# COPPER COUNTRY MENTAL HEALTH SERVICES
# ANNUAL QUALITY IMPROVEMENT REPORT
# FY 2021

## Introduction

Copper Country Mental Health Services (CCMHS) focuses on improving the quality of its 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, 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, ad hoc subcommittees are 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 on QI teams and review QI reports. Input is sought through 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.

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 also publishes other performance reports, such as the CCMH Annual Report and the Consumer Satisfaction Survey Report, which are also distributed to the Board of Directors, management, supervisors, stakeholders, and consumers served.

## Consumer Satisfaction Survey Report FY 2021

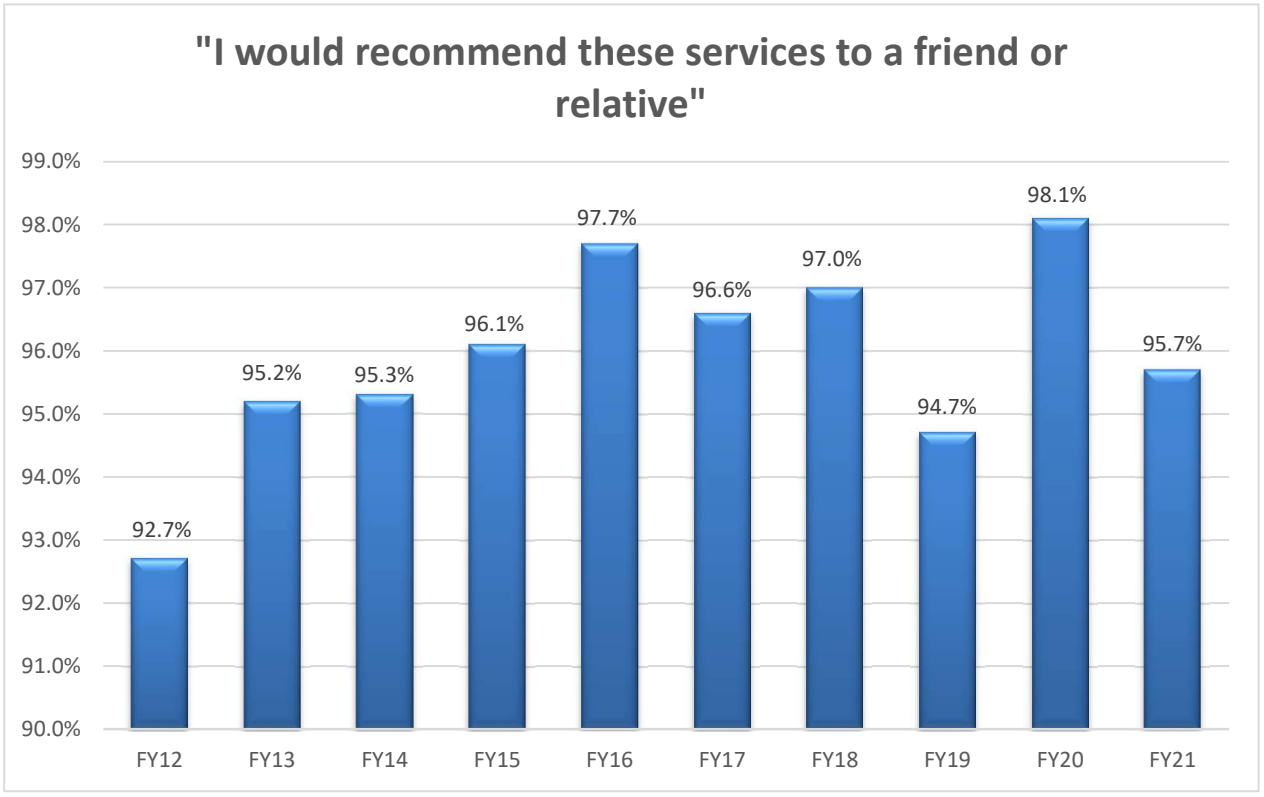
The Consumer Satisfaction Survey Report FY 2021 provides an annual look at the results of the Consumer Satisfaction Survey responses collected throughout the year. Consumers who have had an IPOS meeting or have been discharged from services receive a follow-up satisfaction survey. Surveys are mailed 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, 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. The Overall Consumer Satisfaction rate in FY 2021 was 91.0%, which decreased from the rate of 96.4% in FY 2020.

## HIGHLIGHTS IN FY 21

### Customer Services

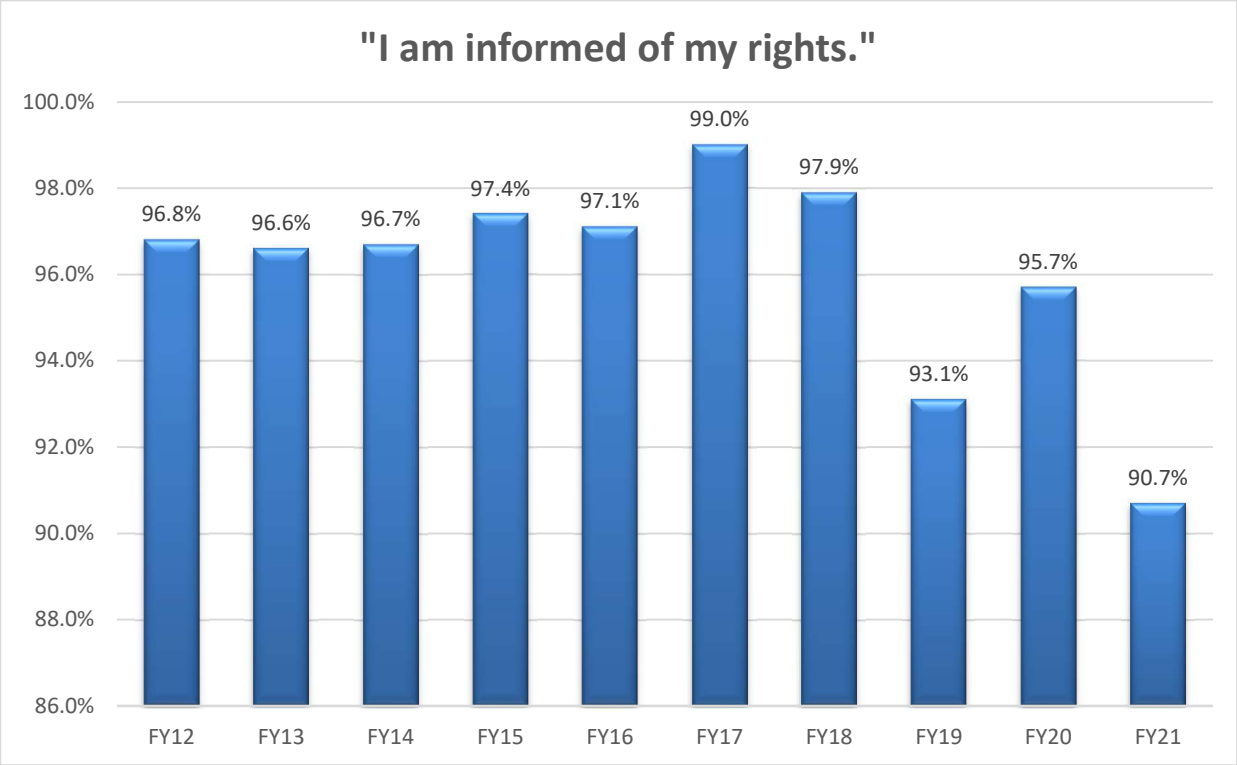
Customer Services' goal for quality improvement is to ensure that consumers are satisfied with the services they receive. The objective that measures this is a 95% overall satisfaction (agree or strongly agree) with the following statement, "I would recommend these services to a friend or relative" which is question #10 on the Consumer Satisfaction Survey. In FY 2021 Customer Services received a satisfaction rate of 94.6% a decrease from FY 2020.

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 21 was 90.7%, a decrease from the previous year which was 95.7%.




## Office of Recipient Rights

The Office of Recipient Rights received fifty-eight allegations. There were forty-six investigations and five interventions. Twenty one investigations and one intervention was substantiated. There was one allegation with no code protected right involved and six allegations that were out of the jurisdiction of the Rights Office. Nine of the allegations were reported by 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 1013 incidents reported this fiscal year, nine were defined as sentinel events, thirty as critical events and seventeen 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 | 1 | 3 | 0 | 5 | 9 |
| Critical Events | 5 | 7 | 9 | 9 | 30 |
| Risk Events | 6 | 3 | 0 | 8 | 17 |
| Incident Reports | 259 | 225 | 247 | 282 | 1013 |

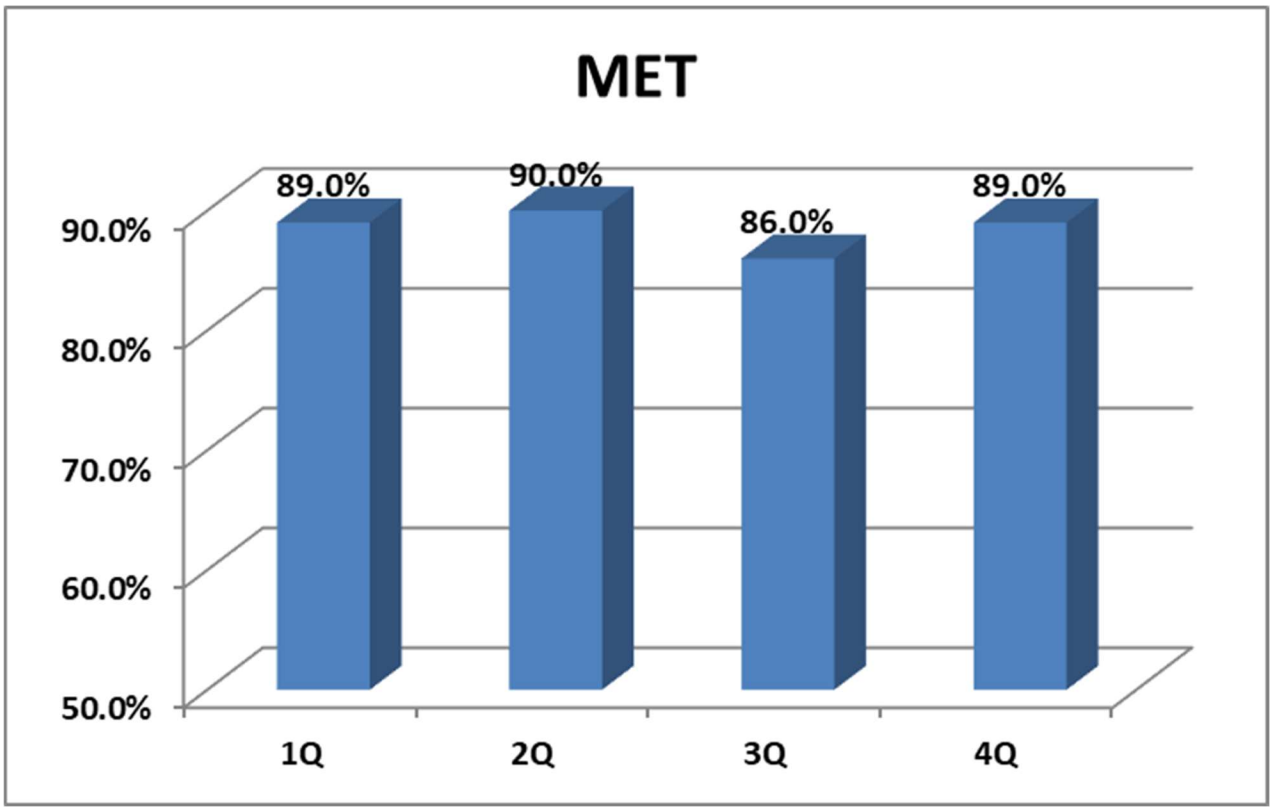
## Outcomes Measures

Outcomes data were collected and reported to the Quality Improvement Committee through the 4th quarter of FY 2021. Program supervisors will continue to report to the QI Committee on these outcomes on a quarterly basis. The results are included in the table beginning on page seven.

## 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 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. In the fourth quarter, at the recommendation of NorthCare, we switched to an updated version of the review form.

For the 1st quarter, 18 reviews were completed with a review of 522 standards; 20 reviews were completed in the 2nd quarter with a total of 525 standards; 20 reviews with 566 standards were completed in the 3rd quarter; and finally, 15 reviews were completed in the 4th quarter with 372 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. This information is tracked on a quarterly basis. 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 generally due to the very small numbers reported, which unfavorably skews our results. Note that performance indicators #2 and #3 changed on April 1, 2020 and the 95% standard is no longer applicable. Before this, we could exclude "exceptions" from the data for these indicators. No exceptions are allowed now, but MDHHS is only collecting data at this time. MDHHS wants to know what the real reason is for individuals not coming to their intake or first appointment and to collect data to get a better standard.

As of this writing, 2/14/2022, we have not received the 4th quarter results from the state. This will be updated when available.

## Calls for After Hours Service

In FY 2021 the provider of after-hours support was changed to the Michigan Crisis and Assessment Line (MiCAL). At this time we do not have data on the number of calls in FY 2021, but we will report them at a later time if they become available. CCMHS continues the practice of not completing pre-admission screens for hospitalizations of people who only have private insurance or Medicare, unless they are current consumers.

## In Summary

Overall, CCMHS has met the objectives set forth in the Quality Improvement Plan for 2021 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 about quality improvement projects and results, please feel free to contact the staff of CCMHS for additional reports and information.

| | OUTCOME MEASURES | | FY 2021 | | | |
|---|---|---|---|---|---|---|
| **Program** | **Measure** | **Goal** | **1Q** | **2Q** | **3Q** | **4Q** |
| ACT/IDDT #1 | Percentage of consumers remaining free from psychiatric hospitalization. | **90%** | **97%** | **93%** | **97%** | **97%** |
| ACT/IDDT #2 | Percentage of consumers remaining free from arrest and/or prosecution. | **90%** | **98%** | **100%** | **100%** | **97%** |
| **Program** | **Measure** | **Goal** | **1Q** | **2Q** | **3Q** | **4Q** |
| Acute Services #1 | % of consumers screened by CCMH w/out psychiatric admission to hospital. | **60%** | **78%** | **65%** | **70%** | **78%** |
| Acute Services #2 | % of consumers not re-hospitalized for at least 30 days post hospital discharge. | **90%** | **92%** | **89%** | **92%** | **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%** | **82%** | **100%** | **100%** | **100%** |
| BRAVO #2 | % of consumers who report accomplishing something important during the past year | **80%** | **25%** | **33%** | **100%** | **78%** |
| BRAVO #3 | % of consumers and guardians who report visits are on time “almost always” or “usually” | **90%** | **67%** | **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%** | **94%** | **100%** | **88%** |
| Case Management #2 | % of consumers receiving a copy of their plan within 15 days of the plan date. | **100%** | **100%** | **94%** | **100%** | **100%** |
| Case Management #3 | % of consumers who receive clinical assessment within 14 days of referral for CSM services. | **100%** | **100%** | **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 #3 | Percent of members in supported employment. | **30%** | **57%** | **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%** | **NA No one was referred** | **100%** | **100%** | **100%** |
| Community Supports #2 | % of consumers maintaining/decreasing the frequency of medication deliveries or assistance with medications. | **90%** | **100.0%** | **98%** | **98%** | **91%** |
| **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% | NA community outings on hold due to COVID. Do go through drive throughs, rides, etc | | | 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 | 3% | 1.4% | 1.6% | 0.4% | 2% |
| EBP #2 | % of consumers receiving integrated treatment. | 50% | 37% | 38% | 32% | 32% |
| EBP #3 | % of consumers receiving Supported Employment services | 6% | 1.9% | 1.7% | 6.10% | 6% |
| **Program** | **Measure** | **Goal** | **1Q** | **2Q** | **3Q** | **4Q** |
| Outpatient #1 | % of children that improve as measured by the Child & Adolescent Functional Assessment Scale | 40% | 60% | 57% | 55% | 49% |
| Outpatient #2 | Review of Unsigned Documents Queue and Calendar | 90% | 97% | 94% | 96% | 93% |
| **Program** | **Measure** | **Goal** | **1Q** | **2Q** | **3Q** | **4Q** |
| Skill Building Programs #1 | % of people who encounter new experiences | 95% | No Data due to Covid 19 | 71% | 100% | 100% |
| Skill Building Programs #2 | % of people making money through paid skill building activities | 80% | | 100% | 89% | 86% |
| Skill Building Programs #3 | % of workers wages covered by Onto Car Wash | 100% | | 100% | 118% | 123% |
| **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% | 81% | 96% | 86% | 100% |
| Supports Coordination #2 | % of consumers who report accomplishing something important during the past year. | 80% | 60% | 90% | 82% | 84% |
| Supports Coordination #3 | % of consumers who begin to receive services within 14 calendar days of intake appointment. | 100% | n/a | n/a | 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% | No Data due to Covid 19 | 89% | 92% | 100% |
| Vocational Services #2 | % of consumers employed at least 90 days. | 90% | | 98% | 75% | 100% |
| Vocational Services #3 | % discharged that pursue community employment | 50% | | No Data due to Covid 19 | | |

**MICHIGAN'S MISSION-BASED PERFORMANCE INDICATORS**

| | | | FY 2021 | |
|---|---|---|---|---|
| | | 1Q21 | 2Q21 | 3Q21 |
| | | | | |
| 1 | **Indicator #1 Table 1: Access - Timeliness/Inpatient Screening** | 13 | 30 | 30 |
| 1a | # of Children Pre-Admin Screen w/in 3 hrs | 2 | 6 | 11 |
| | Total # of Children Pre-Admin Screen | 2 | 6 | 11 |
| | **95% is the standard** | **100.00%** | **100.00%** | **100.00%** |
| 1b | # of Adults Pre-Admin Screen w/in 3 hrs | 11 | 24 | 19 |
| | Total # of Adults Pre-Admin Screen | 11 | 24 | 19 |
| | **95% is the standard** | **100.00%** | **100.00%** | **100.00%** |
| | | | | |
| 2 | **Indicator #2 Table 2: Timeliness/First Request** | 54 | 73 | 80 |
| 2a | MI - C - Initial Assmnt. w/in 14 days of 1st Request | 12 | 19 | 20 |
| | Total MI - C - Initial Assmnt. Following 1st Request | 15 | 23 | 22 |
| | | **80.00%** | **82.61%** | **90.91%** |
| 2b | MI - A - Initial Assmnt. w/in 14 days of 1st Request | 28 | 33 | 35 |
| | Total MI - A - Initial Assmnt. Following 1st Request | 36 | 42 | 47 |
| | | **77.78%** | **78.57%** | **74.47%** |
| 2c | DD - C - Initial Assmnt. w/in 14 days of 1st Request | 3 | 2 | 3 |
| | Total DD - C - Initial Assmnt. Following 1st Request | 3 | 4 | 3 |
| | | **100.00%** | **50.00%** | **100.00%** |
| 2d | DD - A - Initial Assmnt. w/in 14 days of 1st Request | 0 | 1 | 7 |
| | Total DD -A - Initial Assmnt. Following 1st Request | 0 | 4 | 8 |
| | | **#DIV/0!** | **25.00%** | **87.50%** |
| | | | | |
| 3 | **Indicator #3 Timeliness/First Service** | 54 | 51 | 65 |
| 3a | MI-C - Start Service w/in 14 days of Assmnt | 12 | 15 | 19 |
| | Total MI-C - Start Service | 14 | 19 | 22 |
| | | **85.71%** | **78.95%** | **86.36%** |
| 3b | MI-A - Start Service w/in 14 days of Assmnt | 29 | 20 | 30 |
| | Total MI-A - Start Service | 35 | 31 | 36 |
| | | **82.86%** | **64.52%** | **83.33%** |
| 3c | DD-C - Start Service w/in 14 days of Assmnt | 2 | 1 | 1 |
| | Total DD-C - Start Service | 3 | 3 | 3 |
| | | **66.67%** | **33.33%** | **33.33%** |
| 3d | DD-A - Start Service w/in 14 days of Assmnt | 2 | 1 | 7 |
| | Total DD-A - Start Service | 2 | 1 | 7 |
| | | **100.00%** | **100.00%** | **100.00%** |
| | | | | |
| | **Indicator #4 Continuity of Care - Follow-up Psych Inpatient** | 12 | 10 | 17 |
| 4a(1) | # of Children Seen w/in 7 Days After Discharge | 1 | 1 | 3 |
| | # of Children Discharged | 1 | 1 | 2 |

| | | | | |
|---|---|---|---|---|
| | **95% is the standard** | **100.00%** | **100.00%** | **66.67%** |
| 4a(2) | # of Adults Seen w/in 7 Days After Discharge | 11 | 9 | 15 |
| | # of Adults Discharged | 1 | 9 | 15 |
| | **95% is the standard** | **1100.00%** | **100.00%** | **100.00%** |
| | | | | |
| | **Indicator #10**<br>**Outcome:Inpatient Recidivism** | 13 | 14 | 21 |
| 10a | # of Children Discharged | 1 | 2 | 4 |
| | # of Children Re-admitted w/in 30 Days | 0 | 0 | 0 |
| | **15% or less is the standard** | **0.00%** | **0.00%** | **0.00%** |
| 10b | # Adults Discharged | 12 | 12 | 17 |
| | # Adults Re-admitted w/in 30 Days | 0 | 3 | 3 |
| | **15% or less is the standard** | **0.00%** | **25.00%** | **17.65%** |