SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

Quality Assurance and Performance Improvement Program (QAPIP)

9/25/17

FY 2016 Report and Three-Year Plan

Introduction and Overview

Every annual quality report is written in the context of the business environment of the moment. This might well be said of any such report. If all is well, then the organization is in a constant state of assessing and responding to change. In the annual report the leadership team reflects on how the organization responded to challenges of the past year, then assesses the challenges ahead and sets a plan for the next year. This particular year's report, FY 2016, encompasses changes that tested our ability to respond at a deeper level than we had encountered in the past and the challenges demanded rapid responses. It was not unusual to have just 30 days to change course or to vision and propose a total redesign or to respond to a policy or financial turnabout.

> *"Quality is never an accident; it is always the result of high intention, intelligent direction, and skillful execution. It represents the wise choice of many alternatives."*
>
> Will Foster

In 2016 there were two significant themes to the forces driving change in our organization, first, the maturing of our electronic business infrastructure and second, the turmoil of health care reform. The quality program, which was in the first year of implementation of a Rapid Cycle Change model, served us well. We were prepared to respond to challenges and initiatives with data and narrative as well as readiness for implementation. Decision making in the face of opportunities such as whether or not to participate in the pilot of a state financing reform initiative or whether to apply for a demonstration grant with far reaching strategic implications, was supported by our ability to assess our strengths and the risks and to measure our current performance against both internal and external benchmarks. The time frames of the past were not acceptable, we needed to have information not from prior years but from current reality, and we needed that data to be refreshed as often as possible, daily information refresh was a new normal.

The first driver, the Electronic Business Environment: The dimension of health care reform which is seldom addressed in the political rhetoric of our day is the work and investment in the electronic infrastructure. SCCMHA has made good investment decisions and has been strategically placed to respond to challenges and opportunities because of the maturity of our health record implementation and our data services. In 2016 the Quality Program leveraged this capacity to demonstrate a metric driven platform for monitoring, decision making and response. The essential components in this capacity were:

- Electronic Health Record
- Meaningful Use Certification and Attestation
- Health Information Exchange
- Data Analytics
- Business Reporting

The second driver, Health Care Reform: This driver has been a constant from the beginning of the federal administration led by President Obama as well as the State of Michigan administration led by Governor Snyder. The Quality Program provided us with the ability to monitor our course, ensure compliance and demonstrate capacity in these contexts which coming closer and closer to home:

- Reduction and Realignment of PIHPs
- Medicaid Expansion
- Medicaid Waiver Renewal
- Performance Based Payment Systems
- Budget Bill, Section 298

Demonstration Opportunities

The list of initiatives that follows is presented here at the opening of this report to give the reader examples of the organizational responsiveness described above and for appreciating the dynamic environment that marked the first year of the reorganized SCCMHA Quality Program. The time period of items included on the list ranges a little wider than just the 2016 fiscal year for a couple of reasons. The SAMHSA system transformation grants for System of Care and Primary Care Behavioral Health Integration were newly underway or moving into a second phase of implementation at the start of 2016. At the same time, SCCMHA has also applied for consideration in two other health policy initiatives the SIMS and CCBHC. These intensive capacity assessments demonstrated the agency's ability to rapidly configure resources and marshal collaborative relationships in order to demonstrate our capacity for strategic responsiveness. SCCMHA leadership took on grant opportunities both large and small which were in alignment with our strategic plan; each initiative whether it was funded or not, had a transformative effect on our organization and quality program.

October 2014 Primary Behavioral Health Care Integration

- Funded for a five year period, this SAMHSA grant is the foundation of the SCCMHA Health Home.
  - Quality program impacts included the identification of biometrics in the electronic health record for monitoring and demonstration of outcomes. Performance of screening and monitoring of health measures such as A1C hemoglobin, BMI, smoking, blood pressure, and CO2 are considered collaborative.

October 2014 System of Care Expansion

- Funded for a five year period this SAMHSA grant continued the work of the initial five year grant by expanding the focus of work to address the special populations of kids with multi system involvement in schools, primary care and the youth with Sexual Orientation and Gender Identity concerns.
  - Quality program impacts included the development of co-location and consultation collaborative sites expanding the multi system outreach of the SOC along with a network wide training for implementation of SOGI safe practices. The impact of these grant funded components along with the continuation of peer mentoring and faith based Open Table are measured with a NOMS program evaluation.

May 2015 SIMS State Innovation Model

- Saginaw Community was not a selected site: Although Saginaw was not selected as a SIMS community, this collaborative endeavor reached deep into Saginaw health systems relationships and created the ground work for future partnerships.
  - Quality program impacts included the creation of a portfolio of the organization's projects as abstracts which were used to demonstrate the agency's ability to direct resources to innovation and readiness for participation in population health initiatives which would require data partnerships.

August 2015 Zenith Integrated Care Data Platform Quality Project

- The Plan All-Cause Readmission pilot project was a demonstration project to show the use of the predictive analytics capacity of the ICDP.

- Quality impacts included the use of the ICDP tool for stratification for population health.

May 2016 CCBHC Certified Community Behavioral Health Center

- State of Michigan not selected: the CCBHC application was an enormous undertaking for the leadership and much was drawn from the SIMS portfolio, all projects that demonstrated various dimensions of the federal CCBHC model.
  - Quality impacts included preparation to demonstrate ability to report on quality metrics that would be reported.

October 2016 Client Health Self-Management Adult Block Grant

- Funded for two years this MDHHS block grant provides consumer input to the development of the health integration.
  - Quality impacts included the identification of barriers and supports for effective interventions addressing health outcomes across initiatives.

May 2017 PIPBHC Promoting Integration of Primary and Behavioral Health Care

- Newly submitted by Michigan Department of Health and Human Services
  - Quality impacts will expand the health home to include children and further develop the capacity to collect and share biometric monitoring with primary care in a virtual care plan supported with ICDP data analytics.

January 2017 Meaningful Use A/I/U Attestation

- SCCMHA attested and received incentive payment for two physicians.
  - Quality impacts included the introduction of Quality Measures and Meaningful Use performance measures. SCCMHA is preparing for enrollment in the Merit-Based Incentive Payment System and other value based reimbursement models. These systems require the provider to collect health metrics and analyze performance in federally defined quality measures, including the ability to communicate electronically with health partners.

June 2017 Community of Practice Cancer Screening and Prevention

- This grant opportunity is newly underway at the writing of this report.
  - Quality impacts included the ability to demonstrate partnerships with primary health to impact health outcomes for a shared population for cancer screening and prevention. This demonstration will position SCCMHA as a capable partner in value based reimbursement models.

Summary

The nine projects described above have in common the goal of transformation of the service delivery system which operates in an electronic health environment. This electronic environment has three dimensions:

- First, an electronic health record that supports work flows and the management of health care for better outcomes. To this end, SCCMHA works closely with PCE to maximize implementation of the meaningful use certified platform.

- Secondly, the ability to collect, analyze and report health data. This year SCCMHA celebrated the tenth anniversary of the OASIS Data warehouse developed by the SCCMHA IS department. The occasion was marked with a quiet celebration in the computer lab with cake and reflection by users, programmers and leadership on all that had transpired to create the robust capacity presently supporting the Quality Program and a broad array of business operations.
- Third, the ability to interface electronically with health partners. To this end, SCCMHA has joined the Mid-State Health Network Organized Health Delivery System and enrolled numerous staff in the MDHHS Care Connect 360 and Zenith Integrated Care Data Platform which leverages CC360 data. Admission Discharge and Transfer (ADT) data is directly imported through the MiHIN HIE to the Sentri electronic record. Electronic lab orders, results and prescriptions are applications of the meaningful use capacity of the EHR which demonstrate electronic communications. Referral and Summary of Care HIE communications are in development as of this writing.

This focus on the development of electronic infrastructure converged with the redesign of the SCCMHA Quality Program with its focus on the use of metric reporting for both quality assurance and quality improvement. An effective Rapid Cycle quality program requires the ability to monitor and communicate performance in time frames and measures sensitive enough to inform us of the need to sustain or correct performance. The underpinning of every Quality activity is the use of information for decision making. The movement of information to where it is needed, upward in the organization to both governance and executive leaders, outward to consumers and the public, and inward to those staff who deliver services both clinical and administrative.

SOGI Capstone Story: As this year came to a close, the System of Care project demonstrated a good example of the core value of our Quality Program**,** *moving information to create and support change.*

The SOC expansion grant included the development of resources for the delivery of services to youth with Sexual Orientation Gender Identity concerns (SOGI). An advisory group was formed that included representatives from the major advocacy organizations in the region. The group decided to implement a SOGI Safe Practices program in which clinicians and support staff who chose to participate complete an eight week training and are endorsed as SOGI Safe Practitioners. Their availability to consumers will be made known in a visible way in the signage of the buildings. Another component of the SOGI project was the Transgender 101 training which was made available for all network staff. The positive report of participants in the training was immediate and it sparked a discussion about the adequacy of gender demographics in the Electronic Health Record. The SOGI story captures the dynamic of both system transformation and the power of information moving through the organization.

"Hoshin Kanri" (also called Policy Deployment) is a method for ensuring that the strategic goals of a company drive progress and action at every level with that company. This eliminates the waste that comes from inconsistent direction and poor communication."

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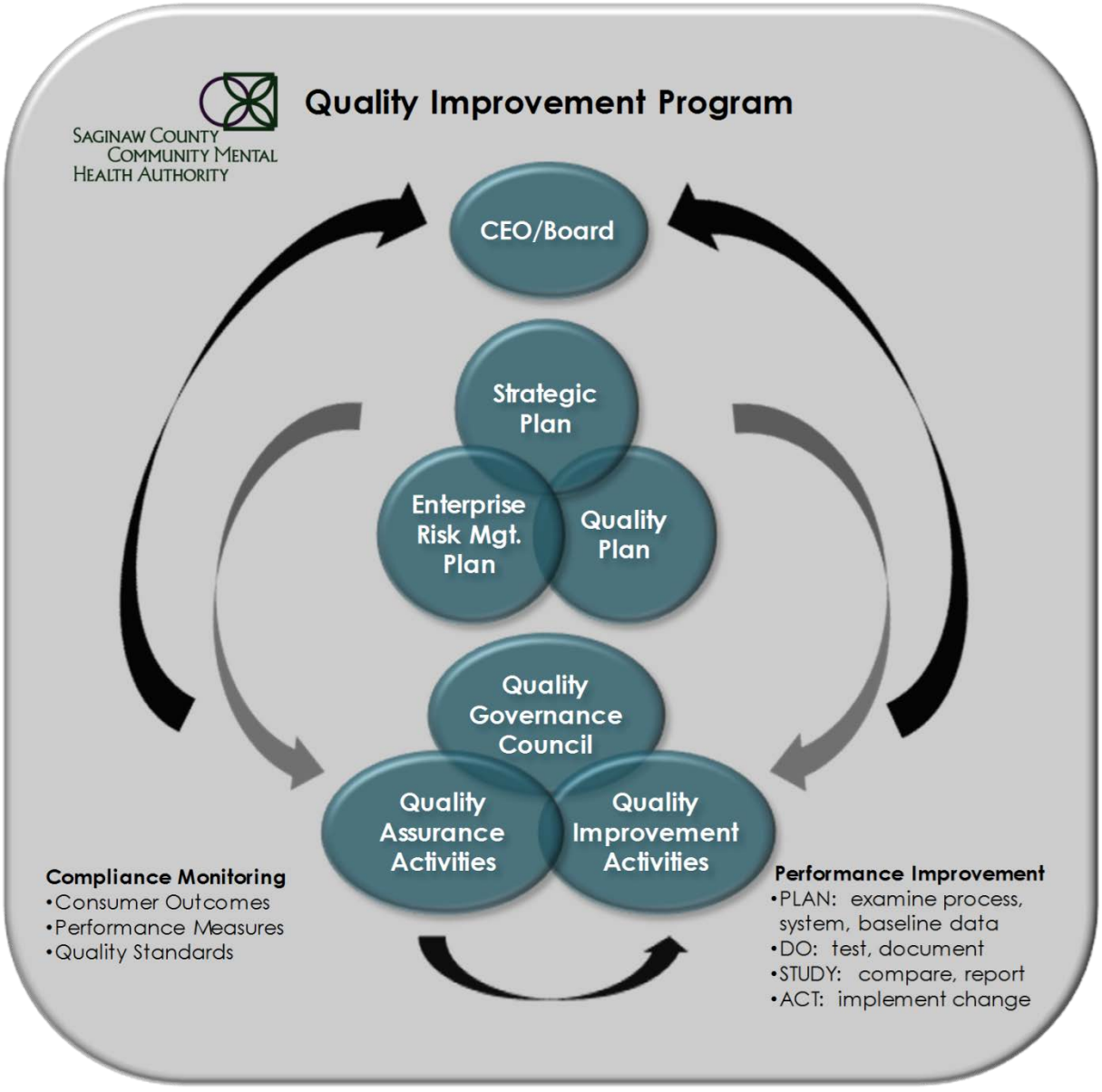
The literature on quality speaks of the difficulty and the importance of aligning intention, resources and actions to achieve results. This alignment has been referred to as achieving "hoshin." Hoshin is a lean six sigma quality model that uses a compass metaphor; when the entire organization is engaged in achieving the "true north" objectives it can be said that hoshin has been reached. Information is as essential to quality improvement as the face of the compass is when striving to reach a destination. The right information to the right people at the right time is fundamental to a successful quality program. The SOGI project demonstrated that alignment.

Plan All-Cause Readmission Capstone Story: This project was implemented as a pilot demonstration with the leadership of Zenith Data Analytics. The goal of the project was to reduce "Plan-All Cause Readmissions" with the implementation of two tools, the ADT files and the Nine Touch protocol. Admission Discharge and Transfer (ADT) data is now available throughout our electronic data platform. ADT information informs us of when our consumers have been admitted, transferred or discharged to hospitals and emergency departments. The information is essential to addressing the key performance measure of Plan All Cause Re-admissions which is a Mid-State Health network monitored measure. Interventions must occur within 30 days if they are to have an impact on the performance measure. The ADT data is now available to our network in three ways, through our electronic health record with direct messaging to case holders, in Zenith Integrated Care Data Platform (ICDP) which adds predictive analytics and risk stratification and through Care Connect 360. This particular quality project has been highly technical with many months of configuration of the presentation of the data and placement of the information in the staff workflow. Like other quality projects in the realm of primary care behavioral health integration, the introduction of ADTs challenged both the technology and the clinical practice and has been transformative in its impact. The function of care coordination had to be completely rethought and brought into a new business environment which required communication across the health care system and with payors. As this report is being prepared the redesign of nursing services and the placement of nursing services in the service delivery system is underway. This is another example of how the quality program has been tested to promote the alignment needed to achieve policy deployment.

SCCMHA Quality Program Schematic

This new schematic was approved by the newly formed Quality Governance Council in 2017. Several values are captured in this schematic: first, the leadership of the Executive and the Board in documents defining vision and priorities, second, the movement of information to and from operations and leadership, and third, the ability to be responsive whether to changes in direction, new opportunities or corrective action supporting compliance or quality improvement.



Our schematic doesn't carry a subtitle, but a good one would be ***"Moving information to create and support change."*** The essential work of FY 2016 has been the design, development, distribution and acculturation of a data driven quality program.

Chartered Workgroups

In FY 2016 twenty-six chartered workgroups were formed, some were newly formed and others were existing groups which were incorporated into the new model of Quality Governance. This model of Quality Governance ensures that resources are used efficiently and the workgroups are given defined scopes of work. Our goal in work group deployment is to achieve as broad a reach as possible throughout the operation with a high level of integration across departments reducing the silo effect of department level operations.

- Access and Identity Management (AIM) Team: The AIM Team will monitor the risk of privacy breach of the Sentri II electronic health record in regular sessions. The objective of the cross division workgroup is to ensure that a standard of operation is met in each of the security sectors of the Sentri II set up including staff security level, staff program assignment, log on frequency, approval and termination, consumer program assignment, and break-the-glass (BTG) utilization. The group will also continue to examine all system functions which pose possible access to records beyond the HIPAA allowed Treatment, Payment and Operations (TPO) or reasonable Incidental Exposure. The Metric Report developed by this team includes "Break the Glass" uses, staff (user) records and program enrollment This Metric Report is reviewed by Compliance and Policy Team.
- Access Management Group (AMG): Reporting to the Service Management Team, the AMG is a utilization management group responsible for monitoring the penetration and engagement rates with a focus on the patient experience. The newly developed Metric Report from the AMG groups four stages of Access including Outreach, Access, Engagement, and Activation activities. The AMG Metric Report is reported to the Services Management Team.
- Adult Case Management (ACM) Team Leaders: The ACM Team Leaders, from both direct and contracted programs, meets regularly to address critical issues relative to service delivery compliance and needs. Team Leaders are asked to give input on training needs, to discuss implementation of compliance corrective action plans or remedies, and to get updates from SCCMHA on key areas pertaining to their work. The venue often serves as mini-training sessions or to orient the supervisors to key system changes, including EMR updates. Data relative to consumer population assessments and outcomes is shared.
- Behavior Treatment Committee (BTC): The Behavior Treatment Committee is a mandated committee that reviews behavioral plans which contain restrictive or intrusive interventions and approves or denies the use of that intervention. The BTC has also taken on the coordinating role of improving the quality of positive support plans through training and the implementation of the Behavioral Champions program. The BTC Metric Report includes quarterly emergency intervention data is submitted to MSHN and it is monitored by the BTC and the Service Management Team.
- Board Operated Billing Integrity (BOBI) Workgroup: The objective of BOBI is to prevent errors from occurring at any point in the documentation of services provided through the construction of a billing file whether paper or electronic to any payer and to establish a routine monitoring and self-audit procedure to ensure that such errors or fraudulent charges do not occur through any SCCMHA billing. A revenue cycle critical path analysis is done to be sure that, as the system evolves, any set up changes which could be problematic are identified and monitored.
- Care Management Conference (CMC): Care Management Conference is charged with monitoring all dimensions of managed care authorization processes. Their objective is to demonstrate optimal functioning of the system of controls for authorization. The Care Management Metric Report includes

aggregate authorization status and timeliness data and it is reviewed by the Services Management Team on a monthly basis.

- Children's Case Management (CCM) Team Leaders: The CCM Team Leaders, from both direct and contracted programs, meets regularly to address critical issues relative to service delivery compliance and needs. Team Leaders are asked to give input on training needs, to discuss implementation of compliance corrective action plans or remedies, and to get updates from SCCMHA on key areas pertaining to their work. The venue often serves as a mini-training session or to orient the supervisors to key system changes, including EMR updates. Data relative to consumer assessments and outcomes is shared.
- Claims/Contracts/Care Management/Coding (CCCC): The CCCC workgroup consists of Coding, Care Management, Claims, Contracts departments working together in efforts to ensure State service code/modifier/credential compliance, rate setting integrity, and various departmental functions such as authorizations and claims entry/processing on behalf of the external SCCMHA service provider network. Workgroup goal is to streamline processes between departments to ensure timely service delivery to SCCMHA consumers, troubleshoot problems, and standardizing systems to support provider relations.
- Clinical Risk Committee (CRC): The CRC monitors clinical issues related to the safe and appropriate treatment of consumers through an interdisciplinary review. The committee addresses and recommends treatment approaches for consumer's whose conditions are at high risk, complicated, or unusual. They review cases brought forth with concerns regarding diagnosis and treatment, and may review and recommend modifications to agency policy and/or practices that negatively affect the treatment of consumers and/or the safety of consumers, staff and/or visitors.
- Compliance and Policy Team (CPT): The Compliance and Policy Team serves as a venue for the intake and distribution of regulatory, policy and laws which impact the agency's strategic plan and corporate obligations. The agenda is twofold with the Compliance Officer presenting newly published content gathered from public sources and members of the team surveying their respective scopes of policy information from Michigan Department of Health and Human Services or Mid-State Health Network committees. This workgroup also monitors the Quality Assurance Metrics of relevant chartered workgroups working in the area of compliance.
- Continuing Education Committee (CEC): It is the expectation that SCCMHA will ensure a competent network of service providers. SCCMHA specifies required instruction in specific areas for service delivery providers of mental health and substance use disorder services. When on-site audits and other compliance reviews of SCCMHA operations are conducted, proof of those required education standards for employees, staff and providers must be provided. In addition, the provision of ongoing education and competency testing ensures at a minimum, compliance with the State and Federal standards, and also the provision of appropriate and quality services that maintain and promote the health, safety and goal achievement of persons served by the SCCMHA network.
- Credentialing Committee (CC): The Credentialing Committee provides oversight for needed credentialing activities across the network, assuring compliance and appropriate processes and policies in keeping with any federal, state or regional requirements and changes. Maintains summary reference documents and may consult with specific persons as needed to conduct work.
- Critical Incident Review Committee (CIRC): The purpose of CIRC is to monitor and review all consumer-related critical incidents, risk events, and sentinel events to determine what action needs

to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. The CIRC review process is a retrospective peer review process in that any records, data or knowledge collected in this process is confidential and not available under the FOIA or by court subpoena. The CIRC will analyze aggregate incident report data, seeking both common cause and special cause variances which indicate the need for quality improvement interventions. Critical Incidents are submitted to MSHN monthly and the work of the CIRC is trended on the CIRC Metric Report also monitored by the Service Management Team.

- Employee Wellness Committee: To keep energy around the focus of wellness, the Employee Wellness Committee will generate ideas to encourage employees to participate and engage in wellness initiatives to improve overall health and wellness. The Committee will develop goals and activities, such as a personal health assessment, as a means to provide feedback to an individual to assist employee decision making regarding personal wellness and health decisions. Information, such as a personal health assessment, will be developed and shared in an effort to engage employees in determining if a personal call to action is warranted. The Committee's goals and activities will focus upon a personalized service approach with a special emphasis upon face to face communication as the primary vehicle for communication of wellness education. The Annual Wellness Plan will guide and inform development of goals and activities. These goals and activities will be generated at the committee level for the purpose to develop individual and group interventions. Success will be measured by tracking the number of employees who engage in education related activities as well as the number and level of contact of each engagement.
- Environment of Care Committee (EOC): The Environment of Care Program was designed to provide a functional and safe environment for SCCMHA employees, consumers of service, and visitors to provide an environment that is safe from recognized and potential physical hazards. The EOC Program also provides guidelines for managing staff activities with the goal of reducing the risk of accidents and mishaps. The EOC Program provides guidance consistent with the SCCMHA mission and vision and ensures compliance with applicable local, state and federal codes and regulations as well as other legal and regulatory guidelines including CARF, OSHA and the National Fire Protection Agency. The EOC Program consists of Five Environment of Care Plans that is maintained by SCCMHA Supervisors and Directors and consists of Fire Safety; Health Management; Safety Management; Security Management; and Emergency Management.
- Evidence-Based Practice (EBP) Leadership Team: The Evidence-Based Practice (EBP) Leadership Team was formed shortly after the Evidence-Based Practice Coordinator position was created. The team was created to provide oversight and consultation to the Evidence-Based Practice Coordinator. The EBP Leadership Team will also provide consultation to the EBP Coordinator on such things as privileging, fidelity reviews, and vetting of new Evidence-Based Practices. The EBP Leadership Team will also be the group that researches new practices and identifies practice needs within the network. The team will oversee the implementation of new EBPs and the vetting of all new practices being implemented in the agency and network.
- General Fund Reduction Workgroup (GFRW): The purpose of this committee it to bring key persons together to discuss ways to reduce SCCMHA General Fund costs and still provide quality services to consumers. Its objectives are to 1) determine who and why persons do not have insurance coverage, 2) determine if we can assist the consumer in obtaining insurance coverage, 3) review persons in State Hospitals that are paid by General Fund dollars and determine if these persons can be placed in the community with supports, 4) provide input to SCCMHA policies related to the above objectives, 5) support the system management of deductibles, and 6) monitor non Medicaid or General Fund use

and benefits status of those consumers receiving services. The Services Management Team monitors the monthly Entitlements Office Metric Report and the Operations Committee monitors the Medicaid Penetration Metric Report.

- HCBS Rule Implementation Workgroup: Statewide HCBS Rule Implementation as required by recent federal Medicaid regulation changes necessitate improvements in applicable mental health service settings for covered beneficiaries/consumers to ensure funded system compliance by the March 2019 federal deadline. Michigan's plan calls for a September 30, 2018 compliance deadline. Through direction of the PIHPs, for SCCMHA via Mid-State Health Network, SCCMHA as a CMHSP will work with residential, skill build, other CLS and supported employment providers to ensure consumer freedom, privacy, choice and all other conditions of the federal statue(s) are met in order to continue to use Medicaid funds for such services. Although the Michigan transition plan is not yet officially approved by the federal government, it is assumed that this will apply to all state B 3 setting based services as well, not just habilitation waiver, including specialized residential sites, and community living supports, skill build and supported employment services for all such consumers. Change parameters include but are not limited to the following protections: selection of provider, choice of roommate, ability to lock bedrooms and bathrooms, ability to furnish and decorate private spaces, freedom of movement in the community, open access to food and visitors, access to funds and existence of a lease or otherwise compliant legal agreement and various person-centered planning and accessibility requirements. In keeping with adjustments being made in state licensing standards to accommodate elements of the rule, SCCMHA will offer guidance and oversee local compliance during 2017 and 2018 for these needed changes across its provider network.
- Health Care Integration Committee (HCIC): The Health Care Integration Committee will focus upon agency-wide transformation to health care integration and meaningful use capacity, implementation and certification. The committee will focus upon establishing, identifying and/or reviewing existing key performance indicators that impact consumer health outcomes across the life span of the consumers we serve.
- Peer Support Specialists (PSS) Workgroup: The purpose of this meeting is a platform for peer education, information, news and issues as well as an opportunity to discuss their unique roles with the services they provide to the populations served by SCCMHA. Additionally, this meeting provides an opportunity for networking and support for the peers in their roles within the SCCMHA system. It is also a venue for direct communication between Peer Support Specialists throughout the SCCMHA system and the SCCMHA administration. The goal of this meeting is to provide the Peer Support Specialists within the SCCMHA system the support and information they need to feel confident and successful in their roles.
- Quality of Life (QOF) Workgroup: The mission of the QOL Workgroup is to improve the quality of life for adults who reside in licensed settings in Saginaw County. The QOL work group is concerned with health and safety, living arrangements, community involvement, positive relationships and staff supports, income resources, home conditions, rights, freedoms and choice as well as transportation needs for these persons served. Some of the past accomplishments of the QOL workgroup include home manager training curriculum development, First Choice of Saginaw creation, development of the quality of life workbook - "A World of Choices," recognition of direct care staff, development of uniform house rules and approval process for all homes, publication of Licensed Residential Homes Directory (which assists consumers and others in selection of home settings and promotion of independent living skills) and implementation of Memorandum of Understanding (MOU) agreement with general (non-contract) AFC providers.

- Residential Provider Watch Committee (RPWC): This committee started to preempt closures of residential facilities and to offer support for residential providers that might be struggling. Prior to the inception of this committee, the clinical staff were having to deal with residential closures especially around holidays when there were minimal staff available to assist with finding placement options for consumers. We have identified areas of risk of displacement from consumer residential living arrangements and work with the providers to prevent, when possible, this potential risk. This is also a venue to bring concerns noted by others in the community, staff at SCCMHA, or other interested parties for discussion and possible solutions for providers under contract as well as providers that may not be under contract but may need some additional education or monitoring by support staff. At times it has been necessary to have key members of the committee meet with providers to discuss the issues and come up with a workable solution agreeable by the committee and the provider. The objective is to minimize the necessity to move consumers out of a residential facility due to loss of licensure or poor quality care of consumers by offering additional monitoring, supports in way of trainings, additional quality reviews such as quality of life reviews or audits, property inspections and additional visits by clinical staff already involved with consumers at the facilities.
- Security Management Committee (SMC): Information security is a set of strategies for managing the processes, tools and policies necessary to prevent, detect, document and counter threats to digital and non-digital information. The purpose of the Security Management Committee is to establish and oversee business processes that will protect information assets.
- Sentri II: This group meets to review decisions on how Sentri II should be configured as a whole. Representatives from various users and management combine to establish consensus. Information is distributed as to upcoming changes. The meeting agenda is set by requests as well as discussions from the Sentri Planning Team.
- State Reporting Workgroup (SRW): This workgroup is charged with ensuring SCCMHA compliance with MDHHS and MSHN contractually defined reporting requirements; documenting the data collection processes on which those reports are based and monitoring the completeness of the submitted data. This workgroup is responsible for monitoring sources of state reporting policy communications such as EDIT, CIO Forum and MSHN QIC and UM. Encounter, BH-TEDS and Performance Indicator counts are trended on the State Reporting Workgroup Metric Report which is submitted to the Operation Committee each month.
- Supports Coordination Team Leaders: The Supports Coordination Team Leaders, from both direct and contracted programs, meet regularly to address critical issues relative to service delivery compliance and needs. Team Leaders are asked to give input on training needs, to discuss implementation of compliance corrective action plans or remedies, and to get updates from SCCMHA on key areas pertaining to their work. The venue often uses mini-training sessions or to orient the supervisors to key system changes, including EMR updates. Data relative to consumer assessments and outcomes is shared.
- Trauma Informed Care (TIC) Core Implementation Team: SCCMHA has been accepted in the National Council for Behavioral Health TIC Learning Community, for 2017 - 2018. Kick off was in April 2017, with required representation at Nat Con conferences in 2017 and 2018. Historically, SCCMHA has maintained a training program and work plan related to the promotion of trauma informed services, including hosting a community event in May 2008, development of a policy in 2012, implementation of various evidence-based practices recognizing trauma, hosting a community webinar in 2015, some trauma informed assessment of the SCCMHA environment, and continued emphasis on trauma and

building resiliency in the support of persons being served. SCCMHA's trauma work has been part of the Saginaw Community Health Improvement Plan, Behavioral Health Action Group plan. In 2016 SCCMHA initiated the provision of routine Trauma 101 training, now a mandated training for the service network but also available to community partners in Saginaw. Including through SCCMHA's support of the Saginaw MAX System of Care, SCCMHA has also actively recognized the effect of various forms of trauma on adults, children and families, and recently has focused on secondary or vicarious trauma of the workforce. SCCMHA sought participation in this learning community to continue to be more effective in all aspects of trauma informed care across the local service network.

- Waiver Management Teams: The purpose of this group is to ensure that operational waiver regulations are in compliance, that system interfaces are synchronized, and that waiver specific revenue payments are optimized. This group meets as three teams in back to back work sessions with the relevant staff attending the waiver session they are associated with. At the time of this charter there are three teams: HSW, Autism and DHS SED/SOC (this last group also address SOC grant revenue in the same manner.) Waiver activity is trended on the WMT Metric Report and monitored monthly by the Operations Committee.

Quality Metric Reporting

The ability to move performance information throughout the organization in a standardized design was an important feature to the redesigned QAPIP model. Much of 2016 was spent developing the design, incorporating metric approval and distribution flow into the Governance of the Quality Program. Each of the reports mentioned in this document have been approved and incorporated or are in development. A metric report addresses the scope of the work, key performance indicators within that scope and each report measures both progress toward goals, compliance with standards and variance in performance.

During FY 2016, the consideration of metric reports in various venues has become routine part of agendas. Sometimes they are a “receive and file” and other times they are used to inform discussion and decisions. Building familiarity and acceptance with the standardized metric design was accomplished within the first year and as we have moved into FY 2017 metric reports are now maturing in their role of informing business discussions. We have referred to this as the “acculturation” of the reports. An organization is not different than an individual; old habits die hard and new habits take time to build. Our goal is to create an expectation for information to be available, to be standardized in look and concept, to be consistently delivered and ultimately a part of the organization’s culture and infrastructure for compliance and quality.

Incorporating older reports as well as new initiatives into the standard metric report will continue to be on the QAPIP work plan for 2017 and 2018. Those reports on this list which are in development should be in full implementation by the end of FY 2017.

While the creation of reports continues to fill in, the dissemination throughout the organization will become the next phase of work. Making sure that the information gets to everyone who needs to know is almost as much of a challenge as getting the information published. This activity is critical for achieving alignment with the strategic plan.

QAPIP Compliance

In 2016 SCCMHA was surveyed by CARF and received a three year accreditation. The SCCMHA quality program was also reviewed in 2016 by Mid-State Health Network and was found in compliance with all standards at the midyear follow up from the 2015 survey. The Mid-State review captures all 12 elements of our contractual Quality Program requirements including both direct and delegated responsibilities. SCCMHA publishes separate reports on most of these dimensions including Medicaid Event Verification, Customer Satisfaction, Network Auditing and we share in reports published by MSHN including the Michigan Mission-Based Performance Indicators, the RAS and Diabetes Screening PIP projects. These compliance and quality focused activities are monitored by our new Quality Governance Council and disseminated through the chartered workgroups.

Our redesigned quality program strives to keep a balance in quality assurance and quality improvement. The schematic shows both elements and the active interplay of monitoring and process improvement throughout the organization and the network.

Performance Measures

Performance Indicators: The Quality Program monitors performance in the areas of service access, efficiency and outcomes through the Michigan Mission-Based Performance Indicator System (MMBPIS) and implements quality improvement initiatives on an as needed basis. In FY 2016, all performance indicators were above standard.

- Access Timeliness/Inpatient Screenings: 100% of the 522 children and 2,207 adults that received a pre-admission screening for psychiatric inpatient care had a disposition completed within 3 hours. Standard = 95%.
- Access Timeliness/First Request: 99.91% of the 1,097 new persons receiving a face-to-face assessment with a professional did so within 14 calendar days of a non-emergent request for service. Standard = 95%.
- Access Timeliness/First Service: 685 of the 699 (98%) of the new persons starting any on-going service with a professional did so within 14 days of a non-emergent face-to-face assessment. Standard = 95%.
- Access/Continuity of Care: 96.55% (84) of the children and 98.26% (282) of the adults that were discharged from a psychiatric inpatient unit were seen for follow up care within 7 days. Standard = 95%.
- Access/Denials: 1.77% (20) of the 1,131 face-to-face assessments with a professional resulted in denials of services. Three (3) requests for a second opinion resulted in the individual receiving services. Standard = n/a.
- Outcomes/Inpatient Recidivism: 9.09% (11) of the 121 children and 8.58% (35) of the 708 adults were readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15%.

Consumer Satisfaction: Two surveys were implemented by the Quality Program in 2016 to measure consumer satisfaction with care and treatment outcomes:

- Mental Health Statistics Improvement Program (MHSIP): The MHSIP survey was administered to consumers served by ten adult services teams. Of the 2,319 surveys distributed, 449 (19%) were completed. The survey measured seven domains of consumer satisfaction: 1) General Satisfaction (90%), 2) Access to Services (89%), 3) Quality/Appropriateness of Services (87%), 4) Participation in Treatment Planning (89%), 5) Outcomes (72%), 6) Functioning (72%), and 7) Social Connectedness (83%) for an overall satisfaction score of 83%. Responses revealed that the highest increases in consumer satisfaction from the previous year's survey were in the "Access to Services" and "Participation in Treatment Planning" domains.
- Youth Services Survey for Families (YSS-F): The YSS-F survey was administered to the parents/guardians of children and adolescent consumers served by ten children's services teams. Of the 935 surveys distributed, 105 (11%) were returned. The survey measured seven domains of consumer satisfaction: 1) Access to Services (86%), 2) Participation in Treatment Planning (89%), 3) Cultural Sensitivity (97%), 4) Appropriateness (82%), 5) Outcomes (55%), 6) Social Connectedness (82%), and 7) Functioning (56%) for an overall satisfaction score of 78%. Responses revealed a slight decrease in scores from the previous year's survey for all but one of the consumer satisfaction domains.

Performance Improvement Projects

- Increasing Diabetes Screenings: The goal of this statewide performance improvement project was to ensure that adult consumers with Schizophrenia or Bipolar Disorder who are taking anti-psychotic medications are receiving the necessary and relevant diabetes screening (specifically glucose or HbA1c screenings) related to mental health medicines prescribed. This study topic aligns with the HEDIS measure "Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications." MSHN provided monthly care alerts run through the Zenith Technology Solutions ICDP database. Review and follow up for those individuals who had not had a diabetes screening completed in the previous 12 month was completed for continued quality improvement. Our performance in 2016 was at 77%.
- Recovery Assessment Scale: The Recovery Assessment Scale (RAS) was implemented for the third year in FY 2016 to measure the perception of individual recovery. The RAS, which is part of the regional performance improvement project, was completed by 700 adult consumers with a diagnosis of mental illness. On a scale of 1 (strongly disagree) to 5 (strongly agree), scores were at 3.16 for the Clinical Recovery domain, 3.89 for the Personal Recovery domain, and 3.67 for the Social Recovery Domain.

Critical Incident Reports

The Quality Systems Department reviewed and processed over 7,000 incident reports in FY 2016. Included in that count are 123 critical incidents (deaths, emergency medical treatment and hospitalizations due to injury or medication error, and arrests) that were reported to MDHHS via MSHN and reviewed by the SCCMHA Critical Incident Review Committee for quality improvement opportunities. An intervention to address the cause of variation was performed in thirty of the cases involving a critical incident.

Program Progress

The 2016 QAPIP Work Plan was ambitious, but most tasks were accomplished. Changes in the organizations revenue as well as the numerous competing initiatives described in the introduction to this report slowed our implementation. Nonetheless, we have reached a reasonable level of adoption and are now building depth.

Task	Results	Status
Transitional event(s) Closure and Launch	New design introduced at Leadership team and incorporated as new standing agenda item	Complete
Select Quality Governance Group	CEO selected membership	Complete
Convene and select Governance chair	Director of Quality appointed as Chair	Complete
Draft revised QAPIP Policy	Quality Program Policy written with new schematic approved	Complete
Draft supporting forms: Charter, Project & Report	Forms for Charters complete and implemented. Project reports are not yet consistently in use. The AIM project report was first one published.	Partially complete
Diagram Project Work Flow	Not yet started	Incomplete
Draft Job Description for Project Managers	New job description approved	Complete
Recruit, Hire and Train PMs	Two of four positions filled with two suspended	Partially complete
Approve QAPIP Curriculum	The Quality Governance Council agreed to adopt the Public Health Quality Curriculum with resources from Michigan Public Health Institute.	Complete
Select trainers and build training schedule	Not yet started	Incomplete
Inventory currently active quality projects which will require charters	All active projects were given charters	Complete
Approve initial Quality Project Charters	26 Charters approved	Complete and ongoing
Identify/Contract Consultant QAPIP Faculty	None selected at this time	Incomplete
Establish consent agenda for compliance	Consent agenda established	Complete

Quality Program Plan for FY 2017 - FY 2019

The work plan for FY 2017 through FY 2019 includes new and carried forward items:

1. Recruit and hire at least one more Quality Project Specialist.
2. Develop and publish metric reports for Environment of Care, Credentialing, Health Integration, Zenith and Board Operated Billing Integrity.
3. Implement the Access Management Group and Outcomes Measurement Group metric reports which are in development.
4. Link the revised Care Management Plan to the Quality Plan with concurrent review metric reports.
5. Implement and report on MIPS (Merit-based Incentive Program) Quality Measures.
6. Fully implement Meaningful Use measures and report on performance.
7. Consider Charter for Customer Service Customer Satisfaction workgroup.
8. Create stakeholder membership lists and create events for stakeholder input.
9. Finish the revision of the Enterprise Risk Management Plan.
10. Create and implement Quality Curriculum with Continuing Education Unit.
11. Identify Quality Consultants/Faculty for ongoing training and consultation.
12. Complete a communication plan for distribution of reports outward through the organization to consumers and the public.
13. Initiate project reports at least annually summarizing work of Chartered Workgroups.
14. Discuss and draft a Data Governance policy.