FY 2025
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, 2024 through September 30, 2025.

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	FY2025 TIMELINE-STATUS
Strategic Plan Education #2	1. **PAID ADVERTISING & SPONSORSHIPS:** • Promotion of CMH services through paid advertising or sponsorship of an external event. ○ Ex: Billboards, boosted social media posts, mental health minutes, Thumbcoast TV interviews.	**Paid Advertisements:** Ongoing (all quarters): Yale Expositor (monthly); The ARC of SCC monthly newsletter (monthly) Q1: BW Area Chamber, Business Guide; Blue Water Women Magazine Q2: Marine City Chamber of Commerce, Visitor's Guide; Marine City Chamber of Commerce, Business Guide Q3: Blue Water Area Chamber of Commerce, Member Directory ad **Q4:** No updates **Radio First/WGRT Mental Health Minute:** Q1: Bullying Prevention Month, Gratitude and Kindness, Caring for your mental health during the holiday season Q2: Prioritizing your mental health during the new year, Healthy Relationships, Intellectual/Developmental Disabilities Awareness Month Q3: Children's Mental Health, Mental Health Month, Men's Mental Health Awareness **Q4:** National Friendship Day, Back to School Mental Wellness, Suicide Prevention Month **EBW-TV:** 10/1/24, 10/15/24, 11/4/24, 11/12/24, 12/2/24, 12/17/24, 1/2/25, 1/16/25, 2/3/25, 2/17/25, 3/3/25, 3/17/25, 4/15/25, 5/14/25, 6/18/25, 7/17/25, 8/26/25, 9/18/25 **The Keel/Second Wave Media:** 12/8/24: Mental Health Matters During the Holidays 1/6/25: Start the New Year Prioritizing Your Mental Health 2/10/25: Show Love by Talking About Mental Health 3/11/25: Support is Out There: CMH Services for St. Clair County 4/12/25: April is Autism Awareness Month 5/3/25: May is Mental Health Month 6/8/25: June is Men's Mental Health Month 7/25/25: Mental Health Advocates Say State Proposal Could Threaten Patient Care 8/7/25: Back-to-School Mental Wellness: Helping students thrive in a digital world. 9/30/25: Recovery: A journey as unique as every individual. **Billboards:** Q1: General CMH (October), Veteran Navigator (November), Happy Holidays (December), Q2: MCU (January), MCU (February), Courage/Run/MCU (March) Q3: Mental Health Month (April), Mental Health Month (May), Men's Mental Health Awareness (June) **Q4:**Your Mental Health Matters (July, August), MCU (August), Walk for Suicide Prevention (September), Building Resilience (September) **Sponsorship Advertisements – Q1:** • United Way Centennial Celebration Silver Sponsor • NAACP Freedom Fund Gala Sponsor • BWROC 4th Annual Banquet Sponsor • Marine City Chamber of Commerce Christmas Tree Sponsor • Sanborn Gratiot Memorial Home, Dueling Pianos Fundraiser • Catholic Charities of SE MI, Hearts for Hope • Marine City Chamber of Commerce, Fire, Ice and Spice

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		Sponsorship Advertisements – Q2: • Lake Huron Foundation, Vineyards of the World • Port Huron Museum, Marvelous Museums • CSCB, Community Resource Fair • Rotary Club of Port Huron, Grand Slam • The Arc, Show the Love Dance • BW Area Chamber of Commerce, State of the County • BW Area Chamber of Commerce, Golf Outing • Hunter Hospitality House, Hope Blooms • Operation Transformation, Family Night • Dementia & Alzheimer's Association of SCC, Caregiver Expo • Marysville Little League, Challenger League • Community First Health Centers, Health Fair • BW Habitat for Humanity, Rock the Block **Sponsorship Advertisements – Q3:** • CAN Council, Dinner for Kids Sake • Visiting Nurse Association, 5K River Run • Marine City Festival • Capac Chamber of Commerce, Movie Night at Melody Park • Blue Water Recovery and Outreach Center, Recovery Fest • Blue Water Developmental Housing, Cornhole Tournament • SCC Department of Veteran's Affairs, Annual Golf Outing • Mid-City Nutrition, Empty Bowls • SONS Outreach, Golf Country Classic • CAN Council, Tee Off Fore Kids **Sponsorship Advertisements – Q4:** • Blue Water Recovery and Outreach Center, Recovery Fest • Mid-City Nutrition, Empty Bowls • SCC Department of Veterans Affairs, Annual Golf Outing • Blue Water Developmental Housing, Cornhole Tournament • SONS Outreach, Golf Country Classic • SCC Child Abuse and Neglect Council, Tee Off Fore Kids Sake • Operation Transformation, Annual Benefit Dinner • Lake Huron Medical Center, Happy Gilmore • SCC Council on Aging, Senior Power Day • NAMI Michigan, NAMI Walks • Port Huron High School, Football Program • CL Spirit Booster Club • Blue Water Safe Horizons and Blue Water Allies, Jeep Run • Port Huron Police Department, Tee Box Ad

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Strategic Plan Education #2	**2. OUTREACH & SPEAKERS' BUREAU ACTIVITIES:** • Participation in another organizations' event by attending in-person or providing materials for their distribution per their request. • Presentations made to community organizations or for general community members. • Includes training and presentations that are not exclusive to CMH staff only. ○ Ex: Resource table to promote CMH services and provide mental health information; Presentations made in the community or for outside community agencies, including MHFA, presentations at school, law enforcement trainings.	10/01/24: Marine City High School Health Class Presentation 10/03/24: Building Community Partners meeting 10/03/24: Hispanic Heritage Day Celebration 10/04/24: SCC Health Department, Basic Motivational Interviewing Training for Staff 10/08/24: Community Baby Shower 10/09/24: SCC Chiefs Quarterly Meeting 10/11/24: Capac Senior Health Fair 10/11/24: SC4 Nursing Students Training 10/13/24: Walk 2 Remember, Walk 2 Prevent 10/18/24: SCC Sheriff's Department, Donuts with Deputies 10/18/24: Washington Life Center Senior Health Fair 10/21/24: Capac Community Schools, Mental Health Matters Presentation for School Staff 10/24/24: Port Huron Trunk or Treat 10/24/24: Marine City Treat Trek 10/25/24: Council on Aging Senior Power Day 10/26/24: Nature's Canvas – Art, Recreation & Well-Being 10/27/24: Marine City Trunk or Treat on Water Street 10/29/24: Harbor Impact Ministries Impact Day 10/31/24: PHPD Platoon Training 11/01/24: Memphis Community Schools, Suicide Prevention Presentation for Staff 11/04/24: Vicksburg Housing, How to Cope with Seasonal Blues 11/05/24: Youth MHFA 11/07/24: Building Community Partners meeting 11/08/24: Adult MHFA 11/12/24: NAMI, Coping with the Holidays Presentation for Staff 11/15/24: Youth MHFA 11/19/24, 11/26/24: Adult MHFA 11/26/24: Marine City Holly Jolly Christmas Parade 11/26/24: Harbor Impact Ministries Impact Day 12/07/24: YMCA Breakfast with Santa and Santa Hop 12/07/24: Rivertown Christmas 12/17/24: Harbor Impact Ministries Impact Day 1/14/25: Transition Council Meeting 1/28/25: Harbor Impact Ministries Impact Day 1/30/25: Creekside Learning Center Open House 1/27/25: All About CMH, SC4 Nursing Students Training 2/08/25: Marine City Chamber of Commerce, Fire Ice and Spice 2/12/25: YMCA Senior Health Expo 2/12/25: YMCA Senior Day Presentation 2/25/25: Harbor Impact Ministries Impact Day 2/06/25: Building Community Partners Meeting 2/07/25: Girlfriend's Luncheon Meeting 2/21/25: Adult MHFA 2/28/25: Adult MHFA for BWROC 3/06/25: Creekside Learning Center, March is Reading Month 3/12/25: Creekside Learning Center, March is Reading Month

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		3/13/25: Gift of Knowledge presentation, SCC Library 3/18/25: Youth MHFA 3/21/25: Creekside Learning Center, March is Reading Month 4/10/25: Wayne State Career Fair 4/19/25: Maritime Days Easter Eggstravaganza 4/19/25: PHPD Special Needs and Autism Acceptance Day 4/24/25: HIV Prevention 101 (Ally Center) 4/26/25: YMCA Healthy Kids Day 4/29/25: Harbor Impact IMPACT Day 5/10/25: Healthy Minds, Healthy Bodies Run for Recovery 5/14/25: Community Resource Fair 5/20/25: Harbor Impact IMPACT Day 5/21/25: SCCCMH Annual Awards & 60th Anniversary Celebration 6/03/25: Caregiver Connections Expo 6/07/25: Celebrate Your Kid Day (Head Start) 6/10/25: Auria Solutions Employee Event 6/10/25: St. Clair County MDOC Resource Fair 6/18/25: IMPACT Fun Fitness Day 6/20/25: Autism Support Group Family Fun Day 6/20/25: Baker Culinary Institute Student Orientation 6/24/25: Harbor Impact IMPACT Day 6/28/25: Habitat for Humanity Rock the Block 6/29/25: Blue Water Pride Festival 7/09/25: Rotary International Parade 7/10/25: Operation Transformation Family Night 7/17/25: SCC 4-H Fair 7/18/25: Odyssey House Community BBQ 7/23/25: Youth Mental Health First Aid 7/29/25: Sanborn Memorial Staff Training – Self Care 7/29/25: Harbor Impact Day 7/31/25: Port Huron Police Department Platoon Training 8/01/25: Marine City Maritime Days 8/03/25: Marine City Maritime Parade 8/04/25: Council on Aging presentation (Yale) – Mental Wellbeing 8/05/25: National Touch a Truck Night Out 8/06/25: Port Huron Police Department New Hire Training 8/08/25: SONS Golf Outing 8/08/25: Community First Health Centers Health Fair 8/12/25: Port Huron Police Department Safety Training 8/13/25: Back to School Backpack Giveaway 8/13/25: Council on Aging presentation (PH) – Mental Wellbeing 8/13/25: Mental Health First Aid – SC4 Nursing Students 8/15/25: Victory Day 8/19/25: North Port Village – Why Mental Health is Important 8/21/25: Port Huron Housing Commission End of Summer Block Party 8/21/25: Council on Aging Presentation (Wash Life) – Mental Wellbeing 8/22/25: Council on Aging Presentation (Capac) – Mental Wellbeing

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		8/23/25: Back to School Community Giving Day 8/26/25: Harbor Impact Ministries IMPACT Day 8/29/25: SC4 Nurses Training – All About CMH 8/31/25: Overdose Awareness Walk 9/02/25: Port Huron Lions Club 9/13/25: BWROC Recovery Fest 9/17/25: Council on Aging (PH) - Caring for Yourself 9/17/25: Council on Aging (Wash Life) - Caring for Yourself 9/26/25: Council on Aging (Capac) - Caring for Yourself 9/27/25: Alzheimer's 5K Run/Walk for the Cure 9/30/25: Port Huron Police Department Platoon Training
Strategic Plan Education #2	**3. PUBLIC RELATIONS & EXTERNAL COMMUNICATIONS:** • Activities that benefit the community and/or enhances our image through the community and are hosted/lead by CMH. o Ex: Run for Recovery, Trunk or Treat, Unpaid Media (Paul Miller radio interviews, press releases, PSAs, responding to media inquiries), Social Media Posts, Monthly Communication Newsletter, Website.	**WPHM Radio Interview:** 10/2/24, 11/6/24, 12/4/24, 1/6/25, 2/5/25, 3/5/25, 4/2/25, 5/7/25, 6/4/25, 7/2/25, 8/6/25, 9/3/25 **In Focus with Paul Dingeman:** 10/3/24, 11/7/24, 12/5/25, 1/2/25, 2/6/25, 3/13/25, 4/3/25, 5/1/25, 6/5/25, 7/3/25, 8/7/25
Strategic Plan Education #2	**4. MARKETING:** • Unsolicited information about CMH to create and provide information about access or mental health education to community organizations, which includes creating brochures and other materials to be shared externally. o Ex: Information packets to be sent to schools; outreach made to primary care physicians.	**Q1:** Packets sent to all school districts with SCCCMH information. **Q2:** no updates **Q3:** 5/30/2025 - Blue Water Hope – packets of Service information 6/27/25 Informational Packages with marketing and service information provided to all Community First Health Center locations and discussed with all staff at the CFHC all staff in-service. **Q4:** no updates
Strategic Plan Workforce #3	**5. STAFF TRAINING/PROFESSIONAL DEVELOPMENT:** • Non-required trainings offered to staff/contract agencies to increase competency and promote professional development.	10/02/24: Mentorship Matters 10/07/24: Social Media Addiction 10/08/24: Interactive Journaling 10/14/24: PMTO Internal Coaching 10/15/24: Cyberbullying 11/07/24: Primary Caseholder Training 11/13/24: Leadership BBL 11/19/24, 11/20/24, 11/21/24: MEND Training 12/09/24: PMTO Internal Series 2/03/25: Medication Management Clinic 2/06/25: Adult Primary Caseholder Meeting 2/11/25: Ethics and Boundaries for Peer Workers 2/18/25: Medication Management Clinic 2/24/25: Ethics for Social Workers 2/26/25: THRIVE Veteran's Training 3/04/25: Pain Management Training for Social Workers

Reference	Employee & Community Relations-Karen Zultak PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		3/10/25 and 3/11/25: Cognitive Behavioral Therapy II 3/13/25: How to Navigate ADP 3/13/25: How to Use Microsoft Teams 3/18/25: Medication Management 3/19/25: Enhancing Productivity 3/24/25: Peer Support Services 3/31/25: Mental Health Code and Treatment for Minors 4/04/25: Essential Skills Staff Development Series: Building Bridges, Engagement, and Rapport 4/22/25: Engagement: Building a Therapeutic Relationship 4/29/25: CMH Program Spotlight: Integrated Dual Disorder Treatment 5/01/25: Adult Primary Caseholder Meeting 5/12/25: PMTO Staff Training 5/15/25: CMH Program Spotlight Series: MCU & Law Enforcement Embedded Clinician 5/28/25: Mental Health First Aid (1/2 day) 5/29/25: Mental Health First Aid (1/2 day) 6/03/25: MEND Training (4 sessions) 6/05/25: Essential Skills Staff Development Series – Session 3 6/09/25: PMTO Training 6/25/25: CMH Program Spotlight: OBRA & Self Determination 6/26/25: Men's Health Presentation 7/02/25: Leadership Panel – Federal and State Updates for Staff 7/14/25: PMTO Training 7/29/25: Implicit Bias Training 8/07/25: Adult Primary Caseholder Training 8/11/25: Safe and Sound Kick-Off Training 8/11/25: PMTO Training 8/13/25: CMH Program Spotlight – Residential I/II and CIS September: 19 Recovery Summit presentations 9/09/25: Essential Skills Series – Session 4
Good Business Practice CARF Requirements Sec.1.1.d-e Sec 1.1.9.f b) Sec.10, Goal 2 b) Sec.10, Goal 1 Strategic Plan Workforce #3	**6. STAFF TRAINING/REQUIRED TRAININGS:** Ensure staff are trained in topics required by Local, State, Federal, and Accreditation bodies. a. Provide centralized training calendar identifying topic/date/location for all trainings. b. Update/modify required training grid based on regulatory requirements and ensure staff compliance. c. Offer/mandate supervisory courses to current/potential supervisors via MyLearningPointe. d. Administer "Training Needs" survey at each CMH sponsored training.	a. Centralized training calendar is operational and continuously updated as needed. b. Training grid for 2025 has been completed. c. Supervisory courses are assigned throughout the year as part of the required training assignments. d. Surveys are sent out after all trainings and include a question that allows staff to identify training topics that they would like CMH to offer in the future. **Q2:** No additional updates **Q3:** No additional updates **Q4:** No additional updates

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Strategic Plan Workforce #3	**7. EMPLOYEE ENGAGEMENT & INTERNAL COMMUNICATIONS:** • Activities and communication aimed at fostering a positive, informed and engaged workforce. ○ Ex: Monthly "In The Know" newsletter, Pop-Up, Employee/Team of the Month, group photos for awareness days, staff appreciation lunches, staff emails.	10/10/24: Wear Green for Mental Health 10/16/24: Unity Day 10/18/24: Wear Pink for Breast Cancer Awareness Month 10/25/24: U of M Tailgate Lunch 12/12/24: Visit with Santa 12/18/24: All Agency In-Service 2/20/25: Resource & Referral Fair 3/10/25: Employee Appreciation Day Ice Cream Social 3/17/25: St. Patrick's Day photos 4/24/25: Administrative Professionals Day 5/06/25: Employee Appreciation Week 5/10/25: Run for Recovery 7/09/25: Rotary International Day Parade
Strategic Plan Education #2	**8. LEGISLATIVE & ADVOCACY EFFORTS** • Communication with legislators or others who make policy decisions, encouraging stakeholders to advocate for/against policies that affect the mental health systems. ○ Ex: Attending Eggs & Issues, sending letters to legislators, emails to staff with advocacy alert information.	10/17/24: Senator Peters' Staff Visit **Q2:** No updates **Q3:** No updates **Q4:** Legislative updates are included monthly in In the Know newsletter, Leadership legislative briefing was held on 7/2/25 and 9/9/25 for all staff, email updates are sent periodically.

Reference	Corporate Compliance-Joy Vittone PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
Medicaid Integrity Program Corporate Compliance Plan	1. **Report monthly on corporate compliance complaints**; identify trends (SCCCMH).	**Q1: October 1, 2024 – December 31, 2024** **Oct 2024 – 7 total reports** • 5 HIPAA – 4 Substantiated (2 Breaches), 1 Unsubstantiated • 1 Fraud/Waste/Abuse – Unsubstantiated, policy revision required • 1 Policy Violation – Unsubstantiated **Nov 2024 – 8 total reports** • 5 HIPAA – 5 Substantiated (0 Breaches) • 1 Fraud/Waste/Abuse – Overpayment, no FWA • 1 Conflict of Interest – Unsubstantiated • 1 Ethics/Billing Violation – Unsubstantiated **Dec 2024 – 6 total reports** • 2 HIPAA – 2 Substantiated (1 Breach) • 2 Fraud/Waste/Abuse – 1 Substantiated; 1 Unsubstantiated • 1 Policy Violation – Unsubstantiated • 1 Ethics/Billing Violation – Referred/Pending **Q2: January 1, 2025 – March 31, 2025** **Jan 2025 – 2 total reports** • 1 HIPAA – Substantiated (0 Breaches) • 1 Fraud/Waste/Abuse and HIPAA – Unsubstantiated **Feb 2025 – 2 total reports** • 2 HIPAA – 1 Substantiated (0 Breaches), 1 Unsubstantiated **Mar 2025 – 2 total reports** • 2 HIPAA – 2 Substantiated (0 Breaches) **Q3: April 1, 2025 – June 30, 2025** **Apr 2025 – 6 total reports** • 5 HIPAA – 3 Substantiated 0 Breaches); 2 Unsubstantiated • 1 Ethics – Unsubstantiated **May 2025 – 7 total reports** • 5 HIPAA – 4 Substantiated (0 Breaches), 1 Unsubstantiated • 1 Fraud/Waste/Abuse -- Unsubstantiated • 1 Policy violation – Unsubstantiated, with opportunity identified **Jun 2025 – 5 total reports** • 2 HIPAA – 1 Substantiated (0 Breaches); 1 Unsubstantiated • 2 Fraud/Waste/Abuse - 1 Unsubstantiated; 1 pending • 1 Conflict of Interest - Unsubstantiated A noted trend of increased complaints beginning Nov 2024 from Region 10 PIHP to report documents containing PHI attached to incorrect Waiver Services Applications. Upon inquiry to PIHP Corporate Compliance Office about whether its monitoring or reporting of these occurrences changed in FY25 and whether SCCCMH is an outlier for these occurrences, the response was that monitoring for this issue began in late FY24 in coordination with PIHP quality team and that SCCCMH is not an outlier.

Reference	Corporate Compliance-Joy Vittone PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		Q4: July 1, 2025 – September 30, 2025 **Jul 2025 – 10 total reports** • 9 HIPAA – 7 Substantiated 0 Breaches); 2 Unsubstantiated • 1 Conflict of Interest – Unsubstantiated **Aug 2025 – 4 total reports** • 2 HIPAA – 2 Substantiated (0 Breaches) • 2 Fraud/Waste/Abuse – 2 Unsubstantiated **Sep 2025 – 8 total reports** • 7 HIPAA – 4 Substantiated (0 Breaches), 1 Unsubstantiated, 4 Pending • 1 Fraud/Waste/Abuse – Unsubstantiated
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.).	**Q1: October 1, 2024 – December 31, 2024** Program Integrity Report was submitted to Region 10 PIHP on 1/15/2025. **Q2: January 1, 2025 – March 31, 2025** Program Integrity Report was submitted to Region 10 PIHP on 4/10/2025. **Q3: April 1, 2025 – June 30, 2025** Program Integrity Report was submitted to Region 10 PIHP on 4/10/2025. **Q4: July 1, 2025 – September 30, 2025** Program Integrity Report was submitted to Region 10 PIHP on 10/15/2025.
Corporate Compliance Plan	3. **Report quarterly on grievance and appeals activities.**	**Q1: October 1, 2024 – December 31, 2024** • Medicaid Grievances: 0 received or pending • Non-Medicaid Grievances: 0 received or pending • Non-Medicaid Appeals: 0 received or pending **Q2: January 1, 2025 – March 31, 2025** • Medicaid Grievances: 1 grievance; not substantiated • Non-Medicaid Grievances: 0 received or pending • Non-Medicaid Appeals: 0 received or pending **Q3: April 1, 2025 – June 30, 2025** • Medicaid Grievances: 0 received or pending • Non-Medicaid Grievances: 0 received or pending • Non-Medicaid Appeals: 0 received or pending **Q4: July 1, 2025 – September 30, 2025** • Medicaid Grievances: 0 received or pending • Non-Medicaid Grievances: 0 received or pending • Non-Medicaid Appeals: 0 received or pending

Reference	Corporate Compliance-Joy Vittone PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
Corporate Compliance Plan	**4. SCCCMH Corporate Compliance Committee meets quarterly or more frequently as deemed necessary.**	**Q1: October 1, 2024 – December 31, 2024** The SCCCMH Corporate Compliance Committee met on **11/19/2024**. **Q2: January 1, 2025 – March 31, 2025** The SCCCMH Corporate Compliance Committee met on **4/22/2025.** **Q3: April 1, 2025 – June 30, 2025** The SCCCMH Corporate Compliance Committee met on **7/22/2025.** **Q4: July 1, 2025 – September 30, 2025** The SCCCMH Corporate Compliance Committee met on **10/14/2025.**
Good Administrative Practice	**5. Monitor and report any legal/regulatory changes.**	**Q1: October 1, 2024 – December 31, 2024** Monitoring is ongoing. HIPAA Privacy Rule to Support Reproductive Health Care Privacy, compliance with applicable requirements 12/23/24. **Q2: January 1, 2025 – March 31, 2025** Monitoring is ongoing. **Q3: April 1, 2025 – June 30, 2025** Monitoring is ongoing. SCCCMH Privacy Notice implemented, effective May 1, 2025. **Q4: July 1, 2025 – September 30, 2025** Monitoring is ongoing.
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 screening and Provider Trust's Vendorproof screening software. The Corporate Compliance Committee and CEO approved plan to add all employees for monitoring and this change is in the process of being implemented. **Q1: October 1, 2024 – December 31, 2024** • Business monitored: 93 with 0 alerts • Individuals monitored: 413 with 0 alerts **Q2: January 1, 2025 – March 31, 2025** • Businesses monitored: 91 with 0 alerts • Individuals monitored: 436 with 0 alerts **Q3: April 1, 2025 – June 30, 2025** • Businesses monitored: 93 with 0 alerts • Individuals monitored: 413 with 2 alerts, resolved **Q4: July 1, 2025 – September 30, 2025** • Businesses monitored: 93 with 0 alerts • Individuals monitored: 413 with 0 alerts

Reference	Corporate Compliance-Joy Vittone PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
Good Clinical Practice	**7. Provide training and education on corporate compliance, including HIPAA.**	**Q1: October 1, 2024 – December 31, 2024** **Compliance & Ethics Week Nov 3-9, 2024** • Presented daily videos from leaders at SCCCMH sharing important tips about confidentiality, compliance, and ethics. • Distributed compliance magnets and handouts about compliance topics and how to report compliance concerns. • Compliance "Meet and Greets" conducted at each SCCCMH location. • Presented daily interactive activities to increase awareness about compliance. **Emails** • 2024-10-09 Email from IT and Security Director about phishing emails and phone calls for Security Awareness. • 2024-11-22 Texting and Email Subject Lines – Guidance on PHI inclusion. • 2024-11-19 forwarded PIHP Corporate Compliance Office guidance about Passwords. **New Employee Orientation – Live Training** • Oct 21, 2024; Nov 18, 2024; Dec 2 & 16 2024 **MyLearningPointe – New Employee and Annual Training** • Region 10 Corporate Compliance Training • HIPAA for Behavioral Health Professionals **Staff Meeting Presentations** • Oct 29, 2024 – Office of Recipient Rights • Dec 16, 2024 – Peer Services **In the Know SCCCMH Newsletter** • Nov 2024 – HIPAA Enforcement Actions with recent examples • Dec 2024 – Important Message about Texting and Email Subject Lines **Q2: January 1, 2025 – March 31, 2025** **Emails** • 2025-01-31 REMINDER – Work Use of Personal Cell Phones, provided guidance that it is a violation to use a personal cell phone to text, email, or electronically transmit information about recipients. • 2025-03-04 Email from IT titled IT Security – Phishing Email Reminder, guidance on phishing emails, common signs, and how to report • 2025-03-12 forwarded PIHP Corporate Compliance Office guidance about HIPAA privacy and security measures and HIPAA breach notifications • 2025-03-25 Need-to-Know Rule for Confidential and Protected Health Information, reminder not to disclose PHI to co-workers if not needed for the task being worked on. **New Employee Orientation – Live Training** • Jan 17 & 27, 2025; Feb 10 & 24, 2025; March 24, 2025 **MyLearningPointe – New Employee and Annual Training** • Region 10 Corporate Compliance Training • HIPAA for Behavioral Health Professionals **In the Know SCCCMH Newsletter** • Jan 2025 – Ethical Workplace & Martin Luther King Jr.'s Teachings

Reference	Corporate Compliance-Joy Vittone PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		• Feb 2025 - Personal Cell Phone Use Violations **Q3: April 1, 2025 – Jun 30, 2025** **Emails** • 2025-04-23 Email from IT and Security Director about Email Security • 2025-05-05 Email from IT and Security Director about Fake captcha phishing attacks • 2025-06-10 forwarded PIHP Corporate Compliance Office guidance about Compliance Program Elements and COMPLIANCE mnemonic. **New Employee Orientation – Live Training** • Apr 7 & 21, 2025; May 19, 2025; Jun 2 & 16 & 30, 2025 **MyLearningPointe – New Employee and Annual Training** • Region 10 Corporate Compliance Training • HIPAA for Behavioral Health Professionals **In the Know SCCCMH Newsletter** • Apr 2025 – New for 2025! Conflict of Interest Disclosure; All Employees are required to complete • May 2025 – Confidential and Protected Health Information (PHI) – "Need-to-Know" Rule **Q4: July 1, 2025 – September 30, 2025** **Emails** • 2025-07-29 Email from Corporate Compliance about revised policy Access, Use, and Disclosure of Confidential and Protected Health Information (PHI) alerting employees to review the policy • 2025-09-16 Email from Dr. Brandon Moore, Medical Director, reminding employees not to access charts without a need to know information to perform their job tasks (not to "snoop") **New Employee Orientation – Live Training** • Jul 14, 2025; Aug 11 & 25, 2025; Sep 8, 2025 **MyLearningPointe – New Employee and Annual Training** • Region 10 Corporate Compliance Training • HIPAA for Behavioral Health Professionals **In the Know SCCCMH Newsletter** • Jul 2025 – Reminders for Protecting Health Information • Aug 2025 – Service Animals vs. Emotional Support Animals: What's the Difference? • Sep 2025 – Recent Enforcement Actions (2 real life examples; HIPAA violation and False Claims Act violation)

Reference	Corporate Compliance-Joy Vittone PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
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.**	**Q1: October 1, 2024 – December 31, 2024** Received Quarterly Reports from 30 Contracted Network Providers/ Community Agency Contractors. • 1 complaint disclosed was not compliance related. **Q2: January 1, 2025 – March 31, 2025** • 1 HIPAA violation investigated by a Contracted Service Provider was substantiated. **Q3: April 1, 2025 – Jun 30, 2025** • 28 reports received; 1 unsubstantiated report by a Contracted Service Provider. **Q4: July 1, 2025 – September 20, 2025** • Aug 25, 2025: 1 HIPAA violation reported and investigated by a Contracted Service Provider was substantiated. Corporate Compliance provided guidance for HIPAA risk assessment. Determined there was no reportable breach. • Five additional reports investigated by Contracted Service Providers, included 1 ethical violation, 1 HIPAA violation, and 3 Fraud/Waste/Abuse violations. All five were substantiated.
Corporate Compliance Plan	**10. Conduct an annual evaluation of the Compliance Plan and report to the St. Clair County CMH Board.**	**Q1: October 1, 2024 – December 31, 2024** • The FY24 Annual Report was presented to the SCCCMH Board at its regular meeting on 12/10/24. • The FY25 Plan with Goals was presented to the SCCCMH Board at its regular meeting on 11/12/24.

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 & Danielle Hazelwood PRIORITY GOAS/KEY TASKS	FY2025 TIMELINE-STATUS
Good Administrative Practice	**1. Implement budget and financial risk strategies to maintain a balanced budget.** **Objectives:** ○ Establish procedures for timely identification and communication of areas of concern.	A thorough review of the YTD Revenue and Expense is done prior to the preparation of the Funding Bucket Report. A deeper dive is done on those expense accounts with a significant variance from the YTD budget to determine if further action is required other than just noting the difference had been looked into and not a concern at that time. **Q1:** As of YTD November 2024, no specific concerns require additional communication to management or the Board. **Q2:** As of YTD March 31, 2025, no specific concerns required additional communication to management or the Board. **Q3:** As of YTD May 31, 2025, we have communicated to Management and the Board that we are seeing unusual trend changes in the spread of the expenses due to the significant underspending in the Direct Run locations and an increase in the Autism expenses from a rate increase on a particular code resulting in less than budgeted CCBHC deficit spending and an increase in Traditional Medicaid spending YTD. **Q4:** As of YTD August 31, 2025, we have communicated to Leadership and the Board that we are continuing to see the trend in the spread of the expenses as reported last quarter.
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 revenue 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 FY 2025 budget was revised and presented for approval at the December 2024 Board meeting. The revision included an increase in expenses of approximately $2.8m, including those increases identified from the salary study results and negotiated with the union for the CY 2025 wage scales. This increase in expense was able to be absorbed within our current traditional Medicaid and HMP allocation but increased the CCBHC deficit by approximately $1.6m. **Q1:** The YTD November 2024 Funding Bucket Report (FBR) was presented to the board Finance committee before the January 14, 2025 Board meeting. Currently our YTD expenses are running$1,635,000 under our Revised Budget with a surplus of approximately $379,000 of traditional Medicaid and Healthy MI Plan funding that would lapse back to Region 10. In addition, we have a CCBHC deficit of approximately $156,000 that we will have to cover with Local Funds and $382,000 of CCBHC surplus that we would have to be returned to Region 10. We are currently running a deficit of $453,000 with our CCBHC Non-Medicaid which we will cover with our surplus GF of approximately $88,000 and the balance with Local of approximately $365,000. **Q2:** The YTD March 2025 Funding Bucket Report (FBR) will be presented to the Board Finance Committee before the May 12, 2025 Board meeting. Currently our YTD expenses are running $2,400,000 under our Revised Budget with a surplus of approximately $372,000 of traditional Medicaid and Healthy MI Plan funding that would lapse back to Region 10 PIHP. In addition, we have a CCBHC Medicaid and Healthy MI Plan deficit of approximately $1.2 million that we will have to cover with Local Funds. We are currently running a deficit of $1.8 million with our CCBHC Non-Medicaid which we will cover with our surplus GF of approximately $346,000 and the balance of approximately $1.5 million with Local Funds.

Reference	Finance-Karen Farr & Danielle Hazelwood PRIORITY GOAS/KEY TASKS	FY2025 TIMELINE-STATUS
		Q3: The YTD May 2025 Funding Bucket Report was presented to the Board Finance Committee before the July 8, 2025 Board meeting. Currently our YTD expenses are running $3.1 million under our Revised Budget with a surplus of approximately $197,000 of Traditional Medicaid and Healthy MI Plan (HMP) funding. In addition, we have CCBHC Medicaid and HMP deficit of approximately $650,000 that we will have to cover with Local funds. We are currently running a deficit of approximately $2.5 million with our CCBHC Non-Medicaid which we will cover with surplus GF and the balance of approximately $1.9 million with Local Funds. **Q4:** The YTD August 2025 Funding Bucket Report was presented to the Board Finance Committee before the October 14, 2025, Board meeting. Currently our YTD expenses are running at $5.5 million under the FY 25 Projection with a deficit of approximately $1.2 million in Traditional Medicaid and Healthy MI Plan funding. Region 10 has committed to funding the deficit in Medicaid and HMP spending approved in the Projection at the time of cost settlement. In addition, we have a CCBHC Medicaid and HMP deficit of $339,000 that we will have to cover with Local funds. We are currently running at a deficit of approximately $3.5 million with our CCBHC Non-Medicaid which we will cover with surplus GF and the balance of approximately $2.7 million in Local Funds. We have communicated to Leadership and the Board that expenses are continuing to run under the FY25 YTD Projection mainly in the areas of payroll costs and contracted service costs. Some budgeted positions remain vacant through August, and the staff retention payment built into the projection has not yet occurred.
MDHHS	**3. Ensure compliance with local, state, and federal budgetary reporting requirements.** **Objectives:** ○ Coordinate and ensure completion of the annual Financial, Compliance, and Single Audits. ○ Complete all required Federal, State, and Local financial reporting per the Regional Medicaid, MDHHS General Fund contracts and grants. ○ Coordinate and ensure compliance with the MDHHS Standard Cost Allocation Methodology and the CCBHC Demonstration.	Finance Supervisors regularly attend MDHHS Standard Cost Allocation (SCA) and CCBHC Demonstration meetings to ensure that we are accurately capturing the financial data in our records for reporting purposes as required contractually. Our General Ledger and Excel workbook tools are setup and maintained to accurately reflect the requirements and updated for reporting changes as necessary. **Q1:** The FY24 Financial audit fieldwork is currently in process with the Compliance audit to take place after the February 28 FSR filing. **Q2:** The FY24 Financial audit is completed, and we received an unqualified opinion (Clean Report). The FY 2024 Compliance Exam is in process and at this reporting there are no findings. The report is expected to be completed within the next couple of weeks. Both reports will be presented to the Board at the June 17, 2025, Board meeting. **Q3:** The FY24 Compliance Exam is final and there were no reported findings. Both the FY24 Financial Audit Report and the Compliance Exam Report were presented by our Auditors to the Board at the June 17, 2025 meeting. The FY25 Projection was completed and submitted to Region 10 by the requested due date of July 11. This Projection reflects the additional costs associated with the Autism code rate increase and an increase associated with increased Self Determination service costs. **Q4:** The FY 25 Projection was submitted to MDHHS timely.

Reference	Finance-Karen Farr & Danielle Hazelwood PRIORITY GOAS/KEY TASKS	FY2025 TIMELINE-STATUS
ARR 7/3	**4. Promote collaboration, efficiency, and uniformity between PIHP members.** **Objectives:** ○ Utilize the Region 10 Finance Officer's workgroup to share information and identify best practice strategies. ○ Participate in Regional CFO goals.	**Q1:** The Regional CFO's continue to meet monthly and collaborate as mush as possible. The FY25 goal is continuation of FY24 related to standardizing the CCBHC cost reporting with quarterly trainings. **Q2:** Region 10 PIHP trainings related to CCBHC Demonstration and EQI reporting have been scheduled for applicable staff in June and September 2025. **Q3:** The Regional Finance Committee QAPIP training related to CCBHC and EQI reporting was held at Lapeer CMH on June 20, 2025 with the final training to be held in September in Genesee County. **Q4:** The Regional Finance Committee QAPIP training related to the EQI reporting was held at GHS on September 19, 2025.
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 risk of fraudulent activity. ○ Develop and monitor effective cross-training among staff and continued succession planning. ○ Research and recommend technology enhancements to ensure efficient and accurate financial information. ○ Establish, review, and update policies and procedures related to our CMHSP Local Fund Balance.	**Q1:** The Board Fiscal Responsibilities Policy and related Administrative Procedures related to the Board Fiscal Polices is currently being reviewed and updated as needed. **Q2:** The updates to the Board Fiscal Responsibilities Policy and the related Administrative Procedures related to the Board Fiscal Responsibilities Policies have been completed and approved. We are in the process of adding an additional section to those policies and procedures related to Debt. This should be completed for the Board to review at the May 2025 Board meeting. **Q3:** The revised Board Fiscal Responsibilities Policy and the Administrative Procedures related to that Policy were presented to the Board Finance Committee prior to the May 2025 Board meeting, then and approved at the Board meeting. The Finance department is continuing the cross-training of tasks, and the succession planning progress is on track. The new Purchase Requisition software has been implemented and all staff impacted have been trained. The new GL software has been acquired, and the transfer of data is taking place with full implementation planned for 10/1/2025. **Q4:** The implementation and training on the new Business Central cloud-based general ledger system is in process. Due to unforeseen complications, the Go Live date has been postponed to January 1, 2026.

Reference	Human Resources and Development-Stephanie Shank PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
Good Business Practice Strategic Plan Education #2	**1. Access and improve upon current Human Resource related practices and software systems including:** a. Ongoing improvement and enhanced use of the ADP Human Resources Information System (HRIS). b. Continuous improvement efforts and building of the ADP module to create HR process efficiencies. c. Ongoing improvement efforts of the Annual Employee Assessment tool. d. Enhance recruitment efforts through utilization ADP and other new sources as identified. 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. Review and amend as appropriate the CMH Job Descriptions annually. i. Evaluate and assist in the development of an agency-wide succession planning and opportunities for future agency leaders. j. Improve volunteer recruitment process. k. Enhance diversity, equity, and inclusion (DEI) based practices. l. Strengthen engagement and alignment across satellite locations.	a. **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, record retention and dashboard report enhancements. This will continue in FY2025. **Q3:** Increased streamlining regarding carrier connections is being discussed with ADP, specific to ACA reporting and COBRA. Carrier feed with Symetra Insurance being implemented, specific to Evidence of Insurability (EOI) administration. Updates to HR reporting to all staff regarding movement within agency related to position changes. b. **Ongoing:** TinyPulse has been replaced with Voice of the Employee, a module included in ADP. Several test surveys went out to employees over the 1st quarter of FY2025 and we will continue to utilize this module in addition to other tools (Survey Monkey, Monday.com, etc.). **Ongoing:** MDHHS compliance requests, in collaboration with QIDM, have changed slightly regarding name changes for employees and what information is needed on file to support name changes for audit purposes. This began in the 2nd quarter of FY2025 and will continue to evolve over FY2025. **Q2:** Implemented EI-9 and E-Verify electronic processes into new employee onboarding process. Purging old I-9 information and performing internal audit of processes in place for compliance. Released COI to staff through ADP in collaboration with Corporate Compliance. **Q3:** Created and issued policy to all staff regarding new I-9 process. Working with Corporate Compliance on new COI process that R10 requires. **Q4:** COI process rolled out in collaboration with Corporate Compliance. HR facilitating staff Confidentiality Statement issuance and attestation during onboarding. c. New employee annual assessment process rolled out in Q2. Employees with the hire dates of Jan-March are completing the full assessment as issued 1/10. Employees with the hire dates of April-December will complete a brief touch base until their hire date comes around, at which time they will complete the full assessment. We are hoping with the new process that the annual assessment will provide a space for more meaningful conversations. **Q3:** Ongoing: Continue to work through this process with Supervisors/staff, but overall, process is working as designed. **Q4:** HR continues to reach out to staff about compliance with Annual Assessment participation and supporting documents required to be on file. d. **Q2:** Recruiter has attended two Career Fairs in the last quarter (Wayne State University and Walsh College). Scheduled to attend SC4's Career Fair at the end of April and also participate in a virtual CMHA Career Fair.

Reference	Human Resources and Development-Stephanie Shank PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		Q3: New Staffing Support Specialist started on 7/14/2025. Agency remains supportive of internship placement, and serves as primary preceptor for Wayne State University and placement of PMHNP's. e. *No updates* f. **Ongoing:** Personnel records are still being converted to an electronic format. A new system for purging old records was put into place in compliance with record retention laws for the State of Michigan. We now have only one part-time scanner. **Q3:** P/T scanner was able to increase hours for the month of July to help us finish the training scanning project. She continues to make progress on the complete move to electronic records. g. **Q2:** Interview best practices are now being shared with staff as a result of feedback from Supervisors. **Q3:** Ongoing support continues to be provided and reviewed. h. **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 being reviewed by program supervisors currently to have a base "template" that all programs can utilize when building a task list for staff. Tasks may be added, but the base template will remain the same. We are trying to streamline the process for supervisors/staff and ensure that FJTL's are accurate and reflective of job descriptions. When this process concludes, employee's will be required to have their FJTL reviewed and approved annually between employee and supervisor as was done historically during the annual assessment. 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. **Q3:** Job descriptions continue to have the need to be evaluated and updated. New Recruiter will have the task of this overhaul once she is trained. i. **Ongoing:** Succession planning assessment will continue to evolve in FY2025. After feedback from Leadership on the ADP module for succession planning, we are looking at alternatives. **Q2:** Succession Planning tool has been developed and shared with Leadership. Tool identified primary level of successors and several factors to consider in planning. Tool is able to have edits made as needed. **Q3:** In planning stages for development of a Succession Planning Document/Policy to be reviewed at Leadership level and shared with staff. j. *No updates* k. *No updates*

Reference	Human Resources and Development-Stephanie Shank PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		l. **Ongoing:** Foster employee engagement and inclusion. In Q2, we initiated in-person, monthly visits to all satellite offices. The goal of these visits is to enhance employee morale, provide staff and supervisors the opportunity to connect and facilitate one-on-one discussions with members of the HR team regarding personal or work-related concerns. These visits aim to strength the connection between the satellite offices and the main office, build relationships with all staff members, and offer hands-on guidance about agency policies and the Union Contract. **Q4:** HR continues to foster relationships with staff and the outlying locations. Open Enrollment will open earlier than ever on the first full week of October, and remain open for 5 full weeks. HR staff offers drop-in enrollment, one-on-one appointments, and visits all locations multiple times. In addition, HR will host a Brown Bag luncheon for staff on Benefits Education.
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 Workforce #3	**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 MyLearningPointe 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. Administer "Training Needs" survey at each CMH sponsored training. h. Work with identified employee groups to address improvement opportunities. i. Develop a robust retention plan. j. Create a succession plan which identifies leadership potential at all levels of the agency. k. Develop effective recruitment plan. l. Develop and implement the CMH Mentorship Program.	a. *No updates* b. *No updates* c. *No updates* d. *No updates* e. **Ongoing:** The "New Employee Orientation" process has been continuously reviewed, seeking feedback from new staff in order to implement better practices. **Q2:** Employee Handbook is being revised, and several improvements are being made to be a better resource to all staff. **Q3:** Ongoing: New Employee Handbook is near completion and will be released to all staff. Development of document to aid in cross-training of HR staff to ensure onboarding consistency to all new employees. **Q4:** New Employee Handbook has been released to Leadership for final review. Pending any feedback, the handbook will be released to employees via My Learning Pointe as a training. f. In pilot program with CMHA to plan for collaboration on a wide range of topics throughout the year. **Q3:** Ongoing collaboration with statewide CMH HR groups **Q4:** Ongoing, though low participation has prohibited this from growing as expected. g. *No updates* h. *No updates* i. **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. j. **Q3:** See letter i. in section above

Reference	Human Resources and Development-Stephanie Shank PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		k. **Ongoing:** Additionally, HR will bolster its work around the attainment and retention of interns for in-demand positions as well as other behavioral health positions. l. Mentorship program is up and running with 24 staff (12 pairs) in initial implementation. **Q3:** Hosted luncheon to discuss first 6 months of Mentorship program, received positive feedback and additional feedback to make the program more successful. Updated pairings for next 6 month session of program.
Good Business Practice	**3.** Reward employees for performance that meets and exceeds defined expectations and recognize continued efforts. a. Continue to evaluate CMH "Staff of the Year" and "Team of the Year" recognition programs. b. Continue to evaluate CMH staff recognition and enrichment process and explore cost-effective options. c. Continue yearly CMH anniversary recognition. d. Continue CMH "Years of Service" recognition. e. Assist with/Sponsor Wellness Activities.	a-e. **Ongoing:** In 1st Quarter 2025, the *Employee and Community Relations Team* no longer falls under the HR umbrella and instead reports to Deb Johnson directly. **Ongoing:** Discussion have started again regarding the merging of the "Rights Champion" luncheon and "EOM/TOM" recognition or what a new process might look like. Discussion will continue into FY2025 for this potential process change. **Q3:** RR and HR will not combine these recognition processes, both departments will make changes as they see fit. **Q2:** EOM/TOM discussions with ECRT are currently taking place. Looking at ways to improve this recognition and make it more meaningful to the staff/agency. Recently completed assessment for the Michigan Health Worksite Award through MDHHS. We will use the toolbox associated with the award to create an Action Plan on navigating Wellness with the agency. **Q3:** EOM/TOM process was rebranded and changes were announced to staff. Programs paused for Summer and will restart in September under new parameters. HR Director and ECWC Chair working together on this project in addition to rebrand to ECWC Committee. **Q4:** New EOM program, C.A.R.E.S. Champion will roll out to staff in September. In addition, the Agency reapplied for the Michigan Healthy Worksite Award after completing some suggestion action plans in hopes of obtaining Gold status.
Good Business Practice	**4.** Utilize the Employee Culture & Wellness 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 & Wellness Committee to support and advise in the areas of staff wellness and development.	a. **Ongoing:** The Employee Culture & Wellness Committee continues to meet monthly and provide recommendations to HR and/or Leadership as a result of survey outcomes or committee discussions related to staff wellness. This will continue in FY2025. **Q3:** ECWC is on a pause while it is being rebranded in conjunction with the new EOM/TOM process. More information to be shared in Q4 update.

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
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 improvements activities with QIC. "Workers Compensation: Accident Reporting and OSHA Recordkeeping"	**FY2025 Q4: July 1, 2025 – September 30, 2025** 1. Labor/Employee Relations Manager received six (6) Employee Accident Reports this quarter from all combined service locations. • One (1) Assault by a 13-year-old child; human bite, strained torso. • One (1) Assault by a 13-year-old child; scratched, beaten, struck; open wounds & muscle tendon injuries. • One (1) Assault by a 13-year-old child; displaced shoulder. • One (1) Vehicular accident; soreness to back and hips. • One (1) Injured while transferring individual from wheelchair to gait trainer, sprain of ligaments and thoracic spine. • One (1) Scratched by multiple dogs during home visit; no bites; wound care treatment. • One (1) Pinched hand in gate, wound treatment. • Compliance: 6/7 Reported within 24 hours • **85% Compliance** a. No current compliance difficulties b. Past improvement activities include reminding Supervisors that documentation is due within 24 hours of Employee Accidents. • CARF documentation requirements discussed in NEW Safety Updates Presentations. 30 completed since September 2025. **FY2025 Q3: April 1, 2025 – June 30, 2025** 1. Labor/Employee Relations Manager received three (3) Employee Accident Reports this quarter from all combined service locations. • One (1) stepped into a hole in the pavement, wrist sprain, ankle sprain, contusion of knee. • One (1) injured while assisting an individual served getting out of a van when individual lost control, strain to lower back. • One (1) human bite to the left, middle finger. • Compliance: 3/3 Reported within 24 hours. • **100% Compliance.** a. No current compliance difficulties. b. Past improvement activities include reminding Supervisors that documentation is due within 24 hours of Employee Accidents. **FY2025 Q2: January 1, 2025 – March 31, 2025** 1. Labor/Employee Relations Manager received four (4) Employee Accident Reports this quarter from all combined service locations. • One (1) Vehicular accident; concussion, fractured rib, pulled muscles, minor cuts. • One (1) Slip and fall on ice; contusions of right shoulder and knee; contusion of left hand. • One (1) Vehicular accident; sprain of ligaments of spine and left shoulder joint. • One (1) Slipped on ice without falling; strain of muscle in left thigh and hip.

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		• Compliance: 4/4 reported within 24 hours. • **100% Compliance** a. No current compliance difficulties. b. Past improvement activities include reminding Supervisors that documentation is due within 24 hours of Employee Accidents. **FY2025 Q1: October 1, 2024 – December 31, 2024** 1. Labor/Employee Relations Manager received four (4) this quarter from all combined service locations. • One (1) Trip and fall on sidewalk; sprain to shoulder, elbow and contusion to knee. • One (1) Slipped while walking down decline grass; sprain to shoulder and wrist. • One (1) Vehicular Collison; soreness due to airbag. • One (1) Slipped on ice in parking lot; twisting of lower back and knee. • Compliance: 4/4 reported within 24 hours. • **100% Compliance.** a. No current compliance difficulties. b. Past improvement activities include reminding Supervisors that documentation is due within 24 hours of Employee Accidents.
Good Administrative Practice	**2. Report all Non-Employee Accidents within 24 hours.** Target Compliance: 100%	**FY2025 Q4: July 1, 2025 – September 30, 2025** These reports are currently completed through OASIS and Non-Employee Accident Reports (NAR). a. Safety Coordinator received one (1) NAR this quarter from all combined service locations. • **One (1)** Was headed downstairs and tripped, hurting wrist. b. Compliance: 1/1 reported within 24 hours. **100% Compliance.** **FY2025 Q3: April 1, 2025 – June 30, 2025** These reports are currently completed through OASIS and Non-Employee Accident Reports (NAR). a. Safety Coordinator received two (2) NARs this quarter from all combined service locations. • One (1) individual became diaphoretic, nauseous, and dizzy while the SCCCMH nurse was drawing blood. Vitals were monitored and First Aid was administered. • One (1) Individual waiting for class in the lobby with service dog stood up from chair and tripped over leash of service animal, landing on knees. b. Compliance:.2/2 reported within 24 hours. **100% Compliance.**

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		FY2025 Q2: January 1, 2025 – March 31, 2025 These reports are currently completed through OASIS and Non-Employee Accident Reports (NAR). a. Safety Coordinator received zero (0) NARs this quarter from all combined service locations. b. Compliance: 0/0 reported within 24 hours. **100% Compliance.** **FY2025 Q1: October 1, 2024 – December 31, 2024** These reports are currently completed through OASIS and Non-Employee Accident Reports (NAR). a. Safety Coordinator received three (3) NARs this quarter from all combined service locations. • One (1) individual fell in the parking lot. • One (1) individual tripped on the curb. • One (1) individual stepped off the sidewalk and fell. b. Compliance: 3/3 reported within 24 hours. **100% Compliance.**
CARF Health & Safety	**3. Ensure easy access to First Aid:** **a.** Expertise **b.** Equipment **c.** Supplies **d.** Inspections	**FY2025 Q4: July 1, 2025 – September 30, 2025** **a. Expertise** • Staff are trained in First Aid/CPR/AED usage. • 47 newly trained staff in Q4 FY2025. ***Trending upward over two (2) previous quarters.*** **b. Equipment** • Emergency Evacuation Bags (EEBs) are in strategic locations at every service location operated by SCCCMH and brought by Supervisors to evacuation/shelter areas during emergency event/drills. • Emergency Evacuation Bags have been evaluated by Nursing Staff to include Trauma supplies. • Automated External Defibrillators (AEDs) are available at every service location and are inspected quarterly. • First Aid Kits and AEDs are easily accessible, in labeled boxes affixed to the wall, and have signage near the ceiling at every service location operated by SCCCMH. These areas are considered "Safety Zones". • **LifeVac** - anti-choking devices are labeled and present in every safety zone at all service locations. Nursing staff trained through video and demonstration and directions and link to training provided at NEW Safety Updates Presentations. **c. Supplies** • First Aid Kits are easily accessible at every service location operated by SCCCMH. • First Aid Kits are easily accessible in the trunks of 73 agency vehicles. **d. Inspections** • **Capac:** All inspections were completed by **9/12/2025.** Vehicle First Aid Kit Inspections received **8/4/2025.**

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		• **Child & Family Services:** All inspections were completed by **9/12/2025.** Vehicle First Aid Kit Inspections completed **8/15/2025.** • **Electric Avenue:** All inspections were completed by **9/9/2025.** Vehicle First Aid Kit Inspections completed **8/15/2025.** • **Marine City – Broadway:** All inspections were completed by **9/12/2025.** Vehicle First Aid Kit Inspections completed **N/A.** • **Marine City – King Rd:** All inspections were completed by **9/12/2025.** Vehicle First Aid Kit Inspections completed **8/15/2025.** **FY2025 Q3: April 1, 2025 – June 30, 2025** **a. Expertise** • Staff are trained in First Aid/CPR/AED usage. • 46 newly trained staff in Q3 FY2025. ***Trending upward from 17 in the previous quarter.*** **b. Equipment** • Emergency Evacuation Bags (EEBs) are in strategic locations at every service location operated by SCCCMH and brought by Supervisors to evacuation/shelter areas during emergency event/drills. • Emergency Evacuation Bags have been evaluated by Nursing Staff to include Trauma supplies. • Automated External Defibrillators (AEDs) are available at every service location and are inspected quarterly. • First Aid Kits and AEDs are easily accessible, in labeled boxes affixed to the wall, and have signage near the ceiling at every service location operated by SCCCMH. These areas are considered "Safety Zones". **c. Supplies** • First Aid Kits are easily accessible at every service location operated by SCCCMH. • First Aid Kits are easily accessible in the trunks of 73 agency vehicles. **d. Inspections** • **Capac:** All inspections were completed by **6/19/2025.** Vehicle First Aid Kit Inspections received **6/4/2025.** • **Child & Family Services:** All inspections were completed by **6/19/2025.** Vehicle First Aid Kit Inspections received **6/18/2025.** • **Electric Avenue:** All inspections were completed by **6/20/2025.** Vehicle First Aid Kit Inspections received **6/18/2025.** • **Marine City – Broadway:** All inspections were completed by **6/19/2025.** Vehicle First Aid Kit Inspections received **N/A.**

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		• **Marine City – King Rd:** All inspections were completed by **6/19/2025.** Vehicle First Aid Kit Inspections received **6/27/2025.** **FY2025 Q2: January 1, 2025 – March 31, 2025** **a. Expertise** • Staff are trained in First Aid/CPR/AED usage. • 17 newly trained staff in Q2 FY2025. **b. Equipment** • Emergency Evacuation Bags (EEBs) are in strategic locations at every service location operated by SCCCMH and brought by Supervisors to evacuation/shelter areas during emergency event/drills. • Emergency Evacuation Bags have been evaluated by Nursing Staff to include Trauma supplies. • Automated External Defibrillators (AEDs) are available at every service location and are inspected quarterly. • First Aid Kits and AEDs are easily accessible, in labeled boxes affixed to the wall, and have signage near the ceiling at every service location operated by SCCCMH. **c. Supplies** • First Aid Kits are easily accessible at every service location operated by SCCCMH. • First Aid Kits are easily accessible in the trunks of 73 agency vehicles. • Supplies Cache is kept in a locked cabinet and cage in the Facilities Department. **d. Inspections** • **Capac:** All inspections were completed by **1/22/2025.** Vehicle First Aid Kit Inspections received **1/02/2025.** • **Child & Family Services:** All inspections were completed by **1/22/2025.** Vehicle First Aid Kit Inspections received **2/14/2025.** • **Electric Avenue:** All inspections were completed by **1/22/2025.** Vehicle First Aid Kit Inspections received **1/28/2025.** • **Marine City – Broadway:** All inspections were completed by **1/22/2025.** Vehicle First Aid Kit Inspections received **1/22/2025.** • **Marine City – King Rd:** All inspections were completed by **1/22/2025.** Vehicle First Aid Kit Inspections received **2/7/2025.** **FY2025 Q1: October 1, 2024 – December 31, 2024** **a. Expertise** • Staff are trained in First Aid/CPR/AED usage. • 30 newly trained staff in Q1 FY2025. **b. Equipment**

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		• Emergency Evacuation Bags (EEBs) are in strategic locations at every service location operated by SCCCMH and brought by Supervisors to evacuation/shelter areas during emergency event/drills. • Emergency Evacuation Bags have been evaluated by Nursing Staff to include Trauma supplies. • Automated External Defibrillators (AEDs) are available at every service location and are inspected quarterly. • First Aid Kits and AEDs are easily accessible, in labeled boxes affixed to the wall, and have signage near the ceiling at every service location operated by SCCCMH. **c. Supplies** • First Aid Kits are easily accessible at every service location operated by SCCCMH. • First Aid Kits are easily accessible in the trunks of 73 agency vehicles. • Supplies Cache is kept in a locked cabinet and cage in the Facilities Department. **d. Inspections** • **Capac:** All inspections were completed by **11/13/2024.** Vehicle First Aid Kit Inspections received **1/2/2025.** • **Child & Family Services:** All inspections were completed by **11/13/2024.** Vehicle First Aid Kit Inspections received **11/21/2024.** • **Electric Avenue:** All inspections were completed by **11/13/2024.** Vehicle First Aid Kit Inspections received **12/11/2024.** • **Marine City – Broadway:** All inspections were completed by **11/13/2024.** • **Marine City – King Rd:** All inspections were completed by **11/13/2024.** Vehicle First Aid Kit Inspections received **12/3/2024.**
CARF Health & Safety	**4.** Quarterly, complete **Building Inspections.** **a.** Site Participation, (5) locations. Target Compliance: 100% **b.** Safety/Infection Control Checklist, Target Compliance: 95%	**FY2025 Q4: July 1, 2025 – September 30, 2025** a. Site Participation, five (5) service locations: • **Building Inspections include testing Lock Down Buttons, Silent Alarms (Panic Buttons), Megaphone Inventory, AED Testing and Inventory, LifeVac Inventory, and Safety/Infection Control Checklist.** ○ All Sites Participated in Building Inspections from **9/12/2025 and 9/23/2025.** ○ **Compliance = 100%** b. Safety/Infection Control Checklist Compliance Results: • Capac: **100%** • Child & Family Services: **100%** • Electric Avenue: **100%** • Marine City – Broadway: **100%** • Marine City – King Rd: **100%**

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		FY2025 Q3: April 1, 2025 – June 30, 2025 a. Site Participation, five (5) service locations: • **Building Inspections include testing Lock Down Buttons, Silent Alarms (Panic Buttons), Megaphone Inventory, AED Testing and Inventory, LifeVac Inventory, and Safety/Infection Control Checklist.** o All Sites Participated in Building Inspections from **6/12/2025-6/13/2025.** o **Compliance = 100%** b. Safety/Infection Control Checklist Compliance Results: • Capac: **100%** • Child & Family Services: **97%** • Electric Avenue: **100%** • Marine City – Broadway: **100%** • Marine City – King Rd: **97%** **FY2025 Q2: January 1, 2025 – March 31, 2025** a. Site Participation, five (5) service locations: • **Building Inspections include testing Lock Down Buttons, Silent Alarms (Panic Buttons), Megaphone Inventory and Safety/Infection Control Checklist.** o All Sites Participated in Building Inspections from **1/29/2025 – 1/31/2025.** o **Compliance = 100%** b. Safety/Infection Control Checklist Compliance Results: • Capac: **96.6%** • Child & Family Services: **100%** • Electric Avenue: **100%** • Marine City – Broadway: **98.3%** • Marine City – King Rd: **96.6%** **FY2025 Q1: October 1, 2024 – December 31, 2024** a. Site Participation, five (5) service locations: • **Building Inspections include testing Lock Down Buttons, Silent Alarms (Panic Buttons), Megaphone Inventory and Safety/Infection Control Checklist.** o All Sites Participated in Building Inspections from **11/13/2024 – 11/14/2024.** o **Compliance = 100%** b. Safety/Infection Control Checklist Compliance Results: • Capac: **98.3%** • Child & Family Services: **98.3%** • Electric Avenue: **98.3%**

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		• Marine City – Broadway: **95%** • Marine City – King Rd: **98.3%**
Good Administrative Practice	**5.** Quarterly, complete **Kitchen Inspections**; via the Kitchen Safety Inspection Checklist and the Kitchen Classroom Safety Checklist. Target Compliance: 95%	**FY2025 Q4: July 1, 2025 – September 30, 2025** a. Kitchen Inspection: • Lotus Café: **100%** b. Kitchen Classroom Inspections: • Electric Avenue (CIS): **100%** **FY2025 Q3: April 1, 2025 – June 30, 2025** a. Kitchen Inspection: • Lotus Café: **100%** b. Kitchen Classroom Inspections: • Electric Avenue (CIS): **100%** • Marine City – Broadway: **CLOSED/Repurposed** **FY2025 Q2: January 1, 2025 – March 31, 2025** a. Kitchen Inspection: • Lotus Café: **96.4%** b. Kitchen Classroom Inspections: • Electric Avenue (CIS): **100%** • Marine City – Broadway: **91% (non-compliant)** **FY2025 Q1: October 1, 2024 – December 31, 2024** a. Kitchen Inspection: • Lotus Café: **96%** b. Kitchen Classroom Inspections: • Electric Avenue (CIS): **100%** • Marine City – Broadway: **95%**
CARF Health & Safety	**6.** Annually, complete **Emergency/Event Procedures** (8 types) at all locations. Completion may be per "actual event" or drill. Target Compliance: 95% *Conducted, monitored, and recorded quarterly. a. Bomb Threat b. Chemical-Biological c. Fire d. Dangerous Person e. Medical Emergency f. Natural Disaster g. Suspicious Mail/Parcel h. Utility Failure	**FY2025 Q4: July 1, 2025 – September 30, 2025** V = Visitors **Total Staff Participants = 466/478** • No duplications (97.48% Quarter Compliance – running total) **Total Vistors = 66** • May be duplications. **a. Active Shooter Drill: (1)** 8/5/2025 • Capac – 1 • Child & Family Services – 1 • Electric Avenue – 5 • Marine City – Broadway & King Rd – 2 **b. Bomb Threat Tabletop: (4)** 8/18/25, 8/25/25, 9/2/25, 9/4/25 • Capac – 3 • Child & Family Services – 0 • Electric Avenue – 8 • Marine City – Broadway & King Rd – 2

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		c. Dangerous Person Events: Various Dates • Capac – 4, V-2 • Child & Family Services – 7 • Electric Avenue – 9, V-2 • Marine City – Broadway & King Rd – 0 **d. Medical Emergency Events:** Various Dates • Capac – 0 • Child & Family Services – 11, V-1 • Electric Avenue – 25, V-6 • Marine City – Broadway & King Rd – 0 **e. New Employee Orientation – Safety/Q&A: (4)** Various Dates • Capac – 2 • Child & Family Services – 2 • Electric Avenue – 5 • Marine City – Broadway & King Rd – 0 **f. Safety Updates w/ Q&A: (17)** Various Dates • Capac – 2 • Child & Family Services – 26 • Electric Avenue – 168 • Marine City – Broadway & King Rd – 31 **g. Suspicious Mail/Package: (2)** Various Dates • Capac - 2 • Child & Family Services – 0 • Electric Avenue – 7, V-1 • Marine City – Broadway & King Rd – 0 **h. Tornado Drill: (1)** 9/10/25 • Capac – 16, V-4 • Child & Family Services – 35, V-8 • Electric Avenue – 154, V-17 • Marine City – Broadway & King Rd – 16, V-4 **i. Utility Drill: (1)** 7/23/25 • Capac – 12, V-2 • Child & Family Services – 36, V-4 • Electric Avenue – 158, V-11 • Marine City – Broadway & King Rd – 14, V-4 **FY2025 Q3: April 1, 2025 – June 30, 2025** V = Visitors **Total Staff Participants = 304/478** • No duplications (86.40% Quarter Compliance – running total) **Total Vistors = 55**

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		• May be duplications. **a. Active Shooter Drill: (1)** 5/6/2025 • Capac – 0 • Child & Family Services – 1 • Electric Avenue – 7 • Marine City – Broadway & King Rd – 0 **b. Active Shooter Tabletop: (1)** 6/11/2025 • Capac – 0 • Child & Family Services – 0 • Electric Avenue – 21 • Marine City – Broadway & King Rd – 0 **c. Dangerous Person Events: (6)** Various Dates • Capac – 0 • Child & Family Services – 4, V-1 • Electric Avenue – 22, V-5 • Marine City – Broadway & King Rd – 0 **d. Fire Drill: (1)** 6/26/2025 • Capac – 13, V-1 • Child & Family Services – 34, V-9 • Electric Avenue – 148, V-20 • Marine City – Broadway & King Rd – 15, V-15 **e. Medical Emergency Events: (3)** Various Dates • Capac – 0 • Child & Family Services – 0 • Electric Avenue – 14, V-4 • Marine City – Broadway & King Rd – 0 **f. New Employee Orientation – Safety/Q&A: (7)** Various Dates • Capac – 1 • Child & Family Services – 3 • Electric Avenue – 6 • Marine City – Broadway & King Rd – 3 **g. Suspicious Mail/Package Drill: (1)** 6/26/2025 • Capac – 3 • Child & Family Services – 3 • Electric Avenue – 3 • Marine City – Broadway & King Rd – 5 **h. Safety Training/Q&A: (2)** 6/18/2025 & 6/24/2025 • Capac – 0 • Child & Family Services – 0 • Electric Avenue – 13

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		• Marine City – Broadway & King Rd – 0 **FY2025 Q2: January 1, 2025 – March 31, 2025** V = Visitors **Total Staff Participants = 280/471** • No duplications (59.45% Quarter Compliance) **Total Vistors = 32** • May be duplications. **a. Active Shooter Drill: (1)** 11/5/2024 • Capac – 1 • Child & Family Services – 0 • Electric Avenue – 7 • Marine City – Broadway & King Rd – 1 **b. Chemical/Biological Drill:** 2/20/2025 • Capac – 13, V-4 • Child & Family Services – 34, V-2 • Electric Avenue – 6, V-1 • Marine City – Broadway & King Rd – 15, V-12 **c. Dangerous Person Events:** Various Dates • Capac – 0 • Child & Family Services – 0 • Electric Avenue – 5, V-3 • Marine City – Broadway & King Rd – 0 **d. Fire Event: (1)** 3/5/2025 • Capac – 0 • Child & Family Services – 0 • Electric Avenue – 1 • Marine City – Broadway & King Rd – 6, V-5 **e. Medical Emergency Events:** Various Dates • Capac – 4, V-1 • Child & Family Services – 0 • Electric Avenue – 30, V-10 • Marine City – Broadway & King Rd – 10, V-3 **f. New Employee Orientation:** Various Dates • Capac – 0 • Child & Family Services – 0 • Electric Avenue – 7 • Marine City – Broadway & King Rd – 0 **g. QIDM Safety Presentation/Q&A: (1)** 2/18/2025 • Capac – 0

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		• Child & Family Services – 1 • Electric Avenue – 18 • Marine City – Broadway & King Rd – 0 **h. Safety Training Refresher/Q&A: (1)** 2/11/2025 • Capac – 0 • Child & Family Services – 0 • Electric Avenue – 20 • Marine City – Broadway & King Rd – 0 **i. Safety Orientation/Discussion w/ Q&A:** Various Dates • Capac – 1 • Child & Family Services – 0 • Electric Avenue – 8 • Marine City – Broadway & King Rd – 2 **j. Utility Event: (2)** 1/6/2025 & 3/31/2025 • Capac – 2 • Child & Family Services – 1 • Electric Avenue – 98, V-8 • Marine City – Broadway & King Rd – 0 **FY2025 Q1: October 1, 2024 – December 31, 2024** V = Visitors **Total Staff Participants = 330/476** • No duplications (69.32% Quarter Compliance – 26% to Annual 95% Compliance Requirement) **Total Vistors = 59** • May be duplications. **a. Medical Emergency Events:** Various Dates • Capac – 0 • Child & Family Services – 0 • Electric Avenue – 24, V-6 • Marine City – Broadway & King Rd – 8, V-4 **b. Dangerous Person Events:** Various Dates • Capac – 0 • Child & Family Services – 1, V-1 • Electric Avenue – 11, V-2 • Marine City – Broadway & King Rd – 10, V-2 **c. Suspicious Mail Event: (1)** 11/27/2024 • Capac – 0 • Child & Family Services – 0 • Electric Avenue – 3 • Marine City – Broadway & King Rd – 0

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		d. Safety Orientation/Discussion w/ Q&A: Various Dates • Capac – 1 • Child & Family Services – 0 • Electric Avenue – 8 • Marine City – Broadway & King Rd – 2 **e. Active Shooter Drill: (1)** 11/5/2024 • Capac – 0 • Child & Family Services – 0 • Electric Avenue – 17 • Marine City – Broadway & King Rd – 1 **f. Bomb Threat Tabletop/Drill w/ Discussion: (1)** 11/14/2024 • Capac – 15, V-4 • Child & Family Services – 29 • Electric Avenue – 168, V-16 • Marine City – Broadway & King – 21, V-4 **g. Bomb Threat Drill: (1)** 11/20/2024 • Capac – 15, V-4 • Child & Family Services – 29 • Electric Avenue – 168, V-16 • Marine City – Broadway & King Rd – 21, V-4 **h. Utility Drill: (1)** 12/19/2024 • Capac – 11, V-2 • Child & Family Services – 29 • Electric Avenue – 161, V-15 • Marine City – Broadway & King Rd – 14, V-2
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 Emergencies via "actual event" or emergency drill. Target Compliance: 95% Participation of 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. b. Supervisors to receive notification in Q3 of staff that have not participated in an emergency drill or actual emergency event. c. Annually, Supervisors of employees **who did not participate** in at least one emergency event (drill or actual) are required to review safety protocol, via the Building Health and Safety policy #09-001-0005 or Emergency Procedures Handbook, with applicable staff.	**FY2025 Q4: July 1, 2025 – September 30, 2025** a. **TOTAL Participation:** • Staff Participants – 466 • Total Visitors* – 66 b. Supervisors will receive notification in Q3 of those staff who have not completed a drill/event. c. **Staff with No Drill in Q4 – 65 **Percentage to Compliance Goal as of Q4 – **97.48%** *as there is no way to separate individual visitors for events/drills, this number is skewed and therefore not used in the annual total or percentage to goal. **FY2025 Q3: April 1, 2025 – June 30, 2025** a. **TOTAL Participation:** • Staff Participants – 304 • Total Visitors* – 55 b. Supervisors will receive notification in Q3 of those staff who have not completed a drill/event.

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		c. **Staff with No Drill in Q3 – 65 **Percentage to Compliance Goal as of Q3 – **86.40%** *as there is no way to separate individual visitors for events/drills, this number is skewed and therefore not used in the annual total or percentage to goal. **Safety Coordinator on LOA through part of Q2 and Q3, as numbers are cumulative, participation percentage was missed for Q2. This has been corrected for Q3 moving forward. **FY2025 Q2: January 1, 2025 – March 31, 2025** a. **TOTAL Participation:** • Staff Participants – 280 • Total Visitors* – 32 b. Supervisors will receive notification in Q3 of those staff who have not completed a drill/event. c. **Staff with No Drill in Q1 – 176 **Percentage to Compliance Goal as of Q2 – **69%** *as there is no way to separate individual visitors for events/drills, this number is skewed and therefore not used in the annual total or percentage to goal. **FY2025 Q1: October 1, 2024 – December 31, 2024** a. **TOTAL Participation:** • Staff Participants – 280 • Total Visitors* – 32 b. Supervisors will receive notification in Q3 of those staff who have not completed a drill/event. c. **Staff with No Drill in Q1 – 176 **Percentage to Compliance Goal as of Q1 – **69%** *as there is no way to separate individual visitors for events/drills, this number is skewed and therefore not used in the annual total or percentage to goal.
Good Administrative Practice	**8.** Quarterly, count the number of **Green Button & Panic Button activations.** a. Number of Actual Alarms b. Number of False Alarms	**FY2025 Q4: July 1, 2025 – September 30, 2025** **Green Panic Button Alarms** a. Actual Alarm – 8 b. False Alarm – 8 **Black Panic Button Alarms** a. Actual Alarm – 0 b. False Alarm – 2 **Lockdown Button** a. Actual Alarm – 1 b. False Alarm – 0 **FY2025 Q3: April 1, 2025 – June 30, 2025** **Green Panic Button Alarms** a. Actual Alarm – 6 b. False Alarm – 11

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		Black Panic Button Alarms a. Actual Alarm – 1 b. False Alarm – 2 **Lockdown Button** a. Actual Alarm – 1 b. False Alarm – 0 **FY2025 Q2: January 1, 2025 – March 31, 2025** **Green Panic Button Alarms** a. Actual Alarm – 6 b. False Alarm – 11 **Black Panic Button Alarms** a. Actual Alarm – 1 b. False Alarm – 2 **FY2025 Q1: October 1, 2024 – December 31, 2024** **Green Panic Button Alarms** a. Actual Alarm – 3 b. False Alarm – 5
CARF Health & Safety Emergency Procedures 1.H.5.c.5.	**9.** Supervising staff to ensure **Staff Accountability** during large evacuation drills and actual events (i.e., Fire, Bomb Threat, Chemical-Biological, Tornado, etc.). a. Supervisors to ensure use of sign in/out binders, roll call, and/or text messaging when applicable.	**FY2025 Q4: July 1, 2025 – September 30, 2025** This is an ongoing practice during drills/events; however, additional training will be provided to supervisors to support this goal. Supervisors were asked during Q4 drills if they had a plan of action/method to address accounting for staff. **FY2025 Q3: April 1, 2025 – June 30, 2025** This is an ongoing practice during drills/events; however, additional training will be provided to supervisors to support this goal. **FY2025 Q2: January 1, 2025 – March 31, 2025** This is an ongoing practice during drills/events; however, additional training will be provided to supervisors to support this goal. **FY2025 Q1: October 1, 2024 – December 31, 2024** This is an ongoing practice during drills/events; however, additional training will be provided to supervisors to support this goal.

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
	10. Quarterly, review of **"Medication Errors"** reports. a. Error Type b. Error Location c. Trends d. Improvement Opportunities via Error Type	**FY2025 Q4: July 1, 2025 – September 30, 2025** **a. Error Type – TOTAL = 36** • Missed Medications – 22 • Other (Special Instructions) – 0 • Wrong Documentation – 5 • Wrong Dose – 7 • Wrong Medication – 0 • Wrong Person – 0 • Wrong Time – 2 **b. Error Location Total:** • AFC Homes – 0 • Blue Water Developmental Housing – 2 • CMH (ACT, CIS, Jail) – 0 • Community Enterprises – 1 • Home of Your Own – 0 • IMPACT – 17 • Innovative – 16 • Life Skills – 0 • Other – 0 **c. Trends** – Errors down from #59 in FY25 Q3. **d. Improvement Opportunities –** This quarter 3 med error reports were received from Lincoln home; 4 med error reports were received from Ravenswood home; 6 med error reports were received from Riverbend side #1; 2 med error reports were received from Vine home; 4 med error reports were received from Roehl home; there were no medication errors which resulted in an ER visit or hospitalization this quarter; there were no medication error reports referred to recipient rights this quarter; again the majority of medication errors this quarter were missed medications; at the request of the Recipient Rights office, a medication audit was completed at Roehl home this quarter and no significant medication errors or issues were found; continued education and monitoring of staff for following policy and procedures related to medication is needed. **FY2025 Q3: April 1, 2025 – June 30, 2025** **a. Error Type – TOTAL = 59** • Missed Medication – 12 • Other (Special Instructions) – 1 • Wrong Documentation – 1 • Wrong Dose – 7 • Wrong Medication – 25 • Wrong Person – 1 • Wrong Time – 12 **b. Error Location Total:** • AFC Homes – 0

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		• Blue Water Developmental Housing – 35 • CMH (ACT, CIS, Jail) – 0 • Community Enterprises – 0 • Home of Your Own – 0 • IMPACT – 3 • Innovative – 21 • Life Skills – 0 • Other – 0 **c. Trends** – Errors up from #42 in FY25 Q2. **d. Improvement Opportunities** – A medication that was discontinued was given for 17days by Springborn home which occurred during the 2nd quarter in March but the med error report was not completed until 4/22/25; 7 medication errors were reported to Recipient Rights for review; there were no were no medication errors which resulted in an ER visit or hospitalization this quarter; EMS was called related to one medication error but the individual was not transported to the hospital; 3 medication error reports were received from Oakleaf home this quarter; 4 medication error reports were received from Maple Street home this quarter (1 sent to Recipient Rights); 4 medication error reports were received from Stonybrook home this quarter (all 4 errors were the same by staff and all 4 were sent to Recipient Rights); 3 medication error reports were received from Stone Creek home (1 sent to Recipient Rights); 2 medication error reports were received from Ravenswood home (1 sent to Recipient Rights); 2 medication error reports were received from Thornhill home; education has been provided to contracted agency staff by RN on following policy and procedure and importance of Supervisors observing staff med passes to ensure proper procedure is followed; staff continue to need education and accountability in observing the 6 rights of medication administration and checking the medication 3 times before administration. **FY2025 Q2: January 1, 2025 – March 31, 2025** **a. Error Type – TOTAL = 42** • Missed Medication – 30 • Other (Special Instructions) – 1 • Wrong Documentation – 0 • Wrong Dose – 9 • Wrong Medication – 0 • Wrong Person – 0 • Wrong Time – 2 **b. Error Location Total:** • AFC Homes – 0 • Blue Water Developmental Housing – 2 • CMH (ACT, CIS, Jail) – 2 • Community Enterprises – 2 • Home of Your Own – 0 • IMPACT – 0

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		• Innovative – 33 • Life Skills – 0 • Other – 5 **c. Trends** – Errors up from #30 in FY25 Q1. **d. Improvement Opportunities –** This quarter the majority of medication errors were missed medications; 22 of the missed medications were due to the homes not receiving the medications from the pharmacy in a timely manner; 7 medication error reports were received from Vine St Group Home this quarter; 3 hospitalizations this quarter; the medication error reports that were due to medications not being delivered by pharmacy were sent to Recipient Rights; staff continue to need education and accountability in observing the 6 rights of medication administration and checking the medication 3 times before administration. **FY2025 Q1: October 1, 2024 – December 31, 2024** **a. Error Type – TOTAL = 30** • Missed Medication – 3 • Other (Special Instructions) – 1 • Wrong Documentation – 7 • Wrong Dose – 2 • Wrong Medication – 9 • Wrong Person – 3 • Wrong Time – 5 **b. Error Location Total:** • AFC Homes – 0 • Blue Water Developmental Housing – 14 • CMH (ACT, CIS, Jail) – 1 • Community Enterprises – 1 • Home of Your Own – 0 • IMPACT – 12 • Innovative – 2 • Life Skills – 0 **c. Trends** – Errors down from #40 in FY24 Q4. **d. Improvement Opportunities –** This quarter 10 medication error reports were received from Thornhill Group Home, which included 12 medication errors; there were no medication errors that resulted in an ER visit or hospitalization this quarter; there were no medication error reports referred to Recipient Rights this quarter; most of the medication errors could have been prevented by observing the 6 rights of medication administration and checking the medication 3 times before administration; medication passers need to implement and put into practice what they have learned in medication training to prevent/reduce the medication error occurrence.

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
MIOSHA R325.70001	**11.** Annually, review the **"Exposure Control Plan,"** update as needed. Bloodborne Pathogens Exposure and Infection Control Plan).	**FY2025 Q4: July 1, 2025 – September 30, 2025** Reviewed and updated – August 2025. **FY2025 Q3: April 1, 2025 – June 30, 2025** Reviewed and updated – July 2025. **FY2025 Q2: January 1, 2025 – March 31, 2025** Reviewed and updated – January 2025. **FY2025 Q1: October 1, 2024 – December 31, 2024** Reviewed and updated – January 2025.
CARF Health & Safety	**12.** Annually, complete (update/revise) **Board Statement** "Health & Safety Work Plan."	**FY2025 Q4: July 1, 2025 – September 30, 2025** Updated 4/8/2025. **FY2025 Q3: April 1, 2025 – June 30, 2025** Updated 4/8/2025 **FY2025 Q2: January 1, 2025 – March 31, 2025** Updated 4/8/2025 **FY2025 Q1: October 1, 2024 – December 31, 2024** Updated 4/9/2024
CARF	**13.** Promote Safety by ensuring current **Written Safety Procedures** as applicable.	**FY2025 Q4: July 1, 2025 – September 30, 2025** Written Safety Procedures are outlined in the Employee Emergency Procedures Handbook. This Handbook is available on each employee's computer desktop and in written format and updated as needed, at least quarterly. **Updated 9/2025.** **FY2025 Q3: April 1, 2025 – June 30, 2025** Written Safety Procedures are outlined in the Employee Emergency Procedures Handbook. This Handbook is available on each employee's computer desktop and in written format and updated as needed, at least quarterly. **FY2025 Q2: January 1, 2025 – March 31, 2025** Written Safety Procedures are outlined in the Employee Emergency Procedures Handbook. This Handbook is available on each employee's computer desktop and in written format and updated as needed, at least quarterly. **FY2025 Q1: October 1, 2024 – December 31, 2024** Written Safety Procedures are outlined in the Employee Emergency Procedures Handbook. This Handbook is available on each employee's computer desktop and in written format and updated as needed, at least quarterly.
N/A	**14.** Promote implementation of **"Risk Awareness List" (formerly Threat List)**.	**FY2025 Q4: July 1, 2025 – September 30, 2025** This list is updated by the Medical Director and Chief Clinical Officer, quarterly, or as needed. The list is sent to key personnel, including the Safety Coordinator. The Reception/Scheduling Team reviews the list and procedures quarterly, or as new individuals are added. **Updated June 2025.** 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")

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		4. Clerical/Reception staff are trained on how to look for this banner and follow instructions accordingly. **FY2025 Q3: April 1, 2025 – June 30, 2025** This list is updated by the Medical Director and Chief Clinical Officer, quarterly, or as needed. The list is sent to key personnel, including the Safety Coordinator. The Reception/Scheduling Team reviews the list and procedures quarterly, or as new individuals are added. **Updated June 2025.** 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 this banner and follow instructions accordingly. **FY2025 Q2: January 1, 2025 – March 31, 2025** This list is updated by the Medical Director and Chief Clinical Officer, quarterly, or as needed. The list is sent to key personnel, including the Safety Coordinator. The Reception/Scheduling Team reviews the list and procedures quarterly, or as new individuals are added. 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 this banner and follow instructions accordingly. **FY2025 Q1: October 1, 2024 – December 31, 2024** This list is updated by the Medical Director and Chief Clinical Officer, quarterly, or as needed. The list is sent to key personnel, including the Safety Coordinator. The Reception/Scheduling Team reviews the list and procedures quarterly, or as new individuals are added. 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 this banner and follow instructions accordingly.
CMH Policy	**15. Address other safety-related items as needed.**	**FY2025 Q4: July 1, 2025 – September 30, 2025** 1. Safety Program Goals were updated for 2026. 2. Updated Employee Orientation Safety Training. 3. Staff Emergency Responders Training. 4. New Safety Updates Presentations 5. New Equipment: LifeVac Anti-Choking Devices

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		6. Follow up After Action Report/Improvement Plan (AAR/IP) after every drill/event. 7. Introduced Tabletop Exercise as new type of training/drill. 8. Evacuation Mapping Project completed. 9. Held 1st Annual OSHA Safety Week 10. Reviewed Safety Plan 2026 **FY2025 Q3: April 1, 2025 – June 30, 2025** 1. Safety Program Goals were updated for 2025. 2. Updated Employee Orientation Safety Training. 3. Staff Emergency Responders Training. 4. New Equipment: Chemical/Biological Bags, five (5) for all sites. 5. Follow up After Action Report/Improvement Plan (AAR/IP) after every drill/event. 6. Introduced Tabletop Exercise as new type of training/drill. 7. Evacuation Mapping Project completed. 8. Safety Program Annual Report completed October 2024. Submitted to Board of Directors. **FY2025 Q2: January 1, 2025 – March 31, 2025** 1. Safety Program Goals were updated for 2025. 2. Updated Employee Orientation Safety Training. 3. Staff Emergency Responders Training. 4. New Equipment: Chemical/Biological Bags, five (5) for all sites. 5. Follow up After Action Report/Improvement Plan (AAR/IP) after every drill/event. 6. Introduced Tabletop Exercise as new type of training/drill. 7. Evacuation Mapping Project completed. 8. Safety Program Annual Report completed October 2024. Submitted to Board of Directors. **FY2025 Q1: October 1, 2024 – December 31, 2024** 1. Safety Program Goals were updated for 2025. 2. Updated Employee Orientation Safety Training. 3. Staff Emergency Responders Training. 4. New Equipment: Chemical/Biological Bags, five (5) for all sites. 5. Follow up After Action Report/Improvement Plan (AAR/IP) after every drill/event. 6. Introduced Tabletop Exercise as new type of training/drill. 7. Evacuation Mapping Project completed. 8. Safety Program Annual Report completed October 2024. Submitted to Board of Directors.
Good Administrative Practice	**16.** Maintain a **Safety Data Sheet (SDS) manual**, including pictures of products, and completed training with staff concerning use of products and appropriate storage.	**FY2025 Q4: July 1, 2025 – September 30, 2025** 1. Safety Data Sheets (SDS) are updated as new Chemical information is provided by the Facilities Department, at least annually, and includes pictures of product labels and graphics to identify products and labels for storage/bottles. **a.** Additional face-to-face training was provided to Facilities staff. 2. SDS posters are available in employee areas indicating where to find SDS binders and who is responsible for that information at all SCCCMH sites. 3. Staff completed initial training upon hire and then, yearly training called "Hazard Communication Standards" which covers SDS standards.

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		FY2025 Q3: April 1, 2025 – June 30, 2025 1. Safety Data Sheets (SDS) are updated as new Chemical information is provided by the Facilities Department, at least annually, and includes pictures of product labels and graphics to identify products and labels for storage/bottles. a. Additional face-to-face training was provided to Facilities staff. 2. SDS posters are available in employee areas indicating where to find SDS binders and who is responsible for that information at all SCCCMH sites. 3. Staff completed initial training upon hire and then, yearly training called "Hazard Communication Standards" which covers SDS standards. **FY2025 Q2: January 1, 2025 – March 31, 2025** 1. Safety Data Sheets (SDS) are updated as new Chemical information is provided by the Facilities Department, at least annually, and includes pictures of product labels and graphics to identify products and labels for storage/bottles. 2. SDS posters are available in employee areas indicating where to find SDS binders and who is responsible for that information at all SCCCMH sites. 3. Staff completed initial training upon hire and then, yearly training called "Hazard Communication Standards" which covers SDS standards. **FY2025 Q1: October 1, 2024 – December 31, 2024** 1. Safety Data Sheets (SDS) are updated as new Chemical information is provided by the Facilities Department, at least annually, and includes pictures of product labels and graphics to identify products and labels for storage/bottles. 2. SDS posters are available in employee areas indicating where to find SDS binders and who is responsible for that information at all SCCCMH sites. 3. Staff completed initial training upon hire and then, yearly training called "Hazard Communication Standards" which covers SDS standards.
Good Administrative Practice CARF Health & Safety	**17. 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: i. Continue participation in MiHAN (Health Alert Network). ii. Implement CMH closed WINS group for staff notifications. iii. Update existing document to include the Pandemic Plan and also update to reflect any changes in process, advances in technology, etc. iv. Complete planning process documents for each program. Documents identify: • Possible alternative locations • Prioritization of essential functions	**FY2025 Q4: July 1, 2025 – September 30, 2025** This is ongoing. A team consisting of the COO, Facilities Supervisor, IT and Safety Coordinator are meeting to update the Disaster Recovery/Business Resumption Plan/Contingency Plan. **FY2025 Q3: April 1, 2025 – June 30, 2025** This is ongoing. A team consisting of the COO, Facilities Supervisor, IT and Safety Coordinator are meeting to update the Disaster Recovery/Business Resumption Plan/Contingency Plan. Safety Coordinator has submitted the Safety Plan for Review. **FY2025 Q2: January 1, 2025 – March 31, 2025** This is ongoing. A Team consisting of the COO, Facilities Supervisor, IT, and Safety Coordinator are meeting to update the Disaster Recovery/Business Resumption Plan. Safety Coordinator is currently revising the Safety Plan. **FY2025 Q1: October 1, 2024 – December 31, 2024**

Reference	Safety-Jennifer Dugger PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
	• Order of succession • Vital information/records v. Identify process for addressing internal disaster (small and large scale). vi. 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.	This is ongoing. A team consisting of the COO, Facilities Supervisor, IT, and Safety Coordinator are meeting to update the Disaster Recovery/Business Resumption Plan. Safety Coordinator is currently writing an Emergency All-Hazards Plan, which is set to be completed by February 2025.

Reference	Privileging & Credentialing-Amy Kandell PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
MDHHS/PIHP Contract	**1. Maintain/update as applicable the Provider Enrollment and Credentialing Policy #01-003-0011, credentialing applications and forms.**	**4th Quarter:** SCCCMH is now using BH-CRM Universal Credentialing for all internal, licensed staff who are applying for Full or Re-Credentialing status. SCCCMH staff who are degreed but non-licensed and/or have a certification and are requesting Provisional, Full or Re-Credentialing status will need to complete a Privileging and Credentialing Application via St. Clair's internal database. **3rd Quarter:** Contract agencies are still completing paper applications for individual staff. Some Contract agencies have begun to use BH-CRM Universal Credentialing System. SCCCMH has goal of Sept 2025 to begin using the BH-CRM Universal Credentialing System with internal licensed staff. Provisional staff and all non-licensed, degreed staff will need to complete a Privileging and Credentialing Application via St. Clair's internal database. **1st and 2nd Quarter:** Contract agencies are still completing paper applications for individual staff. The Privileging & Credentialing Policy (#01-003-0011) has been updated. The state has created a new Universal Credentialing online application. All licensed staff and contract agencies will need to submit their application via the BH-CRM Universal Credentialing System. SCCCMH will be transitioning to this process in the next 1 to 2 months. SCCCMH will still need to use their internal P&C database for non-licensed staff (i.e., Peers, Interns, Bachelors level staff, etc.)
State Licensing MDHHS Requirement	**2. Monitor the credentials of all staff requesting privileges to provide services to individuals in SCCCMH presented to the committee.**	P&C Committee continues to meet bimonthly to review applications and the credentials of staff. **Q4:** The committee is now reviewing applications in from the BH-CRM database and St. Clair's internal P&C database. The P&C committee and HR will be meeting to discuss how best to track the QMHP, QIDP, and CMHP Attestation on an on-going basis. The P&C Chairperson is now assisting new required employees in filling out the attestation form during first day orientation. Prior to each P&C meeting, HR staff is sending licensed staff's BH-CRM application to P&C Chairperson to review accuracy of certain credentials (i.e. QIPD, CMHP, CMHP) because certain elements that are on the internal P&C application are not on the universal credentialing application. As of Q4, Kerrie Kozloff is no longer Co-Chairing the committee. **Credentialing Numbers for 4th Quarter:** Re-credentialed: 43 Provisional: 16 Full: 17 Organizations: 6 **Total # for 4th Quarter: 82**

Reference	Privileging & Credentialing-Amy Kandell PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
MDHHS Requirement	**3. Review and privilege as appropriate, organizational applications of provider agencies.**	**4th Quarter:** Contract Management assists contract agencies in completing the required BH-CRM Universal Credentialing system and presenting the application at the P&C committee for the committee to review. **3rd Quarter:** The committee meets up to twice a month to review applications. Contract agencies have begun to use BH-CRM Universal Credentialing System. **1st and 2nd Quarter:** No changes/ongoing reviews. The committee meets up to twice a month to review applications. Contract agencies will need to transition to the BH-CRM Universal Credentialing System. To date, 1 contract agency has completed their application via the new system.
MDHHS Requirement	**4. Maintain the SCCCMH list of credentialed positions and coordinated with Medicaid/Medicare/MDHHS definitions.** a. Monthly update Provider Registry Reports to ensure compliance with credentialing timeframes. b. Ensure list of practitioners and organizational providers is available upon request.	**4th Quarter:** Meeting was held and the committee and certain committee members will continue to monitor necessary and required elements of the privileging and credentialing process. HR has taken on more of a role of assisting in the monitoring of credentialed timeframes and providing the Registry Reports. HR is assisting licensed staff in completing the BH-CRM application. **3rd Quarter:** Privileging and Credentialing committee members are meeting in August to discuss how St. Clair will monitor and track timeframes of applications in the BH-CRM Universal Credentialing System and St. Clair's internal P&C database. Region 10 has aligned with MDHHS 3 year time frame for privileging and credentialing applications. St. Clair P&C committee is now requiring staff to renew their P&C applications every 3 years vs every 2 years once they have Full status. **1st and 2nd Quarter:** No current changes/ongoing. Prior to P&C meeting, clerical and P&C members review databases to compare and comprise a list applicants that are due for credentialing. The new Universal Credentialing System may impact this process.
Good Clinical Practice	**5. Monitor staff training requirements. Make recommendations for training and direction as needed.**	**4th Quarter:** No changes from last quarter. **3rd Quarter:** No changes from last quarter. **1st and 2nd Quarter:** A staff member from the Training Department attends P&C meetings to bring up and address any issues, concerns, or updates as needed. P&C Committee has reduced the number of Provisional applications that are being reviewed, due to changes to Region 10's Privileging & Credentialing policy and application. SCCCMH's P&C Committee are not placing staff on provisional status if they change positions within the agency that affects their grade level and population they are seeing.

Reference	Privileging & Credentialing-Amy Kandell PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		HR has developed a new process for monitoring these situations and informs the P&C Committee if there are any issues. No updates at this time.
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.	**4th Quarter:** The P&C committee continues to audit contract agencies' individuals' P&C applications during each meeting. HR will be running reports from BH-CRM database, while data management staff will run reports from the internal P&C database. Contract Management oversee P&C applications for contract agencies. **3rd Quarter:** Privileging and Credentialing committee members are meeting in August to discuss how St. Clair will monitor and track timeframes of applications in the BH-CRM Universal Credentialing System and St. Clair's internal P&C database. Auditing contract agencies individual applications will also be discussed at this meeting. Currently, reports are reviewed prior to the P&C meeting to ensure providers & practitioners are reviewed in timely manner. The Committee performs bimonthly audits of contract providers' P&C applications to ensure they are filled out correctly. **1st and 2nd Quarter:** Reports are reviewed prior to the P&C meeting to ensure providers & practitioners are reviewed in timely manner. The Committee performs bimonthly audits of contract providers' P&C applications to ensure they are filled out correctly. The new Universal Credentialing System may impact this process.

Reference	Program Development-Kathleen Gallagher PROPRITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
Best Practice	**1. Evidence Based Practices (EBPs):** a. Sustain current Evidence-Based Practices (EBP). b. Expand number of CMH staff trained in an applicable EBP. c. Continue to monitor current EBPs for fidelity. d. Expand number of individuals receiving EBPs through the CMH system.	a. Ongoing. b. We have 1 staff pursuing their EMDR consultant certification. We have staff in the current TF-CBT co-hort. A monthly EMDR supervision group has been started and is offered agency wide. c. Ongoing. d. Ongoing.
Best Practice Strategic Plan Program Excellence #4	**2. Trauma Informed Care:** Implement a trauma informed system of care across all of SCCCMH and its contract system. a. Continue to provide Trauma Informed Care (TIC) to new staff at orientation and refresher trainings to existing staff. b. Expand TIC to contract system so that all are Trauma Informed. c. Survey current perceptions from staff and those served regarding our current standing with regard to TIC.	a. Ongoing. b. Ongoing. c. In August 2025, the Advisory Board and Board of Directors reviewed the CCO's recommendations from the TIC Survey. Based on these recommendations, the following actions are being implemented: i. A series of Trauma Informed Trainings have been scheduled to begin in November 2025, in response to staff requests identified in the TIC survey. ii. Nightlock devices are being installed agency-wide to address environmental safety concerns reported in the survey. iii. In October 2025, the Chief Clinical Officer (CCO) and Medical Director began conducting debriefings with teams affected by the death of a person served. This practice will continue.
Grant FY19-20 CCBHC	**3. Veterans Services:** 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.	a. Ongoing. b. Continued issues with Veterans getting the VA auths denied due to the single mental health provider available in Yale. Continued advocacy efforts with our Senators. No updates.
Best Practice	**4. Explore Evidence Based Practices (EBPs) for SUD Services.** a. Train staff identified in EBPs for SUD Services. 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. Ongoing. d. Ongoing.
Best Practice	**5. To Provide State-of-the-Art, Evidence-Based Assessment and Treatment to Individuals at Risk of Suicide.** a. Train staff system wide in Zero Suicide EBP for treatment for individuals at risk for suicide. b. Train staff system-wide on the use of the Columbia-Suicide Severity Rating Scale (C-SSRS) and other applicable clinical tools for treatment. c. Assess current EBPs for effectiveness. d. Research other EBPs that may be beneficial to implement throughout the system.	a. There is a virtual training by Dr. Saeed that is available on our website. b. Ongoing. c. Ongoing. d. Ongoing.

Reference	Program Development-Kathleen Gallagher PROPRITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
Staff Recruitment Program Staff Training Expand Programs	**6. Develop and Implement a Plan to Recruit & 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 persons served. e. Work with supervisors to identify need areas and complete work plans to address those need areas.	a. Ongoing. b. Ongoing. c. Based on the results of the TIC Survey, a series of Trauma Informed Trainings have been scheduled to begin in November 2025. d. Ongoing. e. Ongoing.
Strategic Plan Program Excellence #4	**7. Community Based Crisis Services.** a. Behavioral Health Urgent Care (BHUC) b. Children's Crisis Residential Home c. Crisis Stabilization Unit (CSU)	a. The Behavioral Health Urgent Care opened on 10/1/2025. This opening coincided with SCCCMH taking over direct access for services, excluding inpatient authorizations. MCU staff are in the process of taking the state required crisis worker training. b. A RFP for the building of the Children's home as gone out. c. The CSU will remain on hold, as the current need for this service has not yet been determined.

Reference	Recipient Rights-Sandy O'Neill Priority Goals/Key Tasks	FY2025 TIMELINE-STATUS
MI MHC MDHHS	**1. ADMINISTRATIVE FUNCTION:** a. Submit the SCCCMHA Semi-Annual Report to the MDHHS-ORR by June 30th of each year. b. Submit the SCCCMH Annual Report to the MDHHS-ORR by December 30th of each year.	**FY2025: Q1: October 1, 2024 – December 31, 2024** a. No activity b. Annual report submitted on December 19, 2024 **FY2025: Q2: January 1, 2025 – March 31, 2025** a. No activity b. No activity **FY2025: Q3: April 1, 2025 – June 30, 2025** a. Submitted June 16, 2025 b. No activity **FY2025: Q4: July 1, 2025 – September 30, 2025** a. No activity b. No activity
MDHHS GF Contract	**2. COMPLAINT RESOLUTION SYSTEM FUNCTION:** a. Report the number of substantiated Recipient Rights violations in St. Clair Country by classification and provider location (identified by month/quarter).	**FY2025 Q1: October 1, 2024 – December 31, 2024** **a. Substantiated Violations = 33 Total** **-October 2024: Seventeen (17) Violations Established:** ▪ BlueMind Therapy: Dignity & Respect (2) ▪ BWDH: Oakleaf: Abuse: Class II – Exploitation ▪ BWDH: Springborn: Services Suited to Condition ▪ BWDH: Supported Housing: Personal Property ▪ Community Enterprises: Services Suited to Condition ▪ Eisenhower North: Abuse: Class II – Unreasonable Force ▪ IMPACT: Charmwood: Services Suited to Condition ▪ IHDC: Roehl: Services Suited to Condition ▪ IHDC: Ponderosa: Dignity & Respect ▪ SCCCMH: Outpatient: Dignity & Respect ▪ SCCCMH: Children's: Services Suited to Condition (1); Confidentiality (1); Family Rights (1) ▪ SCCCMH: Facilities: Dignity & Respect ▪ SCCCMH: IDDT: Confidentiality ▪ SCCCMH: Mobile Crisis: Confidentiality **-November 2024: Seven (7) Violations Established:** ▪ BWDH: Supported Housing: Dignity & Respect ▪ IHDC: Ravenswood: Abuse: Class II - Unreasonable Force (1); Abuse: Class III (1) ▪ IMPACT: Michigan: Abuse: Class II - Unreasonable Force ▪ IMPACT: Charmwood: Dignity & Respect ▪ SCCCMH: Children's: Services Suited to Condition ▪ SCCCMH: Outpatient: Confidentiality **-December 2024: Nine (9) Violations Established:** ▪ All-Ways Care - Community Based: Services Suited to Condition ▪ BlueMind Therapy: Abuse: Class II - Unreasonable Force ▪ BWDH: Maple: Dignity & Respect ▪ SCCCMH: Case Management: Services Suited to Condition ▪ SCCCMH: Peer Services: Services Suited to Condition ▪ GT: Services Suited to Condition

Reference	Recipient Rights-Sandy O'Neill Priority Goals/Key Tasks	FY2025 TIMELINE-STATUS
		▪ Hope Network: River Valley: Abuse: Class II - Exploitation ▪ IMPACT: Charmwood: Dignity & Respect (1); Services Suited to Condition (1) **FY2025: Q2: January 1, 2025 – March 31, 2025** **a. Substantiated Violations = 39 Total** **-January 2025: Twenty-One (21) Violations Established:** ▪ BWDH: Oakleaf: Services Suited to Condition ▪ Creative Empowerment Opportunities: Services Suited to Condition ▪ IMPACT: Michigan: Abuse II - Unreasonable Force (3); Fingerprints, Photographs (1); Freedom of Movement (1); Services Suited to Condition (1) ▪ IMPACT: Wells: Services Suited to Condition ▪ IDHC: Hopps: Dignity & Respect ▪ IDHC: Mayfield: Services Suited to Condition ▪ IDHC: Oak Street: Dignity & Respect ▪ IDHC: Vine: Confidentiality ▪ IDHC: Vine: Services Suited to Condition (2); Dignity & Respect (1) ▪ Life Skills: Bright Futures: Confidentiality ▪ SCCCMH: Marine City: Services Suited to Condition ▪ SCCCMH: Peer Services: Abuse: II - Exploitation (2) ▪ SCCCMH: Physician Services: Confidentiality **-February 2025: Eight (8) Violations Established:** ▪ Beacon-Lennon: Abuse II: Unreasonable Force (1); Services Suited to Condition (1) ▪ BWDH: Oakleaf: Confidentiality ▪ BWDH: Hayes: Services Suited to Condition ▪ IMPACT: River Bend I: Services Suited to Condition ▪ IMPACT: Simpson: Services Suited to Condition ▪ IHDC: Vine: Abuse II: Emotional Harm ▪ SCCCMH: Children's: Confidentiality **-March 2025: Ten (10) Violations Established:** ▪ BWDH: Hayes: Abuse: III (1); Services Suited to Condition (1) ▪ BWDH: Maple: Dignity & Respect ▪ IHDC: Ponderosa: Services Suited to Condition ▪ IMPACT: Belle River: Dignity & Respect (1); Services Suited to Condition (1); Abuse: III (1) ▪ IMPACT: Michigan: Abuse: III ▪ IMPACT: Wells: Services Suited to Condition ▪ SCCCMH: CIS: Dignity & Respect **FY2025: Q3: April 1, 2025 – June 30, 2025** **a. Substantiated Violations = 42 Total** **-April 2025: Twenty-One (17) Violations Established:** ▪ All-Ways Care: Oakleaf: Neglect I ▪ Beacon-Cottage: Abuse III (1); Dignity & Respect (1) ▪ Beacon-Eau Claire: Abuse: III (1), Abuse: II Unreasonable Force (1) ▪ BWDH- Maple: Dignity & Respect

Reference	Recipient Rights-Sandy O'Neill Priority Goals/Key Tasks	FY2025 TIMELINE-STATUS
		▪ BWDH- Support Living: Services Suited to Condition (2) ▪ SCCCMH- ACT: Dignity & Respect ▪ SCCCMH-MC-Children: Confidentiality ▪ SCCCMH-MC: Confidentiality ▪ SCCCMH-Infant Mental Health: Confidentiality (3) ▪ IDHC: Ponderosa: Dignity & Respect ▪ IMPACT-Michigan: Neglect: II-Failure to Report **-May 2025: Fourteen (14) Violations Established:** ▪ Autism Systems-Marysville: Abuse: II-Unreasonable Force ▪ Beacon-Cottage: Neglect: III ▪ BWDH: Hayes: Abuse: III ▪ BWDH-Maple: Services Suited to Condition ▪ BWDH-Stonybrook: Services Suited to Condition ▪ BWDH-Thornhill: Services Suited to Condition (1); Dignity & Respect (1) ▪ Community Enterprises: Neglect: III ▪ IHDC: Lincoln: Civil Rights ▪ IHDC: Roehl: Services Suited to Condition (1); Dignity & Respect (1) ▪ Life Skills: Bright Futures: Neglect: III ▪ Port of Hopes: Services Suited to Condition ▪ SCCCMH: Children: Freedom of Movement **June 2025: Ten (10) Violations Established (14 Pending):** ▪ BWAT: Dignity & Respect ▪ Community Enterprises: Neglect: III ▪ Creative Employment Opportunities: Neglect: III ▪ IMPACT: Wells: Services Suited to Condition (1); Abuse: III (1) ▪ IHDC: Vine: Dignity & Respect ▪ IHDC: Ravenswood: Neglect: III ▪ IHDC: Stone Creek: Services Suited to Condition ▪ SCCCMH: MC: Services Suited to Condition ▪ SCCCMH: Physicians: Dignity & Respect **FY2025: Q4: July 1, 2025 – September 30, 2025** **a. Substantiated Violations = 37 Total** **-July 2025: Fourteen (14) Violations Established:** ▪ Autism Systems-Keewahdin: Dignity & Respect ▪ Beacon: The Cottage: Dignity & Respect ▪ BWDH: Stonybrook: Services Suited to Condition (2) ▪ IMPACT: Charmwood: Services Suited to Condition ▪ IMPACT: River Bend I: Services Suited to Condition (2) ▪ IMPACT: River Bend II: Abuse: III ▪ IMPACT: River Bend II: Neglect: III ▪ IMPACT: River Bend II: Religious ▪ IHDC: Abbottsford: Neglect III ▪ SCCCMH: Children's: Confidentiality ▪ SCCCMH: Clerical: Confidentiality ▪ SCCCMH: Transportation: Neglect: III

Reference	Recipient Rights-Sandy O'Neill Priority Goals/Key Tasks	FY2025 TIMELINE-STATUS
		-August 2025: Fourteen (14) Violations Established: ▪ AVID ABA: Confidentiality ▪ BWDH: Hayes: Dignity & Respect ▪ BWDH: Hayes: Neglect: III: Failure to Report ▪ BWDH: Oakleaf: Confidentiality ▪ Community Living Network: Confidentiality ▪ Creative Employment Opportunities: Dignity & Respect ▪ IHDC: Hancock: Abuse: II-Emotional Harm ▪ IHDC: Hancock: Abuse: III (2) ▪ IHDC: Hancock: Dignity & Respect ▪ IHDC: Ponderosa: Services Suited to Condition ▪ IHDC: Roehl: Services Suited to Condition ▪ Life Skills: Blue Water Choices: Services Suited to Condition ▪ SCCCMH: Mobile Crisis Unit: Services Suited to Condition **-September 2025: Nine (9) Violations Established:** ▪ BWDH: Supported: Photographs ▪ BWDH: Supported: Abuse: II – Exploitation ▪ BDHW: Hayes: Abuse: II –Unreasonable Force ▪ BWDH: Oakleaf: Abuse: II- Unreasonable Force ▪ BWDH: Oakleaf: Neglect: III ▪ BWDH: Oakleaf: Services Suited to Condition ▪ IMPACT: Belle River: Services Suited to Condition ▪ IMPACT: Wells: Abuse: III ▪ Professional Counseling Center: Family Rights
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.	**FY2025 Q1: October 1, 2024 – December 31, 2024** a. Site visits completed this quarter: 23 Total **FY2025: Q2: January 1, 2025 – March 31, 2025** a. Site visits completed this quarter: 60 Total **FY2025: Q3: April 1, 2025 – June 30, 2025** a. Site visits completed this quarter: 24 Total **FY2025: Q4: July 1, 2025 – September 30, 2025** a. Site visits completed this quarter: 18 Total
Strategic Plan Organizational Efficiency	**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 Chief Clinical Officer/Designee within 3 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)	**FY2025 Q1: October 1, 2024 – December 31, 2024** a. Incident Reports Reviewed: **877 Total** b. **Critical Incidents:** ▪ Deaths: Suicide: 0 ▪ Deaths: Natural Causes: 14 ▪ EMT d/t Injuries/Medication Errors: 4 ▪ Hospitalizations d/t Injuries/Medication Errors: 0 ▪ Arrests: 4

Reference	Recipient Rights-Sandy O'Neill Priority Goals/Key Tasks	FY2025 TIMELINE-STATUS
	d. Identify potential Risk Events per MDHHS established guidelines.	c. **Event Reporting:** ▪ October 2024: Submitted on 11/13/2024. ▪ November 2024: Submitted on 12/12/2024. ▪ December 2024: Submitted on 01/15/2025. d. **Risk Events:** ▪ Harm to Self w/ EMT/Hospitalization: 5 ▪ Harm to Others w/ EMT/Hospitalization: 0 ▪ Police Calls by Mental Health Staff: 28 ▪ Physical Management: 11 ▪ Hospitalizations (Unscheduled Medical): 16 **FY2025: Q2: January 1, 2025 – March 31, 2025** a. Incident Reports Reviewed: **926 Total** b. **Critical Incidents:** ▪ Deaths: Suicide: 0 ▪ Deaths: Natural Causes: 8 ▪ EMT d/t Injuries/Medication Errors: 9 ▪ Hospitalizations d/t Injuries/Medication Errors: 0 ▪ Arrests: 3 c. **Event Reporting:** ▪ January 2025: Submitted on 02/11/2025. ▪ February 2025: Submitted on 03/13/2025. ▪ March 2025: Submitted on 04/11/2025. d. **Risk Events:** ▪ Harm to Self w/ EMT/Hospitalization: 1 ▪ Harm to Others w/ EMT/Hospitalization: 1 ▪ Police Calls by Mental Health Staff: 72 ▪ Physical Management: 15 ▪ Hospitalizations (Unscheduled Medical): 8 **FY2025: Q3: April 1, 2025 – June 30, 2025** a. Incident Reports Reviewed: **1146 Total** b. **Critical Incidents:** ▪ Deaths: Suicide: 0 ▪ Deaths: Natural Causes: 10 ▪ EMT d/t Injuries/Medication Errors: 19 ▪ Hospitalizations d/t Injuries/Medication Errors: 0 ▪ Arrests: 2 c. **Event Reporting:** ▪ April 2025: Submitted on 0513/2025. ▪ May 2025: Submitted on 06/10/2025. ▪ June 2025: Submitted on 07/10/2025.

Reference	Recipient Rights-Sandy O'Neill Priority Goals/Key Tasks	FY2025 TIMELINE-STATUS
		d. **Risk Events:** ▪ Harm to Self w/ EMT/Hospitalization: 5 ▪ Harm to Others w/ EMT/Hospitalization: 3 ▪ Police Calls by Mental Health Staff: 74 ▪ Physical Management: 8 ▪ Hospitalizations (Unscheduled Medical): 16 **FY2025: Q4: July 1, 2025 – September 30, 2025** a. Incident Reports Reviewed: **1099 total** b. **Critical Incidents:** ▪ Deaths: 9 ▪ EMT d/t Injuries/Medication Errors: 5 ▪ Hospitalizations d/t Injuries/Medication Errors: 0 ▪ Arrests: 4 c. **Event Reporting:** ▪ July 2025: Submitted on August 15, 2025 ▪ August 2025: Submitted on September 9, 2025 ▪ September 2025: Submitted on October 15, 2025 d. **Risk Events:** ▪ Harm to Self w/ EMT/Hospitalization: 0 ▪ Harm to Others w/ EMT/Hospitalization: 0 ▪ Police Calls by Mental Health Staff: 33 ▪ Physical Management: 4 ▪ Hospitalizations (Unscheduled Medical): 26
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.	**FY2025 Q1: October 1, 2024 – December 31, 2024** a. During the reporting period, the ORR reviewed four (4) policies and administrative procedures. **FY2025: Q2: January 1, 2025 – March 31, 2025** a. During the reporting period, the ORR reviewed six (6) policies and administrative procedures. **FY2025: Q3: April 1, 2025 – June 30, 2025** a. During the reporting period, the ORR reviewed six (9) policies and administrative procedures. **FY2025: Q4: July 1, 2025 – September 30, 2025** a. During the reporting period, the ORR reviewed four (4) policies and administrative procedures.

Reference	Recipient Rights-Sandy O'Neill Priority Goals/Key Tasks	FY2025 TIMELINE-STATUS
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 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 member/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/online Recipient Rights Refresher training on an annual basis. i. Provide in-person Recipient Rights Refresher training at least two times per month or ensure online training is accessible through MyLearningPointe or the SCCCMH website. ii. Report the number of staff trained. 1. Direct-Operated staff members/volunteers 2. Contract System staff members/volunteers	**FY2025 Q1: October 1, 2024 – December 31, 2024** **a. New Hire Training Data:** **i. Trainings Provided:** Six (6) trainings provided this quarter: Six (6) in person. **ii. Staff Trained within 30 Days of Hire:** 127/137 employees trained within 30 days of hire (93%) **1. Direct-Operated Employees:** 9/9 employees trained within 30 days of hire (100%) **2. Contract Provider Employees:** 118/128 employees trained within 30 days of hire (92%) **b. Annual Refresher Training Data:** **i. Trainings Provided:** All trainings were provided through online/electronic manual methods (Direct-Operated employees through MyLearning Pointe; Contract Provider employees through electronic manual/test). **ii. Employees Trained:** 402 total **1. Direct-Operated Employees:** 9 employees this quarter. **2. Contract Provider Employees:** 393 employees this quarter. **FY2025: Q2: January 1, 2025 – March 31, 2025** **a. New Hire Training Data:** **i. Trainings Provided:** Six (6) trainings provided this quarter: Six (6) in person. **ii. Staff Trained within 30 Days of Hire:** 107/112 employees trained within 30 days of hire (96%) **1. Direct-Operated Employees:** 4/4 employees trained within 30 days of hire (100%) **2. Contract Provider Employees:** 103/108 employees trained within 30 days of hire (95%) **b. Annual Refresher Training Data:** **i. Trainings Provided:** All trainings were provided through online/electronic manual methods (Direct-Operated employees through MyLearning Pointe; Contract Provider employees through electronic manual/test). **ii. Employees Trained:** 594 Total **1. Direct-Operated Employees:** 375 employees this quarter. **2. Contract Provider Employees:** 219 employees this quarter.

Reference	Recipient Rights-Sandy O'Neill Priority Goals/Key Tasks	FY2025 TIMELINE-STATUS
		FY2025: Q3: April 1, 2025 – June 30, 2025 **a. New Hire Training Data:** **i. Trainings Provided:** Six (6) trainings provided this quarter: Six (6) in person. **ii. Staff Trained within 30 Days of Hire:** 124/128 employees trained within 30 days of hire (97%) **1. Direct-Operated Employees:** 8/8 employees trained within 30 days of hire (100%) **2. Contract Provider Employees:** 116/120 employees trained within 30 days of hire (97%) **b. Annual Refresher Training Data:** **i. Trainings Provided:** Most all trainings were provided through online/electronic manual methods (Direct-Operated employees through MyLearning Pointe; Contract Provider employees through electronic manual/test). Some trainings were conducted face to face as requested by the contract agency. **ii. Employees Trained:** 223 Total **1. Direct-Operated Employees:** 56 employees this quarter. **2. Contract Provider Employees:** 167 employees this quarter. 23 in-person; 144 electronically **FY2025: Q4: July 1, 2025 – September 30, 2025** **a. New Hire Training Data:** a. **Trainings Provided:** Six (6) trainings provided this quarter, Six (6) in-person b. **Staff Trained within 30 Days of Hire:** 146/159 employees trained within 30 days of hire (92%) **1. Direct-Operated Employees:** 20/20 employees trained within 30 days of hire (100%) **2. Contract Provider Employees:** 126/139 employees trained within 30 days of hire (91%) **b. Annual Refresher Training Data:** **i. Trainings Provided:** Most all trainings were provided through online/electronic manual methods (Direct-Operated employees through MyLearning Pointe; Contract Provider employees through electronic manual/test). Some trainings were conducted face to face as requested by the contract agency. **ii. Employees Trained:** 366 Total

Reference	Recipient Rights-Sandy O'Neill Priority Goals/Key Tasks	FY2025 TIMELINE-STATUS
		3. **Direct-Operated Employees:** 10 employees this quarter. 4. **Contract Provider Employees:** 356 employees this quarter. 23 in-person; 333 electronically
Good Clinical Practice	7. **MONITORING & OVERSIGHT: BTPRC** Conduct quarterly oversight of the Behavior Treatment Plan Review Committee's (BTPRC) activities with the use of the Quarterly Risk Events Analysis Report. a. Emergency use of Physical Management tracking. b. Systems Improvements identified at BTPRC to provide additional training opportunities for staff and/or opportunities to reduce risk factors for individuals served.	**FY2025 Q1: October 1, 2024 – December 31, 2024** **Quarterly Risk Events Analysis Report** a. Emergency use of Physical Management: **11 incidents** b. System Improvement Recommendations: i. Employees receive training, per the SCCCMH Training Grid, and as needed, in motivational interviewing, positive behavior supports, and the individual-specific interventions established by each recipient's Individual Plan of Service to support the mental health needs of the individuals served by SCCCMH. 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 SCCCMH. **FY2025: Q2: January 1, 2025 – March 31, 2025** **Quarterly Risk Events Analysis Report** a. Emergency Use of Physical Management: **15 incidents** b. System Improvement Recommendations: i. Employees receive training, per the SCCCMH Training Grid, and as needed, in motivational interviewing, positive behavior supports, and the individual-specific interventions established by each recipient's Individual Plan of Service to support the mental health needs of the individuals served by SCCCMH. 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 SCCCMH. **FY2025: Q3: April 1, 2025 – June 30, 2025** **Quarterly Risk Events Analysis Report** a. Emergency Use of Physical Management: **8 incidents** b. System Improvement Recommendations: i. Employees receive training, per the SCCCMH Training Grid, and as needed, in motivational interviewing, positive behavior supports, and the individual-specific interventions established by each recipient's Individual Plan of Service to support the mental health needs of the individuals served by SCCCMH. 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 SCCCMH.

Reference	Recipient Rights-Sandy O'Neill Priority Goals/Key Tasks	FY2025 TIMELINE-STATUS
		FY2025: Q4: July 1, 2025 – September 30, 2025 **Quarterly Risk Events Analysis Report** a. Emergency Use of Physical Management: **4 incidents** b. System Improvement Recommendations: i. Employees receive training, per the SCCCMH Training Grid, and as needed, in motivational interviewing, positive behavior supports, and the individual-specific interventions established by each recipient's Individual Plan of Service to support the mental health needs of the individuals served by SCCCMH. 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 SCCCMH.

<table>
<tr><th>Reference</th><th>System Improvement-Denise Choiniere & Michelle Measel-Morris
PRIORITY GOALS/KEY TASKS</th><th>FY2025 TIMELINE-STATUS</th></tr>
<tr><td></td><td>1. Maintain agency accreditation.</td><td><u>CARF:</u> The next CARF review will be in early 2026 (January/February). The current accreditation is for 3 years (maximum amount). Preparation has begun.</td></tr>
<tr><td>Regulatory Requirement</td><td>2. Ensure compliance with applicable Corrective Action Plans (e.g., Region 10 PIHP, MDHHS, HSAG, etc.)</td><td><u>MDHHS:</u> MDHHS has accepted SCCCMH's Corrective Action Plan (CAP). Next review is in 2026.</td></tr>
<tr><td>MDHHS

Strategic Plan Organizational Efficiency #1</td><td>3. Monitor performance of each location through program performance indicators (PIs).</td><td><u>PIs (Local):</u> FY2025 4Q Program Performance Indicators (Local PIs) are in the process of being completed. The FY2025 Quality Improvement Plan Annual Report will go to the board in November as well as the FY2026 Quality Improvement Program Plan.</td></tr>
<tr><td>MDHHS

CARF

Strategic Plan Organizational Efficiency #1</td><td>4. Achieve overall satisfaction through annual surveys:
a. Customer Experience
b. Provider Satisfaction
c. Post-Discharge
d. Prescriber Satisfaction
e. NCI Project</td><td>a. <u>Customer Experience</u> (Customer Satisfaction/Accessibility to Services): The FY2025 Customer Experience Summary Report has been completed and reviewed by the Advisory Council it will go to the board in November.
b. <u>Provider Satisfaction:</u> Survey has been completed and the report presented at the SCCCMH Board Meeting.
c. <u>Post-Discharge:</u> FY25 survey is ongoing on a monthly basis.
d. <u>Prescriber Satisfaction:</u> Administered from 1/6/25-1/17/25. Survey report was completed and provided to the Leadership Team for review.
e. <u>NCI Project:</u> The NCI Project for FY2025-2026 has been forwarded and QI will begin the process this week.</td></tr>
<tr><td>HHS
P.6.5.1.1</td><td>5. Monitor performance on the following MDHHS Performance Indicators (MA/GF and MA only).
a. <u>PI 1: Access: Timeliness:</u> 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).

b. <u>PI 2: Access: Timeliness:</u> 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.
(Standard: 50th percentile, 57% or 75th percentile, 62%)

c. <u>PI 3. Access: Timeliness:</u> Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergency face-to-face assessment with a professional.
(Standard: 50th percentile, 72.9% or 75th percentile, 62%)

d. <u>PI 4a. Access: Continuity of Care:</u> The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up within 7 days.
(Standard 95%)</td><td>
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%)
<table>
<tr><th>Quarter</th><th></th><th>Child</th><th>Adult</th><th>Total</th></tr>
<tr><td rowspan="2">Q4-FY24</td><td>CMHSP</td><td>98.53%</td><td>96.26%</td><td>96.81%</td></tr>
<tr><td>Medicaid</td><td>98.51%</td><td>96.97%</td><td>97.36%</td></tr>
<tr><td rowspan="2">Q1-FY25</td><td>CMHSP</td><td>95.19%</td><td>91.15%</td><td>94.42%</td></tr>
<tr><td>Medicaid</td><td>95.15%</td><td>91.63%</td><td>92.77%</td></tr>
<tr><td rowspan="2">Q2-FY25</td><td>CMHSP</td><td>95.19%</td><td>91.15%</td><td>92.42%</td></tr>
<tr><td>Medicaid</td><td>95.15%</td><td>91.63%</td><td>92.77%</td></tr>
<tr><td rowspan="2">Q3-FY25</td><td>CMHSP</td><td>98.81%</td><td>92.24%</td><td>93.99%</td></tr>
<tr><td>Medicaid</td><td>98.78%</td><td>92.00%</td><td>93.81%</td></tr>
</table>
PI 2) 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%)
<table>
<tr><th>Quarter</th><th></th><th>Child MI</th><th>Adult MI</th><th>Child DD</th><th>Adult DD</th><th>Total</th></tr>
<tr><td rowspan="2">Q4-FY24</td><td>CMHSP</td><td>77.30%</td><td>70.62%</td><td>64.62%</td><td>84.00%</td><td>72.05%</td></tr>
<tr><td>Medicaid</td><td>79.04%</td><td>72.49%</td><td>66.67%</td><td>82.61%</td><td>73.92%</td></tr>
<tr><td rowspan="2">Q1-FY25</td><td>CMHSP</td><td>65.67%</td><td>60.92%</td><td>69.64%</td><td>56.67%</td><td>62.55%</td></tr>
<tr><td>Medicaid</td><td>64.16%</td><td>59.71%</td><td>67.31%</td><td>59.26%</td><td>61.46%</td></tr>
<tr><td rowspan="2">Q2-FY25</td><td>CMHSP</td><td>65.67%</td><td>60.92%</td><td>69.64%</td><td>56.67%</td><td>62.55%</td></tr>
<tr><td>Medicaid</td><td>64.16%</td><td>59.71%</td><td>67.31%</td><td>59.26%</td><td>61.46%</td></tr>
<tr><td rowspan="2">Q3-FY25</td><td>CMHSP</td><td>78.77%</td><td>74.73%</td><td>81.36%</td><td>80.00%</td><td>76.34%</td></tr>
<tr><td>Medicaid</td><td>78.29%</td><td>74.49%</td><td>80.70%</td><td>80.49%</td><td>76.20%</td></tr>
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Reference	System Improvement-Denise Choiniere & Michelle Measel-Morris PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
	e. **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%)	**PI 3)** Percentage of new person during the quarter starting any medical necessary on-going covered services within 14 days of completing a non-emergent biopsychosocial assessment. *(Standard: 50th Percentile 72.9%, 75th Percentile 83.3%)*

Quarter		Child MI	Adult MI	Child DD	Adult DD	Total
Q4-FY24	CMHSP	73.13%	60.00%	70.91%	70.83%	**64.42%**
	Medicaid	73.10%	62.72%	70.91%	72.73%	**66.55%**
Q1-FY25	CMHSP	64.60%	65.46%	77.55%	63.64%	**66.13%**
	Medicaid	65.69%	66.12%	80.00%	61.90%	**67.06%**
Q2-FY25	CMHSP	64.60%	65.46%	77.55%	63.64%	**66.13%**
	Medicaid	65.69%	66.12%	80.00%	61.90%	**67.06%**
Q3-FY25	CMHSP	74.68%	64.44%	73.08%	83.78%	**68.44%**
	Medicaid	77.04%	64.09%	76.00%	85.71%	**69.42%**

PI 4) The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up within seven (7) days. *(Standard: 95%)*

Quarter		Child	Adult	Total
Q4-FY24	CMHSP	100%	95.77%	**96.67%**
	Medicaid	100%	95.59%	**96.55%**
Q1-FY25	CMHSP	100%	97.50%	**98.10%**
	Medicaid	100%	97.33%	**98.02%**
Q2-FY25	CMHSP	100%	97.50%	**98.10%**
	Medicaid	100%	97.33%	**98.00%**
Q3-FY25	CMHSP	100%	97.94%	**98.32%**
	Medicaid	100%	97.92%	**98.31%**

PI 10) The percentage of readmissions of child and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. *(Standard ≤ 15%)*

Quarter		Child	Adult	Total
Q4-FY24	CMHSP	8.70%	15.97%	**14.79%**
	Medicaid	8.70%	16.52%	**15.22%**
Q1-FY25	CMHSP	6.90%	15.08%	**13.55%**
	Medicaid	6.67%	15.00%	**13.33%**
Q2-FY25	CMHSP	6.90%	15.08%	**13.55%**
	Medicaid	6.90%	14.88%	**13.33%**
Q3-FY25	CMHSP	7.69%	14.50%	**13.38%**
	Medicaid	7.69%	14.84%	**13.64%**

Quality Initiatives	**6. Fidelity Reviews:** a. ACT b. DBT c. IDDT d. Employment Services e. LOCUS Assessment	a. ACT: completed in-person on 9/5/2024. b. DBT: completed in-person on 11/13/2024. c. IDDT: completed in-person on 8/18/2025. d. Employment Services: completed in-person on 4/28/2025-4/29/2025 e. LOCUS Assessment: TBD

Reference	System Improvement-Denise Choiniere & Michelle Measel-Morris PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
Quality Initiatives	**7. Quality Initiatives:** a. Implement technology to improve patient access and quality of service. b. Establish routine reports and set up report automation. c. Audit of database (i.e., identifying data errors that occur in our system and implement corrective actions). d. Provide support to assist in special projects.	a. Working with PCE on Clinical Workflows. Project will end in 2026. b. Analysts have streamlined multiple programs and financial reports. Ongoing c. In progress - many updates made 10/1. d. Contract Monitoring PIHP – completed for the year.
Region 10 Contract Requirements	**8. Enhance Dashboard Indicators and other data mining capabilities that facilitates population management/analysis.** a. Utilize CC360 or other population analytics. b. Utilize Dashboard for Quality Improvement Projects c. Monitor CCBHC metrics monthly.	a. In progress b. Multiple dashboards created for programs & Fidelity Reviews c. Multiple dashboards created for programs, CCBHC, and metrics.
CCBHC	**9. Review and monitor the CCBHC Report at least quarterly.**	**CCBHC:** PCE updated OASIS for I-Serve Measure. FY25 CCBHC measures completed.
Strategic Plan Organizational Efficiency #1	**10. Support administrative and clerical workflows and agencies processes to maximize time, resources, and improve performance.**	**Support:** Clinical Workflows 5/19 meeting with PCE, meeting with MEND and Eleos, scheduled 4/30/2025. On-going biweekly meetings with Mend/Eleos. Planned updates on-going.
Good Clinical Practice	**11. To participate in the Region 10 PIHP QAPIP Performance Improvement Projects.** a. Hospital Follow Up b. Racial/Ethnic Disparities	a. Submitted quarterly by Adult Service Director b. Submitted quarterly by Adult Service Director
MDHHS Audit Requirement	**12. To participate in the MDHHS Quality Improvement Project for HSW, CWP, and SEDW.** a. Staff training compliance b. Service provision compliance	a. Quarterly reviews b. CAP submitted, MDHHS approved. c. Audits will now be on an annual schedule.

Reference	Information Technology-Dann Hayes PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
Good Administrative Practice	**1. Continuous Improvement of Customer Service:** Disaster Recovery Preparedness (45 CFR 164.308). a. Review IT Department Written Plan to ensure it addresses ongoing software/hardware solutions and process changes. b. Complete annual simulated Disaster Recovery Test and implement corrective actions and/or compensating controls, where appropriate. i. Electric Avenue ii. Marine City iii. Capac iv. Children's c. Complete HIPAA Risk Assessment and develop/implement plan (45 CFR 164).	a. The IT Department DR plan was completed in April. b. Disaster Recovery Test was completed on Feb 27th. Both the Facilities team and IT team had no major findings or corrections. Only one minor suggestion was added, and that was to include testing our new Agency Text-alert system while also performing this exercise.
Good Administrative Practice	**2. Promote Efficient Use of Existing Technology:** Replace/Upgrade hardware related to IT Equipment Replacement Schedule to remain current with technology and support agreements. a. Upgrade network switches in MDF. **(Completed)** b. Upgrade WIFI infrastructure. c. Replace Lifesize room hardware with equipment that will work with Microsoft Teams. **(Completed)** d. Purchase and roll out 100 replacement laptops.	a. All switches purchased to replace aged Cisco switches in the MDF have been completed as of March 2025. Additional switches were purchased in July due to an opportunity to purchase at nearly half the price for end of Cisco's fiscal year promotion. We took advantage of that and moved our FY26 upgrades for Capac and Broadway up. Both sites were upgraded in September 2025. b. WIFI coverage was reviewed at all locations and additional access points were purchased where necessary to provide better coverage. We also repositioned a few existing access points to provide better overall coverage. c. All Lifesize hardware and licensing was replaced by March 31, 2025. All rooms and devices now are leveraging Microsoft Teams. d. All laptops were deployed and are in use by August 5, 2025.
Good Administrative Practice & Strategic Plan Organizational Efficiency #1	**3. Improvement Technology to Increase Operational Efficiency:** a. Implement Microsoft Teams for the Agency. b. Remove Sendio Spam application and replace it with Microsoft Quarantine c. Network Security Assessment (3/31/25) and Remediation of any vulnerabilities found. d. Provide training and implement stronger security strategies pertaining to social engineering, including phishing e. Provide training for staff for Microsoft Teams. f. **Replace Zix email encryption with Microsoft Encryption.**	a. Microsoft Teams was installed and activated on all agency workstations in late 2024. Continued efforts to train and gain efficiencies have been provided by the IT Team through FY 2025. b. Sendio was replaced with the Microsoft Quarantine application in November 2024. Sendio was removed from the network and powered off on January 6, 2025. c. Trace3 completed our Microsoft 365 assessment in April of 2025. Findings were reported to the IT Director at the end of April. The IT Team worked with Trace3 and independently to adjust and address the findings related to better security practices within M365. Endeavor completed a physical social engineering test and a phishing and vishing tests as a part of this Assessment. Staff were given additional online training where necessary. IT Director followed up with recommendations and findings with the Safety Committee. d. The IT Team, utilizing the KnowBe4 platform, continues to test staff as it relates to phishing. After each test we provide mandatory online training modules to all who fail the test. We then provide follow up communication recapping our test and how the agency did as well as reminders of what to do

Reference	Information Technology-Dann Hayes PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
		with suspicious emails and calls. The IT Director also worked with Jennifer Dugger, the Safety Coordinator to educate staff as it relates to safety awareness and unauthorized staff in our buildings. e. Two trainings were provided at the end of December 2024. The trainings were recorded and posted for staff to review. The IT Department also provided training in March for staff regarding the new Teams TV's placed in the conference rooms. Feedback requests of our trainings were sent to all supervisory staff in the hopes of gaining knowledge of what we could do better in terms of future trainings. f. The IT Team has spent time testing and reviewing all configurations related to the removal of ZIX as our encryption provider, and onboarding Microsoft's solution. The team sent communications to staff reminders and documentation in July before finally moving to Microsoft as our quarantine and removing Zix from our network.

Reference	Facilities-James Krzywiecki PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
Good Administrative Practice	1. **Continuous Improvement of Customer Service:** a. Review/revise Department written procedures, as appropriate. b. Complete Annual Simulated Disaster Recovery Test and implement corrective actions/compensating controls, where appropriate; perform periodic testing of generators and emergency lighting at Electric Avenue, Marine City, Children's & Capac offices.	a. Establishing a written punch list for the early morning associates to check building conditions before business hours. (completed and on-going) b. The DR test was completed on Feb 27, 2025, with Facilities assisting the IT Department. The IT Department did the full report.
Good Administrative Practice	2. **Promote Efficient Use of Existing Facilities:** a. Complete comprehensive updates to the Facilities Operations Manual detailing responsibilities, functions, vendor contacts and maintenance/replacement schedule of all CMH facilities for preventative maintenance. b. Develop and maintain a Facilities Procedure Manual, identifying and documenting all "key" tasks in the department; use for staff training and reference. c. Expand upon existing parking lot at King Rd in Marine City. Add asphalt parking lot on CMH owned property.	a. The new Facilities Operational Manual is completed and is a living document to be updated. b. Jim Krzywiecki is working to develop a digital version of the Facilities Procedure Manual that will be more efficient for updating and referencing. Completed and is on the share drive. c. The project was awarded to ML Chartier and should be completed this month. The parking lot lights have been installed. In-Progress waiting for the final walk-through
Good Administrative Practice	3. **Improvements to Increase Operational Efficiency:** a. Monitor and maintain existing CMH facilities. b. Utilize the Kace System (Help Desk) to document and monitor maintenance requests. c. Search, evaluate, and purchase residential property to replace and expand bed capacity. Find a replacement for the current Hopps home (Woodstock). d. Complete renovation and install furniture and appliances at 135 Broadway St. to prepare it for use to host groups and other program initiatives as a second site for CMH in Marine City. (Completed) e. New Transportation room at Electric Avenue. (Completed) f. Capac renovations to increase the number of offices for one-on-one sessions. (Completed) g. IT renovation at Electric Avenue and the addition of more meeting rooms. (Completed) h. Electric Nursing renovations i. CIS classroom new flooring and paint	a. Maintenance has been performed on 18 group homes and 5 commercial buildings. b. No open work orders in the system; all work orders are completed or in progress. c. There is an ongoing search for a 6-bedroom house. Work has begun on the Hopps home with the crawlspace being encapsulation d. The Broadway St. office was finished and is open as of late February 2024. (Completed) e. The addition of a new Transportation office at Electric Avenue has been completed. (Completed) f. Capac renovations to increase the number of offices for one-on-one sessions have been completed. (Completed) g. IT renovations at Electric Avenue and the addition of more meeting rooms have been completed. (Completed) h. Electric Nursing renovation (Completed) i. CIS classroom POs completed and will be scheduling the work. (Completed)

Reference	Utilization Management – Amy Kandell PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
Region 10 Delegation Contract Requirement	1. **Utilization Management Committee:** The UM committee will meet once a quarter to discuss findings, trends, and recommendations from chart record reviews and audits for direct run programs and contract agencies.	**Q4:** Since goal was created, UM committee has met once and will be meeting again in Oct. Trends found for Direct Run Programs were: objectives identify too many target behaviors and are not measurable, the Diagnostic Summary in BPS is not consistently completed correctly, guardianship paperwork is not consistently in the chart, BPSs are missing answers, and templates in BPS and IPOS are not consistently used. ABA staff are not consistently obtaining signatures correctly on documents. **Q3:** This section was updated this quarter.
Good Clinical Practice CARF Recommendation	2. **Utilization Review for Direct Care & Contract Providers:** 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-coordinated services. b. Conduct claims verification associated with clinical case record reviews. Report on claims discrepancies. Identify and address over/underutilization. c. Complete special UM reviews upon request/need. d. Produce and distribute semi-annual reports at minimum.	**Q4:** On going. Currently, there have not been any significant claims discrepancies reported. Staff are reducing over-authorizing services. **Q3:** UM staffing recently changed again. Training new UM staff has been taking place which has slowed down the UM process. Clinical reviews associated with claims verification reviews were completed for 1st Qtr. FY25 and the UM team is currently working on 2nd Qtr. An IPS fidelity review was completed in Qtr. 3. No other special UM reviews were completed however, UM team had to assist with a few Region 10/State audits **Q2:** The UR process has been modified to make it more streamlined and efficient with running reports and reviewing charts. It has almost been a year since the new UM/Authorization process began, implementation date was May 20, 2024. Changes are ongoing as Region 10 and the 3 CMHs finalize the UM/Authorization process. Updates to Reion 10 Authorization Service Grids occur quarterly.
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 on up to 2.5% of Medicaid individuals receiving services through Contract Agencies. a. Complete primary and non-primary case holder reviews which may be concurrent with Contract Management site visits for Residential, CLS, and other community providers. b. Complete annual Medicaid Claims Verification Methodology report.	**Q4:** This is ongoing. UM Team continues to complete quarterly claims verification reviews on primary, non-primary, and ABA providers. A new ABA UM Tool was completed for UM Tech to use during the claims verification reviews. No concurrent reviews with contract management were completed during this quarter. **Q3:** On going. First quarter claims verification for direct run programs, contract agencies, and ABA providers were completed for 1st Qtr. and currently working on 2nd Qtr. Staff changes during 2nd and 3rd Qtr. affected timeliness of audits due to training and job transitions. **Q2:** This section may be updated. The UR process has been modified to make it more streamlined and efficient with running reports and viewing charts. Also, UM recently had staff changes which may impact the amount of claims verifications and URs that will be completed for the next 1-2 quarters.

Reference	Provider Network Management – Kim Prowse PRIORITY GOALS/KEY TASKS	FY2025 TIMELINE-STATUS
Strategic Plan Organizational Efficiency	1. **Ongoing:** Establish and maintain positive working relationships throughout the Provider Network through more enhanced communication efforts, primarily focusing on informal on-site visits in addition to the formal contract monitoring process. a. Report the following numbers for the quarter: i. New/Potential provider site visits (in-person & virtual) participated in for the quarter. ii. Informal visits to existing providers iii. Informal meetings with existing providers where there was a change in the CMH Contract Manager for that agency.	i. New/Potential provider sites visited: N/A ii. Informal visits to existing providers: Beginning starting 1st Quarter FY26 (1 scheduled) iii. Informal visits with existing providers that had a change in CMH Contract Manager: Beginning in 1st Quarter FY26 (1 scheduled)
Strategic Plan Organizational Efficiency	2. **Ongoing:** Timely desk and onsite compliance monitoring for Provider Network Agencies. a. Report the following numbers and/or types for the quarter: i. Agencies that participated in the contract monitoring process. ii. Agencies that met the identified standards (%). iii. Agencies that had corrective action item(s) & follow-up steps taken.	i. Number of agencies that participated in the contract monitoring process: N/A - Monitoring to resume in FY26 ii. Percentage of agencies that met the identified standards: 97% Overall (9 Domains Reviewed – Met / 1 Domain – Partially Met) N/A - Monitoring to resume in FY26 iii. Number of agencies that had corrective action item(s) & follow-up steps taken: N/A - Monitoring to resume in FY26
Strategic Plan Organizational Efficiency	3. **Quarterly:** Provider Contract Monitoring tool revisions. a. Report the following for the quarter: i. Status updates. ii. Significant changes.	i. Significant revisions will begin during FY26, Q1
Strategic Plan Organizational Efficiency	4. **Quarterly:** Implement and/or approve upon an organizational, contract monitoring software systems for contracts. a. Report the following for the quarter: i. Status updates.	i. CMH secured a contract with Contract Safe in FY2025, a new electronic contract management software system. Contract Safe has replaced the previously utilized Cobblestone software. This change has resulted in cost savings to the agency as well as internal efficiencies. During FY25 Q4, the Contract Management Team worked with Contract Safe and Cobblestone representatives to successfully transfer all documents. Contract Safe was utilized in the FY2026 contract development and renewal process as was shown to be successful. More enhanced utilization of the system will be utilized in FY2026.
Strategic Plan Organizational Efficiency	5. **Quarterly:** Seek out software to assist the Contract Management team in a more efficient RFI/RFP process. Primarily focusing on establishing a fully electronic process. a. Report the following for the quarter: i. Status updates.	i. COMPLETED: See #4