Quality Improvement Plan

for

Fiscal Year 2024

INTRODUCTION

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) have a Quality Assessment and Performance Improvement Program (QAPIP), which meets the specified standards in the contract with MDHHS. In addition to the QAPIP, MDHHS requires each Community Mental Health Services Program (CMHSP) to have a Quality Improvement Program (QIP). Most of the requirements are met through the Regional Quality Improvement Plan. Areas where CMHSP distinctions are necessary have been included in this document. The distinct areas include:

1. Elements of the CMHSP Quality Improvement (QI) structure, and
2. Specific CMHSP QI goals and/or objectives.

OUR MISSION

Improving the lives of people in Allegan County through exceptional behavioral health and homelessness services.

OUR VISION

An inclusive community with integrated behavioral health services and safe, affordable housing for all.

OUR CORE VALUES

Integrity, Inclusivity, Honor, Equality, Humility, Innovation, Teamwork, and Cultural Competency.

OUR COMMITMENT

OnPoint is committed to providing quality improvement throughout the mental health and substance abuse system of care. Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by OnPoint leadership, is understood, accepted, and utilized throughout the organization as a result of continuous education and involvement of staff at all levels in performance improvement. Quality improvement involves two primary activities:

1. Measuring and assessing the performance of services through the collection and analysis of data, and
2. Conducting quality improvement initiatives and acting where indicated, including the design of new services and/or improvement of existing services or processes that affect the quality of care at OnPoint.

QUALITY IMPROVEMENT ASSUMPTIONS

The following assumptions are accepted:[1]

1. Health care is not an individual act between clinician and consumer, but a collective series of processes within a formal and informal system of care.
2. Most problems with quality in health care relate to defects in processes, not individual failings.
3. Measurement of crucial processes and outcomes play an important role in improving the quality of care. Through statistical analysis, processes can be compared to evidence-based treatment guidelines and outcomes can be compared to norms and benchmarks to identify opportunities for improvement.
4. Improvement efforts should be focused on the needs of the consumer.
5. Quality Improvement draws upon the knowledge, expertise, and efforts throughout the entire agency.
6. The improvement process prioritizes key problems, utilizes hypotheses about the nature of these problems, and develops targeted interventions.
7. Many quality problems are multidimensional, and the improvement process often occurs through incremental efforts.

PURPOSE

The purpose of the OnPoint QI Plan is to establish a written description by which the specific structure, process, scope, and role of the quality improvement program is articulated. The OnPoint Quality Improvement Program exists to improve the overall performance in the areas of access, clinical care, consumer protection, integrating care, and consumer satisfaction. The OnPoint QI Plan will be evaluated at least annually and updated whenever necessary. The QI Plan is the responsibility of the QI Coordinator, in collaboration with staff and the Management Team.

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 provider's compliance with regulations and requirements.

[1] Adapted from "Selecting Process Measures for Quality Improvement in Mental Healthcare," Richard C. Hermann, M.D., M.S. H. Stephen Leff, Ph.D. and Greta Lagodmos, B.A. Center for Quality Assessment and Improvement in Mental Health

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 including recidivism, appropriateness, and continuity of care.
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 STRUCTURE AND ACTIVITIES

Board of Directors
The OnPoint Board of Directors receives reports regarding performance indicators, program data, and consumer satisfaction data. The OnPoint Board of Directors will regularly review outcome measurement data, consumer feedback activities, and improvement actions taken.

Management Team
The OnPoint Management Team is comprised of the Executive Director, Chief Operating Officer, Chief Financial Officer, Director of Program Operations, Director of Evidenced Based Practices, and the Director of Quality Innovation and Compliance. The Management Team will demonstrate OnPoint's commitment to continuous quality improvement by fulfilling the following responsibilities:

- Ensuring that all employees are aware of the organization's vision, mission, and values.
- Collaborating with the QI Coordinator and other staff members to identify improvement opportunities.
- Reviewing and acting on reports from the QI Coordinator or other teams/committees on performance findings and recommendations.
- Reviewing and evaluating employee generated suggestions for quality improvement within the agency.
- Ensuring plans for improving systems are in place and effectively implemented, communicated, and monitored.
- Identifying staff training needs.

QI Coordinator
The Quality Improvement Coordinator is the author of the QI Plan and has the following additional responsibilities:

- Developing, managing, and implementing activities stated in the QI Plan.
- Ensuring QI data is regularly presented to the Management Team and the OnPoint Board of Directors.
- Identifying staff training opportunities related to quality improvement.
- Tracking improvement data and follow-up methods.
- Collaborating with Program Managers/Supervisors to implement and monitor QI goals.
- Coordinating data collection to and from committees, staff, and service teams.
- Collaborating with the Lakeshore Regional Entity (LRE) on regional quality improvement activities.

Supervisors/Leadership
OnPoint Supervisors/Leadership help OnPoint establish a culture of quality improvement and fulfill the following responsibilities related to quality improvement:

- Encouraging involvement of staff in the QI process.
- Collaborating with the QI Coordinator to implement OnPoint QI Goals.
- Compiling/utilizing outcome measurement data for analysis.
- Communicating QI goals, activities, and results to staff.

Staff
OnPoint staff play a key role in the quality improvement process and may conduct the following activities:

- Collecting and reviewing program data.
- Providing suggestions and recommendations for quality improvement.
- Collaborating with the QI Coordinator on performance improvement projects and recommendations.
- Serving on improvement committees/teams.

Subcontracting Agencies
Subcontracting Agencies may fulfill the following responsibilities related to the OnPoint QI process:

- Participating in quality improvement activities (when mandated).
- Ensuring staff are compliant with appropriate credentials and training requirements.
- Implementing improvement actions and communicating improvement actions to OnPoint.

Consumers/Other Stakeholders
OnPoint consumers/other stakeholders may participate in the OnPoint QI Process by conducting the following activities:

- Actively participating in quality improvement activities designed to obtain stakeholder input.
- Using the systems and procedures in place.
- Identifying improvement opportunities.
- Participating in teams, work groups, and committees.
- Providing feedback regarding agency changes and process improvement projects.

OVERVIEW OF COMMITTEES

Quality Improvement Council

- Supports the overall mission, vision, and values of OnPoint.
- Builds a culture of continuous quality improvement within OnPoint.
- Participates in the development of the annual Quality Improvement Plan.
- Monitors key performance indicators compared to organizational goals and industry benchmarks.
- Ensures conformance to accreditation and other external requirements.
- Reviews and recommends revisions to quality/safety-related policies and standards.
- Supports the OnPoint Strategic Plan by collaborating with other agency teams/committees on quality improvement projects.

Recipient Rights Committee

- Maintains compliance with Chapter 7 of the Michigan Mental Health Code.
- Tracks and trends Office of Recipient Rights (ORR) data.
- Provides recommendations for process improvements.

Behavior Treatment Committee

- Monitors enrollment and exit from the Behavior Treatment Program for trend analysis.
- Monitors and analyzes behavior modification techniques, including the emergency use of physical interventions.

Community Opportunity Advisory Panel (COAP)

- Analyzes consumer feedback surveys/focus groups.
- Identifies future consumer opportunities.
- Provides OnPoint with feedback regarding policy development and change.
- Analyzes quality activity reports and provides feedback.
- Identifies community opportunities for consumers and families.

Utilization Management Committee

- Ensures consumers receive timely, quality, medically necessary, value-based services in the most appropriate and least restrictive treatment setting.
- Ensures OnPoint has an effective mechanism to manage the utilization of clinical resources.

Health and Safety

- Ensures compliance with OSHA/MIOSHA.
- Develops infection control procedures.
- Conducts staff training related to health and safety goals.
- Updates required information for posting.
- Inspects buildings/grounds/equipment.
- Conducts safety drills.
- Ensures physical accessibility.
- Completes annual inspections.

Corporate Compliance

- Ensures that the regulatory environment of OnPoint meets legal requirements.
- Monitors internal and external compliance audits/investigations to identify areas in need of improvement and to implement corrective and preventive actions.
- Monitors the effectiveness of corrective action and adjusts as needed.
- Reviews and recommends changes/revisions to the Compliance Program and related education/training, policies, and procedures.
- Maintains a confidential database that includes all alleged and substantiated complaints/issues related to fraud, waste, abuse, and other compliance matters.

QUALITY MANAGEMENT / IMPROVEMENT SYSTEM

The OnPoint Quality Management System combines the traditional aspects of quality assurance and adds the elements of continuous quality improvement. The Quality Management System helps OnPoint achieve its mission, realize its vision, and live its values. It protects against adverse events and provides mechanisms to implement positive changes within the agency.

The *Quality Management System* includes:

- Predefined quality standards
- Formal assessment activities
- Measurement of outcomes and performance
- Strategies to improve performance that falls below standards.

The various aspects of the system are not mutually exclusive to just one category, as an aspect can overlap into more than one category. The following table identifies some of the more common standards, assessment activities, measurements, and improvement strategies used by the ONPOINT Quality Management System.

ONPOINT QUALITY MANAGEMENT SYSTEM

Quality Standards	Assessment Activities	Performance Measurements	Improvement Strategies
•Federal & State Rules/Regulations •Stakeholder Expectations •MDHHS/PIHP Contract •Provider Contracts •Practice Guidelines •Accreditation Standards •Affiliation Policies and Standards •Evidence-Based Practices	•Quality Records Reviews •Accreditation Surveys •Credentialing •Risk Management •Utilization Reviews •External Quality Reviews •Stakeholder Input •Sentinel Event Reports •Critical Event Reports •MDHHS Site Review Report •Behavior Treatment Analysis	•MDHHS MMBPIS •LRE Performance & Dashboard Reports •Benchmarking •Status Reports on Strategic Planning •Audit Reports •Grievances & Appeals •OnPoint Dashboard Reports	•Corrective Action/ Improvement Plans •Improvement Projects •Improvement Teams • Strategic Planning •Adherence to Practice Guidelines •Organizational Learning •Staff Development and Training •Improvements through Root Cause Analysis

I. Quality Standards

Quality Standards provide the specifications, practices, and principles by which a process may be judged or rated. OnPoint identifies and sets standards by reviewing, analyzing, and integrating such areas as:

- Performance expectations of stakeholders for both clinical services and administrative functions
- Accreditation standards
- Practice Guidelines
- Clinical pathway protocols and other authorization criteria
- Government requirements, regulations, and rules

OnPoint quality standards are documented in policy and procedure, contracts with providers, and the quality review process. OnPoint standards are evaluated, at least annually, to ensure continued appropriate and relevant application.

Confidentiality

OnPoint is committed to maintaining the confidentiality of persons served by the organization. Specific details of this commitment are reflected in the organizational policies and procedures related to confidentiality, as well as OnPoint HIPAA policies and procedures.

II. Assessment Activities

Quality assessment consists of various strategically planned activities that help to identify the actual practices, attitudes, performance, and conformance to standards that are enhancing or inhibiting the achievement of quality. Obtaining stakeholder input is critical to quality assessment activities.

Stakeholder Input

OnPoint recognizes that obtaining stakeholder input is a vital aspect of any system designed for continuous quality improvement. Typical stakeholders identified to provide input to OnPoint include individuals receiving services, staff, contract service providers, families/advocates, and the local community. Input is collected to better understand how OnPoint is performing from the perspective of its stakeholders. Quantitative and qualitative assessments are conducted to address issues of quality, availability, and accessibility of care. The input is continually analyzed, and the analysis is integrated into the practices of OnPoint.

As a result of input from stakeholders, OnPoint:

A. Takes specific action on individual cases as appropriate.
B. Identifies and investigates sources of dissatisfaction.
C. Outlines systemic action steps to follow up on findings.
D. Utilizes stakeholder input in decision making.
E. Informs practitioners, providers, persons served, and the OnPoint Board of Directors of the results of assessment activities.

The following table summarizes some of the various methods and sources OnPoint uses to obtain stakeholder input.

STAKEHOLDER INPUT-METHODS & SOURCES

Type of Input	Consumer	Staff	Providers	Family/ Advocates	Community
Interviews	*MDHHS Site Reviews, Accreditation, Individual Assessments, Evaluations*	*Performance Evaluations, Termination/Exit Interviews*	*ORR Site Visit, Quality Review of Providers*	*MDHHS Site Reviews*	
Suggestions	*Case Management/ Supports Coordination Contacts or Customer Service Contacts*	*Supervision, Quality Improvement Ideas*	*Quality Monitoring Reviews, Case Management Contacts*	*Case Management/ Supports Coordination Contacts*	*Contacts made to OnPoint*
Forums	*Consumer Opportunity Advisory Panel, Board Meetings*	*Team/Unit Meetings*	*MDHHS Reviews, Contract Negotiations, Meetings*	*MDHHS Reviews, Advisory Council*	*MDHHS Reviews, Open Forums at Board Meetings, Advisory Council*
Surveys	*Consumer Surveys*	*Staff Surveys*	*Provider Surveys, Accreditation surveys*	*Satisfaction Surveys*	*Community Needs Assessment Stakeholder Survey*
Planning	*Service Planning Meeting*	*Program Planning*	*Budget Planning*	*Service Planning Meeting*	
Assessment	*Pre-planning Information, Progress Notes Reviews, Discharge Summary*	*Performance Evaluations*	*Quality Review of Providers.*	*Surveys assessing family/advocate satisfaction level/needs*	*Community Needs Assessment*
Grievances /Appeals	*Grievance Systems to File a Grievance, Appeal, or Recipient Rights Complaint*	*Staff Grievance*	*Provider Grievance, Placement Reconsideration for Inpatient Requests*	*Grievance Systems*	*Contacts made to Customer Services*
Complaints	*Recipient Rights Complaint, Complaints Discussed with Customer Services*	*Employee Complaint*	*Recipient Rights Complaint*	*Recipient Rights Complaint*	*Recipient Rights Complaint*

Quality Records Reviews

OnPoint has a Quality Records Review Team comprised of staff that are knowledgeable in external compliance standards and reimbursement practices. The team meets to complete random and/or focus reviews depending on present issues. Formal reports are generated from these reviews and are shared with the staff providing the service, managers/supervisors, the Director of Program Operations, and the QI Council. The Quality Records Review Team notifies the Corporate Compliance Committee when an issue warranting further investigation is identified. In addition, OnPoint adheres to the LRE policy on provider network monitoring, which describes additional mechanisms for monitoring and assessing compliance with contract, state, and federal requirements of service providers.

MDHHS Reviews

MDHHS conducts reviews of the quality of OnPoint administrative and clinical services. In response to the reviews, improvement plans are developed and implemented. The LRE will monitor affiliate member performance on site reviews conducted by MDHHS. OnPoint will draft remedial action for all citations for which OnPoint has been identified as out of compliance. The LRE completes the overall response, provides consultation for affiliate members, and oversees the implementation of improvement actions.

LRE Site Reviews

As part of a delegated model, the LRE completes annual site visits that include reviewing administrative standards and clinical practices. Any areas of noncompliance receive a written Corrective Action Plan (CAP) from the LRE. The CAP is submitted to the LRE for its approval of the quality improvement process to addresses the area(s) of concern.

External Quality Reviews

The Balanced Budget Act (BBA) of 1997 requires that states contract with an External Quality Review Organization (EQRO) for an annual independent review of each Pre-paid Inpatient Health Plan to evaluate the quality, timeliness of, and access to health care services provided to Medicaid enrollees. MDHHS contracts with the Health Services Advisory Group (HSAG) to conduct the reviews within the state of Michigan. OnPoint participates in the HSAG Review as a CMHSP of the Lakeshore Regional Entity.

The stated objective of the annual evaluation is to provide meaningful information that MDHHS and the LRE can use for:

- Evaluating the quality, timeliness, and access to mental health and substance abuse care.
- Identifying, implementing, and monitoring system interventions to improve quality.
- Evaluating one of the two performance improvement projects of the LRE.
- Planning and initiating activities to sustain and enhance current performance processes.

Critical Incidents, Risk Events, Complaints, & Sentinel Events

The OnPoint QI Coordinator is responsible for tracking critical incidents, risk events, and sentinel events reported to OnPoint via incident reports. The Office of Recipient Rights (ORR) is responsible for reviewing consumer incidents and all complaints that may violate the rights of consumers. In combination of efforts from the OnPoint QI Program and the Office of Recipient Rights, the critical incidents, complaints, and sentinel events review processes includes:

- Investigating complaints of rights violations.
- Reviewing incident reports, conducting follow-up activities and investigations.
- Monitoring incidents for the identification of sentinel events.
- Analyzing for trends and providing suggestions to prevent recurrence.
- Reviewing consumer death reports and investigating any unexpected death to identify potential system improvements.
- Sharing and discussing information with the Recipient Rights Committee, Sentinel Events Review Committee, the OnPoint Board of Directors, and Management Team.

The QI Coordinator notifies the Sentinel Event Review Committee of issues that are determined to be a sentinel event. The QI Coordinator reports sentinel events as required by MDHHS following the LRE's Sentinel Event Review Reporting Process. When appropriate, the QI Coordinator conducts a Root Cause Analysis (RCA) and submits the findings to the Sentinel Event Review Committee for further process improvement recommendations.

Sentinel Events (SEs) will be investigated, reported, and documented in accordance with the timeline and details outlined in OnPoint Policy #*805 Critical Incident and Sentinel Event Reporting.* In summary:

- Notification will be made to the LRE within 24 hours of potential event/knowledge of event.
- Determination will be made within 3 Business Days of the knowledge of an SE.
- If determined to be an SE, an RCA shall commence within 2 business days.
- The RCA is to be completed within 45 days after a SE determination is made.
- The final report shall be submitted to the LRE within 48 hours of completion.
- SE details, results, and follow-up plans will be documented and monitored by the QI department.
- QI will collaborate with OnPoint leadership to create and monitor Action Plans.

Credentialing

The OnPoint Credentialing Team will ensure services and supports are consistently provided by staff that are properly and currently credentialed, licensed, and qualified. OnPoint will follow OnPoint and LRE Credentialing and Re-Credentialing Policies, which outlines the guidelines and responsibilities for credentialing and re-credentialing for CMHSPs of the LRE and their contract service providers.

Accreditation

The Director of Quality Innovation and Compliance serves as the CARF Liaison and chairs the CARF/QI Team. The Director of Quality Innovation and

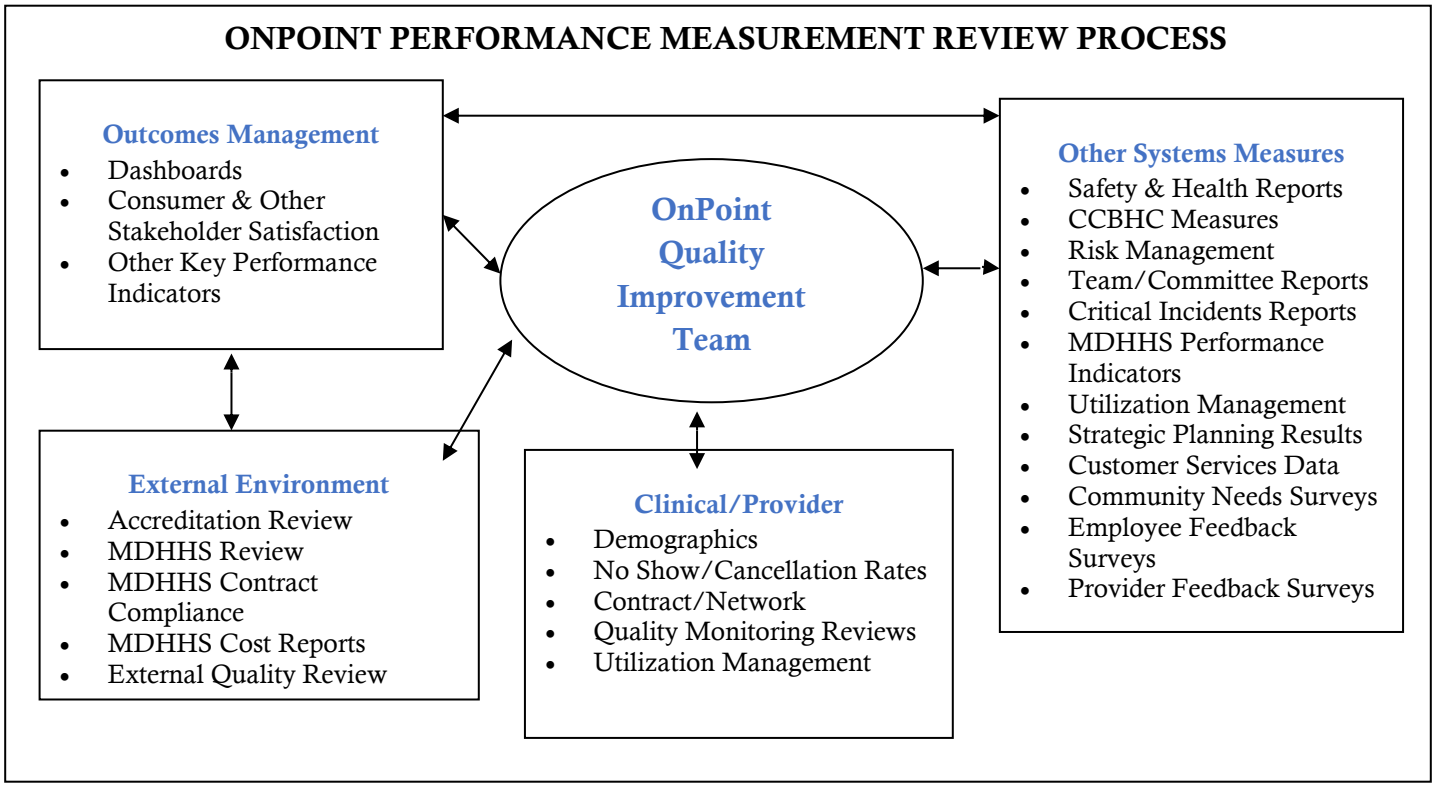
Compliance organizes the CARF survey process and offers extensive consultation to the Management Team and Managers/Supervisors on meeting and exceeding CARF standards. Other members of the CARF/QI Team also assist with the preparation process, as well as provide consultation to staff on how best to meet standards. OnPoint uses the results of the survey to implement improvements within the agency. On an ongoing basis, the Director of Quality Innovation and Compliance remains familiar with CARF changes and reports information to staff members as appropriate.

III. Performance Measurement

Through monitoring and evaluating expected performance on operational activities, the efforts, and resources of OnPoint can be redirected to obtain the desired outcomes.

By using performance indicators, the variation between the target desired and current status of the item(s) being measured can be identified. Indicators are used to alert organizational leadership of issues that need to be addressed immediately, to monitor trends and contractual compliance, and to provide information to consumers and the public.

The following figure displays many of the performance indicators that are monitored and reviewed by OnPoint to determine significant trends and to plan, design, measure, assess, and improve services, processes, and systems. If performance does not meet established standards, an improvement strategy will be determined and implemented by OnPoint.



Performance indicator results are used to guide management decisions related to:

- Strategic planning
- Resource allocation
- Modification of service delivery
- Process improvements
- Staff training
- Marketing and outreach activities
- Other activities identified by consumers and/or other stakeholders.

OnPoint monitors and reviews significant sets of performance indicators, including Michigan Mission-Based Performance Indicator System, Utilization Management, and the Verification of the Delivery of Medicaid Services.

A. **Michigan Mission-Based Performance Indicator System (MMBPIS)**
The Michigan Mission-Based Performance Indicator System (MMBPIS) was fully implemented by MDHHS on October 1, 1998, and is in its 6th revision. There are both PrePaid Inpatient Health Plans (PIHP) and Community Mental Health Services Programs (CMHSP) level indicators within the system. The affiliation (PIHP) and each of the affiliate members (CMHSP) submits data to MDHHS on a quarterly basis. MDHHS collects, aggregates, trends, and publishes the MMBPIS information on the indicators MDHHS has determined would best monitor the implementation of managed care throughout the state. As the PHIP for OnPoint, the LRE and the Information Systems Coordinator ensure the reliability and validity of the data across the affiliation, as well as the conformance of the indicators to the "Validation of the Performance Measures" of the Balanced Budget Act protocols. In partnership with OnPoint, the LRE reviews MMBPIS results. If OnPoint is out of compliance with MDHHS standards, OnPoint will work with the LRE to ensure the implementation of an effective corrective action plan.

B. **Utilization Management**
The OnPoint Utilization Management Process is guided by organizational policy and procedure and the annual OnPoint Utilization Management Plan. OnPoint conducts utilization management activities to ensure the appropriate delivery of services. Utilization mechanisms identify and correct under-utilization as well as over-utilization. Utilization reviews include the review/monitoring of individual consumer records, specific provider practices, and system trends.

C. **Verification of the Delivery of Medicaid Services**
The Michigan Department of Health and Human Services (MDHHS) requires each PIHP to complete reviews that meet the Verification of the Delivery of Medicaid Services (VDMS) requirements. The purpose of the process is to verify that adjudicated claims are for services identified by MDHHS as Specialty Mental Health and/or Substance Abuse Services, and that the services are sufficiently supported by case record documentation. OnPoint will follow the LRE's policy and procedure for the VDMS.

IV. Improvement Strategies

Establishing and successfully carrying out strategies to minimize statistical performance outliers, incorporate best practices, and optimize consumer outcomes is key to continuous quality improvement. The strategy or sets of strategies used vary according to the situation and the kind of improvement that is desired. OnPoint will develop improvement strategies based on performance reviews, evaluation methods, and stakeholder input.

The OnPoint Quality Improvement Program utilizes the Plan-Do-Check-Act (PDCA) process as a problem-solving approach, commonly used in quality control efforts. The process can be repeated indefinitely until the desired outcome is achieved. The four-step process includes:

1. **Plan:** Design (or revise) a process to improve results.
2. **Do:** Implement the plan and measure its performance.
3. **Check:** Measure and evaluate the results to determine if the results met the desired goals.
4. **Act:** Decide if changes are needed to improve the process. If so, begin the PDCA process again.

ONPOINT QUALITY IMPROVEMENT GOALS FOR FISCAL YEAR 2023

Goal #1	Objective(s)	Action(s)/ Success Measure(s)	Responsible Party	Target Date
Achieve and maintain all standards of the Michigan Mission-Based Performance Indicator System (MMBPIS).	-To meet all standards for MMBPIS (quality of care) Indicators for access, timeliness to services, continuity of care, efficiency, and outcomes. -To report MMMBPIS results to stakeholders on a consistent basis.	**Actions:** -The QI Coordinator will work with IT staff to ensure accurate reports are submitted in a timely manner. -Managers/Supervisors will oversee the activities related to MMBPIS standards and will encourage staff to strive to meet them on a consistent basis. -When a *Corrective Action Plan* is required, Supervisors will be responsible to write it and the QI Coordinator will submit it in a timely manner. **Success Measures (Ind 1, 4a, 4b, 10):** MMBPIS results are measured in percentages as required by the state. The standard for Indicators 1 (children/adults), 4a (children/adults), and 4b (SUD) is 95% or greater. The standard for Indicator 10 is 15% or less. Indicator 1 (PreScreen): The percentage of children/adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition	QI Coordinator, Directors, Supervisors, Clinical Staff	9/30/24

		was completed within 3 hours must be equal to or greater than 95%. Indicator 4a (Hospitalization Follow-up): The percentage of children/adults discharged from a psychiatric inpatient unit who were seen for follow-up care within 7 days must be equal to or greater than 95% Indicator 4b (Detox follow-up): The percentage of SUD consumers discharged from a sub-acute detoxification unit who were seen for follow-up care within 7 days must be equal to or greater than 95%. Indicator 10 (Recidivism): The percentage of children/adults readmitted to inpatient psychiatric units within 30 calendar days of discharge from a psychiatric inpatient unit is 15% or less. **Success Measures (Ind 2a, 2e and 3):** The standards for Indicators 2a, 2e, and 3 are yet to be determined by MDHHS. Indicator 2a (New Request): The percentage of new persons (DDC, DDA, MIC, MIA) receiving a completed biopsychosocial assessment within 14 days of request for service.		

		Indicator 2e (New Request for SUD Services): The percentage of new SUD consumers receiving a completed assessment within 14 days of request for service. Indicator 3 (Start of Services) The percentage of qualified new persons (DDC, DDA, MIC, MIA) starting services within 14 days of receiving a completed biopsychosocial.		
Goal #2	**Objective(s)**	**Action(s)/ Success Measure(s)**	**Responsible Party**	**Target Date**
To improve the physical and behavioral health outcomes for persons served by achieving and maintaining all CCBHC clinic required and MDHHS identified quality measures.	OnPoint currently monitors CCBHC quality measures 1-9 indicated within the chart below. Upon inclusion in the CCBHC demonstration project, OnPoint proposes the following plan to measure the state reported measures 10-22 as indicated in the chart below:	Please see the following table.	Please see the following table.	9/30/24

	Quality Measure Name	Measure Description	Measure Steward	Data Collection Form	Data Collection Staff	Reporting Mechanism	Monitoring Staff	Quality Benchmark
1	Time to Initial Evaluation (I-EVAL)	Percentage of patients who receive an initial evaluation service within 10 business days from the request for treatment.	SAMHSA	EMR Client Episodes & qualifying procedure code	Access Clinician	EMR CCBHC Module (I-Eval)	QI Staff & IBH Analytics	
2	Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or within the previous twelve months AND who had a follow-up plan documented if most recent BMI was outside of normal parameters.	CMS	Screening Results and follow-up documented in the EMR Flowsheet	Primary Care Screener	EMR CCBHC Module (CMS 69)	QI Staff & IBH Analytics	
3	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times during the measurement period AND who received tobacco cessation intervention if identified as a tobacco user.	NCQA	Screening Results and intervention documented in the EMR Flowsheet	Primary Care Screener	EMR CCBHC Module (CMS 138)	QI Staff & IBH Analytics	

4	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	The percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized tool and received appropriate follow-up care if they screened positive.	NCQA	NIAAA Single Alcohol Screening Question (SASQ) and intervention documented in the EMR Flowsheet	Primary Care Screener	EMR CCBHC Module (ASC 3301)	QI Staff & IBH Analytics	
5	Screening for Clinical Depression and Follow-Up Plan (CDF-BH)	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.	CMS	Self-administered PHQ9 and PHQ-A completed. Screening data and follow-up for all positive screens are documented by Access Clinician in the EMR PHQ-9/A Form.	Access Clinician	EMR CCBHC Module (CMS 2)	QI Staff & IBH Analytics	
6	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period: BMI documented, counseling for	NCQA	Screening Results and intervention documented in the EMR Flowsheet	Primary Care Screener	EMR CCBHC Module (CMS 155)	QI Staff & IBH Analytics	

		nutrition, and counseling for physical activity.						
7	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk	Mathematica	Columbia Suicide Severity Rating Scale (C-SSRS) Form in EMR	Access & Primary Clinicians	EMR CCBHC Module	QI Staff & IBH Analytics	
8	Adult Major Depressive Disorder: Suicide Risk Assessment (SRA-A)	All patient visits during which a new diagnosis of MDD or a new diagnosis of recurrent MDD was identified for patients aged 18 years and older with a suicide risk assessment completed during the visit.	Mathematica	Columbia Suicide Severity Rating Scale (C-SSRS) Form in EMR	Access & Primary Clinicians	EMR CCBHC Module	QI Staff & IBH Analytics	
9	Depression Remission at Twelve Months (DEPREM-12)	The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event.	MN Community Measurement	PHQ9 and PHQ-A readministered every 90 days	Primary Clinician	EMR CCBHC Module (CMS 159) & Power BI Dashboard	QI Staff & IBH Analytics	

10	Housing Status (HOU)	The percentage of consumers in 10 categories of living situation (collected 2x/year): 1. Private residence 2. Foster home 3. Residential care 4. Crisis residence 5. Residential treatment center 6.Institutional setting 7. Jail (correctional facility) 8. Homeless (shelter) 9. Other 10. Not available	MDHHS-CCBHC Demonstration	EMR Client Episodes	Access and/or Primary Clinician	EMR CCBHC Module	QI Staff & IBH Analytics	
11	Patient Experience of Care Survey (PEC)	Annual completion and submission of Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey.	MDHHS-CCBHC Demonstration	Paper/Electronic surveys	Persons Served	Power BI Dashboard	QI Staff & IBH Analytics	
12	Youth/Family Experience of Care Survey (Y/FEC)	Annual completion and submission of Youth/Family Services Survey for Families (VSS-F) Experience of Care Survey.	MDHHS-CCBHC Demonstration	Paper/Electronic surveys	Persons Served	Power BI Dashboard	QI Staff & IBH Analytics	
13	Follow-Up After Emergency Department	Percentage of emergency department (ED) visits for beneficiaries aged 6 years and older with a primary diagnosis	MDHHS-CCBHC Demonstration	A/D/T reporting in EMR	Care Coordinators	EMR CCBHC Module	QI Staff & IBH Analytics	

	Visit for Mental Illness (FUM)	of mental illness, who had an outpatient visit, an intensive outpatient visit, or a partial hospitalization for mental illness. Two rates are calculated: • Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit						
14	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	The percentage of emergency department (ED) visits for consumers 13 years of age and older with a primary diagnosis of alcohol or other drug (AOD) dependence, who had an outpatient visit, an intensive outpatient encounter or a partial hospitalization for AOD. Two rates are reported: • Percentage of ED visits for which the beneficiary received	MDHHS-CCBHC Demonstration	A/D/T reporting in EMR	Care Coordinators Case Managers Hospital Liaison	CCBHC EMR Module	QI Staff & IBH Analytics	

		follow-up within 30 days of the ED visit. • Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit.						
15	Plan All-Cause Readmissions Rate (PCR-AD)	For consumers aged 18 and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. Data are reported in the following three categories: • Count of Index Hospital Stays (IHS) (denominator) • Count of 30-Day Readmissions (numerator) • Readmission Rate	MDHHS-CCBHC Demonstration	A/D/T reporting in EMR	Care Coordinators Case Managers Hospital Liaison	CCBHC EMR Module	QI Staff & IBH Analytics	
16	Diabetes Screening for People with schizophrenia or bipolar disorder who are using	The percentage of consumers 18-64 years of age with Schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and	MDHHS-CCBHC Demonstration	CCBHC Screening Reporting (Custom) in EMR	Clinic Staff	CCBHC EMR Module	QI Staff & IBH Analytics	

	antipsychotic medications (SSD-AD)	had a diabetes screening test during the measurement year.						
17	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	Percentage of enrollees ages 19 to 64 with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.	MDHHS-CCBHC Demonstration	CCBHC Medication Reconciliation Reporting (Custom) in EMR	Care Coordinators Clinical Staff	CCBHC EMR Module	QI Staff & IBH Analytics	58.5%
18	Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)	The percentage of discharges for consumers aged 18 and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported: 1. Percentage of discharges for which the consumer received follow-up within 7 days of discharge. 2. Percentage of discharges for which the consumer received follow-up within 30 days of discharge.	MDHHS-CCBHC Demonstration	A/D/T reporting paired with CCBHC reporting (Custom)	Care Coordinators Clinical Staff Hospital Liaison	CCBHC EMR Module	QI Staff & IBH Analytics	58%

19	Follow up after hospitalization for mental illness, ages 6 to 17(child/adolescent) (FUH-CH)	Percentage of discharges for children and adolescents ages 6 to 17 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported: 1. Percentage of discharges for which children received follow-up within 7 days of discharge. 2. Percentage of discharges for which children received follow-up within 30 days of discharge.	MDHHS-CCBHC Demonstration	A/D/T reporting paired with CCBHC reporting (Custom)	Care Coordinators Clinical Staff Hospital Liaison	CCBHC EMR Module	QI Staff & IBH Analytics	70%
20	Follow-up Care for Children Prescribed ADHD Medication (ADD-CH)	Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. Initiation Phase: Percentage of children ages 6 to 12 as of the Index Prescription Start Date (IPSO) with an ambulatory prescription	MDHHS-CCBHC Demonstration	CCBHC Medication Reconciliation Reporting (Custom) in EMR	Care Coordinators Clinic Staff	CCBHC EMR Module	QI Staff & IBH Analytics	

		dispensed for ADHD medication who had one follow- up visit with practitioner with prescribing authority during the 30-day Initiation Phase. Continuation and Maintenance (C&M) Phase: Percentage of children 6 to 12 years old as of the IPSO with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.						
21	Antidepressant Medication Management (AMM-BH)/(AMM-AD)	The percentage of consumers aged 18 and older who were treated with antidepressant medication, had a diagnosis of major depressive disorder and who remained on an antidepressant medication treatment. Two rates are reported: 1. Effective Acute Phase Treatment. Percentage of consumers who remained on an	MDHHS-CCBHC Demonstration	CCBHC Medication Reconciliation Reporting (Custom) in EMR	Care Coordinators Clinic Staff	CCBHC EMR Module	QI Staff & IBH Analytics	

		antidepressant medication for at least 84 days (12 weeks). 2.Effective Continuation Phase Treatment. Percentage of consumers who remained on an antidepressant medication for at least 180 days (6 months). For the numerator, two measurement periods are used: 1. Acute Phase: The time between 114 days after the IPSO measurement period begins and 114 days after the IPSO measurement period ends. 2. Continuation Phase: The period between 231 days after the IPSO measurement period begins and 231 days after the IPSO measurement period ends.						
22	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)	The percentage of consumers aged 13 and older with a new episode of alcohol or other drug (AOD) dependence who received the following: 1.Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial	MDHHS-CCBHC Demonstration	A/D/T reporting paired with CCBHC reporting (Custom) and client episodes	Care Coordinators Case Managers	CCBHC EMR Module	QI Staff & IBH Analytics	Initiation - 25%

		hospitalization within 14 days of the diagnosis 2.Initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit						