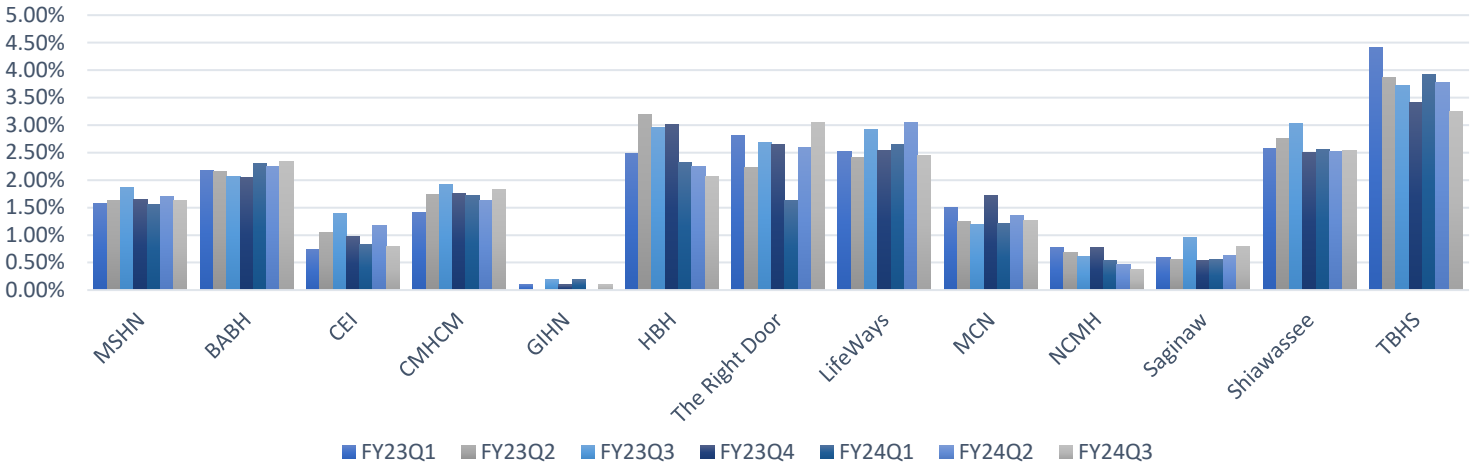
Title of Measure: Behavior Review Data
Summary of Project: The analysis of behavior treatment data is required by the Michigan Department of Health and Human Services (MDHHS). The data collected is based on the definition and requirements that have been set forth within the Standards for Behavioral Treatment Review attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract.

MSHN delegates the responsibility for the collection and evaluation of data to each local CMHSP Behavior Treatment Review Committee (BTRC), including the evaluation of effectiveness of the BTRC by stakeholders. Data will be collected and reviewed quarterly by the CMHSP where intrusive and restrictive techniques have been approved for use with individuals, and where physical management or 911 calls to law enforcement have been used in an emergency behavioral situation. This data is to be reviewed as part of the CMHSP Quality Improvement Program (QIP) and reported to the PIHP. MSHN monitors to ensure the local CMHSP BTRC follows the requirements outlined within the Standards for Behavior Treatment Review Committees. The following measures are trend data; therefore, no external standard exists. The trend is used to identify any areas requiring further analysis to improve the safety of the individuals we serve. This is done by reviewing quarterly data to identify causal factors contributing to undesirable patterns. CMHSP and/or MSHN will implement interventions to improve safety, thereby changing the direction of the trend. The expectation is that each year will demonstrate improvement from the previous year.

Data Analysis
Goal 1: The proportion of individuals with a restrictive and/ or intrusive behavior treatment plan will be monitored quarterly to address causal factors for positive or negative change**.**
Numerator: The total number of plans with restrictive and intrusive interventions reviewed during the reporting period.
Denominator: The total number of individuals who are actively receiving services during the reporting period.

Figure 1. Percent of Individuals served who have a Behavior Treatment Plan with Intrusive/Restrictive interventions.



Goal 2: MSHN will ensure behavioral treatment plans are developed in accordance with the Standards for Behavior Treatment Plan Review Committees. (Data through FY24Q1).

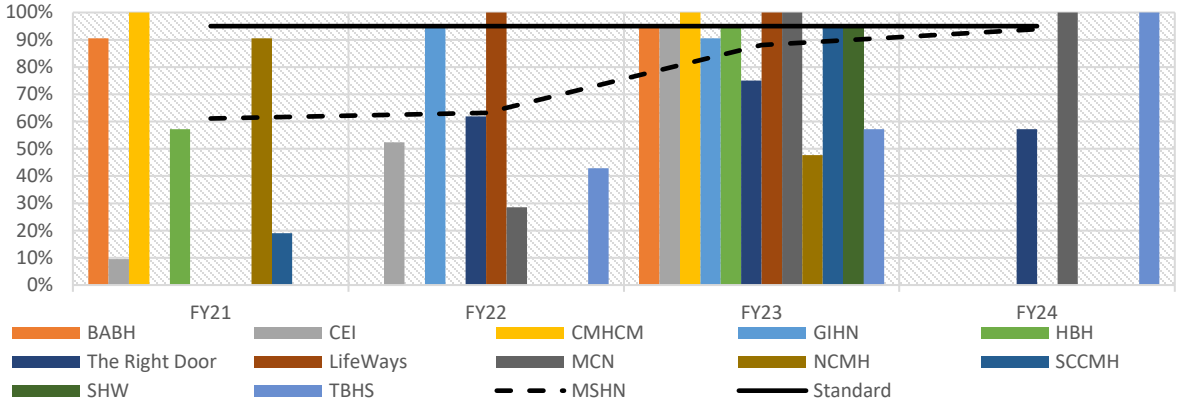
Study Question 2: Have the targeted interventions been effective in increasing the percentage of compliance with the Behavioral Treatment Standards.

Numerator: The number of Behavior Treatment standards meeting full compliance through the monthly delegated managed care reviews.

Denominator: The total number of Behavior Treatment Standards reviewed through the monthly delegated managed care reviews.

The process for collecting data changed in FY24. The numerator and denominator will be revised to reflect change for FY25.

Figure 2. Percentage of Behavioral Treatment Plan Standards Met (Cumulative)



Goal 3: The percentage of emergency interventions per person served during the reporting period will demonstrate a decrease from the previous measurement period.

Study Question 3: Has the proportion of incidents in which the use of emergency intervention decreased over time (Figure 3)?

Numerator: The total number of emergency interventions reviewed during the reporting period. (Total # of physical management, and 911 call for behavioral assistance)

Denominator: The total number of individuals who are actively receiving services during the reporting period.

Figure 3. The percentage of emergency interventions used per person served for MSHN

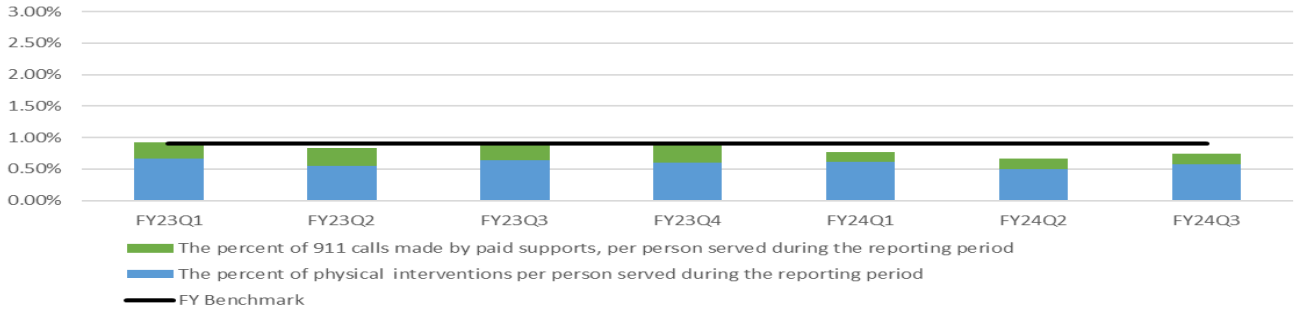
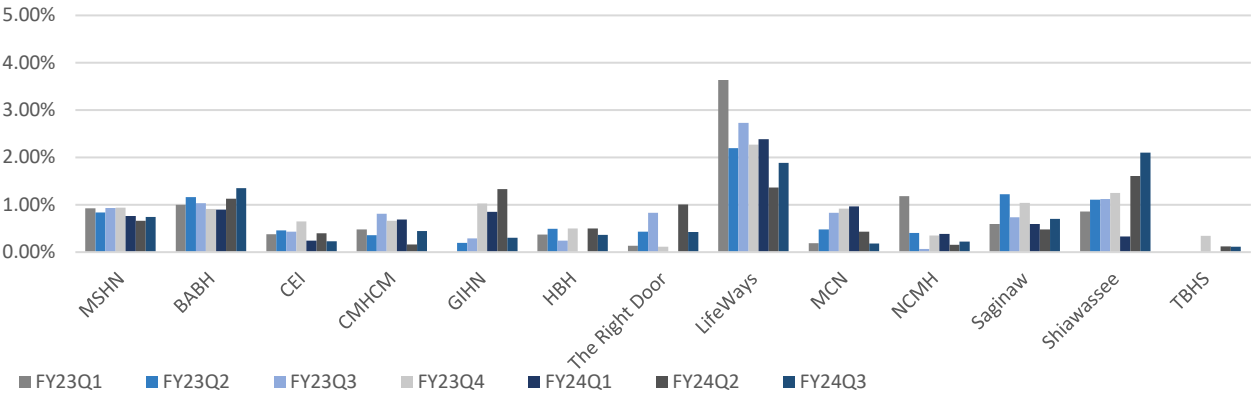


Figure 3a. The percentage of emergency intervention per person served for each CMHSP Participant



Conclusions:

Goal 1: The proportion of individuals with a restrictive and/ or intrusive behavior treatment plan will be monitored quarterly to address causal factors for positive or negative change.
The percent of individuals served who have a behavior plan that include intrusive or restrictive interventions for FY24Q3(1.63%) demonstrated a decrease from FY24Q2 (1.71%). The variance in the data relates to three main categories which are addressed in the recommendations and included in ongoing discussion with regional BTPRC.

Barriers/Causal Factors

1. The number of plans may be attributed to the increased monitoring and oversight from MDHHS and MSHN as it relates to the monthly review of HSW re-certification, HSW initial applications as well (when potential restrictive/intrusive techniques identified); and increased monitoring of the Individual plans of Service, Behavior Treatment Plans and home visits where unreported restrictions are identified, through Provisional Approval Progress(for new settings); and more accurate identification and oversight of restrictions, and regional BTPRC training.
2. The incorporation of the individuals receiving autism services including ABA into the CMHSP BTRC process. MSHN and our CMSHPs have worked to review and ensure that Applied Behavioral Analysis plans written for individuals enrolled in autism services including ABA also meet all requirements if restrictive and/or intrusive methods are recommended.
3. Medications that are prescribed outside of standard dosage or treatment for the individual's diagnosis or condition, must be addressed by the committee quarterly. This does not necessarily require a BTP, but these reviews are likely to lead to the creation of a BTP in order to adequately address the standards.

Goal 2: MSHN will ensure behavioral treatment plans are developed in accordance with the Standards for Behavior Treatment Plan Review Committees. (95% Standard)
There are no updates to the data at this time. MSHN implemented a new process for oversight of the delegated managed care activities. The numerator and denominator will be updated to reflect the change in process for FY25.

Goal 3: The percentage of emergency interventions per person served during the reporting period will demonstrate a decrease from the previous measurement year.
MSHN met the standard for FY24 YTD (Q3). MSHN demonstrated an increase in the number of emergency interventions in FY24Q3 compared to FY24Q2, however, the rate continues to be less than 1%.

Barriers/Causal Factors:

1. Limited availability of care.
2. The reduction in inpatient hospital options for individuals with IDD and Autism.
3. Workforce shortage and staff turnover.
4. Transitions of care-limited staffing and higher level of care placements.
5. Behavior plans not being followed consistently.
6. Instances of physical management in the family home may not get reported even when Medicaid paid supports are present.
7. Work required to ensure standards addressed when long-term restrictions have found to be in place.
8. Out of county placements where different levels of monitoring and oversight occur.
9. The occurrence of overarching restrictive and intrusive techniques with providers who serve individuals with challenging needs.

Recommendations:

- Continue to provide support in collaboration with the Regional Medical Directors and local Behavior Treatment Review Committees as it relates to oversight/monitoring of medications when prescribed outside of standard dosage or treatment for the individual's diagnosis or condition (i.e., for behavioral control).
    1. CMHSPs to share current processes with one another.
    2. MSHN BTR Workgroup Chair/members will consult with Medical Directors as needed.
    3. BTP training will be made available as requested by MSHN staff and/or CMHSP BTP Leads. Through the Statewide BTPRC Workgroup, several BTP trainings sessions are being planned through partnership with MDHHS, CMHA, PIHPs, and CMHSP leads. Planning includes presentations at conferences in FY24/25, including Fall Conference, Winter Conference, Waiver Conference, RR Conference, and Self-D conference.
    4. BTRCs will encourage conversations within Committee Members, including assigned Physician/Psychiatrist.

- Evaluate and monitor the development of the streamlined data collection process for restrictive and intrusive interventions, emergency physical interventions, and 911 calls.
    1. MSHN BTR Workgroup Members will have a clear understanding of definitions and expectations for data collection.
    2. MSHN BTR Workgroup will upload required data within the specified time frame.
    3. MSHN quality manager will work with IT/PCE to coordinate a more streamlined approach to data submission in REMI.

- Continue efforts to create Behavior Treatment monitoring templates and modules into PCE for consistency, compliance, and tracking purposes.
  1. BTR Workgroup members will share documentation and processes for consistent monitoring and tracking purposes.
  2. CMHSPs will identify ways to incorporate standards into their EMR.
  3. CMHSPs will share progress on EMR development of BTP standards.

- Improve overall compliance of BTP reviews resulting in a regional average of 95% standards fully compliant for cases reviewed.
  1. MSHN will continue to review BTP charts through the Delegated Managed Care Review and also through the MDHHS 2024 Site Review.
  2. MSHN will offer individual training to CMHSPs as needed/requested.
  3. MSHN will make regional BTPRC Training recording accessible to providers and stakeholders.

Completed Date: 10/09/2024