Annual Effectiveness Review

FY 2024, Year-to-Date

**West Michigan Community Mental Health**

**August 29, 2024**

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# Introduction

The Annual Quality Measure Performance Analysis provides a summary of performance on key performance measures, including recommendations for improvement. Where applicable, efforts that were made to improve performance are described including whether they were successful, or not.

The purpose of this document is to give an analysis of WM's performance at meeting its most important goals in FY24, in order to inform strategic planning and organizational goal setting for the coming year.

Types of measures:

* Access
* Effectiveness
* Efficiency
* Customer Satisfaction / feedback
* Stakeholder feedback
* Business indicators
* Health and safety

Documentation of the QAPIP annual review, its findings, and recommendations are forwarded to Directors and the Senior Management Team. The annual review may lead to:

* Identification of educational/training needs.
* Establishment and revision of policies and procedures related to quality initiatives.
* Recommendations regarding credentialing of providers.
* Changes in operations to minimize risks in the delivery of quality services.
* Development of objectives for the coming year.

# Executive Summary

## Areas of Strength

* MMBPIS Indicator 4b (Follow up after detox in 7 days).
* LRE Site Review, specifically Chart Review performance.
* Consumer Net Promoter Score continues to be above target.
* Medicaid verification continues to be at 100%.
* CAFAS and PECFAS average change scores were above target.
* Customer Service Activity – timeliness to resolve grievances exceeded target.
* Clinical Services Delivered is exceeding target.
* Project Past Due is exceeding target.
* CCBHC Quality Bonus Payment Measures – WMCMH was the only CCBHC in Michigan to achieve all targets and receive the payment award.

## Suggested Areas for Improvement and Recommendations

### Timeliness to Care (See MMBPIS Indicators 2a, 2b, and 3)

Rationale for selection: performance is continuing to trend downward and is below standard; interventions taken have not resulted in improvement.

Recommendations:

* Work already in progress to improve performance: Real-time monitoring of appointment scheduling; Revise screening and assessment process to facilitate timeliness.
* If performance does not improve in Quarter 1 of FY25, recommend a formal Quality Improvement Project.

### Suicide Attempts

Rationale for selection: Number of suicide attempts has significantly risen each year since FY22.

Recommendation: As part of the Zero Suicide project, develop and implement protocols for individuals at high-risk for suicide.

### Recipient Rights Violations

### Rationale for selection: Target not met for second consecutive year; ratio of abuse and neglect violations has risen since FY23.

Recommendations: Use data to identify risk factors and provide targeted outreach and training for prevention.

# Updates on 2023 Suggested Areas for Improvement

|  |  |
| --- | --- |
| **Recommendation from 2023 Annual Effectiveness Review** | **2024 Year-To-Date Results** |
| Improve performance on timeliness to care (MMBPIS). | Not achieved; recommended area for improvement for FY 2025. New approaches need to be taken to achieve results. |
| Use MHSIP, YSS, and Customer NPS for performance improvement | Developed a work plan to address top areas of concern from these surveys; all recommended action steps are in process or completed. |
| Suicide Attempts and Overdose deaths: continue more in-depth reviews of attempts and deaths; implement Zero Suicide | Both recommendations are in process; attempts continue to rise but suicide deaths continue to be down from FY22. |
| Physical Management and Law Enforcement: Continue to maintain close communication with specialized residential and SIP providers, clearly communicate about reporting requirements, and coordinate closely with the care teams that do home visits in order to minimize the chance of underreporting. | Network team conducted outreach with providers especially those caring for individuals with high frequency of aggressive behaviors; trained providers to reporting requirements, and required plans of correction for failing to meet reporting requirements when needed. |
| Employee Net Promoter Score: Share results of eNPS at all teams, possible focus groups, 360 feedback on supervisors | Results were shared. Many other action steps were taken this year to improve workplace experience, with good results. See FY 2024 performance summary in this document. |
| Clinical Outcomes: identify new clinical outcome indicators and implement | It was determined to continue using the ANSA and CANS as outcome indicators since it is the best data we have at this time. |
| CCBHC quality measures and quality bonus payment measures: develop data reports that drive action and help us meet the standard. For non-quality bonus payment measures, perform an audit on reporting logic to confirm data sources and care processes. Make a decision whether to use measures to drive quality care; use data to drive improvement. | Where possible and helpful, data reports were developed and shared. WMCMH did meet the QBPM targets! The quality measure audit and the decision whether to drive action was delayed but will be addressed as part of a project on organizational metrics. |

# Performance Analysis 2024, YTD

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# MMBPIS Indicator 1

**Data Source:** R3 Data Quality Control, Performance Indicators by Period, WMCMH Affiliate, Reports, CMHSP Total; MMBPIS Workbook

**Description:** Percent ofPreadmission Screenings completed within 3 hours of request.

**Benchmark:** 95%

**Lead:** Betsy Reed-Henry and Kristin Graham

## Performance Summary for FY 2024, YTD

Performance was below standard for children in 1 quarter in the past 4 consecutive quarters. Otherwise, within standard.

## Comparative Analysis

In the past 3 years, WM performed below standard only 1 of 12 consecutive quarters.

## Trends

Performance is continuing to trend back upward after some process changes were made.

## Causes

Causes for out of compliance cases in FY24 included hospital staff not being available to coordinate zoom timely, and not having enough staff between WM and Hospital staff (2 cases came in at the same time and we were unable to accommodate timely).

## Impact of Other Factors

Workforce shortages and increase in crisis has been noted across the board.

## Actions Taken and Their Effectiveness

Clinical staff were trained to report in person rather than use zoom when unable to coordinate with hospital staff, staff were trained to contact secondary staff if primary staff is unable to complete timely, and also trained to be more assertive with hospital staff to get zoom meetings set up timely and document the attempts appropriately.

## Recommendations

Continue monitoring performance and do regular training with individuals who do PAS.

# MMBPIS Indicator 2a

**Data Source:** R3 Data Quality Control, Performance Indicators by Period, WMCMH Affiliate, Reports, CMHSP Total; MMBPIS Workbook

**Description:** MH assessment within 14 days of request for services.

**Benchmark:** Low target (state 50th percentile): 56.39%

High target (state 75th percentile): 62.08%

**Lead:** Betsy Reed-Henry

## Performance Summary for FY 2024, YTD

WM has been below standard for 3 consecutive quarters. Preliminary data for the most recent quarter (FY24, Q3) indicates even lower dip in performance.

## Comparative Analysis

Performance continues to be lower in FY24 than in the previous 3 fiscal years.

## Trends

After an upward trend in Quarters 1-3 in FY23, WM’s performance dropped in Quarter 4 and was below the low standard and continues to be below in Quarters 1-2 in FY24.

## Causes

The most common cause of out of compliance in the past 4 consecutive quarters has been staff scheduling errors. Next most common is Consumer No Show, Client Choice of Date, and Client Reschedule.

## Impact of Other Factors

Workforce shortages on Access team.

## Actions Taken and Their Effectiveness

Drilled into causes with Access leadership and discussed solutions. In attempt to reduce scheduling errors, staff were trained individually and as a group on the indicator requirements. New job aids were created and distributed. So far these interventions have not resulted in improvement.

## Recommendations

Recommend daily monitoring of screenings and assessments to remove scheduling errors as a cause.

# MMBPIS Indicator 2b

**Data Source:** R3 Data Quality Control, Performance Indicators by Period, WMCMH Affiliate, Reports, CMHSP Total; MMBPIS Workbook

**Description:** SUD start of care within 14 days of request.

**Benchmark:** Low target (state 50th percentile): 64.48%

High target (state 75th percentile): 75.97%

**Lead:** Betsy Reed-Henry

## Performance Summary for FY 2024, YTD

Performance was within standard for 2 of the past 4 consecutive quarters.

## Comparative Analysis

Performance is lower than the previous 1-year period.

## Trends

Performance is trending downward.

## Causes

The most common causes of out of compliance were Other, consumer No Shows, Unable to reach, and Client choice of date.

## Impact of Other Factors

Workforce shortage on Access team.

## Actions Taken and Their Effectiveness

Drilled into causes with Access leadership and discussed solutions. In attempt to reduce scheduling errors, staff were trained individually and as a group on the indicator requirements. New job aids were created and distributed. So far these interventions have not resulted in improvement.

## Recommendations

 Recommend daily monitoring of screenings and assessments to remove scheduling errors as a cause.

# MMBPIS Indicator 3

**Data Source:** R3 Data Quality Control, Performance Indicators by Period, WMCMH Affiliate, Reports, CMHSP Total; MMBPIS Workbook

**Description:** MHStart of care within 14 days of assessment.

**Benchmark:** Low target (state 50th percentile): 72.85%

High target (state 75th percentile): 84.66%

**Lead:** Betsy Reed-Henry

## Performance Summary for FY 2024, YTD

WM was below standard for 3 of the past 4 consecutive quarters.

## Comparative Analysis

Performance is lower than the 1 year prior.

## Trends

Performance seems to be steadily on a downward trend.

## Causes

The most frequent cause of out of compliance were consumer no shows, Client reschedule, Client cancel, and staff scheduling errors.

## Impact of Other Factors

Staffing shortages mean that there are fewer appointment times available.

## Actions Taken and Their Effectiveness

Drilled into causes with Access and CSP leadership and discussed solutions. Staff were trained individually and as a group on the indicator requirements. New job aids were created and distributed. So far these interventions have not resulted in improved performance.

## Recommendations

Recommendations include implementation of new scheduling procedures for CSPs, new no-show, cancellation, reschedule reach-out procedures, and ensuring all staff who schedule these are aware of the indicator and reschedule timely and document reasons if not.

# MMBPIS Indicator 4a

**Data Source:** R3 Data Quality Control, Performance Indicators by Period, WMCMH Affiliate, Reports, CMHSP Total

**Description:** Percent of MH inpatient discharges receiving follow up service by a professional in 7 days

**Benchmark:** 95%

**Lead:** Betsy Reed-Henry

## Performance Summary for FY 2024, YTD

Performance is reported for two populations, adults and children. In the past 4 consecutive quarters, WM missed the standard 3 of out 4 quarters.

## Comparative Analysis

Performance was trending upward compared to FY23 but dropped back down in quarter 2 FY24.

## Trends

In FY20 and FY21, performance was at 100% for 7 out of 8 quarters. Since then, performance has gone up and down, with the last year being the lowest overall.

## Causes

Most common cause of exception is consumer no show. Most common cause of out of compliance is staff errors in scheduling and lack of coordination from hospitals for discharge planning.

## Impact of Other Factors

Many of the staff who made scheduling errors were newer in their roles and were not familiar with the procedures to schedule timely aftercare. In several cases, the hospitals discharged the person 1 day early making the scheduled appointment too late. Also noted that because the number of discharges is small, 1 or 2 cases can make us out of compliance.

## Actions Taken and Their Effectiveness

Trained clinical teams on procedures to schedule timely. Several teams implemented tracking mechanisms that they review at huddle to track consumers who are in the hospital and discharge follow-up plans. The LRE was tasked with reaching out to hospitals about discharge practices.

## Recommendations

Continue providing regular training to staff who provide follow-up care. Jail Liaison position should help by concentrating this work into one person.

# MMBPIS Indicator 4b

**Data Source:** R3 Data Quality Control, Performance Indicators by Period, WMCMH Affiliate, Reports, CMHSP Total

**Description:** Percent of SUD detox discharges receiving follow up service within 7 days.

**Benchmark:** 95%

**Lead:** Betsy Reed-Henry

## Performance Summary for FY 2024, YTD

In the past 4 consecutive quarters, WMCMH exceeded the standard in 3out of 4 quarters.

## Comparative Analysis

Performance is lower than in the previous 1-year period.

## Trends

Performance has been 100% for the past 3 quarters.

## Causes

WM exceeded standard with 100%. No causes to list for out of compliance at this time.

## Impact of Other Factors

N/A

## Actions Taken and Their Effectiveness

SUD provider was given a written communication about discharge documentation and WM Access staff were trained on looking at recent treatment episodes and offering SUD follow up care to recent discharges.

## Recommendations

Recommend that WM continue to train Access team on MMBPIS indicators, including 4b, and send regular communications to SUD providers on how to document consumer choice of no services at discharge.

# MMBPIS Indicator 10

**Data Source:** Data source: R3 Data Quality Control, Performance Indicators by Period, WMCMH Affiliate, Reports, CMHSP Total

**Description:** Percent of MH inpatient discharges followed by readmission in 30 days or less.

**Benchmark:** 15% or less

**Lead:** Betsy Reed-Henry

## Performance Summary for FY 2024, YTD

Performance is reported for two populations, adults and children. Quarter 1 WMCMH was outside standard for children but was within standard for adults. Quarter 2 children was below standard and within standard for adults.

## Comparative Analysis

Performance seems to be poorer in the most recent 4 quarters than in the previous 1-year period.

## Trends

Trending upward (poorer performance).

## Causes

There are multiple causes for readmission. Teams cite more complexity of cases and higher needs.

## Impact of Other Factors

It’s possible that quality of inpatient care is a factor as well.

## Actions Taken and Their Effectiveness

Each readmission case is reviewed to determine if there was anything the care team could have done to prevent the need for readmission.

## Recommendations

It is recommended that teams continue to review readmission cases in order to learn causes and possibly prevent recurrence.

# LRE Site Review

**Data Source:** LRE reports

**Benchmark:** None

**Description:** Annual review of clinical charts, and staff training and credentialing records; biannual review of policy and procedures.

**Lead:** Betsy Reed-Henry

## Performance Summary for FY 2024, YTD

The 2024 LRE Site Visit included a desk audit, staff training and credentialing review, and clinical chart review.

Desk Audit and Program Specific Audit:

Overall compliance: not reported in aggregate.

Most common citations were:

|  |  |
| --- | --- |
| **Desk Audit and Programs and Services Citation Type** | **Count of Citations** |
| Person centered planning policy | 16 |
| Provider Network policies and procedures | 8 |
| Financial policies and procedures | 6 |
| CSS Program Plan and policy revision | 4 |
| Utilization Management plan | 3 |
| Work to expand provider network  | 3 |
| Trauma policy | 2 |
| Other policy changes | 2 |

Staff Training and Credentialing:

Overall compliance: 90.5%

Most common citations were:

|  |  |
| --- | --- |
| **Staff training and credentialing citations** | **Count of citations** |
| Trainings missing or not timely (new ABA provider staff) | 18 |
| Trainings missing or not timely (contract provider staff) | 10 |
| Credentialing process (contract provider) | 7 |
| Credentialing process (new ABA provider staff) | 3 |
| Missing proof of supervision (ABA tech) | 3 |
| Criminal background checks (New ABA provider staff) | 2 |
| IPOS training documentation (new ABA provider) | 2 |

Clinical Chart Reviews:

Overall compliance: 96.2%

Most common citations were:

|  |  |
| --- | --- |
| **Chart Review Citation Type** | **Count of Citations** |
| IPOS meets requirements | 22 |
| CLS Progress notes - residential provider | 10 |
| Services not provided in amount, scope, duration authorized | 9 |
| CELSS Team progress notes - WMCMH | 7 |
| IPOS Training | 7 |
| Autism variance | 3 |
| Periodic Reviews timely and complete | 3 |
| Autism Progress notes: Advisacare (Rebound) | 2 |
| Copy of SD Budget and Agreement in Chart | 2 |
| IPOS addendum to add new services | 2 |
| Pre-Plans meet requirements | 2 |

## Comparative Analysis

Desk audit and program specific were last audited in 2022, and most areas declined in compliance since then. Staff training and credentialing performance improved over last year in some areas, and declined in others. Chart review results improved for all populations except MI Adult.

## Trends

Performance is trending towards improvement for Clinical Chart review, is fairly steady for training and credentialing, and is down for desk audit.

## Causes

See areas most commonly cited.

## Impact of Other Factors

The LRE Audit team interpreted some desk audit standards differently in 2024 than they did in 2022, i.e. proofs that were previously accepted were not accepted this time. Provider training compliance was similarly low, however quite a few training proofs were present just not provided in time for the audit.

## Actions Taken and Their Effectiveness

All corrective action plans from FY23 were completed timely.

## Recommendations

The Quality Records Review process started in FY24 focuses on areas of lower performance in the clinical chart review. Recommend a better process of gathering training provider proofs prior to audit. Recommend that remaining desk audit corrective actions are completed.

# Consumer Net Promoter Score

**Data Source:** Customer Engagement Team Records

**Description:** Brief customer satisfaction survey

**Benchmark:** Score of 30 or higher; 100 or more responses per month.

**Lead:** Jodi Garrow

## Performance Summary for FY 2024, YTD

Performance continues to trend in the excellent range.

## Comparative Analysis

While within standard, performance is slightly higher than previous years. There was an increase in the number of surveys being completed.

## Trends

Consumers continue to share satisfaction overall.

## Causes

Identified causes for dissatisfaction were communication, access to services, and staff turnover.

## Impact of Other Factors

Staff shortages and lack of training are factors contributing to dissatisfaction.

## Actions Taken and Their Effectiveness

No corrective action needed as score remained in the “excellent” range entire fiscal year.

## Recommendations

Continue to monitor performance. Pareto consumer concerns and identify plan to address.

##



# MHSIP and YSS

**Data Source:** Customer Engagement Team Records

**Description:** Comprehensive Customer Satisfaction Survey

**Benchmark:** To be determined

**Lead:** Jodi Garrow

## Performance Summary for FY 2024, YTD

No data yet for FY24 (survey is being administered in August 2024).

## Comparative Analysis

N/A

## Trends

N/A

## Causes

N/A

## Impact of Other Factors

N/A

## Actions Taken and Their Effectiveness

N/A

## Recommendations

N/A

# Provider Net Promoter Score

**Data Source:** Provider NPS Survey

**Description:** Brief feedback and input survey for contracted service providers, requesting input on relationship with WMCMH.

**Benchmark:** Score of 24 or higher

**Lead:** Michele Condit

## Performance Summary for FY 2024, YTD

WMCMH performance was above the target for Q1 and dropped below target for Q2 and Q3 but still remains in the excellent range.

## Comparative Analysis

In the previous FY, WMCMHS’ performance on the NPS survey remained steadily over target, FY24 started well but seems to be declining.

## Trends

Performance has improved since the previous fiscal year for Q1. Performance has remained below the target for the rest of FY24.

## Causes

While performance has been in the excellent range, just not above target, common feedback received from contract providers who complete the NPS survey is that communication between contract providers and WMCMH is an opportunity for improvement. WMCMH continues to work on improving communication with contract providers. Contract providers also would like to see an easier accessible system for information.

## Impact of Other Factors

N/A

## Actions Taken and Their Effectiveness

See note above under “Causes.” In addition to the information noted above, WMCMH has begun to share NPS results with the Stakeholders group at their quarterly meetings along with actions taken to address concerns. In addition to reviewing the results of the survey at the meeting, we also create an opportunity at each meeting to gather feedback from providers regarding any improvements needed.

## Recommendations

Continue to administer NPS survey on a quarterly basis. Continue to monitor survey results. Continue to work on methods of improving communication between WMCMH and contract providers.

# Health Disparities (CCBHC Grant)

**Data Source:** Persons Served: Most Recent Demographics: Distinct Cases by Hispanic Ethnicity

**Description:** Percent increase of persons served in the target populations (people of Hispanic origin)

**Benchmark:** None at this time.

**Lead:** Julie Sherlock / REA LLC

## Performance Summary for FY 2024, YTD

Data below for FY24 is year to date; on track to exceed target.

## Comparative Analysis

Numbers should end slightly higher than last year.

## Trends

Modest upward trend.

## Causes

None identified.

## Impact of Other Factors

WMCMH has been unable to recruit and hire a Spanish-speaking clinical staff person.

## Actions Taken and Their Effectiveness

Expanded service hours, My Strength is available in Spanish, attempts to recruit and hire a Spanish-speaking clinical staff, Contract arrangement with Services of Hope offering telehealth therapy in Spanish, WMCMH signage, consumer informational documents, and outreach media in Spanish, attend community meetings and events that serve and reach the target population, trained staff, improved data tracking in clinical record to identify and measure persons served in the target population. Effectiveness is demonstrated by increase in persons served.

## Recommendations

* Ensure that board members include representatives from the community, persons with lived experience, and family members who are active decision-makers.
* Continue to develop effective strategies for the recruitment of bilingual therapists.
* Coordinate transportation assistance to appointments for Migrant/Seasonal Agricultural Workers with Migrant Program Workers from MDHHS. (this will be happening in FY25 as part of the Hispanic grant)

# CARF Accreditation Summary

**Data Source:** CARF accreditation report

**Description:** Triannual survey of services and business functions to assure quality.

**Benchmark:** 3-year accreditation

**Lead:** Betsy Reed-Henry

## Performance Summary for FY 2024, YTD

No CARF Survey in 2024

## Comparative Analysis

N/A

##

## Trends

N/A

## Causes

N/A

## Impact of Other Factors

N/A

## Actions Taken and Their Effectiveness

N/A

## Recommendations

Continue educating new leaders on the CARF standards for their area of business.

# Quality Improvement Steering Committee Self-Evaluation

**Data Source:** Survey results

**Description:** The QI Committee annually assesses the effectiveness of the QI program via a survey

**Benchmark:** None

**Lead:** Betsy Reed-Henry

## Performance Summary for FY 2024, YTD

No data yet for 2024 (survey is administered in September)

## Comparative Analysis

## Trends

## Causes

## Impact of Other Factors

## Actions Taken and Their Effectiveness

## Recommendations

# Accessibility Planning

**Data Source:** Accessibility Plan Results

**Description:** WMCMH assesses accessibility of our services. WM identifies priority areas and sets action plans to improve accessibility.

**Benchmark:** 100% of barrier areas are assessed, and 100% of prioritized barriers are addressed in the plan or rationale for not being addressed is documented.

**Lead:** Betsy Reed-Henry

## Performance Summary for FY 2024, YTD

The Accessibility Assessment for FY23 (conducted in fall 2022) addressed all barrier areas. All barriers prioritized by the committee were addressed in the plan. In FY23, WMCMH completed the following action plans: installed ADA door openers, installed acoustic artwork to brighten the décor and dampen sound, exterior and lawn maintenance schedule was increased, translated more documents into Spanish, Limited English Proficiency training was updated, Braille signage added, Internet bandwidth increased in Baldwin office and VPN updates made, transportation grant dollars used to provide bus tokens and gas cards, multiple strategies implemented to reduce waitlist.

## Comparative Analysis

Comparable to past years.

## Trends

None identified.

## Causes

N/A.

## Impact of Other Factors

Some projects were delayed due to budget.

## Actions Taken and Their Effectiveness

See Performance Summary for actions taken. The Accessibility Assessment procedures have been streamlined for future years in order to bring more efficiency to the process.

## Recommendations

Continue Accessibility assessment per policy and procedure.

# Sentinel Events

**Data Source:** Incident reports

**Description:** A sentinel event is an unexpected occurrence involving death of a person served, or serious physical harm or emotional harm, or the risk thereof. See policy 2-6-6 for full definition.

**Benchmark:** None set

**Lead:** Betsy Reed-Henry

## Performance Summary for FY 2024, YTD

There are 9 sentinel events so far in 2024. This drastic increase is due to the LRE’s definition of a sentinel event now including all unexpected deaths. Using the prior definition of a sentinel event WMCMH would 2 sentinel events year-to-date.

## Comparative Analysis

In FY23 there was 1 sentinel event, but not very comparable given the change in definition resulting in such an increase.

## Trends

No trends identified.

## Causes

None identified.

## Impact of Other Factors

None identified.

## Actions Taken and Their Effectiveness

All remedial actions were completed. There were no changes to RCA procedures in FY2024.

## Recommendations

Per LRE Requirements, WMCMH began performing root cause analysis on all unexpected deaths at the beginning of FY24. It’s recommended that this continues.

# Suicide Deaths and Suicide Attempts, Death by Cause of Death

**Data Source:** Incident Reports

**Description:** Count of deaths by suicide and other categories, count of suicide attempts.

**Benchmark:** None

**Lead:** Josh Snyder

## Performance Summary for FY 2024, YTD

Year to date, there have been 2 deaths by suicide, 1 death by overdose, and a total of 12 deaths.

There were 56 suicide attempts. Three (3) individuals attempted multiple times; all 3 attempted 2 times.

## Comparative Analysis

Comparing to FY23 is difficult given we are only reporting a partial FY. There are fewer deaths so far in FY24 but nearly double the amount of suicide attempts.

## Trends

The increase in overdose deaths and the number of suicide attempts over the last year warrants continued monitoring which will occur this year.

## Causes

None identified.

## Impact of Other Factors

No specific influencing factors for the increase in suicide attempts and overdose deaths was identified as it is very challenging to isolate factors that lead to the act of suicidal behaviors.

## Actions Taken and Their Effectiveness

Clinical Oversight Committee took several steps to improve this process this year including updating the Suicide and Death review process to include needed prompts for more thorough information and additional questions to prompt identification and documentation of action steps with a follow up procedure to ensure implementation and monitoring. In addition, there are methods for conducting 2 levels of Root Cause Analysis on every death depending on the level of complexity. In FY23, QI Team began providing data to COC to ensure all suicide attempts are reviewed. Improved process for evaluating, too early to evaluate their effectiveness, will do so this year.

## Recommendations

Continue with implemented changes and evaluate effectiveness over the course of the year.





# Physical Management and Law Enforcement Involvement

**Data Source:** Incident report data, NQC Workbook metric

**Description:** PM is a technique used by staff as an emergency intervention to restrict the movement of an individual by direct physical contact to prevent the individual from seriously harming himself, herself, or others. LE involvement is instances in which staff call 911 for assistance in a behavior-related crisis. Both types of incidents put consumers at risk of injury by use of force, or at risk of arrest, and are considered a failure of behavior treatment or positive behavior supports.

**Benchmark:** PM: Fewer than 2 incidents per year quarter. LE: Fewer than 4 incidents per quarter.

**Lead:** Betsy Reed-Henry

## Performance Summary for FY 2024, YTD

Physical Management was consistently at or below target for all 3 quarters. Law Enforcement was on target quarters 1-2 but we had 15 LE interventions for quarter 3 (8 of these were the same consumer)

## Comparative Analysis

In FY23 we had a higher target but stayed consistently below target with fewer in the year overall.

## Trends

Trending upward (mostly due to one consumer).

## Causes

One individual who is the subject of multiple interventions in FY24 has been moved to a new home and continues to struggle with behaviors. Other causes cannot be identified, however we are working to provide more stability in the workforce, better training for direct care staff, better behavior treatment, and better quality of care.

## Impact of Other Factors

No additional factors identified.

## Actions Taken and Their Effectiveness

None.

## Recommendations

Recommend that we continue to maintain close communication with specialized residential and SIP providers, clearly communicate about reporting requirements, and coordinate closely with the care teams that do home visits in order to minimize the chance of underreporting.

# Recipient Rights Violations

**Data Source:** RR Annual Report

**Description:** Percent of substantiated Recipient Rights allegations that are abuse or neglect.

**Benchmark:** Less than 40% of total substantiated allegations will be abuse or neglect.

**Lead:** Kara Rose

## Performance Summary for FY 2024, YTD

In FY24, 50% of substantiated allegations were abuse and neglect, 10% being abuse and 40% being neglect. The Network, Quality Control, and Compliance team has worked in cooperation with Recipient Rights to continue monitoring pareto data for action planning and results tracking. It is recommended that this continues.

## Comparative Analysis

Performance improved from FY22 to FY23, but is declining in FY24 year to date.

## Trends

Trend is above target.

## Causes

Continued to provide more educational opportunities for provider staff. This year, expanded beyond traditional trainings to add Recipient Rights Q&A sessions as requested by providers or internal staff.

## Impact of Other Factors

Compared to last year, seeing destabilization of workforce at some homes. Homes are reporting high turnover, which may result in lack of consistent and timely training in those homes.

## Actions Taken and Their Effectiveness

Educational outreach including Q and A sessions – these have been well-received however A&N violations are up.

## Recommendations

Continue to monitor performance and expand educational opportunities for staff so that they feel confident working with consumers.

# Medicaid Verification Results

**Data Source:** LRE reports

**Description:** Results of audits that verify Medicaid services are appropriately documented, are provided by credentialed staff, and are authorized by the person-centered planning process.

**Benchmark:** 100% of services meet requirements

**Lead:** Devon Hernandez

## Performance Summary for FY 2024, YTD

So far, WM has received 100% on both the Medicaid verification audits completed for FY24. WMCMH has not received a report yet for Quarters 3 and 4.

## Comparative Analysis

All audits in FY23 were also 100%.

## Trends

Steady at 100% across the past 2 years.

## Causes

N/A due to meeting target.

## Impact of Other Factors

This audit continues to show WM is providing services, documenting, and billing appropriately.

## Actions Taken and Their Effectiveness

Director of Corporate Compliance proactively performs internal Medicaid Verification audits to catch trends that occur. No findings of fraud, waste, and abuse this year.

## Recommendations

Continue quarterly proactive internal audits.





# CAFAS and PECFAS

**Data Source:** State FAS system

**Description:** CAFAS and PECFAS are scales that measure functioning of children and adolescents. A positive change score indicates improvement in functioning over time.

**Benchmark:** Average change score (decrease) of 15 points from initial to most recent, for CAFAS and PECFAS

**Lead:** Keeli Sholtey

## Performance Summary for FY 2024, YTD

Average change scores were above target (signifying good performance) for both CAFAS and PECFAS.

## Comparative Analysis

Performance is similar to FY22.

## Trends

For CAFAS trend data is staying consistent overall. PECFAS dropped significantly in FY23 but is back up in FY24.

## Causes

N/A

## Impact of Other Factors

Homebased vacancies have had some impact, however we’re able provide services for high-need consumers. IMH position remains open so we have limited capacity to serve children aged 0 to 5.

## Actions Taken and Their Effectiveness

Other than Homebased and IMH, the team became fully staffed this year. Spent more time monitoring the completion of CAFAS so that there was more data. Maintained appropriate caseload sizes because team is staffed. Therapy positions have been filled. More staff have been PMTO certified or are working towards PMTO certification; same for TF-CBT certification. ICSS (Intensive Crisis Stabilization Services) was moved to children’s team, which has provided more stability in staffing, and we were able to increase staffing so that we have a dedicated team covering 11am-7pm Monday through Friday, which is when most crises occur. The change also has allowed for more continuity of care and more timely access to services including crisis services.

## Recommendations

CAFAS and PECFAS will be discontinued as we transition to the MichiCANS. We will have to think differently about how to monitor performance using the MichiCANS because the data isn’t as easily quantifiable as the CAFAS And PECFAS. Recommend we keep an eye out for how the state or region recommends we use MichiCANS data for population management.

# Customer Service Activity

**Data Source:** Grievance Report

**Description:** Grievances are complaints made by persons served or consumers.

**Benchmark:** Grievances are resolved in 5 days or less

**Lead:** Jodi Garrow

## Performance Summary for FY 2024, YTD

Performance year to date is below standard, indicating excellent performance.

## Comparative Analysis

Performance has significantly improved.

## Trends

Performance is trending better each year.

## Causes

N/A.

## Impact of Other Factors

N/A.

## Actions Taken and Their Effectiveness

No corrective actions were needed as last year was within target as well.

## Recommendations

Team will continue efforts to be within standard as possible.

# Prescriber Peer Review

**Data Source:** Prescriber Peer Review Study

**Description:** Medication clinic prescribers review a sample of each other’s charts to ensure quality of care.

**Benchmark:** No target; if any quality of care issues are identified they will be addressed with the provider as appropriate.

**Lead:** Nicole Whitman

## Performance Summary for FY 2024, YTD

No quality of care issues were identified in FY24.

## Comparative Analysis

No quality of care issues were identified in FY23.

## Trends

Trend is steady and consistently finds no areas for improvement.

## Causes

## Impact of Other Factors

## Actions Taken and Their Effectiveness

## Recommendations

# Employee Net Promoter Score

**Data Source:** HR Workbook

**Description:** Brief employee satisfaction survey

**Benchmark:** NPS Score of 30 or greater

**Lead:** Angie Kuhn

## Performance Summary for FY 2024, YTD

Performance improved in March (into excellent range) but declined again in June, likely due to scheduling expectations roll-out.

## Comparative Analysis

Improvement over FY23 scores. Scores in both FY23 and FY24 showed higher satisfaction in March and lower in June but still within the favorable range.

## Trends

Score is trending up across past 2 years.

## Causes

The pareto data shows staff are noting high workloads, better training improve SOPs and orientation, supervisor support needed, and communication.

## Impact of Other Factors

Organizational changes including the scheduling expectations, and restructure of SSRs and CERs.

Vacancies from leaves of absence. We had 25 staff out at various times on leaves.

## Actions Taken and Their Effectiveness

WM has continued our increased recruitment efforts to fill positions, continuing to find ways to change staffing model (more non-degreed or lower-degreed positions) so that positions are able to be filled, continued supervisor training, continued bi-monthly all-team meetings with notes shared, implemented Adaptative leadership training for all new leaders, continued CE CERT trainer training, participation in National Council ECHO training to address workforce issues, adding more focus on cross-team collaboration and coordination. Results of our work related to the strategic goal of Workplace Experience. Employee engagement summer picnic was well-attended and enjoyed, we offered an employee recognition day, continued our program of recognition of staff life events including births and marriages. New benefits were offered including: Credential stipends to cover cost for staff to renew job-required credentials and a wellness stipend. These benefits demonstrate our commitment to continually assess and remain competitive for recruitment and retention.

## Recommendations

Continued commitment to cross-team coordination and communication. Continue workplace experience as strategic goal for next FY. Recommend 360 feedback on supervisors. All-staff development day will occur on September 13.

# Persons Served

**Data Source:** SMT Workbook

**Description:** Count of persons served by WMCMH (received an encounter)

**Benchmark:** 3,832 Persons Served in FY24

**Lead:** Josh Snyder

## Performance Summary for FY 2024, YTD

At the time of this report, WMCMH is on track to achieve results that are very close to goal.

## Comparative Analysis

Performance year-to-date is essentially the same as it was last year; target also has not changed.

## Trends

Trend is consistent.

## Causes

N/A

## Impact of Other Factors

Demand for services continues to be high with new requests for services.

## Actions Taken and Their Effectiveness

More stable staffing in FY24 in most levels of care (excluding Level 2). Addition of Level 2 pathway 4 was advantageous for those needing therapy. In FY24, WMCMH used a staff recruitment agency to hire temp to permanent therapist and this was successful for increasing capacity to provide services. Utilization with our DCO Services of Hope has gradually increased. Improved scheduling and backfilling of canceled appointments (was implemented in FY23 and processes were continued and improved through FY24).

## Recommendations

Post for additional TRG position – should be filled in early September 2024. Will clarify new Level 2 metrics to evaluate the utilization of new pathways. Evaluate referral process, and services provided. Projected to be fully staffed for the TRG group as of 9/6/24.

# Clinical Services Delivered: Internal Encounters

**Data Source:** Metric in SMT and Directors Workbook

**Description:** A measure of number of services provided by WMCMH staff

**Benchmark:** 298,944 units

**Lead:** Josh Snyder

## Performance Summary for FY 2024, YTD

Goal was raised over last year, and performance is on track to exceed goal.

## Comparative Analysis

Compared to last year at this time, we have reported 13% more encounters.

## Trends

Trending positively.

## Causes

N/A as we are exceeding target.

## Impact of Other Factors

None.

## Actions Taken and Their Effectiveness

Staffing has been more stable through recruitment and retention. Work associated with the Workplace Experience goal has resulted in higher employee satisfaction scores, and turnover rates have been really good. Organizational Scheduling practices were implemented to maximize productive time. Supervisors have really focused on Services Delivered metrics and working with their staff and teams to continually reduce inefficiencies. Maximizing efficiency goal has resulted in us redistributing caseloads to reduce the number of counties and number of populations served by each individual staff.

## Recommendations

Continue effective actions. For Level 2 consumers, continue implementing strategies to get them into services. Continue work to utilize groups more effectively.

# Clinical Outcomes

**Data Source:** Metric in SMT and Directors Workbook

**Description:** A measure of how persons served improve during the course of care, measured by the ANSA/CANS assessment tools

**Benchmark:** No target set

**Lead:** Josh Snyder

## Performance Summary for FY 2024, YTD

Data continues to show greatest improvement on adjustment to trauma, and lowest improvement in Psychosis. Moderate improvement on medication compliance and suicide risk.

## Comparative Analysis

Performance is similar to previous years.

## Trends

Trend is consistent.

## Causes

N/A

## Impact of Other Factors

The denominator includes individuals who did not report the identified problems at all, therefore showed no improvement. This skews the results.

## Actions Taken and Their Effectiveness

Continuing to provide integrated care, guided by CCBHC model and quality measures.

## Recommendations

Continue using the ANSA/CANS. Ending CAFAS, Moving to MichiCANS. Determine how MichiCANS can be used as an outcome measure. Continue to implement Zero Suicide.

# Residential Costs

**Data Source:** Metric in NQC Workbook

**Description:** Dollars spent on contracted services for Specialized Residential and Supported Independent Placement

**Benchmark:** H2016/T1020 (Specialized Residential) Target: $9,691,572

H2015 (Supported Independent Placement) Target: $671,820

**Lead:** Betsy Reed-Henry

## Performance Summary for FY 2024, YTD

WMCMH is under budget for Specialized Residential costs so far for FY24. WMCMH has been slightly over target every month in FY24 for Supported Independent Placement (SIP) costs.

## Comparative Analysis

FY23 was well below target all year for specialized residential, and just met target for SIP. FY24 specialized residential has gone down while SIP has gone up.

## Trends

WMCMH continues to remain under or just slightly over budget on SR and SIP costs.

## Causes

Budgets are set using the best estimate of what costs will be.

## Impact of Other Factors

WMCMH has done a significant amount of work over the past few years related to developing and implementing new specialized residential processes – in order to create efficiencies for WMCMH staff and to ensure the best outcome for individuals served. One piece of the work that was done was related to creating alternatives to specialized residential and ensuring we are using those alternatives when appropriate. One possible reason for being over budget on our SIP costs is that we’re using SIP placements more frequently than in the past – as an alternative to SR.

We will need to continue to closely monitor our SR and SIP costs as we are seeing the rates that we are being charged for these services increasing steadily. Based upon the information we’re receiving from our providers, rate increases are tied to things such as the general increase in the cost of doing business and the increase in wages needed to hire quality staff.

## Actions Taken and Their Effectiveness

See above.

## Recommendations

Continue to monitor and drive action as needed.

# Financial Summary

**Data Source:** Metric in CIA Team workbook

**Description:** WMCMH expenditures compared to budget

**Benchmark:** To established budget

**Lead:** Bethany Sherfinski

## Performance Summary for FY 2024, YTD

Revenue was more than expected due to CCBHC performance incentive payment from prior year. Overall revenue is sufficient to cover expenditures, although surplus/deficit by fund source is resulting in projected shortfalls in all major funding sources with QBIP and local revenue from interest assisting to cover for CCBHC and GF.

## Comparative Analysis

Overall performance is similar to prior year. Staffing expenditures continued to be less due to vacancies and turnover.

## Trends

Medicaid revenue is not keeping up with increases in expenditures due to re-enrollment causing declining eligibles and CCBHC rate trending economic factors less than experience. Inpatient and residential services are trending due to increased use, rate increases, and higher level of need.

## Causes

Staffing costs and retention continue to impact expenditures significantly.

## Impact of Other Factors

CCBHC revenue will be able to be carried forward due to performance incentive payments from prior year that are able to be retained.

## Actions Taken and Their Effectiveness

FY24: Monthly monitoring of revenue and expense changes by various types. Adjustments to budget in annual budget amendment

## Recommendations

FY24: Continue monitoring and watching MCD enrollment levels impact on revenue. Ensure high dollar spending decisions consider emerging trends.

# Projects Past Due

**Data Source:** Metric in Development Team workbook

**Description:** Measure of timeliness of completing planned work. Projects are time-bound initiatives that have defined deliverables and involve more than one department.

**Benchmark:** Fewer than 2 past due per month

**Lead:** Megan Chaffee

## Performance Summary for FY 2024, YTD

Performance is within target all year, year to date.

## Comparative Analysis

Performance appears to be better this year than last year.

## Trends

Trending upward from below target to exceeding target.

##

## Causes

Throughout FY24, there was some ongoing work that should have been designated as projects, but was not. So this has not been tracked as it should, and as a result the data below does not reflect timeliness of all the work being done.

## Impact of Other Factors

Capacity issues, many mandates due at beginning of FY25.

## Actions Taken and Their Effectiveness

We began reviewing project list at directors and discuss barriers to things that are overdue. Some work dropped off the project list. This year, Megan spent time with project leads whose work is running behind, to review deliverables and set more realistic timelines. This has been very effective.

##

## Recommendations

Require status reports for all projects (previously we required them only for projects that were behind). Use SharePoint, Teams, and other tools to maintain project files and track tasks and deliverables, in order to reduce duplication and add efficiency.

# CCBHC Quality Measures

**Data Source:** R3 CCBHC Quality Measure reports

**Description:** A set of quality measures reported by WMCMH to MDHHS for CCBHC demonstration.

**Benchmark:** No benchmarks set

**Lead:** TBD

## Performance Summary for FY 2024, YTD

The CCBHC Quality Measures are reported to MDHHS annually, however little is done at WMCMH to monitor performance and drive improvement. COC made some recommendations in FY23 to perform an audit on the measures.

## Comparative Analysis

Comparative data is not reported here since WM is not driving action on these.

## Trends

N/A.

## Causes

N/A.

## Impact of Other Factors

WMCMH tracks dozens of metrics. Metrics were prioritized based on those that have the greatest impact on consumer care and outcomes; based on that analysis these metrics were determined not a priority at this time.

## Actions Taken and Their Effectiveness

None to report at this time.

## Recommendations

PCE will update reporting logic for the CY2025 measures. In conjunction with metrics project with TBD, consider driving performance on select CCBHC QMs.

# CCBHC Quality Bonus Payment Measures

**Data Source:** R3 CCBHC Quality Measure reports, CC360 reports

**Description:** A subset of quality measures, including measures reported by WMCMH and by MDHHS, which have MDHHS-set targets tied to performance bonus payments.

**Benchmark:** SRA: 23.9%. FUH-A: 58%. FUH-CH: 70%. SAA: 58.5%. IET-14: 25%. IET-34: 18.5%.

**Lead:** Betsy Reed-Henry

## Performance Summary for FY 2024, YTD

FY23 performance was reported in June 2024, and was excellent – WMCMH was the only CCBHC in Michigan to meet all of the QBPMs!

## Comparative Analysis

Improvement over FY22.

## Trends

N/A.

## Causes

None identified.

## Impact of Other Factors

None identified.

## Actions Taken and Their Effectiveness

WMCMH continued regular reporting on performance and team-level work to drive performance.

## Recommendations

Continue to focus resources on doing the work that achieves results for consumers and leads to better performance. For example, for IET, we should continue our efforts to get everyone into care timely.

# Zero Inbox / Weekly Review

**Data Source:** Leadership tracking sheet in Teams

**Description:** Percentage of staff reporting completion of Zero Inbox and Weekly Review, two processes intended to improve work efficiency and productivity.

**Benchmark:** 85% for Zero Inbox; 85% for Weekly Review.

**Lead:** Betsy Reed-Henry

## Performance Summary for FY 2024, YTD

WM continues to meet the target as a whole, however there continue to be some trends as far as which teams are not meeting the target. Need to decide whether we drive action on this, and what action steps might be. Reminded leaders who have blanks to enter data, as not everyone is doing so consistently.

## Comparative Analysis

Reported performance is slightly better than last year.

## Trends

Slight upward trend.

##

## Causes

Unknown what the causes are.

## Impact of Other Factors

There are quite a few blanks in the tracking spreadsheet thus making results not accurate.

## Actions Taken and Their Effectiveness

Each leadership team member who leads a team should be driving action to complete zero inbox and weekly review. QISC looks at data reports quarterly.

## Recommendations

Recommend that we continue tracking and reporting the data to drive performance.

# Appendix 1: Characteristics Of Persons Served

Data Source: WM Dashboard Reports, Persons Served, Most Recent Demographics

## Age Groups of Persons Served

|  |
| --- |
|  |

About 20% of persons served are children and youth aged 0-18. Over 60% of persons served are adults aged 18-54.

## Race of Persons Served

The large majority of persons served (over 80%) in 2024 are white. The next largest race group is Black, at just over 4%.

## Gender Identity of Persons Served

The largest groups are male and female, with a significant percentage (15.57%) not having a gender identify recorded.

# Appendix 2: Applicability of Measures for CARF

| **Measure and Brief Description** | **Brief Description** | **Applicability** | **Category** |
| --- | --- | --- | --- |
| 1. MMBPIS Indicator 1
 | Timely response to urgent requests for psychiatric inpatient care | All Clinical programs (MH) | Access |
| 1. MMBPIS Indicator 2a
 | Timeliness of initial assessment for MH | All Clinical programs (MH) | Access |
| 1. MMBPIS Indicator 2b
 | Timeliness of care for SUD | All Clinical programs (SUD) | Access |
| 1. MMBPIS Indicator 3
 | Timely start of care for MH | All Clinical programs (MH | Access |
| 1. MMBPIS Indicator 4a
 | Timely follow up after hospitalization | All Clinical programs (MH) | Access |
| 1. MMBPIS Indicator 4b
 | Timely follow up after detox (SUD) | All Clinical programs (SUD) | Access |
| 1. MMBPIS Indicator 10
 | Inpatient recidivism | All Clinical programs (MH) | Effectiveness |
| 1. LRE Site Review
 | WMCMH’s services, policies, and procedures are reviewed annually by the LRE (Lakeshore Regional Entity), the body which funds our Medicaid services and provides quality oversight. | All Clinical programsAll Business Functions | Business indicator |
| 1. Consumer Net Promoter Score
 | Brief satisfaction survey for consumers.  | All Clinical programs | Customer Satisfaction / feedback |
| 1. MHSIP and YSS
 | Customer Satisfaction survey.  | All clinical programs | Customer Satisfaction / feedback |
| 1. Provider Net Promoter Score
 | Brief satisfaction survey for our network providers (agencies we contract with to provide services to our consumers) | All contracted services providers | Stakeholder feedback  |
| 1. Health disparities
 | Compares treatment outcomes and service access of minority groups to the majority group. | All clinical programs | Access |
| 1. CARF Accreditation Summary
 | Being accredited by CARF holds us to a higher quality standard and demonstrates to the public that we are a high-quality provider of services.  | All Clinical programsAll Business Functions | Business indicator |
| 1. Quality Improvement Committee Self-Evaluation
 | The QI Committee annually assesses the effectiveness of the QI program.  | Business function | Business indicator |
| 1. Accessibility Planning
 | WMCMH annually does an assessment of how accessible our services are to the community. We identify priority areas and set action plans to improve accessibility. | All clinical programs All business function | Access |
| 1. Sentinel Events
 | A sentinel event is an unexpected occurrence involving death of a person served, or serious physical harm or emotional harm, or the risk thereof. All sentinel events are investigated via Root Cause Analysis and are responded to with a remedial action plan for quality improvement. | All clinical programs | Health & Safety |
| 1. Suicide Deaths and Suicide Attempts
 |  | All clinical programs | Health & Safety |
| 1. Physical Management and Law Enforcement Involvement
 | Physical management A technique used by staff as an emergency intervention to restrict the movement of an individual by direct physical contact to prevent the individual from seriously harming himself, herself, or others. In this measure, Law Enforcement involvement is when staff call 911 for assistance in a behavior-related crisis. Both types of incidents put consumers at risk of injury by use of force, or at risk of arrest, and are considered a failure of behavior treatment or positive behavior supports. | All clinical programs | Health & Safety |
| 1. Recipient Rights Violations
 | Abuse, Neglect, Confidentiality, Dignity and Respect | All clinical programs | Health & Safety |
| 1. Medicaid Verification Results
 | Medicaid verification is a process to verify that Medicaid services are appropriately documented, were provided by credentialed staff, and were authorized by the person-centered planning process | All clinical programs | Business indicator |
| 1. CAFAS and PECFAS
 | CAFAS and PECFAS are scales that measure functioning of children and adolescents. A positive change score indicates improvement in functioning over time. | All clinical programs serving children and youth | Effectiveness |
| 1. Customer Service Activity
 | Grievances are complaints made by persons served or consumers.  | All clinical programs | Business Function |
| 1. Prescriber Peer Review
 | Medication clinic prescribers review a sample of each other’s charts to ensure quality of care.  | All clinical programs | EffectivenessHealth & Safety |
| 1. Employee Net Promoter Score
 | A brief employee satisfaction survey | Business function | Business indicator |
| 1. Persons served
 | A measure of how many people were served by WMCMH | All clinical programs | Efficiency and Access |
| 1. Clinical Services Delivered – Number of internal encounters
 | A measure of total visits provided to persons served | All clinical programs | Efficiency |
| 1. Clinical outcomes
 | A measure of how persons served get better during the course of care. | All clinical programs | Effectiveness |
| 1. Residential Cost
 | Measure of dollars spent on contracted services included in Specialized Residential or Supported Independent Living arrangements.H2015: Comprehensive Community Support Services.H2016: Comprehensive Community Support Services in specialized residential settings.H1020: Personal Care. | Individuals receiving residential services | Efficiency |
| 1. Financial Summary
 | Compares WMCMH expenditures to budget.  | All clinical programs and business functions | Business indicator |
| 1. Projects past due
 | Measures timeliness of completing planned work. Projects are time-bound initiatives that have defined deliverables and involve more than one department.  | Business function | Business indicator |
| 1. CCBHC Quality Measures
 | CCBHC-reported quality measures reported to MDHHS for CCBHC Demonstration. | All clinical programs | Effectiveness and Efficiency |
| 1. CCBHC Quality Bonus Payment Measures
 | CCBHC-report quality measures reported to MDHHS for quality bonus payment, for CCBHC demonstration. | All clinical programs | Effectiveness  |
| 1. Zero Inbox / Weekly Review
 | Frequency that staff complete tasks to improve efficiency and accuracy of work. | Business function | Business indicator |