SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

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FY 2023 QUALITY REPORT

FY2024 QUALITY PLAN

PREPARED BY QUALITY & MEDICAL RECORDS SUPERVISOR

APPROVED BY THE CIO/CQCO

SCCMHA Annual Quality Report for FY 2023

Introduction and Overview

Saginaw County Community Mental Health Authority (SCCMHA) is a local, independent, governmental unit serving the greater Saginaw County area, a Community Mental Health Services Program (CMSHP) and has been a mental health authority under contract with the Michigan Department of Health and Human Services since October 1, 1997. SCCMHA received its 3 -year accreditation from Commission on Accreditation of Rehabilitation Facilities (CARF) in the fall of 2022. In 2021, it 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.

Mission 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.

Vison 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 consumer and community needs.
- Promote consumer 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 consumer rights and cultural diversity.
- Promote innovation and creativity to better serve our consumers.
- 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.

Purpose

SCCMHA is responsible for managing a local quality assessment and performance improvement program for its CMHSP provider operations and ensuring its contracted network clinical service providers address quality improvement in their own operations through the SCCMHA Quality Assessment and Performance Improvement Program (QAPIP) along with meeting the standards in the following documents.

1) MDHHS/CMHSP Managed Health Supports and Services Contract
2) Mid-State Health Network (MSHN) Quality Management Policy
3) Commission on Accreditation of Rehabilitation Facilities (CARF) Manual
4) Certified Community Behavioral Health Clinic (CCBHC) Handbook
5) Behavioral Health Home (BHH) Handbook

Overview We believe that information must be accessible, predictable, continuous, and must meet the needs of all levels of the organization. You will see this demonstrated in metric reports which are a signature feature of our program. Quality *assurance* activities are typically monitoring key areas of compliance or required performance. Quality *improvement* activities are interventions with the specific intent of resolving a problem or variance from performance or implementation of a new initiative. Our objective is to ensure that all dimensions of operations and service delivery are involved in quality activities and that those activities are visible throughout the organization. Three global plans underpin and drive the quality program, the first of which is the Strategic Plan. This plan is reviewed and updated annually. The strategic plan report is published for stakeholders and presented at the annual public hearing concurrent with the annual cycle of budgeting and community needs assessment. The Compliance Plan and the Quality Plan are subordinate to the Strategic Plan and all three are reviewed and approved by the SCCMHA Board of Directors.

Organizational Structure and Committees

Services Management Team - Under the leadership of the CEO, the Service Management Team is a subset of the management team and focuses on clinical service delivery. Metric reports reviewed by this group include Access Management Group metric report, Behavior Treatment Review metric report, and Care Management Conference metric report.

Operations Team: Under the leadership of the Finance Director, this team is comprised of the management team and their agenda is the working discussion of all matters related to finance and operations. The group reviews the Waiver Management Team metric report.

Quality Governance Council: Under the leadership of the Quality and Medical Records Supervisor, the management team assembles to provide oversight of the quality process, approve new charters, and guide the overall implementation of activities under the plan. The MSHN Key Performance Indicator metric report along with the Performance Indicator Trending reports, Critical Incident Review Committee metric report and the IR trending report are reviewed by Quality Governance.

Business Intelligence Governance: Under the leadership of the CIO/CQCO, this governing body oversees the Agency's Business Intelligence Model which consists of three organizational pillars. The first is the agency's Core Competency, in SCCMHA's case it is the provision and delivery of Clinical Services. The second is the agency's Operational units which consist of Finance, Human Resources, Facilities, and Consumer Service. The third pillar is Business Intelligence which includes Information Systems, Data Warehousing, Data Analytics, Reporting, Quality and Compliance. The purpose of this model is to:

Gather Data -> Manage Data -> Transform Data - > Report Data -> Use Data -> Improve Business Decision Making -> Make more informed Clinical Decisions -> Producing Better Outcomes

Chartered Workgroups - This model of Quality Governance ensures that resources are used efficiently, and the workgroups are given defined scopes of work. Our goal in workgroup deployment is to achieve as broad a reach as possible throughout the operation with a high level of integration across departments reducing the silo effect of department level operations.

- Access Management Group (AMG): Reporting to the Services Management Team, the AMG is a utilization management group responsible for monitoring penetration and engagement rates with a focus on the patient experience. The newly developed Metric Report from the AMG groups four stages of Access including Outreach, Access, Engagement, and Activation activities. The AMG Metric Report is reported to the Services Management Team.
- Adult Case Management Supports Coordination Supervisors (ACM-SC): The ACM and Supports Coordination Supervisors, from both direct and contracted programs, meets regularly to address critical issues relative to service delivery compliance and needs. Supervisors are asked to give input on training needs, to discuss implementation of compliance corrective action plans or remedies, and to get updates from SCCMHA on key

areas pertaining to their work. The venue often serves as mini-training sessions or to orient the supervisors to key system changes, including EMR updates. Data relative to consumer population assessments and outcomes is shared.

- Adult Clinical Risk Committee (ACRC) and Children's Clinical Risk Committee (CCRC): The ACRC and CCRC monitors clinical issues related to the safe and appropriate treatment of consumers through an interdisciplinary review. The committee addresses and recommends treatment approaches for consumers whose conditions are at high risk, complicated, or unusual. They review cases brought forth with concerns regarding diagnosis and treatment and may review and recommend modifications to agency policy and/or practices that negatively affect the treatment of consumers and/or the safety of consumers, staff and/or visitors.
- Behavior Interventions and Practice Committee (BIPC): One of the goals of the workgroup would be to use the existing Behavior Treatment Committee to intervene proactively, reaching out to staff when data suggests a need for a positive support plan. The group will also review policies for when there is a behavior present to obtain a better/clearer understanding of the policies and how they relate to our procedure and practice. Another goal of the group is to identify a format for positive behavior support plan to formalize the document throughout the network. Lastly, the group wants to monitor the effectiveness and impact of trainings at SCCMHA for behavior on a spectrum (case holders, home provider staff, community living support staff) and if updated/additional trainings are needed the group will be involved in what those trainings will look like and include.
- Behavior Treatment Committee (BTC): The Behavior Treatment Committee is an MDHHS mandated committee that reviews behavioral plans which contain restrictive or intrusive interventions and approves or denies the use of that intervention. The BTC has also taken on the coordinating role of improving the quality of positive support plans through training and the implementation of the Behavioral Champions program. The BTC Metric Report includes quarterly emergency intervention data and is submitted to MSHN and is monitored by the BTC and the Service Management Team.
- Business Intelligence Data Integrity (BIDI): This workgroup researches and drills down into processes, systems, and regulatory changes to identify ways in which we can improve and enhance the integrity of our agency's data. The committee digs through data, reports and Sentri to identify improvements and data cleanup that must occur. The members of this team are either be a subject matter expert, key informants, or boots on the ground when it comes to creating, modifying, processing, reporting, or utilizing specific data. The aim of the workgroup is to ensure: Accurate, Complete, Secure, Consistent and Timely data throughout the agency's systems, processes & reports.
- Care Management Conference (CMC): Care Management Conference is charged with monitoring all dimensions of managed care authorization processes. Their objective is to demonstrate optimal functioning of the system of controls for authorization. The Care Management Metric Report includes aggregate authorization status and timeliness data, and it is reviewed by the Services Management Team on a quarterly basis.
- Children's Case Management Supervisors (CCM): The CCM Team Leaders, from both direct and contracted programs, meets regularly to address critical issues relative to service delivery compliance and needs. Supervisors are asked to give input on training needs, to discuss implementation of compliance corrective action plans or remedies, and to get updates from SCCMHA on key areas pertaining to their work. The venue often serves as a mini-training session or to orient the supervisors to key system changes, including EMR updates. Data relative to consumer assessments and outcomes is shared.
- Compliance and Policy Team (CPT): The Compliance and Policy Team serves as a venue for the intake and distribution of regulatory, policy and laws which impact the agency's strategic plan and corporate obligations. The agenda is twofold with the Compliance Officer presenting newly published content gathered from public sources and members of the team surveying their respective scopes of policy information from Michigan Department of Health and Human Services or Mid-State Health Network committees. This workgroup also monitors the Quality Assurance Metrics of relevant chartered workgroups working in compliance.

- Continuing Education Committee (CEC): It is the expectation that SCCMHA will ensure a competent network of service providers. SCCMHA specifies required instruction in specific areas for service delivery providers of mental health and substance use disorder services. When on-site audits and other compliance reviews of SCCMHA operations are conducted, proof of those required education standards for employees, staff and providers must be provided. In addition, the provision of ongoing education and competency testing ensures at a minimum, compliance with the State and Federal standards, and the provision of appropriate and quality services that maintain and promote the health, safety and goal achievement of persons served by the SCCMHA network.
- Credentialing Committee (CC): The Credentialing Committee provides oversight for needed credentialing activities across the network, assuring compliance and appropriate processes and policies in keeping with any federal, state, or regional requirements and changes. Maintains summary reference documents and may consult with specific persons as needed to conduct work.
- Critical Incident Review Committee (CIRC): The purpose of CIRC is to monitor and review all consumer-related critical incidents, risk events, and sentinel events to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. The CIRC review process is a retrospective peer review process in that any records, data or knowledge collected in this process is confidential and not available under the FOIA or by court subpoena. The CIRC will analyze aggregate incident report data, seeking both common cause and special cause variances which indicate the need for quality improvement interventions. Critical Incidents are submitted to MSHN monthly and the work of the CIRC is trended on the CIRC Metric Report is also monitored by the Quality Governance Council.
- Employee Wellness Committee (EWC): To keep energy around the focus of wellness, the Employee Wellness Committee will generate ideas to encourage employees to participate and engage in wellness initiatives to improve overall health and wellness. The Committee will develop goals and activities, such as a personal health assessment, to provide feedback to an individual to assist employee decision making regarding personal wellness and health decisions. Information, such as a personal health assessment, will be developed and shared to engage employees in determining if a personal call to action is warranted. The Committee's goals and activities will focus upon a personalized service approach with a special emphasis upon face-to-face communication as the primary vehicle for communication of wellness education. The Annual Wellness Plan will guide and inform development of goals and activities. These goals and activities will be generated at the committee level for the purpose of developing individual and group interventions. Success will be measured by tracking the number of employees who engage in education related activities as well as the number and level of contact of each engagement.
- Environment of Care Committee (EOC): The Environment of Care Program was designed to provide a functional and safe environment for SCCMHA employees, consumers of service, and visitors to provide an environment that is safe from recognized and potential physical hazards. The EOC Program also provides guidelines for managing staff activities with the goal of reducing the risk of accidents and mishaps. The EOC Program provides guidance consistent with the SCCMHA mission and vision and ensures compliance with applicable local, state and federal codes and regulations as well as other legal and regulatory guidelines including CARF, OSHA and the National Fire Protection Agency. The EOC Program consists of Five Environment of Care Plans that is maintained by SCCMHA Supervisors and Directors and consists of Fire Safety; Health Management; Safety Management; Security Management; and Emergency Management.
- Evidence-Based Practice (EBP) Leadership Team: The Evidence-Based Practice (EBP) Leadership Team was formed shortly after the Evidence-Based Practice Coordinator position was created. The team was created to provide oversight and consultation to the Evidence-Based Practice Coordinator. The EBP Leadership Team will also provide consultation to the EBP Coordinator on such things as privileging, fidelity reviews, and vetting of new Evidence-Based Practices. The EBP Leadership Team will also be the group that researches new practices

and identifies practice needs within the network. The team will oversee the implementation of new EBPs, and the vetting of all new practices being implemented in the agency and network.

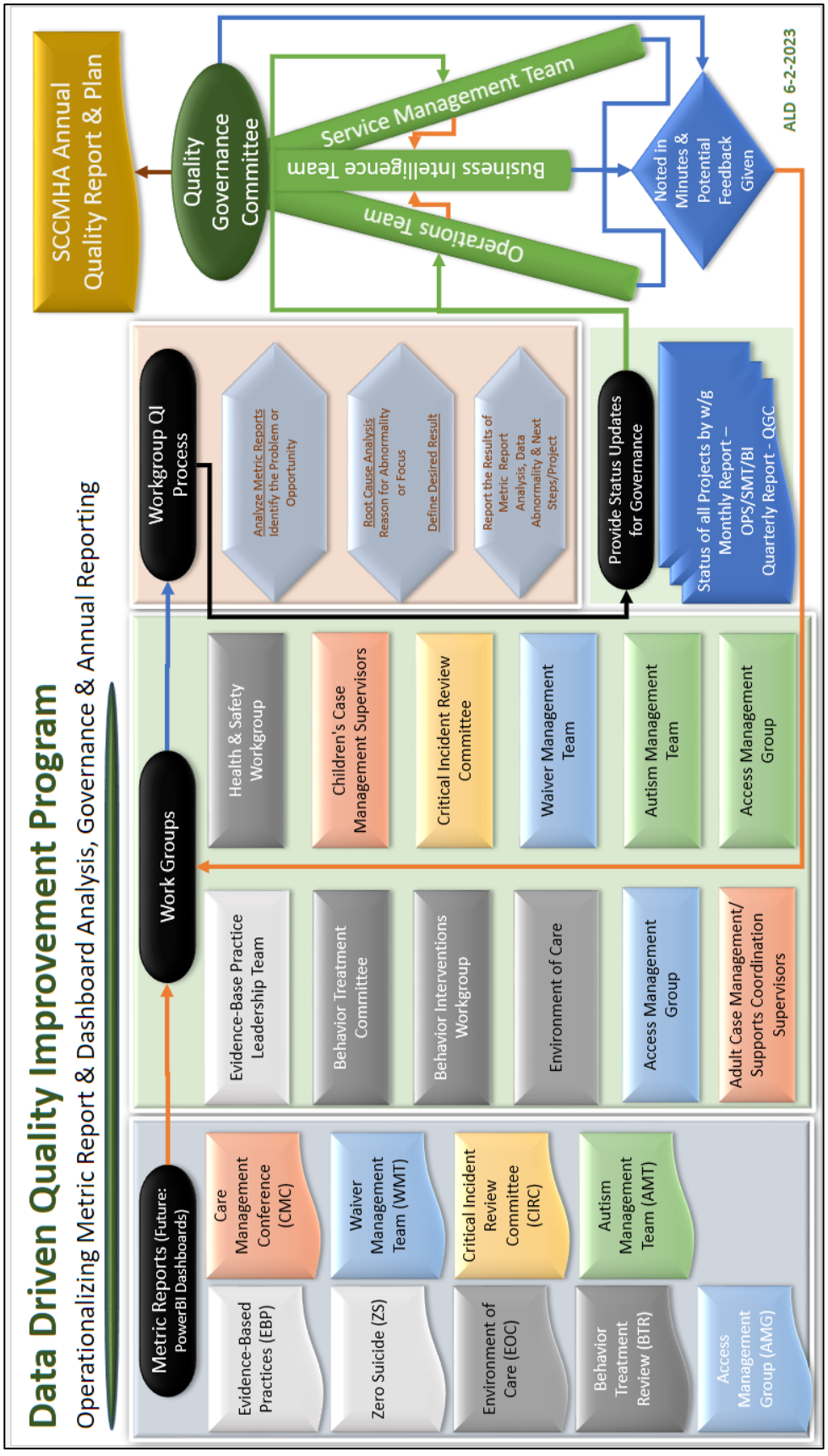
- Health Care Integration Committee (HCIC): The Health Care Integration Committee will focus upon agency-wide transformation to health care integration and meaningful use capacity, implementation, and certification. The committee will focus upon establishing, identifying and/or reviewing existing key performance indicators that impact consumer health outcomes across the life span of the consumers we serve.
- Quality of Life (QOL) Workgroup: The mission of the QOL Workgroup is to improve the quality of life for adults who reside in licensed settings in Saginaw County. The QOL work group is concerned with health and safety, living arrangements, community involvement, positive relationships and staff supports, income resources, home conditions, rights, freedoms, and choice as well as transportation needs for these persons served. Some of the past accomplishments of the QOL workgroup include home manager training curriculum development, First Choice of Saginaw creation, development of the quality of life workbook - "A World of Choices," recognition of direct care staff, development of uniform house rules and approval process for all homes, publication of Licensed Residential Homes Directory (which assists consumers and others in selection of home settings and promotion of independent living skills) and implementation of Memorandum of Understanding (MOU) agreement with general (non-contract) AFC providers.
- Residential Provider Watch Committee (RPWC): This committee started to preempt closures of residential facilities and to offer support for residential providers that might be struggling. Prior to the inception of this committee, the clinical staff had to deal with residential closures, especially around holidays when there were minimal staff available to assist with finding placement options for consumers. We have identified areas of risk of displacement from consumer residential living arrangements and work with the providers to prevent, when possible, this potential risk. This is also a venue to bring concerns noted by others in the community, staff at SCCMHA, or other interested parties for discussion and possible solutions for providers under contract as well as providers that may not be under contract but may need some additional education or monitoring by support staff. At times it has been necessary to have key members of the committee meet with providers to discuss the issues and come up with a workable solution agreeable by the committee and the provider. The objective is to minimize the necessity to move consumers out of a residential facility due to loss of licensure or poor-quality care of consumers by offering additional monitoring, supports in way of trainings, additional quality reviews such as quality of life reviews or audits, property inspections and additional visits by clinical staff already involved with consumers at the facilities.
- Trauma Informed Care Workgroup (TICW): As a means to maintain and further enhance the development of a trauma informed care environment and workforce, as well as to meet the standards and requirements of MDHHS-BHDDA a committee/workgroup with representatives from direct service operations and network providers including children, adult, SUD, I/DD services, and consumers will be formed. This workgroup's primary focus is to ensure the building and maintenance of a trauma informed care system within Saginaw CMHA's direct service and network operations.
- Waiver Management Teams: The purpose of this group is to ensure that operational waiver regulations are complying, that system interfaces are synchronized, and that waiver specific revenue payments are optimized. This group meets as three teams in back-to-back work sessions with the relevant staff attending the waiver session they are associated with. Waiver activity is trended on the WMT Metric Report and monitored monthly by the Operations Committee.
- Zero Suicide Implementation Committee: This charter is for the Implementation Team to bring the EBP, Zero Suicide, to our organization. This EBP is a requirement for CCBHC. Zero Suicide is a transformational framework for health and behavioral health care systems. The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving patient safety, Zero Suicide presents an aspirational challenge and practical framework for system-

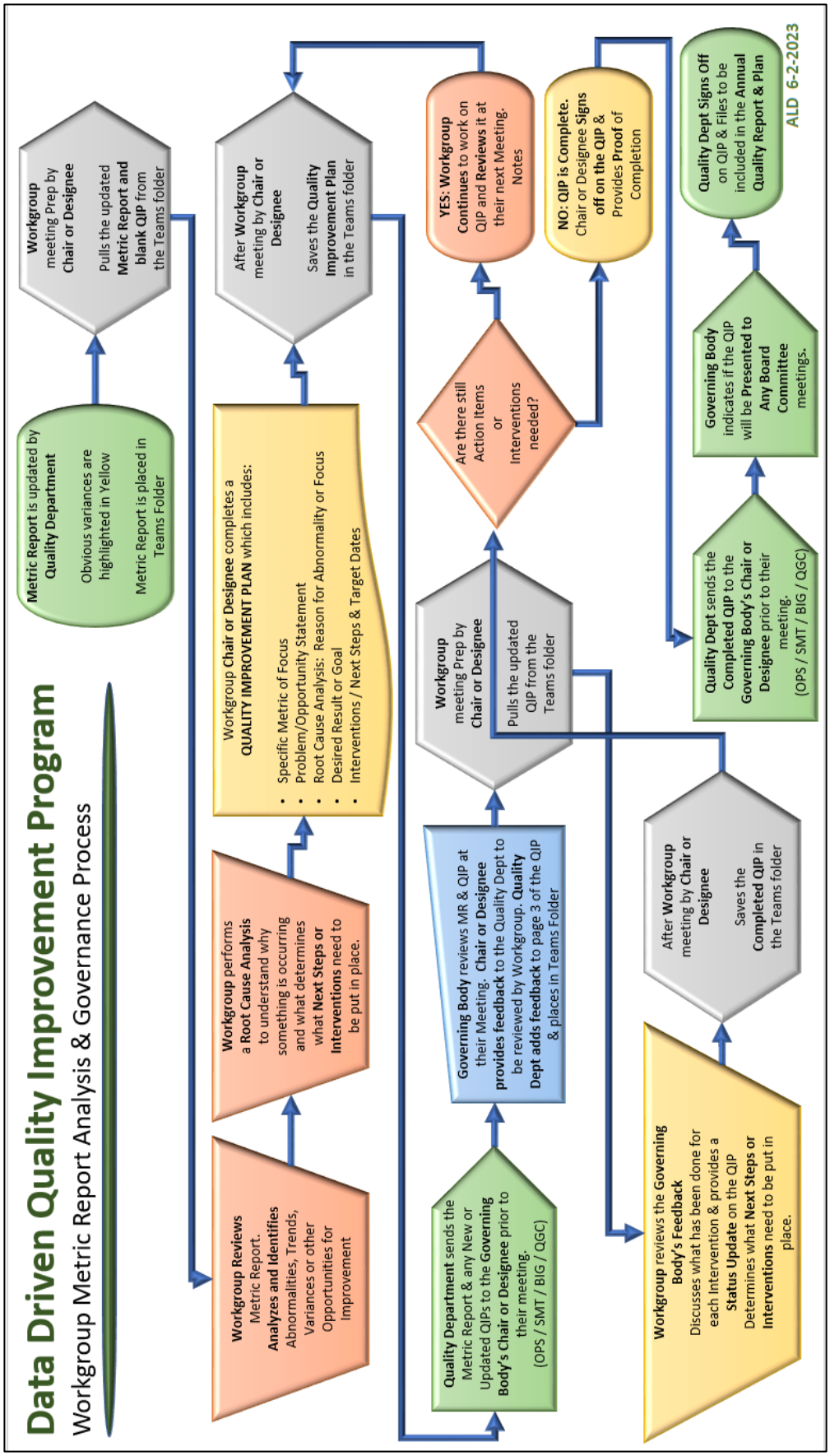
wide transformation toward safer suicide care. This transformation will include staff training and full implementation of the model to fidelity.

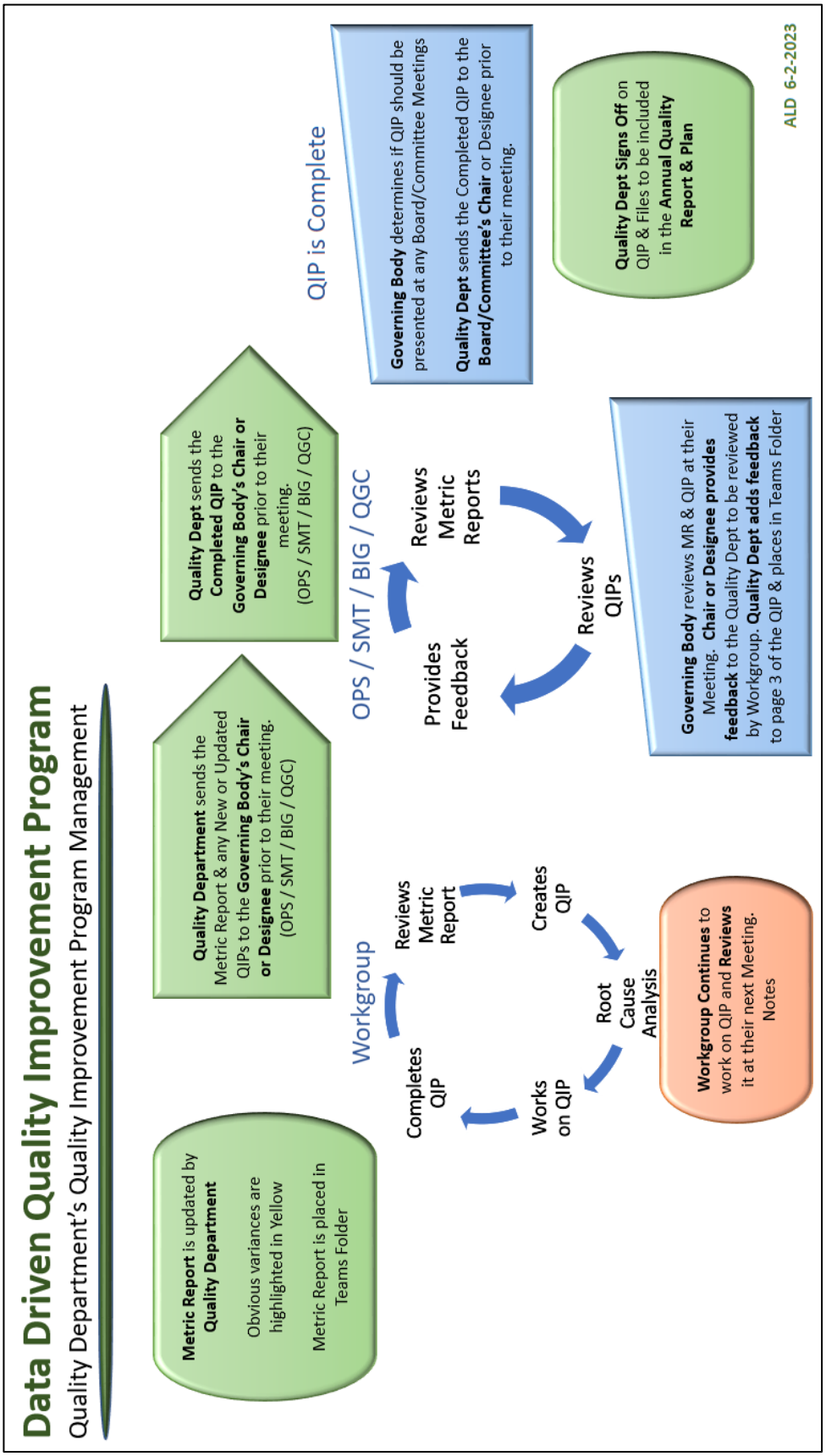
SCCMHA'S Data Driven Quality Improvement Program (DDQIP) - Information obtained from metric reports must be reviewed, analyzed, and translated into focused interventions aimed at improving Quality through Quality Improvement Plans (QIP). This demonstrates our commitment to the continuous improvement of organizational quality and service excellence. When a new (QIP) is created the applicable workgroup must review metric results and identify opportunities for improvement. The Quality department has developed a form to document the results of the root cause analysis, the improvement goal(s), any intervention(s) or steps that will be taken to work through the QIP to address the identified issues. A separate form should be completed for each metric identified. Until the QIP is complete, the form is a living document that is used to provide status updates after each workgroup meeting. Senior Level Management will also review the form's status updates and offer feedback if necessary. The parts of a proper QIP is as follows:

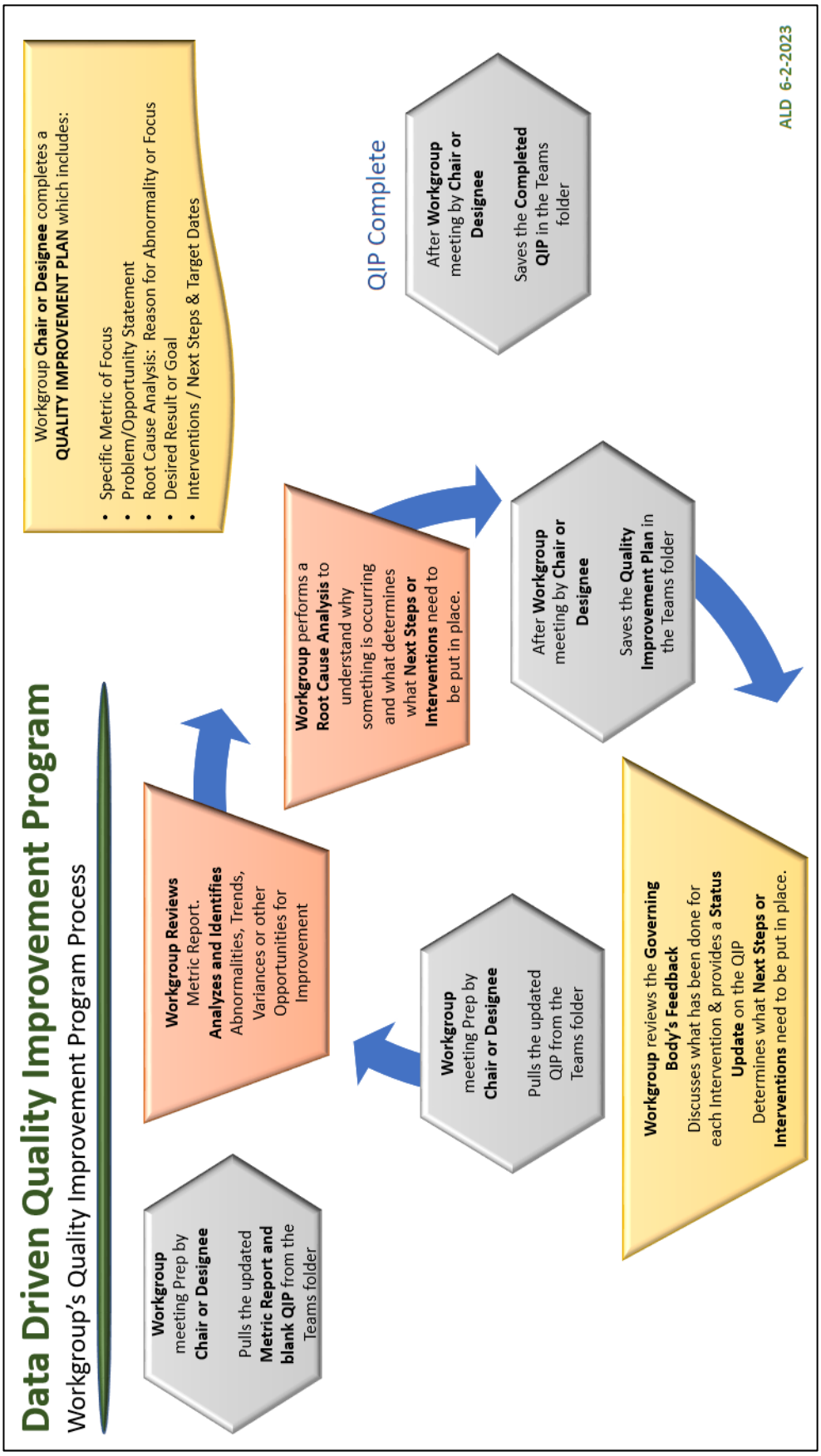
- Responsible Workgroup Assignment
- Metric Report and date that informed the workgroup of the opportunity for a QIP
- The specific Metric of Focus
- Problem/Opportunity Statement: What problem will be addressed by the team through the improvement effort.
- Root Cause Analysis: Reason for Abnormality or Focus - Identify the underlying factors that lead to the problem. Ask "why" the problem occurs.
- The desired result of the improvement process
    - Specific measurable goals
    - How much change is expected (increase/decrease)
    - Timeline for completion
- Tracked Interventions & Next Steps
    - Intervention(s)
    - Next step(s)
    - Start Date
    - Target Completion Date
    - Task Lead
    - Completion Date
    - Status Updates after each meeting
- Continuous Senior Management Team Feedback
- Workgroup Signoff when QIP has been complete
- Senior Management Team Signoff
- Quality Department Signoff

Data Driven Quality Improvement Program Process - Operationalizing Metric Report & Dashboard Analysis, Governance & Annual Reporting Process




Data Driven Quality Improvement Program
Workgroup Metric Report Analysis & Governance Process
Metric Report is updated by Quality Department
Obvious variances are highlighted in Yellow
Metric Report is placed in Teams Folder
Workgroup meeting Prep by Chair or Designee
Pulls the updated Metric Report and blank QIP from the Teams folder
Workgroup Reviews Metric Report. Analyzes and Identifies Abnormalities, Trends, Variances or other Opportunities for Improvement
Workgroup performs a Root Cause Analysis to understand why something is occurring and what determines what Next Steps or Interventions need to be put in place.
Workgroup Chair or Designee completes a QUALITY IMPROVEMENT PLAN which includes:
Specific Metric of Focus
Problem/Opportunity Statement
Root Cause Analysis: Reason for Abnormality or Focus
Desired Result or Goal
Interventions / Next Steps & Target Dates
After Workgroup meeting by Chair or Designee
Saves the Quality Improvement Plan in the Teams folder
Quality Department sends the Metric Report & any New or Updated QIPs to the Governing Body's Chair or Designee prior to their meeting. (OPS / SMT / BIG / QGC)
Governing Body reviews MR & QIP at their Meeting. Chair or Designee provides feedback to the Quality Dept to be reviewed by Workgroup. Quality Dept adds feedback to page 3 of the QIP & places in Teams Folder
Workgroup meeting Prep by Chair or Designee
Pulls the updated QIP from the Teams folder
Are there still Action Items or Interventions needed?
YES: Workgroup Continues to work on QIP and Reviews it at their next Meeting. Notes
NO: QIP is Complete. Chair or Designee Signs off on the QIP & Provides Proof of Completion
Workgroup reviews the Governing Body's Feedback
Discusses what has been done for each Intervention & provides a Status Update on the QIP
Determines what Next Steps or Interventions need to be put in place.
After Workgroup meeting by Chair or Designee
Saves the Completed QIP in the Teams folder
Quality Dept sends the Completed QIP to the Governing Body's Chair or Designee prior to their meeting. (OPS / SMT / BIG / QGC)
Governing Body indicates if the QIP will be Presented to Any Board Committee meetings.
Quality Dept Signs Off on QIP & Files to be included in the Annual Quality Report & Plan
ALD 6-2-2023


Data Driven Quality Improvement Program
Quality Department's Quality Improvement Program Management
Metric Report is updated by Quality Department
Obvious variances are highlighted in Yellow
Metric Report is placed in Teams Folder
Quality Department sends the Metric Report & any New or Updated QIPs to the Governing Body's Chair or Designee prior to their meeting. (OPS / SMT / BIG / QGC)
Workgroup
Reviews Metric Report
Creates QIP
Root Cause Analysis
Works on QIP
Completes QIP
Workgroup Continues to work on QIP and Reviews it at their next Meeting. Notes
Quality Dept sends the Completed QIP to the Governing Body's Chair or Designee prior to their meeting. (OPS / SMT / BIG / QGC)
OPS / SMT / BIG / QGC
Reviews Metric Reports
Provides Feedback
Reviews QIPs
Governing Body reviews MR & QIP at their Meeting. Chair or Designee provides feedback to the Quality Dept to be reviewed by Workgroup. Quality Dept adds feedback to page 3 of the QIP & places in Teams Folder
QIP is Complete
Governing Body determines if QIP should be presented at any Board/Committee Meetings
Quality Dept sends the Completed QIP to the Board/Committee's Chair or Designee prior to their meeting.
Quality Dept Signs Off on QIP & Files to be included in the Annual Quality Report & Plan
ALD 6-2-2023


Data Driven Quality Improvement Program
Workgroup's Quality Improvement Program Process
Workgroup Chair or Designee completes a QUALITY IMPROVEMENT PLAN which includes:
Specific Metric of Focus
Problem/Opportunity Statement
Root Cause Analysis: Reason for Abnormality or Focus
Desired Result or Goal
Interventions / Next Steps & Target Dates
QIP Complete
After Workgroup meeting by Chair or Designee
Saves the Completed QIP in the Teams folder
Workgroup performs a Root Cause Analysis to understand why something is occurring and what determines what Next Steps or Interventions need to be put in place.
After Workgroup meeting by Chair or Designee
Saves the Quality Improvement Plan in the Teams folder
Workgroup Reviews Metric Report. Analyzes and Identifies Abnormalities, Trends, Variances or other Opportunities for Improvement
Workgroup meeting Prep by Chair or Designee
Pulls the updated QIP from the Teams folder
Workgroup reviews the Governing Body's Feedback
Discusses what has been done for each Intervention & provides a Status Update on the QIP
Determines what Next Steps or Interventions need to be put in place.
Workgroup meeting Prep by Chair or Designee
Pulls the updated Metric Report and blank QIP from the Teams folder
ALD 6-2-2023

Consumer Satisfaction Measurement

SCCMHA assesses quantitative and qualitative consumer satisfaction through an annual survey process. SCCMHA in conjunction with MDHHS, also participates in the National Core Indicators survey on an annual basis to provide additional satisfaction information for individuals receiving services for intellectual/developmental disabilities. SCCMHA utilizes the Mental Health Statistical Improvement Program (MHSIP) and Youth Services Survey for Families (YSS-F) as the survey tools. SCCMHA will analyze the data from all survey results for trends and to identify opportunities for improvement.

	Provider Attributes				Consumer Attributes			
Provider	General Satisfaction	Access to Services	Quality / Appropriateness	Participation in Treatment Planning	Outcomes	Functioning	Social Connectedness	Overall
DNMM Supports Coordination	95%	97%	100%	97%	85%	86%	100%	**95%**
HNNP Adult Case Management	89%	79%	87%	89%	70%	73%	79%	**81%**
HNNP Case Management I/DD**	50%	50%	50%	73%	50%	50%	70%	**56%**
SCCMHA Community Support Services	83%	81%	80%	84%	74%	82%	84%	**81%**
SCCMHA Supports Coordination Services	93%	93%	94%	93%	81%	82%	94%	**90%**
SPS Adult Case Management	84%	86%	84%	84%	70%	66%	85%	**80%**
TTI Adult Case Management TTI Assertive Community Treatment	73%	74%	75%	87%	66%	64%	78%	**74%**
WGC Supports Coordination Services	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**
Overall	**86%**	**86%**	**87%**	**90%**	**75%**	**76%**	**88%**	**84%**
MSHN 2023	90%	88%	89%	85%	71%	71%	74%	n/a

***FY23 HNNP I/DD New Team Surveyed*

	Provider Attributes				Consumer Attributes		
Provider	**Access to Services**	**Participation in Treatment Planning**	**Cultural Sensitivity**	**Appropriateness**	**Outcomes**	**Social Connectedness**	**Overall**
SCCMHA Access Stabilization for Children	100%	100%	100%	100%	100%	100%	**100%**
SCCMHA Autism Services	92%	97%	97%	97%	89%	95%	**95%**
SCCMHA Family Services	94%	94%	88%	82%	60%	88%	**85%**
SCCMHA Supports Coordination Services	93%	93%	100%	80%	67%	87%	**87%**
SCCMHA Transitional Age Youth Services	100%	100%	100%	100%	67%	100%	**94%**
SCCMHA Wraparound Services	75%	75%	75%	75%	50%	75%	**71%**
SPS Children's Outpatient & Case Management SPS School-Based Services	100%	100%	100%	88%	63%	100%	**92%**
WGC Children's Outpatient & Case Management WGC School-Based Services	100%	100%	100%	86%	71%	100%	**93%**
Overall	**94%**	**96%**	**96%**	**89%**	**75%**	**92%**	**90%**
MSHN 2023	90%	92%	95%	84%	67%	87%	n/a

Pilot Quality Improvement Project

Access Management Group

Specific Metric of Focus: The percentage of new persons during the period receiving a completed initial biopsychosocial assessment within 14 calendar days of a non-emergency request for service (2a).

Problem/Opportunity Statement: There has been a decrease in the number of persons receiving a completed initial biopsychosocial assessment within 14 calendar days of a non-emergency request for service over the last fiscal year. For FY23Q2, **15.73%** (391/464) of new consumers received an initial assessment. Three-hundred thirty-nine were due to no appointment available within 14 days with any staff.

Desired Result: 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%

Michigan's Mission Based Performance Indicator System (MMBPIS)

SCCMHA uses the MMBPIS to monitor service delivery that was established by MDHHS. There are five performance measures that address services and outcomes and are submitted quarterly to MSHN and MDHHS.

Goals	FY'23	Status
Indicator 1: ACCESS-TIMELINESS/INPATIENT SCREENING: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within 3 hours. Standard = 95%	Children: 100% Adults: 100%	Met
Indicator 2A*: ACCESS-TIMELINESS/FIRST REQUEST The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. *Effective FY20Q3, MDHHS has removed all exception reasons. No standard.	25.13%	No Standard
Indicator 3*: ACCESS-TIMELINESS/FIRST SERVICE Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional. *Effective FY20Q3, MDHHS has removed all exception reasons. No standard.	61.71%	No Standard
Indicator 4a: ACCESS-CONTINUITY OF CARE The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. Standard = 95%	Children: 95.00% Adults: 99.09%	Met
Indicator 5: ACCESS-DENIALS Percentage of face-to-face assessments with professionals during the quarter that result in denials.	1.13%	No Standard
Indicator 10: OUTCOME: INPATIENT RECIDIVISM The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less	Children: 9.43% Adults: 11.60%	Met

Regional Quality Performance Improvement Projects (PIPs)

SCCMHA supports the two PIPS selected by MSHN with data submission and intervention as requested by MSHN Quality Improvement Council.

Objective	CY'23
PIP #1: 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 without a decline in the index population rate.	Monitoring Year
PIP #2: The goal of the indicator is to reduce or eliminate racial or ethnic disparities between the African American/Black minority penetration rate and the index (white) penetration rate.	Monitoring Year

CCBHC Clinical Quality Measures

CCBHC Clinical Quality Measures		
Quality Bonus Payments	**DY2023**	**Status**
Follow-Up After Hospitalization for Mental Illness (FUH - Adults) Standard - 58%	75.3%	Met
Follow-Up After Hospitalization for Mental Illness (FUH - Children/Adolescents) Standard - 70%	81.3%	Met
Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD) Standard - 58.5%	59.2%	Met
Initiation of Alcohol and Other Drug Dependence Treatment (Standard 25%)	35.8%	Met
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Child) Standard 12.5%	13.3%	Not Met
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-Adults) Standard 23.9%	55.4%	Met

SCCMHA Annual Quality Plan for FY 2024

1. Quality External Compliance Requirements
    a. MDHHS/MSHN Waiver Review: The review of waivers by the Michigan Department of Health and Human Services (MDHHS) and Mid-State Health Network (MSHN) will focus on Children's Waiver Program (CWP), Habilitation Supports Waiver (HSW), Wavier for Children with Serious Emotional Disturbances (SEDW), and the 1915(i) State Plan Amendment (iSPA). MDHHS and MSHN conduct thorough evaluations of waivers related to behavioral health services, considering factors such as treatment effectiveness, service integration, and equity in access.
    b. MSHN MEV Review: The Mid-State Health Network (MSHN) Medicaid Event Verification (MEV) review process plays a pivotal role in ensuring the efficacy and quality of behavioral health services across the state. Through meticulous analysis and assessment, MSHN evaluates MEV submissions pertaining to behavioral health programs, interventions, and practices.
    c. HSAG PMV Review evaluates the accuracy of performance measures reported by the PHIPs and determine the extent to which performance indicators reported follow state specifications and reporting requirements related to behavioral health interventions and programs.
2. In Demonstration Year 4 of the Certified Community Behavioral Health Clinic, SCCMHA plans to work on the following in FY2024:
    a. Successfully completing the 2024 CCBHC Recertification Process.
    b. Achieving the CCBHC Quality Bonus Payment Benchmarks and Targets set for FY2024.
    c. Expanding Substance Use Disorder (SUD) service availability through DCOs.
    d. Developing and implementing a Mild to Moderate service plan.
3. Adhering to the Michigan Mission Based Performance Indicator System (MMBPIS) Codebook by Community Mental Health Service Programs (CMHSP) and Prepaid Inpatient Health Plans (PHIP) which is a comprehensive framework that sets forth standards for data collection, reporting, and analysis. SCCMHA plans to work on the following:
    a. Improving the percentage for MH/IDD consumers receiving services within 14 days of a non-emergency request for service.
    b. Improving the percentage of persons receiving medically necessary on-going services within 14 days of completing the assessment.
4. SCCMHA implemented Zero Suicide initiative will continue and SCCMHA plans to expand this initiative within the organization by:
    a. Continual training of staff on Zero Suicide philosophy and organizational program and expectations to create a competent, confident, and caring workforce.
    b. Identifying assessments and screenings that assist staff in pinpointing individuals with suicide risk.
    c. Engaging all individuals at-risk of suicide using a suicide care management plan.
    d. Ensuring patient treatment plans explicitly focus on reducing suicidality and suicide risk directly.
    e. Establishing effective transition plans for individuals through care.
    f. Improving policies and procedures through continuous quality improvement.
5. Follow-Up After Hospitalization is ensuring regular follow-up appointments, medication management, therapy sessions, and lifestyle interventions are conducted as integral components aimed at promoting long-term recovery and wellness. SCCMHA plans to do the following in FY2024.
    a. Continue to work towards reduction of disparities between index populations and minority populations.
    b. Monitoring the readmission rates and crisis events of consumers after hospitalization.
6. Community Needs Assessments are a comprehensive evaluation of a community's unique challenges, strengths, and resources. Needs assessments provide invaluable insights into where support is most urgently required.

SCCMHA will conduct an annual Community Needs Assessment requesting feedback from stakeholders within the community and present that information as well as the plan of action for the identifiable priorities.

7. Measuring Outcomes – Evidence Based Practices
    a. Enhance the utilization of Cognitive Behavioral Therapy (CBT) within the Evidence-Based Practice (EBP) metric report. Ensure that each team with therapists provides data demonstrating CBT utilization. Require each team with one or more therapists to exhibit CBT utilization in their metric data, with a minimum of 10 documented notes per quarter by end of FY2024.
    b. Ensure accurate data representation by restricting Mobile Response Stabilization Services (MRSS) entries to the designated MRSS team. Aim to minimize instances of MRSS data appearing under incorrect teams to fewer than 10 errors per report by the conclusion of FY2024.
8. SCCMHA assesses quantitative and qualitative consumer satisfaction through an annual survey process. SCCMHA in conjunction with MDHHS, also participates in the National Core Indicators survey on an annual basis to provide additional satisfaction information for individuals receiving services for intellectual/developmental disabilities. SCCMHA utilizes the Mental Health Statistical Improvement Program (MHSIP) and Youth Services Survey for Families (YSS-F) as the survey tools. SCCMHA will analyze the data from all survey results for trends and to identify opportunities for improvement.
9. Expanding Power BI reporting to harness the potential of behavioral health data visualizations, providing valuable insights that can inform decision-making and drive improvements in care delivery. By leveraging Power BI's robust analytics capabilities, we can create dynamic dashboards and interactive reports that present behavioral health data in a clear, intuitive manner. These visualizations have the potential to uncover trends, patterns, and correlations within complex datasets, empowering stakeholders to identify areas for intervention, track outcomes, and optimize resource allocation. SCCMHA plans to explore more regarding Power BI Dashboard opportunities in the following areas:
    a. CCBHC
    b. General Services Provided to Consumers
    c. Zero Suicide Initiative