SAGINAW COUNTY
COMMUNITY MENTAL
HEALTH AUTHORITY

Quality Improvement Program, FY25 Report & FY26 Plan

FY2026 – AmyLou Douglas, CIO/CQCO

INTRODUCTION

Saginaw County Community Mental Health (SCCMHA) is a local, independent, governmental unit serving the greater Saginaw County area, a Community Mental Health Services Program and has been a mental health authority under contract with the Michigan Department of Health and Human Services since October 1, 1997.

In 2021, SCCMHA was named a Certified Community Behavioral Health Clinic (CCBHC) by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA). We were also selected for Cohort 1 of the Michigan Department of Health and Human Services (MDHHS) Demonstration site and have continued to serve as an active demonstration site. As a CCBHC, SCCMHA is a "one stop wellness center" and offers a full range of services that create access to care, stabilizes individuals in crisis and provides the necessary treatment for those with mental illnesses, intellectual and developmental disabilities with a secondary psychiatric disorder, , children and youth with emotional disorders and substance use disorders regardless of their insurance coverage.

SCCMHA is a behavioral health provider but also a specialty network. The network is comprised of organizations that provide professional services, but also housing and other support services and interventions in both office and site-based locations as well as in the homes of persons served and their families.

MISSION STATEMENT:

As the public manager of supports and services for citizens with mental illness, developmental disabilities and chemical dependency and their families, SCCMHA actively strives to develop a system of care and a community that values and embraces the potential and contributions of all individuals with disabilities.

OUR VISION:

A belief in potential. A right to dream. An opportunity to achieve.

OUR VALUES:

In support of our Mission and Vision, we pledge to develop and offer services that:

- Promote individual and community health, as well as treatment of illness and/or disability.
- Are responsive to person served and community needs.
- Promote person served choice and maximize self-determination.
- Focus on outcomes.
- Are integrated with the community, including collaboration with other service providers and family caregivers.
- Respect and value person served rights and cultural diversity.
- Promote innovation and creativity to better serve our persons served.
- Assure accessibility to services.
- Promote an organizational culture committed to a learning organization that is responsive to change.
- Provide services that are cost effective and efficient.

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QUALITY IMPROVEMENT PROGRAM

ADMINISTRATIVE RULE REQUIREMENTS

CMHSPs are required by administrative rules to have a quality program (Michigan Administrative Code R. 330.2805). Quality programs are critical to person-centered services. Administrative Rule Requirements:

- Continuously evaluate and improve organizational processes and performance.
- Solicit customer feedback…to improve service delivery.
- Compile, analyze, and use data on service outcomes to improve performance.
- Promote consumer …participation in the design of the programs and services.
- Promote consumer …participation in the evaluation of programs and services.

DESCRIPTION

The Saginaw Quality Improvement Program (QIP) emphasizes the need for a clear organizational structure, accountability to a governing body, and a senior official responsible for the program. Active participation from providers and persons served is crucial, along with the use of standardized performance indicators and maintaining minimum performance levels. The QIP also stresses the importance of thorough documentation and regular reporting to stakeholders, aiming for continuous quality improvement and better health outcomes for individuals served.

SCOPE

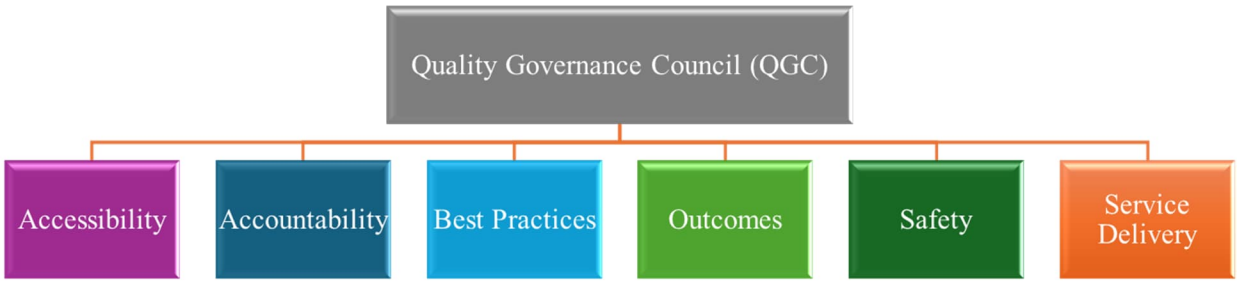
Ensuring that all demographic groups, care settings, and types of services are included in the scope of the QIP is crucial for comprehensive and equitable care. The Saginaw QIP addresses the needs of adults with Severe Mental Illness (SMI), children with Serious Emotional Disturbance (SED), individuals with Intellectual and Development Disorders (I/DD), youth and adults with substance use disorders (SUD), Mild to Moderate (M/M) mental health issues, Co-Occurring Disorders (COD) as well as individuals with co-morbid conditions. The QIP includes all care settings from residential to outpatient, and all services from inpatient to community-based services. The plan encompasses both clinical and non-clinical areas. The QI committees review aggregated data. The QI Committees are not treatment teams and therefore do not discuss individual cases of recipients of care. The one exception is the Safety Committee who is tasked with looking in detail at individual critical events for purposes of quality improvement. The treatment team for individuals involved in critical events are responsible for amending their treatment plans.

CULTURE OF QUALITY

- Organizational leadership's visible support for and reinforcement of continuous quality improvement.
- Clear communication (e.g., procedures, training) that enables SCCMHA staff to execute on expectations.
- A focus on data, both quantitative and qualitative, to drive quality efforts.
- Active participation by every member of each quality committee.
- Feedback loops within functional teams about quality issues and initiatives.
- Quality is not seen as a department so much as a responsibility of everyone.
- Success stories are shared throughout the organization.

QIP SYSTEM STRUCTURE

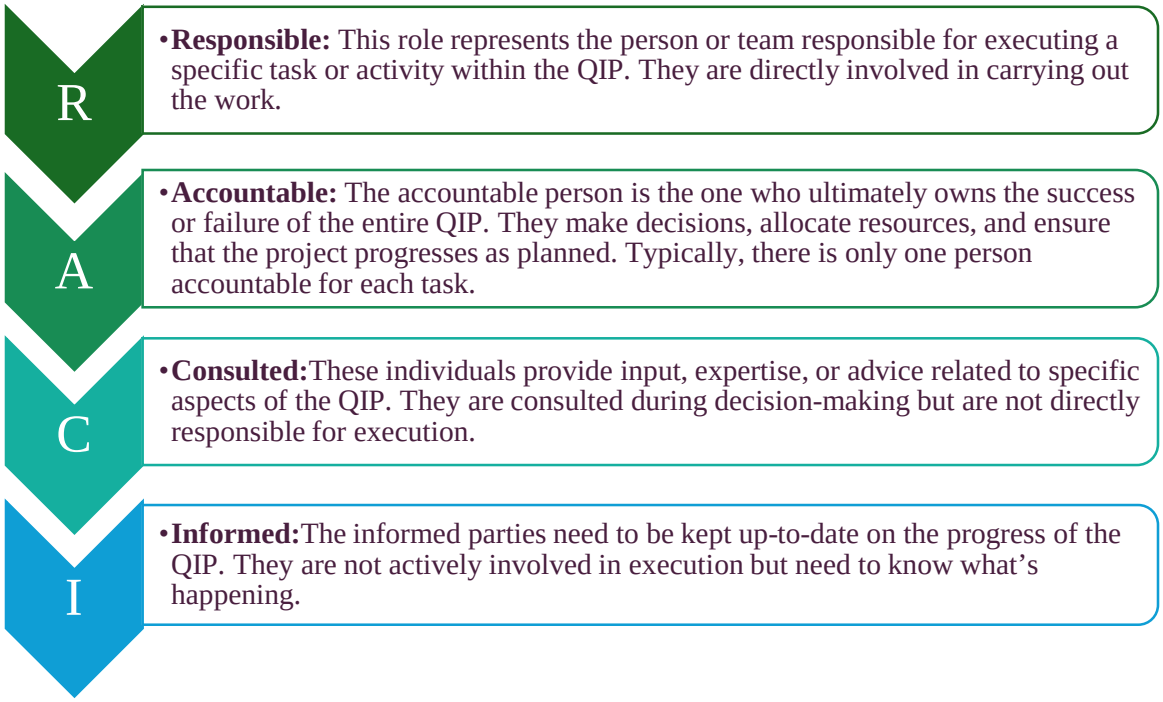
The Saginaw QIP system structure is a comprehensive framework designed to enhance service quality within the organization. It includes leadership and governance to oversee the program, assessment and planning to identify improvement areas, and data collection and analysis to monitor progress. Interventions are implemented based on evidence, with staff training and client education supporting these changes. Regular evaluation and feedback ensure continuous improvement, while strategies for sustainability and scaling help maintain and expand successful interventions. Documentation and reporting keep all stakeholders informed and engaged throughout the process.



RESPONSIBILITIES[1] FOR THE QIP

The QIP uses a RACI (Responsible, Accountable, Consulted, and Informed) matrix to clarify roles and responsibilities, ensuring quality and efficiency in the QIP execution. A RACI matrix is a valuable tool used in project management to define team roles and responsibilities. The matrix ensures that communication flows smoothly. Team members know whom to consult or inform, reducing confusion and preventing bottlenecks.

[1] MDHHS/CMHSP Managed Mental Health Supports and Services Contract Attachment QUALITY IMPROVEMENT PROGRAMS FOR CMHSPs TECHNICAL REQUIREMENT



GOVERNING BODY - BOARD OF DIRECTORS — INFORMED

The SCCMHA's Board of Directors approves the overall QIP and the annual quality improvement plan, as noted in the meeting minutes. The governing body regularly receives written reports from the QIP, describing actions taken, progress in meeting objectives, and improvements made. They also ensure the QIP aligns with Saginaw's mission and vision. Annually, the Governing Body formally reviews a written report on the QIP, which includes: studies undertaken, results, subsequent actions, and aggregate data on service utilization and quality. This review assesses the QIP's continuity, effectiveness, and current relevance. The Governing Body ensures that the CEO acts when appropriate and directs that the operational QIP be modified to address findings and concerns within the Community Mental Health Service Program (CMHSP).

CHIEF EXECUTIVE OFFICER — INFORMED

The Chief Executive Officer (CEO) provides overall direction and support for the QIP. The CEO ensures necessary resources, such as staff and budget, are available and keeps the governing body informed about QIP progress and challenges.

QUALITY GOVERNANCE COUNCIL (QGC) — ACCOUNTABLE

The QGC provides oversight of the activities of the QI Committees. They identify the annual goals of the QIP, ensure the progress of the goals through the work of the QI Committees and receive regular reports from the QI Committees regarding the measures the QIP is responsible for monitoring.


QUALITY GOVERNANCE COUNCIL
Accountable for Quality Program
QUALITY IMPROVEMENT PLAN (ANNUAL)
QUALITY REPORT (ANNUAL)
STRATEGIC ALIGNMENT WITH SCCMHA
OVERSIGHT OF QUALITY COMMITTEES

MEDICAL DIRECTOR AND CLINICAL LEADERS — CONSULTED

The medical director, along with clinical leadership, ensures quality and safety standards are met and provides expertise and guidance on clinical issues and improvement strategies.

SENIOR OFFICIAL – CIO / CHIEF QUALITY & COMPLIANCE OFFICER — ACCOUNTABLE

The CIO/CQCO is the designated senior official responsible for implementing the QIP. This person will also chair the QGC.

EXECUTIVE SPONSOR — RESPONSIBLE

Responsible for the operations of the QIP Committee. Selects the Chair & Co-Chair of the committee. Provides representation of the Management Team to the committee. Possesses the authority to tentatively approve process changes on behalf of leadership. Requests nominations for membership from the various agency department's leadership members.

PROGRAM LEADERSHIP AND FRONT-LINE CARE TEAMS — RESPONSIBLE

Program leadership and front-line staff carry out improvement initiatives in their daily work, provide insights and data on the effectiveness of changes, participate in training, and contribute to a culture of continuous improvement. Program leadership from subcontracting agencies or designated collaborating organizations (DCO) are enlisted as subject matter experts as needed.

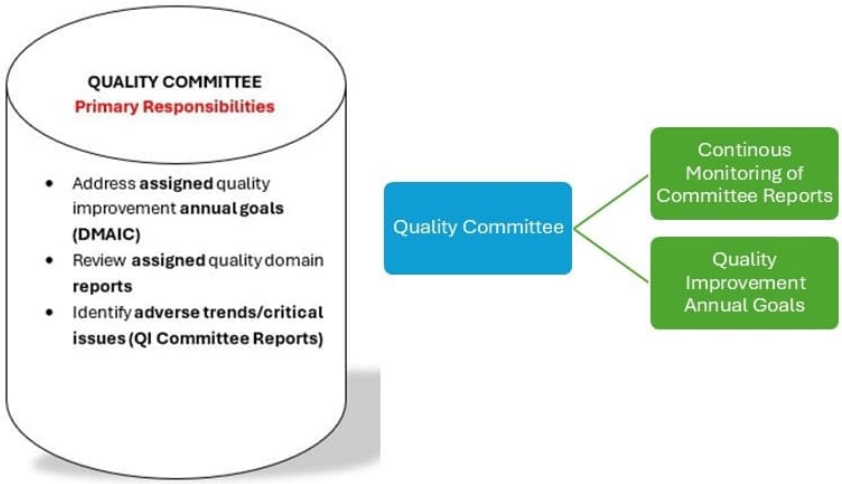
INDIVIDUALS WITH LIVED EXPERIENCE — CONSULTED

Individuals with lived experience provide valuable insights based on personal experiences with services and represent the perspectives of service users. They contribute to the development and evaluation of improvement initiatives to ensure that changes meet client needs.

QUALITY IMPROVEMENT COMMITTEES RESPONSIBLE

Quality improvement committees implement the QIP, communicate initiatives, and monitor and evaluate the effectiveness of quality improvement efforts. They keep detailed records of the monitoring process, the changes implemented, and the outcomes achieved. Quality Improvement Committees are tasked with two major components of the QIP which are continuous monitoring of metrics and reports and annual quality improvement goals.

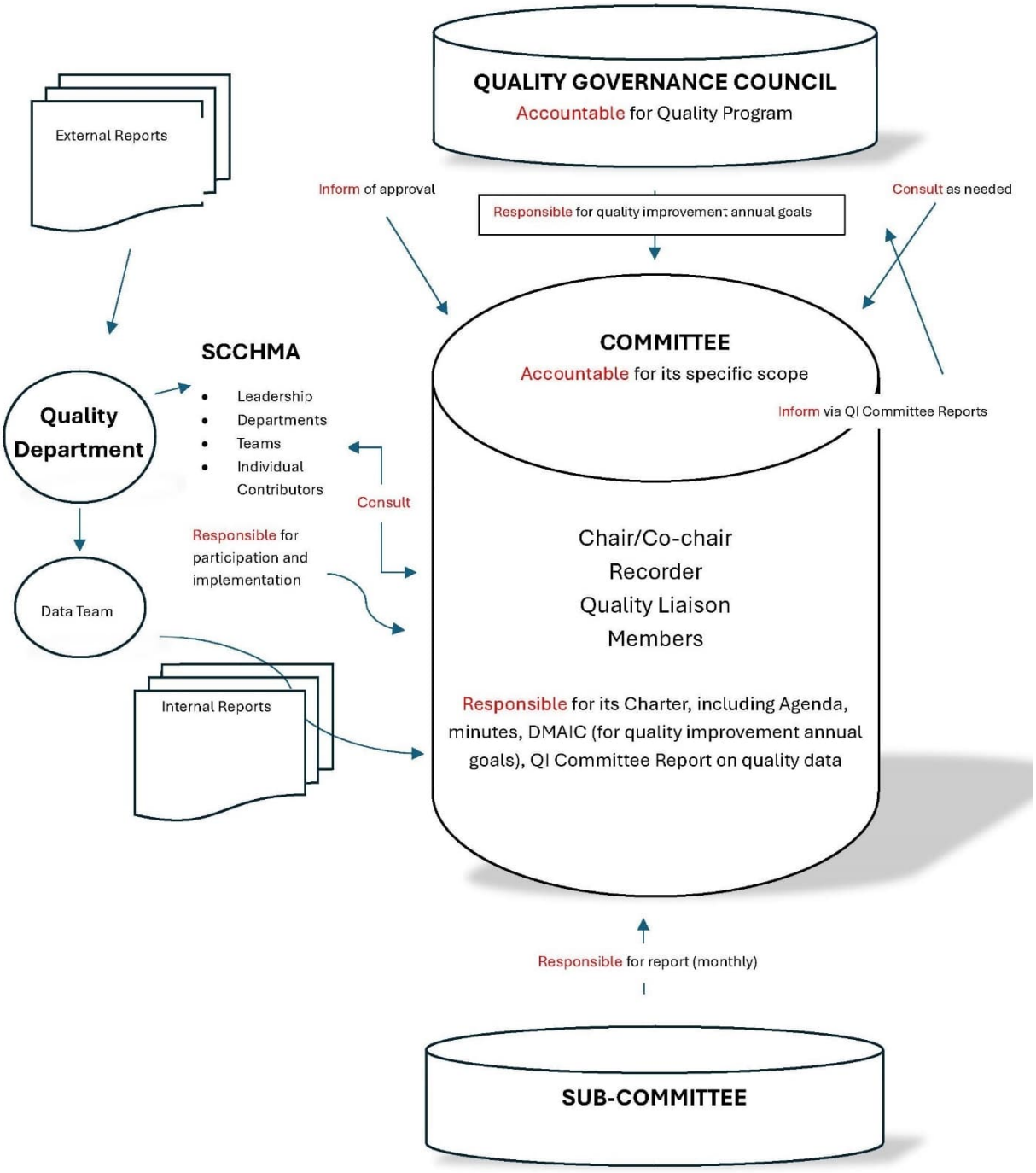
Each committee is governed by a QI Committee Charter (Appendix C) that outlines the responsibilities of the committee(s). Each committee is facilitated with the QI Committee Agenda (Appendix F) as a guide. Each committee is responsible for completing a QI Committee Report (Appendix E) on all continuous monitoring of reports and measures. All Quality Improvement Annual Goals are worked via a performance improvement framework and documented on the QI Annual Goals Report (Appendix D). The QI Committee Report and QI Annual Goals Report are provided to the Quality Governance Council by the committee chair.



Quality Committees vs Treatment Teams

• Quality Committee	• Treatment Team
Focuses on the overall quality of care provided by the organization	Directly involved in the care and treatment of individual patients
Develops and monitors quality improvement initiatives.	Develops & Implements individualized treatment plans.
Reviews performance metrics and outcomes.	Provides direct patient care and therapeutic interventions.
Ensures compliance with regulatory standards and accreditation requirements.	Monitors patient progress and adjusts treatment plans as needed.
Identifies areas for improvement and implements strategies to enhance care quality.	Collaborates with patients and their families to ensure comprehensive care.
Reviews Non-Identifiable PHI	Team knows the patient.
Reviews Aggregate Data	Reviews patient specific information and data
Protections for quality improvement and peer review activities	Discoverable

QIP RACI PROCESS ASSIGNMENT

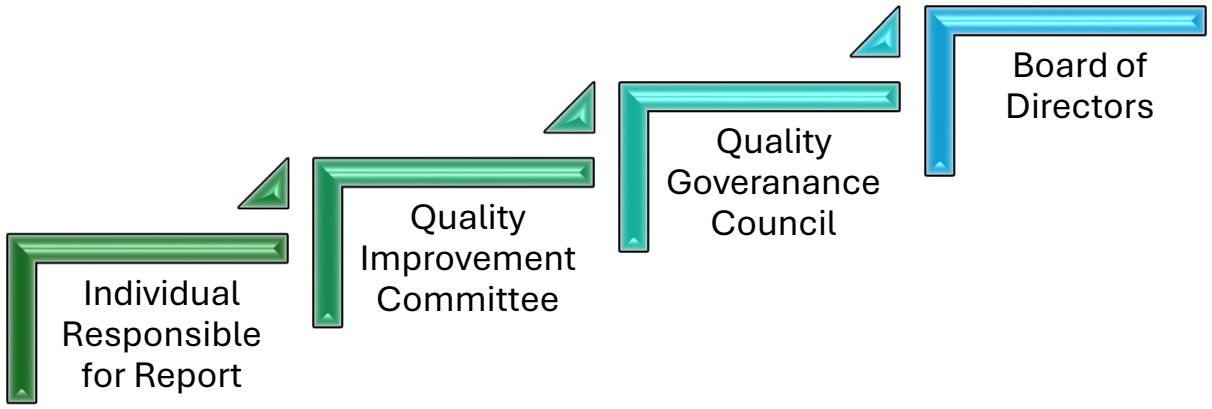


CONTINUOUS MONITORING OF COMMITTEE REPORTS

The QIP routinely monitors qualitative and quantitative data. Qualitative data provides insights into client and staff experiences, while quantitative data offers measurable metrics. Together, they inform decision-making, support continuous improvement, ensure accountability and transparency, and help sustain long-term improvements. This balanced approach enables timely identification of trends and issues, fostering a culture of ongoing enhancement and better outcomes.

The QIP requires that *corrective measures* must be implemented whenever services provided are deemed inappropriate or below standard.

Continuous Monitoring follows a schedule for reporting. Saginaw QIP Monitoring and Reporting Schedule (Appendix B) lists the reports provided to each QIP committee, the individual responsible for submitting the report, the frequency, the due date, and the timeframe.



QUALITY IMPROVEMENT ANNUAL GOALS

The QIP is responsible for developing annual goals to provide clear and focused direction for enhancing Saginaw's services, products, and processes. These goals help prioritize areas for improvement, establish benchmarks to measure progress, promote accountability among team members, and encourage a culture of continuous improvement. Additionally, the QIP ensures that quality improvement efforts align with SCCMHA's priority needs and the broader strategic plan objectives, leading to better outcomes and higher satisfaction for clients and stakeholders.

The QIP runs on a yearly basis aligned with the fiscal year October to September. Planning for the development of annual goals begins in the summer and is confirmed in the first quarter of the fiscal year. It is important to note however that effective 2025, some QIPS connected to CCBHC metrics will run on a calendar year as required by SAMHSA.

October to December
• Identify opportunities for improvement • Confirm annual goals • Develop workplan • Obtain approval
January to March
• Conduct interventions • Test and measure results • Make changes until desired results are achieved
April to June
• Measure and Monitor outcomes
July to September
• Implement changes within policies and procedures • Plan for continued or new priorities

MECHANISMS TO REMAIN EFFECTIVE

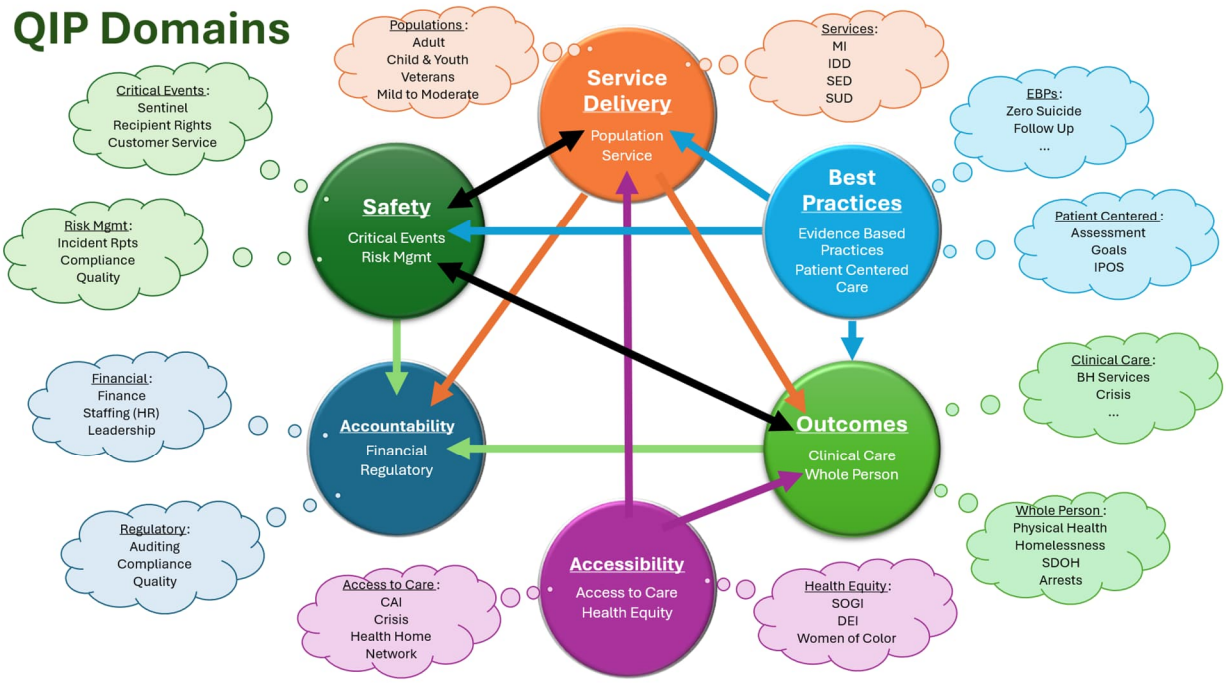
The following mechanisms are employed to ensure the QIP remains effective and up to date:

- Regular Review of Performance
  - Monitoring of performance metrics and comparing outcomes against industry standards.
- Qualitative Analysis
  - Collecting feedback from persons served, employees, providers, and other stakeholders through surveys and questionnaires. Focus groups may also be organized to gather in-depth insights and suggestions.
- Quantitative Analysis
  - Analysis of key performance indicators such as service delivery times, error rates, and other numerical data to understand patterns, relationships, and trends.
- Audits
  - Conducting internal reviews, such as clinical record reviews or mock audits. Monitoring performance of external reviews from funders and/or accreditors.
- Strategic Initiatives

- Ensuring that performance aligns with and supports the achievement of strategic objectives.

MONITORING – QIP DOMAINS

The Saginaw QIP monitors the quality of care in six domains. Quality domains refer to specific areas that are used to evaluate and improve the quality of care provided. Each domain is outlined below, and the specific report and any related metrics are referenced in the Saginaw Quality Reports and Measures by Domain document (Appendix A). This document is the sole reference for reports and measures monitored by each committee.



QUALITY DOMAIN: ACCESSIBILITY

Accessibility refers to the ease with which individuals can obtain and receive services. It ensures that everyone regardless of residence, ability to pay, or abilities can have timely access and benefit from the services provided.

Access to Care

Access Standards: As a community mental health service provider, Saginaw is required to comply with Access Standards as part of the contract with MDHHS.

Diversion: Diversion data is gathered to determine the effectiveness of crisis services. Aggregated data include:

- Number of individuals pre-screened for inpatient and disposition.
- Number of mobile crisis responses and disposition.
- Number of calls received that were transferred to Mobile Crisis.

Performance Improvement Projects (PIP)[2]: The Accessibility Committee monitors Saginaw's performance on PIPs and requires improvement plans for areas that Saginaw performs poorly. MSHN has approved the following Non-clinical Performance Improvement Projects to address service access for the historically marginalized groups within the MSHN region:

1. Study Topic - Improving the rate of new persons who have received a medically necessary ongoing covered service within 14 days of completing a biopsychosocial assessment and reducing or eliminating the racial or ethnic disparities between the Black/African American population and the white population.

   Study Question - Do the targeted interventions reduce or eliminate the racial or ethnic disparities between Black/African American population and white populations receiving medically necessary ongoing service within 14 days of completing a biopsychosocial assessment?

The second or additional PI project(s) is chosen by the PIHP. MSHN QIC has recommended and MSHN Operations Council has approved the following Non-clinical Performance Improvement Project to ensure time access to treatment:

2. Study Topic - The racial or ethnic disparities between the Black/African American penetration rate and the index (white) penetration rate will be reduced or eliminated.

   Study Questions - Do the targeted interventions reduce or eliminate the racial or ethnic disparities in the penetration rate between the Black/African American penetration rate and the index (white) penetration rate?

Second Opinions and Denials: The Accessibility Committee reviews aggregated data on second opinions and denials. Monitoring these areas helps Saginaw maintain high standards of care, ensures patients receive appropriate treatments, identifies errors or oversights, and ensures efficient resource use.

[2] Mid-State Health Network PIP

Timeliness Metrics: Timeliness metrics in behavioral health are crucial to ensure that individuals receive the care promptly. These metrics help identify gaps in the system and guide improvements in access to behavioral health services.

Utilization: The Accessibility Committee monitors data related to high utilizers of services, as they pose inherent risks to the organization. Underutilization of services is also monitored as individuals that do not receive the prescribed care are at risk of decompensation.

Health Equity

CLAS Standards: The National Culturally and Linguistically Appropriate Services (CLAS) Standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate healthcare disparities by providing a blueprint for individuals and healthcare organizations to implement culturally and linguistically appropriate services. The Accessibility Committee reviews a status report on implementation of CLAS standards and practices. The CLAS standards are found here: An Implementation Checklist for the National CLAS Standards (hhs.gov)

Monitoring Disparities: The CQI (Continuous Quality Improvement) plan monitors and reduces disparities by systematically collecting and analyzing data that is disaggregated by factors such as race, ethnicity, sexual orientation, and gender identity. This data helps identify specific gaps or inequalities in care that may exist between different populations. Here's how the process works to monitor and reduce disparities:

Data Collection: The CQI plan ensures that data on key quality measures is collected in a way that distinguishes between different demographic groups, allowing for the identification of disparities in healthcare access and outcomes.

Analysis: The disaggregated data is analyzed to spot trends and patterns in care that show whether certain populations are experiencing worse outcomes or barriers to access, such as higher rates of missed appointments, longer wait times, or lower treatment success rates.

Targeted Interventions: Once disparities are identified, the CQI process allows the organization to design and implement targeted interventions aimed at reducing these gaps. This might involve adjusting care protocols, offering additional support services, or increasing cultural competency training for staff.

Insurance Monitoring: The Accessibility Committee reviews an aggregate report which assists in identifying any populations areas that may be underserved. The committee also reviews data to determine if Saginaw is meeting its target goals for populations served.

- Total number of individuals served by population (SMI, SED, SUD, COD, I/DD).
- Total number of individuals enrolled in CCBHC.
- Total number of individuals enrolled in Behavioral Health Home.
- Percentage of individuals who are uninsured or underinsured.
- Percentage of individuals by insurance type (Medicaid, Medicare, Dual, Third Party).

QUALITY DOMAIN: ACCOUNTABILITY

Accountability & Compliance refers to the obligation that individuals and the agency have to take responsibility for their actions, decisions, and outcomes. It ensures that everyone involved in the delivery of services is held to high standards of performance and ethical behavior.

Financial

BH TEDS Review: Saginaw monitors BH TEDS against the standards outlined by Mid-State Health Network (Reference 02).

Encounter Review: Saginaw monitors encounters against the standards outlined by Mid-State Health Network (Reference 03).

Medicaid Event Verification (MEV): As part of the 21st Century Cures Act, the Centers for Medicare & Medicaid Services (CMS) requires states to implement an Electronic Visit Verification (EVV) system. Electronic Visit Verification (EVV) is a validation of the date, time, location, type of Personal Care or Home Health Care Services provided, and the individual(s) providing and receiving services. This information helps to ensure that beneficiaries, clients, or participants receive the expected care. The MEV review is conducted utilizing a sampling methodology from which a random case selection is selected. The review involves a claims test where 7 attributes are tested for compliance per the MDHHS Medicaid Verification Process. The test can either yield a Y, N, or NA (for Attribute G) response. The attributes tested are as follows:

A. Code is an 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.
D. Documentation of the service agrees to the claim date and time of service.
E. Documentation of the service provided falls within the scope of the service code billed.
F. Amount billed/paid does not exceed contractually agreed amount.
G. Modifiers are used in accordance with the HCPCS/MDHHS guidelines.

Regulatory

BHH standards: Saginaw is a Behavioral Health Home (BHH). A Behavioral Health Home is a comprehensive care model that integrates primary care, mental health, and substance use services to provide holistic support for individuals. This approach aims to improve overall health outcomes by addressing both physical and behavioral health needs in a coordinated manner. The Accountability Committee monitors work plans to ensure compliance with BHH standards.

CARF Accreditation: Saginaw is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The Accountability Committee monitors work plan progress related to CARF readiness or any required corrective action plans.

CCBHC: As a Certified Community Behavioral Health Clinic (CCBHC), Saginaw must comply with certification requirements and state demonstration requirements. The Accountability Committee monitors work plans to ensure compliance with these requirements.

Clinical Record Reviews: Clinical teams review aggregate data on clinical records and outcomes, with the Accountability Committee reviewing the reports. The aggregate data offers valuable insights into patterns and trends in patient care, outcomes, and practices over time. This information supports policy changes, protocol updates, and informs training needs. The clinical record report includes at a minimum the following information:

- Scores from Records Reviews (References 04, 09-13)
    - CMH Clinical Chart Review Tool
    - CMH FY 1915i Chart Review – Final
    - CMH FY CWP Chart Review – Final
    - CMH FY HSW Chart Review – Final
    - CMH FY SEDW Chart Review – Final
    - CMH FY Waiver Administrative Review – Final

Community Needs Assessment: A community needs assessment is a systematic process used to identify and evaluate the needs, assets, and resources of a specific community. As part of its participation in the MDHHS CCBHC demonstration, SCCMHA conducts a comprehensive assessment of the needs of the CCBHC population within the service area. In addition, as stipulated by MDHHS contract, SCCMHA also conducts an annual needs assessment for all populations served. These assessments help to understand the physical, mental, and social well-being of the community members. The Accountability Committee monitors Saginaw's progress on meeting the behavioral health needs of the community.

Corporate Compliance: The Accountability Committee reviews reports on aggregated data concerning Fraud, Waste, and Abuse. The committee also reviews updates on compliance plans and trends.

MDHHS Standards: The Accountability Committee monitors the results of MSHN reviews and implements plans for improving performance or preparing for future reviews. These reviews include monitoring performance related to Medicaid waivers (SED, HSW, CWP), 1915 iSPA, EPSDT and State Plan Services using these tools:

- CMH Clinical Chart Review Tool.
- CMH Delegated Managed Care Tool – PSV.
- Critical incident PSV Supplemental Tool.
- Program Specific Review Tool Non-Waiver PSV.
- Provider Network Review Tool.

Policies and Procedures: The Accountability Committee ensures policies and procedures are reviewed annually.

Practice Guidelines: The Michigan Department of Health and Human Services (MDHHS) provides a comprehensive set of practice guidelines designed to ensure high-quality care. These guidelines cover mental health, substance use disorders, and general health services. Saginaw monitors and evaluates its adherence to these guidelines through data analysis and MSHN site reviews. MDHHS and Regional Practice Guidelines are available here: Practice Guidelines - Mid-State Health Network (midstatehealthnetwork.org)

Provider Network Monitoring – Saginaw monitors providers of its network via contract and credential reviews. The results are shared with the Accountability Committee.

Staffing Plan: The credentialing committee is responsible for ensuring that staff and the network of providers are appropriately credentialed. The Accessibility Committee receives, and reviews aggregated data on the number of types of credentials that make up the workforce and provider network. This information is used to ensure the make-up of the workforce addresses the needs of the persons served. The staffing plan required for CCBHC is regularly compared to the credentialing report to ensure alignment with workforce needs.

Quality Domain: BEST PRACTICES

Best Practices refers to the established methods and techniques that are widely accepted as the most effective and efficient ways to achieve desired outcomes. These practices are based on research, experience, and industry standards.

Evidence-Based Practices

Evidence-Based Practices Fidelity: Saginaw employs a variety of evidence-based practices that are monitored for fidelity. Fidelity refers to ensuring that programs or interventions are implemented as intended. Methods for ensuring fidelity involve peer-lead technical assistance from the Michigan Fidelity Assistance Support Team (MIFAST), internal chart reviews, observations, fidelity checklists, and feedback from participants and implementers. The Best Practices Committee oversees the results of these reviews and recommends quality improvement projects for practices that do not meet requirements.

Follow Up: Regular follow-up care after hospitalization or emergency visits for mental health issues can significantly improve patient outcomes. Follow-up appointments also provide an opportunity to monitor and encourage treatment and medication adherence. Saginaw monitors several metrics regarding follow-up care.

Trauma Informed Care (TIC): Trauma-informed care (TIC) is an approach that recognizes the widespread impact of trauma and integrates this understanding into all aspects of service delivery, with a goal to create an environment that promotes healing and recovery while avoiding re-traumatization. The Service Delivery Committee tracks progress in the following areas as outlined by SAMHSA[3]:

- Trauma Informed Staff Development
  - Training and Education
  - Staff Supervision, Support, and Self-Care
- Trauma Informed Environment
  - Safe Physical Environment
  - Supportive Environment
- Trauma Informed Assessment and Planning Services
  - Conducting Intake Assessments, Process, and Follow-up
  - Developing Goals and Plans
  - Offering Services and Trauma-Specific Interventions
- Involving Persons served
  - Involving Current and Former Persons served
- Adapting Policies for Trauma Informed Care
  - Creating and Reviewing Policies

Person-Centered Care

Person-Centered Care: Saginaw aims to provide person-centered treatment as well as youth and family-guided care. Individual plans of service are tailored to individual strengths, needs, abilities, and preferences. Persons served and family members are encouraged to actively participate in care decisions, promoting self-determination. These practices are evidenced by the golden thread, a concept that ensures all clinical information is coherently linked from the initial

[3] Trauma-Informed Organizational Toolkit (wa.gov)

assessment through to the treatment plan and progress notes. Peer and clinical audits of charts are conducted to monitor person-centered care.

QUALITY DOMAIN: OUTCOMES

Outcomes refers to Saginaw's holistic approach to behavioral healthcare that considers the entire spectrum of a person's health needs, including physical, mental, behavioral, and social aspects. The purpose of monitoring outcomes is to provide comprehensive and coordinated care that addresses all dimensions of a person's well-being.

Clinical Care

Functioning Outcomes: Summary reports are provided to the Outcomes Committee to review and identify areas of improvement and successes. These reports include results from LOCUS, ASAM, DECA and MichiCANS.

Medication Management Monitoring: The Outcomes Committee reviews aggregate data on the use and adherence to medications.

Whole Person

Care Coordination*:* Coordination of care between Saginaw and the individual's primary care physician (PCP) occurs when there is a significant change in care. At minimum, this coordination includes sending the primary assessment, treatment plan updates, changes in level of care, and medication changes. The Outcomes Committee monitors physician coordination through reports.

Physical Health Monitoring: Monitoring physical health focuses on outcomes related to co-morbid conditions such as diabetes, obesity, and heart disease.

Screening and Assessment: Data from screenings and assessments are used to evaluate the quality of care provided by Saginaw. This information helps identify areas for improvement and guides strategies to enhance the overall quality of behavioral health services.

Social Drivers of Health (SDoH)*:* Monitoring social drivers of health includes the status of those served related to homelessness, employment, and arrests. Improvement in social drivers of health has a direct link to behavioral health outcomes.

QUALITY DOMAIN: SAFETY

Safety focuses on minimizing risks and preventing harm to persons served and providers during the delivery of services. It includes implementing systems and processes to prevent errors, identifying potential risk and taking proactive measures to mitigate them, encouraging the reporting of errors and near misses to learn from them and improve practices, and ensuring that the environment is safe for both persons served, staff, and guests.

Risk Management

Behavior Treatment Plans: The Safety Committee reviews aggregate data on the number of individuals with a behavior treatment plan, the number of behaviors addressed in each plan, and the percentage of emergency interventions used. (e.g.,911 calls and physical management). Trends are identified and improvement plans are requested as needed to meet target goals. Additionally, files are reviewed to ensure consent was documented consent was obtained before plan implementation.

Individual Behavior Treatment Plans are reviewed quarterly by the Behavior Treatment Committee. The roles and responsibilities of the Behavior Treatment Committee are outlined in the Technical Guidelines for Behavior Treatment Committees.

Critical Events

Critical Events: Critical Events are aggregated in the following categories, trended over time, and categorized by primary service:

- Arrests
- Emergency Medical treatment due to Injury or Medication Error
- Hospitalization due to Injury or Medication Error
- Non-suicide death
- Suicide

Health and Safety Reporting: The Safety Committee reviews aggregated data on health and safety issues. This data includes the type of health and safety issues and the length of time someone has an unresolved health and safety flag.

Mortality Data: The Safety Committee reviews mortality data over time to identify trends. Aggregate data for mortality analysis includes:

- Demographic Data:
    - Age: Mortality rates often vary significantly by age group.
    - Gender: Differences in mortality rates between males and females.
    - Ethnicity and Race: Mortality rates can differ across various ethnic and racial groups.
- Geographic Data:
    - Location: Mortality rates can be influenced by geographic factors such as urban vs. rural areas.
    - Regional Variations: Differences in mortality rates across different regions or countries.
- Socioeconomic Data:

  - Income Level: Higher or lower mortality rates associated with different income levels.
  - Education Level: Impact of education on mortality rates.
- Health Data:
  - Cause of Death: Specific causes of death, such as heart disease, cancer, or accidents.
  - Pre-existing Conditions: Influence of chronic illnesses or conditions on mortality.
- Temporal Data:
  - Time Period: Trends in mortality rates over different time periods.
  - Seasonal Variations: Changes in mortality rates during different seasons or month

Recipient Rights

Recipient Rights Complaints: Safety involves reviewing aggregated data from recipient rights complaints that include the following:

- Number of Complaints: Total complaints filed, received, and investigated.
- Types of Complaints: Categories such as abuse, neglect, or rights violations.
- Outcomes: Results of investigations, including substantiated and unsubstantiated findings.
- Timeliness: Time taken to resolve complaints.
- Provider Data: Breakdown by service providers, showing which ones have more complaints.
- Trends: Patterns over time, identifying recurring issues or improvements.

Sentinel Events and Root Cause Analysis

As needed, members of the Safety Committee will convene to conduct a Root Cause Analysis for any incident deemed a Sentinel Event.

Sentinel event: is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome (jcaho, 1998). Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

Root cause analysis: Saginaw has 3 business days after an incident occurs to determine if it is a sentinel event, and 2 subsequent business days to commence a root cause analysis of the event. Following completion of a root cause analysis, or investigation Saginaw is required to develop and implement either a plan of correction or an intervention to prevent further occurrence or recurrence of the adverse event, or to document the rationale of why corrective actions are not needed.

Staff requirements: the makeup of the root cause analysis/sentinel event review team is comprised of individuals with the skill and knowledge to review the incident, determine if any rights or compliance issues are present and includes individuals with resource knowledge to gather and review information medically and clinically. Saginaw ensures that individuals involved in the review of sentinel events have the appropriate credentials to review the scope of care (e.g., deaths or serious medical conditions involve a review by a physician or nurse).

QUALITY DOMAIN: SERVICE DELIVERY

Service Delivery refers to the processes and practices involved in providing services to persons served in a way that meets or exceeds expectations. Monitoring of service delivery encompasses reliability, responsiveness to assist individuals promptly, knowledge and courtesy of staff, providing care and personalized attention, and ensuring a welcoming environment.

Perception of Care

Grievance and Appeals:

The Service Delivery Committee reviews grievance and appeal reports, aggregated into the following categories:

- Quality of Care: High numbers of grievances related to the quality of care can indicate issues such as inadequate treatment, poor patient outcomes, or substandard practices. This data helps identify areas where providers/clinicians may need to improve their clinical practices.
- Access: Numerous appeals and grievances about service denials or delays may suggest problems with access to necessary medical services. This could be due to restrictive policies, insufficient provider networks, or logistical barriers.
- Attitude and Service: Complaints about staff behavior, communication, and overall person served experience can highlight issues with the attitude and service provided by personnel. This data can be used to improve customer service training and patient interaction protocols.
- Billing and Financial Issues: Grievances related to billing errors, unexpected charges, or financial disputes can reveal systemic problems in the billing processes. This information is crucial for Saginaw to streamline billing systems and ensure transparency and accuracy in financial transactions.

Perception of Care

Understanding the experiences of stakeholders is crucial for identifying areas for improvement at Saginaw. The organization ensures the inclusion of persons served receiving long-term supports or services (e.g., persons receiving case management or supports coordination) in the review and analysis of the information obtained from quantitative and qualitative methods Annually, Mid-State Health Network (MSHN) distributes the following surveys:

TOOL	POPULATION
Mental Health Statistics Improvement Program (MHSIP)	Adults with a Mental Illness, Adults with Intellectual and Developmental Disabilities, CCBHC, and Individuals receiving Long Term Supports and Services (LTSS)
Youth Satisfaction Survey (YSS)	Youth with a Severe Emotional Disturbance, CCBHC, and Individuals receiving LTSS
Substance Use Disorder Satisfaction Survey	Individuals with a substance use disorder
National Core Indicators (NCI)	Adults with Intellectual and Developmental Disabilities

The aggregated results of the surveys and/or assessments are collected, analyzed, and reported by MSHN and provided to Saginaw via participation in MSHN committees and councils. The Saginaw liaison shares the MSHN reports with Saginaw. The Service Delivery Committee identifies and investigates sources of dissatisfaction; outlines systemic action steps, and communicates results to practitioners, providers, recipients of service, and the governing body. The organization evaluates the effects of the above activities, and the Saginaw Office of Recipient Rights takes specific action on individual cases as appropriate.

Persons served receiving long-term supports or services, including but not limited to case management and supports coordination, are incorporated into the quality improvement activities as survey and focus group participants. Additionally, analysis and review of results are provided to persons served for input via their membership on the SCCMHA Citizen's Advisory Committee to the Board of Directors or Quality of Life Workgroup.

PROCESS OF QUALITY ASSESSMENT AND IMPROVEMENT

ESTABLISHING PERFORMANCE MEASURES

Performance measures, developed in alignment with Saginaw's strategic priorities, address clinical and non-clinical areas. The Saginaw QIP uses, but is not limited to, the following means for identification of issues and opportunities for improvement:

- Growth areas identified based on performance.
- Stakeholder feedback.
- Oversight and monitoring reviews.

PRIORITIZING MEASURES

Measures are prioritized based on factors such as organizational goals, stakeholder feedback, community needs, industry standards, legal requirements, resource constraints, risk management, and impact on performance and outcomes. The following characteristics[4] are weighed more heavily for prioritization:

- High volume issues affecting many persons served.
- High frequency/multiple occurrences.
- High risk, placing persons served at risk for poor outcomes.
- Longstanding issues.
- Multiple unsuccessful attempts to resolve the issue in the past.
- Strong and differing opinions on cause or resolution of the problem.

DATA COLLECTION, ANALYSIS, AND REPORTING

Methods of Data Collection:

- Surveys and Questionnaires: Collect feedback from patients, staff, and stakeholders.
- Electronic Health Records (EHRs): Use data from EHRs to track patient outcomes and service utilization.
- Direct Observations: Conduct observations of clinical practices and patient interactions.
- Interviews and Focus Groups: Gather in-depth insights from patients and providers.

Frequency of Data Collection:

- Continuous Monitoring: Implement real-time data collection for ongoing assessment.
- Periodic Reviews: Conduct monthly or quarterly reviews to identify trends and areas for improvement.
- Annual Evaluations: Perform comprehensive annual evaluations to assess overall program effectiveness.

Data Analysis and Reporting:

- Regular Reporting: Generate regular reports to share findings with stakeholders. Reporting will be based on stakeholder reporting period requirements (e.g., calendar year for CCBHC reporting).
- Benchmarking: Compare data against industry standards and benchmarks to identify gaps.
    - Meet Standard.
    - Excel from Benchmark.
    - Improvement from Baseline.

[4] https://www.ruralcenter.org/sites/default/files/HRSAQIToolkit.pdf

- Feedback Loops: Establish feedback mechanisms to ensure data is used to inform program changes.

Performance Tracked Over Time: Performance is tracked on a monthly, or at a minimum, quarterly basis.

PERFORMANCE IMPROVEMENT ACTION STEPS

Action plans are based on a framework designed to enhance the quality of services and use a core component of the Six Sigma methodology. Define, Measure, Analyze, Improve and Control (DMAIC) is a structured, data-driven approach used to improve existing processes. (Appendix D).

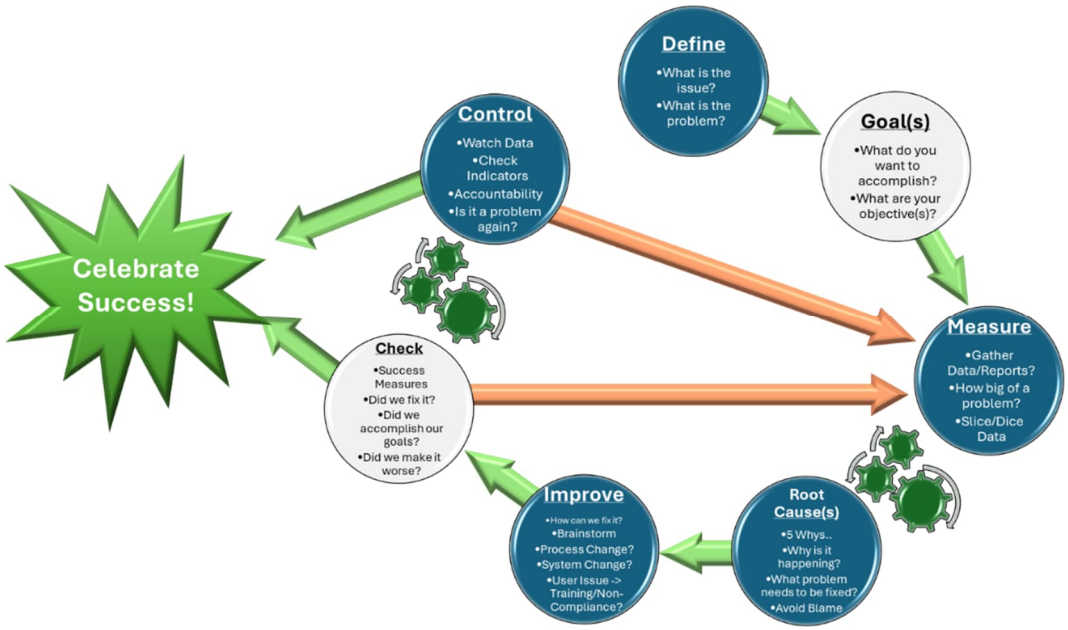
Define: Performance improvement plans (PIPs) will either be defined by the Quality Governance Council's annual plan and assigned to the committee or by the QI Committee itself in its ongoing data monitoring responsibilities. Definitions typically include 2 components: 1) a problem and 2) a goal. (e.g., Reduce the average response time to a Grievance from 35 to 28 days by mm/yy). This phase of quality improvement is meant to answer the question, "What is the performance issue?"

Measure: Once a performance issue has been defined, the QI Committee will 1) determine whether and what types of additional data are needed to better understand the issue (e.g., investigating and learning more about processes involved), 2) identify possible contributing issues, and 3) develop hypotheses about the root issue. This phase of quality improvement is meant to answer the question, "How big is the problem?"

Analyze: The QI Committee will review all available data to identify contributing and root causes of the performance issue. This phase of quality improvement is meant to answer the question, "Why is this performance issue occurring?"

Improve: Once the driver(s) of the performance issue have been identified, the QI Committee identifies an effective solution(s). While the QI Committee is responsible for identifying a solution(s), teams outside of the committee will be responsible for implementing the proposed solution(s). Members of the QI Committee will be consulting and informing SCCMHA staff throughout the DMAIC process, but extra-committee communication is critical at this phase to ensure the solution can be implemented. This phase of quality improvement is meant to answer the question, "How can we meet our defined goal?"

Control: Once a solution(s) has been implemented, the QI Committee will identify and monitor key performance indicators to ensure the performance issue is resolved. On-going monitoring may be needed to determine whether the solution is effective and sustainable. This phase of quality improvement is meant to answer the question, "How can we be sure that the solution(s) implemented will create permanent change?"



PROVIDER QUALIFICATIONS AND SELECTION

The QIP contains written procedures to determine whether physicians and other health care professionals--licensed by the State and employed by or contracted to the CMHSP--are qualified to perform their services. The QIP also has written procedures to ensure that non-licensed providers of care or support are qualified for their roles. These procedures are outlined in Policy and Procedure *05.06.03.01* titled *Credentialing and Recredentialing of Providers and Staff*. These procedures describe how findings of the QIP are incorporated into the re-credentialing process.

ENROLLEE RIGHTS AND RESPONSIBILITIES

Monitoring of Rights – Saginaw monitors compliance with and ensures that each individual has all the rights established in Federal and State law.

Recipient Rights Office – Saginaw has established an Office of Recipient Rights (ORR) that is monitored for compliance with the requirements of Chapter 7 of the Michigan Mental Health Code, as evidenced by a site review conducted by the state agency.

Recipient Rights Annual Report – Saginaw ORR submits an annual report of the to the state office as required by Chapter 7 of the Michigan Mental Health Code.

UTILIZATION MANAGEMENT

Written Program Description - The Utilization Management Department of SCCMHA is tasked with effectively managing the specialty services funded by Medicaid and Healthy Michigan and organized under the following federal authorities including Medicaid Waivers (HSW, SED and CWP), 1915 iSPA, and specialty behavioral health services contained in the Early Periodic Screening Diagnosis and Treatment (EPSDT) and State Plan Services sections of the Michigan Medicaid Program.

UM develops policies and procedures to fulfill all requirements of the MSHN UM Plan related to medical necessity, criteria used, information resources, and the process used to review and approve the provision of medical services.

Scope – The UM plan has mechanisms to identify and correct under-utilization and overutilization of services.

Procedures – Procedures are in place to conduct prospective, concurrent, and retrospective reviews. In compliance with MDHHS, the UM plan ensures the following:

- Review decisions are supervised by qualified medical professionals.
- Saginaw collects all necessary information, including pertinent clinical information, and consults with the treating physician as appropriate.
- The reasons for decisions are clearly documented and available to the person served.
- There are clearly communicated and readily available appeals mechanisms for both providers and patients. Notification of a denial includes a description of how to file an appeal.
- Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
- Saginaw evaluates program effectiveness through data on person served satisfaction, provider satisfaction or other appropriate measures.
- SCCMHA does not delegate UM functions.

FY 2025 ANNUAL QUALITY REPORT

Accessibility Committee Report

Committee Purpose: Promoting timely and greater ease of access to care for any person eligible for SCCMHA services, regardless of age, race, ethnicity, gender identity, sexual orientation, residence, or ability to pay.

FY25 Goals	Success/Barriers	Status (Completed/ Not Completed)	Date of Completion (for completed goals)	Recommendation for Goal (Continue/Discontinue /Modify/ Monitor Only)
In FY25, SCCMHA will identify ABA service utilization themes across the network and develop a plan of correction to manage financial risk.	ABA service analysis was moved to Senior Clinical Leaders. QIP will continue to monitor utilization.	Cancelled	N/A	Discontinue / Monitor Only)
In FY25, SCCMHA will increase the overall compliance rate of receiving a medically necessary ongoing service within 14 days of the biopsychosocial assessment from the previously reported rates of 57.72% for African American/Black individuals and 61.11% for White individuals while decreasing the 3.39% gap.	As of the close of FY25, the disparity between the two populations has been statistically eliminated.	Completed	9/30/25	Discontinue.
In FY25, SCCMHA will increase the Medicaid Penetration rate from the previously reported rates of 8.34% for African American/Black individuals and 9.19% for White individuals.	We do not have a way to track this data outside of reports from MSHN. Medicaid Penetration rates slightly decreased for both populations this Fiscal Year.	Not Completed	N/A	Modify to decrease/eliminate the disparity between penetration rates to align with regional goals.
I-SERV 1A: In FY25, SCCMHA will perform monthly monitoring to ensure the average number of calendar days between first contact and initial evaluations for new clients is at or below 14 days.	Because of the rough start to the year, we were unable to bring the average rate for the year down to the standard, however, in the last month of the fiscal year the goal was surpassed.	Not Completed	N/A	Continue.
I-SERV 1B: In FY25, SCCMHA will perform monthly monitoring to ensure the average number of calendar days between first contact and initial clinical services for new clients is at or below 28 days.	As with I-SERV 1A, the fiscal year average remained above the goal, however, the goal was surpassed during the last two months of the fiscal year.	Not Completed	N/A	Continue.

FY25 Goals	Success/Barriers	Status (Completed/ Not Completed)	Date of Completion (for completed goals)	Recommendation for Goal (Continue/Discontinue /Modify/ Monitor Only)
I-SERV 1C: In FY25, SCCMHA will perform monthly monitoring to ensure the average time between first crisis episode contact and provision of crisis services remains at or below 1.5 hours.	The average time between first crisis episode contact and provision of crisis services was 0.6 hours.	Completed	9/30/25	Continue.

FY25 Accomplishments
Created the Case Management Dashboard to help case holders keep track of important deadlines.
Completed the Demographic Update Face Sheet project, automating the sending of face sheets to Customer Service for that day's appointments.
Created the CEHR Portal Utilization Dashboard to track CEHR signup and usage.
Worked with IT to ensure an onboarding process to sync Sentri appointments to the Outlook Calendar.

FY26 Goals	Improvement Objectives/Activities	Frequency of Monitoring (Monthly, Quarterly, Semi-Annual, Annual)	Expected Completion Date
I-SERV 1A: In FY26, SCCMHA will perform monthly monitoring to ensure the average number of calendar days between first contact and initial evaluations for new clients is at or below 14 days.	Dashboard monitoring.	Monthly	9/30/26
I-SERV 1B: In FY26, SCCMHA will perform monthly monitoring to ensure the average number of calendar days between first contact and initial clinical services for new clients is at or below 28 days.	Dashboard monitoring.	Monthly	9/30/26
I-SERV 1C: In FY26, SCCMHA will perform monthly monitoring to ensure the average time between first crisis episode contact and provision of crisis services remains at or below 1.5 hours.	Monitoring and regular data clean-up of incorrectly entered dates and times.	Monthly	9/30/26
In the third quarter of FY26, implement a standardized process for appointment reminder calls across the agency and keeping Sentri calendars	Finalize policy drafts for appointment reminder calls and keeping calendars updated for review and approval from QGC.	Monthly	6/30/26

FY26 Goals	Improvement Objectives/Activities	Frequency of Monitoring (Monthly, Quarterly, Semi-Annual, Annual)	Expected Completion Date
updated.	Train Customer Service staff how to utilize the Appointment Dashboard for reminder calls.		
In the second quarter of FY26, provide staff with a map and guide for reserving appropriate rooms through Outlook.	Finalize the room map. Send out to staff with guidelines for booking.	Monthly	3/31/26
In the second quarter of FY26, provide staff with a tool to identify when to correctly use each appointment status type.	Finalize appointment status scenarios and matrix and submit to QGC for approval.	Monthly	3/31/26
In the second quarter of FY26, implement a standardized process for collecting and uploading insurance cards.	Create a procedure to communicate with staff to send cards to Scanning and methods to get the cards to Scanning.	Monthly	3/31/26
In the third quarter of FY26, provide staff and persons served with guides and training on the CEHR portal.	Restart the CEHR Portal Workgroup. Answer remaining questions so that guides and tutorial videos can be created and finalized.	Monthly	6/30/26
In FY26, decrease the disparity in the Medicaid Penetration rate between African American/Black individuals and White individuals.	Monitoring reports from MSHN.	As reports are released	9/30/26

Accountability & Compliance Committee Report

Committee Purpose: Upholding the obligation of individuals and the agency to take responsibility for their actions, decisions, and outcomes. Ensuring that everyone involved in the delivery of services is held to high standards of performance and ethical behavior.

FY25 Goals	Success/Barriers	Status (Completed/ Partially Completed/ Not Completed)	Date of Completion (for completed goals)	Recommendation for Goal (Continue/Discontinue /Modify)
Throughout FY25, SCCMHA will perform monthly monitoring of the BH-TEDS completion rate to ensure a completion rate of 95% or above.	Need to finalize dashboard.	Not Completed	N/A	Discontinue.
In FY25, SCCMHA will identify areas of the BH-TEDS data set that would benefit from data validation to improve data integrity.	Need to finalize dashboard.	Not Completed	N/A	Continue.
Improve score on 1915i Wavier Review over FY24 results. Improve score on Plan of Service and documentation Improve score on Health and Welfare. Goal will be further defined at start of FY.	FY24 had a full waiver audit, FY25 was a review of last year's CAPs and making sure all we're remedied.	N/A	N/A	Modify to follow through on all CAPs from the waiver review to reduce repeat citations.
Improve score on Hab Support Waiver Review over FY24 results. Goal will be further defined at start of FY.	FY24 had a full waiver audit, FY25 was a review of last year's CAPs and making sure all we're remedied.	N/A	N/A	Modify to follow through on all CAPs from the waiver review to reduce repeat citations.
Improve score on SED Waiver Review over FY24 results. Goal will be further defined at start of FY.	FY24 had a full waiver audit, FY25 was a review of last year's CAPs and making sure all we're remedied.	N/A	N/A	Modify to follow through on all CAPs from the waiver review to reduce repeat citations.

FY25 Accomplishments
Dashboards were developed to identify and capture missed revenue from data entry errors.
Created the IPOS In-Service dashboard to identify missing in-service records.
Developed process to receive signatures from Scott Lange and remedy delays in services.
MEV CAPs reviewed to verify that follow-up was occurring from staff and providers.
Identified and followed up on incorrect SALs to capture missed revenue.
Implementation of role based security for dashboard access.

FY26 Goals	Improvement Objectives/Activities	Frequency of Monitoring (Monthly, Quarterly, Semi-Annual, Annual)	Expected Completion Date
In FY26, the committee will develop a process for collecting the new SAMHSA requirements for Mental Health Client Level Data (MH-CLD).	Work with the State Workgroup and PCE to develop a process.	Monthly	9/30/26
In FY26, SCCMHA will identify areas of the BH-TEDS data set that would benefit from data validation to improve data integrity.	Complete BH-TEDs Dashboard. Perform an analysis of the dashboard to identify data that needs validation.	Monthly	9/30/26
SCCMHA will address the findings from all FY26 audits to reduce repeat citations.	Prior to each audit, review the findings from the previous year's audit. Ensure completion of all corrective action plans in response to external review findings. Develop and implement performance improvement goals in response to audit findings.	With auditing cycle	9/30/26
By the end of the third quarter of FY26, a Decision Tree for Place of Service/Parties Present Selection on SALs will be created and distributed to staff.	Compile supervisor training processes. Define Best Practice for Place of Service and Parties Present selections. Create decision tree and distribute it to staff once approval is received from QGC.	Monthly	6/30/26
Review quarterly reports on Fraud, Waste, and Abuse.	The auditing team will provide the committee with a quarterly Fraud, Waste, and Abuse report for review.	Quarterly	9/30/26
By the end of FY26, 90% of treatment plans (IPOS) that require an in-service will have an associated in-service record.	Utilize the IPOS In-Service dashboard to identify plans that do not have an associated in-service record. Complete monthly follow-up with staff to obtain in-service records.	Monthly	9/30/26

Best Practices Committee Report

Committee Purpose: Promoting established practice guidelines, including evidence-informed and evidence-based services to ensure high quality and effective behavioral health services are provided to SCCMHA persons served.

FY25 Goals	Success/Barriers	Status (Completed/ Partially Completed/ Not Completed)	Date of Completion (for completed goals)	Recommendation for Goal (Continue/Discontinue /Modify)
In FY25, SCCMHA clinical staff will develop Collaborative Safety Plans for 55% of persons served with Serious Mental Illness.	The timeline for completing Collaborative Safety plans was originally to do them with the annual reviews. It is now to complete them as soon as possible. We did get close to the goal, attaining 44.1% completion on 09/22/25.	Not Completed	N/A	Modify by increasing the target percentage.
Throughout FY25, for adults hospitalized for treatment of mental illness or intentional self-harm, SCCMHA clinicians will have a 30 day follow up rate of 75% and a 7 day follow up rate of 48%.	We cannot internally track all the follow-ups, because they can be with other providers, so the numbers on our dashboard will be lower than the actual number and there will be a delay in getting final numbers. From Zenith estimates, SCCMHA achieved a 30 day follow up rate of 62.3% and a 7 day follow up rate of 40.6%.	Not Completed	N/A	Continue.
Throughout FY25, for children hospitalized for treatment of mental illness or intentional self-harm, SCCMHA clinicians will have a 30 day follow up rate of 88% and a 7 day follow up rate of 60%.	We cannot internally track all the follow-ups, because they can be with other providers, so the numbers on our dashboard will be lower than the actual number and there will be a delay in getting final numbers. From Zenith estimates, SCCMHA achieved a 30 day follow up rate of 73.1% and a 7 day follow up rate of 53.8%.	Not Completed	N/A	Continue.
In FY25, SCCMHA will develop a process to collect data on the	This is a State led measure.	Not Completed	N/A	Modify to quarterly monitoring of state

FY25 Goals	Success/Barriers	Status (Completed/ Partially Completed/ Not Completed)	Date of Completion (for completed goals)	Recommendation for Goal (Continue/Discontinue /Modify)
initiation and engagement of SUD treatment and establish a baseline for improvement.				reported data.

FY25 Accomplishments
Consolidated the Trauma Informed Care and Evidence Based Practices workgroups into this committee.
Developed an Evidence Based Practice review schedule to meet standards.
Started tracking suicide attempts and ideation on the Zero Suicide Dashboard.
Developed Follow Up to Hospitalization dashboard to identify individuals that need follow up.

FY26 Goals	Improvement Objectives/Activities	Frequency of Monitoring (Monthly, Quarterly, Semi-Annual, Annual)	Expected Completion Date
In FY26, SCCMHA will increase the percentage of completed Collaborative Safety Plans to 90% of persons served with Serious Mental Illness.	Reminding supervisors to remind their staff of the importance of completing the plans. Monthly reviews of completion percentage.	Monthly	12/31/26
The committee will perform quarterly reviews of the of the EBP dashboard and review all EBP Program evaluations completed by Apprecots.	Committee review of the EBP dashboard in October, January, April, and July. Reviewing Apprecots Program evaluations and passing items requiring action to leadership.	Quarterly/As Needed	9/30/26
The committee will complete quarterly reviews of the Trauma Informed Care Domains.	Quarterly reviews of different domains, evaluating whether the agency is meeting Trauma Informed Care standards.	Quarterly	9/30/26
The committee will perform quarterly reviews of the trauma report/dashboard.	Dashboard monitoring.	Quarterly	9/30/26
The committee will complete the organizational Trauma Informed Care Survey by June 30th.	Finalize survey. Send survey out to staff. Analyze results and create new goals from findings.	Monthly	6/30/26
By the end of FY26, for adults hospitalized for treatment of mental illness or intentional self-harm, SCCMHA clinicians will have a 30 day follow up rate of 71% and a 7 day	Dashboard monitoring. Tracking progress of CAI or supervisors completing Hospital Discharges for persons served open to primary teams.	Monthly	9/30/26

FY26 Goals	Improvement Objectives/Activities	Frequency of Monitoring (Monthly, Quarterly, Semi-Annual, Annual)	Expected Completion Date
follow up rate of 47%.	Regularly reminding staff of the codes that count towards the measure and that seeing primary care satisfies the measure.		
By the end of FY26, for children hospitalized for treatment of mental illness or intentional self-harm, SCCMHA clinicians will have a 30 day follow up rate of 83% and a 7 day follow up rate of 61%.	Dashboard monitoring. Tracking progress of CAI or supervisors completing Hospital Discharges for persons served open to primary teams. Regularly reminding staff of the codes that count towards the measure and that seeing primary care satisfies the measure.	Monthly	9/30/26
The committee will perform quarterly monitoring of the state reported Initiation and Engagement into SUD Treatment data, to hit the benchmark of 42% for Initiation and 14% for Engagement.	Monitoring State reported data.	Quarterly	9/30/26

Outcomes Committee Report

Committee Purpose: Promoting holistic care that addresses the whole-person needs of SCCMHA persons served.

FY25 Goals	Success/Barriers	Status (Completed/ Partially Completed/ Not Completed)	Date of Completion (for completed goals)	Recommendation for Goal (Continue/Discontinue /Modify)
In FY25, SCCMHA will establish a baseline rate for persons served aged 20 years or older who had a preventive or ambulatory care visit during the last 12 months.	SCCMHA is at 80.4% for all persons served. We are at 92.3% for BHH. State goal is 85.6% for the HEDIS measure.	Complete	9/30/25	Modify to meet the state benchmark of 85.6%.
In FY25, SCCMHA will identify the data measures related to MichiCANS that need to be monitored for quality improvement.	MichiCANS was implemented timely and people are using it. Currently there are no identified data measures to monitor. Will revisit after FY26.	Not Completed	N/A	Discontinue.
In FY25, SCCMHA will monitor the blood pressure of persons served, with a focus on individuals with a diagnosis of hypertension, to establish a baseline rate of adequately controlled blood pressure.	According to Zenith, 1 of the 4 BHH individuals with a diagnosis of hypertension have adequately controlled blood pressure. The standard is 55.5%	Complete	9/30/25	Modify to meet the standard of 55.5%.
In FY25, SCCMHA will develop a process to collect hemoglobin A1C levels for persons served between the ages of 18-75 with diabetes and establish a baseline for improvement.	The clinic performing A1C tests may not count towards the measure. Decided that the measure should be addressed clinically with primary care.	Partially Completed	N/A	Modify to meet standard once released.
In FY25, SCCMHA will perform a quarterly review of persons served with Major Depression or Dysthymia who did and did not reach remission within six months after an index event date to identify services and practices that positively contribute to reaching a PHQ-9 score of less than 5.	The data in the dashboard does not appear to be correct and needs to be validated.	Not Complete	N/A	Continue.
In FY25, SCCMHA will perform an analysis of factors that influence unplanned acute readmission following an acute	Case study has been completed and factors that influence readmission have been uncovered and	Completed	9/16/2025	Discontinue.

FY25 Goals	Success/Barriers	Status (Completed/ Partially Completed/ Not Completed)	Date of Completion (for completed goals)	Recommendation for Goal (Continue/Discontinue /Modify)
inpatient or observation stay, specific to our persons served, to develop best practices to support persons served and reduce the number of readmissions.	reported to QGC/Clinical leaders. Clinical leaders can use these results to inform agency practices.			
SCCMHA will standardize annual SDoH screenings for clients 18 years and older, to reach a screening rate of 100% by the end of the FY25.	SDoH Screenings have been added in Sentri but are not required.	Not Completed	N/A	Modify to develop a dashboard on the screener to identify and respond to needs.
In FY25, SCCMHA will perform monthly monitoring to raise Suicide Risk Assessment rate for adults with major depressive disorder to 80% by identifying teams and clinicians that may need additional guidance.	Suicide Risk Assessment rate for adults with major depressive disorder was 96.5% in FY25.	Completed	9/30/26	Continue.
In FY25, SCCMHA will perform monthly monitoring to raise Suicide Risk Assessment rate for children with major depressive disorder to 60% by identifying teams and clinicians that may need additional guidance.	Suicide Risk Assessment rate for children with major depressive disorder was 95.1% in FY25.	Completed	9/30/26	Continue.

FY25 Accomplishments
Created the Diabetes monitoring dashboard.

FY26 Goals	Improvement Objectives/Activities	Frequency of Monitoring (Monthly, Quarterly, Semi-Annual, Annual)	Expected Completion Date
In FY26, SCCMHA will develop a process to collect hemoglobin A1C levels for persons served between the ages of 18-75 with diabetes and will meet state standards once the standard is released.	Complete a case study of persons served with a Diabetes diagnosis, checking for proof of diagnosis and for A1C lab results. Update A1Cs in Sentri that are not up to date with current lab results. Health Home will reach out to primary care for anyone without an A1C result from the last year to get updated labs	Monthly	6/15/26

FY26 Goals	Improvement Objectives/Activities	Frequency of Monitoring (Monthly, Quarterly, Semi-Annual, Annual)	Expected Completion Date
	and monitor the diabetes monitoring dashboard.		
In FY26, SCCMHA will perform a quarterly review of persons served with Major Depression or Dysthymia who did and did not reach remission within six months after an index event date to identify services and practices that positively contribute to reaching a PHQ-9 score of less than 5.	Validate the Depression Remission Dashboard to see where the agency stands on this measure, then perform quarterly monitoring.	Quarterly	9/30/26
In FY26, SCCMHA will perform monthly monitoring to maintain Suicide Risk Assessment rates for adults with major depressive disorder of above 76%.	Dashboard monitoring.	Monthly	9/30/26
In FY26, SCCMHA will perform monthly monitoring to maintain Suicide Risk Assessment rates for children with major depressive disorder of above 60%.	Dashboard monitoring.	Monthly	9/30/26
In FY26, SCCMHA will perform monthly monitoring to track Plan All-Cause Readmissions to maintain a rate of 10% or less.	Dashboard monitoring.	Monthly	9/30/26
In FY26, SCCMHA will meet the benchmark of 85.6% for persons served aged 20 years or older who had a preventive or ambulatory care visit during the last 12 months.	Monitor data from Zenith. Perform case review.	Monthly	9/30/26
In FY26, 55% of BHH persons served with a diagnosis of hypertension will have adequately controlled blood pressure.	Monitor data from Zenith. Perform case review.	Monthly	9/30/26
In FY26, SCCMHA will develop a Social Drivers of Health dashboard to identify and respond to client needs.	Develop SDoH dashboard. Analyze for common needs that are unmet. Problem solve response to address needs.	Monthly	9/30/26
The committee will develop a process for staff to assist persons served in contacting MDHHS to update their Medicaid Primary Care Physician when incorrect.	Map out instructions. Create a procedure. Take procedure to QGC for approval.	Monthly	6/30/26
A committee taskforce will clean up the Sentri address book with correct addresses and input missing fax information.	Identify which addresses are incorrect or missing information in spreadsheet. Taskforce member look up and correct/input information into	Monthly	6/30/26

FY26 Goals	Improvement Objectives/Activities	Frequency of Monitoring (Monthly, Quarterly, Semi-Annual, Annual)	Expected Completion Date
	spreadsheet. Send spreadsheet to LaDonna to update the address book in Sentri.		

Safety Committee Report

Committee Purpose: Promoting proactive interventions and the safety of persons served, staff, and visitors.

FY25 Goals	Success/Barriers	Status (Completed/ Partially Completed/ Not Completed)	Date of Completion (for completed goals)	Recommendation for Goal (Continue/Discontinue /Modify)
Reduce the number of physical interventions and 911 calls for behavioral assistance.	The number of physical interventions in FY24 were 80 and the number of physical interventions in FY25 were 30. The number of 911 calls in FY24 was 30 and the number of 911 calls in FY25 was 51.	Partially Completed	N/A	Modify to monitoring and investigating adverse trends.
Evaluation of the BTP Committee's effectiveness by stakeholders, individuals who have a plan, family members and advocates shall occur annually as part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP).	Not completed this year.	Not Completed	N/A	Continue.
Reduce arrests of SCCMHA persons served over FY25.	The number of arrests in FY24 was 261 and the number of arrests in FY25 was 340.	Not Completed	N/A	Modify to monitoring and investigating adverse trends.
Reduce non-suicide deaths of SCCMHA persons served over FY25.	The number of non-suicide deaths was 52 in FY24 and 47 in FY25.	Completed	9/30/25	Modify to monitoring and investigating adverse trends.

FY25 Accomplishments
Created incident reporting code to track evictions.
Provided secure badge holders to staff.
Created a dashboard to track falls and shared it with facility maintenance.
Created MRSS dashboard of top ten callers to identify individuals to build supports into their plans.

FY26 Goals	Improvement Objectives/Activities	Frequency of Monitoring (Monthly, Quarterly, Semi-Annual, Annual)	Expected Completion Date
The Security alerts will be separated out of the Health and Safety alerts in Sentri.	Encourage PCE to finalize updates in Sentri. Alert staff of the change in Sentri.	Monthly	4/30/26
The committee will perform monthly monitoring of physical interventions and 911 calls for behavioral assistance and will investigate any adverse trends.	Dashboard monitoring.	Monthly	9/30/26
The committee will perform monthly monitoring of arrests and will investigate any adverse trends.	Dashboard monitoring.	Monthly	9/30/26
The committee will perform monthly monitoring of non-suicide deaths and will investigate any adverse trends.	Dashboard monitoring.	Monthly	9/30/26
The committee will monitor evictions to make sure they are reported through Incident Reports so that the reasons for evictions can be reviewed at the end of the year.	Dashboard monitoring and comparison with known evictions to make sure all evictions are reported through incident reports.	Monthly	9/30/26
Evaluation of the BTP Committee's effectiveness by stakeholders, individuals who have a plan, family members and advocates shall occur annually as part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP).	Send out surveys for the Behavior Treatment Survey, last completed in 2024. Compile and review data with the committee.	Annual	9/30/26
Develop Direct Care Staff Training for Incident Reports.	The committee will look at Direct Care Staff Training as it pertains to Incident Reporting and compare what the homes train on verse what SCCMHA trains on. Develop a final training to be consistent among all Direct Care Workers.	Monthly	6/30/26
The committee will enhance the Incident Report Categories cheat sheet to distribute to AFC homes.	Review the current cheat sheet. Edit and elaborate on the categories and expectations. Gain approval from QGC to distribute to the homes.	Monthly	6/30/26
The committee will investigate how the homes are training Direct Care Workers on Incident Reports and develop resources to standardize the trainings.	Compare how the homes are training Direct Care Workers on Incident Reporting and compare it to how SCCMHA trains. Identify areas where training is	Monthly	9/30/26

FY26 Goals	Improvement Objectives/Activities	Frequency of Monitoring (Monthly, Quarterly, Semi-Annual, Annual)	Expected Completion Date
	lacking to provide resources. Develop training resources to address the training shortfalls. Gain approval from QGC to distribute to the homes.		

Service Delivery Committee Report

Committee Purpose: Promoting person-centered, trauma-informed, and recovery-oriented services that are person served-focused and responsive to the needs of SCCMHA persons served.

FY25 Goals	Success/Barriers	Status (Completed/ Partially Completed/ Not Completed)	Date of Completion (for completed goals)	Recommendation for Goal (Continue/Discontinue /Modify)
Improve performance on MHSIP over FY25.	Survey was completed. Results are still being analyzed.	Partially Completed	N/A	Continue.
Improve performance on YSS over FY25.	Survey was completed. Results are still being analyzed.	Partially Completed	N/A	Continue.

FY25 Accomplishments
Made progress on the consumer address cleanup, reducing incorrect address errors from 1849 to 76.
Created new address guides for staff to correctly enter addresses into Sentri.

FY26 Goals	Improvement Objectives/Activities	Frequency of Monitoring (Monthly, Quarterly, Semi-Annual, Annual)	Expected Completion Date
Improve performance on MHSIP from FY25.	Complete survey. Analyze results.	Annual	9/30/26
Improve performance on YSS from FY25.	Complete survey. Analyze results.	Annual	9/30/26
Inform staff of the tuition reimbursement program when sending communication about the loan repayment program.	Send communication to staff.	Annual	4/30/26
Add a Home Help reminder checkbox to Sentri.	Finalize what the checkbox should say and receive approval from QGC. Submit ticket to PCE for implementation.	Monthly	6/30/26
The committee will review the State master code list and customize it into a guide for SCCMHA and the Provider Network of what codes can be billed.	Review the State code book and pull out what codes our organization and providers can bill. Compile the codes into a user-friendly guide. Gain approval from QGC to distribute to staff.	Monthly	6/30/26

FY26 Goals	Improvement Objectives/Activities	Frequency of Monitoring (Monthly, Quarterly, Semi-Annual, Annual)	Expected Completion Date
The committee will perform a monthly review of all of the person served suggestions that are received by Customer Service.	Bring the suggestion from persons served presented at QGC to the committee for review.	Monthly	9/30/26

FY 2026 ANNUAL QUALITY PLAN

The intent of the QIP is to continuously monitor and improve in all areas. The annual QI goals are intended to take a deep dive into an area that has continually struggled to meet targets or requirements.

FY 2025 QUALITY IMPROVEMENT PROGRAM GOALS	RESPONSIBLE
BEGIN TO INVESTIGATE THE OPPORTUNITY TO CHANGE THE PROCESS IMPROVEMENT METHODOLOGY TO PLAN DO STUDY ACT (PDSA)	QIP Leadership

FY2025 ANNUAL SUBMISSION & COMMUNITY NEEDS ASSESSMENT'S PRIORITY NEEDS & PLANNED ACTIONS FOR FY2026

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
1. Access & Navigation - Service availability & wait times	Significant and growing unmet mental health needs across all ages, particularly anxiety, depression, serious mental illness (SMI), co-occurring substance use, and impacts of generational trauma, resulting in increased crisis events, hospitalizations, and criminal justice involvement. Insufficient provider capacity and workforce instability, including shortages of therapists, psychiatrists, case managers, and direct care workers, leading to long wait times, inconsistent services, reduced service hours, and difficulty maintaining continuity of care. Barriers to timely, affordable, and appropriate access to care, such as complex intake processes, delays in medication access, a lack of Medicaid-accepting providers, transportation challenges, and financial hardship, cause individuals to disengage or rely on emergency services.	SCCMHA will strengthen access to timely, appropriate mental health services by improving intake efficiency, expanding provider capacity, enhancing care coordination, and increasing community awareness of available resources. Initial efforts will focus on streamlining access points, prioritizing individuals with high-risk and acute needs, and reducing delays following a crisis or hospitalization. Over the next 12–18 months, SCCMHA will continue our work to simplify and standardize intake and referral processes, including reviewing internal workflows, reducing duplicative requirements, and improving coordination between crisis, outpatient, and community-based services. SCCMHA will continue to assess wait times across service types and use data to guide service prioritization and resource allocation. The QIP Accessibility Committee regularly monitors Time to Initial Evaluation, Time to Clinical Services, and Time to Crisis Services, so any rise in wait times can be addressed.

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
	Gaps in care coordination, follow-up, and system navigation, particularly after crisis or hospitalization, result in fragmented services, poor transitions to outpatient care, recidivism, and individuals falling through service gaps (including ALICE populations). Limited community integration, education, and stigma reduction, including a lack of psychosocial and peer support opportunities, inadequate public awareness of available resources, insufficient cross-system collaboration, and ongoing stigma that discourages individuals from seeking or continuing treatment.	To help persons served begin and navigate their services, the QIP Accessibility Committee will develop a Roadmap to Starting Services to answer common questions, clarify processes, and outline what to expect. The goal is to create a more welcoming experience to help people achieve full engagement with services. To address workforce and provider shortages, SCCMHA will continue to collaborate with network providers and community partners to support recruitment, retention, and service capacity, including exploring alternative service models (e.g., group services, peer support, telehealth where appropriate). Emphasis will be placed on improving continuity of care and ensuring timely follow-up after emergency department visits, hospitalizations, or crisis interventions. The QIP Best Practices Committee created and monitors a Follow-Up to Hospitalization dashboard to identify individuals who require follow-up and communicate with existing and newly assigned case holders. SCCMHA will also strengthen care coordination and system navigation, particularly for individuals with serious mental illness, co-occurring conditions, and those at risk of disengagement. This includes reinforcing expectations for timely follow-up, improving cross-system communication, and supporting coordination with primary care, hospitals, law enforcement, courts, and social service partners. The QIP Outcomes Committee has created a dashboard to monitor faxes marked “unable to be sent” to improve care coordination for document requests and responses. SCCMHA is exploring opportunities to strengthen and improve care coordination with hospitals and to ensure

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
		Adult Foster Care homes provide the necessary and accurate information to the medical profession where a person served is receiving treatment. SCCMHA works in conjunction with local law officials and monitors Court Order Cases to help monitor services and decrease gaps or lapses in services for individuals on a court order. Tools are created to improve care coordination with law enforcement and the courts and to track follow-up. To address transportation challenges, members of the QIP Accessibility Committee are launching an awareness campaign to help persons served learn how to schedule transportation via their Medicaid Health Plan and easily contact the transportation liaison for assistance. SCCMHA will improve access to services by strengthening education and navigation support related to Medicaid transportation options. SCCMHA will offer ongoing monthly transportation training sessions to help persons served and case holders understand how to schedule rides through their Medicaid Health Plans, learn about available transportation options, and receive answers to common transportation-related questions. These sessions will be offered at a consistent location and time to promote accessibility and predictability. They will be supported by direct assistance from SCCMHA's designated Transportation Liaison, who is available to help individuals navigate scheduling challenges, resolve barriers, and connect with appropriate transportation resources. This planned action is intended to reduce missed appointments, improve timely access to mental health and related services, and support individuals' ability to independently manage transportation needs, particularly

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
		for those with limited resources or complex service schedules. The QIP Accessibility Committee is also working to increase use of the CEHR portal to help reduce service gaps when IPOSs and other documents are awaiting signatures that can now be signed through the portal. SCCMHA works diligently to remind persons served of their appointment times via phone calls and text messages. SCCMHA is working to create an external provider orientation notification to assist with care coordination of initial appointments between persons served and case management. SCCMHA is working with our EHR vendor to implement an external referrals and referral follow-up document and tracking system with primary care providers or specialists to improve care coordination. In parallel, SCCMHA will expand community education, outreach, and stigma reduction efforts, including clearer communication about how to access services, what supports are available, and how to navigate the system. Efforts will include collaboration with community organizations to increase awareness of mental health resources and promote early engagement in care. Progress will be monitored through ongoing review of access metrics (e.g., wait times, follow-up completion, service engagement) and stakeholder feedback, with adjustments made as needed to improve responsiveness and outcomes. SCCMHA continues to work within the parameters of the State grant for Veteran's and Military families. This grant allows for a Veteran's Navigator to provide resources and

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
		education to individuals in the community in regard to mental health services in locations and areas where veterans and their family members frequent. SCCMHA also works with local law enforcement agencies to receive referrals and calls from local law enforcement when on duty so that individuals can be linked to mental health services while law enforcement is present with the individual while on a call. Mental Health staff provide stabilization and support as needed and requested, either by law enforcement or by the person served. SCCMHA has hired a Spanish Bilingual Coordinator, whose primary job it is to provide outreach and engagement to the Hispanic/Bilingual population in Saginaw County. This individual's job is to reduce the stigma and to assist with helping individuals navigate the complexities of the mental health system.
2. Housing & Basic Needs - Homelessness & shelter access	Rising homelessness and housing instability, including individuals and families experiencing eviction, couch surfing, living in vehicles, or relying on unsafe or overcrowded shelters, create ongoing uncertainty, stress, and trauma. Insufficient availability of safe and appropriate shelter options, particularly for families, low-income households, and individuals with mental health conditions, resulting in unmet basic needs and increased risk to personal safety. Barriers for individuals with mental illness and co-occurring substance use disorders, as many shelters are unable or unwilling to accommodate people engaged in mental health treatment, leaving high-need individuals without stable housing options.	SCCMHA will continue to address homelessness and shelter access by strengthening coordination with housing, shelter, and community partners; improving linkage to supportive services; and prioritizing stability for individuals and families with mental health needs. Initial efforts will focus on mitigating immediate safety risks, supporting continuity of mental health care for unhoused individuals, and reducing reliance on emergency and crisis systems driven by housing instability. Over the next 12–18 months, SCCMHA will enhance coordination with local shelters, housing providers, and community agencies to improve access to safe and appropriate shelter options, particularly for individuals with mental illness and co-occurring substance use disorders. This includes clarifying referral pathways, strengthening communication between mental health

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
	Homelessness significantly limits access to mental health care, with unstable housing contributing to missed appointments, disrupted treatment, and a lack of continuity in care for individuals already experiencing mental health challenges. Increased vulnerability of unhoused and high-risk populations amid funding constraints, heightening risks related to safety, health outcomes, and long-term stability when shelter, transportation, and supportive services are reduced or unavailable.	providers and shelter systems, and supporting reasonable accommodations that enable individuals engaged in treatment to access shelter services. SCCMHA will prioritize outreach, engagement, and follow-up for unhoused and high-risk individuals, with emphasis on maintaining access to mental health services despite housing instability. Efforts will include reinforcing expectations for timely follow-up after crises, emergency department visits, or hospitalizations, and improving coordination to reduce missed appointments, treatment disruptions, and recidivism. The agency is working to make the Social Drivers of Health Screening mandatory as part of the annual Psychosocial Assessment to ensure that the current needs of persons served are captured, and community coordination and education can occur. Over 25 years ago, SCCMHA was a founding member of the Saginaw Consortium of Homeless Assistance Providers (SC-CHAP). SC-CHAP was organized as the local HUD continuum of care as per HUD regulations and qualified members for competitive HUD grant opportunities. SC-CHAP is the local collaborative body addressing both homelessness and housing affordability. To support the work at SCCMHA in this space, a dedicated unit of the agency called the Housing Resource Center (HRC) was developed. The HRC is the lead for SCCMHA in housing and homelessness collaboration in Saginaw County. To address barriers related to transportation and basic needs, SCCMHA will support integration of housing-related supports with mental health services, including coordination around transportation, benefits navigation, and linkage to available community resources. Particular attention will be given to individuals and families

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
		experiencing repeated episodes of homelessness or instability. In parallel, SCCMHA will participate in cross-system planning and advocacy efforts focused on homelessness prevention, shelter capacity, and service sustainability, particularly amid funding constraints. Progress will be monitored through review of service utilization patterns, crisis system involvement, and stakeholder feedback, with adjustments made to improve safety, stability, and continuity of care for unhoused populations. SCCMHA will continue and formalize weekly, as needed, outreach visits to local homeless shelters to identify individuals in need of mental health services and facilitate timely access to care. SCCMHA's HRC staff conduct regular shelter visits to engage residents, assess needs, and assist with connection to Community Access Intake (CAI). When clinically appropriate, on-site eligibility screenings are completed by licensed staff, enabling immediate initiation of services and reducing barriers related to transportation and system navigation. For individuals requiring additional support, staff assist with referrals to CAI and linkage to other community resources to support stabilization and engagement in services. This ongoing outreach strengthens early identification, reduces delays in access, and supports continuity of care for individuals experiencing homelessness, particularly those with serious mental illness or co-occurring conditions. SCCMHA will continue to participate annually in the HUD-required Point-in-Time (PIT) Count, which identifies sheltered and unsheltered individuals experiencing homelessness during the last ten days of January. SCCMHA

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
		staff support both daytime and evening counts, including outreach to unsheltered locations such as parks, abandoned buildings, and other places not meant for human habitation. Data from the PIT Count informs local and federal planning, funding decisions, and system-level strategies to address homelessness. SCCMHA uses this information to understand better trends, service gaps, and the scope of housing needs among individuals with mental health conditions in Saginaw County. SCCMHA will continue community education and outreach efforts related to homelessness, permanent supportive housing, and access to mental health services. Housing Resource Center staff regularly provide presentations and trainings to internal teams, community partners, service providers, and community groups, including coordinated entry partners and advocacy organizations. These efforts increase awareness of eligibility criteria, referral pathways, and available housing supports, while strengthening collaboration across systems and reducing stigma associated with homelessness and mental illness.
3. Housing & Basic Needs - Affordable/supportive housing	Increasing housing instability among individuals and families receiving mental health services, with homelessness occurring at higher and more alarming rates than in previous years due to the limited availability of safe and affordable housing. Severe shortages in affordable, income-based, and supportive housing, including long waitlists and insufficient low-income options, make it difficult for individuals with mental illness to secure and maintain stable living situations.	SCCMHA will work to improve housing stability for individuals and families receiving mental health services by strengthening partnerships with housing providers, addressing barriers to affordable and supportive housing, and enhancing coordination between housing and mental health services. Initial efforts will focus on reducing housing instability that contributes to homelessness, hospital utilization, and disrupted treatment for individuals with mental illness. Over the next 12–18 months, SCCMHA will collaborate with local housing authorities, developers, and

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
	Financial and administrative barriers to housing access, such as application fees, security deposits, first month's rent, past financial challenges, and family conflict, prevent otherwise eligible individuals from obtaining housing. Concerns regarding the quality, safety, and oversight of Adult Foster Care (AFC) homes, including overcrowding, inadequate staffing, inappropriate client placement, and policies that limit staff ability to respond to safety or elopement risks. Lack of integrated housing supports linked to services, including transportation, payee services, and case management, resulting in increased hospital utilization, disrupted treatment, and poorer mental health outcomes when stable housing is unavailable.	community partners to support access to affordable, income-based, and supportive housing options for individuals with mental health needs. This includes participating in cross-system planning efforts, identifying gaps in housing availability, and supporting strategies that prioritize individuals with serious mental illness and those experiencing repeated housing instability. SCCMHA will address financial and administrative barriers to housing access by strengthening coordination on application assistance, benefits navigation, and linkage to resources that cover application fees, security deposits, and initial housing costs. Efforts will focus on reducing preventable barriers that delay or prevent housing placement for otherwise eligible individuals and families. To improve safety and quality of care, SCCMHA will reinforce oversight, coordination, and expectations for Adult Foster Care (AFC) settings, including collaborating with licensing entities and providers to promote appropriate placement, adequate staffing, and responsiveness to safety and elopement risks. Emphasis will be placed on ensuring AFC settings align with individuals' clinical needs and support stability. The QIP Safety Committee reviews provider trends each month to identify AFC homes that may need additional support or intervention. In parallel, SCCMHA will strengthen the integration of housing supports with mental health services, including transportation coordination, payee services, and case management, to support sustained housing stability and continuity of care. Progress will be monitored through reviews of housing stability indicators, service utilization trends, and stakeholder feedback, with adjustments made

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
		to improve outcomes and reduce reliance on the system. Reviews of housing stability indicators, service utilization trends, and stakeholder feedback will be conducted, with adjustments made to improve outcomes and reduce reliance on the system driven by housing instability. SCCMHA will maintain active participation in the Saginaw County Consortium of Homeless Assistance Providers (SC-CHAP) and the countywide Coordinated Entry system to support equitable and efficient access to housing resources. Through monthly coordinated entry meetings, SCCMHA collaborates with HUD-funded providers to review the Homeless Management Information System (HMIS) priority list and determine appropriate placement based on acuity, chronicity, and program availability. This coordinated approach ensures individuals experiencing homelessness—particularly those with serious mental illness—are prioritized appropriately for permanent supportive housing, rapid rehousing, or transitional housing, and reduces duplication, fragmentation, and delays in housing placement. SCCMHA will continue to ensure safe, decent, and sanitary housing for individuals receiving rental subsidies through initial, quarterly, and annual housing inspections conducted by qualified housing inspection staff. Quarterly inspections are conducted in addition to annual inspections to proactively identify maintenance concerns, monitor housing conditions, and support early intervention when issues arise, rather than waiting for annual review. SCCMHA currently utilizes HUD Housing Quality Standards (HQS) and is actively preparing for HUD's transition to NSPIRE inspection standards, scheduled for implementation on October 1, 2026. SCCMHA has invested

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
		in NSPIRE-compatible inspection software and is coordinating across departments to ensure compliance with updated federal requirements, continuity of housing assistance, and minimal disruption to persons served. SCCMHA will prioritize eviction-prevention efforts for individuals receiving housing assistance by working directly with landlords and program participants to resolve issues before eviction proceedings begin. When housing stability is threatened, staff engage early to support communication, address compliance concerns, and pursue alternatives, such as notices to vacate when appropriate, to prevent formal evictions that would otherwise result in program termination. When eviction cannot be avoided, SCCMHA ensures individuals have access to available community resources and referrals, with continued emphasis on minimizing housing disruptions and preventing repeat homelessness whenever possible. SCCMHA has had a HUD funded permanent supported housing grant for 25+ years. The grant provides tenant-based rental assistance for 70-80 households annually. SCCMHA is currently in the process of submitting our funding request to HUD for the second year of our current HUD grant award. The second year of funding for the competitive award will commence on July 1, 2026.
4. Workforce & System Capacity - Case management quality & follow-through	Insufficient care coordination for individuals with serious mental illness (SMI), including gaps in ACT/ATO services, limited psychosocial rehabilitation options, a lack of appropriate AFC placements, and inadequate coordination across service systems. Inconsistent and delayed follow-through by case management, including untimely IPOS development,	SCCMHA will strengthen workforce and system capacity by improving the quality, consistency, and accountability of case management services, with a focus on care coordination for individuals with serious mental illness (SMI). Initial efforts will prioritize reducing service gaps, improving follow-through on required actions, and ensuring individuals receive timely, appropriate, and coordinated supports across service systems.

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
	authorizations, guardianship actions, and service implementation, resulting in individuals falling through system gaps. Concerns regarding case manager training, role clarity, and accountability, with reports of inadequate preparation, task shifting, minimal engagement, and failure to connect individuals to evidence-based treatments and appropriate supports. Limited system capacity to respond to acute and high-risk needs, including increased suicidal ideation among consumers, insufficient psychiatric resources, strained family supports, and lack of timely intervention pathways. Challenges in cross-system collaboration and continuity of care, including coordination with law enforcement, courts, providers, and families, as well as insufficient support for sustained client engagement after initial contact.	SCCMHA is reviewing the training that AFC home staff receive to develop and enhance current training to better support appropriate AFC placements. Over the next 12–18 months, SCCMHA will reinforce expectations and standards for case management practice, including timely IPOS development, authorizations, guardianship actions, and service implementation. SCCMHA will review internal processes and monitoring practices to identify barriers to timely follow-through and support corrective actions that reduce individuals falling through system gaps. A Case Management dashboard has been created by the QIP Accessibility Committee to highlight tasks and documents that are due or overdue, to help improve follow-through and reduce service gaps. SCCMHA will support enhanced training, role clarity, and accountability for case managers, with an emphasis on care coordination for SMI populations, evidence-based practices, and effective engagement with individuals and families. Efforts will focus on improving understanding of case management responsibilities, strengthening linkage to appropriate services, and supporting consistent, person-centered engagement. After fidelity reviews, the QIP Best Practices committee has teams report back on what they are doing to meet the recommendations, resulting in training for Case Managers on program philosophies, admission criteria, stage-wise interventions, proper documentation, and how to access and utilize data.

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
		To address high-risk and acute needs, SCCMHA will strengthen system capacity to respond to individuals experiencing crisis, including improved coordination with psychiatric services, crisis providers, and families. Emphasis will be placed on timely intervention pathways, follow-up after crisis or hospitalization, and continuity of care to reduce risk, recidivism, and avoidable system involvement. In parallel, SCCMHA will enhance cross-system collaboration and communication, including coordination with law enforcement, courts, providers, and community partners, to support continuity of care and shared accountability. Progress will be monitored through review of care coordination indicators, timeliness of required actions, service engagement, and stakeholder feedback, with adjustments made as needed to improve system performance and outcomes. SCCMHA works with local and State Universities to provide an array of internship and learning opportunities for individuals seeking both Bachelor and Master level degrees. SCCMHA also offered internship stipends from the State to attract applicants. This has encouraged and increased both Bachelor and Master level applicants to apply for vacant positions and fill the current work force needs. SCCMHA offers student loan forgiveness through the State and Federal fundings to attract new applicants.
5. Access & Navigation - Insurance & affordability	High numbers of underinsured and uninsured individuals and families, resulting in delayed or forgone mental health services due to lack of coverage, fear of losing benefits, or insurance lapses tied to income instability and health challenges.	SCCMHA will improve access to mental health services by addressing insurance-related and financial barriers that prevent individuals and families from obtaining timely, appropriate care. Initial efforts will focus on supporting individuals who are underinsured or uninsured, reducing cost-related obstacles to care, and improving navigation of available benefits and resources.

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
	Cost-related barriers to accessing care, including unaffordable therapy services, limited coverage for non-ASD treatment, and out-of-pocket expenses that disproportionately impact low-income families, students, and those relying on SSI. Limited access to providers who accept Medicaid or offer adequate coverage restricts timely and appropriate care for Medicaid-eligible individuals and families, contributing to unmet mental health needs. Insufficient understanding and navigation of insurance benefits, with a need for education and advocacy to help individuals and families access, utilize, and maintain available coverage and resources. Broader financial instability affects basic needs, including housing affordability, discontinued social support programs, and reduced service capacity, further complicating mental health challenges and limiting continuity of care.	CCBHC services are available to any person in need, including but not limited to those with serious mental illness, serious emotional disturbances, long-term chronic addiction, mild or moderate mental illness, and substance use disorders. Any person with a behavioral health diagnosis is eligible for CCBHC services. All persons are entitled to walk into CCBHC clinics and be screened for service eligibility. CCBHC clinics must serve all individuals regardless of residency or ability to pay. For individuals residing out of state, CCBHC clinics are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services. They should have protocols in place to coordinate care across state lines. CCBHCs offer a sliding fee scale for uninsured or underinsured individuals. The Ability to Pay/Sliding Fee Discount Program is a Federal program that allows Saginaw County Community Mental Health to discount our normal charges on services provided. The Federal Poverty Guidelines are used to determine eligibility for the Sliding Fee Discount Program. Eligibility is determined by household size and annual gross income. (Net income for self-employment) for the household, completed application, and proof of income. Over the next 12–18 months, SCCMHA will strengthen coordination with network providers and community partners to support access to services for Medicaid-eligible, underinsured, and uninsured individuals. This includes promoting service options that reduce out-of-pocket costs, supporting continuity of care for individuals experiencing insurance lapses, and identifying strategies to improve provider participation where coverage limitations restrict access.

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
		SCCMHA will enhance education, navigation, and advocacy related to insurance benefits, including clearer communication about available coverage, eligibility requirements, and how to access and maintain benefits. Efforts will focus on supporting individuals and families in understanding their options, reducing fear of benefit loss, and improving successful utilization of covered services. The QIP Accessibility Committee reviews the Insurance Monitoring dashboard to track the number of individuals who are insured, underinsured, and uninsured, as well as those who are CCBHC, while ensuring they have active consents. The Accountability Committee assists by monitoring the Unsigned Documents dashboard to ensure timely billing to Medicaid and Third-Party Billing. To address broader affordability challenges, SCCMHA will support the integration of financial and basic needs assistance with mental health services, including coordination on benefits navigation, housing affordability resources, and linkage to available social supports. Particular attention will be given to populations disproportionately impacted by cost barriers, including low-income families, students, and individuals relying on SSI. In parallel, SCCMHA will monitor trends related to insurance coverage, service access, and affordability, using available data and stakeholder feedback to identify gaps and inform ongoing system improvement efforts. Progress will be reviewed through assessment of service engagement, continuity of care, and reported access barriers, with adjustments made as needed to improve equity, access, and outcomes.

PRIORITY ISSUE	REASONS FOR PRIORITY	CMHSP PLAN OVERVIEW
		The QIP Best Practices Committee is working on tip sheets for Supported Employment to help individuals prepare for the workforce and understand what is needed to enter it. These sheets will also help individuals navigate their benefits. Assisting individuals with gaining employment may help them acquire better insurance through their employers. SCCMHA is working to improve the coordination of benefits so persons served who are insured can be appropriately matched to providers that accept their insurance.

FY2025 SAGINAW COUNTY CCBHC COMMUNITY NEEDS ASSESSMENT

MAJOR THEME	FINDINGS
SUBSTANCE USE DISORDERS	Substance use disorder (SUD) is a top community need. Employees and partner agencies rank SUD among the most significant challenges and lived-experience comments call for more harm-reduction and recovery supports. This convergence strengthens the case to expand medications for addiction treatment (MAT), recovery supports, and warm handoffs from emergency departments and justice settings. In FY2024, SCCMHA served 86 individuals with a primary SUD diagnosis, about 0.3% of residents estimated to be experiencing SUD countywide.
ACCESS FRICTION	"Access friction" refers to the avoidable steps, waits, and uncertainties that delay or deter people from getting behavioral healthcare, especially first contact and first treatment. In Saginaw County, access friction shows up as slow or complicated intake, unclear wayfinding (not knowing who to call or what to ask for), limited appointment windows, after-hours gaps, cost and insurance hurdles, and logistics barriers such as transportation and technology.
EQUITY GAPS IN ACCESS AND OUTCOMES	Saginaw County's behavioral health needs are concentrated in communities that face structural barriers including poverty, unstable housing, limited transportation, and stigma. These conditions do not impact residents evenly; they cluster by ZIP code and identity (e.g., LGBTQIA+, disability, veterans, older adults), shaping when, where, and whether people get care. Survey responses point to consistent disparities that SCCMHA can address through targeted outreach, tailored service design, and accountability measures. LGBTQIA+ People with Disabilities, Including Autism Veterans Justice-Involved Individuals
ACCESS TO CARE	Many underserved communities face barriers to accessing mental healthcare, including lack of insurance, high costs, and limited availability of providers. This often results in untreated mental health conditions.
STIGMA AND DISCRIMINATION	Stigma around mental health can be more pronounced in marginalized communities, making individuals less likely to seek help. Discrimination and lack of culturally competent care further exacerbate these issues.
ECONOMIC AND SOCIAL FACTORS	Poverty, unemployment, and unstable housing are more prevalent in underserved populations, contributing to higher stress levels and mental health issues. These factors also make it harder to access and afford care.
HEALTH OUTCOMES	Poor mental health can lead to severe consequences, such as increased risk of substance abuse, homelessness, and involvement in criminal activities. It also negatively affects physical health, leading to a cycle of poor overall health

FY2026 STRATEGIC PLAN

GOAL	PLAN
STRATEGIC GOAL 1.1:	Increase the Numbers of Persons Served Across All Populations (and Improve Persons Served Experience at all Access Points)
STRATEGIC GOAL 1.2:	Expand the Expectation and Use of the Service Array Across All Populations
STRATEGIC GOAL 1.3:	Expand Data Collection and Quality Reporting
STRATEGIC GOAL 2.1:	SCCMHA Leadership Training
STRATEGIC GOAL 2.2:	Institutionalize Relationships with Community Partners to Ensure They Are Not Personality Dependent (predictable environment)
STRATEGIC GOAL 2.3:	Staff Retention, Recruitment and Supporting Equity, Diversity, & Inclusion (DEI) Among the Workforce and Network
STRATEGIC GOAL 2.4:	Addressing and Enhancing Staff Safety & Accountability
STRATEGIC GOAL 2.6:	Expanding Organization Mastery of Benefit Interpretation
STRATEGIC GOAL 2.7:	Knowledge Transfer to Emerging Leaders
STRATEGIC GOAL 3.2:	Information Systems - Future Electronic Expansion
STRATEGIC GOAL 3.3:	Information Technology - Update and Improve the Information Technology Infrastructure and Workforce Technologies
STRATEGIC GOAL 3.4:	Business Intelligence - Transform Information Management to "Business Intelligence" to Measure Persons Served Quality of Care, Informed Decision Making and Improved Business and Clinical Outcomes
STRATEGIC GOAL 3.5:	Quality Improvement - Build a Data Driven Quality Program Based on Business Intelligence
STRATEGIC GOAL 3.6:	Information Security - Ensure all Information Technology Assets, Information Systems, Digital Property and Sensitive Data stay protected, safe, secure, available, and free of any damage, breach, or security incident caused by an internal or external bad actor.
STRATEGIC GOAL 4.1:	Explore and Develop our Roles in Healthcare
STRATEGIC GOAL 4.2:	Core Skills for Workforce on Physical Health and Substance Use Disorders
STRATEGIC GOAL 4.3:	Achieve and Maintain Certified Community Behavioral Health Clinic Status
STRATEGIC GOAL 4.5:	Surveillance of Any and All Mental Health Code and Social Welfare Act amendments and Related Legislation Pertaining to System Redesign Impacting PIHPs, CMHSPs and their Networks

GOAL	PLAN
STRATEGIC GOAL 4.6:	Enhance the integration and delivery of comprehensive behavioral and physical health services through the Behavioral Health Home (BHH) program, ensuring improved health outcomes, patient satisfaction, and system efficiency
STRATEGIC GOAL 5.1:	Health and Wellness
STRATEGIC GOAL 5.2:	Proactive policy review and revision for medical, nursing, and general healthcare best practices, regulatory requirements, and the evolving needs of our community
STRATEGIC GOAL 6.1:	Capital Asset Projects
STRATEGIC GOAL 6.2:	Develop a Long-Term Financial Stability Plan
STRATEGIC GOAL 6.3:	Develop a Long-Term SCCMHA Staffing and Network Provider Stabilization Effort

FY 2026 QUALITY IMPROVEMENT COMMITTEE DOMAIN GOALS

ACCESSIBILITY

DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	TARGET COMPLETION DATE	JUSTIFICATION
Accessibility	I-SERV 1A	I-SERV 1A -Meet Time To Services Metrics	I-SERV 1A: In FY26, SCCMHA will perform monthly monitoring to ensure the average number of calendar days between first contact and initial evaluations for new clients is at or below 14 days.	9/30/26	The standard for the I-SERV metrics to receive the CCBHC Quality Bonus Payment is to be greater than or equal to the 25th percentile. As we do not currently know what the 25th percentile rate will be, we are striving for improvement from our current performance.
Accessibility	I-SERV 1B	I-SERV 1B - Meet Time To Services Metrics	I-SERV 1B: In FY26, SCCMHA will perform monthly monitoring to ensure the average number of calendar days between first contact and initial clinical services for	9/30/26	The standard for the I-SERV metrics to receive the CCBHC Quality Bonus Payment is to be greater than or equal to the 25th percentile. As we do not currently know what the 25th percentile rate will be, we are

DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	TARGET COMPLETION DATE	JUSTIFICATION
			new clients is at or below 28 days.		striving for improvement from our current performance.
Accessibility	I-SERV 1C	I-SERV 1C - Meet Time To Services Metrics	I-SERV 1C: In FY26, SCCMHA will perform monthly monitoring to ensure the average time between first crisis episode contact and provision of crisis services remains at or below 1.5 hours.	9/30/26	The standard for the I-SERV metrics to receive the CCBHC Quality Bonus Payment is to be greater than or equal to the 25th percentile. As we do not currently know what the 25th percentile rate will be, we are striving for improvement from our current performance.
Accessibility	N/A	Appointment Reminder Calls	In the third quarter of FY26, implement a standardized process for appointment reminder calls across the agency and keeping Sentri calendars updated.	6/30/26	Departments have different standards of if, when, and to what extent appointment reminder calls are made. For consistency and to better meet the needs of persons served, a policy that outlines standards and expectations for reminder calls will be beneficial.
Accessibility	N/A	Room Reservation Map and Guide	In the second quarter of FY26, provide staff with a map and guide for reserving appropriate rooms through Outlook.	3/31/26	Staff have reported having difficulty booking rooms and also having their room bookings ignored by other staff. A map of which rooms are available for different purposes and a guide on room booking and etiquette will help resolve the issues staff are having.
Accessibility	N/A	Appointment Status Guide	In the second quarter of FY26, provide staff with a tool to identify when to correctly use each appointment status type.	3/31/26	Staff have differing definitions of when to use each appointment status type. A guide will increase reporting consistency and improve documentation.
Accessibility	N/A	Insurance Cards	In the second quarter of FY26, implement a standardized process for collecting and uploading insurance cards.	3/31/26	While some staff may be collecting insurance information, they are not uploading it to a single spot for finance to access it. A standardized process will

DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	TARGET COMPLETION DATE	JUSTIFICATION
					increase the number of insurance cards collected for finance to accurately bill and help the information get stored in a single spot to easily view.
Accessibility	N/A	CEHR Portal Guides and Training	In the third quarter of FY26, provide staff and persons served with guides and training on the CEHR portal.	6/30/26	While the CEHR Portal has been launched, many staff and persons served are still unsure of how to use it. Providing them with guides and training should help increase use of the CEHR Portal.
Accessibility	FY25 MSHN PIP 2	Increase Access To BIPOC Community (MSHN PIP 2)	In FY26, decrease the disparity in the Medicaid Penetration rate between African American/Black individuals and White individuals.	9/30/26	This is an MSHN PIP. As a region, the disparity in the penetration rate between the Black and white individuals eligible for Medicaid Services is statistically significant.

ACCOUNTABILITY

DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	TARGET COMPLETION DATE	JUSTIFICATION
Accountability	MH-CLD	Mental Health Client Level Data	In FY26, the committee will develop a process for collecting the new SAMSHA requirements for Mental Health Client Level Data (MH-CLD).	9/30/26	In place of BH-TEDs, SAMSHA is changing requirements to collect Mental Health Client Level Data. The agency needs to develop a process to collect this new data.
Accountability	BH-TEDS	Behavioral Health Treatment Episode Data Set	In FY26, SCCMHA will identify areas of the BH-TEDS data set that would benefit from data validation to improve data integrity.	9/30/26	There are often many human errors with manual data entry. It is important to regularly validate that our data is correct and complete while cleaning up any errors.

Accountability	N/A	Reducing Repeat Citations	SCCMHA will address the findings from all FY26 audits to reduce repeat citations.	9/30/26	SCCMHA has had many repeat citations over the past few years that need to be addressed.
Accountability	N/A	SAL Decision Tree	By the end of the third quarter of FY26, a Decision Tree for Place of Service/Parties Present Selection on SALs will be created and distributed to staff.	6/30/26	Per dashboard reviews, staff have been making incorrect selections on the SALs for Place of Service and Parties Present. This has resulted in missed revenue. Providing a decision tree may remedy the confusion over which selections to make to ensure billing goes through.
Accountability	FWA	Fraud, Waste, and Abuse	The committee will review quarterly reports on Fraud, Waste, and Abuse.	9/30/26	MSHN requires that we review aggregated data on Fraud, Waste, and Abuse.
Accountability	N/A	In-Service Records	By the end of FY26, 90% of treatment plans (IPOS) that require an in-service will have an associated in-service record.	9/30/26	SCCMHA receives many repeat citations during audits on not having in-service records in charts. It is important that in-services are occurring and being documented, as services should not be provided by staff that have not been in-serviced on a plan.

BEST PRACTICE					
DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	TARGET COMPLETION DATE	JUSTIFICATION
Best Practice	ZS	Zero Suicide	In FY26, SCCMHA will increase the percentage of completed Collaborative Safety Plans to 90% of persons served with Serious Mental Illness.	12/31/26	Reactive interventions are not an option for Zero Suicide. We must be proactive in our efforts and create collaborative safety plans for the persons we serve that are at the highest risk.
Best Practice	FUH-AD	Follow-up Metrics	By the end of FY26, for adults hospitalized for treatment of	9/30/26	FUH is a CCBHC Quality Bonus payment metric. We have not been hitting the

DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	TARGET COMPLETION DATE	JUSTIFICATION
			mental illness or intentional self-harm, SCCMHA clinicians will have a 30 day follow up rate of 71% and a 7 day follow up rate of 47%.		benchmarks for adults or children. The group needs to dive into why we are not hitting the metrics and implement strategic plans to meet the marks.
Best Practice	FUH-CH	Follow-up Metrics	By the end of FY26, for children hospitalized for treatment of mental illness or intentional self-harm, SCCMHA clinicians will have a 30 day follow up rate of 83% and a 7 day follow up rate of 61%.	9/30/26	FUH is a CCBHC Quality Bonus payment metric. We have not been hitting the benchmarks for adults or children. The group needs to dive into why we are not hitting the metrics and implement strategic plans to meet the marks.
Best Practice	IET IET14 AD IET34 AD	Initiation and Engagement into SUD Treatment	The committee will perform quarterly monitoring of the state reported Initiation and Engagement into SUD Treatment data, to hit the benchmark of 42% for Initiation and 14% for Engagement.	9/30/26	This is a state reported measure that we are currently not tracking ourselves but is attached to a quality bonus payment. We need to develop a way to collect this data and track it to regularly see if we are hitting the benchmarks and where we need to improve.
Best Practice	TF-CBT ZS Fidelity - OTH	EBP Reviews	The committee will perform quarterly reviews of the of the EBP dashboard and review all EBP Program evaluations completed by Apprecots.	9/30/26	These reviews will ensure compliance with fidelity for evidence-based practices.
Best Practice	TIC	Trauma Informed Care	The committee will complete quarterly reviews of the Trauma Informed Care Domains.	9/30/26	Reviewing the Trauma Informed Care Domains provides a self-assessment on how the agency is performing regarding Trauma Informed Care and guides improvement.
Best Practice	TIC	Trauma Informed Care	The committee will perform quarterly reviews of the trauma report/dashboard.	9/30/26	Reviewing the trauma report/dashboard supplements reviewing the Trauma Informed Care Domain with actual outcomes.

DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	TARGET COMPLETION DATE	JUSTIFICATION
Best Practice	TIC - Survey	Trauma Informed Survey	The committee will complete the organizational Trauma Informed Care Survey by June 30th.	6/30/26	The Trauma Informed Care Survey is required every three years, with 2026 being a required year.

OUTCOMES					
DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	TARGET COMPLETION DATE	JUSTIFICATION
Outcomes	AAP	BHH Quality Bonus Metrics: Adults Access to Preventive/Ambulatory Health Services	In FY26, SCCMHA will meet the benchmark of 85.6% for persons served aged 20 years or older who had a preventive or ambulatory care visit during the last 12 months.	9/30/26	This standard is tied to a quality bonus payment that is measured by exceeding the state and regional rates.
Outcomes	CBP	BHH Quality Bonus Metrics: Controlling High Blood Pressure	In FY26, 55% of BHH persons served with a diagnosis of hypertension will have adequately controlled blood pressure.	9/30/26	This standard is tied to a quality bonus payment that is measured by exceeding the state and regional rates.
Outcomes	GSD-AD (Previously HBD-AD)	Glycemic Status Assessment for Patients with Diabetes (Previously Hemoglobin A1C Control)	In FY26, SCCMHA will develop a process to collect hemoglobin A1C levels for persons served between the ages of 18-75 with diabetes and will meet state standards once the standard is released.	6/15/26	This is a state reported measure that we now have a dashboard for. We need new labs for individuals that have not had one in the last year so that we may monitor hemoglobin A1C levels and meet the state standard for percentage of test results in the controlled range.
Outcomes	DEP-REM-6	DEP-REM-6	In FY26, SCCMHA will perform a quarterly review of persons served with Major Depression or Dysthymia who did and did not reach remission within six months after an index event date to identify services and practices that positively contribute to reaching a PHQ-9 score of less than 5.	9/30/26	DEP-REM-6 is another CCBHC quality bonus standard where we must be greater than or equal to the 25th percentile. Comparing cases where remission was reached in six months to cases where remission was not reached may give insight to treatment plans, service considerations, or supports that have a higher efficacy with reaching remission from a Depression diagnosis.

DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	TARGET COMPLETION DATE	JUSTIFICATION
Outcomes	PCR-AD	PCR-AD	In FY26, SCCMHA will perform monthly monitoring to track Plan All-Cause Readmissions to maintain a rate of 10% or less.	9/30/26	This is a state reported measure attached to a quality bonus payment that we are barely hitting the 10% benchmark for. It is important that the group identify best practices that have been shown to reduce the number of readmissions, so that we may proactively support persons served in the best way.
Outcomes	SDoH	Screening for SDoH	In FY26, SCCMHA will develop a Social Drivers of Health dashboard to identify and respond to client needs.	9/30/26	Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety play a huge role in a person's mental health care. These screenings need to be prioritized and reviewed to identify areas where assistance is needed.
Outcomes	SRA-A	Suicide	In FY26, SCCMHA will perform monthly monitoring to maintain Suicide Risk Assessment rates for adults with major depressive disorder of above 76%.	9/30/26	The Suicide Risk Assessment metrics are tied to quality bonus payments.
Outcomes	SRA-C	Suicide	In FY26, SCCMHA will perform monthly monitoring to maintain Suicide Risk Assessment rates for children with major depressive disorder of above 60%.	9/30/26	The Suicide Risk Assessment metrics are tied to quality bonus payments.
Outcomes	N/A	Medicaid Primary Care Physicians	The committee will develop a process for staff to assist persons served in contacting MDHHS to update their	6/30/26	Medicaid Primary Care Physician is automatically loaded into Sentri from MDHHS data. When this information is incorrect, we are unable to change it. The person served must contact MDHHS to

DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	TARGET COMPLETION DATE	JUSTIFICATION
			Medicaid Primary Care Physician when incorrect.		update the information, which can be a confusing process. It would be beneficial to have staff assist persons served in contacting MDHHS so our information is up to date in Sentri.
Outcomes	N/A	Correcting Addresses for Health Care Coordination	A committee taskforce will clean up the Sentri address book with correct addresses and input missing fax information.	6/30/26	Health Care Coordination relies on addresses and fax numbers being correct in Sentri. Staff have found this information to be incorrect or missing, resulting in the need for a clean up effort.

SAFETY					
DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	TARGET COMPLETION DATE	JUSTIFICATION
Safety	Behavior Review Data	Physical intervention reduction	The committee will perform monthly monitoring of physical interventions and 911 calls for behavioral assistance and will investigate any adverse trends.	9/30/26	The study is required by the Michigan Department of Health and Human Services (MDHHS). The data collected is based on the definition and requirements that have been set forth within the Standards for Behavioral Treatment Review attached to the Pre-Paid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) contract.
Safety	Behavior Review Data	Improve the Behavior Treatment Plan	Evaluation of the BTP Committee's effectiveness by stakeholders, individuals who have a plan, family	9/30/26	The purpose of this procedure is to guide Mid-State Health Network (MSHN) in monitoring the delegated function of Behavior Treatment Plan (BTP) Review

DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	TARGET COMPLETION DATE	JUSTIFICATION
		Committee's effectiveness	members and advocates shall occur annually as part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP).		Committees to the Community Mental Health Service Program (CMHSP) Participants in accordance with the Michigan Department of l Health and Human Services Medicaid Managed Specialty Supports and Services Contract, P.1.4.1 Standards for Behavior Treatment Plan Review Committees (BTPRC).
Safety	Critical Incident - Arrest	Reduce arrests	The committee will perform monthly monitoring of arrests and will investigate any adverse trends.	9/30/26	Quality Assessment Performance Improvement Program Quality Improvement Council – Critical Incidents: Quality Assessment Performance Improvement Program MSHN will demonstrate a decrease in the rate of critical incidents, excluding deaths from the previous year. Critical Incidents include an arrest, emergency medical treatment/hospitalization for an injury or medication error for individuals who are receiving a waiver service.
Safety	Critical Incident - Non-Suicide Deaths	Reduce non-suicide deaths	The committee will perform monthly monitoring of non-suicide deaths and will investigate any adverse trends.	9/30/26	Quality Assessment Performance Improvement Program Quality Improvement Council – Critical Incidents: MSHN will demonstrate a decrease in the rate of Suicide Deaths and Non-Suicide Deaths from the previous year.
Safety	N/A	Evictions	The committee will monitor evictions to make sure they are reported through Incident Reports so that the	9/30/26	Evictions have not been being reported on incident reports. It is important that these are reported so we can understand

DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	TARGET COMPLETION DATE	JUSTIFICATION
			reasons for evictions can be reviewed at the end of the year.		why and develop supports for persons served to maintain their housing.
Safety	N/A	Security Alerts	The Security alerts will be separated out of the Health and Safety alerts in Sentri.	4/30/26	To improve safety of all persons served, visitors, and staff.
Safety	N/A	Incident Report Cheat Sheet	The committee will enhance the Incident Report Categories cheat sheet to distribute to AFC homes.	6/30/26	Many staff are unaware of what incidents to report and how to appropriately report them.
Safety	N/A	Direct Care Worker Incident Report Training	The committee will investigate how the homes are training Direct Care Workers on Incident Reports and develop resources to standardize the trainings.	9/30/26	Many staff are unaware of what incidents to report and how to appropriately report them. Since we do not directly train the direct care workers on Incident Reports, every home is training differently and providing different information, resulting in underreporting or incorrect reporting.

SERVICE DELIVERY					
DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	TARGET COMPLETION DATE	JUSTIFICATION
Service Delivery	MHSIP	MHSIP performance improvement.	Improve performance on MHSIP from FY25.	9/30/26	Annual completion and submission of the Patient Experience of Care Survey analysis of results and comparison to region.
Service Delivery	YSS	YSS performance improvement.	Improve performance on YSS from FY25.	9/30/26	Annual completion and submission of the Youth Services Survey for Families (YSS)

DOMAIN	REFERENCE	QI GOAL NAME	SMART GOAL	TARGET COMPLETION DATE	JUSTIFICATION
					analysis of results and comparison to region.
Service Delivery	N/A	Staff Development	Inform staff of the tuition reimbursement program when sending communication about the loan repayment program.	4/30/26	There have been many questions from staff on development opportunities and comments from staff that they are unaware of the tuition reimbursement program, indicating the need to inform staff of the development opportunity.
Service Delivery	N/A	Home Help Reminder	Add a Home Help reminder checkbox to Sentri.	6/30/26	Many staff forget to fill out a Home Help application annually for persons served receiving Home Help services, resulting in the loss of services. A Home Help checkbox will remind staff of the need to complete the applications.
Service Delivery	N/A	Billing Code List	The committee will review the State master code list and customize it into a guide for SCCMHA and the Provider Network of what codes can be billed.	6/30/26	After dashboard review, it is evident that not all staff are aware of what codes can be billed for all purposes. A reference guide will provide staff with a convenient tool to make sure they are billing the correct codes.
Service Delivery	N/A	Person Served Suggestions	The committee will perform a monthly review of all of the person served suggestions that are received by Customer Service.	9/30/26	Reviewing the suggestions from persons served will provide the committee with timely feedback of the perceptions of persons served and alert the group of topic that may need to be discussed.

REFERENCES

1. A - Quality Reports and Measures by Domain
2. B - Saginaw QIP Reporting and Monitoring Schedule
3. C.1 - Charter - Accessibility Quality Committe.docx
4. C.2 - Charter - Accountability Quality Committe.docx
5. C.3 - Charter - Best Practice Quality Committe.docx
6. C.4 - Charter - Outcomes Quality Committe.docx
7. C.5 - Charter - Safety Quality Committe.docx
8. C.6 - Charter - Service Delivery Quality Committe.docx
9. D - QI Annual Goal Report DMAIC Template.docx
10. QIP Universe of Measures.xlsx
11. 2025 CMH BHTEDS Monitoring.xlsx
12. 2025 CMH Encounter Monitoring.xlsx
13. CMH Clinical Chart Review Tool
14. CMH Delegated Managed Care Tool - PSV.docx
15. Critical incident PSV Supplemental Tool.xlsx
16. Program Specific Review Tool Non-Waiver PSV.docx
17. Provider Network Review Tool.docx
18. CMH FY25 1915i Chart Review - Final.docx
19. CMH FY25 CWP Chart Review - Final.docx
20. CMH FY25 HSW Chart Review - Final.docx
21. CMH FY25 SEDW Chart Review - Final.docx
22. CMH FY25 Waiver Administrative Review - Final.docx