Macomb County Community Mental Health (MCCMH) Quality Assessment Performance Improvement Program

Year End Report 2020

MCCMH Quality Assessment Performance Improvement Program Evaluation

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Introduction

The MCCMH Prepaid Inpatient Health Plan (PIHP) is required by the Michigan Department of Health and Human Services to maintain a Quality Assessment and Performance Improvement Program (QAPIP). The final approval of the QAPIP lies with the MCCMH Board of Directors. The previous QAPIP remains in effect until the new one is finalized. The final QAPIP will be disseminated to the Board, the Citizen Advisory Council, and the MCCMH Providers. The QAPIP will be posted on the MCCMH website and provided to the public upon request.

Board input and approval are necessary components of the QAPIP. The Board will receive progress reports on focus areas of the QAPIP through various presentations on the specific projects identified in the QAPIP. Please note that the QAPIP is not all inclusive as there are a number of improvement activities ongoing throughout the organization. An annual summary of the QAPIP will be submitted to the Board which will include actions taken, progress to meeting the goals and improvements to the quality of the services provided.

MCCMH Accomplishments

Establishment of a Certified Community Behavioral Health Clinic

MCCMH was granted approval and federal funding to establish a Certified Community Behavioral Health Clinic (CCBHC) which will be known as "Integrated Health Macomb." The purpose of the proposed Integrated Health Macomb (IHM) project is to expand and enhance targeted protocols, services, rate and ease of access, and community capacity consistent with the CCBHC expansion grant requirements for all residents living in Macomb County, Michigan, the surrounding area, and those in need of services beyond the traditional catchment areas. Community needs were identified though a needs assessment. The services will be focused on increased access to services, primary and behavioral healthcare

integration, community relationships and care coordination, clinical excellence, crisis emergency response, training for community and staff, and services to veterans. Services will be documented in a manner that demonstrates proven outcomes. National outcomes measures are entered and monitored within the CMS-SPARS database. Mid-year and annual reports are provided directly to CMS.

Coronavirus Response

The Coronavirus dramatically impacted services within MCCMH. Although the virus is a negative factor in the lives of many of the people that we serve, the exemplary response by MCCMH staff and administration allowed for services to continue in an efficient and effective manner. MCCMH was able to provide services via telecommunication utilizing various forms of contact, including phones, computers, I-Pads, etc. to reduce the risk of the spread of the disease. When those forms of communication were deemed inadequate, essential services continued face to face using utilizing appropriate personal protective equipment. Outreach to the Provider Agencies through meetings, memos, directives, and phone calls on a consistent basis to provide them with the support that is needed through this time. MCCMH continues to provide services in any way possible to ensure the safety of the persons that we serve. A Provider Sustainability Plan was also developed, updated and reported to BHDDA on a monthly basis from June through December of 2020.

Data Collection and Analytics

MCCMH has developed numerous reporting capabilities to include access and monitoring. Network providers now have access to individualized reports and dashboards. Ongoing development of HEDIS reporting continues including completion of the follow up hospitalization (FUH) indicator.

Increased participation in Member Satisfaction Surveys

Participation in the Member satisfaction surveys grew from 300 in 2019 to 1100 in 2020. This increase was directly impacted by a tracking system that was implemented with the case managers and supports coordinators to ensure all persons served were given the opportunity to provide feedback. Previous surveys were distributed to the person that we serve via the case manager giving them a paper copy of the survey and having it mailed back to the Quality department. Since the pandemic dramatically limited the number of persons that were seen face to face, Quality utilized other methods. The primary case holder contacted persons

they served by phone to inform them that they could complete the survey either via phone with their primary provider, use survey monkey via a link they were sent, request a paper copy via US mail, or provide a phone number to the Quality department who would contact them for feedback. Questions were revised to indicate any deficiencies that might not have been identified in previous questions. The survey results indicated only one area was below the threshold of 80% agree or strongly agree, which was access to a psychiatrist when needed. This may be due to the fact that the survey did not have an N/A for those who do not see a psychiatrist. However, since the question fell below the 80%, the Chief Medical Officer will address this issue through the new QAPIP work plan goal to improve doctor services and access to services.

Disparity Workgroup

MCCMH has written a strategic plan and developed a workgroup to ensure that disparity is addressed within the network. This workgroup has developed a work plan and is currently gathering data to identify any disparities in the system.

Website

An updated website has been developed that offers ease of access and navigation throughout the site.

Evidence Based Practices

Cognitive Enhancement Therapy (CET) and Prolonged Exposure Therapy (PET) were offered for the first time this year. During the pandemic, the provision of the CET therapy underwent some changes but continued virtually. A graduation of CET participants occurred in October 2020.

Organizational Quality Structure

The QAPIP is managed by the MCCMH Quality Council, which is chaired by the MCCMH Chief Operating Officer, and includes the Chief Executive Officer, Chief Financial Officer, Chief Medical Officer, Chief Clinical Officer, Director of Managed Care Operations, Chief Network Officer, Chief Information Officer, Director of Substance Use Services, Chief Quality Officer, Director of Community Behavioral Health Services, Chief Compliance Officer, Chief of Staff, Communications Director and the Director of Recipient Rights.

The Quality Council is the highest oversight committee under the MCCMH Board of Directors. The Council convenes at least quarterly to ensure the MCCMH Mission and strategic plan are interwoven with all policies and procedures throughout the network. The Council oversees the various subcommittees and functions of the MCCMH QAPIP. The Council identifies and addresses specific issues in need of remediation and reviews on-going activities of the various subcommittees. Grievances and appeals are tracked and the trends reported to the Quality Council. The Council also reviews input from persons served utilizing satisfaction questionnaires, forums, and other forms of stakeholder input. All committee meeting minutes are continuously monitored and integrated into the overall quality improvement program. Necessary actions related to the QAPIP are taken to the Board regularly through the Chief Executive Officer, and annually through the QAPIP report.

The Council's objectives are to improve quality, maximize clinical outcomes, reduce cost and increase efficiency in service delivery. Through collaboration amongst the departments, the Quality Council is responsible for oversight of ongoing implementation of quality indicators, processes and outcomes across Macomb County as defined through the goals of the QAPIP. The QAPIP goal domains of Effectiveness, Efficiency, Satisfaction and Access support the mission of Macomb County Community Mental Health.

The Quality Council supports the following overall activities as these relate to the QAPIP goal domains of Effectiveness, Efficiency, Satisfaction and Access:

- Outcome Measurement
- Data integrity
- Performance Improvement Projects
- Clinical decision support and behavior treatment standards
- Oversight and implementation of Evidence Based Practices
- Assessment of consumer perception of care (surveys)
- Implementation of clinical training

MCCMH Committees and Work Groups

The following MCCMH committees promote the assurance of Quality Clinical Services and report to the Quality Council on at least a quarterly basis. These work groups represent a portion of those within MCCMH and are not all inclusive.

Improving Practices Leadership Team (IPLT) – This committee evaluates proposed and current evidence based practices and promising practices and outcomes. Clinical Practice Guidelines are reviewed at least annually.

Behavior Treatment Plan Review Committee (BTPRC) – This committee reviews behavior treatment plans with restrictive or intrusive techniques and provides approval or denial of plans with these techniques.

Clinical Risk Management Committee (CRMC) – The Clinical Risk Management Committee (CRMC) reviews areas of clinical risk within the MCCMH provider network. These include incident reports, findings of mortality reviews and Root Cause Analyses. Key findings and recommendations are provided to the Quality Council or Executive Staff for action, as necessary. The CRMC monitors process improvements in care to reduce morbidity and mortality in the MCCMH system.

Utilization Management Committee (UM) – The Utilization Management function is part of the overall QAPIP and operates as a main leadership group with periodic sub-groups (e.g., financial / insurance identification, integration of care, co-occurring workgroup). The UM committee ensures clinical practice guidelines are implemented throughout the network with specific protocols implemented. Use of physical and behavioral health utilization data is examined for improved health outcomes. The Utilization Management establishes mechanisms to ensure consistent and appropriate access to behavioral healthcare and member services. Benefit management including documented capacity and services packages is overseen by Utilization Management.

Integrated Health Care (IHC) – This committee ensures integration of medical and behavioral health, along with SUD.

Process Improvement Committee (PIC) - Development of the new data warehouse, dashboards, and reports. It also assists in the development and maintenance of the data dictionary.

Citizens Advisory Council (CAC) - The Citizens Advisory Council (CAC) is comprised of primary and secondary individuals served, service and advocacy representatives, and interested members of the community. It provides an avenue of access to MCCMH leadership for these groups, and a means for leadership to obtain direct constituent and community feedback on issues that impact the quality and range of services provided by MCCMH, as well as other issues that impact the MCCMH system overall.

Substance Abuse Advisory Council (SAAC) – The Substance Abuse Advisory Council (SAAC) is comprised of primary and secondary individuals served, service and advocacy representatives, and interested members of the community. It provides an avenue of access to MCOSA and MCCMH leadership for these groups, and a means for leadership to obtain direct constituent and community feedback on issues that impact the quality and range of services provided by MCOSA and MCCMH.

Mental Health Disparity Improvement Committee (MHDIC) – The Mental Health Disparity Improvement Committee (MHDIC) is comprised of stakeholders, persons served, community members, and providers. This group provides an avenue to identify and address disparity in access, engagement and on-going treatment provision, as well as outcomes.

In January 2020, the Clinical and Quality Departments were separated for a renewed focus on each of the departments. A Chief Clinical Officer was added to the Organization. This Officer provides support to the Organization though ongoing review of clinical practice guidelines and protocols, increased scrutiny of evidence based practices, management of the Behavioral Treatment Practices, enhanced integration of services, engagement of providers in the clinical oversight group and an ongoing focus on network training.

In July 2020, a Chief Medical Officer was added to the Organization, following the retirement of the previous Medical Director. The Chief Medical Officer provides oversight to the organization though ongoing scrutiny of all medical matters and integration of medical and behavioral health services. With the support of the Chief Quality Officer, the Chief Medical officer chairs risk management activities.

A Director of Communications began work with MCCMH in late 2019 and has been developing a new website and enhanced communications within the network.

As the public face of MCCMH, the Director is committed to an increase in consumer forums, community activities and communications, media correspondences, advertisements, and community outreach.

QAPIP Work Plan Evaluation

Key Performance Indicators

MCCMH works to ensure all Federal, State and Local contractual obligations are met. MCCMH has consistently met the key performance indicator to determine medical necessity for acute inpatient psychiatric hospitalization in a timely manner. MCCMH continues to work on network capacity regarding appointment availability addressing initial and ongoing appointments. MCCMH is working with hospital liaisons and developed a new contract with a provider to secure expedited appointments. A Request for Proposal (RFP) has been initiated to increase the provider network thereby increasing the number of available appointments. Discrepancies in the calendars between the Access Center and the providers are being investigated by the IS department to find a resolution. FUH (follow-up hospitalization) HEDIS measure and supporting reports have been implemented into dashboards for ongoing monitoring. Recidivism is being addressed through a performance improvement plan (PIP). The PIP for Recidivism was not validated, however, due to the importance of this project, it will continue with ongoing initiatives. The COO, with the support of the Quality Department, holds monthly meetings to identify issues and resolve them. MCCMH implemented a process for face to face interventions, including crisis assessment, hospital determination, and community referrals, as appropriate. This has afforded the persons that we serve more timely access to services in a lesser restrictive level of care. This goal will be continued through fiscal year 20/21.

Improve Access to Services

In Fiscal Year 2019/2020, the Managed Care Department set a goal of answering all calls within 30 seconds. The intent of this goal was to improve access to services. The data collected by the call center phone system software indicates that in the first quarter the average speed in which the calls were answered was 2

minutes and 42 seconds. In the fourth quarter the average speed to answer was 56 seconds. This data shows that there have been significant gains made toward reaching this goal. This goal will continue and be monitored on an on-going basis through the Quality Council.

Community and Behavioral Health Department's goal of 100% of Walk-in individuals will be triaged for services within 30 minutes of arrival for fiscal year 19/20 was impacted by Covid-19. Although Open Access suspended face to face services on March 20, 2020, all services were continued via tele-health throughout the Pandemic.

The media campaign to increase the penetration rate continued through the year. Articles and interviews were expanded with the media to increase community knowledge of the system. Brochures were developed to enhance resource knowledge. A new user-friendly ADA compliant website was developed and will be implemented by December 2020. Promotion of service contracts were aligned with the media in preparation for the new fiscal year. Due to COVID, no public forums took place. This goal will continue with modifications.

Increase engagement in employment services

Due to COVID the activities for this goal were halted. An RFP was initiated by MCCMH to identify an agency that can enhance supported employment activities.

Expand Integrated Care and Improve Trauma Services

During FY 2020, the clinical department worked on training providers in writing integrated care goals. The goal was exceeded as 16 trainings were delivered to the network (the goal was set at 7 trainings). The trainings were on Hypertension and Circulatory Concerns for Adult and Child, and Child and Adult Diabetes and how to address these conditions in the person-centered planning process.

The Clinical Department identified five opportunities for a system of integrated care. They were identified as providing integrated care trainings, developing an integrated goal check box in FOCUS to measure integrated care plans, identifying a MyCare Wellness Coordinator and hospital liaison to bridge gap between medical and behavioral health, identifying an integrated care liaison in order to work out of three medical clinics to coordinate care and link individuals to

services, and an application to become a CCBHC (Certified Community Behavioral Health Clinic). All were met with the exception of the development of a check box in FOCUS to measure integrated care plans. Further development of the check box in the electronic health record (EHR) will continue to be a goal for the next fiscal year.

A Wellness Coordinator was identified to improve service integration at the co-located site with MyCare. Referral data was collected.

Additionally, the goal of implementing trauma screen into the FOCUS EMR was a focus. The Adult Screening for trauma (Life Events Checklist) was integrated into initial and annual assessments. The Child Screening (Young Child PTSD Checklist) is in the queue for implementation into the initial and annual assessments. This will be a continued goal for the next fiscal year.

Increasing staff competence in trauma was also a goal. Trainings related to working with trauma survivors were scheduled to be completed by end of second quarter. Due to COVID, these trainings were rescheduled into the new fiscal year and the goal will continue. The aforementioned initiatives have expanded the ability of the staff to provide more integration into their work and to address trauma when it is presented.

Ensure Member's Rights

The goal to ensure the completion of all Right's investigations within the mandated timeframes has been met consistently through the year. The Right's Department has consistently exceeded contract requirements and expectations. Due to the importance of this goal and to ensure member's rights within MCCMH, this goal will continue.

Customer Service Improvement

During fiscal year 19/20, a review of MCCMH's customer service documents, procedures and preliminary data was completed. Based on the review, goals to enhance written policies, procedures and team member training were established. In order to increase accountability and structure, a Customer Service Administrator position was created and filled by an experienced customer call center professional. As the lead of Customer Service, the new Administrator began to

create a Customer Service Handbook with corresponding procedures and a system wide training. The improvement of this office will allow for increased consistency and accountability for anyone contacting MCCMH. This goal will continue.

PIHP accreditation

The CCBHC readiness tool and RFP were completed and submitted. The CCBHC expansion grant was awarded to MCCMH May 2020. Integrated Health Macomb, the MCCMH CCBHC program, started providing services to persons served on 9/30/2020. Integrated Health Macomb continues to work on implementation of services and incorporating the philosophy into all domains of service. This Goal is complete.

An NCQA lead was identified and hired. The lead is attending conferences and trainings to formulate a plan to ensure implementation of NCQA standards across the entire system. The plan moving forward is detailed in the Rock description below. This goal will continue.

Workforce development and satisfaction

In FY2019/2020, the Team Member Engagement and Satisfaction Workgroup met and established a goal to improve overall communication at all levels of team members. During the period monthly CEO Newsletters and weekly Workforce Updates were established to increase timely and open communication. Team building activities occurred including, but not limited to, a LinkedIn Remote Worker social networking site, RN Team Member Appreciation week, Virtual Lunch Breaks with Games, Guess the Baby Contest, the creation of a Team Member Handbook and the selection of a Team Member Engagement Coordinator to enhance team member onboarding and continuous engagement. Data on staff satisfaction is being collected and will be reported and disseminated in January 2021, improvement of at least 2% is projected.

Network Adequacy

Network Operations began 2019/2020 fiscal year with the goals of developing a licensed residential placement tracking tool by March 31 in coordination with

Access Center referrals, continuing provider monitoring meetings to monitor the quality of work being performed and any service line that appears to have limited availability, at least twice annually for each provider and continuing monthly meetings where adequacies and inadequacies within the provider network are addressed.

Currently, the date for completion of the residential placement list has been extended to 10/2021 due to more pressing concerns because of the Covid-19 pandemic. However, a data driven workgroup has begun to discuss ability of MCCMH EMR (FOCUS) to manage placement tracking tool. Network Operations conducted monthly provider monitoring meetings to address overall network and provider needs. Adequacies and inadequacies within the MCCMH network are addressed at these provider monitoring meetings. Due to the pandemic, these meetings were conducted more frequently with the specific focus on provider needs due to COVID 19 pandemic. All providers were contacted via phone to offer assistance and address individual needs. An RFP was initiated to increase specialized residential service and ACT providers in the network. These goals will continue through FY20/21.

Increase report availability and accuracy

Information Systems goal at the beginning of this fiscal year was to move significantly forward in report development. A new data warehouse was developed with accurate data sets and functional reporting capabilities. The data warehouse continues to be refined. A weekly Process Improvement Committee (PIC) workgroup continues to develop, validate and disseminate reports throughout the network. Progress was made and these goals will continue.

Operate within MCCMH allocations and restore the Financial Risk Reserve

The department was able to successfully produce meaningful monthly financial statements suited to providing the board and management the needed information for making timely business decisions. The organization was also able to maximize the Medicaid Risk Reserve Funds.

Increase Quality services throughout the Network

MCCMH Quality Department is currently responsible for oversight of all network audits ensuring the safety and wellness of all persons served. Audits were conducted on an ongoing basis.

Internal Audits

Residential Audits –FY 2019/2020, MCCMH Quality performed audits of twenty seven residential homes. These audits are a comprehensive look at group homes in the domains of: person served charts, home maintenance, interviewing persons served and staff members, staffing, vehicle maintenance, medications, incident reporting, and training. The audits continued through the coronavirus pandemic via a virtual format. Although persons served interviews took place, a challenge presents itself in an effort to ensure confidentiality from the provider staff since the interview is virtual. Staff request that the consumer be able to speak without home staff present, however, it is not always possible depending upon the person's abilities. Once Quality is allowed to resume in person audits, in person interviews will resume. Due to identified deficiencies, some placements required intensive monitoring, ensuring necessary improvements were made. Remediation activities included staffing, training, maintenance, and placement changes.

Waiver Audit - The Quality department initiated staff qualification and training audits in November and December 2019. The Waiver programs include Child Waiver Program (CWP), Habilitation Supports Waiver (HAB), Autism Waiver, and Serious Emotional Display Waiver (SED). Three providers were reviewed initially with an additional ten providers reviewed in August 2020. The trending of the results showed that many of the providers were not up to date on the required trainings. The trainings were addressed in the corrective action plans submitted by the providers with a 99% compliance rate. In addition, a review of the MCCMH Children's Service Provider was conducted on a quarterly basis to ensure close monitoring of the choice voucher, billing discrepancies, and quality concerns to ensure appropriate tracking took place.

Hospital Audits - In January of 2020, MCCMH Quality completed 2 hospital audits. These audits consisted of looking at the physical site, quality initiatives, policies, interviewing persons served and staff members and

person served charts. In August/September of 2020 an audit was completed for an additional two hospitals under the same domains. Treatment planning was identified as an area for improvement. When necessary, corrective action plans were submitted and evidence was provided to remediate outstanding recommendations. Quality will continue to audit the hospitals on an annual basis.

ABA Audit - In February 2020 an Applied Behavioral Analysis (ABA)/Autism Waiver audit was completed, which surveyed the clinical, case management, diagnostic, training, and credentialing of the MCCMH ABA providers. Quality reviewed 15 providers, both contract and direct. Trend for improvement included implementation of credentialing and privileging committees as well as documentation of updated and ongoing trainings. Due to COVID-19 Corrective Action Plans (CAPS) were delayed until May 2020. Quality provided clinical, technical and training reviews for all network providers.

Clinical and Technical Audit - Clinical and Technical audits for MCCMH's outpatient providers began in April 2020. This audit reviewed consumer charts for clinical and technical content as well as training, and credentialing and privileging. Eight direct providers and fifteen contract providers were a part of this audit. Due to the pandemic, corrective action dates were extended but have since been returned. Currently, the Direct providers have satisfied all requirements and the contract providers are in the process of delivering evidence for their remediation.

All providers are afforded individual consultative meetings to support quality improvement efforts. This consultation was put into place to reduce the amount of time that the provider spends attempting to satisfy the requirements of the audit. The providers have reported approval of the initiation of the consultations.

In addition, when the Clinical Risk Management Committee identified areas of concern, specific audits were conducted and remediation was requested. When systemic actions or remediation was identified, communications were sent out to the providers.

MCCMH Network Operations continues to monitor the residential financial audits on an ongoing basis. Recipient Rights complaints and/or licensing are filed if violations are identified or suspected. Network Operations continues

to audit Home and Community Based Services (HCBS). MCCMH fulfilled the obligation for B3 HCBS corrective action submissions.

External Audits

The Health Services Advisory Group (HSAG) is contracted by MDHHS to provide a required external audit. The progress of the FY 17/18 and 18/19 corrective action plans was the focus of this year's HSAG activity. The 17/18 audit reviewed subcontracts and delegation, customer service, appeals and grievances, provider network, access and availability, appeals, disclosure of ownership, control and criminal convictions, and management and information systems. The 18/19 review appraised the QAPIP plan and structure, performance measurement, practice guidelines, staff qualifications and training, utilization management, member's rights and protections, individual and organizational credentialing, confidentiality, and coordination of care. There were four areas of deficiency identified. Utilization management scored 94%, organizational credentialing was 94%, QAPIP plan and structure scored 88% and the performance measurement scored 88%. The organization is working in consultation with HSAG to improve the scores to the 95% benchmark. A consultative meeting was held in December 2020 to identify possible remediation efforts.

The Health Services Advisory Group (HSAG) also conducted the Performance Measure Validation (PMV) and Information Systems Capabilities Assessment Tool (ISCAT) review. The purpose of the review is to assess the accuracy of performance measures reported by PIHPs and to determine the extent to which performance measures reported by the PIHPs follow state and federal specifications and reporting requirements. During the PMV review, HSAG also conducted a readiness review of information systems and processes used for data collection and reporting that will be used to calculate future performance measure rates. All applicable audit elements were found to have been met giving Macomb County full compliance with the review.

The CARF survey was conducted on October 22 and 23rd, 2020. The original date for this survey was set in May/June of 2020, but was pushed back due to the coronavirus pandemic. This virtual survey was administered to continue MCCMH's National accreditation for the following programs incorporated into the survey: assessment and referral, court treatment, case

management/support coordination, integrated behavioral health/primary care: comprehensive care, outpatient treatment, intensive family based services, crisis intervention, and call centers. MCCMH was awarded a three year accreditation.

Critical Incidents, Sentinel Events, Deaths, and Risk Events

During the 19-20 FY the Clinical Risk Management Committee (CRMC) and Quality reviewed areas of clinical risk within the MCCMH provider network. Incident reports were scrutinized which resulted in root cause analysis (RCA) or mortality reviews, when needed. At times, these analyses and reviews resulted in individual and systemic remediation.

Some notable actions which resulted out of the trending and systemic remediation included recommendations to providers to proactively serve as advocates for preventative care by providing education and direction in this area. Another action included the development of the Clinical Case Presentation and Review Team (CCPRT) which was developed to aid in problem solving challenging clinical concerns arising in the provision of treatment to individuals when clinical concerns were not been resolved with in-house clinical/team supervision. This group acts as an oversight for "vulnerable" individuals to determine opportunities to improve their care and outcomes. In the case of a trend occurring within any residential setting, a health and safety residential audit is prompted and completed.

Improve Opioid Treatment Services

In Fiscal Year 2020, the Substance Use Division focused on improving treatment services for individuals with opioid use disorder. The goal of this improvement was to develop and implement an Opioid Health Home (OHH) model of care. An Opioid Health Home is a model of care that provides comprehensive care management and coordination services to Medicaid beneficiaries with opioid use disorder. The model takes a holistic approach to health care and provides one "home" base for coordinating recovery and health needs while functioning as the central point of contact for directing patient-centered care across the broader health care system.

The Substance Use Division successfully recruited and contracted with two new Office Based Opioid Treatment providers and expanded this service with three

additional contracted Opioid Treatment Providers. Procedures were developed to identify and enroll individuals into the OHH program, training on the procedures, MDHHS data base, and OHH requirements was provided to all participating programs. A data tracking system has been developed to manage enrollment and disenrollment within the system.

Designed Process Improvement Projects

Rocks - MCCMH instituted Rock projects to ensure focus on identified improvement areas move forward as part of a newly implemented strategic planning process consisting of 90-day (Rocks) and annual initiatives. Examples:

Accreditation and Standards Rock

Achieve NCQA Accreditation for the organization by 2022. A staff member was hired to focus on incorporating NCQA standards into MCCMH practices. HEDIS measures were identified and a Request for Proposal (RFP) for an NCQA consultant group will be initiated, with a request to issue an RFP going to the Board in January. HEDIS measures will continue to be incorporated into the electronic health record and a readiness assessment will be completed in FY 20/21. The implementation of NCQA standards will allow for more uniform quality services throughout the system and the incorporation of complex care management on a more consistent basis to the individuals that we serve. The short term 90 day Rock project was complete. This project will continue for at least one year or until NCQA accreditation has been achieved.

Substance Use Disorder (SUD) Accreditation Standards were met for CCBHC requirements. This ROCK ensured that MCCMH is accredited to provide primary SUD services and can bill appropriately. A plan to provide evidence based services through an accredited staff with appropriate supervision and psychiatric services has been put in place for the Direct Operated Clinics under Integrated Health Macomb. There is ongoing work on the electronic health record to allow for documentation of substance use services in an electronic format. This project was successful. SUD services have been initiated through Integrated Health Macomb for anyone needing stand-alone SUD services who meets the criteria for IHM.

Improve Customer Service Department/Call Center Rock

This Rock is to ensure that the call center is timely and responsive by clarifying the call center function, developing one phone number for system navigation, identifying additional digital methods for consumer communication, identifying additional metrics and staffing to put in place, and refine after hours procedures. During the initial 90 days, MCCMH hired a new customer service administrator, performed a customer service survey, and researched regulations, call center calculators, and models. Over the next year, work will continue on the other aspects of the project identified above. Once completed, access will improve for all persons contacting MCCMH for any reason, thereby increasing communication with persons served and other stakeholders. This project will continue until complete. Completion date is expected to be September 2021.

Data Reliability Rock

MCCMH will clarify needed data and any inaccurate data, then develop a plan to ensure it is accurate and trusted. Reports and dashboards will be implemented and utilized daily for decision making, including key financial components. A weekly Process Improvement Committee (PIC) workgroup continues to develop, validate and disseminate reports throughout the network.

Develop and Implement a Team Member Engagement Process Rock

In FY2019/2020, the Team Member Engagement and Satisfaction Workgroup met and established a goal to improve overall communication at all levels of team members. During the period monthly CEO Newsletters and weekly Workforce Updates were established to increase timely and open communication. Team building activities occurred including, but not limited to, a LinkedIn Remote Worker social networking site, RN Team Member Appreciation week, Virtual Lunch Breaks with Games, Guess the Baby Contest, the creation of a Team Member Handbook and the selection of a Team Member Engagement Coordinator to enhance team member onboarding and continuous engagement. Data on staff satisfaction is being collected and will be reported and disseminated in January 2021, improvement of at least 2% is projected.

Recidivism Performance Improvement Project

Recidivism to inpatient hospitalization is an opportunity for improvement. The validation of this PIP was withheld by Health Services Advisory Group (HSAG) but will continue to be a point of focus moving forward through MCCMH. Multiple interventions have been and continue to be implemented to improve statistical success. The goal of this project is to improve process and outcomes with the explicit purpose to continually reduce the burden of illness, injury, and disability of severely mentally ill adults by better identifying people at risk for behavioral health inpatient readmissions.

Consultations were conducted within the MCCMH hospital team to assist the Access managers in identifying the appropriate level of care needed following hospitalization. These meetings included the Access psychiatrist, Access leadership, and Access managers. The quality team evaluated the effectiveness based upon the quarterly recidivism report. It was determined additional training of new and existing Access staff occur. Recidivism did not continue the downward trend. There was an increase in the number of recidivistic cases. Turnover of staff has been an issue at the Access Center, therefore, needed trainings of new staff and additional supervision is required. Currently, there is a ROCK project to implement a team member engagement process, which should lead to increased retention of trained staff at the Access Center.

A dashboard was developed to include current data reflecting total number of daily inpatient requests, total hospitalized with details, length of hospital stays, and specific provider admission/discharge information. Usage of the dashboards are monitored. Quality determined that this intervention is effective as the Access staff is now able to view timely data to better track inpatient information and to make informed discharge and follow up decisions. The intervention will be continued as it was determined to be successful with continued validation on an on-going basis. Usage of the dashboards will continue to be monitored.

Increased trainings of the use of Assisted Outpatient Treatment included hospitals, law enforcement, court staff, clinical staff, etc. The trainings were implemented to increase the understanding of how to assist with mandatory community treatment rather than utilizing focusing only on the Alternative Treatment Orders which remanded people into the hospitals. Eighteen trainings were provided. The number of AOT orders increased from 18 to 145 orders, and increase of 67 orders. The

grant that was utilized to educate the community and staff on the use of Assisted Outpatient Treatment orders was successful.

Hospital discharge planners are to consult with the Access Managers to arrange for post discharge services. The hospital team obtained additional staffing to allow for increased scrutiny on recidivistic cases and ensure appropriate community services in an effort to reduce unneeded hospital stays. There continues to be difficulty in obtaining the consultations between hospital staff and the Access managers. The CEO has requested that the hospitals work with the Access department to identify a specific time for consults to discuss the level of care needed for each individual prior to discharge.

MCCMH initiated intensive follow up services post hospital in an effort to increase community follow up post discharge. Clinical staff will provide immediate services with persons to promote effective discharge planning. There will be ongoing meetings with Access, Quality, Network Operations and top administration to formalize a process for sanctions and/or incentives to ensure appropriate discharge plans are completed for each individual who is hospitalized.

Supports Intensity Scale Performance Improvement Project

SIS Assessments were not being completed due to refusals and poor Support Coordinator commitment. Quality worked to improve the process of initiating the SIS Process. A contract was initiated with MORC due to the success that MORC demonstrated in other regions throughout Michigan. The interventions included educating supports coordinators at the Quality Improvement meetings, MORC presentations to educate individuals, families and guardians of the importance of completing the SIS, and exploring value based contracting for providers to increase completion of the SIS on a regular basis. This Project was successful as the baseline completion rate for the SIS was 57.86. The improved outcome was 75%, which includes refusals. Due to COVID 19, the SIS Assessments transitioned to tele-health.

Trends in Service Delivery and Outcomes

Macomb County is working toward the delivery of services in which outcomes can be measured to determine effectiveness in the improvement in quality of health care and services for members as a result of the improvement activities. Data driven measurements are conducive to better outcomes. MCCMH is committed to ensuring that effectiveness, efficiency, satisfaction and access to services is paramount within the network. The CCBHC grant has assisted Macomb County is developing and refining the measurements needed to prove quality of services within the Macomb County Community Mental Health system.

Through the last year, the most pressing challenge was the Coronavirus Pandemic. It changed the way services are provided. A shut down of face to face services was mandated except for the most critical services, in an effort to keep all persons safe from the virus. Tele-health services were provided to the persons that we served in an expedient and efficient manner. Staff were expected to provide these services from a home environment, with some limited staff continuing to provide crisis and/or medical services from the office, when it was impossible to do so via tele-health. Administrative services continue to be delivered via face to face as well as telecommunication methods where possible. The Board continued its service utilizing telecommunication methods. This trend in the delivery of services has proven beneficial in some cases, but challenging in others. MCCMH positioned itself to provide services in challenging situations and continues to look to the future for possible trends that may impact services moving forward.