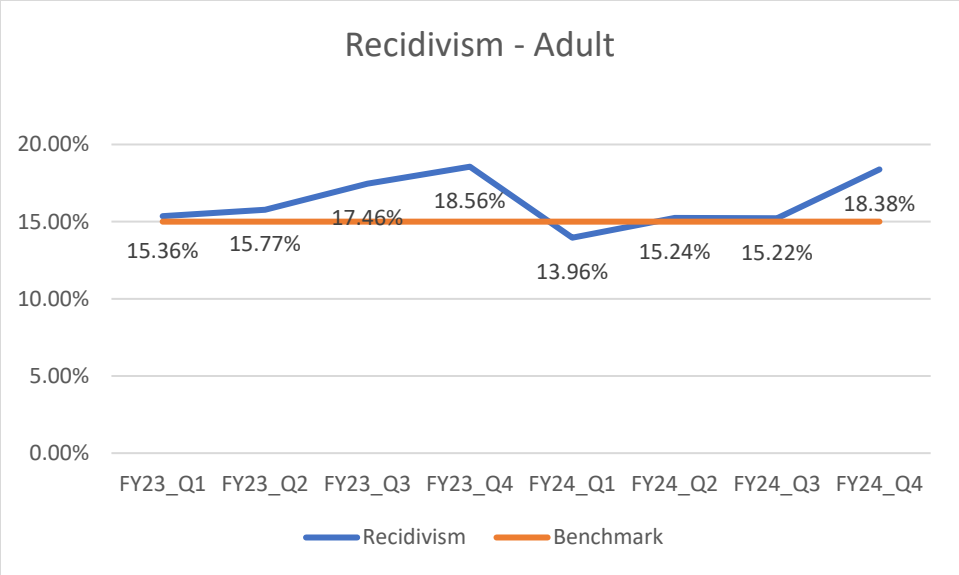
Indicator #10:

(15% or Less Standard: Partially Met)

The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within thirty (30) days of discharge. Based on internal tracking, MCCMH saw an overall increase in recidivism for children and adults represented by Indicator #10 for FY 2024.

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 spike in recidivistic cases during Q1 of FY 2024. Ongoing efforts to address this area are occurring across MCCMH departments. The Quality Department in collaboration with the medical office to review highly recidivistic cases to identify underlying reasons and identify possible remediations.





FY 2024 Performance Measure Improvement Strategies Overview:

MCCMH internal performance goals were partially met throughout FY 2024. Below is a chart that depicts MCCMH's target improvement areas throughout FY 2024, and status based on completion and implementation.

Target Improvement Area	Status
Collect, analyze and monitor PI data on a quarterly 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	Ongoing

FY 2024 Performance Measure Improvement Strategies:

MCCMH worked towards meeting or exceeding MDHHS benchmarks for each of the MMBPIS performance measures. For any areas that perform below the standard, MCCMH developed 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 initiatives 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 performance indicator (PI) reports. This will support the provider network to implement provider level strategies to target their specific areas or deficiencies and overall access to care.

In October 2023, the Bureau of Specialty Behavioral Health Services began a comprehensive review of the existing quality assessment and performance improvement program and implemented a new set of quality programs. This will be in the form of a 3-year rollout. The rollout plan was shared with the PIHPS in September of 2024. Year- 1 (2025) measures are as follows:

Year-1 Rollout of New Performance improvement Initiative

	Measure	**Program**	**Domain**
ADD	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	BHCS	MH
CDF	Screening for Depression and Follow-up Plan*	BHCS	MH
FUH	Follow-up After Hospitalization for Mental Illness*	BHCS	Access
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	BHCS	MH
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	BHCS	MH
FUA	Follow-up After Emergency Department Visit for Substance Use*	BHCS	Access
FUM	Follow-up After Emergency Department Visit for Mental Illness*	BHCS	Access
IET	Initiation and Engagement into Substance Use Disorder Treatment	BHCS	SUD
MSC	Medical Assistance with Smoking and Tobacco Use Cessation	BHCS	SUD
AMM	Antidepressant Medication Management	BHCS	MH

To prepare for the Behavioral Health Quality Overhaul 3YR Rollout, MCCMH has participated in several Quality Improvement activities throughout FY 2024. The initial goal for the new measures involves establishing a baseline for those that have not previously been tracked. Utilizing CC360, MCCMH established a baseline to compare to the State average. After comparing MCCMH to the State Medicaid average, MCCMH determined the new Key Performance Indicators (KPIs) that were below the benchmark and required additional intervention. Those KPIs are as follows:

- ADD-CH: Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase

- APP-CH: Use of First-Line Psychosocial Care for Children/Adolescents on Antipsychotics
- IET-ADOT: Initiation and Engagement of SUD Treatment – Engagement Phase for the "Other Drug" population
- FUH-AD: Follow-Up After Hospitalization for Mental Illness - Adult
- FUM-CH: Follow-Up After ED Visit for Mental Illness - Child

These specific KPIs will continue to be the focus of MCCMH's Performance Improvement initiatives in FY 2025. MCCMH engaged in high level data discussions with external provider network as well as the Quality Committee. These discussions have led to several insights into additional areas for improvement including provider education surrounding psychosocial care and the importance of having standardized discharge processes for newly assigned persons served.

To continue with the performance improvement initiatives in these areas, MCCMH is creating Quick Reference Tools for each of the new KPIs. This provides MCCMH Providers quick access to the measure specifics and the appropriate codes to utilize.

Additionally, MCCMH is working to standardize the following processes amongst all providers:

- Discharge Planning, Outreach, and Billing for Newly Assigned Members
- Post-Emergency Department Visit Planning for Children/Adolescents
- Outreach for the Substance Use Disorder (SUD) Population that Falls into the "Other Drugs" Category
- Use of Psychosocial Care

MCCMH is continuing to analyze this data as it becomes available and identify opportunities for further interventions and types of intervention.

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 utilized recommendations from the PIP Validation Report from HSAG throughout FY 2024 to guide organization wide initiatives and specialized workgroups. Based on recommendations from the report, MCCMH 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 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 person served 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 was 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 FY 2024.

The pilot program's intended target population included individuals admitted to the hospital for inpatient psychiatric treatment who were not open and active with a primary clinical provider. Due to staff shortages, this pilot did not see its intended outcome.

Based on additional barrier analyses, transportation was identified as a significant barrier for individuals to attend their follow up appointments after hospitalization. Therefore, MCCMH has developed a document with the Medicaid health plan transportation guide for providers to

share with members to be able to access transportation. MCCMH's Leadership Team is also looking at other options to bridge the existing transportation gap.

Remeasurement 1 data was collected in 2024. The table below depicts identified barriers, interventions, and status based on MCCMH progress towards implementation throughout FY 2024.

Measurement Period	Intervention Description	Evaluation Process	Evaluation Results	Next Steps
Baseline and Re-measurement 1	Increased number of available appointments at MCCMH North and East locations for individuals discharged from inpatient hospital settings. MCCMH leadership implemented one on one meetings with providers to address barriers and creating more opportunities for walk-in appointments.	Reviewed data to assess the impact of additional walk-in appointments at North and East locations and to external providers. The outcome was insignificant, so additional walk-in appointments are needed. Leadership will continue to have one-on-one meetings with primary providers to support them adopting the walk-in appointment module.	Two additional intake appointments were added to the weekly schedule at the East and West locations starting in January of 2023. Further review shows that more intake appointments are needed. Due to the one-on-one meetings with providers by leadership, three primary providers have engaged and have opened slots for walk-in appointments with the aim to improve appointment availability.	Continue to follow-up in internal Access to Care meetings on status of increasing East/North Walk in appointments. MCCMH's leadership is working with primary providers to increase appointment availabilities and walk-ins. This intervention is new so there is not enough data to show improvement.
Baseline and Re-measurement 1	Update electronic medical record (EMR) calendar to accurately represent available appointments within the network.	Available calendar appointments was being be monitored bi-weekly to support increased availability.	Limited availability continues to present challenges for follow-up after hospitalization. Not all providers use the FOCUS calendar, so MCCMH encourages them to use the	Network Operations will continue to work with providers for a long-term solution on how to make appointments more visible to MCCMH staff.

			system. For providers who use the FOCUS calendar, they do not put all availability, so MCCMH staff must call for more appointments.	
Baseline And Re-measurement 1	MCCMH Hospital Liaison Team updated formal processes to improve communication with members after discharge to provide support attending their follow-up appointment.	Formal process update was completed at the Quality ROCK initiative. Implementation was delayed due to staffing challenges.	The Hospital Liaison role was redefined at Quality ROCK. Full implementation was delayed due to staffing challenges.	Monitor the impact of reshaping the Hospital Liaison role. However, full implementation is still pending.
Baseline and Re-measurement 1	Managed Care Operations staff improved coordination with the MCCMH Hospital Liaison Team for discharging members by having weekly standing meetings to address and issues.	There is a weekly standing meeting scheduled via Teams with Managed Care Operations and the Hospital Liaison Team. Participants include staff and supervisors from both teams.	During the weekly standing meetings, barriers were identified and addressed.	Weekly standing meetings will continue to occur, and barriers will be identified and addressed accordingly.
Baseline and Re - measurement 1	Conducted a provider survey to identify network-wide barriers related to follow-up care coordination.	MCCMH reviewed survey data and assessed initial patterns and trends. Survey results were aggregated and formalized for reference.	Results of the provider survey were reviewed by the Clinical PIP workgroup. The major barriers identified were transportation and staffing challenges. MCCMH's leadership continues to work with	The PIP workgroup will continue to monitor trends from the survey and ensure that barriers are addressed appropriately. Transportation and network capacity were the main barriers identified. MCCMH Leadership is exploring various options to address transportation challenges among the underserved population.

			providers to address these barriers.	
Baseline and Re - measurement 1	Utilize dashboards to trend out-of- compliance cases and identify trends and patterns specific to race and ethnicity.	Internal dashboards were reviewed bi-weekly to track reported compliance, specific to race and ethnicity, with MDHHS performance measures.	The Informatics department continues to review ways to effectively pull data to create dashboards.	Develop and revise initiatives, specific to race and ethnicity, as data trends and patterns emerge.
Baseline and Re - measurement 1	Developed dashboards for providers on compliance rates based on MMBPIS performance standards.	Internal dashboards were reviewed weekly to track improvements in reported compliance with MMBPIS performance standards.	The Informatics department continues to explore ways to effectively pull data to create dashboards.	Establish internal benchmarks for compliance rates.
Baseline and Re - measurement 1	Developed formalized processes with providers to review their current compliance rates.	Out of Compliance data, specific to providers, were shared with providers. This data was reviewed and tracked quarterly to understand reasons for out of compliance, reviewed plans for improvement and evaluated outcome.	MCCMH Quality department developed a process to provide out-of-compliance data to providers to understand reasons for out-of-compliance and develop possible interventions.	MCCMH Quality Department is using the state standard to educate providers on why they are out of compliance and possible improvements they can make to become compliant. Some improvement has been observed but the Quality Department continues to analyze the data for additional trends.
Baseline and Re - measurement 1	Issued a memo to provider network to remind providers of the required standard and detail	A memo was issued to providers on 05/23 to the provider network on	This additional training took place in July 2024.	The Quality Department will continue to monitor provider

	MDHHS MMBPIS PIHP standards.	the importance of meeting this standard. As of July 2024, the Quality Department provided additional training to the provider network. This training explained what each KPI means and how to meet each standard.	This training was made available to the entire provider network.	network on this standard and assist to bridge barriers.
Baseline and Re - measurement 1	Met with providers to reiterate the importance of follow-up after inpatient stay and provided opportunities to further discuss challenges providers may be facing.	Monitor improvements in compliance per provider between baseline findings and re-measurement 1.	The Quality Department has been meeting with the network providers monthly. Part of this meeting is to discuss what providers are doing when their member goes in inpatient and steps to ensure timely follow-up appointments.	The Quality Department will continue to have monthly meetings with providers to maintain ongoing discussions around follow-up after hospitalization.

Non-Clinical PIP:

For its Non-Clinical Performance Improvement Project, MCCMH focused on improving its MDHHS Habilitation Supports Waiver (HAB) enrollment across the provider network. MCCMH's average enrollment rate throughout FY 2024 exceeded 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 477 allotted HAB slots for 2024 and currently has 8 slots available that need to be filled. This places MCCMH's benchmark.

- 477 Slots Available
- 469 Slots Utilized *(442 for FY 2024)*
- 8 Slots Available
- 98.3%

Coordinated efforts between the Quality Department and Network Operations began in Q1 of FY 2024 to assess current and ongoing barriers impacting HAB enrollment. Systematic barriers included the waiver's 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 developed strategies to effectively approach barriers through specific and measurable interventions. MCCMH developed training materials to distribute to the network and has 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 for ways to improve the enrollment process for providers.

MCCMH's focus for FY 2024 was to create a structured approach based on identified barriers to ensure the Provider Network received more formal education and training on the benefits of HAB Waiver services.

Barrier Priority Ranking	Barrier Description	Intervention Description	Intervention Status	Intervention Type
1.	Low enrollment in MDHHS' Habilitation Supports Waiver	Review previous MDHHS reports to identify patterns and trends.	Ongoing	System Intervention

	(HAB) was reported throughout FY 2022	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.	Complete	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.	Complete	System Intervention
2.	Lack of network initiatives to improve enrollment numbers	Determine any previous or existing initiatives that were developed on this area.	Ongoing	System Intervention
		Gain deeper understanding of current state HAB workgroup and the scope of work it entails.	Complete	System Intervention
3.	Lack of education at provider level regarding eligibility for HAB waiver services	Educate providers on MDHHS' enrollment criteria for HAB.	Ongoing	Provider Intervention
		Develop training and resources on eligibility criteria and scope of services to share with network providers.	Complete	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.	Complete	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.	Complete	System Intervention
		Work with Children's Department to identify children transitioning from	Ongoing	Provider Intervention

		Children's Waiver Program (CWP) to encourage enrollment up until 6 months prior to 21st birthday.		

Auditing and Monitoring Activities

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 FY 2024, which began October 1, 2023, and ended December 31, 2023.

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 15, 2024, and MCCMH received its final report in September 2024. 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 2025 QAPIP Workplan.

HSAG Compliance Review:

MCCMH engaged in its FY 2024 Compliance Review with the Health Services Advisory Group (HSAG). This was the first year in 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 the following standards:

- Standard I – Member Rights and Member Information
- Standard III – Availability of Services
- Standard IV – Assurances of Adequate Capacity
- Standard V – Coordination and Continuity of Care

- Standard VI – Coverage and Authorization of Services

Following its Compliance Review in September of 2024, MCCMH achieved an overall compliance score of 84 percent, indicating adherence to many of the reviewed federal and state requirements. However, opportunities for improvement were identified in several of the areas.

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	21	17	4	3	**81%**
Standard III—Availability of Services	20	18	17	1	2	**94%**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100%**
Standard V—Coordination and Continuity of Care	16	15	14	1	1	**93%**
Standard VI—Coverage and Authorization of Services	23	22	14	8	1	**64%**
Total	**94**	**85**	**71**	**14**	**9**	**84%**

Upon receiving its results, MCCMH developed a Corrective Action Plan (CAP) to remediate all areas identified as "Not Met." Ongoing internal meetings began in December of 2024 to begin implementation of CAP elements within MCCMH's system of care.

To improve coordination of care standards, MCCMH Clinical Administrators held information sessions with all MCCMH Certified Community Behavioral Health Clinic (CCBHC) Designated Collaborating Organization (DCOs) and MCCMH direct service providers and provided them instructions, screenshots, and reminders to collect and complete coordination of care (COC) forms. MCCMH Clinical Risk Management Committee (CRMC) subgroup streamlined the COC form to allow the case holder to request specific records from the prescriber. Additional changes to the COC form and the ability to pull the consent to exchange health information (modeled after MDHHS-5515) into the COC when faxing directly from the EMR has been submitted for implementation.

<u>Quality Hospital Audits:</u>

MCCMH conducted its Fiscal Year 2024 Quality Hospital Audits for Behavioral Center of Michigan, Ascension Macomb-Oakland, and Harbor Oaks. An audit period from October 1, 2023, to September 30, 2024, was used and 5% of clinical charts from this period were reviewed. Charts were randomly selected and included length of stay outliers. The combine hospital result for 2024 is 97.82%

The Quality team conducted in-person site reviews in addition to desk chart reviews. The site reviews included a facility tour, staff record review, staff interviews, review of open cases, and

discussion on the hospitals' experiences with MCCMH. At the end of each visit, an exit conference was conducted to discuss findings and next steps. Each hospital received a comprehensive written report once the audit process was complete. If a hospital scored below 95% compliant, a corrective action plan was implemented, and they had thirty (30) calendar days to submit evidence to close their respective corrective action plan (CAP). Once a hospital audit report was finalized, MCCMH's Quality team uploaded the report and supporting notices to the MDHHS Inpatient Reciprocity Group for other regions in Michigan to reference.

MCCMH 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, discussing the importance of initiating discharge planning on the day of admission and collaborating with the outpatient provider, and discussing changes in the continuous stay review (CSR) form that will clearly indicate when a member opts to continue care with an out of network provider. Improvement initiatives are regularly discussed and monitored through MCCMH's quarterly meeting with hospitals.

Direct Provider Audit:

A review of MCCMH's directly operated programs was completed in 2024. The review comprised of all six divisions. The combined audit results were 85.41%. The Quality Department will meet with the direct sites in-person to review scores, discuss each area of the review tool, and discuss next steps with the department head and program supervisors. The Quality Department continues to provide technical support as the departments work through areas of improvement that were requested.

Residential Provider Audit:

During FY 2024, 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 followed a phase-based strategy for residential audits.

Since re-launching the residential audits in August 2023, MCCMH completed Licensed Residential Audits for 46% of residential homes (109/224) and 50% of its providers (34/68).

Of the residential homes reviewed, 72 homes (66%); 25 providers (74%) of the audited homes/providers scored below a 95% compliance threshold. When providers are found to fall below this threshold, MCCMH 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. Incident Report was not appropriately reported to MCCMH within 24 hours of the incident or not reported at all with 56.76% of homes being compliant.

2. MCCMH Coordination of Care Form: There is evidence of Coordination of Care form completed – 65.57% of homes compliant.

3. HIPPA Training: (Annual; completed within 90 days of hire) – 65.89% compliant

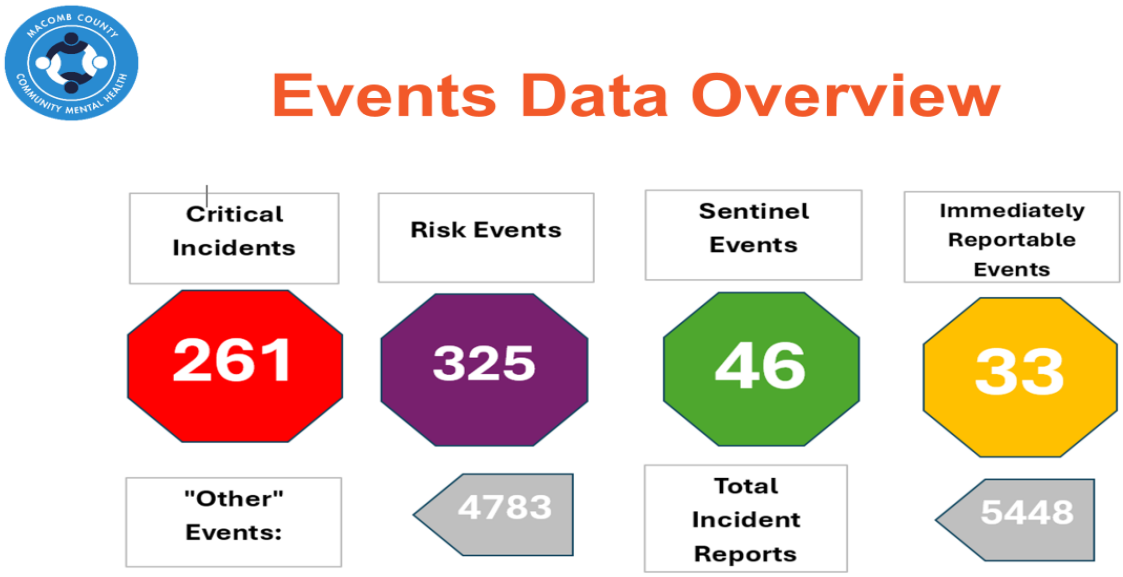
The current compliance rate for residential homes audited is 89.45%. MCCMH continues to partner with providers to highlight areas of strength as well as identify areas for improvement. MCCMH continues to provide technical assistance to support the providers through one on one meetings with providers to address their specific needs and also during the general region wide residential provider meetings.

Total Audits	
Providers	68
Homes	224
Completed Audits	
Homes	Providers
109	34
49%	50%
CAP Needed	
Homes	Providers
72	25
66%	74%
CAP Completed	
Homes	Providers
68	23
94%	92%

Events Data

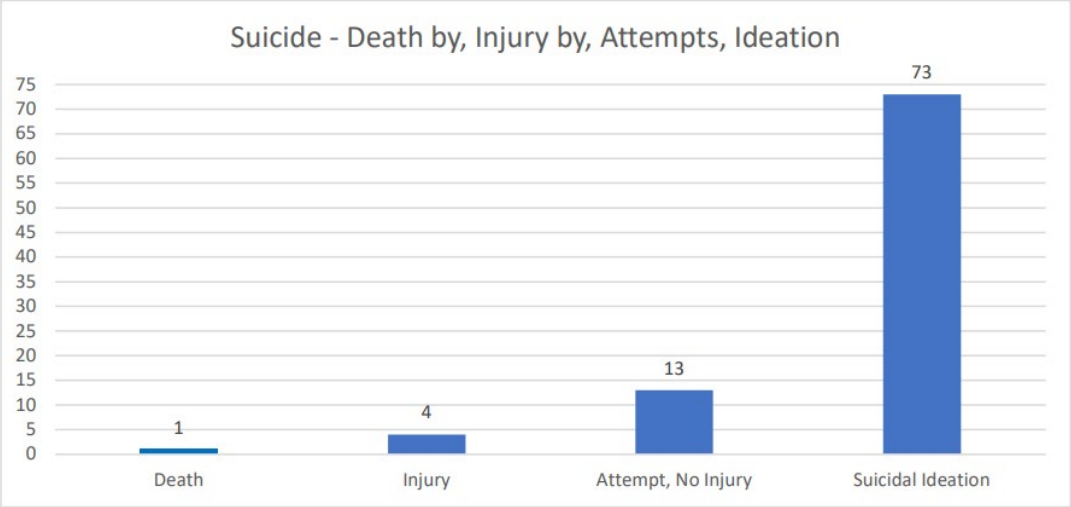
Incident reports are required to be submitted to MCCMH by the provider network for all incidents considered unusual. Incidents are reported via fax or directly submitted using a portal in MCCMH's electronic medical record (EMR) system. Reports submitted through the fax line are uploaded to the MCCMH incident report module in its EMR and reviewed by the Quality Department for tracking, trending and remediation purposes. Incident reports are coded, and critical/sentinel events are submitted to MDHHS in accordance with MDHHS reporting requirements. 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 all medication error incidents that are neither critical nor sentinel events. Suicide ideation incidents are reviewed by the Clinical Department in accordance with the CCBHC guidelines to establish system-wide risk reduction strategies and direct initiatives to persons served with trending risk concerns including behavior treatment planning.

There were 5448 incidents reported in FY 2024. 261 of these reports were considered Critical, 46 were Sentinel, 325 were Risk Events, and 33 were immediately reportable, while 4783 of the incidents were labeled "other." All incidents were reviewed by the Quality Department. Medication error incidents were reviewed by the Clinical Department and if it was critical or sentinel, it was also reviewed by the Clinical Risk Management Committee (CRMC). Recipient Rights concerns were reviewed by the right Department. MCCMH's improved incident tracking mechanisms have improved visibility in trending data and allowed the CRMC to develop appropriate strategies to mitigate risk, even those that fall outside of state reporting requirements. Some examples of such initiatives included 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 and the reviewing non-critical/sentinel medication errors and implementing interventions.



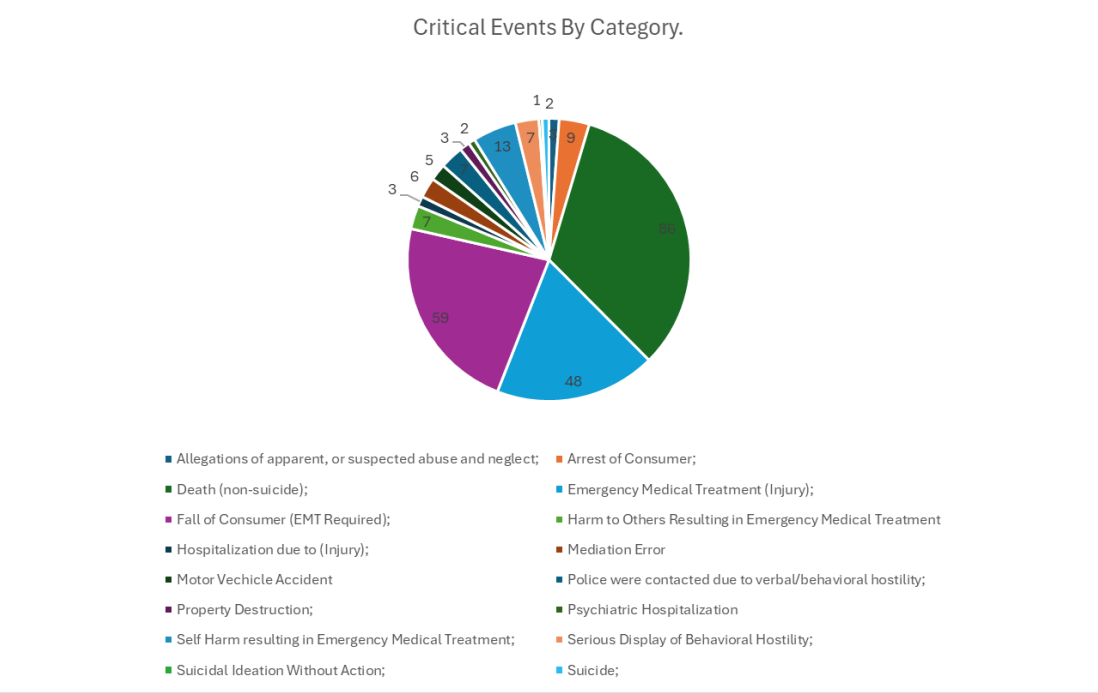
Suicide - Death by, Injury by, Attempts, and Ideation

The *Suicide - Death by, Injury by, Attempts, and Ideation Graph* below 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.



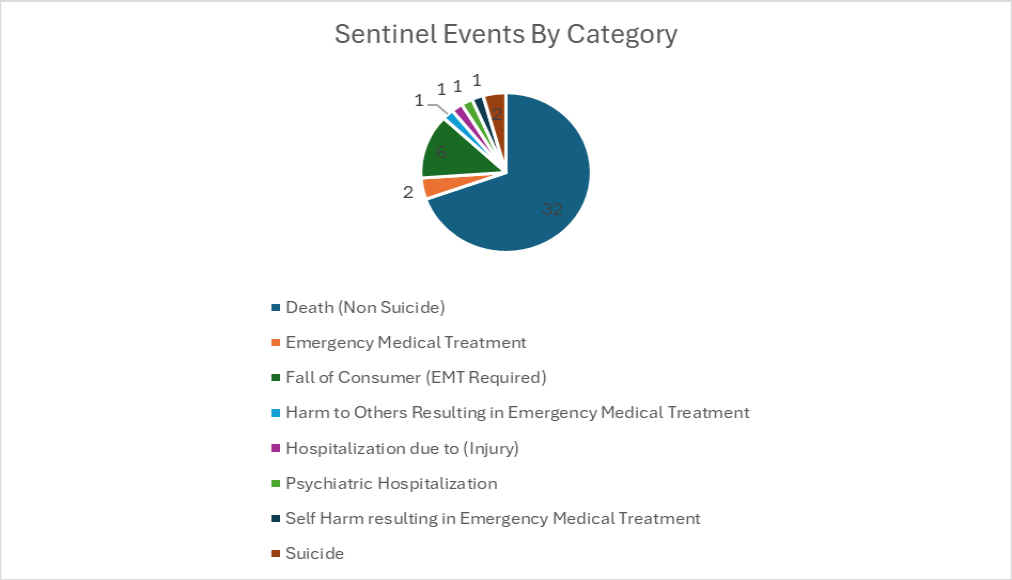
Critical Incidents by Category

The *Critical Incidents by Category Graph* below shows the number of Critical Incidents that were submitted for FY 2024. All Critical Events were reported to MDHHS.



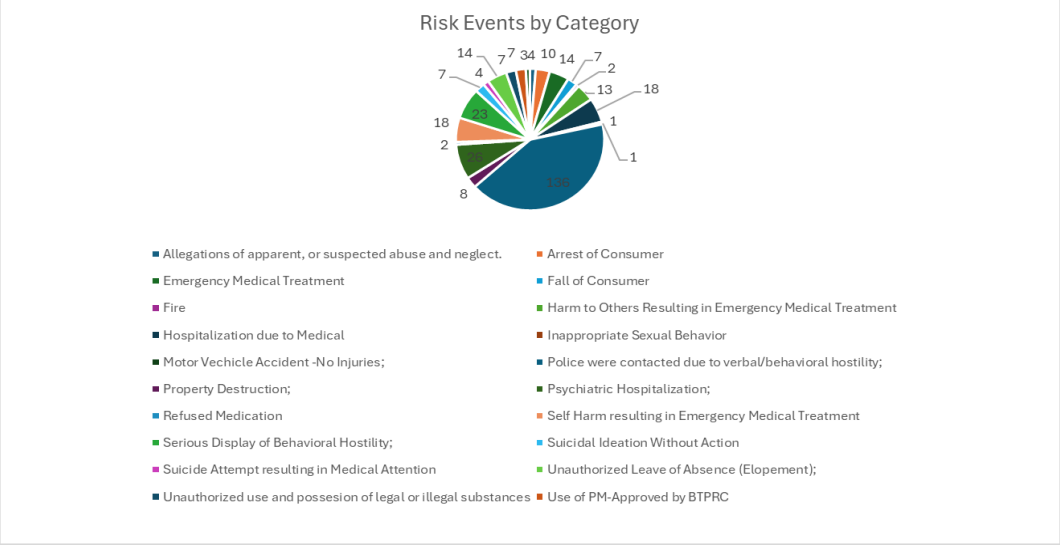
Sentinel Events by Category

The *Sentinel Events by Category Graph* below shows the number of Sentinel Events that were identified for FY 2024. All Sentinel Events lead to a root cause analysis request. All sentinel death cases are reviewed by the Critical Risk Management Committee (CRMC).



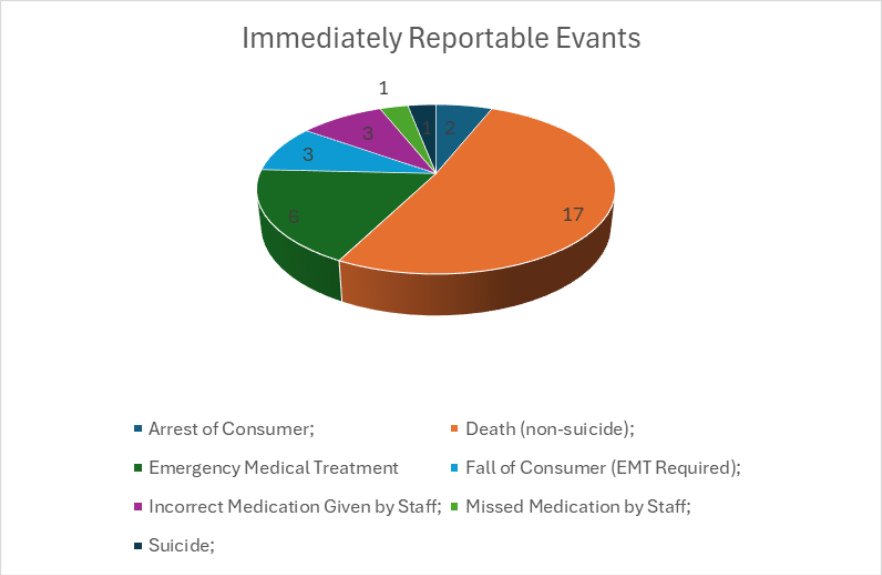
Risk Events by Category

The *Risk Events by Category Graph* below show the number of Risk Events that were identified for FY 2024. 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 Graph* below shows the number of Immediately Reportable Events that were identified for FY 2024. 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 have been provided to improve accuracy of reporting. Improvement initiatives have also been put in place to mitigate the future occurrence of reported events. For example, MCCMH's Chief Medical Office (CMO) developed numerous best practice guidelines to support the provider network in reducing incidents. In FY 2024 the CMO implemented an initiative to reduce falls of persons served by distributing grip-socks to residential homes for residents to wear.



Behavior Treatment Plan Review Committee (BTPRC).

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 FY 2024, the BTPRC reviewed 642 duplicated behavior treatment plans where restrictive or intrusive interventions have been utilized. This is an increase of 118 reviews since FY 2023. During FY 2024, there were 58 interventions; emergency physical management was used 19 times (may have been used on the same individual). This is a decrease from FY 2023 where the total count was 21. Where three (3) 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 may have been made as the Committee saw fit to assure quality of care for persons served. A total of twenty-four (24) 9-1-1 calls were made by staff to seek emergency intervention in cases where all other interventions failed or staff were not trained or approved for the use of emergency physical management. This is a decrease by two (2) calls from FY 2023.

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

Utilization Management (UM)

MCCMH's Managed Care Operations (MCO) division received 57,206 service authorization requests in FY 2024. 99.98% of these requests were processed within the required standard of fourteen (14) calendar days. MCO recognizes that turnaround time is a crucial metric as persons served are at times in urgent need of clinical services that require review and authorization. Delays in the processing of these requests could lead to individuals not receiving medically necessary services. For this reason, the MCO team attempts to meet a benchmark that is half the length of time of the required standard resulting in 93.4% of the requests received in FY 2024 being processed within seven (7) calendar days.

In FY 2024, the MCO Access Call Center received 19,437 phone calls from the public seeking access to services through MCCMH. MCO tracks several metrics to ensure there is a timely response to callers as this is essential to providing a welcoming and responsive access system. Two of the metrics used to monitor these calls are average speed-to-answer and abandonment rates. In FY2024, the calls were handled with an average speed to answer of 1:28 minutes, exceeding the required standard of 3:00 minutes. The average abandonment rate for the same period was 2.5%, which exceeded the required standard of 5%.

Following the relaunch of MCCMH's Utilization Management (UM) Committee in FY 2024, MCCMH also refined this committee's functions and oversight. In FY 2025, the UM Committee will be focusing on provider specific data within its network specific to hospitalization and specialized residential services to identify over- and under-utilization patterns and make recommendations for performance improvement. UM-related policies and procedures will continue to be examined and revised to ensure the highest standards are achieved.

The MCCMH Managed Care Operations (MCO) division will continue working closely with the MCCMH Clinical Informatics division to design and implement increased data-driven procedures and further improve utilization management outcomes. MCO will expand Inter-Rater Reliability (IRR) activities throughout the department to ensure consistency in the application of criteria in UM decisions.

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

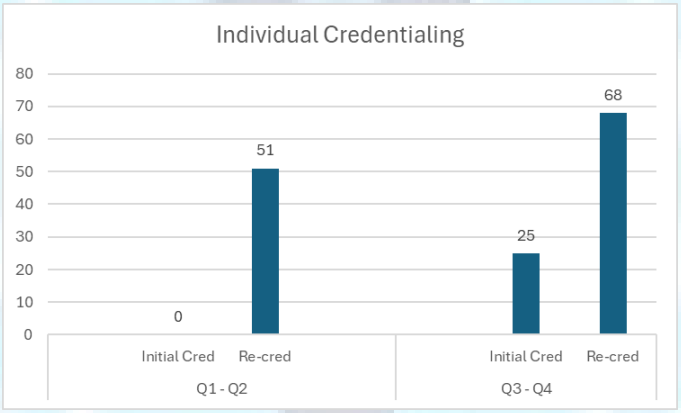
- Clinical Practice Guidelines – Schizophrenia

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

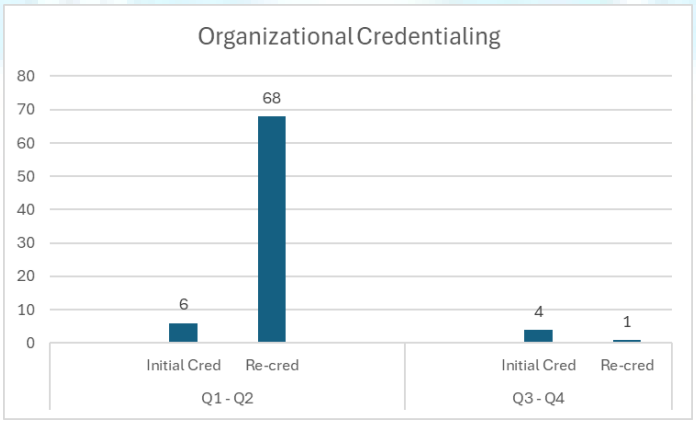
Clinical Practice Guidelines are reviewed and updated every two years. Throughout FY 2024, MCCMH's updated guidelines were presented to providers during network meetings where feedback was sought. After a period of review and feedback was given, the updated guides were formally adopted. Current Clinical Practice Guidelines are posted on MCCMH's website for ongoing reference and review.

Credentialing and Re-Credentialing Activities

In FY 2024, MCCMH credentialed and re-credentialed 144 individual practitioners and 79 organizations. Out of the 144 individual practitioners, 119 were re-credentialing decisions and 25 were initial credentialing decisions. All credential outcomes were made within thirty (30) business days from the date a complete package was received to when a decision was made. Performance data that MCCMH considers at the time of a provider's re-credentialing includes but is not limited to grievances, performance indicators, utilization, appeals, member satisfaction, provider monitoring reviews, critical incidents, etc.



In FY 2024, MCCMH credentialed 79 organizations. Ten (10) were initial credentialing and 69 were re-credentialing decisions.



To maintain the Certified Community Behavioral Health Clinic (CCBHC) Demonstration designation, MCCMH, as the CCBHC, provides quality oversight to its designated collaborating organizations (DCO). Part of this oversight includes overseeing the credentialing function for associated DCOs. In FY 2024, the Quality Department credentialed twenty-four (24) DCO staff utilizing a similar process as its internal credentialing.

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 were 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 person's served 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, 2024.

Mental Health Services

A total of 66 vendors were audited. Clinical records and payment documentation for a random sample of 3,697 claims, with a total dollar amount of $628,583.78. The audit period used was March 1, 2022, through February 28, 2024. The claims were reviewed for compliance with the MDHHS Quality Assessment and Performance Improvement Program.

The review focused on three specific areas of compliance:

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

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

Description	Recoverable	Non-Recoverable	Total Exceptions
$ Amount	$91,935.31	$536,648.47	$628,583.78
# of Claims	618	3,079	3,697
Percent of Total Exceptions $	14.6%	85.4%	100.0%
Percent of Total Audited $	2.0%	11.8%	13.9%

Prior Audit Comparison – a detailed comparison of current year audit results to 2022 results was prepared, with the following summary highlights:

Description	Year	Recoverable	Non-Recoverable	Total Exceptions
$ Amount	2024	$91,935.31	$536,648.47	$628,583.78
	2022	$22,195.43	$20,492.56	$42,687.99
Percent of Total Exceptions $	2024	14.6%	85.4%	100.0%
	2022	52%	48%	100.0%
Percent of Total Audited $	2024	2.0%	11.8%	13.9%
	2022	0.6%	0.6%	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, 2023, through February 28, 2024. Billing Verification audits were also completed for non-Medicaid covered services.

This verification included a review of:

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

Clinical records and payment documentation for 2,042 claims, classified under 19 vendors, for the period of March 1, 2023, through February 28, 2024, were randomly selected. The samples were selected representing 5.5% 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:

Description	# of Cases	# of Claim Lines	Amounts Paid
Claims Population	5,383	366,541	$16,029,878.37
Sample Claims	294	20,193	$929,377.52
Percent of Claims Population	5.5%	5.5%	5.8%

Description	Recoverable	Non-Recoverable	Total Exceptions
$ Amount	$10,164.36	$194,227.35	$204,391.71
# of Claims	72	755	827
Percent of Total Exceptions $	5.0%	95.0%	100.0%
Percent of Total Audited $	1.1%	20.9%	22.0%

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 2 of FY 2024 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 the 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 FY 2024.

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 200 vendors and 500 providers 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:

- Applied Behavioral Analysis
- Assertive Community Treatment
- Behavioral Services
- Campership
- Children's Residential
- Case Management Services
- Community Living Supports
- Crisis Residential (Adult)
- Crisis Residential (Children)
- Home Based Services
- Intensive Crisis Stabilization Services
- Interpreter Services

- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Music Therapy
- Art Therapy
- Recreation Therapy
- Massage Therapy
- Peer Support Services
- Private Duty Nursing
- Psychiatric Hospital (Adult or Child)
- Psycho-Social Rehabilitation Programs
- Respite Services
- Skill Building Services
- Specialized Residential Services
- Wrap Around Services

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:

- Withdrawal Management
- Residential Treatment Services
- Medication Assisted Treatment (MAT)
- Intensive Outpatient Treatment
- Outpatient Treatment
- Opioid Health Home Services
- Women's Specialty Services
- Recovery Coaching
- Recovery Housing
- 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 FY 2024 to expand MCCMH's network adequacy though not all the vendors were selected, and not all the needs were filled:

- Crisis Stabilization Unit: 1
- ABA: 4
- Behavioral Management Services: 1
- CRU: Current
- Interpreter Services:1
- Mobile Crisis Services: 1
- MST Therapy: 1
- Music, Art, Rec & Massage Therapy: 1
- Primary Provider: 1
- Private Duty Nursing: 0
- Residential: Current
- CLS/Respite
- Medicaid Verification Audit

Member Satisfaction

MCCMH conducted its 2024 Member Satisfaction Survey for Adults and Children/Caregivers 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, 530 Adults and 133 Children/Caregivers participated in the survey.

All seven (7) of the improvement strategies from FY 2023 were implemented during the FY 2024 survey period. Improvement strategies implemented included: more demographic information collected from participants, collection of primary provider data, revision of the layout of the survey and questions, improvement of survey distribution efforts (focusing on directly operated programs and designated collaborating organizations (DCOs)) as well as promoting electronic and paper submission of survey data and aligning improvement strategies with MCCMH's QAPIP. The results of the survey were presented to the Quality Committee, member advisory group, MCCMH Board, provider network, and posted on the MCCMH website for the public to access. There were discussions at various levels, on initiatives to improve member satisfaction. The Quality Department is also meeting with individual providers with negative responses to understand their challenges and support them on improvement initiatives.

Survey Results:

2023-2024 Comparison

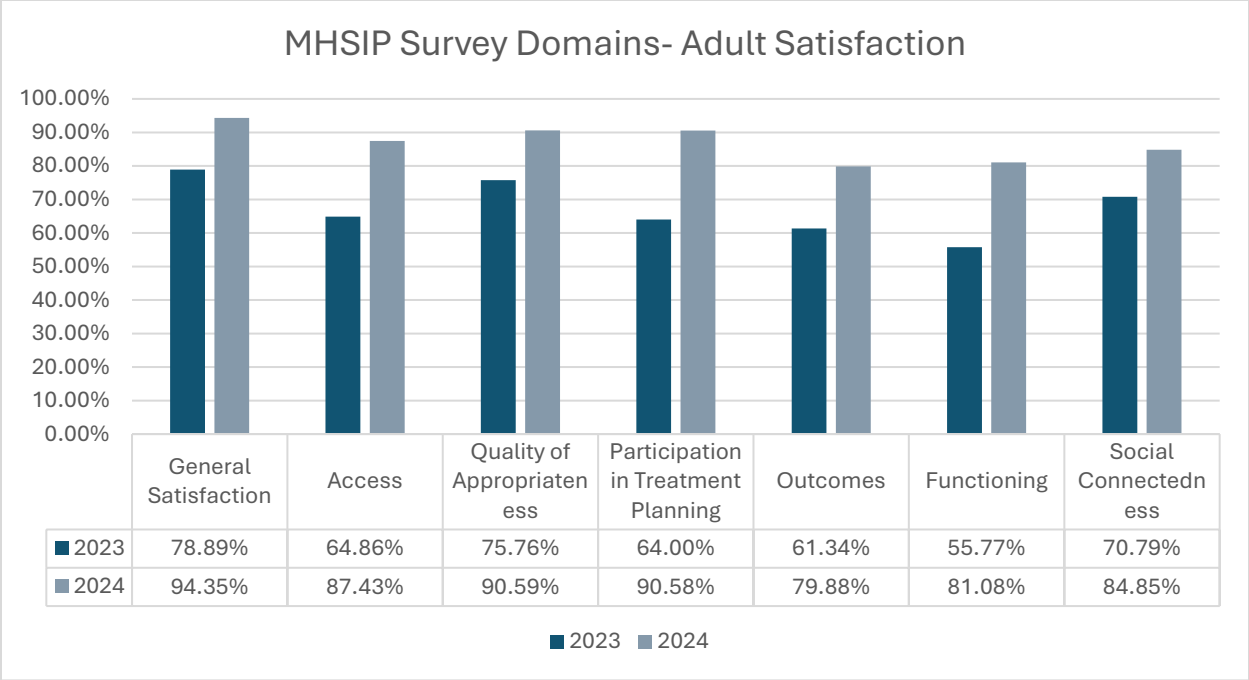
Population	2023 Total	2024 Total
Adult	393	530
Children	137	133

2024 Adult Results

MHSIP- Domains	Satisfied	Neutral	Dissatisfied
General Satisfaction	94.35%	6.10%	2.55%
Access	87.43%	8.79%	3.78%
Quality of Appropriateness	90.59%	6.88%	2.53%
Participation in Treatment Planning	90.58%	7.35%	2.07%
Outcomes	79.88%	12.64%	7.48%
Functioning	81.08%	14.30%	4.62%
Social Connectedness	84.85%	10.84%	4.31%

Some key-takeaways from the adult survey results include but are not limited to:

- The majority of adults identified as female (48.22%) compared to male (46.72%).
- Survey collection efforts focused on providing more frequent in-person collection and distribution of survey materials as well as frequent e-mail correspondence.
- MCCMH directly operated programs increased their survey response rate from 146 to 213.
- The provider agency MORC had the greatest response rate amongst designated collaborating organizations (DCO) with 69 responses.
- The majority of respondents had either Medicaid (60.04%), or dual eligibility Medicare/ Medicaid (24.58%).
- Most respondents identified as White (71.29%), or Black/ African American (14.63%)
- Most respondents were in the 30-64 age range (65.85%) followed by 18-29 years of age (22.33%).
- 85.74% of respondents reported working with a case manager within the last six (6) months.

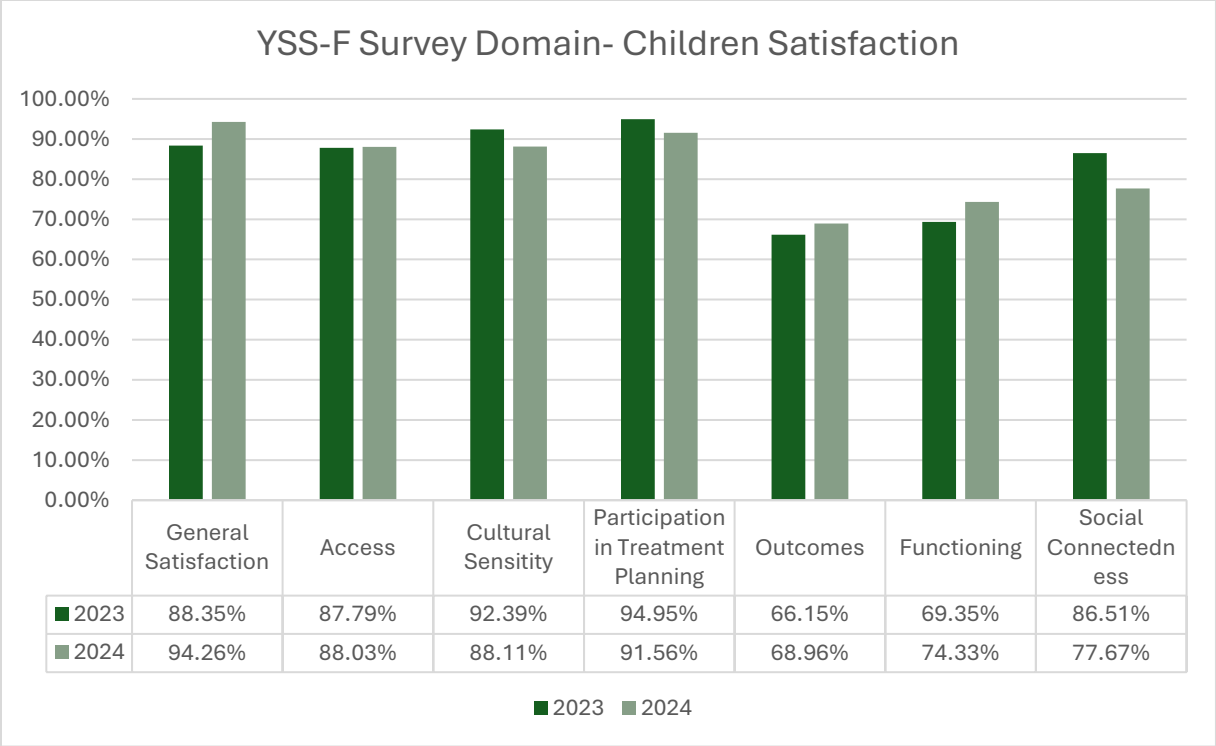


2024 Children Results

YSS-F Domains	Satisfied	Neutral	Dissatisfied
General Satisfaction	94.26%	5.74%	0.00%
ACCESS	88.03%	9.40%	2.57%
Cultural Sensitivity	88.11%	10.89%	1.00%
Participation in Treatment Planning	91.56%	6.75%	1.69%
Outcomes	68.96%	23.27%	7.77%
Functioning	74.33%	20.35%	5.32%
Social Connectedness	77.67%	18.75%	3.58%

Some key-takeaways from the children survey results include but are not limited to:

- MCCMH- Children's Department had the most respondents with 74.
- The provider agency Treatment and Training Innovations (TTI) had the next highest count with 9.
- Most respondents reported Medicaid (83.87%) as their insurance type.
- The majority of respondents reported White (Caucasian) as their race (62.90%) followed by Black or African American (12.90%).
- Most respondents fit into the 5-12 years age bracket (50.00%) followed by 13-18 years of age (40.32%).
- Most respondents identified as male (54.84%) with female being the next closest (38.17%).



	General Satisfaction	Access	Cultural Sensitity	Participation in Treatment Planning	Outcomes	Functioning	Social Connectedness
2023	88.35%	87.79%	92.39%	94.95%	66.15%	69.35%	86.51%
2024	94.26%	88.03%	88.11%	91.56%	68.96%	74.33%	77.67%

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 support 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 support received based on the individual's plan of service. Specific findings from MCCMH's Member Satisfaction Survey that was completed in FY 2024 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 settings and a comparison of services and supports. LTSS members remain included as survey participants and members of the Citizens 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

Throughout FY 2024, MCCMH's goal to ensure the completion of all Office of Recipient Right's investigations within the mandated timeframes has been met. 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

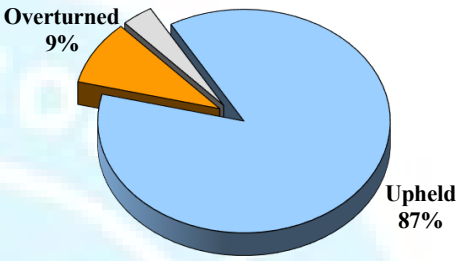
A grievance is a formal expression of dissatisfaction with something MCCMH has done. A Local Appeal is a formal request for a review of an action made by MCCMH. The following report highlights the total number of grievances and appeals for the Fiscal Year of 2024 for MCCMH. It breaks down both to categories and frequency. Possible trends, improvements, and actions will also be identified.

The data reflects the information required by and submitted to MDHHS

Grievance & Appeal
Fiscal Year 2024 Analysis Report
10/1/23 – 9/30/24

Grand Total of Appeals

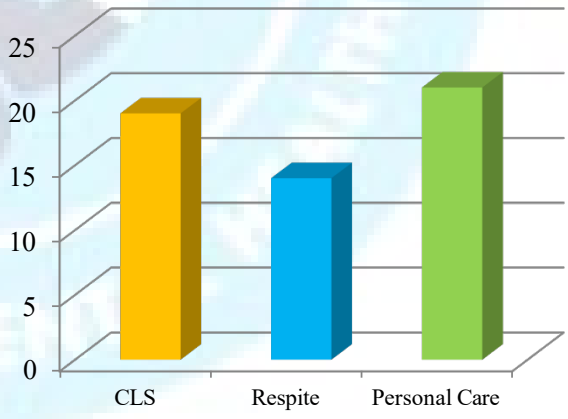
Fiscal Year by Quarters	Q1	Q2	Q3	Q4
Appeals Upheld	7	15	17	36
Appeals Overturned	3	3	0	2
Appeals Partially Upheld/Overturned	1	1	0	1
Total Appeals	**11**	**19**	**17**	**39**



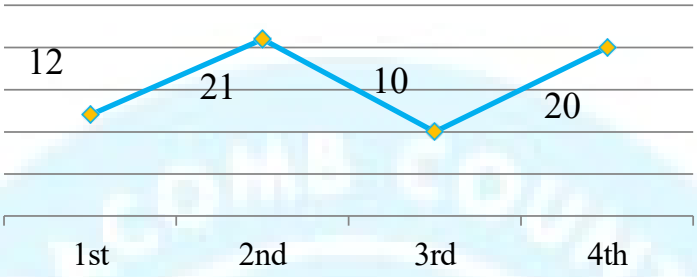
Services Appealed

FY by Quarters	Q1	Q2	Q3	Q4	%
CLS	4	0	7	8	22%
CLS/Respite	3	1	0	4	9%
Crisis Stabilization	0	0	1	0	1%
Goods/Services	0	0	1	1	2%
Local Inpatient	0	1	1	1	3%
Occupational Therapy	0	0	0	5	6%
Outpatient	0	0	1	0	1%
Personal Care	2	10	4	5	24%
Private Duty Nursing	0	0	0	1	1%
Skill Building	1	1	0	1	3%
Physical Therapy	0	0	0	5	6%
PT/OT	0	0	0	1	1%
Respite	0	6	1	7	16%
Supported Employment	1	0	0	0	1%
Wraparound	0	0	1	0	1%

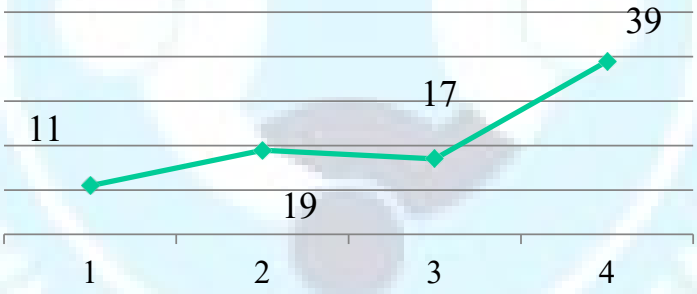
Top Four Appealed Services



FY 2023 Appeals Per Quarter

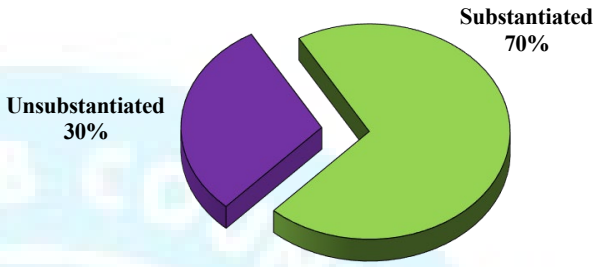


FY 2024 Appeals Per Quarter



Grand Total of Grievances

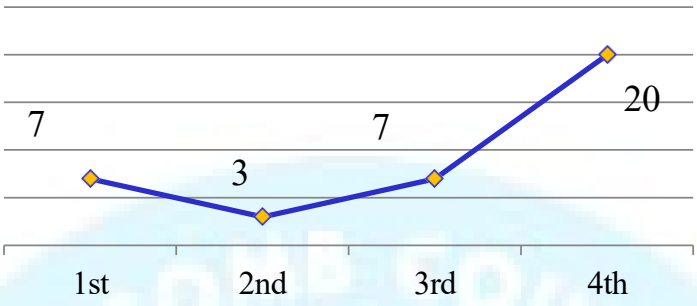
Fiscal Year by Quarters	Q1	Q2	Q3	Q4
Grievances Substantiated	4	12	7	10
Grievances Unsubstantiated	12	0	0	2
Total Grievances	**16**	**12**	**7**	**12**



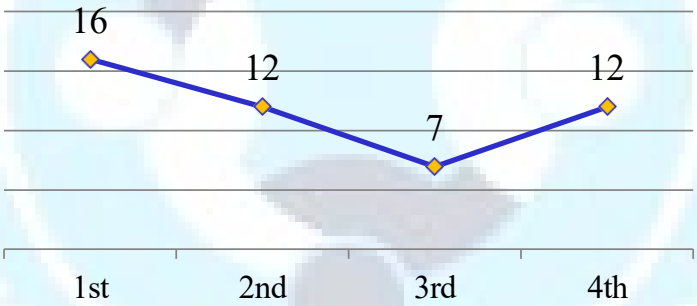
Grievance Categories

FY by Quarters	Q1	Q2	Q3		%
Access & Availability	12	12	3	11	80%
Abuse, Neglect or Exploitation	1	0	0	0	2%
Financial	1	0	3	0	10%
Member's Rights	0	0	0	1	2%
Service Environment	1	0	0	0	2%
Quality of Care	1	0	1	0	4%

FY 2023 Grievances Per Quarter



FY 2024 Grievances Per Quarter



A total of 86 appeals were reviewed during FY 2024, with approximately 87% of resolutions being upheld. This marks a significant improvement compared to the prior year, where only 43% of appeals were upheld. The number of appeals experienced a sharp increase in the last quarter compared to the same period in FY 2023.Personal Care services represented 24% of the total appeals for FY 2024, a notable increase from 6.3% the previous year. This equates to an 18% rise in appealed services so far in FY 2024. Additionally, there were 11 appeals related to Physical Therapy (PT) and Occupational Therapy (OT) in the last quarter, whereas no PT/OT appeals were recorded in the first three quarters or in FY 2023.

A total of 47 grievances were recorded for FY 2024, with 70% of cases substantiated—a figure consistent with FY 2023, where 57% of grievances were substantiated. However, the substantiation rate varied significantly throughout FY 2024: 75% of grievances were unsubstantiated in the first quarter, while 96% were substantiated across the second, third,

and fourth quarters.

Access and Availability issues accounted for 80% of grievances in FY 2024, compared to 92% in FY 2023. There were no grievances related to substance abuse and only one Mental Health Liaison (MHL) grievance during this period

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. Customer Service staff also assist callers who 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 FY 2024 Customer Service handled 64,925 calls. This is almost 10% less than the 72,082 cal ls handled during FY 2023. Currently. the Customer Service team includes 8 full-time staff - including a Customer Service Specialist (who provides training and support for the team in addition to taking calls) and 1 part-time Customer Service Administrator. MCCMH plans to bring on one (1) additional Mental Health Worker in FY 2025 to work in the call center and one (1) Customer Service Assistant to assist with administrative tasks. The MCCMH Customer Service Team has a keen focus on providing excellent experiences to every customer, every time. To achieve this mark, Customer Service Team Members embody the spirit of service to the community and the core values of MCCMH, which are: collaboration, accountability, and respect.

Customer Service Metrics and Key Performance Indicators (KPIs): 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 questions and address the caller's needs without having to transfer the call whenever possible. If the call must be transferred, it is MCCMH's goal to connect the caller directly to the subject matter expert who 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: MCCMH's 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 re-queued 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 reported to MCCMH's Quality Committee.

Month	Average Wait Time (IN) <2 min.		Call Abandon Rate 5%	Average Speed to Answer 90% in <30 sec.	Total Calls
Oct-23	CSR	00:37	2.18%	82%	6,116
Nov-23	CSR	00:23	1.96%	85%	6,057
Dec-23	CSR	00:19	0.94%	90%	4,968
Jan-24	CSR	00:13	0.70%	92%	6,497
Feb-24	CSR	00:32	1.94%	85%	5,496
Mar-24	CSR	00:19	1.04%	88%	5,448
Apr-24	CSR	00:35	1.80%	82%	5,631
May-24	CSR	00:27	1.73%	85%	5,334
Jun-24	CSR	00:24	1.82%	86%	4,306
Jul-24	CSR	00:33	2.95%	80%	5,107
Aug-24	CSR	01:04	5.13%	71%	5,008
Sep-24	CSR	00:28	1.71%	84%	4,957
Total Calls FY24					64,925
FY24 Average			1.99%	84%	5,410

Customer Service Silent Call Monitoring: While the above metrics are important and tied to team performance, they do not offer insight into the quality of service provided. It is the expectation of MCCMH that all customers are treated with dignity and respect, including on phone calls. To accomplish the task of monitoring call quality, Customer Service calls are routinely monitored by the Customer Service Specialist (Team Lead) and/or the Customer Service Administrator. Soft skills can sometimes be subjective; therefore, a call monitoring tool was created to identify important elements that MCCMH expects to occur during each call. Rather than giving a subjective rating scale, the tool has been designed with a 'met/not met' scoring format. This data is monitored and reviewed to look for areas of improvement and to ensure efficient operations of MCCMH's Customer Service Department. All Customer Service data is compiled by the Customer Service Administrator and reported to MCCMH's Quality Committee and to external governing bodies accordingly. Call monitoring feedback is also shared with Customer Service team members during their individual supervision meetings. MCCMH's goal is to monitor a randomly selected, statistically significant number of calls each month. As a contact center advisory service, 1%-6% is considered a statistically significant sample size. Customer Service team members are monitored silently during at least one (1) call per week. While labor intensive, this task is essential for success. MCCMH is committed to monitoring at least 1% of the calls during each fiscal year. Protocols from the call monitoring tool are as follows:

- Protocol 1: Followed MCCMH Customer Service Telephone Script: Thanked the caller for calling MCCMH, Identified the line as Customer Service, Stated First Name, asked caller "How may I assist you today?"
- Protocol 2: Assessed call with active listening to quickly identify caller's needs and identify whether a crisis call.
- Protocol 3: Demonstrated empathy and treated caller with dignity and respect.
- Protocol 4: Demonstrated program knowledge, sounded confident and comfortable.

- Protocol 5: Demonstrated a welcoming customer service attitude and willingness to help throughout the call.
- Protocol 6: Used positive language and remained solution focused throughout the call.
- Protocol 7: Spoke clearly throughout the call, did not use jargon, and did not rush the caller.
- Protocol 8: Explained to the caller what steps were being taken to address their needs during the call.
- Protocol 9: Asked caller if all their questions were answered prior to transferring/ending the call.
- Protocol 10: Assessed the caller's satisfaction before transferring/ending the call.
- Protocol 11: Call classification was assessed, and call was transferred to the appropriate department.

Call monitoring data for FY 2024:

Each Customer Service team member is monitored on at least one (1) call per week. A score of at least 90% must be achieved in all protocol areas indicated on the call monitoring tool. If 90% is not attained, the Customer Service Administrator will assess team-wide patterns and, as appropriate, offer team-wide training and support as outlined in the Customer Service Call Monitoring and Quality Improvement Procedure. The CS KPIs were consistently met, and no corrective action plan was warranted during FY 2024.

Column1	Q1	Q2	Q3	Q4	FY24 Cumulative
# Calls Monitored	222	245	199	149	815
Protocol 1	100%	100%	100%	98%	99.5%
Protocol 2	100%	100%	100%	98%	99.5%
Protocol 3	100%	100%	100%	100%	100.0%
Protocol 4	100%	100%	100%	100%	100.0%
Protocol 5	100%	100%	100%	100%	100.0%
Protocol 6	100%	100%	100%	100%	100.0%
Protocol 7	100%	100%	100%	100%	100.0%
Protocol 8	100%	100%	100%	100%	100.0%
Protocol 9	99%	100%	100%	94%	98.3%
Protocol 10	100%	100%	100%	94%	99.5%
Protocol 11	100%	100%	100%	100%	100.0%

Training Opportunities

As part of the ongoing implementation of MCCMH's Zero Suicide Philosophy, MCCMH's Training Department continued to host Assessing and Managing Suicide Risk (AMSR) trainings for clinical staff members, and Question, Persuade, Refer (QPR) trainings for support staff. There was a total of 19 AMSR trainings held for a total of 418 clinical staff members. There was a total of 72 QPR trainings held for a total of 1,619 nonclinical staff members. Motivational Interviewing (MI) and Integrated Dual-Disorder Treatment (IDDT) are evidenced-based programs that were required per the CCBHC handbook beginning in 2024. MCCMH offered six (6) sessions of IDDT for a total of 215 clinical staff members and six (6) MI sessions for a total of 215 individuals.

The MCCMH Learning Management System, Brainier, was updated with a new Specialized Residential Curriculum that increased participation and engagement by offering interaction in each module. This update also condensed the curriculum from over 100 separate modules to 22 streamlined learning tracks.

Policies and Procedures

During FY 2024, MCCMH began utilizing the Policy Management Software, LogicGate, to standardize and streamline policy reviews and approval lifecycles. LogicGate's governance, risk, and compliance (GRC) software assists 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 MCCMH subject matter expert on at least an annual basis and then formally approved by the Macomb County Executive's Office and MCCMH's Chief Executive Officer.

MCCMH began building the policy management system in FY 2023 and since then has developed the necessary workflows, permission sets, and logic behind each policy and coded such information into the system. MCCMH officially rolled out the new policy management system for agency-wide use in Q3 of FY 2024 through a series of individualized trainings for each department. Each training reviewed the functionality of the LogicGate system and reviewed each department's assigned policies and associated workflows.

MCCMH's policy management system brings the functionality to run reports on policy reviews and updates to satisfy audit requests. MCCMH is now in the process of finalizing its library of reports to enable its Quality Committee to review policy progress on at least a quarterly basis to mitigate risk and optimize value.

FY 2024 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 includes; measuring evidence-based treatment outcomes; implementing specific updates to the 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)

In 2024, MCCMH made significant strides in advancing diversity, equity, and inclusion (DEI) across the organization. This report highlights our initiatives, shaped by recommendations from Health Management Associates (HMA) in the 2023 Equity Assessment. From building culturally affirming spaces to enhancing DEI training, our accomplishments demonstrate our ongoing commitment to a diverse and an equitable, inclusive, and trauma-informed environment for our team members and the communities we serve.

FY 2024 Progress and Key Accomplishments

1. Culturally Affirming Spaces
    - Objective: Foster welcoming and culturally responsive environments at MCCMH locations.
    - Progress in 2024: Site assessments across all locations led to specific recommendations for enhancing cultural affirmation. In collaboration with stakeholders, we are actively working to implement these recommendations, including visual displays and multi-language signage to celebrate diverse identities.
    - Next Steps: In 2025, we will continue implementing design changes based on these recommendations, promoting cultural sensitivity and comfort within our physical spaces.
2. Expanded DEI Training and Education
    - Objective: Equip team members with knowledge and skills to provide culturally responsive and trauma-informed care.
    - Training Initiatives:
        - Cultural Competency Training: Updated in 2024, this training module helps team members better understand and respond to the diverse cultural backgrounds of clients.
        - Implicit Bias Training: Revised to address the impact of unconscious biases, creating a more inclusive and supportive atmosphere for clients and team members alike.

- Impact: These training sessions enhance MCCMH's ability to provide equitable, culturally responsive care, aligning with our DEI and trauma-informed care principles.

3. Job Description Updates

- Objective: Ensure DEI values are embedded in every role.

- Progress in 2024: MCCMH updated all job descriptions to include the statement: "Engage effectively with diverse communities; interact with people in an inclusive manner that respects cultural and socio-economic differences." This addition emphasizes the importance of DEI across all levels of the organization.

4. Comprehensive DEI Communication Strategy

- Objective: Foster DEI awareness and engagement among team members.

- *P.E.O.P.L.E. Newsletter*: Launched in 2023, the P.E.O.P.L.E. Newsletter remains a cornerstone of MCCMH's DEI communication efforts. This monthly publication provides education on critical DEI topics such as racial identity, systemic inequality, and trauma-informed practices. Its consistent presence builds awareness and engagement, aligning closely with HMA's recommendation for a comprehensive DEI communication strategy.

- *Mystery Coffee Initiative*: Continuing its success from 2023, the Mystery Coffee Initiative brings team members together to build meaningful connections, fostering empathy and inclusivity. By encouraging engagement and mutual understanding, it strengthens workplace relationships and supports MCCMH's commitment to creating an inclusive and collaborative environment.

- *DEI Steering Committee (DEISC)*: The DEI Steering Committee remains integral to MCCMH's DEI journey. Since its inception in 2023, the DEISC has played a vital role in integrating DEI principles into organizational policies and operations, providing guidance and oversight for MCCMH's long-term equity strategies.

- Outcomes: These communication efforts foster a shared understanding of DEI values, enhancing a sense of community within MCCMH.

5. Accessibility and Multilingual Resources

- Objective: Improve access to MCCMH resources for clients with limited English proficiency.

- Progress in 2024: Key resources, including the "Help When You Need It" handbook, are now available in Spanish, Arabic, and Bengali. The MCCMH website also includes a language dropdown for improved accessibility.

- Client Impact: Feedback from clients has been positive, indicating that these resources enhance their experience and comfort with MCCMH services.

6. Data-Driven Approach to Client Demographics and Outcomes

    - Objective: Ensure equitable service delivery through ongoing demographic and outcome analysis.
    - Achievements: MCCMH monitors client demographic data, tracking treatment outcomes to identify and address disparities. This approach ensures that all clients receive equitable, effective services.
    - Results: Data-driven insights have allowed us to refine our programs, improving client satisfaction and outcomes, particularly for historically underserved groups.

7. Taste of Diversity Event

    - Objective: Celebrate cultural diversity and foster inclusivity among MCCMH team members.
    - Event Overview: Originally planned for July 2024, the Taste of Diversity event was postponed. The event aimed to allow team members to share and experience culinary traditions from various cultures, strengthening team cohesion and cultural awareness. Its postponement underscores MCCMH's ongoing commitment to ensuring a well-organized and impactful celebration of diversity and inclusion.

Commission on Accreditation of Rehabilitation Facilities (CARF)

During FY 2024, 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 ongoing 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; Credentialing system controls; Appeals process flows; Provider and Practitioner directories; and complex case management program development.

Health Plan Quality Initiatives

In adherence to the Michigan Department of Health and Human Services (MDHHS) contractual Performance bonus withholds, Macomb Region 9-PIHP has established partnerships with the eight (8) Medicaid Health Plans (MHP) and developed joint management standards and processes to ensure communication exists to support the success of our mutually shared persons served. The eight (8) MHPs encompassing Macomb Region-9 are Aetna, Blue Cross Complete, HAP Care Source, McLaren, Meridian Health Plan, Molina, United Health Plan, and Priority.

In FY 24, the following eight (8) Performance Bonus projects for MCCMH:

<u>Contractor-only Pay for Performance (P4P) Measures</u>

1. Implement data driven outcomes measurement to address social determinants of health
2. Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD)

3. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
4. Increased Participation in Patient-centered Medical Homes

Joint Care Management Metrics with the MHPs
Ensures collaboration and integration between PIHP and Medicaid Health Plans (MHPs) for the Integration of Behavioral Health and Physical Health Services.
1. Care Coordination
2. Follow-up after Hospitalization (FUH)
3. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-14 and IET-34)
4. Follow-up after Emergency Room Department Visit for Alcohol and Other Drug Dependence (FUA)

In FY 2024, MCCMH Region-9 PIHP performed the following efforts, activities, deliverables, and achievements:

Contractor-Only
1. Provided an in-depth analysis to MHDDHS regarding the implementation of data driven outcomes measurement to address social determinants of health of the BHTEDS records to improve housing and employment outcomes for persons served.
2. Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD) performance rate was 60%, which is 2% below the benchmark.
3. Initial Engagement - IET 14 performance rate was 41%, which met the benchmark by 1%. Initial Engagement - IET 34 performance rate was 11%, which did not met the benchmark by 3%.
4. Provided a ten (10) page narrative of Region 9-MCCMH system of care covering the Increased Participation in Patient-centered Medical Homes in the areas of Increased Participation in Patient-centered Medical Homes including comprehensive care, patient care, coordinated care, accessible services, and quality and safety.

Joint Care Management

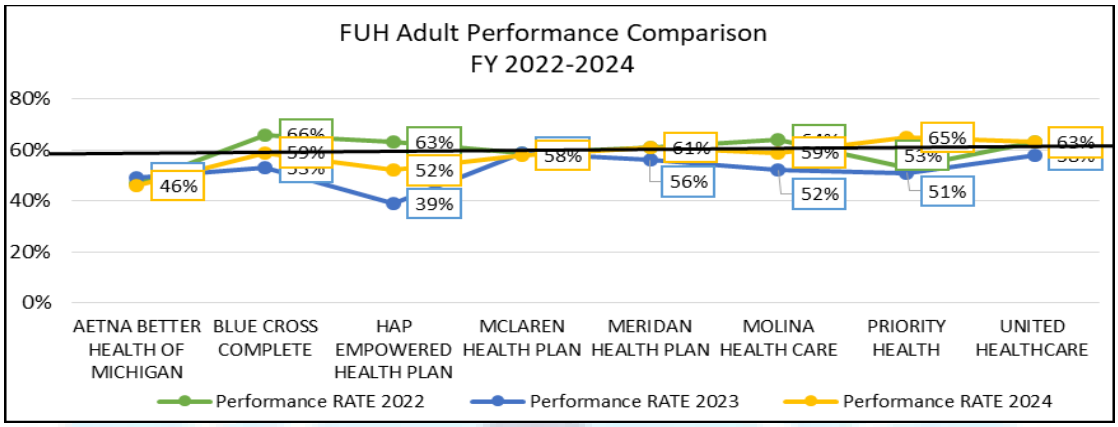
1. Care Coordination -conducted ninety-six (96) care coordination meetings and developed joint care coordination plans with the MHPs and increased care coordination to 25% of the high-risk population. A total of one hundred and three (103) persons served were provided with care coordination. Forty-seven (47) care plans were closed and fifty-six (56) persons served remain receiving care coordination services.
   Participated in all state-wide collaborative workgroup meetings as scheduled with the ten (10) PIHP and eleven (11) MHP partners across the state of Michigan to develop, discuss, and establish the CC360 platform and protocols to meet the MDHHS initiatives.

2. Follow-up after Hospitalization - Developed weekly individualized FUH reports and sent them to MDHHS to distribute to the MHPs.

   Outcome Results
   Follow-up after Hospitalization for the Adult population – Trend FY 2022-2024 - As

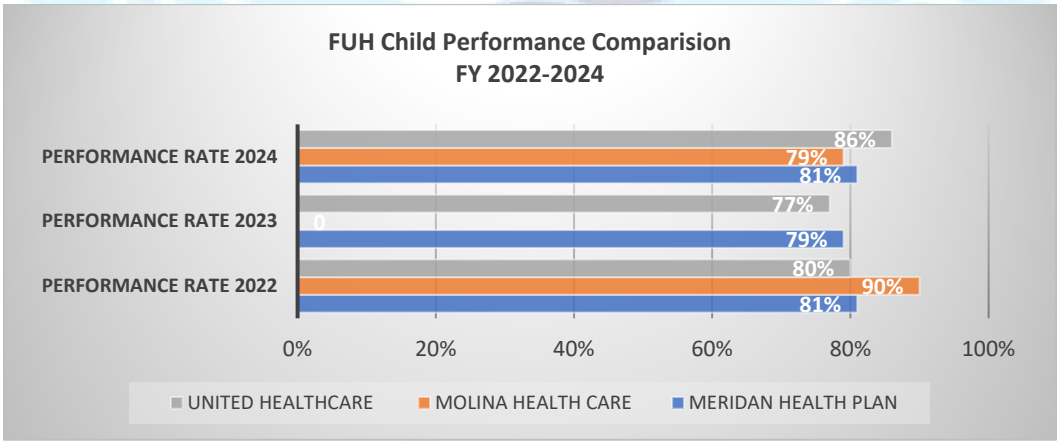
shown below in Chart 1, for the FY 2024 the FUH outcome resulted in Aetna and HAP below the 58% benchmark. Aetna has been below the benchmark for the past three years and HAP has been below benchmark for the past two years.

Chart 1



Follow-up after Hospitalization for the Child population – Trend Analysis FY 2022-2024
As shown below in Chart 2, the FUH outcomes resulted in Meridian, Molina and United meeting the 70% benchmark rate. For the past three years, the three MHPs met the benchmark.

Chart 2



FUH measure is also measured by racial disparity and the results will be formulated in the state financial report.

3. Initial Engagement - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

IET 14 performance rate resulted in McLaren, Meridian, Molina, Priority, and HAP meeting the 40% benchmark. Aetna, Blue Cross Complete, and United Healthcare did not meet the benchmark.

IET 34 performance rate resulted in McLaren, Meridian, and HAP meeting the 11% benchmark. Aetna, Blue Cross, Molina, Priority, and United did not meet the benchmark. IET measure is also measured by racial disparity and the results will be formulated in the state financial report.

4. Follow-up after Emergency Room Department Visit for Alcohol and Other Drug Dependence- FUA is measured by racial disparity and the results will be formulated in the state financial report.

- Worked co-jointly with AFIA to develop internal quality reports to track/monitor the social determinants of health for employment and housing, Follow-up Hospitalization (FUH), Follow-up after Emergency Department Visits for Alcohol and Other Drug Dependence (FUA) reports, Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD), Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), and verification of the data has and will continue to be reviewed during the internal Performance Improvement Committee for efficacy
- Collaborated with MHP partners to develop initiatives to address the racial disparity measures
- Development of processes for Foster Care coordination are underway to provide integrated health services.

MI Health Link Initiatives

The program operates under the MI Health Link Three-Way Contract (3WC), a capitated financial alignment model, signed by the Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and each Integrated Care Organization (ICO).

In FY 2024, MCCMH partnered with three ICOs. As the primary behavioral health provider, Macomb PIHP was delegated with the following functions:

- Referral and Member engagement
- Level 2 Assessments
- Clinical Credentialing and Recredentialing Activities
- Utilization Management (UM) functions for outpatient (OP) and inpatient (IP) services
- Member Appeals
- Member Grievances
- Provider Appeals

- Claims Payment (Medicare and Medicaid services)
- Call Center Performance and Member Critical Incidents

Regular reporting duties to the ICO were performed, with some weekly, monthly and quarterly.

Weekly UM-IP admissions/discharge details were reported, including Follow-Up After Hospitalization (FUH) and Transition of Care (TOC) measures, as outlined in the 3WC and PIHP-ICO Agreements.

Monthly the PIHP provides comprehensive reporting to the ICO on all delegated functions. Quarterly the PIHP and the ICO have respective Joint Oversight Committee meetings, to review basic performance.

Encounter reporting was submitted to the ICO twice per month.

Also, monthly CMS protocol reporting was completed, called Service Authorization Request, Appeals and Grievances (SARAG).

Quarterly, reporting was completed on Member engagement in PIHP services, including existing and new enrollments as well as outreach efforts to engage.