COPPER COUNTRY MENTAL HEALTH SERVICES
ANNUAL QUALITY IMPROVEMENT REPORT
FY 2023

Introduction

Copper Country Mental Health Services (CCMHS) focuses on improving the quality of its services and identifying those processes that could be improved upon and/or changed throughout the Agency by participating in comprehensive efforts at the local, regional, and state levels. The Agency has a comprehensive Quality Improvement (QI) Program that brings together information from across the Agency that monitors, evaluates, and improves the quality, effectiveness, and efficiency of services to consumers as well as to meet regulatory requirements.

The QI Committee administers the QI Program and is comprised of the Executive Director, Associate Director, QI Coordinator, Recipient Rights Officer/Customer Services Coordinator, Finance Director, Human Resources Director, Medical Director, IT Manager, Clinical Services Program Director, Institute Director and three CCMHS Board members who represent people the Agency serves as well as the community. The committee meets eight times a year to review the numerous agency-wide goals and objectives identified in the QI Program and Work Plan. In addition, the QI committee creates ad hoc subcommittees, developed as necessary, to address issues that arise.

The QI Program is integrated into all services provided by the Board of Directors and works across department lines to address issues such as accessibility to services, consumer satisfaction, quality records reviews, and staff development. It receives reports from various Agency committees including the Behavior Treatment Committee, Recipient Rights Advisory Committee, Consumer Advisory Committee, Risk Management Committee, Safety Committee, Trauma Committee, and Infection Control Committee. With information from across the Agency and the community, the QI Committee can make recommendations to improve services with the goal of meeting or exceeding consumer and other stakeholder expectations.

The QI process encourages consumers and other stakeholders to identify improvement opportunities, participate in QI teams and review QI reports. Advisory committees, focus groups, suggestions boxes, ongoing feedback to clinicians, the Customer Services Coordinator, the annual Consumer Satisfaction Survey, and the bi-annual Stakeholder Survey are the sources of input used for this process.

This annual report focuses on highlights from the QI Committee and is only a summary of some of the areas that are monitored and reported upon throughout the year. A quarterly report which details the activities of the QI Committee is presented to the Board of Directors and distributed to supervisors. CCMHS publishes other performance reports, such as the CCMH Annual Report and the Consumer Satisfaction Survey Report, and these are distributed to the Board of Directors, management, supervisors, stakeholders, and consumers served.

HIGHLIGHTS IN FY 2023

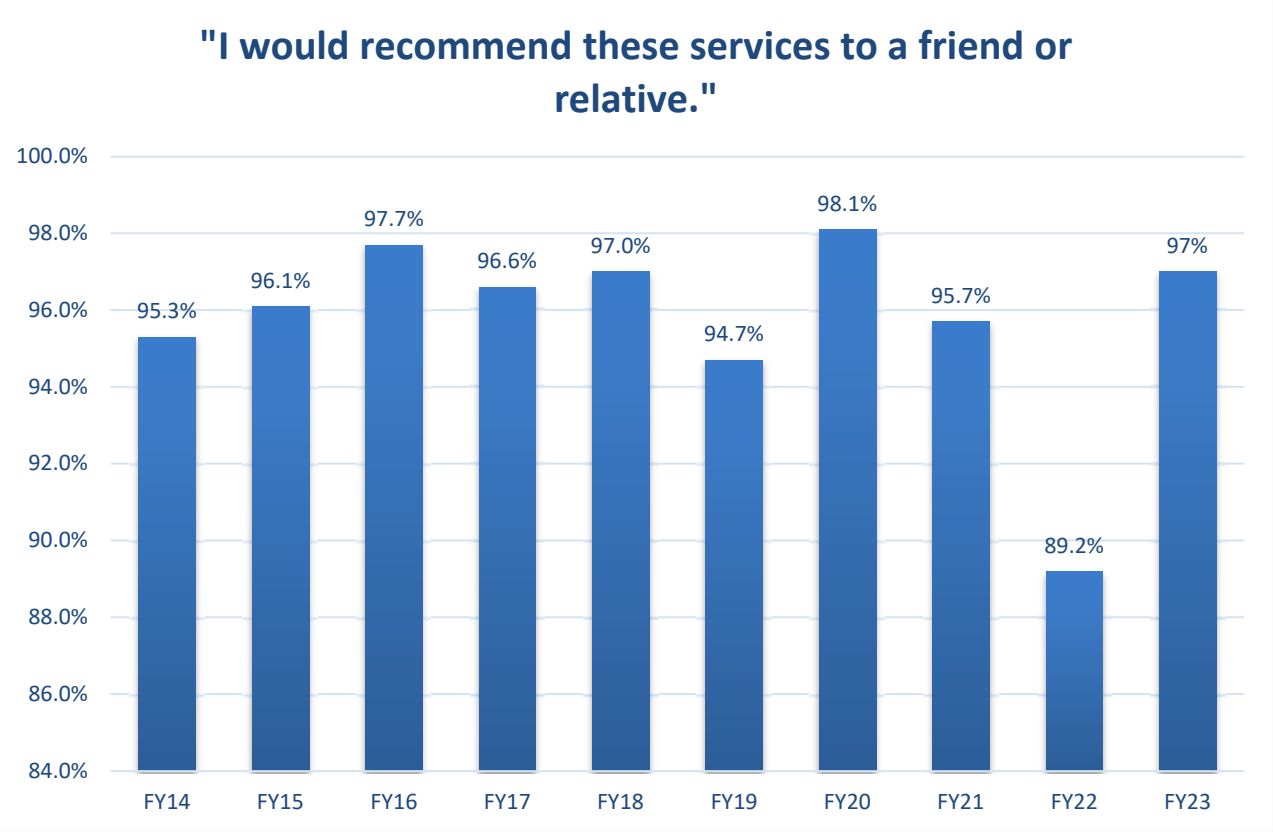
Consumer Satisfaction Survey Report FY 2023

The Consumer Satisfaction Survey Report FY 2023 provides an annual look at the results of the Consumer Satisfaction Survey responses collected throughout the year. Consumers who have had an IPOS meeting or have been discharged from services receive a follow-up satisfaction survey. Surveys are mailed monthly, and the results are summarized and presented for review in an annual report. This report is distributed to the Board of Directors, all program areas, and the Consumer Advisory Committee and is made available to staff and consumers throughout the agency. It is also mailed to various community agencies and is available on the Agency's website at www.cccmh.org.

Customer Services

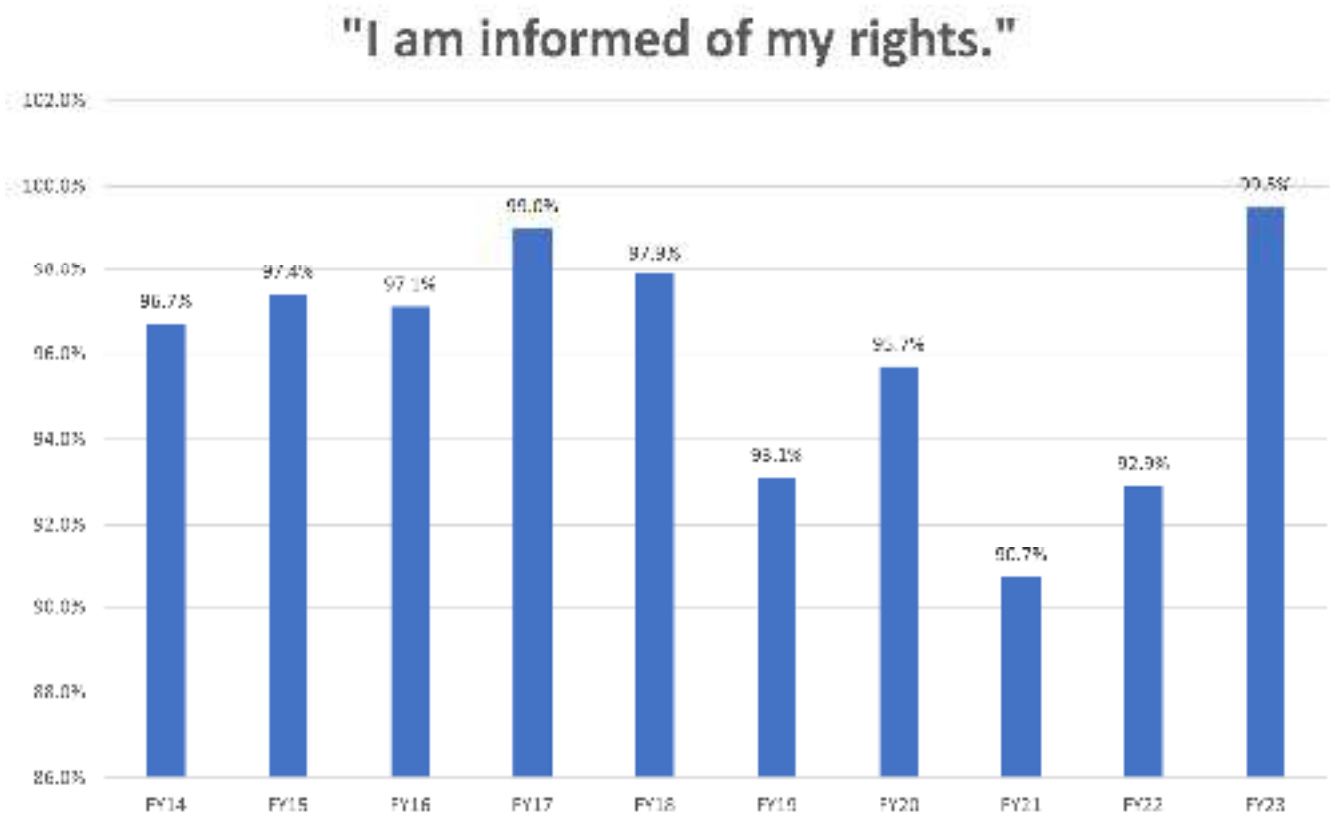
Customer Services' goal for quality improvement is to ensure that consumers are satisfied with the services they receive. The objective that measures this is a 95% overall satisfaction (agree or strongly agree) with the following statement, "I would recommend these services to a friend or relative" which is question #15 on the Consumer Satisfaction Survey. In FY 2023 Customer Services received a satisfaction rate of 97%, an increase from FY 2022.

The following chart illustrates the results of this objective over the past 10 fiscal years.



Recipient Rights Satisfaction

Consumer satisfaction with recipient rights is measured by question two on the Consumer Satisfaction Survey. The overall rate of satisfaction expressed by consumers in FY 23 was 99.5%, an increase from the previous year which was 92.9%.



Office of Recipient Rights

The Office of Recipient Rights received Eighty-one allegations. There were seventy-four investigations and seven interventions. Fifty-one investigations and one intervention. were substantiated by the Recipient Rights Office. There was one allegation with no code-protected rights involved and seven allegations that were out of the authority of the Rights Office.

Risk Management

The Risk Management Committee provides a quarterly report regarding finance and risk management to the Quality Improvement Committee. With the use of a Risk Assessment Grid the committee monitors identified risk areas for their likelihood of occurrence, severity of risk, and financial as well as non-financial costs. The Risk Categories include Utilization Management, Environmental Safety, Human Resources, Sub-Contracts, HIPAA Security/Privacy, Finance, Consumer Risks, Clinical Documentation, and Accreditation/External Audits. The committee also

serves as an oversight committee for review of sentinel events and corporate compliance. Issues that have a risk of potential loss exposure are brought to the committee for review, discussion, and recommendation. The Committee meets quarterly, and all Risk Categories are reviewed at least once during the year.

Event Monitoring

Event monitoring and reporting involves the review of every incident report submitted by staff over the course of a year. MDHHS provides the definition of what constitutes sentinel events, critical incidents, and risk events. A small percentage of these incidents are serious enough in nature that they are reported to NorthCare and MDHHS and depending upon their severity, are investigated using a process called a Root Cause Analysis. The QI Committee, the Behavior Treatment Committee and the Safety Committee continue to monitor various incidents for patterns and/or trends. Training for staff and pro-active strategies are implemented, as needed, to assist in the decrease of incidents. In January 2015, all Upper Peninsula CMHs began using a system in our electronic medical record for submitting incident reports and "coding" the type of incidents that occur.

Of the 1592 incidents reported this fiscal year, twenty-two were defined as sentinel events, twenty-four as critical events and thirty-three as risk events. Some events fall into more than one category, i.e., a critical event may also be classified as a sentinel event.

	1Q	**2Q**	**3Q**	**4Q**	**Total**
Sentinel Events	3	6	10	3	22
Critical Events	7	8	7	2	24
Risk Events	1	8	15	9	33
Incident Reports	390	519	387	296	1592

Outcomes Measures

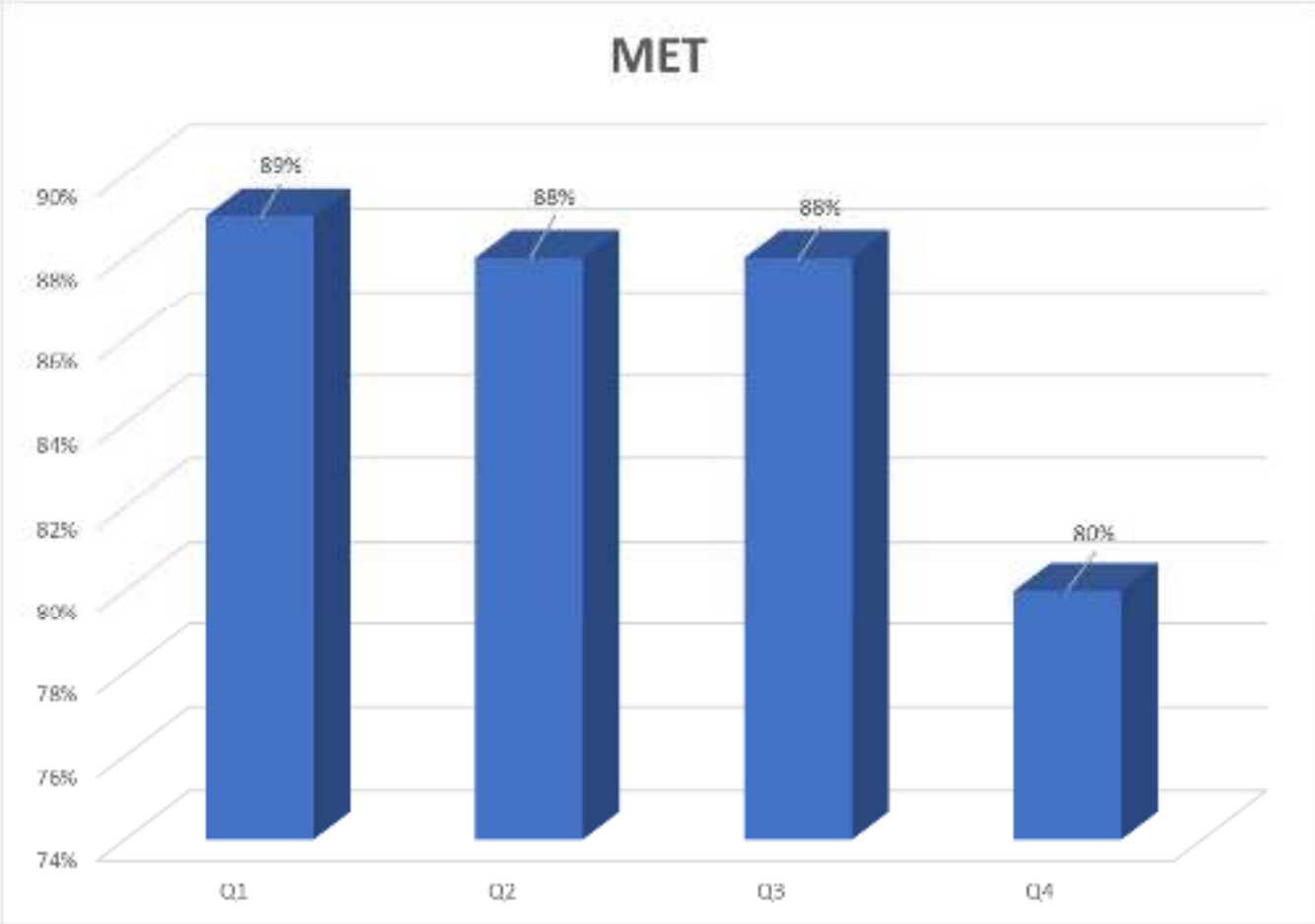
Outcomes data were collected and reported to the Quality Improvement Committee through the 4th quarter of FY 2023. Program supervisors continue to report to the QI Committee on these outcomes on a quarterly basis. Some of the Outcome Measures are a way for the Program Managers to get feedback from those consumers and Parents/Guardians who use those programs. This allows those programs to better understand what is working and what isn't. The results of all those programs by quarter are available in the table beginning on page eight.

Quality Record Reviews

The supervisor of each clinical program completes a review of one record per quarter for each of the clinicians they supervise. The records reviewed are chosen randomly, and the supervisor uses a CCMHS

documentation review form to conduct the review. Not every standard is applicable for each record reviewed.

For the 1st quarter, 15 reviews were completed with a review of 372 standards; 14 reviews were completed in the 2nd quarter with a total of 334 standards; 16 reviews were completed in the 3rd quarter with a total of 387 standards, and in the 4th quarter, 18 reviews were completed with a total of 450 standards. The graph below displays the rate of compliance in completing required documentation measured by the review form.



Michigan Mission-Based Performance Indicators

CCMHS reports performance indicator data relevant to statewide monitoring to NorthCare and MDHHS; this data measures timeliness of inpatient screening, initial assessment, and services; inpatient recidivism, and continuity of care after psychiatric hospitalization. The indicators are reported on a quarterly basis to the QI committee, and they are a reporting requirement by the State. The table beginning on page ten illustrates the quarterly data sent to the state and monitored internally by the Quality Improvement Committee. Although CCMHS occasionally does not meet an indicator goal, it is often due to factors for which there is little control, and this can unfavorably skew the results. See page seven for the MBPIS measures for FY2023.

Calls for After Hours Service

In FY2023, the Michigan Crisis and Assessment Line (MiCAL) reported 1354 encounters. MiCal continues to have problems gathering and reporting data. CCMH believes this number to be significantly higher than the 1354 reported for reasons including omission of 988 calls and lack of identifying affiliated CMH for some calls. CCMH is in the process of transitioning from MiCAL to a private call service, Protocol. This change was explored by Northcare for the Upper Peninsula region and is currently expected to go live on March 4th, 2024. CCMH continues to contract with Pathways CMH for the provision of after-hours preadmission and crisis intervention screenings.

In Summary

Overall, CCMHS has met the objectives set forth in the Quality Improvement Plan for 2023 and is pleased to present this summary to its Board of Directors, staff, and stakeholders. As stated earlier in this document, this annual report focuses on highlights from the Quality Improvement Committee and is only a summary of those areas covered. This report is a highlight but does not fully encompass all the ways that CCMHS works towards improving the lives of our consumers and our community. For additional information about quality improvement projects and results, please feel free to contact the staff of CCMHS for additional reports and information.

MICHIGAN'S MISSION-BASED PERFORMANCE INDICATORS					
		FY2023			
		1Q23	2Q23	3Q23	4Q23
1	**Indicator #1** **Table 1: Access - Timeliness/Inpatient Screening**	33	57	51	19
1a	# of Children Pre-Admin Screen w/in 3 hrs	3	15	14	1
	Total # of Children Pre-Admin Screen	3	15	14	1
	95% is the standard	**100.00%**	**100.00%**	**100.00%**	**100.00%**
1b	# of Adults Pre-Admin Screen w/in 3 hrs	30	42	37	18
	Total # of Adults Pre-Admin Screen	30	42	37	18
	95% is the standard	**100.00%**	**100.00%**	**100.00%**	**100.00%**
2	**Indicator #2** **Table 2: Timeliness/First Request**	78	94	94	78
2a	MI - C - Initial Assmnt. w/in 14 days of 1st Request	11	16	15	9
	Total MI - C - Initial Assmnt. Following 1st Request	20	23	26	20
		55.00%	**69.57%**	**57.69%**	**45.00%**
2b	MI - A - Initial Assmnt. w/in 14 days of 1st Request	28	37	26	35
	Total MI - A - Initial Assmnt. Following 1st Request	50	59	53	53
		56.00%	**62.71%**	**49.06%**	**66.04%**
2c	DD - C - Initial Assmnt. w/in 14 days of 1st Request	4	3	5	2
	Total DD - C - Initial Assmnt. Following 1st Request	5	6	9	2
		80.00%	**50.00%**	**55.56%**	**100.00%**
2d	DD - A - Initial Assmnt. w/in 14 days of 1st Request	2	4	3	2
	Total DD -A - Initial Assmnt. Following 1st Request	3	6	6	3
		66.67%	**66.67%**	**50.00%**	**66.67%**
3	**Indicator #3** **Timeliness/First Service**	55	58	58	57
3a	MI-C - Start Service w/in 14 days of Assmnt	11	11	11	9
	Total MI-C - Start Service	16	14	19	15
		68.75%	**78.57%**	**57.89%**	**60.00%**
3b	MI-A - Start Service w/in 14 days of Assmnt	21	33	27	30
	Total MI-A - Start Service	37	40	33	41
		56.76%	**82.50%**	**81.82%**	**73.17%**
3c	DD-C - Start Service w/in 14 days of Assmnt	3	2	4	1
	Total DD-C - Start Service	5	4	6	3
		60.00%	**50.00%**	**66.67%**	**33.33%**
3d	DD-A - Start Service w/in 14 days of Assmnt	2	2	2	1
	Total DD-A - Start Service	2	4	6	1
		100.00%	**50.00%**	**33.33%**	**100.00%**
	Indicator #4 **Continuity of Care - Follow-up Psych Inpatient**	16	18	17	7
4a(1)	# of Children Seen w/in 7 Days After Discharge	2	1	2	0
	# of Children Discharged	2	3	3	0
	95% is the standard	**100.00%**	**33.33%**	**66.67%**	**#DIV/0!**
4a(2)	# of Adults Seen w/in 7 Days After Discharge	10	13	8	7
	# of Adults Discharged	14	15	14	7
	95% is the standard	**71.43%**	**86.67%**	**57.14%**	**100.00%**
	Indicator #10 **Outcome:Inpatient Recidivism**	25	20	23	9
10a	# of Children Discharged	6	5	4	0
	# of Children Re-admitted w/in 30 Days	1	0	0	0
	15% or less is the standard	**16.67%**	**0.00%**	**0.00%**	**#DIV/0!**
10b	# Adults Discharged	19	15	19	9
	# Adults Re-admitted w/in 30 Days	0	2	2	0
	15% or less is the standard	**0.00%**	**13.33%**	**10.53%**	**0.00%**

	OUTCOME MEASURES		FY 2023			
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
ACT/IDDT #1	Percentage of consumers remaining free from psychiatric hospitalization.	**90%**	**93%**	**88%**	**88%**	**96%**
ACT/IDDT #2	Percentage of consumers remaining free from arrest and/or prosecution.	**90%**	**82%**	**84%**	**96%**	**96%**
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
Acute Services #1	% of consumers screened by CCMH w/out psychiatric admission to hospital.	**60%**	**69%**	**70%**	**63%**	**73%**
Acute Services #2	% of consumers not re-hospitalized for at least 30 days post hospital discharge.	**90%**	**93%**	**94%**	**88%**	**100%**
Acute Services #3	% of preadmission screens completed in 3 hours or less.	**95%**	**100%**	**100%**	**100%**	**100%**
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
BRAVO #1	% of consumers and guardian's satisfaction surveys with average results of 4.00 or better	**90%**	**100%**	**100%**	**0%**	**100%**
BRAVO #2	% of consumers who report accomplishing something important during the past year	**80%**	**100%**	**100%**	**75%**	**100%**
BRAVO #3	% of consumers and guardians who report visits are on time “almost always” or “usually”	**90%**	**100%**	**100%**	**100%**	**100%**
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
Case Management #1	% of consumers receiving TCM or SC services who have an IPOS completed within 365 days of the last service plan.	**100%**	**93%**	**100%**	**89%**	**92%**
Case Management #2	% of consumers receiving a copy of their plan within 15 days of the plan date.	**100%**	**93%**	**75%**	**78%**	**100%**
Case Management #3	% of consumers who receive clinical assessment within 14 days of referral for CSM services.	**100%**	**80%**	**67%**	**89%**	**100%**
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
Clubhouse #1	Percent of members who report that Clubhouse has increased the quality of their lives.	**95%**	**100%**	**100%**	**100%**	**100%**
Clubhouse #3	Percent of members in supported employment.	**30%**	**50%**	**50%**	**50%**	**50%**
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
Community Supports #1	% of consumers receiving orientation to CSP services within seven (7) days of referral date OR first date of service.	**90%**	**100%**	**100%**	**100%**	**100%**
Community Supports #2	% of consumers maintaining/decreasing the frequency of medication deliveries or assistance with medications.	**90%**	**100%**	**96%**	**90%**	**94%**
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
ID Group Homes #1	% of satisfaction surveys with average results of 4.0 or better.	**90%**	**100%**	**100%**	**100%**	**100%**
ID Group Homes #2	% of consumers who report at least 2 community activities per week.	**80%**	**100%**	**100%**	**100%**	**100%**

ID Group Homes #3	% of guardians/consumers who report being satisfied with safety.	100%	100%	100%	100%	100%
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
EBP #1	% of adult consumers with a MI diagnosis receiving Peer Support Specialist services; quarterly	2%	0.8%	1.3%	1.6%	n/a
EBP #2	% of consumers receiving integrated treatment.	25%	15%	15%	23%	28%
EBP #3	% of consumers receiving Supported Employment services	5%	1.6%	5.2%	6.2%	4.1%
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
Outpatient #1	% of children that improve as measured by the Child & Adolescent Functional Assessment Scale	40%	58%	54%	41%	54%
Outpatient #2	Review of Unsigned Documents Queue and Calendar	90%	85%	90%	93%	96%
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
Skill Building Programs #1	% of people who encounter new experiences	95%	100%	100%	100%	100%
Skill Building Programs #2	% of people making money through paid skill building activities	80%	100%	81%	76%	60%
Skill Building Programs #3	% of workers' wages covered by Onto Car Wash	100%	112%	83%	119%	106%
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
Supports Coordination #1	% of consumer and guardian Satisfaction Surveys with average results of 4.00 or better.	90%	100%	94%		On leave
Supports Coordination #2	% of consumers who report accomplishing something important during the past year.	80%	100%	91%		
Supports Coordination #3	% of consumers who begin to receive services within 14 calendar days of intake appointment.	100%	100%	100%		
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
Vocational Services #1	% of consumers who complete the MRS application within 30 days of received referral.	100%	8%	75%	84%	100%
Vocational Services #2	% of consumers employed at least 90 days.	90%	66%	100%	100%	100%