COPPER COUNTRY MENTAL HEALTH SERVICES
ANNUAL QUALITY IMPROVEMENT REPORT
FY 2018

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 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, 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 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 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.

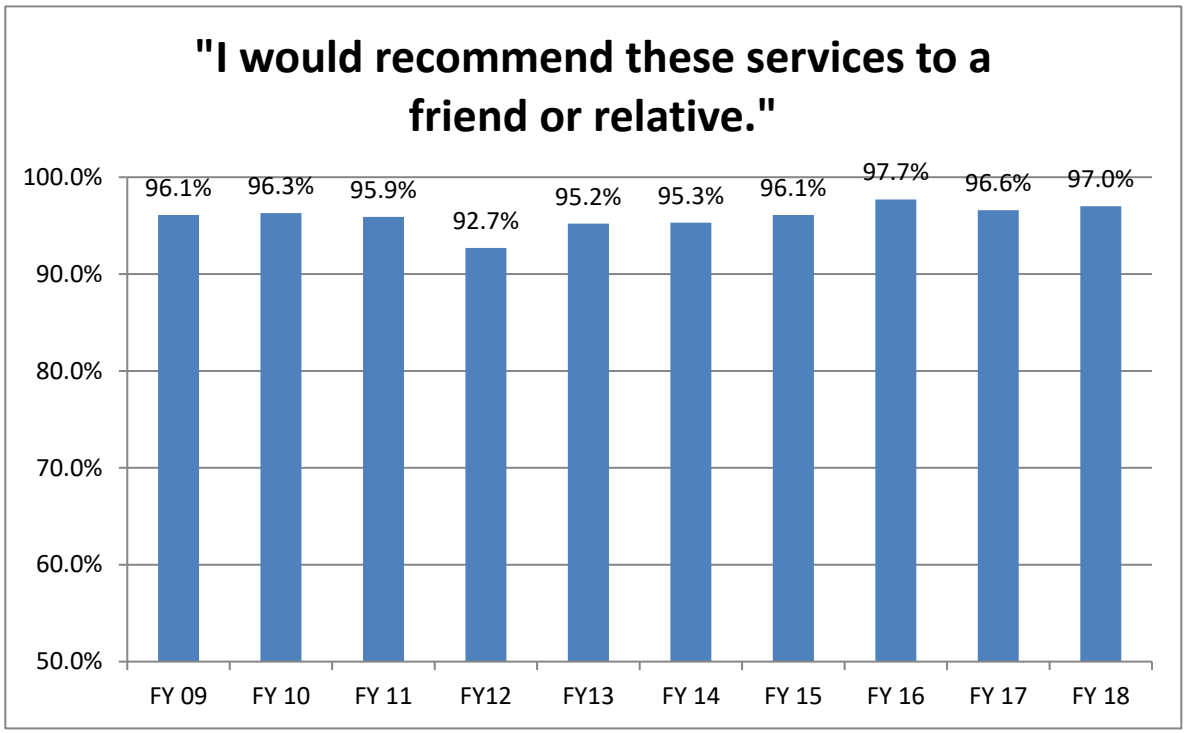
This annual report focuses on highlights from the Quality Improvement Committee and is only a summary of some of the areas that are monitored and reported upon throughout the year. A quarterly report which details the activities of the Committee is presented to the Board and distributed to supervisors. 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 18

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 2018 Customer Services exceeded this goal once again with a satisfaction rate of 97 %, a slight increase from FY 17.

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

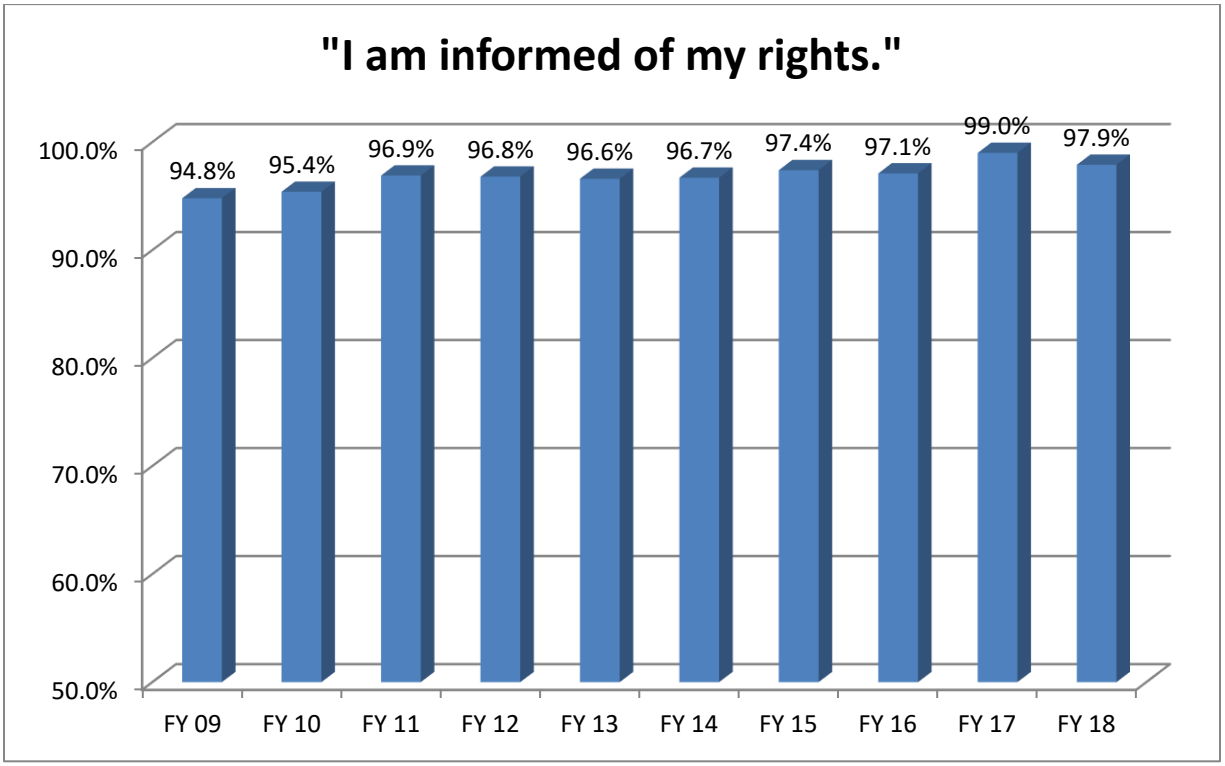


Consumer Satisfaction Survey Report FY 2018

The Consumer Satisfaction Survey Report FY 2018 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 18 was 97.8%, a decrease from the previous year which was 99%.



Office of Recipient Rights

The Office of Recipient Rights received sixty-two (62) allegations. There were fifty-one (51) investigations and six (6) interventions. To date, seventeen (17) investigations and one (1) intervention resulted in substantiations of the allegations. There were two (2) allegations with no code protected rights involved and three (3) allegations that were out of the jurisdiction of the Rights Office. Sixteen (16) 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 878 incidents reported this fiscal year, 8 were defined as sentinel events, 23 as critical events and 5 as risk events. Some events fall into more than one category, i.e., a sentinel event may also be classified as a critical event.

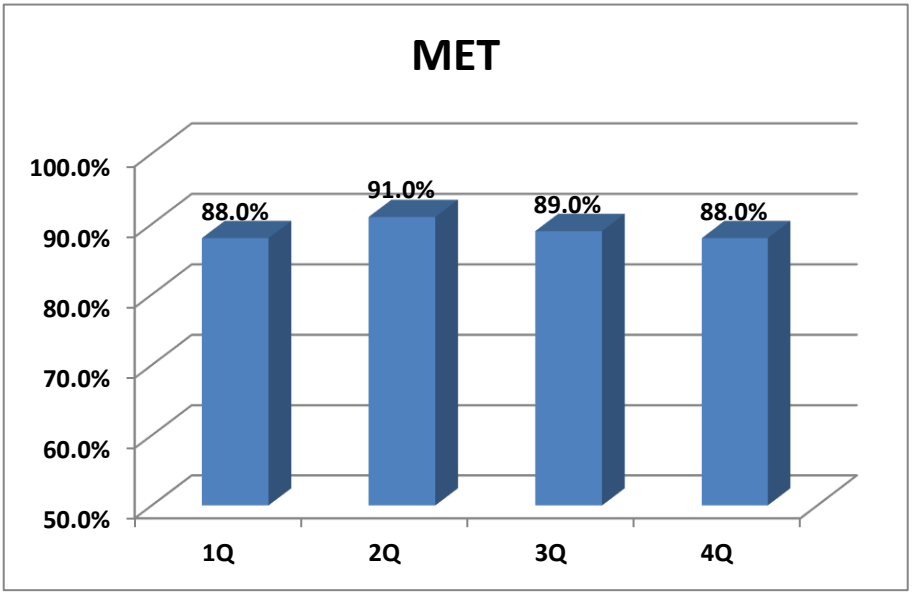
	1Q	2Q	3Q	4Q	Total
Sentinel Events	3	2	1	2	8
Critical Events	9	6	4	4	23
Risk Events	1	2	1	1	5
Incident Reports	263	166	218	231	878

Outcomes Measures

Outcomes data were collected and reported to the Quality Improvement Committee through the 4th quarter of FY 2018. 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 a CCMH documentation review form to conduct the review. This chart illustrates the percentage of standards that were met for FY 2018. For the 1st quarter, 15 reviews were completed with a review of 231 standards; 13 reviews were completed in the 2nd quarter with a total of 212 standards; 19 reviews with 269 standards were completed in the 3rd quarter, and finally, 17 reviews were completed in the 4th quarter with 232 standards. The graph below represents the rate of compliance in completing required documentation measured by the review form.

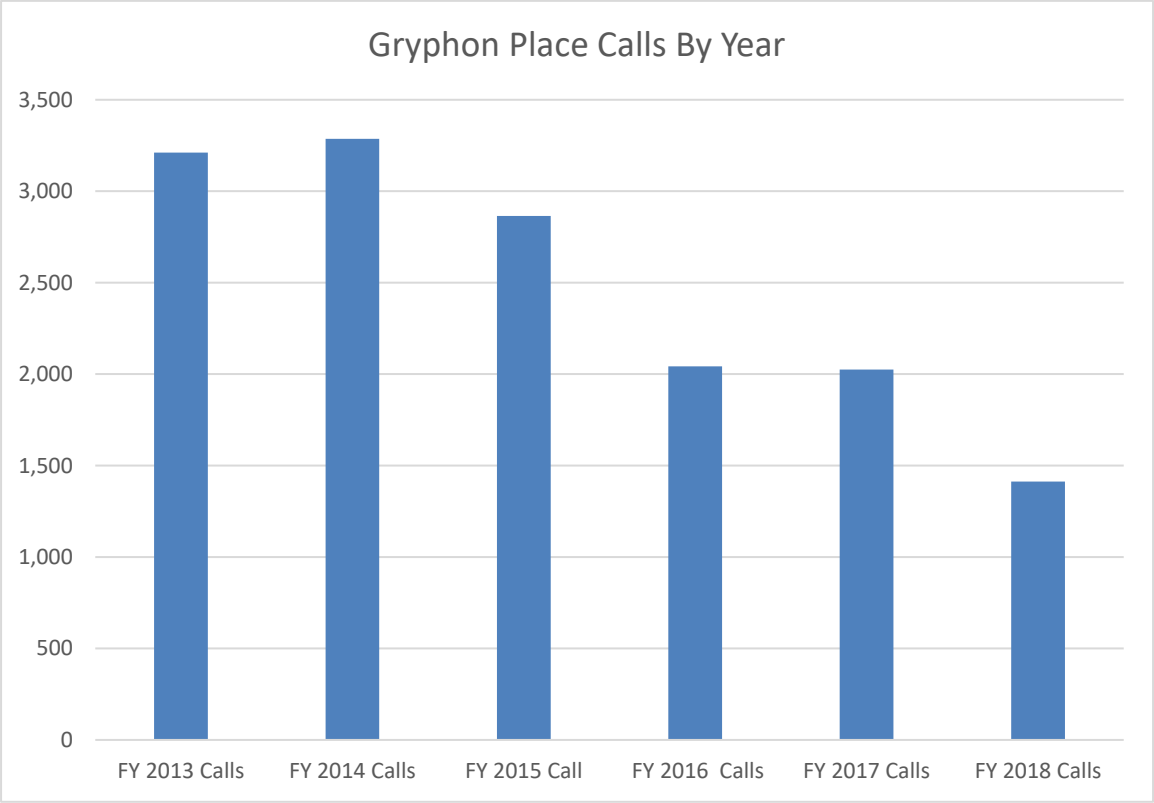


Michigan Mission-Based Performance Indicators

CCMHS reports performance indicator data relevant to statewide monitoring to NorthCare and MDHHS; this data 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.

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 2018, compared to FY2017, continuing the downward trend. FY 2018 was the first full year that the Agency did not complete pre-admission screens for hospitalizations for people who only have private insurance or Medicare.



In Summary

Overall, CCMHS has met the objectives set forth in the Quality Improvement Plan for 2018 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.

OUTCOME MEASURES			FY 2018			
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
ACT/IDDT #1	Percentage of consumers remaining free from psychiatric hospitalization.	**90%**	**100%**	**85%**	**100%**	**92%**
ACT/IDDT #2	Percentage of consumers remaining free from arrest and/or prosecution.	**90%**	**100%**	**100%**	**96%**	**96%**
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
Acute Services #1	% of consumers screened by CCMH w/out psych admit.	**60%**	**71%**	**62%**	**74%**	**78%**
Acute Services #2	% of consumers not re-hospitalized for at least 30 days post hospital discharge.	**90%**	**100%**	**97%**	**96%**	**100%**
Acute Services #3	% of preadmission screens completed in 3 hours or less.	**100%**	**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%**	**0%**	**75%**	**83%**
BRAVO #2	% of consumers who report accomplishing something important during the past year	**80%**	**100%**	**100%**	**100%**	**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%**	**100%**	**100%**	**100%**	**94%**
Case Management #2	% of consumers receiving a copy of their plan within 15 days of the plan date.	**100%**	**100%**	**67%**	**91%**	**100%**
Case Management #3	% of consumers who receive clinical assessment within 14 days of referral for CSM services.	**100%**	**75%**	**100%**	**100%**	**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 #2	Percent of members working in the PSR units to increase production of the “work ordered day”	**80%**	**53%**	**54%**	**54%**	**NA**
Clubhouse #3	Percent of members in supported employment.	**30%**	**38%**	**38%**	**40%**	**63%**
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%**	**33%**	**80%**	**100%**	**100%**
Community Supports #2	% of consumers maintaining/decreasing the frequency of medication deliveries or assistance with medications.	**90%**	**96%**	**95%**	**99%**	**99%**

Program	Measure	Goal	1Q	2Q	3Q	4Q
DD Group Homes #1	% of satisfaction surveys with average results of 4.0 or better.	90%	100%	100%	100%	100%
DD Group Homes #2	% of consumers who report at least 2 community activities per week.	80%	100%	100%	100%	71%
DD 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	3%	2.8%	3.4%	1.9%	2.7%
EBP #2	% of consumers receiving integrated treatment.	50%	52%	56%	75%	65%
EBP #3	% of consumers receiving Supported Employment services	6%	3.7%	3.5%	3.8%	2.8%
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
Outpatient #1	% of children that improve as measured by the Child & Adolescent Functional Assessment Scale	40%	44%	46%	56%	40%
Outpatient #2	Review of Unsigned Documents Queue and Calendar	98%	99%	99%	95%	97%
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
Skill Building Programs #1	% of people who encounter new experiences	95%	87%	100%	92%	94%
Skill Building Programs #2	% of people making money through paid skill building activities	80%	96%	100%	96%	95%
Skill Building Programs #3	% of worker's wages covered by Onto Car Wash	90%	88%	75%	71%	67%
Skill Building Programs #4	ELMER report of CLS vs Skill Building	75%	n/a	42%	160%	49%
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%	88%	88%	86%
Supports Coordination #2	% of consumers who report accomplishing something important during the past year.	80%	88%	96%	100%	95%
Supports Coordination #3	% of consumers who begin to receive services within 14 calendar days of intake appointment.	100%	100%	100%	100%	100%
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
Vocational Services #1	% of consumers enrolled in less than 30 days from referral date.	100%	n/a	100%	83%	75%
Vocational Services #2	% of consumers employed at least 90 days.	90%	91%	93%	100%	100
Vocational Services #3	% discharged that pursue community employment	50%	0%	0%	0%	50%

MICHIGAN'S MISSION-BASED PERFORMANCE INDICATORS						
FY 2018						
		4Q17	1Q18	2Q18	3Q18	4Q18
1	**Indicator #1 Table 1: Access - Timeliness/Inpatient Screening**	**25**	27	36	25	**21**
1a	# of Children Pre-Admin Screen w/in 3 hrs	6	4	5	1	1
	Total # of Children Pre-Admin Screen	6	4	5	1	1
	95% is the standard	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**
1b	# of Adults Pre-Admin Screen w/in 3 hrs	18	23	31	24	20
	Total # of Adults Pre-Admin Screen	19	23	31	24	20
	95% is the standard	**94.70%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**
2	**Indicator #2 Table 2: Timeliness/First Request**	28	40	60	44	62
2a	MI - C - Initial Assmnt. w/in 14 days of 1st Request	12	13	21	8	22
	Total MI - C - Initial Assmnt. Following 1st Request	12	13	21	8	24
	95% is the standard	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**91.67%**
2b	MI - A - Initial Assmnt. w/in 14 days of 1st Request	14	23	35	33	31
	Total MI - A - Initial Assmnt. Following 1st Request	14	23	35	33	31
	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	1	1	0	1	4
	Total DD - C - Initial Assmnt. Following 1st Request	1	1	0	1	4
	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	1	3	4	2	3
	Total DD -A - Initial Assmnt. Following 1st Request	1	3	4	2	3
	95% is the standard	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**
3	**Indicator #3 Timeliness/First Service**	25	30	44	25	49
3a	MI-C - Start Service w/in 14 days of Assmnt	10	12	17	5	14
	Total MI-C - Start Service	11	13	17	5	15
	95% is the standard	**90.90%**	**92.30%**	**100.00%**	**100.00%**	**93.33%**
3b	MI-A - Start Service w/in 14 days of Assmnt	13	15	23	19	26
	Total MI-A - Start Service	13	15	23	19	27
	95% is the standard	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**96.30%**
3c	DD-C - Start Service w/in 14 days of Assmnt	0	1	0	0	2
	Total DD-C - Start Service	0	1	0	0	2
	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	1	4	1	5
	Total DD-A - Start Service	1	1	4	1	5
	95% is the standard	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

MICHIGAN'S MISSION-BASED PERFORMANCE INDICATORS						
FY 2018						
		4Q17	1Q18	2Q18	3Q18	4Q18
	Indicator #4 Continuity of Care - Follow-up Psych Inpatient	8	7	13	5	
4a(1)	# of Children Seen w/in 7 Days After Discharge	2	0	1	1	0
	# of Children Discharged	2	0	1	1	0
	95% is the standard	**100.00%**	**0.00%**	**100.00%**	**100.00%**	**NA**
4a(2)	# of Adults Seen w/in 7 Days After Discharge	6	6	12	4	6
	# of Adults Discharged	6	7	12	4	7
	95% is the standard	**100.00%**	**86.00%**	**100.00%**	**100.00%**	**85.71%**
	Indicator #10 Outcome: Inpatient Recidivism					
10a	# of Children Discharged	3	2	1	1	0
	# of Children Re-admitted w/in 30 Days	0	0	0	1	0
	15% or less is the standard	**0.00%**	**0.00%**	**0.00%**	100.00%	**NA**
10b	# Adults Discharged	7	11	14	12	12
	# Adults Re-admitted w/in 30 Days	0	0	0	0	0
	15% or less is the standard	**0.00%**	**0.00%**	**0.00%**	**0.00%**	0.00%