QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM (QAPIP)

FY24 QAPIP Annual Effectiveness Review

Prepared by LRE Transitioning Quality Manager: March 18, 2025

Reviewed by LRE Executive Team: March 24, 2025

Reviewed by LRE Board of Directors: March 26, 2025

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I. INTRODUCTION

Lakeshore Regional Entity (LRE) is a regional entity, designated as Region 3, under Section 1204(b) of the Michigan Mental Health Code and responsible for the financial and administrative management of Behavioral Health, Mental Health and Substance Use Disorder Services for adults and children who reside in one of our seven (7) county areas: Kent, Muskegon, Ottawa, Oceana, Lake, Mason, and Allegan.

This document fulfills the evaluation requirement for the annual Quality Assessment and Performance Improvement Program (QAPIP) as set forth in the PIHP/MDHHS Medicaid Managed Specialty Supports and Services Program Contract Attachment and the MDHHS Policy - QAPIP for Specialty Prepaid Inpatient Health Plans.

II. PURPOSE

In addition to meeting contractual requirements, the Fiscal Year 2024 (FY24) Annual QAPIP Review evaluates LRE's performance on each QAPIP component ensuring that LRE monitors all QAPIP components as well as deploying Quality Improvement (QI) Processes when performance improvement is required.

Specifically, LRE monitors and evaluates each of the following QAPIP components, at a minimum:

<u>Michigan Mission Based Performance Indicator System (MMBPIS)</u>

1) Performance Improvement Projects (PIPs)
2) Critical Incidents (CI)
3) Risk Events (RE)
4) Sentinel Events (SE)
5) Unexpected Deaths (UD)
6) Immediate Event Notifications
7) Behavior Treatment Reviews (BTR)
8) Consumer Experience Assessment
9) Clinical Practice Guidelines (CPGs)
10) Credentialing
11) Staff Training and Development
12) Medicaid Services Verification (MEV)
13) Utilization Management (UM)
14) Oversight of Provider Network
15) Long Term Services and Supports (LTSS)

LRE's Annual FY24 QAPIP Annual Effectiveness Review (AER) will discuss each component one at a time.

III. PERFORMANCE INDICATORS

Michigan Mission Based Performance Indicator System

Michigan Department of Health and Human Services (MDHHS) mandates compliance with established measures related to access, efficiency, and outcomes. MDHHS' established measures are known as the Michigan Mission Based Performance Indicator System (MMBPIS).

LRE MMBPIS data to MDHHS quarterly, which consist of the following 20 metrics, also known as indicators:

	MMBPIS INDICATORS		
Indicator #	***Description***	***Threshold***	***Populations***
Indicator 1	Percentage Who Received a Prescreen within 3 Hours of Request	≥ 95%	Child/Adult
Indicator 2a	Percentage of New Persons during the Quarter Receiving a Completed Biopsychosocial Assessment within 14 Calendar Days of a Non-emergency Request for Service	*50th Percentile = 57.0%. 75th Percentile = 62.0%.*	MI Child/Adult DD Child/Adult Total
Indicator 2e	Percentage of New Persons during the Quarter Receiving a Face-to-Face Service for Treatment or Supports within 14 Calendar Days of a Non-emergency Request for Service for Persons with Substance Use Disorders	*50th Percentile = 68.2%. 75th Percentile = 75.3%.*	SUD
Indicator 3	Percentage of New Persons During the Quarter Starting any Medically Necessary On-going Covered Service within 14 days of Completing a Non-emergent Biopsychosocial Assessment	*50th Percentile = 72.9%. 75th Percentile = 83.8%.*	MI Child/Adult DD Child/Adult Total
Indicator 4a	Follow-Up within 7 Days of Discharge from a Psychiatric Unit	≥ 95%	Child/Adult
Indicator 4b	Follow-Up within 7 Days of Discharge from a from a SUD Detox Unit	≥ 95%	SUD
Indicator 5	% of Area Medicaid Having Received PIHP Managed Services	None	All
Indicator 6	% of HSW Enrollees in Quarter who Received at Least 1 HSW Service Each Month other than Support Coordination	None	All
Indicator 10	Re-admission to Psychiatric Unit within 30 Days	≤ 15%	Child/Adult

LRE's FY24 MMBPIS goal was to meet or exceed all MMBPIS Indicators for which MDHHS has established a threshold. MDHHS established new benchmarks starting Oct 1, 2023, for Indicators 2, 2e and 3. MDHHS established benchmarks are based on the statewide aggregate data reported in FY2022. The following MDHHS criteria for benchmarks effective in FY24 are as follows for all three indicators:

1. If PIHP's 2022 data was below the 50th percentile they will be expected to reach or exceed the FY2022 50th percentile.
2. If PIHP's 2022 data was in the 50th-75th percentile of the benchmark they will be expected to reach or exceed the FY22 75th Percentile.
3. If PIHP's 2022 data was above the FY22 75th percentile they are expected to maintain their level of performance.

Based on the above criteria, LRE's FY24 benchmarks for MMBPIS Indicator 2, 2e and 3 are as follows:

Indicator 2: 62.0%
Indicator 2e: 68.2%
Indicator 3: 72.9%

In FY24, LRE implemented a comprehensive Microsoft® Power BI Dashboard for the MMBPIS Indicators, which has improved efficiencies in data analysis and reporting. LRE has used this data analysis tool to identify issues and trends. The MMBPIS Power BI Dashboard has also been made available to appropriate staff at the five CMHSPs in our Region.

The MMBPIS Dashboard below shows Lakeshore Regional Entity's MMBPIS Performance Indicator scores per quarter per indicator for FY 2024. Scores in green indicate the MDHHS Standard was met, data highlighted in red indicate noncompliance with MDHHS Standards. The MDHHS State averages per quarter were added to this dashboard as well as LRE ranking within the State, per quarter, per indicator.

Lakeshore Regional Entity

MMBPIS Performance Indicator

FY 24 Dashboard

	Meets or exceeds target for goal
	Does not meet target for goal

MMBPIS Indicator #	PIHP Quarterly Measures	Target	Oct-Dec 23	Q1 State Avg	Q1 Ranking in State	Jan-Mar24	Q2 State Avg	Q2 Ranking in State	Apr-Jun24	Q3 State Avg	Q3 Ranking in State	July-Sept24	Q4 State Avg	Q4 Ranking in State
Indicator #1	% of Pre-Admission Screening Dispositions 3 hrs or less - Children	95%	98.7%	99.3%	8th	99.5%	99.1%	6th	99.4%	98.1%	4th	98.4%	98.5%	7th
	% of Pre-Admission Screening Dispositions 3 hrs or less - Adults	95%	98.4%	98.8%	7th	99.3%	98.7%	5th	99.2%	98.8%	7th	98.8%	98.6%	6th
Indicator #2	F/F Assessment within 14 days -- MIC	62%	58.0%	50.2%	5th	57.3%	59.1%	5th	55.8%	60.2%	6th	57.3%	62.5%	7th
	F/F Assessment within 14 days -- MIA	62%	48.0%	54.4%	9th	51.9%	58.5%	7th	51.6%	59.5%	8th	54.9%	63.0%	9th
	F/F Assessment within 14 days -- DDC	62%	39.3%	43.4%	6th	46.2%	42.4%	6th	46.6%	47.7%	8th	60.4%	57.5%	6th
	F/F Assessment within 14 days -- DDA	62%	54.2%	53.8%	6th	61.6%	54.3%	4th	68.7%	55.9%	3rd	36.8%	59.0%	9th
	F/F Assessment within 14 days -- LRE Total	62%	51.7%	52.7%	5th	54.3%	56.5%	5th	54.1%	59.6%	8th	55.0%	62.2%	8th
Indicator #3	Start of Service Within 14 Days -- MIC	72.9%	59.8%	67.6%	8th	59.6%	70.5%	9th	53.6%	71.2%	10th	56.9%	70.6%	10th
	Start of Service Within 14 Days -- MIA	72.9%	60.8%	70.4%	6th	57.9%	75.8%	10th	53.5%	74.5%	10th	58.1%	74.4%	10th
	Start of Service Within 14 Days -- DDC	72.9%	47.8%	68.5%	9th	57.6%	73.6%	8th	58.5%	79.9%	9th	66.7%	84.1%	9th

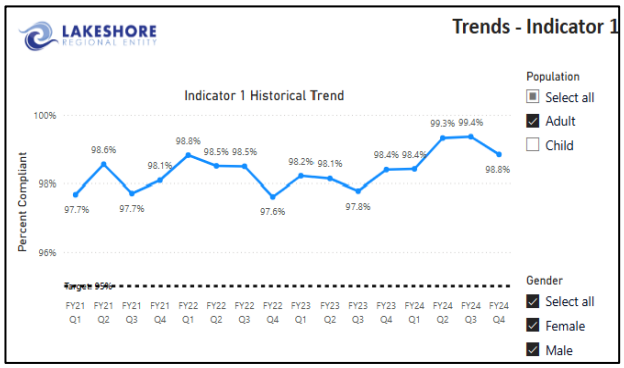
	Start of Service Within 14 Days --DDA	72.9%	51.9%	78.2%	10th	62.8%	76.1%	8th	62.0%	80.7%	10th	65.0%	77.5%	8th
	Start of Service Within 14 Days --LRE Total	72.9%	58.7%	58.7%	9th	58.9%	73.9%	10th	54.7%	74.3%	10th	59.4%	74.6%	10th
Indicator #4a	% Seen Within 7 Days of Inpatient Discharge - Children	95%	96.8%	90.6%	3rd	96.2%	94.7%	6th	97.7%	97.9%	5th	96.5%	97.5%	9th
	% Seen Within 7 Days of Inpatient Discharge - Adults	95%	94.8%	90.4%	5th	97.3%	94.5%	3rd	96.6%	96.3%	6th	96.2%	95.8%	5th
Indicator #4b	% Seen Within 7 Days of SA Detox Unit Discharge -SUD	95%	100%	97.5%	1st - 3rd	96.7%	96.9%	5th	97.9%	96.6%	5th	100%	97.4%	1st
Indicator #10	Inpatient Recidivism Rate - Children	15% or less	18.5%	9.8%	10th	12.3%	9.7%	9th	10.6%	11.5%	4th	16.1%	10.9%	10th
	Inpatient Recidivism Rate - Adults	15% or less	12.8%	12.1%	5th	9.2%	13.5%	2nd	13.8%	14.7%	6th	9.0%	14.0%	1st
MDHHS collects and reports the following indicators														
Indicator #2e	F/F Service for Treatment Support within 14 days --SUD	68.20%	67.9%	66.8%	5th	66.3%	68.3%	6th	64%	63.9%	7th	68.0%	69.4%	8th
Indicator #5	% of Area Medicaid Having Received PIHP Managed Services	MDHHS INFO	5.4%	6.6%	9th	5.7%	6.83%	8th	6%	7.2%	9th	6.4%	7.5%	9th
Indicator #6	% of HSW Enrollees in Quarter who Received at Least 1 HSW Service each Month other than Support Coordination	MDHHS INFO	95.0%	95.8%	8th	94.0%	96.0%	9th	95%	94.7%	6th	94.7%	94.7%	4th

Table-1.

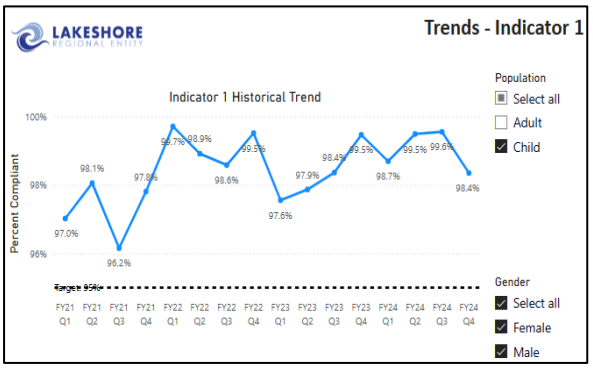
A: MMBPIS Indicator 1

Percent of Pre-Admission Screening Dispositions Completed 3 Hours or Less.

The FY24 MMBPIS Dashboard (Table 1) above shows that Lakeshore Regional Entity met the 95% MDHHS Standard for Indicator #1, 4 out of 4 quarters, 100% of time for 2024. The following two trend reports demonstrate LRE has met the 95% MDHHS Standards for Indicator #1 consistently for both Adults and Children since FY21.



Graph-1



Graph-2

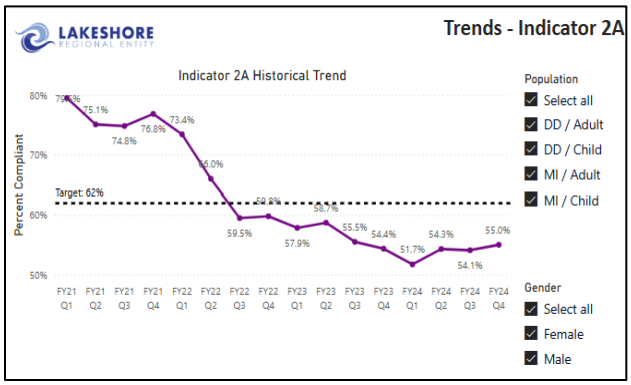
Indicator 1: *Issues / Concerns*

In reviewing Indicator 1 data over time, no real issues / concerns are noted. (See Graph 1 & 2). CMHSPS are asked to review outliers watching for possible trends and these are discussed during QI ROAT and Quarterly MMBPIS Meetings. Staffing issues at times are a problem, it is difficult trying to meet the 3-hour standard when more than one person is in crisis at the same time. During the quarterly MMBPIS Review, LRE selects a sample of cases with a disposition of 5 minutes or less during the quarter to review. Again, no concerns noted, generally it was found cases taking 5 minutes or less till disposition were due to the fact the individuals were well known, generally receiving ACT Services or another frequent service and CMHSP staff were aware of individuals increased mental health issues prior to request for inpatient hospitalization.

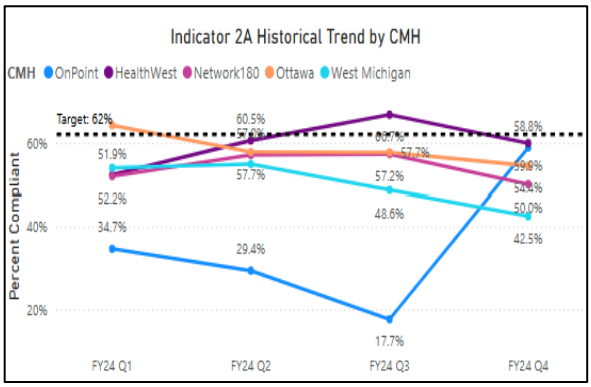
B. MMBPIS Indicator 2a

Request to Assessment Within 14 Calendar Days

MDHHS added Standards to Indicator 2 starting in FY 2024 based on the statewide data from FY2022. As LRE's 2022 data was above the 75th percentile, LRE target is 62% or better. LRE did not meet the MDHHS Standard for FY24. The trending graph (Graph-3) on the next page shows that LRE's results for Indicator 2a continually decreased since FY22 Q1. The data steadily decreased until FY24 Q2. In FY23, LRE attributed the decline in Indicator 2a to two primary reasons based on "Out of Compliance" codes: 1) "Staff Issue/Resource Shortage" and 2) "Consumer No Show". Graph-4 on the next page shows CMHSP scores for Indicator 2 for FY24. Reviewing this graph provides information that 4 of the 5 CMHSPs are close to meeting the MDHHS 62% standard, however OnPoint struggled in the first three quarters of the fiscal year, the reason provided was staff shortage. The table (Table-2) on the next page shows the comparison of "out of compliance" codes used for Indicator 2a from FY21 – FY24. As in FY23, "Staff Issues/ Resource Shortage" and "Consumer No Show" continues to be the primary reason given for Indicator 2 cases being out of compliance.



Graph-3



Graph-4

LRE MMBPIS Indicator 2a: Year over Year Trend					
MMBPIS Out of Compliance / Exception Codes	**FY21**	**FY22**	**FY23**	**FY24**	**FY24 vs FY23**
Staffing Issue/Resource Shortage	33%	23%	25%	26%	
Client No Show	34%	24%	20%	21%	
Client Choice of Date	8%	9%	9%	14%	
Client Choice Not to Use CMHSP	2%	2%	9%	2%	
Reschedule by Client	8%	8%	8%	2.5%	
Client Canceled	5%	6%	8%	1.5%	
Unable to Reach w/in Timeframe	1%	4%	5%	1%	
System Issues	1%	9%	4%	5%	
Documentation Issues	3%	7%	4%	7%	

Table-2

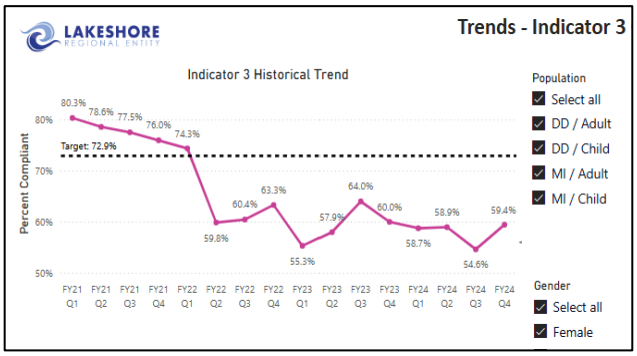
LRE's analysis also found that the out of compliance codes Client's Choice of Appointment Date increased by 5% as compared to FY23; Appointment Rescheduled by Consumer shows a 5.5% decrease compared to FY23; Client Canceled 5.5% decrease of 2% over FY22; and Client's Choice not to Use CMHSP decreased by 7%.

The reasons MMBPIS cases were out of compliance were discussed at the QI ROAT and the MMBPIS Quarterly Meetings. The LRE QI ROAT and MMBPIS Workgroup agree that the out of compliance codes that can be influenced by CMHSP intervention are Client No Show, System Issue, and Documentation Issue. In FY23 and again in FY24, LRE and its CMHSPs deployed informal efforts surrounding these three codes by improving outreach processes, retraining staff on access processes, and reiterating documentation expectations, however these efforts did not result in less out of compliance cases in these areas as noted by a 9% aggregate increase in the use of these three codes compared to FY23. LRE continues monitoring quarterly MMBPIS submissions for improvement in these areas.

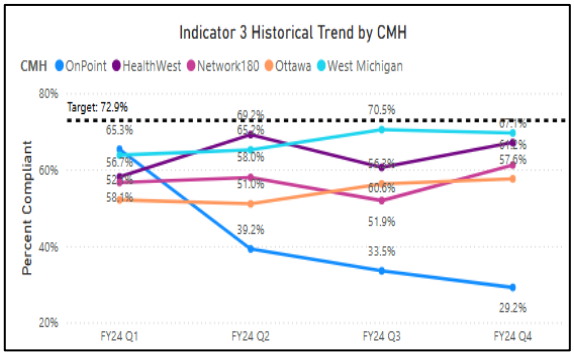
C. MMBPIS Indicator 3

Assessment to Start of Ongoing Services Within 14 Calendar Days

MDHHS added Standards to Indicator 3 starting in FY 2024 based on the statewide data from FY2022. As LRE's 2022 data was below the 50th percentile, LRE target is 72.9% or better. LRE did not meet the MDHHS Standard for FY24. The trending graph (Graph-5 & 6) shows that LRE's results for Indicator 3 continually decreased since FY22 Q1 similar to what was discussed above concerning Indicator 2. When discussed at QI ROAT and the MMBPIS Workgroup, the reasons for out-of-compliance cases are also similar to that mentioned in the Indicator 2 discussion above. In reviewing the data found in Power Bi, it was found that 30% of "out of compliance" cases were due to "staffing issues/resources"; 20% due to "No Shows"; and 12% due to "Documentation Issues". LRE and CMHSPs will continue in their efforts to improve client access to services.



Graph-5

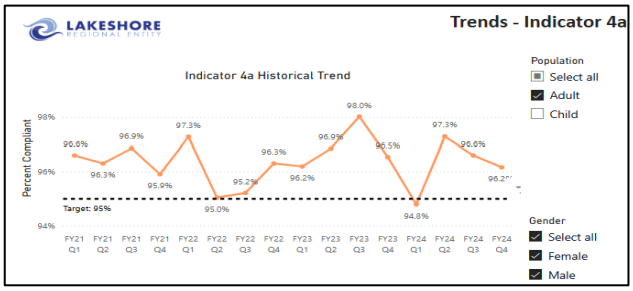


Graph-6

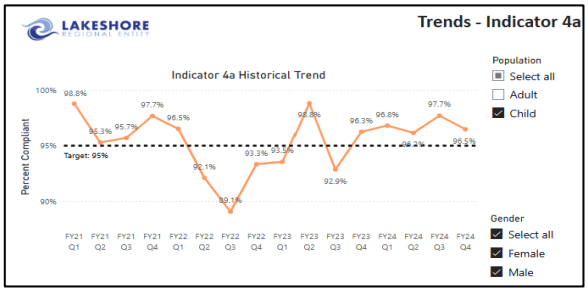
D. MMBPIS Indicator 4a:

Follow-up Following Inpatient Discharge within 7 Calendar Days

Indicator 4a, is about continuity of care. It is important that when an individual is discharged from an inpatient unit, the shift in responsibility for the care to the CMHSP is uninterrupted and continuous. LRE analyzed the data for Indicator 4a from FY21 Q1 through FY24 Q4. As shown in Graph-7 below, the historical trend for Adults shows that 15 out of 16 quarters (94%), LRE met the 95% MDHHS Standards. However, the quarter that LRE did not meet standards occurred in FY24. Hopefully this will not happen again. The review of the historical trend data for Children, Graph-8 shows that LRE me the MDHHS 95%, 11 out of 16 quarters (69%). When discussing the quarterly data with the CMHSPs, they report that generally it only takes one or two cases not seen within the 7 days to not meet the MDHHS Standards as the number of children seen is small. It is further noted that for Children, the trend is now improving and LRE has met the MDHHS Standards the last 5 quarters.



Graph-7

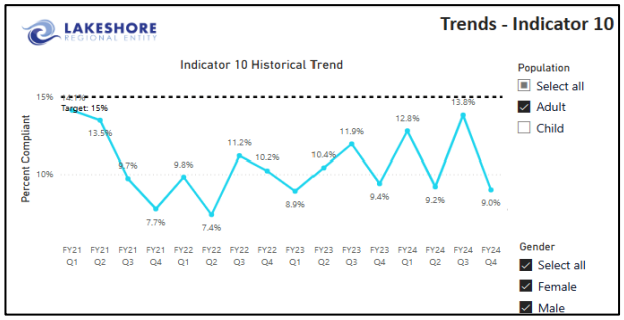


Graph-8

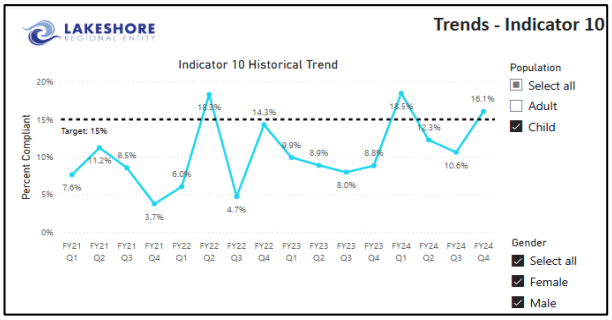
As part of the requirements for Indicator 4a, MDHHS allows exceptions. In reviewing the exception reasons, the majority of the exception cases were due to client "No Show" (56%), and the second most used exception reason used for FY24 was. "Client Choice not to use CMHSP Services." (22%).

E. MMBPIS Indicator 10: *Inpatient Recidivism within 30 Days of Discharge*

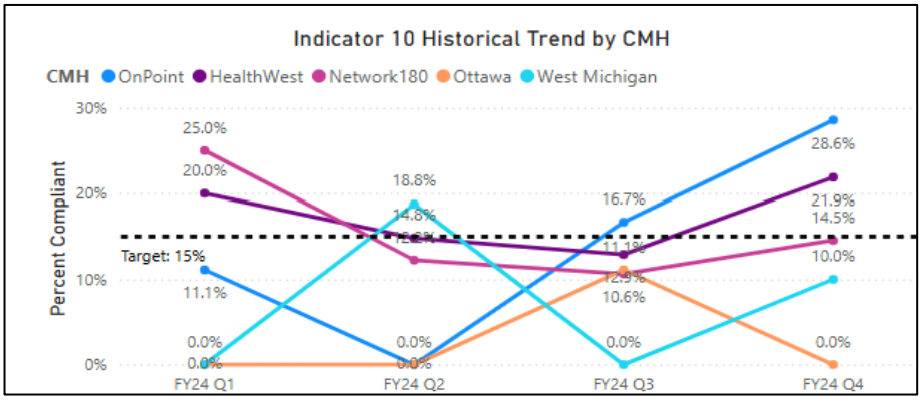
The MDHHS Standard for Recidivism is 15% or less. This is an important indicator because a quick readmission following discharge may suggest that the individual might have been prematurely discharged or that the post discharge follow-up was not timely or sufficient. LRE has consistently done well with this indicator. Graph-9 below demonstrates that LRE has consistently met the 15% or less MDHHS Standard for Adults since FY21 Q1. Graph-10 below shows the trend line for Children for Indicator 10, indicating LRE done well with Children, but not quite as good as Adults. LRE met the 15% or less for Children 13/16 (82%). Concern noted in that two of the three times LRE did not meet the 15% or less for Children occurred in FY24. Graph-11 below shows that 4 of the 5 CMHSPS had issues meeting this standard in 2024. HealthWest and OnPoint both did not meet the MDHHS Standards, two quarters each in FY24. Ottawa CMHSP was the only CMHSP meeting the MDHHS Standard of 15% or less 100% in FY24. CMHSPs are in the process of remediating Plans of Correction for this Indicator. LRE will continue to monitor and work with the CMHSPs for improvement in this area.



Graph-9



Graph-10



Graph-11

IV. PERFORMANCE IMPROVEMENT PROJECTS

LRE conducts performance improvement projects ("PIPs") that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and individual satisfaction.

LRE is required to conduct at least two PIPs each fiscal year. One of the two PIPs is mandated by MDHHS and is reviewed and evaluated by HSAG for compliance with the PIP requirements. The second PIP is the LRE's choice.

For Fiscal Year 2024, LRE continues to conduct two PIPs centered on improving the HEDIS® Follow-up After Hospitalization. LRE's research suggests that an increase in the FUH metric can improve outcomes, decrease suicides, decrease recidivism, and increase satisfaction.

A. FUH Metric

Improve FUH Data Distribution, Submission, and Tracking

In developing the PIP, LRE determined it was necessary to standardize the process for distributing FUH data to the Medicaid Health Plans, submitting FUH data to MDHHS, and following up with consumers within the FUH population.

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

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

B. FUH Metric:

Decreasing Racial Disparity between Whites and African American/Blacks

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

LRE created a Power-BI Dashboard that utilizes Region 3's FUH data and applies filters that allow LRE to monitor FUH with and without a race/ethnicity lens by Member CMHSP. LRE continues to monitor

FUH metrics while the FUH Workgroup solidifies a standardized process for Member CMHSP reporting to the LRE and the distribution of data to MHPs.

LRE continues developing interventions for deployment across Region 3 during the 2nd measurement period, which runs from January 1, 2024, to December 31, 2024. In completing the PIP for FY24, the interventions and improvement strategies implemented did not result in significant improvement in overall compliance rates nor in a significant decrease in disparity. The table below reports the scores LRE received for their PIP for FY24. LRE did receive 100% for the critical elements, however received a confidence level of "Low Confidence" as there was no statistically significant difference between measurement periods.

Appendix B: State of Michigan SFY2024 PIP Validation Tool
Decrease in Racial Disparity Between Whites and African Americans/Blacks
for R3 - Lakeshore Regional Entity

Table B—1 SFY2024 PIP Validation Tool Scores
for *Decrease in Racial Disparity Between Whites and African Americans/Blacks* for Region 3 - Lakeshore Regional Entity

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
1. Review the Selected PIP Topic	1	1	0	0	0	1	1	0	0	0
2. Review the PIP Aim Statement(s)	1	1	0	0	0	1	1	0	0	0
3. Review the Identified PIP Population	1	1	0	0	0	1	1	0	0	0
4. Review the Sampling Method	5	0	0	0	5	2	0	0	0	2
5. Review the Selected Performance Indicator(s)	2	2	0	0	0	1	1	0	0	0
6. Review the Data Collection Procedures	4	3	0	0	1	2	1	0	0	1
7. Review Data Analysis and Interpretation of Results	3	1	2	0	0	1	0	1	0	0
8. Assess the Improvement Strategies	5	3	2	0	0	3	2	1	0	0
9. Assess the Likelihood that Significant and Sustained Improvement Occurred	4	2	0	1	0	1	1	0	0	0
Totals for All Steps	**26**	**14**	**4**	**1**	**6**	**13**	**8**	**2**	**0**	**3**

Table B—2 SFY2024 Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Step 1 through Step 8)
for *Decrease in Racial Disparity Between Whites and African Americans/Blacks*
for Region 3 - Lakeshore Regional Entity

Percentage Score of Evaluation Elements *Met**	*75%*
Percentage Score of Critical Elements *Met***	*78%*
Confidence Level***	*Low Confidence*

Table B—3 SFY2024 Overall Confidence That the PIP Achieved Significant Improvement (Step 9)
for *Decrease in Racial Disparity Between Whites and African Americans/Blacks*
for Region 3 - Lakeshore Regional Entity

Percentage Score of Evaluation Elements *Met**	*67%*
Percentage Score of Critical Elements *Met***	*100%*
Confidence Level***	*Low Confidence*

The *Not Assessed* and *Not Applicable* scores have been removed from the scoring calculations.
* The percentage score of evaluation elements *Met* is calculated by dividing the total number *Met* by the sum of all evaluation elements *Met, Partially Met,* and *Not Met.*
** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met, Partially Met,* and *Not Met.*
*** Confidence Level: See confidence level definitions on next page.

Table-3

V. CRITICAL EVENT REPORTING

LRE requires each Member CMHSP with direct services as well as contracted, external providers to record, assess, and report critical incidents, risk events, sentinel events, unexpected deaths, and immediately reportable events (a/k/a immediate event notification) according to LRE 's policies and procedures. LRE reports critical incidents, risk events, sentinel events, unexpected deaths, and immediately reportable events in accordance with MDHHS contractual requirements.

LRE's FY24 Event Reporting and Notifications Goal was to report all critical incidents, sentinel events, and unexpected deaths to MDHHS in a timely and accurate manner, meaning meeting contractual requirements. LRE has achieved its FY24 goal through timely and accurate reporting of its critical incidents to MDHHS for the entirety of Fiscal Year 2024. LRE developed a tool used to monitor Member CMHSP timeliness of reporting sentinel events and unexpected deaths to LRE.

Beginning October 1, 2022, MDHHS required all critical incidents and unexpected deaths be reported via MDHHS' CRM (Customer Relationship Management Platform), which interfaces with PCE Systems for data transfer. LRE discovered that the PCE Systems was not programmed to manage Risk Event data along with the Critical Incident data. LRE commissioned PCE Systems to enhance the LRE's Critical Incident module to include the ability to handle the LRE's Critical Incident and Risk Event data seamlessly. In FY24 LRE QI Staff worked with LRE IT Staff to develop a Power-BI database to assist in monitoring / trending and evaluating Critical Incident and Risk Event data.

A. Critical Incidents

For FY24, LRE reported a total of 437 critical incidents, which is a decrease of 22 compared to FY23. It is further noted that the distinct number of individuals reported on for FY24 was 317, which is a slight increase of 7 compared to FY23. During FY24, LRE reviewed and discussed Critical Incidents with QI ROAT quarterly.

Critical Incident Data Comparison

Critical Incidents	FY21	FY22	FY23	FY24	FY24 vs FY23
Suicide	7	13	8	13	Up 5
Accidental Deaths	28	19	26	17	Down 9
Homicides	0	1	1	2	Up 1
Natural Deaths	134	106	99	97	Down 2
Injuries Requiring Emergency Medical Treatment	178	176	151	254	Up 103
Medication Errors Requiring Emergency Medical Tx	5	4	4	6	Up 2
Injuries Requiring Hospitalization	18	12	19	20	Up 1
Medication Errors Requiring Hospitalization	1	1	0	2	Up 2
Arrests	17	23	23	24	Up 1

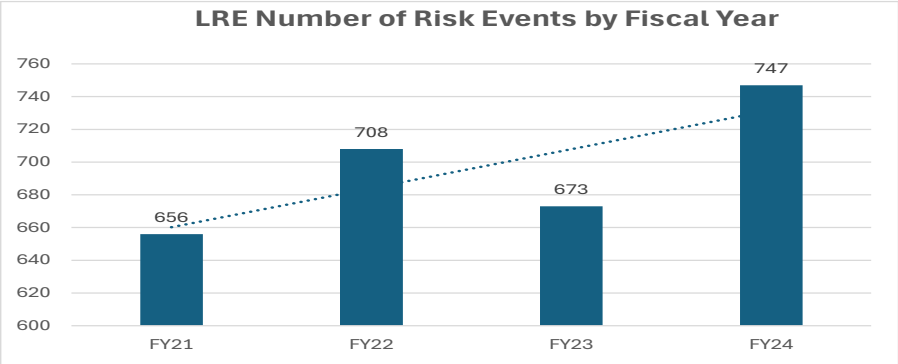
Table-4 above compares the total number of critical incidents reported per type per year over the last four years. Most are basically consistent from year to year with only a small difference noted. There is one category, however, "Injuries Requiring Emergency Medical Treatment" that increased by 103 incidents in FY24 compared to FY23. The 254 incidents are the most ever reported in this area and shows an increase of more than 70 for both FY21 and FY22. The increase is attributed to better defined reporting requirements and the new MDHHS CRM reporting platform and the training and discussions that occurred.

FY24 Critical Incident in Specialized Residential Setting	% FY24 Total Critical Incidents that occurred in Specialized Residential Settings
Zero Suicides	0%
3 Accidental Deaths	18%
Zero Homicides	0%
42 Natural Deaths	43%
250 Injuries Requiring Emergency Medical Treatment	97%
6 Medication Errors Requiring Emergency Medical Treatment	100%
20 Injuries Requiring Hospitalization	100%
2 Medication Errors Requiring Hospitalization	100%
24 Arrests	100%

For FY 24, of the 437 reported critical Incidents, 347 (80%) occurred at a residential setting. That makes sense as only a select group of individuals are reported on through the critical incident process. Death when it occurs, no matter the type, is reported for any individual receiving CMHSP services, however for "Injuries/Med Errors Requiring Emergency Medical Treatment", "Injuries / Med Errors Requiring Hospitalization", and "Arrests" the individual needs to be on a HAB Waiver, SED Waiver, Child Waiver or living in Specialized Residential or Child Care Institution.

B. Risk Events

For FY24, LRE reported 747 Risk Events, which is an increase of 74 compared to FY23. (Graph-12). There were 262 unduplicated individuals reported in the FY24 Risk Events, which is an increase of 23 compared to FY23. The trend line shows the number of reported risk events is increasing over time.



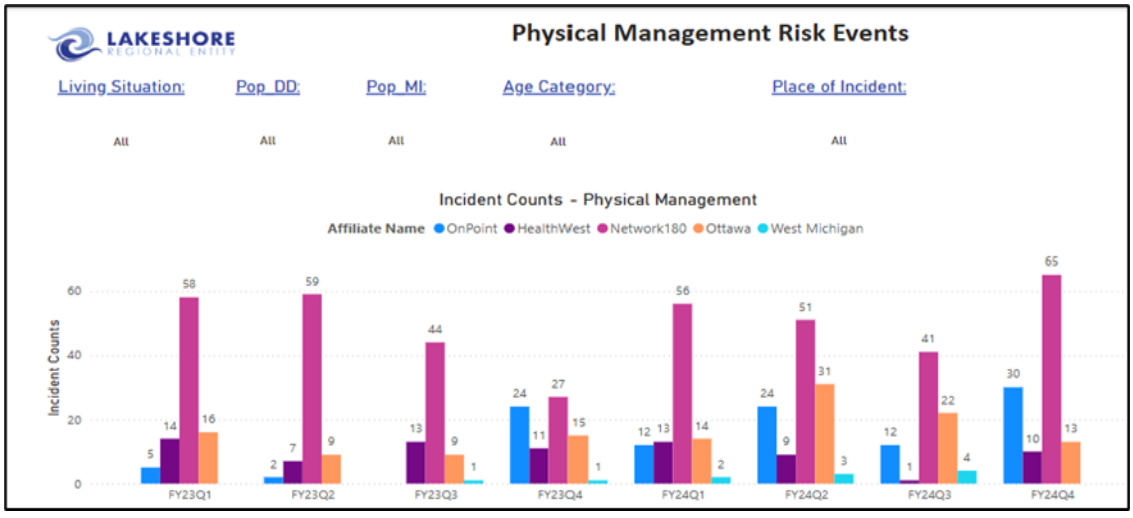
Graph-12

LRE analyzed the risk event data and determined the following when comparing FY24 to FY23. The table below (Table-6) shows the number of Risk Events reported by type for fiscal years 2021 – 2024. As shown all but "Harm to Others" increased during FY24.

Risk Event Data Comparison					
Risk Event	**FY21**	**FY22**	**FY23**	**FY24**	**FY24 vs FY23**
Harm to Self	52	74	147	120	Down 27
Harn to Others	13	11	36	21	Down 15
Police Calls	189	165	149	161	Up 11
Emergency Use of PM	335	390	315	413	Up 98
2+ Unscheduled Hospitalizations	37	68	26	32	Up 6

Table-6

During FY24, LRE reviewed Risk Events with QI ROAT quarterly and specifically discussed the cause for the increase in Police Calls and Emergency Use of Physical Management. Graph-13 shows the number of physical managements reported by CMHSP by quarter for FY23 and FY24. It shows that N180 reports the most physical management episodes, with OnPoint second and Ottawa CMHSP third. The CMHSPs report that it is generally one or two individuals who the need for emergency use of physical management occurs.



Graph-13

Risk Events in Specialized Residential Settings.

When analyzing the Risk Events occurring only in Specialized Residential (SR) settings in FY24, LRE found the following:

Risk Events in SR Settings	% of Total Risk Event by Category
41 Self Harm	35%
15 Harm to Others	71%
129 Police Calls	80%
354 Emergency Uses of Physical Management	86%
30 Two or More Unscheduled Hospitalizations in 12 Months	94%

Table-7

C. Sentinel Events and Unexpected Deaths

In FY24, LRE experienced 58 Sentinel Events and Unexpected Deaths (SE|UD), which is an increase of 5 over FY23. Upon analysis, LRE determined that the three categories dominating the Region 3's Unexpected Deaths relate to 1) Accidental Death (31%), 2) Suicide (17%), and 3) Sentinel Event (16%). (Table 9).

LRE FY 24 Sentinel Event & Unexpected Death by Category		
Category	**Count**	**%**
Accidental Death (includes car accidents, overdose, hit by car, drowning)	18	31%
Suicide	10	17%
Sentinel Event (includes tx issues, drug use on site, falls, injuries, self-harm)	9	16%
Attempted Suicide	8	14%
Overdose	6	10%
Unexpected / Unknown Death	4	6%
Homicide	2	3%
Med Error Requiring Hospitalization	2	3%

Table-8

LRE also determined that the most vulnerable population serviced as it relates to SE|UD is the Mentally ill Adult population (47%). (Table 9 on next page).

LRE FY 24 Sentinel Event & Unexpected Death by Population		
Population	**Count**	**%**
MIA	27	47%
MIA/SUD	13	23%
SUD	6	10%
DDA / HAB	5	9%
DDA	5	9%
MIA/DDA	1	1%
LEAD (Law Enforcement Assisted Diversion)	1	1%

Table-9

In FY24, LRE continued monitoring the SE|UD Timeliness and Review Standards and evaluated its Member CMHSP performance related to these standards. (Tables 10). Year over year, Region 3 CMHSPs improved the Timeliness Standards for determining if event was a sentinel event, days to complete RCA and submitting the final review of SE|UD to LRE. For a second year in a row, Region 3 CMHSPs have completed the necessary Root Cause Analyses (RCAs) well below the Region 3 45-day standard. (Table 10).

	TIMELINESS STANDARDS			
	#Days from knowledge of occurrence to LRE Notification Standard: 24 hours	# Days to Determine it is a Sentinel Event Standard: 3 days to determine if SE then 2 business days to commence RCA	Days to Complete RCA after started: Standard: 45 Days	# Days to Send LRE Completed Unexpected Death Form: Policy states within 48 hours Data below in Days
Target	1	5	45	2
FY24 Average:	6	10	44	12
FY23 Average:	6	16	33	4
Change Year over Year	Same as last year	Average improved by 6 days	Average increased by 11 days –Still meets standards.	Average increased by 8 days. Decrease in compliance noted

Table-10

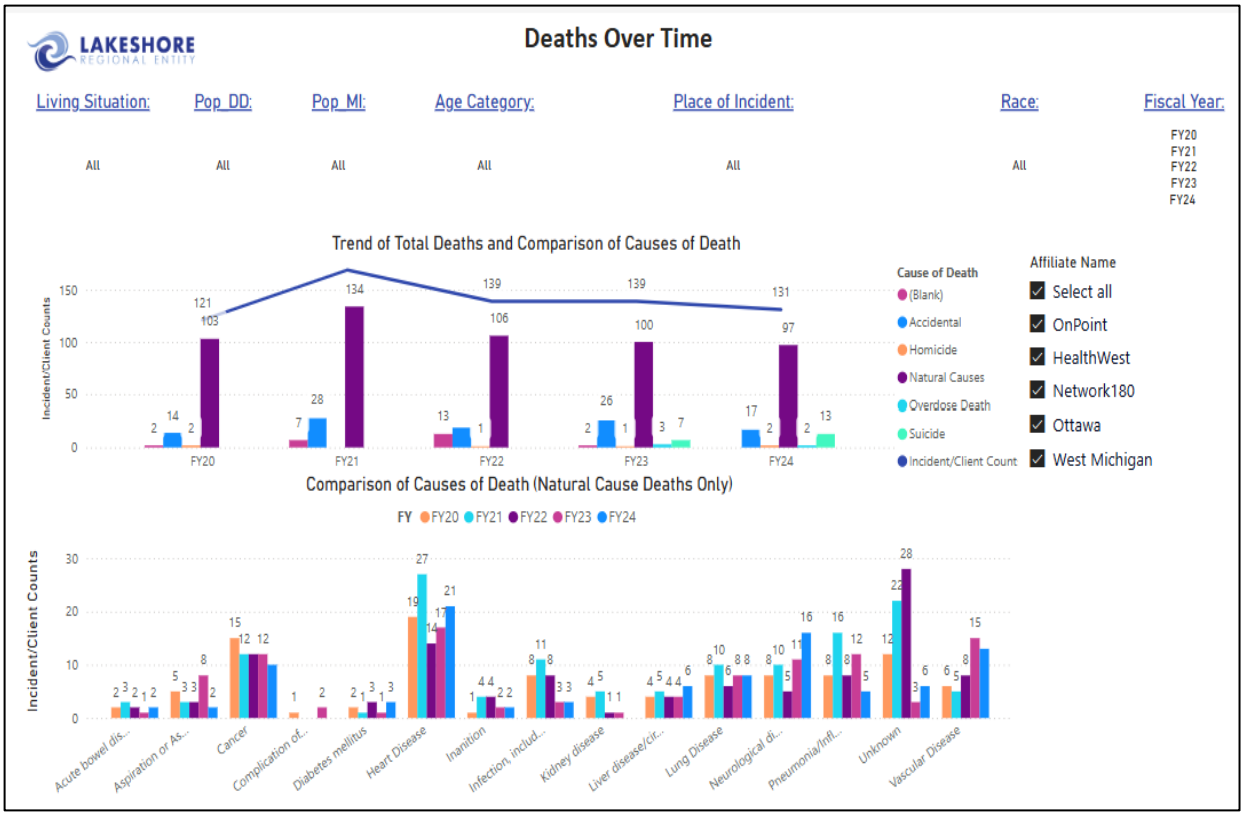
	REVIEW STANDARDS					
	Health Care Professional Signature	**Health Care Professional Credentials**	**Health Care Professional Signature Date Signed**	**Quality Improvement Personnel Signature**	**Quality Improvement Personnel Credentials**	**Quality Improvement Professional Date Signed**
Target	100%	100%	100%	100%	100%	100%
FY24 Average:	93%	91%	93%	97%	97%	86%
FY23 Average:	92%	92%	91%	94%	85%	98%
Change Year over Year	Percent improved by 1%	Percent decreased by 1%	Percent improved by 2%	Percent improved by 3%	Percent improved by 12%	Percent decreased by 12%

Table-11

Table-11, reviews how the CMHSPs did in FY24 with the Sentinel Event Review Standards. Four of the six areas showed improvement. Two showed a decrease in the percentage achieved for FY24, one of these only 1%. However, in the review standard of the date signed for the Quality Improvement Professional there was a decrease of12%. In reviewing the data, it is noted that 8 RCA's did not have a date completed by the Quality Improvement Professional. The RCA's without a signature date were completed by West Michigan, Ottawa CMHSP and one by HealthWest. LRE will continue to work with the CMHSPs to ensure the Health Care Professional and Quality Improvement Professional signs, dates and includes their credentials when completing an RCA.

Mortality Reports

In FY24, LRE's review of its Mortality Report determined that Natural (77%) and Accidental Death (15%) continue to be the primary causes of death regardless of setting, meaning data includes both Specialized Residential and non-Specialized Residential. (Graph 14).



Graph-14

For all Natural Deaths in FY24, LRE determined that Heart Disease, Neurological Disorders, Vascular Disease, Cancer, Lung Disease & Pneumonia/Influenzas contributed to 80% of the Natural Deaths in FY24. (Table 12).

LRE FY24 Mortality Report – Cause of Death					
	Fiscal Year				
Cause of Death	**FY20**	**FY21**	**FY22**	**FY23**	**FY24**
Heart Disease	18%	20%	13%	16%	23%
Neurological Disorders	8%	7%	5%	11%	17%
Vascular Disease	6%	4%	8%	13%	13%
Cancer	15%	9%	11%	12%	10%
Lung Disease	8%	7%	4%	4%	8%
Liver Disease / Cirrhosis	4%	4%	4%	4%	6%
Unknown	12%	16%	26%	10%	6%
Pneumonia / Influenza	8%	12%	8%	12%	5%
Diabetes Mellitus	2%	1%	3%	1%	3%
Infection, including AIDS	8%	8%	8%	3%	3%
Acute Bowel Disease	2%	2%	2%	1%	2%
Aspiration or Aspiration Pneumonia	5%	2%	6%	7%	2%
Inanition	1%	3%	4%	2%	2%
Complication of Treatment	1%	0%	0%	2%	0%
Kidney Disease	4%	4%	1%	1%	0%

Table-12

LRE anticipates MDHHS' CRM platform will assist Region 3 in having better visibility to Sentinel Events and Unexpected Deaths in FY25 with syncing to Critical Incidents to ensure a robust reconciliation process within the CRM platform.

LRE achieved its FY24 Event Reporting and Notifications Goals.

VI. BEHAVIOR TREATMENT REVIEW

The FY24 QAPIP Behavior Treatment goal is "LRE will review and analyze behavior treatment review committee physical management data by individual and length of time for each instance of physical management used in an emergency behavior crisis." Each quarter, the CMHSPS submits quarterly physical management data to the LRE using a developed and agreed upon excel Physical Management Reporting Form. Submitted data contains every instance of individual physical management events. Data collected includes the following for every individual physical management event that occurred, population group, Hab Waiver: Yes or No, Total Minutes / Seconds for each physical management event, and Behavior Plan: Yes or No.

LRE aggregates the Physical Management Data quarterly and reviews it by CMHSP and by LRE totals. Table-13 on the next page shows four years' worth of aggregate Physical Management Data. Each year's data is broken out by CMHSP with an overall total for the LRE. Over the 4-year span, the number of Physical Management Events ranged from a low of 307 (FY23) to a high of 434 (FY24). However, even though FY24 had the most Physical Management Events, it also had the lowest average time for these events at 3 minutes 28 seconds.

Physical Management Data Aggregated and Compared By Fiscal Year

FY21

CMHSP	Total Events	Unique Count	Total Minutes Reported	Total Seconds Reported	Avg Time
On Point	25	9	85	93	3.462
HW	7	4	17	0	2.429
N180	232	68	591	0	2.55
Ottawa	85	10	562	205	6.65
West Mich	26	3	130	55	5.04
LRE Total	**375**	**94**	**1385**	**353**	**3.71**

FY22

CMHSP	Total Events	Unique Count	Total Minutes Reported	Total Seconds Reported	Avg Time
On Point	29	8	43	133	1.66
HW	7	6	11	0	1.57
N180	237	52	730	627	3.14
Ottawa	39	8	203	60	5.23
West Mich	108	4	614	153	5.71
LRE Total	**420**	**78**	**1601**	**973**	**3.85**

FY23

CMHSP	Total Events	Unique Count	Total Minutes Reported	Total Seconds Reported	Avg Time
On Point	67	11	334	355	5.07
HW	35	22	111	255	3.30
N180	164	36	572	310	3.52
Ottawa	39	9	190	258	4.98
West Mich	2	2	16	0	8
LRE Total	**307**	**80**	**1223**	**1178**	**4.05**

FY24 Q1 - Q4

CMHSP	Total Events	Unique Count	Total Minutes Reported	Total Seconds Reported	Avg Time
On Point	99	10	187	970	1.24
HW	38	13	86	870	2.64
N180	212	40	523	1419	2.57
Ottawa	76	13	534	462	7.13
West Mich	9	2	32	60	3.66
LRE Total	**434**	**78**	**1362**	**3781**	**3.28**

Table-13

LRE discusses/reviews the Physical Management Data Reports quarterly with the LRE Behavior Treatment Committee. LRE also presents this data to the QI ROAT quarterly.

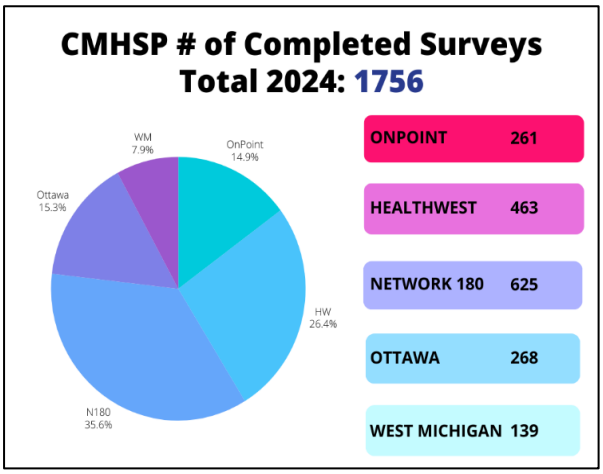
LRE achieved its FY24 Behavior Treatment Reviews Goal.

VII. CUSTOMER SATISFACTION ASSESSMENT

The LRE Customer Satisfaction Survey is offered each year to consumers involved in CMHSP services. Patient feedback concerning their experience of care is an important part of the efforts to improve quality and health outcomes in populations experiencing mental health difficulties.

For FY24, LRE used the Mental Health Statistics Improvement Program survey (MHSIP) for adults receiving LRE services and the Youth Services Survey (YSS) for children. The MHSIP uses a Likert scale for responses ranging from one (strongly agree) to five (strongly disagree). The YSS also uses a Likert scale for responses with the scale ranging from one (strongly disagree) to five (strongly agree).

Graph-15 below shows that 1,756 satisfaction surveys were completed for 2024. The number of surveys completed in 2023 was 1,997. However, it was a smaller survey consisting of only 12 questions and the length of time the survey was distributed was three months longer.



Graph-15

The outcomes of the MHSIP and YSS-F function as a "report card" on how satisfied consumers are with community mental health services and provide insight for what is needed to enhance quality and continuity of care. The perspective of the consumer is valuable in that it provides a unique opportunity for the region to determine what changes may be needed for delivery, to foster collaboration with provider agencies, and to enhance service delivery and implementation strategies. The outcomes are graded in terms of category requirements for CCBHC. In Table-14 on the next page, each question is placed in one of the categories which are graded in total below:

Report Card 2024

YSS	FY24 Score	MSHIP	FY24 Score
Outcomes	70%	Outcomes	78%
Social Connectedness	82%	Social Connectedness	81%
Access & Availability	85%	Access & Availability	85%
Quality	88%	Quality	86%
Functioning	70%	Functioning	77%
Total	79%	Total	81%

Table-14

The FY24 Customer Satisfaction Survey workgroup was created to collaborate with the CMHSPs on all matters related to surveys in the region. The focus of the group for FY24 was the implementation of the MHSIP and YSS which would address the following: CCBHC requirements, data to share throughout the state, consistent data throughout the years. We are reviewing the data and determining the best practices moving forward to address the needs of the individuals we serve.

VIII. CLINICAL PRACTICE GUIDELINES

LRE supports the use of Clinical Practice Guidelines ("CPGs") in service provision. CPGs are available to assist practitioners and members in making decisions about appropriate health care for specific clinical circumstances. LRE endorses CPGs that have been adopted by the American Psychiatric Association. LRE adopted the American Psychiatric Association CPGs in concert with Member CMHSPs through the Clinical ROAT and Utilization Management ROAT. LRE disseminates the CPGs via LRE and CMHSP websites, and ROAT reviews and education.

LRE's FY24 Clinical Practice Guidelines Goals were to ensure continued education and monitoring of Clinical Practice Guidelines while improving dissemination and education to the LRE Provider network. Adopt new/alternate practice guidelines as necessary. Specifically, LRE's FY24 CPG Objectives were that LRE will.

1) Review, and if appropriate update, the CPGs two times a year with the LRE Medical Director and the Clinical / UM Department staff.

2) Disseminate the CPGs to the provider network through various educational opportunities as well as links to the LRE CPGs via CMHSP and LRE Websites.

3) Disseminate the CPGs to its Regional Provider Network via LRE newsletter at least annually.

LRE has reviewed the CPGs two times during FY24 with the LRE Medical Director, Clinical Director, UM ROAT, and Clinical ROAT. Upon conclusion of the collaborative review sessions, LRE disseminated the CPGs to the provider network via the ROAT meeting minutes, LRE Website and the LRE newsletter.

LRE achieved its FY24 Clinical Practice Guidelines Goal.

IX. MEDICAID SERVICES VERIFICATION

LRE's FY24 Medicaid Services Verification Goal was to complete the Medicaid Verification of services reimbursed by Medicaid as required by the MDHHS Contract.

A. Non-SUD Services

Claims/Encounters Tested & Invalid Claims/Encounters Identified.

During Fiscal Year 2024, LRE performed Medicaid Services Verification audits on 9,853 claims/encounters totaling $3,854,459.89 Medicaid dollars. LRE determined that $42.84, or 0.00%, was subject to recoupment.

Audit Period	*Total Medicaid Dollars*	*Amount Recouped*	*% Recoupment*
FY24 Quarter 1	$ 918,312.49	$ -	0.00%
FY24 Quarter 2	$ 1,116,182.50	$ -	0.00%
FY24 Quarter 3	$ 1,176,989.48	$ 42.84	0.00%
FY24 Quarter 4	$ 642,975.42	$ -	0.00%
Total	**$ 3,854,459.89**	**$ 42.84**	**0.00%**

Table-15

Number & Population of Providers, Claims, Encounters Tested.

For Fiscal Year 2024, LRE's Medicaid Services Verification audit efforts encompassed 9,853 claims/encounters across 30 different service types (Table 16), 1,536 consumers (Table 17), and five distinct population groups (Tables 17 & 18) for 102 unique providers (Table 18).

Number of Audits Completed by Service Type							
ACT	2,247		Fiscal Intermediary	63		Residential CLS	2,125
Autism	4,210		Home Based	2,872		Respite	1,730
Behavior Treat	138		Inpatient Hospital	4		Screening for Inpatient	103
CCBHC	108		Med Injections	202		Skill Building	1,531
Clinical Assessments	476		Nursing Services	119		Supported Employment	585
CLS (H2015)	18,379		Outpatient Services	1,463		Supports Coord/ Case Management	4,525
Clubhouse	252		Overnight CLS	187		Therapy: OP other-OT, PT, Massage	114
Crisis Assessments	271		Peer Support	576		Transport	6
Crisis Residential	92		Personal Care	2,089		Treatment Planning	460
Family Training	217		Psychiatric Services	720		Wrap Around	560

Table-16

Number of Consumers by Population Group					
Population	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
	Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024	Jul – Sept 2024	
MI Adult	221	167	129	89	606
MI Child	153	120	111	92	476
I/DD Adult	130	74	75	63	342
I/DD Child	24	20	31	37	112
Totals Reviewed	528	381	346	281	1,536

Table-17

Number of Encounters Completed by Population Group					
Population	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
	Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024	Jul – Sept 2024	
MI Adult	1,030	1,261	1,002	554	3,847
MI Child	738	643	790	565	2,736
I/DD Adult	494	549	754	733	2,530
I/DD Child	103	138	252	247	740
Totals Reviewed	2,365	2,591	2,798	2,099	9,853

Table-18

Status of Corrective Action Plans.

In Fiscal Year 2024, LRE's Medicaid Services Verification audits found all CMHSPs/providers to be in substantial compliance with federal and state regulations. Therefore, LRE did not put any CMHSP/provider on corrective action plans. Because LRE does not currently have any CMHSPs/providers on Medicaid Services Verification corrective action plans, LRE did not take any providers off corrective action plans nor did LRE cite any provider for repeat/continuing issues.

STATUS OF CORRECTIVE ACTION PLANS - NON-SUD	***COUNT***
Number of Providers Reviewed	102
Number of Claims/Encounters Reviewed	9,853
Number of Consumers Reviewed	1,889
Number of Service Types Reviewed	30
Number of Consumer Population Groups Reviewed	5
Number of Providers Put on Corrective Action Plans	0

Number of Providers on Correction Action for Repeat/Continuing Issues	0
Number of Providers Taken Off Correction Action Plans	0

Table-19

Summary of Medicaid Services Verification for Non-SUD Services.

In Fiscal Year 2024, Region 3 providers performed well during the LRE Medicaid Services Verification audits. Overall, LRE audited a total of 9,853 claims/encounters and found a total of six (6) non-compliant claims/encounters. LRE determined that all six (6) claims/encounters were non-compliant because the services rendered were not identified in the Individual Plan of Service. LRE recouped Medicaid funds related to these six (6) claims/encounters, which totaled $42.84.

B. SUD Services

Claims/Encounters Tested & Invalid Claims/Encounters Identified.

During Fiscal Year 2024, LRE performed Medicaid Services Verification audits on 1,962 claims/ encounters totaling $475,539.78 Medicaid dollars. LRE determined that $594.52, or 0.13%, was subject to recoupment. (See Table-20)

Audit Period	*Total Medicaid Dollars*	*Amount Recouped*	*% Recoupment*
FY24 Quarter 1	$ 143,053.45	$ 109.28	0.08%
FY24 Quarter 2	$ 132,613.80	$ -	0.00%
FY24 Quarter 3	$ 74,967.73	$ 485.24	0.65%
FY24 Quarter 4	$ 124,904.80	$ -	0.00%
Total	**$ 475,539.78**	**$ 594.52**	**0.13%**

Table-20

Number & Population of Providers, Claims, Encounters Tested.

For Fiscal Year 2024, LRE's Medicaid Services Verification audit efforts for SUD Services encompassed 1,962 claims/encounters across 22 different service types (Table-21), 353 consumers (Table-22), and two distinct population groups (Tables-22 & 23) for 22 unique providers (Table-24).

Number of Audits Completed by Service Type			
Alcohol/Drug Testing	83	OP per diem	32
Brief Intervention	55	Outpatient Therapy - Groups	56
Brief Screening	18	Outpatient Therapy Services - Individual	679
Case Management	109	Psychiatric Services	158
Clinical Assessments	54	Recovery Coach	171
Crisis Intervention	6	Recovery Housing	12
Early Intervention	6	Recovery/Peer Supports	70
Intensive OP	10	Residential – Detox	15
Intensive Outpatient	38	Residential – long term	43
Medication Injection	13	Residential – short term	16
Methadone Services	273	Treatment Planning	53

Table-21

Number of Consumers by Population Group					
Population	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
	Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024	Jul – Sept 2024	
SUD Adult	106	73	95	77	351
SUD Child	2	0	0	0	2
Totals Reviewed	108	73	95	77	353

Table-22

Number of Encounters Completed by Population Group					
Population	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
	Oct – Dec 2023	Jan – Mar 2024	Apr – Jun 2024	Jul – Sept 2024	
SUD Adult	463	441	715	337	1,956
SUD Child	6	0	0	0	6
Totals Reviewed	469	441	715	337	1,962

Table-23

Providers Audited by Service Type	
ACAC	OP, Psych, CM
Arbor Circle	OP, CM, Rec Coach
Bear River	OP, Residential
Building Men for Life	Residential
Catholic Charities	OP, CM, Rec Coach
Cherry Health	OP, Psych, CM, Methadone
Eastside	OP, Psych, Methadone
Family Outreach Center	OP, CM, Rec Coach
Great Lakes Recovery	OP, Residential
Harbor Hall	OP, Residential
Healthwest CMH	OP, CM, Recovery supports, Tx planning, Assessments
Network 180 CMH	OP, CM, Recovery supports, Tx planning, Assessments
Onpoint/Allegan CMH	OP, CM, Recovery supports, Tx planning, Assessments
Our Hope	Residential
Pine Rest	OP, Rec Coach
Reach For Recovery	OP, Psych, Res, Coach,
Sacred Heart	Residential
Salvation Army	OP, Residential, Detox
Samaritas	OP, Psychiatric
Victory Clinic	OP, Psych, Methadone
West MI CMH	OP, CM, Recovery supports, Tx planning, Assessments
West MI Treatment Center	OP, Psych, Methadone

Table-24

Status of Corrective Action Plans.

In Fiscal Year 2024, LRE's Medicaid Services Verification audits found all CMHSPs/providers providing SUD services to be in substantial compliance with federal and state regulations. Therefore, LRE did not put any CMHSP/provider on corrective action plans. Because LRE does not currently have any CMHSPs/providers on Medicaid Services Verification corrective action plans, LRE did not take any providers off corrective action plans nor did LRE cite any provider for repeat/continuing issues. (See table-25)

STATUS OF CORRECTIVE ACTION PLANS - SUD SERVICES	***COUNT***
Number of Providers Reviewed	22
Number of Claims/Encounters Reviewed	1,962
Number of Consumers Reviewed	5353
Number of Service Types Reviewed	22
Number of Consumer Population Groups Reviewed	2
Number of Providers Put on Corrective Action Plans	0
Number of Providers on Correction Action for Repeat/Continuing Issues	0
Number of Providers Taken Off Correction Action Plans	0

Table-25

Summary of Medicaid Services Verification Audits – SUD Services

In Fiscal Year 20234, Region 3 SUD providers performed well during the LRE Medicaid Services Verification audits. Overall, LRE audited a total of 1,962 claims/encounters and found a total of eight (8) non-compliant claims/encounters. Of these eight (8) claims/encounters, the following issues were found: (See Table-26)

REASON FOR NON-COMPLIANCE	*COUNT*	*OUTCOME*
Individual Plan of Service ("IPOS") in effect for the date of service available for review	1	Recoupment
Service delivered by a staff person not qualified to provide the service	2	Recoupment

Table-26

LRE recouped Medicaid funds related to these eight (8) claims/encounters, which totaled $594.52.

LRE achieved its FY24 Medicaid Services Verification Goal.

X. CREDENTIALING

LRE ensures that services and supports are consistently provided by staff (contracted or directly operated), who are properly and currently credentialed, licensed, and qualified.

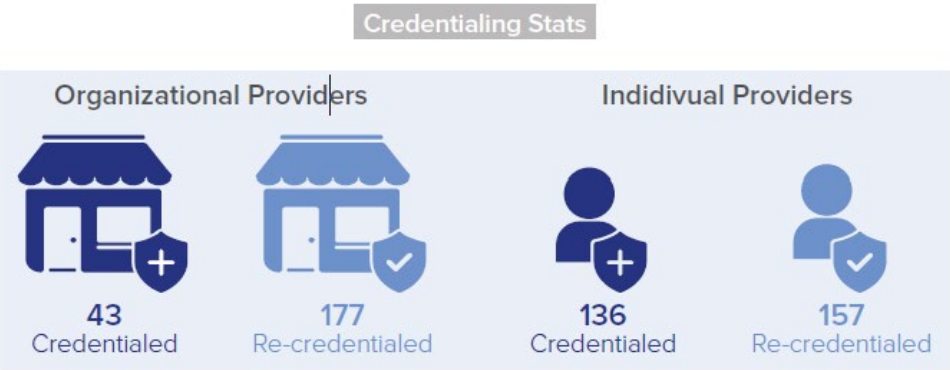
FY24 Credentialing Goals were as follows:

1) Enhance the credentialing/recredentialing process through successful implementation of the MDHHS CRM Universal Credentialing Module.
2) Develop a Credentialing/Recredentialing Module within LIDS, LRE's electronic health record (EHR).
3) Develop a process for tracking, reporting, and monitoring Credentialing & Recredentialing Efforts.
4) Integrate quality metrics and consumer concerns into LRE recredentialing processes.

LRE has worked diligently as part of the MDHHS Universal Credentialing Workgroup by attending all meetings, contributing during meetings, and disseminating information from the meetings to LRE and CMHSP staff.

In FY24, LRE continues to use the tracking process for its credentialing and recredentialing efforts, which tracks not only the number individual practitioners and organizational providers that are credentialed and recredentialed, but also tracks the timeliness of application approvals, timeliness of bi-annual recredentialing efforts.

Credentialing for LRE focuses on ensuring highly qualified providers and practitioners are serving our consumers and families to support them in achieving their wellness goals. The primary activity for LRE is to ensure that all provider organizations in the service delivery network are appropriately credentialed to perform their contracted services. In addition, LRE provides oversight and coordination for individual practitioner credentialing completed by our CMHSP partners. Twice per fiscal year, LRE submits a summary of regional credentialing activities to MDHHS.



XI. OVERSIGHT OF PROVIDER NETWORK

In FY24, LRE continues to use the comprehensive Microsoft® Power BI Dashboard for Audits, CAPs, and Encounter

A. *CMHSP Site Reviews*

LRE's FY24 CMHSP Site Review Goal was to ensure CMHSP Site Review Tools comply with Federal regulations and State requirement. On a regular basis the Quality Staff reviewed 42 CFR 438 to ensure Federal regulations have not changed and if they did, changes were documented to incorporate in the CMHSP Site Review Tools for the following audit year.

In Fiscal Year 2024 (FY24), LRE conducted comprehensive reviews of all five Community Mental Health Services Programs (CMHSPs). The audits included an examination of CMHSP administrative and managed care functions, program-specific standards, health information services, clinical and credentialing records, waiver compliance, and critical incident verification.

Aggregate CMHSP Site Review Results for FY24:

CMHSP	Sum of Score	Sum of Possible Score	Percent
CMH of Ottawa County	4268	4644	91.9%
HealthWest	4772	5070	94.1%
network180	5500	5886	93.4%
OnPoint	4668	5018	93.0%
West Michigan CMH	4293	4564	94.1%

Table-27

B. Provider Facilities Reviews

LRE also maintains oversight of its Provider Network by conducting annual Facilities Reviews for all external providers to ensure compliance with the following requirements:

1. General Health and Safety Standards,
2. Emergency Procedures,
3. Medication Reviews,
4. Resident Funds Reviews,
5. Policies and Procedures, and
6. HCBS Final Rule.

The Facilities Review Goal for FY24 was conducting Facilities Reviews of all Region 3 settings. This was made possible because LRE hired two new staff in 2024 to assist with the Facilities Review.

In FY24, LRE completed 349 Facility and HCBS Physical Assessments. These assessments encompass a comprehensive review of the facility's environment, emergency and medication procedures, policies, and HCBS compliance. Additionally, LRE evaluates the Individual Plan of Services (IPOS) and Behavior Treatment Plans (BTP) for residents to ensure full alignment with the HCBS Final Rule.

Aggregate Facility and HCBS Physical Assessments Results for FY24:

Sum of Score	Sum of Possible Score	Percent
79404	82530	96.2%

Table-28

The LRE Quality Specialists reviewed Crisis Residential Facilities that are available in the LRE region.

The LRE Quality Specialists reviewed clinical services, employee credentialing and training, and facility health and safety when applicable. In FY2024 separate Recipient Rights audits were completed for the Crisis Residential Facilities. The Recipient Rights audits were consultative, but providers received corrective action plans which were remediated and then validated.

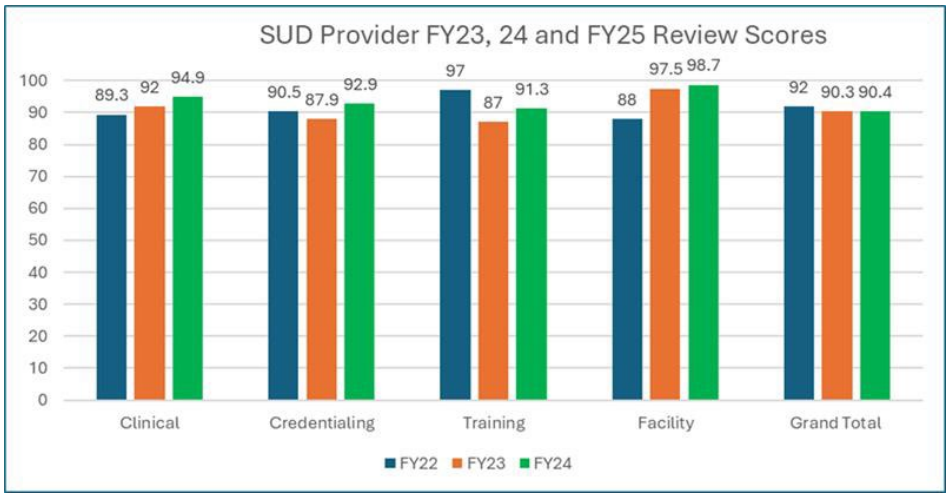
The LRE Quality Specialists reviewed the Inpatient Facilities that are available in the LRE region. The Inpatient Facilities include St. Mary's Healthcare PMU, Forest View Hospital, Pine Rest, Holland Hospital and Trinity Health Behavioral Health Muskegon. The LRE Quality Specialists reviewed the Inpatient Facilities clinical services. Table-29 below show the aggregate percentage scores for the Inpatient Providers by fiscal year.

Inpatient Provider Scores Comparison by Fiscal Year	
FY22	93.6%
FY23	98.9%
FY24	97.9%

Table-29

SUD services available in the LRE region include outpatient, intensive outpatient, residential treatment, sub-acute detox, medication assisted treatment, case management, recovery supports and women's specialty services. The LRE Quality Specialists reviewed SUD providers for employee credentialing and training, clinical services, and facility health and safety when applicable.

In FY 2024 a separate SUD Recipient Rights audit was completed with each SUD provider. The audits were consultative, but providers received corrective action plans which were remediated and then validated.



Graph-27

C. MDHHS Site Reviews

LRE's FY24 MDHHS Site Review Goal was to actively participate in the Site Review and oversee CAP development and remediation validation. LRE participated in the Site Review and monitored CAP development at the CMHSP level. LRE is working to validate CAP remediation efforts at the CMHSP level.

LRE achieved its FY24 MDHHS Site Review Goal.

D. External Quality Reviews

LRE participates in External Quality Reviews (EQRs), which are conducted by Health Services Advisory Group (HSAG) and required under The Balanced Budget Act of 1997 (BBA). Generally, HSAG evaluates the quality and timeliness of, and access to, health care services provided to consumers.

LRE's FY24 HSAG Audit Goals were to 1) continue integrating LRE Subject Matter Experts (SMEs) into the preparation of HSAG Compliance Review tools and proofs and 2) perform at least as well as years past.

HSAG conducted its Audit in three parts:

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

Performance Measurement Validation

For FY24, HSAG validated LRE's Performance Measurements.

HSAG commended LRE on the following strengths:

Strength #1: "LRE continued to demonstrate strength in its efforts toward quality improvement, performance monitoring, and CMHSP oversight using its Power BI technology dashboard and Arc of Treatment Model. [Quality]"

Strength #2: "LRE also demonstrated strength in its efforts to ensure BH-TEDS data completeness and accuracy. LRE hired an actuarial to research factors impacting performance indicator rates, and in doing so was able to identify that the BH-TEDS completion rate had a significant rate impact. LRE then actively worked with a majority of its CMHSPs (three of five) on timely improvement efforts. In addition, LRE continued to use its dashboard for overall BH-TEDS completeness monitoring and oversight. [Quality] "

HSAG also noted four improvement opportunities for Region 3:

Weakness #1: "Upon review of OnPoint's member-level detail file, HSAG identified one case with an incorrect discharge date documented for indicator #4b."

Weakness #2: "Upon review of Ottawa's member-level detail file, HSAG identified one case with an incorrect discharge date documented for indicator #4b. [Quality]"

Weakness #3: "LRE's indicator #2 total rate fell below the 50th percentile benchmark. [Quality and Timeliness]"

Weakness #4: "LRE's indicator #3 total rate fell below the 50th percentile benchmark. [Quality and Timeliness]"

Performance Improvement Projects Validation

HSAG validated LRE's race/ethnicity PIP titled FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites. (See Section IV, pp. 9-11).

Compliance Review

In FY24, HSAG conducted its Compliance Review of LRE, which was year one of the three-year review cycle. LRE's SMEs prepared HSAG tools and proofs.

Summary of Findings: See table-30 below

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Member Rights and Member Information	24	21	16	5	3	**76%**
Standard III—Availability of Services	20	18	18	0	2	**100%**
Standard IV—Assurances of Adequate Capacity and Services	11	9	9	0	2	**100%**
Standard V—Coordination and Continuity of Care	16	15	15	0	1	**100%**
Standard VI—Coverage and Authorization of Services	23	22	15	7	1	**68%**
Total	**94**	**85**	**73**	**12**	**9**	**86%**

M = Met; NM = Not Met; NA = Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

LRE achieved an overall compliance score of 86 percent, indicating adherence to many of the reviewed federal and State requirements. However, opportunities for improvement were identified in the areas of Member Rights and Member Information and Coverage and Authorization of Services as these program areas received performance scores below 90 percent.

LRE achieved its FY24 HSAG Goals.

XIII. *LONG TERM SERVICES* AND SUPPORTS

LRE's FY24 Long Term Services and Supports Goal was to elucidate the avenues LRE explores to ensure consumers receiving Long Term Services and Supports are well represented in LRE's QAPIP efforts ensuring improved quality of care and maximum outcomes for consumers.

During the CMHSP Site Reviews, LRE ensures its sampling methodology used to select consumers for clinical chart audits is a representative cross-section of the overall distribution of service types provided in Region 3 by distinct consumer. When LRE selects its random sample for its clinical chart audits, most of the samples selected tether to individuals receiving LTSS. LRE's sampling methodology is the first step ensuring that LRE is able to assess the quality and appropriateness of care furnished to individuals receiving LTSS.

Secondly, LRE's Clinical Chart Audit Tool, which is used during CMSHP Site Reviews, is the mechanism used to assess the quality and appropriateness of care furnished to individuals receiving LTSS. Specifically, LRE's Clinical Chart Audit Tool contains sections on Person- Centered Planning (PCP), which allows LRE to assess member care between care settings, and Service Delivery, which allows LRE to compare the services received by the individuals identified in the individuals treatment/service plan.

LRE's Clinical Chart Audit Tool is compliant with MDHHS' PCP Guidelines Policy and the Medicaid Provider Manual ensuring LRE assesses the quality and appropriateness of care furnished to individuals receiving LTSS. For FY24, LRE has modified its Clinical Chart Audit Tool to capture the LTSS population so that data can be analyzed specifically to this population for comparison with the non-LTSS population to ensure equivalent delivery and quality of care.

LRE also ensures all individuals, including those receiving LTSS, receive a LOCUS/CAFAS upon admission, annually, and when there has been a significant change in consumer's presentation. In an effort to improve visibility of LOCUS utilization, LRE has developed Power-BI Dashboards. Additionally, with the sundowning of the SIS, LRE has engaged in the soft launch of MichiCANS throughout Region 3, which will only strengthen LRE's commitment to ensuring individuals receiving LTSS receive quality, appropriate care over the long-term.

LRE's Microsoft Power-BI Dashboards for Critical Incidents, Risk Events, Physical Management, and Audits provide the ability to view individuals in Specialized Residential settings, which are the vast majority of individuals receiving LTSS.

Critical Incidents in Specialized Residential Settings.

When analyzing the Critical Incidents occurring only in Specialized Residential (SR) settings in FY24, LRE found the following:

FY24 Critical Incident in Specialized Residential Setting	% FY24 Total Critical Incidents that occurred in Specialized Residential Settings
Zero Suicides	0%
3 Accidental Deaths	18%
Zero Homicides	0%
42 Natural Deaths	43%
250 Injuries Requiring Emergency Medical Treatment	97%
6 Medication Errors Requiring Emergency Medical Treatment	100%
20 Injuries Requiring Hospitalization	100%
2 Medication Errors Requiring Hospitalization	100%
24 Arrests	100%

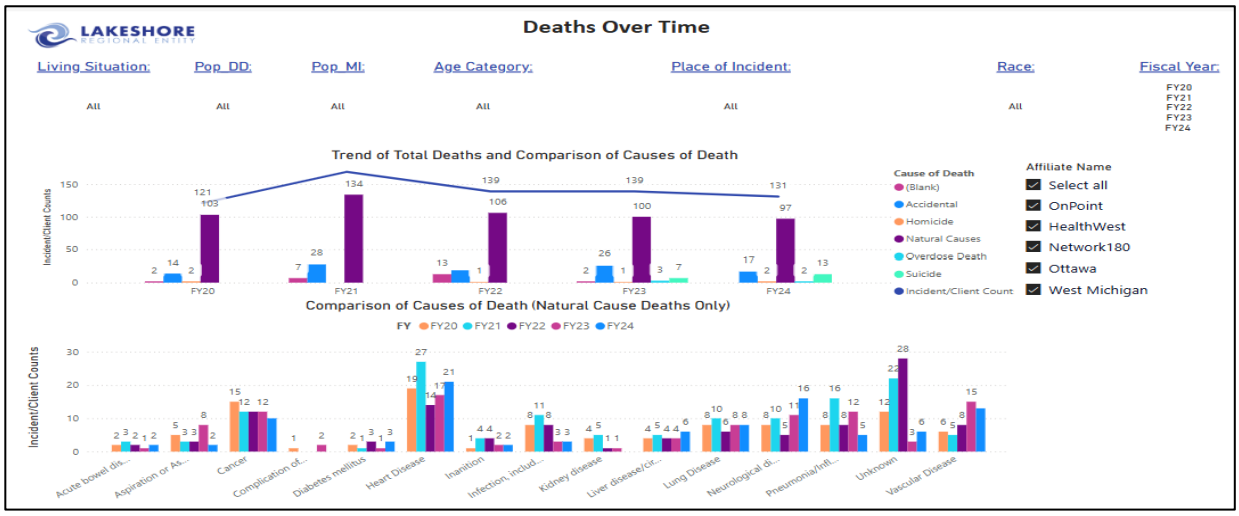
Risk Events in Specialized Residential Settings

When analyzing the Risk Events occurring only in Specialized Residential (SR) settings in FY24, LRE found the following:

Risk Events in SR Settings	% of Total Risk Event by Category
41 Self Harm	35%
15 Harm to Others	71%
129 Police Calls	80%
354 Emergency Uses of Physical Management	86%
30 Two or More Unscheduled Hospitalizations in 12 Months	94%

Mortality Report for Individuals in Specialized Residential Settings

In FY24, LRE's review of its Mortality Report determined that Natural (77%) and Accidental Death (15%) continue to be the primary causes of death regardless of setting, meaning data includes both Specialized Residential and non-Specialized Residential. (See Graph on following page)



For all Natural Deaths in FY24, LRE determined that Heart Disease, Neurological Disorders, Vascular Disease, Cancer, Lung Disease & Pneumonia/Influenzas contributed to 80% of the Natural Deaths in FY24.

LRE FY24 Mortality Report – Cause of Death					
	Fiscal Year				
Cause of Death	**FY20**	**FY21**	**FY22**	**FY23**	**FY24**
Heart Disease	18%	20%	13%	16%	23%
Neurological Disorders	8%	7%	5%	11%	17%
Vascular Disease	6%	4%	8%	13%	13%
Cancer	15%	9%	11%	12%	10%
Lung Disease	8%	7%	4%	4%	8%
Liver Disease / Cirrhosis	4%	4%	4%	4%	6%
Unknown	12%	16%	26%	10%	6%
Pneumonia / Influenza	8%	12%	8%	12%	5%
Diabetes Mellitus	2%	1%	3%	1%	3%
Infection, including AIDS	8%	8%	8%	3%	3%
Acute Bowel Disease	2%	2%	2%	1%	2%
Aspiration or Aspiration Pneumonia	5%	2%	6%	7%	2%
Inanition	1%	3%	4%	2%	2%
Complication of Treatment	1%	0%	0%	2%	0%
Kidney Disease	4%	4%	1%	1%	0%

LRE achieved its FY24 Long Term Services and Supports Goal.

XIII. ACRONYMS

AER	Annual Effectiveness Review
API	Application Programming Interface
BBA	Balanced Budget Act
BTC	Behavior Treatment Committee
BTP	Behavior Treatment Plan
BTR	Behavior Treatment Review
CAP	Corrective Action Plan
CAFAS	Child and Adolescent Functional Assessment Scale
CEO	Chief Executive Officer
CI	Critical Incidents
CQO	Chief Quality Officer
CMCO	Chief Managed Care Officer
CMHSP	Community Mental Health Service Provider
CMS	Centers for Medicare and Medicaid Services
COO	Chief Operations Officer
CPG	Clinical Practice Guideline
CRM	Customer Relationship Management
CS	Customer Satisfaction
CSR	Continued Stay Review
EHR	Electronic Health Record
EQR	External Quality Review / External Quality Review Organization
EMR	Electronic Medical Record
FTE	Full-Time Equivalent
FUH	Follow-up After Hospitalization for Mental Illness
HSAG	Health Services Advisory Group(External Quality Review Organization)
HCBS	Home and Community Based Services
HIPAA	Health Insurance Portability and Accountability Act
HLOC	Higher Level of Care
HMP	Healthy Michigan Plan
ICO	Integrated Care Organization
I/DD	Intellectual/Developmental Disability
IP	Inpatient
IPOS	Individual Plan of Service
IRR	Interrater Reliability
KPI	Key Performance Indicator
LOCUS	Level of Care Utilization System
LTSS	Long Term Services and Supports
LRE	Lakeshore Regional Entity
MDHHS	Michigan Department of Health and Human Services
MHP	Medicaid Health Plan
MI	Mental Illness
MMBPIS	Michigan Mission Based Performance Indicator System
PAS	Preadmission Screening

PCP	Person Centered Planning
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
QAPIP	Quality Assessment and Performance Improvement Plan
QIC	Quality Improvement Council
QI	Quality Improvement
RCA	Root Cause Analysis
RE	Risk Event
ROAT	Regional Operations Advisory Team
SE	Sentinel Event
SIS/CLS	Supports Intensity Scale/Community Living Supports
SME	Subject Matter Expert
SUD	Substance Use Disorder
Survey	Customer Satisfaction Survey
UD	Unexpected Death
UM	Utilization Management