Quality Improvement (QI) Council Meeting Snapshot

Meeting Date: April 24th 2025, 9:00-11:00

Attendance:

- ☒ MSHN – Kara Laferty
- ☒ MSHN – Bo Zwingman-Dole
- ☒ MSHN – Kim Zimmerman
- ☐ BABH –Sarah Holsinger
- ☐ CEI – Elise Magen
- ☒ CEI – Shaina McKinnon
- ☐ CEI – Bradley Allen
- ☒ CEI – Kaylie Feenstra
- ☒ CEI – Michael Gardyko
- ☒ Central – Jenelle Lynch
- ☒ Central – Alysha Burns
- ☒ GIHN – Taylor Hirschman
- ☒ Huron – Levi Zagorski
- ☒ Lifeways – Emily Walz
- ☒ MCN – Sally Culey
- ☒ MCN – Joe Cappon
- ☒ MCN- Melissa MacLaren
- ☒ Newaygo – Andrea Fletcher
- ☒ SCCMH – Holli McGeshick
- ☐ SCCMH – Jenna Brown
- ☒ SHW – Amy Phillips
- ☐ SHW – Becky Caperton
- ☒ TBHS – Josie Grannell
- ☒ The Right Door – Susan Richards
- ☒ The Right Door – Jill Carter
- ☒ Other: Lisa Nagel (BABH)

AGENDA ITEM TOPIC	KEY DECISIONS/QUESTIONS	ACTION REQUIRED (WHO, WHEN)

Review/Approvals (All)	• Review/Approve Meeting Minutes from March
	  ○ Meeting Minutes Approved
	• Any changes/additions to this month's Agenda?
	  ○ No changes or additions from group	

Consent Agenda (All)	• Quality policies and procedures were approved by the Board on 3/5/2025. These have been updated on the MSHN website.	

Performance Improvement Project (PIPs) Analysis – Follow-up from March Meeting (All)	BOX Document Reference: Website analysis link from TBD Solutions can be found here.
	• Discussion
	  ○ Follow-up occurred from the March meeting on the TBD Solutions analysis. There were no additional questions from the group at this time.
	• What improvement opportunities do you see as a result of this analysis within your own agencies?
	  ○ CEI is further investigating their first service (PIP#1/MMBPIS Indicator 3) disparity for first services for children in particular based off of TBD analysis. CEI completed investigation and data testing to review additional variables- CEI did find that changing certain variables resulted in different outcomes, in particular, they have found that children in particular have a higher rate of being reluctant to engage in services right away, and whereas their adult population just may never show up for	

	services, their youth programs have a better rate of engagement of bringing children in later on (when compared to the adult programs). ○ Saginaw is taking the MMBPIS report and TBD Analysis to their governance council and access committee to take a look at and will be identifying additional improvements. **Action Needed:** No action needed at this time.	
MMBPIS Report FY25Q1 (Kara)	**Discussion:** The group reviewed the MMBPIS FY25Q1 report in BOX. For FY25Q1, both indicators 2 and 3 are below our benchmarks for performance. Indicator 2 is at 58.29% (benchmark 62.30%) and indicator 3 is at 61.76% (benchmark 72.9%). **Discussion took place for those that are under the benchmarks for indicator 2 (Huron, Lifeways, Newaygo, Saginaw, and Shiawassee) around whether there were any specific issues they encountered in Q1 that could have impacted their data:** ▪ GIHN shared that they had quite a few staffing issues internally along with scheduling issues for FY25Q1. ▪ Huron shared that they had a new customer service clerical staff (individual responsible for scheduling initial appointments) who needed additional education around MMBPIS and requirements. In addition, staffing illness impacted their numbers as they only have 1 in-person assessor and a .5 virtual individual so scheduling issues or illness impact their numbers greatly. In addition, Huron is finding process/system areas that need to be resolved with the amount of lag time in getting contact information and completing those due to contracting with another CMHSP for Access and they're working on process improvements for this. There are similar issues with Indicator 3 that include education as well as system/process improvements. One area of improvement that has been implemented already is that they are having their clerical staff pulling MMBPIS reporting in their EMR to review real time data to build their skill set and assist in education around the importance of the indicators. Huron also found that a lot of individuals are requesting outside of 14 days, especially during Q1 when there is the complication of holidays. They're having an increase in individuals showing up for assessments but identifying that they don't want to proceed with services as well. ▪ BABH found that the majority of their non-compliance was relating to consumers requesting appointments outside of the 14 days, in particular for children. They are currently reviewing their own appointment availability to determine if they can adapt scheduling to have additional availability for assessments after school. ▪ Newaygo has offered extended hours to accommodate after-hour appointments. They still have individuals requesting appointments outside of 14 days however, so they're completing additional analysis on this. ▪ Saginaw had difficulty with staffing in FY25Q1 and not having appointments available with staff. Saginaw's leadership plans to take a look at their staffing schedule and availability. No concrete interventions yet- however, Saginaw has developed a new dashboard to take a look at the status of appointments to begin tracking this. Saginaw is also having a lot of individuals cancel and no-	

	show (a lot of this is due to the mild/moderate population and their work schedules). Saginaw offers same day/next day access, but no-show rates remain significant. Currently, they have automated text reminders as well as CS staff cold calling individuals to confirm their appointments and individuals are still not showing up. One area of improvement for Saginaw that is being conducted are consumer education sessions around obtaining transportation through the Medicaid Health plans. Guides are being developed by their customer service staff and they are completing these trainings so that consumers have a greater understanding of how to schedule transportation. ▪ The Right Door and Huron are also having staff call the day before and are having consistent high no-show rates for their assessment appointments. ▪ Central shared that they have extended hours and they have developed a Child and Family Coordinator position on the Access team to assist in outreach to children/families who don't follow through on their Same Day Access process. **In looking at compliance, Montcalm stands out as a positive outlier at 95.38% for this metric- what has been implemented as areas of improvement that might account for this that might be able to be replicated within other CMHSPs?** ▪ Montcalm shared that they are open until 8pm, 3 days a week and their Home-Based team has extended hours as well. Extended hours are definitely a big thing for them to offer consumers so that there is availability after school and after work. They initially began with a day or two and this has expanded to three days and offering this. ▪ In addition, when their reception or access clinicians schedule out an assessment, those are being flagged so the clinician knows that those are first service appointments to ensure those are happening within required timeframes. ▪ Montcalm has been staffed in their access and outpatient programs which has also put them in a better spot for consistent service delivery. **Discussion took place for those that are under the benchmarks for indicator 3 (Bay, Huron, Lifeways, Saginaw, and Shiawassee) around whether there were any specific issues they encountered in Q1 that could have impacted their data:** ▪ The group shared that findings for indicator 2 are also impacting indicator 3 (no-shows, cancellations, staffing issues). ▪ The Right Door shared that they're struggling with children who are looking for autism services. These individuals are provided children's case management until their autism testing has been completed but families do not want to engage in those services, they are only looking for autism services. Education hasn't assisted in this and families are declining appointments within 14 days consistently. **In looking at rates of compliance, Central and CEI are at 71% and Tuscola is even higher; are there any areas of improvement that you've implemented that would account for your positive rates of compliance that could be replicated amongst other CMHSPs?**	

	▪ CEI- doesn't know of any specific intervention that would cause their positive rates however, their Access department is very consistent and very good at putting in a lot of time to make sure people are being seen. They are currently still working on implementation of text reminders. ▪ Tuscola shared that case management/outpatient staff are doing their own intakes and establishing connections, so this process is much faster as consumers know who they're working with. Interim plans are completed so they can get into services faster. Having coordinators and supervisors who are aware of the PI measures and knows what the expectations are is incredibly helpful. ▪ The Right Door has been conducting ongoing education around MMBPIS indicators. TRD questioned the group who might have a centralized process for having staff do intakes and first services as they have supervisors who are assigning first service appointments. Huron, GIHN, TBHS, and CEI are mostly centralized along with Shiawassee just implementing this. What areas of opportunity are there that still need to be looked into? • Saginaw looking into PCE cancellation list/module to have someone own this and use this for their appointments to fill in cancelled appointments. o Central is implementing this for health services and then OPT for cancellation list • CEI noted that for indicator 3 in the PIHP performance metrics that Detroit and Oakland are near perfect compliance and would love to know how they are getting those numbers. Kara will be adding this to her next PIHP Quality Workgroup meeting as an agenda topic to determine calculations/logic that other PIHPs are using to try to uncover the differences in numerators/denominators and rates of performance. Action Needed: Kara to finalize FY25Q1 MMBPIS Summary with improvement opportunities as discussed in April's meeting.	
Critical Incident Report FY25Q1	Discussion: Review took place of the MSHN Critical Incident Process Improvement FY25Q1 report in BOX as well as the Proposed Remediation form draft. Under the goal progress for further consideration by QIC, discussion took place on the following areas: • There continues to be interest in establishing an electronic process for submission of sentinel events/immediate notification, remediation documentation, and written analysis for those deaths that occurred within one year of discharge from state operated service, however, this is currently on the low end of priorities. • Discussion around new standardized remediation form- Bo reviewed the document with the group who expressed that they liked this form. There was discussion around updating "Type of Medication" field to "Name of Medication field". The group thinks this standardized form will be extremely helpful and that it will be easier to complete, especially if MSHN is filling out the top section of the form as well. Bo will email this standardized form out when she emails the CMHSP that a remediation is needed.	

	• The group mentioned that they would also prefer a standardized immediate notification form as it will be easier to keep track of for auditing purposes as well as to know what needs to be provided to us for immediate notifications. Bo will begin work on this form once the standardized remediation form has been completed. • Implement Root Cause Analysis template with standardized elements - Taylor H. from GIHN will provide the sub workgroup document that was developed to Kara. At this time, this has been on the backburner due to conflicting priorities, but will remain on the list for development and implementation of EMR forms. Discussion with the group on whether there are specific areas of improvement that you see for critical incidents in FY25: • None of note at this time. • GIHN mentioned that in the last two years they have implemented a critical incident event response review team where they meet and go over critical incidents, sentinel events, and incidents and do a provider analysis form. Provider then responds back as to what they're looking at improving. Looking at internally at what they can do and seeing if there's additional training needs from RR and others. This flow has really helped GIHN's processes. There was a question from CEI as to whether PCE had implemented the fall category for IR's yet – this was implemented by PCE on 10/1/2024 as was indicated in contract language. CEI's Streamline system has not yet been including falls in their sub category options. There was a request that a master list of IR codes could be shared. CMHSPs will be uploading these to the BOX folder for review of CEI and other CMHSPs to verify their own systems and clean those up if needed. Action Needed: Kara to finalize FY25Q1 Critical Incident Summary with improvement opportunities as discussed in April's meeting. CMHSPs to upload their critical incident coding to BOX for review and validation that all critical incident types/subtypes are being captured in their systems.	
Satisfaction Surveys	• Discussion: Satisfaction documents for FY25 can be found in BOX • CMHSPs are in agreement that we should continue with our previous satisfaction survey process (MHSIP and YSS) without change for this fiscal year in light of upcoming changes with the expected MDHHS behavioral quality overhaul of their program. There remains the CCBHC requirement to use the MHSIP and YSS and would like to continue this to make this more efficient for them. Additional discussion took place around the burden of moving to CAHPS and the survey burdens that consumers and staff are feeling. Available methods for this years survey are mailing, calling, in-person surveys, and electronic surveying. • There was a question from BABH relating to how others are capturing LTSS and CCBHC consumers and request for suggestions on how they are distinguishing surveys and having consumers know what to select since these are anonymous:	

	○ The Right Door (listed out ALL services on their surveys for individuals to select rather than the acronym LTSS as people don't know what this includes). ○ Saginaw is doing a data pull and filtering their consumers by service array to then mail out surveys to those populations (they know which surveys are which as they have different headers). ○ Lifeways emails links and does text appointment reminders through PCE (sending out links this way). They mail out postcards stating that the full survey is coming. They also list out all services and ask whether someone is CCBHC (this is based on self-report). ○ Central pulls data based on service array and then emails out links to those individuals to ensure they are sending the correct links. Constant contact then can monitor who opened email and resending can occur if they aren't opened. • Discussion also took place around offering gift cards for completing the surveys as an incentive to combat survey fatigue for consumers. CMHSPs are allowed to provide gift cards that come from CMH credit card points or local dollars for these initiatives. CMHSPs may also decide to utilize GF funds if they are available. ○ To ensure that surveys remain anonymous, a separate form must be included so that a consumer's name is not tied back to the survey if gift cards are being offered. • **Action Needed:** CMHSPs to begin looking at survey documents and bring any questions to May meeting as surveying period will be opened in June.	
MDHHS Updates	• **Behavioral Health Quality Overhaul** MDHHS Behavioral Health Quality Overhaul FAQ Document (Updated 1/23/2025) ○ AMM measure has been removed ○ Metrics are moving to calendar year data instead of fiscal year data ○ MDHHS working on establishing benchmarks where they don't currently exist • **MMBPIS** ○ MDHHS considering continuing with MMBPIS indicator #2 as the access to care measure that is required- this has not been finalized yet. The reasoning for this is lack of guidance being provided by CMS. • **PIP** ○ MDHHS is currently reviewing- they're debating extending the current PIP and measurement periods. They're not looking to add anything new for FY26 at this time.	
Upcoming Reporting Requirements	• **BTC data submission** due 4/30/2025 • **CCBHC Clinic Quality Measures** due to MSHN 4/30/2025 • **HSAG PMV Kick off meeting-** May 7th with MSHN- we will be getting our sample, so please keep an eye out for an email relating to CMHSP follow-up needed.	

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<tr><td>Standing Agenda Item:
Committee Updates (Kara/All)</td><td>

MDHHS QIC Updates: Meeting cancelled. Next meeting in June.
PIHP Quality Workgroup Updates (Kara): No meeting in April, next meeting in May.
BH-TEDs Updates: Holli reported that they met on April 6th- nothing definitive but they are looking at changes to BH-TEDs for FY26. Their workgroup talked MDHHS out of adding another type of record (for employment) and there is potential change for LOCUS reporting coming up and sexual orientation for FY26. They meet again in May. State is currently under a CAP by SAMHSA for having invalid data for BH-TEDs and they're asking for updates back to FY16 from CMHSPs.
National Core Indicator Advisory Council: April meeting cancelled- next meeting in July. Currently there are 275 interviews that have been completed and 76 interviews scheduled (their goal was 660 interviews).

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<tr><td>Standing Agenda Item: DMC Consultation/Regional Interventions (All)</td><td>

No discussion at this time

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<tr><td>Standing Agenda Item: Open Discussion/Consultation (All)</td><td>

No discussion at this time

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<tr><td>Relevant Documents that may be of Interest:
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Priority Measures Report FY25Q1
CMHA advocacy around system improvement and potential procurement

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<tr><td>Previous Action Item Follow-up</td><td>

Date/time of QIC meeting has been finalized- meetings to remain on the fourth Thursday of the month from 9-11am. I've had CMHSPs reach out for ongoing plans to ensure that this doesn't pose an issue. If others need to brainstorm or discuss participation, please let me know.
The Data Validation Project with MDHHS for the FUM30-AD metric has been completed as of 4/15/2025. Overall, there was a 67.4% match with MDHHS logic for numerator and denominator. The below table shows a breakdown in these validation findings:

<table>
<tr><th>Validation Value</th><th>Description</th><th>Count</th><th>Percentage</th></tr>
<tr><td>AG</td><td>PIHP agrees with both denominator and numerator</td><td>1379</td><td>67.4%</td></tr>
<tr><td>D4</td><td>Denominator: Member did not have required utilization for denominator inclusion</td><td>333</td><td>16.3%</td></tr>
<tr><td>D5</td><td>Denominator: Member not known to PIHP</td><td>323</td><td>15.8%</td></tr>
<tr><td>N1</td><td>Numerator: Change result flag to 'yes' based on follow up visits criteria</td><td>3</td><td>0.1%</td></tr>
<tr><td>N2</td><td>Numerator: Change result flag to 'no' based on follow up visits criteria</td><td>8</td><td>0.4%</td></tr>
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Summary Action Items from Meeting

CMHSP's	**Consumer Satisfaction Surveys:** CMHSPs to begin looking at survey documents and bring any questions to the May QIC meeting as surveying period will be open in June. **Critical Incidents:** CMHSPs to upload their critical incident coding to BOX for review and validation that all critical incident types/subtypes are being captured in their systems.
MSHN/Kara	**MMBPIS Report FY25Q1:** Kara to finalize FY25Q1 MMBPIS Summary with improvement opportunities as discussed in April's meeting. **Critical Incident Report FY25Q1:** Kara to finalize FY25Q1 Critical Incident Summary with improvement opportunities as discussed in April's meeting. CMHSPs to upload their critical incident coding to BOX for review and validation that all critical incident types/subtypes are being captured in their systems.