NMRE FY 2021 QAPIP Evaluation Summary Report

And

2022 QAPIP Workplan

Approved By	**Date**
Operations Oversight Committee (OOC)	02/01/22
Quality Oversight Committee (QOC)	02/01/22
NMRE Board of Directors	01/26/22

1. Performance Improvement Projects (PIPs)

a. Increasing Diabetic Screenings for Consumers with SMU Prescribed an Antipsychotic Medication

While the Diabetic PIP is in maintenance mode, NMRE continues to monitor the progress of the CMHSPs. The Diabetic PIP data was shared bi-annually with the CMHSPs for their review and to identify areas for improvement. This is the last year working with this PIP.

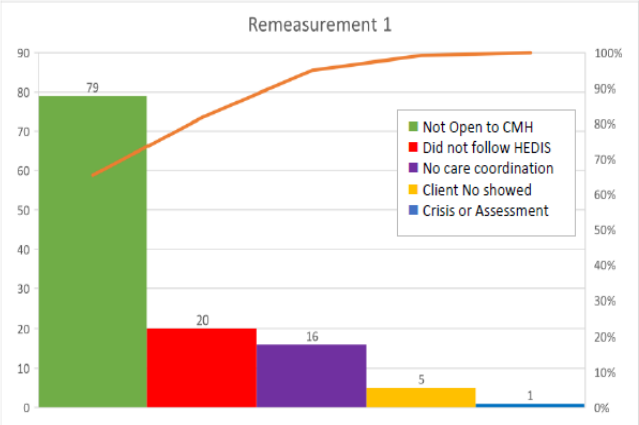
b. Follow-up Care for Children Prescribed ADD Medication (ADHD)

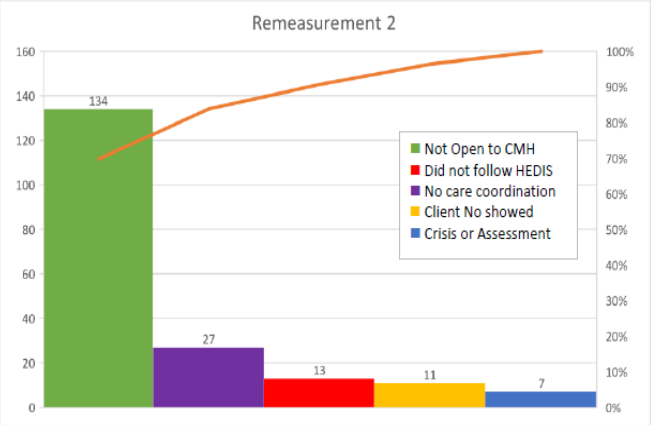
The NMRE uses a third-party data collection company called AFIA, to supply the data regarding the HEDIS measures. The data that AFIA provides is based on data they receive from the State of Michigan's claims' warehouse. Once received NMRE reviews to assure data accuracy.

There were a series of data challenges which produced highly skewed baseline data. As a result of the inaccurate baseline data, the NMRE was not able to meet the requirements of this PIP. However, monthly reports of individuals that were found to be non-compliant were provided to the CMHSPs for review. This allowed the CMHSPs to investigate those cases and complete the Causal Barrier Analysis (CBA). This data was also discussed quarterly at the QOC meetings.

NMRE ADHD PERFORMANCE IMPROVEMENT PLAN RE-MEASUREMENT 1 VS. REMEASUREMENT 2

	Remeas 1 AVCMH	Remeas 2 AVCMH	Remeas 1 CWN	Remeas 2 CWN	Remeas 1 NCCMH	Remeas 2 NCCMH	Remeas 1 NeMCMH	Remeas 2 NeMCMH	Remeas 1 NLCMH	Remeas 2 NLCMH	Total Remeas 1	Total Remeas 2
Crisis or Assessment	0	0	0	0	0	5	1	0	0	6	1	11
Client No showed	5	2	0	1	0	2	0	1	0	1	5	7
Not open to CMH at time Medication was prescribed.	12	24	13	10	23	32	6	21	25	47	79	134
No care coordination between CMH and prescribing provider	0	1	6	14	7	8	1	0	2	4	16	27
Did not follow HEDIS Prescribing procedure	8	1	0	1	5	7	6	2	1	2	20	13
Total	25	28	19	26	35	54	14	24	28	60		





2. Satisfaction Surveys

The NMRE conducted five satisfaction surveys in 2021.

1. Mental Health Services Survey - April 1st-April 22, 2021.
2. Home Base Services Survey – ongoing; given to consumers at close of case.
3. Substance Use Disorder (SUD) Survey
    a. Methadone - January 1st-Jan. 18th, 2021
    b. Detox - January 1st-Jan 18th
    c. Outpatient/SUD OHH- July 1st -July 23rd

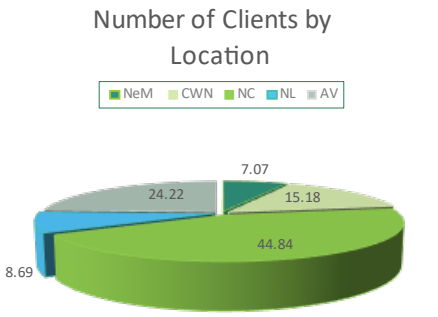
a) **The Mental Health Services Survey** was consolidated: Outpatient Therapy, Medical Services, Adult Case Management, Youth Case Management, Assertive Community Treatment (ACT), Opioid Health Home (OHH), Peer Support Services, and Clubhouse Services.

Participation

- Total Responses: 853
- Total Served: 6,512
- Participation Rate: 13.1%

Location # of Clients Completing Survey

Northeast Michigan CMH	61
Centra Wellness Network	131
North Country CMH	387
Northern Lakes CMH	75
AuSable Valley CMH	209



Key areas of improvement include:

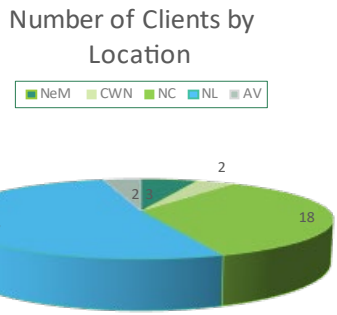
- Implement better survey administration and communication process.
- Improve information sharing and implementation of the grievance and appeals process.
- Share more information on OHH program to both staff and clients.
- Improve communication between staff and clients regarding coordination of care paperwork.

Overall, all CMHSPs scored above 90% in the areas of cultural competency, dignity, and respect, and communicating.

b) Home Based Services Survey was ongoing. It was given to consumers at the close of their case. Results were tallied at the end of the fiscal year and shared with the CMHSPs.

Participation

- Total Responses: 59

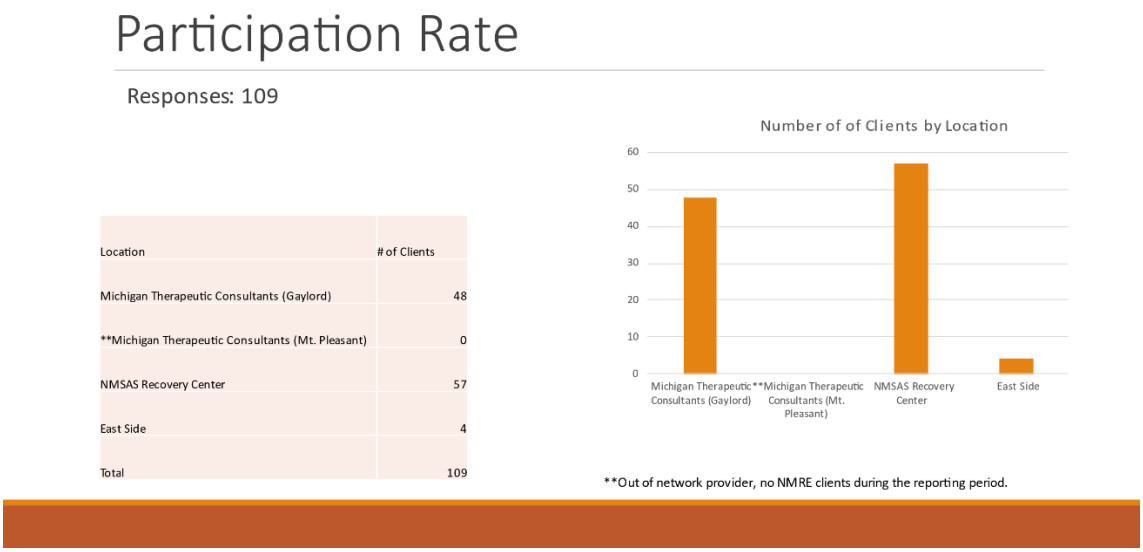


Location # of Clients Completing Survey	
Northeast Michigan CMH	3
Centra Wellness Network	2
North Country CMH	18
Northern Lakes CMH	27
AuSable Valley CMH	2

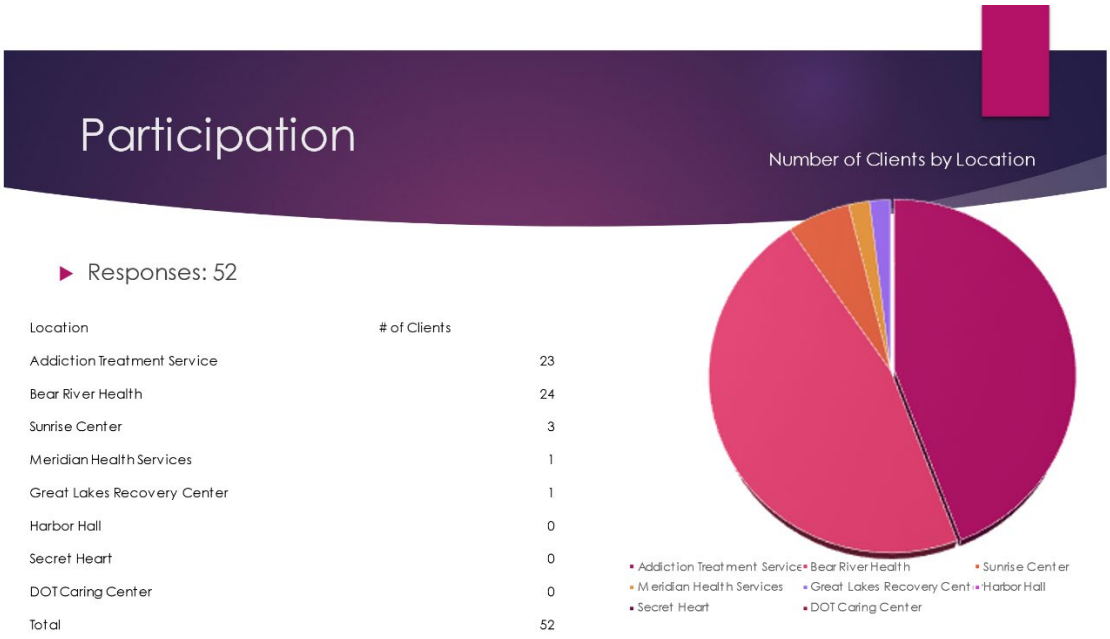
All CMHSPs scored above 85% in every area, indicating a decent level of satisfaction with the Home-Based Services Program. However, there are some opportunities for improvements mainly around information sharing.

c) Methadone – Providers scored above 95% in the areas of overall satisfaction, ease of access to their care team, comfort in asking questions about their treatment, recipient rights, information privacy, treatment goals, and funding.

The area that needs improvement is the need to share information about peer recovery support.



d) Detox - Regionally the participation rate was 93%. providers scored above 90% in the areas of cultural competency, dignity and respect, ease of access to the program, satisfaction with treatment during their stay, and speed of admission.



The areas in need of improvement were:

a. Sharing information regarding peer recovery support.

b. Discharge planning.

e) **Outpatient /SUD OHH –** Outpatient providers scored above 90% in all areas other than peer recovery support. Areas that scored above 95% included: explanation of services in a way the client could understand, information privacy, coordination of care, grievances, rights, funding, and recovery support resources.

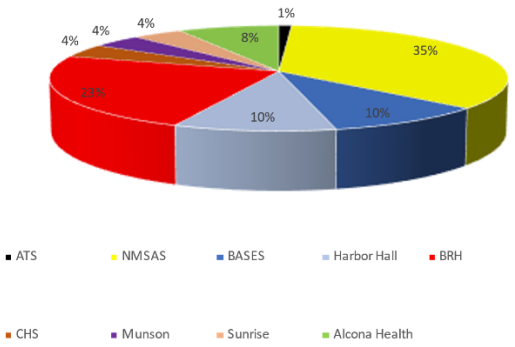
Participation

Outpatient Responses: 323

OHH Responses: 18

Total Responses: 341

Location	# of Clients
Addiction Treatment Service	3
Bear River Health	80
Sunrise Center	14
Catholic Human Services	15
Munson	12
Harbor Hall	34
BASES	35
NMSAS	120
GRACE Center	0
Traverse Health Clinic	0
Alcona Health	27
Thunder Bay	0



All survey results were shared with the providers and presented at the QOC meetings and SUD Directors meetings for discussions and learning opportunities. In the future, survey results will also be available on the NMRE website.

3. Performance Indicators

The NMRE continued to monitor data from the Michigan Mission Based Performance Indicator System. If a Provider fell below the standard for two consecutive quarters, a Corrective Action Plan was requested. No provider fell below the standard in 2021. Beginning April 1, 2020, MDHHS removed exceptions for Tables 2 and 3; the NMRE continued to monitor the impact of this change as part of its FY21 Work Plan. Performance Indicator reports were shared with the providers, the QOC and the NMRE Governing Board quarterly.

Table 1: Percentage Receiving a Pre-Admission Screening for Psychiatric Inpatient Care for Whom the Disposition was Completed Within Three Hours ≥ 95%				
	1Q FY20	2Q FY20	3Q FY20	4Q FY20
Children	99.30%	99.49%	100%	98.82%
Adults	99.23%	99.02%	99.09%	99.27%
Totals	99.36%	99.13%	99.23%	99.18%

Table 2: The Percentage of New Persons Receiving a Face-to-Face Assessment with a Professional Within 14 Calendar Days of Non-Emergent Request for Services				
	1Q FY20	2Q FY20	3Q FY20*	4Q FY20*
MI Child	69.72%	72.04%	69.42%	54.96%
MI Adult	61.56%	65.97%	62.80%	52.29%
DD Child	81.82%	82.35%	70.67%	46.43%
DD Adult	80.77%	66.67%	62.16%	48.98%
total	65.52%	68.82%	65.49%	52.68%
Table 3: The Percentage of New Persons Starting any Needed On-going Service Within 14 Days of Non-Emergent Assessment With a Professional				
	1Q FY20	2Q FY20	3Q FY20*	4Q FY20*
MI Child	71.81%	75.47%	69.11%	63.92%
MI Adult	69.90%	74.76%	73.59%	68.05%
DD Child	86.89%	85.48%	76.92%	86.36%
DD Adult	86.96%	75.00%	79.17%	73.17%
total	72.17%	75.58%	72.29%	68.00%

Table 4a: The Percentage of Persons Discharged from a Psychiatric Inpatient Unit Who were seen for Follow-up Within 7 days ≥ 95%				
	1Q FY20	2Q FY20	3Q FY20	4Q FY20
Children	97.73%	100%	94.74%	100%
Adults	99.27%	98.74%	97.85%	97.83%
Total	98.50%	98.99	97.12%	98.39

Table 4b: The Percentage of Persons Discharged from a Substance Abuse Detox Unit Who were seen for Follow-up Within 7 days ≥ 95%

	1Q FY20	2Q FY20	3Q FY20	4Q FY20
SA	95.56%	91.18%	95.19%	80.65%

Table 6: The Percentage of Persons Readmitted to Inpatient Psychiatric Unit Within 30 Calendar Days of Discharge from a Inpatient Psychiatric Unit is 15% or Less				
	1Q FY20	2Q FY20	3Q FY20	4Q FY20
Children	9.62%	7.14%	8.57%	8.00%
Adults	11.27%	10.00%	11.92%	11.83%
Total	10.44%	9.46	11.21	11.02%

4. Annual Site Review

a) NMRE Site Review: The NMRE conducts regional CMH site reviews biannually where year one is a full review and year two is a review of the Corrective Action Plan (CAP) inolementation. 2021 was a Corrective Action Plan (CAP) year for the NMRE's site review. This year the NMRE requested evidence of CAPs that were activated as a result of the 2020 NMRE site review. Upon review of the CAPs the Region was substantially compliant with the CAPs.

b) MDHHS Review: The team worked with the CMHSPs and MDHHS to complete the initial 2021 C Waiver (HSW, CWP, SEDW) review; this review occurs every other year. There were no outstanding trends among the 5 CMHSPs reviewed. However, there was a need for a technical assistance call with the five CMHSPs to clarify certain areas.

c) HSAG Review: The 2021 compliance review was the beginning of a new three-year cycle of HSAG compliance reviews. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable State contract requirements. The compliance review consists of 13 standards/program areas.

MDHHS requested that HSAG conduct a review of the first six standards in Year One (SFY 2021). The remaining seven standards will be reviewed in Year Two (SFY 2022). In Year Three (SFY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the SFY 2021 and SFY 2022 compliance reviews.

The NMRE demonstrated compliance in 56 of 65 elements, with an overall compliance score of 86 percent, indicating that some program areas had the necessary policies, procedures, and initiatives in place to carry out many required functions of the contract, while other areas demonstrated opportunities for improvement. A CAP was submitted as required and the NMRE is actively working on implementing the CAPs aa indicated.

Below is a summary results of standards reviewed in SFY 2021.

Compliance Review Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Member Rights and Member Information	19	19	16	3	0	**84%**
II	Emergency and Poststabilization Services*	10	10	10	0	0	**100%**
III	Availability of Services	7	7	7	0	0	**100%**
IV	Assurances of Adequate Capacity and Services	4	4	2	2	0	**50%**
V	Coordination and Continuity of Care	14	14	14	0	0	**100%**
VI	Coverage and Authorization of Services	11	11	7	4	0	**64%**
	Total	**65**	**65**	**56**	**9**	**0**	**86%**

d) **SUD Provider Review:** The NMRE completed a full annual review of all SUD Providers in the region. This review process was a hybrid of in-person visit to all Providers as well as uploads of requested polices and program documents. The in-person visits were from June 3, 2021 – July 29, 2021. The DRAFT reports were submitted to the Providers for their review, and they were given a chance to submit any documentation they believed could have been missed.

2022 will be a CAP year, the NMRE will be requesting a Quality Improvement Plan (QIP) from each Provider in response to their individual review reports. The Compliance and Quality Department will be monitoring the QIP to verify that steps are taken, as reported, to correct any deficiencies.

Delegated Functions Administrative Review		Program Scores	Possible Scores	Not Applicable	Total Compliance Score
1	Information/Customer Service	297	336	0	**88%**
2	Enrollee Rights	286	336	24	**92%**
3	Grievance & Appeals	271	408	2	**67%**
4	Quality & Compliance	46	48	0	**96%**
5	Individual Treatment & Recovery Planning	296	312	0	**95%**
6	Coordination of Care/Quality Improvement	81	96	8	**92%**
7	Provider Staff Credentialing	391	408	14	**99%**
	Total	**1668**	**1994**	**48**	**88%**

Program Specific Services Review		Program Scores	Possible Scores	Not Applicable	Total Compliance Score
1	ASAM	48	48	0	**100%**
2	Residential	68	168	98	**97%**
3	Peer Recovery	18	24	6	**100%**
4	Women's Specialty Services	38	96	58	**100%**
5	Medication Assisted Programs	50	168	116	**96%**
6	Recovery Residences	35	216	180	**97%**
	Total	**257**	**720**	**458**	**98%**

Consumer		Program Scores	Possible Scores	Not Applicable	Total Compliance Score
1	Consumer Charts Totals	4424	12562	7264	**84%**

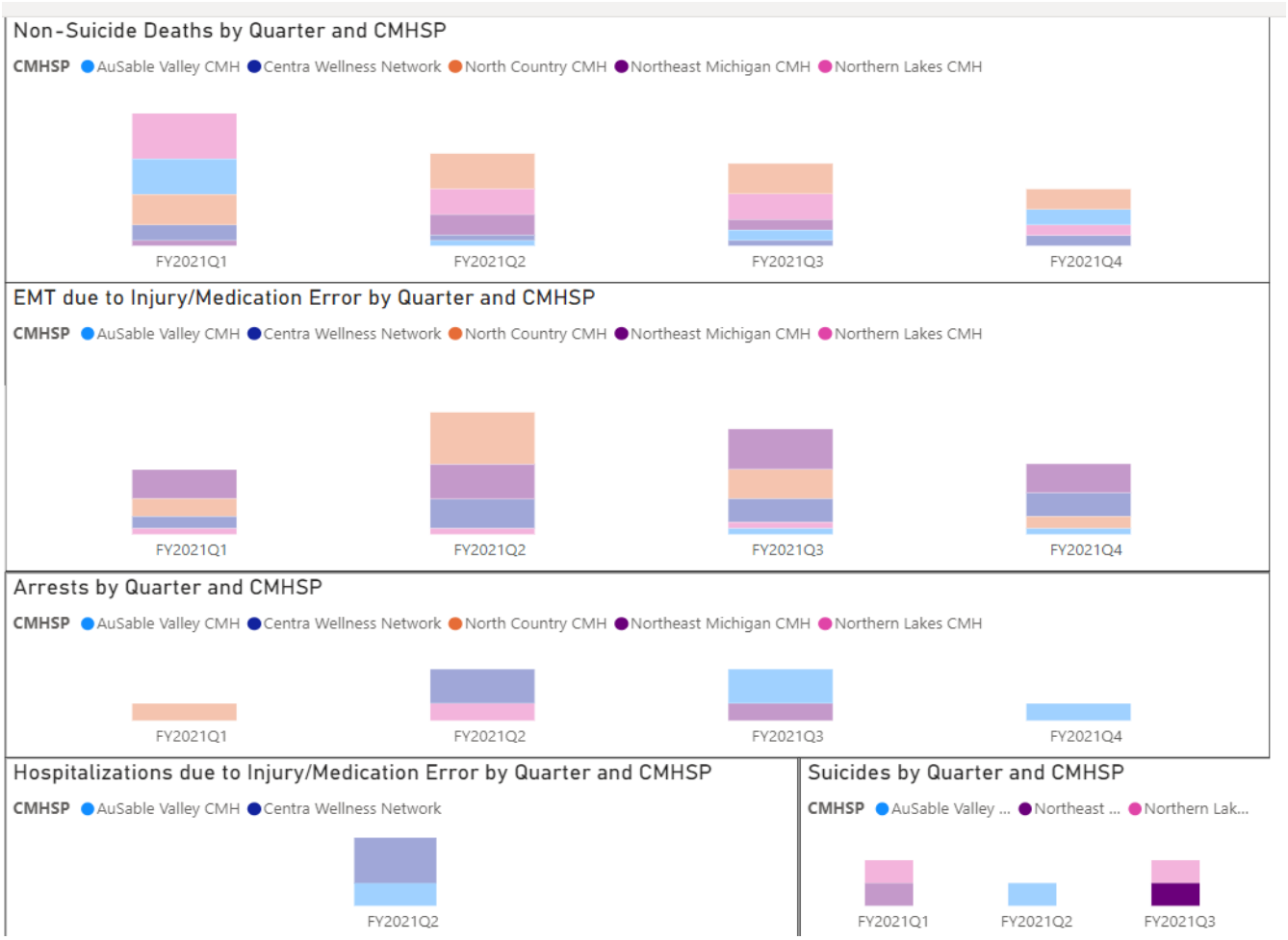
5. Critical Incidents, Sentinel Events and Risk Events

NMRE tracked critical incidents monthly. The total number of incidents in FY2020 compared to FY2021 increased from 123 to 149; an increase of 26 incidents.

Based on the analysis, most of the incidents were from Non-Suicide death. The second highest came from EMT due to Injury/Medication Error. Suicide also went up compared to 2020. Hospitalization due to injury or medication error and Arrest both went down.

Providers were required to complete an RCA on Sentinel Events. The NMRE Compliance and Quality team reviewed the RCA summary to ensure that proper corrective action plans were implemented. During site reviews, the team also reviews the implemented CAPs and the credentials of the staff involved.

NMRE FY 2020 and 2021 Critical Incident Comparison			
	FY 2020	**FY2021**	**Difference**
Suicide	1	5	↑**4**
Non-Suicide Death	47	71	↑**24**
EMT due to Injury/Medication Error	61	62	↑**1**
Hospitalization due to Injury/Medication Error	6	3	↓ **3**
Arrest	16	8	↓ **8**
Totals	**123**	**149**	↑**26**

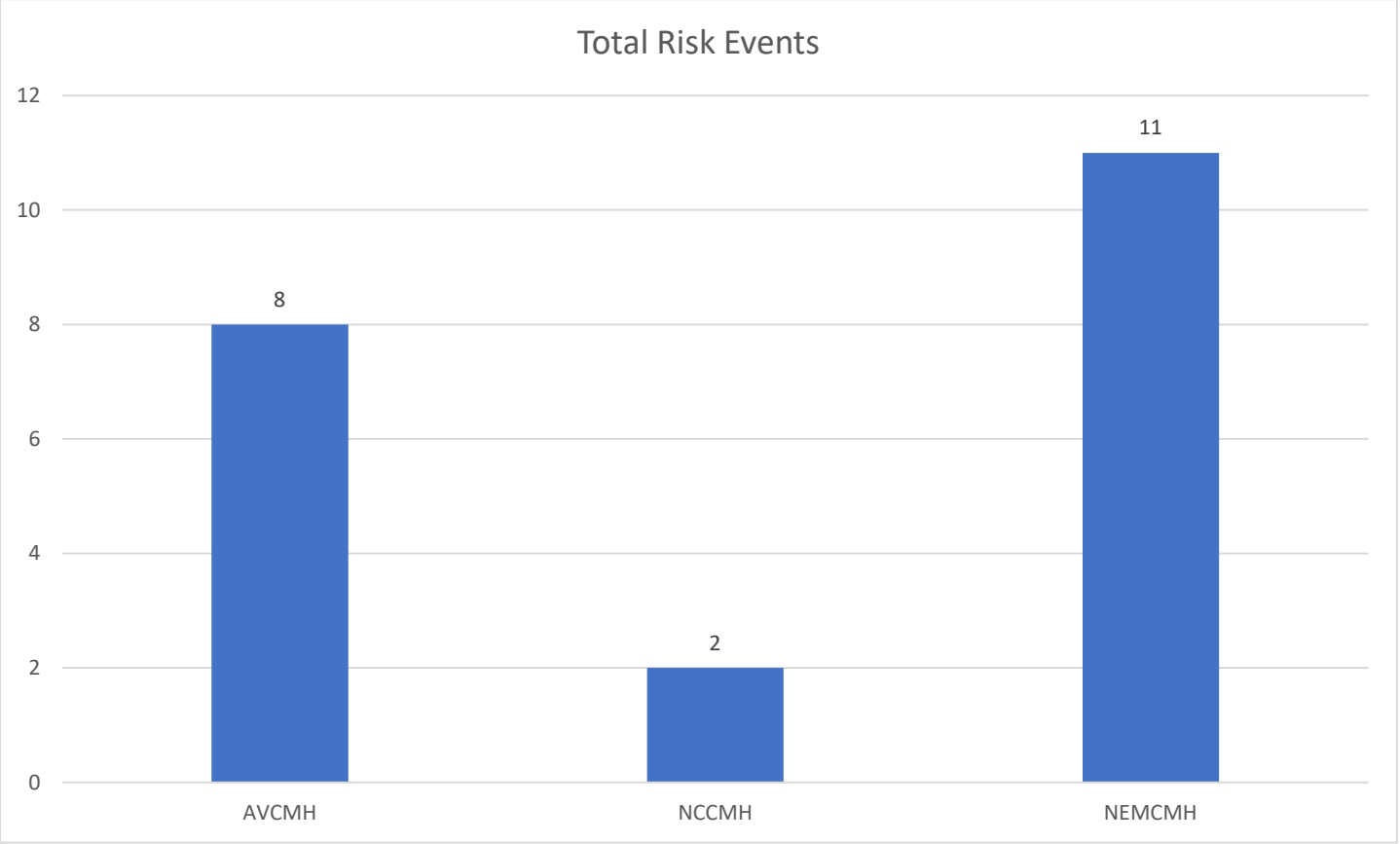


Risk Events

The collecting and analyzing of risk events data is a new process for the CMHSPs Although there continue to be challenges with this data, some progress is being made. Not all the CMHSPs provided timely data, but the group went ahead and analyzed what

was received for a start. The committee will continue to identify better ways to gather and analyze risk events data.

	Harm to Self	Harm to Others	Police Call	Emergency use of Physical Management due to a Behavioral Crisis	Physical Management	Unscheduled Hospitalization	Total Events
AVCMH	0	0	0	0	2	6	8
NCCMH	0	0	1	1	0	0	2
NEMCMH	2	0	9	0	0	0	11



6. Behavior Treatment

The NMRE had ongoing challenges with aggregating the behavior treatment data in a systematic way. This is because the collection of data from the five CMH providers has not been consistent with each other in the past. A new process has been implemented.

The five CMH providers will send their Behavioral Treatment Review Committee (BTRC) meetings minutes along with any trends identified during the BTRC meetings to the NMRE. These trends will be tallied quarterly and presented for discussion during the QOC meetings.

The NMRE will continue to work with the five CMH providers on this new process to best accommodate all involved and to adequately trend and review the data at a regional level for improvement.

FY22 Work Plan

Goal #1: The NMRE will conduct Performance Improvement Projects (PIPs) that will include ongoing measurements and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that are expected to have positive impact on health outcomes and member satisfaction.

Objective 1: The NMRE Data Analyst will continue to collect ADHD data and share with the CMHSPs to conduct analysis and follow up with individuals that meet criteria. This data will be discussed quarterly with QOC to identify areas for improvement.

Objective 2: The Compliance and Quality team will work with HSAG and MDHHS to identify a new PIP starting FY2022.

Goal #2: The NMRE Compliance and Quality team will continue to work with IT and QOC to develop a standardized method to collect data on risk events and sentinel events.

Objective 1: The NMRE Compliance and Quality team will draft a form that will be used to collect risk event data by the CMHSPs.

Objective 2: The NMRE Compliance and Quality team will share the Risk Event reporting form with the CMHSPs and continue to educate them on how to complete the form and the importance of this activity.

Objective 3: The NMRE Compliance and Quality (C&Q) team will review the reporting process and requirements of the events data with the providers to avoid under reporting by 09/30/22.

Objective 4: Through the annual site review process, the C&Q team will check to assure that interventions are improving patient safety. This will be done by reviewing the data submitted which will include the numbers or events.

Objective 5: The analysis of Sentinel Events, Critical incidents, and Risk Events will include a review of data per event type per 1,000 members to complete a comparative analysis and trend these data over time.

Goal #3: The NMRE will continue to conduct quantitative and qualitative assessments of member experiences with services. These assessments will be representative of the persons served and the services and supports offered.

Objective 1: The NMRE will revise survey questions to assure the right questions are asked and that the questions are returning meaningful data.

Objective 2: The NMRE will work with providers to identify ways to implement surveys in a way that will not cause survey fatigue amongst participants.

Objective 3: The NMRE will take specific actions on individual cases of the survey results as appropriate.

Objective 4: Survey results will be shared with QOC to discuss and identify possible solutions to resolve areas of dissatisfaction on an ongoing basis.

Objective 5: Survey results will be shared directly with providers and presented to the NMRE Board of Directors. Survey results will also be made accessible to participants and the public on the NMRE website.

Goal #4: The NMRE will measure its performance using standardized indicators based upon the systemic, ongoing collection and analysis of valid and reliable data.

Objective 1: The NMRE QOC will monitor comparative provider performance of quarterly MMBPIS measures within 30 days of the quarterly report from MHDDS.

Objective 2: NMRE will share performance data with CMHSPs for their review. This data will be discussed in QOC quarterly.

Objective 3: The NMRE QOC will continue to monitor the impact of removing exceptions for Tables 2 and 3 performance indicators by 09/30/2022.

Goal #5: The team will continue to monitor its Network Providers at least annually.

Objective 1: The NMRE will coordinate and conduct site reviews annually for all contracted service providers by 9/30/2022.

Objective 2: The NMRE will monitor and follow-up with corrective action plans to assure these CAPs are being implemented as stated by the network providers.

Objective 3: The NMRE QOC will receive regular updates from the providers on the progress of the site review CAPs.

Objective 4: The NMRE will perform quarterly audits to verify Medicaid and Healthy Michigan Plan claims/encounters submitted within the provider network. This will include verifying data elements from individual claims/encounters to ensure proper codes are used.

Goal #6: Update and improve NMRE Provider Directory and work with NMRE's contracted providers in the region to update their directories accordingly.

Objective 1: Gather information from NMRE's providers about physical accommodations such as ramps, restrooms, electronic doors, exams rooms, etc. to each specific location.

Objective 2: Create a more user-friendly interface; rather than a spreadsheet platform, this will include using drop down options, more visible links to CMH pages, and maps with travel distances.

Goal # 7: Update and improve the Network Adequacy Plan that will incorporate time/distance standards within the region.

Objective 1: The NMRE will create a report that will allow users to determine mileage from a geographic location to a provider clinic using network adequacy standards for each individual mental health and SUD provider service.

Objective 2: Once the network adequacy plan is in place, the NMRE will make it accessible to the public through its website.

Goal #8: The NMRE Compliance and Quality Team will conduct quarterly reviews and analyses of data from the CMHSP Providers where intrusive, or restrictive techniques have been approved for use with members and where physical management or 911 calls to law enforcement have been used in an emergency behavioral crisis.

Objective 1: The NMRE will monitor that only techniques permitted by the Technical Requirements for Behavior Treatment Plans and that have been approved during person-centered planning by the member or his/her guardian may be used with members through annual site reviews by 9/30/2022.

Objective 2: QOC will oversee the operations of the Behavioral Health Treatment operations through 09/30/2022 by reviewing data and trends.

Objective 3: QOC will review/discuss behavior treatment data; this includes trends analysis received from individual CMHSPs quarterly through 12/31/2022.

Goal #9: NMRE will continue to improve the process to provide quarterly updates to the Governing Body regarding routine QAPIP activities.

Objective 1: QAPIP activities will be reviewed and evaluated by QOC quarterly.

Objective 2: The QAPIP quarterly evaluation report will be share with the NMRE Governing Board.