

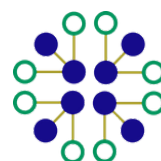


**QUALITY ASSESSMENT AND
PERFORMANCE IMPROVEMENT
PROGRAM (QAPIP)
ANNUAL REPORT
FY25**

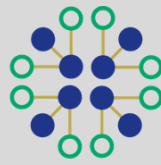
PREPARED BY

RENEE RAUSHI, CHIEF OPERATING OFFICER

Approved by:
Board Services Committee - 11.13.2025
CMHCM Board of Directors - 11.25.2025



**Community
Mental Health**
FOR CENTRAL MICHIGAN



**Community
Mental Health**
FOR CENTRAL MICHIGAN

Vision

**Communities where all individuals
experience healthy and meaningful lives.**



Mission

**To promote whole-person wellness through
community inclusion and a comprehensive
system of quality integrated mental health
services and supports.**



CMHCM Values

**Support of the dignity, worth, autonomy, and
empowerment of each individual**

Early intervention, prevention, and wellness

Dynamic, competent, and qualified staff and providers

Whole-person wellness and integrated care

**High quality services that are affordable and
accessible**

Team-Based Care

Diversity, equity, and inclusion

Advocacy and public education

**Creativity, innovation, and evidence-based
practices**

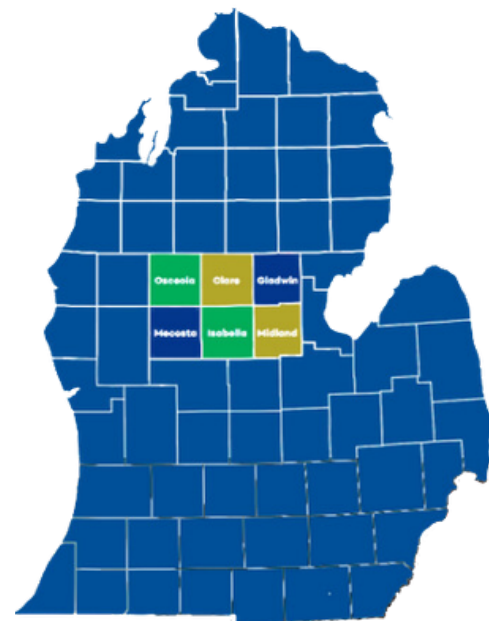
Responsiveness to local community needs



PURPOSE AND SCOPE

Community Mental Health for Central Michigan (CMHCM) provides an array of behavioral health services and supports to individuals in the Michigan counties of Clare, Gladwin, Isabella, Mecosta, Midland, and Osceola through a network of direct-operated programs and contracted service providers.

CMHCM is a Michigan Department of Health and Human Services (MDHHS) certified Community Mental Health Service Program (CMHSP) and is accredited by The Joint Commission. CMHCM places quality care for consumers at the core of its mission utilizing the Quality Assessment and Performance Improvement Program (QAPIP) Plan and Strategic Plan to advance its agency mission, vision, and values.

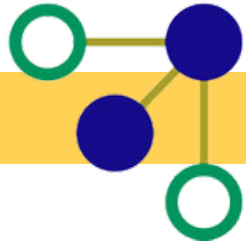


THE CMHCM QAPIP OBJECTIVELY AND SYSTEMATICALLY MONITORS AND EVALUATES THE QUALITY OF CARE AND SERVICE TO MEMBERS THROUGH QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROJECTS, AND PURSUES OPPORTUNITIES FOR IMPROVEMENT ON AN ONGOING BASIS FOR ALL DEMOGRAPHIC GROUPS, CARE SETTINGS, AND TYPES OF SERVICES.

CMHCM encourages participation in the quality improvement process from all levels within the agency in addition to consumers, families, advocacy groups, the CMHCM Provider Network, and the community. This FY25 QAPIP report represents how quality improvement initiatives implemented throughout the fiscal year support the mission, vision, and values of the agency and most importantly the individuals receiving services and supports.



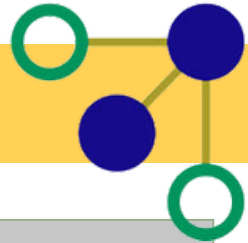
CLINICAL SERVICES



CMHCM envisions communities where all individuals experience healthy and meaningful lives. CMHCM is proud of the services that it provides along with the partnerships and collaborations that have been developed with community leaders and organizations to engage a community-wide approach for the treatment of severe and persistent mental illnesses, developmental and intellectual disabilities, and co-occurring substance use diagnoses through the person-centered planning process.

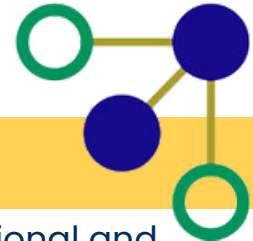
OBJECTIVE	NOTEWORTHY ACCOMPLISHMENTS
A.1.1. Increase the percent of individuals requesting CMH services who receive an assessment by 5%.	In FY25 there were: • 3125 Navigator Screens completed with a disposition of "Refer to Assessment" • 2865 Initial Assessments Completed The data shows that 91% of individuals requesting CMH services received an assessment in FY25. This is an 8% improvement over FY24 (83%).
A.1.2. Expand Same Day Access outreach and engagement peer support pilot to five additional counties (Clare, Isabella, Midland, Mecosta, and Osceola).	The peer support pilot in Gladwin county was suspended in FY25 due to staff turnover so CMHCM was unable to expand this peer support specific pilot to additional counties. CMHCM did implement another engagement initiative in its place that began in Osceola County and includes asking a treatment team member to come in at the end of the initial assessment for adults with SMI to discuss next steps and engage them into the next stage of services. Data is being collected for further analysis and a determination on next steps.
A.1.5. CMHCM will establish small work group to analyze Year one data from Clare/Gladwin to determine feasibility for children's mobile crisis expansion.	The Family stabilization grant ended at the end of FY25. A program evaluation was completed and an Intensive Crisis Stabilization Services (ICSS) workgroup has been established to determine next steps for expansion across the agency. Continued advocacy to MDHHS on a billing code for crisis peer services is in progress as this is a barrier for expansion efforts.

CLINICAL SERVICES



OBJECTIVE	NOTEWORTHY ACCOMPLISHMENTS
A.1.6. Develop contract with Listening Ear and complete the Children's Therapeutic Family Care (CTFC) application packet for MDHHS to continue development of CTFC program.	CMHCM entered a partnership with Listening Ear (LE) for Children's Therapeutic Family Care (CTFC) and the contract has been signed. This partnership allows CMHCM to provide clinical delivery of intensive, comprehensive mental health services and allows LE to provide training, recruitment, licensing, and retention of youth foster care homes. The CTFC application was completed and approved, and CMHCM has a grant in place from MDHHS. The grant will assist CMHCM with planning and preparing for implementation of this service.
A.1.7. CMHCM will develop at least two children's mobile crisis care pathways with community providers and provide training within the community to enhance use of program.	Referral pathways to family stabilization (FSS) were successfully established between local schools and local DHHS offices. Face to face trainings on FSS with numerous community providers were completed as well as trainings with DHHS and schools around de-escalation. CMHCM continues to encourage DHHS to participate in the family foundational training series.
A.1.9. Develop process for teams to utilize Length of Stay (LOS) data to identify individuals who could be transitioned to another program or community provider for improved outcomes and case load management.	Revisions to the team based care dashboard were made to better track length of stay data. These edits will assist teams in having discussions around potential transitions to a different program or to a community provider.
A.1.10. Establish system for ongoing monitoring of metrics for service delivery needs that include frequency, duration, and documentation requirements to inform caseload size and staffing needs.	Recommended average caseload sizes for CM and OPT were set by Chief Clinical Officer's and the Executive Director in FY25.

CLINICAL SERVICES



Data Outcomes

CMCHM collects, compiles, and analyzes objective data to improve organizational and service performance. QAPIP data is reviewed with staff on a monthly basis and the same data is accessible in real-time for staff through the Team- Based Care (TBC) dashboard. Key data points include: Service Activity Log (SAL) timeliness, Psychosocial assessment completed within 365 days, PCPs completed within 365 days, and PCP distributed to the consumer/guardian within 14 days.

Psychosocial Assessments within 364 days:

- 82% in FY25
- 6.33% improvement over FY24

PCPs within 364 days

- 93% in FY25
- 3.25% improvement over FY24



PCPs given within 14 days

- 93.07% in FY25
- 2.21% improvement over FY24

SAL timeliness

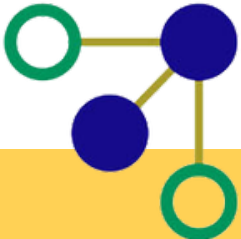
- Average of 2.58 days
- 0.25 day improvement over FY24

Unsigned documents

The number of consumer and staff unsigned documents is monitored continuously. Use of Adobe sign and standardized consumer check-in processes across counties has been implemented to assist with targeting a reduction in unsigned documents.



CLINICAL OVERSIGHT



Behavior Treatment

The Behavior Treatment Committee is a specially constituted committee whose purpose is to review and approve or disapprove any Behavior Plans that propose to use restrictive or intrusive interventions with individuals served by CMHCM who exhibit seriously aggressive, self-injurious, or other challenging behaviors that place the individual or others at imminent risk of physical harm.

The Behavior Treatment Policy (2.200.001) guides the administration of the BTC. The BTC also tracks patterns of incidents or interventions that suggest opportunities for improvement, planning, or training, and arranges for follow-up. Over FY25 the BTC team also worked on development of an agency process related to prior authorization of Behavior Treatment Services, including both the Behavior Plan process itself but also the ongoing oversight of BTC reviews. This will work will continue into FY26.

OBJECTIVE	NOTEWORTHY ACCOMPLISHMENTS
B.4.1. The Behavior Treatment Committee will work with the Quality Department to formalize a process to gather feedback and analyze data regarding BTC’s effectiveness annually from individuals who had approved plans, guardians, family members and advocates, and CMHCM case holders	The BTC team reviewed the process by which feedback is gathered on BTC’s effectiveness. Behavior Treatment Plans must be developed through the PCP process and written special consent must be given by the individual, or their guardian on their behalf if one has been appointed, or the parent with legal custody of a minor prior to the implementation of the Behavior Treatment Plan that includes intrusive or limiting interventions. There are multiple points where feedback can be obtained prior to development of, and implementation of the Behavior Treatment Plan. The team decided not to continue with a plan to formalize anything in addition to the existing processes following review of the system.

98

AVERAGE NUMBER OF
BEHAVIOR PLANS WITH
QUARTERLY BTC
OVERSIGHT IN FY25

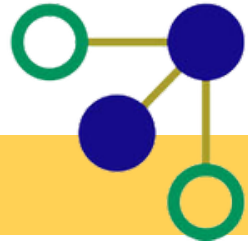
KEY MEMBERSHIP:

*5.77% decrease
over FY24

- LICENSED CLINICAL PSYCHOLOGISTS
- MEDICAL DIRECTOR
- ADMINISTRATIVE NURSE
- ROTATING RIGHTS TEAM MEMBER
- CLINICAL REPRESENTATION



CLINICAL OVERSIGHT



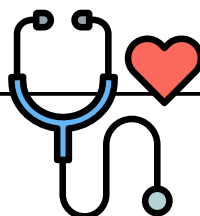
Integrated Health

CMHCM continues to focus on integration of physical and mental health services in order to improve overall whole-person wellness.

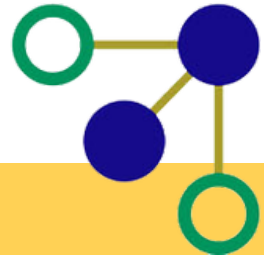
OBJECTIVE	FY24	FY25	TARGET
B.2.1. The Abnormal Involuntary Movement Scale (AIMS) will be performed as indicated in at least 90 percent of consumers within Health Services.	85%	88%	90%
B.2.2. Nursing Health Assessments will be completed as indicated in at least 60 percent of consumers.	68%	49%	60%
B.2.3. Psychiatric evaluation no-show rates will decrease to 7.25 percent or less.	11.46%	10.6%	<7.25%

NOTEWORTHY ACCOMPLISHMENTS

- The Abnormal Involuntary Movement Scale (AIMS) was completed for 88% of consumers within the Health Services program, representing a 3 percent **increase** over FY24.
- A Nursing Assessment was offered to 2,360 consumers. In FY25 the organization experienced nursing shortages across the agency which contributed to the reduction in the number of nursing assessments offered as coverage of health services clinics was prioritized. A small workgroup concurrently was working on edits to the content of the nursing assessment to streamline questions in order to maximize value to the consumer and increase efficiency for staff.
- Psychiatric no show rates ended at 10.60 percent for FY25, and while this did not achieve the target of 7.25 percent or below, review of the data showed a 1 percent improvement in the no show rate over FY24. Several process improvements were implemented to continue to work toward further reduction including: discussion on barriers to engagement during team meetings and ongoing data monitoring to look for trends so that improvement opportunities could be put into place.
- CMHCM expanded Behavioral Health Home (BHH) workflows into Clare and Gladwin counties in FY25. This makes a total of five CMHCM counties accepting enrollments.



CLINICAL OVERSIGHT

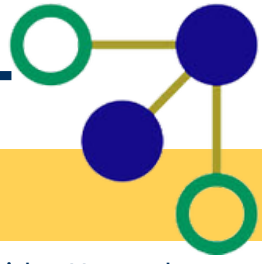


Utilization Management

Utilization Management (UM) practices are guided by the CMHCM Utilization Management Policy (2.400.001). The UM team reviews service authorization requests for medical necessity as defined in the Michigan Medicaid Provider Manual. The target is to assure services are provided in an appropriate amount, scope, and duration based on the individual's specific needs. Services are required to be the least restrictive, equitable, and most cost-effective.

OBJECTIVE	NOTEWORTHY ACCOMPLISHMENTS
B.1.1. Utilization Review Specialist (URS) tool reviews to achieve or exceed 70% compliance for the review element, "Does the information support the medical necessity of the service amount being requested?"	There were 1789 URS review tools completed in FY25 and 64% of the time the information found in the file during the course of the URS review DID support the medical necessity of the service amount being requested. While the target of 70% was not met, there was a staff training on medical necessity completed in FY25 and review of data following that training on April 8, 2025 did demonstrate improvement in this area. Data by Quarter: FY25Q1: 154 "yes", 275 "no" = 64% FY25Q2: 183 "yes", 266 "no" = 59% FY25Q3: 146 "yes", 318 "no" = 68% FY25Q4: 165 "yes", 282 "no" = 63% Total: 648 "yes", 1141 "no" = 64%
B.1.2. Utilization Management will complete 100% of quarterly tracking of community living supports and licensed residential setting outliers to identify outliers (outliers are defined as falling outside of three standard deviations from the mean) within each level of care	Outlier review was completed as required in FY25. The number of outlier reviews fluctuated, particularly between Q3 (29 reviews) and Q4 (12 reviews) due to individuals moving back into our catchment area and the move resulted in the individual case no longer meeting criteria for an outlier review.

ADMINISTRATIVE OVERSIGHT

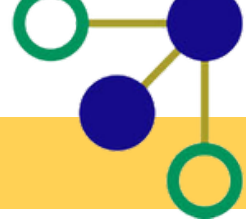


Provider Network Management

The CMHCM Provider Network Management Department is responsible for maintaining the Provider Network to assure it is adequate and meets the needs of the consumers. CMHCM holds regular meetings with contracted service providers to identify system issues, discuss regulatory and process changes, and to gather feedback from providers on quality improvements. Medicaid Event Verification (MEV) audits are conducted internally to ensure that requirements are being maintained by providers.

OBJECTIVE	NOTEWORTHY ACCOMPLISHMENTS
B.3.1. Monthly provider trainings will be conducted and monitored with the goal of increased attendance by 10 percent over FY24.	146 provider staff attended FY25 trainings, representing a 111% increase over the 69 attendees in FY24. Training topics included: • 2025: The Year Ahead • Teaching Emotion Regulation to Consumers • Impact of Trauma/Grief in Behaviors & Trauma Informed Care • Medical Necessity: Why is it important and what role do providers play? • Coordinating Employment Supports • Using ACT as a BCBA – With Parents, Consumers, and Staff • Overview of PEAK– Promoting the Emergence of Advancing Knowledge • Strategies for Effective Family Guidance
B.3.2. Quarterly residential provider forums will be held with contracted Adult Foster Care (AFC), CLS, and ABA providers to improve communication.	Quarterly forums with AFC, CLS and ABA providers are ongoing. Provider staff is encouraged to attend and reminders are sent out through Constant Contact. FY25 Quarterly Forum Attendees: AFC – 47 provider staff, 24 CMHCM staff CLS – 81 provider staff, 17 CMHCM staff ABA– 106 provider staff, 25 CMHCM staff Discussion is ongoing around the possibility of replicating the format of the ABA quarterly forums based on review of the attendance numbers.
B.3.3. Achieve a 4% increase in the number of out-of catchment consumers successfully returning to the CMHCM catchment area. This will be measured through monthly monitoring reports that track progress to identify and address barriers.	The Out-of-Catchment (OOC) team has been working closely with the Residential Placement Coordinator and the Behavior Services Team to prioritize moving individuals back into CMHCM's catchment area. A spreadsheet tracker has been implemented and discussion is ongoing at the OOC team meetings. In FY25, 4 individuals were transitioned back into the CMHCM catchment area and looking ahead into FY26, there are 3 additional moves projected.
B.3.4. Track and report the number of days specialized residential vacancies remain unfilled to facilitate review of one Type B specialized residential provider each month.	The Residential Review Committee has ongoing discussions related to vacancies that remain unfilled within the CMHCM catchment area. The Committee analyzes trends, discusses barriers to filling the available vacancies and recommends follow-up with the provider organization as needed.

ADMINISTRATIVE OVERSIGHT

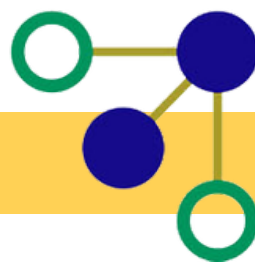


Information Systems

The Information Systems Department at CMHCM provides a number of services to support the agency in the field, in the office and working from home. The IS Department is comprised of network administrators, help desk professionals, a database administrator, and programmers. In FY25, IS continued to prioritize ensuring uniform guidance on technological platforms, identifying efficiencies, and communicating expectations for the use of technology.

OBJECTIVE	NOTEWORTHY ACCOMPLISHMENTS
B.5.1. Develop periodic reporting of metrics for turnaround times on helpdesk tickets and network availability.	The IS Department has been monitoring turnaround times on helpdesk tickets throughout the fiscal year. FY25 data indicates the following: • 11021 IS helpdesk tickets were processed • Average ticket turnaround time: 4 hours
B.5.3. Work with the Management Team will be completed to develop a list of processes which have the potential to be automated to increase efficiencies.	The IS Department worked with Management team over FY25 on a number of projects and processes: • Updates to Windows 11 • Implementing Microsoft Teams Phone • Beginning implementation of SharePoint/One Drive • Updates to the agency intranet page to include training information for staff on various topics (Adobe, Microsoft Teams, Doxy.me, etc.) The Chief Information Officer (CIO) has also been focused on key security domains including: identity and access management; network security; endpoint security; data security and privacy; and cloud security. This work will continue into FY26.

ADMINISTRATIVE OVERSIGHT



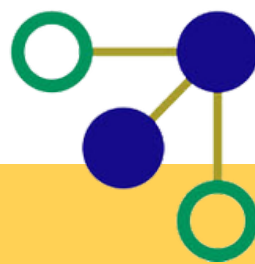
Human Resources

The Human Resources (HR) Department assists all employees in what matters – their job, benefits, and well being. HR is committed to attracting, developing, motivating and retaining a talented workforce along with helping employees achieve their highest job satisfaction possible. The CMHCM HR team of 3.0FTE staff provides support and assistance to 473 current employees.

OBJECTIVE	NOTEWORTHY ACCOMPLISHMENTS
B.7.1. Establish relationships with at least three new universities through targeted recruitment efforts, including internships, career fairs, hiring events, and classroom/student organization presentations.	Human Resources (HR) attended numerous career fairs in FY25. Grand Valley State University (GVSU), Davenport and Aquinas hosted a combined career fair in Grand Rapids in the fall of 2025. HR connected with various career advisors from these colleges/universities and made connections to increase the talent pipeline from these schools. HR also attended career fairs at Central Michigan University, Saginaw Valley State University, and Ferris State University. In FY25, we had three students complete internships with us and transition into full-time employment with the agency upon graduation.
B.7.3. Strengthen CMHCM's agency culture and core values by updating the external website and rolling out a monthly content campaign on the agency Intranet, ensuring consistent messaging and achieving at least 90% of planned content releases.	In lieu of a formalized process on the external website, Human Resources rolled out the HR Buzz newsletter. In each edition there is a CE-CERT spotlight where the HR team get content from the in-house CE-CERT Coalition group to help boost morale and build agency culture. Human Resources has also presented to Super Management Team and Management Team on numerous occasions regarding findings from the FY24 and FY25 Engagement and Retention Survey to address areas of need.



ADMINISTRATIVE OVERSIGHT

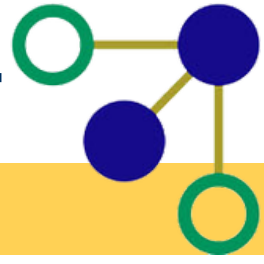


Executive Director

The Executive Director functions as the chief executive and administrative officer of agency programs. The Executive Director administers the programs of the agency in accordance with the approved strategic plan and operating budget, the general policy guidelines established by the Board, the applicable governmental procedures and policies, and the provisions of the Michigan Mental Health Code.

OBJECTIVE	NOTEWORTHY ACCOMPLISHMENTS
B.8.1. Forms and methods of agency communications will be analyzed for effectiveness.	CMCHM made progress in this area across FY25 in a number of ways. • The agency intranet underwent a redesign in order to streamline resources and communication to agency staff. ' • An "Important Communications" section of the intranet was developed along with email listservs able to send out those agency wide communications. • Administrative department leads created team specific mission, vision and values statements. • Management Team members selected an agency value to highlight to staff in "Values into Action" videos. • Administrative Manager meetings were reinstated in FY25 and occur monthly.
D.2.8. CMHCM will increase advocacy efforts with MDHHS to reduce auditing activities and administrative burdens that do not support person-centered services for consumers.	Over FY25 agency staff had many opportunities to provide advocacy to MDHHS around administrative burdens. • The agency Quality Manager was appointed to an Administrative Efficiencies workgroup. • Public comment was submitted to MDHHS on policy updates in a number of areas. • Staff in attendance at conferences and workshops had the opportunity to provide ongoing feedback to MDHHS.

ADMINISTRATIVE OVERSIGHT

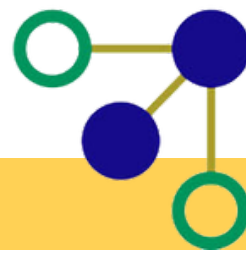


Finance Department

The CMHCM Finance Department is responsible for supporting all aspects of financial sustainability and operations within the agency. In FY25, the Finance Department focused on educating staff on budgeting, revenue, payroll, and benefits along with identifying financial metrics for operational review.

OBJECTIVE	NOTEWORTHY ACCOMPLISHMENTS
B.6.1. Provide trainings to services staff on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) coding practices to expand staff knowledge and improve the accuracy of coding for services provided.	The Finance Team completed formal training on CPT and HCPC coding practices to staff in FY24 at the Super Management meeting. In FY25 the efforts continued through ongoing technical assistance to staff through email and meetings. Targeted education in FY25 was provided in the psychiatric provider meeting, where a review occurred around complexity billing rules.
B.6.2. Build the financial management knowledge and skills among the Management Team through trainings topics such as: budgets, agency revenues, and reading financial reports.	The Chief Financial Officer (CFO) provides monthly updates to the agency Management Team. During those updates, the finance report is reviewed and education provided to the Management team in how to read and interpret the reports. The CFO has also taken this information to the agency Super Management Team during quarterly meetings. All of these efforts have led to an additional knowledge base in the leadership team in the areas of: agency revenues, MSHN Internal Service Fund, cost containment strategies, budgeting and expense review.
B.6.3. Finance metrics will be identified and operationalized for regular monitoring by the Management Team.	The Finance Team focused on review of monthly budget reports (actual vs. budget) with Chief Clinical Officers and their respective staff. Discussions in Management Team focused on a review of trends related to service expenses in key areas including: Autism, Community Living Supports (CLS), Residential, and Local Inpatient Hospitalization. This information was then able to be communicated to the Board Finance Committee on an ongoing basis.

QUALITY MANAGEMENT



Customer Service

Customer Service practices are guided by the CMHCM Customer Services Policy (5.300.002). Customer Service manages all calls in which a consumer expresses dissatisfaction and assists individuals understand their options when filing a grievance, appeal, or second opinion. All Customer Service goals were achieved in FY25.

Grievances

of Grievances:

4

Days to Resolve:

31.5

MDHHS Standard:

90

Appeals

of Appeals:

25

Days to Resolve:

11.56

MDHHS Standard:

30

In FY25, CMHCM processed a total of 48 requests for grievances, appeals, second opinions, and State Fair Hearings. This represents a 36% decrease from FY24.

Second Opinions (Hospitalization)

of Second Opinions Completed:

3

of Second Opinions Withdrawn:

7

Days to Resolve:

1.67

MDHHS Standard:

3

Second Opinions (Services)

of Second Opinions Completed:

11

of Second Opinions Withdrawn:

2

Days to Resolve:

2.36

MDHHS Standard:

5

State Fair Hearings

of State Fair Hearings:

1

No resolution standard has been established by MDHHS



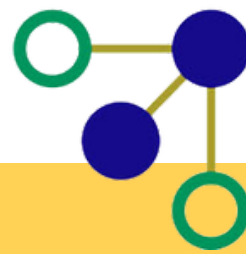
Performance Improvement Projects (PIPs)

CMHCM supports two PIP projects selected by MSHN within the region. In FY25, penetration rates and performance indicator access data was utilized to identify targeted interventions at individual CMHs. CMHCM will participate in interventions as appropriate and necessary to support the overall PIP projects within the region in FY26.

PIP #1: Reducing or eliminating the racial or ethnic disparities between the rate of new persons who are black/African American and the rate of new persons who are white and have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment (HSAG Submission)

PIP #2: Penetration rates by race: Reducing or eliminating the racial or ethnic disparities in penetration rates between Medicaid recipients who are black/African American and Medicaid recipients who are white (Internal MSHN Submission).

QUALITY MANAGEMENT



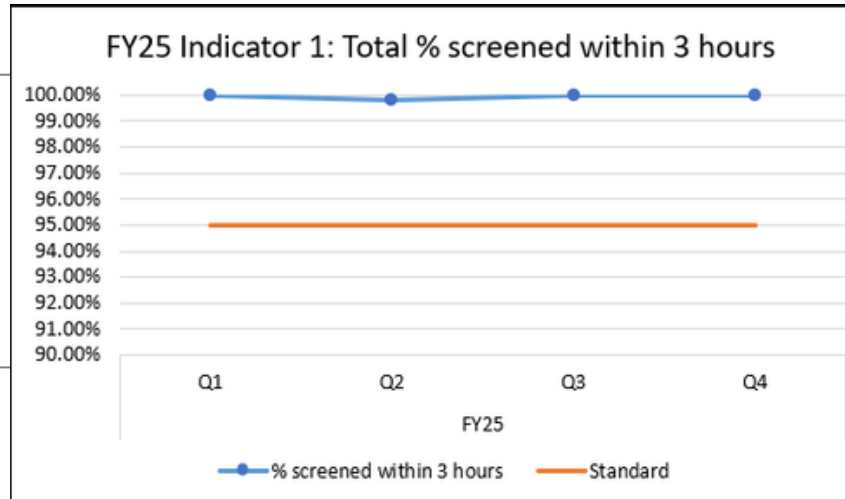
Performance Measurement

Five MDHHS performance measures addressing access to services and outcome metrics are monitored by the Quality Team and submitted quarterly to MSHN and MDHHS. In FY25, CMHCM met annual performance goals for all indicators. MDHHS began a 3 year performance measure overhaul with FY25 being the first measurement year. As a result, the monitoring of indicators 1, 4, and 10 will discontinue while indicator 2 will continue to be monitored as an Access measure through the end of FY26.

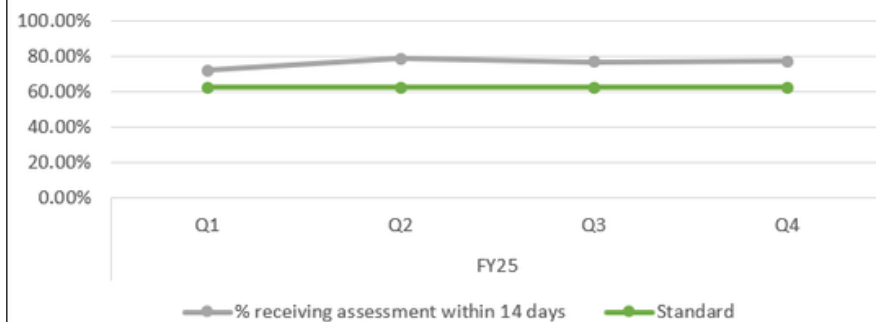
Indicator #1: The percentage of consumers receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.

FY25 Performance: 99.95%

MDHHS Performance Target: 95%



FY25 Indicator 2: % of Total Assessments Completed within 14 Days of Request for Service



Indicator #2: Individuals complete an intake assessment within 14 days of their request for CMHCM services.

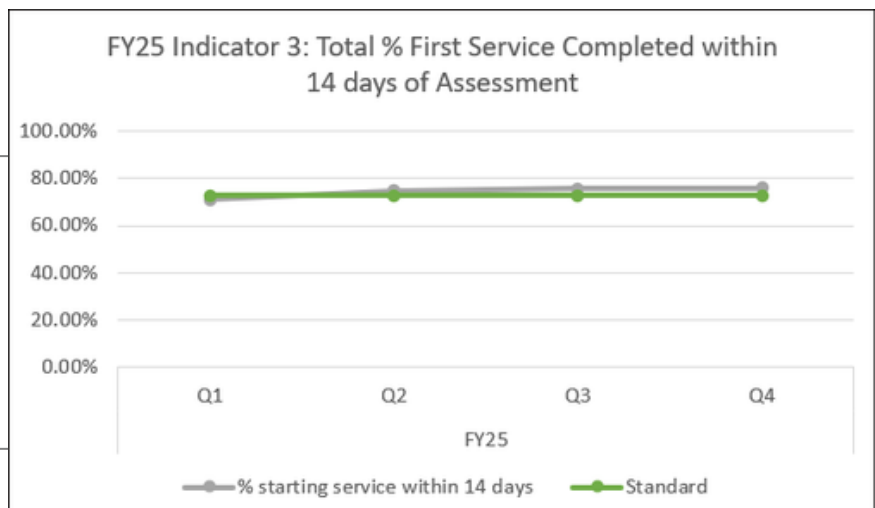
FY25 Performance: 76.22%

MDHHS Performance Target: 62.30%

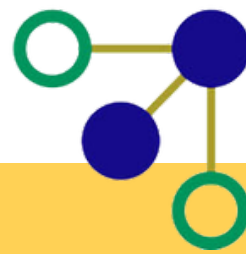
Indicator #3: Individuals receive a first services within 14 days of initial assessment.

FY25 Performance: 74.38%

MDHHS Performance Target: 72.90%



QUALITY MANAGEMENT

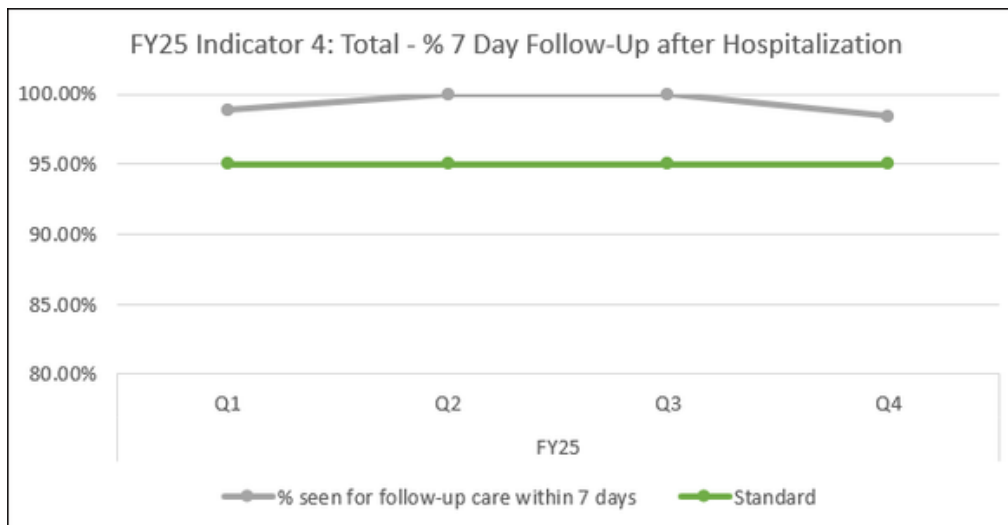


Performance Measurement Continued

Indicator #4: Consumers discharged from the hospital are provided follow-up within seven days.

FY25 Performance: 99.31%

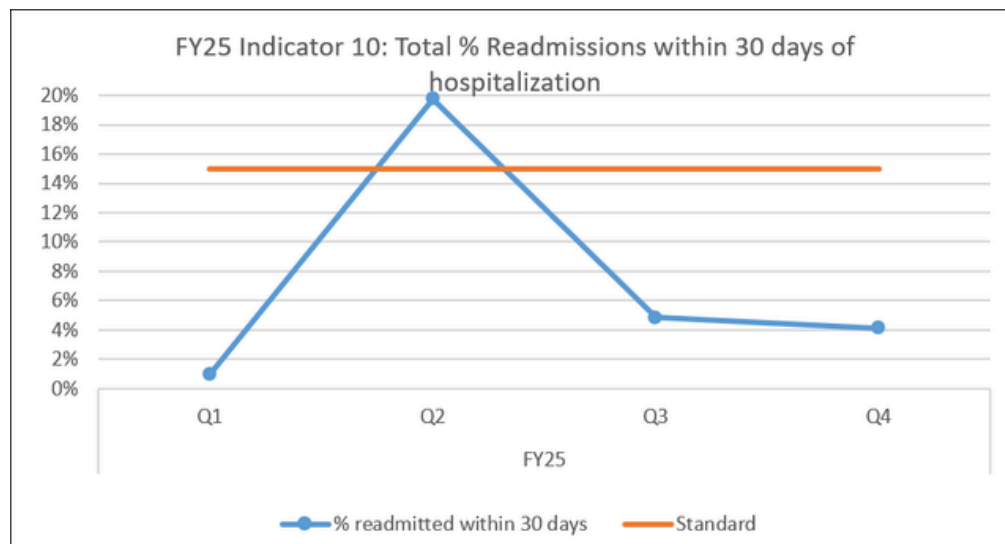
MDHHS Performance Target: 95%



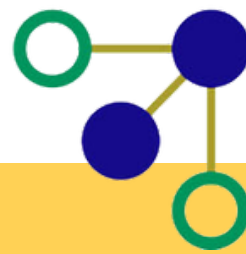
Indicator #10: Fifteen (15) percent or less of consumers will be re-admitted to the inpatient unit within 30 days of discharge from the hospital.

FY25 Performance: 7.00%

MDHHS Performance Target: <15%



QUALITY MANAGEMENT



Continuous Quality Improvement Projects

The CMHCM Quality Team strives to engage in continuous ongoing improvement projects that enhance agency operations, improve clinical services, and create efficiencies for staff. Key accomplishments in continuous quality improvement projects are included below.

NOTEWORTHY ACCOMPLISHMENTS

- The initiative to streamline the Individual Plan of Service (IPOS) in the Electronic Medical Record (EMR) was placed on pause while the Quality Team made significant process revisions as a result of the MDHHS Waiver review. A nursing assessment queue was developed to ensure consumers are offered and scheduled for nursing assessments. Processes for prior authorization of nurse injection services and behavior treatment services were implemented. Medications consents were made electronic to ensure completion within required timeframes. The Quality Team will resume efforts to streamline the IPOS in FY26 to continue improving efficiency and compliance.
- The Quality Team successfully completed the next five priority workflows, building on the initial five developed in FY24. This ongoing project continues to strengthen consistency and efficiency across programs by providing staff with clear, standardized procedures to guide their daily work.

External Compliance Review

CMHCM participates in numerous external reviews throughout the fiscal year for delegated functions, clinical documentation, and service provision by MSHN, MDHHS, and The Joint Commission. These activities allow the agency to continuously evaluate and improve organizational processes and performance.

- The Joint Commission Intracycle Monitoring was completed in Spring 2025 to prepare for the next accreditation survey
- Health Services Advisory Group (HSAG) Performance Measure Validation was completed in July 2025 with a resulting score of 100%

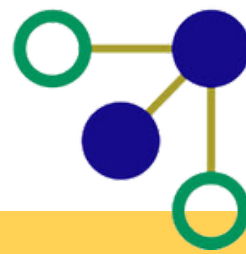
MSHN DELEGATED FUNCTION SITE REVIEW

The MSHN Delegated Function was held in May 2025. The agency achieved full compliance, meeting all standard thresholds. MSHN discontinued routine site reviews effective June 2025 through the end of FY26. Corrective actions will continue to be monitored by MSHN.

MDHHS WAIVER REVIEW

The waiver review was held in June 2024 and finalized in March 2025. The agency submitted corrective action plans on time and received approval from MDHHS to maintain full compliance. This review will move to annual frequency in FY26.

QUALITY MANAGEMENT



Quality Record Review

The CMHCM clinical record review process is a stratified, random review of clinical charts to ensure compliance with required elements established by MDHHS, The Joint Commission, and Mid-State Health Network delegated requirements. Those compliance requirements are intended to increase the consumer experience in receiving services. In FY25, the quality record review process continued to include team and individual training as well as maintaining job aids and reference documents to assist clinical staff with improving clinical documentation in support of consumer outcomes.

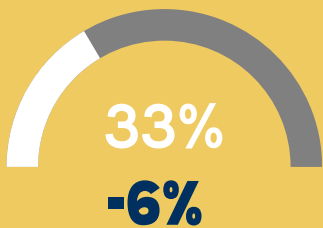
In FY25, the overall average record review score was unchanged and remained at 83%. Compliance for element #4 decreased 6% from 39% to 33%, and for element #14 decreased 6% from 43% to 37%, both remaining below the 75% performance standard. Continued efforts in FY26 will focus on targeted strategies to improve consistency and move closer to meeting established compliance goals.

146

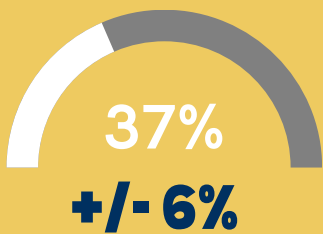
Total number of records reviewed in FY25

83%
+/- 0%

Average record review compliance score in FY25



Achieve or exceed 75% compliance for the record review element #4, "Does the psychosocial assessment accurately reflect the current diagnosis, selected designation, and chosen level of care?"



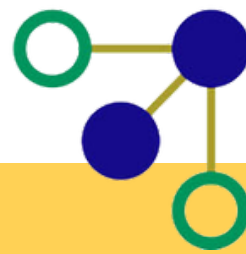
Achieve or exceed 75% compliance for the record review element #14, "Does the Intervention/Supports section of each goal explain the services that each provider or natural/community supports are responsible to provide?"

Program Evaluation



In FY25, the Quality Team refined the monthly Program Evaluation process by implementing a streamlined data summary that highlights key performance metrics. This revised approach promotes more targeted analysis of outcomes and improves efficiency while maintaining a high level of accountability and transparency in performance reporting.

QUALITY MANAGEMENT



Consumer Satisfaction

Each year, CMHCM's Quality Department conducts a self-reflective survey to evaluate consumers' perception of the mental health services they have received. The survey provides both qualitative and quantitative assessment of consumer experience for all representative populations in the areas of overall satisfaction, outcomes, functioning, appropriateness, quality, availability, and accessibility of care. CMHCM assesses consumer satisfaction for individuals receiving services through an annual survey. The surveys were conducted between June 23, 2025, to July 21, 2025. Satisfaction scores with overall services for each survey population are found below.

86%

77%

94%

86%



**Adults receiving
services for
Mental Illness
(MI)**
(253 respondents)

**Adults receiving
Assertive
Community
Treatment (ACT)
Services**
(31 respondents)

**Adults receiving
services for I/DD**
(64 respondents)

**Adults receiving
Behavioral Health
Home services**
(22 respondents)

95%

79%

92%

88%

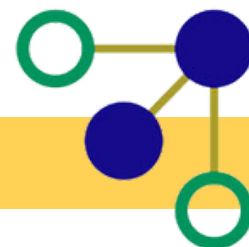


**Children/Families
receiving Home-
Based services**
(22 respondents)

**Children/Families
receiving MI
services**
(58 respondents)

**Children receiving
services for I/DD**
(39 respondents)

**Total CMHCM
Satisfaction Score**
(489 respondents)



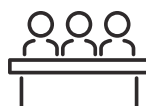
Corporate Compliance

The Corporate Compliance Program (CCP) within CMHCM demonstrates efforts to promote prevention, detection, and resolution of instances of conduct that do not conform to: Federal and State Law, Federal, State, private pay, or health care program requirements, and agency ethical and business policies. The CCP provides a system of reporting suspected fraud, waste, and abuse in health care delivery to assist in the provision of quality care to consumers. The CCP incorporates the seven areas of corporate compliance suggested by the Office of the Inspector General (OIG). The seven areas include:

1) Designation of a Corporate Compliance Officer and naming of a compliance committee



CORPORATE COMPLIANCE OFFICER:
Chief Operating Officer (COO)



COMPLIANCE COMMITTEE:
Standards Compliance Committee

2) Implementation of written policies, procedures, and standards of conduct

The following policies in the CMHCM Administrative Manual are in support of the CCP:

Board Administration

- Bylaws (includes section on Conflict of Interest pertaining to CMHCM)
- Conflict of Interest Pertaining to Mid-State Health Network

Services Administration

- Concerns, Complaints, Disputes, Grievances, Appeals – Overview 2-100-002
- Utilization Management 2-400-001

Provider Network

- Corporate Compliance and Ethical Standards 3-100-005
- Provider Network, Clinical Credentialing and Privileging 3-300-001
- Provider Site Review 3-500-002
- Event Verification 3-500-003
- Ad Hoc Investigations Process – Guideline 3-500-004
- Disqualified Individuals/Organizations 3-400-002

Personnel Administration

- Employee Qualifications 4-200-002
- Credentialing and Recredentialing 4-200-003
- Ethical Behavior 4-200-007
- Progressive Discipline 4-200-013

General Administration

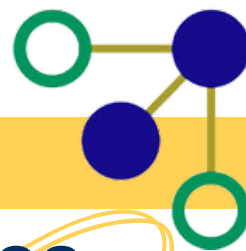
- Corporate Compliance 5-100-011
- Ethical Practices – Operations 5-100-012
- Quality Assessment and Performance Improvement 5-300-004
- Privacy and Security Incident Response 5-700-006

Financial Administration

- Annual Audit 6-400-004
- Internal Accounting Controls 6-400-006
- Worker Classification: Independent Contractor vs. Employee 6-400-016

Recipient Rights

- Recipient Rights, General Administration, General Rights 7-100-006



Corporate Compliance

3) Conducting effective training and education

Corporate Compliance training is provided during orientation for all new staff. Ongoing corporate compliance training for staff occurs on an annual basis.

392

**number of staff
trained in FY25 on
Corporate
Compliance**

4) Development of effective lines of communication

Employees received annual training as indicated above which includes information relating to how to directly access the Corporate Compliance Officer for issues addressed under the CCP. Concerns may be reported on an anonymous basis (if desired) and can be verbal, in person, via telephone, or in writing (through US mail or via e-mail). Any provider with knowledge or concern about an ethical violation or compliance issue is encouraged to report that concern to the CMHCM Provider Network Manager or Corporate Compliance Officer who shall review available information and take appropriate steps.

There shall be no retaliation against any employee or contractor who submits a compliance report/complaint for what the employee reasonably believes to be a violation of CCP standards.

5) Enforcement of standards through well-publicized disciplinary guideline

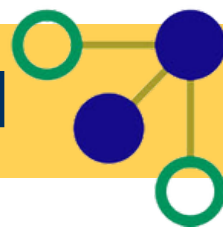
Employees violating the agency standards of conduct, policies, and/or procedures are subject to disciplinary action up to, and including, termination from employment. Disciplinary guidelines are documented in the Ethical Behavior Policy (4.200.007) and Progressive Discipline Policy (4.200.013). Violation of the Code of Ethics by contractors may be considered a material breach of contract and may result in contract termination.

6) Conducting internal monitoring and auditing

The internal monitoring and auditing component of the CCP is conducted by several departments and also includes efforts of external review entities to enhance internal processes. The Standards Compliance Committee reviews the effectiveness of the CCP during its regularly scheduled meetings.

7) Responding promptly to detected offenses and developing corrective action

Upon becoming informed of a complaint, the Corporate Compliance Officer (or designee) determines whether the alleged wrongdoing suggests a material violation of an applicable law or whether the requirements of the CCP have occurred. If so, immediate action is taken to preserve potential evidence and an immediate investigation occurs. If the complaint is substantiated, immediate steps for corrective action occurs.



WALK AND ROLL & WALK A MILE EVENTS



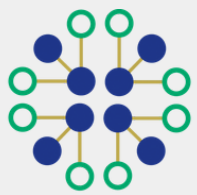
The 27th Annual Walk & Roll event hosted by Mid-Michigan Industries and CMHCM was held on May 10, 2025 at Island Park in Mt. Pleasant. Over 130 individuals participated in this free community event to promote mental health awareness, diversity, inclusion, and person-centered perspectives. The Annual Walk a Mile Rally organized by CMHAM was held on the Capital Lawn in Lansing on September 17, 2025. In addition, New Journey Clubhouse and CMHCM hosted a Walk a Mile on June 12, 2025. The Walk a Mile Rally has played a critical role in reducing stigma, educating policymakers, and spotlighting the ongoing need for behavioral health funding and services across Michigan.



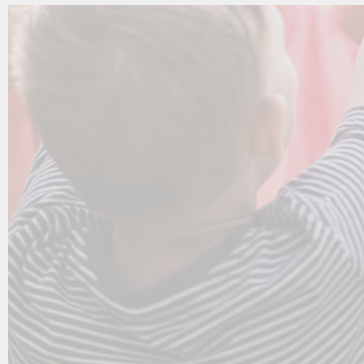
In April of 2025 CMCHM renewed the MoodFit contract for another year after an evaluation of the benefits of its free availability to the community by CMHCM. Data from May of 2025 showed 610 users. This represents a 13% increase over the 535 users in May of 2024. New marketing procedures have been implemented as well as a new procedure for providing MoodFit as a resource to those who are denied services at Access.



30 events were held from January 1 – present. These included resource tables at community events and health fairs, community baby showers, our own in-house health fairs, and Anthony Grupido giving key note addresses at local schools. Over 5,000 people were reached during these events.



**Community
Mental Health**
FOR CENTRAL MICHIGAN



CMHCM Locations:

Clare County
789 North Clare Avenue
Harrison, MI 48625

Gladwin County
655 East Cedar Avenue
Gladwin, MI 48624

Isabella County
301 South Crapo Street
Mt. Pleasant, MI 48858

Mecosta County
500 South Third Avenue
Big Rapids, MI 49307

Midland County
218 Fast Ice Drive
Midland, MI 48642

Osceola County
4473 220th Avenue
Reed City, MI 49677



CMHCM Crisis Hotline (24/7)
1-800-317-0708

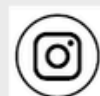
CMHCM Main Line
1-989-772-5938



Website:
www.cmhcm.org



Facebook:
<https://www.facebook.com/CMHforCentralMichigan>



Instagram:
@cmhforcentralmichigan