Quality Assessment and Performance Improvement Program
FY23 Report and FY24 Plan Executive Summary

Mid-State Health Network (MSHN) as the Prepaid Inpatient Health Plan (PIHP) is responsible for monitoring quality improvement through the Quality Assessment and Performance Improvement Program (QAPIP). The scope of MSHN's QAPIP program is inclusive of all CMHSP Participants, the Substance Use Disorder Providers and their respective provider networks, and the Certified Community Behavioral Health Clinics within the MSHN region. The QAPIP is reviewed annually for effectiveness as required by the Michigan Department of Health and Human Services (MDHHS) PIHP contract and the Balanced Budget Act (BBA). Following the review of the Annual QAPIP Report, recommendations are made for the Annual QAPIP Plan. The Board of Directors receives the Annual QAPIP Report and approves the Annual QAPIP Plan for the following year. The QAPIP is reviewed and approved by the Quality Improvement Council (QIC), Leadership, Operations Council and MSHN's Board of Directors. Once reviewed and approved by the Board of Directors the plan and report will then be submitted to MDHHS by the required due date of February 28. The measurement period for the QAPIP Report is October 1, 2022 through September 30, 2023.

Annual QAPIP Report

The QAPIP Report is the annual effectiveness review of the QAPIP Plan. The report includes a review of the required components of the QAPIP description, the tasks associated with improvement activity (workplan), and each performance measure relevant to the QAPIP is reviewed to determine if the expected outcome has been achieved. Areas that have not met the standard will include a goal and action step for FY23. Areas that have met the standard and are required by MDHHS, will continue to be monitored. Recommendations are developed for areas that may benefit from additional interventions to improve the performance or the quality of a process.

Annual Review of the QAPIP Components: MDHHS reviewed the QAPIP Plan and Report, indicating the QAPIP Plan and Report included all required components of the QAPIP description, evaluation, and work plan(page 18-25). Upon MSHN review at the close of FY23, MSHN demonstrated continued compliance with all the required components of the plan.

Annual Review of Performance Measures: Through an evaluation of the effectiveness, the performance measures were reviewed to determine if the action steps identified in the work plan were effective in producing the desired outcome.
MSHN has recommended goals and action steps (workplan) for those areas that did not meet the standard or require action to enhance or further develop the process to ensure effectiveness for FY24.

Performance Measurement

MDHHS Performance Indicators

Goals:

- MSHN will meet or exceed the MMBPIS standards for Indicators as required by MDHHS.

Status:

- MSHN met or exceeded the standard for 7/7 performance indicators that included standards.

Recommendations:

- Discontinue primary source verification during DMC reviews. Complete primary source during external review and prior to quarterly submission to MDHHS.

- Beginning in FY24 the following standards were applied to Indicator 2, 2e and 3, based on MSHN's performance.
  Indicator 2. a. The percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children. Standard: 62%
  Indicator 2. E. The percentage of new persons during the quarter receiving a face-to-face service for treatment or support within 14 calendar days of a non-emergency request for service for persons with substance use disorder. Standard: 75.3%
  Indicator 3: The percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children). Standard: 72.9%
- MSHN has implemented a performance improvement project to address the performance of Indicator 3.

Goal:

- MSHN will demonstrate an increase in compliance with access standards for the priority populations.

Status:

- MSHN did not meet the performance standard.

Recommendations:

- Monitor performance and review progress (including barriers, improvement efforts, recommendations, and status of recommendations).
- Develop/identify regional improvement strategies used to identify barriers and interventions.

<u>Performance Improvement Projects</u>

Goals:

- The percentage of new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergency biopsychosocial assessment will demonstrate an increase.
- The racial or ethnic disparities between the black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated.

Status:

- Interventions to address the barriers have been identified and are in development. As of FY23Q3 the rates have decreased for both groups. Effectiveness will be determined following the review of CY23 data, which will be available in March of 2024.

Recommendations:

- Collaborate with PIP Team members and relevant committee.
- Utilize quality tools to identify barriers and root causes.
- Implement interventions.
- Evaluate the effectiveness of interventions.
- Submit PIP 1 to HSAG as required for validation as applicable.
- Submit to MDHHS with QAPIP Evaluation.

<u>Adverse Event Monitoring and Reporting</u>

Goal:

- The rate of critical incidents/non-suicide deaths/suicide deaths/sentinel events per 1000 served will demonstrate a decrease from previous year.

- MSHN will ensure Adverse Events (Sentinel/Critical/Risk/Unexpected Deaths) are collected, monitored, reported and followed up on as specified in the PIHP Contract.

Status:

- MSHN met the standard for four out of four performance monitoring measures. Due to the newly developed process for submission and remediation of events, improvement is needed for the timeliness of remediation and submissions.

Recommendations:

- Develop dashboard for tracking and monitoring timeliness.
- Develop training documents, including policies/procedures based on the new requirements and process for reporting.
- Complete the CIRS Performance Reports (including standards, trends, barriers, improvement efforts, recommendations, and status of recommendations to prevent reoccurrence) quarterly.
- Complete CIRS Process Improvement Report.
- Validate / reconcile reported data through the CRM.
- Implement the use of the Root Cause Analysis template with standardized elements.
- Establish electronic process for submission of sentinel events/ immediate notification, remediation documentations, and written analysis for those deaths that occurred within one year of discharge from state operated service.

Behavior Treatment

Goals:

- MSHN will demonstrate an increase in compliance with the Behavioral Treatment Standards for all IPOS reviewed during the reporting period. (Standard-95%)
- The percentage of emergency physical interventions per person served during the reporting period will decrease from the previous year.

Status: MSHN did not meet the standard for the performance measures, however, there was improvement and no statistically significant negative change.

Recommendations:

- MSHN quality manager will work with IT/PCE to coordinate a more streamlined approach to data submission in REMI.
- MSHN will reach out to the State Workgroup about training opportunities (including Direct Care Workers) and work with BTPR Workgroup provide/offer training opportunities for those working in direct care roles.
- CMHSPs will collaborate on the following through the BTPR workgroup: share details of their training platforms, documentation and processes for consistent monitoring and tracking purposes, and EMR development with others.
- MSHN will continue to review BTP charts through the DMC Review and the MDHHS 2024 Site Review.

Stakeholder Feedback

Goals:

- 80% of consumers will indicate satisfaction with SUD services/ children and adult mental health service/ long term supports and services.

Status:

- MSHN met the standard by obtaining an 80% or higher on four out of four performance measures. MSHN in collaboration with the NCI Advisory Council will identify focus areas for FY24.

Recommendations:

- Implement the MHSIP Survey for SUD Services, consistent with other programs and as required by CCBHC.
- Develop proposal for the administration of qualitative and quantitative assessment of member experience, and provider satisfaction for the region.
- Complete member experience annual report with causal factors, interventions, and feedback provided from relevant committees/councils. CMHSPs to document action steps on QIC action plan.
- Establish a QI Team to streamline surveys and processes. Identify sources of feedback to include in the regional assessment of member experiences. Complete performance summaries, reviewing progress (including barriers, improvement efforts, recommendations, and status of recommendations).

Member Appeals and Grievance

Goal:

- The percentage (rate per 100) of Medicaid consumers who are denied overall eligibility were resolved with a written notice letter within 14 calendar days for a standard request of service. (Standard 95%)
- The percentage (rate per 100) of Medicaid appeals which are resolved in compliance with state and federal timeliness standards including the written disposition letter (30 calendar days) of a standard request for appeal. (Standard 95%)
- The percentage (rate per 100) of Medicaid grievances are resolved with a written disposition sent to the consumer within 90 calendar days of the request for a grievance. (Standard 95%)

Status:

- MSHN met the performance standard for three of the three performance measures.

Recommendations:

- Implement a corrective action plan process for FY24 reporting when CMHSPs do not meet the 95% timeliness standard for Appeal and Grievance reporting.

Clinical Practice Guidelines

Goal:

- MSHN will demonstrate full compliance with the use of MDHHS required practice guideline. (PM) Inclusion, Consumerism, Personal Care in Non-Specialized Residential Settings, Family Driven and Youth Guided, Employment Works Policy and Practice Guidelines. (Met)
- MSHN will demonstrate an increase in the implementation of Person-Centered Planning and Documentation in the IPOS. (MDHHS Waiver Review FY22) (Not Met)
- MSHN will demonstrate an increase in fidelity to the Evidenced Based Practice-Assertive Community Treatment Michigan Field Guide, for average minutes per week per consumer. (Not Met)

Status:

- MSHN did not meet the standard for one of three performance measures.

Recommendations:

- Monitor ACT utilization summary of the average minutes for consumer per week.
- Recommend improvement strategies where adverse ACT utilization trends are detected.
- Establish a Person-Centered Planning QI Team to review process steps to identify efficiencies.
- Develop report to monitor, analyze, and improve the amount/scope and duration of services received by individuals enrolled in waivers and those not enrolled in waiver programs/services.

Provider Qualifications/Credentialing/Recredentialing

Goal:

- Licensed providers will demonstrate an increase in compliance with staff qualifications, credentialing and recredentialing requirements. Status: In Progress/Continue

- Non-licensed providers will demonstrate an increase in compliance with staff qualifications, and training requirements.

Status:

- MSHN met the standard for two out of two performance measures for staff qualifications. Staff qualifications are reviewed during the MDHHS Site Review and internally through the Delegated Managed Care Review. Based on the DMC review in FY23, improvement has been made.

Recommendations:

- Will evaluate the MDHHS credentialing report for CMHSP timeliness in decision making and credentialing activities, completing additional monitoring for those CMHSP who demonstrate a compliance rate of =<90% based on the credentialing report.
- Will complete primary source verification and review of the credentialing/recredentialing policy and procedure during the DMC review.
- Will complete primary source verification for professionals that have/require the designation of Qualified Intellectual Disability Professional (QIDP).

Verification of Services -Medicaid Event Verification

Goal:

- MSHN will address and verify whether services reimbursed by Medicaid were furnished to enrollees by affiliates, providers, and subcontractors.

Status:

- MSHN did not meet the performance standard for SUD.

Recommendations:

- Complete Medicaid Event verification reviews in accordance with MSHN policy and procedure.
- Complete The MEV Annual Methodology Report identifying trends, patterns, strengths and opportunities for improvement.

Utilization Management/ Long Term Supports and Services including priority and performance-based measures.

Goals:

- Reduction in number of visits to the emergency room for individuals in care coordination plans between the PIHP and MHP (Target 100%)
- Percent of acute service cases reviewed that met medical necessity criteria as defined by MCG behavioral health guidelines. (Target 100%)
- Percentage of individuals served who are receiving services consistent with the amount, scope, and duration authorized in their person-centered plan. (Standard 100%)
- Service utilization remains consistent or increases over previous year due to improved access to services through the use of telehealth. (Standard 0% decrease over previous FY)
- Consistent regional service benefit is achieved as demonstrated by the percent of outliers to level of care benefit packages (Standard <=5%)
- MSHN will be in full compliance with the Adverse Benefit Determination notice requirements.
- MSHN's Habilitation Supports Waiver slot utilization will demonstrate a consistent minimum or greater performance of 95% HSW slot utilization
- Percent of individuals eligible for autism benefit enrolled within 90 days with a current active IPOS. (Standard 95%)
- MSHN will demonstrate improvement from previous reporting period of the percentage of patients 8-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Diabetes Screening

Report (Data Source-ICDP) Michigan 2020-84.43%

- MSHN will demonstrate an increase from previous measurement period in the percentage of individuals 25 to 64 years of age with schizophrenia or bipolar who were prescribed any antipsychotic medication and who received cardiovascular health screening during the measurement year. Cardiovascular Screening (Data Source-ICDP)
- The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. (Data Source-ICDP) Michigan 2020 54.65%
- Plan All-Cause Readmissions-The number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. (<=15%) (Data Source-ICDP) Michigan 2020 9.09%
- The percentage of members 20 years and older who had an ambulatory or preventative care visit. Adult Access to Care (>=75%) (Data Source – ICDP) Michigan 2020 82.49%
- The percentage of members 12 months-19 years of age who had a visit with a PCP. Children Access to Care (>=75%) (Data Source-ICDP) Michigan 2020 89.64%
- The percentage of discharges for adults (18 years or older) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. FUH Report (Standard-58%) Data Source CC360
- The percentage of discharges for children (6-17 years) who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge. Follow-Up After Hospitalization Mental Illness Children (Standard-70%) Data Source CC360
- Racial/ethnic group disparities will be reduced. (*Disparities will be calculated using the scoring methodology developed by MDHHS to detect statistically significant differences) Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following a psychiatric hospitalization (adults and children)
- Reduce the disparity BSC Measures for FUA. Will obtain/maintain no statistical significance in the rate of racial/ethnic disparities for follow-up care within 30 days following an emergency department visit for alcohol or drug use.

Status:

- MSHN met the standard for twelve of the twenty performance measures. Four were discontinued or did not have information available at the time of this report. The QAPIP was partially effective.

Recommendations:

- MSHN to complete performance summary quarterly reviewing under / over utilization, medical necessity criteria, and the process used to review and approve provision of medical services. Identify CMHSPs/SUDPs requiring improvement and present/provide to relevant committees.
- Continued analysis of differences in amount/ duration of services received by individuals enrolled in waivers and non-waiver individuals.
- Develop and monitor reports and identify any areas where improvement is needed.
- Integrate standard assessment tools into REMI- MichiCANS implementation.
- Review tools for determining medical necessity for community living supports; recommend regional best practice.
- Develop process and identify report to monitor aggregate data on the quality and appropriateness of care for those receiving LTSS.

- Establish process and identify report to monitor aggregate data for assessment of care between care settings.
- Analyze performance reports (including barriers, improvement efforts, recommendations, and status of recommendations) for community integration and assessment of care between settings.
- Include information in the QAPIP description, workplan, evaluation.
- MSHN clinical team will review community integration during regional site reviews, implementing quality improvement when evidence of community integration is not found, and monitor for effectiveness to ensure community integration is occurring.

Provider Monitoring/External Review

Goal:

- MSHN will monitor the provider network including affiliates or subcontractors to which it has delegated managed care functions, including service and support provision, following up to ensure adherence to the required functions.
- Provider surveys demonstrate satisfaction with REMI enhancements - Provider Portal (SUD Network) (Standard >=3.50)
- SUD providers satisfaction demonstrates 80% or above with the effectiveness and efficiency of MSHN's processes and communications (SUD Network) (Standard >= 3.50)
- MSHN will demonstrate an increase in compliance with the External Quality Review-Compliance Review. Comprehensive Score for FY21 and FY22. (Next measurement is FY25).

Status:

- MSHN partially met the performance standards. The MDHHS 1915 review has not occurred yet for standards. The findings and recommendations will be incorporated into the QAPIP Performance Measures and Work Plan for FY24.
- MSHN will demonstrate full compliance with the EQR-Performance Measure Validation Review.

Recommendations:

- Conduct delegated managed care reviews to ensure adequate oversight of delegated functions for CMHSP, and subcontracted functions for the SUDP.
- Coordinate quality improvement plan development, incorporating goals and objectives for specific growth areas based on the site reviews, and submission of evidence for the follow up reviews.
- Implement corrective action plans for areas that were not in full compliance, and quality improvement plans for recommendations. See CAP for specific action steps.
- Verify Medicaid Eligibility and data accuracy through primary source verification.
- Validate data collection process, both administrative and manual.
- Develop / modify ongoing training documents.
- Provide technical assistance to CMHSPs related to standards.
- Develop and monitor systematic remediation for effectiveness through delegated managed care reviews and performance monitoring through data.

Annual QAPIP Plan- Summary of Changes

General Changes: Updated the dates and references to reflect current MDHHS contract requirements and MSHN policy/procedures updates. Minor changes to improve flow of information. Removed areas that were no longer applicable or were redundant.

I. **Overview/Mission Statement:** No changes
II. **Scope of Plan-**Added CCHC and Health Homes
III. **Definitions/Acronyms-** Added CCBHC and Health Homes
IV. **Philosophical Framework**: No changes.
V. **Organizational Structure and Leadership**: No substantive changes
VI. **Performance Management**: No changes
VII. **Stakeholder Experience/Engagement:** Removed the Supports Intensity Scale as it was discontinued.
VIII. **Adverse Events:** Added language to include the QAPIP requirement for reporting deaths within 12 months of a discharge from a State operated service**.**
IX. **Clinical Quality Standards**: Added b) Integrated Care which includes CCBHC and Health Homes. Included required language for Long Term Supports and Services including community integration, assessment of care between transition, and specific services identified as LTSS.
X. **Provider Standards**: Added d) Value Based Purchasing
XI. **QAPIP Priorities FY2024:**
The QAPIP Priorities and Work Plan Updated the work plan based on the QAPIP Evaluation of Effectiveness.