COPPER COUNTRY MENTAL HEALTH SERVICES
ANNUAL QUALITY IMPROVEMENT REPORT
FY 2024

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, 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 2024

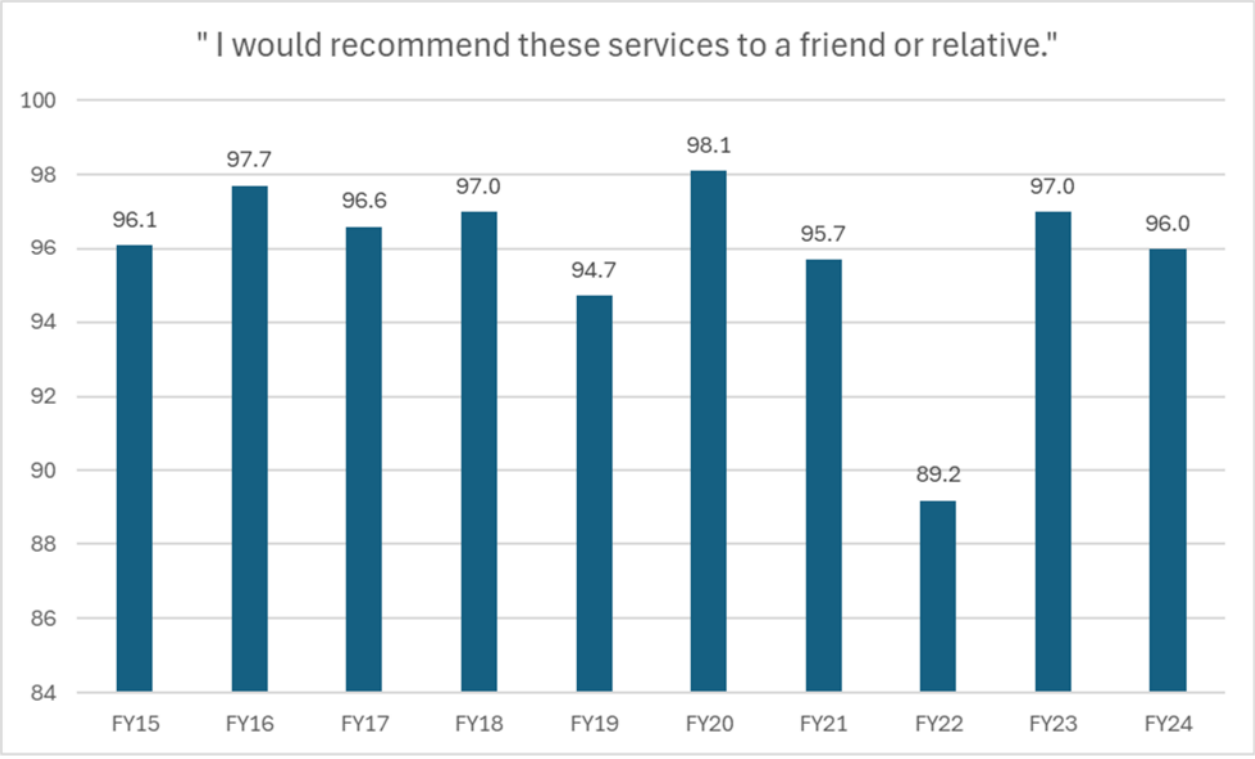
Consumer Satisfaction Survey Report FY 2024

The Consumer Satisfaction Survey Report FY 2024 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

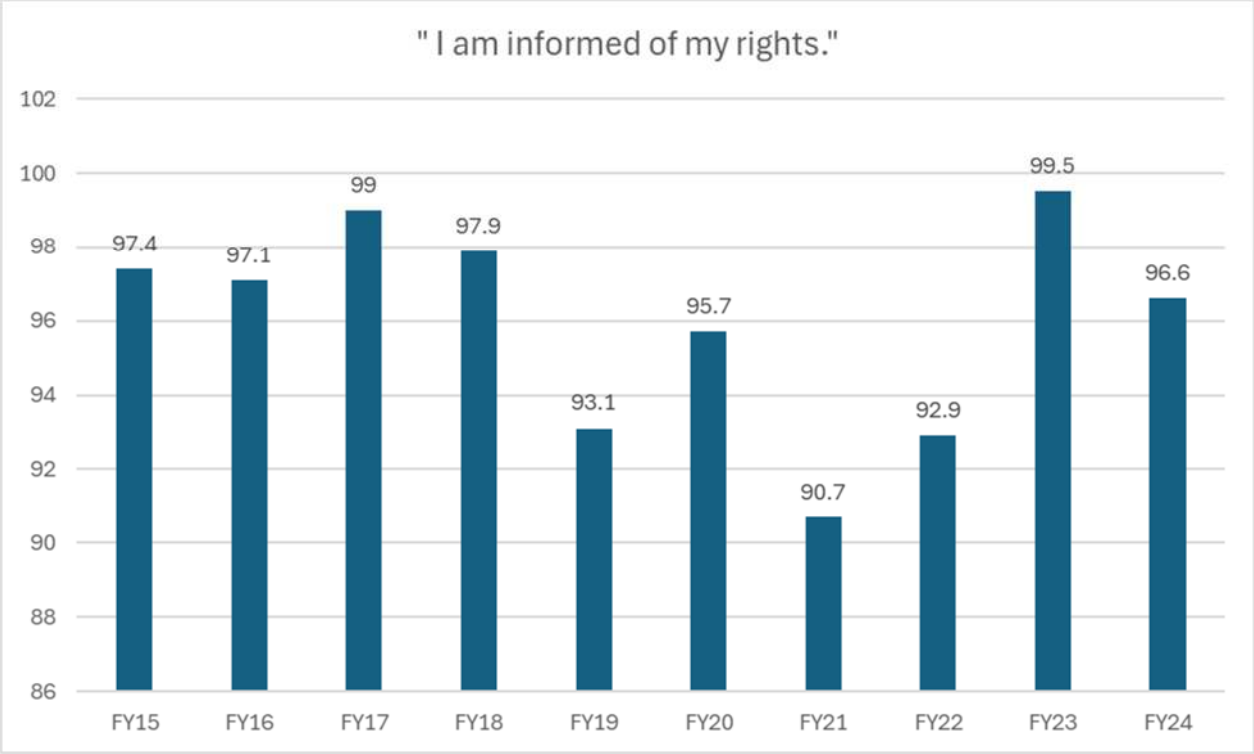
Customer Services' goal for quality improvement is to ensure that consumers are satisfied with the services they receive. The objective that measures this is a 95% overall satisfaction (agree or strongly agree) with the following statement, "I would recommend these services to a friend or relative" which is question #15 on the Consumer Satisfaction Survey. In FY 2024 Customer Services received a satisfaction rate of 96%, a slight decrease from FY 2023.

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 24 was 96.6%, a small decrease from the previous year which was 99.5%.



Office of Recipient Rights

The Office of Recipient Rights (ORR) monitors and investigates allegations of misconduct by Agency staff against recipients of mental health services and their families. For FY 24 the ORR received one-hundred and six allegations. Of those allegations, eighty-seven were investigations, nineteen were interventions, and Forty-three were substantiated by the Recipient Rights Office.

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.

Of the 1715 incidents reported this fiscal year, twenty were defined as sentinel events, twenty-two as critical events and thirty-four 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	5	5	6	4	20
Critical Events	4	5	7	6	22
Risk Events	11	3	13	7	34
Incident Reports	313	371	549	482	1715

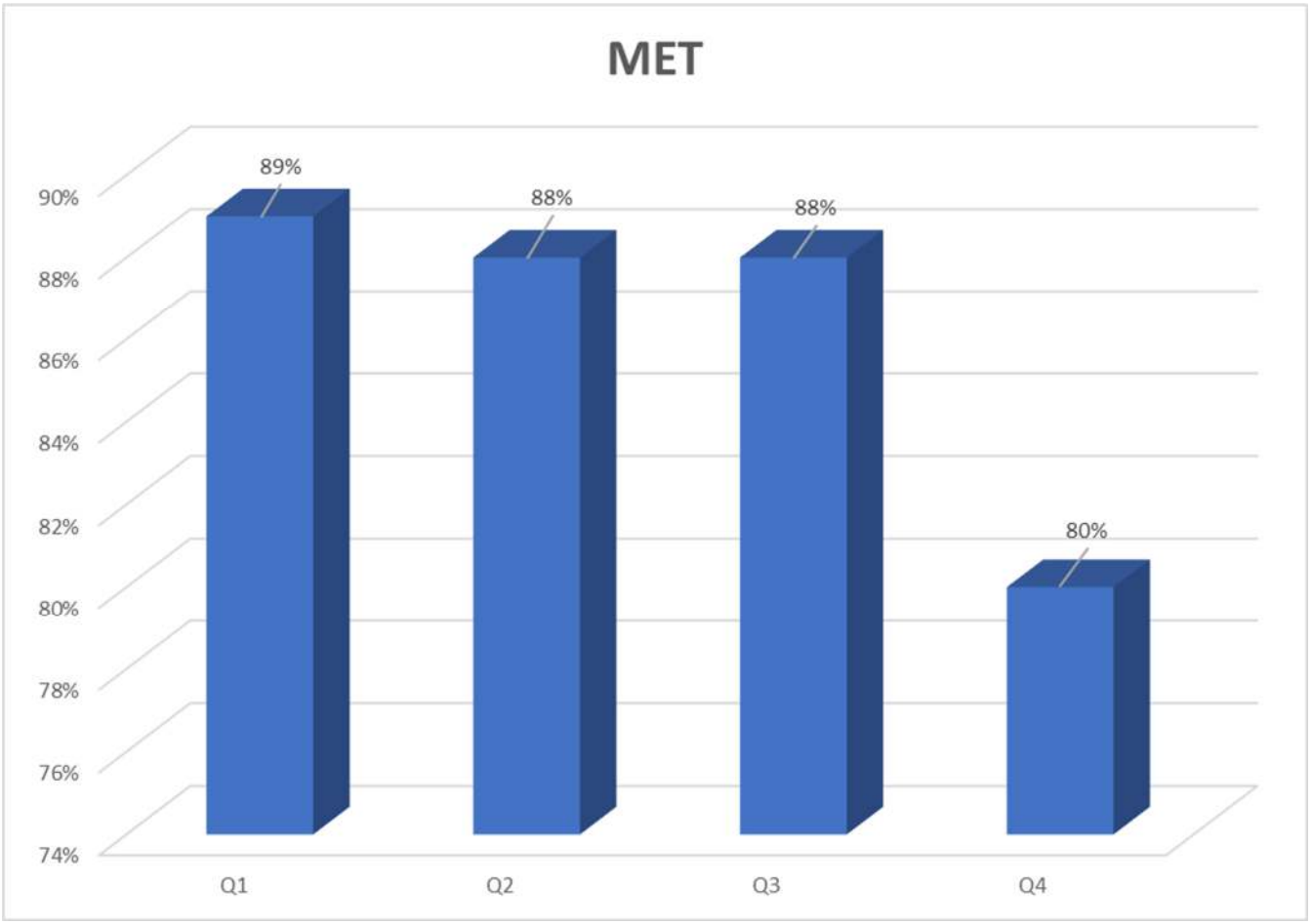
Outcomes Measures

Outcomes data were collected and reported to the Quality Improvement Committee through the 4th quarter of FY 2024. 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. The QI Committee has the mandate to ask those supervisors to revise goals and objectives to continue to serve the mission of the agency in supporting independence. The results of all those programs by quarter are available in the table beginning on page six.

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 eight for the MBPIS measures for FY2024.

In Summary

Overall, CCMHS has met the objectives set forth in the Quality Improvement Plan for 2024 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.

	OUTCOME MEASURES		FY 2024			
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
ACT/IDDT #1	Percentage of consumers remaining free from psychiatric hospitalization.	**90%**	**96%**	**90%**	**100%**	**100%**
ACT/IDDT #2	Percentage of consumers remaining free from arrest and/or prosecution.	**90%**	**96%**	**95%**	**100%**	**95%**
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
Acute Services #1	% of consumers screened by CCMH w/out psychiatric admission to hospital.	**60%**	**70%**	**63%**	**65%**	**65%**
Acute Services #2	% of consumers not re-hospitalized for at least 30 days post hospital discharge.	**90%**	**90%**	**83%**	**93%**	**88%**
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%**	
BRAVO #2	% of consumers who report accomplishing something important during the past year	**80%**	**100%**	**75%**	**100%**	
BRAVO #3	% of consumers and guardians who report visits are on time “almost always” or “usually”	**90%**	**100%**	**100%**	**0%**	
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%**	**88%**	**86%**	**86%**	**100%**
Case Management #2	% of consumers receiving a copy of their plan within 15 days of the plan date.	**100%**	**100%**	**100%**	**25%**	**36%**
Case Management #3	% of consumers who receive clinical assessment within 14 days of referral for CSM services.	**100%**	**80%**	**100%**	**50%**	**50%**
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%**	**43%**	**43%**	**43%**	**38%**
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%**	**93%**	**92%**	**96%**	**93%**
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%**	n/a	n/a	n/a	n/a
EBP #2	% of consumers receiving integrated treatment.	**25%**	38%	29%	23%	26%
EBP #3	% of consumers receiving Supported Employment services	**5%**	5.7%	4.3%	1.7%	1.5%
Program	**Measure**	**Goal**	**1Q**	**2Q**	**3Q**	**4Q**
Outpatient #1	% of children that improve as measured by the Child & Adolescent Functional Assessment Scale	**40%**	41%	53%	53%	40%
Outpatient #2	Review of Unsigned Documents Queue and Calendar	**90%**	97%	97%	86%	92%
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%**	46%	47%	71%	50%
Skill Building Programs #3	% of workers wages covered by Onto Car Wash	**100%**	113%	104%	144%	141%
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%	100%	91%
Supports Coordination #2	% of consumers who report accomplishing something important during the past year.	**80%**		100%	100%	100%
Supports Coordination #3	% of consumers who begin to receive services within 14 calendar days of intake appointment.	**100%**		0%	n/a	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 Coordinator			
Vocational Services #2	% of consumers employed at least 90 days.	**90%**				

MICHIGAN'S MISSION-BASED PERFORMANCE INDICATORS					
		FY2024			
		1Q24	2Q24	3Q24	4Q24
1	**Indicator #1** **Table 1: Access - Timeliness/Inpatient Screening**	40	41	42	41
1a	# of Children Pre-Admin Screen w/in 3 hrs	11	2	9	7
	Total # of Children Pre-Admin Screen	11	2	9	7
	95% is the standard	**100.00%**	**100.00%**	**100.00%**	**100.00%**
1b	# of Adults Pre-Admin Screen w/in 3 hrs	29	38	33	34
	Total # of Adults Pre-Admin Screen	29	39	33	34
	95% is the standard	**100.00%**	**97.44%**	**100.00%**	**100.00%**
2	**Indicator #2** **Table 2: Timeliness/First Request**	204	97	80	91
2a	MI - C - Initial Assmnt. w/in 14 days of 1st Request	16	17	10	8
	Total MI - C - Initial Assmnt. Following 1st Request	23	36	17	16
	62% is the standard	**69.57%**	**47.22%**	**58.82%**	**50.00%**
2b	MI - A - Initial Assmnt. w/in 14 days of 1st Request	32	31	38	44
	Total MI - A - Initial Assmnt. Following 1st Request	51	50	54	65
	62% is the standard	**62.75%**	**62.00%**	**70.37%**	**67.69%**
2c	DD - C - Initial Assmnt. w/in 14 days of 1st Request	1	2	1	3
	Total DD - C - Initial Assmnt. Following 1st Request	2	5	6	4
	62% is the standard	**50.00%**	**40.00%**	**16.67%**	**75.00%**
2d	DD - A - Initial Assmnt. w/in 14 days of 1st Request	77	4	3	4
	Total DD -A - Initial Assmnt. Following 1st Request	128	6	3	6
	62% is the standard	**60.16%**	**66.67%**	**100.00%**	**66.67%**
3	**Indicator #3** **Timeliness/First Service**	59	69	67	59
3a	MI-C - Start Service w/in 14 days of Assmnt	11	12	17	4
	Total MI-C - Start Service	16	21	19	7
	73% is the standard	**68.75%**	**57.14%**	**89.47%**	**57.14%**
3b	MI-A - Start Service w/in 14 days of Assmnt	23	27	29	37
	Total MI-A - Start Service	40	42	45	47
	73% is the standard	**57.50%**	**64.29%**	**64.44%**	**78.72%**
3c	DD-C - Start Service w/in 14 days of Assmnt	3	3	3	4
	Total DD-C - Start Service	3	5	4	4
	73% is the standard	**100.00%**	**60.00%**	**75.00%**	**100.00%**
3d	DD-A - Start Service w/in 14 days of Assmnt	3	3	2	3
	Total DD-A - Start Service	3	6	3	5
	73% is the standard	**100.00%**	**50.00%**	**66.67%**	**60.00%**
	Indicator #4 **Continuity of Care - Follow-up Psych Inpatient**	10	17	14	15
4a(1)	# of Children Seen w/in 7 Days After Discharge	1	1	1	3
	# of Children Discharged	1	1	1	3
	95% is the standard	**100.00%**	**100.00%**	**100.00%**	**100.00%**
4a(2)	# of Adults Seen w/in 7 Days After Discharge	7	13	12	12
	# of Adults Discharged	9	16	13	12
	95% is the standard	**77.78%**	**81.25%**	**92.31%**	**100.00%**
	Indicator #10 **Outcome:Inpatient Recidivism**	17	17	17	21
10a	# of Children Discharged	3	1	2	4
	# of Children Re-admitted w/in 30 Days	1	0	0	0
	15% or less is the standard	**33.33%**	**0.00%**	**0.00%**	**0.00%**
10b	# Adults Discharged	14	16	15	17
	# Adults Re-admitted w/in 30 Days	1	0	0	6
	15% or less is the standard	**7.14%**	**0.00%**	**0.00%**	**35.29%**