Northern Lakes Community Mental Health Authority

Committee of the Whole Packet

January 18, 2024

Northern Lakes
COMMUNITY MENTAL HEALTH AUTHORITY

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

COMMITTEE OF THE WHOLE - AGENDA

DATE: January 18, 2024

TIME: 12:30 p.m.

PLACE: NLCMHA Cadillac Office - 527 Cobb Street, Cadillac
And Virtual Meeting
Dial 1-810-258-9588 364 573 74#

TIME	ID #	ITEM	POLICY #
12:30 p.m.		Call to Meeting	2.8
12:35 p.m.		Public Comment *(May be limited to three minutes by the Committee Chairperson)*	
12:40 p.m.	1	Update on Recipient Rights	
12:45 p.m.	2	Redbook Training – Chip Johnson	3.4
1:45 p.m.	3	Annual Review – Brian Martinus	
2:00 p.m.		February 15, 2024 COW Agenda Planning - Agency Performance Assessment - Annual Recipient Rights to the Board	
2:05 p.m.		Evaluation/Comments	
2:10 p.m.		Other/Adjourn	

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

NEXT MEETING: February 15, 2024

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

Office of Recipient Rights Director's Report
January 2024

Dates represented	10/01/21-01/09/22	10/1/22-01/09/23	10/1/23-01/09/24
Complaints	145	100	134
OJ, No Right Inv.	21	16	16
Interventions	7	2	17
Investigations	117	82	102
Investigations Comp	117	82	25
Investigations open	0	0	77
Inv > 90 days	0	0	0
Inv < 90 days	117/117 (100%)	82/82 (100%)	25/25 (100%)
Summary Report Avg	116/117 (99.1%)	85/85 (100%)	22/22 (100%)
NLCMHA staff alleg.	10	16	13
NLCMHA Staff W/I 1 yr	0	5	3

Complaint Source

Complaint Source	Count
Anonymous	2
Community/General Public	9
Guardian/Family	11
ORR	36
Recipient	28
Staff	48
Total	**134**

Complaints Per Provider:

July 1, 2023- January 9, 2024

See attached chart. (all NLCMHA areas have been added to report)

Notes:

Substantiation rate continues to be 51%

Respectfully submitted,

Brian Newcomb

Director of Recipient Rights

January 2024 ORR Provider Investigation Report:

Program	Substantiated	Pending	Not Substantiated	NA
Assertive Community Treatment	0	5	3	0
AuSable In Home Care, LLC	0	1	0	0
Beacon Breakwater East	1	0	0	0
Beacon Fife Lake	0	1	0	0
Beacon Home at Blue Lake	1	3	0	0
Beacon Home at Cogswell	1	0	0	0
Beacon Home At Ludington	5	0	3	0
Beacon Home at Trolley Center	0	2	0	0
Beacon Home at Washburn	2	1	0	0
Beacon Mission Point	2	1	4	0
Beacon Silverview	2	0	1	0
Beacon Wave Crest	1	1	1	0
Bell Oaks at Ionia	2	0	0	0
Brightside Living - Whispering Oaks	0	3	0	0
Cedar Valley AFC	1	1	0	0
Club Cadillac	0	3	0	0
Cornerstone AFC, LLC	0	1	0	0
Covenant to Care	0	1	1	0
Crisis Services	1	2	3	0
Crisis Welcoming Center	0	3	2	0
Danes AFC	10	1	3	0
Eden Prairie Residential Care Services, LLC	2	0	0	0
Elmwood AFC	1	3	0	0
Evergreen Home	0	4	1	0
Fort Road Residence, LLC	1	0	0	0
Frances Specialized Residential	0	3	0	0
Friendship Family Home	1	0	0	0
Glen Oaks Home	0	2	0	0
Grand Traverse Industries, Inc.	1	0	0	0
Grayling Office/Crawford County	1	0	0	0
GT Street Flint Home SIP	2	2	0	1

Heart and Soul Living LLC	2	3	0	0
Hickory Hill AFC LLC	1	2	4	2
Hillcrest AFC	0	1	0	0
Hope Network Behavioral Health Services	0	0	1	0
Hope Network Neo Rockford	1	0	2	0
Hope Network Neo Wyoming	1	0	1	0
IDD Adult Case Management	2	3	3	0
IDD Children's Case Management	1	0	1	0
Jones Lake AFC Home	2	5	1	0
Lincoln House LC	0	0	2	0
Magnolia Care AFC West	1	0	0	0
MIA Case Management	3	4	3	0
North Hope Crisis	1	0	0	0
Northern Family Intervention Services	0	0	1	0
Northern Lakes CMH Authority	13	9	8	9
Ohana AFC	0	2	2	0
Outpatient Services	1	0	3	0
Packard Specialized Residential	0	1	0	0
Pearl Street Home	4	7	0	1
Peer Support	0	1	0	0
Premier Care Assisted Living 1	0	0	2	0
Premier Care Assisted Living 3	0	3	0	0
Premier Care Assisted Living 4	0	1	0	0
Psychiatric Services	0	5	2	0
R.O.O.C., Inc.	0	0	3	0
Real Life Living Services	1	6	3	2
Seasons of Life AFC Home, LLC	1	0	2	0
Seneca Place Home	5	0	4	1
Shepler AFC Home	0	1	0	0
Shepler's AFC Home, LLC	0	2	0	0
Shur Care AFC Home, LLC	0	0	1	0
Spectrum Community Services SIP - Bremmer	1	2	0	0
Spectrum Community Services SIP - Kentucky	2	0	0	0

Spectrum Freedom Residence	0	0	2	0
Spectrum New Horizon	1	0	0	0
Spectrum Ridge Home	1	0	0	0
Summerfield AFC	2	6	0	0
TC Office/Grand Traverse County	5	1	4	0
Weeping Willow AFC Home LLC	0	0	10	0
Woodland AFC Home	0	0	3	0
Wright Street AFC Home	1	2	0	0
Zenith Home	0	5	0	0

Red Book

From 5,000 feet to 50

Perhaps I should use Meters, but...

Nah

The Constitution of the State of Michigan

Article IV § 51 Public Health and General Welfare

Sec. 51. The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the protection and promotion of the public health.

Article VIII § 8 Services for disabled persons.

Sec. 8. Institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled shall always be fostered and supported.

The Constitution of the State of Michigan Continued

Article IX Finance and Taxation §18. 6. Purchases

6. Pledge of state's credit would not be involved if county mental health board expended public money to purchase service from a public or private agency under the Community Mental Health Services Act but the county mental health board would have to remain responsible for and in control of mental health program authorized by Act and could not surrender grant to another public or private agency and allow it to operate the program without violating this section forbidding pledging the state's credit.

The Mental Health Code
Powers and Duties

- MCL 330.1116 (1) consistent with section 51 of Article IV …and as required by section 8 of Article VIII of the state constitution of 1963….the department shall …ensure that adequate and appropriate mental health services are available to all citizens throughout the state...shall have the general powers and duties described in this section"
- MCL 330.1116(2)(ii)(b) Administer the provision of chapter 2 so as to promote and maintain an adequate and appropriate system of community mental health services programs throughout the state….to shift primary responsibility for the direct delivery of public mental health services from the state to the cmhsp whenever the cmhsp has determined a willingness ….for the citizens of that service area.

Governmental Immunity

- Cmhsp's are granted governmental immunity under MCL 330.1205(3)(b). There are exceptions: These narrow exceptions involve: (1) maintenance of public highways, MCL 691.1402; (2) negligent operation of a government-owned motor vehicle, MCL 691.1405; (3) public building defects, MCL 691.1406; (4) performance of proprietary functions by government entities, MCL 691.1413; (5) medical care or treatment provided to a patient, MCL 691.1407(4); and, (6) sewage disposal system events, MCL 691.1417. Other than the medical care or treatment exception, these apply only to governmental agencies and not individuals. Examples in the Red Book.
- The chain of governmental immunity is broken when state or federal dollars leave the public system. Roberts v City of Pontiac Doc. No. 103630

Governmental Immunity Legal

- Roberts v City of Pontiac – Chain of governmental immunity
- Jackson v New Center – Governmental immunity is not conferred to subcontractors of cmhsp's.
- Hayes v Emerick – Immunity not extended to an M.D. working with a county jail.
- McClean v Sam Harma, CEO Hiawatha Behavioral Health, Sam was protected
- Huff v Lynn Doyle, CEO Ottawa CMH et al, Absolute Immunity/due diligence

Administrative Rules

- MCL 330.1114 Rules, Sec. 114. (1) Subject to section 114a, as provided in section 9 of Act No. 380 of the Public Acts of 1965, being section 16.109 of the Michigan Compiled Laws, the director may promulgate rules as necessary to care out the functions vested in the department.

Administrative Rules Certification

- R 330.2005 A community mental health board shall ensure that the following minimum types and scopes of mental health services are provided…: Emergency intervention services, Prevention services, Outpatient services, Aftercare services, Day program and activity services, Public information services, Inpatient services, Community/caregiver services.
- R 330.2701 (1) As a condition of state funding, a single overall certification is required for each community mental health services program.

Board Governance

- CMHSP Governance can be found in R 330.2802 to R 330.2814
- It is important to demonstrate all of the key aspects contained within the Administrative rules to maintain a CMHP's certification with the State of Michigan.

Legal

- Campbell v Patterson – Opinions of the A.G. are binding upon state departments and agencies.
- Attorney General 5791– Withholding State Funds
- Attorney General 5665 – Expenditure of monies appropriated for CMH programs
- Attorney General 6600 – Consolidation of county community mental health programs
- Legal Opinion – Review of Partnership Agreement Ionia County
- MBCMH v MDCH – Medicaid in addition to G.F. is tied to the local CMH program

County Board/UCA/Authorities

In this section of your Red Book you would put your own local information.

County Boards – No information would be required here as you are a department of the county.

Urban Cooperation Act Boards – Only one remaining in the state, Manistee-Benzie Community Mental Health d/b/a Centra Wellness Network

Authorities per MCL 330.1205 – The vast majority of the CMHSP's in the state at this time. All local agreements are different.

Name Changes

In order to change your name, you must:

- Have a Board Resolution to do a d/b/a
- Inform you counties of said change
- Inform MDHHS
- You are not registered with the Secretary of State as you are a governmental entity. Therefore, they are not involved.

History

- Document by Mr. Patrick Berrie included for historical references.
- House Fiscal Forum "Mental Health Services in Michigan" Jan. 2014

Federalization $$$

- Federal Money began to pour into the CMH system when the move went from Medicaid Fee-for-Service to Capitated funding based on "Medicaid Lives" in 1998.
- CMH's were required to band together if the Medicaid population was below 20,000 lives (previously discussed MBCMH v. MDCH).
- Revised Plan for Procurement Patrick Berrie 2000
- Application for Participation 2013

Brief Summary

- Medicare and Medicaid.
- Medicare is also known as Title XVIII
- Medicaid is Title XIX

Medicaid Waivers

Home and Community-Based Services HCBS 1915 programs:

- 1915 (b)(b1)(b3)(b4) Kids Dental, MI Choice, MI Healthlink, Health Plans,
- 1915 (c) Children's waiver, MI Choice, Hab. Waiver, MI Health Link, Children SED
- 1915(i) Behavioral Health State Plan Amendment Community Supports and SUD
- 1915 (j) Not in Michigan
- 1915(k) Used during Covid-19 Emergency

1115 Demonstration projects, Healthy Michigan, Behavioral Health Demonstration (transition to 1915(i)SPA) adds SUD

NORTHERN LAKES COMMUNITY MENTAL HEALTH AUTHORITY
FY 2023 Annual Review
12/30/23

Dear NLCMHA Board of Directors,

FY 2023 was an extraordinary year that saw many internal and external challenges to the organization. The Leadership Team is proud to present the ninth edition of Northern Lakes Community Mental Health Authority's (NLCMHA) Annual Reviews reflecting the Accomplishments of FY 2023 and the Works in Progress for FY 2024. Each leader summarized their Team's accomplishments associated with our Ends policies (Attachment A) and their Works in Progress for next year. Below is a quick summary of each department.

Administrative Activities

The Leadership Team Members and Organizational Leaders had a busy year full of activities to support our vision, mission, and values. This review highlighted our top strengths as well as areas we need to improve. Overall, our review went well, and we look forward to the formal report.

The Leadership Team remains focused on supporting our vision, mission, values, and efforts to support healthy individuals, healthy staff, healthy communities, and financial stability. In addition to our focus on the populations we serve (SMI/SED/IDD), there is a focus on treating mild to moderate behavioral health conditions through our Integrated Primary Health Care Clinic and the Behavioral Health Home program. I would like to highlight this past year, Northern Lakes has worked in partnership with community partners to in Munson in the development of a Center for Mental Wellness. In addition, six county administrators worked in conjunction with the Northern Michigan Regional Entity to rework the Enabling Agreement for NLCMHA, keeping the agency from disbanding. The Board of Commissioners from all six counties voted in 100% favor of ratifying the re-worked Enabling Agreement, keeping Northern Lakes as a mental health authority. During this time, NLCMHA staff was committed to providing world-class services to consumers within our six counties. I am proud of the work the staff has done in support of the vision, mission, and values of the agency.

Integrated and Managed Health Care

NLCMHA continued to be the premier provider of integrated behavioral and physical health services. We focused our efforts in our six-county region through our Integrated Health Clinic, our Behavioral Health Home (BHH) program, and through collaborative efforts with primary care providers. We were very encouraged that the expansion of BHH allowed us to provide behavioral health services to people with mild to moderate behavioral health concerns in addition to the specialty populations we serve.

There continues to be growing interest by the Michigan Department of Health and Human Services (MDHHS) to include Long Term Supports and Services into a managed care model. These services have been transferred to the Medical Services Administration (MSA) within

MDHHS. NLCMHA is the only Community Mental Health Service Program (CMHSP) to serve as a MI Choice Waiver Agent. We serve the elderly by providing these long-term supports and services through this program, as well as providing nursing home monitoring and support.
These services are invaluable in ensuring NLCMHA is positioned to meet the needs should these funds be moved to a managed care model.

Clinical Operations

We continued to use and enhance our IT hardware and software, which allowed us to continue telephone and telehealth services. As Essential Service Providers we continued to employ our staff, kept our offices open, and provided services both in person and via telehealth.

We continue to focus on our clinical and operational consistency, effectiveness, efficiency, and use of data with the goal of improving and increasing our services.

As we have noted in past Annual Reviews, the public mental health system has been and continues to be underfunded, so we continue to be good stewards of our funding. Despite the underfunding, the past freeze on Medicaid redeterminations has allowed us, as well as the Northern Michigan Regional Entity (NMRE) to replenish reserves.

Community Collaboration

We have maintained support and collaboration with our six Community Collaboratives, schools, the Community Health Innovation Region (CHIR), and many other agencies and units of government. A collaboration partnership was formed between Grand Traverse County, Munson Healthcare, NMRE, and NLCMHA, which will be essential in getting the Center of Mental Wellness off the ground.

On a state-wide and regional basis, we continued to foster very robust and collaborative relationships with the NMRE and the Community Mental Health Association of Michigan (CMHAM) on financial, operational, and clinical issues to improve our system of care.

Please contact me with any questions that you may have about this FY 2023 Annual

Review. Respectfully submitted,

Brian Martinus

Interim Chief Executive Officer

Medical Director - Curtis Cummins, M.D., FAPA

Accomplishments and Updates:

- Since Winter 2022, have worked with leadership from Munson Healthcare, NW CHIR and others surrounding the development of Grand Traverse Center for Mental Wellness.
- In FY 2023, 1591 persons were served by Psychiatric Services and 129 persons were served by ACT.
- In FY 2023, 291 unique persons served cumulatively received 2121 long-acting medication injections (LAI). Collectively, ~20% of adults served open to ACT or Psychiatric Services received LAIs.
- Welcomed two early career nurses and three early career psychiatrists to our team.
- Welcomed a new partnership with Munson Healthcare and Northwestern Michigan College in hosting and educating nursing students.
- Entered our second year of partnership with Munson Healthcare and Pine Rest in hosting third-year psychiatric resident physicians as part of the MSU-Pine Rest Rural Track Psychiatry Residency Program.
- Ongoing education of ~18 medical students yearly from Michigan State University's College of Human Medicine and College of Osteopathic Medicine.
- Over FY 2023, Psychiatric Services has consistently demonstrated a No-Show rate of 10- 13%.
- Ongoing support to NLCMHA Integrated Health Clinic's Family Nurse Practitioner utilizing Collaborative Care Model practices to support patient care.
- Continuing to foster a Community of Practice complimented with ongoing Peer Review within Psychiatric Services, which is incorporated into our Quality Improvement Plan.

Works in Progress:

- Ongoing engagement with Munson Healthcare, NW CHIR and others, in the development, design and staffing of Grand Traverse Center for Mental Wellness.
- Improving our practices surrounding Assisted Outpatient Treatment (AOT) court orders, while working in concert with staff, local probate courts, Munson Healthcare, and others.
- Maintaining high quality health care and access to services amid ongoing workforce shortage challenges.
- Ongoing advocacy for enhancing 24/7 direct admissions to Munson Medical Center's behavioral health inpatient unit (D6) across Munson Healthcare's regional emergency rooms.

Chief Operations Officer - Clinical, Nancy Stevenson LMSW, QMHP

Case Management/Operations (IDD):

- **696** Adults with Intellectual and Developmental Disabilities were served in 2022-23
- **221** individuals resided in Specialized Residential Homes

- **414** utilized Community Living Supports
- **62** received respite
- **130** had Self Direction arrangements.
  1.0.4, 2.0.5, 1.0.7
- NLCMH currently has **173** Hab Waiver slots. 1.0.1, 1.0.2, 1.0.4, 1.0.5, 1.0.7, 1.0.91.0.10, 1.0.11
- NLCMH had the Traverse City Adult IDD supervisor retire. We now have Kiley Fields overseeing all six counties for adult IDD services.
- NLCMH recently posted a team lead position for the Adult IDD services, interviews for that position will take place after the start of the new year.

Personal Emergency Response System:

Personal Emergency Response System (PERS), also known as Medical Emergency Response System, lets you call for help in an emergency by pushing a button. PERS has 3 components: a small radio transmitter, a console connected to your telephone and an emergency response center that monitors calls.

- NLCMHA has developed an assessment tool to assist with clinical necessity.
- **12** consumers are being serviced with PERS. 1.0.1, 1.0.2, 1.0.5, 1.0.7, 1.0.10, 1.0.11

Community Living Supports:

Community Living Supports (CLS) services are meant to increase and maintain a person's independence and support an individual's achievement of their goals promoting community.

- NLCMHA staff have provided services to 39 consumers this year and continue to provide support in the home and community. 1.0.1, 1.0.2, 1.0.4, 1.0.5, 1.0.7, 1.0.9, 1.0.10, 1.0.11
- 7 staff have been hired for the Community Living Supports position. One staff has resigned and 1 has retired.

Community Connections:

- IEP's-IDD adult team staff in TC continue to attend students' IEP's primarily in person and also zoom when requested. The purpose of attending is to provide information about CMH services, explain CMH services aren't just about diagnoses but about functioning and medical necessity to link students with other resources in the community. It is also an opportunity to explain there are other alternatives to guardianships.
- Transition Council meetings-organized by Northwest Education Services (formerly TBAISD). The purpose of the meetings is to network and share resources among community agencies. Each agency gives an update of services available, how to access services and discuss challenges.

Children's IDD Team:

- The Children's IDD Team covers the 6 counties of NLCMH; children with an IDD have reintegrated back to school and primarily work with the ISD academic support services while in school. Janell has been actively engaged with our Autism service providers as well as CLS providers.

- Janell and her Children's IDD team primarily provide in person services though will meet with family members via telehealth when requested 1.0.3
- Through the collaboration between the Children's SED team and Children's IDD teams, a Multi-Disciplinary Team was developed to address more intense and high risk families for both crisis and inpatient; meet with Children's psychiatry team once a week.
- Children's IDD service work predominately with children diagnosed with Autism Spectrum Disorder; our main service/support/treatment is ABA (Applied Behavior Analysis). 1.0.1, 1.0.2, 1.0.3, 1.0.4 Janell and the Children's IDD team regularly meet with and consult cases on a monthly basis with several Autism providers.
    - Expanded our contract provider network to include 2 additional ABA providers and 3 more assessment providers that can support our NLCMH community. 1.0.10, 1.0.11

OBRA Program:

The NLCMH OBRA program continues to provide comprehensive OBRA services to our six-county service area.

OBRA had been directed by our state office that when evaluations are being conducted, we must have in-person contact with the client depending upon nursing facility access due to continued COVID episodes that at times limit in-person visitation. We may still utilize remote review of records which we are able to do with most of the 13 nursing facilities we service as well as by utilizing Powerchart & VIPR to access various medical records.

With the implementation of the OBRA electronic referral system in September 2021, we have experienced significant challenges with its utilization by referral sources. Due the complexity of the system, the state removed the requirement that community referrals use the electronic referral (this includes home health agencies, physician's office practices, human services agencies, etc.). Hospitals and nursing facilities are still mandated to use the electronic system. As anticipated, OBRA Coordinators are the primary contact for referrals needing assistance with the process which has increased need for one-on-one case consultation exponentially. Our OBRA office has implemented a more aggressive triage process for screening and determining the need for in-person OBRA evaluations. Findings are showing exceptional productivity, essentially due to an extensive list of clients needing evaluation. Volume of activity has increased compared to last year's total (1071 cases vs. 953 – see attached Fiscal Year End Evaluation Totals). This is primarily due to the new administrative requirement of screening & triaging incoming cases to determine level of OBRA involvement.

OBRA has received approval to add an evaluator for our Southeast area earlier this year but had not had qualified applicants. We are excited to identify that a qualified applicant has come forward and accepted the position and shall be starting by end of January 2024. We have been assigning staff to address those evaluations as able, but this is resulting in excessive delays beyond standards of completion required by our contract (Pre-Admission Screenings (PAS) should be completed in 4 days; Annual Resident Reviews, Change in Condition, Hospital Exempted Discharge & Re-Evaluations should be completed in 14 days)

2022 Traverse region: PAS Avg. time for completion -- 18.5 days
All other evaluations Avg time for completion – 34.33 days

2022 Southeast region: PAS Avg. time for completion – 10.2 days
All other evaluations Avg. time for completion – 39.23 days

2023 Traverse region: PAS Avg. time for completion – 9.39 days
All other evaluations Avg time for completion – 70.84

2023 Southeast region: PAS Avg. time for completion – 13 days
All other evaluations Avg time for completion – 80.18 days

The monthly average times of completing cases are increasing in the Southeast due to lack of staffing to service the area. This is resulted in the request & approval of additional staffing.

Until such time that timeliness can be rectified, assignments will continue to be absorbed by existing OBRA staff in the Traverse City office. Nursing service evaluations for the Southeast area are unaffected. Due to closing of the nursing agency that we previously contracted with for provision of evaluation in our Southeast area (Healthcare Coordinates), we have initiated a contract with a new agency, Health Coordinates & Patient Advocates, which was implemented service on Oct. 01, 2023.

Now that OBRA Coordinators are tasked with providing consultative services to locally assist nursing facilities and hospitals with problem-solving electronic data submission issues, outreach and contact has become an important and expanding role. Our office has one staff member beside the coordinator who has authority to perform preliminary OBRA case opening and registration but is not able or available to perform such training and problem-solving as regularly needed. Offers of assistance to hospitals has continued on a case-by-case basis with good results. Corrective actions needed from hospitals to address incomplete referral processes has not been systematically addressed despite numerous offers by this OBRA office to assist. This challenge will continue to need attention.

Therapy services for those Seriously Mentally Ill and Intellectually/Developmentally Disabled clients in our 13 nursing facilities in our region identified as needing OBRA mental health monitoring and/or specialized services continues to be provided for the Southeast Counties by the CMH OBRA Therapist, Dona Veddler, LLPC. and by Kurt Klein, LPC for Grand Traverse & Leelanau counties. On average, Mr. Klein has an active, open case load of 40 - 45 cases that have been determined by the Michigan Dept. of Health & Human Services as meeting criteria of serious mental illness and/or intellectual/developmental disability as well as meeting Medicaid criteria for requiring nursing facility care. Ms. Veddler has 18 – 20 clients. A trail program was implemented to utilize Ms. Veddler in providing case management assistance to the I/DD and MI programs for 6 months. The project did not fare well and was discontinued.

OBRA offices relocation to the second floor of the T.C. building in May ’22 continues to be a successful transition. The conference room, storage, cubes and offices are all working out very well.

OBRA continues to utilize virtual Team meeting technology for meeting with the T.C. team as well as the contracted workers of the Cadillac team. This has actually improved contact with the Cadillac area team since we no longer worry about travel conditions and can make much better use of time rather than traveling. Most staff are utilizing the home office option for remote work since visitations occur at nursing and hospital facilities and reports are relayed electronically.

Another creative utilization of community resources has been realized as staff has continued to take advantage of Webinar video presentations offered by the Michigan Center for Rural Health. Such video presentations occur over the lunch hour and offer Free Continuing Education Unit hours for nursing and social work participants. Over the past year, staff have cumulatively realized over 60 CEUs at NO CHARGE to address state-mandated credentialing requirements.

Challenges will include continued training and implementation of the electronic OBRA referral process with providers which is something the OBRA team shall tackle creatively and effectively over the next year.

Resiliency: Children and Families Experiencing Serious Emotional Disturbance <u>Accomplishments:</u>

1. We continue to have a multidisciplinary team to review children and families for high risk of out-of-home placement and/or inpatient hospitalization on a weekly basis. **1.0.5, 1.0.3, 1.0.6**
2. The Michigan Child Collaborative Care (MC3) has successfully enrolled #_13_ of new providers.
   1.0.6, 1.0.9
   a. We offer perinatal and pediatric webinars on various topics. We also do have
3. We enhanced our expertise in evidenced based practices (EBP) and have participated in the second cohort for the State of Michigan for Dialectal Behavioral Therapy for Adolescents. We have 4 clinicians and one supervisor working on the certification process. 1.0.2, 1.0.3, 1.0.7
4. We enhanced our expertise in trauma focused care. 1.0.2, 1.0.3, 1.0.7
   a Two clinicians and a supervisor were certified in Trauma Focused Cognitive Behavioral Treatment.
   b Staff who have completed the Trauma Caregiver Resource Training Cohort have provided Trauma Informed Caregiver Groups to caregivers via telehealth and in person.
   c We are working with Cadillac Area Public Schools to provide Trauma Informed Caregiver Groups in the school setting.
   d We currently have two interns on the SED children's team
5. Community Collaboration **1.0.1, 1.0.5, 1.0.7, 1.0.10, 1.0.11**

   a. Participated in the TRUST (Trauma & Resilience Unified Support Team) meetings, including the Handle with Care Program.
   b. Participated in County Child Death Review meetings. Once trained and certified, Nancy Stevenson will attend these meetings.
   c. Participated in the MDHHS Children's Administration Forum Meetings.
   d. Active participation in Child Abuse forum meetings is being continued.
   e. Participated in the System of Care Meetings.
   f. Participated in the Clinical Community Linkage Workgroup in Traverse City.
   g. Continued participation in the Roscommon and Crawford County Substance Use Coalition.
   h. Participated in the Roscommon and Crawford County Collaborative Body Meetings, monthly.
   i. Operation Manager's continue to participate in Infant Mental Health Reflective Supervision sessions.
   j. Participated in Case Coordination meetings with Crawford County Juvenile Court.
   k. Participated in Case Coordination meetings with Grayling School Social Worker.
   l. Participated in Case Coordination meetings with Houghton Lake Community School.
   m. Participated in Case Coordination meeting with Cadillac Community Schools and ISD.
   n. Participated in Case Coordination meeting with Wexford and Missaukee DHHS

o. Staff serve as the Secretary on the Child Protection Council Board in Crawford and Roscommon counties.
p. Continued collaboration with Child and Family Services who have identified crisis and planned respite homes in the Grand Traverse, Leelanau, and Wexford Counties.
q. Youth Peer Support Services in Roscommon and Crawford Counties.
r. Facilitate Quarterly Wraparound Staffing to collaborate.

6) Worked with Grand Traverse County Prosecuting Attorney, Schools, MDHHS, and primary care providers to assess for justice diversion services prior to referring cases to the Family Court.
7) Worked with Grand Traverse County Family Court to provide post adjudication services to reduce out of home placements and reduced sentencing.
8) The Justice Diversion Program Staff completed Community Presentations:
   a. We Fight Community Mental Health Summit
   b. Community Conversations: Mental Health Matters
   c. Recovery Feature Segment on 9 & 10 News: The Four
   d. Community Recovery Celebration
9) Clinical Treatment provided by NLCMHA Children and Family staff: **1.0.1, 1.0.2, 1.0.3, 1.0.4, 1.0.6**

Child and Family Service Numbers for FY 22023 (10/1/2022—9/30/2023)				
Program	**Distinct Consumers**	**Contacts**	**Units**	**Total Cost**
Outpatient Therapy	**516**	**5,181**	**5,194**	**$1,095,924.00**
Psychiatric Services	**86**	**447**	**447**	**$87,798.00**
Parent Support Partners	**38**	**570**	**570**	**$140,220.00**
SED CSM	**149**	**1,106**	**2,758**	**$253,376.00**
Wraparound	**35**	**762**	**2,605**	**$251,699.00**
Homebased, including Infant Mental Health	**171**	**3,698**	**15,143**	**$1,199,256.00**
Juvenile Justice Diversion Program	**264**	**1,379**	**2,122**	**$387,744.00**
Totals		**13,143**	**28,839**	**$3,416,017.00**

Works completed FY 2023:

1) Assist the Grand Traverse County 13th Circuit Court Family Division in developing and implementing a Child Behavioral Health Court.
2) Build awareness of our justice diversion services and increase referral sources.
3) Promote Resilience by celebrating the accomplishments children and families have achieved (Similar to the Recovery and Culture of Gentleness Celebrations).
4) Increase Caregiver Trauma Education Training Groups for Caregivers.
5) Work with Child and Family Services in expanding their services for crisis respite services to divert from psychiatric hospitalizations.

6) Partner with community partners to explore more options to create homes available to provide planned respite services.
7) Continue training and expansion of Dialectical Behavior Therapy for Adolescents (DBT-A) service in all counties.

Access/Utilization Management
Accomplishments: 1.0.1—1.0.11

1. Hired an Access Operations Manager who will begin this position on 1.3.24
2. Community outreach, providing education regarding NLCMHA Access process, denial, and grievance and appeals to multiple community service providers and stakeholders.
3. Continue to coordinate and train with Crisis Services Team (CST) to provide Access screenings during crisis contacts in order streamline processes to ensure timely response for Initial Clinical Assessment. This collaboration also resulted in meeting Performance Indicators required for post-hospital discharge timeframes.
4. Working with NLCMHA Operations Managers to acclimate new staff on processes and procedures of the role and practices of the Access Department.
5. Completed 2,447 Access screens.
6. Completed 1,734 Initial Clinical Assessments for individuals requesting NLCMHA services.
7. Referrals and linking to community resources for persons who did not meet medical necessity for NLCMHA services.
8. Completion of 2,250 Continued Stay Reviews to determine ongoing medical necessity for persons being served in an inpatient setting.
9. Completion of 14 Second Opinions for Clinical Assessment denials.
10. Completion of 11 authorizations for Peer Support Services upon completion of assessments were made.
11. Continued to remote work, coordinating video/telehealth for completing Screening and Initial Clinical Assessments, while continuing to provide face to face services when requested or medically necessary.
12. Provided education for community stakeholders and providers regarding the process for determining if an individual meets criterion for NLCMHA services.
13. Traveled to community locations including jails, hospitals, and Michigan Department of Corrections to complete Initial Clinical Assessments.
14. Collaboration with PMQI membership to review and manage General Fund spending**.**

Clubhouse:

1. Traverse House received a full 3-year unconditional accreditation
2. Traverse House became a member of the Sunrise Rotary in Traverse City
3. Club Cadillac Advisory Board gained 8 new board members from the community
4. Club Cadillac Advisory Board continues to be the non-profit affiliate for starting a NAMI Wexford/Missaukee Chapter
5. 9 members enrolled in higher education
6. Attended and advocated for mental health awareness at the Walk a Mile Rally in Lansing
7. Attended and presented at the Clubhouse Michigan Conference in Kalamazoo
8. Attended and presented at the Clubhouse International World Seminar in Baltimore

9. Club Cadillac successfully completed Two-Week Comprehensive Training in October 2022. One staff, one member and one administrator attended in Greenville, South Carolina.
10. Club Cadillac was elected to the Guidance Board of the Clubhouse Michigan Coalition.
11. Traverse House and Club Cadillac serve on the Training Committee for the Clubhouse Michigan Coalition and help facilitate a variety for trainings for Michigan Clubhouses.
12. Club Cadillac obtained four YMCA passes for the Clubhouse and began attending daily for wellness.
13. Club Cadillac joined the Human Services Leadership Council for Wexford and Missaukee County and spoke as a panelist on the Mental Health Symposium in September 2023.
14. Club Cadillac partnered with MSU Extension to host "Cooking for One" class to encourage healthy eating habits and cooking.
15. Club Cadillac has been trending at pre-covid average daily attendance of 26 members a day and an active membership of 90 members.
16. Club Cadillac hosted a variety of Lunch and Learn opportunities to members by partnering with local businesses and organizations.
17. Supported Education: Traverse House has 7 members engaged in educational opportunities
18. Traverse House has an average daily attendance of 25 and 85 active members.
19. Traverse House developed 3 new employment partners who offer Member Colleagues opportunities for supported and transitional employment.
20. Traverse House successfully hosted 2 Employment and Education Dinner Celebrations with community employers and community partners in attendance.
21. Traverse House serves as the Quality Assurance Clubhouse for MDHHS in the Michigan Clubhouse Coalition.
22. Wellness: Traverse House provided YMCA scholarships to 10 members to work on exercise and health goals.

Clubhouse (Club Cadillac and Traverse House) Employment data:

Traverse House Transitional Employment: 7 members, $38,500 earned
Traverse House Supported Employment: 5 members, $82,992 earned
Traverse House Independent Employment: 16 members, $151,638 earned
Club Cadillac Transitional Employment: 0 positions/ 0 earned
Club Cadillac Supported Employment: 2 positions/ $11,830 earned
Club Cadillac Independent Employment: 39 positions / $ 291,475 earned-
Transitional Employment: **7 members** employed ear
Transitional Employment: **7 members** employed earning **$12,937.00 and 5 positions** vacant
Supported Employment: 5 members earning $49,076.00
Independent Employment: **47 members earning $457,053.00**

Recovery and Peer Services:

Ten staff earned their Certification for Certified Peer Support Services!
Recovery Celebration: We had a very successful Recovery Celebration, held in person at The Barn Hall in Manton, MI. 83 people attended a fun filled day with games, a Scavenger hunt, a raffle, and an Awards Ceremony. Our keynote was Joseph Reid, a person in Recovery who is now an author and motivational speaker.

Crisis Services, including Jail and Diversion Services:

Training:

1. NLCMHA provided mental health first aid training to all of the Grand Traverse County Sheriff Departments in February.

2. Provided annual mental health and de-escalating training to Wexford County Sheriff department corrections and road patrol in May.
3. Continue to provide crisis assessment training to new staff on a monthly basis
4. Provided training to Northwest Michigan College Police academy recruits on mental health in August of 2023

Community Connections:

1. Provided over 20 ipads to the Grand Traverse County Sheriff department road patrol. Provided 1 ipad to the Manton City Police Chief. Provided 3 ipads to Missaukee County Sheriff department.
2. Provided over 500 carter kits to community partners including all area fire departments, police departments, EMS, schools, courthouses, and wellness centers. Included presentations regarding the Carter Kits to each agency.
3. Provided cell phones and ipads to area shelters in Wexford County, and Grand Traverse County. Provided cell phone and 1 staff once a week to Grand Traverse County library.
4. Meet monthly with Grand Traverse County, ATS, Traverse City Police, QRT to further collaboration amongst all parties. NHS and CFS have also attended these meetings.
5. Crisis staff and COO have participated in regular ride alongs with the police officers and deputies.
6. Met quarterly with Roscommon County, Crawford County, Missaukee County and Wexford County for interagency agreements.
7. Met monthly with Wexford and Missaukee counties on jail diversion programming.
8. Attended 9/11 event in Cadillac MI and provided educational materials to attendees. Had over 300 attendees.
9. Provided educational materials to open houses for Cadillac Area Public Schools on FAST program and Team.

e. Quantitative Data for Services

- The Crisis Services Team provided the following services:
- 5,905 crisis contacts, a 17.5% increase from last FY.
- 2,572 inpatient screens, an 13% increase from last FY.
- The FAST Team provided 758 transactions for 291 cases. This is a 77% increase in the number of families served.
- Outpatient Services provided 7,558 transactions for 639 cases.
- Peer Support Specialists provided 2,678 transactions for 155 cases.
- Pre CPSS hospitalizations totaled 32 and post hospitalizations 16.
- Jail contacts totaled 2,582 which is an increase of 74% from last FY, and we completed 512 Jail Diversion assessments which is an increase of 180% from last FY.

Completed in 2023:
Meeting with Wayne State University to improve data collection for ipad contacts with law enforcement.
Providing AMSR training to clinical staff
Providing Critical incident stress management training to the community and staff in January 2024
Creating a critical incident stress management team (CISM) for community response in all 6 counties.
Increasing numbers of jail diversions, working with community partners to have more pre jail diversion plans.

Provide more carter kits to the community.
We will continue to partner with the Grand Traverse and Leelanau courts with regard to Behavioral Treatment Court (BTC) that is pending.
MST therapists and supervisor will continue training with MST Substance Abuse.
Building awareness through community groups to increase referral sources (i.e. Families Against Narcotics, 217 Recovery, Students Against Negative Decisions, The Porch Recovery Center, Various AA/NA/Recovery Coach groups)
Building Community Resilience
Continue to focus on providing community events, such as Building Community Resilience, for those we serve to be heard by community partners and stakeholders. Building Community Resilience is an educational event sponsored by NLCMH three to four times a year. Consumers and staff work together on developing the program for these events.
Continue treatment efforts using evidenced based practices.
Continue our work around the LOCUS to improve consistency. A MIFast review of the LOCUS will be completed the end of November.

- Ongoing community outreach with stakeholders, building collaborative relationships. • Continued collaboration with other areas of NLCMHA to increase quality of services provided.
- Access/crisis services continue to assist each other in completion of screens.
- Initial Clinical Assessments completed face to face, unless requested otherwise by consumer.
- Reintegrating back into the office, full time.

FY23 MIA Services Annual Review to the Board

Submitted By: Kim Silbor, LPC, NCC, MHP, QIDP, *Interim COO (Southeast)*

Adult Outpatient Services—Adult outpatient therapy services are offered in the office, jail and by telehealth video. The frequency of outpatient therapy interventions is based on the needs of the person as identified in their person-centered plan. Referral sources for outpatient services can be both internal and external. Internal programs such as the psychiatric med clinic, case manager, or Clubhouse programs may make referrals to the outpatient therapy program supervisor for review. Other referrals come from hospitals, primary care offices, the court, jails, DHHS, schools, parents, guardians, and mental health or SUD providers in the community. Services provided directly by the outpatient therapist include: assessment, crisis intervention, individual and group therapies. Treatment for primary substance use disorders are referred to community providers.

Accomplishments and Updates:

- From 2022-2023, a total of 1,824 consumers were served in adult outpatient therapy services.
- We have seven full-time therapists and two “part-timers” employed in the agency.
- We welcomed two new therapists in Houghton Lake and Grayling respectively, and one in Traverse City.
- We had three new master’s level interns

- We provided evidence-based group therapies such as DBT and Seeking Safety in each office location.
- We continue to use evidence-based practices in outpatient therapy services such as CBT, DBT, EMDR, and Motivational Interviewing.
- Inpatient hospitalization count pre-admission to outpatient services was 229; post-admission was 126.
- Total number of services: 16,646; Total number of units billed: 17,649

Works in Progress:

- With the departure of two MIA Operations Managers from Cadillac in October/November 2023, there is an unmet need for a full-time outpatient supervisor or Operations Manager to provide clinical supervision for limited licensure as well as program supervision to all outpatient therapists.
- We need to increase our master's internship program so that it is more robust.
- Continued challenges in high caseloads (above 70 for each FTE employee) in each office and admissions that extend beyond a 24 month period.
- Continued challenges recruiting external employee candidates for the Houghton Lake and Grayling offices.
- Movement from providing "DBT informed" therapy to adopting the full DBT model would require significant investment of training all outpatient, case management and peer staff in the model as well as adjustments within our crisis services program. However, the benefit could result in reduced recidivism for inpatient stays.

MIA Case Management Services--

Adult targeted case management services are offered in a variety of settings including: the office, the consumers residence, licensed AFC homes; the community; jails; telehealth video; emergency departments and day program sites. The frequency of targeted case management services is based on the needs of the person as identified in their person-centered plan. Referral sources for targeted case management services can be both internal and external. Internal programs such as the psychiatric med clinic, outpatient therapist, or Clubhouse programs may make referrals to the case management program supervisor for review. Other referrals come from hospitals, primary care offices, the court, jails, DHHS, parents, guardians, and mental health or SUD providers in the community. Services provided directly by the targeted case manager include: assessment, crisis intervention, linking, planning, coordinating, monitoring and advocacy to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Provision of skill development services such as budgeting, meal planning, housekeeping and home maintenance are typically referred to a community support service provider. Case management services can also be contracted with another CMH outside the NLCMHA service area via a "COFR" agreement. Transportation needs for medical or dental appointments are referred to DHHS or the Medicaid Health plan.

Accomplishments and Updates:

- From 2022-2023, a total of 804 were served in adult case management program.

- We had 11 FTE case managers and 2 FTE Supports Coordinators employed, and one position in Traverse City remained vacant.
- We welcomed two new supports coordinators in Grayling and Traverse City, respectively. We welcomed one new case manager in Traverse City.
- Inpatient hospitalization count pre-admission to case management was 165; post-admission was 125.
- Total number of services: 7,700; Total number of units billed: 19,121
- The DHHS inclusion of other bachelor-level human service degrees for the QMHP allows us to fill positions traditionally exclusively occupied by BSW's.
- All case managers completed "Core Elements of Case Management" training for CARF QIP

BH-TEDS DATA	Employment Status As of: 10/01/2022 - 09/30/2023	
Full-time competitive	32	8.3%
Not collected (exception, etc.)		0.0%
Not in competitive labor force	130	33.7%
Part-time competitive	33	8.5%
Unemployed	191	49.5%
Total	**386**	

Works in Progress:

- Add one FTE Housing Supports Coordinator under the 1915(i)SPA waiver for FY24
- Goal to add two bachelor-level interns for FY24
- Addressing housing needs is a continual challenge in all counties with lack of community resources and high cost of living, particularly in Traverse City
- Getting all case managers trained in evidence-based modalities such as motivational interviewing and DBT skills coaching.
- High caseloads averaged 50-55 per case manager
- Filling vacancies takes several months to a year on average. One position in Traverse City remained vacant for a year.

Assertive Community Treatment:
Accomplishments and Updates—

- From 2022-2023, a total of 129 consumers were served in the ACT programs across four offices.
- We have 11 FTE clinical workers and 4 FTE peers employed with the ACT programs.
- Inpatient hospitalization count pre-admission to ACT was 37; post-admission was 16
- Total number of services: 4,397; Total number of units billed: 10,375
- All clinical workers were provided IPads to improve timeliness of documentation while spending time with consumers in the community

BH-TEDS DATA	Employment Status As of: 10/01/2022 - 09/30/2023

Full-time competitive	1	3.8%
Not in competitive labor force	12	46.2%
Part-time competitive		0.0%
Unemployed	13	50.0%
Total	**26**	

Works in Progress—

- Two FTE clinical positions in the Grayling office remain vacant
- Establish one Family psychoeducation group in Traverse City and Cadillac
- Establish a IDDT group in Traverse City
- Implement a software application such as VelloHealth that offers built-in safety, accountability, and efficiency measures that will enhance use of the current EHR as compatible on portable devices.
- Ensure that all ACT team members receive annual training in both ACT and Motivational Interviewing or IDDT
- Ensure all ACT team members receive annual safety training relevant to community-based programs
- Develop a NLCMHA policy that defines ACT eligibility and referral process as well as discharge criteria.

Resiliency: Children and Families Experiencing Serious Emotional Disturbance
Community Collaboration 1.0.1, 1.0.5, 1.0.7, 1.0.10, 1.0.11
Submitted by: Emily Friske, LBSW, *MIAT Community Coordinator*

Accomplishments and Updates—

- Participated in the TRUST (Trauma & Resilience Unified Support Team) meetings, including the "Handle with Care" Program.
- Participated in the Roscommon and Crawford County Substance Use Coalition.
- Participated in the Roscommon Suicide Prevention Coalition meeting monthly and attended community suicide prevention events.
- Participated and served as secretary in the Roscommon and Crawford County Collaborative Body Meetings, monthly.
- Participated and chaired in FAST collaborative meetings with county schools, police officers, Child and Family Services, and Munson.
- Staff serve as the Secretary on the Child Protection Council Board in Crawford and Roscommon counties.
- Staff developed and chaired Northern Michigan United Suicide Prevention coalition that meets monthly.
- Attended Community Health Fairs hosted by TCAPS, Roscommon Collaborative, and Crawford Collaborative

NLCMHA Specialized Residential Board Operated Homes

Submitted by: David H. Simpson, M.A., *Residential Services Administrator*
The Specialized Residential Services (SRS) Unit of Northern Lakes is comprised of six licensed Specialized Residential Homes in addition to the Glen Oaks Apartments, an unlicensed semi-

independent living unit of apartments serving persons who do not require 24-hour care or support. The SRS Unit serves up to forty total recipients. The SRS Unit workforce totals seventy-one full and part time employees…or about 20% of the total employees of NLCMHA. Facilities are in Crawford, Roscommon, and Wexford Counties. The SRS Unit serves recipients from all NLCMHA counties.
The philosophy of the SRS Unit is simple and direct:

- Operate Happy Homes that residents, workforce members, clinicians, guardians, and families are proud to be associated with. 1.0.1, 1.0.2, 1.0.4, 1.0.5, 1.0.7, 1.0.9
- Operate services that are compliant with ORR, LARA (Michigan Licensing and Regulatory Affairs) and NLCMHA Network Management audit standards.
- Operate in accordance with the Culture of Gentleness and the Recovery Model.

SRS Unit services are comprised of three primary domains. All communication, documentation, and collaboration on the part of recipients falls within these domains:

- Resident Health and Safety
- Workforce
- Operations in support of each service delivery site.

<u>Resident Health and Safety:</u>
100% of the residents from Jones Lake Home and Woodland Home now utilize NLCMHA's Integrated Health Center (Grayling) as their Primary Care Physician provider of choice. 1.0.9
Bed occupancy for 2023 was calculated at 94% for the year based on the following assumptions:

- Seneca Place Home operated at a 3-bed capacity until measured outcomes were met. Referrals are now being evaluated to fill a fourth bed.
- Pearl Street home was utilized twice during the year to meet emergent short-term placement needs vs long term specialized residential placement.
- The bed for a Woodland Home resident was held open during a lengthy (90+day) hospitalization from an injury that occurred at school after which the resident returned.

<u>Workforce:</u>

2023 was a year in which the challenging lessons learned from late 2021 through 2022 were actualized into new and elevated standards of operation. COVID drove many lessons learned and created opportunities for creative and innovative practices.

Direct care staffing rates for Residential Care Aides (RCAs) hit an all-time low in November 2021 resulting in a less than 50% overall staffing level. This was due primarily to COVID related essential worker shortages throughout the industry. NLCMHA was able to avoid this for the first 18 months following the onset of the pandemic in 2020, but that honeymoon ended in late 2021. The path to staffing solvency in 2023 was challenging throughout 2022 due to much being learned.
Direct care (RCA) staffing levels for 2023 in the BOHs was over 85% collectively for the year.

- Three homes maintained 100% staffing levels for the entire year.
- Pearl Street Home ran at 50% staffing Jan-June; 100% staffing June-December.
- All 3 Cadillac homes have been at full staffing capacity since July.

Takeaways from the direct care staffing crisis and operational changes are:

- Operationally more resources were committed to workplace conflict resolution conducted consistently and in real time by the leadership team (Home Supervisor and Assistant Home Supervisors) at each home.

- Initiative-taking use of temporary and permanent worker transfers between homes was utilized successfully in 5 of 6 cases, thereby retaining the worker.
- The EAP (Employee Assistance Program) was utilized on both a voluntary (by the employee) and prescriptive (by NLCMHA as a condition of employment) basis to successfully retain workers who were in job jeopardy.
- The Human Resource Department and Home Supervisors (who conduct all RCA interviews) improved the timeliness and screening of Indeed.com applicants improving hire rates as positions came open. This resulted in more timely hires and reduced premium overtime or added duties to remaining staff. The orientation process for onboarding RCAs was reviewed and streamlined.
- Compensation for RCAs was enhanced by an August contractual step increase and a 10.1.23 wage pass-through increase from the state of $.85/ hour that raised start pay for RCAs to a more competitive $16.44.
- Consideration of NLCMHA benefits, PTO, flexible schedules, and holiday pay incentives sets NLCMHA RCA positions apart from many employment options for essential workers.

<u>Operations in support of each service delivery site:</u>
The Wright Street Home Supervisor accepted additional duties in May/ 2023 to oversee the operation of Seneca Place Home; successfully improving outcomes at Seneca.
The Assistant Home Supervisor II position was successfully implemented. A direct outcome of that decision has been stabilization of the leadership teams in each home. There has been zero turnover in the Home Supervisor position since implementation of this position.
Fourteen total members of Board Operated Home leadership teams are enrolled in the Health Care Worker National Certification course. This 160-hour course available to Home Supervisors and Assistant Home Supervisors (I and II) is offered via on- line live course work or virtual independent study; two have graduated to date.
The Home Supervisor of Woodland Home became certified as an instructor in CPI (Crisis Prevention Intervention). Six trainings in this evidence-based de-escalation practice were conducted in 2023 to over 50 SRS Unit and clinical staff members.
At least one staff member at each SRS Unit site has been certified as a First Aid/ CPR Instructor.
Two LARA recertifications and fourteen annual ORR and NLCMHA Network Management audits were successfully completed in 2023 resulting in full compliance at all sites.
2023 Success Stories:
Jones Lake Home--A higher functioning new admission was assessed and transitioned to a less restrictive setting.
Glen Oaks Apartments--A roommate arrangement has been utilized for the first time in many years providing potential financial and independence benefits to both tenants.
Evergreen Home--An elderly resident who was placed on hospice services has responded so well to care and support services provided by the home that hospice will soon be discontinued.

Woodland Home—A resident who lives with autism was seriously injured at school and was hospitalized for over 90 days. As a result of close collaboration with clinical teams from NLCMHA and the hospital, a successful transition back to the home was achieved.
Pearl Street Home—1) One resident was transitioned to a less restrictive setting after stabilizing at Pearl Street. 2) Two short-term placements were admitted in response emergent system needs during 2023.
Seneca Place Home—1) Guardian satisfaction improved as an outcome of a leadership transition and RCA transfers. 2) All residents enjoyed an increased level of community engagement (4th of July fireworks; Halloween parade and a deer park safari among other activities).
Wright Street Home---1) A longtime resident just celebrated an 89th birthday! 2) A behaviorally

challenged resident was diagnosed with cancer. Based on relationships developed with care providers, the resident successfully completed all diagnostic tests, chemo and radiation therapy treatments. 3) A new admission was determined to be misdiagnosed. Clinical collaboration has resulted in dramatically improved levels of functioning and independence.

Community Living Supports and PERS

Submitted by: Heather Sleight, *CSW Supervisor*

Community Living Support (CLS) Services are meant to increase and maintain a person's independence and support an individual's achievement of their goals promoting community inclusion. Skills staff assist with include but are not limited to: budgeting, cooking, cleaning, socializing and community access. 1.01, 1.0.2, 1.04, 1.05, 1.0.10, 1.0.11

Personal Emergency Response System (PERS) also known as Medical Emergency Response Systems; lets you call for help in an emergency by pushing a button. PERS has 3 components: a small radio transmitter, a console connected to your telephone and an emergency response center that monitors calls. 1.01, 1.02, 1.04, 1.05, 1.07, 1.0.10, 1.0.11

Accomplishments and Updates--

- NLCMHA Community Support Worker (CSW) staff have provided services to 29 consumers this year over six counties for supports in their private residence and in the community. 1.01, 1.02, 1.04, 1.05, 1.07, 1.09, 1.0.10, 1.0.11
- During 2022-2023, a total of 7,039 units of H2015 were billed across six counties
- Three staff have been hired for the CSW positions. One supervisor resigned, but was replaced in September 2023.
- Five homes are currently being serviced with PERS in our six counties and 18 total consumers

Works in Progress--

- Despite much effort, the two CSW Traverse City positions remain unfilled. Response to the postings has been very minimal. There has been some discussion around raising the wage for CSW staff. It is felt this could be a factor in the lack of applicants.
- All CSW staff are required to obtain a Community Health Worker certification for continued employment with the agency. As of today, two of the three CSW workers in the southeast have obtained that certification while one staff remains enrolled in the class at a self-paced level.
- The CSW supervisor hired two IDD Peer Mentor Support staff - one is in Traverse City, and one serves the southeast. They are both part-time, and both have lived experience with a developmental disability. These staff are required to obtain a Peer Mentor Certificate. However, that training is not available until September 2024. In the meantime, they are shadowing case managers, working on their internship, and training to be able to serve consumers in need of Peer Mentoring services. IDD Peers are able to provide CLS services until they become certified peers.
- We will continue to educate clinical staff, consumers and guardians about our CSW and IDD Peer Mentoring programs
- Will continue to train different departments on the PERS program to increase persons served

Integrated and Behavioral Health Home Services

Submitted by: Andrew Waite, LMSW, *BHH Operations Manager*

Integrated Health Clinic (IHC)

IHC is a fully integrated primary care health clinic embedded in NLCMHA, which is co-located in two NLCMHA buildings, Traverse City and Grayling, and shares an electronic health record (Nola). IHC includes the services of a Family Nurse Practitioner, Registered Nurse, Licensed Professional Counselor, and a receptionist. IHC continues to provide primary care services to the community at large and serves a primary population of persons who live with Severe Mental Illness and Co-Occurring Disorders (COD).

Accomplishments and Updates:

- Provided Primary Care Services in Traverse City four days per week and in Grayling one day per week, with two additional days established in Grayling each month in response to increased demand. 1.0.5-1.0.9
- Provided ongoing primary care services directly in NLCMHA Board Operated Homes. 1.0.5-1.0.9
- Increased current patient census to 549 individuals receiving primary care services. 1.0.1-1.0.11
- Completed review of patient census and initiated reengagement efforts for patients who had not been seen in more than one year. 1.0.5-1.0.9
- Ongoing consultation with NLCMHA Medical Director for psychiatric needs of shared patients as well as other patients of IHC with severe mental illness. 1.0.1-1.0.11
- Ongoing development of care integration with NLCMHA staff. 1.0.1-1.0.11
- Continued to foster and develop positive, productive, and trusting relationships with patients served by IHC. 1.0.1-1.0.11
- Completed Substance Use Disorder screens for new patients and annual screening for current patients. 1.0.1-1.0.11
- Provided evidence-based outpatient therapy for those who do not meet criteria for NLCMHA services, including adults with mild to moderate mental illness. 1.0.1-1.0.11
- Provided support to the Behavioral Health Home Program, CHAT, through primary care medical consultation. 1.0.1-1.011
- Worked collaboratively with incoming BHH staff to transition program in order to meet needs of the larger population of persons served by NLCMHA. 1.0.1-1.0.11
- Provided ongoing referrals for BHH, with collaborative follow up to work collaboratively to ensure care coordination and patient needs were met. 1.0.1-1.0.11
- Continued telehealth, as appropriate, in order to provide primary care services to patients during pandemic response and after the end of the public health emergency. 1.0.1-1.0.11
- Developed marketing messages and materials to use in a community education campaign. 1.0.5-1.0.11
- Worked collaboratively with Finance to engage in ongoing review and follow up of Explanation of Benefits received from payors to increase revenues for IHC. 1.0.1-1.0.11
- Continued to pursue completion of contracts with Medicaid Health Plans who have previously declined to contract for primary care services. 1.0.1-1.0.11
- Embedded a Behavioral Health Home RN care manager in the IHC clinic to provide BHH services to patients of IHC. 1.0.1- 1.0.11

Works in Progress:

- Development of work plan and/or work group to explore additional opportunities for marketing.
- Continue to pursue completion of contracts with Medicaid Health Plans who have previously declined to contract for primary care services.
- Increase in third party reimbursement.
- Evaluation of new models of collaborative care to improve service to patients with severe mental illness.
- Continue to emphasize preventative care for IHC patients.
- Enhance and optimize options for use of NoLa for primary care purposes.

- Complete needs assessment for further expansion of IHC in to other NLCMHA offices.
- Become an Opiate Health Home Provider and targeted Medication Assisted Treatment (MAT) for individuals enrolled in the Opiate Health Home program.
- Develop a self-sustainability plan including strategic plan, needs assessment, and grant funding sources.

Behavioral Health Home

The NLCMHA Behavioral Health Home (BHH) was a pilot project implemented in 2014 through MDHHS in two counties, one of which was Grand Traverse County. In FY2020, MDHHS expanded BHH to three regions in the state including Region 2 and all 21 counties served through the NMRE. The services included in BHH are comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. This service is available to individuals in our catchment area who have Medicaid and meet diagnostic criteria for Serious Mental Illness or Severe Emotional Disturbance. The program assesses and supports the needs for persons in their physical health, behavioral health, and psychosocial needs. During the rollout of this expansion, based on feedback from persons served, the Behavioral Health Home was "rebranded" and is now known as our own CHAT Program (Comprehensive Health Assistance Team).

<u>Accomplishments and Updates</u>:

- Continued to provide CHAT services to all six counties. 1.0.1-1.0.11
- Ongoing collaboration with IHC, enhancing coordination of care opportunities for persons served. 1.0.1-1.0.11
- Ongoing participation in team meetings to introduce, teach, and support behavioral health clinicians in the development and implementation of CHAT. 1.0.1-1.0.11
- Enhanced care coordination, including supporting enrollees at medical appointments, obtaining preauthorization for medical services, medication education and management,
- Increased enrollment by 12% in FY23 to 175 enrollees. Unduplicated count of persons served in FY23 was 261 persons. 1.0.1-1.0.11
- Participation in NMRE discussions and reviews of current Health Home programming and growth. 1.0.1-1.0.11
- Collaborated with other CMHSPs to support regional efforts. 1.0.1-1.0.11

<u>Works in Progress</u>:

- Exploring opportunities to increase staff training for in Evidence Based Practices.
- Continue to identify and introduce new community services and opportunities to persons served by CHAT.
- Continue to assess staffing needs and create plan as needed to serve enrollees and meet MDHHS requirements.
- Continue to build relationships with community partners to increase accessibility of persons in the community who meet criteria for CHAT.
- Continue efforts to fully integrate CHAT services into the Integrated Health Clinic

Recovery and Homeless Prevention

Submitted By: Kim Silbor, LPC, NCC, MHP, QIDP, *Interim COO (Southeast)*

<u>Accomplishments and Updates--</u>

- We had a very successful Recovery Celebration, held in person at The Barn Hall in Manton, MI in October. 86 people attended a fun-filled day with a message of "Hope". It included consumer recovery stories, a scavenger hunt & bingo, 14 raffle baskets, lunch, and an awards ceremony. Our keynote speaker was David Woods-Bartley, (a person in recovery himself), who is an author and motivational speaker. 1.0.1, 1.0.2, 1.0.5, 1.0.7
- We continue to focus on providing community events, such as "Building Community Resilience", for those we serve to be heard by community partners and stakeholders. "Building Community Resilience" is an educational event sponsored by NLCMH three to four times a year. Consumers and staff work together on developing the program for these events. 1.0.1, 1.0.2, 1.0.5, 1.0.7
- We work collaboratively to end homelessness by making homelessness rare, brief, and one time by attending the IST meetings to support people we serve in locating affordable housing. 1.0.1, 1.0.2, 1.0.5, 1.0.7
- We address housing issues through a community-based process that develops a comprehensive, coordinated continuum of care to individuals and families who are homeless or at risk of becoming homeless in our communities by serving on the "Northwest Michigan Coalition to End Homelessness" Steering Committee. 1.0.1, 1.0.5, 1.0.7
- We attended the annual Homeless Summit, which is a state-wide conference dedicated to exploring homelessness and potential solutions to homelessness in Michigan.
- We have ten full-time employed Peer Support Specialists who work full-time with adults with mental illness. 1.0.1
- In 2022-2023 Peer Support served 122 total consumers and billed 5,316 units
- Inpatient hospitalization count pre-admission to Peer Support was 20; post-admission was 12, 1.0.6
- Peers have been active in the following programs: jail diversion; CHAT; crisis services; youth and young adults; and the mentally ill adult unit with ACT and case management. 1.0.1
- Peers also participated in: the NMRE Day of Recovery Education; training for crisis prevention; "Mental Health Awareness" month activities; "Walk a Mile in My Shoes" in Lansing; "Community Connects" in Grayling; presentation to NLCMHA Board; attended "Deaf and Hard of Hearing" training with the NMRE 1.0.1, 1.0.2, 1.0.5

<u>Works in Progress--</u>

- Continue to focus on providing community events such as "Building Community Resilience". These are collaborative initiatives between consumers and staff in an effort to reach community members and stakeholders with prevention education.
- Increase support to the MI case management team to link with housing resources and completing housing applications as a billable Peer Support activity
- Continue to attend the local coalitions on homeless prevention and participate in homeless awareness activities with stakeholders.
- Continue to educate NLCMHA staff on Recovery and Homeless prevention initiatives

Adult with Mental Illness Clinical Services and Treatment 1.0.1, 1.0.2, 1.0.3, 1.0.4, 1.0.5, 1.0.6, 1.0.7, 1.0.9

Treatment continues to be provided in a variety of settings, including offices, homes, communities, hospitals, jails, detention centers, and telehealth video. We provide evidenced-based practices such as Dialectal Behavioral Therapy (DBT), Motivational Interviewing, Seeking Safety, Eye Movement Desensitization and Reprocessing, Cognitive Behavioral Therapy, Integrated Dual Disorder Treatment,

and Family Psychoeducation. Case management and ACT teams provide linking, planning, coordinating, monitoring and advocacy to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Referrals are made to Clubhouse and day programs for supported employment, job coaching and vocational skill building by both ACT and case management teams. ACT provides skill development services directly such as budgeting, meal planning, housekeeping and home maintenance, community inclusion/integration, recreation and vocational assistance. ACT teams also deliver 24 hour on-call services for crisis intervention outside normal business hours to ACT consumers.

Adult Outpatient Therapy:
Accomplishments and Updates--

- From 2022-2023, a total of 1,824 consumers were served in adult outpatient therapy services.
- We have seven full-time therapists and two "part-timers" employed in the agency.
- We welcomed two new therapists in Houghton Lake and Grayling respectively, and one in Traverse City.
- We had three master's-level interns
- Inpatient hospitalization count pre-admission to outpatient services was 229; post-admission was 126
- Total number of services: 16,646; Total number of units billed: 17,649

Works in Progress--

- With the departure of two MIA Operations Managers from Cadillac in October/November 2023, there is an unmet need for a full-time outpatient supervisor or Operations Manager to provide clinical supervision for limited licensure as well as program supervision to all outpatient therapists.
- We need to increase our master's internship program so that it is more robust.
- Continued challenges in high caseloads (above 70 for each FTE employee) in each office and admissions that extend beyond a 24-month period.
- Moving from the provision of "DBT informed" therapy to the full DBT model would require significant investment of training all outpatient, case management and peer staff in the model, as well as adjustments within our crisis services program. However, the benefit could result in reduced recidivism for inpatient stays.
- Continue our work around the LOCUS to improve consistency and fidelity of the assessment tool.

Chief Information Officer – Daniel Mauk

Accomplishments for all Consumer and Community Ends for FY 2023:

As a purely support department, the IT accomplishments are linked to the Consumer and Community Ends through the services provided by other departments.

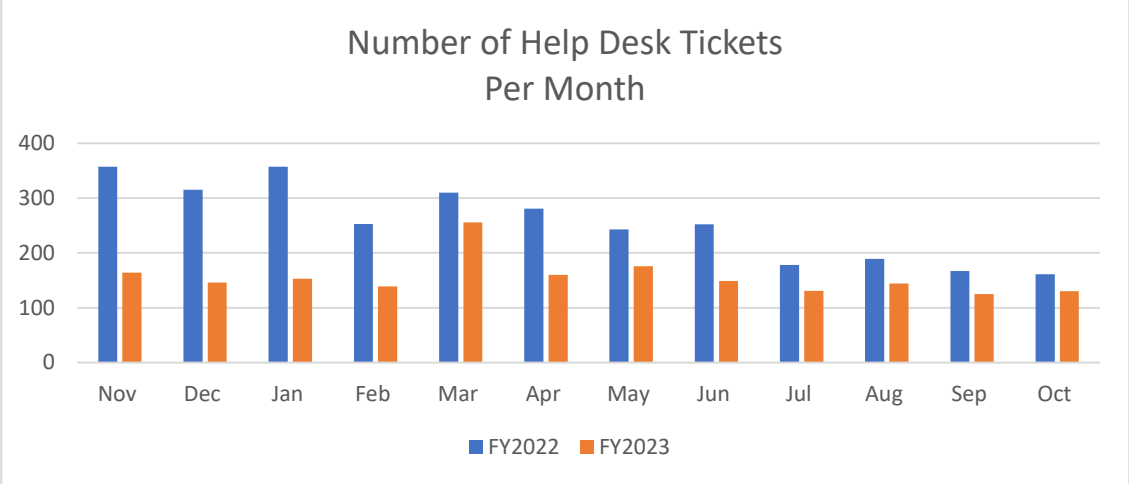
Summary

In the past fiscal year, our organization achieved significant advancements in operational efficiency, security, and staff support. Key accomplishments include a proactive approach to security risk assessment leveraging the Arctic Wolf Portal, upgrading bandwidth and transitioning to SD-WAN technology to meet increased demands from cloud-based solutions, enhancing cybersecurity awareness, implementing multi-factor authentication in Office 365, enforcing conditional access

policies, migrating antivirus protection to Microsoft Defender, upgrading conference rooms to Teams Room devices, transitioning to a native Azure Active Directory, migrating file shares to cloud-based storage, replacing aging hardware, and addressing security incidents through improved training and protocols. These efforts reflect our unwavering commitment to providing excellent services while ensuring data security and infrastructure resilience.

Staff Support

Last fiscal year we had rolled out a new help desk ticketing system to better manage and track our staff support. COVID had our support team off balance, trying to support a mostly remote workforce. As you can see below our monthly ticket count had steadily drop last year and has stabilize all this year, except for March. We continue to utilize the helpdesk information to direct the development of training materials, such as tutorials and "lunch and learn" sessions.



Security Risk Assessment

The following is our current risk score as shown in our Arctic Wolf Portal:

We are currently monitoring over 500 devices and all traffic within our facilities with Arctic Wolf. We have been mitigating identified risks as they emerge and are seeing our basic risk score hovering at about 8.0. You can see that over the past week we have seen a 92% increase in new risks, totaling 647 new risks. Over that same period, we have mitigated almost 3500 risks. We work daily to mitigate as many risks as possible and have a weekly planning meetings to understand the risks and address the approach needed to mitigate emerging risks. This is one of our primary areas of focus and where a considerable amount of our time is spent in this department. Arctic Wolf has proven to be an invaluable tool in the process.

Upgraded bandwidth at all sites and migrated to an SDWAN topology.

Several factors: a post COVID move back to the office, increasing reliance on cloud-based services, to name a couple, had put increasing pressure on our available bandwidth. To address these new demands, we upgraded the available bandwidth at all 4 main sites to 1000 mbps from 50 mbps at

Houghton Lake and Grayling and 100 mbps at Cadillac and Traverse City. Further improvements in access were realized by redesigning our network and switching to a SD-WAN topology from an ePLN topology. The ePLN topology was more localized and primarily focuses on on-premises network connections, while SD-WAN is designed to provide efficient, dynamic, and cost-effective wide area networking solutions for organizations like ours with multiple branches and remote locations, leveraging software-defined and cloud-centric approaches for network management and optimization.

Migrating to Enhanced Cybersecurity Awareness.

Over 70% of all cybersecurity breaches are accomplished through social engineering. These attacks are successful because end users are tricked into inviting the bad actors into our environment, many times, by providing them with their credentials. Our previous awareness package mostly focused on testing, lacking a solid training and educational approach. Arctic Wolf's Managed Security Awareness service is designed to bolster an organization's cybersecurity posture by educating and training employees to recognize and mitigate security threats effectively. This service includes features such as continuous and engaging security awareness training, simulated phishing exercises to test employees' responses to phishing attempts, tracking, and reporting on individual and overall employee performance, and customized content to address specific industry and organizational needs. It also provides insights and analytics to help organizations measure the effectiveness of their security awareness efforts, ultimately reducing the risk of successful cyberattacks by enhancing employees' security awareness and response capabilities.

Enforcing Multi-Factor Authentication in Office 365.

Multi-factor authentication (MFA) plays a pivotal role in enhancing the security of our Office 365 environment and is integral to our comprehensive cybersecurity strategy. By requiring multiple forms of verification, such as a password and a temporary authentication code sent to a mobile device, MFA significantly reduces the risk of unauthorized access to our critical data. This safeguard ensures that only authorized personnel can access sensitive information, thereby protecting our organization from data breaches and unauthorized intrusions. Additionally, MFA promotes a culture of accountability, making it easier to track user activity and detect any suspicious behavior. As we continue to navigate the evolving threat landscape, the implementation of MFA in our Office 365 environment remains a crucial investment in safeguarding our digital assets and protecting the information we have been entrusted with by all stakeholders.

Implemented Conditional access policies.

Conditional access policies in Microsoft Azure Active Directory are like digital gatekeepers for your online accounts and data. Think of them as rules you set to determine who can access your stuff and under what conditions. For example, you can make a rule that says, "Only allow access to my agency email when using a trusted device." This means that even if someone knows your password, they can't get in unless they're using a device you trust. It's a way to keep your digital world safe and secure. The process of implementing these policies requires extensive research to ensure that staff access is maintained while bad actors are restricted.

Migrated antivirus protection.

Microsoft Defender offers robust protection against malware and threats. Microsoft Defender is integrated into Windows, ensuring seamless compatibility and regular updates with the operating system. This integration can lead to better system performance and fewer compatibility issues. Additionally, Microsoft Defender is known for its strong real-time protection and phishing detection capabilities.

Upgraded conference rooms to Teams Room devices.

Teams Rooms devices are preferred over standard computers due to their dedicated, purpose-built design and integrated capabilities. Teams Rooms devices are optimized for seamless video conferencing, ensuring a consistent and user-friendly experience. They offer simplified setup, one-touch joining of meetings, and high-quality audio and video. Moreover, these devices receive regular updates and maintenance, which is essential for maintaining the security and functionality. Keeping devices up to date is critical to ensure data privacy, compliance with healthcare regulations, and the

delivery of reliable, secure, and up-to-date telehealth services. This is especially important in healthcare, where patient information and communication must be protected and reliable.

Migrating to a native Azure Active Directory environment.

Migrating to native Azure Active Directory (Azure AD) is the preferred choice over managing an on-premise mixed mode infrastructure for several reasons. First, native Azure AD aligns with the modern cloud-first and mobile-first business landscape, eliminating the need for on-premises infrastructure and reducing administrative overhead. It offers a globally distributed, easily accessible platform, making it ideal for organizations with remote or global operations. Additionally, by transitioning to native Azure AD, we can harness advanced cloud-based security and scalability features. In contrast, managing a mixed mode infrastructure introduces complexity, synchronization challenges, and potential limitations on advanced on-premises features. Choosing native Azure AD streamlines our operations and enhances security, agility, and overall efficiency, aligning us with the future of cloud-centric identity and access management.

Migrated all file shares to cloud-based storage.

Transitioning from traditional file servers to cloud-based solutions like SharePoint and Microsoft Teams offers a range of advantages, which can have a profound impact on an organization's efficiency, flexibility, and overall productivity. The shift from traditional file servers to cloud-based solutions bring numerous advantages, including improved accessibility, collaboration, security, scalability, and cost savings. This transition enables NLCMHA to work more flexibly, securely, and efficiently in an increasingly digital and remote work-oriented landscape.

Hardware replacements and upgrades

Two major hardware projects that we successfully completed in the last fiscal year were the replacement of 100 aging agency laptops and the installation of a Storage Area Network (SAN) unit with the integration of three new hosts at our Cadillac location. The laptop replacement project was a critical response to the aging technology that could compromise productivity and security, ensuring our employees have reliable and efficient tools for their tasks. The SAN unit and host integration in Cadillac significantly expanded our data storage and processing capabilities, addressing a vulnerability in our infrastructure and bolstering data access resilience, especially during power outages.

Two security incidents

Over the past year, we encountered two noteworthy security incidents, each presenting unique challenges and valuable lessons. The first incident involved a breach of a contracted provider’s email system, which was subsequently used to send a fraudulent request to our finance department, seeking a change in bank routing information. Unfortunately, staff did not verify the legitimacy of this request with the contracted provider. As a result of this incident, we have implemented a new policy to enhance communication and verification protocols between departments, significantly reducing the risk of similar deception in the future.

In the second incident, a deceptive email, from a legitimate mental health agency, was received by one of our users. Again, the sender’s email account had been compromised by cybercriminals. A staff member unwittingly clicked on a link in the email, resulting in their login credentials being stolen.

Unfortunately, the user did not report the breach to our IT department, leaving a critical security vulnerability unaddressed. Fortunately, Arctic Wolf was able to identify the intrusion and we were able to stop the access quickly. The breach exposed sensitive consumer information, including names, Medicaid numbers, and addresses.

These incidents emphasize the need for ongoing staff training and awareness when it comes to recognizing and reporting phishing attacks. Quick reporting is essential to mitigate damage and ensure an effective response.

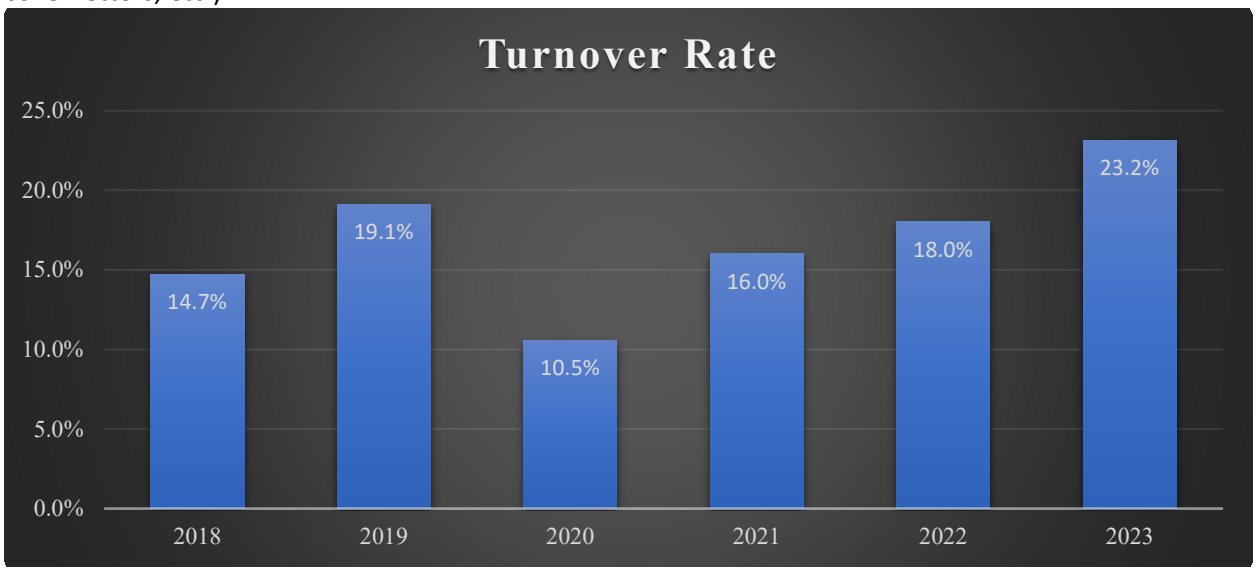
Our security and privacy officers worked together in line with HIPAA guidelines to inform the affected individuals about the breach and its potential consequences.

the Northern Lakes CMHA HR Dept.

Human Resources, as the forward-facing instrumental department that it is, continues to look at past practices to refine and define the practices of tomorrow. HR handles the flow of multiple organizational priorities while juggling the immediate to-dos of departments and their employees. HR comes to 2024 with new ideas and looking forward to increasing engagement with employees while supporting the strategic goals and initiatives of the organization. Below is a snapshot view of 2023, including info from the areas of Talent and Recruitment, Training and Development, and Workforce Injury and Workers' Compensation.

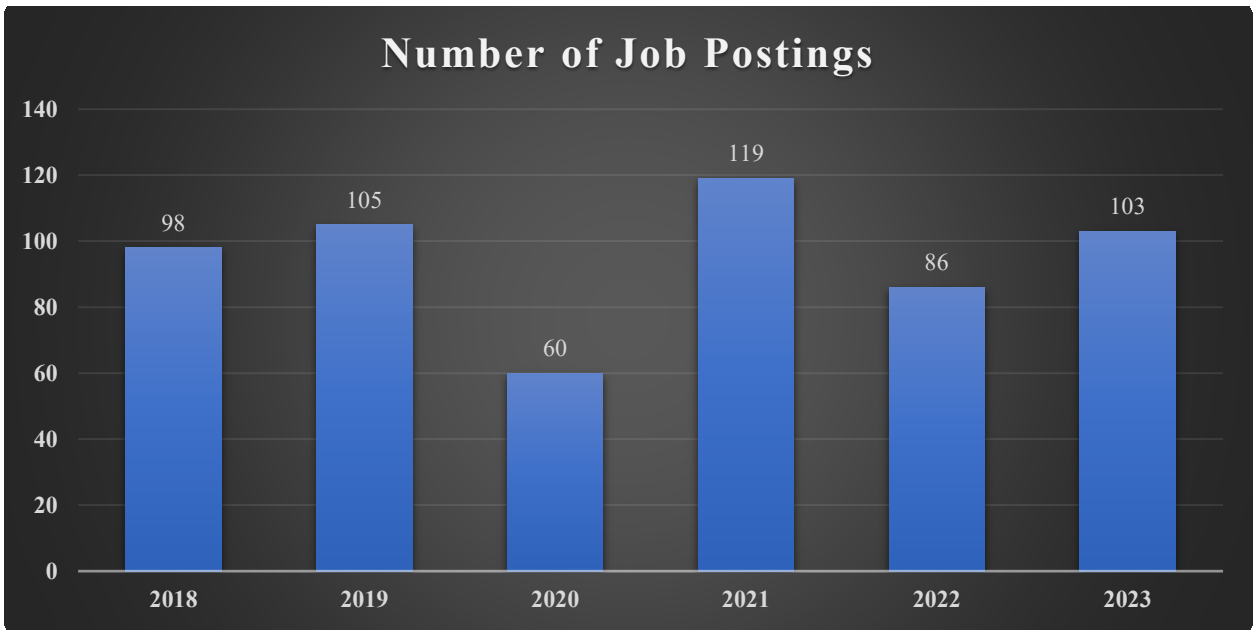
HR Talent Acquisition and Recruitment

As our turnover rate steadily increases (10.5% in 2020 to 24% in 2023), so does the amount of time and attention required to keep our positions filled. We are working to expand our use of our Paychex system to streamline our hiring process; using the system to its full potential will modernize the way we collect documents and enable us to safely share/track applicant's documents (resumes, cover letters, etc.).



Our vacancy postings can currently be viewed on Indeed, SimplyHired, Glassdoor & ZipRecruiter. We will be adding LinkedIn to that list very soon!

We are happily still able to provide new hires $500 after 6 months of continued employment and then $500 after their 1-year anniversary. Additionally, the employee referral incentive continues to be well-received by current employees; we had 18 employee referrals in 2023!



Postings:

103 (33 Exit, 16 New, 47 Position Changes, 7 Retire)

- Access UM Specialist/Screener: 4 (1 NEW)
- ACT Advocate: 2
- ACT Case Manager: 2
- ACT Team Lead: 1
- Admin. Staff: 5
    - Administrative Specialist: 1
    - Reception: 1
    - Human Resources Specialist: 2
    - Quality & Compliance Secretary: 1
- Psychiatrist: 2
    - Adult, Child & Adolescent Psychiatrist: 1 (NEW)
    - Psychiatrist – PT
- Management Staff: 7
    - Chief Operations Officer:1
    - Child & Family Ops Manager: 1 (NEW)
    - Contract & Facilities Manager: 1 (NEW)
    - HR Manager: 1
    - CSW Manager: 1
    - Access Ops Manager: 1
    - MIA Ops Manager: 1
- Child & Family Case Manager: 3
- Clinical Review Manager: 1
- Clinical Therapist: 20 (3 NEW)
- Community Support Worker: 5
- Compliance Specialist: 1 (NEW)
- Crisis Stabilization Unit Coordinator: 1 (NEW)
- FAST Therapist: 1
- Peer Recovery Coach: 1 (NEW)
- Homebased Therapist: 2

- IDD Behavioral Therapist: 1
- IDD Case Manager: 9
- IDD Nurse: 1
- NHCM Transition Navigator: 4 (1 NEW)
- NHCM Support Services Coordinator: 1
- NHCM Program Administrator: 2 (1 NEW)
- Nurse Care Manager: 2
- AFC Home Supervisor: 1
- Peer Mentoring Specialist: 2 (2 NEW)
- Peer Support Specialist: 8
- Psych Services Nurse: 2
- Recipient Rights Advisor: 1
- RN Lead Worker: 1
- Service Information Specialist: 1
- Support Services Coordinator: 1
- Supports Coordinator: 3
- NHCM Transportation Service Coordinator: 1 (NEW)
- Wraparound Facilitator: 1
- Youth Peer Support – PT: 2 (NEW)

Exits:
63 (45 Voluntary Exits; 4 Interns; 7 Involuntary; 7 Retirees = 11.11%)

- Access UM Specialist: 2
- Administrative Staff: 12
    - Customer Service Reps: 2
    - Federal Program Payroll Specialist: 1
    - Assistant Home Supervisor: 2
    - Human Resources Specialist/Representative: 2
    - Quality & Compliance Secretary: 1
    - Service Information Specialist: 1
    - HR Supervisor: 1
    - Team Lead Clinical Therapist: 2
- Case Manager: 3
- Child & Family Therapist/Specialist: 2
- Clinical Therapist/Specialist: 13
- Community Support Worker: 4
- Crisis Services Specialist: 1
- Crisis Stabilization Unit Coordinator: 1
- Management Staff: 6
    - CSW Supervisor: 1
    - Home Supervisor: 1
    - Human Resources Officer: 1
    - IDD Case Manager Family Supervisor: 1
    - Managed and Integrated Health Care Director: 1
    - Operations Manager – Access: 1
- Executive: 2
    - Chief Population Officer: 1

    - Executive Secretary: 1
- IDD Nurse: 1
- Intern: 4
- Nurse Care Manager: 1
- Nurse: 1
    - Nurse Non-BSN: 1
- Peer Support Specialist: 7
- Recipient Rights Advisor: 1
- Support Intensity Scale Coordinator: 2 (position eliminated)
- NHCM Transition Navigator: 1

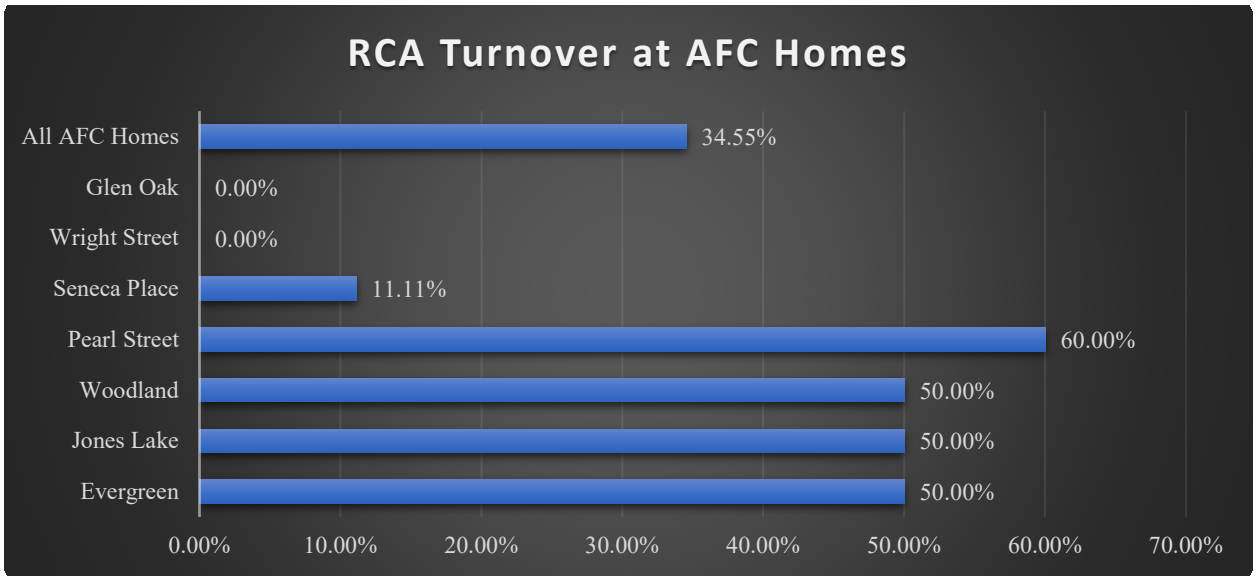
New Hires (regular staff): (5 rehires)

- Case Managers: 11
- Management Staff: 4
    - Chief Operating Officer: 1
    - Child & Family Ops Manager: 1
    - Human Resources Manager: 1
    - Access Ops Manager: 1
- Clinical Review Manager: 1
- Clinical Therapist/Specialist: 7
- Community Support Worker: 5
- Compliance Specialist: 1
- FAST Therapist: 1
- Homebased Therapist: 1
- Administrative Staff:
    - Human Resource Specialist: 2
    - Customer Provider/Services Rep = 5
- Supports Coordinator: 3
- Interns: 7
- Nurse Care Manager: 1
- Parent Support Partner: 1
- Peer Support Specialist: 5
- Psychiatrist: 3
- Recipient Rights Advisor: 1
- NHCM Transition Navigator: 1
- NHCM Transportation Services Coordinator: 1
- Wraparound Facilitator: 1
- Youth Peer Support – PT: 2

Board Operated Homes: Specialized Residential Services (SRS) Unit Direct Care Workforce Report:
Currently, all Cadillac and Houghton Lake area homes are fully staffed, and their typically perpetual vacancy postings have been put on hold. The only area that has postings is for the Grayling area. Applicants are being screened for at least 1 year of experience in the field of direct care in the homes. Pearl Street had the most exits (6) in the past year, while Wright Street and Glen Oak had the least (0).

In July, a Memo of Understanding was signed by Northern Lakes CMHA and the AFSCME Union to recruit and retain a skilled workforce in the AFC homes. This Memo of Understanding did 3 things:

- Removed the temporary trainee designation for newly hired staff.
- Provided 3 sign-on incentives (previously was just one incentive at 6 months)
    a. 60 days - $250 sign-on incentive if core training requirements have been completed.
    b. 6 months - $250 sign-on incentive with positive 6-month performance evaluation, 100% attendance (1 day allowance for illness), 100% punctuality for arrival/departure from assigned shifts & required trainings are complete.
    c. 1 year - $500 sign-on incentive if positive annual performance evaluation & annual training is complete or scheduled.
- Assistant Home Supervisor II staff are now eligible to receive a one-time $500 incentive less applicable deductions after positive completion of CHW certification. Home Supervisors and Assistant Home Supervisor I staff continue to be eligible for this incentive.



HR Training Team

Our HR training team continues to seek out, create, and capitalize on opportunities to provide quality training and education that empowers Northern Lakes CMHA employees, providers, and community members. A total of 1,261 people were trained in 2023 (up 332 people from 2022)! Note, this data does not include the training conducted on Relias or the offerings through our Staff Development, Education, and Training Committee for special occasions such as the May is Mental Health Month series.

Courses taught in person (50):
Recipient Rights Refresher (9)
Medication Administration (1)
Crisis Prevention Intervention (7)

Mental Health First Aid-Adult (6)

Mental Health First Aid-Youth (3)

CPR / First Aid (17)

CPR (3)

Applied Suicide Intervention Skills Training (ASIST) (1)

Assessing & Managing Suicide Risk (AMSR) (3)

Courses taught via TEAMS (41):
Recipient Rights Refresher (9)
Health & Wellness (11)
Medication Administration (10)

Compliance & Ethics (4)
Transition Discharge Planning (4)

Implicit Bias (2)

Level of Care Utilization (LOCUS) (1)

Audiences reached (1,261):
Staff 642
Providers 541
Community Members 78

Training Expenditures:

Staff Development Requests: $42,117.39 registration fee/lodging +$1,785 air travel

Relias Learning: $36,130.71

CPR/FA Instructor Training: $3,400

CPR/FA Training: $1,836

CPI Instructor Recertifications: $0 this year

CPI Workbooks: $2,429.31

Additional training opportunities provided:

- The leadership team often created and held required training on a regular basis. They have also provided required clinical training throughout the year.
- Our IT department holds regular short instructional team meetings to help Northern Lakes CMHA staff gain knowledge and awareness and skills regarding software, IT security issues, general creation of documents, etc. Dan Mauk, and his team are always willing to help put a training together.
- Our Wellness committee provides short information flyers every week to our staff. This is a great way to provide awareness within an email to help staff gain self-care skills. This helps build community with the workforce.
- Our interim CEO, along with the All-Staff Committee have planned exceptional programs featuring national and international speakers for our Celebration/Training programs that

take place each year. This collaboration within the agency helps to build community, improve morale, retain staff, and promotes a strong supportive culture.

All Staff Planning Committee

The All Staff Planning Committee focuses on providing captivating training and education, and celebrating our workforce and their dedication to those we serve. We plan and schedule twice yearly meetings for all staff across all offices. The team meets to discuss and review training topics, presenters, locations, and venues of Northern Lakes CMHA current and future All Staff events.

- We held our year end Staff Celebration event on December 9, 2022, at the Hagerty Center in Traverse City. The music was provided by West Senior High and Tim Cusack, an accomplished author and speaker, presented "The Brain is the Bridge" on Emotional Intelligence, Problem Solving, and Critical Thinking. We had 224 staff attend.
- We contracted Peter Diaz, CEO of the Workplace Mental Health Institute to provide the All Managers "Building Resilient Teams" leadership series on training day September 6, 2023, at the Gateway Center and 39 managers attended. Mr. Diaz also provided the All Staff "Resilience at Work" workplace wellbeing series at our September 7, 2023, training at the Grand Traverse Resort where 251 workforce members attended. We were able to provide Social Work CEU's (Continuing Education Units) for both presentations which was very well received.
- We are planning an end of year staff celebration and learning session December 6, 2023, at the Grand Traverse Resort. We have an excellent keynote speaker and an afternoon presentation scheduled.

Staff Development Education & Training Committee

To ensure Northern Lakes CMHA develops and maintains a competent workforce committed to effective and efficient services through planned staff development and training activities. This committee meets the 3rd Tuesday of every month.

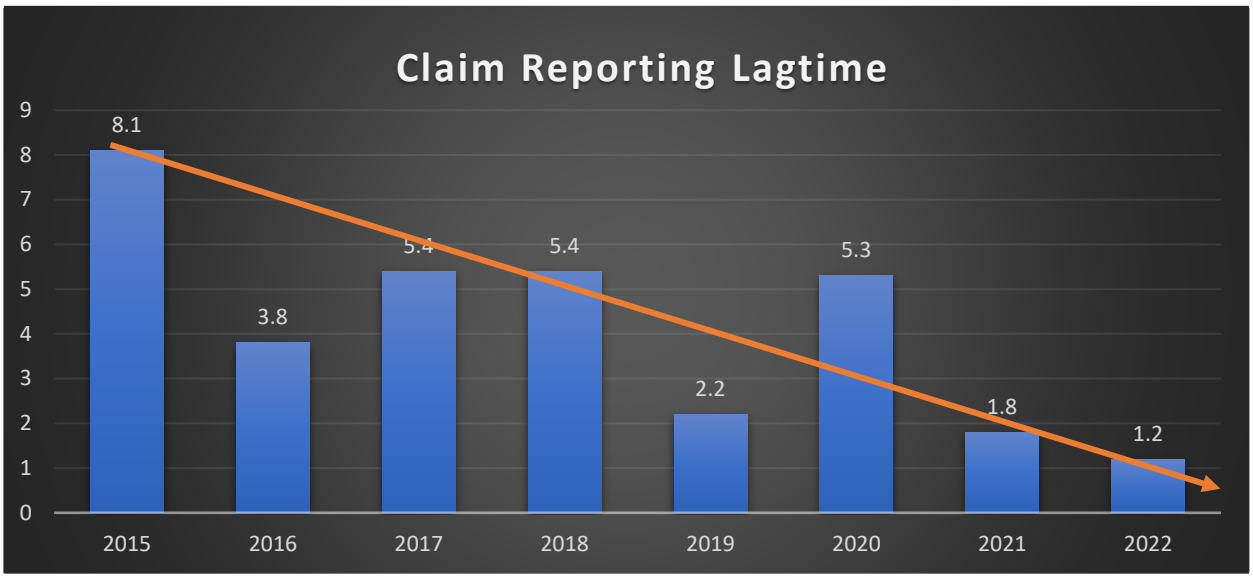
- We continue to provide monthly live virtual Health & Wellness Medication Administration training for our direct care staff and providers. Our nurses continue to provide excellent training to our direct care staff.
- We are bringing back the in-person Recipient Rights trainings, which includes the New Hire training that will be offered approximately twice each month and the Refresher training for DCP will be offered once each month, and the Refresher for LMHP will be offered 6 times this year. The training locations will alternate between Cadillac and Traverse City offices and are provided by our ORR staff.
- May is Mental Health month Tools 4 Resilience Virtual Series: Northern Lakes CMHA trainers teamed up with North Country CMH to provide 1-hour programs on Tues/Wed/Thurs throughout the month of May. Over 1,000 flyers were distributed, there was a newspaper release, a Facebook post, and emails sent to get the word out to area agencies, staff, consumers, and families. Our effort produced over 130 registrations to attend these programs: May 4, 2023 – Letting go of the Heavy Backpack-Working through Difficult Situations. May 9, 2023 – Navigating Conflict Resolution. May 11, 2023 – A Dose of Life. May 16, 2023 – Developing Cultural Intelligence. May 18, 2023 – Strong Foundation Bright Futures.

Building a Healthy Tomorrow. May 23, 2023 – Trying to Keep Yourself Safe Online. May 25, 2023 – Health is our Wealth.

- The group home curriculum continues to be provided and monitored by our training team. Through various modes of development and delivery, the provider homes continue to be able to access training. We communicate directly with home managers on a regular basis to assure clarity of directives for compliance.
- Northern Lakes CMHA continues to support the MyStrength application for staff, consumers, and community members. The program increases awareness and provides valuable tools for both clinicians and client support. This program was used for the virtual training series provided in May & September. Note, since MyStrength is going through rebranding we anticipate a name change soon.
- Relias on-line learning program is utilized by all Northern Lakes CMHA staff to obtain initial and annually required training. The program has the additional benefit of staff being able to obtain CEU's for credentialing and licensing. This fiscally responsible program saves time and money by enabling training from their expansive library of course offerings without travel.
- CPI (Crisis Prevention Intervention) training is offered to all workforce throughout the year alternating between Cadillac and Traverse City offices.
- Compliance Department continues providing bi-monthly Compliance & Ethics training for all staff. This will be switching to a quarterly training in 2024.
- Mental Health First Aid (Adult & Youth) training programs were offered 7 times this FY and Mental Health for Administrators (MHFA) was offered once to our staff, providers, and community members. These courses provide 7.5 SW CEU's for each of the 2-days attended! Additionally, the MHFA Instructor Training was provided to law enforcement members from the counties we serve.

Workforce Injury and Workers' Compensation

The goal of the Work Injury Department is to bridge the gap between workers' comp and the employee in order to get them the assistance needed and returned to work as early as medically advised. We are currently among the lowest reporters of lost time injuries when compared to other organizations in our field. Our success in this area is due in large part to our prompt and thorough reporting and diligent review and analyzation by the Safety Committee. The 2022 work comp year produced favorable numbers going into the 2023 work comp policy renewal. Claims reporting lag time (time from injury to reporting claim to Accident Fund) has successfully decreased 85% since 2015 to current.



Workers' Compensation Lag Time (Goal is within 48 hours)

- 2023 – 1 day
- 2022 - 1.2 days
- 2021 – 7.1 days
- 2020 – 2.4 days

Number of claims reported to Accident Fund:

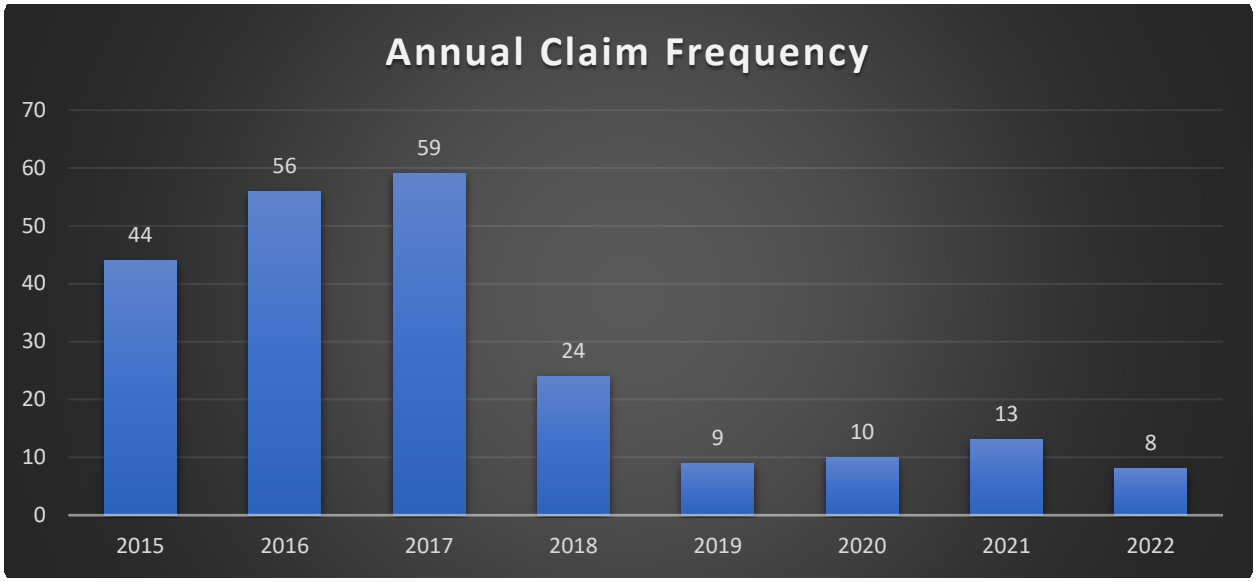
- 2023 – 4
- 2022 – 13
- 2021 - 7
- 2020 – 13

Annual Incurred Claim Costs for all claims:

- 2023 - $14278
- 2022 - $29,360
- 2021 - $ 2915
- 2020 - $ 5489

Average Cost per Claim:

- 2023 - $1428
- 2022 - $2258
- 2021 - $ 416
- 2020 - $ 422



OSHA Recordable Injuries and any lost time due to work injury (Note, OSHA reports by calendar year and there are 2 months left in 2023):

2023

- TC/TC Clubhouse – 0
- Cad – 0
- HL – 0
- Gray – 0
- Club Cad – 0
- Evergreen Home – 0
- Glen Oaks Apt – 0
- Jones Lake Home – 0
- Pearl Street Home - 2 Recordable (3 days lost work and 2 days with restrictions) / 1-Medical beyond first aid
- Seneca Place Home – 1 Recordable (44 days lost work)
- Woodland Home – 0
- Wright Street Home – 1 Recordable (20 days lost work)

Policy Year Premium Savings; Based on Net Rate Decrease

- 12/31/2016 WC Premium Savings ……..$88,169
- 12/31/2017 WC Premium Savings ……..$163,243
- 12/31/2018 WC Premium Savings ……..$180,411
- 12/31/2019 WC Premium Savings ……..$184,204
- 12/31/2020 WC Premium Savings ……..$217,362
- 12/31/2021 WC Premium Savings ……..$254,704
- 12/31/2022 WC Premium Savings ……..$293,408
- 12/31/2023 WC Premium Savings……..$326,194

Total 8 Years Workers' Comp Premium Savings $1,708,596

The cost saving trend is a result of our decreasing MOD (Experience Modification Factor) rate which increases cost savings at annual renewal time. A MOD rate is due to the amount of lost time an injury

takes an employee away from work and the associated medical expenses. Our goal is to reduce employee lost time by offering a light duty assignment and having the injured worker work in some capacity within their medical limitations. Statistically, the longer the injured worker is away from work due to injury the less chance the employee will return to work. Average MOD rate is considered a 1.00 MOD. Going into the 2023 renewal, Northern Lakes CMHA has a (very impressive) 0.62 MOD rate.

Work Injury Goals for next year:

- Get annual OSHA reporting from all Northern Lakes CMHA locations before it is due.
- Obtain an organizational list of light duty assignments to accommodate injured workers.
- Continue to have workstation ergonomics looked at by Accident Fund. This will help to identify factors that could contribute to repetitive motion injuries.
- Have Accident Fund do annual or bi-annual walk throughs to assess safety hazards for all locations.
- Track causes, trends, implementation of actions and other information thereby improving our safety records and keeping up with our CARF requirements.
- Continue to promote work injury reporting throughout the organization as well as thoroughly investigating all reported injuries to correct factors within our control and lower our workers' comp injuries even further.
- Continue to improve and streamline the Northern Lakes CMHA Return-to-Work program.

Network Management

Accomplishments:

- Completion of 312 contracts, amendments, and agreements, including 18 single case agreements. ***1.0.1, 1.0.5, 1.0.10***
- Updated NLCMHA contract templates to align with region, while maintaining Appendices for NLCMHA-specific contract requirements. **1.0.1-1.0.11**
- Review and consultation with NLCMHA attorney to ensure appropriate creation and implementation of contracts**. 1.0.1-1.0.11**
- Participation at provider meetings with the NMRE, CMHSPs in our region, and other providers throughout the state. **1.0.10-1.0.11**
- Lead Quarterly Provider Quality Council meetings for all NLCMHA Providers, with an increase in attendance and diverse subjects. **1.0.1-1.0.11**
- Engaged in roundtable discussions with provider by type in order to identify and support provider needs. **1.0.1-1.0.11**
- Collaboration with Training Department and Compliance to review and ensure Provider compliance with training requirements. **1.0.1-1.0.11**
- Ongoing review of clinical documentation to authorize rates for services provided by SRS homes. **1.0.1-1.0.11**
- Completed 162 annual in person site visits for new and existing Providers to monitor compliance with contract requirements. Completion of Corrective Action Plans, follow up, and/or heightened scrutiny, as needed based on outcome of review. **1.0.1–1.0.11**
- Provided support for providers in obtaining resources to ensure compliance with contract requirements. **1.0.1-1.0.11**

- Monitored monthly attestations provided by SRS Providers to ensure use of DCW Premium Pay passed through to staff, in compliance with MDHHS requirements. **1.0.1-1.0.11**
- Monthly updates to Provider Directory for ease of use by community, providers, and clinical staff. **1.0.1-1.0.11**
- Collaborated with ORR in coordinating oversight and site visits/audits of NLCMHA providers. **1.0.1-1.0.11**

Works in Progress:

- Review of options for new provider channel in Teams or Nola for submission of documents.
- Working with providers to prepare for Electronic Visit Verification (EVV).
- Ongoing coordination with Training Department and Compliance to ensure ongoing education for providers in a virtual environment.

Northern Health Care Management (NHCM) - Darryl Washington, Ed. D., Chief Operations Officer

There are four grant-funded programs operated under the auspices of the Northern Lakes Community Mental Health Authority, Division of Long Term and Supports Services, or Northern Health Care Management (NHCM). NHCM encompasses.

- MI Choice Waiver (Home and Community-Based Services)
- Nursing Facility Transition (NFTI)
- Michigan Merit Award Trust Fund Grant (Aging and Adult Services Grant Agency).
- Medicare Improvements for Patients and Providers Act (MIPPA)

Each program is guided by a distinct set of contract responsibilities, processes, policies, and procedures. Convergence between the business of MI Choice and CTS is prohibited as each program has specific contract responsibilities and we must avoid any potential conflict of interest. There is a specified division of labor, to ensure contract compliance.

Planned Improvements:

- MI Choice Waiver- Continued efforts to Increase slot utilization.
- Community Transition Services (CTS/NFT)- In FY22 NHCM became he only CTS provider in regions 9 and 10, therefore a staff was added I order to address the increased need for participant support.
- MATF- Increase the number of caregivers that receive respite services. Develop a pilot project for short term adult day support for caregivers.
- MIPPA-Identify Medicare beneficiaries likely to be eligible for Medicare Part D Low-Income Subsidy (LIS) or Medicare Savings Program (MSP) and Assist beneficiaries to apply for those benefits. Ultimately to advance the education and outreach activities about Medicare prevention and wellness benefits
- Technilodge Project: To eliminate barriers to receiving services through the increased utilization of technology.
- Continue to Develop all Internal Processes: Document, improve processes, implement, and train. MDHHS has issued several new required reports aimed at being compliant with Federal mandates.
- Develop the Eligibility Team: This team was created a year ago and it has proven to be

successful in being far more efficient and effective. It also helps to ensure that participants entering the program receive consistency in the assessment, intake, and enrollment process. Supports Coordinator (RN) to eligibility team to preemptively assess potential participants to be served. This was implemented and has proven to be effective in expediting referrals received. There are planned improvements for this team that will be implemented in the upcoming year.

- Develop a Training & Orientation: NHCM will continue to offer new hires a comprehensive training plan that extends approximately 60 days on average. The training team will be enhanced as we have added a separate training component that covers the use of the EHR system based on the staff role. This level of training ensures that staff are prepared to provide quality services.

Annual Budgets:

MI Choice:	The grant amount for MI Choice services for FY22/23 is $12,100,160 586 slots.
Community Transition Services:	The CTS budget for FY 22/24 is $210000. NHCM added 10 additional counties to our services area in 2022, and in FY23 became the only provider for regions 9 and 10.
MATF	NHCM renewed the Merit Award Trust Grant through Aging and Adult Services Agency for $89,374. We are on average offering increased caregiver awards due to flexibilities being allowed in the distribution of funding during the COVID period, and these will continue into FY24. NHCM awarded a total of $22,212 to our community ADC and $19,681 for caregiver respite. The impact of the pandemic continues to negatively affect Adult Day Services and well as caregiver respite, however we have developed strategies, such as marketing and program development in order to increase opportunities to provide these supports.

Staffing

Staffing was somewhat more stable in FY23, and generally, NHCM has been fully staffed. Supports Coordinator (Case management) staff have been partnered in groups of two, four and six. This team approach allows for each grouping to serve specified regions within our 10-county region. Instead of individuals being assigned participants throughout the 10 regions one group manages all cases within a group. Overall, this helps to decrease travel, time, and expense, and improves the continuity of care for participants. Despite this more positive trend, finding creative staffing options will remain a top priority. 1.0.4, 1.0.7, 1.0.10

The remote work option continues to support staff retention:

- Increased efficiencies and decrease costs in delivering quality care. Clinicians will be geo-located with the participants they serve. The cost of travel will be decreased substantially.

- Attract and sustain a quality workforce. This is a national trend

that is ever increasing in every business sector of the workforce, and workers are seeking this option wherever they can find it. *When hiring staff over the past two years, candidates have said that the flexibility in working remotely was a factor that attracted them to our agency.*

- Offer this option as an incentive for employees, providing them the opportunity to achieve a healthy work-life balance. Human service work is complex and can be physically and emotionally draining. This offers employees a better opportunity to address self-care. *Workers have voiced that this work option has helped them maintain the balance of work and lifestyle.*

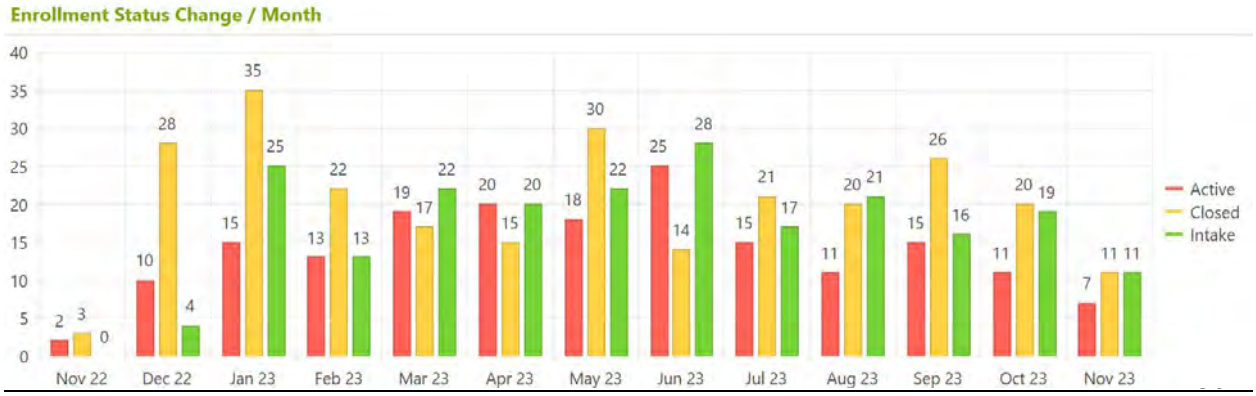
Process Improvement/Quality Improvement:

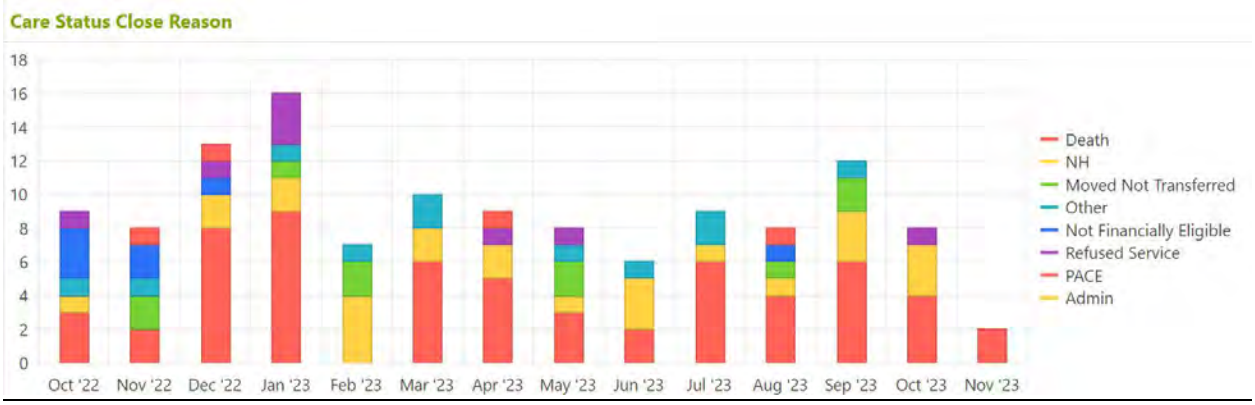
Increasingly, NHCM is required to meet quality standards, especially as it pertains to MDHHS contract requirements. This year a Provider Adequacy Reporting, financial reporting, EVV preparation reporting, AQAR, CQAR, etc., was either increased in requirements, or wholly new reporting. Staff assignments and the addition of staff is how these demands were met.

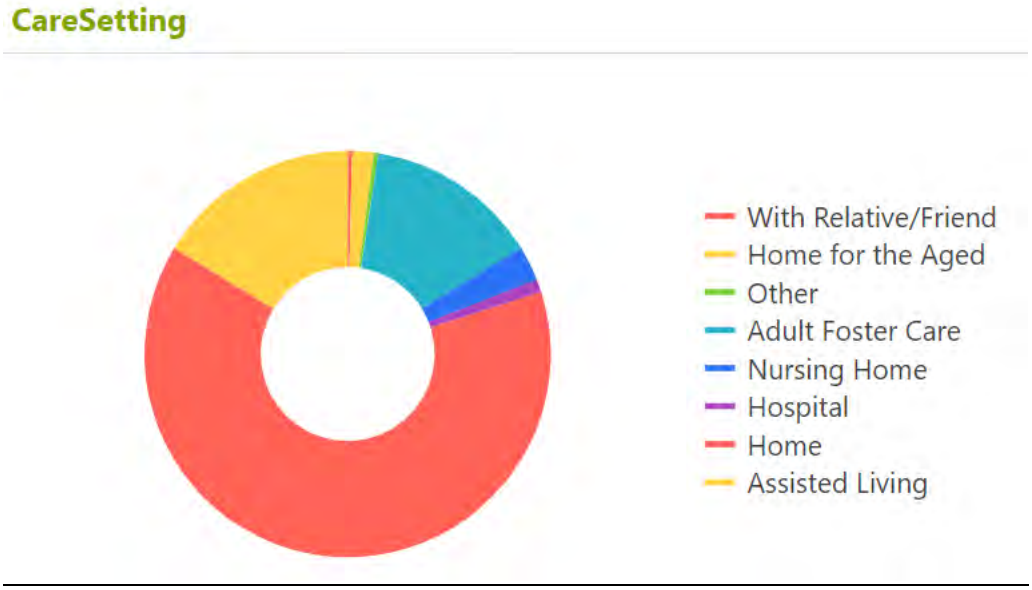
To address the heightened scrutiny NHCM has a weekly program administration meeting to address all areas that need process improvement. We address every aspect of programming and identify potential improvements. We have also created a Administrative Review Committee to address the increasing requirements and demands of improving quality within the program.

Clinical Quality Assessment/Review (CQAR) is currently underway for FY23. NHCM State surveyors conducted in-person home visits. In addition, records were reviewed during the clinical record review by the CQAR team. Each participant record was reviewed utilizing CQAR standards with multiple requirements in place to meet each standard. CQAR on hold due to COVID-19.
A consumer surveys was conducted by Michigan State University, the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) was conducted in FY23, and NHCM achieved 91 % overall. 1.0.4, 1.0.7, 1.0.10.

Important Trends to Monitor:







Achievements:

Northern Health Care Management underwent its 3 year National Committee for Quality Assurance (NCQA) re-accreditation review and was reaccredited with the highest status distinction and 3 years of accreditation with a score of 99.53%.

Community Engagement:

Accomplishments/Planned Improvements:

MHCSN- NHCM has been an associate member of the Michigan Home and Community Services Network (MHCSN) since its inception in 2014. NHCM has partnered with the association to distinguish itself from Area Aging on Agency, and other Waiver agents' providers. During the past two years the association has re-focused its efforts to present as a more unified body and to strengthen the mission and to promulgate more influence as a statewide healthcare system.

To advance the Association's impact and reach, the MHCSN has partnered with the AAA association and has begun to engage in joint ventures, including contracting with another actuarial firm to review and comment on MDHHS's Milliman Report as appropriate.

The leadership of MHCSN has changed, Steve Velzen-Haner is not the president, and Darryl Washington is the vice president.**1.0.10**

Provider Meetings: NHCM, in partnership with Area Agency on Aging, sponsors meetings with our contracted providers which are held on a quarterly basis. The format has significantly changed, which

has resulted in providers being more receptive and they have responded with more positive feedback. 1.0.10

NHCM works collaboratively with Michigan Home and Community Services Network (MHCSN) partners, to conduct Participant Satisfaction surveys in addition to the survey that MSU conducted to gain a larger return and increased feedback. The participant experience survey is hand delivered by case management staff and mailed to participants. Consumer Satisfaction Surveys per guidance from the State, Michigan State University are annually completed by all primary MI Choice Waiver agencies.

Director, Office of Recipient Rights – Brian Newcomb

ORR Accomplishments for FY 2023

- ✓ Our department has completed 488 recipient rights allegations for FY 2023. **1.0.4, 1.0.5, 1.0.7**
- ✓ A total of 182 site visits for FY 2023. **1.0.4**
- ✓ Completed Recipient Rights training for persons in FY 2023. **1.0.4, 1.0.5, 1.0.7**
  - 273 persons received training as a Refresher for Direct Care staff.
  - 70 persons trained in Recipient Rights as Licensed Mental Health Professionals
- ✓ Continued to provide training, and consultations for contract providers. **1.0.4, 1.0.5, 1.0.7**
- ✓ Ongoing consultations for staff regarding protection of recipient rights including restrictions, limitations, use of video cameras and the freedoms protected by the Mental Health Code 1.0.4**, 1.0.5, 1.0.7**
- ✓ ORR continued to provide vetting of potential candidates for hire as Residential Care Aides for both NLCMHA and contracted providers. **1.0.4, 1.0.7**
- ✓ Participation and recommendations to Behavior Treatment Committee on all developed Behavior Support Plans that were created and reviewed for persons served with such a plan. **1.0.5, 1.0.6, 1.0.7**
- ✓ Continued coordinated efforts with Network Management to share in site visits and Corrective Action Plans to provide consistency and ensure ongoing compliance for contract providers. **1.0.1, 1.0.4, 1.0.5, 1.0.7, 1.0.10**
- ✓ Continued to participate with New Hire Orientation to provide an introduction to the Recipient Rights system and ORR team. **1.0.1, 1.0.11**
- ✓ Continued to coordinate with Adult Foster Care (AFC) Licensing Consultants and Adult Protective Services (APS)/Child Protective Services (CPS) as needed for investigations and reporting. **1.0.3, 1.0.4, 1.0.6, 1.0.7**
- ✓ Continued to present monthly ORR reports to the Board of Directors to ensure state compliance **1.0.11**

ORR Works in Progress for FY 2024:

- ➢ Continue to Pre-schedule site visits and work closely with providers to ensure all requirements are met **1.0.4, 1.0.5, 1.0.7**
- ➢ Increase training opportunities for ORR staff beyond the yearly annual conference. **1.0.4, 1.0.5, 1.0.7**
- ➢ Continue ongoing monitoring and consulting for Behavior Treatment Plans that include restrictions and intrusions. **1.0.4, 1.0.5, 1.0.7**
- ➢ Develop and provide training to guardians, covering the role of the guardian and how this role fits into the recipients' protected rights as established in the mental health

code. **1.0.5, 1.0.7**

- Provide timely and thorough investigations and advocacy for persons we serve. To include reducing the investigation time frames for all abuse and neglect investigations to be completed within 60 days.**1.0.4, 1.0.5, 1.0.7**
- Return to in-person training for Recipient Rights Refresher and LMHP professionals, as well as returning to provide all New Hire ORR training to enhance the quality of the training information **1.0.1, 1.0.5, 1.0.7**
- Begin to provide ORR refresher training at each large contract provider for all staff in one setting**. 1.0.1,1.0.2,1.0.4**

Fiscal Year 2023 – Year in Review -Laura Argyle, Deputy Chief Financial Officer

Accomplishments with Consumer and Community Ends:

Financial:

- Successfully navigated the expiration of the public health emergency regarding changes in telehealth/telemedicine codes.
- Established processes to manage the Medicaid redeterminations and related deductibles phased back in.
- Assisted in transitioning the contracts department our of the accounting team supervision
- Successful financial, single and compliance audit
- Further integrated the Paychex human resources and payroll software following the initial implementation.
- Processed the new layer of direct care wage premiums effective 10/1/23 for behavioral health direct care workers including the residential care aides employed by NLCMHA.
- Processed provider stability requests for CLS programs as part of a year end cost settlement.
- General Fund expenditures remained within funding limits in FY 2023. The freezing of Medicaid redeterminations and deductibles continued throughout the year.
- Increased our reimbursements for the Health Home Billing from $484,689.57 in FY22 to $651,049.35 in FY23.
- Reimbursed $344,888.71 for FY23 services provided to consumers of other counties (COFRs).
- Increased reimbursements from Medicare from $117,216.26 in FY22 to $122,499.72 in FY23.
- Increased our reimbursements from BCBSM and other commercial health insurance from $55,845.55 in FY22 to $72,935.32 in FY23.
- The number of consumers participating in Self Determination has increased which requires more need for individual budget reviews.
- Completed amendment with Blue Cross Blue Shield to include crisis services in our contract as a payable service.

Works in Progress into Fiscal Year 2024:

- Continue to manage the redeterminations and deductibles that are being phased back in by MDHHS.
- Continue working on a contract with Optum (United Healthcare Dual Complete) for consumers that increasingly have dual Medicaid and Medicare health plans.
- Increase the number of clinical staff who are credentialed with Priority Health to increase the reimbursement rate.
- Implement recommendations that are made during the Rehmann Financial Activity assessment process.

Director of Quality Improvement & Compliance,
Kari Barker MSW, LBSW
Team: Jessica Williams, Melanie Schopieray, Amanda Ritchie, Trapper Merz, Cindy Peterson, Aimee Horton-Johnson, Jan Pytlowany, Shelly Smith, Heather Pollington, Candace Kauska-Dietrich, Cassie Garland, Kasie Morse, Christina Hasty, Heidi Neiderer, Laura Draeger, Sheila Lacy-Stidham, Bobbie Hudson, Gina Schlegel, Teri Dougherty

The accomplishment of these Ends will be promoted by having services grounded on accessible and culturally competent services, evidenced-based practices, consumer choice, a commitment to recovery and reintegration, resilience, empowerment, and independence. A cornerstone is our commitment to excellence in person/family-centered planning and services. We will utilize the most objective data available and a variety of methods to measure the degree of achievement of our Ends and will do so consistent with the MDHHS Quality Improvement Performance Indicators (measures), satisfaction surveys, third-party perspectives regarding our performance such as audits and Medicaid Encounter Verification, and other locally adopted measures.

Accomplishments-Quality Improvement:

- **PMQI:** We decided that to focus more attention on specific areas of agency function with a smaller group, so we have broken PMQI into 4 sub-committees (Quality Comm., Risk Comm., UM Comm., Compliance Comm.) Each of the groups are meeting every 4 months and are drilling down on areas of service for the purpose of identifying needed changes and then acting on improvement efforts. **1.0.10, 1.0.11**
- **HSW (Home & Community Based Waiver) SEDW (Serious Emotional Disturbance Waiver) and CWP (Child Waiver Program):** The annual MDHHS Waiver reviews were conducted in the spring of 2023, receiving feedback about the strengths of several areas such as assessment, person-centeredness, family involvement, as well as recommendations that were addressed in a corrective action plan (CAP).

  1.0.1-1.0.9 & 1.0.10, 1.0.11
- **CARF:** We began preparing for our CARF survey May of 2024. The system to collection documentation was set up and organized, manuals were provided to appropriate teams, meetings were facilitated and assignments given. Application for the survey was made on 11/30/23 **1.0.10, 1.0.11**

NMRE Quality Indicators:

- **Telehealth's effect on No-Shows:** There was a significant (11%) decrease the no-show rate for psychiatric services with the use of telehealth services. **1.0.6, 1.0.7**
- **Decrease in Hospitalization due to BHH:** Behavioral Health Home saw a significant reduction (37%) of the number of Emergency Room visits and Hospital admissions due to medical conditions in individuals that were receiving BHH(CHAT) services. They also report instances in which serious medical conditions were identified and addressed due to the BHH intervention.

Works in Progress-Quality Improvement

- **QI Campaign:** As the Public Health Emergency was again extended, through April of 2023, we haven't completed a QI campaign throughout our office buildings. The monthly Quality and Compliance newsletter is allowing us the opportunity to continue to reach staff and reinforce those standards as we continue to strive to build a culture of integrity. **1.0.1-1.0.9 & 1.0.10, 1.0.11**
- **Satisfaction:** We have continued to conduct a 5-question satisfaction survey over the phone for our consumers with IDD and their families. We've received positive feedback generally, and also some negative feedback that we have followed up on.
  In the Spring of 2023, the NMRE conducted their annual satisfaction survey, and for the first time it included individuals with IDD and their families, so we discontinued the phone survey that was being utilized in the absence of another measure. We may consider re-implementing if we're not reaching enough families.
- **Inpatient screen review:** As Munson Medical Center in Traverse City has contracted with us to complete our inpatient screens at the ED, we are randomly and regularly reviewing inpatient screens to monitor the frequency of, and justification for, inpatient admission. This has provided us the opportunity to work with Munson to improve the quality of inpatient screens.
- **iSPA Waiver:** We successfully completed enrollment of all eligible individuals according to the timeline established by MDHHS. We have begun annual re-enrollments, and some disenrollments of individuals are no longer eligible. This "waiver" requires all eligible individuals to be enrolled; there is no consent for participation, and there are no additional funds attached.

Accomplishments-Compliance:

- **MEV:** Medicaid Encounter Verification (MEV) audits have been conducted for the 1st and 2nd quarter by a third party during the last fiscal year and were met at 100% and 85% respectively. For the Q1 review all pieces of documentation to support that claim were in the clinical record, in Q2 there were 3 pieces of missing documentation. **1.0.10**
- **Virtual Compliance & Ethics training:** Is being conducted every other month, with good turnout. This training is in addition to the annual mandatory Relias Compliance training modules and is part of our ongoing efforts towards a Culture of Integrity. Beginning in January of 2024, we will be able to offer 2CEUs for SW Ethics. **1.0.10, 1.0.11**
- **Agency Plans:** All agency plans (Quality, Regulatory Compliance, Utilization Management, Risk Management, Accessibility, Cultural Diversity, and Agency Integrated Workplan) were reviewed and updated as required for FY2023. **1.0.10, 1.0.11**
- **Compliance training for the board:** Training was completed with Board members by Tema Pefok, Compliance Coordinator from the NMRE, during the winter. Disclosure of ownership forms were completed during the summer and are currently up to date. **1.0.1.0, 1.0.11**

- **Newsletter:** The Quality & Compliance Newsletter is a quarterly one-page publication that highlights the things that are going well and reinforces areas that need attention in an engaging way. Its purpose is to highlight our shared responsibility to guard against fraud, waste and abuse of Medicaid funds and the improvement of services. **1.0.10, 1.0.11**
- **Performance Indicators:** We have struggled getting children with SED in for 1st appointment within 14 days and recidivism is up a bit as well. Post-pandemic we've found ourselves challenged with the 7day post-discharge from hospital Indicator as staff have continued to utilized phone calls, we are re-training that face-to-face contacts are now required again.

  1.0.1-1.0.9 & 1.0.10, 1.0.11
- **The Clinical Record Review**: Due to several situations that have taken time and resources, our clinical record review has not been completed consistently this year. Improvements continue to be seen. **1.01.0**
- **Professional Credentialing:** All new hires have been credentialed at the time of hire and all individuals who were due, have been re-credentialed. We have now begun the same process for unlicensed individuals such as peers. Credentialing of Professional staff allows them to bill for services being provided, it is a mandated requirement with time limits, so it is critical to the agency's good standing. **1.01.0**
- **Exclusionary Reporting:** All checks have been clear, with no employees or contract providers having Medicaid sanctions. **1.0.11**

Works in Progress-Compliance:

Additional Staffing: Additional positions have been added to the team as part of restructuring, Cindy Peterson, Community & Public Relations, Reception and Transcription team, and Trapper Merz, Business Intelligence Analyst. At this time our needs are met, but if demands increase we may need additional resources so we can continue to meet regulations.

Accomplishments - Customer Service: Melanie Schopieray

- **Discharge Surveys:** Customer Service requested that email addresses for those consumers that provided them be added to the discharge report so that surveys could be sent via email. Since the success rate of telephone contact has been declining, we needed to find a new way to communicate with our discharged consumers. This also allows consumers to answer the survey at a time when it is convenient to them. **1.0.1-1.0.11**

- There were 17 Second Opinions requested, with 14 being completed and 3 being withdrawn. Of those 14, the initial decision was upheld 7 times (50%) and overturned 7 times (50%).
- There were 22 Local Appeals requested with 19 being completed and 3 being withdrawn. Of those 19, the initial action was upheld 13 times (68%) and overturned 6 times (32%).

- There were 7 Administrative/Fair Hearing decisions. Of the 7 Fair Hearing appeals 2 were upheld by the Administrative Law Judge. **1.0.1-1.0.11**
- 114 Customer Service Inquiries were received and resolved.
- 103 Grievances were received. Of those, 89 (86%) were requests for a Change of Provider. **1.0.1-1.0.11**
- Accommodations were requested and provided 73 times.
- Review of documentation to ensure accurate, updated, and relevant information presented to persons served, including guidelines for Mediation. **1.0.1-1.0.11**
- Attempted 123 Consumer Discharge Surveys and completed 49, with overall satisfaction post-discharge being a 3.8. **1.0.1-1.0.11**
- IDD Satisfaction Surveys are now sent out by the NMRE

Works in Progress:

- **Satisfaction Survey/Comments:** With the assistance of Jeremiah from IT, Customer Service has been able to create a scannable QR Code that will eventually be placed in the lobby areas where consumers can scan it using a mobile phone and it will take them to a page where they can leave a comment-much like a comment card-for a specific department or they can also leave a complaint that will then be followed up by Customer Service or other appropriate staff person. **1.0.11**
- **Data:** We continue to streamline the process for tracking and reporting Customer Service data. All reports were submitted to the NMRE in a timely manner. **1.0.1-1.0.11**

Clerical Support Aimee Horton-Johnson

Accomplishments:

1) Continue to quickly and effectively adapt to changing procedures while maintaining our expected levels of service and care.
2) Demonstrate a caring, welcoming attitude to individuals presenting to the office as their first point of contact.
3) Support Clinical Services by scheduling appointments, processing electronic information, and triaging incoming and outgoing information.
4) Collaborate with Psychiatric Services to assist in on boarding Doctors and developing Resident workflow.
5) Worked collaboratively to manage increased requests in Document Disclosure Queue.
6) Continue to adapt to changes with Microsoft Teams as our new phone system.
7) In collaboration with Psychiatric Services, implemented a uniform procedure across all four offices for entering doctor's schedule availability.
8) Began scanning in Identification Cards to be uploaded into PCE for the purpose of increased safety and security.

Works in Progress for Fiscal Year 2023

Continue to refine clinical workflow in partnership with Psychiatric Services

1) Collaborate with Psychiatric Services to develop a process for on boarding clinical staff and Resident workflow

2) Continue to work with the Safety Committee in developing and refining the emergency procedure(s) while conducting agency wide safety trainings and drills.
3) Continue leading the Safety Committee.
4) Continue to support Recovery by having a representative serve with the Recovery Logistics Workgroup.
5) Continue to support employee wellness by having representatives on the Wellness Committee.
6) Continue to monitor and support building maintenance by contributing to the Facilities Committee.
7) Assist in implementing new Emergency Alert System.

Northern Lakes Community Mental Health Authority

QUALITY ASSURANCE AND IMPROVEMENT PLAN

FY 2023

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 the 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

STUDY		**PLAN**
ACT		**DO**

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, immediate notice within 24 hours of incident and Sentinel Even Review initiated within 2 business days.

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.

Northern Lakes Community Mental Health Authority
FY 2023 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 55

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. Reporting - 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), 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

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
2023

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

2023 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.

NLCMHA Board Governance Policies – Section 1 - Ends

1.0 Consumer and Community Ends

We are committed to the guiding principles of Culture of Gentleness and Recovery. We are committed to the Person Centered planning process and the development of an individual Plan of Service within the context of available funding and services. We are committed to be a strong and effective partner in Michigan to improve the overall health, wellness and quality of life of the individuals, families, and communities we serve. We believe the systems of care and support we create and manage must serve and provide encouragement, support and opportunities that promote growth and create desired and positive outcomes for all persons served. We are committed to the elimination of stigma in cooperation with welcoming communities, and must meet owner expectations. As a manager and a provider of public health services utilizing federal, state, local funding sources and other reimbursements we hold ourselves accountable and are held accountable. Our responsibility is not to simply serve, but to ensure eligible persons with severe mental illnesses (including those with co-occurring conditions), children with serious emotional disturbances, persons with intellectual/developmental disabilities and persons with substance use disorders have satisfying, hopeful, and contributing lives that are consistent with their hopes and dreams.

We believe active consumer involvement is critical to Ends accomplishment and in ensuring consumers served achieve the following Ends consistent with individual choice and self-determination.

<u>Consumer Ends:</u>

1.0.1 Meaningful and satisfying community experiences, work (income generation) and/or volunteering, and/or success in an educational or vocational setting
1.0.2 Meaningful relationships within an ever expanding circle of support.
1.0.3 Children and families have rewarding family relationships
1.0.4 A safe living environment of their choice and with whom they want (adults) as identified through the Person Centered Planning process and reflected in the Individual Plan of Service within available resources and services.
1.0.5 Community membership, inclusion and participation
1.0.6 A reduction in psychiatric symptoms (as applicable)
1.0.7 An enhanced overall quality of life
1.0.8 Sobriety (as applicable)
1.0.9 Integration of behavioral health and physical health services

There are multiple community stakeholders that impact and/or are impacted by what we do and we place a high priority on working cooperatively with them toward the accomplishment of our Vision, Mission, and Ends. Key stakeholders include, but are not limited to, consumers, consumer parents, families, and/or guardians; health care providers; schools; law enforcement; the spiritual community; and local, state, and federal elected officials. To promote Ends accomplishment we need skilled providers and constructive relationships with organizations who provide funds including the MDHHS, managed care organizations, health insurance providers, etc.

Community Ends:

We are committed to the following Community Ends.
1.0.10 Our respective communities and key stakeholders accept and treat consumers with the same respect and dignity that should be afforded to ay member of the community.
1.0.11 Community Stakeholders are given opportunities to know and demonstrate support of the Northern Lakes Community Mental Health Authority Ends.
Accomplishment of these Ends will be promoted by having services grounded on accessible and culturally competent services, evidenced-based practices, consumer choice, a commitment to recovery and reintegration, resilience, empowerment, and independence. A cornerstone is our commitment to excellence in person/family centered planning and services. We will utilize the most objective data available and a variety of methods to measure the degree of achievement of our Ends and will do so consistent with the MDHHS Quality Improvement Performance Indicators (measures) and satisfaction surveys, third party perspectives regarding our performance, and other locally adopted measures.