NorthCare Network

Quality Assessment and Performance Improvement Plan (QAPIP)

FY24 QAPIP and Workplan
FY24 Annual Effectiveness Review &
FY25 QAPIP and Workplan

Reviewed and Approved by: Quality Management Committee – 1.29.25
Reviewed by: NorthCare Leadership – 1.31.25
Reviewed and Approved by: NorthCare Governing Board – 2.12.25

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 and the contracted providers. 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 Community Mental Health Service Program (CMHSPs) and their respective provider networks and the Substance Use Disorder (SUD) Providers. MDHHS requires each PIHP to 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 initiatives 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 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 through September 30, and is due to MDHHS by February 28, each year.

The effectiveness and progress of the QAPIP builds on the creation of the next years QAPIP. NorthCare's QAPIP consists of the following areas that are reviewed annually for effectiveness. The FY24 QAPIP and associated work plan starts on page 12 and includes the following elements and highlights:

I. Introduction
II. Purpose
III. Quality Improvement Authority and Structure
    a. Change in committees from FY23 to FY24 and again in FY25.
IV. Quality Management System (components and Activities)
    a. FY24 movement of appeals and grievances being handled at the CMH's to being handled at the PIHP
    b. FY24 decentralization of the regional Access center for Mental Health. Substance Use Disorder Access is still completed at the PIHP.
V. Procedures Adopting & Communicating Process & Outcome Improvements
VI. Evaluation
VII. References
VIII. Attachments

In meeting the QAPIP requirements, NorthCare conducts an annual review of the effectiveness of components under the Quality Management System 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 FY24 QAPIP effectiveness review begins on page 44.

The FY25 QAPIP and Work Plan starts on page 103.

Organizational Structure

NorthCare Network's organizational structure allows for evaluation of the Quality Assessment and Performance Improvement Plan (QAPIP). The QAPIP is reviewed by the Board of Directors annually. Further the Board of Directors oversees the QAPIP via frequent updates on progress based on analysis of data. Communication about the QAPIP, updates on progress, and ongoing activities is provided throughout the agency and with providers via various committees. NorthCare maintains responsibility for the evaluation and monitoring of its program providers and evaluation of the annual QAPIP. Policy and procedure guidelines uniform practice. The Clinical Practice Guidelines are reviewed in the Clinical Practices/Quality Improvement committee and are available on the NorthCare Website. The Substance Use Disorder (SUD) operations manual is reviewed with the SUD providers. Providers consistently falling below expectations are required to complete corrective action plans to improve measures. Data is shared at the various committees and annual reports are publicly available on the website.

NorthCare Organizational Chart

The Board of Directors (Board) is the Governing Board for NorthCare. The Board manages the day-to-day business, property, and affairs of NorthCare. They approve policies/plans, contracts, approve financial reports, and employ the Chief Executive Officer (CEO). In FY23 Megan Rooney became the CEO. The Board approves the PIHP QAPIP which was developed by the Quality Improvement team. The Board also approves the annual QAPIP effectiveness review.

The CEO is hired by the Board. The CEO establishes a leadership team responsible for heading each area of the agency. The CEO reports to the Board the outcomes of various quality efforts and improvement initiatives of the agency.

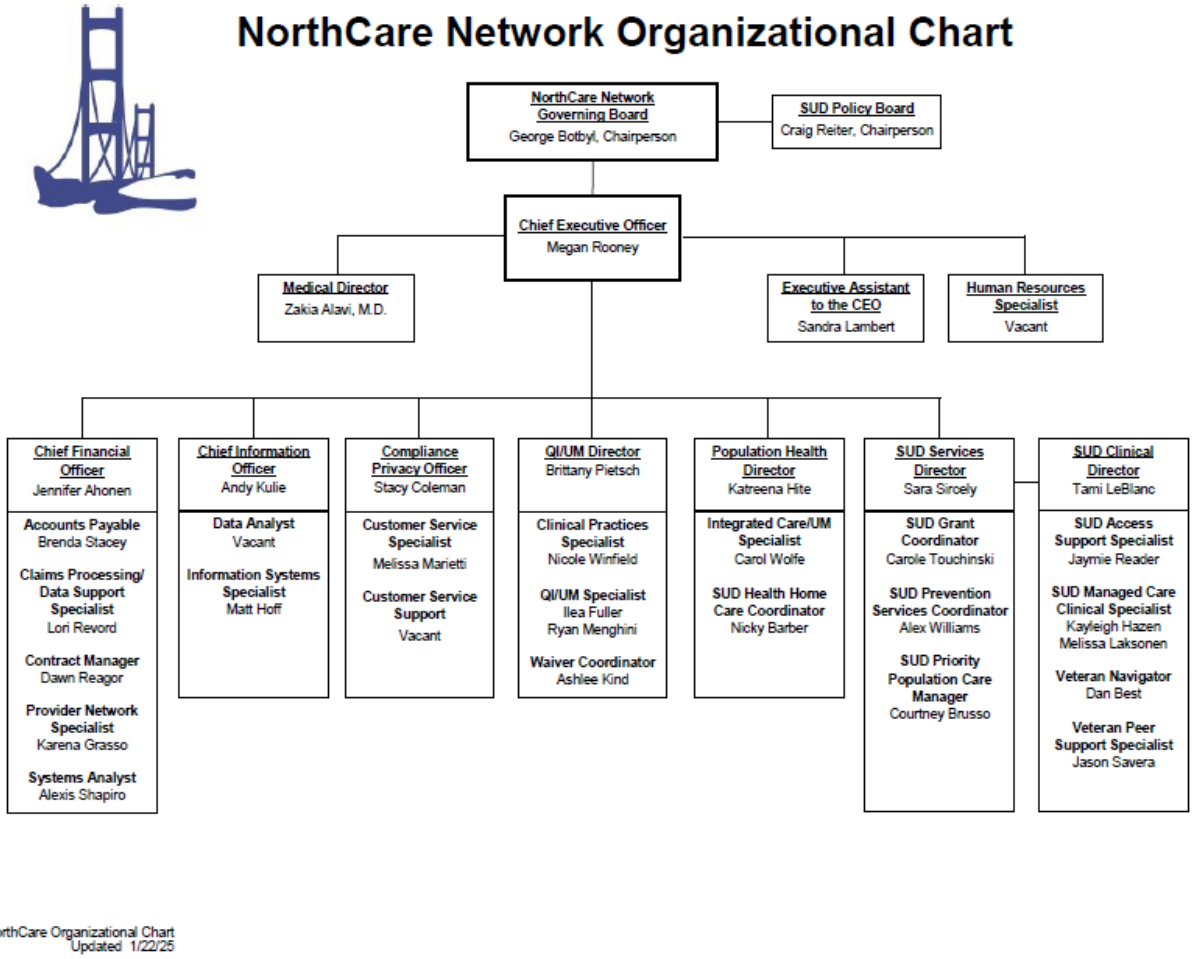
The Medical Director provides general oversight and consultation to psychiatric, medical services, and other behavioral health services for NorthCare. The Medical Director consults with clinical staff regarding utilization management, quality, health and safety, and other concerns during regularly scheduled meetings for mental health and substance use disorders. The Medical Director participates in risk management activities and serves as a liaison with community physicians. The Medical Director also provides consultation for inpatient psychiatric continuing and retrospective stay reviews, and inpatient Electroconvulsive Therapy (ECT) treatments.

Community Mental Health (CMH) and SUD providers participate in various committees. Committees review applicable data, discuss current MDHHS mandates/requirements, provide support and suggestions for improvement, and discuss any concerns or barriers they are experiencing. They provide input into processes, especially as it pertains to changes in the Electronic Medical Record (EMR).

The following organizational chart, as of 11.4.24, reflects the agency structure in FY24. A major change included the decentralization of the Access center which allowed for some shifting of staff supervisors. On January 2, 2024, NorthCare Network moved from a regional Access Center to local Access at each CMH. Access responsibilities for Substance Use Disorder Residential Services remained, and continues to remain, with NorthCare Network. In June 2024 NorthCare added an

SUD Grant Coordinator position. In June 2023 NorthCare created and filled a position for an SUD Priority Population Specialist.

In FY25, the Senior Clinical Director retired. This position was not filled. The agency is increasing its Quality Improvement and Utilization Management (QI/UM) team and will focus on having a team of staff to review the quality management program and quality improvement efforts of the agency. One QI/UM position was filled in October 2024. One more QI/UM position was filled December 2024 with a start date in January 2025. It is recognized that quality improvement, utilization management, and clinical practices often overlap and intersect. Population Health is a subset of Quality and will remain part of the QI/UM team but took a leadership role. The positions of QI/UM, Population Health, Integrated Care, Waiver Coordinator, and Clinical Practices will all work closely to address Community Mental Health (CMH) quality. Additional staff will be consulted with as necessary. For Substance Use Disorder Services quality, the SUD Services Director, SUD Clinical Director, and SUD health home, prevention, priority population, and access staff will be the clinical leads consulting with the QI/UM director.



NorthCare Governing Body

The Board of Directors is NorthCare's Governing Body and is responsible for employing the Chief Executive Officer (CEO) and approving the QAPIP. They also receive status updates during board reports. Meeting minutes are available upon request or on NorthCare Network's website: https://northcarenetwork.org/board.html. The NorthCare Board of Directors is comprised of members of the CMHSPs Boards of Directors. The following table details board membership as of 9.10.24. There were two changes in board membership in FY24. Craig Reiter (Hiawatha) and Kathy Thompson (Northpointe).

Name	**Credentials**	**Organization** (if applicable)	**Appointed**
1. Michael Koskinen	Retired	Copper Country CMHSP	1/2014
2. Patrick Rozich, *secretary*	BA, MA-Retired School Superintendent	Copper Country CMHSP	1/2014
3. Jim Tervo	Inventory Control	Copper Country CMHSP	1/2014
4. Richard Herrala (alternate)	Retired	Copper Country CMHSP	4/2022
5. Colleen Kichak	Retired	Gogebic County CMHSP	4/2022
6. Joe Bonovetz	Retired Letter Carrier County Commissioner	Gogebic County CMHSP	11/2015
7. William Malloy, Jr.	Retired Clinical Social Worker	Gogebic County CMHSP	4/2022
8. Susan Roberts (alternate)	Retired	Gogebic County CMHSP	4/2024
9. George Ecclesine	Retired -Real Estate, HR, Banking	Hiawatha CMHSP	7/2015
10. Craig Reiter		Hiawatha CMHSP	9/2024
11. Dr. John Shoberg	PhD Psychologist	Hiawatha CMHSP	1/2014
12. Ann Martin	Retired Teacher, Master's Degree in Education, County Commissioner	Northpointe CMHSP	5/2017
13. Mari Negro	MCAO and Retired Publisher	Northpointe CMHSP	1/2014
14. Kevin Pirlot	Self-Employed	Northpointe CMHSP	4/2022
15. Kathy Thompson	Retired	Northpointe CMHSP	4/2024
16. George Botbyl, *Chair*	Retired LMSW	Pathways CMHSP	4/2015
17. Margaret Rayner, *vice-chair*	Retired RN	Pathways CMHSP	4/2022
18. Glenn Wing	Retired	Pathways CMHSP	2/2021

NorthCare Substance Use Disorder Policy Board

The Substance Use Disorder (SUD) Policy Board is a committee of the Governing Board. Many members of the governing body are also on the SUD Policy Board. The board is comprised of one member from each county of the Upper Peninsula. The following represents board membership as of 10.29.24.

Name	**County**	**Appointed**
1. Stephen Adamini	Marquette	4/2018
2. Joe Bonovetz	Gogebic	7/2018
3. Roy Britz	Houghton	2/2019

4. Rick Capogrossa	Alger	4/2023
5. Corina Clark	Mackinac	4/2023
6. Randy Eckloff (*vice chair)*	Keweenaw	11/2014
7. Mike Koskinen	Baraga	11/2014
8. Damon Lieurance	Chippewa	10/2024
9. Ann Martin	Dickinson	4/2021
10. Nancy Morrison	Luce	11/2014
11. Robert Nousianinen	Ontonagon	9/2018
12. Patti Peretto	Iron	8/2022
13. Craig Reiter *(Chair)*	Schoolcraft	1/2017
14. Steven Viau	Delta	5/2024
15. Connie Westrich	Menominee	1/2023

NorthCare Committee Chart

Annually, NorthCare updates the committee fact sheets. Committee fact sheets detail the purpose of the committee, committee membership, and the deliverables of the committee.

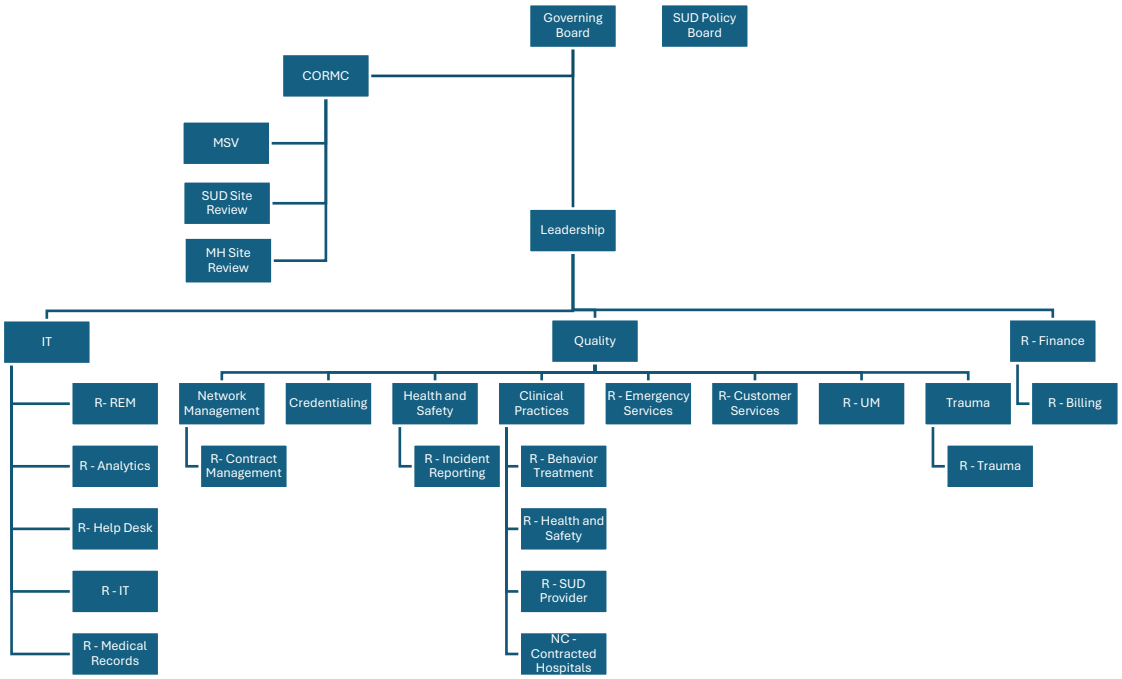
- The NorthCare Leadership Committee is comprised of NorthCare supervisory staff and is responsible for monitoring and discussing regional concerns. Information from internal and regional committees filters up to the leadership committee. Decisions made in leadership filter down to other committees.
- The NorthCare Information Technology (IT) Committee acquires and manages standards-based technology that supports PIHP and Provider clinical and business operations. It ensures compliance with oversight agency requirements including External Quality Review Organization, Accreditation, Michigan Department of Health and Human Services (MDHHS), and Centers for Medicare and Medicaid (CMS)/ Office of National Coordinator (ONC), and ensures the confidentiality, integrity and availability of electronic protected health information through regional collaboration and coordination of technical/security solutions.
    - The regional ELMER Management (REM) Committee has an executive function with a regional focus to implement and maintain an electronic medical record that fulfills administrative, business, clinical documentation and reporting requirements.
    - The regional Analytics Committee provides and facilitates provision of information necessary to support business decisions from clinical and administrative perspectives as well as oversight and support of data integrity and information. It provides and facilitates provision of information to improve delivery of quality services and meet reporting requirements.
    - The regional Help Desk Committee ensures that regional shared technology is functioning at optimal levels and addresses problems that cannot be solved locally.
    - The regional Medical Records Committee has a medical records management function to minimize risks, optimize benefits, and comply with legal requirements of a hybrid medical record. This committee is committed to achieving standardization of policies, procedures, and assuring that the medical record maintains efficient

clinical utility while maintaining the required integrity of the record and uniform application of the system.

- The NorthCare Trauma Committee is responsible for the agency self-assessment every 3 years. Upon completion of the self-assessment, the committee ceases meeting until it is time to complete the self-assessment again.
    - The regional Trauma Committee is comprised of members from the CMH and SUD provider network and meets quarterly to address trauma in the lives of consumers by ensuring a trauma-informed system that 1. Understands trauma and its impact on consumers, staff, and community, 2. Promotes agency self-assessment, 3. Provides a safe and understanding environment for consumers and staff, and 4. Provides trauma specific services for all populations served. This committee adopts MDHHS definition of trauma; *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being*.
- The NorthCare Quality Management committee promotes objective and systematic measurement, monitoring and evaluation of clinical and non-clinical services and implements quality improvement activities based upon the findings as well as implementation of the QAPIP. It promotes a culture based on the continuous quality improvement model as a means to develop and implement improvement processes and monitor their ongoing success is promoted.
    - The NorthCare Network Management committee ensures adequate provider capacity throughout the NorthCare Network to meet current and anticipated demands of services.
    - The regional Credentialing Committee promotes safe and effective treatment with credentialing and re-credentialing NorthCare Network healthcare practitioners and organizational providers.
    - The NorthCare Health and Safety Committee reviews critical incidents, sentinel and risk events from CMH's and reported events from SUD providers to look for trends, address issues, and follow up with providers to ensure improved practice and overall safety of the environment.
        - The regional Incident Reporting workgroup is morphing into a committee. Quarterly it reviews CMH trend data related to incidents and confirms consistent process.
    - The regional Clinical Practices and Quality Improvement (CPQI) Committee engages consumers and staff in accurate, data-driven affiliation-wide processes, resulting in quality and performance improvement, the achievement of standards, and the establishment of new standards. The CPQI Committee primary charge is to implement the QAPIP while working to establish a culture based on the continuous quality improvement model as a means to develop and implement improvement processes and monitor their ongoing success. Use of data driven reporting to ensure progress towards quality improvement and compliance is promoted. The committee reviews and addresses issues of non-compliance and monitors plans of correction in coordination with Provider Network Management. Quality measures focus on ensuring the full array of services are provided according to best clinical practices

by a qualified workforce that supports the recovery of the individuals and families we serve in accordance with the Michigan Mental Health Code, Michigan Medicaid Provider Manual and MDHHS Technical Requirements attached to the MDHHS/PIHP Contract.
    - The regional Behavior Treatment Committee (BTC) is a subcommittee of CPQI and is responsible to review data trends from BTC committees and ensure consistent process of conducting and completing behavioral treatment plans and committees.
    - The regional Health Services Committee leverages health information technology and regional expertise to develop and deliver interventions to improve the whole-person health of people served under the Medicaid Specialty Mental Health Benefit.
    - There are also meetings with various contracted hospitals, individually, as a quality method to ensure contract compliance and emergency service processes are working effectively and efficiently.
  - The regional Emergency Services (ES) Committee seeks to fulfill Section 330.1206 of the Michigan Mental Health code 1a. "*Crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service that is prepared to respond to persons experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment.*" Additionally, ES committee looks to fulfill Section 8 of the Behavioral Health Section of the Michigan Medicaid Provider Manual, "*The PIHP is responsible to manage and pay for Medicaid mental health services in community-based psychiatric inpatient units for all Medicaid beneficiaries who reside within the service area covered by the PIHP. This means that the PIHP is responsible for timely screening and authorization/ certification of requests for admission, notice and provision of several opinions, and continuing stay for inpatient services.*" Finally, ES addresses concerns related to Emergency Services availability and utilization and discusses any associated issues, including Information Technology (IT) systems and state-level mandates.
  - The regional Customer Services (CS) Committee reviews customer service related issues and events that are relevant to assuring regional programs are able to effectively implement changes and monitor the public behavioral health service delivery system.
  - The regional Utilization Management (UM) Committee monitors utilization of clinical resources and provides supports that ensure services are used only for authorized purposes, uniformly available to eligible persons, and are provided in an effective and efficient manner.
- The regional Finance Committee makes recommendation on regional best practices for Financial Management that demonstrates our fiduciary responsibility of being a "value" purchase of MDHHS.
  - The regional Billing Committee is a subcommittee of the regional finance committee. It seeks to ensure that the ELMER Billing Module is used uniformly across the region by identifying current billing procedures and best practices in the region and aligning them with ELMER's existing billing and encounter reporting system. Best Practices include but are not limited to the following: current billing

procedures, MDHHS requirements for claims billing and encounter reporting, state, and national coding standards, CHAMPS, and other eligibility sources. Functional and procedural needs include Data Management practices, SALs, Claims Management and AP support, preprocessing data scrubbing and post processing review.



FY24 QAPIP

The FY24 QAPIP begins on the next page. These 24 pages represent what the plan was in FY24. It is followed by the FY24 QAPIP workplan, which details the tasks and goals for the year. These 24 pages will then be reviewed for effectiveness starting on page 44.

FY24

NorthCare Network

FY24 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN (QAPIP)

Quality Management Department
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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.

NorthCare Network is the prepaid inpatient health plan (PIHP) for the five community mental health agencies serving the Upper Peninsula. The five consist of Copper Country Community Mental Health, Gogebic County Community Mental Health, Hiawatha Behavioral Health, Northpointe Behavioral Health System, and Pathways Community Mental Health. The counties in which each serve are detailed below.

- Copper Country: Baraga, Houghton, Keweenaw, Ontonagon
- Gogebic: Gogebic
- Hiawatha: Chippewa, Mackinac, Schoolcraft
- Northpointe: Dickinson, Iron, Menominee
- Pathways: Alger, Delta, Luce, Marquette

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. It supports our vision to ensure a full range of accessible, efficient, effective, and integrated quality behavioral health services and community-based supports for residents of Michigan's Upper Peninsula.

We achieve this by staying true to our values.

- We believe in respect, consumer empowerment, person centered care, self-determination, full community participation, recovery, and a culture of gentleness.
- We endorse effective, efficient community-based systems of care based on the ready availability of a competent workforce and evidence-based practices.
- We believe in services that are accessible, accountable, value based, and trauma informed.
- We support full compliance with state, federal and contract requirements, and responsible stewardship.
- The right care, and the right time, for the right cost, and with the right outcome.

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.

We do this to achieve the following desired outcomes:

- Meet, or exceed, state performance metrics as well as improving performance for identified projects.
- Improved data analysis of critical incidents to reduce adverse effects on consumers and behavior treatment committee data to reduce the need for physical intervention.
- Ensure satisfaction of services and HCBS rules and quality clinical practice guidelines that are accessible to consumers and staff.
- Verify staff are qualified to complete their duties and there is network adequacy to provide necessary services.
- Ensure services meet Medicaid standards. Ensure appeal and grievance information is provided to members.
- Increase consistency in Utilization Management decisions across the region and assess the appropriateness of individuals' level of care and the services they are providing.

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 Responsibility

NorthCare Network Governing Board

- *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, due February 28th, which includes a list of members.
- *Reporting Frequency:* Quarterly

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 below.

Title	Department	Average percent per quarter devoted to QM
Senior Clinical Director	Clinical/Access	15%
SUD Clinical Director	Clinical/ SUD Access	15%
Clinical Floater/Social Worker	Clinical/Access	10%
Clinical Practices Coordinator	Clinical	15%
Customer Service Specialist	Customer Service	10%
Data Analyst	Information Management	5%
Population Health Specialist	Integrated Care/Population Health	20%
Medical Director (Part-time)	Clinical	75%
Provider Network Specialist	Network Management	10%
QI/UM Specialist	QI	50%
Systems Analyst	Information Management	25%
Compliance-Privacy Officer	Compliance	25%

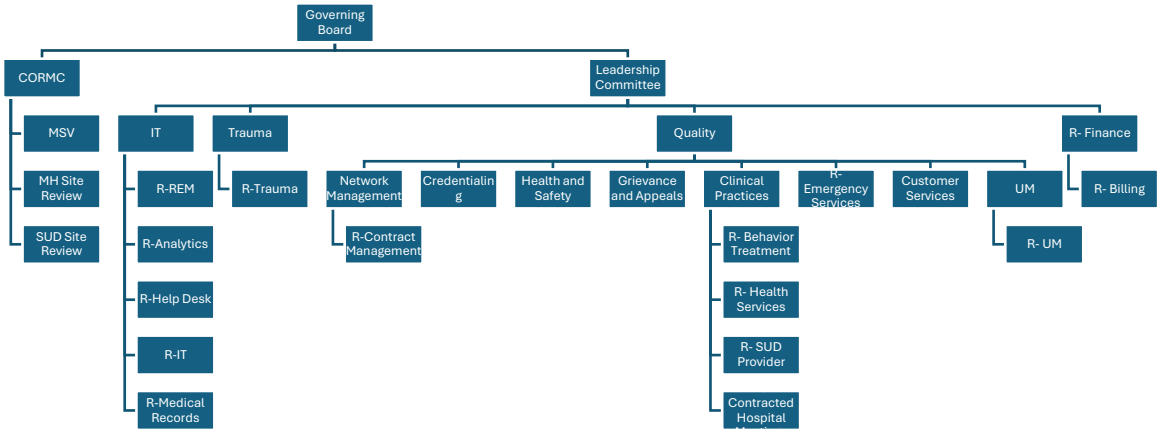
QAPIP Committee/Teams

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. Regional committees are denoted with an "R" on the chart.

NorthCare Governing Board of Directors

A. NorthCare Compliance Oversight and Risk Management Committee (CORMC)
    1. NorthCare Medicaid Service Verification Team (MSV)
    2. NC Site Review Team (MH)
    3. NC Site Review Team (SUD)
B. NorthCare Leadership Committee
    1. NorthCare Information/Technology Management Committee
        a) Regional Elmer Management Committee (REM)
        b) Regional Analytics Committee
        c) Regional Help Desk Committee
        d) Regional Information Technology and Security Committee
        e) Regional Medical Records Committee
    2. NorthCare Trauma Informed Committee
        a) Regional Trauma Informed Committee
    3. NorthCare Quality Management Committee
        a) NorthCare Network Management Committee
        b) Regional Contract Management Committee
        c) NorthCare Credentialing Committee
        d) NorthCare Health and Safety Review Committee

e) Regional Grievance & Appeal Committee
f) Regional Clinical Practices/QI Committee
    a. Regional Behavioral Treatment Committee
    b. Regional Health Services Committee
    c. SUD Provider Clinical Meeting
    d. NC/UPHS-Marquette QI Committee
    e. NC/War Memorial QI Committee
    f. NC/Willow Creek QI Committee
    g. NC/Aspirus QI Committee
    h. Regional Emergency Services Committee
    i. NorthCare Utilization Management Committee
    j. Regional Utilization Management Committee
    k. Regional Customer Services Committee
    l. Regional Finance Committee
    m. 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.

Additionally, each CMHSP has a quality improvement process to address quality issues within its operations. Each CMHSP also has a customer services meeting for increased consumer involvement and voice. Regional satisfaction results are shared and reviewed by NorthCare Network. NorthCare reviews the CMHSP websites and publications annually.

Substance Use Disorder (SUD) services are delivered through a network of contracted provider organizations. No managed care functions are delegated to SUD providers. To ensure

representation, SUD providers are involved in the Regional SUD Provider Clinical Meetings and concerns are brought to leadership.

Quality Management System

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

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

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.

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. Surveys are sent to staff periodically, as determined necessary, to identify training needs.

SUD providers are invited to provide input in the regional SUD clinical meeting. Grievance and appeals are also a valuable source of stakeholder input, as well as consumer satisfaction surveys and targeted surveys based on program (e.g., the BTC bi-annual survey).

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

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, and the services and supports offered. Members of services are encouraged to complete the satisfaction survey. Surveys are mailed to a sample of individuals monthly, but the survey is always available online at https://forms.office.com/r/FAbuLXDuFh. To increase consumer input, CMHSPs have provided this survey link on appointment reminder cards, posted it in waiting room lobbies, and it has been advertised in the annual consumer newsletter. Survey results are shared in the annual newsletter and other reports as necessary.

A survey is completed annually to assess member experience with the Access and Intake process. This survey is competed on a sample of individuals who were approved for services as well as those who weren't.

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.

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

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.

Some UM activities overlap with other areas and may be led by various committees but be pertinent to UM, such as recidivism for inpatient psychiatric admissions. UM areas of focus include over and under utilization, appropriate level of care, eligibility criteria, and medical necessity for specific services.

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.

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 at 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.

We also complete metabolic monitoring for individuals receiving services with the CMHSPs. NorthCare Network works with designated representatives from each CMHSP to implement practices for the monitoring, prevention, and treatment of metabolic syndrome. In FY2023, NorthCare will implement system updates to ELMER to capture hip circumference and measure that against waist circumference. This will enable early monitoring and intervention with diet/exercise to address the metabolic impacts of psychotropic medications.

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.

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. Specialty residential providers will report incidents to the CMHSP, either via electronic or paper process. Other Network Providers, including residential SUD treatment providers, may continue to report on paper. Incidents will be reviewed during the NorthCare Health and Safety meeting. Analysis and trend lines will be reviewed frequently.

- 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.

- 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.

- 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.

- 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.

- 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. Unexpected deaths are marked as either critical, sentinel, or both. Specifics for reporting are included in NorthCare's Incident, Event & Death Reporting & Monitoring Policy.

Critical Incidents are automatically uploaded into the CRM as of 10.1.22. Immediately reportable events and SUD sentinel events are manually uploaded into the CRM within the specified

timeframes identified in the MDHHS guidelines. Remediation details for events, as necessary, are also submitted via the CRM.

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,
- Goods 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, Massage),
- 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 in place 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). For individuals on a waiver, or attempting to be on a waiver, there is additional paperwork and approval process for waiver covered services identified above. The new iSPA waiver also has additional process and scrutiny for identification of individuals receiving the services that are considered LTSS and qualifying for iSPA.

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*

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.

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

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 measures 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.

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.

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. Beneficiaries are informed of the guidelines annually in the newsletter. CMHSP staff attest to having access to the guidelines annually. SUD provider staff attest to having access to the guidelines and, more importantly, the SUD operations manual- which is an SUD focused guide. 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 ensure services are planned and delivered in a manner that reflects the values and expectations contained in practice guidelines adopted.

Additionally, for emergency services, NorthCare Network member CMHSPs use the MCG Indicia tool embedded into the regional preadmission screening form to assist in determining medical necessity for inpatient psychiatric admission.

To ensure fidelity to practice, NorthCare and the affiliate CMHSPs 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 is available ongoing.

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.

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.

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. The Performance improvement projects must be included in the QAPIP and must include the following elements:

1. Measurement of performance using objective quality indicators.
2. Implementation of interventions to achieve improvement in the access to and quality of care.
3. Evaluation of the effectiveness of the interventions based on the performance of measures in F(i).
4. Planning and initiation of activities for increasing or sustaining improvement.

PIP's are selected based on requirements of the PIP structure when possible. The most recent co-occurring PIP was selected and modified as there is not enough ethnic variation in the UP to create a PIP centered around racial disparity. Data that was gathered indicated that Native American's were receiving SUD treatment at a higher rate than their white counterparts. Therefore, MDHHS allowed for the PIP to be related to age rather than race.

When determining a PIP, NorthCare meets with the region via regional committee to discuss possible PIP topics. A topic is picked if it has the most regional support and the initial data review supports the need for a PIP that meets any of the criteria of the PIP structure. NorthCare then continues PIPs until improvement is shown that allows for sunsetting of the PIP. At times, a PIP will need to be modified based on additional discovery found in the data or review of literature.

Oversight of the PIPs is achieved through collaboration with regional committees and workgroups. Improvement is tracked on an ongoing basis through reviewing and updating the workplan, data collection reports, and analysis of the data. Results are communicated to appropriate committees and stakeholders.

FY23 PIPs include:

1. PIP #1 (modified): 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.

a. NorthCare measured 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).
b. The enrollment requirement is the "Date of discharge through 30 days after discharge" under Continuous Enrollment for the eligible population, as specified in the HEDIS 2018 Volume 2 Technical Specifications for Health Plans Follow-up After Hospitalizations for Mental Illness (FUH) specification. However, recently this was modified to include T1017, case management, as this is provided face to face in Michigan and often an appropriate appointment to have post hospital discharge. A new baseline was determined.
c. NorthCare is sunsetting this previously HSAG validated clinical PIP. Follow up to hospitalization data is already tracked via MMBPIS performance indicators as well as via HEDIS for the Performance Based Incentive Pool.

2. PIP #2: To Increase the Percentage of Individuals Ages 12 and Older Who Are Diagnosed With a Co-Occurring Disorder That Are Receiving Co-Occurring Treatment.

    a. 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 is 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.
    b. This is a HSAG validated clinical PIP.

3. PIP #3: To improve documentation of skill building (H2014) and supported employment (H2023) services.

    a. 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.
    b. 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.

c. Findings have been positive overall, although there have been dips in certain areas.

4. PIP #4: To increase the number of individuals who receive services for at least 90 days after initial assessment indicates eligibility for specialty mental health services.

    a. This PIP has evolved over time. 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.
    b. 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.
    c. For this PIP, data reviews the total admissions to those still in services 90 days later. In late 2023 or early 2024 the PIP will be adjusted to also review the number of services obtained in that time period, as cases may be open for 90 days while CMHSP attempts to engage individuals, but the treatment is lacking due to issues with engagement by the individual.
    d. NorthCare is sunsetting this PIP.

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 is being updated late FY23 to come into alignment with LOCUS for SMI adults and better match the parity initiative. This clinical decision-support tool allows for greater consistency in level of care assignments and is 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.

Quality Measures

NorthCare reviews the following quality measures to ensure quality care.

- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD): The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
- Plan All-Cause Readmissions (PCR): For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
- Initiation and Engagement of Substance Use Disorder Treatment (IET): The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement.
- Follow-Up After Emergency Department Visit for Mental Illness (FUM): The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.
- Follow-Up After Hospitalization for Mental Illness (FUH): The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.
- Follow-Up After Emergency Department Visit for Substance Use (FUA): The percentage of emergency department (ED) visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up.
- Antidepressant Medication Management (AMM): The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment.

- Spirometry Testing for Newly Diagnosed COPD (SPR): Percentage of adults with newly diagnosed COPD who receive spirometry testing within 6 months of diagnosis.
- Preventative Dental Examination: presence of a dental exam every two years for all individuals with Medicaid Dental Coverage.

Procedures for Adopting and 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 for a program at the initiation of the program.
- Discovery: Engaging in a process of discovery to collect data and direct participant experiences 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. This document details the specific actions NorthCare is completing related to quality improvement and is a working document. The document will be reviewed and updated at the quarterly Quality Management meetings.

Evaluation and Monitoring

A meeting is convened if NorthCare becomes aware of any significant provider-related issues of quality concern. Issues would be added to the Quality Improvement Workplan. The Quality

Improvement Workplan is a document that summarizes areas of quality concern, the intervention plan in place for improvement, and the staff responsible for the implementation and target resolution dates. The Quality Improvement Workplan considers severity, duration, frequency, and if the concern is clinical or not. Items in the workplan will be monitored quarterly unless otherwise specified. The workplan is a living document, updated throughout the year.

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.

Additionally, the Network Adequacy standards are also completed annually, and this information is provided to MDHHS by February 28th each year and is available on the NorthCare website. Network Adequacy is reported using the MDHHS template once available, however Network Adequacy will be reviewed every 6 months and deficiencies and concerns brought to the attention of leadership, provider network management, and contract committees.

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
- 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
B – Work Plan

Approvals

Reviewed/Revised Date: 8/15/23
Quality Management and Oversight Committee Approval: 9/14/23
Policy Committee/CEO Approval: 9/5/23
Board of Directors Approval: 9/13/23

Attachment A- Acronyms used in this document

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

FY24 QAPIP WORKPLAN

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Performance Indicators and Measures						
PI1: PAS within 3 hours. NorthCare will continue to exceed the 95% expectation for this measurement and will continue to measure and report PI timely.	QI	95%	100%	FY23 (mid) Quarterly Ongoing	Continue / bring to CPQI, QM, and PMC	Contract MMBPIS Standards
PI2a: BPS within 14 days: Given FY24 new measurement goals, NorthCare will seek to improve this measure beyond the 75th percentile of 62%. PI will be reviewed with each CMH and data presented to appropriate regional meetings.	QI	57%	62%	FY23 (mid) Quarterly FY24Q2 and Ongoing	Continue / bring to CPQI, QM, and PMC	Contract MMBPIS Standards
PI2b/e: SUD admissions in 14 days: NorthCare will identify providers by way of PI2b monitoring report that fall below the goal and work with them to address barriers.	QI / SUD	80%	68.2% (MDHHS benchmark)	FY23 (mid) Quarterly Ongoing	Continue / bring to SUD regional meeting, QM, and PMC	Contract MMBPIS Standards
PI3: Ongoing service within 14 days: Given FY24 new measurement goals, NorthCare will seek to improve this measure beyond the 50th percentile of 72.9%. PI will be reviewed with each CMH and data presented to appropriate regional meetings.		70%	72.9%	FY23 (mid) Quarterly FY24Q2 and Ongoing	Continue / bring to CPQI, QM, and PMC	Contract MMBPIS Standards
PI4a: Follow up to hospitalization within 7 days: NorthCare was within state requirements of 95% ¾ quarters in FY22. NorthCare will achieve 95% compliance every quarter and will require corrective action plan if any CMH is not within 95% 2 or more quarters in a row. Data will be reviewed at appropriate regional meetings.	QI	95%	95%	FY22 Quarterly Ongoing	Continue / bring to CPQI, QM, PMC, and ES meetings. Bring hospital specific information to contracted hospital quality meetings.	Contract MMBPIS Standards
PI10: Recidivism: Achieve under 15% recidivism every quarter. A corrective action plan will be required for any CMH outside 15% for 2+ quarters in a row.	QI	15% or less	<15%	FY23 (mid) Quarterly Ongoing	Continue / bring to CPQI, QM, PMC, and ES meetings. Bring hospital specific information to contracted hospital quality meetings.	Contract MMBPIS Standards
Identification of trends for any statistical decline in performance measures. Address trends with appropriate providers.	QI	NA		FY24 Annual Ongoing	Continue / bring to CPQI, QM, and PMC	
Identify trends in recidivism and 7-day follow up; their relationship to inpatient ALOS, and correlations between the 3. Address trends with appropriate providers.	QI	NA		FY24 Quarterly Ongoing	Continue / bring to CPQI, UM, PMC, and hospital specific information to contracted hospital meetings.	

Improve timeliness of priority population admissions for SUD populations by developing a monitoring method and monitoring frequently. Overall decrease in number of out of compliance priority population admissions.	QI / SUD	NA	80%	FY24 Quarterly Ongoing	Continue / bring to SUD regional meeting, QM, and PMC	
Increase validation checks to ensure appropriate populations are included in PI reporting and update system logic to remove members admitted that are mild/moderate for 2a/b, 4a, and 10.	QI	NA	100% accuracy	FY24 Once 4.1.24		
Review indicator 9 – minimum wage- to determine who is employed but not earning minimum wage and verify data.	QI	NA	Increase from 92% (DDA) and 91.3% (MI and DDA)	FY24 Quarterly 10.1.24	Continue	
Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Performance Improvement Project - Increase the percentage of individuals ages 12+ who are diagnosed with cooccurring disorders that are receiving cooccurring treatment						
Baseline Data Calendar year 21 – 17.78%. NorthCare will review data timely and bring to appropriate meetings to discuss improvement strategies.	QI / SUD / Data	NA	Better than 23	FY23 Quarterly Ongoing	Continue / bring to CPQI, UM, PMC, and PIP workgroup	QAPIP
Offer consultative services to CMHSPs to improve co-occurring illness, via contract with psychiatrist board certified in addiction medicine.	SUD / ICT	Began June 23	Increased utilization from 23	FY23 Monthly Ongoing	Continue	QAPIP
Performance Improvement Project – To improve documentation of skill building (H2014) and supported employment (H2023) services.						
Increase the percentage of records for individuals living in the NorthCare Network region receiving skill building (H2014) and/or supported employment (H2023) services randomly selected for review who have what the staff person action/intervention (service provided) clearly documented. Baseline data was 60.9% (FY18).	QI / CP	89.3%	95%	FY18 Biannually June 2024	Sunset / recommended discontinuation of this PIP post FY24. FY23 showing improvement; limited interventions left. Retraining necessary considering staff turnover.	QAPIP
Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Event Reporting – Increase data reporting capability by building better reports and using the data to analyze improvements in the quality of healthcare and services for members.						
Utilize Power BI for better data analysis and review data during the Health and Safety Committee (internal) and Regional Incident Reporting (regional) meetings.	QI	NA	Begin use	FY23 Quarterly Ongoing	Continue	QAPIP
Increase timely categorization of incidents as being critical, sentinel, risk, immediately reportable to 95% within 3 business days of incident.	QI	NA	95%	FY23 Quarterly Ongoing	Continue / given methods at the time in FY23, average of 93%, however improved data	QAPIP

					capabilities available in FY24 show unfavorable difference.	
Ensure individuals living in residential living arrangements are in the correct level of care; ensuring discussion of transition for any found in appropriate levels of care.	QI / CP	Completion of quarterly review	Completion of quarterly review	FY23 Quarterly Ongoing	Continue / recommend setting a schedule for this activity	QAPIP
Review RCA Outcomes data to assess common causal factors for possible improvement project.	QI / CP	NA	Annual review	FY23 Annually Ongoing	Continue / determine if completion during site review makes most sense or mid-year review	QAPIP
Review all untimely deaths with NorthCare Medical Director and trend data over time.	QI / CP	NA	Monthly	FY24 Monthly Ongoing	Continue	QAPIP
Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Behavior Treatment Plan Review – NorthCare will complete analysis of BTC data and implement systemic change related to data findings as necessary.						
NorthCare will collect quarterly data from the CMH's and present data at the regional BTC meeting and internal health and safety committee meeting. Determine the "why" of the incident.	QI / CP	Completion of quarterly review	Completion of quarterly review	FY23 Quarterly Ongoing	Continue / bring data and specific consumer concerns to each CMH.	42 CFR 438.100 (b)(2)(v). Balanced Budget Act of 1997
NorthCare will utilize data to determine improvements/ changes in care due to BTC both on select individuals and programmatically. Review interventions and incidents; specifically 911 use and physical management.	QI / CP	Reduction in use of physical management (325 events)	Reduction in use of physical management	FY23 Quarterly Ongoing	Continue / bring data and specific consumer concerns to each CMH.	42 CFR 438.100 (b)(2)(v). QAPIP
Analysis of BTC survey data to determine any concerns related to the program.	QI / CP	Completion of survey (311 responses)	NA – biannual	FY24 Biannual Ongoing	Continue	42 CFR 438.100 (b)(2)(v).
HCBS Modifications – Modifications of HCBS conditions will be supported by an assessed need that is justified in the person-centered plan.						
Review of HCBS limitations at annual site reviews.	QI	NA	Begin review	FY22 Annually Ongoing	Continue	42 CFR §441.301 (c)(4)(vi)(A-D)
Monitoring of HCBS limitations and ensure that the limitation is justified and addressed in the person-centered plan.	QI	NA	Unknown baseline; ultimate goal 100%	FY22 Annually Ongoing	Continue	
Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Member Experience with Services – Use of an annual assessment addressing member experience, national data, LTSS, focus areas, and NCI results to address dissatisfaction and improve overall consumer satisfaction.						
Update the electronic process to achieve higher response rates to customer satisfaction survey.	CS	Low	25%	FY23 Annually 9.1.24	Continue	
Analyze satisfaction survey data, address areas of dissatisfaction, and publish associated interventions in annual QAPIP effectiveness review.	CS	NA		FY23 Annually 2.28.25	Continue	

Evaluate program satisfaction rate for all, including those receiving LTSS services.	CS	NA		FY24 Annually 2.28.25	Continue	42CFR438.10e.2.x
Grievance and Appeals – ensure grievance and appeals are completed timely, provide appropriate						
Pull a random sample, by provider, of ABD notices to ensure ABDs have all necessary elements, are written at an appropriate readability, and are completed timely.	CS	80%	90%	FY22 Quarterly Ongoing	Continue	42 CFR 438.400, 42 CFR 438.210, 42 CFR 438.408
Pull a random sample of Integrated Denial Notices (IDN) for MI Health Link individuals to ensure necessary elements.	CS	NA	90%	FY24 Quarterly Ongoing	Continue	PIHP – MHP Contract
Ensure grievance letters are written to the member, error free, and written at an appropriate readability via quarterly reviews.	CS	NA	90%	FY22 Quarterly Ongoing	Continue	42 CFR 438.400
Review grievance extension letters to ensure they are error free and completed on the developed template.	CS	NA	90%	FY23 Quarterly Ongoing	Continue	
Acknowledge receipt of each member appeal timely.	CS	NA	100%	FY22 Quarterly Ongoing	Continue	42 CFR 438.406
Create a mailing policy and procedure to ensure mailings are completed in a timely manner.	CS	NA	Completion of policy	FY24 Once	Completed	
Provide training regarding the difference between an extension request and ABD delay.	CS	NA	Develop Training	FY24 Once	In Process	
Application Programming Interface – API – NorthCare will implement a patient access API and provider directory API.						
Implement a Patient Access API by participating in a statewide workgroup and working with EHR vendor to achieve publicly accessible standards.	IT			FY22 Once 10.1.24		42 CFR §431.60; CMS Interoperability and Patient Access Final Rule (CMS-9115-F).
Implement a provider directory API to ensure access to published provider directory information.	IT			FY22 Once 10.1.24	Continue	42 CFR §431.670
Update the website to be more user friendly and accessible to multiple stakeholders and developers.	IT			FY24 Once 10.1.24		
Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Practice Guidelines – Ensure development of requested CPGs, adoption of updated MDHHS CPGs, and dissemination of all CPGs to regional providers.						
Ensure review and updates to CPG's annually. Providers to acknowledge updates.	CP	Annual	Attestation from each CMH LMS user and SUD providers	FY23 Annually 1.25.24	Continue / make part of annual training requirements	QAPIP
Create/find and implement CPG related to eating disorders as requested in the Clinical Practices / Quality Improvement committee meeting.	CP	One time	Adoption of guideline	FY23 Once 4.1.24	Continue / options presented, to be voted on in FY24	

Review of effectiveness of CPGs based on available data regarding a particular guideline.	CP	Annual review	Annual review	FY23 Annually Ongoing	Continue	
Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Credentialing and Re-credentialing – Ensure consistent factors considered during credentialing and recredentialing (grievances, PI, utilization, appeals, member satisfaction, and provider reviews) and that MDHHS requirements are met.						
Develop and implement detailed credentialing/recredentialing file auditing plan addressing credentialing/ recredentialing requirements, citations, and recommendations made in HSAG review.	PNM	Annual audit	Decreased number of charts out of compliance.	FY22 Annually September	Continue	42CFR438.214
Ensure non-licensed providers meet all Medicaid requirements.	PNM	Annual audit	Decreased number of files out of compliance.	FY22 Annually September	Continue	
Conduct annual audit of all delegates performing credentialing activities according to audit plan.	PNM	Annual audit	Decreased number of files out of compliance.	FY22 Annually September	Continue	
Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Verification of Services – Medicaid Service Verification – Complete Medicaid Service Verification timely and address any barriers identified for services delivery and health outcomes.						
Obtain / maintain compliance with requirements for Medicaid Service Verification. Share data in appropriate committees.	CO	90%	95%	FY22 Annually Ongoing	Continue / in FY22, 331 SAL/Claims were reviewed for 100% compliance.	QAPIP
Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Utilization Management – Improve consistency in UM decisions across various areas of need, such as: residential level of care, eligibility criteria, medical necessity criteria for specific services.						
Review underutilization and denoted reasons for underutilization in progress notes, periodic reviews, and other sources.	UM			FY23 Biannual Ongoing	Continue / introduction of new reporting tool, Power BI, will greatly assist with analysis	
Review overutilization of services as indicated by additional authorization requests.	UM			FY23 Biannual Ongoing	Continue	
Discuss Interrater reliability (IRR) in the state PIHP workgroup for statewide consistency.	UM	NA	Use of IRR for pre-admission screenings	FY23 Annually Ongoing	Continue	Parity – required use of MCG tool for inpatient; workgroup discussing IRR
Complete a sample of chart reviews to ensure accuracy and completeness of charts and compliance with C waiver requirements.	UM			FY24 Biannual Ongoing	Continue	MDHHS C-Waiver
Access to Services – Improve consistent access to services across the region						
Review a random selection of screenings for screener approval rate, determination at BPS, and other factors	UM			FY24 Quarterly Ongoing	Continue / previous data based on centralized access at	

to identify trends and address any concerns.					the PIHP. In FY24, distributed to CMHs	
Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Provider Network Management – Ensure there is an adequate provider network.						
Review the service array and address areas of deficiency.	PNM / QI			FY23 Annually Ongoing	Continue	42CFR438.207
Review ABD capacity related denials and address areas of deficiency.	PNM / QI	3% of FY23 denials were due to capacity	2%	FY23 Quarterly Ongoing	Continue	
Expansion of Behavioral Health Home (BHH) providers.			Recruitment of additional providers	FY23 Monthly Ongoing	Continue	
Create and run report to assess significant changes in provider network or membership, including location of providers to members.	QI			FY24 Biannually Ongoing	Continue	HSAG Standard 4 / Element 4
Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Long Term Services and Supports – LTSS – Compare services received by LTSS consumers vs what was authorized in their plan (over/under utilization of LTSS services).						
Review individuals in AFC level of care that do not have a matching LOC in the system to determine if AFC level of care appears appropriate	QI / CP / UM	Review 5 cases per quarter	Review 5 cases per quarter	FY23 Quarterly Ongoing	Continue	
Review underutilization of authorized LTSS services.	QI / UM	Review 10 cases per quarter	Review 10 cases per quarter	FY23 Quarterly Ongoing	Continue	
Individuals hospitalized for psychiatric or physical health needs will receive comprehensive discharge planning and coordination between hospital and community-based settings to ensure conditions leading to hospitalization are addressed in community settings. PCR HEDIS measures will be addressed.	QI / ICT	.96 report end 3.31.23	.92	FY23 Quarterly Ongoing	Discontinue / NorthCare has been better than the All Medicaid data in FY23.	MDHHS Contract, HEDIS, Performance Based Incentive Pool
Oversight of Vulnerable Individuals –Integrated/Coordinated Care - Care coordination between the behavioral health and physical health providers will occur.						
Individuals receiving specialty care will have the recommendations of those providers incorporated into their behavioral health IPOS and a consent to share information. This will be reviewed via annual site reviews.	ICT	85%	85%	FY22 Annually Ongoing	Continue	
Behavioral Health Home (BHH) services will expand for individuals with at least 1 co-morbid physical health condition at the CMHSPs.	PHS	110 enrollees, 5 HH Partners	117 enrollees, 6 HH partners (Jan 2024)	FY23 Monthly Ongoing	Continue	
CMHSP's will expand the provision of H0034 – Medication Training and Supports, S9445 Patient Education individual, T1001 and T1002 RN/Nursing Services.				FY23 Annual Ongoing	Continue	

NorthCare and UPHP will have bi-monthly data collaboration workgroup meetings to address shared member health care outcomes and gaps.	ICT	8210 unduplicated shared members		FY23 Bi-monthly Ongoing	Continue	
Individuals with high ER utilization, that are enrolled in MI Health Link, will reduce ER visits and increase preventative care by coordination between the PIHP and MHP.	ICT			FY23 Monthly Ongoing	Continue	
Transition of Care – Care will be coordinated when transitions are occurring.						
The Medicaid Health Plan (UPHP) will be notified of all psychiatric hospitalizations and discharges for shared members.	UM		100%	FY23 Weekly Ongoing	Continue	As part of information provided to CC360
Individuals discharging from the psychiatric unit will have a follow up appointment within 7 days (see PI4a).	QI		95%	FY23 Quarterly Ongoing	Continue	MMBPIS
Plan-All-Cause Readmission (HEDIS Measurement) instances will be reviewed by NorthCare/UPHP in the Data Collaboration workgroup.	ICT	.96		FY23 Quarterly Ongoing	Discontinue	
Waiver transitions to another PIHP area will be coordinated as they occur.	WC			FY24 PRN Ongoing	Continue	
Waiver Services – Ensure timely HSW recertifications and pended cases.						
NorthCare will provide ongoing monitoring and reminders to the CMH's about expiring cases.	W.C.			FY24 Monthly Ongoing	Continue	Result of performance issue
NorthCare will notify the CMH CEOs of data and data will also be shared in regional meetings.	W.C.			FY24 Monthly Ongoing	Continue	Result of performance issue

FY24 QAPIP Effectiveness Review

The FY24 QAPIP Effectiveness Review begins on the next page. It details the various areas of NorthCare performance and progress on the quality plan for FY24. It also indicates initiatives that are ongoing into FY25.

FY24 QAPIP Effectiveness Review

Quality Management System

NorthCare Network quality management focuses on areas for review based on mandates and recommendations from auditing bodies, questions posed from the field, and concerns noted when conducting monitoring activities and analyzing data and utilization. NorthCare utilizes Centers for Medicaid and Medicare Services (CMS) and Michigan Department of Health and Human Services (MDHHS) regulations and rules, contract requirements, and evidence-based practices to set expectations for clinical and administrative functions. The timing of various MDHHS and Health Services Advisory Group (HSAG) audits is often mid-year for the QAPIP and workplan. Therefore, there may be additional quality related activities that are completed during the year that are in addition to the QAPIP and workplan.

Quality Management Workplan

The FY24 QAPIP Workplan focused on many areas. Key highlights are listed below:

- Performance Indicators, especially PI2a and 3, aimed at improving access to care within 14 days. MDHHS set new baselines for these two indicators in FY24 and eliminated the ability to have exceptions. Representatives from each Community Mental Health (CMH) and NorthCare met in April and August to brainstorm solutions to poor performance. These indicators are changing in 2026.
- Data analysis capabilities were expanded late in the year with the purchase of Power BI, a data analytics tool. In FY25, a contract with TBD Solutions was created to set up the framework of various reports. This will improve quality in a variety of ways as increased data will allow for more effective review of programs and outcomes.
- Increased review of critical incidents and sentinel events and later in FY24, identifying the need for Electronic Medical Record (EMR) change to add a standardized risk assessment tool into various documents, which will occur in FY25.
- Identification of the need to add a Home and Community Based Services (HCBS) section to the Individual Plan of Service (IPOS). Due to indecision from MDHHS about some components of HCBS (mainly related to medical limitations) implementation has been delayed, but changes will be implemented into the Electronic Medical Record (EMR) in FY25 with updates expected.
- Updates to the satisfaction survey questions and process and creation of NorthCare's FY25 Performance Improvement Project. Posters and survey links were updated in early FY25 to reflect the change.
- Addition of Care Coordination standard to Site Review Protocols, analyzing incorporation of physical health findings into the Individual Plan of Service (IPOS), and sharing of records with primary care physicians.
- Network Management reviews all providers contracted with to ensure an adequate provider network during annual site reviews.
- Credentialing to ensure all regional organizations and individuals meet requirements set in the Medicaid Provider Manual.

Quality Assessment Activities

The following provides details about each quality initiative in FY24. Activities that were not completed in FY24 are carried into FY25 unless otherwise indicated to discontinue the project or initiative.

Stakeholder Input and Assessment of Consumer Experience with Services

Satisfaction surveys, grievances, appeals, and information availability via the Application Programming Interface (API) and website are evaluated as part of the consumer service experience.

Satisfaction Survey

To ensure there are no trending patterns of dissatisfaction, to improve practices across the region, and to improve overall consumer satisfaction, NorthCare encourages completion of the satisfaction survey. In FY24, the satisfaction survey was available online and via paper, but the use of the electronic completion option was minimal. There were 3 surveys completed that respondents didn't select a CMH that they were reporting satisfaction on; one reported response for a Substance Use Disorder (SUD) provider, the other 2 didn't designate what type of provider they were reporting on. These 3 results were removed from the regional results, reflected below. FY23 data is reflected in the second line, indicated in blue, highlighting the significantly reduced number of responses in FY24 compared to FY23. In FY23 there were 9 responses removed from the data due to either not indicating a provider (6) or due to the low number of SUD surveys results (3).

Question	Strongly Agree	Agree	NA/ No Response	Disagree	Strongly Disagree
1. Appointments are scheduled at times that work best for me.	294 675	111 321	10 28	6 22	3 12
2. I am informed of my rights as a Community Mental Health (CMH) or Substance Use	271 643	114 333	30 45	5 13	4 9
3. I feel welcomed and comfortable where I receive services.	297 701	108 307	11 25	5 17	3 8
4. Staff speak in ways I can understand easily.	301 680	105 325	12 28	4 18	2 7
5. I know what to do if I have a concern or complaint.	257 528	133 365	14 36	17 56	3 19
6. Staff are sensitive to my cultural/ethnic and spiritual background.	247 560	120 343	51 50	4 21	2 12
7. Staff are sensitive when I am discussing my past.	256 604	120 342	39 72	6 25	3 15
8. I am aware of the types of services available.	221 516	163 419	13 41	23 65	4 17
9. I was able to get the type of services I feel I needed.	236 537	149 395	9 39	21 53	9 34
10. My wishes about who is and who is not given information about my treatment are respected.	284 651	117 343	16 43	4 12	3 9
11. I feel involved in my care and included in the decision-making process regarding my services.	268 604	131 358	14 48	7 31	4 17
12. I feel staff see me as a whole person and address all my needs.	267 611	129 344	13 43	11 41	4 19
13. I am satisfied with the telephone crisis service when calling the crisis line after 5 p.m.	43 120	25 89	328 791	16 32	12 26
14. I am able to communicate with my CMH/SUD provider easily.	236 542	125 339	51 128	9 35	3 14

15. I would recommend these services to a friend or relative.	246 595	133 326	32 86	6 27	7 24

Due to the loss of responses in FY24, midway through FY24 NorthCare determined the FY25 Performance Improvement Project (PIP) is to increase the number of completed Satisfaction Surveys. A workgroup was created to evaluate current survey questions and discuss the process for administering the survey. The group reviewed other satisfaction surveys and reviewed articles that highlighted how to increase satisfaction survey responses and what pitfalls to avoid. The satisfaction survey questions were revamped. They were checked for overall reading level and formatted to fit 1 page if completing on paper. The surveys were also made electronic and a QR code created to link respondents to the survey. Posters were made available in early FY25, and the PIP will officially begin in FY25. In addition to attempting to regain responses for the CMH surveys, NorthCare also provided posters to SUD providers early in FY25 to gather data from individuals receiving SUD services. More information on the new PIP can be found at the end of this report.

It is worth nothing that the MDHHS 3-year quality rollout will impact the satisfaction survey in year 3. The 2027 calendar year will focus on implementing patient experience and Home and Community Based (HCBS) measures, using Consumer Assessment of Healthcare Providers and Systems (CAHPS) and HCBS CAHPS measures. Per MDHHS, "the ultimate goal of the survey is to get feedback from patients/consumers on their experience getting care. Questions cover topics such as getting services, communication with providers, case managers, choice of services, transportation, personal safety, and community inclusion and empowerment. … The survey is trying to measure quality of care and where MDHHS/PIHPs need to improve services. The adult and child CAHPS surveys are administered once per year and are conducted for Medicaid health plan and fee-for-service members. In the past, the surveys have been administered by Health Services Advisory Group (HSAG) using a mixed method approach including web-based surveys, mailed surveys, and telephone follow-up. HSAG contacted individuals who received services (or their caregivers) first by mail, then by telephone, to conduct the survey. The survey administration protocols employed by the adult MHPs included mail, telephone, and/or web. MDHHS provided HSAG with a list of all eligible members of the sampling frame. The MHPs sent the adult population data to HSAG for incorporation in the report. HSAG then presented statewide aggregate and plan-level results to MDHHS and compared them to national Medicaid data and prior years' results, where appropriate. The state is still determining if each PIHP will need to obtain a certified vendor to administer the CAHPS survey."

Yearly Measures: Year 3 (MY2027)

The third year will focus on implementing patient experience and Home and Community Based Services (HCBS) measures. Both standard CAHPS (included in the required CMS Quality Rating System) and HCBS CAHPS measures are included.

All plans (MCOs, PIHPs, and PAHPs) are required to have a QRS publicly available by 2027.

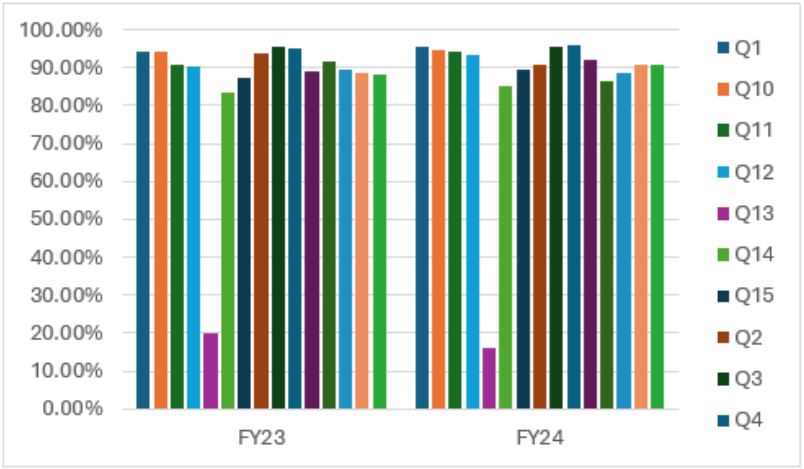
	Measure	Program	Domain
CAHPS	How people rated their health plan	QRS	Patient Experience
CAHPS	Getting care quickly	QRS	
CAHPS	Getting needed care	QRS	
CAHPS	How well doctors communicate	QRS	
CAHPS	Health plan customer service	QRS	
HCBS CAHPS	Choosing the Services that Matter to You	HCBS	Patient Experience and Home and Community Based Services
	Community Inclusion and Empowerment		
	Transportation to Medical Appointments		
	Physical Safety		
	Personal Safety and Respect		
	Staff are Reliable and Helpful		
	Staff Listen and Communicate Well		
	Unmet Needs Composite Measure		
MLTSS-1	Medicaid Managed Long-Term Services and Supports Comprehensive Assessment and Update	MLTSS	
MLTSS-2	Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update	MLTSS	

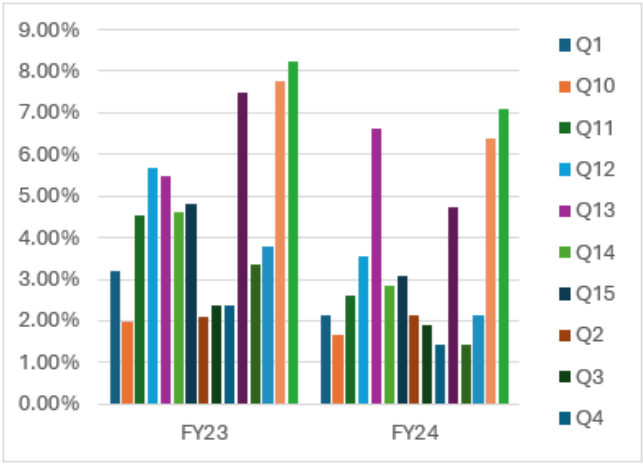
Center for Social Change (CSC) MPHI

Unfortunately, this information wasn't presented until after the FY25 PIP was already selected. NorthCare will have to determine how to pivot in the future related to satisfaction PIP and implementation of the CAHPS survey.

Data from the FY23 and FY24 satisfaction survey shows most respondents as reporting satisfaction for both years. Question 13 has a low number of respondents due to the high number of no responses due to respondents not using the crisis line. Satisfaction for those using the line was reported as low. The satisfaction rating was worse for this question in FY24 than FY23. Graphs and tables below report on the percent agree/strongly agree and disagree/strongly disagree.

Percent Response Agree or Strongly Agree, by Question															
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15
FY23	94.14%	93.58%	95.27%	94.99%	88.94%	91.58%	89.41%	88.37%	88.09%	93.95%	90.93%	90.26%	19.75%	83.27%	87.05%
FY24	95.52%	90.80%	95.52%	95.75%	91.98%	86.56%	88.68%	90.57%	90.80%	94.58%	94.10%	93.40%	16.04%	85.14%	89.39%





Percent Disagree or Strongly Disagree, by Question															
	Q1	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**	**Q7**	**Q8**	**Q9**	**Q10**	**Q11**	**Q12**	**Q13**	**Q14**	**Q15**
FY23	3.21%	2.11%	2.36%	2.36%	7.47%	3.35%	3.78%	7.75%	8.22%	1.98%	4.54%	5.67%	5.48%	4.63%	4.82%
FY24	2.12%	2.12%	1.89%	1.42%	4.72%	1.42%	2.12%	6.37%	7.08%	1.65%	2.59%	3.54%	6.60%	2.83%	3.07%

NorthCare executed a contract with Protocall, an after-hours crisis call-center provider, in February 2024, due to concerns with the state-contracted provider MiCal. Four of the 5 CMH's joined this contract. The clinical quality of the summary reports provided by Protocall in FY24 are an improvement compared to the summary information provided by MiCAL in FY23, however Protocall also has difficulty calling the correct after-hours on-call staff person at the CMH. Protocall attended some Emergency Services (ES) Committee meetings in FY24 to address concerns expressed by CMH staff. Pathways reports improved services from MiCAL in FY24 compared to FY23, possibly a result of a reduction in demand.

In FY24, question 13, broken by CMH, shows skewed results for Hiawatha Behavioral Health as they only had 5 respondents answer question 13 and 1 responded indicated disagreement with the question. Of the other CMH's, Pathways does have a slightly higher percentage of respondents indicating they either disagree or strongly disagree that they are satisfied with the after-hours crisis line. As satisfaction related to crisis services could directly impact health outcomes, NorthCare is continuing to contract with Protocall in FY25 for the NorthCare lines and for 4 of the 5 CMH lines. Pathways CMH has continued to contract with MiCAL for after-hours crisis call-center services.

CMH	Copper	Gogebic	HBH	Northpointe	Pathways
Percent	7.84%	2.70%	20.00%	3.40%	8.48%

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24 / ACTUAL ACHIEVEMENT**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Member Experience with Services – Use of an annual assessment addressing member experience, national data, LTSS, focus areas, and NCI results to address dissatisfaction and improve overall consumer satisfaction.						
Update the electronic process to achieve higher response rates to customer satisfaction survey.	CS	Low	The electronic survey link was available in FY24 however had low utilization. At the end of FY24 the survey was updated and a new link created to prepare for the FY25 Satisfaction PIP.	FY23 Annually 9.1.24	Continue with new PIP	
Analyze satisfaction survey data, address areas of dissatisfaction, and publish associated interventions in annual QAPIP effectiveness review.	CS	NA	The number of completed surveys significantly declined.	FY23 Annually 2.28.25	Continue	
Evaluate program satisfaction rate for all, including those receiving LTSS services.	CS	NA	Limited ability to determine satisfaction by service at this time.	FY24 Annually 2.28.25	Continue	42CFR438.10e.2.x

Grievance and Appeals

In March 2024 NorthCare looked at Adverse Benefit Determinations (ABDs) due to concerns with capacity. That led to a review of ABD's for certain services and by certain staff. Communication with CMH clinical leads occurred to relay NorthCare concerns. A sample of 98 ABD's were selected again at the end of FY24 and review continued into FY25. The main findings identified that reading levels were too advanced, the service was not clearly identified in consumer-oriented language, and the action rationale lacked particulars and did not provide guidance or recommendations for alternative care. NorthCare will continue to pull samples of ABDs in FY25 and, depending on performance, require intervention accordingly.

At the beginning of the Fiscal Year 2024, NorthCare assumed responsibility for Local Appeals and Grievances for three of the five CMHSPs. NorthCare had stated their intention to resume responsibility for all Local Appeals, Grievances and Medicaid Fair Hearings for Substance Use Disorder Providers in Fiscal Year 24. Medicaid Fair Hearings for the entire region are the responsibility of NorthCare and are facilitated and coordinated by Customer Services and Compliance.

Training Opportunities have been and will continue to be offered to CMHSPs, Provider Agencies and individuals served. Signage has been created and provided for posting at CMHSPs and service providers with contact information for filing Local Appeals and Grievances.

Self-Audit tools have been created and shared with the CMHSPs for Grievances and Local Appeals.

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24 / ACTUAL ACHIEVEMENT**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Grievance and Appeals – ensure grievance and appeals are completed timely, provide appropriate						
Pull a random sample, by provider, of ABD notices to ensure ABDs have all necessary elements, are written at an appropriate readability, and are completed timely.	CS	80%	90%/ NorthCare pulled a random sample and reviewed ABD's however did not pull as many as planned and will continue data reviews in FY25. We did not achieve our goal of 90% review or accuracy / completeness.	FY22 Quarterly Ongoing	Continue	42 CFR 438.400, 42 CFR 438.210, 42 CFR 438.408
Pull a random sample of Integrated Denial Notices (IDN) for MI Health Link individuals to ensure necessary elements.	CS	NA		FY24 Quarterly Ongoing	Discontinue	PIHP – MHP Contract
Ensure grievance letters are written to the member, error free, and written at an appropriate readability via quarterly reviews.	CS	NA	90% / not measured	FY22 Quarterly Ongoing	Continue	42 CFR 438.400
Review grievance extension letters to ensure they are error free and completed on the developed template.	CS	NA	None to review	FY23 Quarterly Ongoing	Continue	
Acknowledge receipt of each member appeal timely.	CS		100% / not measured	FY22 Quarterly Ongoing	Continue	42 CFR 438.406

Create a mailing policy and procedure to ensure mailings are completed in a timely manner.	CS	NA	Policy Completed	FY24 Once	Completed / Discontinue	
Provide training regarding the difference between an extension request and ABD delay.	CS	NA	NA	FY24 Once	Continue	

API & Website

NorthCare Network has worked with our EMR vendor to implement Patient Access Application Programming Interface (API) and Provider Directory API standards that are readily accessible and follow applicable standards. NorthCare Network continues to evaluate to achieve full and clear accessibility for potential API users. NorthCare Network began the process of overhauling our website to ensure user friendliness and compliance with ADA requirements; in 2024, we completed a request for information (RFI) process and hired a contractor to fully redesign the website accordingly. Work has begun in earnest on this task in FY25 and is anticipated to finish in FY25. The website will be more streamlined, easier to use, and will have useful information that will be easier to find. In addition to reformatting the website to appear more like most standardized websites of 2024, clinical staff are also reviewing the information that is on the current website, updating it accordingly, to ensure the new website is a resource to staff and consumers.

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24 / ACTUAL ACHIEVEMENT**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Application Programming Interface – API – NorthCare will implement a patient access API and provider directory API.						
Implement a Patient Access API by participating in a statewide workgroup and working with EHR vendor to achieve publicly accessible standards.	IT		95% / 95%	FY22 Once 10.1.24		42 CFR §431.60; CMS Interoperability and Patient Access Final Rule (CMS-9115-F).
Implement a provider directory API to ensure access to published provider directory information.	IT		100%/100%	FY22 Once 10.1.24	Continue	42 CFR §431.670
Update the website to be more user friendly and accessible to multiple stakeholders and developers.	IT		25% / 25%	FY24 Once 10.1.24	Continue	

Provider Network Monitoring

NorthCare reviewed Adverse Benefit Determinations (ABDs) specifically related to capacity concerns. In March, Copper Country CMH had lost their supported employment staff, causing suspension in that service. Similarly, Northpointe lost a home-based therapist, Pathways lost an in-person therapist. NorthCare requested a plan from each CMH about how they were going to manage their capacity. Each CMH CEO was provided with the L letter, L 22-72, and reminded the denials due to capacity require action by the CMH to create capacity to provide the full array of medically necessary Medicaid services. Additionally, NorthCare continued to review ABDs for capacity purposes. Capacity related ABDs has been reduced as CMH staff have worked to hire, contract, and implement creative solutions to the staffing shortage. The number of ABD's and capacity related ABDs for each month in FY24 is represented below. Capacity related ABD's were down at the end of the fiscal year, with no adequate capacity denials in August or September.

Type of ABD	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Adequate	78	65	79	168	189	124	153	122	127	93	101	121
Adequate Capacity	1			5	9	3	1	2	2	1		
Advanced	548	445	341	612	505	443	457	429	495	574	473	484
Advanced Capacity	44	14	9	74	70	10	6	3	29	7	2	3
Grand Total	626	510	420	780	694	567	610	551	622	667	574	605
Total Capacity	45	14	9	79	79	13	7	5	31	8	2	3
Percent Total Capacity	7.19%	2.75%	2.14%	10.13%	11.38%	2.29%	1.15%	0.91%	4.98%	1.20%	0.35%	0.50%

Some counties lost their Drop-In programming and/or Assertive Community Treatment (ACT) programming in FY24. Staff also reported concerns about their ability to provide music and art therapy, child therapeutic foster care, transportation, and parent support partners. These positions are harder to fill and have variable utilization.

The Network Adequacy standards for FY24 specifically were focused on ensuring the following services were available within the set time and distance standards.

- Inpatient Psychiatric (Adults and Children)
- Crisis Residential (Adults and Children)
- Assertive Community Treatment (ACT)
- Opioid Treatment Programs (Adults and Children)
- Community Living Services (CLS)
- Psychosocial Rehabilitation (Clubhouses)
- Children's Therapeutic Foster Care
- Respite Services
- Youth Peer Supports
- Parent Support Partner
- Home-Based Services
- Wraparound Services
- Intensive Crisis Stabilization Services
- Applied Behavioral Analysis (Autism)

Per discussion with MDHHS in October 2023, all counties within NorthCare Network qualified as Counties with Extreme Access Considerations (CEAC), requiring inpatient care within 155 minutes and 140 miles and outpatient care within 125 minutes and 110 miles. This is a relaxation of the old rural or frontier requirement for outpatient services, which previously required 60min/60mile (rural) or 90min/90mile (frontier). However, the new standards are harder to meet for inpatient services. Previously inpatient services were required to be within 330min/355mile for youth, and 150min/125miles for adults.

In late December 2024, MDHHS sent the Network Adequacy reporting template and the County Designations for completion of FY24 Network Adequacy reporting. This updated information from MDHHS does not indicate that all Upper Peninsula counties are CEAC. The new proposal results in 6 counties meeting CEAC status, 8 meeting rural status, and 1 being a micropolitan county based on the population per square mile in the county. This changes the expectations for time/distance traveled. This is most concerning for Marquette County as the "micro" classification is a shorter time/distance requirement than the prior 60min/60mile requirement set up for rural counties.

County	Status	CMH
Marquette	Micro	Pathways
Delta	Rural	
Alger	CEAC	
Luce	CEAC	
Iron	Rural	Northpointe
Menominee	Rural	
Dickinson	Rural	
Gogebic	Rural	Gogebic
Ontonagon	CEAC	Copper
Baraga	CEAC	
Houghton	Rural	
Keweenaw	CEAC	
Mackinac	Rural	Hiawatha
Schoolcraft	CEAC	
Chippewa	Rural	

Micropolitan ("Micro") refers to a CMS county-based geographic designation. Micro counties are counties with: (1) a population size greater than or equal to 50,000 persons and less than or equal to 199,999 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 99.9 persons per square mile; (2) a population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density greater than or equal to 50 persons per square mile and less than 999.9 persons per square mile.

Rural refers to a CMS county-based geographic designation. Rural counties are counties with: (1) a population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density of greater than or equal to 10 persons per square mile and less than or equal to 49.9 persons per square mile; (2) a population size less than 10,000 persons with a population density greater than or equal 50 persons per square mile and less than or equal to 999.9 persons per square mile.

Counties with Extreme Access Considerations (CEAC) refers to a CMS county-based geographic designation. CEAC counties are counties with any population size with a population density of less than 10 people per square

Additionally, the staff to consumer ratio requirements remain in FY24 and FY25.

Adult Services	**Standard**
Assertive Community Treatment (ACT)	30,000:1 (Medicaid Enrollee to Provider Ratio)
Psychosocial Rehabilitation (Clubhouse)	45,000:1 (Medicaid Enrollee to Provider Ratio)
Opioid Treatment Programs	35,000:1 (Medicaid Enrollee to Provider Ratio)
Crisis Residential	16 beds per 500,000 Total Population
Children's Services	**Standard**
Home-Based	2,000:1 (Medicaid Enrollee to Provider Ratio)
Wraparound	5,000:1 (Medicaid Enrollee to Provider Ratio)
Crisis Residential	8-12 beds per 500,000 Total Population

NorthCare is aware of network adequacy issues with a variety of the identified programs. There are no youth inpatient psychiatric beds in the Upper Peninsula (UP). NorthCare has contracted with a hospital in Wisconsin for services. There are no youth or adult crisis residential beds in the UP. On two separate occasions there has been an adult crisis residential provider in the UP, one in Marquette the other in St. Ignace. Neither lasted and both were converted into adult specialized residential homes. There has never been a youth crisis residential facility in the UP.

NorthCare has ACT available in 2 counties at the end of FY24. The ACT team model was found to be restrictive and by removing the team model but providing like services, staff have found they can serve more individuals. It is also difficult to ensure the required level of staffing at all times to maintain fidelity to the model. Home-based services have a similar concern. The limited caseload size is often exceeded as there are not enough staff to provide services. MDHHS has required every county to have a home-based team.

Peer services have always been difficult to staff, particularly as training is held downstate which is a financial, geographic, and child-care barrier for peers. Additionally, the coaching call requirements

have limited people's ability to be a parent support partner as the calls don't allow for enough flexibility. These barriers especially impact parent support partners and youth peer supports.

There were no NorthCare contract changes in FY24, although there were additional hospital contracts added in FY25 for both inpatient psychiatric care, inpatient Electroconvulsive Therapy (ECT) and Partial Hospital Programming.

In FY24, a substance use disorder drop-in center was implemented with Western UP Health Department in Hancock. The center allows individuals with substance use issues to come in for support and connection to both the recovery community and to treatment services. In addition, two mobile care units began to offer harm reduction services. The Western UP Health Department ran one of the mobile units with Public Health Delta Menominee running the other. The mobile units are able to offer services in remote areas.

Behavior Health Home services expanded with the addition of Great Lakes Recovery Centers (GLRC) being added to the provider panel in FY24 second quarter. GLRC served 9 individuals in FY24.

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24 / ACTUAL ACHIEVEMENT**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Provider Network Management – Ensure there is an adequate provider network.						
Review the service array and address areas of deficiency.	PNM / QI		Staff completed the service array annually. Some services identified there was no request or need for the service but staff would contract if necessary.	FY23 Annually Ongoing	Continue	42CFR438.207
Review ABD capacity related denials and address areas of deficiency.	PNM / QI	3% of FY23 denials were due to capacity	2% / 0.05% of ABDs were due to capacity (even less denials due to capacity).	FY23 Quarterly Ongoing	Continue	
Expansion of Behavioral Health Home (BHH) providers.			Recruitment of additional providers/ Added GLRC to provider panel Q2.	FY23 Monthly Ongoing	Continue	
Create and run report to assess significant changes in provider network or membership, including location of providers to members.	QI		The network was reviewed once to review adequacy, as the crow flies.	FY24 Biannually Ongoing	Revise. MDHHS has indicated that they would calculate time/distance standards in FY25	HSAG Standard 4 / Element 4

Utilization Management and Authorizations

Penetration Rates

Between FY23 and FY24 the total number of unduplicated consumers increased but the total number of units of service provided decreased slightly. Data is based on encounters via the Master Eligibility File. Consumers include any consumer who had an encounter at the given affiliate in the given fiscal year who had Medicaid or Healthy Michigan eligibility indicated on the Master Eligibility File for the date of service. Units is the sum of units on those encounters. S0280 was excluded from this query.

The most significate change in consumers was at Gogebic and Hiawatha Behavioral Health. Similarly, these agencies had an increase in utilization. NorthCare SUD had the greatest decline in consumers and the greatest decrease in utilization. It is believed this is a stabilizing effect post COVID-19. During the pandemic services decreased, followed by an increase right after, and now numbers reflect pre-COVID utilization.

Affiliate	Fiscal Year	Unduplicated Consumers	Units	Change in Consumers	Change in Units
Copper Country CMH	FY23	922	253714		
Gogebic CMH	FY23	482	175745		
Hiawatha Behavioral Health	FY23	1244	254119		
NorthCare SUD	FY23	1807	72235		
Northpointe BHS	FY23	1452	341744		
Pathways CMH	FY23	2674	1044200		
Total	**FY23**	**8115**	**2141757**		
Copper Country CMH	FY24	981	249666	6.40%	-1.60%
Gogebic CMH	FY24	571	189729	18.46%	7.96%
Hiawatha Behavioral Health	FY24	1389	277215	11.66%	9.09%
NorthCare SUD	FY24	1635	66735	-9.52%	-7.61%
Northpointe BHS	FY24	1558	327450	7.30%	-4.18%
Pathways CMH	FY24	2778	1024496	3.89%	-1.89%
Total	**FY24**	**8366**	**2135291**	**3.09%**	**-0.30%**

Staff Only Documentation

NorthCare staff did notice an alarming number of documents completed as "staff only" in FY24. NorthCare had a discussion with CMH's about potential reasons for staff only documentation. There were some identified system logic changes that are necessary to allow for a more accurate reflection of the various combinations of service activity log (SAL) selections that can happen. Regionally, 16.83% of BPS's reviewed were completed as staff only.

	Count	Distinct	Percent "staff only" by CMH
Copper Country CMH			
Client Present	408	396	
Family Present w/o Beneficiary	4	4	
Staff Only	51	48	11.01%
Gogebic CMH			
Client Present	280	260	
Staff Only	2	2	0.71%
Hiawatha			
Client Present	589	581	
Family Present w/o Beneficiary	7	7	
Staff Only	65	62	9.83%
Northpointe			
Client Present	601	589	
Family Present w/o Beneficiary	12	12	
No-Show	1	1	
Staff Only	125	115	16.91%
Pathways			
Client Present	924	899	
Family Present w/o Beneficiary	14	14	
No-Show	2	2	
Staff Cancellation	4	4	

Staff Only	333	310	20.57%
Grand Total	**3422**	**3184**	**16.83%**

Additionally, Individual Plan of Services (IPOS), IPOS Amendments, IPOS Periodic Reviews, and IPOS Pre-planning documents were reviewed. The majority of the staff only documents are from IPOS Amendments (68.6%). The IPOS meeting had the least number of staff only documentation (2.2%). Data for all the IPOS documents combined is reflected below.

	count	distinct	percent
Copper Country CMH			
Client Present	1184	578	
Family Present w/o Beneficiary	44	33	
No-Show	1	1	
Staff Cancellation	3	3	
Staff Only	609	376	33.08%
Gogebic CMH			
Client Present	1214	389	
Family Present w/o Beneficiary	22	19	
Staff Cancellation	3	3	
Staff Only	388	204	23.85%
Hiawatha			
Client Present	2255	924	
Family Present w/o Beneficiary	50	36	
No-Show	2	1	
Staff Cancellation	2	2	
Staff Only	613	367	20.98%
Northpointe			
Client Present	2675	1056	
Family Present w/o Beneficiary	51	34	
No-Show	4	4	
Staff Cancellation	2	2	
Staff Only	1073	564	28.20%
Pathways			
Client Cancellation	1	1	
Client Present	3570	1577	
Family Present w/o Beneficiary	169	88	
No-Show	4	4	
Staff Cancellation	21	21	
Staff Only	2543	1283	40.31%
Grand Total	**16503**	**4906**	

Data and information gathered from the clinical staff was summarized and provided in October 2024 to the CMHs. The main points discovered included previous communication that two of the same service code shouldn't be billed on the same day, inconsistent understanding of when to update a BPS including if update is necessary for demographic changes, IPOS's expiring due to consumer no-shows, IPOS amendments being added because the authorizations ran out in number or timeframe, or there was a change in service provider agency. NorthCare will continue to work with the CMH's in FY25 to further address these issues.

Engagement Efforts

While the official *Engagement Performance Improvement Project* (PIP) was sunset at the end of FY23, Utilization Management continued to review engagement in FY24Q1 to ensure continued quality was maintained. Each admission represents an initial biopsychosocial (BPS) and the associated discharge reason if discharged within 90 days. This report was to verify if someone was still open to CMH within 90 days. Most individuals discharged within 90 days were discharged because they dropped out of treatment. Engagement efforts were reviewed, and the importance of engagement was discussed with various clinical staff at the CMH's.

FY24-Q1 Length of Stay Data - Consumers Admitted 10/1/23 through 12/31/23 and Discharged within 90 Days (10/1/23 through 03/31/24)

Discharge Reason / CMHSP	Treatment completed		Dropped out of treatment		Terminated by facility		Transferred to another treatment program or facility		Incarcerated or released by or to courts		Death		Other (includes aging out of children's MH system, extended placement (conditional release), and all other reasons)		No Corresponding Discharge Summary		Total Discharges 0-90 Days of those admitted from 10/1/23 through 03/31/24)	Total Admissions from 10/1/23 through 12/31/23	Percent Discharged 0-90 Days
	Discharges	% of Total Admissions	Discharges	% of Total Admissions	Discharges	% of Total Admissions	Discharges	% of Total Admissions	Discharges	% of Total Admissions	Discharges	% of Total Admissions	Discharges	% of Total Admissions	Discharges *	% of Total Admissions			
Copper Country CMH	2	2.70%	10	13.51%	1	1.35%	1	1.35%	0	0.00%	0	0.00%	1	1.35%	0	0.00%	15	74	20.27%
Gogebic CMH	0	0.00%	5	16.67%	2	6.67%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	2	6.67%	9	30	30.00%
Hiawatha Behavioral Health	1	1.20%	5	6.02%	0	0.00%	0	0.00%	1	1.20%	0	0.00%	0	0.00%	3	3.61%	10	83	12.05%
Northpointe BHS	0	0.00%	10	9.90%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	2	1.98%	0	0.00%	12	101	11.88%
Pathways CMH	2	1.06%	15	7.98%	1	0.53%	3	1.60%	0	0.00%	1	0.53%	0	0.00%	0	0.00%	22	188	11.70%
NorthCare	5	1.05%	45	9.45%	4	0.84%	4	0.84%	1	0.21%	1	0.21%	3	0.63%	5	1.05%	68	476	14.29%

Chart Reviews

As part of the MDHHS C-Waiver Corrective Action Plan (CAP), NorthCare QAPIP, and in effort to improve the quality of consumer charts, NorthCare completed a review of a random sample of charts in January and September 2024. The chart reviews focus on reviewing charts for a variety of requirements that are also reviewed by MDHHS C-waiver reviews and Health Services Advisory Group (HSAG). The FY25 chart review tool was updated to include more standards from HSAG.

In January, 75 charts were pulled in the random sample, 57 of which were able to be reviewed. Charts removed from the sample were removed because they were only open to OBRA or crisis services, or they were removed because they were a new case that didn't yet have time to begin services. In September, 109 charts were pulled in the random sample, 85 of which were able to be reviewed.

CMH	# charts reviewed January	Average Percent January	# charts reviewed September	Average Percent September
Copper	13	86.61%	15 of 20 pulled	86.66%
Gogebic	12	91.30%	15 of 18 pulled	86.79%
Hiawatha	8	88.39%	16 of 20 pulled	87.04%
Northpointe	12	89.59%	15 of 21 pulled	90.83%
Pathways	12	80.20%	25 of 30 pulled	77.01%
Regional	75	87.22%	86 of 109 pulled	84.68%

As part of these reviews, NorthCare completed a summary of trends and sent the trends to the CMH. In FY25, NorthCare will be increasing training efforts and continue further reviews. The concerns noted across both reviews in FY24 include:

- Objectives are not SMART (Specific, Measurable, Attainable, Realistic, and Time-Bound). Some are too short and vague. Others have numbers in the objective, but the numbers are

not meaningful. Goals and objectives often aren't obvious in how they are related as the objectives don't seem like they would apply to the goal.

- Adverse Benefit Determinations (ABDs) are not completed correctly. ABD's either have nothing added to them, or the written text is at a significantly higher reading level. ABDs denial statements should include:
    - The service, date of admission, symptoms at the time of admission
    - Description of the treatment received
    - Denial rationale and evidence to support the denial
    - Services are not medically necessary
    - Alternative level of care recommendation

- Underutilization of services is a large issue. At times, scheduling doesn't reflect the frequency/amount in the authorization. Progress notes don't reflect the reason for underutilization. Periodic reviews and IPOS amendments do not always reflect underutilization reason. For those that do not show, engagement is often lacking.

In FY25, NorthCare has contracted with TBD solutions to develop the PowerBI framework for easier data analysis. One of the first dashboards that will be created will relate to over/under utilization of authorized services for better data analysis of authorized vs. utilized services. The anticipated dashboard will also show the typical utilized amount of service per level of care, which may help with the development of appropriate amounts of services expected within a level of care benefit plan.

This will improve the ability for review of under/over utilization. Thus far review has been prompted by complaints, random findings during chart reviews, capacity related ABDs, or looking at encounter data and network adequacy service array data to speculate areas of underutilization.

High service utilizers, especially individuals who utilize the inpatient psychiatric units frequently, that are associated with UPHP are referred for the integrated care team. Staff are also referring more consumers for Behavioral Health Home services.

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24 / ACTUAL ACHIEVEMENT**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Utilization Management – Improve consistency in UM decisions across various areas of need, such as: residential level of care, eligibility criteria, medical necessity criteria for specific services.						
Review underutilization and denoted reasons for underutilization in progress notes, periodic reviews, and other sources.	UM		Power BI program was purchased. No data reports completed in FY24	FY23 Biannual Ongoing	Continue	
Review overutilization of services as indicated by additional authorization requests.	UM		Discussed but report has not been completed yet.	FY23 Biannual Ongoing	Continue	
Discuss Interrater reliability (IRR) in the state PIHP workgroup for statewide consistency.	UM		IRR has been used for preadmission screenings. There is discussion of potentially using IRR for other services as well.	FY23 Annually Ongoing	Continue	Parity – required use of MCG tool for inpatient; workgroup discussing IRR

Complete a sample of chart reviews to ensure accuracy and completeness of charts and compliance with C waiver requirements.	UM		Chart review tool utilized for a random sample of charts. Tool updated for FY25 as well.	FY24 Biannual Ongoing	Continue	MDHHS C-Waiver

Access to Services

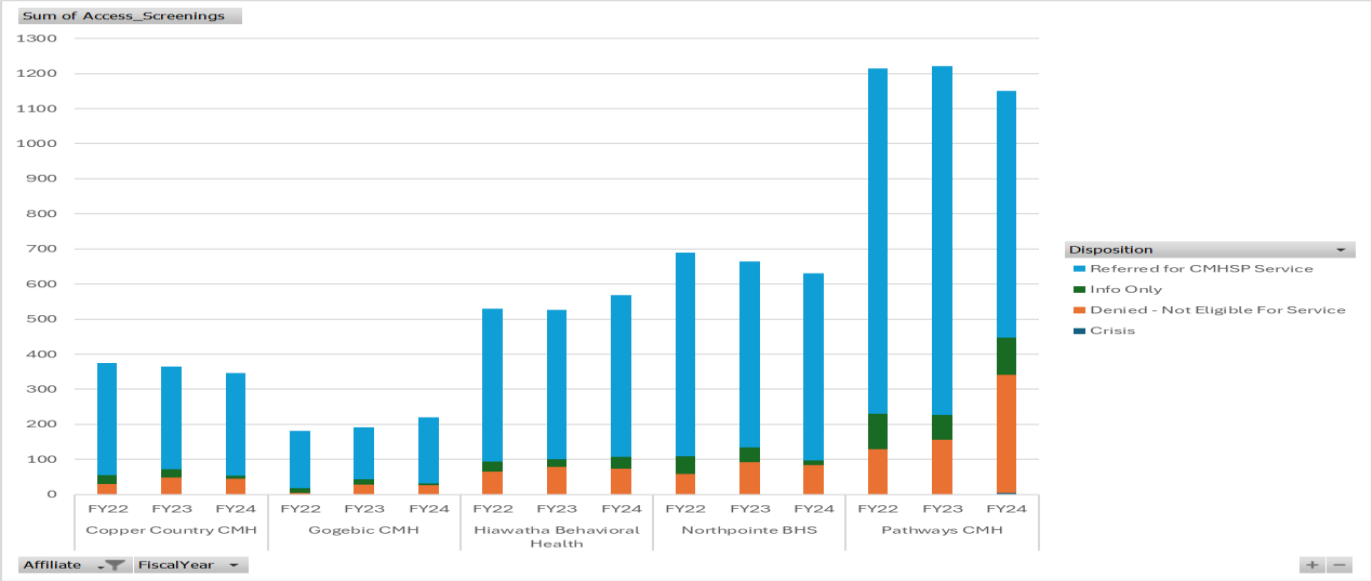
In FY24, NorthCare hired an additional Substance Use Disorder Clinical Care Manager in the Access department which allowed increased availability for SUD screenings. This allowed 88% of the individuals receiving screenings to receive a screening within one day, not taking into account screening day/time offered. Clinical Care Manager's began to provide care coordination to individuals receiving a screening to support them in attending their admission. In addition, the NorthCare Priority Populations Care Manager began working with individuals who met priority population criteria (pregnant, IV drug use, jeopardized child custody, or MDOC involvement). Care coordination was provided after screening to support individuals in attending their admission and post admission to support continuation in care.

On 1.2.24 NorthCare transitioned from a centralized access department for mental health services to each CMH doing their own mental health access screenings. The number of access screenings in FY22 was 2988. FY23 slightly decreased to 2967 and then slightly decreased again in FY24 to 2916 access screenings regionally. The number of screenings completed is reflected below.

	Copper	Gogebic	HBH	Northpointe	Pathways
FY22	375	181	529	689	1214
FY23	364	191	526	665	1221
FY24	346	220	568	631	1151

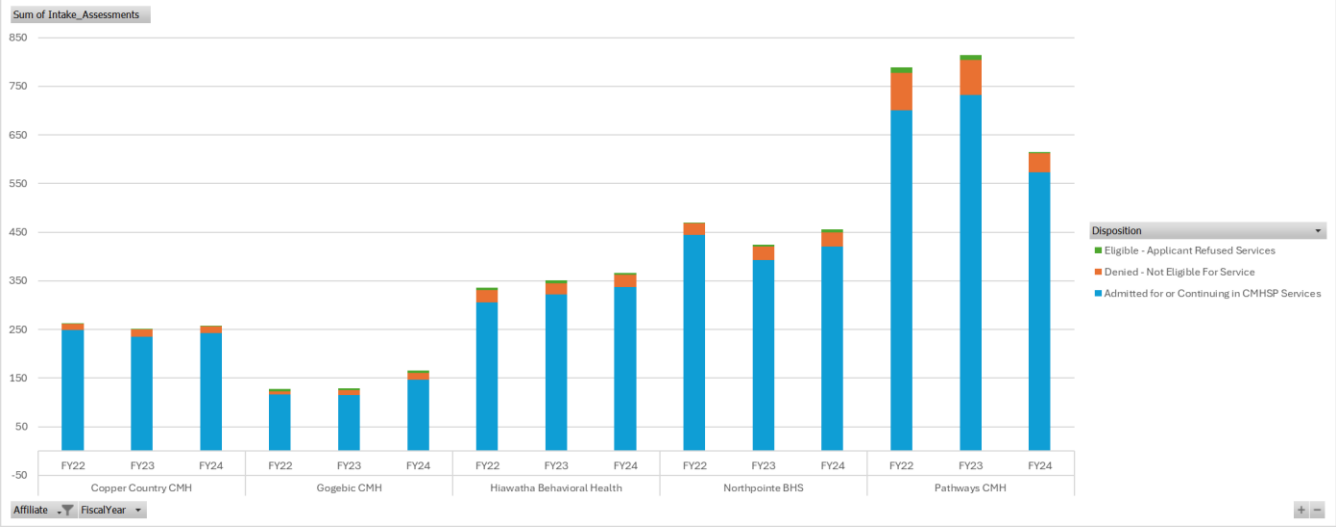
The number of access screenings that resulted in denial increased, specifically at Pathways CMH, from 156 denials in FY23 to 338 denials in FY24. The other CMH's had a reduced rate of denial at Access screening from FY23 to FY24. The percentage of Access screening denials by CMH for FY22, FY23, and FY24 are reflected below.

	Copper	Gogebic	HBH	Northpointe	Pathways
FY22	8.00%	2.21%	12.25%	8.42%	10.63%
FY23	13.46%	14.66%	15.02%	13.83%	12.78%
FY24	13.01%	12.27%	11.09%	13.15%	29.37%



However, a review of Biopsychosocial (BPS) assessments reflects that the number of individuals who had a BPS and were subsequently denied significantly decreased, especially noticeable at Pathways in FY24. Essentially, if CMH approved the person at access it was unlikely that the person would be denied at BPS. In some situations, the staff member who completed the access screening was the same staff member that completed the BPS. Given this scenario, it makes sense that the number of BPS assessments that result in denial would decrease. The percentage denied at BPS is reflected below.

	Copper	Gogebic	HBH	Northpointe	Pathways
FY22	4.94%	5.47%	7.74%	5.11%	9.63%
FY23	5.98%	7.75%	6.55%	6.37%	8.85%
FY24	5.45%	7.88%	6.83%	6.36%	6.34%



The graph above shows a significant reduction in BPS's completed by Pathways in FY24, due to the increased number of denials at the time of the access screening. The table below reflects the

number of people referred for a BPS following an Access screening that did not attend the BPS. Reduction in individuals not showing for their BPS may be related to the Access screening being completed at the CMH.

	Copper	Gogebic	HBH	Northpointe	Pathways
FY22	57	35	99	110	195
FY23	41	19	75	107	181
FY24	35	23	95	77	88

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24 / ACTUAL ACHIEVEMENT**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Access to Services – Improve consistent access to services across the region						
Review a random selection of screenings for screener approval rate, determination at BPS, and other factors to identify trends and address any concerns.	UM		Data has been collected to review the number of approvals/denials at Access. Data captured daily needs to be compiled and analyzed.	FY24 Quarterly Ongoing	Continue	Access Standards

Credentialing and Qualification for Scope of Practice

In FY24, all SUD providers were credentialed and met criteria for continued service provision. One Single Case Agreement was completed with provider credentialing completed and provider staff credentialing reviewed and met all criteria.

In January 2024, NorthCare and MDHHS communicated about credentialing concerns related to overdue files. Credentialing policies were updated, and it was ensured that the updates were made in CMH policies as well. Meetings were held with CMH's to help them come into compliance with credentialing. A change form was added into ELMER, the electronic record, to capture all data fields. Information was captured on paper prior to being implemented in ELMER. An audit was conducted on the CMH's credentialing files in April 2024. Three CMH's met their CMH audit at 100% related to credentialing. One was 95% compliant and the other 83% compliant. The state is moving to universal credentialing in the CRM. In FY25 all information will be available within this MDHHS platform. NorthCare Network will be training in March 2025 for credentialing in the CRM for Universal Credentialing.

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24 / ACTUAL ACHIEVEMENT**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Credentialing and Re-credentialing – Ensure consistent factors considered during credentialing and recredentialing (grievances, PI, utilization, appeals, member satisfaction, and provider reviews) and that MDHHS requirements are met.						
Develop and implement detailed credentialing/recredentialing file auditing plan addressing credentialing/ recredentialing requirements, citations, and recommendations made in HSAG review.	PNM	Annual audit	Decreased number of charts out of compliance.	FY22 Annually September	Continue	42CFR438.214
Ensure non-licensed providers meet all Medicaid requirements.	PNM	Annual audit	Decreased number of files out of compliance.	FY22 Annually September	Continue	

Conduct annual audit of all delegates performing credentialing activities according to audit plan.	PNM	Annual audit	FY24 CMH audit resulted in 3 CMH's audits met at 100%: Gogebic, Hiawatha, and Northpointe. Pathways was 95% compliant and Copper was 83%.	FY22 Annually September	Continue	

Oversight of Vulnerable Individuals / LTSS

HCBS

In FY24, Northcare assisted with a secure setting scan in coordination with MDHHS Home and Community Based Services (HCBS) Transition Team. The secure setting scan was sent via survey to every licensed residential setting. The purpose of the survey was to develop an inventory of all settings providing specific HCBS Medicaid funded services, and to identify the features of each setting. NorthCare and MDHHS' goal is to obtain an accurate list of settings that are restrictive/secure in nature and would require high scrutiny reviews for continued use of Medicaid funded services.

Statewide the documentation of HCBS limitations has been on the forefront. Northcare recognizes the current lack of a system to ensure all required information is documented around HCBS limitations. NorthCare is in the beginning stages of implementing enhancements to the Individual Plan of Service (IPOS) to capture all the required elements prior to imposing any modification or limitations to individual's HCBS rights. In addition to making enhancements to the EMR, Northcare has developed an in-depth training explaining the process and expectation of how and why HCBS modifications should be documented.

NorthCare will follow MDHHS HCBS monitoring requirements and technical advisory which includes a triannual review of all HCBS cases and annual on-site provider reviews once timelines and review tools have been finalized by MDHHS HCBS transition team. These are anticipated in FY25.

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24 / ACTUAL ACHIEVEMENT**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
HCBS Modifications – Modifications of HCBS conditions will be supported by an assessed need that is justified in the person-centered plan.						
Review of HCBS limitations at annual site reviews.	QI	NA	Begin review	FY22 Annually Ongoing	Discontinue	42 CFR §441.301 (c)(4)(vi)(A-D)
Monitoring of HCBS limitations and ensure that the limitation is justified and addressed in the person-centered plan.	QI	NA	The specification for updates to the Electronic Medical Record (EMR) has been created, reviewed by the CMHs, and MDHHS. Implementation is expected in FY25.	FY22 Annually Ongoing	Continue	HCBS Monitoring Requirements and Technical Advisory

LTSS

NorthCare was working off the list of Long Term Services and Supports (LTSS) services that were identified in the 1115 Pathway to Integration Waiver. As this list includes case management many individuals fall into the LTSS category. Other PIHP areas were utilizing the LTSS list shared by MDHHS which is less inclusive than the list indicated in the long-term services and supports waiver. In mid-FY25, NorthCare is revising its LTSS list to match what is suggested by MDHHS following review by HSAG. If MDHHS makes any revisions to the list, those will be reflected. Targeted Case Management is included in both lists currently, which many individuals receive. Looking at an unduplicated count, around half of served individuals have case management (S0280 was excluded from this encounter report). Home-based and Assertive Community Treatment (ACT) services include case management components. The inclusion of those services is represented in the rightmost two columns, however, did not change the percentage significantly. The amount of case management services is lower than anticipated and will be discussed with the region in FY25.

Affiliate	Consumers	Cons_w_T1017	Percent	Cons_w_T1017, H0036, H0039	Percent
Copper Country CMH	1140	415	36.40%	452	39.65%
Gogebic CMH	665	356	53.53%	407	61.20%
Hiawatha Behavioral Health	1763	581	32.96%	594	33.71%
Northpointe BHS	1703	1095	64.30%	1159	68.06%
Pathways CMH	3238	1449	44.75%	1536	47.44%

The following table compares LTSS services between the 1115 Pathway to Integration Waiver (FY24) and a description of LTSS services which NorthCare received following an email inquiry. NorthCare will consider a revised definition list of LTSS services in FY25 if not otherwise instructed. HSAG had encouraged the PIHPs to discuss the definition of LTSS with MDHHS so all PIHPs were considering LTSS consistently. It is believed most are using the FY24 list. The PIHP's are working together with MDHHS to determine a consistent list.

LONG TERM SERVICES & SUPPORTS 1115 Pathway to Integration Waiver (michigan.gov)	**CPT/HCPCS** MDHHS SFY 2022 Behavioral Health Code Chart	**FY24 1115 waiver**	**FY25? Email answer**
Respite	H0045 (Out-of-Home Setting) S5150 (Unskilled caregiver, "family friend") S5151 (In-Home Setting) T1005 (15 minutes)	X	X
Community Living Supports	H2015 (Unlicensed Setting) H2016 (Licensed Residential Setting)	X	X
Private Duty Nursing	S9123 (Registered Nurse, Hour) S9124 (Licensed Practical Nurse, Hour) T1000 (RN or LPN, 15 minutes)	X	X
Supported Integrated Employment	H2023	X	
Out of Home Non-Vocational Rehab	H2014	X	
Goods & Services	T5999	X	
Environmental Modification	S5165	X	X
Supports & Service Coordination	T1017	X	X
Enhanced Pharmacy	T1999	X	
Personal Emergency Response (PERS)	S5160 (Installation and testing) S5161 (Service fee, per month, excludes installation and testing)	X	X
Community Transition Services	T2038	X	

Enhanced Medical Equipment & Supplies (including vehicle modification)	E1399 (Durable Medical Equipment) S5199 (Personal Care Items) T2028 T2029 T2039 (Vehicle Mod)	X	
Family Training	G0177 (Family Education Groups) S5110 (Family Psycho-Education Skills Workshop) S5111 (Home care training; family) T1015 (Family Psycho-Education, Joining)	X	
Non-Family Training	S5116	X	
Specialty Therapies (Music, Art, Massage, etc.)	G0176 (Music, Art, Recreation Therapy) 97124 (Massage) 97530 (Therapeutic Activities)	X	
Children Therapeutic Foster Care	S5140 (age 11 and older) S5145	x	
Therapeutic Overnight Camping	T2036	X	
Transitional Services	T2038	X	
Fiscal Intermediary	T2025	X	
Prevocational Services	T2015	X	

Specialized Residential Level of Care

NorthCare Utilization Management pulled a March data review of individuals indicated in specialized residential settings that had a designated level of care that seemed incongruent to this living arrangement. NorthCare did a preliminary review of the level of care, the number of incident reports the person had, the length of time in that particular placement, and any concerns related to the placement. Staff also reviewed if the person had a restrictive behavior plan, looking at this sample of cases from a qualitative perspective. There is limitation to the data results given the data source. The source of the data, Diver, is changing on 1.1.25. These reviews will likely continue in a different way, depending on the data output, but the intent of the data review remains in FY25.

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24 / ACTUAL ACHIEVEMENT**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Long Term Services and Supports – LTSS – Compare services received by LTSS consumers vs what was authorized in their plan (over/under utilization of LTSS services).						
Review individuals in AFC level of care that do not have a matching LOC in the system to determine if AFC level of care appears appropriate	QI / CP / UM	Review 5 cases per quarter	Review 5 cases per quarter / data reviewed once	FY23 Quarterly Ongoing	Continue	
Review underutilization of authorized LTSS services.	QI / UM	Review 10 cases per quarter	Review 10 cases per quarter/ did not achieve	FY23 Quarterly Ongoing	Continue	

Integrated Care

Integrated Care activities, explained in greater detail in the Performance Based Incentive Pool (PBIP) Section, are also listed below in the measurement grid. For more information on the Data Collaboration Workgroup and Integrated Care Team interventions, refer to the PBIP section.

The first item, monitoring to ensure individuals receiving specialty care – care from a medical specialty beyond primary care, was reviewed in a random, representative sample from all 5

CMHSP's in the annual site review. This care could be from a medical doctor, like a cardiologist or neurologist, or from a special discipline, like a physical or occupational therapist, dietician, diabetic educator, or other condition focused discipline.

The use of RN nursing service codes was identified as a deficit due to very low utilization of the codes and delivery of these services. H0034 – could be used following any medication change from a CMH prescriber, or other physical health prescriber. It can increase medication adherence by providing people with education on what medications are prescribed for, troubleshooting side effects – like recommending when to take a medication during the day, or taking it with or without food.

Other nursing services – the S9445 and S9446, can be used to provide education on managing physical health conditions like diabetes, digestive concerns, headaches, incorporating physical or dietary interventions into daily life.

NorthCare continues to meet with the Medicaid Health Plan in the region, Upper Peninsula Health Plan (UPHP). There are 8336 unduplicated shared members. In a typical meeting there are approximately 30-34 shared members to discuss, which recently in FY25 includes reviewing approximately 5-6 children. Additionally, there are 2-4 individuals with Mi Health Link which are also reviewed in a separate meeting with UPHP.

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24 / ACTUAL ACHIEVEMENT**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Oversight of Vulnerable Individuals –Integrated/Coordinated Care - Care coordination between the behavioral health and physical health providers will occur.						
Individuals receiving specialty care will have the recommendations of those providers incorporated into their behavioral health IPOS and a consent to share information. This will be reviewed via annual site reviews.	ICT	85%	85%/ 92.6% Overall. One provider receive CAP due to 80% performance rate.	FY22 Annually Ongoing	Continue	
Behavioral Health Home (BHH) services will expand for individuals with at least 1 co-morbid physical health condition at the CMHSPs.	PHS	110 enrollees, 5 HH Partners	117 enrollees, 6 HH partners (Jan 2024) / 164 Enrollees (September, 2024)	FY23 Monthly Ongoing	Continue	
CMHSP's will expand the provision of H0034 – Medication Training and Supports, S9445 Patient Education individual, T1001 and T1002 RN/Nursing Services.			Review of FY23 compared to Q1-2 FY24 – no statistically significant change	FY23 Annual Ongoing	Continue	
NorthCare and UPHP will have bi-monthly data collaboration workgroup meetings to address shared member health care outcomes and gaps.	ICT	8210 unduplicated shared members	8336 Unduplicated shared members	FY23 Bi-monthly Ongoing	Continue	
Individuals with high ER utilization, that are enrolled in MI Health Link, will reduce ER visits and increase preventative care by coordination between the PIHP and MHP.	ICT		3-4 mutually served members per month	FY23 Monthly Ongoing	Continue	

Transition of Care

MDHHS finalized the transition of care technical guideline in FY25. In FY24, NorthCare ensured smooth transitions of care by reporting inpatient psychiatric discharges for shared Medicaid Health Plan members and MiHealthLink members to the Medicaid Health Plan, UPHP on a weekly basis. Individuals transitioning from inpatient to outpatient services were seen for a 7-day follow up appointment. More information about 7-day follow up can be found in the Performance Indicator section.

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24 / ACTUAL ACHIEVEMENT**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Transition of Care – Care will be coordinated when transitions are occurring.						
The Medicaid Health Plan (UPHP) will be notified of all psychiatric hospitalizations and discharges for shared members.	UM		100% / 100%	FY23 Weekly Ongoing	Continue	As part of information provided to CC360
Individuals discharging from the psychiatric unit will have a follow up appointment within 7 days (see PI4a).	QI		95%/97.88%	FY23 Quarterly Ongoing	Continue	MMBPIS
Waiver transitions to another PIHP area will be coordinated as they occur.	WC			FY24 PRN Ongoing	Continue	

Waiver services

Effective 11/01/2023 Northcare Network was under an action plan relating to timely submission of Habilitative Support Waiver (HSW) recertifications and pend-back cases. Northcare Network, among all other PIHP's, were asked by MDHHS to produce an Action Plan around ensuring timely submission of HSW recertifications and the return of pend-back cases. The following were steps in NorthCare's action plan submitted to MDHHS:

- PIHP Waiver Coordinator will provide ongoing reminders and correspondence of HSW recertifications due dates to each CMHSPs at least two months prior to the certification expiration starting 11/1/2023 through at least 5/1/2023.
- PIHP Waiver Coordinator will include CMHSP CEO on notifications when there is a past due recertification or failure to complete HSW pend back within the required 15 days. Should the CMHSP indicate that additional time is needed for requested pend back, PIHP will request extension with MDHHS to ensure awareness of the importance and work being done to complete the request.
- Northcare currently holds a regional waiver meeting each quarter. Standing business is to discuss specific waiver requirements; including timely submission of recertifications and the need to return any pended back cases or recerts within 15 days.
- Each quarter at the regional wavier meeting, de-identified recertification data and pend back cases will be shared with the region.
- HSW related data will be shared quarterly at Northcare' s Regional Quality Management Committee.
- HSW related data will be shared monthly at Northcare' s PMC Performance Management Committee Meeting.

Northcare continued sending monthly reminders of coming due HSW recerts to all HSW CMHSP Leads until May 2024. This process had a significant positive impact on the timeliness of HSW recertifications and recertification continues to be timely. When there are circumstances of expired HSW recertifications the CMHSP CEO will continue to be notified of the issue and action will be requested as soon as possible.

Quarterly waiver meetings continue to discuss and provide updates on all waivers (SED, HSW and CWP). There is an opportunity for discussion around any barriers to waiver compliance, issues or questions around all waivers and services related. Regional waiver data is shared quarterly with the CMHSPs, in addition to our internal Quality Management committee and Northcare's Performance Management Committee.

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24 / ACTUAL ACHIEVEMENT**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Waiver Services – Ensure timely HSW recertifications and pended cases.						
NorthCare will provide ongoing monitoring and reminders to the CMH's about expiring cases.	W.C.		Met	FY24 Monthly Ongoing	Discontinue	Result of performance issue
NorthCare will notify the CMH CEOs of data and data will also be shared in regional meetings.	W.C.		Met	FY24 Monthly Ongoing	Continue	Result of performance issue

Behavior Treatment Review

The regional Behavior Treatment Committee meets quarterly to review aggregate data received from the CMH's. Data includes restrictive and intrusive techniques, psycho-active medication use, and behaviors exhibited during that quarter. CMH specific data is reviewed at each CMH in the CMH behavior treatment committee to determine correlations with interventions that have statistical significance in increasing or reducing restrictive techniques or behavioral responses. These barriers and interventions and shared in the regional committee as a method of the CMH's supporting each other.

The regional Behavior Treatment Committee discusses changes regionally that can affect implementation of Home and Community Based Services (HCBS) rules and behavior treatment monitoring. The regional Behavior Treatment Committee is reviewing and working on implementation of HCBS rules into the IPOS which also impacts behavior treatment committee. Additionally, to increase reliability of data collection and reporting measures, the regional behavior treatment committee are considering adding an ELMER module to electronically enter data into consumer charts that will allow more detailed reporting mechanisms to isolate measures for analysis. This discussion and change will continue in FY25 and possibly FY26. Each quarter the committee identifies areas that can increase the quality of reporting, adherence to authority of behavior treatment, and alternative measures to implement and reduce restrictive measures.

The average percentage of all reported incidents recorded in the incident reporting module, by reason for reporting, are indicated below. Harm to others (89) and harm to self (68) were both primary reasons for behavior plans and the issues reviewed during a quarter.

The main types of intervention reported included limiting freedom of movement (68) and use of medications for behavior control (49). Each individual could have multiple behaviors being addressed within an intervention and multiple interventions for a behavior being addressed. Typically, the behavior plan is continued from one quarter to the next, although recommendations may change. This is true for both plans using antipsychotics as well as plans using psychotropics and regardless of the behaviors being reviewed.

The length of physical interventions varies from less than 5 minutes to over 90 minutes, as reported by CMH. The median time was 11-15 minutes. Gogebic did not report physical intervention in FY24.

BTC reported review on 81 unique individuals over the year.

	Copper	Gogebic	HBH	Northpointe	Pathways	Total
Unique Individuals Reviewed by BTC	6	8	4	29	34	81

In looking at incident reports related to 911 use and physical management, in FY24, there were 73 incidents of 911 calls and 194 incidents of physical management. While not specific to individuals with behavior treatment plans, this is a reduction for the region from FY23. There were 286 events of physical management in FY23 (3%) down to 194 events in FY24 (2%). The number of 911 calls in FY23 totaled 130 (1.3%), which decreased in FY24 to 73 (.7%).

Code Use	Copper	Gogebic	HBH	Northpointe	Pathways	Total
911 (BC13)	26	1	12	7	27	73
Physical Management (HS09)	22	0	26	2	144	194

There are 22 behavior codes in the incident reporting system, which behavior treatment committee may review for consumers that have an incident that are involved with behavior treatment committee. Codes are reported on incident reports, which are completed for individuals in specialized residential settings, or in some situations, are involved in certain types of CMH services. The use of these codes is reflected below. Those that rise to critical status are reported to MDHHS. More information about event reporting can be found in the next section.

Code	Description	Count FY24	FY23
BC00	Preadmission Screening	19	*code added in FY24
BC01	Psychiatric Hospitalization	30	18
BC02	Threat of Suicide or Homicide	89	125
BC03	Non-Serious Physical Aggression	1182	1273
BC04	Verbal Aggression	693	770
BC05	Property Destruction	165	191
BC06	Elopement	53	75
BC07	Missing Person	4	4
BC08	Committed Criminal Offense	5	9
BC09	Victim of Criminal Offense	3	10
BC10	Inappropriate Sexual Behavior	62	54
BC11	Arrest	52	36
BC12	Conviction	5	3
BC13	Staff called 911 due to Behavior Crisis	73	130
BC14	Harm to Others resulting in Physical Injury	51	42

BC15	Harm to Others resulting in Hospitalization	1	0
BC16	Inappropriate Alcohol Use	6	7
BC17	Substance Abuse	10	14
BC18	Possession of a Controlled Substance	16	4
BC19	Other Behavior	553	614
BC20	Disruptive Behavior	429	510
BC21	Employment Related Behaviors	8	1

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24/ ACTUAL ACHIEVEMENT**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Behavior Treatment Plan Review – NorthCare will complete analysis of BTC data and implement systemic change related to data findings as necessary.						
NorthCare will collect quarterly data from the CMH's and present data at the regional BTC meeting and internal health and safety committee meeting. Determine the "why" of the incident.	QI / CP	Completion of quarterly review	Completion of quarterly review, data brought to committee as relevant	FY23 Quarterly Ongoing	Continue / bring data and specific consumer concerns to each CMH.	42 CFR 438.100 (b)(2)(v). Balanced Budget Act of 1997
NorthCare will utilize data to determine improvements/ changes in care due to BTC both on select individuals and programmatically. Review interventions and incidents; specifically 911 use and physical management.	QI / CP	Reduction in use of physical management	Reduction of Physical management and 911 calls achieved (per incident reporting module)	FY23 Quarterly Ongoing	Continue / bring data and specific consumer concerns to each CMH.	42 CFR 438.100 (b)(2)(v). QAPIP
Analysis of BTC survey data to determine any concerns related to the program.	QI / CP	Completion of survey (311 responses)	NA – biannual	FY24 Biannual Ongoing	Continue	42 CFR 438.100 (b)(2)(v).

Event Reporting and Notification

MDHHS requires data be tracked for critical, sentinel, risk, death, and SUD sentinel events. Data is reported to MDHHS via the CRM platform for CMH critical incidents, SUD sentinel events, and all immediately reportable events. In FY25, crisis stabilization unit incidents are also tracked via the CRM. Each type of incident has its own reporting timeline.

The MDHHS critical incident reporting policy was updated in August 2024. An immediately reportable event category was added. Additionally, tracking falls was added. The definition of a sentinel event is also changed and, while similar, does not exactly match the definition in the MDHHS/PIHP contract. At this time, both definitions are being used.

A critical incident is a suicide, non-suicide death, emergency medical treatment or hospitalization due to injury or medication error, or an arrest of a consumer. Each category has different populations that apply. "Critical incidents that are determined newsworthy" is a new added category of an immediately reportable event. The other immediately reportable events include death due to staff action/inaction or open to investigation, relocation of consumer placement due to licensing suspension, relocation of a provider site for more than 24 hours, conviction of staff for job related offenses, and changes to the provider network that negatively impacts access to care. Risk events are those that put individuals at risk for harm. Sentinel events, per MDHHS contract, are

unexpected occurrences that cause a serious injury to the person, or the risk thereof, including death. SUD sentinel events are those that result in death, permanent harm, or temporary harm and include death, hospitalization due to illness or injury, emergency medical treatment due to injury, abuse/neglect allegations, arrest/conviction, serious challenging behaviors, or medication errors.

Critical, Sentinel, and Risk events, including death, are reviewed monthly by members of the NorthCare Health and Safety Committee, including the NorthCare Medical Director. Immediately reportable events are reviewed by the Quality Improvement/Utilization Management Director as they are reported. Incidents for the Medicaid Health Plan, UPHP, consumers are reported to UPHP as well via monthly reporting. Data is taken to the regional incident reporting group and questions are discussed there.

Each CMH reviews their own incident reports and identified a goal related to incident reporting. NorthCare's goal was related to timely reporting and review.

- Copper: reduction in medication errors. Training and retraining provided and appears to be improving. The frequency of required training has increased. Staff are currently considering the next goal. Possibly timeliness and ensuring IRs don't bottleneck.
- Gogebic: Prevention of falls. Falls have decreased. Shifted focus to completion of Root Cause Analysis.
- Hiawatha: Ensuring sufficient detail is present in the Root Cause Analysis, goal met. Ensuring sufficient detail is present in the incident report is ongoing. While improving, staff are lacking information specific to medications. Guidance, directives, and training have been updated and provided. Goal may shift to timeliness.
- Northpointe: reduction in medication errors. Training changed and the trainer is more consistent. This has resulted in improvement.
- Pathways: Timely categorization of incidents. Improving; working with homes to ensure incidents are submitted in a timely manner and staff are notified. CMH is fully staffed with recipient rights officers now. Goal continues.

As a result of incident reviews, NorthCare identified the need for a standardized suicide risk assessment to be embedded in select documents within the EMR and be available as a stand-alone document for all staff to access. These upgrades are to be completed in FY25.

Each month, the total number of events are tracked. The average percentage of each type of incident compared to the overall number of incidents for that CMH that month is reflected below.

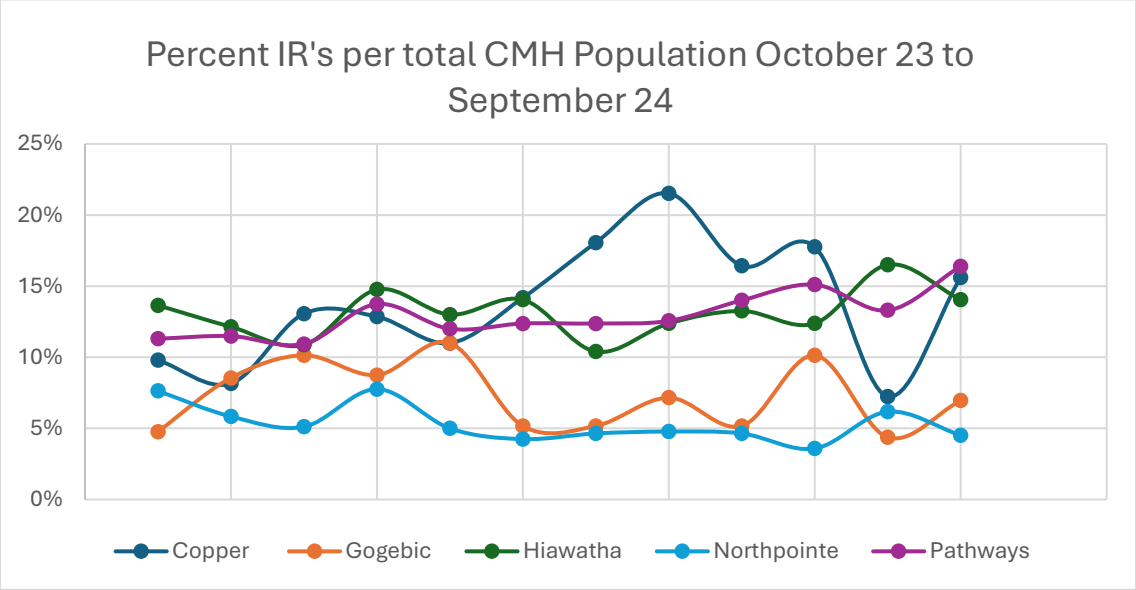
CMH	Risk Events	Critical Incidents	Sentinel Events	Immediately Reportable	Deaths (avg. #/month)
Copper	2.00%	1.27%	1.21%	0	1.33
Gogebic	.81%	1.23%	3.02%	0	.5
HBH	1.46%	2.14%	.48%	.08%	1.08
Northpointe	1.31%	2.34%	1.22%	.08%	1
Pathways	4.35%	2.19%	.21%	.25%	1.58
Total	2.90%	1.97%	.67%	.41%	5.25

The total number of IR's by category are reflected below.

	Risk	Critical	Sentinel	Immediately	Total IRs

Copper Country CMH	34	24	20	0	1715
Gogebic CMH	5	6	12	0	528
Hiawatha Behavioral Health	36	39	8	3	2047
Northpointe BHS	12	21	13	1	940
Pathways CMH	205	100	4	2	4383
Total	292	190	57	6	9613

NorthCare also monitored the reporting rate of each CMH to look for underreporting of incident reports (IR's). The percentage of IR's compared to the service population of the CMH is reflected across months. This is to review the CMH to itself across the months and to compare the CMH's to the regional average. Northpointe tends to have lower rates of incidents although the reason for this is undetermined. Northpointe, Copper, and Gogebic own some specialized residential homes. Pathways contracts for all specialized residential services. This variation may account for some of the difference.



The percentage of incident reports categorized timely also increased in FY24 with some months achieving under a 5% uncategorized rate. The following are percents of uncategorized incidents by month per CMH. Many CMH's had a goal in FY24 to increase their timely reporting. Reporting was determined to be untimely for a variety of reasons, including delay in receiving the incident from the residential home provider, delay in review by CMH staff, or limited information being available in the incident report, making accurate categorization of the incident unlikely.

	Oct	Nov	Dec	24-Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Copper	2.7	2.9	23.7	3.3	3.3	2.3	0.8	3.9	1.1	1.25	2.8	1.3
Gogebic	0	0	33.3	0	0	0	0	0	0	2.6	0	0
HBH	9.1	3.1	5.3	0	2.7	0.9	1.6	3.5	5.2	4.5	3.3	0

Northpointe	6	3.9	7.7	0	0	0	3.5	2.3	5.0	0	1.0	2.9
Pathways	7	9	5.2	2.8	3.7	12.1	17.3	8.5	29.5	15.6	11.3	6.5
Regional	**6.3**	**5.8**	**9.1**	**1.8**	**2.9**	**6.4**	**8.9**	**6.2**	**16.2**	**9.5**	**6.7**	**3.7**

A 6-month review of specialized residential home incident reporting (October – March) indicates that approximately 85% of incident reports occur at specialized residential facilities. Given the reporting requirements and the fact that staff are with this population all the time to be aware of incidents, this makes sense. Approximately 20% of the incidents happen at CMH run homes.

	October	November	December	January	February	March
Total Specialized Residential IRs	703	671	589	815	670	625
IR total for the month	714	675	689	845	712	741
% IR's happening at Specialized Residential	85.15%	85.48%	85.49%	84.02%	83.29%	84.35%

There were 9613 CMH incidents recorded in the system in FY24. There are 3 codes in the NorthCare incident reporting system that denote falls; CI06F – accidental serious injury from fall, CI07F – accidental non-serious injury from fall, and CI12F – fall with no injury. There were 34 serious injuries from falls in FY24, 347 non-serious injuries from falls, and 545 falls with no injury reported.

There were 52 arrests indicated by incident reports in FY24.

Incidents considered critical are reported into the CRM system. This data is not currently extractable in report format from the EMR but is housed in the CRM. None of the 231 injuries reported in the CRM from 10.1.22 – 1.13.25 were reported as occurring during physical management. Two Hundred Sixteen specifically state that they did not occur during physical management. The other 15 indicate they were due to a fall. MDHHS added the "fall" category in FY25. Data specific to dates in FY24 in the CRM indicates there were 99 injuries not during physical management, and 4 were due to falls. The addition of "fall" is in the same sub-element as physical intervention which eliminates the ability to indicate if injury was during physical management if the injury was due to a fall. The assumption is that if injured during a fall, the injury was not during physical management. There were 9 suicides reported in the CRM in FY24.

A specific individual may warrant greater review based on their data. Individuals with 2 or more critical or sentinel events in 1 month, or 3 or more risk events in 1 month are reviewed in greater detail. Many of the same individuals were coming up every month. Issues or questions identified by NorthCare are communicated with the CMH's every month.

Sentinel events include a root cause analysis (RCA) to determine potential causes and actions to mediate future reoccurrence. NorthCare reviews the completion of RCA's during the annual CMH site review process to ensure RCAs are completed by the CMH and include the appropriate staff.

Substance Use Disorder Service Provider Incidents reflected 22 Emergency Department visits, 20 medication errors, and 18 behavioral issues. Reports of Sentinel Events for residential services showed 3 Emergency Department visits.

Type		Number

Sentinel Events		
	Emergency Department Visits	3
	Medication Error	1
	Assault	1
	Overdose	1
	Behavioral Issue	1
Incidents		
	Emergency Department Visits	22
	Medication Error	20
	Assault	4
	Overdose	1
	Behavioral Issue	18
	Psychiatric Screening	5

In FY25, MDHHS is updating the incident and event reporting manual and is seeking a workgroup of PIHP's to review the document for content edits. NorthCare is participating in this workgroup.

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24 / ACTUAL ACHIEVEMENT**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Event Reporting – Increase data reporting capability by building better reports and using the data to analyze improvements in the quality of healthcare and services for members.						
Utilize Power BI for better data analysis and review data during the Health and Safety Committee (internal), Regional Incident Reporting (regional) meetings, and the Risk Review meeting (internal).	QI	NA	Power BI has been purchased, TBD solutions has been contracted with to develop the reporting framework, but no reports were available in FY24. They are anticipated in FY25.	FY23 Quarterly Ongoing	Continue	QAPIP
Increase timely categorization of incidents as being critical, sentinel, risk, immediately reportable to 95% within 3 business days of incident.	QI	93%	95% / 25% Average across the year was 6.95 days. There were 3 months of the year where categorization achieved 95% timeliness.	FY23 Quarterly Ongoing	Continue	QAPIP
Ensure individuals living in residential living arrangements are in the correct level of care (LOC); ensuring discussion of transition for any individual who is identified to need another LOC.	QI / CP	Completion of quarterly review	Completion of quarterly review / not achieved. This is reflected under oversight of vulnerable individuals	FY23 Quarterly Ongoing	Continue	QAPIP
Review RCA Outcomes data to assess common causal factors for possible improvement project.	QI / CP	NA	Annual review / not achieved	FY23 Annually Ongoing	Continue / determine if completion during site review makes	QAPIP

					most sense or mid-year review	
Review all untimely deaths with NorthCare Medical Director and trend data over time.	QI / CP	NA	Monthly / deaths reviewed	FY24 Monthly Ongoing	Continue	QAPIP

Performance Measurement

MMBPIS is converting to HEDIS in FY26. Both HEDIS and MMBPIS will be calculated in FY25. MDHHS has a 3-year quality plan and has included various indicators to begin calculating each Fiscal Year.

NorthCare struggled with CMH Performance Indicators (PI) PI 2a and PI 3 in FY24, and SUD PI 2e. Each CMH created a plan of correction. The CMH's and NorthCare met on 4.15.24 and 8.15.24 to discuss PI2a and PI3, trouble shoot barriers and discuss ideas. Transportation and the inability to effectively communicate when individuals do not answer phone calls was identified as the biggest barriers. Due to the lack of exceptions, there is little CMH's can do outside of engagement attempts to try to improve these standards. CMH's have been making engagement attempts via phone calls and providing call reminders on the same day as the appointment. There may be an increase in reschedules now that there is the automated appointment reminder text that allows people to cancel or reschedule their appointment from a text. One CMH also identified an issue with process where reschedules were only looking at the calendar of the person the appointment was originally scheduled with and not considering possible alternative staff. They have since addressed this issue.

CMH's have started to try to schedule individuals sooner so if there is a no-show or reschedule, they have the potential to reschedule during the 14-day window. However, this is not always possible and is more difficult for certain populations where staffing may be tighter. Some CMH's have started to schedule the first ongoing service of preliminary planning on the same day as the Biopsychosocial (BPS) intake. PI logic does not count this as an additional service if completed on the same day. Therefore, while this is improved quality and progresses the person to move forward in their treatment, it is not benefiting PI. NorthCare still supports doing this for individuals who are interested in creating their preliminary plan on the same day regardless of the lack of impact on PI.

The following PI metrics are reviewed quarterly by the PIHP. Each CMH views their own metrics. The PIHP has a meeting with each CMH every quarter to discuss and review measures out of compliance or any cases that appear to have quality issues. NorthCare Quality Improvement / Utilization Management staff specifically watch for the following when reviewing PI.

- PI1: screenings completed in under 10 minutes. An EMR edit was put in place in October 2023 to prevent zero-minute screenings.
- PI2a: looking for missing BPS dates, General Fund Waitlist, and Individuals availability dates (e.g. hospital discharge date becomes the date of request)
- PI2b/e: checking the main referral date
- PI3: General Fund Waiting List, lack of consent, and same day appointments
- PI4a: appointment no-shows, exclusion of Medicare
- PI4b: use of exceptions for appropriateness

- PI10: exclude Medicare. Review crisis alerts.

Following discussion with the CMH's and making any corrections necessary, data is reported to MDHHS. As data entry errors were discovered in FY24, in FY25 the data reports are being run, saved, and highlighted as data is entered and submitted to MDHHS. As a final verification, the draft report data from MDHHS is then reviewed against the data report from the EMR.

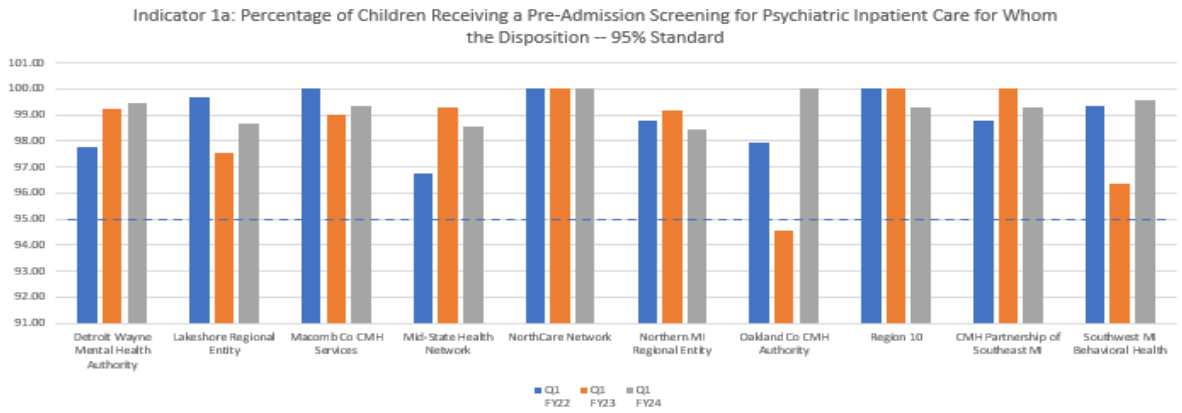
PI1, the completion of a Preadmission Screening within 3 hours has historically been well met. The number of children and adults screened each quarter is also consistent. NorthCare does review any screenings that take 10 minutes or less to check for errors in reporting start/stop times as well as to check for quality of the screening. In FY25 NorthCare has also begun looking at any individual consumers that have 2 or more screenings in 1 day, at the suggestion of HSAG.

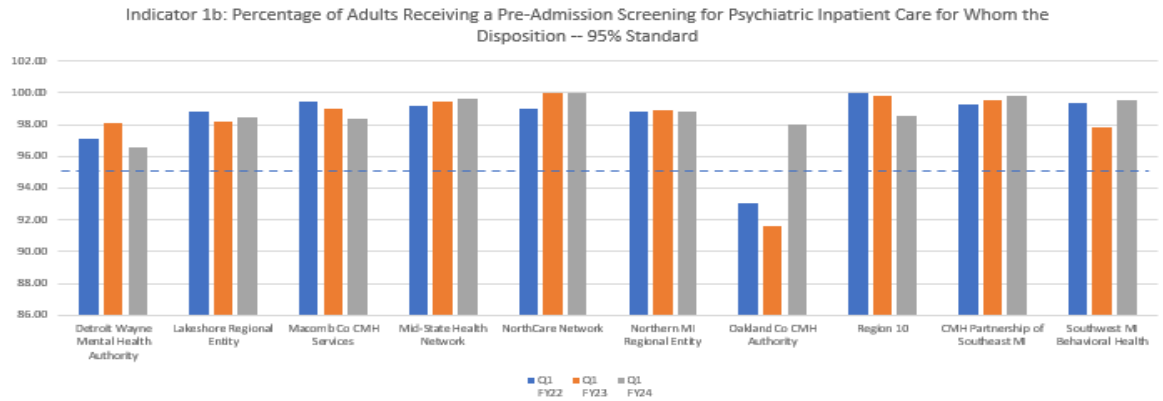
NorthCare Total	Q1	Q2	Q3	Q4
# Children Completed w/in 3 Hrs.	68	69	75	48
# Children Referred for Inpt. Screen	68	69	75	48
	100.0%	100.0%	100.0%	100.0%
# Adults Completed w/in 3 Hrs.	250	253	265	259
# Adults Referred for Inpt. Screen	248	255	264	259
	99.2%	99%	99.6%	100.0%

This indicator has performed well across the state. FY24Q4 state data isn't yet available. Quarters where NorthCare did worse than the state average are in red. This does not mean that NorthCare did below the standard. The standard for PI1 is 95%. NorthCare and MDHHS have met that standard for all quarters reflected. State data for FY24Q4 is draft.

PI #1 - Percent w/pre-admissions screening for psychiatric inpatient and disposition completed w/in 3hrs. Standard is 95%																
	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22	Q1FY23	Q2FY23	Q3FY23	Q4FY23	Q1FY24	Q2FY24	Q3FY24	Q4FY24
NC Children	100.0%	98.3%	100.00%	100%	100%	98.68%	100%	100%	100%	100%	100%	100%	100.00%	100.00%	100.00%	100.00%
State Child	99.0%	98.7%	99.0%	99%	98.91%	98.77%	99%	99.16%	98.53%	98.87%	99.15%	99.35%	99.26%	99.38%	98.19%	98.63%
NC Adults	100.0%	99.6%	99.12%	100%	99%	100.00%	100%	100%	100%	100%	99.63%	100%	99.20%	99.22%	99.60%	100.00%
State Adult	98.3%	98.1%	97.67%	98%	98.41%	98.59%	98%	98.49%	98.24%	98.95%	98.79%	98.84%	98.78%	98.96%	98.89%	98.74%

MDHHS further supported this ongoing performance by comparing Q1 data across 3 years for all PIHPs.





PI2a monitors the percentage of new persons during the quarter receiving a completed biopsychosocial (BPS) assessment within 14 calendar days of non-emergency requests for service by four subpopulations: Mentally ill adults, Mentally ill children, Intellectually/Developmentally disabled adults, Intellectually/Developmentally disabled children.

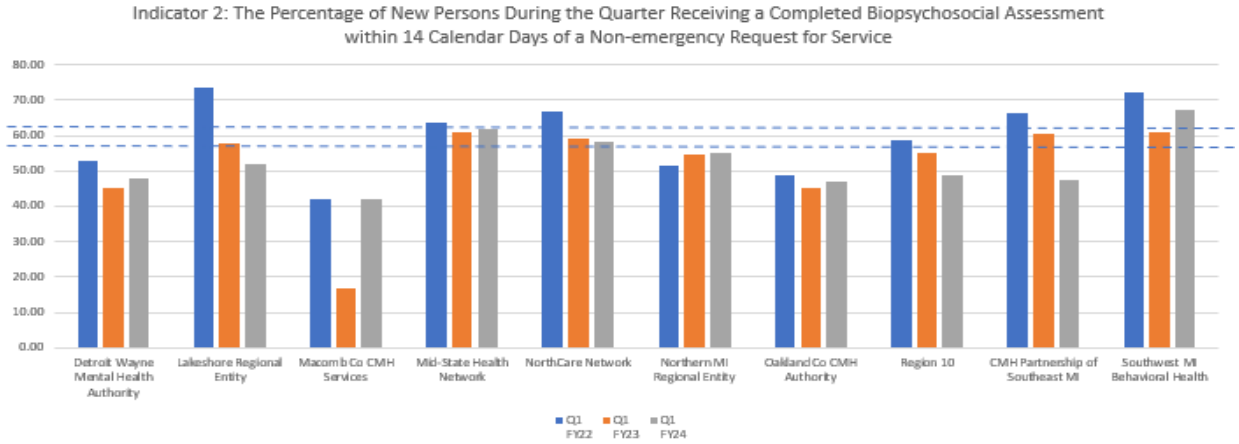
NorthCare quarterly percents, by population show a struggle with indicator 2a. This is partially due to the lack of exceptions; therefore no-shows, cancellations, and reschedules outside of 14 days reflect against the percentages. Percents in red in the table below reflect populations below the benchmark. NorthCare total met the 62.0% benchmark in quarter 4. The number of new requests each quarter were consistent.

MI - Children	FY24Q1	FY24Q2	FY24Q3	FY24Q4
# New Req FTF Asmt	166	254	172	177
# Complete BPS	103	141	100	117
% Req and Complete BPS	62.05%	55.51%	58.14%	66.10%
MI - Adult				
# New Req FTF Asmt	367	251	269	292
# Complete BPS	208	134	153	178
% Req and Complete BPS	56.68%	53.39%	56.88%	60.96%
DD - Children				
# New Req FTF Asmt	25	28	41	19
# Complete BPS	12	15	20	12
% Req and Complete BPS	48.00%	53.57%	48.78%	63.16%
DD - Adult				
# New Req FTF Asmt	21	20	17	19
# Complete BPS	14	10	15	12
% Req and Complete BPS	66.67%	50.00%	88.24%	63.16%
Totals				
# New Req FTF Asmt	579	553	499	507
# Complete BPS	337	300	288	319
% Req and Complete BPS	58.20%	54.25%	57.72%	62.92%

Reviewing PI2a to the state average, NorthCare was below the total average for the state two quarters in FY24. Data reflected in red below indicate quarters and populations where NorthCare was below the state average but does not reflect if the benchmark was met. Quarter 4 for FY24 data for the state is draft data. In FY24 the benchmark was set at 62.0% for NorthCare based on baseline data from FY22. There was no state benchmark in FY23. The graph below the table reflects the PIHP data across the state, for Q1 for three consecutive years, provided by MDHHS.

PI #2a - Percent of completed BPS w/in 14 calendar days of non-emergent request for service.																
	Q1FY21	**Q2FY21**	**Q3FY21**	**Q4FY21**	**Q1FY22**	**Q2FY22**	**Q3FY22**	**Q4FY22**	**Q1FY23**	**Q2FY23**	**Q3FY23**	**Q4FY23**	**Q1FY24**	**Q2FY24**	**Q3FY24**	**Q4FY24**
MIC	70.70%	70.72%	71.43%	67.40%	71.90%	58.57%	61.71%	64.15%	65.33%	57.36%	65.95%	73.45%	62.10%	55.51%	58.14%	66.10%
State	68.16%	65.40%	64.43%	62.89%	59.21%	54.88%	50.52%	52.72%	48.83%	47.84%	46.20%	52.12%	50.22%	55.38%	60.15%	54.96%

MIA	65.60%	60.06%	60.42%	56.50%	64.60%	56.75%	56.30%	54.89%	55.94%	57.95%	61.89%	66.13%	56.70%	53.39%	56.88%	60.96%
State	66.35%	65.47%	64.55%	59.91%	59.60%	52.17%	50.84%	53.35%	53.02%	52.74%	52.96%	55.07%	54.44%	56.23%	61.51%	60.64%
DDC	75.00%	75.86%	72.73%	67.40%	55.60%	66.67%	36.84%	64.00%	51.85%	63.89%	64.00%	84.21%	48.00%	53.57%	48.78%	63.16%
State	74.29%	68.00%	66.61%	61.89%	62.91%	62.40%	52.39%	53.04%	46.58%	46.67%	46.68%	50.39%	43.37%	44.73%	47.72%	58.74%
DDA	66.70%	53.33%	83.33%	80.00%	63.60%	58.33%	60.00%	52.00%	53.33%	73.68%	63.64%	66.67%	66.70%	50.00%	88.24%	63.16%
State	75.13%	67.24%	67.30%	63.32%	56.29%	55.79%	52.67%	52.71%	50.88%	49.57%	52.83%	54.00%	53.82%	42.49%	55.86%	57.82%
TOTAL	67.60%	64.81%	65.90%	61.80%	66.80%	57.90%	57.75%	57.81%	59.20%	58.48%	63.34%	69.27%	58.20%	54.25%	57.72%	62.92%
State	67.98%	65.98%	64.51%	60.81%	59.61%	54.10%	51.03%	53.34%	51.57%	51.03%	50.92%	54.42%	52.71%	55.00%	59.64%	60.80%



50th Percentile = 57.0%
75th Percentile = 62.0%

PI2e measures the number of new persons during the quarter receiving face to face service for treatment or supports within 14 calendar days of a non-emergency request for services for persons with substance use disorders. The benchmark was set at 75.3% for FY24. The state average is below the benchmark and NorthCare has been below the state average. This indicator is calculated based on BH-Teds data reported by the PIHP in combination with the expired request data reported quarterly. FY24Q4 data is draft data.

There was a meeting of SUD Coordinators across the state 6.14.24. One of the items discussed was PI measurement and the vast difference in scores between the PIHPs. It was determined that PI was measured differently based on the PIHP. The "date of request" at some PIHPs was considered the date of request to attend Provider A. Other PIHP's considered date of request to be the first date any provider was requested, regardless if the provider changed. In the first method of calculation, there could be multiple request dates; one for each provider. The second method of calculation allows for only the 1 request date within that episode of care. Once beyond 60 days, a new request date would be calculated. This variation in reporting accounts for the variation in results across PIHPs.

PI #2b/e - Percent of SUD admissions within 14 calendar days of non-emergent request for service.																
	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22	Q1FY23	Q2FY23	Q3FY23	Q4FY23	Q1FY24	Q2FY24	Q3FY24	Q4FY24
SUD 2b	62.34%	70.99%	74.42%	72.77%	74.56%	86.62%	74.05%	75.97%	64.61%	65.90%	56.89%	46.04%	54.41%	63.31%	64.84%	74.19%
State 2b	74.56%	76.12%	74.56%	75.15%	71.79%	70.85%	70.40%	70.70%	69.99%	69.55%	70.16%	69.04%	66.75%	68.04%	69.50%	69.64%
NOTE: Both SUD totals taken from MDHHS Consultation Draft or Final Report as this measure is calculated by MDHHS.																

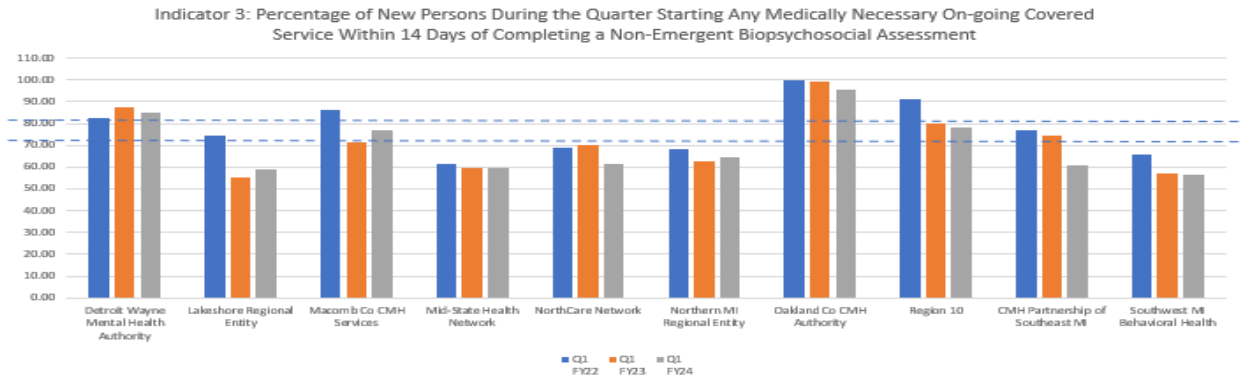
PI3 measures the percentage of new persons starting on-going services within 14 days of completing a BPS broken by the four sub-populations. NorthCare quarterly percents, by population show a struggle with indicator 3. This is partially due to the lack of exceptions; therefore no-shows,

cancellations, and reschedules outside of 14 days reflect against the percentages. Percents in red below reflect populations below the benchmark. NorthCare total met the 72.9% benchmark in quarter 4. The number of new requests each quarter were fairly consistent each quarter.

MI - Children	FY24Q1	FY24Q2	FY24Q3	FY24Q4
# New Completed BPS	145	180	139	143
# Started Srv w/14	94	122	90	101
% Started Srv	64.83%	67.78%	64.75%	70.63%
MI - Adult				
# New Completed BPS	268	189	208	210
# Started Srv w/14	160	129	145	157
% Started Srv	59.7%	68.25%	69.71%	74.76%
DD - Children				
# New Completed BPS	23	28	32	18
# Started Srv w/14	12	18	18	17
% Started Srv	52.17%	64.29%	56.25%	94.44%
DD - Adult				
# New Completed BPS	21	14	19	16
# Started Srv w/14	15	8	17	12
% Started Srv	71.43%	57.14%	89.47%	75.00%
Totals				
# New Completed BPS	457	411	398	387
# Started Srv w/14	281	277	270	287
% Started Srv	61.49%	67.40%	67.84%	74.16%

Reviewing PI3 to the state average, NorthCare was below the total average for the state three quarters in FY24. Data reflected in red in the table below indicates quarters and populations where NorthCare was below the state average but does not reflect if the benchmark was met. Quarter 4 for FY24 data for the state is still in draft. In FY24 the benchmark was set at 72.9% for NorthCare based on baseline data from FY22. NorthCare improved in quarter 4, reaching the benchmark for all populations except mentally ill children. The graph below the table reflects the PIHP data across the state, based on quarter 1 data across 3 years, provided by MDHHS.

PI #3 - Percent starting ongoing service w/in 14 days of FTF assessment.																	
	Q1FY21	**Q2FY21**	**Q3FY21**	**Q4FY21**	**Q1FY22**	**Q2FY22**	**Q3FY22**	**Q4FY22**	**Q1FY23**	**Q2FY23**	**Q3FY23**	**Q4FY23**	**Q1FY24**	**Q2FY24**	**Q3FY24**	**Q4FY24**
MIC	76.90%	82.90%	77.98%	70.63%	72.70%	81.03%	69.10%	74.81%	70.73%	77.17%	71.43%	70.87%	64.80%	67.78%	64.75%	70.63%
State	76.58%	79.95%	76.32%	74.99%	77.47%	72.62%	72.94%	75.29%	70.11%	70.63%	69.31%	70.11%	67.55%	71.97%	71.19%	72.58%
MIA	76.40%	73.63%	76.85%	70.95%	67.40%	73.33%	67.29%	68.31%	69.09%	60.94%	64.84%	68.53%	59.70%	68.25%	69.71%	74.76%
State	79.02%	80.50%	79.78%	76.18%	76.90%	74.76%	73.93%	74.81%	71.70%	72.31%	72.78%	72.51%	70.36%	74.24%	74.53%	74.57%
DDC	69.20%	78.26%	81.25%	71.43%	78.60%	69.57%	84.21%	73.68%	65.22%	60.61%	52.38%	58.82%	52.20%	64.29%	56.25%	94.44%
State	80.99%	84.17%	83.83%	83.88%	83.17%	81.95%	81.51%	80.78%	77.21%	75.99%	73.63%	75.23%	68.54%	73.40%	79.97%	83.54%
DDA	86.40%	90.91%	100.00%	90.90%	55.00%	76.68%	71.43%	70.59%	88.24%	69.23%	58.82%	76.92%	71.40%	57.14%	89.47%	75.00%
State	84.33%	82.79%	84.20%	81.39%	77.43%	75.74%	76.35%	80.34%	74.07%	75.73%	73.61%	77.13%	78.02%	71.27%	80.74%	76.95%
TOTAL	76.90%	78.24%	78.26%	71.40%	69.20%	76.31%	68.79%	70.73%	70.28%	67.28%	66.37%	69.15%	61.50%	67.40%	67.84%	74.16%
State	72.23%	80.94%	79.41%	77.53%	77.53%	74.99%	74.26%	75.72%	71.78%	72.31%	72.23%	72.52%	69.72%	73.55%	74.34%	75.06%



50th Percentile = 72.9%
75th Percentile = 83.8%

PI4a measures the percent of discharges from inpatient psychiatric hospitalization who were seen for follow-up care within 7 days. NorthCare met this at 100% for 3 of 4 quarters for children. All quarters were above the standard of 95%. PI4b measures the percent of discharges from substance abuse detox seen for follow-up within 7 days. Quarters highlighted in the table in red did not meet the 95% standard. In the review of NorthCare data across the years compared to the state average, numbers in red reflect areas that NorthCare scored below the state average. It does not reflect compliance with the standard.

Children - MH/DD	Qtr 1	Qtr 2	Qtr 3	Qtr 4
# Discharges	32	27	36	30
# D/C Exceptions	7	3	9	5
# D/C F/U wi/in 7 days	25	24	26	25
% seen w/in 7 days	100.00%	100.00%	96.30%	100.00%
Adults - MH/DD				
# Discharges	110	85	94	107
# D/C Exceptions	29	11	10	13
# D/C F/U wi/in 7 days	81	71	82	92
% Seen w/in 7days	100.00%	95.95%	97.62%	97.87%

PI4b	Qtr 1	Qtr 2	Qtr 3	Qtr 4
# Discharges	38	31	51	39
# D/C Exceptions	4	2	7	6
# D/C F/U wi/in 7 days	32	28	42	31
% Seen w/in 7days	94.1%	96.6%	95.5%	93.9%

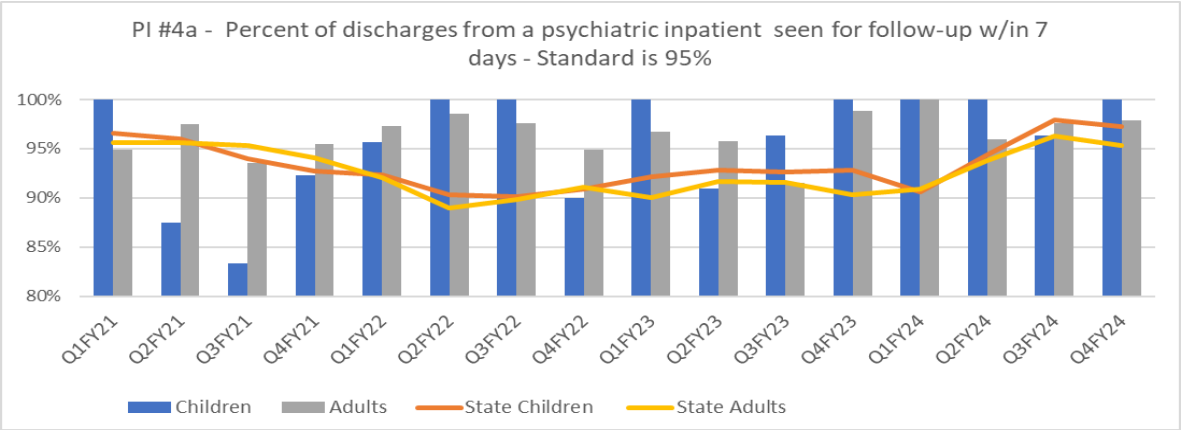
PI #4a - Percent of discharges from a psychiatric inpatient seen for follow-up w/in 7 days. Standard is 95%

	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22	Q1FY23	Q2FY23	Q3FY23	Q4FY23	Q1FY24	Q2FY24	Q3FY24	Q4FY24
Children	100.00%	87.50%	83.33%	92.31%	95.70%	100.00%	100.00%	90.00%	100.00%	90.91%	96.30%	100.00%	100.00%	100.00%	96.30%	100.00%
State	96.56%	96.02%	93.99%	92.69%	92.34%	90.31%	90.11%	90.89%	92.18%	92.84%	92.60%	92.87%	90.64%	94.35%	97.91%	97.25%
Adults	94.87%	97.47%	93.59%	95.45%	97.30%	98.53%	97.59%	94.94%	96.74%	95.79%	91.57%	98.81%	100.00%	95.95%	97.62%	97.87%
State	95.59%	95.61%	95.37%	94.07%	92.01%	88.93%	89.86%	91.10%	90.05%	91.70%	91.58%	90.34%	90.94%	93.76%	96.26%	95.30%

PI #4b - Percent of discharges from a substance abuse detox seen for follow-up care w/in 7 days. Standard is 95%

	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22	Q1FY23	Q2FY23	Q3FY23	Q4FY23	Q1FY24	Q2FY24	Q3FY24	Q4FY24
SUD	66.67%	100.00%	88.89%	0.00%	100.00%		100.00%		97.06%	93.33%	93.75%	94.12%	94.10%	96.55%	95.45%	93.94%
State	94.08%	96.64%	94.05%	86.10%	97.70%	96.29%	97.86%	96.36%	96.55%	96.66%	97.67%	97.44%	97.45%	96.78%	96.62%	96.73%

NOTE: None reported for Q2 and Q4 FY22

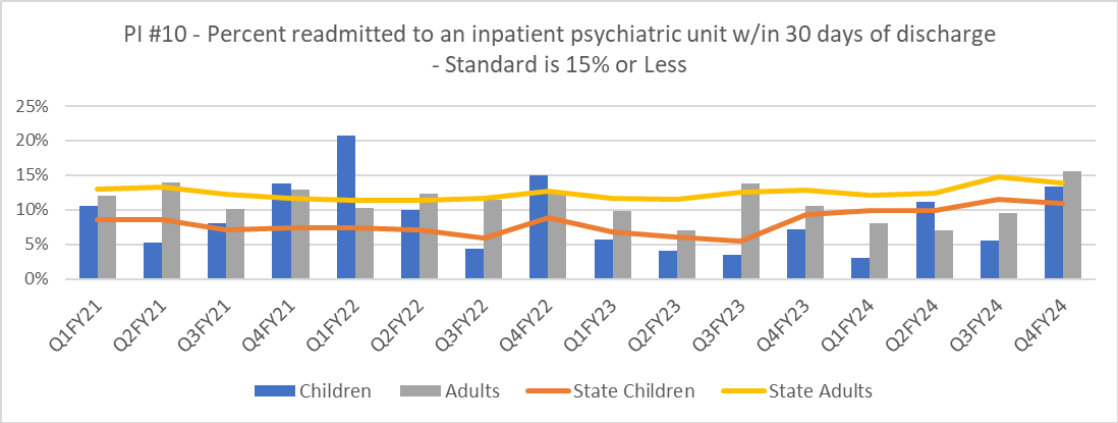


PI10 measures recidivism within 30-days of discharge from inpatient psychiatric hospitalization. The standard is to be below 15%. The region was compliant with recidivism in all quarters except FY24Q4 for adults in which we just missed the standard at 15.6%. The comparison of NorthCare to the state average below the table reflects NorthCare average compared to the state average. Quarters reflected in red indicate that NorthCare average was below the state average for that quarter but does not reflect incompliance with the standard. FY24Q4 recidivism spiked but it is the first time adults have been over the standard in all the quarters reflected.

Children Recidivism	Q1	Q2	Q3	Q4
# of Discharges	32	27	36	30
# of D/C Exceptions	0	0	0	0

# readmitted w/in 30days	1	3	2	4
% readmitted w/in 30days	3.13%	11.11%	5.56%	13.33%
Adult Recidivism				
# of Discharges	111	85	94	109
# of D/C Exceptions	0	0	0	0
# readmitted w/in 30days	9	6	9	17
% readmitted w/in 30days	8.11%	7.06%	9.57%	15.60%

PI #10 - Percent readmitted to an inpatient psychiatric unit w/in 30 days of discharge. Standard is 15% or less.																
	Q1FY21	Q2FY21	Q3FY21	Q4FY21	Q1FY22	Q2FY22	Q3FY22	Q4FY22	Q1FY23	Q2FY23	Q3FY23	Q4FY23	Q1FY24	Q2FY24	Q3FY24	Q4FY24
Children	10.50%	5.26%	8.11%	13.79%	20.80%	10.00%	4.35%	15.00%	5.71%	4%	3.45%	7.14%	3.10%	11.11%	5.56%	13.33%
State	8.57%	8.55%	7.10%	7.37%	7.41%	7.06%	5.88%	8.93%	6.86%	6.11%	5.53%	9.26%	9.83%	9.87%	11.45%	10.91%
Adults	12.05%	14.00%	10.10%	12.94%	10.20%	12.36%	11.38%	12.50%	9.82%	7.08%	13.73%	10.58%	8.10%	7.06%	9.57%	15.60%
State	12.97%	13.30%	12.30%	11.66%	11.37%	11.35%	11.67%	12.73%	11.63%	11.54%	12.47%	12.83%	12.06%	12.38%	14.70%	13.88%



SUD PI measure 2b/e excludes priority population individuals. In FY24, the Priority Population Case Manager provided care coordination to individuals meeting priority population criteria (pregnant, had IV drug use, had children in jeopardized custody, and/or had MDOC involvement). Care coordination occurs after screening to assist individuals with admitting into treatment services and approximately two weeks after residential admission to support transitional care. One of the major challenges with providing these services is the ability to contact individuals. In FY24, out of 608 screenings for individuals who were either pregnant, had IV drug use, had children in jeopardized custody, or had MDOC involvement across 439 unique individuals, 1330 attempts were made to contact individuals for care coordination. Only 385 of those contact attempts were successful. As FY24 was the first full year this was completed, that is 385 attempts that had not previously been made.

In the summer of 2023, it was determined that the Electronic Medical Record (EMR) SUD Priority Population Timeliness Detail report was not providing accurate information. A spreadsheet was developed to monitor timeliness of admission, after-care, and to track priority population clients. Care coordination was also documented on this spreadsheet, while awaiting a call log feature in the EMR. To address questions regarding priority populations and receive feedback from state-wide Priority Population Coordinators, NorthCare facilitated a Priority Population Coordinator group. This facilitation has recently been transferred to several SUD Directors.

In an effort to improve timeliness of admission, and to provide outreach to pregnant and/or Intravenous Drug Use (IDU) populations, NorthCare attends Region 1 Perinatal Quality and

Perinatal SUD Workgroup meetings. The Priority Population Specialist also attempts to contact Priority Population clients within days of screening, to improve timeliness and provide coordination of care.

A request was made to create a report for Pre-Screens and Brief Screens in the EMR, to more accurately identify priority populations and timeliness of admission. For clients who are not screened through NorthCare, it was also determined that NorthCare was not being informed of Priority Population non-admissions, due to lack of consent and 42CFR2. A form was developed and is now submitted monthly to NorthCare Priority Population Specialist, to identify pregnant and/or IDU clients who are not admitted.

Attempts were made to contact Child Protective Services staff and develop a process to improve the timeliness of admission. This issue was brought to the statewide Priority Population Coordinator's meeting, and a process is pending through MDHHS.

A "MDOC Screening Outcome Letter" was developed to notify Michigan Department of Corrections (MDOC) Agents of level of care recommendations and referral information. It is now sent via fax to MDOC Agents through the electronic medical record and assists with timeliness of admission and coordination of care. Also, for those MDOC clients not screened by NorthCare, providers were requested to send NorthCare the CFJ-306 form with the MDHHS 5515, to accurately monitor timeliness of admission. NorthCare provided training to MDOC Agents across the region regarding Accessing SUD services.

A barrier was identified with NorthCare's largest provider. Referrals are mostly taken via voicemail, which affects timeliness of admission. Priority Population contacts at each provider were identified, in an attempt to provide a seamless referral and improve timeliness. Three-way referral calls were reinforced for all outpatient and residential services.

It was determined that interim services were not being provided to Priority Population clients. A process is in development, which includes a three-way referral call to prenatal care and provision of counseling and education. OB/GYN provider listings were sent to Access staff for all UP counties, to facilitate the referral call. Educational resources were obtained, a letter to clients is in draft form, and a process to send interim service information via text message is in development. A suggestion was made to utilize Women's Specialty Services or recovery coach services, to provide interim services and improve timeliness of admission.

Additional discoveries determined that pregnant clients are not tracked in the electronic medical record regarding timeliness of admission. A request was made to improve data collection within the admission. Additionally, it was found that the providers were not reporting timeliness of admission deficiencies to NorthCare. This is now monitored via spreadsheet. A list of out-of-compliance priority population admissions was sent to our largest provider, with a request to identify solutions for timely admission.

Lack of MDHHS 5515 on file with NorthCare prevented follow-up with the provider regarding admission. The question was brought to MDHHS regarding the necessity of MDHHS 5515 to inquire on Priority Population admission, if NorthCare is the payor. This is pending MDHHS legal review.

Objective/Activities	Lead	Previous Measure FY23	Goal Measure FY24 / ACTUAL ACHIEVEMENT	Start/ Frequency/ Due Dates	Status / Recommendation	Guiding Criteria (CFR, contract, HSAG, C-waiver)
Performance Indicators and Measures						
PI1: PAS within 3 hours. NorthCare will continue to exceed the 95% expectation for this measurement and will continue to measure and report PI timely.	QI	95%	100% / 100% - Met	FY23 (mid) Quarterly Ongoing	Continue / bring to CPQI, QM, and PMC. MMBPIS is converting to HEDIS in FY26. Both HEDIS and MMBPIS will be calculated in FY25.	Contract MMBPIS Standards
PI2a: BPS within 14 days: Given FY24 new measurement goals, NorthCare will seek to improve this measure beyond the 75th percentile of 62%. PI will be reviewed with each CMH and data presented to appropriate regional meetings.	QI	57%	62% / 58.3% - Not Met	FY23 (mid) Quarterly FY24Q2 and Ongoing	Continue / bring to CPQI, QM, and PMC	Contract MMBPIS Standards
PI2b/e: SUD admissions in 14 days: NorthCare will identify providers by way of PI2b monitoring report that fall below the goal and work with them to address barriers.	QI / SUD	80%	75.3% / 60.85% - Not Met	FY23 (mid) Quarterly Ongoing	Continue / bring to SUD regional meeting, QM, and PMC	Contract MMBPIS Standards
PI3: Ongoing service within 14 days: Given FY24 new measurement goals, NorthCare will seek to improve this measure beyond the 50th percentile of 72.9%. PI will be reviewed with each CMH and data presented to appropriate regional meetings.		70%	72.9% / 67.7% - Not Med	FY23 (mid) Quarterly FY24Q2 and Ongoing	Continue / bring to CPQI, QM, and PMC	Contract MMBPIS Standards
PI4a: Follow up to hospitalization within 7 days: NorthCare was within state requirements of 95% ¾ quarters in FY22. NorthCare will achieve 95% compliance every quarter and will require corrective action plan if any CMH is not within 95% 2 or more quarters in a row. Data will be reviewed at appropriate regional meetings.	QI	95%	95% / 97.88% - Met	FY22 Quarterly Ongoing	Continue / bring to CPQI, QM, PMC, and ES meetings. Bring hospital specific information to contracted hospital quality meetings.	Contract MMBPIS Standards
PI10: Recidivism: Achieve under 15% recidivism every quarter. A corrective action plan will be required for any CMH outside 15% for 2+ quarters in a row.	QI	15% or less	<15% / achieved 7 of 8 quarters of information.	FY23 (mid) Quarterly Ongoing	Continue / bring to CPQI, QM, PMC, and ES meetings. Bring hospital specific information to contracted hospital quality meetings.	Contract MMBPIS Standards
Identification of trends for any statistical decline in performance measures. Address trends with appropriate providers.	QI	NA	Performance concerns with PI2 and PI3 were addressed with the CMH's. Each CMH came up with a plan to address the concern.	FY24 Annual Ongoing	Continue	
Identify trends in recidivism and 7-day follow up; their relationship to	QI	NA	Not achieved	FY24 Quarterly		

inpatient ALOS, and correlations between the 3. Address trends with appropriate providers.				Ongoing		
Improve timeliness of priority population admissions for SUD populations by developing a monitoring method and monitoring frequently. Overall decrease in number of out of compliance priority population admissions.	QI / SUD	NA	80% / 45.5% - Not Met	FY24 Quarterly Ongoing	Continue/bring to SUD regional meeting, QM, PMC	CFR 96.131 CFR 96.126
Increase validation checks to ensure appropriate populations are included in PI reporting and update system logic to remove members admitted that are mild/moderate for 2a/b, 4a, and 10.	QI	NA	100% accuracy / completed. NorthCare staff use a checklist when reviewing PI and have begun double checking for data entry errors	FY24 Once 4.1.24	Completed and will continue to monitor to ensure no misreporting	
Review indicator 9 – minimum wage- to determine who is employed but not earning minimum wage and verify data.	QI	NA	Increase from 92% (DDA) and 91.3% (MI and DDA) / inability to complete. This data is old and isn't reported to PIHP. Unable to effectively monitor.	FY24 Quarterly 10.1.24	Discontinue	

Performance Bonus Incentive Program

In FY2024, the Performance Bonus Incentive Program targeted the following for PIHP only measures P.1, P.2, P.3, and P.4:

- P.1.Implement data driven outcomes measurement to address social determinants of health. This was achieved by required monitoring and analysis of BH-TEDS data on housing and employment outcomes. The summary report provided to MDHHS is as follows:

Section 1: Introduction

NorthCare Network's Data Analyst compiled BHTEDS Housing and Employment data in accordance with the MDHHS guidance shared on 3/26/2024. We used the MDHHS excel template and did not deviate from the data field selection and process provided by MDHHS.

Section 2: General Summary of Findings

NorthCare compared rates of housing outcomes for Fiscal Year (FY) 22 and FY23 and analyzed the rates of change for the following demographic categories of the population:

1. Individuals with I/DD Only Designation: small denominator, homelessness decreased from 5 people to 4 in FY22 T1 to T2, decreased year over year to T2 of 2 people. More noticeable increase in placement in provider-owned from independent living with FY22 T1 of 12 people to T2 of 10, and FY23 T1 and T2 were 15 people.

2. Individuals with MI Only Designation: homelessness relatively stable with 1% increase in unhoused from T2 FY22 to T2 FY23. There was a 1.4% year over year decrease in provider-owned living arrangements from FY22 T1 of 114 people to 76 people at T2 FY23.
3. Individuals with I/DD and MI Designation: relatively stable levels of homelessness, increased rate 0.87% year over year at T2. Movement from provider owned to non-provider owned settings decreased by 1.25% year over year at T2.
4. Individuals with Substance Use Disorders: most noticeable improvement of the population categories for movement from homelessness to housed at 3.32%.

Employment data comparisons between FY22 and FY23 for each demographic category below:

1. Individuals with I/DD Only Designation: stable year over year with a rate increase of 0.65% in employment of potentially employable persons. There was an increase of 1 person, for a rate of 1.12% increase in people stating that they could not work due to disability symptoms.
2. Individuals with MI Only Designation: FY22 employment rate was stable from T1 to T2 with a 0.1% decrease in employment rate among potentially employable people who were employed. In FY23, the potentially employable population increased and the rate of persons employed increased 1.23% year over year at T2 between FY22 and FY23. This demographic had a decrease in the rate of people not working due to disability symptoms of 2.88% at T2 year over year.
3. Individuals with I/DD and MI Designation: between FY22 and FY23, there was an increase in the employment rate at T2 of 2.81%, however, during both years, the rate between T1 and T2 decreased. In FY22, there was a decrease of 0.93% of individuals stating that they could not work due to their disability symptoms. This demographic also experienced a stable rate of people employed, potentially employable, and those stating disability symptoms prevented them from working.
4. Individuals with Substance Use Disorders: still stable, but this diagnostic category experienced the highest rate increase in employment at T2 year over year, with employment rate increasing by 4.07%. The percentage of individuals in FY22 and FY23 reporting that their disability symptoms prevented them from working was static with 0.67% less people reporting disability preventing them from working from FY22 to FY23 at T2.

Section 3: Conclusion, Projects Planned as a Result of Findings

Rates of all categories of employment and housing status were relatively stable, with no category experiencing a rate change of more than 5% in any direction. The most movement of any category is for those individuals with SUD only diagnoses receiving services through NorthCare Network. Homelessness decreased in this population by 3.32% and employment increased by 4.07%. NorthCare plans to work with our SUD staff to identify any programming in that service umbrella which may have impacted these outcome improvements. Further analysis of how increased recovery housing/sober living arrangements have impacted homelessness is needed.

An investigation of more detailed data than rates of change in employment and housing is needed to understand factors that have led to people obtaining employment, moving into housing, or moving into independent living arrangements. With the rates being stable, business as usual should create continued gradual movement into these preferred outcomes. Once NorthCare

understands the factors impacting movement or stagnation, we can attempt to implement programming, find training, and focus advocacy efforts to improve outcomes. NorthCare does have a shortage of staff who are trained in Benefit to Work coaching. We anticipate the potential to improve employment outcomes for individuals on SSDI if we increase staff who can help people navigate the nuances of working while receiving benefits.

Regionally, the Upper Peninsula is experiencing a huge housing shortage. The shortage of affordable housing is especially concerning as wait lists for public housing continue to get longer and rent has increased exponentially during the years since the COVID-19 pandemic began. NorthCare will work with local communities and community action agencies to advocate for increased MSHDA funding and housing developments across the region.

- P.2. Adherence to antipsychotic medications for individuals with schizophrenia: Percentage of adults age 18 and older with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.
    - Although this measure is PIHP only, NorthCare and the Medicaid Health Plan, Upper Peninsula Health Plan (UPHP) have addressed this metric in the Data Collaboration workgroup. In FY24, the care gap file has been developed and in FY25 will be refined to allow for streamlined data sharing with only CMHSP prescribers included in the file for CMHSP distribution and follow-up. In FY24, data validation activities were the only assigned task by MDHHS.
    - NorthCare's rate as of the measurement period ending 6/30/2024 is 73.75%, compared to the Michigan Medicaid Total rate of 57.68%.
- P.3. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (AOD) -the percentage of adolescents and adults with a new episode of alcohol or other drug abuse or dependence who received the following:
    - Initiation of AOD treatment: the percentage of beneficiaries who initiate treatment within 14 calendars days of the diagnosis
        - 6/30/2024 Measurement end date performance is 29.83%, compared to the Michigan Medicaid total rate of 37.16%.
    - Engagement of AOD treatment: the percentage of beneficiaries who initiated treatment and who had two or more AOD services or Medication Assisted Treatment (MAT) within 34 calendar days of the initiation visit.
        - 6/30/2024 measurement end date performance for NorthCare is 11.18%, compared to the state Medicaid total of 10.76%
    - The measurement period assessed by MDHHS is CY22 to CY23, stratified by race/ethnicity for reduction in disparities.
- P.4. PA 107 of 2013 Sec. 105d (18): Increased participation in patient-centered medical homes. A narrative report was submitted summarizing activities aimed at increasing regional delivery of patient-centered medical home care. The narrative submitted to MDHHS is as follows:

PHIP Level Interventions and Initiatives

NorthCare Network and Upper Peninsula Health Plan Collaboration:

NorthCare Network (NorthCare) continues efforts initiated in 2014 to provide coordinated comprehensive care to all adults with severe mental illness (SMI), intellectual and developmental disabilities (I/DD) and children shared as enrollees with the Region 1 Medicaid Health Plan (MHP), Upper Peninsula Health Plan (UPHP).

A targeted, grant-supported Integrated Care Project between both payors measures impacts on adults with SMI, in FY2024 8,366 unduplicated adults with SMI were served by these interventions. New metrics targeting children were added in FY24, with 474 unduplicated children and adolescents served.

NorthCare and UPHP meet bi-monthly in a data collaboration workgroup to share population level data. NorthCare and UPHP utilize a shared tableau symmetry dashboard, Care Connect 360, and UPHP's HEDIS Engine files to monitor progress and develop interventions. In FY2024, the following HEDIS/Quality Measures were addressed:

1. Plan All Cause Readmission
2. Follow Up after Hospitalization for Mental Illness
3. Follow-up after Emergency Department visit for Mental Illness
4. Dental Exam in the past 24 months
5. Spirometry Testing for newly diagnosed COPD
6. Diabetes Monitoring for adults with Schizophrenia or Bipolar Disorder
7. Cardiovascular Screening for adults dispensed Antipsychotic Medications
8. Hepatitis C Testing
9. Hepatitis C Treatment
10. Anti-depressant Medication Monitoring
11. Colorectal Cancer Screening
12. Breast Cancer Screening
13. Cholesterol Screening for adults on psychotropic medications
14. Antipsychotic medication adherence
15. New: Follow-up Care for Children Prescribed ADHD Medication
16. New: Metabolic Monitoring for Children and Adolescents on Antipsychotics

*NorthCare has elected to review all children/adolescents prescribed <u>any</u> *psychotropic* medications, which includes anti-depressants, stimulants (for ADHD), and antipsychotics

The data files from UPHP's HEDIS engine are analyzed by NorthCare's Population Health Specialist and Data Analyst and combined with other information from our Electronic Health Record (EHR). Data sets with information from both systems are shared with the nursing staff at each Community Mental Health Service Provider (CMHSP) in NorthCare's network for client level interventions. NorthCare's Data Analyst provides a return file identifying shared members who are not prescribed by the CMHSP. If a psychotropic medication is prescribed by a CMHSP prescriber, that prescriber orders the corresponding lab screening or testing for the individual with the identified need for intervention. FY24 upgrades to NorthCare's data flow with the Upper Peninsula Health Information Exchange (UPHIE) have increased the amount of labs which flow into our EHR. Provided there is an active care relationship between the CMH and the individual Medicaid beneficiary, their lab results, regardless of ordering provider, are directly

transmitted through UPHIE into the client's chart for review by the CMH prescriber. Individuals who are not prescribed by a CMHSP provider receive encouragement from their case manager to complete the screening. In addition to encouragement, the CMHSP case manager or nursing staff coordinate care with the primary care physician or specialist prescribing the medication under Targeted Case Management or other CMHSP services to ensure that the care gap is addressed. Simultaneously, UPHP provides care gap alerts to their providers about the individual's need for the screening.

NorthCare also works with UPHP on two targeted Integrated Care Team (ICT) interventions for adults who have high emergency department utilization or recent/repeat hospitalizations.

- The first is the joint care protocol High Utilizer ICT for adults with SMI who are enrolled in Medicaid or Healthy Michigan Plans with UPHP and receiving services with a CMHSP in Region 1. In FY24, 58 unduplicated individuals were served in this intervention.
- The second ICT is for shared members enrolled in the MI Health Link Program. In FY24, 9 mutually shared individuals were served through this intervention.

Both ICT interventions involve monthly monitoring meetings with both payors. NorthCare monitors care coordination provided by the CMHSP with a UPHP care coordinator to ensure that it occurs and addresses the shared member's needs leading to the increased hospitalization or emergency department utilization. UPHP ensures that individuals have prior authorizations as needed for specialty services to address the underlying condition(s) driving the increased service utilization. When the need is behavioral health related, the CMHSP is responsible for care coordination and increased comprehensive care to address the condition. In most cases, the individual has needs in both payor domains. Each individual receives a person-centered care plan to address the underlying conditions and determine solutions to alleviate the conditions and improve the individual's health and well-being. Children and adolescents were added to the ICT intervention in July, 2024 with a focus on children in foster care, and those with care gaps in their well-child examinations and developmental screenings.

<u>NorthCare Pilot Program to Aid Adults at risk of or experiencing Homelessness:</u>

NorthCare has a pilot program targeting individuals experiencing or at risk of experiencing homelessness in Marquette County with a contractor through the Integrated Health Care grant. It has been the hope that this program would expand to additional counties. Through this intervention, 102 individuals received community health worker (CHW) supports to be linked into a primary care provider, obtain permanent housing, and address social determinant of health needs. All individuals served in this intervention have a mental illness or a co-occurring substance use disorder. They receive comprehensive, patient-centered care plans and the support of an advocate to ensure their health care needs are addressed by medical providers. These individuals are typically difficult to engage in the mental health system due to difficulties in compliance with expectations – having the CHW support has increased attendance and achievement of mental health goals for this population.

<u>NorthCare and CMHSP Regional Health Services Committee:</u>

NorthCare also began a regional Health Services Committee (HSC) with membership from each CMHSP's health services staff and under the direction of NorthCare's Medical director. Data from the NorthCare-UPHP data collaboration workgroup is shared here, in addition to addressing specific CMHSP driven interventions. In FY2024, the HSC continued work in increasing nursing services delivered to beneficiaries through study of the units of service of H0034, T1001, T1002, S9445, and S9446 and identification of areas and clients who could benefit from increased access to health services. The committee worked to add pulse oximetry readings to the EHR in FY24.

Behavioral Health Home Program:

NorthCare's 5 member CMHSP's have continued to increase enrollment in the Behavioral Health Home Program (BHH), a pilot program supported by the Michigan Department of Health and Human Services (MDHHS). NorthCare participates in the program as a lead entity and the 5 CMHSP's and Great Lakes Recovery Centers (added in FY24) are Health Home Partners delivering the BHH services to persons with qualifying mental health conditions and at least one chronic health condition. The BHH is a Patient Centered Medical Home Model recognized by the Center for Medicare and Medicaid Services under Section 2703 of the Patient Protection and Affordable Care Act of 2010 (ACA). It is a health home service model meant to help chronically ill Medicaid and Healthy Michigan Plan beneficiaries manage their conditions through an intensive level of care management and coordination. It is centered on whole-person, team-based care.

BHH core services are:

1. Comprehensive Care Management
2. Care Coordination
3. Health Promotion
4. Comprehensive Transitional Care
5. Individual and Family Support
6. Referral to Community and Social Support Services

In FY2024, NorthCare met all pay for performance quality measures under the BHH model – the performance was measured on FY22 data. Those metrics were: Reduction in Ambulatory Care: Emergency Department (ED) visits (AMB-HH), Increase in Controlling High Blood Pressure (CBP-HH), and Access to Preventative/Ambulatory Health Services (AAP).

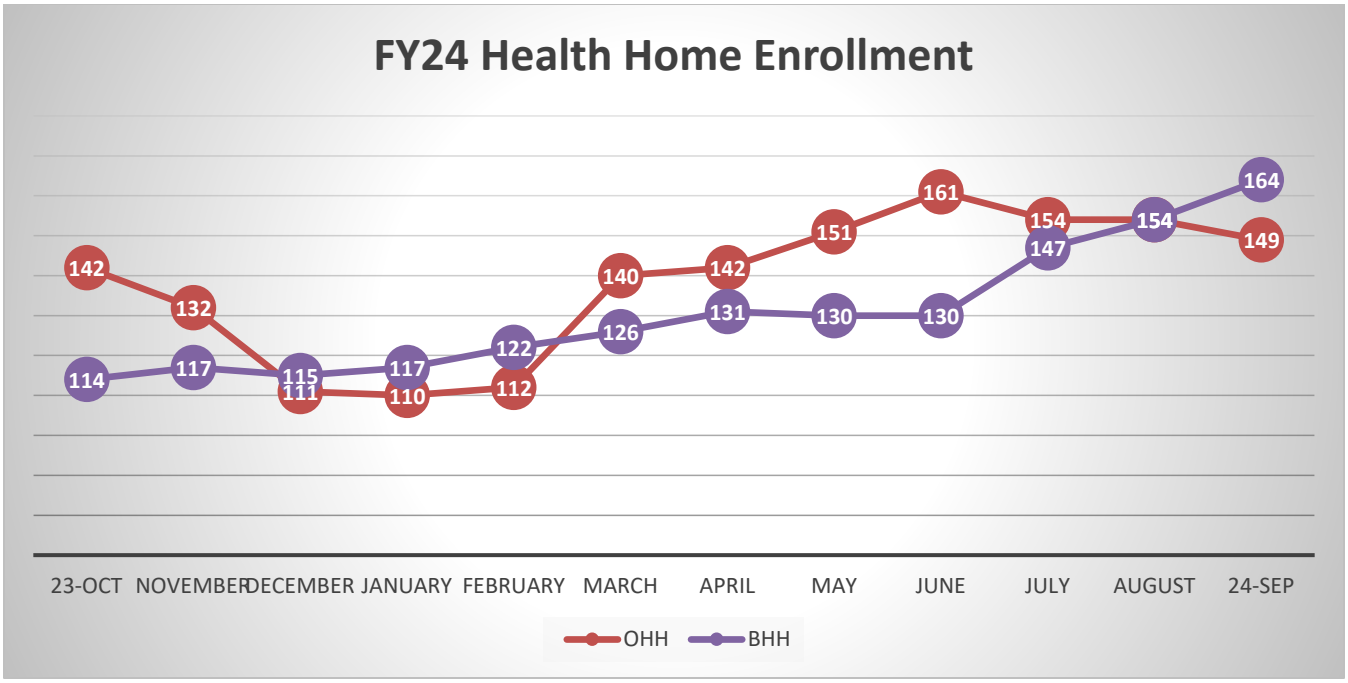
4 of the 5 member CMHSP's, Gogebic, Hiawatha, Northpointe, and Pathways follow a nurse care manager model with the Registered Nurse (RN) as the hub of BHH service delivery. They have chosen to focus on serving adults with multiple complex co-morbidities with their BHH rollout. Across all 5, they have case studies where people with unmanaged diabetes have significantly reduced their A1c levels, including some who have reversed diabetes with dietary and exercise interventions. Pathways has more younger adults enrolled in the program, particularly those diagnosed with PTSD where they take a preventative approach to physical health comorbidities, which helps to connect people to their bodies and lessen the physically debilitating effects of trauma on their physical functioning.

Copper Country CMH has taken a peer driven approach to their BHH program, incorporating their FITtogether program which supports physical exercise, healthy eating, and social connectedness to others in the community experiencing the effects of severe mental illness, obesity, and metabolic syndrome conditions (diabetes, heart disease). Measurable improvements in stamina, reductions in obesity, and improvements to social functioning have been demonstrated through their approach. In FY24, Copper added an RN dedicated to the BHH program, who has been targeting clients with more complex medical conditions that require more physician coordination to manage their physical health conditions.

Hiawatha Behavioral Health's (HBH) program has targeted adults with 5 or more chronic health comorbidities, in a severely medically underserved area for primary care physician access. The RN care manager spends considerable time advocating for enrollees to receive medically necessary care through their primary physicians, frequently attending appointments with them and offering her expertise in disease management. Results from these efforts are significant declines in emergency department (ED) utilization and a shift to care through the BHH program and primary care providers. HBH has an example of a case where a beneficiary frequently visited the ED due to gastrointestinal complaints – constipation. A successful intervention used by HBH to lower these ED visits was daily – sometimes multiple times per day – calls from the nurse to suggest home/over-the-counter remedies to help the patient manage their discomfort. HBH and Pathways have both targeted patients with new cancer diagnoses for enrollment in the BHH program. They help enrollees navigate the medical system with the new condition and prevent the development of PTSD following the diagnosis of cancer.

Opioid Health Home Program

NorthCare is a Lead Entity for the Opioid Health Home Program (OHH). The OHH program mirrors the BHH program except that the eligibility criteria is persons with opioid use disorder. NorthCare's OHH HHP's are the regional Federally Qualified Health Center – Upper Great Lakes Family Health Centers (UGL), Sacred Heart - an Opioid Treatment Provider, Great Lakes Recovery Center (GLRC), and Catholic Social Services (CSS). UGL operates in 5 of the 9 central and western counties of the Upper Peninsula. GLRC operates in population hubs in 10 separate offices across all geographic sublocations of Region 1. Sacred Heart operates in Mackinac County. CSS operates in Marquette and Delta Counties, and serves people from Menominee, Dickinson, Alger, and Schoolcraft counties. Like the BHH, the OHH is approved under the ACA and includes the same 6 core services. Enrollment across both programs in FY2024 is as follows:



The dip in OHH enrollments from December through February was due to an audit and streamlining of process with a staffing change at UGL resulting in disenrollments of inactive enrollees. This occurred at the same time as CSS was increasing enrollments following their joining of the panel in FY24.

CSS's OHH program is driven by their Medical Director, a Board-Certified Psychiatrist and Addiction Medicine Specialist, Dr. Steven Miljour. Dr. Miljour's approach is to treat the OHH program like a prescription, which he recommends to all his OHH eligible Medicaid patients with *any* social determinant of health needs or co-morbid physical health conditions. The CSS approach has resulted in stable enrollment gains and a high-quality, physician driven and monitored process. NorthCare uses the positives of each provider to drive performance and quality improvement with other OHH providers.

GLRC's program is guided by a nurse care manager as the lead referral source, monitoring health needs and heavy involvement of Peer Recovery Coaches and Certified Community Health Workers guiding lifestyle interventions. Their enrollments are stable with steady increases and demonstrate effectiveness in helping clients to maintain recovery and prevent relapse while improving their quality of life.

Further Support of 5 required components:

1. Comprehensive Care: Member CMHSP's and Substance Use Disorder Providers (SUD) offer the full array of Medicaid Behavioral Health Services. These include:
    a. Assessment and linking between the mental health and physical health systems of care.
    b. Services focused on prevention and wellness, acute emergency services.

c. Coordinating with: health care providers, community resources, family members, social supports, social determinant of health supports, education, employment, housing, etc.
d. Provision of peer support, case management, therapy, psychiatric, and social services, support groups, therapy groups, dietary/nutrition counseling, inpatient and residential levels of care.

2. Patient-Centered: NorthCare and all member providers provide patient centered services in accordance with MDHHS's patient-centered practice guidelines. CMHSP's and SUD providers are audited annually and more frequently to ensure compliance with Patient-Centered Care philosophies. All individual plans of service and treatment plans must demonstrate patient-centered development of goals; determined by the patient, not the provider. Services are delivered as determined by the individual's preferences for their needs, culture, values, and level of support they desire.
3. Coordinated Care: All CMHSP's and SUD Providers are required to coordinate care for all persons receiving services. This is audited in the site review protocols and all CMHSP's performed at 85% or higher in all measured aspects of care coordination (sharing of records, documentation of care conferences with other providers, incorporation of health care goals). We utilize the services of our Veteran Navigator to ensure care coordination with the Veteran's Administration and providers engaged in care for people who have served in the armed forces, including linking to specialized veteran service organizations in addition to mental health providers. Care coordination is provided with primary care physicians, community resources and supports (social, food, housing, employment), with individuals and their families, schools, hospitals, home health, and spiritual and recreational providers. All individuals entering the PIHP system of care are asked if they have a primary care physician. If they do, the providers are required to seek a release and coordinate care with that provider. If the individual does not have a primary care physician, the CMH or SUD provider is required to assist the individual with establishing care with a primary care physician. People with UPHP coverage are referred to UPHP for help with primary care physician selection. In FY24, 6680 of NorthCare's 6,896 (96.87%) individuals receiving ongoing services had a primary care physician indicated in their client record, a decrease of less than 1% who indicated having a primary care physician in FY23.

   Any elements not meeting the 85% threshold in the representative sample audit by the CMHSP's required a plan of correction, and technical assistance has been and will continue to be offered to ensure improvements in any deficient areas. The FY24 site review results, performed in July, 2024 are below:

Care Coordination Site Review Elements	Copper	Gogebic	Hiawatha	Northpointe	Pathways
Signed MDHHS 5515 with Primary Care Physician and any applicable specialty providers (e.g., Neurology, Physical therapy, Cardiology, Substance use discorder treatment providers.). Or, documentation of the individual's refusal for care coordination with other providers.	100%	100%	100%	90%	100%
Records from Specialty providers or evidence in progress notes of care coordination addressing specialty health provider	93%	100%	90%	84%	86%
Individuals who have an identified co-morbid physical health condition checked under Demographics/Consumer Information/Health will have a corresponding health goal in their IPOS, or documented refusal to address that condition with the	92%	100%	100%	91%	80%
A copy of an annual physical from a primary provider, performed within 12 months of the IPOS will be included in the health record. The record from the physical health provider will include, at a minimum: medication history, identification of current and past physical health care and referrals for appropriate services.	93%	100%	79%	60%	76%
All people enrolled in Medicaid Health Plan (MHP) will have an MDHHS-5515 that includes their MHP to facilitate care coordination of physical health care between PIHP and MHP systems.	88%	60%	23%	50%	38%
Behavioral health findings which relate to the delivery of physical health care will be shared, as authorized by the person receiving services, with their physical health providers.	100%	100%	85%	89%	72%

4. Accessible services: all services are compliant with expectations of the Americans with Disabilities Act regulations. NorthCare's Customer Services Specialist and Compliance Officer provide regular and ongoing support to all network providers to ensure that the diverse needs of people served by NorthCare's Medicaid Benefit are receiving accessible care. All facilities are free of physical barriers. Individuals are offered services in ways that meet their needs – including telehealth, home-based, community delivered, in office, etc. as determined by the individual receiving the services. Crisis services are offered 24/7, and ACT services are offered 7 days per week between 8am and 10pm as determined by the individual. Interpreter services are available for people who need them. Services are compliant with all Home and Community Based Services Waiver requirements as identified by the Federal Department of Health and Human Services.
5. Quality and Safety: all services provided by the CMHSP and SUD provider networks are evidence-based, including, but not limited to: Assertive Community Treatment, Dialectical Behavioral Therapy, Eye-Movement Desensitization and Reprocessing, Cognitive Behavioral Therapy, Trauma-Informed CBT, Motivational Interviewing, Assessing and Managing Suicide Risk, Seeking Safety, Clubhouse, Family Psycho-Education, Parent Management Training – Oregon Model, Crisis Intervention Training – Memphis Model, Jail Diversion, Supported Employment, Wraparound. CMHSP staff receive annual CPR training through their local health departments. All 5 CMHSP's have received training on Narcan administration and have Narcan available on site and in group homes.

CMHSP Initiatives of Note

1. Copper Country CMH: CCCMH continues to offer the Fit Together Program, and has incorporated these interventions into the BHH enrollee service array. Fit Together is an evidence-based model that connects CMHSP beneficiaries with physical health and fitness interventions. It is run by peers with lived experience and coordinates with local gyms. Dietary and nutrition coaching are included. Enrollment continues to increase in this program.
   CCCMH continues to operate their training institute and offers space for regional trainings, as well as onboarding for all of their providers to ensure they are oriented to evidence-based practices and expectations in the Medicaid Provider Manual.

2. Pathways Community Mental Health: Pathways has operated the INShape program, another Evidence-based model which partners with gyms, nutrition specialists, and is run by a certified personal trainer who is also a nurse employed by the CMH. It incorporates group exercise and has incredible results in reducing weight, hip and waist circumference, blood pressure, cholesterol, blood sugar, all while offering individuals a social activity with peers in the community.

The joint care metrics – which measure performance on metrics for beneficiaries shared by the Medicaid Health Plan (MHP/UPHP) and NorthCare Network. The measures addressed in FY24 were:

- J.1 Implementation of Joint Care Management Process: collaboration between entities for the ongoing coordination and integration of services.
    - Measurement is based on the presence of joint care plans in CC360 – MDHHS's data warehouse and care coordination platform – for individuals who are determined at risk based on the Risk Stratification tool in the CC360 platform. MDHHS is expecting that 25% of individuals who are identified as at risk due to high emergency department (ED) utilization will have a care plan opened within the measurement year of the risk triggering ED visits. NorthCare's rate has been at least 50% and we worked with UPHP to further address all individuals who have identified high ED utilization.
    - A narrative report was submitted to MDHHS in August, 2024, and is as follows:

1. NorthCare Network uses qualitative factors in risk stratification for shared enrollees under 18 years of age for joint care management referrals. Barriers to joint care management processes for beneficiaries under 18 were related to the length of time the Joint Care Protocol Workgroup took taking to decide what criteria to use for determining high-risk children/adolescents. Despite that, NorthCare has identified internal processes and risk stratification criteria and has had multiple discussions with our regional Medicaid Health Plan (MHP) partner, Upper Peninsula Health Plan (UPHP) about what subpopulations to target. In June, there were three children under 18 with joint care plans open from the FUH report – two with genetic disorders and one with obesity and sleep apnea. Two additional cases, both children who were adopted from foster care, are planned for review in July. For shared enrollees under 18, we have agreed to target the following criteria/conditions:
    - Children in out-of-home placement which includes those in foster care
        - Out of home placement also includes:
            - Children in juvenile detention who retain Medicaid

        - Children who are wards of the state of Michigan: those pending adoption, in permanent foster care
        - Children in guardianships
        - Children in therapeutic foster care settings
    - Children administered psychotropic medications including stimulants, antipsychotics, mood stabilizers, antidepressants, and anxiolytics.
    - Children with obesity, asthma, allergies, or other physical health conditions exacerbating mental health or requiring coordination with physical health providers
    - Children with recent inpatient psychiatric hospitalizations
    - Children with any of the above risk factors who have not had their annual well-child exam and/or recommended developmental screenings.

1.a. Shared enrollees are identified based on the Medicaid eligibility file. Medicaid eligibility/enrollment is readily accessible in NorthCare's Electronic Health Record (EHR) via individual's chart and in SQL reporting services built into the platform.

1.b. No specific quantitative risk levels have been established for selecting members at the time of this report. However, meetings with NorthCare and UPHP data analysts to develop a dashboard with the conditions listed under 1 began on 7/15/2024. NorthCare and UPHP share encounter and claims information via an MOU and data use agreement which have been in place since 2014. Outputs of the data exchange are housed in UPHP's tableau server and through their HEDIS engine, with specific targeted groups/conditions/interventions addressed in our bi-monthly Data Collaboration Workgroup. NorthCare and UPHP review the HEDIS report for Metabolic Monitoring for Children and Adolescents on antipsychotic medications – prescribers from both networks are notified of children who need metabolic screenings ordered/completed for this measure. In addition to the factors listed under 1, NorthCare also factors claims/encounters/service utilization across both payer systems into risk level selection for interventions.

1.c. Individuals who are identified via risk stratification are generally referred to targeted interventions within NorthCare and the member CMHSP service array to address their specific needs.

- Persons with obesity, asthma, hypertension, diabetes, high cholesterol, and other comorbidities are referred to health and wellness programs at the CMHSPs like INShape and Fit Together – evidence-based interventions which include a health coach and fitness programming. The CMHSPs who do not have these specific programs partner with their local YMCAs to link persons served to fitness programs.
- All members identified in risk stratification are reviewed for eligibility in the Behavioral Health Home program at the CMHSP, and/or the Joint Care Management Integrated Care Team intervention with UPHP. If eligible for either, they are referred to those programs for intervention.
- Those who do not receive targeted interventions still receive care coordination through their primary case holder at the CMHSP.

2. Care coordination is required for all people served by the CMSHP regardless of age or health condition. Children in foster care receive enhanced care coordination with their foster care case manager in accordance with MDHHS foster care team meeting

requirements. The CMHSP is an active participant in care with the child, their biological parents, school, foster parents, and health providers for those children who meet criteria for CMHSP services. CMHSPs are reviewed annually in the CMH Site Review Care Coordination Protocol for compliance.

2.a. Please see 2 and 2.b. for overall approach. Challenges with care coordination for people under 18 include a need for additional training of CMHSP staff about how the MHP can help with meeting the child's health care needs. CMHSP staff do not regularly seek releases of information with the MHP included – there are in-services planned for the MHP and CMHSPs to provide education on MHP services available for shared enrollees in Summer-Fall of FY24. Other challenges are securing releases from parents/persons with authority to sign for minors for coordination with other providers. Based on the site review protocols reviewed below – corrective action plans with the CMHSPs will include training on care coordination and the regulations requiring it.

2.b. The care coordination protocols address 2.b. Compliance of 85% or better of the sample reviewed by NorthCare Network is required, or the CMHSP receives a corrective action plan. Results for each CMSHP for FY24 for the following reviewed criteria:

Clients receiving services from the CMHSP will receive care coordinated with providers across all health domains. Charts will have the following elements:	Copper Country CMH	Gogebic County CMH	Hiawatha Behavioral Health	Northpointe Behavioral Health Services	Pathways CMH
Signed MDHHS 5515 with Primary Care Physician and any applicable specialty providers (e.g., Neurology, Physical therapy, Cardiology, Substance use discorder treatment providers.). Or, documentation of the individual's refusal for care coordination with other providers.	100%	100%	100%	90%	100%
Records from Specialty providers or evidence in progress notes of care coordination addressing specialty health provider recommendations.	93%	100%	90%	84%	86%
Individuals who have an identified co-morbid physical health condition checked under Demographics/Consumer Information/Health will have a corresponding health goal in their IPOS, or documented refusal to address that condition with the behavioral health provider.	92%	100%	100%	91%	80%
A copy of an annual physical from a primary provider, performed within 12 months of the IPOS will be included in the health record. The record from the physical health provider will include, at a minimum: medication history, identification of current and past physical health care and referrals for appropriate services.	93%	100%	79%	60%	76%
All people enrolled in Medicaid Health Plan (MHP) will have an MDHHS-5515 that includes their MHP to facilitate care coordination of physical health care between PIHP ande MHP systems.	88%	60%	23%	50%	38%
Behavioral health findings which relate to the delivery of physical health care will be shared, as authorized by the person receiving services, with their physical health providers.	100%	100%	85%	89%	72%

3. CC360 is not used for the identification of children under 18 at this time as the capabilities have not been added to the system as of the date of this report. CC360's Integrated Care Plan widget is used for children identified via avenues described above between NorthCare and UPHP to record monthly documentation of care coordination interventions across both payer systems.

- J.3. Follow-up After ED visit for Alcohol or Other Drug Dependence: beneficiaries 13 years and older with a ED visit for AOD that had a follow-up visit within 30 days.
    - This measure also seeks to reduce racial/ethnic disparities. However, NorthCare and UPHP's region does not have enough shared members in the denominator of this metric to be measured by specific ethnicities. Therefore, MDHHS will likely calculate with all non-white populations combine – provided there are at least 30 instances to include in the denominator. For the 6/30/2024 measurement period, there were only 27 shared members between NorthCare and UPHP who were non-white in the denominator.
    - NorthCare-UPHP performance as of 6/30/2024 in this metric is:
    - White: 52.16%NorthCare's total population (all Medicaid types) performance for the period ending 6/30/2024 is 48.8%

Practice Guidelines

Northcare discussed the clinical practice guidelines in regional quarterly meetings and identified resources the region desired. The committee also provides input as to which practice guidelines to adopt. One specific resource requested was eating disorder treatment guidelines. These selected guidelines will be added to the website as a resource in FY25. In FY25 the Clinical Practice Guidelines (CPGs) are being revamped and a workplan is in place to review current guidelines for quality, accuracy, and relevancy and streamline the format as the new website is developed. Once the new website and updated format is active, staff will attest to having access to the CPGs. A print version of the CPG's is available within 5 business days, free of charge, upon request.

NorthCare started a complete overhaul of the Substance Use Disorder Services Provider Operations Manual in FY24. It is set to be completed in FY25. In addition, at least two SUD specific practice guidelines will be completed and implemented. These will include SUD recovery housing, SUD recovery coaching, and SUD case management as these are services not specifically defined in the Medicaid Manual or MDHHS / Substance Use, Gambling, and Epidemiology (SUGE) Treatment Policies.

Per the MDHHS trauma policy/guideline, NorthCare completed a trauma informed self-assessment using the Trauma Informed Oregon standards of practice, starting in December 2021 and ending in July 2022. Ideas and suggestions for improvement continued into 2023 and in December 2023 most suggestions from the group had been implemented. Recommendations from the trauma self-assessment that have been implemented at NorthCare included: updating job descriptions and interview questions to assess knowledge of trauma informed agency, adding a staff suggestion box, reinstatement of staff meetings for transparency, seating someone at the front desk to make the office more welcoming, and creation of a trauma training for non-clinical staff. In January 2025 the group will begin meeting again for the next agency self-assessment, which is due every 3 years.

MDHHS practice guidelines are required, and therefore there is no control group to compare against to truly show effectiveness of the guidelines. Staff should implement evidence-based practices (EBP) whenever possible when the practice is applicable and staff are adequately trained in the EBP.

Objective/Activities	Lead	Previous Measure FY23	Goal Measure FY24 / ACTUAL ACHIEVEMENT	Start/ Frequency/ Due Dates	Status / Recommendation	Guiding Criteria (CFR, contract, HSAG, C-waiver)
Practice Guidelines – Ensure development of requested CPGs, adoption of updated MDHHS CPGs, and dissemination of all CPGs to regional providers.						
Ensure review and updates to CPG's annually. Providers to acknowledge updates.	CP	Annual	New staff at CMH's attested to the CPGs.	FY23 Annually 1.25.24	Continue / make part of annual training requirements—this is achieved by site reviews requesting documentation of staff completed an EBP training.	QAPIP
Create/find and implement CPG related to eating disorders as requested in the Clinical Practices / Quality Improvement committee meeting.	CP	One time	Adoption of guideline/ A guideline for eating disorders was agreed upon, but not accessible within the guidelines online in FY24.	FY23 Once 4.1.24	Continue – Clinical practices has decided on reference materials to be added to website which includes practice guidelines for the treatment of patients with eating disorders 3rd edition, Academy for Eating disorder (AED) 4th edition: guide to medical care.	
Review of effectiveness of CPGs based on available data regarding a particular guideline.	CP	Annual review	Unachieved in FY24. The goal for FY25 is to identify pre-existing measurement questions/tools.	FY23 Annually Ongoing	Continue with modifications	

Verification of the Delivery of Medicaid Services

NorthCare was 100% compliant in both FY23 and FY24 with the Medicaid Service Verification audit samples. In FY24, 766 units of service were reviewed.

Objective/Activities	Lead	Previous Measure FY23	Goal Measure FY24 / ACTUAL ACHIEVEMENT	Start/ Frequency/ Due Dates	Status / Recommendation	Guiding Criteria (CFR, contract, HSAG, C-waiver)
Verification of Services – Medicaid Service Verification – Complete Medicaid Service Verification timely and address any barriers identified for services delivery and health outcomes.						
Obtain / maintain compliance with requirements for Medicaid Service Verification. Share data in appropriate committees.	CO		95% /100% in review of 766 units of service.	FY22 Annually Ongoing	Continue	QAPIP

Performance Improvement Projects

NorthCare Performance Improvement Projects (PIPs) are chosen based on general guidance about topic areas, identified areas of improvement based on quality review, in coordination with CMH and SUD provider workgroups, as applicable, and with the approval of the CEOs. The new FY25 PIP is a non-clinical PIP as the HSAG validated PIP is clinically focused. Ideas for the new FY25 PIP included improving the accuracy of Adverse Benefit Determination (ABD) documentation and Increasing the

number of returned satisfaction surveys. Ultimately, the satisfaction survey PIP was selected, and is included at the end of this document. The ABD idea is being worked on in FY25 and, while not yet an official PIP, improvement efforts are starting. There is the potential for it to become an official PIP for FY26 depending on results of improvement efforts.

There were two PIPs in FY24.

Co-Occurring Disorder Treatment PIP

The HSAG-validated, clinical PIP started in calendar year 2021 with an aim to increase the percent of individuals with co-occurring disorders receiving co-occurring integrated treatment. This PIP did not show improvement, and corrective action is expected in FY25 as a result of HSAG performance review.

According to SAMHSA's Treatment Improvement Protocol (TIP) 42: Substance Use Disorder Treatment for People with Co-Occurring Disorders (COD), updated 2020, 28% of adults with a Severe Mental Illness also have a SUD. SAMHSA noted that in 2018, more than 90% of adults with a prior year MI and SUD diagnosis did not receive services for both conditions. For adults with SMI, in 2018, 30.5% received no treatment, 56% received mental health services only, 3% received SUD treatment only, and only 11% received both. Internal data supports that co-occurring individuals in the CMH system are not receiving COD services at a satisfactory rate to meet the complex needs of their COD conditions.

The PIP data is looking at individuals with both SMI and SUD diagnoses and corresponding designation on the diagnostic page of receiving co-occurring integrated mental health treatment or not. Baseline data (CY2021) calculated for Indicator 1 shows a total of 2660 individuals ages 12 and older who have co-occurring diagnoses, with 473 of these individuals receiving integrated treatment or 17.78% in the denominator are receiving co-occurring treatment. NorthCare provided funding for trainings to increase staff's ability and comfort level treating individuals with co-occurring disorders. Trainings such as ASAM Criteria, Crisis Intervention Training, Seeking Safety, and Motivational Interviewing have been provided at no cost to the CMH/staff. NorthCare also contracted with Dr. Miljour for consultation. Currently, every Monday staff have the opportunity to meet with Dr. Miljour for an hour to discuss any struggles they are having, receive case consultation, or seek general support.

There was no statistical significance between Year 1 measurement and Remeasurement 1. The P value is less than 0.5 (confidence interval), therefore the interventions have not achieved a statistically significant change in persons receiving COD treatment at CMSHP's.

Youth and young adults continue to receive cooccurring treatment at a lower rate than adults. The difference between those ages 12-25yo and those 26+ has decreased as youth rates increased slightly. Unfortunately, adult rates also declined slightly. Overall, cooccurring treatment rates are still down from baseline year, but increased by 2.49% from the intervention year from 16.41% to 16.82% in 2023 and increased again to 17.12% in 2024. This is not a statistically significant change.

COD 1.1.23 - 12.31.23			
	Numerator	Denominator	%
12 to 25 Years of Age	53	364	14.56%

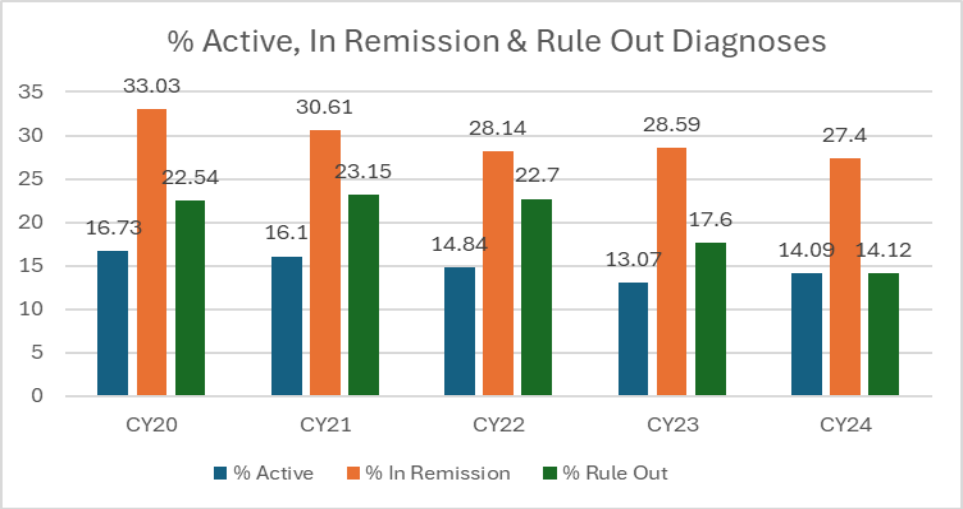
26 to 65+ Years of Age	365	2121	17.21%
Grand Total	418	2485	16.82%

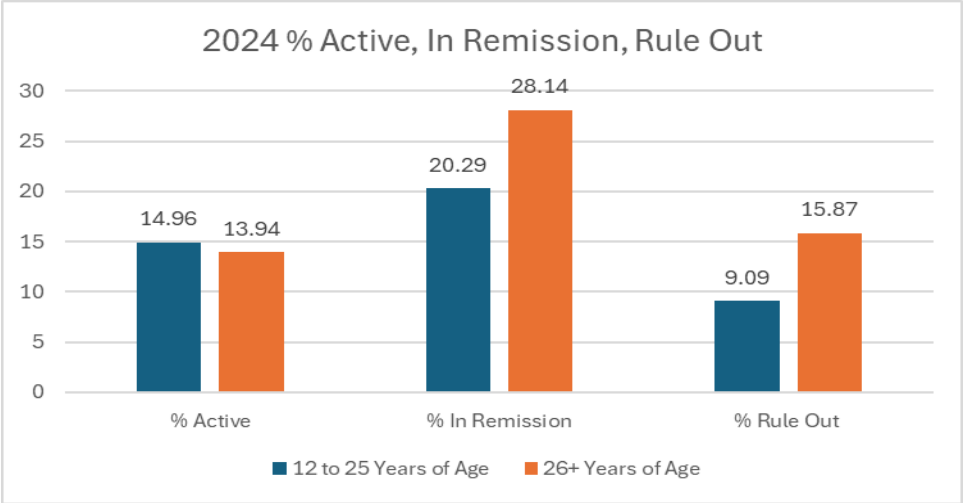
COD 1.1.24 - 12.31.24			
	Numerator	Denominator	%
12 to 25 Years of Age	69	454	15.20%
26 to 65+ Years of Age	480	2753	17.44%
Grand Total	549	3207	17.12%

It is recognized that at times, per consumer preference, a person may receive mental health services via Community Mental Health and substance use disorder services via the substance use disorder providers. While we would recommend treatment at one provider, we aim to honor choice and recognize that while not integrated, this is meeting the needs of the consumer.

It was identified in a regionwide Performance Improvement Project (PIP) meeting with the CMH's that the data collection points may not be accurately reflecting cooccurring treatment. Currently, staff mark if a person is receiving integrated treatment on the Biopsychosocial assessment (BPS). The BPS occurs prior to the Individual Plan of Service (IPOS) meeting, at which a person may choose to defer elements of treatment, including treatment for their cooccurring disorder. Therefore, treatment is being identified before creation of the person-centered plan. When someone defers cooccurring treatment during their person-centered plan, the BPS is not then updated just to reflect this change. A request was added to change the Electronic Medical Record (EMR) to track "deferrals" of cooccurring treatment on the IPOS document. This change was implemented at the end of January 2025.

Additionally, it was identified that the data at baseline and during remeasurement 1 included the following diagnostic specifiers: "in remission," "active," "rule out," and "resolved." As baseline and remeasurement period 1 data were measured the same this did not impact the comparability of the data. For remeasurement period 2 the specifier of "resolved" and "in remission" will be removed. This will impact the comparability of the data for remeasurement 2 but will improve the overall validity of the data. NorthCare has remeasured baseline data and remeasurement period 1 with the exclusion of these specifiers to make the data comparison across all three measurement periods. NorthCare has also identified other concerns with the data and set up of this PIP. NorthCare is reviewing methods to provide increased validation of the data and quality review of the data for 2024 data in 2025. Assuming this method proves effective, it will continue in 2025. Data regarding the percent of diagnoses in each status is broken across calendar years below, and for 2024, stratified by age group.





A survey sent to staff in September 2024 reflects that staff do not feel comfortable with providing COD treatment. Fifteen of the 22 respondents indicated that trainings attended were satisfactory and 13 felt like trainings helped them provide co-occurring treatment. Of the 22 responses only 5 staff were aware of the PIP. A total of 5 staff who completed the survey indicated they have attended a consultation session with Dr. Miljour (1 of the 5 staff who indicated they were aware of the PIP). All 5 did find his consultation helpful; rating him a 4.6 (out of 5) average. The responses to the question asking how NorthCare can aid staff in providing COD treatment included training, reimbursement of co-occurring costs, transportation to get consumers to treatment, and stigma reducing efforts in the community.

Documentation of Skill Building and Supported Employment PIP

The second PIP aimed to improve documentation of skill building and supported employment services. This PIP began in FY20 because of poor performance on Medicaid Service Verification. This PIP was selected because of unsatisfactory documentation for skill building and supported employment across our region. Data reviewed was from activities such as Medicaid service verification and auditing covering a period of 10/1/16 – 2/28/18 where it was realized that CMHSPs within the region had different documentation standards for one provider who contracted with

multiple CMHSPs. This caused confusion, a lot of work on the subcontractors' part and resulted in inconsistent and sometimes unsatisfactory documentation.

The PIP looked at documentation of the consumers action/response and the documentation of the staff's action/intervention. Interventions included creating a template for documenting services. Additionally, a one page example reference guide was created to highlight the differences in terminology used to accurately reflect which service is provided and provide examples of how to write a concise narrative that reflected all necessary elements of a potential contact. A training and quiz was developed and the CMH Corrective Action Plans primarily included having staff take the training.

During the course of the PIP, the documentation of consumer action/response quickly improved, and therefore was only remeasured 4 times. However, documentation of staff action/intervention plateaued throughout the course of the PIP. This was remeasured 6 times with no marked improvement between remeasurement period 1 and remeasurement period 6. There was improvement from baseline to remeasurement period 1.

Study Indicator 1 Title: Increase the percentage of records for individuals living in the NorthCare Network region receiving skill building (H2014) and/or supported employment (H2023) services randomly selected for review who have what the staff person's action/intervention (service provided) clearly documented.					
Time Period	**Measurement**	**Numerator**	**Denominator**	**Results**	**Goal**
10/1/2019 – 10/31/2019	*Baseline*	187	307	60.9%	95.0%
10/1/2020 – 10/31/2020	Remeasurement 1	132	156	84.6%	95.0%
06/01/2021 – 06/30/2021	Remeasurement 2	184	213	86.4%	95.0%
02/01/2022 – 02/28/2022	Remeasurement 3	186	228	81.6%	95.0%
2/1/23 – 2/28/23	Remeasurement 4	204	233	87.5%	95.0%
8/1/23 – 8/31/23	Remeasurement 5	243	272	89.3%	95.0%
2/1/24 -2/29/24	Remeasurement 6	169	195	86.7%	95.0%
Study Indicator 2 Title: Increase the percentage of records for individuals living in the NorthCare Network region receiving skill building (H2014) and/or supported employment (H2023) services randomly selected for review that have the consumer's action/response to the service provided clearly documented.					
Time Period	**Measurement**	**Numerator**	**Denominator**	**Results**	**Goal**
10/1/2019 – 10/31/2019	*Baseline*	306	307	99.7%	95.0%
10/1/2020 – 10/31/2020	Remeasurement 1	147	156	94.2%	95.0%
06/01/2021 – 06/30/2021	Remeasurement 2	209	213	98.1%	95.0%
02/01/2022 – 02/28/2022	Remeasurement 3	227	228	99.6%	95.0%
2/1/23 – 2/28/23	Remeasurement 4	233	233	100.0%	95.0%

Results of remeasurement 6 did not achieve the goal. The average of the remeasurement periods prior to remeasurement 6 was 85.88%. Remeasurement 6 was slightly above the average of the past 5 remeasurement periods but was not an improvement from remeasurement period 5. In comparing remeasurement 6 with the average of the 5 prior remeasurement periods, 3 were above average and 1 was below average. H2014 SAL was above the 5-period average of 86.2%. H2014 Claim was above the 5-period average of 79.88%. H2023 SAL was above the 5-period average of 84.66%. H2023 Claim was below the 5-period average of 86.22%. In remeasurement 5, H2023 Claims had achieved the goal of 95%. In remeasurement 6, only H2023 SALS achieved above 95%, and there was a limited sample size.

	H2014 Skill Building		**H2023 Supported Employment**	
	SALS	Claims	SALS	Claims

	Staff Action	Consumer Action	Staff Action	Consumer Action	Staff Action	Consumer Action	Staff Action	Consumer Action
2019 Baseline								
2020 1st remeasure	70%	100%	65%	65%	86%	100%	94%	90%
2021 2nd remeasure	90%	100%	90%	98%	78%	96%	86%	98%
2022 3rd remeasure	86%	100%	75%	100%	85%	100%	78%	98%
2023 4th remeasure	91.5%	100%	87%	100%	89.5%	100%	77.5%	100%
2023 5th remeasure	93.5%	NA	82.4%	NA	84.8%	NA	95.6%	NA
2024 6th remeasure	92.1%	NA	88.3%	NA	100%	NA	76.7%	NA

This PIP was sunset at the end of FY24 as performance improvement has plateaued and the PIP had gone beyond the planned duration for two remeasurement periods already.

Objective/Activities	**Lead**	**Previous Measure FY23**	**Goal Measure FY24 / ACTUAL ACHIEVEMENT**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Performance Improvement Project - Increase the percentage of individuals ages 12+ who are diagnosed with cooccurring disorders that are receiving cooccurring treatment.						
Baseline Data Calendar year 21 – 17.78%. NorthCare will review data timely and bring to appropriate meetings to discuss improvement strategies.	QI / SUD / Data	NA	Better than 23 / 16.82%. Data was brought to PIP workgroup.	FY23 Quarterly Ongoing	Continue / bring to CPQI, UM, PMC, and PIP workgroup	QAPIP
Offer consultative services to CMHSPs to improve co-occurring illness, via contract with psychiatrist board certified in addiction medicine.	SUD / ICT	Began June 23	Increased utilization from 23 / 48 unduplicated staff attended at least once in the FY. This is an increase, although prior year was a partial year.	FY23 Monthly Ongoing	Continue	QAPIP
Performance Improvement Project – To improve documentation of skill building (H2014) and supported employment (H2023) services.						
Increase the percentage of records for individuals living in the NorthCare Network region receiving skill building (H2014) and/or supported employment (H2023) services randomly selected for review who have what the staff person action/intervention (service provided) clearly documented. Baseline data was 60.9% (FY18).	QI / CP	89.3%	95% / Actual Achievement 86.7%. Goal not obtained but progress has plateaued.	FY18 Biannually June 2024	Sunset end of FY24.	QAPIP

Conclusion

Quality initiatives in FY24 were aimed at increasing the monitoring and oversight of utilization. Initial quantitative and qualitative reviews identified areas for improvement that will be addressed in FY25. Many initiatives were identified in FY24 and specific activities will be undertaken in FY25 to address the workplan. FY25 has renewed focus on reporting the results of NorthCare reviews to the CMH and SUD providers, as applicable, and completing follow up and recurrent reviews to ensure improvement following an intervention period. NorthCare is also reviewing current Electronic Medical Record documents to update them and reviewing and updating clinical practice guidelines in FY25.

FY25 QAPIP

The following pages detail the FY25 QAPIP and associated workplan. This will be the focus area of the quality department over the fiscal year. This plan and associated workplan will adjust as indicated by results of HSAG and MDHHS audits indicate, and as NorthCare quality and utilization reviews deem necessary.

FY25

NorthCare Network

FY25 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN (QAPIP)

Quality Management Department
NorthCare Network
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Contents

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 is also part of the Behavioral Health Home (BHH) and SUD Health Home (SUD HH) programs.

NorthCare Network is the prepaid inpatient health plan (PIHP) for the five Community Mental Health Services Programs (CMHSP) serving the Upper Peninsula: Copper Country Community Mental Health, Gogebic County Community Mental Health, Hiawatha Behavioral Health, Northpointe Behavioral Health System, and Pathways Community Mental Health. The counties which each serve is detailed below.

- Copper Country: Baraga, Houghton, Keweenaw, Ontonagon
- Gogebic: Gogebic
- Hiawatha: Chippewa, Mackinac, Schoolcraft
- Northpointe: Dickinson, Iron, Menominee
- Pathways: Alger, Delta, Luce, Marquette

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. It supports our vision to ensure a full range of accessible, efficient, effective, and integrated quality behavioral health services and community-based supports for residents of Michigan's Upper Peninsula.

We achieve this by staying true to our values.

- We believe in respect, consumer empowerment, person centered care, self-determination, full community participation, recovery, and a culture of gentleness.
- We endorse effective, efficient community-based systems of care based on the ready availability of a competent workforce and evidence-based practices.
- We believe in services that are accessible, accountable, value based, and trauma informed.
- We support full compliance with state, federal and contract requirements, and responsible stewardship.
- The right care, and the right time, for the right cost, and with the right outcome.

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.

We do this to achieve the following desired outcomes:

- Meet, or exceed, state performance metrics as well as improving performance for identified projects.
- Improved data analysis of critical incidents to reduce adverse effects on consumers and behavior treatment committee data to reduce the need for physical intervention.
- Ensure satisfaction of services and HCBS rules and quality clinical practice guidelines that are accessible to consumers and staff.
- Verify staff are qualified to complete their duties and there is network adequacy to provide necessary services.
- Ensure services meet Medicaid standards. Ensure appeal and grievance information is provided to members.
- Increase consistency in Utilization Management decisions across the region and assess the appropriateness of individuals' level of care and the services they are providing.

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 QI/UM Specialist 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 Responsibility

NorthCare Network Governing Board

- *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, due February 28th, which includes a list of members.
- *Reporting Frequency:* Quarterly

Designated Senior Official

NorthCare's QI/UM Specialist 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 below.

Title	Department	Average percent per quarter devoted to QM
SUD Clinical Director	Clinical/ SUD Access	15%
Integrated Care / UM Specialist	Clinical	10%
Clinical Practices Specialist	Clinical	15%
Customer Service Specialist	Customer Service	10%
Data Analyst	Information Management	5%
Population Health Specialist	Integrated Care/Population Health	35%
Medical Director (Part-time)	Clinical	75%
Provider Network Specialist	Network Management	10%
QI/UM Director	QI	50%
Systems Analyst	Information Management	25%
Compliance-Privacy Officer	Compliance	25%

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. Regional committees are denoted with an "R" on the chart.

NorthCare Governing Board of Directors

A. NorthCare Compliance Oversight and Risk Management Committee (CORMC)
    1. NorthCare Medicaid Service Verification Team (MSV)
    2. NC Site Review Team (MH)
    3. NC Site Review Team (SUD)
B. NorthCare Leadership Committee
    1. NorthCare Information/Technology Management Committee
        a) Regional Elmer Management Committee (REM)
        b) Regional Analytics Committee
        c) Regional Help Desk Committee
        d) Regional Information Technology and Security Committee
        e) Regional Medical Records Committee
    2. NorthCare Quality Management Committee
        a) NorthCare Network Management Committee
        b) NorthCare Credentialing Committee
        c) NorthCare Health and Safety Review Committee
        d) Regional Grievance & Appeal Committee
        e) Regional Clinical Practices/QI Committee
            - Regional Behavioral Treatment Committee
            - Regional Health Services Committee
            - SUD Provider Clinical Meeting

- NC/UPHS-Marquette QI Committee
- NC/My Michigan Sault QI Committee
- NC/Willow Creek QI Committee
- NC/Aspirus QI Committee
- Regional Trauma Informed Committee

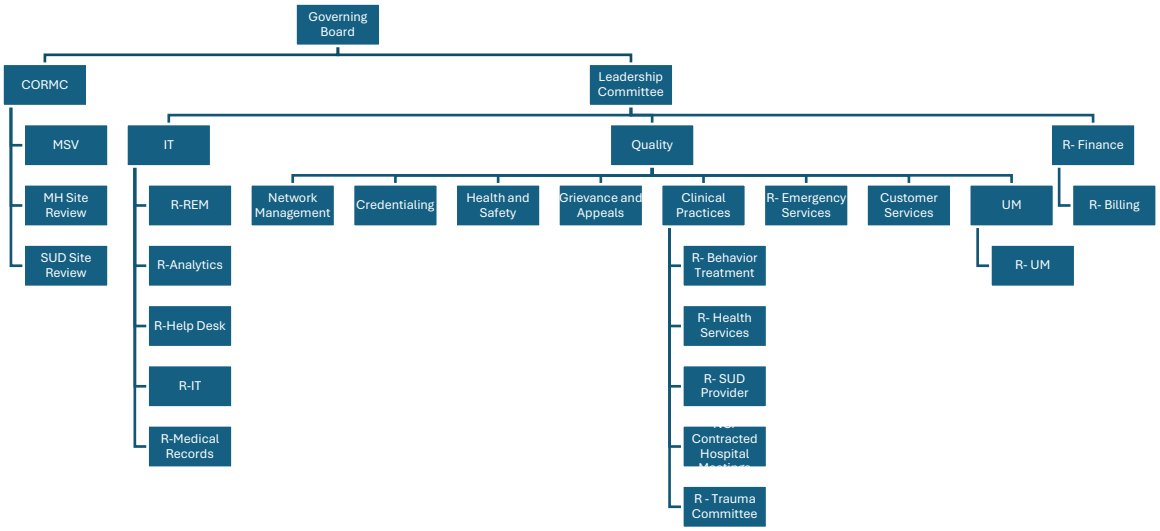
f) Regional Emergency Services Committee

g) NorthCare Utilization Management Committee

- Regional Utilization Management Committee

h) Regional Customer Services Committee

3. 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.

Additionally, each CMHSP has a quality improvement process to address quality issues within its operations. Each CMHSP also has a customer services meeting for increased consumer involvement and voice. Regional satisfaction results are shared and reviewed by NorthCare Network. NorthCare reviews the CMHSP websites and publications annually.

Substance Use Disorder (SUD) services are delivered through a network of contracted provider organizations. No managed care functions are delegated to SUD providers. To ensure representation, SUD providers are involved in the Regional SUD Provider Clinical Meetings and concerns are brought to leadership.

Quality Management System

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 Service Verification ▪ Performance Improvement Projects ▪ Critical Event Reporting	▪ MDHHS MMBPIS ▪ Audit Reports ▪ External Quality Reviews (HSAG) ▪ MDHHS Site Reviews ▪ Outcome Reports ▪ Benchmarking ▪ Grievance & Appeals ▪ MDHHS Performance Based Incentive Pool	▪ 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

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

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.

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. Surveys are sent to staff periodically, as determined necessary, to identify training needs.

SUD providers are invited to provide input in the regional SUD clinical meeting. Grievance and appeals are also a valuable source of stakeholder input, as well as consumer satisfaction surveys and targeted surveys based on program (e.g., the BTC bi-annual survey).

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, Satisfaction	Performance Evaluations, Termination/Exit Interviews	ORR Site Visit, Contract Provider	MDHHS Site Reviews Fidelity Reviews of	Open Door Policy of the NorthCare Network CEO	MDHHS Site Reviews, External Quality Review

	Surveys, Person Centered Planning (PCP) process		Quality Review	Evidence Based Practices		Organization (EQRO)– under contract w/MDHHS
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
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
Surveys	Consumer surveys, Health Plan Survey per Accreditation	Staff surveys	Provider surveys, Accreditation surveys	Satisfaction surveys	Stakeholder Surveys	MDHHS, EQRO
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
Due Process Grievance, Appeals, Medicaid Fair Hearings	Filing of appeals and grievances	Review dispositions with staff	Review dispositions with providers	Due Process	Comments via NorthCare Network Website	MDHHS, EQRO
Complaints	MDHHS-ORR Audit reviewed as completed Compliance Complaints	Recipient Rights Complaints as mandated reporters Compliance Complaints	Recipient Rights Complaints as mandated reporters Compliance Complaints	RR Complaint, Compliance complaint process, Customer Service compliant process	RR Complaint, Compliance complaint process	MDHHS, EQRO

Ongoing Assessments of Consumer Experiences with Services and the PIHP

NorthCare Network conducts assessments of member experiences with its services. These assessments must be representative of the individuals served, including individuals receiving long-term supports or services, and the services and supports offered. Members of services are encouraged to complete the satisfaction survey. Surveys were previously mailed to a sample of individuals monthly, and the survey is always available online via the NorthCare website. To increase consumer input, CMHSPs have provided this survey link on appointment reminder cards, posted it in waiting room lobbies, and it has been advertised in the annual consumer newsletter. In FY25, NorthCare is implementing a Satisfaction Performance Improvement Project (PIP) to increase the number of returned surveys.

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.

Provider Network Monitoring

NorthCare Network conducts annual site reviews of organizational providers with whom we directly contract to ensure compliance with all contracted functions as well as state and federal mandates.

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, if applicable
- 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 reports

- 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

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 Clinical Practices and Quality Improvement 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.

Some UM activities overlap with other areas and may be led by various committees but be pertinent to UM, such as recidivism for inpatient psychiatric admissions. UM areas of focus include over and underutilization, appropriate level of care, eligibility criteria, and medical necessity for specific services.

Credentialing and Qualification for Scope of Practice

The NorthCare Network Credentialing Committee is responsible for applying 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 and unlicensed 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.

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.

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.

Oversight of Vulnerable Individuals

NorthCare Network utilizes the appropriate qualified 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. Individuals with increased needs due to multiple conditions may be referred to the Behavioral Health Home (BHH), Substance Use Disorder Health Home (SUDHH), or Integrated Care Team (ICT) meetings with the Medicaid Health Plan, Upper Peninsula Health Plan (UPHP). If an issue that places an individual at 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.

Home and Community Based Service (HCBS) recipients, individuals on c-waivers, and individuals receiving Long-Term Services and Supports (LTSS), as well as those with various health conditions involved in Integrated Care Team meetings or the Health Homes are considered vulnerable and will be considered in data review. Some populations require the use of MDHHS developed tools or have data collected and reported on via Care Connect 360.

Behavior Treatment Review

NorthCare Network's Clinical Practices Specialist 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 Clinical Practices and Quality Improvement 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.

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. Specialty residential providers will report incidents to the CMHSP, either via electronic or paper process. Other Network Providers, including residential SUD treatment providers, may continue to report on paper. Select incidents will be reviewed during the NorthCare Health and Safety meeting. Analysis and trend lines will be reviewed frequently.

A. Critical Events: Critical Event Reporting will be uploaded nightly to MDHHS's CRM 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.

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. Unexpected deaths are marked as either critical, sentinel, or both. Specifics for reporting are included in NorthCare's Incident, Event & Death Reporting & Monitoring Policy.

Critical Incidents are automatically uploaded into the CRM nightly via information transfer from PCE. Immediately reportable events and SUD sentinel events are manually uploaded into the CRM

within the specified timeframes identified in the MDHHS guidelines. Remediation details for events, as necessary, are also submitted via the CRM.

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,
- Goods 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 in place 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). For individuals on a waiver, or attempting to be on a waiver, there is additional paperwork and approval process for waiver covered services identified above. The new 1915(i)SPA waiver also has additional process and scrutiny for identification of individuals receiving the services that are considered LTSS and qualifying for1915(i)SPA.

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 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.

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

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 QI/UM Specialist 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 measures 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/UM Specialist and the Quality Oversight Committee to ensure the implementation of effective improvement plans.

- MDHHS is moving toward nationally recognized measures via a 3-year quality transformation roll out. The MMBPIS measures will be phased out over that period and replaced with the new quality measures. Measurement years will be calendar years starting 1.1.25. It is anticipated that in 2025 MMBPIS and the new measures will both be calculated; and the new measures will be informational only. The measures will also be stratified by race/ethnicity, biological sex, and geography. Measures that are separated by child/adult will also stratify based on age.

    i. The new measures are not entirely new to us. They come from the Behavioral Health Core Set required by CMS.

	Measure	Program	Domain
ADD	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	BHCS	MH
CDF	Screening for Depression and Follow-up Plan*	BHCS	MH
FUH	Follow-up After Hospitalization for Mental Illness*	BHCS	Access
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	BHCS	MH
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	BHCS	MH
FUA	Follow-up After Emergency Department Visit for Substance Use*	BHCS	Access
FUM	Follow-up After Emergency Department Visit for Mental Illness*	BHCS	Access
IET	Initiation and Engagement into Substance Use Disorder Treatment	BHCS	SUD
MSC	Medical Assistance with Smoking and Tobacco Use Cessation	BHCS	SUD
AMM	Antidepressant Medication Management	BHCS	MH
ACC	Access to Care—appointment within 10 days of request	Final Rule	Access

- 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.

Outcomes Management

NorthCare Network's Clinical Practices and Quality Improvement 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.

In FY2023, NorthCare upgraded ELMER vitals to include hip-to-waist circumference measures. This allows for early detection of metabolic syndrome for individuals on psychotropic medications, receiving health services from the CMHSPs. Early detection enables staff to implement lifestyle interventions like physical activity and dietary changes to reduce the chances of people developing metabolic syndrome conditions: diabetes, hypertension, and obesity.

New to FY25, NorthCare will, in accordance with MDHHS policy, monitor the transition of care for individuals between levels of care, between populations, between residential to outpatient settings, and between the legal system, as well as between PIHPs and from Medicaid Health Plan to PIHP (or vice versa), as applicable and as data allows.

Practice Guidelines

NorthCare Network's Clinical Practices Specialist 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 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. Beneficiaries are informed of the guidelines annually in the newsletter. CMHSP staff attest to having access to the guidelines annually. SUD provider staff attest to having access to the guidelines and, more importantly, the SUD operations manual- which is an SUD focused guide. 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 ensure services are planned and delivered in a manner that reflects the values and expectations contained in practice guidelines adopted.

Additionally, for emergency services, NorthCare Network member CMHSPs use the MCG Indicia tool embedded into the regional preadmission screening form to assist in determining medical necessity for inpatient psychiatric admission.

To ensure fidelity to practice, NorthCare and the affiliate CMHSPs 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 is available ongoing.

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.

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.

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. The Performance improvement projects must be included in the QAPIP and must include the following elements:

1. Measurement of performance using objective quality indicators.

2. Implementation of interventions to achieve improvement in the access to and quality of care.
3. Evaluation of the effectiveness of the interventions based on the performance of measures.
4. Planning and initiation of activities for increasing or sustaining improvement.

PIP's are selected based on requirements of the PIP structure when possible. The HSAG validated co-occurring disorder treatment PIP was selected and modified as there is not enough ethnic variation in the UP to create a PIP centered around racial disparity.

When determining a PIP, NorthCare meets with the region via regional committee to discuss possible PIP topics. A topic is picked if it has the most regional support and the initial data review supports the need for a PIP that meets any of the criteria of the PIP structure. NorthCare then continues PIPs until improvement is shown that allows for sunsetting of the PIP. At times, a PIP will need to be modified based on additional discovery found in the data or review of literature.

Oversight of the PIPs is achieved through collaboration with regional committees and workgroups. Improvement is tracked on an ongoing basis through reviewing and updating the workplan, data collection reports, and analysis of the data. Results are communicated to appropriate committees and stakeholders.

NorthCare PIPs include:

1. To Increase the Percentage of Individuals Ages 12 and Older Who Are Diagnosed With a Co-Occurring Disorder That Are Receiving Co-Occurring Treatment.
    a. This HSAG validated PIP started in FY22, 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 is 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 with co-occurring treatment.
2. Starting in FY25, NorthCare is implementing a new non-clinical, non-HSAG validated, PIP to increase the number of satisfaction survey responses received.
    a. This PIP will increase options for responses by increasing the number of formats and methods.
    b. The survey will be available to consumers utilizing SUD providers as well; although the methods will be limited.
    c. There will be increased data collection and analysis from the additional data obtained.
    d. Responses will be used to improve the network.

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. 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. Staff also use MDHHS required tools to assess the appropriateness of care given the individuals population status, including LOCUS, CAFAS/PECFAS, DECA, and in FY25 MichiCANS, and, once available, the WHODAS-2. 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 decisions 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. In FY25, a dashboard for over/underutilization is being created using the PowerBI program. This will significantly increase the data capabilities associated with utilization management and allow for both qualitative and quantitative review.

Quality Measures

NorthCare reviews the following quality measures to ensure quality care.

- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD): The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
- Plan All-Cause Readmissions (PCR): For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
- Initiation and Engagement of Substance Use Disorder Treatment (IET): The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement.
- Follow-Up After Emergency Department Visit for Mental Illness (FUM): The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.
- Follow-Up After Hospitalization for Mental Illness (FUH): The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.

- Follow-Up After Emergency Department Visit for Substance Use (FUA): The percentage of emergency department (ED) visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up.
- Antidepressant Medication Management (AMM): The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment.
- Spirometry Testing for Newly Diagnosed COPD (SPR): Percentage of adults with newly diagnosed COPD who receive spirometry testing within 6 months of diagnosis.
- Preventative Dental Examination: presence of a dental exam every two years for all individuals with Medicaid Dental Coverage.
- Well-Child Visits in the First 30 Months of Life: Assesses children who turned 15 months old during the measurement year and had at least 6 well-child visits with a primary care physician during their first 15 months of life. Assesses children who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician in the last 15 months.
- Child and Adolescent Well-Care Visits: Assesses members 3-21 years of age who received one or more well-care visits with a primary care practitioner or an OB/GYN practitioner during the measurement year.

Procedures for Adopting and 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 for a program at the initiation of the program.
- Discovery: Engaging in a process of discovery to collect data and direct participant experiences 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. This document details the specific actions NorthCare is completing related to quality improvement and is a working document. The document will be reviewed and updated at the quarterly Quality Management meetings.

Evaluation and Monitoring

A meeting is convened if NorthCare becomes aware of any significant provider-related issues of quality concern. Issues would be added to the Quality Improvement Workplan. The Quality Improvement Workplan is a document that summarizes areas of quality concern, the intervention plan in place for improvement, and the staff responsible for the implementation and target resolution dates. The Quality Improvement Workplan considers severity, duration, frequency, and if the concern is clinical or not. Items in the workplan will be monitored quarterly unless otherwise specified. The workplan is a living document, updated throughout the year.

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 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 because 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.

Additionally, the Network Adequacy standards are also completed annually, and this information is provided to MDHHS by February 28th each year. Identified concerns are brought to the attention of leadership, provider network management, and contract committees.

References

- The Balanced Budget Act of 1997 (BBA)
- MDHHS /PIHP Master Contract
- MDHHS Michigan Mission Based Performance Indicator System V6.0 Codebook
- ICO/PIHP Contract for the MI Health Link Demonstration Program
- NorthCare Network Policies -- www.northcarenetwork.org

Attachments

A - Acronyms Used in this Document
B – Work Plan

Approvals

Reviewed/Revised Date: 8/23/24, 1/29/25
Quality Management Committee Approval: 8/26/24, 1/29/25
Policy Committee/CEO Approval: 8/28/24, 2/4/25
Board of Directors Approval: 9/11/24, 2/12/25

Attachment A- Acronyms used in this document

BBA – Balanced Budget Act
BHH – Behavioral Health Home
BTC – Behavior Treatment Committee
CEO – Chief Executive Officer
CMH – Community Mental Health
CMHSP – Community Mental Health Service Program
CMS – Centers for Medicare and Medicaid Services
COD – Cooccurring Disorder
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
LTSS – Long Term Supports and Services
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
SUD – Substance Use Disorder
SUDHH- Substance Use Disorder Health Home
UM – Utilization Management

FY25 QAPIP Workplan

Objective/Activities	Lead	Previous Measure	Goal Measure	Start/ Frequency/ Due Dates	Status / Recommendation	Guiding Criteria (CFR, contract, HSAG, C-waiver)
Performance Indicators and Measures						
PI1: PAS within 3 hours. NorthCare will continue to exceed the 95% expectation for this measurement and will continue to measure and report PI timely. Review situations with multiple PAS's for the same individual on the same day.	QI	99.5% (based on average of Q1-2)	Requirement is 95%. Our goal to strive for is 100% but accept 95% as minimum standard.	FY23 (mid) Quarterly Ongoing	Continue / bring to CPQI, QM, and PMC	Contract MMBPIS Standards
PI2a: BPS within 14 days: Given FY24 new measurement goals, NorthCare will seek to improve this measure beyond the 75th percentile of 62%. PI will be reviewed with each CMH and data presented to appropriate regional meetings.	QI	56% (based on average of Q1-2)	62%	FY23 (mid) Quarterly FY24Q2 and Ongoing	Continue / bring to CPQI, QM, and PMC	Contract MMBPIS Standards
PI2b/e: SUD admissions in 14 days: NorthCare will identify providers by way of PI2b/e monitoring report that fall below the goal and work with them to address barriers.	QI / SUD	58.5% (based on average of Q1-2)	68.2% (MDHHS benchmark)	FY23 (mid) Quarterly Ongoing	Continue / bring to SUD regional meeting, QM, and PMC	Contract MMBPIS Standards
PI3: Ongoing service within 14 days: Given FY24 new measurement goals, NorthCare will seek to improve this measure beyond the 50th percentile of 72.9%. PI will be reviewed with each CMH and data presented to appropriate regional meetings.		64% (based on average of Q1-2)	72.9%	FY23 (mid) Quarterly FY24Q2 and Ongoing	Continue / bring to CPQI, QM, and PMC	Contract MMBPIS Standards
PI4a: Follow up to hospitalization within 7 days: NorthCare will achieve 95% compliance every quarter and will require corrective action plan if any CMH is not within 95% 2 or more quarters in a row. Data will be reviewed at appropriate regional meetings.	QI	95% 99% (based on average of Q1-2)	95% Requirement is 95%. 99% is goal to strive for but accept 95% as minimum standard.	FY22 Quarterly Ongoing	Continue / bring to CPQI, QM, PMC, and ES meetings. Bring hospital specific information to contracted hospital quality meetings.	Contract MMBPIS Standards
PI4b: Follow up to detox within 7 days: review all exceptions; and run the data separate from MH data.	QI	95%	95%	FY24 Quarterly Ongoing	Bring to SUD regional meeting	Contract MMBPIS Standards
PI10: Recidivism: Achieve under 15% recidivism every quarter. A corrective action plan will be required for any CMH outside 15% for 2+ quarters in a row.	QI	7.35%	<15% The standard is under 15%. Our goal is under 10% but will accept under 15%.	FY23 (mid) Quarterly Ongoing	Continue / bring to CPQI, QM, PMC, and ES meetings. Bring hospital specific information to contracted hospital quality meetings.	Contract MMBPIS Standards
Identification of trends for any statistical decline in performance measures. Address trends with appropriate providers.	QI	NA		FY24 Annual Ongoing	Continue / bring to CPQI, QM, and PMC	

Identify trends in recidivism and 7-day follow up; their relationship to inpatient ALOS, and correlations between the 3. Address trends with appropriate providers.	QI	NA		FY24 Quarterly Ongoing	Continue / bring to CPQI, UM, PMC, and hospital specific information to contracted hospital meetings.	
Improve timeliness of priority population admissions for SUD populations by developing a monitoring method and monitoring frequently. Overall decrease in number of out of compliance priority population admissions.	QI / SUD	NA	80%	FY24 Quarterly Ongoing	Continue / bring to SUD regional meeting, QM, and PMC	
Increase validation checks to ensure appropriate populations are included in PI reporting and update system logic to remove members admitted that are mild/moderate for 2a/b, 4a, and 10.	QI	NA	100% accuracy	FY24 Once 4.1.24		
Compare with PBIP data to better impact employment and housing related concerns.	QI			FY24 Quarterly 10.1.24	Continue	PBIP reporting
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Performance Improvement Project - Increase the percentage of individuals ages 12+ who are diagnosed with cooccurring disorders that are receiving cooccurring treatment						
Baseline Data Calendar year 21 – 17.78%. NorthCare will review data timely and bring to appropriate meetings to discuss improvement strategies.	QI / SUD / Data	NA	Better than 23	FY23 Quarterly Ongoing	Continue / bring to CPQI, UM, PMC, and PIP workgroup	QAPIP
Offer consultative services to CMHSPs to improve co-occurring illness, via contract with psychiatrist board certified in addiction medicine.	SUD / ICT	Began June 23	Increased utilization from 23	FY23 Monthly Ongoing	Continue	QAPIP
Performance Improvement Project						
Increase the responses to the satisfaction survey	CS/ QI	FY25 start date – baseline data		FY25	Start/ Continue	QAPIP
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Event Reporting – Increase data reporting capability by building better reports and using the data to analyze improvements in the quality of healthcare and services for members.						
Utilize Power BI for better data analysis and review data during the Health and Safety Committee (internal) and Regional Incident Reporting (regional) meetings.	QI	NA	Begin use	FY23 Quarterly Ongoing	Continue	QAPIP
Increase timely categorization of incidents as being critical, sentinel, risk, immediately reportable to 95% within 3 business days of incident.	QI	NA	95%	FY23 Quarterly Ongoing	Continue / given methods at the time in FY23, average of 93%, however improved data capabilities available in FY24	QAPIP

					show unfavorable difference.	
Ensure individuals living in residential living arrangements are in the correct level of care; ensuring discussion of transition for any found in appropriate levels of care.	QI / CP	Completion of quarterly review	Completion of quarterly review	FY23 Quarterly Ongoing	Continue / recommend setting a schedule for this activity	QAPIP
Review RCA Outcomes data to assess common causal factors for possible improvement project.	QI / CP	NA	Annual review	FY23 Annually Ongoing	Continue / determine if completion during site review makes most sense or mid-year review	QAPIP
Review all untimely deaths with NorthCare Medical Director and trend data over time.	QI / CP	NA	Monthly	FY24 Monthly Ongoing	Continue	QAPIP
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Behavior Treatment Plan Review – NorthCare will complete analysis of BTC data and implement systemic change related to data findings as necessary.						
NorthCare will collect quarterly data from the CMH's and present data at the regional BTC meeting and internal health and safety committee meeting. Determine the "why" of the incident.	QI / CP	Completion of quarterly review	Completion of quarterly review	FY23 Quarterly Ongoing	Continue / bring data and specific consumer concerns to each CMH.	42 CFR 438.100 (b)(2)(v). Balanced Budget Act of 1997
NorthCare will utilize data to determine improvements/ changes in care due to BTC both on select individuals and programmatically. Review interventions and incidents; specifically 911 use and physical management.	QI / CP	Reduction in use of physical management (325 events)	Reduction in use of physical management	FY23 Quarterly Ongoing	Continue / bring data and specific consumer concerns to each CMH.	42 CFR 438.100 (b)(2)(v). QAPIP
Analysis of BTC survey data to determine any concerns related to the program.	QI / CP	Completion of survey (311 responses)	NA – biannual	FY24 Biannual Ongoing	Continue	42 CFR 438.100 (b)(2)(v).
HCBS Modifications – Modifications of HCBS conditions will be supported by an assessed need that is justified in the person-centered plan.						
Review of HCBS limitations at annual site reviews.	QI	NA	Begin review	FY22 Annually Ongoing	Discontinue; will follow MDHHS HCBS Monitoring Technical Requirement	42 CFR §441.301 (c)(4)(vi)(A-D)
Monitoring of HCBS limitations and ensure that the limitation is justified and addressed in the person-centered plan.	QI	NA	Unknown baseline; ultimate goal 100%	FY22 Annually Ongoing	Discontinue; will follow MDHHS HCBS Monitoring Technical Requirement	
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Member Experience with Services – Use of an annual assessment addressing member experience, national data, LTSS, focus areas, and NCI results to address dissatisfaction and improve overall consumer satisfaction.						
Update the electronic process to achieve higher response rates to customer satisfaction survey.	CS	Low	25%	FY23 Annually 9.1.24	Continue	
Analyze satisfaction survey data, address areas of dissatisfaction, and	CS	NA		FY23 Annually	Continue	

publish associated interventions in annual QAPIP effectiveness review.				2.28.25		
Evaluate program satisfaction rate for all, including those receiving LTSS services.	CS	NA		FY24 Annually 2.28.25	Continue	42CFR438.10e.2.x
Grievance and Appeals – ensure grievance and appeals are completed timely, provide appropriate						
Pull a random sample, by provider, of ABD notices to ensure ABDs have all necessary elements, are written at an appropriate readability, and are completed timely.	CS	80%	90%	FY22 Quarterly Ongoing	Continue	42 CFR 438.400, 42 CFR 438.210, 42 CFR 438.408
Ensure grievance letters are written to the member, error free, and written at an appropriate readability via quarterly reviews.	CS		90%	FY22 Quarterly Ongoing	Continue	42 CFR 438.400
Review grievance extension letters to ensure they are error free and completed on the developed template.	CS			FY23 Quarterly Ongoing	Continue	
Acknowledge receipt of each member appeal timely.	CS		100%	FY22 Quarterly Ongoing	Continue	42 CFR 438.406
Create a mailing policy and procedure to ensure mailings are completed in a timely manner.	CS	NA	Completion of policy	FY24 Once	Completed	
Provide training regarding the difference between an extension request and ABD delay.	CS			FY24 Once		
Review targeted scenarios to ensure ABD completion – decision delays and commencement date of services	CS			FY25 Quarterly	start	
Application Programming Interface – API – NorthCare will implement a patient access API and provider directory API.						
Implement a Patient Access API by participating in a statewide workgroup and working with EHR vendor to achieve publicly accessible standards.	IT			FY22 Once 10.1.24		42 CFR §431.60; CMS Interoperability and Patient Access Final Rule (CMS-9115-F).
Implement a provider directory API to ensure access to published provider directory information.	IT			FY22 Once 10.1.24	Continue	42 CFR §431.670
Update the website to be more user friendly and accessible to multiple stakeholders and developers.	IT			FY24 Once 10.1.24		
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Practice Guidelines – Ensure development of requested CPGs, adoption of updated MDHHS CPGs, and dissemination of all CPGs to regional providers.						
Ensure review and updates to CPG's annually. Providers to acknowledge updates.	CP	Annual	Attestation from each CMH LMS user and SUD providers	FY23 Annually 1.25.24	Continue / make part of annual training requirements	QAPIP
Create/find and implement CPG related to eating disorders as requested in the Clinical Practices / Quality Improvement committee meeting.	CP	One time	Adoption of guideline	FY23 Once 4.1.24	Continue / options presented, to be voted on in FY24	

Review of effectiveness of CPGs based on available data regarding a particular guideline.	CP	Annual review	Unachieved in FY24. The goal for FY25 is to identify pre-existing measurement questions/tools	FY23 Annually Ongoing	Continue	
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Credentialing and Re-credentialing – Ensure consistent factors considered during credentialing and recredentialing (grievances, PI, utilization, appeals, member satisfaction, and provider reviews) and that MDHHS requirements are met.						
Develop and implement detailed credentialing/recredentialing file auditing plan addressing credentialing/ recredentialing requirements, citations, and recommendations made in HSAG review. Developing an area in ELMER for region to utilize for credentialing/recredentialing of staff that will capture all required information of the staff as well as timeframes effective.	PNM	Annual audit	Decreased number of charts out of compliance. Spec was created this month and plan is to implement and train region before the end of FY24 and begin utilizing it in FY25 as a region.	FY22 Annually September	Continue	42CFR438.214
Ensure non-licensed providers meet all Medicaid requirements.	PNM	Annual audit	Decreased number of files out of compliance.	FY22 Annually September	Continue	
Conduct annual audit of all delegates performing credentialing activities according to audit plan.	PNM	Annual audit	Decreased number of files out of compliance.	FY22 Annually September	Continue	
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Verification of Services – Medicaid Service Verification – Complete Medicaid Service Verification timely and address any barriers identified for services delivery and health outcomes.						
Obtain / maintain compliance with requirements for Medicaid Service Verification. Share data in appropriate committees.	CO	90%	95%	FY22 Annually Ongoing	Continue / in FY22, 331 SAL/Claims were reviewed for 100% compliance.	QAPIP
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Utilization Management – Improve consistency in UM decisions across various areas of need, such as: residential level of care, eligibility criteria, medical necessity criteria for specific services.						
Review underutilization and denoted reasons for underutilization in progress notes, periodic reviews, and other sources.	UM			FY23 Biannual Ongoing	Continue / introduction of new reporting tool, Power BI, will greatly assist with analysis	
Review overutilization of services as indicated by additional authorization requests.	UM			FY23 Biannual Ongoing	Continue	

Discuss Interrater reliability (IRR) in the state PIHP workgroup for statewide consistency.	UM	NA	Use of IRR for pre- admission screenings	FY23 Annually Ongoing	Continue	Parity – required use of MCG tool for inpatient; workgroup discussing IRR
Complete a sample of chart reviews to ensure accuracy and completeness of charts and compliance with C waiver requirements and CFR.	UM			FY24 Biannual Ongoing	Continue	MDHHS C-Waiver Code of Federal Regulations (HSAG)
Determine the utilization and authorization mean and median for all services during a given time period to analyze the variance and determine appropriate benefit plans	UM			FY25	Start	
Compare like services for areas that are lacking a service	UM			FY25	Start	
Complete targeted reviews as necessary in areas necessary such as % of the population in each LOC	UM			FY25	Start	UM plan
Review penetration rates, by CMH, by program	UM			FY25	Start	UM plan
Access to Services – Improve consistent access to services across the region						
Review a random selection of screenings for screener approval rate, determination at BPS, and other factors to identify trends and address any concerns. (second opinions, calls by agency, duplicate screenings, crisis and access interaction, etc.)	UM			FY24 Quarterly Ongoing	Continue / previous data based on centralized access at the PIHP. In FY24, distributed to CMHs	
Review data related to Emergency Services (ES) such as Average Length of stay, recidivism, 7-day follow up, IPOS amendments post hospitalization (change in need), hospital denials, ER boarding, diversion rates, denial trends)	UM			FY25	start	
Objective/Activities	**Lead**	**Previous Measure**	**Goal Measure**	**Start/ Frequency/ Due Dates**	**Status / Recommendation**	**Guiding Criteria** (CFR, contract, HSAG, C-waiver)
Provider Network Management – Ensure there is an adequate provider network.						
Review the service array and address areas of deficiency.	PNM / QI			FY23 Annually Ongoing	Continue	42CFR438.207
Review ABD capacity related denials and address areas of deficiency.	PNM / QI	3% of FY23 denials were due to capacity	2%	FY23 Quarterly Ongoing	Continue	
Expansion of Behavioral Health Home (BHH) providers; specifically CSS in FY25.			Recruitment of additional providers. GLRC joined the BHH panel in FY24	FY23 Monthly Ongoing	Continue	BHH Handbook
Create and run report to assess significant changes in provider network or membership, including location of providers to members.	QI			FY24 Annually Ongoing	Continue	HSAG Standard 4 / Element 4

Objective/Activities	Lead	Previous Measure	Goal Measure	Start/ Frequency/ Due Dates	Status / Recommendation	Guiding Criteria (CFR, contract, HSAG, C-waiver)
Long Term Services and Supports – LTSS – Compare services received by LTSS consumers vs what was authorized in their plan (over/under utilization of LTSS services).						
Review individuals in AFC level of care that do not have a matching LOC in the system to determine if AFC level of care appears appropriate	QI / CP / UM	Review 5 cases per quarter	Review 5 cases per quarter	FY23 Quarterly Ongoing	Continue	
Review underutilization of authorized LTSS services.	QI / UM	Review 10 cases per quarter	Review 10 cases per quarter	FY23 Quarterly Ongoing	Continue	
Oversight of Vulnerable Individuals –Integrated/Coordinated Care - Care coordination between the behavioral health and physical health providers will occur.						
Individuals receiving specialty care will have the recommendations of those providers incorporated into their behavioral health IPOS and a consent to share information. This will be reviewed via annual site reviews.	ICT	92.6%	95%	FY22 Annually Ongoing	Continue	
Behavioral Health Home (BHH) services will expand for individuals with at least 1 co-morbid physical health condition at the CMHSPs.	PHS	154 enrollees, 6 HHP's (Aug 2024)	175 enrollees	FY23 Monthly Ongoing	Continue	
Use health home data to create quality improvements within the programs and expand the programs appropriately.						
CMHSP's will expand the provision of H0034 – Medication Training and Supports, S9445 Patient Education individual, T1001 and T1002 RN/Nursing Services.	PHS			FY23 Annual Ongoing	Continue	Health Services Committee
NorthCare and UPHP will have bi-monthly data collaboration workgroup meetings to address shared member health care outcomes and gaps.	ICT	7603 unduplicated shared members (FY24Q1-3)		FY23 Bi-monthly Ongoing	Continue	
Individuals with high ER utilization, that are enrolled in MI Health Link, will reduce ER visits and increase preventative care by coordination between the PIHP and MHP.	ICT			FY23 Monthly Ongoing	Continue	
Transition of Care – Care will be coordinated when transitions are occurring.						
The Medicaid Health Plan (UPHP) will be notified of all psychiatric hospitalizations and discharges for shared members.	UM	100%	100%	FY23 Weekly Ongoing	Continue	PIHP-MHP Joint Care Protocol Workgroup
Individuals discharging from the psychiatric unit will have a follow up appointment within 7 days (see PI4a).	QI		95%	FY23 Quarterly Ongoing	Continue	MMBPIS
Waiver transitions to another PIHP area will be coordinated as they occur.	WC			FY24 PRN Ongoing	Continue	
Waiver Services – Ensure timely HSW recertifications and pended cases.						
NorthCare will provide ongoing monitoring to the CMH's about expiring cases.	W.C.			FY24 Monthly Ongoing	Continue	Result of performance issue

NorthCare will notify the CMH CEOs of data and data will also be shared in regional meetings.	W.C.			FY24 Monthly Ongoing	Continue	Result of performance issue
Review of service utilization specific for waiver services/waiver individuals	w.c.			FY25	start	

FY25 Satisfaction Survey Performance Improvement Project (PIP)

The FY25 non-HSAG validated, non-clinical Satisfaction Survey PIP is detailed in the following pages. The workgroup, comprised of CMH staff and NorthCare staff, has worked to develop an updated survey questionnaire and format. The survey is available electronically here: https://forms.microsoft.com/r/aE7sDR8GtL. Paper versions of the survey are still available, although electronic completion is encouraged. The standard operating procedure was updated to reflect the changes in the survey and process on 10.1.24. Use of the new survey began 10.7.24.

Name of Project: Satisfaction Survey Response	
Project Leader Name: Brittany Pietsch / Stacy Coleman	**Title:** Customer Service / Quality Improvement / Compliance
Phone Number: / 906-205-4347 /	**E-Mail Address:** bpietsch@northcarenetwork.org / scoleman@northcarenetwork.org

Type of Project:
☐ Clinical ☒ Non-Clinical ☐ Health ☐ Safety
☐ Required by ☐ Plan of Corrective as a Result of

Summary of Consumer Involvement (Identify consumer group, committee, etc. and how they are involved):

The Customer Services Committee, comprised of regional CMH Customer Services staff and PIHP representation meets quarterly. The Satisfaction Survey has been a topic of ongoing interest and concern in that group since 2021. Satisfaction Survey Response Rates have been and remain low, regardless of previous efforts to increase response rates. In July 2021, the survey was changed to an electronic format in Microsoft Forms hoping to increase response rates. The online form did not gain traction of use until December 2022. Most entries, however, are staff data entering paper survey responses. Overall rates of response are still low.

The Customer Services Committee will continue to be involved in a consultative nature for their input on format, editing/proofing of documents, and as a conduit for information to the rest of the CMH staff. The Regional Clinical Practices / Quality Improvement Committee will be informed of data updates. A Performance Improvement Project sub-workgroup will be the primary group formulating and implementing the PIP intervention strategies.

Substance Use Disorder (SUD) providers will also be updated regarding the PIP in regional SUD committee meetings. The satisfaction survey is currently available to track SUD service satisfaction, however, has not been promoted and had no formal process previously. As part of this PIP, SUD providers will be educated about the satisfaction survey and a process will be implemented to ensure SUD consumers are aware of the option to indicate satisfaction with providers. The updated survey, process, and expectation will be communicated via the regional SUD committee meetings.

Step I: Select the Study Topic PIP topics should target improvement in relevant areas of care/services and reflect the population in terms of demographic characteristics, prevalence of disease, and the potential risks. The goal of the project should be to improve processes and/or outcomes of health care or services.

The study topic should:

- Be selected following the collection and analysis of specific data.
- Have the potential to improve consumer health, functional status, or satisfaction.
- Be based on high-volume, high-risk, or problem-prone areas for which improvement is needed.

Study Topic:

Increased Data Regarding Satisfaction, Including an Increased Number of Satisfaction Survey Responses for those served by NorthCare Network at a Community Mental Health (CMH) provider or Substance Use Disorder (SUD) provider.

Provide specific data:

This Performance Improvement Project (PIP) was selected due to poor response rates to the current satisfaction survey over the past few years. The survey questions and method have changed over time with no improvement. Increased efforts to improve the response rate are necessary to ensure we are meeting the needs of individuals served in a satisfactory way.

Historically, the satisfaction survey was only available on paper. In June 2021, Microsoft Forms was used to make an online survey. When the survey was available solely on paper, the survey results were positive, but response rates were low. Reporting of data was also inconsistent, with some CMH's reporting data for Medicaid consumers, some reporting data for all consumers, and some not completing all fields for data reporting. The response rate in the table below is reflective of Medicaid consumers whenever available. Rates in green reflect total response rates of both Medicaid and non-Medicaid respondents. The satisfaction survey has not, and will not, be restrictive to insurance and neither will this PIP. Historical response rates for Medicaid vs. non-Medicaid individuals were similar. Data was not provided in Fiscal Year (FY)21. Since FY17 response rates have been around 19%.

	FY17			FY18			FY19			FY20			FY21			FY22			Avg
	Mailed	Returned	Rate	Mailed	Returned	Rate	Mailed	Returned	Rate	Mailed	Returned	Rate	Mailed	Returned	Rate	Mailed	Returned	Rate	
Copper	817	196	24.0%	797	173	21.7%	913	182	19.9%	763	162	21.2%				856	143	16.7%	19.0%
Gogebic	354	68	19.2%	363	79	21.8%	389	65	16.7%	376	63	16.7%				373	65	17.4%	18.4%
Hiawatha	485	85	17.5%	775	133	17.2%	997	293	29.4%				1032	220	21.3%	758	201	26.8%	21.3%
Northpointe	1210	227	18.8%	1179	239	20.3%	1069	213	19.9%	1315	207	15.7%	991	150	15.1%	1311	113	8.6%	16.6%
Pathways	1873	242	12.9%	1739	310	17.8%	1526	224	14.7%	1463	228	15.6%				1639	208	12.7%	14.7%

In FY21, the data moved to the Microsoft Forms document for data collection but did not gain traction until FY23. With the option to take the survey via paper or complete it online, it is not possible to determine a rate of response; instead, it is only possible to determine the number of respondents. This process does not allow for determining how many surveys are data entered by staff receiving answers

on paper verse surveys submitted directly from individuals served/guardians electronically. The online form allows individuals to complete the survey even if it was not mailed to them.

For FY23, there were 702 responses. When compared to FY19, which had 796 responses, FY18 with 921 responses, and FY17 with 818 responses, there does not appear to be any improvement in response rates given the electronic format. In FY23, there were 114 responses for Copper Country CMH, 53 for Gogebic, 212 for Hiawatha, 89 for Northpointe, and 224 for Pathways CMH.

	21				22												23												24		Total
	Jun	Jul	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	
#	1	3	1	1	1	1	7	2	3	2	6	4	1	1	12	76	85	50	76	112	65	58	48	56	56	28	44	24	41	10	875

Many of the responses were data entered by staff following receiving the paper copy of the electronic version back. Some of the confusion may be related to the branching on the electronic survey that does not translate well to paper. Based on responses, individuals do not fully understand how to complete the survey via the Microsoft Forms template. For example, individuals have selected that they are reporting on SUD services but then select the CMH as the provider and indicate that they are reporting satisfaction about services related to their serious mental illness but do not select that they have a co-occurring SUD disorder. This speaks to the need to revise the survey questions and the process. There were two responses that indicated they were reporting satisfaction on a SUD treatment provider.

This Performance Improvement Project (PIP) will be implemented in three phases.

- Phase 1: Development – FY24-FY25
    - Phase 1 will consist of Clinical and Customer Service staff developing survey questions applicable, measurable, and easily understood. Standardized survey questions will be utilized whenever possible. The procedure/process for survey dissemination will also be reviewed and updated to maximize utility of the survey methods. Clearer expectations regarding who is surveyed (guardian and consumers) and the frequency and situation of survey will be identified (e.g., survey for planned and unplanned discharges).
        - Applies to CMH and SUD
    - IT will develop a report to pull data from the current Electronic Medical Record (EMR) progress notes, Individual Plan of Service (IPOS), and periodic review which has a section embedded in it addressing satisfaction. The data report will reflect how many progress notes reflect a response each time and if that response was positive or negative, and how many have no response. While this is not a full satisfaction survey, it is another source of satisfaction data available to be completed. *Not Measured in PIP data – but information from survey responses will be used to inform practice.
        - Applies to CMH
    - CMH and SUD provider staff will be educated on the survey, how to help consumers access the survey, and the goal of this PIP. Staff will also be educated about grievances and given information about filing a grievance that they can provide to individuals served who express dissatisfaction.
        - Applies to CMH and SUD

- Complaints in areas related to questions addressed on the satisfaction survey will be reviewed as additional information for the implementation of the project and any potential interventions necessary.
    - Applies to CMH and SUD

- Phase 2: Growth FY25-FY26
    - Information Technology (IT) staff will take the developed survey questions and will implement the questions into the ELMER, the Electronic Medical Record, as part of the pre-planning process. Case Managers will offer the survey as part of the person-centered planning process. Those individuals brand new to the system with only a preliminary IPOS will not receive a survey until they complete the pre-plan or survey information will be sent to them as part of discharge mailing if they drop out of services before a pre-plan is completed. *Measured – Denominator = number of IPOS completed in a measurement period. Numerator = number completed/returned.
        - Applies to CMH
    - IT will develop a link that can be sent to consumers via text message or email (*optional)* to prompt rating their visit and/or taking the satisfaction survey following a service. This point-in-time satisfaction assessment would be available to anyone who signed up to receive these messages. The rate your visit question would be a simple 5-star rating, with a text prompt similar to the following: “Please leave a review of your appointment.” Below the star selection, the full satisfaction survey link would be available: “If you would like to take the full satisfaction survey, please click here.” *Measured – Denominator = number texts sent. Numerator = number responses (5 star rating) AND Denominator = number texts sent. Numerator = number responses (linked to survey).
        - Applies to CMH
    - IT will develop a Quick Response (QR) code to be printed on posters and cards for the waiting rooms/ provider lobbies. Posters and cards will be created by NorthCare Customer Services and provided to the CMH and SUD provider agencies with the QR code. The QR code will take the individual to the satisfaction survey. *Not Measured in PIP data – but information from survey responses will be used to inform practice.
        - Applies to CMH and SUD
    - Links to the survey will be posted on the NorthCare Network website and Facebook page. Each provider will also be encouraged to link this on their website with the results going to NorthCare. *Not Measured in PIP data – but information from survey responses will be used to inform practice.
        - Applies to CMH and SUD
    - IT will develop a report to indicate the number of text reminders sent vs. received.
        - Applies to CMH
    - IT will develop a report to pull the satisfaction data from the document completed during the pre-planning process.
        - Applies to CMH
    - IT will develop a report to pull the satisfaction data from the progress notes. The report will be structured to indicate the provider agency, program, and individual providers to allow for filtering and data analysis. The report will either be able to be run by provider agency or NorthCare will parse out the data for each provider agency if its not possible to run by

provider agency. *Not Measured in PIP data – but information from survey responses will be used to inform practice.
    - Applies to CMH
- Phase 3: Expansion – FY27
    - CMH and SUD provider waiting rooms/lobbies will have an iPad or kiosk available for consumers to rate their visit, and/or complete the satisfaction survey when leaving the office. Consumers will be able to rate if they desired. *Not Measured in PIP data – but information from survey responses will be used to inform practice.
        - Applies to CMH and SUD

For all three phases, data will be evaluated and analyzed to assess improvement and ongoing barriers.

Describe how the study topic has the potential to improve consumer health, functional status, or satisfaction:
Individuals who are dissatisfied are less likely to engage with a treatment provider. Collaboration between individuals served and providers improves health outcomes by increasing engagement and adherence to treatment recommendations. Motivation to collaborate is decreased if individuals served are not satisfied with their provider or the services provided. One way for providers to be aware of what individuals served want is to assess for satisfaction.[1]

As true with any survey, behavioral health surveys allow the surveyor to build rapport with the surveyed and provide education and support if dissatisfaction is expressed to the provider during a meeting. Surveys identify what is, and what is not, working well. Surveys help identify new opportunities for improvement and aid in making informed decisions about potential changes. Past survey data, while minimal in rate, has resulted in changes of contracted providers for specific services.

NorthCare is starting at a baseline of approximately 18% given an average of known data points since FY17. This number is a very rough approximation given missing data. According to Delighted[2], by Qualtrics survey response rates vary widely depending on method and how “on brand” a survey is. Generally, they saw an average response rate of 33% and consider a rate over 20% to be a good response rate. Xola[3] agrees that 33% is an average response rate. Delighted data reflected that email surveys had the lowest response rate of 6% while in-app response rates were 16%. They only measured electronic methods. However, resources also reflect on the importance of timing with a survey. Requesting survey responses while the event is fresh in peoples minds and is easily identifiable as to what the survey is about is important. Xola broke down survey responses by method and had different findings. They also noted a 17% drop in response rates if the survey was more than 12 questions and warned against creating surveys longer than 15 questions.

- In person – 57%
- Mail – 50%
- Email – 30%
- Online – 29%
- Phone – 18%
- In-app – 13%

Nigel Lindemann from Pointerpro[4], suggests enhancing the user experience by making the survey fun such as linking to a chance to win some kind of incentive, is easy and quick to navigate, and ensure it is

mobile friendly (e.g. no horizontal scrolling). He recommends limiting the number of surveys to once a month for individuals with a long-standing good relationship and encourages the use of a peer-review of the survey to ensure it is understandable to those it is marketed to. He also encourages a live person to respond to survey questions/concerns, acting on results, and publishing results with said actions to be transparent and increase potential future survey responses.

1. What Do Patients Want? Patient Satisfaction and Treatment Engagement - The Wiley Handbook of Healthcare Treatment Engagement - Wiley Online Library
2. What is a good survey response rate for customer surveys in 2022? (delighted.com)
3. Survey Benchmarks: What's a good survey response rate? - Xola
4. 36 Ways to improve your survey response rate - Pointerpro

Step II: Define the Study Question(s) Stating the question(s) helps maintain the focus of the PIP and sets the framework for data collection, Analysis, and interpretation.

The Study Question(s) should:

- Answer: "Does doing X result in Y?"
- State the problem in clear and simple terms.
- Be answerable based on the data collection methodology and study indicator(s) provided.

Study Question(s):

1. Did the development of better survey questions and clearer expectations increase the number of surveys completed?
    a. Compare number of survey responses pre and post intervention by region
2. Do modern methods of survey completion (e.g., text reminders, iPads available in waiting rooms) and education about survey availability (e.g., posters) improve satisfaction survey response rates?
    a. Compare the number of surveys responded to via text reminder and iPad/kiosk to overall number of responses.

Step III: Use a Representative and Generalizable Study Population. The study population should be clearly defined to represent the population to which the study question and indicators apply.

The study population definition should:

- Include the requirements for the length of enrollment, defining continuous enrollment, new enrollment, and allowable gaps in enrollment.
- Include the complete age range of the study population and the anchor dates used to identify age criteria, if applicable.
- Clearly define the inclusion, exclusion, and diagnosis criteria.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify consumers, if applicable.
- Capture all consumers to whom the study question(s) applies.
- Include how race/ethnicity will be identified, if applicable.

Study Population:
All individuals served, including parents of young children and guardians for those who have a designated guardian. Children old enough to complete the survey (14+) and individuals with guardians will be encouraged to complete the survey in addition to the consenting party*.

*consenting party- the parent of the minor child or the guardian of an adult.

Consumer enrollment requirements:
There are no enrollment requirements. Survey responses for SUD treatment providers will be separated from survey responses for CMHSP providers.

Consumer age criteria (if applicable):
NA

Inclusion, exclusion, and diagnosis criteria:
NA

Diagnosis/procedure/pharmacy/billing codes (if applicable):
NA

Activity IV: Select the Study Indicator(s) The selected indicators(s) should track performance or improvement over time; they should be objective, clearly defined, measurable and based on current clinical knowledge or health services research.

The description of the study indicator(s) should include:

- the complete title of the study indicator(s).
- complete descriptions of numerators and denominators.
- reference if the indicator(s) is a nationally recognized measure, i.e., HEDIS, including the year of the HEDIS technical specifications used.

• complete dates for all measurement periods. • plan-specific goals for the remeasurement periods.	
Study Indicator #1 *(Enter title of indicator)* Regionally, Increase the Number of Satisfaction Survey Responses evaluating the CMHSP providers.	*(Provide narrative description and the rationale for selecting the study indicator. Describe the basis on which each indicator was adopted, if internally developed).*
Numerator Description	All individuals completing the survey via ELMER/paper/Electronic form (any method) during the measurement period. *Individuals will be offered a satisfaction survey as part of the person-centered planning process. Individuals can complete the survey with their case manager at the time or be given a hard copy of the survey to fill out and return later. They can also find survey information online and on posters. Any completed/returned surveys are the numerator. PIP measured regionally (all responses regardless of CMH provider).
Denominator Description	All individuals completing an IPOS during the measurement period across the PIHP region. *Individuals will be offered a satisfaction survey as part of the person-centered planning process. Therefore, these are our denominator.
Baseline Period	FY25
Remeasurement 1 Period	FY26
Remeasurement 1 Goal	5% increase over number of responses in baseline period
Remeasurement 2 Period	FY27
Remeasurement 2 Goal	10% increase over baseline period

Study Indicator #2 *(Enter title of indicator)* Regionally, Increase the Number of Satisfaction Survey Responses evaluating the CMHSP providers.	*(Provide narrative description and the rationale for selecting the study indicator. Describe the basis on which each indicator was adopted, if internally developed).*
Numerator Description	All individuals completing the satisfaction questions via text during the measurement period. The text will (hopefully) have the ability to rate the visit today (out of 5 stars) and a link to a survey link for the satisfaction survey. Both will be measured, separately Numerator 1: the number of satisfaction responses giving a starred rating Numerator 2: the number of satisfaction survey responses following a request sent via text message (this link will be different than the link to the QR

	codes or other methods of accessing the survey, but the survey questions will be the same).
Denominator Description	The number of satisfaction related text messages sent during the measurement period.
Baseline Period	FY25 (likely later in the year – partial year measurement)
Remeasurement 1 Period	FY26
Remeasurement 1 Goal	5% increase over number of responses in baseline period
Remeasurement 2 Period	FY27
Remeasurement 2 Goal	10% increase over baseline period

Study Indicator #3 *(Enter title of indicator)* Begin to receive satisfaction data from SUD providers.	*(Provide narrative description and the rationale for selecting the study indicator. Describe the basis on which each indicator was adopted, if internally developed).*
Numerator Description	Provide paper surveys, a special QR code, and weblink to SUD providers. Questions are the same but will identify as responding to SUD program.
Denominator Description	As anyone could have access – aim is to receive responses.
Baseline Period	FY25
Remeasurement 1 Period	FY26
Remeasurement 1 Goal	5% more surveys returned/completed over baseline period
Remeasurement 2 Period	FY27
Remeasurement 2 Goal	10% more surveys returned/completed over baseline period

Step V: Use Sound Sampling Techniques. If sampling is to be used to select consumers of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling techniques should be in accordance with accepted principles of research design and statistical analysis. Representative sampling techniques should be used to ensure generalizable information.

The description of the sampling methods should:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each study indicator.
- Include a detailed narrative description of the methods used to select the sample.

Measurement Period	Study Indicator	Population Size	Sample Size	Margin of Error and Confidence Level

Describe in detail the methods used to select the sample:

NA – Sampling is not used.

Activity VI: Reliably Collect Data. The data collection methods must ensure that data collected on the study indicators are valid and reliable.

Data collection methodology should include the following:

- Identification of data elements and data sources.
- When and how data is collected.
- How data is used to calculate the study indicators.
- How data is analyzed.

Data Sources (Select all that apply).

☒ Clinical Record Abstraction ☒ Elmer ☐ Other_____. To determine the number of individuals served by each provider.	☒ Administrative Data ☒ Programmed pull from claims/encounters ☒ Complaint/Appeal ☐ UPHP Data ☐ Care Connect 360/CMT Data ☐ Diver Data ☐ Phone System Data ☒ Appointment/Access Data ☐ Provider Data ☐ Other_____ For those with text prompts, prompt will be based on calendar entry or Service Activity Log (SAL) Complaints related to any item assessed on the satisfaction survey will be reviewed as additional information to the PIP.	☒ Survey Data ☒ Personal interview ☒ Mail ☐ Phone with script ☒ Internet ☒____ kiosk
Other Requirements: ☐ Data collection tool attached ☐ Data collection instructions attached ☐ Data collection training summary attached ☐ Other _____	Other Requirements: ☐ Codes used to identify data elements, i.e., HCPCS, ICD,etc._____ ____ ☐ Data completeness assessment attached ☐ Coding verification process attached ☐ Quality control process attached Estimated % of data completeness: ____	Other Requirements: ☐ Number of waves_____ ☐ Response rate_____ ☐ Incentives used_____
☐ Manual Data Collection: Collection Staff: Staff Training/Experience: Staff Qualifications:	Describe the process used to determine data completeness:	

Determine the data collection cycle.	Determine the data analysis cycle.
☐ Once a year ☐ Twice a year ☐ Once a season ☐ Once a quarter ☒ Once a month ☐ Once a week ☐ Once a day ☐ Continuous ☐ Other (list and describe):	☒ Once a year ☐ Once a season ☐ Once a quarter ☐ Once a month ☐ Continuous ☐ Other (list and describe):

Step VII: Data analysis plan and other methodological features.

- Include the type of statistical testing to be used to compare study indicator results between baseline and the most recent remeasurement period and between each remeasurement period, details of how data will be analyzed, and how the rates compare to stated goal/ benchmark.
- Include clear definitions of the data elements to be collected.
- Include a systematic process with an ordered sequence of steps. Each step dependent on the outcome of the previous step. Can use narrative or algorithms/flow charts.

Describe the data analysis plan:

Survey responses received will be reviewed and shared with the appropriate provider monthly. Data will be analyzed for the PIP at least annually, up to quarterly, based on rate of response. Deidentified data will be shared with various committees including the Customer Services Committee, Clinical Practices/Quality Improvement, and the PIP workgroup (for as long as it is operational).

Statistical Testing:

- The number of responses pre-baseline will be compared with the number of responses during baseline.
- The number of baseline responses will be compared with the number of remeasurement one responses.
- The number of remeasurement two responses will be compared to remeasurement one responses as well as to baseline responses.
- The percent increase/decrease between each measurement period will be calculated and compared to goal percent.
- Statistical significance will be determined.
- The increase/decrease will be plotted on a graph.
- Analysis will be conducted to the responses to individual survey questions to identify any of the following which may suggest survey question reform is necessary.
    - Frequently skipped or unanswered questions
    - Frequent NA response questions
- Analysis will be conducted regarding the content of the survey questions and written responses and addressed accordingly (beyond the scope of this PIP).

Definitions:

- Pre-baseline: All historical satisfaction data prior to FY25 (10.1.24)
- Baseline: All satisfaction data in FY25 (10.1.24-9.30.25).
- Remeasurement 1: All satisfaction data in FY26 (10.1.25-9.30.26)
- Remeasurement 2: All satisfaction data in FY27 (10.1.26-9.30.27)
- Satisfaction data: a combination of Satisfaction Survey data (full survey) and *rate your visit* data.
- Satisfaction Survey: a multiple question survey rating satisfaction to be completed by individuals served and/or their parent/guardian.
- Rate Your Visit: a single Likert scale question asking individuals served and/or their parent/guardian to rate their experience for that service/provider.

Describe the data collection process:

Survey responses will be obtained in various methods. The method determines if a full Satisfaction Survey or a Rate Your Visit response is elicited. Individuals can complete the survey on an iPad in the office, on their smartphone via a link sent to them via text post appointment, via QR code available on posters positioned in waiting rooms, or via link on NorthCare's website. Individuals desiring a paper copy of the form will be provided with such a form. Staff can encourage completion of the satisfaction survey and provide the form with a return envelope during the annual person-centered planning process and possibly at other times of review; such as the IPOS periodic review or IPOS amendment. The paper form responses will be data entered into the system by Customer Services at CMH or by NorthCare Network.

Step VII: Data Analysis and Interpretation of Results. Clearly present the results of the study indicator(s). Enter results for each study indicator – including the goals, statistical testing, etc.						
Study Indicator 1 Title:						
Time Period	**Measurement**	**Numerator**	**Denominator**	**Results**	**Goal**	**Statistical Test, Statistical Signifi-cance, *p* value**
10/1/24 - 9/30/25	*Baseline*					
10/1/25 - 9/30/26	Remeasurement 1					
10/1/26 - 9/30/27	Remeasurement 2					
If necessary	Remeasurement 3					

Study Indicator 2 Title:						
Time Period	**Measurement**	**Numerator**	**Denominator**	**Results**	**Goal**	**Statistical Test, Statistical Signifi-cance, *p* value**
10/1/24 - 9/30/25	*Baseline*					
10/1/25 - 9/30/26	Remeasurement 1					
10/1/26 - 9/30/27	Remeasurement 2					
If necessary	Remeasurement 3					

Study Indicator 3 Title:						
Time Period	**Measurement**	**Numerator**	**Denominator**	**Results**	**Goal**	**Statistical Test, Statistical Signifi-cance, *p* value**
10/1/24 - 9/30/25	*Baseline*					
10/1/25 - 9/30/26	Remeasurement 1					
10/1/26 - 9/30/27	Remeasurement 2					
If necessary	Remeasurement 3					

Step VII: Data Analysis and Interpretation of Results. Clearly present the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis and interpret the findings. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Summarize the data analysis process conducted on the selected study indicators, including the statistical testing performed and the *p* values calculated to four decimal places (i.e., 0.0235).
- A description of the results for the statistical analysis, an interpretation of the findings, and a comparison of the results/changes from measurement period to measurement period, including a comparison to the goal.
- Identification of any factors that could influence the comparability of measurement periods or the validity of the findings for each measurement period.
- Address any random, year-to-year variations, population changes, sampling errors, or statistically significant increases or decreases that may have occurred during the remeasurement process.

- Address the extent to which the PIP was successful, and any follow-up activities planned.

Describe the data analysis process and provide an interpretation of the results for each measurement period.

Baseline Measurement: FY25

Remeasurement 1: FY26

Remeasurement 2: FY27

Step VIII: Improvement Strategies (interventions for improvement because of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify them and evaluate their effectiveness. Do not include intervention planning activities.

This activity will include the following:

- Pre-baseline interventions.
- Baseline and remeasurement barriers/interventions.
- The processes used to identify barriers/interventions and to evaluate the effectiveness of the interventions.

Pre-Baseline Interventions: If interventions were implemented prior to the start of the baseline period, please enter each intervention in the table below. If not, please enter "not applicable" in the first row of the Pre-Baseline table.

Date Implemented (MM/YY)	Pre-Baseline Interventions
January 2021	Updated satisfaction survey questions and scoring. Previous scoring ranked on a 4-point scale. A neutral category was added. Questions were updated in the following ways:

Satisfaction Survey Questions	
1. Appointments are scheduled at times that work best for me.	1. Appointments are scheduled at times that work best for me.
2. I am informed of my rights.	2. I am informed of my rights as a Community Mental Health (CMH)or Substance Use Disorder (SUD) service recipient.
3. I feel better because of the services received.	3. I feel welcome and comfortable where I receive services.
4. I know what to do if I have a concern or complaint.	4. Staff speak in ways I can understand easily.
5. Staff are sensitive to my cultural/ethnic background.	5. I know what to do if I have a concern or complaint.
6. I was able to get the type of services I needed.	6. Staff are sensitive to my cultural/ethnic and spiritual background.
7. My wishes about who is and who is not *given information* about my treatment are respected.	7. Staff are sensitive when I am discussing my past.
8. My wishes about who is and who is not *involved* in my treatment are respected.	8. I am aware of the types of services available.
9. I am satisfied with the telephone crisis service when calling the crisis line after 5pm on weekdays and/or on weekends.	9. I was able to get the type of services I feel I needed.
10. I would recommend these services to a friend or relative.	10. My wishes about who is and who is not *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.

<table>
<tr><td></td><td>
<table>
<tr><td></td><td>13. I am satisfied with the telephone crisis service when calling the crisis line after 5 p.m. on weekdays and/or on weekends.</td></tr>
<tr><td></td><td>14. I can communicate with my CMH/SUD provider easily.</td></tr>
<tr><td></td><td>15. I would recommend these services to a friend or relative.</td></tr>
<tr><td colspan="2">Recovery Specific Questions</td></tr>
<tr><td>I am hopeful about my future.</td><td>I am hopeful about my future.</td></tr>
<tr><td>I am willing to ask for help.</td><td>I am willing to ask for help.</td></tr>
<tr><td>I believe that I can meet my current personal goals.</td><td>I believe that I can meet my current personal goals.</td></tr>
<tr><td>I have people I can count on.</td><td>I have people I can count on.</td></tr>
<tr><td>Coping with my mental illness is no longer the focus of my life.</td><td>I feel coping with my mental illness is easier to do now than it was when I began services.</td></tr>
<tr><td>My symptoms interfere less and less with my life.</td><td>My symptoms interfere less and less with my life.</td></tr>
<tr><td>My services and supports from Community Mental Health are helping me in my recovery.</td><td>My services and supports from Community Mental Health or Substance Use Provider are helping me in my recovery.</td></tr>
</table>
</td></tr>
<tr><td>July 2021</td><td>Implemented an electronic Microsoft Form to try to capture data in an electronic method</td></tr>
<tr><td>May 2024</td><td>Started reformulation of survey questions in May 2024 via a CMH led PIP workgroup. The group reviewed questions from the following surveys to develop the new satisfaction survey. The neutral category and NA were removed. The questions were changed. The updated format was created and the questions were placed in Microsoft Forms. Questions were finalized in August 2024. Questions were developed using the following sources:
The NorthCare satisfaction survey at the time
YSSF Parent Survey: sbcounty.gov/uploads/DBH/2022/04/cps/ENG/YSSF_PARENT_EN_Spring2022.pdf
BHSS Annual Survey: BHSS_Annual Report_FY17_20180221_REQ1011 (002) - FINAL.pdf (dc.gov)
TPS Adult Survey: uclaisap.org/dmc-ods-eval/assets/documents/TPS/v10/Adult/TPS-Adult-V10-EN.pdf
The workgroup identified 4 categories of satisfaction questions; comfort (1-2), planning (3-5), goal progress (6-9), and staff presentation/assistance (10-14). The new questions are as follows:</td></tr>
</table>

AGENCY NAME ON HEADER

Satisfaction Questions

Hello! We want to ensure we are providing you with the services you want. Your responses will help shape our improvement efforts. Please complete this brief form. Thank you for your response. If you need help completing this, please contact Customer Service at 906-225-7254 or 1-888-333-8030.

Where did you hear about this questionnaire?

☐ Website/Social ☐ Agency Staff ☐ Waiting Room ☐ Poster ☐ Text Message ☐ Other: _____

Please indicate your relationship to the person receiving services.

☐ Myself ☐ Parent/Guardian of a minor (under 18) ☐ Guardian of an adult

Service / Staff I am reporting satisfaction on: _____

	Check the box that best reflects your level of satisfaction.	**Strongly Agree** ★★★★	**Agree** ★★★	**Disagree** ★★	**Strongly Disagree** ★
1	I know where to voice concerns about services and feel safe doing so.				
2	Appointments and services are available at times that work well for me.				
3	Staff included me in making decisions and let me pick my goals.				
4	I chose who was involved in developing my plan with me.				
5	I had a chance to review and make changes to my plan.				
6	I know what to do if I am in crisis.				
7	Services have helped me.				
8	I am better able to do the things I want to do because of services I have received.				
9	I have learned skills to handle difficult times.				
10	Staff are welcoming and make me feel comfortable.				
11	Staff have helped me reach my goals and/or work towards reaching them.				
12	I was told about services that are available.				
13	Staff coordinate care with my doctors and agencies I use.				
14	Staff helped me find supports outside of my current services when needed.				
15	I am satisfied with the services I receive here.				

Additional Comments:

_____

_____

_____

If you would like to be contacted about this survey, please indicate your name and phone number below.

Name: _____ Phone: _____

Step VIII Continued:

Baseline Interventions: If interventions were implemented during the baseline period, describe the process used to identify barriers and the process to develop the corresponding interventions for the baseline measurement period. Please include the team/committee/group that conducted the causal/barrier analysis and any QI tools that were used to identify barriers such as data mining, fishbone diagram, process level data, etc. Describe the process used to prioritize the barriers. Lastly, describe the process that will be used to evaluate the effectiveness of each intervention. If interventions were not implemented during the baseline period, please enter "not applicable" in the first row of the baseline table below.

For each remeasurement period, copy the ongoing interventions from the previous measurement period to the current remeasurement table and select whether the intervention was (1) new, continued, or revised, and (2) consumer, provider, or system.

Date Implemented (MM/YY)	Note if Consumer, Provider, or System Intervention	Baseline Barriers	Baseline Intervention That Addresses the Barrier Listed in the Previous Column
10/1/24 - 9/30/25			

Step VIII Continued:

Remeasurement 1 Interventions: In the space below, describe the process used to identify barriers and the process to develop the corresponding interventions for the Remeasurement 1 period. Please include the team/committee/group that conducted the causal/barrier analysis and any QI tools that were used to identify barriers such as data mining, fishbone diagram, process level data, etc. Describe the process used to prioritize the barriers. In addition, describe the process used to determine if existing interventions were continued, revised, or discontinued. Lastly, describe the process that will be used to evaluate the effectiveness of each intervention.

Date Implemented (MM/YY)	Note if Continued, New, or Revised	Note if Consumer, Provider, or System Intervention	Remeasurement 1 Barriers	Baseline Intervention That Addresses the Barrier Listed in the Previous Column
10/1/25 – 9/30/26				

Step VIII Continued:

Remeasurement 2 Interventions: In the space below, describe the process used to identify barriers and the process to develop the corresponding interventions for the Remeasurement 2 period. Please

include the team/committee/group that conducted the causal/barrier analysis and any QI tools that were used to identify barriers such as data mining, fishbone diagram, process level data, etc. Describe the process used to prioritize the barriers. In addition, describe the process used to determine if existing interventions were continued, revised, or discontinued. Lastly, describe the process that will be used to evaluate the effectiveness of each intervention.

Date Implemented (MM/YY)	Note if Continued, New, or Revised	Note if Consumer, Provider, or System Intervention	Remeasurement 2 Barriers	Baseline Intervention That Addresses the Barrier Listed in the Previous Column
10/1/26 – 9/30/27				

Step VIII Continued:

<u>Remeasurement 3 Interventions:</u> In the space below, describe the process used to identify barriers and the process to develop the corresponding interventions for the Remeasurement 3 period. Please include the team/committee/group that conducted the causal/barrier analysis and any QI tools that were used to identify barriers such as data mining, fishbone diagram, process level data, etc. Describe the process used to prioritize the barriers. In addition, describe the process used to determine if existing interventions were continued, revised, or discontinued. Lastly, describe the process that will be used to evaluate the effectiveness of each intervention.

Date Implemented (MM/YY)	Note if Continued, New, or Revised	Note if Consumer, Provider, or System Intervention	Remeasurement 3Barriers	Baseline Intervention That Addresses the Barrier Listed in the Previous Column

Step IX: Assess for Real Improvement. Enter results for each study indicator, including benchmarks and statistical testing with complete *p* values, and statistical significance.

Quantifiable Measure 1 – Title of Indicator:

Measurement Time Period	Measurement	Numerator	Denominator	Results	Industry Benchmark	Statistical Test Significance and *p* value
10/1/24 - 9/30/25	Baseline					
10/1/25 – 9/30/26	Remeasurement 1					
10/1/26 – 9/30/27	Remeasurement 2					
If necessary	Remeasurement 3					

Step IX Continued:

Quantifiable Measure 2 – Title of Indicator:

Measurement Time Period	Measurement	Numerator	Denominator	Results	Industry Benchmark	Statistical Test Significance and *p* value
10/1/24 - 9/30/25	Baseline					
10/1/25 – 9/30/26	Remeasurement 1					
10/1/26 – 9/30/27	Remeasurement 2					
If necessary	Remeasurement 3					

Step IX Continued:						
Quantifiable Measure 3 – Title of Indicator:						
Measurement Time Period	**Measurement**	**Numerator**	**Denominator**	**Results**	**Industry Benchmark**	**Statistical Test Significance and *p* value**
10/1/24 - 9/30/25	Baseline					
10/1/25 – 9/30/26	Remeasurement 1					
10/1/26 – 9/30/27	Remeasurement 2					
If necessary	Remeasurement 3					

Step IX: Continued – Assess for Real Improvement – Address the results for each study indicator in a narrative below. Include benchmarks and statistical testing and statistical significance.

Baseline Compared to Remeasurement 1:

Remeasurement 1 Compared to Remeasurement 2:

Remeasurement 2 Compared to Remeasurement 3:

Overall Comparison of Baseline to Remeasurement 3:

Step X: Assessment for Sustained Improvement – Re-evaluate performance. Identify time used for re-evaluation. Describe any demonstrated improvement through repeated measurement over comparable time periods, address any random year-to-year variations, population changes, sampling errors, or statistically significant declines that may have occurred during the re-evaluation process. address any continuing monitoring or interventions needed to ensure sustained improvement.

Re-evaluation Period: MM/DD/YYYY – MM/DD/YYYY

Overall Comparison of Baseline to Re-evaluation Period for each Indicator.