Summary of Quality Improvement Activities
Fiscal Year 2022

MISSION

Strengthening our community by improving and advocating for the lives of individuals and families.

VISION

Building a community which provides integrated behavioral health care effectively, efficiently, and sustainably for all who require it.

CORE VALUES

- Integrity
- Inclusion
- Honor
- Equality
- Innovation
- Teamwork
- Cultural Competency

PURPOSE

OnPoint is committed to providing quality improvement throughout the mental health system of care. More specifically, OnPoint is concerned with areas that limit access to services, quality of care, coordination of necessary services and supports, integrated care, and consumer satisfaction. Within each area are a set of performance indicators and program outcomes that are continuously tracked and analyzed.

The Purpose of the OnPoint Quality Improvement Program is to:

- Continually evaluate and enhance quality management processes, program outcomes, and administrative efficiencies.
- Monitor and evaluate the systems and processes related to the quality of services that can be expected to affect the health status, quality of life, and satisfaction of persons served by OnPoint.
- Identify and assign priority to opportunities for performance improvement as identified by stakeholders (e.g., staff, consumers, providers).
- Create a culture that encourages stakeholder input and participation in problem solving.
- Outline the structure for monitoring and evaluating OnPoint and service providers' compliance with regulations and requirements.

GOALS

The OnPoint Quality Improvement Program will:

1. Target improvement at all levels including management, administration, and programs to include access, coordination of services, timeliness, safety, respect, effectiveness, appropriateness, and continuity.
2. Involve people served as well as those who care for them, in assessing and improving satisfaction of outcomes and services.

3. Develop performance indicators to ensure services are effective, safe, respectful, and appropriate.
4. Track key performance indicators, comparing performance to statewide or other comparable data when available.
5. Continuously monitor and analyze data related to program outcomes and consumer satisfaction to identify opportunities for improvement.
6. Ensure providers of service fulfill their contractual or employment obligations in accordance with applicable regulatory and accreditation standards.
7. Ensure providers of service are competent and capable of providing services through a system of competency evaluation and credentialing.

QUALITY IMPROVEMENT ACTIVITIES

We, at OnPoint, work to constantly improve our services. We monitor how our services are delivered and the ways our services help people in Allegan County through various internal quality monitoring reviews; input from consumers, stakeholders, and the community; and outside audits and reviews. The following report summarizes the quality improvement activities for FY22.

SUMMARY OF QI GOALS FROM THE FY22 QI PLAN

GOAL 1: Achieve and maintain all standards of the Michigan Mission-Based Performance Indicator System (MMBPIS).

MMBPIS Indicators focus on access/timeliness to services, continuity of care, efficiency, and outcomes. MMBPIS Standards are developed and monitored by the Michigan Department of Health and Human Services (MDHHS). Reports are provided to the Lakeshore Regional Entity (LRE) and to MDHHS on a quarterly basis. The LRE requires a *Plan of Correction* to be written whenever a standard is not met.

Beginning in Q3 of FY20, the state made changes to Indicators 2 & 3, which resulted in removing exceptions for these indicators. Currently, there is no standard for Indicators 2 & 3. The state will be setting a standard after they identify the baseline for these indicators.

OnPoint monitors the following MMBPIS Indicators:

- **Indicator 1 (Standard - at least 95%):**
  Hospital preadmission screenings are completed within 3 hours.
- **Indicator 2a (No Current Standard):**
  New persons requesting an intake appointment receive a face-to-face assessment with a professional within 14 calendar days of their request for service.
- **Indicator 3 (No Current Standard):**
  New persons start their on-going service by meeting face-to-face with a professional within 14 days of their intake date.
- **Indicator 4a & 4b (Standard - at least 95%):**
  4a. Persons discharged from a psychiatric hospital are seen within seven days.
  4b. Persons discharged from a substance abuse detox unit are seen within seven days.
- **Indicator 10 (Standard – readmission rate of 15% or lower):**

Persons discharged from a psychiatric hospital are not readmitted within 30 days of discharge.

The following table displays the MMBPIS scores reported to LRE & MDHHS for FY22:

FY22 MMBPIS REPORT							
Indicator	**Description**	**Population**	**Goal**	**1st Qtr FY22**	**2nd Qtr FY22**	**3rd Qtr FY22**	**4th Qtr FY22**
1	Emergency Referrals Completed in 3 Hours	Children	>=95%	100	100	100	100
		Adults	>=95%	100	99	99	100
2	Assessment within 14 Days of First Request	SED Children	No MDHHS Standard	80	88	77	85
		MI Adults	No MDHHS Standard	87	82	93	81
		DD Children	No MDHHS Standard	100	97	85	76
		DD Adults	No MDHHS Standard	75	88	86	100
3	Started Service within 14 Days of the Assessment	SED Children	No MDHHS Standard	55	68	69	71
		MI Adults	No MDHHS Standard	50	48	72	90
		DD Children	No MDHHS Standard	79	75	80	69
		DD Adults	No MDHHS Standard	88	82	57	100
4a	Seen within 7 Days of Discharge	Children	>=95%	100	66.7 (2/3)	100	100

	from Hospital	Adults	>=95%	100	81.2 (13/16)	100	93.3 (14/15)
4b	Seen within 7 Days of Discharge from SU Detox	SUD	>=95%	90 (9/10)	100	100	100
10	Readmitted to Inpatient within 30 Days of Discharge	Children	<= 15%	0	0	11	0
		Adults	<= 15%	0	15.8 (3/19)	8	14

NOTE:	When a standard is not met for a specific indicator, the process is analyzed and revised to improve outcomes. A plan of correction is also required to be submitted to the LRE.
GREEN	Indicates 95% Standard was met for Indicators 1, 4a, and 4b. Indicates 15% (or less) Standard was met for Indicator 10. **NOTE: No set standard for Indicators 2 and 3 for FY22. Percentages do no included "exceptions".**
RED	Indicates 95% Standard was NOT met for Indicators 1, 4a, and 4b. Indicates 15% (or less) Standard was NOT met for Indicator 10.

When a standard was not met (numbers in **red**), the numbers within the parentheses show how the percentage was calculated. (For standards #1, #2, #3, 4a, and 4b: how many consumers met the standard / how many consumers were counted for that standard. For standard #10: how many consumers did **not** meet the standard / how many consumers were counted for that standard.)

With the exception of 4a Adults for Q2, the few times that we did not meet a standard for FY22, we were just one person away from meeting the goal.

OnPoint continues to work with staff and the LRE to improve our MMBPIS ratings by identifying and overcoming barriers to timely service provision.

Goal #2: Fully implement services for the Certified Community Behavioral Health Clinic (CCBHC) Expansion Grant

To help us meet the integrated and holistic behavioral health needs for the people of Allegan County, OnPoint applied for the federal CCBHC (Certified Community Behavioral Health Clinic) Expansion grant. In July of 2021, we received notice that our request was approved and

we were awarded a two-year grant for a total of $3,990,749 (approximately $2,000,000 a year).

The CCBHC grant will enable us to blend mental health, substance use disorder, and physical health treatment services, thus improving health outcomes along with behavioral health results. The funds will be used to:

- Improve the access of mental and primary healthcare for people who wouldn't ordinarily qualify for our services (all persons with a mental illness and/or substance abuse diagnosis can receive CCBHC services, regardless of where they live or their ability to pay)
- Improve timely access to crisis services
- Integrate primary care for those with mental illness and/or substance use issues
- Integrate complex care management and care protocols that include evidence-based treatment, wellness services, condition-specific care, and health risk behavioral management
- Improve the identification and treatment of trauma through consistent screening and application of specialized trauma-focused, cognitive-behavioral (evidence-based) treatment

As a CCBHC, we must meet strict care standards and provide the following nine core services:

1. Crisis mental health services (24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization)
2. Screening, assessment, and diagnosis
3. Patient-centered treatment planning or like processes (including risk assessment and crisis planning)
4. Outpatient mental health and substance use disorder services
5. Outpatient clinic primary care screening (including review of key health indicators and health risks)
6. Targeted case management
7. Psychiatric rehabilitation services
8. Peer support, counselor services, and family support services
9. Intensive, community-based mental health care for members of the armed forces and veterans (particularly those members and veterans located in rural areas)

CCBHC First Year Accomplishments

Over the next two years of the grant, OnPoint is required to serve a minimum of 500 people through our CCBHC services. During our first year, the CCBHC program served 194 adults and 90 children, which exceeded our enrollment rate target.

Many of our CCBHC goals were accomplished during the first year of the grant by making workflow improvements, process adjustments, and staffing additions.

Some of the highlights include:

- New preliminary screening and risk assessment tools

- An expanded comprehensive assessment (that includes the primary care screening and NOMs intake data collection)
- A NOMS dashboard in PowerBI (created by our IBH Analytics team) to monitor program access, functional status at intake, and CCBHC outcomes
- Targeted staff education and coaching opportunities (by using the PowerBI dashboards as a manager's tool)

OnPoint made significant progress during the first implementation year (FY22) of the CCBHC program and we're confident that we'll be able to meet our goals for the second year of the grant (FY23).

Goal #3: OnPoint Building Relocation

Consumer survey results have consistently identified a need for a more convenient location of our services. In addition, our services would be easier to access if they were consolidated into one place. Our new building at 540 Jenner Drive is located in the town of Allegan and will be able to accommodate additional services (e.g., CCBHC) as well as additional OnPoint staff.

The target date for this goal was March 31, 2023 (during FY23). OnPoint Management Team worked diligently to complete the building as planned. Groundbreaking took place on January 28, 2022 and services began in the new building on May 8, 2023. More details of this project will be given in the FY23 Summary of Quality Improvement Activities report.

Goal #4: ACCMHS Rebranding Project

On April 18, 2022, Allegan County Community Mental Health Services (ACCMHS) officially changed their name to "OnPoint". Our new look and feel represents our commitment to innovation and the agency's role and purpose of helping individuals get back into the fold of life.

Inspiration Studios worked to increase name recognition by coordinating our rebranding transition with our expanded CCBHC services, building relocation, and increased social media presence.

New Brand Purpose Statement: Caring for Allegan County.

New Name and Logo: Our new name reflects the agency's transformation of its culture and a redefined strategy focused on the expansion of care for the people of Allegan County. As a prominent representation of the agency, people and brand, Allegan County CMH's new logo, OnPoint, is colorful, optimistic and smart. Inspired by the features of origami, the primary focus will be on the "O" to symbolize the services that fold together by the agency to help individuals get back into the "fold" of life — whether this is through mental health or developmental disability services, substance use disorder treatment, or housing services. The crafted combination of the origami folds also symbolize what origami is known for, hope and healing.

New Brand Colors: The multitude of fresh colors speaks to the diversity and richness OnPoint represents, all working together to shift and evolve — synonymous with OnPoint's commitment to continual improvements.

Goal #5: Increased Social Media Presence

As part of our rebranding efforts, it was determined that a new website should be designed to better meet the needs of our stakeholders. Our new user-friendly website was launched near the end of 2021. The website has since been updated with our new OnPoint logo and includes information regarding our rebranding campaign.

The Home Page gives information about our services as well as Emergency Crisis Contact information. Key areas on the top of the webpage include Home Page, About Us, Services, Providers, Careers, FOIA, Contact Information, Customer Services, COVID-19 Plan, and Driving Directions. Important Contact Information listed on the bottom of the webpage include: Our Address/Phone/Hours, Access & Emergency Service Information, Compliance Contact Information, and Recipient Rights Contact Information. The search bar at the top of the webpage makes it easy for users to find information throughout the website.

Additionally, in FY22 OnPoint began utilizing two social media sites (Facebook and Instagram). Staff were encouraged to participate in the acceleration of our social media growth by sharing/liking/following OnPoint.

The efforts to increase our social media presence resulted in increased awareness of our services, increased access to information/resources for the behavioral health industry, and increased opportunities for community/consumer input.

Goal #6: Implement the new LRE Performance Improvement Projects (PIP)

The LRE is required to conduct at least two PIP projects each fiscal year. One PIP is mandated by MDHHS and is reviewed/evaluated by HSAG for compliance with the PIP requirements. The second PIP may be of the LRE's choosing and must be submitted to MDHHS for approval.

The LRE worked with the regional CMHs to select PIP projects that can be expected to have a beneficial effect on health outcomes and individual satisfaction in significant aspects of clinical care and non-clinical services. The purpose of the projects is to achieve demonstratable and sustained improvement through ongoing measurement and intervention.

The FY22 goal was to identify two regional Performance Improvement Projects to work on during the next three years. LRE research suggested that an increase in the HEDIS Follow-up After Hospitalization (FUH) metrics can improve outcomes, decrease suicides, decrease recidivism, and increase satisfaction. For this reason, the following two PIPs were selected:

1. FUH Metric: Improvement FUH Data Distribution, Submission, and Tracking

   The LRE created a cross-functional FUH Workgroup that includes Provider Network Management, Information Technology, Utilization Management, and all Member CMHSPs to develop the technical requirements for reporting tools and

processes/procedures to improve timeliness for FUH. The workgroup meets weekly and has developed an FUH Roadmap that guides activities and produces intentional planning by all FUH Workgroup members.

2. FUH Metric: Decrease in Racial Disparity between African Americans/Blacks and Whites

   This PIP was selected in accordance with the MDHHS mandate for the LRE to choose a project centered on decreasing the race/ethnicity disparity in Region 3. Through targeted interventions, the region is working towards significant improvement (over time) in the number of African American/Black members (with a principal diagnosis of mental illness or intentional self-harm) that receive follow-up within 30 days after an acute inpatient discharge, without a decline in follow-up for the white members.

   The baseline portion of this FUH was completed during FY22. The first measurement period runs from January 1, 2023, through December 31, 2023. The LRE continues to develop interventions for deployment across the region.

OnPoint FY22 SURVEY RESULTS

Follow-Up Survey

Customer Services mail out a *Follow-Up Survey* to consumers who are discharged from our services. A postage-paid envelope is provided for the return of the survey. In FY22, we received back 18 completed surveys.

The survey provides a place for comments and includes the following eight questions:

1. How much did services help you with resolving the problems that led you to seek help?
2. How much did services help you with improving your overall emotional state?
3. How much did services help you with improving your feelings about yourself (self-esteem)?
4. How much did services help you with improving your overall activity level?
5. How much did services help you to feel confident about handling problems as they come up?
6. How much did you feel involved in planning the course of your services/discharge?
7. Overall, how satisfied are you with the staff's treatment of your problem?
8. To what extent would you be willing to call again for services if the need should arise?

The questions are rated using the following scale:

- 0 = not at all
- 1 = a little bit
- 2 = somewhat

- 3 = quite a bit
- 4 = a lot
- NA = not applicable

The average ratings for the questions above (as well as the Overall rating) are displayed in the following chart for FY20, FY21, and FY22:

FY	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Overall
20	2.96	2.61	2.57	2.35	2.65	2.48	2.78	3.40	**2.70**
21	3.00	3.04	3.00	2.96	2.89	3.00	3.31	3.38	**3.06**
22	3.11	3.17	2.69	2.80	2.83	2.59	3.18	3.50	**2.98**

The chart demonstrates an overall satisfaction of consumers who are discharged from our services. If we consider a rating of 2.5 to be "satisfied" (halfway between a "somewhat agree" rating of 2 and a "quite a bit agree" rating of 3), then our percentage of satisfied consumers for the FY22 *Follow-Up Survey* is 83% (15/18), compared with 69% (20/29) in FY21 and 71% (17/24) in FY20.

There was an increased rating for 3 questions (#1, #2, and #8) and a decrease for 5 questions (#3, #4, #5, #6, and #7). The largest decrease (.31) was due to 4 individuals giving a low rating for Q3 (How much did services help you with improving your feelings about yourself?). The largest increase (.13) was for Q2 (How much did services help you with improving your overall emotional state?). Consumers are given the opportunity to have Customer Services contact them to discuss their satisfaction with services.

LRE Consumer Satisfaction Survey

The LRE revised their *Consumer Satisfaction Survey* that is used throughout the region. This new survey is comprised of twenty questions designed to collect data from the following domains: Access, Quality, Outcome, Long Term Services, and Telehealth Services. The back page of the survey has a "Comment Section" where the consumer is asked to identify what they liked, did not like, or thought was missing from the services that they received. There is also an area for the consumer to provide their phone number if they would like to be contacted by a Customer Services Representative. Surveys were mailed out with return postage-paid envelopes. We received back 37 completed surveys.

The 20-questions survey makes positive statements that the consumer/guardian rates using the following 6-point scoring system:

2: Disagree
3: Mildly Disagree
4: Mildly Agree
5: Agree
6: Strongly Agree

The following chart and graph display the FY21 and FY22 results. A score of "4" or above represents "satisfaction".

FY	Access	Quality	Outcome	Long Term	Telehealth
FY21	4.7	5.2	5.1	5.2	4.4
FY22	5.1	5.3	5.2	5.2	4.8

The overall average rating was 5.1. The lowest category for both years was *Telehealth*, with a satisfaction score of 4.4 (FY21) and 4.8 (FY22). In FY22, the question with the lowest score (4.4) was in the "Telehealth" category: "I would like to use Telehealth for future appointments."

Approximately 38% of the surveys that we received had comments. Of the 14 comments:

- Six were positive (e.g., "I have a better relationship with my wife now", staff are "…very dedicated and professional people who truly care about the people they work with.").
- Seven had comments about access to services
    - Four comments were related to needing more service options and/or providers
    - Three comments were related to preferring/needing non-telehealth services
- One had a comment regarding communication issues with a provider (which they were already addressing).

In response to the preference and/or need for non-telehealth services, OnPoint has offered more opportunities for face-to-face services.

Behavior Treatment Plan Satisfaction Survey

The Behavioral Tr4eatment Plan Satisfaction Survey is a tool designed to evaluate the effectiveness of approved Behavioral Treatment Plans. During FY22, we distributed the survey to 31 guardians / home managers of 40 consumers who were receiving Behavioral Services through OnPoint. The recipients were provided with self-addressed stamped envelopes to return their surveys within a 2-week period.

Survey Questions

Based on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree), recipients rated the following areas:

1) My opinions were listened to during the development of the Behavior Treatment Plan.
2) The Behavior Treatment Plan was explained to me in a way that I understood.
3) The Behavior Treatment Plan is Person Centered.
4) The Behavior Treatment Plan is consistently implemented.
5) I know the Behavior Treatment Plan is being monitored.
6) The Behavior Treatment Plan has helped to reduce problematic or potentially harmful behaviors.
7) The Behavior Treatment Plan has improved the quality of life for the individual receiving services.
8) I know who to contact if I have questions regarding the Behavior Treatment Plan.

We received 4 of the 40 surveys back, for a response rate of 10%. Our overall rating was 3.9 out of a possible 5.0 points (which is considered "Satisfied"). Three of the four guardians rated all questions as "Satisfied."

One guardian had an overall rating of 2.9 (3 is "Neutral"), with "Disagree" ratings for Questions 4, 5, and 7. Comments for this consumer were regarding lack of services received from the provider home (e.g., need more outings); however, the consumer's name was not provided for follow up.

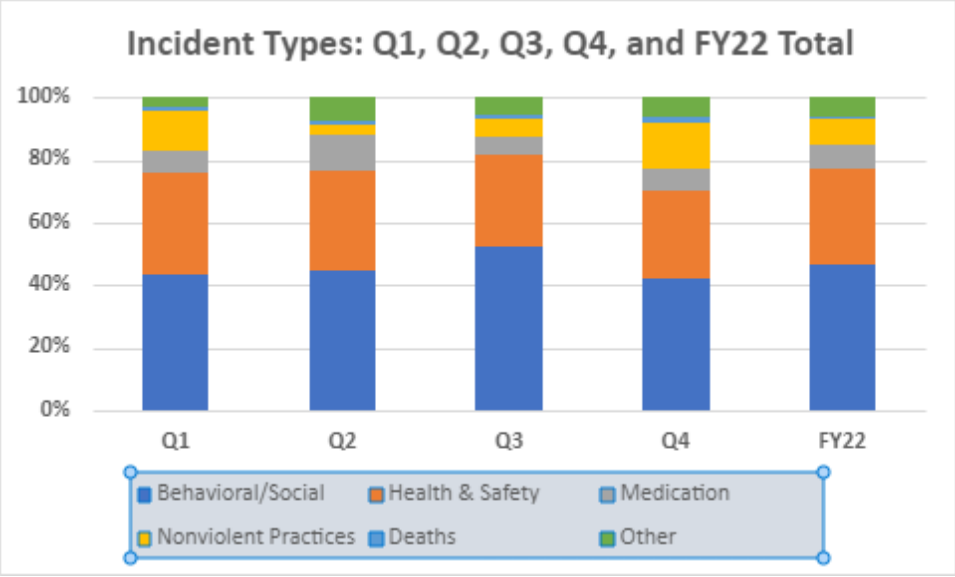
FY22 INCIDENT REPORTS

Incident Reports are monitored to ensure that incidents are appropriately responded to in an effective, timely manner; determine specific trends or patterns of incidents; and to create mechanisms (based on specific trends) designed to prevent or minimize the negative impact that these incidents have on the lives of those we serve.

As part of the incident report monitoring process, incident reports are categorized into six areas:

- Behavioral/Social Issues
- Health & Safety Issues
- Medication Issues
- Nonviolent Practices
- Deaths
- Other Issues

The following chart and graph display the total percentages of Incident Reports received within each category for Q1, Q2, Q3, Q4, and total for FY22:



CATEGORY	Q1 (208)	Q2 (365)	Q3 (331)	Q4 (162)	FY22 (1066)
Behavioral/Social	44%	45%	52%	42%	47%
Health & Safety	32%	32%	29%	28%	30%
Medication	7%	12%	6%	7%	8%
Nonviolent Practices	13%	3%	6%	15%	8%
Deaths	1%	1%	1%	2%	1%
Other	3%	7%	6%	6%	6%

The numbers listed in parenthesis show the total number of Incident Reports that we received for that time period. There was an increase in "Medication Issues" during Q2 due to a higher number of "Missed Medications" (mostly due to hospitalizations). During Q3, there was an increase in "Behavioral/Social" issues due to a higher number of "Disruption of Service Routine" (mostly due to refused medications by a few individuals). No significant patterns/trends were identified (for consumers, agencies, or circumstances) during the FY.

The following chart compares the Incident Reporting for FY19, FY20, FY21 and FY22.

CATEGORY	FY 19 (n=2310)	FY20 (n=2094)	FY 21 (n=1022)	FY 22 (n=1066)
Behavioral/Social	53%	53%	51%	47%
Health & Safety	25%	23%	29%	30%
Medication	12%	13%	10%	8%
Nonviolent Practices	5%	4%	4%	8%
Deaths	0%	1%	2%	1%
Other	5%	5%	4%	6%

Percentages during FY22 were consistent with FY21. Since FY19, there has been a decrease in the number of Incident Reports being submitted to our agency from our contracted providers (with a significant decrease in FY21 as compared to FY20). During FY21, the Corporate Compliance (CC) Team and Recipient Rights (RR) Team discussed this issue during a combined CC/RR meeting. The decrease in Incident Reports was mainly due to a few consumers (who historically had a high number of Incident Reports) who moved out of the county. Other CMHs in our region have noted similar findings, especially since the beginning of the COVID-19 Pandemic (as discussed during our regional QI ROAT meeting). Continued provider staff

shortages / high turnover rates may have contributed in the decreased number of Incident Reports, as new staff members are learning incident reporting requirements and processes.

If a Critical Incident meets the criteria of a Sentinel Event (unexpected death, serious injury, or risk thereof), then a Root Cause Analysis (RCA) must be conducted to investigate the circumstances leading to the event. The purpose of the RCA is to identify any process changes that could reduce the risk of a similar incident. During FY22, the QI Department created a more detailed tracking tool for monitoring Sentinel Events (SE) and RCA activities. The excel tracker identifies the reporting requirements and timelines that need to be adhered to, if a Sentinel Event were to occur (we didn't have any SEs during FY22).