NMRE FY 19 QAPIP Work Plan Summary

October 1, 2018 to September 30, 2019

Performance Improvement Projects

Increasing Diabetic Screenings for Consumers with SMU Prescribed an Antipsychotic Medication

The NMRE continued to monitor the Diabetes PIP projects to assure sustained improvement. MDHHS developed a report in the CC360 system which allowed the CMHs to access their data on a more frequent basis and do analysis as often as they determined necessary to monitor their protocols which was effective. This measure was one of the Incentive Based Performance measures by MDHHS. NMRE. received full payment based on performance. Based on results, the progress obtained in this PIP continues.

Follow-up Care for Children Prescribed ADD Medication

The NMRE submitted the PIP for Follow-up Care for Children Prescribed ADD Medication to HSAG for validation. The NMRE received a full validation score at 100% compliance. The NMRE shared the data for the baseline year with the CMH providers and each provider did a RCA and developed interventions to utilize in order to improve results for the next measurement period. The NMRE will be completing re-measurement #1 in April 2020.

Satisfaction Surveys

During FY19, Northern Michigan Regional Entity (NMRE) conducted a series of 11 surveys intended to measure client/participant satisfaction with Mental Health and Substance Use Disorder (SUD) services. Clients maintained the right to decline to take the survey which was offered via the Survey Monkey website. Clients were given the opportunity to complete the survey at the time of their appointment through a kiosk at the provider, or in certain instances where a kiosk was not available, the client was offered a paper copy of the survey to complete. In FY19, the NMRE purchased 8 IPAD tablets to be distributed among SUD providers to assist with the survey process. This also allowed providers to move away from paper surveys which are costly in terms of postage, time required for manual entry, and environmental impact. It is the goal of the NMRE to phase out paper surveys entirely by 2021. The Quality Department is currently seeking resources to provide additional IPADS to providers to facilitate this transition.

Each survey contained questions pertaining to the quality of services rendered, environment and ease of access, staff knowledge, provider communication, grievances and rights, availability of varied services, cultural competency, additional needs, demographics, peer services, coordination of care, convenience of schedule and location, staff interaction, dignity and respect, and overall helpfulness of services rendered. Clients were given the opportunity to provide their contact information if they would like Customer Services to call them to discuss their experiences or further treatment options. At the end of the survey period, the results were tallied by NMRE Customer Services and the results were provided to the Quality Committee for review. Results were separated by provider as well as grouped to give a

snapshot of regional performance. These results were then shared with providers to indicate areas requiring improvement as well as strengths.

A summary of each survey including description, dates of coverage, number of participants, and highest/lowest rated questions are listed below.

Residential SUD:
Date: February 2019
Participants: 50
The 28-question survey was offered to each NMRE funded participant attending residential SUD treatment at Addiction Treatment Services, Bear River Health, Great Lakes Recovery, Harbor hall, Meridian Health Services, Munson, Sunrise Centre, and Ten Sixteen Recovery during the month of February 2019.
High: 99% of participants felt that staff believed they could change and recover.
Low: 84% of participants stated that they were given information on peer recovery services.

Outpatient SUD:
Date: April 2019
Participants: 289
The 41-question survey was offered to each NMRE funded participant receiving SUD outpatient services at AVCMH, Addiction Treatment Services, BASES, Bear River, Catholic Human Services, Grace Center, Harbor Hall, Munson, NMSAS, and Sunrise Centre during the month of April 2019.
High: 100% of participants felt that staff were helpful and knowledgeable.
Low: 80% of participants stated that they were given information on peer recovery services.

Youth CMS:
Date: May 2019
Participants: 160
The 31-question survey was offered to all participants under the age of 18 receiving case management services at any of the 5 CMHSPs in the NMRE service area during the month of May 2019.
High: 96% of participants felt staff treated them with dignity and respect.
Low: 70% stated that they knew about the grievance process and how to file.

Adult CMS:
Date: May 2019
Participants: 227
The 31-question survey was offered to all participants 18 years of age and older who were receiving case management
High: 94% of participants felt staff treated them with dignity and respect.
Low: 56% of participants stated that their case manager coordinated with their health care provider.

Methadone Services:
Date: June 2019
Participants: 74

The 36-question survey was offered to each NMRE funded recipient of Methadone Assisted Treatment provided by Northern Michigan Substance Abuse Services (NMSAS), Michigan Therapeutic Consultants (MTC), and East Side Outpatient Clinic during the month of June.
All responses above 96%

Medical Services:
Date: June 2019
Participants: 304
The 31-question survey was offered to each participant receiving medical services at any of the 5 CMHSPs in the NMRE service area during the month of June.
High: 92% of participants felt staff treated them with dignity and respect.
Low: 49% of participants stated they were given assistance finding other services they needed (eye doctor, specialist, etc.)

PSR/Clubhouse:
Date: July 2019
Participants: 80
The 28-question survey was offered to everyone attending a clubhouse in Northern Lakes, AuSable Valley, Northeast, and Northern Lakes CMH service areas during the month of July.
High: 91% of participants felt staff treated them with dignity and respect.
Low: 75% of participants stated that staff talked with them about recovery.

ACT:
Date: July 2019
Participants: 65
The 28-question survey was offered to each individual and/or responsible party receiving ACT services in the NMRE Region during the month of July.
High: 90% of participants felt staff treated them with dignity and respect.
Low: 63% of participants stated that their ACT team coordinated with their health care provider

Sub Acute Detox Services:
Date: August 2019
Participants: 30
The 21-question survey was offered to each NMRE funded client receiving Detox services at Addiction Treatment Services, Bear River, and Sunrise Centre during the month of August.
High: 100% of participants believed their interaction with staff was helpful.
Low: 75% of participants stated that staff worked with them on a discharge plan

Outpatient MH:
Date: September 2019
Participants: 367
The 31-question survey was offered to each NMRE funded client receiving outpatient MH services at any of the 5 Community Mental Health Service Providers in Region 2 during the month of September.
High: 94% of participants felt that staff treated them with dignity and respect.

Low: 50% of participants stated that their therapist coordinated with their health care provider.

Recovery Self-Assessment
Date: September 2019
Participants: 357 client, 101 provider support staff, 47 provider managers, 29 family/other
The Recovery Self-Assessment (RSA) is a regional annual survey and report mandated by attachment P4.13.1 of the Medicaid Managed Specialty Supports and Services Program Rules as part of establishing and maintaining a regional recovery-oriented system of care (ROSC).

Tool

The process was modeled after a 2007 survey designed by Yale University and originally utilized by the Connecticut Department of Mental Health and Addiction Services.

1.) The survey contained 32 items that reflect practices identified to be associated with the conceptual domains of recovery. These items were compared to previous years to demonstrate areas of growth and/or areas which require improvement.

2.) Participants rated the degree to which their agencies engaged in the recovery-oriented practices on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree), or N/A.

3.) There were 4 versions of the survey: Provider Management, Provider Staff, Person in Recovery, and Family Member/Significant Other/Advocate.

4.) The survey was offered to each individual client and any family member that attended with the client at the time of their annual Person-Centered Planning meeting. The client/family member were told that they may decline to take the survey. The survey was also provided to program support staff and management during the survey time period.

For the purposes of this report, "consumers" also included scores for the family group. Staff consisted of both providers and management. The following tables indicate the highest rated items for consumers and staff and the lowest rated items for the two groups. Region 2 will address these strengths and weaknesses, seeking strategies to increase recovery across all domains.

Highest Rated Items According to Staff	
STRENGTHS	
	Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.
	Staff welcome people in recovery and help them to feel comfortable here.
	Staff encourage program participants to have hope and high expectations for their recovery.
	Staff believe people in recovery can make their own life choices regarding things they like to do in the community
	Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies).
	Staff believe in people's ability to recover

Highest Rated Items According to Consumers	
STRENGTHS	I feel staff are dedicated to assisting me with fulfilling my goals and aspirations.
	I feel welcome in recovery and I feel comfortable in this program.
	This facility is clean, comfortable, and inviting.
	Staff believe in the ability of the program participants to recover.
	Staff encourage program participants to have hope and high expectations for their recovery.
	Staff encourage program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer).
	Staff does not use threats, bribes, or other forms of pressure to influence my choices

Lowest Rated Item According to Consumers	
GROWTH AREAS	I am encouraged to attend agency advisory/board meetings if I want to.
	Persons in recovery can be involved with staff trainings and education programs at this agency.
	I am encouraged to help staff with the development of new groups, programs, or services.
	Groups, meetings, and other activities are scheduled so as not to conflict with other recovery activities.
	I am given opportunities to discuss my sexual needs and interests when I wish.
	Persons in recovery are involved with staff trainings and education at this agency.
	Staff help program participants to find ways to give back to the community.
	Staff encourage people in recovery to take risks and try new things.
Lowest Rated Item According to Staff	
GROWTH AREAS	Staff offer participants opportunities to discuss their sexual needs and interests when they wish.
	Groups, meetings, and other activities are scheduled so as not to conflict with other recovery activities.
	People in recovery are encouraged to help staff with development of new groups, programs, or services.
	People in recovery are encouraged to attend agency advisory boards and management meetings.
	Persons in recovery are involved with facilitating staff trainings and education at this program.
	Agency staff is diverse in terms of culture, ethnicity, lifestyle, and interests.

The combined survey results demonstrated that Region 2 is committed to providing individualized services in a welcoming environment where clients are treated with dignity and respect. Areas requiring the greatest degree of improvement were coordination of care, client ownership/involvement, peer support services, and knowledge of grievance/appeal procedures. This information was shared with the Recovery Council which is revising the Recovery Oriented System of Care (ROSC) guidelines for the region to address the areas of deficiency and improve the quality and availability of services.

Performance Indicators

NMRE PERFORMANCE INDICATORS FY19

Table 1: Percentage Receiving a Pre-Admission Screening for Psychiatric Inpatient Care for Whom the Disposition was Completed Within Three Hours ≥ 95%

	1Q FY19	2Q FY19	3Q FY19	4Q FY19
Children	100.00%	97.27%	97.71%	96.77%
Adults	99.23%	99.34%	98.52%	97.21%

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 ≥ 95%

	1Q FY19	2Q FY19	3Q FY19	4Q FY19
MI Child	99.39%	98.77%	98.22%	99.51%
MI Adult	99.60%	99.02%	99.13%	99.57%
DD Child	97.87%	100.00%	100.00%	100.00%
DD Adult	96.00%	100.00%	100.00%	100.00%
SA	96.22%	97.18%	97.24%	98.47%
total	98.18%	98.34%	98.26%	99.13%

Table 3: The Percentage of New Persons Starting any Needed On-going Service Within 14 Days of Non-Emergent Assessment With a Professional ≥ 95%

	1Q FY19	2Q FY19	3Q FY19	4Q FY19
MI Child	95.86%	97.16%	93.68%	90.97%
MI Adult	100.00%	98.64%	96.44%	96.57%
DD Child	93.33%	100.00%	93.33%	93.75%
DD Adult	94.74%	100.00%	89.66%	96.15%
SA	95.23%	92.09%	93.62%	95.88%
total	96.80%	95.48%	94.38%	95.36%

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

	1Q FY19	2Q FY19	3Q FY19	4Q FY19
Children	95.74%	91.89%	100.00%	100.00%
Adults	93.38%	98.84%	91.79%	96.92%

Table 4b: The Percentage of Persons Discharged from a Substance Abuse Detox Unit Who were seen for Follow-up Within 7 days ≥ 95%				
	1Q FY19	2Q FY19	3Q FY19	4Q FY19
SA	92.47%	96.47%	100.00%	96.94%

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 FY19	2Q FY19	3Q FY19	4Q FY19
Children	8.33%	11.54%	3.64%	25.71%
Adults	13.21%	11.24%	10.95%	9.94%

Annual Site Review

In the Annual Monitoring for all SUD Providers in the Region for FY19, we had an overall passing score in all sections except for the Residential Specific Standards. These results show an improvement overall in documentation and treatment planning for all Providers that was an area of focus in previous Fiscal Years. Although the NMRE Region did have an overall passing score in most sections of review, there were a couple standards that stood out as needing improvement throughout the Region. These standards were: having measurable goals and objectives (2.6), having the correct frequency of periodic reviews of the treatment plan documented (2.8), Coordination of care with primary care physician (4.1) and having a descriptive discharge summary for the client that has all relevant information (5.1). Some of these standards, 2.6 and 4.1 for example, have been ongoing areas of improvement for the regional SUD Providers. The section that the NMRE Region did not show passing scores in, the Residential standards (6.1 – 6.3), are an area that the NMRE is closely working with Providers to improve on separately as well.

NMRE SUD Site Review Compliance Report Summary

Provider:	Regional Scores	Date of Review:	N/A
		# cases reviewed:	N/A

Compliance Score	Program Score	Possible Score	N/A
Delegated Functions Adminstrative F 92.84%			
2 Information/Customer Service	191	220	16
3 Enrollee Rights	279	308	22
4 Grievance & Appeals	349	396	0
5 Quality & Compliance	42	44	0
6 Individual Treatment & Recovery Planning	253	286	32
7 Coordination of Care/Quality Improvement	80	88	0
8 Provider Staff Credentialing	323	374	12
Total	**1517**	**1716**	**82**
Program Specific Services Review 98.06%			
1 ASAM	65	66	0
2 Residential	67	154	84
3 Case Management	58	66	8
4 Peer Recovery Support Services	6	22	16
5 Women's Speciality Services	16	88	72
6 Medication Assisted Programs	23	132	108
7 Recovery Residences	18	198	180
Total	**253**	**726**	**468**

#	Standard/Elements	AVERAGE
Screening/Admissions/Assessment		
1.1	Screen includes: • Date of initial contact, Signature of Staff Person Collecting Information • Presenting Issue • Priority Population Status • Eligibility Determination	1.801
1.2	Provider obtains the following information: • Medical Information including Primary Care Provider & Date of Last Physical • Mental Health background & present issues • Legal background and present issues • Emergency Contact • Financial Information (Block Grant Only)	1.883
1.3	Evidence of screening for: • Co-occurring disorder(s) • HIV/AIDS, STD/s, TB, Hepatitis • Trauma • FASD referrals, when applicable	1.854
1.4	Evidence consumer has received information regarding: • General nature and objectives of the program • Grievance & Appeal (Medicaid Only) • Notice of Privacy • Consent to Treatment • Advanced Directives • 24/7/365 Access Information	1.836
1.5	Consumer strengths are clearly documented. Examples of strengths: healthy support network, stable employment, stable housing, willingness to participate in treatment, etc.	1.786
1.6	FASD: • FASD prevention efforts are documented in chart (Men & Women with children and/or potential parents) • FASD prescreen is complete • Referral, if applicable	#DIV/0!
1.7	ASAM Level of Care Determination is justified and meets the needs of consumer.	1.760
14	Section Total NA Value	91.04%
Treatment/Recovery Planning		
2.1	The amount, scope, and duration are identified in the authorization and: • Authorized services are medically necessary; • reflected in the plan; • appropriate for consumer's identified goals & objectives:	1.740
2.2	Initial treatment plan is developed before consumer is engaged in extensive therapeutic activities: • Outpatient • Residential • Detoxification	1.962
2.3	Consumer strengths are identified and utilized in treatment planning process	1.724
2.4	Plan(s) address needs/issues identified in assessment(s) (or clear documentation of why issue is not being addresssed) including but not limited to: • Substance Use Disorder(s) • Medical/Physical Wellness • Co-Occurring D/O • Women's Specialty Needs • History/Risk/Present Trauma	1.890
2.5	Treatment & service plan(s) reflect individual's chosen outcomes & preferences: • Goals written in 1st person or • Clearly based on consumer's reported concerns (Severity Rating 4-9 on the ASI/BHI/CHAT) • Limit Use of Clinical Jargon	1.899
2.6	Goals & Objectives are: • Specific - Individualized, Concise, Clear • Measurable • Attainable • Realistic/Relevant • Timely	1.669
2.7	Services/supports/interventions identified in the individualized treatment plan assist the individual in pursuing outcomes consistent with their preferences and goals. (Providers utilize evidence-based/promising practices.)	1.814
2.8	Frequency of periodic reviews of the plan are based on the time frame in treatment and any adjustments to the plan. • Outpatient – minimal 90-day • Residential – 7-day	1.570
2.9	There is evidence of ongoing consumer involvement regarding services: • Plan(s) signed by consumer • Review(s) include consumer feedback and participation • There is evidence consumer was informed of, or did include, any chosen natural/community/professional identified supports in the treatment/recovery process	1.787
18	Section Total NA Value	89.52%

Progress Notes		
3.1	Progress notes reflect information in treatment plan(s).	1.752
3.2	Documentation reflects adjustments made to the plan to address additional needs, goals, or objectives.	1.658
3.3	Documents include all required signature(s), qualifications and dates.	1.975
3.4	There is a progress note completed for all billed services (non-Medicaid funded).	1.847
8	Section Total NA Value	91.68%
Coordination of Care		
4.1	There is evidence of primary care physician coordination of care efforts.	1.511
4.2	There is evidence of coordination of care with external entities including legal system, child welfare system, behavioral healthcare system.	1.959
4.3	There is evidence of effective coordination of care for any consumer enrolled with more than 1 SUD-service provider & coordinating efforts align with best practice guidelines. *Consumer is free to choose own recovery path including MAT.	1.871
4.4	There is evidence that provider makes appropriate referrals and documents follow-up and outcomes, as is applicable to meet the consumer/family needs	1.897
8	Section Total NA Value	89.03%
Discharge/Continuity in Care		
5.1	Discharge Summary includes all Continuum of Care Detail(s) including next provider information, date/time of intake appointment, relevant information etc.	1.635
5.2	Consumer's treatment episode is summarized including: • status at time of d/c • Summary of received services/participation • Discharge rationale is clearly & accurately documented	1.8
4	Total NA Value	86.08%
Residential		
6.1	Client received a medical exam within 6 months prior to admission but not later than 14 days after admission.	1.742
6.2	The client entering residential treatment and residential detoxification must be tested for TB upon admission and TB results are reflected in client file.	1.089
6.3	Chart reflects services provided in accordance with the ASAM LOC Determination.	1.0
6	Section Total NA Value	62.16%
Medication Assisted Treatment		
7.1	Documentation that a medical evaluation, including a medical history and physical examination, has been performed before the patient receives the initial methadone or Suboxone dose. (However, in an emergency situation the initial dose of methadone may be given before the physical examination)	2.0
7.2	Informed consent for pregnant women and all women admitted to methadone or Suboxone assisted treatment that may have become pregnant, stating they would not knowingly put themselves and their fetus in jeopardy by leaving treatment against medical advice.	2.0
7.3	Documented random toxicology testing. Methadone ONLY: consumer screened weekly. Monthly only occurs after 6-months of consecutive negative screens. Any positive results in new 6-month cycle of weekly screens.	2.0

7.4	Copies of the prescription label, pharmacy receipt, pharmacy print out, or a Michigan Automated Prescription System (MAPS) report must be included in the individual's chart or kept in a "prescribed medication log" that must be easily accessible for review.	2.0
7.5	Documentation of Michigan Automated Prescription System (MAPS) is included in the client file at admission, a prior to any off site dosing, and prior to any reauthorization requests.	2.000
7.6	If applicable, for enrolled individuals there must be a copy of the MDHHS registration card for Medical Marijuana issued in the individual's name in the chart. Provider Note: Behavioral Health symptoms, related to the issuance of a medical marijuana card are identified in assessment/progress note, and addressed within the treatment plan.	1.500
7.7	All alcohol use and illicit drug use during treatment is addressed in treatment and documented in Progress Notes	1.8
7.8	**METHADONE ONLY:** Documentation that the client has been continuously physiologically addicted to a narcotic for at least 1 year before admission to a program.	2.0
7.9	**METHADONE ONLY:** Documentation that the physical examination includes medical assessment to confirm the current DSM Diagnosis of Opioid dependency of at least one year as was identified during screening process	2.0
7.10	**METHADONE ONLY:** Documentation that the OTP, as part of the informed consent process, has ensured that individuals are aware of the benefits and hazards of methadone treatment.	1.909
7.11	**METHADONE ONLY:** Documentation that the client is informed of emergency procedures to be followed when there is an adverse reaction, overdose, or withdrawal. (Client is given emergency numbers to contact in case of emergency with medications that occur outside regular business hours).	1.091
7.12	**METHADONE ONLY:** Documentation of a client-signed consent to contact other OTPs within 200 miles to monitor for enrollments in other methadone programs	1.909
7.13	**METHADONE ONLY:** Evidence that daily attendance at the clinic is occurring for methadone dosing, including Sundays and holidays if criteria for take home medication are not met.	2.0
26	Section Total NA Value	93.78%
Women's Designated/Women's Enhanced		
8.1	Designated: There is an assessment of needs completed on consumer & each dependent child.	2.0
8.2	Evidence consumer received supports for birth control/family planning, pregnancy, postpartum and/or parenting issues.	2.0
8.3	There is evidence consumer received required elements of WSS: • Primary / prenatal care • Pediatric care • Case Management • Transportation • Child Care	2.0
8.4	There is evidence of gender-specific service provision as required by State policy.	2.0
8	Section Total NA Value	100.00%

Individual Standard Ratings		Aggregate Standard Ratings		
2	Standard Met	Completely Met	>1.99	100% Compliance
1	Partially Met	Substantially Met	1.7-1.98	85-99% Compliance
0	Standard Not Met	Partially Met	1.4-1.69	75-84% Compliance
NA	Not Applicable	Not Met	<1.39	74% and Below

The NMRE did not conduct on site reviews for the CMH providers for Fiscal Year 19. The NMRE is revising the site review tools and will be doing CMH site reviews in April and May of 2020.

Behavior Treatment

The NMRE struggled to aggregate the behavior treatment data in a systematic way due to the five CMH providers providing data inconsistently with each other. The NMRE developed a template, however, this did not remedied the areas of concern. The NMRE QOC will focus on consistently collecting the data to assist the NMRE in trending the data.

Once the data is being consistently reported then the NMRE will be able to evaluate the trends. The NMRE will also focus attention on plans that are not improving behaviors frequency of changes and revisions in an effort to develop a plan that is effective for those individuals served in reducing harmful behaviors.

The NMRE is working with the CMH providers as well as the EHR vendor to evaluate the possibility of this information being entered into the PCE product and the NMRE receiving a standard report from each provider's EHR.

Critical Incidents, Sentinel Events, Risk Events

NMRE tracked critical incidents on a monthly basis. The total number of critical incidents decreased between FY18 and FY19.

NNRE FY 18 & FY 19 Critical Incident Comparison			
	Fiscal Year 18	Fiscal Year 19	Difference
Suicide	12	1	-11
Non-Suicide	63	64	1
EMT due to Injury or Med Error	56	43	-13
Hospitalization due to Injury or Med Error	4	6	2
Arrest	16	9	-7
Totals	151	123	-28

Each CMH completed a RCA on any Sentinel Event and the NMRE site review team reviewed a summary of any improvements while on site, as well as checks the credentials of the staff involved. If the sentinel event was a death or serious injury a doctor or nurse must participate in the RCA process.