Van Buren Community Mental Health Authority

FY 2019-2020 OPERATING PLAN STATUS

Executive Summary of Performance in 2019-2020

Attached please find the table of organizational performance objectives and the year-end status for each objective for last fiscal year. The document is used internally to track performance on key measures and is an integral part of the organization's quality improvement plan.

HIGHLIGHTS

- **Worldwide the performance of all services and businesses were disrupted by the COVID 19 pandemic. The state of Michigan took many precautionary steps to mitigate the spread of this disease and its potentially devastating impacts. Although the pandemic impacted VBMH and its services greatly, VBCMH adapted practices and continued to bring essential behavioral health services to the community.**

- **109 of the** operating plan objectives were met including standards by programs for access, effectiveness, efficiency, and satisfaction. 19 objectives were impacted by the changes caused by the pandemic and those were deferred or not calculated. VBCMH implemented a written Emergency preparedness and response plan specific to the COVID 19 pandemic and updated it multiple times as rules and public health information changed.

- Requests for services increased including increases in crisis intervention, psychiatric hospitalizations, first assessments (to open for services.)

- Additional funding was made available to behavioral health services organizations and VBCMH experienced positive revenue to expense in all major fund sources.

- The results of the 5th annual independent assessment of customer satisfaction through SWMBH indicate a **higher level of customer satisfaction** with services through VBCMH than found nationally for both adults and youth.

- **All** standards set by DHHS for performance indicator data involving customer care were exceeded.

- Increased community education groups to prevent suicide when the evidenced based training model allowed for virtual trainings.

- Successful implementation of **Trauma Focused Cognitive Behavioral Therapy** (TF-CBT) continued with approved adaptations to include virtual sessions. Two staff completed training in Parent Child Interaction Therapy, an evidenced based model for treating trauma in young children

- Successful continuation of grant funded services including: **Bangor Health Center**, **Michigan Child Collaborative Care (MC3)** project, , **mental health courts** for adults and youth, **treatment court programs** for persons with Substance Use Disorders, **Multi-Systemic Therapy** and **Youth Intervention Screening** and **psychiatric consultation** provided to primary care physicians of adults.

VBCMH wide objectives to assure **accessibility of services**

OBJECTIVES	MEASUREMENT	STATUS
1. At least 95 % of new person will receive a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service	Performance Indicator Report	**Occurred 100%** 429 of 429 with 8 exceptions (Exceptions are where customers are offered an appointment within the time frame but prefer an appointment outside of the time frame.)
2. At least 95 % of new persons will start needed on- going service within 14 days of a non-emergent assessment with a professional.	Performance Indicator Report	**Occurred 99.7%** 290 of 291 with 26 exceptions **(Exceptions are where customers are offered an appointment within the time frame but prefer an appointment outside of the time frame.)**
3. 95% of individuals who are Medicaid or indigent who are discharged from inpatient shall be seen within 7 days for follow up care, (allows for exceptions if date offered within 7 days,) and complete required narratives.	Performance Indicator Report	**Occurred 100%** 89 of 89 with 9 exceptions. (Exceptions are where customers are offered an appointment within the time frame but prefer an appointment outside of the time frame)
4. Meet state's performance-based incentive bonus standards for follow up after psychiatric hospitalization discharge for youth and adults. (no exceptions allowed; includes patient follow up with Medicaid health plan provider including primary care.)	SWMBH FUH Report	**Occurred Performance bonus incentive paid by state to SWMBH and to VBCMH largely due to exceeding standards for this measure.**
5 95% of persons requesting a pre-admission screening for psychiatric inpatient care will receive a disposition within 3 hours.	Performance Indicator Report	**Occurred 100% 251 of 251**
6. The number of children served by VBCMH will remain above 700 (number served in 2012-2013.).	Unduplicated Count summary report	**Occurred 751** youth served in mental health service with additional youth served in SUD prevention.
7. Penetration rate for the percentage of Van Buren Medicaid recipients receiving a Van Buren Community Mental Health service will be above 7 percent.	Performance Indicator Report	**Occurred**
8. Continue to offer screening services for youth throughout the county and provide follow up services where needed.	Report to Youth Suicide Prevention Coalition	**Occurred Grant reports submitted and funding continues; when schools went to virtual referrals decreased greatly. Were able to offer virtual screenings**
9. Participate in at least 8 events to provide to the community outreach and information on available services	Report on each event	**Occurred pre pandemic done face to face;** completed virtually during pandemic stay at home orders,
10. Continue to provide Medicaid benefit services to eligible youth with autism that meet requirements while also reducing costs to be in line with the revenue provided for these services.	Regional report	**Occurred** Standards met per SWMBH report
11. Continue to serve as navigator partner agency for MI Bridges including Medicaid and Healthy Michigan program (enrolled in new navigator program in January 2018.)	Signed agreement	**Occurred**
12. Staff will continue work with local DHHS staff and continue trauma screening, assessment and follow up of youth served by DHHS.	Completion of training activities and referrals by VBDHHS for trauma assessments	**Occurred**

13. Provide appropriate assessments for young children placed in foster care in partnership with VB DHHS	Completed assessments	 **Occurred**
14. Continue content improvements to VBCMH website and maintain social media presence for VB Suicide Prevention Coalition, VB substance Abuse Prevention Task Force, and Bangor Health Center.	Review of the sites	 **Occurred**

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VBCMH wide objectives to assure services are of **high value to customers, stakeholders and the community**.

OBJECTIVES	MEASUREMENT	STATUS
1. Customer Satisfaction as demonstrated on the regional survey will be above the national average.	Survey Report	**Occurred**
2. Improvement plans for site reviews completed by DHHS and SWMBH will be developed, implemented and monitored, updated as needed. Complete CARF quality improvement plan in response to survey's recommendations.	Written plan; internal report Feedback from SWMBH site survey.	**Occurred**
3. Provide, monitor, and report on jail diversion program. Train new clinicians to take on role of primary jail clinicians	Internal and PIHP Data base (SWMBH doesn't have a data base they report to the state)	**Occurred**
4. At least one annual training for area police officers will be held.	Sign In Sheet for participants	**Occurred**
5. Meet objectives set in for Michigan Collaborative Child Care (MC3) U of M grant in providing psychiatric consultation to primary care providers for youth	Reports provided from U of M	**Occurred during pandemic much change for primary care resulting in fewer referrals**
6. Meet objectives set in grant for providing psychiatric consultation to primary care providers serving adults.	Grant report	**Occurred**
7. Meet objectives set in grant for providing Youth Intervention screening.	Grant report	**Occurred grant continued**
8. Continue improvement project suggested from psychiatric peer review process: Implement QI project to increase patient completion of ordered lab work.	Internal report	Due to labs shut down and increased unwillingness to go in person for medical tests, this objective is deferred until the pandemic conditions are greatly improved
9. Participation in PIHP project to increase completion of diabetes screening lab test for adults not currently diagnosed with diabetes who are prescribed antipsychotic medications to 85% (baseline for VBCMH is 77%.)	State provided data on lab work completion	Continued participation in project but due to pandemic, persons going for routine lab work greatly decreased everywhere
10. Active participation with VB Community Health Committee, including continued promotion of the Crisis Text Line and utilize regional data when available.	Crisis Text Line data for those texting HAND	**Occurred**
11. 95 % of Behavioral Health Treatment Episode Data Set will meet completion and quality standards.	Error and Missing Reports will be within regional averages	**Occurred**
12. Meet requirements of demonstration programs and pilots continuing this fiscal year including Medicare/Medicaid eligibles demonstration project.	Regional report	**Occurred**
13. Complete action plans to respond to priorities identified in stakeholder input process from January 2019.	Written report to DHHS	**Occurred**
14. Continue implementation of Mental Health Court in accordance with grant guidelines, including addition of new full time clinician position.	Grant payments made as expected	**Occurred**
15. Participate as preferred provider in Van Buren County Treatment Courts	Payments for services provided	**Occurred**

16. Meet requirements of Family Treatment Court SAMHSA grant, State Opioid Response grant and Strategic Prevention Framework Partnerships for Success grant	Grant reports and payments made as expected	**Occurred**
17. Continue work to meet standards of Home and Community Based Services rules for internal services and entire provider network in conformance with guidelines and multi year plan of the state.	Successful completion of tasks requested by MDHHS	**Occurred**
18. Review with Board compensation schedules and implement steps to maintain competiveness and fiscal soundness of organization	Meeting minutes	**Occurred**
19. Continue implementation of integrated SUD/MH process that meets standards for SUD and MH rules and improves efficiency for customers, staff, and community.	Plans developed and implemented	**Occurred**
20. Trauma Informed Leadership Team will oversee implementation of projects to ensure a trauma informed agency including training, assessment and treatment, and will meet agreed upon objectives for regional grant.	TILT minutes and documentation Regional report	**Occurred** but Team did not meet virtually however much of the work previously initiated continued
21. Continue Intensive Crisis Stabilization Services (mobile crisis) for youth.	Encounters for service reported	**Occurred** was not available for referrals during stay at home orders but was available once things opened up. Few referrals
22. Clinicians currently in training of Child Parent Psychotherapy will complete requirements	Internal Report	**Occurred**
23. Programs will track in SmartCare and meet productivity standards	Internal report	Deferred due to many changes in what meets state definitions of service (such as phone now) Reports not set up to capture all info. Will reinitiate when new EMR and reports available
24. Implement at least one Caregiver Education training group with full curriculum for customers.	Group logs	**Occurred** virtually
25. Provide trauma impact training to staff members of at least one other human services agency.	Training Log	**Occurred**
26. Continue implementation of project to ensure actions to decrease suicide for open customers.	Internal report	**Occurred greater participation in community education (QPR) with virtual training**
27. Continue to coordinate county suicide prevention coalition	Meeting minutes	**Occurred** greater participation with virtual
28. Evaluate whether to have staff person trained to teach gentle teaching .	Training Logs	Did not occur/deferred
29. Complete implementation plan for HOPE Center to become certified Clubhouse.	Clubhouse International accreditation	Plan completed; accreditation survey deferred due to pandemic scheduled for 2021
30. Continue to develop and implement plans to serve customers well in alternatives to specialized residential settings.	Plan developed; expenses saved tracked	Deferred additional steps due to pandemic
31. Increase use of current thin client laptops in community from baseline collected in 2018.	Internal report	Dropped. With need for so many to work from home security issues addressed with other devices and made much more widely available

32. Implement plan developed regionally to assure ABA services for youth with autism meet regionally developed medical necessity criteria.	Feedback from SWMBH	**Occurred**
33. Implement regionally developed medical necessity criteria for services for persons with I/DD	Feedback from SWMBH	**Occurred**

VBCMH wide objectives to assure services **attain positive customer outcomes**

OBJECTIVES	MEASUREMENT	STATUS
1. Continue monitoring to ensure LOCUS scores and level of services provided will match per regional guidelines and for any that do not match the clinical rationale will be documented.	Internal and Regional Reports	**Occurred**
2. The total number of consumers in community supported employment will remain above 80.	Internal report from placement records	**Occurred**
3. Serve at least 15 adults using the Evidenced Based Supported Employment model.	Internal Report	**Occurred**
4. Percentage of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge will be less than 15%.	Performance Indicator Report	**Occurred**
5. MHSIP and YSS scores achieved on applicable dimensions for applicable VBCMH customer populations will be equal to or greater than comparable state or national benchmark scores.	SWMBH survey reports and Monitoring Reports to the Board	**Occurred**
6. Customer ratings of outcomes on MHSIP and YSS regional surveys will be above the national average	SWMBH Customer survey data	**Occurred** .

VBCMH wide objectives to **reduce risk and to reduce the likelihood of negative consequences in any area exposed to risk, including: fiscal management, quality, public perception, or litigation.**

OBJECTIVES	MEASUREMENT	STATUS
1. Develop and maintain an annual budget and provide revenue and expenditure analysis on a regular basis to ensure fiscal integrity.	Annual budget Monthly Financial Status Reports	**Occurred**
2. Ensure a system of internal controls to properly safeguard the assets of the agency continues as recommended by independent auditor	Financial Procedures followed	**Occurred**
3. Ensure insurance coverages adequate to meet the needs of the agency	Insurance policies	**Occurred**
4. Ensure fiscal management in accordance with all State and Federal legal requirements, and the requirements of the Michigan Department of Community Health	Annual audit Reports to DHHS	**Occurred**.
5. Site surveys of contracted providers shall be completed utilizing new shared review provider site review system developed with PIHP	Internal Report and PIHP Report	**Occurred**
6. All internal and external providers shall complete (re) credentialing, (re) privileging process as appropriate	Internal Reports	**Occurred**
7. Ensure completion of requirements for screening and excluded provider disclosure.	Internal & PIHP review	**Occurred**
8. Maintain systems to record all revenues and expenditures by capitation and other funding sources.	Reports to DHHS and PIHP	**Occurred**
9. Maintain costing and rate-setting methodologies consistent with state and PIHP requirements.	Unit Cost Reports	**Occurred**
10. Continue meeting operational and process standards, including compliance with HIPAA regulations and DHHS requirements.	DHHS, PIHP Site Reviews	**Occurred.**
11. Building and Safety self-inspections for each agency site will be completed and necessary corrections will be made; Fire drills, severe weather drills, power outage drills, bomb threat drills and medical emergency drills will be completed at each site with all sites meeting agency standards.	ESSIC Monthly Checklists and Drill Performance Evaluations	**Occurred** moved to email simulations during stay at home orders
12. Continue implementation of AED checklist project started in 2018.	Checklist developed and utilized per plan	**Occurred**
13. Remain in the supported window of technology: a. Maintain appropriate licenses b. Recommend appropriate upgrades to software systems. c. Maintain and upgrade hardware as appropriate.	Internal report	**Occurred**
14. Complete trainings for staff and Board on corporate compliance.	Training logs	**Occurred**
15. Report quarterly to the Board of Directors on corporate compliance.	Reporting log	**Occurred**.
16. Board of Directors will monitor compliance with Executive limitation policies	Meeting minutes	**Occurred.**
17. Clinical documentation monitoring process on internal and external providers will indicate less than 10% of claims not meeting verification	Internal Report	**Occurred specific issues with specific providers**

standards prior to corrective process.		**addressed**
18. Plan and implement activities throughout the year to insure high level of compliance with clinical documentation standards	Internal report	**Occurred**
19**.** Update as needed, Emergency Action and Communication Plan and distribute to staff; complete Emergency Guide Flip charts for each location.	Plan completed and Flip charts at each location	Flip charts were not updated this year but multiple updates to COVID 19 specific response plan occurred and were disseminated as information and conditions changed
20. Train new instructor for CPR/ First Aid to train VBCMH staff.	Completed training	**Occurred**
21. Continue iimplementation of new model for providing utilization management in alignment with SWMBH guidelines	New system implemented SWMBH site review	Occurred
22. Continue internal mentoring program with at least 1 additional cohort	Internal report of matched mentors and group kick off	Deferred
23. Continue to improve safety planning process for high risk customers.	Increased use of safety plans in line with CARF standards	Deferred
24. Implement internal training series begun in 2018 for staff on topics indicated on survey of staff.	Training logs	Deferred
24. Achieve at least 80% of objectives written in the Cultural diversity plan, Risk management plan and Accessibility plan.	Per plan reviews	Deferred

Program objectives to **assure accessibility; efficiency, positive outcomes and customer satisfaction.**

OBJECTIVES	MEASUREMENT	STATUS
A. **<u>ACT (Steps and MI/CA)</u>** *are multidisciplinary teams that provide acute, active and ongoing psychiatric treatment, outreach, rehabilitation, and support services*		
1. 90% of STEPS members will remain out of Medicaid/GF funded psychiatric inpatient during the year	Hospitalization Report	**Occurred**
2. Face to face units of service per month with members will average 420 units for the STEPS team.	Monthly SALs Report	**Did not calculate**
3. Results of customer satisfaction survey for STEPS members will result in a mean rating above good) for all dimensions surveyed.	PIHP Survey Report Analysis from VB QI	**Occurred**
4. 95% of planned discharged STEPS members will remain out of Medicaid/GF funded psychiatric inpatient services for 90 days post discharge	Hospitalization Report	**Occurred**
5. 90% of ACT members will remain out of Medicaid/GF funded psychiatric inpatient during the year	Hospitalization Report	**Occurred**
6. Face to face service units per month with members will average 420 for the MI/CA team	Monthly SALs Report	**Did not calculate**
7. Results of customer satisfaction survey for MI/CA members will result in a mean rating above good for all dimensions surveyed	PIHP survey Report Analysis from VB QI	**Occurred**
8. 95% of planned discharged MI/CA members will remain out of Medicaid/GF funded psychiatric inpatient services for 90 days post discharge	Hospitalization Report	**Occurred**
9. 80% of ACT members will demonstrate higher levels of community stability by having fewer days inpatient or in jail or if all days the previous year in the community then will remain at that level.	QI report	**Occurred**

Program objectives to **assure accessibility, efficiency, positive outcomes and customer satisfaction**.

OBJECTIVES	MEASUREMENT	STATUS
B. **<u>Access</u>** *provides assessment, crisis intervention, pre-admission screening for psychiatric inpatient services, and referral to needed services during business hours*		
1. 95% of persons requesting a pre-admission screening for psychiatric inpatient care will receive a disposition within 3 hours	DHHS Performance Indicator Report	**Occurred**
2. Less than 2% of customers served through Access will request a second opinion or submit a formal grievance and appeal	Internal Tracking of Second Opinion Requests/PIHP Grievance and Appeal Reporting	**Occurred**
3. Less than 2% of customers assessed and assigned to services by Access will be transferred within the first 30 days of service	Internal Utilization Management Monitoring	**Occurred**
4. 95% of completed pre-admission screening forms reviewed by UM will be confirmed as appropriate disposition	Internal Utilization Management Monitoring	**Occurred**
C. **<u>Case Management for Adults</u>** *provides individualized supports to persons served through assessment, linking and coordinating, advocacy and monitoring activities*		
1. 90% of CMS customers will remain out of Medicaid/GF funded psychiatric inpatient during the year	Hospitalization Report	**Occurred**
2. Face to face contacts per month average per CM will increase over 2016-17.	Service Activity Log Report	**Did Not Calculate**
3. 90% of all planned discharged customers will remain out of Medicaid/GF funded psychiatric inpatient for 90 days post discharge	Hospitalization Report	**Occurred**
4. Results of customer satisfaction survey for open case management customers will result in a mean rating above good for all dimensions.	PIHP Survey Report Analysis from VB QI	**Occurred**

Program objectives to **assure accessibility, efficiency, positive outcomes and customer satisfaction**.

OBJECTIVES	MEASUREMENT	STATUS
D. **<u>Children's Intensive Services</u>** *provides clinical, case management and support services to children with a severe emotional disturbance and their families*		
1. 85% of accepted referrals to Children's Intensive Services will be seen within five (5) business days.	Referral Forms/Service Activity Logs Report to Division Manager	**Occurred**.
2. 75% of CIS customers opened in the current FY will have demonstrated improvement in level of functioning	Outcome Measures Form and/or CAFAS Face Sheet Report to Division Manager	**Occurred**.
3. Results of customer satisfaction survey for open CIST customers will result in a mean rating above good for all dimensions.	PIHP Survey Report Analysis from VB QI	**Occurred**
4. 85% of customers closed from Children's Intensive Services will remain out of psychiatric hospital for six (6) months post discharge	Hospitalization Report	**Occurred**

Program objectives to **assure accessibility, efficiency, positive outcomes and customer satisfaction**.

OBJECTIVES	MEASUREMENT	STATUS
E. **Community Support Services for persons with developmental disabilities** *provides supports and services to adults and children with developmental disabilities to optimize their personal, social and vocational competency in order to live as independently as desired in the community*		
1. The total number of persons with DD employed in the community will remain above 75.	Placement records	**Occurred** –
2. Family Support will serve a minimum of 60 persons.	Staff Meeting Notes & Sign-in Sheet	**Occurred** –
3. Results of customer satisfaction survey for customers with developmental disabilities will result in a mean rating above good for all dimensions.	PIHP survey report	**Occurred**
4 Complete SIS assessments as required by DHHS. Utilize information in partnership with SWMBH to align customer need and service intensity.	Assessments completed	**Occurred**
5. At least one session regarding employment and social security benefits will be provided.	Training logs	Deferred
F. **HOPE Center** *helps persons with psychiatric disabilities to optimize their personal, social and vocational competency in order to live successfully in the community*		
1. To promote recovery and decrease stigma HOPE Center will integrate/engage with the community through events, volunteering & advocacy at least two times per year	Report to Division Manager	Deferred
2.. At least 25% of active HOPE members will be employed on average per month	HOPE Center report	Deferred
3. An average of 6,000 units of service will be provided each month by HOPE Center	Monthly Time Card Summary and PSR Report of Services	Did not calculate
4. HOPE Center will obtain & maintain Clubhouse International Accreditation	International Accreditation Status.	Deferred
5. 85% of Hope Center members will report that they are satisfied with HOPE Center services	HOPE Center Member Report	**Occurred**
6. 90% of planned discharged customers will remain out of Medicaid/GF funded psychiatric inpatient services for 90 days post discharge	Hospitalization Report	**Occurred**
7. HOPE Center will ensure access to the building, HOPE Center sponsored events (including evenings, weekends, & holidays) and employment sites (Transitional Employment) is available to membership as specified in the Michigan Medicaid Manual.	Internal Report	**Occurred**

Program objectives to assure **accessibility, efficiency, positive outcomes and customer satisfaction**.

OBJECTIVES	MEASUREMENT	STATUS
G. **<u>New Outlook</u>** *provides wraparound services to children at risk of removal from their home. Services are designed to support families in improving their children's quality of life. This program is collaboratively supported by CMH, DHS, and the Family Court Juvenile Division*		
1. 80% of children enrolled in New Outlook will remain in community-based living arrangements	Report to Division Manager From Strong Families Safe Children Report	**Occurred**
2. Customer satisfaction survey reports will result in mean rating above good for all dimensions.	SWMBH report Internal analysis	**Occurred**.
3. 80% of children disenrolled from New Outlook will remain in community-based living arrangements 90 days post disenrollment	Report to Division Manager	**Occurred**
4. 75% of the initial CAFAS scores of customers in New Outlook will improve (decrease) by at least 20 points at the time of a planned discharge/transfer.	Outcome Measures Form and/or CAFAS Face Sheet Report to Division Manager	**Occurred**
H. **<u>On-Call Services</u>** *provides emergency mental health services after normal business hours including crisis resolution, pre-admission screening for psychiatric inpatient services and referral to appropriate services*		
1. 95% of persons requesting a pre-admission screening for psychiatric inpatient care will receive a disposition within 3 hours	Performance Indicator Report	**Occurred**
2. Results of PIHP customer satisfaction survey for Van Buren will result in a mean rating above good for questions related to after hours service.	PIHP Survey Report Analysis from VB QI	**Occurred**
3. 95% of completed pre-admission screening forms reviewed by UM will be confirmed as appropriate disposition	Internal Utilization Management Monitoring	**Occurred**
I. **<u>Outpatient Services</u>** *provides individual, family, and group therapy and crisis resolution for adults and children*		
1. Less than 5% of persons served in OP will be admitted to Medicaid/GF funded psychiatric inpatient	Hospitalization Report	**Occurred**
2. No show cancellation rate for year will be below 25 percent	Internal Report on No Shows Cancellations Generated From Day Sheet Data	**Occurred** no shows decreased with f teleservices
3. Results of customer satisfaction survey for Outpatient customers will result in a mean rating above good for all dimensions.	PIHP Survey Data	**Occurred**
4. OP clinicians will provide an average of 60% face to face service per month	Internal report	**Occurred**

Program objectives to assure **accessibility, efficiency, positive outcomes and customer satisfaction.**

OBJECTIVES	MEASUREMENT	STATUS
K. **Substance Use Disorder Treatment and Prevention Services** provides *evidenced based treatment and recovery services for adults and youth struggling with substance issues. Services include prevention and early intervention services.*		
1. Continue to provide Intensive Outpatient services and Case management services as needed and continue to implement plan to begin new services of Recovery coaching; achieve certification to provide women's specialty services;	Services provided per encounter reports to SWMBH	Did not implement peer services but will start in 2021 fiscal year
2. 95% of new customers will receive face to face assessment within 14 days and at least 95% of new customers will start needed ongoing service within 14 days of non-emergent assessment	Regional Monitoring report	**Occurred**
3. Customer satisfaction average score will equal 4 or higher on RSA-r survey done in partnership with SWMBH. (4 = agree with positive statements; 5 = strongly agree)	Regional report	**Occurred**
4. Explore if BH TEDs data on incarceration and days of use can be obtained from the data submitted to SWMBH and utilized as measures of effectiveness of treatment services.	Regional reports	**Occurred**
5. Improvements will be made in at least 85% of SUD prevention priority areas.	PIHP OMI report	**Occurred**
6. Evidenced based practices will be used in accordance with PIHP requirements	PIHP site review and report	**Occurred**
7. BH TEDs collections for SUD services will be in accordance with PIHP requirements	PIHP reports	**Occurred**