SHIAWASSEE Health & Wellness

Annual Summary Report 2020

Quality Assessment and Performance Improvement Plan (QAPIP) Summary

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I. Overview

The Performance Improvement Program works with all CMHSP departments to ensure that the standards required by MDHHS are communicated, measured, and reported upon. These standards are found in the MDHHS/CMHSP Managed Mental Health Supports and Services Contract FY2019. The standards reflect the principles of exemplary clinical and operational aspects of care. They are reviewed and amended as needed to ensure alignment with the unique needs and requirements of the populations served by CMHSP's.

The PI Program maintains an annual Quality Assessment and Performance Improvement Plan (QAPIP). The QAPIP fulfills the requirements set forth by MDHHS and also achieves compliance with other accrediting and regulatory bodies (e.g., local, state, or federal statutes).

The following Summary Report encompasses the quality and performance related initiatives completed by SHW during the 2020 Fiscal Year. Any areas in which performance fell below the required threshold were addressed by the implementation of corrective action plans. The creation of a corrective action plan is a collaborative process between organizations and departments and allows for a complete examination of factors across the system that contribute to performance below the set standard. These plans are monitored for ongoing compliance by the PI Program.

II. Goals

1. SHW will provide individuals seeking treatment timely access to care and services.

- The Michigan Mission Based Performance Improvement Indicator System (MMBPIS), evaluates several key factors related to the timeliness of provided services. Shiawassee is required to demonstrate compliance with the MMBPIS Key Performance Indicators as defined in the MDHHS/PIHP Contract.

Figure 1: MMBPIS

Michigan Mission Based Performance Indicator 1: The percent receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.	**Standard**	**FY20Q1**	**FY20Q2**	**FY20Q3**	**FY20Q4**	**Recommendation**
MSHN Medicaid children	**95%**	98.60%	99.51%	99.19%	98.57%	
SHW Medicaid children	**95%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**Continue**
MSHN Medicaid adult	**95%**	99.17%	98.71%	99.44%	99.16%	
SHW Medicaid adult	**95%**	**97.65%**	**100.00%**	**100.00%**	**100.00%**	**Continue**

Michigan Mission Based Performance Indicator 2: The percent of new Medicaid beneficiaries receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.	Standard	FY20Q1	FY20Q2	FY20Q3	FY20Q4	Recommendation
MSHN - Total	**95%**	98.52%	98.11%	75.52%	71.69%	
SHW - Total	**95%**	**98.81%**	**100%**	**81.97%**	**84.55%**	**Continue**
MSHN MI-C	**95%**	98.04%	97.83%	79.72%	76.93%	
SHW MI-C	**95%**	**96.67%**	**100%**	**87.50%**	**82.76%**	**Continue**
MSHN MI-A	**95%**	98.41%	98.09%	74.15%	69.25%	
SHW MI-A	**95%**	**100%**	**100%**	**80.00%**	**83.78%**	**Continue**
MSHN IDD-C	**95%**	95.58%	93.04%	69.05%	68.56%	
SHW IDD-C	**95%**	**100%**	**N/A**	**100%**	**100%**	**Continue**
MSHN IDD-A	**95%**	98.78%	97.22%	81.13%	78.72%	
SHW IDD-A	**95%**	**100%**	**100%**	**100%**	**N/A**	**Continue**
Michigan Mission Based Performance Indicator 3: The percent of new Medicaid beneficiaries' new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional.	**Standard**	**FY20Q1**	**FY20Q2**	**FY20Q3**	**FY20Q4**	**Recommendation**
MSHN - Total	**95%**	95.64%	95.03%	75.57%	75.33%	
SHW- Total	**95%**	**100%**	**100%**	**84.44%**	**86.21%**	**Continue**
MSHN MI-C	**95%**	95.36%	94.97%	70.83%	71.90%	
SHW MI-C	**95%**	**100%**	**100%**	**87.50%**	**91.30%**	**Continue**
MSHN MI-A	**95%**	93.58%	93.01%	77.61%	76.80%	
SHW MI-A	**95%**	**100%**	**100%**	**85.29%**	**82.46%**	**Continue**
MSHN IDD-C	**95%**	90.79%	89.00%	71.74%	78.49%	
SHW IDD-C	**95%**	**100%**	**N/A**	**50.00%**	**100%**	**Continue**
MSHN IDD-A	**95%**	86.36%	92.86%	76.74%	74.03%	
SHW IDD-A	**95%**	**100%**	**100.00%**	**100%**	**N/A**	**Continue**
Michigan Mission Based Performance Indicator 4: The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days.	**Standard**	**FY20Q1**	**FY20Q2**	**FY20Q3**	**FY20Q4**	**Recommendation**
MSHN Child	**95%**	98.28%	98.64%	98.17%	97.30%	
SHW Child	**95%**	**100%**	**100%**	**100%**	**100%**	**Continue**

MSHN Adult	**95%**	95.14%	95.92%	96.77%	98.51%	
SHW Adult	**95%**	**100%**	**100%**	**100%**	**100%**	**Continue**
Michigan Mission Based Performance Indicator 10: The percent of MI and IDD children/adults readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days (Old Indicator #12)	**Standard**	**FY20Q1**	**FY20Q2**	**FY20Q3**	**FY20Q4**	**Recommendation**
MSHN MI and IDD children	**15%**	4.35%	5.97%	16.06%	7.45%	
SHW MI and IDD children	**15%**	**0%**	**0.00%**	**0.00%**	**14.29%**	**Needs Action**
MSHN MI and IDD adults	**15%**	11.59%	10.06%	14.30%	13.98%	
SHW MI and IDD adults	**15%**	**10.53%**	**9.09%**	**31.58%**	**17.65%**	**Needs Action**

In April 2020, MDHHS implemented significant changes to Indicator 2 and Indicator 3. MDHHS had planned to collect baseline data with these new changes and then set a standard of compliance. To date, this standard has not been set. SHW staff has been collecting and analyzing data related to Indicator 2 and Indicator 3.

Indicator 2: The percent of new Medicaid beneficiaries (new persons) receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service.

Data Analysis: Overall, SHW has been performing in line or above average for MSHN for the Child and Adult populations. SHW staff has identified that a majority of the cases that fall out-of-compliance were the result of consumers not showing up for their appointments. Because the changes implemented in April 2020 do not have a formal target set yet, SHW will continue to monitor and review.

Indicator 3: The percent of new Medicaid beneficiaries (new persons) starting any needed on-going service within 14 days of a non-emergent assessment with a professional.

Data Analysis: Overall, SHW has been performing comparable to the average for MSHN for the Child and Adult populations. SHW staff has identified that a majority of the cases that fall out-of-compliance were the result of consumers not showing up for their appointments. Because the changes implemented in April 2020 do not have a formal target set yet, SHW will continue to monitor and review. **Improvement Opportunities**: SHW has identified a need for ongoing education related to Indicator 3 and how to appropriately document attempts to schedule appointments.

Indicator 10: The percent of SMI (severe mental illness) and IDD (intellectual/developmental disability) children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge.

Data Analysis: SHW was above the 15% standard of inpatient psychiatric unit re-admissions for adults for two quarters in FY20. SHW has identified that there are a

few consumers that accounted for repeated hospitalizations due to unique and intense needs. **Improvement Opportunities**: SHW staff will discuss ways to encourage consumer participation and follow through with appointments after discharge from the inpatient psychiatric unit. SHW will continue to assess for appropriate level of care upon discharge from the inpatient psychiatric unit.

Goal:

2. **SHW will collaborate with internal and external stakeholders to increase consumer health and wellbeing.**

- Leaders of SHW complete the Recovery Self-Assessment (RSA) annually. The survey is dispersed to members of the supervisory team overseeing programs serving adults diagnosed with a mental illness. The RSA is intended to measure the strengths and weaknesses of SHW's recovery oriented system of care. Results of the RSA were compared with the other CMHSP's in the region.
    - In 2020, 11/11 supervisors completed the RSA.

Figure 2: RSA Administrator Response Data

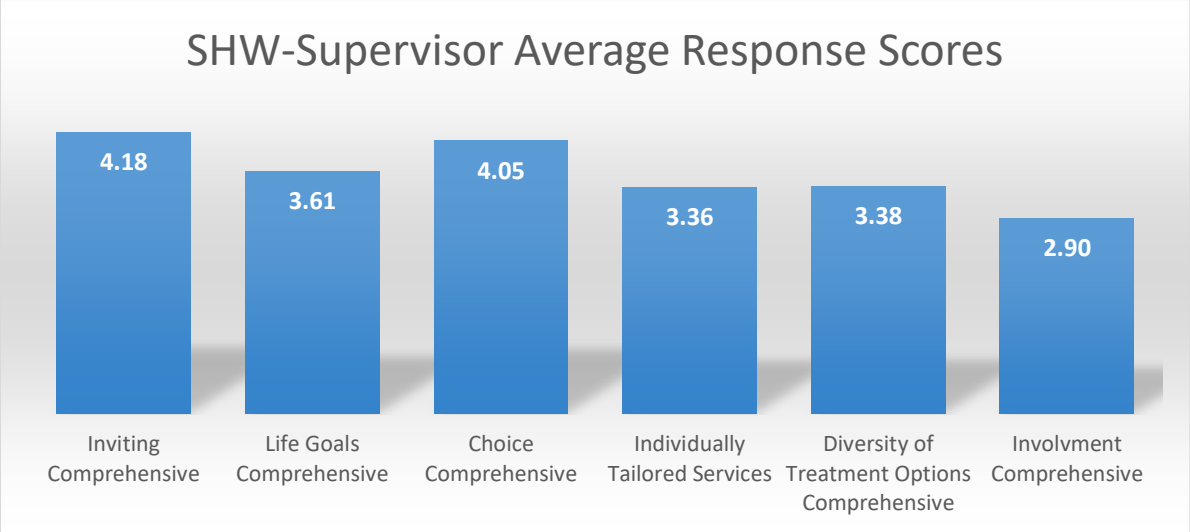
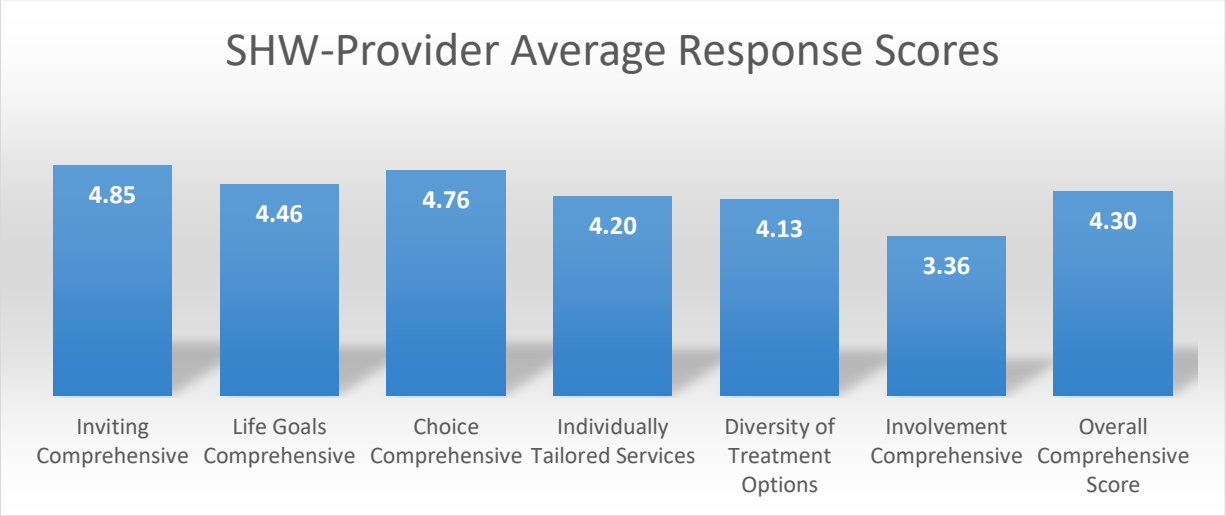


Figure 3: RSA Provider Response Data



- Additional information and next steps are further outlined in Attachment B: Perception of Care Survey Summary.
- The Healthcare Effectiveness Data and Information Set (HEDIS Measure), requires internal SHW staff to coordinate with external primary care providers. The goal of this measure is to ensure Medicaid Beneficiaries between the ages of 18 and 64 with a diagnosis of Schizophrenia and Diabetes complete both a low-density lipoprotein cholesterol (LDL-C) test and a hemoglobin A1C test.

Figure 4: Diabetes Monitoring

Diabetes Monitoring: The percentage of individuals that have received diabetes monitoring labs	Goal	FY20Q1	FY20Q2	FY20Q3	FY20Q4	Recommendation
SHW	**36.4%**	53%	36%	33%	37.5%	**Needs Action**

In 2019, only 22.2% of individuals served by Shiawassee County, who met the criteria of the measure, received both the LDL-C and A1C test. Although the overall adherence to this standard increased in 2020, an overall process breakdown due to staffing changes was identified by SHW staff. A workgroup was created to re-define roles/responsibilities and refine the monitoring plan for this measure and the impact is just beginning to be noted.

Goal:

3. **SHW values and regularly solicits feedback from the consumers receiving care and services.**

- Historically, the ACT Program recipients have been administered the Mental Health Statistics Improvement Survey (MHSIP), annually as directed by

MDHHS through the PIHP. In 2020, the MHSIP was administered to all individuals with a mental illness, receiving services through SHW between June 1, 2020 and July 30, 2020. The MHSIP is a satisfaction survey that focuses on the individuals' perception of care.

- The Youth Services Survey (YSS) is a satisfaction survey which concentrates on the perception of care for children and families receiving mental health services. The survey was provided to all families of individuals 17 years or younger who received services between June 1, 2020 and July 30, 2020.

Figure 5 2020 MHSIP and YSS Summary Table

Survey	FY19 Response Rate	Total Distributed 2020	Total Returned 2020	SHW FY20 Response Rate	MSHN FY20 Response Rate
MHSIP	56%	214	42	20%	18%
YSS	52%	120	13	11%	17%

- The MHSIP and YSS experienced decreases in the response rates in 2020. It is important to note that more individuals were sent the survey in 2020, however, the distribution method was changed from being offered in person, to being mailed. The decision to mail surveys was based on the COVID-19 pandemic, which resulted in services being primarily telehealth based.
  - Additional information can be found in Attachment B: Perception of Care Survey Summary.

- The FY2020 QAPIP included the requirement of increasing consumer feedback through mailing discharge surveys to 100% of the individuals concluding treatment. In 2020 the discharge surveys were temporarily discontinued. Due to MDHHS Communication #20-01 requiring services be continued for all individuals receiving behavioral health services, discharges were not occurring.
  - In 2021, PI will reassess the discharge survey process and re-implement.

- Both the state of Michigan (via the Michigan Department of Health and Human Services – MDHHS - contract) and the United States Government (via the Social Security Act) set forth requirements related to due process for Medicaid and more recently Healthy Michigan beneficiaries. For the 4 Grievance and Appeal Indicators (a total of 18 areas including the subcategories), SHW had 100% compliance.
  - In 2021, PI will continue a collaborative relationship with the Compliance Department monitoring our adherence rate and implementing corrective action, should it be required.

Goal:

4. **SHW will provide care and services to consumers in a manner that assures their safety and individual rights are upheld.**

- The PI Program provided oversight and/or reporting on Recipient Rights statistics, Critical Incidents, data from the Behavior Treatment Plan Review Committee, and Medicaid Event Verification.
- The Critical Incident numbers below were submitted to MDHHS and are based on state definitions and reporting populations for said indicator.
- The Behavior Treatment related data was submitted to and reviewed by the SHW Utilization Management and Performance Improvement Committee and Mid-State Health Network prior to being submitted to MDHHS.

Figure6- Recipient Rights, Critical Incidents and Medicaid Event Verification Data

Reference	Standard	FY19	FY 20
Recipient Rights	The number of Recipient rights complaints filed: Abuse I & II	**8**	**11**
Recipient Rights	The number of Recipient rights complaints filed: Neglect I & II	**0**	**5**
Critical Incidents	The number of critical events: Suicide	**0**	**0**
Critical Incidents	The number of critical events: Arrest	**0**	**5**
Critical Incidents	The number of critical events: Hospitalization due to injury or medication error.	**3**	**2**
Critical Incidents	The number of critical events: Emergency medical treatment due to injury or mediation error.	**24**	**27**
Critical Incidents	The number of critical events: non-suicide death	**9**	**2**
Medicaid Event Verification (MEV)	Claims/encounters meeting billing and documentation guidelines.	**95.5%**	**97.3%**

- There was a slight increase in the number of Abuse and Neglect complaints in 2020. In 2021, these areas will continue to be monitored by the Recipient Rights Department and reported on by the PI Program.
- Although there was an increase in two areas of Critical Incidents for FY2020, the increase was not significant enough to require corrective action. Shiawassee has a low/average critical incident rate when compared with other agencies in the PIHP.

- The MEV audits completed in 2020 found a 97.3% compliance rate, which was a slight increase over 2019. Of the 924 records reviewed by the PIHP, only 7 records were identified as having errors and these were corrected. In 2021, PI will continue its oversight of the MEV audits.

Goal:

5. **SHW programs will provide care and services to consumers in a manner that supports and upholds industry best practice.**
   - The Michigan Fidelity Assessment Support Team (MIFAST) performs an annual evaluation of the Dialectal Behavior Treatment (DBT), Integrated Dual Disorder Treatment (IDDT) Programs and LOCUS. The reviews highlight areas of possible improvement and help create a work plan to address these areas. Due to the impact of COVID-19, these reviews were not completed, however, MIFAST consultants were able to continue phone contacts with the supervisors to ensure work is ongoing for these areas. PI meets regularly with the supervisors of these programs to implement and monitor work plans. In addition, progress is reviewed twice per year by the Utilization Management and Performance Improvement Committee (UMPI).
     - Should MIFAST reviews be scheduled in 2021, PI will help facilitate the evaluation and continue to work with the supervisors of DBT, IDDT as well as all supervisors overseeing use of the LOCUS to further improve the services they provide.

III. Conclusion and Looking Forward

The Performance Improvement Team has reviewed all performance measures completed by Shiawassee Health and Wellness during FY2020 and can happily report exceptional performance in most areas. The small number of areas requiring Corrective Action will be closely monitored during FY2021 for compliance and improvement. These measures will also be discussed and reviewed by various internal committees at SHW. The annual Quality Assessment and Performance Improvement Plan (QAPIP) will be updated in 2021 to reflect ever changing state and federal requirements. The PI Program will continue its role within SHW and the PIHP.