
# Quality Assessment Performance Improvement Program – Year End Report FY 19

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## Introduction

The State of Michigan (MDHHS – Michigan Department of Health and Human Services) requires that each Prepaid Inpatient Health Plan (PIHP) have a Quality Assessment and Performance Improvement Program, commonly referred to as the QAPIP. The QAPIP includes specific standards and requirements that a quality improvement program must meet. These standards are based upon the Balanced Budget Act of 1997, 42 Code of Federal Regulations (CFR) 438.358 of 2002 and other CMS (Center for Medicaid Services) requirements. The QAPIP describes quality management and improvement activities in place at the Oakland Community Health Network (OCHN). QAPIP activity occurs on a continuous cycle. New initiatives that are implemented do not cease at fiscal year-end or at a pre-determined time. With this said, the Board approved QAPIP remains in effect until the Oakland Community Health Network (OCHN) Board approves a new QAPIP. The foundation of the OCHN QAPIP aligns with the following NCQA focus areas: Quality and Safety of Clinical Care, Quality of Service, and Member Experience.

The quality committees supporting each of the NCQA focus areas are as follows:

Quality and Safety of Clinical Care

- Risk Committee/Quality Improvement Council
- Improving Practices Leadership Team
- Integrated Health
- Sentinel Event Review Committee
- Medical Directors Advisory Group
- Utilization Management Committee

Quality of Service

- Credentialing and Privileging
- Quality Improvement Committee

Member Experience

- Community Evaluation and Education Committee
- Citizens Advisory Committee
- Member Experience/Satisfaction Surveys

Our Board receives periodic progress reports on components of the QAPIP during the year. This is accomplished via staff presentations on initiatives and progress reports on projects that are presented to the Board. Through this process, additional opportunities for improvement are identified and implementation plans developed. It is important to note that Oakland implements many quality initiatives throughout the year. Please note that there are additional initiatives that are not described in the QAPIP. Many of these initiatives are addressed in the OCHN Annual Plan. OCHN contracted core providers are required to have a QI Plan which aligns to the OCHN QI Plan objectives.

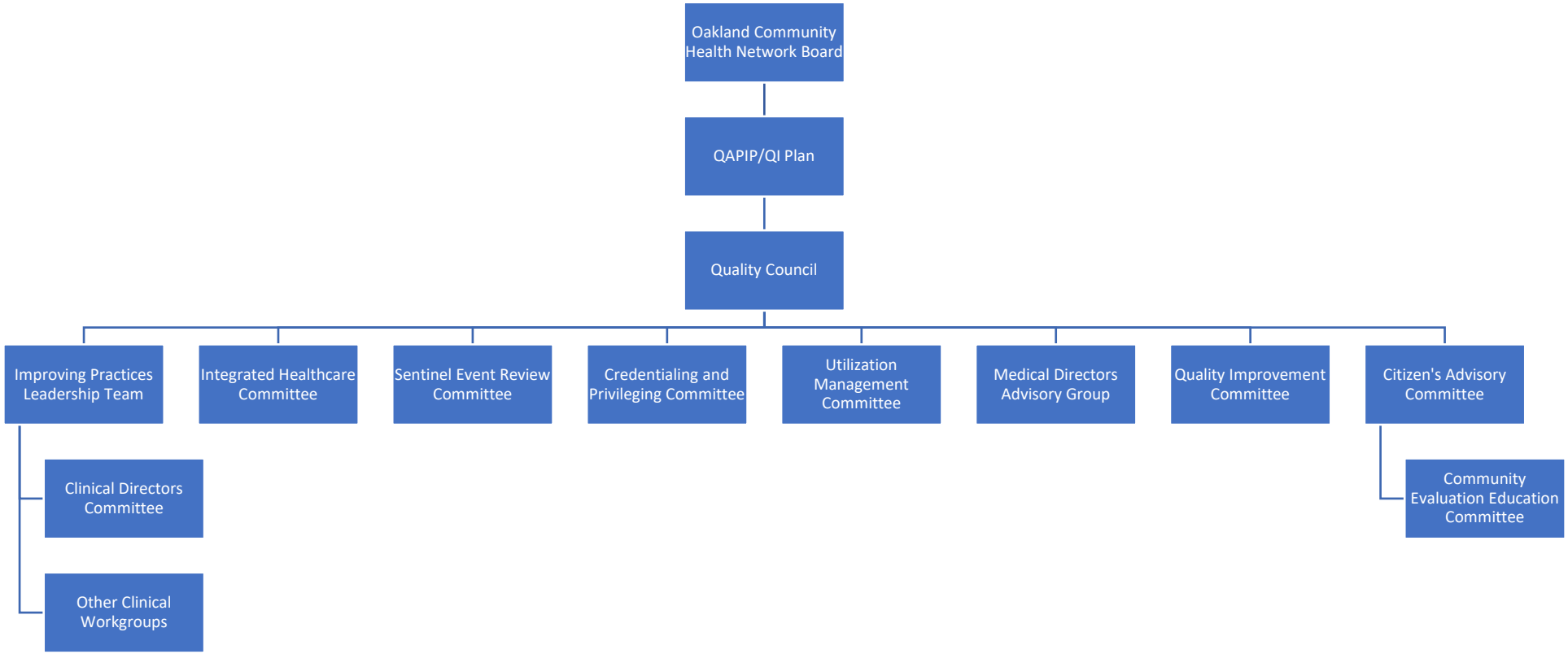
Persons served are involved in the QAPIP and quality improvement processes through participation and membership on Quality Committees. Several quality committees are in place where persons served are chairpersons and comprise most of the membership. The following quality committees meet these criteria:

- Citizens Advisory Committee
- Education and Evaluation Committee
- Strategic Planning Committee

- Recipient Rights Advisory Committee

As the governing body of OCHN, the Center for Medicaid Services (CMS) and the Michigan Department of Health and Human Services (MDHHS) standards require that the Board approve the annual Quality Assessment Performance Improvement Program (QAPIP). The Board must also receive periodic progress reports on the implementation of the QAPIP and review an annual summary on the progress of the QAPIP. Progress reports must describe actions taken, progress in meeting QI objectives, and improvements made.

Oakland Community Health Network Quality Structure



Quality and Safety of Clinical Care

**Committee Name:** Risk Committee / Quality Improvement Council

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| **Purpose of this Committee:** The QI Council Reviews progress on Quality Measures for the organization and advises on strategy changes as needed. The committee monitors environmental changes to identify future measures. The committee monitors performance on the clinical issues (minimum of three) identified by the organization for focused activity. Conducts oversight of all QI Activities. Endorses quality indicators for the QAPIP and ensures QAPIP activity/outcomes is reported to the Board. |

| Goals for FY19 | Status at Year End |
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| Review HEDIS rates and ensure implementation on needed interventions:<br><br>❖ Provide education and performance updates to MDAG<br>❖ Provide education and performance updates to Integrated Healthcare Committee<br>❖ Risk Tracking | The QI Council convened for seven (7) meetings in FY 19. This exceeded our plan for quarterly meetings. More meetings were required to ensure that members were informed of all activity underway in preparation for the NCQA survey. Specific outcome areas discussed, and actions taken are as noted below:<br><br>Provider education and performance updated to Medical Director Advisory Group (MDAG):<br><br>Implementation of process to share treatment data on common persons served with CCBHCs, HONOR (an Oakland County Federally Qualified Health Clinic) and hospitals as permitted by MI Mental Health Code. This activity helps to promote the objectives of the OCHN Integrated Healthcare Committee and MDAG. MDAG committee regularly discusses selected HEDIS measures. Actions and interventions related to these measures are discussed later in this section under the segment on Medication adherence. Meeting minutes reflect discussion and progress on these topics.<br><br>HEDIS Measures: Selected measures for focus for FY 19 were -<br><br>Adherence to Antipsychotic Medication for Persons with Schizophrenia;<br>1. Presence of at least 84 days of continuous treatment with anti-depressant medication (910)<br>2. Presence of at least 180 days of continuous treatment with anti-depressant medication (911).<br><br>Table 1 - Presence of at least 84 days of continuous treatment with anti-depressant medication (910)<br>• Denominator shows that 2,121 persons met this criterion; numerator shows |

that 770 persons met this criteria

Table 2 - Presence of at least 180 days of continuous treatment with anti-depressant medication (911)

- Denominator shows that 2,121 persons met this criterion; numerator shows that 770 persons met this criteria

| Time period | Measurement | Num* | Den* | Rate |
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| FY18 Q4, FY19 Q1, Q2, & Q3 | Baseline | 577 | 1838 | 31% |

These measures were selected as focus areas in early 2019. At that time, OCHN's HEDIS results for antidepressant compliance for at least 84 days was 36% which is below the benchmark of the 2018 HEDIS Aggregate Report for Michigan Medicaid of 58.27%. Based on comparison to the benchmark data noted above there was a noted opportunity for improvement as OCHN results were below the national health plan and Michigan health plan average.

OCHN's HEDIS results for antidepressant compliance for 180 days or greater was 31% which is below the benchmark of the 2018 HEDIS Aggregate Report for Michigan Medicaid of 41.25%. Based on comparison to the benchmark data noted above there was a noted opportunity for improvement as OCHN results are below the national health plan and Michigan health plan average.

Current performance shows improvement but is still below our goal. Adherence to antidepressant medication for individuals with depression increased during fiscal year 2019, as evidenced by HEDIS measure 910 increasing by 7%. HEDIS measure 911 also demonstrated progress by increasing by 4% this current fiscal year. Although the adherence fell below the goal of 10% in each measure, OCHN will continue to work towards this goal in FY20. This information is highlighted in the Medical Directors Advisory Group section of this document.

<u>Barriers to Medication Adherence</u>

According to literature review, medication nonadherence cannot simply be regarded as "difficult" behavior on behalf of the patient; rather, it can result from a range of factors that encompass the illness, medication, plus attributes of the clinician, patient, and caregivers. As a result, improving adherence often requires a range of interventions.

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| | OCHN identified the following barriers that influence non-adherence to antidepressant medication treatment:<br>- Poor communication between provider and individual related to rate of medication adherence<br>- Lack of individual understanding of the proper use of antidepressant medications and the importance of maintaining adherence to treatment<br>- Insufficient knowledge and expertise of medical practitioners with regard to the recognition of signs and symptom of depression, appropriate treatments, and the array of behavioral services available within community mental health<br>- The individual's low health literacy and reason for taking the medication<br>- Patient expectation around length of time for symptom improvement<br><br><u>Interventions and Actions</u><br>OCHN developed an improvement plan that includes interventions targeted at provider and member improvements. The MDAG voted to adopt the interventions identified by the National Council of Medical Directors Institute published on September 2018 under the title "Medication Matters: Causes and Solutions to Medication Nonadherence". Each intervention is designed to address an identified barrier in the treatment related factors.<br><br>- Poor communication between provider and individual served: A key finding on adherence to medications for chronic medical illnesses was the impact of poor communication between patient and provider. Providers tend to overestimate rates of adherence, while patients overreport adherence. Concrete solutions exist to improve that communication.<br>1. Improving Assessment of Non-adherence<br>2. Shared decision-making<br>- The individual's low health literacy and reason for taking the medication<br>- Complexity of medication regimen: Complex medication regimens, including, for example, higher dosing frequency and complicated instructions for drug-taking, can reduce the likelihood of adherence in various disease areas. Simplifying the treatment regimen can improve adherence.<br>- Increasing knowledge and expertise of medical practitioners with regard to the recognition of signs and symptom of depression, appropriate treatments, and the array of behavioral services available within community mental health<br>- Effectiveness of the medication: individuals typically expect immediate relief from symptoms. This highlights that practitioners should ensure that patients are aware of the time course for symptom improvement. |

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| | Additional Interventions and Actions in FY 2019:<br>• **MDAG:** MDAG committee reviewed the HEDIS measures that were identified to improve quality of care. Improving adherence to antidepressant medication management through collaboration with behavioral health and medical practitioners was one of the HEDIS measures selected for improvement.<br>• **MDAG Meeting:** committee adopted the interventions as developed by the National Council of Medical Directors. The committee was presented with data on OCHN's performance network wide.<br>• **Improving the assessment of adherence to medication:** To elicit the extent of nonadherence requires time, with questions being asked in a nonjudgmental manner. For example, the following two simple questions might be used:<br>- "Most people find it hard to stick perfectly to the treatment plan all the time; do you ever have any problems taking all the medications as prescribed?"<br>- "Do you ever try and cope with the illness on your own without taking the medications?"<br><br>If these screening questions reveal nonadherence, it is helpful to try and quantify this, for example, with a question such as: "How many day's medication do you think you may have missed in the last ten days?"<br>• MDAG members will each discuss the importance of a thorough adherence assessment with all their prescribers and nurses and add this into the minutes of their staff meeting. OCHN Medical Director issued OCHN Bulletin 19-15 titled "Polypharmacy Prescribers" which included OCHN and the MDAG's recommendations regarding prescribers improving their assessment of medication non-adherence.<br>• **Employ Shared Decision-Making Strategy:** Shared Decision Making focuses on both the decision about whether to take medication and on which medication to take. It allows patients to be active participants in their care and to articulate the role of medication in their goals for recovery. This process also can address patients' preferences for how to be adherent, as well as any self-identified risks or triggers for non-adherence.<br><br>MDAG members will discuss employing shared decision-making strategies with all their prescribers and nurses and add this into the minutes of their staff meetings. OCHN Medical Director issued Bulletin 19-15 titled "Polypharmacy Prescribers" which included OCHN and the MDAG's recommendations regarding prescribers involving individuals with decision making about their medication as part of person-centered strategy. |

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<td></td>
<td>HEDIS Measure- Presence of a follow-up visit within 7 and 30 days after hospitalization for mental illness.<br><br>Outcomes: The seven (7) day measure is a MDHHS performance metric that is reported to MDHHS quarterly. This is part of the quarterly performance indicator reporting. Historically, OCHN network has consistently met this standard. The thirty (30) day measure is a MDHHS selected shared performance metric with the Medicaid Health Plans. The MDHHS established benchmarks for this metric are: Children – 70% and Adults 58%.<br><br>The current MDHHS metric allows for exceptions persons to be removed from the calculations. Examples of exceptions MDHHS allows are: person cancelled or rescheduled follow up appointment, person's insurance coverage was private pay or Medicaid with another county. Soon, the department will begin disallowing exceptions. This will align MDHHS measures more closely with HEDIS measures. The table below shows OCHN performance for the HEDIS measure for the 7-day and 30 day follow up visit for Adults and Children for the most recent quarter. This data is obtained from OCHNs population health management tool and is based on claims data. There is about a two – month lag time from service delivery to availability of data.<br><br>
<table>
<tr><td></td><td></td><td>Rate</td></tr>
<tr><td>7-day</td><td>Dec. 2019</td><td>65.6%</td></tr>
<tr><td></td><td>Nov. 2019</td><td>60.2%</td></tr>
<tr><td></td><td>Oct. 2019</td><td>65.7%</td></tr>
<tr><td>30-day</td><td>Dec. 2019</td><td>85.8%</td></tr>
<tr><td></td><td>Nov. 2019</td><td>82.2%</td></tr>
<tr><td></td><td>Oct. 2019</td><td>86.6%</td></tr>
</table>
<br>Risk Tracking: Throughout fiscal year 2019 OCHN addressed risk areas and discussed opportunities for improvement. In FY 2020, we will focus on utilizing a system for formal tracking in order to identify trends where systemic change may be helpful. The Quality Improvement Council/Risk Committee will continue to meet at least quarterly to discuss and address these concerns.</td>
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<td>Oversight and evaluation of QI Plans of OCHN Quality Committees.</td>
<td>The OCHN QAPIP will be reviewed at the Quality Improvement Council meeting. Minutes will reflect discussion of barriers to achieving goals and the identification of any additional objectives.</td>
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**Committee Name:** Improving Practices Leadership Team

| **Purpose of this Committee:** To ensure consistent and reliable Best and Evidence Based Practices throughout the entire system of care. |
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| Goals for FY19 | Status at Year End |
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| REVIEW PROTOCOLS IN UM MANUAL | |
| Ensure all protocols reflect the mission, vision and values of the system as well as all current Federal and State guidelines. | The following OCHN Protocols were reviewed/updated in FY19 to ensure that they reflect the mission, vision and values of the OCHN system and meet Federal and State Guidelines:<br><br>❖ Acute Care Discharge Protocol<br>❖ Administrative Denial and Appeal<br>❖ Assessment<br>❖ Audit<br>❖ Autism<br>❖ Care Coordination<br>❖ Clinical Chart Review Protocol<br>❖ Complex Case Management<br>❖ Crisis Prevention & Response Planning<br>❖ Home - Based (age 7-21)<br>❖ Inpatient, CRU, PHP<br>❖ Individual Plan of Service (IPOS)<br>❖ Parent Support Partner (PSP)<br>❖ PASRR (OBRA Assessment) Referral<br>❖ Psychiatric<br>❖ State Facility<br>❖ Telemedicine<br>❖ Temporary Housing Protocol<br>❖ To/From Residential SUD Tx<br>❖ Transition b/w CPA's<br>❖ Transition between disability designations<br>❖ Transition Between Intensity Groups<br>❖ Transition Between Restrictive to Community Placement Adults<br>❖ Transition Between Restrictive to and from Community Placement SED Networks<br>❖ Transition Community Resources<br>❖ Transition from Youth to Adult Services |

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| | ❖ Wraparound Protocol & Audit Tool<br>❖ Youth Peer Support Services<br>❖ Private Duty Nursing<br>❖ Administrative Denial and Appeal Protocol<br><br>All new and/or updated /revised Protocols were published in the OCHN Utilization Management Manual.<br><br>In FY 19, OCHN Clinical Diagnosticians, Service Network Analysts, and/or UM Analysts audited the following protocols:<br><br>❖ IPOS<br>❖ Crisis Planning<br>❖ Acute Care Discharge<br><br>Clinical and Quality Analysts ensured that all audit results were analyzed, reports were developed, and shared with providers via management meetings, Clinical Directors meetings, as well as IPLT. Summary data on audit outcomes for the IPOS and Acute Care Discharge are provided in the Utilization Management section of the QAPIP.<br><br>Practitioner participation in the development of the protocols occur within the IPLT. Workgroups are formed for reviewing and providing input on each protocol. Final drafts of protocols are shared with the network for a 20-business day review prior to implementation and publishing in the UM Manual. |
| Ensure all protocols reflect most up to date clinical best practice. | The protocols listed above were newly developed or updated/revised in FY19 to reflect the most up-to-date clinical best practice. As new protocols were developed, when applicable, clinical references were reflected in the protocols. |
| Ensure all protocols meet NCQA guidelines. | The protocols listed above were newly developed or updated/revised in FY19 to ensure compliance with NCQA guidelines, as well as updated Federal and State regulations (ex., BBA, HCBS) when applicable. The Clinical Team and the SU Team worked closely with an OCHN Quality Analyst to ensure adherence to NCQA requirements. OCHN held NCQA meetings every 2 weeks in which the standards relating to Protocols are included in the discussion. |
| Ensure those who receive services and providers can provide input and feedback. | The protocols listed above that were newly developed or updated/revised in FY19 received feedback from individuals served. Individuals served sit on the IPLT Committee and were invited to participate in workgroups whose task was to develop or update/revise the protocols. Providers were also encouraged to send |

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| | representatives to each work group. Provider staff that attend IPLT were sent all protocols via email and allotted at least 3 weeks for final feedback. Additionally, executive leadership from all providers were sent all protocols via email and allotted 20 additional days to provide feedback. Protocols were also presented to the CAC for feedback. |
| DEVELOP NEW PROTOCOLS AS NEEDED | |
| Infant Mental Health Services protocol will be developed. | In lieu of a protocol, OCHN developed a 0-6 service model and Home-Based Protocol for ages 0-6 that includes expectations related to service delivery. Prior to implementation, this was reviewed with the one provider who contracts to provide this service. OCHN did develop a 0-6 home-based protocol which also documents expectations related to IMH services. |
| Other protocols as needed. | In FY 19, OCHN created Zero Suicide processes which included: clinical pathway for suicide care, the caring letter, and suicide care plan agreement. Training was also provided to OCHN and network staff. |
| EVIDENCE BASED PRACTICES | |
| Continue to develop dashboards or other reporting mechanisms to measure/track outcomes for EBP's. | Clinical Analysts participate in State-wide meetings to ensure appropriate implementation, fidelity and ongoing monitoring of EBPs. Clinical Analysts have worked with MDHHS staff to bring EBP Training to OCHN: Family Psych-Education, LOCUS (Level of Care Utilization System); future plans include: Motivational Interviewing, Trauma Focus Cognitive Behavior Therapy. MIFAST reviews (Michigan Fidelity Assistance Support Team) have provided positive feedback regarding the good work being performed within the network.<br><br>OCHN developed dashboards to monitor EBPs. OCHN developed service models to provide enhanced rate to the Core Provider agencies to provide EBPs promulgated by MDHHS and OCHN.<br><br>OCHN uses dashboards to monitor utilization of the following EBPs:<br><br>❖ Dialectic Behavior Therapy (DBT)<br>❖ Trauma Recovery Model (TREM<br>❖ Men's Trauma Recovery Model (MTREM)<br>❖ Trauma Focused CBT<br>❖ Moral Reconation Therapy (MRT)<br>❖ Stage wise SU Treatment Groups<br>❖ Trauma Focused Cognitive Behavior Therapy (TFCBT)<br>❖ Parent Management Training Oregon (PMTO)<br>❖ Seeking Safety |

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| Utilize dashboards to track use of EBP's in each network. | In FY19, OCHN continued to develop dashboards to measure and track the outcomes for evidence-based practices, which as previously noted, are tied to OCHN service models. These dashboards will track incentives related to outcomes in the following areas:<br><br>❖ Crisis Interventions, including Common Ground OACIS and Intensive Crisis Stabilization Services (ICSS)<br>❖ Education<br>❖ Engagement in Substance Use Disorder (SUD) Recovery<br>❖ Family engagement<br>❖ Provision of Expanded Home-Based Services<br>❖ Psychiatric In-Patient Admissions<br>❖ Updating Crisis Plan after Crisis Contact |
| Work to ensure continued fidelity to EBP's. | Clinical Analysts are assigned the oversight of fidelity to EBP's in a specific network. Fidelity was monitored in a variety of ways, including ensuring supervision requirements were met, MDHHS ongoing certification requirements were met, and where applicable, a review by the MDHHS MI FAST team. |
| PERSON AND FAMILY CENTERED PLANNING | |
| Review MDHHS Policy and DDPIT PCP Brief as best practice guidelines. | The OCHN COO and Clinical Director are members of the DDPIT Committee and attend the meetings. OCHN staff have reviewed the policy brief issued by the State. We have developed a survey to be administered to persons served, peers and providers for OCHN to use in developing a local training. This will be developed in FY 20. Practitioners from the network will be included in the development. Draft curriculum will be shared with IPLT prior to finalizing. |
| Review how independent facilitation and self-determination are currently utilized throughout the system. | OCHN collects Self-Determination (SD) Data from Providers on a quarterly basis. Totals for Self-determination denote that compared to other PIHPs OCHN has the highest percentages of individuals participating in self-determined arrangements compared to other PIHPs.<br><br>As noted above, OCHN is working diligently to increase the number of IFs used by individuals served by our network and is committed to following the DDPIT recommendations regarding SD and IF.<br><br>In FY 19, OCHN initiated a contract with an individual to provide Independent Facilitation (IF). The contractor met with persons served and providers to provide education and material. Prior to the initiation of this contract, OCHN had minimal |

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| | persons using IF. We are pleased to report that our numbers have increase<br>Barriers:<br><br>❖ Individuals not having the opportunity or the understanding of what a Self-determined arrangement is or how to create one<br>❖ Individuals not having a good understanding about and benefits of independent facilitation. |
| DAILY LIVING ASSESSMENT 20 (DLA) | |
| Conduct Ongoing Training for use of the tool. | The DLA 20 is a functional assessment proven to be reliable and valid. It is designed to assess the areas impacted by mental illness or disability (National Council, 2018). The tool provides a quick way to identify where outcomes are needed so clinicians can address functional deficits on individualized service plans. This tool ensures valid scores and consistent utilization for healthcare report cards.<br><br>Ongoing training on the tool was conducted for all core providers.<br>Each CPA also has trained trainers that can offer in house training to staff. In 2019 we offered training to new trainers and offer a "booster" training to all current trainers as well as offering the system wide training quarterly for each network. |
| Continue to implement use of the tool with additional programs. | As noted below, we will continue to utilize the DLA20 for analyzing and improving service delivery. |
| Collect and analyze data. | A dashboard for monitoring the DLA 20 is currently in use. OCHN can review how many DLA 20s were completed and look at trends in the scoring. The dashboard also show trends on the mGAF (modified Global assessment of functioning). |
| ENSURE SYSTEMIC COMPLIANCE WITH TRAUMA INFORMED POLICY | |
| Continue to support the committee and ensure there are representatives of person's served and provider organizations actively participating. | OCHN continues to hold system wide meetings quarterly for the CPA's to offer support and leadership in the development of a trauma informed system of care. Each CPA has provided OCHN with information related to their own self-assessments and an approximate date of when they would like OCHN to schedule their MIFast review. MDHHS has required that an annual assessment be completed OCHN will complete this assessment to determine where training opportunities exist. OCHN will defer scheduling its MIFAST review until the new Executive Director is on board. |
| Implement recommendations based on the results of the organizational self-assessment of trauma informed care. | OCHN will implement the recommendations made as a result of the MIFAST review once completed. |

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| Implement/maintain the provision of trauma specific services for each population using evidence-based practice(s) (EBP); or evidence informed practice(s). | OCHN's providers of youth services have participated in the majority of the TBCFT Training Cohorts and will continue to participate as opportunities are made available by MDHHS. OCHN supports the following EBP's specific to trauma: TFCBT, Seeking Safety, TREM and MTREM. These trauma treatment methods are available throughout our adult network for individuals who have experienced trauma and can benefit from a trauma informed treatment. |

**Committee Name:** Integrated Healthcare Committee

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| **Purpose of this Committee:** Integrated learning collaborative members meet quarterly to discuss the Behavioral Pharmacy Management Report from ProAct, the population health management tool. The data from ProAct drives the meeting. The group has worked on projects related to QI activity and HEDIS measurements inside ProAct. Members report progress on initiatives. |

| Goals for FY19 | Status at Year End |
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| COMPLEX CASE MANAGEMENT | |
| OCHN Nurse Case Managers perform care coordination with Medicaid Health Plans via monthly meetings. | OCHN Nurse Case Managers held 12 monthly meetings with the Medicaid Health Plans to support Primary Care Physician Coordination, as well annual health maintenance exams and labs. |
| Provide education to network on chronic conditions. | September 2019 - Heather Gibson, PhD, from the Department of Oncology at the Karmanos Cancer Institute, presented on Cancer Treatment in the Age of Immunotherapy. Dr. Gibson presented on an overview of cancer, as well as the genetic, biological, and environmental factors that can lead to cancer development. Dr. Gibson also discussed how advancements in immuno-oncology are very effective in treating cancer, in certain individuals.<br><br>March 2019 – The OCHN Nurse Case Managers shared a new web resource, called myStrength, that provides education information on physical and mental conditions, including high blood pressure, diabetes, depression, sleep problems, and stress management. |
| Eighty percent of individuals will rate satisfactory on Complex Case Management survey at end of program. | During fiscal year 2019, 25 individuals were enrolled into the OCHN Complex Case Management Program. The Complex Case Management Program began in 2018, and supports children, youth, and adults who are open with an OCHN Core Provider Agency, have active Medicaid, and have complex health needs.<br><br>20 individuals have completed the program during this year. |

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| Complex Case Management Post Activation survey will show an increase in confidence of 5% from the pre-activation survey. | The CCM Post-Activation Survey demonstrated a 5% increase in confidence from the pre-activation surveys, for those surveys that were completed and returned. Post-survey data from Quarter 3 and Quarter 4 data is not currently available, as individuals are still participating in the program.<br><br>The Post Activation survey is a mailed survey, and the CCM Nurse Case Managers experienced barriers of receiving the returned survey, following program completion. The CCM Nurse Case Managers received 4 returned post-surveys. |
| Participants will note an increase of functionality of one level for the health practices anchor of the DLA-20 Assessment (Question 1 - Health Practices: self-care for physical and mental health, including treatment plan compliance, medication compliance) | Of the individuals that completed the Complex Case Management program, Quarter 1 demonstrated a mean 0.37 increase in health anchor #1, and Quarter 2 demonstrated a mean increase of 0.5 in health anchor #1. |

**Committee Name:** Sentinel Event Review Committee (SERC)

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| **Purpose of this Committee:** To establish a Peer Review process for collecting and reviewing Sentinel Events and other reportable events information. Analysis of the underlying causes lead to an understanding of what system/process changes may be necessary to reduce the risk of future occurrences. This policy also ensures that any recommended changes are implemented and monitored in a timely, thorough and credible way. |

| Goals for FY19 | Status at Year End |
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| SENTINEL EVENTS | |
| Root Cause Analysis (RCA) reports are submitted to OCHN within 30 days of notification for Sentinel and Risk Events. | In FY 19, over 23,000 incidents were reported to OCHN. Of those incidents, the SERC reviewed and analyzed over eight-hundred and thirty (830) critical incidents. Critical Incidents include arrests, deaths, emergency medical treatment due to injuries or medication errors, and hospitalizations due to injuries or medication errors. If a CI is determined to be a Sentinel Event, OCHN requests that a Root Cause Analysis (RCA) be conducted by the Provider. RCAs are completed in ODIN. The SERC reviews and approves the RCAs. The official completion date is noted by the SERC approval date. A report enhancement will be developed to provide ability to track timeliness.<br><br>Eighteen (18) were categorized as Sentinel Events.<br><br>If an RCA is found to be insufficient, the Clinical Analyst will request revisions prior to SERC review of the RCA. Reasons for requests for revisions include improper completion |

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| | of the form, missing staff credentials, unacceptable measures of effectiveness, or lack of necessary information.<br><br>Of the 830 Critical Incidents identified in FY19, 534 were determined to be reportable to MDHHS, based on criteria established by the state that includes the program the individual is assigned to (i.e., Habilitation Supports Waiver, Child Waiver, and Serious Emotional Disturbances Waiver) and the type of incident.<br><br>Dashboards were reviewed to prepare a trend report on actions taken in response to these incidents and identify opportunities for improvement. |
| RISK EVENTS | |
| Use of dashboards to complete analysis of casual factors and identify any systemic actions required. | There were two-hundred twenty-five (225) Risk Events identified in FY19.<br><br>❖ Hospitalization due to Illness or Medical Condition- 98<br>❖ Emergency due to Injury from Self Injurious Behavior- 73<br>❖ Hospitalization due to Injury from Self Injurious Behavior- 18<br>❖ Harm to Others Resulting in Emergency Medical Treatment- 33<br>❖ Harm to Others Resulting in Hospitalization- 3<br><br>In FY18, there were 661 Risk Events, with a decrease of 436 in FY19. The significant decrease in the number of Risk Events is due to the removal of two categories of incidents, which MDHHS no longer defines as Risk Events. *Staff Calls to Police due to Behavioral Crisis* and *Physical Management* incidents are no longer considered Risk Events, and these types of incidents are reviewed in Behavior Treatment Review Committees. With the removal of the category of the *Staff Calls to Police, Hospitalizations due to Illness or Medical Condition* is now the most frequently reported Risk Event category.<br><br>Each Risk Event is analyzed by a staff member at the core provider agency or OCHN Quality Management team member, and a causal factor is identified following the root cause analysis. The most frequently identified causal factor is "Other", which was identified as the causal factor for 108 Risk Events. This category includes incidents where the root cause is often related to ongoing medical conditions, or the cause of the incident clearly does not fall into any of the other categories.<br><br>Other causal factors include:<br>❖ Communication- 36<br>❖ Method/Procedure- 59 |

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| | ❖ Staff Related- 1<br>❖ Environment- 2<br>❖ Equipment- 1<br><br>In FY19, members of the Quality Team at OCHN reviewed Risk Events that occurred at residential sites. Clinical concern calls or emails were made based on RCAs for incidents involving 5 separate individuals. A Performance Improvement Plan was issued to one provider related to the use of restrictive plans of service. |
| BEHAVIOR TREATMENT PLAN REVIEWS | |
| Review quarterly data on Behavior Treatment Plan Review Committee outcomes submitted to ensure BTP restrictions are appropriately used and time limited. | Contracted Providers submitted quarterly data to OCHN on a template that includes the data requirements from the MDHHS Behavior Treatment Plan Review Committee Technical Requirement. To ensure compliance, this data was reviewed at the Quality Improvement Committee (QIC) Meetings and at the Sentinel Event Root Cause Analysis SE/RCA Meetings. The OCHN Chief Operating Officer/Deputy Director and the Medical Director attend both of those meetings. This data is also sent to the Manager of the Recipient Rights Team for review.<br><br>Any issues of concern, such as a plethora of calls to law enforcement by staff, use of physical management three times within a 30-day time period, or absence of evidence of positive interventions being used prior to restrictive interventions being employed identified by these committees were fed back to the provider agencies for resolution and subsequent response to the OCHN Quality Analyst who collects the data. In these types of circumstances, the Quality Analyst coordinates with Recipient Rights as needed, and also coordinates with the Outcomes Improvement Committee (OIC) to see if an individual with a restrictive or intrusive behavior plan is already being followed by the OIC or may need to be followed by the OIC.<br><br>OCHN Providers also submitted QI Plans and QI Plan Annual Status Reports, which assist in facilitating tracking the status of behavior plans. The QI Plan and Status Reports include questions related to the Behavior Treatment Plan Review Committee (BTPRC) process to which Providers responded.<br><br>In FY19, the number of individuals served across the OCHN network via a 1915(c) waiver who had a restrictive/intrusive behavior plan was as follows:<br><br>• Q1- 60 individuals w/ an IDD on the HSW, 2 plans not approved<br>• Q2- 60 individuals w/ an IDD on the HSW, 1 plan not approved<br>• Q3- 61 individuals w/ an IDD on the HSW |

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| | • Q4- 72 individuals w/ an IDD on the HSW, 2 individuals on the CWP<br><br>Many of the individuals with I/DD have restrictions in their behavior plans due to health and safety issues that have caused or have a high likelihood of causing physical harm to the individual or others. For example, locks on the refrigerator doors to prevent a person with Prader Willie Syndrome from continuous eating that is dangerous to their health, mitts on someone's hands to prevent the person from pulling out a G tube, electronic wander guards to prevent elopement from the home, restrictions from water for someone who has polydipsia, locking seatbelts to prevent aggressiveness in a vehicle, etc.). This fact may explain why the number of individuals with I/DD on a restrictive/ intrusive behavior plan does not vary much from quarter to quarter or year to year.<br><br>This BTPRC data was reported to MDHHS on a quarterly basis. In FY20, OCHN will increase BTPRC monitoring functions by: 1) Presenting BTPRC data and trends at the QIC and Sentinel Event Review Committee (SERC) at least twice a year, 2) Requesting BTPRC meeting minutes along with quarterly submissions, and 3) Explore options of standardizing behavior plan assessment and review processes (e.g. through policy revision and consultation with other CMH agencies). |

**Committee Name:** Medical Directors Advisory Group

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| **Purpose of this Committee:** The responsibility of the Medical Directors Advisory Group is to assure that evidenced based standards are met by our provider network. The primary focus of the Medical Directors Advisory Group is to assist with the development and monitoring of evidenced based care, and participation in OCHN Performance Improvement Activities. |

| Goals for FY19 | Status at Year End |
|---|---|
| HEDIS RATES | |
| Review progress on HEDIS rates and implement actions as needed (902 – Increasing adherence to antipsychotic medication for individuals with schizophrenia and 910/911 – increasing adherence to antidepressant medication for individuals with depression). | The HEDIS measure goals and data were reviewed at 6 Medical Director's Advisory Group (MDAG) meetings.<br><br>The OCHN Core Provider Agencies were successful in increasing adherence to medications for HEDIS measures 902, 910, and 911 during fiscal year 2019. OCHN's overall goal for improvement in each measure was an increase in adherence by 10%.<br><br>HEDIS measure 902 demonstrated increased adherence to antipsychotic medication by |

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| | an average 3%, from fiscal year 2018 to fiscal year 2019. Adherence to antidepressant medication for individuals with depression increased during fiscal year 2019, as evidenced by HEDIS measure 910 increasing by 7%. HEDIS measure 911 also demonstrated progress by increasing by 4% this current fiscal year. Although the adherence fell below the goal of 10% in each measure, OCHN will continue to work towards this goal in FY20. |
| Decrease percentage of persons that show as "no data" on the 902 report. | The OCHN Core Provider Agencies were successful in reducing the "No Data" measures from fiscal year 2018 to fiscal year 2019; with an average reduction of 4%. The average no data rate was 61% in fiscal year 2018 and was remeasured with an average 57% in fiscal year 2019. "No Data" means that an individual in the system has been diagnosed at some point in treatment as a person with schizophrenia, but there is no data showing that person has been prescribed an anti-psychotic medication. In these cases, OCHN prescribers are reviewing the person's medical data to confirm appropriate diagnosis. |
| Implement interventions as noted in the QIP for the HEDIS Measures; identify and address barriers. | An intervention discussed at the January 2019 MDAG meeting, is how intravenous injectable medication is an intervention that supports improvement in the 902 measure.<br><br>At the February 2019 MDAG Meeting, OCHN presented that 188 letters were sent to individual's served, encouraging individuals to have their glucose/diabetes annual screening completed. This is directly related to the 904 HEDIS measure, which measures the number of adults who were prescribed an antipsychotic medication and has a diabetes screening during the year.<br><br>At the April 2019 MDAG meeting, a commitment to improve adherence by 10% for all measures, was agreed to. OCHN began sending the 902, 910, and 911 data to OCHN Medical Directors to analyze, and OCHN encouraged the Core Provider Network to review the data on a monthly basis to identify individuals that were flagged. |
| OCHN Medical Director provides recommendation for annual medication regimen review for polypharmacy prescribers. | During the February 2019 MDAG Meeting, the polypharmacy update discussed was that all prescribers of clozapine, as well as pharmacies, are required to be registered. The group discussed how Ketamine nasal spray was approved for the treatment of depression.<br><br>In March 2019, OCHN and OCHN Medical Director, Dr. Leonard Rosen, released a provider network bulletin entitled, *Polypharmacy Prescribers*. The bulletin discussed OCHN's commitment to achieving NCQA accreditation, the importance of the Care Coordination standard, opportunities to improve individuals' medication management, as well as the OCHN's recommendations to the Provider Network, when staff are prescribing psychotropic medications: |

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| | • Interviewing individual regarding adherence during medication reviews<br>• Engage individuals in the decision-making process regarding their medications, as part of the Person-Centered Planning Process<br>• Implement annual review of medication list, for individuals prescribed more than one psychotropic medication<br>• Update Medication Consent Forms to include language on the importance of adherence, as well as discussing potential side effects.<br><br>At the May 2019 MDAG meeting, the group discussed how prescribed medications can be packed in bubble packs by pharmacies to support medication compliance. The OCHN Core Provider Agencies are then monitoring the success of this initiative. |
| Provide ongoing education to medical staff via pharmacy updates | At the January 2019 MDAG meeting, there was a presentation regarding treatment options for opioid addiction. Another pharmacy update included that Neurontin is now a schedule 5 medication. Guidance that Neurontin is helpful to use with individuals with alcohol use, however not with opiate use, was shared.<br><br>At the May 2019 MDAG meeting, MDAG member Steve Cincotta discussed the shortage of first-generation antipsychotic medications, however higher strengths were still available. Also, at the May meeting, the following OCHN policies were approved:<br><br>• Primary health care coordination; MS.21<br>• Medical directors Advisory Group; MS.1.1<br>• Nurse practitioner and physician assistant policy; MS. 4.1<br><br>At the July 2019 MDAG meeting, Dr. Wedes, St. Mary's Medical Director, presented on the newest long-acting injectable medication, called Aristada. Aristada is prescribed to treat schizophrenia.<br><br>At the August 2019 meeting, Dr. Rosen discussed how MDHHS is recommending that Nalaxone be distributed, at no cost. Genoa is willing to participate in this initiative. Dr. Rosen shared how Medicaid covers the cost of Narcan and private insurers, such as Blue Cross of Michigan, offer Narcan with a $70 co-pay. Dr. Fred Washington, Washtenaw Community Mental Health Psychiatric, discussed Abilify Maintena and the benefits of psychiatrist utilizing long-acting injectable medications to treat schizophrenia and bipolar 1 disorder. |

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| Provide outcome reports on progress of Outcomes Improvement Committee. | At the January 2019 MDAG meeting, the group discussed how an article on the Outcomes Improvement Committee would be published in the May 1, 2019 publication of Psychiatric Services. |
| Provide ongoing education on State and National updates that pertain to Medical Services. | At the June 2019 MDAG meeting, Dr. Rosen shared a MDHHS 298 proposal update. This pilot project aims to test the financial integration of Medicaid funded health organizations and specialty mental health services. OCHN presented to the State legislature how Prepaid Inpatient Health Plans could use Care Connect 360 to share information with Medicaid Health plans to support integrated care coordination. Further, Dr. Rosen shared Iowa's experience with the privatization of Community Mental Health services was unfruitful, as the Medicaid Health Plans lacked experience with treating severe mental illness and intellectual/development disability. Similarly, Dr. Rosen shared how privatization in Missouri led to decreased inpatient utilization, however inpatient readmission and the rate of suicide increased.<br><br>At the July 2019 MDAG meeting, Dr. Rosen discussed how the National opiate epidemic is being addressed by the Federal administration and that many U.S. states have sued pharmaceutical companies due to their contribution to the epidemic and misleading prescribers and the public.<br><br>At the August 2019 MDAG meeting, Dr. Rosen presented the controversial issues surrounding the Affordable Care Act. While most Americans approve of the continuation of the Affordable Care Act, per Dr. Rosen, the U.S. Federal Judges are deciding upon its constitutionality. Dr. Rosen also discussed that National prescription costs remain to be an important issue that the U.S. administration is concerned about and are deciding how the American public should be informed of drug costs. Dr. Rosen also discussed the Michigan Department of Health and Human Services (MDHHS) confirmed that Caro Center, one of Michigan's main psychiatric hospitals, will remain open to serve individuals requiring long term inpatient psychiatric hospitalization. Dr. Rosen also shared an MDHHS proposal update, with how the 298 pilots will begin in October 2020 and are planned to be a 3-year-long project. |

**Committee Name:** Utilization Management Committee

**Purpose of this Committee:** Oakland Community Health Network acknowledges the importance of using effective resource management tools, evidence-based practices, and practice-based evidence to meet our mission. OCHN Utilization Management process serve to ensure that clinical authorization decisions are made according to level of need.

<table>
<tr><th>Goals for FY19</th><th>Status at Year End</th></tr>
<tr><td>UM PROTOCOL AUDITS</td><td></td></tr>
<tr><td>Improve performance rates on protocol audits (acute care discharge, IPOS and crisis and response planning)</td><td>The Core Provider Agencies and the OCHN system demonstrated improved performance on the FY19 Individual Plan of Service audit, for the third consecutive year. Overall, the OCHN system improved by 4% from FY18 to FY19.<br><br>
<table>
<tr><th>IPOS Audit Provider Overall Performance</th><th>FY19</th><th>FY18</th><th>FY17</th></tr>
<tr><td>SED Provider Network</td><td>86%</td><td>85%</td><td>80%</td></tr>
<tr><td>MI Provider Network</td><td>79%</td><td>72%</td><td>66%</td></tr>
<tr><td>I/DD Provider Network</td><td>94%</td><td>91%</td><td>89%</td></tr>
<tr><td>Overall OCHN Provider Network</td><td>85%</td><td>81%</td><td>76%</td></tr>
</table>
<br>The overall OCHN system performance fell from FY18, by 5%, for the FY19 Acute Care Discharge audit. In FY19, the I/DD Service Providers increased their performance by 19% from FY18, whereas the SED and MI service provider performance decreased from FY18. At present, several providers are no longer using OCHN's EMR (Electronic Medical Record). When a provider is not using OCHNs EMR, all medical record documents are still required to be available in ODIN. As part of fact-finding to address performance in this area, it was revealed that several provider's documents were not being transmitted to OCHNs EMR. This impacts performance outcomes. Providers were required to submit a corrective action plan to address this issue. Performance rates are expected to improve once corrective actions are implemented.<br><br>
<table>
<tr><th>ACD Audit Provider Overall Performance</th><th>FY19</th><th>FY18</th><th>FY17</th></tr>
<tr><td>SED Provider Network</td><td>75%</td><td>76%</td><td>68%</td></tr>
<tr><td>MI Provider Network</td><td>50%</td><td>59%</td><td>54%</td></tr>
<tr><td>I/DD Provider Network</td><td>78%</td><td>59%</td><td>49%</td></tr>
<tr><td>Overall OCHN Provider Network</td><td>60%</td><td>65%</td><td>58%</td></tr>
</table>
</td></tr>
</table>

The Core Provider Agencies and the OCHN system also improved their performance for the Crisis Response and Planning audit from fiscal year 2018. Overall, the OCHN system improved by 10% from FY18 to FY19.

| Crisis Audit Provider Overall Performance | FY19 | FY18 |
|---|---|---|
| SED Provider Network | 93% | 89% |
| MI Provider Network | 81% | 60% |
| I/DD Provider Network | 89% | 85% |
| **Overall OCHN Provider Network** | **88%** | **78%** |

MONITORING OF SERVICE UTILIZATION RATES

Analyze dashboard data to decrease gap between authorization and utilization by population, provider, level of care and funding via dashboards.

The OCHN Utilization Management's goal is to improve underutilization of authorized services by 50%, beginning at baseline measurement for FY19. The baseline measurements are outlined, below. Remeasurement will occur in FY20.

| Units Authorized vs Units Used - Current IPOS | FY19 Q2 | FY19 Q3 | FY19 Q4 | AVG |
|---|---|---|---|---|
| Home-based Services 0-6 (H0036) | 117.40 % | 94% | 95% | 95% |
| Home-based Services 7+ (H0036) | 90% | 84% | 105% | 97% |

| Units Authorized vs Units Used - Current IPOS | FY19 Q2 | FY19 Q3 | FY19 Q4 | AVG |
|---|---|---|---|---|
| I/DD Adult -Service Array 1 (T1016) | | 60% | 56% | 57% |
| I/DD - Array 1 (T1016) | | 73% | 65% | 69% |
| I/DD - Array 2 (T1016) | | 46% | 30% | 38% |

| Units Authorized vs Units Used - Current IPOS | FY19 Q2 | FY19 Q3 | FY19 Q4 | AVG |
|---|---|---|---|---|
| Outpatient Service Model 4-6 (992XX-E&M) | | | 57% | 57% |
| Outpatient Service Model 7+ (992XX-E&M) | 76% | 96% | 88% | 90% |
| Outpatient Service Model 7+ (T1017 TCM) | | | 48% | 48% |

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| | <table><tr><th>Units Authorized vs Units Used - Current IPOS</th><th>FY19 Q2</th><th>FY19 Q3</th><th>FY19 Q4</th><th>AVG</th></tr><tr><td>SED-W Homebased Services Model 3-6 (H0036)</td><td></td><td>252%</td><td>201%</td><td>220%</td></tr><tr><td>SED-W Homebased Services Model 7+ (H0036)</td><td>156%</td><td>140%</td><td>149%</td><td>147%</td></tr></table><br><table><tr><th>Units Authorized vs Units Used - Current IPOS</th><th>FY19 Q2</th><th>FY19 Q3</th><th>FY19 Q4</th><th>AVG</th></tr><tr><td>ABA Only - Children Focused (T1017 TCM)</td><td></td><td></td><td>81%</td><td>81%</td></tr><tr><td>ABA Only - Children Comprehensive (T1017 TCM)</td><td></td><td>45%</td><td>56%</td><td>51%</td></tr></table><br><table><tr><th>Units Authorized vs Units Used - Current IPOS</th><th>FY19 Q2</th><th>FY19 Q3</th><th>FY19 Q4</th><th>AVG</th></tr><tr><td>AMH (LOC 3) Intensive Care Management (T1017 TCM)</td><td></td><td>55%</td><td>65%</td><td>60%</td></tr><tr><td>AMH (LOC 4) ACT (T1017 TCM)</td><td>43%</td><td>42%</td><td>60%</td><td>52%</td></tr><tr><td>AMH (LOC 5) Specialized Residential (T1017 TCM)</td><td>75%</td><td>67%</td><td>65%</td><td>67%</td></tr></table> |
| Issue quarterly performance reports to the network. | Individual provider audit reports for the Acute Care Discharge Protocol, Individual Plan of Service Protocol, and the Crisis Response and Planning protocol were returned to each provider, following the fiscal year 2019 audit period. System network reports for the three audits were provided to the OCHN Utilization Management Team and the OCHN Internal Utilization Management Committee and are scheduled to be presented at the November 2019 network Quality Improvement Committee and the January 2020 network Improving Practices Leadership Team meeting. |

## Member Experience

**Committee Name:** Community Evaluation and Education Committee (CEEC)

| Purpose of this Committee: The mission of the CEEC is to improve the experience of services for all individuals. The CEEC is a person served operated, focused group organized to evaluate and analyze data relevant to OCHN programs and services, advice on current and/or planned programs, and to evaluate the use of assessment instruments and tools with the goal to make tools more consumer friendly. |
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| Goals for FY19 | Status at Year End |
|---|---|
| OBTAINING INPUT FROM PERSONS SERVED | |
| Review and revise committee policy to adjust to changes in responsibility. | The committee brainstormed what the committee wanted to focus on for the FY 19 Work Plan on 10/3/2018. The committee members were passionate about continuing to recruit new members.<br><br>CEEC Policy was reviewed by the committee on 6/5/19. The word Consumer has been removed from the policy and changed to person served language. In addition, the committee changed some language to state "OCHN Provider Network" as it was unclear and inconsistent in many areas.<br><br>The Committee began to review the By-Laws on 8/7/2019. The Committee identified the following changes:<br>• CMH to change to OCHN<br>• Consumer Advisory Committee changes to Citizens Advisory Committee<br>• Committee votes that elections shall be held every 2 years and now it is reflected in the By-laws. |
| Track committee input on OCHN policies, strategic plan and performance indicator and satisfaction reports through implementation. | On 2/6/19 the OCHN staff presented the policy on Self Determination to the committee. Committee members admitted they had not had time to review the policy (which they added was quite lengthy) and did not understand self-determination to be able to effectively review the policy and provide feedback. It was suggested that we invite a guest later to educate the committee on Self-Determination before the policy is reviewed again. The educational component was re-scheduled for 11/6/2019. This review and discussion was completed by OCHN Service Network Staff.<br><br>Annual Plan was reviewed by the committee on August 7, 2018 by Monika Sanders, LMSW, Provider Network Analyst. Originally, Kathleen Kovach, COO, was going to present on this but had to cancel due to a scheduling conflict. Monika reviewed the plan from last year and showed what goals were being addressed/worked on in the different domain areas. A form was passed out to the committee with any/all feedback relating to the plan and was asked to return to Kathleen Kovach within a week. |

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| | Contracting with an Independent Facilitator through Recovery Concepts is new this fiscal year. Deborah Monroe, the Independent Facilitator, came to the committee meeting on 4/3/2019 to present on her services and how Independent Facilitation can support the person-centered planning process. The committee was extremely positive about this service and flyers were disturbed to members to pass along to their peers who are interested in Independent Facilitation and to educate others.<br><br>Since OCHN has been actively working towards NCQA accreditation, a new Provider Directory was launched 12/1/2018. The directory was presented members on the committee on 4/3/2019. The committee was educated on how to use the searchable directory and how it benefits current people served as well as community members and other stakeholders. |
| Recruit new committee members in newsletters, at Clubhouse meetings/events, and via Peer Ally, specifically individuals to represent adults diagnosed with developmental disabilities and substance use disorders. | Staff from the Communications Team attended our CEEC meeting on 12/5/2018 to get input from the committee on the type of flyer they wanted to create to attract new members. The committee expressed the following:<br>• Two-part incentive. Education on the community mental health services, as well as a $25 incentive to add to their monthly budget to be a part of this committee.<br>• Community inclusion, understanding the mission and vision and value of OCHN, changing the system and seeing behind the scenes of the changes being made to persons being served.<br>• Committee receives information and education, as well as give feedback and a voice to certain issues (i.e. policies).<br>• Collaborating with departments within OCHN and give opinions to topics being discussed on agenda/being presented.<br>• Need multiple avenues to get the information out (I.e. social media, printed flyers on bulletins, on OCHN website, etc.)<br><br>Communications staff returned to the 2/6/2019 meeting with a draft flyer. Additional feedback was provided by the committee<br>• Add the time/commitment that potential new members need to know<br>• Give out flyers within provider/case management meetings here at OCHN to let homes/communities know about the inclusion<br>• Members are in agreeance that a hint of red needs to be on a flyer, just like the green, in order to get more potential members' attention |

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| | The CEEC had gained 1 new member who was voted in on 6/5/2019.<br><br>3 other members have attended due to recruitment initiatives and will be voted on during the FY19-20 meetings. |
| Review OCHN Performance Indicator Reports. | OCHN Quality Analyst, reviewed Performance indicators on 10/3/2019. Staff provided handouts to aid in visually understanding trends, from a person serve perspective. Staff discussed how the PI's impact the people serve and why it is important. The handouts breaks down measurements/outcomes and evaluations by quarter, for children with SED, adults with MI, adults with DD and children with DD etc. The network met or exceeded the standards for the 3rd quarter in FY 19 in all of the PI's except indicator 1 (timeliness of inpatient screening) |
| Review and provide feedback on OCHN QAPIP – Quality Assessment Performance Improvement Plan. | QAPIP was Reviewed on 10/3/2018 by Marquitta Massey, Director of Quality Management, with the committee. She explained QI plan, that it is state required and required by CMS and it is developed annually. Marquitta reviewed the PowerPoint that was shared with the board the week prior and explained that the board does get periodic progress reports. Reviewed the highlights from FY 18, activity does not start/stop at year-end (on-going process). Areas addressed in QAPIP include CAC, CEEC, Improving Practice Leadership, IHCC, Sentinel Events, QIC. |
| Review and provide feedback on OCHN Satisfaction outcomes. | The results from the ECHO Survey were reviewed by OCHN Quality Analyst on 4/3/2019. The trends and changes from the last two fiscal years were reviewed. The committee was passionate about discussing the wait times when an individual is in crisis at Common Ground. They felt the MDHHS standards of 180 minutes was far too long and not healthy for someone going through a hard time.<br>MCET did not provide any satisfaction surveys this fiscal year to be reviewed by the committee. |

**Committee Name:** Citizens Advisory Committee (CAC)

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| **Purpose of this Committee:** To provide advice and recommendations to the OCHN Board and to the OCHN Executive Director based on information shared/provided by OCHN. |

| Goals for FY19 | Status at Year End |
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| OBTAINING INPUT FROM PERSONS SERVED | |
| Provide education on advocacy opportunities. | • October 2018-Involved in Campaign for #LessLabelsMore Respect. Flyers were shared with members of the CAC group and provided feedback on the posters.<br>• February 2019- CAC members were educated on the Zero Suicide Efforts |

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| | presented by Clinical Team Members, Christine Mary and Lauren Jozlin. Christine and Lauren discussed OCHN's Zero Suicide Philosophy.<br>• February 2019-Members of the CAC committee were shown the new Provider/Practitioner Directories on the OCHN Website. Committee provided some feedback on how to improve the directories (i.e. make the search fit into a single page, a note regarding calling Customer Service for further help, etc.)<br>• March 2019-B.E.S.T. Presentation Malkia Newman and Glenda Vidosh. A video was shown titled "We're Just Like You". The anti-stigma team is excited about opportunities to reduce stigma within the system of core providers and community. This video is on the OCHN website and will be presented to clubhouses, drop-in centers, group homes, and the provider network.<br>• April 2019- Christine Burk came to talk to members of CAC regarding "Walk a Mile Rally" scheduled on May 9th, 2019. The event is important to remind legislators the importance of the mental health system.<br>• May 2019- Presentation completed by Deb Monroe educating the committee on Independent Facilitation. They were educated on the goal of Independent facilitation in that the person aids in the PCP process alongside the person receiving supports. All individuals are eligible for this service. Independent Facilitators provide support for individuals and ensuring the person is heard and understood. They also provide information and resources.<br>• June 2019- Monika Sanders, Provider Network Analyst, educated the CAC members on the CEEC committee and that the committee is in search of new members.<br>• June 2019-The CAC was educated on the Annual Plan and how the committee can provide feedback.<br>• August 2019- member Sharon Valente, educated the CAC that there was an Independent Living Training hosted by AAOM on September 19. The training will address maintaining best health, community integration, safety in the home and community, disability specific tools and resources and disability rights and independence. |
| Provide ongoing progress reports on implementation status of Federal Regulation – Home and Community Based Services Rule. | • September 2019 - The current information materials about HCBS rules, developed by Developmental Disabilities Institute at Wayne State University, were distributed to the group and discussed. |
| Committee members participate in community outreach. | • October 2018<br>Easterseals held "Voter Bingo" and it was a success<br>Our House Clubhouse reported One staff and one member attended the |

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| | National Clubhouse conference October 14-17. It was reported that 13 members participated in the NAMI walk the previous month.<br>Dreams Unlimited reported sending 2 members and 2 staff to the Clubhouse Conference and had many staff attend the NAMI walk as well.<br>• March 2019<br>Easterseals Family held Parent Advisory Committee and Teen Advisory Committee meetings.<br>Oakland Family Services-The teen advisory and parent advisory committee met and did "kindness rocks" which are rocks that were painted and then hid for people to find.<br>• April 2019<br>CNS Healthcare reports hosting its second annual Men's Health Fair June 14 from 10am-3pm. The purpose is to increase awareness for preventable and treatable health concerns<br>• May 2019<br>Members discussed their participation in the Walk A Mile Rally in Lansing<br>OFS- held a luau for families that they work with.<br>• July 2019<br>Veterans event held on July 12th at the VFW Hall in Southfield<br>Minority Mental Health Event held July 16 at OCHN |

**Committee Name:** Member Experience/Satisfaction Surveys

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| **Purpose of this Committee:** To assess the satisfaction of services in a variety of domains to improve satisfaction of persons served and quality of care. |

| Goals for FY19 | Status at Year End |
|---|---|
| ACCESS DEGREE OF SATISIFACTION OF INDIVIDUAL SERVED | |
| Analyze outcomes and work with providers to improve outcomes. | **ECHO-** Experience of Care and Health Outcomes Survey<br>3rd fiscal year of data collected for the Experience of Health and Care Outcomes (ECHO) survey. Results of the 2019 ECHO survey were collected and reported in October 2019. 1200 surveys were mailed. MCET received 742 responses (575 adults, 167 children) in 2019 and compiled the data for analysis. Related questions were grouped together to provide results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures. The measures are as follows:<br>• Getting Treatment Quickly<br>• How Well Clinicians Communicate |

- Getting Treatment and Information
- Overall Rating of Treatment

The following are areas of analysis and possible provider outcomes:

- Significant trend in the survey item 'were you told about self-help groups, such as consumer-run groups or 12-step programs'. Protocol amendment will be made to address this negative trend.
- A significant positive trend appeared in the question that asks respondents to rank their overall services from 0 to 10, where 10 is the best.
- Responding to the question "In the last 12 months, how many times did you go to the ER or crisis center to get counseling or treatment for yourself", the average responses increased by 15% in 2019. Through 2019, hospital recidivism worsened as a network. Performance improvement plans were issued to providers failing to adhere to the 15% compliance standard. Interventions that were implemented by providers included implement Zero Suicide protocols, training of supports coordinators at supervisor meetings, and reviewing hospital discharge protocols.
- The percentage of individuals responding that they were informed about medication side effects dropped by 3.50% in 2019. QM will plan to attend a medical director advisory committee meeting to address this issue with clinical staff. QM will discuss the informed consent letter and discuss if this ECHO item addresses it, or if this item represents a lack of understanding of medication side effects by individuals.
- More information about patient rights was given in 2019.
- In 2019, individuals rated that they were helped more by their services, and their overall mental health was better.

Each provider was shared personal measure data to be incorporated into their annual workplan and to address areas of concern.

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Completed bi-annually to align with OCHN's annual and strategic plans. There are several questions on the survey that capture helpful data on how OCHN is doing in areas outlined in the annual and strategic plans. These areas include:

- Trauma

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| | • Care Coordination<br>• Population Health Management<br>• Person-Centered and Family-Centered Planning<br>• Culturally Competent Services<br>• Substance Use Prevention and Treatment<br><br>Comparing the current data to 6 months ago, it is more mixed, with more questions trending positively than negatively. Comparing FY19 fall to FY19 spring, 40 questions either remained the same or improved, while 35 questions worsened.<br>Areas that the current administration data improved over the previous (spring) administration:<br>• Sexual orientation support and staff dealing with sexual orientation issues.<br>• Stress management.<br>• Overall positive outlook.<br>• Wellness programs like nutrition and relaxation classes.<br><br>Areas that the current Fall data decreased when compared with the data from the spring administration:<br>• Having personal identity and being seen than more than a 'case'.<br>• Staff believing, they have a positive future.<br>• Avoiding relapse and managing symptoms.<br>• Control over their life -Staff assisting and not controlling individuals.<br>• Staff assisting with rent, subsidies, and basic income.<br><br>Access Experience Survey-<br>In the fiscal year 2018, 2019, there were 693 individuals who received services from the OCHN Access Department and agreed to be surveyed. Of those 693 individuals, 608 were determined to be eligible for services. The results described below include responses from people who received services only in fiscal year 2018/2019.<br>Findings related to the respondents' perceptions of the initial engagement and process of the Access System reveled that almost all respondents agreed that person they spoke with was "easy to talk to" (99%) and "a good listener" (99%). |

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| | • Less than one fifth (14%) of the respondents were placed on hold. Of the individuals placed on hold, 96% said they were only on hold for one to five minutes.<br>• Almost all the respondents (99%) who were found eligible for services reported that they did have adequate opportunity to express their situation and circumstances before a decision was made by Access Staff.<br>• An overwhelming majority of respondents (95%) who were found not eligible for services reported that they did have adequate opportunity to express their situation and circumstances before a decision was made by Access staff.<br>• A strong majority of the respondents who were determined not eligible agreed that the "Determination was fair" (88%), while slightly more "Understood the reason for the determination" (89%).<br>• Most respondents (83%) reported they were provided a summary of their Recipient Rights. Approximately four-fifths of respondents (81%) were very pleased with their experience with Access. |
| Implement actions to improve performance (i.e. recovery enhancing environment survey, trauma training, person centered planning, experience of care and health outcomes survey (ECHO), access satisfaction survey). | REE analysis and findings were sent to clinical and SUD teams for feedback.<br><br>Provider Quality Improvement Plans address all areas of improvement in response to REE and ECHO results, as addressed in the QIC workplan for FY 19.<br><br>ECHO survey results presented at CEEC. Feedback from persons served was shared on possible causes for increased hospitalization rates. One comment stated that persons served sometimes view hospitals as an outlet to 'escape their group home', or as a 'vacation spot'. OCHN will continue to assess residential sites for compliance with HCBS (Home and Community Based Services) requirements, ensuring that persons are provided with options for choice and expressing satisfaction. HCBS standards require that individuals have regular and ongoing access to the community and locations where persons are living are not institutional in nature.<br>Meetings with customer service to address contact/timeliness issues will be scheduled and interventions will be implemented.<br><br>Actions taken in FY 2019 - Protocol audit tool update: language includes "discharge planning activities include the exploration of the individuals/families support, family support and community support such as but not limited to 12-step programs, local medical educational programs." This was done to address the negatively trending ECHO question "Were you told about self-help or support groups, such as consumer- |

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| | run groups or 12-step programs".<br><br>Continue to provide Trauma trainings and comply with the MDHHS Trauma Policy requirements per the contract. |
| LANGUAGES SPOKEN | |
| Ensure that persons served have access to providers who can communicate with them in their primary language by analyzing data on languages spoken by network staff. (Data Source – OCHN Provider Directory – 2019) | |

| Language Spoken | Service Provider | Total |
|---|---|---|
| ALBANIAN | Macomb-Oakland Regional Center, Inc. | 1 |
| | **ALBANIAN** | 1 |
| ARABIC | Arab-American & Chaldean Council, Inc | 1 |
| | Catholic Charities of Southeast Michigan | 1 |
| | Common Ground, Inc. | 1 |
| | **ARABIC** | **3** |
| ARAMAIC | Arab-American & Chaldean Council, Inc | 1 |
| | **ARAMAIC** | **1** |
| DUTCH | Common Ground, Inc. | 1 |
| | **DUTCH** | **1** |
| FRENCH | Common Ground, Inc. | 1 |
| | **FRENCH** | **1** |
| GERMAN | Common Ground, Inc. | 1 |
| | Easter Seals Michigan, Inc. | 1 |
| | Macomb-Oakland Regional Center, Inc. | 1 |
| | **GERMAN** | **3** |
| HEBREW | Oakland Family Services | 1 |
| | **HEBREW** | **1** |
| HINDI | Training and Treatment Innovations, | 1 |
| | **HINDI** | **1** |
| ITALIAN | Oakland Family Services | 1 |
| | **ITALIAN** | **1** |
| JAPANESE | OFS - (SUD) Walled Lake | 1 |
| | **JAPANESE** | **1** |
| KOREAN | Therapeutics, LLC | 1 |
| | **KOREAN** | **1** |
| Other | Arab-American & Chaldean Council, Inc | 1 |
| | **Other** | **1** |
| POLISH | Turning Point - State Street | 1 |
| | **POLISH** | **1** |
| RUSSIAN | Common Ground, Inc. | 1 |
| | **RUSSIAN** | **1** |
| SPANISH OR CASTILIAN | ASD Latinos Unlimited LLC | 1 |
| | Common Ground, Inc. | 4 |
| | Easter Seals Michigan, Inc. | 5 |
| | Macomb-Oakland Regional Center, Inc. | 1 |
| | Oakland Family Services | 1 |
| | **SPANISH OR CASTILIAN** | **12** |
| URDU | Training and Treatment Innovations, | 1 |
| | Training and Treatment Innovations, | 1 |
| | **URDU** | **2** |
| **GRAND TOTAL** | | **32** |

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| | OCHN also has 4 agencies that provide interpreter services. These include the Telelanguage Line, Bromberg & Associates, Speak Easy, and DeafCAN. As noted, the data source for languages spoken by staff in the OCHN Provider Directory. The Provider Directory lists the availability of languages spoken within the network. This is a useful tool for persons served to identify providers where his/her communication needs can best be accommodated. The OCHN EMR does not currently capture languages spoken in a discrete field. This is an opportunity for improvement that will be explored to enhance this area. |
| Obtain baseline data on staff speaking Spanish and Arabic. | In Q1 of FY2020, the OCHN network has 12 unique staff members throughout the network being listed as speaking Spanish, 2 of which are physicians, 1 doctoral licensed psychologist, and 1 nurse practitioner.<br>The OCHN network also has 3 unique staff members throughout the network that speak Arabic, 2 of which are physicians, and 1 that is a physician's assistant. |

Quality of Service

**Committee Name:** Credentialing and Privileging Committee

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| **Purpose of this Committee:** Oversight of credentialing process for OCHN Clinical Staff; provide consultation and TA on credentialing concerns that arise within the network; perform oversight of delegated credentialing/privileging functions via review of reports from network. |

| Goals for FY19 | Status at Year End |
|---|---|
| CREDENTIALING | |
| Conduct quarterly credentialing meetings with network practitioners. | To improve internal practices and work towards implementing NCQA standards, OCHN has developed a Quarterly Credentialing Meeting effective 11/29/2018. This committee is composed of OCHN HR Director, QM Director, Manager and Provider Network Analyst, OCHN Clinical Director, OCHN Medical Director, OCHN Director of SUD Network, and various quality members or HR directors from Core Provider Agencies (Inc. TTI, OFS, CLS). The committee reviews and approved presented files from the network that have been completed and reviewed to meet all credentialing requirements at the local provider level. These files are considered "clean files" as the files meet all criteria and are ready for OCHN Committee approval. The list of clinicians presented for credentialing is listed by Organization, License type, Date of Credentialing (local and OCHN) and Credentials granted. OCHN Medical Director, reviews and approves the presented files. In addition to the role of final credentialing decisions, the committee has also reviews the Credentialing Policy, Credentialing Application, Reviewed Provider Directory Requirements, Terminated Practitioner Requirements, discussed the outcomes of the Core Provider HR Directors Meeting, and reviews ongoing credentialing reports (license status, complaints, adverse events). |
| Conduct credentialing reviews of network staff. | The credentialing reviews were conducted to ensure compliance with NCQA standards. Outcomes from the accreditation review required corrective action. Plans for improvement were submitted in November 2019. Additional credentialing reviews were completed for vocational and ABA providers in the first and second quarter of FY 19. |
| Review and approve credentialing reports of clean files submitted by delegated providers. | Clean files were presented for approval at OCHN Credentialing Committee meeting throughout the FY. In FY 2019, the committee met five times. Files were presented and approved as credentialed at the meetings. Over 200 files were reviewed/approved during the FY. This activity ensures that all practitioners published in the OCHN directory are credentialed. |
| Review delegated providers credentialing policies. Present findings to credentialing committee. | The OCHN Quality Management Team designated staff reviewed the Provider Credentialing policies in October of 2019. OCHN Quality Management Team will be |

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| | working with the Core Provider Agencies regarding their policies (along with the PIPs submitted 11/1/2019) to ensure their Policies align with OCHNs Policies and Procedures which encompasses NCQA requirements. |
| Ensure Provider Directory is user friendly and obtains current data. | The OCHN searchable Provider Directory was launched 12/1/2018. There are two directories; 1) Provider Agency 2) Practitioners in the Network. The Provider directory allows the user to search by Provider, by Service or by Service Site. The results to the search show the user the Name of the Provider, PIHP, Address, Phone, ADA Accessible, Accepting New People, Accreditation (if applicable), Website (if applicable) and services provided. The Directory includes the Customer Services phone number for reference if the user has difficulty navigating the directory. There is also a PDF download available for those who prefer a hardcopy of the directory. This is obtained from Customer Services. The practitioner search allows the user to search by Provider, Gender, Language Spoken, Specialty, License Type or City. The results will show the information listed above, along with Certifications, Status of Accepting New People, Disciple/Provider Type (i.e., MI, IDD, SUD, etc.), and that staff are trained in cultural competency. When searching for a physician, there is information on how the user can verify the physicians board certification. Upon introduction of the Directory, OCHN Provider Network Analyst, attended various internal committees at OCHN (CEEC, CAC, Recipient Rights Advisory Committee) to demonstrate the directory and obtain feedback relating to usability. In FY 20, it is scheduled for the Provider Network Analyst, to attend these committees again to have the committee members complete a survey relating to usability testing. The formal survey will assist with capturing data on the usability of the survey (e.g., legible, easy to read, easy to understand, ease of navigation, etc.) to help OCHN best meet the needs of the people we serve who are utilizing the directory. |

**Committee Name:** Quality Improvement Committee

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| **Purpose of this Committee:** Quality Improvement staff of the provider network participate on this committee formed to identify and initiate performance improvement opportunities for the network. Monitor of network wide performance improvement projects is completed and progress is reported to OCHN. |

| Goals for FY19 | Status at Year End |
|---|---|
| INTEGRATED CARE | |
| Access performance and identify opportunities for improvement on HEDIS Measures (910, 911, and 904). | **Measure #910**- Antidepressant Medication Management: Initial Phase – Presence of at least 84 days of continuous treatment with an antidepressant medication. |

| Time Period | Numerator | Denominator | Rate | Goal | Comparison to Goal |
|---|---|---|---|---|---|
| QTR 1 FY19 | 181 | 510 | 35% | 49% | Below |
| QTR 2 FY19 | 168 | 469 | 36% | 49% | Below |
| QTR 3 FY19 | 173 | 412 | 42% | 49% | Below |
| QTR 4 FY19 | Pending | Pending | Pending | Pending | Pending |

Measure #911- Continuation and Maintenance Phase: Presence of at least 180 days of continuous treatment with an antidepressant medication.

| Time Period | Numerator | Denominator | Rate | Goal | Comparison to Goal |
|---|---|---|---|---|---|
| QTR 1 FY19 | 119 | 510 | 23% | 35% | Below |
| QTR 2 FY19 | 110 | 469 | 23% | 35% | Below |
| QTR 3 FY19 | 112 | 412 | 27% | 35% | Below |
| QTR 4 FY19 | Pending | Pending | Pending | Pending | Pending |

Measure #904- Presence of a diabetes screening test during the measurement year for a patient diagnosed with schizophrenia or bipolar disorder who was dispensed an antipsychotic medication.

| Time Period | Numerator | Denominator | Rate | Goal | Comparison to Goal |
|---|---|---|---|---|---|
| QTR 1 FY19 | 1580 | 2133 | 74% | 80% | Below |
| QTR 2 FY19 | 1762 | 2373 | 74% | 80% | Below |
| QTR 3 FY19 | 1988 | 2824 | 70% | 80% | Below |
| QTR 4 FY19 | Pending | Pending | Pending | Pending | Pending |

All rates reported are showing progress towards meeting goals. These goals and activities will continue into FY 2020.

| PERFORMANCE INDICATORS | |
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| Percentage of persons receiving an initial assessment within 14 calendar days of first request. | The graph below displays performance data for the most recent five quarters. Quarter 4 performance data will be submitted to the State in January 2019. There was decline in |

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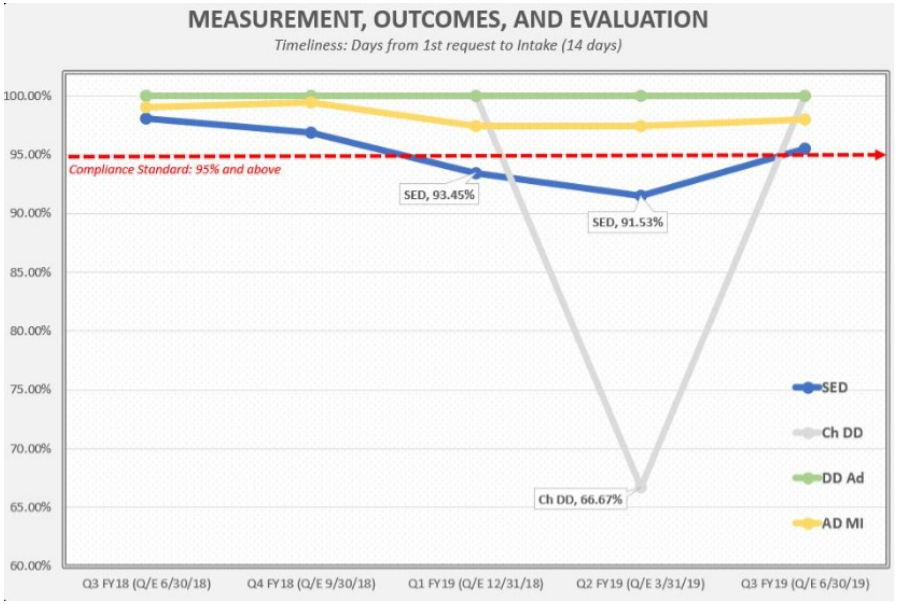
| |  <br>performance for Q2 for Children with DD. The denominator indicating total number of persons is small for this population. For this quarter 3 number of children were included measure, 2 of which were compliant. In this instance, the provider was still required to complete a performance improvement plan to address performance. This particular performance improvement plan addressed having back-up staff to receive phone calls that might otherwise go unanswered, as well as reviewing process with administrative assistants and intake departments to assure all calls are answered or returned the same day they were received. As the population is small, if one person does not meet the standard compliance rate will fall below standards. |
| Percentage of persons who started face to face service within 14 days of assessment. | Data for Quarter 4 will be analyzed in early FY20, however, results for Q1 – Q3 demonstrate full compliance with this indicator. The graph below displays performance data for the most recent five quarters. Quarter 4 performance data will be submitted to the State in January 2020. |

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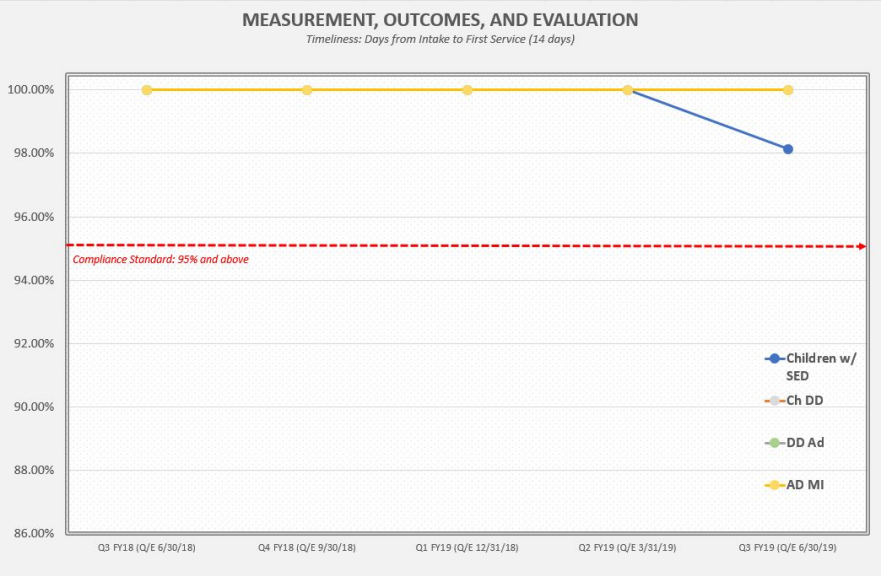
| |  |
| COMPLIANCE PLANS | |
| Develop and implement corrective action plans for areas found to be out of compliance (acute care discharge, IPOS, Medicaid Services Verification, credentialing, customer services, audit outcomes for contracted providers (licensed and unlicensed), residential, vocational) | The Acute Care Discharge Protocol is intended to articulate discharge planning "best practice" for the Network Providers. The Network Providers are charged with the responsibility of facilitating successful transition of individuals served from acute care settings (e.g., community hospital, Partial Hospital Program (PHP), and crisis residential units) into community services and supports.<br><br>To properly assess the service provided, the OCHN UM team completes 60 audits per provider per year. If a provider does not have 60 records to review, then all available records are audited. The average overall audit score was 59.57%. This was a decrease of 5.12% from FY18. Please see the UM section of the QAPIP for more information on this indicator.<br><br>The Individual Plan of Service (IPOS), provides individual/family supports, services and treatment goals that assists individuals/families in working towards attaining appropriate recovery and positive outcomes. The individual plan of service provides the input from the Person-Centered Planning Process. The Individual Plan of Service Audit is comprised of 5 sections: |

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| | ❖ Preliminary Plan<br>❖ Pre-Planning meeting<br>❖ Individual Plan of Service<br>❖ Periodic Review<br>❖ Addendum<br><br>This IPOS audit for providers was conducted by the UM staff for IPOS's completed during the 1st quarter of FY 18. The audit was conducted using a random sample of 60 records for each provider. If there were less than 60 records, 100% of the records were reviewed. The average overall audit score was 85.04%. From fiscal year 2017 to fiscal year 2019, there was a 9.09% increase in overall provider network performance. From the previous fiscal year alone, there was a 4.01% increase in overall network performance. During fiscal year 2019, two providers met the 95% overall performance compliance standard. Lastly, for the third consecutive fiscal year, all providers demonstrated improvement in overall quality performance in following the OCHN IPOS Protocol.<br><br>MSV (Medicaid Services Verification) reviews were completed in September – October of 2019 for services directly provided by CPA staff. The scope of the review included 30 randomly selected services that were provided in Q1-Q2. Of the 7 providers tested, 3 received Performance Improvement Plans, with scores ranging from 80% to 96.7%. 4 Providers received a score of 100% in the review. Areas determined to be deficient included the following:<br><br>1. 7 services did not include credentials for the person providing the service.<br>2. 1 service was incorrectly coded.<br><br>Payments made by OCHN for services determined to be deficient were recouped from the provider and noted in the year-end Financial Status Reports.<br><br>Pilot MSV reviews were also completed for 18 of the Residential providers, with claims reviewed from 39 provider sites. The pilot study was very beneficial for OCHN and the service providers. 40 claims were reviewed from the 39 sites. The overall score of the audits is 87.1%. The following observations were made:<br><br>• A significant number of progress notes were found to be lacking in narrative strength and/or not clearly aligned with IPOS goals.<br>• Notes did not consistently have a clear start/stop time and dates and |

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| | times were often not clearly marked.<br>• Some notes were not clear and legible.<br><br>There were no Performance Improvement Plans issued for this initial pilot review. A review of all providers will occur in FY20. Payments made by OCHN for services determined to be deficient were recouped from the provider and noted in the year-end Financial Status Reports. Credentialing reviews were also included as part of this pilot review. It was discovered that Background checks were not consistently completed a minimum of once every two years. ICHAT was suggested as a source for ongoing checks and is free to use for non-profit providers.<br><br>The QM team conducted "mock" credentialing reviews in preparation for the NCQA Credentialing Review. Please refer to the Credentialing Committee Work Plan Status report for more information on the work that was completed in FY19 related to OCHN Credentialing reviews.<br><br>10 records of individuals who contacted OCHN Customer Service were reviewed from each core provider and Common Ground. The overall score of the audits was 93%. This is an improvement of 4% from FY18. The most frequently cited issue was lack of documentation in the EHR to record the interaction with the OCHN Customer Service Department.<br><br>258 Health & Safety Reviews of subcontracted providers were conducted, with an average score of 98.6% compliance. 115 Corrective Action Plans were issued for providers that were not in full compliance. OCHN and CPA reviewers followed up on all CAP's and documented the actions taken and timeframe for completion. |
| Implement and oversee the HCBS corrective action plan process. | In FY19, OCHN has made significant progress towards compliance with the Home and Community Based Services (HCBS) final rule. Michigan Department of Health and Human Services (MDHHS) has determined that the Habilitation Supports Waiver (HSW) and b/i-waiver would be assessed and require remediation to come into compliance with HCBS. Since data on settings serving individuals on the HSW was collected a year prior to the B3 data, each waiver is at different points in the remediation process. With the exception of Heightened Scrutiny (HS) work, HSW compliance work has been completed. The federal compliance deadline for the completion of all HCBS work is March 17, 2022.<br><br>Regarding HCBS compliance with the Habilitation Supports Waiver (HSW), OCHN has required Corrective Action Plans (CAPs) based on MDHHS guidelines for a total of 250 |

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| | individuals in residential settings and 503 individuals in non-residential settings. As of the end of FY19, OCHN has completed 100% of compliance work for HSW providers, including written corrective action plans and follow up site visits to verify compliance.<br><br>Based on b/i-waiver remediation work, service providers of 668 individuals require CAPs, and as of the beginning of FY20, 483/668 (72%) of CAPs have received written approval, and OCHN is verifying compliance within 90 days on written CAP approval via audit. Based on data reported to MDHHS in October, 3% of b/i-waiver work is completed. Other HCBS efforts that are underway include: 1) MDHHS is partnering with MSU in the winter of 2020 to complete HS site visits for HSW providers. OCHN will be assisting providers in this effort, and 2) MDHHS has released an HSW and b/i-waiver list of providers released from HS. OCHN will be responsible for verifying compliance via the CAP process. |

## Analysis and Evaluation

### Evaluation and Overall Effectiveness

An evaluation of OCHN's QI program has been conducted. This evaluation included review of trended results for QI measures over time, comparison against performance objectives, quantitative and qualitative analyses for completed and ongoing QI activities. Overall, improvements were achieved in planned QI initiatives, both clinical and service. In addition, programs that address patient safety were implemented.

The Quality Improvement Committee (QIC) and the OCHN Board reviewed and approved the 2019 QI Program Description. The 2019 QI Work Plan was implemented in accordance with the plan. The indicators measured cover a broad spectrum, including quality of clinical care, quality of service and safe clinical practices. The QI initiatives are relevant to the needs of the residents of Oakland County and in alignment with OCHN's mission and vision. OCHN's organizational structure and resources are adequate and supportive of the QI process.

### Adequacy of QI Program Resources

As part of OCHN's QI Program development, resource evaluation is ongoing throughout the year. In2019, staffing resources were adequate for implementation of the OCHN QI Program. Staff included OCHN Medical Director, Quality Director, Clinical Director, Quality Manager, and Utilization Management and Review Manager and the clinical and analytic staff reporting to them. Additional OCHN staff performing QI functions include: Network Analysts, Integrated HealthCare Nurses and Delegation oversight staff embedded in departments such as Customer Service and Recipient Rights.

OCHN has sufficient resources to meet the QI Program objectives, carry out the scope of activities to be conducted and complete annual and ongoing activities. Staffing and resources supporting the QI Program include but are not limited to:

- Customer Service
- Delegation Oversight staff embedded in various departments
- Quality Improvement Program staff
- Information Technology and Reporting staff (Systems and Reporting and Analytics and Information Management)
- I- Dashboards and other systems/platforms as needed such as CC360 & Proact
- Utilization Management and Review Staff
- Case Management Nursing Staff
- Network Management Staff (e.g., provider services and provider contracting, and relations)
- Value Based Service Models for the following services: Assertive Community Treatment, Specialized Residential Services, Children with Serious Emotional Disturbances, Targeted Case Management and Individuals with Developmental Disabilities.

### QI Committee Structure

I. The OCHN Board of Directors

The OCHN Board of Directors is the governing body for the Agency. As the governing body, the Board of Directors bears overall responsibility for assuring that OCHN persons served receive high quality care and service. The OCHN Board has twelve (12) members. Board membership is open to Oakland County residents and members are appointed by Oakland County Board of Commissioners. All prospective applicants are required to apply and submit application and if successful end with an appointment to the Board of Directors for a period of three (3) years. Appointment can be renewed and several of OCHN's Board members have served multiple terms. The OCHN Board of Directors is representative of persons served as one- third of its members are required to be persons receiving services or family

members of persons receiving services. Of this one-third, one- half of these members are required to be persons receiving services in accordance with the Michigan Mental Health Code – Section 330.1222.

Responsibilities The Board of Directors has ultimate responsibility for policy setting and operation of OCHN, including but not limited to the following:

1. The Board of Directors annually reviews the specific goals and objectives of OCHN, including a description of the services provided. This includes, but is not limited to, the Quality Assessment Performance and Improvement Plan, Year End Evaluation, and periodic review of quality improvement progress reports.
2. The Board of Directors is responsible for assuring the appropriate organizational structure of OCHN and establishing appropriate councils that report to the Board.
3. The Board of Directors establishes and maintains a clearly defined system of financial management that includes an annual, independent audit of financial/operational performance, as well as internal audit procedures.
4. The Board of Directors is responsible for approval and oversight of OCHN's Strategic Plan, consistent with the mission, vision, and values of OCHN.
5. The Board of Directors ensures that the strategic plan adopts a systematic continuous quality improvement program to assure clinical and administrative quality.

As the governing body, the Board of Directors, with recommendations from appropriate clinical personnel, act on all major contracts and other arrangements affecting the delivery of health care services. The Board of Directors actively supports the Quality Improvement Program as demonstrated by ongoing involvement in the policy making process of the organization.

II. Quality Improvement Council

The OCHN Quality Improvement Council is responsible for providing oversight and direction to the QI Program. The QIC is chaired by the Medical Director. The QIC also reviews and approves the QI Work Plan and the annual QI Program Evaluation.

In early 2018, the Quality Improvement Council and the OCHN Risk Committee were merged. Going forward, this committee will be referred to as the QIC in the remainder of this document. As membership and objectives of both committees were similar, this helped to improve organizational efficiencies. The OCHN QIC is accountable to the OCHN Board of Directors. The OCHN QIC identifies opportunities for improvement, prioritizes actions to be taken, and initiates action and monitors progress. The QIC ensures that periodic progress reports on the implementation of the QAPIP and an annual summary on the progress of the QAPIP is provided to the public, the Board of Directors and other stakeholders. Persons served, network providers and staff participate in the quality program via quality improvement committees, satisfaction surveys, and performance improvement plans.

Council Structure, Role and Function The OCHN QIC is composed of eight (8) voting members including the Service Delivery Leadership Team as well as the Manager of Customer Services. The Medical Director chairs the QIC as the lead behavioral health practitioner. The Deputy Director/Chief Operating Officer serves as co-chair of this committee. The QIC serves as the OCHN QI oversight body and has responsibilities for the day to day management of the QI Program. The QIC is responsible for achievement of high-quality delivery of care and directs quality improvement initiatives associated with clinical care and service utilization. Additional aspects of quality improvement overseen by the QIC include credentialing, contracting, and network development.

Quality Improvement Council Membership

OCHN Medical Director - Chairperson
Deputy Director/Chief Operating Officer - Co-Chair
Director of Quality and Provider Network Management - Member
Clinical Director - Member
Director of Substance Use Disorders Prevention and Treatment Services - Member
Director of Service Network - Member
Manager of Customer Service – Member
Manager of Utilization Management and Review - Member

III. Medical Directors Advisory Group

Advisory Group Structure, Role and Function The Medical Director Advisory Group (MDAG) is composed of 8 voting members, including OCHN Core Provider Medical Directors, and various physician/health practitioners representing numerous primary and specialty care categories such as those indicated below.

- Addiction Psychiatry
- Child and Adolescent Psychiatry
- Geriatric Psychiatry
- Neurology and Psychiatry

The MDAG is chaired by OCHN's Medical Director. The MDAG also includes non-physician non-voting members such as a Quality Analyst and the Integrated Healthcare Nurses that provide support to the MDAG and ensure appropriate flow of information from and to the Group and the various OCHN committees. Additional specialists and various staff are added in consultation, as needed, for input and recommendations relative to the topics being discussed.

Purpose The primary purpose of the Medical Directors Advisory Group (MDAG) is to assure that evidenced based standards are met by OCHN's provider network. The primary focus of the Medical Directors Advisory Group is to assist with the development and monitoring of evidenced based care, and participation in OCHN Performance Improvement Activities.

1. Review and discuss OCHN Medical Services Policies and revise as needed
2. Review progress on selected HEDIS measures and implement actions as needed
3. Continue to discuss applicability of telemedicine
4. Provide ongoing education to OCHN Medical staff via Pharmacy Updates from pharmaceutical companies and relevant guest speakers
5. Provide outcome reports to OCHN Network on progress of the Outcomes Improvement Committee
6. Discuss updates to protocols and policies on an ongoing basis
7. Provide ongoing education on State and National updates that pertain to Medical Services.
8. Develop and support processes to ensure integrated and coordinated care (Mental Illness/Substance Use Disorders /Developmental Disabilities/Physical Health)

## Leadership Involvement in the QI program

OCHN's Medical Director is the organization's lead behavioral practitioner. In this role, the Medical Director serves as the chair of the following councils/groups: Quality Improvement Council/Risk Committee (QIC) and the Medical Directors Advisory Group (MDAG). As the chair of the QIC, the Medical Director provides leadership, guidance, advises on quality improvement priorities and initiatives in the QAPIP. Additionally, the Medical Director is the behavioral healthcare practitioner involved in the implementation of the behavioral health aspects of the Utilization Management Program. The Medical Director is an active member of the Utilization Management Committee and approves all Utilization Management protocols as well as provides input on service provision policies. The medical director also chairs the Outcomes Improvement Committee. The primary function of this committee is to serve as a resource for practitioners to bring forth case review and consultation on individuals with complex needs. The committee is structured in a peer review forum and provides recommendations to clinicians for improving service outcomes.

The Quality Improvement Council is composed of the leadership staff at OCHN and includes Chiefs, Directors and Managers, as listed in the description above.

## Persons Served and Provider Involvement in the QI Program

Persons served, network providers and staff participate in the quality program via quality improvement committees, satisfaction surveys, and performance improvement plans. All quality committees are foundational components of the OCHN quality structure.

OCHN values the contributions of persons served and strives to include them and their input in all aspects of the organization. Persons served play an integral role in the development and implementation of the Quality Improvement Program and QAPIP activities. Quality improvement committees include persons served as part of its membership. Additionally, there are multiple committees in which persons served comprise most of the committee membership. These committees include:

- Citizens Advisory Committee
- Community Evaluation Education Committee
- Empowerment Team
- Strategic Planning Workgroup
- Peer Support Specialist Workgroup
- Recipient Rights Advisory Committee

On an annual basis, OCHN contracted Core Provider Agencies are required to develop a quality improvement plan. Quality improvement activity from the Core Provider Quality Improvement plans is incorporated into the overarching OCHN Quality Improvement Plan as appropriate.

## Need to Restructure or Change the QI Program for 2020

OCHN evaluated the results and resources from the 2019 QI Program. The following activities were assessed for QI operations during the year: Adequacy of the QI Program resources, QI Committee Structure, Practitioner participation and leadership involvement, changes and need for restructure for the subsequent year. A summary of this assessment is noted below. Of note, it was determined that the current QI Program results and resources were consistent with a successful QI Program. Medical Director focus and clinical analytic activities were enhanced to provide additional focus on improving quality across our entire member population. Building on the success of 2019, additional quality focus in 2020 will include:

I. Adequacy of QI Program Resources: QI program resources were sufficient to address QI objectives established for the fiscal year. Resources utilized included staff from Information Technology, Program Leadership and network practitioners.

II. QI Committee Structure: No changes are anticipated for FY 2020.

III. Practitioner Participation/Leadership in the QI Program: Practitioner participation is evident on the following QI Committees: Clinical Directors, Improving Practices Leadership Team, Credentialing Committee and the Medical Directors Advisory Group. Meeting minutes denote input and feedback from practitioners.

IV. Expected Restructuring of Changes to the QI Program for 2020: Good progress was made on all goals and objectives established for the Fiscal Year. Many objectives are continuous and are carried forward to the next fiscal year. There were no instances where a goal was not met or had no process due to inadequate resources. Therefore, no structural changes will be made to the QI Program for Fiscal Year 2020.