QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

FY21 ANNUAL PLAN

Community Mental Health
FOR CENTRAL MICHIGAN

Quality Assessment and Performance Improvement Program

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FY21 Annual Plan

I. INTRODUCTION AND PURPOSE

Community Mental Health for Central Michigan (CMHCM) provides an array of behavioral health services and supports to individuals in the Michigan counties of Clare, Gladwin, Isabella, Mecosta, Midland, and Osceola counties through a network of direct operated programs and contracted service providers. CMHCM is a Michigan Department of Health and Human Services (MDHHS) certified Community Mental Health Service Program (CMHSP) and is accredited by The Joint Commission.

CMHCM places quality care for consumers at the core of its mission utilizing the Quality Assessment and Performance Improvement Program (QAPIP) Plan and Strategic Plan to advance its agency mission, vision, and values. The QAPIP and CMHCM Quality Assessment and Performance Improvement Program Policy (5.300.004) both support this focus through various quality improvement initiatives along with meeting the standards in the following documents:

1. MDHHS/CMHSP Managed Health Supports and Services Contract - Attachment C6.8.1.1
2. Mid-State Health Network (MSHN) Quality Management Policy and MSHN Quality Assessment and Performance Improvement Program
3. The Joint Commission Comprehensive Accreditation Manual

The CMHCM QAPIP "objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members, through quality assessment and performance improvement projects, and related activities, and pursues opportunities for improvement on an ongoing basis" for "all demographic groups, care settings, and types of services".[1] In addition, the agency collects, compiles, and analyzes data through the QAPIP program to improve organizational and service performance.[2]

II. SCOPE

The QAPIP defines how processes, systems, functions, and outcomes related to all consumers, staff, and service delivery provided by the agency directly or by contract through the CMHCM Provider Network is monitored and evaluated. The CMHCM QAPIP includes delegated functions of the Pre-Paid Inpatient Health Plan (PIHP) MSHN in support of the MSHN QAPIP.

III. ORGANIZATIONAL ELEMENTS AND ACTIVITIES

The agency encourages active involvement in the quality improvement process from all levels within the agency in addition to the involvement of consumers, families, advocacy groups, the community, the CMHCM Provider Network, and coordinated efforts through MSHN. The Board of Directors are responsible for approving the QAPIP Plan and the QAPIP Policy; the Executive Director carries out the annual QAPIP Plan; the Deputy Director for Administration is responsible for the QAPIP implementation; the Medical Director advises on the QAPIP Plan regarding clinical standards/practice guidelines; the Management Team implements performance improvement principles in all programs; direct service staff provide first-hand perspectives on improvement effectiveness and make suggestions for improvement; and subcontracting agencies offer suggestions for improvement. Subcontracting agencies carry out quality improvement efforts and performance activities within their own organizations.

A. Performance Improvement Committee (PIC) and the Management Team

The PIC and the Management Team provide oversight to the QAPIP. Agency standing committees and performance improvement teams provide reports on a regular basis to the assigned oversight committee.

[1] MDHHS/CMHSP FY20 Contract, Attachment C 6.8.1.1

[2] Joint Commission Standards: PI.01.01.01, PI.02.01.01, PI.03.01.01

Agency standing committees are responsible for performance improvement in their area of expertise. Standing committees are listed in Appendix A along with their charges. Each committee publishes minutes documenting its activities, quality improvement suggestions, findings, recommendations, and actions. Process improvements are adopted through PIC and Management Team and are communicated to the agency through published minutes as well as agency communications. The flow of quality information throughout the agency is outlined in the Quality Improvement Process located in Appendix B.

B. Performance Improvement (PI) Teams

PI teams are initiated and operated under the direction of an agency standing committee and the Executive Leadership Team (ELT). Teams meet on an ad hoc basis to address an assigned issue, agency process, or to design a new process, and may form workgroups to address specific components of more complex processes. The process and outcome improvements implemented by the PI teams are communicated at staff meetings, provider network updates, websites, through online/in-person trainings, and/or all staff email, as appropriate. The improvement process is monitored, as designed, under the direction of an agency committee or team and reported to the applicable oversight committee.

C. Performance Improvement System

Identified initiatives follow the various stages of the PI process through ongoing measurement and intervention based on a problem-solving model. The CMHCM QAPIP Policy (5.300.004) describes the model of design, measure, assess, and improve and is depicted in Appendix B. This model is incorporated in scheduled progress reports for quality initiatives.

PI initiatives are identified through various means such as by contract with MDHHS or MSHN; external review entities; QI suggestions from consumers, providers, and staff; QAPIP goal progress report recommendations; or CMHCM Strategic Plan initiatives. All demographic groups, care settings, and types of service are included in PI initiatives. These opportunities for improvement are prioritized by the ELT, Management Team, and/or PIC according to the severity of the issue, the impact on services and supports for consumers and agency operations.

Quality assessment and PI initiatives involve data analysis as applicable to support problem identification. Appropriate follow-up as related to either an individual case or systemic action includes communication with those involved, staff, Provider Network, or MSHN. The Quality Improvement Department tracks the progress of PI initiatives and suggestions. Additionally, performance indicators are monitored and compared to available benchmark statistics to identify additional opportunities for internal agency improvements.

D. Recipient Rights

CMHCM is committed to ensuring that all consumers are treated with respect, dignity, and consideration that acknowledges all of a consumer's rights and responsibilities. It is CMHCM Policy (7.100.006, Recipient Rights, General Administration, General Rights) to monitor and ensure that a recipient of mental health services has all of the rights guaranteed by state and federal law in addition to those guaranteed by the Mental Health Code. Procedures have been established to address complaints and appeals through the CMHCM Recipient Rights office. The Recipient Rights Department will monitor and evaluate substantiated Recipient Rights complaints to identify trends or patterns that occur to ensure that additional staff training is completed as necessary.

E. Adverse Event Management

Critical events, sentinel events, and other events that put people at risk of harm will be identified, reported, analyzed, and managed in an effort to understand root causes and identify opportunities for risk reduction.

The Sentinel Event Review Committee will review critical incidents, sentinel events, and develop action plans that minimize future occurrences on a quarterly basis. As necessary, root cause analyses are completed and risk reduction strategies are recommended to reduce the likelihood of recurrence. Event data will be submitted to MSHN for benchmark analysis and to MDHHS in fulfillment of critical incident reporting requirements. Timeframes for reporting are identified within the CMHCM Sentinel Event Policy (5.300.001).

IV. CMHCM QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT INITIATIVES

A. Clinical Services

CMHCM promotes community inclusion and whole-person wellness through the provision of comprehensive and quality integrated services to children and adults with an intellectual/developmental disability (I/DD), children with Serious and Emotional Disturbance (SED), and adults with a Serious and Persistent Mental Illness (SPMI) and co-occurring substance use disorder. The below goals represent priority areas for CMHCM which align with the 2021-2023 Strategic Plan.

Objectives:

1. Case Management contacts will increase by ten percent over FY20.
2. An open access model will be implemented for consumers to decrease the overall time from the request for CMHCM treatment at access to first service by five days compared to FY20.
3. Baseline data will be collected for outcome measurement for the MI and I/DD populations through adoption and implementation of the DLA20 screening tool in FY21.
4. Exploration of Recovery Coaches will take place to bring in these staff as part of the CMHCM clinical treatment teams in FY21.
5. Case holders will be trained on the charting the life course model for person-centered planning and incorporate this into the pre-planning process for consumers by the end of FY21.
6. The number of individuals with an I/DD diagnosis working in a competitive or integrated setting will increase by five percent over FY20.
7. Each Autism Center will host a minimum of two community outreach activities/events in FY21.
8. Youth Intervention Specialists will complete a minimum of ten presentations on the YIS program to increase youth referrals.
9. Training on the use of the Problematic Social Media Use screening will be completed with all children and youth staff in FY21.

B. Clinical Oversight

1. Behavior Treatment

The Behavior Treatment Policy (2.200.001) guides the administration of the Behavior Treatment Committee (BTC). The BTC submits quarterly reports to the PIC on data for intrusive or restrictive techniques that have been approved for use with consumers and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis. The BTC will also track patterns of incidents or interventions that suggest opportunities for improvement, planning, or training, and arrange for follow-up. This includes review of children on psychotropic medications who are not currently participating in an evidence-based practice (EBP) treatment or who have a positive support plan in place. The data will be submitted to MSHN on a quarterly basis for benchmark analysis. The PIC will review the report for improvement opportunities. The goals identified below will help the effectiveness of behavior treatment plans implemented for individuals receiving CMHCM services.

Objectives:

1. BTC will establish a review process for individuals with a primary I/DD designation with multiple antipsychotic medications.

2. BTC will focus on decreasing the overall percentage of children prescribed antipsychotic medication, when the medication is used to manage or control behavior or restrict freedom of movement and is not a standard treatment or dosage for the individual's condition, as compared to FY20.
3. Staff training on developing and monitoring behavior plans will occur for identified staff in each county in FY21.

2. Practice Guidelines

CMHCM utilizes practice guidelines based on the Medicaid Provider Manual, the MDHHS Waiver Program, and evidence-based practice (EBP) models. The Clinical Oversight Committee (COC) oversees the use of EBPs and also evaluates new EBPs for potential implementation. CMHCM voluntarily requests external fidelity reviews on EBPs to identify quality improvement opportunities.

Objectives:

1. A level of care grid and associated guidelines will be developed for case management based on consumer acuity.
2. A team-based treatment model will be adopted to improve care coordination, consumer access, and treatment outcomes in FY21.

3. Oversight of Individuals at Risk

CMHCM assures the health and welfare of its consumers by assuring that services are consistently provided in a manner that considers the health, safety, and welfare of consumers, family, providers, and other stakeholders. CMHCM reviews service provision data regularly to monitor adequacy of treatment approach for consumers based on medical necessity.

Objectives:

1. Criminal justice liaisons for each team will be identified and training on assessing for criminogenic factors will occur in FY21 with the goal of providing more targeted treatment interventions for consumers.
2. The number of consumers with active crisis plans will increase to 40 percent or more in FY21.

4. Integrated Health

CMHCM continues its efforts to integrate physical and mental health services with the goal of improving consumer health. The focus will be on the following to impact whole-person wellness and to increase partnerships with community health and primary care systems to improve consumer's physical health outcomes.

Objectives:

1. Care coordination documents from the three major health systems in the CMHCM region will be integrated into CMHCM's EMR in FY21.
2. Training will be provided to the three health systems on CMHCM roles and responsibilities.
3. Enhancement of the integrated health dashboard will take place to include real time lab data feeds.

5. Quantitative and Qualitative Assessment of Consumer Experiences

CMHCM assesses consumer satisfaction for those individuals receiving services through an annual survey, as well as from feedback obtained by the clinician during the course of a consumer's treatment. In addition, a post-service survey is sent to all discharged consumers to evaluate their satisfaction with the services and supports received. CMHCM, in conjunction with MDHHS, also participates in the National Core Indicators survey on an annual basis to provide additional satisfaction information for individuals receiving services for intellectual/developmental disabilities.

For the annual consumer satisfaction survey, adults with a mental illness, families of youth receiving services, and consumers or guardians of consumers with an intellectual/developmental disability are offered a survey which assesses satisfaction with CMHCM staff and services, as well as how services have impacted the consumer. As part of the survey process, consumers receiving Assertive Community Treatment (ACT) are surveyed using the Mental Health Statistical Improvement Program (MHSIP) survey and families of youth receiving home-based services are surveyed using the Youth Services Survey for Families (YSS-F). CMHCM will analyze the data from all survey results for trends and to identify opportunities for improvement.

Objectives:

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."
2. Consumer feedback/satisfaction will be sought in a minimum of 75 percent of regular clinical service contacts.

6. Utilization Management

Utilization Management (UM) practices are guided by the CMHCM Utilization Management Policy (2.400.001) that assures medically necessary services are delivered and provided in an appropriate amount, scope, and duration to provide individuals with the least restrictive, equitable, and most cost-effective service(s). The UM Department completes prospective, concurrent, and retrospective reviews of service utilization to monitor authorization decisions and congruencies regarding level of care determinations that are consistent with MSHN and MDHHS policies, standards, and protocols. Data analysis identifies areas where efficiencies/improvements may be made particularly in service areas that represent over or under utilization, exceed traditional/typical service use, require high level approval, cross several programs, and/or involve physical health care needs. The UM Department will utilize region-wide benchmarks to identify agency performance improvement opportunities.

Objectives:

1. Reduce inpatient psychiatric readmission rates within 30 days of discharge over FY20.
2. CMHCM compliance with medical necessity criteria for acute care services will meet the 95 percent standard for FY21.
3. An evaluation will be conducted of the agency's current Utilization Management structure and opportunities will be identified for efficiency and consistency of this function agency-wide.

C. Provider Network Management

The CMHCM Provider Network Management Department is responsible for maintaining the Provider Network to assure it is adequate and meets the needs of the consumers. CMHCM holds regular provider meetings with contracted service providers to discuss system issues, regulatory changes, process changes, and to garner feedback from providers on quality improvements. CMHCM assures appropriate access and choice of provider in concert with MSHN Provider Network adequacy efforts. The Provider Network is responsible for assuring that federal, state, and local regulations and requirements are met. When a deficiency is identified, providers complete a corrective action plan.

Provider scores are aggregated to identify opportunities for systemic improvement. The Provider Network is guided by the CMHCM Event Verification Policy (3.500.003) for event verification. CMHCM performs event verification on a sampling of all services provided according to this policy. MSHN performs a Medicaid Event Verification (MEV) review to verify that Medicaid services claimed by providers were authorized by CMHCM, delivered as described in the Individual Plan of Service (IPOS), and billed at the correct rate. CMHCM provides data and support as requested by MSHN to verify internal/external Medicaid claims/events.

Objectives:
1. Achieve 92 percent documentation compliance with service documentation requirements for CMHCM providers.
2. Achieve 92 percent provider compliance with staff training requirements for CMHCM providers.
3. Increase the number of TLLP, LLP, and LPs that provide autism testing over FY20.
4. Increase of the number of independent facilitators over FY20.
5. Implement electronic progress note documentation within the electronic health record for all licensed residential service providers.

D. Quality Management

1. Customer Service

Customer Service practices are guided by the CMHCM Customer Services Policy (5.300.002). Customer Service will handle all calls where a consumer expresses dissatisfaction and helps individuals understand their options when filing a grievance, appeal, or second opinion. Data will be collected and reported for grievances filed, appeals filed, second opinion requests, and state fair hearing requests along with the disposition. The customer service and denial of request for services data will be reported to MSHN quarterly for benchmark analysis. PIC will review aggregate trends on a semi-annual basis to determine any opportunities for improvement.

Objectives:
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.

2. Mystery Shopper

The internal Mystery Shopper program for FY21 will be in year two of the two-year cycle where a consumer will be trained to call and visit each CMHCM service location with specific scenarios to assess customer service. The agency will also participate in the Community Mental Health Association of Michigan Customer Service Workgroup Mystery Shopper Program to evaluate the consumer's experience. Other CMH Customer Service staff and/or consumers will call and evaluate CMHCM's quality of welcoming. Data is benchmarked against all CMH participants for improvements.

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

3. Performance Improvement Project (PIP)

CMHCM will support the two PIPs selected by MSHN with data submission and intervention implementation as requested and determined by the MSHN Quality Improvement (QI) Council.

Objectives:

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. FY21 data will be compared to measurement data collected during FY20 with the goal to increase the number of annual screenings for this population.
2. The Recovery Self-Assessment (RSA) surveys (Administrator, Provider, and Consumer) were selected by MSHN for the second PIP and will take place over a three-year period. The RSA survey assesses the degree to which CMHCM implements recovery-oriented practices for consumers with mental illness and/or co-occurring substance use disorders. 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.

4. Performance Measurement

Five MDHHS performance measures addressing access to services and outcome metrics are submitted quarterly to MDHHS and MSHN and are reviewed and reported to the PIC. Each measure is reported for adults with a mental illness, children with a serious emotional disturbance, and individuals with an intellectual/developmental disability. For FY21, MDHHS has updated data collection and methodology for two of the performance indicators; this update no longer allows for exceptions to be documented for outliers. Because of this, FY21 will be considered a baseline year with no target values set for Indicators #2a and #3.

Objectives:

1. Indicator #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. Indicator #2a: Collect baseline data for consumers who meet with a professional for an intake assessment within 14 days of request for service.
3. Indicator #3: Collect baseline data for consumers who have a first service within 14 days of their intake assessment.
4. Indicator #4a: 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. Indicator #10: Compliance equal to or less than 15 percent for consumers readmitted to an inpatient psychiatric unit within 30 days of discharge.

5. Program Evaluations

Program evaluation principles are employed by CMHCM to assure the ongoing assessment of the quality of clinical services that are provided to consumers. The program evaluation process is a systematic method for collecting, analyzing, and using qualitative and quantitative data to review clinical service programs including their effectiveness, efficiency, consumer access, and consumer satisfaction with the service.

Objective: A clinical program evaluation dashboard will be utilized to provide analysis and comparison between FY19 and FY20 outcome metrics on key performance indicators to COC, Management Team, and the Board Services Committee within each service program identified for program evaluation.

6. Quality Assessment and Performance Improvement Program (QAPIP) Annual Plan

The Quality Improvement Department will identify performance improvement projects for the coming year with input from PIC, ELT, Management Team, and MSHN initiatives to develop the FY22 QAPIP Annual Plan. The annual plan will be submitted to the Board of Directors for final approval.

Objective: Prepare and review the FY22 QAPIP Plan in August 2021 for Board approval in September 2021.

7. Quality Record Review

The CMHCM record review process involves a stratified random selection for review of staff's clinical consumer charts. Four critical elements that are consistent with agency priorities were identified to continue in FY21 to compare to FY20 data which was a baseline collection year for a new process implemented by the Quality Department for increased reliability. In FY20, a focus was placed on new staff entering into the CMHCM system, in FY21, this process will continue with additional training being provided for current clinical staff to ensure compliance standards are met. Interventions will be developed and implemented to increase compliance in each of the following priority areas that are not meeting the below goal percentages:

Objectives:

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 individuals with a co-occurring Substance Use Disorder (SUD) diagnosis will address SUD diagnosis in the IPOS.
4. Seventy-five (75) percent of consumer charts for individuals with a trauma diagnosis will address the trauma diagnosis in the IPOS.

CMHCM AGENCY STANDING COMMITTEES

Behavior Treatment Committee

Charge: The Behavior Treatment Committee oversees the provision of behavior services at CMHCM and provides a forum for: 1) review and approval or disapproval of behavior treatment plans which include intrusive or restrictive behavioral interventions, 2) review of behavior treatment progress reports, including behavior and intervention data, to determine whether an approved plan should be continued, discontinued, or revised, and 3) review of all incident reports describing emergency use of physical management, PRN medication, and involvement of law enforcement. The purpose of the oversight activities of the Behavior Treatment Committee is to assure that recipients receive high quality services within a culture of gentleness, utilizing best practices in the field of behavior treatment, that applicable regulatory requirements and agency policies are consistently applied, and that recipients are afforded due process and protection of their rights as specified in the Michigan Mental Health Code.

Meeting Times: Monthly, fourth Thursday, 1:30 p.m.

Children's Services Committee

Charge: To guide agency practices of services and supports for children and families that embodies the principles of a family-driven/youth-guided philosophy.

Meeting Times: Monthly, Fourth Wednesday, 1:00 p.m.

CIGMMO Committee

Charge: To oversee the ongoing updates and maintenance of the Electronic Medical Record (EMR) to fulfill contract and accreditation requirements and facilitate clinically and fiscally sound practice.

Meeting Times: Monthly, second Tuesday, 8:30 a.m.

Clinical Oversight Committee

Charge: To evaluate current clinical practice for efficacy and sustainability agency-wide and to provide oversight and guidance on quality of service delivery to improve outcomes.

Meeting Times: Monthly, first Thursday, 1:00 p.m.

Consumer Action Committee

Charge: The Consumer Action Committee will serve as a forum for consumers to exercise leadership and support advocacy endeavors on mental health issues.

Meeting Times: Monthly, second Wednesday, 1:30 p.m.

Credentialing Committee

Charge: To provide for the development, implementation, and ongoing review of the CMHCM credentialing and privileging process and to make recommendations regarding provider applications for clinical privileges.

Meeting Times: As needed.

Executive Leadership Team

Charge: To establish policy direction and strategic outcomes.

Meeting Times: Semi-monthly, Thursdays, 8:30 a.m.

Management Team

Charge: To provide leadership, direction, and management of resources to enable staff to achieve the mission of the agency while adhering to the values established by the Board.

Meeting Times: Semi-monthly, first and third Wednesdays, 9:30 a.m.

Office Managers Committee

Charge: To share information and to review and coordinate implementation of agency policies and procedures to assure efficient and consistent office operations in the six county offices of the agency.

Meeting Times: Monthly, second Tuesday, 1 p.m.

Performance Improvement Committee

Charge: To advance and improve services for consumers through the philosophy and process of Quality Improvement.

Meeting Times: The Committee meets on the fourth Wednesday at 9:30 a.m. in November, February, May, August, September, and October

Residential Review Committee

Charge: The Residential Review Committee is a resource and support for staff by reviewing existing resources, monitoring utilization, anticipating needs and demands for future placements, and educating staff when needed on compliance standards for state laws, licensing rules and regulations, foster care practices, as well as, industry best practice standards.

Meeting Times: Monthly, fourth Friday, 8:30 a.m.

Safety Committee

Charge: To promote consumer safety, safe employee work practices and a healthful environment in support of MDHHS, the Joint Commission, and other regulatory standards.

Meeting Times: Quarterly, second Tuesday, 10 a.m.

Sentinel Event Review Committee

Charge: To identify and respond appropriately to all sentinel events occurring in the organization or associated with services that the organization provides or provides for.

Meeting Times: As needed.

Standards Compliance Committee

Charge: To identify, interpret, and ensure compliance of external regulations, rules, and standards.

Meeting Times: Bi-monthly, first Wednesday, 9 a.m.

Super Management Team

Charge: To provide leadership, direction, and management of resources to enable staff to achieve the mission of the agency while adhering to the values established by the Board.

Meeting Times: Quarterly, third Wednesday, 9:00 a.m.

Appendix B – Quality Improvement Process