Management Summary

Annual Performance Report

October 1, 2014 – September 30, 2015

Community Mental Health

103 West U. S. 2
Wakefield, MI 49968
906-229-6100
www.gccmh.org

COMMUNITY MENTAL HEALTH AUTHORITY BOARD

It is the mission of the Community Mental Health Authority Board to enhance the quality of life for our community by offering comprehensive behavioral health services. It is the ultimate goal of all services provided or contracted by the Authority to assist all residents of Michigan to attain or to maintain the capacity to participate in the opportunities, benefits and responsibilities of society.

CMH Authority Board: The CMH Authority Board consists of 12 members appointed by the Gogebic County Board of Commissioners pursuant to the Michigan Mental Health Code. Two (2) primary and two (2) secondary consumers were added to the Board per the Mental Health Code changes of 1996.

The Board meets monthly and works with a number of sub-committees that research/study various issues and make recommendations to the full CMHA Board for final action. Sub-committees include: Personnel, Finance, Nominating/By-Laws Review, and Steering. In addition, there is Board member representation on the agency's Recipient Rights Advisory Committee, the Consumer Advisory Council and on the NorthCare Network Governing Board.

Chief Executive Officer: The CEO is responsible for the overall day-to-day operation of CMHA Board-operated services including: all personnel, contracted services, planning, policy development, risk management, training, quality assurance, capital outlay, and physical plant improvements.

The CEO is hired and employed by the CMHA Board. The CEO has direct supervision over three department directors: Clinical Services, Board Administration, and Community Services. The CEO also has direct supervision over the positions of CMHA Board's Administrative Assistant/ Quality Improvement Coordinator, Recipient Rights Officer/Integrated Healthcare Coordinator/ Contract Manager/Purchasing Coordinator, Management Information Systems staff, the Human Resources Coordinator, the Support Intensity Scale (SIS) Assessor, and the Maintenance Coordinator.

Finance Director: The Finance Director is responsible for all financial reporting and preparing the agency budget in coordination with the CEO and the Management Team. The Finance Director is responsible for the Board Administration and Finance Departments and its personnel. This includes Medical Records, Accounts Payable, Payroll, Accounts Receivable, and Secretarial.

Clinical Services Director: The Clinical Services Director is responsible for services for adults with a serious mental illness, children with serious emotional disturbance and/or intellectual/ developmental disabilities, and/or co-occurring disorders. The Clinical Services Director oversees all programs within the outpatient/clinical services department and ensures that services provided meet contractual requirements. The Clinical Services Director directly supervises the Utilization Management Coordinator, the Clinical Services Supervisor, the Assertive Community Treatment Team (ACT) Supervisor, the Adult Community Services Supervisor, and oversees contracted medical/specialty services including Board Certified Behavior Analysts, psychiatrists, and the agency physician.

Community Services Director: The Community Services Director is responsible for services for individuals with intellectual/developmental disabilities. The Community Services Director

supervises the Health Services, Rehabilitation, and Residential Services programs, and staff working within those programs. The Community Services Director oversees the specialty contracts for Physical Therapy and Occupational Therapy services. The Community Services Director is responsible for overseeing all individuals with intellectual/developmental disabilities who reside out of county as well as the agency's Habilitative Supports Waiver Coordinator.

Recipient Rights: The Recipient Rights Officer (RRO) is responsible to assure that agency policy and practices are in compliance with State Office of Recipient Rights Guidelines. The RRO is charged with protecting the rights of consumers by providing rights training, investigating reported rights violations and reviewing all incident reports. The RRO shall initiate investigation of apparent or suspected rights violations in a timely and efficient manner. The RRO shall complete the investigation no later than 90 days after it receives the rights complaint. The RRO shall determine whether a right was violated by using the preponderance of the evidence as standard of proof. The RRO shall issue a written status report every 30 calendar days during the course of the investigation, submitted to the complainant, the respondent, and the responsible mental health agency. Upon completion of the investigation, the RRO shall submit a written investigative report to the respondent and the responsible mental health agency. Within 10 business days of the investigative report, a summary report will be prepared and sent to the complainant and recipient and guardian (if recipient has a guardian). The RRO chairs the quarterly Recipient Rights Advisory Committee meetings.

- The RRO also serves as the Integrated Healthcare Coordinator (IHC); the IHC is the liaison for the agency physician and other providers who utilize the Integrated Healthcare Office. IHC chairs health and wellness related committees (i.e., Integrated Healthcare, Wellness, Tobacco Free Campus, etc.). IHC provides training on integrated health and health and wellness activities and assists Serenity Center with integrated health activities, as well.
- The RRO also serves as the Contract Manager (CM) and Purchasing Coordinator (PC); the CM is responsible for the management of Gogebic CMHA's contracts and the contracting process and is the liaison between Gogebic CMHA and contractors/vendors. The CM leads contract procurement through the competitive bid process and prepares contracts according to policies and procedures. The CM participates in CMHA site reviews to assure compliance with licensing, rights, etc. The CM also functions as the Board of Financial Responsibility liaison for inter-county agreements. As the PC, responsibilities include purchasing of internal and external items needed for CMHA. PC/CM will perform S.A.M. checks as applicable for purchasing and contracts.

Human Resources (HR) Coordinator: The HR Coordinator supports the CEO in coordinating the HR function. This includes recruitment of personnel, training, and orientation of new employees, co-management of the agency's training program, health insurance and other benefit administration, workers compensation, unemployment claims, hiring and discharge details, EEOC, FMLA, and ADA.

Quality Improvement (QI) Coordinator: Duties of the QI Coordinator include coordinate the Quality Assessment and Performance Improvement Program (QAPIP), be an Ad Hoc member of all QI work groups, maintenance of agency policy and procedure manual, co-management of the agency's training program, maintenance of CARF Accreditation, liaison for external site reviews, and chair of the agency's Consumer Advisory Council, the agency's Quality Improvement/ Utilization Management (QI/UM) Committee, and the agency's Anti-Stigma Committee.

- The CMHA Board's QAPIP has developed an organizational structure for evaluation, goal attainment and continuous quality improvement. This structure is parented by the Steering

Committee. The Steering Committee has the responsibility to maintain a corporate culture based on continuing quality improvement philosophies and to oversee its progress and for the design and operation of the structure and systems to support QI. The Steering Committee is comprised of the CEO, Program Directors, and the QI Coordinator. To assist the Steering Committee in carrying out the Board's mission, a QI/UM Committee will be maintained for the purpose of reviewing QAPIP activities, reviewing and analyzing data, and recommending changes for service improvement on an on-going basis. The QI/UM Committee will serve as a medium for communication and integration across all areas of quality improvement throughout the agency. Standing members of the QI/UM Committee shall be the QI Coordinator, Utilization Management Coordinator, the Recipient Rights Officer, the Safety Committee Chairperson, the Medical Records Coordinator, and representatives from the I/DD/MI Children/Adult populations. The Medical Director/designee participates in the meetings when available. The QI/UM Committee meets as needed but not less than quarterly.

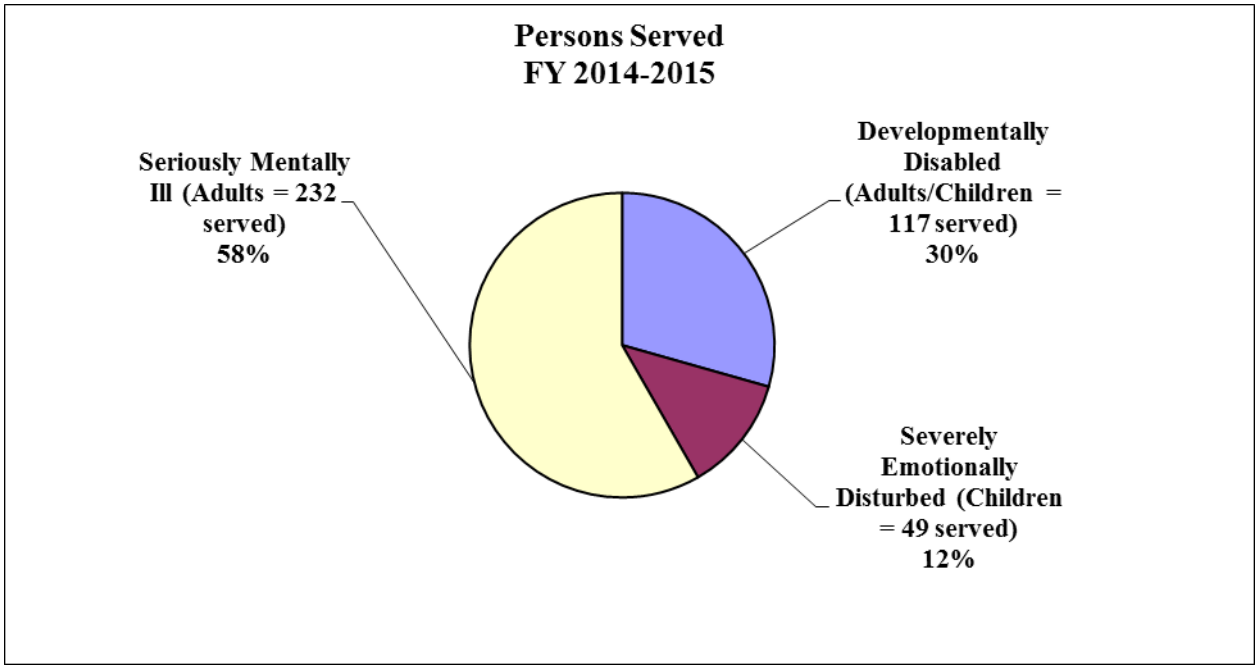
Maintenance Coordinator: The Maintenance Coordinator is responsible to perform repairs, snow shoveling/blowing/plowing, maintain buildings and grounds, coordinate agency vehicle maintenance, assist with building security and safety, and coordinate maintenance and repairs with the lessee when a leased building is involved. The Maintenance Coordinator is responsible for the direct supervision of the custodian.

Available Services

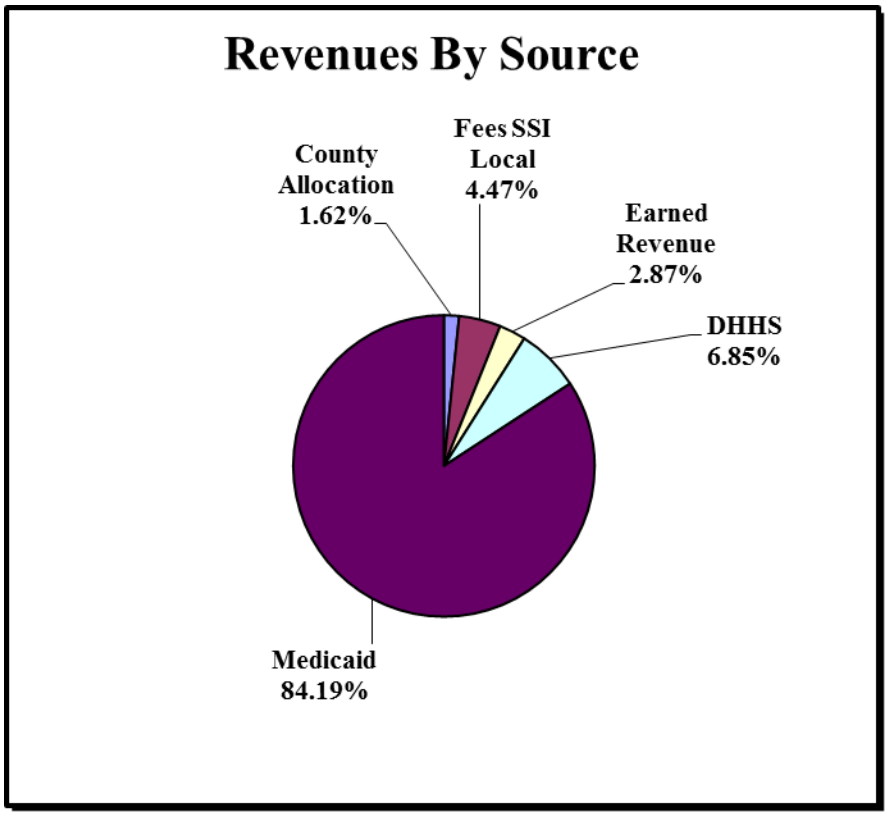
CMHA provides a variety of services for consumers with a serious mental illness, serious emotional disturbance, and/or co-occurring disorder, and/or an intellectual/developmental disability. Some of the services include Community Inpatient, Case Management/Supports Coordination, Therapy, Jail Diversion, Medication Administration, and Home-based; a complete listing of services provided is available by contacting CMHA. The programs specifically accredited by *CARF International . . . Commission on Accreditation of Rehabilitation Facilities*, include Case Management/Services Coordination, Community Housing (Residential), Employment Services (Supported Employment), Crisis Intervention (Emergency Services), and Assertive Community Treatment.

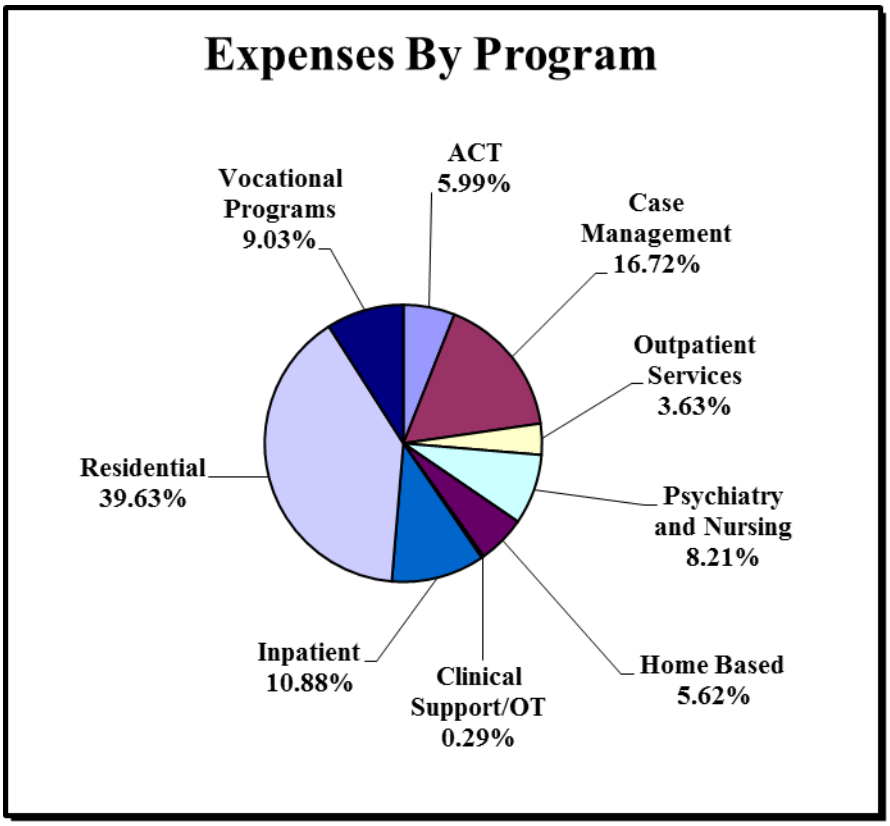
Persons Served

An unduplicated count of 398 individuals (a decrease from 460 last fiscal year) received reportable services during FY 2015; a break down per population is shown in the graph.



Financial Profile
FY 2015





Site Visits By Rights Office Staff
Ten (10) visits were made to various sites that included monitoring facilities for rights compliance, investigating complaints, incident reports, and visits with consumers and staff to appraise progress and maintain accessibility.

Training Provided By Rights Office Staff
Orientation to Rights = 22; Refresher Rights = 43; Right to Vote = 36; HIPAA Privacy/ Retaliation/Harassment = 12; Consumer Rights = 22; Recipient Rights Advisory Council (RRAC) = 6. These numbers are not all inclusive as others have received training, however appropriate paperwork is not always returned.

Training Received By Rights Office Staff (Training that fulfills Recipient Rights Officer requirements)
Recipient Rights Officer (RRO) received 16.75 hours of training to include Sexual Harassment; Customer Service Training; Closing the Investigative Interview; State Innovation Model; Disney & Ritz Carlton Customer Service Tailored for your Organization; HIPAA for Behavioral Health Provider; and Organizational Compliance and Responsibilities.

Complaints Received
Six (6) complaints were received that included seven (7) various allegations regarding Recipient's Right Sanitary/Humane Environment; Abuse Class II-Unreasonable Force; Abuse Class III; Neglect Class III; Restraint; and one (1) outside of RRO jurisdiction; and one (1) no right involved. The 'outside of jurisdiction' was given information to proper resources to assist them and the other allegations were investigated with follow-up action taken as appropriate.

Incidents
Four hundred eighty-three (483) incidents occurred (see table on next page), a significant increase from last fiscal year (355). Incidents can be duplicated when categorized, therefore, some incidents are counted more than once (i.e., an incident can be counted multiple times if it is identified as (1) consumer experienced serious hostility, (2) consumer hit another consumer, and (3) consumer hit back by consumer). Forty (40) different consumers were involved in the various incidents, a decrease of seven consumers from last fiscal year. The QI/UM, Safety, and Pharmacy & Therapeutics/Medical Services Committees continue to monitor the various incidents for patterns and/or trends. Training for staff and proactive strategies are implemented, as needed, to assist in decreasing incidents.

Location* of Incident	# of Incidents	Category^ of Incident	# of Incidents
Lakeshore Home	137	accidental non-serious injury from fall	11
Lakeview Home	124	Serious hostility	105
Greenbush Home	81	Other behavior of recipient	31
CMH	2	Subject of aggression by other without apparent injury	47
Community	3	Physical management performed	21
Serenity Center	5	Non-serious self-inflicted injury	17
Highline	14	Non-serious injury inflicted by another resident	19
Residential Placement	5	Non-serious aggression toward others	35
		Property destruction	27
		Non-serious injury of unknown origin	4
		Serious injury inflicted by another recipient	1
		Medication refusals	16
		Missed medication by staff	11
		Incorrect medication dose given by staff	17
		Incorrect of time of medication administration by staff	2
		Falls with no injury	17
		Emergency medical treatment due to self-injurious behavior	1
		Emergency medical treatment due to injury	4
		Emergency medical treatment due to illness/medical condition	10
		Hospitalization due to illness/medical condition	4
		Accidental non-serious injury from fall	4
		Exposure to blood/body fluids	1
		Other medical or health/safety issue	37
		Unauthorized Leave of Absence	13
		Accidental non-serious injury	2
		Inappropriate sexual behavior	6
		Medical/adaptive equipment problems	2
		Arrest	3
		Unexpected death	1
		Inappropriate alcohol use	5
		911/police called due to behavior crisis	3
		Harm to others result in emergency medical treatment	3
***unduplicated count** **^duplicated count**		TOTAL	483

Quality Assessment and Performance Improvement Program (QAPIP)
Outcomes Summary for FY 2015
(with Quality Improvement Plans for FY 2016)

Quality Improvement/Utilization Management (QI/UM) Committee

- The Committee continued to meet quarterly to review various QI data (i.e., satisfaction, performance indicators, program outcomes, record review, unusual incidents, suggestions, etc.), to receive QI sub-committee updates, and to review regional information.

➢ *QI Plan*

- Continue to meet not less than quarterly to develop, implement and monitor all aspects of the QI program.

Utilization Management (UM)

- In the interim of not having an Outpatient staff member assuming UM Coordinator roles and responsibilities, the Clinical Director continued to participate in regional UM meetings.
- Evidence Based Practices (EBP) continued to be monitored and discussed during department staff meetings, with quarterly EBP updates provided at QI/UM Committee meetings.

➢ *QI Plan*

- Identify and train an Outpatient staff member to assume UM Coordinator roles and responsibilities.
- Continue to develop, implement and monitor all aspects of the UM system.

Safety and Risk Management Committee

- The Committee continued to be a strong and active committee. The Committee conducted numerous disaster drills in the CMH main building throughout the fiscal year, including but not limited to carbon monoxide detector checks, internal fire extinguisher checks, monthly environmental emergency drills, etc. In addition, the Serenity Center Director conducted safety drills on a monthly basis at the Center. Residential safety data can be found in each group home. In addition to the drills conducted, there were two "actual" events (power outage and fire) that occurred during the fiscal year with appropriate follow-up conducted by CMH staff. Vehicle inspections continued to be performed routinely on agency fleet vehicles throughout the fiscal year with documentation on file in the Maintenance Coordinator's office. Routine inspections were performed on vehicles utilized at the group homes as well, with documentation on file in each group home. Internal quarterly building inspections at the CMH main building were conducted; any follow-up action needed was documented on the Internal Inspection Checklist and completed by the Maintenance Coordinator. Quarterly inspections were conducted at the three group homes as well, with documentation on file in each group home. The Serenity Center Director conducted quarterly building inspections at the Center; documentation is filed with the Recipient Rights Officer.
- The annual "external" building inspection was completed on October 23, 2014 by a Michigan Certified Building Inspector; the inspection report noted all areas compliant and contained many positive comments, such as "*the overall appearance of the CMH facility is clean and orderly; you can tell the employees take pride in their work and should be commended*".
- In May 2015, a Loss Prevention Consultant from Citizen's Management Inc (Workman's Comp Carrier) conducted a workplace hazard assessment at one of CMH's group homes which resulted in the need to have a Hoyer Lift checklist due to an issue with a lift. It was also noted that CMH does not have to carry additional volunteer insurance with a different company as CMH volunteers would be covered under the current workman's comp insurance.

- Twenty-eight (28) different safety trainings were conducted (i.e., CPR and First Aid for both child and adult; various OSHA trainings; medication administration; tobacco-free campus; medical emergency-locating a CMH defibrillator; wheelchair and van lift; seizures; Violence in the Workplace; etc.).
- The Safety Committee continued to be committed to providing on-going safety awareness for employees and consumers by conducting various safety activities/projects and by providing safety information to new employees during orientation and to employees throughout the year via paycheck stuffers, memos, and posters; examples include: implemented a tobacco-free campus and created smoking cessation packets for staff and consumers; adopted a new Hazard Written Communication Plan and trained staff on such; proper use of infant car seat training provided by the Gogebic County Sheriff's Department; vaccinations for consumers; etc.
- There were 16 staff injuries (the same as last fiscal year) resulting in a total of 5.5 lost work days and 21 days of light duty work, compared to zero lost time last fiscal year; total exposure for medical costs remains minimal. The Safety Committee reviewed all staff injuries on a monthly basis with analysis and follow-up recommendations, as appropriate.
- Through the QI process, consumer incidents continued to be monitored. The Person-Centered-Planning (PCP) Team continued to address individual consumer risk for injuries with follow-up intervention as directed by the PCP team, including behavior treatment plans, psychiatric medication monitoring, fall-prevention guidelines, and assessment for and utilization of adaptive equipment, assistive devices, durable medical equipment, and anatomical supports.
- As a commitment to promoting accessibility, the Safety Committee continued quarterly reviews of the Accessibility Plan, identifying and removing accessibility barriers, with reasonable accommodation, when identified.
- The Safety Committee reviewed agency policies, procedures, and CARF standards relating to health, safety, and transportation to assure on-going compliance with standards.
- The Pharmacy & Therapeutics/Medical Services Committee continued to meet every six weeks. The Committee consists of both agency RNs, the agency's Clinical Director, with Drs. Joe & Jan Cools, and Dr. Rocco. The Committee reviews and monitors all pharmacy and therapeutic related data, such as medication incidents, applicable policy and procedures, along with conducting Peer Reviews. Infection Control meetings were also held on a quarterly basis.

➢ *QI Plan*

- Continue to monitor the safety and risk management goals and objectives and unusual incidents pertaining to health and safety and implement prevention and pro-active plans as needed.
- Maintain quarterly review of the Accessibility Plan and update as needed.
- Review agency policies and procedures and assure continued compliance with applicable CARF standards and other regulatory agencies relating to accessibility, health, safety, and transportation.
- Continue P & T/Medical Services and Infection Control Committee meetings and responsibilities.

Strategic Plan

- Strategic Plan goals and objectives were reviewed and updated quarterly.

➢ *QI Plan*

- Maintain quarterly monitoring of the Plan's goals and objectives.

Outcomes Management System (OMS)

- The function of the OMS is to collect and monitor outcome goals and objectives, developed by QI work groups, for CARF accredited programs. Although not CARF affiliated, goals and

objectives for Customer Services continued to be monitored, as well. OMS data for the fiscal year shows 63% overall compliance, a decrease from 71% last fiscal year (includes access standards but does not include satisfaction – see *Satisfaction Survey Summary* section of this report). Areas of non-compliance were continually monitored by the QI/UM Committee. The OMS work groups reviewed the goals and objectives and the Program Descriptions and Plans and modified them as needed for FY 2016.

- *Michigan Mission-Based Performance Indicators* ~ Of the five indicators monitored, four have an established compliance rate of 95%; compliance *exceeded* the established standard (scoring 100%) every quarter for each indicator except for one indicator that scored 92% (11/12=92%) and 91% (10/11=91%) in the 2nd and 3rd quarters, respectively. One indicator was also NA in the 3rd quarter. One indicator has a '15% or less' standard which monitors children and adults who are readmitted to an inpatient psychiatric unit within 30 days of discharge. This CMH was in full compliance at 0% (0 readmissions within 30 days of discharge) for the entire fiscal year (one quarter was NA).
- *Pre-paid Inpatient Health Plan (PIHP) Performance Indicators* ~ The indicators monitored mirror those for the *Michigan Mission-Based Performance Indicators*; however, they focus solely on *Medicaid* beneficiaries served. For the four indicators having an established compliance rate of 95%, compliance *exceeded* the established standard (scoring 100%) every quarter for each indicator except for one indicator that scored 91% (10/11=91%) in the 3rd quarter. One indicator was also NA in the 3rd quarter. For the indicator having a '15% or less' standard, this CMH was in full compliance at 0% (0 readmissions within 30 days of discharge) for the entire fiscal year (one quarter was NA).

➢ *QI Plan*
- Continue to monitor and maintain the OMS, making modifications to increase compliance, as needed.
- Continue to monitor all performance indicators.

State Performance Improvement Projects (PIP) ~ Standards published by the Centers for Medicare and Medicaid Services (CMS) require that the PIHP "conduct performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction." Two PIPs are required, one project topic typically mandated by the State and one project topic chosen by the PIHP that takes into account the prevalence of a condition among, or need for a specific service by the organization's consumers, consumer demographic characteristics and health risks and the interest of consumers in the aspect of service to be addressed. In addition, NorthCare is now an accredited Health Plan through the Utilization Review Accreditation Commission (URAC), which requires *three* PIP's. All three PIP's must focus on clinical quality and at least one of the three must address consumer safety for the population served.

➢ **PIP #1 FY 15** (continued from FYs '13 & '14): Children's Health and Safety ~ Indicator #1: 95% of all *health* concerns identified in the Bio-psychosocial assessment (BPS) will be addressed in the IPOS. Indicator #2: 95% of all *safety* concerns identified in the BPS will be addressed in the IPOS. This project focused on activities to assure adequate follow-up is provided for when health and safety concerns are identified in the BPS.
  - NorthCare conducted an *Intervention Chart Review* in March 2015, reviewing three (Gogebic) charts. As a result of that review, each chart reviewed scored 73% compliance. An initial Plan of Correction regarding the review was submitted to NorthCare in May 2015 and progress reports were submitted in July 2015 and October 2015.

- **PIP #2 FY 15** (continued from FY '14): Engagement in Service ~ This is a clinical project that focused on increasing the number of persons served by reducing the number of consumers discharged from services due to no-shows. Follow up reviews of selected consumer records, by NorthCare, revealed characteristics associated with service discharges due to no-shows included no outreach phone calls or letters following initial no-show, no-shows following changes to previously scheduled appointments that were initiated by office/clinician, and notices of planned case closure sent to consumers that lacked clear instructions to prevent case closure. This project focused on activities to ensure consumer access to due process mechanisms and adequate re-engagement efforts were undertaken to prevent unnecessary discharge and assure continuity of care. NorthCare's goal was a 20% or more reduction in percent of persons discharged from services due to no-shows for scheduled appointments within 90 days of admission.
  - FY 15 regional data has not yet been received by NorthCare.

- **PIP #3 FY 15** (continued from FY '14): Improving Primary Health Services for Consumers with Self-Reported Obesity ~ The focus of the project was to increase the percentage of adults, with a mental illness who indicate a medical diagnosis of obesity in the self-reported health measures, who receive nutritional therapy or counseling from their primary health care provider or dietician.
  - The Health Services Advisory Group (HSAG) validated both Phase I (Design) and Phase II (Implementation and Evaluation) of this project. Validation of the project means that the project will achieve, through ongoing measurements and interventions, significant improvement and will be sustained over time.
  - During the 2nd quarter, data from the Upper Peninsula Health Plan showed there were 1,200 people within the NorthCare Network with a mental illness that self-reported health measures who receive primary health services to address obesity/nutrition.
  - During the 3rd quarter, NorthCare modified the diagnosis and procedure codes that were used to include consumers in this project, noting that the initial data collection could have inflated the baseline data. Also during the 3rd quarter, NorthCare implemented a *Referral for Medical Nutritional Therapy* procedure, hoping to have 25 individuals (five from each CMH) within the NorthCare Network referred and receiving medical nutritional therapy. Gogebic mailed Medical Nutritional Therapy referral letters to Primary Care Physicians for 10 (Gogebic CMH) consumers; as a result, four (Gogebic CMH) consumers are following through with medical nutrition therapy from their Primary Care Physician.
  - FY 15 regional data shows that NorthCare's goal of increasing the percentage of adults receiving nutritional therapy or counseling from their primary health care provider or dietician by 2.4% was not met; FY data shows an increase of only 1.73%.

- *QI Plan*
  - Continue to participate in the regional PIPs during FY 2016.

Record Review and Service Verification

- Quarterly record reviews were conducted with data analysis reports developed. One hundred and fifty-two (152) consumer records were reviewed for FY 15. Twenty-one (21) indicators were monitored (eight less than last fiscal year). Of the 21 indicators, 16 scored as "met" (95% or higher) for 76% compliance, a significant increase from 52% last fiscal year. Three indicators continued to be non-compliant for anywhere from 15 to 22 consecutive quarters (3 ¾ – 5 ½ years).

- CMH service verification (includes *all* services), assuring that services provided are accurately reflected in billing (services cannot be billed unless if first authorized) is conducted automatically via various Management Information Systems reports, utilizing the electronic medical record (ELMER). There are three Record Review indicators that are utilized for service verification. Fiscal year data shows 100% compliance for Indicator 2.04 (*IPOS clearly indicates services and supports including: amount, scope, and duration*); 98% compliance for Indicator 2.09 (*Frequency of FTF contacts identified in the IPOS match services received or documented why not*); and 93% for Indicator 2.10 (*IPOS is reviewed/updated per agency policy [frequency of periodic reviews occurs as noted in IPOS]*). Two indicators increased in their percentage from last fiscal year and one decreased by only two percentage points.
- A Qualitative Record Review was implemented during FY 15 whereby Supervisors conduct record reviews focused on qualitative indicators. A total of 16 records with 15 indicators each were reviewed during the fiscal year. Of the 15 indicators, 9 scored as "met" (95% or higher) for an overall fiscal year compliance score of 60%.
- NorthCare conducts annual Verification of *Medicaid* Services audits by reviewing clinical and billing documentation for the purpose of measuring the appropriate use of Medicaid dollars. For the FY 15 audit, 30 services were reviewed and the results are shown below. Gogebic submitted a Plan of Correction to NorthCare for the two indicators scoring less than 100%.

Service is Identified in IPOS	Documented Evidence Service Was Provided	Documentation Supports Service Code
30/30 = 100%	29/30 = 96.67%	28/30 = 93.33%

- Highline Service Verification: All scoring sections (as many as 108) in consumer charts where Highline services were provided were 100% compliant for the entire fiscal year.
- Education, training, and in-services for providers regarding the record review process was on-going throughout the fiscal year.

➢ *QI Plan*

- Review the current Record Review Checklist, Qualitative Record Review Checklist, and the Record Review Plan and modify as necessary for FY 16.
- Continue CMH quarterly record reviews and data analysis reports.
- Clinical and Community Services Directors to review record review data with staff and discuss ways to increase compliance for those indicators consistently non-compliant.
- Implement a process to address documentation deficiencies on performance evaluations.
- Continue record review education and training for staff.

Input from the Persons Served and the Community

- Input, suggestions, and recommendations received from the persons served, their families, guardians and the community is valued, is a vital part of service improvement, and is one of the best ways to assist the agency in improving the services that are provided. Input is received through various means, i.e., suggestion box, satisfaction surveys, grievances via Customer Services, representation on the CMH Board and various committees. There were four consumer-related suggestions received via the suggestion box; appropriate responses were developed and the suggestions and responses were posted throughout the CMH building and provided to the group homes. There were six grievances received via Customer Services and all were resolved within the required 60-day time frame. Suggestions and their responses and the grievances were also reviewed by the Consumer Advisory Council (CAC) and the QI/UM Committee; there were no patterns or trends noted.

➢ *QI Plan*

- Continue to receive, review and respond to input as appropriate.

Education *(monitored calendar year, not fiscal year)*

- Required training for staff continued to be provided and monitored. Staff also participated in various competency-based trainings relating to their specific job responsibilities.
- CMH's Training Coordinators continued to participate in the myLearningPointe User's Group meetings.
- Various CMH staff provided presentations to the CMH Board of Directors at their monthly meetings. These presentations focused on issues and topics relating to mental health and/or intellectual/developmental disabilities, and staff responsibilities; question and answer sessions followed each presentation.
- For Calendar Year 2015, CMH staff provided and/or sponsored 10 trainings in/for the community, various topics included: suicide awareness; recipient rights; integrated healthcare; anti-bullying; non-violent crisis intervention, and Mental Health First Aid Training.

➢ *QI Plan*

- Continue to utilize the regional Required Training List and assure required training is assigned. Assign additional trainings as needed and/or requested.
- Continue to monitor training via myLearningPointe and enter 'other/external' trainings that staff participate in.
- Training Coordinators to continue to participate in the myLearningPointe User's Group meetings.
- Schedule/participate in/provide community education trainings as needed and/or requested and track such trainings.

Site Surveys

- **NorthCare**: NorthCare conducted their annual site survey of this CMH on June 23, 2015. Out of the 151 applicable indicators reviewed, 131 indicators scored as "fully met", 16 indicators scored as "partially met", and four indicators scored as "not met", for an overall compliance score of 92.1% (a slight decrease from 92.75% last fiscal year). Plans of Correction (POC) were developed for indicators scoring "partially met" and "not met" and were submitted to NorthCare. The POC continues to be monitored until all plans are complete.

➢ *QI Plan*

- On-going monitoring of the Plan of Correction and prepare for FY 2016 site review.

- **CARF**: With receiving a 3-year CARF accreditation award in 2013 and in accordance with *Accreditation Conditions*, an Annual Conformance to Quality report must be submitted to CARF annually, on each anniversary of the accreditation term. The 2015 annual report was submitted to CARF in May 2015 and acknowledged by CARF that they '*recognize Gogebic's ongoing efforts to provide quality services to persons Gogebic serves*'.

  In accordance with *Step 10* of the *Steps to Accreditation*, an organization must maintain contact with CARF for various reasons. The *Ongoing Communication of Administrative Items and Significant Events* document was submitted to CARF in October 2015, specific to the topic of "*Change in Leadership*" (CEO).

➢ *QI Plan*

- Continue on-going monitoring of applicable CARF standards and assure on-going compliance.
- Provide applicable CARF standards to applicable staff to review and provide supporting documentation of compliance in preparation for the 2016 re-survey.

- In preparation for the 2016 re-survey, complete and submit the Re-Survey Application, applicable supporting documents, and required re-survey fee by the deadline established by CARF.

- **Department of Health and Human Services (DHHS)**: DHHS staff were in the Upper Peninsula from August 3 – 27, 2015, conducting site reviews throughout NorthCare Network. DHHS staff were on-site at Gogebic on August 11th to review the Children's Waiver (CWP) and the Habilitation Supports Waiver (HAB) programs. After receiving the site review reports, Gogebic developed a Plan of Correction (POC) for the CWP and submitted it directly to the State; NorthCare was responsible for submitting a regional POC for the HAB review. Some POC's from both reviews are complete and others continue to be monitored until they are complete.

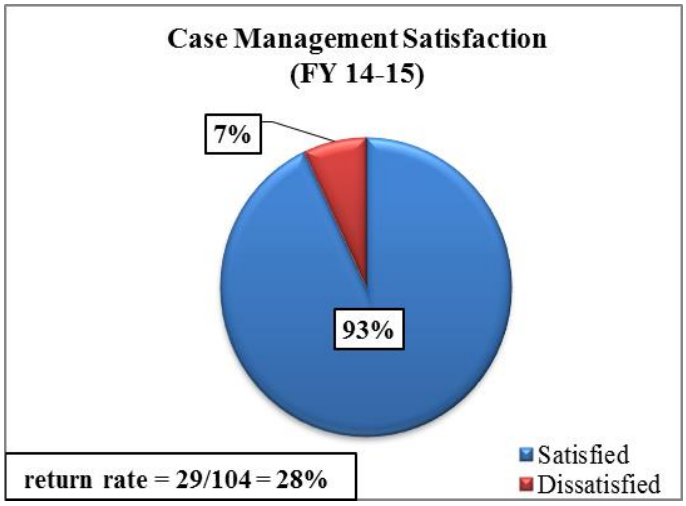
➢ *QI Plan*
- On-going monitoring of DHHS standards and plans of correction.

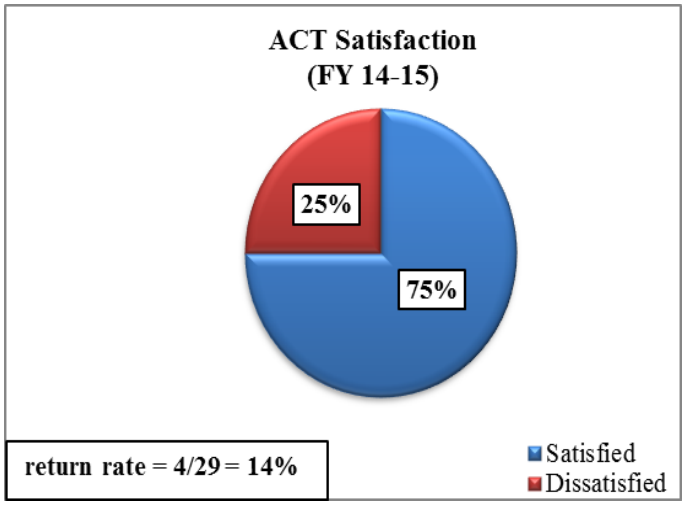
- ***Other Surveys***
  - Throughout the fiscal year, the residential group homes experienced various safety reviews, i.e., an inspection by the Fire Marshall; inspection of fire extinguishers; and inspection of smoke detectors, fire panels, and sprinklers. There were no issues with any of the safety inspections at the residential group homes.
  - NorthCare visited the Lakeview Home during their on-site review in June 2015 and DHHS also visited the Lakeview Home during their on-site Waiver review in August 2015. Two issues were noted on the DHHS report and plans of correction were implemented.

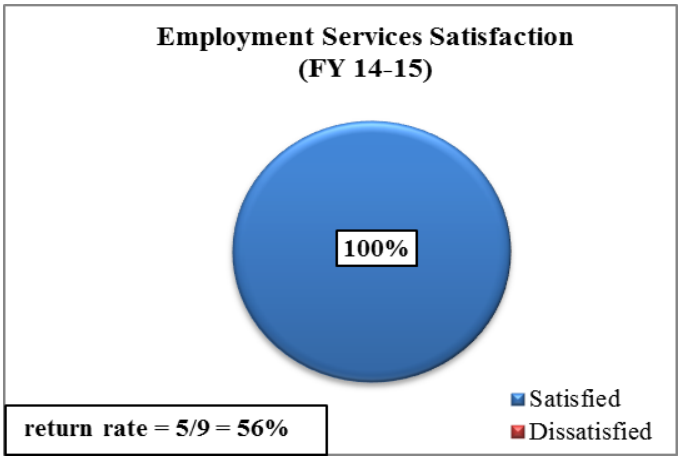
➢ *QI Plan*
- On-going monitoring of plans of correction.

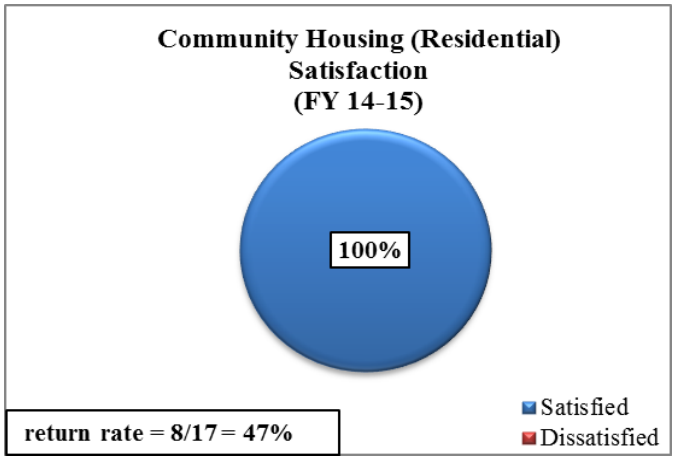
Satisfaction Survey Summary
- Satisfaction surveys were distributed monthly to consumers. Satisfaction data is reviewed by the CMH Board, the QI/UM Committee, the Consumer Advisory Council, and staff.
- The following graphs show satisfaction results for each CARF accredited program (Case Management, Assertive Community Treatment [ACT], Employment Services [Supported Employment], Community Housing [Residential], and Crisis Intervention [Emergency Services]), along with satisfaction results of programs not CARF accredited (Outpatient, Home Based, Peer Support Specialists, Serenity Center).
- For the 8th year in a row, Gogebic CMH once again participated in a State-wide satisfaction survey process of the Assertive Community Treatment (ACT) and Home Based programs. The survey was to measure satisfaction among adults and children/adolescents receiving these services. Two different survey tools were utilized, the *Mental Health Statistics Improvement Program* survey was used for adults receiving ACT services and the *Youth Satisfaction Survey for Families* survey was used for children/adolescents receiving Home Based services. Results of these surveys are not yet available.

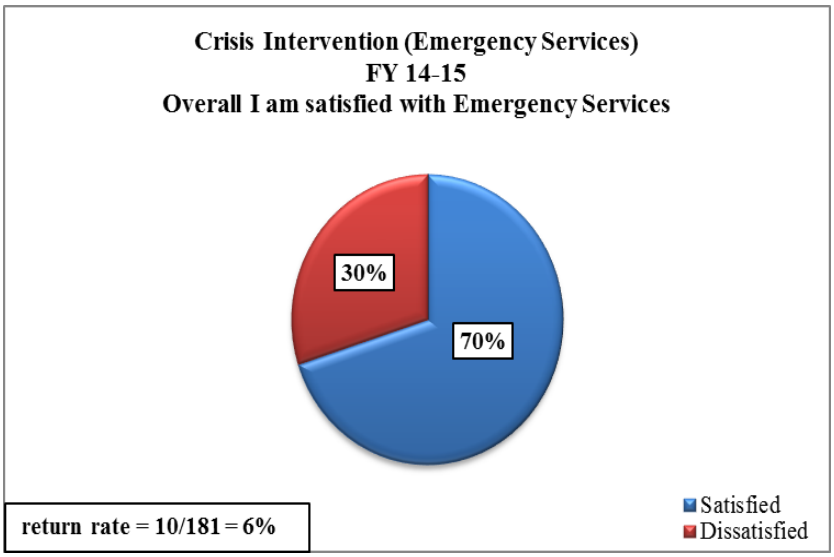
➢ *QI Plan*
- Continue to assess satisfaction with CMH services and programs.

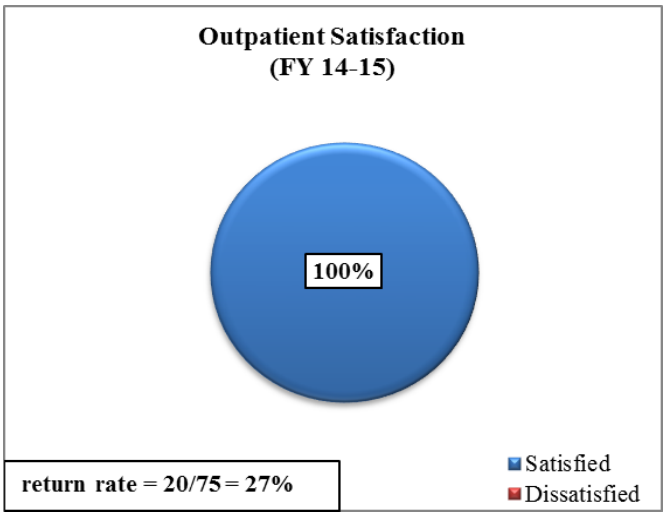

Case Management Satisfaction
(FY 14-15)
7%
93%
return rate = 29/104 = 28%
Satisfied
Dissatisfied

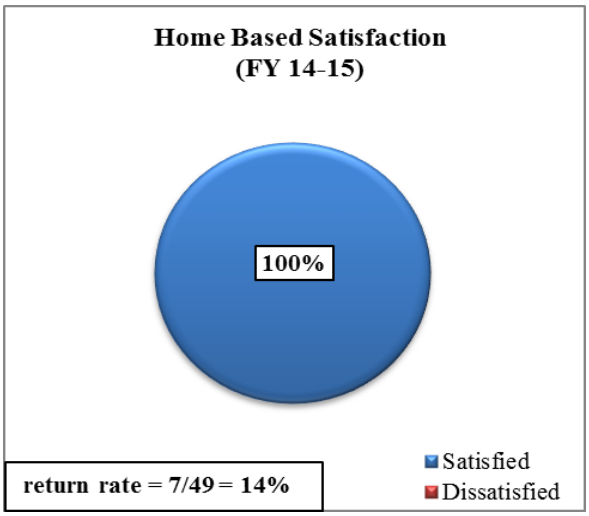

ACT Satisfaction
(FY 14-15)
25%
75%
return rate = 4/29 = 14%
Satisfied
Dissatisfied

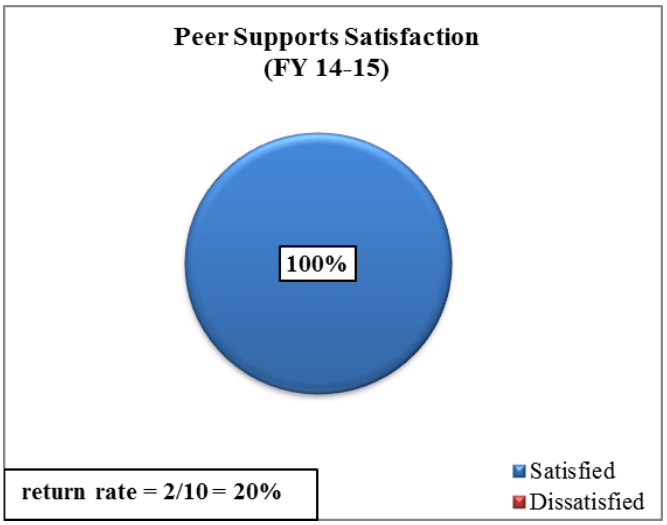

Employment Services Satisfaction
(FY 14-15)
100%
return rate = 5/9 = 56%
Satisfied
Dissatisfied

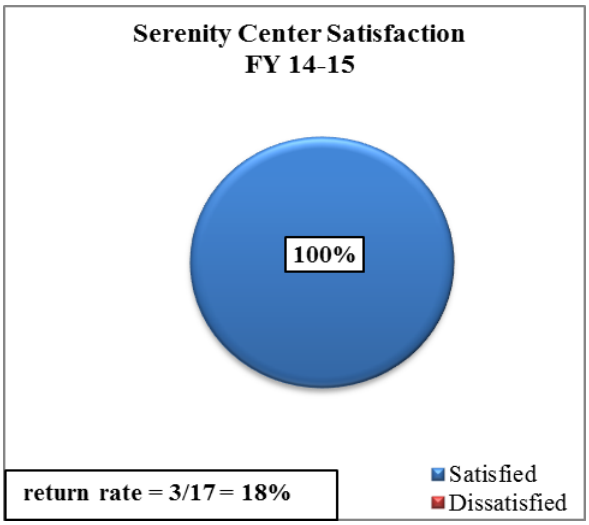

Community Housing (Residential)
Satisfaction
(FY 14-15)
100%
return rate = 8/17 = 47%
Satisfied
Dissatisfied

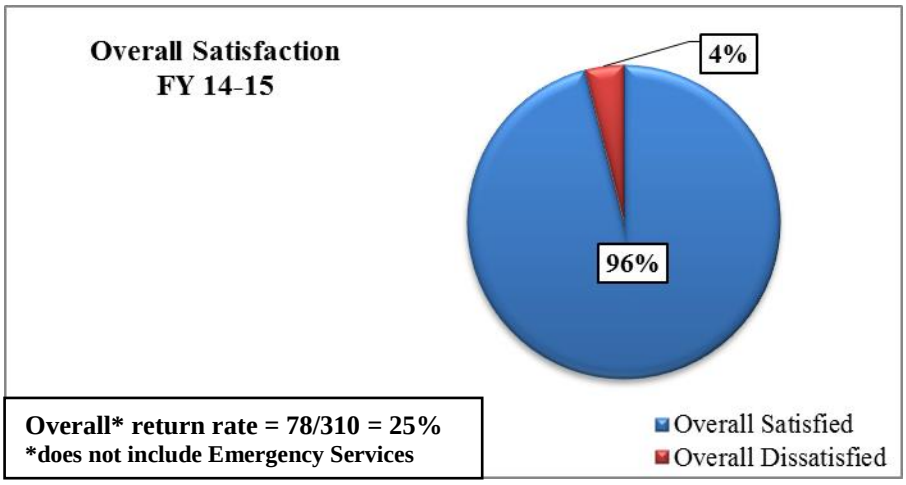

Crisis Intervention (Emergency Services)
FY 14-15
Overall I am satisfied with Emergency Services
30%
70%
return rate = 10/181 = 6%
Satisfied
Dissatisfied


Outpatient Satisfaction
(FY 14-15)
100%
return rate = 20/75 = 27%
Satisfied
Dissatisfied


Home Based Satisfaction
(FY 14-15)
100%
return rate = 7/49 = 14%
Satisfied
Dissatisfied


Peer Supports Satisfaction
(FY 14-15)
100%
return rate = 2/10 = 20%
Satisfied
Dissatisfied


Serenity Center Satisfaction
FY 14-15
100%
return rate = 3/17 = 18%
Satisfied
Dissatisfied


Overall Satisfaction
FY 14-15
4%
96%
Overall* return rate = 78/310 = 25%
*does not include Emergency Services
Overall Satisfied
Overall Dissatisfied

Consumer Comments on Satisfaction Surveys

- Wendy Krall is extremely helpful and caring. She is always there to listen and calls us to see how (name) is doing. She is a great comfort to us to have her at our IEP meetings. Someone who is on the outside. She is our angel.
- Right now we do not have any help from CMH and we need it. We need Wendy to help us and give advice on how to better deal with (name) at school. She was a huge help to us when she went to school and observed (name) and his class and gave us insight on what is going one. We need Wendy back to help us. Please.
- Backsliding. Demons are back. Am I that much less important than the illegals? I'm feeling desperate. I have MS. It is strongly recommended that I have intense therapy at least 3 times a week. Instead I've been cut way back on my therapy sessions. More therapy is recommended by MS specialists and the MS society.
- If a person doesn't have good insurance or Medicaid they are set free. I am no longer receiving services.
- I am a guardian and feel the services we receive are excellent.
- We had Wendy and then she got a new position so we have Ashley and at first I was apprehensive because (name) was doing so well. We got to know Wendy and we liked her and when they switched (name's) case worker it was a disaster but we have come to know and like Ashley just as much as Wendy. I think your staff is professional and kind. My son has non-verbal autism. I lived in Wisconsin and Wyoming and never received services that helped my son. He does well in school here and he does well in other services. Your staff is great and I am happy and relieved that finally I can see a future for him.
- Love the staff at CMH they are the best.
- I have not called the crisis line for a while, 2 or 3 years. I feel I am doing pretty good with my health and taking my meds every day.
- Our home base program with our family has been awesome and very helpful for the four of us.
- My stay at Kalamazoo was total neglect on my behalf. It was the worst time of my life. I lost 35 lbs, was getting meds stole, got bed bugs, and had to deal with a criminal staff.
- I just with these services could help others. Thank you, we are people just wanting to get better.
- Worry is interest already paid on problems that haven't even happened yet.
- Staff are considerate and kind in all areas.
- We are satisfied with (name's) care.
- Love this place.
- I wish the programs were the same.
- When I called the crisis line I was hung up on only a couple of times. Did I feel like they listened to me, they said I was drunk. Like a person with mental illness can't be in crisis if they are drinking which I hear is common for Bipolar people. I feel used and abused by the system and disrespected. I wouldn't bring my dog to you people. You are a joke. If it wasn't so important I think I should sue you for negligence and malpractice. Have a nice day.
- I was told the last time I me with ACT that they didn't provide the services I needed or requested. That psychotherapy is not done anymore and that the doctor I was promised to was not going to work there anymore. I decided not to waste my time anymore, being lied to and being a lab rat to be abused.
- I wish I could see the doctor soon. I believe that having a doctor prescribing medicines to me could be so close to me. Amy is wonderful, caring, and I believe she really cares about my needs.

- I am coping better with my symptoms of my illness since I have been seeing Amy. I have to remind myself that it is okay to ask for help and to talk to people when I need to. I am one who will just keep my problems to myself. I feel comfortable with talking to Amy about most of my problems.
- It is a great program for those who need to get back on track. They also help get you rehabilitation. I feel great with their help. I am more mature about life.
- I like everything about this program.
- I am very satisfied with the mental health services.
- Tara did a wonderful job working with "name". She never pushed her when she didn't want to speak with Tara. Also very aware of the dynamic of the case.
- Very friendly and professional. I feel comfortable and able to be me and open around the staff.
- I never feel judged or wrong for how I feel and think.
- CMH does a great job with my sister "name".
- I have been battling mental illness most of my life. It will always be a part of me. I also have many physical ailments that are on-going and which do not aid matters. I do my best.
- I am happy with the peer support services and I enjoy seeing Karl every week. He is a good friend and caring. It helps me to get out of here for a while; get out and visit.
- Thanks to the awesome Lakeshore staff for their TLC. Without their dedicated care this resident wouldn't be able to do the things he most enjoys in life. Huge thanks to Leah for coordinating his amazing team. She has a huge heart.
- I used the services of similar agencies in other states and CMH excels in all areas. I am very pleased with all that I received from it.
- I am very pleased with your team at CMH. Thank you so much.
- Your team at CMH is very cooperative. They always take our suggestions seriously and are very helpful.
- We are very grateful for the services we receive at CMH.
- Wendy Krall is super. She is very caring and supportive and always willing to listen and give advice. She is our rock when we need help. She is a calming influence on us and "name" and gives us encouragement. She is our angel.
- I love my home team support provided by CMH. Everyone is kind and supportive and that's greatly appreciated. Tara and Karin have been awesome support for us all.
- "Name" is not able to complete the above survey on his own. As his guardian, I filled it out on his behalf. "Name" cannot read or write. "Name" also cannot speak. He makes himself understand via gestures. I believe "name" has people he can count on, including myself. I also believe that the services and supports he receives from CMH are beneficial to him.
- My counselor Amy, and Brad and Karen, so far, I have spent the most time with, I trust them a lot. I am very grateful they are here for me and my son "name".
- I have friends that self-medicate to feel better mentally. I used to also. CMH has so much patience with me. I now no longer need to self-medicate to feel normal. I do, and will forever recommend CMH to all I see struggle mentally and use.
- Yes all these questions are answered 100% honestly. I am so thankful for the staff at CMH. They are such a support. I believe in myself. I live every day with more and more confidence in myself. Thank you all very much.
- I have suggested to a family member, he called the screener and how can you tell someone how you feel over the phone. I am receiving services but only through my son's insurance, very disappointed that my individual mental health has been compromised because my insurance changed. Mental Health sure wants to help only when you have insurance.

- No insurance, no mental health, wow what has this world come to?!?!
- Excellent. Staff is very professional and exemplifies thoughtful, caring people who really care about the residents that they serve.

Supported Employment Review FY 15

Supported Employment (SE) Reviews were utilized as part of the agency's Outcomes Management System Data Collection. A sampling of SE Program and Employee Reviews were distributed quarterly to contract sites and community placements.

All surveys returned (13 of 16) by employers indicated 100% satisfaction with SE services they received. Satisfaction with the individual's job performance at their place of work was 100%.

Comments on Supported Employment Reviews

- "Name" has been doing a great job for us!
- Any concerns I have had with this program have been addressed VERY timely. "Name" does a wonderful job and brings a great deal of joy to our residents. We recently increased her sessions to twice a week.
- "Name" has been here a few times now. He is familiar with his duties. We appreciate his time and help. I will continue to find work for him. "Name" listens well and does his work well.
- "Name" is always a joy to interact with when he is here.
- "Name" is very helpful and we're glad she can volunteer with us.
- "Name" is a pleasure to work with.
- Have to occasionally remind "Name" to stay at her station, but otherwise is a welcome addition to the team. "Name" seems to enjoy helping and talking with theatre patrons.
- Always very friendly and respectful.
- We love having "Name" in our classroom!! The kids look forward to Wednesdays. He is very comfortable in the classroom and does a great job!

Note: The SE Department considered all recommendations from employers and addressed them as needed.

***PLEASE NOTE**:*

This Management Summary includes just that ~ <u>summary</u> information. For more detailed reports regarding satisfaction, safety, record review, recipient rights, etc., please request through the Quality Improvement Office.