FY 2021

Quality Improvement Plan

Annual Report

St. Clair County

Community Mental Health Authority

3111 Electric Avenue, Port Huron, MI

Overview

The purpose of this report is to provide the annual status of the Quality Improvement Plan (goals) for St. Clair County Community Mental Health Authority (SCCCMHA), which is developed and approved annually. The data included in this report covers the reporting period of October 1, 2020 through September 30, 2021.

This report summarizes the status of priority goals / key tasks that were established by the Committees and Workgroups of the Quality Improvement Council (QIC). The goals focused on efforts in specific areas designed to improve SCCCMHA's overall systemic processes. All Workgroups, Committees and Sub-Committees have reported the status of each goal assigned.

QUALITY IMPROVEMENT PLAN GOALS: FY 2021

Community Activities-Adrienne Luckenbacher

Reference	PRIORITY GOALS/KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated

MDHHS Contract Attachment C.6.9.3.3,B3 and A4	1. ANTI-STIGMA
	Complete a variety of anti-stigma projects with the public each month.
	Examples:
	• Public awareness events during recognition "months" or "weeks"
	  o Mental Illness Awareness Week
	  o Intellectual/Developmental Disability Month
	  o Mental Health Month
	  o National Recovery Month
	• Paid advertising (television, print, radio)
	• Public information (television, print, radio, social media)
	• Other
		FY 21 Fourth Quarter: Goal Met
		• Variety of public awareness events completed including but not limited to Man to Man Series (3), Virtual and Face to Face presentations for organizations including but not limited to Lake Huron Hospital, St. Clair Rotary, YMCA, Michigan Youth Opportunities Initiative, Resource Fairs, Annual Run for Recovery and Recovery Awards, Walk to Remember Walk to Prevent Support, and the Virtual Recovery Summit supporting Recovery Month, activities highlighted Suicide Prevention month, Recovery month, Self care awareness month, Childhood obesity, Breast cancer awareness.
		• SCCCMH continues paid advertising on a regular basis including but not limited to Radio First Mental Health Minutes, Yale Expositor, Blue Water Senior Options, WGRT, EBW TV and billboards (static and digital) within St. Clair County as well as Times Herald publications multiple per month
		• In addition to paid advertising, goals continue to be met via social media, see social media goal.
		• Other: Mental Health First Aid (Youth and Adult), NAMI walk, NAACP Music Fest Resource Table, Sunday Funday and CAN Council Roof Sit, LIVE United Monthly Interviews, Advocacy awareness related to public behavioral health, Senior Power Day (complete listing of activities can be found on 2021 board reports)
			9/30/21

MDHHS Contract Attachment C.6.9.3.3,B3	2. COMMUNITY EDUCATION Participate in public education and opportunities to share information and eligibility and access to CMH services (minimum 12 per year) and opportunities to enhance services through community feedback. Examples: 1. Public education programs 2. Speakers' Bureau 3. Health Fairs 4. Community Perception Survey and follow up 5. Miscellaneous	**FY 2021 Fourth Quarter – Goal Met** Public education programs: 11+ Resource Tables, Recovery Summit, Marine City Police Department Overview and Connecting to Services Presentation, Continued distribution and coordination of Back to School Resource Boxes for RESA and additional schools. Detailed information or any of the above can be found on the SCCCMH Board Report	9/30/21

Reference	PRIORITY GOALS/KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
Good Community Collaboration	3. CRISIS INTERVENTION Provide crisis intervention through CISM program as needed.	**FY 2021 Fourth Quarter** • August 1 CISM, 0 Pandemic Response Interventions • September 4 CISM, 1 Pandemic Response Interventions • October 1 CISM, 1 Pandemic Response Interventions (October data pending completion) Both the CISM and Pandemic Response continue to be available and openly marketed.	9/30/21
MDHHS Contract Attachment C.6.9.3.3,B3	4. ONLINE PRESENCE Update information on website at least weekly. Facebook: make a new post minimum of 4 times per week. LinkedIn: make a new post minimum 2 times per week (HR & CR both post to this account) YouTube: add videos to account when available and share on Facebook.	**FY 21 Fourth Quarter – Goal Met** Face Book: August 17 posts, September 23 posts, October info pending LinkedIn (CRT only post) : August 4: 1 post, September 4 posts, October pending Instagram: August 4 posts, September 9 posts, October info pending U Tube: August: 754 impressions, September 2095 impressions, October info pending SCCCMH Website: August 17,879 views, September 16,351 views, October information pending CSCB Webpage: August 1,758 views, September 651 views, October information pending	9/30/21
MDHHS Contract Attachment C.6.9.3.3,B3	5. RELATIONSHIP BUILDING a) Build/maintain contacts and communicate CMH events/resources to local churches/faith leaders. b) Build/maintain contacts and communicate CMH events/resources to area physician offices, health care professionals and integrated health partners as it relates to CMH services, opportunities, and integrated healthcare advancements. c) Build/maintain contacts and communicate CMH events/resources with area educators, buisness' and first responders.	**FY21 Fourth Quarter – Goal met** Continued collaboration as well as increase in collaboration with community stakeholders as shown in goals above. Multitude of stakeholders in a variety of events. Additional events including but not limited to vaccination clinic, Man to Man Series, Collaboration Training for Marine City Police Department, Blue Water Race Series, NAMI (EVS) and Walk, Virtual Recovery Summit, Lake Huron Medical, local business manufacturing (SMR), – Detailed information can be found on the SCCMH Board Reports for the quarter.	9/30/21
Good Community Collaboration	6. HEALTHCARE INTEGRATION OUTREACH a) Host at least two events promoting integrated healthcare. b) Provide ongoing physical/behavioral health and wellness resources and information to persons receiving CMH supports and their family members (i.e. Wellness Wednesdays, resource tables, marketing materials, health screening days, etc.) c) Promote healthcare messages through staff photos, post to Facebook for public awareness.	**FY 2021 – Fourth Quarter – Goal Met** • Goal met including but not limited to (third quarter) in person and online Yoga, Tai Chi, MSU extension partnership, Man to Man Series, continued vaccination clinic, Virtual Recovery Summit, Mental Health Awareness, Mental Health Spirit Week for Staff. • Social Media posts reflect integrated health care messages	9/30/21

Reference	PRIORITY GOALS/KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
Good Community Collaboration	7. COMMUNITY COLLABORATIVE Promote community collaboration and community benefit through support and participation in CSCB efforts. a) Active CMH representation on the CSCB executive committee and workgroups. b) Staff support of the CSCB provided by CMH. c) Engage in networking, communication, and collaboration between CSCB and CMH.	**FY 21 – Fourth Quarter – Goal Met** • CMH continues active representation and engagement/participation in the CSCB and workgroups • CMH staff continue to support CSCB and engage in networking, communication and collaboration including COVID support, Walk to Remember Walk to Prevent and additional community needs. See social media goal for CSCB website info	

Corporate Compliance-Abbey Brown

Reference	PRIORITY GOALS/KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Reviewed
Medicaid Integrity Program, Corporate Compliance Plan	1. Report monthly on corporate compliance complaints; identify trends (St. Clair County CMH).	**1st Quarter FY21**: 1st Quarter FY21 Corporate Compliance Complaint Reports submitted to R10 on 1/27/21 (October, November, and December 20). NOTE: Reports sent quarterly versus monthly. October 20: One (1) complaint received: 1. Policy Violation – Unsubstantiated (Contract Agency) OASIS log-in issue November 20: One (1) complaint received: 1. Policy Violation and HIPAA Privacy/Security Violation – Substantiated (SCCCMHA),Email issue December 20: One (1) complaint received: 1. Policy Violation and HIPAA Privacy/Security Violation – Unsubstantiated (SCCCMHA) Email issue **2nd Quarter FY21**: 2nd Quarter FY21 Corporate Compliance Complaint Reports submitted to R10 on 4/16/21 (January, February, and March 21). January 21: No complaints received. February 21: No complaints received.	9/30/21

Reference	PRIORITY GOALS/KEY TASKS	TIMELINE	
		March 21: One (1) complaint received: 1. Possible Medicaid Fraud/Abuse/Waste Violation – Pending (Contract Agency used billing code improperly) **3rd Quarter FY21**: 3rd Quarter FY21 Corporate Compliance Complaint Reports submitted to R10 on 7/15/21 (April, May, and June 21). April 21: No complaints received. May 21: Two (2) complaints received: 1. HIPAA Privacy/Security Violation – Unsubstantiated (SCCCMHA), Email issue 2. HIPAA Privacy/Security Violation – Unsubstantiated (SCCCMHA) Inappropriate building access June 21: No complaints received. **4th Quarter FY21**: 4th Quarter FY21 Corporate Compliance Complaint Reports submitted to R10 on 10/15/21 (July, August, and September 2021). July 21: One (1) complaint received: 1. HIPAA Privacy/Security Violation - Unsubstantiated (SCCCMHA) Inappropriate sharing of PHI August 21: Two (2) complaints received: 1. HIPAA Privacy/Security Violation and Policy Violation – Unsubstantiated (SCCCMHA), Email issue 2. HIPAA Privacy/Security Violation – Unsubstantiated (SCCCMHA), Email Issue September 21: No complaints received.	
Corporate Compliance Plan	2. Report quarterly on Program Integrity activities (i.e., tips/grievances received, data mining, claims analysis, audits, overpayments collected, identification and investigation of fraud, waste, abuse, etc.).	1st Quarter FY21 Program Integrity Report submitted to R10 on 1/28/21. 2nd Quarter FY21 Program Integrity Report submitted to R10 on 4/30/21. 3rd Quarter FY21 Program Integrity Report submitted to R10 on 7/15/21. 4th Quarter FY21 Program Integrity Report submitted to R10 on 10/15/21.	9/30/21

Reference	PRIORITY GOALS/KEY TASKS	TIMELINE	
Corporate Compliance Plan	3. Report monthly on grievance and appeals activities.	**1st Quarter FY21**: October G & A Report submitted to R10 11/15/20, nothing to report. November G & A Report submitted to R10 12/14/20, nothing to report. December G & A Report submitted to R10 1/11/21, nothing to report. **2nd Quarter FY21**: January G & A Report submitted to R10 2/8/21, nothing to report. February G & A Report submitted to R10 3/11/21, nothing to report. March G & A Report submitted to R10 4/13/21, nothing to report. **3rd Quarter FY21**: April G & A Report submitted to R10 5/21/21, nothing to report. May G & A Report submitted to R10 6/30/21, nothing to report. June G & A Report submitted to R10 7/15/21, One (1) Medicaid grievance (quality of care). Resolved June 16, 2021. **4th Quarter FY21**: The G & A Report is now quarterly and was submitted to R10 on 10/15/2021.-One (1) Medicaid grievance (quality of care). Resolved August 19, 2021.	
Corporate Compliance Plan	4. St. Clair County CMH Corporate Compliance Committee to meet quarterly or more frequently as deemed necessary.	SCCCMHA Corporate Compliance Committee met 8/3/21; complaint reviews completed.	9/30/21
Good Administrative Practice	5. Monitor and report any legal/regulatory changes.	Nothing to report.	9/30/21
CFR Requirement 438.610	6. Monitor and report on debarred, suspended, or otherwise excluded (from participation in any federal healthcare program) providers.	Nothing to report.	9/30/21
CFR Requirement 438.608	7. Provide training and education on corporate compliance.	Email sent 7/12/21 to all staff regarding building security. Email sent 8/2/21 to all staff and contract agencies regarding people protecting their private information during the COVID-19 pandemic.	9/30/21
Corporate Compliance Plan	8. Monitor subnetwork providers' corporate compliance activities.	Ongoing monitoring of contract agencies' corporate compliance plans/activities per contract managers.	9/30/21
Corporate Compliance Plan	9. Conduct an annual evaluation of the Compliance Plan and report to the St. Clair County CMH Board.	FY21 CC Annual Report will be presented to SCCCMHA Board 11/2/21. FY22 Compliance Plan will be presented to SCCCMHA Board 11/2/21.	9/30/21

Note: Claims verification and under/over utilization reported under Utilization Management, although part of Compliance Plan and quarterly Program Integrity Reports.

Finance-Karen A. Farr

Reference	PRIORITY GOALS/KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
Good Administrative Practice	1. Manage financial risks through establishment and maintenance of fund balances. Objectives: o Establish, review and update policies and procedures related to our CMHSP Local Fund Balance	Nothing new to report.	9/30/21
Good Administrative Practice	2. Provide CEO, Management Team and Board of Directors with timely financial information to be used for decision making and strategic planning. Objectives: o Identify fiscal concerns through monthly analysis of revenues and expenditures o Analyze trends and provide revenue forecasts o Prepare annual budget and provide comparison of budget to actual revenues and expenditures on a monthly basis o Prepare amended budget to reflect significant changes in revenues and expenditures of the agency, as needed o Make recommendations about how to best utilize agency resources o Interact with other managers to provide consultative support to planning initiatives through financial information analyses, reports, and recommendations	The YTD May 31, 2020 FBR was presented to the Board at the July 6, 2021 Board meeting. Currently our YTD expenditures are $2,869,000 under our Revised Budget with a Medicaid surplus of $3,878,612 YTD and a GF surplus of just over $88,360. The significant surplus is related to the anticipated expenditures that will take place over the remainder of the FY. The FY21 Revised Budget was approved by the Board of Directors at the April 2021 Board meeting reflecting budgeted expenditures of just over $73 million; an increase of approximately $5.5 million. The increase includes: Direct run payroll of $1.2 million, Contractual costs of $1.1 million and External Provider costs of $3.3 million. The FY21 Original Budget was approved by the Board of Directors at the September Board meeting reflecting budgeted expenditures of just over $68 million including: $58.5 million of Medicaid and Healthy MI Plan expenditures, $2.4 General Fund and COFR expenditures, $3.8 of CCBHC & SUD expenditures, and $3.3 million of Earned Contracts and Local/Other expenditures.	9/30/21
MDHHS	3. Ensure compliance with local, state, and federal budgetary reporting requirements. Objectives: o Coordinate and ensure completion of the annual Financial, Compliance and Single Audits. o Complete all required Federal, State and local financial reporting per the Medicaid and General Fund contracts.	The FY20 Compliance audit is complete and the report is finalized. There were no reported Findings for FY2020! The Single Audit report is slated to be completed for the August Board meeting presentation. The FY20 audited financial statements have been issued and submitted timely to the State of MI. We received an unqualified opinion (this is good! ☺) and the reports will be presented to the Board once the Compliance and Single audit reports are completed. The FY20 contractual reporting has been submitted timely to both MDHHS and Region 10. The FY20 audit has begun and is completely virtual at this time. The audited financial statements will be issued prior to the March 31, 2021 due date. The Single audit and the Compliance audit will begin upon completion of the financial audit to ensure the reporting due dates are met.	9/30/21

Reference	PRIORITY GOALS/KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
ARR 7/3	4. Promote collaboration, efficiency and uniformity between PIHP members. Objectives: o Utilize the Region 10 Finance Officer's workgroup to share information and identify best practice strategies. o FY 2021 Regional CFO goals: o Funding allocation Methodology – Payment Reports o Risk-Based Payment Methodology o Implementation of MDHHS Standardized Cost Allocation Model	The CFO workgroup continues to meet on a monthly basis. The first two goals of FY 2021 have been completed and the SCA Methodology implementation work is in process. The CFO workgroup submits monthly Funding Bucket Reports to the Region 10 CFO so that the regional spending can be monitored timely for informed budget decisions. Currently there is a Medicaid and HMP funding surplus anticipated for FY21.	9/30/21
Good Administrative Practice	5. Establish and maintain appropriate internal controls over record keeping and safeguarding of assets Objectives: o Establish, review and update policies and procedures for record keeping, handling of cash and tracking of assets o Ensure separation of duties to reduce the risk of fraudulent activity	The majority of the Finance policies were consolidated into one "Board Fiscal Responsibilities" Policy with a related Finance Procedures manual for each of the Standards included within the policy which was approved by the Board of Directors at the June 2021 Board meeting. The consolidated Board Fiscal Responsibilities Policy has been drafted, consolidating 12 finance policies into one. This policy has been presented to the Board for review at the March Board meeting. Along with the new policy is a related Board Fiscal Responsibilities Procedures guide. Finance policies are currently being reviewed and consolidated to separate out those which are Board approved policies from those identified as Administrative Procedures.	9/30/21

Human Resources and Development-Kim Prowse

Reference	PRIORITY GOALS/KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
Good Business Practice	1. Review current Human Resource-related practice and software system including: a. Work with Sage implementation team to develop a bridge between Sage and Cybertrain to improve workflow efficiency. b. Work with Sage implementation team to introduce Sage Recruit (Applicant Tracking System) to replace Applitrack. c. Coordinate training/rollout of Sage People Human Capital Management (HCM) and Recruit to agency. d. Evaluate current recruitment and selection policy. Update to align with new Sage Recruit workflow process. e. Evaluate and establish best practice model of interview/selection process.	a. Experienced delays from Sage after Recruit system implementation. Followed up with Sage. Call set for Sage, Cybertrain, and Jodi to discuss file information. Expected to have complete in the next 30 days. b. Sage Recruit and WX are live and troubleshooting of initial small items has been successful. c. Training videos and job aids have been created. Videos will be viewed through MLP. Supervisor videos and job aids will also go in Supervisors folder in Fileshare under Sage. Training Completed. d. Ongoing e. Interview process has been developed; scoring form completed. Currently being utilized.	9/30/21

Reference	PRIORITY GOALS/KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
	f. Evaluate and develop agency-wide succession planning program to provide development opportunities for future agency leaders. g. Improve volunteer recruitment process h. Work towards movement to electronic personnel file	f. 3Q 2021 g. Ongoing h. Had some initial discussions with IT, plan to begin mid-2Q	
Good Business Practice CARF Requirements Sec.1.1.4 d,e Sec. 1.1.9 f b)Sec.10, Goal 2 d)Sec.10, Goal 1	2. Provide an opportunity for professional growth to enhance performance, skill development and cross training. a. Provide centralized training calendar identifying topic/date/location for all trainings. b. Continuously update/modify required training grid based on regulatory requirements, and ensure staff compliance. c. Offer/mandate supervisory courses to current/potential supervisors via MyLearningPoint as courses become available. d. Provide trainings on a variety of topics related to job development, mental health, physical health, etc., as directed by management, for all CMH staff. e. Evaluate / improve "New Employee Orientation" process. f. Collaborate with Regional HR staff, as appropriate, to offer/develop regional training options. g. Review Job Descriptions at least annually. h. Administer "Training Needs" survey at each CMH sponsored training. i. Work with identified employee groups to address improvement opportunities. j. Provide Compliance training on an annual basis. k. Provide Trauma Informed Care training for all new hires. l. Provide LOCUS training for all new and existing hires who will work with the Adult MI population.	Leadership trainings are still on hold due to the pandemic. a. All trainings are posted on our website calendar. Upcoming specialized training reports are made available at Supervisors meeting. b. Ongoing c. Ongoing d. Recent trainings: Trauma Informed Care, Motivational Interviewing 101; CPR/First Aid, Interactive Journaling, MHFA Adult & Youth . Upcoming trainings: Zero Suicide, Caseholder Training, Trauma Informed Care, Motivational Interviewing 101; and CPR/First Aid. e. Surveys are reviewed after each session; feedback is shared with presenters. f. Ongoing g. Ongoing h. Ongoing i. Ongoing j. Ongoing k. Ongoing l. All current and new staff who serve adults are being training on LOCUS training.	9/30/21
Good Business Practice	3. Reward employees for performance that meets and exceeds defined expectations and recognize continued efforts. a. Continue to evaluate CMH "Staff of the Year" and "Team of the Year" recognition programs b. Continue to evaluate CMH staff recognition and enrichment process and explore cost-effective options c. Continue yearly CMH anniversary recognition d. Continue CMH "Years of Service" Recognition e. Assist with/Sponsor Wellness Activities	a. Ongoing b. Had some initial discussions with Tammy Lake. Plan to discuss with EWDC. c. Ongoing d. Ongoing e. Carrot Wellness phone application for staff launched 2/15. First Survivor Challenge complete.	9/30/21
Good Business Practice	4. Utilize the Employee Wellness and Development Committee to evaluate needs in areas such as training, education, opportunities for growth, advancement, recognition, wellness, and personal enrichment.	EWDC meetings started back up in November 2020. Committee meets quarterly.	9/30/21

<table>
<tr><th></th><th></th><th colspan="2">TIMELINE</th></tr>
<tr><th>Reference</th><th>PRIORITY GOALS/KEY TASKS</th><th>Status (with Recommendations)</th><th>Date Updated</th></tr>
<tr><td>OSHA
08.450</td><td>1. Quarterly, report Employee Accidents within 24 hours. Target compliance 100%.

a. Advise on issues of compliance difficulty with Program Supervisors to develop and implement improvement activities.
b. Report all findings and improvement activities to the QIC.

“Workers Compensation. Accident Reporting and OSHA Recordkeeping”</td><td>
<table>
<tr><th>24 hrs.</th><th>48 hrs.</th><th>72 hrs.</th><th>1 wk.</th><th>2 wk.</th><th>3 wk.</th><th>4 wk.</th></tr>
<tr><td>3</td><td>1</td><td></td><td></td><td>1</td><td></td><td></td></tr>
</table>
QUARTER ACCIDENTS: 5
• <u>Received Treatment</u>: 2
1-Hi elbow on cement planter
1-Fell while walking down steps
• <u>Sought Own Treatment</u>: 0
• <u>Declined Treatment</u>: 3
1-Child scratched employee’s chest and forearm while receiving task assistance
1-Child scratched employee’s forearm during session
1-Employee kicked in knee by child
<table>
<tr><th>1Q</th><th>2Q</th><th>3Q</th><th>4Q</th><th>Annual</th></tr>
<tr><td>100% (2)</td><td>100% (5)</td><td>100% (1)</td><td>60% (3/5)</td><td>85% (11/13)</td></tr>
</table>
</td><td>9/30/21</td></tr>
<tr><td>CARF
Health &
Safety</td><td>2. Ensure easy access to First Aid:
a. Expertise
b. Equipment
c. Supplies</td><td>
<table>
<tr><th>Event/Quarter</th><th>1Q</th><th>2Q</th><th>3Q</th><th>4Q</th><th>Total</th></tr>
<tr><td>FA & CPR</td><td>0</td><td>24</td><td>42</td><td>24</td><td>90</td></tr>
</table>
</td><td>9/30/21</td></tr>
<tr><td>CARF
Health &
Safety</td><td>3. Quarterly, completed Building Inspection.
a. Site Participation, (5) locations. Target compliance, 100%.
b. Safety/Infection Control Checklist. Target compliance, 95%.</td><td>
<table>
<tr><th></th><th>Child & Family Services</th><th>Capac</th><th>Electric</th><th>Marine City</th></tr>
<tr><td>Site Participation</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Inspection Checklist</td><td>100%</td><td>100%</td><td>100%</td><td>96%</td></tr>
</table>
<table>
<tr><th>1Q</th><th>2Q</th><th>3Q</th><th>4Q</th></tr>
<tr><td>100%</td><td>96%</td><td>99%</td><td>100%</td></tr>
</table>
</td><td>9/30/21</td></tr>
</table>

	4. Quarterly completed **Kitchen Inspection**; via the Kitchen Safety Inspection Checklist. Target compliance, 95%.		9/30/21
CARF Health & Safety	5. Annually completed Emergency/Event Procedures (9 types) at all locations. Completion may be per "actual event" or drill. Target compliance 95%. *Conducted, monitored, recorded, and reported quarterly • Active Shooter • Chem./Biological • Fire • Natural Disaster • Utility Failure • Bomb Threat • Dangerous Person • Medical Emergency • Suspicious Mail/Parcel		9/30/21

Galley Kitchen Inspection			
1Q	2Q	3Q	4Q
100%	100%	100%	100%

*Not a CARF requirement.

Event / Location	Child and Family	Capac	Electric	Marine City
**Active Shooter	8.10.21 9.14.21	8.10.21 9.14.21	8.10.21 9.14.21	8.10.21 9.14.21
Adverse Weather	***8.11.21***	-	-	-
Bomb Threat	-	-	-	-
Chem./ Biological	-	-	-	-
Dangerous Person	-	-	***3.18.21*** ***5.24.21*** ***6.14.21***	-
Fire	-	-	-	-
Medical Emergency	-	-	***1.13.21*** ***2.19.21*** ***3.11.21*** ***3.18.21*** ***4.28.21*** ***5.5.21*** ***8.6.21*** ***8.6.21*** ***8.18.21*** ***9.13.21***	-
Pandemic	***Oct.1-Dec. 31*** ***Jan.1-Mar. 31*** ***Apr.1-Jun. 30*** ***July 1-Sept 30***	***Oct.1-Dec. 31*** ***Jan.1-Mar. 31*** ***Apr.1-Jun. 30*** ***July 1-Sept 30***	***Oct.1-Dec. 31*** ***Jan.1-Mar. 31*** ***Apr.1-Jun. 30*** ***July 1-Sept 30***	***Oct.1-Dec. 31*** ***Jan.1-Mar. 31*** ***Apr.1-Jun. 30*** ***July 1-Sept 30***
Utility Failure	***7.14.21***	-	***7.14.21***	-
Suspicious Mail	3.8.2021 3.16.2021	3.8.2021	3/15.2021 (2nd fl.)	3.9.2021

*Not a CARF requirement.

Type/ Timeframe	1Q	2Q	3Q	4Q	Total
Actual Event	**4**	**9**	**8**	**11**	**32**
Drill	0	5	0	8	13
Total	4	14	8	19	45

** Select employee/not a CARF requirement.

<table>
<tr>
<td>CARF
Health &
Safety</td>
<td>6. Annually, all full time and part – time employees will participate as applicable in at least one (1) of the nine (9) types of Emergency via “actual event” or emergency drill. Target compliance 95%. Participation visitors and recipients of services will be included (counted) and identified as “V” on the report table.

a. Quarterly, track /record /report emergency event participation.

• Scheduled emergency drill participation will be electronically tracked via email voting responses or the “Emergency Event” form.
• Actual emergency event participation is recorded via the “Emergency Event” form or email voting when applicable.

b. Supervisors to receive notification, during third quarter of staff that have not participated in an emergency drill or actual emergency event.

c. Annually, Supervisors of employees who did not participate in at least one emergency event (drill or actual) are required to review safety protocol , via the Building Health and Safety policy (09.001.000) or Emergency Procedures Handbook, with applicable staff.</td>
<td>
<table>
<tr><th>Event / Location</th><th>Child & Family Services</th><th>Capac</th><th>Electric</th><th>Marine City</th></tr>
<tr><td>*Active Shooter</td><td>4
2</td><td>1
2</td><td>19
20</td><td>4
2</td></tr>
<tr><td>Adverse Weather</td><td>18, V=5</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>Bomb Threat</td><td>-</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>Chem./
Biological</td><td>-</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>Dangerous Person</td><td>-</td><td>-</td><td>8, V=1
1, V=2
53, V=12</td><td>-</td></tr>
<tr><td>Fire</td><td>-</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>Medical Emergency</td><td>-</td><td>-</td><td>4, V=1
5, V=1
7, V=1
9, V=1
8, V=1
8, V=1
4, V=1
4
4, V=1
4, V=1
2, V=1</td><td>-</td></tr>
<tr><td>*Pandemic</td><td>64</td><td>13</td><td>308</td><td>24</td></tr>
<tr><td>Utility Failure</td><td>20, V=6</td><td>-</td><td>97, V=11</td><td>-</td></tr>
<tr><td>Suspicious Mail</td><td>2</td><td>4</td><td>3</td><td>3</td></tr>
</table>
*Not a CARF requirement.
Cumulative employee participation:
<table>
<tr><th>ABA Center</th><th>Capac</th><th>Electric</th><th>Marine City</th></tr>
<tr><td>100% (63)</td><td>100% (13)</td><td>100% (308)</td><td>100% (24)</td></tr>
</table>
</td>
<td>9/30/21</td>
</tr>
<tr>
<td>CARF, Health and Safety, Emergency Procedures 1.H.5.c.5</td>
<td>7. Supervising staff to ensure for Staff Accountability during large evacuation drills and actual events (i.e. Fire, Bomb Threat, Chemical Biological, Tornado, etc.). Supervisors to ensure use of sign in/out binders, roll call, and/or text messaging when applicable.</td>
<td>On going</td>
<td>9/30/21</td>
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<table>
<tr>
<td>CARF
Health & Safety, Medication Use

MHC
R330.1719
R330.2813
R330.7158</td>
<td>8. Quarterly review “Medication Errors” reports.
a. Error type
b. Error location
c. Trends
d. Improvement opportunities Error type</td>
<td>
<table>
<tr><th>Location</th><th>1Q</th><th>2Q</th><th>3Q</th><th>4Q</th><th>Total</th></tr>
<tr><td>Missed Med.</td><td>2</td><td>4</td><td>2</td><td>0</td><td>8</td></tr>
<tr><td>Pharmacy</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>SMMO</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Wrong Doc.</td><td>7</td><td>0</td><td>0</td><td>0</td><td>7</td></tr>
<tr><td>Wrong Dose</td><td>7</td><td>0</td><td>0</td><td>0</td><td>7</td></tr>
<tr><td>Wrong Med.</td><td>0</td><td>7</td><td>13</td><td>5</td><td>25</td></tr>
<tr><td>Wrong Person</td><td>0</td><td>0</td><td>6</td><td>0</td><td>6</td></tr>
<tr><td>Wrong Time</td><td>0</td><td>1</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>Total Errors</td><td>16</td><td>12</td><td>21</td><td>5</td><td>54</td></tr>
</table>
<table>
<tr><th>Location</th><th>1Q</th><th>2Q</th><th>3Q</th><th>4Q</th><th>Total</th></tr>
<tr><td>AFC Homes</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>BWDH</td><td>16</td><td>1</td><td>7</td><td>0</td><td>24</td></tr>
<tr><td>CMH</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>CE</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Genoa Pharm.</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>HOYO</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>IMPACT</td><td>0</td><td>1</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>Innovative</td><td>0</td><td>8</td><td>14</td><td>5</td><td>27</td></tr>
<tr><td>Lake Huron Comm. Pharmacy</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Life Skills</td><td>0</td><td>1</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>Other</td><td>0</td><td>1</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>COFR</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Total Errors</td><td>16</td><td>12</td><td>21</td><td>5</td><td>54</td></tr>
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</td>
<td>9/30/21</td>
</tr>
<tr>
<td>MIOSHA
R325.70001</td>
<td>9. Annually review the “Exposure Control Plan,” update as needed. (Blood Borne Pathogens Exposure and Infection Control Plan)</td>
<td>Completed in February and updated in August.</td>
<td>9/30/21</td>
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<tr>
<td>CARF
Health & Safety</td>
<td>10. Annually, complete (update/revise) Board Statement: “Health & Safety Work Plan”.</td>
<td>Completed in April.</td>
<td>9/30/21</td>
</tr>
<tr>
<td>CARF</td>
<td>11. Promote Safety by ensuring current Written Safety Procedures as applicable.</td>
<td>Service Animals and Emotional Support Animals 03.003.0075
Smoking on SCCCMHA Campus 09.001.0025
Personal Protective Equipment 09.003.0005
Weapons and or Drugs in the Workplace 09.003.0025
Safety Precautions for In the Office Services 09.003.0045
First Aid Kits 09.003.0035</td>
<td>9/30/21</td>
</tr>
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N/A	12. Promote implementation of **Threat List** individual's photos in OASIS.	8 Threat List individuals, of which 6 have photos in OASIS.	9/30/21
CMH Policy	13. Address other safety-related items as needed.	Take additional steps to ensure staff are better inform of potentially dangerous persons.	9/30/21

Privileging and Credentialing-Andrea Velez

Reference	PRIORITY GOALS/KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
MDHHS/ PIHP contract	1. Maintain/update as applicable the Provider Enrollment and Credentialing Policy (01.003.0011), credentialing applications and forms.	April 2021 updated organization "Deemed Status" provider verbiage. July 2021 updated form in electronic version as a trial/draft.	9/30/21
State Licensing & MDHHS Requirement	2. Monitor the credentials for all staff requesting privileges to provide services to individuals in SCCCMHA presented to committee.	Re-credentialed: 34 Provisional: 82 Full: 42 Total Credentialed: 480 Organizations: 71	9/30/21
MDHHS Requirement	3. Review and privilege as appropriate organizational applications of Provider agencies.	71	9/30/21
MDHHS Requirement	4. Maintain the SCCCMHA list of credentialed positions and coordinate with Medicaid Medicare/MDHHS definitions. a. Monthly update Provider Registry Reports to ensure compliance with credentialing timeframes. b. Ensure list of practitioner and organizational providers are available upon request.	Continues ongoing monthly or more as needed/requested. Last reviewed 10/07/21	9/30/21
Good Clinical Practice	5. Monitor staff training requirements. Make recommendations for training and direction as needed.	Collaboration continues w/ training department Last reviewed 10/07/21 P & C meeting.	9/30/21
Good Clinical Practice	6. Monitor delegated provider credentialing processes. a. Practitioner credentials – via monthly provider registry reports. b. Credentialing policy – via desk audits and site visits.	Reviewed reports on 06/30/21 for April P & C meeting. No changes to policy in 2021.	9/30/21

Program Development-Kathleen Gallagher

Reference	PRIORITY GOALS / KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
Best Practice	1. Sustain current Evidence-Based Practices (EBP). 2. Expand number of CMH staff trained in an applicable EBP. 3. Continue to monitor current EBP for fidelity. 4. Expand number of individuals receiving EBP throughout the CMH System through CCBHC funding.	• Supervisors continue to ensure that EBP's continue to be offered and provided to person's served. • Staff continue to enroll in training for EBP- including PE, CPT, and EMDR. Zero Suicide training for all staff has begun. • Continue to monitor fidelity through UM reviews and supervisory oversight DBT fidelity review is scheduled for November 21. • Continue to increase number of person's served receiving an EBP. • Work with Data department on using LOCUS and CAFAS reporting data to obtain reports on fluctuations in scores in relation with services provided.	9/30/21
Best Practice	5. Implement trauma informed system of care. a. Continue to provide TIC training to new staff at orientation and refreshers to existing staff. b. Expand TIC to contract system so all are Trauma Informed. c. Survey current perceptions from staff and those served regarding our current standing with regard to TIC.	• TIC training continues to occur at New Employee Orientation... • TIC /training department to develop a plan to offer TIC to contract agencies Will develop a survey in the next quarter to monitor our progress as a Trauma Informed Agency.	9/30/21
Grant FY19-20	6. Continue to Provide services for Veterans a. Be in compliance with work plan as outlined in grant. b. Continue to advocate at a regional and state level to get Veterans access to needed care. c. Utilize CCBHC to provide Veterans' access to care outside of their typical benefits.	a. Our Veteran Navigator Grant is ongoing .We have met with court and VA officials to explore starting a Veteran's Court in St Clair County. c. The Veteran Navigator continues to advocate and link with the VA to ensure that recipients get needed services. This has also included linkage with ACCESS, especially with regard to SUD inpatient treatment. d. Veteran's continue to receive services above and beyond their VA or other private insurance benefit through the CCBHCA new Veteran's Walking group has been started. We have started a Yoga Nidra course that has been recognized by the Department of Defense as a valuable treatment for use with Veterans.	9/30/21
Integrated Care /CCBHC	7. Implement Well Environment • Implement a Healthy Environment for staff and individuals we support. • Assist in facilitating Wellness Wednesdays.	• Carrot App was implemented as a staff wellness tool. • Wellness resource table with educational materials is displayed with changing information monthly. Information is displayed digitally on TVs located in waiting areas.	9/30/21

Reference	PRIORITY GOALS / KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
	• Continue to work with the People's Clinic on improving primary care service delivery to the community. • Fully implement the wellness arm of CMH, supported through CCBHC funding (In Shape, Mediation, Yoga, etc.)	• An updated Clinic flyer was developed and put out for distribution to increase participation in integrated healthcare efforts. • Yoga, meditation, in-shape, nutritionist, MSUE classes are all fully implemented.	
Best Practice	8. Assess and explore EBP to provide SUD services. • Train Staff identified EBP for SUD • Additional staff to obtain their substance use credential. • SUD services to continue to expand agency wide/ • SUD groups to be developed and implemented	• Staff continue to work toward CE's and taking the test to obtain their SUD credentials. We have one staff working on a supervisory credential –in the event that a backup supervisor is needed. • SUD services have expanded- intake slots are continually full and services are offered in all parts of the county. • SUD groups are occurring virtually and in person.	9/30/21

Best Practice	9. To provide state- of the art, evidence based assessment and treatment to individuals at risk for suicide.
	• Train staff system wide in EBP for treatment for individuals at risk for suicide.
	• Train staff system wide on use of Columbia and applicable clinical tools for treatment.
	• Assess current EBP's for effectiveness
	• Research EBP's that may be implemented throughout the system.
		• CMH staff have received the Beck Institute CBT for Suicide.
		• Additional staff received training on assessing suicide through the Starr Behavioral Health Trainings.
		• Training on the Columbia Suicide Assessment has occurred and is available online for viewing for any staff that missed or started employment after the training
		• Zero Suicide trainings for all staff are underway. Core Staff Members attended the two day training this quarter.
		• Assessment of EBP's is ongoing through UM reviews, supervisory oversight and fidelity reviews.
		  • Research for additional EBP's is ongoing.
		  • Additional trainings in CPT, EMDR and PE are being offered.
			9/30/21

Staff Recruitment Program Staff Training Expand Programs	10. Develop and Implement a plan to recruit and maintain quality staff. • Work with HR and Program Supervisors to identify targeted problem areas in hiring and retention and develop an action plan. • Develop and implement a plan to offer comprehensive training and support to both new hires in operations and existing employees. • Identify training areas for program staff and develop training modules/online assistance/mentors for staff. • Develop programs to fill gap need areas of people served. • Work with supervisors to identify need areas and complete work plans to address those need areas. • Next step to become operational.	• HR has been working on a recruitment plan and have hired a recruitment specialist. HR is also working on developing a comprehensive training program for staff. . Resources for staff are on File Share 1 in an easily accessible format with "How to" PowerPoints, videos and tutorials. • Supervisors continue to assess the system to see what gaps exist and how best to fill them	9/30/21

Reference	PRIORITY GOALS / KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
MI MHC MDHHS	1. **Administrative Function** a. Submit the MDHHS-ORR Annual Monitoring Form to the MDHHS-ORR by January 15th of each year. b. Submit the SCCCMHA Semi-Annual Report to the MDHHS-ORR by June 30th of each year. c. Submit the SCCCMHA Annual Report to the MDHHS-ORR by December 30th of each year.	a. Annual Monitoring Form Q1: October 1, 20-December 31, 20-No activity Q2: January 1, 21-March 31, 21-Report submitted January 14, 21 Q3: April 1, 21-June 30, 2021-No activity Q4: July 1, 21-September 30, 2021-No activity b. Semi-Annual Report Q1: October 1, 20-December 31, 20-No activity Q2: January 1, 21-March 31, 21-No activity Q3: April 1, 21-June 30, 21-Report submitted on June 18, 21 Q4: July 1, 21-September 30, 21-No activity c. Annual Report Q1: October 1, 20-December 31, 20-Annual Report (FY20) submitted to MDHHS-ORR on 12/04/2020 Q2: January 1, 21, - March 31, 21-No activity Q3: April 1, 21-June 30, 21-No activity Q4: July 1, 21-September 30, 21-No activity	9/30/21
MDHHS GF Contract	2. **Complaint System** a. Report the number of substantiated Recipient Rights violations in St. Clair County by classification and provider location (identified by month/quarter).	a. Number of substantiated violations by classification and provider location **Q1: October 1, 20 – December 31, 20 – 18 Total** October 20 – 5 Substantiated Violations - Blue Water Developmental Housing, Inc. – Community Based Services: Dignity & Respect - Hope Network – Harbor Point Lapeer: Abuse: Class III - Professional Counseling Center: Dignity & Respect; Services Suited to Condition - SCCCMHA-Day Treatment/Night Watch Program: Confidentiality November 20 – 8 Substantiated Violations - Blue Water Developmental Housing, Inc. – Community Based Services: Family Dignity & Respect - IMPACT: Services Suited to Condition - Innovative Housing Development Corporation – Abbottsford Group Home: Abuse: Class II-Unreasonable Force - Innovative Housing Development Corporation – Hopps Adult Foster Care Home: Dignity & Respect - Innovative Housing Development Corporation – Liberty	9/30/21

Reference	PRIORITY GOALS / KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
		Group Home: Services Suited to Condition - Innovative Housing Development Corporation – Mayfield Group Home: Abuse: Class II-Emotional Harm; Dignity & Respect - Innovative Housing Development Corporation – Scott Group Home: Services Suited to Condition December 20 – 5 Substantiated Violations - Blue Water Developmental Housing, Inc. – Maple Group Home: Dignity & Respect; Family Dignity & Respect - Innovative Housing Development Corporation – Hopps Adult Foster Care Home: Dignity & Respect - Innovative Housing Development Corporation – Mayfield Group Home: Services Suited to Condition - Professional Counseling Center: Confidentiality **Q2: January 1, 21 – March 31, 21 – 16 total** January 21 – 5 Substantiated Violations - Blue Water Area Transit Commission: Dignity & Respect - IMPACT – Community Based Services (2): Disclosure of Confidential Information (2) - IMPACT – River Bend II: Dignity & Respect - IHDC – Ponderosa Group Home: Safe Environment February 21 – 8 Substantiated Violations - BWDH - Semi-Independent Group Home: Neglect: Class III - BWDH - Thornhill Group Home: Services Suited to Condition - IHDC – Hopps Adult Foster Care: Dignity & Respect - IDHC – Ponderosa Group Home: Services Suited to Condition - IHDC – Stone Creek Group Home: Abuse: Class II-Unreasonable Force - McIntyre Adult Foster Care Home (2): Safe Treatment Environment & Services Suited to Condition - SCCCMHA - Mobile Crisis Unit: Dignity & Respect March 21 – 3 Substantiated Violations - All-Ways Care: Services Suited to Condition - BWDH – Semi-Independent Group Home: Neglect: Class III - IMPACT – Community Based Services: Services Suited to Condition	

Reference	PRIORITY GOALS / KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
		Q3: April 1, 21 – June 30, 21 – 18 Total April 21 – 7 Substantiated Violations - All-Ways Care: Confidentiality & Services Suited to Condition - Community Enterprises – Port Huron: Dignity & Respect - Hope Network – Harbor Point Dearborn Heights: Dignity & Respect - IHDC – Hopps AFC: Dignity & Respect - IMPACT – River Bend II: Neglect: Class III - SCCCMHA – ACT: Confidentiality May 21 – 3 Substantiated Violations - BWDH – Community Based Services: Services Suited to Condition - IHDC – Scott Group Home: Services Suited to Condition - IMPACT – Community Based Services: Neglect: Class III June 21 – 8 Substantiated Violations - BWDH – Community Based Services: Abuse: Class II-Emotional Harm; Dignity & Respect; Services Suited to Condition - Hope Network – Harbor Point Lapeer: Abuse: Class II-Unreasonable Force - IHDC – Ponderosa Group Home: Neglect: Class III - ResCare Premier – Lawndale: Abuse: Class III; Dignity & Respect; Confidentiality **Q4: July 1, 21 – September 30, 21 – 16 Total** July 21 – 7 Substantiated Violations - BWDH – Community Based Services: Dignity & Respect - BWDH – Springborn Group Home: Family Dignity and Respect - Hope Network - Westlake Cottage #2: Dignity and Respect; Services Suited to Condition - IHDC - Abbottsford Group Home: Abuse: Class III - IHDC - Lincoln Group Home: Abuse: Class III - ResCare Premier – Raymond Group Home: Dignity and Respect August 21 – 5 Substantiated Violations - BWDH - Community Based Services: Dignity and Respect (2) - BWDH - Maple Group Home: Neglect: Class III - BWDH - Stoneybrook Group Home: Services Suited to	

Reference	PRIORITY GOALS / KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
		Condition - IMPACT - River Bend II: Sanitary/Humane Environment September 21 – 4 Substantiated Violations - BWDH -Community Based Services: Abuse: Class III - Hope Network – Harbor Point Lapeer: Neglect: Class III and Services Suited to Condition - IHDC – Progression AFC: Dignity and Respect	
MI MHC MDHHS	3. **Monitoring & Prevention** a. On an annual basis, ensure a Recipient Rights site review is completed at each direct-operated service location and each contracted service location.	**a. Site Reviews** **Q1: October 1, 20 – December 31, 20** October 20: 23 Site Visits November 20: 7 Site Visits December 20: 3 Site Visits **Q2: January 1, 21 – March 31, 21** January 21: 3 Site Visits February 21: 24 Site Visits March 21: 6 Site Visits **Q3: April 1, 21 – June 30, 21** April 21: 8 Site Visits May 21: 10 Site Visits June 21: 10 Site Visits **Q4: July 1, 21 – September 30, 21** July 21: 16 Site Visits August 21: 1 Site Visit September 21: 3 Site Visits	9/30/21
CARF MDHHS	4. **Monitoring: Incident Report System** a. Review Incident Reports within 10 business days of each reported incident. b. Identify and forward potential Critical Incidents to the Program Director/designee within three days of the incident to determine if the event meets Sentinel Event criteria. c. Enter "Critical Events" meeting MDHHS established criteria in OASIS on a monthly basis (Event Reporting). d. Identify potential Risk Events per MDHHS established guidelines.	a. **Review Incident Reports within 10 business days of each incident** **Q1: October 1, 20 – December 31, 20** - Reports reviewed within 10 business days: 514/514 **Q2: January 1, 21 – March 31, 21** - Reports reviewed within 10 business days: 591/591 **Q3: April 1, 21 – June 30, 21** - Reports reviewed within 10 business days: 696/696 **Q4: July 1, 21 – September 30, 21** - Reports reviewed within 10 business days: 787/787 b. **Critical Incidents** **Q1: October 1, 20 – December 31, 20** - Deaths - Suicide: 0 - Deaths – Non-Suicide: 18 - Hospitalizations due to Injuries/Medication Errors: 10 - EMT due to Injuries/Medication Errors: 2	9/30/21

Reference	PRIORITY GOALS / KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
		- Arrests: 1 **Q2: January 1, 21 – March 31, 21** - Deaths – Suicide: 1 - Deaths – Non-Suicide: 22 - Hospitalizations due to Injuries/Medication Errors: 1 - EMT due to Injuries/Medication Errors: 10 - Arrests: 2 **Q3: April 1, 21 – June 30, 21** - Deaths – Suicide: 0 - Deaths – Non-Suicide: 15 - Hospitalizations due to Injuries/Medication Errors: 1 - EMT due to Injuries/Medication Errors: 5 - Arrests: 0 **Q4: July 1, 21 – September 30, 21** - Deaths – Suicide: 0 - Deaths – Non-Suicide: 16 - Hospitalizations due to Injuries/Medication Errors: 2 - EMT due to Injuries/Medication Errors: 10 - Arrests: 2 c. **Enter Critical Incidents in OASIS** **Q1: October 1, 20 – December 31, 20** - October: Submitted on 11/19/20 - November: Submitted on 12/15/20 - December: Submitted on 01/12/21 **Q2: January 1, 21 – March 31, 21** - January: Submitted on 02/23/21 - February: Submitted on 03/18/21 - March: Submitted on 04/19/21 **Q3: April 1, 21 – June 30, 21** - April: Submitted on 05/14/21 - May: Submitted on 06/15/21 - June: Submitted on 07/15/21 **Q4: July 1, 21 – September 30, 21** - July: Submitted on 08/11/21 - August: Submitted on 09/16/21 - September: Submitted on 10/12/21 & 10/14/21 d. **Risk Events** **Q1: October 1, 20 – December 31, 20** - Harm to Self w/ EMT: 2 - Harm to Others w/ EMT: 0 - Police Calls by Mental Health Staff: 25	

Reference	PRIORITY GOALS / KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
		- Physical Management: 6 - Hospitalizations (Unscheduled Medical): 0 **Q2: January 1, 21 – March 31, 21** - Harm to Self w/ EMT: 2 - Harm to Others w/ EMT: 0 - Police Calls by Mental Health Staff: 36 - Physical Management: 13 - Hospitalizations (Unscheduled Medical): 14 **Q3: April 1, 21 – June 30, 21** - Harm to Self w/ EMT: 1 - Harm to Others w/ EMT: 0 - Police Calls by Mental Health Staff: 103 - Physical Management: 5 - Hospitalizations (Unscheduled Medical): 16 **Q4: July 1, 21 – September 30, 21** - Harm to Self w/ EMT: 0 - Harm to Others w/ EMT: 0 - Police Calls by Mental Health Staff: 108 - Physical Management: 13 - Hospitalizations (Unscheduled Medical): 21	
MI MHC	5. **Prevention** a. Review and update, as necessary, all SCCCMHA recipient rights related policies and procedures to ensure compliance with the Michigan Mental Health Code, MDHHS & PIHP Contracts, and requirements established by other regulatory and accrediting bodies.	**a. Policies Reviewed by the Office of Recipient Rights** **Q1: October 1, 20 – December 31, 20** - October: 1 policy reviewed - December: 4 policies reviewed **Q2: January 1, 21 – March 31, 21** - February: 4 policies reviewed **Q3: April 1, 21 – June 30, 21** - April: 4 policies reviewed - June: 4 policies reviewed **Q4: July 1, 21 – September 30, 21** - August: 5 policies reviewed	9/30/21
MI MHC MDHHS GF Contract	6. **Education/Training** a. Monitor training data to determine if staff members/volunteers (direct-operated & contract system) completed in-person Recipient Rights New-Hire training within 30 days of hire. i. Provide in-person New-Hire Recipient Rights training at least two times per month. ii. Report the number of staff trained compared to the number of staff hired. 1. Direct-Operated staff members/volunteers 2. Contract System staff members/volunteers	a. **All new-hire employees received recipient rights training within 30 days of hire** **i. Provide two trainings per month** **Q1: October 1, 20 – December 31, 20** - October: 3 trainings: 10/07/20, 10/15/20, & 10/20/20 - November: 3 trainings: 11/04/20, 11/13/20, 11/19/20, & 11/24/20 - December: 2 trainings: 12/02/20 & 12/15/20 **Q2: January 1, 21 – March 31, 21** - January: 2 trainings: 01/06/21 & 01/21/21	9/30/21

Reference	PRIORITY GOALS / KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
	b. Monitor training data to identify the staff members/volunteers (direct-operated & contract system) who completed in-person Recipient Rights Refresher training on an annual basis. i. Provide in-person Recipient Rights refresher training at least two times per month. ii. Report the number of staff trained. 1. Direct-Operated staff members/volunteers 2. Contract System staff members/volunteers	- February: 2 trainings: 02/03/21 & 02/18/21 - March: 03/03/21 & 03/18/21 **Q3: April 1, 21 – June 30, 21** - April: 2 trainings: 04/07/21 & 04/15/21 - May: 2 trainings: 05/05/21 & 05/20/21 - June: 2 trainings: 06/02/21 & 06/17/21 **Q4: July 1, 21 – September 30, 21** - July: 2 trainings: 07/14/21 & 07/15/21 - August: 2 trainings: 08/04/21 & 08/19/21 - September: 2 trainings: 09/01/21 & 09/30/21 **ii. Report percentage of employees trained within 30 days of hire** **Q1: October 1, 20 – December 31, 20** - October: SCCCMHA: 6/6 (100%); Contract Network: 7/8 (87.5%) - November: SCCCMHA: 10/10 (100%); Contract Network: 24/24 (100%) - December: SCCCMHA: 1/1 (100%); Contract Network: 14/16 (87.5%) **Q2: January 1, 21 – March 31, 21** - January: SCCCMHA: 3/3 (100%); Contract Network: 22/26 (85%) - February: SCCCMHA: 2/2 (100%); Contract Network: 24/27 (89%) - March: SCCCMHA: 1/1 (100%); Contract Network 13/13 (100%) **Q3: April 1, 21 – June 30, 21** - April: SCCCMHA: 3/3 (100%); Contract Network: 20/20 (100%); Outliers: 3 (not new-hires) - May: SCCCMHA: 5/5 (100%); Contract Network: 27/29 (93%); Outliers: 6 (not new-hires) - June: SCCCMHA: 10/10 (100%); Contract Network: 25/32 (78%); Outliers: 5 (not new-hires) **Q4: July 1, 21 – September 30, 21** - July: SCCCMHA: 11/13 (85%); Contract Network: 18/29 (62%) *Both of these percentages do not support the MHC requirement that all new-hire staff receive training in recipient rights protection within 30 days of hire - August: SCCCMHA: 7/11 (64%); Contract Network: 13/24 (54%) *Both of these percentages do not support the MHC	

Reference	PRIORITY GOALS / KEY TASKS	TIMELINE	
		Status (with Recommendations)	Date Updated
		requirement that all new-hire staff receive training in recipient rights protection within 30 days of hire - September: SCCCMHA: 11/11 (100%); Contract Network: 35/42 (83%) *The Contract Network percentage does not support the MHC requirement that all new-hire staff receive training in recipient rights protection within 30 days of hire b. **All employees received annual recipient rights training** **i. Provide two trainings per month** **Q1: October 1, 20 – December 31, 20** Due to COVID-19, the annual recipient rights training was conducted via paper manual this quarter. **Q2: January 1, 21 – March 31, 21** Due to COVID-19, the annual recipient rights training was conducted via paper manual this quarter. **Q3: April 1, 21 – June 30, 21** Due to COVID-19, the annual recipient rights training was conducted via paper manual this quarter. **Q4: July 1, 2021 – September 30, 2021** Due to COVID-19, the annual recipient rights training was conducted via paper manual this quarter. **ii. Report number of employees trained** **Q1: October 1, 20 – December 31, 20** 1. SCCCMHA employees: 5 employees trained 2. Contract Network employees: 96 employees trained **Q2: January 1, 21 – March 31, 21** 1. SCCCMHA employees: 5 trained 2. Contract Network employees: 304 trained **Q3: April 1, 21 – June 30, 21** 1. SCCCMHA employees: 160 2. Contract Network employees: 128 **Q4: July 1, 21 – September 30, 21** 1. SCCCMHA employees: 184 2. Contract Network employees: 161	

System Improvement-Denise Choiniere

		TIMELINE	
Reference	**PRIORITY GOALS / KEY TASKS**	**Status (with Recommendations)**	**Date Updated**
CARF	1. Maintain agency accreditation.	St. Clair received official notification on 4/22/20 of CARF's three-year accreditation (the maximum allowed amount). All needed follow up (Quality Improvement Plan) has been completed and submitted. Next, audit 2023.	9/30/21
Regulatory Requirement	2. Ensure compliance with applicable Corrective Action Plans (e.g. Region 10 PIHP, MDHHS, HSAG etc.)	MDHHS St. Clair CMH audit (SED,CW, HSW) has been completed. MDHHS has accepted St. Clair's Plan of Correction.	9/30/21
MDHHS	3. Monitor performance of each location through program performance indicators.	FY21, 3Q Local Program Performance Indicators have been forwarded to Direct Run Programs & Contract Agencies for completion. Information is being received and processed on a daily bases. All PI's will be going out for annual review in mid-August.	9/30/21
MDHHS, CARF	4. Achieve overall satisfaction through the annual surveys. a. Customer Satisfaction Survey b. Accessibility / Barriers to Services Survey c. Provider Satisfaction Survey d. Post-Discharge Survey e. MDHHS Satisfaction Survey f. Prescriber Satisfaction Survey	a. Customer Satisfaction Survey: FY21 survey will be administered in August. b. Accessibility to Services Survey: FY21 survey will be completed with the FY21 Customer Satisfaction survey. c. Provider Satisfaction Survey: The Provider Satisfaction Survey was administered in March and the report is completed. d. Post Discharge Survey: The Post Discharge Survey is ongoing. e. MDHHS Satisfaction Survey: The survey was not administered in 2018, 2019 or 2020. No additional information has been provided to the CMH's by MDHHS. f. Prescriber Satisfaction Survey: The Prescriber Satisfaction survey has not been administered. Date of administration is yet to be determined.	9/30/21

Reference	PRIORITY GOALS / KEY TASKS	TIMELINE Status (with Recommendations)	Date Updated
HHS P.6.5.1.1	5. Monitor performance on the following MDHHS performance indicators (MA/GF and MA only). PI 1. Access: Timeliness: The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within 3 hours. (95% standard) PI 2. Access: Timeliness: The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. ~~(95% standard)~~ PI 3. Access: Timeliness: Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional. ~~(95% standard)~~ PI 4a. Access: Continuity of Care: The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up within 7 days. (Standard: 95%) PI 10. Quality of Life: Adverse Customer Outcomes: The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. (Standard: 15% or less)	**PI 1) The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within 3 hours.** ***(Standard: 95%)*** **PI 2) The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for services.** ~~***(Standard: 95%)***~~ **PI 3) Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face to face assessment with a professional.** ~~**(Standard: 95%)**~~	9/30/21

PI 1)

	Q4 – FY20	Q1 – FY21	Q2 – FY21	Q3 – FY21
CMHSP	**100% Total** 100% Child 100% Adult	**100% Total** 100% Child 100% Adult	**100% Total** 100% Child 100% Adult	**100% Total** 100% Child 100% Adult
Medicaid	**100% Total** 100% Child 100% Adult	**100% Total** 100% Child 100% Adult	**100% Total** 100% Child 100% Adult	**100% Total** 100% Child 100% Adult

PI 2)

	Q4 – FY20	Q1 – FY21	Q2 – FY21	Q3 – FY21
CMHSP	**73.91% Total** 75.00% MI Child 72.15% MI Adult 82.98% DD Child 72.73% DD Adult	**80.43% Total** 82.14% MI Child 77.92% MI Adult 87.10% DD Child 92.59% DD Adult	**81.37% Total** 76.28% MI Child 83.06% MI Adult 83.33% DD Child 88.89% DD Adult	**80.04% Total** 82.26% MI Child 79.63% MI Adult 70.59% DD Child 89.47% DD Adult
Medicaid	**75.69% Total** 79.61% MI Child 71.37% MI Adult 90.70% DD Child 73.68% DD Adult	**79.77% Total** 80.65% MI Child 77.39% MI Adult 86.67% DD Child 92.00% DD Adult	**80.86% Total** 76.81% MI Child 82.11% MI Adult 82.86% DD Child 88.00% DD Adult	**79.90% Total** 83.18% MI Child 78.54% MI Adult 71.88% DD Child 94.44% DD Adult

PI 3)

	Q4 – FY20	Q1 – FY21	Q2 – FY21	Q3 – FY21
CMHSP	**78.38% Total** 87.50% MI Child 72.73% MI Adult 86.11% DD Child 93.33% DD Adult	**83.50% Total** 89.19% MI Child 79.91% MI Adult 85.29% DD Child 88.46% DD Adult	**84.39% Total** 84.55% MI Child 83.00% MI Adult 82.76% DD Child 100% DD Adult	**81.41% Total** 85.71% MI Child 80.48% MI Adult 75.00% DD Child 82.35% DD Adult
Medicaid	**78.78% Total** 86.90% MI Child 72.47% MI Adult 86.11% DD Child 92.31% DD Adult	**82.44% Total** 87.88% MI Child 78.79% MI Adult 84.38% DD Child 87.50% DD Adult	**84.33% Total** 83.67% MI Child 83.25% MI Adult 82.14% DD Child 100% DD Adult	**82.04% Total** 84.88% MI Child 81.91% MI Adult 75.00% DD Child 82.35% DD Adult

<table>
<tr><th></th><th></th><th colspan="2">TIMELINE</th></tr>
<tr><th>Reference</th><th>PRIORITY GOALS / KEY TASKS</th><th>Status (with Recommendations)</th><th>Date Updated</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th colspan="5">PI 4a) The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow up care within 7 days. (Standard: 95%)</th></tr>
<tr><th></th><th>Q4 – FY20</th><th>Q1 – FY21</th><th>Q2 – FY21</th><th>Q3 – FY21</th></tr>
<tr><td>CMHSP</td><td>95.08% Total
81.25% Child
97.17% Adult</td><td>97.14% Total
95.65% Child
97.56% Adult</td><td>96.97% Total
100% Child
96.34% Adult</td><td>98.11% Total
100% Child
97.33% Adult</td></tr>
<tr><td>Medicaid</td><td>94.92% Total
81.25% Child
97.06% Adult</td><td>97.12% Total
95.65% Child
97.53% Adult</td><td>96.84% Total
100% Child
96.15% Adult</td><td>98.06% Total
100% Child
97.22% Adult</td></tr>
</table>
<table>
<tr><th colspan="5">PI 10) The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. (Standard: 15%)</th></tr>
<tr><th></th><th>Q4 – FY20</th><th>Q1 – FY21</th><th>Q2 – FY21</th><th>Q3 – FY21</th></tr>
<tr><td>CMHSP</td><td>18.59% Total
18.18% Child
18.66% Adult</td><td>12.59% Total
11.54% Child
13.27% Adult</td><td>14.81% Total
21.05% Child
13.79% Adult</td><td>14.29% Total
12.90% Child
14.68% Adult</td></tr>
<tr><td>Medicaid</td><td>19.08% Total
18.18% Child
19.23% Adult</td><td>12.95% Total
11.54% Child
13.27% Adult</td><td>15.38% Total
21.05% Child
14.41% Adult</td><td>14.60% Total
12.90% Child
15.09% Adult</td></tr>
</table>
</td><td></td></tr>
<tr><td>Medicaid Meaningful Use</td><td>6. MU (Meaningful Use)
a. Reports are run and monitored per prescriber.
b. All measures must be met to obtain MU incentive monies.
c. Staff work closely with M-CEITA to ensure all measures are met.</td><td>1. No longer required.
2. Data was submitted March 20
3. M-CEITA completed SRA (Security Risk Assessment) as part of contract. Meeting occurred with M-CETA on 12.17.20. Follow up occurred January 21.</td><td>9/30/21</td></tr>
<tr><td>MIPS</td><td>7. MIPS/Choosing Wisely
a. Staff work with Alterum to avoid possible Medicare penalties.
b. Implement Choosing Wisely Guidelines
c. Implement PDSA Cycles (Plan, Do, Study, Act)
d. Implement technology to improve patient access and quality of service.</td><td>a. Reports have been run for Group Reporting. No longer required.
b. No update FY21, waiting on contract, delayed due to COVID.
c. Information provided to the prescribers.
d. PDSA Cycles (Plan, Do, Study, Act) has been completed (e.g. AFC/CFC training requirements).
e. New version of program may start in 21. Still waiting for information.</td><td>9/30/21</td></tr>
<tr><td>Region 10 Contract Requirement</td><td>8. Enhance Dashboard Indicators and other data mining capabilities that facilities population management/analysis.
a). Improve usage of CC360 reports for population analytics.
b). Utilize Dashboard for Quality Improvement Projects.</td><td>a. Data analyst is working with Care Connect 360 reports, Crystal reports and with Power BI dashboard. Additional CCBHC reports to be added from PCE.</td><td>9/30/21</td></tr>
</table>

Information Technology-Dann Hayes

		TIMELINE	
Reference	**PRIORITY GOALS / KEY TASKS**	**Status (with Recommendations)**	**Date Updated**
Good Administrative Practice	1. Continuous improvement of Customer Service. a. Disaster Recovery Preparedness (45 CFR 164.308.) 1. Review IT Department Written Plan to ensure it addresses on-going software/hardware solutions and process changes (7/31/21). 2. Complete annual simulated disaster recovery test and implement corrective actions and/or compensating controls, where appropriate. • Electric Avenue – (7/31/21) • Marine City – (7/31/21) • Capac – (7/31/21) • ABA – (7/31/21) 3. Complete HIPAA Risk Assessment (1/31/21) and Develop/Implement Plan (45 CFR 164) (9/30/21).	a. 1 An on-going document that IT uses to track projects. Always under review by IT supervisor/Director. a. 2 Full successful restore of the old Linux based Finance server was done on Jan 15, 2021. The Children's building also had a final full test of the new generator which required a full power down event for the building. All network components passed the test with no issues to report. Annual Disaster Recovery Test was Aug 5th, 21. No significant issues to report as all went as planned. a. 3 HIPAA Risk assessment and Plan is completed and documented for FY21.	9/30/21
Good Administrative Practice	*2.* Promote the efficient use of existing technology. a. Replace/Upgrade Hardware related to IT Equipment Replacement Schedule to remain current with technology and support agreements. 1. Upgrade network switches in IDF 2. Upgrade WIFI access points b. Implementation of Netmotion to streamline the VPN experience for all remote employees. c. Implementation of Papercut to streamline all secure printing. d. Upgrade to Cisco Jabber for all employees.	a. 1 The new cabinet in the IDF now has a new switch in place to give additional capacity to the main building. a. 2. All access points have been upgraded as of 12/31/2020. With the new area of offices created at the main office, we have identified opportunities to strengthen our coverage. We are working on adding new access points on first floor. All Access points at all locations have been upgraded as needed as of 5/25/21 . – COMPLETED b. Netmotion is licensed and installed on all laptops. – COMPLETED c. Papercut installed throughout the agency and fully available as of March 2021. – COMPLETED d. IT Resources has been working with the IT Dept. to prepare this upgrade giving more functionality to the Jabber experience, including a potential chat feature and easier voicemail indicators and access. All users utilizing jabber have been upgraded. All new users will be on the newest version going forward. – COMPLETED	9/30/21
Good Administrative Practice	3. Improve technology to increase operational efficiency. a. e911 – Updating our phone system to give responders a better idea of where people are physically located within buildings. A new state law that begins in January of 20. b. Password requirement changes for ALL PCs and other technology. c. Network Security Audit (7/31/21) and Remediation of any	a. The Cisco Presence server was added in Spring 2021. We are working through the configurations to add e911 next. ONGOING to FY22 b. We are still discussing the necessary need for this in our environment with other security experts to see if this change is necessary considering the additional layers we have added in the past	9/30/21

		TIMELINE	
Reference	**PRIORITY GOALS / KEY TASKS**	**Status (with Recommendations)**	**Date Updated**
	vulnerabilities found. (12/31/21) d. Review Internet bandwidth needs for the agency with the increase in mobility and video conferencing. e. Review and update/upgrade Video Conferencing needs across the agency. f. Implement new strategy for updating all agency devices, with special attention to update devices that are mobile (laptops).	two years to our network. The bigger emphasis appears to be on the EMR, which plans are underway to provide MFA (Multi Factor Authentication). c. The IT Department has been utilizing Rapid7's InsightVM to run our own tests against our servers and external facing devices. We remediate all findings when they are reported to us. We test monthly. We will have a full security audit from an external auditor in Fiscal Year 22. d. The internet bandwidth was increased from 100mb to 1,000mb speeds in late December 2020. This had immediate impact on improvement of video call qualities as well as other network access for staff both from a remote use, and from an interoffice use. -- COMPLETED e. Lifesize licensing was increased in FY21 1Q to accommodate all staff needing it. Zoom licensing was also acquired for large conferences that address community events for the Community Relations Team. Two new rooms received Lifesize video units, and another room on the first floor of main will be receiving one by June 1. All UNITS have been deployed as of June 1 -- COMPLETED f. The IT Dept. purchased KACE. We have already implemented the patching solution and ran the first set of patching to all workstations as of 7/10/2021. We had a 55% success rate on the first attempt. Follow up this week got us to 77% patched as of 7/14/21.	

Facilities-Mike Klemmer

		TIMELINE	
Reference	**PRIORITY GOALS / KEY TASKS**	**Status (with Recommendations)**	**Date Updated**
Good Administrative Practice	1. Continuous improvement of Customer Service a. Disaster Recovery Preparedness (45 CFR 164.308.) 1. Review/Revise Department written procedures, as appropriate. (9/30/21) 2. Complete Annual simulated DR test and implement corrective actions/compensating controls, where appropriate; perform periodic testing of generators and emergency lighting. Electric Avenue, Marine City, Children's & Capac (6/30/21)	Generator has been delivered and installed at the Children's location on 24th Street. Unit is fully functional as of 1/20/21. Purchased a remote monitoring system for each of the four generators which will allow us to communicate, monitor and control all of them from a central PC, projected installation/set-up is May 21. Remote monitoring system for generators has been delayed due to supply chain issues. Units arrived last week and hope to have installed before 7/30/21. Monitors are in process of being installed as of 9/30/21 by our electrician. Annual DR test tentatively scheduled for August 3rd after hours. DR	9/30/21

		TIMELINE	
Reference	**PRIORITY GOALS / KEY TASKS**	**Status (with Recommendations)**	**Date Updated**
		test was performed with no significant issues related to Facilities.	
Good Administrative Practice	2. Promote the efficient use of existing Facilities a. Complete comprehensive updates to the Facilities Operations Manual detailing responsibilities, functions, vendor contacts and maintenance/ replacement schedule of hardware and vehicles as well as all CMH facilities preventative maintenance. (9/30/21) b. Develop and maintain a Facilities Procedures Manual identifying and documenting all "key" tasks in the department; use for staff training and reference. (9/30/21)	Ongoing	9/30/21
	3. Renovate existing space at Electric Avenue to accommodate 18 new offices and 1 meeting room. Furnish new spaces. Have all inspections passed, obtain occupancy for this area and move staff in by mid December 20. a. Install new parking lot at 24th Street Children's location. Engineer has been hired, complete all survey's and testing, design parking lot, obtain all necessary permitting, solicit bids from contractors, select contractor to perform work and complete by late spring 21.	Renovation of the 1st Floor area at Electric Ave with 18 new offices and 1 meeting room is complete. All inspections have been passed and occupancy has been issued. Furniture has been delivered and installed. First group of staff are moving in on 1/20/21. BMJ Engineers has been working on the design phase of the new parking lot at 24th Street. Plans are being submitted to the proper permitting agencies a tentative schedule has been done up with work beginning mid to late April 21. Due to the timing of the township Planning Commission meeting and required responses to the township engineers review of the submitted plans the tentative start date has been pushed back to early July 21. Advertisement for bids has been published. Bid opening scheduled for July 29th, with the goal of starting mid August. Contractor was selected and approved at the August board meeting. Work commenced on-site on September 7th. Work was temporarily halted due to exposing a water main on the property. Revised plans were completed and submitted to the township. Work resumed the week of September 27th.	9/30/21
Good Administrative Practice	4. Improvements to increase operational efficiency a. Maintain a "Vehicle Use Policy" including general usage guidelines, balancing mileage/age of vehicles by location and routine mileage reports to dictate ideal agency vehicle fleet size. b. Maintain a SDS manual, including pictures of products, and complete training with staff concerning use of products and appropriate storage. c. Monitor and maintain existing CMH properties. d. Follow a fueling and maintenance schedule for all company vehicles to better track fueling and maintenance costs. e. Utilize Track-It to document and monitor maintenance requests. f. Utilize Fleet Commander software to optimize vehicle fleet	Ongoing. Fleet Commander (vehicle reservation software) is fully operational. Staff feedback overall has been very positive and scheduling/efficiency of vehicle usage appears to be much better with a corresponding decrease in staff mileage reimbursement. The search for an additional group home has begun. Criteria has been given to a realtor to aid in the search process. There has been no success so far with regards to an additional home, the search continues.	9/30/21

		TIMELINE	
Reference	**PRIORITY GOALS / KEY TASKS**	**Status (with Recommendations)**	**Date Updated**
	efficiency, use reporting capabilities to analyze optimal fleet size.		
Good Administrative Practice CARF Health & Safety	5. Implementation of Disaster Recovery/Business Resumption Plan meeting CMS requirements. *coordinate with Region 2 North a. Build on existing Disaster Recovery/Business Resumption Plan (DR/BRP) with the following activities: 1. Continue participation in MiHAN (Health Alert Network) 2. Implement CMH closed WINS group for staff notifications. 3. Update existing document to include the Pandemic Plan and also update to reflect any changes in process, advances in technology, etc. 4. Complete planning process documents for each program. Documents identify: • Possible alternative locations • Prioritization of essential functions • Order of succession • Vital information/records 5. Identify process for addressing internal disaster (small and large scale) 6. Identify process for addressing community disaster (working with EOC, Homeland Security, etc.) b. Disseminate updated DR/BRP to key staff c. Train staff on the DR/BRP d. Periodically conduct tabletop exercises/drills	a.1. Ongoing a.3. Formal updates to COVID-19 Preparedness & Response Plan June 20, 7/31/20, 12/11/20, 3/5/21, and 6/11/21. Living document with periodic updates. Periodic email updates sent to staff as CDC, MDHHS, OSHA/MIOSHA regulations change. b. COVID-19 Preparedness & Response Plan binders created and shared with all supervisory staff March 21 (updates and supporting documents always available via Sage People and CMH website).	9/30/21

Utilization Management-Michelle Measel-Morris

Reference	PRIORITY GOALS / KEY TASKS	TIMELINE	
		Status (with Recommendations	Date Updated
Region 10 Delegation Contract Requirement	1. Integrated Health Care: Staff will participate in joint care meeting with Medicaid Health Plans and Region 10 PIHP. a. Monitor and report on Care Connect 360 program implementation and usage. b. Random select cases will be reviewed for reduction in non-emergent emergency department use, linkage with primary health care access and applicable linkage with Veterans' services. c. Random select cases will be reviewed for follow up after hospitalization for mental illness within 30 days (Standards: 70% ages 6-20 and 58% ages 21 and older). d. Annual narrative is due to the PIHP summarizing improvements in joint care activities/metrics.	Efforts continue w/joint care meetings.	9/30/21
Good Clinical Practice/CARF Recommendation	2. Utilization Review: For both Contract Provider and Direct Care: Conduct quarterly clinical case record review analyses on select General Fund and Medicaid medical records. a. Clinical review to ensure adherence to clinical protocol for cost effective and well coordinate services. b. Conduct claims verification associated with clinical case record reviews. Report claims discrepancies. Identify and address over/under-utilization. c. Completed special UM reviews upon need or request. d. Produce and distribute quarterly reports.	In process	9/30/21

Reference	PRIORITY GOALS / KEY TASKS	TIMELINE	
		Status (with Recommendations	Date Updated
Good Business Practice	3. Claims Verification: Conduct claims verification reviews on select medical records in the Provider Network to determine whether customer services / supports are appropriately delivered by all providers (i.e., all program clinical case records/recording comply with all applicable internal and external customer requirements) at a 95% compliance rate (no more than 5% errors). Complete Claims Verification Reviews of 2.5% of Medicaid individuals receiving services through Contract Agencies a. Complete non-primary case holder review concurrent with Contract Management site visits for Residential, CLS and other community providers. b. Complete annual Medicaid Claims Verification Methodology Report. c. Implement Service Activity Log requirement for contract agency staff – tie to claims review (supporting documentation must be available in the electronic health record for a warning will show to not pay the claim).	In process	9/30/21
Region 10 Delegation Contract Requirement	4. Utilization Management / Trend Analyses: Report on over / under-utilization of the following programs: ACT, Home Based, ABA and Supports Coordination/ Case Management to the PIHP monthly QMC.	Being revised due to UM redesign.	9/30/21
Good Clinical Practice	5. BTPRC: Conduct quarterly oversight of Behavior Treatment Plan Review Committee (BTPRC) activities. a. Risk Events Analysis Report – quarterly 1.) HSW, SEDW and CW Emergency use of Physical Management tracking b). System Improvements identified at BTPRC to provide additional training opportunities for staff and/or opportunities to reduce risk factors for individuals served.	a. Risk Events Analysis Report – Quarterly **Q1: October 1, 20 – December 31, 20** 1.) HSW, SEDW, and CW Emergency Use of Physical Management: 0 Incidents of PM this quarter for this population b.) System Improvement Recommendations: None **Q2: January 1, 21 – March 31, 21** 1.) HSW, SEDW, and CW Emergency Use of Physical Management: 0 Incidents of PM this quarter for this population b.) System Improvement Recommendations: None **Q3: April 1, 21 – June 30, 21** 1.) HSW, SEDW, and CW Emergency Use of Physical Management: 0 Incidents of PM this quarter for this population. b.) System Improvement Recommendations: - Employees receive training, per the SCCCMHA training grid and as needed, in motivational interviewing, positive behavior supports, and the individual-specific interventions established by Individual Plans of Services in support of the mental health needs of the individuals served by our agency.	9/30/21

Reference	PRIORITY GOALS / KEY TASKS	TIMELINE	
		Status (with Recommendations	Date Updated
		- Employees continue to utilize motivational interviewing and positive behavior supports while following the pro-active and re-active strategies in an individual's Individual Plan of Services to support the mental health needs of each individual served by our agency. - Employees continue to encourage recipients to obtain ongoing physical health services and mental health services as part of the agency's integrated healthcare model. **Q4: July 1, 21 – September 30, 21** 1.) HSW, SEDW, and CE Emergency Use of Physical Management: 1 Incident of PM this quarter for this population b.) System Improvement Recommendations: - Employees receive training, per the SCCCMHA training grid and as needed, in motivational interviewing, positive behavior supports, and the individual-specific interventions established by each recipient's Individual Plan of Services to support the mental health needs of the individuals served by SCCCMHA. - Employees utilize motivational interviewing, positive behavior supports, and the individual-specific interventions identified in each recipient's Individual Plan of Services to support the mental health needs of the individuals served by SCCCMHA. - Employees continue to encourage recipients to obtain ongoing physical health services and mental health services as part of SCCCMHA's integrated healthcare service model.	

QAPIP Performance Improvement Projects-Michelle Measel-Morris

		TIMELINE	
Reference	**PRIORITY GOALS / KEY TASKS**	**Status (with Recommendations)**	**Date Updated**
Good Clinical Practice	1. To participate in the Region 10 PIHP QAPIP Performance Improvement Projects a. Medical Assistance for Tobacco Use Cessation b. Follow up visit after Hospitalization of Mental Health Diagnosis	Data Management supervisor researching options to progress improvement. a. Tobacco Cessation (PIP 1): 1. Tobaccos Cessation information was added in the waiting room area of the main building and also to the Virtual Awareness Month Topic Program that is shown on the TVs at all three CMH sites. 2. Peer started the Smoking Cessation Group on June 29th but no one has attended yet. 3. Educating staff about the importance of Smoking Cessation services and Nicotine Replacement Therapy should be going out this month. b. Follow Up to Hospitalization (PIP 2): 1. The two pilot programs to see if having a worker make person to person appointment reminder calls and doing a person to person phone call or face to face outreach within 24 hours of missed apt improves the chances of individuals keeping follow up to hospitalization apt started in June. 2. The following things continue to occur: a. McLaren Hospital Liaison (HL) staff continue to discuss barriers with individuals making it to their follow up to hospitalization apt while on the unit. b. McLaren HL staff verify and update contact info in OASIS chart. c. McLaren HL staff make sure follow up apt is highlighted in hospital D/C packet. d. CIU does outreach phone calls. e. Automated phone calls/texts are being done. f. ACCESS is emailing case holder and supervisor about admits and discharges. g. Out-of-County HL staff are working on improving communication with hospitals. i. More staff continue to be hired.	9/30/21
MDHHS Audit Requirement	2. To participate in the MDHHS Quality Improvement Project for HSW, CWP and SEDW a. Staff training compliance b. Service provision compliance	Ongoing	9/30/21