Annual Performance Report

October 1, 2015 – September 30, 2016

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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 agency's Consumer Advisory Council, the NorthCare Network Governing Board, and the NorthCare Network Member Services Committee.

FY 16 Board members included Steve Thomas, (Chairperson), George Beninghaus, (Vice Chairperson), Robert Lynn, (Secretary/Treasurer), Patricia Crabtree, Valerie Swanberg, Dan Siirila, Ken Wegmeyer, Colleen Kichak, Carrie Braspenick, Margaret Rayner, Donald Pezzetti, and Joe Bonovetz.

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, 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, Purchasing, 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 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 Community 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. The IHC chairs health and wellness related committees (i.e., Integrated Healthcare, Wellness, etc.). The IHC provides training on integrated health and health and wellness activities and assists the Serenity Center with integrated health activities, as well.
- The RRO also serves as the Contract Manager (CM); 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. The CM performs 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, hiring and discharge details, EEOC, FMLA, and ADA. The HR Coordinator also manages the agency's health insurance, workers compensation, unemployment claims, and other benefits administration, and also co-manages the agency's training program.

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-manages the agency's training program, maintenance of CARF Accreditation, liaison for external site reviews,

and Chairs the agency's Consumer Advisory Council, Quality Improvement/ Utilization Management (QI/UM) Committee, and 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.

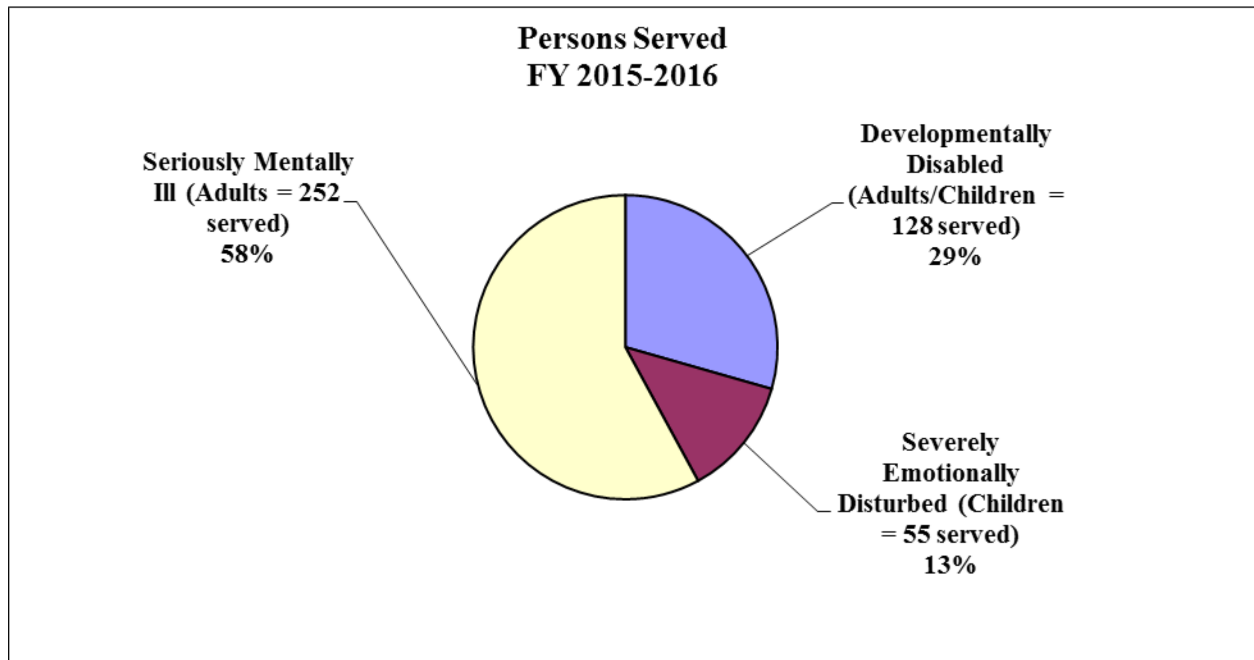
Maintenance Coordinator: The Maintenance Coordinator is responsible to perform repairs, snow shoveling/blowing/plowing, maintain buildings and grounds, coordinate agency vehicle maintenance, assist with building security and safety, and coordinate maintenance and repairs with the lessee when a leased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

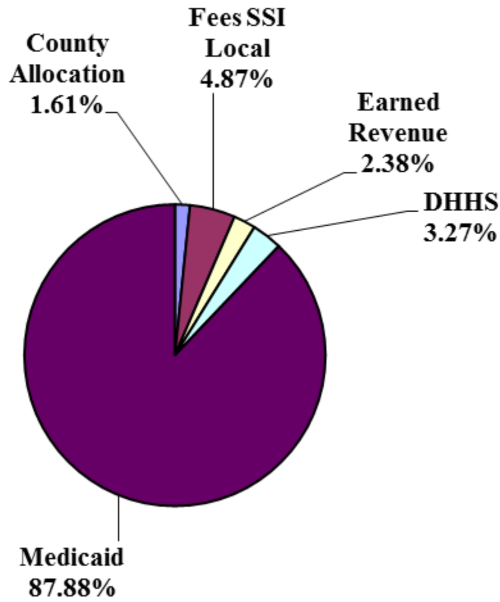
Persons Served

An unduplicated count of 435 individuals (an increase of 37 individuals seen from last fiscal year) received reportable services during FY 2016; a break down per population is shown in the graph.

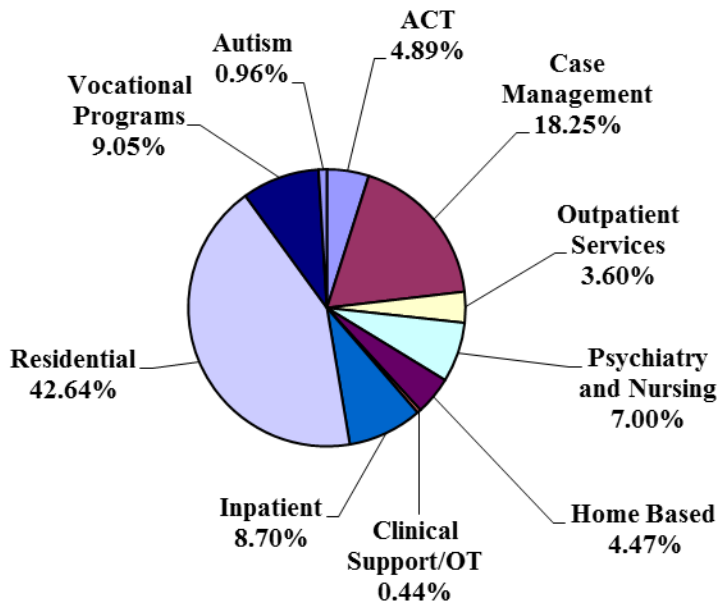


Financial Profile
FY 2016

Revenues By Source



Expenses By Program



Site Visits By Rights Office Staff

Sixteen (16) 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

- Training provided to staff: Orientation to Rights = 20; Annual Recipient Rights = 58
- Training provided to consumers: Rights of Recipients = 18
- 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 10.5 hours of training to include Behavior Treatment Plan, RRAC Training, RRAC Appeals, Responding to Unpredictable Behavior, and Plain Language.

Complaints Received

Seven allegations of complaints were received. Of the seven, one was determined ‘no right involved’, one was ‘outside provider jurisdiction’, and five were investigated. Of the five investigations, one pertained to the category of ‘Abuse Class III’; one pertained to ‘Neglect Class I’; two pertained to ‘Neglect Class III’; and one pertained to ‘Mental Health Services Suited to Condition’. Of the five that were investigated, two were substantiated.

Incidents

Four hundred eighty-five (485) incidents occurred (see table on next page), compared to 480 last fiscal year. 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). Thirty-nine (39) different consumers were involved in the various incidents, compared to 40 consumers 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	
	FY 16	FY 15		FY 16	FY 15
Lakeshore Home	127	137	Accidental non-serious injury from fall	22	15
Lakeview Home	122	124	Accidental serious injury from fall	3	0
Greenbush Home	123	81	Other behavior of recipient	48	31
CMH	3	2	Subject of aggression by other without apparent injury	60	47
Community	6	3	Physical management performed	10	21
Serenity Center	0	5	Non-serious self-inflicted injury	9	17
Highline	10	14	Non-serious injury inflicted by another recipient	9	19
Residential Placement	1	5	Non-serious aggression toward others	12	35
Total*	392	371	Verbal aggression	30	NA
			Non-serious physical aggression	3	NA
			Property destruction	39	27
			Disruptive household behavior	8	NA
			Non-serious injury of unknown origin	1	4
			Serious injury inflicted by another recipient	1	1
			Medication refusals	24	16
			Missed medication by staff	11	11
			Incorrect medication dose given by staff	1	17
			Incorrect medication given by staff	1	0
			Incorrect of time of medication administration by staff	2	2
			Falls with no injury	29	17
			Emergency medical treatment due to self-injurious behavior	0	1
			Emergency medical treatment due to injury	3	4
			Emergency medical treatment due to illness/medical condition	18	10
			Hospitalization due to illness/medical condition	4	4
			Non-urgent medical condition/illness	1	NA
			Exposure to blood/body fluids	1	1
			Other medical or health/safety issue	15	37
			Unauthorized Leave of Absence	5	13
			Accidental non-serious injury	6	2
			Inappropriate sexual behavior	8	6
			Medical/adaptive equipment problems	2	2
			Arrest of recipient	3	3
			Unexpected death	1	1
			Threat of suicide/homicide	6	NA
			Inappropriate alcohol use	0	5
			911/police called due to behavior	2	3
			Serious hostility	79	105
			Harm to others result in emergency medical treatment	0	3
			Harm to others result in physical injury	2	NA
			Employment related behavior in shelter workshop	2	NA
			Other – recipient injury	1	NA
			Other – not categorized	3	NA
unduplicated count** ***^duplicated count			Total^	485	480

Quality Assessment and Performance Improvement Program (QAPIP)

Outcomes Summary for FY 2016

(with Quality Improvement Plans for FY 2017)

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)

- The Clinical Director continued to be the agency's UM Coordinator and 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
  - 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 continued to conduct numerous disaster drills in the CMH main building throughout the fiscal year. Safety drills were also conducted at the Serenity Center; data can be found in the Safety Committee Chairperson's office. Safety drills were also conducted at all three Residential group homes; data can be found in each group home. In addition to the drills conducted, there were four "actual" events (three power outages and one gas leak) 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 Coordinator conducted building inspections at the Center; documentation is filed in the Safety Committee Chairperson's office.
- The annual "external" building inspection was completed on October 14, 2015 by a Michigan Certified Building Inspector; the inspection report noted some restrooms signage needed to be moved to comply with barrier free codes and some offices had clutter/cords on the floor that were a tripping hazard – all of which have been addressed. The inspection report also stated, "*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*".
- A Loss Prevention Consultant from York Risk Services Group, Inc. (Workman's Comp Carrier) conducted an annual loss prevention review, designed to promote and maintain a safe working environment. At the time of the review, Gogebic CMH had three workers' comp claims, an incurred cost of $3,150; this is a decrease from 2015, which had nine claims and an incurred cost of $4,640. Various risk management suggestions were provided (i.e., claims reporting tips, incident tracking, safety analysis, safety awareness training).

- Various safety trainings were conducted throughout the fiscal year (i.e., CPR and First Aid for both child and adult; various OSHA trainings; wheelchair and van lift; Violence in the Workplace; Wander Guard System, driver safety, disaster drills, 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: availability of smoking cessation packets for staff and consumers; proper use of infant car seat training provided by the Gogebic County Sheriff's Department; vaccinations for consumers; etc.
- There were 14 staff injuries (two less than last fiscal year) resulting in zero lost time, compared to 5.5 lost work days and 21 days of light duty work last fiscal year. 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, in conjunction with the QI Coordinator, 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, the agency's psychiatrist/medical director, and the agency's physician. The Committee reviews and monitors all pharmacy and therapeutic related data, such as medication incidents, and applicable policy/procedures, and conducts Peer Reviews. Infection Control meetings were held on a quarterly basis.

➢ *QI Plan*
  - Continue to monitor the Strategic Plan's safety and risk management goals and objectives.
  - Continue to monitor unusual incidents pertaining to medication, and health and safety and implement prevention and pro-active plans as needed.
  - Continue to conduct annual Peer Reviews.
  - 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 Strategic Plan 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 50% overall compliance, a decrease from 63% 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 2017.

- *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. 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 two quarters and was non-compliant for two quarters, scoring 33% in both the 1st and 3rd quarters. In the 1st quarter, there were two readmissions within 30 days of discharge (out of six discharges) and in the 3rd quarter, there was one readmission within 30 days of discharge (out of three discharges).
- *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. 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 two quarters and was non-compliant for two quarters, scoring 33% in both the 1st and 3rd quarters. In the 1st quarter, there were two readmissions within 30 days of discharge (out of six discharges) and in the 3rd quarter, there was one readmission within 30 days of discharge (out of three discharges).

➢ <u>QI Plan</u>
  - 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 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 16** (continued since FY 2013): 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.
    - FY 16 regional data: There were 44 charts that were reviewed. Overall compliance for Indicator #1 scored 77% (baseline 89%; FY 15 100%) and overall compliance for Indicator #2 scored 100% (baseline 97%; FY 15 98%).

- FY 16 Gogebic CMH data: Of the 44 charts that were reviewed, three were Gogebic CMH charts. Overall compliance for both Indicator #1 and #2 scored 100%. NorthCare provided the following positive comments regarding the charts: "*This case file is an example of fine team work and the use of a variety of service providers to meet the need of the consumer/parents. Well done.*"; "*This case has been well managed.*"; *Fine work done to engage this family and consumer in treatment and support law enforcement in their role in the consumer's life.*"

- **PIP #2 FY 16** (continued since FY 2014): 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 and FY 16 data has not yet been received from NorthCare. The NorthCare UM Coordinator has been working to revise this project.

- **PIP #3 FY 16** (continued since FY 2014): 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.
  - FY 16 data has not yet been received; however, preliminary data for the 1st three quarters in FY 16 shows a significantly statistical improvement over baseline data, showing a 3.2% increase (an increase of 23 adults, over baseline data [10], had a medical nutritional therapy service from a primary care provider).
- *QI Plan*
  - Continue to participate in the regional PIPs during FY 2017.

Record Review and Service Verification

- Quarterly record reviews were conducted with data analysis reports developed. One hundred and twenty-four (124) consumer records were reviewed for FY 16. Twenty-two (22) indicators were monitored (one more than last fiscal year). Of the 22 indicators, 20 scored as "met" (95% or higher) for 91% compliance, a significant increase from 76% last fiscal year.
- Quarterly Qualitative Record Reviews, consisting of 15 *qualitative* indicators, were also conducted by supervisors. A total of 16 records were reviewed during the fiscal year. Of the 15 indicators, 10 scored as "met" (95% or higher) for an overall fiscal year compliance score of 67%, an increase from 60% last fiscal year.
- 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), same as last fiscal year; 69% compliance for Indicator 2.09 (*Frequency of FTF contacts identified in the IPOS match services received or documented why not*), a decrease from 98% last fiscal year; and 97% for Indicator 2.10 (*IPOS is reviewed/updated per agency policy [frequency of periodic reviews occurs as noted in IPOS]*), an increase from 93% last fiscal year.

- 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 16 audit, 30 services and 31 claims were reviewed; the results are shown below. Gogebic submitted a Plan of Correction to NorthCare for the three indicators scoring less than 100%.
    - ➢ Service Activity Logs
        - Beneficiary is eligible on the date of service: 100%
        - Service is include in the IPOS: 100%
        - Documented of service agrees with claim date: 96.7%
        - Service was provided by a qualified practitioner: 100%
        - Service falls within the scope of the code billed/paid: 96.6%
    - ➢ Claims
        - Beneficiary is eligible on the date of service: 100%
        - Service is include in the IPOS: 100%
        - Documented of service agrees with claim date: 100%
        - Service was provided by a qualified practitioner: 100%
        - Service falls within the scope of the code billed/paid: 96.8%
- Highline Service Verification: For FY 16, there were 12 charts reviewed with a total of 432 sections scored; overall compliance for the fiscal year was 99%.
- Education, training, and in-services for providers regarding the record review process were 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 17.
- Continue CMH quarterly record reviews and qualitative reviews and develop data analysis reports with recommendations to increase compliance, as applicable.
- Clinical and Community Services Directors to review record review data with staff to assure on-going compliance.
- 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, and representation on the CMH Board and various committees. There was one consumer-related suggestion received via the suggestion box which the Clinical Director discussed with appropriate clinical staff; the individual who submitted the suggestion was then contacted with resolution to their suggestion. There were eight grievances received via Customer Services (two more than last fiscal year) and all were resolved within the required 60-day time frame. Suggestions and 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

- Required training for staff continued to be assigned, 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, as applicable.
- 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 2016, CMH staff provided and/or sponsored 17 trainings in/for the community, various topics included: suicide prevention; trauma; Culture of Gentleness; non-violent crisis intervention; and Mental Health First Aid Training.

➢ *QI Plan*
  - Continue to utilize NorthCare's 'Training Expectations by Staff Category' grid 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/sponsor 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 14, 2016. Out of the 155 applicable indicators reviewed, 139 indicators scored as "met", 13 scored as "partially met", and three scored as "not met", for an overall compliance score of 94% (a slight increase from 92.1% 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 on a quarterly basis until all plans are complete.

➢ *QI Plan*
  - On-going monitoring of the Plan of Correction and prepare for FY 2017 site review.

- **CARF**: CARF was on-site to conduct the accreditation re-survey April 4 – 5, 2016. The site review went very well with the agency receiving only five written recommendations and receiving another 3-year accreditation award. The POC was submitted to CARF and continues to be monitored on a quarterly basis until all plans are complete.

➢ *QI Plan*
  - Continue on-going monitoring of the POC and applicable CARF standards to assure on-going compliance.

- ***Other Surveys***
  - Throughout the fiscal year, the residential group homes experienced various safety reviews (i.e., Fire Marshall, fire extinguishers, smoke detectors, fire panels, sprinklers, etc.). Any deficiencies were corrected promptly.
  - Lakeview and Greenbush group homes both experienced a State Licensing renewal inspection in March and Lakeshore experienced same in May. All three homes were in compliance with all applicable rules and statutes and the Licensing Consultant recommended issuance of a regular license to all group homes.

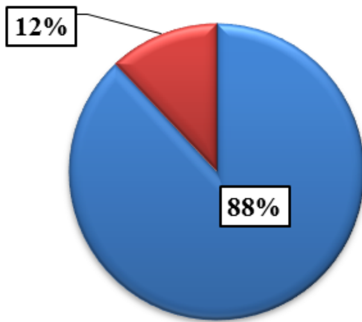
- *QI Plan*
  - Assure on-going compliance with applicable standards and indicators pertaining to the licensed residential group homes.

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 9th 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 measures 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 the 2015 State-wide satisfaction survey were recently received; *regional* data for the ACT program scored lower than the State-wide PIHP averages for all seven domains that were scored and regional data for the Home-Based program were comparable in score to the State-wide PIHP averages for all six domains that were scored. Gogebic CMH also scored lower that the State-wide CMH averages for all seven domains scored for the ACT program and scored above five of the six domains scored for the Home-based program. FY 16 data is not yet available.

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

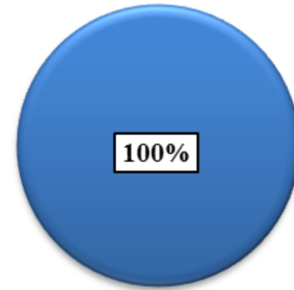
Case Management Satisfaction
(FY 15-16)



Satisfied
Dissatisfied

return rate = 26/107 = 24%

ACT Satisfaction
(FY 15-16)



Satisfied
Dissatisfied

return rate = 1/24 = 4%

Employment Services Satisfaction
(FY 15-16)

Satisfied
Dissatisfied

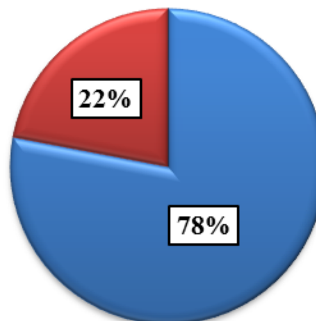
return rate = 4/12 = 33%

Community Housing (Residential)
Satisfaction
(FY 15-16)

Satisfied
Dissatisfied

return rate = 12/21 = 57%

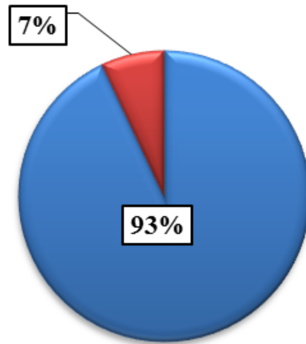
Crisis Intervention (Emergency Services)
FY 15-16
Overall I am satisfied with Emergency Services



Satisfied
Dissatisfied

return rate = 18/192 = 9%

Outpatient Satisfaction
(FY 15-16)



■ Satisfied
■ Dissatisfied

return rate = 16/82 = 19.5%

Home Based Satisfaction
(FY 15-16)

■ Satisfied
■ Dissatisfied

return rate = 5/54 = 9%

Peer Supports Satisfaction
(FY 15-16)

■ Satisfied
■ Dissatisfied

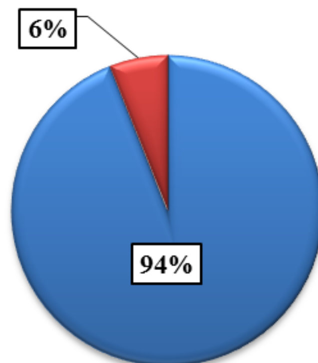
return rate = 2/12 = 17%

Serenity Center Satisfaction
FY 15-16

■ Satisfied
■ Dissatisfied

return rate = 3/18 = 17%

Overall Satisfaction
FY 15-16



■ Overall Satisfied
■ Overall Dissatisfied

Consumer Comments on Satisfaction Surveys

- Would not recommend employment services.
- I don't know what I would have done without all your help. I am thankful for all you have done for my son.
- I am a guardian for someone. Services have been excellent.
- Dr. Burrows is very patient and understanding. She takes the time to listen to your concerns. She is great with *name* and he has become more and more comfortable with her. We are very happy with the care *name* is getting.
- Maybe offer some sort of text based alternative to the crisis line. I have never used it but I imagine people who live with others would get more out of it if they weren't required to speak out loud. CMH did in fact help me recover, but it may not be applicable as there is not any active service happening for me.
- I've called the crisis line and no one answered. Maybe you could look into having a worker available when a parent is having extreme behaviors and we need help. I don't like calling the police department when I'm in serious need.
- I just wish to be a good person and be respected. I count on myself and countless other people.
- Staff and caseworkers are professional and still very caring. These people are a credit to the community.
- Mental Health has helped me very much.
- I am very pleased with all the help I have received from the individuals who work with me. I am also very pleased with the doctor who has replaced Dr. Cools.
- As a guardian I believe he has people he can count on. I also believe that the services and supports he receives from CMH are beneficial to him.
- Very poor communication and was not happy with the services for my 3.5 year old son.
- CMH is very helpful to me and my grandson. Keep up the good work.
- CMH is very good treatment.
- CMH people do a wonderful job.
- Janet DiGiorgio is a fantastic, organized case worker. She is always so helpful.
- Overall I think my brother is satisfied with his support services.
- Stacey at the front desk is wonderful. She always makes me feel like I am important no matter what I say or ask.
- Fantastic.
- I'm having good results.
- I like it here.
- When I was there everyone made me feel welcomed and the Doctors helped me until I moved.
- I was treated well and then I had to move to Minnesota, but things are not any better here than in Michigan but going to try my best.
- Need more transportation for my appointments, I don't have much money or driver's license.
- I was not happy with previous case manager when I was receiving services there. It didn't seem like he had enough time for me and he was very busy. I would like to receive services again.

Supported Employment Review

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 (11 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 going above and beyond to cover shifts, which is greatly appreciated! There have been times when it's slow that we've had to remind her to find things to do, but all in all doing well.
* I've been pleased with this program so far. It is nice to have "ETS" come in every now and then to check in on "Name".
* "Name" is fun to work with.
* "Name" works better with "ETS" present.
* "ETS" is on the spot anytime we have concerns. "ETS" works with us and coaches "Name" on what is needed.
* "Name" continues to do well with our residents and staff.

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

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