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**SAGINAW COUNTY COMMUNITY
MENTAL HEALTH AUTHORITY**
FY 2020 ANNUAL QUALITY REPORT AND FY 2021 QUALITY PLAN



SCCMHA Annual Quality Report for FY 2020

Executive Summary: The purpose of the annual quality report is to inform the public of the achievements and overall performance of the SCCMHA Quality Program. The writing of the 2020 report presented us with a challenge; out of necessity we had transitioned from a mode of *Quality Improvement* to one of *Quality Assurance* with a focus on risk management activities during this year of the Covid 19 pandemic. The activities of the Quality Program for the year were disrupted by the need to implement a Pandemic Response and this report describes that change and its results.

The report highlights five areas of quality assurance and the application of our SCCMHA Quality Program model to achieving outcomes in these areas.

- Crisis Resource Management: Comprehensive implementation of public health mandates.
- Health and Safety: Secure facility access cleaning and personal protective equipment (PPE).
- Continuity of Care: Quickly accommodating social distancing through virtual services.
- Workforce Stabilization: Identifying essential workers and creating work at home policies.
- Community and Consumer Wellness: Sharing information and resources.

During this period, the SCCMHA Quality Program continued to operate in the background in full compliance with both MDHHS and MSHN contractual obligations. An annual customer satisfaction survey was completed in July 2020--the report is available on the SCCMHA website. The July 2020 MSHN Interim Compliance review found SCCMHA in full compliance in all, but one dimension of the Quality Program, the performance of behavioral treatment reviews. The Behavior Treatment Review committee did not meet the goals of the corrective action plan that had been approved and in FY 2021 will continue to work on a finding a successful strategy for improving compliance. Performance measure reporting, critical incident reporting, BH Teds reporting, encounter reporting and Medicaid Event Verification reviews were all submitted to MDHHS and MSHN without interruption during FY 2020.

Overview: Duty of Care is a legal obligation that applies to all healthcare providers. The question which it presents is always the first question in a quality inquiry; did the provider have a duty of care? Duty of Care simply means that a provider must anticipate risks for their consumers and be able to show that they took measures to prevent foreseeable harm while patients are under their care. SCCMHA is very aware of the vulnerability of consumers in our care, we are often the only advocate that they have in the community. The scope and degree of this duty of care obligation became intensively apparent during the Covid-19 pandemic. The need to take action to address the health and safety of the consumers and staff became the priority ahead of all other activities, permeating clinical services as well as business operations.

Under ordinary circumstances, the SCCMHA annual quality report would have provided a review of the previous year's work under the leadership of the Quality Governance Council and the 25 chartered work groups which report up to them. Each of those chartered work groups represents a team of staff who are focused on a specific area of SCCMHA operations. The goals of the workgroups are to ensure compliance and to support best practices for performance outcomes, whether those are clinical services or business operations. Under the circumstances of the pandemic though, all normal business activities were disrupted while the necessary duties of the pandemic crisis response took to the fore. Wherever

possible, non-essential meetings were cancelled and replaced with ad hoc groups which were formed under the leadership of the new Emergency Management Team (EMT). According to the SCCMHA Pandemic Plan, an Emergency Management Team is put in place to implement the pandemic response plan. It seemed appropriate given the uniqueness of the work, which was done during 2020, that the quality report should highlight those activities and examine how the SCCMHA Quality Program was able to pivot the dedicated staff resources and skills to address the urgent needs presented by the pandemic.

We surmised that the impact of Covid-19 on our quality program at SCCMHA would be a universal experience for healthcare providers, and indeed it was. In a brief review of the literature regarding how quality programs responded during the pandemic internationally, we found that throughout the healthcare environment, similar strategies and learnings emerged. An article in the *International Journal for Healthcare*, titled “Quality and Safety in the Time of Coronavirus; Design Better, Learn Faster,” provided a useful interpretation of the dynamics SCCMHA faced in 2020 at SCCMHA and so we will use the key points from the article to frame this report.¹

The author, John Fitzsimmons, offered these particularly relevant paradigms which are applicable to the Saginaw experience and our reflection on the work accomplished during 2020.

- **Shift from Elective to Urgent:** The healthcare terms “elective” and “urgent” are used to describe patient-level assessments. Fitzsimmons suggests that these terms can also be effectively borrowed to describe the scenarios health systems faced during the pandemic. Under normal conditions, quality projects are elective, healthcare teams choose from among numerous concerns and work to achieve desired improvement in outcomes in focused areas of patient care. At SCCMHA, the chartered work groups were working on quality projects related to consumer access, health record security, discharge follow-up, and other topics. The typical quality project is very methodical, using relatively generous time periods for meeting goals and measuring performance by the quarter or by the year rather than by the day or week. In a crisis, the situation time frames condense to form a “rapid cycle” application of effort to address imminent risk.
- **Implement Crisis Resource Management (CRM):** CRM is not normally a part of routine quality operations, but its relevance and application during the pandemic set the tone and guiding values for the Emergency Management Team’s work. At its most basic level this is the shift from improvement to prevention. CRM is established on a set of seven principles: fairness, duty to care, duty to steward resources, transparency, consistency, proportionality, and accountability, and these principles in action could be seen throughout the work of the SCCMHA Emergency Management Team (EMT).
 - **Fairness:** In times of crisis all are dependent on the fair decision making of those in charge of critical actions and resources. When anyone group is treated differently than others there must be a justifiable reason that can be accepted for its consistent and transparent application. The Covid-19 Email box for staff questions revealed just how concerned staff were with the fair and equal application of the Covid related limitations.

¹ John Fitzsimmons. June 2, 2020. “Quality and Safety in the Time of Coronavirus: Design Better, Learn Fast.” *International Journal for Quality in Healthcare* 33(1): 1–5. Accessed May 30, 2021. <https://academic.oup.com/intqhc/article/33/1/mzaa051/5836318>

- Duty to care: The evidence of SCCMHA EMT attention to welfare of the consumers under their care was through the scope of concern about continuity of care, outreach, and associated messaging and activity related to social welfare such as food and stability of direct care environments.
- Duty to steward resources: The pandemic quickly created shortages in resources which were felt by the community, staff, and consumers. As a large employer and public agency SCCMHA was placed in the role of securing and distributing PPE and cleaning supplies sufficient to make public buildings safe work environments.
- Transparency: When decisions move quickly, the need for transparency is heightened to engage the active support of the stakeholders. During the period of EMT operations, the CEO communicated regularly with the Board of Directors. She prepared CEO COVID Updates and emailed them to the Board of Directors weekly during the first months of the pandemic and later provided updates at regular committee and board meetings. Status reports to the community at large on SCCMHA operations were sent periodically to agency contacts through the pandemic. EMT members created a website with daily information about changes in operations, new policy, metrics, and information links. The Human Resources department published a monthly FAQ document to respond to staff questions. The flow of communication was constant. Identical information was also published to the HR ADP Site for SCCMHA staff member reference as some staff did not have email addresses initially like custodial and day program staff.
- Consistency: The role of the EMT was to apply the public health rules communicated by the county, the state, and the CDC. Their course of decision making had to be consistent and in alignment with public policy. Everyone is vigilant and all eyes are on the leadership in a crisis, consistency is critical to confidence.
- Proportionality: This value is less easy to describe, except that when proportionality is attended to the result is stabilizing. When acting during the crisis the tone of the messaging needed to be consistent with the degree of risk and the reach of any action needed to be proportional to the risk and the achievable result.
- Accountability: The SCCMHA leadership, both in their executive roles and in their consensus development of action and policy, demonstrated accountability for the care of the consumers of SCCMHA.

A well implemented Crisis Response sustains the confidence of the stakeholders, stops loss, and preserves resources for the common good. At SCCMHA this capacity for effective Crisis Management was demonstrated both in the continuity of care provided to consumers during Covid-19 pandemic management but also in the response to the failure of the Sanford dam in May of 2020 and the ensuing flood waters which moved through the county displacing many residents and placing SCCMHA properties at risk.

- **Mobilize “Plan, Do, Study, Act” (PDSA)**: PDSA is the core principle of most models of quality improvement, and it is also at the heart of the SCCMHA Quality Program. Fitzsimmons describes how the PDSA cycle throughout quality programs changed because of the urgency brought on by the pandemic, but even under the intense applications required for crisis response, it continued to be the essential method for assessing, testing, analyzing, and implementing change. Similarly, the SCCMHA Quality Program also rapidly shifted focus to meet the demands

of new standards of care, new policies, and the unplanned impact of the pandemic response. Feedback cycles were now occurring daily and weekly rather than quarterly and annually and the EMT leadership learned to “turn on a dime” to meet short deadlines, to respond to unexpected needs and to stage the rollout of directives in response to data from testing in real time.

Using this three-part framework from the Fitzsimmons article, the following material describes the nature and accomplishments of the SCCMHA 2020 Quality Program. Many of the accomplishments were adopted into ongoing operations while others inspired new projects based on these successes.

Plan, Do, Study, Act: PDSA & Quality Assurance during Covid-19

P is for PLAN: The planning element of a quality program requires the leadership to assess agency performance relative to goals set. In normal times, the goals under scrutiny might be clinical outcomes, compliance performance, financial efficiencies, customer satisfaction, accreditation or any other clinical or strategic operational metric. Analysis of performance is measured both internally against established goals, as well as externally in comparison to regional, state, or national standards. Performance data is essential to planning. Once the quality program goals are selected an analysis of base line performance is completed to begin the process of measuring change.

In a Crisis Response Management environment, the “business as usual” goals are suspended while the leadership of the agency shifts focus to addressing safety and preventing harm. (Having said this, we can still report that SCCMHA continued to participate in quality data submissions to Mid-State Health Network and MDHHS.)

SCCMHA entered this period of planning with a formal written Pandemic Response Plan which had been initially adopted in 2014. That plan was ready to be brought forward to address this new pandemic. The executive leadership as per the plan convened the Emergency Management Team (EMT) which met weekly, or more frequently, to review and discuss new directives, to identify areas of risk and to plan responses. All incoming, information about the pandemic was forwarded to EMT members for review, discussion, and implementation planning.

During the pandemic, the CEO participated in regular information dissemination calls with MDHHS leadership and distributed notes from these calls along with interpretive communications from Mid-State Health Network to all members of the EMT. MSHN also convened regular meetings of the Medical Directors from each of the member CHMs and the SCCMHA Health Home Director participated and brought guidance from that group into the EMT discussions. Each week as the circumstances unfolded new expectations and goals were set to be achieved in real time.

These are the activities of the **Planning** step of quality improvement and often the adjective “continuous” is applied to describe how organizational leadership is continually scanning the environment to identify and address new areas of concern. This could not have been truer than for the EMT during Covid-19!

The Governor's lockdown order in March of 2020 provided a good example of how the leadership "unpacked" a new directive and planned a response. On the face of it, the simple questions of "where are we", "where do we need to be" and "how do we get there?" These questions describe the analysis and planning required to meet the new objectives. As the EMT was working, they also had to provide immediate guidance to the organization and so they quickly set up communication channels with staff and network providers. They created a COVID Section of the agency web page and a dedicated question line with FAQ published and posted to the agency web site and the Human Resources (HR) ADP portal as another source for such information. The question box became an effective feedback loop to the EMT as their first phase strategies were rolled out. Sometimes initial strategies evolved and were amended based on barriers identified and reported by staff in the initial days of implementation. This type of feedback was as important as data for planning as were the ad-hoc data tools that were built to address critical information needs for planning.

EMT relied on both internal and external sources of data to plan. One external source was the Saginaw County Department of Public Health which published Covid-19 case rate data for the county which was included in regular EMT meeting agendas. An internal source for Covid-19 case rate among SCCMHA consumers was data collected from providers in a spreadsheet created by Network Services. This internal data provided critical information for informing EMT on where risk was occurring and where measures were effectively preventing risk. The report was based on an internal registry of SCCMHA consumers who were exposed, tested, quarantined, and found positive for Covid-19. A similar internal "registry" of staff was established by the HR department and included the number of staff whose security badges were in "deactivation" status while they waited to be cleared for return to work. This activation data allowed building access management to be effective in controlling the spread of the virus.

The demand for Personal Protective Equipment (PPE) was immediate. The EMT needed to know current supply and demand as well as the capacity of the supply chain to meet the demand. The planning phase of the PPE acquisition and distribution included in depth discussion of procurement, distribution, and workplace rules. As national and state debate raged on about the efficacy of masks and the agency of individuals in their personal risk management, the EMT was met with challenges and the need to review and reiterate their decisions and directives.

EMT took up another crisis resource management task when national and state health administrations approved the use of telehealth for non-traditional services during Covid-19. And yet again, the planning required new information regarding the current and needed capacity. The EMT had to ensure that mobile devices for remote workers were available and distributed to essential remote workers. The planning for telehealth included the selection of a virtual platform but also extended into monitoring the adoption of the practice with data available from the IS department regarding the number of sessions and the number of minutes of virtual service time provided by staff. Data from the Doxy. Me virtual platform showed that in the third and fourth quarters of FY 2020, SCCMHA opened 47 virtual clinics, provided 4,532 virtual visits for a total of 81,674 minutes of care.

The SCCMHA EMT needed rapid access to information about the effectiveness of their interventions to quickly respond to barriers to implementation and to address any engagement concerns from the relevant staff across every dimension of the pandemic response. The values of Crisis Resource Management were evident in many ways.

These are just a few examples of how quality planning necessitated base line data and continuous data trending.

D is for DO: The **Do** step, the second step in the quality cycle, might be better called the Testing step. This is the part where ideas are tested to see if they work. Under routine operations, the quality literature recommends testing interventions on a narrow sample of the total population at risk, but when time is of the essence this would be impractical. Many of the new directives from the Governor's Office were announced with less than a week's notice for expected implementation, conditions were very fluid. Implementation of the Governor's directives regularly required department planning and coordination. The EMT was the venue for performing gap analysis with any new directive and they were tasked with the implementation. Interventions were staged by necessity; the first response was for mitigation, the second response was for stabilization, and the third response was for adoption.

The acquisition of PPE was a good example of a staged intervention. First, all existing inventory was identified with distribution to onsite essential workers. Second, a search for immediately accessible supply extended to the known vendors in the region as well as receiving and distributing urgent supplies from MSHN. Third, long term supply sources were identified but when it was discovered that they were limiting sales to larger buying groups, SCCMHA worked with the Network to leverage the purchase. This type of staged intervention is structured differently than the typical quality project in which a proposed intervention would be applied to a small study group for review before broader applications. In the context of Crisis Management, the intervention test is shallow in its duration with data collected immediately upon implementation and with multiple amendments to the strategy until an optimal solution is attained and adopted.

The lockdown order was among the most demanding on the crisis resource management skills of the EMT. The closing of program sites where consumers were served in daily congregate care involved the collaborative work of human resources for the management of layoff of staff, of network services management for alternative home-based services. The start-up of remote workforce included IT for management for telehealth virtual services, clinical services for skill training for the provision of telehealth, and of data services for coding new locations of care and telehealth modifiers.

EMT worked closely with community partners to ensure continuity of care not just in professional therapeutic care, but also in the distribution of medications. Genoa Pharmacy, located in the Hancock Mental Health Center, partnered with the SCCMHA Customer Services office to perform car side pick up of medications. They in addition made their own staff safety modification to their Med-Drop Program and continued to serve consumers in their homes (from their porches) throughout the pandemic.

The selection of a platform for virtual consumer services was tested by the CIO with a team of IS staff. The goal of testing this action was to identify a product with critical technical capacity, one meeting health privacy compliance, and one which would be capable of earning user acceptance. The selection of Doxy.me is an example of a quality test that was wide and shallow vs. narrow and in depth would have occurred in a more typical quality improvement project. The Doxy.me decision was one which continues to be monitored and showing success as demonstrated by the volume of use and increasing versatile provider applications. Careful planning before making a business decision to implement system wide can be credited with this success.

These were examples of the types of change that were implemented with a staged approach, broad and shallow initially, then based on further information, moved to a second stabilizing action and then thirdly, to the action that was adopted for the duration. The return to work after lockdown presented another analysis and step wise series of changes for the workforce. The learning cycle was continuous.

In addition to the work of the EMT, a sub-group was created to address the worst-case scenario of the catastrophic loss of direct care staff which would require the closing of an AFC home. The Residential Contingency Planning Workgroup developed a plan to open a congregate care short term residential site in the then-unused day program location. The plan was fully detailed to include needed beds, use of room space, food service, personal care facilities and staffing.

S is for STUDY: Fitzsimmons proposes that the **Study** phase of a quality program answers these questions: What did we expect was going to happen? What happened? Why was there a difference? What can we learn or do differently? The Study step of the PDSA quality cycle during Covid-19 required EMT members to be nimble with their desktop data skills. Unlike the ability to sort and sift data derived from claims and medical records, decision making during the pandemic response required ad hoc information. Team members were tasked with creating spread sheets, collecting data, and reporting new elements within weeks.

The SCCMHA Covid-19 Registry was a good example of information used in the Study phase. A simple spread sheet functioned as a “registry” to collect provider reported data on those consumers who had been exposed, tested, found positive for Covid-19 and quarantined. This simple bit of feedback was enough to provide the EMT with guidance on where risk was breaking through and where next level mitigation efforts would be needed. At one point the registry contained 271 names with 171 positive tests for Covid-19.

EMT also needed information about staff Covid-19 exposures. Staff data was collected both from front door screenings which were logged on paper and from electronic daily self report by staff and from supervisor’s reports. Workforce resources were stressed and the EMT monitored both professional and administrative staff in the board operated programs as well as the direct care workforce in the Network.

A is for ACT: Adopt, Amend or Abandon: The fourth step of the quality cycle is not the final one. An active quality program continues to trend results over time and assess the effectiveness of the intervention with re-measurements of the chosen metric. In this step the decision is usually to expand the intervention from a sample population to the entire population, but for much of the Covid-19 action, the decision was to adopt, amend, or abandon an idea after a sample period.

A decision to **Adopt** an EMT action occurred with selection of the Doxy.me platform for telehealth. The careful vetting of this platform was done by the CIO and IT department. The positive engagement from staff and consumers was slow to build initially, but data from the system reported to EMT showed a steady increase in use evident in both the total number of visits and the length of session. This was a crisis response action to keep and expand. The versatile use of the technology greatly improved access for consumers.

A decision to **Abandon** an EMT action occurred with the closure of the Injection Shelter. This choice was made in part based on feedback received by the EMT from staff and finally its use was ended due to the weather and vandalism. The Injection Shelter was designed to control Covid-19 exposure; it was a

temporary shelter which was constructed in front of the Hancock mental health center. It was to be used by SCCMHA Health Home nurses who needed a safe location to provide injections to consumers while avoiding bringing them into the center itself. The shelter was built and served its purpose for a period of what we have referenced as stage one—mitigation. The Injection Shelter was the deconstructed. The Injection Shelter is also a good example of the EMT's understanding of the CRM value of proportionality. As the urgency of the need for mitigation moved into a period of stabilization, it was clear that the Injection Shelter exceeded the need. After several months of use, The EMT agreed with the Health Home recommendations to allow routine entrance of consumers to the main building to a sequestered room specifically adapted for injection visits and with direct exit to avoid any unnecessary exposures. Reliably available PPE, effective front door screening, along with feedback from staff and consumers all contributed to the information needed for EMT to make the decision to abandon this strategy.

Summary: For nine months of FY 2020 Covid-19 commanded nearly the full attention of the SCCMHA leadership and as the year came to a close, the work of the EMT had resulted in a new equilibrium, a new normal. Remote working, telehealth, and more vigilant health and safety protocols had all attained permanence in the future of the SCCMHA workplace culture. Even though the Covid-19 case rates would rise again across the State of Michigan, the tasks presented to the EMT would be different in FY 2021. The return of the workforce and the support of vaccinations for staff and consumers were the next challenges. Ongoing advocacy for telehealth and the needs of the direct care work force are also topics on the agenda as the work of the EMT is absorbed back into the routine management venues.

The Emergency Management Team met the challenges of the seven values of effective Crisis Resource Management and in doing so was able to make these achievements:

- Crisis Resource Management: Comprehensive implementation of public health mandates.
- Health and Safety: Secure facility access with cleaning and personal protective equipment (PPE).
- Continuity of Care: Quickly accommodating social distancing through virtual services.
- Workforce Stabilization: Facilitating remote work and compensating direct care workers.
- Community and Consumer Wellness: Sharing information and resources with consumers, the Provider Network and the community.

The SCCMHA Quality Governance Council approved the chartered workgroups for 2021 with updates to membership and scope of work. The array of metric reports generated by the Quality Program were reviewed with amendments and plans for development of new ones. The following Plan for FY 2021 incorporates the ongoing contractual work of quality improvement under Mid-State Health Network with an emphasis on Follow-up After Hospitalization as a new pay for performance measure established by MDHHS. This new measure includes a specific challenge to examine disproportionate representation of minority populations who do not meet the standards set by MDHHS.

SCCMHA Annual Quality Plan for FY 2021

1. Michigan Mission Based Performance Indicator System's Indicators 2 and 3: The MMBPIS's reporting requirements removed all exceptions for indicators 2 and 3. Because of this, SCCMHA will work with PCE Systems to create the logic and source code within the Sentri system for reporting of these indicators. The Quality Department will continue to work closely with PCE Systems to streamline these processes and ensure data integrity.
2. New Quality Coordinator Positions: Two new Coordinator job positions will be created which will create the opportunity to expand the Quality Department. This will allow the department to continue to meet contractual agreements as well as expand the reach of quality improvement efforts and add additional focus to the data integrity within the information systems and data warehouse for more accurate reporting.
3. Development of a Business Intelligence Unit: SCCMHA will begin to define a Business Intelligence model for data-driven decision making. This model will assist with all areas of process and quality improvement by providing tools for Data mining, Reporting, Performance metrics, Benchmarking, Descriptive analytics, Querying, Statistical analysis, Data visualization, Visual analysis, and Data preparation. These tools will assist the agency to make data-driven decisions by identifying, analyzing, comparing, tracking, optimizing, predicting, spotting, and discovering various behaviors, trends, and opportunities for improvement. To support this new BI model, a BI Unit will be created which will merge the efforts of the Information Systems, Data Management, Reporting and Quality staff. This umbrella will synergize the actions of collecting data, managing data, reporting data, and utilizing the data to provide the agency with state-of-the-art decision-making tools.
4. Power BI Reporting: SCCMHA's Quality and IS staff will begin to train and identify potential use cases for Microsoft PowerBI Reporting Dashboards. Power BI dashboards use data visualizations to show highlights of stories that are relevant to that particular use case. The viewers of these dashboards are given the opportunity to see upward and downward trends of the agency's activities and other metrics. These dashboards will be highly interactive and the individual tile's data will update as the underlying data changes. The viewer of the dashboard will have the opportunity to select a tile and drill down into the details of data for more in-depth data analysis.