FY 2024

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 (SCCCMH), which is developed and approved annually. The data included in this report covers the reporting period of October 1, 2023 through September 30, 2024.

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 SCCCMH's overall systemic processes. All Workgroups, Committees and Sub-Committees have reported the status of each goal assigned.

Reference	Employee & Community Relations – Karen Zultak PRIORITY GOALS/KEY TASKS	TIMELINE- Status (with Recommendations)
Strategic Plan Priority 2 Objective 2.6.a Priority 3 Objective 3.2.a Objective 3.2.b	**ADVERTISING & COMMUNICATIONS ACTIVITIES** The activities intended to promote SCCCMHA service information, integrated healthcare initiatives, and community events through paid and unpaid media, and effective communication methods to effectively reach internal and external audiences. (Legislative communications/activities are listed in a separate goal) Print ads, radio ads, television ads, billboards, social media ads, on-line streaming stations/publications, editorial content, distribution of event flyers, public service announcements, press releases.	FY 2024 – Q1: October 1, 2023 – December 31, 2023 • Blue Water Senior Options • Blue Water Woman Magazine • Ebw/Thumbcoast tv • LAMAR (billboards, digital and static) • Radio First • The Keel • WGRT • Yale Expositor • WPHM Interview, Paul Miller Show (interview on 12-6-24) • In Focus with Paul Dingeman (interview on 12-7-24) FY 2024 – Q2: January 1, 2024 – March 31, 2024 • Blue Water Senior Options • Blue Water Woman Magazine • Ebw/Thumbcoast tv: 1-5-24, 1-15-24, 2-5-24, 2-19-24, 3-11-24, 3-25-24 • LAMAR (billboards, digital and static) – Run for Recovery event promotion • Radio First (Mental well-being in the new year) • The Keel/Second Wave Media: Articles published on 1-9-24, 1-11-24, 1-16-24, 1-23-24, 1-23-24, 2-15-24, 3-8-34 • WGRT (Mental well-being in the new year) • Yale Expositor • In Focus with Paul Dingeman: 1-18-24, 2-1-24 • WPHM Interview, Paul Miller: 1-3-24, 2-7-24 • 3-14-24: CMH Brief (external newsletter) FY 2024 – Q3: April 1, 2024 – June 30, 2024 • Ebw/Thumbcoast tv: 4/4/24, 4/12/24, 5/3/24, 5/13/24, 6/3/24, 6/17/24 • LAMAR (billboards, digital and static) – General MCU, Mental Health Month • Radio First Mental Health Minute: Autism Acceptance Month, Mental Health Month, Stigma, Pride Month, Men's Health Month • WGRT Mental Health Minute: Autism Acceptance Month, Mental Health Month, Stigma, Pride Month, Men's Health Month • The Keel/Second Wave Media: Article published on 6/4/24 • Yale Expositor – Medical Directory Listing • In Focus with Paul Dingeman: 4/18/24 • WPHM Interview, Paul Miller: 5/1/24 • CMH Brief (external newsletter): 6/18/24

Reference	Employee & Community Relations – Karen Zultak PRIORITY GOALS/KEY TASKS	TIMELINE- Status (with Recommendations)
		FY 2024 – Q4: July 1, 2024 – September 30, 2024 • EBW/Thumbcoast TV: Minority Mental Health Culturally Competent Care, Suicide Prevention, National Recovery Month, Recovery Focused Communities • LAMAR (billboards, digital and static): SCCCMH services, Mobile Crisis Unit, Recovery Summit • Radio First Mental Health Minute: BIPOC month, National Recovery Month, Positive Effects of Friendship • WGRT Mental Health Minute: BIPOC Month, National Recovery Month, Positive Effects of Friendship • The Keel/Second Wave Media: Veteran's Services, Stigma
Strategic Plan Priority 2 Objective 2.1.a Objective 2.1.b Objective 2.1.c Objective 2.1.d Objective 2.4.c Objective 2.6.d Objective 2.6.e	**MARKETING, OUTREACH & COMMUNITY COLLABORATION ACTIVITIES** Participation in community benefit activities intended to promote SCCCMHA services and good mental health, reduce stigma, and increase community collaboration (with external organizations, court systems, law enforcement, schools, etc). Providing resource materials (booklets, brochures, fact sheets, giveaway items, etc.), speakers' bureau presentations for external organizations, trainings and presentations open to the community, sponsorships, and participation in health fairs and other community events.	FY 2024 – Q1: October 1, 2023 – December 31, 2023 • Ongoing updates to various booklets, brochures, and fact sheets • 10-6-23: Marine City Middle School – How to Help a Friend • 10-9-23: SCC Library Staff Training – Stress Reduction Skills • 10-10-23: RESA Counselors training – Inservice • 10-13-23: MHFA Adult • 10-13-23: SCC Nursing Students – CMH Services • 10-18-23: Wadhams Baptist Church Senior Group – Depression and Anxiety • 10-24-23: Community presentation w/ ADCC – What Self-Care in Caregiving Really Means • 10-25-23: MHFA Adult • 11-7-23: Community presentation with ADCC – What Self-Care Really Looks Like FY2024 – Q2: January 1, 2024 – March 31, 2024 • Sponsorships: Marine City Chamber of Commerce Fire, Ice and Spice Winter Festival, Blue Water Safe Horizons LOL Comedy Club, The Arc Show the Love Dinner Dance, SCC CAN Council Dinner for Kids' Sake, SCC CAN Council Tee off for Kids, Hunter Hospitality House Hope Blooms, SCC Council on Aging Main Street Memories, Carrie Kerbrat Memorial golf outing, Operation Transformation Family Night, Port of Hopes Bowling fundraiser, Marysville Little League. • Casual for a Cause: Mid-City Nutrition, Blue Water Recovery Outreach Center, People's Clinic for Better Health, Kids in Distress, Habitat for Humanity, CMH Lifeline Fund, CMH Endowment Fund, CMH Caring for Kids Fund • 1-12-24: SC4 Nurses Training (for SC4) • 1-15-24: Trauma Informed Care and Resilient Educators (for East China School District) • 1-15-24 and 1-16-24: MHFA-A (Algonac Fire Department)

Reference	Employee & Community Relations – Karen Zultak PRIORITY GOALS/KEY TASKS	TIMELINE- Status (with Recommendations)
		• 1-24-24: Embedded Clinician Presentation (for PHPD Chief Resource Committee) • 2-2-24: Belle River Winery Autism Night (resource table) • 2-6-24: Michigan Group Home Staff Training: Trauma and Self Care • 2-10-23: Fire, Ice and Spice (resource table) • 2-14-24: Self Care (for Algonac High School staff) • 2-27-24: Harbor Impact Ministries (resource table) • 3-16-24: Home and Garden Show (Veteran's Navigator resource table) • 3-26-24: Gift of Knowledge Presentation (SCC Library) • 3-31-24: Port Huron Police Department Platoon Training FY 2024 – Q3: April 1, 2024 – June 30, 2024 • Sponsorships: Dementia & Alzheimer Association of St. Clair County, Lake Huron Foundation annual golf outing, Victory Day • Casual for a Cause: YMCA, CMH Employee Emergency Fund, Blue Water Safe Horizons, Autism Support Group, Community Resource Fair, Car Seat Program, A Beautiful Me, People's Clinic for Better Health, YMCA • 4/8/24: Port Huron Police Department New Hire Training • 4/8/24: Marine City High School #1: Social Supports and Empathy vs Sympathy • 4/15/24: Marine City High School #2: Self Esteem and Social Supports • 4/16/24: SONS Ribbon Cutting (resource table) • 4/20/24: Port Huron Police Department Autism Event (resource table) • 4/22/24: Marine City High School #3: Communication and Emotions • 4/27/24: YMCA Healthy Kids Day (resource table) • 4/29/24: Mental Health First Aid – Youth • 4/30/24: Harbor Impact Day • 4/3/24: Marine City Chamber of Commerce Autism Presentation • 4/5/24: Mental Health First Aid – Adult • 5/6/24: Marine City High School Health Class Presentation #5 • 5/8/24: Community Resource Fair (resource table) • 5/9/24: Yale Public Schools Board of Education Presentation (creative arts contest announcement) • 5/10/24: State of the County (informational packets for all attendees) • 5/13/24: Marine City High School Health Class Presentation #6 • 5/13/24: Boundaries Training • 5/20/24: Algonac Community Schools Board of Education Presentation (creative arts contest announcement) • 5/20/24: East China School District Board of Education Presentation (creative arts contest announcement) • 5/20/24: Memphis Community Schools Board of Education Presentation (creative arts contest announcement) • 5/21/24: Harbor Impact Days (resource table)

Reference	Employee & Community Relations – Karen Zultak PRIORITY GOALS/KEY TASKS	TIMELINE- Status (with Recommendations)
		• 5/23/24: Marysville Public Schools Board of Education Presentation (creative arts contest announcement) • 5/31/24: Health & Resource Day at the Ally Center (resource table) • 5/20/24: Marine City High School Health Class Presentation #7 • 5/29/24: Women's Health Awareness • 6/1/24: Celebrate your Kid Day (resource table) • 6/11/24: Supporting the Emotional Health of Kids (St. Clair Parks and Rec staff) • 6/12/24: Marine City Connect and Grow (resource table) • 6/13/24: Supporting the Emotional Health of Kids (YMCA Summer Staff) • 6/14/24: What is Mental Health First Aid (BWDH staff) • 6/19/24: Juneteenth Celebration (resource table) • 6/20/24: Autism Support Group Fun Day (resource table) • 6/25/24: Workplace Wellness & Auria Solutions (resource table) • 6/26/24: Fun & Fitness Day (resource table) • 6/30/24: Blue Water Pride Fest (resource table) FY 2024 – Q4: July 1, 2024 – September 30, 2024 • Ongoing updates to various booklets, brochures, and fact sheets • 7/12/24: Recovery BBQ – Odyssey House • 7/13/24: Blue Water Allies Open House • 7/17/24: SCC 4-H Fair Military Day • 7/17/24: Port Huron Rotary International Parade • 7/18/24: Operation Transformation Family Night • 7/27/24: Main Street Memories • 7/29/24: Law Enforcement New Hire Training • 7/30/24: Harbor Impact Day • 7/30/24: Port Huron Police Department Platoon Training: Compression is Healing • 8/3/24: Marine City Maritime Days • 8/4/24: Marine City Maritime Parade • 8/5/24: MHFA for SC4 Nursing Students • 8/6/24: City of Algonac Touch A Truck • 8/14/24: BWCA Backpack Giveaway • 8/16/24: Victory Day at PHHS • 8/17/24: Lake Huron Medical Center Health Fair • 8/23/24: CMH101 for SC4 Nursing Students • 8/27/24: Harbor Impact Day • 9/3/24: Algonac High School staff presentation: Bullying Prevention • 9/8/24: CAN Council Sunday Funday • 9/14/24: BWROC Recovery Fest • 9/15/24: Capac Chamber of Commerce Health Fair • 9/18/24: MDHHS Meet & Greet

Reference	Employee & Community Relations – Karen Zultak PRIORITY GOALS/KEY TASKS	TIMELINE- Status (with Recommendations)
		• 9/21/24: Dementia Alzheimer Walk/Run • 9/24/24: Harbor Impact Day • 9/27/24: Baker College Employee Health Fair
Strategic Plan Priority 2 Objective 2.6.b Priority 3 Objective 3.2.a Objective 3.2.b	**PUBLIC RELATIONS & COMMUNICATIONS ACTIVITIES** The promotion of SCCCMHA community relations activities CMH Players, SCCCMHA Celebration of Recovery Awards, SCCCMHA Creative Arts Contests, SCCCMHA Run for Recovery, External crisis/advocacy alert communications, internal communications, In the Know newsletters, email communications to staff, Pop-up News, Intranet postings, social media activities, and operation of SCCCMHA web-site.	FY 2024 – Q1: October 1, 2023 – December 31, 2023 • 10-2-23: MIAW Hidden Battles – Identifying and Addressing Anxiety and Depression in Children and Adults • 10-3-23: Blue Water Area Chamber of Commerce Women's Leadership Conference • 10-3-23: Celebration of Recovery • 10-4-23: MIAW Hope in the Darkness – Suicide Prevention Strategies and Community Support • 10-8-23: Walk to Remember, Walk 2 Prevent (CMH Resource Table) • 10-20-23: Donuts with Deputies • 11-16-23: Great American Smokeout activities • 11-17-23 and 11-18-23: CMH Players • 11-28-23: Harbor Impact Ministries – IMPACT Day • 11-28-23: Giving Tuesday • 12-6-23: Blue Water Area Chamber f Commerce Lunch and Learn • 12-6-23: WPHM Interview, Paul Miller Show • 12-7-23: In Focus with Paul Dingeman • 12-18-23: MHFA Adult FY 2024 – Q2: January 1, 2024 – March 31, 2024 • 3-15-24: Prowler's Mental Health Awareness Night FY 2024 – Q3: April 1, 2024 – June 30, 2024 • 5/22/24: SCCCMH Annual Awards breakfast • 5/29/24: Marine City – Broadway Open House & Ribbon Cutting FY 2024 – Q4: July 1, 2024 – September 30, 2024 • 7/12/24: MHFA Youth • 8/12/24: MHFA Adult • 8/26/24: Overdose Awareness Week, staff photo • 9/8/24: 988 day • 9/17/24: Walk A Mile in My Shoes • 9/21/24: NAMI Walk • 9/1 – 9/30/24 – Recovery Summit
Strategic Plan Priority 1 Objective 1.1.d Priority 3 Objective 3.4.b Priority 4 Objective 4.2.c	**TRAINING ACTIVITIES** The activities intended to promote professional development, promote staff competency and skill development for SCCCMHA employees and other trainings that are required by federal, state or accreditation bodies. Required trainings as listed on the training grid, Brown Bag Lunch trainings, leadership trainings, trainings in evidence-based practices,	FY 2024 – Q1: October 1, 2023 – December 31, 2023 • 11-7-23: Primary Caseholder Training • 11-8-23 and 11-9-23: Benefits and Work Coaching • 11-20-23: HSW Goal Writing • 12-6-23: Leadership Lunch and Learn, Self Care of A Leader • 12-8-23: All Staff In-Service: Connecting Across Generations • 12-18-23: MHFA Adult • 12-13-23: Overdose Response and Prevention Lunch and Learn

Reference	Employee & Community Relations – Karen Zultak PRIORITY GOALS/KEY TASKS	TIMELINE- Status (with Recommendations)
	etc. that are offered to internal SCCCMHA staff only (not offered to the community)	FY2024 – Q2: January 1, 2024 – March 31, 2024 • 1-8-24, 1-9-24, 1-10-24: Eleos Virtual Training • 1-19-24: Interactive Journaling • 1-23-24: Peer Ethics Training • 1-23-24 and 1-24-23: Eleos Training • 2-7-24: Leadership BBL: 15 Invaluable Laws of Growth • 2-12-24: Veteran's Training • 2-28-24 and 2-29-24: Practicing Effective Management (training for supervisors, presented by TBD Solutions) • 3-5-24: Pain Management (SW license requirement) • 3-7-24: Practicing Effective Management – Advanced (training for supervisors, presented by TBD Solutions) • 3-8-24: MHFA-Y • 3-11-24: Human Trafficking • 3-12-24 and 3-13-24: Motivational Interviewing – Basic • 3-22-24: Nutrition Lunch and Learn FY 2024 – Q3: April 1, 2024 – June 30, 2024 • 4/8/24: PMTO Internal Coaching • 4/10/24: Leadership Gold • 4/23/24: Autism 101 • 5/13/24: Prolonged Exposure • 5/13/24: PMTO Internal Coaching • 5/15/24: CMH Peer Supports MI Series Part 1 • 5/17/24: Interactive Journaling • 5/30/24: Primary Case Holder Training • 5/20/24: Mentorship Matters • 6/5/24: Everyone Communicates Few Connect • 6/10/24: PMTO Internal Coaching • 6/10/24: Boundary Training • 6/21/24: Mentorship Matters • 6/26/24: CMH Peer MI Series Part II • 6/26/24: Working with LGBTQI+ Individuals FY 2024 – Q4: July 1, 2024 – September 30, 2024: • 7/10/24: Put Your Dreams to the Test Leadership Training • 7/22/24: Motivational Interviewing for Certified Peers • 7/24/24: Implicit Bias • 8/12/24: PMTO Internal Coaching • 8/14/24: Motivational Interviewing • 8/14/24: Implicit Bias • 8/19/24: CBT Essentials • 8/22/24: Primary Caseholder Training • 9/4/24: De-escalation Training for Clerical Staff

Reference	Employee & Community Relations – Karen Zultak PRIORITY GOALS/KEY TASKS	TIMELINE- Status (with Recommendations)
		• 9/9/24: Motivational Interviewing for Supervisory Staff • 9/9/24: PMTO Internal Coaching • 9/11/24: Becoming A Person of Influence Leadership Training • 9/13/24: ACT Team Training
Strategic Plan Priority 3 Objective 3.1.c	**EMPLOYEE RELATIONS /ENGAGEMENT** The activities intended to promote a positive organizational culture and employee engagement. New Employee luncheon, culture change committee activities, staff awareness days, staff appreciation activities, etc.	FY 2024 – Q1: October 1, 2023 – December 31, 2023 • Culture & Wellness Committee Meetings continue to meet monthly on the 1st Wednesday of each month. • 12-31-23: Merry Grazing Day FY 2024 – Q2: January 1, 2024 – March 31, 2024 • Wear Red for Heart Health (staff photos) • 2-19-24 – 2-23-24: Kindness Week (daily challenges sent to staff to participate in) • 3-1-24: Employee Appreciation Day (email and coupon code for SCCCMHA branded item from store) FY 2024 – Q3: April 1, 2024 – June 30, 2024 • 4/2/24: World Autism Day (staff photo) • 5/11/24: SCCCMH Run for Recovery (volunteers, runners, walkers) • 6/14/24: Men's Health Month (staff photo) FY 2024 – Q4: July 1, 2024 – September 30, 2024 • 7/17/24: Rotary International Day Parade (staff and family members participated in the parade and helped decorate the float) • 8/30/24: Wear Purple for Overdose Awareness
Strategic Plan Priority 2 Objective 2.5.a Objective 2.5.b Objective 2.5.c Objective 2.5.d	**LEGISLATIVE EFFORTS** Activities intended to enhance relationships with legislators, recruit support for issues pertaining to mental health care, and offer opportunities for staff, persons served and community members to learn about how to become more active with national, state and local legislative efforts. Emails and letters to legislators, advocacy efforts for SCCCMHA staff and persons served, attendance at legislative open house events, etc.	FY 2024 – Q1: October 1, 2023 – December 31, 2023 None FY 2024 – Q2: January 1, 2024 – March 31, 2024 • 2-27-24: SCCCMHA staff attended The Senate Committee on DHHS meeting • 3-1-24: SCCCMHA staff attended Quarterly Capital Talk with Senator Dan Lawyers FY 2024 – Q3: April 1, 2024 – June 30, 2024 • Letters sent to advocate against Conflict Free Access & Planning • Letters sent to advocate against Veteran's Administration rules for mental health care FY 2024 – Q4: July 1, 2024 – September 30, 2024 • 8/16/24: Attended Eggs and Issues with State Rep. Andrew Beeler, Senator Dan Lauwers

Reference	Corporate Compliance-Joy Vittone PRIORITY GOALS/KEY TASK	TIMELINE- Status (with Recommendations)
Medicaid Integrity Program, Corporate Compliance Plan	1. Report monthly on corporate compliance complaints; identify trends (St. Clair County CMH).	**1st Quarter**: FY24 Corporate Compliance Complaint Reports submitted to Region 10 on 1/16/24. October 2023: One (1) complaint received: 1. HIPAA Privacy/Security Violation - Unsubstantiated HIPAA violation Substantiated policy violation November 2023: Zero (0) complaints received. December 2023: One (1) complaint received: 1. HIPAA Privacy/Security Violation - Substantiated HIPAA violation (no breach reporting required) **2nd Quarter**: FY24 Corporate Compliance Complaint Reports submitted to Region 10 on 4/16/24. January 2024: One (1) complaint received: 1. HIPAA Privacy/Security Violation • Unsubstantiated HIPAA violation • Substantiated Policy violation February 2024: Two (2) complaints received: 1. HIPAA Privacy/Security Violation • Unsubstantiated HIPAA violation • Substantiated Policy violation 2. HIPAA Privacy/Security Violation • Unsubstantiated HIPAA violation • Substantiated Policy violation March 2024: Two (2) complaints received: 1. Policy Violation • Substantiated • HIPAA Privacy/Security Violation, Fraud/Waste/Abuse, Policy Violation • 2 Individuals - Substantiated HIPAA violations • 7 Individuals - Substantiated Policy violations • 2 Individuals – Fraud/Waste/Abuse Referral to PIHP; PIHP referred to OIG and MFCU **3rd Quarter**: April 2024: Two (2) complaints received: 1. HIPAA Privacy/Security Violation • Unsubstantiated 2. HIPAA Privacy/Security Violation

		• Unsubstantiated HIPAA violation • Substantiated Policy violation May 2024: Three (3) complaints received: 1. HIPAA Privacy/Security Violation • Substantiated HIPAA Violation (no breach reporting required) 2. HIPAA Privacy/Security Violation/Policy Violation • Unsubstantiated HIPAA violation • Substantiated Policy violation 3. HIPAA Privacy/Security Violation • Substantiated HIPAA Violation (no breach reporting required) June 2024: One (1) complaint received: 1. Fraud/Waste/Abuse • Substantiated Policy Violation • Unsubstantiated Fraud/Waste/Abuse **4th Quarter**: The number of HIPAA-related reports trending upward, likely related to increased messaging and training about HIPAA, secure messaging, and importance of reporting concerns. Positive response illustrating that HIPAA concerns are "top-of-mind." **July 2024: Four (4) complaints received:** 1. HIPAA Privacy/Security Violation by Contracted Network Provider • Substantiated HIPAA Violation 2. HIPAA Privacy/Security Violation & Policy Violation • Unsubstantiated HIPAA violation • Substantiated Policy violation 3. Other Violation • Unsubstantiated • Opportunity identified 4. HIPAA Privacy/Security Violation/ Policy Violation • Unsubstantiated • Opportunity identified **August 2024: Five (5) complaints received:** 1. HIPAA Privacy/Security Violation & Policy Violation • Unsubstantiated HIPAA Violation • Substantiated Policy Violation 2. Ethics Violation • Unsubstantiated • Opportunity identified 3. Other Violation • Pending resolution

		4. HIPAA Privacy/Security Violation • Unsubstantiated 5. HIPAA Privacy/Security Violation • Unsubstantiated HIPAA • Substantiated Policy violation **September 2024: Seven (7) complaints received:** 1. Other Violation • Pending resolution 2. HIPAA Privacy/Security Violation • Pending resolution 3. HIPAA Privacy/Security Violation • Unsubstantiated 4. HIPAA Privacy/Security Violation • Unsubstantiated 5. HIPAA Privacy/Security Violation • Substantiated Reportable HIPAA Breach 6. HIPAA Privacy/Security Violation • Unsubstantiated HIPAA • Substantiated Policy violation 7. HIPAA Privacy/Security Violation by contracted network provider • Substantiated HIPAA violation (no breach reporting required)
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**: FY24 Program Integrity Report will be submitted to Region 10 by the due date of 1/29/24. **2nd Quarter**: FY24 Program Integrity Report was submitted to Region 10 on 4/16/24. **3rd Quarter**: FY24 Program Integrity Report will be submitted to Region 10 by the due date of 7/15/24. **4th Quarter**: FY24 Program Integrity Report will be submitted to Region 10 by the due date of 10/15/24.
Corporate Compliance Plan	3. Report quarterly on grievance and appeals activities.	**Q1: October 1, 2023 – December 31, 2023** FY2024 MDHHS Medicaid & Non-Medicaid Grievance Reporting was submitted to Region 10 PIHP on 01/12/2024. No grievances were closed during the quarter. As such, there was no activity to report. **Q2: January 1, 2024 – March 31, 2024** FY2024 MDHHS Medicaid & Non-Medicaid Grievance Reporting was submitted to Region 10 PIHP on 04/16/2024. There were two Medicaid Grievances closed during the quarter. One grievance was entered into Oasis as three separate cases due to one grievance involving three individual providers. No Non-Medicaid Grievances were closed during the quarter. As such, there was no activity to report.

		Q3: April 1, 2024 – June 30, 2024 FY2024 MDHHS Medicaid & Non-Medicaid Grievance Reporting was submitted to Region 10 PIHP on 07/15/2024. No Medicaid grievances were closed during this quarter. No Non-Medicaid grievances were closed during this quarter. **Q4: July 1, 2024 – September 30, 2024** No Medicaid grievance were closed during this quarter. No Non-Medicaid grievances were closed during this quarter. **Q1: October 1, 2023 – December 31, 2023** FY2024 MDHHS Non-Medicaid Appeal Reporting was submitted to Region 10 PIHP on 01/12/2024. No appeals were closed during the quarter. As such, there was no activity to report. **Q2: January 1, 2024 – March 31, 2024** FY2024 MDHHS Non-Medicaid Appeal Reporting was submitted to Region 10 PIHP on 04/16/2024. No appeals were closed during the quarter. As such, there was no activity to report. **Q3: April 1, 2024 – June 30, 2024** FY204 MDHHS Non-Medicaid Appeal Reporting was submitted to Region 10 PIHP on 07/15/2024. No appeals were closed during this quarter. As such, there was no activity to report. **Q4: July 1, 2024 – September 30, 2024** No activity to report.
Corporate Compliance Plan	4. St. Clair County CMH Corporate Compliance Committee to meet quarterly or more frequently as deemed necessary.	**1st Quarter**: The SCCCMHA Corporate Compliance Committee did not meet this quarter. **2nd Quarter**: The SCCCMHA Corporate Compliance Committee met on 03/26/2024. **3rd Quarter**: The SCCCMHA Corporate Compliance Committee scheduled for 7/23/2024. **4th Quarter**: The SCCCMHA Corporate Compliance Committee rescheduled due to conflicts to 11/19 2024.
Good Administrative Practice	5. Monitor and report any legal/regulatory changes.	Monitoring is ongoing 42 CFR Part 2, Confidentiality of Substance Use Disorder Patient Records, Final Rule changes became effective on 4/16/2024 with compliance required by 2/16/2026.
CFR Requirement 438.610	6. Monitor and report on debarred, suspended, or otherwise excluded (from participation in any federal healthcare program) providers.	Monitoring is ongoing via new hire checks and Provider Trust enrollment – nothing to report.

CFR Requirement 438.608	7. Provide training and education on corporate compliance, including HIPAA.	**1st Quarter**: An email was issued to all SCCCMHA employees on 12/28/23 with a reminder regarding the requirement that all employees lock their computer workstations whenever they step away from their devices. Education provided on the quick lock method. New employee training on Corporate Compliance and annual training via MyLearningPointe. **2nd Quarter**: • February 2024 In the Know SCCCMH Newsletter contained reminders about HIPAA requirements, safeguards to protect PHI, and compliance reporting. • 3/8/24 Email to All CMH and placement in March 2024 In The Know SCCCMH Newsletter about appropriate use of agency-owned devices and compliance reporting. • New employee training on Corporate Compliance and annual training via MyLearningPointe. **3rd Quarter**: • Continued new employee training on Corporate Compliance and annual training via MyLearningPointe. April 2024 • New Compliance Flyer posted at on-site facilities in visible areas that publicizes the ways to report compliance concerns to the Corporate Compliance Office. • Presented General Compliance Training at Supervisors Meeting on 4/11/24. May 2024 • New Compliance Flyer published in May 2024 In The Know SCCCMH Newsletter. • Presented Board-focused Compliance Training to SCCCMH Board of Directors on 5/14/24. • Email to all staff on 5/21/24 provided Region 10 PIHP reminder about how to report compliance concerns and file complaints. • Presented General Compliance Training at SCCCMH Inservice to all staff on 5/22/24. • Provided new employee compliance training on 5/6/24 and 5/20/2024. June 2024 • June 2024 In The Know SCCCMH Newsletter included Corporate Compliance Reminder from Region 10 PIHP about how the report compliance concerns and file complaints. • Provided new employee compliance training on 6/3/24, 6/17/24, 6/20/24, and 6/28/24. • Email on 6/14/24 to all staff from IT Director relayed Michigan State Policy Cyber Command Center communication about increased Ransomware and cybersecurity threats. Instruction provided on reporting suspicious email with the Phish button, to slow down when reading emails or responding, not to provide account/password information to callers, and not to click links for "IT support." • 6/25/24 Compliance Meet and Greet at In-Shape Staff Meeting to discuss compliance and answer questions.

		4th Quarter: • Continued new employee training on Corporate Compliance and annual training via MyLearningPointe. July 2024 • July 2024 In the Know SCCCMH Newsletter included Corporate Compliance article with recent enforcement actions by the DOJ against behavioral health entities, to highlight the need for vigilance related to complying with False Claims Act. • Provided new employee compliance training on 7/1/24, 7/15/24, 7/29/24. • Supervisor meeting 7/11/24: Provided overview of reportit anonymous reporting application to be launched in early Nov. August 2024 • August 2024 In the Know SCCCMH Newsletter included a Compliance Alert about the newly revised Conflict of Interest Board Policy including the new requirement for all workforce to complete annual conflict of interest disclosures. • Provided new employee compliance training on 8/12/24 and 8/26/24. • Email on 8/12/24 to all staff from IT Director regarding Phone Call Spoofing that occurred, what to be vigilant for, and how to handle situation. • Supervisor meeting 8/8/24: Reviewed updates to the HIPAA policy #08-002-0006 for supervisors to discuss with their staff. September 2024 • September 2024 In the Know SCCCMH Newsletter included article titled "Key Rules for Sharing Confidential Information and PHI" and a second printing of the Conflict of Interest guidance from August 2024 newsletter. • Provided new employee compliance training on 9/9/24. • Supervisor meeting 9/12/24: Reviewed two guidance documents to share with staff: Key Rules for Sharing Confidential Information and PHI, and Key Rules for Consent Requirements. • Email to all staff on 9/30/24 forwarded to all staff a message from the PIHP Corporate Compliance Office about Protected Health Information (PHI) Identifiers.
Corporate Compliance Plan	8. Monitor technology use and needs as they relate to PHI and HIPAA.	Ongoing monitoring of agency technology use and needs.
Corporate Compliance Plan	9. Monitor subnetwork providers' corporate compliance activities.	Ongoing monitoring of contract agencies' corporate compliance plans/activities per review of quarterly performance indicators.
Corporate Compliance Plan	10. Conduct an annual evaluation of the Compliance Plan and report to the St. Clair County CMH Board.	**1st Quarter**: FY2023 Annual Report and FY2024 Plan with Goals were presented to the CMH Board at their regular meeting on 11/14/23.

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

Reference	Finance-Karen Farr PRIORITY GOALS/KEY TASKS	TIMELINE – Status (with Recommendations)
Good Administrative Practice	1. Manage financial risks through establishment and maintenance of fund balances. Objectives: ○ Establish, review and update policies and procedures related to our CMHSP Local Fund Balance	Nothing to report at this time. Board Fiscal Responsibilities Policy will be updated to include Fund Balance and Investments.
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: ○ Identify fiscal concerns through monthly analysis of revenues and expenditures. ○ Analyze trends and provide revenue forecasts. ○ Prepare annual budget and provide comparison of budget to actual revenues and expenditures on a monthly basis. ○ Prepare amended budget to reflect significant changes in revenues and expenditures of the agency, as needed. ○ Make recommendations about how to best utilize agency resources. ○ Interact with other managers to provide consultative support to planning initiatives through financial information analyses, reports, and recommendations.	The Preliminary YTD September 2023 FBR was presented to the Finance Committee of the Board at the November 14, 2023 committee meeting. Total expenses were preliminarily coming in approximately $1.4m under the Revised Budget; including Direct Run payroll costs under $790k, Net Residential and Contract Agencies over $380k, Hospitals under $353k, and all other budgeted line items under $604k. Due to the unknown impact of the Medicaid Redetermination Region requested that we come in flat to FY23 actual costs for Medicaid and Healthy MI Plan funding sources. The increase in FY24 budgeted expenses over FY23 Revised budget is mainly in the estimate of the FY24 CCBHC supplemental funding and other non-Region 10 funded costs. The FY24 Original Budget was approved by the Board of Directors at the September 2023 Board meeting reflecting budgeted expenses of approximately $104m; an increase of approximately $4.2m over the FY23 Revised Budget. The increase includes Direct Run payroll costs of $2.5m, Residential and Contract Agencies costs of $1.3m and Other budgeted cost increases of approximately $420k. The August 2024 YTD FBR was presented to the Board Finance committee before the October 8, 2024, Board meeting. Currently, our YTD expenses are $3.7m under the Revised Budget with a traditional Medicaid and HMP surplus of approximately $2.8m that would lapse back to the Region 10 PIHP. In addition, we have a deficit in CCBHC Demonstration Medicaid/HMP funding of approximately $5.3m that would be due to us from the Region 10 PIHP. $4.2m of the CCBHC Demonstration Medicaid/HMP surplus is the surplus CCBHC earnings over expenses we are allowed to retain as Local. We are currently running at a $2.2m deficit with our CCBHC Demonstration Non-Medicaid and are having to utilize surplus GF of approximately $571k and Local of approximately $1.6m to fund the costs. The September 2024 Preliminary YTD FBR was presented to the Board Finance committee before the November 12, 2024, Board meeting. Preliminary expectations are that the expenses are going to come in approximately $550k under the revised budget. We anticipate a lapse of approximately $378k in traditional Medicaid and HMP back to the Region 10 PIHP. A net CCBHC Medicaid and MHP balance due to us from Region 10 PIHP of approximately $5.7m. We will be using approximately

Reference	Finance-Karen Farr PRIORITY GOALS/KEY TASKS	TIMELINE – Status (with Recommendations)
		$554k of GF and $2.0m of Local to cover the CCBHC Non -Medicaid deficit of approximately $2.6m. We are expecting an approximately surplus of $660k in Local.
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. o Coordinate and ensure compliance with the MDHHS Standard Cost Allocation Methodology and the CCBHC Demonstration beginning 10/1/21.	The FY23 Financial audit fieldwork took place in January 2024 with the Compliance audit to take place after the February 28 FSR filing date. The required MDHHS reporting for FY23 was submitted timely in accordance with Region 10 PIHP and MDHHS contract requirements. The FY23 Financial audit report has been issued and we received an unqualified opinion. The FY23 Compliance Exam was completed and both were presented to the Board at our June Board meeting. There is no Single audit required this year as our Federal grants fell below the $750,000 threshold requiring one to be conducted. The FY24 Preliminary FSR was completed and submitted to Region 10 PIHP and MDHHS timely in August 2024. The FY24 Interim FSR was completed and submitted to Region 10 and MDHHS timely in November 2024 per contract requirements.
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 2022 Regional CFO goals: o Independent Rate Model analysis	Nothing to report at this time. The Regional CFOs continue to meet monthly to share information and identify best practices. The FY24 goal is to standardize CCBHC cost reporting with quarterly trainings. SCCCMH will assist with the training of the other 3 sites per the request of the Region 10 CFO. The initial CCBHC training was held at Region 10 PIHP and included various staff from all four CCBHCs in our Region. A basic overview of CCBHC was provided by Richard Carpenter. The second training is scheduled for August 13 to be held at Lapeer. This training is more focused on the CCBHC funding flow and will be attended by Finance and Data staff from each regional CCBHC. The August 13, 2024, training was cancelled by Region 10 and rescheduled for December 2024.

Reference	Finance-Karen Farr PRIORITY GOALS/KEY TASKS	TIMELINE – Status (with Recommendations)
Good Administrative Practice	5. Establish and maintain appropriate internal controls over record keeping and safeguarding of assets Objectives: ○ Establish, review and update policies and procedures for record keeping, handling of cash and tracking of assets. ○ Ensure separation of duties to reduce the risk of fraudulent activity	Nothing to report at this time. Policies will be reviewed and updated as they relate to staff payments in excess of the union contract pay schedules to ensure that we are following our policies and that they are in accordance with the CFR, MDHHS contract and the State of MI guidelines. A draft of a Credit Card policy was submitted for review along with related forms. The language related to the credit card usage was incorporated into the Board Fiscal Policy and the Administrative Procedures related to the Board Fiscal Policy and the forms were updated to reflect the new requirements.

Reference	Human Resource and Development-Kim Prowse PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
Good Business Practice	1. Assess and improve upon current Human Resource-related practice and software system including: a) Implementation of new Human Resources Information System (ADP Transition). b) Continuous improvement efforts and building of the ADP module to create HR process efficiencies. c) Implementation of a new Annual Employee Assessment tool and transition to an electronic format. d) Enhance recruitment efforts through utilization of new tools through ADP. e) Work with ADP implementation and support teams to develop a bridge between ADP and Cybertrain. f) Work towards complete move to electronic personnel records g) Evaluate and establish best practice model of interview/selection process. h) Evaluate and assist in the development of an agency-wide succession planning and opportunities for future agency leaders. i) Improve volunteer recruitment process j) Enhance utilization of and staff communications/survey through TINYpulse software k) Enhance diversity, equity and inclusion (DEI) based practices	FY2024 - 4th Quarter/Year End a) Ongoing: Implementation of the ADP-Workforce Now system modules were ongoing throughout FY2024 and will continue into FY2025. b) Ongoing: ADP capabilities continue to be enhanced as a result of the addition of "HR Comprehensive". This new contractual support that began in 2024 will continue to focus on efficiencies for the HR department. Meetings with ADP and HR/SMEs were ongoing throughout FY2024 with targeted areas being addressed strategically. Initial work focused on onboarding platform, benefit platform, employee assessment platform, record retention and dashboard report enhancements. This will continue into FY2025. c) Ongoing: The electronic format was introduced in January of 2023. The process was better streamlined in 1st Q 2024 and utilized in the 2023 employee assessment process. Improvement efforts took place in Q3 and Q4 of FY2024 with a new roll-out expected during the 2nd Q of 2025. d) Ongoing: The recruitment tool in ADP will continue to be utilized and new program enhancements will be used within the module as they become available. During 4th Q 2024, system barriers were eliminated in order to better utilize the recruitment and onboarding module. Full implementation is expected in 1st Q 2025. e) Ongoing: During 4th Q, the HRIS Specialist and Training Department Specialist worked on cross training efforts between both systems to better understand capabilities and compatibility between systems. Work to integrate ADP/HR capabilities and efficiencies continues. f) Ongoing: During 2nd Q, two part-time scanning techs were hired to begin the process of transferring paper personnel records to electronic format. This continued over the course of the fiscal year and will continue into FY2025. g) Ongoing: HR Staffing Specialist will continuously assess best practices, seek trainings and provide recommendations for process change. h) Ongoing: In collaboration with Leadership Team, HR will help guide the development of a succession planning assessment, learning opportunities, and format for outlining plans to assist supervisors and their teams, agency-wide. The succession planning module within ADP was shown to Leadership Team in Q4. Feedback was provided and follow-up w/ADP support took place in Q4. Continued improvement efforts and additional presentations of information will continue into FY2025. i) Ongoing: While volunteer recruitment will take place as needed a larger focus in FY2024 was on increasing internship opportunities and expanding relationships w/colleges and universities. This ongoing effort will continue into FY2025.

Reference	Human Resource and Development-Kim Prowse PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
		j) Ongoing: Utilization of weekly "pulse" surveys are used with results being reviewed by the Employee Culture &Wellness Committee monthly. Recommendations for change, significant concerns and trends are shared with Leadership Team as appropriate. In FY2025, this process will move to the "Voice of the Employee" platform in ADP. Research into how this platform will be utilized took place in 4th Q 2024. Rollout of the platform will come in stages in FY2025. k) Ongoing: Review of MDHHS plan and implementation of current practices as applicable to St. Clair CMH. This will take on a greater priority in FY2025.
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 Strategic Plan Priority3 Object 1 Strategic	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) Develop a robust retention plan	FY2024 – 4th Quarter/Year End a) Complete/Ongoing Updates: The Training Department has created a monthly training calendar that is available to all staff that is inclusive of specialty trainings. b) Ongoing: The staff training grid is continually updated to include trainings that are required to be in compliance. c) Complete/Ongoing Updates: In 4th Quarter 2023 three additional supervisor specific trainings were added to the required training grid for applicable staff. New trainings will be vetted ongoing and offered/required as applicable. d) Ongoing: The Training Department will take lead in seeking out and implementing trainings for CMH staff at the request of management and/or staff as appropriate. e) Ongoing: The New Employee Orientation" process has continuously been reviewed, seeking feedback from new staff in order to implement better practices. f) Ongoing: As Region 10 and/or affiliated CMHs offer trainings, St. Clair CMH will collaborate as appropriate to share resources and providing training consistencies across the Region.

Reference	Human Resource and Development-Kim Prowse PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
Plan Priority 3 Objective 4 Strategic Plan Priority 4 Objective 2	k) Create a succession plan which identifies leadership potential at all levels of the agency. l) Develop effective recruitment plan	g) Ongoing: Job Descriptions are continuously reviewed each time a new posting is created to ensure accurate information is outlined and that all requirements of compliance are noted as applicable to that job. Additionally, functional job task lists (FJTL) are required to be reviewed and approved annually between employee and supervisor. These updates help ensure that any transition or addition of tasks within a particular role can be adequately reflected in both job descriptions and job postings. h) Ongoing: The Training Dept. consistently provides survey opportunities for each specialty/CMH sponsored training. i) Ongoing: Through survey feedback in Tinypulse, Leadership and the HR/Training Dept. is able to identify employee groups to target for needed trainings. j) Ongoing: HR will work with ADP HR Comprehensive support throughout the FY to assist in the development of a retention plan, review benefits and other opportunities to offer incentives or culture enhancements to aid in retention. k) Ongoing: a. HR added a question to the FY2023 annual employee assessment process to gage interest in job advancement within the agency. These results were reviewed in 2nd Quarter & 3rd Quarter 2024 and development activities targeted to either individuals and/or groups interested in similar promotion will be discussed and implemented in FY2024 and into 2025. b. Additionally, leadership trainings (Scott Babin) continued throughout 2024. Lunch and learns are scheduled every other month for all staff interested in learning leadership skills. Leadership skill building and training takes place during supervisor meetings 6x annually. This will continue in FY2025 c. In FY2024 CMH contracted w/TBD solutions to offer Management Training and advanced Management Training for staff interested in advancement and/or increasing their management skills. l) Ongoing: HR will work with ADP HR Comprehensive support throughout the FY to assist in the development of an enhanced recruitment plan, review benefits and other opportunities to offer incentives or culture enhancements to aid in recruitment efforts. Additionally, HR will bolster its work around the attainment and retention of interns for in-demand positions as well as other behavioral health positions.

Reference	Human Resource and Development-Kim Prowse PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
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	FY2024 – 4th Quarter/Year End a.-e. Ongoing: In 1st Quarter 2024, the Community Relations Team transitioned to become the *Employee and Community Relations Team* and is now included, along with Training, under the Human Resources umbrella. This transition created enhanced opportunities and supports in each of the areas outlined in this goal. Functions of staff and review of each of these goal activities will continue to be assessed in FY2025. In 4th Q there was discussion regarding the merging of the "Rights Champion" luncheon and "EOM/TOM" recognition. Discussion will continue into FY2025 for this potential process change. The idea was taken to the 4th Q Wellness Committee for feedback. Additionally, staff anniversary congratulations messages go out to staff through ADP as well as birthdays.
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. a) Work collaboratively with the CMH Culture Committee to support and advise in the areas of staff wellness and development.	FY2024 – 4th Quarter/Year End a) Ongoing: The Employee Culture and Awareness Committee continues to meet monthly and provide recommendations to HR and/or Leadership as a result of survey outcomes or committee discussion related to staff wellness. This will continue in FY2025.

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
OSHA 08.450	1. 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"	**FY 2024 Q1: October 1, 2023 – December 31, 2023** a.) All combined service locations: - Auto Accident: Vehicle was rear-ended. No serious injury. Employee received treatment. - Auto Accident: Employee backed a vehicle into a cement curb. No injury sustained. Employee declined treatment. - Physical Aggression: Employee was punched and kicked. Objects were thrown at the Employee. No serious injury. Employee declined treatment. b.) Compliance: 2/3 reported within 24 hours. 67% compliance. **FY2024 Q2: January 1, 2024 – March 31, 2024** a.) All combined service locations: - Auto Accident: No serious injury. Employee declined treatment. - Accident: Employee hit in the eye with a playing card while engaging with individual served. - Accident: Employee fell on ice in the parking lot. b.) Compliance: 2/3 reported within 24 hours. 67% compliance. **FY2024 Q3: April 1, 2024 – June 30, 2024** a.) All combined service locations: - Auto Accident: Minor collision at intersection. Minor injury. Employee received treatment. - Accident: Employee received a sliver from a porch railing. Employee sought their own treatment. - Accident: Employee hit their head on the corner of a cabinet. Employee declined treatment. - Auto Accident: Vehicle was swiped by another vehicle. No serious injury. Employee declined treatment. b.) Compliance: 3/4 reported within 24 hours. 75% compliance. **FY2024 Q4: July 1, 2024 – September 30, 2024** a.) All combined service locations: - Accident: Employee was punched in the mouth and kicked in the legs. No serious injury. Employee declined treatment. b.) Compliance: 1/1 reported within 24 hours. 100% compliance.

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
	2. Report all Non-Employee Accident Reports within 24 hours. Target compliance 100%.	**FY2024 Q2: January 1, 2024 – March 31, 2024** These reports are currently completed through Oasis and a Non-Employee Accident Report (NAR). No NARs received/reported for Q2. **FY2024 Q3: April 1, 2024 – June 30, 2024** a.) Safety Coordinator received three (3) this quarter. • One (1) individual tripped over a rug in the lobby. First aid provided. • Two (2) individuals fell during the In-Shape program while planting flowers. Both individuals declined treatment. b.) Compliance: 1/3 Reported within 24 hours. 33% compliance. **FY2024 Q4: July 1, 2024 – September 30, 2024** a.) Safety Coordinator received two (2) this quarter. • One (1) individual fell to the floor after trying to stand up from a chair with wheels. Individual declined treatment. • One (1) individual fell off the curb at their home and declined treatment. Individual declined treatment. b.) Compliance: 2/2 Reported within 24 hours. 100% compliance.
CARF Health & Safely	3. Ensure easy access to First Aid: a) Expertise b) Equipment c) Supplies	**FY2024 Q1: October 1, 2023 – December 31, 2023** First Aid kits are easily accessible at every service location operated by SCCCMHA. • Capac: First Aid Kits/Inventory inspected on 12/15/2023 • Child and Family Services: First Aid Kits/Inventory inspected on 12/13/2023 • Electric Avenue: First Aid Kits/Inventory inspected on 12/04/2023 (Agency Vehicles), 12/07/2023 (Auditorium), 12/07/2023 (Facilities and Case Management), 12/07/2023 (Galley Program), 12/07/2023 (2nd Floor – East), 12/07/2023 (2nd Floor – West), and 12/20/2023 (CIS Program) • Marine City Service Location – First Aid Kits/Inventory inspected on 12/21/2023. **FY2024 Q2: January 1, 2024 – March 31, 2024** First Aid kits are easily accessible at every service location operated by SCCCMHA. Emergency Evacuation bags are located in strategic locations at every service site and brought to evacuation/shelter areas during emergency event/drills. Staff are trained in First Aid/CPR (15 trained for Q2). • Capac: First Aid Kits/Inventory/Evacuation Bags inspected on 1/31/24 • Child and Family Services: First Aid Kits/Inventory/Evacuation Bags inspected on 3/06/24 • Electric Avenue: First Aid Kits/Inventory/Evacuation Bags inspected on 3/25/24, 3/25/24-3/29/24 (Agency Vehicles), 3/25/24 (Auditorium), 3/25/24 (Facilities and Case Management), 3/25/24 (Galley Program),

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
		Closed, (2nd Floor – East), 3/25/24 (2nd Floor – West), and 3/25/24 (CIS Program) • Marine City – King: First Aid Kits/Inventory/Emergency bags inspected on 3/28/2024 & 4/16/2024, and 3/28/2024 (Agency Vehicles) • Marine City – Broadway: First Aid Kits/Inventory inspected on 3/28/2024, Emergency Evacuation Bag 3/28/2024 **FY2024 Q3: April 1, 2024 – June 30, 2024** First Aid kits and AEDs are easily accessible, in boxes affixed to the wall, and now have signage near the ceiling at every service location operated by SCCCMHA. Emergency Evacuation bags are in strategic locations at every service site and brought to evacuation/shelter areas during emergency event/drills. Emergency Evacuation Bags have been evaluated by Nursing Staff to include new Trauma supplies and increase number of available bags (15 by Q4-currently have 8). Staff are trained in First Aid/CPR/AED usage (34 newly trained for Q3). **Capac:** • First Aid Kits/Inventory/Evacuation Bags inspected on 6/13/2024 & 6/18/2024. • Agency Vehicles First Aid Kit inspected 6/18/24, • AEDs inspected 6/19/24. **Child and Family Services:** • First Aid Kits/Inventory/Evacuation Bags inspected on 6/13/2024. • Agency Vehicles First Aid Kit inspected initial request 6/13/2024, completed 7/16/2024. • AEDs inspected 6/19/2024. **Electric Avenue:** First Aid Kits/Inventory/Evacuation Bags inspected on 6/12/2024: • Auditorium • Facilities • Case Management • New First Aid Kit (Kitchen Classroom) • 2nd Floor – East • 2nd Floor – West • CIS Program First Aid Kits/Inventory/Evacuation Bags inspected on 07/02/2024: • NEW First Aid Kit • Agency Vehicles 6/17/2024-6/28/2024 • AEDs Inspected 6/19/2024.

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
		Marine City – King: • First Aid Kits/Inventory/Emergency bags inspected on 6/13/24 & 6/21/2024, • Agency Vehicles 6/21/2024 • AED inspected 6/19/2024. **Marine City – Broadway:** • First Aid Kits/Inventory/Emergency bags sent out 6/13/2024 inspected on 7/15/2024. • AED inspected 6/19/2024. **FY2024 Q4: July 1, 2024 – September 30, 2024** **A. Expertise** • Staff are trained in First Aid/CPR/AED usage. • 22 newly trained in Q4. **B. Equipment** • Emergency Evacuation bags are in strategic locations at every service site and brought to evacuation/shelter areas during emergency event/drills. • Emergency Evacuation Bags have been evaluated by Nursing Staff to include new Trauma supplies and increase number of available bags to 15 (nearly double that of Q3). • First Aid kits and AEDs are easily accessible, in boxes affixed to the wall, and now have signage near the ceiling at every service location operated by SCCCMHA. **C. Supplies** • First Aid Kits, Agency Vehicle First Aid Kits, Supplies Cache, and Emergency Evacuation Bags are inspected and filled Quarterly. **D. Inspections** Capac: • First Aid Kits inspected on 08/15/2024. • Agency Vehicles First Aid Kits inspected on 09/26/2024. • AEDs inspected on 08/6/2024. • 1 New Emergency Evacuation Bag added on 08/30/2024. Child and Family Services: • First Aid Kits (3) inspected/inventoried on 08/05/2024. • Agency Vehicles First Aid Kit inspected 09/19/2024 – 09/20/2024. • AEDs inspected on 08/06/2024. • 3 New Emergency Evacuation Bags added on 08/30/2024. Electric Avenue:

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
		First Aid Kits Inspected/Inventory Adjusted between 08/13/2024-08/16/2024: • Auditorium inspected on 08/16/2024. • Facilities Department inspected on 08/13/2024. • Adult Services (formerly Case Management) inspected on 08/14/2024. • New First Aid Kit (CIS Kitchen Classroom) added on 08/14/2024. • 2nd Floor – East inspected on 08/13/2024. • 2nd Floor – West inspected on 08/13/2024. • CIS Program First Aid Kit & Emergency Bag inspected on 08/15/2024. • Nursing inspected on 08/14/2024. • Scheduling/Reception inspected on 08/16/2024 • ECRT inspected on 07/18/2024 • Emergency Evacuation Bags inspected on 07/02/2024. • Agency Vehicles First Aid Kits inspected 09/11/2024-09/13/2024. • AEDs inspected on 08/06/2024. • 8 New Emergency Evacuation Bags added on 08/30/2024. Marine City – King: • First Aid Kits/Inventory/Emergency bags inspected on 08/13/2024. • Agency Vehicles inspected 09/23/2024 – 09/27/2024. • AED inspected on 08/06/2024. • 2 New Emergency Evacuation Bags added on 08/30/2024. Marine City – Broadway: • First Aid Kits/Inventory/Emergency bags inspected on 08/15/2024. • AED inspected on 08/06/2024. • 1 New Emergency Evacuation Bag added on 08/30/2024.
CARF Health & Safety	4. Quarterly, completed **Building Inspection.** a) Site Participation, (5) locations. Target compliance, 100%. b) Safety/Infection Control Checklist. Target compliance, 95%.	**FY2024 Q1: October 1, 2023 – December 31, 2023** **Building Inspections:** • Capac: Completed on 12/19/2023 • Child and Family Services: Completed on 12/14/2023 • Electric Avenue: Completed on 12/26/2023 • Marine City – Broadway: Completed on 12/13/2023 • Marine City – King: Completed on 12/13/2023 **FY2024 Q2: January 1, 2024 – March 31, 2024** **Building Inspections:** • Capac: Completed on 03/05/2024 • Child and Family Services: Completed on 03/06/2024 • Electric Avenue: Completed 03/27/2024 – 03/28/2024 • Marine City – Broadway: Completed on 03/21/2024 • Marine City – King: Completed on 03/21/2024

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
		FY2024 Q3: April 1, 2024 – June 30, 2024 **Building Inspections and testing Lock Down Buttons** **Safety/Infection Control inspected during First Aid Kit inspections:** • Capac: Completed on 06/06/2024 – 100% • Child and Family Services: Completed on 6/13/2024 – 100% • Electric Avenue: Completed on 06/20/2024 – 100% • Electric Avenue – Classroom Kitchen: Completed on 06/20/2024 – 100% • Marine City – Broadway: Completed on 06/06/2024 – 100% • Marine City – Broadway (Classroom Kitchen): Completed on 06/06/2024 – 100% • Marine City – King: Completed on 06/06/2024 **– 100%** **FY2024 Q4: July 1, 2024 – September 30, 2024** **Building Inspections, testing Lock Down Buttons, Silent Alarms (Black Buttons), and Safety/Infection Control inspected during First Aid Kit inspections:** • Capac: Completed on 08/06/2024 – 100% • Child and Family Services: Completed on 08/06/2024 – 98% • Electric Avenue: Completed on 08/09/2024 – 98% • Marine City – Broadway: Completed on 08/06/2024 – 96% • Marine City – King: Completed on 08/06/2024 – 100%
	5. Quarterly completed **Kitchen Inspection**; via the Kitchen Safety Inspection Checklist. Target compliance = 95%	**FY2024 Q1: October 1, 2023 – December 31, 2023** Inspection completed on 12/07/2023 **FY2024 Q2: January 1, 2024 – March 31, 2024** Galley Closed, No Inspection Completed. Will re-establish inspection schedule before Touchstone moves in. *Classroom Kitchen inspection was completed using the Galley inspection report. New report for classroom kitchen needs to be created as most points were N/A. Corrective action taken: Heimlich Maneuver (HM) poster, first aid kit, "call 911" posted on HM poster, and wet floor sign. Classroom had 13/13 applicable items. Compliance (per limited inspection) = 100% **FY2024 Q3: April 1, 2024 – June 30, 2024** **a.)** Touchstone moved into the kitchen at the Electric Avenue service location (formerly The Galley). No inspection completed this quarter as the program was not operational. Inspections will begin in the 4th quarter. **b.) New Inspection Report Created for Kitchen Classrooms:** • Marine City – Broadway = 100% • Electric Avenue = 100%

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
		FY2024 Q4: July 1, 2024 – September 30, 2024 • **Marine City – Broadway (Classroom Kitchen):** Completed 08/06/2024 = 100% • **Electric Avenue (Classroom Kitchen):** Completed 08/14/2024 = 100% • **Electric Avenue (Lotus Café):** Completed 08/14/2024 = 96%
CARF Health & Safety	6. Annually completed Emergency / Event Procedures (8 types) at all locations. Completion may be per "actual event" or drill. Target compliance 95%. *Conducted, monitored, recorded, and reported quarterly • Chemical-Biological • Fire • Natural Disaster • Utility Failure • Bomb Threat • Dangerous Person • Medical Emergency • Suspicious Mail/Parcel	**FY2024 Q2: January 1, 2024 – March 31, 2024** Natural Disaster/Adverse Weather/Tornado Drill completed on 3/28/2024 as new Safety Coordinator Started 3/23/2024. Q1 reported 8-actual events, 4-drills total 12. Q2 reported 2-actual events and 1 drill at 5 drill locations, total 3. **FY2024 Q3: April 1, 2024 – June 30, 2024** **A.) DRILLS** • **Active Shooter Drill** 5/7/24 (1) • **Utility Failure Drill** 5/15/24 (1) • **Fire Drill** 6/26/24 (1) **B.) EVENTS** • **Dangerous Person Events** 4/15-6/28/24 (4) • **Medical Emergency Events** 4/1-6/25/24 (21) • **Utility Failure Event** 6/5-6/7/24 (3) **C.) Q3 reported 28-actual events, 3-drills, total 31.** **FY2024 Q4: July 1, 2024 – September 30, 2024** **A.) DRILLS = 3** • Chemical/Biological – 07/31/2024 (1) • Active Shooter – 08/06/2024 (1) • Bomb Threat Tabletop Exercise – Electric Avenue (1) **B.) EVENTS = 11** • Utility/Boil Water Advisory – 07/5/2024 (1) • Medical Emergency Events – 07/26/2024-08/26/2024 (7) • Fire Alarm Event – 09/04/2024 (1) • Suspicious Mail Event – 09/11/2024 (1) • New Employee Orientation/Discussion (1)

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
CARF Health & Safety	7. Annually, all **full time and part – time employees** will *participate* as applicable in at least one (1) of the eight (8) 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 Emergency Procedures Handbook, with applicable staff.	**FY2024 Q2: January 1, 2024 – March 31, 2024** Staff participation for Drills/Events. Participation for Adverse Weather Drill: Only 210 voted (all sites). Large number of staff out at all sites on March 28 (Tornado Drill). Numbers include actual medical events and Active shooter drills. Total for all sites drill/events (200/456) – 44% V=Visitors **Tornado Drill 3/28/2024 – (participants/total voted), (participants/total employees)** Capac – 7, V=4 (11/10) 110%, (11/23) 48% Child & Family – 23, V=6 (29/30) 97%, (29/76) 38% Electric – 99, V=11 (110/152) 72%, (110/326) 34% Marine City (King & Broadway) – 13, V=10 (23/15) 153%, (23/31) 74% **Active Shooter 2/6/2024** Capac – 1 Child & Family – 5 Electric – 10 Marine City (King & Broadway) – 3 **Medical Emergency** Electric 6, V=2 **Totals All Drills/Events** Capac – (12/23) 52% Child & Family – (34/76) 45% Electric – (128/326) 39% Marine City (King & Broadway) – (26/31) 84%

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
		FY2024 Q3: April 1, 2024 – June 30, 2024 a.) V=Visitors b.) **Active Shooter (5/7/2024)** • Capac – 0 • Child & Family Services – 2 • Electric Ave. – 10 • Marine City (King & Broadway) – 0 c.) **Fire Drill (6/26/2024)** • Capac – 11, V=5 • Child & Family Services – 33, V=1 • Electric Ave. – 155, V=9 • Marine City (King & Broadway) – 14, V=4 d.) **Dangerous Person (various dates within Q3)** • Child & Family Services – 3, V=1 • Electric Ave. – 5, V=1 • Marine City (King & Broadway) – 2, V=1 e.) **Medical Emergency (various dates within Q3)** • Child & Family Services – 4, V=1 • Electric Ave. – 58, V=17 • Marine City (both) – 15, V=7 f.) **Utility Drill (5/15/2024)** • Capac – 12, V=2 • Child & Family Services – 27, V=8 • Electric Ave. – 131, V=13 • Marine City (King & Broadway) – 13, V=15 g.) **Utility Event (6/5/2024-6/7/2024)** • Child & Family Services – 1 • Electric Ave. – 158, V=12 h.) **Suspicious Mail** • Electric – 3

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
		i.) **TOTAL INDIVIDUAL PARTICIPATION ALL DRILLS/EVENTS = 368/461 = 79.83%** • Capac **– 17/19 = 89.47%** • Child & Family Services – **54/74 = 73%** • Electric Ave. **– 269/336= 80.05%** • Marine City (King & Broadway) **– 28/33 = 85%** j.) **TOTAL VISITOR PARTICIPATION=92** • Capac **– V=7** • Child & Family Services **– V=12** • Electric Ave. **– V=52** • Marine City (King & Broadway) **– V=21** **FY2024 Q4: July 1, 2024 – September 30, 2024** a.) **Utility Event/Boil Water Advisory (07/05/2024)** • Capac = 1 • Child & Family Services = 13 • Electric Avenue = 111 Employees, 6 Visitors • Marine City (King & Broadway) = 0 b.) **Chemical/Biological Incident Drill (07/31/2024)** • Capac = 12 • Child & Family Services = 36 Employees, 10 Visitors • Electric Avenue = 180 Employees, 24 Visitors • Marine City (King & Broadway) = 18 Employees, 6 Visitors c.) **Active Shooter (08/06/2024)** • Capac = 1 • Child & Family Services = 3 • Electric Avenue = 7 • Marine City (King & Broadway) = 1 d.) **Medical Emergency (various dates within Q4)** • Capac = 0 • Child & Family Services = 0 • Electric Avenue = 14 Employees, 5 Visitors • Marine City (King & Broadway) = 7 Employees, 2 Visitors

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
		e.) **Suspicious Mail (9/11/2024)** • Capac = 0 • Child & Family Services = 0 • Electric Avenue = 6 • Marine City (King & Broadway) = 0 f.) **Orientation (Various Dates in Q4))** • Capac = 0 • Child & Family Services = 0 • Electric Avenue = 9 • Marine City (King & Broadway) = 2 g.) **Fire Alarm Event (9/4/2024)** • Capac – 0 • Child & Family Services - 0 • Electric – 152 Employees, 27 Visitors • Marine City (King & Broadway) – 0 h.) **Bomb Threat Tabletop Drill (started 9/26/24 – 10/01/2024)** • Capac – 4 • Child & Family Services - 0 • Electric – 32 • Marine City (King & Broadway) – 0 i. **Emergency Procedures Handbook Review (completed 9/13/24)** • Capac - • Child & Family Services - • Electric – • Marine City (King & Broadway) – • **64 total as of 9/30/2024.** j.) **TOTAL INDIVIDUAL PARTICIPATION ALL DRILLS/EVENTS AS OF 9/30/24 = 472/475 = 99.4%** • Capac – **20/20= 100%** • Child & Family Services – **75/75 = 100%** • Electric Ave. – **341/344= 99.13%** • Marine City (King & Broadway) – **36/36 = 100%**

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
		k.) **TOTAL VISITOR PARTICIPATION = 80** • Capac – **V=0** • Child & Family Services – **V=10** • Electric Ave. – **V=62** • Marine City (King & Broadway) – **V=8**
	8. Number of Green Panic button alarms. Actual/ False alarm	**FY2024 Q2: January 1, 2024 – March 31, 2024** Not recorded for Q1 or Q2 **FY2024 Q3: April 1, 2024 – June 30, 2024** **Only False Alarms (3)-Accidental activation. Actual Events tracked through Emergency Event Forms. Recommend that we do not track False Alarms.** **FY2024 Q4: July 1, 2024 – September 30, 2024** False Alarms (3; Accidental activation). Actual Events tracked through Emergency Event Forms. Recommend that we do not track False Alarms.
CARF, Health and Safety, Emergency Procedures 1.H.5.c.5	9. 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.	**FY2024 – Q1: October 1, 2023 – December 31, 2023** This is an ongoing practice during drills; however, additional training will be provided to supervisors to support this goal. **FY2024 Q2: January 1, 2024 – March 31, 2024** This is an ongoing practice during drills; however, additional training will be provided to supervisors to support this goal. **FY2024 Q3: April 1, 2024 – June 30, 2024** This is an ongoing practice during drills; however, additional training will be provided to supervisors to support this goal. **FY2024 Q4: July 1, 2024 – September 30, 2024** This is an ongoing practice during drills/events; however, additional training will be provided to supervisors to support this goal.
CARF Health &Safety, Medication Use MHC R330.1719 R330.2813 R330.7158	10. Quarterly review **"Medication Errors"** reports. a) Error type b) Error location c) Trends d) Improvement opportunities Error type	**FY2024 Q2: January 1, 2024 – March 31, 2024** a. Missed medication -16, Wrong Dose-2, Wrong Time-6 b. Blue Water Developmental Housing – 6, Innovative 17, Life Skills-1 c. Down from 1st quarter (36 to 24) d. Could be down due to less reporting **FY2024 Q3: April 1, 2024 – June 30, 2024** **a.** Missed Medication-15, Wrong Documentation-2, Wrong Dose-1, Wrong Medication-11, Wrong Person-5, Wrong Time-4 = 47 **b.** Blue Water Development Housing-14 CMH (ACT, CIS, Jail)-2

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
		IMPACT-5 Innovative-26 Total=47 **c.** Up from 1st & 2nd quarter (36 & 24) **d.** 3Q: Contracted agencies continue to need reminders and education on following CMH policies and medication training when administering medications (ie: not presetting medications, doing 3 checks/5 rights before passing medication, contacting physician at the time of error/discovery); one individual missed 9 doses of his medication due to attending Goodwill and they would not administer medication there (the medication was later discontinued by prescriber); one medication error report was referred to recipient rights related to an individual received a double dose of his medication because one staff gave it early and the other staff did not check the medication administration record before giving the medication to see it had already been given. The individual was sent to the ER for evaluation of ongoing issues along with medication error; one medication error report was referred to recipient rights related to 6 medications were given to the wrong consumer resulting in a hospital admission; and one medication error report was referred to recipient rights related to 6 medications were given to the wrong consumer due to staff presetting medications. The staff member had taken med training 4 days prior and were told presetting medications was not allowed. Also the symptoms the individual presented with were different than what poison control said therefore additional medical intervention should have been sought when the individual started experiencing those symptoms. **FY2024 Q4: July 1, 2024 – September 30, 2024** a. Missed Medication – 7 Other (special instructions) – 0 Wrong Documentation – 4 Wrong Dose – 14 Wrong Medication – 1 Wrong Person – 1 Wrong Time – 13 b. AFC Homes - 0 Blue Water Developmental Housing – 11 CMH (ACT, CIS, Jail) – 9 Community Enterprises – 0 Home of Your Own – 0 IMPACT – 2 Innovative – 18 Lake Huron Community Pharmacy – 0 Life Skills – 0 Other – 0

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
		c. Down from 3Q (47 & 40) d. 4Q: Contracted agencies continue to need reminders and education on following CMH policies/procedures and medications training especially observing the 5 rights of med administration and checking the medications 3 times before administering. It was also noted that staff continue to not contact the physician, not contact the correct physician, or contact the physician in a timely manner to report the error. There were two medication error reports that were forwarded to Recipient Rights: one individual was given the wrong medications and was sent to the ER, the individual was treated in the ER and sent home; one individual was given their long-acting bedtime insulin instead of their short acting insulin to scale, the staff reported they grabbed the wrong insulin pen. The majority of the medication errors received could have been prevented if staff would have followed the 5 rights of med administration and checked the medication three times before administering it.
MIOSHA R325.70001	11. Annually review the "**Exposure Control Plan,**" update as needed. (Blood Borne Pathogens Exposure and Infection Control Plan)	**FY2024 – Q1: October 1, 2023 – December 31, 2023** This is updated annually. **FY2024 Q2: January 1, 2024 – March 31, 2024** This is updated annually. **FY2024 Q3: April 1, 2024 – June 30, 2024** Updated to include new procedures for disposal of sharps**.** **FY2024 Q4: July 1, 2024 – September 30, 2024** Updated and includes new procedures for disposal of sharps in Q3**.**
ARF Health & Safety	12. Annually, complete (update/revise) **Board Statement**: "Health & Safety Work Plan".	**FY2024 – Q1: October 1, 2023 – December 31, 2023** No activity this quarter. **FY2024 Q2: January 1, 2024 – March 31, 2024** No activity this quarter. **FY2024 Q3: April 1, 2024 – June 30, 2024** No activity this quarter. **FY2024 Q4: July 1, 2024 – September 30, 2024** No activity this quarter.

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
CARF	13. Promote Safety by ensuring current **Written Safety Procedures** as applicable.	**FY2024 – Q1: October 1, 2023 – December 31, 2023** Safety procedures are outlined in the Employee Emergency Handbook, which is available on each employee's desktop and in written format. **FY2024 Q2: January 1, 2024 – March 31, 2024** Safety procedures are outlined in the Employee Emergency Handbook, which is available on each employee's desktop and in written format. **FY2024 Q3: April 1, 2024 – June 30, 2024** Safety procedures are outlined in the Employee Emergency Handbook, which is available on each employee's desktop and in written format. **FY2024 Q4: July 1, 2024 – September 30, 2024** Safety procedures are outlined in the Employee Emergency Handbook, which is available on each employee's desktop and in written format and updated as needed, at least quarterly.
N/A	14. Promote implementation of **Risk Awareness List (formerly Threat List)** individual's photos in OASIS. Procedure: 1. Safety Coordinator receives the Risk Awareness List from Prescriber's Clerical, after initiation and approval by Medical Director and Chief Clinical Officer. 2. A Health Safety warning is added to the banner of that individuals Oasis account. 3. When the Banner is clicked it provides instructions, for example, "contact the ACT Team". 4. Clerical/Reception staff are trained on how to look for this banner and follow instructions accordingly.	**FY2024 – Q1: October 1, 2023 – December 31, 2023** This list is updated consistently with information shared with reception staff, as needed. **FY2024 Q2: January 1, 2024 – March 31, 2024** This list is updated consistently with information shared with reception staff, as needed. 2 individuals reported on the Threat List currently. **FY2024 Q3: April 1, 2024 – June 30, 2024** This list is updated consistently with information shared with reception staff, as needed. 1(one) individual reported on the Risk Awareness List currently. **FY2024 Q4: July 1, 2024 – September 30, 2024** This list is updated by the Medical Director and Chief Clinical Officer, quarterly. The list is sent to key personnel, including the Safety Coordinator. The Reception/Scheduling Team reviews the list and procedures quarterly. 1. Safety Coordinator receives the Risk Awareness List from Prescriber's Clerical after initiation and approval by Medical Director and Chief Clinical Officer. 2. A Health Safety warning is added to the banner of that individual's Oasis record. 3. When the banner is clicked, instructions notify the employee how to proceed, i.e., "Contact the ACT Team." 4. Clerical/Reception staff are trained on how to look for

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
		this banner and follow instructions accordingly.
CMH Policy	15. Address other safety-related items as needed.	**FY2024 – Q1: October 1, 2023 – December 31, 2023** This is an ongoing practice. Currently, the Chief Operating Officer is in the process of creating a full-time Safety/Security position for the agency. **FY2024 Q2: January 1, 2024 – March 31, 2024** This is an ongoing practice. The new Safety Coordinator started March 23, 2024. **FY2024 Q3: April 1, 2024 – June 30, 2024** This is an ongoing practice. **FY2024 Q4: July 1, 2024 – September 30, 2024** This is an ongoing practice.
Good Administrative Practice CARF Health & Safety	16. 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)	A regular full-time Security/Safety Specialist will be hired during the 2nd quarter to address the growing security and safety needs of the agency as we serve more individuals at more locations and employ greater numbers of staff. The job description and functional job task list are under development and will be informed by the recent Homeland Security assessment. Expanding on our current disaster recovery and business resumption plan will be a priority job task. **FY2024 Q2: January 1, 2024 – March 31, 2024** Safety Coordinator was hired with a start date of March 23, 2024. **FY2024 Q3: April 1, 2024 – June 30, 2024** **This is ongoing.** **FY2024 Q4: July 1, 2024 – September 30, 2024** This is ongoing. A Team of COO, Facilities Supervisor, IT, and Safety Coordinator are meeting to update the Disaster Recovery / Business Resumption Plan. Safety Coordinator is currently writing an All-Hazards Plan, which is set to be completed by February 2025.

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
	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	

Reference	Privileging and Credentialing-Amy Kandell & Kerrie Kozloff PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
MDHHS/PIHP contract	1. Maintain/update as applicable the Provider Enrollment and Credentialing Policy 01-003-0011, credentialing applications and forms.	Contract agencies are still completing paper applications. The old paper copy application is being updated to match the database application. IT is still assessing if it is viable for contract agencies to transition to the on line data base. Privileging and Credentialing is still working on updating the P and C policy. It is anticipated the policy should be ready for review by November/December 2024
State Licensing & MDHHS Requirement	2. Monitor the credentials for all staff requesting privileges to provide services to individuals in SCCCMHA presented to committee.	No changes to this task. P & C committee continues to meet bi-monthly to review applications and the credentials of staff. Re-credentialed: **31** Provisional: **19** Full: **14** Organizations: **7** **FOR 4th Q: 7/1/24 – 9/30/24** **Total Credentialed Practitioners: 64**
MDHHS Requirement	3. Review and privilege as appropriate organizational applications of provider agencies.	No changes/ongoing reviews. The committee meets up to 2x's a month to review applications
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. a) Ensure list of practitioner and organizational providers are available upon request.	No changes/ongoing. Prior to P&C meeting clerical and P&C committee members review databases database to compare and comprise a list of applicants due to credentialing
Good Clinical Practice	5. Monitor staff training requirements. Make recommendations for training and direction as needed.	Staff member from the HR training department attends P & C meetings to bring up and address any issues, concerns or updates as needed. P and C committee has reduce the number of Provisional applications we are reviewing based on the changes by the Region to their P & C policy and application. P and C are not placing staff on provisional status if they change positions in the agency that affects their grade level and population they are seeing. HR has developed a new process for monitoring these situations and informs P and C committee if there are any issues.
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	Reports are reviewed prior to P & C meeting to ensure providers/practitioners are reviewed in timely manner. Currently updating the policy to reflect the online changes and results from audits. Committee performs bimonthly audits of contract providers P and C applications to ensure they are filled out correctly.

Reference	Program Development-Kathleen Gallagher PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
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.	1. EBP's continue throughout the agency. 2. An ACT fidelity review was completed over the last quarter. 3. Continue to be scheduled for regular fidelity reviews 4. Ongoing
Best Practice Strategic Plan Priority 4 Object 2	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	a. Ongoing b. Collaborating with Contracts ensure this happens c. Survey to occur by January 2025
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.	In compliance with grant: a. Ongoing Advocating with Senator Peters on Community Care Authorizations for Veterans to continue with their care at SCCCMH- VA recently made a change – discontinuing these authorizations. b. Ongoing
Integrated Care/CCBHC Strategic Plan Priority 2 Object 2	7. Implement Well Environment a. Implement a Healthy Environment for staff and individuals we support. b. Assist in facilitating Wellness Wednesdays. c. Continue to work with the People's Clinic on improving primary care service delivery to the community. d. Fully implement the wellness arm of CMH, supported through CCBHC funding (In Shape, Mediation, Yoga, etc.)	a. Ongoing b. Ongoing c. Ongoing d. Ongoing
Best practice	8. Assess and explore EBP to provide SUD services. a. Train Staff identified EBP for SUD b. Additional staff to obtain their substance use credential c. SUD services to continue to expand agency wide/ d. SUD groups to be developed and implemented	a. Ongoing b. Ongoing c. Assessing needs throughout the county d. Ongoing assessment
Best Practice	9. To provide state -of -the art, evidence based assessment and treatment to individuals at risk for suicide. a. Train staff system wide in EBP for treatment for individuals at risk for suicide. b. Train staff system wide on use of Columbia and applicable clinical tools for treatment. c. Assess current EBP's for effectiveness d. Research EBP's that may be implemented throughout the system.	a. Ongoing b. Ongoing c. Working with data analyst to begin assessment d. Ongoing

Reference	Program Development-Kathleen Gallagher PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
Staff Recruitment Program Staff Training Expand Programs	10. Develop and Implement a plan to recruit and maintain quality staff a. Work with HR and Program Supervisors to identify targeted problem areas in hiring and retention and develop an action plan. b. Develop and implement a plan to offer comprehensive training and support to both new hires in operations and existing employees. c. Identify training areas for program staff and develop training modules/online assistance/mentors for staff. d. Develop programs to fill gap need areas of people served. e. Work with supervisors to identify need areas and complete work plans to address those need areas.	a. Ongoing b. Currently there is a posting for an operations trainer- not yet filled due to lack of applicants c. Ongoing d. Ongoing e. Have added supervisory staff to increase availability for mentorship and clinical guidance.
Strategic Plan Priority 4 Objective 1	11. Community Based Crisis Services a. Psychiatric Urgent Care b. Children's Crisis Residential Home c. Crisis Stabilization Unit	a. Attempting to find a location. Planning committee has been established/ b. An RFP for a children's crisis residential provider has been issued and will remain out until a provider is secured c. Plans are in place to open a Behavioral Health Urgent Care- in some capacity within this fiscal year.

Reference	Recipient Rights-Sandy O'Neil PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
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.	**1.) ADMINISTRATIVE FUNCTION** **FY2024 – Q1: October 1, 2023 – December 31, 2023** a.) MDHHS no longer requires this report b.) No activity c.) No activity **FY2024 – Q2: January 1, 2024 – March 31, 2024** a.) MDHHS no longer requires this report b.) No activity c.) No activity **FY2024 – Q3: April 1, 2024 – June 30, 2024** a.) MDHHS no longer requires this report b.) Submitted to MDHHS June 21, 2024 c.) No activity **FY2024 – Q4: July 1, 2024 – September 30, 2024** a.) MDHHS no longer requires this report b.) Submitted to MDHHS June 21, 2024 c.) No activity
MDHHS GF Contract	2. **COMPLAINT RESOLUTION SYSTEM FUNCTION** a.) Report the number of substantiated Recipient Rights violations in St. Clair County by classification and provider location (identified by month/quarter).	**2.) COMPLAINT RESOLUTION SYSTEM FUNCTION** **FY2024 – Q1: October 1, 2023 – December 31, 2023** a.) **Substantiated Violations = 24 Total** **- October 2023: Nine (9) Violations Established** ▪ Autism Systems – Marysville: Services ▪ Suited to Condition ▪ Beacon Services – Beacon Home at Ypsilanti: Abuse: Class III (1); Neglect: Class III (1) ▪ BWDH – Hayes Group Home: Services Suited to Condition ▪ BWDH – Oakleaf Group Home: Confidentiality ▪ BWDH – Springborn Group Home: Services Suited to Condition ▪ BWDH – Stonybrook Group Home: Dignity and Respect ▪ IHDC – Roehl Group Home: Services Suited to Condition ▪ SCCCMHA – CIS: Neglect: Class III **- November 2023: Eleven (11) Violations Established** ▪ Beacon Services-Beacon Home at The Lodge: Services Suited to Condition ▪ BWDH – Hayes Home: Family Rights ▪ BWDH – Oakleaf Group Home: Service Suited to Condition ▪ BWDH – Semi-Independent Group Home: Dignity and Respect (1); Services Suited to Condition (1) ▪ IMPACT – River Bend I: Abuse: Class III ▪ IHDC- Hancock Group Home: Dignity and Respect ▪ Community Enterprises- ECL: Dignity and Respect (1) ; Services Suited to Condition (1) ▪ SCCCMHA – Outpatient: Confidentiality

Reference	Recipient Rights-Sandy O'Neil PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
		- **December 2023: Four (4) Substantiated Violations** ▪ BWDH – Hayes Group Home: Services Suited to Condition ▪ GT Independence: Self-Determination: Abuse: Class III ▪ IHDC – Ponderosa Group Home: Services Suited to Condition ▪ SCCCMHA – Children's: Services Suited to Condition **FY2024 – Q2: January 1, 2024 – March 31, 2024** a.) **Substantiated Violations = 28 Total** - **January 2024: Twelve (12) Violations Established** ▪ All Ways Care – Community: Services Suited to Condition ▪ Autism Systems – Marysville: Abuse: III (1); Abuse II (1) ▪ Beacon Services – Beacon Home at Woodland: Services Suited to Condition ▪ Berg AFC: Services Suited to Condition ▪ BWDH – Springborn Group Home: Safe Environment ▪ IMPACT – Charmwood: Abuse : II (2) ▪ IHDC – Hancock Group Home: Abuse: II ▪ SCCCMHA – Peer Services: Dignity and Respect ▪ SCCCMHA – Wrap Around/Children's: Services Suited to Condition (1); Confidentiality (1) - **February 2024: Nine (9) Violations Established** ▪ Autism Systems-Keewahdin: Abuse: II Unreasonable Force ▪ Beacon Services-Beacon Home at Woodland: Services Suited to Condition ▪ BWDH – Hayes Home: Services Suited to Condition ▪ BWDH – Semi-Independent Group Home: Abuse: III ▪ IMPACT – River Bend II: Services Suited to Condition (1); Dignity and Respect (2) ▪ IMPACT – Wells Group Home: Services Suited to Condition ▪ IHDC- Liberty Group Home: Neglect: III - **March 2024: Seven (7) Substantiated Violations** ▪ All-Ways-Care-Community Based: Services Suited to Condition; Abuse: III (2) ▪ BWDH – Stonybrook Group Home: Services Suited to Condition **FY2024 – Q3: April 1, 2024 – June 30, 2024** a.) **Substantiated Violations = 23 Total** - **April 2024: Five (5) Violations Established** ▪ BWDH – Hayes: Dignity and Respect ▪ Innovative – Oak Group Home: Dignity and Respect ▪ Port of Hopes – Abuse: III ▪ SCCCMHA – CIS: Disclosure of Confidential Information (2) - **May 2024: Ten (10) Violations Established** ▪ All-Ways Care – Abuse: II – Exploitation (1); Abuse: III (1) ▪ BWDH – Maple Group Home: Family Rights ▪ IMPACT – Wells Group Home: Dignity and Respect

Reference	Recipient Rights-Sandy O'Neil PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
		▪ Innovative – Abbottsford Group Home: Abuse: II – Unreasonable Force (2); and Abuse: III (2) ▪ Innovative – Ravenswood Group Home: Services Suited to Condition ▪ SCCCMHA – Capac: Disclosure of Confidential Information - **June 2024: Eight (8) Violations Established** ▪ Beacon – Eau Claire: Abuse: III ▪ BWDH – Stonybrook Group Home: Neglect: III ▪ GT Financial: Services Suited to Condition ▪ IMPACT – Support Housing: Abuse: III ▪ Innovative – Abbottsford Group Home: Freedom of Movement ▪ ResCare – Lawndale: Services Suited to Condition ▪ SCCCMHA – Residential I: Dignity and Respect (1); Disclosure of Confidential Information (1) **FY2024 – Q4: July 1, 2024 – September 30, 2024** a.) **Substantiated Violations = 21 Total** - **July 2024: Three (3) Violations Established** ▪ BWDH – Supported Housing- Services Suited ▪ Innovative – Abbottsford Home – Family Rights ▪ Innovative – Roehl Home: Neglect: III - **August 2024: Ten (10) Violations Established** ▪ Autism Systems – Marysville – Abuse: II- Unreasonable Force ▪ BWDH – Springborn – Abuse: III (3) ▪ IMPACT – River Bend II – Neglect: III (2) ▪ Innovative – Abbottsford – Service Suited to Condition ▪ Innovative – Abbottsford – Confidentiality ▪ Port of Hopes – Services Suited to Condition ▪ SCCCMH Case Management – Dignity and Respect - **September 2024: Eight (8) Violations Established** ▪ Beacon – Lennon -Abuse: II- Exploitation ▪ BWDH – Thornhill Group Home: Freedom of Movement ▪ Innovative – Liberty Group Home – Services Suited to Condition ▪ Innovative – Progression AFC – Personal Property ▪ Innovative – Progression AFC – Services Suited to Condition ▪ SCCCMHA – Capac – Confidentiality ▪ SCCCMHA – Outpatient – Services Suited to Condition ▪ SCCCMHA – Transportation – Dignity and Respect

Reference	Recipient Rights-Sandy O'Neil PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
MI MHC MDHHS	3. **MONITORING & PREVENTION FUNCTION: SITE VISITS** a.) On an annual basis, ensure a Recipient Rights site review is completed at each direct-operated service location and each contracted service location.	**3.) MONITIORING & PREVENTION FUNCTION: SITE VISIT** **FY2024 – Q1: October 1, 2023 – December 31, 2023** a.) Site Visits completed this quarter: 41 Total **FY2024 – Q2: January 1, 2024 – March 31, 2024** a.) Site Visits completed this quarter: 30 Total **FY2024 – Q3: April 1, 2024 – June 30, 2024** a.) Site Visits completed this quarter: 27 Total **FY2024 – Q4: July1,2024 – August 31, 2024** a.) Site Visits completed this quarter: 15 Total
CARF MDHHS	4. **MONITORING FUNCTION: 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.	**4.) MONITORING FUNCTION: INCIDENT REPORT SYSTEM** **FY2024 – Q1: October 1, 2023 – December 31, 2023** a.) Incident Reports: 826 Total reports reviewed this quarter b.) Critical Incidents: ▪ Deaths – Suicide: 0 ▪ Deaths – Natural Cause: 11 ▪ EMT d/t Injuries/Medication Errors: 7 ▪ Hospitalization d/t Injuries/Medication Errors: 0 ▪ Arrests: 3 c.)Event Reporting: ▪ October 2023: Submitted on 11/14/2023 ▪ November 2023: Submitted on 12/15/2023 ▪ December 2023: Submitted on 01/16/2023 d.) Risk Events: ▪ Harm to Self w/ EMT/Hospitalization: 1 ▪ Harm to Others w/ EMT/Hospitalization: 0 ▪ Police Calls by Mental Health Staff: 30 ▪ Physical Management: 3 ▪ Hospitalization (Unscheduled Medical): 9 **FY2024 – Q2: January 1, 2024 – March 31, 2024** a.) Incident Reports: 879 Total reports reviewed this quarter b.) Critical Incidents: ▪ Deaths – Suicide: 1 ▪ Deaths – Natural Cause: 16 ▪ EMT d/t Injuries/Medication Errors: 3 ▪ Hospitalizations d/t Injuries/Medication Errors: 0 ▪ Arrests: 0 c.) Event Reporting: ▪ January 2024: Submitted on 02/14/2024 ▪ February 2024: Submitted on 03/14/2024 ▪ March 2024: Submitted on 04/11/2024 d.) Risk Events: ▪ Harm to Self w/ EMT/Hospitalization: 2

Reference	Recipient Rights-Sandy O'Neil PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
		▪ Harm to Others w/ EMT/Hospitalization: 0 ▪ Police Calls by Mental Health Staff: 42 ▪ Physical Management: 11 ▪ Hospitalization (Unscheduled Medical): 15 **FY2024 – Q3: April 1, 2024 – June 30, 2024** a.) Incident Reports: 860 Total reports reviewed this quarter b.) Critical Incidents: ▪ Deaths – Suicide: 1 ▪ Deaths – Natural Cause: 11 ▪ EMT d/t Injuries/Medication Errors: 6 ▪ Hospitalization d/t Injuries/Medication Errors: 0 ▪ Arrests: 8 c.)Event Reporting: ▪ April 2024: Submitted on 05/09/2024 ▪ May 2024: Submitted on 06/10/2024 ▪ June 2024: Submitted on 07/10/2024 d.) Risk Events: ▪ Harm to Self w/ EMT/Hospitalization: 3 ▪ Harm to Others w/ EMT/Hospitalization: 0 ▪ Police Calls by Mental Health Staff: 39 ▪ Physical Management: 6 ▪ Hospitalization (Unscheduled Medical): 14 **FY2024 – Q4: July 1, 2024 – September 30, 2024** a.) Incident Reports: 811 Total reports reviewed this quarter b.) Critical Incidents: ▪ Deaths – Suicide: 0 ▪ Deaths – Natural Cause: 7 ▪ EMT d/t Injuries/Medication Errors: 6 ▪ Hospitalization d/t Injuries/Medication Errors: 0 ▪ Arrests: 1 c.) Event Reporting: ▪ July 2024: Submitted on 08/08/2024 ▪ August 2024: Submitted on 09/11/2024 ▪ September 2024: Submitted on 10/10/2024 d.) Risk Events: ▪ Harm to Self w/ EMT/Hospitalization: 2 ▪ Harm to Others w/ EMT/Hospitalization: 1 ▪ Police Calls by Mental Health Staff: 31 ▪ Physical Management: 7 ▪ Hospitalization (Unscheduled Medical): 7

Reference	Recipient Rights-Sandy O'Neil PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
MI MHC	5. **PREVENTION FUNCTION** 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.	**5.) PREVENTION FUNCTION** **FY2024 – Q1: October 1, 2023 – December 31, 2023** a.) During the reporting period, the ORR reviewed seven (7) policies and administrative procedures. **FY2024 – Q2: January 1, 2024 – March 31, 2024** a.) During the reporting period, the ORR reviewed five (5) policies and administrative procedures. **FY2024 – Q3: April 1, 2024 – June 30, 2024** a.) During the reporting period, the ORR reviewed nine (9) policies and administrative procedures. **FY2024 – Q4: July 1, 2024 – September 30, 2024** a.) During the reporting period, the ORR reviewed Seven (7) policies and administrative procedures.
MI MHC MDHHS GF Contract	6. **EDUCATION/TRAINING FUNCTION** 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/virtual 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 b) Monitor training data to identify the staff members/volunteers (direct-operated & contract system) who completed in-person/on-line Recipient Rights Refresher training on an annual basis. i. Provide in-person Recipient Rights refresher training at least two times per month or ensure on-line training is accessible through MyLearningPointe or the SCCCMHA web-site. ii. Report the number of staff trained. 1. Direct-Operated staff members/volunteers 2. Contract System staff members/volunteers	**6.) EDUCATION/TRAINING FUNCTION** **FY2024 – Q1: October 1, 2023 – December 31, 2023** **a.) New-Hire Training Data** a.i.) Trainings Provided: Six (6) trainings provided this quarter; Three (3) in-person/Three (3) virtual a.ii.) Staff Trained Within 30 Days of Hire: 117/127 employees trained within 30 days of hire (92%) a.ii.1.) Direct-Operated Employees: 21/21 employees trained within 30 days of hire (100%) a.ii.2.) Contract Provider Employees: 96/100 employees trained within 30 days of hire (93%) **b.) Annual Refresher Training Data** b.i.) Trainings provided: All trainings were provided through on-line/electronic manual **b.)** b.i.) Trainings provided: All trainings were provided through on-line/electronic manual methods (Direct-Operated employees through MyLearningPointe; Contract Provider employees through electronic manual/test) b.ii.) Employees Trained: 200 total b.ii.1.) Direct-Operated Employees: 5 employees trained this quarter b.ii.2.) Contract Provider Employees: 195 employees trained this quarter **FY2024 – Q2: January 1, 2024 – March 31, 2024** **a.) New-Hire Training Data** a.i.) Trainings Provided: Six (6) trainings provided this quarter; Three (3) in-person/Three (3) virtual

Reference	Recipient Rights-Sandy O'Neil PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
		a.ii.) Staff Trained Within 30 Days of Hire: 87/93 employees trained within 30 days of hire (94%) a.ii.1.) Direct-Operated Employees: 12/12 employees trained within 30 days of hire (100%) a.ii.2.) Contract Provider Employees: 75/81 employees trained within 30 days of hire (93%) **b.) Annual Refresher Training Data** b.i.) Trainings provided: All trainings were provided through on-line/electronic manual methods (Direct-Operated employees through MyLearningPointe; Contract Provider employees through electronic manual/test) b.ii.) Employees Trained: 596 total b.ii.1.) Direct-Operated Employees: 472 employees trained this quarter b.ii.2.) Contract Provider Employees: 124 employees trained this quarter **FY2024 – Q3: April 1, 2024 – June 30, 2024** **a.) New-Hire Training Data** a.i.) Trainings Provided: Six (6) trainings provided this quarter; Three (3) in-person/Three (3) virtual a.ii.) Staff Trained Within 30 Days of Hire: 128/131 employees trained within 30 days of hire (97%) a.ii.1.) Direct-Operated Employees: 17/17 employees trained within 30 days of hire (100%) a.ii.2.) Contract Provider Employees: 111/114 employees trained within 30 days of hire (97%) **b.) Annual Refresher Training Data** b.i.) Trainings provided: All trainings were provided through on-line/electronic manual **b.)** b.i.) Trainings provided: All trainings were provided through on-line/electronic manual methods (Direct-Operated employees through MyLearningPointe; Contract Provider employees through electronic manual/test) b.ii.) Employees Trained: 200 total b.ii.1.) Direct-Operated Employees: 85 employees trained this quarter b.ii.2.) Contract Provider Employees: 115 employees trained this quarter **FY2024 – Q4: July 1, 2024 – September 30, 2024** **a.) New-Hire Training Data** a.i.) Trainings Provided: Six (6) trainings provided this quarter; Three (3) in-person/Three (3) virtual a.ii.) Staff Trained Within 30 Days of Hire: 77/84 employees trained within 30 days of hire (92%)

Reference	Recipient Rights-Sandy O'Neil PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
		a.ii.1.) Direct-Operated Employees: 18/18 employees trained within 30 days of hire (100%) a.ii.2.) Contract Provider Employees: 59/66 employees trained within 30 days of hire (89%) **b.) Annual Refresher Training Data** b.i.) Trainings provided: All trainings were provided through on-line/electronic manual **b.)** b.i.) Trainings provided: All trainings were provided through on-line/electronic manual methods (Direct-Operated employees through MyLearningPointe; Contract Provider employees through electronic manual/test) b.ii.) Employees Trained: 314 total b.ii.1.) Direct-Operated Employees: 31 employees trained this quarter b.ii.2.) Contract Provider Employees: 283 employees trained this quarter

Reference	System Improvement-Denise Choiniere & Michelle Measel-Morris PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
CARF	1. Maintain agency accreditation.	On 3/14/2023 SCCCMHA received a three year accreditation letter from CARF International. The next CARF review will be in 2026.
Regulatory Requirement	2. Ensure compliance with applicable Corrective Action Plans (e.g. Region 10 PIHP, MDHHS, HSAG etc.)	**MDHHS** St. Clair has submitted all required documentation for the FY24 MDHHS/Region 10 Waiver Audit. The audit period is from 8/12-9/30. There were 19 cases (HSW, CWP, SEDW and 1915i) selected for review. The Waiver Audit has been completed SCCCMH is waiting on the FINAL REPORT
MDHHS Strategic Plan Priority 4 Object 2 Strategic Plan Priority 1 Objective 3	3. Monitor performance of each location through program performance indicators.	**FY24, 4Q** 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.
MDHHS, CARF Strategic Plan Priority 4 Objective 2	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) Prescriber Satisfaction Survey f) NCI Project g) RSA Survey- Region 10	a) **Customer Satisfaction Survey:** The FY24 Region 10 Customer Satisfaction has been completed. SCCCMH has also completed their Customer Satisfaction Survey. The SCCCMH response rate is 19%, 1 % greater than FY23. The "Overall Satisfaction was 92% a 3% decrease from FY23. b) **Accessibility/Barriers to Services Survey**: The FY24 Accessibility/Barriers to Services Survey was administer March 6th – March 27th in person at all four location (Children's, Port Huron, Capac and Marine City). The report is in draft format and will be presented to the SCCCMHA May board meeting. c) **Provider Satisfaction Survey:** The FY24 Provider Satisfaction survey was administered in the month of February and the report was taken to the SCCCMHA Board in March. The overall average satisfaction rate was 98%. d) **Post Discharge Survey:** The Post Discharge Surveys is ongoing (monthly). e) **Prescriber Satisfaction Survey:** The FY24 Prescriber Satisfaction Survey was administer between the dates of 1/24/2024 and 2/7/2024. The combined percentage for the questions "I would recommend this prescriber to others" was 92%. The questions regarding wait times for an appointments (i.e. 15 Minutes) was 98%. The report was presented to the SCCCMHA Board in March. f) **NCI Project:** NCI project (survey), informational letters and consents have been mailed out. Case Holder(s) of the individuals will returned/signed consent will be forwarded the Pre Survey/Background portion of the survey to be completed.

Reference	System Improvement-Denise Choiniere & Michelle Measel-Morris PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
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. (50th Percentile, 57% standard) or (75% Percentile, 62% 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. (50th Percentile, 72.9% standard) or (75% Percentile, 83.8% 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 three hours. *(Standard: 95%)*** **Q4 – FY23** / **Q1 – FY24** / **Q2 – FY24** / **Q3 – FY24** **CMHSP:** **100% Total** 100% Child 100% Adult / **100% Total** 100% Child 100% Adult / **100% Total** 100% Child 100% Adult / **99.67% Total** 98.55% Child 100% Adult **Medicaid:** **100% Total** 100% Child 100% Adult / **100% Total** 100% Child 100% Adult / **100% Total** 100% Child 100% Adult / **99.66% Total** 98.53% Child 100% Adult **PI 2a) The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service. *(Standard: 50th Percentile 57%, 75th Percentile 62%)*** **CMHSP:** **63.08% Total** 64.42% MI Child 61.54% MI Adult 71.64% DD Child 63.64% DD Adult / **47.00% Total** 46.31% MI Child 49.35% MI Adult 32.20% DD Child 39.29% DD Adult / **43.34% Total** 40.08% MI Child 45.28% MI Adult 31.82% DD Child 45.16% DD Adult / **56.58% Total** 61.40% MI Child 55.17% MI Adult 69.44% DD Child 39.29% DD Adult **Medicaid:** **62.31% Total** 63.24% MI Child 60.49% MI Adult 72.31% DD Child 61.90% DD Adult / **45.37% Total** 47.57% MI Child 46.50% MI Adult 30.19% DD Child 40.00% DD Adult / **43.79% Total** 41.09% MI Child 45.58% MI Adult 30.95% DD Child 50.00% DD Adult / **55.37% Total** 61.44% MI Child 52.74% MI Adult 73.53% DD Child 40.74% DD Adult **PI 3) Percentage of new persons during the quarter starting any medical necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment. *(Standard:-50th Percentile 72.9%, 75th Percentile 83.8%)*** **CMHSP:** **66.83% Total** 73.08% MI Child 63.64% MI Adult 70.18% DD Child 73.33% DD Adult / **57.40% Total** 61.84% MI Child 54.00% MI Adult 61.54% DD Child 70.37% DD Adult / **64.22% Total** 71.76% MI Child 63.32% MI Adult 41.94% DD Child 56.00% DD Adult / **59.78% Total** 65.79% MI Child 56.19% MI Adult 72.97% DD Child 64.00% DD Adult **Medicaid:** **67.05% Total** 74.82% MI Child 62.86% MI Adult 69.64% DD Child 73.33% DD Adult / **59.93% Total** 61.88% MI Child 57.76% MI Adult 62.00% DD Child 72.00% DD Adult / **67.63% Total** 74.32% MI Child 67.98% MI Adult 37.04% DD Child 56.00% DD Adult / **63.90% Total** 67.65% MI Child 60.87% MI Adult 75.00% DD Child 66.67% DD Adult **PI 4a) The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up within seven (7) days. *(Standard: 95%)*** **CMHSP:** **93.83% Total** 86.67% Child 95.45% Adult / **91.46% Total** 87.50% Child 92.42% Adult / **96.19% Total** 95.65% Child 96.34% Adult / **98.78% Total** 100% Child 98.51% Adult **Medicaid:** **94.87% Total** 86.67% Child 96.83% Adult / **91.03% Total** 87.50% Child 91.94% Adult / **96.15% Total** 95.65% Child 96.30% Adult / **98.75% Total** 100% Child 98.46% Adult **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% or less)*** **CMHSP:** **11.48% Total** 20.00% Child 9.80% Adult / **10.53% Total** 5.26% Child 11.58% Adult / **10.95% Total** 4.00% Child 12.50% Adult / **13.64% Total** 11.76% Child 13.91% Adult **Medicaid:** **11.86% Total** 20.00% Child 10.20% Adult / **10.91% Total** 5.26% Child 12.09% Adult / **10.53% Total** 4.00% Child 12.04% Adult / **13.95% Total** 11.76% Child 14.29% Adult

Reference	System Improvement-Denise Choiniere & Michelle Measel-Morris PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
Quality Initiatives	6. Fidelity Review a) ACT b) DBT c) IDDT d) IPS e) LOCUS Assessment f) OFS	a) ACT: Fidelity Review Completed (In Person) 9/5/24 b) DBT: Fidelity Review Scheduled 11//12/24 & 11/13/24 (In Person) c) IDDT: Completed Next Review 2025*2022 Final Report Received d) IPS: Completed Next Review TBD*2023 Final Report Received e) LOCUS Assessment: Completed Next Review TBD*2023 Final Report Received f) OFS: TBD
Quality Initiatives	7. Quality Initiatives a) Implement Choosing Wisely Guidelines b) Implement PDSA Cycles (Plan, Do, Study, Act) c) Implement technology to improve patient access and quality of service	a) will review with prescribers - completed b) will review at February staff meeting – via Monday - completed c) In progress- Eleos & Mend and iCarol
Region 10 Contract Requirement	8. Enhance Dashboard Indicators and other data mining capabilities that facilities population management/analysis. a) Utilize CC360 or population analytics. b) Utilize Dashboard for Quality Improvement Projects. c) Enhance CEHR usage for e-signature collection, patient education and program improvement.	a) Analyst Supervisor position filled 3/25/24 b) Analyst Supervisor position filled 3/25/25/Dashboard in Progress c) Analyst Supervisor position filled 3/25/24
CCBHC	9. Review and monitor the CCBHC Report at least quarterly.	CCBHC metrics was just transferred to Data Management. Report is due 1/30/24 to Region 10 PIHP. Report was forwarded on time.
Quality Initiatives	10. Streamline and improve data reports and the data request process by focusing on the following item: a) Create and implement a staff request for data/data reports process b) Establish routine reports and set up report automation c) Audit of databases (i.e. identifying data errors that occur in our system and implement corrective actions) d) Provide support to assist in special projects	a) Will be reviewed by new Analytics Supervisor b) in progress c) in progress d) in progress
Strategic Plan Priority 1 Objective 1 & 2	11. Support administrative and clinical workflows and agencies processes to maximize time, resource and improve performance.	Hired 3/25/2024 a new Data Analytics Supervisor
Good Clinical Practice	12. To participate in the Region 10 PIHP QAPIP Performance Improvement Projects a) Hospital Follow Up b) Racial/Ethnic Dipartites	a) Ongoing. Reviewed with the PIHP. b) It is for the SUD Program.
MDHHS Audit Requirement	13. To participate in the MDHHS quality Improvement Project for HSW, CWP and SEDW a) Staff training compliance b) Service provision compliance	Preparing for MDHHS Audit Aug/Sep. 2024

Reference	Information Technology-Dann Hayes PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
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 (7/31/2024). 2. Complete annual simulated disaster recovery test and implement corrective actions and/or compensating controls, where appropriate. • Electric Avenue – (8/31/2024) • Marine City – (8/31/2024) • Capac – (8/31/2024) • ABA – (8/31/2024) 3. Complete HIPAA Risk Assessment (8/28/2024) and Develop/Implement Plan (45 CFR 164) (9/30/2024).	1. The IT Department Written Plan for Disaster Recovery was reviewed and completed at the end of March 2024. --COMPLETED 2. The new Electric Ave building Generator has been pushed back to an expected delivery and install the week of November 6th. We plan to push the testing to late November to give time for the generator to be installed. We could then incorporate it into this year's annual test. 3. HIPAA Risk Assessment and Plan is being evaluated to see if there's a better way to define and report on this. We also recently hired a new Corporate Compliance officer that I would like to have review our process and potentially offer suggestions or ideas.
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 (3/30/2024) 2.) Upgrade all Agency routers at all locations (3/30/2024) 3.) Bring 135 Broadway in Marine City back online with all technology needs. (12/31/2023) 4.) Upgrade remaining expiring Cisco Switches in MDF to Meraki (12/31/24)	a1.) All switches in the IDF have been replaced with Meraki switches as of May 2024. New Battery Backups were also installed in the lower cabinet during this same interval and Stephenson Electric completed the change in amperage needed to accommodate the new equipment. – COMPLETED a2.) Main office, King Road, and Broadway have all been upgraded. Capac and CFS are left to do but we are scheduling them for FY2025. a3.) Broadway is online and all technology needs have been met. Upgraded the WIFI 1/25/24. Surveillance cameras are being added by Dyck Security 2/2/24. Informacast provided us the replacement hardware needed to get it in place, so this site is now 100% functional in terms of technology. -- COMPLETED. a4.) Switches have arrived and are being configured. These switches impact the entire back half of the building including parts of the network and server racks in the Main Distribution Frame (MDF). We will need to schedule this after hours to avoid impacting staff production. This is being scheduled for late October.

Reference	Information Technology-Dann Hayes PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
Good Administrative Practice & Strategic Plan Priority 1 Objective 4	3. Improve technology to increase operational efficiency. a) Upgrade all agency workstations to Windows 11 (11/30/2023) b) Move the Exchange server to the Microsoft Cloud (Microsoft 365) to prepare agency for M365 Upgrade (1/30/2024) c) Network Security Assessment (3/31/23) and Remediation of any vulnerabilities found. (9/31/23) d) Review Internet bandwidth needs for the agency with the increase in mobility and video conferencing e) Provide training and implement stronger strategies pertaining to social engineering, including phishing. f) Upgrade the Agency to Microsoft 365 (8/31/2024) g) Assist in all needs pertaining to AI Initiative (Eleos). h) Implement new cell phone strategy for staff requesting communication needs for Individuals they serve. (12/31/2023) i.) Implement Microsoft Teams for the Agency	a) Microsoft Windows 11 upgrades are now complete. This took a bit longer due to a smaller IT team than anticipated and the volume of staff working remotely. Project completed 1/19/24. b.) Microsoft Cloud licensing has been purchased as of 1/17/24. Email Migrations were completed as of 4/19/24. Next steps involve email quarantine management and more back-end cleanup/testing prior to pushing the new version of M365 to all staff. c.) IT is currently working with Trace3 to provide us a quote for a Security Assessment. Due to multiple projects and the availability of Trace3 staff, we are looking at a January/February 2025 timeline for this audit. d.) Bandwidth was reviewed for the agency multiple times over the past year and we are doing very well with our current connectivity. We continue to monitor this on a routine basis. -- COMPELTED e.) We are working with Trace3 and other consultants to review stronger strategies for social Engineering, physical security, and phishing training. f.) the IT Team started the initial testing and prep work for Microsoft 365 on 1/22/24. As we have done for all major rollouts of Microsoft Office products, we will thoroughly test and prep the software prior to rollout to the agency. We are currently projecting this rollout to staff before Memorial Day 2024. This rollout completed in early June. All staff now have M365. --COMPLETED g.) Eleos Sensi devices are currently being configured for deployment. Eleos support was onsite to kick off pilot of Sensi devices in late January. Eleos Sensi hardware has been given to staff and working well. More devices will be deployed in the coming months as we move forward with the adoption of Eleos.--COMPLETED h.) Over 100 cell phones are now deployed to staff. Early reports are positive in that they are helping staff communicate with the individuals they server more efficiently. All 125 phones involved in the initiative were given to staff by 2/1/24. Going forward any new staff requiring a phone, will request through their supervisor during onboarding or changes in their job tasks. – COMPLETED i.) The IT Dept is currently setting up all necessary security parameters, backup infrastructure, and BETA testing for Teams. BETA rollout expected in August. Staff rollout expected in November 2024.

Reference	Facilities-James Krzywiecki PRIORITY GOALS / KEY TASKS	TIMELINE-Status (with Recommendations)
Good Administrative Practice	1. Continuous improvement of Customer Service 1. Review/Revise Department written procedures, as appropriate. (9/30/2024) 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 (7/31/24)	
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 as well as all CMH facilities preventative maintenance. (9/30/2025) b) Develop and maintain a Facilities Procedures Manual identifying and documenting all "key" tasks in the department; use for staff training and reference. (9/30/2025) c) Expand upon existing parking at King Rd in Marine City. Add asphalt parking lot on CMH owned property. (1/30/2024)	a) A new Facilities Operations Manual is currently being developed. b) Jim Krzywiecki is working to develop a digital manual that will be more efficient to update and reference. c) The SCCCMH King Road parking lot has been expanded and is in use by staff and visitors. The lighting for the parking lot is on order and will be installed when the fixtures come in.
Good Administrative Practice	3. Improvements to increase operational efficiency a) Monitor and maintain existing CMH properties Utilize Kace Systems (HelpDesk) to document and monitor maintenance requests. b) Search, evaluate, purchase residential property to replace and expand bed capacity – find replacement for current Hopps home (Woodstock). 9/30/2024. c) Complete renovation and install furniture and appliances at 135 Broadway to prepare it for use to host groups and other program initiatives as a second site for CMH in Marine City. (1/31/2024)	a) Work orders are reviewed Monday thru Friday and dispatched upon urgency of the work order staff is instructed to open and review work orders on an daily basis. b) The search continues in 2024 and into 2025. A few homes were reviewed before 2/1/24 to see if they are a fit for our needs, but they were not. We are still actively looking. c) Appliances are delivered and installed for the kitchen at Broadway as of 1/19/24. Furniture has been placed as directed by Melissa Hunt. Building use will officially begin in Mid February.The Broadway office was completely finished and open as of late February 2024. –COMPLETED

Reference	Utilization Management-Amy Kandell PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
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.	a) Ongoing b) Ongoing c) Ongoing d) Ongoing This section is in the process of being updated for FY25
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.	a) Ongoing b) Ongoing c) Ongoing d) Ongoing This section is in the process of being updated for FY25. The New UM/Authorization began on May 20. Overall the process is going fairly smoothly. Sanilac, Lapeer, and St.Clair continue to meet with the Region on a monthly basis to assess how the new authorization process is functioning.
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 up to 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	a) Ongoing b) Ongoing c) Ongoing d) Ongoing This section is in the process of being updated for FY25

Reference	Utilization Management-Amy Kandell PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
Good Clinical Practice	4. BTPRC: Conduct quarterly oversight of Behavior Treatment Plan Review Committee (BTPRC) activities. a.) Risk Events Analysis Report – quarterly 1.) Emergency use of Physical Management tracking 2.) System Improvements identified at BTPRC to provide additional training opportunities for staff and/or opportunities to reduce risk factors for individuals served.	**FY 2024 – Q1: October 1, 2023 – December 31, 2023** a.) Risk Events Analysis Report – Quarterly 1.) Emergency Use of Physical Management tracking: 4 incidents 2.) System Improvement Recommendations: i. 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. ii. 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. **Q2: January 1, 2024 – March 31, 2024** a.) Risk Events Analysis Report – Quarterly 1.) Emergency Use of Physical Management tracking: 11 incidents 2.) System Improvement Recommendations: i. 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. iii. 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. **FY 2024 – Q3: April 1, 2024 – June 30, 2024** b.) Risk Events Analysis Report – Quarterly 3.) Emergency Use of Physical Management tracking: 8 incidents 4.) System Improvement Recommendations:

Reference	Utilization Management-Amy Kandell PRIORITY GOALS/KEY TASKS	TIMELINE-Status (with Recommendations)
		iv. 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. v. 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. **FY 2024 – Q4: July 1, 2024 – September 30, 2024** c.) Risk Events Analysis Report – Quarterly 5.) Emergency Use of Physical Management tracking: 6 incidents 6.) System Improvement Recommendations: vi. 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. vii. 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.