**COPPER COUNTRY MENTAL HEALTH SERVICES ANNUAL QUALITY IMPROVEMENT REPORT**

**FY 2016**

**Introduction**

Copper Country Mental Health Services (CCMHS) focuses on improving the quality of our services and identifying processes that could be improved upon and/or changed throughout the Agency by participating in many 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 so that it can be used to monitor, evaluate, and improve 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, Human Resources Coordinator, Rights Officer/Customer Services Coordinator, Finance Director, Human Resources Director, Medical Director, IT Director, 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, ad hoc subcommittees are developed as necessary to address issues that arise.

The QI Program is integrated into all services provided by the Board 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 Management Committee, the Safety Committee, the Recipient Rights Advisory Committee, the Consumer Advisory Committee, the Risk Management Committee, Safety Committee, and the Infection Control Committee. With information from across the Agency and the community, the 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 on QI teams and review QI reports. Input is sought through advisory committees, focus groups, suggestions boxes, ongoing feedback to clinicians, availability of a Customer Services Coordinator, the annual Consumer Satisfaction Survey, and the bi-annual Stakeholder Survey.

This annual report focuses on highlights from the Quality Improvement 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 Committee is presented to the Board and distributed to supervisors. CCMHS also publishes other performance reports, such as the Annual Report to the Community and the Consumer Satisfaction Survey Report, which are also distributed to the board of directors, management, supervisors, stakeholders, and persons served.

**HIGHLIGHTS IN FY 16**

**Customer Services**

Customer Service’s goal for quality improvement is to ensure that customers 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” question #10 on the consumer satisfaction survey. In FY 2016 Customer Services met and exceeded this goal once again with a satisfaction rate of 97.7 %, an increase over FY 15.

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

**Consumer Satisfaction Survey Report FY 2016**

The Consumer Satisfaction Survey Report FY 2016 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, all program areas, the consumer advisory group 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.

**Recipient Rights Satisfaction**

Consumer satisfaction with recipient rights is measured by question #2 on the Consumer

Satisfaction Survey. The overall rate of satisfaction expressed by consumers in FY 16 was

97.1%, slightly lower than the previous year.

**Office of Recipient Rights**

The Office of Recipient Rights received forty–two (42) allegations. There were thirty-one (31) investigations and three (3) interventions. Twenty (20) investigations resulted in substantiations of the allegations. There were three (3) allegations with no code protected rights involved and five (5) allegations that were out of the jurisdiction of the Rights Office. Twenty-three (23) of the allegations came from consumers.

**Risk Management**

The Risk Management Committee brings issues and recommendations 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, Accreditation/External Audits, and Accessibility to Services. The committee also monitors recipient rights activities and 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 were reviewed 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 583 incidents reported this fiscal year, 1 was defined as a sentinel event, 11 as critical events and 7 as risk events. Some events fall into more than one category, i.e., a sentinel event may also be classified as a critical event.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | 1Q | 2Q | 3Q | 4Q | Total |
| Sentinel Events | 0 | 0 | 1 | 0 | 1 |
| Critical Events | 6 | 0 | 3 | 2 | 11 |
| Risk Events | 5 | 0 | 0 | 2 | 7 |
| Incident Reports | 152 | 117 | 162 | 152 | 583 |

**Outcomes Management**

Outcomes data were collected and reported to the Quality Improvement Committee through

the 4th quarter of FY 2016. Program supervisors will continue to report on these outcomes to the QI Committee on a quarterly basis. The results are included in the table beginning on page 7.

**Quality Record Reviews**

The supervisor of each clinical program completes a review of one record for each of the clinicians they supervise. The records are chosen randomly and the supervisor uses the NorthCare Documentation Review form to conduct the review. This chart illustrates the percentage of standards that were met for FY 2016. For the 1st quarter, 17 reviews were completed with a review of 378 standards; 18 reviews were completed in the 2nd quarter with a total of 396 standards; 15 reviews with 321 standards were completed in the 3rd quarter, and finally, 18 reviews were completed in the 4th quarter with 410 standards. The graph below represents the improvement that is being made in required documentation.

**Michigan Mission-Based Performance Indicators**

CCMHS reports performance indicator data relevant to statewide monitoring to NorthCare and MDHHS; this data is tracked on a quarterly basis. The table on page 9 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 generally due to the very small numbers reported, which unfavorably skews our results.

* CCCMHS has not yet received the 4th quarter numbers from the State of Michigan

**CALLS FOR AFTER-HOURS SERVICE**

Another area of interest is the number of calls that are placed during non-business hours to Gryphon Place, the agency that holds the contract to provide after-hours support to consumers and dispatching of emergency services workers in the Upper Peninsula Region. The graph below indicates that overall, calls for after-hours assistance decreased in FY 2016 as compared to FY 2015.

**In Summary**

Overall, CCMHS has met the objectives set forth in the Quality Improvement Plan for 2016 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 some of the areas that are monitored and reported upon throughout the year. For additional information on quality improvement projects and results, please feel free to contact the staff of CCMHS for additional reports and information.





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| --- | --- | --- | --- | --- | --- | --- |
| **MICHIGAN'S MISSION-BASED PERFORMANCE INDICATORS** | | | | | | |
| **FY 2016** | | | | | | |
|  |  | **4Q15** | **1Q16** | **2Q16** | **3Q16** | **4Q16** |
|  |  |  |  |  |  |  |
| 1 | **Indicator #1 Table 1: Access - Timeliness/Inpatient Screening** | 41 | 35 | 45 | 43 |  |
| 1a | # of Children Pre-Admin Screen w/in 3 hrs | 3 | 2 | 13 | 8 |  |
|  | Total # of Children Pre-Admin Screen | 3 | 2 | 13 | 8 |  |
|  | **95% is the standard** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** |
| 1b | # of Adults Pre-Admin Screen w/in 3 hrs | 38 | 33 | 32 | 35 |  |
|  | Total # of Adults Pre-Admin Screen | 38 | 33 | 32 | 35 |  |
|  | **95% is the standard** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** |
|  |  |  |  |  |  |  |
| 2 | **Indicator #2 Table 2: Timeliness/First Request** | 34 | 40 | 34 | 46 |  |
| 2a | MI - C - Initial Assmnt. w/in 14 days of 1st Request | 3 | 15 | 7 | 19 |  |
|  | Total MI - C - Initial Assmnt. Following 1st Request | 3 | 15 | 7 | 19 |  |
|  | **95% is the standard** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** |
| 2b | MI - A - Initial Assmnt. w/in 14 days of 1st Request | 27 | 14 | 23 | 26 |  |
|  | Total MI - A - Initial Assmnt. Following 1st Request | 27 | 14 | 23 | 26 |  |
|  | **95% is the standard** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** |
| 2c | DD - C - Initial Assmnt. w/in 14 days of 1st Request | 4 | 7 | 2 | 0 |  |
|  | Total DD - C - Initial Assmnt. Following 1st Request | 4 | 7 | 2 | 0 |  |
|  | **95% is the standard** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** |
| 2d | DD - A - Initial Assmnt. w/in 14 days of 1st Request | 0 | 4 | 2 | 1 |  |
|  | Total DD -A - Initial Assmnt. Following 1st Request | 0 | 4 | 2 | 1 |  |
|  | **95% is the standard** | **NA** | **100.00%** | **100.00%** | **100.00%** | **100.00%** |
|  |  |  |  |  |  |  |
| 3 | **Indicator #3 Timeliness/First Service** | 22 | 23 | 20 | 31 |  |
| 3a | MI-C - Start Service w/in 14 days of Assmnt | 2 | 10 | 6 | 13 |  |
|  | Total MI-C - Start Service | 1 | 9 | 6 | 13 |  |
|  | **95% is the standard** | **50.00%** | **90.00%** | **100.00%** | **100.00%** | **100.00%** |
| 3b | MI-A - Start Service w/in 14 days of Assmnt | 17 | 8 | 11 | 16 |  |
|  | Total MI-A - Start Service | 17 | 8 | 11 | 15 |  |
|  | **95% is the standard** | **100.00%** | **100.00%** | **100.00%** | **93.75%** | **100.00%** |
| 3c | DD-C - Start Service w/in 14 days of Assmnt | 2 | 3 | 0 | 0 |  |
|  | Total DD-C - Start Service | 2 | 3 | 0 | 0 |  |
|  | **95% is the standard** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** |
| 3d | DD-A - Start Service w/in 14 days of Assmnt | 1 | 2 | 3 | 2 |  |
|  | Total DD-A - Start Service | 1 | 2 | 3 | 2 |  |
|  | **95% is the standard** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MICHIGAN'S MISSION-BASED PERFORMANCE INDICATORS (CONT’D)** | | | | | | | | | | | | |
| **FY 2016** | | | | | | | | | | | | |
|  |  | | **4Q15** | **1Q16** | **2Q16** | | | **3Q16** | | | **4Q16** | |
|  |  | |  |  |  | | |  | | |  | |
|  | | **Indicator #4 Continuity of Care - Follow-up Psych Inpatient** | | | |  |  | |  |  | |  |
| 4a(1) | | # of Children Seen w/in 7 Days After Discharge | | | | 2 | 2 | | 2 | 3 | |  |
|  | | # of Children Discharged | | | | 2 | 2 | | 2 | 3 | |  |
|  | | **95% is the standard** | | | | **100.00%** | **100.00%** | | **100.00%** | **100.00%** | | **100.00%** |
| 4a(2) | | # of Adults Seen w/in 7 Days After Discharge | | | | 8 | 5 | | 6 | 5 | |  |
|  | | # of Adults Discharged | | | | 8 | 5 | | 6 | 5 | |  |
|  | | **95% is the standard** | | | | **100.00%** | **100.00%** | | **100.00%** | **100.00%** | | **100.00%** |
|  | |  | | | |  |  | |  |  | |  |
|  | | **Indicator #10 Outcome:Inpatient Recidivism** | | | |  |  | |  |  | |  |
| 10a | | # of Children Discharged | | | | 2 | 2 | | 3 | 3 | |  |
|  | | # of Children Re-admitted w/in 30 Days | | | | 0 | 0 | | 0 | 0 | |  |
|  | | **15% or less is the standard** | | | | **0.00%** | **0.00%** | | **0.00%** | **0.00%** | | **0.00%** |
| 10b | | # Adults Discharged | | | | 10 | 6 | | 6 | 7 | |  |
|  | | # Adults Re-admitted w/in 30 Days | | | | 3 | 0 | | 1 | 1 | |  |
|  | | **15% or less is the standard** | | | | **30.00%** | **0.00%** | | **16.67%** | **14.29%** | | **100.00%** |