Northern Lakes Community Mental Health Authority

Committee of the Whole Packet

March 17, 2022

Administrative Office, 105 Hall Street, Suite A, Traverse City, MI 49684

COMMITTEE OF THE WHOLE - AGENDA

DATE: March 17, 2022

TIME: 12:30 p.m.

PLACE: Northern Lakes Community Mental Health Authority
Virtual Meeting and 527 Cobb Street, Cadillac
Dial 1-810-258-9588 Conference ID 677 786 686#

TIME	ID #	ITEM	POLICY #
12:30 p.m.		Receive and Review February 17, 2022 Minutes	2.08
12:35 p.m.		Public Comment *(May be limited to three minutes by the Board Chairperson)*	
12:40 p.m.	1	Update on Recipient Rights	3.7
12:50 p.m.	2	FY 2022 NLCMHA Quality Assurance and Improvement, Regulatory Compliance, and Customer Services Report	3.4
1:20 p.m.	3	Security Annual Report	3.4
1:30 p.m.	4	Administrator Paper	3.3
1:40 p.m.		Board Retreat Planning	3.4
2:00 p.m.		April 21, 2022 Agenda Planning Options -Update on Recipient Rights -CEO Evaluation -Financial, Single and Compliance Audit -Code of Conduct and Conflict of Interest	3.2, 3.5
2:05 p.m.		Meeting Evaluation/Comments	
2:10 p.m.		Other/Adjourn	

Note: This is the Board's work group and often times the Board's work groups do not follow set times.

NEXT MEETING: April 21, 2022

NOTICE: If any person with a disability needs accommodations, please call the CEO's Office three days prior to the posted meeting date.

Northern Lakes Community Mental Health Authority
Committee of the Whole
Annotated Agenda
March 17, 2022

12:30 p.m. **Receive and Review February 17, 2022 Meeting Minutes**

12:35 p.m. **Public Comment**
This is an opportunity for the public to provide input consistent with board policy.

12:40 p.m. **Update on Recipient Rights – Brian Newcomb**
The Board will receive the monthly update.

12:50 p.m. **FY 2022 NLCMHA Quality Assurance and Improvement – Kari Barker Regulatory Compliance, and Customer Services Report**

1:20 p.m. **Security Annual Report – Dan Mauk**

1:30 p.m. **Administrative Paper – Board Members**

1:40 p.m. **Board Retreat Planning – Board Members**

2:00 p.m. **April 21, 2022 Agenda Planning Options**
-Update on Recipient Rights
-CEO Evaluation
-Financial, Single and Compliance Audit
-Code of Conduct and Conflict of Interest

2:05 p.m. **Meeting Evaluation/Comments – Board Members**
In keeping with our focus on continued improvement of Board operations, time is scheduled for review and comment on the effectiveness of this meeting using the Board adopted evaluation form.

2:10 p.m. **Other/Adjourn**

Note: This is the Board's work group and often times the Board's work groups do not follow set times.

NEXT MEETING: April 21, 2022

Office of Recipient Rights Director's Report
March 2022

Dates represented	10/1/19-03/08/20	10/1/20-03/08/21	10/1/21-03/04/22
Complaints	203	97	225
OJ, No Right Inv.	25	13	31
Interventions	6	1	12
Investigations	174	83	182
Investigations Comp	174	83	119
Investigations open	0	0	63
Inv > 90 days	7	23	0
Inv < 90 days	167/174 (96%)	60/83(72.3%)	119/119(100%)
Summary Report Avg	173/174 (99.4%	81/83(97.6%)	93/93 (100%)
NLCMHA Staff	35	14	18
NLCMHA Staff W/I 1 yr	11	2	5

	Substantiation Rate
FY2013	31%
FY2014	42%
FY2015	42%
FY2016	44%
FY2017	43%
FY2018	39%
FY2019	51%
FY2020	49%
FY2021	45%
FY2022	43%

-Currently achieving a 60-day Investigation completion time frame.

Respectfully submitted,

Brian Newcomb

Director of Recipient Rights

ITEM # 1

Quality, Compliance, and Customer Services Report to the Board of Directors

March 17, 2022 Covering FY22 Q1

Presented by Kari Barker, LBSW, MSW, Director of QI & Compliance

Compliance/Privacy & Security	Quality
• Compliance inquiries resolved within 60 days: **There were no compliance issues reported. There were 2 reports handled by HR.** • Monthly exclusionary report clear: **100% Note: This reporting responsibility will transfer to NLCMHA Compliance team from the NMRE this month.** • MEV audit success: **100%** • OIG/Fraudulent conduct: **There were no OIG reports submitted.** • Security inquiries resolved within 30 days: **None reported.** • Privacy inquiries **(2)** resolved within 30 days: **100% Neither were HIPAA breaches. Both were emails that went to an entire office instead of team.** • Annual Relias staff compliance training completed: **94% Note: Regulatory Compliance training beyond Relias will be offered every other month beginning in April. Core features as well as specific areas of need.** • **No inappropriate access to records.**	• We received a 3yr CARF accreditation, with a minimal QIP. Lots of positive feedback re: consumer care. • The region is still waiting on the results of our annual MDHHS audit. • Cultural Intelligence project continues to move forward, we received positive support from CARF reviewers. • It was decided that exclusionary reporting and internal staff credentialing will transfer from HR to Quality & Compliance. Both groups will be working together towards a smooth transfer in Q2. • As a region we will be developing new PIPs (Performance Improvement Projects) for implementation this Spring. HSAG's direction is that it supports health and cultural equity.
Customer Service See below	**Training Opportunities** • New hire NOLA/compliance training continues • Facts & Snacks began by Customer Service • Annual mandatory compliance training continues through Relias

Performance Indicators Q1
Q1 data is not available yet.

Critical Incident	Codes Total
Attempted Suicide	0
Non-Suicide Death - Natural Causes	3 Cancer and heart disease
EMT Due to Illness	3 Chronic conditions
Refused Meds	3 Non-serious
Other Challenging Behavior	17 Smoking in the house, accessing another resident's room, behavioral issues supported in the IPOS/Behavioral Supports plan
Med Error - Missed Dose	1 Non-serious
Non-Suicide Death - Unexpected	0
Verbal Aggression to Other	0
Non-Suicide Death - Natural Causes	0
EMT Due to Injury Not During Physical Management	1
Hospitalization Due to Injury Not During Physical Mgmt.	0
Self-Injury	0
Fall	0
Med Error - Wrong Dose	1 Non-serious

Sentinel Events	
Head injury due to fall	SRS resident slipped on ice on the deck and fell, EMT provided, non-serious injury.
Attempted suicide in jail	Individual was provided crisis service and screened for inpatient, no suicidal indications. Was seen in the hospital ED.

Customer Services FY22Q1 Outcomes

Grievances-

17 total Grievances

100% were resolved in 30 days with an average of 16.5 days to resolution.

10 COP grievances, 6 grievances

COP requests: 6 OPT, 4 Psych Services

COP Outcome: 6 approved, 3 denied, 1 pending

Appeals –

8 Local Appeals

100% resolved in the 30 day timeframe, with a 22 day average for resolution

Appeal Outcome: 2 upheld, 2 overturned, 2 withdrawn, 1 pending

Second Opinion: 8 total, 5 inpatient and 3 access, 7 upheld, 1 overturned

CS Inquiries-

37 CS inquiries, 12 being CS only (not grievance or appeals) 100% resolved within 1 day, with an avg of 4 hour resolution.

7 accommodations were requested and provided

Recipient Satisfaction Surveys:

100% attempted, about 40% response

More responses received in the first quarter than collectively for the last FY due to trimming the questions from 26 to 5.

Highlights:

I had a voice in my services: 4.2

Staff treats me with dignity and respect: 4

Overall satisfaction: 4

I/DD Survey

Little data yet, but overall satisfaction is 3.8

Northern Lakes Community Mental Health Authority

QUALITY ASSURANCE AND IMPROVEMENT PLAN

FY 2022

OVERVIEW:

This document presents the comprehensive and systematic plan for the operation of the quality assurance program of Northern Lakes Community Mental Health Authority (NLCMHA). The Quality Assurance Plan shall be the standard that guides business function and service delivery and applies to all programming and services at the agency. NLCMHA is a not-for-profit behavioral health care treatment provider offering mental health and substance abuse services for children, adolescents, and adults. The agency's Board of Directors has adopted the philosophy of continuous quality improvement to ensure organization-wide ongoing quality assurance. NLCMHA understands the need to strategically monitor and assess its performance as defined by the agency and state Performance Indicators.

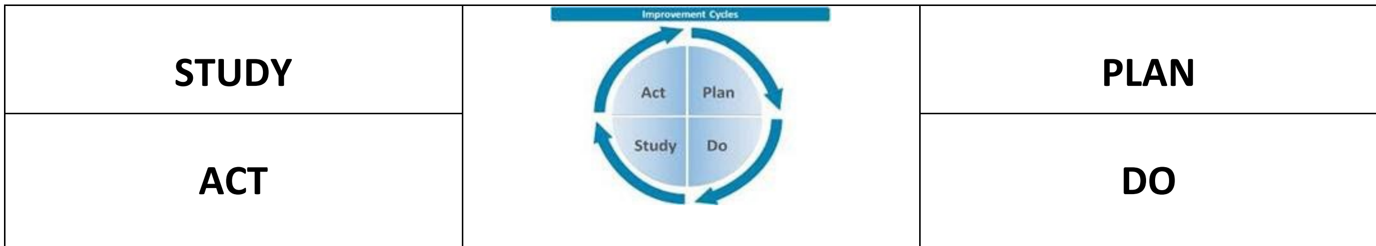
OBJECTIVES:

1. Identify problem trends and gaps related to service delivery.
2. Provide information about service needs to persons in the organization responsible for planning.
3. Develop corrective action plans that address problems at the appropriate level of the organization.
4. Promote opportunities to improve service delivery through a process of case review, consumer satisfaction, performance indicator analysis and internal audits.
5. Ensure that consumers served, employees, and the Board of Directors have the opportunity for feedback in the development of the Quality Improvement Plan as well as the components of Quality Assurance planning and evaluation.

QUALITY ASSURANCE AND IMPROVEMENT MODEL:

Quality assurance and improvement is a systematic, ongoing process that is designed to assess and evaluate the quality and appropriateness of services, to resolve identified problems, to identify gaps in service, to promote opportunities to improve business practices and service delivery and overall organizational performance.

THE QUALITY ASSURANCE MODEL



1. **Study** the system or process where improvement is needed. Evaluate the available information and describe what the information is telling you. Are there particular problems and what are the causes?

2. **Act** and decide what change is needed. Will this be a large-scale or small-scale change?

3. **Plan** on how the data will be collected. When will the progress be reviewed? Who will do the work?

4. **Do** the work according to the plan that was created.

5. **Study** the gathered information and determine whether the desired outcome was achieved or not?

6. **Act** by deciding if any further action is needed to bring improvement to noted area.

SCOPE OF SERVICE:

NLCMHA is a comprehensive provider of mental health and substance use services to a six (6) county service area that includes Grand Traverse, Leelanau, Wexford, Missaukee, Roscommon, and Crawford. Services provided (internal and contracted) include, case management, outpatient, psychiatric, integrated healthcare, crisis intervention, crisis residential, community living supports, respite, substance use disorders treatment, assertive community treatment, residential care, clubhouse, peer-delivered & peer specialist services, infant mental health, intensive home-based for children, autism, support groups, consultation, prevention, and community education.

The agency's structure is based on a decentralized model and operates offices in 4 counties of the service area (Grand Traverse, Wexford, Crawford, and Roscommon). These four (4) sites provide a full range of mental health and cooccurring disorders services. The services below are CARF accredited programs. CARF is an international accrediting body that seeks to promote strong values and quality care to organizations that provide services to consumers, which further demonstrates NLCMHA's commitment to providing the highest quality of service.

1. Assessment and referral
2. Assertive Community Treatment (ACT)
3. Crisis Intervention (Specifically Pre-Hospitalization Screening)

4. Outpatient Treatment
5. Intensive Family-Based Services
6. Case management and Supports
7. Prevention, Education, Consultation

IMPORTANT ORGANIZATIONAL FUNCTIONS AND DIMENSIONS OF QUALITY ASSURANCE:

The framework and process of the Quality Plan complies with applicable standards of the Michigan Department of Health and Human Services (MDHHS), the Northern Michigan Regional Entity Prepaid Inpatient Health Plan (NMRE-PIHP), and the Centers for Medicare and Medicaid Services (CMS). NLCMHA's focus is on improvements in functions and processes in the areas of direct consumer care, governance, management operations and support functions.

QUALITY ASSURANCE AND IMPROVEMENT RESPONSIBILITIES:

Monitoring and evaluating activities are performed through committee structure, designed to assure appropriate representation of all functional areas of the agency.

1. **Board of Directors**: The Board of Directors maintains ultimate responsibility for agency quality standards. The Chief Executive Officer (CEO), Director of Quality Improvement and Compliance (DQIC), and the Performance Measurement & Quality Improvement Committee (PMQI), assume quality assurance and improvement responsibilities for the Agency.

2. **Performance Measurement and Quality Improvement Committee:** This committee is chaired by the DQIC and convenes on a monthly basis to meet with Clinical and other Program leaders across the agency. The committee is responsible for implementing, revising, and monitoring adherence to agency quality performance goals and delineating these findings to the Board of Directors, leadership, and staff.

3. **Chief Population Officers (CPOs) & Directors:** The CPOs and Directors play a vital role in ensuring that their staff work toward the stated performance goals in the Quality Plan. This is accomplished through guidance, supervision, relaying information in meetings, and upholding agency standards for ongoing quality assurance and improvement.

4. **Agency Staff:** Quality is the collective responsibility of every employee and is maintained by adherence to this plan and by ensuring that all work is done in an ethical and proper manner.

NLCMHA Data System

Specific data management processes support the use of high-quality data to develop information about the quality of care or services being provided, the performance of various organizational processes and the overall

performance of the organization. In individual quality improvement studies, the reliability, validity, and completeness of data is described, and specific data collection and aggregation techniques designed to quantify quality of the data are used. In addition, data accuracy is estimated quantitatively and reported.

The management information system, which also fuels quality improvement activities with data, utilizes forced-choice mechanisms to ensure the completion of required fields within data entry screens. In addition, regular auditing is used to report the integrity of data and that information is used to further target and prioritize data improvement efforts.

Dissemination of Performance Information

Performance and quality information is shared in format(s) that are useful to the persons served, personnel and other stakeholders. Specifically, the quality improvement process frequently transforms raw or complex data into meaningful information designed to be useful in the education of key stakeholders and further, establishes or increases motivation and designs incentives to influence improved performance. The Northern Lakes CMHA DQIC individually and the PMQI committee collectively, will develop information that is produced in ways that encourage and engage people in its use.

Sentinel Events

Processes designed to identify sentinel events and in response, conduct thorough and credible root cause analysis are specified in NLCMHA policy and procedure. The PMQI committee will regularly review the findings of root cause analysis with specific attention to opportunities to systematically improve performance, reduce risk and ensure safety as a result of review of the findings. These events are reported to the NMRE-PIHP according to contract requirements.

Utilization Management

The NLCMHA Utilization Management Plan specifies the goal, scope, authority, responsibility, objectives, organizational structure and specific activities of the utilization management program. The plan also describes how the agency makes uniform service authorization and reduction decisions. The PMQI committee embraces a goal of ensuring the provision of high-quality services. As such, during data collection, analysis and monitoring, the committee may determine an issue could best be addressed by a subcommittee that will investigate and report back. In these cases, the collaborative, consultative relationship between PMQI and subcommittees is used to ensure the most appropriate organizational component is addressing important issues in improving the quality of care.

Credentialing and Privileging Processes

NLCMHA conducts credentialing and privileging according to established policies and procedures. The credentialing and privileging committee is represented on the PMQI committee by the chairperson. Clinical staff are credentialed at the time of hire and when required, privileged to perform specific duties for which they are qualified. Re-credentialing occurs at least every two years or may occur more often under special circumstances. The credentialing committee establishes standards for credentialing and re-credentialing, and provides orientation to the affiliate providers regarding standards, and monitors for implementation.

Staff Training and Development

The NLCMHA training and staff development plan specifies that all clinical staff members, both internal and external practitioners are required to receive initial and continuing education and staff development which includes minimum annual training requirements. The quality improvement process will identify issues which require additional training or revisions in currently provided training. These will be referred to the staff development and training committee for action and implementation through the PMQI committee participant.

Quality Improvement Performance Goals and Work Plan

The NLCMHA leadership establishes broad performance goals for the organization. The PMQI committee establishes specific measures and ongoing monitoring to ensure continuous pursuit of those goals. Performance goals are based on contractual performance requirements, industry benchmarks, historical performance trends of the organization, and new performance targets established internally or externally to the organization. Annually, the PMQI committee establishes formal written quality improvement performance goals and incorporates the content of those goals into a specific work plan to be accomplished during the year.

Interaction with the NMRE Quality Oversight Committee

This quality improvement plan is written with the expressed intention to be complimentary to the NMRE Quality Assessment Performance Improvement Plan. Of note is that the Quality Assessment Performance Improvement Projects (QAPIP) references the affiliation process for identifying, reporting and processing sentinel events, the process for adopting practice guidelines and how the affiliation will ensure the verification of Medicaid reimbursed services. The NLCMHA quality improvement process will utilize and fully participate in the affiliation system of quality and performance improvement oversight. In addition, NLCMHA will participate in coordinated studies of service satisfaction, specific quality improvement initiatives and QAPIP with the NMRE.

Annual Agency Review

On an annual basis the PMQI committee participates in an annual agency review. This effectiveness analysis includes the development of an overall description of the business and service delivery functions of the organization including trending and comparative quality and performance information where available, a summary of the input obtained from persons served, personnel and other stakeholders and a description of how the information was used to improve quality and performance. Analysis of specific performance indicators for service access, effectiveness and efficiency of services is provided as well as a summary of annual work plan achievements and challenges. Finally, the effectiveness analysis process will result in the identification of areas needing performance improvement and an action plan to address the improvements as well as the establishment of revised performance goals. Overall, information from the process is used to review the implementation of the NLCMHA mission and core values of the organization, improve the quality of programs and services and facilitate organizational decision making and strategic planning.

Annual Quality Review

On an annual basis the DQIC will draft a report summarizing all efforts by the PMQI committee and present the results for review and approval by the NLCMHA Board.

PMQI - January 5, 2022

- Last month's minutes reviewed
- MIChoice Program Integrity Review
- NMRE/QOC Updates

Attendance: Kari Barker, Jess Williams, Brie Molaison, Michelle Dosch, Tracy Andrews, Darryl Washington, Dave Simpson, Dan Mauk, Trapper Merz, Curt Cummins, Carrie Gray, ~~Lauri Fischer~~, ~~Joanie Blamer~~, Lisa Woodcox, Aaron Fader, Brian Newcomb~~, Kim Silbor~~, Andrew Waite, ~~Kaitlyn Reinink~~
Guests: ~~Melissa Trout~~, Erika Solomonson, Erica Longstreet

Report	Objectives	Outcome	Follow Up	Analysis	Extenuating Circumstances	Action Taken
Psychiatric Services - Curt & Kaitlyn	• Video vs phone services: 80% • Video vs phone for dually enrolled Medicaid/Medicare: 100% • Psych services no-show rate in-person: <10% • Psych services telehealth no-show rate: <10% • IPOS within 365 days for psych services: 95%					
SED - Melissa/Erika	• Avg SED caseload: • Homebased discharge surveys completed: 95% • Monitoring transition of care to determine appropriate LOC: 2x/year • Track consumer engagement in the first 3 months post-Access					
Critical/Risk/Sentinel Events - Kari	• Critical events: <20 • Risk events: <30 • Sentinel events: <2 • Mortality reviews completed: • Suicides: 0					

Clinical Record Review - Jess	Individual record reviews per quarter: 15 • Two records each from ACT, IDD Adults, IDD Children, MIA, Outpatient Therapy and SED • One closed record each from ACT, IDD Adults and IDD Children					
Customer Service - Brie	• Grievances resolved within 30 days: 80% • Appeals resolved within 30 days: 100% • Inquiries resolved within 1 day: 95% • Appeals upheld: 80% • Fair Hearings requested: <2 • Satisfaction surveys completed: 75% • Issues from CAC meeting					
QI - Kari	• IPOS Goal/Objectives met - IDD: 60% • IPOS Goal/Objectives met - MIA: 60% • IPOS Goal/Objectives met - Children: 60% • Staff productivity: 30% • Grant monitoring					
Self-Determination - Lisa	• SD arrangements with agreements in place: 100% • Budget outliers (10%+ increase): <1					
Access/GF - Erica	• Denials at Access: • Avg wait time for initial screening: • Non-MA transition to MA: 95% • Non-MA active: <5%					

MIChoice - Darryl	• Meet Quality & Compliance Measures: 95% • Increase returned to community by 10% • Increase enrollment by 5% • Quality withhold returned: 100%					

PMQI - February 2, 2022

• **Last month's minutes reviewed** - No questions or concerns
• **MIChoice Program Integrity Review**- Darryl: There is one risk related issue- we received the quality indicators report from the state.
One of the indicators is fall prevention. Baseline goal is 23%. They are Tracking how many times an individual falls after they are enrolled.

Attendance: Kari Barker, Jess Williams, Brie Molaison, Michelle Dosch, Tracy Andrews, Darryl Washington, Dave Simpson, Dan Mauk, Trapper Merz, Curt Cummins, Carrie Gray, Lauri Fischer, ~~Joanie Blamer~~, Lisa Woodcox, ~~Aaron Fader~~, Brian Newcomb, Kim Silbor, Andrew Waite

Guests: ~~Stacey Kaminski~~, Aimee Horton-Johnson, Darlene Buchner, Janell Briggs, Sheryl Dey

Report	Objectives	Outcome	Follow Up	Analysis	Extenuating Circumstances	Action Taken
Compliance - Kari	In-service revision proposal Policy reboot					
Crisis Services - Stacey	request: 95% • Decrease inpatient recidivism by 10% • Increase hospital diversion by 20% • Decrease inpatient costs by 10% • Increase prebooking jail diversion by 10% • Increase completion of Crisis					
Facilities/Safety - Aimee	• Facility accidents: <1 • Staff injuries requiring medical intervention: <2 • Required emergency drills conducted: 100% • Outliers:					
HSW - Darlene	• Increase waiver slots by 5% • Complete HSW re-certifications: 100% • IPOS for HSW recipients within 365 days: 100% • Providers on HCBS heightened scrutiny list: <5%					

Autism Services/ABA - Janell	• ABA: 30% center / 70% home • Average length of treatment: • ADOS scores improve: 30% • Participants to be discharged: • Outliers:					
Recipient Rights - Brian	• NLCMHA staff ORR training: 100% • External providers ORR training • Trends • Outliers					
MIA/SED - Kim/Sheryl	• Pre/Post-Hospitalization • Annual increase in employment status: 10%					
Integrated Health Clinic - Tracy	• IHC patient numbers increase by 10% • No-show rate: • Annual wellness visits: • Third party billings					
CHAT - Andrew	• CHAT enrollment increases by 10% • CHAT referrals increase by 10% • Avg Health Risk Score improvement					

PMQI - March 2, 2022

<table>
<tr><td colspan="2">• Last month's minutes reviewed N/A
•MIChoice Program Integrity Review
• NMRE/QOC Updates
• Establish a regular subcommittee to provide UM for high-cost SRS situations and get the Access UM group up and running again. We'll need to select a group of 3-4 people to meet monthly and review specific cases.</td><td colspan="5">Attendance: Kari Barker, Jess Williams, Brie Molaison, Michelle Dosch, Tracy Andrews, Darryl Washington, Dave Simpson, Dan Mauk, Trapper Merz, Curt Cummins, Lauri Fischer, Aaron Fader, Brian Newcomb, Kim Silbor

Guests: Sheryl Dey, Hannah Driver, Amy Kotulski, Stacey Kaminski, Pam Blue Absent: Carrie Gray, Joanie Blamer,Lisa Woodcox, Andrew Waite, Kaitlyn Reinink, Marshall Cronican-Walker</td></tr>
<tr><th>Report</th><th>Objectives</th><th>Outcome</th><th>Follow Up</th><th>Analysis</th><th>Extenuating Circumstances</th><th>Action Taken</th></tr>
<tr><td>Psych Services - Curt/Kaitlyn</td><td>• Video vs phone services: 80%
• Video vs phone for dually enrolled Medicaid/Medicare: 100%
• Psych services no-show rate in-person: <10%
• Psych services telehealth no-show rate: <10%
• IPOS within 365 days for psych services: 95%</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Crisis Services - Stacey</td><td>• Disposition within 3 hours of request: 95%
• Decrease inpatient recidivism by 10%
• Increase hospital diversion by 20%
• Decrease inpatient costs by 10%
• Increase prebooking jail diversion by 10%
• Increase completion of Crisis Prevention Plans by 20% across populations</td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

HR - Aaron	• Required training completed: 100% • Staff evaluations completed: 100% • Ongoing credentialing completed: 100% • Systemic staff issues to be addressed: <2% • Exit trends					
BTC - Carrie	• Physical Management resulting in injury: none • Functional assessments current: 100% • Quarterly BTC reviews completed: 100% • Postive Behavioral Support plans increased by 10%					
Board Operated Homes - Dave	• Culture of Gentleness training for all staff: 100% • Staffing levels in homes: 75% • Individuals making progress toward objectives: 60% • House meetings including leadership quarterly at minimum: 100% • SRS Operations Manual revised and updated by 4/1/21 • Existing staff trained on updated manual by 12/31/21					

Compliance/Privacy & Security - Kari	• Compliance inquiries resolved within 60 days: 100% • Monthly exclusionary report clear: 100% • MEV audit success: 95% • OIG/fraudulent conduct: 0% • Security inquiries resolved within 30 days: 100% • Privacy inquirires resolved within 30 days: 100% • Annual staff compliance training: 100%					
Outpatient Therapy - Sheryl	• Average length of therapy: Collecting baseline data • Outpatient therapy will reduce the number of individuals in care for more than 12 months by 20% by 10/1/21					
LOCUS - Kim	• LOCUS completed annually: 100%					
OBRA - Marshall	• OBRA assessments completed per timelines: 95%					
Clubhouse - Hannah/Amy	• % of Clubhouse only members: • Staff training current: 100% • Clubhouse only IPOS current: 100% • Clubhouses open weekends and holidays: 100% • Annual increase in employment status: 20%					

PMQI - March 2, 2022

• Last month's minutes reviewed • MIChoice Program Integrity Review • NMRE/QOC Updates	Attendance: Kari Barker, Jess Williams, Brie Molaison, Michelle Dosch, Tracy Andrews, Darryl Washington, Dave Simpson, Dan Mauk, Trapper Merz, Curt Cummins, Carrie Gray, Lauri Fischer, Joanie Blamer, Lisa Woodcox, Aaron Fader, Brian Newcomb, Kim Silbor, Andrew Waite Guests: Melissa Trout, Erika Solomonson, Erica Longstreet

Report	Objectives	Outcome	Follow Up	Analysis	Extenuating Circumstances	Action Taken
SED - Melissa/Erika	• Avg SED caseload: • Homebased discharge surveys completed: 95% • Monitoring transition of care to determine appropriate LOC: 2x/year • Track consumer engagement in the first 3 months post-Access					
Critical/Risk/Sentinel Events - Kari	• Critical events: <20 • Risk events: <30 • Sentinel events: <2 • Mortality reviews completed: • Suicides: 0					
Clinical Record Review - Jess	Individual record reviews per quarter: 15 • Two records each from ACT, IDD Adults, IDD Children, MIA, Outpatient Therapy and SED • One closed record each from MIA, Outpatient and SED					

Customer Service - Brie	• Grievances resolved within 30 days: 80% • Appeals resolved within 30 days: 100% • Inquiries resolved within 1 day: 95% • Appeals upheld: 80% • Fair Hearings requested: <2 • Satisfaction surveys completed: 75% • Issues from CAC meeting					
QI - Kari	• IPOS Goal/Objectives met - IDD: 60% • IPOS Goal/Objectives met - MIA: 60% • IPOS Goal/Objectives met - Children: 60% • Staff productivity: 30% • Grant monitoring					
Self-Determination - Lisa	• SD arrangements with agreements in place: 100% • Budget outliers (10%+ increase): <1					
Access/GF - Erica	• Denials at Access: • Avg wait time for initial screening: • Non-MA transition to MA: 95% • Non-MA active: <5%					
Performance Indicators - Trapper						

MIChoice - Darryl	• Meet Quality & Compliance Measures: 95% • Increase returned to community by 10% • Increase enrollment by 5% • Quality withhold returned: 100%					

PMQI - May 4, 2022

• Last month's minutes reviewed • MIChoice Program Integrity Review • NMRE/QOC Updates	Attendance: Kari Barker, Jess Williams, Brie Molaison, Michelle Dosch, Tracy Andrews, Darryl Washington, Dave Simpson, Dan Mauk, Trapper Merz, Curt Cummins, Carrie Gray, Lauri Fischer, Joanie Blamer, Lisa Woodcox, Aaron Fader, Brian Newcomb, Kim Silbor, Andrew Waite Guests: Stacey Kaminski, Aimee Horton-Johnson, Darlene Buchner, Janell Briggs, Sheryl Dey, Pam Blue

Report	Objectives	Outcome	Follow Up	Analysis	Extenuating Circumstances	Action Taken
Crisis Services - Stacey	request: 95% • Decrease inpatient recidivism by 10% • Increase hospital diversion by 20% • Decrease inpatient costs by 10% • Increase prebooking jail diversion by 10% • Increase completion of Crisis					
Facilities/Safety - Aimee	• Facility accidents: <1 • Staff injuries requiring medical intervention: <2 • Required emergency drills conducted: 100% • Outliers:					
HSW - Darlene	• Increase waiver slots by 5% • Complete HSW re-certifications: 100% • IPOS for HSW recipients within 365 days: 100% • Providers on HCBS heightened scrutiny list: <5%					

Autism Services/ABA - Janell	• ABA: 30% center / 70% home • Average length of treatment: • ADOS scores improve: 30% • Participants to be discharged: • Outliers:					
Recipient Rights - Brian	• NLCMHA staff ORR training: 100% • External providers ORR training • Trends • Outliers					
MIA/SED - Kim/Sheryl	• Pre/Post-Hospitalization • Annual increase in employment status: 10%					
Integrated Health Clinic - Tracy	• IHC patient numbers increase by 10% • No-show rate: • Annual wellness visits:					
CHAT - Andrew	• CHAT enrollment increases by 10% • CHAT referrals increase by 10% • Avg Health Risk Score improvement					
Provider Network Management - Tracy	• SRS need decreased by 2% • Appropriate staffing level: 95% • Site reviews: 95% • Provider contracts current: 100%					

PMQI - June 1, 2022

• Last month's minutes reviewed • MIChoice Program Integrity Review • NMRE/QOC Updates	Attendance: Kari Barker, Jess Williams, Brie Molaison, Michelle Dosch, Tracy Andrews, Darryl Washington, Dave Simpson, Dan Mauk, Trapper Merz, Curt Cummins, Carrie Gray, Lauri Fischer, Joanie Blamer, Lisa Woodcox, Aaron Fader, Brian Newcomb, Kim Silbor, Andrew Waite Guests: Kaitlyn Reinink, Sheryl Dey, Marshall Cronican-Walker, Hannah Driver, Amy Kotulski

Report	Objectives	Outcome	Follow Up	Analysis	Extenuating Circumstances	Action Taken
Psych Services - Curt/Kaitlyn	• Video vs phone services: 80% • Video vs phone for dually enrolled Medicaid/Medicare: 100% • Psych services no-show rate in-person: <10% • Psych services telehealth no-show rate: <10% • IPOS within 365 days for psych services: 95%					
HR - Aaron	• Required training completed: 100% • Staff evaluations completed: 100% • Ongoing credentialing completed: 100% • Systemic staff issues to be addressed: <2% • Exit trends					
BTC - Carrie	injury: none • Functional assessments current: 100% • Quarterly BTC reviews completed: 100% • Postive Behavioral Support plans					

Board Operated Homes - Dave	• Culture of Gentleness training for all staff: 100% • Staffing levels in homes: 75% • Individuals making progress toward objectives: 60% • House meetings including leadership quarterly at minimum: 100% • SRS Operations Manual revised and updated by 4/1/21 • Existing staff trained on updated manual by 12/31/21					
Compliance/Privacy & Security - Kari	within 60 days: 100% • Monthly exclusionary report clear: 100% • MEV audit success: 95% • OIG/fraudulent conduct: 0% • Security inquiries resolved within 30 days: 100% • Privacy inquirires resolved within 30 days: 100% • Annual staff compliance training:					
Outpatient Therapy - Sheryl	• Average length of therapy: Collecting baseline data • Outpatient therapy will reduce the number of individuals in care for more than 12 months by 20% by 10/1/21					
LOCUS - Kim	• LOCUS completed annually: 100%					
OBRA - Marshall	• OBRA assessments completed per timelines: 95%					

PMQI - July 6, 2022

• Last month's minutes reviewed • MIChoice Program Integrity Review • NMRE/QOC Updates	Attendance: Kari Barker, Jess Williams, Brie Molaison, Michelle Dosch, Tracy Andrews, Darryl Washington, Dave Simpson, Dan Mauk, Trapper Merz, Curt Cummins, Carrie Gray, Lauri Fischer, Joanie Blamer, Lisa Woodcox, Aaron Fader, Brian Newcomb, Kim Silbor, Andrew Waite Guests: Melissa Trout, Erika Solomonson, Erica Longstreet

Report	Objectives	Outcome	Follow Up	Analysis	Extenuating Circumstances	Action Taken
SED - Melissa/Erika	• Avg SED caseload: • Homebased discharge surveys completed: 95% • Monitoring transition of care to determine appropriate LOC: 2x/year • Track consumer engagement in the first 3 months post-Access					
Critical/Risk/Sentinel Events - Kari	• Critical events: <20 • Risk events: <30 • Sentinel events: <2 • Mortality reviews completed: • Suicides: 0					
Clinical Record Review - Jess	Individual record reviews per quarter: 15 • Two records each from ACT, IDD Adults, IDD Children, MIA, Outpatient Therapy and SED • One closed record each from ACT, IDD Adults and IDD Children					

Customer Service - Brie	• Grievances resolved within 30 days: 80% • Appeals resolved within 30 days: 100% • Inquiries resolved within 1 day: 95% • Appeals upheld: 80% • Fair Hearings requested: <2 • Satisfaction surveys completed: 75% • Issues from CAC meeting					
QI - Kari	• IPOS Goal/Objectives met - IDD: 60% • IPOS Goal/Objectives met - MIA: 60% • IPOS Goal/Objectives met - Children: 60% • Staff productivity: 30% • Grant monitoring					
Self-Determination - Lisa	• SD arrangements with agreements in place: 100% • Budget outliers (10%+ increase): <1					
Access/GF - Erica	• Denials at Access: • Avg wait time for initial screening: • Non-MA transition to MA: 95% • Non-MA active: <5%					
MIChoice - Darryl	• Meet Quality & Compliance Measures: 95% • Increase returned to community by 10% • Increase enrollment by 5% • Quality withhold returned: 100%					

PMQI - August 3, 2022

• Last month's minutes reviewed
• MIChoice Program Integrity Review
• NMRE/QOC Updates

Attendance: Kari Barker, Jess Williams, Brie Molaison, Michelle Dosch, Tracy Andrews, Darryl Washington, Dave Simpson, Dan Mauk, Trapper Merz, Curt Cummins, Carrie Gray, Lauri Fischer, Joanie Blamer, Lisa Woodcox, Aaron Fader, Brian Newcomb, Kim Silbor, Andrew Waite

Guests: Stacey Kaminski, Aimee Horton-Johnson, Darlene Buchner, Janell Briggs, Sheryl Dey, Pam Blue

Report	Objectives	Outcome	Follow Up	Analysis	Extenuating Circumstances	Action Taken
Crisis Services - Stacey	request: 95% • Decrease inpatient recidivism by 10% • Increase hospital diversion by 20% • Decrease inpatient costs by 10% • Increase prebooking jail diversion by 10% • Increase completion of Crisis					
Facilities/Safety - Aimee	• Facility accidents: <1 • Staff injuries requiring medical intervention: <2 • Required emergency drills conducted: 100% • Outliers:					
HSW - Darlene	• Increase waiver slots by 5% • Complete HSW re-certifications: 100% • IPOS for HSW recipients within 365 days: 100% • Providers on HCBS heightened scrutiny list: <5%					

Autism Services/ABA - Janell	• ABA: 30% center / 70% home • Average length of treatment: • ADOS scores improve: 30% • Participants to be discharged: • Outliers:					
Recipient Rights - Brian	• NLCMHA staff ORR training: 100% • External providers ORR training • Trends • Outliers					
MIA/SED - Kim/Sheryl	• Pre/Post-Hospitalization • Annual increase in employment status: 10%					
Integrated Health Clinic - Tracy	• IHC patient numbers increase by 10% • No-show rate: • Annual wellness visits: • Third party billings					
CHAT - Andrew	• CHAT enrollment increases by 10% • CHAT referrals increase by 10% • Avg Health Risk Score improvement					

PMQI - September 7, 2022

• Last month's minutes reviewed • MIChoice Program Integrity Review • NMRE/QOC Updates		Attendance: Kari Barker, Jess Williams, Brie Molaison, Michelle Dosch, Tracy Andrews, Darryl Washington, Dave Simpson, Dan Mauk, Trapper Merz, Curt Cummins, Carrie Gray, Lauri Fischer, Joanie Blamer, Lisa Woodcox, Aaron Fader, Brian Newcomb, Kim Silbor, Andrew Waite Guests: Kaitlyn Reinink, Sheryl Dey, Marshall Cronican-Walker, Hannah Driver, Amy Kotulski				
Report	**Objectives**	**Outcome**	**Follow Up**	**Analysis**	**Extenuating Circumstances**	**Action Taken**
Psych Services - Curt/Kaitlyn	• Video vs phone services: 80% • Video vs phone for dually enrolled Medicaid/Medicare: 100% • Psych services no-show rate in-person: <10% • Psych services telehealth no-show rate: <10% • IPOS within 365 days for psych services: 95%					
HR - Aaron	• Required training completed: 100% • Staff evaluations completed: 100% • Ongoing credentialing completed: 100% • Systemic staff issues to be addressed: <2% • Exit trends					
BTC - Carrie	• Physical Management resulting in injury: none • Functional assessments current: 100% • Quarterly BTC reviews completed: 100% • Postive Behavioral Support plans increased by 10%					

Board Operated Homes - Dave	• Culture of Gentleness training for all staff: 100% • Staffing levels in homes: 75% • Individuals making progress toward objectives: 60% • House meetings including leadership quarterly at minimum: 100% • SRS Operations Manual revised and updated by 4/1/21 • Existing staff trained on updated manual by 12/31/21					
Compliance/Privacy & Security - Kari	• Compliance inquiries resolved within 60 days: 100% • Monthly exclusionary report clear: 100% • MEV audit success: 95% • OIG/fraudulent conduct: 0% • Security inquiries resolved within 30 days: 100% • Privacy inquirires resolved within 30 days: 100% • Annual staff compliance training: 100%					
Outpatient Therapy - Sheryl	• Average length of therapy: Collecting baseline data • Outpatient therapy will reduce the number of individuals in care for more than 12 months by 20% by 10/1/21					
LOCUS - Kim	• LOCUS completed annually: 100%					
OBRA - Marshall	• OBRA assessments completed per timelines: 95%					

Clubhouse - Hannah/Amy	• % of Clubhouse only members: • Staff training current: 100% • Clubhouse only IPOS current: 100% • Clubhouses open weekends and holidays: 100% • Annual increase in employment status: 20%					

PMQI - October 5, 2022

• Last month's minutes reviewed • MIChoice Program Integrity Review • NMRE/QOC Updates	Attendance: Kari Barker, Jess Williams, Brie Molaison, Michelle Dosch, Tracy Andrews, Darryl Washington, Dave Simpson, Dan Mauk, Trapper Merz, Curt Cummins, Carrie Gray, Lauri Fischer, Joanie Blamer, Lisa Woodcox, Aaron Fader, Brian Newcomb, Kim Silbor, Andrew Waite Guests: Melissa Trout, Erika Solomonson, Erica Longstreet

Report	Objectives	Outcome	Follow Up	Analysis	Extenuating Circumstances	Action Taken
SED - Melissa/Erika	• Avg SED caseload: • Homebased discharge surveys completed: 95% • Monitoring transition of care to determine appropriate LOC: 2x/year • Track consumer engagement in the first 3 months post-Access					
Critical/Risk/Sentinel Events - Kari	• Critical events: <20 • Risk events: <30 • Sentinel events: <2 • Mortality reviews completed: • Suicides: 0					
Clinical Record Review - Jess	Individual record reviews per quarter: 15 • Two records each from ACT, IDD Adults, IDD Children, MIA, Outpatient Therapy and SED • One closed record each from MIA, Outpatient and SED					

Customer Service - Brie	• Grievances resolved within 30 days: 80% • Appeals resolved within 30 days: 100% • Inquiries resolved within 1 day: 95% • Appeals upheld: 80% • Fair Hearings requested: <2 • Satisfaction surveys completed: 75% • Issues from CAC meeting					
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Self-Determination - Lisa	• SD arrangements with agreements in place: 100% • Budget outliers (10%+ increase): <1					
Access/GF - Erica	• Denials at Access: • Avg wait time for initial screening: • Non-MA transition to MA: 95% • Non-MA active: <5%					
Performance Indicators - Trapper						

MIChoice - Darryl	• Meet Quality & Compliance Measures: 95% • Increase returned to community by 10% • Increase enrollment by 5% • Quality withhold returned: 100%					

PMQI - November 2, 2022

<table>
<tr><td colspan="2">• Last month's minutes reviewed
• MIChoice Program Integrity Review
• NMRE/QOC Updates</td><td colspan="5">Attendance: Kari Barker, Jess Williams, Brie Molaison, Michelle Dosch, Tracy Andrews, Darryl Washington, Dave Simpson, Dan Mauk, Trapper Merz, Curt Cummins, Carrie Gray, Lauri Fischer, Joanie Blamer, Lisa Woodcox, Aaron Fader, Brian Newcomb, Kim Silbor, Andrew Waite

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<tr><th>Report</th><th>Objectives</th><th>Outcome</th><th>Follow Up</th><th>Analysis</th><th>Extenuating Circumstances</th><th>Action Taken</th></tr>
<tr><td>Crisis Services - Stacey</td><td>• Disposition within 3 hours of request: 95%
• Decrease inpatient recidivism by 10%
• Increase hospital diversion by 20%
• Decrease inpatient costs by 10%
• Increase prebooking jail diversion by 10%
• Increase completion of Crisis Prevention Plans by 20% across populations</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Facilities/Safety - Aimee</td><td>• Facility accidents: <1
• Staff injuries requiring medical intervention: <2
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• Outliers:</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>HSW - Darlene</td><td>• Increase waiver slots by 5%
• Complete HSW re-certifications: 100%
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</table>

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Recipient Rights - Brian	• NLCMHA staff ORR training: 100% • External providers ORR training • Trends • Outliers					
MIA/SED - Kim/Sheryl	• Pre/Post-Hospitalization • Annual increase in employment status: 10%					
Integrated Health Clinic - Tracy	• IHC patient numbers increase by 10% • No-show rate: • Annual wellness visits:					
CHAT - Andrew	• CHAT enrollment increases by 10% • CHAT referrals increase by 10% • Avg Health Risk Score improvement					
Provider Network Management - Tracy	• SRS need decreased by 2% • Appropriate staffing level: 95% • Site reviews: 95% • Provider contracts current: 100%					

PMQI - December 7, 2022

• Last month's minutes reviewed
• MIChoice Program Integrity Review
• NMRE/QOC Updates

Attendance: Kari Barker, Jess Williams, Brie Molaison, Michelle Dosch, Tracy Andrews, Darryl Washington, Dave Simpson, Dan Mauk, Trapper Merz, Curt Cummins, Carrie Gray, Lauri Fischer, Joanie Blamer, Lisa Woodcox, Aaron Fader, Brian Newcomb, Kim Silbor, Andrew Waite

Guests: Kaitlyn Reinink, Sheryl Dey, Marshall Cronican-Walker, Hannah Driver, Amy Kotulski

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OBRA - Marshall	• OBRA assessments completed per timelines: 95%					

Northern Lakes Community Mental Health Authority
FY 2022 Regulatory Compliance Plan

1.0 Introduction

It is the policy of Northern Lakes Community Mental Health Authority (NLCMHA), to obey the law and to follow ethical business practices. NLCMHA has a commitment to ensure employees and contract providers are fully informed about applicable laws and regulations so that they do not inadvertently engage in conduct that may raise compliance issues. The legal requirements relating to the quantitative and qualitative documentation of professional services, fee billing, and reimbursement are primary concerns. NLCMHA recognizes that its business relationships with other providers, vendors, and clients are subject to legal requirements and accountability standards.

2.0 Purpose

To ensure, to the fullest extent possible, compliance with laws and regulations; that ethical business practices are followed; and that contractual and legal requirements are met. Further, to provide the highest quality of service in accordance with applicable regulations through service provision, documentation of the service provided, and reimbursement for the service.

To further the organization's commitment to compliance and to protect its employees and contract providers, emphasis is placed on this compliance plan to address those regulatory issues likely to be of most consequence to its operations.

Compliance is accurately following the government's rules on Medicaid billing system requirements and other regulations. A compliance program is a self-monitoring system of checks and balances to ensure that an organization consistently complies with applicable laws relating to its business activities. The compliance program and plan described in this document is intended to establish a framework for legal compliance by employees and contract providers. It is not intended to set forth all the substantive programs and practices that are designed to achieve compliance.

3.0 Application

Northern Lakes is a Community Mental Health Services Program covering Leelanau, Grand Traverse, Wexford, Crawford, Roscommon, and Missaukee counties. Affiliated with 4 other CMH boards to comprise the Northern Michigan Regional Entity (NMRE). It is the intent of NLCMHA that the scope of all compliance policies and procedures should promote integrity, support objectivity, and foster trust within the NMRE as well.

This Plan shall apply to all NLCMHA operational activities and administrative actions and includes those activities that come within federal and state regulations relating to health care providers. Of particular concern to NLCMHA, is compliance with respect to human resources practices and training, under or over utilization of services, quality of care, data collection and submission processes, appropriate service authorization and documentation, and proper medical coding.

The primary provider network for NLCMHA covers the six counties, offering services for adults and children with mental illness, intellectual/developmental disabilities, and co-occurring mental health and substance abuse disorders. All employees of NLCMHA are subject to the requirements of this Plan as a condition of employment. All aspects of this Plan that address "provider organizations" shall also apply to the participating provider network.

4.0 General Overview

It is acknowledged that efforts to maintain compliance must be organization-wide and must be ongoing. In order to assure that these efforts are sustained, compliance activities are developed from a performance improvement perspective. Northern Lakes Community Mental Health Authority believes that for services to be of the highest quality, they must be provided, documented, and reimbursed in accordance with applicable regulations. Assuring this compliance, both prospectively and retrospectively, is best done through a focus on improvement, utilizing objective data, systems analysis, participant input, and continuous feedback.

The compliance plan has the following key features:

- Designation of NLCMHA officials responsible for directing the effort to enhance compliance, including implementation of the plan;
- Incorporation of standards and policies that guide personnel and others involved with operational practices and administrative guidelines;
- Identification of legal issues that may apply to business relationships;
- Development of compliance initiatives/requirements at the unit level;
- Coordinated training of clinical and administrative staff and contract providers concerning applicable compliance requirements and policies;
- A uniform mechanism for employees and contract providers to raise questions and receive appropriate guidance concerning operational compliance issues;
- Regular review and audit to assess compliance, to identify issues requiring further education, and to identify potential problems;
- A process for employees and contract providers to report possible compliance issues and for such reports to be fully and independently reviewed;
- Enforcement of standards through well publicized disciplinary guidelines and development of policies addressing dealings with sanctioned individuals;
- Formulation of corrective action plans to address any compliance problems that are identified;
- Regular reviews of the overall compliance effort to ensure that operational practices reflect current requirements and that other adjustments are made to improve operations.

5.0 Administrative Responsibilities

Primary responsibility for implementing and managing NLCMHA's compliance effort shall be assigned to the Director of Quality Improvement and Compliance. The position of Director of Quality Improvement and Compliance will directly report to the NLCMHA CEO and indirectly, as required, to the governing body of NMRE. As appropriate, compliance program findings will be reported to the Performance Measurement & Quality Improvement, and the Executive Team Committees. The Director of Quality Improvement and Compliance will, with oversight of the NLCMHA CEO, engage the assistance of legal counsel and the NMRE where appropriate, and perform the following activities:

- Review and amend, as necessary, the Code of Conduct that includes a code of ethics and ethical standards.
- Assist in the review, revision, and formulation of appropriate policies to guide any and all activities and functions that involve issues of compliance.
- Develop methods to ensure that employees are aware of the Code of Conduct and Code of Ethics Policy and understand the importance of compliance.
- Develop methods to ensure that provider organization Code of Conduct and compliance standards are on par with NLCMHA and staff understand the importance of compliance.
- Assist in developing and delivering educational and training programs.
- Coordinate compliance reviews and audits, as required.
- Receive and investigate instances of suspected compliance issues, as set forth in this Plan.
- Develop appropriate corrective actions, as set forth in this Plan.
- Prepare Annual Compliance Review, as set forth in this Plan.
- Prepare Annual Compliance Work Plan, as set forth in this Plan.
- Prepare proposed revisions to the Compliance Plan as needed, with a review at least annually.
- Provide other assistance as directed by the CEO.

6.0 Compliance Oversight and Structure

As the agency’s compliance officer, they have the primary responsibility for oversight and implementation of this plan and is given sufficient authority to promote and enforce compliance program issues.

The Compliance officer will work with the Regional Compliance Committee as established by the NMRE, and may include, but not be limited to, the following representatives:

- Compliance Leader from each Member Board
- Human Resources
- Information Systems
- Quality Assurance/improvement
- Finance/Reimbursement

The committee activities will include the following:

- Assist in implementation of the compliance program within the boundaries of the NMRE
- Analyze the external business environment
- Conduct risk analysis and assessment for the NMRE
- Determine overall strategy or approach to promoting compliance and/or detecting
- violations of regulation
- Develop, approve, and evaluate compliance policy and guidance
- Participate in compliance training
- Audit Compliance Plan

The Director of Quality Improvement and Compliance will review NLCMHA's system of recordkeeping (either manual or electronic) for each employee's participation in this Plan and maintain documentation of participation for submission to the NMRE. This record will include documentation of related training, acknowledgment of receipt of pertinent documents, details of any non-compliance and the actions taken, and evidence of participation in compliance related activities.

Participation in, and acceptance of, this Plan is a condition of employment for NLCMHA. For providers contracted with the PIHP participation in, and acceptance of, this Plan is required. Each employee and agent bears responsibility for compliance. This responsibility includes:

A. Read the Compliance Plan

B. Be familiar with, and use, the compliance requirements

C. Pay attention to correspondence, both by paper and by electronic mail, and return acknowledgement statements promptly when required

D. Participate in training sessions

E. Utilize the Compliance Access System as needed

F. Review, periodically, this Compliance Plan

G. Report immediately when and if made aware of any violation of this Compliance Plan, or related policies and procedures. Reports can be made to the Director of Quality Improvement and Compliance (See attachment A). Failure to report a violation is itself, is a violation and therefore subject to disciplinary action.

H. Cooperate with all compliance related efforts

I. Submit any suggestions for improvement of this Plan

J. Refer ALL inquiries relating to compliance efforts and results to the NLCMHA's

K. Director of Quality Improvement and Compliance, or Chief Executive Officer

L. Submit evidence of compliance attestation annually, acknowledging that all potential non-compliance issues have been reported. (Attachment B)

7.0 Policy Guidelines

Policies specific to NLCMHA's operational practices will be reviewed on an annual basis and revised as necessary. The Code of Conduct will guide in all business activity. This Code reflects good common sense and ethical behavior. All new hires receive and acknowledge the Code of Conduct as a requirement of employment. The Code is reviewed and acknowledged annually thereafter.

8.0 Clinical and Administrative Plans

NLCMHA will be responsible for the development and implementation of a plan to address compliance efforts. These plans shall, at a minimum, include the following features:

A. Written policies and procedures for operational activities undertaken by organization personnel, including any specialty specific standards that may be relevant to regulatory compliance

B. Educational and training programs to address operational issues of particular importance to the organization

C. A program for ensuring and documenting that all new personnel receive training regarding operational compliance issues

D. A program for routine "spot checks" of compliance activities, sharing the results of such reviews with the NMRE's Compliance Coordinator

E. A system that tracks operational compliance issues within NLCMHA that have been raised within the organization and the resolution of those issues

F. An annual review of the existing compliance plan in order to identify the need for changes and to identify specific compliance objectives during the succeeding year

9.0 Communication, Education and Training

A compliance plan cannot be successful as a static, written document. It requires a dynamic implementation process that provides ongoing communication, education and training to all participants. This includes the NLCMHA governing body, direct employees, and contract agents. The plan is intended to be "the way we do business" and, as such, be second nature to all employees and agents. This same rigor will apply to the external provider network.

The compliance plan provides an internal process to clarify, educate, and train staff in contractual and regulatory requirements, and appropriate use of the CMH Prepaid Medicaid dollars. This section describes the communication, education and training efforts utilized to achieve this goal.

A. Communication - The success of this Plan is largely dependent upon the ability of NLCMHA to sustain the efforts identified within this Plan. As with any improvement effort, sustaining this Plan will require regular communication to employees and agents. This includes communication regarding applicable laws and regulations; monitoring efforts; training efforts; improvement

activities; and achievements. The Director of Quality Improvement and Compliance, as well as the administrative team and all supervisors, are responsible for this communication.

B. Education and Training – The compliance plan identifies three categories of education/training to meet all state and federal requirements. They are as follows:

1. *Initial Training* - NLCMHA is responsible for developing and assuring that initial training is provided to all employees during their orientations. This training will address the substantive legal standards and the processes identified in this manual. Completion of this training will be documented.

   Each employee will receive a Regulatory Compliance Plan at orientation, along with a Compliance Plan Acknowledgement Form (Attachment C) and the Compliance Attestation Form (Attachment B). Each employee, upon receipt of this Plan, will have one week to read the Plan and acknowledge acceptance of its principles and obligation to report fraud, abuse or waste of public funding, as evidenced by signing the Acknowledgement Form and the Attestation Form. Evidence of acknowledgement and attestation must be submitted to the PIHP at least annually.

   Employees are encouraged to actively participate in this training process and to ask questions. It is essential that all employees understand these requirements and processes. It is the responsibility of the employee to assure that he or she understands this Plan.

2. *Focus Training* - In addition to the initial training for all employees, specialized training will be developed for targeted positions and functions. The NLCMHA Director of Quality Improvement and Compliance, in coordination with the Executive management team, will identify those positions requiring additional, targeted training due to the particular tasks for which they are responsible. This would include, but not be limited to; NLCMHA CEO, CFO, Director of IT and IT staff. NLCMHA is responsible for providing compliance training to the CMH Board of Directors, as well.

3. *Ongoing Training* - The Director of Quality Improvement and Compliance and Executive Management team will routinely review available data to identify emerging trends and training needs relating to compliance issues and this Plan. Data sources include, but are not limited to: performance indicator report, question/answer or reporting via *e-mail/voicemail/website/mail (*access systems),* record audit results (see Ongoing Monitoring and Reporting), MDHHS report, and staff activity reports, as required.

   - As training opportunities and needs are identified, either for targeted staff or all staff, the Director of Quality Improvement and Compliance will develop and implement appropriate training. Training may be provided by NLCMHA staff or be arranged through outside sources.

   - Compliance training will be incorporated in the organization's annual training requirements. This annual training will have three objectives: (1) provide detailed information regarding false claims recovery under the federal and State False Claims Act, various protections under the Whistleblower Protections Act and other regulations as they apply, (2) review the Compliance Plan and efforts, and (3) address emerging needs as determined through monitoring and data analysis.

   - All ongoing training, whether annual or targeted, will be documented.

- Ongoing training occurs as well through correspondence and communication from the Director of Quality Improvement and Compliance. The question/answer and hotline reporting system *will be utilized* as a tool for identifying, and promptly responding to, staff questions and requests.

C. Training Personnel - All staff providing training relating to compliance issues, will be required to certify, in writing, that he or she has never been convicted of any crimes (other than traffic related offenses); has never had a professional license revoked or suspended, and has never been sanctioned, whether personally or through an entity, by the Medicare or Medicaid programs. Compliance and DRA training is mandated to be completed by all NLCMHA staff annually. The Director of Quality Improvement and Compliance will also review the content information for compliance training done via webinars or e-learning systems.

10. Ongoing Monitoring and Reporting

Compliance activities are developed from a performance improvement (PI) perspective. This approach uses the objective of providing high quality services. To meet the objective of high quality services in accordance with applicable regulations, the service must be provided, documented, and be reimbursable. Assuring compliance is best done through a PI focus on improvement, utilizing objective data, systems analysis, participant input, and continuous feedback.

Errors in compliance may be rooted in a number of causes. Frequently, the source of difficulty may be traced to deficiencies in the systemic processes used by staff. When compliance errors or lapses are determined to be rooted in individual behavior, the quality improvement process will likely not be appropriate. Such errors may be the result of insufficient information and training, individual carelessness, or willful acts. Each of these causes requires a different response. It is essential that the Director of Quality Improvement and Compliance conduct an investigation to determine the source and cause of errors prior to determining the response.

The monitoring and reporting processes are designed to facilitate continuous improvement and to identify errors and wrongdoing. This is accomplished through routine review of records and through input from staff.

A. Audits – The Director of Quality Improvement and Compliance may conduct audits of the compliance plan. This includes, but is not limited to:

1. Clinical record audits
2. Reviewing the sufficiency and completeness of training
3. Reviewing staff training records
4. Auditing the response to employee/agent questions or comments to the question and Answers or reports through the access system
5. Reviewing the response to any finding during the past quarter
6. Review of adherence to policies and procedures relating to contracting, and
7. Monthly verification that no employee/agent of NLCMHA is listed on any federal or state sanctioned providers list.

Annually, the Director of Quality Improvement and Compliance will review this Plan and the activities carried out pursuant to this Plan. The review will be designed to assess the effectiveness and current applicability of each aspect of the Compliance Plan and will incorporate input from appropriate NLCMHA Committees. Appropriate changes will be made and submitted to the Board for review. Upon Board approval, the changes will be distributed to all employees

and agents. Changes to the Regulatory Compliance Plan will be included in the annual compliance training and employees will be required to sign an Acknowledgement Form.

B. <u>Reporting</u> - This Plan addresses two types of reporting. The first involves the obligation to and avenues for, employees and agents reporting noncompliance. The second involves the regular reporting of data and information pertinent to the compliance activities.

1. *Reporting by Employee and Agents* - If an employee or agent becomes aware of any wrongdoing under this Plan, whether intentional or unintentional, by that employee or another employee, he or she must report the wrongdoing to the Director of Quality Improvement and Compliance through one of the methods described below (*e-mail/voicemail/website/mail - access system)*. Individuals reporting anonymously must follow-up within a few days via voice mail or e-mail to answer follow-up questions. Specific elements to include in a report are addressed in "Non-compliance Reporting" (See Attachment A).

   a. ***Hotline*** - Reporting can be done by e-mail or voicemail or postal or interagency mail, and via web-based reporting.

   b. ***Postal or Interagency mail*** – This method of reporting is to be directed to the Compliance Officer marked "Confidential – Personal".

   c. **Anonymous Reporting -** If an employee or provider chooses to submit a report anonymously, he or she may do so. In this case, the time and date must be clearly stated on the report, as this information will be used to identify follow-up questions.

   d. The Director of Quality Improvement and Compliance will check each reporting system (*e-mail/voicemail/mail)* each business day. Upon receiving a call or e-mail, the Director of Quality Improvement and Compliance will ask questions, listen to (or read e-mail) the report, and complete a written report of the call.

   e. If further investigation is warranted, the Director of Quality Improvement and Compliance shall conduct the investigation. As appropriate, consult with the CEO or legal counsel.

   f. As needed, questions will be asked of the employee making the report. If the individual chooses to make the report anonymously, the Director of Quality Improvement and Compliance shall make arrangements for the individual to call back at specified times, or e-mail, for follow-up questions or communication.

   g. The employee must answer those follow-up questions via electronic mail or voice mail. Anonymity may be maintained to the limits of the law.

   h. Whatever the method of reporting, when the Director of Quality Improvement and Compliance receives a report alleging wrongdoing, he or she shall take the following response steps:

      - Initiate an inquiry within three (3) business days after receiving any report alleging wrongdoing.

- Determine whether the alleged wrongdoing is a violation of federal or state law, contract requirements, this Compliance Plan, or other organizational standard or policy, or in some way jeopardizes, or puts at risk, the organization's operations or reputation. As necessary, the Director of Quality Improvement and Compliance shall access legal counsel, consult the CEO, or seek other appropriate guidance.

- If the alleged wrongdoing is a violation, action shall be taken commensurate with the gravity of the allegation. As appropriate, the Director of Quality Improvement and Compliance shall consult with the CEO, and/or legal counsel.

- If, upon investigation, the allegation is proven by the preponderance of evidence to be true, the Director of Quality Improvement and Compliance shall immediately report this to the CEO, with recommendations regarding appropriate disciplinary and corrective action.

- If the situation constitutes a potential payback of reported services, the Director of Quality Improvement and Compliance, CEO and CFO may consult with legal counsel to determine the appropriate course of action, if any. Payback of reported services must be completed within 60 days after discovery.

- A full and complete written report of the allegation, investigation, determination, and actions shall be written by the Director of Quality Improvement and Compliance. This report is to be submitted to the CEO, the NMRE Compliance Coordinator, and maintained in a secure location.

- If systemic corrections are indicated, the Director of Quality Improvement and Compliance shall submit appropriate information (*Appropriate information includes that necessary to institute a quality action team process while protecting the confidentiality of the people involved to the extent appropriate and necessary*.) to the appropriate quality improvement body. The Committee will conduct the review consistent with PDCA (Plan, Do, Check, Act) model, make final recommendations, and communicate recommendations to the Director of Quality Improvement and Compliance, as appropriate.

- If there is any knowledge of potential fraud and or abuse allegations within any program, the Director of Quality Improvement and Compliance must inform the CEO, who will then report allegations directly to the NMRE, who will inform the Michigan Department of Health and Human Services, and the Office of the Health Services Inspector General.

- The Director of Quality Improvement and Compliance will prepare a report at the end of each fiscal year of all suspected fraud and/or abuse reports made to the NMRE. This report will be submitted to the CEO no later than December 31st of each year. In addition to the number of complaints of fraud and abuse made, the report will include the following elements for each complaint:
    - Name of individuals investigated
    - Patient ID number
    - Source of complaint
    - Type of provider
    - Nature of complaint

- Approximate dollars involved, and
- Legal and Administrative disposition of the case.

i. Under no circumstances will Northern Lakes Community Mental Health Authority tolerate retribution against any employee or agent simply for making a “good faith” report.

   ▪ However, intentionally erroneous reports will be subject to disciplinary action.

   ▪ Similarly, if an employee or agent intentionally minimizes their own involvement when making a report, either to protect themselves or a co-worker, appropriate disciplinary action may be taken.

   ▪ If any supervisor or employee is determined to be retaliating against an employee for making a report, that supervisor or employee will be subject to disciplinary action.

2. *Reporting Compliance Data and Results* - Accurate and complete monitoring of the compliance plan requires the use of a variety of objective data sources. Information used in this monitoring process will be routinely reported. The NLCMHA Director of Quality Improvement and Compliance will provide information to the NMRE’s Compliance Coordinator regarding any reports (of non-compliance) they have received, at least quarterly. A regular reporting schedule will be established which will minimally include:

   ▪ Quarterly reports of record audits
   ▪ Quarterly reports of Hotline access system (*e-mail/voicemail/ website/land-mail)*
   ▪ Annual review of the Compliance Plan
   ▪ Annual summary of Compliance activities, including number of investigations, summary of results of investigations, number of staff trained, and summary of disciplinary actions.

11.0 Responding to Non-compliance

Instances of non-compliance will receive quick and certain responses.

A. When systemic issues are determined to be the cause, in part or in full, the NLCMHA PMQI Committee, will act quickly to address the systems involved.

B. When individual action is determined to be the cause, in part or in full, quick and appropriate disciplinary action will be taken. Intentional non-compliance WILL NOT be tolerated and will be subject to immediate disciplinary action up to and including termination of employment and reporting to federal or state authorities.

C. See Non-compliance Reporting, Attachment A.

12.0 Performance Improvement to Prevent or Correct Non-compliance

Compliance, when possible, should be a proactive process. In other words, the surest way to assure that NLCMHA maintains the highest level of compliance with applicable laws and regulations is to develop systems and processes to facilitate and incorporate compliance from the beginning. This is the essence of performance improvement and the reason for developing this Compliance Plan from a performance improvement perspective.

A. There are several sources of data that will be utilized to monitor and improve the systemic processes necessary for compliance. These may include audit results, MMBPIS reports, Key Indicators, QI Council Indicators, staff activity reports, and employee input processes.

B. The Director of Quality Improvement and Compliance and PMQI committee will review information from these sources cited in 12.0(A) of this Plan on a regular basis. When trends are suspected or identified, they will be discussed with the appropriate groups and additional data will be sought as needed.

   1. When such a review is indicated by either objective or sufficient anecdotal information, the Committee will review the issue and make recommendations regarding the process in question.

   2. The PMQI will utilize the Plan/Do/Check/Act (Shewart model).

13.0 Annual Regulatory Compliance Review

On or before the end of each fiscal year, the Director of Quality Improvement and Compliance will arrange for a review of the current compliance and regulatory operations. The purpose of the review should include probe samples to ascertain whether the compliance operations are within standards. A written report describing the results of the audit should be prepared on or before December 1.

14.0 Annual Report and Work Plan

On or before December 1, the Director of Quality Improvement and Compliance should prepare and distribute to the CEO and the NLCMHA governing body a report describing the compliance efforts during the preceding fiscal year and a proposed work plan for next fiscal year. The report should include the following elements:

A. A summary of the general compliance activities undertaken during the preceding fiscal year, including any changes made to the Compliance Plan

B. A copy of the Hotline access system log for the preceding fiscal year

C. A copy of the preceding fiscal year's Compliance Review

D. A description of actions taken to ensure the effectiveness of the training and education efforts

E. A summary of actions to ensure compliance with NLCMHA's policy on dealing with excluded persons

F. Recommendations for changes in the Plan that might improve the effectiveness of NLCMHA's compliance effort

G. A copy of the proposed work plan for the next fiscal year

15.0 Revisions to this Plan

This Compliance Plan is intended to be flexible and readily adaptable to changes in regulatory requirements and in the health care system. The Plan should be regularly reviewed to assess whether it is working. The Plan should be changed as experience shows that a certain approach is not effective or suggests a better alternative

16.0 Excluded Persons Policy

Northern Lakes Community Mental Health Authority confirms the importance of compliance with 42U.S.C.1320a-7(b), which imposes penalties for "arranging or knowing (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program…for the provision of items or services for which payment may be made under such a program."

A. Accordingly, prior to employing or contracting with any provider, NLCMHA will take appropriate steps to confirm that the provider has not been excluded. Those steps will include 1) checking the provider's name against the HHS/OIG Cumulative Sanctions List, 2) the GSA Debarred Bidders List and 3) the State of Michigan Sanctioned Providers List.

B. If NLCMHA learns that a prospective provider (either as an employee or contractor) is excluded, NLCMHA will not hire or use that provider.

C. Additionally, the NMRE will check the OIG List of Excluded Individuals//Entities, the GSA Excluded Party List, the MDHHS Sanctioned Providers (Michigan), every 30 days and provide reports to NLCMHA. This is to assure that no name of any individual hired, under contract, or appointed as a Board Member appears in these databases.

D. If NLCMHA learns that any of its current providers (either as employees or contractors) have been proposed for exclusion or excluded, it will remove such individuals from any involvement in or responsibility for federal health insurance programs until such time that it has confirmed that the matter has been resolved. If NLCMHA learns that one of its Board Members has been proposed for exclusion or excluded, it will ask that the Board Member step down from any responsibility relating to federally funded programs until such time as the matter is resolved.

E. If an individual has been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; had a professional license revoked or suspended, or has been sanctioned, whether personally or through an entity, by the Medicare or Medicaid programs after being hired, contracted or appointed, they must report such to the CEO within 3 (three) business days of such action. Failure to provide such notification will result in disciplinary action, up to and including immediate termination of employment, contract, or appointment.

REFERENCES

-- CMHSP Contract with MDHHS...FY 2020

- *PIHP Contract with MDCH Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 2020*

- *Department of Health and Human Resources, Centers for Medicare and Medicaid Services, 42CFR438, Part II, Subpart I, Section 438.700, Subsections (a)(b)(c) and (d), Basis for Imposition of Sanctions*

- *Department of Health and Human Resources, Centers for Medicare and Medicaid Services, 42CFR438, Part II, Subpart H, Section 438.608, Subsections (a) and (b), Program Integrity Requirements*

- *Department of Health and Human Resources, Centers for Medicare and Medicaid Services, 42CFR438, Part II, Subpart C, Section 438.106, Subsection (a), (b), and (c), Liability for Payment*

- *Federal Register/Vol. 63, No. 243/Friday, December 18, 1998/Notices – Department of Health and Human Services, Office of Inspector General, "Publications of the OIG Compliance Program Guidance for Third-Party Medical Billing Companies"*

- *Center for Medicare and Medicaid (CMS) State Medicaid Director Letter, June 12, 2008 regarding Medicaid provider requirements for monthly verification of excluded individuals and entities.*

- *Office of Inspector General (OIG) Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs - Issued May 8, 2013*

- *Office of Inspector General (OIG) News Release, April 7, 2013 – "Provider's Self Disclosure Protocols"*

- *Federal Sentencing Guidelines, Section 8 Sentencing of Organizations, as amended November 1, 2011*

- *Centers for Medicare and Medicaid (CMS) State Medicaid Director Letter, September 1, 2010 regarding Additional Medicaid Integrity Program Provisions of the Affordable Care Act 2010, Section 6507*

Northern Lakes Community Mental Health Authority

CMHSP – Mental Health
Regulatory Compliance

REGULATORY NON-COMPLIANCE REPORTING

Purpose: **To provide an internal process for the referral and monitoring of contractual non-compliance, regulatory non-compliance, or inappropriate use of community mental health Prepaid Medicaid service dollars.**

Intent: **To facilitate the reporting on health care waste, questionable practices, or inappropriate use of Medicaid service dollars.**

Who can report: **All individuals affiliated with Northern Lakes Community Mental Health Authority are responsible for compliance with regulations and contracts; this includes Board Members, all staff employed by NLCMHA, as well as sub-contractors.**

Who it is reported to: **Kari Barker, Director of Quality Improvement and Compliance, Northern Lakes Community Mental Health Authority.**

How it is reported: **Regulatory non-compliance reporting can be done by voice mail, email, web access, or in writing. The disclosure can be anonymous.**

Overview

The Office of Inspector General (OIG) in Washington D.C. published a detailed self-disclosure protocol in October 1998 as a part of the pilot voluntary disclosure program. An open letter to Health Care Providers from the OIG, dated March 9, 2000 and March 24, 2009 followed up on various aspects of the October 1998 letter, and notified providers of the responses from providers on self-disclosure.

When fraud is uncovered by the OIG they will look to see whether NLCMHA took appropriate steps to prevent and detect the misconduct and whether there is a likelihood that the same or similar abuse of the Medicaid services will reoccur.

The outcome of any case identified by the OIG will be impacted by NLCMHA's ability to point to tangible, positive outcomes stemming from its own compliance efforts.

Evidence that NLCMHA's regulatory compliance program is operating effectively includes the following:

1. Problematic conduct, such as questionable practices, health care waste, or inappropriate use of Medicaid service dollars, is identified.

2. Appropriate steps are taken to remedy and prevent the conduct from recurring.

3. When misconduct appears to be a violation of the law, a full and timely disclosure of the violation of law is made to Medicaid.

4. That matters of overpayment or errors that do not suggest a violation of law, are dealt with promptly by the individuals responsible for claims processing and payment. (The entity accountable and responsible for the Prepaid Health Plan Medicaid dollars.)

5. An internal process for non-compliance reporting is an active part of the Regulatory Compliance Program.

Errors in compliance may be rooted in a number of causes. Frequently, the source of difficulty may be traced to deficiencies in the systemic processes used by staff.

When compliance errors or lapses are determined to be rooted in individual behavior, the quality improvement process will likely not be appropriate. Such errors may be the result of insufficient information and training, individual carelessness, or willful acts. Each of these causes requires a different response. It is essential that sufficient investigation be conducted by NLCMHA's Compliance Program to determine the source and cause of errors prior to determining the response.

The monitoring and reporting processes are designed to facilitate continuous improvement and to identify errors and wrongdoing. This is accomplished through routine review of records and through input and reporting of non-compliance from individuals.

NLCMHA's Compliance Plan addresses two types of non-compliance reporting. The first type of reporting involves the obligation to and avenues for, employees and agents reporting non-compliance. The second type of reporting involves the regular reporting of data and information pertinent to the compliance activities of

- ***Under no circumstances will NLCMHA tolerate retribution*** *against any employee or agent simply for making a "good faith" report to the Compliance Coordinator.*
- However, **intentionally erroneous** reports will be subject to disciplinary action.
- Similarly, if an employee or agent **intentionally minimizes** a wrongdoing when making a report, either to protect themselves or a co-worker, appropriate disciplinary action will be taken.
- If any supervisor or employee is determined to be **retaliating against an employee for making a report**, that supervisor or employee will be subject to harsh disciplinary action.

Health care waste, questionable practices, contractual or regulatory non-compliances, or inappropriate use of the Medicaid Service dollar can be identified in varied aspects of the service delivery process. The following are provided as a point of reference when completing a non-compliance report:

Non-compliance reporting can include:

a. Administrative processes
b. Billing Practices
c. Clinical services
d. Contractual requirements
e. Information system and data collections

Who Reports Non-compliance?

If an employee or agent becomes aware of any wrongdoing, whether intentional or unintentional, by that employee or another employee, he or she must report the wrongdoing to the Compliance Coordinator, or the Compliance Leader at the member CMH Board. Regulatory non-compliance reporting can be done by voice mail, e-mail, web access, or in writing. The disclosure can be anonymous.

How are Non-compliance Issues to be reported?

Non-compliance reporting can be done by voice mail, e-mail, web access, in person or in writing. *The report can be anonymous.*

Compliance Leader at Northern Lakes CMH – Kari Barker
- Voice mail reporting – Call (231)935-3679 and leave a voice message of all required reporting information.
- E-mail all required reporting information to Kari Barker at kari.barker@.org or compliance@nlcmh.org
- Send written non-compliance reports to the attention of Kari Barker at 105 Hall St, Suite A, Traverse City, MI 49684

Compliance for the Northern Michigan Regional Entity – Tema Pefok:
- Voice mail reporting – Call (231) 439-1278 and leave a voice message of all required reporting information.
- E-mail all required reporting information to Tema Pefok at tpefok@nmre.org
- Web Access - Go to nmre.org, click on Compliance Resources, select Report Compliance Issue, enter summary of issue in the text box. To maintain anonymity, use a non-identifying email address (example Hotmail, Gmail or other email account)
- Send written non-compliance reports to the attention of Tema Pefok at 1999 Walden Dr, Gaylord, MI 49735

Responding to Non-compliance

Instances of non-compliance will receive quick and certain responses. When systemic issues are determined to be the cause, in part or in full, the appropriate committee will act quickly to address the systems involved. When individual action is determined to be the cause, in part or in full, quick and appropriate disciplinary action will be taken. Wrongdoing WILL NOT be tolerated and will be subject to immediate disciplinary action up to an including termination of employment and reporting to federal or state authorities.

Definitions

Abuse – Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR § 455.2).

Contractual Non-compliance – Contractual non-compliance is when the provider does not follow specific criteria stated in a contract.

Fraud – Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR § 455.2).

Health Care Waste - Health care waste is providing services longer than medically necessary.

Inappropriate use of Medicaid service dollars – Inappropriate use of Medicaid services dollars is the intentional deception or misrepresentation of deliberate and improper billing. Some examples of fraudulent use are claims submitted for the following:

- Billing amounts greater than usual and customary charges.
- Billing for services not provided or not fully provided.
- Billing higher paying procedures than the ones actually provided.
- Billing multiple procedures rather than comprehensive procedures.
- Billing unnecessary, inappropriate or harmful services.
- Billing non-authorized services, by using an authorized procedure code.

Non-compliance reporting – reporting of health care waste, questionable practices, or fraudulent use of Medicaid service dollars to the Regulatory Compliance program of the Northern Regional Entity.

Regulatory Non-compliance – Regulatory non-compliance is when a provider does not meet standard stated in Federal Law or State Rule/Regulation

Questionable Practices - Questionable practices are practices inconsistent with generally accepted business or behavioral health care practices and that fail to meet professionally recognized standards for behavioral health care. Some examples of questionable practices (might involve **unintentional** actions by providers, but involve unacceptable practices) are:

- The provision of inappropriate services.
- Providing services that are of inferior quality.
- Inadequate clinical record documentation.
- Poor communication and coordination of treatment/services.

RESOURCES:

CMHSP Contract…FY 2020
Northern Michigan Regional Entity – Northern Regional Entity Compliance Plan

PIHP Contract with MDCH Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 2020

Department of Health and Human Resources, Centers for Medicare and Medicaid Services, 42CFR438, Part II, Subpart I, Section 438.700, Subsections (a)(b)(c) and (d), <u>*Basis for Imposition of Sanctions*</u>

Department of Health and Human Resources, Centers for Medicare and Medicaid Services, 42CFR438, Part II, Subpart H, Section 438.608, Subsections (a) and (b), <u>*Program Integrity Requirements*</u>

Department of Health and Human Resources, Centers for Medicare and Medicaid Services, 42CFR438, Part II, Subpart C, Section 438.106, Subsection (a), (b), and (c), <u>*Liability for Payment*</u>

OIG News Release, April 7, 2013 – "Provider's Self Disclosure Protocols"

Northern Lakes Community Mental Health Authority
Regulatory Compliance Report

Date of reporting: ____________________ *(Use back of sheet or additional pages as needed.)*

Name of the provider reporting about: ____________________

If consumer specific, provide name and/or consumer identification number: ____________________

County where the provider is located: ____________________

Describe (in detail) the alleged Medicaid fraud, waste, or abuse issue:

____

____

____

____

____

Describe any actions that may have been previously done to resolve the issue in question:

____

____

____

____

____

Send to Kari Barker, Director of Quality Improvement and Compliance, Northern Lakes Community Mental Health Authority (NLCMHAAA), 105 Hall St., Traverse City, MI 49684, 231.935.3679 or fax 231.935.3082, or attach to email to kari.barker@nlcmh.org or compliance@nlcmh.org

Print Name: ____________________ **Phone #:** ____________________

Signature: ____________________

Note: This report can be submitted anonymously. If reported anonymously, a call or email must be generated within (3) business days of original report for follow-up questions or information by the Compliance Coordinator.

Northern Lakes Community Mental Health Authority
Compliance Attestation
2022

I, _________________________________, as an employee/board member of Northern Lakes Community
(Insert name)
Mental Health Authority or a Contracted Provider, recognize and acknowledge my obligation to report any incidence of fraud, abuse or waste of public funding to the organization.

I understand that this obligation is explained in the Northern Lakes Community Mental Health Authority Regulatory Compliance Plan. This Plan gives guidance on what is reportable, where to direct questions, and how to report.

As of this date, I am not aware of any reportable incident, or I have reported any incidence of non-compliance of which I am aware, and it has been objectively reviewed and I have received a response from the organization. Should I become aware that a situation is potentially a violation of the False Claims Act, or an otherwise reportable occurrence, I will report immediately, as specified in the Regulatory Compliance Plan.

Compliance Training Date: _______________________________

My signature below is my certification that I have never been convicted of or had a civil judgment rendered against me for commission of fraud, or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction or contract under public transaction; violation of federal or state antitrust statutes or destruction of records, making false statements, or receiving stolen property; have never had a professional license revoked or suspended and have never been sanctioned, whether personally or through an entity, by Medicare or Medicaid programs.

I also understand that I am under obligation to report to the CEO, within three (3) business days, any convictions of or civil judgment rendered against me for any of the above offenses.

____   ____________________________

NORTHERN LAKES COMMUNITY MENTAL HEALTH AUTHORITY

2022 Regulatory Compliance Plan

Compliance Plan Acknowledgement Form

On ______________________ I received orientation and training pertaining to the Regulatory
(Today's Date)
Compliance Plan.

I received a copy of the Regulatory Compliance Plan ______________
(Initials)

I understand that I am to read the Regulatory Compliance Plan within one week from today. I contact: Kari Barker, Director of Quality Improvement and Compliance for clarification. She can be reached at: Northern Lakes Community Mental Health Authority, 105 Hall St., Traverse City, MI 49684 Phone: 231-935-3679 or compliance@nlcmh.org or kari.barker@nlcmh.org

____
(Initials)

Within the next seven (7) days I will return this form signed as my acknowledgement of acceptance with the compliance plan's principles.

I ______________________________ have read and accept the compliance plan principles.
(Print Name)

My signature is acknowledgement of the above: ______________________________
(Signature)

Agency I work for: ______________________________
(Please print clearly)

____
Date

Evidence of initial training (either manual or electronic version) must be maintained by the employer.

Security Annual Report

Summary

- The Agency experienced zero reportable incidents in the past year.
- We are on-boarding with Arctic Wolf to provide real time threat assessment.
- We continue to use Microsoft Attack Simulation for Phishing campaigns.
- We have made great progress on hardware and software upgrades.

Security Risk Assessment

Our previous process for assessing security risks involved doing a yearly risk assessment and mitigating any identifiable risk in our security defenses at that time. Then, throughout the year, we would identify as may potential endpoint risks monthly and review for best practices. What we found was that many emerging threats were not being identified or being addressed in a timely manner due to our inability to track them based on the sheer number of devices, the varying models of those devices, and no real way to cross reference fixes to the specific devices and software that we have deployed. On top of that, we were scheduling fixes and patches monthly, based on what we had identified as critical devices, those devices that are our first layer of defense from outside compromises. That process has been considered *best practice* for many years but as noted, fails to recognize emergent threats, or position the agency to respond to emergent threats in a timely manner.

Emergent threats can trigger multiple patches in rapid succession. If we only evaluate the security risk that a device exposes the agency to monthly and only complete a risk assessment yearly, we had been leaving the door open for compromise for the period between those monthly and yearly activities. To address this, we are moving to a real time monitoring product called Arctic Wolf (AW). This month we will be completing the on boarding process for AW and begin the process of mitigating threats identified in real time.

Below You will find our current Network Risk Summary that has been pulled from the Executive summary report provided by AW.

Network Risk Summary

Current Risk Score

Every potential risk goes through a complex analysis to determine a risk score for that specific risk. Things like the attack vector, attack complexity, privileges required, user interaction, and scope of the attack are rated, and a composite Risk Score is assigned. Vulnerabilities are maintained by the MITRE

Corporation (https://www.mitre.org/) with funding from the US Division of Homeland Security. Based on scores AW develops a composite score for all the vulnerabilities detected on our network. Each risk is assigned a score from 1 to 10 and the following shows how these scores are categorized.

Severity	Base Score
None	0
Low	0.1-3.9
Medium	4.0-6.9
High	7.0-8.9
Critical	9.0-10.0

Once evaluated and identified, vulnerabilities are listed in the publicly available MITRE glossary. After listing, vulnerabilities are analyzed by the National Institute of Standards and Technology (NIST). All vulnerability and analysis information are then listed in NIST's National Vulnerability Database (NVD (https://nvd.nist.gov/)).

Putting behind us the complexities involved in deriving the Risk Score we should note these scores are widely accepted as the standard score for all identified risks. AW Uses these risk scores to develop a composite risk score to be applied across the entire agency. Our current risk score of 7.6 compares well with the Industry Risk Score of 7.2, which is the average score for other AW customers and is updated daily. Since we are still in the on-boarding phase of implementing our immediate goal is to reach the Industry Risk Score. Once we have completed or on-boarding we should have all the tools needed and will begin working towards the target goal of 4.0.

Currently we have 1344 unresolved risks, which is the current number of active medium to critical severity vulnerabilities in the network.

These numbers change daily as we eliminate risk from our environment and as new risks are identified.

Risk Score Trends

Part of the executive summary provided by AW is a Risk Score Trend. The summary can be produced at any time but is automatically delivered to us by AW as a monthly report. Below you can see that our initial Risk Score was 9.1 in November of 2021 and that we have made a lot of progress in reducing that score to the current 7.6 score.

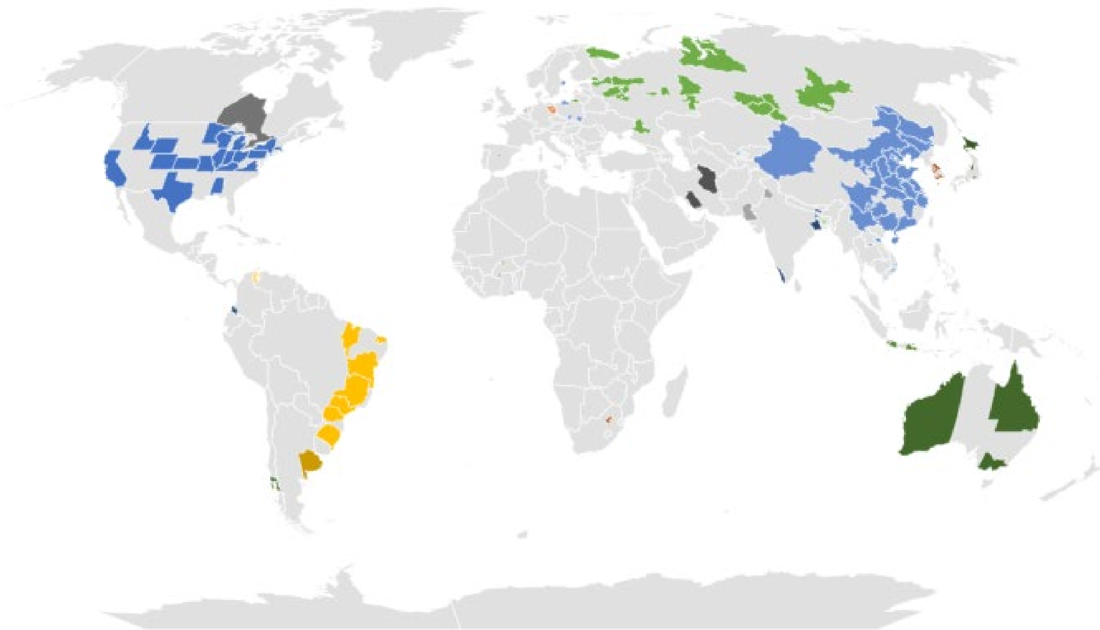
As we were deploying, we discovered that the product we use to manage Microsoft patches was having an issue deploying a major patch, known as a feature pack, in January of 2022. This patch had 10.0 risk score associated with it and by not being applied it effectively stalled out any progress in the month of March. This issue was brought to light very visibly in the AW *Managed Security Awareness Dashboard.* In late February and early March we worked with the vendor of the patch management software and believe this issue has been resolved and automatic patching has resumed.

Clear and Present Risks

Our security perimeter is very complex. One point on our perimeter is our Microsoft Office 365 interface. This includes our Teams environment and our OneDrive file storage. Microsoft offers robust tools to report on access to these resources so we will use that reporting here as an example of threats that we need to be aware of. Prior to implementing AW, we monitored the risks that are present from having an Office 365/Teams (O365) presence on a weekly basis. AW now monitors this interface in real time and reports any suspicious activity, like logins from outside the United States. Below is a map of all the regions that have attempted an interactive login to our O365 environment.

Global access attempts - Office 365

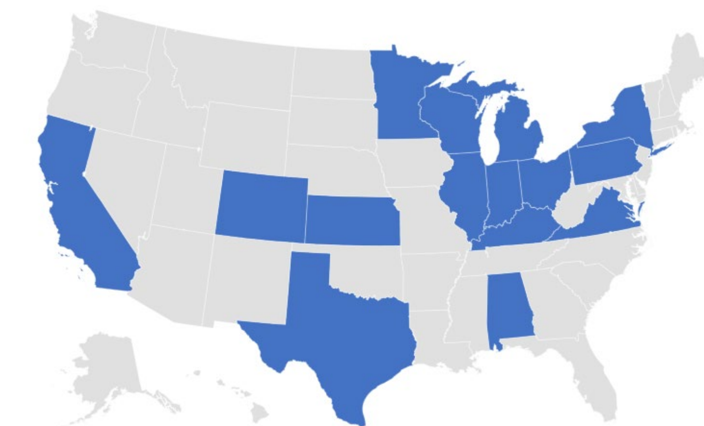
Week of 2022-02-24 to 2022-03-03



If we filter this information for successful interactive logins, we can quickly see that all successful logins are from within the United States. As reassuring as this might be, it does not preclude a foreign actor from staging an attack from a US location.

Successful Global access - Office 365

Week of 2022-02-24 to 2022-03-03



AW will monitor these connections to our environment and either shutdown and/or alert us if these logins produce suspicions activity. It is important to note that we have hundreds of other interfaces that are experiencing similar attack profiles and we now have AW between our internal devices and the internet to monitor the activities. Every mobile computer in our agency has an AW client installed that is monitoring a reporting on the risks that that device poses to our environment. Those clients have the capability of stopping suspicious activities as well.

Leveraging Microsoft Attack Simulation

We continue to utilize Microsoft Attack Simulation to provide exercises and training to protect the agency from Phishing threats. We provide a monthly campaign and are seeing less that a five percent failure rate. We are working on some follow up training that will be targeted at repeat offenders. Phishing is still the primary way organizations are compromised. We have many tools in place to combat the array of attack vectors that are out there, but protection from phishing is in the hands of the end user and how well they can identify the various social engineering tricks that are employed in a phishing attack. Little, or no, actual phishing emails make it through our defenses against phishing, but it only takes one and if we fail, the results could be a virus or a crypto-locking event.

Hardware and software upgrades

Over the past four years we have been very successful at identifying and replacing devices and software that was at or near end of life. Because of our past efforts, this past year we had a very short list. We have replaced several of our wireless access points that had been at end of life. The new devices support newer formats of encryption and provide faster access.

Respectfully,

Daniel W Mauk, Chief Information Officer / Security Officer

The State of Wexford County Administrators

Wexford County has had 14 administrators since July 1, 1985, when Larry Huebner was the county administrator. Larry was also the administrator with the longest tenure, which ended on November 30, 1994, after nine years and five months. That beat the national average of five years per administrator by four years and five months.

Since November of 1994, Wexford County has had 13 other administrators in 26 years. Anyone good in Math can see the average administrator during that time was two years, or 24 months. So, what happened? I believe the results can be seen by the facts presented in this paper. Five of the administrators, including Huebner, lasted longer than 30 months, or two and a half years. That means the other nine were basically the shortest termed administrators possible. Only one lasted the national average of 5 years.

But the overall timeline in administrators is also quite telling. Please note in the chart below, where the blue lines represent these five longest termed, the dark brown represents the shortest with 3 to 17 months each, and the light brown in inbetweeners of 22 to 28 months each.

		Approx. start date	Approx. end date	Length of tenure (in months)
1	Larry Huebner	7/1/1985	11/30/1994	113
2	Sue Vander Pohl (interim)	12/1/1994	2/28/1995	3
3	Charles Protasio	3/1/1995	5/31/1995	3
4	Richard Schuknecht	9/1/1995	9/30/1996	13
5	Pat Yoder	9/1/1996	2/28/1999	30
6	Tim Dolehanty	2/1/1999	5/31/2001	28
7	Denise Koning	7/1/2001	5/31/2003	23
8	Pat Yoder (interim)	6/1/2003	8/31/2003	3
9	Mike Sutter	9/1/2003	6/30/2006	34
10	Cya Stambaugh	6/1/2006	5/31/2008	24
NA	Vacant	6/1/2008	3/31/2010	22
11	Ken Hinton	4/1/2010	4/30/2015	61
12	Patrick Jordan	11/9/2015	3/31/2017	17
13	Elaine Richardson/Jayne Stanton (interim)	4/1/2017	2/18/2019	23
14	Janet Koch	2/19/2019	1/19/2022	35

You will notice a pattern of Long Term, followed by 3 of the shortest terms, Longer Term, followed by 3 short terms, Longer Term, followed by 2 short terms (one being vacant, when no administrator could be found), Longer Term, followed by 2 short terms (one basically being vacant with Clerk/Treasurer sharing duties), and finally a Longer Term that is now the third longest serving administrator in the last 36 years.

Again, the pattern: 1 long, 3 short, 1 long, 3 short, 1 long, 2 short (with second being vacant), 1 long, 2 short (with second being vacant). And finally, 1 long, the third longest overall. So, what are your guesses as to the next 2 administrators after this one? What this actually reveals is that a long-lasting administrator is no guarantee, especially if the administrator is not allowed the freedom to build their own system of guiding the county under the helpful guidance of the full body of County Commissioners.

The axiom for this type of situation, true since the beginning of county government, is that a plethora of short-term administrators is not the administrator's fault. Turnover has to do with an inherent, systemic problem with the institution or municipality. Several theories have been given by Wexford commissioners in the news in the past, and also suggestions of what the ideal administrator should be like.

"I find it hard to believe we've had **nine bad administrators in a row**," (Les) Housler said, citing the county's structure. "Now I'm in a situation I don't really appreciate and I'm going to need support from everyone." (2008, Cadillac News.) (Note: 9 runs from Huebner to Stambaugh)

"Mr. Housler further states that he doesn't understand why the turnover of administrators is so high. Maybe the problem lies with the board itself." (2017, Cadillac News, Thomas Mannor, Supervisor, Slagle Township.)

Commissioner Sarah McKeever: "**What is this board doing wrong** to **drive administrators out** of the county?" (2008, Cadillac News.) (Note: That is a great question that has still not been honestly answered.)

"You have to want to be here," he (Comm. Bengelink) said. "I want to find a person who wants to be here. At this point, until you get the whole board or a majority of the board on the same page, we probably are not going to look for an administrator for awhile." (2016, Cadillac News)

"(Julie) Theobald said her ideal candidate is someone who will serve county residents, elected officials, employees and board members with their very best ability." (2016, Cadillac News)

"(Gary) Taylor had similar wants for the new administrator...looking for an administrator with experience, a finance and budget background, problem-solving skills, great communication and people skills, the ability to work with the board and other elected officials and department heads, and someone who can promote Wexford County." (2016, Cadillac News)

What is the Reputation of Wexford County?

"Prior to Hinton, the county had earned the reputation of not being able to retain administrators, having had three in six years." (2018, Cadillac News)

"Some members of that board sought stability, especially after the administrator's office had seen a number of administrators come and go." (2018, Cadillac News)

"Other municipalities find it humorous that Wexford County has had a difficult time filling its administrator position." (2018, Cadillac News)

"This isn't anything new to me," Housler said. "If I knew (why the job had such a high turnover rate), we wouldn't be in this position now." (2017, Cadillac News)

"Commissioner Les Housler said he has been with the county commission since 2002, and he personally worked with four different administrators. He also said Wexford County was considered a 'joke' across the state for awhile." (2015, Cadillac News)

So, Why do Administrators Leave a County?

The "American Review of Public Administration" suggests that "Political conflict has been a topic of research for nearly two decades" (Klase and Song, 2000). DeHoog and Whitaker found that disagreements between elected board members and administrators directly influence turnover (1990). DeSantis and Newell solidified this view by estimating that roughly one half of all administrator turnovers are attributed to political conflict (1996). Kaatz, French, and Printess-Cooper point out that disagreements may be attributed to role conflict between board members and administrators, or simply a dislike on the part of the board to a particular managerial style or behavior (1999). As a general rule, the elected body (Commissioner Board), is responsible for establishing jurisdictional missions and policies; administrators are responsible for carrying them out

(Ihrke and Niederjohn, 2005). As they suggest, any deviation from this model such as the board meddling in operational aspects of the jurisdiction may lead to increased conflict between board members and administrators (I & N, 2005). Recent research on county administrator turnover shows that the "influence of political conflict," that is, a County Board not taking measures to "help the administrator succeed," but instead turns into a "board that causes conflict," this conflict can be used as accurate predictors of county administrator turnover (Tekniepe & Stream, 2010). To be precise, according to experts who study this turnover, a change in board leadership, and ensuing conflicts "increase the odds of county administrator turnover (Francis, Feiock, & Kassekert, 2009)."

This whole academic study shows the County Board's effect in having a higher incidence of "push-induced" administrator turnover. "Push-induced" is contrasted with "Pull-induced," or the difference between a board "pushing" an administrator out versus the "pull" of another job awaiting that advances the administrator's wages or position elsewhere. So, what causes the push-inducement? Many laypeople would offer that the wages just are not high enough to ensure a long-term administrator. This would be false. Watson and Hassett (2003 study) determined that economics had no effect on administrator turnover. In an attempt at explaining the tenure of administrators, Feioch and Stream (1998 study) determined that lower poverty levels of counties were associated with lower turnover levels. In other words, those administrators stayed because of other factors than the size of their salary. They factored in that the emotional state and high-calling of these administrators of smaller jurisdictions far outweighed any salary benefits of leaving. Thus, being joyful in the job was more important than working for wages. This study showed that an accurate indication of a push-induced administrator turnover rate (like Wexford County has had for 26 years) is a county with greater unemployment rates and higher poverty rates.

So What? Administrators All Leave!

Of the 50 different counties in the above study, 44% (22) were attributed to "push-induced" departures, with 19 of those counties having multiple departures in a relatively short period of time. Push-induced departures were individuals who were dismissed due to elected board agenda item action, or those who resigned because of impending dismissal (consider the Cynthia Stambaugh fiasco in 2008). The remaining 28 counties (56%) represented career advancement departures. And most of these were, of course, from long-term tenures. In other words, if an administrator does well in a smaller county for an extended period of time, larger counties will court them as being "ready" for their use (think Ken Hinton). The success of a county administrator, even one who leaves after a lengthy tenure, spells the success of the County Board and its leadership. Only when a County Board recognizes this correlation, and chooses to act appropriately in changing the culture of the board to one of assistance and edification, backing the administrator even if it is in opposition to other elected department heads, does a county stand a good percentage of keeping the administrator for much longer than the national average of five years.

There are six predictors of "push-induced" county administrator turnover. The top two predictors are (1) a Board Leadership change, where the leadership have had no experience working effectively with an administrator, and (2) a 40% Board Membership change, where almost half of the board have no idea what an administrator's basic needs are in administering a county. Both of those factors came to fruition in 2019 in Wexford County, two months before the current administrator was hired by the board. To quote the study, "Changes in board leadership and board membership leads to a push-induced turnover." And, each change factor creates a 5% increase in the rate of push-induced turnover for each unit increase in the measure. In layman's terms, a change in Chair is 5%, Vice-chair is 5%, and every new board member is a 5% increase each. Thus, after the first year, there is already a 30% push-induced cloud that is over any new administrator's job. This instability only increases after two years if the board culture is not corrected. However, if a board chooses to stop this deterioration in correctly backing the administrator, then after a few years the ratio of long-term stability indi-

cates there is a 21% decrease in the rate of push-induced turnover for each unit. In other words, the more mature the new board members become, it only takes just three to produce a 63% decrease in the turnover. This is also a pattern noticed for all county jobs, as the trust in the administrator increases, the trust in the County Board also increases.

Conclusion

"County administrators should recognize that an adversarial mindset in some elected officials toward managerial leadership can precipitate an elected board to dismiss the administrator or encourage him or her to seek employment elsewhere." County Boards should "develop stronger employment contracts that provide insulation from board member turnover and strife (Feiock & Stream, 1998). One example given was to negotiate longer guaranteed employment provisions. This provides stability and consistency in leadership and direction. The opposite consequence of political conflict from a County Board leaves a county administrator fearful to take risks that could lead to long-term success (Feiock & Stream, 1998). The futility of signing a one-year contract with a new administrator, while waiting to see if they "will work out," places the administrator in a position of having to please everyone from the start with no room to set any administrative leadership for the county. It leaves department heads with no assurance of any stable leadership or help, forcing them to be more independent from the administrator's office, for fear of losing budgetary items, including pay raises. All the studies concluded that "the outcome of an entire election (of board officers and members) can significantly alter the policy environment, leading even the most successful administrator toward a confusion that can lead to uncertainty. Government policy becomes hard to predict in this setting, and its impact is felt community-wide."

Once again, the County Board should be reminded of the terms, in order of longevity, of the Wexford County administrators of the past thirty-six years (Chart below). And each member of the board must ask themselves the question, "Am I part of the problem, or will I be part of the solution?" This paper is a contribution to being part of the solution.

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8	Pat Yoder (interim)	6/1/2003	8/31/2003	3

Most sincerely and lovingly,

Dr. Ben Townsend

(Note: References and studies utilized were not added for brevity sake. They can and will be supplied if one wishes to check my resources.)