NorthCare Network

Quality Assessment and Performance Improvement Plan (QAPIP)

FY22 Annual Effectiveness Review &

FY23 QAPIP

Reviewed and Approved by: Quality Management Committee – February 14, 2023
Reviewed by: NorthCare Leadership – February 14, 2023
Reviewed and Approved by: NorthCare Governing Board – February 15, 2023

Contents

Executive Summary

NorthCare Network, as the Prepaid Inpatient Health Plan (PIHP), is responsible for monitoring the overall Quality Improvement and Quality Assurance activities of the organization. Responsibilities of the Quality Management Program are outlined in the Quality Assessment and Performance Improvement Plan (QAPIP). The scope of NorthCare's QAPIP program is inclusive of all Member CMHSPs and their respective provider networks and the Substance Use Disorder Providers. MDHHS requires each PIHP have a QAPIP that meets the standards outlined in the Medicaid Managed Specialty Supports and Services Contract and Attachment: Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans. The review includes the components of the QAPIP, performance measures, and improvement initiates based on the MDHHS PIHP contract, managed care rules and results of annual external quality reviews. The QAPIP and annual effectiveness review is reviewed and approved by the NorthCare's Quality Management and Oversight Committee and Board of Directors on an annual basis. The QAPIP effectiveness review covers the period of October 1, 2021, through September 30, 2022, and is due to MDHHS by February 28, 2023.

NorthCare's QAPIP consists of the following areas that are reviewed annually for effectiveness. Changes to FY23 QAPIP are summarized below.

I. Introduction – no changes
II. Purpose – minor grammatical changes, removed reference to URAC Accreditation
III. Quality Improvement Authority and Structure – reorganized committee structure with all committees ultimately accountable to the NorthCare Governing Board and/or NorthCare Leadership Team.
IV. Quality Management System (components and Activities) – added reference to new automated reporting of critical incidents to the BH-CRM; added definition of LTSS services and mechanisms to assess the quality and appropriateness of care furnished to beneficiaries using LTSS; updated URAC accreditation time frame that is set to expire 3/1/2023 and NorthCare's decision to not seek renewal; and minor wording updates.
V. Procedures Adopting & Communicating Process & Outcome Improvements – no changes.
VI. Evaluation – updated annual due date for the effectiveness review to MDHHS by February 28.
VII. Cross References – no changes
VIII. Attachments – no changes

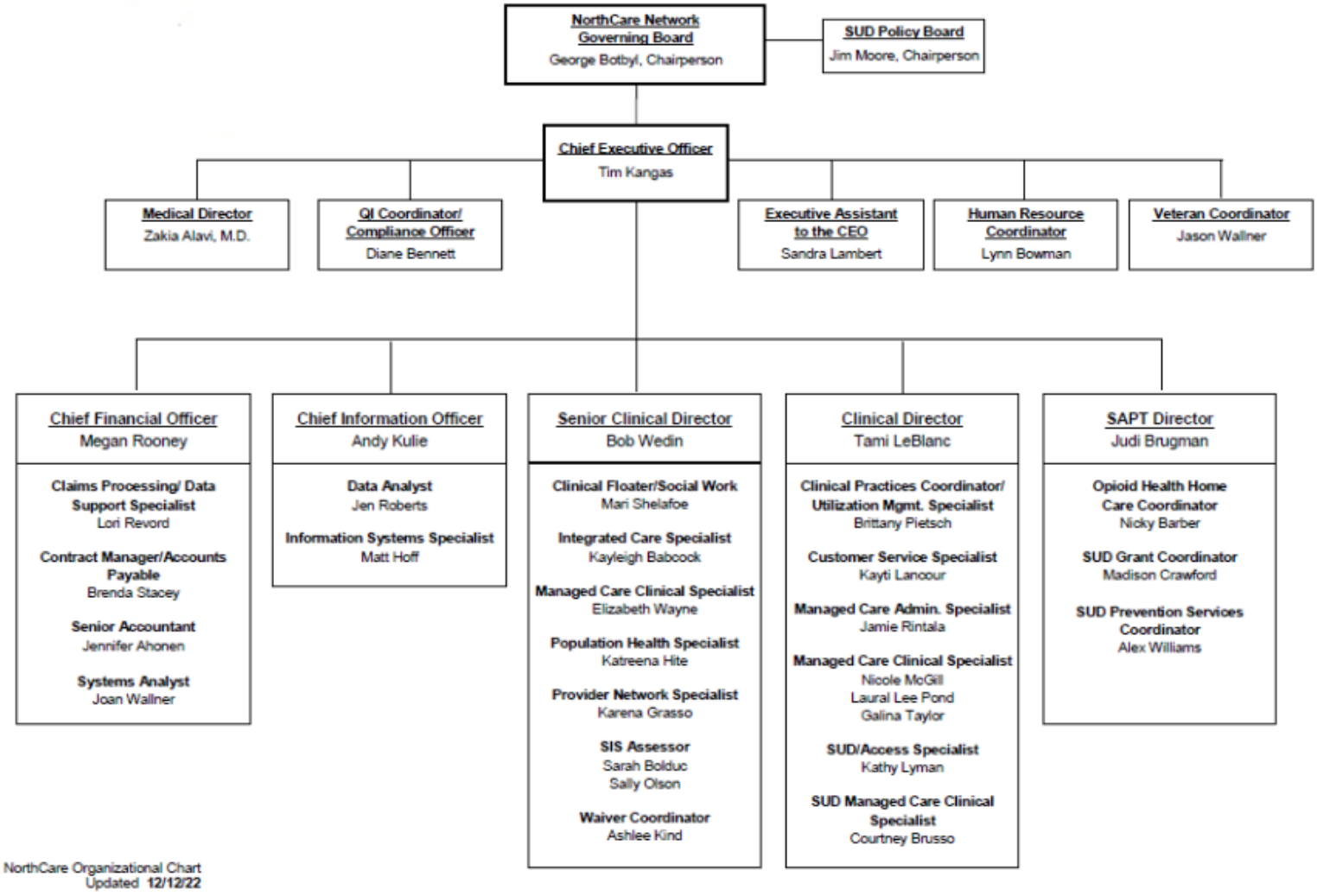
In meeting the QAPIP requirements, NorthCare conducts an annual review of the effectiveness of components within the QAPIP. In addition, the QI Work Plan is reviewed with goals not met at year end carried forward to the next year's work plan. New goals and objectives as well as recommendations made by the EQRO (External Quality Review Organization) and MDHHS may be included in the QI Work Plan. The following information contained in this report reflects the effectiveness review of the FY22 QAPIP. In addition, the FY23 QAPIP and Work Plan are attached at the end of the effectiveness review.

NorthCare improved its engagement in services measured at 90 days post intake due to the efforts of the engagement PIP. There was increased monitoring and oversight of Substance Use Disorder Utilization and services. Individuals hospitalized on an inpatient psychiatric unit received an appointment within 7 days of discharge at a rate higher than the state average and overall consumer satisfaction remained high.

1. Organizational Structure

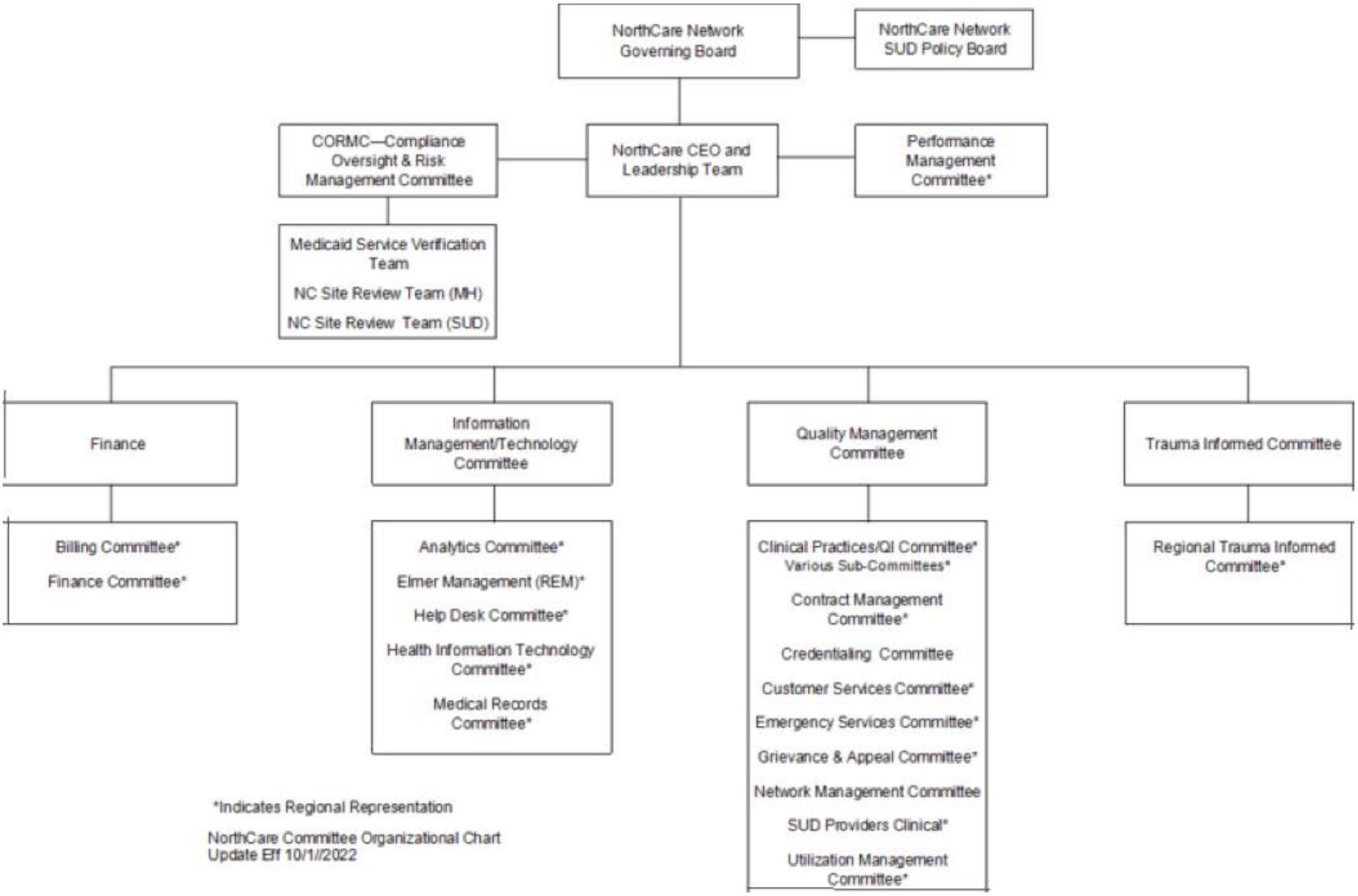
NorthCare Organizational Chart

The following organizational chart, as of December 2022, reflects the agency. Changes in staff happen throughout the year and therefore may vary at any given point in time.



NorthCare Committee Organizational Chart

The following standing committees also may have sub-committees or time-limited workgroups based on current need. Those denoted with an asterisk have regional representation.



Governing Body Form

The MDHHS governing body form is to be completed by the PIHP and submitted to MDHHS along with its annual QAPIP submission no later than February 28th of each year. Governing Body meeting minutes are available to MDHHS upon request. The following are the names of those on the governing body.

Name of PIHP		
NorthCare Network		
List of members of the Governing Body (add additional rows as needed)		
Name	**Credentials**	**Organization** (if applicable)
1. Michael Koskinen	Retired	Copper Country CMHSP
2. Patrick Rozich	BA, MA-Retired School Superintendent	Copper Country CMHSP
3. Jim Tervo	Inventory Control	Copper Country CMHSP
4. Richard Herrala (alternate)	Retired	Copper Country CMHSP
5. Carrie Braspenick	N/A	Gogebic County CMHSP
6. Joe Bonovetz	Retired Letter Carrier County Commissioner	Gogebic County CMHSP
7. William Malloy, Jr.	Retired Clinical Social Worker	Gogebic County CMHSP
8. Colleen Kichak (alternate)	Retired	Gogebic County CMHSP
9. George Ecclesine	Retired -Real Estate, HR, Banking	Hiawatha CMHSP
10. Jim Moore	Township Supervisor	Hiawatha CMHSP
11. Dr. John Shoberg	PhD Psychologist	Hiawatha CMHSP
12. Ann Martin	Retired Teacher, Master's Degree in Education, County Commissioner	Northpointe CMHSP
13. Mari Negro	MCAO and Retired Publisher	Northpointe CMHSP
14. Kevin Pirlot	Self-Employed	Northpointe CMHSP
15. Patricia Phillips (alternate)	Retired	Northpointe CMHSP
16. George Botbyl, *Chair*	Retired LMSW	Pathways CMHSP
17. Margaret Rayner	Retired RN	Pathways CMHSP
18. Glenn Wing	Retired	Pathways CMHSP
Changes to membership during the past year: Changes from FY21 to FY22 include: • Removal of George Beninghaus (4/22), Stephen Thomas (4/22), William Davie (4/22), Tom Korpi-alternate (9/22), and Patricia Phillips (4/22). New Members in FY22: • William Malloy, Jr. (4/22), Patricia Phillips (10/22), Kevin Pirlot (4/22), Richard Herrala -alternate (4/22), Colleen Kichak -alternate (4/22), Margaret Rayner (4/22) Carrie Braspenick was an alternate and is now a board member. Ann Martin was a board member and is now an alternate.		
Date the Governing Body approved the annual QAPIP (prior SFY QAPIP evaluation, current SFY QAPIP description, and current SFY QAPIP work plan)*		
Date: 9/8/21		
Dates the Governing Body received routine written reports from the QAPIP (during the prior SFY; add additional rows as needed)*		
Date: 10/13/21		
Date: 11/10/21		
Date: 12/8/21		
Date: 2/16/22		
Date: 3/9/22		

Date: 4/13/22
Date: 5/11/22
Date: 6/15/22
Date: 8/10/22
Date: 9/14/22
MDHHS Feedback

2. FY22 QAPIP

Page 8 through page 24 represent a copy of the FY22 QAPIP.

NorthCare Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN (QAPIP)

FY22

Quality Management Department

NorthCare Network

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INTRODUCTION

NorthCare Network is a regional entity under Section 1204(b) of the Michigan Mental Health Code and is governed by a board of directors with representation from the five member Community Mental Health Authorities. NorthCare Network holds a Standard Contract with the Michigan Department of Health and Human Services (MDHHS) for the Medicaid Managed Specialty Supports and Services 1115 Demonstration Waiver, 1915 (c)/(i) Waiver Programs, the Healthy Michigan Program, the Flint 1115 Waiver and SUD Community Grant Programs and the MI Health Link Demonstration Program. NorthCare Network is also a contractor for the Upper Peninsula Health Plan L.L.C, identified by MDHHS as the Integrated Care Organization (ICO), for the provision of Covered Services to Enrollees in the MI Health Link Program.

This document outlines requirements for the annual QAPIP (Quality Assessment and Performance Improvement Program) as set forth in the PIHP/MDHHS Medicaid Managed Specialty Supports and Services Program Contract Attachment. It also describes how these functions are accomplished and the organizational structure and responsibilities relative to these functions.

This QAPIP aids in supporting NorthCare's mission, which is "NorthCare Network ensures that every eligible recipient receives quality specialty mental health and substance use disorder services and supports through the responsible management of regional resources." This mission guides the activities of NorthCare Network.

PURPOSE

The QAPIP is intended to outline requirements and provide guidance for carrying out several functions, including but not limited to:

- ✓ Outlining the quality improvement structure for the managed care activities of the NorthCare Network.
- ✓ Evaluating and updating, as appropriate, NorthCare Network's QI processes and outcomes.
- ✓ Monitoring and evaluating the systems and processes related to the quality of clinical care and non-clinical services that can be expected to affect the health status, quality of life, and satisfaction of persons served by Network Providers.
- ✓ Identifying and assigning priority to opportunities for performance improvement.
- ✓ Creating a culture that encourages stakeholder input and participation in improvement initiatives and problem solving.
- ✓ Stressing the value of employees; cooperation between employees; team building; and a partner relationship between the PIHP, Member CMHSPs, Network Providers, advocacy groups and other human service agencies within a continuous quality improvement environment.
- ✓ Promoting the basic quality management principle of prevention over remediation. It is less expensive in the long run to build quality into an organization's services than it is to expend additional resources on rework and dissatisfied customers.

- ✓ Providing guidance for the PIHP Performance Improvement Projects.

- ✓ Ensuring verification that services reimbursed by Medicaid were actually provided to enrollees by Network Providers according to the plan of service and adequately documented.

- ✓ Working with the Regional Quality Improvement and Clinical Practices Committee to assure implementation of clinical evidence-based practices throughout the region.

- ✓ Meeting standards specified in the NorthCare Network Medicaid Managed Specialty Supports and Services QAPIP contract attachment, the ICO/PIHP Contract for the MI Health Link Project, quality assurance provisions of the Balanced Budget Act of 1997, as amended, HSAG, and URAC Accreditation Standards.

QUALITY IMPROVEMENT AUTHORITY AND STRUCTURE

The QAPIP is reviewed and approved on an annual basis by the NorthCare Network Governing Board. Through this process, the governing body gives authority for the implementation of this plan and all components.

NorthCare Network's Chief Executive Officer provides day-to-day guidance and authority to the Quality Improvement Coordinator who is responsible for implementation of the QAPIP. The Performance Management Committee and Governing Board also receive routine reports on the progress of the QAPIP including performance indicators, quality improvement projects, progress and actions taken, and the results of those actions. The committee structure is designed to encourage contributions from a variety of sources, facilitate accountability, and ensure follow through on improvement efforts. NorthCare Network's Medical Director is involved in QI, UM, and credentialing activities and is available for consultation to any of the regional committees as requested, including review and consultation regarding sentinel events.

The Customer Services Committee and NorthCare Network's Governing Board provide significant opportunity for involvement by consumers. Additionally, focus groups and surveys are utilized to elicit consumer feedback.

ACCOUNTABILITY AND RESPONSIBILITIES

I. <u>NorthCare Network Governing Board</u>

Membership: NorthCare Network's 15-member Governing Board includes three representatives from each of the five Member CMHSP Boards of Directors.

Role/Function: The NorthCare Network Governing Board retains the ultimate responsibility for review and approval of the QAPIP, policy approval and governance. Functions include, but are not limited to:

- ***Oversight of the QAPIP:*** This includes documented evidence that the Board has approved the overall QAPIP and QI Plan. The Board's role is to monitor, evaluate and establish policy that supports improvements to care.
- ***QAPIP Progress Reports:*** The NorthCare Network Governing Board routinely receives written reports from the Chief Executive Officer describing performance improvement initiatives undertaken, the actions taken, and the results of those actions.

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

Reporting Accountability: The NorthCare Network Governing Board reports to stakeholders via committee and Board meeting minutes. The Governing Body submits a written annual report to MDHHS following its review, which includes a list of members.

- ***Reporting Frequency:*** Quarterly

II. **Designated Senior Official:**

NorthCare's Quality Improvement Coordinator/Compliance-Privacy Officer is responsible for coordinating activities related to the design, implementation, management and evaluation of the quality improvement and compliance programs. Quality management works collaboratively with many different functional areas. Although each position identified below is not assigned to the quality management function, they maintain an active role in quality related activities. The following grid provides a representation of what percentage of total time is spent by NorthCare staff on quality related activities. Much of NorthCare's quality management work is implemented through the various committees listed in Section III.

Title	Department	Average percent per quarter devoted to QM
Clinical Director	Clinical/Access	25%
Clinical Floater/Social Worker	Clinical/Access	2%
Clinical Practices Coordinator	Clinical	15%
Customer Service Specialist	Customer Service	10%
Data Analyst	Information Management	5%
Integrated Care Specialist	Integrated Care/Population Health	6%
Medical Director (Part-time)	Clinical	75%
Network Management Specialist	Network Management	10%
QI Coord/Compliance-Privacy Officer	QI/Compliance	50%
Systems Analyst	Information Management	25%

III. **QAPIP Committee/Teams**

NorthCare Network's QAPIP is implemented through various PIHP and regional committees/teams as listed below.

a. NorthCare Leadership Committee
b. NorthCare Compliance Oversight and Risk Management Committee (CORMC)
c. NorthCare Information/Technology Management Committee
    - Regional Elmer Management Committee (REM)
    - Regional Analytics Committee
    - Regional Help Desk Committee
    - Regional Information Technology and Security Committee
    - Regional Medical Records Committee
d. NorthCare Network Management Committee
    - NorthCare Network Site Review Team(s)
    - Regional Contract Management Committee
e. NorthCare Credentialing Committee
f. NorthCare Quality Management Committee
    - NorthCare Network Medicaid Service Verification Team
    - Regional Quality Improvement Committee
    - NorthCare Trauma Informed Committee

g. Regional QI and Clinical Practices Committee
    - Regional Employment Leadership Committee
    - Regional Jail Diversion Committee
    - Regional Autism Committee
    - Regional Behavioral Treatment Committee
    - Regional Trauma Informed Committee
    - Health and Safety Review Committee
    - NC/UPHS-Mqt QI Committee
    - NC/War Memorial QI Committee
    - NC/Willow Creek QI Committee

h. NorthCare Utilization Management Committee
    - Regional Utilization Management Committee
    - Regional Emergency Services Committee

i. Regional Customer Services Committee

j. Regional Finance Committee
    - Regional Billing Committee

k. Regional Information Technology and Security Committee

Each committee has an approved "Fact Sheet" which documents the committee charge, reporting requirement(s), membership, deliverables, and meeting frequency. Project specific or time specific workgroups are established as appropriate.

QUALITY MANAGEMENT SYSTEM

(Components and Activities)

NorthCare Network's Quality Management System combines the traditional aspects of quality assurance and adds the elements of continuous quality improvement. The Quality Management System helps NorthCare Network achieve its mission, realize its vision, and live its values. It protects against adverse events and it provides mechanisms to bring about positive change while ensuring quality services. Continuous quality improvement efforts assure a proactive and systematic approach that promotes innovation, adaptability across the Network, and a passion for achieving best practices.

The *Quality Management System* includes:

- Predefined standards
- Formal and informal assessment activities
- Measurement of performance in comparison to standards
- Strategies to improve performance that is below standard

The various aspects of the system are not mutually exclusive. However, for descriptive purposes, the following table separates the components.

QUALITY MANAGEMENT SYSTEM			
Quality Standards	Assessment Activities	Performance Measurements	Improvement Strategies
▪ Federal & State Rules/Regulations ▪ Stakeholder Expectations ▪ MDHHS Contract ▪ Provider Contracts ▪ Practice Guidelines and Evidence Based Practices ▪ Network Standards	▪ Quality Monitoring Reviews ▪ Accreditation Surveys ▪ Credentialing ▪ Risk Assessment/ Management ▪ Utilization Reviews ▪ External Quality Reviews ▪ Stakeholder Input	▪ MDHHS MMBPIS ▪ Audit Reports ▪ External Quality Reviews (HSAG) ▪ MDHHS Site Reviews ▪ Outcome Reports ▪ Benchmarking ▪ Grievance & Appeals	▪ Corrective Action/Improvement Plans ▪ Improvement Projects ▪ Improvement Teams ▪ Strategic Planning ▪ Practice Guidelines ▪ Organizational Learning

▪ Accreditation Standards ▪ Network Policies and Procedures ▪ Delegation Agreement ▪ Clinical Documentation Standards ▪ AFP/ARR	▪ Sentinel Events ▪ Critical Incident Reports ▪ Documentation Reviews ▪ Medicaid Verification of Service Reviews ▪ Performance Improvement Projects ▪ Critical Event Reporting		▪ Administrative and Clinical Staff Training ▪ Cross Functional Work Teams ▪ Reducing Process Variation

I. Quality Standards

Quality Standards provide the specifications, practices, and principles by which a process may be judged or rated. NorthCare Network identifies and sets standards by reviewing, analyzing, and integrating such areas as:

- Performance expectations of network providers for both clinical services and administrative functions
- Government regulations/rules
- Practice Guidelines
- Accreditation and/or Network Standards
- External review findings
- Utilization Management and Authorizations

II. Quality Assessment Activities

Quality assessment consists of various strategically planned activities that help to identify the actual practices, attitudes, performance, and conformance to standards that are enhancing or inhibiting the achievement of quality. Obtaining stakeholder input is critical to quality assessment activities.

A. *Stakeholder Input*

NorthCare Network recognizes that a vital aspect of any continuous improvement system is a means to obtain stakeholder input and satisfaction information. Stakeholders identified to provide input to NorthCare Network include individuals who are or have received services, staff, contract service providers, families/advocates, and the local communities; representing both internal and external customers.

Input is collected to better understand how NorthCare Network is performing from the perspective of its stakeholders. The input is continually analyzed and integrated into the practices of the PIHP. NorthCare Network's Customer Services Committee and Governing Board both provide opportunity for stakeholder input. NorthCare Network encourages stakeholder participation on other committees as appropriate. Each Member CMHSP will ensure that there is adequate input from stakeholders for local decision-making.

The table below summarizes methods and sources for obtaining stakeholder input.

STAKEHOLDER INPUT METHODS AND SOURCES						
Type of Input	Consumer	Staff	Providers	Family/ Advocates	Community	MDHHS/EQRO
Interviews	MDHHS Site Reviews, Accreditation, NorthCare Network Site Reviews, Satisfaction Surveys, PCP process	Performance Evaluations, Termination/Exit Interviews	ORR Site Visit, Contract Provider Quality Review	MDHHS Site Reviews Fidelity Reviews of Evidence Based Practices	Open Door Policy of the NorthCare Network CEO	MDHHS Site Reviews, External Quality Review Organization (EQRO)– under contract w/MDHHS, Accreditation
Suggestions	Ongoing opportunity through PCP process	Supervision, Suggestion for Improvement process	Quality reviews	Ongoing opportunity through PCP process per consumer choice	Focus Groups or Public Forums	MDHHS, EQRO, Accreditation

Forums	Consumer advisory committees, Board meetings	Team/Dept Meetings, All staff meetings	MDHHS Review, Contract negotiations, meetings	MDHHS Review, Advisory committees	MDHHS /EQR/ Accreditation Reviews, Annual PRR forum, Public comments at Board meetings	MDHHS, EQRO, Accreditation
Surveys	Consumer surveys Health Plan Survey per Accreditation	Staff surveys	Provider surveys, Accreditation surveys	Satisfaction surveys	Stakeholder Surveys	MDHHS, EQRO, Accreditation
Assessment of experience with services/ organization	Ongoing through PCP process, progress notes, d/c summary, Various regional committee membership	Performance evaluations	Quality review of provider, AFC licensing reports	Regional committee membership	Community Needs Assessment	MDHHS, EQRO, Accreditation
Grievance & Appeals	Recipient Rights, Grievance & Appeals Process	Staff Grievance	Provider Grievance	Grievance systems	Comments via NorthCare Network Website	MDHHS, EQRO, Accreditation
Complaints	RR Complaint, Complaints discussed w/customer services, Compliance complaint process	Employee complaint, Compliance complaint process	RR Complaint, Compliance complaint process	RR Complaint, Compliance complaint process, Customer Service compliant process	RR Complaint, Compliance complaint process	MDHHS, EQRO, Accreditation

B. *Ongoing Assessments Of Consumer Experiences With Services and the PIHP*

NorthCare Network conducts ongoing quantitative (e.g., surveys) and qualitative (e.g., focus groups, interviews) assessments of member experiences with its services. These assessments must be representative of the individuals served, including individuals receiving long-term supports or services (i.e., individuals receiving case management or supports coordination) and the services and supports offered.

Assessment results will be used to improve services, processes, communication, etc. Processes found to be effective and positive will be continued, while those with questionable efficacy or low consumer satisfaction will be revised by:

- Taking specific action on individual cases as appropriate.
- Identifying and investigating sources of dissatisfaction.
- Outlining systemic action steps to follow-up on the findings.
- Informing practitioners, providers, recipients of service, and the NorthCare Network Governing Board of assessment results.

Just as the original processes must be evaluated, the interventions used to increase quality, availability, satisfaction, and accessibility to care and services must also be assessed. Therefore, all actions taken as a result of assessments will be evaluated periodically. Quality improvement is never static, and it is an expectation that all evaluation efforts will be examined on an ongoing basis.

C. *Provider Network Monitoring*

NorthCare Network conducts annual site reviews of organizational providers with whom we directly contract to ensure compliance with delegated functions as well as regional, state, and federal mandates. NorthCare Network delegates and monitors annual review of Member CMHSP sub-contractors.

NorthCare Network's process is a systematic and comprehensive approach to monitor, benchmark, and make improvements in the provision of mental health and substance use services. NorthCare Network conducts annual (at minimum) site reviews to evaluate:

- Compliance with regional, state, federal and accreditation standards through annual site visits
- Compliance with delegated functions
- Clinical documentation reviews

- Verification of Medicaid services
- Clinical Implementation of effective treatments

The Provider Network Monitoring process provides NorthCare Network the ability to:

- Establish clinical and non-clinical priority areas for improvement
- Use a number of measures to analyze the delivery of services and quality of care
- Establish performance goals and compares findings and ratings with past performance
- Provides performance feedback through written report
- Requires an improvement/corrective action plan from providers in areas not achieving targets or in non-compliance with accepted standards
- Ensures implementation of the improvement plan by providers

D. *Utilization Management and Authorizations*

NorthCare Network implements a Utilization Management Plan within the provisions of its Standard Contract with Michigan Department of Health and Human Services (MDHHS). NorthCare Network has oversight authority and performs utilization management functions sufficient to control costs and minimize risk while assuring quality care. The UM Plan establishes a framework for oversight and guidance of the Medicaid and MI Health Link (MHL) Programs by assuring consistent application of program/service eligibility criteria, and in decisions involving the processing of requests for initial and continued authorization of services.

Utilization Management is committed to not only reviewing practices related to resource utilization, but also to taking action to modify inappropriate, inefficient or ineffective utilization. Many of the NorthCare Network Utilization Management functions overlap or are reliant on coordination with, Quality Assessment & Performance Improvement, Provider Relations, Regional Quality Improvement and Clinical Practices Committee, Claims/Reimbursement, Management of Information Services and other managed care functions. Successful interface among the various functions of the PIHP is essential for effective and efficient management of resources, identification of gaps in service delivery and resolution of over- and under-utilization of services and resources. Interface between Utilization Management and other PIHP functions occurs through exchange of data, information and reports, joint participation in a variety of committees and collaboration in planning, projects and operational initiatives.

Compensation to individuals or entities that conduct utilization management activities cannot be structured to provide incentives to the individual or entity to deny, limit, or discontinue medically necessary services to any recipient.

E. *Credentialing and Qualification for Scope of Practice*

The NorthCare Network Credentialing Committee is responsible to apply legal, professional and ethical scrutiny to applicants seeking to be credentialed as a provider in the network and to approve the re-credentialing of existing providers. NorthCare Network retains final authority for the credentialing of individual and organizational providers as a member of the provider panel employed or under contract. The qualifications of physicians and other licensed behavioral healthcare practitioners/professionals employed by or under contract to the PIHP are reviewed according to the NorthCare Network Credentialing and Privileging Policies to ensure they are qualified to perform their services. Continuous monitoring of the credentialing program occurs across the network to ensure compliance and identify quality or network issues. Organizations are responsible for ensuring that individual practitioners/providers, employed or under contract, and organizational providers meet all applicable licensing, scope of practice, contractual, and payor requirements. The oversight and monitoring of the credentialing of sub-contract provider

staff is delegated to direct contractors.

NorthCare Network requires professional staff in the network to have a documented review and approval of their clinical privileges as needed to assure services provided to the network members are delivered by qualified and competent staff. Minimally, this is done as part of the initial credentialing/re-credentialing process and when duties/responsibilities change in terms of primary eligibility group a person is working with and/or scope of work. MI Health Link (MHL) Community Providers are privileged per the MHL Standard Operating Procedures as codes are identified by professional discipline.

NorthCare Network and network providers shall train new personnel regarding their responsibilities, program policy, and operating procedures and identify staff training needs and provide in-service training, continuing education and staff development activities according to NorthCare Network's Training – Personnel Policy and the Training-Network Provider Policy.

F. *Oversight of Vulnerable Individuals*

NorthCare Network utilizes the appropriate clinical staff and various reporting mechanisms and data sets to identify vulnerable individuals and events that put them at risk of harm, including required health measures and health assessments. Such events and data, that are not a product of a protected peer review process, will be used to determine opportunities for improving care and outcomes and reported to the Compliance Oversight and Risk Management Committee as appropriate. However, if an issue that places an individual in imminent risk to health or welfare is identified, NorthCare will take immediate action to ensure their safety. NorthCare will invoke an immediate review and require a response by the Provider, within seven (7) calendar days.

G. *Behavior Treatment Review*

NorthCare Network's Clinical Practices Improvement Coordinator will review analyses of data from Member CMHSP behavior treatment review committee(s) on a quarterly basis where intrusive or restrictive techniques have been approved for the use with beneficiaries and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. Patterns and trends will be evaluated for possible system and/or process improvement initiatives and will be reported to NorthCare Network's Quality Management and Oversight Committee. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plan Review Committees and that have been approved during person-centered planning by the beneficiary or his/her guardian may be used with beneficiaries. Data includes numbers of interventions and length of time the interventions were used with the individual.

H. *Event Reporting and Notification*

Each Network Provider will record, assess, and report critical incidents according to NorthCare Network policy. They will analyze at least quarterly the cumulative critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents and report the outcome of this analysis to NorthCare Network. NorthCare Network's Health and Safety Review Team will analyze aggregate data to identify any trends or patterns and may follow-up on individual events as warranted. The Health and Safety Review Team will report aggregate high-risk areas and concerns to NorthCare Network's Compliance Oversight and Risk Management Committee as appropriate. Member CMHSPs utilize NorthCare Network's Incident Report Module to report all events defined below. Other Network Providers may continue to report on paper.

1) Critical Events: Critical Event Reporting will be uploaded, monthly at minimum, to MDHHS's PIHP Event Reporting Data Warehouse by PCE (NorthCare Network's software

vendor) automatically. This Critical Incident Reporting System captures information on five specific reportable events based on varying populations as mandated by MDHHS. Detailed requirements can be found in NorthCare Network's Incident, Event & Death Reporting & Monitoring Policy and the PIHP/ MDHHS Reporting Requirements Policy.

2) Event Notification: The PIHP is also required to immediately notify MDHHS of specific events as outlined in the MDHHS Reporting Requirement Policy and NorthCare Incident, Event & Death Reporting & Monitoring Policy.
3) Sentinel Events, as defined in the MDHHS Reporting Requirement Policy must be reviewed and acted upon as appropriate and in accordance with NorthCare Network's Incident, Event & Death Reporting & Monitoring Policy.
4) Risk Events are additional events that put individuals at risk of harm, including at minimum: actions taken by individuals that cause harm to themselves or others; two or more unscheduled admissions to a hospital within a 12-month period; emergency use of physical management by staff in response to a behavioral crisis, and police calls by staff under certain circumstances. For detailed information refer to PIHP/ MDHHS QAPIP Guideline. NorthCare Network's Health and Safety Review Team and CMHSP staff review trends and follow up as indicated.
5) All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed. Unexpected deaths include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect. Specifics for reporting are included in NorthCare's Incident, Event & Death Reporting & Monitoring Policy.

I. External Quality Reviews

1) MDHHS *Site Reviews*

Follow up activities for site reviews conducted by MDHHS are carried out and/or monitored by NorthCare Network's Network Management and/or Quality Management and Oversight Committees. To best address local concerns, each Member CMHSP may be asked to draft a remedial action plan for all citations for which the Member CMHSP has been identified as being out of compliance. NorthCare Network will consider each response for inclusion in the Plan of Correction submitted to MDHHS. NorthCare Network also provides consultation for Member CMHSPs and monitors the implementation of improvement activities.

2) *External Quality Review Organization*

The Michigan Department of Health and Human Services (MDHHS) will arrange for an annual, external independent review of the quality and outcomes, timeliness of, and access to covered services provided by the PIHP. The External Quality Review (EQR) includes an on-site review of the implementation of the QAPIP. The EQR also validates methodologies used in conducting the required performance improvement projects (PIP) as well as validates performance measure data collection and reporting to MDHHS. The PIHP addresses the findings of the external review through its QAPIP. The PIHP develops and implements performance improvement goals, objectives and activities in response to the external review findings as part of this QAPIP. A description of the performance improvement goals, objectives and activities developed and implemented in response to the external review findings will be included in the PIHP's Quality Improvement Plan and provided to the MDHHS upon request. The MDHHS may also require separate submission of an improvement plan specific to the findings of the external review.

3) *Accreditation*

As evidenced by developments in federal and state policy, the ability to perform managed care functions to industry standards while also assuring program integrity with federal and state funds is an expectation for the PIHPs. The URAC accreditation process demonstrates NorthCare Network's commitment to quality services and will provide a framework to improve business processes through benchmarking NorthCare Network against nationally recognized standards.

NorthCare informs MDHHS of accreditation status which is to be included on the MDHHS website (42 CFR 438.332). NorthCare authorizes the Accrediting Body to forward a copy of the most recent accrediting review to the MDHHS.

III. Performance Measurement

NorthCare Network measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data. Through monitoring and evaluation, the efforts and resources of the Network can be redirected to obtain the desired outcomes.

By using performance indicators, the variation between the target desired and the performance being measured can be identified. Indicators are used to alert NorthCare Network and the Network Providers of issues that need to be addressed immediately, to monitor trends and contractual compliance, and to provide information to consumers and the public. Performance indicators are the foundation to control and improve processes.

Performance indicator results are used to guide management decision-making related to:

- Strategic planning
- Resource allocation
- Modification of service delivery
- Administrative process changes
- Staff training, credentialing and privileging
- Other activities identified by our various stakeholders

A. Performance Indicators [Measures]

NorthCare Network's Quality Oversight Committee monitors performance indicators for individual Member CMHSPs and collectively for the region. The QAPIP is utilized to assure that at least the minimum performance level on each indicator is achieved. A plan of correction that includes a review of possible causes for outliers is required from any Member CMHSP for each Performance Indicator out of compliance for two consecutive quarters. NorthCare Network's Quality Oversight Committee and/or Quality Improvement Coordinator will monitor any plans of correction. Performance data is reviewed and discussed with the various QAPIP committees.

- Michigan Mission Based Performance Indicator System (MMBPIS)
  NorthCare Network utilizes performance measure established by the MDHHS that address areas of access, efficiency, and outcomes and report to the State as established in the contract. NorthCare Network and Member CMHSP staff will ensure the reliability and validity of the data on these indicators across the Network and that these conform to the "Validation of the Performance Measures" of the BBA protocols. The Quality Oversight Committee will review MMBPIS results. Member CMHSPs and SUD Providers who are out of compliance with MDHHS and/or NorthCare standards will work with NorthCare Network QI Coordinator and the Quality Oversight Committee to ensure the implementation of effective improvement plans.
- Regional Measures

NorthCare Network may establish and monitor additional performance indicators specific to an individual program for the purpose of identifying process improvement projects. Performance indicators employed should be objective, measurable, and based on *current* knowledge and experience to monitor and evaluate key aspects of care and service. Performance goals and/or a benchmarking process are utilized for the development of each indicator.

- NorthCare Network will ensure compliance with, and sustainability to meet, performance measures as outlined in the contract between the State of Michigan - Michigan Department of Health and Human Services with NorthCare Network and the Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans.
- NorthCare Network will participate and collaborate with the ICO in regular and ongoing initiatives that address methods of improved clinical management of chronic health conditions and methods for achieving improved health outcomes for Members enrolled in the MI Health Link Demonstration Program.

B. Outcomes Management

NorthCare Network's Clinical Practices Quality Committee will establish outcome measures and conduct quality improvement efforts to assure effective clinical practices based on a recovery and trauma informed system of care.

C. Practice Guidelines

NorthCare Network's Clinical Practices Coordinator is charged with the task of overseeing the adoption, development, implementation and continuous monitoring and evaluation of Practice Guidelines when there are nationally accepted, or mutually agreed upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices and promising practices that are relevant to the individuals served. Working together, the Clinical Practices Quality Committee, Quality Oversight Committee, and the regional UM Committee monitors and measures the effectiveness of newly implemented treatment practices required by MDHHS for all populations. The NorthCare Network Practices Guideline Manual provides detailed information regarding the process for the adoption, development, implementation, and monitoring and evaluation of the guidelines. This manual can be found at www.northcarenetwork.org

The Contractor must disseminate all practice guidelines it uses to all affected providers and, upon request, to beneficiaries. The Contractor must ensure decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. The Contractor must assure services are planned and delivered in a manner that reflects the values and expectations contained in practice guidelines adopted by NorthCare.

To ensure fidelity to practice, NorthCare and the affiliate CMHSP's will participate in Michigan Fidelity Assistance Support Team (MiFAST) reviews, as required by MDHHS. MIFAST is required prior to implementation or use of specific Medicaid codes or modifiers and every 2-3 years thereafter.

D. Verification of the Delivery of Medicaid Services

Verification of Medicaid services is conducted in accordance with NorthCare Network's Medicaid Service Verification Policy. This process is to ensure Medicaid services were furnished to enrollees by member CMHSPs, providers, and subcontractors with corrective action taken as warranted.

IV. Improvement Strategies

Establishing and successfully carrying out strategies to eliminate outliers, incorporate best practices, and optimize consumer outcomes is key to continuous quality improvement. The particular strategy or sets of strategies used vary according to the situation and the kind of improvement that is desired. The following provides a brief description of some of the improvement strategies utilized.

A. Performance Improvement Projects (PIP)

Standards published by the Centers for Medicare and Medicaid Services (CMS) require that the PIHP (Prepaid Inpatient Health Plan) conduct, "performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction."

NorthCare Network must engage in at least two affiliation-wide projects during each waiver period, which must address clinical and non-clinical aspects of care. Project topics are either mandated by MDHHS or selected by the PIHP in a manner that takes into account the prevalence of a condition among, or need for a specific service by, the organizations' consumers, consumer demographic characteristics and health risks, and the interest of consumers in the aspect of service to be addressed. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care; while non-clinical areas would include, but not be limited to, appeals, grievances, trends and patterns of incident reports as well as access to, and availability of, services.

In addition, URAC Accreditation requires that at any given time the organization has underway a minimum of three Quality Improvement Projects (QIP). All three QIPs must focus on clinical quality and at least one of the three must address consumer safety for the population served.

Projects selected may fulfill both MDHHS /HSAG and URAC requirements.

B. Utilization Management (UM)/Authorization strategies

NorthCare Network UM activities are specifically designed to ensure only eligible beneficiaries receive plan benefits; that services received meet medical necessity criteria and are linked to other services when needed. To achieve these goals, various methods are used that focus on eliminating outliers, incorporate best practices, and optimize consumer outcomes. For example, NorthCare Network directly operates a centralized access system which assures more uniform access to non-emergent services and reduces variability in eligibility determinations in access to the public mental health system. To improve overall quality of consumer outcomes and consistency in the amount, scope, and duration of services, clinicians use the NorthCare Network level of care placement protocols to guide level of care determinations. This clinical decision-support tool allows for greater consistency in level of care assignments and aimed at reducing variances in service delivery. Finally, utilization review activities are employed which include monitoring of individual consumer records, specific provider practices and system trends. Review and monitoring activities are used to determine appropriate application of guidelines and criteria for decision involving level of care assignments, service selection, authorization, and best practices. Tracking consumer outcomes, detecting over utilization/underutilization and reviews of outliers are also the subject of utilization review efforts.

PROCEDURES FOR ADOPTING & COMMUNICATING PROCESS & OUTCOME IMPROVEMENTS

NorthCare Network will incorporate the Home and Community-Based Services (HCBS) Quality Framework developed for the Centers for Medicare and Medicaid (CMS) into its Quality Management Program. This Quality Framework is intended to serve as a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of services and supports provided by NorthCare Network's provider network. The Framework focuses attention on critical dimensions of service delivery and the desired outcomes of the four functions of quality management: design, discovery, remedy and improvement. Further, definitions of the functions of quality are:

- Design: Designing quality assurance and improvement strategies to a program at the initiation of the program.
- Discovery: Engaging in a process of discovery to collect data and direct participant experiences in order to assess the ongoing implementation of the program, identifying both concerns as well as other opportunities for improvement.
- Remedy: Taking actions to remedy specific problems or concerns that arise.
- Continuous Improvement: Utilizing data and quality information to engage in actions that assure continuous improvement in the program.

Focus will be on the following seven broad categories as outlined by CMS:

1. Participant access
2. Person-centered planning and service delivery
3. Provider capacity and capabilities
4. Participant safeguard
5. Participant rights and responsibilities
6. Participant outcomes and satisfaction
7. System performance

Suggestions for improvement can come from a variety of sources. Feedback from consumers, advocates, stakeholders, network providers, MDHHS, and NorthCare Network Personnel is incorporated into the QI Plan's components and activities. NorthCare Network's QI Work Plan will identify measurable objectives, as well as the individuals and/or departments responsible for each objective. Also included, will be a timeline for completion of tasks and schedule for ongoing monitoring as appropriate.

EVALUATION

NorthCare Network's QAPIP is reviewed and updated at least annually with input from various stakeholders and approved by the Governing Board. The NorthCare Network Governing Board and NorthCare Network Quality Management and Oversight Committee are responsible for the evaluation of the effectiveness of the QAPIP. This Annual Effectiveness Review includes analysis of whether there have been improvements in the quality of health care and services for recipients as a result of quality assessment and improvement activities and interventions carried out by the PIHP. The analysis considers trends in service delivery and health outcomes over time and includes monitoring of progress on performance goals and objectives. Information on the effectiveness of the QAPIP must be provided annually to network providers and to recipients upon request. This annual analysis will be provided to the MDHHS.

NorthCare Network publishes an Annual Performance Management Report that provides a summary of accomplishments and highlights from the previous Fiscal Year as well as key information that will identify whether current systems and processes are providing desired outcomes. This report will be posted at www.northcarenetwork.org, posted at NorthCare Network's main office, a copy sent to all

Network Providers and members of NorthCare Network Governing Board and copies provided to stakeholders as requested.

CROSS REFERENCES

- The Balanced Budget Act of 1997 (BBA)
- MDHHS /PIHP Master Contract and pertinent Attachments
- MDHHS Michigan Mission Based Performance Indicator System V6.0 Codebook
- ICO/PIHP Contract for the MI Health Link Demonstration Program
- URAC (Utilization Review Accreditation Commission) Health Plan 7.1 Standards
- NorthCare Network Credentialing Program Policy
- NorthCare Network Incident, Event & Death Reporting & Monitoring Policy
- NorthCare Network Methodology – Michigan Mission Based Performance Indicator System V6.0
- NorthCare Network Annual Performance Management Report
- NorthCare Network QI Work Plan
- NorthCare Network Training-Personnel Policy
- NorthCare Network Utilization Management (UM) Plan
- NorthCare Network Training-Network Provider Policy
- NorthCare Network/CMHSP Delegation Agreement
- NorthCare Network Cultural Sensitivity Policy

All NorthCare Network policies can be found at www.northcarenetwork.org.

ATTACHMENTS

A - Acronyms Used in this Document

APPROVALS

Reviewed/Revised Date: 9/8/2021
Quality Management and Oversight Committee Approval: 9/9/21
Policy Committee/CEO Approval: 10/5/21
Board of Directors Approval: 11/10/21

ATTACHMENT A

NorthCare Network

ACRONYMS USED IN THIS DOCUMENT

BBA – Balanced Budget Act
CA – Coordinating Agency
CEO – Chief Executive Officer
CMHSP – Community Mental Health Service Provider
CMS – Centers for Medicare and Medicaid Services
EBP – Evidence Based Practices
EQR/EQRO – External Quality Review / External Quality Review Organization
HSAG – Health Services Advisory Group (External Quality Review Organization contracted by MDHHS to conduct annual reviews of each PIHP.)
HCBS – Home and Community-Based Services

HIPAA – Health Insurance Portability and Accountability Act
HMP – Healthy Michigan Plan
ICO – Integrated Care Organization
I/DD – Intellectual/Developmental Disability
MDHHS – Michigan Department of Health and Human Services
MI – Mental Illness
MHL – MI Health Link Demonstration Program
PIHP – Prepaid Inpatient Health Plan
PMC – Performance Management Committee (A NorthCare Network Committee represented by Directors of each Member CMHSP and NorthCare Network's CEO)
QAPIP – Quality Assessment and Performance Improvement Plan
QC – Quality Council
QI – Quality Improvement
QIP – Quality Improvement Plan
UM – Utilization Management
URAC – Accrediting Body which originally incorporated under the name "Utilization Review Accreditation Commission." The name was shortened to the acronym "URAC" in 1996 when URAC began accrediting other types of organizations such as health plans and preferred provider organizations. In addition, URAC sometimes uses a second corporate name or DBA which is the "American Accreditation HealthCare commission, Inc." This corporate name is sometimes used on URAC certificates and other written communications to help explain what URAC does.

3. FY22 NorthCare Network Quality Management Components

Standards

Quality Standards provide the specifications, practices, and principles by which a process may be judged or rated. NorthCare Network identifies and sets standards by reviewing, analyzing, and integrating such areas as:

- Performance expectations of network providers for both clinical services and administrative functions
- Government regulations/rules
- Practice Guidelines
- Accreditation and/or Network Standards
- External review findings
- Utilization Management and Authorizations

As a result of the review and analysis of specific areas in FY21, NorthCare established new quality standards for FY22, two of which are outlined below.

The first new quality standard focused on increasing the rate at which individuals who are requesting SUD services, and are found eligible for PIHP services, are admitted within 14-days of the non-emergent request. Since the State has no set benchmark for this standard, NorthCare has established that providers will meet or exceed the State rate each quarter with a regional goal of reaching 80%. NorthCare looks to identify providers that fall below the 80% regional goal and works with them to identify and address barriers to improve. The two measures are due to the State calculation of this indicator for the PIHP as a whole and the inability to drill down to the provider level for their individual rates. Throughout FY22 NorthCare has exceeded the State's percentage as noted in the chart below.

SUD 2b	Q1FY22	Q2FY22	Q3FY22	Q4FY22
NorthCare	74.56%	86.62%	74.05%	75.97%
State	71.79%	70.85%	70.40%	70.70%

Although MDHHS calculates this measure on a regional basis, NorthCare monitors quarterly based on calculations performed via the regional performance indicator module which provides the ability to review provider level performance. This calculation typically produces a little higher percentage than the State's calculation. In looking at FY22, PI2b shows all but one provider at or above 80% for all four quarters. The one provider dipped below the regional goal of 80% in quarter 2 where they reached a 79% compliance with an average for the year of 84.8% compliance. The following chart shows the compliance rating, as calculated by NorthCare's PI module, for each SUD provider for FY22.

Provider	# Compliant	% Compliant
Bear River	36 of 38	94.7%
Calumet Family Health Center	39 of 40	98%
Catholic Social Service	56 of 66	85%
DOT Caring	40 of 41	98%
Great Lakes Recovery Center	1289 of 1477	87%
Keweenaw Bay Indian Community	20 of 20	100%
Phoenix House	150 of 159	94%
Sacred Heart	19 of 19	100%

Effective 10/1/21, NorthCare implemented a new regional procedure to ensure NorthCare's follow-up, review and remediation is completed thoroughly and consistently throughout the region regarding consumer satisfaction survey data. The region moved to a new process whereby consumer satisfaction data is collected electronically throughout the fiscal year and is required to be reported out to the respective providers monthly to ensure prompt follow-up to feedback, comments and/or concerns received. NorthCare's Customer Services Specialist is responsible for the dissemination of survey data received.

NorthCare Network and all Network Providers will have paper copies of the satisfaction survey available upon request, free of charge. Starting FY23 all written surveys received by NorthCare/Network Providers will be manually entered into the online survey system, staff should note in the comments the date the written survey was received. NorthCare will report back the compiled survey data to each CMHSP monthly.

NorthCare Network completes an in-depth review of consolidated survey data annually. When any question on the satisfaction survey data averages a score of 90% or below, each CMHSP is to ensure prompt and appropriate systemic follow up/action is taken to improve satisfaction in that area. This is true for all questions except the question about after-hours crisis, as this service is contracted by MDHHS with MiCAL.

Quality Management Workplan

Each year a workplan is created. FY22's workplan with updates over the year is reflected below. Some items were carried forward to FY23 workplan. The workplan is reflected from this page through page 41 and shows updates as of December 2022.

NorthCare Network Quality Improvement Work Plan Closed – 12/12/22								
1.								
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**			
HSAG	FY21	St IV.	Brittany	2.28.22	N:\Reports & Data\Network Adequacy Data			
Description of Standard/Initiative								
The PIHP gives assurances to MDHHS and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with MDHHS' standards for access to care under 42 §438.207, including the standards at §438.68 and §438.206(c)(1). Each PIHP must submit documentation to MDHHS, in a format specified by MDHHS, to demonstrate that it complies with the following requirements: - Offers an appropriate range of behavioral health, development disability, substance use and specialty services, and LTSS that is adequate for the anticipated number of members for the service area. - Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.								
Findings			**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**
Recommendation - The PIHP should work with MDHHS to determine when the annual submission of its assessment of adequate capacity, in accordance with MDHHS' defined network adequacy standards, should be submitted. Additionally, while the PIHP indicated that it considers its region as frontier moving forward, based on consultation with MDHHS, HSAG recommends that the PIHP evaluate its entire region by ZIP Codes using the sources provided by MDHHS in the PIHP Network Adequacy Standard Procedural Document for determining urban, rural, and frontier status as the PIHP's geographical			NorthCare will identify the required due date and format for the Network Adequacy Report and will identify the regional status by geographical location to ensure Network requirements are met	NorthCare will contact MDHHS to determine the due date by DATE.	Complete or not	2.28.22	10.22.21	Diane
				NorthCare will review the requirements for determining frontier status using verified sources by DATE.	Complete or not	2.28.22	11.10.21	Brittany

region may include both rural and frontier areas.						
Citation - The PIHP must give assurances to MDHHS and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with MDHHS' standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1). **MDHHS/HSAG Response:** The PIHP's remediation plan is sufficient to ensure compliance with the requirements for this program area. However, HSAG recommends that the PIHP's time/distance analysis includes the location of provider types/services (specified in MDHHS' procedural document) that are not available at a particular CMHSP physical location (i.e., clubhouse, opioid treatment program, etc.). During the next three-year compliance review cycle, the PIHP should be prepared to provide evidence of implementation of its plans of action and HSAG's recommendations.	NorthCare will identify and indicate its capacity to serve the expected enrollment of the region and explain current adequacy in the required report	NorthCare will complete the Network Adequacy Report by 2.28.21	Complete or not	2.28.22	2.28.22	Brittany
		NorthCare will review the required components of the Network Adequacy Report, including but not limited to time/distance standards to inpatient psychiatric providers	Complete or not	2.28.22	11.10.21	Brittany
		NorthCare will pull data to determine current provider to consumer ratios by 2.1.22	Complete or not	2.28.22	2.22	Jen
Updates	FY22Q2: 1.20.22 began work on the Demand and Network Adequacy (DNA) report.					
Monitoring						

NorthCare Network
Quality Improvement Work Plan

2.

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location
MDHHS	FY22	Contract Req.	Diane	2/17/22	..\1. Effectiveness Review

Description of Standard/Initiative

PIHPs must conduct an annual effectiveness review of their QAPIP per MDHHS/PIHP Contract and QAPIP

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
Annual Goal	Submit completed QAPIP effectiveness review to MDHHS.	All NC Staff respective assignments to be completed and documentation filed in N:\Committees\Internal\Quality Management and Oversight Committee\1. Effectiveness Review\2021 QAPIP Effectiveness Review\FY21 Original - Source Documents - READY FOR REPORT folder.	Completion	2/6/22	2/4/22	Various staff per assignments.
		Compile and PDF all completed documentation and submit to S.Lambert for Board Packets.	Final Draft to S.Lambert	2/7/22	2/7/22	Diane
		Scheduled for board approval on 2/16/22	Board Approval	2/16/22	2/16/22	Board/Diane
		Submit approved report to MDHHS	Submission	2/28/22	2/17/22	Diane
Updates	Completed 2/17/22.					
Monitoring						

NorthCare Network
Quality Improvement Work Plan

3.

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location
HSAG PIP Validation	FY	N/A	Diane	Pulled forward to FY23 Work Plan	..\..\..\..\Quality Management\Performance Improvement Projects\PIP_FUH-2018 HSAG PIP

Description of Standard/Initiative

To increase the percentage of discharged enrollees ages six (6) and older, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within seven (7) days of discharge.

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
This PIP was validated by HSAG and found not met due to not reaching a statistically significant improvement over baseline. This PIP validation cycle has ended, but because of the importance of ensuring timely follow-up, NorthCare chose to continue with some revisions. We have clarified the use of the H0002 code and services such as case management (T1017) is not an allowable follow-up service under HEDIS specifications, but is a common service provided and should be counted as this service is conducted face-to-face.	Revise PIP to account for additional FTF services that are outside the HEDIS code sets as these are allowable FTF services and important follow-up services.	Update PIP project summary.	Completion	10/20/21	10/20/21	Diane/Brittany
	Develop report in house due to termination of Relias contract in May 2021.	NorthCare IT staff to develop report to mirror and replace Relias report with additional data fields.	Validated FUH Report	6/2021		Andy/Jen
	Achieve a statistically significant improvement in percentage of children seen within 7-days of discharge.	Achieve a rate of 77.88% for children	77.88	TBD		Diane/Brittany
	Achieve a statistically significant improvement in percentage of adults seen within 7-days of discharge.	Achieve a rate of 66.40% for adults	66.40%	TBD		Diane/Brittany

Updates	FY21Q1 – Updated PIP project summary and the SOP. FY21Q3 - Updated the SOP-Follow up to Hospitalization(FUH) Services Procedure to allow the H0002 to be used for consumers who are open to CMH at the time of discharge. FY21Q4 – Updated SOP approved by policy committee in July. The use of H0002 for open consumers should be used as the exception, not the rule. HEDIS allows for H0002 but does not allow for T1016/T1017 so it is not expected that this will improve outcomes to this measure much. Slight improvement in both measures, but it does not meet goal and is not significantly different. FY22Q3 – Received date of 5/2/22 for completed report.
Next Steps	Review FY21 data when available. Meet with FUH PIP Workgroup to review FY21 and identify barriers and interventions.

NorthCare Network
Quality Improvement Work Plan

4.

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location
HSAG	FY20	St II.8	Kayti	Pulled forward to FY23 Work Plan	

Description of Standard/Initiative

The QAPIP includes periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered.

a. The assessments must address the issues of the quality, availability, and accessibility of care.
b. As a result of the assessments, the organization:
    i. Takes specific action on individual cases as appropriate.
    ii. Identifies and investigates sources of dissatisfaction.
    iii. Outlines systemic action steps to follow-up on the findings; and
    iv. Informs practitioners, providers, recipients of service and the governing body of assessment results.
c. The organization evaluates the effects of the above activities.

d. The organization insures the incorporation of members receiving long-term supports or services (e.g., persons receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
HSAG Findings: While the PIHP had yet to implement its member experience with services activities, the PIHP demonstrated that it had been working on its methodology and experienced delays due to the current pandemic. As such, HSAG was unable to evaluate the PIHP's compliance with all requirements of this element. While the PIHP's CAP had yet to be fully implemented, the supporting documentation and narrative explanation indicated that the PIHP's actions will bring it into compliance with the requirements of this element. Full implementation of requirements will be reviewed during future compliance reviews. The PIHP's CAP narrative also suggested that it will produce a more comprehensive annual report of members' experience with services that will incorporate access and satisfaction survey results along with associated interventions and follow-up to findings. Recommendations: Once the PIHP completes its member satisfaction survey and compiles data from other activities that assess member experience with services, HSAG strongly recommends that the PIHP clearly document identified areas of member dissatisfaction, implement interventions targeted at increasing member satisfaction in those areas, and complete a subsequent evaluation to determine if the interventions implemented led to increased member	Address dissatisfaction trends and patterns across the region.	Incorporate into electronic process the ability for NorthCare to review and follow-up on areas of dissatisfaction across provider network.	Quarterly review of survey data.	Q1FY22 by 3/1/22		Kayti
		Publish comprehensive annual report that incorporates the access and satisfaction survey results and associated interventions/follow-up as well as any new survey process.	Completed Annual Report	3/1/22		Kayti
		Continued education of online survey including poster for offices with a QR code, business cards with QR codes, newsletter articles, etc.	Posters up in all offices; annual newsletter article.	4/1/22 for posters; 3/1/22 Newsletter		

Updates	FY21Q2 - Meeting w/Northpointe to address drop in satisfaction ratings. FY21Q3 - Developed and implemented a new standard operating procedure to lay out expectations for consumer satisfaction survey data monitoring; effective 10/1/21.

	FY21Q4 - Developed and implemented online satisfaction survey effective 10/1/21. FY22 will be a transition year with expectation that most will be completed electronically while still offering a paper survey when requested. FY22Q1 - Will review new process and expectations with regional CP/QI group on 1/27/22.
Monitoring	

NorthCare Network
Quality Improvement Work Plan

5.

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location
Contract	FY21	HSAG PMV	Diane	Pulled forward to FY23 Work Plan	

Description of Standard/Initiative

PI 2b: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders.

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
Monitoring -	NorthCare will meet or exceed targeted goal of 90% for MMBPIS PI 2b measure for SUD by 10.1.22. Improvement each quarter with goal of 80% for SUD.	Identify providers who consistently don't meet this indicator to focus improvement efforts.	80% of individuals requesting services has an admission within 14 days of request.	10/1/22	Q2FY22	Diane

Updates	FY21Q2 – Scheduled meeting with GLRC in April FY21Q3 - With the change by MDHHS, NorthCare's target is now 90%. Meetings with GLRC. April 1, a Recovery Coach- will count for PI measure. NorthCare was last at 62.34% per MDHHS data presented at the I/O conference. FY22Q1 – Per PCE report the region was at 86.34% while, GLRC was at 81.98% compliance with this measure. We have seen improvement and will continue to monitor. Due to MDHHS average, this goal is reset to 80% for FY22. Q2FY22 – NorthCare's percentage was 86.62% while the State's average was 70.85%. We will continue to monitor against State average with the goal of maintaining 80% or higher. PCE percentages tend to be higher than the State's percentages, we will continue to monitor against the State percentages. Q3FY22 – As there is still no MDHHS set benchmark, NorthCare continues to strive for 80% and will consider met if at 80% or above State rate. The first three quarters of FY22 NorthCare scored higher than the State each quarter: Q1 - 74.56% NC/71.79% State, Q2 - 86.62%NC/70.85%State, and Q3 - 74.05% NC/70.40% State.
Monitoring	Quarterly

NorthCare Network
Quality Improvement Work Plan

6.

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location
HSAG	FY21	St VI.6	Brittany	Pull forward to FY23 Work Plan	

Description of Standard/Initiative

The PIHP's ABD notices must meet the content requirements of 42 CFR §438.404.

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
Required Actions: For standard authorization decisions, the PIHP must provide notice as expeditiously as the member's condition requires and within MDHHS-established time frames that may not exceed 14 calendar days following receipt of the request for service.	NorthCare will make the ABD notice available for all providers in the EMR.	Implement the ABD Notice for SUD providers in the EMR.	Completed or not	2.15.22	4/26/22	Joan
		Create recorded training for SUD and MH providers	Completed or not	2.15.22	Help guide created 11.10.21. Powerpoint	Brittany

		regarding use of the ABD notice.			created 6.20.22. Training updated 9.29.22 with statewide changes to the ABD.	
	NorthCare will ensure the reasons for adverse benefit decisions are clearly documented and available to the member in consumer-oriented language. The region will effectively use the ABD notice by 10.1.21. (9.06)	Pull a random sampling, by provider, of all ABD notices in June 2022, and conduct review of 10 ABD notices per provider to ensure effective use of ABD notice.	Review will include SUD and MH providers. Random sample review period will be from 3.1.22 to 5.31.22.	7.1.22		Brittany
Updates	FY22Q1: ABD Help Guide and LMS PowerPoint training created and made available to staff. FY22Q2:					
Monitoring	Will continue monitoring via random CMH chart reviews. At this time, only ABDs that I can pull are for initial denials. Andy is working on a report to pull all ABDs. While the monitoring didn't happen in FY22 – it is only monitoring going forward.					

NorthCare Network Quality Improvement Work Plan					
7. Standard V, Coordination and Continuity of Care, HSAG: Integrated Physical and Mental Health Care					
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**
HSAG	FY22	V.5.; V.7; V.8.; V.9. V.10.a, b.	Katreena	Pull forward to FY23 Work Plan	

Description of Standard/Initiative

1. The PIHP must ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards.
2. The PIHP must implement mechanisms to comprehensively assess each member needing LTSS or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring
3. The PIHP must produce a treatment plan meeting the needs of the member for those who are determined through assessment to need a course of treatment or regular care monitoring.
4. The PIHP must ensure the integration of primary and specialty behavioral health services for Medicaid Members. These efforts must focus on persons that have a chronic condition such as a serious mental illness, co-occurring substance use disorder, children with serious emotional disorders or a developmental disability.
5. The PIHP must implement practices to encourage all members eligible for PIHP services receive a physical health assessment including identification of a primary care physician, medication history, identification of current and past physical health care and referrals for appropriate services. The physical health assessment will be coordinated through the person's Medicaid Health Plan.
6. The PIHP must include the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the person-centered planning process. Those findings must be shared, as authorized, with the member's physical health care providers.

Findings	**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**

	Individuals served by NorthCare Network providers will receive care coordination between the behavioral health providers and their physical health providers.	Assigned case holders will coordinate care with primary care physicians (PCP), sharing records and recommendations between the providers to ensure collaborative care to meet individual health goals.	From a random sample, 95% or more of individuals will have a signed consent for sharing of information between the CMHSP and their PCP in their record. 100% of records with a signed consent for PCP will have documentation of care coordination in the record.	FY22Q4	12/31/2021	Katreena
		Individuals receiving specialty care (i.e. Neurology, cardiology) will have the recommendations of those providers incorporated into their behavioral health plan to support primary prevention recommendations in daily living.	85% of individuals who identify a specialty condition in their annual health questionnaire will have a signed consent for sharing of records between that physical health specialist and the CMHSP	FY22, Q4		
		LTSS will incorporate co-morbid disease management interventions into person-centered-plans of care	85% of individuals who have an identified co-morbid physical health condition in their annual health questionnaire will have a corresponding health goal in their IPOS.	FY22, Q4		

Updates	FY21 measurement and assessment of description items 1 and 4 found 100% compliance with obtaining releases and sharing information with primary care physicians. The goals in the FY21 workplan were completed and not carried forward to FY22. Although reporting will not be completed on those specific items, monitoring does continue due to their requirements as a first step in meeting the goals and objectives above.
Monitoring	Quarterly random chart review of a random sample of individuals drawn from all five CMHSPs for all persons served who had a CPT service of H0032 (mental health service plan development); excluding those with a TS modifier.

NorthCare Network
Quality Improvement Work Plan

8.Coordination of Care for persons with Co-morbidities

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location
HSAG	FY22	V.2.b.,V.2.c.; V.4., V.6.	Katreena	9/30/22	

Description of Standard/Initiative

1. The PIHP must coordinate the services the PIHP furnishes to the member with the services they receive from any other payer.
2. The PIHP must share with MDHHS and other payers serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities
3. The PIHP must implement mechanisms to identify persons who need LTSS (long term supports and services) or persons with special health care needs.

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead

	NorthCare Network will identify, develop treatment protocols, and provide comprehensive care and support to individuals with co-morbid physical health conditions	Data analysis of claims for all PIHP service recipients to identify individuals with co-morbid conditions	100% of individuals with co-morbidities will be identified via CC360 and WSA support tools.	FY22Q4	9/13/2022	Katreena
		Disseminate health care claims analytics to network providers	Data on individuals with co-morbidities, their ERG score, and their counts of potentially chronic conditions will be provided to the CMHSP liaisons monthly. Measurement is 100% of monthly reports provided to the CMHSPs.	FY22Q4	9/13/2022	Katreena
		Ensure network providers are aware of individuals who have co-morbid conditions (i.e. diabetes, hypertension)	Same as above		9/13/2022	Katreena
		Provide consultation and guidance for developing person-centered co-morbid condition treatment and management	Evidence of consultation – trainings/presentations with providers, ELMER direct messaging, call logs with CMHSP staff, guidance documents produced		9/30/2022	Katreena

Updates	FY22Q1 – BHH Chronic Conditions Counts Files pulled 10/7/2021; 10/29/2021; 11/18/2021. FY22Q2 – Files pulled 1/6/2022 (2 of 3), 3rd file pulled 1/21/2022; sent on 2/3/2022 to CMHSPs During December and January, MDHHS deployed several patches and fixes to the WSA system and CC360. There were multiple instances of the WSA system being down and reports were unable to be pulled timely. The CC360 platform and WSA were both at risk of the Log4j hack, which necessitated upgrades to the data warehouse security. These upgrades rendered the systems inaccessible for pulling data on comorbidities. FY22Q3: BHH Chronic conditions files sent to CMHSP's: 4/25/2022, 5/11/2022, 6/13/2022; Diabetes Screening for persons diagnosed with schizophrenia or bipolar and prescribed a psychotropic medication (SSD), hepatitis C testing, spirometry testing for new diagnosis of COPD (SPR), and dental care gap file sent to CMHSP's in May, 2022 FY22Q4 – BHH Chronic conditions files sent to CMHSPs: 7/12/2022, 8/11/2022, 9/13/2022. Health services committee established in August, SSD, Dental, Hep C, and SPR testing file sent to CMHSP's in August. Metabolic monitoring for children and adolescents on psychotropic medications sent to prescribing physicians ongoing August-September, 2022.
Monitoring	Ensure that files are sent to CMHSPs on a regular monthly cadence.

NorthCare Network Quality Improvement Work Plan								
9.Coordination of Care Transitions								
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**			
HSAG		V. 2. A	Katreena	9/30/22				
Description of Standard/Initiative								
4. The PIHP Must coordinate the services the PIHP furnished to the member: between settings of care, with the services member receives from any other Medicaid payer, and with the services the member receives from community and social support providers.								
Findings		**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**	

	NorthCare Network will partner with the Medicaid Health Plan (MHP) to address the care needs of individuals served by both entities.	Individuals transitioning from inpatient hospitalization for physical or behavioral health needs will receive coordinated care	A. 95% of individuals who have triggered for FUH and PCR metrics will have documentation of care coordination during their hospitalization.	FY22, Q4	9/30/2022	Katreena/ Kayleigh

Updates	
Monitoring	Weekly transmission of Hospitalization report for all mutually served members with the Medicaid Health Plan. Hospitalization report includes a review of notes from the CMHSP ES staff to ensure coordination of care and supports during transition from inpatient hospitalization to aftercare.

NorthCare Network
Quality Improvement Work Plan

10.

Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**
QAPIP	FY21-22	QAPIP	Brittany	Pulled forward to FY23	

Description of Standard/Initiative

The PIHP's analysis considered all UDs (those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect), including aggregated mortality data over time to identify possible trends.
The PIHP's analysis considered CIs for residential treatment providers.
The QAPIP work plan identified a goal(s) and/or objective(s) related to CIs, SEs, UDs, and other REs.
The PIHP's analysis considered REs that put individuals at risk of harm. These events minimally include actions taken by individuals who receive services that cause harm to themselves; actions taken by individuals who receive services that cause harm to others; and two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period.

Findings	**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**
	NorthCare will Increase data reporting capabilities by building report(s) to better analyze improvements in the quality of health care and services for members over the next year. (IRs)	Develop a new report that allows for detailed data analysis and trending by 2.1.22	Completion of report(s) in EMR	2.1.22		Brittany
		Create SMART goals.	Identify SMART goals and take goals to the regional IR committee	12.1.21	12.21.21	Brittany
		Increase timely categorization of incidents as being sentinel, critical, risk, a combination, or none, to 95% within 3 days of incident.	Reduction of IRs not classified prior to Health and Safety Committee Meetings.	3.1.22		Brittany
		Review and analyze data at internal and regional meetings, to identify progress, identify trends, identify concerns, verify improvements in the quality of health care services, and better the lives of individuals served.	Identify potential changes, trends, concerns, and act as necessary.	9.30.22	quarterly	Brittany
		Ensure individuals living in residential living arrangements are in the correct level of care and help transition to less restrictive levels of care any individuals that it would be appropriate to do so.	Completion of review	6.1.22	7.8.22	Brittany

		Develop a way to review RCA outcomes via a report, gather data, and review data for possible implementation of performance improvement projects.	Add RCA categories to reporting spec.	9.30.22		Brittany and Joan

Updates	FY22Q1: Identified SMART goals. Began reviewing untimely deaths monthly. Began reviewing rate of IR categorization as sentinel, critical, risk. FY22Q2: Developed a report to pull total number of incidents by IR code.
Monitoring	Review data at the health and safety committee meetings

NorthCare Network
Quality Improvement Work Plan

11.

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location
QAPIP	FY22		Brittany	10.27.22	N:\Confidential\Incident Reporting\FY22 CMH IRs N:\Confidential\BT Regional Reports\FY22

Description of Standard/Initiative

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
The PIHP analyzed progress on meeting its performance goal(s). The evaluation should identify the prior year's performance goal and whether that goal was met or not met.	NorthCare will continue to gather and begin to analyze BTC data for trends during the fiscal year. Review of data will allow NorthCare to determine what changes need to take place systemically. Review will take place quarterly (4.05) (BTC)	Collect and analyze quarterly data provided by the CMHSPs in correlation with data from the incident reporting module to determine any trends related to BTR activities over the fiscal year	Completion of data review	9.30.22	10.19.22	Brittany
		The PIHP will analyze data to determine if there have been improvements/changes to care quality because of BTC on an individual and/or systemic level over the course of the year by looking at frequency of interventions used, and incidents reported	Identification of individual consumer trends, CMH trends, and regional trends from data	9.30.22	10.19.22	Brittany
		The PIHP will take data analysis results to the quarterly BTC and Regional Clinical QI committees for further input in identifying specific actions a CMHSP or the PIHP can take to improve the outcomes of consumers.	Discussion of potential action steps	9.30.22	10.27.22	Brittany
		Identify if there are alternative ways to analyze data and complete consumer specific reviews as necessary	Meet w/Data Analyst to determine potential data analytics	9.30.22	10.19.22	Brittany

Updates	
Monitoring	

NorthCare Network
Quality Improvement Work Plan

12.

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location
HSAG	FY21	St 1.16	Karena	4/2022	

Description of Standard/Initiative

The PIHP must make available in paper form upon request and electronic form, information about its network providers—Refer to the Provider Directory Checklist.

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
Citation - The PIHP and CMHSPs' provider directories did not contain all required content. The specific details of provider office accommodations for persons with physical disabilities were not listed, only whether or not the provider was ADA compliant. Further, the identification of the providers' cultural capabilities, specialties (as appropriate), and website information were not consistently populated fields; and the format of the CMHSPs' directories differed. **Recommendation - MDHHS/HSAG Response:** The PIHP's remediation plan is sufficient to ensure compliance with the requirements for this program area. However, HSAG recommends that the PIHP's small list of accessibility accommodations includes exam rooms and equipment to ensure alignment with 42 CFR 438.10(h)(1)(viii). During the next three-year compliance review cycle, the PIHP should be prepared to provide evidence of implementation of its plans of action and HSAG's recommendations.	NorthCare's Provider Director will be in full compliance	Develop spec for PCE to include all required data points.	All data points are in training for testing.	12/10/21	12/21	Andy
		Develop survey form for current providers to complete with accommodations.	All surveys returned.	12/10/21	12/21	Karena
		Add list of accommodations to Provider Application	Updated application	12/10/21	1/22	Karena
		Additional data fields to be deployed in ELMER to all for data entry.	Changes deployed in live system.	1/5/22	1/26/22	Andy/Karena
		Data entry completed from survey for initial upload. Entry will be ongoing after this with data provided on the Provider Application and changes sent to NC.	Audit of data entry fields	2/28/22	April 2022 and ongoing	Karena
		Complete needed code changes to Provider Directory logic.	Review of Provider Directory in Training.	2/15/22	April 2022	Andy
		Develop SOP for data collection and entry.	Approved SOP	2/1/22	2/2/22	Diane
		Audit provider directories to ensure full compliance.	Completed audit	2/15/22	April 2022 and ongoing	Karena
		Internal meeting to finalize process is scheduled for.	Meeting Minutes	1/17/22	1/17/22	Karena
		Regional Meeting to review and Implement process scheduled for 1/19/22; rescheduled for later date.	Meeting Minutes	2/9/22	March 2022	Karena
Updates						
Monitoring						

NorthCare Network Quality Improvement Work Plan					
13.					
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**
HSAG	FY21	St.III.5	Tami	Pull forward to FY23 Work Plan	
Description of Standard/Initiative					
1. Meet and require its network providers to meet MDHHS standards for timely access to care and services, taking into account the urgency of the need for services. 2. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider serves only Medicaid members. 3. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. 4. Establish mechanisms to ensure compliance by network providers.					

5. Monitor network providers regularly to determine compliance.
6. Take corrective action if there is a failure to comply by a network provider.

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
The PIHP did not provide evidence of a process to actively monitor adherence to all time frame standards; for example, adherence to admission time frames for pregnant women receiving services for a SUD, which are more stringent than the appointment standards tracked and reported via Michigan's Mission-Based Performance Indicator System (MMBPIS). The PIHP acknowledged in follow-up that it did not have monitoring documentation for appointment times for all priority population requirements. The PIHP must meet and require its network providers to meet MDHHS standards for timely access to care and services and establish mechanisms to regularly monitor compliance and take corrective action if there is a failure to comply. This should apply to all screening and appointment standards in addition to those reported through MMBPIS.	Update SUD Treatment Contracts	SUD Treatment Contract Language has been updated for new FY22 contracts as of 11/29/21.	10/1/21	11/29/21	11/29/21	Judi/Brenda
		Language in current SUD treatment contracts will be amended and sent to providers by 12/10/2021; requesting provider signatures by 12/28/21.	Fully executed contracts.	12/28/21	3/23/22	Judi/Brenda
	Identify data points, data collection needed, and report mechanism to track and monitor access timeliness for SUD priority population.	NorthCare will conduct an analysis of current data and develop plan for tracking and monitoring access timeliness.	Documented Plan.	2/1/22		Tami
		NorthCare will implement the plan for tracking and monitoring access timeliness once all data is collected and available.	Timeliness report.	6/1/22		Tami

Updates	Q1FY22 - Contract language has been updated. All SUD treatment contracts have been sent and we have received 5 of 7 signed contracts back as of January 2022. NorthCare's Contract Manager continues to follow-up. Q2FY22 – Last signed SUD treatment contract was received on 3/23/22.
Monitoring	

NorthCare Network
Quality Improvement Work Plan

14.

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location
HSAG	FY21	St V.13	Ashlee	Pull forward to FY23 Work Plan	

Description of Standard

Any modification of the conditions, under 42 CFR §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead

While case examples were provided after the interview session, the PIHP's initial documentation primarily focused on behavior treatment plans/reviews; however, it did not specifically address the HCBS Final Rule, a member's freedom and rights afforded under that rule, or the specific service plan documentation required should there be a modification to those freedoms and rights. While not cited as evidence of compliance, the PIHP's Site Review Protocol tool included a scoring element evaluating whether the provider has a current policy that addresses all regulations set forth in the HCBS Final Rule, including the rights and freedoms listed in the HCBS Final Rule, and how to handle and document a health and safety need when it warrants a restriction to an individual. However, documentation did not support that the PIHP implemented processes to specifically review member records and service plans to verify if all required documentation elements are consistently being included in the service plan when a modification to a member's freedom and rights under the HCBS Final Rule is imposed. The Documentation Review Form included several review elements related to the service plan, but no elements related to the requirements of this element. The Site Review Protocol tool did indicate that the review will include a chart review on a sample of HCBS charts; however, it also documented that, as a region, the PIHP was finishing up corrective action plans and desk audits for the "HS exit ramp case." It was unclear what these chart reviews consist of or the entity conducting the audits (i.e., if audits were being completed by the PIHP versus MDHHS).	Any modification of the conditions, under 42 CFR §441.301(c)(4)(vi)(A) through (D), will be supported by a specific assessed need and justified in the person-centered service plan. The service plan will include all documentation required by this element and the HCBS Final Rule.	Addition of HCBS site review standards will be added for FY22 site reviews which are typically conducted between July and October.	New/Updated form with all standards.	03/01/22	9/23/21	Ashlee Brittany
		Documentation will be reviewed at time of annual site reviews starting in FY22 which are typically conducted between July and October	Documentation review reports.	09/30/22		Ashlee
		Develop a report to easily identify limitations documented in the Individual Plan of Services.	Report completion	3/1/22		Ashlee
		NorthCare will conduct ongoing monitoring to ensure that limitations noted in the IPOS have been reviewed by Provider. Quarterly	Monitoring Reports	5/1/22		Ashlee
Updates	Q2 Update: HCBS standards have been added to the FY22 site review tool as of 3.14.22; data points for the report for monitoring have been identified and the report is in development.					
Monitoring						

NorthCare Network Quality Improvement Work Plan					
15.					
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**
HSAG	FY21	St.VI.8	Bob	9/30/2022	
Description of Standard					
For standard authorization decisions, the PIHP must provide notice as expeditiously as the member's condition requires and within MDHHS-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if— a. The member, or the provider, requests extension; or b. The PIHP justifies (to MDHHS upon request) a need for additional information and how the extension is in the member's interest.					

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
Per the case file review, one case (case 2) was not determined, and an ABD notice sent within the required 14-day time frame. **Recommendations:** HSAG strongly recommends the PIHP conduct routine monitoring of its CMHSPs to ensure that authorization decisions are being made in accordance with required time frames.	For standard authorization decisions, the PIHP will provide notice as expeditiously as the member's condition requires and within MDHHS-established time frames that may not exceed 14 calendar days following receipt of the request for service.	Develop report for monitoring of ABD timeliness.	Completed Report	3/1/22	12.1.22	Andy
		Implement a process for ongoing monitoring of timeliness of ABD notices	Documented Process Completed	3/1/22	12.1.22	Bob
		Review will be conducted for period beginning 12/1/21.		5/1/22	Q3FY22	Bob
Updates	FY22Q1 – The first review will be conducted by 5/1/22 for period beginning 12/1/21, due to the date of request not collected prior to the changes made to the ABD and deployed in our EHR on 12/1/22, and quarterly thereafter. NorthCare sought clarification from HSAG/MDHHS in regard to the date of request when an individual was requesting services at time of assessment versus time of initial request for service/eligibility screen. MDHHS confirmed in their 6/16/22 email that the PIHP or its delegate has 14 days the start date of the authorization request. Quarter 3 data shows six cases out of 164 or 3.6% were out of compliance with the 14-day time frame compared to quarter 2 where19 cases out of 164 or 11.6% were found to be out of compliance with the 14-day time frame showing significant improvement. NorthCare will continue to monitor quarterly					
Monitoring						

NorthCare Network
Quality Improvement Work Plan

16.

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location
MDHHS	FY21	C-Waiver Review	Diane	3/3/2022	..\..\..\..\MDHHS\Site Reviews\2021 Waiver-SUD Review\5. 90 Day -F-U Review

Description of Standard

MDHHS Site Review Protocols – SEDW, CWP, HSW

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
All citations will be reviewed and monitored by the PIHP.	Ensure all citations have been adequately addressed to bring NorthCare into full compliance with FY21 MDHHS C-waiver review.	Collect all evidence of compliance from CMHSPs.	Receipt of documentation.	1/31/21	1/31/22	Diane
		Review all evidence submitted to ensure all citations have been addressed.	Documented review.	2/15/22	2/11/22	Ashlee Brittany Diane
		Upload all submitted evidence to MDHHS for follow-up review.	FTP confirmation	2/16/22	2/11/22	Diane
		Achieve full compliance on CAP follow-up by MDHHS	MDHHS report. Letter dated 3/3/22 filed at link above.	N/A	3/3/2022	Team
Updates	FYQ2 – Received letter dated 3/3/2022 from MDHHS informing that all corrective action has been completed and accepted.					
Monitoring	**FY22 MDHHS Waiver Review Completed 3/3/2022.**					

NorthCare Network Quality Improvement Work Plan								
17.								
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**			
HSAG	FY21	Standard 2	Brittany	4.11.22				
Description of Standard/Initiative								
All of Standard 2								
Findings			**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**
Recommendations: HSAG strongly recommends that the PIHP develop a written procedure specific to behavioral health/SUD emergency and post-stabilization services. This procedure should consider all federal requirements and how they apply to the scope of services provided by and financial responsibilities of the PIHP. Additionally, the PIHP should consider how these requirements apply to the emergency room and hospital setting versus emergency services obtained through community provider locations. The PIHP's implementation of HSAG's recommendations will be reviewed during future compliance reviews, and the PIHP will receive a score of *Not Met* if not adequately addressed.			NorthCare will determine what they are responsible for regarding Emergency Services and will update policy to reflect any changes.	NorthCare will update all associated policies to meet HSAG standards by 3.1.22.	Policy update	3.1.22	4.11.22	Brittany Bob
Updates	FY22Q1: NorthCare met with Detroit Wayne to better make sense of the standard. NorthCare staff met internally to try to identify what changes are necessary to policy. FY22Q2: Changes made to policy.							
Monitoring								

NorthCare Network Quality Improvement Work Plan								
18.								
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**			
HSAG	FY21	Standard 3. 2	Brittany	February, 2022				
Description of Standard/Initiative								
The PIHP provides for a second opinion from a network provider or arranges for the member to obtain one outside the network, at no cost to the member.								
Findings			**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**
Recommendations: HSAG recommends that the PIHP educate its staff members and update policy, as needed, to ensure a member's right to a second opinion as required under the federal Managed Care Rule is widely understood in addition to a member's right to a second opinion for the denial of eligibility and the denial of inpatient hospitalization required under the Michigan Mental Health Code. The PIHP's implementation of HSAG's			NorthCare will add information regarding second options to its training.	NorthCare will add 2nd opinion language to ABD training. Will also mention 2nd opinions in the recorded ABD training.	Completed or not	12.1.21	Completed – LMS training	Brittany

recommendation will be reviewed during future compliance reviews, and the PIHP may receive a score of *Not Met* if not adequately addressed.		NorthCare will add an "other" option to 2nd opinion letter in EMR	Completed or not	12.1.21	Completed	Brittany and Joan

Updates	FY22Q1:
Monitoring	

NorthCare Network Quality Improvement Work Plan					
19.					
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**
MDHHS	FY21	P.5.1-2 C-waiver	Brittany	9.30.22	

P.5.2**.** Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency, and timeframe for implementing. (HSW PM D-7)
P.5.1 Specific services and supports that align with the individual's assessed needs, including measurable goals/objectives, the amount, scope, and duration of services, and timeframe for implementing are identified in the IPOS. (HSW PM D-1)

Findings	**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**
Services and treatment identified in the IPOS are provided as specified in the plan, including measurable goals/objective, the type, amount, scope, duration, frequency, and timeframe for implementing.	Develop tool and process for documenting over/under utilization in the ELMER record with the ability to provide rational for disparities between the IPOS and documented service.	Develop process for documenting rationale for under-utilization in ELMER.	Fields to document +/- utilization is found in ELMER.	1/31/22	1/26/22	Brittany
	Monitor over/under utilization via quarter documentation reviews. Standard is: A/S/D of FTF contacts identified in the IPOS match services received or over/under utilization is clearly documented why in the progress notes or on the IPOS amendment. [M-C 2.3, P4.7.1, P3.4.1]	Will look at authorization use. If it appears under-utilized will check for consumer no-shows and engagement attempts by the CMH.	Completed Documentation Review	9/30/22	9.30.22 – reviewed Q2 charts for annual site reviews	Brittany
	Remove the auto generated language on page 1 of IPOS that references "range of service".	PCE will remove the auto generated reference to "range of service" per spec.	IPOS' completed after 1/27/22 deploy.	12/31/21	1/27/22	Diane

Updates	
Monitoring	Monitoring of over/under utilization via chart documentation review tool.

4. Quality Management Assessment Activities

Stakeholder Input and Assessment of Consumer Experience with Services

Satisfaction Survey

NorthCare Network's Community Mental Health Services Programs (CMHSPs) send out satisfaction surveys monthly to individuals who have had a new IPOS the previous month, and to individuals who have discharged from services in the previous month. Satisfaction data is collected by the CMHSPs to improve their quality of care regularly. NorthCare receives consolidated data from each Member CMHSP on an annual basis, which is reviewed to assess areas that need improvement, areas that have been improved, and if there are any patterns of dissatisfaction.

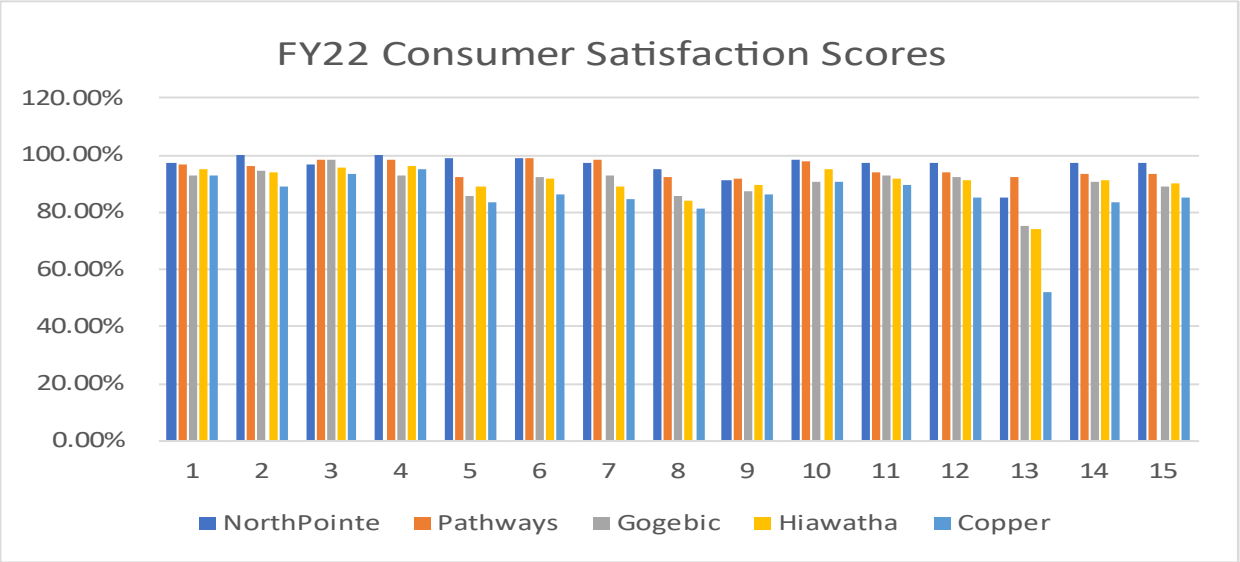
The satisfaction survey tool was available in FY22 online or paper copy and had two parts. Part A addressed the overall consumer satisfaction towards services. Part B addressed the consumers feelings towards the service providers ability to support them in their recovery.

Part A: Satisfaction Questions:

1. Appointments are scheduled at times that work best for me.
2. I am informed of my rights as a CMH/SUD service recipient.
3. I feel welcomed and comfortable where I receive services.
4. Staff speak in ways I can understand easily.
5. I know what to do if I have a concern or complaint.
6. Staff are sensitive to my cultural/ethnic and spiritual background.
7. Staff are sensitive when I am discussing my past.
8. I am aware of the types of services available.
9. I was able to get the type of services I feel I needed.
10. My wishes about who is given information about my treatment are respected.
11. I feel involved in my care and included in the decision-making process regarding my services.
12. I feel staff see me as a whole person and address all my needs.
13. I am satisfied with the telephone crisis service, when calling the crisis line after 5pm on weekdays/ or on weekends.
14. I am able to communicate with my CMH/SUD provider easily.
15. I would recommend these services to a friend or relative.

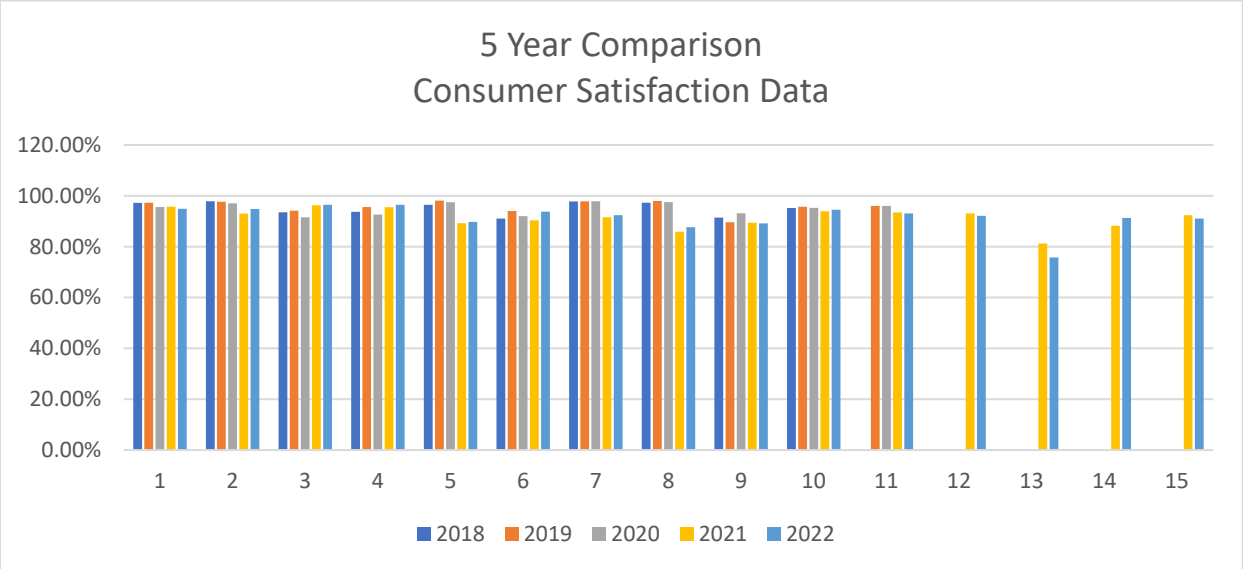
The below graph represents the percentage of consumers that reported overall satisfaction with their CMHSP for questions 1-15 Part A of the Survey: (Note questions 12-15 were added in 2021).

Questions 1, 3, 4, 6, and 10 did not fall below 90% overall satisfaction. While the following questions did not fall below 80%, 2, 5, 6, 7, 8, 11, 12, 14, and 15. Question number 13 did have 3 scores below 80%. Overall consumers seemed to be mostly satisfied with their CMHSPs services.



NorthCare conducted a five-year comparison of the satisfaction survey data to identify areas where progress has been made, and areas that may need improvement individually at each CMHSP, and at the regional level.

The graph below shows the overall satisfaction survey data from 2018-2022. This graph shows that overall satisfaction has stayed consistent. There was however a slight decrease in questions number 1 and 13 from FY21- FY22. As a result, NorthCare will work with the CMHSPs to increase satisfaction scores in those areas. There was a slight increase in satisfaction for questions 2, 4, 6, 8, and 14 from 2021-2022, showing that overall satisfaction has improved.

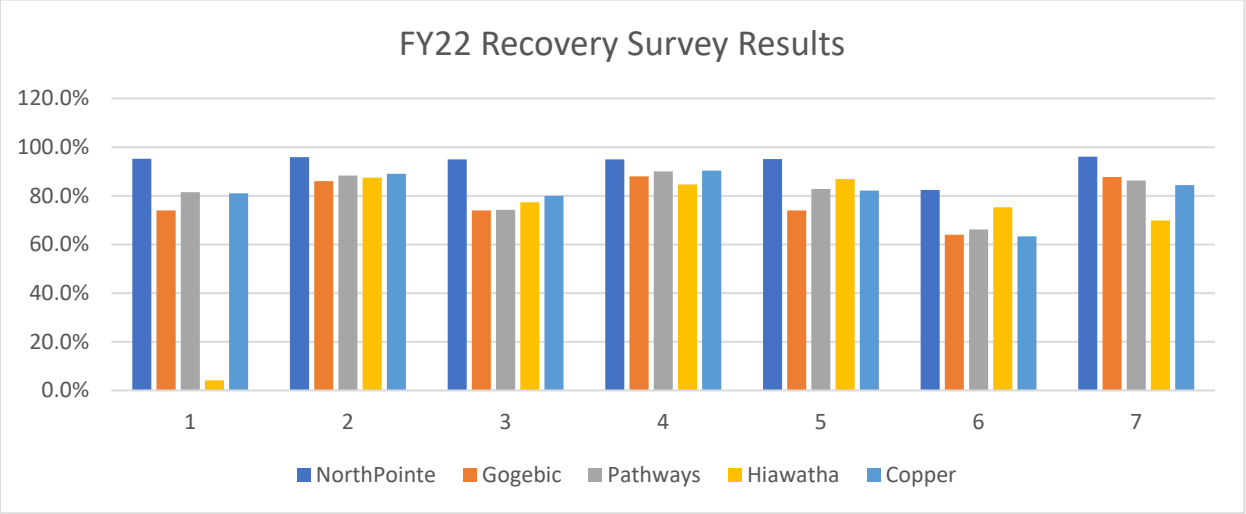


<u>Part B: Recovery Survey Questions</u>

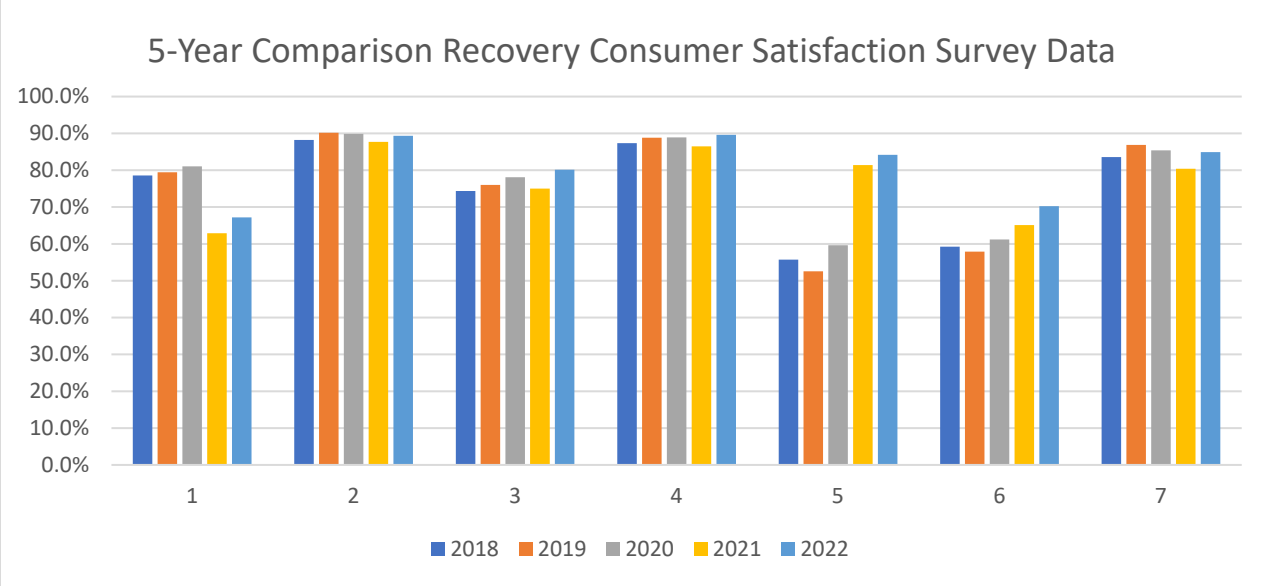
1. I am hopeful about my future.
2. I am willing to ask for help.
3. I believe that I can meet my current personal goals.
4. I have people I can count on.
5. Coping with my mental illness is no longer the main focus of my life.
6. My symptoms interfere less and less with my life.

7. My services and supports from Community Mental Health are helping me in my recovery.

The graph below represents the percentage of consumers who were overall satisfied with their Recovery and the support they received or are receiving from the CMHSP.



The final graph shows a comparison of Part B of the Recovery Survey data over the past five years. Compared to the previous year there is an increase in satisfaction question results with all questions from 2021 to 2022. Showing that consumers are feeling supported in their mental health and or substance use recovery journey.

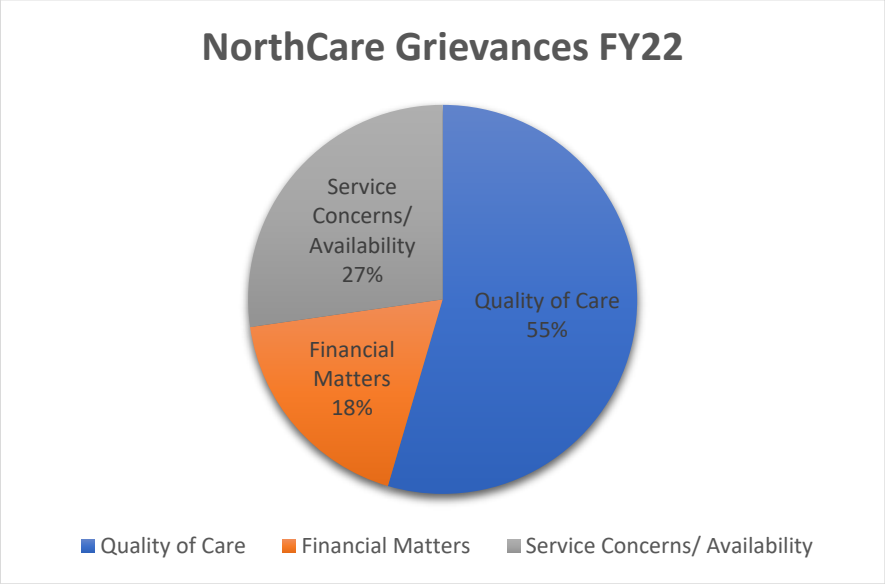


Grievances

The Grievance system divides Enrollee dissatisfaction into two categories. (1) Those that challenge an "Adverse Benefit Determination" which is a decision that adversely impacts the Enrollee's claim for services due to denial or limited authorization of a requested service or a reduction, suspension, or termination of a previously authorized service; a denial, in whole or in part, of payment for a service; failure to make service authorization decisions within established time frames; or failure to resolve standard appeals or grievances within established time frames. (2) An Enrollee's expression of dissatisfaction about the PIHP and/or the CMHSP services issues, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services

provided, aspects of interpersonal relationships between a service provider and the Enrollee, failure to respect the Enrollee's rights regardless of whether remedial action is requested, or the Enrollee's dispute regarding an extension of time proposed by the PIHP to make a service authorization decision. 42 CFR 438.4

NorthCare Network received a total of 11 grievances, while Member CMHSPs had 27 grievances in FY22. SUD Providers had a total of 3 grievances in FY22. Across the region there was a total of 41 grievances. All grievances were resolved within the required 90 calendar days or less timeframe. The 11 grievances that NorthCare Network received and resolved involved quality of care, financial matters, and service concerns/availability.

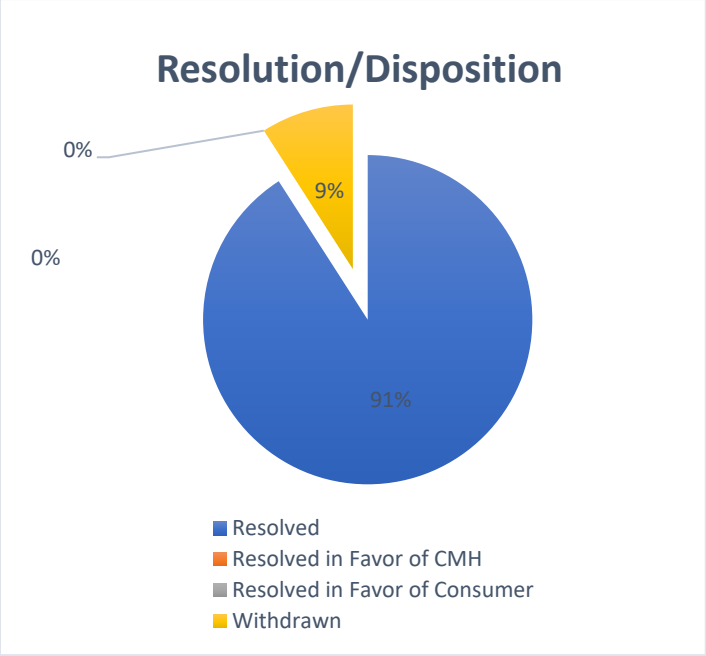


Grievance Categories are defined as:

Quality of care: include any dissatisfaction with the quality of care that is being received. (Complaints may be against primary service providers, agencies, other staff members, how services are being delivered).

Service Concerns/ Availability: include anything that prevents access to services or any dissatisfaction or issues with the services that are being received. (How they are being received.

Financial Matters: include instances that involve financial concerns, related to services.



Resolution Categories defined as:

When a Grievance's disposition is ***resolved in favor of consumer*** it has been found that the CMHSP and/or staff associated with the complaint was at fault and there will be action steps to remediate the issue(s) and resolve the problem.

When a Grievance's disposition is ***resolved in favor of the CMHSP*** it has been found that the CMHSP has followed appropriate policy/procedures and/or federal and state regulations regarding the complaint.

When a Grievance's disposition is ***resolved*** the CMHSP was not at fault, however they may introduce new policy/procedures to prevent the same issue for occurring again.

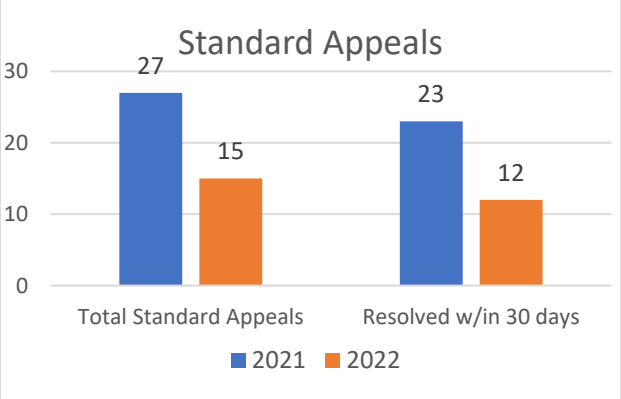
When a Grievance's disposition is ***withdrawn,*** the consumer has decided to drop the complaint.

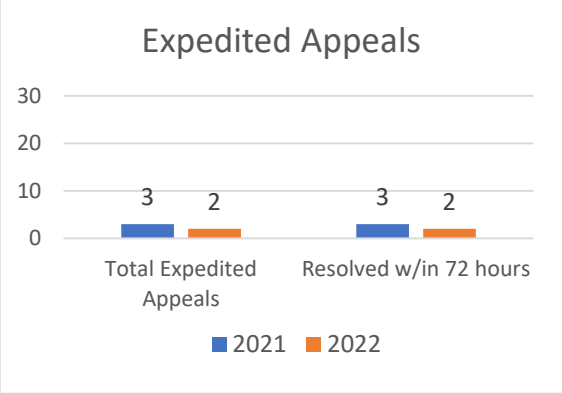
Appeals

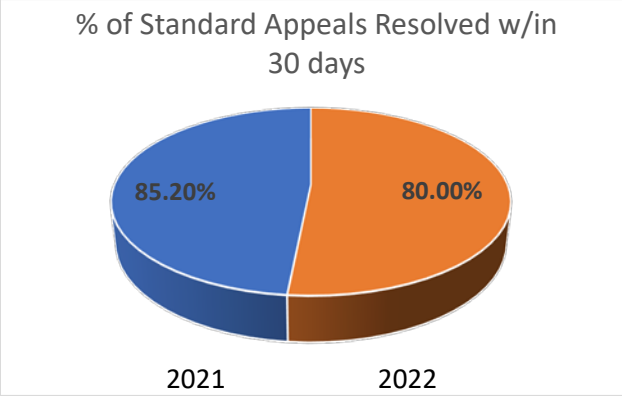
Under the Due Process Clause of the U.S. Constitution, Medicaid Enrollees are entitled to "Due Process" whenever their Medicaid benefits are denied, reduced, or terminated. Due Process requires that

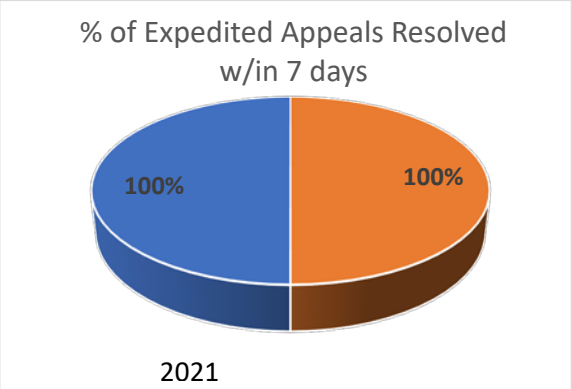
Enrollees receive: (1) prior written notice of the adverse action; (2) a fair hearing before an impartial decision maker; (3) continued benefits pending a final decision; and (4) a timely decision measured from the date the complaint is first made. Nothing about managed care changes these Due Process requirements. The Medicaid Enrollee Appeal and Grievance Resolution Process provides a process to help protect the Medicaid Enrollee Due Process rights. The PIHP/CMHSP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the Enrollee's health condition requires, but not to exceed 30 calendar days from the day the PIHP/CMHSP receives a Standard Appeal or within 72 hours of receiving an Expedited Appeal.

In keeping with strict timeframes for notices and resolutions of standard and expedited appeals, NorthCare Network continues to monitor and meet required timeliness standards. The charts below show timeliness declined in 2022 compared to 2021 for standard appeals while the timeliness standard has been met for expedited appeals at 100% for both years. NorthCare has developed a new training and regional grievance and appeals workgroup to focus on grievance and appeals reporting. NorthCare is also in the process of developing a quality assurance plan to ensure the content of notices are compliant with federal and state regulations as well as written to the member and at a 6.9 grade reading level. This plan will include monitoring of timeliness of appeal resolutions and notices.







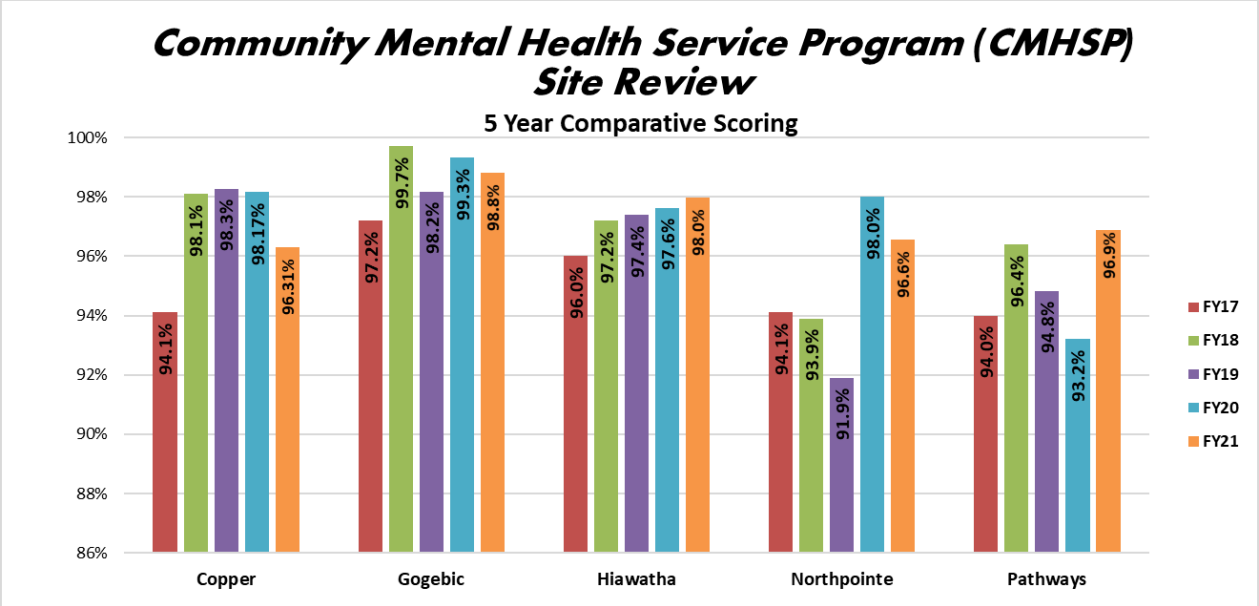


Federal regulations also provides the Enrollee the right to an impartial review by a State-level Administrative Law Judge (a State Fair Hearing), of an action of a local agency or its agent, in certain circumstances such as, 1) After receiving notice, the PIHP/CMHSP is, after Appeal, upholding an Adverse Benefit Determination, or 2) When the PIHP/CMHSP fails to adhere to the notice and timing requirements for resolution of Appeals and Grievances. In FY22, NorthCare had 4 State Fair Hearings compared to three in FY21. Three of these were dismissed while one was upheld. NorthCare has averaged 3.2 State Fair Hearings a year over the past five years with 43.8% being upheld, 18.8% overturned, 18.7% withdrawn, and 18.7% dismissed.

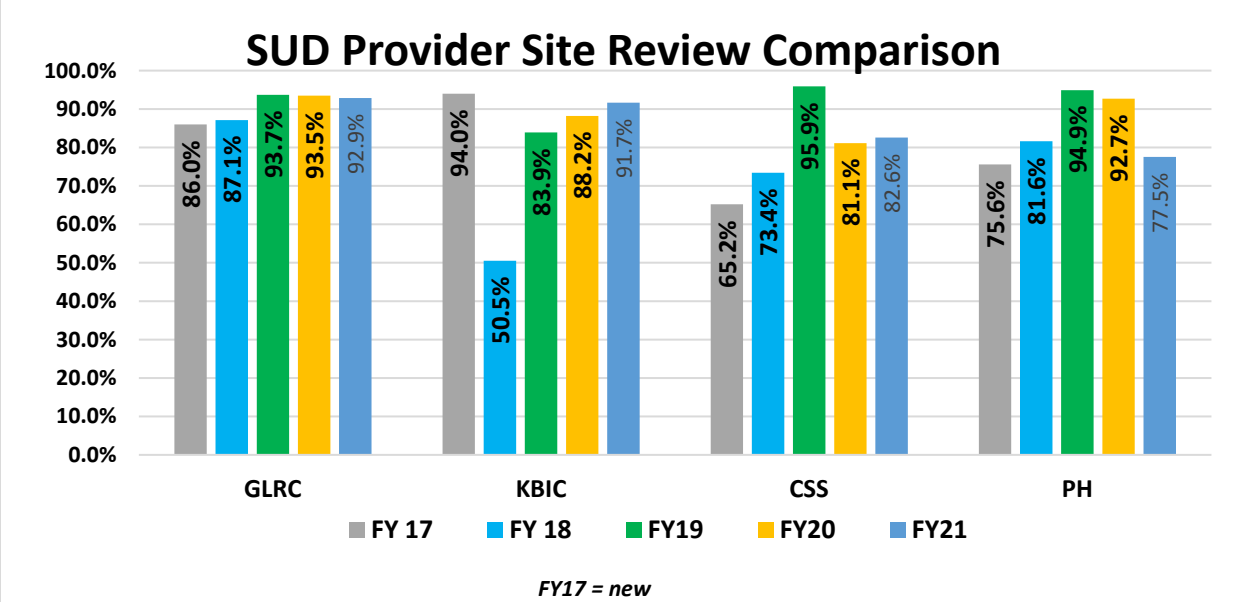
Provider Network Monitoring

NorthCare Network conducts annual reviews of contract providers to ensure compliance with federal, State and NorthCare laws and policy. The review consists of several standards addressing requirements by contract, subcontract and delegation (where applicable) and accreditation. The review process is initiated with a request for information that is reviewed via desk audit. This is to review documented policy and procedure and is followed-up with an onsite visit to evaluation how the policies and procedures are operationalized. When a provider's on-site review results in an overall compliance rating of 95% or above the following year review is a "follow-up" review where NorthCare monitoring corrective actions for any standard not meeting fully compliance and may be completed by desk audit only. This provides some incentive to the provider while reducing the administrative burden of a full on-site review every year when performance is at or above 95%. All standards receiving less than "Met" requires corrective action. Corrective actions plans are reviewed and approved by the NorthCare's site review team and Quality Management Committee.

The FY20 and FY21 reviews for all providers were conducted by desk audit only to ensure the safety of our staff and providers due to the COVID-19 pandemic public health emergency. FY22 reviews for all CMHSPs were follow-up reviews due to meeting the minimum score of 95%. The chart below shows a five-year comparison of CMHSP site review scoring.



The site review survey process is the same for SUD providers. However, it is important to note that the site review protocols were completely revised and more comprehensive for FY17 which contributes to the drop in compliance rating across all providers. NorthCare staff worked closely with SUD providers to provide clarification on the new standards. FY22 audits of the SUD providers was not completed although a solution was approved by the state to complete an 18-month review. The review period will be 10/1/2021-3/31/2023. This will meet both fiscal year audits of FY22 and FY23. The review process will be finalized in July of 2023.



Utilization Management & Authorization

NorthCare Network manages a regional electronic health record, which provides NorthCare Utilization Management (UM) the ability to monitor service utilization through clinical documentation and authorization and claims data. A regional Utilization Management Committee reviews utilization patterns and identifies areas of over and underutilization. The regional Utilization Management Committee is made up of representatives from each CMHSP and NorthCare and meets quarterly.

The Utilization Management Committee has looked at underutilization patterns and are working on increasing consumers engagement in the CMHSP. NorthCare is in the process of identifying services that had been authorized at a higher rate than actual utilization. The NorthCare UM committee has identified the services that will be targeted for review once a report is available that will identify discrepancies between service utilization vs services authorized. NorthCare has changed the authorization function in the electronic record this year. NorthCare is working on a report to identify accurate service utilization which will provide the ability to look at requested authorizations during the person-centered planning process and compare that to actual utilization patterns. The report continues to be worked on and the ability to obtain accurate data will occur in FY23. This will result in a baseline for improvement initiatives over the next fiscal year. Quarterly monitoring will include a review of underutilization patterns.

NorthCare has also identified underutilization through the engagement PIP. There have been problems getting persons who are eligible for specialty mental health services engaged in services at the CMHSP which can result in poor outcomes. Please look at the engagement PIP under Performance Improvement Projects within this report for more information on this topic.

NorthCare looks at the recidivism rate for consumers who have been in an inpatient psychiatric facility. The standard is that less than 15% of persons who are discharged from inpatient psychiatric treatment and readmitted within 30 days. When a CMHSP has two consecutive quarters where they have rates that exceed the standard, they submit a plan of correction. The recidivism data is reviewed on a quarterly basis.

Inpatient Length of Stay is reviewed across the region. Data is reviewed by each individual Inpatient Psychiatric Unit and by each CMHSP. When continuing stay reviews were conducted for inpatient

psychiatric stays it was noted that there were times when an inpatient discharge appeared to have been delayed due to lack of discharge planning by the CMHSP and the inpatient facility. NorthCare Network reviewed clinical documentation at both the CMHSP and the Inpatient Psychiatric facilities during site reviews to see if discharge planning was documented in the medical record. Site reviews completed in FY22 showed improvements in the discharge planning process but was still inconsistent by both inpatient psychiatric providers and the CMHSP. Expectations for Plans of Correction for each provider will hopefully show increased discharge planning within 48 hours of Admission to the psychiatric unit and CMHSP.

For substance use disorders, in FY22, a plan was developed to monitor the SUD priority population timeliness standards for entry to care. A new report, developed as part of this plan, shows every case that was an "outlier" or out of compliance with State and Federal guidelines. The report is run, at a minimum, on a quarterly basis and includes review of the date of first request, the date of screening and referral, and the date of admission to services for every outlier. Each outlier is then reviewed, and patterns are identified and addressed with NorthCare and SUD provider staff for improvement. For example, for FY23-Q1, a pattern emerged at NorthCare with screening/referral timeliness. Some NorthCare staff were misinterpreting the 24-hour standard of screening and referring for 24 business hours. This resulted in a review of the priority population standards with NorthCare staff which will hopefully result in a reduction of these outliers. Additionally, a meeting was held with SUD provider staff across the NorthCare region which included a review of the timeliness standards and how SUD Provider staff are monitoring their admission timeliness standards.

Additional NorthCare SUD UM activity includes review of ASAM Continuum (AC) occurrences to identify the number of AC assessments being completed per client in keeping with the limitations imposed by MDHHS which allow for four AC's to be completed and reimbursed with Medicaid funds, per client, per fiscal year.

NorthCare SUD UM also monitors the number of requested treatment planning sessions which utilized T1007. This review found that the number requested was significantly underutilized. At the quarterly SUD Regional Clinical Providers meeting, this was reviewed with SUD providers, who were encouraged to request two (2) authorizations per month and then request additional authorization as needed, as providers were not requesting authorizations based on projected utilization.

Monitoring is also taking place with monthly reporting on Opioid Health Home (OHH) monthly service requirements. One SUD provider, due to a staffing issue, was not complying with this requirement which resulted in an action plan being implemented. The provider was limited to three-month authorization requests; and any OHH client who does not receive a minimum monthly OHH service, has the case referred to the NorthCare Clinical Director for review with the provider before additional encounters are authorized.

Quarterly, SUD Regional Clinical Provider meetings take place, facilitated by NorthCare's Clinical Director to discuss regional issues, including UM. Additionally, the NorthCare Clinical Director facilitates regular, monthly meetings with all SUD providers to discuss any UM issues/concerns.

NorthCare's internal SUD UM team, also meets on a minimum monthly basis. The UM Team consists of NorthCare clinicians who are available to consult with one another on a regular basis.

Credentialing and Qualification for Scope of Practice

NorthCare Network assures due diligence with a regional credentialing and re-credentialing processes to provide competent providers for the individuals we serve. NorthCare monitors the credentialing and re-credentialing process of contract providers during annual site reviews. The oversight and monitoring of

the credentialing of sub-contract provider staff is delegated to direct contractors. NorthCare policy sets standards and guidelines for NorthCare Network and Network Providers to assure that clinical oversight, management, and services are provided by providers who are fully qualified, competent, and in good standing. In addition, NorthCare policy sets the expectation and guidelines for contract and sub-contract providers, within the NorthCare Network, to comply with applicable rules and regulations including, but not limited to, the Balanced Budget Act (BBA), Michigan Department of Health and Human Services (MDHHS), applicable Accreditation standards and NorthCare Network's Credentialing Program. These standards apply to both individual providers as well as organizational providers.

NorthCare developed a new onboarding credentialing checklist in FY20 that is used to ensure all documents are obtained prior to presenting to the NorthCare Credentialing Committee. CMHSP providers were encouraged to use this same checklist or one of their own incorporating all elements listed. Organizational providers are responsible for ensuring that individual practitioners/providers, employed or under contract, and subcontract organizational providers meet all applicable licensing, scope of practice, contractual, and payor requirements. Credentialing decisions are made based on multiple criteria related to professional competency, quality of care and the appropriateness by which behavioral health services are provided. Continuous monitoring of the credentialing program occurs across the network to ensure compliance and identify quality or network issues. NorthCare Network will utilize the onboarding credentialing and re-credentialing checklist as one tool to monitor.

Along with all other required credentialing activities, including primary source verifications, NorthCare contracts with Verify Comply to conduct the ongoing monthly exclusion checks for all employees and contract providers.

NorthCare's Credentialing Committee retains final authority for the credentialing of individual practitioners/providers, employed or under contract, and organizational providers under contract. NorthCare monitors contract provider staff through monthly staff change forms to ensure providers do not utilized Medicaid funding for a staff who has been excluded from participation in federal or State publicly funded programs.

In FY23, NorthCare will continue to establish and implement a formal comprehensive onboarding process for all providers both inside and outside of the Customer Relationship Management System (CRM).

Oversight of Vulnerable Individuals / Health and Safety

Behavior Treatment Review

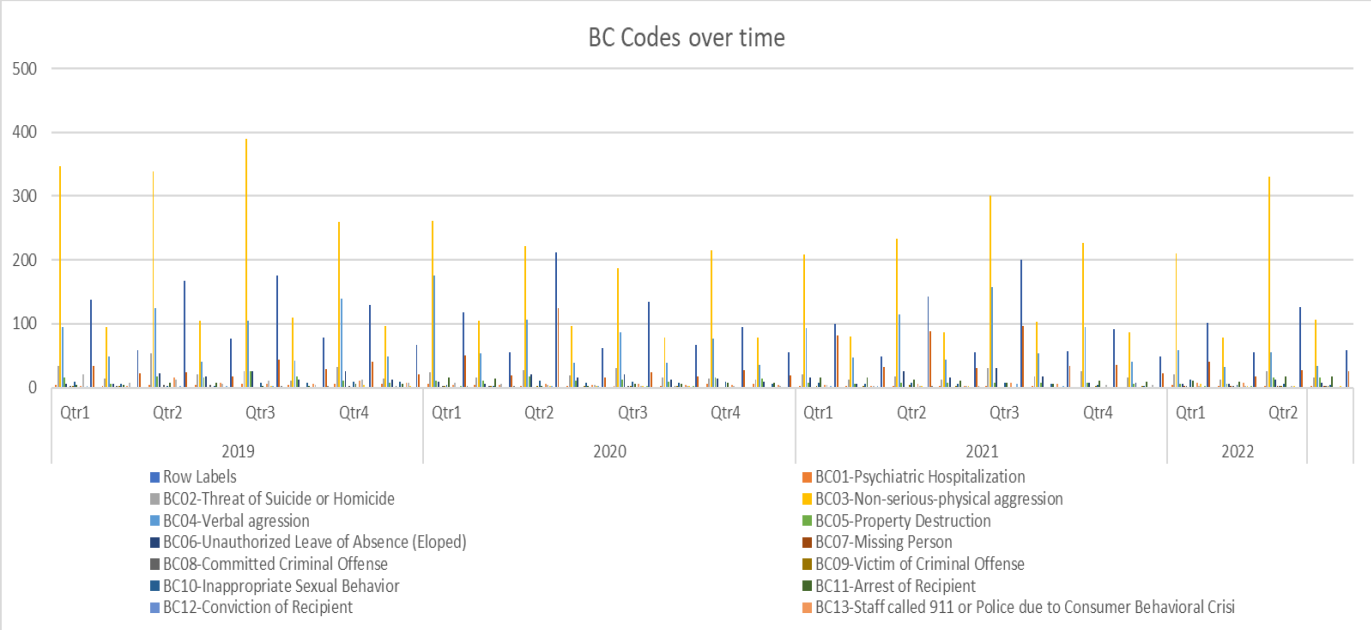
Each Community Mental Health Service Program (CMHSP) has an internal Behavior Treatment Committee for the approval or disapproval of behavior plans that propose to use restrictive or intrusive techniques as outlined in the Michigan Department of Health and Human Service (MDHHS) contract with NorthCare Network and NorthCare Policy. Each CMHSP has an established BTC policy that is reviewed by NorthCare Network at annual site reviews. BTC data is submitted to NorthCare quarterly using the MDHHS approved data excel sheet. Additionally, NorthCare has a data excel sheet for tracking incidents of physical intervention.

Data is reviewed by the Regional BTC committee and is taken to the NorthCare Network Health and Safety Committee as well as the Regional Clinical Practices and Quality Improvement Committee. Any events involving calling 911 or ER visits due to physical intervention would be entered as an incident in our EMR incident reporting module and would also be individually reviewed by the Health and Safety Committee.

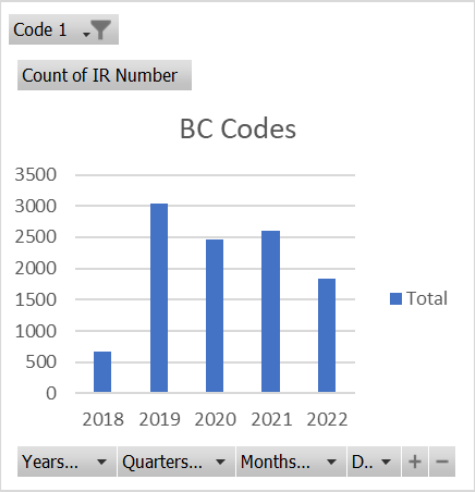
Use of incident reporting codes was compared across the year and with the total from the prior year. The behavioral codes show that there is similar utilization of the codes between the two years. Of note, there was increase in individuals being identified as missing or having committed crimes in FY22. Verbal aggression was reduced and calls to 911 were also reduced.

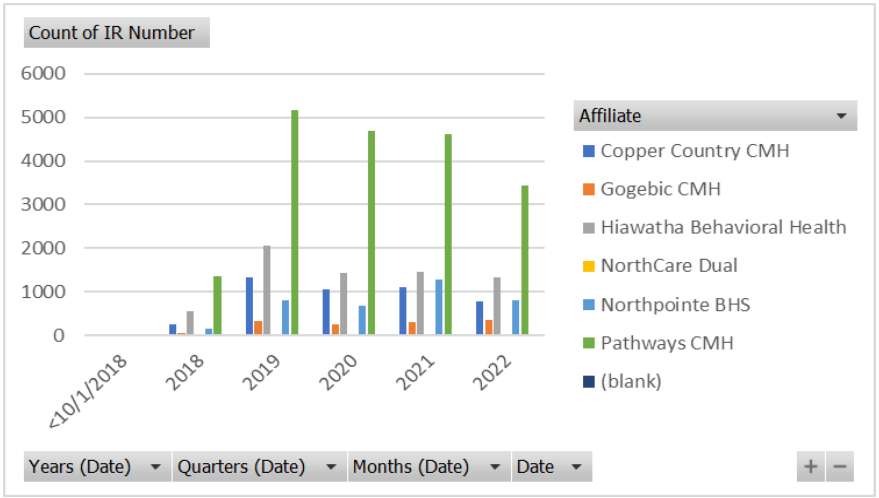
Code	FY21	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	FY22
BC01-Psychiatric Hospitalization	**11**	0	0	1	0	3	1	1	1	0	1	0	0	**8**
BC02-Threat of Suicide or Homicide	**83**	7	9	8	10	2	7	8	3	7	5	14	3	**83**
BC03-Non-serious-physical aggression	**984**	87	75	70	85	62	67	61	96	97	107	111	56	**974**
BC04-Verbal aggression	**701**	66	41	47	37	39	33	19	22	34	56	46	26	**466**
BC05-Property Destruction	**96**	13	5	7	10	5	1	3	10	12	18	13	6	**103**
BC06-Unauthorized Leave of Absence (Eloped)	**104**	5	4	2	1	6	0	6	7	0	0	5	5	**41**
BC07- Missing Person	**0**	0	0	0	1	1	0	0	2	2	0	1	1	**8**
BC08- Committed Criminal Offense	**0**	0	0	1	0	2	0	0	0	2	1	1	1	**8**
BC09-Victim of Criminal Offense	**9**	0	1	2	0	1	0	3	0	0	0	0	0	**7**
BC10-Inappropriate Sexual Behavior	**32**	0	3	5	2	8	6	1	1	0	5	6	4	**41**
BC11-Arrest of Recipient	**44**	0	9	4	4	1	5	2	9	4	2	3	4	**47**
BC12-Conviction of Recipient	**1**	0	0	0	0	0	0	0	0	0	0	2	0	**2**
BC13-Staff called 911 or Police due to Consumer Behavioral Crisis	**98**	7	5	5	7	5	4	3	2	3	4	4	2	**51**
BC14-Harm to Others resulting in physical injury	**16**	0	5	2	2	3	4	2	0	0	3	3	1	**25**
BC15- Harm to Others resulting in Hospitalization	**0**	0	0	0	0	0	0	0	1	0	0	0	1	**2**
BC16-Inappropriate Alcohol Use	**3**	0	0	0	4	3	1	0	2	2	0	0	0	**12**
BC17-Substance Abuse	**8**	0	0	0	0	1	0	0	2	0	0	0	1	**4**
BC18-Possession of a Controlled Substance	**1**	0	0	0	0	1	0	0	0	0	0	0	0	**1**
BC19-Other Behavior of Recipient	**601**	49	40	18	24	31	50	21	38	25	32	21	20	**369**
BC20-Disruptive behavior	**476**	32	31	22	33	29	20	13	24	12	31	52	22	**321**
BC21-Employment Related Behaviors	**3**	0	0	0	0	0	0	0	0	1	0	0	0	**1**

Trending over longer periods of time is also occasionally reviewed. Showing historically “frequently used” codes, which are primarily non-serious physical aggression, other behavior of recipient, and verbal aggression.



Overall reporting rates appear consistent across the years. Data from 2018 and 2022 are incomplete, as this data is shown in calendar year, although the dates run are for fiscal year. The first table shows the behavior codes, where the code is the first code listed, from 10.1.18-9.30.22. The second shows all IR codes across the same time span, broken out by provider.





At times, incidents for specific individuals are also reviewed at the NorthCare level. This is identified in the monthly Health and Safety meetings. Data can also be parsed out to only review specific codes of interest (second chart).

Quarterly, BTC data is compiled and reviewed. Most of the time, the behavior plan is continued as a result of the BTC meeting. In FY22Q, 24 of 29 reviews resulted in plan continuation. In Q2, 35 of 38 and

in Q3 25 of 36. Three were 10 new plans in Q3; only 1 plan was discontinued. This individual had PRN medication for behavior control, and it was determined this plan was no longer needed. Typically, behavior plans are reporting progress or stability, but that the plan is still necessary.

Physical Interventions are also reviewed quarterly. The reasons for physical intervention tend to be aggression toward staff or self.

Quarter	AGG STF	AGG PEER	AGG OTH	SIB	DES	DIS	ELO	SEX	OTH
1	35	4	0	31	5	3	0	1	0
2	36	8	0	29	8	0	0	2	1
3	23	4	0	23	11	1	3	0	0

In FY23, NorthCare will continue to review data quarterly, take data to the Regional BTC Committee, the NorthCare Health and safety committee, and the Regional Clinical Practices and Quality Improvement committee.

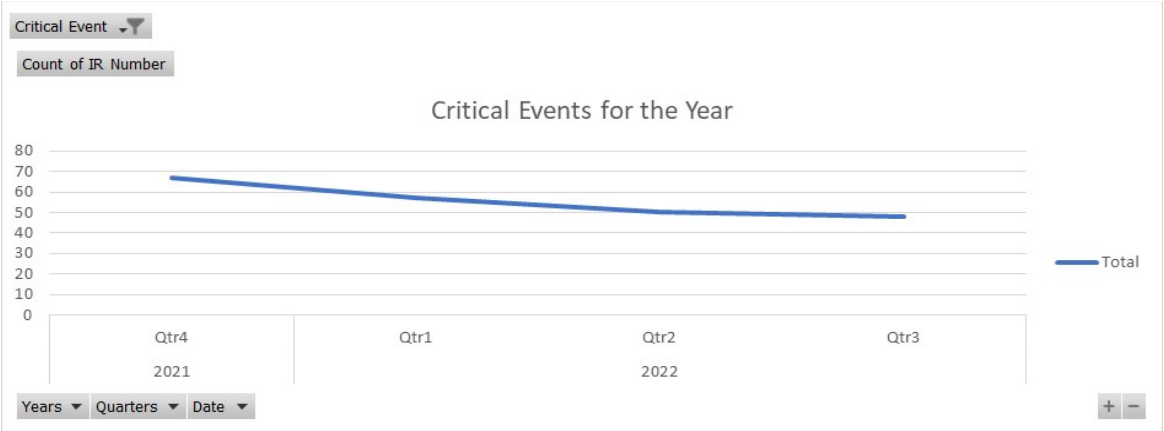
Event Reporting

Incident Reports (IR) are added to a separate IR module housed in the Electronic Medical Record, named ELMER, and are reviewed by the supervisor of the staff writing the incident as well as by Recipient Rights, Quality Improvement staff, or both. Additional reviewers can be added, as necessary. Additional reviewers might include BCBAs or RNs depending on the type of incident and the staff involved in that person's treatment plan. Writers of Incident reports may be AFC home staff or CMHSP employees. Critical, Sentinel, and Risk events are also reviewed by NorthCare Network Health and Safety Committee.

Critical Incidents that meet the state reporting definitions defined by the MDHHS/PIHP contract, include Suicide, Non-Suicide Death, Emergency Medical treatment due to Injury or Medication Error, Hospitalization due to Injury or Medication Error, Arrest of Consumer, or Injury because of physical management.

Populations that qualify:

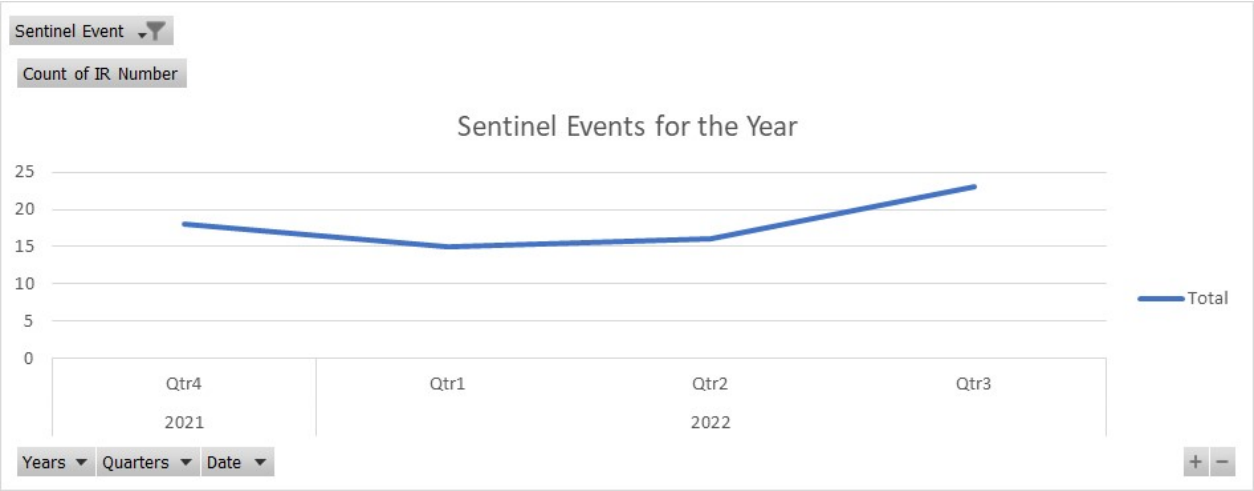
- Individuals who are living in a Specialized Residential facility (per Administrative Rule R330.1801-09) including substance use disorder residential programs or
- Individuals who are living in a Child-Caring institution; or
- Individuals who are receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.
- For non-suicide related deaths: for individuals who were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving community living supports, supports coordination, targeted case management, ACT, Home-based, Wraparound, Habilitation Supports Waiver, SED waiver or Children's Waiver services.
- Suicide for any individual actively receiving services at the time of death, and any who have received emergency services within 30 days prior to death. Once it has been determined whether a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was determined. If ninety calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide. In this event the time frame described in "a" above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred. Untimely deaths are considered a critical incident.



CMHSP Critical Incidents are reported to MDHHS via the ELMER Incident Reporting System Module and are uploaded to the Data Warehouse nightly. Starting 10.1.22, they are uploaded to the CRM.

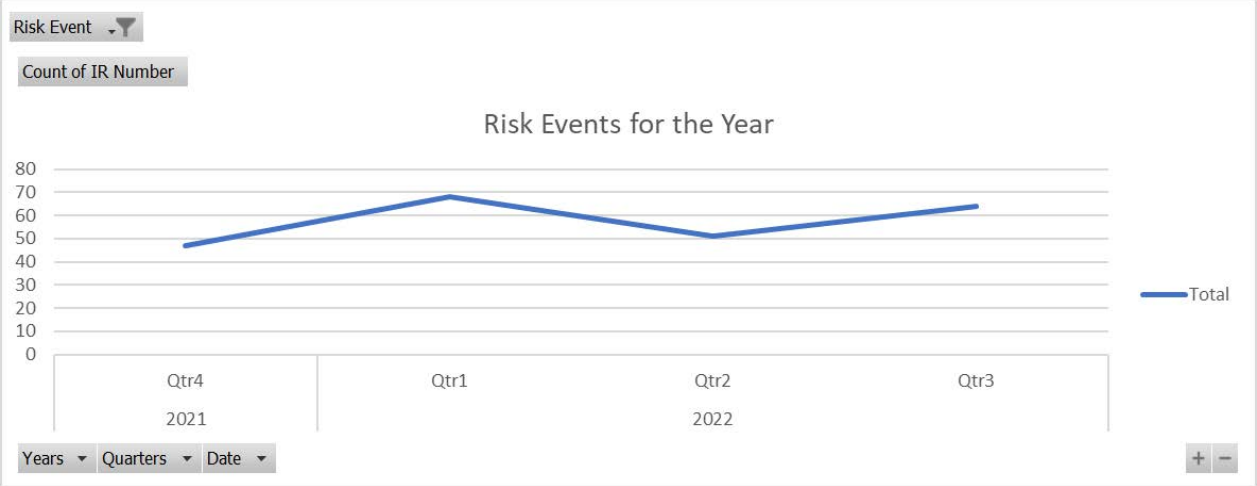
CMHSP staff fill out the section of the Incident Reporting system when incidents are ready to submit, within the required timeframes set forth by MDHHS. Substance Use Disorder (SUD) residential providers are required to submit incident reports per MDHHS guidelines to NorthCare Clinical staff for review and follow up as indicated. SUD providers do not enter incidents directly into the ELMER IR Module.

Sentinel Events are “unexpected occurrences” involving death (not due to the natural course of a health condition) or serious physical or psychological injury or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase “or risk thereof” includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome. (JCAHO, 1998) Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.



Risk Events are defined in the MDHHS QAPIP as additional incidents that put individuals (in the same population categories as the critical incidents above) at risk of harm. This analysis should be used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. These events minimally include:

- Actions taken by individuals who receive services that cause harm to themselves.
- Actions taken by individuals who receive services that cause harm to others.
- Two or more unscheduled admissions to a medical hospital (not due to a planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period.



NorthCare's Clinical Practices Coordinator reviews each critical, sentinel, or risk event and summarizes the information within. That information is brought to the NorthCare Health and Safety committee monthly. Incidents are reviewed and discussed and, for any incidents that generate questions or comments, the Clinical Practices Coordinator follows up with the CMHSP Quality Improvement or Recipient Rights staff. Incidents that are indicated as immediately reportable are reviewed immediately by NorthCare Compliance officer and Clinical Practices Coordinator and brought to MDHHS attention. Those incidents are also reviewed at the monthly Health and Safety committee. Incidents that are labeled as CMHSP events are not reviewed by NorthCare.

Incidents are expected to be categorized as critical, sentinel, or risk within 3 days of the event occurrence. Each incident can be coded with up to ten incident code descriptors. Monitoring of timely categorization has been tracked. NorthCare is working with providers who are struggling with these timelines.

	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
CCCMH	4.7	0	0	1.5	1.4	1.4	2.6	0	3.7	3.3	1.5	4.2	2.6	0	2.7
Gog	0	3.9	0	3.4	2.3	0	0	0	0	0	0	8.3	1.4	0	0
HBH	14.4	0	4.1	2.3	3.9	7.1	4.7	15.5	19.7	10.6	7.2	2.2	4.1	3.3	3.6
NP	0	2.9	3.3	5.1	22.8	8.1	1	0	0	1.4	0	27.1	0	5.4	3.6
Path	23.6	16.6	15.3	22.5	61.9	24.8	24.8	44.2	31.9	44.8	45.8	34.3	20.6	33.2	75.1
TOTAL	**8.5**	**4.7**	**10.1**	**11.5**	**33.8**	**13.9**	**12.6**	**24.4**	**20.4**	**26.4**	**24.5**	**22.7**	**12.2**	**19.6**	**40.1**

Incident Report data is reviewed in a variety of ways. Reporting rates are also reviewed for consistency.

	Total (excluding MHL)	April IRs	# IR/ Consumer	May IRs	# IR/ consumer May	June IRs	#/ con June	July IRs	#/con July	Aug IRs	#/con Aug	Sept IRs	#/con Sept
Copper	909	61	.067	69	.08	71	.08	77	.08	114	.13	148	.16
Gogebic	451	48	.106	61	.14	24	.05	74	.16	24	.05	40	009
Hiawatha	1137	113	.099	166	.15	135	.12	121	.11	183	.16	140	.12
Northpointe	1441	72	.049	92	.06	122	.08	84	.06	74	.05	55	.04
Pathways	2487	339	.136	384	.15	335	.13	417	.16	494	.20	406	.16

Each CMHSP conducts a Root Cause Analysis of all sentinel events, and other events as deemed appropriate, with a team of staff from the CMHSP. In the event of deaths or serious medical conditions, a physician or nurse must be involved in the review. NorthCare monitors Incident Reporting and Root Cause Completion during the annual CMHSP site reviews.

NorthCare identified the following goals and objectives related to Incident Reports in FY21. Additionally, less formal goals include increased monitoring of medication errors and fall data.

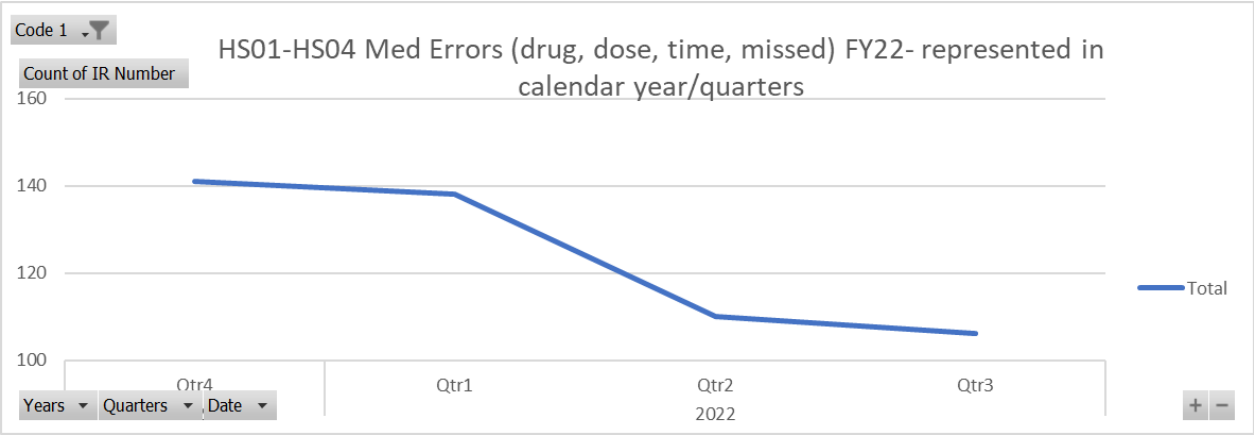
1. Increase timely categorization of incidents as being sentinel, critical, risk, a combination, or none.
    a. CMHSPs will categorize 95% of incidents within three business days of the incident over the next fiscal year.
    b. NorthCare will monitor the completion of incident categorization monthly over the next fiscal year and will communicate with any CMHSPs not meeting the standard.
    c. NorthCare will review compliance with this standard on the annual CMHSP site review.
        i. If they do not meet 95% - keep pushing them toward compliance and if it continues to be an issue, then we talk to them about prioritizing their efforts.

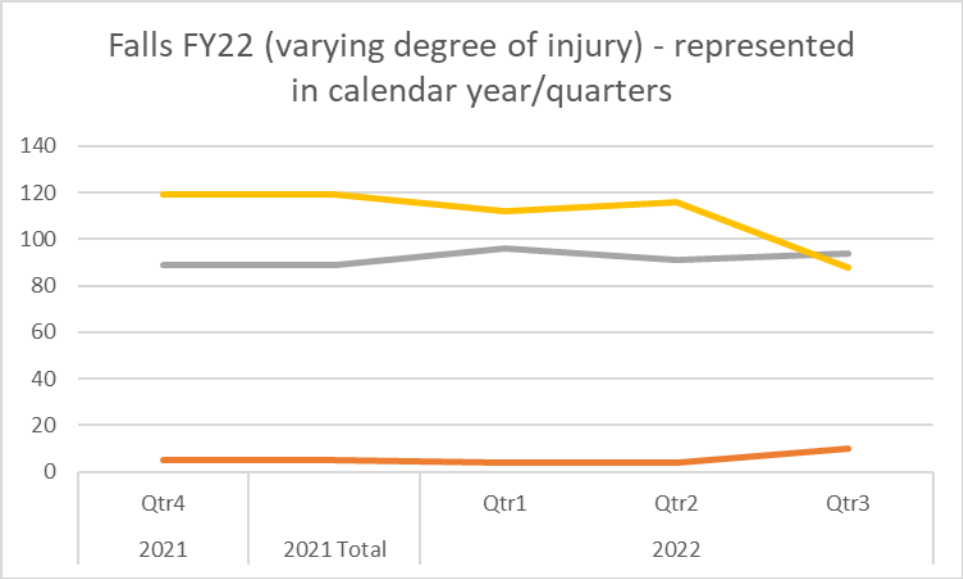
This goal remains a work in progress. One CMH continues to struggle with meeting this standard, which impacts overall regional numbers. The CMH impacted is the largest, and therefore has the largest number of incidents that would be considered out of compliance with the standard.

2. Ensure individuals living in residential living arrangements (RLA) are in the correct level of care and help transition to less restrictive levels of care any individuals that it would be appropriate to do so.
    a. NorthCare will review data to identify consumers that may be better served in a less restrictive level of care by June 1, 2022.
        i. This will be achieved by reviewing RLA codes to identify consumers living in residential settings. Scope will be focused on Individuals in a Level of Care that does not match that setting. IR's will be reviewed for those individuals. Any individuals in a residential setting with a LOC that does not match that level and who do not have IRs for a period of a year will have an in-depth chart review to determine if this setting seems appropriate.
    b. NorthCare will review documentation in the charts of the identified consumers to determine current appropriateness of residential level of care.
        i. This project and deidentified data found, will be reviewed with the regional Incident Reporting workgroup.
        ii. CMHSP will complete further review of cases, as needed.

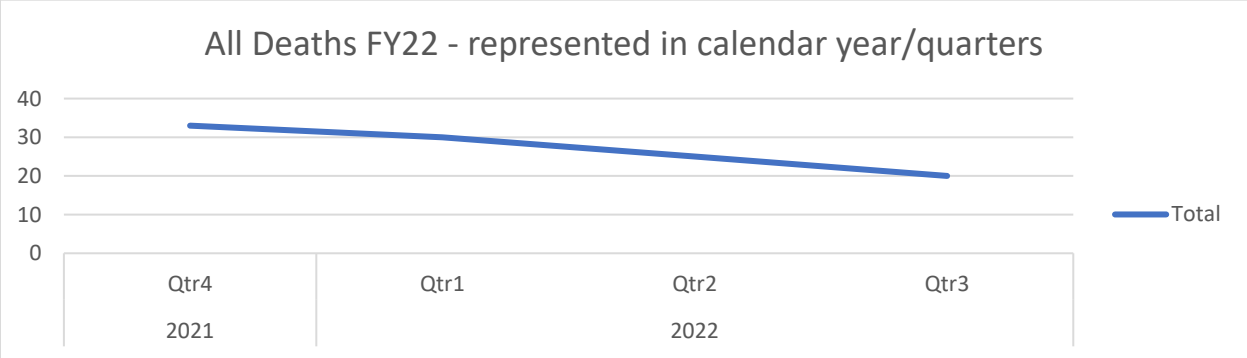
There were two reviews of this data. The first review identified 1 individual that appeared to not need to specialize residential care he was receiving. Upon bringing this question to his service providers, they further reviewed the case and were able to identify more appropriate services for him. This review is ongoing.

Reduction in Medication errors was identified by some CMH's, and NorthCare, as a goal. Med errors have decreased across the fiscal year. Fall data is another area of review. Most falls have no injury (yellow), or have non-serious injury (grey). Very few falls result in serious injury (orange).





There was a total of 108 deaths in FY22. This is up from 80 the previous year. Deaths are reported as critical incidents in the reporting system.



CMHSPs are responsible for training their staff and residential treatment provider staff on how to complete incident reports. NorthCare Network developed a basic Incident Report Training that network providers can use. In FY21, NorthCare developed a more detailed Root Cause Analysis training, per the CMHSP request. No updates were made to these trainings in FY22, however in FY23, with MDHHS transition to the CRM and adding additional fields, all trainings will need to be revamped. As of mid-October, there are still kinks in the Incident Reporting module, limiting the ability to create a usable training. Staff have had 3 meetings with the PCE developer to work out the issues.

NorthCare policies are made available to CMHSP and SUD providers via the NorthCare Network website and via email to the providers. The policies, in addition to other documents, help guide the CMHSPs and SUD providers. The policy includes definitions of events, timeliness standards, and provider expectations.

SUD providers are responsible for reviewing, investigating, and acting on sentinel events, critical incidents, and immediately reportable events. The SUD reporting requirements are outlined in NorthCare policy, the NorthCare SUD Operations Manual, and MDHHS online reporting. Residential SUD Treatment Providers are to report immediately, within 1 business day, any immediately reportable event via the NorthCare SUD Immediate Notification Report form. This form was updated and shared at the SUD provider meeting in October 2022. SUD Sentinel Events submitted on this form will be entered into the CRM by NorthCare Network staff.

In addition to the review of the CMHSP submitted Incident Reports, NorthCare Network's Health and Safety Committee also reviews the reports submitted by the SUD providers during their regularly scheduled committee meetings. During the desk audit portion of SUD provider site reviews, providers are required to submit agency policies/procedures specific to sentinel events which also includes a process for outlining their clinical review of incidents for trends related to an individual consumer and risk events. There were no sentinel events reported by SUD providers within NorthCare Network during FY22.

In FY23, NorthCare will continue to review data and present data to the Regional IR Committee quarterly, the NorthCare Health and Safety committee monthly, and the Regional Clinical Practices and Quality Improvement committee as needed.

External Quality Reviews

NorthCare Network is monitored each year for performance in a variety of ways, one of which is through an independent External Quality Review Organization (EQRO). The Health Service Advisory Group (HSAG) is the EQRO under contract with the Michigan Department of Health and Human Services (MDHHS) to conduct a 3-part survey of all Prepaid Inpatient Health Plans (PIHPs) in Michigan. This external review is mandated by the Balanced Budget Act (BBA) of 1997 and is conducted in accordance with the Centers for Medicare and Medicaid Services EQR (External Quality Review) guidelines.

1. **Compliance Monitoring –** This part of the review focuses on standards identified in 42 CFR §438 and applicable State contract requirements. FY22 was the second year in the 3-year compliance monitoring review cycle. The compliance review consists of 13 standards or program areas. HSAG conducted a review of the first six standards in Year One (FY 2021). The remaining seven standards were reviewed in Year Two (FY 2022). In Year Three (FY 2023), HSAG's review activity will focus on an evaluation of NorthCare's implementation of its corrective action plans developed to address standards scored as Not Met in FY2021 and FY2022 as well as any recommendations made by HSAG. In FY2021 NorthCare demonstrated compliance in 54 of the 65 elements, with an overall compliance score of 83% and in FY2022 compliance was demonstrated in 99 of the 118 applicable elements with an overall compliance score of 84%. Evidence provided indicated that some program areas had the necessary policies, procedures, and initiatives in place to carry out many required functions of the contract, while other areas demonstrated opportunities for improvement to operationalize the elements required by federal and State regulations. Standards being reviewed by HSAG have been revised with changes to many elements reviewed which does not allow for a logical comparison to prior years.

Areas Reviewed for Compliance in FY21		
I	Member Rights and Member Information	84%
II	Emergency and Post stabilization Services*	100%
III	Availability of Services	71%
IV	Assurances of Adequate Capacity and Services	25%
V	Coordination and Continuity of Care	93%
VI	Coverage and Authorization of Services	82%
	Total Score FY21	**83%**
Areas Reviewed for Compliance in FY22		
VII	Provider Selection	75%
VIII	Confidentiality	100%
IX	Grievance and Appeal System	79%
X	Sub contractual Relationships and Delegation	80%
XI	Practice Guidelines	86%

XII	Health Information Systems	82%
XIII	Quality Assessment and Performance Improvement Program (QAPIP)	90%
	Total Score FY22	**84%**

**Performance in Standard II was not scored and should be interpreted with caution as there were noted opportunities for all PIHPs statewide to enhance documentation to support the applicability of the federal requirements to the scope of the PIHPs' services. The PIHPs' progress in implementing HSAG's recommendations will be further assessed for continued compliance in future reviews. [HSAG State Fiscal Year 2021 Compliance Review for Prepaid Health Plans – Region 1 NorthCare Network, October 2021]*

2. **Performance Measure Validation (PMV) –** This part of the review is a comprehensive review of our state mandated performance measure, encounter, and demographic data as well as a review of source code. HSAG looks at how the data is collected, calculated, and reported, and evaluates the accuracy, completeness, and timeliness of our data. They continue to find our data integration, data controls, and performance indicator documentation to be acceptable.

   HSAG had no concerns with how NorthCare received and processed eligibility data or claims and encounter data for performance indicator reporting. They had no concerns with the BH-TEDS data entry and production processes used by NorthCare. HSAG found that NorthCare had sufficient oversight of its five affiliated CMHSPs.

   By assessing NorthCare's performance and performance measure reporting process, HSAG identified areas of strength and opportunities for improvement as it relates to the domains of quality, timeliness, and access. NorthCare has shown strides in increasing the completeness and accuracy of data by proactively working with PCE toward implementing inpatient hospital electronic submission. At the time of our HSAG review NorthCare was validating the completeness of the test files structure in our system and work is now being scheduled to move the first hospital to begin testing the electronic submission process. In addition, HSAG recognized NorthCare's continued improvement in the accuracy of data by ensuring alignment between its member-level data provided to HSAG and final rates reported to MDHHS. During SFY2022 audit, HSAG was able to easily confirm that the data counts and rates form the member-level data provided to HSAG and the final rates reported to MDHHS aligned. This is a direct result of improvement initiatives implemented in the way performance measure reports were run for the region, based on FY2021 PMV findings. HSAG also noted some areas for improvement which included, 1) various errors in the data where cases would have benefitted from enhancements to the validation process to include deeper quality checks prior to submission of data to MDHHS, and 2) five member records with discrepant employment and minimum wage BH-TEDS data and noted that while not impactful to the reported rates, manual data entry may result in discrepancies and suggested the PIHP/CMHSPs employ additional enhancements to the BH-TEDS validation process to ensure there are not discrepant data entered.

   HSAG validated a set of performance indicators that were developed and selected by MDHHS for validation. Overall, HSAG determined that the documentation of performance indicator calculations by NorthCare was acceptable.

   The following chart represents a five-year comparison of indicators that measure timeliness of service delivery. It is important to note that the MDHHS made changes in how PI #2 and PI #3 are calculated in the third quarter of FY20 which is why these two indicators were not reviewed in FY20. FY21 reflects the new calculation method where any exceptions based on member cancellation or no show for services allowed prior to FY20 are no longer allowed. This, in large part, contributes to the decrease in percentages for PI 2 and 3. Another contributing factor to the lower percentages in 2022 is reported staffing challenges as providers across the Upper Peninsula have reported difficulty in maintaining adequate staffing levels.

Performance Measures	2018	2019	2020	2021	2022
PI #1-Child: Percentage of Children Receiving a Pre-Admission Screening for Psychiatric Inpatient Care for Whom the Disposition Was Completed Within Three Hours	97%	100%	100%	100%	100%
PI #1-Adults: Percentage of Adults Receiving a Pre-Admission Screening for Psychiatric Inpatient Care for Whom the Disposition Was Completed Within Three Hours	100%	100%	100%	100%	98.99%
PI #2: Percentage of new persons receiving an assessment w/in 14 days of request for non-emergency service.	96%	95%	NA	67.39%	66.79%
PI #3: Percentage of new persons starting on-going services w/in 14 days of non-emergent assessment.	99%	99%	NA	76.92%	69.21%
PI #4a-Child: Percentage of children discharged from psychiatric inpatient unit who are seen for follow-up care w/in 7 days of discharge.	100%	100%	100%	100%	95.65%
PI #4a-Adult: Percentage of adults discharged from psychiatric inpatient unit who are seen for follow-up care w/in 7 days of discharge.	87%	100%	100%	94.87%	97.30%
PI #4b-SUD: Percentage of discharges from a substance abuse detox unit who are seen for follow-up care w/in 7 days of discharge.	100%	100%	100%	66.67%	100%

3. **Performance Improvement Project (PIP) Validation –** This is the evaluation of the PIP as required by the MDHHS. HSAG evaluates the technical structure of the PIP to ensure that NorthCare Network designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., study question, population, indicator(s), sampling techniques, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

   HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well NorthCare improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

   The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that any reported improvement is related to and can be logically linked to the quality improvement strategies and activities conducted by the PIHP during the PIP.

   FY2022 started a new PIP evaluation cycle. Three stages of the project are evaluated. Stage 1 is to establish the study design. Stage 2 is the implementation stage where data is evaluated and analyzed and identifies barriers to performance and interventions are identified targeted to improve the outcome. And Stage 3 is the final stage which focuses on outcomes. This involves the evaluation of real and sustained improvement based on data and statistical testing. Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not*

Assessed. HSAG designates evaluation elements vital to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*.

NorthCare's goal for this PIP is to increase the percentage of individuals, ages 12 years and older who are diagnosed with a co-occurring disorder, that receive co-occurring treatment from a Community Mental Health Services Program (CMHSP). Members receiving co-occurring treatment is crucial to meeting the complex needs of their co-occurring disorder. Treating co-occurring disorders simultaneously reduces the chances of a relapse and/or hospitalization.

NorthCare Network submitted the Design and Implementation stages of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements received a score of *Met*. NorthCare Network used data collection and analysis to determine its PIP topic and developed an appropriate Aim statement. The performance indicators were well-defined, objective, and measurable, and the data collection methods were valid and reliable. The technical design of the PIP was sufficient to measure and monitor PIP outcomes. NorthCare Network met 100 percent of the requirements for the data analysis portion of the Implementation stage. NorthCare Network reported accurate, clear, and consistent baseline data and included a narrative interpretation of the results. NorthCare Network had not progressed to implementing improvement strategies. Baseline data shows that 17.78% of individuals ages 12 years and older who are diagnosed with a co-occurring disorder received treatment from a CMHSP during the measurement period. NorthCare's goal is to achieve significant improvement over the baseline performance during the first remeasurement period and sustain that improvement during a second remeasurement.

Table 2-1—2021–2022 PIP Validation Results for NorthCare Network

Name of Project	Type of Annual Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
To Increase the Percentage of Individuals Ages 12 and Older Who Are Diagnosed With a Co-Occurring Disorder That Are Receiving Co-Occurring Treatment	Submission	92%	100%	*Met*
	Resubmission	100%	100%	*Met*

Next steps in this project will include completion of a causal/barrier analysis to identify barriers to desired outcomes and implementation interventions to address those barriers in a timely manner. NorthCare does realize that interventions implemented late in the Remeasurement 1 period may not have the time to impact the performance indicator rate or achieve significant improvement. Improvement strategies that have the potential to impact the performance indicator outcomes or achieve significant improvement will be implemented and evaluated to determine the effectiveness of each intervention.

More information about the Performance Improvement Projects can be found in that section of this report, page 90.

URAC Accreditation

NorthCare Network's URAC Accreditation will expire March 1, 2023. After 8 years of accreditation, NorthCare has made the decision not to renew accreditation at this time due to the redundancy in compliance reviews conducted by MDHHS and HSAG as well as the human and financial resources necessary to ensure a full accreditation status.

QAPIP Checklist

The QAPIP Checklist shows MDHHS Feedback and is reflected from page 62- 68 of this report.

PIHP Name: Northcare	
Michigan Standards	**MDHHS Feedback**
Section I. Performance Measures	
1. The QAPIP **description** included a summary of the PIHP's process to measure its performance using standardized indicators based upon the systematic, ongoing collection, and analysis of valid and reliable data. *The description should expand on the PIHP's internal processes and validation activities to ensure data is valid and reliable.*	
a. The PIHP included the performance measures established by MDHHS in the areas of access, efficiency, and outcomes. *The description should identify the actual performance indicators; or at minimum, reference Michigan's Mission-Based Performance Indicator System (MMBPIS).*	
2. The QAPIP **work plan** identified a goal(s) and/or objective(s) for each performance indicator with a minimum performance standard (MPS).	
a. A SMART (specific, measurable, achievable, realistic, and timely) goal(s) was identified. *The work plan should identify the actual performance standards; or at minimum, reference the MMBPIS standards set by MDHHS.*	
3. The QAPIP **evaluation** included an analysis of the PIHP's performance measure activities.	
a. The PIHP analyzed the causes of negative statistical outliers when they occurred. *The evaluation should discuss region-wide trends when indicators did not meet the MMBPIS performance standards.*	
b. The PIHP analyzed trends in service delivery and health outcomes over time, including whether there have been improvements or barriers impacting the quality of health care and services for members as a result of the activities.	
c. The PIHP analyzed progress on meeting its performance goal(s). *The evaluation should identify the prior year's performance goal and whether that goal was met or not met.*	
Action Required:	
Section II. Performance Improvement Projects (PIPs)	
1. The QAPIP **description** included a summary of the PIHP's methodology for implementing PIPs that achieve through ongoing measurement and intervention, demonstrable, and sustained improvement in significant aspects of clinical (clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care) and non-clinical services (non-clinical areas would include, but not be limited to, appeals, grievances, trends, and patterns of substantiated member rights complaints as well as access to, and availability of, services) that can be expected to have a beneficial effect on health outcomes and individual satisfaction. *The description should expand on the PIHP's internal methodology for conducting PIPs (for example, plan-do-study-act (PDSA), Centers for Medicare & Medicaid Services (CMS) protocols, model for improvement, etc.).*	
a. At least two PIPs were described. *The description should identify at least two PIP study topics and the clinical and/or non-clinical aspect of care for each PIP.*	

PIHP Name: Northcare	
Michigan Standards	**MDHHS Feedback**
2. The QAPIP **work plan** identified a goal(s) and/or objective(s) for each PIP.	
a. A SMART (specific, measurable, achievable, realistic, and timely) goal(s) was identified. *The work plan should identify a SMART outcome or process measure that drives improvement.*	
3. The QAPIP **evaluation** included an analysis of the PIHP's PIP activities.	
a. The PIHP analyzed trends in service delivery and health outcomes over time, including whether there have been improvements or barriers impacting the quality of health care and services for members as a result of the activities.	
b. The PIHP analyzed progress on meeting its performance goal(s). *The evaluation should identify the prior year's performance goal and whether that goal was met or not met.*	
Action Required:	
Section III. Critical Incidents (CIs), Sentinel Events (SEs), Unexpected Deaths (UDs), and Risk Event (RE) Management	
1. The QAPIP **description** included the PIHP's process of the review and follow-up of SEs and other CIs and events that put individuals at risk of harm.	
a. The PIHP identified reportable CIs for members as: Suicide; Non-suicide death; Arrest of Consumer; Emergency Medical Treatment due to injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of physical management; Hospitalization due to Injury or Medication Error: Hospitalization due to injury related to the use of physical management. *The description should define CIs; or at minimum, reference the MDHHS definitions and/or reporting requirements for CIs.*	
b. The PIHP included language to support that residential treatment providers prepare and file CIs reports.	
2. The QAPIP **description** included the process of how the PIHP will review all UDs (those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect) of members, who at the time of their deaths were receiving specialty supports and services. *The description should define UDs; or at minimum, reference the MDHHS definitions and/or reporting requirements for UDs.*	
3. The QAPIP **description** included the process of how the PIHP will analyze REs that put individuals at risk of harm. These events minimally include: actions taken by individuals who receive services that cause harm to themselves; actions taken by individuals who receive services that cause harm to others; and two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period. *The description should define REs; or at minimum, reference the MDHHS definitions and/or reporting requirements for REs.*	
4. The QAPIP **description** included the process of how the PIHP will analyze, at least quarterly, the CIs, SEs, and REs to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.	
5. The QAPIP **work plan** identified a goal(s) and/or objective(s) related to CIs, SEs, UDs, and other REs.	
a. A SMART (specific, measurable, achievable, realistic, and timely) goal(s) was identified.	

PIHP Name: Northcare	
Michigan Standards	**MDHHS Feedback**
The work plan should identify a SMART outcome or process measure that drives improvement, when possible.	
6. The QAPIP **evaluation** included an analysis of the PIHP's CIs, SEs, UDs, and RE management activities:	
a. The PIHP's analysis considered CIs (Non-suicide death; Arrest of Consumer; Emergency Medical Treatment due to injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of physical management; Hospitalization due to Injury or Medication Error: Hospitalization due to injury related to the use of physical management).	
b. The PIHP's analysis considered CIs for residential treatment providers.	
c. The PIHP's analysis considered SEs.	
d. The PIHP's analysis considered all UDs (those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect), including aggregated mortality data over time to identify possible trends.	
e. The PIHP's analysis considered REs that put individuals at risk of harm. These events minimally include: actions taken by individuals who receive services that cause harm to themselves; actions taken by individuals who receive services that cause harm to others; and two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period.	
7. The QAPIP **evaluation** included an analysis to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents.	
a. The PIHP analyzed trends in service delivery and health outcomes over time, including whether there have been improvements or barriers impacting the quality of health care and services for members as a result of the activities.	
b. The PIHP analyzed progress on meeting its performance goal(s). *The evaluation should identify the prior year's performance goal and whether that goal was met or not met.*	
Action Required:	
Section IV. Behavioral Treatment Review	
1. The QAPIP **description** included the PIHP's process to quarterly review an analysis of data from the Behavior Treatment Review (BTR) Committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis.	
2. The QAPIP **work plan** identified a goal(s) and/or objective(s) related to BTR.	
a. A SMART (specific, measurable, achievable, realistic, and timely) goal(s) was identified. *The work plan should identify a SMART outcome or process measure that drives improvement, when possible.*	
3. The QAPIP **evaluation** included an analysis of the PIHP's BTR activities.	
a. The PIHP analyzed trends in service delivery and health outcomes over time, including whether there have been improvements or barriers impacting in the quality of health care and services for members as a result of the activities.	MDHHS did not note any trends, barriers or improvements identified.

PIHP Name: Northcare	
Michigan Standards	**MDHHS Feedback**
b. The PIHP analyzed progress on meeting its performance goal(s). *The evaluation should identify the prior year's performance goal and whether that goal was met or not met.*	MDHHS could not identify where any goals were set.
Action Required:	
Section V. Member Experience with Services	
1. The QAPIP **description** included the PIHP's methodology to assess member experience with services.	
a. The methodology included a quantitative assessment (e.g., surveys) of member experience with services. *The description should expand on the PIHP's internal process for implementing a quantitative assessment/member survey(s) and identify the survey instrument(s) used.*	
b. The methodology included a qualitative assessment (e.g., focus groups) of member experience with services. *The description should expand on the PIHP's internal process for implementing a qualitative assessment and identify the activity(ies) conducted by the PIHP (for example, focus groups, consumer advisory board, targeted interviews).*	
c. The methodology described how the PIHP ensured the incorporation of members receiving LTSS into the review and analysis of the information obtained from quantitative and qualitative methods.	
2. The QAPIP **work plan** identified a goal(s) and/or objective(s) to assess member experience of services.	
a. A SMART (specific, measurable, achievable, realistic, and timely) goal(s) was identified. *The work plan should identify a SMART outcome or process measure that drives improvement, when possible.*	
3. The QAPIP **evaluation** included an analysis of the results of member experience with services activities.	
a. The PIHP analyzed trends in service delivery and health outcomes over time, including whether there have been improvements and barriers impacting in the quality of health care and services for members as a result of the activities.	
b. The PIHP analyzed progress on meeting its performance goal(s). *The evaluation should identify the prior year's performance goal and whether that goal was met or not met.*	
Action Required:	
Section VI. Practice Guidelines	
1. The QAPIP **description** included the PIHP's process for the adoption, development, implementation, and continuous monitoring and evaluation of clinical practice guidelines (CPGs) when there are nationally accepted, or mutually agreed-upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individuals served.	
2. The QAPIP **work plan** identified a goal(s) and/or objective(s) related to CPGs.	MDHHS was not able to locate this in the QAPIP.
a. A SMART (specific, measurable, achievable, realistic, and timely) goal(s) was identified.	

PIHP Name: Northcare	
Michigan Standards	**MDHHS Feedback**
The work plan should identify a SMART outcome or process measure that drives improvement, when possible.	
3. The QAPIP **evaluation** included an analysis of the PIHP's CPGs activities.	
a. The PIHP analyzed trends in service delivery and health outcomes over time, including whether there have been improvements and barriers impacting in the quality of health care and services for members as a result of the activities.	MDHHS did not note any trends, barriers or improvements identified.
b. The PIHP analyzed progress on meeting its performance goal(s). *The evaluation should identify the prior year's performance goal and whether that goal was met or not met.*	MDHHS could not identify where any goals were set.
Action Required:	
Section VII. Credentialing and Re-Credentialing	
1. The QAPIP **description** contained a summary of procedures to ensure physicians and other health care professionals, and non-licensed providers are qualified to perform their services.	Procedures for non-licensed providers is not included in the QAPIP; however, it does mention that NCN does have a policy regarding non-licensed providers. MDHHS was unable to locate this policy, **please provide a copy of this.**
a. The PIHP described how findings of the QAPIP are incorporated into the recredentialing process. *The description should identify the specific performance data that the PIHP considers at the time of a provider's recredentialing (for example, grievances, performance indicators, utilization, appeals, member satisfaction, provider monitoring reviews, CIs, etc.).*	This information does not appear to be included in the QAPIP; however, after reviewing NCN Credentialing Program Policy, it was noted that performance data is considered during the re-credentialing process.
2. The QAPIP **work plan** identified a goal(s) and/or objective(s) related to credentialing and re-credentialing.	MDHHS was not able to locate this in the QAPIP.
a. A SMART (specific, measurable, achievable, realistic, and timely) goal(s) was identified. *The work plan should identify a SMART outcome or process measure that drives improvement, when possible.*	
3. The QAPIP **evaluation** included an analysis of the PIHP's credentialing and re-credentialing activities.	
a. The PIHP analyzed trends in service delivery and health outcomes over time, including whether there have been improvements and barriers impacting in the quality of health care and services for members as a result of the activities.	MDHHS did not note any trends, barriers or improvements identified.
b. The PIHP analyzed progress on meeting its performance goal(s). *The evaluation should identify the prior year's performance goal and whether that goal was met or not met.*	MDHHS could not identify where any goals were set for FY 21, only that in FY 22 NorthCare will establish and implement a formal comprehensive onboarding process for all providers.
Action Required:	
Section VIII. Verification of Services	

PIHP Name: Northcare	
Michigan Standards	**MDHHS Feedback**
1. The QAPIP **description** addressed how the PIHP verifies whether services reimbursed by Medicaid were furnished to members by affiliates (as applicable), providers, and subcontractors.	
2. The QAPIP **work plan** identified a goal(s) and/or objective(s) related to verification of services.	
a. A SMART (specific, measurable, achievable, realistic, and timely) goal(s) was identified. *The work plan should identify a SMART outcome or process measure that drives improvement, when possible.*	
3. The QAPIP **evaluation** included an analysis of the PIHP's verification of services activities.	
a. The PIHP analyzed trends in service delivery and health outcomes over time, including whether there have been improvements and barriers impacting in the quality of health care and services for members as a result of the activities.	MDHHS did not note any trends, barriers or improvements identified over a period to time.
b. The PIHP analyzed progress on meeting its performance goal(s). *The evaluation should identify the prior year's performance goal and whether that goal was met or not met.*	MDHHS could not identify where any goals were set. It was noted the NCN's expectation is that all claims/encounters are in full compliance.
Action Required:	
Section IX. Utilization Management	
1. The QAPIP **description** included the mechanisms to monitor utilization of services.	
a. The PIHP described mechanisms to detect underutilization of services. *The description should identify the activities conducted by the PIHP to detect underutilization (for example, various service utilization reports, performance measures, adherence to CPGs, provider/member profiling, appeals and grievances, financial reports, etc.).*	
b. The PIHP described mechanism to detect overutilization of services. *The description should identify the activities conducted by the PIHP to detect overutilization (for example, various service utilization reports, performance measures, adherence to CPGs, provider/member profiling, appeals and grievances, financial reports, etc.).*	
2. The QAPIP **work plan** identified a goal(s) and/or objective(s) related to underutilization and overutilization.	
a. A SMART (specific, measurable, achievable, realistic, and timely) goal(s) was identified. *The work plan should identify a SMART outcome or process measure that drives improvement, when possible.*	
3. The QAPIP **evaluation** included an analysis of the PIHP's underutilization and overutilization activities.	
a. The PIHP analyzed trends in service delivery and health outcomes over time, including whether there have been improvements and barriers impacting in the quality of health care and services for members as a result of the activities.	
b. The PIHP analyzed progress on meeting its performance goal(s). *The evaluation should identify the prior year's performance goal and whether that goal was met or not met.*	
Action Required:	
Section X. Provider Network	

PIHP Name: Northcare	
Michigan Standards	**MDHHS Feedback**
1. The QAPIP **description** included the PIHP's process to annually monitor its provider network(s), including any affiliates or subcontractors to which it has delegated managed care functions, including service and support provision.	
2. The QAPIP **work plan** identified a goal(s) and/or objective(s) related to its provider network.	
a. A SMART (specific, measurable, achievable, realistic, and timely) goal(s) was identified. *The work plan should identify a SMART outcome or process measure that drives improvement, when possible.*	
3. The QAPIP **evaluation** included an analysis of the PIHP's provider network monitoring activities.	
a. The PIHP analyzed trends in service delivery and health outcomes over time, including whether there have been improvements and barriers impacting in the quality of health care and services for members as a result of the activities.	
b. The PIHP analyzed progress on meeting its performance goal(s). *The evaluation should identify the prior year's performance goal and whether that goal was met or not met.*	
Action Required:	
Section XI. Long-Term Services and Supports (LTSS)	
1. The QAPIP **description** included mechanisms to assess the quality and appropriateness of care furnished to members receiving LTSS.	
a. The PIHP's process included an assessment of care between care settings. *The description should expand on the activities conducted by the PIHP to assess member care between care settings.*	
b. The PIHP's process included a comparison of services and supports received with those set forth in the member's treatment/service plan. *The description should expand on the activities conducted by the PIHP to compare services received by members compared to the services identified in members' treatment/service plan.*	
2. The QAPIP **work plan** identified a goal(s) and/or objective(s) related to LTSS.	
a. A SMART (specific, measurable, achievable, realistic, and timely) goal(s) was identified. *The work plan should identify a SMART outcome or process measure that drives improvement, when possible.*	
3. The QAPIP **evaluation** included an analysis of the PIHP's LTSS activities.	
a. The PIHP analyzed the results of efforts by the PIHP to support community integration for members using LTSS.	
b. The PIHP analyzed trends in service delivery and health outcomes over time, including whether there have been improvements and barriers impacting in the quality of health care and services for members as a result of the activities.	
c. The PIHP analyzed progress on meeting performance goal(s). *The evaluation should identify the prior year's performance goal and whether that goal was met or not met.*	
Action Required:	

Performance Measurement

Performance Indicators (MMBPIS)

The Michigan Mission-Based Performance Indicator System was first implemented in fiscal year 1997 and is contractually required of the 10 PIHPs and 46 CMHSPs. Since 1997, the system has undergone changes based on feedback from consumers, families, advocates, and mental health professionals. These indicators include measures on timeliness of access to service, continuity of care, Medicaid penetration rate, adequacy and appropriateness, efficiency, and outcomes.

The following tables show percentages for Region 1 (Upper Peninsula) compared to the State percentage. NorthCare considers each measure fully met if above the State established standard or above the State percentage for PI 2 and PI 3 as there is no State standard set at this point for these two indicators. Percentages in red indicate measures falling below State percentages.

Performance Indicator #1:

NorthCare Network utilizes a regional team of clinicians who conduct pre-admission screenings for psychiatric inpatient care at local emergency departments when called. Screenings are available to all Michigan residents 24 hours per day, 7 days per week. This allows for individuals to be screened locally as soon as the individual is available to be screened. As issues occur, they are addressed as expeditiously as the situation warrants and/or at quarterly quality meetings that are held with representation from NorthCare, involved CMHNSP staff, and the hospital staff. As displayed in the table below, NorthCare consistently meets or exceeds this measure.

Indicator #1: Percent of children and adults receiving a pre-admissions screening for psychiatric inpatient care for whom the disposition was completed w/in 3Hrs.									
State Standard is 95%									
	Q3FY20	**Q4FY20**	**Q1FY21**	**Q2FY21**	**Q3FY21**	**Q4FY21**	**Q1FY22**	**Q2FY22**	**Q3FY22**
NC Children	100%	100%	100%	98.3%	100%	100%	100%	98.7%	100%
State Children	100%	98.8%	99.0%	98.7%	99.0%	99%	98.9%	98.8%	99.0%
NC Adults	99.5%	100%	100%	99.6%	99.1%	100%	99%	100%	100%
State Adults	98.6%	97.9%	98.3%	98.1%	97.7%	98%	98.4%	98.6%	98.0%

Performance Indicator #2:

Historically, MDHHS required a 95% minimum standard for PI 2. Beginning from April 2020 this standard was removed as well as the allowance for exceptions to this measure. With no minimum standard, NorthCare compares our regional percentage to that of the State with a goal to meet or exceed the State's percentage each quarter. As the charts for PI 2 indicate, NorthCare has achieved improvement since FY21 with only two quarters for children with I/DD falling below the State's percentage. NorthCare has initiated a Call-to-Action group that is addressing coordination between the Access center and the CMH intake staff with the goal of reducing duplication and increasing efficiency. NorthCare continues to monitor quarterly. The tables below show the NorthCare totals compared to the state totals over time. Additionally, a break down for FY22 with CMH specific data is included.

Indicator #2a: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of non-emergency request for service (by four sub-populations, MI-adults, MI-children, I/DD-adults, I/DD-children).										
MDHHS has not established a minimum threshold for this measure.										
	Q3FY20	**Q4FY20**	**Q1FY21**	**Q2FY21**	**Q3FY21**	**Q4FY21**	**Q1FY22**	**Q2FY22**	**Q3FY22**	**Q4FY22**
MIC	73.0%	70.2%	70.7%	70.7%	71.4%	67.4%	71.9%	58.6%	61.7%	64.15%
State MIC	76.3%	71.7%	68.2%	65.4%	64.4%	62.9%	59.2%	54.9%	50.5%	52.72%
MIA	60.6%	62.9%	65.6%	60.1%	60.4%	56.5%	64.6%	56.8%	56.3%	54.9%

State MIA	71.2%	65.8%	66.4%	65.5%	64.6%	59.9%	59.6%	52.2%	50.8%	53.5%
DDC	91.7%	83.3%	75.0%	75.9%	72.7%	67.4%	55.60	66.7%	36.8%	64.0%
State DDC	81.7%	74.7%	74.3%	68.0%	66.6%	61.9%	62.9%	62.4%	52.4%	53.0%
DDA	88.9%	68.2%	66.7%	53.3%	83.3%	80.0%	63.6%	58.3%	60.0%	52.0%
State DDA	81.2%	72.4%	75.1%	67.2%	67.3%	63.3%	56.3%	55.8%	52. 7%	52.7%
TOTAL	66.3%	65.7%	67.6%	64.8%	65.9%	61.8%	66.80%	57.9%	57.7%	57.8%
State Total	73.2%	68.2%	68.0%	66.0%	64.5%	60.8%	59.61%	54.1%	51.0%	53.3%

Performance Indicator by CMH Compared to State Average - Access to Intake

	Quarter 1				Quarter 2				Quarter 3				Quarter 4			
	MI Adult	I/DD Adult	MI Child	I/DD Child	MI Adult	I/DD Adult	MI Child	I/DD Child	MI Adult	I/DD Adult	MI Child	I/DD Child	MI Adult	I/DD Adult	MI Child	I/DD Child
Copper	82.1%	0.0%	75.0%	100.0%	62.3%	55.6%	65.4%	75.0%	66.7%	44.4%	68.8%	50.0%	64.0%	0.0%	84.6%	83.3%
Gogebic	57.1%	100.0%	69.6%	75.0%	52.0%	NA	41.7%	50.0%	71.4%	0.0%	85.7%	50.0%	63.6%	NA	44.4%	80.0%
Hiawatha	61.8%	100.0%	65.7%	0.0%	55.0%	40.0%	59.3%	75.0%	54.2%	83.3%	50.0%	0.0%	58.7%	60.0%	60.5%	20.0%
Northpointe	57.3%	66.7%	80.0%	50.0%	48.3%	50.0%	54.2%	75.0%	52.7%	33.3%	65.5%	100.0%	49.3%	33.3%	61.1%	50.0%
Pathways	64.7%	81.8%	72.4%	57.1%	60.7%	66.7%	62.7%	57.1%	55.4%	62.5%	58.9%	50.0%	53.1%	60.0%	65.2%	80.0%
NorthCare	64.6%	63.6%	71.9%	55.6%	56.8%	58.3%	58.6%	66.7%	56.3%	60.0%	61.7%	36.8%	54.9%	52.0%	64.2%	64.0%
Statewide	59.6%	56.3%	59.2%	62.9%	52.2%	55.8%	54.9%	62.4%	50.8%	52.7%	50.5%	52.4%				

Substance Use Disorder timely access to services is reflected in indicator 2b.

Indicator # 2b*: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports (BH-TEDS admission) within 14 calendar days of a non-emergency request for service for persons with substance use disorders. Red indicates NorthCare below State percentage.

MDHHS has not established a minimum threshold for this measure. Region 1 is working toward a goal of 80%.

	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
SUD 2b	73.6%	68.2%	62.3%	71.0%	74.4%	72.8%	74.6%	86.6%	74.1%	76.0%
State SUD 2b	77.9%	77.7%	74.6%	76.1%	74.6%	75.2%	71.8%	70.9%	70.4%	70.7%

** PIHPs report expired requests to MDHHS who uses that number in their calculation to determine the percent of individuals having an admission withing 14 calendar days of non-emergency request for services. Expired requests are those requests for services that are approved at an SUD provider that do not result in an admission within 60 days of the request date. Calculated percentages are posted on the MDHHS website within 4 months after the end of the quarter.*

Performance Indicator #3:

This indicator mirrors PI 2 in that MDHHS required a 95% minimum standard for several years and as of April 2020 this standard was removed as well as the allowance for exceptions to this measure. With no minimum standard, NorthCare compares our regional percentage to that of the State with a goal to meet or exceed the State's percentage each quarter. As the chart for PI 3 indicates, NorthCare has struggled to get individuals in to start ongoing treatment within 14 calendar days of completion of their biopsychosocial assessment. This is attributed to staffing shortages across the region. Additionally, FY22 data broken by CMH is portrayed in the second table. NorthCare continues to monitor quarterly.

Indicator #3: Start of ongoing service w/in 14 days of non-emergent face-to-face assessment w/a professional (by four sub-populations, MI-adults, MI-children, I/DD-adults, I/DD-children).

MDHHS has not established a minimum threshold for this measure.

	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22
MIC	70.1%	81.4%	76.9%	82.9%	78.0%	70.6%	72.7%	81.0%	69.1%	74.8%
State MIC	80.4%	77.2%	76.6%	80.0%	76.3%	75.0%	77.5%	72.6%	72.9%	75.3%
MIA	78.4%	76.0%	76.4%	73.6%	76.9%	71.0%	67.4%	73.3%	67.3%	68.3%

State MIA	82.1%	79.8%	79.0%	80.5%	79.8%	76.2%	76.9%	74.8%	73.9%	74.8%
DDC	72.7%	81.8%	69.2%	78.3%	81.3%	71.4%	78.6%	69.6%	84.2%	76.7%
State DDC	80.4%	83.7%	81.0%	84.2%	83.8%	83.89%	83.2%	82.0%	81.5%	80.8%
DDA	80.0%	92.9%	86.4%	90.9%	100%	90.9%	55.0%	76.7%	71.4%	71.0%
State DDA	82.8%	82.1%	84.3%	82.8%	84.2%	81.4%	77.4%	75.7%	76.4%	80.3%
TOTAL	76.0%	78.3%	76.9%	78.2%	78.3%	71.4%	69.2%	76.3%	68.8%	70.7%
State Total	82.0%	79.5%	72.2%	80.9%	79.4%	77.5%	77.5%	75.0%	74.2%	75.7%

Performance Indicator by CMH Compared to State Average - BPS to 1st Ongoing Service																
	Quarter 1				Quarter 2				Quarter 3				Quarter 4			
	MI Adult	I/DD Adult	MI Child	I/DD Child	MI Adult	I/DD Adult	MI Child	I/DD Child	MI Adult	I/DD Adult	MI Child	I/DD Child	MI Adult	I/DD Adult	MI Child	I/DD Child
Copper	61.1%	50.0%	61.9%	100.0%	71.8%	66.7%	87.0%	50.0%	69.6%	70.0%	62.5%	50.0%	78.8%	50.0%	91.7%	75.0%
Gogebic	57.1%	66.7%	52.6%	66.7%	100.0%	0.0%	54.5%	100.0%	52.2%	100.0%	58.3%	100.0%	64.7%	NA	50.0%	50.0%
Hiawatha	70.2%	66.7%	84.4%	100.0%	80.0%	100.0%	82.9%	100.0%	81.4%	100.0%	80.8%	75.0%	75.6%	100.0%	81.5%	100.0%
Northpointe	65.3%	66.7%	61.5%	50.0%	67.7%	88.9%	77.5%	60.0%	68.3%	0.0%	65.3%	100.0%	66.7%	0.0%	75.9%	33.3%
Pathways	70.7%	54.5%	90.9%	100.0%	76.1%	50.0%	83.3%	60.0%	65.2%	50.0%	73.1%	100.0%	65.3%	66.7%	70.7%	100.0%
NorthCare	67.4%	78.6%	72.7%	55.0%	73.3%	69.6%	81.0%	76.7%	67.3%	84.2%	69.1%	71.4%	68.3%	70.6%	74.8%	73.7%
Statewide	76.9%	83.2%	77.5%	77.4%	74.8%	82.0%	72.6%	75.7%	73.9%	81.5%	72.9%	76.4%				

Performance Indicator #4:

NorthCare has seen a nice improvement in FY22 and has met or exceeded this standard in each of the first three quarters. Review of this standard has been part of discussion at the Emergency Services committee. Awareness of this standard may have helped with the improvement. A breakdown by CMH is reflected in the second table. The third table reflects SUD data. This data is obtained from the state. There was no data available for FY22Q2.

Indicator#4a: The percentage of discharges from a *psychiatric inpatient unit* who are seen for follow-up care within 7 days.									
MDHHS minimum threshold is 95%.									
	Q3FY20	**Q4FY20**	**Q1FY21**	**Q2FY21**	**Q3FY21**	**Q4FY21**	**Q1FY22**	**Q2FY22**	**Q3FY22**
Children	94.1%	88.9%	100%	87.5%	83.3%	92.3%	95.7%	100%	100%
State Children	97.9%	95.2%	96.6%	96.0%	94.0%	92.7%	92.3%	90.3%	90.1%
Adults	96.2%	91.8%	94.8%	97.5%	93.6%	95.5%	97.3%	98.5%	97.6%
State Adults	95.3%	95.0%	95.6%	95.1%	95.4%	94.1%	92.0%	88.9%	89.9%

Performance Indicator by CMH Compared to State Average - 7 Day Follow Up								
	Quarter 1		Quarter 2		Quarter 3		Quarter 4	
	Adults	Children	Adults	Children	Adults	Children	Adults	Children
Copper	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	33.3%
Gogebic	100.0%	100.0%	100.0%	NA	100.0%	100.0%	100.0%	100.0%
Hiawatha	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Northpointe	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%	100.0%	100.0%
Pathways	100.0%	75.0%	96.7%	100.0%	100.0%	100.0%	96.6%	100.0%
NorthCare	97.30%	95.70%	98.53%	100.00%	97.59%	100%	94.9%	90.0%
Statewide	92.01%	92.34%	88.93%	90.31%	89.86%	90.11%		
*Performance Indicator Report. Excludes those following up with other providers only, autism, OBRA, dual eligible, care/caid, transfers. Exceptions include those refusing appointment within 7 days or those who had an appointment scheduled but then no-show or cancel.								

Indicator#4b: The percentage of discharges from a *substance abuse detox unit* who are seen for follow-up care within 7 days.										
MDHHS minimum threshold is 95%.										
	Q3FY20	**Q4FY20**	**Q1FY21**	**Q2FY21**	**Q3FY21**	**Q4FY21**	**Q1FY22**	**Q2FY22**	**Q3FY22**	**Q4FY22**
SUD	100.0%	90.0%	66.7%	100%	88.9%	0.00%	100%		100%	
State SUD	96.4%	95.5%	94.1%	96.6%	94.1%	86.1%	97.7%	96.3%	97.9%	96.7%

Note: NorthCare found errors in the process and logic for PI4b which resulted in quarters 2 and 4 not reporting any detox discharges. Staff are working to identify proper training and logic changes to correct these issues.

Performance Indicator #10:

Emergency Services (ES) clinicians from across the region cover after hours crisis work when called out to the local hospital Emergency Departments. NorthCare and member CMHSPs continue to train and ensure clinicians document crisis alerts in the electronic health record to inform regional ES workers if there are specific interventions recommended or concerns to be aware of when an individual known to the CMHSP presents at the Emergency Department. Crisis alerts assist the ES worker in assuring the most appropriate level of service for each individual noting that readmission in some circumstances may be the most appropriate; crisis alerts are required when an individual is readmitted. There are processes in place for review of cases such as consultation with the Medical Director to determine if there were other options to divert the individual. There are also individuals who are readmitted due to new medications upon discharge or not following through with medications upon discharge which sometimes leads to readmission.

Indicator #10: The percentage of children and adults readmitted to an inpatient psychiatric unit w/in 30 days of discharge.										
MDHHS minimum threshold is 15% or less w/in 30 days.										
	Q3FY20	**Q4FY20**	**Q1FY21**	**Q2FY21**	**Q3FY21**	**Q4FY21**	**Q1FY22**	**Q2FY22**	**Q3FY22**	**Q4FY22**
Children	8.3%	10.0%	10.5%	5.3%	8.1%	13.8%	20.8%	10.0%	4.4%	15.0%
State Children	12.2%	10.2%	8.6%	8.6%	7.1%	7.4%	7.4%	7.1%	5.9%	8.9%
Adults	10.4%	15.5%	12.1%	14.0%	10.1%	12.9%	10.2%	12.4%	11.4%	12.5%
State Adults	17.0%	13.9%	13.0%	13.3%	12.3%	11.7%	11.3%	11.4%	11.7%	12.7%

Performance Indicator by CMH Compared to State Average - Recidivism								
	Quarter 1		Quarter 2		Quarter 3		Quarter 4	
	Adults	Children	Adults	Children	Adults	Children	Adults	Children
Copper	5.6%	0%	0%	0%	25%	0%	0%	33.3%
Gogebic	0%	0%	0%	NA	25%	0%	0%	0%
Hiawatha	15.8%	50%	23.5%	0%	8.7%	0%	19.2%	25%
Northpointe	11.1%	18.2%	0%	33.3%	10%	11.1%	19.0%	0%
Pathways	3.3%	0%	17.5%	3.0%	11.9%	0%	6.3%	16.7%
NorthCare	10.20%	20.80%	12.36%	10.00%	11.38%	4.35%	12.5%	15.0%
Statewide	11.37%	7.41%	11.35%	7.06%	11.67%	5.88%		
*Performance Indicator Report. Excludes those following up with other providers only, autism, OBRA, dual eligible, care/caid, transfers. Number of days calculated at 30 or less the event is considered a readmission.								

Performance Indicator #13 (Annual):

The PIHP is required to report the total number of complaints classified as Abuse Class I and II and Neglect Class I and II annually to MDHHS along with the number of these complaints that were substantiated. The following table illustrates the total number of complaints for all four categories along with the total number in all four categories that were substantiated. Although as a region NorthCare saw a 28% decrease in the number of recipient rights complaints for these four categories in FY21 as compared to FY20 and a 45% decrease in the number being substantiated, FY22 shows a substantial increase in both the number of complaints and the total number substantiated across the region over FY21.

Indicator #13: The annual number of substantiated recipient rights complaints in the categories of Abuse I and II and Neglect I and II per 1,000 persons served by CMHSPs.

	# Of Complaints			# Substantiated		
	FY20	**FY21**	**FY22**	**FY20**	**FY21**	**FY22**
NorthCare	39	28	55	20	11	24
Copper	9	9	11	4	5	1
Gogebic	0	2	0	0	0	0
Hiawatha	3	3	5	2	2	4
Northpointe	5	5	19	4	2	10
Pathways	22	9	20	10	2	9

Outcomes Management

Various committees and workgroups work on improving the quality of care and improving outcomes across the region. The regional and internal trauma informed committees (TIC) met throughout FY22. The NorthCare internal TIC worked on the Agency Self-Assessment, an assessment completed every 3 years to determine a general score of how trauma informed the agency is, as well as to identify ideas and solutions to improve overall performance. The Regional TIC committee is representative of CMHSP and SUD providers and discusses ideas and solutions, provides feedback to each other, and problem solves barriers impacting trauma informed care. The regional employment leadership team (RELT) has been working on a report to better capture data regarding how often a person is meeting their objective within their skill building program. This is an ongoing project that is almost finalized. Data has also been shared with the RELT committee, which is available online taken from BH-Teds data. Near the end of FY22, a Call-to-Action committee was formed. The goal of this committee is to address the Access process to reduce inefficiencies and improve access to care for individuals. This committee is comprised of CMHSP and NorthCare staff and in FY23 will pilot implementation of various ideas identified to potentially improve access to care.

MDHHS Performance Bonus Incentive Program

NorthCare's contract with the Michigan Department of Health and Human Services (MDHHS) includes contract withholds for a Performance Bonus Incentive Pool for all Michigan PIHPs. Contract withholds and the Performance Bonus Incentive Program have been established to support program initiatives specified in the MDHHS Medicaid Quality Strategy. Awards will be given to PIHPs according to criteria established by the State. Criteria for Performance Bonus awards will include, but is not limited to, assessment of performance in quality of care, access to care and administrative functions. Each year, the State will establish and communicate to the PIHPs the criteria and standards to be used for the performance bonus awards.

NorthCare is pleased to announce per MDHHS PBIP Consultation Draft that full withhold performance bonus was awarded for FY22.

NorthCare Network

CONSULTATION DRAFT

FY22 Performance Bonus Incentive Pool (PBIP)
Contractor-only and MHP/Contractor Joint Metrics
Deliverables/Narratives Scoring

This communication serves as the consultation draft review response to your PIHP regarding the FY2022 performance bonus, contract section 8.4.2.
Scoring is based on Contractor-only and MHP/Contractor Joint Metrics deliverables.

TOTAL WITHHOLD	TOTAL WITHHOLD UNEARNED
$965,369.34	$0

PIHP Only Metrics (45% of total withhold)

These metrics are: 1) Veteran Services Navigator data quality, 2) increase data sharing with other providers, 3) Initiation, engagement and treatment of alcohol and other drug dependence, and 4) increased participation in patient centered medical home narrative. Data analyzed for each of these metrics is delayed due to claims lag and availability of validated data in the CC360 data warehouse.

PBIP (P.1) – Improve and maintain data quality on BH_TEDS military and veteran fields

MDHHS acknowledges that not all Veterans interacted with by the Veteran Services Navigator (VSN) and reported with the VSN quarterly report will have a CMHSP contact. However, the intent of this measure is to improve and maintain data quality by monitoring and analyzing data discrepancies between the VSN reports and BH-TEDS data. The MDHHS/PIHP contract requires the PIHP to conduct a comparison analysis of data reported on the Veteran Services Navigator (VSN) reports and PIHP BH-TEDS data. This analysis is comparing the number of veterans who were referred to the VSN from NorthCare Access and CMH/SUD providers and the number of veterans who were referred to NorthCare Access and CMH/SUD providers by the VSN to the total number from that list with a BH-TEDS A, M, or Q record.

BH-TEDS and Access/CMH referral data shows a total of 61 veterans with a BH-TEDS A, M, or Q record during this reporting period (10/1/21-3/31/22). Of these 61, 28 show that they are enrolled in a veteran resource while eight veterans had contact with NorthCare's VSN during the reporting period. Six veterans were referred to the VSN by NorthCare Access and two additional veterans were referred by CMH.

VSN data provided for this report shows a total of nine veterans who were referred to the VSN during this reporting period. Six veterans were referred by NorthCare Access, two referred by CMH, and one referred by VSO. Eight of these veterans had a BH-TEDS A, M, or Q record during the reporting period. The VSN was unable to contact three of the nine veterans due to no answer/voicemail or no contact number provided. There were no veterans referred from the VSN to NorthCare Access or CMH/SUD providers.

Changes in Data:
Although the description of the measure is to maintain data quality on BH-TEDS military and veteran fields, it states under the deliverable column to "compare total number of individual veterans reported…" thereby omitting other military status fields. Therefore, numbers reported in the past have been corrected

in the table below to reflect those with a status of veteran only. Additionally, prior reporting periods did not include the BH-TEDS Q records, these were added during this reporting period as were the referrals from CMHs to the VSN.

	# Of Veterans Referred to Access and CMH by VSN	# Of Veterans eligible for CMH asmt and referred to VSN by Access	# Of Veterans eligible for CMH service referred to VSN by CMH	**Total # of Veterans eligible for CMH asmt and/or Srv referred to VSN by Access and CMH**	# Of Veterans eligible for asmt and/or CMH service on VSN list w/BH-TEDS data	% Of Veterans eligible for asmt and/or CMH services on VSN list w/BH-TEDS Data
10/1/20 – 3/31/21	0	8	NA	**NA**	5	62.5%
04/1/21 – 9/30/21	0	6	NA	**NA**	3	50.0%
10/1/21 – 3/31/22	0	6	2	**8**	7	87.5%

Denominator:
All individuals reported by the VSN who are identified as a "veteran" who have been referred to the VSN by Access and CMH and all individuals identified as a "veteran" who have been referred to Access and CMH by the VSN.

Numerator:
All individuals in the denominator who have a BH-TEDS admission during the reporting period.

The opportunities for improvement identified after analysis of data from the first remeasurement period (4/1/21 – 9/30/21) and action taken include the following.

1. Opportunity for Improvement
   Include the secure auto generated message to be triggered from the question, "Would you like to be referred to a Veteran Navigator" from the Access screening form.
   Not yet completed.
2. Opportunity for Improvement
   Develop tracking form and process to aid VSN in documenting referrals to and from the VSN as the State reporting form does not allow for the detail needed.
   Completed in January 2022.
3. Opportunity for Improvement
   With the question, "Would you like to be referred to a Veteran Navigator" added to the CMHSP or SUD TEDS data collection tools, as noted above, we are now able to easily capture referrals from the CMHSPs directly to the VSN. These will be included with the analysis of the second remeasurement period.
   CMH data is included in the 10/1/21-3/31/22 report data. We continue to work on SUD referral processes.

Opportunities for Improvement Identified with this reporting period.

1. Opportunity for Improvement
   Review referral processes from Access to VSN, from CMH to VSN, and from VSN to Access.
   Opportunity for Improvement
   Provide guidance to ensure BH-TEDS selections are consistent across our region.
2. Opportunity for Improvement
   Implement new tracking spreadsheet that will auto populate quarterly reports.

PBIP (P.2) – Increased data sharing with other providers

NorthCare network met the requirement to have at least one CMHSP within a PIHP's region, or the PIHP, to submit Admission, Discharge, and Transfer (ADT) messages to the Michigan Health Information Network (MiHIN) Electronic Data Interchange (EDI) pipeline daily by the end of FY21. In fact, all five member CMHSPs were live and sending ADTs as of 10/1/21.

All five Community Mental Health Service Providers (CMHSPs) are sending and receiving Admission, Discharge, and Transfer Records (ADT's) via MiHIN (Michigan Health Information Network). NorthCare is a party to both an ADT Use Case Agreement and Active Care Relationship (ACR) Use Case Agreement with MiHIN. Our Electronic Health Record, ELMER, is fully functional to send ADT's via MiHIN. NorthCare Network's five member CMHSP's were live and sending as of 10/1/2021.

NorthCare Network member CMHSP's send Admission and discharge records via MiHIN for our populations which are not subject to 42 CFR Part 2 regulations. Substance Use Disorder (SUD) records are not transferred. Records for all non-SUD ADT's are shared automatically via MiHIN under PA 559, or with a MDHHS 5515 consent to share information; or both. NorthCare Admission events are triggered when a Biopsychosocial assessment which indicates admission to CMHSP services is generated by a CMHSP provider. Discharge events are triggered when a Discharge Summary is created in ELMER. Northcare is not currently sending transfer records; however, transfer records are sent through the processes in the following paragraph.

In addition to the automatic processes, NorthCare Network shares a weekly data file of all inpatient psychiatric admissions via the CC360 Psych Discharge Upload feature. In addition, we send that spreadsheet file directly to our largest volume Medicaid Health Plan partner, Upper Peninsula Health Plan (UPHP). This data file is shared between designated NorthCare Network staff and two designated care coordination staff at UPHP. These efforts are in addition to the Integrated Care Team shared between NorthCare and UPHP addressing "super-utilizers."

Response to inbound ADT's:

CMHSP staff responses to incoming ADT's are monitored in NorthCare's Quality Assurance Performance Improvement plan as well as those persons receiving Integrated Care Team supports. NorthCare's Integrated Care Specialist and Population Health Specialist periodically assess the CMHSP staff utilization of ADT's and regularly find that CMHSP staff receive ADT's within 24 hours in the client screen of ELMER for each person served. CMHSP staff (case managers, nursing/medical services) utilize ADT's for care coordination with Emergency Departments, Primary Care Physicians, Community Resources, and with the individuals served themselves to address their whole-person health needs.

In addition to the individual person served ADT utilization; NorthCare Network Population Health Specialist staff monitor ADT's via CC360's "Plan Events" tool to inform population health and care coordination efforts within the PIHP system and with partner agencies/providers.

PBIP (P.3) Initiation, engagement and treatment of alcohol and other drug dependence

This measures the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) abuse or dependence who either initiated treatment for AOD or engaged in treatment for AOD. PHIPs were encouraged to track, trend and address statistically significant racial or ethnic groups within this data set. Claims and encounters from the MDHHS data warehouse and CC360 are used for this validation. The review is in progress at the time of this report. The intent of this measure for FY21 and FY22 is for data validation and is informational during both years.

Description: Percentage of Medicaid beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit. See here for full details: Measure Details (cms.gov)

Evaluation: The file MDHHS sent to us had 365 Indexed Episodes. In this, there were 142 (39%) that met the measure, and 223 (61%) that did not meet the measure.

Matching the Beneficiary Id with the Medicaid ID in our records using a mix of a SQL report for claims and the SUD Admissions report, our data was compared with what is in the data warehouse.

NorthCare had a Denominator of 329 Indexed Episodes. In this, there were 152 (46%) that met the measure, and 177 (54%) that did not meet the measure. Below is the charting of the analysis.

MDHHS Analysis		
Denom	**Yes**	**No**
365	142	223
%	39%	61%

NorthCare Analysis		
Denom	**Yes**	**No**
329	152	177
%	46%	54%

The Denominator was less for NorthCare because 36 of the Indexed Episodes were found to not have AOD and/or an admission or known to NorthCare, so that was noted back to MDHHS by marking D4 or D5.

There were more "Yes's" because some of the ones marked "No" by MDHHS were found to have the AOD treatments at before 14 days as well as 2 more within 34 days of initiation. There was a total of 18, and were all marked as N2, which means Numerator: Change result flag to 'yes' based on procedure, revenue, or other billing codes.

D4	33
D5	3
N2	18

PBIP P.4 Patient Centered Home Narrative

Each PIHP is to submit a qualitative narrative report that contains a summary of efforts, activities, and achievements of the PIHP/CMHSP's efforts in expanding participation in patient-centered medical homes (or characteristics thereof).

MEMO TO: MDHHS-BHDDA-Contracts-MGMT (MDHHS-BHDDA-Contrcts-MGMT@michigan.gov)
Ms. Jackie Sproat, Director
Division of Program Development, Consultation and Contracts
MDHHS Behavioral Health & Developmental Disabilities Administration

CC: Mr. Mike Bach, CEO Copper Country CMHSP; Ms. Melissa Hall, CEO Gogebic County CMHSP; Mr. Daniel McKinney, CEO Hiawatha Behavioral Health CMHSP; Ms. Jennifer

Cescolini, CEO Northpointe Behavioral Healthcare Systems CMHSP; Mr. Matt Maskart, CEO Pathways CMHSP

FROM: Dr. Tim Kangas, CEO NorthCare Network PIHP

DATE: November 15, 2022

RE: R1 NCN_FY2022 PIHP Performance Bonus Narrative Report – **Contractor-only Pay for Performance Measures** (October 1, 2021 – September 30, 2022; Due Date 11/15/22)

P.4. PA 107 of 2013 Sec. 105d (18): Increased participation in patient- centered medical homes (25% of total withhold)

NorthCare Network presents the following information which summarizes some of the highlights and achievements during FY2022 in the areas of increased participation in patient-centered medical homes. In addition to the narrative below, initiatives addressing NorthCare's partnership with the Medicaid Health Plan and joint care management noted in previous narratives continue and have expanded. If you have any questions or concerns, please contact me at your convenience.

Focused initiatives at the PIHP level over the past year include NorthCare's continued work addressing areas such as ensuring comprehensive patient-centered care, ensuring care coordination, development and implementation of health homes, and that services are accessible with quality and safety in mind. We also include under each heading below highlights of initiatives and work by Member CMHSPs.

NorthCare continues to work closely with the region's only Medicaid Health Plan, the Upper Peninsula Health Plan (UPHP), to coordinate and integrate services to shared adults who have a mental illness or co-occurring disorder comprised of 6,010 unduplicated individuals served in joint population health measures. NorthCare and UPHP continue to address the joint care protocols through data sharing with bi-monthly data meetings to share information from UPHP's HEDIS engine on antipsychotic medication adherence, anti-depressant medication adherence, follow-up after hospitalization for mental illness, follow-up after an emergency room visit for alcohol or other drugs or mental illness, annual dental screenings, and on multiple measures related to preventative or monitoring screenings for metabolic syndrome. In FY2022, 52 individuals were served by the high-utilization Integrated Care Team program jointly managed by NorthCare and
UPHP. NorthCare continues to work collaborative with the UPHP on metrics to monitor and address Hepatitis C (HCV) testing, diabetes screening, dental care, and follow-up to inpatient psychiatric hospitalization

The Opioid Health Home (OHH) model was implemented in Region 1 on October 1, 2019. OHH enrollment as of 9/30/2022 included 154 individuals from 13 of the 15 counties in the Upper Peninsula. During FY2022, providers experienced staffing shortages in all areas of programming. This impacted continuity of services and in some cases resulted in beneficiaries disenrolling from the program. With positions being filled later in the fiscal year, enrollment has begun to increase. NorthCare anticipates adding two additional OHH partners early in FY2023. Access to programming will increase in the eastern Upper Peninsula counties of Chippewa, Luce, Mackinac, and Schoolcraft. Total enrollments are anticipated to increase by 85-100 over the next fiscal year.

NorthCare Network is a participating lead entity in the Behavioral Health Home (BHH) Program implemented in Region 1, on October 1, 2020. This program is an evidence-based model for the delivery of comprehensive, patient-centered, fully coordinated whole person health care. The BHH model utilizes additional standards for coordination and care transitions, supports for integrating wellness into a person's daily life, and managing complex co-morbid conditions collaboratively with all health providers,

community resources, families, and social supports. NorthCare Network continued with 5 BHH Health Home Partners (HHPs), all of which are Member CMHSPs. Enrollment in FY2022 started at 28 individuals. Forty-two additional individuals were enrolled in the BHH program at the CMHSPs in FY2022. The total number of individuals served by the BHH in FY2022 is 70, with 3 disenrollments, resulting in a final FY2022 enrollment number of 67 unique individuals receiving BHH services as of 9/30/2022. NorthCare Network staff worked collaboratively with HHP lead staff via ongoing consultation and technical assistance and monthly meetings with all 5 HHPs. BHH services are provided in many locations beyond the HHP offices, including other physician offices, the person's home, community-based resources, and with family/social supports. The BHH program delivery was reviewed throughout the fiscal year to ensure that services were delivered in accordance with the model. Quality is assessed via client feedback, ongoing assessment of Body Mass Index Scores, PHQ-9 depression screenings, GAD-7 anxiety screenings, and other health screening/assessment tools based on the individual's specific needs. For example, a person working on a goal to reduce their hypertension would have regular blood pressure screenings, evidence of support for physical activity, dietary plans, and coordination with specialist/primary care physicians also working towards reduction of hypertension. All five Member CMHSPs have been found compliant with expectations of the BHH program and deficiencies are addressed on an ongoing basis. Challenges encountered during FY2022 with the BHH were related to low staffing ratios, difficulty in hiring/placing staff in the HHP BHH Coordinator Roles.

NorthCare Network and Network Providers responded quickly to changes brought about by the COVID-19 public health emergency and stay at home orders. NorthCare's priority from the start of the pandemic was to ensure behavioral health services could be provided while protecting the health and safety of individuals served as well as our staff who serve them. As the crisis continued throughout 2021 and 2022, NorthCare staff and our providers promptly addressed the challenges that arose. NorthCare continued to purchase and distribute Personal Protective Equipment (PPE) to our entire provider network. With the MDHHS expanding allowable services through telehealth technology, providers continue to deliver a broader array of services on a platform previously not allowed by Medicaid. NorthCare Network providers used technologies like Zoom and LifeSize prior to the pandemic, which supported our region in adapting quickly to this expansion of service delivery. Telehealth was, and continues to be, instrumental in helping providers and individuals served connect and receive services. This technology provides continuity for the individual to choose what they feel works best for their care and safety. Audio and video options have decreased transportation barriers and has increased choice for individuals engaged in services. Clinicians continue with new approaches and adapted practices to aide in providing services via telehealth options.

1. **Comprehensive Care:**
   Member CMHSPs and other network providers offer the full array of Medicaid behavioral health services either directly or through sub-contractors, which includes assessment and linking and coordinating with other appropriate providers within their organizations and their respective communities. Clinicians offer support and ensure continuity and comprehensive care by participating in psychiatric appointments as necessary, and coordinating with the individual, physician and other supports involved in their care. In addition to the traditional office and community-based treatment and support services, several support groups are offered such as DBT-related skills training; co-occurring support group; in-house AA meetings; AMAT Recovery and Schizophrenia Alliance group meetings are held.

   "Fit Together," is a grant-funded program in the Copper Country that connects consumers with area fitness opportunities, such as yoga, hiking, and kayaking. It also pays for and provides transportation to local gyms and links people to coaching on nutrition and healthy grocery shopping. They currently have 50 active consumers in this program. Fitness partners include UP Health System-Portage, Aspirus Keweenaw Hospital, and the Michigan Tech University Student

Development Center. Copper CMHSP's Training Institute offers prevention programs in several area schools, focusing on coping skills, building healthy relationships, and good nutrition. They have also developed menus for group homes, so that residents can choose from a variety of healthy options. Group home residents in the Houghton/Hancock area receive their primary care services from a physician contracted through Upper Great Lakes Family Health FQHC. This physician works closely with group home staff and Copper Country CMHSP nurses to ensure well-coordinated care for residents. This has been especially valuable as residents age and have higher medical needs. The physician provides services in the group home, as needed. Copper Country CMHSP currently has Youth and Adult peer support specialists and is trying to hire a Parent Support Partner. Copper CMHSP currently has fifteen people enrolled in the Behavioral Health Home (BHH) benefit. They have had success selecting people who receive services through their Community Treatment Team (CTT), made up of prescribers, case managers, a nurse, an Occupational Therapist, and an Employment Specialist. During weekly meetings, they discuss the progress and obstacles to success of people enrolled. The ACT team has enrolled consumers in the program and regularly discusses integrated health needs during daily team meetings. They plan to expand enrollment by focusing on other case management treatment teams and nursing teams. BHH services have helped people lose weight, increase physical activity, and manage chronic pain.

Gogebic CMHSP continues to offer comprehensive care to consumers through ongoing assessment and linking to appropriate providers and services in their organization and within the larger community. A continuum of supports and services for individuals and families are available at Gogebic CMHSP including prevention-direct services such as Infant Mental Health, screenings to help divert youth from entering the juvenile justice system through their Juvenile Justice Prevention program and community education offerings such as Mental Health First Aid along with direct care supports/services ranging from psychiatric services to intensive programming through Home-based or Assertive Community Treatment teams. Gogebic CMHSP joined the region as a Behavioral Health Home partner in 2020 and continues to encourage participation in this program. Gogebic CMHSP continues to offer co-located physician services for consumers in need of support to establish a relationship with a primary care physician. This physician is also available for consultation and support in cases where there are co-morbid health concerns that may impact a consumer's overall health and wellbeing and is identified as the Medical Consultant for Gogebic CMHSP's BHH Team. Gogebic CMHSP's Wellness and Anti-Stigma committees focus on providing increased awareness and education surrounding various health conditions and wellness activities through participation in community events, a monthly wellness information table in the main lobby and as a member of other community groups.

Hiawatha CMHSP staff regularly attend community comprehensive care meetings with a local hospital and some local planning body meetings are also attended monthly with community partners regarding housing and homelessness. Hiawatha CMHSP also continues to work on its Integration Plan that outlines comprehensive steps to improve holistic care through education of staff and individuals served, improving partnerships in the community, and creating focused indicators to measure improvement including increased outreach and collaborative efforts with primary care providers.

Pathways CMHSP participated in Health Fairs held at local colleges as well as the high school level to bring to light what a CMHSP is, how they can be accessed by the community members, and the variety of services that are provided. Points of emphasis were to reduce stigma and reinforce the importance of a "whole-person" approach to healthcare. They have improved our collaborative efforts with local hospitals to improve communication, transitions to a different level of care and efficiency of care. An educational presentation was provided to MD residents at UPHS on what mental health services were available in the community and how to refer individuals.

Northpointe CMHSP staff regularly attend community collaborative groups with local hospitals, Doctor's offices, ISD's, and other community agencies. In addition, some local planning body meetings are also attended regularly with community partners regarding a variety of community concerns regarding comprehensive care. Northpointe also continues to offer quarterly community huddles to allow for additional problem solving relating to care gaps within the community.

All Member CMHSPs continue to have representation at collaborative meetings with multi-purpose collaborative bodies and school districts to mitigate duplication of services and ensure collaboration among all entities serving the same communities.

2. **Patient-Centered**

From the first contact an individual has with NorthCare Network or a network provider, their needs, preferences, culture, and values are respected. This philosophy is the foundation of all services provided. The individual is the core member of their treatment team and the leader in the development of their Individual Plan of Service. The underlying spirit of our relationship with the consumer is a motivational interviewing communication style that emphasizes collaboration, acceptance, and exploring the person's own reasons for change. We focus on the whole person utilizing person-centered planning and a family-driven and youth guided approach where individuals, guardians & families are core members of their care team. We believe in transparency and involve the individual served in determining the types of supports and services they may need to accomplish their goals which may include transition to or from an inpatient stay or to a community provider. Individuals served also provide feedback on services and programs by completing satisfaction surveys and through membership on the Consumer Advisory Committees, Recipients Rights Advisory Committees, Trauma Committees, Regional Member Services Committees, and CMHSP/PIHP Boards of Directors.

For those individuals and families receiving services at Gogebic CMHSP staff review the importance of preventative services including annual physicals, available immunizations, proper nutrition and can offer education and support with the assistance of our Integrated Care Coordinator and agency RNs. Staff also provide support to individuals during medical or other specialty health visits, as appropriate.

Hiawatha CMHSP continues to monitor a performance initiative to have 95% of individuals prescribed psychotropic medications by their CMHSP psychiatrist receive A1C testing at least annually. Hiawatha CMHSP also monitors tardive screening for individuals prescribed psychotropic medications and conducts regular screenings during psychiatric appointments. Hiawatha CMHSP continues to monitor the initiative, introduced in FY2021, to improve the percentage of utilization of authorized services. They have realized a significant increased enrollment in ABA services and are exploring options for off-site services for the ABA program.

Pathways and Northpointe CMHSPs continue to focus on patient centered practices, emphasizing an individual's choice in the services they receive and the way that they receive them. As we have been able to offer services in-person, virtually, and by phone we stress the individual's choice in what they identify will work best for them. Jail Diversion liaisons work with local law enforcement on education, coordination, and identification of behavioral health needs in the community.

Northpointe currently offers telehealth services, emphasizing an individual's choice in the services they receive and the way that they receive them. Jail therapists work with local law enforcement on education, coordination, and identification of behavioral health needs in the community in addition to providing in person and telehealth therapy as requested.

NorthCare Network continues to focus on improvement of its culture and practices to conform with Trauma Informed Practices. This has resulted in changes in policy and practices and continues to be a primary focus.

3. **Coordinated Care**

NorthCare Network policy requires that all persons served by network providers receive coordinated care across all systems of care the person utilizes. Network providers must coordinate an individual's care with their primary care physician, specialist physicians, community services and supports, medical facilities, and with the individual's health care payer which includes NorthCare Network, Medicaid Health Plans (MHP), and the Michigan Department of Health and Human Services (MDHHS). Coordinated care is necessary to ensure that persons served receive holistic and effective care to enhance recovery across all domains of an individual's life. The Person-Centered Planning Process is required to identify care coordination needs. The Individual Plan of Service (IPOS) must document the goals and objectives of the consumer, incorporate physical and social domain of health goals, and outline the coordination plan to address health and safety concerns or document consumer refusal. If a person served chooses not to incorporate physical health goals, this must be documented in the individual's record.

NorthCare Network has initiated regional Population Health (PH) Programming. Public health programs include the utilization of the MDHHS Care Connect 360 Platform, UPHP-NorthCare Share Tableau Database, MDHHS WSA, and a Data/PH workgroup with UPHP and NorthCare participating and developing PH initiatives. UPHP and NorthCare continue to address anti-depressant medication adherence and gaps in dental care. Other existing initiatives at NorthCare, some which are coordinated with UPHP, are metabolic monitoring for individuals prescribed psychotropic medications, follow-up after emergency room visit for mental illness or substance abuse, diabetes screening and prevention, hypertension, hyperlipidemia, and obesity. Individuals served with these conditions are monitored using the CMS Core Measure Set and evidence-based recommended interventions are applied via notification of care gaps by NorthCare's Integrated Care Specialist to the CMHSP liaisons for PH initiatives. NorthCare Network shares information on a case-by-case basis to the respective network provider about the treating primary care physician and specialists involved in an individual's care as identified in the MDHHS Care Connect 360 platform/data warehouse. For individuals who receive NorthCare-UPHP Integrated Care Team supports, physical health care is coordinated with the Medicaid Health Plan, UPHP, at least monthly; UPHP provides information on physical health interventions/referrals/specialty care and NorthCare provides information on behavioral health care, treatment recommendations, and treatment progress. The Access Screening asks for the primary care physician information. If a primary care physician is not identified, upon the initial BPS/intake at the CMHSP, the CMHSP requests the individual sign a consent to share behavioral health information to coordinate with the MHP to secure a primary care physician for the individual. Records from other providers are requested by the CMHSP and entered into the individual's record. Member CMHSPs work with individuals served and educate on the importance of care coordination with their primary care physician (PCP). Clinicians will also assist individuals in contacting the UPHP for assistance in finding a PCP if they don't already have one. Staff coordinate with all active providers and other agencies working with the individual such as medical specialists, hospitals, home health, and nursing homes. Staff work closely with the Medicaid Health Plan (UPHP) Care Coordinators regarding individuals served by both the PIHP/CMHSP and UPHP as well as those enrolled in the MI Health Link program.

Copper CMHSP's Clubhouse assists members in setting up doctor's appointments and they have a wellness committee that provides healthy lunch options each day. The Assertive Community Treatment (ACT) Team assists consumers with making medical appointments and with transportation, and they deliver both physical and psychiatric medications. ACT provides information on healthy shopping, the importance of exercise, smoking cessation, and medication

adherence. Our Community Support Program provides transportation to medical appointments and labs.

Hiawatha CMHSP meets with War Memorial Behavioral Health Center providers and social workers on a regular basis to ensure processes are working and mutually served individuals are receiving the care needed. CMHSP staff provide training and consultation for medical staff in local Emergency Departments and Acute Care settings regarding behavioral health emergency services. Pre-admission screenings are conducted by local CMHSP staff and in one area the local Emergency Department provides support to conduct these via telehealth.

Northpointe's BHH program continues to expand, enroll additional individuals, assist individuals in setting up doctor's appointments, provides transportation to medical appointments and labs. The Intensive Adult Services Team and the Adult ICSS Team also assist individuals with making medical appointments and with transportation while utilizing RNs to monitor healthcare goals.

4. **Accessible Services**

It is the policy of NorthCare Network to recognize the diversity in the population of its service area along a number of dimensions including, but not limited to ethnicity, gender, age, language proficiency, socioeconomics, spiritual beliefs, and physical and communication challenges. Providers and staff must be sensitive to and appreciate how important accommodation is to effective service delivery. Creating an atmosphere of welcoming, openness and equal opportunity requires a physical environment designed to eliminate potential barriers; ongoing staff training regarding the assessment of the need for accommodations; and the actual implementation of necessary modifications.

NorthCare Network continues to operate a centralized access system that provides prompt, responsive, timely and easy access to specialty services and supports for all beneficiaries.
The Access Unit functions as the front door for obtaining behavioral health services and the staff provide an opportunity for callers with perceived problems resulting from trauma, crisis, or problems with functioning to be heard, understood, and are provided with options including treatment and provider options. The Access Unit is available, accessible, and welcoming to all individuals on the telephone and a walk-in basis. All Michigan residents are assisted when contacting the Access Unit. Individuals presenting with real and imminent danger to self or others and/or require immediate diagnosis and treatment are considered an emergent situation and are immediately transferred to a qualified provider without requiring an individual to call back. Upon determination that a caller is eligible for PIHP services an appointment is scheduled directly with a Member CMHSP or a warm transfer is made for Substance Use Disorder (SUD) specialty services. Individuals may present directly to a SUD provider for outpatient treatment. Access to emergency services guarantees assistance 24 hours a day, 7 days a week for crisis support and referral. All Member CMHSPs offer telehealth services.
During the pandemic, providers assisted people who wanted to attend their medication appointments via video, but had technology challenges, by bringing them iPads to use for the appointment. NorthCare Network also provided phone cards to people who needed them.

The use of telehealth continues across Region 1 and people are more comfortable providing, and receiving, services via this method. Individuals' preferences regarding the delivery of medically necessary services, including the method of delivery, are discussed on an ongoing basis. Accommodation to meet outside business hours is also made when appropriate. NorthCare Network Providers are able to offer individuals served, families, staff, and community members access to myStrength, which gives them access to digital behavioral health support from wherever they have access to the internet 24 hours-day.

Gogebic CMHSP currently offers telehealth services up to 10 days per month (2-3 days per week) which allows staff, consumers & families increased access to specialty providers, as applicable and appropriate.

Hiawatha CMHSP has a new contract in place for Infant Mental Health Services for Schoolcraft, Mackinac and Chippewa Counties. They have also implemented an "engagement committee" that will review current processes and implement changes to make services more user friendly. This has resulted in the "follow protocol" intended to improve accessibility to services.

Northpointe currently offers telehealth services for Case Management, Emergency Services, ICSS for adults and children, Psychiatric appointments, Homebased services, Individual, Family, and Group therapy, Peer Support, and Psychological Services as clinically appropriate and medically necessary to all individual's served.
Pathways CMHSP's ACT EARLY program census has reached its maximum of 5 individuals. The ACT EARLY team coordinates with local doctors' offices, hospitals, and providers. The program is focused on bringing young people (ages 18-30) with first-episode psychosis into treatment. The outcomes and advantages of starting treatment as early as possible after symptom onset include such benefits as higher functioning with more days spent in school or at work, fewer hospitalizations, better treatment adherence, greater improvement in symptoms, and higher social functioning. For the Pathways ACT EARLY program, the biggest success is that many participants are maintaining steady employment.

5. **Quality & Safety**

NorthCare Network continues to work with network providers to ensure quality and safety through various regional and internal committees such as Quality Management and Oversight, Health and Safety, Utilization Management, Regional Clinical Practices/QI, and Regional ELMER Management. NorthCare's Member CMHSPs utilize a regional EHR as well as an electronic reporting module for all incident reporting that provides the ability for NorthCare's Clinical Practices Coordinator to review, track and trend incidents and ensure accurate reporting of critical incidents to MDHHS. Data from CareConnect 360 is utilized to address issues around social determinants and population health, focusing on high utilizers of both medical and behavioral health services. Several evidence-based practices have been implemented across the region including, but not limited to: Eye Movement Desensitization and Reprocessing (EMDR), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Seeking Safety group, Family Psychoeducation (FPE), Motivational Interviewing (MI), Parent Management Training-Oregon Model (PMTO), Applied Behavioral Analysis (ABA), Integrated Dual Disorder Treatment (IDDT), and Assertive Community Treatment (ACT). Clubhouses across the region have been accredited or are in the accreditation process by Clubhouse International. Annual consumer satisfaction surveys are conducted with data and suggestions for improvement addressed at the local level and aggregate data reviewed at the PIHP level. NorthCare continues to see high levels of satisfaction across our region. Any specific feedback from survey respondents is shared with the applicable programs. When requested, individuals served are contacted regarding the concerns expressed in the surveys. NorthCare's Quality Improvement (QI) program provides ongoing mechanisms that objectively and systematically monitor, evaluate, and improve the quality and appropriateness of network services. The QI Work Plan addresses areas for improvement in response to federal, State, and regional audits and identified areas for improvement, which include but is not limited to accessibility to services, behavioral treatment, consumer satisfaction, and credentialing. Incident reports are evaluated on a regular basis by recipient rights, clinical practices, and QI staff to look for trends or issues that require systemic interventions.

In 2020 Gogebic CMHSP created a new Medication Distribution Specialist position as part of our Community Living Support services. The Medication Distribution Specialist/Community Living Supports Technician primarily supports consumers (adults and children) who live in various

community settings and have been determined to need assistance with medication support by their treating CMH physician. The supervising RN works with the MD and the individual to evaluate and identify medication support/management needs including prescription renewal requests, education surrounding medications and medication adherence based on diagnosis and any other needs regarding medications identified during ongoing assessment and person-centered planning and is an integral part of a consumer's support team. The goal of this program is to support a transition to independence for those who are able. Gogebic CMHA is CARF accredited and measures outcomes on a quarterly basis.

Hiawatha CMHSP has implemented a process where peers reach out to persons served to guide and encourage responding to survey questions. They have also developed a comprehensive COFID Response Plan to assure provision of ongoing services while maintaining safety controls. Along with this, staff conducted regular and thorough outreach to determine the comfort and safety of the best service mode for consumers based on their preference and level of susceptibility. Staff training and performance evaluations have been revised and enhanced to be more trauma UM focused. Staff attend weekly meetings to monitor MiCAL performance to assure prompt and thorough crisis response efforts are maintained. Hiawatha has been working closely with NorthCare's Veteran Navigator to ensure comprehensive services for all veterans who meet eligibility criteria, addressing individual needs on a case-by-case basis.

Joint Metrics

To ensure collaboration and integration between the Medicaid Health Plans (MHPs) and the PIHPs, MDHHS has develop joint expectations for both entities. Three joint metrics were applicable in FY21 and continued in FY22. They are: 1) implementation of joint care plans for shared members, 2) follow-up after hospitalization for mental illness within 30 days of discharge, and 3) follow-up after emergency department visit for alcohol and other drug dependence. Joint metrics allow for earing up to 30% of the withhold.

J.1 Implementation of Joint Care Management Processes

In FY22, 6,010 (compared to 5,203 last year) mutually enrolled adults with mental illness and/or co-occurring disorders received joint care management supports from NorthCare Network and our regional Medicaid Health Plan in population health initiatives including: annual dental care, metabolic syndrome (Obesity, High Blood Pressure, Diabetes) monitoring and treatment, diabetes prevention and monitoring, preventative/early detection cancer screenings, COPD/Asthma spirometry testing, Hepatitis C testing and treatment, and transition of care planning/coordination. Supports for some of these initiatives, especially addressing metabolic syndrome, are also offered to individuals who are enrolled in straight/fee-for-service Medicaid without a health plan.

Individuals with a high service utilization that includes emergency department visits are addressed in a comprehensive Integrated Care Team managed jointly by NorthCare Network and the Medicaid Health Plan. In FY22, 52 (56 last year) individuals had an open joint care plan in Care Connect 360. NorthCare also incorporates a weekly review of people who have been hospitalized for mental illness for inclusion in the Integrated Care Team intervention.

While there was a decrease in the total integrated care plans from FY21 to FY22; NorthCare is still well above MDHHS's expectations for penetration for that intervention; and uses looser criteria (3 ED visits in the prior 6 months instead of 5; 2 chronic conditions instead of 3) to capture more people who could benefit from the Integrated Care Plan.

The total SMI population served by the PIHP with population health interventions (beyond those with the Medicaid Health Plan); for FY21 that was 6,892; and in FY22 was 6,367 from Diver data.

J.2 (a) Follow-Up after Hospitalization for Mental Illness - Adult (30 days)

NorthCare incorporates a weekly review of people who have been hospitalized for mental illness for inclusion in the Integrated Care Team intervention.

This metric measures the percentage of discharges for enrollees aged 21-64 who are hospitalized for treatment of a selected mental illness diagnosis, and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge. The data source is the MDHHS data warehouse. For this measure, the Event Date is the Discharge Date. MHP/PIHP pairs with a denominator of less than 30 are not counted in the final rate.

Adults	NorthCare	State	NorthCare*	State*
	FY21	FY21	FY22	FY22
Medicaid	75.11%	65.70%	76.80%	63.51%
Medicaid White Population	75.20%	69.75%	77.03%	67.80%
Medicaid American Native/Alaska Native	72.60%	68.37%	73.68%	64.01%

**Data is for 12-month period ending 6/30/22.*

J.2 (b) Follow-Up after Hospitalization for Mental Illness – Child (30 Days)

This metric measures the percentage of discharges for enrollees aged 6-20 who are hospitalized for treatment of a selected mental illness diagnosis, and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge. The data source is the MDHHS data warehouse. For this measure, the Event Date is the Discharge Date. MHP/PIHP pairs with a denominator of less than 30 are not counted in the final rate.

Children	NorthCare	State	NorthCare*	State*
	FY21	FY21	FY22	FY22
Medicaid	88.66%	85.31%	91.36%	82.09%
Medicaid White Population	87.50%	87.47%	92.06%	84.28%
Medicaid American Native/Alaska Native	92.31%	85.53%	92.31%	89.06%

**Data is for 12-month period ending 6/30/22.*

NOTE: According to www.census.gov/quickfacts/table, Michigan's total population of American Indian/Alaskan Native (AI/AN) individuals is 1%. NorthCare's largest diverse group is the AI/AN population, comprising 5.54% of the total population. We continue to monitor with a goal to eliminate any noted disparities among these two primary populations across the region.

J.3 Follow-up within 30 days after ED visit for AOD

This metric measures the patient(s) 13 years and older with an ED visit for alcohol and other drug dependence that had a follow-up visit within 30 days. The data source is the MDHHS data warehouse. For this measure, the Event Date is the Date of the ED visit. MHP/PIHP pairs with a denominator of less than 30 are not counted in the final rate.

Individuals 13 years and older	NorthCare	State	NorthCare*	State*
	FY21	FY21	FY22	FY22
Medicaid	45.05%	27.65%	31.39%	24.09%

Medicaid White Population	42.14%	33.17%	30.64%	27.83%
Medicaid American Native/Alaska Native	57.35%	35.87%	32.00%	25.90%

**Data is for 12-month period ending 6/30/22.*

Clinical Practice Guidelines

NorthCare Network adopts the Clinical Practice Guidelines (CPGs) issued by MDHHS as stated in NorthCare Network's Clinical Practices policy. These guidelines, in addition to the Substance Use Disorder (SUD) operations manual, and other guidelines and resources, are made available on NorthCare Network's website at NorthCare Network Clinical Practices Guideline Manual. In FY22, each Clinical Practice and Quality Improvement quarterly committee meeting presented the opportunity to propose additions or changes to the CPGs. The guidelines were sent to each Community Mental Health Service Provider (CMHSP) clinical lead and regional Learning Management System administrators on July 12, 2022, informing them that the CPGs were available on NorthCare's website. Information was provided to the SUD Providers on July 14, 2022 at the regional SUD provider meeting. SUD providers primary resource for practice guidelines is the SUD Operations Manual, also found on NorthCare's website, however some practice guidelines pertain to co-occurring individuals.

The CPGs are updated as identified at the quarterly meetings. There were updates in July 2022, adding the MDHHS guideline of Personal Care in Non-Specialized Home Guideline. Additionally, a pre and postvention section was added to address suicide. Forms for waiver services were updated and made available on the website.

Substance Use Disorder (SUD) Providers have access to the NorthCare SUD Operations Manual located at www.northcarenetwork.org. which adopts the clinical practice guidelines issued by MDHHS, found at MDHHS - Policies and Advisories (michigan.gov) under Polices and Advisories. The purpose of this Operations Manual is to outline the basic framework for NorthCare Network SUD processes. The NorthCare Network SUD Services Operations Manual is incorporated by reference as part of the Provider Contract agreement. As updates, clarifications, and changes are made to our Master Contracts or the Medicaid Provider Manual, this SUD Operations Manual will also be updated, and our SUD Provider Network will be notified in writing. Additionally, the SUD Operations Manual is updated on at least an annual basis and the link for this is given in writing to our SUD Provider Network. The SUD Providers in FY22 also completed attestations which included language that they were aware of how to locate the NorthCare SUD Operations Manual and that all staff are required to review all sections pertinent to their position. Attestations are required to be completed annually by Provider Network leadership and returned to NorthCare's Provider Network Specialist. NorthCare also supports our SUD Provider Network by facilitating a quarterly Regional Clinical meeting where new policies are introduced and reviewed, as well as any updates to MDHHS and NorthCare existing policies/procedures. This forum is also used to provide technical support as needed and provide clinical direction to the region.

NorthCare Network had a waiver to conduct the annual site review in FY22; and are having the site review mid-year in FY23. SUD providers are also, as of FY21, required to administer to clients a Trauma Informed Screening tool to identify clients and appropriately refer and provide treatment suited to condition. As a region, NorthCare has initiated a cross-disciplinary Trauma Informed Committee to ensure that our provider network operates as a Trauma Informed and Responsive System of Care. Additionally, within NorthCare there is an internal trauma informed workgroup to ensure promotion of trauma informed care within the network.

As part of MDHHS' required use of one standardized, validated, SUD assessment tool across the State of Michigan, NorthCare Network continues to develop practice guidelines for the ASAM Continuum

assessment tool and provide ongoing training and technical assistance to our providers for ASAM related issues.

On October 1, 2019, NorthCare Network, along with other PIHP regions across the State, launched the Opioid Health Home (OHH) initiative with the Behavioral Health Home (BHH) initiatives starting October 1, 2010. NorthCare began identifying and enrolling Medicaid recipients that have a qualifying diagnosis of Serious Mental Illness (SMI), Severe Emotional Disturbance (SED), or Intellectual/Development Disability (ID/DD) for BHHs, and Medicaid recipients with a qualifying Opioid Use Disorder (OUD) for OHHs. Both programs offer incentive payments to HH providers for the provision of this enhanced level of service which focuses on care integration/coordination amongst all the client's health care providers as it relates to promoting, improving, and maintaining the health of these vulnerable populations. Regularly scheduled meetings are conducted internally, externally with HH Providers (HHPs), and at the State level (MDHHS) during which policies/procedures are reviewed, barriers to enrollment or treatment are discussed for problem solving, etc. NorthCare's development of policies/procedures continues on an ongoing basis as guided by MDHHS and the OHH and BHH handbooks.

Verification of the Delivery of Medicaid Services

The Medicaid Service Verification for FY22 was completed 12/27/22.

NorthCare Network is pleased to present this report outlining the methodologies used and the outcome of the FY22 Medicaid Service Verification.

I. Methodology

Sampling Methodology - Statistically sound sampling methodology, in accordance with OIG standards, were used to determine sampling. Separate sampling and verification was performed for each provider paid via a sub-capitation arrangement and any other provider that represent more than 25% of all claims/encounters in either unit volume or dollar value, whether direct contract of the PIHP or sub-contracted through a Member CMHSP. Separate sampling and verification were conducted for claims and encounters generated by provider staff and claims, and encounters generated through subcontractors of the Member CMHSP. This resulted in five (5) extracts, one for each Member CMHSP SAL (Service Activity Log) data (which represents the internal staff encounters); five (5) extracts of the Member CMHSP claims data (subcontractors); and one (1) extract for the SUD provider claims data. Each of these extracts (11 files in total) contained a list of all claims and SALs for the period where a random number was generated and applied. The extract was sorted on this random number with the top 10 claims and top 10 SALs selected as the probe sample. This service verification is conducted on a quarterly basis.

Probe samples of 10 claims and 10 encounters are to be examined per extract. An over sample of 5 claims and 5 encounters was included with each extract to assure a total of 10 per extract were reviewed. The minimum sample sizes used in the probe sample for this annual analysis meets the OIG requirement of 90% confidence level at 25% precision so there was no need to pull a larger sample to ensure validity of the sample.

II. Staff Qualifications and Disclosure

Staff determined qualified for data analytics included individuals who have had training and/or professional experience in the areas of billing/coding, finance, compliance, analytics, and/or auditing. Staff qualified for the validation of the clinical record included licensed staff who are clinically trained in the health care and/or human service field. One Licensed Masters Social Worker (LMSW) (serves as consultant) and one Bachelor Level staff along with compliance and billing staff reviewed clinical and billing records associated with the claims and encounters selected. Staff assigned service verification responsibilities did not identify or disclose any

potential or known conflicts of interest regarding any provider of services being verified.

III. Data Analytics – Testing of claims/encounters to determine validity.

Encounter service data for the five Member CMHSP's is consolidated into a Data Model with discrete dimensions that allow quick analysis of the data. This data model was used to evaluate the duplicate threshold of a selected list of HCSPCS codes. The dimension of one HCSPCS code was selected, then the consumers Medical Record number (unduplicated in the region) was added as well as the date of service. The total unit summary column was then sorted from high-low to identify the largest number of units per day. For the per year threshold, the data was also viewed without the date to see the yearly total of units.

Service data was analyzed for the duplicate threshold of units reported for the codes noted below. All served consumers were analyzed for this metric, ignoring Medicaid eligibility. As duplicate thresholds are no longer indicated on the MDHHS's updated code chart, the thresholds used in Fiscal Year 2021 data mining activities were used to complete this analysis.

In summary, a total of approximately 5,017 consumers who received at least one of the services listed below were reviewed with 4,647 or 93% of them being covered by Medicaid. The data mining is performed on a data model of services reported that is updated daily; since the total of consumers was calculated after the final data mining exercise was performed for the year; thus the number of consumers total is a point-in-time estimate. Approximately 473,707 unique combinations of consumer Medical Record number, service code, and service date dimensions were included in the per day duplicate threshold analysis. 1,085 unique combinations of consumer Medical Record number and service code dimensions were included in the per year duplicate threshold analysis. Service codes reviewed include, H0039 (excluding H0039 TG), H2015, H2016, H2014, T1020, H2030, T1017, and H2011. Codes were selected based on the unit volume and potential for issues with the H2011 when the service spans past midnight. Results of this data mining activity indicate a high rate of compliance and are reported on quarterly Program Integrity reporting to MDHHS-OIG.

IV. Clinical Record Validation – Testing of claims/encounters against clinical records.

Testing data elements from individual claims/encounters were validated against clinical records. Review of the following data was included in this validation.

1. Code is approved under the PIHP/MDHHS contract,
2. Eligibility of the beneficiary on the date of service,
3. Service is included in the beneficiaries' individual plan of service,
4. Date and time of the service,
5. Service was provided by a qualified practitioner,
6. Service falls within the scope of the code billed/paid,
7. Amount billed does not exceed the payer (PIHP/CMHSP) contracted amount, and
8. Amount paid does not exceed the payer (PIHP/CMHSP) contracted amount.

The electronic health and billing records (ELMER) is the source used to conduct the Medicaid service verification for mental health claims and paper records were reviewed for the SUD providers with the exception of one SUD provider who grants access to NorthCare staff to their EHR for this review. NorthCare Network Member CMHSPs and most other providers use a consistent electronic claims/encounter system.

V. Scoring, Corrective Action and Recoupment

It is NorthCare's expectation that all claims/encounters are in full compliance with testing methodologies. All claims/encounters found to be invalid must be appropriately addressed. A written corrective action plan is required from each provider scoring below 95% for any one of the eight elements listed in Section IV of this report. This corrective action plan is due to NorthCare

within 30 days of receiving the service verification report.

VI. Documentation and Provider Reports

All NorthCare documentation supporting the verification process is filed electronically for seven years. Results of Medicaid service verification will be communicated to each provider CEO or designee, via a written Medicaid Service Verification report no later than 30 days after completion of all verification activities. Reports will include a summary detailing the overall review process and findings; detail pertaining to claims/encounters reviewed; recommendations, as applicable, pertaining to any finding that will require corrective action for claims/encounters that are found not to be in compliance; and time frames for corrective action and any follow-up activities. A summary of findings shall be shared with NorthCare's Board of Directors, Performance Management Committee, Compliance Oversight and Risk Management Committee, Quality Management Committee and other NorthCare committees as appropriate. NorthCare Network did not identify any suspected fraud, waste or abuse during this Medicaid Service Verification.

VII. Summary of Results

1. Population of Providers Surveyed – Five-member CMHSPs, sub-contract providers, and SUD licensed sites representing services such as: Supported Employment, Skill Building, Personal Care, Community Living Supports, Therapy/Counseling, Clubhouse, Overnight Health and Safety, Fiscal Intermediary, Home-based, Targeted Case Management, ABA, ACT, SUD services, and Respite were randomly selected for review.
2. Number of Providers Tested – A total of 58 unduplicated sub-contract services providers, 67 unique CMHSP programs, and 10 unique SUD licensed sites were reviewed as part of this verification.
3. Number of Providers Put on Corrective Action Plans – As a result of this verification, NorthCare is not requiring a formal corrective action plan from any provider at this time. Ongoing monitoring will ensure issues identified are addressed. Systemic issues identified will be addressed at the regional level.
4. Number of Providers on Corrective Action Plans for Repeat/Continuing Issues – There are no Providers on corrective action plans for repeat or continuing issues.
5. Number of Providers Taken Off Corrective Action Plans –There were no providers on corrective actions plans specific to FY21 Medicaid Service Verification activities.
6. Population of Claims/Encounters Tested (units & dollar value) – Both Service Activity Logs (SALs) and claims were tested for each Member CMHSP, including their sub-contractors who had claims/encounters selected via the random selection process. All SUD treatment providers were also grouped for a random selection of claims reviewed.
7. Claims/Encounters tested (units & dollar value) – A total of 2,462 units of service with a total charge amount of $117,798.47 were tested. Per this methodology a total of 440 claims/SALs should be tested per year, however due to staffing issues it is important to note that NorthCare tested 331 claims/SALs or 75.2% of this total in FY22.
8. Invalid Claims/Encounters Identified (units & dollar value) – Of the 331 claims/SALs tested during this verification process, 100% were found to be valid per this methodology.

5. Improvement Strategies

Performance Improvement Projects

Performance Improvement Project #1:

Goal: *To increase the percentage of enrollees ages six (6) and older, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within seven (7) days after discharge.*

NorthCare measures this goal by two populations: ages six to twenty years old and for enrollees ages twenty-one and older. The numerator and denominator are calculated based on claims data provided by the Michigan Department of Health and Human Services (MDHHS). This PIP project is validated by the External Quality Review Organization under contract with MDHHS, HSAG (Health Services Advisory Group). This year completed the validation cycle for this project which did not receive a full validation due to not achieving a statistically significant improvement over baseline. As displayed in the tables below, the denominator for both remeasurement one and remeasurement two has continually decreased. It is likely that the sizeable reduction in the denominator experienced in remeasurement period two (CY2020) for both populations is largely due to the COVID-19 public health emergency and lock downs. Calendar year 2021 is a new baseline year due additional CPT codes being added that count as 7-day follow up for our purposes. Calendar year 2022 data is not yet available due to claims lag.

Study Indicator 1 Title: The Percentage of discharged for enrollees ages six (6) to 20 years, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within seven (7) days of discharge.

Time Period Measurement Covers	Indicator Measurement	Numerator	Denominator	Rate or Results	Goal
01/01/2018 – 12/01/2018	***Baseline***	93	142	65.49%	
01/01/2019 – 12/01/2019	**Remeasurement 1**	64	104	61.53%	75.28%
01/01/2020 - 12/01/2020	**Remeasurement 2**	51	80	63.75%	77.88%
01/01/2021 - 12/01/2021	**Baseline 2**	94	162	58.02%	
01/01/2022 - 12/01/2022	**Remeasurement 2.1**				

Study Indicator 2 Title: The Percentage of discharged for enrollees aged 21 and older, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within seven (7) days of discharge.

Time Period Measurement Covers	Indicator Measurement	Numerator	Denominator	Rate or Results	Goal
01/01/2018 – 12/01/2018	***Baseline***	328	544	60.29%	
01/01/2019 – 12/01/2019	**Remeasurement 1**	321	518	61.96%	61.98%
01/01/2020 - 12/01/2020	**Remeasurement 2**	225	368	61.14%	66.40%
01/01/2021 - 12/01/2021	**Baseline 2**	317	606	52.31%	
01/01/2022 - 12/01/2022	**Remeasurement 2.1**				

HSAG's validation report was not met due to not having a statistically significant improvement. "*The Follow-up After Hospitalization for Mental Illness Within Seven Days of Discharge for Members Ages 6 Years and Older PIP received a Met validation score for 90 percent of critical evaluation elements, 90 percent for the overall evaluation elements across all steps validated, and a Not Met validation status. The PIHP developed a methodologically sound improvement project. The PIHP collected and reported accurate study indicator results using systematic data collection process and conducted appropriate statistical testing for comparison between measurement periods. The causal/barrier analysis process included the use of appropriate quality improvement tools in the identification and prioritization of barriers. Although the PIHP implemented timely interventions, the PIHP was unsuccessful in achieving statistically significant improvement over the baseline performance for the second remeasurement period for each study indicator resulting in a Not Met validation status.*"

NorthCare updated the PIP at the end of 2021 to include T1017, H0031 and H0032, with the termination of the Relias report.

Performance Improvement Project #2:

Goal: *To increase the number of individuals who receive services for at least 90 days after initial assessment indicates eligibility for specialty mental health services.*

All Medicaid individuals discharged within 90 days of initial assessment where it is determined the individual meets medical necessity criteria for specialty mental health services and supports are included in the numerator. All individuals approved for ongoing specialty mental health services and supports are included in the denominator.

This study has the potential to improve the health, functional status or satisfaction of individuals meeting criteria for specialty mental health services and supports because of the of the importance of engaging this population in care. If these individuals do not participate in needed treatment for their severe mental illness, intellectual/developmental disability or severe emotional disturbance, there is an increased likelihood of ineffective treatment and a decreased quality of life.

The National Alliance on Mental Illness (NAMI) reports that 70% of persons seeking mental health services drop out within the first or second visit. NorthCare is responsible to ensure services are available to individuals who meet criteria for specialty mental health services. If the consumers can be engaged into services, they should receive needed mental health services and have a better quality of life.

From 10/01/20 to 9/30/21 the goal was to improve from the last measurement period measurement engagement rate (13.86%). The regional Utilization Management Committee looked at the individuals who were not engaged and identified specific issues related to engagement which included barriers to receiving services.

Measurement period	Numerator	Denominator	% Not engaged	Goal
10/01/17 to 9/30/18	307	1882	16.31%	Baseline
10/01/18 to 9/30/19	225	1592	14.13%	< 16.31%
10/01/19 to 9/30/20	216	1559	13.86%	<14.86%
10/01/20 to 9/30/21	211	1617	13.05%	<13.86%
10/1/21 to 9/30/22	225	1820	12.36%	<13.05%

After the review of the specific issues related to engagement, NorthCare has developed an engagement policy to set specific standards for engagement for the region. Currently all but one of the CMHSP's have gone to automated appointment reminders for consumers. In FY22, the permitted use of telehealth when appropriate also allows individuals to be engaged in services when they are unable or unwilling to attend an appointment. Expectations are that the numbers of consumers who are not engaged will show an improvement over the last reporting period (13.05%).

Performance Improvement Project #3:

Goal: *To improve documentation of skill building and supported employment services.*

As a result of various auditing and monitoring processes across NorthCare's provider network, the need for consistent documentation tools and training across the region has been identified. Improving the documentation of these services will provide accurate and timely information to ensure most appropriate level of service and information to support movement to more independence as most appropriate for everyone.

It is agreed that the ability to have an adult life characterized by financial wellbeing, self-direction, self-determination, and richness of experiences is highly dependent on an individual's ability to utilize his/her skills and talents to engage in a successful career path. Simply put, finding, and maintaining successful employment is central in reaching these goals. The experiences of young people during their teenage years and transition from school to adulthood, will heavily influence and impact their success as

adults in terms of employment, and in turn many other aspects of their lives. Working affects financial security, personal relationships, community engagement, and numerous other aspects of personal well-being.

A sample of February 2022 skill building (H2014) and supported employment (H2023) notes were reviewed in June 2022. Ten (10) claims and ten (10) SALs were randomly selected for each provider location utilizing the Claim Detail Report and SAL Download Reports in ELMER. Notes for each claim and SAL selected were reviewed by NorthCare Network's Clinical Practice Coordinator, Brittany Pietsch, LMSW. Focus of the review was on two elements.

1. Did the note identify staff's action or intervention? This should detail the service that staff provided.
2. Did the note identify the consumers action or possible response to staff?

There were 57 H2014 claim notes reviewed and 72 H2014 SAL notes reviewed. There were 6 H2014 claim notes from 1 provider that were not located in the ELMER record. They are not counted below.

- For claims
  - 43/57 (75%) indicated staff's action. This is a decline from last review (90%).
    - Three providers accounted for the 14 notes not indicting staff action.
  - 57/57 (100%) indicated consumer's action. This is an improvement from last review (98%).
- For SALS
  - 62/72 (86%) indicated staff's action. This is a decline from last review (90%).
    - Four providers accounted for the 10 notes not indicating staff action.
  - 72/72 (100%) indicated consumer's action. This is consistent with last review (100%).

There were 45 H2023 claim notes reviewed and 54 H2023 SAL notes reviewed.

- For claims
  - 35/45 (78%) indicated staff's action. This is a decline from last year (86%).
    - Two providers accounted for the 10 notes not indicating staff action.
  - 44/45 (98%) indicated consumer's action. This is consistent with last year (98%).
    - The one that did not indicate consumer action is completely missing a narrative.
- For SALS
  - 46/54 (85%) indicated staff's action. This is an improvement from last year (78%).
    - Two providers accounted for the 8 notes not indicating staff action.
  - 54/54 (100%) indicated consumer's action. This is an improvement from last year (96%).

There is variation in documentation. Some providers SAL multiple times on one note without referring to AM vs PM activities within the body of the narrative. Others indicate times within the narrative. Some do different notes for each time. This variation makes it hard to score each provider similarly. For this review, if there was staff action in the note, it was counted – even if the staff action occurred at a different time of day than the sample SAL time, but all were lumped into the same note.

Example:

- John did x, y, z. John and staff worked on x, y, z.
  - In this method, there are 2 SAL times associated with one narrative/note. The narrative doesn't distinguish what happened when.
- John did x, y, z in AM. After lunch, John and Staff worked on x, y, z.
  - In this method, there are 2 SAL times associated with one narrative/note. The narrative briefly distinguishes what happened when by am/pm.
- 9-11:30am: John did x, y, z. 1-3pm: John and staff worked on x, y, z.
  - In this method, there are 2 SAL times associated with one narrative/note. The narrative specifically distinguishes what happened when.

- 9am narrative/note: John did x, y, z. 1pm narrative/note: John and staff worked on x, y, z.
    - In this method, there are 2 narratives/notes. Each SAL has its own narrative/note. This clearly indicates everything that occurred during that specific time.

The last documentation style is the cleanest and clearly lets reviewers know what happened at what time. Regardless of the method of ongoing documentation, the staff action as well as consumer action/response should be visible throughout the day. Narratives should focus on how the staff are supporting consumers to complete their objectives/reach their goals.

Some contract provider objectives and notes continue to sound like skill building when reported as supported employment, or CLS when reported as skill building. There are similarities in these services. Staff who work in multiple capacities were reminded that they can see the variances by reading the attached sections of the Medicaid Provider Manual for more detail about what activities each service covers.

It was identified during the 3rd remeasure that progress notes continued to lack identifying staff action across most agencies. One agency did have exceptional documentation. Results were shared in the Regional Employment Leadership Team (RELT) group in August 2022. A Corrective Action Plan was requested from each CMH. NorthCare updated the training and created a quiz that was specific to skill building / paraprofessional staff which was made available in FY23. CAPs and training results will be reviewed in FY23. A last review will be completed to ensure the CAPs improved performance. Then this PIP will be sunset.

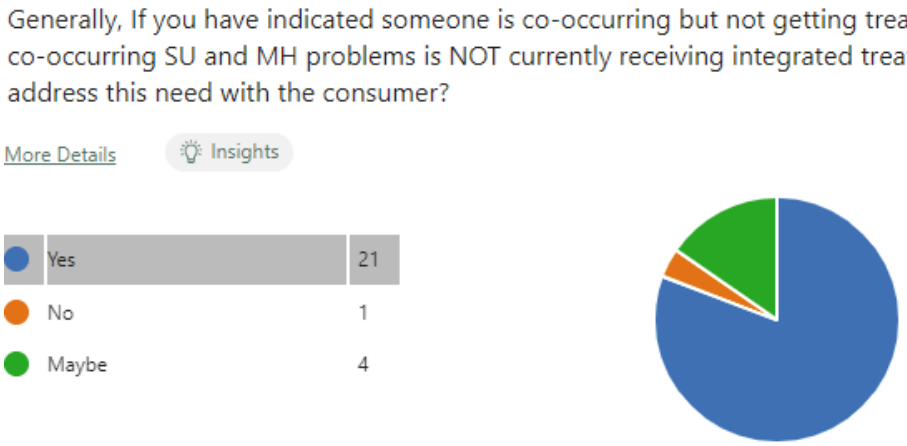
DOC PIP		Baseline 10/19			1st remeasure 10/20			2nd remeasure 6/21			3rd remeasure 2/22			Totals by Provider				
CMH	Provider	Notes Reviewed	Staff Action Not Met	Cons Action Not Met	Notes Reviewed	Staff Action Not Met	Cons Action Not Met	Notes Reviewed	Staff Action Not Met	Cons Action Not Met	Notes Reviewed	Staff Action Not Met	Cons Action Not Met	Notes Reviewed	Staff Action Not Met	Staff Action % Met	Cons Action Not Met	Consumer Action % Met
CC	CCCMH Provider 1	10	4	0	10	9	0	10	2	0	10	1	0	40	16	60.0%	0	100.0%
CC	CCCMH Provider 2	6	4	0	0	0	0	0	0	0	0	0	0	6	4	33.3%	0	100.0%
CC	CCCMH Provider 3	12	10	0	0	0	0	20	1	0	8	0	0	40	11	72.5%	0	100.0%
CC	CCCMH Provider 4	10	0	0	10	3	0	10	1	0	8	3	0	38	7	81.6%	0	100.0%
CC	CCCMH Provider 5	20	7	0	10	0	0	20	0	0	21	3	1	71	10	85.9%	1	98.6%
GO	GCCMH Provider 1	20	1	0	14	0	0	9	1	0	4	0	0	47	2	95.7%	0	100.0%
GO	GCCMH Provider 2	10	0	0	0	0	0	20	3	0	21	12	0	51	15	70.6%	0	100.0%
HBH	HBH Provider 1	10	0	0	0	0	0	0	0	0	0	0	0	10	0	100.0%	0	100.0%
HBH	HBH Provider 2	20	7	0	10	2	3	11	3	0	20	0	0	61	12	80.3%	3	95.1%
HBH	HBH Provider 3	0	0	0	10	3	0	10	3	0	14	0	0	34	6	82.4%	0	100.0%
NP	Northpointe Provider 1	10	2	0	0	0	0	0	0	0	0	0	0	10	2	80.0%	0	100.0%
NP	Northpointe Provider 2	10	1	0	0	0	0	0	0	0	0	0	0	10	1	90.0%	0	100.0%
NP	Northpointe Provider 3	10	9	0	0	0	0	0	0	0	0	0	0	10	9	10.0%	0	100.0%
NP	Northpointe Provider 4	10	10	0	12	0	0	2	0	0	6	0	0	30	10	66.7%	0	100.0%
NP	Northpointe Provider 5	9	1	0	0	0	0	10	0	0	0	0	0	19	1	94.7%	0	100.0%
NP	Northpointe Provider 6	10	1	0	0	0	0	0	0	0	0	0	0	10	1	90.0%	0	100.0%
NP	Northpointe Provider 7	20	10	0	0	0	0	0	0	0	0	0	0	20	10	50.0%	0	100.0%
NP	Northpointe Provider 8	10	0	0	0	0	0	0	0	0	0	0	0	10	0	100.0%	0	100.0%
NP	Northpointe Provider 9	10	9	1	0	0	0	0	0	0	6	3	0	16	12	25.0%	1	93.8%
NP	Northpointe Provider 10	20	10	0	20	3	3	20	3	2	40	5	0	100	21	79.0%	5	95.0%
NP	Northpointe Provider 11	10	7	0	10	1	2	10	2	0	10	0	0	40	10	75.0%	2	95.0%
NP	Northpointe Provider 12	10	7	0	1	0	0	0	0	0	0	0	0	11	7	36.4%	0	100.0%
PW	Pathways Provider 1	10	2	0	2	0	0	9	0	0	10	0	0	31	2	93.5%	0	100.0%
PW	Pathways Provider 2	20	7	0	20	2	1	22	5	2	20	3	0	82	17	79.3%	3	96.3%
PW	Pathways Provider 3	20	11	0	17	1	0	20	5	0	20	12	0	77	29	62.3%	0	100.0%
PW	Pathways Provider 4	0	0	0	10	0	0	10	0	0	0	0	0	20	0	100.0%	0	100.0%
PW	Pathways Provider 5	0	0	0	0	0	0	0	0	0	10	0	0	10	0	100.0%	0	100.0%
		307	120	1	156	24	9	213	29	4	228	42	1	904	215	76.2%	15	98.3%
	Percent Met		**60.9%**	**99.7%**		**84.6%**	**94.2%**		**86.4%**	**98.1%**		**81.6%**	**99.6%**		**76.2%**		**98.3%**	

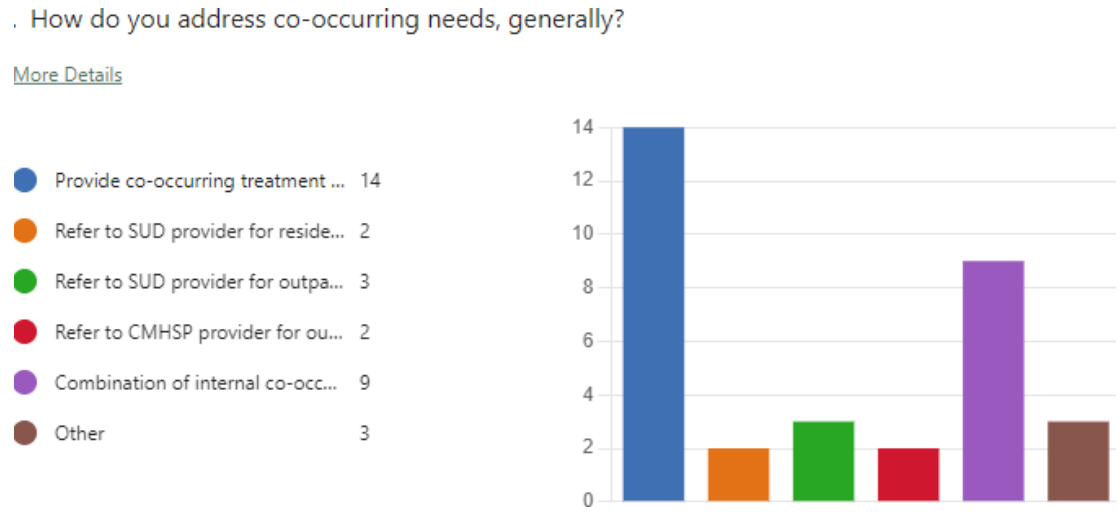
Performance Improvement Project #4:

NorthCare has begun a co-occurring PIP with the goal of increasing the percentage of individuals who are diagnosed with a Co-occurring disorder (COD) for children ages twelve to twenty-five and adults ages twenty-six and older who are receiving integrated COD treatment. Co-occurring defined as having both a mental health and substance use diagnosis. The hope is that both populations will improve in their respective percentages of individuals with co-occurring needs being treated co-occurring treatment. In FY22, approximately 19.4% of the 2,305 individuals identified as having co-occurring needs were receiving co-occurring treatment. This is an improvement from baseline in Calendar year 2021.

Co-Occurring Consumers						
	Calendar Year 21			Calendar Year 22		
	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage
12 to 25 Years of Age	366	48	13.11%	49	353	13.88%
26 to 65+ Years of Age	2294	425	18.53%	404	1985	20.35%
Grand Total	**2660**	**473**	**17.78%**	**453**	**2338**	**19.38%**

NorthCare sent out a survey to providers in FY22 to inquire what training they have had, cooccurring services they offer, and barriers to providing cooccurring services. Most respondents indicated that they address the cooccurring need if the individual is identified as co-occurring and COD treatment is not currently provided. Most providers provided co-occurring treatment internally, but many used a combined approach of internal and referring to external providers.





Utilization Management / Authorization Strategies

There will be ongoing monitoring of Behavioral and Opioid health homes as well as specific code utilization such as the SUD assessment. Monitoring timeliness of SUD access to care for priority population is also a new initiative for FY23. NorthCare conducted an analysis of data elements and developed a plan for tracking and monitoring SUD priority population access timeliness. The plan was developed in FY22. Monitoring of this began in FY23Q1.

6. FY23 QAPIP

The FY23 QAPIP is represented in pages 96-114.

NorthCare Network

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN (QAPIP)

FY23

Quality Management Department

NorthCare Network

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INTRODUCTION

NorthCare Network is a regional entity under Section 1204(b) of the Michigan Mental Health Code and is governed by a board of directors with representation from the five-member Community Mental Health Authorities. NorthCare Network holds a Standard Contract with the Michigan Department of Health and Human Services (MDHHS) for the Medicaid Managed Specialty Supports and Services 1115 Demonstration Waiver, 1915 (c)/(i) Waiver Programs, the Healthy Michigan Program, the Flint 1115 Waiver and SUD Community Grant Programs and the MI Health Link Demonstration Program. NorthCare Network is also a contractor for the Upper Peninsula Health Plan L.L.C, identified by MDHHS as the Integrated Care Organization (ICO), for the provision of Covered Services to Enrollees in the MI Health Link Program.

This document outlines requirements for the annual QAPIP (Quality Assessment and Performance Improvement Program) as set forth in the PIHP/MDHHS Medicaid Managed Specialty Supports and Services Program Contract Attachment. It also describes how these functions are accomplished and the organizational structure and responsibilities relative to these functions.

This QAPIP aids in supporting NorthCare's mission, which is "NorthCare Network ensures that every eligible recipient receives quality specialty mental health and substance use disorder services and supports through the responsible management of regional resources." This mission guides the activities of NorthCare Network.

PURPOSE

The QAPIP is intended to outline requirements and provide guidance for carrying out several functions, including but not limited to:

- ✓ Outlining the quality improvement structure for the managed care activities of the NorthCare Network.
- ✓ Evaluating and updating, as appropriate, NorthCare Network's QI processes and outcomes.
- ✓ Monitoring and evaluating the systems and processes related to the quality of clinical care and non-clinical services that can be expected to affect the health status, quality of life, and satisfaction of persons served by Network Providers.
- ✓ Identifying and assigning priority to opportunities for performance improvement.
- ✓ Creating a culture that encourages stakeholder input and participation in improvement initiatives and problem solving.
- ✓ Stressing the value of employees; cooperation between employees; team building; and a partner relationship between the PIHP, Member CMHSPs, Network Providers, advocacy groups and other human service agencies within a continuous quality improvement environment.

- ✓ Promoting the basic quality management principle of prevention over remediation. It is less expensive in the long run to build quality into an organization's services than it is to expend additional resources on rework and dissatisfied customers.

- ✓ Providing guidance for the PIHP Performance Improvement Projects.

- ✓ Ensuring verification that services reimbursed by Medicaid were provided to enrollees by Network Providers according to the plan of service and adequately documented.

- ✓ Working with the Regional Clinical Practices/Quality Improvement Committee to assure implementation of evidence-based practices throughout the region.

- ✓ Meeting standards specified in the NorthCare Network Medicaid Managed Specialty Supports and Services Contract and QAPIP attachment, the ICO/PIHP Contract for the MI Health Link Project, quality assurance provisions of the Balanced Budget Act of 1997, as amended, Medicaid Managed Care Rules, and Accreditation Standards, as applicable.

QUALITY IMPROVEMENT AUTHORITY AND STRUCTURE

The QAPIP is reviewed and approved on an annual basis by the NorthCare Network Governing Board. Through this process, the governing body gives authority for the implementation of this plan and all components.

NorthCare Network's Chief Executive Officer provides day-to-day guidance and authority to the Quality Improvement Coordinator who is responsible for implementation of the QAPIP. The Performance Management Committee and Governing Board also receive routine reports on the progress of the QAPIP including performance indicators, quality improvement projects, progress and actions taken, and the results of those actions. The committee structure is designed to encourage contributions from a variety of sources, facilitate accountability, and ensure follow through on improvement efforts. NorthCare Network's Medical Director is involved in QI, UM, and credentialing activities and is available for consultation to any of the regional committees as requested, including review and consultation regarding sentinel and critical events.

The Customer Services Committee and NorthCare Network's Governing Board provide significant opportunity for involvement by primary and secondary consumers. Additionally, focus groups and surveys may be utilized to elicit consumer feedback.

ACCOUNTABILITY AND RESPONSIBILITIES

II. <u>NorthCare Network Governing Board</u>

Membership: NorthCare Network's 15-member Governing Board includes three representatives from each of the five Member CMHSP Boards of Directors.

Role/Function: The NorthCare Network Governing Board retains the ultimate responsibility for review and approval of the QAPIP, policy approval and governance. Functions include, but are not limited to:

Oversight of the QAPIP: This includes documented evidence that the Board has approved the overall QAPIP and QI Plan. The Board's role is to monitor, evaluate and establish policy that supports improvements to care.

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

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

Reporting Accountability: The NorthCare Network Governing Board reports to stakeholders via committee and Board meeting minutes. The Governing Body submits a written annual report to MDHHS following its review, which includes a list of members.

Reporting Frequency: Quarterly

III. **Designated Senior Official:**

NorthCare's Quality Improvement Coordinator is responsible for coordinating activities related to the design, implementation, management and evaluation of the quality improvement and compliance programs. Quality management works collaboratively with many different functional areas. Although each position identified below is not directly assigned to the quality management function, they maintain an active role in quality related activities. The following grid provides a representation of what percentage of total time is spent by NorthCare staff on quality related activities. Much of NorthCare's quality management work is implemented through the various committees listed in Section III.

Title	Department	Average percent per quarter devoted to QM
Clinical Director	Clinical/Access	25%
Clinical Floater/Social Worker	Clinical/Access	2%
Clinical Practices Coordinator	Clinical	15%
Customer Service Specialist	Customer Service	10%
Data Analyst	Information Management	5%
Integrated Care Specialist	Integrated Care/Population Health	6%
Medical Director (Part-time)	Clinical	75%
Network Management Specialist	Network Management	10%
QI Coord/Compliance-Privacy Officer	QI/Compliance	50%
Systems Analyst	Information Management	25%

IV. **QAPIP Committee/Teams**

NorthCare Network's QAPIP is implemented through various PIHP and regional committees/teams as listed below. All are ultimately accountable to NorthCare Governing Board and/or NorthCare Leadership.

NorthCare Governing Board of Directors

a. NorthCare Compliance Oversight and Risk Management Committee (CORMC)
b. NorthCare Leadership Committee
    - NorthCare Information/Technology Management Committee
        1. Regional Elmer Management Committee (REM)
        2. Regional Analytics Committee
        3. Regional Help Desk Committee
        4. Regional Information Technology and Security Committee
        5. Regional Medical Records Committee
    2. NorthCare Trauma Informed Committee
        a) Regional Trauma Informed Committee
    3. NorthCare Quality Management Committee
        a) NorthCare Network Management Committee
            - NorthCare Network Site Review Team(s)
            - Regional Contract Management Committee
        b) NorthCare Credentialing Committee
        c) NorthCare Medicaid Service Verification Team
        d) NorthCare Health and Safety Review Committee
        e) Regional Grievance & Appeal Committee
        f) Regional Clinical Practices/QI Committee
            - Regional Employment Leadership Committee
            - Regional Jail Diversion Committee
            - Regional Autism Committee
            - Regional Behavioral Treatment Committee
            - Regional Health Services Committee
            - NC/UPHS-Mqt QI Committee
            - NC/War Memorial QI Committee
            - NC/Willow Creek QI Committee
        g) Regional Emergency Services Committee
        h) NorthCare Utilization Management Committee
            - Regional Utilization Management Committee
        i) Regional Customer Services Committee
    4. Regional Finance Committee
        a) Regional Billing Committee

Each committee has an approved "Fact Sheet" which documents the committee charge, reporting requirement(s), membership, deliverables, and meeting frequency. Project specific or time specific workgroups are established as appropriate.

QUALITY MANAGEMENT SYSTEM

(Components and Activities)

NorthCare Network's Quality Management System combines the traditional aspects of quality assurance and adds the elements of continuous quality improvement. The Quality Management System helps NorthCare Network achieve its mission, realize its vision, and live its values. It protects against adverse events, and it provides mechanisms to bring about positive change while ensuring quality services. Continuous quality improvement efforts assure a proactive and systematic approach that promotes innovation, adaptability across the Network, and a passion for achieving best practices.

The *Quality Management System* includes:

- Predefined standards
- Formal and informal assessment activities
- Measurement of performance in comparison to standards
- Strategies to improve performance that is below standard

The various aspects of the system are not mutually exclusive. However, for descriptive purposes, the following table separates the components.

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

V. Quality Standards

Quality Standards provide the specifications, practices, and principles by which a process may be judged or rated. NorthCare Network identifies and sets standards by reviewing, analyzing, and integrating such areas as:

- Performance expectations of network providers for both clinical services and administrative functions
- Government regulations/rules
- Practice Guidelines

- Accreditation and/or Network Standards
- External review findings
- Utilization Management and Authorizations

VI. Quality Assessment Activities

Quality assessment consists of various strategically planned activities that help to identify the actual practices, attitudes, performance, and conformance to standards that are enhancing or inhibiting the achievement of quality. Obtaining stakeholder input is critical to quality assessment activities.

J. *Stakeholder Input*

NorthCare Network recognizes that a vital aspect of any continuous improvement system is a means to obtain stakeholder input and satisfaction information. Stakeholders identified to provide input to NorthCare Network may include individuals who are or have received services, staff, contract service providers, families/advocates, and the local communities, representing both internal and external customers.

Input is collected to better understand how NorthCare Network is performing from the perspective of its stakeholders. The input is continually analyzed and integrated into the practices of the PIHP, as feasible. NorthCare Network's Customer Services Committee and Governing Board both provide opportunity for stakeholder input. NorthCare Network encourages stakeholder participation on other committees as appropriate. Each Member CMHSP will ensure that there is adequate input from stakeholders for local decision-making.

The table below summarizes methods and sources for obtaining stakeholder input.

STAKEHOLDER INPUT METHODS AND SOURCES						
Type of Input	Consumer	Staff	Providers	Family/ Advocates	Community	MDHHS/EQRO
Interviews	MDHHS Site Reviews, Accreditation, NorthCare Network Site Reviews, Satisfaction Surveys, PCP process	Performance Evaluations, Termination/Exit Interviews	ORR Site Visit, Contract Provider Quality Review	MDHHS Site Reviews Fidelity Reviews of Evidence Based Practices	Open Door Policy of the NorthCare Network CEO	MDHHS Site Reviews, External Quality Review Organization (EQRO)– under contract w/MDHHS, Accreditation
Suggestions	Ongoing opportunity through PCP process	Supervision, Suggestion for Improvement process	Quality reviews	Ongoing opportunity through PCP process per consumer choice	Focus Groups or Public Forums	MDHHS, EQRO, Accreditation
Forums	Consumer advisory committees, Board meetings	Team/Dept Meetings, All staff meetings	MDHHS Review, Contract	MDHHS Review, Advisory committees	MDHHS /EQR/ Accreditation Reviews, Annual PRR	MDHHS, EQRO, Accreditation

			negotiations, meetings		forum, Public comments at Board meetings	
Surveys	Consumer surveys Health Plan Survey per Accreditation	Staff surveys	Provider surveys, Accreditation surveys	Satisfaction surveys	Stakeholder Surveys	MDHHS, EQRO, Accreditation
Assessment of experience with services/ organization	Ongoing through PCP process, progress notes, d/c summary, Various regional committee membership	Performance evaluations	Quality review of provider, AFC licensing reports	Regional committee membership	Community Needs Assessment	MDHHS, EQRO, Accreditation
Grievance & Appeals	Recipient Rights, Grievance & Appeals Process	Staff Grievance	Provider Grievance	Grievance systems	Comments via NorthCare Network Website	MDHHS, EQRO, Accreditation
Complaints	RR Complaint, Complaints discussed w/customer services, Compliance complaint process	Employee complaint, Compliance complaint process	RR Complaint, Compliance complaint process	RR Complaint, Compliance complaint process, Customer Service compliant process	RR Complaint, Compliance complaint process	MDHHS, EQRO, Accreditation

K. *Ongoing Assessments of Consumer Experiences with Services and the PIHP*

NorthCare Network conducts ongoing quantitative (e.g., surveys) and qualitative (e.g., focus groups, interviews) assessments of member experiences with its services. These assessments must be representative of the individuals served, including individuals receiving long-term supports or services (i.e., individuals receiving case management or supports coordination) and the services and supports offered.

Assessment results will be used to improve services, processes, communication, etc. Processes found to be effective and positive will be continued, while those with questionable efficacy or low consumer satisfaction will be revised by:

- Taking specific action on individual cases as appropriate.
- Identifying and investigating sources of dissatisfaction.
- Outlining systemic action steps to follow-up on the findings.
- Informing practitioners, providers, recipients of service, and the NorthCare Network Governing Board of assessment results.

Just as the original processes must be evaluated, the interventions used to increase quality, availability, satisfaction, and accessibility to care and services must also be assessed. Therefore, all actions taken as a result of assessments will be evaluated periodically. Quality improvement

is never static, and it is an expectation that all evaluation efforts will be examined on an ongoing basis.

L. *Provider Network Monitoring*

NorthCare Network conducts annual site reviews of organizational providers with whom we directly contract to ensure compliance with delegated functions as well as regional, state, and federal mandates. NorthCare Network delegates and monitors annual review of Member CMHSP sub-contractors.

NorthCare Network's process is a systematic and comprehensive approach to monitor, benchmark, and make improvements in the provision of mental health and substance use services. NorthCare Network conducts annual (at minimum) site reviews to evaluate:

- Compliance with regional, state, federal and accreditation standards through annual site visits
- Compliance with delegated functions
- Clinical documentation reviews
- Verification of Medicaid services
- Clinical Implementation of effective treatments

The Provider Network Monitoring process provides NorthCare Network the ability to:

- Establish clinical and non-clinical priority areas for improvement
- Use a number of measures to analyze the delivery of services and quality of care
- Establish performance goals and compares findings and ratings with past performance
- Provides performance feedback through written report
- Requires an improvement/corrective action plan from providers in areas not achieving targets or in non-compliance with accepted standards
- Ensures implementation of the improvement plan by providers

M. *Utilization Management and Authorizations*

NorthCare Network implements a Utilization Management Plan within the provisions of its Standard Contract with Michigan Department of Health and Human Services (MDHHS). NorthCare Network has oversight authority and performs utilization management functions sufficient to control costs and minimize risk while assuring quality care. The UM Plan establishes a framework for oversight and guidance of the Medicaid and MHL Programs by assuring consistent application of program/service eligibility criteria, and in decisions involving the processing of requests for initial and continued authorization of services.

Utilization Management is committed to not only reviewing practices related to resource utilization, but also to taking action to modify inappropriate, inefficient or ineffective utilization. Many of the NorthCare Network Utilization Management functions overlap or are reliant on coordination with, Quality Assessment & Performance Improvement, Provider Relations, Regional Quality Improvement and Clinical Practices Committee, Claims/Reimbursement, Management of Information Services and other managed care functions. Successful interface among the various functions of the PIHP is essential for effective and efficient management of resources, identification of gaps in service delivery and resolution of over- and under-utilization

of services and resources. Interface between Utilization Management and other PIHP functions occurs through exchange of data, information and reports, joint participation in a variety of committees and collaboration in planning, projects, and operational initiatives.

Compensation to individuals or entities that conduct utilization management activities cannot be structured to provide incentives to the individual or entity to deny, limit, or discontinue medically necessary services to any recipient.

N. *Credentialing and Qualification for Scope of Practice*

The NorthCare Network Credentialing Committee is responsible to apply legal, professional and ethical scrutiny to applicants seeking to be credentialed as a provider in the network and to approve the re-credentialing of existing providers. NorthCare Network retains final authority for the credentialing of individual and organizational providers as a member of the provider panel employed or under contract. The qualifications of physicians and other licensed behavioral healthcare practitioners/professionals employed by or under contract to the PIHP are reviewed according to the NorthCare Network Credentialing and Privileging Policies to ensure they are qualified to perform their services. Continuous monitoring of the credentialing program occurs across the network to ensure compliance and identify quality or network issues. Organizations are responsible for ensuring that individual practitioners/providers, employed or under contract, and organizational providers meet all applicable licensing, scope of practice, contractual, and payor requirements. The oversight and monitoring of the credentialing of sub-contract provider staff is delegated to direct contractors.

NorthCare Network requires professional staff in the network to have a documented review and approval of their clinical privileges as needed to assure services provided to the network members are delivered by qualified and competent staff. Minimally, this is done as part of the initial credentialing/re-credentialing process and when duties/responsibilities change in terms of primary eligibility group a person is working with and/or scope of work. MI Health Link (MHL) Community Providers are privileged per the MHL Standard Operating Procedures as codes are identified by professional discipline.

NorthCare Network and network providers shall train new personnel regarding their responsibilities, program policy, and operating procedures and identify staff training needs and provide in-service training, continuing education and staff development activities according to NorthCare Network's Training – Personnel Policy and the Training-Network Provider Policy.

O. *Oversight of Vulnerable Individuals*

NorthCare Network utilizes the appropriate clinical staff and various reporting mechanisms and data sets to identify vulnerable individuals and events that put them at risk of harm, including required health measures and health assessments. Such events and data, that are not a product of a protected peer review process, will be used to determine opportunities for improving care and outcomes and reported to the Compliance Oversight and Risk Management Committee as appropriate. However, if an issue that places an individual in imminent risk to health or welfare is identified, NorthCare will take immediate action to ensure their safety. NorthCare will invoke an immediate review and require a response by the Provider, within seven (7) calendar days.

P. *Behavior Treatment Review*

NorthCare Network's Clinical Practices Improvement Coordinator will review analyses of data from Member CMHSP behavior treatment review committee(s) on a quarterly basis where intrusive or restrictive techniques have been approved for the use with beneficiaries and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. Patterns and trends will be evaluated for possible system and/or process improvement initiatives and will be reported to NorthCare Network's Quality Management and Oversight Committee. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plan Review Committees and that have been approved during person-centered planning by the beneficiary or his/her guardian may be used with beneficiaries. Data includes numbers of interventions and length of time the interventions were used with the individual.

Q. *Event Reporting and Notification*

Each Network Provider will record, assess, and report critical incidents according to NorthCare Network policy. They will analyze at least quarterly the cumulative critical incidents, sentinel events, and risk events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents and report the outcome of this analysis to NorthCare Network. NorthCare Network's Health and Safety Review Team will analyze aggregate data to identify any trends or patterns and may follow-up on individual events as warranted. The Health and Safety Review Team will report aggregate high-risk areas and concerns to NorthCare Network's Compliance Oversight and Risk Management Committee as appropriate. Member CMHSPs utilize NorthCare Network's Incident Report Module to report all events defined below. Other Network Providers may continue to report on paper.

a. Critical Events: Critical Event Reporting will be uploaded, monthly at minimum, to MDHHS's PIHP Event Reporting Data Warehouse by PCE (NorthCare Network's software vendor) automatically. This automatic reporting will move from the Event Reporting Data Warehouse to the MDHHS CRM as of 10/1/22. This Critical Incident Reporting System captures information on five specific reportable events based on varying populations as mandated by MDHHS. Detailed requirements can be found in NorthCare Network's Incident, Event & Death Reporting & Monitoring Policy and the PIHP/ MDHHS Reporting Requirements Policy.
b. Event Notification: The PIHP is also required to immediately notify MDHHS of specific events as outlined in the MDHHS Reporting Requirement Policy and NorthCare Incident, Event & Death Reporting & Monitoring Policy.
c. Sentinel Events, as defined in the MDHHS Reporting Requirement Policy must be reviewed and acted upon as appropriate and in accordance with NorthCare Network's Incident, Event & Death Reporting & Monitoring Policy.
d. Risk Events are additional events that put individuals at risk of harm, including at minimum: actions taken by individuals that cause harm to themselves or others; two or more unscheduled admissions to a hospital within a 12-month period; emergency use of physical management by staff in response to a behavioral crisis, and police calls by staff under certain circumstances. For detailed information refer to PIHP/ MDHHS QAPIP Guideline. NorthCare Network's Health and Safety Review Team and CMHSP staff review trends and follow up as indicated.

e. All unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed. Unexpected deaths include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect. Specifics for reporting are included in NorthCare's Incident, Event & Death Reporting & Monitoring Policy.

R. LTSS (Long Term Supports and Services)

The following services are noted as LTSS services per the 1115 Pathway to Integration Waiver: Respite, CLS (Community Living Supports), PDN (Private Duty Nursing), Supported/Integrated Employment, Out of Home Non-Vocational Habilitation, Good and Services, Environmental Modifications, Supports Coordination, Enhanced Pharmacy, PERS (Personal Emergency Response System), Community Transition Services, Enhanced Medical Equipment and Supplies, Family Training, Specialty Therapies (Music, Art, Message), Children Therapeutic Foster Care, Therapeutic Overnight Camping, Transitional Services, Fiscal Intermediary Services, and Prevocational Services.

The PIHP must have mechanisms in place to assess the quality and appropriateness of care furnished to beneficiaries using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan. Mechanisms are to comprehensively assess each Medicaid beneficiary identified as needing LTSS to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or the Contractor as appropriate. This is achieved by, but not limited to review, analysis, and monitoring of person-centered planning, IPOS reviews/amendments, and standardized assessment scores that support level of care such as the Level of Care Utilization System (LOCUS).

S. External Quality Reviews

4) MDHHS *Site Reviews*

Follow up activities for site reviews conducted by MDHHS are carried out and/or monitored by NorthCare Network's Network Management and/or Quality Management and Oversight Committees. To best address local concerns, each Member CMHSP may be asked to draft a remedial action plan for all citations for which the Member CMHSP has been identified as being out of compliance. NorthCare Network will consider each response for inclusion in the Plan of Correction submitted to MDHHS. NorthCare Network also provides consultation for Member CMHSPs and monitors the implementation of improvement activities.

5) *External Quality Review Organization*

The Michigan Department of Health and Human Services (MDHHS) will arrange for an annual, external independent review of the quality and outcomes, timeliness of, and access to covered services provided by the PIHP. The External Quality Review (EQR) includes an on-site review of the implementation of the QAPIP. The EQR also validates methodologies used in conducting the required performance improvement projects (PIP) as well as validates performance measure data collection and reporting to MDHHS. The PIHP addresses the findings of the external review through its QAPIP. The PIHP

develops and implements performance improvement goals, objectives and activities in response to the external review findings as part of this QAPIP. A description of the performance improvement goals, objectives and activities developed and implemented in response to the external review findings will be included in the PIHP's Quality Improvement Plan and provided to the MDHHS upon request. The MDHHS may also require separate submission of an improvement plan specific to the findings of the external review.

6) *Accreditation*
NorthCare Network's URAC accreditation will expire on March 1, 2023, policy and processes established to ensure compliance with accreditation standards will continue. NorthCare's commitment to quality services will continue to provide the framework to improve business processes through benchmarking against nationally recognized standards.

VII. Performance Measurement

NorthCare Network measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data. Through monitoring and evaluation, the efforts and resources of the Network can be redirected to obtain the desired outcomes.

By using performance indicators, the variation between the target desired and the performance being measured can be identified. Indicators are used to alert NorthCare Network and the Network Providers of issues that need to be addressed immediately, to monitor trends and contractual compliance, and to provide information to consumers and the public. Performance indicators are the foundation to control and improve processes.

Performance indicator results are used to guide management decision-making related to:

- Strategic planning
- Resource allocation
- Modification of service delivery
- Administrative process changes
- Staff training, credentialing and privileging
- Other activities identified by our various stakeholders

E. Performance Indicators [Measures]
NorthCare Network's Quality Oversight Committee monitors performance indicators for individual Member CMHSPs and collectively for the region. The QAPIP is utilized to assure that at least the minimum performance level on each indicator is achieved. A plan of correction that includes a review of possible causes for outliers is required from any Member CMHSP for each Performance Indicator out of compliance for two consecutive quarters. NorthCare Network's Quality Oversight Committee and/or Quality Improvement Coordinator will monitor any plans of correction. Performance data is reviewed and discussed with the various QAPIP committees.

- Michigan Mission Based Performance Indicator System (MMBPIS)
NorthCare Network utilizes performance measure established by the MDHHS that address areas of access, efficiency, and outcomes and report to the State as established in the

contract. NorthCare Network and Member CMHSP staff will ensure the reliability and validity of the data on these indicators across the Network and that these conform to the "Validation of the Performance Measures" of the BBA protocols. The Quality Oversight Committee will review MMBPIS results. Member CMHSPs and SUD Providers who are out of compliance with MDHHS and/or NorthCare standards will work with NorthCare Network QI Coordinator and the Quality Oversight Committee to ensure the implementation of effective improvement plans.

- Regional Measures
  NorthCare Network may establish and monitor additional performance indicators specific to an individual program for the purpose of identifying process improvement projects. Performance indicators employed should be objective, measurable, and based on *current* knowledge and experience to monitor and evaluate key aspects of care and service. Performance goals and/or a benchmarking process are utilized for the development of each indicator.

- NorthCare Network will ensure compliance with and sustainability to meet performance measures as outlined in the contract between the State of Michigan - Michigan Department of Health and Human Services with NorthCare Network and the Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans.

- NorthCare Network will participate and collaborate with the ICO/Medicaid Health Plan (MHP) in regular and ongoing initiatives that address methods of improved clinical management of chronic health conditions and methods for achieving improved health outcomes for Members enrolled in any Medicaid program with the ICO/MHP.

F. Outcomes Management
NorthCare Network's Clinical Practices Quality Committee will establish outcome measures and conduct quality improvement efforts to assure effective clinical practices based on a recovery and trauma informed system of care.

G. Practice Guidelines
NorthCare Network's Clinical Practices Coordinator is charged with the task of overseeing the adoption, development, implementation and continuous monitoring and evaluation of Practice Guidelines when there are nationally accepted, or mutually agreed upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices, and promising practices that are relevant to the individuals served. Working with the regional Clinical Practices/Quality Improvement Committee, NorthCare's Quality Management and Oversight Committee, and the regional UM Committee newly implemented treatment practices required by MDHHS are monitored and measured for effectiveness for all populations. The NorthCare Network Practices Guideline Manual provides information regarding the process for the adoption, development, implementation, monitoring, and evaluation of the guidelines. This manual can be found at NorthCare Network Clinical Practices Guideline Manual

NorthCare must disseminate all practice guidelines it uses to all affected providers and, upon request, to beneficiaries. NorthCare must ensure decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are

consistent with the guidelines. NorthCare must assure services are planned and delivered in a manner that reflects the values and expectations contained in practice guidelines adopted.

To ensure fidelity to practice, NorthCare and the affiliate CMHSP's will participate in Michigan Fidelity Assistance Support Team (MiFAST) reviews, as required by MDHHS. MIFAST is required prior to implementation or use of specific Medicaid codes or modifiers and and is available ongoing.

H. Verification of the Delivery of Medicaid Services
Verification of Medicaid services is conducted in accordance with NorthCare Network's Medicaid Service Verification Policy. This process is to ensure Medicaid services were furnished to enrollees by member CMHSPs, providers, and subcontractors with corrective action taken as warranted.

VIII. Improvement Strategies

Establishing and successfully carrying out strategies to eliminate outliers, incorporate best practices, and optimize consumer outcomes is key to continuous quality improvement. The particular strategy or sets of strategies used vary according to the situation and the kind of improvement that is desired. The following provides a brief description of some of the improvement strategies utilized.

C. Performance Improvement Projects (PIP)
Standards published by the Centers for Medicare and Medicaid Services (CMS) require that the PIHP (Prepaid Inpatient Health Plan) conduct, "performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction."

NorthCare Network must engage in at least two affiliation-wide projects during each waiver period, which must address clinical and non-clinical aspects of care. Project topics are either mandated by MDHHS or selected by the PIHP in a manner that takes into account the prevalence of a condition among, or need for a specific service by, the organizations' consumers, consumer demographic characteristics and health risks, and the interest of consumers in the aspect of service to be addressed. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care; while non-clinical areas would include, but not be limited to, appeals, grievances, trends and patterns of incident reports as well as access to, and availability of, services.

Projects selected may fulfill both MDHHS/HSAG and applicable accreditation requirements.

D. Utilization Management (UM)/Authorization strategies
NorthCare Network UM activities are specifically designed to ensure only eligible beneficiaries receive plan benefits; that services received meet medical necessity criteria and are linked to other services when needed. To achieve these goals, various methods are used that focus on eliminating outliers, incorporate best practices, and optimize consumer outcomes. For example, NorthCare Network directly operates a centralized access system which assures more uniform access to non-emergent services and reduces variability in eligibility determinations in access to the public mental health system. To improve overall quality of consumer outcomes and consistency in the amount, scope, and duration of services, clinicians use the NorthCare

Network level of care placement protocols to guide level of care determinations. This clinical decision-support tool allows for greater consistency in level of care assignments and aimed at reducing variances in service delivery. Finally, utilization review activities are employed which include monitoring of individual consumer records, specific provider practices and system trends. Review and monitoring activities are used to determine appropriate application of guidelines and criteria for decision involving level of care assignments, service selection, authorization, and best practices. Tracking consumer outcomes, detecting over utilization/under utilization and reviews of outliers are also the subject of utilization review efforts.

PROCEDURES FOR ADOPTING & COMMUNICATING PROCESS & OUTCOME IMPROVEMENTS

NorthCare Network will incorporate the Home and Community-Based Services (HCBS) Quality Framework developed for the Centers for Medicare and Medicaid (CMS) into its Quality Management Program. This Quality Framework is intended to serve as a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of services and supports provided by NorthCare Network's provider network. The Framework focuses attention on critical dimensions of service delivery and the desired outcomes of the four functions of quality management: design, discovery, remedy and improvement. Further, definitions of the functions of quality are:

- Design: Designing quality assurance and improvement strategies to a program at the initiation of the program.
- Discovery: Engaging in a process of discovery to collect data and direct participant experiences in order to assess the ongoing implementation of the program, identifying both concerns as well as other opportunities for improvement.
- Remedy: Taking actions to remedy specific problems or concerns that arise.
- Continuous Improvement: Utilizing data and quality information to engage in actions that assure continuous improvement in the program.

Focus will be on the following seven broad categories as outlined by CMS:

8. Participant access
9. Person-centered planning and service delivery
10. Provider capacity and capabilities
11. Participant safeguard
12. Participant rights and responsibilities
13. Participant outcomes and satisfaction
14. System performance

Suggestions for improvement can come from a variety of sources. Feedback from consumers, advocates, stakeholders, network providers, MDHHS, and NorthCare Network Personnel is incorporated into the QI Plan's components and activities. NorthCare Network's QI Work Plan will identify measurable objectives, as well as the individuals and/or departments responsible for each objective. Also included, will be a timeline for completion of tasks and schedule for ongoing monitoring as appropriate.

EVALUATION

NorthCare Network's QAPIP is reviewed and updated at least annually with input from various stakeholders and approved by the Governing Board. The NorthCare Network Governing Board and NorthCare Network Quality Management and Oversight Committee are responsible for the evaluation of the effectiveness of the QAPIP. This Annual Effectiveness Review includes analysis of whether there have been improvements in the quality of health care and services for recipients as a result of quality assessment and improvement activities and interventions carried out by the PIHP. The analysis considers trends in service delivery and health outcomes over time and includes monitoring of progress on performance goals and objectives. Information on the effectiveness of the QAPIP must be provided annually to network providers and to recipients upon request. This annual analysis will be provided to the MDHHS annually and no later than February 28.

NorthCare Network publishes an Annual Performance Management Report that provides a summary of accomplishments and highlights from the previous Fiscal Year as well as key information that will identify whether current systems and processes are providing desired outcomes. This report will be posted at www.northcarenetwork.org, posted at NorthCare Network's main office, a copy sent to all Network Providers and members of NorthCare Network Governing Board and copies provided to stakeholders as requested.

CROSS REFERENCES

- The Balanced Budget Act of 1997 (BBA)
- MDHHS /PIHP Master Contract and pertinent Attachments
- MDHHS Michigan Mission Based Performance Indicator System V6.0 Codebook
- ICO/PIHP Contract for the MI Health Link Demonstration Program
- URAC (Utilization Review Accreditation Commission) Health Plan 7.1 Standards *(3/31/23)*
- NorthCare Network Credentialing Program Policy
- NorthCare Network Incident, Event & Death Reporting & Monitoring Policy
- NorthCare Network Methodology – Michigan Mission Based Performance Indicator System V6.0
- NorthCare Network Annual Performance Management Report
- NorthCare Network QI Work Plan
- NorthCare Network Training-Personnel Policy
- NorthCare Network Utilization Management (UM) Plan
- NorthCare Network Training-Network Provider Policy
- NorthCare Network/CMHSP Delegation Agreement
- NorthCare Network Cultural Sensitivity Policy

All NorthCare Network policies can be found at www.northcarenetwork.org.

ATTACHMENTS

A - Acronyms Used in this Document

APPROVALS

Reviewed/Revised Date: 7/25/22
Quality Management and Oversight Committee Approval: 7/25/22
Policy Committee/CEO Approval: 8/2/22
Board of Directors Approval: 9/14/22

ATTACHMENT A
NorthCare Network
ACRONYMS USED IN THIS DOCUMEN
ACRONYMS

BBA – Balanced Budget Act
CEO – Chief Executive Officer
CMHSP – Community Mental Health Service Provider
CMS – Centers for Medicare and Medicaid Services
EBP – Evidence Based Practices
EQR/EQRO – External Quality Review / External Quality Review Organization
HSAG – Health Services Advisory Group (External Quality Review Organization contracted by MDHHS to conduct annual reviews of each PIHP.)
HCBS – Home and Community-Based Services
HIPAA – Health Insurance Portability and Accountability Act
HMP – Healthy Michigan Plan
ICO – Integrated Care Organization
I/DD – Intellectual/Developmental Disability
MDHHS – Michigan Department of Health and Human Services
MI – Mental Illness
MHL – MI Health Link Demonstration Program
MHP – Medicaid Health Plan
PIHP – Prepaid Inpatient Health Plan
PIP – Performance Improvement Project
PMC – Performance Management Committee (A NorthCare Network Committee represented by Directors of each Member CMHSP and NorthCare Network's CEO)
QAPIP – Quality Assessment and Performance Improvement Plan
QC – Quality Council
QI – Quality Improvement
QIP – QI (Quality Improvement) Plan
UM – Utilization Management
URAC – Accrediting Body which originally incorporated under the name "Utilization Review Accreditation Commission." The name was shortened to the acronym "URAC" in 1996 when URAC began accrediting other types of organizations such as health plans and preferred provider organizations. In addition, URAC sometimes uses a second corporate name or DBA which is the "American Accreditation HealthCare commission, Inc."

7. FY23 QI Work Plan

The FY23 QI work plan is a working/living document and is updated as needed. Current targets are listed below. The workplan is reflected on pages 115-128.

NorthCare Network Quality Improvement Work Plan							
FY22 - 3.							
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**		
HSAG PIP Validation	FY23	N/A	Brittany Pietsch				
Description of Standard/Initiative							
To increase the percentage of discharged enrollees ages six (6) and older, who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within seven (7) days of discharge.							
Findings	**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**	
This PIP was validated by HSAG and found not met due to not reaching a statistically significant improvement over baseline. This PIP validation cycle has ended, but because of the importance of ensuring timely follow-up, NorthCare chose to continue with some revisions. We have clarified the use of the H0002 code and services such as case management (T1017) is not an allowable follow-up service under HEDIS specifications, but is a common service provided and should be counted as this service is conducted face-to-face.	Develop report in house due to termination of Relias contract in May 2021.	NorthCare IT staff to develop report to mirror and replace Relias report with additional data fields.	Validated FUH Report	6/2021. As of 12.1.22 report being edited		Andy/Jen	
	Achieve a statistically significant improvement in percentage of children seen within 7-days of discharge.	Achieve a rate of 77.88% for children	77.88	TBD		Brittany	
	Achieve a statistically significant improvement in percentage of adults seen within 7-days of discharge.	Achieve a rate of 66.40% for adults	66.40%	TBD		Brittany	
Updates							
Next Steps							

NorthCare Network Quality Improvement Work Plan					
FY22 – 4.					
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**
HSAG	FY20	St II.8	Kayti Lancour		
Description of Standard/Initiative					
The QAPIP includes periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered. e. The assessments must address the issues of the quality, availability, and accessibility of care. f. As a result of the assessments, the organization: i. Takes specific action on individual cases as appropriate. ii. Identifies and investigates sources of dissatisfaction. iii. Outlines systemic action steps to follow-up on the findings; and iv. Informs practitioners, providers, recipients of service and the governing body of assessment results.					

g. The organization evaluates the effects of the above activities.
h. The organization ensures the incorporation of members receiving long-term supports or services (e.g., persons receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
HSAG strongly recommends that the PIHP clearly document identified areas of member dissatisfaction, implement interventions targeted at increasing member satisfaction in those areas, and complete a subsequent evaluation to determine if the interventions implemented led to increased member.	Address dissatisfaction trends and patterns across the region.	Incorporate into electronic process the ability for NorthCare to review and follow-up on areas of dissatisfaction across provider network.	Quarterly review of survey data.			Kayti
		Publish comprehensive annual report that incorporates the access and satisfaction survey results and associated interventions/follow-up as well as any new survey process.	Completed Annual Report			Kayti
		Continued education of online survey including poster for offices with a QR code, business cards with QR codes, newsletter articles, etc.	Posters up in all offices; annual newsletter article.			Kayti
Updates						
Monitoring						

NorthCare Network
Quality Improvement Work Plan

FY22 – 5.

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location
Contract	FY21	HSAG PMV	QI Coord		

Description of Standard/Initiative

PI 2b: The percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders.

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
Monitoring – Continue to monitor to ensure SUD measure is above state rate or at 80% or above.	NorthCare will meet or exceed State rate each quarter with regional goal of reaching 80%.	Identify providers fall below the 80% regional goal and work	80% of individuals requesting services has an admission			QI Coord

		with them to identify and address barriers in order to improve.	within 14 days of request.			
Updates						
Monitoring	Quarterly					

NorthCare Network Quality Improvement Work Plan						
FY22 - 6.						
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**	
HSAG	FY21	St VI.6	Brittany Pietsch			
Description of Standard/Initiative						
The PIHP's ABD notices must meet the content requirements of 42 CFR §438.404.						

Findings	**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**
Required Actions: For standard authorization decisions, the PIHP must provide notice as expeditiously as the member's condition requires and within MDHHS-established time frames that may not exceed 14 calendar days following receipt of the request for service.	NorthCare will ensure the reasons for adverse benefit decisions are clearly documented and available to the member in consumer-oriented language. The region will effectively use the ABD notice by 10.1.21. (9.06)	Pull a random sampling, by provider, of all ABD notices in June 2022, and conduct review of 10 ABD notices per provider to ensure effective use of ABD notice.	Review will include SUD and MH providers. Random sample review period will be from 3.1.22 to 5.31.22.			Brittany

Updates	Last update - ABDs available to pull were for initial denials. Andy is working on a report to pull all ABDs. While the monitoring didn't happen in FY22 – it is only monitoring going forward.
Monitoring	

NorthCare Network Quality Improvement Work Plan					
FY22 - 7. Standard V, Coordination and Continuity of Care, HSAG: Integrated Physical and Mental Health Care					
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**
HSAG	FY2023	V.5.; V.7; V.8.; V.9. V.10.a, b.	Katreena		
Description of Standard/Initiative					

7. The PIHP must ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards.
8. The PIHP must implement mechanisms to comprehensively assess each member needing LTSS or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring
9. The PIHP must produce a treatment plan meeting the needs of the member for those who are determined through assessment to need a course of treatment or regular care monitoring.
10. The PIHP must ensure the integration of primary and specialty behavioral health services for Medicaid Members. These efforts must focus on persons that have a chronic condition such as a serious mental illness, co-occurring substance use disorder, children with serious emotional disorders or a developmental disability.
11. The PIHP must implement practices to encourage all members eligible for PIHP services receive a physical health assessment including identification of a primary care physician, medication history, identification of current and past physical health care and referrals for appropriate services. The physical health assessment will be coordinated through the person's Medicaid Health Plan.
12. The PIHP must include the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the person-centered planning process. Those findings must be shared, as authorized, with the member's physical health care providers.

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
	Individuals served by NorthCare Network providers will receive care coordination between the behavioral health providers and their physical health providers.	Individuals receiving specialty care (i.e. Neurology, cardiology) will have the recommendations of those providers incorporated into their behavioral health plan to support primary prevention recommendations in daily living.	85% of individuals who identify a specialty condition in their annual health questionnaire will have a signed consent for sharing of records between that physical health specialist and the CMHSP			Katreena
		LTSS will incorporate co-morbid disease management interventions into person-centered-plans of care	85% of individuals who have an identified co-morbid physical health condition in their annual health questionnaire will have a corresponding health goal in their IPOS.			Katreena
Updates						
Monitoring						

NorthCare Network
Quality Improvement Work Plan

FY22 - 10.

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location
QAPIP	FY21-22	QAPIP	Brittany Pietsch		

Description of Standard/Initiative

The PIHP's analysis considered all UDs (those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect), including aggregated mortality data over time to identify possible trends.
The PIHP's analysis considered CIs for residential treatment providers.
The QAPIP work plan identified a goal(s) and/or objective(s) related to CIs, SEs, UDs, and other REs.
The PIHP's analysis considered REs that put individuals at risk of harm. These events minimally include actions taken by individuals who receive services that cause harm to themselves; actions taken by individuals who receive services that cause harm to others; and two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period.

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
	NorthCare will Increase data reporting capabilities by	Develop a new report that allows for detailed data analysis and trending by 2.1.22	Completion of report(s) in EMR	2.1.22		Brittany

	building report(s) to better analyze improvements in the quality of health care and services for members over the next year. (IRs)	Increase timely categorization of incidents as being sentinel, critical, risk, a combination, or none, to 95% within 3 days of incident.	Reduction of IRs not classified prior to Health and Safety Committee Meetings.	3.1.22		Brittany
		Review and analyze data at internal and regional meetings, to identify progress, identify trends, identify concerns, verify improvements in the quality of health care services, and better the lives of individuals served.	Identify potential changes, trends, concerns, and act as necessary.	9.30.22	quarterly	Brittany
		Develop a way to review RCA outcomes via a report, gather data, and review data for possible implementation of performance improvement projects.	Add RCA categories to reporting spec.	9.30.22		Brittany and Joan
Updates	In October the IR reporting module and associated data report changed. This has made some review more difficult. It has helped for monitoring late reports being submitted to the CMHs.					
Monitoring	Review data at the health and safety committee meetings					

NorthCare Network Quality Improvement Work Plan					
FY22 - 13.					
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**
HSAG	FY21	St.III.5	Tami		
Description of Standard/Initiative					
7. Meet and require its network providers to meet MDHHS standards for timely access to care and services, taking into account the urgency of the need for services. 8. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid FFS, if the provider serves only Medicaid members. 9. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. 10. Establish mechanisms to ensure compliance by network providers. 11. Monitor network providers regularly to determine compliance. 12. Take corrective action if there is a failure to comply by a network provider.					

Findings	**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**
The PIHP did not provide evidence of a process to actively monitor adherence to all time frame standards; for example, adherence to admission time frames for pregnant women receiving services for a SUD, which are more stringent than the appointment standards tracked and reported via Michigan's Mission-Based Performance Indicator System (MMBPIS). The PIHP acknowledged in follow-up that it did not have		NorthCare will implement the plan for monitoring access timeliness.	Timeliness report.	November 2022		Tami
		Monitoring will be conducted quarterly starting in November	Quarterly reports.			

monitoring documentation for appointment times for all priority population requirements. The PIHP must meet and require its network providers to meet MDHHS standards for timely access to care and services and establish mechanisms to regularly monitor compliance and take corrective action if there is a failure to comply. This should apply to all screening and appointment standards in addition to those reported through MMBPIS.		2022 for Q4 FY22.				
Updates	Q4FY22 – NorthCare's Clinical Director and CIO have completed the analysis and plan for tacking and monitoring timeliness. Monitoring is scheduled to begin in November with review of quarter 4 FY22 data.					
Monitoring						

NorthCare Network Quality Improvement Work Plan						
FY22 - 14.						
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**	
HSAG	FY21	St V.13	Ashlee			
Description of Standard						
Any modification of the conditions, under 42 CFR §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:						
Findings	**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**
While case examples were provided after the interview session, the PIHP's initial documentation primarily focused on behavior treatment plans/reviews; however, it did not specifically address the HCBS Final Rule, a member's freedom and rights afforded under that rule, or the specific service plan documentation required should there be a modification to those freedoms and rights. While not cited as evidence of compliance, the PIHP's Site Review Protocol tool included a scoring element evaluating whether the provider has a current policy that addresses all regulations set forth in the HCBS Final Rule, including the rights and freedoms listed in the HCBS Final Rule, and how to handle and document a health and safety need when it warrants a restriction to an individual. However, documentation did not support that the PIHP	Any modification of the conditions, under 42 CFR §441.301(c)(4)(vi)(A) through (D), will be supported by a specific assessed need and justified in the person-centered service plan. The service plan will include all documentation required by this element and the HCBS Final Rule.	Addition of HCBS site review standards will be added for FY22 site reviews which are typically conducted between July and October.	New/Updated form with all standards.	03/01/22	9/23/21	Ashlee Brittany
		Documentation will be reviewed at time of annual site reviews starting in FY22 which are typically conducted between July and October	Documentation review reports.	09/30/22		Ashlee
		Develop a report to easily identify limitations documented in	Report completion	3/1/22		Ashlee

implemented processes to specifically review member records and service plans to verify if all required documentation elements are consistently being included in the service plan when a modification to a member's freedom and rights under the HCBS Final Rule is imposed. The Documentation Review Form included several review elements related to the service plan, but no elements related to the requirements of this element. The Site Review Protocol tool did indicate that the review will include a chart review on a sample of HCBS charts; however, it also documented that, as a region, the PIHP was finishing up corrective action plans and desk audits for the "HS exit ramp case." It was unclear what these chart reviews consist of or the entity conducting the audits (i.e., if audits were being completed by the PIHP versus MDHHS).		the Individual Plan of Services.				
		NorthCare will conduct ongoing monitoring to ensure that limitations noted in the IPOS have been reviewed by Provider. Quarterly	Monitoring Reports	5/1/22		Ashlee

Updates	Q4FY22 - HCBS standard reviews will be completed annual site reviews on 9/30/22. The report has been completed and validated as of 4/18/22. A few enhancements to this report have been identified and submitted to IT. In the process of validating and analyzing this new report, NorthCare staff identified inconsistencies in what was documented as a limitation and restriction on consumer rights in the IPOS. Given the variation in current documentation practices it was not deemed efficient to begin monitoring until a training and monitoring plan were developed. Target date for plan development is 11/1/22. **MDHHS/HSAG Response:** The PIHP should prioritize the training and monitoring plan as indicated in its action steps to complete. This element will be reviewed during the third year of the compliance review cycle. The PIHP should be prepared to provide evidence of implementation of its plans of action at that time.
Monitoring	

NorthCare Network Quality Improvement Work Plan					
FY23 - 1.					
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**
QAPIP	FY21-22	QAPIP	Brittany		
Description of Standard/Initiative					
The PIHP's analysis considered all UDs (those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect), including aggregated mortality data over time to identify possible trends. The PIHP's analysis considered CIs for residential treatment providers. The QAPIP work plan identified a goal(s) and/or objective(s) related to CIs, SEs, UDs, and other REs. The PIHP's analysis considered REs that put individuals at risk of harm. These events minimally include actions taken by individuals who receive services that cause harm to themselves; actions taken by individuals who receive services that cause harm to others; and two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period.					

Findings	**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**

	NorthCare will Increase data reporting capabilities by building report(s) to better analyze improvements in the quality of health care and services for members over the next year. (IRs)	Develop a new report that allows for detailed data analysis and trending by 1/1/23	Completion of report(s) in EMR	1.1.23		Jen/ Brittany/ PCE
		Increase timely categorization of incidents as being sentinel, critical, risk, a combination, or none, to 95% within 3 days of incident. (1 CMH in particular)	Reduction of IRs not classified prior to Health and Safety Committee Meetings.	2.1.23		Brittany
		Ensure individuals living in residential living arrangements are in the correct level of care and help transition to less restrictive levels of care any individuals that it would be appropriate to do so.	Completion of review	6.1.23		Brittany
		Develop a way to review RCA outcomes via a report, gather data, and review data for possible implementation of performance improvement projects.	Add RCA categories to reporting spec.	4.1.23		Jen/ Brittany/ PCE
Updates						
Monitoring						

NorthCare Network Quality Improvement Work Plan							
FY23 - 2.							
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**		
MDHHS	FY23	Contract/QAPIP Req	QI Coord.				
Description of Standard/Initiative							
Annual effectiveness review of QAPIP.							
Findings/Requirements			**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**
The QAPIP effectiveness review must be completed annually with board approval prior to submission to MDHHS by 2/28/23.			The effectiveness review must include analysis of whether there have been improvements in the quality of health care and services for beneficiaries as a result of QAPIP activities and interventions carried out by the PIHP.	Analysis must consider trends in service delivery and health outcomes over time.	Sufficient description written in QAPIP eff. Review report.	2/1/2023		QI Coordinator
				The evaluation should identify the prior year's performance goal and whether goals were met or not met.	Sufficient description written in QAPIP eff. Review report.	2/1/2023		QI Coordinator
				Analysis must include monitoring of progress on performance goals and objectives or lack thereof.	Sufficient description written in QAPIP eff. Review report.	2/1/2023		QI Coordinator
				Include language that references the trends and outcomes in the evaluation, i.e. analyzed trends in service delivery and health outcomes over	Sufficient description written in QAPIP eff. Review report.	2/1/2023		QI Coordinator

		time, including whether there have been improvements and barriers impacting he quality of health care and services for members as a result of the activities.				
		Information on the effectiveness of the QAPIP must be provided to the State no later than 2/28/23.	Final Report	2/28/23		QI Coordinator
		Review and incorporation of MDHHS feedback from FY21 QAPIP eff. Review report as applicable.	Documented in FY22 QAPIP Eff. Review Report	2/1/2023		QI Coordinator
		Ensure goals in this QI work plan are measurable.	By ensuring SMART goals throughout this workplan.	2/1/23 and ongoing		QI Coordinator
Updates						
Monitoring						

NorthCare Network Quality Improvement Work Plan								
FY23 - 3.								
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**			
MDHHS	FY23	Contract/QAPIP Req	QI Coord					
Description of Standard/Initiative								
St VII Credentialing and Re-Credentialing								
Findings			**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**
The QAPIP **description** contained a summary of procedures to ensure physicians and other health care professionals, and non-licensed providers are qualified to perform their services - Was unable to find information related to non-licensed providers.			Ensure QAPIP addresses/or references non-licensed providers.	Update QAPIP and/or policy/procedures.	Updated QAPIP and/or policy/procedure language.			QI Coordinator
The PIHP described how findings of the QAPIP are incorporated into the recredentialing process. .			Ensure the QAPIP addresses and/or references specific performance data that the PIHP considers at the time of a provider's recredentialing (for example, grievances, performance indicators, utilization, appeals, member satisfaction, provider monitoring reviews, CIs, etc.)	Update QAPIP and/or policy/procedures.	Updated QAPIP and/or policy/procedure language.			QI Coordinator
Updates								
Next Steps								

NorthCare Network Quality Improvement Work Plan								
FY23 - 4.								
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**			
MDHHS	FY23	Contract/QAPIP Req	QI Coord					
Description of Standard/Initiative								
St XI. Long-Term Services and Supports (LTSS)								
Findings			**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**
QAPIP includes mechanisms to assess the quality and appropriateness of care furnished to members receiving LTSS. The PIHP's process included an assessment of care between care settings. MDHHS was not able to locate language referencing this in the description. In addition, the process must include a comparison of services and supports received with those set forth in the member's treatment plan and it was not clear if there is a separate process for the comparison.			Expand the description to include activities conducted by the PIHP to assess member care between care settings.					CPC/QI Coordinator
			The description should expand on the activities conducted by the PIHP to compare services received by members compared to the services identified in members' treatment/service plan.					CPC/QI Coordinator
Updates								
Monitoring								

NorthCare Network Quality Improvement Work Plan								
5. Coordination of Care for Persons with Co-morbidities								
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**			
HSAG	FY2023	V.2.b.,V.2.c.; V.4., V.6.	Katreena					
Description of Standard/Initiative								
Findings			**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**
			Add data collaboration workgroup. Health services committee. BHH.					
Updates								
Monitoring								

NorthCare Network Quality Improvement Work Plan					
13.					
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**
HSAG	FY22	St VII Provider Selection Stds 13-16	Karena Grasso		
Description of Standard/Initiative					
The PIHP Complies with individual practitioner and organizational credentialing and re-credentialing requirements as outlined in MDHHS contract/policy and/or HSAG credentialing and recredentialing file review tools.					

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
Various findings as outlined in R1-NorthCare_MI2022_PIHP_CR_CAP_F1 HSAG document.	Bring these standards into full compliance with Standards 13 – 16.	Develop and implement detailed credentialing/recredentialing file auditing plan addressing credentialing/recredentialing requirements, citations, and recommendations made in HSAG review.	Documented audit plan.	3/1/23		
		Conduct initial audit of all delegates performing credentialing activities according to audit plan.	Completed audit.	10/1/23		
		Conduct annual audit of all delegates performing credentialing activities according to audit plan.	Completed audit.	At least annually		
Updates						
Monitoring						

NorthCare Network
Quality Improvement Work Plan

8.

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location
HSAG	FY22	IX G&A (Grievances)	Kayti		

Description of Standard/Initiative

St. IX.6 - The PIHP must resolve each grievance, and provide *written* notice *of resolution*, as expeditiously as the member's health condition requires, within MDHHS timeframes that may not exceed the timeframes specified in 42 CFR §438.408.

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
St 6. Complaints not adequately documented, investigated, or resolved.	Bring this standard into full compliance by implementing a QA process to ensure grievance resolution notices are professional, written to the member, free of errors and written at the 6.9 reading grade level.	Develop and implement a plan to ensure grievance letters are reviewed for quality.	Document quality review plan.	4/1/23		
		Complete initial quality review.	Initial quality review report.	4/1/23		
		Complete ongoing quality reviews.	Quarterly	7/1/23 10/1/23		
Updates						
Monitoring						

NorthCare Network
Quality Improvement Work Plan

9.

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location
HSAG	FY22	IX G&A (Grievances)	Kayti		

Description of Standard/Initiative

If the PIHP extends the grievance resolution timeframe not at the request of the member, it must complete all of the following:

a. Make reasonable efforts to give the member prompt oral notice of the delay.

b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
The PIHP's policy did not include the requirements of this element under the grievance process section (only included in the appeal section of the policy), the PIHP did not have a letter template that would be used in such circumstances, and the grievance module did not include data fields for oral or written notice of the extension (only included in the appeal module). There was insufficient documentation to support a process for notification requirements for grievance resolution time frame extensions.	Bring this standard into full compliance.	Update the Enrollee G&A Policy to ensure that within 2 calendar days, the enrollee is given written notice of the reason for the decision to extend the timeframe and inform them of the right to field and grievance if they disagree with the decision to extend.	Updated Policy	12/6/22	12/6/22	Diane/Kayti
		Develop a template to be used to notify the enrollee of this extension.	Extension letter template.	3/1/23		Kayti
		Submit a request to PCE for enhancements to the grievance module to capture the date of oral and written notice of extension.	Spec to PCE for ELMER grievance module enhancements.	3/1/23		Kayti/Joan
		ELMER module enhancements completed.	Deployed in Elmer	5/1/23		Kayti/Joan/PCE
Updates						
Monitoring						

NorthCare Network
Quality Improvement Work Plan

10.

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location

HSAG	FY22	IX G&A (Appeal)	Compliance Officer		

Description of Standard/Initiative

St IX. 16. The PIHP must acknowledge receipt of each appeal.

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
The case file review identified three records in which the acknowledgement letters inaccurately informed members that the appeal would be resolved in 10 business days. Additionally, while one record included an acknowledgement letter, the mailing date was not populated indicating that it was never mailed.	To bring this standard into full compliance.	Update enrollee G&A policy indicating that each appeal will be acknowledge in writing within 5 calendar days of receipt of request.	Updated policy	12/6/22	12/6/22	Diane/Kayti
		Develop and implement a quality review plan to ensure review and monitoring of notices is conducted on a routine and ongoing basis to ensure they are professional and free of errors, etc.	4/1/23			Compliance Officer
		Complete initial quality review.	4/1/23			Compliance Officer
		Complete ongoing quarterly quality reviews.	7/1/23 10/1/23			Compliance Officer

Updates	
Monitoring	

NorthCare Network
Quality Improvement Work Plan

11.

Source	Review Period	Standard #	Standard Lead	Completion Date	N Drive Location
HSAG	FY22	XII HIS	Andy Kulie		

Description of Standard/Initiative

St XII.7 The PIHP must implement an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the PIHP. Information must be made accessible to its current members or the members' personal representatives through the API.

Findings	Goal	Objective	Success Measure	Target Date	Completion Date	Lead
The PIHP has not implemented a Patient Access API that meets the requirements of 42 CFR §431.60 (member access to and exchange of data).	NorthCare will participate in a interoperability sub-workgroup of the statewide CIO Forum and work with our EHR vendor to finalize a plan to implement compliant Patient Access API in the ELMER system and operationalize said API to meet this requirement.	Develop plan.	Documented plan.	2/28/23		Andy
			Operationalized plan	7/31/23		Andy

Updates	
Monitoring	

NorthCare Network
Quality Improvement Work Plan

12.					
Source	**Review Period**	**Standard #**	**Standard Lead**	**Completion Date**	**N Drive Location**
HSAG	FY22	XII. HIS	Andy Kulie		

Description of Standard/Initiative
St XII.8 The PIHP must maintain a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which must include all information specified in 42 CFR §438.10(h)(1) and (2).

Findings	**Goal**	**Objective**	**Success Measure**	**Target Date**	**Completion Date**	**Lead**
The PIHP has not implemented a Provider Directory API that meets the requirements of 42 CFR §431.70 (access to published provider directory information).	The PIHP has not implemented a Provider Directory API that meets the requirements of 42 CFR §431.70 (access to published provider directory information).	Develop plan	Documented plan	1/31/23		Andy
			Operationalized plan	6/30/23		Andy

Updates	
Monitoring	

NorthCare will continue to work on the items listed in the workplan, in addition to items identified in external audits, MDHHS policy and procedural updates, contract amendments, and other department initiatives as they arise.