SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

Quality Improvement Program, FY24 Report & FY25 Plan

FY2025 – AmyLou Douglas, CIO/CQCO

INTRODUCTION

Saginaw County Community Mental Health (SCCMHA) is a local, independent, governmental unit serving the greater Saginaw County area, a Community Mental Health Services Program and has been a mental health authority under contract with the Michigan Department of Health and Human Services since October 1, 1997.

In 2021, SCCMHA was named a Certified Community Behavioral Health Clinic (CCBHC) by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA). We were also selected for Cohort 1 of the Michigan Department of Health and Human Services (MDHHS) Demonstration site and have continued to serve as an active demonstration site. As a CCBHC, SCCMHA is a "one stop wellness center" and offers a full range of services that create access to care, stabilizes individuals in crisis and provides the necessary treatment for those with mental illnesses, intellectual and developmental disabilities with a secondary psychiatric disorder, , children and youth with emotional disorders and substance use disorders regardless of their insurance coverage.

SCCMHA is a behavioral health provider but also a specialty network. The network is comprised of organizations that provide professional services, but also housing and other support services and interventions in both office and site-based locations as well as in the homes of persons served and their families.

MISSION STATEMENT:

As the public manager of supports and services for citizens with mental illness, developmental disabilities and chemical dependency and their families, SCCMHA actively strives to develop a system of care and a community that values and embraces the potential and contributions of all individuals with disabilities.

OUR VISION:

A belief in potential. A right to dream. An opportunity to achieve.

OUR VALUES:

In support of our Mission and Vision, we pledge to develop and offer services that:

- Promote individual and community health, as well as treatment of illness and/or disability.
- Are responsive to person served and community needs.
- Promote person served choice and maximize self-determination.
- Focus on outcomes.
- Are integrated with the community, including collaboration with other service providers and family caregivers.
- Respect and value person served rights and cultural diversity.
- Promote innovation and creativity to better serve our persons served.
- Assure accessibility to services.
- Promote an organizational culture committed to a learning organization that is responsive to change.
- Provide services that are cost effective and efficient.

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QUALITY IMPROVEMENT PROGRAM

ADMINISTRATIVE RULE REQUIREMENTS

CMHSPs are required by administrative rules to have a quality program (Michigan Administrative Code R. 330.2805). Quality programs are critical to person-centered services. Administrative Rule Requirements:

- Continuously evaluate and improve organizational processes and performance.
- Solicit customer feedback…to improve service delivery.
- Compile, analyze, and use data on service outcomes to improve performance.
- Promote consumer …participation in the design of the programs and services.
- Promote consumer …participation in the evaluation of programs and services.

DESCRIPTION

The Saginaw Quality Improvement Program (QIP) emphasizes the need for a clear organizational structure, accountability to a governing body, and a senior official responsible for the program. Active participation from providers and persons served is crucial, along with the use of standardized performance indicators and maintaining minimum performance levels. The QIP also stresses the importance of thorough documentation and regular reporting to stakeholders, aiming for continuous quality improvement and better health outcomes for individuals served.

SCOPE

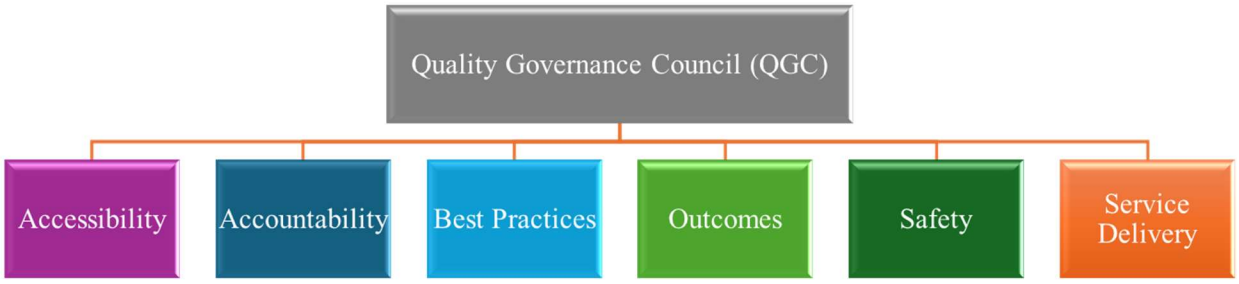
Ensuring that all demographic groups, care settings, and types of services are included in the scope of the QIP is crucial for comprehensive and equitable care. The Saginaw QIP addresses the needs of adults with Severe Mental Illness (SMI), children with Serious Emotional Disturbance (SED), individuals with Intellectual and Development Disorders (I/DD), youth and adults with substance use disorders (SUD), Mild to Moderate (M/M) mental health issues, Co-Occurring Disorders (COD) as well as individuals with co-morbid conditions. The QIP includes all care settings from residential to outpatient, and all services from inpatient to community-based services. The plan encompasses both clinical and non-clinical areas. The QI committees review aggregated data. The QI Committees are not treatment teams and therefore do not discuss individual cases of recipients of care. The one exception is the Safety Committee who is tasked with looking in detail at individual critical events for purposes of quality improvement. The treatment team for individuals involved in critical events are responsible for amending their treatment plans.

CULTURE OF QUALITY

- Organizational leadership's visible support for and reinforcement of continuous quality improvement
- Clear communication (e.g., procedures, training) that enables SCCMHA staff to execute on expectations
- A focus on data, both quantitative and qualitative, to drive quality efforts
- Active participation by every member of each quality committee
- Feedback loops within functional teams about quality issues and initiatives
- Quality is not seen as a department so much as a responsibility of everyone
- Success stories are shared throughout the organization

QIP SYSTEM STRUCTURE

The Saginaw QIP system structure is a comprehensive framework designed to enhance service quality within the organization. It includes leadership and governance to oversee the program, assessment and planning to identify improvement areas, and data collection and analysis to monitor progress. Interventions are implemented based on evidence, with staff training and client education supporting these changes. Regular evaluation and feedback ensure continuous improvement, while strategies for sustainability and scaling help maintain and expand successful interventions. Documentation and reporting keep all stakeholders informed and engaged throughout the process.



RESPONSIBILITIES[1] FOR THE QIP

The QIP uses a RACI (Responsible, Accountable, Consulted, and Informed) matrix to clarify roles and responsibilities, ensuring quality and efficiency in the QIP execution. A RACI matrix is a valuable tool used in project management to define team roles and responsibilities. The matrix ensures that communication flows smoothly. Team members know whom to consult or inform, reducing confusion and preventing bottlenecks.

R

- **Responsible:** This role represents the person or team responsible for executing a specific task or activity within the QIP. They are directly involved in carrying out the work.

A

- **Accountable:** The accountable person is the one who ultimately owns the success or failure of the entire QIP. They make decisions, allocate resources, and ensure that the project progresses as planned. Typically, there is only one person accountable for each task.

C

- **Consulted:** These individuals provide input, expertise, or advice related to specific aspects of the QIP. They are consulted during decision-making but are not directly responsible for execution.

I

- **Informed:** The informed parties need to be kept up-to-date on the progress of the QIP. They are not actively involved in execution but need to know what's happening.

[1] MDHHS/CMHSP Managed Mental Health Supports and Services Contract Attachment QUALITY IMPROVEMENT PROGRAMS FOR CMHSPs TECHNICAL REQUIREMENT

GOVERNING BODY - BOARD OF DIRECTORS — INFORMED

The SCCMHA's Board of Directors approves the overall QIP and the annual quality improvement plan, as noted in the meeting minutes. The governing body regularly receives written reports from the QIP, describing actions taken, progress in meeting objectives, and improvements made. They also ensure the QIP aligns with Saginaw's mission and vision. Annually, the Governing Body formally reviews a written report on the QIP, which includes: studies undertaken, results, subsequent actions, and aggregate data on service utilization and quality. This review assesses the QIP's continuity, effectiveness, and current relevance. The Governing Body ensures that the CEO acts when appropriate and directs that the operational QIP be modified to address findings and concerns within the Community Mental Health Service Program (CMHSP).

CHIEF EXECUTIVE OFFICER — INFORMED

The Chief Executive Officer (CEO) provides overall direction and support for the QIP. The CEO ensures necessary resources, such as staff and budget, are available and keeps the governing body informed about QIP progress and challenges.

QUALITY GOVERNANCE COUNCIL (QGC) — ACCOUNTABLE

The QGC provides oversight of the activities of the QI Committees. They identify the annual goals of the QIP, ensure the progress of the goals through the work of the QI Committees and receive regular reports from the QI Committees regarding the measures the QIP is responsible for monitoring.

MEDICAL DIRECTOR AND CLINICAL LEADERS — CONSULTED

The medical director, along with clinical leadership, ensures quality and safety standards are met and provides expertise and guidance on clinical issues and improvement strategies.

SENIOR OFFICIAL – CIO / CHIEF QUALITY & COMPLIANCE OFFICER — ACCOUNTABLE

The CIO/CQCO is the designated senior official responsible for implementing the QIP. This person will also chair the QGC.

EXECUTIVE SPONSOR — RESPONSIBLE

Responsible for the operations of the QIP Committee. Selects the Chair & Co-Chair of the committee. Provides representation of the Management Team to the committee. Possesses the authority to tentatively approve process changes on behalf of leadership. Requests nominations for membership from the various agency department's leadership members.

PROGRAM LEADERSHIP AND FRONT-LINE CARE TEAMS — RESPONSIBLE

Program leadership and front-line staff carry out improvement initiatives in their daily work, provide insights and data on the effectiveness of changes, participate in training, and contribute to a culture of continuous improvement. Program leadership from subcontracting agencies or designated collaborating organizations (DCO) are enlisted as subject matter experts as needed.

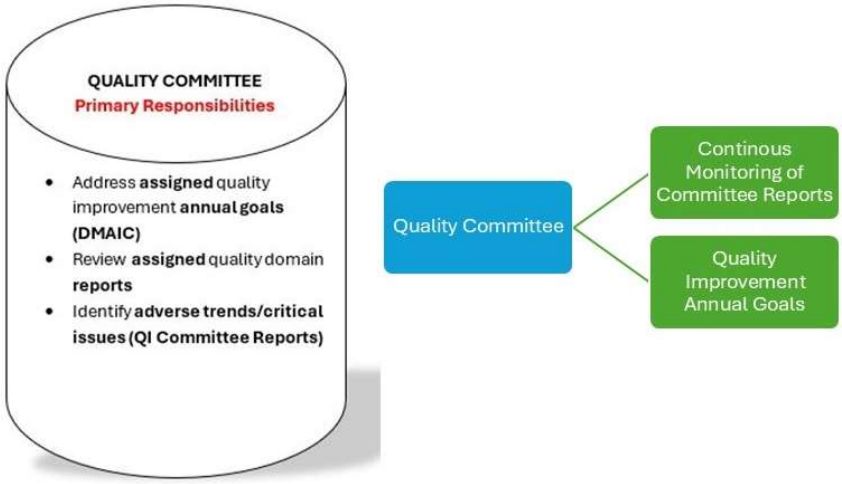
INDIVIDUALS WITH LIVED EXPERIENCE — CONSULTED

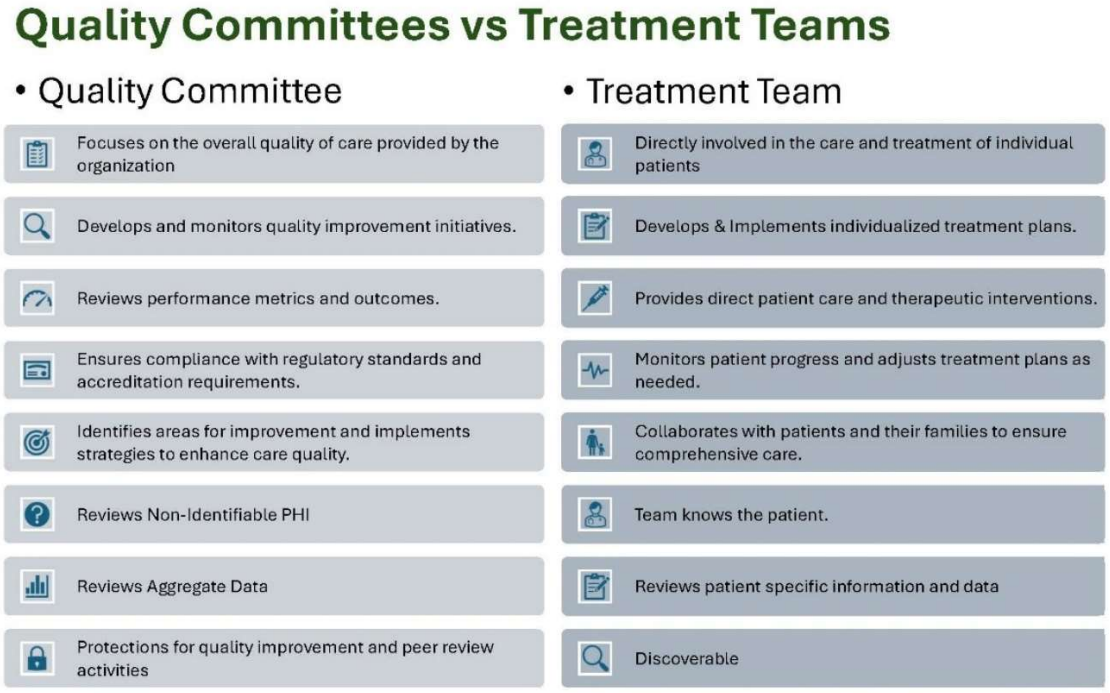
Individuals with lived experience provide valuable insights based on personal experiences with services and represent the perspectives of service users. They contribute to the development and evaluation of improvement initiatives to ensure that changes meet client needs.

QUALITY IMPROVEMENT COMMITTEES RESPONSIBLE

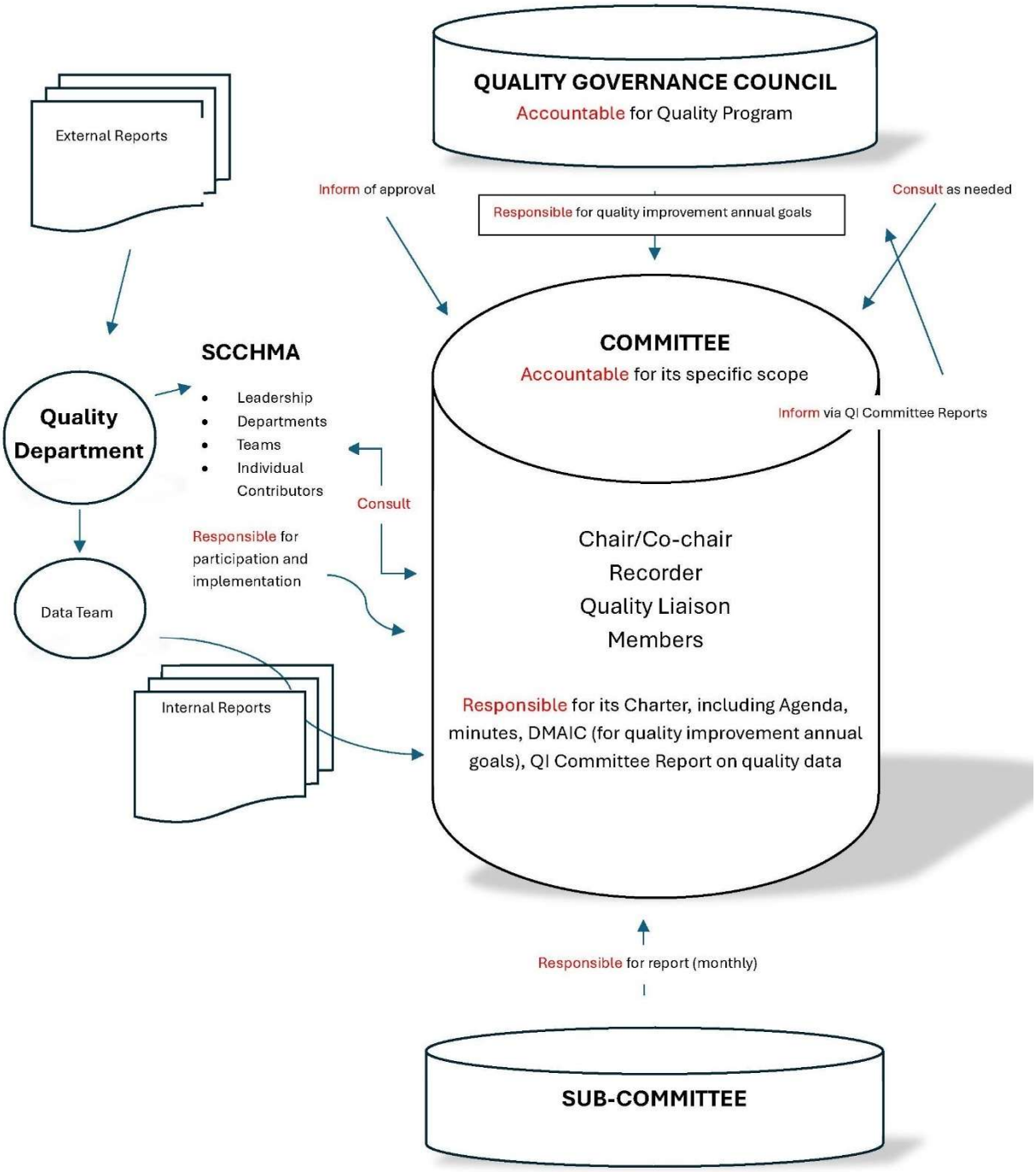
Quality improvement committees implement the QIP, communicate initiatives, and monitor and evaluate the effectiveness of quality improvement efforts. They keep detailed records of the monitoring process, the changes implemented, and the outcomes achieved. Quality Improvement Committees are tasked with two major components of the QIP which are continuous monitoring of metrics and reports and annual quality improvement goals.

Each committee is governed by a QI Committee Charter (Appendix C) that outlines the responsibilities of the committee(s). Each committee is facilitated with the QI Committee Agenda (Appendix F) as a guide. Each committee is responsible for completing a QI Committee Report (Appendix E) on all continuous monitoring of reports and measures. All Quality Improvement Annual Goals are worked via a performance improvement framework and documented on the QI Annual Goals Report (Appendix D). The QI Committee Report and QI Annual Goals Report are provided to the Quality Governance Council by the committee chair.





QIP RACI PROCESS ASSIGNMENT

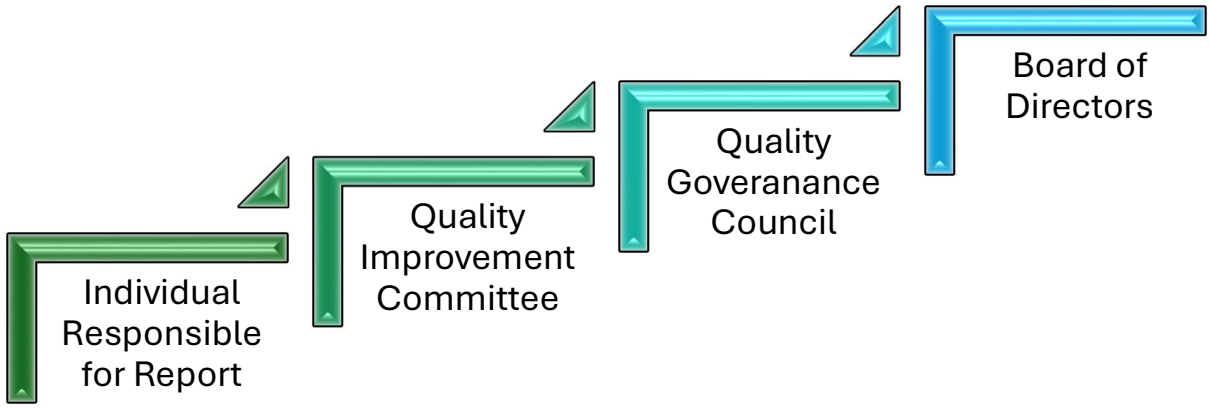


CONTINUOUS MONITORING OF COMMITTEE REPORTS

The QIP routinely monitors qualitative and quantitative data. Qualitative data provides insights into client and staff experiences, while quantitative data offers measurable metrics. Together, they inform decision-making, support continuous improvement, ensure accountability and transparency, and help sustain long-term improvements. This balanced approach enables timely identification of trends and issues, fostering a culture of ongoing enhancement and better outcomes.

The QIP requires that ***corrective measures*** must be implemented whenever services provided are deemed inappropriate or below standard.

Continuous Monitoring follows a schedule for reporting. Saginaw QIP Monitoring and Reporting Schedule (Appendix B) lists the reports provided to each QIP committee, the individual responsible for submitting the report, the frequency, the due date, and the timeframe.



QUALITY IMPROVEMENT ANNUAL GOALS

The QIP is responsible for developing annual goals to provide clear and focused direction for enhancing Saginaw's services, products, and processes. These goals help prioritize areas for improvement, establish benchmarks to measure progress, promote accountability among team members, and encourage a culture of continuous improvement. Additionally, the QIP ensures that quality improvement efforts align with SCCMHA's priority needs and the broader strategic plan objectives, leading to better outcomes and higher satisfaction for clients and stakeholders.

The QIP runs on a yearly basis aligned with the fiscal year October to September. Planning for the development of annual goals begins in the summer and is confirmed in the first quarter of the fiscal year. It is important to note however that effective 2025, some QIPS connected to CCBHC metrics will run on a calendar year as required by SAMHSA.

October to December

- Identify opportunities for improvement
- Confirm annual goals
- Develop workplan
- Obtain approval

January to March

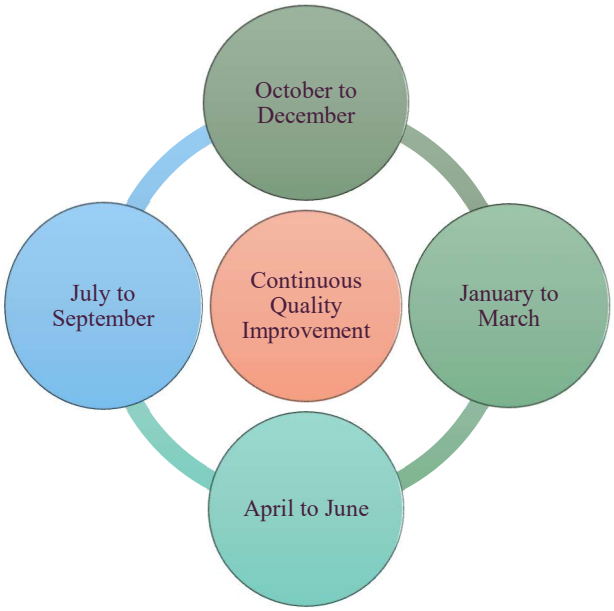
- Conduct interventions
- Test and measure results
- Make changes until desired results are achieved

April to June

- Measure and Monitor outcomes

July to September

- Implement changes within policies and procedures
- Plan for continued or new priorities



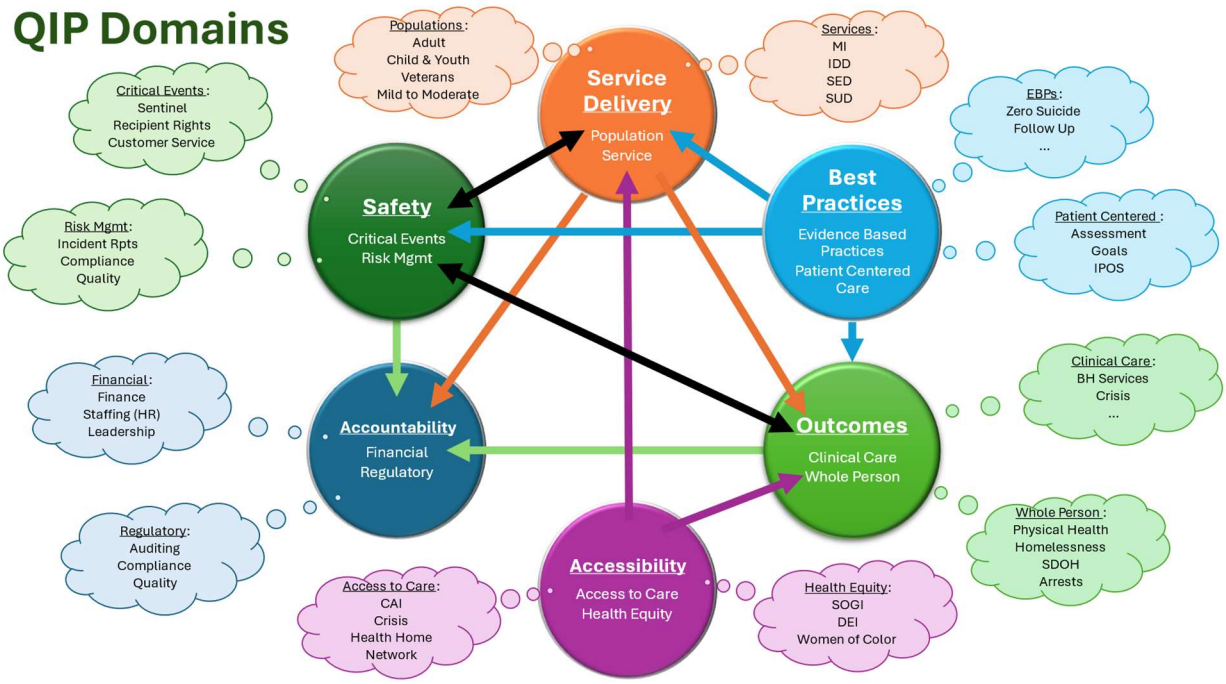
MECHANISMS TO REMAIN EFFECTIVE

The following mechanisms are employed to ensure the QIP remains effective and up to date:

- Regular Review of Performance
  - Monitoring of performance metrics and comparing outcomes against industry standards.
- Qualitative Analysis
  - Collecting feedback from persons served, employees, providers, and other stakeholders through surveys and questionnaires. Focus groups may also be organized to gather in-depth insights and suggestions.
- Quantitative Analysis
  - Analysis of key performance indicators such as service delivery times, error rates, and other numerical data to understand patterns, relationships, and trends.
- Audits
  - Conducting internal reviews, such as clinical record reviews or mock audits. Monitoring performance of external reviews from funders and/or accreditors.
- Strategic Initiatives
  - Ensuring that performance aligns with and supports the achievement of strategic objectives.

MONITORING – QIP DOMAINS

The Saginaw QIP monitors the quality of care in six domains. Quality domains refer to specific areas that are used to evaluate and improve the quality of care provided. Each domain is outlined below, and the specific report and any related metrics are referenced in the Saginaw Quality Reports and Measures by Domain document (Appendix A). This document is the sole reference for reports and measures monitored by each committee.



QUALITY DOMAIN: ACCESSIBILITY

Accessibility refers to the ease with which individuals can obtain and receive services. It ensures that everyone regardless of residence, ability to pay, or abilities can have timely access and benefit from the services provided.

Access to Care

Access Standards: As a community mental health service provider, Saginaw is required to comply with Access Standards as part of the contract with MDHHS.

Diversion: Diversion data is gathered to determine the effectiveness of crisis services. Aggregated data include:

- Number of individuals pre-screened for inpatient and disposition
- Number of mobile crisis responses and disposition
- Number of calls received that were transferred to Mobile Crisis

Performance Improvement Projects (PIP)[2]: The Accessibility Committee monitors Saginaw's performance on PIPs and requires improvement plans for areas that Saginaw performs poorly. MSHN has approved the following Non-clinical Performance Improvement Projects to address service access for the historically marginalized groups within the MSHN region:

1. Study Topic - Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the Black/African American population and the white population.

   Study Question - Do the targeted interventions reduce or eliminate the racial or ethnic disparities between Black/African American population and white populations receiving medically necessary ongoing service within 14 days of completing a biopsychosocial assessment?

The second or additional PI project(s) is chosen by the PIHP. MSHN QIC has recommended and MSHN Operations Council has approved the following Non-clinical Performance Improvement Project to ensure time access to treatment:

2. Study Topic - The racial or ethnic disparities between the Black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated.

   Study Questions - Do the targeted interventions reduce or eliminate the racial or ethnic disparities in the penetration rate between the Black/African American penetration rate and the index (white) penetration rate?

Second Opinions and Denials: The Accessibility Committee reviews aggregated data on second opinions and denials. Monitoring these areas helps Saginaw maintain high standards of care, ensures patients receive appropriate treatments, identifies errors or oversights, and ensures efficient resource use.

Staffing Plan: The credentialing committee is responsible for ensuring that staff and the network of providers are appropriately credentialed. The Accessibility Committee receives, and reviews aggregated data on the number of types of

[2] Mid-State Health Network PIP

credentials that make up the workforce and provider network. This information is used to ensure the make-up of the workforce addresses the needs of the persons served. The staffing plan required for CCBHC is regularly compared to the credentialing report to ensure alignment with workforce needs.

Timeliness Metrics: Timeliness metrics in behavioral health are crucial to ensure that individuals receive the care promptly. These metrics help identify gaps in the system and guide improvements in access to behavioral health services.

Utilization: The Accessibility Committee monitors data related to high utilizers of services, as they pose inherent risks to the organization. Underutilization of services is also monitored as individuals that do not receive the prescribed care are at risk of decompensation.

Health Equity

CLAS Standards: The National Culturally and Linguistically Appropriate Services (CLAS) Standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate healthcare disparities by providing a blueprint for individuals and health and healthcare organizations to implement culturally and linguistically appropriate services. The Accessibility Committee reviews a status report on implementation of CLAS standards and practices. The CLAS standards are found here:

An Implementation Checklist for the National CLAS Standards (hhs.gov)

Monitoring Disparities: The CQI (Continuous Quality Improvement) plan monitors and reduces disparities by systematically collecting and analyzing data that is disaggregated by factors such as race, ethnicity, sexual orientation, and gender identity. This data helps identify specific gaps or inequalities in care that may exist between different populations. Here's how the process works to monitor and reduce disparities:

Data Collection: The CQI plan ensures that data on key quality measures is collected in a way that distinguishes between different demographic groups, allowing for the identification of disparities in healthcare access and outcomes.

Analysis: The disaggregated data is analyzed to spot trends and patterns in care that show whether certain populations are experiencing worse outcomes or barriers to access, such as higher rates of missed appointments, longer wait times, or lower treatment success rates.

Targeted Interventions: Once disparities are identified, the CQI process allows the organization to design and implement targeted interventions aimed at reducing these gaps. This might involve adjusting care protocols, offering additional support services, or increasing cultural competency training for staff.

Insurance Monitoring: The Accessibility Committee reviews an aggregate report which assists in identifying any populations areas that may be underserved. The committee also reviews data to determine if Saginaw is meeting its target goals for populations served.

- Total number of individuals served by population (SMI, SED, SUD, COD, I/DD)
- Total number of individuals enrolled in CCBHC
- Total number of individuals enrolled in Behavioral Health Home
- Percentage of individuals who are uninsured or underinsured
- Percentage of individuals by insurance type (Medicaid, Medicare, Dual, Third Party)

QUALITY DOMAIN: ACCOUNTABILITY

Accountability & Compliance refers to the obligation of individuals and the agency has to take responsibility for their actions, decisions, and outcomes. It ensures that everyone involved in the delivery of services is held to high standards of performance and ethical behavior.

Financial

BH TEDS Review: Saginaw monitors BH TEDS against the standards outlined by Mid-State Health Network (Reference 02).

Encounter Review: Saginaw monitors encounters against the standards outlined by Mid-State Health Network (Reference 03).

Medicaid Event Verification (MEV): As part of the 21st Century Cures Act, the Centers for Medicare & Medicaid Services (CMS) requires states to implement an Electronic Visit Verification (EVV) system. Electronic Visit Verification (EVV) is a validation of the date, time, location, type of Personal Care or Home Health Care Services provided, and the individual(s) providing and receiving services. This information helps to ensure that beneficiaries, clients, or participants receive the expected care. The MEV review is conducted utilizing a sampling methodology from which a random case selection is selected. The review involves a claims test where 7 attributes are tested for compliance per the MDHHS Medicaid Verification Process. The test can either yield a Y, N, or NA (for Attribute G) response. The attributes tested are as follows:

A. Code is an allowable service code under the contract
B. Beneficiary is eligible on the date of service
C. Service is included in the beneficiary's individual plan of service
D. Documentation of the service agrees to the claim date and time of service
E. Documentation of the service provided falls within the scope of the service code billed
F. Amount billed/paid does not exceed contractually agreed amount
G. Modifiers are used in accordance with the HCPCS/MDHHS guidelines

Regulatory

BHH standards: Saginaw is a Behavioral Health Home (BHH). A behavioral health home is a comprehensive care model that integrates primary care, mental health, and substance use services to provide holistic support for individuals. This approach aims to improve overall health outcomes by addressing both physical and behavioral health needs in a coordinated manner. The Accountability Committee monitors work plans to ensure compliance with BHH standards.

CARF Accreditation: Saginaw is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The Accountability Committee monitors work plan progress related to CARF readiness or any required corrective action plans.

CCBHC: As a Certified Community Behavioral Health Clinic (CCBHC), Saginaw must comply with certification requirements and state demonstration requirements. The Accountability Committee monitors work plans to ensure compliance with these requirements.

Community Needs Assessment: A community needs assessment is a systematic process used to identify and evaluate the needs, assets, and resources of a specific community. As part of its participation in the MDHHS CCBHC demonstration, SCCMHA conducts a comprehensive assessment of the needs of the CCBHC population within the service area. In addition, as stipulated by MDHHS contract, SCCMHA also conducts an annual needs assessment for all populations served. .These assessments helps to understand the physical, mental, and social well-being of the community members. The Accessibility Committee monitors Saginaw's progress on meeting the behavioral health needs of the community.

Corporate Compliance: The Accountability Committee reviews report on aggregated data concerning Fraud, Waste, and Abuse. The committee also reviews updates on compliance plans and trends.

MDHHS Standards: The Accountability Committee monitors the results of MSHN reviews and implements plans for improving performance or preparing for future reviews. These reviews include monitoring performance related to Medicaid waivers (SED, HSW, CWP), 1915 iSPA, EPSDT and State Plan Services using these tools:

- CMH Clinical Chart Review Tool
- CMH Delegated Managed Care Tool – PSV
- Critical incident PSV Supplemental Tool
- Program Specific Review Tool Non-Waiver PSV
- Provider Network Review Tool

Policies and Procedures: The Accountability Committee ensures policies and procedures are reviewed annually.

Practice Guidelines: The Michigan Department of Health and Human Services (MDHHS) provides a comprehensive set of practice guidelines designed to ensure high-quality care. These guidelines cover mental health, substance use disorders, and general health services. Saginaw monitors and evaluates its adherence to these guidelines through data analysis and MSHN site reviews. MDHHS and Regional Practice Guidelines are available here: Practice Guidelines - Mid-State Health Network (midstatehealthnetwork.org)

Provider Network Monitoring – Saginaw monitors providers of its network via contract and credential reviews. The results are shared with the Accountability Committee.

QUALITY DOMAIN: BEST PRACTICES

Best Practices refers to the established methods and techniques that are widely accepted as the most effective and efficient ways to achieve desired outcomes. These practices are based on research, experience, and industry standards.

Evidence-Based Practices

Evidence-Based Practices Fidelity: Saginaw employs a variety of evidence-based practices that are monitored for fidelity. Fidelity refers to ensuring that programs or interventions are implemented as intended. Methods for ensuring fidelity involve peer-lead technical assistance from the Michigan Fidelity Assistance Support Team (MIFAST), internal chart reviews, observations, fidelity checklists, and feedback from participants and implementers. The Best Practices Committee oversees the results of these reviews and recommends quality improvement projects for practices that do not meet requirements.

Follow Up: Regular follow-up care after hospitalization or emergency visits for mental health issues can significantly improve patient outcomes. Follow-up appointments also provide an opportunity to monitor and encourage treatment and medication adherence. Saginaw monitors several metrics regarding follow-up care.

Trauma Informed Care (TIC): Trauma-informed care (TIC) is an approach that recognizes the widespread impact of trauma and integrates this understanding into all aspects of service delivery, with a goal to create an environment that promotes healing and recovery while avoiding re-traumatization. The Service Delivery Committee tracks progress on the following areas as outlined by SAMHSA[3]:

- Trauma Informed Staff Development
  - Training and Education
  - Staff Supervision, Support, and Self-Care
- Trauma Informed Environment
  - Safe Physical Environment
  - Supportive Environment
- Trauma Informed Assessment and Planning Services
  - Conducting Intake Assessments, Process, and Follow-up
  - Developing Goals and Plans
  - Offering Services and Trauma-Specific Interventions
- Involving Persons served
  - Involving Current and Former Persons served
- Adapting Policies for Trauma Informed Care
  - Creating and Reviewing Policies

Person-Centered Care

Person-Centered Care: Saginaw aims to provide person-centered treatment as well as youth and family-guided care. Individual plans of service are tailored to individual strengths, needs, abilities, and preferences. Persons served and family members are encouraged to actively participate in care decisions, promoting **self-determination**. These practices are evidenced by the golden thread, a concept that ensures all clinical information is coherently linked from the initial assessment through to the treatment plan and progress notes. Peer and clinical audits of charts are conducted to monitor person-centered care.

[3] Trauma-Informed Organizational Toolkit (wa.gov)

QUALITY DOMAIN: OUTCOMES

Outcomes refers to Saginaw's holistic approach to behavioral healthcare that considers the entire spectrum of a person's health needs, including physical, mental, behavioral, and social aspects. The purpose of monitoring outcomes is to provide comprehensive and coordinated care that addresses all dimensions of a person's well-being.

Clinical Care

Clinical Record Reviews: Clinical teams review aggregate data on clinical records and outcomes, with the Outcomes Committee reviewing the reports. The aggregate data offers valuable insights into patterns and **trends** in patient care, outcomes, and practices **over time**. This information supports policy changes, protocol updates, and informs training needs. The clinical record report includes at a minimum the following information:

- Scores from Records Reviews (References 04, 09-13)
  - CMH Clinical Chart Review Tool
  - CMH FY24 1915i Chart Review – Final
  - CMH FY24 CWP Chart Review – Final
  - CMH FY24 HSW Chart Review – Final
  - CMH FY24 SEDW Chart Review – Final
  - CMH FY24 Waiver Administrative Review – Final

Functioning Outcomes: Summary reports are provided to the Outcomes Committee to review and identify areas of improvement and successes. These reports include results from LOCUS, ASAM, DECA and MichiCANS.

Medication Management Monitoring: The Outcomes Committee reviews aggregate data on the use and adherence to medications.

Whole Person

Care Coordination*:* Coordination of care between Saginaw and the individual's primary care physician (PCP) occurs when there is a significant change in care. At minimum, this coordination includes sending the primary assessment, treatment plan updates, changes in level of care, and medication changes. The Outcomes Committee monitors physician coordination through reports.

Physical Health Monitoring: Monitoring physical health focuses on outcomes related to co-morbid conditions such as diabetes, obesity, and heart disease.

Screening and Assessment: Data from screenings and assessments are used to evaluate the quality of care provided by Saginaw. This information helps identify areas for improvement and guides strategies to enhance the overall quality of behavioral health services.

Social Drivers of Health (SDoH)*:* Monitoring social drivers of health include the status of those served related to homelessness, employment, and arrests. Improvement in social drivers of health has a direct link to behavioral health outcomes.

QUALITY DOMAIN: SAFETY

Safety focuses on minimizing risks and preventing harm to persons served and providers during the delivery of services. It includes implementing systems and processes to prevent errors, identifying potential risk and taking proactive measures to mitigate them, encouraging the reporting of errors and near misses to learn from them and improve practices, and ensuring that the environment is safe for both persons served, staff, and guests.

Risk Management

Behavior Treatment Plans: The Safety Committee reviews aggregate data on the number of individuals with a behavior treatment plan, the number of behaviors addressed in each plan, and the percentage of emergency interventions used. (e.g.,911 calls and physical management). Trends are identified and improvement plans are requested as needed to meet target goals. Additionally, files are reviewed to ensure consent was documented consent was obtained before plan implementation.

Individual Behavior Treatment Plans are reviewed quarterly by the Behavior Treatment Committee. The roles and responsibilities of the Behavior Treatment Committee are outlined in the Technical Guidelines for Behavior Treatment Committees.

Critical Events

Critical Events: Critical Events are aggregated in the following categories, trended over time, and categorized by primary service:

- Arrests
- Emergency Medical treatment due to Injury or Medication Error
- Hospitalization due to Injury or Medication Error
- Non-suicide death
- Suicide

Health and Safety Reporting: The Safety Committee reviews aggregated data on health and safety issues. This data includes the type of health and safety issues and the length of time someone has an unresolved health and safety flag.

Mortality Data: The Safety Committee reviews mortality data over time to identify trends. Aggregate data for mortality analysis includes:

- Demographic Data:
  - Age: Mortality rates often vary significantly by age group.
  - Gender: Differences in mortality rates between males and females.
  - Ethnicity and Race: Mortality rates can differ across various ethnic and racial groups.
- Geographic Data:
  - Location: Mortality rates can be influenced by geographic factors such as urban vs. rural areas.
  - Regional Variations: Differences in mortality rates across different regions or countries.
- Socioeconomic Data:

  - Income Level: Higher or lower mortality rates associated with different income levels.
  - Education Level: Impact of education on mortality rates.
- Health Data:
  - Cause of Death: Specific causes of death, such as heart disease, cancer, or accidents.
  - Pre-existing Conditions: Influence of chronic illnesses or conditions on mortality.
- Temporal Data:
  - Time Period: Trends in mortality rates over different time periods.
  - Seasonal Variations: Changes in mortality rates during different seasons or month

Recipient Rights

Recipient Rights Complaints: Service Delivery involves reviewing aggregated data from recipient rights complaints that include the following:

- Number of Complaints: Total complaints filed, received, and investigated.
- Types of Complaints: Categories such as abuse, neglect, or rights violations.
- Outcomes: Results of investigations, including substantiated and unsubstantiated findings.
- Timeliness: Time taken to resolve complaints.
- Provider Data: Breakdown by service providers, showing which ones have more complaints.
- Trends: Patterns over time, identifying recurring issues or improvements.

Sentinel Events and Root Cause Analysis

As needed, members of the Safety Committee will convene to conduct a Root Cause Analysis for any incident deemed a Sentinel Event.

Sentinel event: is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (jcaho, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

Root cause analysis: Saginaw has 3 business days after an incident occurs to determine if it is a sentinel event, and 2 subsequent business days to commence a root cause analysis of the event. Following completion of a root cause analysis, or investigation Saginaw is required to develop and implement either a plan of correction or an intervention to prevent further occurrence or recurrence of the adverse event, or to document the rationale of why corrective actions are not needed.

Staff requirements: the makeup of the root cause analysis/sentinel event review team is comprised of individuals with the skill and knowledge to review the incident, determine if any rights or compliance issues are present and includes individuals with resource knowledge to gather and review information medically and clinically. Saginaw ensures that individuals involved in the review of sentinel events have the appropriate credentials to review the scope of care (e.g., deaths or serious medical conditions involve a review by a physician or nurse).

QUALITY DOMAIN: SERVICE DELIVERY

Service Delivery refers to the processes and practices involved in providing services to persons served in a way that meets or exceeds expectations. Monitoring of service delivery encompasses reliability, responsiveness to assist individuals promptly, knowledge and courtesy of staff, providing care and personalized attention, and ensuring a welcoming environment.

Perception of Care

Grievance and Appeals:

The Service Delivery Committee reviews grievance and appeal reports, aggregated into the following categories:

- Quality of Care: High numbers of grievances related to the quality of care can indicate issues such as inadequate treatment, poor patient outcomes, or substandard practices. This data helps identify areas where providers/clinicians may need to improve their clinical practices.
- Access: Numerous appeals and grievances about service denials or delays may suggest problems with access to necessary medical services. This could be due to restrictive policies, insufficient provider networks, or logistical barriers.
- Attitude and Service: Complaints about staff behavior, communication, and overall person served experience can highlight issues with the attitude and service provided by personnel. This data can be used to improve customer service training and patient interaction protocols.
- Billing and Financial Issues: Grievances related to billing errors, unexpected charges, or financial disputes can reveal systemic problems in the billing processes. This information is crucial for Saginaw to streamline billing systems and ensure transparency and accuracy in financial transactions.

Perception of Care

Understanding the experiences of stakeholders is crucial for identifying areas for improvement at Saginaw. The organization ensures the inclusion of persons served receiving long-term supports or services (e.g., persons receiving case management or supports coordination) in the review and analysis of the information obtained from quantitative and qualitative methods Annually, Mid-State Health Network (MSHN) distributes the following surveys:

POPULATION	TOOL
Adults with a Mental Illness	Mental Health Statistics Improvement Program (MHSIP)
Youth with a Severe Emotional Disturbance	Youth Satisfaction Survey (YSS)
Individuals with a substance use disorder	Substance Use Disorder Satisfaction Survey
Individuals receiving Long Term Supports and Services (LTSS)	1) Home and Community Based Services Survey 2) National Core Indicators (NCI)

The aggregated results of the surveys and/or assessments are collected, analyzed, and reported by MSHN and provided to Saginaw via participation in MSHN committees and councils. The Saginaw liaison shares the MSHN reports with Saginaw. The Service Delivery Committee identifies and investigates sources of dissatisfaction; outlines systemic action steps, and communicates results to practitioners, providers, recipients of service, and the governing body. The organization evaluates the effects of the above activities, and the Saginaw Office of Recipient Rights takes specific action on individual cases as appropriate.

Persons served receiving long-term supports or services, including but not limited to case management and supports coordination, are incorporated into the quality improvement activities as survey and focus group participants. Additionally, analysis and review of results are provided to persons served for input via their membership on the SCCMHA Citizen's Advisory Committee to the Board of Directors or Quality of Life Workgroup.

TRAUMA INFORMED CARE REPORT

Progress status on TIC organizational assessment and implementation plan

PROCESS OF QUALITY ASSESSMENT AND IMPROVEMENT

ESTABLISHING PERFORMANCE MEASURES

Performance measures, developed in alignment with Saginaw's strategic priorities, address clinical and non-clinical areas. The Saginaw QIP uses but is not limited to the following means for identification of issues and opportunities for improvement:

- Growth areas identified based on performance
- Stakeholder feedback
- Oversight and monitoring reviews

PRIORITIZING MEASURES

Measures are prioritized based on factors such as organizational goals, stakeholder feedback, community needs, industry standards, legal requirements, resource constraints, risk management, and impact on performance and outcomes. The following characteristics[4] are weighted more heavily for prioritization:

- High volume issues affecting many persons served
- High frequency/multiple occurrences
- High risk, placing persons served at risk for poor outcomes
- Longstanding issues
- Multiple unsuccessful attempts to resolve the issue in the past
- Strong and differing opinions on cause or resolution of the problem

DATA COLLECTION, ANALYSIS, AND REPORTING

Methods of Data Collection:

- Surveys and Questionnaires: Collect feedback from patients, staff, and stakeholders.
- Electronic Health Records (EHRs): Use data from EHRs to track patient outcomes and service utilization.
- Direct Observations: Conduct observations of clinical practices and patient interactions.
- Interviews and Focus Groups: Gather in-depth insights from patients and providers.

Frequency of Data Collection:

- Continuous Monitoring: Implement real-time data collection for ongoing assessment.
- Periodic Reviews: Conduct monthly or quarterly reviews to identify trends and areas for improvement.
- Annual Evaluations: Perform comprehensive annual evaluations to assess overall program effectiveness.

Data Analysis and Reporting:

- Regular Reporting: Generate regular reports to share findings with stakeholders. Reporting will be based on stakeholder reporting period requirements (e.g., calendar year for CCBHC reporting).
- Benchmarking: Compare data against industry standards and benchmarks to identify gaps.
    - Meet Standard
    - Excel from Benchmark
    - Improvement from Baseline
- Feedback Loops: Establish feedback mechanisms to ensure data is used to inform program changes.

Performance Tracked Over Time: Performance is tracked on a monthly, or at a minimum, quarterly basis.

[4] https://www.ruralcenter.org/sites/default/files/HRSAQIToolkit.pdf

PERFORMANCE IMPROVEMENT ACTION STEPS

Action plans are based on a framework designed to enhance the quality of services and use a core component of the Six Sigma methodology. Define, Measure, Analyze, Improve and Control (DMAIC) is a structured, data-driven approach used to improve existing processes. (Appendix D).

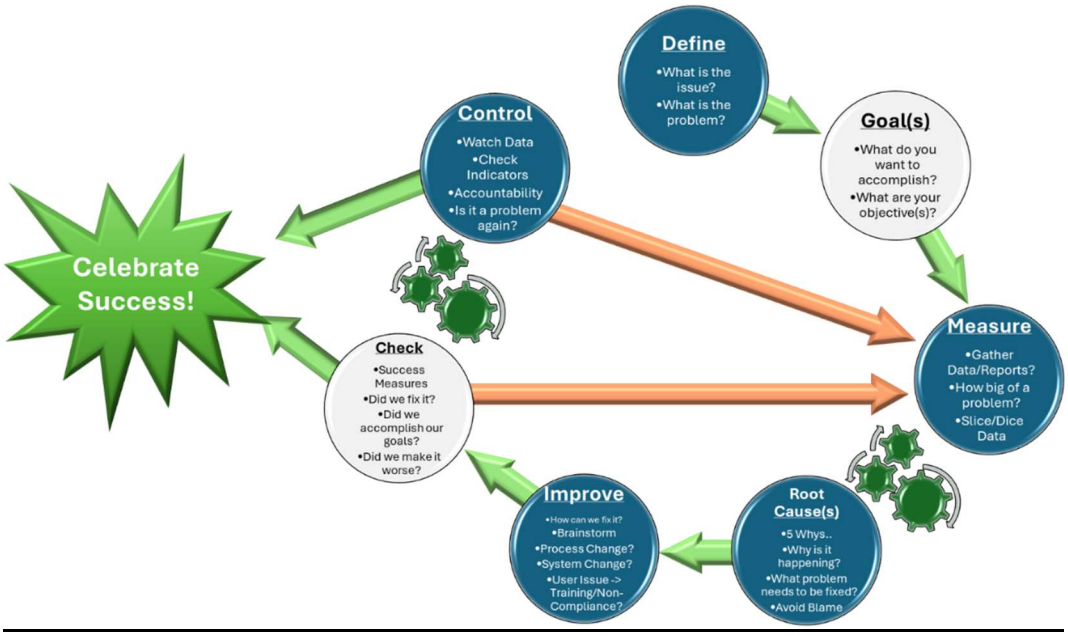
Define: Performance improvement plans (PIPs) will either be defined by the Quality Governance Council's annual plan and assigned to the committee or by the QI Committee itself in its ongoing data monitoring responsibilities. Definitions typically include 2 components: 1) a problem and 2) a goal. (e.g., Reduce the average response time to a Grievance from 35 to 28 days by mm/yy). This phase of quality improvement is meant to answer the question, "What is the performance issue?"

Measure: Once a performance issue has been defined, the QI Committee will 1) determine whether and what types of additional data are needed to better understand the issue (e.g., investigating and learning more about processes involved), 2) identify possible contributing issues, and 3) develop hypotheses about the root issue. This phase of quality improvement is meant to answer the question, "How big is the problem?"

Analyze: The QI Committee will review all available data to identify contributing and root causes of the performance issue. This phase of quality improvement is meant to answer the question, "Why is this performance issue occurring?"

Improve: Once the driver(s) of the performance issue have been identified, the QI Committee identifies an effective solution(s). While the QI Committee is responsible for identifying a solution(s), teams outside of the committee will be responsible for implementing the proposed solution(s). Members of the QI Committee will be consulting and informing SCCMHA staff throughout the DMAIC process, but extra-committee communication is critical at this phase to ensure the solution can be implemented. This phase of quality improvement is meant to answer the question, "How can we meet our defined goal?"

Control: Once a solution(s) has been implemented, the QI Committee will identify and monitor key performance indicators to ensure the performance issue is resolved. On-going monitoring may be needed to determine whether the solution is effective and sustainable. This phase of quality improvement is meant to answer the question, "How can we be sure that the solution(s) implemented will create permanent change?"



PROVIDER QUALIFICATIONS AND SELECTION

The QIP contains written procedures to determine whether physicians and other health care professionals--licensed by the State and employed by or contracted to the CMHSP--are qualified to perform their services. The QIP also has written procedures to ensure that non-licensed providers of care or support are qualified for their roles. These procedures are outlined in Policy and Procedure ***05.06.03.01*** titled ***Credentialing and Recredentialing of Providers and Staff***. These procedures describe how findings of the QIP are incorporated into the re-credentialing process.

ENROLLEE RIGHTS AND RESPONSIBILITIES

Monitoring of Rights – Saginaw monitors compliance with and ensures that each individual has all the rights established in Federal and State law.

Recipient Rights Office – Saginaw has established an Office of Recipient Rights (ORR) that is monitored for compliance with the requirements of Chapter 7 of the Michigan Mental Health Code, as evidenced by a site review conducted by the state agency.

Recipient Rights Annual Report – Saginaw ORR submits an annual report of the to the state office as required by Chapter 7 of the Michigan Mental Health Code.

UTILIZATION MANAGEMENT

Written Program Description - The Utilization Management Department of SCCMHA is tasked with effectively managing the specialty services funded by Medicaid and Healthy Michigan and organized under the following federal authorities including Medicaid Waivers (HSW, SED and CWP), 1915 iSPA, and specialty behavioral health services contained in the Early Periodic Screening Diagnosis and Treatment (EPSDT) and State Plan Services sections of the Michigan Medicaid Program.

UM develops policies and procedures to fulfill all requirements of the MSHN UM Plan related to medical necessity, criteria used, information resources, and the process used to review and approve the provision of medical services.

Scope – The UM plan has mechanisms to identify and correct under-utilization and overutilization of services.

Procedures – Procedures are in place to conduct prospective, concurrent, and retrospective reviews. In compliance with MDHHS, the UM plan ensures the following:

- Review decisions are supervised by qualified medical professionals.
- Saginaw collects all necessary information, including pertinent clinical information, and consults with the treating physician as appropriate.
- The reasons for decisions are clearly documented and available to the person served.
- There are clearly communicated and readily available appeals mechanisms for both providers and patients. Notification of a denial includes a description of how to file an appeal.
- Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
- Saginaw evaluates program effectiveness through data on person served satisfaction, provider satisfaction or other appropriate measures.
- SCCMHA does not delegate UM functions.

SCCMHA FY 2025 ANNUAL QUALITY REPORT - FY 2024 PLAN REVIEW

FY2024 Goal	Update
Create a Business Intelligence Governance Council.	It was determined that the creation of a Business Intelligence Council would not occur at this time as it was not conducive to the creation and implementation moving forward with the Quality Improvement Program.
Establish a Business Intelligence Data Integrity chartered workgroup.	BIDI workgroup was created with the Business Intelligence Coordinator being the chair. The taskforce is focusing on data integrity issues.
Develop a Data Driven Quality Improvement Program.	Completed with the assistance of TBD Solutions.
Complete a communication plan for sharing reports outward through the organization to persons served and the public.	In development with the operationalizing of the QIP Re-Design.
Initiate project reports at least annually summarizing work of Chartered Workgroups.	In development with the operationalizing of the QIP Re-Design.
Ensure compliance with Accreditations and Audits (CARF, MDHHS Waiver Review, MSHN MEV Review, MSHN Quality Assurance Review, HSAG PMV Review	Complete.
Meet CCBHC Demonstration Year 3 Data benchmarks	Progress is being monitored as information is available. Will not know final outcome until well into CY 2025 due to some of the measures being State Reported and need to await data from MDHHS.
Develop Power BI Report Dashboards	In development within the Data and Reporting Team. An additional position was added in late FY2024, and a new staff will begin in early FY2025 to help with the development of new dashboards for the Quality Improvement Program Redesign.
SCCMHA QIP #1: By the end of FY24Q1 (12/31/2023), the overall percentage of new persons receiving a completed initial biopsychosocial assessment within 14 calendar days of a non-emergency request for service (2a) will increase by 10%. Target = 25.73%	Due to the interventions outlined in this QIP, the in-compliance rate for number of persons receiving a completed initial biopsychosocial assessment within 14 calendar days of a non-emergency request for service increased to 46.03% which is 20.3% more than intended target amount.

FY2024 Goal	Update
SCCMHA QIP#2: The goal is to decrease number of MRSS EBP's appearing on the report under the wrong team to no more than 10 errors of this nature per report by the end of FY2024.	The EBP leadership team achieved less than 10 errors specific to MRSS, but we are seeing general errors across the board and are rolling ongoing MRSS errors into another project to address errors more broadly in FY2025.
SCCMHA QIP#3: Increase Cognitive Behavior Therapy (CBT) numbers in the EBP metric report. Each team that has a therapi**st** should have some data showing CBT use. Each team with one or more therapists will show CBT in their metric data of 10 or more notes per quarter by 09/30/24.	Increase in the selection of CBT was evident by the end of FY2024. Monitoring will continue into FY2025.
Develop a Goal Grading Exercise and Tool	The organization recognized the need to improve goal writing and initiated a quality improvement process to develop a Goal Grader tool. The team conducted research on person-centered planning standards and State guidelines to align goal-writing practices with best practices. They reviewed and critiqued existing goals in the EHR, developing objective standards for high-quality goals. These standards guided the creation of an intelligent model that evaluates and provides feedback on goal quality. Experts rigorously tested and refined the tool for accuracy and usability. Clinical and supervisory teams then received training on effective goal-writing and the tool's application, with a set timeline for implementation and feedback to drive continuous improvement.

SCCMHA FY 2025 ANNUAL QUALITY PLAN - FY 2025

The intent of the QIP is to continuously monitor and improve in all areas. The annual QI goals are intended to take a deep dive into an area that has continually struggled to meet targets or requirements.

FY 2025 QUALITY IMPROVEMENT PROGRAM GOALS	RESPONSIBLE
Operationalize The QIP Re-Design	Quality Governance Council
Assisting the CIO/ CQCO with operationalizing the ACCESSIBILITY committee.	Melissa Gutzwiller, Director of Customer Service
Assisting the CIO/ CQCO with operationalizing the ACCOUNTABILITY committee.	Jan Histed, CFO
Assisting the CIO/ CQCO with operationalizing the BEST PRACTICE committee.	Jennifer Keilitz, Director of Network Services
Assisting the CIO/ CQCO with operationalizing the OUTCOMES committee.	Jen Kreiner, Chief of Integrated Health
Assisting the CIO/ CQCO with operationalizing the SAFETY committee.	Kentera Patterson, Officer of Compliance & ORR
Assisting the CIO/ CQCO with operationalizing the SERVICE DELIVERY committee.	Kristie Wolbert, Executive Director of Clin Srvs

FY 2025 COMMUNITY NEEDS PRIORITIES	COMMITTEE RESPONSIBLE
Priority 1: Juvenile Care	Service Delivery Committee
Priority 2: Access To Care - Service Availability	Accessibility Committee
Priority 3: Staffing – Shortages	Accessibility Committee
Priority 4: Awareness Programs	Accessibility Committee
Priority 5: Homelessness	Outcomes Committee

FY 2025 STRATEGIC PLAN
Strategic Goal 1.1: Increase the Numbers of Persons Served Across All Populations (and Improve Persons Served Experience at all Access Points)
Strategic Goal 1.2: Expand the Expectation and Use of the Service Array Across All Populations
Strategic Goal 1.3: Expand Data Collection and Quality Reporting
Strategic Goal 2.1: SCCMHA Leadership Training
Strategic Goal 2.2: Institutionalize Relationships with Community Partners to Ensure They Are Not Personality Dependent (predictable environment)
Strategic Goal 2.3: Staff Retention, Recruitment and Supporting Equity, Diversity, & Inclusion (DEI) Among the Workforce and Network
Strategic Goal 2.4: Addressing and Enhancing Staff Safety & Accountability
Strategic Goal 2.7: Knowledge Transfer to Emerging Leaders
Strategic Goal 3.2: Information Systems - Future Electronic Expansion
Strategic Goal 3.3: Information Technology - Update and Improve the Information Technology Infrastructure and Workforce Technologies
Strategic Goal 3.4: Business Intelligence - Transform Information Management to “Business Intelligence” to Measure Persons Served Quality of Care, Informed Decision Making and Improved Business and Clinical Outcomes
Strategic Goal 3.5: Quality Improvement - Build a Data Driven Quality Program Based on Business Intelligence

FY 2025 STRATEGIC PLAN
Strategic Goal 3.6: Information Security - Ensure all Information Technology Assets, Information Systems, Digital Property and Sensitive Data stay protected, safe, secure, available, and free of any damage, breach, or security incident caused by an internal or external bad actor.
Strategic Goal 4.1: Explore and Develop our Roles in Healthcare
Strategic Goal 4.2: Core Skills for Workforce on Physical Health and Substance Use Disorders
Strategic Goal 5.1: Health and Wellness
Strategic Goal 6.1: Capital Asset Projects
Strategic Goal 6.2: Develop a Long-Term Financial Stability Plan
Strategic Goal 6.3: Develop a Long-Term SCCMHA Staffing and Network Provider Stabilization Effort
Strategic Goal 6.4: Ensuring Mastery for First/Third-Party Service Billing and Related Credentialing for Coordination of Benefits

FY 2025 QUALITY IMPROVEMENT COMMITTEE DOMAIN GOALS				
ACCESSIBILITY				
DOMAIN	**REFERENCE**	**QI GOAL NAME**	**SMART GOAL**	**JUSTIFICATION**
Accessibility	FY25 ABA Utilization	Autism Utilization (ABA)	In FY25, SCCMHA will identify ABA service utilization themes across the network and develop a plan of correction to manage financial risk.	The funding for ABA services has not been sufficient to meet our service population's needs. Care Management has indicated that there may currently be an over utilization of ABA services that reduces funding and service availability for persons that are currently in need of, but not in services. Monitoring the utilization of ABA services and the progress of our persons served will help to identify any service themes that may be contributing to over utilization and identify actions of remediation.
Accessibility	FY25 MSHN PIP 1	Increase Access To BIPOC Community (MSHN PIP 1)	In FY25, SCCMHA will reduce the gap for the standard of receiving a medically necessary ongoing service within 14 days of the biopsychosocial assessment between new persons who are Black/African American compared to white by X days. Goal reduction will be determined at start of FY.	This is a MSHN PIP. As a region, the gap between new persons receiving a medically necessary ongoing service within 14 days of the biopsychosocial assessment between the Black and white population is statistically significant. Specifically, for SCCMHA in CY24 Q1, the in-compliance rate for new persons who are white was 61.11%, while the in-compliance rate for new persons who are black was 57.72%.
Accessibility	FY25 MSHN PIP 2	Increase Access To BIPOC Community (MSHN PIP 2)	In FY25, SCCMHA will implement targeted interventions that reduce the racial and ethnic disparities in the penetration rate between Black/African American and white individuals eligible for Medicaid Services by XX%. Goal reduction will be determined at start of FY.	This is a MSHN PIP. As a region, the disparity in the penetration rate between the Black and white individuals eligible for Medicaid Services is statistically significant. Specifically, for SCCMHA in CY24 Q2, the penetration rate for Medicaid eligible persons who are white was 7.62%, while the penetration rate for Medicaid eligible persons who are Black was 7%.
Accessibility	I-SERV 1A	I-SERV 1A - Meet Time To Services Metrics	I-SERV 1A: In FY25, SCCMHA will perform monthly monitoring to ensure the average number of calendar days between first contact and initial evaluations for new clients is at or below 14 days.	The standard for the I-SERV metrics to receive the CCBHC Quality Bonus Payment is to be greater than or equal to the 25th percentile. As we do not currently know what the 25th percentile rate will be, we are striving for improvement of our current performance.

DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	JUSTIFICATION
Accessibility	I-SERV 1B	I-SERV 1B - Meet Time To Services Metrics	I-SERV 1B: In FY25, SCCMHA will perform monthly monitoring to ensure the average number of calendar days between first contact and initial clinical services for new clients is at or below 28 days.	The standard for the I-SERV metrics to receive the CCBHC Quality Bonus Payment is to be greater than or equal to the 25th percentile. As we do not currently know what the 25th percentile rate will be, we are striving for improvement of our current performance.
Accessibility	I-SERV 1C	I-SERV 1C - Meet Time To Services Metrics	I-SERV 1C: In FY25, SCCMHA will perform monthly monitoring to ensure the average time between first crisis episode contact and provision of crisis services remains at or below 1.5 hours.	The standard for the I-SERV metrics to receive the CCBHC Quality Bonus Payment is to be greater than or equal to the 25th percentile. As we do not currently know what the 25th percentile rate will be, we are striving for improvement of our current performance.
Accessibility	I-SERV 1C.1	I-SERV 1C.1 - Meet Time To Services Metrics	I-SERV 1C.1: In FY25, SCCMHA will perform monthly monitoring to ensure the average number of hours between mobile crisis episode contact and provision of crisis services remains at or below 2 hours.	The standard for the I-SERV metrics to receive the CCBHC Quality Bonus Payment is to be greater than or equal to the 25th percentile. As we do not currently know what the 25th percentile rate will be, we are striving for improvement of our current performance.
Accessibility	I-SERV 1C.2	I-SERV 1C.2 - Meet Time To Services Metrics	I-SERV 1C.2: In FY25, SCCMHA will perform monthly monitoring to ensure the average number of hours between urgent care crisis episode contact and provision of crisis services remains at or below 1 hour.	The standard for the I-SERV metrics to receive the CCBHC Quality Bonus Payment is to be greater than or equal to the 25th percentile. As we do not currently know what the 25th percentile rate will be, we are striving for improvement of our current performance.
Accessibility	I-SERV 1C.3	I-SERV 1C.3 - Meet Time To Services Metrics	I-SERV 1C.3: In FY25, SCCMHA will perform monthly monitoring to ensure the average number of hours between any other episode contact and provision of crisis services remains at or below 1 hour.	The standard for the I-SERV metrics to receive the CCBHC Quality Bonus Payment is to be greater than or equal to the 25th percentile. As we do not currently know what the 25th percentile rate will be, we are striving for improvement of our current performance.

ACCOUNTABILITY

Accountability	BH-TEDS	Behavioral Health Treatment Episode Data Set	Throughout FY25, SCCMHA will perform monthly monitoring of the BH-TEDS completion rate to ensure a completion rate of 95% or above. In FY25, SCCMHA will identify areas of	The standard for BH-TEDS is 95% completeness. BH-TEDS provide a lot of useful data for understanding the people we serve and identifying areas of needs, making it important that these fields be entered into the EHR. There are often many human errors with manual data entry. It

			the BH-TEDS data set that would benefit from data validation to improve data integrity.	is important to regularly validate that our data is correct and complete while cleaning up any errors.

BEST PRACTICE				
Best Practice	ZS	Zero Suicide	In FY25, SCCMHA clinical staff will develop Collaborative Safety Plans for 55% of persons served with Serious Mental Illness.	Reactive interventions are not an option for Zero Suicide. We must be proactive in our efforts and create collaborative safety plans for the persons we serve that are at the highest risk.
Best Practice	FUH-AD	Follow-up Metrics	Throughout FY25, for adults hospitalized for treatment of mental illness or intentional self-harm, SCCMHA clinicians will have a 30 day follow up rate of 85% and a 7 day follow up rate of 60%.	FUH is a CCBHC Quality Bonus payment metric. We have not been hitting the benchmarks for adults or children. The group needs to dive into why we are not hitting the metrics and implement strategic plans to meet the marks.
Best Practice	FUH-CH	Follow-up Metrics	Throughout FY25, for children hospitalized for treatment of mental illness or intentional self-harm, SCCMHA clinicians will have a 30 day follow up rate of 95% and a 7 day follow up rate of 75%.	FUH is a CCBHC Quality Bonus payment metric. We have not been hitting the benchmarks for adults or children. The group needs to dive into why we are not hitting the metrics and implement strategic plans to meet the marks.
Best Practice	IET	Initiation and Engagement into SUD Treatment IET IET14 AD IET34 AD	In FY25, SCCMHA will develop a process to collect data on the initiation and engagement of SUD treatment and establish a baseline for improvement.	This is a state reported measure that we are currently not tracking ourselves but is attached to a quality bonus payment. We need to develop a way to collect this data and track it to regularly see if we are hitting the benchmarks and where we need to improve.
Best Practice	IET14 AD	Initiation and Engagement into SUD Treatment IET IET14 AD IET34 AD	In FY25, SCCMHA will develop a process to collect data on the initiation and engagement of SUD treatment and establish a baseline for improvement.	This is a state reported measure that we are currently not tracking ourselves but is attached to a quality bonus payment. We need to develop a way to collect this data and track it to regularly see if we are hitting the benchmarks and where we need to improve.
Best Practice	IET34 AD	Initiation and Engagement into SUD Treatment	In FY25, SCCMHA will develop a process to collect data on the initiation and engagement of	This is a state reported measure that we are currently not tracking ourselves but is attached to a quality bonus payment. We need to develop a way to collect this data and

		IET IET14 AD IET34 AD	SUD treatment and establish a baseline for improvement.	track it to regularly see if we are hitting the benchmarks and where we need to improve.

OUTCOMES				
Outcomes	AAP	BHH Quality Bonus Metrics: Adults Access to Preventive/Ambulatory Health Services	In FY25, SCCMHA will establish a baseline rate for persons served aged 20 years or older who had a preventive or ambulatory care visit during the last 12 months.	This standard is tied to a quality bonus payment that is measured by exceeding the state and regional rates. We are currently not monitoring this data and need to establish a baseline rate of where we are at and how much we can improve.
Outcomes	MichiCANS	MichiCANS	In FY25, SCCMHA will identify the data measures related to MichiCANS that need to be monitored for quality improvement. i.e. The average time it takes each staff member to complete the assessment.	We are in the early stages of the MichiCANS rollout, which makes it the perfect time to start identifying the measures that we want to monitor for success. Early interventions will help make sure processes are running efficiently before bad habits set in.
Outcomes	CBP	BHH Quality Bonus Metrics: Controlling High Blood Pressure	In FY25, SCCMHA will monitor the blood pressure of persons served, with a focus on individuals with a diagnosis of hypertension, to establish a baseline rate of adequately controlled blood pressure.	This standard is tied to a quality bonus payment that is measured by exceeding the state and regional rates. We are currently not monitoring this data and need to establish a baseline rate of where we are at and how much we can improve.
Outcomes	HBD-AD	Hemoglobin A1C Control	In FY25, SCCMHA will develop a process to collect hemoglobin A1C levels for persons served between the ages of 18-75 with diabetes and establish a baseline for improvement.	This is a state reported measure that we are currently not tracking ourselves but is attached to a quality bonus payment for being at or above the 25th percentile. We need to develop a way to collect this data and track it to see where we currently are at and how we can improve.
Outcomes	DEP-REM-6	DEP-REM-6	In FY25, SCCMHA will perform a quarterly review of persons served with Major Depression or Dysthymia who did and did not reach remission within six months after an index event date to identify services and practices that positively contribute to reaching remission.	DEP-REM-6 is another CCBHC quality bonus standard where we must be greater than or equal to the 25th percentile. Comparing cases where remission was reached in six months to cases where remission was not reached may give insight to treatment plans, service considerations, or supports that have a higher efficacy with reaching remission from a Depression diagnosis.

Outcomes	PCR-AD	PCR-AD	In FY25, SCCMHA will perform an analysis of factors that influence unplanned acute readmission following an acute inpatient or observation stay, specific to our persons served, to develop best practices to support persons served and reduce the number of readmissions.	This is a state reported measure attached to a quality bonus payment that we are barely hitting the 10% benchmark for. It is important that the group identify best practices that have been shown to reduce the number of readmissions, so that we may proactively support persons served in the best way.
Outcomes	SDoH	Screening for SDoH	SCCMHA will standardize annual SDoH screenings for clients 18 years and older, to reach a screening rate of 100% by the end of the FY25.	As of 12/12/24, the percentage of clients 18 years and older that were screened for Social Drivers of Health was 7.5%. Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety play a huge role in a person's mental health care. These screenings need to be prioritized to identify areas where assistance is needed.
Outcomes	SRA-A	Suicide	In FY25, SCCMHA will perform monthly monitoring to raise Suicide Risk Assessment rates for adults with major depressive disorder to 80% by identifying teams and clinicians that may need additional guidance.	The Suicide Risk Assessment metrics are tied to quality bonus payments. In the past SCCMHA has struggled to hit these benchmarks. The benchmarks have been increased to 73% for adults for Demo Year four. An emphasis will be placed on identifying teams and staff that have lower rates of completing the suicide risk assessments so guidance may be given to raise the rates.
Outcomes	SRA-C	Suicide	In FY25, SCCMHA will perform monthly monitoring to raise Suicide Risk Assessment rates for children with major depressive disorder to 60% by identifying teams and clinicians that may need additional guidance. Goal will be further be defined at start of FY.	The Suicide Risk Assessment metrics are tied to quality bonus payments. In the past SCCMHA has struggled to hit these benchmarks. The benchmarks have been increased to 57% for children for Demo Year four. An emphasis will be placed on identifying teams and staff that have lower rates of completing the suicide risk assessments so guidance may be given to raise the rates.
Outcomes	1915i	Improve score on 1915i Wavier Review	Improve score on 1915i Wavier Review over FY24 results. Improve score on Plan of Service and documentation Improve score on Health and Welfare. Goal will be further defined at start of FY.	Requirement of MDHHS & MSHN - CMHSP delegated managed care review

Outcomes	HSW	Improve score on Hab Support Waiver Review	Improve score on Hab Support Waiver Review over FY24 results. Goal will be further defined at start of FY.	Requirement of MDHHS & MSHN - CMHSP delegated managed care review
Outcomes	SEDW	Improve score on SED Waiver Review	Improve score on SED Waiver Review over FY24 results. Goal will be further defined at start of FY.	Requirement of MDHHS & MSHN - CMHSP delegated managed care review

SAFETY				
Safety	Behavior Review Data	Physical intervention reduction	Reduce the number of physical interventions and 911 calls for behavioral assistance.	The study is required by the Michigan Department of Health and Human Services (MDHHS). The data collected is based on the definition and requirements that have been set forth within the Standards for Behavioral Treatment Review attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract. Goal reduction will be determined at start of FY.
Safety	Behavior Review Data	Improve the Behavior Treatment Plan Committee's effectiveness	Evaluation of the BTP Committee's effectiveness by stakeholders, individuals who have a plan, family members and advocates shall occur annually as part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP).	The purpose of this procedure is to guide Mid-State Health Network (MSHN) in monitoring the delegated function of Behavior Treatment Plan (BTP) Review Committees to the Community Mental Health Service Program (CMHSP) Participants in accordance with the Michigan Department of l Health and Human Services Medicaid Managed Specialty Supports and Services Contract, P.1.4.1 Standards for Behavior Treatment Plan Review Committees (BTPRC).
Safety	Critical Incident - Arrest	Reduce arrests	Reduce arrests of SCCMHA persons served over FY25.	Quality Assessment Performance Improvement Program Quality Improvement Council – Critical Incidents: Quality Assessment Performance Improvement Program MSHN will demonstrate a decrease in the rate of critical incidents, excluding deaths from the previous year. Critical Incidents include an arrest, emergency medical treatment/hospitalization for an injury or medication error for individuals who are receiving a waiver service.

Safety	Critical Incident - Non-Suicide Deaths	Reduce non-suicide deaths	Reduce non-suicide deaths of SCCMHA persons served over FY25.	Quality Assessment Performance Improvement Program Quality Improvement Council – Critical Incidents: MSHN will demonstrate a decrease in the rate of Suicide Deaths and Non-Suicide Deaths from the previous year.

SERVICE DELIVERY				
Service Delivery	MHSIP	MHSIP performance improvement.	Improve performance on MHSIP over FY25. Goal will be further defined at start of FY.	Annual completion and submission of the Patient Experience of Care Survey analysis of results and comparison to region.
Service Delivery	YSS	YSS performance improvement.	Improve performance on YSS over FY25. Goal will be further defined at start of FY.	Annual completion and submission of the Youth Services Survey for Families (YSS) analysis of results and comparison to region.

APPENDIXES

- A - Quality Reports and Measures by Domain
- B - Saginaw QIP Reporting and Monitoring Schedule
- C.1 - Charter - Accessibility Quality Committe.docx
- C.2 - Charter - Accountability Quality Committe.docx
- C.3 - Charter - Best Practice Quality Committe.docx
- C.4 - Charter - Outcomes Quality Committe.docx
- C.5 - Charter - Safety Quality Committe.docx
- C.6 - Charter - Service Delivery Quality Committe.docx
- D - QI Annual Goal Report DMAIC Template.docx
- E - QI Committee Report Analysis Template.docx
- F - QI Committee Agenda Template.docx

GRAPHICS DIAGRAMS AND VISUALS

- Monitoring of Committee Reports.pdf
- QIP Domains.pdf
- QIP Life Cycle.pdf
- QIP RACI Model of Quality Improvement.pdf
- QIP RACI Process Assignment.pdf
- QIP System Structure.pdf
- Quality Committee Responsibilities.pdf
- Quality Committees vs Treatment Teams.pdf
- Quality Governance Council.pdf
- Quality Improvement Program.pdf
- SCCMHA's RACI Model of Quality Improvement.pdf
- The Quality Improvement Life Cycle.pdf

REFERENCES

- 01 - QIP Universe of Measures.xlsx
- 02 - 2023 CMH BHTEDS Monitoring.xlsx
- 03 - 2023 CMH Encounter Monitoring.xlsx
- 04 - CMH Clinical Chart Review Tool
- 05 - CMH Delegated Managed Care Tool - PSV.docx
- 06 - Critical incident PSV Supplemental Tool.xlsx
- 07 - Program Specific Review Tool Non-Waiver PSV.docx
- 08 - Provider Network Review Tool.docx
- 09 - CMH FY24 1915i Chart Review - Final.docx
- 10 - CMH FY24 CWP Chart Review - Final.docx
- 11 - CMH FY24 HSW Chart Review - Final.docx
- 12 - CMH FY24 SEDW Chart Review - Final.docx
- 13 - CMH FY24 Waiver Administrative Review - Final.docx