

COPPER COUNTRY MENTAL HEALTH SERVICES

ANNUAL QUALITY IMPROVEMENT REPORT

FY 2025

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 several 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. 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 2025

Consumer Satisfaction Survey Report FY 2025

The Consumer Satisfaction Survey Report has changed for FY 2025. Northcare centralized data collection and standardized questions across the region. All service locations provide a poster with a QR code and instructions to take the survey. Office locations also are to provide paper copies on request. A summary of the results was added to the FY 2025 annual report 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. In FY 2024 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 2025 question #15 now reads, “I am satisfied with the services I receive here.” Customer Services received a satisfaction rate of 94%, a slight decrease from FY 2024.

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



Recipient Rights Satisfaction

Consumer satisfaction with recipient rights was measured previously by question two on the Consumer Satisfaction Survey which stated, “I am informed of my rights.” In FY 2025 the question is now “I know where to voice concerns about services and feel safe doing so.” The

overall rate of satisfaction expressed by consumers in FY 25 was 92%, a small decrease from the previous year, which was 96.6%.



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 25 the ORR received eighty-seven allegations. Of those allegations, sixty-six were investigations, ten were interventions, eleven were No Right Involved or Outside Jurisdictions, and thirty-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 in incidents.

Of the 1923 incidents reported this fiscal year, five were defined as sentinel events, fourteen as critical events and nineteen as risk events. Events can 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	0	1	2	2	5
Critical Events	2	4	4	4	14
Risk Events	8	3	6	2	19
Incident Reports	468	431	435	589	1923

Outcomes Measures

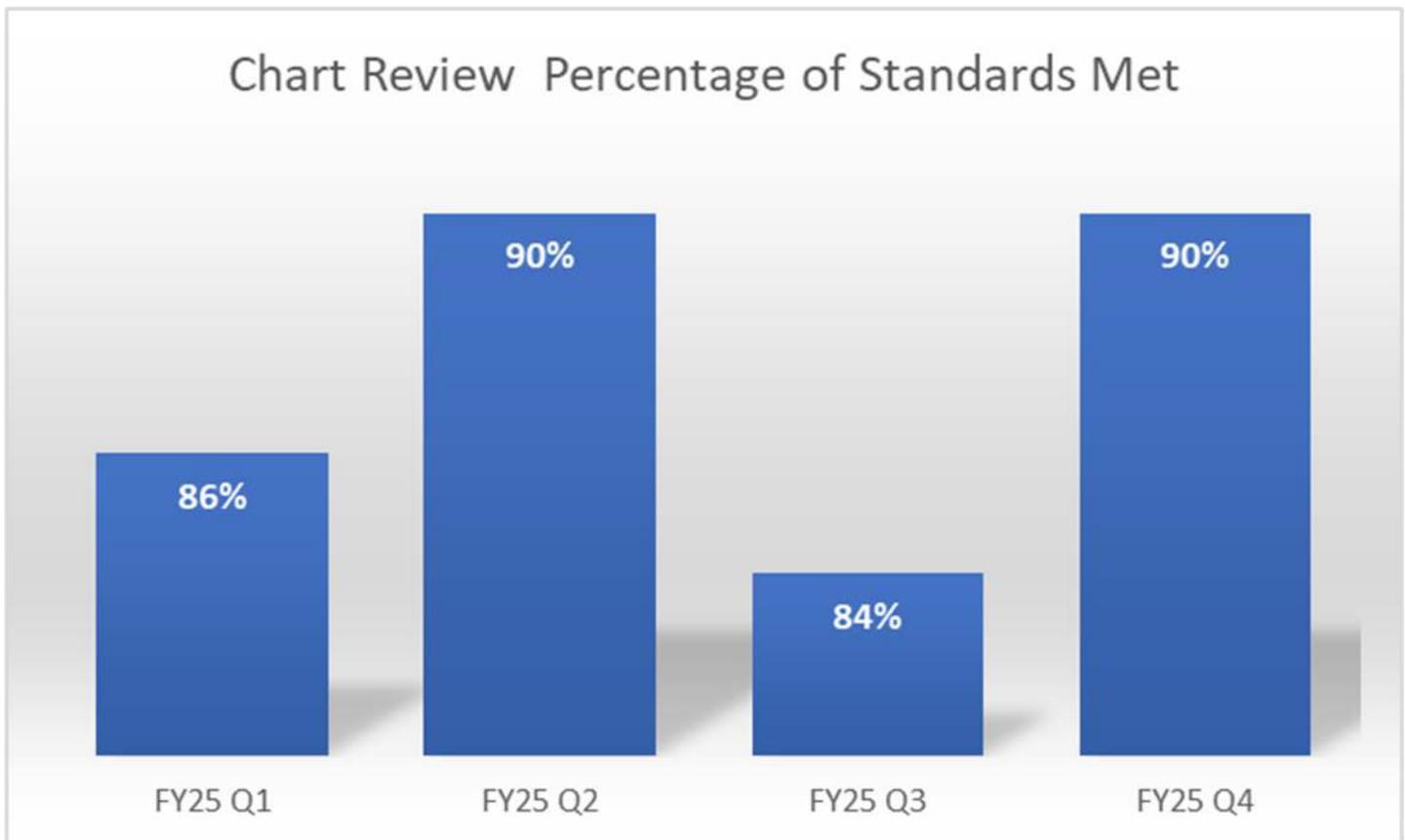
Outcomes data were collected and reported to the Quality Improvement Committee through the 4th quarter of FY 2025. Program supervisors continue to report to the QI Committee on these outcomes on a quarterly basis. Outcome Measures are a way for the Program Managers to get feedback from those consumers 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

Each quarter the clinical supervisors select a random chart to be reviewed by a peer. The supervisor supplies the peer with a chart review form to be utilized as part of the process. Not every standard is applicable for each record reviewed. The completed chart form is reviewed by the supervisor and then submitted to the Utilization Review Manager for a large-scale overview of standards within the organization. At the completion, the chart review form is returned to the supervisor to review with the primary case holder of the chart to rectify any missing standards.

For the first quarter, twelve charts were reviewed for a total of 403 applicable standards; nine charts were reviewed in the second quarter with 299 applicable standards; twelve charts were reviewed with 383 applicable standards in the third quarter; and six charts were completed with 199 applicable standards in the fourth quarter. The graph below displays the rate of compliance in completing required documentation measured by the review form.

Chart Review Percentage of Standards Met



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 FY2025.

In Summary

Overall, CCMHS has met the objectives set forth in the Quality Improvement Plan for 2025 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 2025			
Program	Measure	Goal	1Q	2Q	3Q	4Q
ACT/IDDT #1	Percentage of consumers remaining free from psychiatric hospitalization.	90%	100%	100%	100%	100%
ACT/IDDT #2	Percentage of consumers remaining free from arrest and/or prosecution.	90%	96%	95%	95%	95%
Program	Measure	Goal	1Q	2Q	3Q	4Q
Acute Services #1	% of consumers screened by CCMH w/out psychiatric admission to hospital.	60%	65%	69%	58%	71%
Acute Services #2	% of consumers not re-hospitalized for at least 30 days post hospital discharge.	90%	90%	90%	94%	93%
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 guardians' satisfaction surveys with average results of 4.00 or better	90%	100%	100%	100%	100%
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 Houghton	% of consumers receiving TCM or SC services who have an IPOS completed within 365 days of the last service plan.	100%	88%	94%	94%	96%
Case Management #2 Houghton	10% or less of LOCUS will be overridden	100%	100%	43%	81%	73%
Case Management #3 Houghton	% of consumers who receive clinical assessment within 14 days of referral for CSM services.	100%	67%	67%	82%	80%
Program	Measure	Goal	1Q	2Q	3Q	4Q
Case Management #1 Onto/Baraga	% of consumers receiving TCM or SC services who have an IPOS completed within 365 days of the last service plan.	100%	88%	100%	88%	100%
Case Management #3 Onto/Baraga	% of consumers who receive clinical assessment within 14 days of referral for CSM services.	100%	67%	50%	100%	67%
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%	38%	46%	46%	46%
Program	Measure	Goal	1Q	2Q	3Q	4Q
Community Supports #1 Houghton	% 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 Houghton	% of consumers maintaining/decreasing the frequency of medication deliveries or assistance with medications.	90%	92%	98%	86%	94%
Program	Measure	Goal	1Q	2Q	3Q	4Q
Community Supports #1 Onto/Baraga	% 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 Onto/Baraga	% of consumers maintaining/decreasing the frequency of medication deliveries or assistance with medications.	90%	92%	100%	100%	100%
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
Outpatient #1	LOCUS assessments will have 95% or more without overrides.	95%	91%	91%	93%	97%
Outpatient #2	Clinicians complete and sign all progress notes w/in 48 Hours of service.	90%	92%	92%	92%	88%
Program	Measure	Goal	1Q	2Q	3Q	4Q
Skill Building Programs #1	% of people who feel employment skills have improved through participation in the program	95%	93%	100%	100%	100%
Skill Building Programs #2	% of people who feel confident in their readiness for community employment	80%	73%	45%	78%	42%
Program	Measure	Goal	1Q	2Q	3Q	4Q
Vocational Services #1	% of consumers who meet w/Employment Coord. within 14 days	100%	90%	100%	88%	100%
Vocational Services #2	% of MRS referrals submitted within 14 days of consumer being provided application	90%	50%	100%	100%	100%

MICHIGAN'S MISSION-BASED PERFORMANCE INDICATORS

		1Q25	2Q25	3Q25	4Q25
Indicator #1					
1	Table 1: Access - Timeliness/Inpatient Screening	37	36	36	37
1a	# of Children Pre-Admin Screen w/in 3 hrs	6	4	7	7
	Total # of Children Pre-Admin Screen	6	4	7	7
	95% is the standard	100.00%	100.00%	100.00%	100.00%
1b	# of Adults Pre-Admin Screen w/in 3 hrs	31	32	29	30
	Total # of Adults Pre-Admin Screen	31	32	29	30
	95% is the standard	100.00%	100.00%	100.00%	100.00%
Indicator #2					
2	Table 2: Timeliness/First Request	100	91	74	63
2a	MI - C - Initial Assmnt. w/in 14 days of 1st Request	18	16	16	20
	Total MI - C - Initial Assmnt. Following 1st Request	33	23	22	20
	62% is the standard	54.55%	69.57%	72.73%	100.00%
2b	MI - A - Initial Assmnt. w/in 14 days of 1st Request	36	40	27	34
	Total MI - A - Initial Assmnt. Following 1st Request	62	61	43	34
	62% is the standard	58.06%	65.57%	62.79%	100.00%
2c	DD - C - Initial Assmnt. w/in 14 days of 1st Request	1	2	4	6
	Total DD - C - Initial Assmnt. Following 1st Request	3	4	6	6
	62% is the standard	33.33%	50.00%	66.67%	100.00%
2d	DD - A - Initial Assmnt. w/in 14 days of 1st Request	2	3	2	3
	Total DD - A - Initial Assmnt. Following 1st Request	2	3	3	3
	62% is the standard	100.00%	100.00%	66.67%	100.00%
Indicator #3					
3	Timeliness/First Service	88	74	55	56
3a	MI-C - Start Service w/in 14 days of Assmnt	14	14	13	15
	Total MI-C - Start Service	29	20	19	19
	73% is the standard	48.28%	70.00%	68.42%	78.95%
3b	MI-A - Start Service w/in 14 days of Assmnt	41	34	20	24
	Total MI-A - Start Service	57	51	34	34
	73% is the standard	71.93%	66.67%	58.82%	70.59%
3c	DD-C - Start Service w/in 14 days of Assmnt	1	2	3	4
	Total DD-C - Start Service	4	3	4	5
	73% is the standard	25.00%	66.67%	75.00%	80.00%
3d	DD-A - Start Service w/in 14 days of Assmnt	1	2	2	3
	Total DD-A - Start Service	2	3	2	3
	73% is the standard	50.00%	66.67%	100.00%	100.00%
Indicator #4					
	Continuity of Care - Follow-up Psych Inpatient	11	12	13	8
4a(1)	# of Children Seen w/in 7 Days After Discharge	1	1	3	2
	# of Children Discharged	2	2	3	2
	95% is the standard	50.00%	50.00%	100.00%	100.00%
4a(2)	# of Adults Seen w/in 7 Days After Discharge	7	6	10	4
	# of Adults Discharged	9	10	10	6
	95% is the standard	77.78%	60.00%	100.00%	66.67%
Indicator #10					
	Outcome:Inpatient Recidivism	12	15	15	12
10a	# of Children Discharged	2	2	4	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%
10b	# Adults Discharged	10	13	11	9
	# Adults Re-admitted w/in 30 Days	0	1	1	1
	15% or less is the standard	0.00%	7.69%	9.09%	11.11%