Attachment #6b – April 2020

The Annual Summary and Evaluation of the Quality Assessment and Performance Improvement Program (QAPIP)

COMMUNITY MENTAL HEALTH PARTNERSHIP of Southeast Michigan

FY 2019

This evaluation compiles the quality assessment and performance improvement projects created by the Community Mental Health Partnership of Southeast Michigan (CMHPSM) – Region 6 Pre-Paid Inpatient Health Plan (PIHP)

TABLE OF CONTENTS

Overview

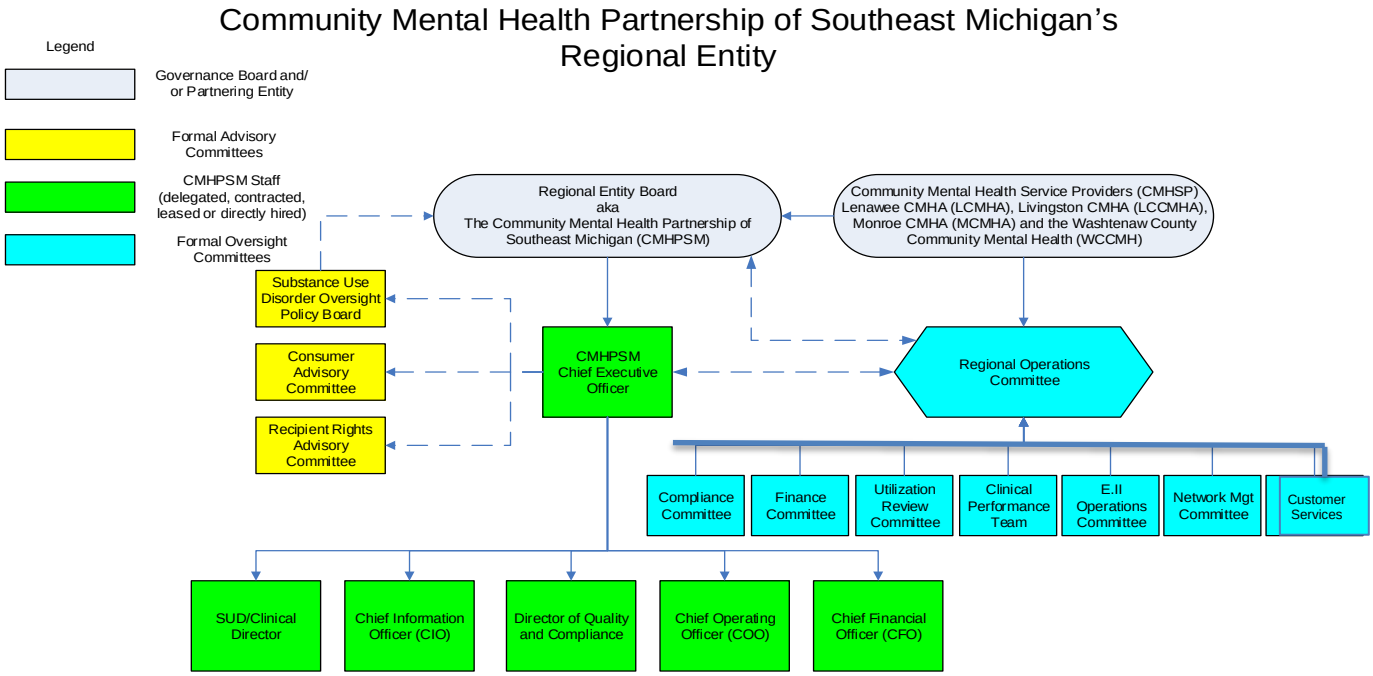
The Community Mental Health Partnership of Southeast Michigan (CMHPSM) is a region of four Community Mental Health Services Programs (CMHSPs), including Lenawee Community Mental Health Authority (LCMHA), Livingston County Community Mental Health Authority (LCCMHA), Monroe Community Mental Health Authority (MCMHA) and Washtenaw County Community Mental Health (WCCMH). Annually, the CMHPSM designs a Quality Assessment and Performance Improvement Program (QAPIP) to consistently assure high quality services across the region. The Clinical Performance Team (CPT), comprised of appointed staff and consumers from each of the four counties, provides oversight of the QAPIP.

The QAPIP establishes a framework for quality and accountability for the safety of consumer care through the work of standing committees, ad hoc teams, and performance measures. The QAPIP establishes processes that promote ongoing systematic evaluation of important aspects of service delivery. The program promotes ongoing improvement, replication of strengths and focuses on ensuring that the safety of consumers is addressed through the delivery of services, while addressing the requirements of network providers and CMHPSM staff and programs.

QAPIP Structure

The Clinical Performance Team (CPT) serves as the regional Performance Improvement Committee and the Improving Practices Leadership Team. Regional membership includes consumer representation, clinical and performance improvement staff from each of the CMHSPs and the PIHP Quality and Compliance Director. In its efforts to monitor and facilitate the performance improvement program, the committee scrupulously works with regional staff and other committees to identify, develop, implement and evaluate quality and performance improvement projects. Some of the CPT members serve as liaisons to other regional committees. Examples include the Regional Consumer Advisory Committee, Utilization Review Committee, Electronic Health Record Operations Committee, Customer Services Committee, Network Management Committee, Compliance Committee and other population specific administrators' groups. These members exchange information, data, questions and concerns with other committees in order to facilitate cross functional improvement opportunities. The Regional Operations Committee, the PIHP Chief Executive Officer and the Regional Board provides monitoring of these functions.

A majority of the QAPIP operations are conducted at the local level by designated Clinical Performance Team members from each CMHSP of the region. Members are assigned to ensure collection, review, and cleaning local data, reporting issues and corrective action to CPT, and conducting performance improvement initiatives within their CMHSP. CPT members meet monthly to share insights, address regional concerns and support each other in performance improvement efforts. The CPT liaisons are staffed by the PIHP for expert level data analytics and data report writing to support local efforts. In addition to leading the CPT members, the PIHP provides leadership for two regional Performance Improvement Project (PIP) studies. The chart below summarizes the flow of organizational operations.



I. Compliance and Quality Review

During FY 19, there were many compliance and quality review activities conducted by the Michigan Department of Health and Human Services (MDDHS) and the CMHPSM. The MDHHS completed full reviews of Substance Use Disorder Services and the 1915(c) Home and Community Based Services waivers of the Habilitation Supports Waiver (HSW), Children's Waiver (CWP), and Children's SED Waiver (SEDWP) programs. The CMHPSM received a full compliance score for the SUD review. The HSW review results report and corrective action plan for this fiscal year extended into October/November of 2019. Results finding in administrative procedures (HSW only), implementation of person-centered planning (HSW and SEWDP only), plan of service and documentation requirements, behavior treatment plan and review committees (HSW only), and staff qualifications. Some findings were related to new interpretations of department reviewers. The corrective action plan was submitted and accepted by MDHHS.

The Code of Federal Regulations (CFR), 42 CFR §438.358 also requires the state, its agent that is not a Medicaid prepaid inpatient health plan (PIHP), or an external quality review organization (EQRO) conduct a review to determine a Medicaid PIHP's compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To comply with the federal requirements, the Michigan Department of Health and Human Services (MDHHS), Behavioral Health and Developmental Disabilities Administration (BHDDA) contracted with Health Services Advisory Group, Inc. (HSAG), as its EQRO to conduct compliance monitoring reviews of the PIHPs. Thus, MDDHS arranged for the Health and Services Advisory Group, Inc. (HSAG), an External Quality Review (EQR) organization, to complete a compliance review for the region, which included the following: 1) Compliance Monitoring Review; 2) Validation of Performance Measures and 3) Validation of Performance Improvement Studies.

A. EQR Compliance Monitoring Review

HSAG performed a desk and on-site review of the CMHPSM The onsite review included examining additional documents and case files and conducting interviews with key CMH Partnership and CMHPSM staff members.

For FY 19, the MDHHS selected for HSAG to evaluate the degree to which CMHPSM complied with federal Medicaid managed care regulations and the associated MDHHS contract requirements for the following 8 out of 17 performance categories:

- Standard I—Quality Assessment and Performance Improvement Program Plan and Structure
- Standard II—Performance Measurement and Improvement
- Standard III—Practice Guidelines
- Standard IV – Staff Qualifications and Training
- Standard V – Utilization Management
- Standard XI - Credentialing
- Standard XIII – Coordination of Care
- Standard XIII – Confidentiality of Health Information

The draft and final compliance reports from HSAG were received in January, with corrective action plans due to HSAG by 3/11/20.

For FY 20, HSAG will conduct a corrective action plan review of both the standards reviewed above from the fiscal year, as well as the remaining standards that were reviewed in FY 17/18

B. EQR Validation of Performance Measures

The Centers for Medicare & Medicaid (CMS) requires that states, through their contracts with the PIHP's measure and report on performance to assess the quality and appropriateness of care and services provided to members. The purpose of performance measure validation is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by the PIHPs follow state specifications and reporting requirements. HSAG conducted the performance measure validation, validating data collection and reporting processes used to calculate performance indicator rates. Validation of Performance Measures tested the capability of the regional information systems. The CMHPSM and each CMHSP were assessed in the following areas:

- Organizational Structure and Reporting Entities
- Evaluation of System Compliance
- Overview of Data Integration and Control Procedures
- Primary Source Verification
- Service Data Preparation and Processing for Quality Improvement Data Processing and Preparation
- Encounter Data Preparation and Specifics Regarding the Flow of Data
- Enrollment and Eligibility

HSAG fully validated the CMHPSM's data integration, data control, performance improvement documentation, validation results, eligibility and enrollment data system, medical services data system (claims and encounters), behavior health treatment episode data set/data production, PIHP's oversight of CMHSPs, PIHP's actions related to previous recommendations and areas for improvement from last year and performance indicators being in compliance with State specifications and the rate can be reported.

C. EQR Validation of Performance Improvement Projects

In order to validate the PIP projects, the HSAG required for the CMHPSM to complete a PIP Summary Report regarding the Patient(s) with Schizophrenia and Diabetes who had an HbA1c and LDL-C Test During the Report Period indicating the following information:

- Topic of Study
- Definition of Study Topic
- Use of a Representable and Generalizable Study Population
- Selection of the Study Indicators
- Use of Sound Sampling Techniques
- Reliably Collect Data
- Data Analysis and Interpretation of Results
- Inclusion of Improvement Strategies and Barrier Analysis

HSAG assessed the validity and reliability of the results based on the Center for Medicaid Services validation protocols and determined that the State and key stakeholders can have high confidence in the reported performance improvement project findings.

II. Clinical Performance Team (CPT) - Performance Improvement Projects (PIP)

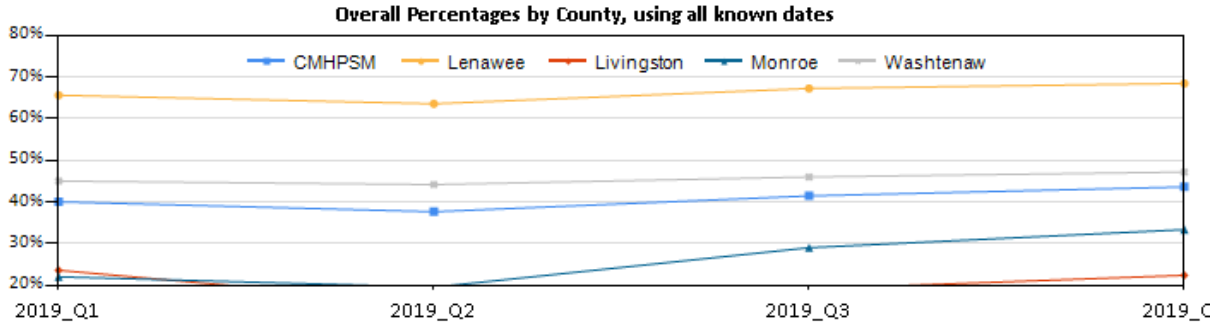
A. New Chosen PIP: Patient(s) with Schizophrenia and Diabetes who had an HbA1c and LDL-C Test During the Report Period.

Research identifies that patients with schizophrenia are at greater risk and higher prevalence rates for diabetes. Patients with diabetes also have a greater increased risk for cardiovascular disease. Drawing HbA1c and LDL-C tests for patients with schizophrenia will help determine whether a patient(s) has abnormal lab value(s), which would assist in comprehensive assessment and treatment planning through the .. Treatment planning may include but is not limited to the following: Informing patient about lab values and strategies to reduce the risk of diabetes/cardiovascular disease (i.e. information and referral to primary care, care coordination with primary care and health plans, transportation to appointments, addressing blood pressure and lipid control, disease self-management (taking and managing medications, when clinically appropriate, self-monitoring of glucose and blood pressure), smoking cessation, weight management, physical activity, healthy eating and coping skills). Providing lab screening and treatment as specified above may improve consumer health, functional status and satisfaction.

Summary: The PIHP's targeted interventions for Medicaid eligible patient(s) with schizophrenia and diabetes will result in an increase in the proportion of those patients receiving a HbA1c and LDL-C test during the report period. The work group plans to achieve the following goals by the end of FY 20:

1) The PIHP's targeted interventions for Medicaid eligible patient(s) with schizophrenia and diabetes will result in an increase in the proportion of those patients receiving a HbA1c and LDL-C test during the report period.
2) Labs will be entered as discrete fields into the regional electronic health record and/or collected from Great Lake Health Connect (GLHC) lab feed and/or CC360 claims data.
3) The baseline measurement was 8/1/2017 to 7/31/2018. The FY19 (remeasurement 1) data period is 5/1/2019-4/30/202020. (The 2018 HEDIS technical specification will be used as our guide during the life of the study).
4) The FY20 (remeasurement 2) data period is 5/1/2020-4/30/2020. (The 2018 HEDIS technical specification will be used as our guide during the life of the study).
5) Prepare for the Health Services Advisory Group (HSAG) - External Quality Review (EQR) for study methodology validation.

Status Report:



Lenawee CMHSP's rates for each subsequent quarter were 66%, 64%, 67% and 68%. Livingston CMHP's rates for each subsequent quarter were 24%, 16%, 19% and 22%. Monroe CMHP's rates were 22%, 20%, 29% and 33%. Washtenaw CMHSP's rates for each subsequent quarter were 45%, 44%, 46% and 47%. The CPT committee and ADT workgroup reviews data sets, identifies problems and proposes solutions to improve rates.

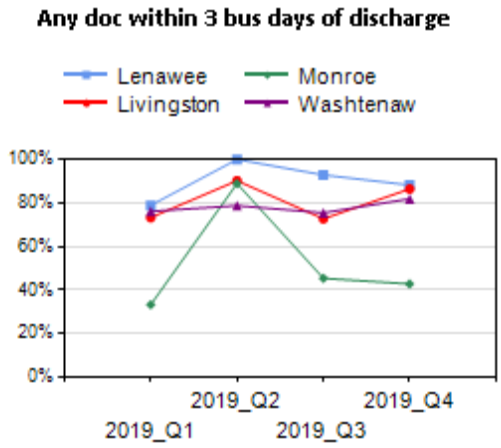
B. Chosen PIP – Admission, Discharge and Transfer (ADT) Study

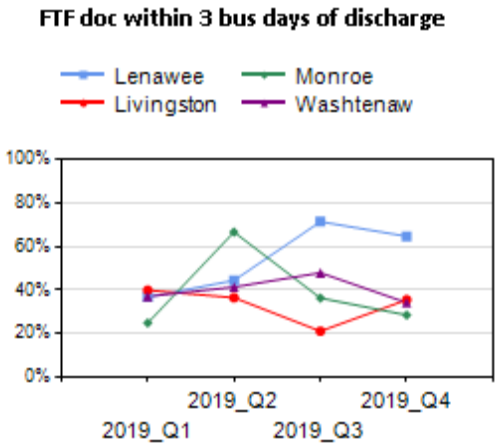
During FY 14, the region developed and implemented a new PIP study to improve the quality of integrated clinical care provided for consumers transitioning in and out of inpatient settings. The purpose is to support consumers who are transitioning in and out of inpatient settings, reduce avoidable re-admissions, improve overall consumer access to a continuum of care, and improve health outcomes. This is accomplished by using admission, discharge and transfer (ADT) alerts received via a Health Information Exchange (HIE) that identify consumers who are experiencing transition in care. Based on the ADT alerts, a clinical protocol is followed directing clinical staff to contact consumers either face to face or by phone/letter and provide support and/or encouragement for follow up with any discharge recommendations.

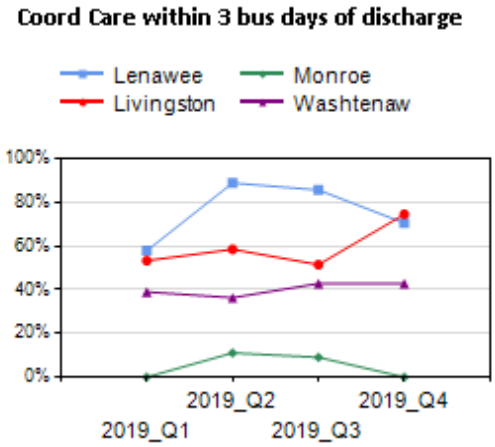
The work group goals for of FY 19 were:

1. Alerts per consumer served will be significantly greater than prior quarters.
2. Continue to develop and refine a formal protocol regarding how to respond to alerts.
3. Continue to develop an indicator that measures the extent to which the protocol is followed.
4. A goal (either a threshold to hit or simply significant improvement from baseline) and timeline will be developed for the new indicator.
5. Work through Health Information Exchange errors.
6. Explore a Health Information Exchange relationship with ProMedica (the largest health care provider for Lenawee and Monroe Counties.

Below is an excerpt from the October 2019 CMHPSM PI report on this indicator:
Alert activities between 10/1/2018 through 9/30/2019. (The ADT data available relies on the hospitals properly coding the ADTs they send).







(Doc=document; Bus=business; FTF doc=document of a face to face (FTF) contact; Care Coordination=activities as defined by the AHQR Patient Centered Medical Home)

Status Report: Lenawee CMHSP's rates for each subsequent quarter were 79%, 100%, 93% and 88%. Livingston CMHP's rates for each subsequent quarter were 73%, 90%, 73% and 86%. Monroe CMHP's rates were 33%, 89%, 45% and 43%. Washtenaw CMHSP's rates for each subsequent quarter were 76%, 79%, 76% and 82%. Performance was related to the participation of hospitals and the HIE they use. The CPT committee and ADT workgroup reviews data sets, identifies problems and proposes solutions to improve rates.

For FY 20 the CPT Committee will be determining revisions to the ADT project that will need to be addressed based on the "Share Metrics Projects Between the CMHPSM, CMHSPs and Michigan Medicaid Health Plans ".

C. Quality Improvement, Assessment and Assurances

The region regularly engages in quality improvement activities including, but not limited to systemic evaluations aimed to improve and manage the efficiency, quality, and performance of services, processes, capacities and consumer outcomes. Indicators and standards are set to monitor performance and ensure compliance. These activities included the Medication Labs Study, the CMHPSM Enhanced Compliance Monitoring Project, Regional Customer Satisfaction Survey, Recovery Self-Assessment Survey, Modernization of the Region's Electronic Health Record and the CMHPSM's Review of MDHHS Performance Indicators. These projects may promote either compliance, program integrity, consumer voice, consumer engagement, staff development, improved clinical services and/or improved consumer outcomes.

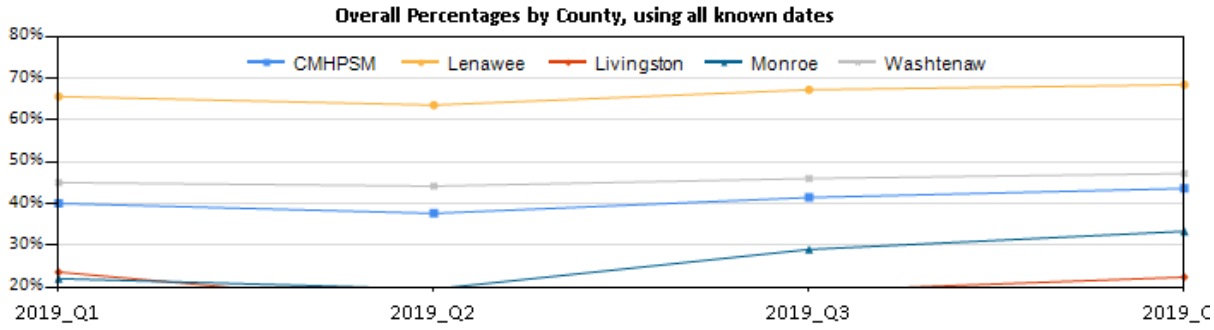
Care Coordination with Medicaid Health Plans (MHPs): Per the FY 19 MDHHS and PIHP contract, there were shared metrics projects between the CMHPSM, CMHSPs and the Michigan Medicaid Health Plans. The Care Coordination for High Consumer Utilizers Project and Protocol for Diabetes Screening for Consumers with Schizophrenia and Bipolar Disorder Using Anti-Psychotic Medication Whom are Mutually Served by the PIHP, CMHSP and Medicaid Health Plan(s) project was continued from last year. Projects added included the Plan All-Cause Readmissions (PCR) and Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA). These projects may promote either compliance, program integrity, consumer voice, consumer engagement, staff development, improved clinical services and/or improved consumer outcomes. These projects promote integrated health, clinical services and improved consumer outcomes.

Medication Labs Study: The CMHPSM continued to implement and evaluate integrated health care efforts through the Medication Labs Study. Obtaining measurements of significant consumer indicators through blood draws and lab values was a critical first step towards physical health care integration.

Initially, this study focused on increasing medication labs entered into the electronic health record for Medicaid and Non-Medicaid consumers prescribed an antipsychotic psychotropic medication and has received two medication reviews. Such psychotropic medications may contribute to various metabolic syndromes such cardiovascular disease and diabetes (type II). When prescribers have access to these lab values, this may further inform their prescribing practices and provides information with community health care providers to promote integrated health. The labs included HbA1c, Glucose, LDL Cholesterol, HDL Cholesterol, Total Cholesterol, and Triglycerides.

Data was sent to each of the regions CMHSP in the form of a "Report Card" for each prescriber to help with focused intervention efforts. Clinical team members such as supports coordinators, therapists, nurses, and peers, as well as contracted community providers, assist consumers with getting these labs completed where needed. Examples of assistance may include verbal prompting, coordination of appointments, transportation to appointments and obtaining written consent to release and/or exchange information between the laboratories and the prescribers. The chart below depicts the percentage of consumers with Medicaid with Labs in the Lab Module for FY 19.

Status Report:



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III. CMHPSM Enhanced Compliance Monitoring Project

A. Compliance Review of the CMHPs

A strong compliance and program integrity system is a critical component of managed care systems. All PIHPs are required to comply with 42 CFR 438.608 Program Integrity Requirements. Designation of a PIHP Compliance Officer, development and implementation of region wide policies and procedures which comply with federal and state laws, training, clear lines of communication with the Compliance Officer, discipline and enforcement, internal monitoring and auditing and prompt responses to detected offenses are key elements of compliance and program integrity.

This is the fourth year that the CMHPSM continues to use the revised tools to monitor the delegated functions as written in the PIHP Contract/CMHSP Contract (Attachment A – Delegation Agreement). During FY 19, the CMHPSM conducted a random clinical chart review of each CMHSP of the following areas: Needs Assessment and Pre-Planning, Treatment Planning and Person-Centered Planning, Behavior Treatment Planning, Medical/Psychiatric, Periodic Reviews, Progress Notes and Discharge Planning.
The CMHSPs received the following total clinical chart review scores: Lenawee 98%, Livingston 99%, Monroe 96% and Washtenaw 99%.
An administrative review of delegated functions also occurred this fiscal year. The CMHSPs received the following combined score for delegated functions and clinical chart review scores: Lenawee 99%, Livingston, 100%, Monroe 99%, and Washtenaw 100%.

Any required corrective action plans were completed and reviewed by the CMHPSM. The CMHPSM will be collecting further documentation that the plan was implemented during FY 20.
Due to the high performance rates and additional opportunities for review from the HSAG EQR review, the CMHPSM monitoring tool will be revised for FY 20.

B. FY 19 Substance Use Disorder (SUD) Prevention Provider Monitoring

All CMHPSM funded prevention programs are monitored by the CMHPSM on a regular basis. The mid-year point allows for a more in-depth analysis based on a variety of factors including: the amount of time for program implementation, the submission of Evidenced-based Initiative (EBI) Implementation and Evaluation Planning Forms, EBI Program Assessment/Fidelity Forms, and Coalition Community Sector Checklists (where applicable). Prevention programs are reviewed from multiple perspectives, including financial, contractual, Michigan Prevention Data System (MPDS) entries, programming, and progress on planned activities in relationship to outcomes.

For those areas that have not produced the results anticipated, either a 'course correction' is required, or a reduction in funds may be warranted. The CMHPSM promotes the rectification of program implementation to enhance the opportunity for successful efforts within the respective targeted community. Thus, feedback and consultation are provided where necessary.

1. FY 19 Prevention Desk Audits: Prevention desk audits were conducted May – July 2019 with all nine SUD Prevention contracted agencies in the four-county region. The Prevention Team utilized an updated monitoring tool that focused on review categories that relate to providers' contractual obligations, LARA licensing requirements, CMHPSM SUD Prevention RFP requirements, etc. Due to the CMHPSM Prevention Team's consistent monitoring of provider performance (i.e. Quarterly Outcome Progress Reports/Questionnaires, Michigan Prevention Data System monthly data entries, Evidence Based Initiative

Program Fidelity Reports, and Financial Status Reports), the Prevention Team chose to focus on the following seven review categories:

I. Prevention Oversight & Collaboration
II. Personnel Management
III. Credentialing & Licensing
IV. Recipient Rights
V. Records Retention
VI. Strategic Prevention Framework – Prevention Prepared Communities
VII. DYTUR (if applicable)
VIII. Subcontractor Compliance (if applicable)

After initial review of desk audit submissions, the Prevention Team requested providers to submit additional clarification materials, as applicable, and two providers with scores below 85% were required to submit a corrective action plan. All follow-up documentation and corrective action plans have been reviewed and scored. The Prevention Team plans to continually provide technical assistance to providers to address issues and will ensure successful implementation of corrective action plans in early FY20. The following table provides the final total score for each of the nine prevention fiduciaries.

CMHPSM SUD Prevention Provider	**Total Desk Audit Score FY 2018-19 Score**
Catholic Social Services of Washtenaw County	63% (CAP required)
Eastern Michigan University	50% (CAP required)
Karen Bergbower and Associates	94%
Lenawee Community Mental Health Authority	87%
Livingston County Catholic Charities	91%
Monroe County Intermediate School District	90%
St. Joseph Mercy Chelsea	87%
University of Michigan Regional Alliance for Healthy Schools	94%

2. FY 20 Provider Monitoring Plans: In accordance with CMHPSM SUD Prevention Monitoring Procedures, the Prevention Team plans to conduct on-site program observations in FY 20, which will include at least one observation per each CMHPSM-contracted provider. Program observations offer a balanced approach to program monitoring as it allows the CMHPSM SUD Prevention Team to look beyond standard reporting and review procedures and view the funded program in action with its intended participants. The Prevention Team will utilize an Observation Tool which will include the following review criteria: staff knowledge of subject/content; program organization and management; instruction and facilitation methods; presentation of information; participant interactions, rapport, and sensitivity. The Tool will also provide an opportunity

for the Team to provide feedback on program and implementer strengths and areas for improvement. Completed Observation Tools will be sent to providers upon completion of their review.

C. FY 19 Substance Use Disorder Treatment Monitoring

The CMHPSM Substance Use Disorder (SUD) Services Team conducted a comprehensive review of the SUD provider network. The review consisted of administrative policies, procedures, environmental site and clinical review of records. Providers were given the evaluation tools and requested to compile information for an on-site review by CMHPSM staff. Clinical records were selected and reviewed either at the provider site, or copies of records were provided to the review team at the CMHPSM. Administrative review was completed by May 2019 and the chart reviews were finalized during 2019, completed by July 2019.

Two standardized survey tools were utilized. One specific to Medication Assisted Treatment at Opioid Replacement Therapy sites and traditional non-medication-assisted treatment sites that provide outpatient, residential, withdrawal management (detox) and women's specific services. A minimum of five charts were randomly selected from provider admission lists for people who received services in FY19. Depending on the time allotted for the review team, number of reviewers and complexity of records, no less than three charts were reviewed per agency.

FY 19 Substance Use Disorder Treatment Providers Review

PROVIDER	TOTAL SCORE	PLAN OF CORRECTION NEEDED?	NEXT PLANNED REVIEW
AA Treatment Center (CRC)	85%	Yes	Q1 19
Catholic Charities Lenawee	81%	Yes	Q1 19
Catholic Charities Monroe	88%	Yes	Q1 19
Dawn Farm	78%	Yes	Q1 19
Hegira	93%	No	FY 20
Home of New Vision	97%	No	FY 20
Key Development	92%	No	FY 20
Livingston County Catholic Charities	86%	Yes	Q1 19
McCullough Vargas	82%	Yes	Q1 19
Parkside	69%	Yes	Q1 19
Passion of Mind	83%	Yes	Q1 19
Personalized Nursing Light House	77%	Yes	Q1 19
Salvation Army	91%	No	FY 20
St. Joseph Greenbrook Recovery Center	95%	No	FY 20
Therapeutics, Inc.	88%	Yes	Q1 19

There were fifteen providers reviewed. A total of 10 providers fell below the 90% compliance threshold for requiring a plan of correction. The average combined score was 86%. Providers were informed of issues that appeared in the review with recommendations. These were around ensuring notes were clearly documented and signed; ability to pay assessments were completed upon admission; treatment plans were individualized;

and coordination of care was documented. The table below contains summary information about the reviews.

Next Steps: The clinical review tools will be revised to update any new contract requirements, correct any review items that were not relevant and ensure the flow of tool captures the intent of the clinical review. There is currently consideration for working with other PIHPs to develop a universal review tool. The FY 20 review will be conducted during quarter three and quarter four. The providers who fell below the threshold and submitted a plan of correction will be reviewed on the plan of correction as well as any standards incorporated into the new tools.

D. Regional Customer Services: Consumer Satisfaction Survey

Over the past five fiscal years, the Performance Improvement program has improved the consumer satisfaction survey process in order to obtain reliable feedback from consumers and their families and/or guardians to be used to improve services across the region. During FY 19, the Customer Services Department revised its survey statements to capture feedback about service environment, dignity and respect, timeliness of returning phone calls and appointments, understanding what was said by CMH staff, CMH helping to achieve consumer goals, CMH staff follow up about consumer physical health needs, consumer ability to complain or disagree with staff and consumers deciding what is important to work on with CMH staff.

Method

In previous years, phone surveys were randomized by a list of active consumers, whereas this year a random sample was generated per population sample (adults with intellectual/developmental disabilities, adults with mental illness/substance use disorders and children) via daily consumer appointments. The spirit of this change was to capture a consumer's experience in real time rather than retrospective. The surveys were administered electronically and in paper form using Survey Monkey Software. After the survey period had closed, the surveys were analyzed using Microsoft Excel.

Measurement

The Customer Satisfaction Survey was designed to accurately gain feedback from consumers. Each survey statement contained an answer choice based on a 3-point Likert Scale:

1= Disagree 2 = Neutral 3= Agree NA = Not Applicable DK = I Do Not Know

Results

There were 375 persons whom participated in this survey. The charts below depict the survey results.

Customer Services Survey FY 2019

MI Adults Survey Results

CMHSP	Lenawee	Livingston	Monroe	Washtenaw	Grand Total
Sample Size	31	34	30	36	127
I feel the agency is a comfortable place.	93.1%	90.91%	96.43%	97.22%	94.44%
I feel respected when I call or see my CMH staff.	96.55%	87.5%	100%	94.44%	94.4%
My phone calls are returned by the next day.	96.55%	79.41%	88.46%	80.56%	85.6%
I saw my CMH staff within 15 minutes of my appointment.	100%	88.24%	90%	91.43%	92.13%
I understood what my CMH staff said today.	96.77%	93.94%	100%	100%	97.58%
My CMH staff helps to achieve my goals.]	93.1%	87.5%	100%	97.22%	94.4%
My CMH staff follow up about my physical health needs.	92.86%	90.32%	92.31%	91.18%	91.6%
I feel able to complain or disagree with my CMH staff.	96.3%	90%	93.1%	100%	94.87%
I know how to file a complaint.	75%*	93.94%	69.23%*	76.67%*	79.49%
I decide what is important when working with my CMH staff	100%	84.85%	92.59%	97.22%	93.39%

(* Indicates sufficient evidence that fewer than 90% of consumers agree with statement).

There were 127 consumers with mental illness whom responded to the survey. The lowest regional satisfaction score was a 79.49% regarding knowing how to file a complaint. The highest regional satisfaction score was a 97.58% regarding understanding what CMH staff said today to consumer.

As compared to FY 18, there were 123 consumers with mental illness whom responded to the survey. The lowest regional satisfaction score was a 93.1% regarding encouraging consumers to ask questions about treatment and medication and consumers deciding treatment goals. The highest regional satisfaction score was a 97.52% regarding trusting information will be kept private.

ID/DD Consumer Survey Results

CMHSP	Lenawee	Livingston	Monroe	Washtenaw	Grand Total
Sample Size	30	31	31	38	129
I feel the agency is a comfortable place.	93.1%	100%	100%	100%	98.45%
I feel respected when I call or see my CMH staff.	93.1%	100%	100%	100%	98.44%
My phone calls are returned by the next day.	78.57%	93.1%	96.55%	94.44%	92.59%
I saw my CMH staff within 15 minutes of my appointment.	91.67%	96.67%	100%	100%	97.44%
I understood what my CMH staff said today.	96.3%	96.67%	96.77%	100%	97.62%
My CMH staff helps to achieve my goals.]	100%	100%	100%	100%	100%
My CMH staff follow up about my physical health needs.	100%	100%	100%	100%	100%
I feel able to complain or disagree with my CMH staff.	88.46%	100%	96.55%	97.3%	95.9%
I know how to file a complaint.	60%*	93.33%	88.46%	96.97%	87.16%
I decide what is important when working with my CMH staff	96.15%	100%	100%	100%	99.19%

(* Indicates sufficient evidence that fewer than 90% of consumers agree with statement).

There were 129 consumers with intellectual/developmental disabilities whom responded to the survey. The lowest regional satisfaction score was an 87.16% regarding knowing how to file a complaint. The highest regional satisfaction score was a 100% for two of the statements: CMH staff helps to achieve my goals and CMH staff follow up on my physical health needs.

As compared to FY 18, there were 121 consumers with intellectual/developmental disabilities whom responded to the survey. The lowest regional satisfaction score was a 90.76% regarding a consumer asking to work with a different CMH staff. The highest regional satisfaction score was a 100% for two of the statements: CMH staff paying attention and listening to consumers and staff encouraging consumers to make choices about how consumers live.

Children Consumer Survey Results

CMHSP	Lenawee	Livingston	Monroe	Washtenaw	Grand Total
Sample Size	30	31	30	31	119
I feel the agency is a comfortable place.	96.3%	96.67%	93.33%	100%	96.58%
I feel respected when I call or see my CMH staff.	100%	96.67%	100%	100%	99.15%
My phone calls are returned by the next day.	93.1%	96%	84%	92.59%	91.51%
I saw my CMH staff within 15 minutes of my appointment.	96.3%	96.67%	96.43%	96.55%	96.49%
I understood what my CMH staff said today.	100%	96.67%	96.43%	100%	98.26%
My CMH staff helps to achieve my goals.]	100%	96.67%	93.1%	100%	97.48%
My CMH staff follow up about my physical health needs.	96.3%	93.55%	96.67%	100%	96.55%
I feel able to complain or disagree with my CMH staff.	92.59%	93.1%	100%	100%	96.46%
I know how to file a complaint.	96.15%	83.33%	75%*	85.71%	84.76%
I decide what is important when working with my CMH staff	96.15%	90.32%	93.1%	100%	94.74%

(* Indicates sufficient evidence that fewer than 90% of consumers agree with statement).

There were 119 child consumers whom responded to the survey. The lowest regional satisfaction score was an 84.76% regarding knowing how to file a complaint. The highest regional satisfaction score was a 99.15% feeling respected when calling or seeing CMH staff.

As compared to FY 18, there were 127 guardians of consumers with intellectual/developmental disabilities whom responded to the survey. The lowest regional satisfaction score(s) was a 98.36% for consumers complaints are taken seriously. The highest regional satisfaction score was a 100% for four of the following survey statements: Understanding consumer/guardian rights while receiving services; Trusting that consumer information is kept private; Feeling welcomed when coming into the building or calling on the phone; Recommending this agency to a friend of family member.

Limitations

Some of surveys were completed on paper. Manual input may contribute to data entry errors.

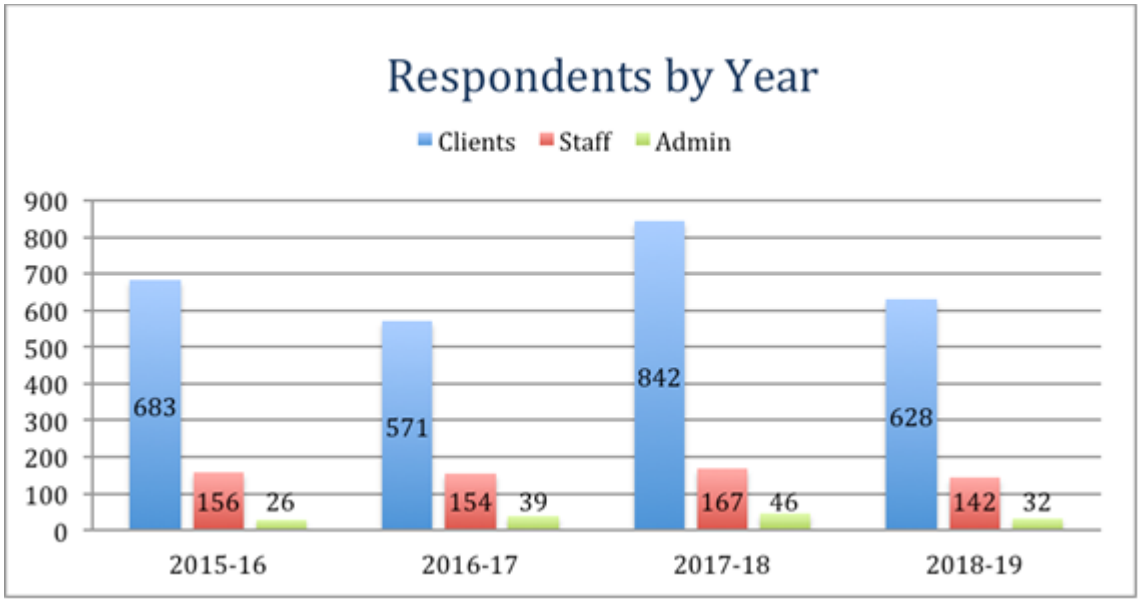
- When using a Likert Scale, some answers may have been given a 1 rating (disagree) when the participant may have intended to record a 3 (agree) and vice versa.
- Some of the surveys were submitted with responses which included the same answer for every question. For example, a score of 3 was given for every question. For these types of surveys, data was still collected and therefore overall data was potentially skewed.
- Missing responses to questions also posed as an issue amongst participants threatening the validity of the data.

Improvement Planning

During FY 20, the Regional Customer Services Department will develop and implement a customer satisfaction improvement plan to improve consumer education about how to file a complaint. For local CMH scores below 90%, the Customer Services staff will develop and implement a customer satisfaction improvement plan.

E. FY 19 Recovery Self-Assessment Survey

During FY 18, the CMHPSM distributed the Recovery Self-Assessment-Revised survey (RSA-R) (O'Conell, Tondora, Croog, Evans, &Davidson, 2005) to the contracted providers in its four-county region that use the Recovery Oriented System of Care (ROSC) model. The counties that the survey was distributed to included: Lenawee, Livingston, Monroe, and Washtenaw. The CMHPSM wanted to accurately assess and measure the effectiveness of substance-use disorder (SUD) and community mental health (CMH) providers in the implementation of recovery focused services from the perspective of consumers, provider staff, and administrative staff. This is the third year that the RSA has been used in CMHPSM's region and comparisons were made between the data from 2016 to 2019. In 2019, there was a total of 802 participants in this survey. See the table below for information about respondents by year.



Measurement

The Recovery Self-Assessment Survey (RSA) was designed with the intent to accurately gain feedback from consumers, provider staff, and administrators. The survey is designed to be administered in 3 separate versions: Consumers, Provider Staff and Administrators. Each survey was broken down into five domains: 1. Life Goals, 2. Involvement, 3. Diversity of Treatment Options, 4. Choice and 5. Individually Tailored Services. Each survey question contained an answer choice based on a 5-point Likert Scale:

1 = Strongly Disagree 2 = Disagree 3 = I am neutral	4 = Agree 5= Strongly Agree NA = Not Applicable	DK = Don't Know Additionally, the survey contained a comment box.

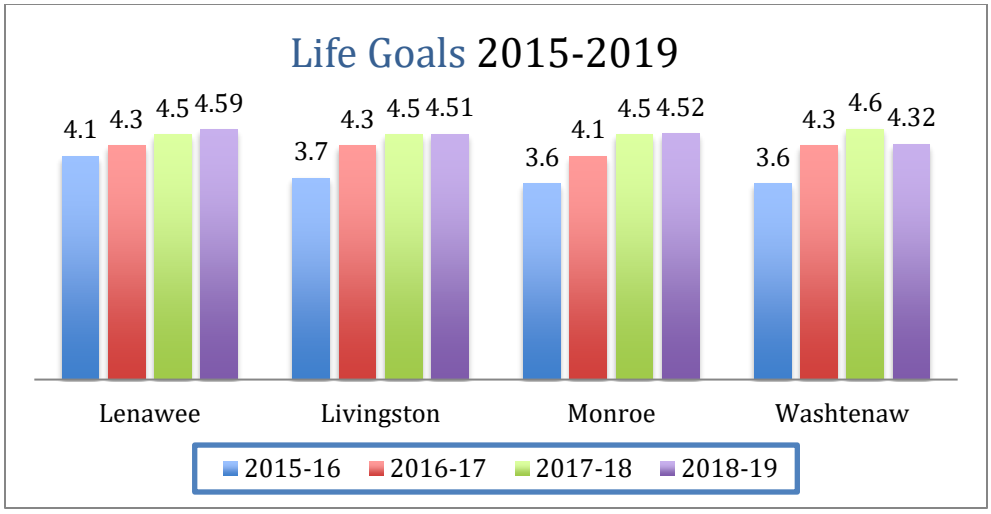
Method

The RSA was distributed to Administrators, Provider Staff, and Consumers both electronically and in paper form using the Survey Monkey Software. After the survey period had closed, the surveys were analyzed using Microsoft Excel.

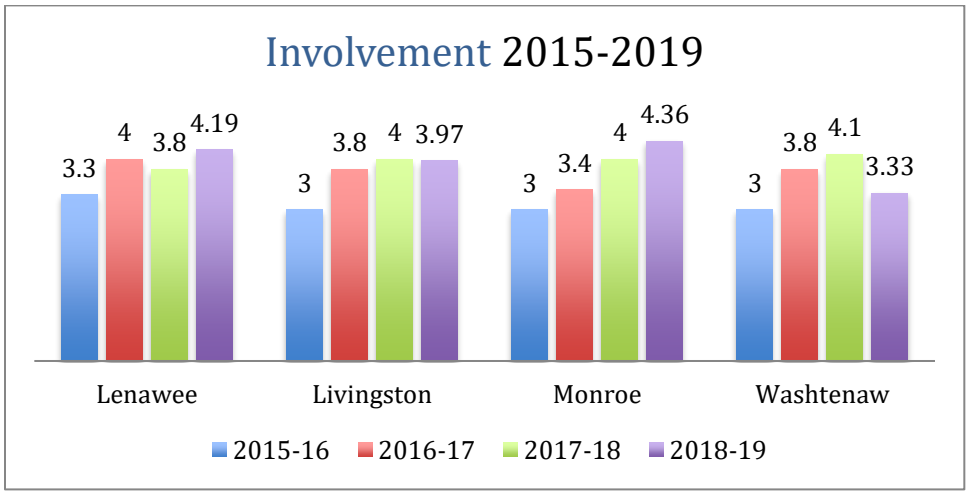
Consumer Participants

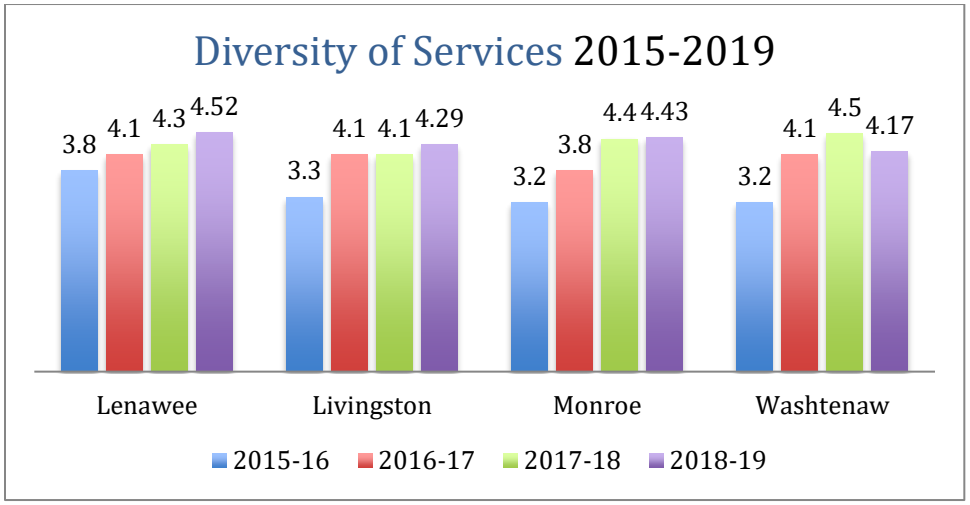
Provider Agencies	# of Client Responders
Parkside for Families (Lenawee)	18
Catholic Charities (Lenawee)	48
Lenawee Country Community Mental Health	22
McCullough-Vargas (Lenawee)	36
Ann Arbor Treatment Center (Washtenaw)	1
Therapeutics (Livingston)	2
Key Development Services (Livingston)	7
Livingston County Catholic Charities	31
Livingston County Community Mental Health Authority	92
Meridian (Monroe)	2
Monroe County Community Mental Health Authority	78
Catholic Charities of Monroe	32
Passion of Mind Healing Center (Monroe)	193
Salvation Army Harbor Light (Monroe)	15
Dawn Farm (Washtenaw)	1
Washtenaw County Community Mental Health	29
Home of New Vision (Washtenaw)	10
Access	3
Hegira Health	7
Oakdale Recovery Center	1
Total	628

Consumer Responses by County 2015-2019

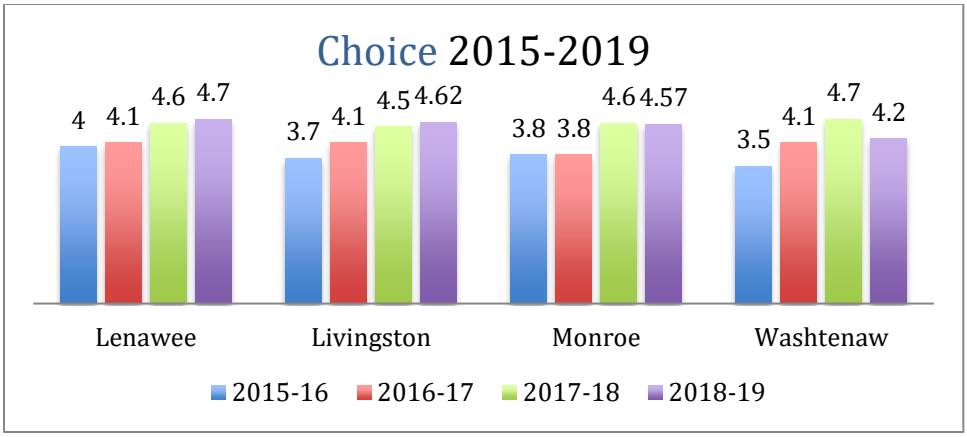


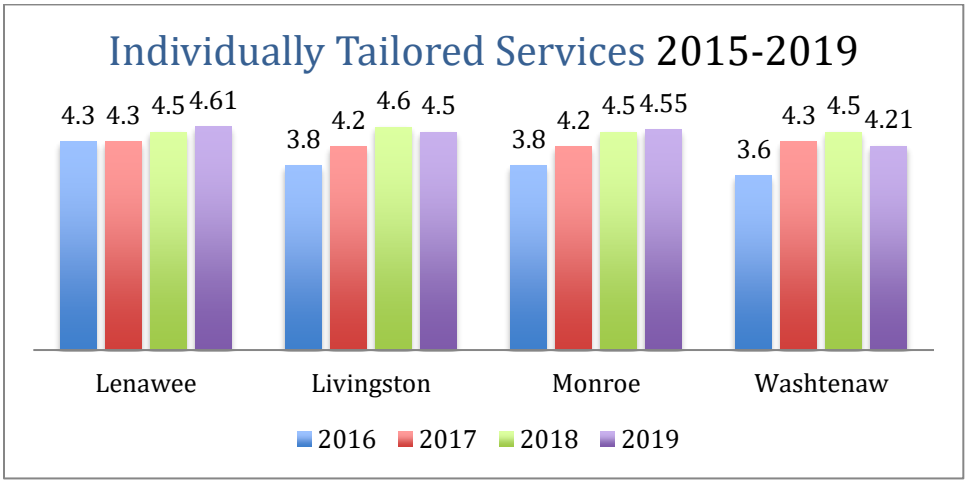
"I am happy with my recovery, this was the best place for me to come."





"Not my first go around but must say, the best. My safe spot/haven."





"I love this place. If it weren't for them, I wouldn't be where I am today. They're my family."

Considerations

Across the region, consumer ratings remained similar from previous years in three of the four counties; while Washtenaw County's scores remained relatively high but decreased slightly from last year. Consumers responses to several questions indicated that improvements can be made to clinical practice to meet client needs. Each county is working with the RSA results to develop a county-specific plan to address the report responses. The following questions highlight "Involvement," one ongoing area where providers scored the lowest, and can consider improvements to increase ratings, particularly in Washtenaw County:

- I am encouraged to help staff with the development of new groups, programs, or services.
- I am encouraged to be involved in the evaluation of this program, services and service providers.
- I am encouraged to attend agency advisory boards and/or management meetings if I want.
- I am/can be involved with staff trainings and education programs at this agency.

Limitations

- Many of the surveys were completed in paper-form, and therefore required manual input. Manual input was completed by provider agencies, which may contribute to some level of variance.
- When using a Likert Scale configuration, some answers may have been given a 1 rating (strongly disagree) when the participant may have intended to record a 5 (strongly agree) and vice versa. However, it is difficult to assess the prevalence of this phenomenon.

- Some of the surveys were submitted with responses which included the same answer for every question. For example, a score of 5 was given for every question. For these types of surveys, data was still collected and therefore overall data was potentially skewed.
- Missing responses to questions also posed as an issue amongst consumers, staff, and administrators threatening the validity of the data.

Improvement Planning
During FY 20, Co-Occurring Administrators Group will be reviewing this data and will determine whether there will be an improvement plan.

F. Modernization of the Region's Electronic Health Record

For over a decade, the region has been in a contractual relationship with Peter Chang Enterprises (PCE) as vendor for the electronic health record. The CMHPSM Chief Information Officer (CIO) and the Electronic Health Record Operations Committee (EOC) are the primary parties responsible for managing the electronic health record in conjunction with PCE. These groups identify regional needs, prioritize those needs, and identifies system problems and troubleshoots those problems with the vendor. In FY 18/19 the region achieved the goal to further modernize the electronic health record. Projective objectives achieved for FY 19 included the following:

- Regional sub-committees modified forms with review and approval by the Regional Implementation Team.
- Approved forms were deployed to the testing system.
- Regional teams were developed to evaluate the forms in the testing system. Errors were communicated to the Regional Implementation Team. Errors were resolved by programmer.
- The Regional Implementation Team continued to provide opportunities for regional staff feedback (e.g. testing in the development module, etc.).
- The Regional Implementation Team continued to use a communication plan to share the status of project with staff and other stakeholders.
- CMHPSM and Super Users continued to provide technical assistance to regional staff. Examples of technical assistance included a month of full day conference calls for reporting electronic health records concerns, recording this information, prioritizing work to be completed and resolving end-user concerns.
- Continued analysis of regional reporting needs was completed the CMPHSM. The CMHPSM has a system in place for the development of and/or revisions of reports to meet stakeholder needs.
- The work to further customize the Performance Indicator Module will continue into FY 20.

G. CMHPSM Michigan's Mission-Based Performance Indicator System (MMBPS)

MDHHS indicators are established in the MDHHS PIHP contract and reported by the CMHPSM. Data is cleaned monthly, aggregated and quarterly reported to MDHHS. Most indicators are held to the required thresholds of 95% or above, except inpatient discharges re-admitted within 30 days, which is below 15%. The chart below specifies the indicators, the State set threshold; region and/or local CMHSP(s) compliance; and whether a corrective action plan was required quarters.

Indicators	Target	QI	Q2	Q3	Q4
Indicator 1: % of Children Pre-Admission Screens for Psychiatric Inpatient Care	95%	99.30%	98.64%	100%	99.18%
Indicator 1: % of Adults Pre-Admission Screens for Psychiatric Inpatient Care	95%	99.09%	99.84%	99.48%	99.25%
Indicator 2: % Initial Assessment within 14 days of Request (MI Child)	95%	99.53%	98.95%	97.96%	99.25%
Indicator 2: % Initial Assessment within 14 days of Request: (MI Adult)	95%	99.66%	99.48%	99.69%	98.44%
Indicator 2: % Initial Assessment within 14 days of Request (DD Child)	95%	100%	100%	96.67%	97.37%
Indicator 2: % Initial Assessment within 14 days of Request (DD Adult)	95%	96.30%	100%	100%	100%
Indicator 2: % Initial Assessment within 14 days of Request (SUD)	95%	97.38%	97.57%	98.93%	98.69%
Indicator 3: % Start Services Within 14 Days of Assessment (MI Child)	95%	95.60%	97.79%	99.37%	98.11%
Indicator 3: % Start Services Within 14 Days of Assessment (MI Adult)	95%	89.44%	95.94%	93.72%	94.25%
Indicator 3: % Start Services Within 14 Days of Assessment (DD Child)	95%	93.33%	100%	100%	100%

Indicators	Target	QI	Q2	Q3	Q4
Indicator 3: % Start Services Within 14 Days of Assessment (DD Adult)	95%	93.94%	93.33%	96.43%	93.33%
Indicator 3: % Start Services Within 14 Days of Assessment (SUD)	95%	97.13%	97.54%	96.33%	97.75%
Indicator 4a: % of Child Discharges from Psych Inpatient Seen within 7 Days	95%	96%	100%	97.73%	100%
Indicator 4a: % of Adult Discharges from Psych Inpatient Seen within 7 Days	95%	96.71%	96.43%	95.27%	98.69%
Indicator 4b: % SUD Discharges from Detox Seen Within 7 Days	95%	97.03%	95.56%	92.31%	96.15
Indicator 10: % Child Psych Inpatient Discharges Readmitted Within 30 Days	15% or less	8.06%	12.50%	5.88%	13.16%
Indicator 10: % Adult Psych Inpatient Discharges Readmitted Within 30 Days	15% or less	10.27%	6.94%	11.95%	4.25%

The data was reviewed by Clinical Performance Team. Strengths, opportunities for improvement and root cause analyses were completed. For any indicators where thresholds are not met, a CAP is required to addresses systemic issues, including a projected timeframe for expected improvements, which may have contributed to low scores. CAPs were required, if an individual CMHSP was out of compliance for any quarter. If this occurred, the CAP was due within 30 days and monitored by the CMHPSM.

H. Shared Metrics Projects Between the CMHPSM, CMHSPs and Michigan Medicaid Health Plans

Per the FY 19 MDHHS and PIHP contract, there were shared metrics projects between the CMHPSM, CMHSPs and the Michigan Medicaid Health Plans. The Care Coordination for High Consumer Utilizers Project and Protocol for Diabetes Screening for Consumers with Schizophrenia and Bipolar Disorder Using Anti-Psychotic Medication Whom are Mutually Served by the PIHP, CMHSP and Medicaid Health Plan(s) project was continued from last year. Projects added included the Plan All-Cause Readmissions (PCR) and Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA).

1. Care Coordination for High Consumer Utilizers Project

The following activities occurred during FY 19:

- The Regional Data Coordinator facilitated monthly meetings with the CMHSPs and the Medicaid Health Plans (e.g. Aetna, Blue Care Complete, Meridian, Molina, McLaren, and United) regarding consumers with the highest utilization via the Stratification Report. Persons that may have been present included the CMHPSM CEO, Data Coordinator, Chief Compliance Officer and Quality Director and CMHSP Clinical Administrators, Supervisors, Supports Coordinators and Registered Nurses. Additionally, Medicaid Health Plan staff were also present (Care Managers, Supervisors and Clinical Administrators). Examples of diagnoses include the following: schizophrenia, borderline personality disorders, generalized anxiety, depression, diabetes, hypertension, heart disease, obesity, and seizures.
- Care coordination activities were recorded into the electronic health record and the CC360 file.
- The CMHPSM continued to evaluate the needs for reports to capture care coordination and utilization of services.
- The region used data from the reports to analyze trends.

2. Protocol for Diabetes Screening for Consumers with Schizophrenia and Bipolar Disorder Using Anti-Psychotic Medication Whom are Mutually Served by the PIHP, CMHSP and Medicaid Health Plan(s)

The Medicaid Health Plans (MHPs) and the 10 PIHPs are implementing a joint care protocol to improve the health and quality of life for individuals 18-64 years old with Schizophrenia or Bipolar Disorder who are using antipsychotic medications. This requires the capacity to identify shared members who meet the inclusion criteria and have not been screened for diabetes in the measurement reporting period. CC360 provides a centralized platform for identifying shared members who meet the inclusion criteria for the NCQA HEDIS measure *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (SSD). During FY 17/18, MDHHS added to the CMHPSM's contract language as it relates to care coordination with the PIHPs, MHPs and CMHSPs.

The PIHP's targeted interventions for Medicaid eligible patient(s) 18 to 64 years old, mutually served by the PIHP, CMHSP and Medicaid Health Plan(s) with schizophrenia and bipolar disorder using anti-psychotic medication will result in an increase in the proportion of those patients receiving a HbA1c and LDL-C test during the report period.

The work group planned to achieve the following goals by the end of FY 19:

1. Labs will be entered as discrete fields into the regional electronic health record.
2. HEDIS technical specification will be used as our guide during the life of the project).
3. If the PIHP/CMHSP has difficulty contacting the consumer and/or completing the labs protocol, the PIHP/CMHSP will seek assistance from the MHP.
4. The PIHP/CMHSP may coordinate care with the consumer's primary care physician for diabetes screening and further follow up for abnormal lab values.
5. The PIHP will provide general education and supports to their providers on standards and screenings for this population in collaboration with MHPs.

Project Updates:

1. Labs were entered into discrete fields. Labs were also drawn from lab feeds.
2. The HEDIS technical specification was used as our guide for this project.
3. The CMHSPs are coordinating with the consumer's primary care physician for diabetes screening and further follow up for abnormal lab values.
4. The PIHP and CMHSPs provided general education and supports to their providers on standards and screenings for this population in collaboration with MHPs.

5. Regular regional and state level meetings occurred to discuss this project.
6. The PIHP engaged in preliminary data validation with MDDHS.

This project was discontinued by MDHHS via the PIHP/MDHHS contract for FY 20.

3. FY 19 Shared Metrics Data Validation Narrative

During FY2019, Medicaid Health Plans (MHPs) and Prepaid Inpatient Health Plans (PIHPs) had the opportunity to review and validate measure data for two performance measures: **Plan All-Cause Readmissions (PCR)** and **Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA**). Event-level data was provided by MDHHS for both measures for the 6/30/18 measurement period. The purpose of the Shared Metrics Data Validation Narrative is to demonstrate participation in these validation activities and to submit a report to MDHHS on findings of efforts to review and validate data, noting discrepancies found that impact the measure results, as well as actions taken to address data issues (as needed). Below is a summary of the findings for these two performance measures:

A. Plan All-Cause Readmissions (PCR)

There were a variety of data reliability matters than needed to be analyzed for this measure.
The Reliability of Discharge Date in Claims Data and its effect on measurement was the first concern and hence CMHPSM's first step in analyzing Plan All-Cause Readmissions (PCR) as claims-derived discharge dates can sometimes differ from the actual day that the consumer left the hospital and this difference can cause problems when calculating the days between discharge and readmit.

The second step was to compare internal denominator calculations with those of the State. Of the events sent by the State:

- 11% did not have a match on the CMHPSM's end. The cause is not clear.
- 85% CMHPSM agreed that they meet denominator criteria.
- 2% were found in the extract, but the CMHPSM believe they did not meet denominator criteria.
- In this case 2% is 87 and is a significant number that would require mining more accurate data of the denominator.

The third step was the Comparison of Internal and State Numerator
Of the cases where the CMHPSM agreed on denominator inclusion, the comparison of numerators was as follows:

- 97% The CMHPSM agreed that there was/was not a qualifying readmission within 30 days.
- 1% of the State's cases found readmission when CMHPSM found none. In most cases, the CMHPSM could not find records in the extract that would indicate a readmission.
- 1% of the State's cases found no readmission when the CMHPSM found one. The CMHPSM are unclear why the State did not count these cases as readmits.

Among the factors explored that may affect this PCR data, CMHPSM found the following factors:

1. <u>Frequency of Physical Health Admission Discharge and/or Transfer(s) (ADT) Alerts to the CMHSPs</u>
2. This is only relevant for Physical Health (PH) visits since the CMHPSM are the payer for Behavioral Health (BH) admissions and an alert is not necessary to know when MH admissions are occurring. For years, the CMHPSM has operated an ADT performance improvement project. Only a small fraction of physical health visits (4.5%) resulted in a received ADT alert. The vast majority (88%) of discharges were for those not open to CMH and not included in our files. There were also (7.4%) CMH consumers whose discharge did not result in an ADT TO-DO. Several theories have been proposed for why there

is such a large gap in the ADT received rate and CMHPSM is still working to fully understand this deficiency. This will be the focus of a CMHPSM study where the CMHPSM will trace a random sample of missing ADTs and find out what barriers tended to keep them from the system.

3. Follow-up Type. Several levels of CMHSP follow-up within 3 days of discharge are compared. For example, face to face (FTF) visits or non-face to face (NFTF) visits. Data was analyzed to understand which type of CMH follow-up is most effective after a discharge. Among Physical Health (PH) visits, most cases were not known to CMH. Among the discharges from a physical health visit where the consumer was open to CMH, the most effective follow-up seemed to be comprehensive transitional care within 3 days of discharge. Comprehensive transitional care is defined as activities including the development and update of transitional care protocols, the exchange of information and direct participation to facilitate planning and decision making when moves between care settings occur. This type of follow-up was associated with only a 6% readmission rate, as compared with the 18%+ readmission rate among other CMH consumers with a physical health inpatient stay.
4. Among Behavioral Health (BH) visits, the readmission rate did not seem to depend on the type of follow-up. The readmission rate was 13% - 15% no matter what type of service the consumers received within 3 days. The readmission rate for cases that were not open to CMH is only 8%. It seems that even without a 3-day follow-up, the opening of their case was an effective intervention for those who were unknown to the CMH system at discharge.
5. Race. The race field in the State's data set was used to subdivide the population to look for racial disparity. The CMHPSM looked at the follow-up that each group received; it did not appear that there was a strong racial disparity. As far as outcomes are concerned, the highest readmission rates are among African Americans for physical health visits. As mentioned, the vast majority of these cases are unknown to the CMHPSM, but among those open to our system at discharge, transitional care within 3 days reduced that readmission rate down to 0%. For BH visits, African Americans and Hispanics had the lowest readmission rates (4% and 7% respectively).

B. Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

Event-level detail for FUA was provided to health plans on March 14, 2019. MHPs and PIHPs received denominator events only. MHPs were to review denominator events against their own emergency department claims and document any members who received numerator compliant follow-up services. PIHPs were to document any members who received numerator compliant follow-up services.

The CMHPSM does not have access to substance use disorder (SUD)-related claims, therefore the CMHPSM was unable to compare internal calculations to the State's denominator. In the analysis, we assume that the State's denominator is the gold standard.

The CMHPSM explored the FUA rate within three factors: relationship with CMHPSM, follow-up type, and race. Also, since follow-up is itself an intervention towards reduced readmissions, the CMHPSM looked at the probability of another emergency room (ER) or inpatient event within 30 days over several levels of follow-up.

The CMHPSM found that consumers who were known to our system had the highest rate of FUA follow-up. Of the events sent by the State, we found:

1. 22% had a qualifying FUA follow-up.
2. 8% had a follow-up that was similar to FUA but did not technically qualify. Most of these (47 or 4%) were cases where there was a follow-up that qualified in every way, except that the AOD diagnosis was not in slot #1 on the claim.
3. 71% did not have a follow-up within 30 days.

Performance Improvement Plan for Plan All-Cause Readmissions (PCR) and Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

For both measures the CMHPSM will continue to have a regional ADT performance improvement project. There has been a large gap in the ADT received rate and the CMHPSM will continue to work on understanding this deficiency. The CMHPSM will trace a random sample of missing ADTs and find out what barriers tended to keep them from the system. Once barriers are further identified, solutions will be developed, implemented and monitored.

In addition to this barrier analysis, regional clinical staff will follow clinical protocols upon receipt of an ADT alert for discharge. Self-serve reports have been developed by the CMHPSM to track and monitor the progress of adherence to the clinical protocols.

There will be ongoing clinical staff training, supervision and coaching regarding this performance improvement project. There is a regional ADT workgroup to manage this project which reports to the regional Clinical Performance and Leadership team (CPT) and the Regional Operations Committee. The ADT workgroup and CPT will have cross communications with Electronic Health Record Committee as it pertains to technology needs and solutions. The ADT workgroup is in the process of evolving into a regional Integrated Health Committee. The purpose of this committee will be to manage integrated health related projects (Performance Improvement Projects, Strategic Plan Initiatives, Mutually Served Project Measures) by engaging in the following tasks:

- Collects, reviews and evaluates the timeliness and cleanliness of outcome data.
- Intervenes on a local level to address any barriers to timely and clean data.
- Examines data to ensure adherence to PIP and/or other project protocols.
- Consulting data exchange vendors such as PCE (electronic health record vendor) and/or Great Lakes Health Connect (health highway data exchange vendor).
- Consulting Medicaid Health Plans to improve communication regarding ED visits for alcohol and other drugs.
- Routes information about the Performance Measures to the Clinical Performance Team (CPT) on a quarterly basis.

Closing Statement

This annual evaluation only represents a snapshot of the performance improvement initiatives throughout the region. Continuous improvement is a vital part of a learning organization. The consumers, employees, supervisors, and directors involved in making services and programs, focus on that aspect, not just as part of a special project, but in their operations.

Respectfully Submitted,

CJ Witherow
Chief Operating Officer
Community Mental Health Partnership of Southeast Michigan – Region 6