EVALUATION OF QUALITY IMPROVEMENT PROGRAM PLAN EFFECTIVENESS FY2025

10/1/2024 - 9/30/2025

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Prepared By:
CMHA-CEI Quality Improvement Team
2/20/2026

Reviewed By:
CMHA-CEI Board Program and Planning Committee
3/9/2026

Approved By:
CMHA-CEI Board of Directors
3/19/2026

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Overview

An evaluation of the QIP plan is completed at the end of each calendar year. The evaluation summarizes activity that occurred around the goals and objectives of the CMHA-CEI's Quality Improvement Program Plan and progress made toward achieving the goals and objectives.

Performance Indicators

Michigan Mission-Based Performance Indicators (MMBPIS)

MDHHS, in compliance with federal mandates, establishes measures in the areas of access, efficiency, and outcomes. Data is abstracted regularly and compiled into quarterly reports that are submitted to MSHN for analysis and regional benchmarking.

If CMHA-CEI performance is below the identified goal, the QI Team will facilitate the development of a Corrective Action Plan (CAP). The CAP will include a summary of the current situation, including causal/contributing factors, a planned intervention, and a timeline for implementation. CAPs are submitted to the PIHP for review/approval.

Changes in established PI reporting standards were adopted beginning FY20 Q3, which eliminated exceptions, exclusions, and the 95% standard for Indicators 2 and 3.

Indicator #1:

- The percentage of persons during the quarter receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. Standard = 95% or greater.
- Two sub-populations: Children and Adults.

Indicator #2a:

- The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. No standard, higher is better.
- Benchmark: 62.3% or greater (measured by total population, not sub-population).
- Four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.

Indicator #3:

- Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional. No standard, higher is better.
- Benchmark: 72.9% or greater (measured by total population, not sub-population).
- Four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.

Indicator #4a:

- The percentage of discharges from a psychiatric inpatient unit during the quarter that were seen for follow-up care within 7 days. Standard = 95% or greater.
- Two sub-populations: Children and Adults.

Indicators #5 and #6:

- The total number of persons receiving a face-to-face assessment with professionals that result in decisions to deny CMHSP services and total number of persons receiving mental health service following a second opinion.
- Submitted as a count of full population records.

Indicator #10:

- The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less.
- Two sub-populations: Children and Adults.

New Behavioral Health Quality Program

Beginning in 2025, new Performance Measures began to be implemented through a new Behavioral Health Quality (BHQ) Program, occurring over a 3-year rollout. These new measures are replacing MMBPIS. Implications for MMBPIS:

- All CMHA-CEI MMBPIS submissions directly to MDHHS ceased after FY24.
    - Included Full Population data for PIs 1, 2a, 3, 4a, 5, 6, and 10.
- Most CMHA-CEI MMBPIS submissions to MSHN ceased after FY25.
    - Included Medicaid Population data for PIs 1, 2a, 3, 4a, and 10.
- Some CMHA-CEI MMBPIS submissions to MSHN are continuing:
    - Medicaid Population data for PI 2a will be submitted to MSHN for continued official reporting throughout FY26. Indicator methodology is unchanged, although a new exclusion has been added for FY26 regarding CCBHC-only consumers.
    - Medicaid Population data for PI 1 will be submitted to MSHN for continued Network Adequacy Reporting requirements indefinitely.
    - Medicaid Population data for PI 3 will be submitted to MSHN through FY26 Q1 for Performance Improvement Project Use.
- Data for MMBPIS measures will continue to be run and used by CMHA-CEI internally throughout FY26 as initial data from the new BHQ measures, reported by the state, is not timely or usable. The QI Team will work on improving processes to incorporate data from the new indicators throughout FY26.

New BHQ Measures:

- The Bureau of Specialty Behavioral Health Services in MDHHS began using new quality reporting measures as part of a 3-year rollout starting in 2025. The transformed program is more comprehensive and better defined, with a more rigorous methodology that aligns with other state and national requirements. Measurement years have switched to calendar years from fiscal years, with many new indicators providing a 12-month look-back period.
- The first year (2025) focused on aligning reporting requirements for PIHPs with CMS Core Set Reporting. The second year (2026) will focus on rolling out stratification of measures, along with adding several key measures. The third year (2027) will focus on implementing patient experience and Home and Community Based Services (HCBS) measures.
- CMHA-CEI and MSHN will continue to be responsible for the continued use of MMBPIS Indicator 2 (the percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service) throughout FY26 as a measure for Access to Care (shown below in red text). Although methodology is unchanged, CCBHC-only consumers should now be excluded from the submission of Medicaid Population data when applicable.
    - A new Access to Care measure is being developed by MDHHS for use from 2027 onward, which will likely be a continuation of the MMBPIS Indicator 2 methodology with further modifications.
- MDHHS will be responsible for all other Measures rolling out over the 3 year period (shown below in black text):

Year	Source	Behavioral Health Quality Measure	Program	Domain	Responsibility
Year 1 (2025)	ADD	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	BHCS	MH	MDDHS
	FUH	Follow-up After Hospitalization for Mental Illness*		Access	
	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics		MH	
	APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
	FUA	Follow-up After Emergency Department Visit for Substance Use*		Access	
	FUM	Follow-up After Emergency Department Visit for Mental Illness*			
	IET	Initiation and Engagement into Substance Use Disorder Treatment		SUD	
Year 2 (2026)	SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	BHCS	Comorbid Conditions	MDHHS
	HPCMI	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)			
	OUD	Use of Pharmacotherapy for Opioid Use Disorder		SUD	
	SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia		MH	
	MMBPIS 2	**Continuation of MMBPIS Indicator 2: The percentage of new persons during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, I/DD-adults, I/DD-children.)**		**Access**	**CMHSPs and PIHPs**
Year 3 (2027)	CAHPS	How people rated their health plan	QRS	Patient Experience	MDHHS
		Getting care quickly			
		Getting needed care			
		How well doctors communicate			
		Health plan customer service			
	HCBS CAHPS	Choosing the Services that Matter to You	HCBS	Patient Experience and Home and Community Based Services	
		Community Inclusion and Empowerment			
		Transportation to Medical Appointments			
		Physical Safety			
		Personal Safety and Respect			
		Staff are Reliable and Helpful			
		Staff Listen and Communicate Well			
		Unmet Needs Composite Measure			
	MLTSS-1	Medicaid Managed Long-Term Services and Supports Comprehensive Assessment and Update	MLTSS		
	MLTSS-2	Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update			
		Social Needs Screening- Tool TBD.	CCBHC	Social Needs	
	MSC	Medical Assistance with Smoking and Tobacco Use Cessation	BHCS	SUD	
	CDF	Screening for Depression and Follow-up Plan*	BHCS	MH	

FY25 MMBPIS Data: MH and IDD

Per regional quarterly reports of data from the MH/IDD Medicaid populations, MSHN demonstrated performance above the MDHHS standards or benchmarks for MMBPIS:

- Indicator 1 – Child – >95% Standard – All Quarters FY24 and FY25
- Indicator 1 – Adult – >95% Standard – All Quarters FY24 and FY25
- Indicator 2 – Total* – >62.3% Benchmark – FY24 Quarters 2/3/4, FY25 Quarter 4
- Indicator 3 – Total* – >72.9% Benchmark – No Quarters FY24 or FY25
- Indicator 4a – Child – >95% Standard – FY24 Quarters 2/3/4, All Quarters FY25
- Indicator 4a – Adult – >95% Standard – All Quarters FY24 and FY25
- Indicator 10 – Child – <15% Standard – All Quarters FY24 and FY25
- Indicator 10 – Child – <15% Standard – All Quarters FY24 and FY25

Per internal quarterly reports of data from the MH/IDD Full Population, CMHA-CEI demonstrated performance above the MDHHS standards or benchmarks for MMBPIS:

- Indicator 1 – Child – >95% Standard – FY24 Quarters 1/2/4, All Quarters FY25
- Indicator 1 – Adult – >95% Standard – All Quarters FY24 and FY25
- Indicator 2 – Total* – >62.3% Benchmark – All Quarters FY24 and FY25
- Indicator 3 – Total* – >72.9% Benchmark – FY25 Quarter 4
- Indicator 4a – Child – >95% Standard – All Quarters FY25
- Indicator 4a – Adult – >95% Standard – FY24 Quarters 1/2/4, All Quarters FY25
- Indicator 10 – Child – <15% Standard – All Quarters FY24 and FY25
- Indicator 10 – Child – <15% Standard – All Quarters FY24 and FY25

From FY24 to FY25, CMHA-CEI saw improvements in MMBPIS Indicators 1 (Child), 2a (Total*), 3 (Total*), 4a (Child/Adult), and 10 (Child). Although the overall scores for Indicators 1 and 10 for Adults decreased from FY24 to FY25, this decrease was very slight and the agency remains compliant with indicator standards. CMHA-CEI data is included below for Indicators** 1, 2a, 3, 4a, and 10 for both the Medicaid Population and Full Population. Graphs are included for the Full Population.

* MDHHS Benchmarks for Indicators 2 and 3 are measured by the total population, not the MI-Adult/MI-Child/IDD-Adult/IDD-Child sub-populations.

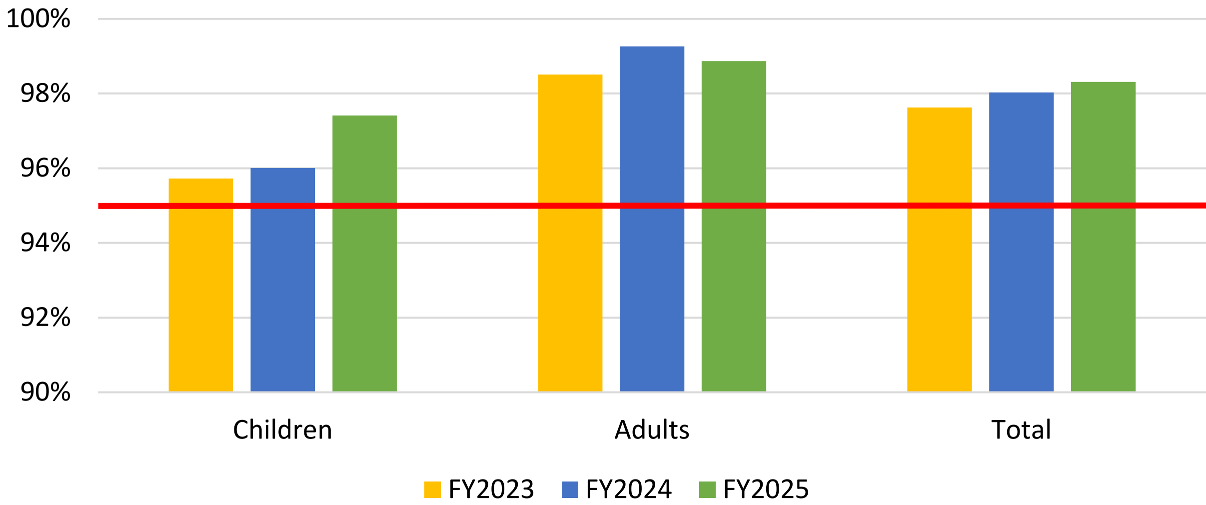
** Internal data is included for MMBPIS Indicators 5 and 6 (the total number of persons receiving a face-to-face assessment with professionals that result in decisions to deny CMHSP services and total number of persons receiving mental health service following a second opinion). Indicators 5 and 6 are no longer submitted (FY25 onward). CMHA-CEI data for PIs 5/6 from FY25 below is internal only and included only for comparison.

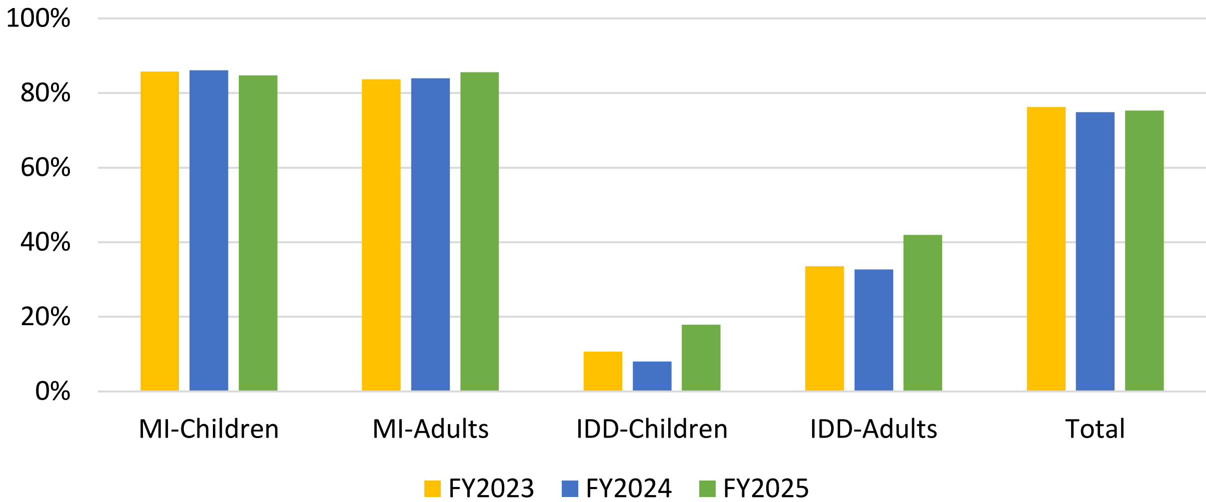
CMHA-CEI Performance Indicator Results (Medicaid Only)

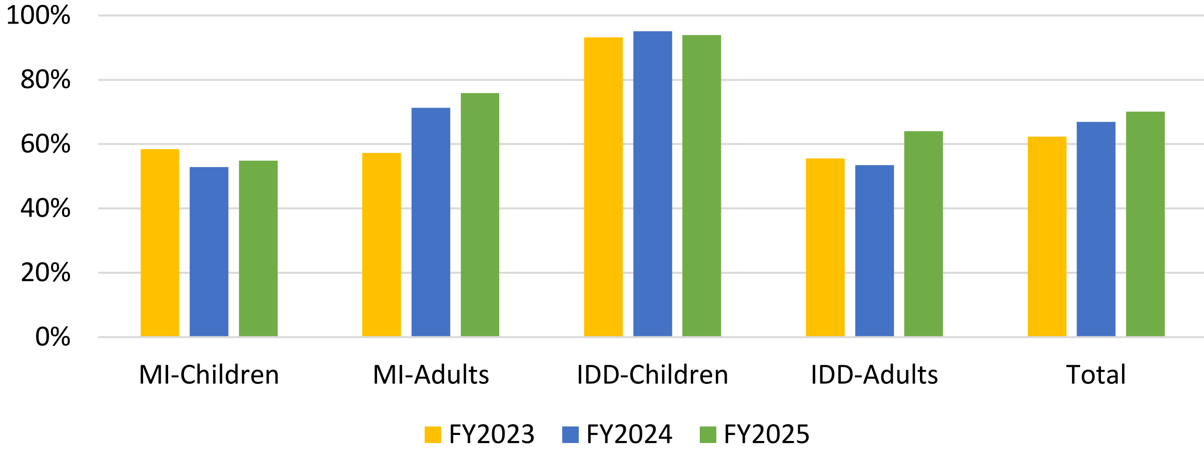
Indicator	Population	FY2023 Total	FY2024 Total	FY2025 Q1	FY2025 Q2	FY2025 Q3	FY2025 Q4	FY2025 Total
PI 1 ≥ 95%	Children	95.82%	96.88%	95.50%	97.34%	97.06%	99.66%	97.33%
	Adults	98.53%	99.32%	98.93%	99.08%	99.17%	98.46%	98.90%
	Total	**97.69%**	**98.45%**	**97.71%**	**98.42%**	**98.36%**	**98.83%**	**98.34%**
PI 2a	MI-Children	84.73%	84.92%	79.05%	82.65%	86.09%	88.61%	83.84%
	MI-Adults	84.31%	83.28%	83.23%	87.23%	85.50%	85.84%	85.47%
	IDD-Children	12.00%	11.63%	45.33%	35.35%	4.82%	8.00%	22.69%
	IDD-Adults	38.50%	33.33%	50.00%	46.15%	53.33%	27.78%	44.12%
	Total	**77.28%**	**75.72%**	**76.28%**	**77.69%**	**75.40%**	**73.16%**	**75.69%**
PI 3	MI-Children	58.62%	52.36%	51.77%	49.62%	57.08%	67.04%	55.56%
	MI-Adults	57.56%	67.76%	80.00%	78.55%	68.94%	72.01%	74.86%
	IDD-Children	93.04%	94.00%	96.81%	92.59%	93.02%	94.07%	94.09%
	IDD-Adults	54.22%	50.00%	72.22%	50.00%	61.54%	66.67%	63.79%
	Total	**62.86%**	**65.54%**	**71.74%**	**69.06%**	**67.74%**	**74.71%**	**70.78%**
PI 4a ≥ 95%	Children	98.91%	99.03%	100.00%	100.00%	100.00%	100.00%	100.00%
	Adults	98.42%	96.37%	96.83%	97.12%	99.33%	97.56%	97.83%
	Total	**98.57%**	**96.88%**	**97.67%**	**97.84%**	**99.47%**	**97.83%**	**98.35%**
PI 10 ≤ 15%	Children	11.30%	8.67%	12.99%	14.71%	10.13%	6.78%	11.67%
	Adults	12.50%	10.40%	8.24%	12.78%	12.28%	8.21%	10.26%
	Total	**12.25%**	**10.17%**	**9.05%**	**13.20%**	**11.86%**	**8.03%**	**10.51%**

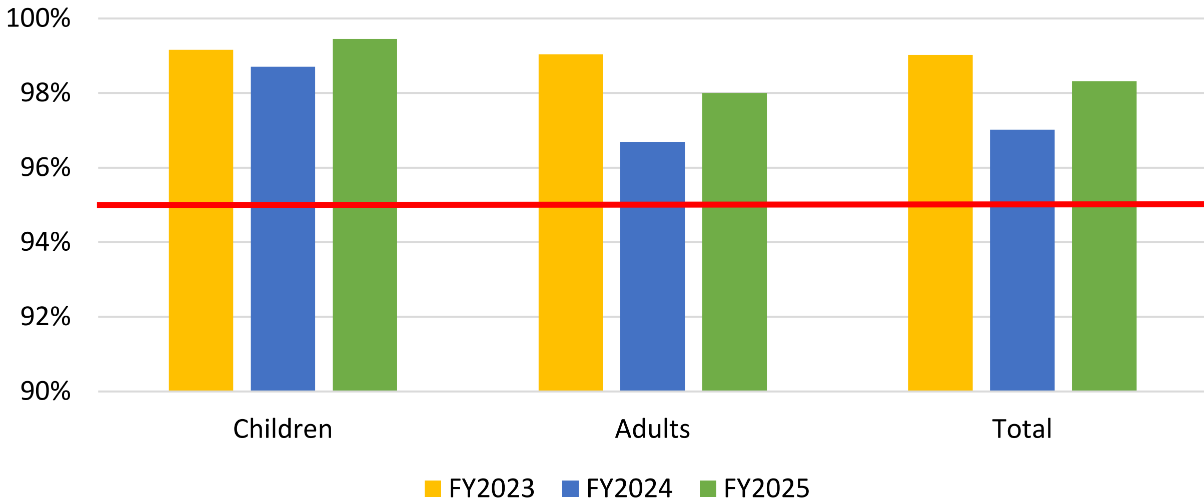
CMHA-CEI Performance Indicator Results (Full Population)

Indicator	Population	FY2023 Total	FY2024 Total	FY2025 Q1	FY2025 Q2	FY2025 Q3	FY2025 Q4	FY2025 Total
PI 1 ≥ 95%	Children	95.72%	96.01%	95.99%	97.01%	97.20%	99.72%	97.41%
	Adults	98.51%	99.26%	98.58%	99.18%	99.26%	98.49%	98.87%
	Total	**97.63%**	**98.03%**	**97.58%**	**98.32%**	**98.43%**	**98.89%**	**98.32%**
PI 2a	MI-Children	85.77%	86.10%	79.63%	83.73%	88.32%	87.45%	84.73%
	MI-Adults	83.68%	83.95%	84.93%	87.10%	84.53%	85.92%	85.62%
	IDD-Children	10.71%	8.03%	37.63%	30.89%	3.25%	6.34%	17.88%
	IDD-Adults	33.58%	32.76%	48.00%	40.00%	50.00%	30.43%	41.98%
	Total	**76.29%**	**74.88%**	**76.74%**	**77.84%**	**75.00%**	**71.55%**	**75.36%**
PI 3	MI-Children	58.48%	52.83%	51.74%	48.79%	55.08%	67.71%	54.89%
	MI-Adults	57.29%	71.29%	80.47%	77.93%	72.92%	72.55%	75.89%
	IDD-Children	93.18%	95.11%	95.83%	92.66%	93.10%	94.21%	93.95%
	IDD-Adults	55.55%	53.49%	71.43%	50.00%	57.14%	70.59%	64.06%
	Total	**62.30%**	**66.89%**	**71.12%**	**67.84%**	**67.58%**	**74.62%**	**70.16%**
PI 4a ≥ 95%	Children	99.16%	98.71%	98.33%	100.00%	100.00%	100.00%	99.45%
	Adults	99.04%	96.69%	97.18%	98.20%	98.61%	98.36%	98.00%
	Total	**99.02%**	**97.01%**	**97.44%**	**98.61%**	**98.91%**	**98.58%**	**98.32%**
PI 10 ≤ 15%	Children	11.24%	8.59%	13.58%	14.56%	9.64%	6.15%	11.45%
	Adults	12.19%	10.07%	7.79%	12.24%	11.26%	7.78%	9.67%
	Total	**11.97%**	**9.88%**	**8.74%**	**12.73%**	**10.96%**	**7.57%**	**9.97%**


PI 1: Crisis Screening Disposition
Standard: ≥ 95% | Full Population
100%
98%
96%
94%
92%
90%
Children
Adults
Total
FY2023
FY2024
FY2025


PI 2a: 14-Day Timeliness from Inquiry to Assessment
No Standard | Higher = Better | Full Population
100%
80%
60%
40%
20%
0%
MI-Children
MI-Adults
IDD-Children
IDD-Adults
Total
FY2023
FY2024
FY2025

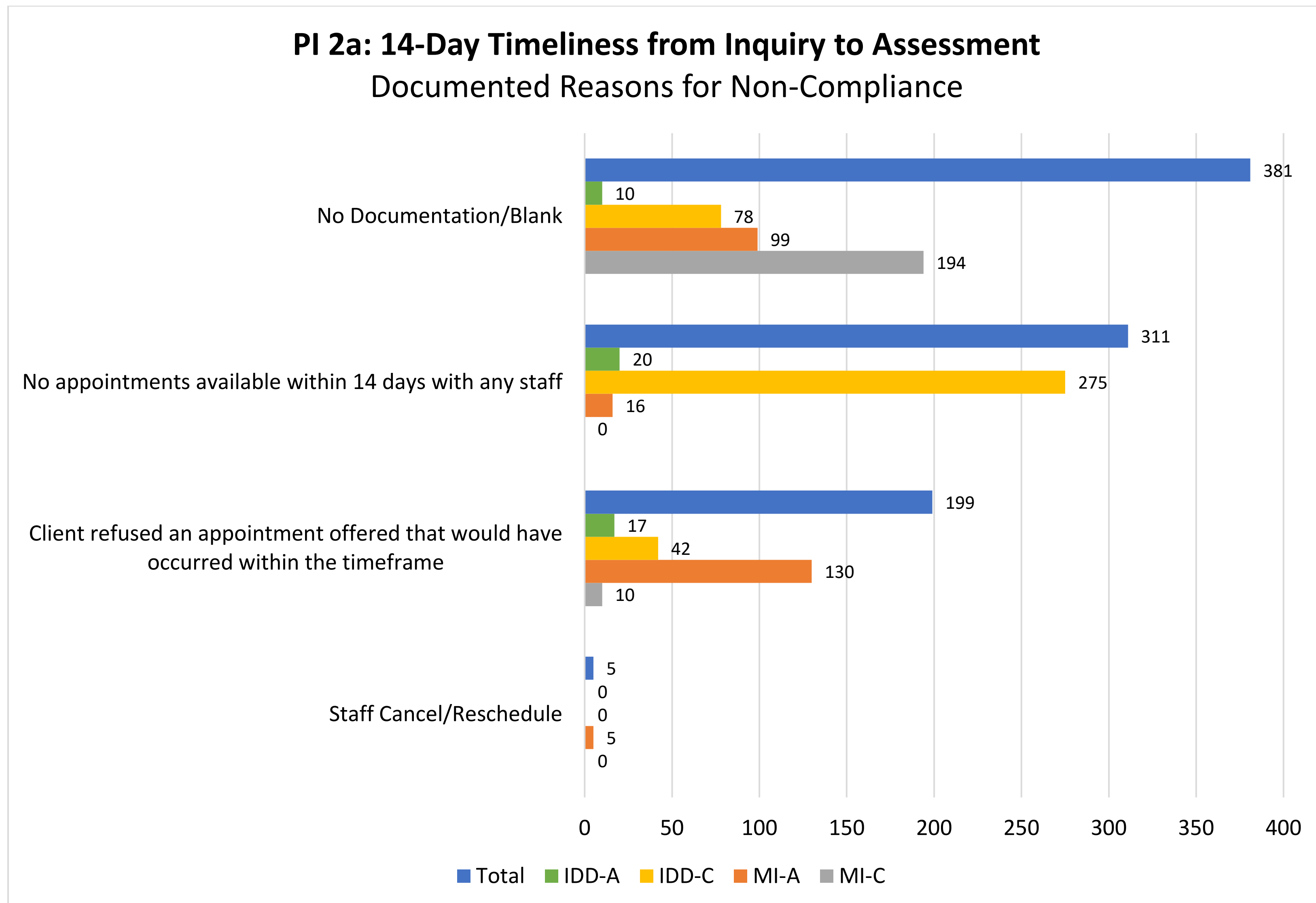

PI 3: 14-Day Timeliness from
Assessment to Start of Service
No Standard | Higher = Better | Full Population
100%
80%
60%
40%
20%
0%
MI-Children
MI-Adults
IDD-Children
IDD-Adults
Total
FY2023
FY2024
FY2025


PI 4a: 7-Day Follow-up after Hospitalization
Standard: ≥ 95% | Full Population
100%
98%
96%
94%
92%
90%
Children
Adults
Total
FY2023
FY2024
FY2025

PI 5/6 *Full Population	Total # of New Persons receiving an initial non-emergent face-to-face professional assessment	Total # of Persons assessed but denied services	Total # of Persons requesting a second opinion	Total # of Persons receiving services after a second opinion
FY22 Total	3205	418	22	21
FY23 Total	3855	397	9	7
FY24 Total	4225	411	3	3
FY25 Q1	989	56	2	2
FY25 Q2	1074	106	0	0
FY25 Q3	1047	90	0	0
FY25 Q4	948	112	0	0
FY25 Total	4058	364	2	2

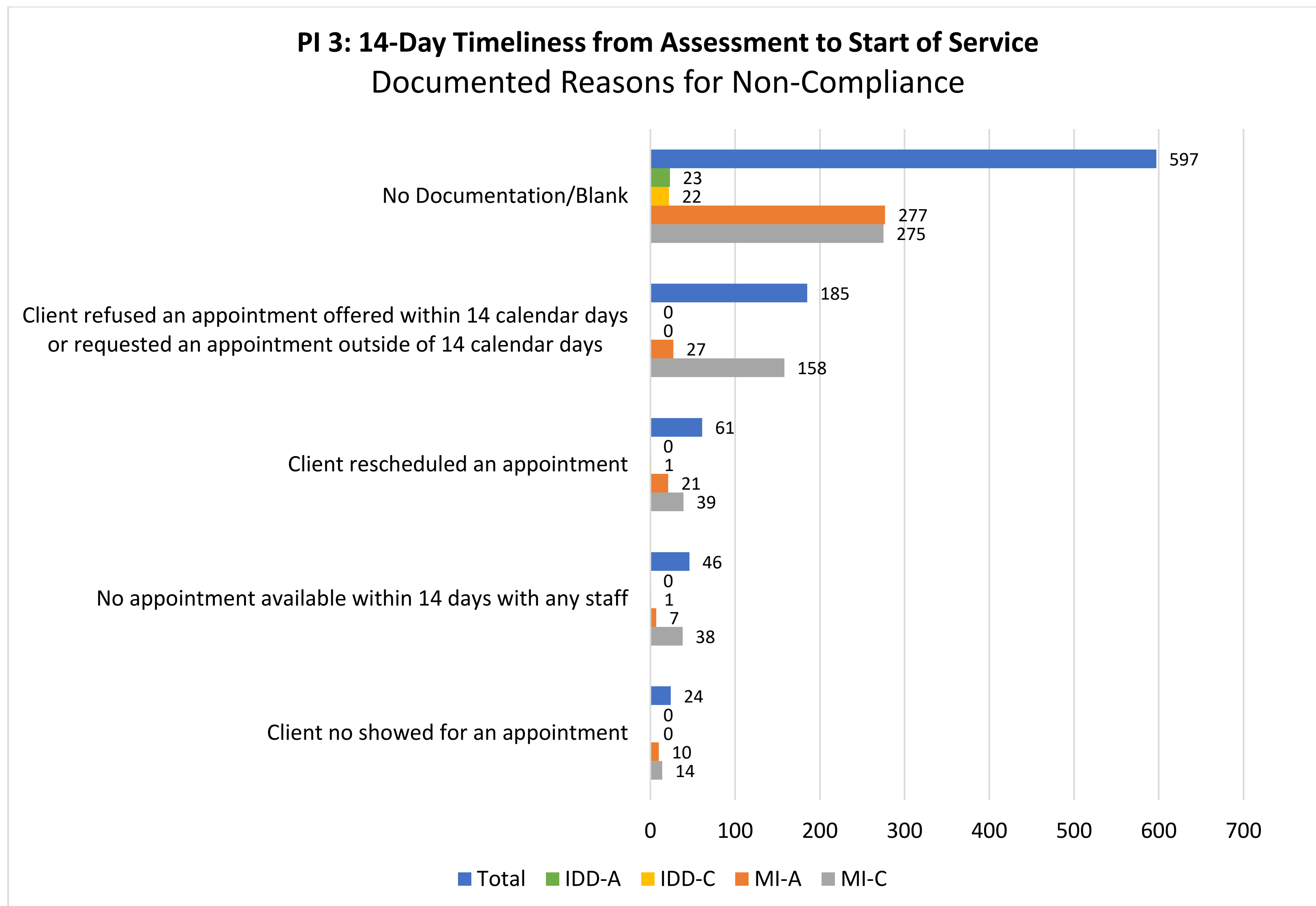
PI 5/6 *Full Population	% of Persons assessed but denied services	% of Persons requesting a second opinion	% of Persons receiving services after a second opinion
FY22 Total	13%	5%	95%
FY23 Total	10%	2%	78%
FY24 Total	10%	1%	100%
FY25 Total	9%	1%	100%

PI 2a: Documented Reasons for Non-Compliance



Full Population (Total)	Q1	Q2	Q3	Q4	FY2025
No Documentation/Blank	135	97	68	81	381
Client refused an appointment offered that would have occurred within the timeframe	34	63	57	45	199
No appointments available within 14 days with any staff	31	49	117	114	311
Staff Cancel/Reschedule	0	4	0	1	5
IDD-Adults	**Q1**	**Q2**	**Q3**	**Q4**	**FY2025**
No Documentation/Blank	4	3	2	1	10
Client refused an appointment offered that would have occurred within the timeframe	6	4	2	5	17
No appointments available within 14 days with any staff	3	2	5	10	20
IDD-Children	**Q1**	**Q2**	**Q3**	**Q4**	**FY2025**
No Documentation/Blank	17	21	7	33	78
Client refused an appointment offered that would have occurred within the timeframe	15	21	5	1	42
No appointments available within 14 days with any staff	26	43	107	99	275
MI-Adults	**Q1**	**Q2**	**Q3**	**Q4**	**FY2025**
No Documentation/Blank	51	16	17	15	99
Client refused an appointment offered that would have occurred within the timeframe	10	33	49	38	130
No appointments available within 14 days with any staff	2	4	5	5	16
Staff Cancel/Reschedule	0	4	0	1	5
MI-Children	**Q1**	**Q2**	**Q3**	**Q4**	**FY2025**
No Documentation/Blank	63	57	42	32	194
Client refused an appointment offered that would have occurred within the timeframe	3	5	1	1	10

PI 3: Documented Reasons for Non-Compliance



Full Population (Total)	Q1	Q2	Q3	Q4	FY2025
No Documentation/Blank	135	181	162	119	597
Client chose not to pursue services	0	0	1	1	2
Client chose a provider outside of network	0	2	1	0	3
Client no showed for an appointment	6	10	5	3	24
Client rescheduled an appointment	2	32	19	8	61
Client refused an appointment offered within 14 calendar days or requested an appointment outside of 14 calendar days	61	21	62	41	185
No appointment available within 14 days with any staff	12	16	9	9	46
Staff Cancel/Reschedule	0	3	0	1	4
Other (Closed client comes back within 60 days; Client is enrolled in school and is unable to take advantage of services; Substance Abuse Enrollment)	0	1	0	3	4
IDD-Adults	**Q1**	**Q2**	**Q3**	**Q4**	**FY2025**
No Documentation/Blank	6	6	6	5	23
IDD-Children	**Q1**	**Q2**	**Q3**	**Q4**	**FY2025**
No Documentation/Blank	4	6	6	6	22
Client rescheduled an appointment	0	1	0	0	1
No appointment available within 14 days with any staff	0	1	0	0	1
Other (Closed client comes back within 60 days; Client is enrolled in school and is unable to take advantage of services; Substance Abuse Enrollment)	0	0	0	1	1

MI-Adults	Q1	Q2	Q3	Q4	FY2025
No Documentation/Blank	50	64	80	83	277
Client chose not to pursue services	0	0	1	1	2
Client chose a provider outside of network	0	2	1	0	3
Client no showed for an appointment	4	3	2	1	10
Client rescheduled an appointment	2	5	8	6	21
Client refused an appointment offered within 14 calendar days or requested an appointment outside of 14 calendar days	9	5	7	6	27
No appointment available within 14 days with any staff	2	1	2	2	7
Staff Cancel/Reschedule	0	3	0	1	4
Other (Closed client comes back within 60 days; Client is enrolled in school and is unable to take advantage of services; Substance Abuse Enrollment)	0	0	0	1	1
MI-Children	**Q1**	**Q2**	**Q3**	**Q4**	**FY2025**
No Documentation/Blank	75	105	70	25	275
Client no showed for an appointment	2	7	3	2	14
Client rescheduled an appointment	0	26	11	2	39
Client refused an appointment offered within 14 calendar days or requested an appointment outside of 14 calendar days	52	16	55	35	158
No appointment available within 14 days with any staff	10	14	7	7	38

Outcomes Management System:
Efficiency Objective Data Collection for Integrative Treatment and Recovery Services

Efficiency Objective:	FY 2024-2025											
	Oct-Dec 2024			Jan-Mar 2025			April-June 2025			July-Sept 2025		
	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj	Total Num	# met Obj	% met Obj
1) The number of consumers who complete treatment successfully. **(ITRS Outpatient Clinton & Ingham)**	116	21	18%	126	32	25%	152	32	27%	163	26	19%
2) 75% of clients have successfully completed the program. **(Cedar Roots Recovery)**	30	9	30%	47	20	42%	46	7	15%	55	29	53%
3) 90% of clients will have a Primary Care Physician by discharge. **(CATS Program)**	252	251	99.6%	656	656	100%	662	662	100%	611	611	100%
4) Increasing successful completions by 5% over last year's numbers **(The Recovery Center)**	106	67	63.21% /67.49%	106	58	54.72% /64%	107	70	65.42% /63%	98	59	60.2% /51%

*Cedar Roots Recovery was known as House of Commons prior to April 2025

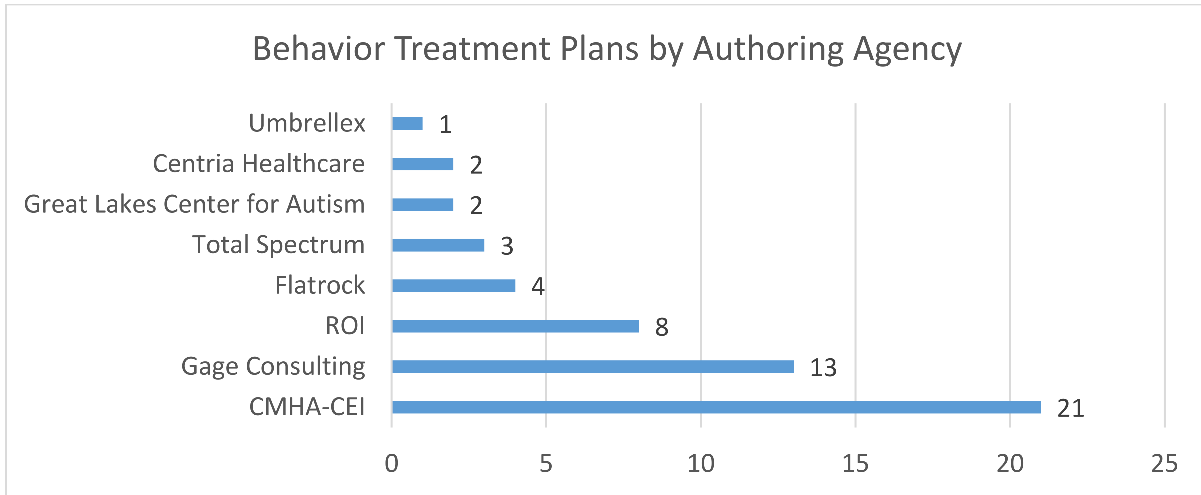
Minimum = 80

Goal = 85

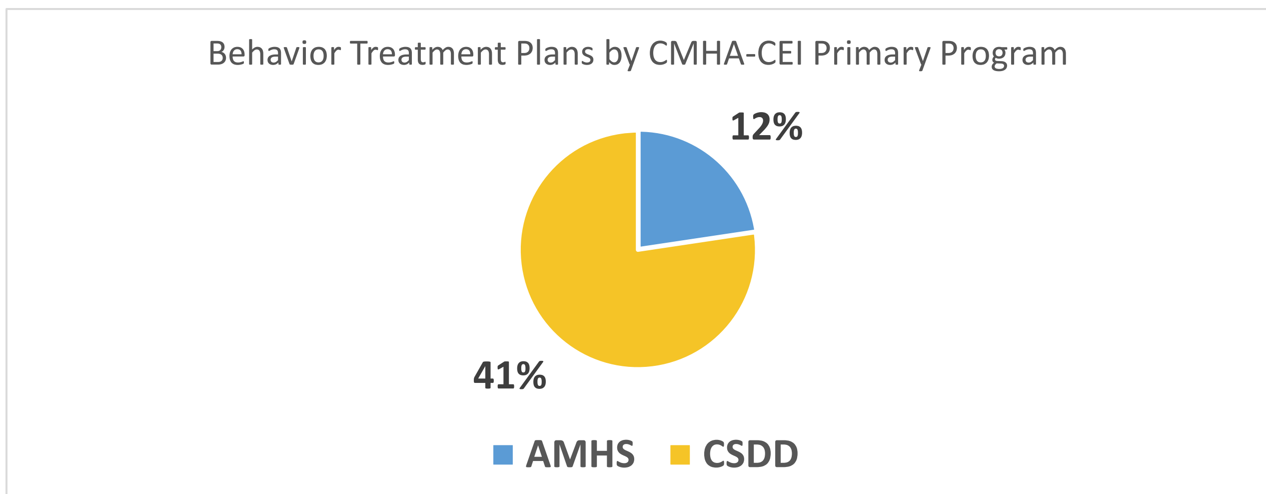
Optimal = 100

Behavior Treatment Plan Review Committee

CMHA-CEI's Behavior Treatment Committee conducts expedited, quarterly, annual, and new plan reviews. All Behavior Treatment Plans are monitored through CHMA-CEI's Behavior Treatment Committee which serve several consumers from various agencies throughout the tri-county area. The BTC consists of the Medical Director, AMHS Representatives, CSDD Representatives, ABA Representatives, Recipient Rights (ex-officio), and QI staff.



Consumer Age Statistics	Age	Quick Facts	
Mean	36	Standing Committee Members	8
Median	33	Active BTP's	55
Mode	31	BTP's with Intrusive Medication	3
Min/Max	7/72	Physical Intervention +15 minutes	0



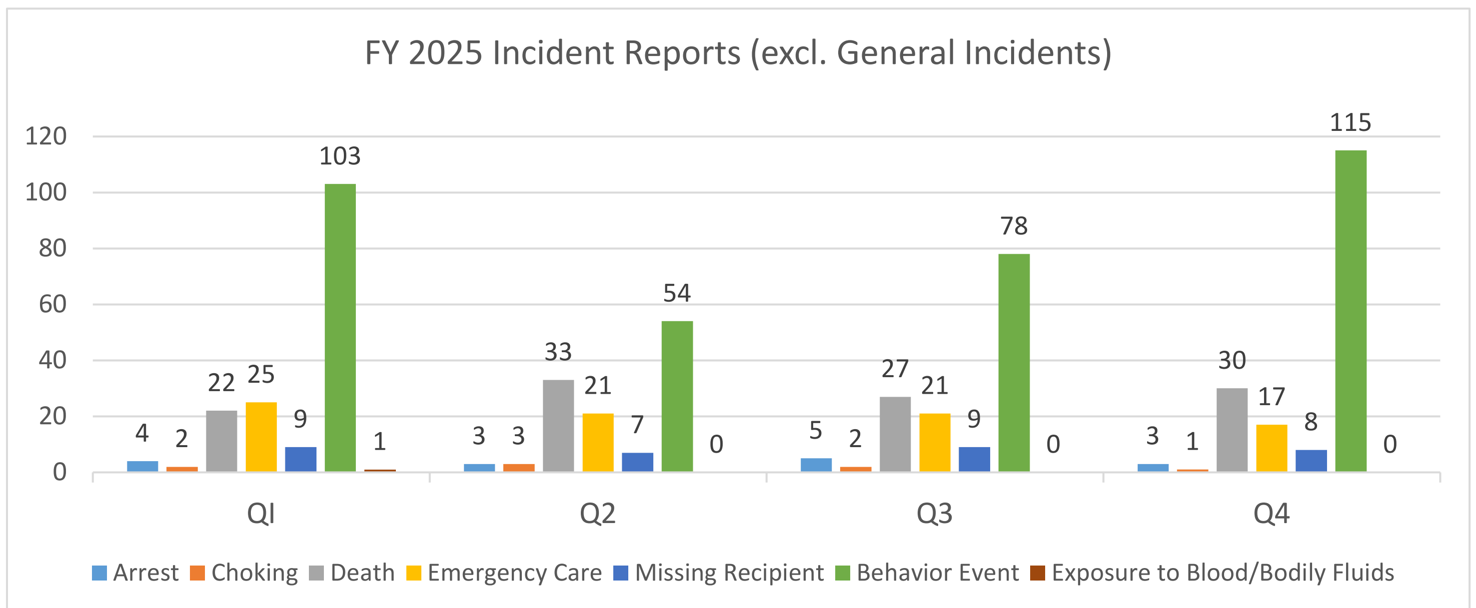
Grievances, Appeals, and Fair Hearings

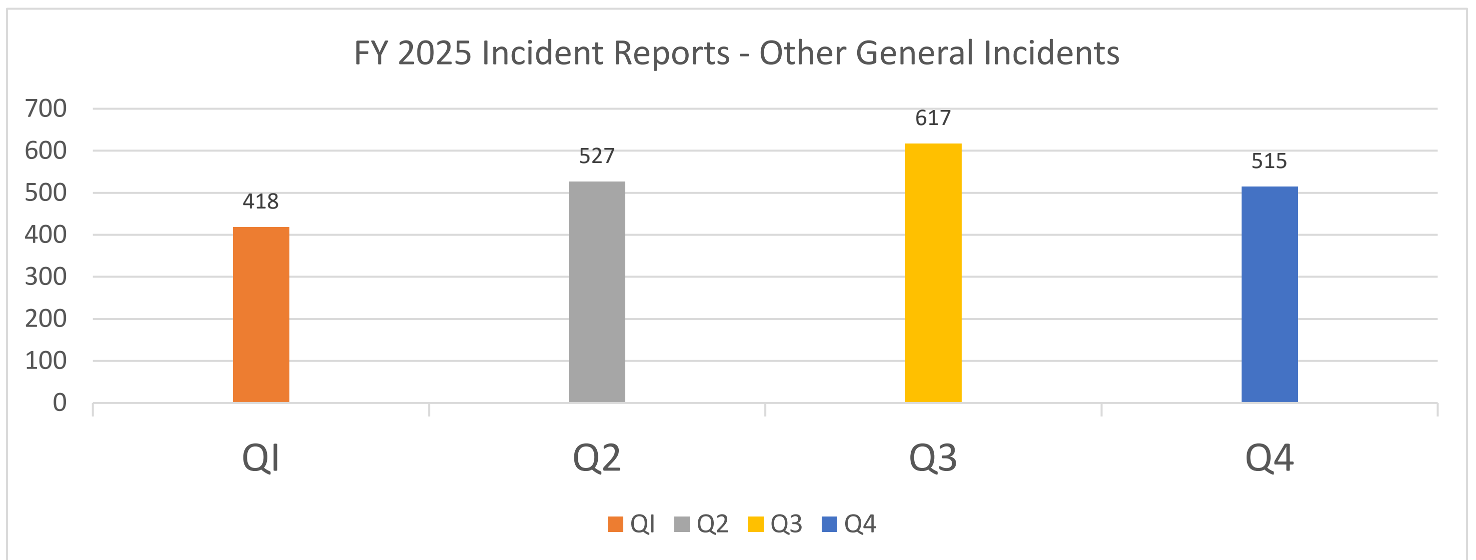
When a consumer/guardian has a complaint, they can file a grievance through the QCSRR office. Staff then work with representatives of the CMHA-CEI Program in question, respond to the grievance, send an acknowledgement letter within three days of the receipt of the grievance and then a disposition letter with the determination of the resolution of the grievance within 90 days. Consumers can file a local appeal or an Administrative Fair Hearing (if they are a Medicaid Beneficiary) and have been denied a requested service(s) or have had their current service(s) delayed, reduced, suspended or terminated.

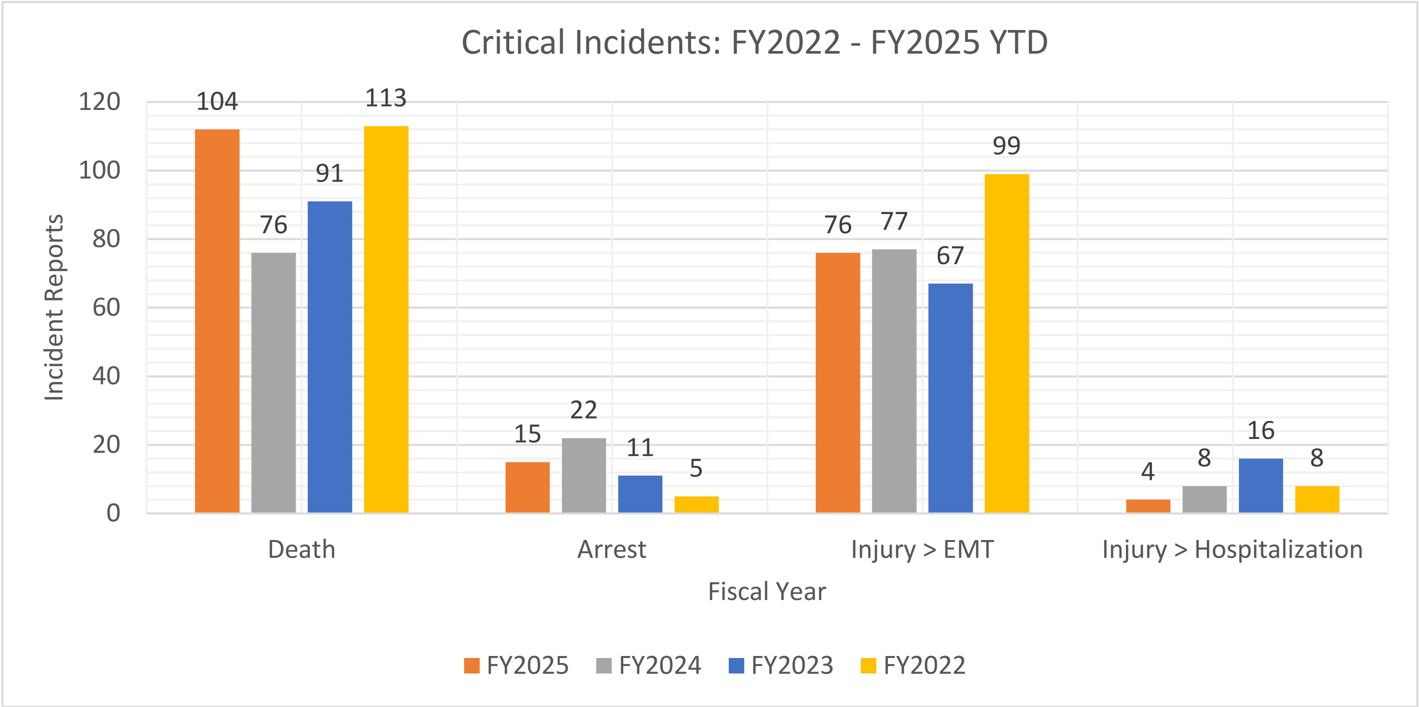
	FY22	FY23	FY24	**FY25**
# of Grievances	16	13	19	56
# of Appeals	7	8	12	9
# of Fair Hearings	0	2	1	0
# **of Alternative Dispute Resolutions**	N/A	N/A	0	0

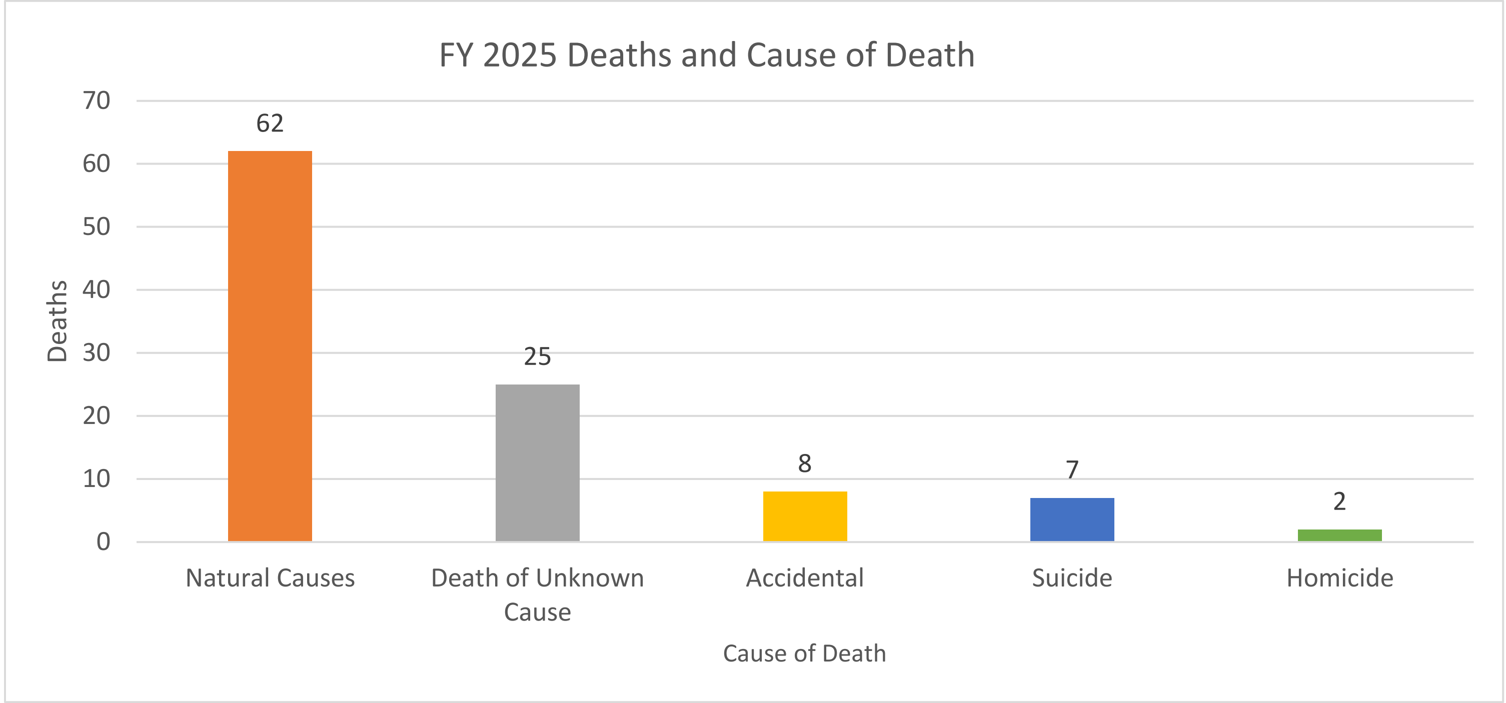
Incident Reporting

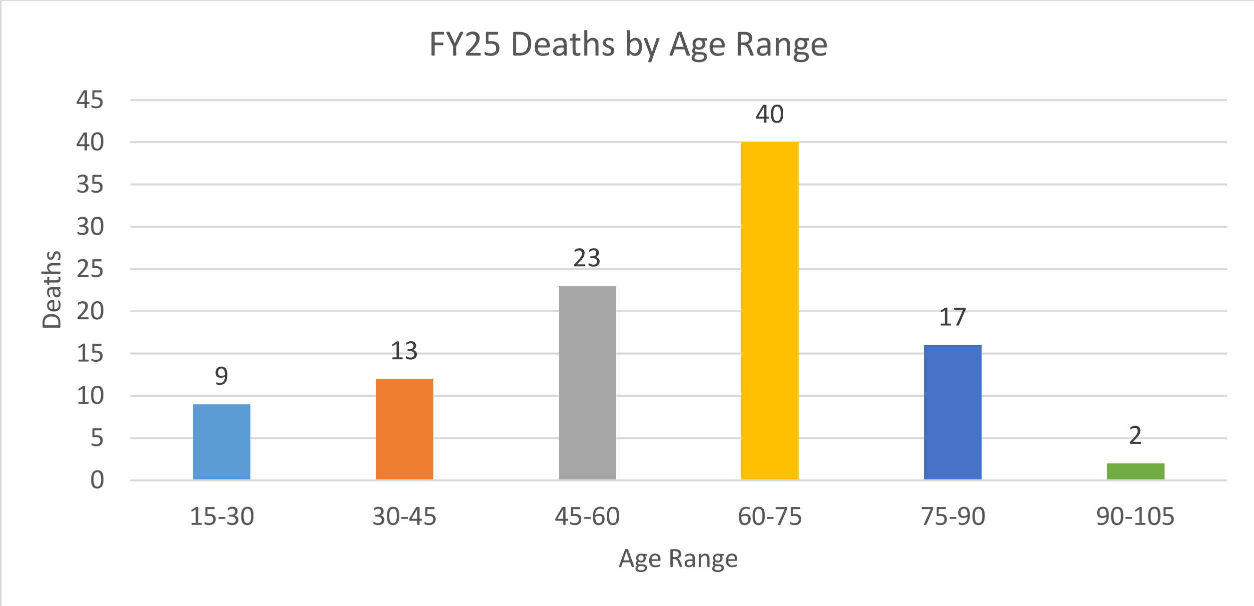
Incident reports are filed on behalf of consumers by staff to record essential details regarding challenging situations, adverse behaviors, and injuries. Some of these categories include serious injuries, medication errors, adverse behavior, death, etc. Documenting these instances are crucial for improving outcomes, facilitating preventative measures, and maintaining compliance. Quality Improvement staff monitor incident reports, assist in implementing Corrective Action Plans, maintain policies/procedures related to incident reporting, and create training for staff. Incident reporting data is analyzed at CIRC for interpretation and trend identification.

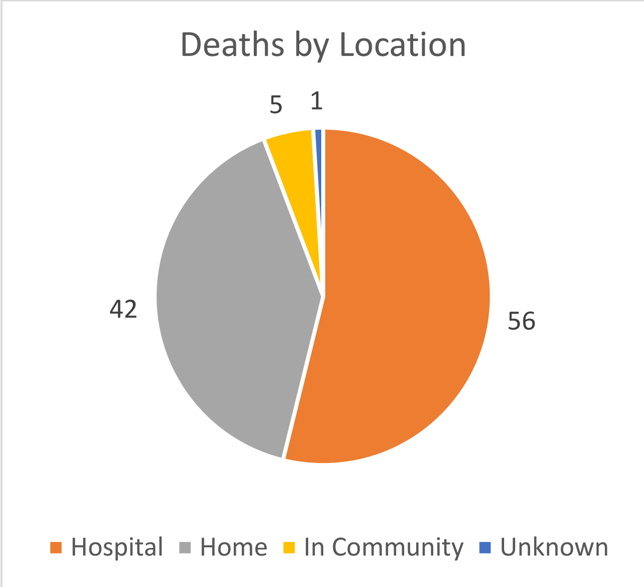


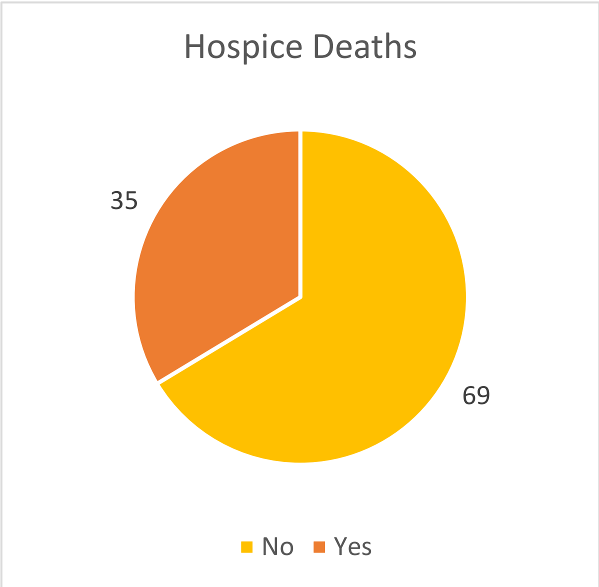


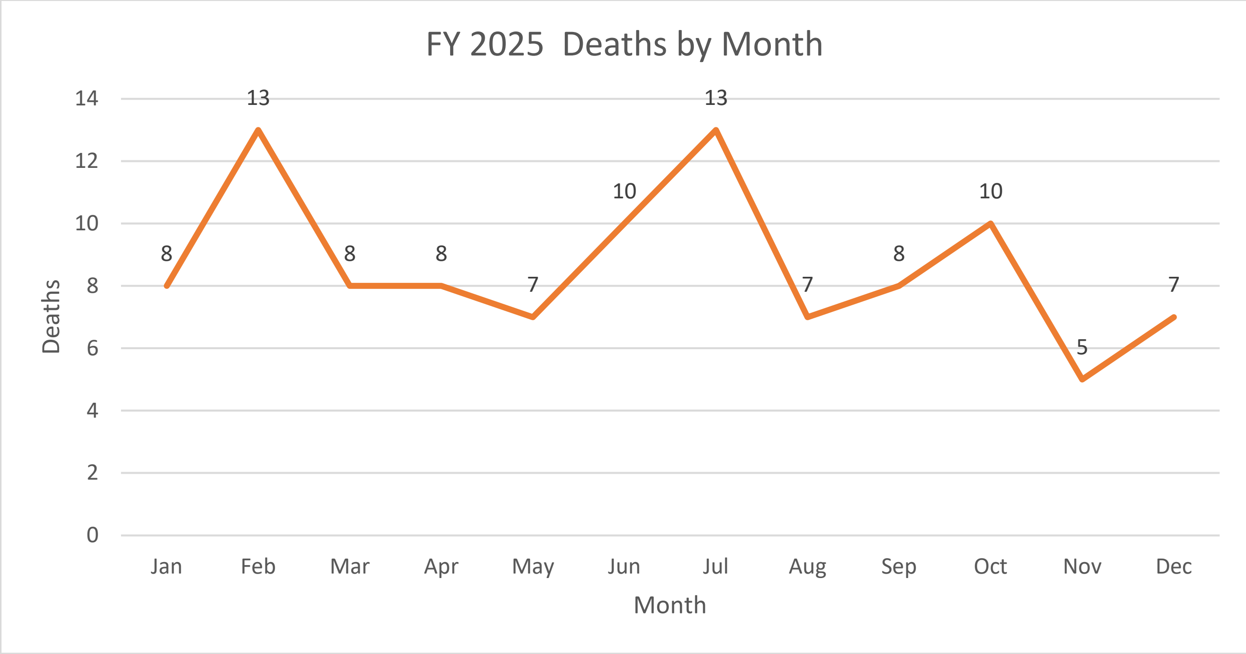

Critical Incidents: FY2022 - FY2025 YTD
Incident Reports
120
100
80
60
40
20
0
104
76
91
113
15
22
11
5
76
77
67
99
4
8
16
8
Death
Arrest
Injury > EMT
Injury > Hospitalization
Fiscal Year
FY2025
FY2024
FY2023
FY2022


FY 2025 Deaths and Cause of Death
Deaths
70
60
50
40
30
20
10
0
62
25
8
7
2
Natural Causes
Death of Unknown Cause
Accidental
Suicide
Homicide
Cause of Death


FY25 Deaths by Age Range
45
40
35
30
25
20
15
10
5
0
Deaths
9
13
23
40
17
2
15-30
30-45
45-60
60-75
75-90
90-105
Age Range

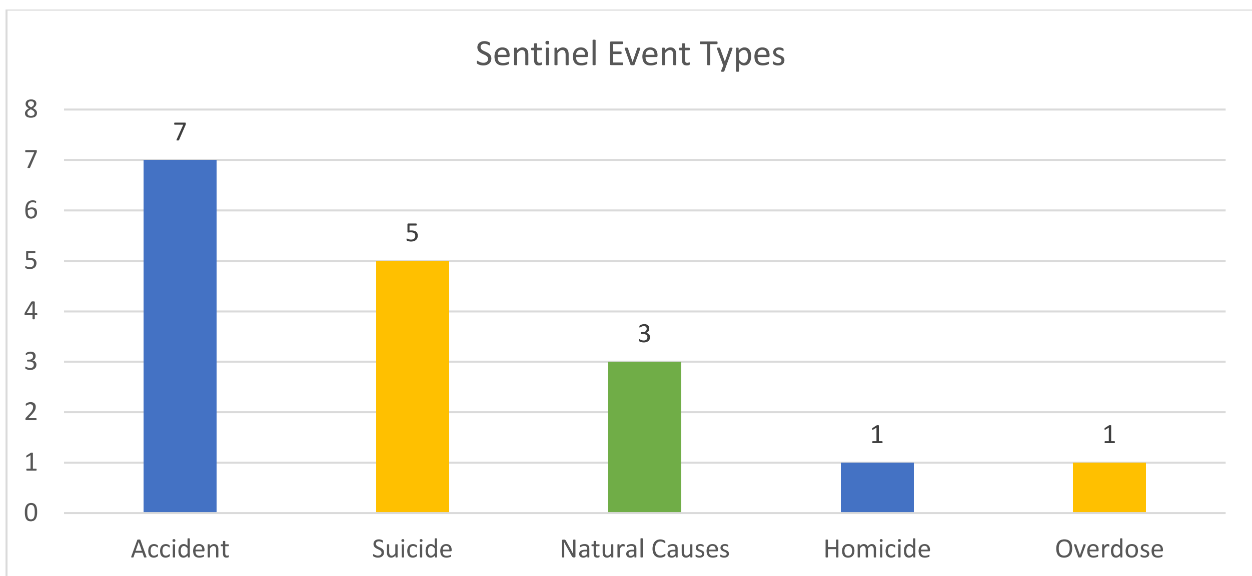

Deaths by Location
5
1
42
56
Hospital
Home
In Community
Unknown

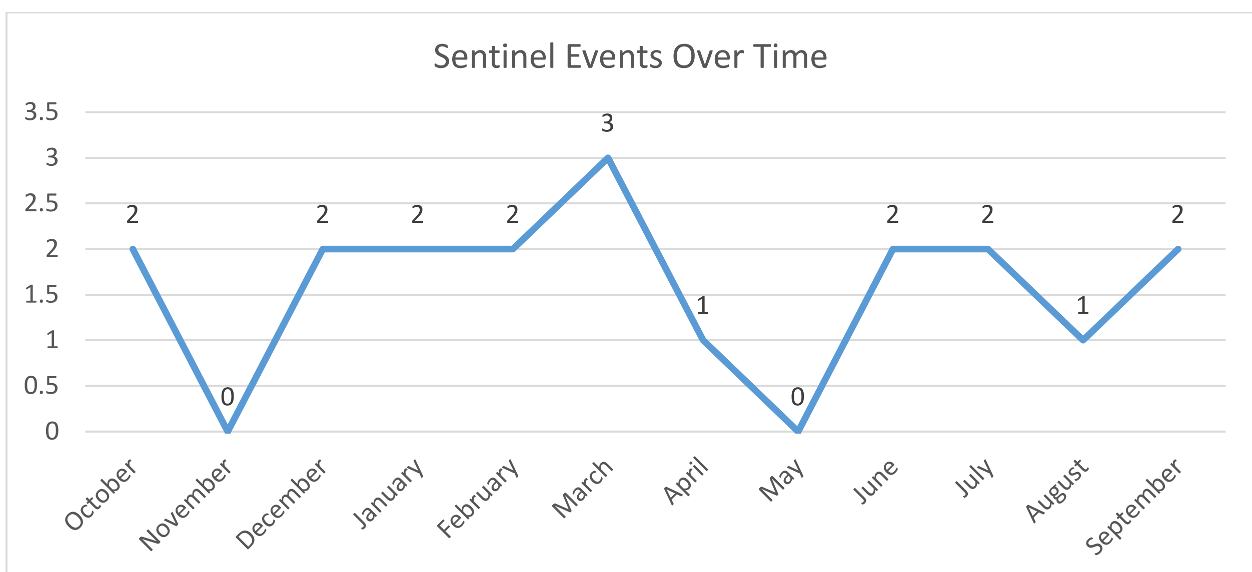

Hospice Deaths
35
69
No
Yes


FY 2025 Deaths by Month
Deaths
Month
14
12
10
8
6
4
2
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
8
13
8
8
7
10
13
7
8
10
5
7

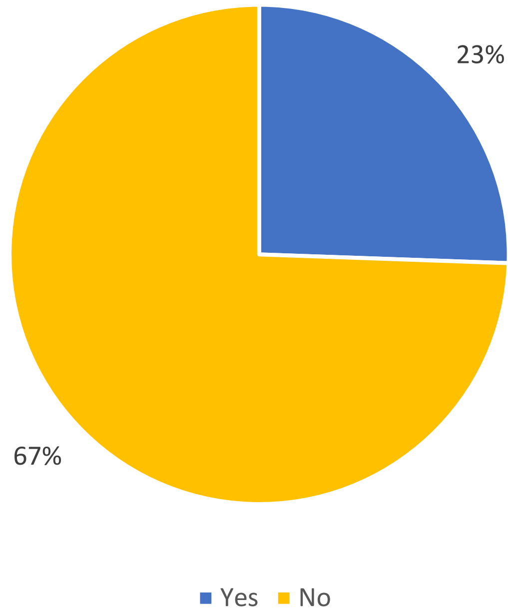
Sentinel Events

Per CMHA-CEI's Sentinel Event Procedure, 1.1.14, a Sentinel Event is defined as "an unexpected occurrence to a recipient of services involving death or serious physical (loss of limb or function) or psychological injury, or the risk thereof. (Risk thereof includes any process variation that would most likely would result in a sentinel event if it reoccurred). All sentinel events are reviewed at CIRC monthly. If the event is determined to be sentinel, and in-depth review of the consumer's chart is conducted to help determine cause and steps to reduce reoccurrence in the future. Sentinel events are reported to MSHN and MDHHS when required.

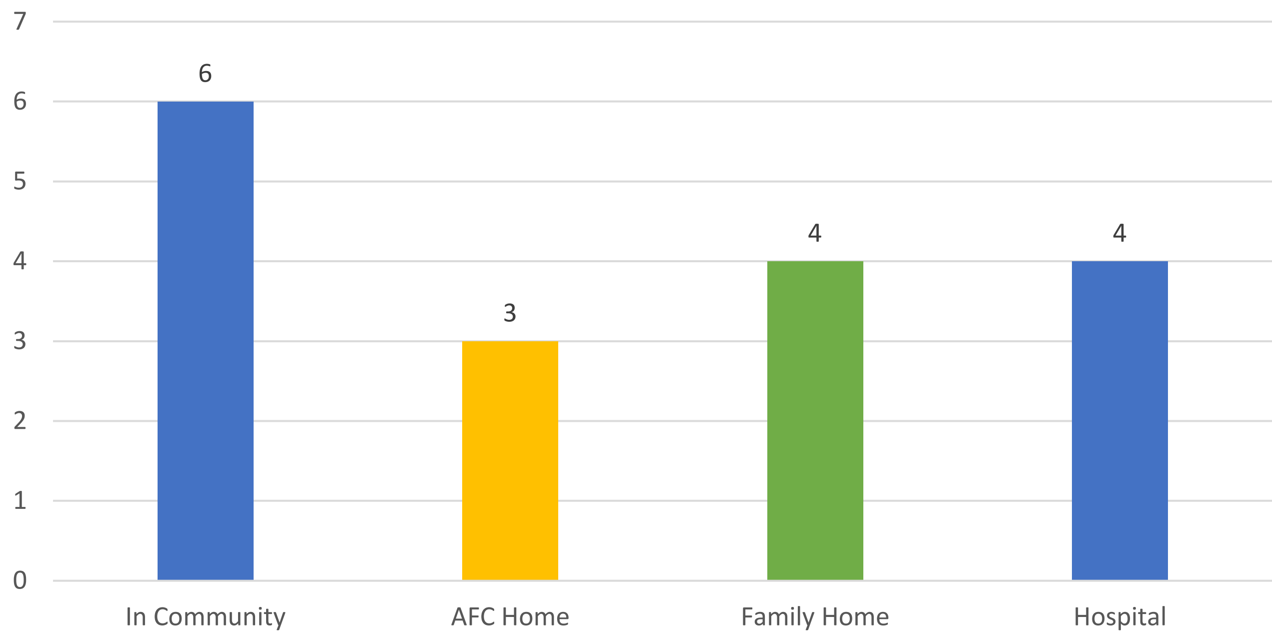




Sentinel Events - Corrective Action Plan Required

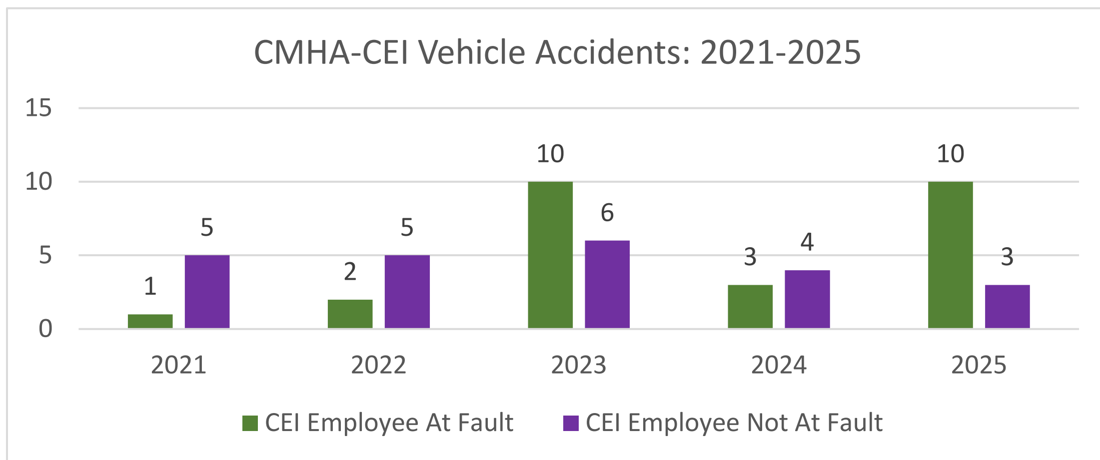


Sentinel Event Location



Staff Vehicle Accidents

Safe driving and proper vehicle maintenance is essential when CMHA-CEI employees operate CHMA-CEI owned vehicles. Drivers of CMHA-CEI vehicles must meet all driver license requirements as established by Michigan law, Procedure 2.2.5 Driving Records, and comply with CMHA-CEI's vehicle insurance carrier. All vehicle accidents are reported to the Property and Facilities Supervisor and Safety Committee who then reviews all accident reports and makes determinations and recommendations based on the review.

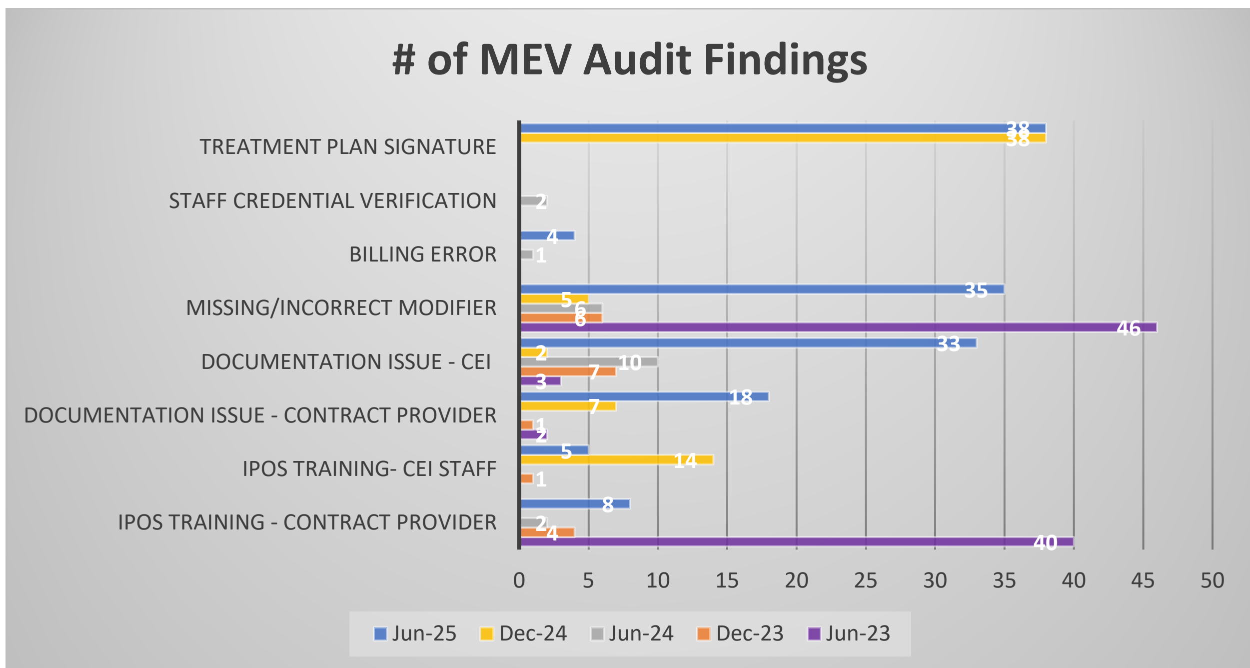


CMHA-CEI Vehicle Accident Costs and Reduction Strategies

Medicaid Event Verification Audit

For FY25, there were two Medicaid Event Verification audits held by MSHN during December 2024 and June 2025. MSHN tracks a variety of attributes of claims during each MEV review. The attributes tested during the Medicaid Event Verification review include A.) The code is allowable service code under the contract, B.) Beneficiary is eligible on the date of service, C.) Service is included in the beneficiary's individual plan of service or in the treatment plan, D.) Documentation of the service date and time matches the claim date and time of the service, E.) Services were provided by a qualified individual and documentation of the service provided falls within the scope of the service code billed, F.) Amount billed does not exceed contractually agreed upon amount, G.) Amount paid does not exceed contractually agreed upon amount, and H.) Modifiers are used in accordance with the HCPCS guidelines.

In FY24, QI started to track the number of findings from MEV audits and their associated categories in order to identify trends and opportunities for targeted improvements. The summary of findings are identified in a chart below.



Findings from the December 2024 MEV are as follows:

- Lines 2-9, 179-193, 277-284, 286-291, 293. The individual plan of service (IPOS) was not signed by the consumer or parent/guardian.
- Line 132. 6:35a-8:01a. Should be 5 units, not 6. The provider uploaded evidence of voided/corrected encounter and advised that error that led to the issue has been resolved. **No further action required**.
- Line 133. 4p-7:29p. Should be 13 units, not 14. The provider uploaded evidence of voided/corrected encounter and advised that error that led to the issue has been resolved. **No further action required**.
- Line 134. 9a-5:10p. Should be 32 hours, not 33. The provider uploaded evidence of voided/corrected encounter and advised that error that led to the issue has been resolved. **No further action required**.
- Line 140. 4p-7:12p. Should be 12 units, not 13. The provider uploaded evidence of voided/corrected encounter and advised that error that led to the issue has been resolved. **No further action required**.
- Line 146. 4p-8:10p. Should be 16 units, not 17. The provider uploaded evidence of voided/corrected encounter and advised that error that led to the issue has been resolved. **No further action required**.
- Line 274. The provider uploaded documentation that said service took place from 1:30-3 and 3-3:30 (as the initial documentation did not contain a start/stop time). The provider should have billed 1:30-2:30 as 96116 (First 60 Minutes) and 2:30-3:30 as 96121 (Each Additional 60 Minutes).
- Line 121. The 0373T service was billed under Trinity Medler in error. Documentation shows that the service was provided by Noah Mehl and Dennis Covert. Service should be billed under one of those staff.
- Line 196. The progress note is missing a description of what occurred during the service - just says "Respite".
- Lines 257, 267, 270. Unable to locate IPOS training for James Wilson.
- Lines 258, 261, 264-266. Unable to locate IPOS training for Tiffany Sims.
- Lines 282, 283, 286, 287, 289, 290. Unable to locate IPOS training for Linda Taylor.
- Line 255. US modifier is missing in billing as 6 patients were served. Provider uploaded evidence with correction to billing to add the US modifier. **No further action required.**
- Lines 259, 262, 268, 271. Staff is an RN, TD modifier should be billed, not AF. *Services should only be billed under the supervisor when the rendering staff is not fully credentialed/qualified to bill the service. In this case, the RN is capable of providing and billing the 96372 service and the service does not need to be billed under a supervising physician – it should be billed with Teri Rodgers as the rendering provider using the TD modifier, not AF. Incident-to billing rules do not apply to Medicaid. Billing should be in accordance with the Medicaid Provider Manual and MDHHS code chart, not Medicare billing rules.

The following Corrective Action Plan was submitted to MSHN to address the above findings:

- Lines 2-9, 179-193, 277-284, 286-291, 293: These findings were brought to the CEI Directors group on 1/28/25 for discussion and clinical review of internal processes on obtaining treatment plan signatures. CEI's Content of the Clinical Record Procedure 3.2.10 has been updated on the requirement to obtain signatures on all treatment plan addendums. This has also been added to the agenda for the next meeting of the internal group tasked with updating the EHR scheduled for 3/6/25 to determine what EHR updates can be completed to ensure clinicians have consistent and accurate reminders/prompts to gather all Treatment Plan signatures. QI is reviewing annual staff training instructions regarding treatment plan signatures and documentation requirements and will complete any updates necessary by 3/14/25.
- Line 274. The CEI Finance team has identified this billing issue was due to a billing code set-up error and has added this to the Reimbursement analyst projects with a plan to correct the code setup by 3/21/25.
- Line 121: CEI Finance-Claims has corrected this issue. Service claim is now billed under Noah Mehl as the rendering provider. Documentation of this correction is located in the file Client 8 Line 121 Finding Proof of Correction
- Line 196. Training regarding service documentation requirements and standards will be provided by the clinician to the provider by 3/14/2025. A reference guide will be created for Employer Of Record expectations and responsibilities related to staff training and service documentation by 2/21/25. This guide will be provided as an additional resource for consumers and families utilizing Self-Determination to ensure required trainings occur and documentation is appropriately maintained.
- Lines 257, 267, 270. The Clinical program has reviewed their process for completing and documenting staff training in the IPOS and in December 2024 implemented a plan to correct this error moving forward for all consumers within the program. In addition, the program Coordinator reviewed the requirements for training in the consumer IPOS with the primary clinician of this consumer.
- Lines 258, 261, 264-266. The Clinical program has reviewed their process for completing and documenting staff training in the IPOS and in December 2024 implemented a plan to correct this error moving forward for all consumers within the program. In addition, the program Coordinator reviewed the requirements for training in the consumer IPOS with the primary clinician of this consumer.
- Lines 282, 283, 286, 287, 289, 290. CEI staff was unable to locate documentation of original IPOS training to Self-Determination service provider, and provider CLN was also unable to locate IPOS training documentation. Training was provided to CEI staff on requirement to maintain documentation of IPOS training and required elements. Training will be provided to the Employer Of Record with reminder that they are required to train staff in the IPOS and maintain documentation by 3/14/25. A reference guide will be created for Employer Of Record expectations and responsibilities related to staff training and service documentation by 2/21/25. This guide will be provided as an

additional resource for consumers and families utilizing Self-Determination to ensure required trainings occur and documentation is appropriately maintained.
- Lines 259, 262, 268, 271. These claims have been corrected and documentation has been uploaded to Box as "Lines 259_262_268_271 Corrections". The CEI Finance department is actively working to address billing set up and prevent future errors.

The June MEV audit included a review of SUD specific claims, which are identified separately below.

Findings from the June 2025 CMH MEV audit are as follows:

- Line 57. Unable to locate H0038 as an authorized service on the PCP. Provider uploaded authorization, but this service should be included on a plan or interim plan and include consumer signature.
- Lines 106, 108, 110, 112, 114, 116. Unable to locate a PCP. Provider uploaded authorization, but this service should be included on a plan or interim plan and include consumer signature.
- Lines 134, 136, 138, 140-147, 149. Unable to locate a consumer/parent/guardian signature on the PCP Addendum.
- Line 151. Unable to locate a consumer/parent/guardian signature on the PCP Addendum.
- Line 151. Unable to locate H2000 as an authorized service on the PCP.
- Line 257. Unable to locate a PCP covering this date of service. Provider uploaded authorization, but this service should be included on a plan or interim plan and include consumer signature.
- Lines 288-304. Unable to locate consumer/parent/guardian signature on PCP.
- Lines 34-38, 41, 46-53. According to provider, Adult Health Home hours are billed 4 hours per day for this consumer. Unable to verify that CLS units were billed correctly as documentation does not explicitly state what times that CLS and AHH occurred.
- Lines 34, 52. Unable to locate documentation that supports the number of units (8) billed.
- Line 53. 8a-2:30p. Units documented (26) do not align with units billed (24). Provider noted that they billed 8a-2p, but their staff included an additional 30 minutes of time (writing 8am-2:30pm) that they did not bill for. The documentation should be amended to reflect the correct time of the service.
- Line 151. Document in EHR for 3/17/25 is signed by staff on 2/21/25. Provider uploaded evidence showing that there was a H2000 service on 3/17/25, but needs to provide an amended document to reflect the attendees, correct date and start/stop time for the CAP.
- Line 236. 2p-4:30p. Units billed (9) do not match units documented (10).
- Lines 15, 23. Unable to locate IPOS training for Jackson Rexrode.

- Lines 17, 21, 22. Unable to locate IPOS training for Miles Stark.
- Lines 18, 25, 26. Unable to locate IPOS training for Kimberly Hicks-Rose.
- Line 151. Document in EHR for 3/17/25 is signed by staff on 2/21/25. Provider uploaded evidence showing that there was a H2000 service on 3/17/25, but needs to provide an amended document to reflect the attendees, correct date and start/stop time for the CAP.
- Lines 174-176, 179, 265. Documentation does not include any narrative of what occurred during the service.
- Lines 174-176, 179, 265. Unable to locate IPOS training for staff. (Documentation is missing the name(s) of the rendering staff.)
- Lines 184, 189. Documentation states that service was provided by Lisa Ross, RN which does not match the staff/staff credential modifier billed. Provider uploaded correction. **No further action required.**
- Line 257. Staff billed does not match staff documented (Kristen Calihan). Provider corrected billing to reflect Kristen Callihan. **No further action required.**
- Line 57. Verified Robert Kanous CPSS (and CPRC). WS modifier should be billed for MH, not WR.
- Line 151. TS modifier billed in error - service was a BTP review, not BTP monitoring.
- Lines 174-176, 179, 265. Unable to verify US modifier billed as the documentation is missing the number of patients served.
- Line 180. Unable to locate any SUD goals on the PCP. HH modifier should not be billed. Provider uploaded evidence of correction. **No further action required.**
- Lines 184, 189. Documentation states that service was provided by Lisa Ross, RN which does not match the staff/staff credential modifier billed. Provider uploaded correction. **No further action required.**
- Line 227. US modifier should be billed (not UP) as documentation shows 7 patients served, not 3. Provider uploaded evidence of correction of group to 6 or more (US). **No further action required.**

The following Corrective Action Plan was submitted and accepted by MSHN to address the above findings:

- Line 57 - CMHA-CEI will review of the use of Authorization Documents and will implement changes as necessary to ensure that services are authorized in the correct document and the required process is followed.
- Lines 106, 108, 110, 112, 114, 116 - CMHA-CEI will review of the use of Authorization Documents and will implement changes as necessary to ensure that services are authorized in the correct document and the required process is followed
- Lines 134, 136, 138, 140-147, 149 - Training has been provided to clinician regarding the requirement to obtain a signature on all treatment plans and treatment plan addendums. The requirement to obtain consumer signatures on all treatment plan and treatment plan

addendums was brought and discussed at the 7/1/25 Quality Improvement and Compliance Committee meeting with clinical leadership attendees.

- Line 151 - Training has been provided to clinician regarding the requirement to obtain a signature on all treatment plans and treatment plan addendums. The requirement to obtain consumer signatures on all treatment plan and treatment plan addendums was brought and discussed at the 7/1/25 Quality Improvement and Compliance Committee meeting with clinical leadership attendees.
- Line 151 - CMHA-CEI Directors met regarding the need to include H2000 services as authorized services on a treatment plan and created a workgroup consisting of key clinical leadership and IS department staff who will identify and implement steps needed to correct this issue. The workgroup will review the process of adding and assigning the service code to an appropriate cost center to prevent issues with billing, discuss process to integrate BTP elements within the PCP, and will determine how to inform staff on updates to the Behavior Treatment Plan review and authorization process. This workgroup will remain active until the situation is resolved.
- Line 257 - CMHA-CEI will review of the use of Authorization Documents and will implement changes as necessary to ensure that services are authorized in the correct document and the required process is followed
- Lines 288-304 - Training has been provided to clinician regarding the requirement to obtain a signature on all treatment plans and treatment plan addendums. The requirement to obtain consumer signatures on all treatment plan and treatment plan addendums was brought and discussed at the 7/1/25 Quality Improvement and Compliance Committee meeting with clinical leadership attendees.
- Lines 34-38, 41, 46-53 - These claims will be recouped from the provider and evidence of voids/recoupments will be uploaded to Box by 8/31/25. CMHA-CEI staff met with the provider to discuss documentation requirements and the provider has agreed to use CEI service note template to ensure this issue is corrected moving forward. Provider also acknowledged in a formal letter that AHH and CLS services would be noted separately on service notes. Provider letter and updated documentation template have been uploaded to Box.
- Lines 34, 52 - These claims will be recouped from the provider and evidence of voids/recoupments will be uploaded to Box by 8/31/25. CMHA-CEI staff met with the provider to discuss documentation requirements and the provider has agreed to use CEI service note template to ensure this issue is corrected moving forward. Provider also acknowledged in a formal letter that AHH and CLS services would be noted separately on service notes. Provider letter and updated documentation template have been uploaded to Box.
- Line 53 - These claims will be recouped from the provider and evidence of voids/recoupments will be uploaded to Box by 8/31/25. CMHA-CEI staff met with the provider to discuss documentation requirements and the provider has agreed to use CEI

service note template to ensure this issue is corrected moving forward. Provider also acknowledged in a formal letter that AHH and CLS services would be noted separately on service notes. Provider letter and updated documentation template have been uploaded to Box.

- Line 151 - The document has been amended to include the information regarding the 3/17/25 meeting date, start and stop time, and has been signed by the medical director. The amended service note has been uploaded to Box, and will be uploaded into the consumer record to reflect the 3/17/25 meeting.
  - 8.20.25 addition – the note has been updated to reflect the required attendees present during the review and has been uploaded to Box.
- Line 236 - The Quality Advisor who works with Royal Care Link informed the provider about this service and the units billed. As this is still within the same FY, the provider was informed on the process to go into the billing system and correct the service units to 10.
- Lines 15, 23 - The Quality Advisor who works with this Provider has provided education regarding the requirements to complete and maintain documentation for staff training in the consumer's IPOS. During this audit, Acorn Health identified there were missing IPOS training documents that were likely due to a supervisor transition. The provider advised that they have revised their IPOS training process and have completed additional staff training in order to prevent this issue from occurring again in the future.
- Lines 17, 21, 22 - The Quality Advisor who works with this Provider has provided education regarding the requirements to complete and maintain documentation for staff training in the consumer's IPOS. During this audit, Acorn Health identified there were missing IPOS training documents that were likely due to a supervisor transition. The provider advised that they have revised their IPOS training process and have completed additional staff training in order to prevent this issue from occurring again in the future.
- Lines 18, 25, 26 - The Quality Advisor who works with this Provider has provided education regarding the requirements to complete and maintain documentation for staff training in the consumer's IPOS. During this audit, Acorn Health identified there were missing IPOS training documents that were likely due to a supervisor transition. The provider advised that they have revised their IPOS training process and have completed additional staff training in order to prevent this issue from occurring again in the future.
- Line 151 - The document has been amended to include the information regarding the 3/17/25 meeting date, start and stop time, and has been signed by the medical director. The amended service note has been uploaded to Box, and will be uploaded into the consumer record to reflect the 3/17/25 meeting.
- Lines 174-176, 179 - 265. Lines will be voided due to the missing required elements on the documentation. The Older Adult Day Treatment program has updated their service documentation template to include a space for a narrative about what occurred during the service, the number of patients served, and noting the name of the staff who

provided the service. Evidence of service voids will be uploaded to Box by 8/31/25. Program has implemented a new process to document staff training in the IPOS to correct the issue moving forward. Updated OAS service note template has been uploaded to Box.

- Line 57. Modifier will be corrected to WS. Evidence of correction will be uploaded to Box by 8/31/25
- Line 151. This service will be voided and rebilled under the correct H2000 code with no TS modifier. Evidence of service void and correction will be uploaded to Box by 8/31/25
- Lines 174-176, 179, 265. Lines will be voided due to the missing required elements on the documentation. The Older Adult Day Treatment program has updated their service documentation template to include a space for a narrative about what occurred during the service, the number of patients served, and noting the name of the staff who provided the service. Evidence of service voids will be uploaded to Box by 8/31/25. Program has implemented a new process to document staff training in the IPOS to correct the issue moving forward. Updated OAS service note template has been uploaded to Box

Findings from the June 2025 SUD MEV audit are as follows:

- Lines 66, 67, 69, 71, 72, 74. Unable to locate assessment. CEI advised that an updated assessment would be uploaded to Smartcare - unable to locate.
- Lines 23, 25. Unable to locate a consumer signature on the treatment plan.
- Lines 52-55. Unable to locate a consumer signature on the treatment plan.
- Lines 66, 67, 69, 71, 72, 74. Unable to locate consumer signature on the treatment plan.
- Line 29. Staff on documentation (Dawn Miller) does not match staff billed (KC Brown).
- Lines 38, 39, 41, 43, 45, 47. Staff on documentation (Theresa Moore) does not match staff billed (KC Brown).
- Line 64. Staff on documentation (Olson Ornevil) does not match staff billed (Amanda Ernst).
- Line 14. Unit rate paid ($124.50) exceeds contract rate ($97.00). Service was 110 minutes, so the 90-minute rate should have been paid, not the 120-minute rate.
- Lines 10, 13, 14, 18, 19, 22. HH modifier should not be billed. Treatment plan does not include integrated MH/SUD goals.
- Lines 15, 21. Two staff credential modifiers billed in error. Staff is a CPRC, so WR modifier should be billed only, not HM.
- Lines 17, 50. Two staff credential modifiers billed in error. Staff is a LLMSW, so HO modifier should be billed only, not AH.
- Lines 23, 25, 38, 66, 67, 69, 72, 74. Missing HH modifier on claims. Treatment plan has both SUD/MH goals.

- Line 29. Plan has a mental health goal, but consumer does not have co-occurring SUD/MH disorders. HH modifier should not be billed.
- Lines 52, 54, 55, 60, 62. HH modifier should not be billed. Consumer does not have co-occurring MH/SUD disorders and plan is not integrated.

The following Corrective Action Plan was submitted and accepted by MSHN to address the above findings:

- Lines 66, 67, 69, 71, 72, 74 – CMHA-CEI acknowledges these claims will be voided. CMHA-CEI will provide training to staff as necessary regarding completion of required documents.
- Lines 23, 25. Signature on treatment plan obtained and uploaded to Box
- Lines 52-55. Signature on treatment plan obtained and uploaded to Box
- Lines 66, 67, 69, 71, 72, 74 - Signature on treatment plan obtained and uploaded to Box
- Line 29. - Resolved via email on 7/23/25
- Lines 38, 39, 41, 43, 45, 47. - Resolved via email on 7/23/25
- Line 64 - Resolved via email on 7/23/25
- Line 14 - CMHA-CEI acknowledges these findings.
- Lines 10, 13, 14, 15, 17, 18, 19, 21, 22, 23, 25, 29, 38, 50, 52, 54, 55, 60, 62, 66, 67, 69, 72, 74 - CMHA-CEI acknowledges these findings. Findings related to use of modifiers were brought to Quality Improvement and Compliance Committee meeting on 7/1/25. Ongoing education regarding correct use of HH modifiers will be discussed with staff during staff trainings. There are active projects which review all staff credentialing information in Smartcare and update as necessary to ensure correct use of modifiers related to credentials

FY25 Chart Review Results

Chart reviews are completed on a quarterly basis by the Quality Improvement and Utilization Management team. Specific programs/units to be chart reviewed are selected through the Quality Improvement and Compliance Committee and by Program request. A random sample of consumer charts are selected for the Clinical Program that is being reviewed, including charts for consumers that have been discharged from services.

Reviews will be completed at least quarterly and will address:

a) Quality of service delivery as evidenced by the record of the consumer;
b) Appropriateness of services;
c) Patterns of services utilization; and
d) Model fidelity, when an evidence-based practice is identified.

QCSRR compiles the aggregate data and forwards the results to the Clinical Programs. QI schedules a meeting with the clinical program to review results, determine areas of improvement, and develop a plan to address the issues identified, if needed. The clinical record review results are discussed quarterly at the Quality Improvement and Compliance Committee.

Chart Review Schedule

Timeframe is when the actual chart reviews were completed, Reviews include documentation from the previous 12 months prior to the review quarter.

Timeframe	Programs for Chart Review
FY25 1st Quarter	ITRS
FY25 2nd Quarter	AMHS
FY25 3rd Quarter	FF
FY25 4th Quarter	CSDD

Chart Review Results

Aggregate Chart Review Standard Ratings	
Completely Met	100% Compliance
Substantially Met	85-99% Compliance
Partially Met	70-84% Compliance
Not Met	69% and Below

FY25 Quarter 1 – ITRS SUD Programs

Standard	Cedar Roots Recovery		The Recovery Center		Corrections Assessment and Treatment Services		ITRS Outpatient		Total ITRS	
	Total Charts	%	**Total Charts**	%	**Total Charts**	%	**Total Charts**	%	**Total Charts**	%
Is Client Info (Admin) section on sexual orientation completed? Or is info in another spot?	15	53%	15	53%	15	67%	15	93%	60	67%
Screen/Admission/ Assessment										
At point of initial contact, provider collected the following: • Date of initial contact, Signature of Staff Person Collecting Information, Follow-up Communication(s) • Presenting Issue • Priority Population Status • Eligibility Determination • ASAM Level of Care Determination • MDOC referred individuals provided assessment regardless of screening documentation • CFJ 306 & MDHHS 5515 are present at time of referral	15	100%	14	79%	15	97%	15	83%	59	90%
For individuals who do not have Medicaid/Healthy Michigan Plan the Financial Information (Block Grant Only) • Verification of Income • Evidence the provider has offered to assist the consumer in applying for Medicaid/Healthy Michigan Plan	11	100%	9	100%	8	100%	12	92%	40	98%
Evidence of screening for: • HIV/AIDS • STD/Is • TB • Hepatitis and	15	90%	15	77%	15	97%	15	83%	60	87%

• Trauma • FASD										
Evidence consumer has received information regarding: • General nature and objectives of the program • Notice of Privacy • Consent to Treatment For MAT-Pregnant women Consent/All women consent • Advanced Directives • Member Handbook • SUD Recipient Rights • Unless notified (in writing) prior to admission, a recipient may utilize medications as prescribed by a physician. (can include separate signed documents or a checklist of the documents the person received.)	15	93%	15	87%	15	97%	15	93%	60	93%
The ASAM Continuum (adults) GAIN I-Core (adolescents) is the only assessment tool used. Initial assessment and/or timely reassessment contains required elements: • ASAM Level of Care Determination is justified and meets the needs of consumer. • Provisional DSM Diagnosis • Clinical Summary • Recommendations for Care (Re-assessment should be completed annually)	15	100%	14	86%	15	93%	15	77%	59	89%
Individual Treatment/Recovery Planning and Documentation										
The amount, scope, and duration for all authorized services are identified in the treatment/recovery plan and appropriate for consumer's needs, objectives, and goals. (should align with what is being requested in authorizations.)	14	100%	12	58%	15	77%	15	80%	56	79%
Initial treatment plan is developed before consumer is engaged in extensive therapeutic activities: • Outpatient – during/before 2nd session • OTP Methadone – within 24 hours of admission • Residential – within - 24 hours of admission	15	100%	14	86%	15	83%	13	73%	57	86%

• Detoxification – within 24 hours of admission (Interim plans are not acceptable)										
Plan(s) address needs/issues identified in assessment(s) (or clear documentation of why issue is not being addressed) including but not limited to: • Substance Use Disorder(s) • Medical/Physical Wellness • Co-Occurring D/O • History/Risk/Present Trauma • Gambling	15	100%	14	46%	15	80%	12	67%	56	74%
Treatment/Recovery Plan is individualized and includes the following: 1. Goals are expressed in the client's words and are unique to the client- No standard or routine goals that are used by all clients. 2. Intervention strategies – the specific types of strategies that will be used in treatment – group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc. 3. Signatures – client, counselor, and involved individuals, or documentation as to why no signature. (Treatment plans should cover all dates of services being requested. Goals & Objectives should not have all the same target & completion dates. No standard or routine goals that are used by all clients.)	15	93%	13	73%	15	83%	13	85%	56	84%
Goals and objectives are written using SMART criteria. (S- Specific, M- Measurable, A- Attainable, R- Relevant, T-Time-bound)	15	70%	13	62%	15	67%	12	50%	55	63%
Frequency of periodic reviews of the plan are based on the time frame in treatment and any adjustments to the plan. Outpatient – ASAM 1.0 LOC – minimally 90 days Outpatient ASAM 2.1 LOC – minimally 30 days ASAM 2.5 LOC – minimally 14 days Residential ASAM LOC's - minimally 14 days	13	81%	5	90%	10	70%	7	86%	35	80%

The treatment and recovery plan progress review includes: 1. Progress note information matching what is in review. 2. Rationale for continuation/discontinuation of goals/objectives. 3. New goals and objectives developed with client input. 4. Client participation/feedback present in the review. 5. Signatures, i.e., client, counselor, and involved individuals, or documentation as to why no signature (Ensure "as evidenced by" is utilized for justification of changes)	14	100%	7	79%	13	81%	6	83%	40	88%
An evidence-based practice was used and documented in the record for trauma in response to a positive screening outcome. (Identify practice in notes)	15	53%	14	43%	14	86%	14	93%	57	68%
An evidence-based practice was used and documented in the record. (Do not include evidence-based practices for trauma as it is included in a separate standard. Identify practice in notes)	14	79%	14	71%	15	93%	13	92%	56	84%
Record Documentation & Progress Notes										
Progress notes reflect information in treatment plan(s): • Identify what goal/objective(s) were addressed during a treatment session • Individual and group sessions that the person participates in must address or be related to the goals and objectives in the plan Document progress/lack of progress toward meeting goals. (For occasions in which goals were not addressed (i.e., crisis), document reason.)	15	97%	14	82%	15	77%	12	92%	56	87%
Services are provided as specified in the plan(s). (Notes are reflective of authorized services and match plan. No shows and cancellations are documented. Amount, scope, and duration of services provided is commensurate with plan or there is documentation if services are provided differently than specified in plan.)	15	90%	12	83%	15	70%	12	67%	54	78%

Consumer strengths are identified within the record and used to drive the person-centered planning process.	15	87%	14	75%	15	93%	15	87%	59	86%
Coordination of Care										
There is evidence of primary care physician coordination efforts. If the client does not have a primary care provider, there is documentation that they were offered information and referral to a provider of their choice. (Evidence must include a signed release of information for the primary care provider, including name and contact information, or documentation of the client's refusal to provide consent.)	15	83%	12	63%	15	50%	13	38%	55	59%
There is evidence of the required release of information (MDHHS Consent) form being used and completed as required for all coordination.	15	100%	15	90%	14	96%	15	93%	59	95%
There is evidence of coordination of care with external entities including, but not limited to, the legal system, child welfare system, behavioral healthcare system. Documentation of coordination of care may include phone calls, non-billable progress notes, letters, emails, etc. A signed release of information is not sufficient to document coordination of care. MDOC referred individuals have evidence of at least monthly coordination (sent by the 5th day of the following month) between agency and supervising agent	14	82%	14	71%	12	75%	12	63%	52	73%
There is evidence of effective coordination between transitions from one provider or level of care to another. Evidence should include sharing of any ASAM Continuum/Gain I-Core assessments and may also include treatment plans and discharge information that improves care and reduces redundancy for the person served.	9	83%	12	67%	11	73%	7	71%	39	73%
There is evidence that provider makes appropriate referrals and documents follow-up and outcomes, as is applicable to meet the consumer/family needs. (If the provider does not	12	83%	15	90%	10	85%	9	78%	46	85%

offer the services, a referral to an agency that offers the services should be made.)										
Discharge/Continuity of Care										
Discharge Summary includes all Continuum of Care Detail(s) including next provider contact information, date/time of intake appointment, relevant information etc. • Discharge from Detox/Withdrawal Management Unit requires documentation of a follow up appointment to occur within 7 days of the date of discharge.	11	68%	15	73%	13	81%	9	67%	48	73%
MDOC referred individuals have evidence of the following (with appropriate release): • Provider will ensure a recovery plan is completed and sent to the supervising agent within five (5) business days of discharge- plan must include individual's knowledge of plan and any aftercare services • The provider will ensure documentation of informing the client's supervising agent prior to any discharge due to violation of program rules/regulations except in extreme circumstances. • The provider will collaborate with the supervising agent for any non-emergency discharge of the referred individual and allow the MDOC time to develop a transportation plan and/or a supervision plan prior to removal.	1	0%	0	N/A	0	N/A	0	N/A	1	0%
Consumer's treatment episode is summarized including: • Status at time of d/c (Status may include prognosis, stage of change, met & unmet needs/goals/objectives, referrals &/or follow-up information) • Summary of received services/ participation • Discharge rationale is clearly & accurately documented	11	77%	15	90%	13	85%	8	69%	47	82%
Residential										
Residential withdrawal management At the time of admission and prior to any medications being	6	100%	12	96%	1	100%	1	100%	20	98%

prescribed or services offered, the medical director, a physician, physician's assistant, or advanced practice registered nurse shall complete and document the medical and drug history, as well as a physical examination, of the recipient. Residential The recipient record for residential service categories shall also include medical history and physical examination										
Residential Treatment Provider must assure all consumers entering residential treatment will be tested for TB upon admission (within 24 hours) and the test result is known within five (5) days of admission	9	89%	13	81%	0	N/A	0	N/A	22	84%
Residential Treatment Sentinel events – unexpected death, overdose, challenging behavior, arrest, injuries and / or medication errors resulting in emergency treatment or hospitalization should be reported with documentation of follow up to prevent recurrence.	2	100%	1	100%	0	N/A	0	N/A	3	100%
MDOC Referred Individuals ONLY (with proper release): • Individual referred does not appear or is deemed to not meet residential medical necessity the provider will notify the supervising agent within one (1) business day • Referred individual may not be given unsupervised day passes, furloughs, etc. without consultation with the supervising agent. • Leaves for any non-emergent medical procedures should be reviewed/coordinated with the supervising agent • If a MDOC referred individual leaves an off-site supervised therapeutic activity without proper leave to do so, the provider must notify the supervising agent by the day on which the event occurred. • The PIHP/designated provider may require individuals participating in residential treatment to submit to drug testing when returning from off property activities and any other time there is a suspicion of use. Positive drug test results and drug test refusals must be reported to the Supervising Agent. (If none of the conditions exist, then it should be N/A.)	0	N/A	0	N/A	0	N/A	0	N/A	0	N/A

MDOC-Additional reporting notifications for individuals receiving residential care include: • Death of an individual under supervision. • Relocation of an individual's placement for more than 24 hours. • The PIHP/designated provider must immediately and no more than one hour from awareness of the occurrence, notify the MDOC Supervising Agent any serious sentinel event by or upon an individual under MDOC supervision while on the treatment premises or while on authorized leaves. • The PIHP/designated provider must notify the MDOC Supervising Agent of any criminal activity involving an MDOC supervised individual within one hour of learning of the activity. (If none of the conditions exist, then it should be N/A.)	0	N/A	0	N/A	0	N/A	0	N/A	0	N/A
Medication Assisted Treatment										
Before any medications are prescribed, the medical director, a physician, physician's assistant, or advanced practice registered nurse shall complete and document the medical and drug history and physical examination of the recipient. In addition, any modification to medications or course of treatment must be documented in the recipient record and ordered by a physician, physician's assistant, or advanced practice registered nurse. Copies of med exam in record. TX History Meds IV Use Pregnancy/Childbearing Age STI's	8	100%	12	96%	1	100%	3	67%	24	94%
OTPs must provide adequate testing or analysis for drugs of abuse, including at least eight random drug abuse tests per year, per patient in maintenance treatment, in accordance with generally accepted clinical practice. For patients in short-	6	50%	3	100%	0	N/A	4	25%	13	54%

term detoxification treatment, the OTP shall perform at least one initial drug abuse test. For patients receiving long-term detoxification treatment, the program shall perform initial and monthly random tests on each patient.										
Suboxone and Methadone: Documented review of Michigan Automated Prescription System (MAPS) is included in the client file at admission, prior to any off-site dosing, and prior to any reauthorization requests. Note: Per MDHHS guidance, the MAPS report cannot be placed in the individual's chart. Information can be documented in the chart.	5	40%	4	75%	0	N/A	1	100%	10	60%
ALL MAT: All alcohol use and illicit drug use during treatment is addressed in treatment and documented in Progress Notes.	4	100%	1	100%	0	N/A	3	67%	8	88%
MDOC Referred Individuals ONLY (with appropriate release): provider informs the Supervising Agent when Medication Assisted Treatment (MAT) is being used, including medication type. If the medication type changes, the Supervising Agent was informed.	0	N/A	0	N/A	0	N/A	0	N/A	0	N/A

FY25 Quarter 1 – ITRS MH Programs

Standard	CSC		JBH		Total ITRS	
	Total Charts	%	Total Charts	%	Total Charts	%
Intake/Assessment						
Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	13	85%	15	90%	28	88%

Are consumer's needs & wants are documented?	13	85%	15	100%	28	93%
Present and history of behavior and/or symptoms are documented and specify if observed or reported	13	88%	15	97%	28	93%
Substance use (current and history) included in assessment?	15	77%	15	97%	30	87%
Current physical health conditions are identified?	13	85%	15	97%	28	91%
Current health care providers are identified?	13	54%	15	73%	28	64%
Previous behavioral health treatment and response to treatment identified?	13	85%	15	97%	28	91%
Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	15	90%	15	70%	30	80%
Did crisis screening and other life domain needs screening occur?	13	46%	15	50%	28	48%
Was consumer offered the opportunity to develop a Crisis Plan? CARF: It is recommended that when the assessment identifies a potential risk for suicide, violence, or other risky behaviors, a safety plan be completed that includes actions to be taken to restrict access to lethal means, preferred interventions necessary for personal and public safety, and advance directives, when available.	7	43%	10	30%	17	35%
Pre-Planning						
Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? Address when/where	13	62%	15	30%	28	45%

meeting will be held, who will be invited, specific format or tool, and accomodations needed?						
Person Centered Planning /IPOS						
The IPOS for individuals is updated within 365 days from their last IPOS.	5	80%	7	57%	12	67%
The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	13	73%	14	96%	27	85%
The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	12	92%	14	100%	26	96%
The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured. (If the consumer identifies a want/need, make sure it is included in the TX Plan)	12	75%	14	75%	26	75%
The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system. **Make note if there are any ranges used for services and give a 1** (MDHHS cited for med clinic, psychology, CLS)	12	71%	14	79%	26	75%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	12	92%	14	79%	26	85%
The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	4	0%	5	0%	9	0%
A timeline for review. (Are reviews occuring at least every 6 months?)	12	83%	14	86%	26	85%

If applicable, the IPOS addresses health and safety issues.	10	80%	10	85%	20	83%
If applicable, identified history of trauma is effectively addressed as part of PCP.	7	43%	7	43%	14	43%
Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	12	25%	14	14%	26	19%
Delivery and Evaluation						
Are services being delivered consistent with plan in terms of scope, amount and duration? Q1: review services from July-September	13	38%	14	64%	27	52%
Monitoring and data collection on goals is occurring according to time frames established in plan?	11	41%	14	68%	25	56%
Are periodic reviews occurring according to time frames established in plan?	7	0%	9	33%	16	19%
Program Specific Service Delivery						
NEW: Did all authorized services begin within 2 weeks of the start date? If not, was an ABDN sent due to service delay or was there a note that the family agreed to delay start of services? Ex: If a consumer was authorized to receive Respite services starting February 1st, but no services actually occured until March 1st, is there an ABDN to explain the delay, or is there a contact note/service note showing that the family chose to delay the start of the service?	13	96%	14	89%	27	93%
For medication services, informed consent was obtained for all psychotropic medications?	N/A	N/A	6	75%	6	75%

Is there evidence of outreach activities following missed appointments?	14	71%	9	33%	23	57%
Is there evidence of coordination with Primary Care Physician in the record?	11	0%	9	22%	20	10%
Integrated Physical and Mental Health Care						
The CMHSP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.	14	57%	15	47%	29	52%

FY25 Quarter 2 - AMHS

	AMHS		67301 Case Mgt Team II		67303 Case Management Team 3		67102 Assertive Comm Tx-Act		67302 OAS Case Mgt		67306 Case Management Team 1	
Standard	Total Charts	%	Total Charts	%	Total Charts	%	Total Charts	%	Total Charts	%	Total Charts	%
Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	79	73%	20	78%	19	78%	20	83%	11	100%	10	75%
Are consumer's needs & wants are documented?	80	94%	20	98%	20	98%	20	90%	11	95%	10	90%
Present and history of behavior and/or symptoms are documented and specify if observed or reported	80	99%	20	100%	20	100%	20	100%	11	95%	10	100%
Substance use (current and history) included in assessment?	80	96%	20	100%	20	100%	20	95%	10	85%	10	90%

Current physical health conditions are identified?	76	96%	20	88%	17	88%	20	100%	11	100%	10	100%
Current health care providers are identified?	80	86%	20	88%	20	88%	20	83%	11	91%	10	75%
Previous behavioral health treatment and response to treatment identified?	80	95%	20	98%	20	98%	20	100%	11	86%	10	95%
Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	80	48%	20	48%	20	48%	20	60%	11	27%	10	60%
Did crisis screening and other life domain needs screening occur?	80	96%	20	90%	20	90%	20	100%	11	91%	10	100%
Was consumer offered the opportunity to develop a Crisis Plan? CARF: It is recommended that when the assessment identifies a potential risk for suicide, violence, or other risky behaviors, a safety plan be completed that includes actions to be taken to restrict access to lethal means, preferred interventions necessary for personal and public safety, and advance directives, when available.	80	91%	20	90%	20	90%	20	93%	11	100%	10	95%
Pre-Planning												
Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? Address when/where meeting will be held, who will be invited, specific format or tool, and accomodations needed?	80	68%	20	83%	20	83%	20	83%	11	45%	10	80%
Person Centered Planning /IPOS												

The IPOS for individuals is updated within 365 days from their last IPOS.	71	56%	20	66%	17	66%	20	50%	10	90%	7	86%
The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	80	94%	20	95%	20	95%	20	93%	11	95%	10	100%
The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	80	96%	19	93%	20	93%	20	98%	11	95%	10	95%
The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured. (If the consumer identifies a want/need, make sure it is included in the TX Plan)	80	53%	20	53%	20	53%	20	48%	11	50%	10	65%
The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system. **Make note if there are any ranges used for services and give a 1** (MDHHS cited for med clinic, psychology, CLS)	80	79%	20	80%	20	80%	20	78%	11	64%	10	65%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	79	63%	20	75%	20	75%	19	24%	11	64%	10	70%
The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	68	71%	20	78%	17	93%	18	67%	9	89%	8	63%

A timeline for review. (Are reviews occurring at least every 6 months?)	79	91%	20	87%	20	78%	20	100%	11	95%	10	90%
If applicable, the IPOS addresses health and safety issues.	73	99%	18	94%	16	87%	20	98%	11	100%	10	100%
If applicable, identified history of trauma is effectively addressed as part of PCP.	58	72%	19	68%	9	94%	16	72%	9	56%	7	64%
Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	78	34%	17	43%	20	68%	20	35%	11	45%	9	17%
Delivery and Evaluation												
Are services being delivered consistent with plan in terms of scope, amount and duration? Q2: Review services that occurred during October - December 2024	78	53%	17	50%	20	43%	19	63%	11	41%	10	60%
Monitoring and data collection on goals is occurring according to time frames established in plan?	73	69%	20	79%	19	50%	19	71%	9	72%	10	70%
Are periodic reviews occurring according to time frames established in plan?	69	69%	18	82%	16	79%	19	58%	10	85%	7	71%
Program Specific Service Delivery												
NEW: Did all authorized services begin within 2 weeks of the start date? If not, was an ABDN sent due to service delay or was there a note that the family agreed to delay start of services?	70	79%	17	71%	17	82%	17	88%	11	55%	10	90%

For medication services, informed consent was obtained for all psychotropic medications?	80	54%	19	58%	20	71%	20	68%	11	45%	10	35%
Is there evidence of outreach activities following missed appointments?	67	67%	20	63%	14	58%	18	89%	8	56%	8	50%
Is there evidence of coordination with Primary Care Physician in the record?	79	40%	19	33%	20	63%	19	47%	11	82%	10	35%
Integrated Physical and Mental Health Care												
The CMHSP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.	80	86%	20	88%	20	88%	20	83%	11	86%	10	95%

FY25 Quarter 3 – FF

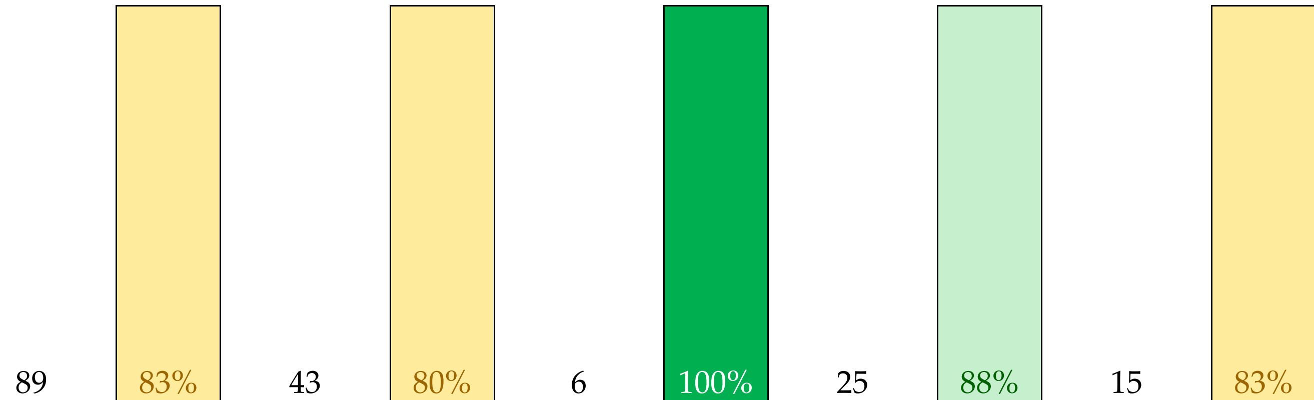
	FF Total		IOP		Urgent Care		FGS		EIS	
Standard	Charts Reviewed	%	Charts Reviewed	%	Charts Reviewed	%	Charts Reviewed	%	Charts Reviewed	%
Intake/Assessment										
Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	85	75%	43	75%	5	80%	23	78%	14	75%
Are consumer's needs & wants are documented?	89	97%	43	98%	6	100%	25	96%	15	100%

Present and history of behavior and/or symptoms are documented and specify if observed or reported	89	98%	43	96%	6	100%	25	100%	15	100%
Substance use (current and history) included in assessment?	78	85%	36	88%	5	80%	24	83%	13	85%
Current physical health conditions are identified?	89	97%	43	93%	6	100%	25	100%	15	100%
Current health care providers are identified?	89	80%	43	74%	6	75%	25	88%	15	80%
Previous behavioral health treatment and response to treatment identified?	87	92%	41	91%	6	100%	25	90%	15	97%
Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	89	100%	43	100%	6	100%	25	100%	15	100%
Did crisis screening and other life domain needs screening occur?	89	99%	43	99%	6	100%	25	100%	15	100%
Was consumer offered the opportunity to develop a Crisis Plan? CARF: It is recommended that when the assessment identifies a potential risk for suicide, violence, or other risky behaviors, a safety plan be completed that includes actions to be taken to restrict access to lethal means, preferred interventions necessary for personal and public safety, and advance directives, when available.	89	93%	43	93%	6	92%	25	98%	15	87%
Pre-Planning										
Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? Address when/where meeting will be held, who will	87	72%	42	61%	5	60%	25	76%	15	93%

be invited, specific format or tool, and accomodations needed?										
Person Centered Planning /IPOS										
The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	85	89%	42	78%	5	100%	23	91%	15	100%
The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	86	97%	42	98%	5	100%	24	92%	15	97%
The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured. (If the consumer identifies a want/need, make sure it is included in the TX Plan)	86	45%	42	34%	5	60%	23	43%	15	67%
The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system. **Make note if there are any ranges used for services and give a 1** (MDHHS cited for med clinic, psychology, CLS)	86	90%	42	89%	5	100%	24	88%	15	87%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	86	79%	42	82%	5	80%	24	71%	15	87%

The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	85	71%	42	66%	5	100%	24	58%	14	86%
A timeline for review. (Are reviews occuring at least every 6 months?)	85	76%	42	74%	5	100%	23	74%	15	80%
If applicable, the IPOS addresses health and safety issues.	82	92%	40	94%	4	88%	23	87%	14	96%
If applicable, identified history of trauma is effectively addressed as part of PCP.	83	93%	40	90%	5	80%	24	96%	14	100%
Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	85	61%	42	56%	5	70%	24	50%	14	79%
Consumer has ongoing opportunities to provide feedback on satisfaction with treatment, services, and progress towards valued outcomes.	84	92%	41	92%	5	100%	23	96%	15	80%
Delivery and Evaluation										
Are services being delivered consistent with plan in terms of scope, amount and duration? Q3: Review services that occurred during January-March 2025	82	52%	40	43%	4	50%	23	54%	15	67%
Monitoring and data collection on goals is occurring according to time frames established in plan?	82	74%	41	67%	4	88%	22	73%	15	90%
Are periodic reviews occurring according to time frames established in plan?	52	62%	25	55%	2	100%	14	64%	11	82%
Program Specific Service Delivery										

Did all authorized services begin within 2 weeks of the start date? If not, was an ABDN sent due to service delay or was there a note that the family agreed to delay start of services? Ex: If a consumer was authorized to receive Respite services starting February 1st, but no services actually occured until March 1st, is there an ABDN to explain the delay, or is there a contact note/service note showing that the family chose to delay the start of the service?	88	89%	43	88%	6	58%	25	88%	15	93%
For medication services, informed consent was obtained for all psychotropic medications?	28	100%	13	100%	3	100%	10	100%	2	100%
Is there evidence of outreach activities following missed appointments?	77	81%	37	67%	6	92%	21	93%	13	96%
Is there evidence of coordination with Primary Care Physician in the record?	86	70%	41	55%	6	67%	24	77%	15	87%
HOME BASED SERVICES Services are provided in the family home or community to an expected/acceptable frequency.	52	93%	9	88%	5	100%	22	98%	15	90%
HOME BASED SERVICES A minimum of 4-hours of individual and/or family face-to-face home-based services per month are provided by the primary home-based services worker (or, if appropriate, the evidence-based practice therapist).	46	80%	6	100%	4	88%	22	73%	14	82%
Integrated Physical and Mental Health Care										



The CMHSP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.	89	83%	43	80%	6	100%	25	88%	15	83%

FY25 Quarter 4 – CSDD

Standard	Life Consultation		FSP Case Management		HSW		Children's Waiver	
	Total Charts	%	Total Charts	%	Total Charts	%	Total Charts	%
Is there a copy of the Initial Assessment (if open for less than one year) or timely Re-Assessment (if open for more than one year) in the file?	19	82%	19	84%	39	83%	17	56%
Are consumer's needs & wants are documented?	19	95%	20	95%	39	100%	17	94%
Present and history of behavior and/or symptoms are documented and specify if observed or reported	19	100%	20	100%	39	100%	17	100%
Substance use (current and history) included in assessment?	19	100%	17	91%	37	99%	15	100%
Current physical health conditions are identified?	19	100%	19	97%	39	99%	16	97%
Current health care providers are identified?	19	100%	20	85%	39	87%	17	91%
Previous behavioral health treatment and response to treatment identified?	19	100%	18	100%	39	99%	17	100%

Present and history of trauma is screened for and identified (abuse, neglect, violence, or other sources of trauma) using a validated, population-appropriate screening tool?	19	87%	20	100%	39	74%	17	100%
Did crisis screening and other life domain needs screening occur?	19	100%	20	100%	39	96%	17	100%
Was consumer offered the opportunity to develop a Crisis Plan? CARF: It is recommended that when the assessment identifies a potential risk for suicide, violence, or other risky behaviors, a safety plan be completed that includes actions to be taken to restrict access to lethal means, preferred interventions necessary for personal and public safety, and advance directives, when available.	19	97%	20	95%	39	96%	17	100%
Did pre-planning occur prior to Person-Centered Planning meeting or the development of a plan? Address when/where meeting will be held, who will be invited, specific format or tool, and accommodations needed?	19	97%	19	66%	39	97%	17	94%
The IPOS for individuals is updated within 365 days from their last IPOS.	19	84%	14	75%	39	94%	17	76%
The IPOS must be prepared in person-first singular language and can be understandable by the person with a minimum of clinical jargon or language.	19	97%	19	89%	39	95%	17	88%

The IPOS includes the following components described below: A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.	19	100.00%	19	92%	39	100%	17	97.00%
The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured. (If the consumer identifies a want/need, make sure it is included in the TX Plan)	19	53%	19	58%	39	54.00%	17	56%
The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system. **Make note if there are any ranges used for services and give a 1** (MDHHS cited for med clinic, psychology, CLS)	19	74%	19	76%	39	77%	17	74%
Signature of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).	19	68%	19	76%	39	87%	17	82%
The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.	19	79%	19	84%	39	86%	17	76%
A timeline for review. (Are reviews occuring at least every 6 months?)	18	94%	19	97%	39	97%	17	100%
If applicable, the IPOS addresses health and safety issues.	17	97%	11	100%	35	99%	15	93%

If applicable, identified history of trauma is effectively addressed as part of PCP.	7	93%	17	80%	16	75%	4	100%
Was the consumer/guardian given a copy of the Individual Plan of Service within 15 business days?	19	29%	19	68%	39	53%	16	44%
Are services being delivered consistent with plan in terms of scope, amount and duration? Q4: Review services that occurred during April - June 2024	18	56%	19	39%	38	63%	17	41%
Monitoring and data collection on goals is occurring according to time frames established in plan?	18	83%	19	79%	38	88%	15	83%
Are periodic reviews occurring according to time frames established in plan?	16	75%	17	71%	35	89%	14	71%
Did all authorized services begin within 2 weeks of the start date? If not, was an ABDN sent due to service delay or was there a note that the family agreed to delay start of services?	17	94%	20	65%	33	92%	16	84%
For medication services, informed consent was obtained for all psychotropic medications?	10	60%	0	N/A	24	58%	2	100%
Is there evidence of outreach activities following missed appointments?	19	89%	11	91%	20	85%	8	94%
Is there evidence of coordination with Primary Care Physician in the record?	19	42%	20	68%	39	53%	17	79%

The CMHSP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.	18	100%	20	78%	38	92%	17	79%
Consent to Share	18	97%	20	75%	38	87%	17	85%
Social Determinants of Health (SDOH)	18	33%	18	17%	38	34%	17	12%
If ABDN in system, check for addendum to remove that service.	10	60%	9	83%	14	64%	9	50%
Documented guardian input in the reviews and preplanning process	19	89%	19	95%	36	89%	17	94%
If the individual has Self Determination, is there a Self D agreement?	3	33%	2	100%	9	67%	11	27%
Are there restrictions in the IPOS? Yes=0, No=2	19	95%	19	95%	38	89%	17	94%
Average of all responses		81%		82%		83%		81%

HCBS Provider Monitoring

Overview

CMHA-CEI has 3 quality advisors who conduct site visits for contract sites for the following contract types:

- Applied Behavior Analysis/Autism provider
- Hospitals/Partial Hospital
- Fiscal Intermediary
- Community Living Support (CLS)/Respite/Nursing
- Residential type A & B
- Pre-Vocational Training/Skill Building
- CMH-CEI-Residential and Non Residential

Quality advisors conduct 3 types of site visits annually, a Recipient Rights (RR) review, a Quality and Compliance (Q&C) review, and a Home and Community Based Services (HCBS) review, if necessary. Items reviewed during the site visits include:

- Recipient Rights standards and training dates for all staff (initial and annual)
- CMHA-CEI required staff training
- Background checks
- Person Centered Plan training and implementation
- Community inclusion documentation
- Documentation related to restrictions (if applicable)
- Medicaid Event Verification – documentation of billed services
- Tour of the site/facility for health or safety concerns

A full in-person site reviews are completed for all in-catchment sites. An option for virtual reviews are available for out-of-catchment sites, and rely on collaboration with other local CMHs to obtain reciprocity review.

2024 Site Visits

- There were 264 contracted providers in 2024. A breakdown of contract type and catchment is shown on figures 1 and 2.
  - 161 (61%) sites are in-catchment and 103 (39%) are out-of-catchment.

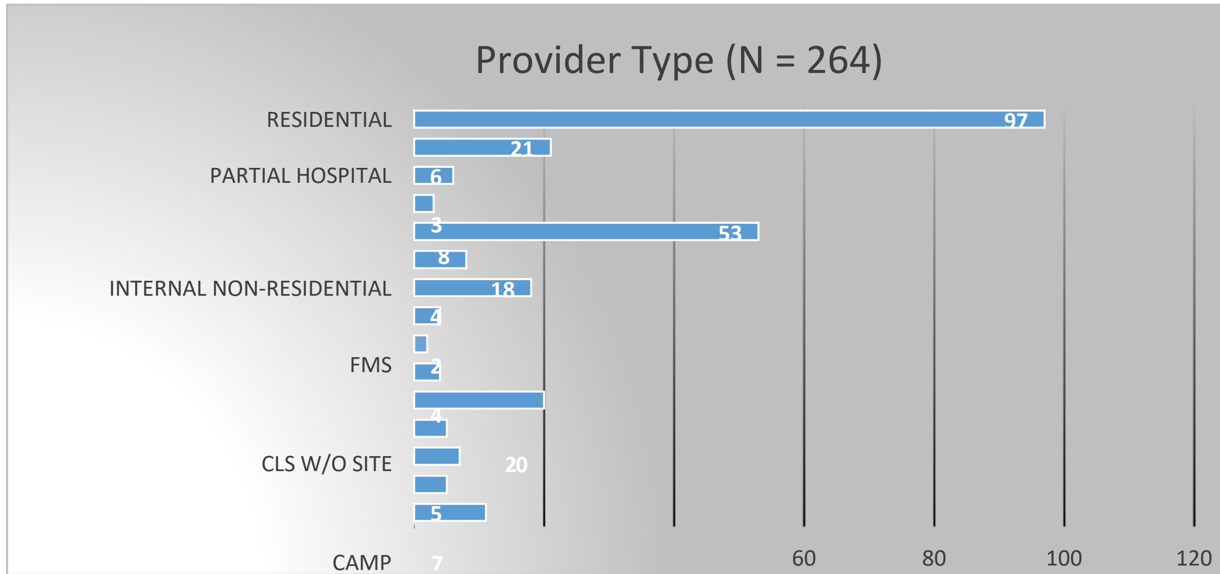


Fig.1. Type of Provider contracted in 2024.

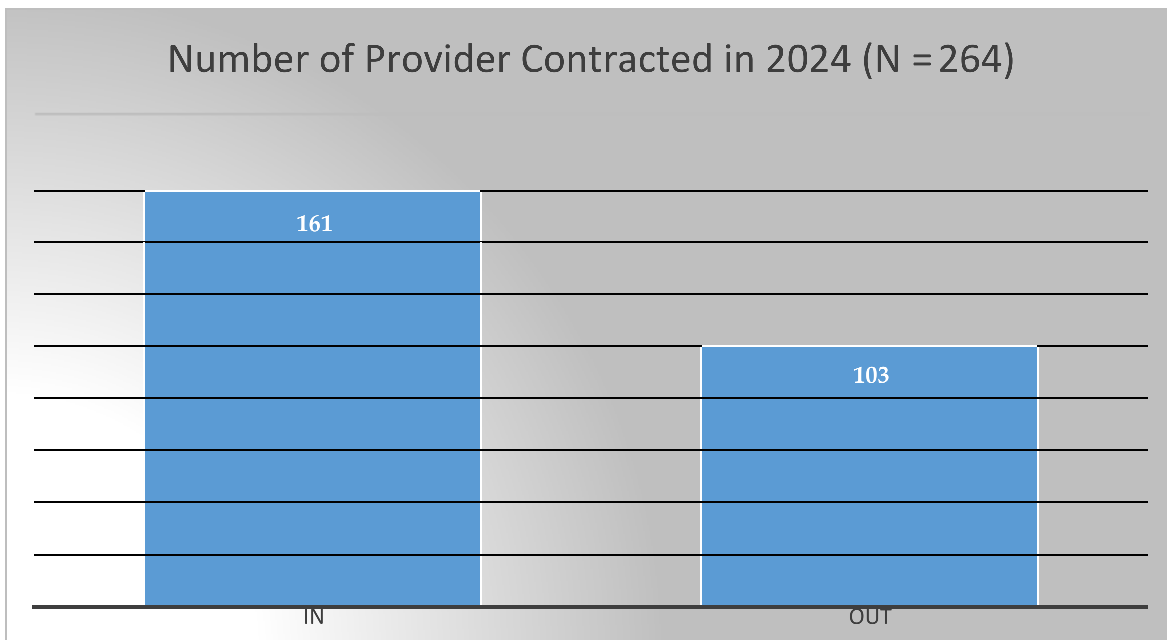


Fig 2. Number of contracted providers according to catchment
(In = located within tri-county areas. Out = located outside the tri-county areas).

276 Site reviews were completed in 2024, a 13% increases from 2023 (completed 240 reviews).

- Some sites were visited multiple times due to comply with site visit protocol and in accordance to Recipient Rights standards.
- With the exception of August, there were more than 15 site visits completed for each month (Fig. 3).

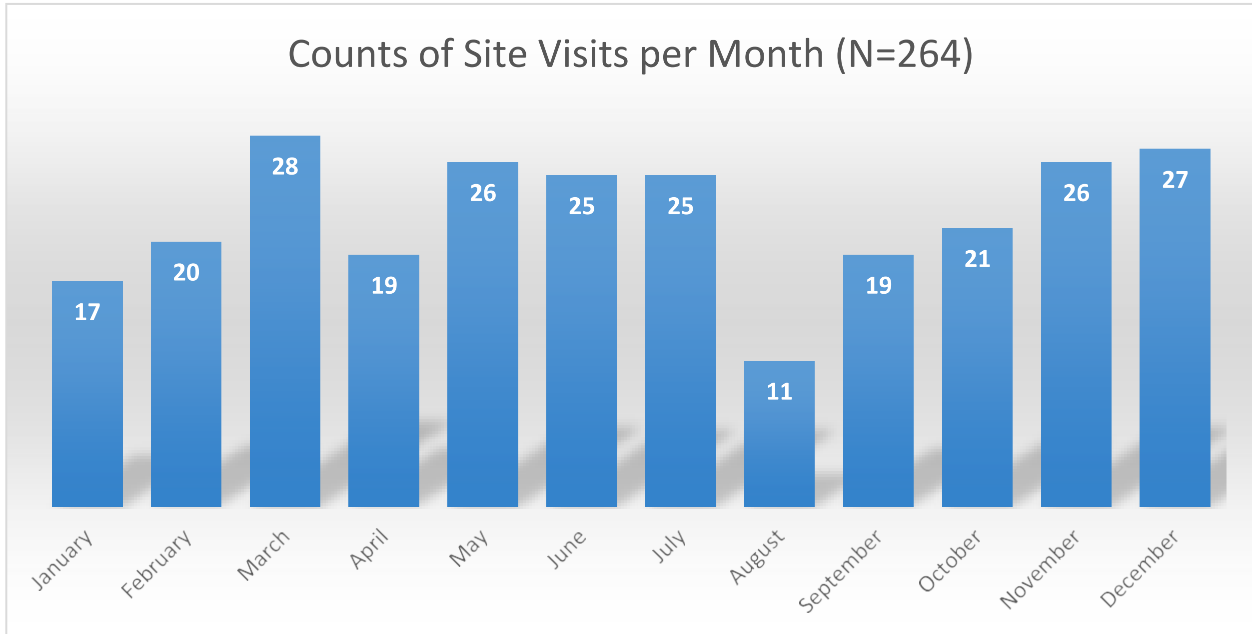


Fig 3. Count of site visits per month in 2024.

As shown on figures 4 and 5, on average, it took provider 50 days to come into compliance (from initial visit date to full compliance), which was slight improvement from 2023 (52 days).

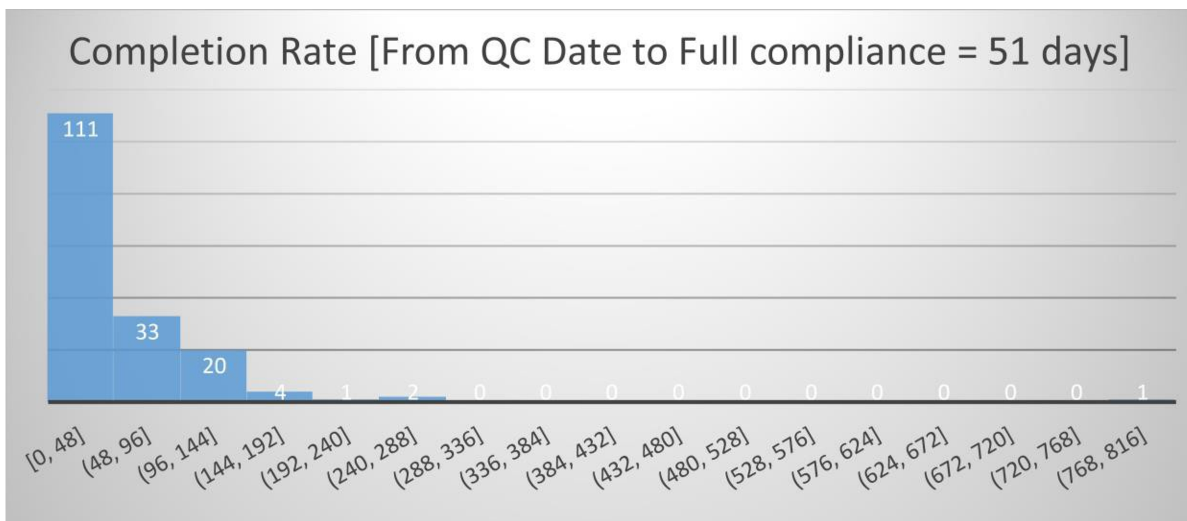


Fig 4. The average completion rate from QC date to full compliance.

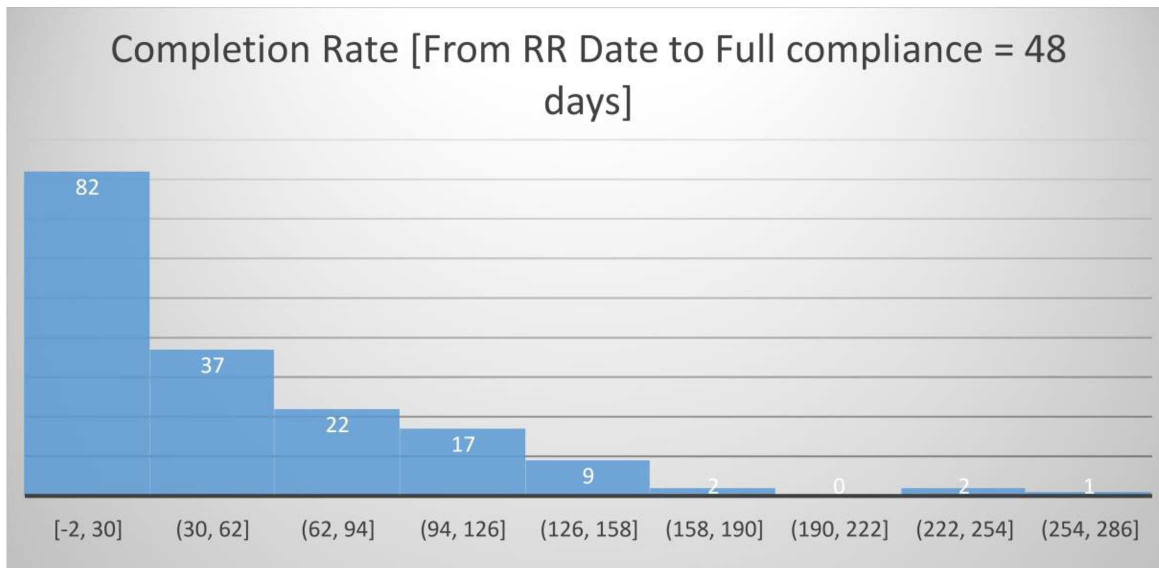


Fig 5. The average completion rate from RR date to full compliance.

2024 POC Data

In 2024, Quality Advisors developed and implement additional process to tract POC data for only selected type of provider. Several standards were selected for this process and it included POC related to medication, IPOS training, IPOS training for other plans, RRO training, incident reporting, and MEV documentation. Additional data tracking included POC that required 90 days monitoring due to RRO, OIG checks, Controlled substances and MEV standards. Below is the breakdown of the type of provider that POC data was collected (N = 170),

- 98 In-Catchment Residential sites
- 45 OOC Residential sites
- 4 CEI internal Residential sites
- 6 CLS with sites and 16 CLS without sites
- 1 Partial Hospital (in-catchment)

Several sites needed 90 days monitoring following the completion of POC,

- One site needed 90 days monitoring due to MEV
- Nine sites needed 90 days monitoring due to OIG checks
- Seven sites needed 90 days monitoring due to Controlled Sub counts
- Nine sites needed 90 days monitoring due to RRO training

The following graphs represents POC data on different standards.

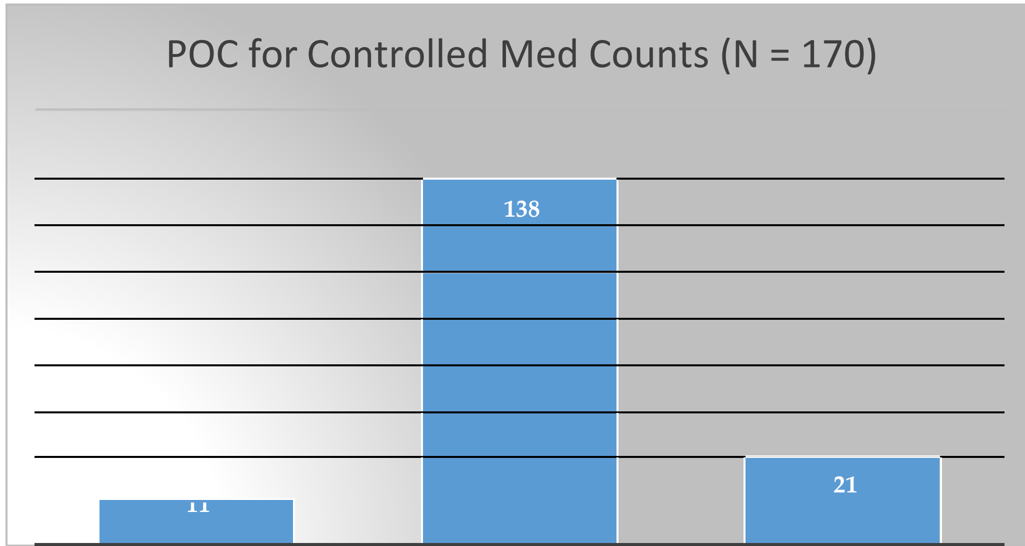


Fig 6. Number of sites that required Plan of Correction (POC) due to Controlled Substance.

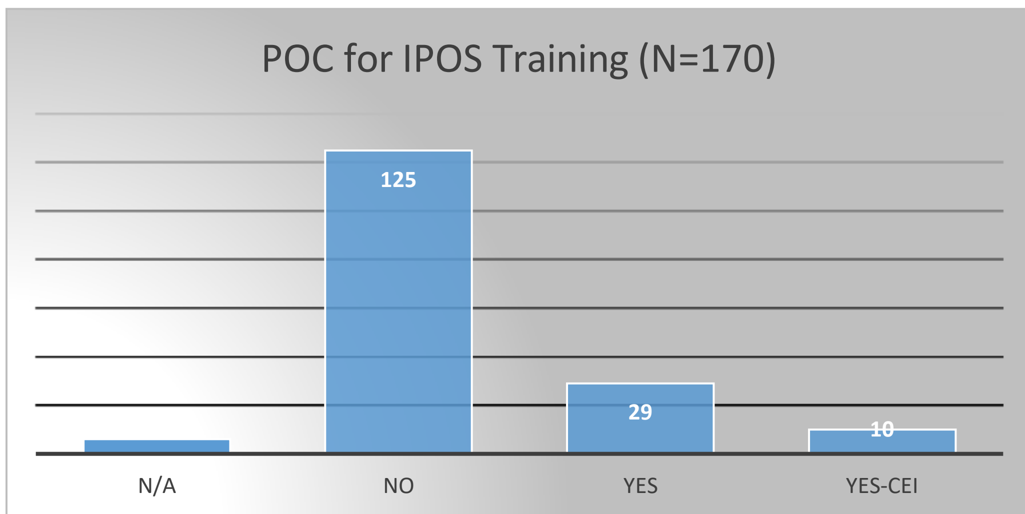


Fig 7. Number of sites that required Plan of Correction (POC) due to IPOS training.

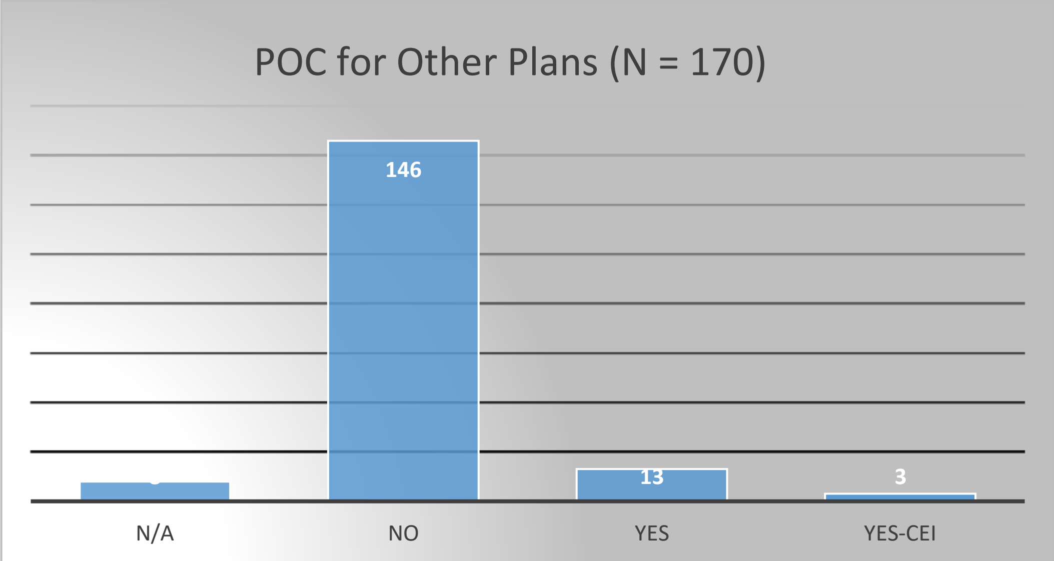


Fig 8. Number of sites that required Plan of Correction (POC) due to Other Plans training (i.e., BTP, Nutrition, and others).

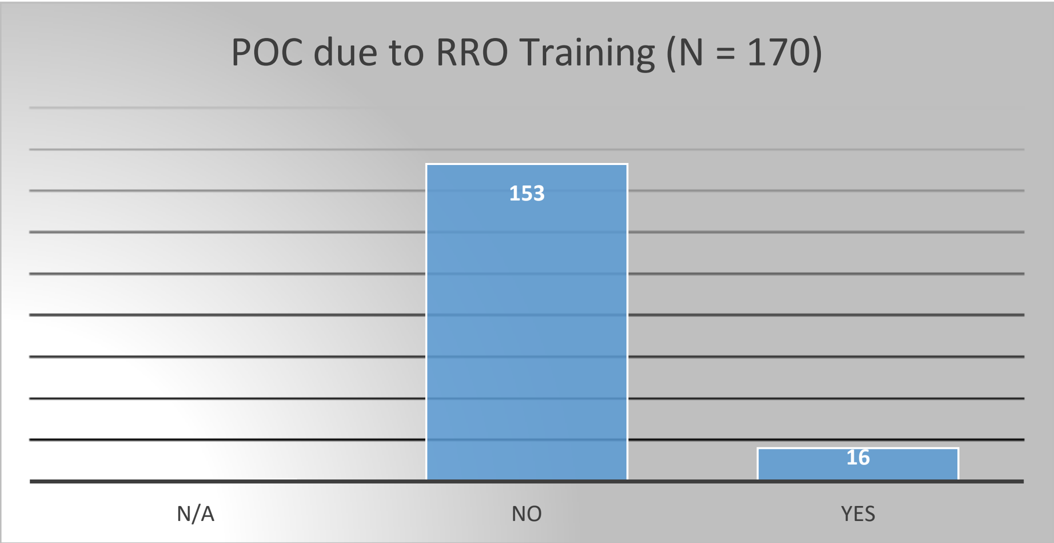


Fig 9. Number of sites that required Plan of Correction (POC) due to RRO training.

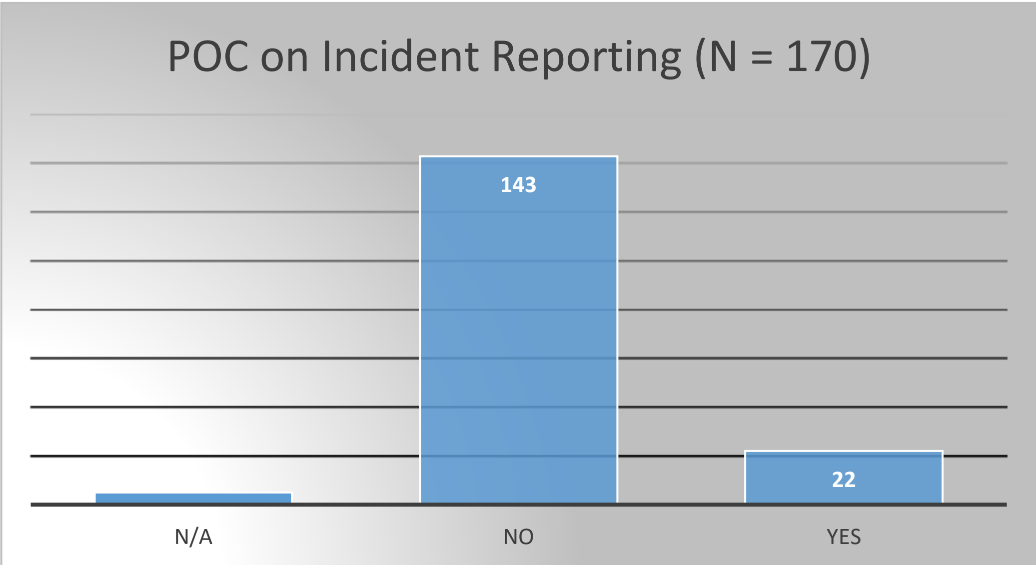


Fig 10. Number of sites that required Plan of Correction (POC) due to Incident Reporting.

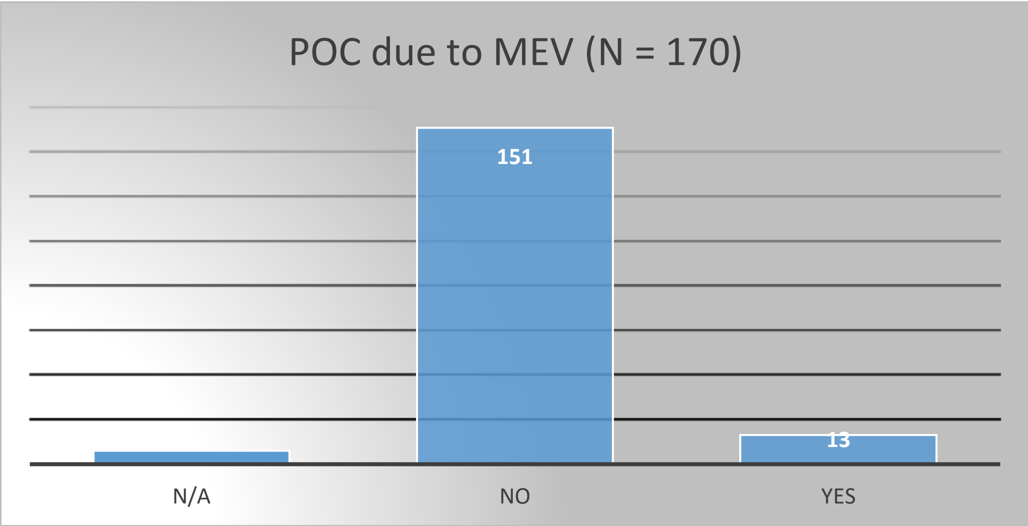


Fig 11. Number of sites that required Plan of Correction (POC) due to MEV.

Improvement Opportunities

Our vision is to facilitate ongoing collaboration by providing support, advocacy and education to contracted service providers. Quality Advisor will be maintaining electronic site visit files, and fidelity reviews of the folders to ensure preparation for upcoming audits (June 2025). Additionally, Quality advisors along with Contract & Finance Dept. and Clinical programs continue to assist providers in the following areas in the coming year:

- Support efforts to move providers to all electronic training
- Allocation of more online resource to cut down operating cost (utilize free online services for human resource management i.e., OIG checks, IChat, etc.)
- Collaborate with other CMHs to improve review process for Out of Catchment sites (i.e., Reciprocity process)
- Enhance the use of CMHA-CEI provider access portal
- Utilize onboarding process to address important topics pertained to compliance (Contract & Finance, and QA's)
- Assisting providers navigate unique challenges caused by the pandemic or any other natural disasters
- Continue to revise site visit process and documentation to improve efficiency
- Collect, review, and assess site visit POC data on a regular basis to make informed choices and target areas for improvement.
- Create site visit specific questions for provider survey.

Policy and Procedure Review

CMHA-CEI hosts 674 active files in PolicyStat, a cloud-based Document Management System. This includes 124 Policies, 249 Procedures, 277 Operating Guidelines, and 24 Forms/User Guides/Plans. The system is available for all staff to view and for applicable staff to edit and manage documents. CMHA-CEI has fully transitioned all agency Policies and Procedures into PolicyStat. This transition remains ongoing for some program Operating Guidelines and other miscellaneous files.

All agency Policies and Procedures are required to be reviewed at least annually. The review process for Policies and Procedures is built into the PolicyStat system, with specific areas and approval workflows for each document type. The system automatically prompts applicable staff for annual updates and reviews to maintain 100% compliance with CARF and other applicable standards.

The following report from PolicyStat tracks the average lifetime workflow turnaround time for Policies and Procedures since the system went live in FY22:

Policy/Procedure Area	Average Days for Approval	Average # of Review Steps	Average Days Per Step
Administrative Policies	30.2	2.5	12
Administrative Procedures	32.2	2.8	11.4
Clinical Policies	20.7	2.7	7.7
Clinical Procedures	23.8	2.7	8.9
Finance Policies	39.9	2	19.9
Finance Procedures	37.8	2	18.9
Human Resources Policies	19.9	2	9.9
Human Resources Procedures	6.4	2.1	3

Notable achievements from FY25:

- 14 new Procedures were created and activated
- 117 Policies and Procedures were edited substantively
- 231 Operating Guidelines were converted from the Intranet to PolicyStat

The Quality Improvement Team continues to integrate agency Operating Guidelines into PolicyStat. The following 277 Operating Guidelines are now in PolicyStat:

Guideline Area	#	Sub-Categorization
Admin Guidelines	44	General Administrative, Access, Corporate Compliance, Customer Service, Property/Facilities, Quality, Recipient Rights
Clinical Guidelines	14	Clinical, CSU
Finance Guidelines	14	Finance, Contracts
ITRS Guidelines	118	Admin, CATS, OP, CRR, ECCC, TRC, RECEIPT, JBH, HCI, MAT, CSC, RP+R
MI-Adult Guidelines	6	AMHS, BCU, Adult Crisis Services
MI-Child Guidelines	79	Families Forward, Youth Crisis Services
Utilization Management	2	UM

Clinical and administrative programs greatly assisted QI with reviewing Intranet documentation throughout FY25 as part of this process. From that review, 71 guidelines located in the Intranet were determined to be no longer in use and archived.

QI has the goal of having all remaining Operating Guidelines in the Intranet converted into PolicyStat and managed by the programs in the system by the end of FY26:

Area	Operating Guidelines	Status	Goal
DD Guidelines **DD Levels of Care**	95 Intranet Files	37 Archived 58 To Convert	FY26 Q3
MI-Adult Guidelines	91 Intranet Files	6 Archived 3 Complete 5 Drafts 77 To Convert	FY26 Q3

HSAG Report FY25

The Health Services Advisory Group (HSAG) conducted its annual evaluation of Mid-State Health Network's data systems, focusing on the processing of data used for reporting performance indicators to the Michigan Department of Health and Human Services (MDHHS). The evaluation covered eligibility and enrollment data, medical services data (claims and encounters), Behavioral Health Treatment Episode Data Set (BH-TEDS) data production, and oversight of affiliated Community Mental Health Centers (CMHSPs), which includes CMHA-CEI.

Eligibility and Enrollment Data System:

HSAG had no concerns with MSHN's receipt and processing of eligibility data.

PIHP Actions Related to Previous Recommendations:

- Two cases for CMHA-CEI in indicators #2 and #3 were identified as having the incorrect populations listed in the member-level detail file. MSHN outlined its intent to put a remediation plan in place to crosswalk the initial report with the final report to identify any changes in population designations before submission. During the SFY 2025 audit, MSHN indicated that it began reviewing cases on a monthly basis for indicators #2 and #3 to identify performance errors. Sample sizes of 15–20 cases were randomly selected for internal validation of reporting accuracy

Strengths and Opportunities for Improvement:

- **Strength #1:**
  MSHN's subcontracted CMHSPs continued to participate in discussions at QIC meetings to assist in identifying causal factors, barriers, and effective interventions. Best practices were also identified and shared with other CMHSPs and PIHPs, including processes, policies and procedures, and protocols used. [Quality, Timeliness, and Access]
- **Strength #2:**
  MSHN's CMHSPs have individually been launching various quality improvement strategies to close performance gaps. This is being done through regional knowledge sharing and localized innovation. Some examples include conducting in-depth analyses of disparities in children's first service engagement, developing new data dashboards and offering consumer education sessions on Medicaid transportation to help mitigate no-shows, addressing both staff training and systemic process delays, integrating real-time data tracking

into clerical workflows, and offering extended hours to meet overall demand for access to services. [Quality, Timeliness, Access]

- **Strength #3:**
  MSHN identified various improvement strategies as well, such as increasing staff and network providers, development of reporting to show where consumer education is needed, expanding upon access staffing to support follow-up after no-shows, offering same day access/walk-in clinics, expanding hours of operation, and conducting reminder phone calls and sending reminder texts. [Quality, Timeliness, Access]

Key Weaknesses & Recommendations

- **Incorrect Medicaid Eligibility cases from CMHA-CEI**:
  Non-Medicaid individuals were being submitted due to a processing issue in the time that CEI ran the report, which impacted eligibility. CEI has since updated their processes so that all performance indicator reports are now run on the submission due date to ensure the most up-to-date plan eligibility information is reflected and MSHN also plans to program a warning error in REMI to flag any individuals that do not have Medicaid when CMHSPs upload their reporting submissions each quarter.
  - **Recommendation:**
    HSAG recommends that MSHN and CEI proceed with the outlined remediation plan. Additionally, HSAG recommends that CEI increase its sample size for cases reviewed each quarter for these performance indicators to improve the accuracy of the reported data and to ensure alignment with the reporting requirements. Testing should also be completed by MSHN once the warning error is programmed in REMI to ensure that it is appropriately applied and capturing non-Medicaid individuals as expected.
- **Incorrect Follow-up Service Date:**
  MSHN confirmed that this was an isolated incident due to logic within CEI's EHR incorrectly capturing the T1020 procedure code as a follow-up service. CEI has worked with its EHR vendor to update the logic and MSHN plans to require a remediation plan from CEI in order to address this issue and ensure that ongoing validation is occurring prior to submission of the performance indicator report.
  - **Recommendation:**
    HSAG recommends that MSHN and CEI proceed with the outlined remediation plan. Additionally, HSAG recommends that CEI increase its

sample size for cases reviewed each quarter for this performance indicator to improve the accuracy of the reported data and to ensure alignment with the reporting requirements.

- **Low Performance on Key Indicators**:
  MSHN's indicator #2 total rate fell below the 75th percentile benchmark, suggesting that some new persons may not have been able to get a timely biopsychosocial assessment completed following a nonemergency request for service.
  - **Recommendation**:
    HSAG recommends that MSHN continue with its improvement efforts related to indicator #2 so that it meets or exceeds the 75th percentile benchmark and further ensures timely and accessible treatments and supports for individuals. Timely assessments are critical for engagement and person-centered planning.

MSHN Audit

MSHN developed a Delegated Managed Care Review cycle that spans over 3 years and consolidates MSHN reviews with external reviews (when possible). The 3-year review cycle was implemented starting in FY24, and is intended to improve agency monitoring and corrective action implementation.

MSHN conducted a virtual desk audit of CMHA-CEI in June 2025. Findings were as follows:

CMH Delegated Managed Care Tool	Finding
Quality Improvement 1.6	• Consumer Incident Reporting Procedure- 3-3-07 • Critical Incident - Possible Sentinel Event Review • Sentinel Events Procedure- 1-1-14 • CMHA-CEI Peer Review Sentinel Event Process • Evaluation of Quality Improvement Plan Effectiveness FY2024 CMHA-CEI Quality Improvement Program Plan FY2025 Also see review of Critical Incidents pulled The Report and Review of Consumers Death Policy contains evidence of information on unexpected deaths and what must be included and reviewed. While policy/procedure identifies the requirements, the PSV of critical incidents (please see FY25 Critical incident PSV Supplemental Tool) did not include all required areas for one of the unexpected deaths reviewed.
Program Specific – Non Waiver	
ACT 1.3	• 2025 04 April Report Excel Sheet (Missing April 30) • 2025 05 May Report Excel Sheet (The May notes did not indicate evidence of Monday through Friday meetings for the whole month) This standard was scored partially met as not all dates had

	a meeting note. Per email follow up from CEI they are aware of this. They shared there was an error when the notes were copied and though there was a meeting there is not evidence for the meeting as the note was deleted once it was copied.
Home-Based 2.2	Based on meeting with CEI (6.26.25), this standard is partially met. Some team members exceed the allowable # of consumers. CEI is aware of this concern and cited in-place 'steps' to correct including attempts to hire capable staff.
SUD Training and Credentialing Review Tool	
Training and Credentialing Review 6.3	Please see staff training worksheet for details. Per email from CEI dated 6/25/25 they do not currently have evidence to meet this standard.

MSHN approved the following Corrective Action Plan to address the above findings:

CMH Delegated Managed Care Tool	Finding
Quality Improvement 1.6	The error in the critical incident reviewed has been corrected. QI has reviewed the process for completing a review of unexpected deaths for clarification opportunities and staff involved in this process have received a training refresher of required elements for unexpected deaths. The monthly Critical Incident Review Committee has been updated to include a review of all critical incidents to help ensure all incidents are reported correctly and timely follow-up occurs.
Program Specific – Non Waiver	
ACT 1.3	ACT Program daily meeting notes are created using the process outlined in the “Morning Report New Sheet Instructions” PDF. At the beginning of a new month, the daily meeting note is “copied” and “moved” into a new

	workbook to create the first sheet for the new month. The ACT Program Coordinator will review this process to ensure it happens correctly and does not inadvertently delete previous month meeting notes.
Home-Based 2.2	Due to Families Forward (FF) staffing needs, additional clinician positions have been allocated through the budgeting process. FF has been working with HR to explore and implement additional recruitment techniques to increase qualified applicants to currently open positions. In addition, FF has increased the number of interns working within the program, as interns become a source of hiring upon successful completion of their practicum, and continues to explore any additional opportunities to add qualified staff to the program. Home-Based caseloads are monitored to identify youth that are able to appropriately transition to other levels of care.
SUD Training and Credentialing Review Tool	
Training and Credentialing Review 6.3	CMHA-CEI is actively evaluating training options to add that address the noted topics. Identified trainings for staff will be added to the training list by 9/30/25.

Consumer Satisfaction Survey

Summary

As part of CMHA-CEI's quality improvement efforts, satisfaction surveys are administered annually to active consumers. Results are used to gauge the level of satisfaction among consumers, determine ways to improve the quality of practice, and address identified areas of need. The purpose of the survey is to measure the quality of CEI services and summarize the level of satisfaction with the CMH service system.

Adults receiving services from AMHS or CSDD Adult completed the MHSIP adult satisfaction survey. The MSHIP template provided by MSHN utilized a 6 point Likert scale for 36 questions across 7 subscale domains.

MHSIP Likert Scale:
- Strongly Agree (1)
- Agree (2)
- Neutral (3)
- Disagree (4)
- Strongly Disagree (5)
- Not Applicable (9)

MHSIP Domains:
1. General Satisfaction
2. Access
3. Quality and Appropriateness
4. Participation in Treatment Planning
5. Outcome of Services
6. Functioning
7. Social Connectedness

Children, or their families if they were younger than 13, receiving services from Families Forward or CSSD Youth completed the YSSF youth satisfaction survey. The YSSF template provided by MSHN utilized a 5 point Likert scale for 26 questions across 7 subscale domains.

YSSF Likert Scale*:
- Strongly Agree (5)
- Agree (4)
- Neutral (3)
- Disagree (2)
- Strongly Disagree (1)

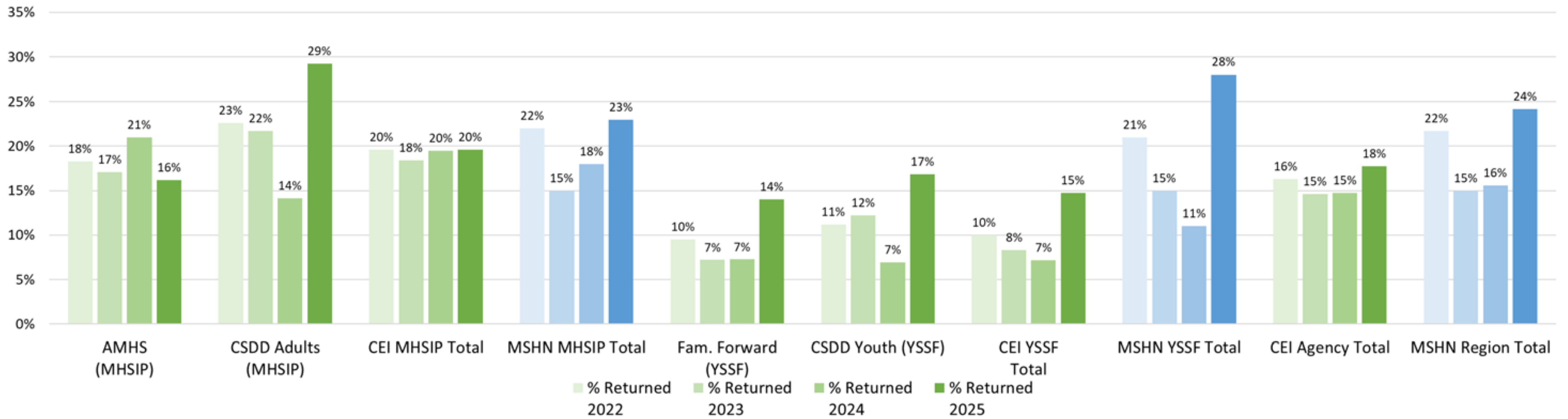
*YSSF numerical order is reversed compared to MSHIP adult survey

YSSF Domains:
1. Cultural Sensitivity
2. Access
3. Appropriateness
4. Participation in Treatment
5. Outcome of Services
6. Social Functioning
7. Social Connectedness

Results from AMHS, Families Forward, and CSDD programs are reported to MSHN annually by the QI Team for analysis. MSHN's report provides CEI with year-over-year regional comparisons and subscale ratings. Further analysis is completed internally to provide a detailed overview of survey performance for each individual CEI program.

In 2025, CMHA-CEI distributed 3,769 consumer satisfaction surveys amongst 5,413 total eligible consumers within mental health programs. 960 surveys were returned, representing 17.74% of total eligible consumers and a percentage increase from 2024 to 2025. Of the consumers who received a distributed survey, 25.47% returned it.

Additionally, ITRS distributes SUD satisfaction surveys to their consumers annually. In 2025, the MHSIP adult consumer satisfaction survey was used. 123 total consumers across 4 ITRS programs were surveyed on the quality of the care they received.



Survey Response Rates YOY								
	Distributed 2022	% Returned 2022	Distributed 2023	% Returned 2023	Distributed 2024	% Returned 2024	Eligible 2025	% Returned 2025
AMHS (MHSIP)	2,153	18.3%	2,338	17.1%	3,420	21.0%	2,474	16.2%
CSDD Adults (MHSIP)	961	22.6%	926	21.7%	942	14.1%	865	29.2%
CEI MHSIP Total	3,114	19.6%	3,264	18.4%	4,362	19.5%	3,339	19.6%
MSHN MHSIP Total	10,600	22.0%	18,793	15.0%	16,567	18.0%	11,522	23.0%
Fam. Forward (YSSF)	1,180	9.5%	1,759	7.2%	2,095	7.3%	1,528	14.0%
CSDD Youth (YSSF)	454	11.2%	491	12.2%	635	6.9%	546	16.8%
CEI YSSF Total	1,634	10.0%	2,250	8.3%	2,730	7.2%	2,074	14.8%
MSHN YSSF Total	3,914	21.0%	6,940	15.0%	8,709	11.0%	3,636	28.0%
CEI Agency Total	4,748	16.3%	5,514	14.6%	7,092	14.8%	5,413	17.7%
MSHN Region Total	14,514	21.7%	25,733	15.0%	25,276	15.6%	15,157	24.2%

MHSIP Response Rates 2025 vs 2024:
The response rate for AMHS is trending downward and underperforming compared to the region, while CSDD Adult has had a significant increase and is outperforming the region. Agency adult response rate is in line with previous years and currently underperforming compared to regional average.

YSSF Response Rates 2025 vs 2024:
Response rates for Families Forward and CSDD Youth have both had significant increases from previous year and are trending upward, however both continue to underperform compared to the region which also saw a significant increase. Agency youth response rate is higher than previous years but currently underperforming compared to regional average.

Overall Response Rates 2025 vs 2024:
Total CEI agency response rate is trending upward, but remains below MSHN average due to significant upward regional trend.

Procedure: Mental Health Programs

Eligible consumers were calculated as consumers active with eligible cost centers on 6/30/25. Response methods in 2025 included face-to-face and electronic submission:

- Surveys were handed directly to consumers (face-to-face) who received services from AMHS, Families Forward, or CSDD programs between the four-week period of Monday 7/7/25 to Friday 8/1/25.
    - The QI Team printed 2,521 physical survey copies for face-to-face distribution in 2025, or a copy for 46.57% of eligible consumers. This represents a significant change in methods from previous years, where a survey copy was printed for every eligible consumer. This measure was taken to save time, money, and paper.
    - 926 print copies were returned, representing 17.11% of eligible consumers and 36.73% of distributed physical copies.
    - Most filled out surveys were completed using the printed version.
- Additionally, eligible consumers who did not receive an in-person service during the first three weeks of the survey period received the survey digitally via email during the fourth week of the survey period (electronic submission).
    - The QI Team provided the survey digitally to via email through Constant Contact on Monday 7/28/25 to 1,248 consumers, representing 23.06% of eligible consumers.

- 34 consumers completed the survey digitally, representing 0.63% of eligible consumers and 2.72% of distributed digital copies.
- Few filled out surveys were completed using the digital version.

Data results in this report came from self-selected consumers who chose to return questionnaires voluntarily. The survey respondents were anonymous, although consumers were given the option to identify themselves at the end of the survey if they wished to be contacted at a later date for follow-up.

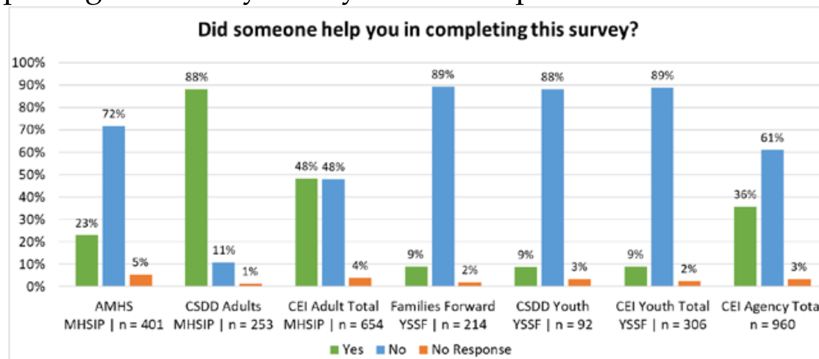
Findings: Mental Health Programs

On average across all questions, AMHS scored worse in 2025 than in 2024. CSDD Adult, Families Forward, and CSDD Youth all had improved average scores from 2024 to 2025. However, across all programs, the difference between the highest and lowest-performing questions remains relatively small. This indicates that consumers remain generally satisfied with CEI services. However, year-over-year, questions about the quality of staff and services generally score above those regarding treatment outcomes.

Regional intervention recommendations include: using the Social Determinants of Health screening tool for all populations and responding to identified consumer needs; providing information on community resources/events; and a focus on helping people facing crises with increased safety planning as well as greater collaboration between crisis services and the consumer's primary behavioral and medical health providers.

Many AMHS subscale scores and all Families Forward, CSDD Adult, and CSDD Youth subscale scores increased from 2024 to 2025. The MSHN regional average increased from 2024 to 2025 in most subscales on the adult surveys and every subscale on the youth surveys. CEI programs outperformed the 2025 MSHN regional average on most subscales in Families Forward as well as all subscales in CSDD Adult and CSDD Youth. CEI underperformed compared to the regional average on all AMHS subscales.

CSDD Adult was the only program surveyed where a majority of consumers received assistance completing the survey. Many AMHS respondents also received assistance.



Analysis of Findings: Mental Health Programs

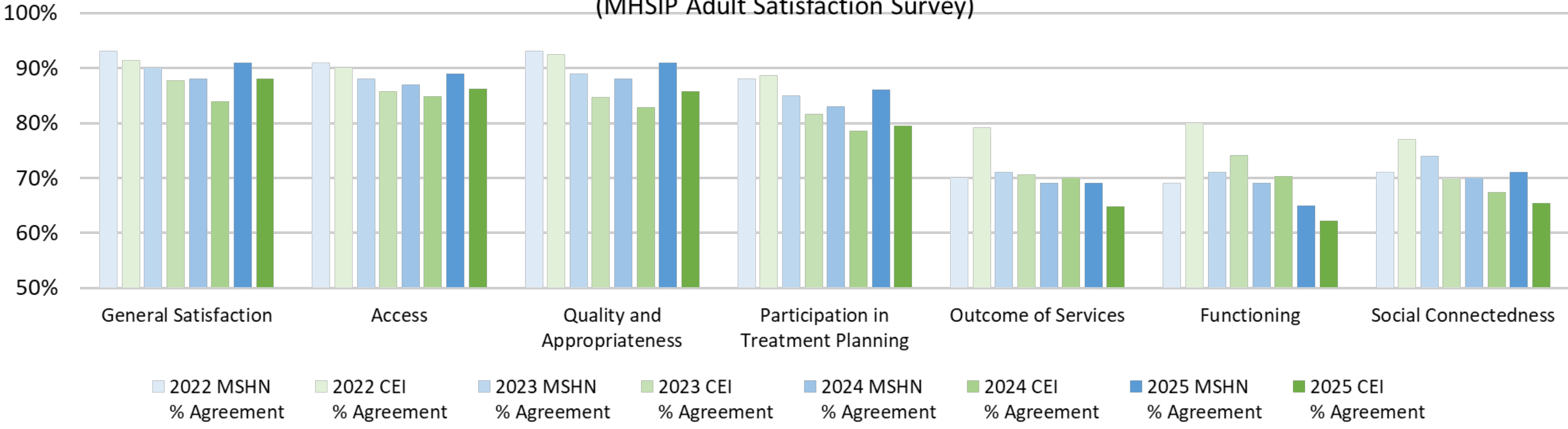
Adult Mental Health Services (AMHS)

Top 3 Questions (average scores)								
	2025 (Score)		2024 (Score)		2023 (Score)		2022 (Score)	
AMHS - MHSIP (Lower = Better)	1. I like the services that I received.	(1.53)	7. Services were available at times that were good for me.	(1.58)	1. I like the services that I received.	(1.58)	1. I like the services that I received.	(1.43)
2025 n = 401; Avg Score = 1.90 2024: n = 718; Avg Score = 1.87	5. Staff were willing to see me as often as I felt it was necessary.	(1.56)	1. I like the services that I received.	(1.59)	11. I felt comfortable asking questions about my treatment, services and medication.	(1.61)	7. Services were available at times that were good for me.	(1.47)
2023: n = 399; Avg Score = 1.86 2022: n = 394; Avg Score = 1.69	16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	(1.57)	16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	(1.60)	5. Staff were willing to see me as often as I felt it was necessary.	(1.62)	10. Staff believed that I could grow, change and recover.	(1.47)

Bottom 3 Questions (average scores)								
	2025 (Score)		2024 (Score)		2023 (Score)		2022 (Score)	
AMHS - MHSIP (Higher = Worse)	28. My symptoms are not bothering me as much.	(2.44)	28. My symptoms are not bothering me as much.	(2.25)	28. My symptoms are not bothering me as much.	(2.25)	26. I do better in school and/or work.	(1.97)
2025 n = 401; Avg Score = 1.90 2024: n = 718; Avg Score = 1.87	35. I feel I belong in my community.	(2.38)	31. I am better able to handle things when they go wrong.	(2.17)	27. I am satisfied with my housing situation.	(2.18)	28. My symptoms are not bothering me as much.	(1.96)
2023: n = 399; Avg Score = 1.86 2022: n = 394; Avg Score = 1.69	31. I am better able to handle things when they go wrong.	(2.32)	35. I feel I belong in my community.	(2.17)	35. I feel I belong in my community	(2.17)	35. I feel I belong in my community.	(1.96)

AMHS Performance Across the MHSIP Subscales

- Scored Best: General Satisfaction (88% agreement)
- Scored Worst: Functioning (62% agreement)
- From 2024 to 2025, AMHS saw an increase in both score and agreement percentage in all Service Quality subscales, while seeing decreased scores and agreement percentages in all Service Outcome subscales.
- Overall, the region saw an improvement across most MHSIP subscales from 2024 to 2025. There was no change in the percentage for Outcome of Services and there was a decrease in the percentage for Functioning.
- AMHS scored below the regional agreement percentage in all subscales in 2025.



AMHS vs Region (MHSIP) Average Scores: Lower = Better	2022 MSHN % Agreement	2022 CEI vs Region	2022 CEI % Agreement	2022 CEI Avg Score	2023 MSHN % Agreement	2023 CEI vs Region	2023 CEI % Agreement	2023 CEI Avg Score	2024 MSHN % Agreement	2024 CEI vs Region	2024 CEI % Agreement	2024 CEI Avg Score	2025 MSHN % Agreement	2025 CEI vs Region	2025 CEI % Agreement	2025 CEI Avg Score
General Satisfaction	93%	-1.66	91%	1.52	90%	-2.24	88%	1.65	88%	-4.16	84%	1.70	91%	-3.00	88%	1.62
Access	91%	-0.97	90%	1.58	88%	-2.21	86%	1.73	87%	-2.12	85%	1.71	89%	-2.78	86%	1.68
Quality and Appropriateness	93%	-0.55	92%	1.56	89%	-4.40	85%	1.75	88%	-5.24	83%	1.76	91%	-5.25	86%	1.69
Participation in Treatment Planning	88%	+0.59	89%	1.52	85%	-3.32	82%	1.68	83%	-4.41	79%	1.72	86%	-6.51	79%	1.69
Outcome of Services	70%	+9.20	79%	1.82	71%	-0.41	71%	2.06	69%	+1.00	70%	2.07	69%	-4.17	65%	2.20
Functioning	69%	+11.00	80%	1.81	71%	+3.07	74%	1.98	69%	+1.31	70%	2.02	65%	-2.80	62%	2.18
Social Connectedness	71%	+6.03	77%	1.85	74%	-4.13	70%	2.06	70%	-2.67	67%	2.06	71%	-5.55	65%	2.19

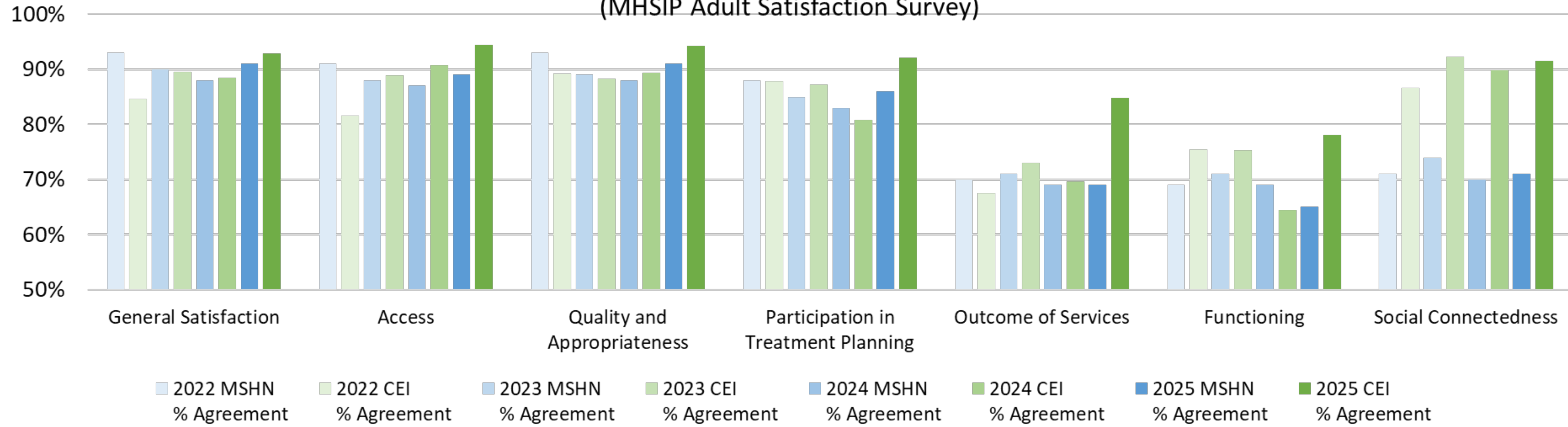
Community Services for the Developmentally Disabled (CSDD) Adult

	Top 3 Questions (average scores)							
	2025 (Score)		2024 (Score)		2023 (Score)		2022 (Score)	
CSDD Adults - MHSIP (Lower = Better) 2025 n = 253; Avg Score = 1.69 2024 n = 133; Avg Score = 1.83 2023 n = 201; Avg Score = 1.82 2022 n = 217; Avg Score = 1.88	1. I like the services that I received.	(1.47)	5. Staff were willing to see me as often as I felt it was necessary.	(1.46)	36. In a crisis, I would have the support I need from family and friends.	(1.49)	11. I felt comfortable asking questions about my treatment, services and medication.	(1.60)
	18. Staff were sensitive to my cultural/ethnic background (e.g., race, religion, language, etc.).	(1.50)	16. Staff respected my wishes about who is and who is not to be given information about my treatment services.	(1.46)	1. I like the services that I received.	(1.58)	5. Staff were willing to see me as often as I felt it was necessary.	(1.64)
	7. Services were available at times that were good for me.	(1.51)	4. The location of services was convenient.	(1.48)	34. I have people with whom I can do enjoyable things.	(1.58)	7. Services were available at times that were good for me.	(1.65)

	Bottom 3 Questions (average scores)							
	2025 (Score)		2024 (Score)		2023 (Score)		2022 (Score)	
CSDD Adults - MHSIP (Higher = Worse) 2025 n = 253; Avg Score = 1.69 2024 n = 133; Avg Score = 1.83 2023 n = 201; Avg Score = 1.82 2022 n = 217; Avg Score = 1.88	31. I am better able to handle things when they go wrong.	(2.26)	31. I am better able to handle things when they go wrong.	(2.75)	31. I am better able to handle things when they go wrong.	(2.25)	26. I do better in school and/or work.	(2.29)
	23. I am better able to deal with crisis.	(2.18)	23. I am better able to deal with crisis.	(2.74)	23. I am better able to deal with crisis.	(2.25)	23. I am better able to deal with crisis.	(2.23)
	30. I am better able to take care of my needs.	(2.03)	30. I am better able to take care of my needs.	(2.55)	28. My symptoms are not bothering me as much.	(2.25)	31. I am better able to handle things when they go wrong.	(2.22)

CSDD Adult Performance Across the MHSIP Subscales

- Scored Best: Access and Quality/Appropriateness (94% agreement)
- Scored Worst: Functioning (78% agreement)
- From 2024 to 2025, CSDD Adult saw increased agreement percentage in all subscales and increased average scores in most subscales (except for a slight decrease in average score in Social Connectedness).
- Overall, the region saw an improvement across most MHSIP subscales from 2024 to 2025. There was no change in the percentage for Outcome of Services and there was a decrease in the percentage for Functioning.
- CSDD Adult scored above the regional agreement percentage in all subscales in 2025.



CSDD Adult vs Region (MHSIP) Average Scores: Lower = Better	2022 MSHN % Agreement	2022 CEI vs Region	2022 CEI % Agreement	2022 CEI Avg Score	2023 MSHN % Agreement	2023 CEI vs Region	2023 CEI % Agreement	2023 CEI Avg Score	2024 MSHN % Agreement	2024 CEI vs Region	2024 CEI % Agreement	2024 CEI Avg Score	2025 MSHN % Agreement	2025 CEI vs Region	2025 CEI % Agreement	2025 CEI Avg Score
General Satisfaction	93%	-8.43	85%	1.83	90%	-0.55	89%	1.65	88%	+0.46	88%	1.62	91%	+1.86	93%	1.57
Access	91%	-9.45	82%	1.82	88%	+0.83	89%	1.70	87%	+3.70	91%	1.64	89%	+5.38	94%	1.58
Quality and Appropriateness	93%	-3.84	89%	1.85	89%	-0.70	88%	1.81	88%	+1.38	89%	1.67	91%	+3.22	94%	1.60
Participation in Treatment Planning	88%	-0.20	88%	1.68	85%	+2.28	87%	1.69	83%	-2.27	81%	1.71	86%	+6.14	92%	1.56
Outcome of Services	70%	-2.47	68%	2.13	71%	+2.08	73%	2.03	69%	+0.64	70%	2.17	69%	+15.78	85%	1.87
Functioning	69%	+6.50	75%	2.00	71%	+4.28	75%	1.97	69%	-4.54	64%	2.21	65%	+13.11	78%	1.89
Social Connectedness	71%	+15.62	87%	1.73	74%	+18.27	92%	1.60	70%	+19.84	90%	1.62	71%	+20.43	91%	1.64

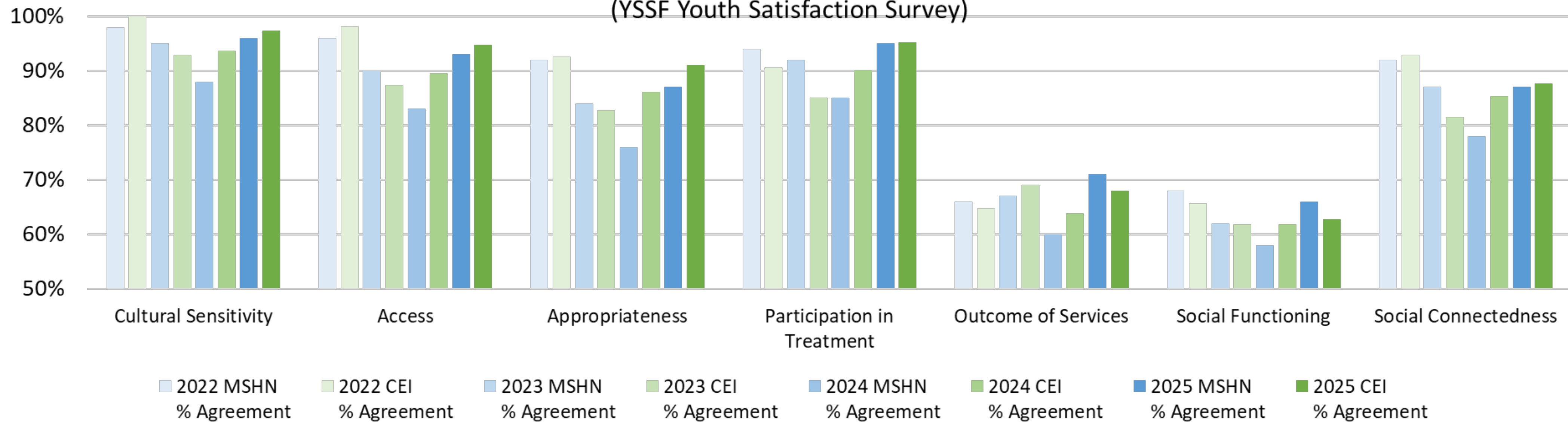
Families Forward

Top 3 Questions (average scores)				
	2025 (Score)	2024 (Score)	2023 (Score)	2022 (Score)
Families Forward - YSSF (Higher = Better) 2025 n = 214; Avg Score = 4.33 2024 n = 152; Avg Score = 4.22 2023 n = 127; Avg Score = 4.24 2022 n = 112; Avg Score = 4.33	12. Staff treated me with respect. (4.78)	12. Staff treated me with respect. (4.74)	12. Staff treated me with respect. (4.67)	12. Staff treated me with respect. (4.85)
	14. Staff spoke with me in a way that I understood. (4.76)	14. Staff spoke with me in a way that I understood. (4.72)	14. Staff spoke with me in a way that I understood. (4.66)	14. Staff spoke with me in a way that I understood. (4.83)
	13. Staff respected my family's religious/spiritual beliefs. (4.72)	13. Staff respected my family's religious/spiritual beliefs. (4.57)	13. Staff respected my family's religious/spiritual beliefs. (4.61)	13. Staff respected my family's religious/spiritual beliefs. (4.73)

Bottom 3 Questions (average scores)				
	2025 (Score)	2024 (Score)	2023 (Score)	2022 (Score)
Families Forward - YSSF (Lower = Worse) 2025 n = 214; Avg Score = 4.33 2024 n = 152; Avg Score = 4.22 2023 n = 127; Avg Score = 4.24 2022 n = 112; Avg Score = 4.33	20. My child is better able to cope when things go wrong. (3.38)	20. My child is better able to cope when things go wrong. (3.41)	19. My child is doing better in school and/or work. (3.59)	19. My child is doing better in school and/or work. (3.56)
	19. My child is doing better in school and/or work. (3.69)	21. I am satisfied with our family life right now. (3.59)	21. I am satisfied with our family life right now. (3.67)	20. My child is better able to cope when things go wrong. (3.64)
	21. I am satisfied with our family life right now. (3.70)	19. My child is doing better in school and/or work. (3.61)	20. My child is better able to cope when things go wrong. (3.79)	18. My child gets along better with friends and other people. (3.72)

Families Forward Performance Across the YSSF Subscales

- Scored Best: Cultural Sensitivity (97% agreement)
- Scored Worst: Social Functioning (63% agreement)
- From 2024 to 2025, Families Forward saw increased agreement percentages and average scores in all subscales.
- The region saw an improvement across all YSSF subscales from 2024 to 2025.
- Families Forward scored near or above the region in most subscales in 2025 (with the exceptions of Outcome of Services and Social Functioning).



Fam. Forward vs Region (YSSF) Average Scores: Higher = Better	2022 MSHN % Agreement	2022 CEI vs Region	2022 CEI % Agreement	2022 CEI Avg Score	2023 MSHN % Agreement	2023 CEI vs Region	2023 CEI % Agreement	2023 CEI Avg Score	2024 MSHN % Agreement	2024 CEI vs Region	2024 CEI % Agreement	2024 CEI Avg Score	2025 MSHN % Agreement	2025 CEI vs Region	2025 CEI % Agreement	2025 CEI Avg Score
Cultural Sensitivity	98%	+2.00	100%	4.76	95%	-2.09	93%	4.63	88%	+5.71	94%	4.65	96%	+1.41	97%	4.74
Access	96%	+2.18	98%	4.69	90%	-2.60	87%	4.51	83%	+6.47	89%	4.48	93%	+1.71	95%	4.68
Appropriateness	92%	+0.59	93%	4.49	84%	-1.32	83%	4.33	76%	+10.09	86%	4.32	87%	+4.00	91%	4.52
Participation in Treatment	94%	-3.35	91%	4.50	92%	-6.96	85%	4.33	85%	+5.13	90%	4.40	95%	+0.22	95%	4.52
Outcome of Services	66%	-1.24	65%	3.75	67%	+2.11	69%	3.80	60%	+3.82	64%	3.73	71%	-3.06	68%	3.77
Social Functioning	68%	-2.29	66%	3.73	62%	-0.21	62%	3.82	58%	+3.84	62%	3.75	66%	-3.32	63%	3.78
Social Connectedness	92%	+0.94	93%	4.35	87%	-5.55	81%	4.26	78%	+7.33	85%	4.25	87%	+0.74	88%	4.33

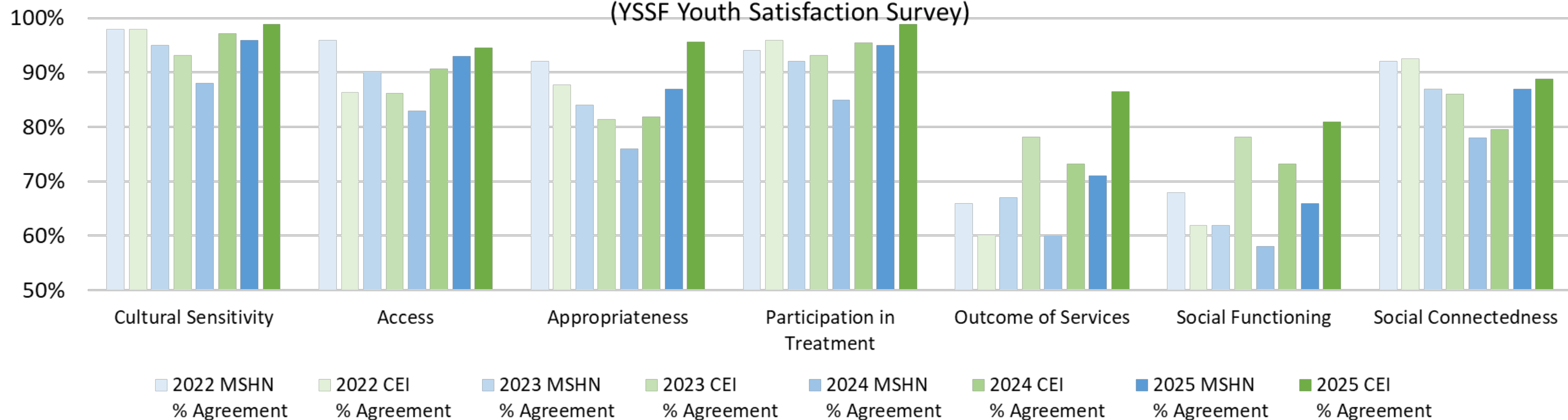
Community Services for the Developmentally Disabled (CSDD) Youth

Top 3 Questions (average scores)				
	2025 (Score)	2024 (Score)	2023 (Score)	2022 (Score)
CSDD Youth - YSSF (Higher = Better) 2025 n = 92; Avg Score = 4.48 2024 n = 44; Avg Score = 4.24 2023 n = 60; Avg Score = 4.25 2022 n = 51; Avg Score = 4.20	14. Staff spoke with me in a way that I understood. (4.78)	14. Staff spoke with me in a way that I understood. (4.72)	12. Staff treated me with respect. (4.57)	14. Staff spoke with me in a way that I understood. (4.69)
	12. Staff treated me with respect. (4.77)	13. Staff respected my family's religious/spiritual beliefs. (4.68)	14. Staff spoke with me in a way that I understood. (4.55)	12. Staff treated me with respect. (4.65)
	3. I helped to choose the goals in my child's service plan. (4.74)	15. Staff were sensitive to my cultural/ethnic background (e.g., race, religion, language). (4.62)	13. Staff respected my family's religious/spiritual beliefs. (4.53)	6. I participated in my child's treatment/services. (4.60)

Bottom 3 Questions (average scores)				
	2025 (Score)	2024 (Score)	2023 (Score)	2022 (Score)
CSDD Youth - YSSF (Lower = Worse) 2025 n = 92; Avg Score = 4.48 2024 n = 44; Avg Score = 4.24 2023 n = 60; Avg Score = 4.25 2022 n = 51; Avg Score = 4.20	20. My child is better able to cope when things go wrong. (3.47)	20. My child is better able to cope when things go wrong. (3.55)	20. My child is better able to cope when things go wrong. (3.75)	20. My child is better able to cope when things go wrong. (3.59)
	22. My child is better able to do things he or she wants to do. (4.12)	22. My child is better able to do things he or she wants to do. (3.63)	22. My child is better able to do things he or she wants to do. (3.91)	16. My child is better at managing daily life. (3.72)
	16. My child is better at managing daily life. (4.18)	16. My child is better at managing daily life. (3.85)	21. I am satisfied with our family life right now. (3.93)	19. My child is doing better in school and/or work. (3.75)

CSDD Youth Performance Across the YSSF Subscales

- Scored Best: Cultural Sensitivity and Participation in Treatment (99% agreement)
- Scored Worst: Social Functioning (81% agreement)
- From 2024 to 2025, CSDD Youth saw increased agreement percentages and average scores in all subscales.
- The region saw an improvement across all YSSF subscales from 2024 to 2025.
- CSDD Youth scored above the region in all subscales in 2025.



CSDD Youth vs Region (YSSF) Average Scores: Higher = Better	2022 MSHN % Agreement	2022 CEI vs Region	2022 CEI % Agreement	2022 CEI Avg Score	2023 MSHN % Agreement	2023 CEI vs Region	2023 CEI % Agreement	2023 CEI Avg Score	2024 MSHN % Agreement	2024 CEI vs Region	2024 CEI % Agreement	2024 CEI Avg Score	2025 MSHN % Agreement	2025 CEI vs Region	2025 CEI % Agreement	2025 CEI Avg Score
Cultural Sensitivity	98%	0.00	98%	4.62	95%	-1.90	93%	4.52	88%	+9.22	97%	4.66	96%	+2.84	99%	4.75
Access	96%	-9.73	86%	4.39	90%	-3.79	86%	4.36	83%	+7.70	91%	4.55	93%	+1.51	95%	4.64
Appropriateness	92%	-4.24	88%	4.21	84%	-2.64	81%	4.22	76%	+5.82	82%	4.26	87%	+8.60	96%	4.58
Participation in Treatment	94%	+2.00	96%	4.47	92%	+1.22	93%	4.46	85%	+10.45	95%	4.49	95%	+3.91	99%	4.72
Outcome of Services	66%	-6.00	60%	3.76	67%	+11.18	78%	3.96	60%	+13.17	73%	3.85	71%	+15.52	87%	4.09
Social Functioning	68%	-6.00	62%	3.73	62%	+16.18	78%	3.96	58%	+15.17	73%	3.85	66%	+14.90	81%	4.06
Social Connectedness	92%	+0.59	93%	4.14	87%	-1.04	86%	4.30	78%	+1.55	80%	4.19	87%	+1.89	89%	4.45

Findings: ITRS Programs

In 2025, the MHSIP adult satisfaction survey described above was distributed by Integrated Treatment & Recovery Services (ITRS) to 123 consumers across 4 programs. The overall 2025 ITRS Response rate was 51.52%, with 136 returned of 264 distributed.

MSHN regional scores decreased in every SUD subscale from 2024 to 2025. The region continues to overall perform better in Service Quality subscales and worse in Service Outcome subscales, while CEI SUD programs do not follow this trend as consistently.

Correctional Assessment & Treatment Services (CATS) – Ingham County jail

- CATS performed near or significantly below the region in all subscales.
- CATS saw decreased scores in nearly all subscales from 2024 to 2025.

Cedar Roots Recovery (CRR) – residential treatment (formerly HOC)

- CRR performed near, significantly above, or significantly below the region depending on the subscale.
- CRR saw decreased scores overall in most subscales from 2024 to 2025.

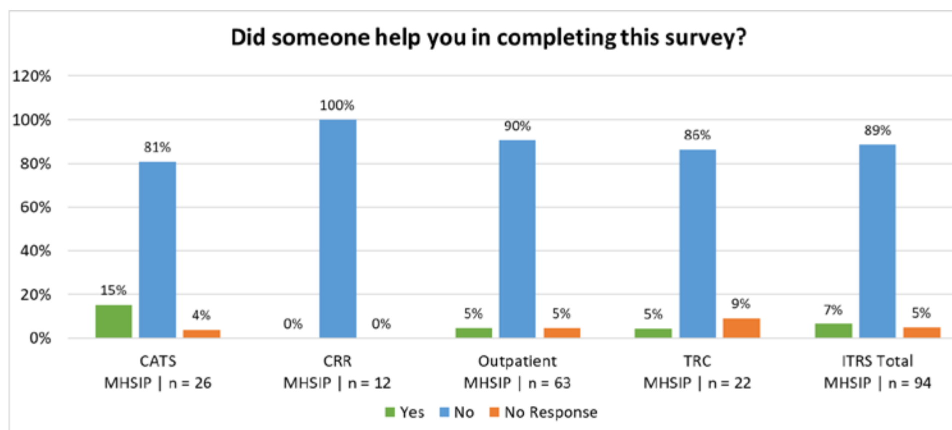
ITRS Outpatient (OP) – outpatient treatment

- OP performed near or above the region in all subscales, sometimes significantly.
- OP saw a mix of decreased and increased subscale scores from 2024 to 2025.

The Recovery Center (TRC) – detox services

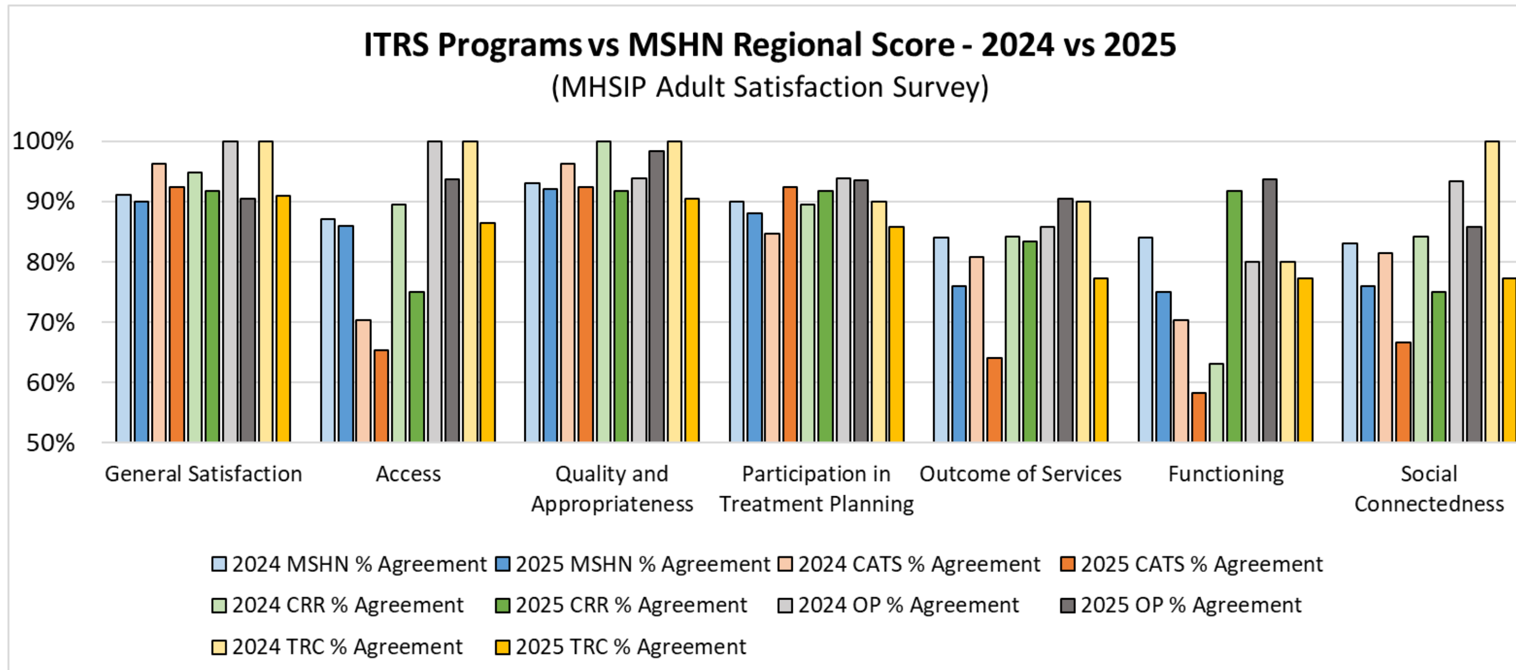
- TRC performed near the region in all subscales with the least variation.
- TRC saw decreased scores in all subscales from 2024 to 2025.

CATS was the ITRS only program surveyed where many consumers received assistance completing the survey. Some OP and TRC respondents also received assistance.



Analysis of Findings: ITRS Programs

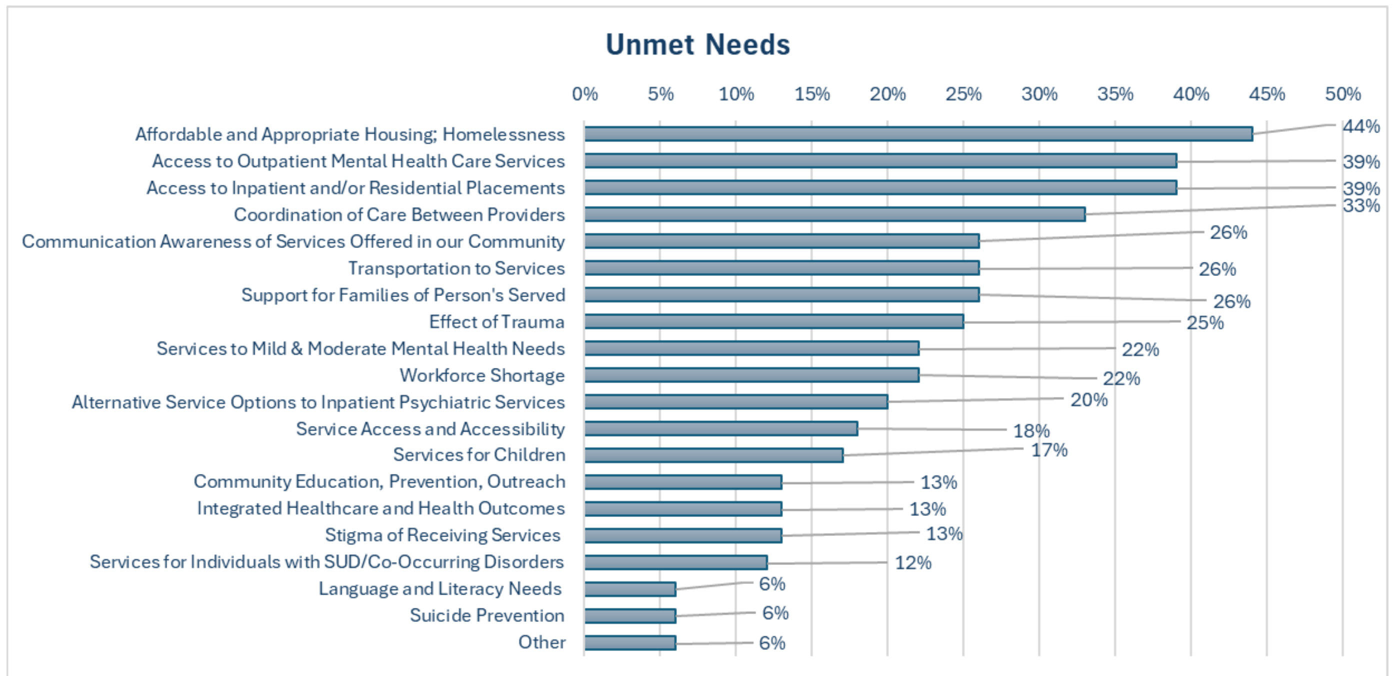
- Questions are scored on a scale of 1 to 5, with lower numerical scores indicating greater performance
- The average satisfaction score across all MHSIP subscales and ITRS programs was 1.66
- Overall, OP had best average score with 1.51 while CATS had the worst average score with 1.95
- Scored Best (across all programs): Quality/Appropriateness – 95% agreement
- Scored Worst (across all programs): Social Connectedness – 80% agreement



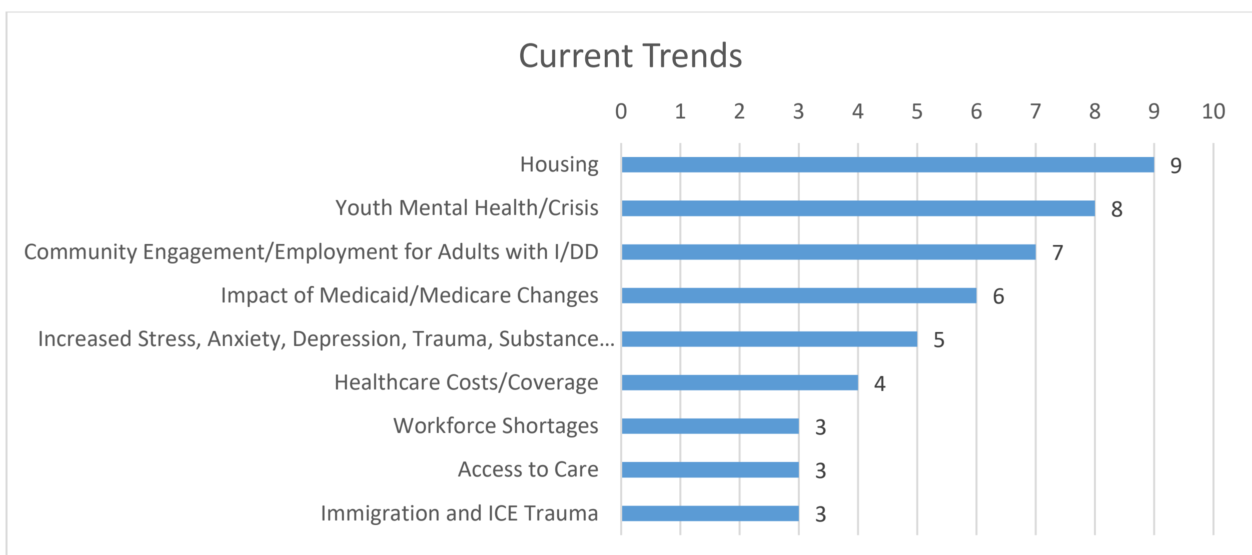
ITRS Programs vs Region (MHSIP) Average Scores: Lower = Better	2024 MSHN % Agreement	2025 MSHN % Agreement	2024 CATS vs Region	2024 CATS % Agreement	2025 CATS vs Region	2025 CATS % Agreement	2024 CRR vs Region	2024 CRR % Agreement	2025 CRR vs Region	2025 CRR % Agreement	2024 OP vs Region	2024 OP % Agreement	2025 OP vs Region	2025 OP % Agreement	2024 TRC vs Region	2024 TRC % Agreement	2025 TRC vs Region	2025 TRC % Agreement
General Satisfaction	91%	90%	+5.30	96%	+2.31	92%	+3.74	95%	+1.67	92%	+9.00	100%	+0.48	90%	+9.00	100%	+0.91	91%
Access	87%	86%	-16.63	70%	-20.62	65%	+2.47	89%	-11.00	75%	+13.00	100%	+7.65	94%	+13.00	100%	+0.36	86%
Quality and Appropriateness	93%	92%	+3.30	96%	+0.31	92%	+7.00	100%	-0.33	92%	+0.75	94%	+6.39	98%	+7.00	100%	-1.52	90%
Participation in Treatment Planning	90%	88%	-5.38	85%	+4.31	92%	-0.53	89%	+3.67	92%	+3.75	94%	+5.55	94%	0.00	90%	-2.29	86%
Outcome of Services	84%	76%	-3.23	81%	-12.00	64%	+0.21	84%	+7.33	83%	+1.71	86%	+14.48	90%	+6.00	90%	+1.27	77%
Functioning	84%	75%	-13.63	70%	-16.67	58%	-20.84	63%	+16.67	92%	-4.00	80%	+18.65	94%	-4.00	80%	+2.27	77%
Social Connectedness	83%	76%	-1.52	81%	-9.33	67%	+1.21	84%	-1.00	75%	+10.33	93%	+9.71	86%	+17.00	100%	+1.27	77%

Stakeholder Survey Results for MDHHS Submission

To gauge factors that may be contributing to mental health needs in our community, CMHA-CEI administers a Stakeholder Survey every two years. Respondents were asked to select up to five unmet needs listed below, which is why the percentages do not total 100 %. The graph below highlights how the community prioritized unmet needs.



Stakeholders were also asked to identify any current trends. The following graph demonstrates current trends the community is concerned about.



Agency Staff Trauma Self-Assessment Results

Total Agency Results (FY24 vs FY21)

<table>
<tr><th>FY 24 Total Result Summary</th><th>FY 21 Total Result Summary</th><td rowspan="4">Survey Score Methodology:
(higher score = more positive)
1 – Strongly Disagree
2 – Disagree
3 – Agree
4 – Strongly Agree

Other Options:
Do Not Know (DNK)
Not Applicable to My Role (NA)</td></tr>
<tr><td>217 Total Completed Surveys</td><td>254 Total Completed Surveys</td></tr>
<tr><td>179 responses from Clinical Programs (83%)</td><td>188 responses from Clinical Programs (74%)</td></tr>
<tr><td>153 responses from Clinical Roles (71%)</td><td>147 responses from Clinical Roles (58%)</td></tr>
</table>

Program	Completed Surveys FY24	Completed Surveys FY21
AMHS	60	72
CSDD	22	50
FF	39	41
ITRS	58	25
Administrative	38	66

Highest Ranking Questions

FY 24 Question	Average Overall Score	Clinical Program Score	Clinical Role Score	FY 21 Question	Average Overall Score	Clinical Program Score	Clinical Role Score
Staff members have regular team meetings.	3.50	3.51	3.54	There are private, confidential spaces available to conduct intake assessments.	3.42	3.42	3.39
Staff does not discuss the personal issues of one consumer with another consumer.	3.44	3.47	3.49	Staff collaborates with consumers in setting their goals.	3.47	3.49	3.52
Staff collaborates with consumers in setting their goals.	3.37	3.40	3.39	Staff does not discuss personal issues of one consumer with another consumer.	3.51	3.36	3.51
FY 24 Highest Section Average: Assessing and Planning Services - Developing Goals and Plans (3.32)				**FY 21 Highest Section Average:** Conducting Intake Assessments -Intake Assessment Follow-Up: Developing Goals and Plans (3.38)			

Lowest Ranking Questions

FY 24 Question	Average Overall Score	Clinical Program Score	Clinical Role Score	FY 21 Question	Average Overall Score	Clinical Program Score	Clinical Role Score
The organization provides a space for children to play.	2.40	2.42	2.37	The program provides a space for children to play.	2.47	2.45	2.32
Staff members ask consumers for their definitions of physical safety.	2.50	2.51	2.52	Material is posted about traumatic stress (e.g. what it is, how it impacts people, and available trauma-specific resources).	2.52	2.43	2.38
Staff at all levels of the agency receive training and education on: What is asked in the intake assessment.	2.55	2.61	2.65	The program incorporates child-friendly decorations and materials.	2.56	2.5	2.4
FY 24 Lowest Section Average: Training and Education - Staff at all levels of the program receive training and education on the following topics (2.74)				**FY 21 Lowest Section Average:** Reviewing Policies (2.77)			

Most Frequent "Do Not Know," "Not Applicable," or Blank Responses

(least answered questions)

FY 24 Question	Number Not Answered	Percent of Question Responses	FY 21 Question	Number Not Answered	Percent of Question Responses
The agency involves consumers in its review of policies.	125	58%	The intake assessment includes questions about: Children's history of physical health issues.	163	64%
The intake assessment includes questions about children's achievement of developmental tasks.	112	52%	The intake assessment includes questions about: Children's history of mental health issues.	162	64%
The intake assessment includes questions about children's history of physical health issues.	107	49%	The intake assessment includes questions about: Children's achievement of developmental tasks.	153	60%
The intake assessment includes questions about children's history of mental health issues.	106	49%	The intake assessment includes questions about: Children's trauma exposure (e.g. neglect, abuse, exposure to violence).	150	59%
The intake assessment includes questions about children's trauma exposure (e.g. neglect, abuse, exposure to violence).	97	45%	The program involves consumers in its review of policies.	143	56%
The intake assessment includes questions about previous head injury.	97	45%	The intake assessment includes questions about: Quality of relationship with child or children (e.g. caregiver/child attachment).	130	51%

Least Frequent "Do Not Know," "Not Applicable," or Blank Responses

(most answered questions)

FY 24 Question	Number Not Answered	Percent of Question Responses	FY 21 Question	Number Not Answered	Percent of Question Responses
Staff members have regular team meetings.	1	0.5%	Staff members have regular team meetings.	6	2%
Bathrooms are well lit.	4	2%	Staff members have a regularly scheduled time for individual supervision.	12	5%
The common areas within the organization are well lit.	8	4%	Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress-reducing strategies).	16	6%
Staff members have a regularly scheduled time for individual supervision.	9	4%	Staff at all levels of the program receive training and education on the following topics: What traumatic stress is.	20	8%
Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress reducing strategies).	14	7%	Staff at all levels of the program receive training and education on the following topics: The relationship between mental health and trauma.	21	8%
The agency has a formal system for reviewing staff performance.	14	7%	The program has a formal system for reviewing staff performance.	21	8%
			Bathrooms are well lit.	21	8%

Overall Section Average Score YOY

#	Overall - All Programs YOY Staff Trauma Assessment Survey Section (Higher score = Better result ǀ Top 3 = Green ǀ Bottom 3 = Red)	2024 Average Overall Score	2021 Average Overall Score	2017 Average Overall Score	Section YOY Trendline 2024 2021 2017
1	Staff at all levels of the program receive training and education on the following topics:	2.74	2.90	2.80	
2	Staff Supervision, Support and Self-Care	3.00	2.95	2.85	
3	Establishing a Safe Physical Environment	2.85	2.94	2.83	
4	Establishing a Supportive Environment - Information Sharing	2.98	3.04	2.92	
5	Establishing a Supportive Environment - Cultural Competence	3.09	3.14	3.02	
6	Establishing a Supportive Environment - Privacy and Confidentiality	3.25	3.34	3.24	
7	Establishing a Supportive Environment - Safety and Crisis Prevention Planning	2.97	2.84	2.92	
8	Establishing a Supportive Environment - Open and Respectful Communication	3.04	3.04		
9	Establishing a Supportive Environment - Consistency and Predictability	3.03	3.01	3.00	
10	Conducting Intake Assessments - The intake assessment includes questions about:	3.15	3.20	3.18	
11	Conducting Intake Assessments - Intake Assessment Process	3.25	3.35	3.30	
12	Conducting Intake Assessments - Intake Assessment Follow-Up	3.31	3.33	3.29	
13	Developing Goals and Plans	3.32	3.38	3.31	
14	Offering Services and Trauma-Specific Interventions	3.14	3.09	3.04	
15	Involving Current and Former Consumers	3.10	2.88	2.88	
16	Creating Written Policies	3.19	3.07	3.03	
17	Reviewing Policies	2.85	2.77	2.65	

AMHS (FY24 Data Only)

60 Completed Program Surveys	*Child-focused questions removed

Highest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff members have regular team meetings.	3.42	2%
Staff does not discuss the personal issues of one consumer with another consumer.	3.30	12%
The program updates releases and consent forms whenever it is necessary to speak with a new provider.	3.29	20%
Highest Section Average: Assessing and Planning Services - Conducting Intake Assessments: Intake Assessment Follow-Up (3.22)		

Lowest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff at all levels of the agency receive training and education on: What is asked in the intake assessment.	2.02	23%
Staff at all levels of the agency receive training and education on: How working with trauma survivors impacts staff.	2.24	18%
Staff members ask consumers for their definitions of physical safety.	2.24	30%
Lowest Section Average: Training and Education - Staff at all levels of the program receive training and education on the following topics (2.45)		

Most Frequent "Do Not Know," "Not Applicable," or Blank Responses

(least answered questions)

Question	Number Not Answered	Percent of Question Responses
The agency involves consumers in its review of policies.	34	57%
The intake assessment includes questions about previous head injury.	32	53%
The agency reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors.	30	50%
The agency recruits former consumers to serve in an advisory capacity.	26	43%
Former consumers are invited to share their thoughts, ideas and experiences with the agency.	26	43%
The agency has a written statement that includes a commitment to understanding trauma and engaging in trauma-sensitive practices.	26	43%

Least Frequent "Do Not Know," "Not Applicable," or Blank Responses

(most answered questions)

Question	Number Not Answered	Percent of Question Responses
The common areas within the organization are well lit.	0	0%
There are private spaces for staff and consumers to discuss personal issues.	0	0%
Bathrooms are well lit.	0	0%
Staff members have regular team meetings.	1	2%
Staff and other professionals do not talk about consumers in common spaces.	2	3%
Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress reducing strategies).	2	3%
Staff members have a regularly scheduled time for individual supervision.	2	3%
Consumer rights are posted in places that are visible (e.g. room checks, grievance policies, mandatory reporting rules).	2	3%

AMHS Section Average Score YOY

#	AMHS YOY (*excludes child-focused questions) Staff Trauma Assessment Survey Section (Higher score = Better result | Top 3 = Green | Bottom 3 = Red)	2024 Average Overall Score	2021 Average Overall Score	Section YOY Trendline 2024 2021
1	Staff at all levels of the program receive training and education on the following topics:	2.45	2.90	
2	Staff Supervision, Support and Self-Care	2.81	2.86	
3	Establishing a Safe Physical Environment	2.70	2.91	
4	Establishing a Supportive Environment - Information Sharing	2.74	3.01	
5	Establishing a Supportive Environment - Cultural Competence	2.90	3.05	
6	Establishing a Supportive Environment - Privacy and Confidentiality	3.10	3.29	
7	Establishing a Supportive Environment - Safety and Crisis Prevention Planning	2.65	2.71	
8	Establishing a Supportive Environment - Open and Respectful Communication	2.80	2.87	
9	Establishing a Supportive Environment - Consistency and Predictability	2.82	2.91	
10	Conducting Intake Assessments - The intake assessment includes questions about:	2.98	3.07	
11	Conducting Intake Assessments - Intake Assessment Process	3.19	3.31	
12	Conducting Intake Assessments - Intake Assessment Follow-Up	3.22	3.26	
13	Developing Goals and Plans	3.20	3.28	
14	Offering Services and Trauma-Specific Interventions	3.05	3.06	
15	Involving Current and Former Consumers	2.97	2.69	
16	Creating Written Policies	3.08	3.11	
17	Reviewing Policies	2.65	2.56	

CSDD (FY24 Data Only)

22 Completed Program Surveys	*Child-focused questions included

Highest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff members have regular team meetings.	3.45	0%
Staff does not discuss the personal issues of one consumer with another consumer.	3.45	9%
Staff members have a regularly scheduled time for individual supervision.	3.43	5%
Staff and/or consumers are allowed to prepare or have ethnic-specific foods.	3.43	36%
Highest Section Average: Assessing and Planning Services - Conducting Intake Assessments: Intake Assessment Follow-Up (3.30)		

Lowest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
The organization provides a space for children to play.	2.06	27%
Each consumer has a written crisis prevention plan which includes a list of triggers, strategies and responses which are helpful and those that are not helpful and a list of persons the consumer can go to for support.	2.38	27%
The agency involves staff in its review of policies.	2.38	41%
Lowest Section Average: Adapting Policies - Reviewing Policies (2.63)		

Most Frequent “Do Not Know,” “Not Applicable,” or Blank Responses

(least answered questions)

Question	Number Not Answered	Percent of Question Responses
The agency recruits former consumers to serve in an advisory capacity.	12	55%
The agency involves consumers in its review of policies.	12	55%
The agency reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors.	11	50%
Consumers who have violated rules are approached in private.	10	46%
The intake assessment includes questions about children's trauma exposure (e.g. neglect, abuse, exposure to violence).	10	46%
The intake assessment includes questions about children's achievement of developmental tasks.	10	46%
Former consumers are invited to share their thoughts, ideas and experiences with the agency.	10	46%

Least Frequent “Do Not Know,” “Not Applicable,” or Blank Responses

(most answered questions)

Question	Number Not Answered	Percent of Question Responses
Program information is available in different languages.	0	0%
Staff and other professionals do not talk about consumers in common spaces.	0	0%
Bathrooms are well lit.	0	0%
Staff members have regular team meetings.	0	0%
Part of supervision time is used to help staff members understand their own stress reactions.	1	5%
The common areas within the organization are well lit.	1	5%

Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress reducing strategies).	1	5%
Staff members have a regularly scheduled time for individual supervision.	1	5%
Agency staff monitors who is coming in and out of the program/agency.	1	5%

CSDD Section Average Score YOY

#	CSDD YOY Staff Trauma Assessment Survey Section (Higher score = Better result | Top 3 = Green | Bottom 3 = Red)	2024 Average Overall Score	2021 Average Overall Score	Section YOY Trendline 2024 2021
1	Staff at all levels of the program receive training and education on the following topics:	2.64	2.60	
2	Staff Supervision, Support and Self-Care	3.04	2.68	
3	Establishing a Safe Physical Environment	2.81	2.77	
4	Establishing a Supportive Environment - Information Sharing	2.97	2.83	
5	Establishing a Supportive Environment - Cultural Competence	3.03	3.10	
6	Establishing a Supportive Environment - Privacy and Confidentiality	3.28	3.28	
7	Establishing a Supportive Environment - Safety and Crisis Prevention Planning	2.83	2.36	
8	Establishing a Supportive Environment - Open and Respectful Communication	2.89	2.91	
9	Establishing a Supportive Environment - Consistency and Predictability	3.09	2.82	
10	Conducting Intake Assessments - The intake assessment includes questions about:	3.13	3.32	
11	Conducting Intake Assessments - Intake Assessment Process	3.23	3.32	
12	Conducting Intake Assessments - Intake Assessment Follow-Up	3.30	3.35	
13	Developing Goals and Plans	3.23	3.39	
14	Offering Services and Trauma-Specific Interventions	2.83	2.69	
15	Involving Current and Former Consumers	3.17	2.54	
16	Creating Written Policies	3.09	3.04	
17	Reviewing Policies	2.63	2.49	

Families Forward (FY24 Data Only)

39 Completed Program Surveys	*Child-focused questions included

Highest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff does not discuss the personal issues of one consumer with another consumer.	3.62	5%
Staff and/or consumers are allowed to speak their native languages within the agency.	3.58	15%
Staff members have regular team meetings.	3.54	0%
Highest Section Average: Assessing and Planning Services - Developing Goals and Plans (3.46)		

Lowest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff at all levels of the agency receive training and education on: The relationship between homelessness and trauma.	2.31	26%
Staff at all levels of the agency receive training and education on: Cultural differences in how people understand and respond to trauma.	2.34	18%
Staff at all levels of the agency receive training and education on: How working with trauma survivors impacts staff.	2.41	26%
Lowest Section Average: Training and Education - Staff at all levels of the program receive training and education on the following topics (2.66)		

Most Frequent “Do Not Know,” “Not Applicable,” or Blank Responses

(least answered questions)

Question	Number Not Answered	Percent of Question Responses
The agency involves consumers in its review of policies.	25	64%
The agency recruits former consumers to serve in an advisory capacity.	19	49%
The organization has regularly scheduled procedures/ opportunities for consumers to provide input.	18	46%
Consumers who have violated rules are approached in private.	17	44%
Former consumers are invited to share their thoughts, ideas and experiences with the agency.	17	44%
Written policies are established based on an understanding of the impact of trauma on consumers and providers.	17	44%
The agency reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors.	17	44%

Least Frequent “Do Not Know,” “Not Applicable,” or Blank Responses

(most answered questions)

Question	Number Not Answered	Percent of Question Responses
Staff members have a regularly scheduled time for individual supervision.	0	0%
Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress reducing strategies).	0	0%
Staff members have regular team meetings.	0	0%
Bathrooms are well lit.	0	0%
Part of supervision time is used to help staff members understand their own stress reactions.	1	3%
The organization incorporates child-friendly decorations and materials.	1	3%

Families Forward Section Average Score YOY

#	Families Forward YOY Staff Trauma Assessment Survey Section (Higher score = Better result ǀ Top 3 = Green ǀ Bottom 3 = Red)	2024 Average Overall Score	2021 Average Overall Score	Section YOY Trendline 2024 2021
1	Staff at all levels of the program receive training and education on the following topics:	2.66	3.01	
2	Staff Supervision, Support and Self-Care	3.12	3.17	
3	Establishing a Safe Physical Environment	2.92	2.92	
4	Establishing a Supportive Environment - Information Sharing	2.97	2.97	
5	Establishing a Supportive Environment - Cultural Competence	3.28	3.15	
6	Establishing a Supportive Environment - Privacy and Confidentiality	3.35	3.38	
7	Establishing a Supportive Environment - Safety and Crisis Prevention Planning	3.37	3.37	
8	Establishing a Supportive Environment - Open and Respectful Communication	3.19	3.08	
9	Establishing a Supportive Environment - Consistency and Predictability	3.08	3.07	
10	Conducting Intake Assessments - The intake assessment includes questions about:	3.26	3.23	
11	Conducting Intake Assessments - Intake Assessment Process	3.27	3.37	
12	Conducting Intake Assessments - Intake Assessment Follow-Up	3.37	3.44	
13	Developing Goals and Plans	3.46	3.49	
14	Offering Services and Trauma-Specific Interventions	3.24	3.28	
15	Involving Current and Former Consumers	3.16	3.11	
16	Creating Written Policies	3.24	3.25	
17	Reviewing Policies	2.86	2.30	

ITRS (FY24 Data Only)

58 Completed Program Surveys	*Child-focused questions removed

Highest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff members have regular team meetings.	3.60	0%
Staff does not discuss the personal issues of one consumer with another consumer.	3.54	2%
Staff collaborates with consumers in setting their goals.	3.50	3%
Highest Section Average: Assessing and Planning Services - Conducting Intake Assessments: Intake Assessment Follow-Up (3.43)		

Lowest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff members ask consumers for their definitions of physical safety.	2.71	29%
Staff at all levels of the agency receive training and education on: Cultural differences in how people understand and respond to trauma.	2.74	9%
Each consumer has a written crisis prevention plan which includes a list of triggers, strategies and responses which are helpful and those that are not helpful and a list of persons the consumer can go to for support.	2.76	29%
Lowest Section Average: Creating a Safe and Supportive Environment - Establishing a Supportive Environment: Safety and Crisis Prevention Planning (3.01)		

Most Frequent "Do Not Know," "Not Applicable," or Blank Responses

(least answered questions)

Question	Number Not Answered	Percent of Question Responses
The agency involves consumers in its review of policies.	27	47%
Outside agencies with expertise in cultural competence provide on-going training and consultation.	24	41%
Written safety plans are incorporated into consumers' individual goals and plans.	21	36%
Staff and/or consumers are allowed to prepare or have ethnic-specific foods.	20	35%
The agency recruits former consumers to serve in an advisory capacity.	20	35%

Least Frequent "Do Not Know," "Not Applicable," or Blank Responses

(most answered questions)

Question	Number Not Answered	Percent of Question Responses
Staff at all levels of the agency receive training and education on: How to establish and maintain healthy professional boundaries.	0	0%
Staff members have regular team meetings.	0	0%
There are private spaces for staff and consumers to discuss personal issues.	0	0%
Staff does not discuss the personal issues of one consumer with another consumer.	1	2%

ITRS Section Average Score YOY

#	ITRS YOY (*excludes child-focused questions) Staff Trauma Assessment Survey Section (Higher score = Better result | Top 3 = Green | Bottom 3 = Red)	2024 Average Overall Score	2021 Average Overall Score	Section YOY Trendline 2024 2021
1	Staff at all levels of the program receive training and education on the following topics:	3.09	3.08	
2	Staff Supervision, Support and Self-Care	3.14	3.05	
3	Establishing a Safe Physical Environment	3.11	3.08	
4	Establishing a Supportive Environment - Information Sharing	3.16	3.24	
5	Establishing a Supportive Environment - Cultural Competence	3.25	3.17	
6	Establishing a Supportive Environment - Privacy and Confidentiality	3.40	3.44	
7	Establishing a Supportive Environment - Safety and Crisis Prevention Planning	3.01	2.94	
8	Establishing a Supportive Environment - Open and Respectful Communication	3.25	3.31	
9	Establishing a Supportive Environment - Consistency and Predictability	3.14	3.10	
10	Conducting Intake Assessments - The intake assessment includes questions about:	3.25	3.25	
11	Conducting Intake Assessments - Intake Assessment Process	3.34	3.44	
12	Conducting Intake Assessments - Intake Assessment Follow-Up	3.43	3.31	
13	Developing Goals and Plans	3.43	3.47	
14	Offering Services and Trauma-Specific Interventions	3.28	3.26	
15	Involving Current and Former Consumers	3.12	3.01	
16	Creating Written Policies	3.29	3.35	
17	Reviewing Policies	3.05	2.82	

Administrative (FY24 Data Only)

38 Completed Admin Surveys		*Child-focused questions included
QCSRR Completed 29 Surveys	IS Completed 9 Surveys	No Surveys completed in other Administrative Programs

Highest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff members have regular team meetings.	3.47	0%
Staff members have a regularly scheduled time for individual supervision.	3.38	11%
The intake assessment includes questions about history of trauma (e.g. physical, emotional or sexual abuse, neglect, loss, domestic/community violence, combat, past homelessness).	3.33	53%
Highest Section Average: Adapting Policies - Creating Written Policies (3.20)		

Lowest Ranking Questions

Question	Average Overall Score	% Not Answered (DNK/NA)
Staff at all levels of the agency receive training and education on: What is asked in the intake assessment.	2.20	34%
The organization provides a space for children to play.	2.27	61%
Staff at all levels of the agency receive training and education on: How to develop safety and crisis prevention plans.	2.28	34%
Lowest Section Average: Training and Education - Staff at all levels of the program receive training and education on the following topics (2.75)		

Most Frequent “Do Not Know,” “Not Applicable,” or Blank Responses

(least answered questions)

Question	Number Not Answered	Percent of Question Responses
Staff members ask consumers for their definitions of physical safety.	32	84%
The intake assessment includes questions about previous head injury.	30	79%
Staff members ask consumers for their definitions of emotional safety.	29	76%
The agency involves consumers in its review of policies.	27	71%
Before leaving the program, consumers and staff develop a plan to address any future needs.	26	68%
The program informs consumers about why questions are being asked.	25	66%

Least Frequent “Do Not Know,” “Not Applicable,” or Blank Responses

(most answered questions)

Question	Number Not Answered	Percent of Question Responses
Staff members have regular team meetings.	0	0%
The common areas within the organization are well lit.	1	3%
Bathrooms are well lit.	2	5%
The agency has a formal system for reviewing staff performance.	2	5%
Staff members have a regularly scheduled time for individual supervision.	4	11%
The agency has written policy to address potential threats to consumers and staff from natural or man- made threats (fire, tornado, bomb threat, and hostile intruder).	4	11%

Admin Section Average Score YOY

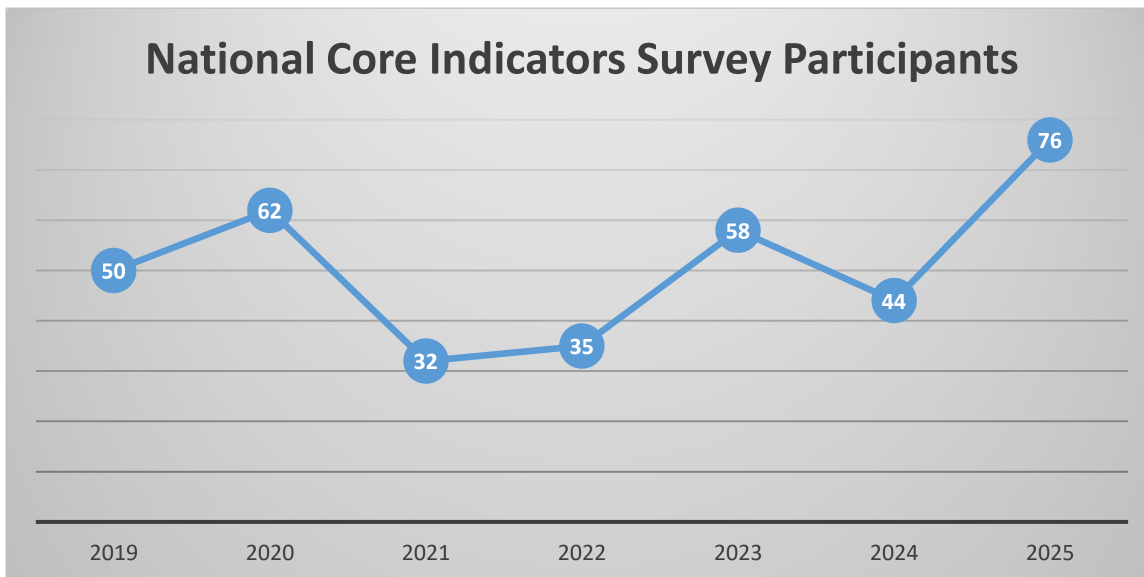
#	Admin YOY (GA/QCSRR/Finance/HR/IS) Staff Trauma Assessment Survey Section (Higher score = Better result ǀ Top 3 = Green ǀ Bottom 3 = Red)	2024 Average Overall Score	2021 Average Overall Score	Section YOY Trendline 2024 2021
1	Staff at all levels of the program receive training and education on the following topics:	2.75	3.06	
2	Staff Supervision, Support and Self-Care	2.93	3.03	
3	Establishing a Safe Physical Environment	2.90	3.09	
4	Establishing a Supportive Environment - Information Sharing	3.13	3.28	
5	Establishing a Supportive Environment - Cultural Competence	3.01	3.24	
6	Establishing a Supportive Environment - Privacy and Confidentiality	3.09	3.41	
7	Establishing a Supportive Environment - Safety and Crisis Prevention Planning	2.99	3.15	
8	Establishing a Supportive Environment - Open and Respectful Communication	3.07	3.24	
9	Establishing a Supportive Environment - Consistency and Predictability	3.16	3.30	
10	Conducting Intake Assessments - The intake assessment includes questions about:	3.14	3.27	
11	Conducting Intake Assessments - Intake Assessment Process	3.12	3.36	
12	Conducting Intake Assessments - Intake Assessment Follow-Up	3.14	3.40	
13	Developing Goals and Plans	3.12	3.32	
14	Offering Services and Trauma-Specific Interventions	3.07	3.45	
15	Involving Current and Former Consumers	3.18	3.46	
16	Creating Written Policies	3.20	3.17	
17	Reviewing Policies	2.87	3.05	

National Core Indicators Survey

The NCI Survey is a collaboration between participating states, Human Services Research Institute, and the National Association of State Directors of Developmental Disabilities Services. Information about specific 'core indicators' are gathered to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. The NCI survey aims to assess family and adult consumer perceptions of and satisfaction with their community mental health system and services.

Consumers are selected at random and asked if they would like to participate in the in person survey. Data gathered through this survey is intended to assist in informing strategic planning, legislative reports, and prioritize quality improvement initiatives.

During the 2025-2026 survey, a total of 76 consumers consented to participate in the survey. This was a 73% increase compared to the previous survey year.



Quality Improvement and Performance Measurement Report: CARF Accredited CMHA-CEI Programs

CMHA-CEI is nationally accredited through the Commission on Accreditation of Rehabilitation Facilities (CARF).

CARF International has announced that the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties (CMHA-CEI) has been accredited through December 31, 2026. This is the seventh consecutive Three-Year Accreditation that the international accrediting body has given to CMHA-CEI. The agency retained accreditation for all applicable clinical programs and all administrative units.

In 2023, CMHA-CEI was granted a three-year accreditation for all administrative units (General Administration, Properties & Facilities, Human Resources, Finance/Contracts, Quality, Customer Service, and Recipient Rights), as well as 19 clinical programs in Adult Mental Health Services (AMHS), Families Forward (FF), Community Services for the Developmentally Disabled (CSDD), and Integrated Treatment and Recovery Services (ITRS). CMHA-CEI's current CARF Accreditation runs through December 2026. An application for re-accreditation will be completed by June 2026 for a survey in the fall of 2026.

Current CARF-accredited CMHA-CEI programs are:

CMHA-CEI Department	CMHA-CEI Program	**CARF Core Program**
AMHS	ACT - Cedar	ACT
AMHS	Team I Case Management	Case Management - MH
AMHS	Team II Case Management	Case Management - MH
AMHS	Team 3 Case Management	Case Management – MH
AMHS	Outreach CM	Case Management - MH
AMHS	Older Adult Services	Case Management - MH
AMHS	ECCC	Case Management - MH
AMHS	CCCC	Case Management - MH
AMHS	MROP	Case Management - MH
AMHS	Waverly Wellness	Case Management - MH
ITRS	ITRS Outpatient	Outpatient Treatment Alcohol and other drugs – Adults
ITRS	CATS	Outpatient Treatment Alcohol and other drugs – Criminal Justice
ITRS	House of Commons	Residential Treatment Alcohol and other drugs – Criminal Justice

ITRS	The Recovery Center	Detoxification/Withdrawal Support Treatment Alcohol and other drugs – Adults
Families Forward	Parent-Young Child Program	Intensive Family Bases Services – Early Intervention
Families Forward	Parent-Infant Program	Intensive Family Bases Services – Early Intervention
Families Forward	Family Guidance Services	Intensive Family Bases Services – Home Based
CSDD	Life Consultation	Case Management – psychosocial rehab
CSDD	Family Support Case Management	Case Management – psychosocial rehab

The QI Team is charged with facilitating and preparing each unit for the survey. Part of survey preparation includes submitting annual efficiency measures and outcomes data from CARF-accredited programs in the form of a Quality Improvement and Performance Measurement Plan. The plan is composed of data from performance indicators, satisfaction surveys, incident reports, and other internal QI initiatives. Additional information on performance can be found in the annual Quality Improvement Plan (QIP) and QIP Evaluations found online here: https://www.ceicmh.org/news-and-events/reports-and-publications.html

Findings, Recommendations, and Accreditation Timeline

CARF Survey and Accreditation Timeline		
Date	**Action**	**Comment**
June 30, 2023	CMHA-CEI Received full accreditation through 2026 as the result of Virtual Survey	
September 5, 2023	CARF QIP reviewed at Quality Improvement and Compliance Committee	Reviewed recommendations and action items for QIP. Assigned responsibilities to programs and Directors with target deadlines.
October 31, 2023	Submitted QIP to CARF	
June 30, 2024	Submitted Annual Conformance to Quality Report to CARF	Updated on QIP Timeline
January 7, 2025	Reviewed CARF QIP at QICC Meeting	Reviewed QIP from last CARF survey, look at additional programs to be added in 2026.

June 30, 2025	Submitted Annual Conformance to Quality Report to CARF	Updated on QIP Timeline
July to Nov 2025	QI has started to prep materials to begin CARF Reaccreditation application process	**Timeline has now shifted back ~ 6 months.**
Nov 2025 to June 2026	QI to prepare for CARF Reaccreditation application, begin consulting with CARF accredited CEI programs (will meet throughout FY26 Q2 as well as Q3/Q4 to discuss remediation from last audit, changes for next, questions, needs)	Meetings to be scheduled with programs to go over documentation and any questions. **Will gain access to 2026 Standards Manual in FY26 Q2**.
June 30, 2026	Application for CARF Reaccreditation Due	Will need documentation: program descriptions, outcome measures, org charts, budgets, etc.
July 2026 to Oct/Nov 2026	QI to prep for CARF Survey – internally and continued meetings with programs	Working to ensure policy, procedure, other documentation is ready to go for audit
Oct or Nov 2026	CARF Survey – will be in-person/On Site, **will now use 2026 Standards Manual**	Survey to be scheduled for Fall 2026.

CARF Survey and Accreditation Timeline		
Date	**Action**	**Comment**
June 30, 2023	CMHA-CEI Received full accreditation through 2026 as the result of Virtual Survey	
September 5, 2023	CARF QIP reviewed at Quality Improvement and Compliance Committee	Reviewed recommendations and action items for QIP. Assigned responsibilities to programs and Directors with target deadlines
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June 30, 2024	Submit Annual Conformance to Quality Report to CARF	Update on QIP Timeline
January 7, 2025	Review of CARF QIP at QICC Meeting	Review QIP from last CARF survey, look at potential additional programs to be added in 2026.
June 30, 2025	Submit Annual Conformance to Quality Report to CARF	Update on QIP Timeline

December 31, 2025	Application for CARF Reaccreditation	Survey to be scheduled Summer of 2026
June 2026	CARF Survey – On Site	

CARF Findings and Recommendations at a Glance	
Responsible Program	**CARF Recommendation**
QI/QCSRR	• Assist all programs and administrative units in implementing changes • Chart reviews highlighting specific recommendations
Finance	• Annual Review of Contracts
Human Resources	• Annual Review of Procedures • Workforce and Succession Planning • Code of Ethics (Addressing Peer Support Services and boundaries) • Diversity, Equity, and Inclusion Plan
Information Systems	• Records in EHR be completed and legible – addressing missing information in Assessment and other fields
Properties & Facilities	• Annual review of procedures, tests, drills, and safety inspections
Medical Director	• Updates to Medication Procedures and Physician Peer Review
Clinical Programs	• Uniform use of supervision notes and Suicide Screening • Updates to Guidelines or Program Descriptions to emphasize admission standards and decision making • CATS: Updates to Person Centered Planning that addresses CARF Standards

ICDP and CC360 Data

To assist CMHA-CEI Departments with Performance Improvement QI has been working to learn ICDP/CC360 Data Systems to pull consumer data. In FY24, QI accessed the Integrated Care Delivery Platform (ICDP) to pull Service Utilization data for consumers enrolled in CCBHC services. QI increased access to monitor CCBHC specific measurements and address Care Alerts noted in the program. The Care Alerts identified as priorities to be addressed in FY25 were Adherence to Antipsychotics for Patients with Schizophrenia, Diabetes Monitoring, Cardiovascular Screening, Follow-Up after Hospitalization for Mental Illness - Adults, Follow-Up after Hospitalization for Mental Illness – Child, and Access to Primary Care for Children. In FY26 QI will continue to monitor CCBHC specific measurements and address priority Care Alerts noted in the program.

Care Coordination Review

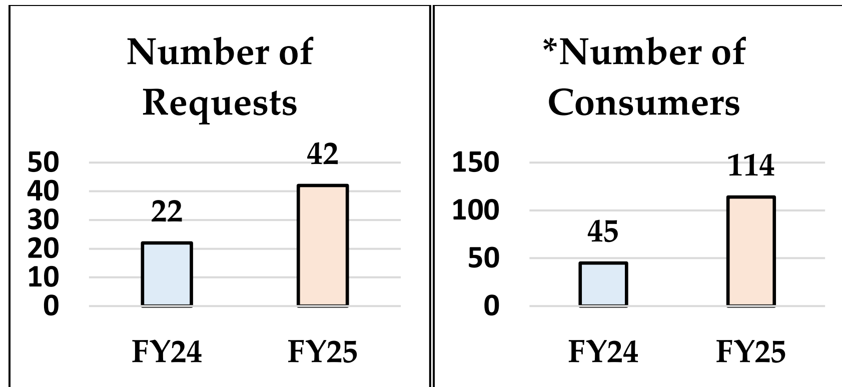
As part of agency-wide care coordination (CC) efforts, the QI Team responds as needed to CC requests from Mid-State Health Network's (MSHN) Complex Care Coordinator. These requests may occur several times per month.

Data for care coordination requests received by QI is tracked and includes the number of requests received and the *number of consumers affected. These are broken down by month, quarter, and fiscal year. Requests began to increase significantly in late FY24. Although data for FY26 is not included below, this trend has continued (with 9 requests for 32 consumers occurring in FY26 Q1).

* The number of consumers affected may include duplicate consumers with multiple information requests in one month, one quarter, or one fiscal year.

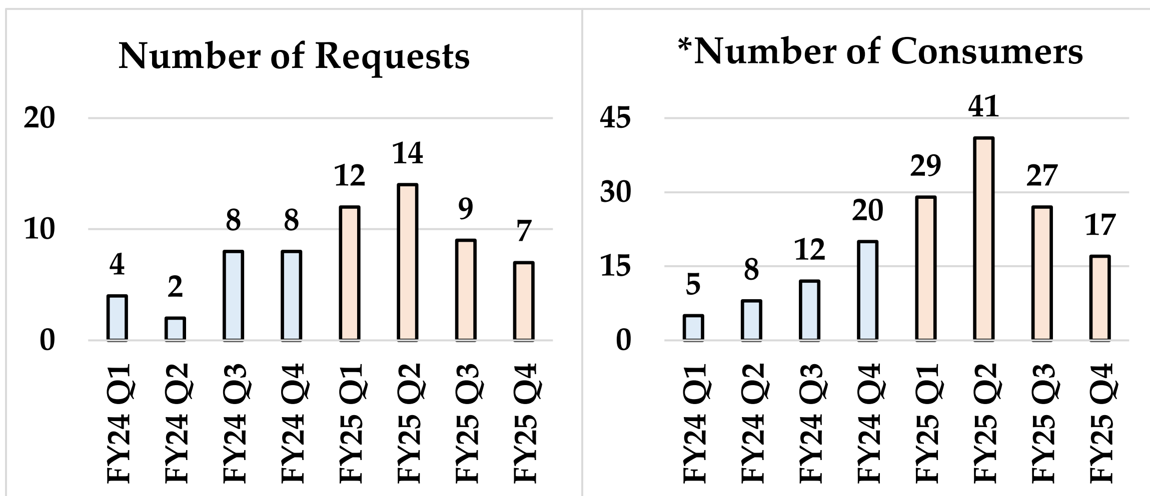
CC Per Fiscal Year

Fiscal Year	Number of Requests	*Number of Consumers
FY24	22	45
FY25	42	114
Total	**64**	**159**



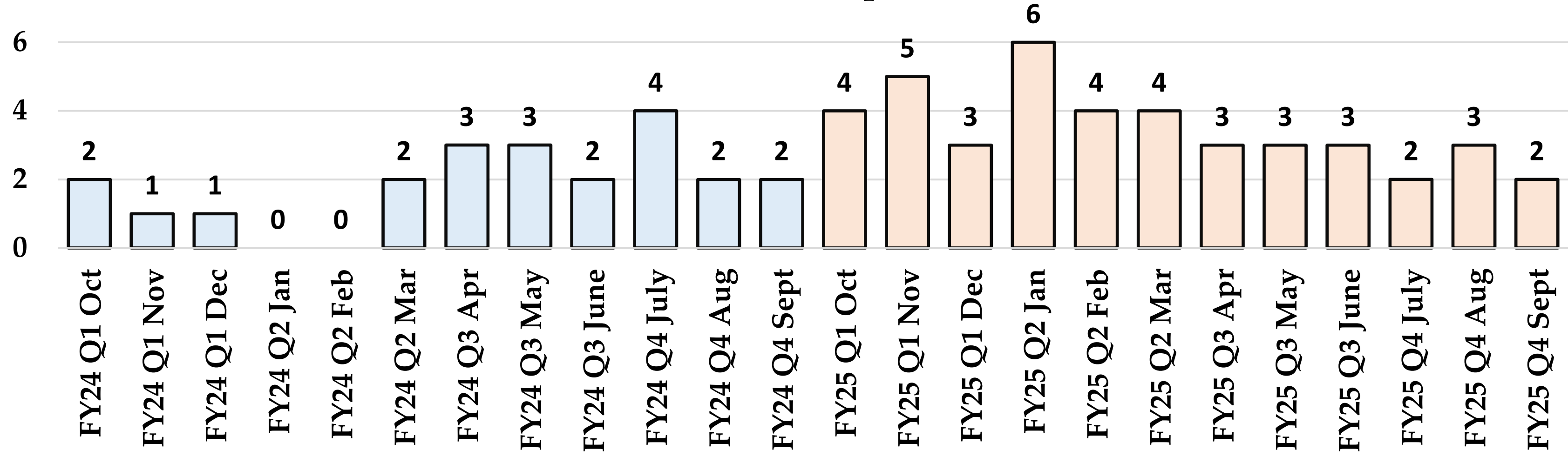
CC Per Quarter

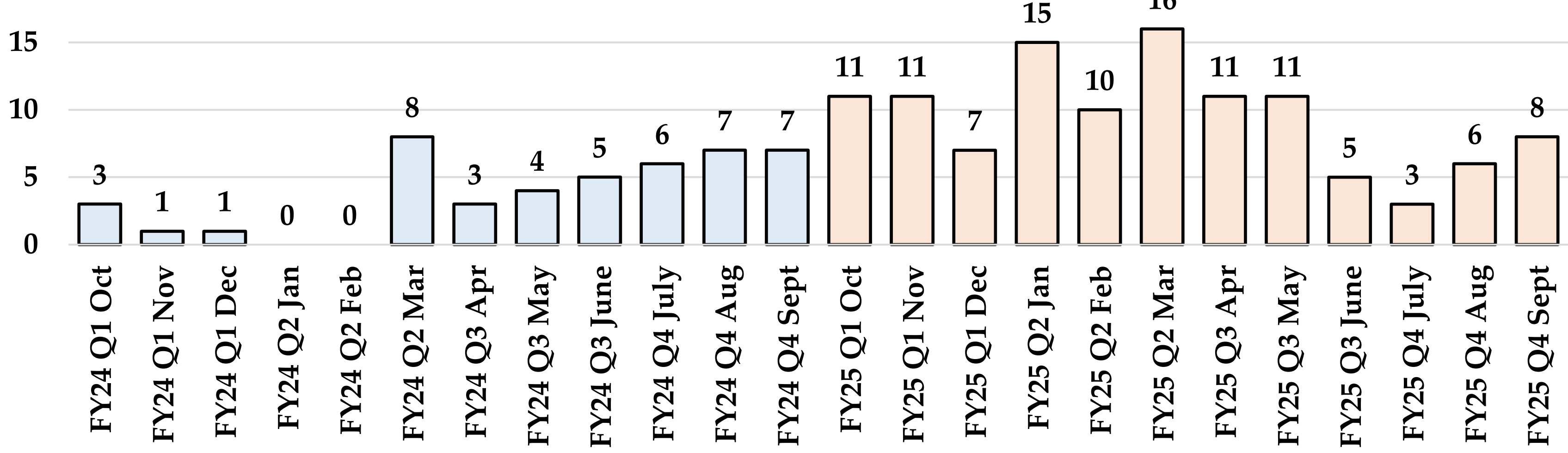
Fiscal Year & Quarter	Number of Requests	Avg # of Requests	*Number of Consumers	*Avg # of Consumers
FY24 Q1	4	5.5	5	11.25
FY24 Q2	2		8	
FY24 Q3	8		12	
FY24 Q4	8		20	
FY25 Q1	12	10.5	29	28.5
FY25 Q2	14		41	
FY25 Q3	9		27	
FY25 Q4	7		17	



CC Per Month

Fiscal Year, Quarter, & Month	Number of Requests	Avg # of Requests	*Number of Consumers	**Avg # of Consumers
FY24 Q1 Oct	2	1.83	3	3.75
FY24 Q1 Nov	1		1	
FY24 Q1 Dec	1		1	
FY24 Q2 Jan	0		0	
FY24 Q2 Feb	0		0	
FY24 Q2 Mar	2		8	
FY24 Q3 Apr	3		3	
FY24 Q3 May	3		4	
FY24 Q3 June	2		5	
FY24 Q4 July	4		6	
FY24 Q4 Aug	2		7	
FY24 Q4 Sept	2		7	
FY25 Q1 Oct	4	3.5	11	9.5
FY25 Q1 Nov	5		11	
FY25 Q1 Dec	3		7	
FY25 Q2 Jan	6		15	
FY25 Q2 Feb	4		10	
FY25 Q2 Mar	4		16	
FY25 Q3 Apr	3		11	
FY25 Q3 May	3		11	
FY25 Q3 June	3		5	
FY25 Q4 July	2		3	
FY25 Q4 Aug	3		6	
FY25 Q4 Sept	2		8	


Number of Requests
6
4
2
0
2
1
1
0
0
2
3
3
2
4
2
2
4
5
3
6
4
4
3
3
3
2
3
2
FY24 Q1 Oct
FY24 Q1 Nov
FY24 Q1 Dec
FY24 Q2 Jan
FY24 Q2 Feb
FY24 Q2 Mar
FY24 Q3 Apr
FY24 Q3 May
FY24 Q3 June
FY24 Q4 July
FY24 Q4 Aug
FY24 Q4 Sept
FY25 Q1 Oct
FY25 Q1 Nov
FY25 Q1 Dec
FY25 Q2 Jan
FY25 Q2 Feb
FY25 Q2 Mar
FY25 Q3 Apr
FY25 Q3 May
FY25 Q3 June
FY25 Q4 July
FY25 Q4 Aug
FY25 Q4 Sept


*Number of Consumers
15
10
5
0
3
1
1
0
0
8
3
4
5
6
7
7
11
11
7
15
10
16
11
11
5
3
6
8
FY24 Q1 Oct
FY24 Q1 Nov
FY24 Q1 Dec
FY24 Q2 Jan
FY24 Q2 Feb
FY24 Q2 Mar
FY24 Q3 Apr
FY24 Q3 May
FY24 Q3 June
FY24 Q4 July
FY24 Q4 Aug
FY24 Q4 Sept
FY25 Q1 Oct
FY25 Q1 Nov
FY25 Q1 Dec
FY25 Q2 Jan
FY25 Q2 Feb
FY25 Q2 Mar
FY25 Q3 Apr
FY25 Q3 May
FY25 Q3 June
FY25 Q4 July
FY25 Q4 Aug
FY25 Q4 Sept

Annual Submission to MDHHS: Requests for Services

CMHA-CEI tracks this data annually as part of its annual submission to MDHHS. MDHHS uses this report to gather data on requests for services and the disposition of those requests (what happens next after someone requests services from CMHA-CEI). Tracking requests for services enables CMHSPs to track noticeable trends and respond to those trends.

	CMH Point of Entry-Screening	DD All Ages	Adults with MI	Children with SED	Unknown and All Others	Total
1	Total # of people who telephoned or walked in	767	3063	1764	1071	6665
2	Of the # in Row 1 (all people who telephoned or walked in), total # of people referred out due to non-mental health needs	84	155	35	56	330
3	Of the # in Row 1 (all people who telephoned or walked in) total # of people who requested services the CMHSP provides, irrespective of eligibility	683	2908	1729	1015	6335
4	Of the # in Row 3 (People requested services the CMHSP provides), total # of people who did not meet eligibility through phone or other screening	20	89	15	6	130
5	Of the # in Row 3 (People requested services the CMHSP provides), total # of people who met eligibility and were scheduled for intake/biopsychosocial assessment	663	2819	1714	1009	6205
6	Of the # in Row 3 (People requested services the CMHSP provides), total # of people with other circumstance - Describe below on line 32	Unknown	Unknown	Unknown	Unknown	Unknown
7	Is Row 1 (all people who telephoned or walked in) an unduplicated count in each category? Answer Yes or No for each category	No	No	No	No	No
	CMHSP Assessment	DD All Ages	Adults with MI	Children with SED	Unknown and all others	Total
8	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who did not receive	Unknown	Unknown	Unknown	Unknown	Unknown

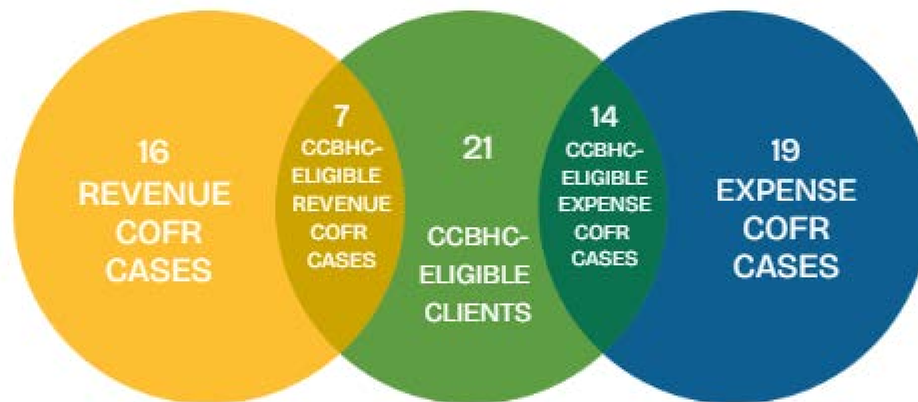
	intake/biopsychosocial assessment (dropped out, no show, etc.)					
9	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who were not served because they were MA FFS enrolled and referred to other MA FFS providers (not health plan)	Unknown	Unknown	Unknown	Unknown	Unknown
10	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who were not served because they were MA HP enrolled and referred out to MA health plan	Unknown	Unknown	Unknown	Unknown	Unknown
11	Of the # in Row 5 (Scheduled for intake/biopsychosocial Assessment) - total # of people who otherwise did not meet CMHSP non-entitlement intake/assessment criteria.	153	853	343	632	1981
11a	Of the # in Row 11 (did not meet CMHSP non-entitlement intake/assessment criteria) - total # of people who were referred out to other mental health providers	153	853	343	632	1981
11b	Of the # in Row 11 (did not meet CMHSP non-entitlement intake/assessment criteria) - total # of people who were not referred out to other mental health providers					
12	Of the # in Row 5, how many people met the CMHSP eligibility criteria?	510	1942	1368	377	4197
13	Of the # in Row 12 (Met CMHSP intake criteria) - total # of people who met emergency/urgent/priority conditions criteria	28	622	477	39	1166
14	Of the # in Row 12 (Met CMHSP intake criteria) - total # of people who met regular/routine/usual admission criteria	482	1320	891	388	3081
15	Of the # in Row 12 (Met CMHSP intake criteria) - total # of people who were put on a waiting list					0
15a	Of the # in Row 15 (Put on a waiting list) - total # of people who received some CMHSP services, but wait listed for other CMHSP services					0
15b	Of the # in Row 15 (Put on a waiting list) - total # of people who were waitlisted for all CMHSP services					0

Environmental Modifications

In fiscal year 2025, CMHA-CEI's Environmental Modifications Committee reviewed two environmental modification requests and determined they met necessary criteria. One modification was for a walk-in shower and the other was for a ramp, door and bathroom. Both projects were completed in FY25.

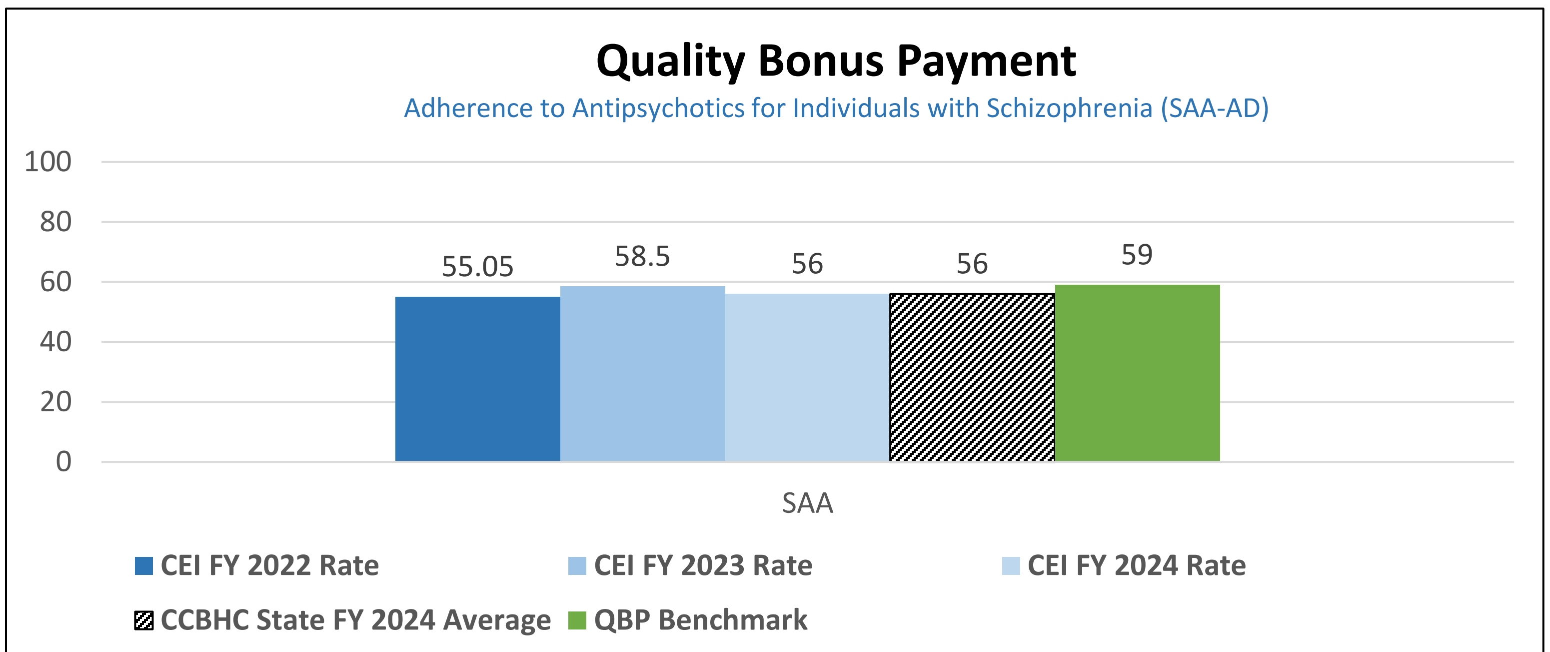
County of Financial Responsibility (COFR) Cases

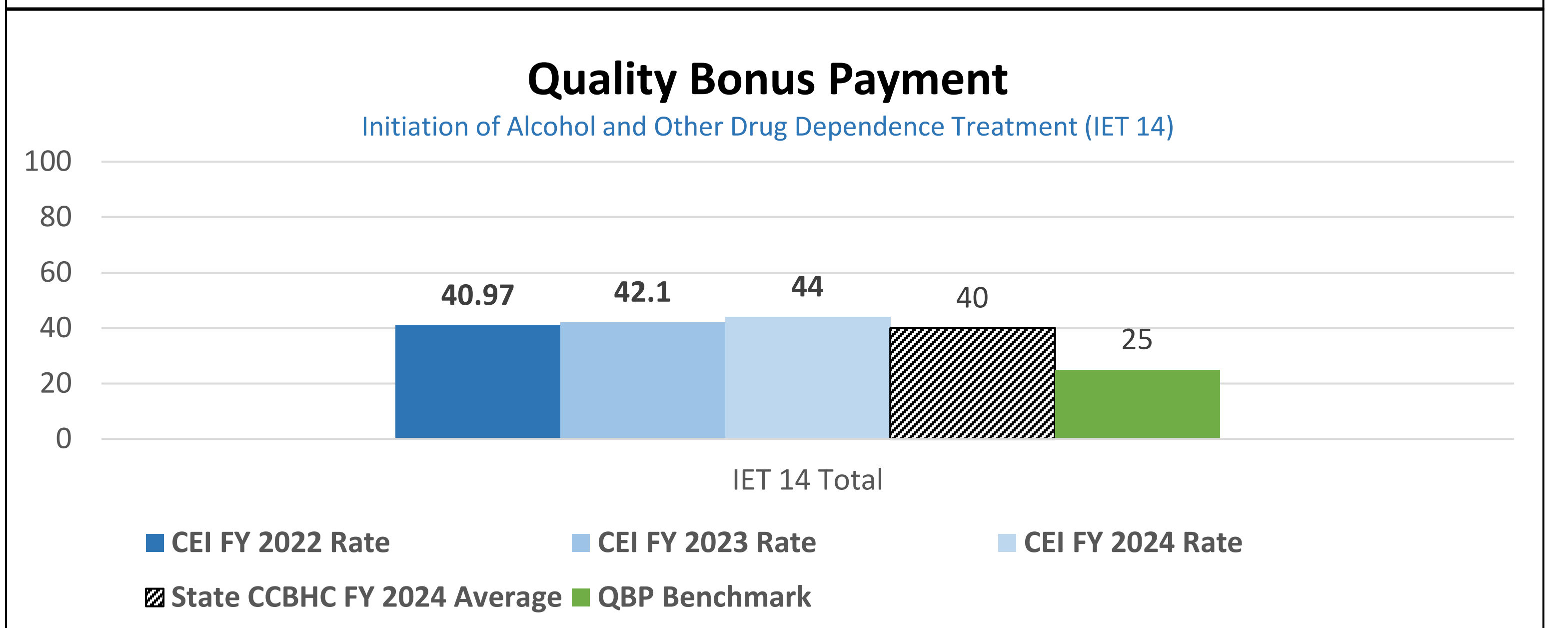
In the calendar year 2025, there were a total of 35 COFR cases. As shown in the diagram below, this included 16 revenue cases, where CEI provides the services and another CMHSP is financially responsible, and 19 expense cases, where another CMHSP provides the services and CEI is financially responsible. Of the total 35 COFR cases, 21 individuals had CCBHC-eligible diagnoses. For the individuals with CCBHC-eligible diagnoses and if the serving CMHSP is also a CCBHC site, a COFR agreement is not needed for CCBHC services.

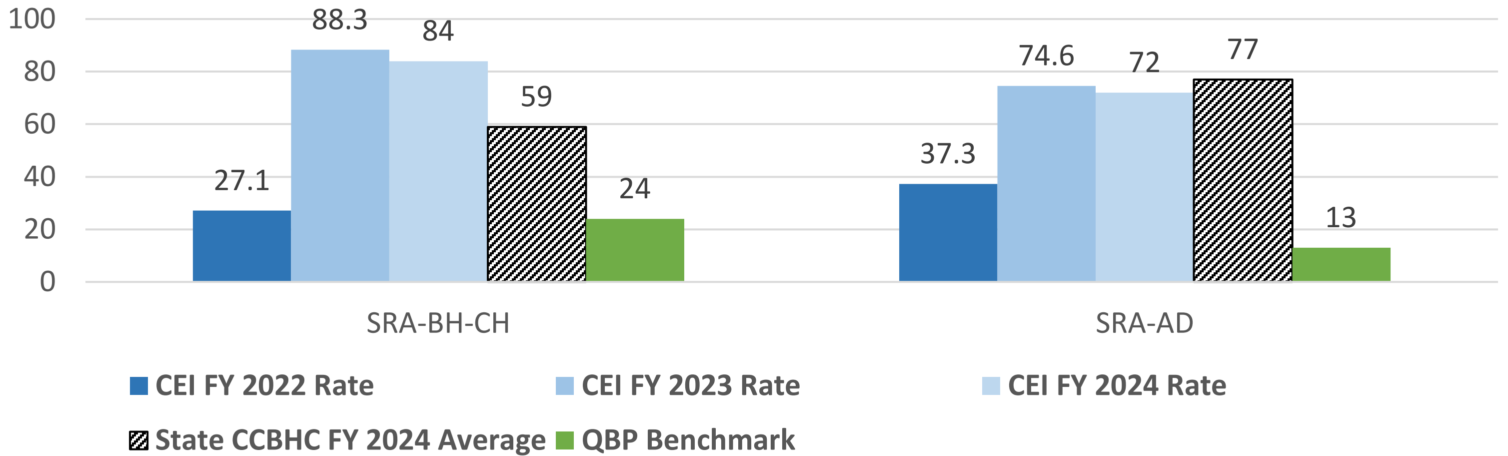


CCBHC

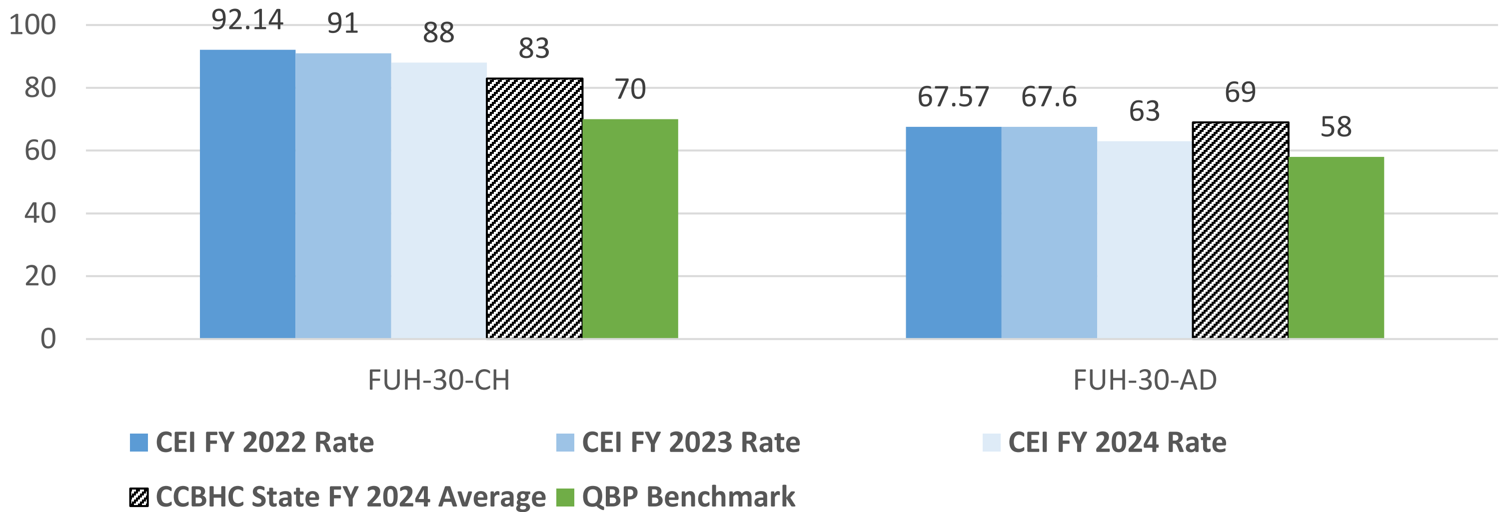
CCBHC stands for Certified Community Behavioral Health Clinic. CCBHC's are required to maintain an array of services that are comprehensive and coordinated for individuals, regardless of their ability to pay. CCBHC's are also required to provide 24/7 access to Crisis Services. In 2024, CMHA-CEI became a fully accredited CCBHC. Requirements are related to access to care, staffing, care coordination, data tracking, and more. Services offered include both mental health services and substance use services, as well as 24/7 access to Crisis Services.







CCBHC Quality Bonus Payment
Suicide Risk Assessment
Child (SRA-BH-CH) and Adult (SRA-AD)
100
80
60
40
20
0
27.1
88.3
84
59
24
37.3
74.6
72
77
13
SRA-BH-CH
SRA-AD
CEI FY 2022 Rate
CEI FY 2023 Rate
CEI FY 2024 Rate
State CCBHC FY 2024 Average
QBP Benchmark



Quality Bonus Payment
Follow- Up After Hospitalization for Mental Illness
(FUH-30 Adults and FUH-30 CHILD)
100
80
60
40
20
0
92.14
91
88
83
70
67.57
67.6
63
69
58
FUH-30-CH
FUH-30-AD
CEI FY 2022 Rate
CEI FY 2023 Rate
CEI FY 2024 Rate
CCBHC State FY 2024 Average
QBP Benchmark

MIFAST

Michigan Fidelity Assistance Support Team (MIFAST) Review

The MIFAST Review team reviews a number of evidence-based programs of within the publicly-funded behavioral system. MIFAST currently reviews the following programs at CMHA-CEI.

- Dialectical Behavior Therapy (DBT)
- Assertive Community Treatment (ACT)
- Motivational Interviewing

The QI Team works with clinical programs to complete these reviews annually. In 2024, QI began working with AMHS to measure the effectiveness of the DBT program. The goal of this collaboration is to monitor consumer hospitalizations during the two years prior to beginning DBT, during DBT, and two years following completing or dropping out of the DBT program. A full analysis of this project will be available in the Evaluation of this QIP in FY27.