Community Mental Health
FOR CENTRAL MICHIGAN

Quality Assessment and Performance Improvement Program Annual Report

2020

Quality Assessment and Performance Improvement Program (QAPIP)
FY20 Annual Report

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MISSION

To promote community inclusion and whole-person wellness through comprehensive and quality integrated services to individuals with a serious emotional disturbance, intellectual/developmental disability, serious mental illness, or co-occurring substance use disorder.

Quality Assessment and Performance Improvement Program
FY20 Annual Report

I. Introduction

Community Mental Health for Central Michigan (CMHCM) places quality integrated services at the core of its mission. Agency resources focus on opportunities to improve performance following internal and external standards in collaboration with Mid-State Health Network (MSHN), the Michigan Department of Health and Human Services (MDHHS), CMHCM service programs, and the CMHCM Provider Network. CMHCM's quality focus is driven by the Board of Directors and agency leadership's commitment to quality care for consumers. The following pages record CMHCM's FY20 efforts to continuously assess service delivery, identify areas for improvement, provide the resources to improve care and operations, and implement quality changes and staff engagement for continuous quality improvement.

In each quality improvement initiative, it is CMHCM's expectation that key findings in the analysis will lead to improvements that are aligned with agency values bringing value to our communities in terms of better health outcomes and better care at lower costs. As areas of improvement are identified, performance improvement teams or workgroups are formed to design and implement improved practices.

II. Clinical Services

A. Children with Serious and Emotional Disturbance (SED)

Goals:

1. More than 60 percent of children served will have meaningful improvement in their CAFAS/PECFAS assessment scores.

   A twenty-point reduction in CAFAS score indicates meaningful improvement. For FY20, the CAFAS dashboard shows that 62 percent of children served had meaningful improvements.

2. There will be an overall increase of contacts within the schools for children with SED by 25 percent over FY19.

   There were 2,432 contacts within the schools for children in FY19. For FY20, there have been a total of 1,322 face-to-face contacts in the schools. This represents a 46 percent decrease in contacts within the schools from FY19 to FY20. Decreases in school contacts can largely be attributed to the COVID-19 pandemic that began in March. With the closure of schools due to the pandemic and the variety of educational options that each school district implemented, face-to-face contacts within the schools diminished greatly. It is likely that FY21 will also be impacted by COVID-19 and decreases in contacts will continue to occur.

B. Adults with a Serious and Persistent Mental Illness (SPMI) and Co-Occurring Disorder

Goals:

1. New Journey and Summit Clubhouses will increase their overall outreach contacts to non-participating members by 30 percent over FY19.

   For the period of October 2019 to August of 2020, New Journey had a total of 4,488 outreach contacts and Summit had a total of 5,379 contacts. This equates to a total of 9,867 outreach contacts between the two Clubhouses which represents an increase over FY19 of 579 percent. Due to the COVID-19 crisis beginning in March, much of the Clubhouse operations shifted to remote contacts to ensure that members remained engaged and focused on their physical/mental wellness.

2. New Journey and Summit Clubhouses will increase Medicaid eligible Clubhouse only members (with a LOCUS of 17 or below) by at least 5-10 members.

County	Number of Consumers
Isabella	4
Mecosta	9
Total	13

Thirteen individuals received clubhouse only services, meeting the goal of serving at least ten members during the year who were able to remain in the Clubhouse for ongoing recovery focused interventions.

3. The number of consumers authorized for clubhouse services at initial assessment will increase over FY19.

Fiscal Year	# of consumers
FY19	4
FY20	11

Success on this goal is attributed to removing barriers for re-entry of members to clubhouse services allowing a seamless transition for access back in to clubhouse services as well as ensuring that consumers are provided with clubhouse services if they do not meet criteria for ongoing case management or outpatient services.

4. A reduction in mental health hospitalization days will occur for consumers with co-occurring disorders over FY19.

Fiscal Year	Hospital Days
FY19	1,940
FY20	1,080

There was a 44 percent reduction in the overall number of mental health hospitalization days for consumers in this population compared to FY19.

5. Access to Recovery Coaches as part of the clinical CMHCM treatment-based care teams will be established in FY20 through partnership with MSHN and community SUD providers.

CMHCM is unable to hire Recovery Coaches directly as CMHCM is not a straight substance abuse treatment provider; however, CMHCM is able to collaborate with Ten-Sixteen Recovery Network and Recovery Pathways to explore the possibility of sharing Recovery Coaches. Unfortunately, due to COVID-19, this was placed on hold temporarily due to the inability of the coaches to provide the in-person, community-based services that were intended. This goal will be continued into the next fiscal year.

C. Children and Adults with an Intellectual/Developmental Disability (I/DD)

Goals:

1. Ninety-five (95) percent of consumers eligible for ABA will start Applied Behavior Analysis (ABA) services within 90 days of their enrollment date.

   Fifty-six (56) percent of consumers eligible for Applied Behavior Analysis (ABA) services were served within 90 days of their determined eligibility in FY20 (19 out of 34 consumers). The COVID-19 pandemic has caused start dates of services to be delayed; of the 15 consumers who had not started within 90 days, 13 of those individuals were assigned to providers; however, they were unable to begin Autism services due to COVID-19 precautions. When taking this into consideration, without COVID-19 delays due to precautions, CMHCM would have been at 94 percent compliance with this metric of consumers starting services within 90 days of enrollment.

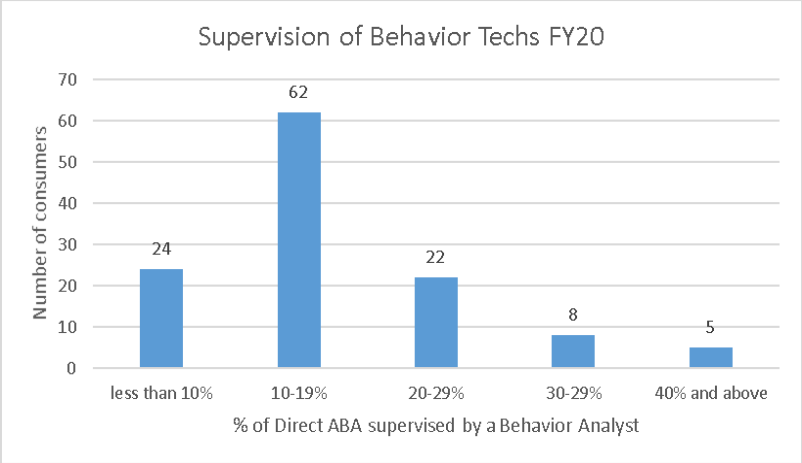
2. Seventy-five (75) percent of active enrollees will engage in 75 percent or more of direct ABA services as authorized.

   The social distancing precautions to mitigate the risk of COVID-19 had a large impact on the direct delivery of ABA services during FY20. By April 2020, contracted Autism providers were instructed to stop delivering face-to-face therapy unless approved by CMHCM Autism services leaders. Some providers opted to stop all direct services during Michigan's Stay At Home order, while others requested to continue serving the most severe cases where there was a serious risk of harm to self or others without ABA being delivered in-person. At the height of the pandemic only 23 consumers were receiving face-to-face ABA services (out of approximately 160 open Autism cases). By August 1, 2020, more than 77 percent of the consumers open to the MDHHS benefit were resuming ABA services, including telehealth services.

   While the interruption in direct services resulted in 32 percent of the authorized ABA service being fully utilized between the dates of 10/1/19 and 8/1/20, there was an increase in parent training provided via telehealth in an effort to help families maintain the ABA programming Of the 86 consumers that did not receive the authorized ABA from a behavior tech, 59 of those families (68 percent) participated in parent training. Overall, 121 consumers received almost 600 hours of parent training between the dates of 10/1/19 and 8/1/20. This allows families to learn to increase their children's skills and reduce problem behaviors before direct services can begin or when they are in the process of fading out the most intensive interventions to generalize and maintain ABA strategies.

3. Ninety-five (95) percent of active ABA enrollees will receive at minimum ten percent direction/observation over their direct services.

   The efficacy of successful ABA programs includes appropriate supervision and direction of behavior technicians by a master's level clinician. During FY20, 80 percent (97 out of 121) of behavior technicians were supervised at a ratio of one-hour supervision to ten hours direct service provided with all behavior technicians receiving some supervision. The option of providing this supervision via telehealth during the pandemic has allowed clinicians a safe alternative to continue to provide best practices.



This graph shows that while the majority of consumers received the minimum 10 percent of supervision, many received well above the minimum requirements.

4. An increase in integrated employment and volunteer opportunities will occur for individuals with an I/DD diagnosis over FY19.

   Overall, there was a decrease of competitive and integrated employment for individuals with an I/DD diagnosis in FY20 compared to that of FY19. In FY19, there were a total of 113 consumers employed competitively (either full-time or part-time). For FY20, there were a total of 98 consumers employed competitively with an I/DD diagnosis. COVID-19 is a contributing factor to the reduction in competitive employment opportunities in FY20.

III. Clinical Oversight

A. Behavior Treatment

Goals:

1. The Behavior Treatment Committee (BTC) will focus on decreasing the overall percentage of children prescribed psychotropic medications.

Report period	Overall # of children open to CMHCM services	# of children prescribed psychotropic medication	% of children open to CMHCM services that are prescribed psychotropic medication	# of children assigned to Case Management/Health Services as a primary program
FY20Q2	1411	322	22.8%	84 (26%)
FY20Q3	1200	304	25.33%	79 (26%)
FY20Q4	1221	311	25.4%	73 (23%)

The BTC reviews children prescribed psychotropic medications to ensure that all children, even in the presence of a psychiatric disorder, have at least a positive behavioral treatment plan or evidence-based treatment plan. The use of a medication or drug when it is used to manage or control an individual's behavior or restrict the individual's freedom of movement (and is not a standard treatment or dosage for the individual's condition) is considered an intrusive intervention requiring BTC review. There are limitations to the data available for FY20 because the Committee did not have the overall number of children open to CMHCM services added to the data table until Quarter 2 of FY20.

Between FY20Q2 and FY20Q4 there were 190 less children open to services. Variance in the use of psychotropic medication is expected based on: admissions and discharges from acute psychiatric units, the number of children who are entering CMHCM services that are not yet established into outpatient treatment, and the primary diagnoses/presenting symptoms of the children open to services. BTC is primarily focusing on children whom are not assigned to an evidence-based treatment program, such as case management or health services, and based upon the data, that percentage remained consistent for the second and third quarters of FY20 and declined slightly in the fourth quarter.

2. A decrease will occur in the number of consumers receiving multiple physical interventions compared to FY19.

Fiscal Year	# of consumers receiving multiple physical interventions
FY19	13
FY20	20

BTC has identified that nearly all of the individuals who received multiple interventions in FY20 have resided in out-of-catchment placements. As a result of these findings, the BTC has focused on ensuring behavior plans are in place for those individuals and that ongoing education and feedback is given to the providers.

3. Staff training on basic behavior modification principles, developing behavior treatment plans, and monitoring behavior treatment plans will occur for identified staff in each county.

BTC conducted several in-person trainings in FY20 which covered: basic behavior modification principles, developing behavior treatment plans, and monitoring behavior treatment plans with staff and supervisors. There were three in-person sessions initially, with feedback from those training being very positive. The sessions were attended by case managers/supports coordinators, outpatient therapists, Assertive Community Treatment (ACT) teams, Multi-Systemic Therapy (MST) teams, home-based staff, and select administrative staff. Individual consultations occurred throughout FY20 with staff and supervisors, and there are additional trainings projected throughout FY21.

B. Event Monitoring and Reporting

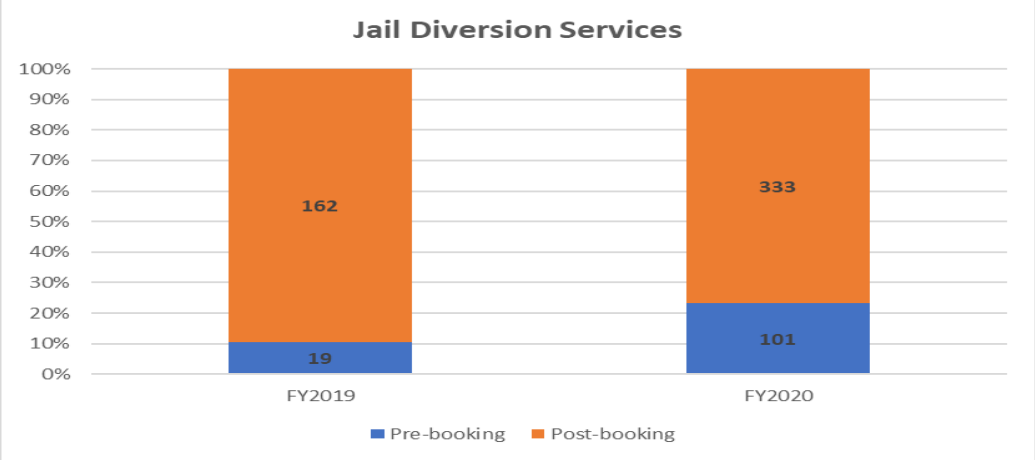
Goal: Implement and develop baseline data collection for Relapse Prevention and Harm Reduction Plans for consumers with co-occurring mental health/substance use disorders.

Due to the unique needs that a consumer has related to this type of plan, the Clinical Oversight Committee (COC) decided that these plans should be incorporated into the consumer's Individual Plan of Service (IPOS). It was determined that collecting data from an IPOS on interventions relating to the Relapse Prevention and Harm Reduction plans would be challenging and would not have a significant impact on treatment that consumers would be provided. As such, it was determined that additional fields would not be added to the IPOS at this time, and instead, the Cognitive Behavioral Therapy (CBT) training that was conducted in FY20 would instruct case holders on proper assessment and engagement for substance use disorders and co-occurring disorders and planning interventions around these issues.

C. Oversight of Individuals at Risk

Goals:

1. Increase overall jail diversion services by 25 percent over FY19.
2. Twenty (20) percent or more of the total number of jail diversion services in FY20 will be pre-booking services.



CMHCM completed 434 jail diversion services with 23 percent (101 services) being pre-booking diversions in FY20. These overall jail diversion numbers are higher than FY19 where a total of 181 jail diversion services were provided; this represents a 239 percent increase in FY20 of total jail diversion services. It is important to note that there were fewer overall opportunities for jail diversion throughout much of FY20 due to COVID-19. Law enforcement agencies were less likely to incarcerate individuals for minor crimes and the after-hours screening location was utilized much less due to telehealth screening being incorporated for safety practices due to the pandemic.

The Jail Services and Community Collaboration Workgroup expanded their focus to include community partnership development, in-jail services, and jail diversion services. The primary goals of this workgroup are to increase both pre- and post-booking jail diversion services and to improve the overall service delivery to individuals who are incarcerated, on probation or parole, or are at risk of arrest, and to ultimately broaden community partnerships with law enforcement, jails, and courts.

3. The number of consumers with active crisis plans will increase to 45 percent or more in FY20.

For FY20, there were a total of 1,884 active crisis plans representing about 20 percent of consumers who have an active crisis plan. This compares to 1,504 consumes with active crisis plans in FY19. The Clinical Review and Consultation Team (CRCT) encouraged the increased use of crisis plans for all consumers. These plans are offered to all consumers at the time of the psychosocial assessment; however, plans can also be completed or updated at any time throughout the year. Although a steady increase in the use of these plans has been seen, CMHCM still fell short of the goal of 45 percent. Crisis planning is offered to all consumers early on when first starting services. While reviewing the data on our crisis plans, we recognized that there are multiple ways to achieve crisis planning outside of our typical format, which is what is used in data tracking. These other avenues of crisis planning include specific evidence-based practice formats, community care plans, family plans, as well as WRAP plans developed with Peer Support Specialists. Different formats are critical to assuring the plan works best for the consumer. Going forward, we will be using data collection to incorporate these other avenues to better capture how many consumers do have crisis plans developed.

4. Baseline data collection will be implemented to establish the number of after-hours crisis contacts that are occurring in FY20.

   The CIGMMO Committee added a location code to all progress notes and emergency screens to track the use of the after-hours screening locations in order to determine overall use of those locations. Baseline data was collected in FY20 to help determine opportunities for improvement. Due to COVID-19, there was a decline in the use of these facilities for safety purposes, instead opting for telehealth screens wherever possible resulting in 277 tele-health screens in FY20. Prior to COVID-19, there was a total of 11 contacts that occurred by the Crisis team in after-hours crisis locations.

D. Practice Guidelines

Goals:

1. Outpatient and home-based staff and supervisors will undergo full Beck Cognitive Behavioral Therapy (CBT) based training in FY20. Supervision groups for model adherence and ongoing training will be implemented to ensure fidelity to the CBT model.

   CMHCM has undergone several changes in FY20 to our training protocols to build on one of our core practices, Cognitive Behavior Therapy (CBT). Through a training program with the Beck Institute (known for Dr. Aaron Beck, one of the founders of CBT), CMHCM was able to provide training to all clinicians in FY20. Staff were trained first on the foundations of the CBT model, and then targeted CBT training was implemented for anxiety, depression, and suicide prevention. CMHCM was unable to finish the training curriculum planned for FY20, which would have included supervisors and CBT in groups, due to the inability to conduct in-person trainings due to COVID-19. The agency intends to pursue this opportunity when able as in-person training is preferable for this model.

2. Training curriculum will be developed by the COC for all clinical staff based on their role and the primary populations served.

   Training plans were reviewed by the Clinical Oversight Committee (COC) and a plan for determining training needs and capacity for clinical staff in each county was created, particularly around evidence-based practices. After Team-Based Care (TBC) is fully implemented, COC will begin work with Human Resources to finalize an updated training grid that will be reflective of TBC and individualized training plans for different positions.

3. Provision of comprehensive whole person wellness will occur by moving toward a team-based care model across CMHCM.

   CMHCM has also been actively pursuing implementation of a Team-Based Care (TBC) model. The agency is currently working with the National Council for consulting services to evaluate agency needs and proceed with staff restructuring into inter-disciplinary teams. In FY20, work plans were developed for both TBC and work on improving the case manager role, as well as updating our access process for more efficiency and better customer service. Focus groups were held to give staff the opportunity to give input into the process, and a communication plan was developed to assure staff have up-to-date information in relation to this agency change. Due to the considerable amount of change that TBC will create in team structure and processes, this goal will be continued into the next fiscal year.

E. Integrated Health

Integrated Health efforts remain a core strategic goal within CMHCM. Integrated Health efforts in FY20 focused on five initiatives.

Goals:

1. Establish and/or maintain routine communication with health leaders to discuss improved coordination, care gaps, and opportunities.

   Due to the current pandemic, communication with health leaders focused primarily on COVID-19 issues. Planning and collaboration occurred within the last six months to ensure a safe and healthy environment for both consumers and staff during the COVID-19 pandemic. Training with supervisors, case holders, and provider network occurred to address safety for all consumers as well as staff during the pandemic.

2. Partner with health systems on serving patients/consumers with high needs.

   CMHCM's Medical Director and Administrative Nurse met with Great Lakes Physicians Group to explore further partnerships and collaboration for shared consumers.

3. Develop electronic health record bridge with local health systems.

   A Continuing Care Document is ready to be deployed between CMHCM and Mid-Michigan Health, which will provide real time coordination of care. The same technology can be transferred to the other health systems using the Electronic Medical Record (EMR), EPIC.

4. Continue to develop and implement an integrated health dashboard for staff.

   Direct lab feeds from Great Lakes Health Connect have been enabled to CMHCM's EMR, CIGMMO. The Integrated Health Team is now working on enabling data elements to automatically populate the integrated health dashboard.

5. Continue to implement training of RNs, Care Managers, and case holders on the fundamentals of behavioral health interventions to improve physical health outcomes.

   Care Managers continue to coordinate with local primary care providers on high needs consumers. There are currently complex care managers covering five out of six CMHCM counties. These care managers follow consumers to coordinate communication and care between providers, PHCPs, and also open the consumer to one-on-one contact if additional coordination is necessary for integrated health care needs. CMHCM continues to work on advocating for the health of its consumers so that they can lead and live healthy and fulfilled lives. All 18 nurses including the care managers have attended a two-day training on Care Coordination, trained by the Michigan Center for Clinical Systems Improvement (Mi-CCSI). The nurses also attended disease management specific trainings with Mi-CCSI.

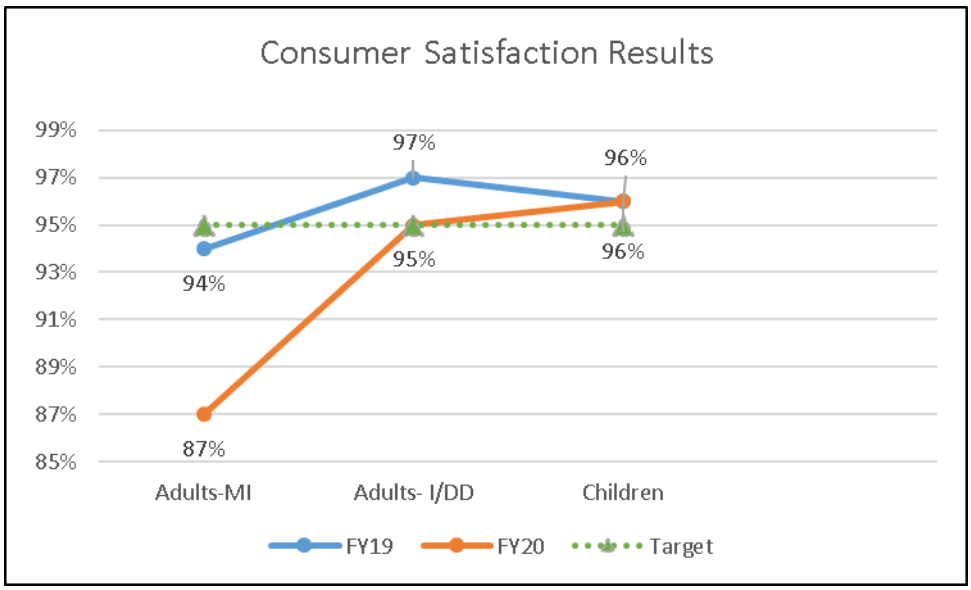
F. Quantitative and Qualitative Assessment of Member Experiences

Goals:

1. Meet or exceed 95 percent satisfaction during the annual survey. This will be measured by consumer response to the question, "Overall, I am satisfied with the services I receive."

   Consumers of CMHCM services completed satisfaction surveys in July of 2020 as a part of annual efforts to assess ongoing consumer satisfaction with clinical services returning a satisfaction rate of 88 percent. To ensure consumer and case holder safety during the COVID-19 pandemic, surveys were distributed using two methods: electronically using the application, Survey Monkey (for those that CMHCM had a valid email address for), and via mailed surveys for those consumers without email addresses. Surveys were distributed on July 1, 2020, for completion by July 31st for all consumers who attended services over the course of June 1- June 30, 2020. Return rates utilizing Survey Monkey and mailing were significantly lower in 2020 (ranging from 6 to 20 percent for the populations surveyed) compared to satisfaction surveys returned in 2019 (which had a return rate range of 15 to 49 percent) when surveys were handed out at face-to-face appointments to consumers.

   The three primary populations surveyed are summarized in the chart below. While there was a decrease in satisfaction scores overall for FY20, the results of the surveys indicate continued satisfaction for consumers accessing services for children and families at CMHCM.



2. Consumer feedback/satisfaction will be sought in a minimum of 50 percent of clinical service contacts.

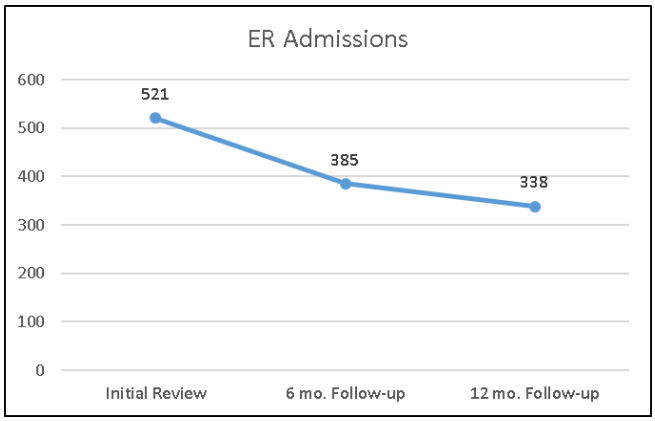
   Individual progress notes prompt staff to ask whether there was satisfaction with services rendered after each service. For fiscal year 2020, data indicates that consumer feedback/satisfaction was sought in 42% of clinical service contacts. Modifications were made during the year for exceptions based on whether the service was a crisis contact or a non face-to-face contact. The prevalence of telehealth services during the COVID-19 pandemic may have impacted staff seeking consumer feedback/satisfaction after a telehealth service.

G. Utilization Management (UM)

Goals:

1. Decrease Emergency Department (ED) visits for individuals with high ED utilization by 25 percent over FY19.

The Clinical Review and Consultation Team (CRCT) continues to meet to review consumers that are high utilizers of emergency departments, inpatient units, and Crisis Team contacts. Since implementation in FY17, six and twelve-month follow-up data which is available for 102 consumers indicated that between initial review and follow-up, ER admissions decreased by 26.1 at the six- month mark and 35.2% at the 12-month mark.



For FY20, the Committee has been shifting its focus to review cases that are requested by a member of the CMHCM treatment team, reviewing lengthy inpatient psychiatric admissions, and reviewing cases where the individual has had inpatient psychiatric unit or crisis residential unit recidivism. This shift was due to CRCT finding that the majority of consumers had already been reviewed who had over 20 cumulative contacts (between emergency department visits, inpatient admissions, and crisis contacts) within the past 180 days. For FY20, CRCT has reviewed 66 individuals, 38/66 (57.6 percent) of those consumers have been referred to the Committee by a member of the treatment team instead of from review of Admissions, Discharge, and Transfer (ADT) data. In comparison, in FY19 the committee reviewed 85 cases and 19/85 of those consumers (22.4 percent) were referred by a member of the treatment team. This is evidence of an increased culture shift of agency staff in adopting integrated healthcare interventions.

2. <u>Reduce inpatient psychiatric readmission rates within 30 days of discharge by one percent over FY19.</u>

The utilization manager continues to conduct a monthly retrospective review of consumers who have been re-admitted to the hospital within 30 days of their previous hospital discharge. Quarterly inpatient psychiatric readmission rates for FY2019 and FY2020 are as follows:

	# of discharges from psychiatric inpatient care during this reporting period	# of discharges readmitted to the psychiatric unit within 30 days of discharge	Percentage (%)
1st Qtr.			
FY19	96	6	6.25%
FY20	111	7	6.31%
2nd Qtr.			
FY19	87	6	6.90%
FY20	99	6	6.06%
3rd Qtr.			
FY19	90	8	8.89%
FY20	89	7	7.87%
4th Qtr.			
FY19	88	14	15.91%
FY20	129	13	10.08%
Total			
FY19	**361**	**34**	**9.42%**
FY20	**428**	**33**	**7.71%**

The target percentage to be below for psychiatric admission recidivism is 15.0%, and each quarter of FY20 CMHCM was well below this standard. Additionally, when comparing inpatient psychiatric recidivism in FY20 and FY19, there were 67 more inpatient hospitalizations in FY20; however, inpatient psychiatric readmissions decreased by 1. This is due, in part, to a continued emphasis on engagement into outpatient treatment services following inpatient psychiatric hospital discharge.

3. Reduce all-cause hospitalization readmission rates by one percent over FY19.

   The All-Cause Hospital Readmissions measure quantifies the percentage of individuals that are readmitted to the hospital within 30 days of discharge from a hospitalization (which includes both psychiatric and medical admissions). Data indicates all-cause readmissions decreased to 7.86 percent in FY20 from 8.95 percent in FY19 further demonstrating CMHCM's culture shift in integrated healthcare. CMCHM performs well in this area for all-cause readmissions by being below the MSHN regional target of 10 percent, the most recent Michigan average from 2018 of 14.56 percent, and the most recent national Medicaid average from 2016 of 13.70 percent. Integrated health initiatives, including a more in-depth focus on team-based care and population health, as well as CRCT initiatives will continue throughout FY21 in an effort to decrease the overall percentage of all-cause hospital readmissions.

H. Cultural Competence

CMHCM demonstrates an ongoing commitment to diversity through our continued development of cultural and linguistic competence for staff to better provide services to a variety of individuals from diverse backgrounds regardless of their race, culture, religious beliefs, gender, gender identification, sexual orientation, marital status, education, employment, and economic factors, to name a few.

Staff are trained on an annual basis through Relias Learning on how to provide culturally and linguistic competent care to the consumers CMHCM serves. This training includes how to understand and respect differences amongst a variety of cultures, how to apply an understanding of the relationships of language and culture to the delivery of services, and how to identify stigma and marginalization within the workplace. In addition to Cultural Competence training, additional training for "Understanding Unconscious Biases" and "Overcoming Your Own Unconscious Biases" training was added to the CMHCM curriculum for FY20.

IV. Provider Network Management

A. Provider Network Monitoring

Goals:

1. Achieve 90 percent documentation compliance with service documentation requirements.

   The Provider Network department at CMHCM continues to monitor provider compliance with service documentation requirements. In FY20, the overall percentage of compliance for service documentation was 89 percent. The two primary areas of issue with documentation compliance included a lack of documentation for the level of assistance the consumer was provided by direct care workers (DCWs) as well as DCWs documenting Adult Home Help tasks on Community Living Support documentation when this is not an authorized service through CMHCM. The Provider Network Department will continue to work with providers to appropriately document the level of assistance the consumer needed to complete activities of daily living and instrumental activities of daily living. Additional training and work will occur with the providers to ensure that DCWs are appropriately differentiating between Community Living Supports and Adult Home Help tasks to make a clear distinction in the services being provided within the documentation submitted.

2. Achieve 90 percent provider compliance with staff training requirements.

   Provider compliance with staff training requirements for FY20 was 87 percent. This goal was not met due to providers allowing training dates to lapse. Additional work is being completed within the Provider Network Department to work with providers on a tracking mechanism to ensure that trainings do not expire. Provider Network staff will also continue to work with providers on education around the minimum trainings required for staff to perform the services that they are contracted for.

3. Improve compliance with the MSHN Medicaid Event Verification (MEV) audit for Autism services to 75 percent.

   There were substantial improvements in FY20 around compliance for the Autism program for compliance metrics with the Mid-State Health Network MEV audit. The compliance percentage for FY20 was 96 percent. There was an ongoing identified issue during reviews with the Autism providers, and this is around providers lacking the follow-up on ensuring that staff trainings are up to date. Provider Network will continue to work with Autism providers on documentation and training requirements for the provision of Autism services to CMHCM consumers.

4. Increase the number of Board-Certified Behavior Analysts (BCBAs) available to conduct Autism testing.

   There was an addition of 11 Board-Certified Behavioral Analysts to the CMHCM provider network in FY20. There continues to be difficulty in recruiting and maintaining BCBAs across the state of Michigan. Ongoing efforts on recruiting BCBAs will continue in the future to develop additional BCBA contracts.

5. Develop and implement a provider network audit module to improve provider monitoring within CIGMMO.

   An audit module was developed and implemented within FY20 to improve provider monitoring of compliance standards within the CMHCM electronic medical record system.

6. Implement a statewide standardized residential site review tool in conjunction with MSHN for increased reciprocity.

   A statewide standardized residential site review tool was developed in FY20 and has been implemented for CMHCM site reviews for the provider network as a whole to increase reciprocity of compliance reviews as well as standardizing this process overall.

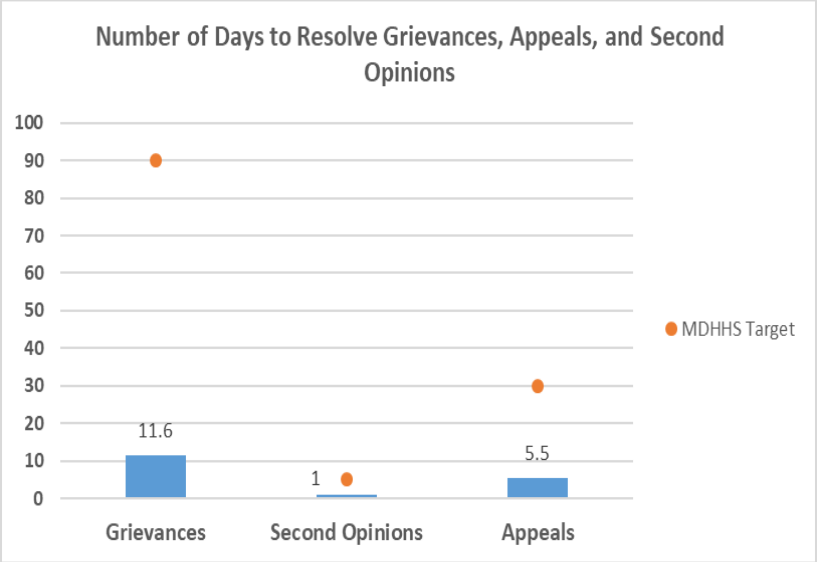
V. Quality Management

A. Customer Service

Goals:

1. The number of days to resolve a grievance is lower than the MDHHS standard of 90 days.
2. The number of days to resolve a local appeal is lower than the MDHHS standard of 30 days.
3. The number of days to resolve a second opinion is lower than the MDHHS standard of five days for service access requests.
4. The number of days to resolve a second opinion is lower than the MDHHS standard of three days for hospitalization requests.

CMHCM processed a total of 17 unique individual requests for grievances, appeals, second opinions, or State Fair Hearings during FY20. During the year, eight grievances were submitted and resolved. For the two local appeals, both were upheld. Of the seven second opinions requested, three were upheld, two were overturned, one was withdrawn, and one was classified as "other". There were no requests for appeals relating to the Family Subsidy Support program. There was one request for a state fair hearing during this fiscal year; however, this case is still pending State Fair Hearing due to COVID-19 restrictions.



All CMHCM Customer Service goals were achieved this year to reduce the number of days to resolve a grievance, second opinion, and local appeal. The average number of days to resolve a grievance was 11.6 days (which is well below the MDHHS standard of 90 days). The average number of days to resolve a local appeal was 5.5 days which is below the MDHHS standard of 30 days. There were no requests for second opinions relating to service access requests. The average days to resolve a second opinion for hospitalization was one day which is lower than the MDHHS standard of five days.

B. Mystery Shopper

In addition to consumer satisfaction surveys, CMHCM also completes Mystery Shopper activity on an annual basis to evaluate consumer experiences within the agency. In FY20, the Mystery Shopper completed phone calls to the six CMHCM offices, targeting staff knowledge of and the ability to provide information on the CMHCM resources for language assistance for anyone seeking services where English is not their first language.

Goal: Achieve 100 percent customer service rating from the Mystery Shopper survey.

An overall score of 100 percent was achieved. The Mystery Shopper initiated calls during normal business hours and 11 elements were evaluated related to the call being courteous, professional, and providing the accurate response to the requested information. All calls resulted in the requested language assistance information being provided. Feedback and comments for the overall calling experience were shared with the Office Managers.

C. Performance Improvement Project (PIP)

CMHCM supports two PIPs with data submission and intervention implementation as requested and determined by the MSHN Quality Improvement Council (QIC) of which CMHCM is a member.

Goals:

1. Consumers with schizophrenia and diabetes who had an HbA1c and LDL-C test during the report period is the PIP topic selected by MSHN. The goal of this PIP is to ensure that adult consumers with schizophrenia and diabetes receive both the HbA1c and LDL-C tests annually to ensure ongoing monitoring of an existing health condition. FY20 data will be compared to baseline data collected during FY19 with the goal to increase the number of annual screenings for this population.

   The primary PIP for the three-year project is Diabetic Monitoring. The goal of this PIP is to ensure that adult consumers with a schizophrenia and diabetes diagnosis receive annual screenings for diabetes and cholesterol (specifically HbA1c and LDL tests). Interventions to increase the number of annual screenings for this population were identified in June of 2019 by the MSHN QIC and were approved by the Health Services Advisory Group (HSAG) for implementation in calendar year 2020. Of note, these metrics are by calendar year rather than fiscal year. The below table shows the progress that has been made from the baseline collection year (calendar year 2018) to the first quarter of calendar year 2020. CMHCM has met the goal of 36.4 percent for this PIP. Additionally, interventions have been implemented in calendar year 2020 which will continue to increase compliance in this area including a transportation resource document that is available for consumers within the lobbies, as well as an ongoing review of care alerts on a monthly basis to determine who has not had labs completed for coordination of care by care managers and nurses.

Organization	Baseline CY18	Goal CY19	1st Remeasurement CY19	CY20 Goal	Progress Monitoring CY20Q1
MSHN	**33.64%**	**35.99%**	**34.0%**	**36.4%**	**39.63%**
BABH	32.04%	**35.99%**	34.3%	**36.4%**	**41.56%**
CEI	30.69%	**35.99%**	26.8%	**36.4%**	**24.85%**
CMHCM	31.30%	**35.99%**	31.7%	**36.4%**	**36.52%**
GIHN	40%	**35.99%**	23.5%	**36.4%**	**55.56%**
HBH	26.67%	**35.99%**	38.5%	**36.4%**	**30.77%**
The Right Door	33.68%	**35.99%**	37.9%	**36.4%**	**100.00%**
LifeWays	39.29%	**35.99%**	44.4%	**36.4%**	**57.69%**
MCN	40%	**35.99%**	33.3%	**36.4%**	**73.91%**
NCMH	32.52%	**35.99%**	36.8%	**36.4%**	**35.29%**
Saginaw	52.94%	**35.99%**	40.0%	**36.4%**	**34.32%**
Shiawassee	41.67%	**35.99%**	22.2%	**36.4%**	**35.71%**
TBHS	53.33%	**35.99%**	57.7%	**36.4%**	**85.71%**

2. The Recovery Assessment Scale (RAS) surveys (Administrator, Provider, and Consumer) were selected by MSHN for the second PIP and will take place over a three-year period. The RAS survey is a nationally-recognized tool used to measure recovery for consumers with a mental illness. CMHCM will submit survey data as requested by MSHN for analysis. CMHCM will also analyze the data to identify areas for improvement within the agency.

   The secondary PIP is completion of the Recovery Self-Assessment (RSA). The RSA surveys selected for FY20 targeted administrators and providers within CMHSPs to assess the degree to which CMHCM implemented recovery-oriented practices for consumers with mental illness and/or co-

occurring substance use disorders. Along with other MSHN Community Mental Health Service Programs (CMHSPs), surveys were sent out and completed during June of 2020. Data aggregation and analysis occurred at the MSHN level for the two survey types: the RSA-R Provider Version and the RSA-R Administrator Version (completed by CMHSPs and SUD providers). Scores above 3.50 indicate satisfaction or agreement within each subcategory of the RSA:

	Provider Assessment		Administrator Assessment	
	2019	2020	2019	2020
Comprehensive Score	4.18	4.27	4.24	4.25
Involvement - Subcategory	3.55	3.70	3.78	3.80
Individually Tailored Services - Subcategory	4.10	4.18	4.26	4.22
Diversity of Treatment - Subcategory	4.17	4.22	4.19	4.20
Life Goals Sub-Category	4.28	4.36	4.34	4.34
Choice - Subcategory	4.47	4.56	4.55	4.56
Inviting - Subcategory	4.46	4.52	4.59	4.67

Interventions and quality improvement efforts for FY21 will be targeted toward below average scores on specific questions with scores lower than 3.50 as identified by regional and CMHCM data. Priority areas for regional interventions will be determined by the MSHN Quality Improvement Council (QIC), the Regional Consumer Advisory Council, and the SUD Provider Network. Effectiveness of the improvement initiatives will be determined as an increase in the regional average for the targeted areas. CMHCM scores will be reviewed to target scores lower than 3.50, and interventions will be determined by the Clinical Oversight Committee. Effectiveness of the improvement initiatives will be determined as an increase in CMHCM's average for the targeted areas in FY21.

D. Performance Measurement

CMHCM uses the Michigan Mission-Based Performance Indicator System to evaluate organizational performance on access and performance outcomes. Five measures were collected and submitted to MDHHS and MSHN each quarter of FY20. Standards are set by MDHHS for each indicator and its applicable population group. In April of FY20, new indicators and background logic changes were developed and implemented by MDHHS to eliminate the ability to categorize events as exceptions to the overarching performance measure for indicators 2 and 3. The intention of this change is to get accurate numbers and reasoning as to why individuals are not being assessed within 14 days of a request for service, and within 14 days of an assessment for a first service. With this change came the elimination of standards for these indicators, and the remainder of FY20 is designated for baseline data collection to develop each standard threshold by MDHHS.

Goals:

1. Achieve or exceed the 95 percent standard for adults and children receiving pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.
2. Achieve or exceed the 95 percent standard for consumers who meet with a professional for an intake assessment within 14 days of request for service. `
3. Achieve or exceed the 95 percent standard for consumers who have a first service within 14 days of intake assessment.
4. Achieve or exceed the 95 percent standard for consumers discharged from a psychiatric inpatient unit who are seen for follow-up care within seven days.
5. Compliance equal to or less than the 15 percent for consumers readmitted to an inpatient psychiatric unit within 30 days of discharge.

CMHCM met or exceeded all standards for the first through third quarters of FY20 (fourth quarter data will not be finalized until mid-November and, therefore, is not included in this data).

	Performance Measure *CMHSP Data Report*	Population	MDHHS Std	1Q FY20	2Q FY20	3Q FY20
ACCESS	**Indicator #1**: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for which the disposition was completed within three hours.	Children Adult	≥95% ≥95%	100% 100%	100% 100%	100% (54/54) 100% (341/341)
	Old Indicator #2 (exceptions allowed): The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergent request for service.	MI Child MI Adult I/DD Child I/DD Adult All Populations	≥95% ≥95% ≥95% ≥95% ≥95%	98.3% 99.4% 100% 100% 99%	99.53% 99.77% 100% 100% 99.71%	
	New Indicator #2a: The percentage of new persons during the period receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service.	MI Child MI Adult I/DD Child I/DD Adult All Populations	No Standard, MDHHS Baseline Year			79.59% (78/98) 79.56% (218/274) 100% (9/9) 100% (6/6) 80.36% (311/387)
	Old Indicator #3 (exceptions allowed): The percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional.	MI Child MI Adult I/DD Child I/DD Adult All Populations	≥95% ≥95% ≥95% ≥95% ≥95%	97.5% 98.6% 100% 100% 98.2%	97.25% 99.22% 95.83% 100% 98.5%	
	New Indicator #3: The percentage of new persons during the Period starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment.	MI Child MI Adult I/DD Child I/DD Adult All Populations	No Standard, MDHHS Baseline Year			88.76% (79/89) 72.29% (180/249) 66.67% (6/9) 85.71% (6/7) 76.55% (271/354)
	Indicator #4a: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days.	SED Children All Others	≥95% ≥95%	100% 97.4%	100% 98.63%	100% (11/11) 100% (75/75)
OUTCOMES	**Indicator #10:** The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge (# of consumers readmitted).	SED Children All Others	≤15% ≤15%	0% (0) 6.31% (7)	0% (0) 6.82% (6)	9.09% (1/11) 7.87% (7/89)

E. Program Evaluations

Goal: A clinical program evaluation dashboard will be implemented to provide outcome metrics to COC, Management, and the Board on key performance indicators within each service program identified for program evaluation.

A clinical program evaluation dashboard was developed and implemented for the following programs in FY20: Access, Assertive Community Treatment (ACT), Autism, Case Management/Supports Coordination, Clubhouse, Employment, Health Services, Home-Based, Jail Diversion, Outpatient, and the Personal Emergency Response Services (PERS) system. These evaluations were completed by the Quality department and reviewed by the Clinical Oversight Committee (COC) and Management teams. A report including an overview of the program, improvement opportunities, data, and recommendations was then presented to the Services Committee of the Board for all program evaluations completed.

Recommendations developed through the program evaluation process were delegated to the appropriate workgroups, committees, and staff for further action on quality improvement suggestions developed through review of the clinical programs.

F. Quality Assessment and Performance Improvement Program Annual Plan

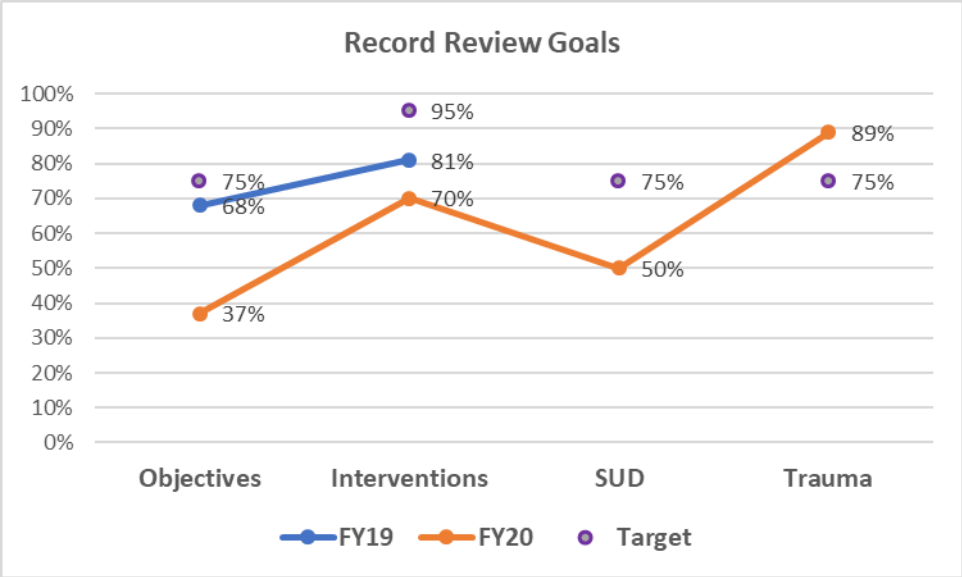
The FY21 QAPIP annual plan was developed in July 2020 and reviewed and was approved by CMHCM's Management Team and Board of Directors. The QAPIP plan highlights areas for quality improvement and includes measures to evaluate progress toward QAPIP and strategic plan goals over the next fiscal year.

G. Quality Record Review

The CMHCM qualitative record review tool now consists of 34 elements to assess compliance with external and internal agency standards. The Record Review tool was updated at the beginning of FY20 to include elements that were determined to be areas of need for staffing on documentation and follow-up. These compliance standards ensure that records meet clinical compliance as outlined by external auditing agencies such as The Joint Commission, MDHHS, and MSHN. In FY20, a total of 96 record reviews were completed for the first three quarters (10/1/2019 and 6/30/2020). Four record review elements were selected in FY20 for improvement. Results from the first three quarters are indicated in the chart below.

Goals:

1. Achieve or exceed 75 percent compliance for the record review element, "Are all objectives measurable?"
2. Achieve or exceed 95 percent compliance for the record review element, "Does the Intervention/Supports section of each goal explain the services that each provider is responsible to provide?"
3. Seventy-five (75) percent of consumer charts for an individual with a Substance Use Disorder (SUD) diagnosis will address SUD diagnosis in the IPOS.
4. Seventy-five (75) percent of consumer charts for an individual with a trauma diagnosis will address the trauma diagnosis in the IPOS.



In FY20, a new process was established for record reviews including only one individual completing those to establish intra-rater reliability and consistency for reviews of compliance with documentation. Due to this, it is difficult to make comparisons between FY19 and FY20 percentages for the above goals. In FY20, this reviewer completed targeted documentation compliance training with all new CMHCM clinical staff responsible for consumer charting. Due to compliance percentages not increasing over time for the established goals, additional training efforts are being developed for FY21 for training with current staff as well as new staff. With this new approach, targeting both new and current staff, it is anticipated that compliance standards will increase and that staff will have a greater understanding of record review elements and documentation standards for FY21.

H. External Quality Reviews

1. Michigan Department of Health and Human Services Waiver Review

MDHHS conducted a full review of the CMHCM waiver programs (Children with Serious Emotional Disturbances Waiver (SED-W), Habilitation Supports Waiver (HSW), and the Children's Waiver Program (CWP)) in July of 2020. CMHCM had several findings during this audit which resulted in a Corrective Action Plan (CAP) being submitted to MSHN for region-wide CMHSP CAP aggregation. Ongoing follow-up relating to these CAP measures will be completed upon request by MDHHS.

2. Mid-State Health Network Delegated Function Review

MSHN completed a remote desktop review for verification and follow-up of CMHCM's corrective action plan from the in-person delegated function review which occurred in May of 2019 along with new established standards. Review of the new standards resulted in several additional findings and recommendations related to agency policy as well as clinical service provision. CMHCM provided a CAP in July of 2020 which was approved by MSHN in August and will be verified next year during MSHN's in-person delegated function review to ensure that all compliance issues were effectively addressed.